Proponent Testimony on HB 466
Commerce and Labor Committee
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Greetings, Chairman Stein, Vice Chair Johnson, Ranking Member Lepore-Hagan, and members of the committee. Thank you for the opportunity to discuss HB 466, and thank you to Representative Jay Edwards for sponsoring this bill.

Currently, staffing agency use in long-term care incites and promotes predatory business models, opportunistic staff, and a lack of accountability for the agencies themselves. In these unprecedented times of workforce shortage, coupled with the pandemic, our major concerns with healthcare staffing agencies are three-fold:

1. Resident Care

CMS and OIG recognize the relationship between care and staffing,[i] as do we. Compassionate, tenured staff know residents' needs and preferences and believe in the mission of long-term care. I have had numerous conversations with facility Administrators, Directors of Nursing, and Corporate Support Team Members. There are consistent themes throughout regarding agency staffing and its impact on resident care.

Many agency staff do not show up for work assignments; refuse to work certain units; will leave before their shift is over or show up late, by hours; will not give shift-to-shift report, which is a communication tool our industry uses to convey change in condition and other important resident care considerations; will not order medications; will not fully and/or in a timely manner complete medication pass or clinical treatments; do not follow specific infection control guidelines; sleep on the job; refuse to work if staffing levels are not to their liking; and do not know the preferences and routines of our residents which causes complaints from residents, families, and to ODH.

Due to the nature of agency-use, (it is used when providers are in desperate need of staff and have run out of other options), onsite orientation and job training at the facility-level is limited and mostly non-existent. This can lead to less than desirable care and poor resident outcomes. Some agency staff are open about their clinical limitations, for example, we have had agency staff refuse to replace Foley catheters; unwilling to work with COVID positive residents; and unable to utilize clinical skill and critical analysis to treat residents in the facility, so residents are sent out to the hospitals instead. These are minimum requirements of facility clinicians, and yet the agency staff paid top dollar for are not able to fulfill these requirements.

Furthermore, agency staff tend not to participate fully in the investigation process if there has been an incident at the facility, both at the time of the incident or if there is litigation afterward. The accountability for care issues in general is lacking. If there is an incident the facility would terminate a nurse for, such as not doing CPR on a resident who is a full-code, the agency will simply send their nurse to another facility; which has unsettling implications for resident care.

2. Facility Culture

The lackluster care performed by agency staff not only negatively affects residents, it also breeds a dysfunctional work culture. It is inherently demoralizing to be tasked with something as important as human care and then to witness or be a part of a job not done well or right. Front-line staff, facility leadership, and corporate staff have all told me how this dysfunction translates into day-to-day operations. Furthermore, I have dealt with it first hand in supporting daily operations. Plenty of agency staff do not seem to care about customer service; have an unpleasant attitude; are argumentative with facility staff; tell facility staff what they make per hour, which is much higher than what facility staff are making, and in doing so causes staff to resent management; will sit in their car demanding a higher wage before actually coming in to work; and ask for bonuses on top of already-high wages.

Intelycare has facilities post bonuses and wages. Agency staff will use those postings to pick the facility offering the most money. An agency nurse told one Administrator that she waits until the last minute to pick the highest paying shift from Intelycare and then will call off to whatever building she was assigned to by her agency, in order to make the higher wage from Intelycare.

3. Operational Viability

Nursing homes must have enough caregivers to meet the needs of residents, who are medically complex and fragile, some being cognitively impaired, and many being indigent. Nursing home residents are the most vulnerable of the vulnerable. Agency use is not something operators are interested in because of the points I have already discussed. But, the current staffing situation and public health emergency are so dire, the industry has been forced to turn to agencies so they can provide care. Staffing agencies do not have the overhead nursing homes have. Their exorbitant rates are not sustainable for us to pay. These days it is not just the agencies' rates that we are contending with, we are also having to compete with pay for our own staff due to the emaciated labor market. Lack of staffing coupled with unaffordable staffing costs are driving nursing homes out of business.

We have numerous safeguards employed in capitalism to ensure the perils of a free market do not overshadow the good. How much more so in the economy of healthcare should we be vigilant with ensuring a fair and just market system. In light of that, I respectfully request that you vote yes on HB 466.

Please contact me if I can address any further questions you may have. Thank you for your time.

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[i] CMS QSO-22-08, Nursing Home Staff Turnover and Weekend Staffing Levels