Oregon Association of Hospitals and Health Systems

Report on Hospital Nurse Staffing Committees During the COVID-19 Pandemic

Hospitals around the state appreciate the work our nurses, direct care staff and physicians do every day to keep our communities safe and our doors open 24/7/365. Without them, hospitals would not exist. It is critically important that hospitals value their staff's input in how to make their work lives better. We respect the testimony provided by individual nurses on February 23 and listened intently to their stories. We feel compelled to share additional information on what hospitals have done to support caregivers, especially as it relates to nurse staffing.

Just as every community was impacted differently by COVID, wildfires and ice storms, so was every hospital's response to the needs of their staff and their patients differed. The beauty of the current staffing law is that it allows for hospitals nurse staffing committees to meet at the call of either co-chair (direct care or manager). These staffing committees seat an equal number of direct care nurses and nurse managers; and as of 2015, a non-RN direct care staff is part of each committee. When nursing staff is represented by organized labor, that bargaining unit selects its unit representation to the committee – selected by their peers. HB 3016 would create a timeline under which staffing committees would be required to meet during a state of emergency. This timeline is not flexible. OAHHS and its members believe the current law allows for the greatest flexibility.

When COVID-19 appeared in Oregon, hospitals and their care teams responded. Under the Governor's declared state of emergency and executive orders OHA suspended rules allowing hospital staffing committees and staffing plans to be put in abeyance. OAHHS surveyed its members to better understand what transpired within their staffing committees and staffing plans. 100% of Oregon's hospitals responded to our survey.

83% of Oregon's acute care hospitals did NOT deviate from their staffing plans

Smaller, rural hospitals that have fewer nurses deviated from their staffing plans more often than larger hospitals. Hospitals that deviated reported the following reasons:

- Minimal staffing (over staffed based on patient numbers)
- Approved deviation by their HNSC or nurses
- Shift deviations because of sick or FMLA

90% of hospitals have been operating under their committee approved nurse staffing plans

OHA suspended its process of approving hospital staffing plans as a result of COVID-19. Hospitals have been operating under their committee approved nurse staffing plans even though OHA has not been able to complete its revisits of hospitals nurse staffing survey. HB 3016 does nothing to improve the approval process.

Hospital Nurse Staffing Committees met 50% more than state law required them to meet during the pandemic

The survey also showed that hospitals struggled to get quorum for their staffing committees to meet but that they met more than the state law requires. Hospitals are required to meet every three months and the majority of hospitals meet more often than required. By June, all staffing committees were able to resume a regular meeting cadence. Hospital nurse staffing committees discussed and planned for surges and minimal staffing. Hospitals also augmented and increased their communication to staff throughout the pandemic including:

- Direct communication or via email in the moment with the house supervisor or unit manager/supervisor.
- Unit based huddles, unit-based practice councils, staff meetings, PPE Safety Committee, and other hospital specific committees.
- Compliance hotline where concerns can be voiced either identifying the person voicing the concern or anonymously, employee access to Human Resources and/or Labor representative from appropriate bargaining units.

Hospitals have done even more to listen to staff during the pandemic, voluntarily and in partnership with workers

Early in the pandemic hospitals heard from nurses, physicians, and other critical hospital staff about their hospital's personal protective equipment (PPE) supplies. Hospitals recognized that a simple communication across a hospital's workforce was not enough as employees cried out for more information about their hospital's response to COVID including PPE, staffing and safety measures.

Early in the pandemic, a workgroup that included representatives of hospital frontline and non-direct care staff (ONA, SEIU and the Oregon chapter of the American College of Emergency Physicians) and associations (OAHHS, OMA, the Oregon Dental Association, and the ASC association) came together to address the issue of elective surgeries and PPE safety. Their recommendations resulted in all Oregon hospitals successfully implementing PPE Safety Committees comprised of equal parts administration/facility leadership and front line and non-direct care staff. The responsibilities of these committees, but not limited to:

- Reviewing and concurring with facilities' attestations that they are able to meet PPE requirements in order to perform elective and non-emergency procedures;
- Reviewing and providing input on facility policies on extended use, limited re-use of PPE and re-processing of PPE;
- Reviewing information on PPE supply chain information and activities;
- Reviewing and providing input on facility mask fit testing process and schedule;
- Providing input about employee education regarding PPE safety practices (e.g., donning and doffing, etc.);
- Making recommendations to hospital leadership related to PPE and safety, including advice on PPE-related policies and procedures;
- Reviewing and providing input on the facility's chain of resolution for complaints related to PPE safety.

This work within hospitals, including additional, clearly defined reporting of PPE to the Oregon Health Authority, has achieved the goals set out by the workgroup of:

- Supporting trust and transparency around PPE data and decision making;
- Addressing accountability mechanisms; and
- Promoting and supporting distribution of PPE across the state.

These committees are still in effect in all hospitals. In addition, OAHHS expressed its sincerity in this approach with ONA by offering to help if there were issues at hospitals. Our ask was to notify OAHHS and allow for us to address the issues with hospitals. ONA came to us on two occasions and we were able to quickly address concerns. The two organizations also implemented a monthly check-in regarding these committees during which no issues have been raised.

HB 3016 does not provide the same or greater flexibility that the current law provides

Current law allows either co-chair to call a hospital nurse staffing committee, meeting at any time, providing hospital nurse staffing committees the most flexibility. This can be applied in any state of emergency, not just a pandemic. HB 3016 does not provide the same or greater flexibility that the current law provides, we ask that you consider the impacts of putting this language into law will have on a hospital's nurse staffing committees ability to work together in a timely and responsive manner to any state or national state of emergency. As this will further add to the heavily administratively burdensome process that OHA and the NSAB are trying to remedy.

We hope this gives legislators a better sense of what is happening within our hospitals and health systems to support employees and to give them a place to provide input and for communication to flow. We recognize hindsight is 20/20 and that there will always be opportunities for improvement. Hospitals are proud of the contributions their employees have made to respond to the COVID-19 pandemic, wildfires and ice storms. Hospitals also believe that the majority of their employees are satisfied with the way their employer has responded to their requests and concerns and feel genuinely supported. Current law provides the flexibility that is needed to respond to short and long-term emergencies.

For More information, please contact:

Andi Easton
Vice President of Government Affairs
Oregon Association of Hospitals & Health Systems
aeaston@oahhs.org

OAHHS Hospital Nurse Staffing Survey

TYPE OF HOSPITAL	Response Rate	Approved NSP prior to the pandemic?	Suspended HNSC meetings	Deviate from your staffing plans
12 Type A Hospitals (with 50 or fewer beds, more than 30 miles from another hospital)	12 responses (100%)	11 approved (92%), 1 in process,	10 did not suspend (83%), 1 still met quarterly	9 did not deviate (75%), 2 did deviate with approval from HNSC (17%)
21 Type B Hospitals (with 50 or fewer beds, within 30 miles of another hospital)	21 responses (100%)	18 approved (86%), 3 not approved	15 did not suspend (71%), 3 still met quarterly, 2 suspended due to lack of quorum	19 did not deviate (89%)
26 DRG Hospitals (Large urban hospitals that receive Medicare DRG-based reimbursement)	26 responses (100%)	24 approved (92%), 1 not approved, 1 missing	14 did not suspend (54%), 6 still met quarterly, 3 suspended due to lack of quorum	21 did not deviate (81%), 5 deviated with minimal census and approved surge plan
59 Total Hospitals*	**59 responses (100%)**	**53 approved (90%)**	**39 did not suspend (66%)**	**49 did not deviate (83%)**

TYPE OF HOSPITAL	Staffing Committee Size	Number of Units Represented	Non-RN Is Mostly	Average meetings in 2020
12 Type A Hospitals (with 50 or fewer beds, more than 30 miles from another hospital)	4 -22 (average of 10 members)	1-6 units (average is 4)	LPNs or CNAs	8 meetings
21 Type B Hospitals (with 50 or fewer beds, within 30 miles of another hospital)	6-21 members (average of 14 members)	1-9 units (average is 5)	CNAs	8 meetings
26 DRG Hospitals (Large urban hospitals that receive Medicare DRG-based reimbursement)	13-64 members (average of 27 members)	8-55 units (average is 17)	CNAs or Techs	9 meetings

*Totals exclude Cedar Hills, Vibra and Shriners Children Hospital