Oregon Nurses Association
Voice of Oregon Nurses Since 1904

February 28, 2023

To: House Committee on Behavioral Health and Health Care
From: Matt Calzia, BSN, RN, Oregon Nurses Association
Re: In Support of House Bill 2697

Chair Nosse, Co-chairs Goodwin and Nelson, esteemed members of the committee:

My name is Matt Calzia and I have been an RN in Oregon for almost 12 years. I am the director of Nursing Practice and Professional Development for the Oregon Nurses Association. I also practice in a catheterization lab at a level II trauma center and prior to that I worked in intensive care and rapid response.

Today you are hearing directly from the professionals who have been voted the most ethical and trustworthy professionals for the more than 20 consecutive years. Trust them and honor them by passing HB 2697.

Rather than tell you my stories, I want to set some of the record straight after yesterday's testimony by the Oregon Association of Hospitals and Health Systems and healthcare executives:

You heard an assertion that there aren't enough nurses, and we can't recruit. Consider the testimony you are hearing today: this may be difficult for some people to understand, but hospitals can't simply pay people more to endure terrible working conditions. Nurses are choosing not to work in hospitals no matter how much money because the working conditions are terrible. And it's getting worse: earlier this month at an Oregon Center for Nursing Friday huddle, where nurse managers from across the state gather to discuss the challenges they face, they complained that new graduate nurses are not applying for jobs in the medical surgical units, which is historically where new grads start careers. The reason is not complicated: after doing their clinical rotations and experiencing the working conditions, they are choosing not to apply to these units. HB 2697 mandates reasonable staffing levels that will fix this problem.

It is not true that we do not have enough nurses, in fact Oregon has more nurses per capita than CA. In 2017 we had about 58,000 RN licenses and this morning we have 80,803. It is not a lack of nurses, it is a lack of nurses willing to accept these conditions, despite having some of the best pay in the country.

According to a widely accepted study by Nursing Solutions Inc. (NSI) , the national average turnover rate for nursing is 27.1% and it was worse in specialty areas like ICU (27.5%), ED (29.7%), telemetry and step down (30.2%). I have a nursing degree, not a business degree, but even I know it is bad business to replace nearly your entire workforce every three years and an immediate intervention is needed. Hospitals are failing to retain the nurses they have and can't recruit because they are not addressing the core issue of staffing. Every shift we are set up to fail and HB 2697 creates regulations that will force hospitals to address the problem.

It has been stated that there is no evidence that setting patient to nurse ratios improve working conditions, workforce stability, or patient outcomes. This is simply not true, and I beg you to not take the demonstrably false assertions of hospital lobbyists and executives at face value:

- A 2022 study found that during the great recession in 2008, nurse staffing in California stayed stable while in all other states it was reduced. Hospitals target profitability and cut the nursing workforce, at the expense of the communities they serve. Passing HB 2697 will ensure the nursing workforce in Oregon is stable.
- Another 2022 study found that hospitals with better staffing before the pandemic did better during the pandemic and that authors concluded that policy makers should establish "minimum hospital patient to nurse ratios."
- A 2015 study compared California to the other 49 states and concluded the implementation of a ratio law led to 31.6 fewer occupational injuries and illnesses among RNs.
- A 2013 study found that after California's regulation went into effect, patient outcomes improved in hospitals that previously had lower staffing. This is critical: hospitals that were forced to staff better by the California law began having better patient outcomes after complying with the law. It is also important to note these hospitals served the most marginalized communities in the state: staffing ratios reduce healthcare disparities.
- Queensland, Australia implemented patient to nurse ratios and a study published in The Lancet found that after the policy was implemented nurse staffing increased and patient mortality and patient length of stay decreased significantly.
- A 2022 Study in BMJ Quality and Safety looked at nearly 67,000 in-patient hospital admissions and 4,498 nurses in 53 different acute care units and found that adding 1 experienced RN per shift reduced the odds of a patient death that day by 9.6%. In this study the mean number of RNs on a ward was 12 for an average of 20.6 patients. The authors of an editorial about that study made a statement that rebuts everything you heard from the testimony by the hospital association on Feb 27, 2023:

  > *"The risk of adverse patient outcomes, including death, is lower in hospitals that provide more registered nurses to care for patients on inpatient wards. The association has been demonstrated in a body of evidence comprising several hundred studies, involving hundreds of hospitals and millions of patients from around the world. The association has been shown at hospital level in large cross-sectional studies and in a growing number of longitudinal studies examining the effect of variation in staffing experienced by individuals. In the context of such an extensive body of evidence, one might ask what could possibly be left to discover?"*

What could possibly be left to discover? There is an abundance of research that consistently comes to the same conclusion: when there are more nurses taking care of patients, the communities being served benefit.

In contrast to the large body of literature demonstrating HB 2697 will improve healthcare for Oregonians, hospitals cannot produce any compelling evidence showing that the legislation will cause harm to patients. There is no evidence to suggest this occurred in California or that this will occur in Oregon.

Failing to pass HB 2697 will ensure things will continue to get worse.

There is an assertion that HB 2697 is more restrictive than California and does not allow hospitals to use LPNs in place of RNs. California's patient to nurse ratios were last updated in 2008 and since then the landscape of hospital care has changed profoundly. We were not overburdened with the electronic

medical record in 2008 and patients are much sicker and are more often treated with advanced technologies and medications such as ECMO, CRRT, and rapidly evolving chemotherapy agents. This all requires more work for RNs and other healthcare workers.

The failure of Oregon to provide adequate mental health resources, in combination with the methamphetamine and opioid epidemic, is the reason we propose that in-patient psychiatric RNs take just one less patient than California mandates. RNs in psychiatric units are the ones burdened with these societal failures and this legislature, and our society, should be more than willing to put into law limits on how many patients they can be assigned.

It is unrealistic to think the LPN workforce is a solution to the problems with hospital nurse staffing. The reality is there are only 6,112 LPN licenses in Oregon today. In 2017 there were 5,156; in the timeframe RN licenses grew by more than 20,000, LPN licenses only grew by 1,000. According to the OSBN's current numbers we have 17 fewer LPNs licensed today than we had on September 20th of last year.

If hospitals start to draw from this very small pool of LPNs, they will be taking them from long term care and skilled nursing – the very places hospitals complain they can't discharge patients to. They will literally make the throughput problems worse. Furthermore, hospitals moved away from LPNs in acute care decades ago because of clear evidence that patient outcomes are better when hospitals staff mostly with RNs.

The ratios in HB 2697 are realistic and based on the realities of the bedside right now, not 15 years ago.

Opponents say that HB 2697 is a "one size fits all blunt instrument" that removes nurse autonomy in making staffing decisions. HB 2697 is not one size fits all – the minimum staffing standards are different for different units and patient classifications. These minimum staffing levels establish a baseline that is already the standard in the best hospitals. Nurse staffing committees will collaboratively build upon these baselines to meet the specific needs of their communities and individual units. The staffing committees must create plans to adhere to the minimum standards and account for details such as patient acuity and nurse competency.

The reality is hospitals are using a one size fits all method for nurse staffing right now. Nurse executives' staff by targeting staffing levels that are near the 50th percentile of comparator hospitals using a metric called Nursing Hours Per Patient Day (HPPD). Yesterday they spoke of aspirations to implement innovative care models, but the fact remains that front line nurse managers are held accountable to staffing within the target HPPD and any potential innovation is dismissed if it may go over that target. That is the reality of how it works today, and hospital executives are heavily invested in ensuring they can perpetuate this one size fits all model.

To claim that executives give charge nurses the resources and authority to meet the needs of their unit is simply not true. Charge nurses are provided insufficient resources shift after shift. The burnout you hear about, the high turnover that is occurring, is because of the status quo the hospitals are so desperate to maintain.

Some have claimed that HB 2697 will make the boarding of patients in EDs even worse than it is now.

This is an oversimplification of the problem. Hospital executives have made, and continue to make, very calculated decisions that result in the throughput issues in our EDs. An editorial in the New England

Journal of Medicine (NEJM) articulated this problem in 2021, explaining that the decision to keep patients boarding in the ED is calculated, intentional, and financial. We hear the hospital executives speak of "innovative care models" yet there is no innovation applied to this chronic problem that has persisted for years.

It is also a weak argument that hospitals cannot understand and plan for the volume of patients that will need emergency care. We witnessed the power of technology and predictive analytics throughout the pandemic. Experts at OHA and OHSU were able to predict with amazing accuracy when, where, and how patients would present to the hospitals. With historical data, technology, and this level of expertise, every hospital in the state can predict with reasonable accuracy how many patients will seek emergency services, what procedural services are needed, and the workforce they will need to meet that demand. It is simply a matter of willingness to invest in that work and act upon the results.

HB 2697 will compel executives to engage in innovations to meet the needs of all patients, those who need procedures and those who need to be admitted from the ED, rather than prioritizing one over the other. This may require innovations in how procedures are scheduled and how health care systems can do better to invest in preventative health care and community initiatives that will keep people out of hospitals.

Instead of innovation, we see cutbacks, like PeaceHealth's decision to close the urgent care near the busiest ED in the region on the day before Thanksgiving and on the cusp of the respiratory virus influx that overwhelmed hospitals last year. This is just one example of the intentional decisions healthcare executives consistently make that decrease access to care and send patients to an already overburdened ED. We should not fear legislating better working conditions for nurses, we should fear the lack of oversight Oregonians have over the healthcare resources we all depend on.

If policymakers allow hospitals to continue placing the burden of the broken system on their existing nurse workforce, there will not be motivation to change the current practices and conditions will continue to deteriorate.

Fears have been expressed that if HB 2697 were law, hospitals will not be able respond to disasters or influxes in patients.

The reality is Oregon's hospitals are not prepared to respond to a disaster now. Few, if any, are prepared for a mass casualty event or an infectious disease outbreak. The system is broken, as the hospital executives pointed out in their testimony. They did not mention they have been the ones running the largest part of the system, and because they bear a great deal of responsibility for the current state of the system.

Yesterday there were assertions made that HB 2697 will result in nurses refusing to care for patients in the event of a mass casualty event or other disaster. Nurses are the most trusted professionals for a reason and it is not reasonable to suggest safe staffing legislation will result in the profession losing its moral fortitude. Some hospitals exploit this dedication to patients and communities by frequently presenting nurses with moral dilemmas, telling them "if you don't stay late, the patient will suffer. If you don't take an extra patient, your community will suffer." This leads to moral injury, burnout, and a 27% national average nurse turnover rate. This legislature needs to pass HB 2697 to disrupt a broken system and a status quo that hospitals are trying to keep in place.

It saddens me that individuals yesterday weaponized our demands for decent and safe working conditions by implying nurses will stand by and watch their community members suffer because a ratio may be broken – that will never happen. When events occur and nurses must deviate from established standards of care it is reasonable that they, and the communities they serve, can expect a review of the event with full transparency and thorough investigations to determine the root causes. This is the process healthcare needs to prevent future unsafe staffing situations. This is not too much to demand.

I hope you all will consider the record of those in charge of the hospital system: in 2008 during the H1N1 outbreak that overwhelmed our hospitals there was a national shortage of N95 respirators. Hospitals were not held accountable, there was not a root cause analysis done, and there were no regulations put in place to prevent this from occurring again. Just over a decade later COVID-19 brought a global pandemic and another N95 shortage, and many healthcare workers died because of that. Please reflect on this when somebody suggests nurses and other healthcare workers won't show up because there is a law mandating safe staffing standards.

Now we have a shortage of nurses willing to work in hospitals and there is no root cause analysis being conducted or any attempts at establishing accountability. Unless policymakers take action to compel executives to create better work environments – and that ultimately comes down to staffing–our healthcare system won't be prepared for the next emergency. It is rational to fear for our healthcare system, but the genesis of this fear is allowing the same mistakes to be made.

HB 2697 is rational legislation that will help fix the healthcare system at the bedside. Please pass this legislation so we can begin developing the high quality, robust healthcare system all Oregonians deserve.

Sincerely,

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Director of Practice and Professional Development
Oregon Nurses Association