St. Charles
PRINEVILLE

February 28, 2023

Oregon Legislative Assembly
2023 Regular Session
900 Court Street NW
Salem, OR 97301

Re: House Bill 2697 - Hospital Staffing Plans

To the Honorable Representatives Nosse and Nelson, Senators Manning Jr., Patterson and Campos:

As manager of a Critical Access Hospital (CAH) Emergency Department (ED) in Oregon I am troubled by the proposed measures in HB 2697. The impact of the proposed ratios on our ability to serve our rural community with our challenges to fill current open positions with experienced staff and the enforcement measures contained in the bill are concerning.

In hospital EDs with mandatory ratios, waiting times have increased, and in some cases EDs were placed on divert (CA Healthcare Foundation, 2009). Full waiting rooms aren't serving the patient's health needs. In the city of Prineville and in Crook County we have no ability to "go on divert." Even if we had the ability to "divert" we'd be sending our local fire / emergency medical service thirty plus miles away from Prineville, leaving the Ambulance Service Area (ASA) with reduced emergency response.

Nurse-to-patient ratios don't account for the patient's acuity. Today we assign staff including nurses and resources using a researched and time-tested patient acuity tool developed by the Emergency Nurses Association (ENA) and the Agency for Healthcare Research and Quality (AHRQ) at the U.S. Department of Health and Human Services (ena.org/docs/default-source/education-document-library/triage/esi-implementation-handbook-2020). The Emergency Severity Index (ESI) is a five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. The ESI developed by the ENA and AHRQ assures we are providing the right resources, at the right time for the patient based on tangible physiologic criteria. In a 2012 study of Emergency Departments, 82% use the ESI and are highly satisfied that it is an accurate and simple to use tool to triage and assign resources to an emergency patient. I suspect that in 2023 the number of EDs utilizing this tool is much higher. There is no "typical day" in a rural CAH ED however, let me describe just one day, February 21, 2023, and how patient acuity affected nurse staffing. The day began at 12 midnight with a surgical patient (ESI Level III – urgent) boarding in the ED awaiting transfer for surgical services at another facility. At the same time, we were boarding a critical cardiac patient (ESI Level II – emergent) who was awaiting an open intensive care bed also at a distant facility. At 7 a.m. we experienced a surge of emergency patients that lasted 8 hours. Due to the size of our ED and the rural area we serve, we have a limited number of beds and nurse staff to serve patients. Of the 23 patients that sought care, one was an ESI

Level 1 (immediate), 8 were ESI Level 2 (emergent), 9 Level 3s (urgent), one Level 4 (less urgent) and four Level 5 (non-urgent). Please note that low acuity patients were triaged back to the waiting room. Using a 3 patient to 1 nurse ratio, we would have needed eight plus nurses to care for those 25 patients that were in or presented to the ED during those hours. Using the ESI Acuity tool, we provided outstanding and safe care with four nursing staff members. Appropriate breaks and meals were provided by a fifth in-house resource nurse according to our current staffing plan. We do not have an additional four nurses waiting on standby to call-in when volumes are high. We are also bound by federal EMTALA regulations meaning we can't turn patients away. If the proposed legislation had been in place on Feb. 21, we would have been in violation and potentially faced tens of thousands of dollars in fines simply because our patients needed us.

To be forthright, length of stay (LOS) is also a factor we consider in our current nurse staffing plan. The dynamics of LOS and the interaction with acuities, arrivals, is far too complex to capture here. ED staffing is likewise more complex than a simple ratio of nurses to patients.

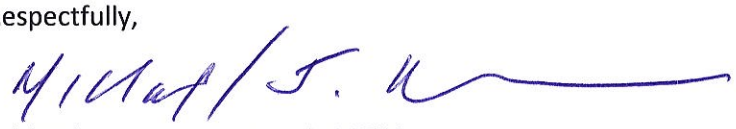
Like us, all CAH EDs in the state are unable to recruit, hire and train to the current level of experienced staff. I can't image the difficulty of finding the additional nursing staff that the proposed ratio would require. Staffing would be prohibitive in the current state of health care finances. In short, the cost of care will go up and access to care could be severely impacted.

We go to great lengths to assure our staff have, and take, all their breaks and meals. Often, I find ED nurses reluctant to take a break because they want to continue caring for the patients who are neighbors, friends and loved ones from the community, not because we don't have appropriate relief staff to cover them. The enforcement measures in the bill, namely fines assessed to the facility, provide a contradictory motivation for staff to miss meals and breaks. The fine, when passed through to the staff member, incentivizes missed breaks.

To conclude, the State's CAH hospitals have spent years working directly with our nursing staffs to ensure we are achieving the current staffing laws with good results for staff and patients. The proposed changes as they currently stand appear to be a step backward.

I welcome your questions and invite you to experience our critical access ED in person.

Respectfully,



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