Submitter: Stacey Vieyra-Braendle

Committee: House Committee On Behavioral Health and Health Care

Measure: HB2697

Dear Chair Noose and committee members,

My name is Stacey Vieyra-Braendle. I am an occupational therapist with Kaiser Permanente and am writing today in support of HB2697. I chose Occupational Therapy (OT) as a second career. I previously worked as a music therapist, and was ecstatic to find another healthcare profession that allowed me to be on the ground floor with patients, but that also afforded me a more respected seat at the table. I was ENERGIZED entering this profession in August of 2020, despite entering the workforce during a very trying time. Now, despite being one of the newest members of my team, I am tired. I am tired because our team remains staffed to serve nearly half the patients we currently have orders to treat during their hospital stay. I am tired because, being so understaffed, I'm unable to serve patients in a way that feels effective and supportive of their rehabilitation – that disappointment is draining. I am tired because we have so many patients to see, that I'm rarely afforded opportunities to advance and grow my skills – I just feel like a cog in a wheel some days.

Maybe 6 years ago, right as I was preparing to enter OT school, a really exciting article came out in the OT world: researchers at Johns Hopkins demonstrated that OT is one of the only spending categories where increased spending has a statistically significant association with lower readmission rates. And last year, another exciting research study was published that linked higher-frequency of OT services while hospitalized to reduced readmission rates. But I don't know how to provide high-quality, high-frequency services when we regularly only have 4, 5, 6 OTs on-site, with capacity to serve 28-42 patients on a good day, and a caseload of 80+. I don't know how to do that when we have already had to decrease the frequency at which we serve patients, and often, the time we spend in the room with them. I don't know how to do that when our patient population is sicker and more complex, when patients have transformed from fairly straightforward patients to patients who are houseless, severely depressed, in the midst of psychosis, experiencing withdrawal, who are food insecure, and/or who are gravely deconditioned after isolating during the pandemic.

A mantra of mine has become "No one is going to die if they don't receive OT services today.", to encourage me and my co-workers to focus on taking time to improve processes, care for ourselves, mentor others. And it's true: patients won't die today. But the implications of unsafe staffing have long-standing impacts on the rest of someone's life. So, maybe my patient doesn't die today, but maybe they do next month, or next year, after several readmissions. After lengthy re-admissions, meaning weeks not days. After a fall at home that maybe we could have prevented with time for caregiver training, or more opportunities to rehearse transfers in and out of their bathtub. After mismanaging their medications, which maybe we could have predicted with more time for cognitive and safety assessment. We all know that, though hospitals are supposed to be places of healing, increased contact with our hospitals, increased lengths of stay, are all risk factors for additional illnesses and injuries. For increased deconditioning, leading to longer rehabilitation journeys.

So, in closing: I am begging you to recognize this “staffing crisis” for what it is: a matter of life and death, for our patients, and our colleagues. I am also begging you to recognize that the moral injury of the terrible working environments our hospitals have become extends far beyond our nursing staff.

Thank you,

Stacey Vieyra-Braendle