Safe staffing act Alex Anderson.pdf
Uploaded by: Alexandra Anderson
Position: FAV

My name is Alex Anderson and I have been a nurse for almost 2 years in Maryland. I am writing in support of HB624 because I believe safe staffing saves lives and this bill is an important step towards protecting quality of care.

Short staffing compromises safe patient care, for example, not having enough time to explain discharge instructions because of pages and calls for your other patients, delays in patient medication administration, and feeling forced into “task mode” instead of practicing patient-centered care. All of these examples can lead to severe moral distress in nurses: feeling guilty after shifts for “not having enough time” to spend or care for patients. Physical and mental burnout is a result of short staffing that many nurses can feel and experience, including anxiety before work because of anticipation of having another unsafe assignment, skipping meals or bathroom breaks, staying late after your shift to finish charting because you didn’t have enough time during the 12 hours to finish. These issues can lead to nurses feeling undervalued and under appreciated at their jobs and create the internal conflict between personal well being and professional commitment.

The staffing crisis is the root cause of healthcare worker burnout and resignations. When direct care workers are part of staffing plans, we create collaborative and transparent processes for addressing the staffing crisis.

Maryland has the longest ER length of stay in the country. While blame for long wait times is sometimes attributed to overuse of the ER by patients, the actual number of ER visits per 1,000 population in Maryland is among the lowest in the U.S., according to Becker’s Hospital Review.

Meanwhile, under-staffed and overwhelmed ER medical staff try to care for emergency patients as best they can. Sadly, there is no end in sight to lengthy waits and no active attempt to fix this urgent problem in the near term. Without a safe level of staffing in the ER, Maryland patients will continue to endure long and potentially life-threatening waits for emergency care.

Staffing conditions are associated with adverse health outcomes for patients, including mortality and longer lengths of stay. 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.

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 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, and direct care workers to address a crisis. Staffing committees allow each hospital to tailor staffing plans to its most pressing needs.

The house has passed this legislation the past two legislative sessions. This legislation is a sensible approach that fosters collaboration and centers hospital worker voices who have often been missing in stakeholder discussions on the healthcare workforce crisis. By mandating a

process, Maryland will have a foundation for adequate data collection and a holistic lens of staffing conditions through worker perceptions. For these reasons and more, I urge a favorable report on the Safe Staffing Act of 2026.

Sincerely,

Alexandra Anderson, aalexandersonn6@gmail.com

Testimony for SB 411

Safe Staffing Act of 2026

Before the Senate

NDWA DMV Chapter Safe Staffing- SB411.pdf
Uploaded by: Allison Yunda
Position: FAV

Testimony on Senate Bill 411 – Favorable

SB 411: Dear Chair Beidle and Members of the Senate Finance Committee,

My name is Allison Yunda and I'm the Maryland Lead Organizer for the National Domestic Workers Alliance (NDWA). I'm a resident of Lanham, Maryland and reside in district 24. On behalf of the NDWA DMV Chapter, I am writing in support of SB411 because we believe direct care workers should be at the table addressing the staffing crisis. Hospital workers save lives, and this bill is an important step towards protecting quality of care for Marylanders. SB411 creates staffing committees at each hospital that ensure the entire care team is at the table to address hospital-wide challenges in providing safe and timely care. Committees will work together to submit a staffing plan that includes recommendations and staffing data on an annual basis to the Maryland Healthcare Commission. The reports will be posted on Maryland Healthcare Commission's website.

The staffing crisis is a primary driver of healthcare worker burnout and resignations. Many of our members, who are domestic workers, have experienced long wait times in emergency rooms as a direct result. We know that when workers' voices are included in decision-making, it leads to more meaningful conversations and solutions that address the root causes of these challenges.

When direct care workers are part of staffing plans, we create collaborative and transparent processes for addressing the staffing crisis. Share a specific example about the importance of collaborative decision making and planning regarding staffing conditions and quality of care. Staffing conditions were associated with adverse health outcomes for patients, including mortality and longer lengths of stay. Describe how patients are impacted by management decisions that lead to understaffing. Maryland has the longest ER length of stay in the country. While blame for long wait times is sometimes attributed to overuse of the ER by patients, the actual number of ER visits per 1,000 population in Maryland is among the lowest in the U.S., according to Becker's Hospital Review. Meanwhile, under-staffed and overwhelmed ER medical staff try to care for emergency patients as best they can. Without a safe level of staffing in the ER, Maryland patients will continue to endure long and potentially life-threatening waits for emergency care.

This legislation, which passed the house the past two years, is a sensible approach that fosters collaboration and centers hospital worker voices who have often been missing in stakeholder discussions on the healthcare workforce crisis. By mandating a process, Maryland will have a foundation for adequate data collection and a holistic lens of staffing conditions through worker perceptions. **For these reasons and more, I urge a favorable report on the SafeStaffing Act of 2026.**

SB411_Marylanders for Patient Rights_fav.pdf
Uploaded by: Anna Palmisano
Position: FAV

MARYLANDERS FOR PATIENT RIGHTS REQUESTS A FAVORABLE REPORT ON SB411 Hospitals - Clinical Staffing Committees and Plans – Establishment The Safe Staffing Act of 2026

Marylanders for Patient Rights is the largest patient advocacy coalition in the state, with 23 groups and a collective membership of over a million. Our coalition has joined with healthcare workers and community organizations to form the **Patient-Worker Collaborative and Caring Across Maryland** in support of the Safe Staffing Act of 2026, SB411. Maryland urgently needs to address the **hospital short staffing crisis.**

Maryland has had the longest ER wait time (ERWT) out of 50 states for over ten years, with a state average wait time over four hours. **Maryland patients lack reliable, timely emergency care**. This problem will never be solved without safe staffing. **Nine other states have already passed a Safe Staffing Act, and Maryland should, too.**

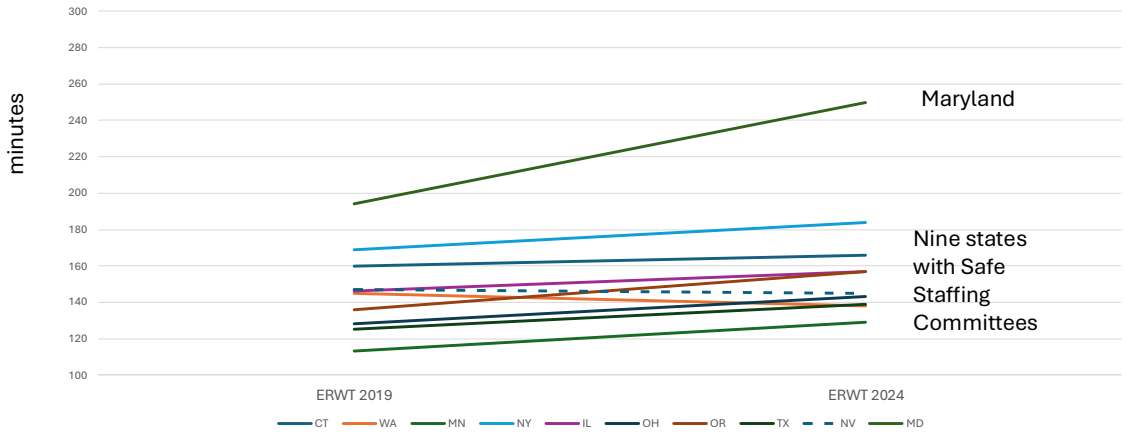
During discussions on last year's Safe Staffing Bill, Senate Finance Chair Pamela Beidle posed a very interesting question: How did the ERWTs in the nine states with Safe Staffing Committees compare to Maryland's ERWTs? I have now done that analysis, and my results are shown on powerpoint graph on the next page.

Analytical Methods: For comparison to Maryland, I used ER wait time (ERWT) data from the Centers for Medicare and Medicaid Services (CMS) from the following nine states with Safe Staffing Committees: Connecticut, Illinois, Minnesota, New York, Nevada, Ohio, Oregon, Texas, and Washington. These states are diverse both geographically and politically. To look at the rate of change of ERWT, I chose time points from 2019 and 2024 to avoid any confounding influences of the pandemic.

Results: The differences between Maryland and the nine states with safe staffing committees are clear. During the study period, Maryland ERWT increased from 194 minutes to 250 minutes—almost an hour more ERWT. In comparison, ER wait times in states with Safe Staffing Committees increased by an average of only ten minutes, and two states actually **decreased** their ERWT during this period. During the five-year period, the average national ERWT for all 50 states increased 28 min.

In other words, Maryland's ERWT was significantly worse than average, while the nine states were significantly better than average.

Increase in ER Wait Times in Maryland vs. States with Safe Staffing Committees*



*Data from the Center for Medicare & Medicaid Services

SB411 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 knowledge and experience. This approach will improve both quality of care and working conditions by improving communication.

MHA opposes SB411 by using false claims that the bill mandates nurse:patient ratios or lacks flexibility. This is simply not true. Instead, SB411 requires experienced employees and managers to talk to each other about safe staffing and develop guidelines. We 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 SB411 and help keep our patients and health care workers safe. Thank you.

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

Aaron Fletcher FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Aaron Fletcher. I've worked in the Facilities department at my hospital as a plumber for the last five years. Short staffing is an inconvenience at best and a safety issue at worst. I urge a **favorable** report on the Safe Staffing Act because I care about the safety of hospital patients and about the safety of my coworkers. Safety is priority #1.

I'm responsible for a wide variety of tasks from maintaining plumbing and heating, to sprinkler systems, water treatment, water heater maintenance, fixture repairs and medical gas lines. Having running water and functioning systems is crucial for sanitation and for the hospital to be able to run effectively. Repairs need to be done in a timely manner so minor issues don't turn into an emergency.

When we don't have enough workers, employees can't spend as much time on repairs as would be considered a best practice in the trades industry because we have to cover someone else's repairs too. **Sometimes when repairs are prolonged when we don't have enough staff, we may have to shut down patient rooms, impacting how long patients wait to get admitted to the hospital or forcing them to endure the discomfort of being moved to a new room.**

Many in my department are working overtime to cover staff shortages. While we do get compensated financially for overtime, we are now working more hours more consistently on less sleep. That impacts our health over time. Rest is necessary for personal wellbeing and also for optimal work performance.

I've worked in the trades for many years, and the typical culture of trades people is we tend to stay in jobs for a long time. But, that is not the case at the hospital where I work. I have seen more tradespeople quit in my time here than I have at any other job. Reasons cited for quitting are issues around scheduling, low pay, and a dictatorial workplace culture. When workers raise these issues to management, they are only loyal to their way of doing things. They don't utilize the experience we have from other jobs we've had that could actually improve the way things are done.

The Safe Staffing Act would help rectify these issues by taking workers' experience into account, and help to make sure the best interest of the patients and the hospital is served. It would help attract more people to work here. Giving people a voice goes a long way. Workers would put in more effort if our suggestions were meaningfully incorporated into the safe staffing plan. Please vote YES on this bill.

In Unity,
Aaron Fletcher

Antia Haskins FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Anita Haskins. I'm an Emergency Room Technician (ERT) and have been working at a hospital in Baltimore for 29 years. It's not an easy job, but I love it because I care for my patients. I'm upset about under staffing at my hospital because patients don't get the full spectrum of care they want when there aren't enough workers. I urge a **favorable** report on the Safe Staffing Act.

Our main role as ERTs is to sit with behavioral health patients and total care patients. I also apply temporary splints, and do wound cleaning and dressing changes. When we have enough staff, ERTs are also responsible for vital signs, helping patients go to the bathroom, assisting nurses, and doing "sharps checks" on psychiatric patients. But when we are understaffed, nurses have to do parts of our jobs because ERTs need to sit with patients who can't be left alone. Sometimes we can't even go to the restroom because there is no one else to sit with the patient.

Workers are getting injured on the job because of unsafe staffing, including me. My injury was caused by a patient who had been brought in by the police. Typically, the charge nurse or the triage nurse would be responsible for doing vital signs on patients in that particular circumstance, but we were short that night, so I was asked to do her vitals. When I leaned in to take her vitals, the patient headbutted me. Since then, I have experienced headaches and blurred vision. I had to take several days off work and worked a reduced schedule for three months, leaving my coworkers further short staffed for that duration of time. If we had the proper number of staff that night, I may not have been injured because we would have had more help calming the patient down.

I support the Safe Staffing Act because we are the ones working in these conditions so we should have a voice in the solutions. When we have better staffing, we can treat more patients, and we can be safe while we are keeping patients safe. Please vote YES on this bill. Thank you.

In Unity,

Anita Haskins

Antonia Brooks FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

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 The Safe Staffing Act of 2026.

Short staffing is getting worse every year. 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 The Safe Staffing Act. Thank you.

In Unity,

Antonia Brooks

Betty McRae FAV Testimony SB422HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Betty McRae. I've worked at a hospital for 25 years. I started working in the transportation department but have spent most of my time working in the food service department. I work in catering on the 6:30am-3pm shift, providing service to the whole hospital. I urge a **favorable** report on the Safe Staffing Act.

We work short almost every day. Management pulls us from our regular jobs to cover other jobs in addition to our work. They don't help; they just dictate. Workers do what we have to do because we want everything to be smooth for our patients, but we get burnt out halfway through the shift because our jobs are so physically demanding. The burden falls most on senior workers. Many workers feel like quitting sometimes because of being overworked, undervalued and short staffed. Often we are required to stay passed our shift time to finish the work load. The bottom of my shoes are worn out from being on my feet so much. It's hard to take breaks because there's so much that needs to be done.

I recently sprained my finger when a refrigerator drawer fell on my hand because the people cleaning the door were rushing due to short staffing. They didn't secure the door properly because they were trying to finish the task as quickly as possible to get on to the next one. I don't blame my coworkers though. They would get in trouble if not all the work is done even when there aren't enough workers to do it. I had to call out for two days because my hand was so swollen.

If we had a safe staffing committee, more people would want to work here. It would allow us to build a team and give workers real respect. Please vote **YES** on the Safe Staffing Act.

In Unity,

Betty McRae

Daniel Carter FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

To Madame Chair and Members of the Committee,

My name is Daniel Carter. I work in facilities management at an understaffed hospital. I support the Safe Staffing Act because bosses sitting behind desks don't understand the obstacles workers have to go through to do our jobs. That's why input from workers across the whole care team needs to be incorporated in staffing plans. I urge you to issue a favorable report on SB411/HB624: The Safe Staffing Act of 2026.

Working short staffed is exhausting. But it's not just workers like me who are affected by short staffing, the patients are impacted too. Maryland has the longest ER wait time in the country. While hospital bosses and legislators have been promising us for years they'll fix it, nothing has changed because those closest to the problem have been left out of the solution. We're tired of being ignored.

Despite strong support from healthcare workers, patients and families, the Safe Staffing Act failed to pass the Senate for two years because of opposition from the Maryland Hospital Association. What are they scared of? Workers and patients creating solutions that actually work?

Hospital executives claim that this bill would hurt them financially, but it doesn't cost anything to give workers a voice. And, they don't seem to have any problem giving their executives multi-million dollar salaries!

The Safe Staffing Act is long overdue. Workers and patients can't wait any longer. Vote YES on this bill. Thank you.

In Unity,

Daniel Carter

EricKa Dunkins FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

To Madame Chair and Members of the 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 The Safe Staffing Act of 2026.

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 this bill. Thank you.

In Unity, Eric'Ka Dunkins

Fabaya Pollard FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

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 SB411/HB624: The Safe Staffing Act of 2026.

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

Kayla Brachmann FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Kayla Brachmann, and I have been a pharmacy technician for more than 15 years, the past nine of which have been in Baltimore City in a hospital setting. I am also an active member and delegate of 1199SEIU. I am writing in support of The Safe Staffing Act because I have experienced the harm inadequate staffing brings to patients and care givers alike. I urge a **favorable** report on SB411/HB624 because healthcare workers should be at the table addressing the staffing crisis, and this bill is an important step towards protecting quality of care.

I first recognized the harm unsustainably low staffing levels cause shortly after I transitioned away from community pharmacy and into the hospital setting I have worked in for the past nine years. Before I was beyond even my 90-day training period, I was being asked to work double shifts, often 17 hours in length with little respite. **There came a point where I would sometimes go days without seeing my family between shifts and to this day I carry the guilt of missing so much of my now-teenage child's early years.**

The height of the COVID-19 pandemic exacerbated our existing staffing issues. The increased stress we were already under – both physically and mentally – made us more vulnerable to contracting the virus and suffering complications from the ensuing illness. Every healthcare worker that I personally know has, at some point, contracted COVID. We carry the lifelong impacts of those physical and emotional scars as we face resurgences of preventable illnesses brought about by inadequate and, frankly, incompetent federal oversight.

In the face of the staffing crisis, I have watched as my fellow pharmacy technicians leave hospital work – or even healthcare altogether. I cannot fault them for this. We are tasked with providing care to an aging, ailing population in the midst of a staffing crisis years in the making with an ever-dwindling pool of resources and personnel. This is an untenable situation and can, undoubtedly, lead to further loss of life on both sides of the pharmacy counter.

When healthcare workers are part of creating staffing plans, there can be a collaborative and transparent process for addressing the staffing crisis. Please vote **YES** on the Safe Staffing Act.

In Unity,

Kayla Brachmann
kayla.ann.brachmann@gmail.com

Kim Jones FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Kim Jones. I've worked at a hospital in Baltimore for 39 years in the kitchen and cafe. When we are short staffed, patients don't get their food on time. I urge a **favorable** report on the Safe Staffing Act. Workers deserve a voice, especially in underrepresented departments like food service that serve a critical role in patient wellbeing.

My department has had six staffing vacancies for years, and when workers call out, we have to work 2-3 jobs to cover the gap. Many of us frequently work overtime, from 6am to 9pm, multiple days in a row to make up for not having enough workers. Chronic overworking leads to exhaustion and burnout. People are more likely to make mistakes when they are tired, and those mistakes can be really dangerous in kitchens where knives and open flames are part of our day to day work. The stress of being overworked also contributes to a hostile work environment as people tend to be more irritable when they're exhausted. Many of the women workers in particular experience verbal abuse in the kitchen.

Workers are dismissed by management when we bring up our concerns about short staffing and our ideas on how to fix it. One issue I brought up is that we are required to do rotating schedules, meaning sometimes we work day shift and sometimes we work night shift. Workers struggle with that amount of inconsistency, and there are more callouts because of it. So we shared with management that if our shift schedules were consistent, it would be easier for the kitchen to be staffed, and we were ignored.

We need the Safe Staffing Act because working conditions and patient care will be better when workers input is valued instead of disregarded. It will feel marvelous and fantastic to be a member of a safe staffing committee. Please vote YES on this bill. Thank you.

In Unity, Kim Jones

Rhonda Stokes FAV Testimony SB411HB624.pdf
Uploaded by: Brige Dumais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

To Madame Chair and Members of the Committee,

My name is Rhonda Stokes. I'm a Patient Care Technician (PCT) at a hospital where I have worked for almost 11 years. I love my job because I get to be a voice for my patients and make sure they are not overlooked. I urge a **favorable** report on the Safe Staffing Act because it would give me a forum to do what I do best, which is advocate for the safety of my patients. For example, one of my patients had Stage IV cancer. He had a history of substance dependence, so he had not been given any pain medication at all. I could see that he was in excruciating pain, so I fought for him to get a non-narcotic pain reliever. Had I not been able to spend as much time with him, he may not have gotten the medication he needed. **Unfortunately, due to short staffing, PCTs often get pulled to work in different areas of the hospital, so we don't always get to provide the focused care I was able to give this Stage IV Cancer patient.**

Normally PCTs should be assigned patients with rooms close together, but when there is a workforce shortage, we get shuffled around the hospital. I feel stretched thin. My body is strained and aching. This isn't good for patients either, because **it slows down our response time when we have more ground to cover. Another safety concern is that we are supposed to have multiple PCTs to lift patients, but with short staffing that is not always the case, which is risky for the patients and for workers.** I hurt my back lifting a patient. When I reported that to management, they just lectured me on how much weight I was supposed to lift instead of figuring out a way to have more staff on the unit to prevent injuries. PCTs don't have an option for "light duty" because our jobs are so physical. We either have to come to work while we are still recovering or take unpaid time off, which is a hardship.

PCTs used to work 8-hour shifts, now we work 12-hour shifts; and we used to work every third weekend but are now required to work every other weekend. Shifting workers schedules like that has led to more call outs and people quitting, which makes short staffing worse. It's frustrating because we're overburdened at work and we get to spend less time with our families. When we let management know that they created a schedule that was making staffing even worse, they just pacified us and didn't make any helpful changes.

It's important for workers to have a seat at the table when solutions to the staffing crisis are proposed, because we are the ones who will be able to determine whether or not those plans will actually work. Right now, management comes up with ideas on their own, we try it for a few months, then it fails because they didn't consult workers, and we have to start over with a new plan. The Safe Staffing Act can help make sure plans work the first time. **Teamwork and fairness are so valuable.** That is what this bill will bring. I'm excited to serve on the safe staffing committee at my hospital when this bill passes! Please vote **YES**. Thank you.

In Unity,
Rhonda Stokes

Written testimony - on letterhead - SB411 - final
Uploaded by: Brooke Rossheim
Position: FAV

Maryland Senate Finance Committee

Bill: Senate Bill 411—Hospitals – Clinical Staffing Committees and Plans – Establishment
Position: Favorable
Organization: Marylanders for Patient Rights, Rockville, Maryland
Hearing Date: February 17, 2026

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

My name is Dr. Brooke Rossheim—I'm a Maryland-licensed physician with training and real-world practice experience in Public Health and Preventive Medicine, Internal Medicine, and Geriatric Medicine. I am board-certified in Public Health and Preventive Medicine and Internal Medicine. I serve as the Senior Medical Advisor for Marylanders for Patient Rights, the largest patient advocacy organization in the state. This testimony is submitted in strong support of SB411.

For many years, Maryland has had the longest Emergency Department (ED) wait times in the nation. Maryland also has the lowest number of patient ED visits per 1,000 population in the U.S. It appears clear that Maryland EDs are not able to handle the current volume of ED patients efficiently. The need for adequate staffing is one of the top issues leading to this situation.

Anecdotally, when in need of emergency care, some Marylanders go to EDs in northern Virginia to avoid predictably long wait times at their local ED. This practice is not optimal, since it leads to more fragmented patient care in a U.S. healthcare system that is already too fragmented.

Long ED wait times are not simply an inconvenience for patients and family members. A 2018 systematic review (see https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0203316) of overcrowding in the ED showed associations with many negative patient consequences including increased mortality, poor patient outcomes (e.g., patients being seen for chest pain), delayed assessment and care, increased inpatient length of stay, and poor patient satisfaction. ED overcrowding also was associated with increased staff stress and staff non-adherence to best practice patient care guidelines. Prolonged ED wait times also increases the exposure time for a medical error to be made on a patient.

From my perspective as a physician, these are serious issues. For patients presenting with common serious illnesses such as heart attacks and strokes or major trauma from car accidents, time is working against them. The ED care team needs to act quickly and decisively for the patient to have a better chance of survival and recovery.

SB411 provides a well-reasoned approach to hospital staffing. It creates staffing committees at each hospital to ensure that the entire care team is at the table to address hospital-wide challenges in providing safe and timely care. Committees will work together to submit a staffing plan that includes recommendations and staffing data on an annual basis to Maryland Healthcare Commission. The reports will be posted on Maryland Healthcare Commission's website.
SB411 has multiple benefits including:

- Obtaining valuable input from frontline workers about staffing conditions to improve them
- Promoting patient safety and optimal care
- Reducing work-related stress and burnout among hospital staff
- Promoting transparency in Maryland's healthcare system

This committee has an important opportunity to act on a bill that may literally touch the life of each Marylander. For these reasons, I respectfully encourage the Senate Finance Committee to vote favorably on SB411. Thank you for your consideration of this bill.

Sincerely,

Brooke Rossheim, M.D., M.P.H.
Senior Medical Advisor, Marylanders for Patient Rights
(www.marylandpatientrights.org)

SB411_MDCEP_FAV.pdf
Uploaded by: Christopher Meyer
Position: FAV

MDCEP
MARYLAND CENTER ON ECONOMIC POLICY

FEBRUARY 17, 2026

Ensure Collaborative Problem Solving at Maryland Hospitals

Position Statement in Support of Senate Bill 411

Given before the Finance Committee

Maryland hospitals are facing a crisis of long emergency department wait times and stay durations, and evidence shows that inadequate staffing is an important contributor. Open communication and collaborative problem-solving, including the front-line workers who experience the impacts of understaffing first-hand, are critical to solving these problems. Senate Bill 411 would create these structures, and similar legislation passed the House of Delegates last year. **For these reasons, the Maryland Center on Economic Policy supports Senate Bill 411.**

- As of 2024, Maryland had the nation's longest emergency department wait times.[i]
- The Maryland Health Services Commission has identified understaffing as an important contributor to long wait times.
- Understaffing leads to poor working conditions and high turnover, creating a vicious cycle.
- Other states have seen successful outcomes from implementing safe staffing committee policies.[ii]

For these reasons, the Maryland Center on Economic Policy respectfully asks that the Finance Committee make a favorable report on Senate Bill 411.

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[i] See Sam Williamson, favorable testimony on House Bill 905 of 2025, https://mgaleg.maryland.gov/cmte_testimony/2025/hgo/1dqvWKgzXFoowCfxcx9sbU3g6ybAqNZyP.pdf

[ii] See Johnine Gunsalus, favorable testimony on House Bill 905 of 2025, https://mgaleg.maryland.gov/cmte_testimony/2025/hgo/13GCseoblMINjnJoUnY8uibouM9s-IIVi.pdf

SUPPORT FOR SB411 AND HB 624.pdf
Uploaded by: Dan Morhaim
Position: FAV

SUPPORT FOR SB411 AND HB 624

Hospitals – Clinical Staffing Committees and Plans – Establishment
(Safe Staffing Act of 2016)

To: Senate Finance Committee and House Health Committee:

I have been a practicing Emergency Medicine physician in Maryland for over 40 years, and I've done shifts at hospitals across the state, including Franklin Square, Sinai, Carroll County, Atlantic General, St. Agnes, and as a volunteer physician at a Baltimore homeless clinic and with Remote Area Medical.

The issue of extended ER wait times has always been a problem, but it has gotten significantly worse over the past 2 decades. There are many reasons for this, and the staffing issue is central.

Hospital work is not done by administrators or executives. The core work of operations is done by people who are too often overlooked, underpaid, underappreciated, and/or not involved in the decision-making process. These include nurses at all levels, housekeeping, transporters, security, dietary, unit clerks, laboratory and imaging staff, pharmacists, respiratory therapists, social workers, chaplains, phlebotomists, tech support, physician assistants, physicians, and the many others who are essential to day-to-day and minute-by-minute functions.

There's an image that comes to mind when doing ER shifts. It feels like being a small boat in the middle of the ocean buffeted by waves. When the waves are small, things are manageable. But when the waves start to amass and grow, the boat gets swamped. When a hospital room needs cleaning and there aren't enough housekeepers to clean it promptly, delays start. When a patient can't be moved because there aren't enough transporters, delays occur. When a phone rings without being answered because of too few unit clerks, more delays occur. And so on for every job listed above. Each delay builds until the hospital backs up, and the ER fills with admitted patients who can't get to a room.

The situation became so dire with risk of harm to patients and their families that there have been job actions here in Maryland by University of Maryland resident physicians who unionized[1] and St. Agnes Hospital nurses[2] because of on-going unsatisfactory working conditions. It should not have come to this. And there are many hospital staff now who are silently enduring those problems and not complaining because they need to continue to work.

SB411 and HB624 address this directly in a safe and responsible way. It brings the staff closest to the problems, who are typically not involved or consulted about hospital operations, to the table. This is a group that can identify action steps that would improve overall hospital function and thereby improve clinical outcomes.

There is no reason for hospitals to fear this process. Instead, hospitals should welcome this opportunity to engage those on frontlines as part of their quality care improvement process. An example of how well this can work is in the true story below*.

These comments are entirely my own and do not represent any other person, organization, or group.

Dan Morhaim, M.D.
Board Certified Emergency Medicine and Internal Medicine
Maryland State Delegate 1995-2019

[1] https://md.aft.org/news/ummc-residents-fellows-vote-ratify-first-ever-union-contract

[2] https://www.nationalnursesunited.org/press/baltimore-nurses-to-rally-for-patient-safety-at-saint-agnes

*At the first meeting of the ER Wait Time Reduction Commission, I shared the story of Zingerman's Roadhouse (a famous restaurant in Ann Arbor, MI.) and how their inclusion of all staff improved operations and saved money. That story is online, and it's below. It makes the case for SB411 and HB624.

Zingerman's Roadhouse Restaurant was facing skyrocketing food costs, and the management team – which includes all employees - met to brainstorm solutions. A dishwasher brought up a consistent pattern: a significant amount of uneaten French fries was coming back to the kitchen on customers' plates, something only a dishwasher might notice. After confirming that the fries tasted good, the team realized the issue wasn't quality, but quantity: the portions were simply too large for many guests to finish and that fries cooled on plate were not desirable to eat. A solution was identified.

The team decided to cut the regular portion in half but offer free extras to anyone who wanted more. The results were thousands of dollars saved annually by reducing food waste with customers enjoying the novelty of "free refills" on fries, appreciating smaller, fresher, hotter batches. This story serves as a powerful internal proof point that any person in any role, even a dishwasher, can provide ideas that significantly benefits the bottom line and customer satisfaction.

Safe staffing speech.pdf
Uploaded by: Danita Tolson
Position: FAV

Greetings

I am in favor of SB 0411 Safe Staffing Act. I am a Registered Nurse and healthcare provider. I have worked with patients and students to try to get patients in and out of the emergency rooms, hospitals, or triage area in a timely fashion. Who determines the waiting time for a patient? Triaging a patient then sitting them back in the waiting room is not cutting down on the patient's wait time because the patients are still waiting. It is too many patients to take care of as a triage nurse. What is a safe nurse to patient ratio? Doing vitals is not cutting down on the waiting it is just a cushion to hush the patient until they are seen by the doctor because they are put back in the waiting room. The patients are being charged by the hospitals from the time of triage and while they are waiting. We don't have enough nurses and staff to take care of patients or cut down on waiting times. Nurses and staff who are overworked and understaffed may cause medication errors and may cause unsafe patient practices that lead to nurse or staff burn out. The goal is to decrease medical

errors by improving safe staffing. More people die from medical errors than MVA, breast cancer and AIDS. There are greater than 1 million people injured in hospitals because of errors and most are preventable. Can you imagine the money Maryland could save and devote somewhere else? I want to add and paint a picture, Sometimes patients are in the halls waiting on stretchers. Increase wait times in the hsp increases the risk for the spread of infection from other patients. The fact is the hospitals are starting the waiting times all over when the patient go back in the waiting area. Are we truly looking at the number of patients who leave the hospitals because of the longer waiting times because of poor staffing and how we can be more efficient? We need to track the patients leaving and comparing their waiting times. I ask that you are in favor of SB 0411.

Thanks,

Dr. Tolson

David Saucedo FAV Testimony SB411HB624.pdf
Uploaded by: David Saucedo
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is David Saucedo. I've worked at a hospital for a total of 9 years and I am a member of 1199SEIU. Have you ever heard the phrase "Safety in numbers?" While this may sound like a cliché, in reality, it is undeniably true! Short staffing is unsafe for patients and health care workers. That is why I support the Safe Staffing Act, and I urge you to issue a favorable report.

For many years, I worked as a cook for six and a half years in the hospital. We once operated multiple kitchens, allowing us to provide more intimate meals for the patients-an approach that fostered a sense of care and attention. However, management decided to cut kitchen staff. As a result, my job was terminated, sixteen cooks lost their jobs that day. I chose to transfer to the Environmental Service Department which I have been working for two and half years. Meanwhile, the dietary workers in the main kitchen have taken in our load of work. With fewer dietary workers responsible for more patients, the remaining staff must work even faster in environments filled with hazards, hot oils, wet floors, sharp knives. Kitchens are chaotic environments because they are so fast paced. It can be incredibly dangerous to increase the workload when there aren't enough staff, leading to increased risk of injuries for workers and compromising the quality of patient care.

As a union delegate, I listen to all my coworkers, not just those in my department. The Geriatric Nursing Assistants told me they have one four letter word for you. HELP! Now they are also covering dietary responsibilities because of short staffing in the kitchen. Taking trays, calling requests, cleaning food spills, and all this takes time. GNAs are floating from floor to floor. Fifteen patients to one GNA, in a 12-hour shift, bath, lifting out of bed, helping the restroom, helping the walk, making their beds, drop off food trays. This is unsafe for patients because if they ring the call bell, their primary caretaker may be on an entirely different floor, unable to hear them. What happens to that patient in an emergency situation?

Anyone could end up in a hospital one day. If we don't fix the short staffing crisis now, even more workers and patients will face unsafe conditions. We need more GNA's, and we need more healthcare workers across the board. Passing this bill will help our hospitals get real solutions about how to fix the staffing crisis and retain more healthcare workers. So, if you want to make sure you and your loved ones get proper care, vote **YES** on the Safe Staffing Act. Thank you.

In Unity,

David Saucedo

written testimony for SB411-Safe Staffing.pdf
Uploaded by: Diane Nemett
Position: FAV

My name is Diane Nemett, I live in Baltimore County and I have been a health care provider for over 50 years. Because of a life-threatening medical event, my husband had six emergency room visits and hospitalizations in the past 10 months. I am writing in support of **SB 411- the Safe Staffing Act of 2026.**I believe that direct care workers should be at the table of addressing the staffing crisis. Safe staffing saves lives and saves money. This bill is an important step toward protecting quality care for patients.

Maryland has the longest ER length of stay in the country!! This is not due to overuse of the ER by patients as the actual number of ER visits per 1000 population in Maryland is among the lowest in the US, according to Becker's Hospital Review. Meanwhile, under-staffed and overwhelmed ER medical staff try to care for emergency patients as best the can. Without a safe level of staffing in the ER, Maryland patients will continue to endure long and potentially life-threatening waits for emergency care. With rising costs of health insurance, the demand will likely get worse when patients don't have insurance for primary care. The staffing crisis is a cause of healthcare worker burnout and resignations which ultimately increases costs and decreases quality of care when permanent, experienced workers need to be replaced by temporary and private service providers.

SB411 creates staffing committees at each hospital that ensure the entire care team is at the table to address hospital-wide challenges in providing safe and timely care. Committees will work together to submit staffing plans that include recommendations and staffing data on an annual basis to the Maryland Healthcare Commission. The reports will be posted on their website. Most of the basic administrative infra-structures already exist to support this.

This legislation, which passed the House the past two years, is a sensible approach that fosters collaboration and the input of hospital worker voices which have often been missing in stakeholder discussions on the healthcare worker crisis. By mandating a process, Maryland will have a foundation for adequate data collection and a holistic lens of staffing conditions through worker perceptions. For these reasons and more, I urge a favorable report on the Safe Staffing Act of 2026. Maryland patients deserve this.

Sincerely,
Diane Nemett
Baltimore County, zip code 21153

SB411_FAV.pdf
Uploaded by: Donna Edwards
Position: FAV

MARYLAND STATE & D.C. AFL-CIO
Affiliated with the National AFL-CIO

Donna S. Edwards
President

Samuel Epps, IV
Secretary-Treasurer

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SB 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)

Senate Finance Committee

February 17, 2026

SUPPORT

Donna S. Edwards

Maryland State and DC AFL-CIO

Madame Chair and members of the Committee, thank you for the opportunity to submit testimony in support of SB 411. On behalf of 700 affiliated unions, 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. SB 411 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.

SB 411 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 by the National Library of Medicine, lower levels of nurse staffing are associated with compromised nursing care. Expecting a single nurse to tend to so many patients puts them in a tough position, not allowing them to deliver quality care effectively or efficiently, which impacts both their well-being and the patients' well-being. Additionally, in a policy brief published by the

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Center for Health Outcomes and Policy Research at the University of Pennsylvania, they reported that there was a 7% increased risk of patient mortality when adding additional patients to a nurse's workload.

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."

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 SB 411.

Donna Ticknor, MD_ Testimony for Safe Staffing 202
Uploaded by: Donna Ticknor
Position: FAV

Testimony for SB 411
Safe Staffing Act of 2026
Position: **FAV**

Date: 02/13/2026

SB 411: Dear Chair Beidle and Members of the Senate Finance Committee,

Introduction:
My name is Dr. Donna Ticknor and I have been a resident in Riva, Maryland for 8 years and previously a resident in Bowie, Maryland for 20 years. I am also a member of the American Psychiatric Association, Maryland Psychiatric Society, Physicians for National Health Plan, MD/DC Chapter and the Progressive Maryland Healthcare Taskforce. I have been a practicing physician for over 25 years. I am writing in support of SB 411 because I believe safe staffing saves lives and this bill is an important step towards protecting quality of care.

Maryland has the longest ER length of stay in the country. While blame for long wait times is sometimes attributed to overuse of the ER by patients, the actual number of ER visits per 1,000 population in Maryland is among the lowest in the U.S., according to Becker's Hospital Review. Meanwhile, under-staffed and overwhelmed ER medical staff try to care for emergency patients as best they can. Without a safe level of staffing in the ER, Maryland patients will continue to endure long and potentially life-threatening waits for emergency care.

While I am usually able to handle most psychiatric emergencies in the outpatient setting, nearly every time that I have needed to send a patient to the ER for hospitalization in the last 5 years, it has taken at least 8 hours, and often longer, to get the patient evaluated and hospitalized, even when I have called the ER in advance of the patient arriving to provide the medical history and recommendation for hospitalization. I usually need to repeatedly call the patient and/or their family to convince them to remain in the ER and wait for their evaluation as they become more emotionally distressed waiting in the overstimulating ER environment. I have had several patients leave the ER against my medical advice because they cannot stand the wait, requiring me to put together inadequate safety and treatment plans with the patient's family and other clinicians. These patients usually worsen and eventually need to return to the hospital for an involuntary admission rather than a voluntary admission. An involuntary psychiatric hospitalization can lead to long term legal and social detriments that could have been avoided if the patient was hospitalized voluntarily in a less acute state. I am not alone in this experience. Most of my Maryland psychiatric colleagues and mental health clinicians have reported similar experiences with their patients/clients.

The staffing crisis is the root cause of healthcare worker burnout and resignations. As a psychiatrist, I treat and manage the mental health concerns of healthcare workers in several of the hospitals in Maryland. I have heard many firsthand accounts from my patients who are high functioning, dedicated nurses, doctors, social workers and other hospital workers who become emotionally burnt out from unmanageable, unsafe working conditions due to understaffing. Several of my patients, who work in Maryland hospitals, leave their positions to find other non-

hospital healthcare positions and some have left the healthcare field entirely. This is a great loss for these dedicated professionals, and to Maryland, who benefit from their professional service.

This measure which passed overwhelmingly in 2024 and 2025 in the House of Delegates is a smart, proven approach (based on the experience of 9 other states) that fosters collaboration and centers hospital worker voices who have often been missing in stakeholder discussions on the healthcare workforce crisis. By mandating a process, Maryland will have a foundation for adequate data collection and a holistic lens of staffing conditions through worker perceptions. For these reasons and more, I urge a favorable report on the Safe Staffing Act of 2026.

Sincerely,

Donna Ticknor, MD
Riva, Maryland, District 33B

Licensed to practice medicine in Maryland and DC
ABPN Board certified in Adult Psychiatry
APA/MPS Member and Fellow
Progressive Maryland member
PNHP, MD/DC chapter member
Committee to Protect Health Care Advocate member
Committee to Protect Public Mental Health member

PMD SB 411. FAV.pdf
Uploaded by: Erica Puentes
Position: FAV

PROGRESSIVE MARYLAND
P.O. Box 7595, Largo MD 20792
ProgressiveMaryland.org
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Bill Title: SB 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)
Position: Support (FAV)
To: Senate Finance Committee
From: Erica Puentes, Legislative Coordinator on behalf of Progressive Maryland
Date: February 13, 2026

Dear Chair Beidle and Members of the Senate Finance Committee:

My name is Erica Puentes and I am the Legislative Coordinator for Progressive Maryland. I am submitting testimony on behalf of Progressive Maryland. **Progressive Maryland is in strong support of SB411 SB 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026).** Progressive Maryland is a statewide member led organization working for a more robust, equitable and patient centered healthcare system. We are proud to be a founding member of the Patient Worker Collaborative, a coalition representing more than a million Marylanders, that is working to sound the alarm about long hospital ER 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 agonizing wait times in emergency rooms. Because our wait times average more than 4 hours (and in many hospital Emergency Departments, waits are often between 11 and 15 hours) our members are telling us that if they live close to Virginia they are opting to travel to their hospitals to be seen. At a recent community meeting, a member talked about calling an ambulance, hoping it would increase their chances to be seen and treated more quickly than if they had had a family member take them to the ER.

We know that the critical staffing shortage in Maryland hospitals exacerbates the problem. In our view, the Safe Staffing Act of 2026 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 and will help ensure that we have the number of staffed beds we need in our ERs.

This legislation gives hospitals clear guidance to develop staffing committees and staffing plans that can improve staff retention, workplace safety, patient care, and health outcomes. It's not acceptable for our state to have the worst ER wait time record in the country year after year! Let's join the nine other states who have successfully adopted measures like this.

We appreciate your holding a hearing on this important legislation. This bill has been passed with overwhelming support in the House of Delegates in the past two years. It's time for the State Senate to follow their lead. **Progressive Maryland respectfully urges the Finance Committee to move with urgency and to offer a favorable report on SB411.**

Houda FAV Testimony SB411HB624.pdf

Uploaded by: Houda Ait rais
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Houda, and I've worked at a hospital for three years in the Environmental Care department. I urge a **favorable** report on The Safe Staffing Act of 2026. Working short-staffed has taken a toll on my physical and mental health. I came to this country with dreams. I was in medical school back home, and I wanted to continue that journey. But the stress and exhaustion from work have made it impossible to even go to school part-time. A job should not destroy a person's future.

When I first started at the hospital, each worker was assigned 10 rooms a day, plus the common areas and any discharges. It was manageable. Some days were harder than others, but the quality of our work was strong, and patient areas stayed safe. Over time, due to short staffing, that number increased to 15 rooms, and eventually we were told to clean 20 rooms a day — on top of 2 discharges minimum. A "daily clean" is supposed to take 15 minutes and involves removing trash, sanitizing all high-touch areas, cleaning the bathroom, and mopping the floor. A "discharge" is a deep sanitization that takes about an hour. This doesn't include the time it takes to walk between rooms, respond to spills, or being called back by families or nurses.

Management recently informed us that we needed to do 20 dailies and it should take us 3 hours. This is incorrect because 15×20 =300 min, which is 5 hours. Before and after entering a room, we need to put on and take off PPE, which takes 2 minutes. 2×20 = 40 minutes. After every 3 rooms we need to empty our trash and linens, so we walk across the unit to the trash room and then outside the unit to the linen shut, which takes up to 10 minutes. But let's say it could be done in 5 minutes - 5×6 = 30 minutes. We also take an hour lunch break. So, let's add all this up! 300 +60+60+40+30 = 8.16 hours. **There simply isn't enough time to safely and properly clean 20 rooms plus multiple discharges in an 8-hour shift.**

I alerted management to their initial mathematical error, and that they were requiring us to do an amount of work that was physically impossible, but nothing has changed. We are still expected to meet those numbers. We are told the math works, even though it doesn't. The expectations are unrealistic, and they ignore the realities of the job because they don't want to admit that we're short-staffed.

EVC workers are exhausted and burned out, which increases workplace injuries. I was rushing to finish my dailies while the floor techs were waxing the floor, they were rushing too because they are also short staffed, and the caution sign wasn't placed right. I stepped, and the next thing I know I was on the floor with a concussion and a sprained ankle, causing me to be out of work for almost 2 months. My ankle still bothers me.

I want to be clear: EVC may not be considered clinical staff, but nothing in a hospital can function without us. If a room isn't clean, the patient can't go in. The nurses can't work. Doctors can't do their jobs. Everything starts with us. That is why **we need a safe staffing committee that represents the entire care team.** This bill is not just a policy — it is protection. It is respect. It is a chance for workers like me to do our jobs safely and for patients to receive the care they deserve. **Please vote YES.** Thank you for considering workers whose voices are rarely heard.

In Unity, Houda

MacMillan Testimony - Safe Staffing 2026 - Google

Uploaded by: Jacqueline (Jackie) MacMillan

Position: FAV

Testimony for SB 411

Safe Staffing Act of 2026

Position: **FAV**

Dear Chair Beidle and Members of the Senate Finance Committee:

My name is Jacqueline MacMillan and I am a member of Progressive Maryland's Healthcare Task Force. I am writing in support of SB411, the Safe Staffing Act, because Marylanders, like everyone, deserve excellent healthcare. And Maryland's hospital staffing crisis is a significant barrier to healthcare quality.

SB411 creates staffing committees at each hospital that involve the entire care team in providing safe and timely care. Modern organizations recognize that collaboration is a key to effective management. Empowering staff empowers the organization, and helps to create success. We all benefit when hospitals tap the hands-on knowledge of hospital staff to ensure appropriate staffing, and thereby improve patient safety and comfort.

This legislation passed the House two years ago, and is a sensible way to include hospital workers' perspectives in solving the healthcare workforce crisis.

I urge a favorable report on the Safe Staffing Act of 2026.

Sincerely,
Jacqueline MacMillan
Baltimore, MD

Safe Staffing Act of 2026 Testimony Lauren Noel.pd
Uploaded by: Lauren Noel
Position: FAV

HB0624/SB0411 Safe Staffing Act of 2026 Testimony

My name is Lauren Noel, and I am a registered nurse with almost 5 years of experience caring mostly for pre- and post-operative Cardiac Surgery patients. I want to express my strong support for HB0624/SB0411, the Safe Staffing Act of 2026.

In my almost 5 years as a nurse, and additional time as a patient care technician, I have personally experienced the consequences of inadequate staffing. When hospitals fail to provide appropriate staffing levels, patient care suffers, medical errors increase, and nurses experience overwhelming stress and burnout. The reality is that nurses are leaving the profession at an alarming rate—not because they don't love patient care, but because they are physically and emotionally exhausted from trying to provide quality care under impossible conditions.

At one hospital, the number of patients that a nurse took care of was directly correlated to how many nurses were working that night. 24 patients and 6 nurses? 4 patients per nurse. 24 patients and only 4 nurses? 6 patients per nurse. The staffing matrix was not reflective of patient acuity and encouraged the hospital to frequently understaff and max nurses out with 6 patients each.

As recently as earlier this month, the hospital's kitchen was understaffed, so our patient's lunch food trays came 3 hours late. Understaffed environmental service employees means less people to clean discharged rooms which prolongs the amount of time a new patient can be admitted. It all impacts patient care. And that's why all employees need a seat at the table when discussing safe staffing in hospitals.

Staffing needs change quickly on hospital units, requiring flexibility and input from the staff caring for the patients. At the start of a shift, the nurse-patient assignment might reflect the patient acuity at that glimpse in time, but we all know everything can change in an instant in healthcare.

For example, I was working a day shift, where there are 1 nurse to 3 patients and 1 nurse to 4 patients at night and one of my patients was on an insulin drip that required precise hourly blood sugar checks and infusion adjustments; my other 2 patients were relatively "okay" but I discharged one and received a patient who was downgraded from the ICU who had cardiac pacing wires, chest tubes and other drains, and was on continuous IV medication that was nurse-managed. Then, my other patient went into a cardiac dysrhythmia, which is not uncommon in our patient population, and required immediate medical interventions. The assignment changed from being safe at the start of the shift to unsafe in an instant.

There is no system in place that I have seen that addresses these volatile and ever changing staffing needs. As a nurse, you're expected to just suck it up and hope that the other overworked nurses can help you bear the burden.

The only opportunity for feedback from bedside nurses is if they raise concerns to the charge nurse, who usually has their hands tied about staffing numbers since it is budget-related and thus overseen by nurse managers. There is no flexibility in the current status quo to accommodate for changing patient conditions. You work day shift? You get 3 patients. You work night shift? You'll get those same 3 patients plus an additional patient just because it's night shift.

This legislation is a critical step toward addressing this crisis. By requiring that direct patient care providers—such as nurses, nursing assistants, and other essential staff—have representation on hospital staffing committees, HB0624/SB0411 ensures that staffing decisions are made with real-world patient care experience and patient safety in mind. Each hospital and unit have unique needs based on patient acuity, and staffing grids must reflect that complexity. This legislation provides hospitals with flexibility to build their staffing committees to meet their hospital staffing needs; this legislation asks for a minimum number of direct patient care representatives to be present on staffing committees, allowing hospitals to add additional committee members to meet their specific needs.

Safe staffing is not just about improving working conditions for nurses—it is about ensuring that patients receive the high-quality care they deserve. Thoughtful and evidence-based staffing policies lead to better patient outcomes, lower readmission rates, and a more sustainable workforce. As someone who is not a member of a union, this legislation is especially important to ensure healthcare workers have a voice and can guide our hospitals to solutions that will actually work.

I urge this committee to pass HB0624/SB0411 and take a stand for patient safety and healthcare worker well-being. Thank you for your time and consideration.

Sincerely,

Lauren Noel, BSN, RN

Shania Oliver FAV Testimony SB411HB624.pdf
Uploaded by: Leyla Adali
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Shania Oliver, and I've been a Patient Care Technician (PCT) working in hospitals for 31 years. PCTs assist nurses with patient care and daily living. That includes feeding, bathing, vital signs and transporting for testing. I like my job because I'm able to build relationships with my patients, especially with the ones who don't have family with them. We become their family while they are there and help their stay in the hospital be as smooth as possible. I urge you to issue a **favorable** report on the Safe Staffing Act because working short staffed is hard on workers, and it's even harder on our patients.

Over the last few years, we have had 1-2 PCTs on the floor with 25 patients. If we have patients that need to be fed and bathed, it's challenging to get to them when we are short staffed. It feels very hard because we want to be able to do everything for our patients, but we are being pulled in too many directions. Staff is burned out. We are having a lot more call outs because workers are facing extreme exhaustion and physical pain, and mood swings. A lot of people are quitting because the workload is so unsustainable.

Management is aware of our concerns, but nothing has changed. It feels like they are more focused on paperwork to show that work was done than actual patient care.

I support this bill because it will bring change for all healthcare workers. It would mean a lot for our voices to be heard. We are the ones doing the work not just sitting in an office. I want my patients to get proper care and for my coworkers to have healthy and safe working environments. Please vote YES on the Safe Staffing Act. Thank you.

In Unity,

Shania Oliver

Shaniqua Covington FAV Testimony SB411HB624.pdf
Uploaded by: Leyla Adali
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

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 SB411/HB624: Safe Staffing Act of 2026.

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

Sharae Stinnette FAV Testimony SB411HB624.pdf
Uploaded by: Leyla Adali
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

Madame Chair and Members of the Committee,

My name is Sharae Stinnette and I am a Patient Care Associate (PCA) at a hospital. PCAs do total care for patients. That means we help them with baths, oral care, changing them and their linens, using the restroom. We are also tasked with finger sticks, EKGs, bladder scans, and turning the patient every two hours so they do not develop bedsores. There are some patients that can't be left alone for any amount of time, so we sit with them. When we don't have enough PCA's patients can't get the care they need. I urge a **favorable** report on the Safe Staffing Act.

PCAs are overworked and underpaid. I work on a unit with 32 beds with one other PCA. We each have 12 patients, with 6 of those patients being total care. I'm busy all day going back and forth. We really need 1-2 more PCAs so that someone can be available to sit with patients and so someone else can help with total care patients. It's so tiring to not have a fully staffed care team.

Patients are getting distressed about the lack of staffing. Sometimes they verbally abuse us. I know they are frustrated, so I reassure them that I am doing the very best that I can, but at the end of the day it's understandable why they are upset. There's only so much we can do when there aren't enough of us.

It is so important that the Safe Staffing Act become law because the perpetual understaffing at my hospital is hurting everyone. Please vote YES on this bill.

In Unity,

Sharae Stinnette

Shirley Randolph FAV Testimony SB411HB624.pdf
Uploaded by: Leyla Adali
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

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

SB 411 Safe Staffing Act_1199SEIU_FAV (1).pdf
Uploaded by: Loraine Arikat
Position: FAV

Testimony for SB 411
Safe Staffing Act of 2026
Before the Senate Finance Committee
February 17th, 2026
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 SB 411. Our members' experiences show that administrative decisions without oversight and worker input can have a major impact on patient quality of care.

SB 411 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. Staffing Committees will submit their annual reports to the Maryland Health Care Commission.

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.

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].

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.

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 and HSCRC's interim report for ED Wait Time Reduction Commission highlighted the importance of collecting adequate data on wages, retention, and staffing conditions. The Safe Staffing Act of 2025 will ensure that State policy makers and regulators will have accurate and timely data on staffing at each hospital in the state in addition to how hospitals incorporate care team recommendations.

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 SB 411. If you have any questions, please email me at ricarra.jones@1199.org.

Sincerely,

Ricarra Jones
Political Director
1199 SEIU United Healthcare Workers East

Lucy Caulker Nelson FAV Testimony SB411HB624.pdf
Uploaded by: Lucy Caulker Nelson
Position: FAV

SB411/HB624
Safe Staffing Act of 2026
Position: **FAV**

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 The Safe Staffing Act of 2026.

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

SB411 -Safe Staffing Act EconAction FAV.docx.pdf
Uploaded by: Marceline White
Position: FAV

SB411 Hospitals - Clinical Staffing Committees and Plans - Establishment
(Safe Staffing Act of 2026)
Position: FAV

February 17, 2026

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401
cc: Members, Senate Finance

Chair Beidle and Members of the Committee,

Economic Action Maryland Fund is here in strong support of SB411.

Patients seeking emergency care at Maryland hospitals face the longest wait-time in the country. In fact, Maryland's wait times have exceeded the national average for more than two decades. Recently, wait times have marginally improved but many patients still languish in emergency rooms waiting to be seen or waiting to be admitted to a hospital room.

There are a number of systems-wide reasons for these long wait times. A shortage of hospital beds,

One critical factor is a staffing shortage. For nurses, in particular, staff shortages directly affect patient outcomes. A 2024 study found that lower levels of nurse staffing in emergency departments are associated with delays in patients receiving treatments and poor quality care including an increase in leaving without being seen, delay in accessing treatments and medications and cardiac arrest.

In addition to nursing staff, there are shortages for other health care staff as well. A 2023 report prepared in accordance with SB440 found that Maryland is not growing its health care workforce at the same rate as other states and that health care workforce shortages are most pronounced in rural parts of the state.

SB411 establishes a commission comprised of an equal number of hospital management staff and frontline and other staff to develop a clinical staffing plan to meet patients needs. It makes sense that both management and workers who are directly engaged in patient care and support work together on solutions to ensure patient and worker safety and security.

Economic Action (formerly the Maryland Consumer Rights Coalition) champions economic rights and housing justice through advocacy, research, consumer education, and direct service. Our 12,500 supporters include consumer advocates, practitioners, and low-income and working families throughout Maryland.

2209 Maryland Ave · Baltimore, MD 21218 | www.econaction.org
Marceline White · Marceline@EconAction.org | Jennifer Bevan-Dangel · Jennifer@EconAction.org

With the rollback of Medicaid and the affordability crisis facing Marylanders across the state, it is likely that emergency departments will see an influx of new patients who can no longer afford health insurance turning to the ER as a first and last resort. It's critical that Maryland hospitals begin to develop plans that include frontline staff and management to reduce wait times, and improve patient care.

For all these reasons, we support SB411 and urge a favorable report.

Best,

Marceline White
Executive Director

2209 Maryland Ave · Baltimore, MD 21218 | www.econaction.org
Marceline White · Marceline@EconAction.org | Jennifer Bevan-Dangel · Jennifer@EconAction.org

SB 411 - FAV - ALZ Association.pdf
Uploaded by: Megan Peters
Position: FAV

Bill: SB 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)
Committee: Finance
Position: Favorable
Date: February 17, 2026

On behalf of the 127,200 Marylanders living with Alzheimer's disease and their 247,000 caregivers, the Alzheimer's Association supports SB 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026). 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 collaborates with health systems, including hospitals, to address the rising costs of dementia care and improve patient care and outcomes. SB 411 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 SB 411, 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 SB 411 does not mandate staffing ratios or force a hospital to make fiscal decisions that negatively impact quality of care.

SB 411 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 SB 411. Please contact Megan Peters, Director of Government Affairs at mrpeters@alz.org with any questions.

SB 411 - FAV.pdf
Uploaded by: Megan Peters
Position: FAV

Maryland Senior Citizens Action Network

MSCAN

AARP Maryland

Baltimore Jewish Council

Catholic Charities of Baltimore

Central Maryland Ecumenical Council

Church of the Brethren

Episcopal Diocese of Maryland

Housing Opportunities Commission of Montgomery County

Lutheran Office on Public Policy in Maryland

Maryland Association of Area Agencies on Aging

Maryland Catholic Conference

Mental Health Association of Maryland

Mid-Atlantic LifeSpan

National Association of Social Workers, Maryland Chapter

Presbytery of Baltimore

The Coordinating Center

MSCAN Co-Chairs:
Carol Lienhard
Megan Peters
410-921-9005

The Maryland Senior Citizens Action Network (MSCAN) is a statewide coalition of advocacy groups, service providers, faith-based and mission-driven organizations that support policies that meet the housing, health, and quality of care needs of Maryland's low and moderate-income seniors.

MSCAN supports SB 411. Older adults represent a significant and growing share of Maryland's hospital patients. As individuals age, they often experience multiple chronic conditions, cognitive impairment, functional limitations, and longer lengths of stay — all of which demand reliable, appropriately trained, and adequately staffed clinical teams. Evidence-informed staffing plans are one of the most effective tools we have to reduce preventable adverse events, improve patient safety, and ensure hospitals can deliver timely, high-quality care to older patients with complex needs.

By requiring hospitals to establish a clinical staffing committee with staff representation, SB 411 promotes a more responsive staffing model, better aligned with real-world clinical demands and the needs of an aging patient population. These committees provide a venue for staff to collaboratively identify gaps, address workflow challenges, and ensure staffing levels are based on clinical needs.

For older adults, appropriate staffing is not simply a workforce issue. It is also a safety issue. Adequate staffing reduces falls, medication errors, infections, and more. It also ensures that individuals with dementia, mobility limitations, or sensory impairments receive the attentive, person-centered care they need to remain safe and avoid unnecessary hospital readmissions.

SB 411 will strengthen Maryland's health care delivery system and improve hospital care for older adults. For these reasons, MSCAN urges a favorable report.

Testimony for SB 411 High Note Consulting 2-17-202

Uploaded by: Michael Dalto

Position: FAV

HIGH NOTE
CONSULTING

Testimony for SB 411
Safe Staffing Act of 2026
Before the Senate Finance Committee
February 17, 2026
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 2026 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 SB 411. Thank you.

Sincerely,

Michael Dalto, President
High Note Consulting, LLC

SB 411 Testimony.pdf
Uploaded by: Michael Massey
Position: FAV

Written Testimony Submitted to the
Maryland Senate Finance Committee
By: Michael Massey, MD
SB 411: Hospitals – Clinical Staffing Committees and Plans – Establishment
Safe Staffing Act of 2026
February 17, 2026

To the respectable Chair Beidle, Vice Chair Hayes, and members of the Senate Finance Committee, my name is Michael Massey, and I am a Resident Physician in both the hospital and clinic setting in the state of Maryland. I am writing on behalf of myself in strong support of SB 411, the Safe Staffing Act of 2026.

I work very closely with my nursing colleagues daily to provide the best possible patient care that we can. I rely on our nurses for so many crucial aspects of hospital care including being the closest point of contact and advocate for our patients when someone's health starts to deteriorate, drawing vital blood work, coordinating transportation to imaging, administering medications and much more.

What I want to emphasize in my letter is how dangerous our current nursing shortage is for the future of healthcare as it relates to burnout. Working in healthcare and as a nurse is already a high-intensity occupation that always demands 100% performance with long hours. In addition to the already demanding job, nurses are now expected to cover more patients per shift than previously promised when they were first hired due to staffing shortages. In fact, the Maryland Healthcare Workforce report found that 1 in 4 nursing positions throughout the entire state are vacant. Because of this, I have worked with nurses on the labor & delivery unit who were unsafely scheduled to cover more than one actively laboring patient.

I have also worked with another excellent nurse for two months now on a medical floor who on the day of me submitting this letter described how nursing shortages have impacted him. When he started nursing 3 years ago, his unit was well staffed and he never had to manage more than 4 patients at a time, which is the recommended number of patients for this floor's acuity, or how sick patients are on this floor. Over the past three years, the patients on this unit have progressively gotten higher in acuity on average, and it is now routine that he has to manage 5 patients and sometimes 6 due to nursing shortages. He said many of the nurses we worked with when he first started have left due to the stress of the job. He told me that it is really upsetting and disheartening having to work in these conditions, because he wants to provide excellent care and have his patients feel supported. However, with 5-6 patients, he constantly feels like patients and families believe he is ignoring them or he feels like he lets down the doctors he is working with to carry out the plan of care for a patient.

SB 411 would simply ask that hospitals set up a clinical staffing committee between management and the hospital employees to discuss a staffing plan to address patient needs. This is critical for the future of good quality healthcare in the state of Maryland, because without it, some of the best nurses I know, like the one whose story I shared, will eventually get burned out and leave the field like so many already have.

Best Regards,
Michael Massey, MD
Resident Physician
Family Medicine

SB 411 Testimony SUPPORT (FAVORABLE) Feb 13th 2026

Uploaded by: Michael Walsh

Position: FAV

Testimony in SUPPORT (FAV) of SB 411
Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)
Senate Finance Committee | Feb. 13th, 2026
Position: **FAVORABLE**

Dear Chair Beidle and Members of the Senate Finance Committee:

My name is Mike Walsh and I have been a resident of Anne Arundel County for 35 years in Shady Side andI am writing in support of SB 411 because we need to take care of our care workers so they can better take care of us. I believe direct care workers should be at the table of addressing the staffing crisis or I believe safe staffing saves lives and this bill is an important step towards protecting quality of care.

SB411 creates staffing committees at each hospital that ensure the entire care team is at the table to address hospital-wide challenges in providing safe and timely care. Committees will work together to submit a staffing plan that includes recommendations and staffing data on an annual basis to the Maryland Healthcare Commission. The reports will be posted on Maryland Healthcare Commission's website.

Creating safe staffing conditions will help our hospitals recruit and retain the workforce they need and will help ensure that we have the number of staffed beds we need in our ERs. This legislation gives hospitals clear guidance to develop staffing committees and staffing plans that can improve staff retention, workplace safety, patient care, and health outcomes. While blame for long wait times is sometimes attributed to overuse of the ER by patients, the actual number of ER visits per 1,000 population in Maryland is among the lowest in the U.S., according to Becker's Hospital Review. Meanwhile, under-staffed and overwhelmed ER medical staff try to care for emergency patients as best they can. Without a safe level of staffing in the ER, Maryland patients will continue to endure long and potentially life-threatening waits for emergency care. I don't know about you, but dreading a long wait time has a major influence on the way myself and my family decide to seek care when ill or injured, and that just shouldn't be the case. In order to better care for all residents in MD, we need to build confidence that the quality care we need can be delivered in a timely manner without putting care workers at harm. It's not acceptable for our state to have the worst ER wait time record in the country year after year! Let's join the nine other states who have successfully adopted measures like this.

This legislation, which passed the house the past two years, is a sensible approach that fosters collaboration and centers hospital worker voices who have often been missing in stakeholder discussions on the healthcare workforce crisis. By mandating a process, Maryland will have a foundation for adequate data collection and a holistic lens of staffing conditions through worker perceptions. For these reasons and more, I urge a favorable report on SB411, the Safe Staffing Act of 2026.

Sincerely,

Michael Walsh
District 30B
walsh2.michael@gmail.com
410-353-2756

official testimony sb0411.docx.pdf
Uploaded by: Miranda Lan
Position: FAV

SB 0411 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)
Senate Finance Committee
February 17, 2026
Favorable

To: Hon. Pamela Beidle, Chair & members of the Senate Finance Committee

From: Courtney Jenkins, President, Metropolitan Baltimore Council AFL-CIO Unions

Chair, Vice Chair, and Members of the Committee:

My name is Courtney Jenkins, and I am the President of the Metropolitan Baltimore Council AFL-CIO, representing tens of thousands of union workers across the Baltimore region, including healthcare workers who keep our hospitals running every day.

We strongly support SB 411.

Maryland hospitals are facing a staffing crisis that directly harms both patients and workers. Our state consistently reports some of the longest emergency room wait times in the nation. Behind those numbers are exhausted healthcare workers managing unsafe patient loads and patients waiting far too long for critical care. This bill addresses that crisis by ensuring that the people doing the work have a real voice in staffing decisions that affect patient safety and workforce stability.

The Safe Staffing Act establishes hospital staffing committees that are evenly split between management and frontline care team workers, with the inclusion of a patient advocate. These committees would develop staffing plans tailored to the realities of each hospital and submit them to the Maryland Healthcare Commission. This is a balanced, collaborative approach that values expertise from the bedside while maintaining accountability.

Safe staffing saves lives. Research shows that short staffing is associated with longer emergency room wait times, increased medical errors, higher rates of infections and bedsores, more patient falls, and worse outcomes when complications arise. Longer ER stays are also linked to higher

patient mortality. This bill would help reduce those risks and improve clinical outcomes across Maryland hospitals.

Safe staffing also strengthens our healthcare workforce. Maryland has struggled to retain healthcare workers, and burnout driven by overwhelming patient loads is a major factor. Studies show a strong correlation between staffing levels and job satisfaction. When workers are supported, they stay. This reduces turnover and preserves institutional knowledge.

Finally, safe staffing saves hospitals money. Preventable injuries, infections, and medical errors are costly. Healthier patients, shorter hospital stays, and fewer readmissions translate into significant long-term savings for our healthcare system.

Other states such as New York, Connecticut, and Illinois have already taken this step; and healthcare workers there report improved morale and better outcomes when staffing committees are empowered to do their jobs. Maryland should not lag behind.

The Safe Staffing Act is a common-sense solution to a decades-long problem. It puts patient safety first, respects healthcare workers, and strengthens our hospitals. We urge a favorable report on SB 411.

Respectfully submitted,
Courtney L. Jenkins
President, Metropolitan Baltimore Council of AFL-CIO Unions

SB0411-LWVMD-FAV-Hospitals-Clinical Staffing Commi

Uploaded by: Nora Miller Smith
Position: FAV

LEAGUE OF WOMEN VOTERS® OF MARYLAND

TESTIMONY TO THE FINANCE COMMITTEE

SB0411: Hospitals- Clinical Staffing Committees and Plans- Establishment (Safe Staffing Act of 2026)

POSITION: Support

BY: Linda Kohn, President

DATE: February 17, 2026

The League of Women Voters of Maryland believes that all residents should have access to affordable, quality health care, and thus the League supports **SB 411, The Safe Staffing Act of 2026.** "Quality health care" is defined by the League as care "consistent with 'standard of care' guidelines, by trained and licensed personnel, **staffed adequately to ensure their own and patient safety."**

Under SB 411, Maryland hospitals would establish clinical staffing committees to develop plans that meet patient and staff needs, ensure quality care, improve patient safety, and reduce the prolonged wait times in Maryland's Emergency Rooms, which are currently among the highest in the nation. The committees would be composed of both management and employees. **By ensuring their full participation in staffing committees, the knowledge and experience of frontline direct care workers would be acknowledged and respected.**

"Inadequate nurse staffing are closely associated with poor patient outcomes."[1] High patient-to-nurse ratios can lead to higher rates of medical errors, more hospital acquired infections and falls, longer hospital stays, increased rates of readmissions, decreased patient satisfaction, and increased mortality.

The goal of Maryland's newly instituted AHEAD model is to optimize Marylanders' health and well-being. One focus is to "provide better care for Marylanders by rewarding hospitals for high quality care."[2] Instituting clinical staffing committees designed to ensure collaboration, with respect for all members of the healthcare team, would help meet the goals of the AHEAD model, and would ultimately lessen healthcare costs.

Marylanders who come to medical facilities need to trust that they will receive the best of care when they are the most vulnerable. **The League and its 2,000 members urge a favorable report on SB 411.**

[1] https://www.dpeaflcio.org/factsheets/safe-staffing-critical-for-patients-and-nurses#:~:text=Inadequate%20staffing%20endangers%20patients%20and%20nurses%20alike,%2Dsurgical%20units.%5B9%5D

[2] https://hscrc.maryland.gov/Pages/ahead-model.aspx

121 Cathedral Street, Suite 2B, Annapolis, MD 21401
410-269-0232 * info@lwvmd.org * www.lwvmd.org

Testimony in support of SB0411 - Safe Staffing Act

Uploaded by: Richard KAP Kaplowitz

Position: FAV

SB0411_RichardKaplowitz_FAV
02/17/2026
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#/0411- POSITION: FAVORABLE

Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)

TO: Chair Beidle, Vice Chair Hayes, and members of the Finance Committee
FROM: Richard Keith Kaplowitz

My name is Richard Keith Kaplowitz. I am a resident of District 3, Frederick County. I am submitting this testimony in support of SB#/0411, **Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)**

Maryland consistently has the longest emergency room (ER) wait times in the United States, with average waits frequently exceeding four hours and some, such as at UM Capital Region Medical Center, reaching up to 17–24 hours. Key factors driving these delays include severe staffing shortages, high patient volume, and a lack of available hospital beds. [1]

The Maryland Safe Staffing Act of 2026 (SB411/HB905) aims to improve hospital safety by requiring the establishment of clinical staffing committees with equal management-employee representation. These committees must create, implement, and annually update comprehensive staffing plans for patient units, with enforcement and public posting required by January 1, 2028. [2]

Key Aspects of the 2026 Safe Staffing Legislation:

- Clinical Staffing Committees
- Plan Requirements
- Implementation & Compliance
- Public Transparency.

The legislation aims to address the state's severe staffing shortages and high emergency room wait times.

This legislation will address Maryland's long emergency room wait times by enabling frontline staff to participate in decision-making.

Maryland can make this happen by requiring certain hospitals licensed in the State to establish and maintain a clinical staffing committee and to implement a clinical staffing plan; requiring each clinical staffing committee to develop a clinical staffing plan; requiring, on or before July 1 each year, each hospital's clinical staffing committee to conduct a review of the clinical staffing plan for certain purposes; requiring, on or before January 1, 2028, each hospital to implement a clinical staffing plan and assign personnel in accordance with the plan; etc.

I respectfully urge this committee to return a favorable report on SB#/0411.

[1] Google AI Search "wait times in er in Maryland"
[2] Google AI Search "maryland safe staffing 2026"

SB 411 Favorable.pdf
Uploaded by: Ruth Carlock
Position: FAV

Date: February 13, 2026 **Hearing Date: February 17, 2026**

Committee: Heath & Government Operations

Bill: SB 0411 Safe Staffing Act of 2025

Position: In Favor and Request Favorable Report Submitted by:

Ruth Carlock

Brain Injury Association of Maryland 2200 Kernan Dr.

Baltimore MD 21207

Dear Chair Beidle and Members of the Senate Finance Committee:

My name is Ruth Carlock, and I am from the Brain Injury Association of Maryland (BIAMD). We are a non-profit organization that is the voice of those affected by brain injury through advocacy, education, and research. I am submitting this testimony in strong support of Senate Bill 411. This critical legislation aims to establish enforceable staffing standards in Maryland hospitals, ensuring adequate patient care and support for healthcare professionals. A recent study by the Maryland General Assembly Hospital Throughput Work Group showed that the state of Maryland had the worst hospital wait times out of all 50 states. SB 411 represents a multifaceted strategy to address this issue by focusing on a collaborative care team approach that remains flexible on how hospitals can manage this crisis and reduce patient risk and wait times.

The BIAMD has witnessed firsthand the profound impact that staffing shortages and clinician burnout have on patients, particularly those who have sustained brain injuries. Individuals recovering from brain injuries require intensive, specialized, and often prolonged rehabilitation services. The success of their recovery heavily depends on consistent, personalized care provided by a dedicated team of healthcare professionals. This legislation offers a way for these hospitals to reduce burnout with a plan to address safety concerns. This legislation allows hospitals to create individualized plans to address the specific issues of each hospital much sooner than top-down legislation could achieve.

However, chronic understaffing and the resultant burnout among clinicians pose significant challenges to delivering such care. Research indicates that burnout is prevalent among professionals in brain injury rehabilitation settings, often stemming from factors such as emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment. These factors are exacerbated by high patient loads, insufficient resources, and the emotional toll of managing complex patient needs.

A study exploring the experiences of support staff in traumatic brain injury rehabilitation centers highlighted several themes contributing to burnout, including the unique challenges of brain injury rehabilitation, emotional experiences associated with treatment, and organizational factors leading to stress. Participants expressed feelings of helplessness due to the slow progress often observed in rehabilitation and the necessity for repetitive interventions. Such conditions not only affect the well-being of healthcare providers but also compromise the quality of patient care.

Right now, one in four nursing positions are vacant, and this crisis only stands to get worse with an aging nursing population and decreasing graduating rates of new nurses in the state. With numerous studies showing the link between excess nurse to patient ratios leading to worse patient outcomes and increases the number of unnecessary deaths. With The Health Services Cost Review Commission showing some patients waiting up to 20 hours to receive emergency care.

Moreover, the unpredictable nature of brain injuries requires healthcare professionals to exercise a high degree of creativity and adaptability in treatment planning. This demand, coupled with organizational stressors like scheduling pressures and extensive documentation requirements, further contributes to burnout and reduces the time clinicians can devote to direct patient care.

Implementing the staffing standards proposed in SB 411 would address these critical issues by:

- **Ensuring Adequate Staffing Levels:** By mandating appropriate clinician-to-patient ratios, hospitals can provide the necessary time and resources for each patient, particularly those with complex conditions like brain injuries.
- **Reducing Clinician Burnout:** Adequate staffing alleviates excessive workloads, allowing healthcare professionals to maintain their well-being, which is essential for delivering high-quality care.
- **Improving Patient Outcomes:** Consistent and personalized care from well-supported clinicians leads to better rehabilitation outcomes for brain injury patients, facilitating their recovery and return to daily life.

Investing in appropriate clinical staffing is not only a moral obligation but also a strategic decision that will benefit Maryland's healthcare system in the long term. I urge this committee to issue a favorable report on SB 411 and support its passage to ensure that Maryland hospitals uphold the highest standards of patient care and workplace safety.

Thank you for your consideration.

Citations:

1. Block, H., Bellon, M., Hunter, S.C. *et al.* Barriers and enablers to managing challenging behaviours after traumatic brain injury in the acute hospital setting: a qualitative study. *BMC Health Serv Res* **23**, 1266 (2023). https://doi.org/10.1186/s12913-023-10279-z

2. Chambers-Baltz S, Knutson D, Chwalisz K, Canby A, Kane T. The experiences of support staff in a traumatic brain injury rehabilitation center. Rehabil Psychol. 2023 Feb;68(1):53-64. doi: 10.1037/rep0000475. Epub 2022 Nov 28. PMID: 36442015.

1. Norman, A., Holloway, M., Dean, J., Patterson, A., Needham-Holmes, B., Curro, V., Andrews, C., Feltham-White, P. and Clark-Wilson, J. (2024) 'Working Within a Perfect Storm: The Current UK Care Crisis in Community Neurorehabilitation', *Journal of Long Term Care*, 0(), p. 464–475. Available at: https://doi.org/10.31389/jltc.336.

2. Powell MA, Oyesanya TO, Scott SD, Allen DH, Walton A. Beyond Burnout: Nurses' Perspectives on Chronic Suffering During and After the COVID-19 Pandemic. *Global Qualitative Nursing Research*. 2024;11. doi:10.1177/23333936241271271

1. Wang, J., Wang, W., Laureys, S. *et al.* Burnout syndrome in healthcare professionals who care for patients with prolonged disorders of consciousness: a cross-sectional survey. *BMC Health Serv Res* **20**, 841 (2020). https://doi.org/10.1186/s12913-020-05694-5

2. Schlenz KC, Guthrie MR, Dudgeon B. Burnout in occupational therapists and physical therapists working in head injury rehabilitation. Am J Occup Ther. 1995 Nov-Dec;49(10):986-93. doi: 10.5014/ajot.49.10.986. PMID: 8585598.

3. Wittig PG, Tilton-Weaver L, Patry BN, Mateer CA. Variables related to job satisfaction among professional care providers working in brain injury rehabilitation. Disabil Rehabil. 2003 Jan 21;25(2):97-106. PMID: 12554384.

https://mhaonline.org/wp-content/uploads/2024/05/maryland-general-assembly-hospital-throughput- work-group-final-report-march-2024.pdf

SB411 - PJC - Support.pdf
Uploaded by: Sam Williamson
Position: FAV

Sam Williamson, Attorney
Public Justice Center
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SB411: Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)
Senate Finance Committee, February 17, 2026
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 SB411, 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 SB411** 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.

SB 411 - Safe Staffing Act - FAV - AARP MD.pdf
Uploaded by: Sara Westrick
Position: FAV

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SB 411 - Hospitals - Clinical Staffing Committees and Plans – Establishment
(Safe Staffing Act of 2026)
Senate Finance Committee
February 17, 2026
FAVORABLE

Good afternoon, Chair Beidle, Vice Chair Hayes, and members of the Senate Finance Committee. Thank you for the opportunity to submit testimony in support of Senate Bill 411, the Safe Staffing Act of 2026. We thank Senators Augustine, Hettleman, Kramer, and McCray for sponsoring this important legislation.

My name is Sara Westrick, Advocacy Director for AARP Maryland, and we are a proud member of the Caring Across Maryland Coalition, which has identified SB 411 as one of its priorities for the legislative session.

AARP Maryland is one of the largest membership-based organizations in the state, with approximately 850,000 members. We represent the interests of Maryland's over 50 population. AARP brings the lived experiences, concerns, and priorities of our members to the discussion table, ensuring that policy decisions reflect the needs of older adults.

Why AARP Maryland Supports SB 411

SB 411 requires hospitals to establish clinical staffing committees with equal representation from management and frontline staff. The committee must include workers who understand patient needs firsthand, including certified nursing assistants, dietary aides, technicians, nurses, environmental services workers, and residents.

By empowering frontline clinicians, Maryland ensures staffing plans are grounded in real-world patient care conditions. In addition, giving employees a real voice in staffing decisions improves morale and retention, which are critical to addressing the chronic understaffing experienced at many Maryland hospitals.

Each staffing committee must evaluate and update the plan each year based on the previous year's events. The committees must also develop a process for receiving, resolving, and tracking complaints when staffing does not match the plan. These provisions ensure that staffing plans are living documents, not check-the-box exercises.

SB 411 creates statewide consistency without imposing rigid ratios, and there are no mandated minimum staffing ratios. Instead, the act requires hospitals to develop evidence-based staffing

plans tailored to each unit. This approach respects hospital differences while ensuring every facility uses a structured, data-driven process.

Similarly, the gradual implementation of the bill gives time to help ensure success. Hospitals will have the time needed to prepare and implement the provisions.

Conclusion

We believe that safe staffing saves lives and improves patient outcomes, and better staffing reduces medical errors, shortens hospital stays, and improves quality of care. By passing SB 411, Maryland will join other states that have successfully implemented similar staffing regulations, resulting in improved patient outcomes and better working conditions for health care professionals.

For these reasons, we respectfully urge a favorable report on Senate Bill 411.

If you have any questions, please contact Sara Westrick at swestrick@aarp.org or by calling 410-310-0374.

SB0411_FAV_MedChi_Hospitals - Clinical Staffing C
Uploaded by: Steve Wise
Position: FAV

MedChi

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Senate Finance Committee
February 17, 2026
Senate Bill 411 – *Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)*
POSITION: SUPPORT

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, submits this letter of **support** for Senate Bill 411.

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 specifies the appropriate number of clinicians needed to administer quality health care by setting. The plan must be reviewed and updated annually.

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 Senate Bill 411, that ensure the availability of sufficient health care and support personnel to meet increased patient needs throughout the entire hospital.

For more information call:
J. Steven Wise
Danna L. Kauffman
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

SB 411-- Safe Staffing Act.pdf
Uploaded by: Todd Reynolds
Position: FAV

A Union of Professionals
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Kenya Campbell
PRESIDENT

LaBrina Hopkins
SECRETARY-TREASURER

Written Testimony Submitted to the
Maryland Senate Finance Committee
SB 411: Hospitals – Clinical Staffing Committees and Plans – Establishment
Safe Staffing Act of 2026
February 17, 2026
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 SB 411.

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 led 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.

SB 411 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 SB 411. Thank you.

Testimony Safe Staffing-Delph-2026-02-17.pdf
Uploaded by: Yvette Delph
Position: FAV

Bill Title: SB0411: Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)
Position: FAVORABLE
To: Senate Finance Committee
Hearing Date: Tuesday, February 17, 2026

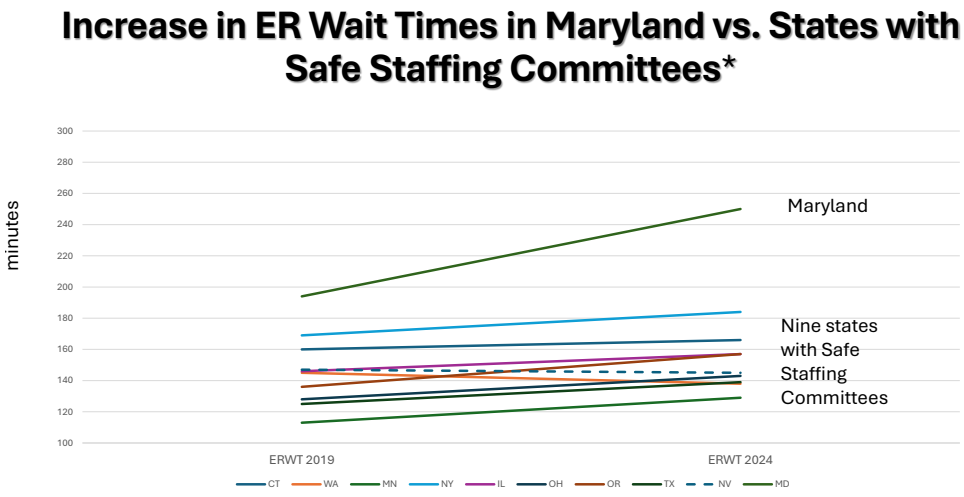
Dear Chair Beidle and Members of the Senate Finance Committee:

My name is Yvette Delph and I am a retired physician living in Silver Spring, District 19. I am a member of Progressive Maryland's Health Care Task Force. I respectfully request you support SB0411, the Safe Staffing Act of 2026, which is vital for Maryland to improve the quality of healthcare, minimize morbidity and mortality, and reduce Emergency Room wait times (ERWT).

The input of healthcare workers is essential to adequately addressing the staffing crisis and other challenges that hospitals face in providing quality care. SB0411 mandates each State-licensed hospital to create a clinical staffing committee to develop and implement a clinical staffing plan that meets patient needs, including appropriate levels and expertise of clinical care staff for each care unit and each shift. Every year, clinical staffing plans would be evaluated, updated, and reported to the Maryland Health Care Commission, and posted publicly.

As a caregiver, I took someone to the emergency room of a hospital in Montgomery County. After a 5-hour wait, he was seen and denied an ultrasound to check for gall bladder problems. He had emergency surgery 36 hours later at a hospital in Washington, DC. A partly gangrenous gall bladder was removed.

For the past 10 years, Maryland has had the longest ERWT among all 50 states—even though the number of ER visits per 1,000 population in Maryland is among the lowest in the United States, according to Becker's Hospital Review. As shown in this graph, data from the Center for Medicare & Medicaid Services reveals that between 2019 and 2024, Maryland's ERWT increased much more steeply than the nine states with Safe Staffing Committees: in that period, Maryland's ERWT increased from 195 to 250 minutes, while the nine states saw increases from 110-170 to 130-185 minutes, with some states lowering their ERWT.



*Data from the Center for Medicare & Medicaid Services

This legislation for Safe Staffing Committees passed the House over the past two years. It is a proven approach that places those with the greatest experience and insight into the problem in the position to develop, implement, and evaluate meaningful solutions. It will provide Maryland with objective data to develop effective strategies. For these reasons and more, I urge a favorable report on SB0411, the Safe Staffing Act of 2026.

Sincerely,

Yvette Delph, MBBS, DA

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Uploaded by: Elias Khan

Position: FWA

SB0411/773722/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

11 FEB 26
13:52:58

BY: Senator Augustine
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 411
(First Reading File Bill)

On page 2, in line 27, strike "**AND**".

On page 3, in line 1, after "**(VII)**" insert "**A STAFF REGISTERED NURSE WHO IS NOT AN EMERGENCY ROOM NURSE; AND**

(VIII)".

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Uploaded by: Elias Khan

Position: FWA

SB0411/403529/1

AMENDMENTS
PREPARED
BY THE
DEPT. OF LEGISLATIVE
SERVICES

11 FEB 26
11:25:35

BY: Senator Augustine
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 411
(First Reading File Bill)

On page 5, in line 11, strike "**THE MAIN PAGE OF**".

FinalReprint_Amendment2.pdf
Uploaded by: Elias Khan
Position: FWA

SENATE BILL 411

J1 6lr2317
CF 6lr2315

By: **Senators Augustine, Hettleman, Kramer, and McCray**
Introduced and read first time: January 29, 2026
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Hospitals – Clinical Staffing Committees and Plans – Establishment
(Safe Staffing Act of 2026)

FOR the purpose of requiring certain hospitals licensed in the State to establish and maintain a clinical staffing committee and to implement a clinical staffing plan; requiring each clinical staffing committee to develop a clinical staffing plan; and generally relating to hospitals and clinical staffing committees and plans.

BY adding to
Article – Health – General
Section 19–393 through 19–397 to be under the new part "Part XIII. Clinical Staffing Committees and Plans"
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–391. RESERVED.

19–392. RESERVED.

PART XIII. CLINICAL STAFFING COMMITTEES AND PLANS.

19–393.

(A) IN THIS PART THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

REPRINT OF SENATE BILL 411 as amended by SB0411/403529/1 02/11/26 at 11:25 AM

(B) (1) "ANCILLARY MEMBER OF THE FRONTLINE TEAM" MEANS AN INDIVIDUAL WHOSE PRIMARY DUTIES INCLUDE SUPPORTING INDIVIDUALS WHO PROVIDE DIRECT PATIENT CARE.

(2) "ANCILLARY MEMBER OF THE FRONTLINE TEAM" INCLUDES:

(I) A DIETARY WORKER;

(II) A PATIENT CARE TECHNICIAN; AND

(III) ANY OTHER NONLICENSED STAFF ASSISTING WITH PATIENT CARE.

(C) "CLINICAL STAFFING COMMITTEE" MEANS A COMMITTEE ESTABLISHED BY A HOSPITAL IN ACCORDANCE WITH SUBSECTION (C) OF THIS SECTION.

(D) "CLINICAL STAFFING PLAN" MEANS A PLAN DEVELOPED UNDER SUBSECTION (D) OF THIS SECTION.

19–394.

(A) THIS PART DOES NOT APPLY TO STATE HOSPITALS.

(B) (1) EACH HOSPITAL LICENSED UNDER THIS TITLE SHALL ESTABLISH AND MAINTAIN A CLINICAL STAFFING COMMITTEE THAT HAS EQUAL MEMBERSHIP FROM MANAGEMENT AND EMPLOYEES.

(2) EACH CLINICAL STAFFING COMMITTEE ESTABLISHED UNDER THIS PART SHALL INCLUDE AT LEAST ONE OF THE FOLLOWING INDIVIDUALS:

(I) A CERTIFIED NURSING ASSISTANT;

(II) A DIETARY AIDE;

(III) AN EMERGENCY ROOM NURSE;

(IV) AN ENVIRONMENTAL SERVICE WORKER;

(V) A RESIDENT, IF THE COMMITTEE IS IN A TEACHING HOSPITAL;

(VI) A STAFF PHYSICIAN WHO IS NOT A HOSPITAL EMPLOYEE OR ADMINISTRATOR; AND

REPRINT OF SENATE BILL 411 as amended by SB0411/403529/1 02/11/26 at 11:25 AM

(VII) A TECHNICIAN.

(3) A CLINICAL STAFFING COMMITTEE ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY INCLUDE A PATIENT ADVOCATE.

(C) EACH CLINICAL STAFFING COMMITTEE SHALL DEVELOP A CLINICAL STAFFING PLAN THAT MEETS PATIENT NEEDS.

(D) WHEN DEVELOPING A CLINICAL STAFFING PLAN, THE CLINICAL STAFFING COMMITTEE SHALL CONSIDER:

(1) EXISTING STAFFING LEVELS;

(2) METHODS TO SECURE COVERAGE NEEDS AS NECESSARY;

(3) EXISTING GAPS IN STAFFING AND HOW TO ADDRESS THE GAPS;

(4) ANY AVAILABLE EVIDENCE–BASED STAFFING STANDARDS; AND

(5) A SCHEDULE FOR PERIODIC REVIEW OF THE STAFFING PLAN.

(E) ON OR BEFORE JULY 1 EACH YEAR, EACH HOSPITAL, THROUGH THE CLINICAL STAFFING COMMITTEE, SHALL CONDUCT A REVIEW OF THE CLINICAL STAFFING PLAN TO:

(1) EVALUATE THE EFFECTIVENESS OF THE CLINICAL STAFFING PLAN DURING THE IMMEDIATELY PRECEDING YEAR;

(2) UPDATE THE CLINICAL STAFFING PLAN TO ENSURE THAT THE CLINICAL STAFFING PLAN CONTINUES TO BE APPROPRIATE AND EFFECTIVE; AND

(3) DEVELOP A PROCESS FOR RECEIVING, RESOLVING, AND TRACKING COMPLAINTS RELATED TO THE CLINICAL STAFFING PLAN.

(F) IN DEVELOPING THE CLINICAL STAFFING PLAN, THE CLINICAL STAFFING COMMITTEE SHALL CONSIDER:

(1) THE AVERAGE NUMBER OF PATIENTS ON EACH UNIT ON EACH SHIFT DURING THE IMMEDIATELY PRECEDING YEAR AND RELEVANT INFORMATION REGARDING PATIENT DISCHARGES, POTENTIAL ADMISSIONS, AND TRANSFERS;

(2) THE AVERAGE LEVEL OF ACUITY FOR PATIENTS ON EACH UNIT ON EACH SHIFT DURING THE IMMEDIATELY PRECEDING YEAR AND THE CORRESPONDING LEVEL OF NURSING CARE REQUIRED; AND

REPRINT OF SENATE BILL 411 as amended by SB0411/403529/1 02/11/26 at 11:25 AM

(3) AN ESTIMATE OF THE APPROPRIATE COMBINATION OF SKILL, EXPERIENCE LEVEL, AND SPECIALTY CERTIFICATION OR TRAINING OF STAFF FOR EACH UNIT ON EACH SHIFT THAT IS REQUIRED TO ADEQUATELY PROVIDE CARE.

19–395.

(A) ON OR BEFORE JANUARY 1 EACH YEAR, BEGINNING IN 2028, EACH HOSPITAL SHALL:

(1) IMPLEMENT THE CLINICAL STAFFING PLAN ADOPTED UNDER § 19–394 OF THIS SUBTITLE; AND

(2) ASSIGN PERSONNEL TO EACH PATIENT CARE UNIT IN ACCORDANCE WITH THE CLINICAL STAFFING PLAN.

(B) A REGISTERED NURSE, A LICENSED PRACTICAL NURSE, AN ANCILLARY MEMBER OF THE FRONTLINE TEAM, OR AN APPLICABLE EXCLUSIVE REPRESENTATIVE MAY SUBMIT A COMPLAINT TO THE CLINICAL STAFFING COMMITTEE REGARDING ANY VARIATION WHERE PERSONNEL ASSIGNMENT IN A PATIENT CARE UNIT IS NOT IN ACCORDANCE WITH THE ADOPTED CLINICAL STAFFING PLAN.

(C) THE CLINICAL STAFFING COMMITTEE SHALL DETERMINE, BY A MAJORITY VOTE, WHETHER A COMPLAINT HAS BEEN ADEQUATELY RESOLVED.

19–396.

(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, ON OR BEFORE JANUARY 1 EACH YEAR, EACH HOSPITAL SHALL:

(1) POST IN A PUBLICLY ACCESSIBLE AND CONSPICUOUS AREA ON EACH PATIENT UNIT THE CLINICAL STAFFING PLAN FOR THE UNIT AND THE ACTUAL DAILY STAFFING FOR EACH SHIFT ON THE UNIT; AND

(2) ENSURE THAT A COPY OF THE CLINICAL STAFFING PLAN IS AVAILABLE, ON REQUEST, ON EACH PATIENT UNIT.

(B) IF A CLINICAL STAFFING PLAN FOR A UNIT IS AMENDED AFTER IT IS IMPLEMENTED, THE HOSPITAL SHALL POST OR PROVIDE THE AMENDED CLINICAL STAFFING PLAN FOR THE UNIT IN THE MANNER REQUIRED UNDER SUBSECTION (A) OF THIS SECTION IN A TIMELY MANNER.

19–397.

REPRINT OF SENATE BILL 411 as amended by SB0411/403529/1 02/11/26 at 11:25 AM

(A) ON OR BEFORE JULY 1 EACH YEAR, BEGINNING IN 2030, EACH HOSPITAL LICENSED UNDER THIS TITLE SHALL SUBMIT A REPORT TO THE MARYLAND HEALTH CARE COMMISSION SUMMARIZING HOW THE HOSPITAL'S CLINICAL STAFFING COMMITTEE HAS ADDRESSED SAFE HOSPITAL STAFFING THROUGH THE HOSPITAL'S CLINICAL STAFFING PLAN DURING THE IMMEDIATELY PRECEDING YEAR.

(B) THE MARYLAND HEALTH CARE COMMISSION SHALL:

(1) COMPILE THE REPORTS SUBMITTED UNDER SUBSECTION (A) OF THIS SECTION; AND

(2) MAKE THE COMPILED REPORT PUBLICLY AVAILABLE BY PUBLISHING THE COMPILATION ON ~~THE MAIN PAGE OF~~ ITS WEBSITE.

SECTION 2. AND BE IT FURTHER ENACTED, That each hospital shall establish a clinical staffing committee as required under § 19–394 of the Health – General Article, as enacted by Section 1 of this Act, on or before January 1, 2027.

SECTION 3. AND BE IT FURTHER ENACTED, That each clinical staffing committee shall develop a clinical staffing plan as required under § 19–394 of the Health – General Article, as enacted by Section 1 of this Act, on or before July 1, 2027.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2026.

FinalReprint.pdf
Uploaded by: Elias Khan
Position: FWA

SENATE BILL 411

J1 6lr2317
CF 6lr2315

By: **Senators Augustine, Hettleman, Kramer, and McCray**
Introduced and read first time: January 29, 2026
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Hospitals – Clinical Staffing Committees and Plans – Establishment
(Safe Staffing Act of 2026)

FOR the purpose of requiring certain hospitals licensed in the State to establish and maintain a clinical staffing committee and to implement a clinical staffing plan; requiring each clinical staffing committee to develop a clinical staffing plan; and generally relating to hospitals and clinical staffing committees and plans.

BY adding to
Article – Health – General
Section 19–393 through 19–397 to be under the new part "Part XIII. Clinical Staffing Committees and Plans"
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–391. RESERVED.

19–392. RESERVED.

PART XIII. CLINICAL STAFFING COMMITTEES AND PLANS.

19–393.

(A) IN THIS PART THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

REPRINT OF SENATE BILL 411 as amended by SB0411/773722/1 02/11/26 at 1:52 PM

(B) (1) "ANCILLARY MEMBER OF THE FRONTLINE TEAM" MEANS AN INDIVIDUAL WHOSE PRIMARY DUTIES INCLUDE SUPPORTING INDIVIDUALS WHO PROVIDE DIRECT PATIENT CARE.

(2) "ANCILLARY MEMBER OF THE FRONTLINE TEAM" INCLUDES:

(I) A DIETARY WORKER;

(II) A PATIENT CARE TECHNICIAN; AND

(III) ANY OTHER NONLICENSED STAFF ASSISTING WITH PATIENT CARE.

(C) "CLINICAL STAFFING COMMITTEE" MEANS A COMMITTEE ESTABLISHED BY A HOSPITAL IN ACCORDANCE WITH SUBSECTION (C) OF THIS SECTION.

(D) "CLINICAL STAFFING PLAN" MEANS A PLAN DEVELOPED UNDER SUBSECTION (D) OF THIS SECTION.

19–394.

(A) THIS PART DOES NOT APPLY TO STATE HOSPITALS.

(B) (1) EACH HOSPITAL LICENSED UNDER THIS TITLE SHALL ESTABLISH AND MAINTAIN A CLINICAL STAFFING COMMITTEE THAT HAS EQUAL MEMBERSHIP FROM MANAGEMENT AND EMPLOYEES.

(2) EACH CLINICAL STAFFING COMMITTEE ESTABLISHED UNDER THIS PART SHALL INCLUDE AT LEAST ONE OF THE FOLLOWING INDIVIDUALS:

(I) A CERTIFIED NURSING ASSISTANT;

(II) A DIETARY AIDE;

(III) AN EMERGENCY ROOM NURSE;

(IV) AN ENVIRONMENTAL SERVICE WORKER;

(V) A RESIDENT, IF THE COMMITTEE IS IN A TEACHING HOSPITAL;

(VI) A STAFF PHYSICIAN WHO IS NOT A HOSPITAL EMPLOYEE OR ADMINISTRATOR; ~~AND~~

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(VII) A STAFF REGISTERED NURSE WHO IS NOT AN EMERGENCY ROOM NURSE; AND

(VIII) A TECHNICIAN.

(3) A CLINICAL STAFFING COMMITTEE ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY INCLUDE A PATIENT ADVOCATE.

(C) EACH CLINICAL STAFFING COMMITTEE SHALL DEVELOP A CLINICAL STAFFING PLAN THAT MEETS PATIENT NEEDS.

(D) WHEN DEVELOPING A CLINICAL STAFFING PLAN, THE CLINICAL STAFFING COMMITTEE SHALL CONSIDER:

(1) EXISTING STAFFING LEVELS;

(2) METHODS TO SECURE COVERAGE NEEDS AS NECESSARY;

(3) EXISTING GAPS IN STAFFING AND HOW TO ADDRESS THE GAPS;

(4) ANY AVAILABLE EVIDENCE–BASED STAFFING STANDARDS; AND

(5) A SCHEDULE FOR PERIODIC REVIEW OF THE STAFFING PLAN.

(E) ON OR BEFORE JULY 1 EACH YEAR, EACH HOSPITAL, THROUGH THE CLINICAL STAFFING COMMITTEE, SHALL CONDUCT A REVIEW OF THE CLINICAL STAFFING PLAN TO:

(1) EVALUATE THE EFFECTIVENESS OF THE CLINICAL STAFFING PLAN DURING THE IMMEDIATELY PRECEDING YEAR;

(2) UPDATE THE CLINICAL STAFFING PLAN TO ENSURE THAT THE CLINICAL STAFFING PLAN CONTINUES TO BE APPROPRIATE AND EFFECTIVE; AND

(3) DEVELOP A PROCESS FOR RECEIVING, RESOLVING, AND TRACKING COMPLAINTS RELATED TO THE CLINICAL STAFFING PLAN.

(F) IN DEVELOPING THE CLINICAL STAFFING PLAN, THE CLINICAL STAFFING COMMITTEE SHALL CONSIDER:

(1) THE AVERAGE NUMBER OF PATIENTS ON EACH UNIT ON EACH SHIFT DURING THE IMMEDIATELY PRECEDING YEAR AND RELEVANT INFORMATION REGARDING PATIENT DISCHARGES, POTENTIAL ADMISSIONS, AND TRANSFERS;

(2) THE AVERAGE LEVEL OF ACUITY FOR PATIENTS ON EACH UNIT ON EACH SHIFT DURING THE IMMEDIATELY PRECEDING YEAR AND THE CORRESPONDING LEVEL OF NURSING CARE REQUIRED; AND

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(3) AN ESTIMATE OF THE APPROPRIATE COMBINATION OF SKILL, EXPERIENCE LEVEL, AND SPECIALTY CERTIFICATION OR TRAINING OF STAFF FOR EACH UNIT ON EACH SHIFT THAT IS REQUIRED TO ADEQUATELY PROVIDE CARE.

19–395.

(A) ON OR BEFORE JANUARY 1 EACH YEAR, BEGINNING IN 2028, EACH HOSPITAL SHALL:

(1) IMPLEMENT THE CLINICAL STAFFING PLAN ADOPTED UNDER § 19–394 OF THIS SUBTITLE; AND

(2) ASSIGN PERSONNEL TO EACH PATIENT CARE UNIT IN ACCORDANCE WITH THE CLINICAL STAFFING PLAN.

(B) A REGISTERED NURSE, A LICENSED PRACTICAL NURSE, AN ANCILLARY MEMBER OF THE FRONTLINE TEAM, OR AN APPLICABLE EXCLUSIVE REPRESENTATIVE MAY SUBMIT A COMPLAINT TO THE CLINICAL STAFFING COMMITTEE REGARDING ANY VARIATION WHERE PERSONNEL ASSIGNMENT IN A PATIENT CARE UNIT IS NOT IN ACCORDANCE WITH THE ADOPTED CLINICAL STAFFING PLAN.

(C) THE CLINICAL STAFFING COMMITTEE SHALL DETERMINE, BY A MAJORITY VOTE, WHETHER A COMPLAINT HAS BEEN ADEQUATELY RESOLVED.

19–396.

(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, ON OR BEFORE JANUARY 1 EACH YEAR, EACH HOSPITAL SHALL:

(1) POST IN A PUBLICLY ACCESSIBLE AND CONSPICUOUS AREA ON EACH PATIENT UNIT THE CLINICAL STAFFING PLAN FOR THE UNIT AND THE ACTUAL DAILY STAFFING FOR EACH SHIFT ON THE UNIT; AND

(2) ENSURE THAT A COPY OF THE CLINICAL STAFFING PLAN IS AVAILABLE, ON REQUEST, ON EACH PATIENT UNIT.

(B) IF A CLINICAL STAFFING PLAN FOR A UNIT IS AMENDED AFTER IT IS IMPLEMENTED, THE HOSPITAL SHALL POST OR PROVIDE THE AMENDED CLINICAL STAFFING PLAN FOR THE UNIT IN THE MANNER REQUIRED UNDER SUBSECTION (A) OF THIS SECTION IN A TIMELY MANNER.

19–397.

REPRINT OF SENATE BILL 411 as amended by SB0411/773722/1 02/11/26 at 1:52 PM

(A) ON OR BEFORE JULY 1 EACH YEAR, BEGINNING IN 2030, EACH HOSPITAL LICENSED UNDER THIS TITLE SHALL SUBMIT A REPORT TO THE MARYLAND HEALTH CARE COMMISSION SUMMARIZING HOW THE HOSPITAL'S CLINICAL STAFFING COMMITTEE HAS ADDRESSED SAFE HOSPITAL STAFFING THROUGH THE HOSPITAL'S CLINICAL STAFFING PLAN DURING THE IMMEDIATELY PRECEDING YEAR.

(B) THE MARYLAND HEALTH CARE COMMISSION SHALL:

(1) COMPILE THE REPORTS SUBMITTED UNDER SUBSECTION (A) OF THIS SECTION; AND

(2) MAKE THE COMPILED REPORT PUBLICLY AVAILABLE BY PUBLISHING THE COMPILATION ON THE MAIN PAGE OF ITS WEBSITE.

SECTION 2. AND BE IT FURTHER ENACTED, That each hospital shall establish a clinical staffing committee as required under § 19–394 of the Health – General Article, as enacted by Section 1 of this Act, on or before January 1, 2027.

SECTION 3. AND BE IT FURTHER ENACTED, That each clinical staffing committee shall develop a clinical staffing plan as required under § 19–394 of the Health – General Article, as enacted by Section 1 of this Act, on or before July 1, 2027.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2026.

MNA Favorable W_ Amendments on Safe Staffing.pdf
Uploaded by: Jamie DeMarco
Position: FWA

Committee: Senate Finance

Bill Number: SB411 Safe Staffing Act

Date: February 17th, 2026

Position: Favorable with Amendments

Dear Beidle, Vice-Chair Hayes, and members of the Finance Committee,

The Maryland Nurses Association urges a **Favorable Report on SB411 with the sponsor's amendments**.

The Maryland Nurses Association celebrates the work of the Joint Commission and the release of their National Performance Goals in January. Our national affiliate, the American Nurses Association, worked with the Joint Commission and we celebrate the safe staffing standards Hospitals will now be required to meet. We believe that The Maryland Safe Staffing Act will help hospitals to create and implement effective plans to meet the requirements set forward by the Joint Commission.

As the frontline workers in a hospital, nurses have valuable insights into how staffing policy should be set in order to improve operations and patient outcomes. A widely cited empirical analysis found that hospitals "where front-line staff nurses held positions on organizational committees with the power to influence institutional policies and decisions" were "significantly less likely to report unfavorable job outcomes and poor ratings of quality and safety." The analysis also found that "Higher levels of nurse engagement were associated with higher Hospital Consumer Assessment of Healthcare Providers and Systems scores."[1]

SB411 simply requires that each hospital create a committee made up in part of management and in part of frontline staff workers, including nurses. Together this committee makes recommendations for staffing plans. The hospital then reviews this staffing plan, makes changes to it, and submits the final plan to the state. The Maryland Nurses Association considers this to be a reasonable requirement that is likely to benefit our members and everyone in the hospital system. Seeking the input of staff who interface directly with the operations of the business is well understood to improve business operations for both staff and patrons.

The Maryland Nurses Association is not a union, and we represent nurses who are not part of a union. We do not see SB411 as a union bill. In fact, our members who are not part of a union may benefit the most from this legislation because they currently lack any direct negotiating power with the leadership team in hospitals. SB411 gives our members a voice in hospital staffing policy without those members needing to form a union.

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC5117656/

A 2024 report from the Maryland Hospital Association found that Maryland has the longest Emergency Room wait times in the country.[2] This is despite the fact that according to Becker's Hospital Review, Maryland has fewer per capita Emergency Room visits than 46th other states.[3] Incorporating the input of frontline hospital staff, including nurses, will improve staffing policy, quality of life for our members, and patient outcomes.

The Maryland Nurses Association is grateful to the Sponsor for accepting our requested amendment to include a staff Registered Nurse in addition to a hospital room nurse in the staffing committee. With this sponsor amendment the Maryland Nurses Association is in support of SB411.

Respectfully,

Jamie DeMarco
Registered Lobbyist,
Maryland Nurses Association
jamie@demarcoadvocacy.com
https://www.marylandrn.org/

[2] https://mhaonline.org/wp-content/uploads/2024/05/maryland-general-assembly-hospital-throughput-work-group-final-report---march-2024.pdf

[3] https://www.beckershospitalreview.com/rankings-and-ratings/ed-visits-per-1000-population-by-state-2/

2026 SB411 NAPNAP.docx.pdf
Uploaded by: JD Murphy
Position: FWA

February 13, 2026

Maryland Senate
Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Dear Honorable Chair, Vice-Chair, and Members of the Committee:

On behalf of the pediatric nurse practitioners (PNPs) and fellow pediatric-focused advanced practice registered nurses (APRNs) of the National Association of Pediatric Nurse Practitioners (NAPNAP) Maryland Chesapeake Chapter, we are writing to express our **support with amendment for Senate Bill 411 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026).**

We enthusiastically support this bill which would create committees of vital members of hospital staff, to determine appropriate staffing requirements. The establishment of clinical staffing committees crucial to addressing the complexities of patient care. It is essential that clinical staffing committees include diverse perspectives from a range of healthcare providers to ensure well-rounded decision-making. To enhance the effectiveness of these committees, we propose an amendment to SB 411 to include an Advanced Practice Provider (APP) as a required member of the clinical staffing committee. Advanced Practice Providers, including Nurse Practitioners and Physician Assistants, play a vital role in patient care across various settings, and their inclusion on the committee would provide critical insights into the staffing needs and challenges faced by healthcare teams. Many APPs function in front-line provider roles which are not represented by the "staff physician" or "nurse" roles listed. We believe that including an APP on the committee aligns with the goals of the Safe Staffing Act to foster collaboration and result in better patient outcomes. It is vital that staffing decisions are informed by a comprehensive understanding of the diverse roles within healthcare teams, including those of Advanced Practice Providers.

For these reasons, the Maryland Chesapeake Chapter of NAPNAP extends their support with amendment for SB 411 Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026) and requests a favorable report.

The pediatric advanced practice nurses of your state are grateful to you for your attention to these crucial issues. The Maryland Chapter of NAPNAP membership includes over 200 primary and acute care pediatric nurse practitioners who are committed to improving the health and advocating for our state's pediatric patients. If we can be of any further assistance, or if you have any questions, please do not hesitate to contact the Maryland Chapter legislative chair, Dr. JD Murphy, at mdchesnapnapleg@outlook.com.

Sincerely,

Dr. Jessica D. Murphy DNP, CPNP-AC, CPHON, CNE
Maryland Chapter Legislative Chair

Dr. Evgenia Ogorodova DNP, CPNP-PC
Chapter Legislative Co-Chair

Dr. Yvette Laboy DNP, CPNP-AC, CCRN, CPN; Chapter President

Ms. Lindsay Ward MSN, CPNP-PC, IBCLC; Immediate Past-President

Dr. Samantha Hoffman DNP, MS, CPNP-PC; Chapter President-elect

SB411.HB624 Letter of Support with amendments 2026

Uploaded by: Malinda Duke

Position: FWA

NURSE PRACTITIONER
Association of Maryland

"Advocating for NPs in Maryland since 1992"

February 11, 2026

Bill: SB 411/HB 624 Hospitals – Clinical Staffing Committees and Plans (Safe Staffing Act of 2026)
Position: Support with Amendments

Dear Chair and Members of the Committee,

On behalf of the Nurse Practitioner Association of Maryland (NPAM), representing over 850 active members, and the 8,500 Nurse Practitioners licensed to practice in Maryland, I am writing to state support for SB 411/ HB 624 – Hospitals – Clinical Staffing Committees and Plans (Safe Staffing Act of 2026) with the following amendments.

We commend the sponsors for their efforts in addressing this important issue related to clinical staffing. As healthcare providers who often are employed in hospital settings and are an essential part of the healthcare team, we respectfully request an amendment to this bill to include a Nurse Practitioner (NP) to the list of those on the Clinical Staffing Committee.

Nurse practitioners (NPs) are advanced practice registered nurses, have advanced clinical training and education, and practice independently in Maryland. In both in-patient and out-patient settings, NPs participate in the healthcare team, deliver cost-effective, high-quality healthcare services to patients, and would contribute positively as a member of the Clinical Staffing Committee.

For these reasons, we respectfully request you support this bill with the above amendments. If you have any questions, please feel free to contact me at NPAMexecdir@gmail.com

Sincerely,
Beverly Lang MScN, RN, ANP-BC, FAANP
Executive Director,
Nurse Practitioner Association of Maryland Inc.
Office: 443-367-0277
NPAMexecdir@gmail.com

LBH UNF Senate Bill 411 Hospitals Clinical Staff
Uploaded by: Amanda Shrout
Position: UNF

LIFEBRIDGE HEALTH®

CARE BRAVELY

Date: February 17, 2026
To: Chair Beidle, Vice Chair Hayes, and Members of the Senate Finance Committee
Re: Senate Bill 411 – Hospitals – Clinical Staffing Committees and Plans
Position: Unfavorable

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

On behalf of LifeBridge Health, a regional health system serving Central Maryland, we respectfully request an unfavorable report on Senate Bill 411. LifeBridge Health shares the Committee's commitment to ensuring safe, high-quality patient care and supporting our nursing workforce. However, SB 411 establishes a prescriptive statutory staffing framework that conflicts with existing federal requirements, newly enhanced national accreditation standards, and the evidence-based, acuity-driven staffing models currently in place across Maryland hospitals.

Effective January 1, 2026, The Joint Commission elevated nurse staffing to a National Performance Goal (NPG 12), further strengthening national oversight of how hospitals determine and evaluate nurse staffing in acute care settings. Under NPG 12, accredited hospitals must:

- Utilize a formal, evidence-based methodology to determine nurse staffing based on patient acuity, complexity, and care needs.
- Incorporate real-time clinical judgment in staffing adjustments.
- Engage frontline nurses in the staffing evaluation process.
- Continuously monitor, evaluate, and improve staffing effectiveness using quality and safety data.

All Maryland acute care hospitals maintain Joint Commission accreditation and are inspected on an ongoing basis. These enhanced national standards create a uniform, enforceable framework that ensures staffing decisions are data-driven, acuity-based, and continuously evaluated for quality and safety outcomes. By codifying a rigid committee and plan structure in statute, SB 411 risks creating conflicting requirements that could undermine compliance with NPG 12 and federal Conditions of Participation (CoPs) under the Centers for Medicare & Medicaid Services (CMS). CMS regulations already require hospitals to maintain recommended number of licensed nurses and other personnel to provide 24-hour care consistent with patient needs and complexity.

A legislatively mandated, house-wide staffing committee model cannot replicate the granularity of unit-based, acuity-driven decision-making that occurs continuously at the bedside. Staffing must remain flexible and responsive to rapidly changing clinical conditions, emergency department surges, seasonal respiratory illness patterns, and specialty-specific care needs.

Staffing levels are evaluated at the departmental level with the 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. 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.

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 assessed to identify trends and anticipate changes in patient care needs, allowing us to adjust to needs.

Clinical team members must develop clinical staffing plans. 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 determined by clinical personnel while non-clinical staff can inform non-clinical staffing. LifeBridge Health 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.

SB 411 includes reporting and posting provisions that raise operational and security concerns. Hospitals across Maryland continue to experience rising incidents of workplace violence. Publicly posting detailed staffing information or internal operational data may unintentionally increase safety risks for both staff and patients.

LifeBridge Health supports strong nurse and staff engagement, transparency, and evidence-based staffing. We have embedded these principles within our shared governance model and align fully with CMS Conditions of Participation and The Joint Commission's enhanced National Performance Goal on nurse staffing. For these reasons, we believe SB 411 is unnecessary, duplicative of strengthened federal and national accreditation requirements, and risks impairing hospitals' ability to staff patient care units dynamically and safely. **Accordingly, we respectfully request an unfavorable report on Senate Bill 411.**

Amanda Shrout, DNP, RN, CCNS, CEN, EBP-C, CENP
Vice President, Patient Care Services and Chief Nursing Officer
Sinai Hospital| Grace Medical Center| Baltimore 410-601-9409 ashrout@lifebridgehealth.org

Jennifer Witten-Vice President Government Relations 505-688-3495 jwitten@2@lifebridgehealth.org

Sinai Hospital of Baltimore District 41
Grace Medical Center Baltimore District 40
Northwest Hospital Baltimore County District 10 & 11
Carroll Hospital District 5 & 42

MONL Testimony 2026 FINAL.pdf
Uploaded by: Amy Alsante
Position: UNF

In Opposition to Senate Bill 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)

Submitted by: Maryland Organization of Nurse Leaders (MONL)

Position: ***OPPOSE***

February 17, 2026

Senate Finance Committee

Chair, Vice Chair, and Members of the Committee:

Position

On behalf of the **Maryland Organization of Nurse Leaders (MONL)** we appreciate the opportunity to comment on the ***opposition to Senate Bill 411/ HB 624***.

The Maryland Organization of Nurse Leaders is a statewide community of 277 nurse executives, directors, managers, educators, and emerging leaders representing acute care hospitals, academic medical centers, community hospitals, ambulatory, and post-acute settings across Maryland.

We respectfully oppose SB 411 / HB 624.

1) Staffing Committees and strict staffing plans do not address the underlying nursing shortage, and can reduce access to care

Maryland, like the nation, is navigating a prolonged nurse workforce challenge. The American Organization of Nurse Leaders (AONL) notes that staffing committees and strict written staffing plans do not guarantee more nurses and have not shown to be stronger or improve outcomes, and can force hospitals that cannot meet written staffing plan minimums to **close beds, divert patients, or delay care**, reducing access to care for Maryland communities.

2) Unintended consequences will include closed beds, service limitations, ED crowding, and heightened risk for workplace violence against health care workers

When inpatient beds are closed, or services are reduced to meet written staffing plan minimums, **emergency department (ED) boarding and crowding** predictably worsen—leading to longer waits, degraded patient experience, and operational strain. ED crowding is a **patient safety crisis**, and

multiple studies link crowding and prolonged boarding to **increased risks of workplace violence** toward staff.

Downstream effects we anticipate if SB 411 / HB 624 pass include:

- **Longer ED wait times** and **increased ED boarding** due to fewer staffed inpatient beds;
- **More crowded EDs** because EDs cannot turn patients away; and
- **Higher instances of workplace violence** in crowded ED environments.

3) The bill is redundant with additional Joint Commission regulatory oversight now in effect with National Performance Goal 12 (NPG 12)- Effective January 1, 2026.

Effective **January 1, 2026**, The Joint Commission (TJC) elevated **Nurse Staffing** to **National Performance Goal (NPG) #12: Health Professional Resource Management**, requiring leadership accountability and **nurse executive oversight** of staffing plans, competency, and safe, quality care **across the organization**. These expectations supplement CMS Conditions of Participation and require **data-driven, ongoing performance improvement**—including evaluation of staffing adequacy when trends or variations exist. This **independent, external oversight** already holds CNOs and hospital leadership accountable without written staffing plans or additional administrative oversight, making the proposed legislation **duplicative**.

4) Flexibility is essential during surges, disasters, and other crises

Maryland hospitals must be able to **flex staffing in real time** to respond to **storm-related surges, infectious disease outbreaks, mass casualty events, and seasonal variation**. Fixed numerical staffing plans risk **hindering surge response**, when rapid redeployment, innovative care models, and temporary practice adjustments are critical to sustaining access and safety. TJC's NPG 12 specifically expects leaders to evaluate and adapt care models (e.g., **virtual nursing**)—the kind of agility that written, numeric static staffing plans constrain.

5) Flexibility in staffing and scheduling is a proven recruitment and retention strategy

To stabilize Maryland's nursing workforce, organizations need the ability to **offer flexible schedules and models of care** that attract and retain nurses at different life stages and experience levels. Prescriptive written staffing plans can **limit creative scheduling,** used by high-performing organizations to improve well-being, autonomy, job satisfaction, and unit stability while maintaining safe and high-quality patient care,

6) Shared governance: Staff have a voice in staffing

Maryland has a strong culture of **shared governance**, particularly among Magnet-designated organizations, where **nurses at all levels have a formal voice** in decisions about practice, staffing, resources, and quality. Shared governance is a hallmark of Magnet culture and a core element of professional nursing practice that **elevates outcomes and engagement**. MONL supports **staffing committees and shared decision-making** structures that keep decision authority **with frontline nurses and nurse leaders**, not statutory numeric formulas.

Context: 30% of acute care hospitals (12 hospitals) in Maryland hold a Magnet designation. The national average is 10%. Four hospitals have the Pathways to Excellence designation. Ten hospitals are planning to pursue Magnet or Pathways in the next two years. These designations prioritize shared governance and support for the nursing workforce. reflecting the state's strong commitment to professional governance and nursing/organizational excellence.

7) Safe staffing is complex and requires nursing clinical judgment and critical thinking

Safe staffing is dynamic, grounded in real-time professional nursing judgment that considers patient acuity, care complexity, team skill mix and experience, unit layout and workflow, available technology, and interprofessional resources. This legislation would replace clinical judgment with a fixed formula and shift authority away from nurse leaders and direct-care nurses who are best positioned to align staffing with patient needs. Nationally, the American Organization for Nursing Leadership (AONL) has stated that strict written staffing plans and staffing committees are not the answer and that staffing should be determined by nursing leaders in collaboration with front-line, direct-care nurses.

What MONL Supports (Constructive Alternatives)

- **Acuity- and competency-based staffing plans** are owned by **nurse executives, managers, and direct-care nurses**, with transparent metrics, collaboration, and continuous quality improvement—rather than additional administrative burdens of Staffing committees and fixed written staffing plans.
- **Strengthening shared governance** ensuring frontline staff have a voice and participate in staffing decisions and accountability for outcomes.
- **Leveraging innovation and team-based care** (e.g., virtual nursing, optimized skill mix, interprofessional models) to improve safety and efficiency.
- **Full adherence to The Joint Commission's NPG 12** expectations for leadership oversight, RN presence and supervision, competency assurance, and ongoing staffing evaluation.

Conclusion

For these reasons, the **Maryland Organization of Nurse Leaders respectfully urges an unfavorable report on SB 411 / HB 624**.

Safe staffing is **essential**—and is best achieved through **nursing clinical judgment, shared governance, flexible and evidence-based staffing plans, and robust accountability mechanisms** already in place with **The Joint Commission's National Performance Goal 12**—not through mandated staffing committees and staffing plans that may compromise access to patient care, ED flow, and clinician safety.

Thank you for the opportunity to testify.
Maryland Organization of Nurse Leaders (MONL)
mdnurseleaders@gmail.com

Name: Christine Frost
Title: Chief Nursing Officer/Vice-President of Nursing, Luminis Health Anne Arundel Medical Center
Credentials: DNP, RN, MBA, NEA-BC
MONL Board Role: President

Name: Amy Alsante
Title: Chief Nursing Officer, Sunburst/Amergis Workforce
Credentials: DNP, RN, NE-BC, CHEP, LSSGB
MONL Board Role: President-Elect

Name: Mandy Bounds
Title: Vice-President, Patient Care Services/Chief Nursing Officer, Atlantic General Hospital/Health System
Credentials: DNP, RN, CCRN, CPHQ
MONL Board Role: Secretary

Name: Meredith Cornett
Title: Senior Director of Surgical Services, Luminis Health Anne Arundel Medical Center
Credentials: RN, MBA-HCA, BSN, CNOR, NE-BC
MONL Board Role: Treasurer

Name: Katelyn Quarry
Title: Assistant Clinical Professor, Nursing/ Assistant Director, BSN Program, Loyola University Maryland
Credentials: DNP, RN, CCRN, CNE
MONL Board Role: Member-at-Large

Name: Quinn Collins
Title: Executive Director, Nursing Strategy and Integration, Johns Hopkins Health System
Credentials: DNP, RN, NE-BC
MONL Board Role: Member-at-Large

Name: Margo Mancl
Title: Senior Director of Nursing Operations & Patient Care Services, MedStar Franklin Square Medical Center
Credentials: DNP, RN, NEA-BC
MONL Board Role: Member-at-Large

Name: Barbara Buckley
Title: Nurse Manager, Neonatal Intensive Care Unit, Johns Hopkins Children's Center
Credentials: MSN, RN, NE-BC, ANLC-N
MONL Board Role: Member-at-Large

Name: Shellie Williams
Title: Chief Nursing Officer/Vice-President of Nursing
Credentials: MSN, MHA, RN, CRRN
MONL Board Role: Member-at-Large

Clinical Staffing Commitments one pager.pdf
Uploaded by: Andrew Nicklas
Position: UNF

Maryland Hospitals' Clinical Staffing Commitments

Maryland Hospital Association

Maryland's hospitals are dedicated to delivering the highest quality health care to the community. This cannot happen without supporting the heartbeat of the hospital – the workforce. Following the conclusion of the 2025 legislative session, the Maryland Hospital Association (MHA) convened a work group of hospital representatives to examine how staffing decisions are made, the current regulations that guide these decisions, and ways that hospitals are supporting their workforce. MHA also surveyed Chief Nursing Officers across acute and specialty hospitals to understand their approach to staffing and staff well-being. Using this information, the work group identified opportunities to build on existing efforts to empower staff, elevate their voice in staffing decisions, and improve their well-being. This report and the following Clinical Staffing Commitments are the culmination of these efforts.

MHA member hospitals commit to adopt the following framework to enhance collaboration between frontline clinical staff and hospital leadership, while allowing flexibility for individual hospitals to implement these actions in a manner that is appropriate to their unique culture, organizational structure, and patient population.

MHA member hospitals will:

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- Provide a readily available, anonymous system to solicit staff feedback
- Participate in forums hosted by the Maryland Hospital Association to share progress on implementation of these efforts

Hospital Endorsements

Maryland
Hospital Association

Clinical Staffing Report December 2025.pdf
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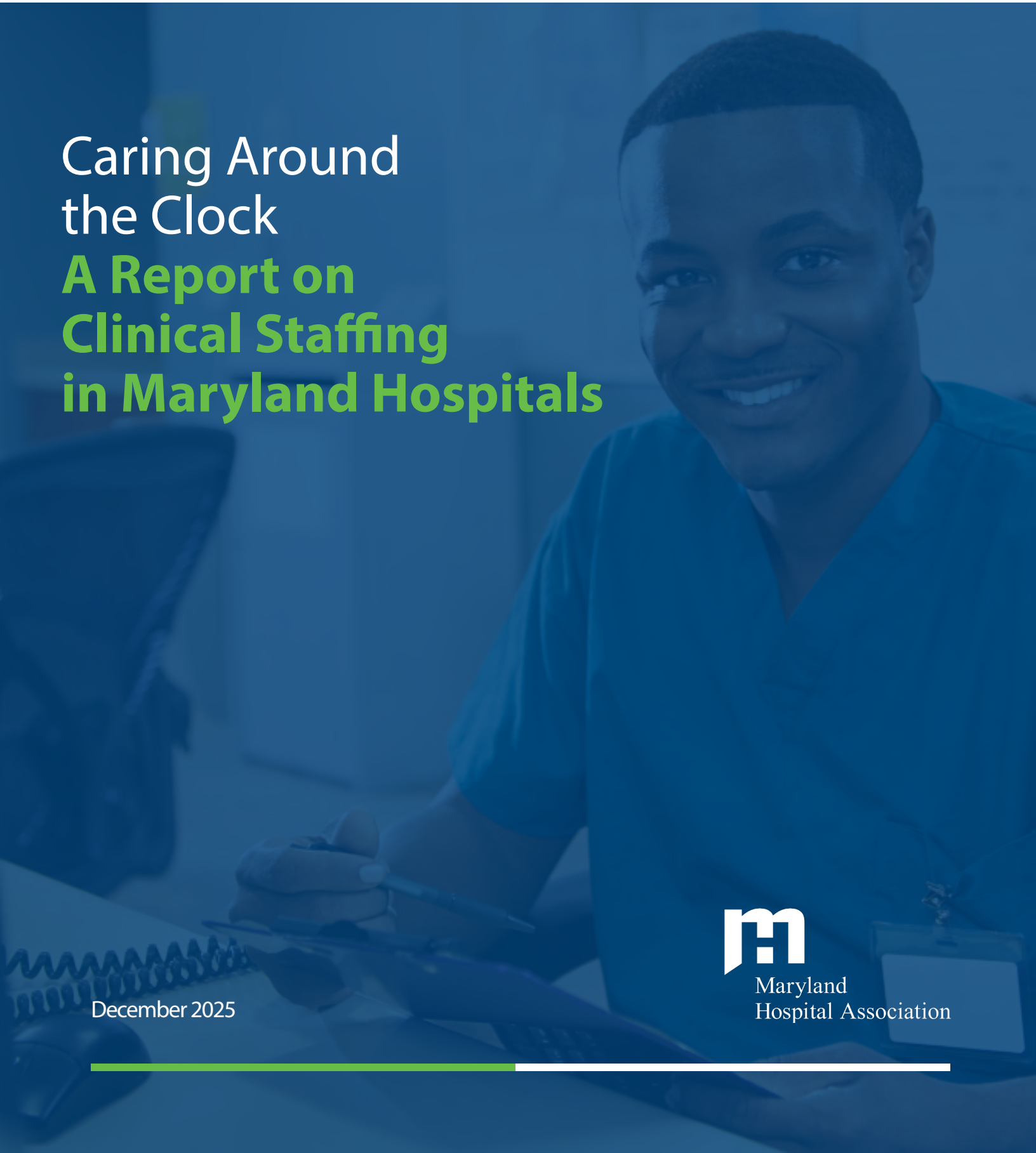

Caring Around the Clock

A Report on Clinical Staffing in Maryland Hospitals

December 2025

Maryland Hospital Association

Maryland
Hospital Association

Table of Contents

Executive Summary

Staffing hospitals safely and effectively every hour of the day is one of health care's greatest challenges. An aging population and rising rates of complex conditions are driving increased demand for hospital care. At the same time, hospitals nationwide continue to face persistent workforce shortages.

Maryland hospitals and health systems have responded with a variety of strategies, giving caregivers a direct role in staffing decisions to align teams with patient needs and, at the same time, making long-term investments in their workforce.

This report offers a behind-the-scenes look at how team-based staffing decisions are made, the requirements that guide them, and the innovative strategies hospitals use to bolster safety, retention, and satisfaction.

In summer 2025, the Maryland Hospital Association (MHA) surveyed chief nursing officers (CNOs) at acute and specialty hospitals across the state about their approach to staffing. MHA received responses from 37 hospitals with details about how they strengthen and sustain hospitals' clinical workforce.

The survey showed that hospitals adapt their unique organizational structure, workforce dynamics, and patient care priorities to ensure adequate staffing that meets real-time patients' needs. Maryland CNOs reported using a combination of tools and strategies, including staffing matrices and grids, self-scheduling tools, and clinical team huddles to appropriately account for patient care needs, while allowing staff flexibility and autonomy in scheduling decisions. In addition, hospitals and health systems have embraced shared governance principles to enhance both daily operational decision-making and long-term strategic planning.

These models allow nurses and other health care professionals to engage in the full spectrum of decision-making, through participation in unit-level, department-level, and hospital/system-level committees.

CNOs also identified several ways the state could strengthen the health care workforce including:

- More support for nurse residency and externship programs
- Increased funding for hospitals to recruit, train, and retain health care staff
- Investment in education and training programs
- Improved placement/treatment options for complex behavioral health patients, leading to lower risk of violence against staff

The survey also revealed opportunities for hospitals to continue to build on existing efforts to engage frontline staff and provide transparency in the staffing and scheduling process. (See page 8 for a detailed breakdown of the survey results). To that end, MHA member hospitals have agreed to voluntarily adopt a framework to increase staff engagement.

MHA Clinical Staffing Commitments

Endorsed by Hospitals Across Maryland

Maryland's hospitals are dedicated to delivering the highest quality health care to the community. This cannot happen without supporting the heartbeat of the hospital – the workforce. Following the conclusion of the 2025 legislative session, the Maryland Hospital Association (MHA) convened a work group of hospital representatives to examine how staffing decisions are made, the current regulations that guide these decisions, and ways that hospitals are supporting their workforce. MHA also surveyed chief nursing officers across acute and specialty hospitals to understand their approach to staffing and staff well-being. Using this information, the work group identified opportunities to build on existing efforts to empower staff, elevate their voice in staffing decisions, and improve their well-being. This report and the following Clinical Staffing Commitments are the culmination of these efforts.

MHA member hospitals commit to adopt the following framework to enhance collaboration between frontline clinical staff and hospital leadership, while allowing flexibility for individual hospitals to implement these actions in a manner that is appropriate to their unique culture, organizational structure, and patient population.

MHA member hospitals will:

- Include efforts to continuously improve staff engagement and work-life balance as part of the hospital's annual operating plans.
    - Engage frontline clinical staff in developing staffing plans and policies
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Hospital Endorsements

Introduction

Maryland is home to more than 60 nonprofit hospitals in almost every one of the state's 24 jurisdictions. Hospitals not only provide life-saving care 24/7/365, but they also are economic engines in their communities, employing more than 168,000 people.[1]

"No single method, model, or assessment tool ... has provided sufficient evidence to be considered optimal in all settings and all situations. Any approach to determining appropriate nurse staffing levels, therefore, must consider all the elements affecting care within the individual practice setting."

- American Nurses Association, 2019 [2]

Hospitals are among the few organizations that face the challenge of maintaining constant operations. They cannot close to celebrate a holiday, when there is severe weather, or if employees call out sick. This requires intentionality and flexibility to maintain operations and to adhere to the accreditation and regulatory standards required to ensure patient safety, quality care, and a supportive work environment.

In 2021, when Maryland hospitals faced the most critical staffing shortage in recent memory due to COVID-19, MHA launched the Task Force on Maryland's Future Health Care Workforce. The Task Force proposed a strategy to build a sustainable health care workforce through:

- Acute care certified nursing assistant training programs
- Apprenticeship opportunities to upskill non-clinical staff
- Community colleges and high school partnerships to grow the workforce pipeline
- International recruitment

Since a peak in 2022, employee vacancy rates have declined.[3] However, staff turnover, an aging workforce, and an increase in patient acuity continue to make daily staffing a challenge. Nurses and nursing support staff make up more than 40% of Maryland's hospitals workforce.[4]

[1] https://mhaonline.org/wp-content/uploads/2025/06/Economic-Impact-2-pager-FINAL.pdf [2] Ibid [3] MHA Workforce Survey – April 2025. NOTE: Q4 2024 data represents 90% Survey Response Rate; 47 of 52 hospitals. [4] MHA Workforce Survey – April 2025. NOTE: Q4 2024 data represents 90% Survey Response Rate; 47 of 52 hospitals.

Based on MHA's quarterly workforce survey, in Q4 2024, there were 20,244 full time RNs, 17,665 full time LPNs and 7,090 full time nursing support staff working in Maryland hospitals. Estimates suggest that by 2035, an estimated 13,800 additional full-time RNs and 9,200 full-time LPNs will be needed to meet Maryland's needs. Based on the current supply, the RN workforce will only be sufficient to meet about 80% of demand in 2035 and for LPNs that number drops to 44%.[5]

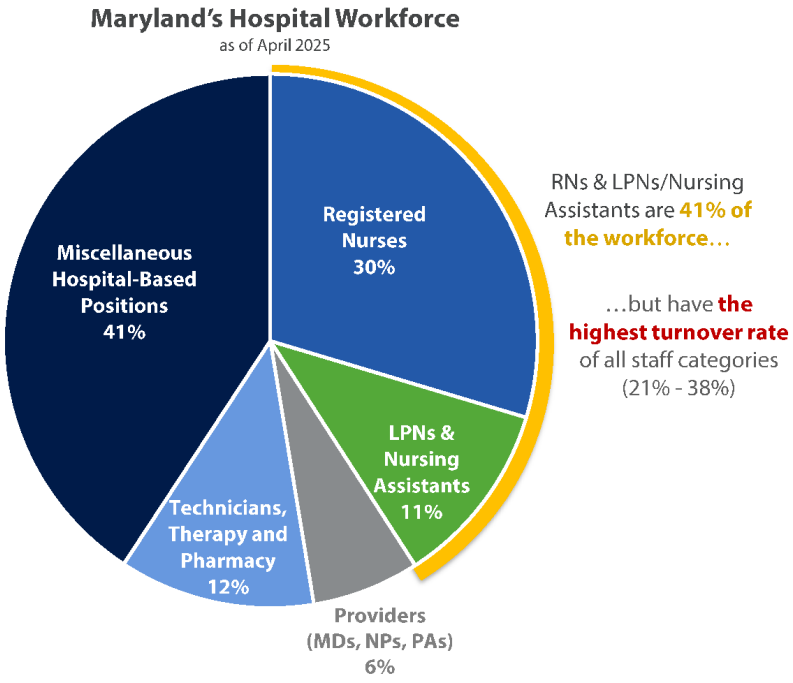
Besides RNs and LPNs, patient care requires support from a broad team of frontline staff including certified nursing assistants (CNAs), patient care technicians (PCTs), respiratory therapists, radiology technologists, laboratory technicians, and other ancillary clinical team members. These frontline staff are critical. At the same time, surgical technicians, respiratory therapists, radiology technicians, pharmacy technicians, and nursing assistive personnel comprise the five positions with the highest vacancies in the state per MHA's latest quarterly workforce survey.

According to the American Nurses Association (ANA), the delivery of nursing care is multifaceted. Determining appropriate nurse staffing is not simply about increasing the number of nurses "beyond what is minimally necessary."[6] Other variables such as patient population needs and staff skills and competencies must be considered. Because non-nursing roles are essential and deeply interconnected with nursing, staffing challenges cannot be solved by adjusting nursing alone.

Even when RN nurse staffing is adequate on paper, a missing respiratory therapist or an absent technician can create bottlenecks that force deviations or inefficient workarounds. Thus, the entire care team must be factored into throughput, safety, and clinical reliability planning. These variables often change throughout a given day depending on the staff, unit, and patient population.

Maryland hospitals are no exception.

Maryland's Hospital Workforce



Top 10 Hospital Occupations by Vacancy Rate as of April 2025	
Surgical Technicians	13.1%
Respiratory Therapist	12.9%
Radiology Technicians	12.4%
Pharmacy Technician	12.2%
Nursing Assistive Personnel	10.5%
Dietitians & Nutritionists	10.3%
Sterile Processing Technician	10.0%
All Other Personnel	9.9%
Housekeeper	9.9%
Registered Nurses	9.9%

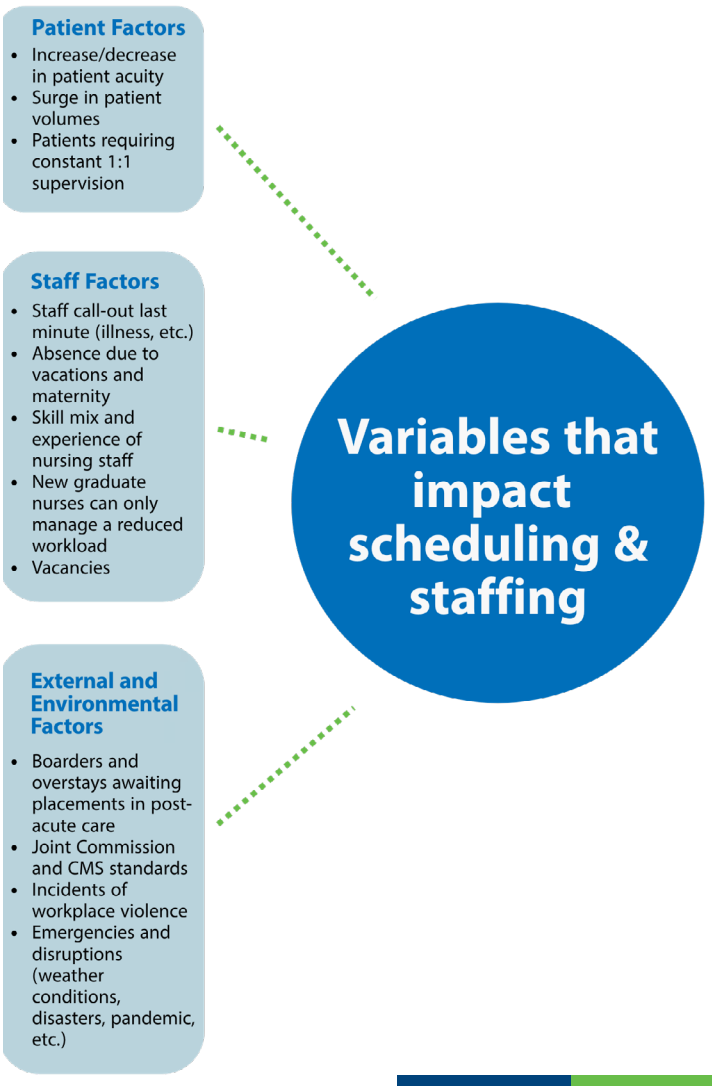
[5] GlobalData - Nurse Workforce Study [6] ANA's Principles for Nurse Staffing, Third Edition

How Hospital Staffing Works

Staffing decisions start with a baseline ratio – a goal for the number of patients a single registered nurse will care for during a shift. These ratios are based on a variety of inputs such as clinical guidelines from national professional bodies for specific units. For example, the American Association of Critical Care Nurses and the Academy of Medical Surgical Nurses produce guidelines, which recommend patient to nurse ratios.[7] [8] However, while these best practices and guidelines are the ideal, scheduling in hospitals is typically based on anticipated census, historical utilization trends, and known leaves or vacancies – striving to align available staff as closely as possible with expected patient volumes. Yet, even the most well-designed plans can diverge from reality. Unanticipated admissions, higher-than-expected acuity, last-minute callouts, or surges in patient volumes can all alter the staffing plans. As a result, actual staffing levels at the unit level may differ significantly from what was planned, requiring dynamic adjustments throughout the day to ensure safe coverage.

For example, the goal might be a 5:1 ratio of patients to a registered nurse on a medical surgical unit. From there, staffing fluctuates throughout the day. Adjustments are made to add or remove a patient from the nurse's ratio based on acuity, the skill of the nurse, the number of admissions and discharges, and what support services – like patient care techs, certified nursing assistants, sitters, or patient observers – are available for each unit.

There is communication among the chief nursing officer, charge nurse, and nursing managers several times a day (prior to each shift starting) to review vacancies, call outs, patient acuity, and new graduate nurses or nurses on orientation who may be supporting fewer patients as they learn. The team must continuously assess patient acuity, care complexity, and staff competencies to redistribute assignments and resources as safely and efficiently as possible. This process is repeated to also project staff schedules throughout the week and on the weekends. This often also means making difficult tradeoffs – balancing the need to maintain quality care and staff well-being against fiscal and operational constraints. Nurse leaders may need to redeploy staff across units, authorize overtime, or rely on float pools and agency nurses to fill critical gaps.[9]



[7] AACN Standards for Appropriate Staffing in Adult Critical Care - AACN
[8] Recommendations for Safe, Effective Medical-Surgical Nurse Staffing
[9] Ibid.

Key Factors Driving Clinical Staffing Decisions in Hospitals

Regulatory & Accreditation Standards for Clinical Staffing Decisions

Hospitals must meet state and federal regulations and maintain accreditation through a Maryland Department of Health-approved organization, such as the Joint Commission, which accredits all the state hospitals.[10] These standards guide staffing and patient care decisions.

With the dedicated teams and managers, these oversight bodies ensure Maryland hospitals uphold the highest standards of patient care, workforce safety, and 24/7 operational readiness.

Notably, The Joint Commission launched National Performance Goals which go into effect Jan. 1, 2026. These goals are described as "requirements that rise above regulation into salient, measurable topics with clearly defined goals."[11] The staffing goal requires hospitals to "be staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care."[12] Hospital leaders are tasked with ensuring there are qualified ancillary staff to meet the needs of the patient population served. The hospital is also required to evaluate staffing during performance improvement activities and report on the adequacy of staffing when undesirable outcomes are identified.

Table 1. An overview of the clinical staffing standards enforced by major state and federal regulatory and accrediting bodies

Agency/Body	Role & Oversight	Staffing Related Standards	Enforcement
Maryland Office of Health Care Quality (OHCQ)	Licenses and regulates hospitals; inspects facilities; investigates complaints	Ensures compliance with quality and safety requirements; can review patient care, supervision, environment, and safety	Inspections, complaint investigations, corrective actions
The Joint Commission	Independent accreditor approved by the Centers for Medicare & Medicaid Services (CMS) and the Maryland Department of Health (MDH); accredits all Maryland hospitals	Requires hospital-wide nursing care plans based on patient needs and nurse competency; emphasizes collaboration, flexibility, and workforce well-being Requires hospitals to meet National Performance Goals. Staffing added as a new goal effective Jan. 1, 2026	Unannounced site visits every 3 years; high standards must be met for accreditation
Centers for Medicare & Medicaid Services (CMS) – Conditions of Participation (CoPs)	Federal agency; hospitals must comply to receive Medicare/Medicaid reimbursement	Requires nursing director to determine staffing levels; mandates 24/7 RN supervision; allows alternative outpatient staffing plans with approval. Patient safety (§482.13) and emergency preparedness (§482.15) standards apply	Regular unannounced surveys and audits; penalties for non-compliance

[10] https://dsd.maryland.gov/regulations/Pages/10.07.01.07.aspx
[11] National Performance Goals | Joint Commission
[12] Hospital National Performance Goals (NPGs)

Hospital Practices & Committees

While accreditation and regulatory standards require hospital leaders – particularly CNOs or directors of nursing – to create and maintain staffing plans that balance patient needs, safety requirements, and budgetary realities, hospitals recognize that safe and effective staffing can only be achieved through teamwork. To capture on-the-ground realities, Maryland hospitals use shared governance principles to bring nurses and other frontline staff into the decision-making process through a combination of daily huddles, standing committees, and broader organizational structures.

Shared governance is a collaborative leadership model that empowers nurses and frontline health care staff to actively participate in the decision-making process, shaping policies, clinical practices, and patient care initiatives.[13] By fostering interdisciplinary collaboration and accountability, shared governance ensures that nurses have a strong voice in leadership, quality improvement efforts, and workforce-related decisions.[14] Hospitals utilizing this model report significant benefits, including improved patient safety, higher staff retention, reduced burnout rates, greater job satisfaction, enhanced interdisciplinary communication, and stronger adherence to evidence-based practices.[15,16]

Table 2. An overview of staffing committees currently in place in Maryland hospitals

Shared Governance Structure	Who Participates	Focus	Implementation*
Huddles (daily/multiple times per day)	Nursing leaders always; often nursing staff and sometimes nursing support staff, ancillary staff, physicians, security personnel [17]	Real-time staffing ratios, patient safety, throughput, shift coverage	100% of hospitals use huddles
Unit-level Committees	Nursing leaders, and nursing staff always; often nursing support staff	Compliance with staffing grids, productivity standards, retention, workflow improvements	67% of hospitals have unit-level committees
Department-level Committees	Hospital leaders always; often nursing staff	Training needs, staffing equity, external resource needs	50% of hospitals have department-level committees
Hospital/System-level Committees	Hospital leadership and nursing leaders	Strategic planning, workforce metrics, quality review, union agreements	53% of hospitals have hospital/system-level committees

*Percentages based on the number of hospitals that responded to the survey
Note: Hospital leaders refers to CNOs, COOs, CEOs, and other executives; Nursing leaders include nurse managers, nurse supervisors, charge nurses; nursing staff refers to RNs and LPNs; nursing support staff includes CNAs and patient care techs; ancillary staff refers to respiratory therapists, radiology techs, social workers, etc.

> Shared governance is a collaborative leadership model that empowers nurses and frontline health care staff to actively participate in the decision-making process.

[13] 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/. [14] Bradley University. "Shared Governance in Nursing." Bradley University Online, accessed March 11, 2025. https://onlinedegrees.bradley.edu/blog/shared-governance-in-nursing. [15] Kutney-Lee, Ann, Hayley Germack, Linda Hatfield, Sharon Kelly, Patricia Maguire, Andrew Dierkes, Mary Del Guidice, and Linda H. Aiken. 2016. "Nurse Engagement in Shared Governance and Patient and Nurse Outcomes." JONA the Journal of Nursing Administration 46 (11): 605–12. https://doi.org/10.1097/nna.0000000000000412. [16] Nantz, Sarah. 2015. "How to Increase Unit-based Shared Governance Participation and Empowerment." 1. American Nurse Today. Vol. 10–10. https://www.myamericannurse.com/wp-content/uploads/2015/01/ant1-Magnet-Highlights_Shared-Gov.pdf. [17] https://www.ihi.org/sites/default/files/SafetyToolkit_Huddles.pdf

To gain further insights into how and to what extent hospitals employ shared governance principles, MHA surveyed CNOs in summer 2025 on their approach to staffing.

MHA received responses from 37 acute and specialty hospitals, which revealed that Maryland hospitals have embraced the idea of shared governance to enhance both daily operational decision-making and long-term strategic planning.

This approach 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.

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.

Accreditation Standards Reinforcing Shared Governance

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association that recognizes hospitals for nursing excellence through Magnet Status, which acknowledges superior nursing practices and patient outcomes, and the Pathway to Excellence program, which recognizes supportive and healthy practice environments that meet certain standards. According to the American Nurses Association, staff satisfaction is an underpinning for the Magnet Recognition Program because it addresses variables that attract (like a magnet) and retain quality nursing staff.[18]

Both these designations involve a rigorous approval process that requires hospitals to meet the highest standards of practice and patient care. Magnet designation mandates policies and procedures that permit and encourage nurses to confidentially express their concerns about their professional practice environment without retribution, as well as the collection of nurse-sensitive quality indicators at the unit level to support research and quality improvement initiatives. Similarly, hospitals seeking recognition through the Pathway to Excellence program must implement shared decision-making practices, prioritize staff and patient safety and wellbeing, and provide professional development opportunities.

In Maryland nearly 30% of acute care hospitals hold a Magnet designation, which is significantly higher than the national average of 10% of all hospitals.[19,20] Four hospitals have the Pathways to Excellence designation. Ten hospitals are planning to pursue Magnet or Pathways in the next two years.

Research shows that hospitals achieving Magnet and Pathway recognition experience: [21,22]

- Lower nurse dissatisfaction and nurse burnout
- Higher job satisfaction among nurses
- Lower registered nurse (RN) turnover
- Greater productivity and teamwork
- Improved patient satisfaction

Magnet Hospitals

- Frederick Health
- Luminis Health Anne Arundel Medical Center
- MedStar Franklin Square Medical Center
- MedStar Harbor Hospital
- MedStar Montgomery Medical Center
- MedStar St Mary's Hospitals
- Mercy Medical Center
- National Institutes of Health Clinical Center (not an acute care hospital)
- Suburban Hospital - Johns Hopkins Medicine,
- The Johns Hopkins Hospital
- University of Maryland Shore Regional Health
- University of Maryland Medical Center

Pathway to Excellence

- Adventist Healthcare White Oak Medical Center
- Luminis Health Doctors Community Medical Center
- MedStar Southern Maryland Hospital Center
- University of Maryland Baltimore Washington Medical Center

[18] ANA's Principles for Nurse Staffing, Third Edition [19] The American Hospital Association's metric 'Total Number of All U.S. Hospitals' as denominator. [20] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_acute_care_fy26_licensedbeds.pdf

[21] American Nurses Credentialing Center. 2020. "About Pathway." ANA. 2020. https://www.nursingworld.org/organizational-programs/pathway/overview/ [22] American Nurses Credentialing Center. 2023. "Why Become Magnet?" ANA. 2023. https://www.nursingworld.org/organizational-programs/magnet/about-magnet/why-become-magnet/

Hospitals Turn Staff Feedback into Action

Hospitals not only gather feedback from staff. They act on it.

Hospitals collaborate with staff and gather input through annual surveys, regular one-on-one employee meetings, townhall meetings, executive rounding both during business hours and non-traditional hours, complaint/grievance hotlines, email and electronic submission options for complaints and ideas, and stay interviews.

The following examples illustrate how frontline voices have directly shaped policies and practices, resulting in safer care and stronger workforce support .

Expanded Weekend Huddles

Staff asked for more support and communication. The hospital expanded its weekday Operations and Safety Huddles to weekends and added weekend leadership rounding.

Improved Safety Feedback

Staff said follow-up on safety events was not consistent.
The hospital created a daily safety/risk huddle for leaders to ensure timely feedback.

Resource Nurse for Off-Hours

Staff requested a resource nurse on night shifts and weekends to cover services not available during those times. The hospital earmarked FTEs for this position, which is now posted.

ICU Role Conversion

ICU staff asked to convert a day secretary role into tech positions. Leadership approved the conversion based on staff justification.

Revised Charge Nurse Model

Bedside teams asked that charge nurses be included in patient assignments. Leadership modified the care model accordingly, with positive results.

Streamlined ED to Med-Surg Transfers

Med-Surg nurses raised concerns about delays in moving ED admissions. The hospital revised handoff processes and expanded the transport pool, improving workflow.

Violence Prevention and Support

Staff raised concerns about workplace violence and injuries. The hospital responded with updated procedures, added support in high-risk areas, and new safety tools, leading to lower turnover and staff feeling more supported.

Improved Communication Tools

Staff wanted broader communication across teams. Leadership launched an all-employee Teams channel and texting platform to improve outreach.

Innovative Staffing Solutions

Hospitals report finding it significantly harder to identify and attract staff that will want to work through holidays, nights, or weekends. Despite nursing leaders' best efforts at forecasting and preparing for staff shortages during these times, additional circumstances (such as an unusual surge in patient volumes, staff calling in sick, etc.) may further complicate staffing during these periods. During such times, almost all hospitals rely on options such as float pools (where nurses are part of the schedule but not to a particular unit, so they can "float" to where they are needed), part-time, or short-term contractual nurses, and remote or virtual nursing options to meet coverage needs.

All 37 hospitals that completed the survey reported using self-scheduling tools (see page 8). These online systems give nurses the autonomy to choose their own work shifts and days off within established organizational parameters and staffing needs. This promotes flexibility, gives nurses more control over their schedule, and helps reduce burnout.

Additionally, most hospital respondents reported using acuity-based or geography-based scheduling tools to ensure staffing plans match nurse workloads to patient care needs rather than just patient volumes. These tools assess each patient's condition, the staff's workload and location, and the nursing care required, enabling managers to create fair and equitable staff assignments that ensure patient safety, optimize workflows, and improve overall care quality.

Similarly, 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 by allocating resources based on identified care needs.

Innovative Staffing Solutions

- Staff float pools
- Part-time or short-term contractual nurses
- Remote and virtual nursing options
- Acuity, geography or patient-based scheduling tools
- Precision staffing models
- Options in shift length
- Workforce management tools
- Workload balancing tools
- Care centric modeling
- Stress injury tools

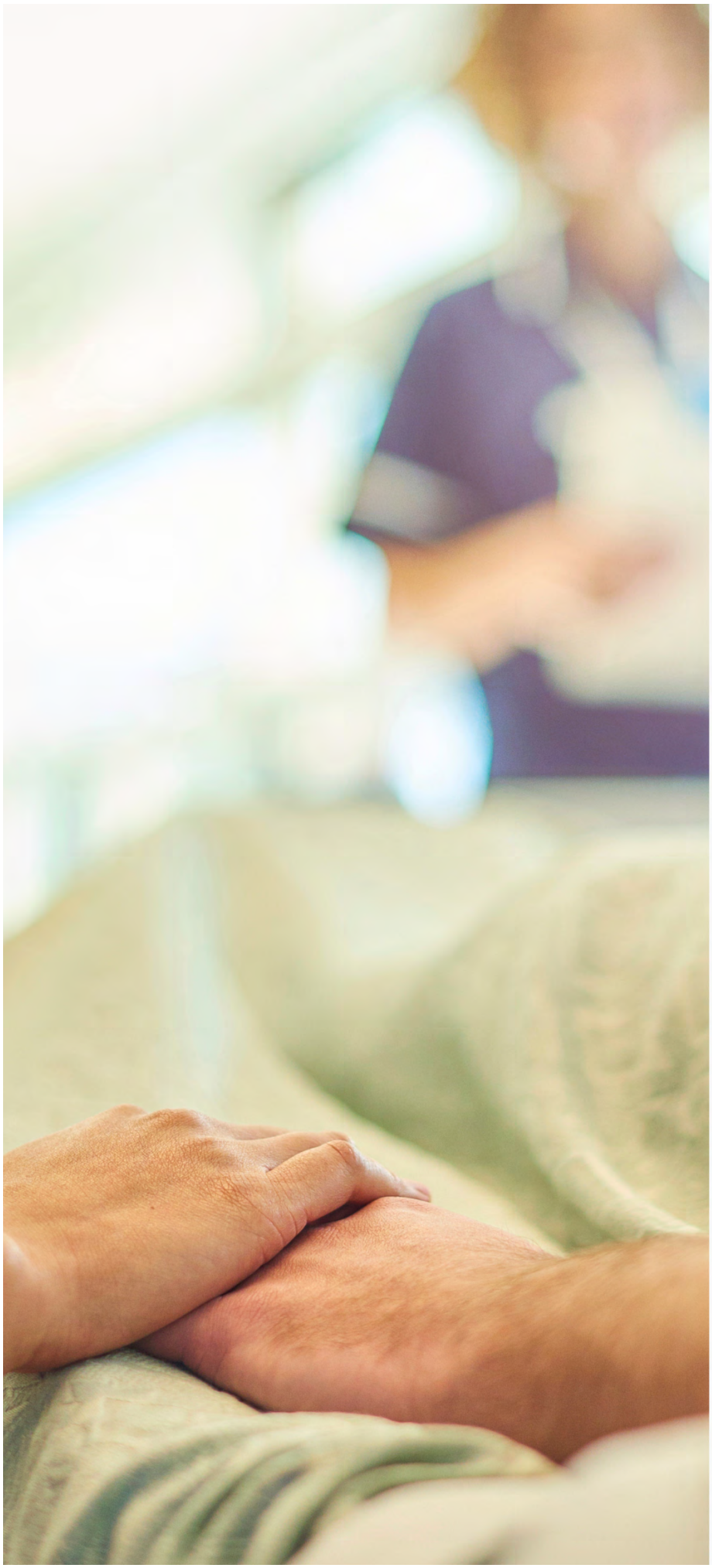
Conclusion

Maryland hospitals uphold the highest standards of care by meeting rigorous state and federal requirements and ensuring staff voices are heard. They make staffing decisions through a shared governance structure which strengthens patient care, improves staff retention, and empowers frontline caregivers.

Hospitals are reinforcing this work by adopting fieldwide commitments to enhance clinical staffing, transparency in how decisions are made, and staff engagement.

State partnership is essential, particularly to expand nurse residency and externship programs, recruit and retain staff, improve behavioral health placements to reduce workplace violence, and invest in education and training pipelines.

Together, Maryland can strengthen its hospital workforce, safeguard access to care, and continue to provide access to high-quality care 24/7/365.



Glossary

Ancillary Staff:

Refers to professionals who support patient care but are not part of the nursing staff, such as respiratory therapists, radiology technologists, laboratory and pharmacy personnel, physical and occupational therapists, social workers, and security officers.

Callout:

When a scheduled employee is unable to report to work due to illness, emergency, or other reasons. Multiple callouts can trigger staffing shortages and require real-time adjustments.

Census:

The total number of patients admitted or assigned to a unit at a given time. Census data drive staffing adjustments throughout the day.

Charge Nurse:

A RN who provides clinical oversight during a shift, coordinates assignments among nursing staff, and serves as the point of contact for the unit during that shift. The charge nurse may still provide direct patient care but also handles staffing coordination.

Chief Nursing Officer:

The CNO oversees nursing practice and policy, staffing models, clinical quality, and patient safety.

Float/Floating:

The practice of temporarily reassigning a nurse or other staff member from one unit to another to address short-term staffing gaps.

Huddle:

A brief (typically <10 minutes) stand-up meeting among staff and leaders at the start of a shift to review staffing assignments, patient updates, and safety issues.

Nurse Manager:

Responsible for daily operations of a specific nursing unit. Manages scheduling, supervises charge nurses and frontline staff, monitors quality and safety metrics, and addresses staffing gaps or callouts.

Nursing Staff:

Includes RNs who are responsible for the type and quality of all nursing care that patients receive, as well as LPNs who work under the supervision of RNs or physicians.

Nursing Support Staff:

A broad category that includes CNAs or equivalent unlicensed staff who assist RNs in providing patient care-related services as assigned by and under the supervision of the RN.

Scheduling:

Balanced forecasting of resource needs based on clinical guidelines, historical trends, anticipated patient volumes, scheduled procedures, etc.

Staffing:

Real time resource allocation of clinical staff to meet a patient's needs while ensuring quality standards are upheld and federal and state laws and regulations are satisfied

Staffing Grid/Matrix:

A planning tool used to determine the number and mix of staff needed per shift or per patient census. Grids typically account for patient acuity, unit type, and regulatory requirements.

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SB 411 - Staffing Act of 2026 - Oppose.pdf
Uploaded by: Andrew Nicklas
Position: UNF

Maryland
Hospital Association

Senate Bill 411 - Hospitals - Clinical Staffing Committees and Plans - Establishment

Position: *Oppose*
February 17, 2026
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 strong opposition of Senate Bill 411.

Maryland hospitals are deeply concerned about the unintended consequences SB 411 could have on hospitals, their employees, and the patients they care for. A singular, hospital-wide clinical staffing committee is an outdated, prescriptive approach that does not serve patients or the clinical workforce. This concept does not align with the dynamic and flexible structure required to meet the fluctuating staffing needs based on patient acuity and staff skill mix. This bill would increase administrative burdens, disrupt hospital day-to-day operations, and duplicate hospitals' governance structures without any positive impact on patient safety or staff well-being.

Maryland Hospital Fieldwide Commitments
During the 2025 interim, MHA studied how staffing decisions are made, the current regulations that guide these decisions, and ways that hospitals are supporting their workforce, culminating in a report that has been shared with the Finance and Health committees.

MHA member hospitals voluntarily committed to adopt actions that enhance collaboration between frontline clinical staff and hospital leadership, while allowing flexibility for individual hospitals to implement these actions in a manner that is appropriate to their unique culture, organizational structure, and patient population.

Maryland hospitals commit to:

- Include efforts to continuously improve staff engagement and work-life balance as part of the hospital's annual operating plans
    - Engage frontline clinical staff in developing staffing plans and policies
    - Create and promote forums for frontline clinical staff to discuss issues and share feedback
    - Establish metrics to ensure accountability and foster a collaborative working environment

- Continue to build and promote programs and supports to prioritize staff well-being and value
- Provide opportunities for career progression, mentorship, and professional development
- Provide a readily available, anonymous system to solicit staff feedback
- Participate in forums hosted by the Maryland Hospital Association to share progress on implementation of these efforts

Hospitals agree on the need to account for frontline staff perspectives/suggestions when developing staffing policies and plans. Their suggestions and feedback have, in fact, directly informed changes and initiatives that many hospitals have implemented. For example, expanded weekend huddles, improved safety feedback, resource nurse for off-hours, revised charge nurse model, violence prevention and support.

Joint Commission Accreditation Requirements

Maryland hospitals must maintain accreditation through a Maryland Department of Health-approved organization, such as the Joint Commission, to be licensed to operate.[1] The Joint Commission sets staffing standards and assesses compliance in collaboration with the Maryland Office of Health Care Quality (OHCQ). The Joint Commission 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 inspections.

Joint Commission National Performance Goal on Staffing

SB 411 conflicts with the national advocacy work of the American Nurses Association and other leading nursing advocacy groups, which established the Joint Commission's new National Performance Goal on staffing. The American Nurses Association and other leading nursing advocacy groups advocated for this change through the National Nurse Staffing Task Force.[2] Instead of staffing committees, they advocated for a more sophisticated approach that requires hospital leadership to evaluate staffing adequacy, competency alignment, and workload. For the first time, the Joint Commission elevated nurse staffing from a national patient safety goal to a national performance goal. This was recognized as a "defining moment for nursing."[3] This change formally links staffing oversight to accreditation, performance improvement, and governance accountability and means that hospitals will be inspected to ensure staffing adequacy.

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[1] Pages - 10.07.01.07.aspx

[2] Nursing World, American Nurses Association Celebrates Inclusion of Nurse Staffing in Joint Commission's National Performance Goals, Oct. 13, 2025

[3] Becker's Hospital Review, 'Defining moment' for nursing: Joint Commission recognizes staffing as quality component," Erica Cerutti, Oct. 14, 2025

Executive leaders and governing boards now must actively monitor staffing metrics, understand staffing-related risks, and ensure appropriate resource allocation. Hospitals will now be inspected by the Joint Commission to evaluate whether hospital leadership receives regular staffing reports, responds to trends, and integrates staffing considerations into strategic planning. A Joint Commission inspection surveyor can arrive at a hospital unannounced or with only short notice provided.[4]

AHEAD Model Transition & Federal Changes

At a time when Maryland hospitals are navigating significant regulatory change through the transition to the AHEAD Model and preparing for potential strain on our health care system stemming from federal H.R. 1. SB 411 would add substantial administrative burden without improving patient care. Hospitals are already operating in a complex and evolving environment that requires flexibility, clinical judgment, and the ability to respond quickly to shifting patient needs.

Maryland hospitals have additional concerns about SB 411:

Scope: The bill does not apply to all Maryland hospitals, only privately-owned hospitals. Exempting state-operated hospitals creates an unfair standard for Maryland hospitals that are otherwise held to the same state licensing and accreditation requirements. This indicates the bill's impact on patient safety, quality of care, and staff wellbeing is not significant enough to merit inclusion of state hospitals, which serve the most vulnerable Marylanders.

Governance Structure and Committee Composition: The bill requires a singular, hospital-wide clinical staffing committee with equal membership from management and employees inclusive of nonclinical staff such as dietary aides and environmental service workers. This structure presents several concerns that would conflict with hospitals' current governance structures.

Hospitals value the voice and insight of frontline staff and have governance structures in place to facilitate this feedback loop. Over half of Maryland's acute care hospitals either have the Magnet designation, Pathways to Excellence designation, or are pursuing one or the other in the next two years. These designations prioritize shared governance and support for the workforce.

The inclusion of non-clinical staff is concerning because the purpose of the committee is to develop clinical staffing plans. Accreditation and regulatory standards require clinical hospital

[4] Hospital Accreditation Survey Activity Guide 2025

leaders—particularly CNOs or directors of nursing—to create and maintain staffing plans that balance patient needs, safety requirements, and budgetary realities.

Reporting Requirements: The bill requires, beginning July 1, 2030, that hospitals report to the Maryland Health Care Commission (MHCC) summarizing how the hospital's clinical staffing committee addresses safe staffing through the hospital's clinical staffing plan during the immediately preceding year. It is unclear what value this requirement brings to MHCC, hospital staff, or the patients they care for.

Staffing plans are and should be dynamic to meet the ever-changing needs of the patient population and clinical workforce skill mix within the unit. Posting a static plan will become outdated the moment it is posted, especially in high volume, unpredictable patient units like the emergency department and maternal health units.

Conclusion

Maryland's hospital employees are the heart of health care. They bring skill, compassion, and commitment to caring for the more than 4.9 million people we serve each year. Hospitals share the goal of SB 411 to ensure safe staffing environments. However, this bill does not achieve these goals. Rigid, one-size-fits-all staffing mandates, like the ones proposed by SB 411, risk undermining the very workforce we all support. They limit hospitals' ability to adjust staffing based on patient acuity, seasonal surges, unit design, workforce availability, and community-specific challenges.

To protect access to care and support the teams at the heart of health care, we respectfully request an unfavorable report on SB 411.

For more information, please contact:
Andrew Nicklas, Senior Vice President, Government Affairs & Policy and General Counsel
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Caroline Doyle_MDENA_ SB0411 Senate Finance Commit
Uploaded by: Caroline Doyle
Position: UNF

EMERGENCY NURSES ASSOCIATION

Maryland State Council
Safe Practice, Safe Care.

To: Maryland Senate Finance Committee
Senate Office Building
Annapolis, MD 21401

From: Maryland State Council of the Emergency Nurses Association

Date: February 17, 2026

Re: **Opposition to SB0411- Hospitals- Clinical Staffing Committees and Plans- Establishment (Safe Staffing Act of 2026)**.

Good afternoon, Chairwoman Pamela Beidle, Co-Chair Antonio Hayes, and Committee Members,

My name is Caroline Doyle, and I am here speaking on behalf of the Maryland Emergency Nurses Association in opposition to SB0411- Hospitals- Clinical Staffing Committees and Plans- Establishment (Safe Staffing Act of 2026).

I have been an emergency department nurse for 35 years and a hospital nursing supervisor/bed flow coordinator for 18 years at a busy Baltimore City hospital that serves a remarkably diverse patient population across the spectrum from well-insured to uninsured vulnerable populations. There is a constant flow of patients, from multiple jurisdictions, seeking emergency and medical care, as well as planned surgical procedures. Patient volume changes very quickly and acutely in any given minute, on any given day. Staffing needs are impacted by multiple variables including volume, acuity (how sick the patients are), and available trained staff for specialty units. Clinical unit leaders, nursing managers, directors, the CNO and nursing supervisors are acutely aware of the dynamics of the staffing needs and necessary resources and spend most of their days involved in ongoing conversations to ensure and maintain safe quality care.

While SB0411's intent is well-meaning, it is redundant to existing professional nursing and hospital staffing guidelines and practices that are already in place and being monitored and tracked on a continuous basis. SB0411 would add another burdensome administrative layer to already overwhelmed hospital systems. Here are some examples of existing staffing practices:

- "**The Joint Commission (TJC) standards** are the basis of an objective evaluation process that can help health care organizations measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organization functions that are essential to providing safe, high-quality care." TJC typically reviews these standards annually to promote continuous improvement in healthcare delivery. Clinical organizations accredited by TJC are tasked to develop policies and procedures addressing the various standards and goals and the various healthcare organizations will implement their approach to meet the general goal.

  And now, "Effective January 1, 2026, Joint Commission introduced National Performance Goals (NPGs) that organize requirements that rise above into salient, measurable topics with clearly defined goals" (TJC). Goal 12 of the NPGs is that "The hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care".

- Emergency Departments are unique units that require a special staffing approach, depending on size, location, population served, and designated trauma level. The **Emergency Nurses Association (ENA)** advocates that "safe emergency department (ED) staffing requires at least two RNs present at all times, with staffing based on patient acuity, volume, and skill mix rather than fixed rations". Raw patient counts are considered inadequate. ENA guidelines include core staffing guidelines and principles, as well as guidelines for managing surge/overcrowding, and are to be considered as guidance rather than imposition (ENA).

- The **American Nurses Credentialing Center (ANCC) Magnet model** mandates that staff and bedside nurses, through shared governance structures, are included and actively involved in decision-making which includes staffing. Decentralized decision-making, professional autonomy, and nursing leadership is

usually done through unit and hospital-based councils rather than just a top-down, non-nursing committee. Magnet hospitals are required to provide documentation on how they evaluate and adjust staffing to meet patient needs (ANCC).

For these reasons, the Maryland Emergency Nurses Association ***opposes*** SB0411 and respectfully requests an ***unfavorable*** report on the bill.

Respectfully submitted,

Caroline L. Doyle, BSN, RN
2026 Maryland Emergency Nurses Association Government Affairs Chair
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References:

Adapted from The Joint Commission Website (https://jointcommission.org/en-us/standards/national-performance-goals) & https://jointcommission.org/en-us/standards/national-patient-safety-goals

Adapted from the 2021 Emergency Nurses Association Staffing and Productivity in the Emergency Department Position Statement (https://www.ena.org/sites/default/files/2025-09/Staffing%20and%20Productivity%20in%20the%20Emergency%20Department.pdf)

Adapted from 2023 Magnet Application Manual (https://www.nursingworld.org/nurses-books/2023-magnet-application-manual2/)

SB 411 submitted .pdf
Uploaded by: Catherine Cardillo
Position: UNF

HOLY CROSS HEALTH
A Member of Trinity Health

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Senate Bill 411 Hospitals
Clinical Staffing Committees and Plans – Establishment
Position: Oppose

Submitted: February 13, 2026

On behalf of Holy Cross Health, including Holy Cross Hospital in Silver Spring and Holy Cross Germantown Hospital, we appreciate the opportunity to provide testimony in opposition to Senate Bill 411.

Holy Cross Health maintains a rigorous, real-time staffing infrastructure designed to ensure safe, high-quality patient care. Staffing is reviewed across all units twice daily, accounting for patient volume, bed capacity, acuity, and skill mix. A designated nursing executive holds 24/7 accountability on a rotating weekly basis to oversee hospital-wide staffing decisions and adjustments. These practices align with standards established by The Joint Commission and the Centers for Medicare & Medicaid Services (CMS), both of which prioritize patient safety and clinical outcomes.

Frontline engagement is foundational to our staffing model. Each unit conducts twice-daily huddles to review staffing, identify high-risk patients, align on daily goals, and address operational needs. Unit-based huddle boards track performance and improvement initiatives. In addition, all nursing units are represented on our Professional Governance Council, and most participate in Comprehensive Unit-based Safety Program (CUSP) initiatives, empowering clinical staff to lead performance improvement efforts.

We are concerned that a single, centralized staffing committee, as proposed in SB 411, would reduce the agility required to respond to the dynamic and rapidly evolving nature of hospital operations. Effective staffing decisions must be timely, data-driven, and responsive at the unit level. A mandated structure risks creating operational rigidity without addressing the underlying drivers of workforce shortages.

Holy Cross Health remains committed to strengthening Maryland's health care workforce and advancing collaborative, sustainable solutions. However, SB 411 does not fully reflect the operational complexity of hospital staffing nor the systemic factors contributing to workforce challenges.

If you have any questions, please contact Cathy Cardillo, Regional Director Advocacy, 610-246-5709/ccardillo@trinity-health.org.

For these reasons, we respectfully request an unfavorable report on SB 411.

staffing committees.pdf
Uploaded by: Courtney Cornell
Position: UNF

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

FROM: Courtney Cornell, RN, MSN
Chief Nursing Officer

SB411
Unfavorable

DATE: February 16, 2026

RE: **SB411: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)**

Suburban Hospital opposes **SB411: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)** which is 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 inpatient units as well as our emergency department. Requirements to establish a clinical staffing committee will reduce the robust engagement of our teams, daily interaction around staffing, and the ability to react in real time to any staffing needs which will 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.

Lastly, I also draw your committee's attention to The Joint Commission's National Performance Goal (NPG) 12 which became effective on January 1, 2026. All Maryland hospitals have to be accredited by The Joint Commission and follow their rigorous, evidence-based frameworks to address operational and safety matters. NPG12 requires hospitals to be "staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care." Standing up clinical staffing committees is not a part of the required framework in NPG12. Rather, the accreditation body charges me, as the nurse executive, with the duty to direct the implementation of a nurse staffing plan and to document the "types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital."

Accordingly, Suburban Hospital respectfully requests an **UNFAVORABLE** committee report on SB411.

SB411 UNFAV Written Testimony Sheppard Pratt.pdf
Uploaded by: Damian Lang
Position: UNF

Sheppard Pratt

Written Testimony

Senate Bill 411 – Hospitals - Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)

Senate Finance Committee

February 17, 2025

On behalf of Sheppard Pratt, Maryland's largest nonprofit behavioral health system and a provider of inpatient psychiatric hospital services across the state, we respectfully submit this testimony in opposition to Senate Bill 411.

While we share the goal of ensuring safe, high-quality patient care and strong workforce support, SB 411 is unnecessary, duplicative of existing federal and accreditation requirements, and would impose rigid operational mandates that do not reflect the complexity of psychiatric hospital care or the realities of Maryland's current health care labor market.

Staffing Oversight is Already Extensively Regulated

Hospitals in Maryland are already subject to comprehensive federal and accreditation staffing standards.

Under 42 CFR §482.23, hospitals must maintain:

- 24/7 registered nurse coverage,
- Competency-based staffing,
- Individualized nursing care plans for each patient,
- Nursing leadership responsible for determining appropriate staffing levels.

CMS surveys and audits enforce compliance, with serious penalties for noncompliance. Additionally, the director of nursing is already legally responsible for determining appropriate staffing numbers and skill mix to ensure safe and adequate patient care.

Additionally, beginning January 1, 2026, staffing adequacy became a National Performance Goal. Hospitals must now demonstrate executive leadership and governing board oversight of staffing models, ensure staffing decisions are acuity-based, and incorporate staffing adequacy into quality and performance improvement monitoring. Failure to comply jeopardizes accreditation status and, in turn, Medicare and Medicaid reimbursement. SB 411 would layer an additional statutory governance structure on top of an already strengthened regulatory framework.

SB 411 Imposes a Rigid Governance Structure That Undermines Flexibility

SB 411 mandates that:

- Equal membership between management and employees on staffing committees,
- Specific required staff categories (CNA, dietary aide, ER nurse, EVS worker, resident, staff physician, technician),
- Majority-vote complaint resolution,
- Mandatory public posting of staffing plans and daily staffing assignments.

While collaboration is important, staffing decisions must remain dynamic, clinically driven, and responsive to real-time acuity, census fluctuations, and emergency conditions.

Psychiatric hospitals, in particular, operate in environments where:

- Patient acuity can change rapidly,
- Safety considerations (including ligature risk mitigation and behavioral escalation) require specialized staffing approaches,
- Interdisciplinary staffing models differ significantly from medical/surgical settings.

In addition, Maryland hospitals are preparing for expanded leave requirements, including Safe and Sick Leave and the forthcoming FAMLI program. These policies, while important for workforce support, will increase extended absences and short-notice call-outs. SB 411 assumes predictable workforce availability and would convert legally protected leave usage into potential staffing variances, exposing hospitals to compliance risk for circumstances beyond their control.

Mandating a specific committee structure and formal voting processes may inadvertently slow operational responsiveness in high-risk behavioral health settings.

Staffing Committees Will Not Solve Workforce Shortages

We agree with proponents that Maryland hospitals face serious challenges:

- Workforce shortages,
- Burnout,
- Workplace violence,
- Emergency department boarding,
- Behavioral health capacity strain.

However, creating mandatory staffing committees will not address:

- National nurse pipeline shortages,
- Competition for specialized psychiatric staff,
- Reimbursement pressures affecting hospital financial stability,

- The operational strain caused by ED boarding and inadequate step-down placements.

Maryland continues to experience persistent vacancy rates across nursing and allied health roles, reflecting structural pipeline constraints rather than internal governance deficiencies. A statutory committee model does not create new clinicians, expand nursing school capacity, or resolve interstate workforce competition.

These issues require targeted workforce investment, pipeline development, safety infrastructure, and reimbursement reform, not structural committee mandates.

Public Posting Requirements Raise Operational Concerns

SB 411 requires posting:

- Unit-level staffing plans,
- Actual daily staffing for each shift,
- Annual public reporting to MHCC.

For psychiatric hospitals, public posting of detailed staffing information may raise safety and security considerations, particularly in units serving individuals with serious mental illness, forensic status, or high-risk behavioral conditions.

Transparency must be balanced with patient and staff safety.

Sheppard Pratt strongly supports:

- Safe staffing,
- Workforce well-being,
- Collaborative governance,
- Accountability and transparency.

However, SB 411 is:

- Redundant with federal and accreditation standards,
- Operationally rigid,
- Unlikely to address the root causes of workforce strain and workforce supply constraints.

We respectfully urge an unfavorable report on Senate Bill 411.

We remain committed to working with the Committee, frontline staff, labor advocates, and regulators to advance meaningful, evidence-based solutions that strengthen Maryland's hospital workforce and protect patient safety.

Letter of oppition - SB411.pdf
Uploaded by: Davion Percy
Position: UNF

Luminis Health℠

2001 Medical Parkway
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LuminisHealth.org

February 18, 2026

The Honorable Senator Pam Beidle, Chair
Senate Finance Committee
Miller Senate Office Building, 3E
Maryland General Assembly Annapolis, Maryland 21401

RE: Opposition to SB 411 – Clinical Staffing Committees

Chair Beidle and Members of the Senate Finance Committee:

Thank you for the opportunity to submit testimony in opposition **to SB 411 – Clinical Staffing Committees.** Luminis Health and hospitals across Maryland are deeply committed to safe, high-quality patient care and to supporting a strong, engaged healthcare workforce. However, SB 411 is unnecessary, duplicative of existing regulatory requirements, and would impose new operational burdens at a time of significant transition for hospitals statewide.

About Luminis Health

Luminis Health is a nonprofit regional health system serving Anne Arundel County, Prince George's County, and the broader region. Our system includes three hospitals:

- **Luminis Health Anne Arundel Medical Center** – a comprehensive regional medical center providing acute care, surgical services, women's and children's health, and a high-volume emergency department.
- **Luminis Health Doctors Community Medical Center** – a key provider of medical-surgical care, behavioral health, and emergency services for northern Prince George's County.
- **Luminis Health McNew Family Medical Center** – a dedicated behavioral health hospital offering inpatient psychiatric care and crisis stabilization.

Across these campuses, thousands of caregivers work every day to deliver safe, compassionate, and equitable care. SB 411 would directly affect our operations and our ability to remain responsive to the needs of the communities we serve.

Existing Federal and Accreditation Requirements Already Regulate Staffing

Hospitals already operate under extensive federal oversight governing staffing adequacy. Centers for Medicare & Medicaid Services (CMS) Conditions of Participation require hospitals to provide 24/7 nursing coverage, competency-based staffing, and individualized nursing care plans. Federal regulations also require the director of nursing to determine the types and numbers of nursing personnel necessary to ensure adequate coverage in all areas of the hospital. CMS enforces these requirements through regular surveys and audits, and non-compliance can result in significant penalties.

Accreditation standards have also become more stringent. The Joint Commission recently established staffing as a National Performance Goal, effective January 1, 2026. Hospitals will now be surveyed on staffing adequacy, and failure to meet these standards could jeopardize accreditation and, by extension, Medicare and Medicaid reimbursement.

Luminis Health℠

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Hospitals must retain flexibility to adjust staffing in real time during surges, disasters, and seasonal variation. Prescriptive staffing plans may limit innovative care models and flexible scheduling strategies that support recruitment, retention, and workforce well-being. Safe staffing is complex and requires professional nursing judgment that considers patient acuity, skill mix, experience, workflow, and available resources.

Maryland Hospitals Already Use Shared Governance and Strengthen Workforce Collaboration

Maryland hospitals have long embraced shared governance models that elevate frontline nursing voices. In our state, 30% of acute care hospitals hold Magnet designation—three times the national average—and several others hold or are pursuing Pathways to Excellence designation. These programs prioritize shared decision-making and support for the nursing workforce.

Following the 2024 legislative session, the Maryland Hospital Association conducted a comprehensive review of staffing practices, regulatory requirements, and workforce support strategies. Luminis Health along other health systems and hospitals throughout the state voluntarily committed to strengthening collaboration between frontline clinical staff and leadership, while preserving the flexibility needed to meet the unique needs of their communities, cultures, and patient populations. Frontline staff input already informs staffing policies and has led to meaningful changes across the field.

AHEAD Implementation Requires Stability

Luminis Health is currently navigating the AHEAD transition, one of the most significant operational and financial shifts in recent years. This period of uncertainty requires flexibility, collaboration, and focus. Imposing a new operational mandate, particularly one that duplicates existing structures, would be premature and counterproductive. We need stability to successfully implement AHEAD and continue delivering high-quality care.

Staffing Committees Will Not Address the Issues Raised by Proponents

We share the concerns raised by proponents regarding workforce shortages, workplace violence, and emergency department throughput. These are real and urgent challenges. However, a mandated staffing committee structure will not resolve them. Addressing these issues requires targeted, evidence-based solutions, not additional administrative layers that divert time and resources away from patient care.

Luminis Health remains committed to working collaboratively with advocates, policymakers, and frontline staff to advance meaningful strategies that improve safety, retention, and patient care.

Conclusion

Hospitals are already held to rigorous staffing standards, are actively strengthening shared governance, and are navigating major systemwide reforms. A new statutory mandate would be redundant, burdensome, and unlikely to address the real challenges facing the healthcare workforce. For these reasons, we respectfully urge an unfavorable report on SB 411.

Respectfully,

Davion E Percy

Davion E. Percy, Vice President, Community Relations & Public Policy

Luminis Health℠

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CC: Victoria “Tori” Bayless, Chief Executive Officer, Luminis Health
Amy Beales, Chief Human Resources Officer, Luminis Health
Deneen Richmond, President, Luminis Health Doctors Community Medical Center
Catherine Maloney, President, Luminis Health Anne Arundel Medical Center
Crystal Beckford, Chief Nursing Officer, Luminis Health Doctors Community Medical Center
Christine Frost, Chief Nursing Officer, Luminis Health Anne Arundel Medical Center

SB 411_MDCC_Safe Staffing Act of 2026_UNFAV.pdf
Uploaded by: Hannah Allen
Position: UNF

MARYLAND
Chamber of Commerce

Senate Bill 411

Date: February 17, 2026
Committee: Finance
Position: Unfavorable

Founded in 1968, the Maryland Chamber of Commerce (the Chamber) is the leading voice for business in Maryland. We are a statewide coalition of more than 7,000 members and federated partners, and we work to develop and promote strong public policy that ensures sustained economic growth for Maryland businesses, employees, and families.

Senate Bill 411 (SB 411) would require hospitals to establish staffing committees and adopt prescriptive staffing-related processes.

The Chamber supports high-quality patient care and a strong health care workforce, but SB 411 is unnecessary and duplicative of existing oversight, and it would impose new operational requirements on hospitals at a time of significant financial and regulatory strain.

Hospital staffing is already extensively regulated. Federal Centers for Medicare & Medicaid Services (CMS) Conditions of Participation require 24/7 nursing coverage, competency-based staffing, and individualized nursing care plans, with compliance enforced through surveys and audits and backed by significant penalties, including loss of reimbursement. In addition, the Joint Commission has adopted staffing as a National Performance Goal effective January 1, 2026, meaning hospitals will now be surveyed directly on staffing adequacy as part of accreditation.

Maryland hospitals are also national leaders in shared governance and workforce engagement. Nearly one-third of the state's acute care hospitals hold Magnet designation, well above the national average, and others have achieved or are pursuing Pathways to Excellence designation. These frameworks already prioritize frontline staff involvement in staffing decisions and workforce support. Hospitals have also completed a recent, comprehensive review of staffing practices and governance structures and shared those findings with the general assembly.

While workforce shortages, workplace violence, and emergency department crowding are real challenges, a mandated staffing committee will not resolve these issues. Instead, it risks adding administrative burden without improving patient outcomes or workforce stability.

Hospitals are currently navigating major delivery-system reforms, including the transition to the AHEAD model, alongside ongoing workforce shortages and financial pressures. We believe that it is not the right time to impose a rigid, one-size-fits-all operational mandate.

For these reasons, the Maryland Chamber of Commerce respectfully requests an **unfavorable report on SB 411.**

SB 411 - Hospitals - Clinical Staffing Committees

Uploaded by: Jeremy Bradford

Position: UNF

CalvertHealth™

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CalvertHealthMedicine.org

February 13, 2026

To: The Honorable Pam Beidle, Chair, Senate Finance Committee
The Honorable Antonio Hayes, Vice Chair, Senate Finance Committee

Re: Senate Bill 411 – Hospitals – Clinical Staffing Committees and Plans - Establishment

Dear Chair Beidle and Vice Chair Hayes,

On behalf of CalvertHealth Medical Center, we appreciate the opportunity to comment **in opposition of** SB411 – Clinical Staffing Committees and Plans. While we all share a commitment to ensuring patient safety and high quality care, CalvertHealth already follows rigorous and dynamic processes to adjust staffing as needed. We are committed to working with our workforce to continue to incorporate their perspectives and ideas when developing staffing policies and plans and have many mechanisms in place to do this. We believe that this bill would impose unnecessary burdens on hospitals at a time when hospitals are already navigating significant change and uncertainty.

The Centers for Medicare and Medicaid Services (CMS) currently establish Conditions of Participation 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. The Joint Commission also recently made staffing a National Performance Goal. CalvertHealth is accredited by the Joint Commission and is committed to adhering to all Joint Commission Standards and CMS Conditions of Participation.

At CalvertHealth, we have many effective mechanisms in place to ensure optimal staffing levels based on the acuity of patients, the complexity of care required, and other critical factors. In addition to engaging in a robust nursing shared governance model, we hold daily safety huddles where our teams assess patient care needs, staff availability, and any emerging concerns. Additionally, hourly checks are conducted to monitor bed status and adjust staffing accordingly. These processes are flexible and responsive, allowing us to make real-time decisions to ensure safe, high-quality care for our patients. This collaborative approach ensures that those directly involved in patient care have a voice in determining appropriate staffing levels. As mentioned above, these processes are informed by the recommendations and requirements of the Joint Commission and Centers for Medicare and Medicaid Services.

CalvertHealth Medical Center is deeply committed to supporting our workforce and collaborating on solutions that strengthen our workforce and advance health care in Maryland. We agree that workforce shortages, workplace violence, and ED throughput are critical issues that need solutions. A staffing committee will not solve these issues.

Jeremy Bradford, MBA
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Senate Bill 411 McQuillan testimony v6.pdf
Uploaded by: Karen McQuillan
Position: UNF

Senate Bill 411 – Hospitals – Clinical Staffing Committees and Plans – Establishment

POSITION: Oppose

February 17, 2026

Senate Finance Committee

Karen A. McQuillan, MS, RN, CNS-BC, CCRN, CNRN, TCRN, FAAN, Lead Clinical Nurse Specialist at the University of Maryland Medical Center respectfully submits this letter **OPPOSING** Senate Bill 411.

I have had the privilege of caring for patients at the R Adams Cowley Shock Trauma Center at the University of Maryland Medical Center for nearly 40 years and I currently serve as the co-chair of the University of Maryland Medical System Nurse Practice Council. The University of Maryland Medical System Nurse Practice Council is a forum composed of frontline nurses and nurse leaders from throughout the Medical System that meet monthly to approve clinical guidelines and policies, recommend changes to improve patient care, and provide feedback on changes proposed by other disciplines that impact nursing.

I can assure you that I and all my nursing colleagues recognize that appropriate staffing is vital for provision of safe and effective care to our patients and is important to nurses' wellbeing. Evidence has shown that benefits of enhanced staffing are contingent on the health of the work environment. Professional Governance, a framework where frontline nursing staff partner with nurse leaders to make decisions about clinical practice fostering accountability and improved patient outcomes is one way a healthy work environment is promoted.

One aspect of professional practice that is enjoyed by nurses in many hospitals is staff led shared scheduling or self-scheduling. For example, all hospitals that have received Magnet or Pathway designation, recognition for nurse excellence, innovation, empowering nurses, and quality patient care, have shared or self-scheduling. Scheduling committees or councils develop nurse scheduling guidelines for the unit or department on which they work, and these guidelines are agreed upon by all the nursing staff on the unit. Nurses can always submit suggested changes to the guidelines for consideration by simply bringing up the recommendation with the Scheduling Committee chair, the nurse manager, or at a unit Shared Governance meeting. Nurses then submit desired schedules based on those staff designed guidelines. This gives nurses a voice in their schedule. Nurses may determine which days or shift times they desire to work. This flexibility allows nurses to continue their education, care for their family members, and/or attend important events. Creating a workplace that fosters this work/life balance assists in attracting and retaining a nursing workforce amid an ongoing shortage of nurses. Once staff-scheduling committee leaders ensure staffing numbers are appropriate to fulfill the established ratios for the unit the schedule is posted.

All staffing guidelines developed are based upon national standards and guidelines established by professional organizations, such as the American Association of Critical Care Nurses and the American Nurses Association. Staffing patterns may vary among member organizations at the University of Maryland Medical System based on differences in patient acuity. The type and acuity of patients is considered when determining nurse: patient ratios but also evaluated when ensuring nurse competencies match the needs of patients on the unit.

Voting for Senate Bill 411 would threaten to eliminate the scheduling flexibility that nurses find essential to maintaining a work/ life balance that fosters nurse wellbeing and retention. Also, standards for nurse scheduling already required by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) would make this Bill duplicative and unnecessary.

SB411_MedStarHealth_UNF
Uploaded by: Kimberly Routson
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MedStar Health

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Kimberly S. Routson
Assistant Vice President,
Government Affairs - Maryland

SB 411 – Hospitals - Clinical Staffing Committees and Plans – Establishment
Position: ***Oppose***
Senate Finance Committee
February 17, 2026

MedStar Health is the largest healthcare provider in the Maryland and 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.

Senate Bill 411 requires every licensed Maryland hospital, except state facilities, to establish a clinical staffing committee composed equally of management and employees. The committee must include representatives from nursing, dietary, environmental services, technicians, and a non-employee physician. The committee must write, and annually review, a unit-specific staffing plan that considers current levels, coverage gaps, patient acuity and evidence-based standards. Beginning January 1, 2028 hospitals must implement the plan and staff accordingly. Nurses and ancillary workers may file committee-level complaints over noncompliance with the plan and resolution of complaints is determined by majority vote. Each unit must publicly post its approved and daily actual staffing numbers and provide copies on request. Starting July 1, 2030 hospitals must file annual reports with the MHCC to be published online.

Flexibility is essential to fulfilling our mission as hospitals, given the inherently dynamic nature of our operations. Patient needs, acuity, and volume change minute by minute. To appropriately respond to constantly changing conditions, clinical leaders rely on the expertise of frontline staff. MedStar Health nursing follows a collaborative shared governance model, with seven professional councils that bring focus to various nursing roles across the organization—clinical nurses, nurse educators, informatics specialists, nurse leaders, and researchers. This model empowers staff to actively engage in the decision-making process, shaping policies, clinical practices, and patient care initiatives.

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association. The ANCC recognizes hospitals for nursing excellence through Magnet Status, which acknowledges superior nursing practices and patient outcomes, and the Pathway to Excellence program, which recognizes supportive and healthy practice environments that meet certain standards. MedStar Franklin Square Medical Center, MedStar Harbor Hospital, MedStar Montgomery Medical Center and MedStar St. Mary's Hospital have all achieved Magnet Status. MedStar Southern Maryland Hospital Center has achieved Pathway to Excellence designation. These recognitions underscore MedStar Health's commitment to shared decision-making practices, professional development, patient safety and staff wellbeing.

In addition to the rigorous review processes that come with Magnet Status and Pathways to excellence, hospital staffing is highly regulated by CMS as a condition to receive Medicare and Medicaid funding. These requirements include 24/7 nursing coverage, competency-based staffing, and individualized nursing care plans for each patient. Notably, CMS requires 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.

MedStar Health

Since last session, The Joint Commission made staffing a National Performance Goal. Now, hospitals will be surveyed on metrics related to staffing adequacy. Failure to comply would jeopardize accreditation which could jeopardize reimbursement from federal payers like Medicare and Medicaid. With this shift, SB 411 would be duplicative and redundant. The Joint Commission goal provides the necessary flexibility for hospitals to comply with significant consequences for noncompliance.

In concert with MHA, MedStar Health hospitals have committed to adopt actions that enhance collaboration between frontline clinical staff and hospital leadership, while allowing flexibility for individual hospitals to implement these actions in a manner that is appropriate to their unique culture, organizational structure and patient population. Each of our seven Maryland hospitals is distinctive, and these commitments will allow staffing needs to remain aligned with specific hospital needs, patient acuity and nursing expertise.

For the reasons stated above, MedStar Health urges an ***unfavorable*** report on **SB 411**.

UNFAVORABLE.SB411.HB624.LauraBogley.MDRTL.pdf
Uploaded by: Laura Bogley
Position: UNF

UNFAVORABLE

SB411/HB624 - Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)

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

On behalf of our Board of Directors and many chapters across the state, we oppose the so-called "Safe Staffing Act of 2026" and urge your unfavorable report. 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 or infringement on their First Amendment freedoms and rights of conscience.

This bill is an attack on the Constitution and free exercise of religion. This bill is an expansion on the Safe Staffing Act of 2025, that established a plan to impose hospital staffing requirements and report back to the State. It is the agenda of the Maryland Department of Health to compel private and faith-based hospitals to retain and compensate abortionists and an 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.

As demonstration of the legislative intent of these staffing committees, a companion bill HB372/SB169 was introduced by abortion activists in 2025 and 2026 to codify Biden-era abortion mandates on hospital emergency rooms, forcing medical providers to participate in elective abortion procedures against their conscience rights and Title VII civil rights as employees. Hospitals are being threatened with fines in the amount of $50,000 for each occurrence when a provider fails to comply, intentionally engineering a hardship for hospitals that allow them to violate an employee's civil rights.

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. 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 interpreted to require faith-based hospitals to keep abortionists on staff for the purpose of committing *elective* abortions, which are never medically necessary. The fact that 85% of ob/gyns refuse to commit abortions is evidence that abortion is not an essential part of women's reproductive healthcare.

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.

There is no law in any states which prohibit medical providers from performing emergency medical procedures to save the life of a mother. All Maryland hospitals already comply with the federal EMTALA statute.

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.

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 regulatory penalties and/or 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 healthy birth and delivery outcomes, 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/.

SB411 Unf JHUM LWeber CORRECTED.pdf
Uploaded by: Leslie Weber
Position: UNF

JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Pam Beidle, Chair
Finance

SB411
Unfavorable

FROM: Leslie Ford Weber, MPP
Associate Director, Maryland Government Affairs

DATE: February 13, 2026

RE: **SB411 - Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)**

Johns Hopkins opposes **SB411 - Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026).**

Clinical staffing committees are not the dominant model for addressing issues of patient safety and staff engagement in the United States. There are only eight states that have a clinical staffing committee law: Connecticut, Illinois, Nevada, New York, Ohio, Oregon, Texas, and Washington. Two other states (California and Massachusetts) have mandated nurse:patient ratios. In the testimony on a similar bill proposed in the 2025 session, proponents of the requirement to have clinical staffing committees asserted that states that have these requirements perform better than other states in important areas such as emergency department wait times, nursing vacancy rates and rates of workplace injuries.

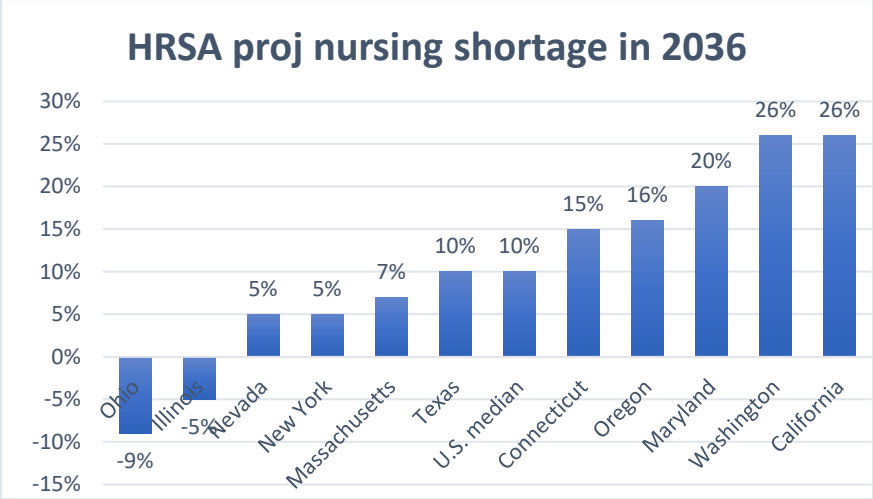
During the interim, I searched for evidence to support these claims and did not find it. Some states with committee requirements perform better when ranked against all other states and some perform worse. The same can be said for the other 40 states – including Maryland – that do not have these requirements. Some are performing above national medians, and some are performing below.

In short, nurse staffing committee requirements cannot be relied upon to ensure safe clinical care and will divert time, attention and resources away from other evidence-based measures.

Nursing Vacancy Rates

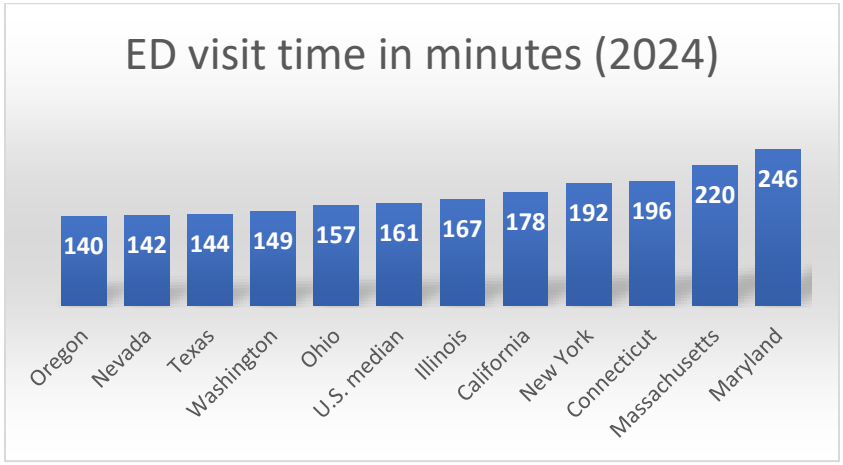
It is difficult to find state-by-state comparisons of current vacancy and retention rates. However, the federal Health Resources & Services Administration (HRSA) has published estimates of the projected nursing shortage in 2036. (See chart on the next page that also includes Maryland.)

Proponents of clinical staffing requirements assert that this is an important measure to recruit and retain nurses, but the available data does not provide strong evidence to support this claim. Of the 10 states studied, only six (or 60%) are projected to experience lower shortages than the projected national average of 10%. As a group, 28 (or 70%) of the remaining 40 states that do not have the requirement for either committees or ratios are expected to outperform the projected national average. Based on this data, it is a better strategy to avoid the committee structure if one is trying to manage the projected nursing shortage.



Emergency Department Visit Times

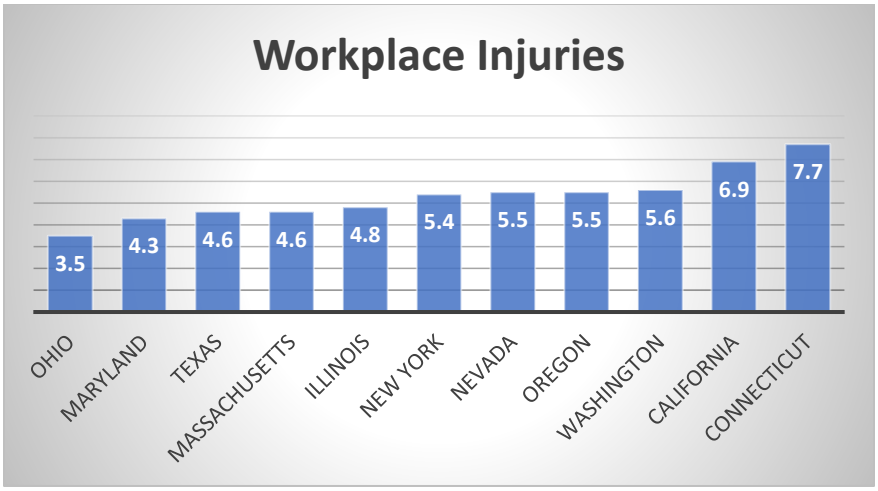
In January 2026, *Becker's* reported on data released by the Centers for Medicare and Medicaid (CMS) about visit times in the emergency departments in all 50 states and the District of Columbia in 2024. The median time in the U.S. was 161 minutes. As noted in the chart below, five of the states with either a clinical staffing committee law or mandated ratios performed above the national median and five performed below.



Workplace Injuries

It is also difficult to find reliable state-by-state comparisons of workplace injuries, including violent acts, in healthcare settings. In 2023, however, the Bureau of Labor Statistics reported incidence rates of nonfatal occupational injuries and illnesses in hospitals. This is a reasonable proxy.

On this measure, in fact, Maryland outperforms nine of the 10 states in the comparison group despite having neither required clinical staffing committees or ratios.



Hospitals in Maryland, including the four in the Johns Hopkins Health System, are committed to providing safe patient care and to supporting our employees. We are also committed to evidence-based practices.

The evidence for the program required by SB411 is not there.

Accordingly, Johns Hopkins respectfully requests an **UNFAVORABLE** committee report on SB411.

Thank you.

SB411 Safe Staffing Act of 2026 JHHCMC oppose.pdf
Uploaded by: Ronald Langlotz
Position: UNF

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

SB411
Unfavorable

TO: The Honorable Pam Beidle, Chair
Finance

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

DATE: February 16, 2026

RE: **SB411: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)**

Johns Hopkins Howard County Medical Center opposes **SB411: Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)** which is 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 hosted the appraisers for the Magnet Recognition Program earlier this month.

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.

Lastly, I also draw your committee's attention to The Joint Commission's National Performance Goal (NPG) 12 which became effective on January 1, 2026. All Maryland hospitals have to be accredited by The Joint Commission and follow their rigorous, evidence-based frameworks to address operational and safety matters. NPG12 requires hospitals to be "staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care." Standing up clinical staffing committees is not a part of the required framework in NPG12. Rather, the accreditation body charges me, as the nurse executive, with the duty to direct the implementation of a nurse staffing plan and to document the "types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital."

Accordingly, Howard County Medical Center respectfully requests an **UNFAVORABLE** committee report on SB411.

SB411_Oppose_St Agnes.pdf
Uploaded by: Wendy Lincoln
Position: UNF

Ascension Saint Agnes

Senate Bill 411 - Hospitals - Clinical Staffing Committees and Plans

Position: Oppose

February 17, 2026
Finance Committee

Good afternoon, Madam Chair and members of the Committee. My name is Wendy Lincoln, Vice President and Chief Nursing Officer for Ascension Saint Agnes Hospital. On behalf of Saint Agnes, we appreciate the opportunity to comment in opposition to Senate Bill 411.

Ascension Saint 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.

Safe staffing is a dynamic process requiring flexibility and nursing clinical judgement to determine the right type and level of care different patient populations require. 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, safe staffing levels based on evidence-based, best-practice standards by nursing specialties. These include the American Association of Critical Care Nurses, Academy of Medical-Surgical Nurses, Association of Women's Health, Obstetric and Neonatal Nurses, and the Emergency Nurses Association.

- Each unit has an interdisciplinary staffing grid based on the number of patients and acuity.
- Staffing decisions are made based on the availability and experience of clinical staff;
- Staffing on every unit is adjusted at a *minimum* of every 12 hours based on both patient volume as well as acuity;
- The hospital has an interprofessional team that looks at staffing daily at noon in anticipation of the next shift;
- Staffing needs are projected out for the next 24-48 hrs as well as longer term planning a week out;
- Opportunities for open shifts, for all levels of staff, are proactively sent out a week ahead of time

Our 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. There is a RN Shift Supervisor on 24/7, as well as Managers and Directors of nursing on call to problem solve and ensure adequate, safe staffing. The staff also has a formal process to bring up any concerns around staffing on any shift.

These processes are mandated by The Joint Commission and Centers for Medicare and Medicaid Services (CMS). These organizations establish requirements and national guidelines which prioritize patient safety and positive clinical outcomes. The Joint Commission standard ***requires*** nursing services to be responsible for determining the types and amounts of nursing personnel to provide adequate coverage. Hospital quality outcomes as well as CMS inspections serve as impartial auditing of adequate staffing that have financial penalties for noncompliance.

Hospitals need real-time flexibility to respond to and accommodate complex, evolving circumstances. A single, centralized staffing committee, as included under this proposed legislation, lacks the dexterity needed to respond in real time to volume changes and care demands. Likewise, a mandated staffing committee, as included under this proposed legislation, can't address the root causes of problems like workforce shortages, recruitment and retention challenges.

Additionally, clinical staffing plans should be developed by clinical team members. These decisions require specific clinical 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.

From the Maryland Department of Health's own letter in 2024 seeking an exemption of the Department's own 11 facilities, they stated: *The Healthcare System is bound to the Joint Commission and the Centers for Medicare and Medicaid Services (CMS) regulations. CMS does not allow external stakeholders to participate in staffing determinations. Determination of hospital policy by external stakeholders would violate CMS regulations, and could jeopardize federal funding.* We wholeheartedly agree.

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 SB 411 and its House companion HB 624 fail to reflect the complexities of hospital staffing, contradict the high professional standards and practices I previously outlined, and do not address the root cause of workforce shortages.

For these reasons, we request an ***unfavorable*** report on SB 411.

Thank you,

Wendy Lincoln MBA, MSN, RN, CMSRN, NEA-BC- FACHE
Vice President, Chief Nursing Officer

SB 411 - LOO - UMMS.pdf
Uploaded by: Will Tilburg
Position: UNF

Senate Bill 411 – Hospitals– Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)

POSITION: Oppose
February 17, 2026
Senate Finance Committee

The University of Maryland Medical System (UMMS) respectfully submits this letter of opposition to Senate Bill 411 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026) 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 11 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.

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

Senate Bill 411 ("SB 411") would require 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 responsible for making clinical staffing plans must include a broad range of clinical and *non-clinical* staff, including certified nursing assistants, dietary aides, environmental service workers, 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.

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, establishes mandates that are duplicative of federal law and accreditation standards, and places significant additional administrative burdens on hospitals without improving employee safety or patient care.

In particular, UMMS and its member hospitals share the following foundational concerns with the legislation:

1. **Clinical Staffing is Extensively Regulated under Federal Law and Accreditation Standards**

Maryland hospitals already operate under clinical staffing requirements established by the federal government and national accreditation organizations. The Centers for Medicare & Medicaid Services (CMS) Conditions for Participation require hospitals to provide 24-hour nursing services and maintain adequate numbers of licensed registered nurses and other personnel to meet patient needs (42 CFR §482.23). CMS enforces these staffing regulations through regular surveys and audits, and may levy penalties that include the loss of Medicare and Medicaid reimbursement.

The Joint Commission (TJC) – an accrediting body for hospitals nationwide – recently established clinical staffing as a National Performance Goal, beginning January 1, 2026. TJC standards align with and supplement the CMS Conditions for Participation for staffing and require hospitals to be adequately staffed to meet patient needs. Specifically, the nursing executive is responsible for the operation of nursing services, which includes determining nursing policies and procedures, and the types and numbers of nursing and other staff necessary to provide nursing care for all units of the hospital, as well as monitor compliance data and address any instances where care failed to meet the expected standards. TJC conducts regular, unannounced inspections to ensure compliance with its standards. Failing a TJC inspection can lead to severe consequences, including loss of accreditation and loss of federal reimbursement (e.g., Medicare and Medicaid reimbursement).

Importantly, CMS regulations and TJC national performance goals each require a nursing executive to direct staffing and prepare staffing plans, including the "types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital." As introduced, SB 411 places this authority in a committee consisting of equal membership from management and employees that includes several non-clinical staff. This requirement is inconsistent with federal law and national accreditation standards, thereby creating two different standards – one federal, one state – for hospital staffing.

2. **Hospitals Engage Frontline Staff Directly and Practice Robust Shared Governance**

Bill proponents argue that hospitals do not meaningfully engage frontline clinical staff in staffing decisions. This is not accurate. Pursuant to CMS requirements and national accreditation standards related to clinical staffing, 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. For instance, at the University of Maryland Baltimore Washington Medical Center (UM BWMC) direct care staff are empowered to present evidence-based recommendations through:

- Daily organizational and unit-based safety huddles
- Leader town halls
- Multidisciplinary rounds
- Staff and committee meetings
- Shared Leadership Councils
- Unit Practice Councils (UPCs)

Daily Safety Huddles bring together patient flow coordinators, senior leaders, managers, supervisors, charge nurses, physicians, care managers, and other service line representatives. Participants openly discuss safety concerns, staffing challenges, risks, and operational needs. When team members identify opportunities for improvement in staffing, safety, or workflow, they discuss potential solutions and may form multidisciplinary taskforces or committees to implement change. Representatives include a wide range of clinical staff to ensure comprehensive and inclusive decision-making. These mechanisms also allow real-time input and flexible solutions, and are far more responsive than a rigid statutory staffing committee structure.

Finally, at several of our member hospitals, employee categories covered by the bill already have collectively bargained rights governing workplace conditions and staffing. The potential impact of the legislation on this class of employees is not clear.

3. **Hospitals are Facing Increased Operational and Financial Challenges Due to Changes in Federal Law and Funding Cuts**

SB 411 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 19-396 of the bill would require a hospital 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.

Moreover, SB 411 proposes to introduce new compliance burdens at precisely the wrong time. Maryland hospitals are preparing for the transition to the AHEAD Model Agreement, and the subsequent loss of hundreds of millions of dollars in federal Medicare and Medicaid funding under the agreement. Federal cuts to Medicaid under the One Big Beautiful Bill Act (H.R.1) and expiration of federal Affordable Care Act premium subsidies will further reduce federal healthcare spending in Maryland and exacerbate financial challenges for hospitals. This is particularly true for safety net hospitals in the State that disproportionately serve patients enrolled in Medicaid and Medicare. Despite these known and significant challenges, SB 411 would require hospitals to implement clinical staffing plans on the exact day, January 1, 2028, that the federal Medicare reimbursement is reduced under the AHEAD Model.

4. **SB 411 Creates an Inequitable System between State and Private, Nonprofit Hospitals**

As introduced, SB 411 proposes to exempt State hospitals from the requirements to establish clinical staffing committees and plans. Last session, in the House hearing, alternative explanations were provided for the decision to exempt State hospitals: (i) extending the mandate to State hospitals would create a large fiscal note, and (ii) State hospitals are subject to clinical staffing requirements set by CMS. In addition, in a 2024 letter of support with amendments to the bill, the Maryland Department of Health (MDH) indicated that State hospitals are "bound to the Joint Commission and the Centers for Medicare and Medicaid Services (CMS) regulations. CMS does not allow external stakeholders to participate in staffing determinations. Determination of hospital policy by external stakeholders would violate CMS regulations, and could jeopardize federal funding." (*see* House Bill 1194 – Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2024) – Letter of Support with Amendments, Maryland Department of Health, March 13, 2024). However, each hospital in the state is subject to identical CMS Conditions of Participation, meaning the same federal staffing standards apply.

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.

5. **Hospital Staffing Committees Will Not Address the Nationwide Healthcare Workplace Shortage**

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 steps 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 more than 1,000 new nurses over the past three 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, SB 411 fails to address this issue in a fair, effective, and evidence-based manner. SB 411 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 federal law and nationally recognized standards to ensure proper staffing.

For these reasons, the University of Maryland Medical System opposes SB 411, and respectfully requests an ***unfavorable*** report on the bill.

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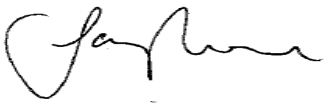

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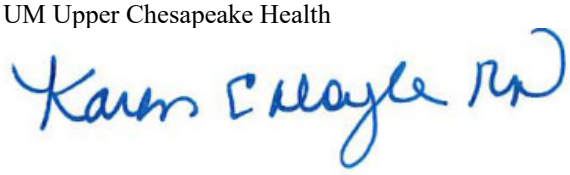

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