OREGON STATE HOSPITAL
Superintendent's Office
Kate Brown, Governor

Oregon Health Authority

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Jake Cornett
Executive Director Disability Rights Oregon
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Dear Mr. Cornett,

On behalf of Governor Brown and Director Allen, I am writing in response to your letter outlining your concerns about staffing at the Oregon State Hospital (OSH). I share your concerns about the impact the COVID-19 pandemic and the long-term Aid and Assist crisis have had on people with severe mental illness who need hospital level of care – and the impact these emergencies have had on the dedicated staff at the Oregon State Hospital who serve them. The leadership team at OSH has addressed these issues with urgency and transparency. That said, OSH is a part of a larger statewide behavioral health and health care system that has been seriously battered by these profound larger crises. Despite an array of intensive efforts to stem the staffing challenges we have faced at the state hospital, I recognize there is more work we need to do to ensure that every patient and staff person experiences a stable and supportive environment at this time. I appreciate your partnership as the hospital navigates the challenges brought on by these extreme external forces.

Let me give you a more complete picture of the steps the hospital has taken to address your concerns.

COVID plans

Since the start of the pandemic in early 2020, the primary focus of state hospital managers and staff has been to keep patients and staff safe and to prevent the spread of COVID-19 infections. OSH has had one of the best track records in the country for patient health and we took immediate action to plan and execute our pandemic response.

Our efforts have worked. While COVID-19 tore through other congregate settings across the nation and Oregon – from nursing homes to state correctional facilities – OSH did not record a single positive patient case until eight months into the pandemic. To date, no patients at the state hospital have died from COVID-19.

Here are the steps we took. When the pandemic began, the hospital immediately began planning to keep patients and staff safe and we activated an emergency operations center to coordinate our response.

To keep staff and patients informed about COVID-related protocols, we issued a series of administrative directives to institute mask-wearing and contact tracing, establish screening stations, make changes to treatment schedules, close parts of the campus that could facilitate the spread of COVID-19 and ultimately to administer vaccinations for patients and staff.

Throughout the pandemic, we have adjusted our protocols based on changes to CDC guidelines and in consultation with the state epidemiologist. As national and state public health experts have learned more about the SARS-CoV-2 virus, we have incorporated the latest scientific evidence into our strategies. For example, we:

- Converted a unit to provide medically isolated treatment to COVID-positive or PUI patients, which meant we had to move some patients to other units.
- Temporarily suspended our very successful treatment mall model, moving back to a unit-based group treatment, to keep patients in their “bubble” and socially distanced.
- Suspended visitation to reduce exposure for patients and staff.

All of these steps have had necessary and unavoidable consequences. Creating a COVID-19 isolation unit meant asking staff to move to other units to manage new patients with higher levels of acuity. The unit-based group treatment model lacks the variety of treatment opportunities we can offer in the treatment mall. Suspended visitations have meant that patients have less connection with family and friends.

While we regret these consequences, we stand by the interventions we’ve taken. I am convinced our efforts have prevented patients from becoming sick with COVID-19 and saved patient lives.

I recognize these COVID-19 prevention steps have caused stress and confusion for some patients, staff and families. However, our priority has been to prevent infection – and long-term illness and death – by limiting the risk of transmission.

That said, I know communication is a vital part of our effective COVID-19 response and we have been focused on keeping staff, patients and families, stakeholders and the broader community informed about conditions at the hospital throughout the pandemic. For example, we have provided information to staff via morning huddles, email, unit reader boards, flyers left where staff can easily pick them up, posters placed where staff can easily see them and on the intranet, where staff can access all of the COVID-related plans and other hospital information at all times.

Staffing

OSH, like every hospital in the country, has suffered a workforce shortage. When the pandemic began, the administration created an emergency staffing plan that was shared with all staff. This plan was developed to ensure we could maintain needed staffing in every unit, in the event large numbers of staff stayed home due to illness, a family member's illness, or lack of childcare.

The first phase of the plan was initiated on the Salem campus in April 2020. As each phase of the staffing plan was implemented, staff were notified of the changes that would occur.

I want to acknowledge that in November 2020, we implemented recommendations from our Nurse Staffing Committee on a new staffing plan. (This committee includes both management and labor representatives.) The Nurse Staffing Committee recommended that OSH enhance staffing levels across units to respond to the increased patient acuity OSH has experienced due to the long-standing Aid and Assist crisis in the community. This change in the staffing formula altered our baseline patient-staff ratios. As a result, the new ratios increased OSH staffing demands and pressures just when the pandemic struck. To meet these challenges, OSH has had to mandate shifts frequently throughout the pandemic. It's no secret that these mandated shifts have had a significant impact on staff morale, but they have been a necessary tool to meet the enhanced unit staffing required under our most recent staffing formula and help patients get through the changes in programming the pandemic has forced on OSH.

As the pandemic has continued, OSH has seen an increase in staff departures and vacancies, just like nearly every other hospital in the country. Although we do not have data on every staff resignation, we know many have left to pursue career opportunities or higher pay elsewhere. Others have left because of a lack of childcare or for personal reasons, including mandates, exhaustion, and burnout.

We thought staffing levels would return to normal when the special COVID leave expired at the end of June. Unfortunately, that time coincided with the beginning of the Delta variant surge, which infected more staff during the summer of 2021 than all the months prior. Stress due to illness, contact tracing notifications, and fear of infection played a large role in staff resigning over the summer, in addition to the reasons mentioned above.

OSH managers have also expanded our recruitment outreach efforts. We have sent press releases about job openings, advertised on social media (such as LinkedIn) and in nursing publications, and we have prominently featured our employment opportunities on our website. In addition, we continue to foster positive relationships with nursing schools, inviting prospective employees to tour the hospital and learn about our state-of-the-art care.

In the meantime, we have increased our contracts with staffing agencies, which continue to bolster our clinical staffing levels. For example, 68 agency RNs, LPNs, CNAs, and MHTs had completed training and begun working on units, as of the start of October.

While these efforts have continued, OSH also addressed staffing shortages over the summer by asking the National Guard to deploy members who could assist staff and keep patients safe. I want to be clear: Oregon National Guard members do not provide direct clinical care to patients. Nor do they wear their ONG uniforms. They offer assistance with meal service, escorting, courtyard supervision, and patient engagement which enable nursing staff and other clinicians to provide treatment. Guard members received training and mentoring to position them for success and a smooth integration into the hospital environment.

We are grateful for the Oregon National Guard partnership, which has supported patient treatment and engagement, staffing stability and safety, and bolstered spirits throughout the hospital. We have had Guard members who were in the initial deployment ask to be redeployed to the hospital. To date, at least four Guard members have applied for open positions at the hospital, as they found the work both meaningful and rewarding. We are happy to have them join our staff as employees.

The partnership we have developed with the National Guard is incredibly valuable to us. They have served critical roles with professionalism and care. The Guard is currently scheduled to remain until Dec. 31, 2021. If needed, we would not hesitate to ask for the Guard's assistance, again.

This summary describes just some of the measures OSH managers have taken to address staffing issues, working in partnership with nurse and staff union members. I am happy to provide more details.

Treatment

There is no question that our ability to offer the breadth and variety of therapeutic groups and activities to which we (and our patients) are accustomed was significantly impacted by COVID-19. In addition to the temporary shift to unit-based treatment, the Behavioral Health Specialists and Treatment Services staff (who, together, provide the largest percent of groups) were extensively deployed in the first three stages of the Emergency Staffing Plan.

While the Emergency Staffing Plan was in place, unit-based clinicians dedicated additional time to providing individual and group treatment. But because these clinicians are also responsible for other critical work – assessments, discharge planning, and individual therapeutic interventions, for example – it was not possible to entirely replace the treatment hours and variety of group options provided by the deployed staff.

Since the Emergency Staffing Plan ended, we have implemented a cohort model of treatment, in which a group of clinicians comprising both Treatment Services and Psychology staff provide group treatment to patients on two or three units. This provides access to a greater breadth of treatment options while also limiting risk of infection spread. We have also begun to resume co-mingled patient activities. Our goal is to return to the treatment mall model once we are confident that no further significant waves of COVID-19 infection are on the horizon.

I also want to be clear that patients continue to receive appropriate substance use treatment, recognizing that the type and intensity of substance use treatment varies among programs, based on clinical factors, treatment plans and legal requirements. For Guilty Except for Insanity (GEI) patients, completion of substance use treatment is often a mandatory requirement before a patient can be considered ready for conditional release. As a result, our programs who treat GEI patients prioritize substance use treatment. However, for patients under Aid and Assist orders, their commitments are for the purpose of restoring competency to aid and assist one's legal defense. While substance use treatment may be part of a patient's treatment plan, it is not a primary objective of their admission. (The therapeutic constraints that Aid and Assist orders impose on clinicians and their patients at the hospital are one of the many reasons OSH is eager to have this Aid and Assist crisis resolved in the community. We want to help patients recover, not just regain a sufficient level of competency to participate in a criminal proceeding.)

I want to acknowledge that staffing our Legal Skills groups has presented a particular challenge during the pandemic. OSH relies on Behavioral Health Specialists to teach most of these groups. The process for training new staff is robust and takes considerable time. Staff efforts to shorten the training time was interrupted by the Emergency Staffing Plan deployment, because most of those staff who could train other clinicians were deployed to other priority assignments. These challenges our staff have faced in delivering our Legal Skills groups have largely affected units whose patient populations have not historically been focused on serving Aid and Assist patients. We continue to work to improve this situation and ensure all .370 patients have timely access to Legal Skills groups.

Patient Transfers

I want to be direct and clear in stating that it is not our policy to move patients between the Salem and Junction City campuses without clinical consideration.

In order to implement the hospital's COVID mitigation strategies and to maximize the use of the hospital's beds, OSH has had to move patients throughout the hospital quickly to ensure the safe and appropriate placement of all of its current and incoming patients.

I have directed my staff to incorporate comprehensive clinical information before any patient is transferred. We have recently updated our policy to include a process for clinicians to escalate significant clinical concerns and highlight any challenging medical treatment needs a patient may face. We reviewed our processes in late August. The target date to implement the most recent policy revisions, new forms and trainings is November 15, 2021.

Discharge planning

The Oregon State Hospital is a highly specialized psychiatric treatment environment that has limited capacity and must be reserved for people who need hospital level of care because they are experiencing the most severe forms of mental illness.

OSH staff have worked closely with partners to reform Oregon's Aid and Assist statutes to preserve hospital care for our most vulnerable mentally ill patients.

In recent years, we have worked with DRO and other advocates to mandate that CMHPs conduct community restoration evaluations, establish a process for OSH to notify the courts when state hospital clinicians determine that patients do not require hospital-level care, and require courts to make hospital-level care determinations before they commit a patient to the state hospital.

OHA advocated for and received an additional $38.6 million in the 2021-23 budget to expand investment in community restoration and to develop secure, community-based residential options for people under Aid and Assist orders, who now comprise OSH's largest patient population.

Each day, OSH clinical staff work with local partners to leverage these reforms and resources to appropriately discharge patients back into the community when they are ready to return. However, despite these reforms – and the legislature's historic investment in behavioral health in the most recent session – demand for treatment and housing continues to far exceed capacity in many Oregon counties. Too many Oregon counties look to the state hospital to commit mentally ill people who have fallen into the justice system because of a lack of appropriate treatment in their communities. While Director Allen and I continue to make it a top priority to solve this issue, these problems will not be resolved until advocates and other stakeholders work to hold county officials accountable for their Aid and Assist decisions, not just the state.

Visitation

The worst impact the pandemic has had on patients is on their ability to visit in-person with their families. Knowing this would be a serious hardship for patients when the pandemic began, OSH staff immediately set up virtual visitation, providing computers in quiet rooms in areas that could be sanitized and safe, where patients could visit with their families online.

We continue to look for way to help patients maintain strong ties to their families and support communities because we know these ties are vital to their recovery and their successful return home. But we also continue to take a science-based approach to COVID-19 prevention. We monitor the COVID positivity rate in Marion and Lane county to determine when we can reopen. If and when the 7-day test positivity average drops below 8 percent, we will open in-person visitation with appropriate safe-guards in place. Last week, we were able to open in-person visitation on our Junction City campus using this methodology.

Conclusion

I appreciate DRO's ongoing advocacy for our patients. I share your passion for our patients' recovery and your concerns about the challenges facing OSH.

At the same time, I am proud of the results we've achieved for our patients, and the staff who've produced them, even as they have weathered unprecedented trials, including a global pandemic. Despite our current challenges, state hospital staff and administrators have prevented large outbreaks of COVID-19, reduced incidents of patient assaults on staff and continued to provide effective, recovery-oriented treatment to an increasing number of patients with higher levels of clinical acuity.

I know it has been a hard time for many of our employees and we have much work to do to fill our vacancies and re-energize morale. However, I am confident our staff, managers and union representatives will continue to work together to ensure our patients have the best possible safe and therapeutic environment. Please continue to share your input and recommendations.

Sincerely,

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