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House Bill 2697, Hospital Staffing: Rules Advisory Committee

March 12 and March 18, 2024
Meeting notes

RAC Members

Name	Organization
Andi Easton	Samaritan Health Services
Becky Kopecky	Providence Health System
Chris Carpenter	Oregon Federation of Nurses & Healthcare Professionals (rep)
Christie Wiles	NSAB / Sky Lakes Medical Center
Gretchen Koch	Oregon State Board of Nursing
Hannah Winchester	Oregon Federation of Nurses & Healthcare Professionals (OFNHP)
Jenn Forrester	SEIU 49
Jenni Word	NSAB / Wallowa Memorial
Joel Hernandez	NSAB / St Charles Bend
Kelsey Betts	NSAB / Providence Seaside
Kerry Kilgore	Samaritan Lebanon
Allea Thomas-Putnam	Legacy Mt. Hood
Lace Velk	NSAB / OHSU
Jessica Reese	Salem Health
Mariah Hayes	NSAB / Oregon Health Sciences University (OHSU)
Matt Calzia	NSAB / Sacred Heart Medican Center Riverbend
Matt Swanson	Service Employees International Union (SEIU)
Meghan Slotemaker	Hospital Association of Oregon (HAO)
Nicole Hudson	NSAB / Providence Willamette Falls Med Center
Odalis Aguilar	AFSCME
Paige Spence	Oregon Nurses Association (ONA)
Tom Doyle	Oregon Nurses Association (ONA)

Samantha ("Sam") Claudio	St Alphonsus Ontario
Sarah Curtis	Oregon Health Sciences University (OHSU)
Sarah Hillyer	Asante Ashland Community Hospital
Shannon Edgar	NSAB / St Charles - Prineville
Todd Luther	NSAB / Mercy Medical
Uzo Izunagbara	NSAB / Kaiser Westside
OHA-HCRQI Staff	
Dana Selover	
Anna Davis	
Kimberly Voelker	
Ilana Kurtzig	

These meeting notes will be posted on the Health Care Regulation and Quality Improvement rulemaking website under "Recently Filed New and Amended Rules."

Meeting notes

Welcome and Overview

Welcome and Overview of HB 2697 and the rulemaking process provided by Dana Selover.

Overview included:

- RAC member introductions (via chat)
- Notification that the RAC membership may have changed since the November meeting based on availability of organizational representatives and in compliance with HB 2993 (2021) which requires inclusion of those who are most likely affected by the rules.
- OHA's timeline for rulemaking
    - September 1, 2023: HB 2697 went into effect
    - November 29, 2023: OHA convened the Rules Advisory Committee meeting to consider draft temporary rules.
    - January 1, 2024: OHA issued temporary administrative rules
    - March 12 and 18: RAC for permanent rulemaking Rules Advisory Committee meetings
    - April: Public comment period
    - May: OHA will issue permanent administrative rules
- HB 2697 made significant changes to Oregon's hospital staffing laws.
    - OHA has limited rulemaking authority under the new law.

The new law expands application beyond nursing and now includes hospital service staff and professional/technical staff.

Temporary hospital staffing administrative rules were posted on Oregon's Secretary of State's website. The temporary rules will be removed when the permanent rules are posted by the Secretary of State.

Hospital staffing statute is under Oregon Revised Statutes, Chapter 441 (ORS 441.760-441.795)

Discussion of draft proposed rules (March 12)

Overview

OHA staff provided an overview of the planned rule updates and described which administrative rules the agency plans to leave in place.

Repeal rules for activities or rulemaking authority no longer supported by HB 2697:

- OAR 333-501-0035 to 0045, Audit Procedures and Civil Penalties for Nurse Staffing Violations.
- OAR 333-510-0105 to 0140, Nurse Staffing Committee, Nurse Staffing Plan and Review, Nurse Staffing Plan Mediation, Replacement Staff, Nurse Staffing Member Overtime, Nurse Staffing Waiver, Nurse Staffing Plan During Emergency.

Rules not impacted by this rulemaking, i.e. OHA regulatory work that is not directly tied to hospital staffing regulation:

- OAR 333-501-0005 to 0030 and -0050 to -0060, General Health & Safety rules for hospital monitoring, surveys, investigations and enforcement.
- OAR 333-510-0001 to 0060, General Health & Safety rules for hospital patient care and nursing services.

Revise existing rules needed for that relate to OHA regulatory work that is not directly tied to hospital staffing regulation:

- OAR 333-510-0002, Definitions
- OAR 333-510-0045, Posting Requirements

Add new rules to implement changes to HB 2697 (Division 503):

- OAR 333-503-0002 and -0005, Applicability and Definitions
- OAR 333-503-0010 and -0020, Filing and Processing Complaints
- OAR 333-503-0040, Enforcement
- OAR 333-503-0050 and -0060, Hospital Staffing Plan waiver and Nurse Staffing Member Overtime

New hospital staffing rules

Applicability (333-503-0002)

No comments.

Definitions (333-503-0005)

Adopt a plan

- Question from a RAC member as to whether the text should say "nurse staffing committee" rather than "hospital staffing"
    - OHA responded that the agency is focusing on whether a plan is adopted and attempting to set a boundary. There will need to be documentation related to adoption to support OHA in its understanding of the adoption of a plan. Whether a particular plan is followed is the role of the staffing committee and hospital.
- Question from a RAC member as to whether there should be in rule a requirement that a CEO or designee who makes a decision on plan adoption have to document criteria for their decision.
    - OHA responded that the agency will think about how that type of requirement would play out in rule.

Allowed deviation

- Question from a RAC member as to whether supporting documents are considered part of the plan.
    - OHA responded that unless additional documents are incorporated by reference into the plan and approved by the hospital staffing committee, they are unlikely to be treated as part of the plan. In addition, the agency noted that any included documents would have to be related to staffing.
- Question from a RAC member as to whether OHA plans to include CNA patient maximums in rule. For the comfort of some members, the agency might want some definition.
    - OHA responded that this issue will be discussed later in the meeting, however, it's unclear what a definition would accomplish.
- The RAC member referenced long-term care CNA ratios and how they might be imported, and the agency agreed to consider this issue further.

Create a plan = adopt a plan

No comments from the RAC.

Experiencing complications

- A RAC member suggested that an LIP should make the determination on whether a patient is experiencing complications rather than providing a separate definition in rule. The specific recommendation is to remove the draft definition and link to the LIP decision.
- Other RAC members agreed that it would make sense for an LIP to make this decision when it is not specified in a staffing plan.

    - OHA responded by asking for clarification on how an LIP would specifically designate a patient as experiencing complications. For example, would the LIP need to document the word "complications"? There might be difficulty in differentiating between an LIP's notes about a patient's history and unrelated conditions versus notations of current complications. What would RAC members suggest be in a record to clearly understand how an LIP determination would affect a staffing plan?
- RAC members agreed this is an issue and the HAO said they would bring additional thoughts to the next meeting.

Processing complaints
No comments

Staffing plan
- RAC members noted a typo in this definition.
    - OHA will correct the typo (should say "nurse staffing plans, hospital service staffing plans, and professional/technical staffing plans"
- ONA staff noted that the organization might have a clearer definition of a staffing plan to suggest and will bring to the next meeting.

These rules
No comments

Trauma Patient
- RAC member recommended that OHA remove "activates" from this definition and keep only "meets." There is concern how this could be applied if there is only a team of two people, for example, at a smaller hospital. Additionally, the RAC member recommended removing "modified."
- Other RAC members agreed with these suggestions.
- RAC members also suggested that there could be some opportunity for OHA to match language in this definition with that of "experiencing complications" in that the LIP could perhaps make a determination. In addition, a RAC member recommended referring only to nurse staffing in this definition as it's the only applicable type of staffing here.
    - OHA responded that there are very clear definitions for trauma hospitals in rule and would be hesitant not to adopt those. For non-trauma hospitals the agency agrees it's not as clear but has some concern about having more than one definition for the same thing.

Valid complaint
- OHA noted that the agency may include some criteria in this definition, while using the statutory definition.

Additional comments

- RAC member wondered whether the days listed in statute and rules for deadlines are calendar days or business days.
    - OHA responded that they are calendar days.
- RAC member suggested that OHA define "charge nurse."
    - OHA responded that there already is a definition in statute. The RAC member expressed satisfaction with the statutory definition.
- RAC member wondered whether OHA should define what it means for a nurse to be assigned to a patient.
    - The OSBN representative said that the Board could think about that and bring a suggestion back for the next RAC meeting.
    - OHA requested that RAC members think further about the issue of patient assignments and bring suggestions back.
- RAC members expressed concern that CNAs, in particular, would be working with patients that they are not actually assigned to, creating issues with maximum patient assignments.
- In this discussion, RAC members brought up again the question of including CNA patient maximums in rule to cut down on the possibility of different hospitals having different interpretations of the assignments themselves.
- There was some agreement that the issues of "assignments" and "ratios" need more discussion.
- A question from a RAC member about clarifying where technical staff sit in all of these discussions.
    - OHA responded that techs do not fall under nurse staffing plans and will be covered in the professional/technical and/or service staffing plans. The professional/technical and service staff are represented in this RAC. The agency is seeing how this new structure plays out.

Filing complaints (OAR 333-503-0010)

- OHA noted that it is in this rule that the agency could include complaint information the agency needs to collect in order to process complaints.

Processing complaints (OAR 333-503-0020)

- OHA provided context letting the RAC know that essentially a first filter would be whether the deviation is an allowed deviation. The second filter would be if the issue is a violation, did the hospital do all of the things required in statute in order to avoid a violation (previously Section 19(4) in the bill, now ORS 441.793).
- RAC member questioned whether OHA is waiting until it determines a complaint is valid before starting the clock on the 30-day notification period.

    - OHA responded that yes, the agency is not starting that clock until it determines whether a complaint is valid. Part of the reason for delays in this timeline is that most often the complaints do not contain enough information for OHA to determine whether the complaint is valid, so the agency has to collect additional information and allow complainants to clarify and/or add details.
- ONA is concerned that OHA may not have the statutory authority to wait until determining the validity of the complaint and rather needs to start the timeline when the complaint is received. ONA may have a proposal for that in the next meeting.
- A RAC member suggested that if the complaint form is clear and criteria clearly laid out, this could cut down on delays due to incomplete information.
- A RAC member pointed out that there is a typo in the statutory reference in subsection 3 of this rule and that it should be 441.791. OHA agreed and will make the change.
- A RAC member expressed concern about the 20-day timeline for hospitals to submit documentation to OHA related to allowed deviations. The member noted that OHA may not have the statutory authority to require 20 days for this particular paperwork and expressed concern about what ramifications there could be for hospitals if they don't meet that deadline. The Hospital Association could provide suggested language to OHA.
- A RAC member wondered how OHA would interpret "deviations" using an example of many deviations during the same event.
    - OHA responded that this is something the agency is learning about and could cover in the webinar in April.

Enforcement (OAR 333-503-0040)

No comments.

Waiver (OAR 333-503-0050)

No comments.

Overtime (OAR 333-503-0060)

- RAC member questioned what "notable" means in terms of an outbreak definition.
    - OHA responded that OHA is using this definition as it is broad enough to apply to hospitals of different sizes. The definition itself is taken from another statute and is the generally accepted epidemiological definition.
- A RAC member suggested that perhaps each hospital should define an outbreak in its NSP thereby determining what is notable and significant for its own hospital.

- OHA reminded the RAC that this is specifically for overtime and not for staffing in an emergency situation as OHA does not have the authority to make a rule about suspension of a nurse staffing plan under ORS 441.769. OHA is using the word "mandatory" to align with hospital language. It is not in statute.

Additional discussion

- A RAC member wondered why, if OHA has the authority to write rules for Emergency Department nurse/patient ratios, the agency has not done so.
  - OHA responded that the agency does not have sufficient clarity to write such a rule and welcomes suggestions/recommendations as soon as possible.

Discussion of draft proposed rules (March 18)

The RAC discussed all follow-up items from March 12 that were sent in advance of, or brought to, the March 18 meeting.

Dana Selover from OHA welcomed the group back, provided a brief overview of the conversation from March 12 and kicked off the meeting with a request from SEIU and AFSCME RAC members to go over the recommendations they sent via email related to CNA shifts and maximum patient assignments. OHA asked that other RAC members provide input and responses to the recommendation as well.

CNA maximum patient assignment discussion

- The AFSCME representative noted that the recommendation uses language from nursing care facilities and long-term care to apply to a hospital facility. Intent is to make sure a CNA is not replacing an RN and vice versa. The options suggest that hospital staffing committees would establish the start and end of shifts and those would be aligned.
- OHA and RAC members asked whether the recommendation is proposed rule language and the reps responded that it is a starting point for discussion that SEIU and AFSCME is proposing.
- The SEIU representative echoed that the intent of the recommendation is to be a starting point and it is currently something that exists for nursing homes. They noted that there is not a common definition of what shifts are and without a definition there could be changes to assignments that have a negative impact on CNAs and patients.
- A RAC member asked whether there could be an option for a 12-hour shift definition noting that in acute in-patient hospitals CNAs are on 12-hour shifts. The member wondered how hospitals would be expected to manage that.

- A RAC member wondered whether under the current structure on the acute care side whether it be possible to be short (down) a CNA and adjust nurse ratios? Or whether a CNA would always have to be there?
    - OHA responded that the agency cannot speak to legislative intent. While NSPs have to have flexibility, they have to have a minimum so that there is something to compare to. OHA is only looking at whether the staffing plan has been followed. The agency also noted there are units that don't use CNAs, where there are just RNs.
- A RAC member commented that it was brought to her attention by other CNAs that there is essentially a loophole that would allow CNAs to care for more patients than what is allowed in statute. For that reason, the union is recommending language to help support CNAs and patients.
- A RAC member from a hospital agreed that CNAs are a very important issue but that the hospital hasn't had a chance to review the recommendations and would need to spend some time looking at the proposal. The member requested additional clarification of the recommendations.
    1. Define shifts, and
    2. Clarity around assigning CNAs to patients. Is the proposal that every patient gets a CNA? There might not be enough CNAs in the state for such a requirement. The hospital wants to focus on good patient care and if there are limits, that would need further discussion.
    - OHA responded that the agency needs to look at its statutory authority.
- In response to the earlier question about the 12-hour shift, a RAC member noted that the definition of night shift is important because the max number of patients for CNAs increases from seven to 11 people. With the 12-hour shift, the idea is to make very clear when the shift changes from seven to 11 people. CNAs need to understand when their shifts switch maximum assignments. In regard to the attempt at an assignment definition, the RAC member noted a concern that even when hospitals/RNs don't assign a CNA, the CNA will take care of a patient if a patient needs it. The recommendations are an attempt to show accountability for what a CNA is doing. The CNA should be accounted for and credited for that their work.
- A RAC member suggested in the chat that it might be better to define the time when the numbers change (e.g. define the hours of night shift only).
- A RAC member echoed OHA's comments about looking at statutory requirements and rulemaking authority.
- A RAC member asked about the public comment period for rules and filing comments with the agency.
    - OHA provided a basic timeline and will follow up with a specific timeline later in the meeting.

- A RAC member expressed concern that the agency might have changed the process from the past and noted that the RAC received draft rules before others.
    - OHA responded that the agency is using the same process but is on a tighter timeline. The RAC was currently reviewing and commenting on the draft rules, which would later be broadly shared for public comment. The agency will provide timelines for the remainder of the rulemaking process.
- A RAC member suggested that CNA shifts should be defined either by CBA (collective bargaining agreement) or by a staffing committee rather than in rule.
- OSBN provided additional context noting that the Nurse Practice Act defines "assign" for RNs, however, the Act does not speak much about accepting an assignment.
    - OHA responded that the agency doesn't want to conflict with other statutes and rules including Nurse Practice Act obligations.
- A RAC member asked OSBN whether a nurse who has accepted a patient assignment has an obligation to that patient until they hand off that patient.
    - OSBN agreed that the scenario sounds reasonable.
- A RAC member posited a different scenario to OSBN: If in the lobby of the ED, the triage nurse decides to administer care (e.g. start an IV) and return the patient to the lobby until they are admitted, has the triage nurse assumed responsibility for the care of that patient?
    - OSBN responded that most likely yes, the triage nurse is looking after that patient, applied their clinical knowledge and has begun that relationship.
    - OHA noted that the agency can't be in conflict with the Nurse Practice Act and neither can NSP and that is not new.
- A RAC member asked OSBN to clarify a point using an example. Example given: If there are 30 patients and three CNAs, then 21 patients are assigned to those CNAs to stay in line with the law (seven each max), are CNAs considered assigned to the other nine patients if they also help with their care?
    - OSBN responded that they are not sure if they are assigned but they are responsible for the patients. OSBN recommends looking to the RN who would have to have assigned them to those other patients.
- A RAC member asked for clarification as to whether a triage nurse in the example just given would then have that patient taken into their ratio?
    - OHA responded that such a question is for OHA and not OSBN, however, OSBN noted that the answer to that likely would depend on the RNs plan and potentially a broader unit plan.

Definitions discussion

OHA asked for any additional feedback on definitions of trauma patient and experiencing complications.

- A RAC member noted that clinicians in their hospital document when there is a complication so there is a process in place already.
    - OHA responded that the Nurse Staffing Plan would need to incorporate that process. OHA would need to know, without getting deep into all of the medical records, whether a specific patient was experiencing complications and the requirement would have to be in the NSP in order to be enforceable.
- A RAC member asked OHA to clarify "diving deep into the medical record." The way that the statute is written, OHA would have to dig into medical records so what more is the agency saying around the investigation process.
    - OHA responded that the agency is applying a new law to old plans at the moment. The violations in the law are pretty specific. OHA noted that the agency may look at the patient record if necessary, looking as far as needed for what the agency needs to see about staffing. If the file just gives a medical history, that doesn't automatically mean there is a complication. In addition, complications can begin after the LIP has examined the patient. The agency provided an example: What if the LIP has seen the patient during the last shift and then there is new staff? Or, what if the LIP saw the patient four hours ago and the patient develops a blood clot two hours after the LIP has seen the patient? The ratio changes. OHA noted that nurse staffing investigations have not previously included patient records since it's not been needed. Thus far the issues have been not following NSP so OHA has gotten NSPs and staffing for the days and shifts and that's different for each hospital and each unit. OHA mostly finds patient census, patient assignments, and time keeping records. These are the most common, but OHA could request other records.
- A RAC member noted that hospitals could provide documents that show clearly when complications happen and welcomes additional conversation later.
- A RAC member wondered about patient records being sent to OHA and whether that's normal as it doesn't seem like medical records would be sent to the agency for determining compliance with this law.
- A RAC member asked whether OHA historically looked at medical records. The member followed up regarding experiencing complications and noted that if the term is defined in the NSP, then OHA could proceed with the NSP's definition. If it isn't, there are national standards and so this is an area where there may be more clarity.

    - OHA responded that the old law was different so what OHA did in investigations is different from what it'll be under the new hospital staffing law. In the past OHA had not looked at patient records for nurse staffing. At the state and federal level, OHA reviews patient records regularly and so OHA is familiar with this process, but it hasn't been part of nurse staffing. OHA is bringing this issue to people's attention because this is new. This is supposed to be easy for everyone, so OHA is trying to build a system to work effectively and efficiently.
- RAC members discussed AWHONN standards that could apply to all levels of staffing at hospitals when thinking about "experiencing complications."
- OHA responded that the agency put this broader option in the draft rules to get feedback from the RAC. If the RAC doesn't think that the agency needs the second part of the rule (e.g. a definition if not defined in an NSP) the OHA can use the broader standard. The agency is encouraging hospitals to put a standard in their plans.
- A RAC member brought up the definition of trauma patient and wondered what happens when a patient stabilizes, and the one-to-one ratio is no longer needed.
    - OHA responded that in regard to the trauma patient definition, previous conversation focused on removing "modified" from the definition, Exhibits 2 and 3 and differences for trauma and non-trauma hospitals. OHA noted that the NSP would need to address specifics and the rule is broader to allow for those details.
- A RAC member noted that related to the trauma definition, the group discussed changing language from "activates" or "meets" criteria to "meets" only.
    - OHA staff noted that if a staffing plan completely redefines trauma patient in a way that is inconsistent with all known reasonable definitions, OHA will flag that as an issue. However, the agency believes that situation is unlikely given the need for NSC approval of a definition.
- A RAC member noted that when a trauma ends, a patient gets an order to another unit which would then be subject to the ratio. The enforcement would be where the patient has been assigned.
    - OHA responded that patients may spend more time in the ED, for example, and not be necessarily moved right away to the next level. The optimal situation is that the patient is moved right away but not necessarily what happens and might not be as obvious what the next step is so it's good to have this conversation.
- A RAC member provided the example of a patient needing to be transferred from the ED but there not being any place for the patient to go. The member

noted that removing "modified" from the definition would make this example situation less of a concern.
    - OHA responded that the agency hopes that the NSP can help fill these types of gaps.
- A RAC member provided a different example for feedback: If a provider has orders in the ED and then a subsequent order to Med/Surg then it would seem that they should follow the staffing plan for Med/Surg. Would it be where the LIP makes the order?
    - OHA responded that this is specified in ORS 441.765(3) to some extent, but that the agency would have to consult with counsel to clarify which ratios apply to patients before they are moved to a separate unit and what documentation OHA would need to see.

Waiver

- A RAC member requested clarification on the waiver rule wondering why there is still a rule requiring a request for waivers when OHA must grant a waiver.
    - OHA responded that the waiver rule is not related to Type A & B hospital variance. The variance is something the committee votes on to approve and then the hospital must notify OHA at which time it takes effect immediately. The waiver rule is related to ORS 441.778. Under that statute, the hospital can request a variance from a plan staffing plan requirement (which OHA calls a waiver). OHA is not sure at this time specifically what a request would look like but it's under the part of the law where OHA has rulemaking authority.

Discussion of the Statement of Need and Fiscal Impact

OHA staff let the group know that the agency has to look at impact of the rules on small businesses. To OHA's knowledge there are no hospitals that fall into the category of small businesses. OHA also noted that while the law itself has fiscal impacts on several groups, this review is for the rules only.

- A RAC member asked OHA to reiterate that the agency is referencing the rules only and not the law. The law will have a big fiscal impact on hospitals even if the rules don't.
    - OHA agreed and noted that if the law was vague and gave OHA the authority to create the entire process and the agency adopted several requirements into rule, there could be big fiscal impact from the rules. However, this law is prescriptive, and OHA has limited rulemaking authority.

Wrap up and next steps

OHA provided a timeline for next steps and requested that RAC members provide additional feedback to OHA by end of day on Wednesday.

- A couple of RAC members expressed concern at the short timeline and asked OHA to provide additional time.
    - OHA responded that the agency is on a tight timeline and has to comply with timeline requirements from the Secretary of State's office to file rules. In order to have the rules effective prior to June 1 (when NSPs must be adopted), OHA needs feedback ASAP. OHA also noted that there will be a public comment period in April and RAC members may submit written comments during that period. In addition, there will be a public hearing on April 16 where RAC members can provide oral testimony. OHA will follow up with the group to ensure members know when the public comments period and public hearing take place and know how to provide input.

March 18 meeting adjourned at 3:05pm PDT.

Accessibility:

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If you need help or have questions, please contact Ilana Kurtzig at 503-201-1859, 711 TTY or ilana.s.kurtzig@oha.oregon.gov.