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TAKING YOUR HEALTH TO HEART

January 31, 2020

Dear Chairwoman Concannon and Members of the House Children and Seniors Committee:

Thank you for allowing me the opportunity to present my testimony regarding workforce challenges. My name is Aimee Zimmerman. I am the Chief Operations Officer (COO) for Logan County Health Services (LCHS) in Oakley, Kansas. Oakley is a rural town in the northwest part of the state with about 2,000 residents. LCHS includes a rural health clinic, critical access hospital and long term care. I have had the pleasure of working for LCHS for the last 18 ½ years. My first years were spent working the floor as a registered nurse in our critical access hospital. Since 2006, I have been involved with both the hospital and long term care as risk manager and then COO. During that time I have seen a change in our workforce particularly in the long term care setting.

In 2006, we had little difficulty meeting staffing needs with our own staff. We had contracts with three staffing agencies to help cover gaps during times of turnover. In the last several years, we have had an increasingly difficult time hiring licensed nursing staff. Our biggest problem has been finding and retaining certified medication aides (CMAs) and certified nurse aides (CNAs) for our long term care. This has been most acutely felt in the last three years. For nursing staff, the difficulty is primarily with the night shift. We have been forced to staff the majority of our night nursing shifts with agency staff. In addition, we have been experiencing shortages with CMAs and CNAs for all shifts. Again, those shortages are then filled by agency staff. Currently, we have contracts with seven staffing agencies to cover our needs. Nationwide, it is projected staffing shortages will continue to grow for long-term care facilities and others serving the needs of our aging population. The number of job openings in these settings could reach 8.2 million by 2028. The increasing shortage is fueled by a decreasing workforce and increasing number of elderly (Meyer, 2020). This is concerning to Oakley given the difficulty we already have with staffing. In addition, the percentage of people over 65 in our county is nearly 21%, which is 5% more than Kansas as a whole (Kansas Health Matters, 2018).

Staffing difficulties have the potential to negatively impact the care of our residents. When shifts are not adequately staffed residents may have to wait longer to have needs met. This increases the risk of falls and injury. Sometimes staff volunteer to work longer hours or more shifts. This is good in the sense that it means our own staff caring for our residents, but it can also lead to worker fatigue, burnout and care issues. For that reason, we have implemented limits to the number of hours an employee can work in a week. The constant strain of covering shifts can lead to poor decision-making by nursing supervisors. We have seen supervisors let performance issues slide because of the fear of not being able to cover a shift. This fear exists not only because of the desire to give residents

the best possible care and prevent falls, but also because continuously working short-staffed can lead to the loss of good employees.

Using staffing agencies helps us cover our needs in the long term care, but it also causes many challenges. The most apparent challenge is cost. Often the hourly rate paid to agencies is double the hourly wage paid to our own staff. There are often mileage fees in addition to the hourly rate. Some contracts require the facility to pay additional fees if the staff member is in overtime, even if the previous hours were worked in a different facility. It can be very difficult to get the needed paperwork, such as background checks, on agency workers prior to having them fill a shift. Staffing agencies are not always familiar with the regulations long term care facilities must follow. Agency contracts usually have a buyout to protect their staff from being recruited to a facility. Buyouts can range anywhere from $5000 to $12,000 making it nearly impossible to buyout a contract. While staffing agencies have built buyouts into contracts to protect their staff, we do not have that same luxury to protect our staff. We notice an increased tendency for agency staff to call off at the last minute which can leave the facility short-staffed. There are also more care issues with agency staffing. While many agency employees are hard-working and caring, we do have a higher number of performance issues with agency staffing. We try to staff the same agency personnel as much as possible, but it is still harder to achieve continuity of care when the facility is staffed with agency personnel.

Staffing challenges have prompted many discussions amongst our leadership on possible causes and solutions. Those discussions have generated the following observations on causes. While we have several very dedicated staff with long tenures, we are noticing essentially no young CNAs entering our workforce with the intention of staying in that position for most of their career. Many of our young CNAs are working in that role to get them to their next career step. They are using it to get them ready for nursing school or pay for college. Some are lured away from CNA work to do other work. CNA work can be emotionally and physically difficult. Therefore, many move to less demanding jobs, such as jobs in the food service industry. These jobs in our community are made more enticing since the salaries paid by these establishments are increasingly competitive. Finally, we see CNAs choosing to work for staffing agencies rather than work for one facility. This is attractive given that the CNA has more say in how and when they work, has little accountability, and often gets paid mileage in addition to their hourly wages.

Our leadership has also been working on solutions to our staffing issues. First, we have been working with our local high school and a nearby community college to offer more CNA classes. The classes through the college are nice since one of our nurses is able to teach the course within our facility. However, often there is little advance notice of the class and the students are mostly from out of town. We have found we get few CNAs from this arrangement.

Second, we have been actively working with the high school to provide CNA classes. The high school offers a CNA class each semester that gives the student both high school and college credit. The class is taught in the high school and clinicals are done at our long term care. This has provided us with several prn CNAs. However, we have found the students taking this class are usually the students that are involved in multiple school activities. The benefit we get from this arrangement is mostly in help during the summer months.

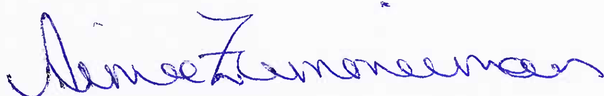
Third, we work to be competitive with wages and benefits. We have been using wage information from Leading Age to compare our wages to like facilities in an effort to ensure we are offering a competitive wage. This can be a helpful tactic to attract and retain staff. However, as other long term cares in the area discover a market adjustment was made, they also make adjustments in pay, which diminishes our ability to compete for staff. We also pay shift and weekend differentials. While we offer a very robust benefit package including health insurance, KPERS, paid time off, paid holidays, long-term disability, life insurance, and wellness center membership, we find many CNAs are not interested in benefits. They are much more interested in their hourly rate which makes working for staffing agencies or leaving CNA work to do some other work with fewer benefits more attractive.

Fourth, and most dramatically, we decreased our licensed number of beds in the long term care. In 2017, we spent $511,000 on agency staffing. In 2018, we were able to make a dent in that amount by utilizing our high school help during the summer and buying out the contract of one of our agency night nurses to become our employee. Still, in the beginning of 2018, we were still spending money on agency staffing at an alarming rate which prompted the decision to decrease our number of licensed beds from 45 to 32. This was a decision with which we struggled. We knew the change would mean less income, but our long term care was not at capacity and we felt compelled to care for our residents with our own staff as much as possible. We were able to decrease our census over the course of several months through attrition. Therefore, in 2018 we were able to decrease our agency staffing costs to $379,000. At a lower census in 2019, our agency costs decreased further to $308,000. The cost of agency staffing only adds to the significant losses our organization incurs in our long term care facility. These losses have been borne by the rest of the organization, but financial resources are tight and becoming tighter. As reimbursement has changed, and our private pay percentage goes up for the hospital and clinic, cash flow is increasingly an issue.

I am hoping this testimony gives you a glimpse in the complexity of challenges we have faced with staffing long term care. This is not an issue exclusive to our facility. I have spoken with other facilities experiencing many of the same issues. I feel as if rural health care needs support from our lawmakers when it comes to considering changes in reimbursement and in regulating staffing agencies.

Thank you for your service to Kansans. I know that like LCHS, you face complicated issues every day. I appreciate the opportunity to present this testimony and present these concerns to you all.

Respectfully,



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