Understanding and Addressing Key Oregon Provider and Workforce Capacity Challenges

Appendix to ATI Advisory Presentation to the Joint Task Force on Hospital Discharge Challenges

April 2024

ATI Advisory

APPENDIX CONTENTS

Key Workforce and Capacity Challenges

Results from ATI Analysis

Post-Acute Care Provider Survey Analysis

Key Findings

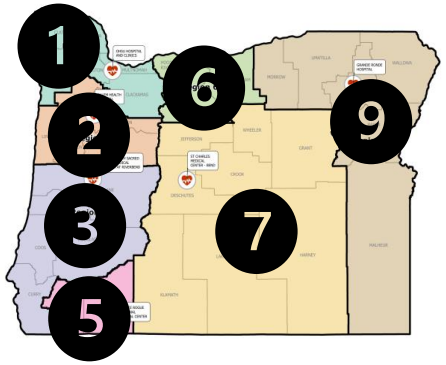
ATI'S SURVEY REACHED 2,136 OREGON PROVIDERS ACROSS THE CARE CONTINUUM, WITH 364 COMPLETED RESPONSES

Who completed the survey?

- Executive directors and administrators across ODHS and OHA licensed organizations received a link to ATI's survey.
- Respondents were encouraged to work with staff closest to the overall experience of the organization when caring for people with complex care needs.

Provider Type	Total Providers Reached [1]	Total Responses Collected	% Responses Collected
NF – Nursing Facility	116	26	22%
RCF – Residential Care Facility	290	58	20%
ALF – Assisted Living Facility	217	41	19%
AFH-APD – Adult Foster Home (Aging and People with Disabilities)	1,154	180	16%
AFH-BH – Adult Foster Home (Behavioral Health)	75	11	15%
IHC – In-Home Care Agency	147	29	20%
Dialysis Center	62	8	13%
Home Health Agency	32	5	16%
Hospice	43	6	14%
Total	**2,136**	**364**	**17%**

ATI presents and discusses findings across these select provider types.



Region	Total Providers Reached [1]	% Responses Collected
1	1,202	17%
2	293	21%
3	215	20%
5	178	23%
6	23	14%
7	126	19%
9	67	17%
Region Total [2]	**1,991**	**18%**

1. Indicates the number of unique providers that successfully received a link to ATI's survey via email address.
2. Not all providers opted to identify the county in which they operated. Accordingly, regional response totals are lower than total response totals.

KEY FINDINGS FROM ATI'S POST-ACUTE CARE PROVIDER SURVEY

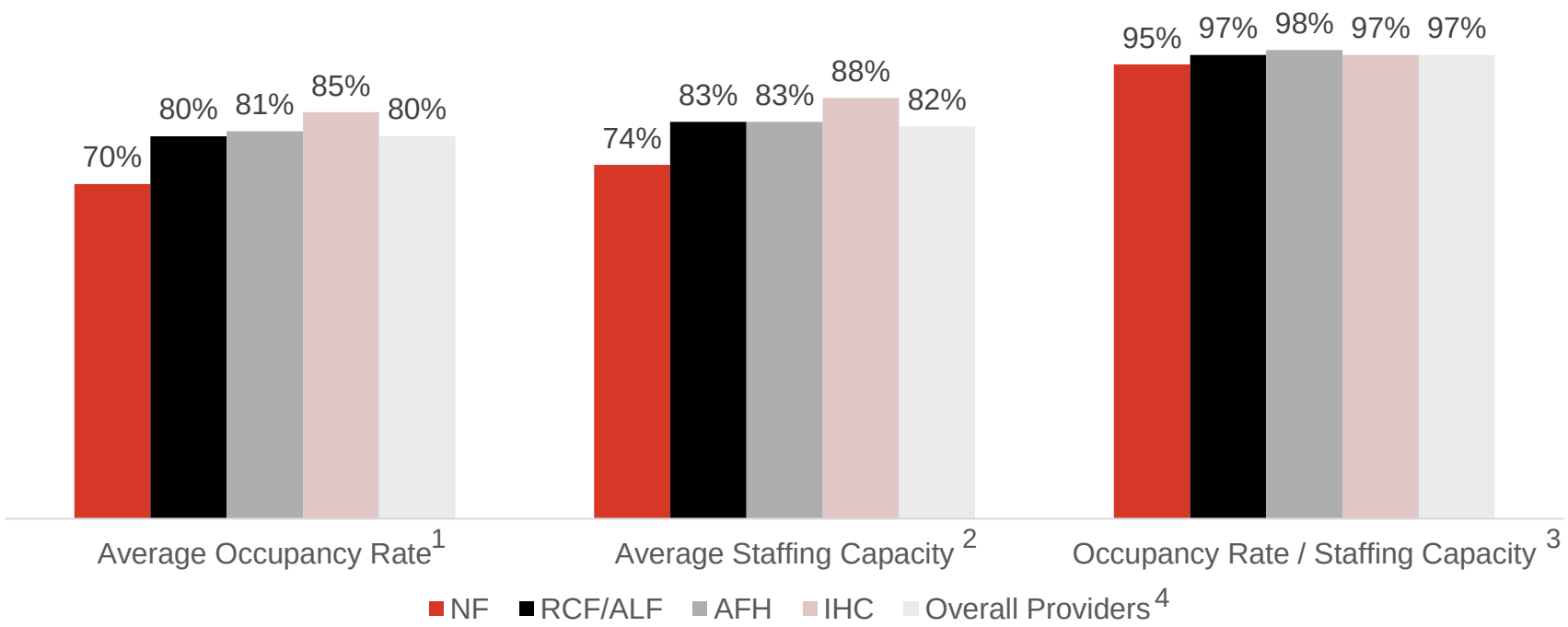
	Key Finding	Implication
	Providers reported myriad challenges to complex care admissions and delivery:	*Policies could:*
	**Most providers feel at-capacity based on their current staff levels.** Interviews with providers and labor groups underscored challenges in providing specialized and resource-intensive staffing and supports on top of existing staffing levels and requirements for more traditional post-acute care cases.	Establish more competitive wages for the post-acute and long-term care workforce and provide opportunities for the current workforce to develop specialized skills.
	**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.	Scale innovative models that have succeeded in expanding post-discharge care options (e.g., medical respite) and meeting specialized needs across the care continuum.
	**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.	Expand community capacity to support safe discharge options and identify opportunities for proactive communication and collaboration between all involved in the transitional care process.
	**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.	Leverage the State's purchasing power with managed care entities (MCEs) to incentivize and/or require MCEs to partner across the care continuum and strengthen linkages to social needs benefits through more targeted care coordination and case management.[1]
	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.	Explore existing state survey rules and processes to determine where there are efficiencies or flexibilities that would enable providers to pursue more specialized care delivery models for 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).

ALL PROVIDERS SURVEYED REPORTED OPERATING AT MAXIMUM STAFFING CAPACITY

→ Providers were asked to report their average bed/client capacities and actual staffing capacities in the last month.



Reported licensed bed/client capacities were lower than reported staffing capacities.

→ ***Interview Insight:*** Providers generally expressed being at maximum capacity with the more traditional needs population they serve. Providers expressed insufficient resources / staff to adequately care for more complex individuals, which require more specialized and resource-intensive staffing and supports on top of existing staffing levels and requirements.

1. Calculated by dividing estimated, average daily census from licensed capacity. **2.** Calculated by dividing total staffing capacity from total licensed capacity. **3.** Calculated by dividing average daily census from total staffing capacity. **4.** '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation:** among *all* providers surveyed, average occupancy rate was 80%.

BEHAVIORAL HEALTH SPECIALISTS ARE IDENTIFIED AS A GAP FOR PROVIDERS SERVING INDIVIDUALS WITH COMPLEX CARE NEEDS

→ **Staffing need:**

"What additional types of staff does your organization currently **not** have…that would be **helpful** in providing care for individuals with complex care needs?"

Provider Type	Nurses	Care Coordinator	Clinical Social Worker	Direct Care Worker	Driver	Lawyer	Med Tech[1]	Mental Health Counselor	Psych.	SUD Specialist	OT/ PT/ RT
NF	19%	19%	38%	19%	35%	35%	15%	69%	54%	58%	46%
RCF/ALF	34%	9%	35%	11%	17%	25%	8%	49%	30%	28%	35%
AFH	19%	12%	14%	19%	13%	12%	12%	28%	18%	14%	20%
IHC	45%	10%	31%	41%	14%	21%	21%	38%	31%	24%	28%
Overall Providers[2]	**26%**	**11%**	**22%**	**19%**	**16%**	**19%**	**12%**	**38%**	**26%**	**23%**	**27%**

Providers reported having greatest need for additional **behavioral health specialists** such as **SUD specialists** and mental health counselors.

→ ***Interview Insight:*** Providers shared differing perspectives on whether traditional post-acute provider types such as NFs, should / can be the appropriate place for individuals with behavioral health needs. For individuals with overlapping LTC and behavioral health needs, specialized facilities or programs with enhanced clinical capabilities for BH treatment may be needed.

OT/PT/RT: Occupational, Physical, or Respiratory Therapy; **Psych:** Psychologist; **SUD:** Substance Use Disorder
1. Med tech includes medical and medication technicians; **2.** '**Overall Providers'** represents the average response among ***all*** provider types surveyed.
Example interpretation: 26% of *all* providers surveyed reported needing additional nursing staff.

ALMOST ALL NURSING FACILITIES REPORTED CHALLENGES IN ACCEPTING INDIVIDUALS WITH CHALLENGING BEHAVIORS, INCLUDING SUBSTANCE USE

→ Challenges accepting complex needs individuals:

"In the last month, did your organization have any problems when trying to **accept** individuals with the following needs?"

Provider Type	Complex Medical Needs [1]	Challenging Behaviors [2]	Homelessness or Housing Insecurity	Legal Guardianship	Obesity	Low or No Social Supports [3]
NF	64%	92%	76%	60%	40%	56%
RCF/ALF	45%	56%	18%	44%	20%	15%
AFH	39%	41%	15%	10%	22%	13%
IHC	43%	81%	19%	14%	43%	57%
Overall Providers[4]	**46%**	**57%**	**26%**	**28%**	**26%**	**25%**

Nursing facilities consistently reported challenges in accepting individuals with **different types of complex care needs**.

Across provider types, individuals with **challenging behaviors** (e.g., aggression, SUD, SMI) were consistently reported as a challenge to providers accepting individuals.

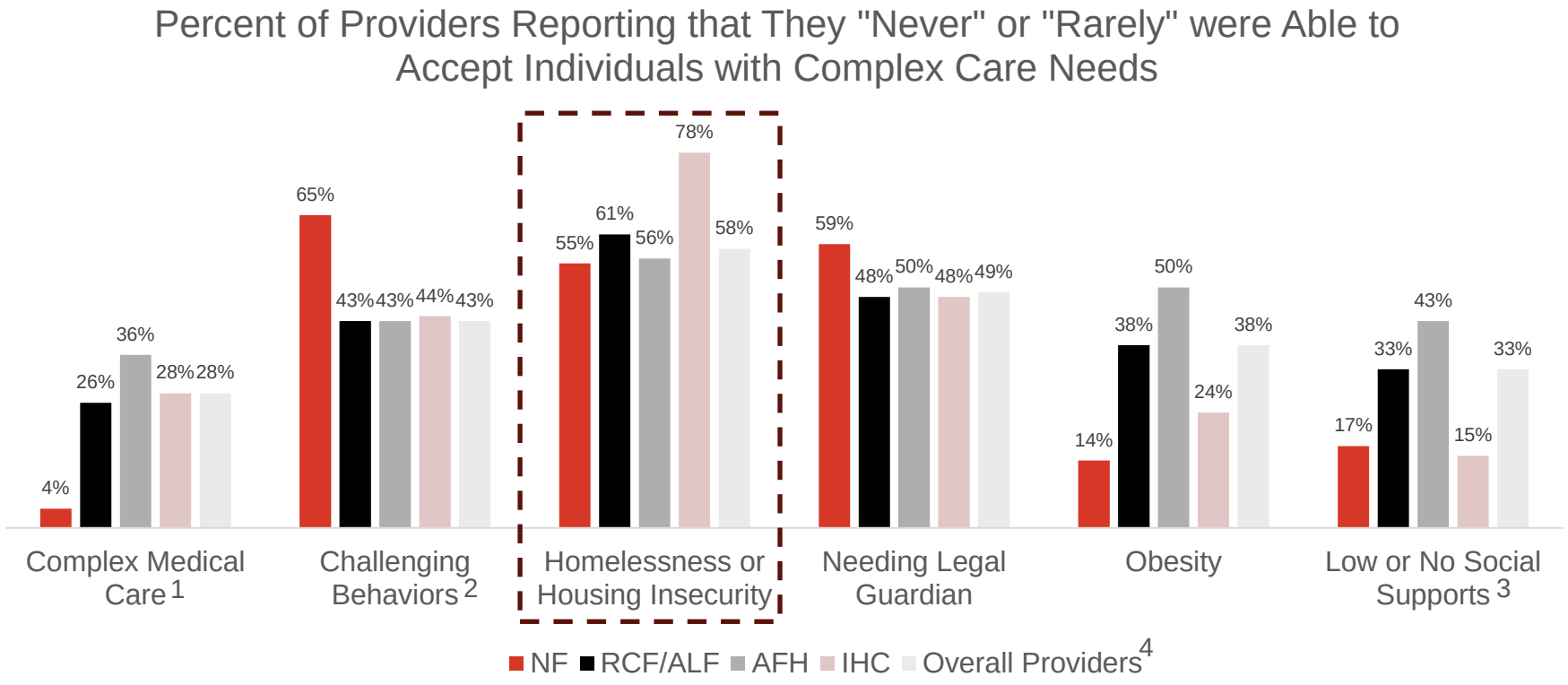
→ ***Federal Policy Insight:*** Medicare SNFs/Medicaid NFs are subject to federal rules for participation, including requirements for appropriate post-SNF/NF discharges. SNF/NFs may be challenged to accept individuals for whom they cannot discharge in accordance with federal rules.

1. E.g., end stage renal disease; **2.** E.g., aggression, serious mental illness (SMI), substance use disorders (SUD) or cognitive impairments; **3.** E.g., lacking close family or friends; **4.** '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation:** 46% of *all* providers surveyed reported challenges in accepting individuals with complex medical needs.

MOST PROVIDERS AMONG OVERALL SURVEYED REPORTED "NEVER" OR "RARELY" ACCEPTING HOMELESS OR HOUSING INSECURE INDIVIDUALS

→ **Challenges in accepting complex needs individuals:**

"In the last month, how often was your organization able to **accept** individuals with needs listed below?"



Nearly three in five of *all* providers reported that they never or rarely accept individuals who are **homeless or housing insecure;** this was more than three-quarters for in-home care agencies and more than half for adult foster homes.

→ ***Interview Insight:*** Federal rules for provider participation in Medicare/Medicaid include expectations for safe discharge. Interviewees frequently noted that providers may not be willing/able to accept individuals experiencing homelessness without assurance of a safe discharge option in place.

1. E.g., end stage renal disease; **2.** E.g., aggression, serious mental illness (SMI), substance use disorders (SUD) or cognitive impairments; **3.** E.g., lacking close family or friends; **4.** '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation:** 58% of *all* providers surveyed reported they never or rarely accept individuals who have homelessness or housing insecurity.

REPORTED BARRIERS TO COMPLEX CARE REFERRAL ACCEPTANCES VARIED BY HOSPITAL REGION

→ Challenges in accepting complex needs individuals:

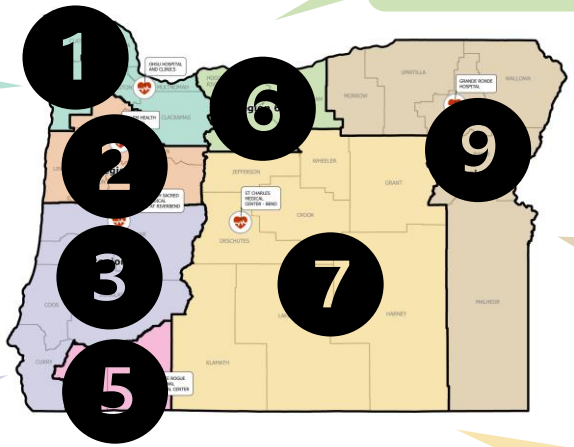
Providers were presented a range of issues and asked to indicate how often in the last month the issue created a barrier to them **accepting** individuals with complex care needs.

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%)

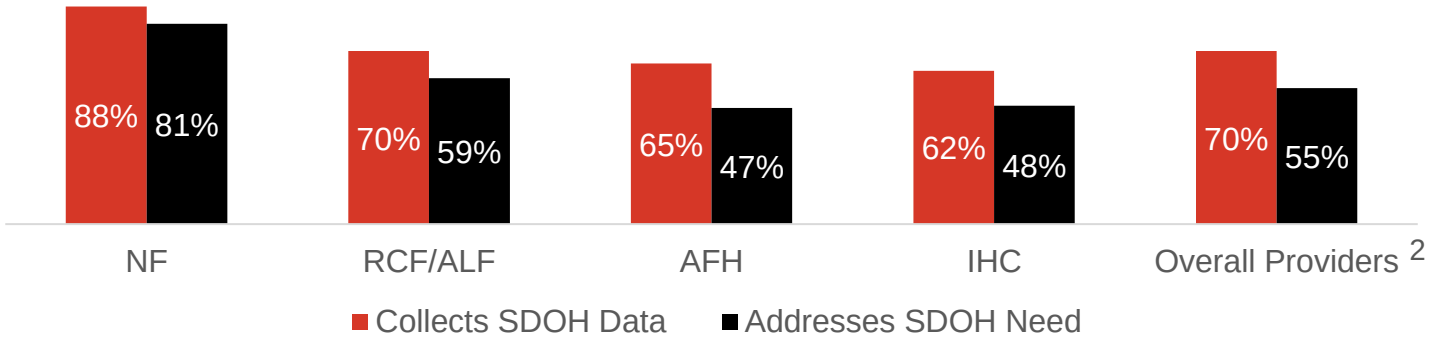
Region 7:
- Most often reported that the **lack of legal guardians or conservators** was **often/always** a barrier (36%) (statewide:18%)

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

MOST PROVIDERS REPORTED ADDRESSING INDIVIDUALS' SOCIAL NEEDS

→ Social determinants of health (SDOH):

"Which **social needs** does your organization collect data on/address?"



Provider Type	By SDOH, Percent of Organizations that Collect Data of SDOH (Percent of Organization that Address SDOH) [1]									
	Nutrition	Hygiene	Finance	Housing	Interpersonal Violence	Legal	Transportation	Social	Language	Work
NF	74% (48%)	65% (29%)	61% (43%)	65% (19%)	39% (19%)	22% (14%)	74% (57%)	57% (43%)	65% (52%)	30% (0%)
RCF/ALF	77% (36%)	71% (33%)	30% (21%)	29% (10%)	23% (7%)	7% (10%)	51% (60%)	57% (31%)	30% (12%)	22% (5%)
AFH	48% (29%)	41% (16%)	21% (12%)	28% (7%)	23% (7%)	8% (7%)	35% (31%)	36% (21%)	16% (3%)	15% (7%)
IHC	67% (57%)	67% (29%)	22% (0%)	61% (7%)	28% (7%)	11% (7%)	67% (64%)	61% (21%)	33% (0%)	33% (21%)
Overall Providers [2]	**60% (36%)**	**53% (24%)**	**29% (18%)**	**37% (9%)**	**26% (9%)**	**9% (9%)**	**46% (46%)**	**46% (27%)**	**28% (14%)**	**20% (7%)**

Half of all post-acute care providers reported that they **address social needs** of individuals.

Of those that address social needs, most common were social needs related to **transportation** (46%), followed by **nutrition** (36%).

→ ***Interview Insight:*** Several interviewees highlighted the need for greater case management and care coordination following hospital discharge. Such services can create linkages not just to appropriate medical care, but also connections to benefits and services that address social needs and provide transitional supports that can keep people in the community.

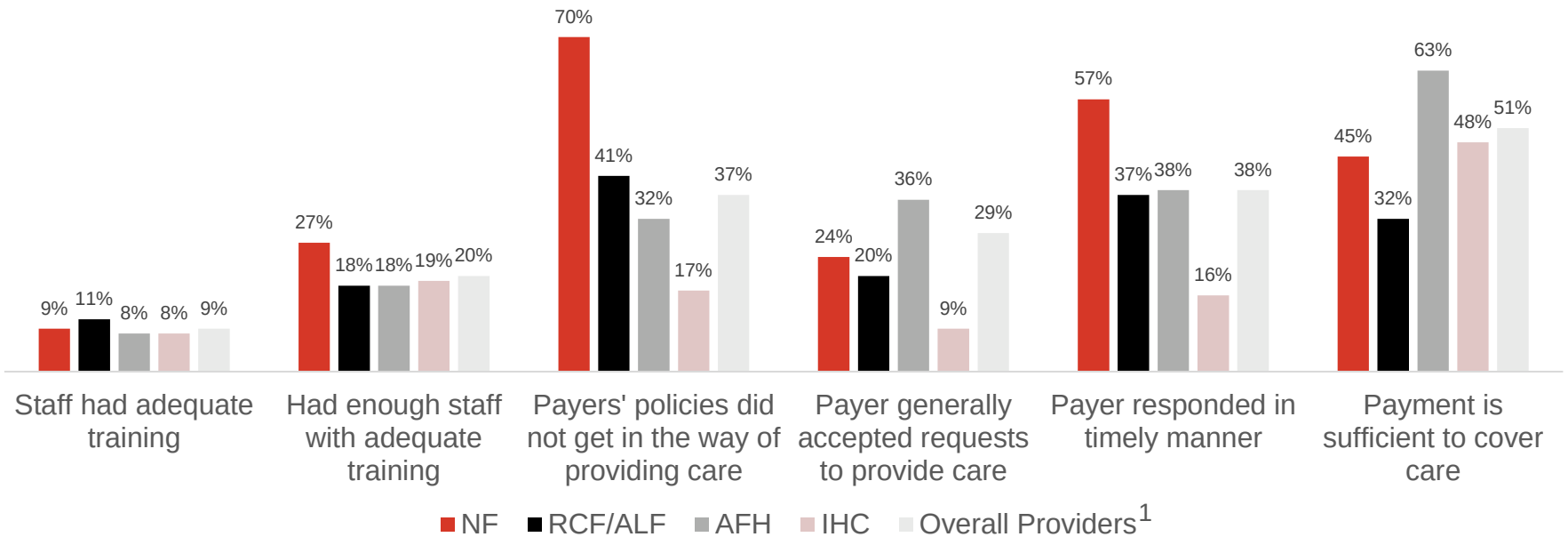
1. Several provider types surveyed inherently address residents' social needs (e.g., NFs provide housing for long-stay residents). It is not clear how provider types may have interpreted social needs in these instances. **2.** '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation:** 60% of *all* providers surveyed reported that they collect data on nutrition needs; 36% reported that they address nutrition needs.

MANY PROVIDERS REPORTED THAT PAYER POLICIES & PRACTICES CREATED BARRIERS IN PROVIDING CARE TO INDIVIDUALS WITH COMPLEX CARE NEEDS

→ **Challenges providing care to complex needs individuals:**

"Score the following statements based on your organization's experience in the last month when **providing care** to individuals with complex care needs…"

Percent of Providers Reporting that they **"Strongly Disagree" or "Disagree"** with the Following Statements:



Three of four provider types – AFH, NF, and RCF – reported **payers' policies,** such as prior authorization, as a barrier.

Half of *all* providers, including two thirds of adult foster homes **disagreed that payments sufficiently covered care** for complex needs individuals.

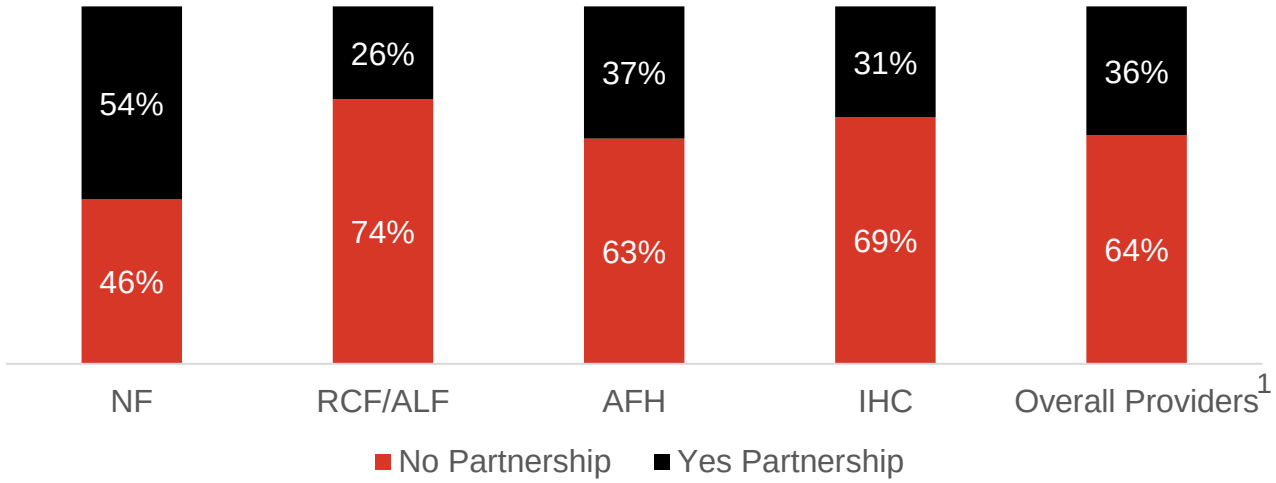
→ ***Interview Insight:*** Perceptions of payment adequacy for individuals with more traditional PAC needs profiles varied among provider types, with NFs generally feeling that payment is reasonable and AFHs largely sharing that payment is insufficient. However, all provider types generally agreed that payment rates for individuals with complex care needs were inadequate.

1. '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation: 9**% of *all* providers surveyed reported that they strongly disagree or disagree with the statement that their staff had adequate training to provide care for individuals with complex care needs.

MOST PROVIDERS REPORTED NO RELATIONSHIP WITH PROVIDERS THAT SPECIALIZED IN HOUSING OR BEHAVIORAL HEALTH, INCLUDING SUBSTANCE USE

→ Partnership with providers that specialized in SUD and housing:

"Does your organization work with any providers…to support residential treatment or housing needs…?"



Provider Type	Detox Program/ MAT center	Affordable Housing	Medical Respite	Residential Mental Health Treatment	SUD Residential Treatment Center
NF	4%	19%	23%	8%	8%
RCF/ALF	1%	4%	5%	6%	5%
AFH	1%	1%	5%	6%	2%
IHC	0%	7%	17%	0%	0%
Overall Providers[1]	**2%**	**5%**	**7%**	**7%**	**4%**

Only a third of providers reported that they partner with organizations that specialize in **homelessness** or **behavioral health treatment.** "Yes" respondents were more likely to be in Region 1.

Of providers with partnerships, **residential mental health treatment centers** and **affordable housing** were the most common.

→ ***Interview Insight:*** Interviewees shared that hospital discharge planning staff are typically not aware of all the differing discharge options and the capabilities that providers may have in place through innovative partnerships with either social service providers, CCOs, D-SNPs, or others.

CCO: Coordinated Care Organization; **D-SNP:** Dual Eligible Special Needs Plan; **MAT:** Medication Assisted Treatment; **SUD:** Substance Use Disorder

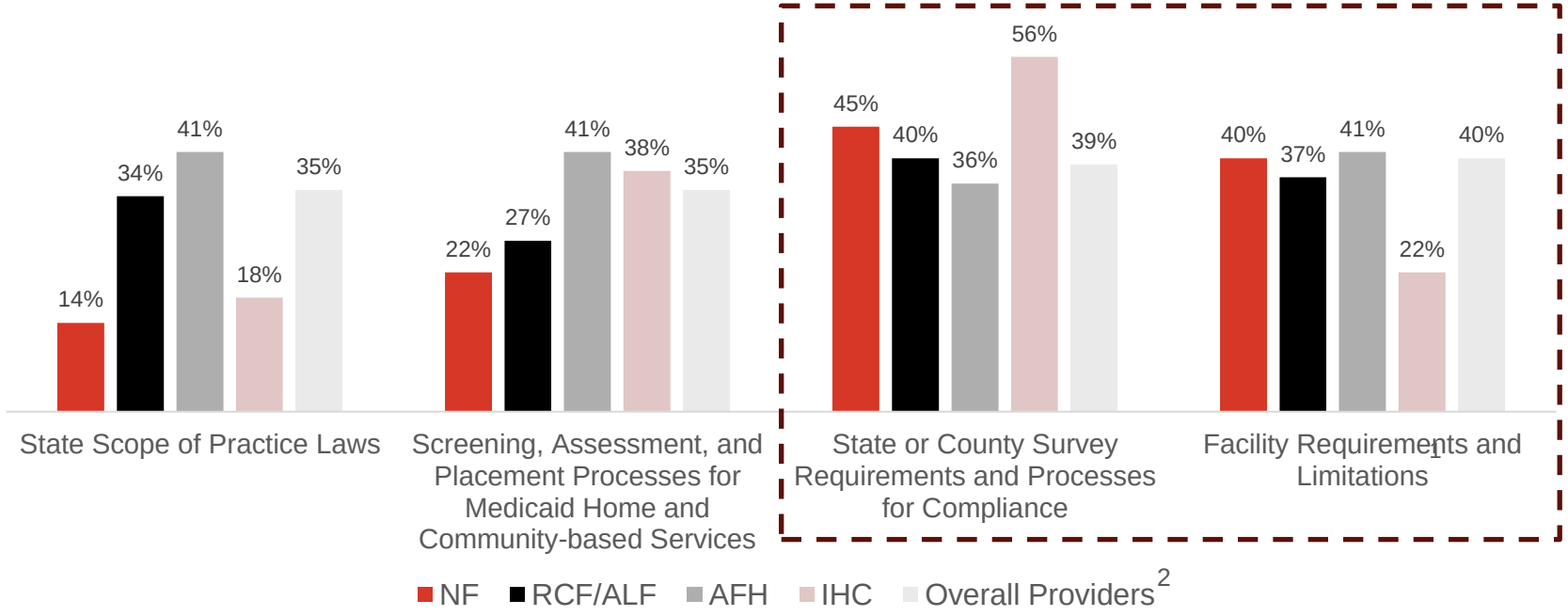
1. '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation:** 2% of *all* providers surveyed reported they have a partnership with detox programs or medication assisted treatment centers.

PROVIDERS RANKED STATE/COUNTY SURVEY REQUIREMENTS AND STATE FACILITY REQUIREMENTS AS CHALLENGES TO COMPLEX CARE ADMISSIONS AND CARE DELIVERY

→ State policy barriers to complex care referral acceptances and care delivery:

Providers scored types of **state** regulations or policies as 1-5 based on how limiting a factor each is in complex care admissions and care delivery; a score of 5 indicates that the rule or policy makes it harder for providers

Percent of Providers Reporting that State Policies make Complex Care Acceptances and Care Delivery Harder (Score of 4 or 5)



Survey requirements and processes for compliance were the biggest reported barriers for providers, with two in five of *all* providers surveyed identifying these policies as barriers.

→ ***Federal Policy Insight:*** State survey requirements and processes reflect federal statute and regulation that CMS sets for participating providers, in addition to state-specific requirements. State surveyors enforce federal and state requirements. **Federal Conditions for Participation (CoPs) for SNFs, a common discharge destination, are discussed in the subsequent slide.**

1. E.g., private room specifications, fire safety code, construction requirements specific to natural disasters. **2.** '**Overall Providers'** represents the average response among ***all*** provider types surveyed. **Example interpretation:** 35% of *all* providers surveyed reported a score of 4 or 5, indicating that state policies related to scope of practice makes complex care referral acceptances and care delivery harder.

FEDERAL STATUTE AND REGULATIONS GOVERN COMMON POST-ACUTE CARE PROVIDERS AND ARE OVERSEEN BY STATE SURVEYORS

- The federal Medicare and Medicaid programs regulate SNFs and NFs through conditions of participation, or CoPs.
- Federal regulations do not explicitly limit the types of patients these facilities can serve.
- However, they are subject to broad quality and safety requirements along with minimum behavioral health services standards based on resident needs.
- Facilities must also adhere to limits protecting residents from unfair transfer or discharge.

Federal Regulatory Insight: Sample Behavioral Health Services Requirement:

"…Based on the comprehensive assessment of a resident, the facility must ensure that—
(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being…"

"Federal rules and policies make it so we can't help certain people due to the risk, but there is no where for them to go . . . the policies set us up to fail . . . we keep trying to make our current system work for some of these residents, and it's just not made for everyone.

We need specialized facilities with a different set of rules, and more supports in place to address the needs of the more complex residents."

- *Survey Respondent*

eCFR :: 42 CFR Part 483 -- Requirements for States and Long Term Care Facilities

→ Most helpful to providers in complex care referral acceptances:

Providers were given opportunity to write-in what would be most helpful to them in **accepting** complex care referrals. Most common responses were:

- Proactive communication, "teamwork", and information sharing between hospital discharge planning staff, AAA/APD staff (as applicable) and the providers' admitting staff, including access to clear and accurate information regarding the individual's medical, behavioral, and social needs, both from hospitals and AAA/APD case workers.
  - *"If we receive a clear understanding of the client's needs, things go well. If a client has a proper discharge plan, and the social supports are engaged, this is also a significant help."*
- Education for hospital discharge planning staff regarding the varying levels of care accommodated across facility types (e.g., ALF, RCF, memory care, AFH, etc.), including clarifying eligibility rules and restrictions across discharge locations.
- Access to a designated care coordinator or case manager to facilitate smoother transitions between the hospital to referral destination.

→ **Most helpful to providers in complex care delivery:**

Providers were given opportunity to write-in what has been most helpful to them in providing care to individuals with complex care needs. Most common responses were:

- CCO collaboration, including CCO flexible spending dollars, to allow for the provision of respite care or temporary hotel stays for individuals with acute conditions (e.g., wound care needs).
- Multidisciplinary approaches to care delivery, (e.g., access to and involvement of behavioral support specialists, psychiatrists).
- Access to education and training for caregivers (e.g., Oregon Care Partners training).

Health Care Workforce Reporting Program (HWRP) Analysis

Key Findings

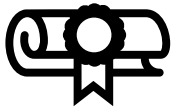
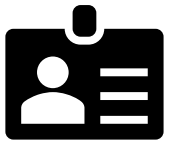
OVERALL SAMPLE SIZE, BY YEAR

Workforce Category	Most Recent Year of Data	Post-Acute[1]	Hospital	Overall
CNA – Certified Nursing Assistant	2022	2,748	2,192	6,271
CNS – Certified Nurse Specialists	2020	1	21	52
CPHT – Certified Pharmacy Technicians	2022	3356	999	5,702
CSWA – Clinical Social Worker Associates	2022	26	49	334
LCSW – Licensed Clinical Social Workers	2022	97	271	2,019
LPC – Licensed Professional Counselors	2022	27	138	3,929
LPN – Licensed Practical Nurses	2022	1,026	124	2,362
NP – Nurse Practitioners	2022	128	232	2,489
OT – Occupational Therapists	2022	361	508	1,964
OTA – Occupational Therapy Assistants	2022	173	35	398
PSY – Psychologists	2022	5	38	1,034
PT – Physical Therapists	2022	684	1,240	4,660
RN – Registered Nurse	2022	2,109	11,639	27,504
RT – Respiratory Therapists	2021	133	1,163	1,724
SLP – Speech Language Pathologists/Pathologists + Audiologists	2021	112	245	2,082
SLPA – SPL Assistants	2021	3	-	227
Grand Total		**7,989**	**18,894**	**62,751**

Data availability influenced which workforce categories were studied in the analysis (e.g., workforce categories in green).

1. See Appendix III for a complete listing of post-acute care provider types represented in this category

KEY FINDINGS FROM ATI'S HEALTHCARE WORKFORCE REPORTING PROGRAM (HWRP) ANALYSIS

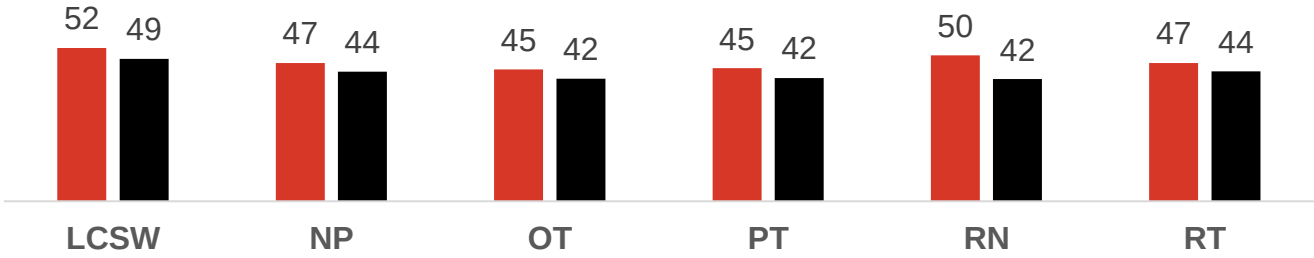
Key Findings		Implication
Compared to workers in the hospital setting, those in the post-acute care setting are:		*Polices could:*
	More likely to **want to increase hours** in the next two years (22% of CNAs, 11% of LPNs, and 7% of RNs).	Consider increasing direct care worker wages to a level at which workers feel that regular working hours provide livable wages. Perceptions of livable wages will vary between urban (e.g., Portland) versus rural regions.
	More likely to **have an Associates degree to be an RN** (46% of RNs in the post acute care setting have an Associates compared to 24% in the hospital setting).	Consider strengthening the associates degree pathway to nursing degrees.
	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).	Consider opportunities to enable career growth and longevity in the post-acute care field.
	More likely to be **older and female**.	Consider the needs of a female workforce and how a younger workforce could be encouraged; e.g., childcare.

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

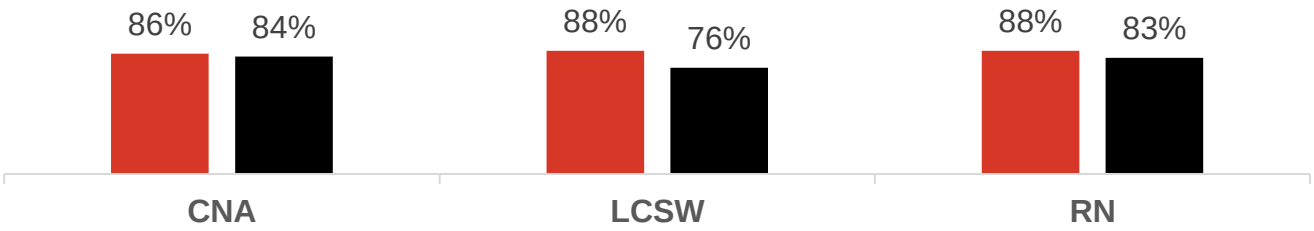
COMPARED TO HOSPITAL WORKERS, THE POST-ACUTE CARE WORKFORCE IS OLDER, MORE FEMALE, AND LESS LIKELY TO HOLD BACHELOR'S DEGREES[1]

- Among workforce categories that often require a Bachelor's degree or higher, those in the post-acute care setting are more likely to be **older** than those in the hospital setting.
- Among key workforce categories, those in the post-acute care setting **are more likely to be female** than those in the hospital setting.
- RNs in the post-acute care setting were nearly **twice as likely to have an Associate's degree** than RNs in the hospital setting, who were more likely to have a bachelor's degree.

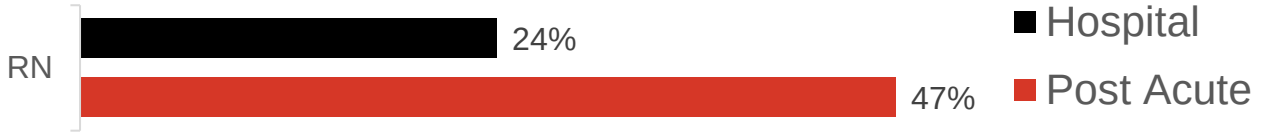
Average Age, by Workforce Category and Setting



Percent Female, by Workforce Category and Setting



Percent of RNs with Associates Degree as Highest Level of Education, by Setting



All comparisons between post-acute and hospital settings displayed here are statistically significant at a p-value of 0.05.
See High Level Methods for total sample sizes by setting/ workforce category and acronym definitions.
1. Education refers to differences in highest degree obtained between settings among RNs.

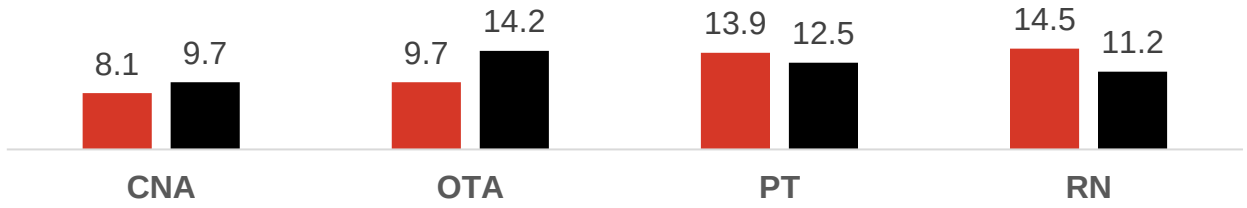
WITHIN A WORKFORCE CATEGORY, A JOB IN THE POST-ACUTE CARE SETTING MAY BE SUBSTANTIALLY DIFFERENT THAN A HOSPITAL SETTING, ATTRACT DIFFERENT WORKERS

→ Among CNAs and OTAs, those in hospital settings have had their license longer but, among RNs and PTs, those in the post-acute care setting have had their **license longer**.

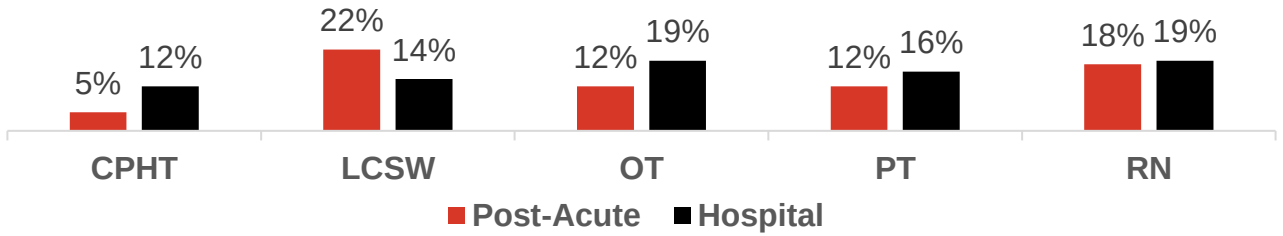
→ The percentage of individuals **working part time varies** by workforce category and setting.

→ For some workforce categories, individuals spend **less time on patient care** in post-acute care settings compared to hospital settings.

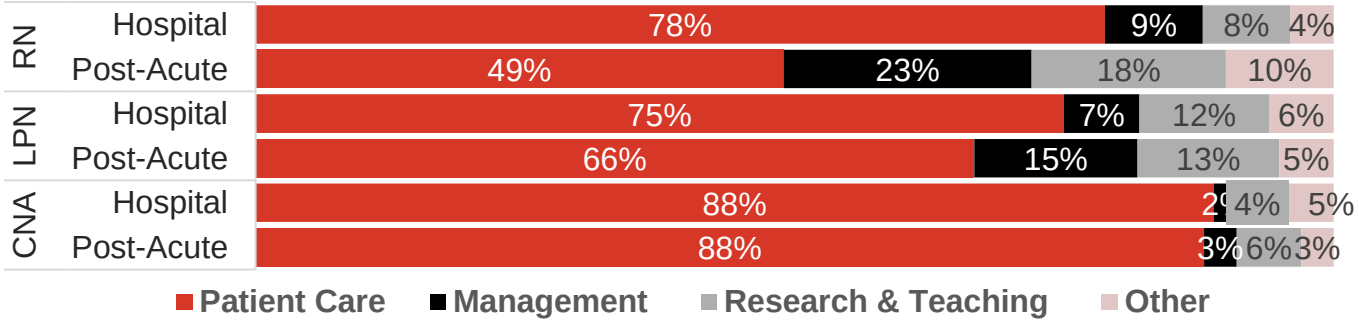
Average License Length (Years), by Workforce Category and Setting[1]



Percent Working Part-Time, by Workforce Category and Setting[1]



Time Distribution, by Task, Workforce Category, and Setting



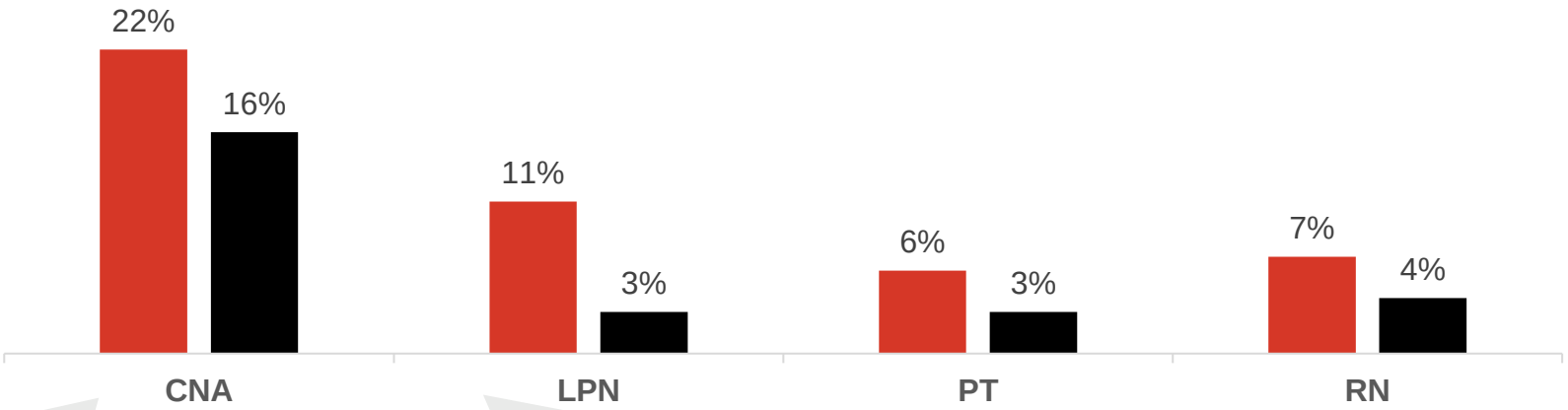
1. All comparisons between post-acute and hospital settings are statistically significant at a p-value of 0.05 and chart reflects only statistically significant comparisons.

See High Level Methods for total sample sizes by setting/ workforce category and acronym definitions.

KEY HEALTHCARE WORKERS IN POST-ACUTE CARE SETTINGS REPORT WANTING TO INCREASE THEIR HOURS

→ Among some workforce categories, individuals in the post-acute care field are **more likely to report wanting to increase hours** than those in hospital settings.

Percent Who Want to Increase Hours in the Next Two Years, by Workforce Category and Setting



Interview Insight: Serving individuals with complex care needs often exceeds benefit and service limits across settings, which may leave post-acute care workers desiring more hours to meet the need.

"The number of home care hours the state approves and pays for are often insufficient, especially for individuals with complex care needs."

- Labor Representative

Interview Insight: 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.

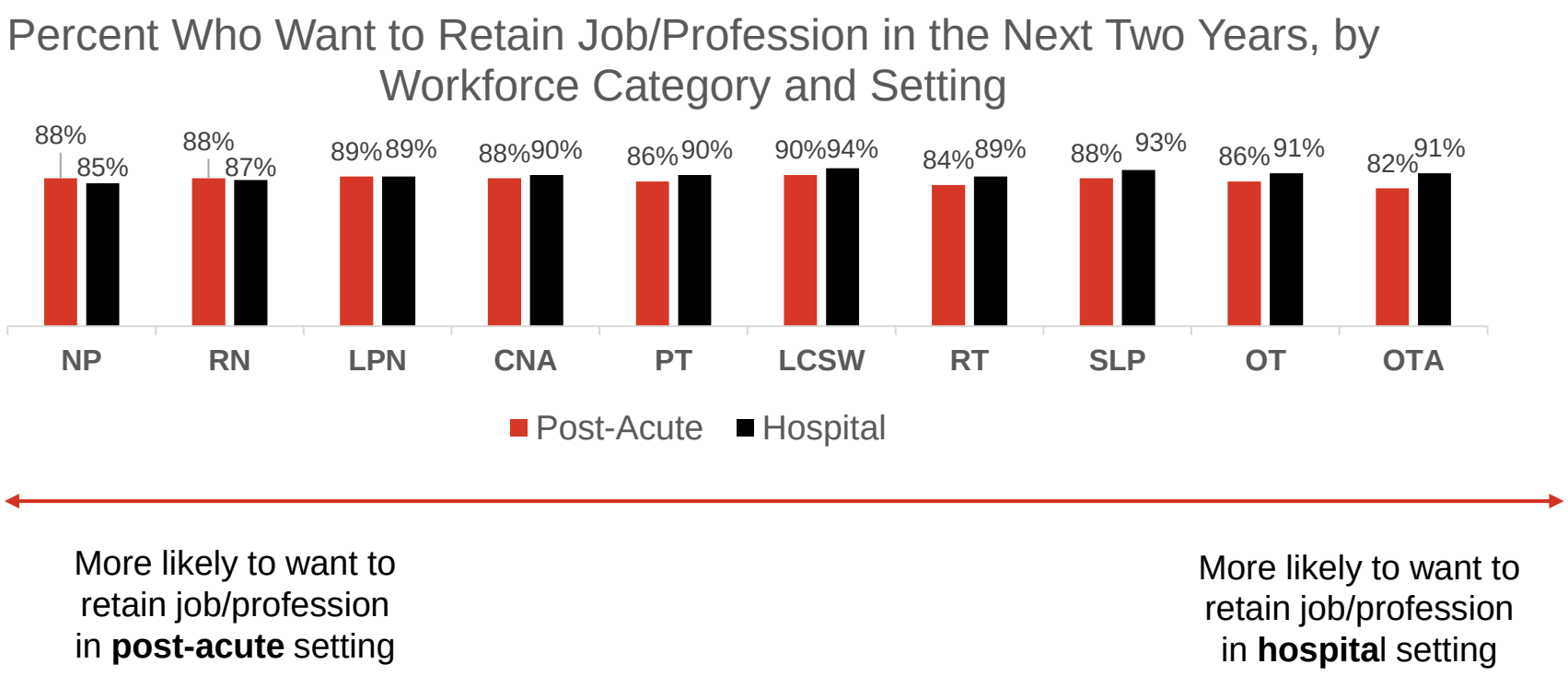
"Workers are living paycheck to paycheck and often pick up overtime to make ends meet, making exhaustion come on even faster."

- Labor Representative

All comparisons between post-acute and hospital settings displayed here are statistically significant at a p-value of 0.05.
See High Level Methods for total sample sizes by setting/ workforce category and acronym definitions.

MOST HEALTHCARE WORKERS WANT TO STAY IN THEIR JOB/PROFESSION

→ Desire to stay in an individual's job and profession varies by setting and workforce category, but overall is high.



All comparisons between post-acute and hospital settings displayed here are statistically significant at a p-value of 0.05.
See High Level Methods for total sample sizes by setting/ workforce category and acronym definitions.

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

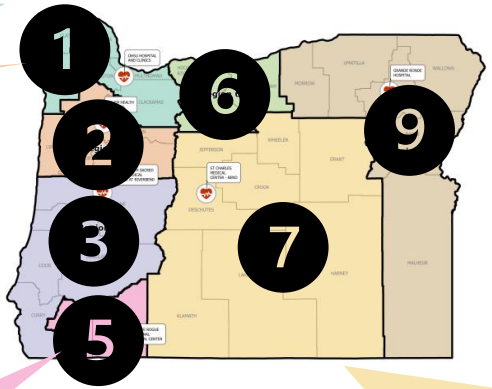
Region 6:
- Highest proportion of workers part-time, 26% (average: 16%)
- Least amount of time spent in research/training, 8% (average: 11%)

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.

ATI Advisory

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