Understanding and Addressing Key Oregon Provider and Workforce Capacity Challenges

ATI Advisory Phase I Research Findings Prepared for the Oregon Joint Task Force on Hospital Discharge Challenges

April 2024

ATI Advisory

AGENDA / CONTENTS

- Key Findings from Post-Acute Care Provider and Workforce Analyses
- Starting the Conversation: State Opportunities to Address Provider and Workforce Capacity
- Facilitated Discussion and Member Comments

ATI'S MIXED-METHODS ANALYTIC APPROACH TO ILLUMINATING KEY FINDINGS AND POLICY OPPORTUNITIES DISCUSSED TODAY

Provider Survey
364 responses

Survey of institutional providers, adult foster homes, home care and home health agencies, dialysis centers, and hospice.

ATI collected responses from 364 unique providers across Oregon's nine regions.

Oregon Agency Data
62.8K providers

Oregon Health Care Workforce Reporting Program (HWRP) data on workforce trends for 16 workforce categories.

The sample represented data for 62,751 Oregon healthcare workers, including 7,989 post-acute and 18,894 hospital workers.

Informant Interviews
16 stakeholders

16 virtual interviews with a wide range of stakeholders, including:

- Hospital Associations (1)
- Post-Acute Care Providers & Associations (6)
- Community Providers & Associations (3)
- Labor Unions (3)
- State Agencies (2)
- Coordinated Care Organizations (1)

Desktop Research

ATI reviewed publicly available white and grey literature for:

- Trends and key factors impacting the post-acute care workforce
- Innovative solutions other states are adopting to expand the post-acute workforce and enable development of service model alternatives to traditional post-acute care provider types

ATI used a mixed methods approach to assess Oregon's institutional and home-based provider capacity and ability, including related workforce capacity, regarding complex care referral acceptances and care delivery.

ATI IDENTIFIED THREE CRITICAL GAPS IN OREGON'S CURRENT POST-ACUTE CARE DELIVERY SYSTEM

Critical gaps in the current system are:

- **Systems that do not adequately support the training, wages, and other supports the post-acute care workforce needs** to care for medically and socially complex individuals.
- **A regulatory and payment environment that common post-acute care providers perceive as limiting** to their ability to pursue the more resource-intensive staffing and supports necessary to care for individuals with complex care needs.
- **A lack of alternative post-discharge options** for individuals with complex care needs, when level of care needs exceed and/or are not appropriate for common post-acute care providers.

ATI directly engaged diverse stakeholders across Oregon's care continuum and analyzed Oregon agency data to better understand post-acute provider and workforce capacity to accept and care for individuals with complex care needs.

- Critical gaps identified in Oregon's delivery system match the on-the-ground experiences of other states navigating hospital discharge challenges for individuals with complex care needs.

Key Finding

Providers reported myriad challenges to complex care admissions and delivery:

	**Most providers feel at-capacity based on their current staff levels.** Interviews with providers and labor groups underscored challenges in providing specialized and resource-intensive staffing and supports on top of existing staffing levels and requirements for more traditional post-acute care cases.
	**Most providers reported there is a need for additional behavioral health treatment capacity to serve individuals with specialized behavioral health needs.** Interviewees shared differing perspectives on appropriate provider types for individuals with behavioral health needs.
	**Providers face challenges in accepting individuals who are homeless or have challenging behaviors** (e.g., ADRDs, substance use). Barriers ranged from lacking or delayed responses from state/county LTSS placement staff to lacking guardians/conservators.
	**Providers shared that insufficient payment, as well as payer prior authorization practices created barriers** in providing care to individuals with complex care needs.
	**While most providers are collecting data on social needs, few report that these needs are being addressed.** Additionally, few providers reported relationships with affordable housing providers or residential treatment centers.
	Providers shared that **state policies and regulations such as facility requirements and state surveys hinder their ability to provide care** to individuals with complex care needs.

ADRD: Alzheimer's Disease and Related Dementias**; LTSS:** Long-Term Services and Supports

1. Managed care entities include managed Medicaid Coordinated Care Organizations (CCOs) and Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).

REPORTED BARRIERS TO COMPLEX CARE REFERRAL ACCEPTANCES VARIED BY HOSPITAL REGION

→ Challenges in accepting complex needs individuals:

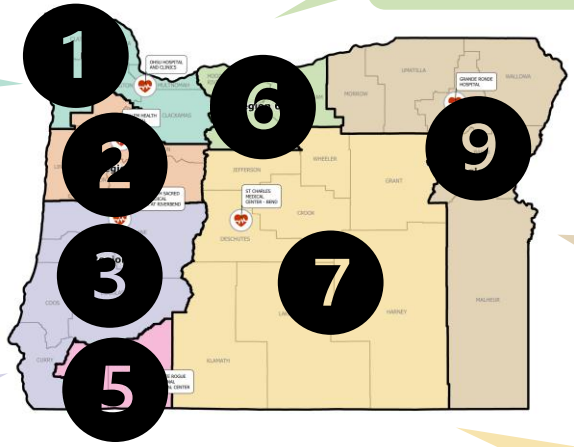
Providers were presented a range of issues and asked to indicate how often in the last month the issue created a barrier to them **accepting** individuals with complex care needs.

Region 1:
- Most often reported that **slow or no responses from state or local LTSS screening & placement staff** was **often/always** a barrier (37%) (statewide: 24%)

Region 2:
- Nearly 1 in 4 reported that the **lack of legal guardians or conservators** was **often/always** a barrier (23%) (statewide: 18%)

Region 3:
- **Lack of legal guardians or conservators** was the highest reported barrier (21%) in the region (statewide: 18%). Other barriers were seldomly reported as an issue (<8% as often/always a barrier).

Region 6 is not included in this analysis due to insufficient regional response rate (< 5 total response).



Region 9:
- Most often reported that **not being within the insurance network** of individuals referred to them for admission was **often/always** a barrier (29%) (statewide: 17%)

Region 5:
- Nearly 1 in 4 reported that **not being within the insurance network** of individuals referred to them for admission was **often/always** a barrier (24%) (statewide: 17%)

Region 7:
- Most often reported that the **lack of legal guardians or conservators** was **often/always** a barrier (36%) (statewide:18%)

Only NF, RCF/ALF, AFH & IHC responses are included in this regional analysis

Key Findings

Compared to workers in the hospital setting, those in the post-acute care setting are:

	More likely to **want to increase hours** in the next two years (22% of CNAs, 11% of LPNs, and 7% of RNs). Hourly wages and regular hours often do not generate sufficient income. Post-acute care workers rely on overtime hours to close the gap, which expedites burnout and workforce turnover.
	More likely to be **earlier in their career for CNAs and OTAs** (average license length 1.6 and 4.5 years shorter respectively) but **further along in their career for RNs and PTs** (average license length 1.4 and 3.3 years longer respectively).
	More likely to be **older and female**.

Regardless of setting and workforce category:

	Most workers **want to stay in their job/profession** (among NPs, RNs, LPNs, and CNAs in the post-acute care setting, at least 88% report wanting to stay in the next two years).

CNA: Certified Nursing Assistant; **LPN:** Licensed Practical Nurse; **OTA:** Occupational Therapy Assistants; **PT:** Physical Therapists; **RN:** Registered Nurse

THE POST-ACUTE CARE WORKFORCE DIFFERS ACROSS HOSPITAL REGIONS, PARTICULARLY ACROSS URBAN VERSUS RURAL REGIONS

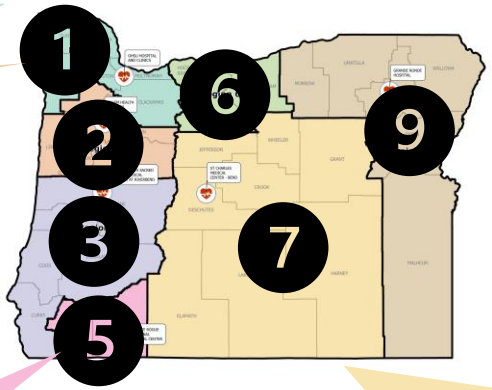
Region 6:
- **Highest proportion of workers part-time**, 26% (average: 16%)
- Least amount of time spent in research/training, 8% (average: 11%)

Region 1:
- **Most racially and ethnically diverse**

Region 2:
- Youngest average age, 41.5 (average: 43.2)

Region 3:
- Least likely to use telehealth, 10% (average: 13%)
- Most likely to want to decrease hours (10%)

Region 5:
- Least likely to use telehealth, 10% (average: 13%)



Region 9:
- Older average age, 44.5 (average: 43.2)
- Highest proportion Latino/a, 16% (average: 10%)
- Highest proportion of providers full-time, 79% (average: 75%)
- Most amount of time spent in research/training, 15% (average: 11%)
- **Least likely to accept Medicaid**, 70% (average: 81%)
- Most likely to use telehealth (16%)
- Least likely to want to retain job/profession (86%)

Region 7:
- Oldest average **age**, 45.1 (average: 43.2)
- Highest proportion female, 90% (average: 85%)
- Least racially and ethnically diverse
- Most likely to accept Medicaid, 90% (average: 81%)
- Most likely to want to retain job/profession (90%)

Note, regional analyses combined years 2021 and 2022 of HWRP data.

State Opportunities to Address Workforce and Provider Capacity

TO ADDRESS GAPS, SOLUTIONS MUST SPAN WORKFORCE INVESTMENTS, SUPPORT FOR EXISTING PROVIDERS, AND PURSUIT OF ALTERNATIVE PROVIDERS AND SUPPORTS

Based on these identified gaps in Oregon's post-acute care delivery system, Oregon can bolster system capacity by:

- → **Investing in and cultivating a post-acute care workforce** with the specialized training and skills necessary to confidently and competently meet complex care needs.
- → **Supporting existing post-acute care providers through policy, programming, and payment flexibilities** that enable innovative and specialized care delivery models that support complex care needs (as appropriate to the individual's needs).
- → **Expanding the types of providers and supports available post-hospitalization** to continue providing recuperative care to individuals and as alternatives to common post-acute care provider types.

Regional needs and experiences differed throughout ATI's research.

As the State explores solutions, regional differences and perspectives will need to be considered. Solutions that are needed and/or feasible in one part of the State may not apply for others.

Investing in and Cultivating the Post-acute Care Workforce

Policy Area 1

DIRECT CARE WORKER WAGES COULD BE ADDRESSED THROUGH A MINIMUM WAGE INCREASE AND/OR MEDICAID PASSTHROUGH REQUIREMENTS

Identified Gaps:

- ❑ Survey findings show that post-acute care workers are seeking more hours, and many interviewees raised the issue of insufficient wages as a key challenge in recruitment and retention.

Topic	Opportunity	In Action
Increase Minimum Wage	States can set minimum wages for specific workforces, including direct care, to guarantee the income individuals can expect if they pursue this career.	 New York set the minimum wage for home care aides at $3 above the prevailing minimum wage.
Require Medicaid Rate Passthrough	States can establish Medicaid reimbursement rate passthrough standards to ensure a minimum share of payments is flowing through to workers. Such a requirement can be accompanied by a rate increase or supplement to rate.	 Minnesota requires a minimum percent of Medicaid reimbursement be spent on aides' wages and benefits.

Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking, Addressing Wages of Direct Care Workforce Through Medicaid: (nga.org), Report on Personal Care Assistance Services: (mn.gov)

ENHANCED TRAINING AND NEW ROLES IN THE POST-ACUTE CARE WORKFORCE CAN HELP INCREASE COMPLEX CARE CAPABILITIES

Identified Gaps:

- ❑ Interviews reflected gaps in the ability of post-acute care providers to treat individuals with complex care needs, especially behavioral health issues.

Topic	Opportunity	In Action
Opportunities for CNA Advancement	Additional partnerships or funding through community colleges could support educational advancement for direct care workers into registered nurse or other roles.	 Washington's Workforce Board, State Board of Nursing and Department of Labor and Industries plans to establish a Licensed Practical Nurse Registered Apprenticeship Program. Employers and community colleges are also partners.
Additional Roles for Aides	Amid workforce challenges and the range of tasks the post-acute workforce must complete, additional training and role development is needed. For example, in instances of registered nurse shortages, allowing aides to perform more advanced tasks can support expanded capacity.	 New York created an Advanced Home Health Aide program allows aides to perform advanced tasks with appropriate training and upon assignment and supervision by registered nurses.
New Certifications for Behavioral Health	Training aide workers, who already provide care in settings like SNFs, in behavioral health could help them better support individuals with complex needs and feel more comfortable when these individuals are in their care.	 Alaska and Colorado have implemented behavioral health aide models, and Alaska's Medicaid program covers their services.

Advanced Home Health Aides (ny.gov), Health Care Workforce Investment: How States Are Leading the Way – NASHP, Long-Term Care | Washington Workforce Training & Education Coordinating Board

Supporting Existing Post-acute Care Providers

Policy Area 2

Identified Gap:

- ❑ Community-based residential care settings, such as ALFs, RCFs, and AFHs, are an appropriate care setting for many individuals with complex care needs, particularly for older adults and people with disabilities; however, current capacity is limited due to workforce and reimbursement constraints.

Topic	Opportunity	In Action
Specialty Care Rates to Support Residential Care	States regulate the number of individuals care settings such as RCFs and AFHs can treat at a given time, as well as Medicaid rates for care settings. While increasing bed limits should be carefully explored with stakeholders before pursuing, providing payment rate increases and adjustments for high-acuity individuals in a more consistent and timely manner could support expansion of these settings.	 AFHs in Washington are paid based on 17 unique classification groups that reflect levels of resources required.

WA Adult Family Homes Payment Methodology Analysis.docx (live.com), RCW 70.128.066: Seven or eight bed adult family homes—Requirements—Licensure. (wa.gov), Nursing Facilities | Colorado Department of Health Care Policy & Financing, Association of a Care Coordination Model With Health Care Costs and Utilization.

Identified Gap:

- Volume dispersed across facilities, lack of enhanced reimbursement reflecting complexity of need, and regulatory risks contribute to lacking capacity among commonly sought discharge destinations.

- The Enhanced Care Services program, a collaborative between OHA and APD, allows for special contracts in select settings (e.g., APD RCFs and NFs) for Enhanced Care Facilities (ECFs) to serve individuals with complex behavioral health needs who require post-cute care. However, current ECF availability and resources are limited, with only eight ECFs operating in 6 of 36 counties.

Topic	Opportunity	In Action
Specialized Facilities	Expanding investments in an elective program that supports NFs and other providers in serving individuals with complex needs could help to create facilities with the volume and expertise needed to provide high quality care.	 Colorado has a Supplemental Behavioral Services Program, which is voluntary and evaluates interested NFs' capabilities to serve individuals with SMI and provides supplemental payments

WA Adult Family Homes Payment Methodology Analysis.docx (live.com), RCW 70.128.066: Seven or eight bed adult family homes—Requirements—Licensure. (wa.gov), Nursing Facilities | Colorado Department of Health Care Policy & Financing, Association of a Care Coordination Model With Health Care Costs and Utilization.

Identified Gap:

- ❑ Today, the role of care coordination is fulfilled by multiple players across the care continuum. Patients are often discharged without fully vetted care plans and lack support in periods of transition between settings, increasing risk of readmission.

Topic	Opportunity	In Action
Dedicated Care Coordination to Facilitate Post-Discharge Transitions	Carving out dedicated care coordination resources could help bridge the gap in care after discharge, improve outcomes, and free up hospital capacity from readmissions. Oregon can also leverage existing Medicaid managed care and State Medicaid Agency Contract (SMAC) authorities with CCOs and D-SNPs, respectively, to require more targeted care coordination and case management in transitional care planning processes.	 John's Hopkins Community Health Partnership Acute Care Intervention pilot, funded by a CMS Innovation Award, delivered bundled services, including early discharge planning, a skilled nurse transition guide, and telephone follow-up to improve discharge transition planning and care coordination.

WA Adult Family Homes Payment Methodology Analysis.docx (live.com), RCW 70.128.066: Seven or eight bed adult family homes—Requirements—Licensure. (wa.gov). Nursing Facilities | Colorado Department of Health Care Policy & Financing, Association of a Care Coordination Model With Health Care Costs and Utilization.

Expanding Alternative Options and Supports Available Post-Hospitalization

Policy Area 3

Identified Gap:

- ❑ Appropriate settings are lacking for individuals who, following hospitalization, still have significant care needs that either are not suited for skilled nursing, or that SNFs feel they are unequipped to serve.

Topic	Opportunity	In Action
Medical Respite Care	Medical respite or recuperative care is a model that provides short-term residential accommodations, necessities such as food and clothing, care coordination and case management, post-acute clinical care, primary care, and behavioral health care. Particularly for individuals experiencing homelessness or other health-related social needs, this model provides a unique opportunity to address medical and social needs. Oregon's current Section 1115 Demonstration could be amended to include new authority for medical respite services within Oregon Medicaid.	 California and North Carolina offer medical respite coverage under Section 1115 Demonstrations, and several other states have submitted or are developing requests to do so (Hawaii, New Mexico, Utah, Washington, New York, Illinois).  Illinois has implemented a capacity building initiative for medical respite care which provides grants to community organizations and hospitals to expand respite services.

Medicaid Structured Family Caregiving: Enabling Family Members to Make Caregiving Their Primary Focus – NASHP, Illinois Medical Respite Capacity Building Initiative - IPHI (iphionline.org), Status of State-Level Benefits for Medical Respite Care (nimrc.org)

Identified Gap:

- Survey respondents and interviewees shared that hospital discharge planning staff were typically not aware of the benefits and services available in the Oregon Health Plan delivery system that could support individuals with lower level of care needs in home or community settings.

Topic	Opportunity	In Action	
Structured Family Caregiving	Structured family caregiving (SFC) is a service structure that supports primary caregivers of HCBS waiver participants. It provides payment, training, and respite care. For individuals with complex care needs who require LTSS and have strong social supports, this model can provide a meaningful alternative to facility or other residential care settings.		Georgia and South Dakota cover SFC services for older adults and people with disabilities through their Medicaid programs under a 1915(c) waiver.
Care Coordination and Case Management	Integrating healthcare coordination with health-related social needs (HRSN) coordination can enhance the whole-person care delivery and wraparound supports necessary to support individuals with complex care needs in alternative settings. Oregon's Medicaid delivery system includes HRSN benefits and services, however, stakeholders generally were unaware of these options for Oregon Health Plan members awaiting discharge.		Through its Section 1115 Demonstration, California offers a statewide Enhanced Care Management (ECM) benefit for select members with complex needs. ECM provides a single point of contact to coordinate qualifying members' health and health-related care and services across all places where individuals seek care.

Medicaid Structured Family Caregiving: Enabling Family Members to Make Caregiving Their Primary Focus – NASHP, Illinois Medical Respite Capacity Building Initiative - IPHI (iphionline.org), Status of State-Level Benefits for Medical Respite Care (nimrc.org)

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