HB905_ Marylanders for Patient Rights_fav.pdf
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Position: FAV

MARYLANDERS FOR PATIENT RIGHTS REQUESTS A FAVORABLE REPORT ON HB905 Hospitals - Clinical Staffing Committees and Plans – Establishment The Safe Staffing Act of 2025

Marylanders for Patient Rights is the largest patient advocacy coalition in the state, with 23 groups and a collective membership over a million.

Our coalition has joined with healthcare workers and community organizations to form the **Patient-Worker Collaborative** in support of the Safe Staffing Act of 2025, HB905. Maryland urgently needs to address the hospital short staffing crisis.

Maryland has had the longest ER wait time out of 50 states for over nine years, with a state average wait time over four hours (see attached chart for individual hospitals). **Maryland patients lack reliable, timely emergency care**. This problem will never be solved without safe staffing.

When my 75 year old husband was seriously ill with COVID, I observed two nurses at Suburban Hospital in Bethesda being overwhelmed with about 35 ER patients. He left without treatment after we waited 5 hours. During that time, he was accidentally injured by one of the two nurses, so he left with a large bandage the entire length of his right arm. It became clear to me that an understaffed ER was more dangerous than taking him home.

I started working on the ER wait time issue three years ago after getting an email from a woman who waited **31 hours** in the Carroll Hospital ER with her father who had dementia. I was the caregiver for a family friend with dementia, and I can only imagine how extremely difficult that was.

Bruce Hartung, President of the Maryland Continuing Care Residents Association, told me that some residents at his retirement community are lining up drivers to take them to Northern Virginia if they need ER. Across the river, **Fairfax Co** has a 172 min. wait time-- almost two hours shorter than Montgomery Co. **Marylanders shouldn't have to go to another state for emergency care.**

So, why are we the worst? What is different about Maryland? My research shows that compared to 50 other states Maryland is:

46th in staffed beds

36th in nurses per 1000 population
45th in nurses salaries, adjusted for cost of living.

Across the river, Fairfax Co. has 30% more staffed beds and a **two hour shorte**r ER wait time. **It's about safe staffing**.

Medical staff have been frustrated by having the **knowledge, but not the voice**, in fixing the short-staffing crisis. HB905 simply requires that each hospital form a safe staffing committee to develop guidelines for a staffing plan. The committee must be at least **50% direct care workers,** so the committee can benefit from their experience.

Guidelines will be flexible enough so the committee can adjust guidelines, based on need. This approach will improve quality of care and working conditions. Hospitals have precedents in successful management-worker committees on Violence in the Workplace, and Safe Lifting.

However, **MHA opposes HB905 by using false claims** that the bill mandates nurse:patient ratios. This is simply not true. Instead, HB905 requires experienced employees and managers to talk to each other about safe staffing and develop guidelines. We have responded to their criticisms last year by deleting 2/3 of the bill, now down to five essential pages.

Without a safe level of staffing the ER, Maryland patients will continue to suffer long and potentially life-threatening waits for emergency care, or leave without the treatment they need.

Please submit a favorable report for HB905, and help keep our patients and workers safe. Thank you.

AC Palmisano
Anna Palmisano, Ph.D, Director
Marylanders for Patient Rights
palmscience@verizon.net

Hospital	ER Wait Time, Minutes*
Northwest	367
MedStar Franklin Square	364
Holy Cross Silver Spring	346
Adventist White Oak	346
Grace Medical	301
Johns Hopkins Bayview	300
MedStar Southern Maryland	296
UMMC	293
Holy Cross Germantown	275
Doctor's Community Hospital	270
UM BWMC	270
Johns Hopkins Hospital	269
MedStar St. Mary's	265
UM St. Joseph	263
UM Upper Chesapeake	263
Frederick	261
UM Capital Regional	260
Howard Co. Medical Center	258
St. Agnes	256
Mercy Medical	256
Adventist Ft. Washington	249
Western Maryland Regional	244
MedStar Good Sam	237
Anne Arundel Medical Center	235
GBMC	230
UM Midtown	228
Meritus	227
UM Charles Regional	225
Suburban	222
Carroll	215
Adventist Shady Grove	214
MedStar Union	214
MedStar Montgomery	213
Calverthealth Med Center	210
UM Harford	205
MedStar Harbor	198
Sinai	183
Tidal Health Peninsula Regional	175

UM Shore at Easton	174
UM Shore at Chestertown	173
Garrett Regional	147
Atlantic	131
average (mean)	246
average (median)	228
*Source: CMS Hospital Compare	

numbers reflect those discharged only

Andre Johnson HB905 FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Andre Johnson. I've worked at a hospital for 26+ years and am currently working in the Environmental Service Department. Short staffing is present at every level of our hospital, impacting everyone from EVS to nurses, general staff, transporters, and nutrition workers. Patient care should be the number one goal of every hospital, but short staffing is hurting the quality of care. I support HB905: The Safe Staffing Act and urge a **favorable** report.

The whole care team contributes to the wellness of the patients. My department keeps the hospital clean, which is important for reducing the spread of infections. Years ago, my department had over 730 workers. As of last year, we had around 400. Around five people call out every day. Workers do our best, but one person can only do so much: hospitals are meant to function as a team setting, and we can't work as a team when we are so understaffed.

Short staffing is dangerous because there is so much pressure on the workers. We put our own health at risk, and stress kills. Workers still have to feed our families, and that fact is used as a tool to manipulate us into working in unsafe conditions. We do multiple jobs all at once because management knows we don't have the luxury to just quit and start something new. Our families depend on us.

I remember seeing a worsening in the short staffing crisis before COVID. During the worst of the pandemic, I saw my coworkers put their lives, and their families' lives, in danger to do what they loved: making people well again. Hospital management saw it was operating understaffed during COVID, but years later, they still haven't done anything to fix it. The hospital I work at used to be proactive, now it's reactive. Safe staffing committees would change that so we can implement real solutions.

Passing the Safe Staffing Act would require hospitals to be transparent about staffing levels. Right now, it feels like management is trying to hide the reality that we are short-staffed. Our vacation requests are frequently denied, and when we ask why, we are told that it's because of short staffing. But that isn't our fault—we work hard and deserve our PTO. The onus should be on management to staff our workplace appropriately so that we have the benefits and protections that we are owed. How can we maintain high value work performance when we can't even take a break and are burned out from being overworked? It's like a tire stuck in the mud, spinning its wheels but not going anywhere.

I was raised to be a fighter and to stick up for people who need help. These are values I have shared with my children and grandchildren as well. I can see right now that my coworkers and I are being taken advantage of by hospital management, facing dangerous staffing shortages that make our jobs borderline impossible and negatively impact patient care. That's why I would absolutely volunteer to be on the safe staffing committee when this bill becomes law. Please vote YES. Thank you.

In Unity, Andre Johnson

Andre Johnson HB905SB720 FAV.pdf

Uploaded by: Brige Dumais

Position: FAV

Testimony on HB905/SB720
The Safe Staffing Act of 2025
Position: **FAVORABLE**

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My name is Andre Johnson. I've worked at a hospital for 26+ years and am currently working in the Environmental Service Department. Short staffing is present at every level of our hospital, impacting everyone from EVS to nurses, general staff, transporters, and nutrition workers. Patient care should be the number one goal of every hospital, but short staffing is hurting the quality of care. I support HB905/SB720: The Safe Staffing Act and urge a **favorable** report.

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Antonia Brooks HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Antonia Brooks. I'm a Physical Medicine Rehabilitation Tech II in the Intensive Care Unit, and a member of 1199SEIU. I am a healthcare worker because I care about people, and I believe healthcare is a human right. Short staffing delays that right. I urge a favorable report on HB905: The Safe Staffing Act.

At my hospital, there are long emergency department wait times and patients are being treated in the hallways. I work short staffed at least twice a week. I treat 24 patients per day, helping them walk and sit up, and providing respiratory assistance. On days we are short, I assist in other areas as well, so I spend half as much time with my patients on those days. Treatments that patients are supposed to receive daily often get postponed.

We are short staffed because healthcare workers are underpaid and overworked. High patient volume and running from building to building is exhausting. New workers quit soon after being hired when they are asked to take on work outside of the job description. Some call the hiring process false advertising.

When workers bring our concerns about staffing to management, they act like they are listening, but they don't use our suggestions, so the problem isn't getting solved. The Safe Staffing Act will change that by giving workers like me a real opportunity to bring our solutions to the table. I'm excited to volunteer to serve on a safe staffing committee when this bill passes! Please vote YES on HB905. Thank you.

In Unity, Antonia Brooks

Antonia Brooks HB905 Testimony FAV.pdf
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Position: FAV

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The Safe Staffing Act of 2025
Position: **FAVORABLE**

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In Unity, Antonia Brooks

Brige Dumais HB905 FAV Testimony to FIN Committee.
Uploaded by: Brige Dumais
Position: FAV

HB905: The Safe Staffing Act of 2025
Position: **FAVORABLE**

Madame Chair and Members of the Senate Finance Committee,

My name is Brige Dumais. I'm the Political Coordinator with 1199SEIU - the largest healthcare workers union in the nation. Over 5,000 of our members work in dangerously understaffed hospitals across the state. Their experiences prove that **short staffing is pervasive and can have serious consequences on both quality of care and workplace safety**. When I ask workers to describe the impacts of short staffing, the common themes are delayed patient care, burnout, and that workers are not heard when they raise alarms about this crisis. **I urge a favorable report on HB905 to enable worker driven solutions for safe staffing.**

At a hospital where 1199SEIU represents members, there were not enough workers in the behavioral health unit to do patient wellness checks every 15 minutes. Tragically, a patient committed suicide in the hospital. At Capital Region Hospital, a member of 1199 was brutally beaten by a patient. She was the only worker on the floor, no one was there to intervene and de-escalate. Our member was so injured and bloodied that she couldn't get herself up, so another patient had to go get help. **Short staffing is traumatic for both workers and patients.**

When workers' ideas are *not* incorporated into staffing plans, as is current practice without HB905, management often comes up with solutions that are unsuccessful because they just look at metrics and don't think about workers as human beings. One hospital's attempted solution was to change workers' shifts so that there would be staggering times for clocking in and out, and to require workers to come in every other weekend. That plan backfired. Workers struggled with childcare and transportation due to the schedule changes. Ultimately, MORE workers called out or quit because of the increased burden on their lives. **The Safe Staffing Act not only gives workers a voice, it gives hospitals the benefit of implementing staffing plans that will actually work.** Please vote YES. Thank you.

In Unity,
Brige Dumais, brigette.dumais@1199.org

Fabaya Pollard HB905 FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Fabaya Pollard. I'm an Environmental Service Staff (EVS) worker at a hospital, and a member of 1199SEIU United Healthcare Workers East. Hospitals are short staffed every day. It doesn't matter what department or shift, everyone is working short. This is unsustainable. We are human beings and we need to have safe work environments. Therefore, I urge a favorable report on HB905: The Safe Staffing Act of 2025.

EVS is essential. We maintain sanitary environments, which is very important for patients' and workers' safety. I work from 7:00am to 3:30pm. I'm responsible for sanitizing four floors including common areas, pharmacies, employee break rooms, and bathrooms. There are only two EVS workers in my building on my shift, so when one of us calls out, the other is responsible for all 10 floors. When night shift workers call out, my shift is responsible for completing their unfinished tasks as well. Our work is literally back-breaking. There aren't enough workers to empty trash cans on a regular basis so the trash bags are getting too heavy from being overstuffed. Workplace injuries are increasing because of this. Then workers have to call out, making the short staffing even worse.

I was out on workers comp for a whole month because I sprained my back lifting a heavy bag, and I'm still in physical therapy. There is a high worker turnover rate because we are overworked and disregarded by management when we raise concerns about short staffing. The Safe Staffing Act can help fix these problems by giving us a voice. A committee that is at least 50% workers will ensure the safe staffing plan is a success when implemented. We all have a part to play in ending the short staffing crisis, so we should all have the opportunity to craft the hospital safe staffing plan together. Please vote YES on this bill.

In Unity, Fabaya Pollard

Fabaya Pollard HB905SB720 FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

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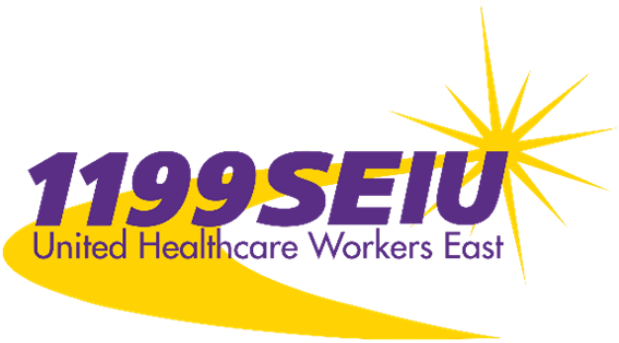
In Unity, Fabaya Pollard

Lucy Caulker Nelson HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV



Testimony on HB905

The Safe Staffing Act of 2025

Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Lucy Caulker-Nelson. I am a Wound Care Technician and have worked at a hospital for 25 years. The number one consequence of short staffing is delayed patient care. In wound care, any delay leads to an increased risk of infection and sepsis, which can be life threatening. Because of short staffing in my hospital, there has been an increase in workplace injuries and adverse mental health outcomes for healthcare workers. Therefore, I urge a **favorable** report on HB905: The Safe Staffing Act of 2025.

Short staffing is a crisis at the hospital where I work. There are only two wound care technicians for the hospital, and every other department is short-staffed too. Patient Care Technicians are working 1:16, Medical-Surgical Nurses are working 1:6, and Intensive Care Unit Nurses are working 1:3. It's difficult to monitor and properly care for patients in a critical care environment with so few workers. We are overwhelmed, and patients must wait for basic but necessary things like a glass of water. With short staffing, it's much harder to monitor and take preventative actions before a patient becomes "code blue," meaning the patient is experiencing a life-threatening emergency.

If one department is short, it creates a domino effect that impacts everyone else. For example, when the kitchen is short, meals don't go out on time, so direct care workers need to delay giving patients their medications that are required to be taken with food. Workers are asked to take on the work of other titles in addition to our own work to cover the gaps. The workforce at my hospital is like a revolving door. There are plenty of new workers that come in, but most of them quit before their probation period is over, and many quit within a few days. Young workers see how burned and overburdened the current staff is and get frustrated because hospital management is not receptive to workers' ideas for how to fix this problem, so they quit. To fill the gaps in the healthcare workforce, workers' voices need to be heard!

If your loved one ended up in the hospital, you'd want to know that there were enough workers to care for them. Patients deserve much better and healthcare workers deserve to be treated as human beings. The Safe Staffing Act recognizes that healthcare is a team effort. It seeks to address staffing on a hospital-wide level and includes workers from the whole care team. That is what we need to achieve for workforce retention, improve working conditions, and maintain high quality care. Please vote YES on this bill. Thank you.

In Unity, Lucy Caulker-Nelson

Lucy Caulker Nelson HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
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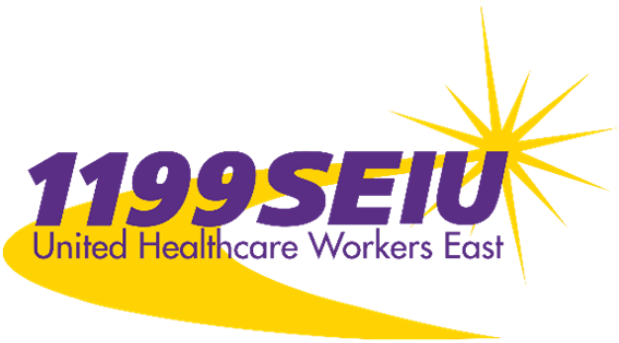

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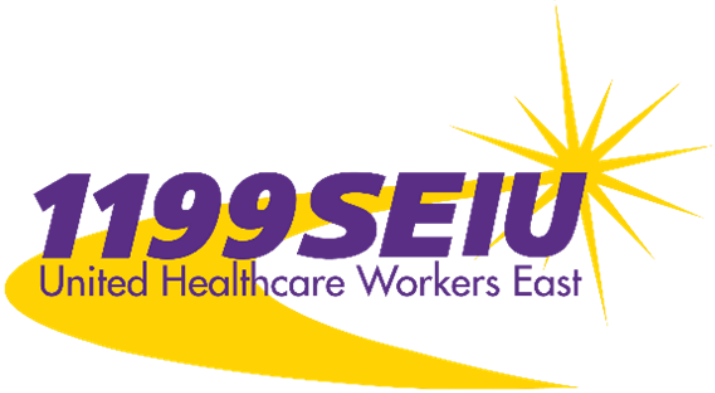
In Unity, Lucy Caulker-Nelson

Rita Crosby HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV



Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Rita Crosby. I am a Cook at a Long-Term Acute Care Hospital. Short staffing is a problem in my workplace, and the only thing management has done to try to fix it is put out a suggestion box. I urge a **favorable** report on the Safe Staffing Act of 2025 because workers voices must be heard.

Short staffing leads to more short staffing. I am so tired from doing what used to be two people's jobs all by myself that I actually have to take more sick days and personal days now to recover from being overworked. I am entitled to the benefits I earned, and I need to take care of my health, but I know that when I call out other workers face the same burden that I am calling out to heal from.

My coworkers and I asked management to purchase cushioned floor mats to help our bodies be in less pain from the long days of laboring on our feet. Management said they would purchase them, but we would have to clean them ourselves, which adds more to our workload when we are already stretched so thin. In the end, the cushioned floor mats never arrived. What I learned from this experience of bringing my ideas to management is that they will 1) try to convince me it is a bad idea even though I know what I need to do my job well and 2) never actually follow through on their commitment. That is why we need the Safe Staffing Act. Please vote YES on this bill. Thank you.

In Unity, Rita Crosby

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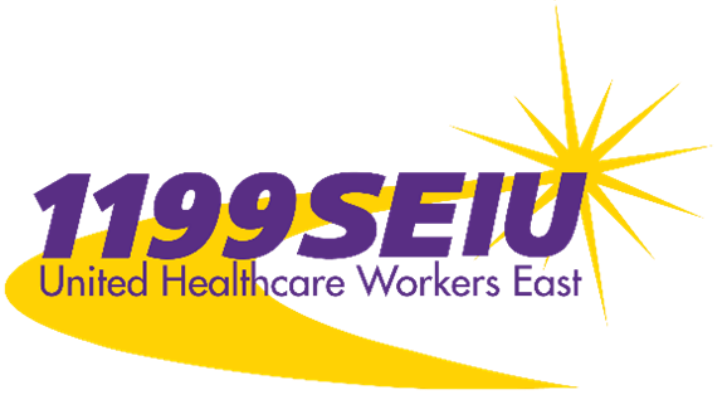
Position: FAV



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In Unity, Rita Crosby

Shaniqua Covington HB905 FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Shaniqua Covington. I'm a Unit Operating Room Associate at a hospital, and a member of 1199SEIU United Healthcare Workers East. Hospital workers do this job because we want to make a positive difference in people's lives. We CARE. It's hard to see our patients hurting due to chronic short staffing. So, I am speaking out and urging you to issue a favorable report on HB905: Safe Staffing Act of 2025.

I position patients for surgery and transport specimens, body parts, and labs to and from the operating room, and support the surgeons and nurses. Support staff like me are the backbone of the hospital. We are often the only ones that patients get to have casual conversations with. Doctors and nurses are clinical, while we get to ask the patient how they are feeling, what they think of the weather, and anything else that helps the patient feel comfortable.

We also advocate for our patients. The operating room is short staffed every day. We frequently delay or reschedule surgeries, which is particularly burdensome on patients who travel long distances to our hospital. Wait times to receive care, medication, and test results have increased as a result of short staffing. This impacts patients greatly. When a patient sits for too long in one position because there aren't enough workers, they are at a higher risk of developing bed sores, falling, and contracting pneumonia.

This bill is the tool we need to fix short staffing because it requires that 50% of the safe staffing committee be workers. We are the ones on the frontlines of the short staffing crisis. We are the ones with the solutions. Anyone could end up in the hospital, and you'd want your hospital to have a safe staffing committee if you did. Please vote YES on this bill so we can end the short staffing crisis.

In Unity,

Shaniqua Covington

Shaniqua Covington HB905SB720 FAV.pdf
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To Madame Chair and Members of the Committee,

My name is Shaniqua Covington. I'm a Unit Operating Room Associate at a hospital, and a member of 1199SEIU United Healthcare Workers East. Hospital workers do this job because we want to make a positive difference in people's lives. We CARE. It's hard to see our patients hurting due to chronic short staffing. So I am speaking out, and urging you to issue a favorable report on HB905/SB720: Safe Staffing Act of 2025.

I position patients for surgery, transport specimens, body parts, and labs to and from the operating room, and support the surgeons and nurses. Support staff like me are the backbone of the hospital. We are often the only ones that patients get to have casual conversations with. Doctors and nurses are clinical, while we get to ask the patient how they are feeling, what they think of the weather, and anything else that helps the patient feel comfortable. We also advocate for our patients. The Operating Room is short staffed every day. We frequently delay or reschedule surgeries, which is particularly burdensome on patients who travel long distances to our hospital. Wait times to receive care, medication, and test results have increased as a result of short staffing. This impacts patients greatly. When a patient sits for too long in one position because there aren't enough workers, they are at a higher risk of developing bed sores, falling, and contracting pneumonia.

This bill is the tool we need to fix short staffing because it requires that 50% of the safe staffing committee be workers. We are the ones on the frontlines of the short staffing crisis. We are the ones with the solutions. Anyone could end up in the hospital. You'd want your hospital to have a Safe Staffing Committee if you did. Please vote YES on this bill so we can end the short staffing crisis.

In Unity, Shaniqua Covington

Sheldon Gooch HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Sheldon Gooch. I'm a cook at a hospital and a member of 1199SEIU United Healthcare Workers East. My department is responsible not only for preparing food for patients, but also for running the food retail operations in the hospital. We currently have over ten vacancies in my department, and we work short staffed daily. On some days it is so severe that we have one worker doing the work of five people. I urge a favorable report on HB905: Safe Staffing Act of 2025.

Short staffing is only getting worse because management keeps insisting that we continue to "scale up" and add more retail operations while there aren't even enough workers to cover the current inpatient and retail operations. Management's focus on constant "growth" despite worker shortages is problematic for workers and for hospital patients. Workers are experiencing burnout and calling out of work frequently to care for our own mental health, but many of us don't have any sick time left to recover from burnout.

Turnover is high in my department because working short staffed every day is untenable. We frequently have to close retail operations because of short staffing, meaning that outpatients and guests can't get food that day. Nutritional aids are responsible for delivering food to inpatients, and they are short staffed too. That means patients have to wait so long to get their food that it is cold when it arrives, and the food needs to be sent back to us in the kitchen to be remade, doubling our workload.

We need The Safe Staffing Act to be implemented as soon as possible. Hospital workers are at a breaking point. With a safe staffing committee that is 50% workers, we would be able to recommend hospitals cease the bad practice of seeking exponential retail growth without adequate staff for existing operations. We could also recommend changes to the hiring process so that it can be more streamlined instead of taking so long to onboard new workers to fill vacancies. Please vote YES on this bill. Thank you.

In Unity, Sheldon Gooch

Sheldon Gooch HB905SB720 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905/SB720
The Safe Staffing Act of 2025
Position: **FAVORABLE**

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In Unity,

Sheldon Gooch

Shirley Randolph HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Shirley Randolph. I am a Cook at a Long-Term Acute Care Hospital. I support the Safe Staffing Act and urge a **favorable** report because my department is short staffed every day, and the Safe Staffing Act allows workers like me to help fix this problem.

Short staffing puts a burden on our bodies and minds. I used to volunteer to do overtime, but I don't do that anymore because I am so overworked on my regular shift that I am completely exhausted. Long hours of being on your feet and lifting things really add up when you are doing the work all by yourself.

My coworkers and I don't talk to management about the struggles we are facing, because we are afraid they will try to retaliate against us. I'm excited about the Safe Staffing Act because it would actually encourage workers to freely share our ideas without fear. It is important that we have a real voice. Please vote YES on this bill. Thank you.

In Unity,

Shirley Randolph

Shirley Randolph HB905 Testimony FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905
The Safe Staffing Act of 2025
Position: **FAVORABLE**

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In Unity,

Shirley Randolph

Vitjiua Mieze HB905 FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905

The Safe Staffing Act of 2025

Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Vitjitua Meize. I'm a Patient Transporter at a hospital and a member of 1199SEIU United Healthcare Workers East. I am a young, able bodied person with a lot of experience in physically demanding labor like working in warehouses. I never had physical injuries while working in warehouses. Since I started working short staffed in the hospital, I have injured my knee and my back numerous times. Understaffing is getting worse every day. Legislators, we need YOUR help. I urge a favorable report on HB905: Safe Staffing Act of 2025.

I decided to start working at a hospital instead of warehouses because I care about people. Helping patients gives me a sense of purpose. The impact that workforce shortages in my department have on patients is heartbreaking. Their health is at risk because they have to wait longer to be transported for testing and procedures. Timing really matters in the hospital. Last week, my department was two hours behind because of short staffing. When you are waiting to get a procedure or a test that could save your life, waiting an additional two hours can have severe consequences.

Working as a Patient Transporter is physically and mentally draining. A lot of us are burning out. I worry about the impact that has on patients, because when workers are exhausted they are more likely to make mistakes and can't move as quickly. I support the Safe Staffing Act because it will improve the quality of care for our patients. Please vote YES on this life saving bill. Thank you. In

Unity, Vitjitua Meize

Vitjiua Mieze HB905SB720 FAV.pdf
Uploaded by: Brige Dumais
Position: FAV

Testimony on HB905/SB720
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Vitjitua Meize. I'm a Patient Transporter at a hospital and a member of 1199SEIU United Healthcare Workers East. I am a young, able bodied person with a lot of experience in physically demanding labor like working in warehouses. I never had physical injuries while working in warehouses. Since I started working short staffed in the hospital, I have injured my knee and my back numerous times. Understaffing is getting worse every day. Legislators, we need YOUR help. I urge a favorable report on HB905/SB720: Safe Staffing Act of 2025.

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Unity, Vitjitua Meize

MaCCRA 2025 Testimony for Senate - House Bill 905-

Uploaded by: Bruce Hartung

Position: FAV

Maryland Continuing Care Residents Association
Protecting the Future of Continuing Care Residents
The Voice of Continuing Care Residents at Annapolis

SUBJECT: House Bill 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)

COMMITTEE: Senate Finance Committee
The Honorable Pam Beidle, Chair

DATE: Tuesday, April 1, 2025

POSITION: **Favorable**

The Maryland Continuing Care Residents Association (MaCCRA) is a not-for-profit organization representing the residents in continuing care retirement communities (CCRCs). Maryland has over 20,000 older adults living in 38 licensed CCRCs. The principal purpose of MaCCRA is to protect and enhance the rights, well-being, and financial security of current and future residents while maintaining the viability of the providers whose interests are frequently the same as their residents. MaCCRA supports efforts to enhance transparency, accountability, financial security, and preserve existing protections in law and regulation for current and future CCRC residents statewide.

On behalf of the MaCCRA, we support House Bill 905. We understand there are differing viewpoints on the components of the bill, however we see potential for benefits to patients in Maryland. There are longstanding concerns with Emergency Department wait times, overall hospital staffing and lack of fair payment and reimbursement for healthcare providers that is exacerbating staffing. Lack of staffing quickly translates into loss of access to care and lengthy wait times. Efforts to measure and better understand staffing needs can only benefit patients as they help identify specific clinical areas on which hospitals can focus and develop specific actions and policies that will improve staff levels and therefore improve care to Maryland residents.

We ask the committee to take favorable action on House Bill 905. The challenges our health care system faces are significant. This is a time to take aggressive action to meet the challenges. House Bill 905 will do that.

Sincerely,

Bruce Hartung, President
Maryland Continuing Care Residents Association
brucehartung@sbcglobal.net

MaCCRA 2025 Testimony for Senate - House Bill 905-

Uploaded by: Bruce Hartung

Position: FAV

Maryland Continuing Care Residents Association
Protecting the Future of Continuing Care Residents
The Voice of Continuing Care Residents at Annapolis

SUBJECT: House Bill 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)

COMMITTEE: Senate Finance Committee
The Honorable Pam Beidle, Chair

DATE: Tuesday, April 1, 2025

POSITION: **Favorable**

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On behalf of MaCCRA, we support House Bill 905. We understand there are differing viewpoints on the components of the bill, however we see potential for benefits to patients in Maryland. There are longstanding concerns with Emergency Department wait times, overall hospital staffing and lack of fair payment and reimbursement for healthcare providers that is exacerbating staffing. Lack of staffing quickly translates into loss of access to care and lengthy wait times. Efforts to measure and better understand staffing needs can only benefit patients as they help identify specific clinical areas on which hospitals can focus and develop specific actions and policies that will improve staff levels and therefore improve care to Maryland residents. Doing this kind of a study makes it possible for the voices of front-line staff to be heard, as they are likely to have important input and suggestions to make concerning these challenges that they see every day.

We ask the committee to take favorable action on House Bill 905. The challenges our health care system faces are significant. This is a time to take aggressive action to meet the challenges. House Bill 905 will do that.

Sincerely,

Bruce Hartung, President
Maryland Continuing Care Residents Association
brucehartung@sbcglobal.net

HB0905 -Senate_FAV_MedChi, MDACEP, MDACOG_Hospital
Uploaded by: Danna Kauffman
Position: FAV

Senate Finance Committee
April 1, 2025
House Bill 905 – *Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)*
POSITION: SUPPORT

On behalf of MedChi, The Maryland State Medical Society, the Maryland Chapter of the American College of Emergency Physicians, and the Maryland Section of The American College of Obstetricians and Gynecologists, we submit this letter of support for House Bill 905.

This bill requires that each hospital establish and maintain a clinical staffing committee with equal membership from management and employees. The committee must develop a clinical staffing plan for the hospital that meets the patients' needs.

It is well-documented that Maryland has the country's longest emergency department (ED) wait times. A major contributing factor is the boarding of patients. The American College of Emergency Physicians defines a boarded patient as "a patient who remains in the emergency department after the patient has been admitted or placed into observation status at the facility, but has not been transferred to an inpatient or observation unit."[1] "Boarding of admitted patients in the ED represents a hospital-wide failure and contributes to lower quality of care, decreased patient safety, reduced timeliness of care, reduced patient satisfaction, an increased number of patients leaving without being seen, and increased mortality."[2]

To address boarding and other issues affecting the availability of health care services, hospitals should have staffing plans, such as required in House Bill 905, that ensure the availability of sufficient health care and support personnel to meet increased patient needs throughout the entire hospital.

For more information call:
Danna L. Kauffman
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

[1] Policy Statement, *Definition of Boarded Patient*, American College of Emergency Physicians, September 2018, https://www.acep.org/siteassets/new-pdfs/policy-statements/definition-of-boarded-patient.pdf

[2] Policy Statement, *Boarding of Admitting and Intensive Care Patients in the ED*, February 2023, https://www.acep.org/siteassets/new-pdfs/policy-statements/boarding-of-admitted-and-intensive-care-patients-in-the-emergency-department.pdf

HB 905 - Hospitals - Clinical Staffing Committees
Uploaded by: Donna Edwards
Position: FAV

MARYLAND STATE & D.C. AFL-CIO

AFFILIATED WITH NATIONAL AFL-CIO

7 School Street • Annapolis, Maryland 21401-2096

Balto. (410) 269-1940 • Fax (410) 280-2956

President
Donna S. Edwards

Secretary-Treasurer
Gerald W. Jackson

HB 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment
(Safe Staffing Act of 2025)
Senate Finance Committee
April 1, 2025

SUPPORT

Donna S. Edwards
President
Maryland State and DC AFL-CIO

Madame Chair and members of the Committee, thank you for the opportunity to submit testimony in support of HB 905. My name is Donna S. Edwards, and I am the President of the Maryland State and District of Columbia AFL-CIO. On behalf of Maryland's 300,000 union members, I offer the following comments.

Patients and healthcare workers need safe staffing plans. Hospitals have pushed unsafe staffing levels to their limit in order to save money. HB 905 creates a strong foundation by aligning Maryland with nine other states (CT, CO, IL, NV, NY, OH, OR, TX, WA) in ensuring hospitals develop safe staffing plans that include direct care workers to reflect the unique and evolving needs of their patients. This legislation creates a framework to force these discussions that highlight the voices of those on the ground seeing the direct impacts of staffing levels while enhancing accountability within our healthcare system.

HB 905 requires hospitals to establish clinical staffing committees responsible for developing clinical staffing plans that consider such factors as existing staffing levels, coverage needs, staffing standards, and plans to address existing staffing gaps. This ensures that staffing plans are driven by those with direct care experience. Additionally, this legislation promotes adaptability in these clinical staffing plans by requiring each hospital to evaluate the plan and periodically update it to maintain their effectiveness and continue to meet the needs of their staff and patients.

Safe staffing ratios in healthcare have been a demand from patient advocates and workers for years, dating back to before the COVID-19 pandemic. As highlighted in a study done by the University of Pennsylvania School of Nursing's Center for Health Outcomes and

Policy Research (CHOPR), one of the leading causes of burnout in nurses is "the chronic stress caused by patient overload," due to improper nurse-to-patient ratios.[1] Expecting a single nurse to tend to so many patients puts them in a precarious position, not allowing them to deliver quality care effectively or efficiently, which impacts both their well-being and the patients' well-being.

Additionally, academic research strongly supports safe staffing ratios. A study of ratios in Illinois found, "Patient-to-nurse staffing ratios on medical-surgical units ranged from 4.2 to 7.6 (mean=5.4; SD=0.7). After adjusting for hospital and patient characteristics, the odds of 30-day mortality for each patient increased by 16% for each additional patient in the average nurse's workload (95% CI 1.04 to 1.28; p=0.006). The odds of staying in the hospital a day longer at all intervals increased by 5% for each additional patient in the nurse's workload (95% CI 1.00 to 1.09, p=0.041). If study hospitals staffed at a 4:1 ratio during the 1-year study period, more than 1595 deaths may have been avoided and hospitals would have collectively saved over $117 million."[2]

A flexible, collaborative, and patient/worker-centered approach to hospital staffing is essential to the future of our healthcare industry and prioritizing the needs and well-being of our dedicated workforce.

For these reasons, we urge a favorable vote on HB 905.

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[1] Hoag Levins, "How Inadequate Hospital Staffing Continues to Burn Out Nurses and Threaten Patients." University of Pennsylvania Leonard Davis Institute of Health Economics. January 2023.

[2] Lasater, Karen B et al. "Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: an observational study." BMJ open vol. 11,12 e052899. 8 Dec. 2021, doi:10.1136/bmjopen-2021-052899

HB905_SAC_FAV
Uploaded by: Erica J. Puentes Martinez
Position: FAV

Solidaridad Action Committee

Of the Gamma Alpha Chapter of Hermandad de Sigma Iota Alpha, Incorporada

Testimony on HB 0905 - Favorable
HB0905 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)
Senate Finance Committee
March 28, 2025

Dear Honorable Chair Beidle and Members of the Committee,

My name is Valeria Salcedo, I am a life-long Marylander, a Public Health Policy graduate student at The George Washington University, and a sister of Hermandad de Sigma Iota Alpha, Incorporada (SIA). I am writing on behalf of The Solidaridad Action Committee (SAC) of the Gamma Alpha Chapter (GA) of SIA. SAC offers a **favorable** testimony in support of **HB0905 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025).** SIA, inc., is a Latina based but not Latina exclusive sorority with a large membership base throughout the state of Maryland. Our organization includes many women from various backgrounds currently studying at the University Maryland, College Park, Towson University, Johns Hopkins University, and McDaniel College with hopes of soon entering the medical field. Our membership also includes alumnae currently working in Maryland hospitals.

Our sorority takes pride in having a significant membership of working-class, first-generation college-educated Latinas. Despite facing structural inequalities, we have worked tirelessly to gain access to higher education, striving to afford tuition while pushing ourselves academically to enter the professional workforce. Many of our sisters are currently studying to pursue careers in healthcare or are already making an impact as medical professionals.They recall experiences of translating for their parents in hospitals, where staff was unable to effectively communicate or understand their linguistic and cultural needs, leading to inadequate care. This inspired them to become changemakers, break through systemic barriers with grit and determination, and vigorously pursue medicine to one day address a need felt deeply by our families and communities.

Many states had implemented their own staffing requirements after seeing the growth in association between the understaffing of nurses and the outcome of those under their care. Per a study conducted by the Center of Health Outcomes and Policy Research at University of Pennsylvania (UPenn) in 2010, it showed that California's 2006 requirements reduced the workload of nurses by one to two patients, which led to a significant decrease in patient mortality rate compared to states with no requirements. In New Jersey and Pennsylvania, there would have been 13.9% and 10.6% fewer deaths if their patient-to-nurse ratios were equal to that of California's.

Solidaridad Action Committee

Of the Gamma Alpha Chapter of Hermandad de Sigma Iota Alpha, Incorporada

Maryland's hospitals are experiencing a workforce shortage, with the gap being even more pronounced when considering the underrepresentation of Latina medical professionals. Given the systemic inequalities Latinas already face, it is important that Maryland ensures that hospital staff are given a voice to better the conditions that medical workers endure as *a matter of equity.* This is why the Safe Staffing Act of 2025 is so important to us. Many Latinas, have faced challenges when entering or trying to enter the medical field, saddled with student debt, and find increased obstacles in Maryland's hospitals that are underpaid and overburdened. With poor treatment in these facilities, hospitals fail at staff retention - and this directly impacts the experiences that Latines face both as staff and patients. The Safe Staffing act would give workers the opportunity to share their experiences and offer input regarding worker conditions. Supporting the Safe Staffing Act would help many of our Latina medical professionals stay and enter the medical field to fulfill the promises they made to their communities.

The Solidaridad Action Committee of SIA's GA **urges the Senate Finance Committee to provide a favorable report on HB0905.**

PM Written Testimony. FAV. HB905.pdf
Uploaded by: Erica Puentes
Position: FAV

PROGRESSIVE MARYLAND
P.O. Box 6988, Largo MD 20774
ProgressiveMaryland.org
Info@progressivemaryland.org

Bill Title: HB0905 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)
Position: Support (FAV)
To: Senate Finance Committee
From: Erica Puentes, Progressive Maryland Legislative Coordinator on behalf of Progressive Maryland
Date: March 28, 2025

Dear Chair Beidle and Members of the Senate Finance Committee:

Progressive Maryland is pleased to offer **a favorable testimony in support of HB0905 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025).** Progressive Maryland (PM) is a statewide grassroots group working for a more robust, equitable and patient centered healthcare system. PM is proud to be part of the Patient Worker Collaborative, a coalition representing more than a million Marylanders, that has come together to raise concerns about emergency room wait times and the ongoing hospital staffing shortage that contributes to them.

Like all of you, we regularly hear stories from our members about very long and frustrating wait times in emergency rooms. During a recent member call, one of our members shared a story about waiting in the Hopkins ER from 5:00 p.m. until 9:00 a.m. the following day—an exhausting 16-hour wait before a doctor finally saw him. Given the critical staffing shortage in hospitals and the need for more nurses, the Safe Staffing Act of 2025 offers an excellent remedy to what is ailing our emergency rooms. Creating safe staffing conditions will help our hospitals recruit and retain the workforce they need to meet Marylander's needs.

This legislation gives hospitals clear guidance to develop nurse staffing committees and staffing plans that will better serve the goals of staff retention, workplace safety, and most importantly, patient care. It's not acceptable for our state to have the worst ER wait time record in the country year after year. HB905 will allow Maryland to join nine other U.S. states who have taken steps to create blended staffing committees, staffing plans, and public reporting requirements to improve the way we deliver care.

Progressive Maryland urges a favorable report on HB905.

TESTIMONY ON HB905 - Google Docs.pdf
Uploaded by: Jacqueline (Jackie) MacMillan
Position: FAV

TESTIMONY ON HB905
SAFE STAFFING ACT OF 2025

April 1, 2025

POSITION: FAVORABLE

Hon. Chair Beidle, Vice Chair Hayes, and Members of the Finance Committee:

I am writing to support HB905, the Hospital Safe Staffing Committees bill, which addresses Maryland's long-running hospital staffing crisis.

Enacting HB905 would help protect hospital patients and healthcare workers, increase transparency and accountability, and improve job satisfaction and retention. Involving direct care workers in the creation of staffing plans is a commonsense step toward achieving better hospital care in Maryland.

Nurses and technicians play a critical role in our safety, comfort, and recovery in the hospital, at those moments when we are most vulnerable. HB905 would help make sure that these direct care staff are adequately supported, so that they can support us when we need them.

I respectfully urge a favorable report on HB905.

Jacqueline MacMillan
Baltimore, MD

HB 905 Testimony FINAL - Senate .pdf
Uploaded by: Jennifer White
Position: FAV

JENNIFER WHITE HOLLAND
Legislative District 10
Baltimore County

Health and Government
Operations Committee

The Maryland House of Delegates
6 Bladen Street, Room 319
Annapolis, Maryland 21401
410-841-3744 · 301-858-3744
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THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

April 1, 2025

Testimony in Support of House Bill 905
Hospitals - Clinical Staffing Committees and Plans - Establishment
(Safe Staffing Act of 2025)

Good afternoon Chair Beidle, Vice Chair Hayes, and members of the Senate Finance Committee. Thank you for the opportunity to present **HB 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)** for your consideration.

Like the House Health and Government Operations Committee, the Senate Finance Committee continues its work in addressing Emergency Department (ED) wait times, healthcare workforce shortages, access to primary care, the rising costs of prescription drugs, and other issues that burdens our healthcare system. **HB 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)** presents an opportunity to improve the workplace environment, center voices of the direct care workforce in staffing decisions, and retain staff.

HB 905 is a hybrid approach that will ensure each hospital can establish its own staffing committee, or reconstitute an existing staffing committee if one already exists, and tailor staffing plans according to their specific needs. This amended bill provides flexibility, allowing hospitals to make changes to their plans at any time while simultaneously ensuring a framework of transparency and accountability. The healthcare sector experienced many setbacks during COVID-19 with high healthcare workforce shortages[1] due to high staff turnover, shifting care delivery models, and insufficient nursing pipelines[2]. As passed in the House, the Safe Staffing Act of 2025 will serve as a tool that aims to do the following:

- Requires hospitals to establish and maintain a clinical staffing committee that has equal membership from management and employees;
- Requires the clinical staffing committee to develop, review, evaluate, revise as appropriate.

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[1] https://health.maryland.gov/docs/SB%20440%20Ch.%20708%20(2022)%20%E2%80%93%202023%20Final%20Report%20%E2%80%93%20Commission%20to%20Study%20the%20Heal.pdf

[2] https://mhaonline.org/wp-content/uploads/2023/02/2022-State-of-Maryland-s-Health-Care-Workforce-Report.pdf

The Issue

Hospitals all over Maryland are currently facing shortages across the board and more specifically, nursing shortages. According to a 2022 report from the Maryland Hospital Association, RNs, and LPNs are experiencing some of the highest vacancy rates among healthcare professionals at 25.4% and 37.7%, respectively.[3] Factors such as burnout, feelings of being undervalued, and overwhelming workloads have been cited as being reasons for departures from the nursing profession.[4]

The Safe Staffing Act of 2025 may be a part of the solution in addressing the nurse staffing shortage and improve the workplace environment in hospitals. Research demonstrates that ample nurse staffing is crucial for quality care; and safe nursing conditions lead to improved patient outcomes.[5] Furthermore, nurse staffing committees were found to satisfy all four key factors of nursing staffing: the use of nurse staffing evidence, cost to hospitals and state governments, political feasibility, and an analysis of the policy's effects on patient outcomes.[6] These staffing committees provide an avenue for input from frontline workers in the planning process recognizing their expertise in addressing patient needs across various healthcare settings.[7] As Maryland experiences ongoing patient growth, it is important that the state sustains and enhances the provision of high-quality healthcare services to effectively meet current and future demand.

Addressing Misconceptions

There are several misconceptions surrounding the aims of this bill such as the following:

1. **Staffing plans are too rigid and can lead to bed closures and put patients at risk.**
    - *Flexibility*: This bill allows for flexibility and does not mandate staffing ratios or penalize hospitals for any staffing plan changes. These committees are free to make changes as they see fit.
2. **There will be a lot of administrative burden placed on hospitals.**
    - *Collaborative*: Hospitals should aim to have joint labor and management committees to address care and staffing because it has proven effective in the past. The Maryland Hospital Association has agreed to set up joint safe lifting committees in 2007 and joint workplace violence committees in 2014.

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[3] https://mhaonline.org/wp-content/uploads/2023/02/2022-State-of-Maryland-s-Health-Care-Workforce-Report.pdf
[4] https://www.nursingworld.org/content-hub/resources/nursing-leadership/why-nurses-quit/
[5] https://pmc.ncbi.nlm.nih.gov/articles/PMC8428863/#:~:text=1%20Empirical%20studies%20have%20shown,increase%20nurse%20staffing%20in%20hospitals.
[6] https://njccn.org/wp-content/uploads/2024/02/Nursing-Forum-2021-Bartmess-Nurse-staffing-legislation-Empirical-evidence-and-policy-analysis.pdf
[7] https://pmc.ncbi.nlm.nih.gov/articles/PMC8428863/

3. **The state currently does enough work on addressing the healthcare staffing crisis.**
    - *Care Team Approach*: Existing state-led commissions have addressed the workforce shortage through loan repayment, sign-on bonuses, and improving the education pipeline, but the issue of understaffing, retention, and declining quality of care in hospitals still remains persistent. This bill recognizes that those closest to the problem are closest to the solutions and no one in the entire care team should be overlooked
4. **The staffing crisis has many factors tied to it and hospitals are not to blame.**
    - Meaningful changes are prevented when there is inaction due to the complex staffing crisis. This bill will allow hospitals to take action to address the overlap of many factors.

The Opportunity
This bill presents an opportunity for our state to integrate the use of staffing committees, staffing plans, and reporting to better support our indispensable healthcare workers. This hybrid approach will establish staffing plans that are worker-driven, flexible, and publicly accessible. Furthermore, the bill ensures that our healthcare workforce is not overlooked in the decision-making process, enhances workplace safety, addresses staff turnover, and improves the overall quality of care.

I respectfully request a **FAVORABLE** report.

Thank you for your consideration,

Delegate Jennifer White Holland

JAS Testimony Favor HB 905.pdf
Uploaded by: John Spillane
Position: FAV

Testimony in SUPPORT of HB905: Safe Staffing Act of 2025

Dear Honorable Madam Chair and Members of the Committee,

My name is John Spillane and I live in Prince George's County.
I'm asking for your support for safe staffing in Maryland's Emergency Rooms and Emergency Departments.

Why do we need HB905: The Safe Staffing Act of 2025? We have a huge problem with Emergency Room wait times in Maryland. This is a problem that I have personally experienced, at Luminis Health Doctors Community Medical Center in Lanham. According to Hospital Stats (hospitalstats.org) this facility has an average wait time of 4 hours and 55 minutes. In March of 2024 I was there for more than eight hours.

The Centers for Medicare and Medicaid Services records that Maryland has had the worst emergency room wait times among 50 states for the past eight years. The average ER wait time for emergency care in Maryland? Over four hours. Many patients may wait as long as 24 hours to receive care. This problem is driven by staffing shortages. There is an acute need for more staff that will provide more capacity to run ERs and reduce wait times.

So I ask you to commit to supporting HB905: Safe Staffing Act of 2025. Thank you for your consideration.

John Spillane
Hyattsville, MD

EricKa Dunkins HB905 Testimony.pdf
Uploaded by: Leyla Adali
Position: FAV

Testimony on HB905: The Safe Staffing At of 2025
Position: **FAVORABLE**

To Chair Pamela Beidle and Members of the Senate Finance Committee,

My name is Eric'ka Dunkins. I am a Registered Nurse, working the night shift in the Labor & Delivery unit at a hospital in Prince George's County. My unit has 27 beds, but we only have 2 to 4 RNs on shift at a time. We don't have techs or charge nurses; many nights we don't even have a unit clerk. I urge a **favorable** report on HB905: The Safe Staffing Act of 2025.

Commented [LA1]: Just a quick Q - does this mean two to four on shift at any given time?

Commented [BD2R1]: yes, sometimes they have 2 RNs, sometimes they have 4 (4 is still short! 2 is absurd)

Commented [LA3R1]: yes sorry was asking because it wasn't clear

Patients aren't statistics, they are real people who face consequences when we are chronically understaffed. Last month, an ante-partum patient ruptured. We called for a doctor, but no one came to assist us for hours. We had to perform an emergency C-section so the baby would survive. If we had enough staff, the patient's condition likely would not have escalated to that extreme. Recently, we had an ante-partum patient's blood sugar drop down to 12. With proper staffing, we could have properly monitored her blood sugar and food intake, but we were short, so that wasn't possible. We caught it right as she was about to become comatose. I still think about what happened to her every time I go to work, and it haunts me. These cases take a mental toll on nurses. We choose to do this work because we care and we want to help people, and short staffing is preventing us from doing that to the best of our ability.

Nurses are burning out because of the mental and physical stress we are faced with. I'm 24 and am already experiencing burnout. I paid for four years of school to become a nurse. I worked hard to get to where I am, and I want to know that I am making a difference when I clock in every day. But nurses in my generation are overwhelmed at the prospect of facing this short staffing crisis for the entirety of our careers.

When younger nurses bring our ideas to management about how to fix the staffing issues in our hospital, we are belittled, and our suggestions are not implemented. That is why so many nurses my age quit. Having a seat at the table to give our perspective will help more nurses in my generation stay in healthcare long term. That is why the Safe Staffing Act is so vital. Please vote YES on HB905. Thank you.

In Unity, Eric'Ka Dunkins

HB905_Finance_1199SEIU_FAV.pdf
Uploaded by: Leyla Adali
Position: FAV

Testimony for HB 905
Safe Staffing Act of 2025
Before the Senate Finance Committee
April 1st, 2025
Position: **FAV**

Dear Chair Beidle and Members of the Committee:

My name is Ricarra Jones, and I am the political director of 1199SEIU United Healthcare Workers East in Maryland/DC. 1199SEIU is the largest healthcare union in the nation, and here in Maryland we have over 10,000 members working in hospitals, long term care settings, and federally qualified health centers. 1199SEIU proudly supports HB 905. Our members' experiences show that administrative decisions can have a major impact on patient quality of care.

HB 905 is collaborative, flexible, and timely. It ensures each hospital establishes a staffing committee with half the committee made up of the diverse care team needed for patient care: physician, resident physician if in a teaching hospital, ER nurse, certified nursing assistant, environmental service worker, dietary aide, and a technician. Staffing committees are responsible to address patient safety challenges due to staffing, process for resolving ongoing challenges, and submitting an annual staffing plan. Beginning in 2029, the hospitals will submit reports to the Senate Finance committee and the House Health and Government Operations Committee.

The healthcare workforce shortage is not due to the lack of nurses but the lack of nurses willing to endure unsafe staffing conditions and burnout, issues that have worsened since the start of the COVID-19 pandemic. This legislation offers a holistic approach to addressing workplace systems that cause unsafe and unnecessarily challenging working conditions that lead to high worker turnover. Right now, workers are telling us that they need more support. Hospital workers are more likely than workers in any other in-patient setting to name burnout as a reason for leaving their occupations.

Poor staffing conditions are also associated with higher mortality rates and longer lengths of stay for patients. If the health worker burnout crisis is not addressed, it will be increasingly difficult for patients to get care when they need it, health costs will rise, health disparities will increase, and it will be harder for Maryland to prepare for the next public health emergency.

Effective staffing plans can be potentially cost-effective for hospitals that rely heavily on contracted staffing agencies for staff. Travel nurses filled a much-needed gap in staffing those hospitals faced during the pandemic. But these temporary workers, contracted by large private equity backed corporations, often receive significantly higher pay than permanent staff nurses, costing the hospitals much more[3]. Now that the need for immediate support from travel nurses is less dire, 1199SEIU believes

that investing in a permanent workforce through higher wages and adequate staffing will improve worker retention and quality of patient care.

With Maryland's unique healthcare financing model and the new AHEAD model, this legislation offers an opportunity to track how staffing conditions impact hospital expenditure and quality of care. It's important to note that this legislation is flexible. It does not mandate staffing ratios, nor does it force a hospital to make fiscal decisions that negatively impact quality of care. It ensures there is open and transparent dialogue between the state, hospital administrations, direct care workers, and patients to address a crisis. Staffing committees allow each hospital to tailor staffing plans to meet its most pressing needs.

When direct care workers are part of staffing plans, they can create collaborative and transparent processes for addressing the staffing crisis. Oregon recognized that its original staffing committee bill was too weak, and in 2015, the state amended the legislation to enhance nurse engagement in the committee, increase transparency in decision-making, and improve state oversight and enforcement. Research shows that Oregon's enhanced law had a positive impact on the availability of LPN and NAP staff. While further research is needed, states that are considering staffing committee legislation approach would do well to examine the transparency and effectiveness of existing staffing committees[4].

1199SEIU believes that transparency and considering worker input will lead to more effective decision making in hospitals. The Commission to Study the Healthcare Workforce Crisis final report highlighted the importance of collecting adequate data on wages, retention, and staffing conditions. The Safe Staffing Act of 2025 will ensure that the Maryland Department of Health will have accurate and timely data on staffing at each hospital in the state.

This bill allows Maryland to be a healthcare policy leader, along with nine other US states, by blending staffing committees, staffing plans, and public reporting to improve the way we deliver care. It will yield staffing plans that address workplace safety, staff retention, and patient care. For these reasons and more, 1199SEIU urges a favorable report on HB 905. If you have any questions, please email me at ricarra.jones@1199.org.

Sincerely,

Ricarra Jones
Political Director
1199 SEIU United Healthcare Workers East

Kiesha Everett HB905SB720 FAV.pdf
Uploaded by: Leyla Adali
Position: FAV

Testimony on HB905/SB720
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Kiesha Everett, and I work as a Geriatric Nursing Assistant at a hospital in Maryland. I'm also a member of 1199SEIU United Healthcare Workers East. Today, I'm asking you to issue a favorable report on HB905/SB720: Safe Staffing Act of 2025.

I've worked as a GNA for thirteen years, and in recent years short staffing has become a much bigger problem than it was when I started in this line of work. I quit my last job at a different hospital because short staffing made it impossible for me to do my job effectively.

The first few weeks of my current job were better, but sure enough, I'm working short again. Recently, I was the only GNA assigned to 22 patients in the psychiatric unit. I'm a "float", which means that I work across multiple units. There should never be 22 patients to one GNA in any circumstance.

When I work short staffed, I don't have enough time to give to each resident. But at the same time, taking a longer time to get to a resident creates a cycle in which I have to spend more time in each resident's room because their needs pile up. A ten-minute visit might become a 25-minute visit. This also means that I'm eating lunch at 3 pm on some days or putting off going to the bathroom myself.

A lot of people don't want to work this job because the pay is unacceptable. If you pay, then we will show up. But it's not right to ask someone to give residents baths and showers and ensure that they eat while offering them $16 an hour. It leaves a lot of people fed up and questioning why they shouldn't quit GNA work entirely.

I support this bill because having safe staffing committees at hospitals will allow workers to make their voices heard. Management needs to be fair and listen to us when we explain what we need to succeed at work. Please vote YES on this bill so we can end the short staffing crisis.

In Unity,

Kiesha Everett

Kongit Nega HB905SB720 FAV.pdf
Uploaded by: Leyla Adali
Position: FAV

Testimony on HB905/SB720
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

My name is Kongit Nega and I have worked as a registered nurse at a hospital in Maryland for 21 years. I am also a member of 1199SEIU United Healthcare Workers East, which represents more than 10,000 members in Maryland and Washington, DC. I'm asking you to issue a favorable report on HB905/SB720: Safe Staffing Act of 2025.

As a medical-surgical nurse, I see patients who have come from the emergency department, the intensive care unit (ICU), and the post-anesthesia care unit (PACU) among others. When we work short staffed, we might not be able to see one patient for four hours. During that time, their condition can change, and it might be necessary to send them back to the ICU, so it's important to maintain a safe nurse to patient ratio. Ideally, each nurse will only have four patients a shift, but we often have six patients, which makes it more difficult for us to give quality care. It's common for us to be short staffed two or three days in a row.

A lot of nurses are hired and quit soon after because they see how short-staffed we are. Working short is emotionally and physically draining; it causes your whole body to ache. Even when I feel exhausted, I don't call out sick, because I don't want my colleagues to work short.

Other workers, like patient care technicians (PCTs) are also short-staffed, which affects RNs, too. I support the Safe Staffing Act of 2025 because working short is a safety issue, and it's important that workers have a place to voice their concerns.

In Unity,

Kongit Nega

VC HB905SB720 FAV.pdf
Uploaded by: Leyla Adali
Position: FAV

Testimony on HB905/SB720
The Safe Staffing Act of 2025
Position: **FAVORABLE**

To Madame Chair and Members of the Committee,

I work as a patient care technician at a hospital in Maryland and am a member of 1199SEIU United Healthcare Workers East, which represents more than 10,000 members in Maryland and Washington, DC. Today, I'm asking you to issue a favorable report on HB905/SB720: Safe Staffing Act of 2025.

I've been at the hospital I work at for fourteen years now. In my role as a PCT, I change and feed patients, take them for walks and to the bathroom, and administer EKGs. I also assist nurses.

Short staffing is a serious problem at my workplace. Sometimes I'm the only tech on the floor with 16 patients, but the ratio that we're supposed to maintain is one to eight. When we work short staffed, we're expected to maintain the same high level of care as when we have a more favorable ratio.

When you're short staffed, everyone needs help at the same time, and you only have two hands. You have to keep rushing, and you can't take your time with a patient. I don't feel like I'm putting my best foot forward when I'm trying to help somebody while rushing to help the next person, and it doesn't leave me time to listen to patients. Some patients want to talk to their PCT because there isn't anyone else around for them to talk to. I'd like to be able to listen to them, but there isn't enough time.

I love my job because I like taking care of people, and that's why I'm holding out hope and telling myself that it's going to get better. But when I'm short staffed, it puts me in a different mood, leaving me stressed and tired. When we try to tell management what we need, they say that they're working on hiring more staff. I see new staff sometimes, but many don't stay for very long. I support this legislation because having safe staffing committees at hospitals will allow workers to have a seat at the table and communicate to management what we need to end the staffing crisis. Please vote YES on the Safe Staffing Act of 2025.

In Unity, VC

HB 905_Finance_PWCTestimony_Fav.pdf
Uploaded by: Loraine Arikat
Position: FAV

HB 905
The Safe Staffing Act of 2025
Before the Senate Finance Committee
April 1, 2025
Position: **FAVORABLE**

The Patient Worker Collaborative is a new coalition of patients and their family members, healthcare workers, and community partners working to pass the Safe Staffing Act of 2025 in the Maryland General Assembly. Collectively, our coalition represents over 1 million Marylanders who are concerned about and affected by the hospital short staffing crisis. This legislation has broad support from patients, physicians of MedChi, emergency responders of the Black Chief Officers Committee, NAACP, Marylanders for Patient Rights, 1199SEIU, Chesapeake Physicians for Social Responsibility, and all the organizations listed below.

Many Maryland hospitals face critical staffing shortages, leading to high staff turnover and burnout, longer emergency room wait times, and reduced quality of care. Research shows that staffing challenges cause not only emergency room wait but also delay in care leading to poor outcomes. The Safe Staffing Act establishes staffing committees in each hospital that bring the knowledge and experience of frontline health care workers to bear on staffing challenges and patient care conditions.

Maryland patients need the Safe Staffing Act of 2025 to address the staffing crisis. It is collaborative, flexible, and timely!

- **Collaborative**: Joint labor and management committees have successfully addressed issues such as safe lifting and workplace violence. This approach now needs to be applied to ensure safe staffing.
- **Flexible**: The staffing plans can be amended at any time and can be adapted to the unique needs of each hospital.
- **Timely**: The Safe Staffing Act will help hospitals meet the quality metrics for the new AHEAD model.

We urge the committee to vote YES on HB 905 because those closest to the problem are closest to the solution.

HB 905 - X - FAV - FIN - ALZ Association.pdf
Uploaded by: Megan Peters
Position: FAV

Bill: HB 905 - Nursing Homes - Direct Care Wages and Benefits and Cost Reports
Committee: Finance
Position: Favorable
Date: April 1, 2025

On behalf of the 127,200 Marylanders living with Alzheimer's disease and their 247,000 caregivers, the Alzheimer's Association supports HB 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025). This bill will establish hospital safe staffing committees, composed of 50% direct care workers, at each hospital that will help drive solutions to staffing and safety issues.

The Alzheimer's Association works with healthcare systems, including hospital settings, to address the rising costs of dementia care and improve patient care and outcomes. HB 905 can further the mission of improving patient care and outcomes through offering an approach to addressing staffing conditions and burnout that contribute to high staff turnover and impacts on patient care.

Poor staffing conditions are associated with higher mortality rates and longer lengths of stay for patients. Longer lengths of stay for patients with dementia can be especially devastating as this is a significant change from their routine and can lead to increased confusion. Staffing conditions and staff burnout must be addressed – if they are not, we know it will be increasingly difficult for patients to get care when they need it, health costs will rise, and health disparities will increase.

A staffing committee, like the one proposed in HB 905, ensures there is open and transparent dialogue between the state, hospital administrations, and direct care workers to address a staffing crisis. Staffing committees allow each hospital to tailor staffing plans to its most pressing needs, and HB 905 does not mandate staffing ratios or force a hospital to make fiscal decisions that negatively impact quality of care.

HB 905 is important legislation that will strengthen our healthcare workforce at hospitals and improve the quality of care for Marylanders. The Alzheimer's Association urges a favorable report on HB 905. Please contact Megan Peters, Director of Government Affairs at mrpeters@alz.org with any questions.

HB905SB720 Johnine Gunsalus_NY_FAV.pdf
Uploaded by: Melissa Hodges
Position: FAV

Testimony for HB 905/SB 720
Safe Staffing Act of 2025
Position: **FAV**

Dear Chair Beidle and members of the Committee:

My name is Johnine Gunsalus and I have been a nurse for 35 years in New York. As a healthcare worker who is part of a clinical staffing committee, I am testifying in support of HB 905. In 2021, New York passed the Safe Staffing Committees legislation and since then, healthcare workers have been key voices in tangible and effective solutions to staffing issues in the hospital.

Before this legislation, I was like many of the healthcare workers in Maryland and in the nation working understaffed, burnt out, disappointed by the inadequate care patients were receiving due to hospital management decisions on staffing, and left out of the discussions to address the healthcare workforce crisis. The Safe Staffing Act gives workers a transparent process to come up with strategies and solutions named by workers who know the issue personally.

Our clinical staffing committee meets monthly to report back on staffing conditions, complaints, issues, and work together to find solutions. It's not just about staffing ratios, but also about addressing issues that certain health care workers might have due to their assignments and unit protocols. The staffing committee holds all stakeholders accountable for making meaningful changes that truly improve the care we deliver.

This legislation will foster true collaboration between hospital management and healthcare workers. I feel more empowered and happier in my position by being a part of the staffing committee because I know that my perspective is considered to help create better jobs for co-workers and better care for my patients.

With Maryland's all-payer model and preparing for the AHEAD model, it is poised perfectly to adopt The Safe Staffing Act of 2025 and connect staffing to quality of care. I urge this committee to issue a favorable report on HB 905/SB72-. I am happy to answer any questions you might have at johnine.gunsalus@1199delegate.org. Please see our staffing committee's annual report below.

Sincerely,

Johnine Gunsalus

1199 SEIU Delegate

Buffalo, New York

Attachment to Johnine Gunsalus Testimony:

Clinical Staffing Committee (CSC) Update

“New York State passed safe staffing legislation that required each hospital to develop Clinical Staffing Committees (CSC). Your Oishei Children's Hospital (OCH) Committee consists of staff from each unit/job title (registered nurses, medical assistants, unit secretaries, surgical technologists and obstetrical technologists), OCH president, chief nursing officer, nurse leaders, labor organizers and delegates, director of finance and chief operating officer.”

This was a historic event in New York State, and we are proud of the OCH CSC for working together in partnership with labor and management to come to an agreement by June 2022 for safe staffing ratios.

- CSC meets monthly. The members of the committee have open discussions daily in real time about staffing
- Staffing levels are evaluated each month including vacancies, disabilities, orients and agency
- Monthly review of any complaint forms submitted
- Formulated plan to resolve subcommittees that are working on solutions for all substantiated complaints

Accomplishments:

- This committee has worked on **increasing staff**, including MAs and unit secretaries, across the hospital to meet ratios
- Added RN positions in EMU to help decrease the use of pediatric float pool (PFP) to provide better coverage house-wide for nursing
- Added in 11 a.m. to 11:30 p.m. medical assistant (MA) on J10 and J11
- Changed unit secretary shift length in NICU to provide consistent coverage per agreed upon staffing plan
- Added a short shift position in PACU for MA coverage
- We have worked diligently to make sure the ancillary team members are an **equal part** of the clinical care team
- We agreed and executed on bringing the NICU POD from **8 beds down to 6**. With this, we moved two Phillips monitors back into the NICU proper
- Added unit secretary in Labor and Delivery 11 a.m. to 11 p.m.
- Increase in staff from 2022 to 2024
    - RN – 532.14 to **582.96**
    - MA – 65.20 to **88.59**
    - Unit Secretary – 14.47 to **16.93**
    - Surgical Technologists – 26.02 to **29.36**
    - OB technologist have stayed steady with **11.03**
    - This represents a total increase of more than **79** positions

Testimony for HB 905 High Note Consulting 4-1-2025

Uploaded by: Michael Dalto

Position: FAV

HIGH NOTE
CONSULTING

Testimony for HB 905
Safe Staffing Act of 2025
Before the Senate Finance Committee
April 1st, 2025
Position: **FAV**

Dear Chair Beidle and Members of the Committee:

My name is Michael Dalto and I am President of a small human service consulting business in Maryland.

My customers include many Marylanders with disabilities who must regularly receive hospital services. I hear reports of their receiving inadequate treatment due to insufficient hospital staffing levels.

I also have a son who is employed as a Certified Nursing Assistant (CNA). My son regularly reports to me the impact of high patient-to-CNA ratios on the quality of care for patients and on the stress, health and morale of my son and his coworkers. Not surprisingly, high ratios correlate with substandard care and poor health outcomes for patients, and declines in health and morale of health care workers. Workers who deliver direct care to patients obviously understand better than anyone else the impact of their working conditions on their lives and the lives of their patients. The Safe Staffing Act of 2025 recognizes that direct care workers should have a major voice in recommending staffing levels that meet the needs of patients and help retain workers.

I urge you to issue a favorable report on HB 905. Thank you.

Sincerely,

Michael Dalto, President
High Note Consulting, LLC

HB905 - Senate - PJC - Support.pdf
Uploaded by: Sam Williamson
Position: FAV

Sam Williamson, Attorney
Public Justice Center
201 North Charles Street, Suite 1200
Baltimore, Maryland 21201
410-625-9409, ext. 234
williamsons@publicjustice.org

HB905: Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)
Senate Finance Committee, April 1, 2025
Position: FAVORABLE

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization that seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Workplace Justice Project works to expand and enforce the right of low-wage workers to receive an honest day's pay for an honest day's work. **The PJC supports HB905, which would establish safe staffing committees for Maryland's hospitals.**

Maryland has the longest Emergency Department (ED) wait times of any state in the country.[1] As the Maryland Health Services Commission identified, understaffing is one of the key factors that increases our ED stay lengths.[2] Staffing turnover is caused by working conditions and workload/staffing ratios.[3] Unless we act, Maryland's staffing shortages will continue to worsen.[4]

It is vital that we give workers opportunities to provide input on staffing ratios and other staffing concerns. Without input from frontline staff, Maryland will continue to see understaffing in our hospitals, and Maryland patients will continue to suffer the consequences. When one additional patient is added to the average nurse workload, odds of death increase for all patients, and odds of death are particularly elevated for Black patients.[5] Maryland patients deserve equitable and sufficient nursing care, and hospital workers deserve sustainable working conditions.

For these reasons, the PJC **SUPPORTS HB905** and urges a **FAVORABLE** report. Should you have any questions, please call Sam Williamson at 410-625-9409 ext. 234.

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[1] Health Management Associates, *Maryland General Assembly Hospital Throughput Work Group Final Report* (Mar. 2024), p.7, https://mhaonline.org/wp-content/uploads/2024/05/maryland-general-assembly-hospital-throughput-work-group-final-report-march-2024.pdf.
[2] Briefing on AHEAD Model Implementation and Emergency Department Wait Times, Senate Finance Committee (Jan. 21, 2025), P.20, https://mgaleg.maryland.gov/meeting_material/2025/fin%20-%20133819452036704332%20-%20Briefing%20Materials%20-%20AHEAD-EDWaitTimes%2001-21-25.pdf.
[3] NSI Nursing Solutions, Inc., *2024 NSI National Heath Care Retention & RN Staffing* Report (Mar. 2024), P.6 https://www.nsinursingsolutions.com/documents/library/nsi_national_health_care_retention_report.pdf.
[4] Global Data, *Maryland Nurse Workforce Projections: 2021-35* (June 2022), p. 28 https://mhaonline.org/wp-content/uploads/2024/05/Maryland-Nurse-Workforce-Projections-GlobalData.pdf.
[5] J. Margo Brooks, *et al.*, *Nursing Staffing and Postsurgical Outcomes in Black Adults*, J. Am. Geriatris Soc., Vol. 60, Issue 6, p.1078-84 (2012), https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03990.x.

HB 905 Clinical Staffing.Crossover.FAV.AARPMD.pdf
Uploaded by: Tammy Bresnahan
Position: FAV

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HB 905 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)
Senate Finance Committee
April 1, 2025
FAVORABLE

Good afternoon, Chair Beidle and Members of the Senate Finance Committee. My name is Tammy Bresnahan; I am the Senior Director of Advocacy for AARP Maryland. I am submitting this testimony on behalf of AARP who represents over 850,000 members in strong support of HB905, the Safe Staffing Act of 2025. This critical legislation, which mandates the establishment of clinical staffing committees and plans in hospitals, is necessary to ensure the safety and well-being of both patients and healthcare workers. We thank Delegate White Holland for her leadership on HB 905.

As an organization that advocates for the health and safety of older Americans, AARP recognizes the urgent need for HB905. Across our state, hospital emergency rooms and critical care departments are experiencing chronic understaffing, placing undue strain on healthcare workers and putting patients at risk. Ensuring adequate staffing levels is essential to delivering high-quality, timely, and effective medical care.

Older patients frequently require more intensive and coordinated care due to chronic conditions, mobility challenges, cognitive impairments, and other age-related health issues. A well-staffed, well-trained, and well-supported clinical workforce is vital to providing the safe, responsive care that older adults deserve. Clinical staffing committees that include both employee and management voices can help ensure that staffing plans are realistic, adaptive, and patient-centered.

This legislation is especially important because it establishes:

- **Annual planning and implementation requirements** to make sure staffing levels match the actual needs on the ground.
- **A mid-year review process** to assess whether the plan is working effectively and to make necessary updates.
- **A clear and transparent complaint process** for addressing issues, empowering workers and other stakeholders to raise concerns and see them resolved fairly.
- **Ongoing accountability through MHA reporting**, ensuring continued progress and transparency beyond the initial implementation phase.

AARP Maryland applauds the General Assembly's recognition that hospitals cannot take a one-size-fits-all approach to staffing, and that those closest to patient care must have a say in how

staffing decisions are made. This collaborative approach will not only improve working conditions for healthcare professionals but also lead to better outcomes for patients—particularly our older population who are most frequently hospitalized and most vulnerable to the consequences of inadequate staffing.

By passing HB905, Maryland will join other states that have successfully implemented similar staffing regulations, resulting in improved patient outcomes and better working conditions for healthcare professionals. The bill is supported by a coalition of patient advocacy groups, reflecting a broad consensus that safe staffing is essential to our healthcare system.

A Call to Action

We respectfully urge the Committee to pass HB905 to protect our patients, safeguard our healthcare workers, and strengthen the integrity of our hospital systems. AARP stands in full support of this legislation and respectfully asks for a favorable report on HB905. Thank you for your time and consideration.

HB 905-- Safe Staffing Act (1).pdf
Uploaded by: Todd Reynolds
Position: FAV

A Union of Professionals
AFT Maryland

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Kenya Campbell
PRESIDENT

LaBrina Hopkins
SECRETARY-TREASURER

Written Testimony Submitted to the
Maryland Senate Finance Committee
HB 905: Hospitals – Clinical Staffing Committees and Plans – Establishment
Safe Staffing Act of 2025
April 1, 2025
SUPPORT

Good afternoon Chair Beidle, Vice Chair Hayes, and members of the Senate Finance Committee. AFT-Maryland is the certified bargaining representative for the hundreds of doctors who are Residents and Fellows at the University of Maryland Medical Center in Baltimore, as well as a number of nursing professionals at the state and local levels. On their behalf, we call on this committee to issue a favorable report to HB 905.

It should be of no surprise to anyone in our state that, due high turnover, burnout, and poor working conditions, our hospitals are severely understaffed. This fact indeed has a negative impact on the quality-of-care our patients receive in Maryland. One-in-four nursing positions are vacant in Maryland, and studies show that these high vacancy rates have lead to a 7% raise in the risk of death by a patient in our state. Maryland has, unfortunately, the longest ER wait times in the nation, with patients often waiting 20 hours or more to receive emergency care, due largely to staffing issues.

HB 905 asks that hospitals establish a committee, comprising 50% direct care workers, that would attempt to create a plan to address these staffing concerns and ensure staff-driven decisions for better care. By establishing safe staffing practices, we in Maryland can begin to reduce turnover and reliance on temporary staffing, lowering overall hospital costs. We can better retain experienced nurses, attract those who left the field, and bring students into the profession. HB 905 follows legislation in other states that have been successful in reversing staffing shortages: States like Oregon show that involving nurses in staffing decisions leads to lower turnover and better patient outcomes. But perhaps most importantly, we can improve the quality of care for the people of Maryland and save more lives when we require hospitals to include their front line staff on a staffing plan.

Again, for these reasons, AFT-Maryland calls on the committee to issue a favorable report for HB 905. Thank you.

HB-905–Safe-Staffing-Testimony-YDelph.pdf
Uploaded by: Yvette Delph
Position: FAV

Bill Title: HB 905 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)
Position: FAVORABLE
To: Senate Finance Committee
Hearing Date: Tuesday, April 1, 2025

Dear Chair Beidle and Members of the Committee,

Maryland is experiencing a crisis of understaffing, retention of staff, and worsening quality of care in hospitals. Marylanders have experienced the longest wait times in US Emergency Rooms (ERs) for the past nine years. I strongly urge you to support HB905. This can't wait. Please vote on this critical legislation next week.

A few years ago, I took my adult son to the Montgomery General Hospital ER with pain in his mid- and right upper abdomen. After waiting for over 6 hours to be seen, the ER staff diagnosed gastritis, refused to order an ultrasound to rule out gall bladder infection, and discharged him. Thirty hours later, the surgeon at a Washington, DC hospital, who had just completed the emergency operation to remove my son's infected gall bladder, told me that a gall stone had become stuck and obstructed the outlet from his gall bladder. The surgeon said that part of the gall bladder wall was gangrenous would have burst if left much longer.

The failure in care my son experienced is, unfortunately, not isolated. The worsening quality of care results in harm to patients and greater healthcare costs. It is critical that this burgeoning crisis be urgently addressed, and HB905 would be an important starting point in achieving adequate staffing levels with higher retention of experienced, competent staff.

Staff members at every level of the hospital play an important role in the timeliness and quality of care patients receive, and it is vital that workers at every level are included in the hospital staffing committees. High retention of staff requires that working conditions be optimized and that workers at every level are full members of the hospital staffing committees and able to provide input on how conditions should be improved.

If successfully implemented with workers at every level providing input and contributing to staffing plans and working conditions, HB905 could do much to alleviate this crisis. The quality of care would be improved, thus reducing medical complications, death, and the resultant additional healthcare costs due to poor care.

I respectfully urge this Committee to vote to fully support House Bill 905.

Sincerely,
Yvette Delph, MBBS, DA
14907 Running Ridge Lane
Silver Spring, MD 20906

NPAM Letter of Support with amendments HB905 .pdf
Uploaded by: Malinda Duke
Position: FWA

NURSE PRACTITIONER
Association of Maryland

"Advocating for NPs since 1992"

RE: House Bill 905- Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)

Position: Support with Amendments

On behalf of the over 850 members of the Nurse Practitioner Association of Maryland, Inc. (NPAM) and the more than 8000 Nurse Practitioners licensed to practice in Maryland, I am writing to express our support, subject to recommended amendments, for **HB 905- Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)**.

We strongly support the establishment of clinical staffing committees in Maryland hospitals as a critical measure for ensuring safe staffing practices. We advocate that these committees be structured with equal representation from all frontline staff, spanning both management and employee positions. We believe that this balanced approach will foster comprehensive insights into staffing needs and ultimately enhance hospital effectiveness.

Accordingly, we respectfully request that the current language of House Bill 905 be **amended to include an Advanced Practice Registered Nurse**

Thank you for your commitment to enhancing healthcare delivery in our state. We appreciate your thoughtful consideration of our recommendations.

Sincerely,

Malinda D. Duke CRNP-PC

Malinda D. Duke MS, CRNP-PC, CDCES
Executive Director
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Fax: 410-772-7915
NPAMexecdir@gmail.com

HB0905 crossfile FWA - Hospitals - Clinical Staffi

Uploaded by: Richard KAP Kaplowitz

Position: FWA

HB0905_Crossfile_Bill_
RichardKaplowitz_FWA
04/01/2025

Richard Keith Kaplowitz
Frederick, MD 21703-7134

TESTIMONY ON HB#0905 - POSITION: FAVORABLE WITH AMENDMENTS
Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)

TO: Chair Beidle, Vice Chair Hayes, and members of the Finance Committee

FROM: Richard Keith Kaplowitz

My name is Richard Kaplowitz. I am a resident of District 3, Frederick County. I am submitting this testimony in support with it amendments of HB0905, Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)

The House version of bill HB0905 passed 100-39 with amendments on 03/13/25 25 and the Senate version of cross-filed bill SB0703 was heard on 03/04/25 but no further action occurred. Please reconcile and pass this important bill and return it for House action.

> Maryland has had the worst emergency room wait time among 50 states for the past eight years, according to data from the Centers for Medicare and Medicaid Services. While the average ER wait time in Maryland is over four hours, many patients who need emergency care may wait as long as 24 hours to receive care. Long ER wait times are more than just an inconvenience; they measurably increased risk for patients, especially those who are elderly or vulnerable.
>
> We need to have right-size ER staffing, particularly nurses and technicians, to reflect the number of ER patients. It is very predictable that in the winter, the number of ER patients will rise when flu, COVID-19 and RSV — respiratory syncytial virus — are at their peak; clearly, more ER staff will be needed at that time.
>
> Maryland is 36th out of 50 states in the number of nurses per 1,000 population, according to Becker Hospital Review. By my observations, and those of others, the current ratio of nurses to patients in the ER can be as low as 1 nurse to 15 patients. It should be closer to 1:4, which is the target in states like California with mandated nurse-patient ratios.
>
> Short-staffing leads to burnout and retention problems: 39% of nurses who left the profession cited overwork and stress as the reason. According to the Becker Hospital Review, Maryland ranked only 45th out of 50 states for salaries of registered nurses, adjusted for cost of living.
>
> Hospitals should recruit new ER medical staff by offering competitive salaries and livable wages and support a work environment where workers are not under constant stress from short staffing. Chronic short staffing is a fixable problem. [1]

[1] https://marylandmatters.org/2024/12/05/how-to-fix-marylands-long-emergency-room-wait-times/

HB0905_RichardKaplowitz_FAV

- The Safe Staffing Bill will establish **safe staffing committees** at each hospital that will help to address the chronic short staffing of hospital Emergency Rooms and other critical departments.
- The committees will include **50% direct care workers**--the medical staff in the front lines who have the knowledge needed to ensure safe staffing for patients.
- Each staffing committee will develop a **clinical staffing plan** which will establish guidelines for appropriate staffing, based on the number of patients and their acuity.
- Each hospital will review the staffing plan annually to evaluate effectiveness and make updates and **post the clinical staffing plan on the hospital websites,** allowing for **transparency** for health care consumers.

This bill, recognizing Maryland has a crisis, would require certain hospitals licensed in the State to establish and maintain a clinical staffing committee and to implement a clinical staffing plan. It would mandate that each clinical staffing committee exists and is required to develop a clinical staffing plan. It sets a specific time for that action, requiring by July 1 each year, each hospital, through the clinical staffing committee, to conduct a review of the clinical staffing plan for certain purposes. It then requires that by January 1, 2026, each hospital to implement a clinical staffing plan and assign personnel in accordance with the plan.

I respectfully urge this committee to return a favorable report with its amendments on HB0905.

SINAI -HB 905- Hospitals - Safe Staffing Act of 20

Uploaded by: Amanda Shrout

Position: UNF

SINAI HOSPITAL
A LifeBridge Health Center

CARE BRAVELY

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: ***Oppose***
April 1, 2025
Senate Finance Committee

On behalf of Sinai Hospital and Grace Medical Center, we want to express our respectful opposition of House Bill 905.

Sinai Hospital and Grace Medical Center have well-established processes for determining appropriate staffing levels. Staffing levels are evaluated daily, based on real-time data that accounts for patient census and acuity levels. This ensures that our staffing decisions are driven by actual patient needs rather than fixed mandates, allowing us to always optimize care for our patients. Our staffing models are flexible, adjusting continuously throughout the day to meet changing patient demands, with optimal staffing levels set based on both patient census and acuity. This ensures that we are responsive to fluctuations in patient volume and care complexity. We have a multifaceted approach to ensuring appropriate staffing.

We utilize daily shift huddles as an essential part of our staffing process. These huddles allow frontline team members such as nurses, techs, administrative associates, and other ancillary team members to receive updates about staffing levels, patient needs, and any potential issues affecting care delivery. These huddles also provide an opportunity for team members to offer input on staffing adjustments and workflow changes based on their firsthand knowledge of patient needs. This flexibility ensures that any gaps in staffing or areas of concern can be identified and addressed quickly.

Our staffing process includes proactive monitoring of callouts and absences for clinical staff such as nurses, technicians, and administrative associates. In the morning and afternoon, we conduct a review of staffing needs in anticipation of the oncoming shift, as well as at the start of each shift for further adjustments. This ongoing assessment allows us to continually meet the needs of our patients without being constrained by a fixed, one-size-fits-all staffing mandate.

Staffing levels are not only evaluated at the departmental level but also have visibility from the frontline up to the executive level. We hold a daily safety huddle to review staffing levels across all departments—clinical and ancillary support services, including transport, environmental services, and dietary workers. We utilize a “stoplight” format providing clear, transparent visibility into staffing concerns, allowing for quick realignment of resources, and ensuring that all departments are adequately staffed to meet the current needs of the hospital.

In addition to daily staffing evaluations, we conduct comprehensive monthly and annual reviews of patient volumes, using flexible budget models that allow us to adjust staffing levels based on fluctuating needs across service lines. This review process ensures that we can appropriately scale our workforce to meet patient demand throughout the year. Annual volumes are thoroughly assessed to identify trends and anticipate changes in patient care needs, allowing us to adjust

staffing levels proactively. This review process informs our decisions to add or flex staff across various service lines, ensuring we have the right resources in place to meet shifting patient volumes and acuity levels. These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Sinai Hospital and Grace Medical Center recognizes the importance of engaging our frontline team members in making staffing decisions. A healthy work environment is essential for both patient safety and staff satisfaction. At our facility, we believe that Professional Governance is a cornerstone of creating such an environment. By fostering a culture of empowerment and inclusiveness, we ensure that both clinical and non-clinical team members are supported, heard, and involved in decision-making processes that directly impact their work and patient care. Our professional governance unit-based councils are open forums for all team members' participation and involvement. Through Professional Governance, we create a safe space for all team members to raise concerns without fear of retribution, ensuring that safety is never compromised. This culture of transparency and open communication helps identify potential issues before they escalate and allows us to implement solutions that directly enhance staffing, patient care, team safety, and work environment quality. Decisions, including staffing decisions, are made with the holistic input of those who are doing the actual work, which leads to more effective policies and practices that positively impact patient care, staff satisfaction, and organizational efficiency. This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels.

Hospital staffing plans are reviewed and updated several times a day to account for fluctuating patient volumes, bed availability, individual patient acuity, and the availability and experience of clinical staff. Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. While we fully support engaging front line staff in these decisions, clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Sinai Hospital and Grace Medical Center is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Amanda Strout
Vice President of Care Services and Chief Nursing Officer
Sinai Hospital and Grace Medical Center LifeBridge Health
ashrout@lifebridgehealth.org

Crossover Testimony HB 905- Safe Staffing Act of 2

Uploaded by: Andrew Nicklas

Position: UNF

Maryland
Hospital Association

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2025)

MHA Position: *Oppose*
April 1, 2025
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in opposition of House Bill 905.

Hospitals must adhere to accreditation and regulatory standards to ensure patient safety, quality care, and a supportive work environment for health care professionals. The Centers for Medicare & Medicaid Services (CMS) establishes Conditions of Participation (CoPs) that hospitals must meet to receive Medicare and Medicaid funding. These requirements include *24/7 nursing coverage* as outlined in 42 CFR §482.23, *competency-based staffing*, and *individualized nursing care plans* for each patient. Specifically, §482.23(a) and §482.23(b) require that the *director of nursing service* be responsible for determining the types and numbers of nursing personnel and staff necessary to provide adequate coverage and nursing care in all areas of the hospital. CMS enforces compliance through regular surveys and audits, with potential penalties for non-compliance.

Furthermore, the Joint Commission (TJC) sets staffing standards and assesses compliance in collaboration with the Maryland Office of Health Care Quality. TJC standards direct the implementation of hospital-wide plans for nursing care, treatment, and services, ensuring that these plans are informed by *patient needs and acuity and nurse competency levels*. They also emphasize *collaboration with the health care team, flexibility* within these plans, and *continuous quality improvement* through on-site reviews and assessments.

All Maryland hospitals adhere to CMS and TJC regulatory and accreditation standards. Additionally, several hospitals are recognized by the American Nurses Credentialing Center (ANCC) for nursing excellence either through a Magnet designation, which acknowledges superior nursing practices and patient outcomes or the Pathway to Excellence program, which recognizes supportive and healthy practice environments that meet certain standards. Both these certifications involve a rigorous approval process that requires hospitals to meet the highest standards of practice, including establishing a secure and confidential complaint reporting process, collecting nurse-sensitive quality indicators, practicing shared decision-making, and providing

professional development opportunities. Research indicates that hospitals with Magnet and Pathway recognition experience[1,2]

- Lower nurse dissatisfaction and burnout
- Higher job satisfaction rates
- Lower RN turnover
- Greater productivity and teamwork
- Improved patient satisfaction

While only 9.8% of all hospitals in the nation have received a Magnet designation, in Maryland nearly 40% of our acute hospitals hold a Magnet designation or have been recognized under the Pathway to Excellence program.

Shared Governance Models

In upholding the accreditation standards detailed above, Maryland hospitals actively engage frontline staff in decision-making processes through a model known as shared governance. Shared governance is a collaborative leadership model that empowers nurses and frontline healthcare staff to actively participate in the decision-making process, shaping policies, clinical practices, and patient care initiatives[3]. This model allows nurses and other health care professionals to engage in a full spectrum of decision-making, from everyday staffing considerations to larger-scale initiatives such as reviewing patient safety policies, clinical practice improvements, and professional development opportunities.

Examples of shared governance models in Maryland hospitals

One hospital has implemented a Nursing Collaborative Governance Structure that involves participation from direct care nurses and nurse leaders. The hospital-level coordinating council oversees nursing practice, quality and safety improvement, professional development, and evidence-based practice and research, in addition to facilitating implementation of system-wide initiatives (See Figure 1).

[1]American Nurses Credentialing Center. 2020. "About Pathway." ANA. 2020. https://www.nursingworld.org/organizational-programs/pathway/overview/

[2] American Nurses Credentialing Center. 2023. "Why Become Magnet?" ANA. 2023. https://www.nursingworld.org/organizational-programs/magnet/about-magnet/why-become-magnet/

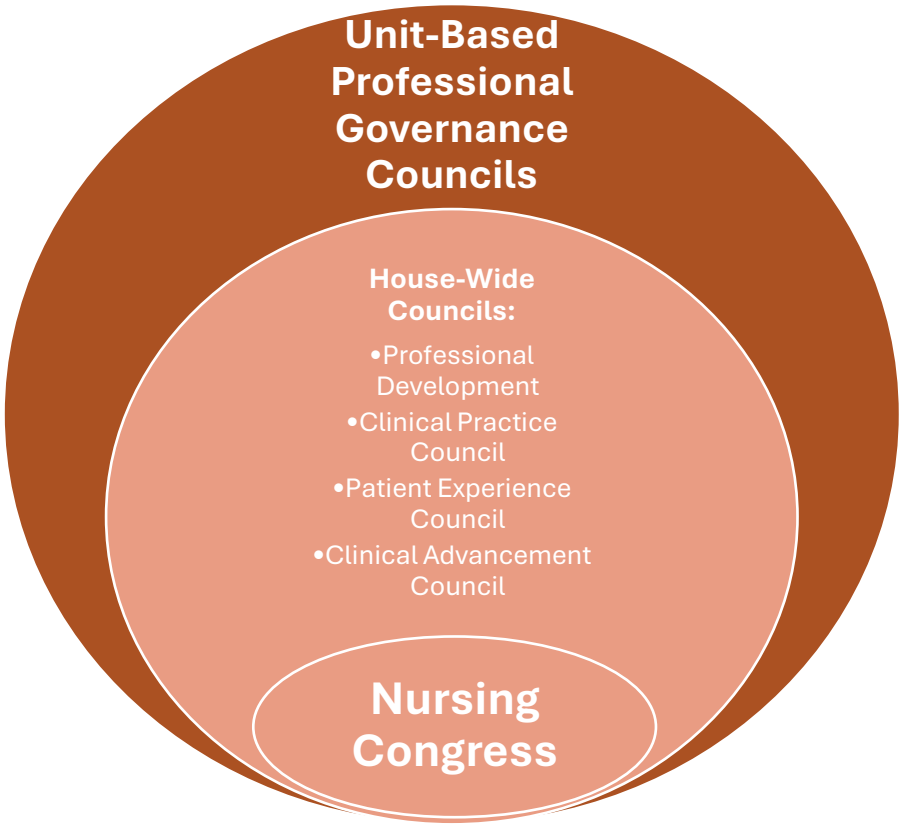
[3] Creative Health Care Management. "Shared Governance: What It Is and What It Is Not." *Creative Health Care Management*, March 11, 2020. https://chcm.com/shared-governance-what-it-is-and-what-it-is-not/.

Fig 1. A shared governance structure that includes issue-specific councils

Another hospital employs a tiered governance structure, engaging nurses at multiple levels (see Figure 2):

- Unit-level decision making and practice initiatives (patient transportation and staffing),
- Hospital-wide council that is tasked with decisions on professional development, clinical advancement, and patient experiences, and
- Nursing Congress, a governing body comprised of front-line nurse representatives elected by peers to participate in decision-making that affects nursing activities at the hospital

Fig 2. A tiered shared governance structure employed in one hospital



Across Maryland hospitals, shared governance serves as the overarching framework that drives participatory decision-making and informs many best practices to support clinical staffing efficiency, patient safety, and resource optimization such as:

- **Daily Safety Huddles**, which include patient flow coordinators, senior leaders, managers, charge nurses, physicians, and other service members, and provide a venue for discussion and collaboration on safety concerns, risk events, staffing concerns, and other important patient safety updates
- **Unit-level frontline staffing committees**, comprising nurses, patient care technicians and unit support coordinators, provide year-round recommendations on staffing and support needs.
- **Shared Leadership Councils and Unit Practice Councils** where staff can present proposals to advance patient care and facility operations. Accepted proposals inform the creation of action plans or taskforces/committees to guide implementation. For instance, at one hospital, leaders, direct-care nurses, doctors, and ancillary staff shared their ideas for reduction improvements in hospital throughput and patient experience. This resulted in the creation of an *Expediting Team* and *Departure Lounge* to increase capacity through improved patient flow.

- **Using innovative staffing solutions** tools such as 'Precision Staffing' use a documentation driven weight-based algorithmic approach to create a workload score. The score allows staff to see equity in their group assignments and encourages teamwork throughout the organization by allocating resources based on identified care needs.

While all hospitals align with the fundamental principles of shared governance, each institution tailors its model to fit its unique organizational structure, workforce dynamics, and patient care priorities. Hospitals need dexterity and real-time flexibility to accommodate their unique, complex, evolving circumstances.

As with other states, Maryland has also been facing an acute shortage of health care professionals. Career advancement has frequently been cited by nursing staff as their reason for quitting, closely followed by personal circumstances. A 2022 report by the Maryland Hospital Association highlighted several other reasons behind nurses' decision to quit the workforce, including aging/early retirement, competitive wages from other industries, alternatives, and accelerated burnout following the pandemic. However, turnover and vacancy rates among nursing staff have both fallen by approximately 10% since the pandemic. This may be attributable to targeted efforts by hospitals and policymakers to improve the workforce pipeline and alleviate shortages. For instance, 10 hospitals operate their own academies to train certified nursing assistants that help recruit and integrate new personnel into the workforce.

HB 905, despite the amendments, fails to account for everyday staffing realities across our hospitals, does not align with our accreditation mandates, and does nothing to address the root causes of staffing shortages. We believe there needs to be a concerted effort to document the best practices and initiatives hospitals are already implementing to address staffing challenges, and collaborate with stakeholders on effective, evidence-based solutions that can strengthen our workforce.

For these reasons, we request an ***unfavorable*** report on HB 905.

For more information, please contact:
Andrew Nicklas, Senior Vice President, Government Affairs & Policy
Anicklas@mhaonline.org

Northwest -HB 905- Hospitals - Safe Staffing Act o

Uploaded by: Ann Marie Madden

Position: UNF

NORTHWEST HOSPITAL
A LifeBridge Health Center
CARE BRAVELY

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: ***Oppose***
April 1, 2025
Senate Finance Committee

On behalf of Northwest Hospital, we appreciate the opportunity to comment in opposition of House Bill 905.

Northwest Hospital has well-established processes for determining appropriate staffing levels. We incorporate staff self-scheduling and utilize float pool, agency and structured bonuses to ensure safe staffing. These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Northwest Hospital recognizes the importance of engaging our frontline team members in making staffing decisions. We have a robust shared governance model that is driven by our staff to make decisions. Our shift huddles, safety huddles, staff meetings, town halls and significant leader presence and daily rounding are excellent venues for staff to voice their concerns and recommendations. This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels.

Hospital staffing plans are reviewed and updated several times a day to account for fluctuating patient volumes, bed availability, individual patient acuity, and the availability and experience of clinical staff. Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. While we fully support engaging front line staff in these decisions, clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Northwest Hospital is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Ann Marie Madden
Vice President of Patient Care Services & Chief Nursing Officer
Northwest Hospital Center
amadden@lifebridgehealth.org

HB 905 Hospitals - Safe Staffing Act of 2025_Holy
Uploaded by: Annice Cody
Position: UNF

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: *Oppose*
April 1, 2025
Senate Finance Committee

On behalf of Holy Cross Health, including Holy Cross Hospital in Silver Spring and Holy Cross Germantown Hospital, we appreciate the opportunity to comment in opposition of House Bill 905.

To meet the needs of our patients our hospitals review staffing on all unit twice daily in light of patient volume, bed availability, acuity and staffing mix. A nursing executive is assigned a week at a time with 24/7 responsibility to manage appropriate staffing throughout the hospital. These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Holy Cross Health recognizes the importance of engaging our frontline team members. Twice daily each unit has a huddle that addresses staffing, announcements, recognition, identification of high risk patients and any goals for the day. Each unit has huddle boards that track progress on department-specific initiatives. This collaborative approach ensures that those directly involved in patient care have a voice in shaping the work environment and priorities.

For longer term planning, all nursing units are represented in our Professional Governance Council. Most units also have Comprehensive Unit-based Safety Program (CUSP) initiatives to engage the clinical staff in performance improvement initiatives prioritized by the staff.

We are concerned that a single, centralized staffing committee could not be sufficiently responsive to the dynamic nature of hospital operations.

Holy Cross Health is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

HB905 Safe Staffing Act of 2025 JHHCMC Unfavorable
Uploaded by: Annie Coble
Position: UNF

Johns Hopkins
Howard County Medical Center
5755 Cedar Lane
Columbia, MD 21044
410-740-8000

HB905
Unfavorable

TO: The Honorable Pamela Beidle, Chair
Finance

FROM: Ron Langlotz, DNP, RN, NEA-BC
Vice President of Nursing / Chief Nursing Officer

DATE: March 28, 2025

RE: **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)**

Johns Hopkins Howard County Medical Center opposes **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)** which passed the House of Delegates and is now before your committee.

This bill isn't necessary and will divert time, attention and resources away from solving critical challenges facing my hospital. Advocates argue that implementing clinical staffing committees could alleviate wait times in the emergency department. However, in our hospital, we face multiple significant challenges. Not only do we lack adequate physical space for patients, but we also contend with a 20% deficit in access to primary care providers in our county. This shortage directly impacts our emergency room, where there has been an alarming 18-20% rise in patients seeking primary care services. These factors contribute directly to prolonged wait times and hinder access to emergency services for those in need. Simply forming a staffing committee will not address these critical issues. To reduce wait times and improve access to care, we need additional patient beds and greater access to primary care.

Similarly, proponents assert that establishing clinical staffing committees will deter workplace violence, but I disagree. Aggressive behaviors and the demonstrated lack of civility by some of our patients or their family members are outside the control of the hospital and reflect larger breakdowns in our society. I will further note that the required posting of staffing plans on individual care units will make it more likely for violence to occur by making it easier for people with bad intentions to identify less busy times and the composition of the care teams.

Most importantly, requiring my hospital to establish a house-wide clinical staffing committee will interfere with our longstanding shared governance structure that engages frontline staff on a regular basis to make decisions about the care environment in each nursing area.

Johns Hopkins Howard County Medical Center is actively working toward MAGNET recognition and is currently on the Pathway to Excellence. Since the early 2000s, our hospital

has implemented various hospital-based and unit-based nurse staffing councils to strengthen our staffing strategies. Each of our 15 inpatient and ambulatory units has a unit-based staffing council or scheduling committee. These committees are developed with direct input from bedside nurses, who provide feedback to ensure balanced schedules that account for both experience and adequate staffing levels. Supported by unit leadership, our scheduling committees undergo careful review to ensure we have the necessary resources to provide high-quality patient care.

This collaborative effort is aimed at achieving better patient outcomes, enhancing employee satisfaction, and optimizing operational processes to allow for real-time adjustments to meet patient needs. To further support these efforts, Johns Hopkins Howard County Medical Center conducts two additional daily staffing sessions at 5:15 AM and 5:15 PM for all inpatient units, ensuring that adequate resources are available throughout each day.

Accordingly, Howard County Medical Center respectfully requests an **UNFAVORABLE** committee report on HB905.

HB905 Safe Staffing Act JHHS Nursing Unfavorable_.

Uploaded by: Cambria Winkel

Position: UNF

Deborah J. Baker, DNP, AG-ACNP, FAAN
Senior Vice President for Nursing
Chief Nurse Executive
Johns Hopkins Health System

550 N. Broadway, Suite 700
Baltimore, MD 21205

TO: The Honorable Pamela Beidle, Chair
Finance

HB905
Unfavorable

FROM: Deborah J. Baker, DNP, AG-ACNP, FAAN
Sr. Vice President for Nursing, Chief Nurse Executive

DATE: March 28, 2025

RE: **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)**

Johns Hopkins Health System opposes **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)** which passed the House of Delegates and is now before your committee.

The Johns Hopkins Health System has four acute-care hospitals in Maryland and I have the honor of being the Chief Nurse Executive for the entire system. I am in this position now after having been a registered nurse for over 30 years and served at the bedside before becoming a nurse manager, leader and executive.

While I respect the intent of the bill, legislation regarding staffing in hospitals is not only unnecessary, but also counterproductive to our efforts to ensure the safe clinical staffing which this bill attempts to address.

Proponents assert that establishing clinical staffing committees will improve wait times in the emergency department. Access to healthcare in Maryland has been identified as a challenge by state and healthcare organization leadership. This lack of access leads to increased volumes in all of our emergency facilities. After the 2023 legislative session, the Maryland Hospital Association was directed to conduct a study on the reasons for emergency room overcrowding and hospital throughput. The results of this study were multifaceted and exposed the complex issues that results in overcrowding and slow hospital throughput. Nurse staffing was not a top issue on their list. Mandating staffing committees and annual reporting will not do anything to move our hospitals towards more efficient operations.

Similarly, proponents assert that establishing clinical staffing committees will deter workplace violence (WPV). Aggressive behaviors and the demonstrated lack of civility by some of our patients or their family members reflect larger breakdowns in our society. There has been a rise

Deborah J. Baker, DNP, AG-ACNP, FAAN
Senior Vice President for Nursing
Chief Nurse Executive
Johns Hopkins Health System

550 N. Broadway, Suite 700
Baltimore, MD 21205

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

in WPV events from year to year at Johns Hopkins Medicine. Best practices necessary to alleviate the risk of harm include prevention, crisis management and de-escalation, and communication. JHHS has employed initiatives to mitigate the risks of WPV with frontline staff involvement. These include the utilization of a violent patient risk assessment tool, the use of Code Green (emergency personnel response within the hospitals), Behavioral Health protective gear for use in violent events, the use of individual wearable panic buttons for staff, training in Crisis Prevention and de-escalation, patient facing behavioral expectations posters, behavioral alerts and flags in the electronic medical record, and an increased public safety officer presence at each hospital.

Public posting of staffing plans on individual care units will in no way assist in decreasing potential violence, but may in fact incite an increase in events if already escalated or angry patients or visitors interpret or misinterpret the posted staffing grid as a unit having insufficient healthcare workers to care for their loved one.

Most importantly, requiring our hospitals to establish a house-wide clinical staffing committee will interfere with our longstanding shared governance structure that engages frontline staff on a regular basis to make decisions about the care environment in each nursing area. The supportive structure of the Johns Hopkins Nursing Professional Practice Model (PPM) is comprised of councils where frontline nursing staff can share their voice and create meaningful, evidence-based change around staffing, practice, care delivery and operations. The five system-wide councils develop and implement a plan to inform and educate stakeholders about changes, new processes, or innovation. Everyone receives the same information within the same timeframe, allowing for consistent and timely implementation across all clinical areas. Improvements are implemented consistently across the hospitals.

Each of our hospitals have corresponding councils where issues like staffing are discussed, in addition to system initiatives. We also have specialty councils which address different populations at our hospitals such as night shift councils, peri-operative councils, and pediatrics councils. These councils accept referrals from any employee who would like to explore an issue or recommend a change. The staff value this opportunity to contribute to their work environment in a positive, evidence-based manner. Shared governance positively impacts the quality and safety of care delivered to our patients and the healthy work environment created for the staff.

Each of our hospitals have a staffing or resource office (staffing pool) which serves as a centralized staffing office which supports the staffing, and allocation of nursing resources throughout the hospital in order to ensure adequate patient care coverage.

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Deborah J. Baker, DNP, AG-ACNP, FAAN
Senior Vice President for Nursing
Chief Nurse Executive
Johns Hopkins Health System

550 N. Broadway, Suite 700
Baltimore, MD 21205

Partnerships with nursing leaders and clinical staff on the units allows for real time adjustments based on patient care demand with the use of a standardized shift readiness tool, along with periodic touchpoint huddles throughout the 24-hour day. Important public reporting platforms like Leapfrog outline the staffing ratios of our hospitals that are better than national benchmarks. In addition to the frequent touchpoint meetings where staffing decisions are made based on patient care demands, charge nurses and staffing coordinators can advocate for more staffing via our float pool offices.

In addition to staffing-specific means of addressing the needs of nursing staff for patient care, frontline forums are held with leadership in order to share innovative solutions, concerns, and interests. These are held with executive level leaders on a regular cadence. These Solution Sessions are led by a trained facilitator and hosted by both nursing and human resources. Audiences include frontline nursing staff and nursing leaders, and content is disseminated broadly after the sessions. This is yet another way frontline staff are accessing our most senior nursing and hospital level executives to share their voices and recommendations

Other processes that exist to make real-time adjustments to meet patient needs are reviewed in safety, and operational huddles. Unit-based huddles happen at the local level each shift and are escalated to specialty area huddles if needed. Daily safety huddles, which includes representation from hospital leadership, ancillary units, and clinical leaders, are held to raise awareness and create just in time solutions to varied operational issues.

Listening to staff, especially in the post-pandemic period, gave hospital leaders creative and innovative approaches to providing care through flexible staffing models. As a system, we are continuously addressing our nursing staff pipeline through multiple career development and training programs. We have many onboarding and retention programs in an effort to address these issues. They include tuition remission and reimbursement programs, funding for entry level nursing, career counseling and technician intern programs for our own employees, high school students and others. In addition to nursing shared governance models, there are multidisciplinary safety meetings, like Comprehensive Unit-Based Safety Program (CUSP) and shift by shift safety huddles that model the precepts of High Reliability Organizations (HRO), where staffing, supplies and other processes are discussed with the goal of providing safe care.

Publicly reported and mandated staffing committees won't fix the workplace violence directed at healthcare workers. The multidisciplinary committee that consists of staff and experts designing preventative solutions to violence is dealing with the issue head on.

Deborah J. Baker, DNP, AG-ACNP, FAAN
Senior Vice President for Nursing
Chief Nurse Executive
Johns Hopkins Health System

550 N. Broadway, Suite 700
Baltimore, MD 21205

Publicly reported and mandated staffing committees won't fix emergency department wait times or boarding. More capacity and funding for capacity expansions for those hospitals whose missions are to care for all, will assist with these issues.

Finally, we need to not distract hospital leaders with more bureaucratic mandates and allow the staff, in collaboration with leadership, design and execute real solutions to the myriad of operational issues present in providing healthcare in our state.

Accordingly, Johns Hopkins Health System respectfully requests an **UNFAVORABLE** committee report on HB905.

HB905_UPMCWesternMaryland_UNF
Uploaded by: Chrissy Lechliter
Position: UNF

UPMC LIFE CHANGING MEDICINE

Chrissy Lechliter, MBA, RN, NE-BC, FACHE
Chief Nursing Officer
VP Patient Care Services

UPMC Western Maryland
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Cumberland, MD 21502
T 240-964-2740
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March 28, 2025

Subject: Opposition to House Bill 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)

Dear Chair Beidle and Vice Chair Hayes,

On behalf of UPMC Western Maryland, I am writing to express opposition to HB 905 which proposes clinical staffing committees requiring representation from all staff levels, developing unit-specific staffing plans, and conducting annual reviews with transparent documentation.

While we appreciate some of the amendments, I remain opposed for the following reasons. I believe this legislation, if enacted, would significantly undermine current efforts and add significant administrative burden without improving employee safety or patient care.

First, UPMC Western Maryland adheres to nationally recognized accrediting bodies such as The Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS). We have staffing standards in place that allow us to address real-time staffing challenges and respond to fluctuating patient needs. We examine the adequacy of staffing based on the number, skill mix, patient acuity, and competency of all staff multiple times per day. We consider processes related to workflow, competency assessment, credentialing, supervision of staff, orientation, training, and education in addition to evaluating each unit. Requiring a pre-determined standing committee of staff to be responsible for developing and posting a staffing plan each time there is any change is not feasible given the real-time changes and demands of clinical settings.

Second, given how dietary and EVS staff are not assigned to unit staffing, participate in bed meetings or staffing calls, these employees would be tasked with undue hardship in determining staff decisions and making judgements on the validity of patient or staff complaints. Their expertise does not include the determination of patient acuity or around evidenced-based nursing which informs our staffing approach.

Third, and most importantly, UPMC Western Maryland is committed to shared governance. Employee feedback, collected through daily leader rounding, staff huddles, town halls, and the MyVoice survey, drives positive change at UPMC Western Maryland.

Through regular town halls, increased leadership update messages to employees, and a revitalized senior leader rounding program, the UPMC Western Maryland clinical leadership team is committed to robust, two-way communication with staff.

Additionally, the following actions demonstrate our commitment, offering opportunities to discuss acuity, patient safety concerns, staffing concerns while allowing us to adapt to the staff/patient needs.

- Culture of safety survey
- Minimum twice daily staffing/bed meetings
- Daily safety huddle

- Risk master system – any staff can submit a complaint. These are followed up and reviewed for opportunities to improve.

I believe this legislation, if enacted, would significantly undermine current efforts and add significant administrative burden without improving employee safety or patient care. I respectfully request that you oppose HB 905 and support policies that strengthen hospital staffing committees.

Thank you for your attention to this important matter.

Sincerely,

Chrissy Lechliter,
Chief Nursing Officer
VP Patient Care Services

HB 905- Hospitals - Safe Staffing Act of 2025.pdf
Uploaded by: Christine Frost
Position: UNF

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: *Oppose*
April 1, 2025
Senate Finance Committee

On behalf of Luminis Health Anne Arundel Medical Center (LHAAMC), we appreciate the opportunity to comment in opposition of House Bill 905.

LHAAMC has well-established, dynamic processes to determine appropriate staffing levels, ensuring optimal patient care. These processes include, but are not limited to:

- Twice daily in-person unit huddles, attended by frontline staff and unit leadership, focused on staffing, assignments, and patient acuity.
- Twice daily virtual Bed Board huddles, attended by frontline leaders, nursing leadership, clinical support leaders, focused on staffing, capacity and resources required to meet patient care and staff demands.
- Daily virtual Safety Call (M-F), addressing safety events, capacity, and staffing, attended by frontline staff, nursing and clinical support leaders and members of the executive team.
- Nursing Supervisor (24/7) responsible for allocating resources in response to patient volume, skill-mix, and acuity with a commitment to ensuring all beds are staffed to meet the demands of the community and maintain staff safety.

These measures align with nationally recognized standards from The Joint Commission and the Centers for Medicare and Medicaid Services, ensuring patient safety and high-quality clinical outcomes. LHAAMC recognizes that frontline nurses are essential decision-makers in staffing. As a three-time American Nurses Credentialing Center Magnet-designated organization, we uphold a multidirectional flow of decision-making between bedside nurses, leadership, interprofessional teams, and the Chief Nursing Officer. Our shared governance model actively engages frontline nurses in staffing decisions through:

- Self-scheduling and unit-based scheduling committees led by bedside nurses.
- Direct escalation pathways for real-time communication of staffing concerns and patient acuity 24/7.
- Twice-daily unit-based huddles and Bed Board huddles seven days a week
- Participation in daily Safety Call five days a week.
- A well-structured shared governance structure, engaging nurses at all levels to engage in matters related to hospital operations and the work environment.

These collaborative approaches ensure that the individuals directly responsible for patient care—nurses—play a primary role in determining staffing levels, responding to patient acuity, and maintaining safety.

Staffing plans at LHAAMC are continuously reviewed and adapted in real time to accommodate fluctuating patient volumes, bed availability, individual patient acuity, and the experience levels of available clinical staff. This review is conducted in real time between bedside nurses and unit leadership. Hospitals must retain this critical flexibility to meet evolving patient care needs. A single, centralized staffing committee, as proposed by HB 905, lacks the agility required for real-time decision-making and fails to reflect the complexity of hospital operations.

Moreover, clinical staffing plans must be developed by clinicians. Effective staffing requires the expertise of those who provide direct patient care—nurses and other clinical professionals—not non-clinical personnel. While we support frontline staff engagement, direct-care nurses must lead the decision-making process for clinical staffing, with non-clinical staff contributing only to non-clinical workforce planning.

LHAAMC remains committed to supporting and strengthening our nursing workforce. However, HB 905 does not account for the multifaceted realities of hospital staffing and does not address the underlying causes of workforce shortages.

For these reasons, we respectively urge an ***unfavorable*** report on HB 905.

Opposition Letter to HB905 March 28 2025.pdf
Uploaded by: Christopher Hall
Position: UNF

TidalHealth™

Executive Office

100 East Carroll Street
Salisbury, MD 21801

O 410-543-7766
TTY/TDD 410-543-7355

March 28, 2025

The Honorable Pamela G. Beidle
Chair, Senate Finance Committee
Maryland State Senate
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Dear Chair Beidle and Members of the Senate Finance Committee,

On behalf of TidalHealth Peninsula Regional, thank you for the opportunity to provide testimony in opposition to House Bill 905.

TidalHealth Peninsula Regional has well-established, evidence-based processes in place to determine and adjust appropriate staffing levels across our hospital. These include multidisciplinary huddles held multiple times per day, a real-time electronic bed board system that monitors patient placement and throughput, and ongoing collaboration between nursing leaders, charge nurses, and care teams. Our approach aligns with the standards set forth by The Joint Commission and the Centers for Medicare and Medicaid Services (CMS), which prioritize patient safety, appropriate clinical staffing, and positive patient outcomes.

We strongly value the input of our frontline team members and actively engage them in staffing decisions through a shared governance model. This model empowers bedside caregivers to participate in decision-making at the unit and organizational levels, including through staffing councils, performance improvement committees, and regular staff meetings. This type of engagement ensures that staffing decisions are made with direct insight from those who are delivering care while also fostering transparency, accountability, and team ownership of patient outcomes.

Our staffing plans are dynamic and are continuously assessed throughout the day to account for changing patient volumes, acuity levels, staff availability, and care complexity. The needs of a hospital can shift significantly within hours, and staffing decisions must be made in real time by clinical leaders with the training and operational insight to respond effectively. A centralized staffing committee, as proposed in HB 905, lacks the flexibility and speed necessary to make immediate, patient-centered adjustments.

Furthermore, we strongly believe that clinical staffing decisions must be led by clinical professionals. Determining safe and effective staffing requires expertise in clinical care, regulatory compliance, licensure requirements, and hospital operations. While we support a collaborative, inclusive approach, those with the appropriate clinical knowledge must guide these decisions, supported by feedback from frontline caregivers and informed by operational realities.

TidalHealth Peninsula Regional remains deeply committed to supporting and retaining a strong, resilient workforce. We share the General Assembly's goal of addressing healthcare workforce challenges and improving care delivery across Maryland. However, we are concerned that HB 905 does not reflect the realities of hospital operations and does not address the root causes of the clinical workforce shortage, including training pipelines, burnout, and recruitment and retention barriers.

For these reasons, we respectfully urge the Committee to issue an **unfavorable report** on House Bill 905.

Sincerely,

Christopher C. Hall
Vice President / Chief Business Officer

SheppardPratt_HB905_UNF.pdf
Uploaded by: Damian Lang
Position: UNF

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: *Oppose*
April 1, 2025
Senate Finance Committee

Chairwoman Beidle, Vice Chair Hayes, and members of the Senate Finance Committee:

On behalf of Sheppard Pratt, we appreciate the opportunity to comment in opposition of House Bill 905.

As the nation's largest private, nonprofit provider of mental health, substance use, special education, developmental disability, and social services, Sheppard Pratt provides care through more than 380 sites and 160 programs across Maryland. We are consistently ranked in the top 10 psychiatric providers in the country and have long-standing, evidence-informed systems in place to guide safe and responsive staffing.

Sheppard Pratt has well-established, dynamic processes for determining appropriate staffing levels based on real-time patient acuity—not static ratios. We employ a flexible, integrated approach that includes:

- **Daily interdisciplinary safety huddles** to identify unit-level needs, staffing concerns, and acuity trends.
- An **acuity-based staffing model**—not just patient volume—to inform nurse-to-patient assignments.
- **A centralized nursing staffing office**, led by a senior director and workforce manager, to deploy float pool resources as needed.
- **Routine 24-hour cycle meetings** between house supervisors, nursing leaders, and admissions teams to match staffing capacity with admissions and discharges.
- A **shared governance structure**, where frontline team members help shape staffing decisions.
- Senior nursing leaders who **review and adjust schedules daily** to proactively address potential gaps.
- Strategic efforts to "overhire" based on predictive need and workforce retention.

These systems are responsive, clinically grounded, and adapted to the behavioral health context—where patient acuity can change rapidly and unpredictable behavioral escalations demand an agile staffing model.

While we appreciate the bill's intent to elevate the role of clinical staff in decision-making, HB 905 mandates a rigid, centralized staffing committee structure that does not reflect the operational complexity or pace of hospital care delivery. A one-size-fits-all approach risks undermining the safety-focused, collaborative models already in place at organizations like ours.

Moreover, HB 905 does not address the underlying root cause of staffing challenges: the ongoing health care workforce shortage. Rather than advancing flexible, sustainable solutions to bolster recruitment, retention, and career development, this bill imposes new layers of governance and documentation without enhancing real-time staffing capacity.

Sheppard Pratt is committed to supporting our nursing and clinical teams—and to working collaboratively with policymakers on meaningful workforce solutions. For the reasons above, we respectfully request an **unfavorable report** on HB 905.

LBH UNFAV House Bill 905 Hospitals Clinical Staff

Uploaded by: Jennifer Witten

Position: UNF

LIFEBRIDGE HEALTH®

Date: April 1, 2025
To: Chair Beidle, Vice Chair Hayes and Senate Finance Committee Members
Reference: House Bill 905- Hospitals – Clinical Staffing Committee and Plans – (Safe Staffing Act of 2025)

Position: Unfavorable
Dear Chair, Beidle and Senate Finance Committee Members,

On behalf of LifeBridge Health, we appreciate the opportunity to share our concerns with Senate Bill-720. LifeBridge Health is a regional health system our concern with the proposed bill is the impact that a prescriptive staffing approach without consideration for real-time best practices and current requirements will jeopardize patient safety and create more dissatisfaction among team members within our health system. The bill does not take into consideration ongoing challenges Maryland's hospitals are facing daily with increased need for services, capitated finances, significant workplace violence, and the ongoing shortage of health professionals including nurses.

The bill also includes reporting and posting provisions that give us serious safety concerns for both staff and patients. We continue to see a rise of workplace violence incidence thus posting public information that can aid in greater access to sensitive areas are a high security risk.

Hospitals are responsible for meeting staffing requirements of the Condition of Participation (and for any of the services that the hospital provides. CMS develops Condition of Participation (CoPs) and Conditions for Coverage that health care organizations must meet to participate in the Medicare and Medicaid programs. These regulations mandate that hospitals must have sufficient nursing staff, including registered nurses, to provide continuous nursing care to all patients, as outlined in the "Conditions of Participation" for hospitals under Medicare. corresponding regulation that outlines the staffing requirements for hospitals, specifically regarding the need for adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide 24-hour services, ensuring proper patient care within a hospital setting; defining the conditions under which a facility can be considered a Medicare-participating hospital.

In addition to CMS, the Joint Commission has staffing standards that outline the appropriate staffing levels based on patient acuity, which means hospitals must ensure sufficient staff are present to safely care for the complexity of their patient population, taking into account factors like patient needs, unit type, and clinical expertise required; this often translates to stricter staffing requirements in critical care units compared to general medical-surgical floors. All hospitals in Maryland maintain accreditation by the Joint Commission and surveyed on an ongoing basis along with the Maryland Office of Health Care Quality meeting the same standards.

LifeBridge Health participates in the data collection of nursing sensitive indicators in the National Database of Nursing Quality Indicators (NDNQI) which analyzes nursing outcomes, quality and patient safety data and staffing. This is a nationally recognized evidence-based practice that informs the decisions made on units. A local house-wide clinical staffing committee will not be in the same position to evaluate the detailed unit-based information that is already available to our unit-based nursing councils. Charge Nurses determine changes in staffing related to volume and acuity. There must be consistent communication through-out the shifts to determine staffing with real-time feedback from team members who contribute to the hospital throughput and management of patients including allied health professionals, nutrition, facilities management, and other clinical leaders.

LifeBridge Health incorporates a shared governance structure within our staffing practice model which is the center stone of engaging front line team members in decision making along with nurse leaders. The main principle of shared governance includes ownership, accountability, team building, leadership, innovation, and equity. Combining these key elements along with other national standards drive solution-based action planning for staffing and improvements.

Given the current requirements and best practices we feel that the legislation will impede on that progress, limit our ability to meet national standards, and risk patient safety. We do agree that staff engagement at all levels is critical, which is why we support the shared governance model. With these above reasons we request an **unfavorable report on House Bill 905**.

For more information, please contact:
Jennifer Witten, M.B.A.
Vice President, Government Relations & Community Development
jwitten2@lifebridgedhealth.org
Mobile: 505-688-3495

HB 905- Hospitals - Safe Staffing Act of 2025 - AH

Uploaded by: Karmen Brown

Position: UNF

800 W Diamond Ave
Suite 600
Gaithersburg, MD 20878

March 28, 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee

The Honorable Antonio Hayes
Vice Chair, Senate Finance Committee

Re: House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: ***Oppose***
April 1, 2025
Senate Finance Committee

On behalf of Adventist HealthCare, we appreciate the opportunity to comment in opposition of House Bill 905.

As President and CEO of Adventist HealthCare, I manage the operations of four hospitals in Maryland: Adventist HealthCare Shady Grove Medical Center, Adventist HealthCare White Oak Medical Center, Adventist HealthCare Fort Washington Medical Center, and Adventist Rehabilitation. Each of our hospitals has well-established processes for determining appropriate staffing levels. These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Adventist HealthCare recognizes the importance of engaging our frontline team members in making staffing decisions. This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels. Our safety and care centered approach has driven our patient safety and employee satisfaction scores. In fact, two of our hospitals, Adventist White Oak Medical Center, and Adventist Fort Washington Medical Center both earned Leapfrog Safety Grade A ratings in 2024.

Hospital staffing plans are reviewed and updated several times a day to account for fluctuating patient volumes, bed availability, individual patient acuity, and the availability and experience of clinical staff. Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. While we fully support engaging front line staff in these decisions, clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Adventist HealthCare is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Respectfully,

John Sackett
President and CEO,
Adventist HealthCare

HB 905- Hospitals - Safe Staffing Opposition - Reh
Uploaded by: Karmen Brown
Position: UNF

9909 Medical Center Dr.
Rockville, MD 20850

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: ***Oppose***
April 1, 2025
Senate Finance Committee

On behalf of Adventist HealthCare Rehabilitation, we appreciate the opportunity to comment in opposition of House Bill 905.

Adventist Rehabilitation has well-established processes for determining appropriate staffing levels. These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Additionally, Adventist Rehabilitation recognizes the importance of engaging our frontline team members in making staffing decisions. This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels.

Hospital staffing plans are reviewed and updated several times a day to account for fluctuating patient volumes, bed availability, individual patient acuity, and the availability and experience of clinical staff. Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. While we fully support engaging front line staff in these decisions, clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Adventist Rehabilitation is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Respectfully,

Brent Reitz
President, Post-Acute Care

House Bill 905 Hospitals Ft Wash Med Ctr.pdf
Uploaded by: Karmen Brown
Position: UNF

Adventist HealthCare
Fort Washington Medical Center

11711 Livingston Road
Fort Washington, MD 20744
Phone 301-292-7000
FortWashingtonMC.org

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: ***Oppose***
April 1, 2025
Senate Finance Committee

On behalf of Adventist Healthcare Fort Washington Medical Center, we appreciate the opportunity to comment in opposition of House Bill 905.

Fort Washington Medical Center has well-established processes for determining appropriate staffing levels. These processes include:

- Setting the initial staffing schedule at the expected census for any given unit.
- Evaluating the patient census and staffing levels prior to each shift and throughout the shift.
- Additionally, staffing is reviewed at unit huddles at the start of each shift and during daily hospital-wide safety huddles.
- Front line staff utilize a self-scheduling model to identify availability and preference for shift work.

The workflows listed above are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Fort Washington Medical Center recognizes the importance of engaging our frontline team members in making staffing decisions.

- A Shared Governance model is in place that is comprised exclusively of bedside and frontline staff, so they have an official and protected space to voice care challenges and propose solutions.
- Cadenced staff surveys with opportunity for anonymous feedback
- Each year, leaders are required to develop process improvement plans for employee engagement and culture of safety topics
- Employee Turnover rate continues to trend to world class set by the Advisory Boards standards.
- The application process is underway for the Pathway to Excellence program, whose focus is on positive practice environment that empowers and engages staff.

This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels.

The impact of this work is readily apparent in our clinical outcomes.

- Fort Washington Medical Center is the only hospital in Prince Georges County that obtained a Leapfrog Grade A in Spring 2024
- Patient Experience has improved since 2022 and trending towards World Class by Press Ganey standards.

Hospital staffing plans are reviewed and updated several times a day to account for fluctuating patient volumes, bed availability, individual patient acuity, and the availability and experience of clinical staff. Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. While we fully support engaging front line staff in these decisions, clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Fort Washington Medical Center is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Respectfully submitted,

Daffodil Baez

President,
Adventist HealthCare Fort Washington Medical Center

Opposition to House Bill 905_AHC White Oak Medical

Uploaded by: Karmen Brown

Position: UNF

Adventist HealthCare
White Oak Medical Center

11890 Healing Way
Silver Spring, MD 20904

March 27, 2025

The Honorable Senator Pamela Beidle, Chair
The Honorable Senator Antonio Hayes, Vice Chair
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Subject: Opposition to House Bill 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment

Dear Chair Beidle, Vice Chair Hayes, and Members of the Senate Finance Committee:

On behalf of Adventist HealthCare White Oak Medical Center (WOMC), I am writing to respectfully express our strong opposition to House Bill 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment. We appreciate and share the legislature's goal of ensuring safe staffing in Maryland's hospitals. However, we believe the prescriptive approach mandated by HB 905 is unnecessary given our existing, successful practices and could unintentionally undermine the agile, patient-centered staffing processes we already have in place.

Proven Staffing Processes at WOMC:

WOMC currently employs several well-established processes to determine and adjust staffing levels in real-time. These include safety huddles at the beginning of each shift and a centralized bed control office that actively manages capacity and acuity to align with ongoing staffing needs. Additionally, departments use robust benchmarking from the Labor Management Institute to guide staffing levels according to best practices and standards.

At WOMC, initial staffing schedules for each care unit are set based on projected census data from year-over-year trends. A shared governance model, driven by frontline clinical staff—including nurses, patient care technicians, and unit support coordinators—guides recommendations for staffing needs and support. For specialty areas, frontline staff refer to their professional organizations for guidance on scheduling standards. For example, Emergency Department nurses follow staffing standards from the Emergency Nurses Association, while Surgical Services aligns staffing needs with guidelines from the Association of periOperative Registered Nurses.

The shared governance committee meets year-round, and WOMC has made several adjustments to staffing mix and ratios based on their input and recommendations. Additionally, we utilize a self-scheduling platform, enabling clinicians to request specific dates and shifts, which supports flexible staffing and aids in workforce recruitment and retention.

All of these tools and approaches are informed by standards from The Joint Commission and the Centers for Medicare & Medicaid Services (CMS), with an unwavering focus on patient safety and positive clinical outcomes.

Frontline Engagement and Excellence:
WOMC is a Pathway to Excellence® designated hospital by the American Nurses Credentialing Center (ANCC). Pathway to Excellence is a global credential highlighting an organization's commitment to creating a healthy work environment where nurses feel empowered and valued. To earn the Pathway to Excellence designation, organizations must demonstrate excellence in six key standards: shared decision-making, leadership, safety, quality, well-being and professional development. Nurses in Pathway to Excellence designated organizations are engaged in both policy and practice, resulting in higher job satisfaction, reduced turnover, improved safety and better patient outcomes. This designation further underscores our commitment to nurses and clinicians on determining optimal staffing levels for providing world-class care.

Real-Time Staffing Flexibility:
Our hospital needs can shift rapidly, and staffing plans at WOMC are reviewed and adjusted continually to reflect patient volume, acuity, and the availability and expertise of clinical staff. Our nursing supervisors and unit leaders make real-time decisions to reallocate resources and maintain safe care delivery. A single, centralized staffing committee, as proposed in HB 905, would not offer the speed or flexibility required to manage such rapidly evolving circumstances.

Clinical Expertise Must Guide Clinical Staffing:
Staffing decisions must be driven by clinical expertise. At WOMC, these decisions are made by experienced clinical leaders who understand the complexities of patient care. While non-clinical staff contribute valuable insights into operations and logistics, they should not be tasked with directing clinical staffing plans. Patient safety demands decisions informed by those who are actively engaged in delivering care. WOMC has a proven track record of providing safe patient care, as evidenced by a four-time hospital safety grade of "A" from The Leapfrog Group – an independent national nonprofit watchdog focused on patient safety – as well as recognition by the Maryland Patient Safety Center and other nonprofit safety and quality organizations.

Ongoing Investment in Workforce Development:
WOMC is committed not only to safe staffing today but also to building a sustainable, resilient workforce for the future. We operate a robust Leadership Institute, which provides development opportunities for emerging and seasoned leaders alike, fostering a culture of excellence and continuous learning. These efforts have produced measurable results. WOMC staff turnover has decreased significantly in one year, and employee engagement has risen to world-class benchmarks established by Press Ganey, which measures employee engagement for hospitals and health systems nationally. These achievements underscore our commitment to retaining skilled professionals and creating an environment where they thrive.

In Conclusion:
Adventist HealthCare White Oak Medical Center is proud of our ongoing work to ensure safe, high-quality care through thoughtful, responsive staffing practices. We strongly believe that HB 905, while well-intended, does not reflect the complexities of hospital operations and could impede our ability to respond quickly to patient needs.

For these reasons, **we respectfully urge an *Unfavorable* report on House Bill 905.**

Thank you for the opportunity to share our perspective and for your continued support of Maryland's healthcare institutions.

Sincerely,

Anthony Stahl, PhD, FACHE
President, Adventist HealthCare White Oak Medical Center

SGMC House Bill 905.pdf
Uploaded by: Karmen Brown
Position: UNF

Adventist HealthCare
Shady Grove Medical Center

House Bill 905- Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: *Oppose*

April 1, 2025
Senate Finance Committee

On behalf of Adventist HealthCare Shady Grove Medical Center, we appreciate the opportunity to comment in opposition of House Bill 905.

Adventist HealthCare Shady Grove Medical Center has well-established processes for determining appropriate staffing levels. These processes include initial staffing schedule set at the expected census for any given unit and then evaluating the patient census and staffing levels prior to each shift and throughout the shift. Additionally, staffing is reviewed at unit huddles at the start of each shift and during daily hospital-wide safety huddles. These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Adventist HealthCare Shady Grove Medical Center recognizes the importance of engaging our frontline team members in making staffing decisions. Recommendations from Professional Organizations for each Service Line are used to inform our staffing guidelines. We utilize a self-scheduling model which allows staff to schedule within the guidelines that have been determined by leadership and frontline staff. Prior to the schedule being posted it is reviewed and balanced in collaboration with frontline staff. Staff are also involved on a shift to shift basis as staffing is adjusted to accommodate the changing patient census. This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels.

Hospital staffing plans are reviewed and updated several times a day to account for fluctuating patient volumes, bed availability, individual patient acuity, and the availability and experience of clinical staff. Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. While we fully support engaging front line staff in these decisions, clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Adventist HealthCare Shady Grove Medical Center is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Sincerely,

X

Daniel Cochran
President

X

Joan Vincent
VP, Chief Nursing Officer

Senate Bill 720.pdf
Uploaded by: Kendra Thayer
Position: UNF

WVU Medicine

GARRETT REGIONAL MEDICAL CENTER

RURAL & COMMUNITY TOP HOSPITAL 2024 CHARTIS | PERFORMANCE LEADERSHIP AWARD 2023 | LEAPFROG HOSPITAL SAFETY GRADE

Senate Bill 720 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)

Garrett Regional Medical Center respectfully submits this letter of opposition to Senate Bill 720-Hospitals-Clinical Staffing Committees and Plans—Establishment (Safe Staffing Act of 2025).

Garrett Regional Medical Center is a small community hospital in Western MD, where we have consistently provided safe levels of staffing and patient care through our frontline self governance and unit based committees. Our staff have always been able to provide suggestions and improvements for the process of delivering safe patient care.

This bill would put additional challenges on small community based hospitals and the administrative burden to carry out these regulations. It would also put additional strain on the frontline staff with the amount of updates that would be needed to comply with the regulations in this bill. Our staffing model and ratio changes multiple times throughout the day to meet the patient acuity levels and we have administrative oversight 24/7 through supervisors and leaders to make sure staffing ratios are safe and appropriate.

We actively engage with our staff regarding staffing needs and concerns they have. We consistently have over 90% participation in our staff engagement survey scores. We respectfully ask for the opposition of this bill as many hospitals have processes in place to ensure safe staffing levels and the extra work and requirements would be more burden placed on the healthcare system.

Sincerely,

Kendra Thayer MSN, FACHE
Chief Nursing Officer/VP Patient Care Services
Garrett Regional Medical Center
251 North Fourth Street
Oakland, MD 21550

HB 905 - Clinical Staffing Committees and Plans -

Uploaded by: Kimberly Routson

Position: UNF

MedStar Health

9 State Circle, Ste. 303
Annapolis, MD 21401
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Kimberly S. Routson
Assistant Vice President,
Government Affairs - Maryland

HB 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment
Position: ***Oppose***
Senate Finance Committee
April 1, 2025

MedStar Health is the largest healthcare provider in Maryland and the Washington, D.C. region. MedStar Health offers a comprehensive spectrum of clinical services through over 500 care locations, including 10 hospitals, 33 urgent care clinics, ambulatory care centers and an extensive array of primary and specialty care providers. As a not-for-profit healthcare system, MedStar Health is committed to its patient-first philosophy, emphasizing care, compassion, and clinical excellence, supported by a dedicated team of more than 35,000 physicians, nurses, and many other clinical and non-clinical associates.

HB 905 mandates that hospitals establish and maintain a clinical staffing committee responsible for implementing a clinical staffing plan. The committee's membership would include a certified nursing assistant, a dietary aide, an emergency room nurse, an environmental service worker, a resident, a staff physician, and a technician. Many of these roles are not clinical in nature and lack the knowledge and expertise required to make clinical decisions. Although heavily amended, the bill does not get at the root cause of workforce shortages, nor does it reflect the intricacies of hospital staffing. Furthermore, no comprehensive review of current hospital practices has been conducted to reflect the requirements of The Joint Commission or Centers for Medicare and Medicaid Services. MedStar Health use a collaborative Shared Governance model that provides a structure for shared decision making and the active engagement of nurses to impact patient outcomes, while creating a positive and inclusive work environment.

Flexibility is required to fulfill our mission as hospitals, as our operations are inherently dynamic. Nurse leaders need the ability to modify staffing levels based on patients' needs, acuity, and volume. Patient flow changes day to day and minute by minute, and a static plan would not account for these critical flexibilities. Nurses are best equipped to use their experience and judgment to determine the specific needs of patients and staff. The clinical staffing committee model could potentially pull providers away from crucial settings such as intensive care, behavioral health, and senior care areas to fulfill plan requirements. Nursing is constantly evolving to reflect science and technology, and this plan would stymie innovation and adoption of new technologies like telesiting for patients – that can both decrease ED wait times and provide quality patient care.

HB 905 could limit health care access for patients and diminish individual patient needs by not allowing adjustments for variability among health care organizations. Ultimately, this legislation and the staffing committee model as proposed will exacerbate hospital ED throughput challenges. HB 905 limits hospitals' capacity management, leading to bottlenecks and potential bed and unit closures to meet rigid requirements.

Our goal as providers is to implement a nimble process that improves patient flow and hospital throughput to provide effective delivery of patient care. The clinical staffing committee and plan attempt to mandate ratios annually that will reduce access, increase inefficiencies, and be counterproductive to positive outcomes.

For the reasons above, MedStar Health and its Maryland hospitals, including MedStar Franklin Square Medical Center, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center, MedStar St. Mary's Hospital and MedStar Union Memorial Hospital, urge an ***unfavorable*** report on **HB 905**.

Conscience-Protections-White-Paper-Updated-10.09.2
Uploaded by: Laura Bogley
Position: UNF

ACLJ

MEMORANDUM

These issue summaries provide an overview of the law as of the date they were written and are for educational purposes only. These summaries may become outdated and may not represent the current state of the law. Reading this material DOES NOT create an attorney-client relationship between you and the American Center for Law and Justice, and this material should NOT be taken as legal advice. You should not take any action based on the educational materials provided on this website but should consult with an attorney if you have a legal question.

Conscience Rights of Health Care Personnel

As founding father, James Madison, once wrote, "conscience is the most sacred of all property."[1] Conscience rights are not only important to the health care community but to every American. In *Cantwell v. Connecticut*, the Supreme Court stated, "Freedom of conscience and freedom to adhere to such religious organization or form of worship as the individual may choose cannot be restricted by law." When it comes to the conscience rights of health care personnel, numerous state and federal laws have been enacted to ensure these individuals' conscience rights are not violated. The three main federal conscience laws that will be discussed below are the Church Amendment, the Coats-Snowe Amendment, and the Weldon Amendment. The discussion below will also analyze Title VII of the Civil Rights Act of 1964 and the right this law gives to health care providers, as well as the Religious Freedom Restoration Act.

The Church Amendment

Following the controversial ruling in *Roe v. Wade*, a federal district court wrongfully forced a religiously affiliated hospital to use its facilities for a sterilization procedure.[2] In response to *Taylor v. St. Vincent's Hospital*, the growing need to protect the conscience rights of health care workers and entities was addressed when Congress passed the "Church Amendment" in 1973 (Senator Frank Church was the principal sponsor of the law).[3] Essentially, the statute protects the conscience rights of health care personnel working at entities that receive funds and grants from the U.S. Department of Health and Human Services. The law provides in relevant part:

> *Discrimination prohibition*
> *No entity which receives a grant, contract, loan, or loan guarantee under the Public Health Service Act [42 U.S.C. 201 et seq.], the Community Mental Health Centers Act [42 U.S.C. 2689 et seq.], or the Developmental Disabilities Services and Facilities Construction Act [42 U.S.C. 6000 et seq.] after June 18, 1973, may—*

[1] James Madison, *Property* (1792), in 1 *The Founders' Constitution* 598, 598 (Philip B. Kurland and Ralph Lerner eds., 1986).
[2] See *Taylor v. St. Vincent's Hospital*, 369 F. Supp. 948 (D. Mont. 1973).
[3] 42 U.S.C. § 300a-7.

(A) discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel, or
(B) discriminate in the extension of staff or other privileges to any physician or other health care personnel,

because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions.[4]

Doctors and health care personnel have "broad and comprehensive conscience protections guaranteed by federal law." *FDA v. All. for Hippocratic Med*., 602 U.S. 367, 390 (2024). The Supreme Court stated:

> [F]ederal conscience laws definitively protect doctors from being required to perform abortions or to provide other treatment that violates their consciences. *See* 42 U. S. C. §300a-7(c)(1); see also H. R. 4366, 118th Cong., 2d Sess., Div. C, Title II, §203 (2024). The Church Amendments, for instance, speak clearly. They allow doctors and other healthcare personnel to "refus[e] to perform or assist" an abortion without punishment or discrimination from their employers. 42 U. S. C. §300a-7(c)(1). And the Church Amendments more broadly provide that doctors shall not be required to provide treatment or assistance that would violate the doctors' religious beliefs or moral convictions. §300a-7(d).

Id. at 387.

The Court continued:

> [F]ederal conscience protections encompass "the doctor's beliefs rather than particular procedures," meaning that doctors cannot be required to treat mifepristone complications in any way that would violate the doctors' consciences. Tr. of Oral Arg. 37; *see* §300a-7(c)(1). As the Government points out, that strong protection for conscience remains true even in a so-called healthcare desert, where other doctors are not readily available.

Id. at 388.

(Though the Court references "doctors" in these paragraphs explaining the breadth of protection afforded by federal law, the Church Amendments do not just protect the conscience rights of doctors but all "health care personnel." 42 U.S.C. § 300a-7(c)(1)(A) and (B).)

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[4] *Id.*

In *All. for Hippocratic Med*., the plaintiff-doctors expressed the fear that Emergency Medical Treatment and Labor Act (EMTALA) "could be interpreted to override those federal conscience laws and to require individual emergency room doctors to participate in emergency abortions in some circumstances. *See* 42 U. S. C. §1395dd." However, as the Supreme Court noted:

> [T]he Government has disclaimed that reading of EMTALA. And we agree with the Government's view of EMTALA on that point. EMTALA does not require doctors to perform abortions or provide abortion-related medical treatment over their conscience objections because EMTALA does not impose obligations on individual doctors. As the Solicitor General succinctly and correctly stated, **EMTALA does not "override an individual doctor's conscience objections."** We agree with the Solicitor General's representation that federal conscience protections provide "broad coverage" and will "shield a doctor who doesn't want to provide care in violation of those protections."

Id. at 388-89 (citations omitted) (emphasis added).

In fact, relying on admissions by the federal government, the Supreme Court went on to observe, that

> [D]octors need not follow a time-intensive procedure to invoke federal conscience protections. A doctor may simply refuse; federal law protects doctors from repercussions when they have "refused" to participate in an abortion. §300a-7(c)(1). And as the Government states, "[h]ospitals must accommodate doctors *in emergency rooms no less than in other contexts*." For that reason, hospitals and doctors typically try to plan ahead for how to deal with a doctor's absence due to conscience objections.

Id. at 389 (internal citations omitted) (emphasis added).

The Coats-Snowe Amendment (42 U.S.C. § 238n)

In response to medical students feeling coerced into learning how to perform abortions, Congress passed the Coats-Snowe Amendment in 1996.[5] The Coats-Snowe Amendment is divided into three sections. In sum, the law prohibits federal and state governments from compelling or coercing participation in abortion training.[6] Additionally, such training cannot be a condition of any accreditation or licensure. The key language of the statute is provides as follows:

> (a) ***In general.*** *The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—*

[5] *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1006 (N.D. Cal. 2019).
[6] 42 U.S.C. 238n.

(1) *the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions;*
(2) *the entity refuses to make arrangements for any of the activities specified in paragraph (1); or*
(3) *the entity attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.*
(b) ***Accreditation of postgraduate physician training programs.***
(1) *In general. In determining whether to grant a legal status to a health care entity (including a license or certificate), or to provide such entity with financial assistance, services or other benefits, the Federal Government, or any State or local government that receives Federal financial assistance, shall deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standards [standard] that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions. The government involved shall formulate such regulations or other mechanisms, or enter into such agreements with accrediting agencies, as are necessary to comply with this subsection.*[7]

It is important to note that "health care entity" is defined by the Amendment as including an "individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions."[8]

Weldon Amendment

Similar to the Coats-Snowe Amendment, the Weldon Amendment protects against governmental coercion in the context of abortion. However, the Weldon Amendment sweeps more broadly across the medical field. The Weldon Amendment cuts federal funding from federal and state government entities if those entities discriminate against health care entities on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.[9] Specifically, the federal funds referenced here are appropriated funds. Where the Weldon Amendment sweeps broader than the Coats-Snowe Amendment is in the definition of "health care entity." In the Weldon Amendment a health care entity is defined as, "individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or

[7] *Id.*
[8] *Id.*
[9] 84 F.R. 23170, 23172.

plan."[10] This law is a vital layer in the protection of health care conscience rights. Virtually, all health care workers are protected from state criminal prosecution or loss of their medical license.[11]

Title VII of the Civil Rights Act of 1964

Title VII of the Civil Rights Act of 1964 serves as a protection for religious rights in the workplace by making it illegal for an employer to discriminate against employees or prospective employees based on his/her religion. The law states in pertinent part:

> *(a) Employer Practices*
>
> *It shall be an unlawful employment practice for an employer-*
>
> (1) *to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's… religion; or*
>
> (2) *to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's…religion.*
>
> *For the purposes of this subchapter-*
>
> *(j) The term "religion includes all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate to an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business.*

The Supreme Court has held that any accommodation requiring the employer to bear "more than a de minimis cost," or, in other words, "additional costs when no such costs are incurred," constitutes an "undue hardship." *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977). This includes any accommodation that results in additional costs in the "form of lost efficiency… or higher wages." *Id.* at 84.

In *Groff v. DJoy*,[12] the Supreme Court held that the term "undue hardship" means "an employer must show that the burden of granting an accommodation would result in substantial increased costs in relation to the conduct of its particular business." The Court clarified further that the determination of undue hardship should be based on a fact-specific inquiry, considering the nature, size, and operating cost of the employer. The impact of a religious accommodation on coworkers is relevant only to the extent that it affects the conduct of the business.

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[10] Weldon Amendment, Consolidated Appropriations Act, 2009, Pub. L. No. 111-117, 123 Stat 3034.
[11] *State ex rel. Lockyer v. United States*, 450 F.3d 436, 441 (9th Cir. 2006).
[12] 2023 U.S. LEXIS 2790 (June 29, 2023).

Importantly, the *Groff* Court emphasized that bias or hostility toward a religious practice or accommodation cannot be considered a valid defense for the employer: "An employer who fails to provide an accommodation has a defense only if the hardship is 'undue,' a hardship that is attributable to employee animosity to a particular religion, to religion in general, or to the very notion of accommodating religious practice cannot be considered 'undue.'"[13]

Groff has significant implications for addressing religious accommodations in the workplace. It reaffirms the protection of religious believers under Title VII and clarifies that employers must demonstrate that the burden of accommodating an employee's religious practice is substantial.

This case also provides a new rubric for assessing future religious accommodation cases under Title VII, requiring a more nuanced analysis that considers the specific circumstances and impact on the employer's business. How that rubric will be applied by the lower courts remains to be seen.

The Religious Freedom Restoration Act

The "Religious Freedom Restoration Act" (RFRA) serves as a protection against the federal government's intrusion on one's religious liberty and freedom of conscience.[14] As part of RFRA, the government may only "substantially burden" one's exercise of religion if it demonstrates that the burden to the person furthers a compelling governmental interest and is the least restrictive means of furthering that interest.[15] RFRA explicitly provides for judicial relief to those whose religious exercise has been burdened due to a violation of this law.[16]

It is important to emphasize that RFRA protects employers as well as employees. In *Burwell v. Hobby Lobby Stores, Inc.*, the Supreme Court held that privately held, for-profit corporations did not have to comply with Department of Health and Human Service (HHS) regulations that were contrary to the business owners' religious beliefs. 573 U.S. 682, 690 (2014). In *Hobby Lobby*, the Supreme Court held that the HHS regulations at issue, which mandated that corporations provide contraceptive coverage (including abortion-inducing drugs), violated RFRA. *Id*. at 736. By applying RFRA to organizations like Hobby Lobby, the Supreme Court effectively ushered in a new era of protections for the religious principles and freedom of conscience rights of private businesses.

Following *Hobby Lobby*, the Supreme Court held in *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, that the federal government had the authority to craft religious exemptions for organizations that opposed the contraceptive mandate on religious grounds. 140 S. Ct. 2367, 2386 (2020). *Little Sisters of the Poor v. Pennsylvania* followed a prior case involving the Little Sisters of the Poor, a Catholic caregiving organization that objected to complying with the Affordable Care Act's contraceptive mandate. *Id*. at 2376. As a result of that first case, in 2017, federal agencies issued new rules which offered moral and/or religious exemptions from complying with the mandate. In response, Pennsylvania and several other states sued to have those exemptions enjoined, forcing the Little Sisters of the Poor and other religious employers to provide contraceptive

[13] 2023 U.S. LEXIS 2790 at *35.
[14] RELIGIOUS FREEDOM RESTORATION ACT OF 1993, 1993 Enacted H.R. 1308, 103 Enacted H.R. 1308, 107 Stat. 1488, 1489
[15] *Id.*
[16] *Id.*

coverage in violation of their religious beliefs. Ultimately, the Supreme Court ruled 7-2 in favor of the Sisters, and found that while Congress could have provided strict statutory protections for contraceptive coverage, it failed to do so. *Id*. at 2382. Because the agencies had the statutory authority to provide the Sisters with a religious exemption, the Court did not have to decide whether the contraceptive mandate violated RFRA. *Id*.

Filing a Complaint with the Equal Employment Opportunity Commission

The Equal Employment Opportunity Commission (EEOC), charged with enforcing Title VII, describes various ways how an employee can file a charge of discrimination based on the employee's belief that he/she has been discriminated against based on his/her religion.[17] A charge of discrimination is "a signed statement asserting that an employer, union or labor organization engaged in employment discrimination."[18] The charge of discrimination, which requests remedial action by the EEOC, *must* be filed before an employee can file a Title VII discrimination lawsuit against an employer in court. As a general matter, the charge of discrimination must be filed within 180 calendar days of the alleged act of discrimination.[19] This deadline will not be extended while the employee attempts to deal with the matter internally. It is therefore best to file the charge as soon as possible and to contact your local EEOC office for guidance.[20]

Last updated: October 9, 2024

[17] *How to File a Charge of Employment Discrimination*, U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, https://www.eeoc.gov/how-file-charge-employment-discrimination.
[18] *Filing a Charge of Discrimination: With the EEOC*, U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, https://www.eeoc.gov/filing-charge-discrimination.
[19] *Public Portal,* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, https://publicportal.eeoc.gov/Portal/Login.aspx.
[20] *EEOC Field Offices,* U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, https://eeoc.gov/field-office.

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Uploaded by: Laura Bogley
Position: UNF

UNFAVORABLE

HB905/SB720 - Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)

Laura Bogley, JD
Executive Director
Maryland Right to Life, Inc.

On behalf of our Board of Directors and many chapters across the state, we oppose **House Bill 905 /Senate Bill 720 the so-called Safe Staffing Act** and urge your unfavorable report.

This bill is an attack on the Constitution and free exercise of religion. This bill could compel private and faith-based hospitals to retain and compensate abortionists and an unlicensed abortion workforce, in violation of their First Amendment rights of conscience and religious liberty, as well as in violation of Title VII of the Civil Rights Act of 1964 and the Religious Freedom Restoration Act.

This bill fails to provide a conscience clause to exempt faith-based hospitals and medical providers from compensating abortion workers or committing abortions, against their deeply held religious beliefs – and in fact, specifically targets private and faith-based hospitals for liability under this bill. As a result, many healthcare providers will be forced to leave the state, exacerbating the problem of medical scarcity in Maryland.

Induced abortion is not health care and is never medically necessary. Faith-based hospitals already regularly comply with the federal Emergency Medical Treatment and Labor Act (EMTALA), and provide emergency medical intervention for pregnant women whose physical lives are at risk – including for ectopic pregnancy and miscarriage. But this bill could be exploited to require faith-based hospitals to keep abortionists on staff for the purpose of committing elective abortions. Hospital administrations are in the best position to make decisions about staffing and required medical expertise and must be free to do so without political interference from the State.

CONSCIENCE RIGHTS MUST NOT BE INFRINGED

The freedom to practice one's religion is one of our most cherished rights. According to a January 2025 Marist poll, 62% of people, including 51% of democrats, responded that medical providers should not be legally required to perform induced abortions against their conscience.

Maryland's existing statutory conscience rights for medical providers are insufficient. While state law prevents employers from discriminating against their employee's rights and compelling them to provide abortions, the law does not protect medical providers who refuse to commit abortions due to their deeply held religious beliefs from civil liability. The State does provide blanket immunity for any provider who commits abortions.

Federal law recognizes this and protects medical personnel from being compelled to do something against their religious convictions. Without comprehensive protection, healthcare rights of conscience may be violated in various ways, such as harassment, demotion, salary reduction, transfer, termination, loss of staffing privileges, denial of aid or benefits, and refusal to license or refusal to certify.

The State also would be in violation of federal **Title VII of the Civil Rights Act of 1964**, which states that an employer must not discriminate against an employee based on the employee's religious beliefs. Employees cannot be subjected to harassment because of their religious beliefs or practices. Title VII requires employers to grant reasonable requests for religious accommodations unless doing so would result in undue hardship to the employer.

But by enacting this bill, the Maryland General Assembly would infringe upon the Constitutional right to the free exercise of religion guaranteed to all citizens under the **First Amendment** and force physicians to violate their Hippocratic Oath in which they swore first to do no harm to their patients. As a result, many healthcare providers will be forced to leave the state, exacerbating the problem of medical scarcity in Maryland.

Current state laws do not provide adequate protections for healthcare providers. While statute protects the right of a provider to refuse to participate in abortion practices on the basis of religious beliefs, the law does not shield the provider from civil suit. Further non-religiously affiliated pro-life professionals, institutions, and payers may have moral (though not religious) objections to participating in, facilitating, and funding life-ending drugs and devices, but are left unprotected. Given this lack of conscience protections, pro-life healthcare providers, institutions, and taxpayers still face coercive efforts by the state government and private institutions to perform induced abortions.

Protecting the freedom of conscience is common sense. Conscience-respecting legislation does not ban any procedure or prescription and does not mandate any particular belief or morality. Protecting conscience helps ensure that healthcare providers enter and remain in their professions, helping to meet the rising demand for quality health care in Maryland.

EMERGENCY MEDICAL TREATMENT AND LABOR ACT

In *Dobbs v. Jackson Women's Health Organization* (2022), the United States Supreme Court overruled *Roe v. Wade* (1973) and held that a right to abortion is not found in the Constitution of the United States. The Court also held that states have an interest in preserving the integrity of the medical profession, which includes protecting the freedom of conscience of healthcare providers.

But in defiance of the Court and the *Dobbs* decision, the Biden Administration weaponized the Department of Justice and the Department of Health and Human Services to once again impose abortion mandates on the states. The Biden administration exploited EMTALA in an attempt to force physicians to perform induced abortions in violation of their oath and religious freedoms.

The EMTALA statute was enacted by Congress in 1986, "to ensure public access to emergency services regardless of ability to pay." EMTALA requires hospitals that receive Medicare funding to medically screen, stabilize, and appropriately transfer an individual with an "emergency medical condition."

EMTALA specifically directs care, where applicable, for **both the pregnant woman and her unborn baby**, and never mentions abortion. The sole purpose of induced abortion is to end the life of the unborn baby, an act of violence that is never medically necessary.

STATE CULPABILITY IN ENGINEERED EMERGENCIES

This bill enables the abortion industry and abortion drug manufacturers to be grossly negligent and endanger the health and lives of their female patients with no consequences. By enacting this bill, the Assembly will be passing the burden of care to hospitals to complete induced abortions or provide emergency interventions for women injured as a result of substandard care at the hands of abortionists.

Maryland is state-sponsor of the abortion industry. Through radical acts of this legislature, the State has endorsed induced abortion practices as healthcare and SAFE. But in a huge contradiction, democrats now demand that taxpayers cover the costs of **medical emergencies caused at the hands of abortionists.**

This legislature has forced taxpayers to fund aggressive campaigns to impose abortion on women and girls in and trafficked into Maryland. The legislature has consistently rejected measures to provide women a right to informed consent or equal access to lifesaving alternatives to abortion. The State has put abortion politics before patients and shielded abortionists from liability for the injury, death, sexual abuse or trafficking of their patients.

The Maryland General Assembly has fully deregulated induced abortion practices, removing induced abortion from the spectrum of healthcare in all ways accept funding. Through the *Abortion Care Access Act* of 2022, the state removed the final safeguard in law for women that permitted only licensed physicians to perform or provide abortions and instead authorized any certified individual to commit abortions. State taxpayers are now forced to fund the training of this substandard abortion workforce.

In 2022, the Biden administration and democrat attorneys general from across the nation, including Maryland Attorney General Brian Frosh, pressured the Food and Drug Administration to remove critical safeguards for women's health when using chemical abortion-inducing drugs. The Biden FDA removed remediation standards which it had put in place to reverse damage or remove risk caused by abortion drugs, including severe hemorrhaging, infection, misdiagnoses and even death. As a result, chemical abortion is 4 times more dangerous than surgical abortion. To date, at least 36 women have been killed by abortionists providing abortion-inducing drugs.

Now democrat lawmakers introduce this bill that asks hospitals and medical providers to bear the burden of the substandard practices of the abortion industry. This bill asks hospitals and medical providers to bear the cost for completing abortions that result from medical negligence or misuse of abortion-inducing drugs. Most reprehensibly, the State is using medical emergencies engineered by its own

willful and wanton disregard for women's safety, to justify religious discrimination, harassment and infringement upon medical providers' Constitutional rights.

HOSPITAL LIABILITY

This bill creates a precarious legal dilemma for hospitals in Maryland. Under this bill, hospitals will face civil liability either for violation of state law, or for violation of their employees' Constitutional rights. This conflict clearly demonstrates why the bill itself is unconstitutional.

Any hospital that violates their employees' religious freedoms will be exposed to litigation, class action suits and accumulating financial liability. Hospitals are subject to the federal conscience laws that, in the words of the Supreme Court in ***FDA v. Alliance for Hippocratic Medicine*** **("*AHA*")**, "allow doctors and other healthcare personnel to 'refuse to perform or assist' an abortion without punishment or discrimination from their employers."

Further, the hospital cannot even force them to assist with abortions in emergency situations, as the Emergency Medical Treatment and Labor Act (EMTALA) does not override federal conscience laws. In *AHA*, the Supreme Court said that "EMTALA does not require doctors to perform abortions or provide abortion-related medical treatment over their conscience objections because EMTALA does not impose obligations on individual doctors." The Supreme Court also stated that hospitals "must accommodate doctors in emergency rooms no less than in other contexts" and "try to plan ahead for how to deal with a doctor's absence due to conscience objections."

In *FDA v. Alliance for Hippocratic Medicine*, the plaintiff-doctors expressed the fear that Emergency Medical Treatment and Labor Act (EMTALA) "*could be interpreted to override those federal conscience laws and to require individual emergency room doctors to participate in emergency abortions in some circumstances.* See 42 U. S. C. §1395dd."

However, as the Supreme Court noted:

> "*[T]he Government has disclaimed that reading of EMTALA. And we agree with the Government's view of EMTALA on that point. EMTALA does not require doctors to perform abortions or provide abortion-related medical treatment over their conscience objections because EMTALA does not impose obligations on individual doctors. As the Solicitor General succinctly and correctly stated, EMTALA does not "override an individual doctor's conscience objections." We agree with the Solicitor General's representation that federal conscience protections provide "broad coverage" and will "shield a doctor who doesn't want to provide care in violation of those protections."*

Finally, federal regulations require hospitals to turn away patients when they are not sufficiently staffed. Under **42 CFR 489.24(b)**, hospitals can and in fact have a duty to initiate drive-by status if they lack "qualified personnel or transportation" required for treatment. This regulation demonstrates that while hospitals have treatment duties, these are limited by capacity constraints. 42 CFR 489.24(b)(4) affirms

hospital authority to redirect incoming ambulances when reaching drive-by status due to capacity saturation or capability constraints. While access has public value, so does preserving institutional competence. Reasonable drive-by policies preserve a hospital's institutional competence and ensure patients are redirected for emergency care.

ABORTION IS NOT HEALTHCARE

Induced abortion is not healthcare. It is violence and brutality that ends the lives of unborn children through suction, dismemberment, chemical poisoning or starvation. The fact that 85% of OB/GYNs in a representative national survey refuse to commit induced abortions is glaring evidence that abortion is not an essential part of women's healthcare.

The sole purpose of induced abortion is to end the life of a preborn patient. Doctors regularly treat serious pregnancy complications without intentionally killing a preborn child. This includes being able to perform maternal-fetal separations when a woman's life is endangered by a pregnancy complication – something that is already allowed by EMTALA as well as by every state law in the country. **No law in any state prohibits medical intervention to treat miscarriage, ectopic pregnancy or to save the physical life of the mother.**

NO PUBLIC FUNDING FOR ABORTION VIOLENCE

Maryland is one of only 4 states that forces taxpayers to fund abortions. There is longstanding bi-partisan unity on prohibiting the use of taxpayer funding for abortion. 57% percent of those surveyed in a January 2025 Marist poll say they oppose taxpayer funding of abortion.

The Supreme Court of the United States, in *Dobbs v. Jackson Women's Health* (2022), overturned *Roe v. Wade* (1973) and held that there is no right to abortion found in the Constitution of the United States. The Supreme Court affirmed in *Harris v. McRae* (1980), that *Roe* had created a limitation on government, not a government funding entitlement. The Court ruled that the government may distinguish between abortion and other procedures in funding decisions -- noting that "*no other procedure involves the purposeful termination of a potential life*", and held that there is "*no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds*."

Furthermore, a state is under no constitutional duty to provide induced abortion services for those within its borders (*Youngberg v. Romeo*, 457 U.S. 307, 317 (1982)). There is no constitutional requirement for a state to fund non-therapeutic abortions (*Maher v. Roe*, 432 U.S. 464, 469 (1977)).

For these reasons we respectfully urge your unfavorable report on this bill. We appeal to you to prioritize the state's interest in human life and restore to all people, our natural and Constitutional rights to life, liberty, freedom of speech and religion.

SOURCES:

James Bopps, Attorney, National Right to Life Committee: https://www.supremecourt.gov/DocketPDF/23/23-726/301631/20240227172259691_NRLC%20Idaho%20Brief%20of%20Amicus%20Curiae.pdf .

Olivia Summers, Attorney, American Center for Law and Justice: https://aclj.org/pro-life/hospital-unlawfully-forcing-three-ultrasound-technicians-to-assist-in-abortions-in-violation-of-their-faith--the-aclj-is-fighting-back .

American Association of Pro-Life Obstetricians and Gynecologists: https://aaplog.org/aaplog-comment-on-fifth-circuit-ruling-on-state-of-texas-v-becerra/.

Carroll Hospital UNFAV HB 905 Finance.pdf
Uploaded by: Leigh Chapman
Position: UNF

Date: April 1, 2025
To: Chair Beidle, Vice Chair Hayes and Senate Finance Committee Members
Reference: House Bill 905- Hospitals – Clinical Staffing Committee and Plans – (Safe Staffing Act of 2025)

Opposition Letter Against House Bill-905
Position: Oppose

Dear Chair Beidle and Senate Finance Committee Members,

On behalf of Carroll Hospital, I appreciate the opportunity to comment in opposition to House Bill 905, which mandates the establishment of clinical staffing committees and plans within hospitals. While we understand and share the goal of improving staffing levels and patient care, we believe this bill, as written, does not adequately address the complexities involved in hospital staffing and could inadvertently hinder hospitals' ability to provide the best care to patients.

Carroll Hospital has a comprehensive and well-established process for determining appropriate staffing levels tailored to the needs of our patients. We have a staffing office and manager that review staffing, acuity, patient flow, and other logistics related to patient care frequently throughout the day. At Carroll Hospital, we recognize the critical importance of involving frontline team members in staffing decisions. Our staffing team also meets with charge nurses from every unit to discuss any clinical concerns that impact staffing or patient care. This collaborative, inclusive approach empowers our staff—those who are most familiar with patient care—to contribute directly to staffing decisions. This is the key to balancing clinical expertise with the realities of day-to-day patient care needs. These processes are designed to meet the ever-changing demands of patient care, in alignment with national guidelines and requirements from organizations such as The Joint Commission and the Centers for Medicare and Medicaid Services. In addition, we leverage other organizations such as Leapfrog and Nursing Database of Nursing Quality Indicators (NDNQI) to benchmark like units nationally. These well-established entities focus on patient safety and clinical outcomes, and our current practices are informed by their evidence-based standards.

The clinical staffing plans at Carroll Hospital are reviewed and adjusted regularly—sometimes multiple times a day—to respond to real-time changes in patient volumes, acuity levels, available beds, and clinical staff capacity. The flexibility to respond to dynamic, fluctuating conditions is paramount. Unfortunately, the bill's requirement for a centralized staffing committee would add a layer of bureaucracy and rigidity, reducing our ability to make quick, informed adjustments to staffing plans based on these real-time demands.

Furthermore, clinical staffing decisions should remain in the hands of those with the specific expertise to make them—clinical team members. While non-clinical staff can provide valuable input regarding non-clinical staffing concerns, we believe the decisions about patient care and clinical staffing must be driven by those who understand the intricacies of healthcare delivery. The complexity of patient care cannot be effectively addressed by a committee without clinical expertise or the ability to adapt quickly to the changing healthcare environment.

At Carroll Hospital, we are dedicated to strengthening our workforce and advancing the quality of healthcare across Maryland. However, we are concerned that HB 905 does not address the underlying factors contributing

to workforce shortages, such as recruitment and retention strategies, and could result in less flexibility and more administrative burden, detracting from our primary focus—patient care.

For these reasons, I respectfully request an unfavorable report on House Bill 905.

Sincerely,
Leigh Chapman MS, RN, CIC
Chief Nurse Officer & Vice President of Patient Care Services
Carroll Hospital Center, A LifeBridge Health Center
lchapman2@lifebridgehealth.org

HB905 Safe Staffing Act of 2025 JHH Unfavorable.pd
Uploaded by: Leslie Weber
Position: UNF

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JOHNS HOPKINS NURSING
THE JOHNS HOPKINS HOSPITAL

TO: The Honorable Pamela Beidle, Chair
Finance

HB905
Unfavorable

FROM: Sharon L. Smyth, DNP, RN, CENP
Chief Nursing Officer, The Johns Hopkins Hospital

DATE: March 28, 2025

RE: **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)**

The Johns Hopkins Hospital opposes **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)** which passed the House of Delegates and is now before your committee.

This bill isn't necessary and will divert time, attention and resources away from solving critical challenges facing my hospital.

The Johns Hopkins Hospital was initially designated as a Magnet[1] hospital in 2003, followed by redesignation in 2008, 2013, 2018, and 2024. As of October 2024, there are 613 Magnet-designated healthcare organizations across the United States and 17 international Magnet Organizations. The Johns Hopkins Hospital is proud of its continued Magnet recognition, a testament to our dedication to nursing excellence, nurse empowerment, and professional growth.

As described below, the implementation of Magnet standards at the Johns Hopkins Hospital inform decisions about patient safety and high-quality outcomes, as well as clinical staffing.

Johns Hopkins nurses continually seek ways to advance our practice, innovate care delivery, foster interdisciplinary collaboration, and enhance patient outcomes (Johns Hopkins Nursing, 2024). Magnet status signifies an organization's commitment to patient-centered care that is evidence-based, improves clinical outcomes, and enhances the patient experience (Johns Hopkins Nursing, 2024). Magnet healthcare organizations and their communities enjoy specific benefits:

- Improved patient outcomes;
- Increased nurse satisfaction; and
- Reduced nurse turnover.

[1] The process for receiving a Magnet designation is described at the end of this testimony.

MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

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The Johns Hopkins Nursing Professional Practice Model

The Johns Hopkins Nursing Professional Practice Model (PPM) is supported by a structure designed to promote excellence in patient care, education, and research using shared governance. JHH nurses understand shared power strengthens the ability to achieve goals; JHH nurses strive to achieve the best outcomes for patients and their families through autonomous and collaborative care, sound clinical judgment, evidence-based practice, and commitment to patient safety. Efforts are directed to excellence and discovery in care, optimizing scope of practice, engaging in lifelong learning, and assuring patient- and family-centered care.

The Johns Hopkins Nursing Governance Process – Leading Clinical Improvement

Anyone can submit their idea for a project or innovation. This includes individual clinical nurses, nursing leadership, [Specialty] Nursing Professional Practice Councils, and interdisciplinary colleagues. This could be anything from a new strategy to reduce falls to the roll-out of a new piece of equipment or a new process for hand-off communication. Projects can apply to individual specialty areas or the entire hospital.

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All submissions are evaluated by the Professional Practice Coordinating Council (PPCC). The PPCC maintains a repository of all projects and provides a global view of all projects that are ongoing around the hospital. The PPCC identifies projects that have a significant impact across the organization and determine whether they align with our nursing strategic priorities and makes recommendations to the Professional Practice Executive Steering Committee (PPESC). The PPESC provides final approval for projects recommended by the PPCC and prioritizes which projects we will allocate our nursing resources towards first.

For approved projects, communities are formed comprising subject matter experts, those interested in becoming subject matter experts, and interdisciplinary partners. The community plans and implements the project on a timeline with a set start and end date. The Office of Nursing Professional Practice provides assistance as needed to overcome any obstacles, and the community reports back to the Professional Practice Coordinating Council with regular progress updates.

Improvements are implemented consistently across the hospital. The community develops and implements a plan to inform and educate stakeholders about the change, new process, or innovation. Everyone receives the same information within the same timeframe, allowing for consistent and timely implementation across all clinical areas.

The Johns Hopkins Nursing Governance Structure (https://youtu.be/fOCTp7YkoLM)

The supportive structure of the Johns Hopkins Nursing Professional Practice Model (PPM) is comprised of several councils where frontline nursing staff can share their voice and create meaningful, evidence-based changes and influence according to the PPM. Each council has a distinct membership and defined purpose and meets as frequently as required to achieve its goals.

The components of the Governance Structure are:

1. Office of Nursing Professional Practice (ONPP) – The core infrastructure to support the Department of Nursing through the following programs:
    - Center for Nursing Inquiry
    - Clinical Informatics
    - Clinical Standards and Practice
    - Clinical Quality
    - Education
    - Magnet
    - Nursing Analytics and Project Management

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2. The Professional Practice Coordinating Council (PPCC) – composed of 12 staff nurses representing each of the specialty professional practice councils, and other nurse leaders and nursing mentors.

3. The Professional Practice Executive Steering Council (PPESC) – composed of six staff nurses plus the Directors of Nursing for all clinical specialties, the Chief Nursing Officer and the Chair of the PPCC.

4. Specialty Nursing Professional Practice Council (SNPPC)
    a. Members: There are councils for each of The Johns Hopkins Hospital's nursing specialties and each has a minimum of 51% clinical nurses. Members represent diverse clinical areas and units within the specialty, as well as a range of levels of experience and expertise
    b. Purpose: Specialty councils can be formed by clinical departments (e.g., medicine, pediatrics), staff who work in a specific type of care setting (e.g., perioperative services, radiology), or staff with similar job titles and responsibilities (e.g., Clinical Nurse Specialists, Nurse Educators). Councils practice shared governance to address issues, implement improvements, and integrate all aspects of their professional practice.
    c. The following specialties are currently represented:
        - Ambulatory
        - Emergency department
        - Float Pool and Resource Management Office
        - Gynecology & Obstetrics
        - Medicine
        - Neurosciences
        - Oncology
        - Pediatrics
        - Perioperative Services
        - Psychiatry
        - Procedural Areas
        - Surgery/Physical Medicine & Rehabilitation

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5. Advisory Groups
    a. Members: Clinical nurse advisory groups provide a two-way forum for clinical or other specified nurses to advise the Chief Nursing Officer and the Directors of Nursing on professional, clinical, and operational topics.
    b. Purpose: To support each other in their roles by identifying and sharing best practices. These groups also identify innovation and improvement projects to address challenges or opportunities in their professional role and ensure that these are communicated to the PPCC. They identify established and emerging subject matter experts to serve on Department of Nursing communities and core routine work groups.
    c. Current Advisory Groups:
        i. Magnet Advisory Group
        ii. Night Shift Advisory Group

6. Communities
    a. Members: Subject matter experts and emerging subject matter experts with expertise on the topic the community has been formed to address, as well as members of the PPCC to serve as facilitator/project manager.
    b. Purpose: Communities are formed to work on specific projects, solving problems and implementing the innovations submitted to the PPCC and approved by the Executive Steering Committee. Their projects have set start and end dates mutually agreed upon by the community members and the PPCC.

Improvement in patient outcomes – Quality Councils and Nurse-led Initiatives

Quality councils have been created to support optimal patient outcomes for nurse-sensitive indicators. Each council has frontline staff representation. The Quality Councils have addressed falls with injury, pressure injuries, central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), hospital-acquired pressure injuries (HAPI), and the use of restraints.

While there are organization-level improvement efforts, many of the challenges faced at the unit level vary depending on the patient population. The shared governance model has empowered clinical nurses to lead quality improvement efforts at the unit level. For instance, the clinicians on the Cardiovascular Progressive Care Unit (CVPCU) observed that their Unit Acquired Pressure Injuries Stage 2 or Greater (UAPI 2+) rate was 6.67 - worse than the NDNQI Benchmark - in the third quarter of 2023. Three CVPCU clinical nurses advocated for Wound Treatment Associate certification and presented a proposal to unit leadership to allocate weekly time outside of direct

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patient care to provide comprehensive skin and wound care for their patients. During rounds, these nurses reviewed Braden Risk Assessments, validated pressure injuries, assisted staff in identifying other types of wounds, ensured wound and pressure injury documentation was appropriate, facilitated preventative measures, provided bedside teaching to staff, and updated plans of care. After months of working on this tailored staffing practice, which was made possible by unit autonomy to make decisions about their care environment, the CVPCU maintained a UAPI 2+ rate of 0.00 throughout most of the following year.

Improvement in employee satisfaction

In partnership with human resources, an employee satisfaction survey was conducted in October 2024, with a response rate of 60%. Fifty-four percent of the units scored above the benchmark on at least three of the top four dimensions, which meets the requirement for ANCC Magnet designation. The top four dimensions were autonomy, leadership access and responsiveness, professional development, and RN-to-RN teamwork and collaboration.

Processes to make real-time adjustments to meet the needs of patients

The Johns Hopkins Hospital Resource Office (RO) serves as a centralized staffing office that is responsible for coordinating and managing the scheduling, staffing, and allocation of nursing resources to ensure adequate patient care coverage and efficient workforce utilization.
The RO partners with nursing leaders to assess staffing resources in real time based on patient care demand with the use of a standardized shift readiness tool, along with periodic touchpoint huddles throughout the 24-hour day.

In addition to the frequent touchpoint meetings where staffing decisions are made based on patient care demands, the charge nurse and the shift coordinators (specialty-based staffing coordinators) can contact the RO as needed to address patient needs.

Other processes that exist to make real-time adjustments to meet patient needs are reviewed in terms of quality, safety, and operational huddles. Unit-based huddles happen at the local level each shift and are escalated to specialty area huddles if needed. A daily safety huddle, which includes representation from hospital leadership and clinical leaders, is held to escalate unresolved patient concerns.

In addition to these staffing-specific means of addressing the needs of nursing staff for patient care, frontline forums for staff to share their innovative solutions, concerns, and interests are held with executive level leaders on a regular cadence. These Solution Session forums are led by a trained facilitator and hosted by both nursing and human resources. Audiences include frontline nursing staff and nursing leaders, and content brought up is addressed following the sessions. This is yet

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another way frontline staff are accessing our most senior nursing and hospital level executives to share their voice.

The Johns Hopkins Hospital is proud of its programs to improve patient safety and support its clinicians and ccordingly, the Johns Hopkins Hospital respectfully requests an **UNFAVORABLE** committee report on HB905.

American Nurses Credentialing Center (ANCC) - Magnet

Magnet recognition is the highest national honor for nursing practice. The Magnet Recognition Program® recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice. Consumers rely on Magnet designation as the ultimate credential for high-quality nursing. Developed by ANCC, Magnet is the leading source of successful nursing practices and strategies worldwide.

Approximately 9 percent of U.S. hospitals have been granted Magnet Recognition since the program was established in 1993. The *US News & World Report* utilizes the Magnet designation as a primary indicator of competence in its assessment of over 5,000 hospitals to rank and report the best medical centers in 15 specialties (ANCC, 2025). In 2024, the top 20 medical centers on the exclusive *US News Best Hospitals in America Honor Roll* are ANCC Magnet-recognized organizations (ANCC, 2025).

The process for applying for Magnet designation is highly rigorous. After the application is accepted, a written document addressing all Magnet application standards of nursing excellence must be compiled and submitted to the ANCC Magnet program, along with the assigned Magnet Appraisers.

If the document is accepted, a site visit occurs with a team of Magnet program appraisers to verify the contents of the written submission through activities such as interviews, focus groups, and observations on various nursing units. The Magnet program appraisers submit a report to The Magnet Recognition Program. From there, the Commission on Magnet Recognition will review and vote on the achievement of Magnet Excellence designation.

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HB905 Safe Staffing Act of 2025 Suburban Hosp unfa

Uploaded by: Michael Huber

Position: UNF

8600 Old Georgetown Road
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TO: The Honorable Pamela Beidle, Chair
Finance

FROM: Karin Nevius, MSN, RN, CCRN-K
Director Professional Practice and
Quality/Magnet Program Director

HB905
Unfavorable

DATE: March 28, 2025

RE: **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)**

Suburban Hospital opposes **HB905: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)** which passed the House of Delegates and is now before your committee.

This bill isn't necessary and will divert time, attention and resources away from solving critical challenges facing our hospital.

Proponents assert that establishing clinical staffing committees will improve wait times in the emergency department. A lack of physical space, increasing patient volumes and acuities and a shortage of inpatient beds are the primary reasons for longer wait times at our community hospital. A clinical staffing committee will not solve these issues.

Suburban Hospital is proud of its two Magnet designations.

Shared governance, as part of a Magnet framework, supports direct care clinicians in pursuing zero harm efforts. Turnover, retention, nurse satisfaction, clinical patient outcomes and patient experience are known to be benefits of this framework. Our hospital's five shared governance councils (Practice, Professional Development, Quality, Evidence Based Practice, and Night Shift) have a reporting structure to corresponding health system shared governance councils, on which we participate. In addition, each of our designated care areas has a comprehensive unit-based safety and quality team that both monitors attainment of safety goals and addresses any safety concerns from clinicians.

Our frontline clinicians are in the best position to identify safety concerns in real-time, and initiate escalation strategies to address these concerns. By engaging predetermined internal resources, staffing needs are flexed and adjusted to meet census and acuity. These strategies arise from a culture that exists within our organization and is driven by a shared-decision making platform. This culture promotes transparent situational awareness and allows our skilled 24/7 house supervisors to navigate the everchanging landscape within the hospital. Engagement of leadership is embedded in our escalation pathway and can be implemented whenever the need arises. A staffing committee will disrupt this process and add unnecessary complexity to the decision-making process.

Staffing matrices guide staffing mix and are adjusted in real-time to meet the needs of our patients. Matrices are routinely reviewed by the thirteen unit-based councils at Suburban Hospital and direct care clinicians are able to advocate for change when needed. Assessments of staffing needs is done a minimum of twice per day and ad hoc with specialty teams such as critical care and the emergency department. Requirements to establish a clinical staffing committee will reduce the robust engagement of our teams and negatively impact the practice environment.

Supporters also assert that establishing clinical staffing committees will deter workplace violence. Aggressive behaviors and a rise in incivility by patients, family members, and visitors are a reflection of a larger societal breakdown. Engaging frontline staff as part of a shared decision-making structure to identify risks and develop mitigation strategies is an ongoing expectation of our organization and is not dependent on creating a clinical staffing committee.

Accordingly, Suburban Hospital respectfully requests an **UNFAVORABLE** committee report on HB905.

HB 905_Oppose_St Agnes.pdf
Uploaded by: Olivia Farrow
Position: UNF

Ascension Saint Agnes

Date: March 28, 2025

To: The Honorable Pamela Beidle, Chair, Senate Finance Committee
Senate Finance Committee

RE: **Letter of Opposition to House Bill 905** - Clinical Staffing Committees and Plans - Establishment
Senate Finance Committee Hearing April 1, 2025

Dear Chair Beidle:

On behalf of Ascension Saint Agnes Hospital, we appreciate the opportunity to comment in **opposition to House Bill 905.**

Ascension Saint Agnes (St. Agnes) has a long history of providing holistic care to a diverse population of over 400,000 residents of the southwest segment of the Baltimore metropolitan area, with a special commitment to serving those most vulnerable and living in poverty. We are a fully accredited, full-service 251 bed teaching hospital offering, each year, Emergency Department services to approximately 80,000 patients and Inpatient care for approximately 15,000 patients.

To ensure we have adequate staffing to meet the needs of this significant volume of patients, St. Agnes has well-established processes for determining appropriate staffing levels:

- Each unit has a staffing grid based on the number of patients and acuity, and the availability and experience of clinical staff;
- Each staffing grid is adjusted at a minimum of every 12 hours based on both patient volume as well as acuity;
- Staffing is adjusted at the early morning daily bed board huddle;
- Staffing may also be adjusted at the late morning hospital safety huddle, and then
- Staffing may be adjusted again at the afternoon nurses staffing meeting.

Our shared governance structure includes front-line staff that help make the staffing assignments and also communicate with the nursing supervisor to adjust whenever the unit or patients' needs change. The charge RN or any front line staff member is empowered to communicate the need for staffing adjustments.This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels and ensures an environment of patient safety.

These processes are informed by The Joint Commission and Centers for Medicare and Medicaid Services. These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes.

Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee lacks the dexterity needed to respond in real time to volume changes and care demands.

Additionally, clinical staffing plans must be developed by clinical team members. These decisions require specific knowledge and expertise to ensure patient safety. We firmly believe that clinical staffing should be guided by clinical personnel while non-clinical staff can inform non-clinical staffing.

Ascension Saint Agnes Hospital is deeply committed to supporting our workforce and to collaborating on solutions that strengthen our workforce and advance health care in Maryland. We are concerned that HB 905 fails to reflect the complexities of hospital staffing and does not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on HB 905.

Thank you,

Olivia D. Farrow, Esq.
Vice President, External Affairs

HB 905 - LOO - UMMS_ FINAL.pdf
Uploaded by: Will Tilburg
Position: UNF

UNIVERSITY of MARYLAND MEDICAL SYSTEM

House Bill 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)

POSITION: Oppose
April 1, 2025
Senate Finance Committee

The University of Maryland Medical System (UMMS) respectfully submits this letter of opposition to House Bill 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025) on behalf of the following member hospitals and health systems: University of Maryland Medical Center, UM Capital Region Health, UM Charles Regional Medical Center, UM Shore Regional Health, UM Upper Chesapeake Health, UM Baltimore Washington Medical Center, UM St. Joseph's Medical Center, UM Rehabilitation and Orthopaedic Institute, and Mt. Washington Pediatric Hospital[1].

UMMS provides primary, urgent, emergency and specialty care at 12 hospitals and more than 150 medical facilities across the state. The UMMS network includes academic, community and specialty hospitals that together provide 25% of all hospital-based care in Maryland. Our acute care and specialty hospitals are located in 13 counties and Baltimore City, and serve urban, suburban and rural communities.

House Bill 905 ("HB 905") requires a hospital to establish a clinical staffing committee – consisting of equal membership from management and employees – to develop and implement mandated clinical staffing plans, by unit, for all staff. The clinical staffing committee must include a broad range of clinical and non-clinical staff, including certified nursing assistants, dietary aides, emergency room nurses, environmental service workers, residents or physicians, and technicians. The clinical staffing plans must be reviewed and amended on at least an annual basis, and the adopted plan must be posted in a conspicuous area in each patient unit of the hospital. If the plan is amended at any time, the amended plan must likewise be posted in a conspicuous area in each patient unit in a timely manner.

HB 905 was heavily amended in the House, and therefore is in a different posture than the cross-file, SB 720, which was considered by the Finance Committee earlier this month. However, the core components of the bill remain, including: (1) mandating clinical staffing committees in each hospital, (2) mandating that the clinical staffing committee include non-clinical staff who lack clinical training and experience, and (3) requiring that the clinical staffing plan be amended and posted publicly each time there is a change to the plan, which can occur several times each day based on a variety of factors. Critically, the amendments do not address the central concerns raised by UMMS and other hospitals: (1) the legislation was drafted without any review or

[1] Mt. Washington Pediatric Hospital is co-owned by UMMS and Johns Hopkins Medicine.

analysis of the current laws, regulations, and accreditation requirements governing clinical staffing in hospitals, or best practices for clinical staffing in Maryland or nationwide, or (2) State hospitals are exempt from the bill and its provisions.

Ensuring safe and effective staffing is critical in healthcare settings. While we understand that the intent of this bill is to support hospital staff, it introduces significant challenges that ultimately do not serve the best interest of patients, hospitals or healthcare professionals, and places significant additional administrative burdens on hospitals without improving employee safety or patient care.

Hospitals already have well-established processes for determining appropriate staffing levels, guided by nationally recognized accrediting bodies such as The Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS), and the American Nurses Credentialling Center (ANCC) Magnet Recognition Program. These organizations set rigorous requirements to ensure safe, effective, and high-quality patient care and routinely conduct accreditation visits to ensure standards are being met. Through these national standards and internal health system policies, UMMS has implemented much of what the bill seeks to mandate, including collaboration between nurse leaders and nurse team members to ensure adequate and safe staffing. Furthermore, at several of our member hospitals, employee categories covered by the bill already have collectively bargained rights governing workplace conditions and staffing.

HB 905 introduces new regulatory requirements that will divert resources away from direct patient care and place unnecessary strains on hospital operations. Rather than improving patient safety, these additional regulatory requirements could reduce operational efficiency and limit hospitals' ability to ability to respond flexibly to patient needs. For example, Section 19-390 of the bill would require a hospital's clinical staffing committee to post a clinical staffing plan on or before January 1 of each year and require the plan to be amended and re-posted each time there is a change to it. Hospital staffing plans are based on the number of patients, types of medical conditions, number of beds, and innumerable other factors that change on a daily or even hourly basis. Given the wide range of factors that must be considered in a clinical staffing plan, and how frequently those factors change, hospitals must adopt and amend staffing plans 4-6 times per day. In addition, staffing plans necessarily look different for each unit and category of staff. Requiring a pre-determined standing committee of staff to be responsible for developing and posting a staffing plan each time there is any change is not feasible given the real-time changes and demands of clinical settings.

Another concern with HB 905 is its exclusion of state hospitals. If mandating staffing committees and staffing plans is in the best interests of staff and patients, then the requirements should be applied to all hospitals. By applying these mandates only to certain hospitals while exempting others, the bill creates an inequitable system. All patients deserve the same standard of care, regardless of where they receive treatment. This exemption undermines the bill's intent and creates an unfair burden on non-state hospitals, which must comply with additional regulations. In response to this concern being raised in the House, the Maryland Department of Health stated in a subcommittee work session that State hospitals were already subject to CMS requirements for staffing. However, **all** hospitals in the State are subject to the same CMS regulations governing staffing and patient care.

Many proponents of the bill have identified mandated clinical staffing committees and clinical staffing plans as a mechanism to address workforce shortages. As the committee is aware, the healthcare workforce shortage is a serious and growing issue, with an estimated 1 in 4 nursing positions in the state currently vacant. More healthcare professionals, including nurses, are desperately needed, but this is a national issue and clinical staffing committees, or clinical staffing plans will not help with employee recruitment or retention. The shortage of healthcare professionals is most directly connected with an aging workforce and an inability of nursing, medical, and other professional schools to graduate enough healthcare professionals to meet current workforce demands. Moreover, states that have adopted mandated clinical staffing committees and clinical staffing plans continue to face the same workforce shortages.

UMMS is taking significant step to address the workforce shortage and ensure adequate staffing. Across the health system, we have created several innovative programs that support training, recruitment, and retention of nurses and other healthcare professionals in Maryland. For example, the UMMS Academy of Clinical Essentials (ACE) initiative and Community College Tuition Reimbursement Program combined have resulted in the training and recruitment of 800 new nurses over the past two years. Requiring hospitals to adhere to inflexible staffing plans will not assist our expanding efforts to recruit and retain nurses and other healthcare professionals.

While the goal of ensuring appropriate staffing levels is laudable, HB 905 fails to address this issue in a fair, effective, and evidence-based manner. HB 905 disrupts this well-functioning system without clear evidence that it would lead to better outcomes. This approach does not reflect the complexities of hospital operations or patient care. The exclusion of state hospitals creates inequities, the bill imposes unnecessary administrative burdens, and hospitals are already following nationally recognized standards to ensure proper staffing.

For these reasons, the University of Maryland Medical System opposes HB 905, and respectfully requests an ***unfavorable*** report on the bill.

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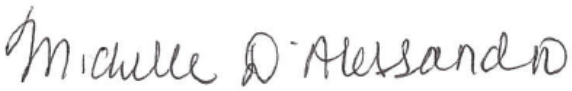

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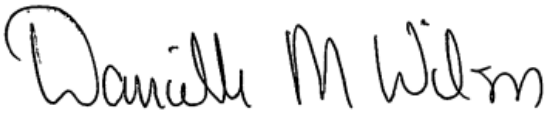

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UM Shore Regional Health

HB905 MNA INFO ONLY 2025.pdf
Uploaded by: William Kress
Position: INFO

Committee:	**Senate Finance Committee**
Bill Number:	**HB 905 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2025)**
Date:	**April 1, 2025**
Position:	**Information Only**

The Maryland Nurses Association is pleased to provide testimony regarding House Bill 905, the "Safe Staffing Act of 2025." MNA supports the goals of HB 905 – to ensure adequate staffing in hospitals for quality patient care. We would like to provide the following informational testimony to assist the committee in its policy deliberations.

The Staffing Committee Composition Lacks Significant Representation by Direct Care Nurses

The current proposed committee composition includes:

- certified nursing assistants
- dietary aides
- emergency room nurses
- environmental service workers
- residents (in teaching hospitals)
- physicians (in non-teaching hospitals)
- technicians.

The composition of the clinical staffing committee under HB 905 appears to be unbalanced and weighted towards non-direct care healthcare providers (CNAs, Dietary Aides, Technicians and Environmental Services Workers). While the bill requires one emergency room nurse, it does not mandate the inclusion of a staff RN. In many cases, ER nurses are not direct hospital employees but rather employees of contractors.

While certified nursing assistants, dietary aides, and environmental service workers all play vital roles in patient care, direct care nurses have a more comprehensive understanding of patient needs, and the challenges faced in hospital settings.

Other Jurisdictions - Greater Representation of Direct Care Nurses

In some states, a higher percentage of direct care nurses are required as members of staffing committees. For example, Illinois mandates that at least 50% of the clinical staffing committee be comprised of direct care nurses. Similarly, the American Nurses Association advocates for at least 55% of staffing committee members to be direct care nurses. Direct care nurses are frontline providers who interact with patients more frequently than any other healthcare professional in a hospital setting. The insights and experiences provided by direct care nurses would be invaluable when creating effective staffing plans.

We respectfully encourage the committee to carefully consider the composition and focus of the clinical staffing committees, as well as the implementation of data-driven approaches to staffing decisions.

For any additional information or clarification, please contact William Kress at bill@kresshammen.com.