

GUIDE · LONG-TERM CARE

Agency, App or In-House? Choosing a Staffing Model for Long-Term Care in 2026

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Most long-term care providers now use a mix of staffing sources. The right mix depends on which shifts are hard to fill, how much consistency residents need, and who carries the compliance work.

The market in 2026

Healthcare staffing has settled after the post-pandemic correction. Staffing Industry Analysts expects the U.S. healthcare staffing market to grow about 1% in 2026 and 3% in 2027 ([SIA, 2026](#)). Three shifts matter for long-term care buyers:

- Shift apps are a large channel. SIA estimates that online staffing platforms held about 28% of per diem staffing revenue in 2025.
- Hospitals buy through vendor programs. A median 86.7% of travel nurse revenue flowed through managed service or vendor management programs, which favors large national firms.
- Care is moving outside hospitals. SIA cites projected job growth of 12.2% in ambulatory care through 2034, against 3.9% for hospitals, with home health and outpatient care among the strongest areas.

In Pennsylvania the pressure on long-term care is sharp. The Pennsylvania Homecare Association reports about 112,500 home care shifts going unfilled each month, and nearly all agencies it surveyed have turned away referrals for lack of staff ([WESA, February 2026](#)).

How the models compare

MODEL	BEST FOR	CONSISTENCY	SPEED	WHO HANDLES COMPLIANCE
In-house float pool	Predictable gaps across several units or buildings	High	Medium; needs hiring lead time	Facility
Shift apps	Last-minute single shifts	Low; different worker each time	Fast	Shared; check what the platform verifies
Agency per diem	Recurring call-off and weekend coverage	Medium	Fast to medium	Agency, with records to the facility
Agency contract (4 to 13 weeks)	Open positions while you recruit	High; same person each week	Medium	Agency, with records to the facility
Interim leadership	DON, ADON or MDS coordinator vacancies	High	Medium	Agency

Costs the hourly rate does not show

Comparing bill rates alone misses several real costs:

- Orientation. Every new face needs a building tour, EHR access and a review of resident care plans. A rotating cast repeats that cost every shift.
- Resident experience. Residents with dementia do better with familiar caregivers, and families notice turnover.

- Overtime on your own staff. Unfilled shifts often become overtime, which raises cost and burnout at the same time.
- Survey risk. Missing credential records for outside staff are a citation risk regardless of who supplied the worker.

Questions to decide the mix

1. Which shifts went uncovered or ran on overtime in the last 60 days? Group them by unit, shift and day of week.
2. Are those gaps predictable (every weekend overnight) or random (call-offs)? Predictable gaps suit contracts or a float pool; random ones suit per diem coverage.
3. Which units need the same caregiver most, such as memory care or rehab?
4. Can you get a complete credential file for every outside worker before the first shift?
5. In Pennsylvania, is the agency registered with the Department of Health under Act 128? See our [Act 128 checklist](#).

Where Present Health Staffing fits

We focus on the gaps that apps and in-house pools handle poorly: the same LPN or RN in your building for 4 to 13 weeks, interim MDS coordinators, and recurring per diem coverage with full credential files. [Send us your open shifts](#).

Sources

1. [US Healthcare Staffing Market Growth Assessment: 2026 \(Staffing Industry Analysts\)](#)
2. [Pennsylvania caregivers and the home health crisis \(WESA, Feb 4, 2026\)](#)