Hospital Staffing Advisory Committee Meeting

Meeting Notes

Date	3/7/2024
Meeting Topic	Hospital Staffing Form Review
Note Taker	Holli Erdahl

Attendees

Standing Attendees			
WSHA		WSNA, SEIU, UFCW	
☒	Chelene Whiteaker	☒	Cara Alderson
☒	Darcy Jaffe	☒	David Keepnews
☒	Jason Hotchkiss	☒	Duncan Camacho
☒	Jennifer Burkhardt	☒	Maureen Hatton
☒	Keri Nasenbeny	☒	Tamara Ottenbreit
☐	Renee Rassilyer Bomers	☒	Vanessa Patricelli
DOH		L&I	
☐	Christie Spice	☐	Caitlin Gates
☒	Holli Erdahl	☒	Lizzy Drown
☐	Ian Corbridge	☒	Carl Backen
☒	Julie Tomaro		
☒	Kristina Buckley		
☒	Tiffani Buck		

Alternates and Other Attendees	
Dino Johnson – Alternate for Renee Rassilyer Bomers	Saba Tilahun for Cara Alderson
Jessica Bell	Sara Arneson
Barbara Friesen	Hanna Welander
Michael Davis	Anthony Cantu
Elizabeth Gordon	Michelle Curry
Trevor Gjendem	Bonnie Fryzlewicz
Ashlen Strong	Dawn Marick
Jacqueline Mossakowski	Jeannie Eylar
Laurie Robinson	Timothy Bock
Trish Anderson	Manda Scott
James Harrigan	

Agenda Item	Notes
WELCOME & ROLE CALL	• Role call completed

LAND AND LABOR ACKNOWLEDGEMENT & SAFETY TOPIC	• Safety Tip – Ladder Safety • Most common ladder accidents – missing last step or overreaching
APPROVE PRIOR MEETING MINUTES	• No amendments suggested, meeting minutes are approved

DOH HOSPITAL STAFFING FORM	• Template needs to be finalized by 4/1
	• Department has developed a final working version of staffing form for review
	• Voting for today: HPPD formula and Signature page, discussion will be around all other pieces
	• General Hospital information
	  ○ Hospital name, location, general info on staffing plan, dates approved,
	  ○ Factors considered have been divided – some per unit, some in initial section for entire hospital
	  ○ One Hospital license that covers more than one license – how will this work? Multiple staffing plans? Or one per building?
	• Factors considered – instructions will include that it is optional – public may not have access to instructions, can we have something on the form to reflect that it is optional?
	  ○ Instructions will be posted for the public as well, but can add some instructions
	• HUCs are no longer listed, however HPPD is listed by unit
	• Matrix examples
	  ○ Inpatient
	  ○ OR – room based (number of rooms being used at a given time)
	  ○ ED – old matrix was anticipated number of visits by hour – HPPD type metric requires patient volume, so we used census – not based on licensed bed count, but on general capacity
	  ○ Outpatient
	• Feedback
	  ○ Emergency Department – not a workable matrix
	  ▪ There are a fixed number of beds, but they do not measure census in this way
	  ▪ Staffing model for ED is measured on visits per day
	  ▪ High volume ED – would you have to fill out examples for 300+
	  ▪ How do we compensate for visit patients?
	  ▪ Additional units in ED? Compensated for unencumbered charge or nurses in previous matrices. Need to have a place to designate unencumbered charge/triage RN.
	  ▪ Unencumbered charge – would be included in the numbers, would not be separately designated. Include in minimum number of RNs – can add context in factors considered?
	  ▪ Consensus for previous model? Example previously provided was voted against? Will revisit

	▪ Fixed model – still need some sort of census or anticipated visits to determine model, will need some sort of hours per unit of service? ▪ In ED, staff is not added when census increases, it is fixed based on previous data ▪ Fixed staffing – is the concern that the formula is difficult to match, or is it that you are trying to convert everything into a specific hours per patient unit ▪ Total number of patients per day is variable ▪ Why did we have low scores when voting for ED matrix? Several outstanding questions, such as hours/schedule. More clarification needed ▪ Max number of beds would be hard for staffing committees to determine ▪ Fixed staffing plan on 3 years of data, built staffing model off of this, concerns of being out of compliance due to variability. ▪ Census driven option and fixed option – having both may be helpful for hospitals to decide ▪ Triage has been taken back to the lobby – shut down floors to stay within compliance • **Should we have a fixed model for ED?** o **Passes with all 4s** • **Should all non-inpatient clinics/services have the option to choose between a census/anticipated visits model and a fixed model?** o **Passes with six 3s and six 4s** • Will create a fixed model Break • Concerns with use of "minimum" throughout staffing form o Minimum number of "CNA" – what if we are short CNAs? Concerns that this will prevent flexibility and safety for patients. o Why was minimum added? Due to conversation about range. The minimum is intended to be the bottom of the range rather than the whole range. Minimum is not discussed? o Minimum vs average – average staffing with adjustments for acuity vs operating from the minimum total amount o Minimum staffing – always considered, shouldn't ever drop below? These conversations should be had in committees and should be considered. o Differences in interpretation of "minimum" o Minimum can flex up – law has changed and accountability has increased. Minimum should be included. o Average and minimum are different, should not be viewed interchangeably. o If/then scenarios? Is there a way to incorporate these rather than being locked into the grid? o Reminder – law addresses adjustments to staffing plans, process in place.

	○ Law was a compromise instead of incorporating mandated ratios, these should be set at the hospital level. Level of accountability at hospital level is what hospitals and legislation agreed to. ○ Flexibility needs to be considered due to the imperfect nature of staffing ○ Staffing committees are capable of working within the structure of the form as is • HPPD Calculations ○ Hours per unit of service (includes Days, Visits, etc) Formula to be used where predictable ○ May not work in all areas ○ **Vote: Use HPPD formula for Staff (RN, LPN, CNA, UAP) Staff count x shift length = Total staff hours worked ÷ census, anticipated visits, # of rooms = HPPD** ▪ **Passes with eleven 4s, one 5** ○ **Vote: Use HPPD formula Sum of all staff HPPD: RN HPPD + LPN HPPD + CNA HPPD + UAP HPPD = Total HPPD** ▪ **Passes with ten 4s and two 5s** • Staffing plan approval page with signatures – anonymous votes but signatures from staffing committee ○ Concerns for privacy of staff who may not want to include last name ○ Could we attest that the voting happened with the chair and co-chair signatures? ○ Should votes still be listed on the form? ▪ Is it necessary if it passes? Don't think so ▪ Anonymous votes should be included for reference. • **Vote: Use signature page that has a chair, cochair, and hospital CEO signatures** ○ **Passes with ten 4s and two 5s** • **Vote: Include anonymous votes** ○ **Passes with one 3 and eleven 4s** Next steps – two different matrices, take into consideration comments for today, fillable form to come!
ALTERNATE COMMENT	• N/A
PUBLIC COMMENT	• James Harrigan – Accountable language is more important than flexibility. We need better staffing laws and better working conditions. We have nurses but need better accountability to retain them. HUCs should be included as well. • Trevor Gjendam – Accountability and responsibility – if we aren't staffed correctly there currently isn't any consequences. HUCs are important and should be included. Discussions around clinics, but this is a bill for Hospital Staffing.

Action Items	Assignment	Deadline
