Chair Nosse, Vice Chair Goodwin and members of the committee, I am Kelly McNitt, a registered nurse of 34 years, having worked in critical care, the emergency department, flight nursing and in management/Administration. I currently serve as the Director of Nursing at Blue Mountain Hospital in John Day, Oregon. As most RNs, I became a nurse to help the community I serve. I chose to move onto leadership to help those who help the patients and family that come to our facility.

Blue Mountain Hospital District is a Type A facility who services a county population for 7, 272 as of 2021. The closest acute hospital is another Type A facility who is 58 miles away, but has a 1 hour and 22 minute drive time, weather permitting. The next hospital that is not a Type A hospital is 148 miles in distance and, again with good weather 2 hours and 52 minutes away. Blue Mountain is licensed to have 25 beds with an average daily census of 5.7. We are a level 4 trauma center, which means, our Emergency department is trained to receive traumas and stabilize them when possible, but transfer out to a higher level of care if the patients need to be admitted. We see 4380 emergency visits a year. Currently we offer Med/Surg, Intermediate care services along with Swing beds. We deliver approximately 45 babies a year along with various outpatient services for this community.

Blue Mountain Hospital currently staffs one OB RN, One M/S RN and one ED RN along with one CNA for each shift. One of those nurses assumes the role of a Charge nurse at this time. Due to the ebb and flow of the hospital, through the work of our Nurse Staffing Committee, we have added an ED Tech position to help 10-12 hours per day. We have filled one ED Tech position and have been actively recruiting 6 other positions that include the other ED Tech for our hospital staff.

Through our Nurse Staffing Committee, we have agreed that our Charge Nurse (CN) can relieve for breaks and lunches. On the rare times that our acuity does not allow the CN to relieve for breaks, we have a process to elicit help from other departments. It is necessary that our Charge Nurses take on patient care so that they can remain competent to do patient care and be a mentor for our less senior staff. I have seen, time and time again, when the CN does not take on patient care, they lose those skills necessary to assist either with staff or be at the bedside in an acute situation.

Currently 35% of our nurses are travelers. HB 2697 will require us, whose daily census is 5.7, to add additional resources and our dependency of travelers will increase to 50%. Due to our size, we can only have one new grad per year as we need to get them competent to at least two different services (MS and OB, MS and ED, etc.) This training takes approximately 9 months to a year to accomplish. It has been more than 3 years, even prior to Covid, since our hospital is fully staffed.

Currently we have 18 positions that we are trying to fill both in our hospital and our ancillary areas. It is extremely difficult to find experienced specialty RNs or ancillary staff to come to rural places. Not only do we need to find the RN, but a large portion of the time, the second income of the family needs to have a job also. This is compounded by the fact that housing is also extremely difficult to find in rural Oregon.

Like most hospitals, patient flow is a big issue due to lack of post-acute care challenges. But for rural hospitals, it can be even more of a challenge. Not only do we transfer our swing bed patients when they still need care but cannot return home safely, but we also rely on higher acute care centers to transfer more critical care and or trauma care patients too. And if they do not have the capacity, the patient suffers. I have seen time and time again where patients who, 3-4 years ago would have been

admitted to the hospital are not being sent home with the words return if not better in 1-2 days because capacity is not available in our facilities.

Our patients are coming in sicker than ever before. We are not treating them early in their health journey. Our larger facilities are also having trouble transferring out so that they can receive these higher level of care patients. By adding a CN position that cannot help with this patient flow and unable to help bedside care occasionally will only increase the issues we are having with patient flow. In my small rural facility, we rely on our CNs to help. In return, we provide our CNs with lighter assignments. This is what our internal Nurse Staffing Committee has agreed to and it works for our staff, our patients and the hospital. HB 2697 would remove that collaborative nature of our internal Nurse Staffing Committee to determine what is best for our teams and patients and sets state wide standard, regardless of size and patient acuity.

I know the strain this pandemic has brought on the hospital staff. The facility I was working at in California was one of the first hospitals to receive Covid + patients from the cruise ships. From the early days of frustration experienced with the lack of understanding of the virus to needing PPE and respirators to the evolving rules and policies that our care givers have had to endure, the frustration is real. And nurses, specifically, also have had the increasing dual role of being by the patient –a role typical of a family member (No patient dies alone when family was not allowed at the bedside)—while also being the needed professional care giver. This combination along with workforce shortages have contributed to the burnout and moral injury our care teams have endured. They are not alone however, every level within the hospital has been effected.

As a nurse leader who deeply cares for her team – like so many of my colleagues – I can honestly say we are constantly working with our care teams to find solutions. It is extremely important to me to hear our staff's concerns and understand them. I elicit ideas from them. It is not uncommon for me to be at the hospital at 6 am to be able to connect with both day and night shifts. Adding three additional committees will create less time to solve problems and less time by the bedside.

HB2697, as drafted, does not address the workforce shortages we are facing. It is a one-size fits all model that does not work for rural hospitals. HB2697 also is a punitive approach that threatens a hospital's ability to serve the community they are obligated and proudly serve.

On behalf of all hospitals, and especially Oregon's 33 small and rural hospitals, we ask that you carefully consider the impacts HB2967 will have to access to care for Oregonians who live in rural Oregon.

I'm am happy to answer any questions the committee may have.