My name is **Elaine Wulff** and I am the **Chief Nursing Officer for Harney District Hospital**. I appreciate the opportunity to share with you my concerns about House Bill 2697.

I am in opposition to House Bill 2697 as currently written.

Harney District Hospital is in the high desert and is 130 miles from the nearest hospital that can provide a higher level of care. Our isolation makes hiring good, qualified staff difficult and it is also what makes the services our hospital provides so essential to our community. Our county is the ninth largest in the country our coverage is vast.

I have advanced in my 30-year career from an ICU nurse, to rural nurse, and now to Chief Nursing Officer for the past 7 ½ years. I have put in countless hours, both on day and night shift, doing my job as CNO and working the floor as a direct care nurse to ensure we have adequate and good care for our patients when census picks up or someone calls in sick.

But how long is this sustainable? I have contracted traveler nurses so our floor nurses could be promoted to supervisors who can ensure patient safety, help with the day-to-day issues, maintain consistency and oversight for staff, and help with lunch breaks.

After promoting some nurses to supervisors and losing some nurses to regular attrition and travel nursing, half our nursing positions are now filled with travelers. Hiring has proven to be more difficult than usual in the past few years due to the nursing shortage caused by burn out with COVID-19, the loss of hired staff to traveling, early retirement of our already aging work force, and the output of nursing graduates too low to meet the demand.

Even before the public emergency our hospital had many challenges in hiring. They are compounded by the isolation of our community, the lack of amenities and shopping larger communities have, lack of desirable jobs for the partners of potential candidates, lack of housing, an inability to compete with the wages larger hospitals provide, and the requirements we have of our nurses to be generalists. Nurses who typically work in a rural hospital are those who have ties to the community through family, find living in a rural community desirable, or find the idea of being generalists exciting and fulfilling. The latter poses the biggest challenge for us. Even though our ratios have probably always been better than most hospitals in the state we still have half our nursing staff positions filled by travelers. We increased our nursing wages by 10% last year to be in the middle range of hospitals with ONA contracts and this also did not help fill positions.

This house bill, as it is written, will likely result in needing extra nurses above what we may need for a shift and beyond what we are already challenged to obtain. This will increase our reliance on travelers – decreasing our ability to have more consistent care, and increase our risk of losing more nursing staff to traveling. The current verbiage does not even allow for the use of Licensed Practical Nurses (LPN), which we find a viable strategy to address the nursing shortage and the cost of travelers.

Unlike larger hospitals that staff nurses for each specific unit, rural hospitals will have one group of nurses to staff several departments. Our volumes are low in all areas so one group of nurses are trained to work in the Emergency Room, Med-Surg, ICU, Labor and Delivery, and Post-partum. Another group of nurses are trained to work in all phases of surgery and the Infusion Clinic. Lower volumes also result in more downtime in rural hospitals, especially on the night shift.

Relieving staff is much more difficult in a rural hospital where our nurses are trained to be generalist. We average 4-5 deliveries per month so having readily available staff to relieve in Labor and Delivery would be too costly to fill with a traveler.

Our supervisors and charge nurses are trained in all areas to be able to relieve all staff, but preventing their ability to relieve for breaks or take patients when we have no one else to take the shift or coverage will either remove them from their designated role if census requires it and always leave the burden on the rest of the staff and nursing leadership to fill. Rural hospitals have no pool of resource nurses. Nurses are usually called on their days off when we need to flex up in staffing or patients will have to be transferred. The need to flex up is sporadic for a rural hospital and could require our staff to take mandatory call to help meet staffing ratios at all times.

What burns out nurses in our hospital? Repeated requests to fill in, which we have been fortunate to minimize by implementing the use of supervisors and charge nurses who can provide relief or flex up if needed. What is a contributing factor of burning out our physicians and contributes to the financial and emotional stress of our patients? Unnecessary transfers, especially when it is already sometimes a challenge to find an accepting hospital for a critical patient.

I was working as an ICU nurse in California when Title 22 was passed in 1999 but left the year it was enforced in 2003. I may not be able to speak to how well it was enforced but know the Oregon bill being proposed seems to be stricter than the one that passed in California, which allowed for a maximum of a 1:4 ratio in Pediatrics, ER, step-down, and telemetry, and a ratio of 1:5 in Med-Surg. Rural hospitals tend to have a mixed unit when staffing for Med-Surg, Swing Bed, and Post-partum patients. Our hospital typically staff 1:5 or less in this mixed area, taking into account patient acuity, intensity, and infectious processes when mixing the care of floor patients with newborns.

The California law also allowed for fluctuations in census caused by a healthcare emergency. In our ER for example, we may have a multi-casual incident (MCI) from an accident that requires us to call other nurses from home to help with the in-coming patients and the patients already in the ER. Help that comes in will not guaranteed to adequately to meet the required ratios. The ratio penalty statute from California states that “A general acute care hospital shall not be subject to an administrative penalty … if the hospital demonstrates to the satisfaction of [CDPH] all of the following:

- That any fluctuation in required staffing levels was unpredictable and uncontrollable.
- Prompt efforts were made to maintain required staffing levels.
- In making those efforts, the hospital immediately used and subsequently exhausted the hospital's on-call list of nurses and the charge nurse." (See Health and Safety Code Section 1280.3(f)(4)(A).)

Also consider patient acuity and intensity fluctuates throughout the day and is not static, especially on a Med-Surg floor or in Post-partum. To say a nurse on the floor could not cover another nurse's patients for a 15 minute break after patient needs are met and are in stable condition should be taken into consideration. Perhaps if the hospital can demonstrate this during a short break it could be allowed for the floor where patients tend to be more reliably stable.

In closing, **Harney District Hospital** and I are opposed to House Bill 2697 as currently written. There should be more considered before it is passed in its final draft and there should be a plan to minimize strict penalties if the nurses do not return to the bedside as predicted by those who are in favor of the bill.

Everyone in the country is competing for the same, small pool of available nurses. I am concerned the need for extra staff will ask for more time from my staff and from our nursing leadership to fill in and will increase burn out.

The extra cost may decrease the financial stability of our organization which could lead to closing down services – services that allow our community members from having to drive two hours through the dessert to another larger hospital, for say chemo treatment or the birth of their child.

Unless the state will provide extra funding or incentives so we can hire more staff, the ultimate burden of filling in will always fall on the leadership of small rural hospitals like ours to maintain compliance and avoid fines.

Please consider taking the time to talk to more representatives from rural hospitals. We all have the same goals for patient and staff safety and hopefully together we can find common ground to shape this bill to be more equitable and reasonable for compliance.

Thank you for the opportunity to testify. I am happy to answer questions should you have any.