HEALTHCARE WORKFORCE TRENDS REPORT

Q2 2026

BILL RATE BENCHMARKS & MARKET SIGNALS

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CONTENTS

INTRODUCTION & OVERVIEW

Specialty-driven pricing. Shifting structures. Rising scrutiny.

Across healthcare markets, familiar pressures continued to surface through new operating questions: how hospitals structure coverage, manage risk, evaluate staffing models, respond to labor activity, and preserve access in challenged markets.

This report pairs national and regional contract labor bill-rate benchmarks with key policy, regulatory, and market signals shaping healthcare workforce strategy. Together, these data points provide a broader view of the environment hospitals are navigating, including pricing trends, staffing model considerations, workforce access challenges, and emerging areas of risk.

Q2 2026 Contract Labor Rate Environment Summary

Q2 contract labor pricing reflected continued stability, with movement shaped by specialty mix, regional variation, and persistent coverage constraints. Rather than a uniform pricing story, the quarter underscored the importance of understanding where rate pressure is concentrated, which roles remain difficult to fill, and how local market dynamics continue to influence staffing costs.

Policy and Regulatory Signals

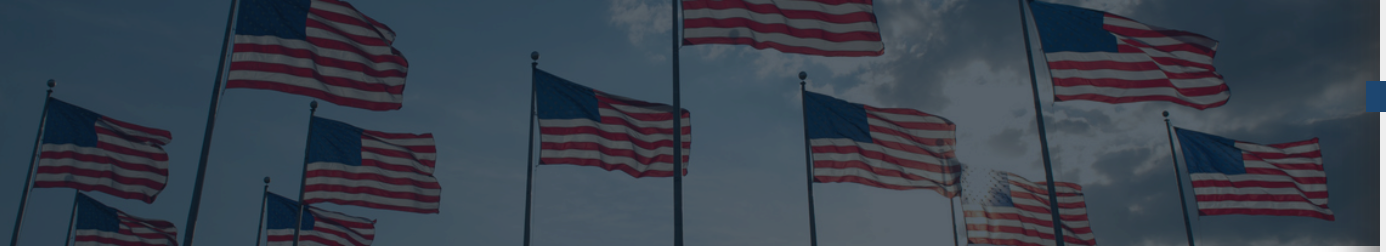
Healthcare workforce policy remained active in Q2, with continued attention to staffing accountability, labor market competition, platform-based workforce models, care model structure, and workplace safety. Developments around Rural Emergency Hospitals, healthcare transaction strategy, gig nursing platforms, labor activity, and staffing-related oversight all point to a workforce environment where compliance, coverage strategy, and operational design are increasingly linked.

Market and Operational Pressures

Q2 market signals reflected a workforce environment shaped by persistent operational strain, evolving care delivery needs, and continued pressure on frontline staffing models. Labor activity remained frequent, workplace violence continued to command attention, and rural access challenges pushed hospitals to evaluate new models of care delivery. These pressures continue to influence staffing decisions, particularly around coverage planning, workforce resilience, and the sustainability of existing labor models.

Workforce Strategy Implications

For hospital leaders, the Q2 strategy message is that workforce decisions are becoming increasingly structure-sensitive. The issue is not only how much temporary labor costs, but how each coverage model affects cost control, compliance, continuity, safety, and operational flexibility. As hospitals evaluate traditional agency staffing, EOR models, gig-style platforms, rural care redesign, and coverage needs, the advantage will go to organizations with clear governance over how labor is sourced, deployed, and aligned with enterprise priorities.



NATIONAL CONTRACT LABOR BILL RATES

National Physicians

National physician bill rates were largely stable in Q2 2026, with limited quarter-over-quarter movement across most specialties. Higher-pressure coverage areas, including Anesthesiology, Psychiatry, OB/GYN, and Radiology, continued to support stronger bill rates, while Emergency Medicine, Hospitalist, Internal Medicine, and Family Medicine remained generally consistent with first quarter rates.

Demand for temporary physician coverage remained meaningful, particularly in specialties where coverage gaps are harder to absorb operationally. Anesthesiology continued to reflect firm nationwide need, while Radiology and OB/GYN sustained comparatively elevated pricing. Hospitalist and Emergency Medicine rates also remained steady, underscoring ongoing reliance on locum coverage for core inpatient and emergency department operations.

National Advanced Practice

National advanced practice bill rates remained largely steady in Q2 2026, with only limited movement across most roles. Higher-need categories, including CRNA, NP Hospitalist, NP Psychiatric, and PA Surgical, continued to support stronger pricing, while Emergency Medicine, Internal Medicine, and Family Medicine roles showed more moderate rate levels.

The Q2 data points to a stable advanced practice environment rather than a period of meaningful rate movement. Demand for flexible coverage persisted across multiple care settings, particularly in hospital-based and acute care roles, where coverage gaps and assignment-based needs continued to support reliance on temporary advanced practice clinicians.

Q2 2026 NATIONAL BILL RATES

Physician	Low	High	Average
Anesthesiology	$460	$570	$515
Emergency Medicine	$345	$395	$370
Family Medicine	$215	$255	$235
Hospitalist	$240	$300	$270
Internal Medicine	$235	$265	$250
OB/GYN	$300	$370	$335
Psychiatry	$285	$325	$305
Radiology	$415	$555	$485
Advanced Practice			
CRNA	$295	$345	$320
NP – Emergency Medicine	$150	$180	$165
NP – Family Medicine	$140	$176	$158
NP – Hospitalist	$185	$225	$205
NP – Psychiatric	$165	$205	$185
PA – Emergency Medicine	$150	$180	$165
PA – Internal Medicine	$135	$175	$155
PA – Surgical	$180	$230	$205

NATIONAL CONTRACT LABOR BILL RATES

National Nursing

National nursing bill rates remained generally steady in Q2 2026, with modest variation across tracked roles. Core acute-care categories, including ER, ICU, Med Surg/Tele, and PACU, stayed within a relatively narrow range, while L&D, Cath Lab, and Radiology remained among the stronger-rate categories.

Some softening was evident in select areas, particularly ER, ICU, Med Surg/Tele, and OR, but the movement was measured rather than dramatic. L&D continued to show relative strength, reflecting ongoing need for specialized maternal care coverage, while Cath Lab and Radiology also remained comparatively elevated. Overall, the Q2 nursing data points to a stable but slightly softer environment.

National Allied

National allied health bill rates remained generally stable in Q2 2026, with targeted strength concentrated in higher-skill diagnostic, procedural, and therapy roles. Cath Lab Tech, CT Tech, Nuclear Medicine Tech, MRI Tech, and Ultrasound Tech continued to command comparatively stronger rates, reflecting sustained demand for specialized technical coverage. Nuclear Medicine and CT remained particularly firm, while Cath Lab continued to sit at the top of the allied rate range.

Therapy roles also showed signs of continued support, particularly Physical Therapy and Occupational Therapy, where demand remained resilient even though rate movement was measured. Speech Therapy also stayed within a relatively strong national range. Taken together, Q2 allied health trends point to a stable segment with selective upward pressure in diagnostic imaging, nuclear medicine, and therapy

Whats Ahead In Q3

Healthcare Organizations Begin Preparing For

- **Fall respiratory season**
- **Holiday scheduling**
- **Year-end staffing plans**
- **Budget planning for 2027**

Q2 2026 NATIONAL BILL RATES

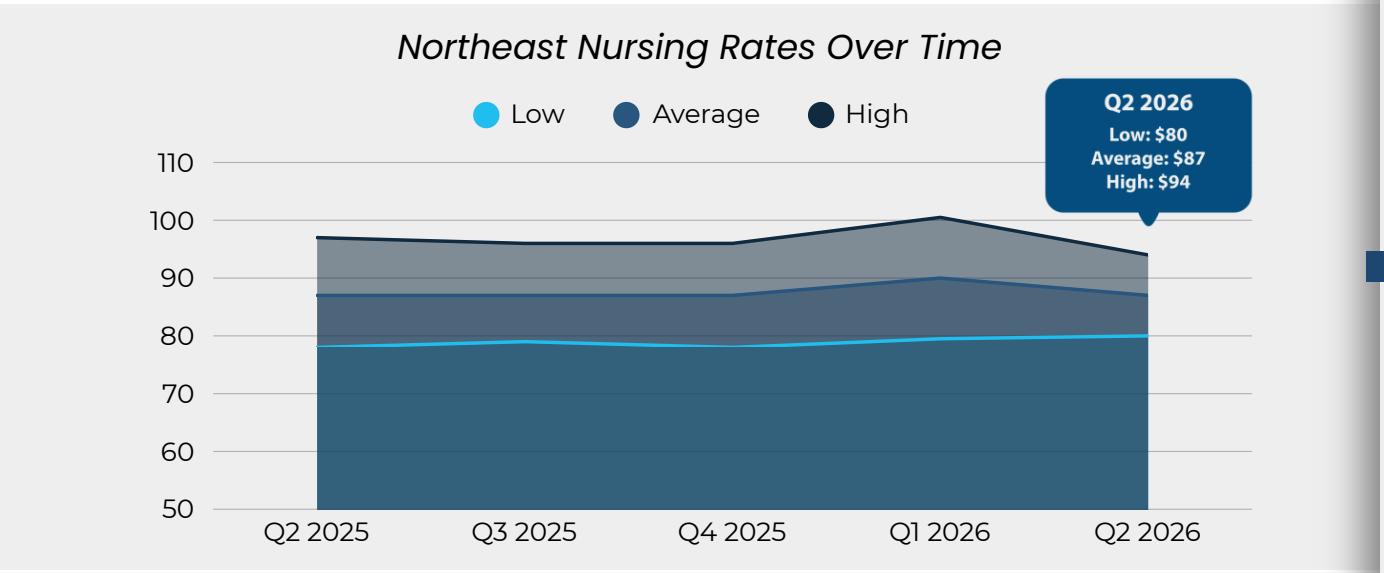
Nursing	Low	High	Average
Case Manager - HH	$81	$105	$93
Cath Lab	$98	$124	$111
CNA	$37	$51	$44
ER	$86	$92	$89
ICU	$90	$94	$92
L&D	$101	$107	$104
Long Term Care	$51	$69	$60
LPN	$52	$69	$61
MA	$37	$49	$43
Med Surg/Tele	$84	$90	$87
OR	$91	$97	$94
PACU	$92	$108	$100
Psych	$76	$98	$87
Radiology	$94	$118	$106
Allied Health			
Anesthesia Tech	$46	$60	$53
Cath Lab Tech	$106	$118	$112
CT Tech	$103	$107	$105
Medical Lab Tech	$66	$84	$75
MRI Tech	$87	$109	$98
Nuclear Medicine Tech	$110	$112	$111
Occupational Therapist	$83	$85	$84
Pharmacy Tech	$45	$59	$52
Physical Therapist	$83	$89	$86
Radiology Tech	$90	$98	$94
Respiratory Therapist	$83	$85	$84
Speech Therapist	$78	$104	$91
Sterile Processing Tech	$46	$62	$54
Surgical Tech	$56	$82	$69
Ultrasound Tech	$85	$107	$96

REGIONAL CONTRACT LABOR BILL RATES

Northeast Region

Bill rates in the Northeast remained generally steady in Q2 2026, with limited movement across most healthcare labor categories. Physician rates reflected continued stability, with Anesthesiology, Radiology, OB/GYN, and Emergency Medicine remaining among the stronger-rate specialties without indicating a broad pricing shift.

Nursing, advanced practice, and allied health rates showed selective firmness in specialized roles. Cath Lab, PACU, OR, Radiology, CRNA, NP Hospitalist, PA Surgical, and key allied technical categories continued to command stronger pricing. While some categories showed modest softening, the overall pattern suggests normalization. The highest-rate areas remained concentrated in roles where coverage gaps are more difficult to absorb through internal staffing alone. Taken together, the Q2 Northeast data points to a stable regional market, with pricing pressure concentrated in specialized clinical and technical roles.



Q2 2026 NORTHEAST BILL RATES

Physician	Low	High	Average
Anesthesiology	$395	$505	$450
Emergency Medicine	$320	$430	$375
Family Medicine	$180	$240	$210
Hospitalist	$220	$290	$255
Internal Medicine	$195	$255	$225
OB/GYN	$285	$395	$340
Psychiatry	$250	$340	$295
Radiology	$350	$490	$420
Advanced Practice			
CRNA	$300	$360	$330
NP – Emergency Medicine	$155	$185	$170
NP – Family Medicine	$145	$181	$163
NP – Hospitalist	$195	$235	$215
NP – Psychiatric	$175	$215	$195
PA – Emergency Medicine	$165	$205	$185
PA – Internal Medicine	$155	$195	$175
PA – Surgical	$195	$235	$215
Nursing			
Case Manager - HH	$84	$108	$96
Cath Lab	$101	$127	$114
CNA	$38	$52	$45
ER	$89	$95	$92
ICU	$90	$96	$93
L&D	$100	$104	$102
Long Term Care	$68	$84	$76
LPN	$53	$71	$62
MA	$38	$50	$44
Med Surg/Tele	$88	$92	$90
OR	$94	$100	$97
PACU	$94	$110	$102
Psych	$79	$99	$89
Radiology	$97	$121	$109
Allied Health			
Anesthesia Tech	$48	$62	$55
Cath Lab Tech	$110	$122	$116
CT Tech	$105	$111	$108
Medical Lab Tech	$68	$86	$77
MRI Tech	$90	$112	$101
Nuclear Medicine Tech	$112	$116	$114
Occupational Therapist	$84	$88	$86
Pharmacy Tech	$47	$61	$54
Physical Therapist	$85	$91	$88
Radiology Tech	$93	$101	$97
Respiratory Therapist	$85	$87	$86
Speech Therapist	$81	$107	$94
Sterile Processing Tech	$48	$64	$56
Surgical Tech	$58	$84	$71
Ultrasound Tech	$88	$110	$99

REGIONAL CONTRACT LABOR BILL RATES

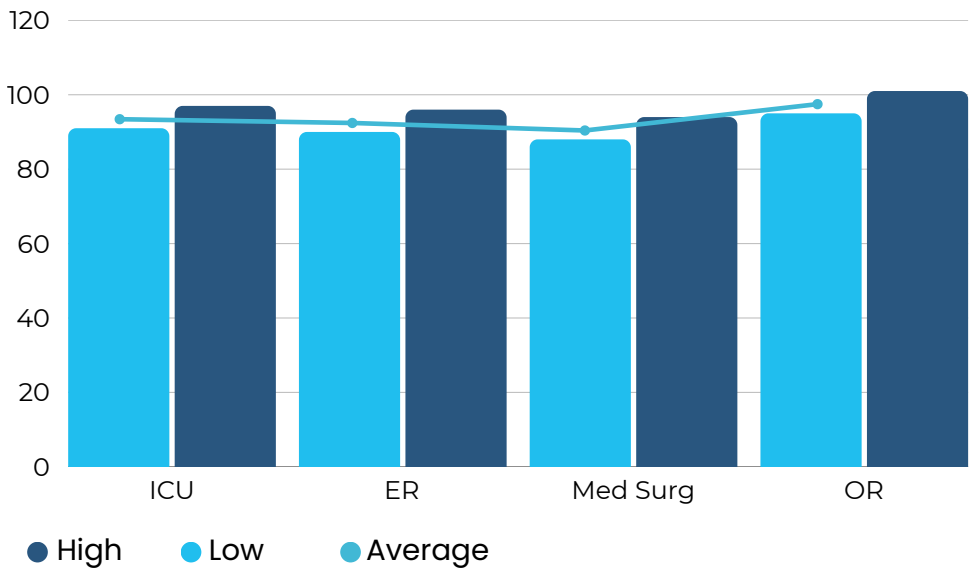
New York State

New York bill rates remained generally steady in Q2 2026, with stronger pricing concentrated in specialized and harder-to-fill roles. Physician rates continued to be led by Anesthesiology, Radiology, Emergency Medicine, and OB/GYN, while advanced practice rates were firmest in CRNA, NP Hospitalist, NP Psychiatric, PA Emergency Medicine, and PA Surgical. Nursing rates showed selective strength in Cath Lab, L&D, PACU, Radiology, and OR, while allied health rates remained strongest in technical specialties such as Cath Lab Tech, CT Tech, Nuclear Medicine Tech, MRI Tech, Radiology Tech, and Ultrasound Tech.

As always, statewide New York averages reflect a blended market shaped by both downstate and upstate dynamics. Downstate demand and cost structures can place upward pressure on rates in certain specialties, while upstate pricing may vary more by facility type, geography, and urgency of need. The Q2 data points to a generally stable New York market, with stronger pricing concentrated in specialized roles where hospitals have fewer internal coverage options.

Q2 Average

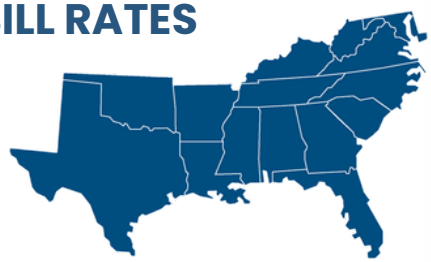
ICU: $94
ER: $93
Med Surg: $91
OR: $98



Q2 2026 NEW YORK BILL RATES

Physician	Low	High	Average
Anesthesiology	$459	$515	$487
Emergency Medicine	$340	$440	$390
Family Medicine	$195	$245	$220
Hospitalist	$220	$300	$260
Internal Medicine	$200	$260	$230
OB/GYN	$290	$415	$353
Psychiatry	$265	$353	$309
Radiology	$360	$510	$435
Advanced Practice			
CRNA	$315	$365	$340
NP – Emergency Medicine	$160	$190	$175
NP – Family Medicine	$150	$186	$168
NP – Hospitalist	$200	$240	$220
NP – Psychiatric	$180	$220	$200
PA – Emergency Medicine	$170	$210	$190
PA – Internal Medicine	$160	$200	$180
PA – Surgical	$200	$240	$220
Nursing			
Case Manager - HH	$85	$109	$97
Cath Lab	$102	$128	$115
CNA	$38	$52	$45
ER	$90	$96	$93
ICU	$91	$97	$94
L&D	$103	$109	$106
Long Term Care	$68	$84	$76
LPN	$53	$71	$62
MA	$38	$50	$44
Med Surg/Tele	$88	$94	$91
OR	$95	$101	$98
PACU	$95	$111	$103
Psych	$80	$100	$90
Radiology	$98	$122	$110
Allied Health			
Anesthesia Tech	$55	$63	$56
Cath Lab Tech	$116	$124	$118
CT Tech	$108	$112	$109
Medical Lab Tech	$77	$87	$78
MRI Tech	$101	$113	$102
Nuclear Medicine Tech	$114	$117	$115
Occupational Therapist	$86	$89	$87
Pharmacy Tech	$54	$62	$55
Physical Therapist	$88	$92	$89
Radiology Tech	$97	$102	$98
Respiratory Therapist	$86	$88	$87
Speech Therapist	$94	$108	$95
Sterile Processing Tech	$56	$65	$57
Surgical Tech	$71	$85	$72
Ultrasound Tech	$99	$111	$100

REGIONAL CONTRACT LABOR BILL RATES

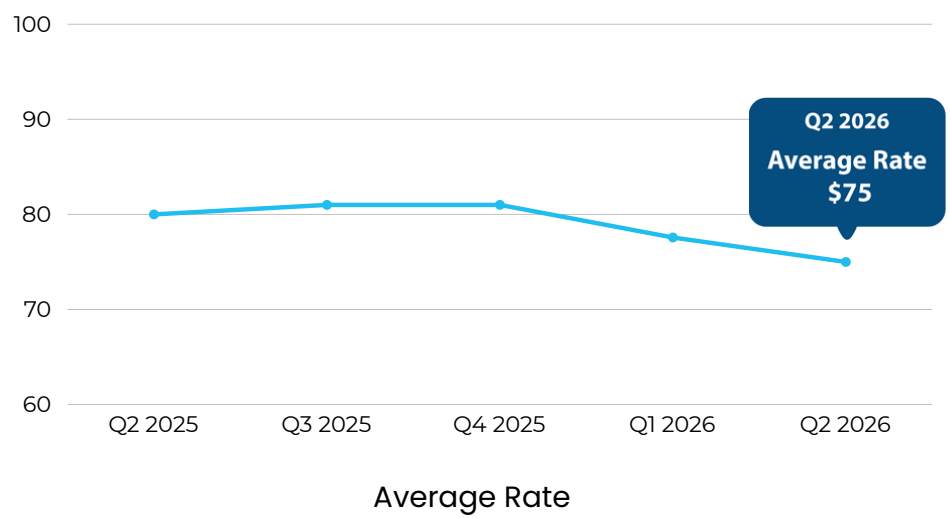


Southern Region

Southern Southern bill rates remained controlled in Q2 2026, consistent with the region's lower-cost profile. Physician and advanced practice rates were broadly stable, with stronger pricing concentrated in Anesthesiology, Radiology, OB/GYN, CRNA, NP Hospitalist, and PA Surgical.

Nursing rates were mostly steady to slightly softer, particularly in ER, ICU, Med Surg/Tele, and OR, while Cath Lab, PACU, Radiology, and L&D remained firmer. Allied health rates also held steady, with strength in Cath Lab Tech, CT Tech, MRI Tech, Nuclear Medicine Tech, and therapy roles. Overall, the Q2 Southern data suggests a stable, cost-sensitive market with selective pressure in specialized roles.

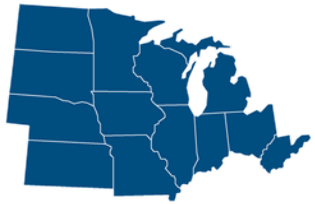
Southern Nursing Rates Over Time



Q2 2026 SOUTHERN BILL RATES

Physician	Low	High	Average
Anesthesiology	$345	$465	$405
Emergency Medicine	$305	$395	$350
Family Medicine	$160	$220	$190
Hospitalist	$205	$265	$235
Internal Medicine	$175	$235	$205
OB/GYN	$260	$360	$310
Psychiatry	$230	$310	$270
Radiology	$310	$450	$380
Advanced Practice			
CRNA	$275	$325	$300
NP – Emergency Medicine	$140	$170	$155
NP – Family Medicine	$130	$166	$148
NP – Hospitalist	$170	$210	$190
NP – Psychiatric	$150	$190	$170
PA – Emergency Medicine	$140	$170	$155
PA – Internal Medicine	$125	$165	$145
PA – Surgical	$170	$210	$190
Nursing			
Case Manager - HH	$75	$93	$84
Cath Lab	$90	$112	$101
CNA	$35	$47	$41
ER	$75	$79	$77
ICU	$75	$79	$77
L&D	$80	$88	$84
Long Term Care	$62	$78	$70
LPN	$49	$63	$56
MA	$35	$45	$40
Med Surg/Tele	$74	$78	$76
OR	$76	$82	$79
PACU	$84	$100	$92
Psych	$73	$91	$82
Radiology	$86	$106	$96
Allied Health			
Anesthesia Tech	$44	$58	$51
Cath Lab Tech	$100	$112	$106
CT Tech	$99	$103	$101
Medical Lab Tech	$64	$80	$72
MRI Tech	$84	$104	$94
Nuclear Medicine Tech	$104	$108	$106
Occupational Therapist	$78	$84	$81
Pharmacy Tech	$43	$57	$50
Physical Therapist	$80	$86	$83
Radiology Tech	$86	$94	$90
Respiratory Therapist	$78	$84	$81
Speech Therapist	$75	$99	$87
Sterile Processing Tech	$44	$58	$51
Surgical Tech	$53	$79	$66
Ultrasound Tech	$82	$102	$92

REGIONAL CONTRACT LABOR BILL RATES



Midwest Region

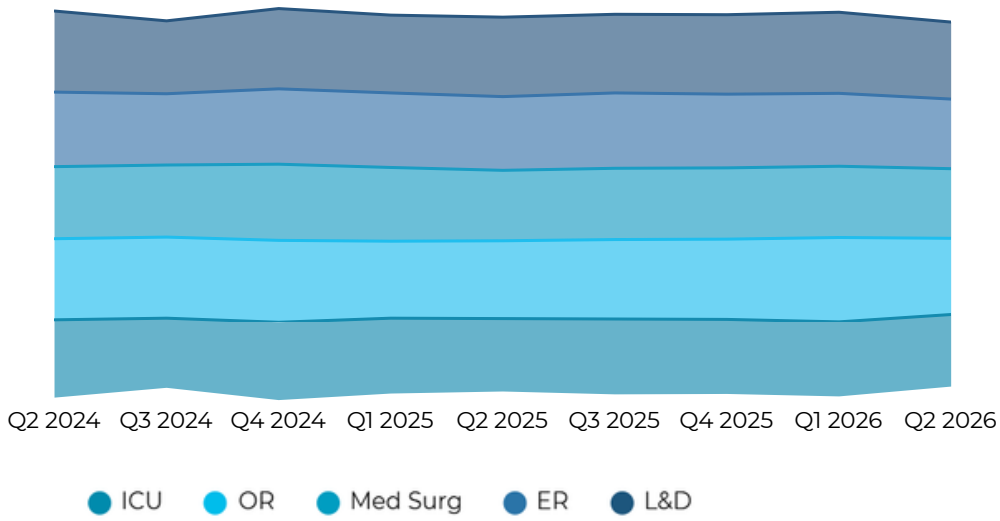
Midwest bill rates showed little broad-based movement in Q2 2026, with most categories staying within a relatively tight pricing band. Physician and advanced practice rates were led by higher-need roles such as Anesthesiology, Radiology, OB/GYN, CRNA, NP Hospitalist, and PA Surgical, while generalist roles remained more moderate.

Nursing rates were similarly measured, with Cath Lab, PACU, Radiology, OR, and L&D at the higher end of the regional range. In allied health, stronger pricing was concentrated in select technical and diagnostic roles, including Cath Lab Tech, Nuclear Medicine Tech, MRI Tech, Ultrasound Tech, and Speech Therapy. Overall, Q2 Midwest pricing reflected specialty-specific pressure rather than widespread rate escalation.

Variability in Midwest Nursing Rates Over Time

Q2 2024
ICU: $95
OR: $99
Med Surg: $88
ER: $91
L&D: $99

Q2 2026
ICU: $88
OR: $93
Med Surg: $87
ER: $85
L&D: $94



Q2 2026 MIDWEST BILL RATES

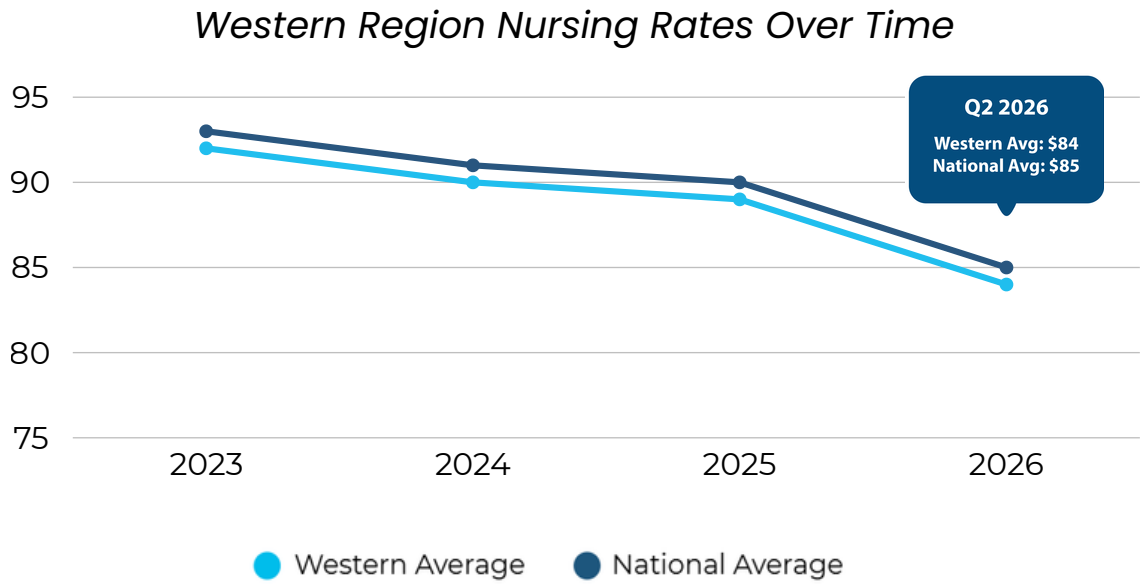
Physician	Low	High	Average
Anesthesiology	$350	$460	$405
Emergency Medicine	$295	$375	$335
Family Medicine	$186	$239	$213
Hospitalist	$223	$291	$257
Internal Medicine	$195	$255	$225
OB/GYN	$265	$365	$315
Psychiatry	$230	$310	$270
Radiology	$310	$450	$380
Advanced Practice			
CRNA	$290	$330	$310
NP – Emergency Medicine	$145	$175	$160
NP – Family Medicine	$135	$171	$153
NP – Hospitalist	$180	$220	$200
NP – Psychiatric	$160	$200	$180
PA – Emergency Medicine	$145	$175	$160
PA – Internal Medicine	$130	$170	$150
PA – Surgical	$180	$220	$200
Nursing			
Case Manager - HH	$80	$104	$92
Cath Lab	$96	$122	$109
CNA	$36	$50	$43
ER	$83	$87	$85
ICU	$86	$90	$88
L&D	$90	$98	$94
Long Term Care	$65	$81	$73
LPN	$50	$68	$59
MA	$36	$48	$42
Med Surg/Tele	$82	$88	$85
OR	$90	$96	$93
PACU	$90	$108	$99
Psych	$75	$95	$85
Radiology	$93	$117	$105
Allied Health			
Anesthesia Tech	$45	$59	$52
Cath Lab Tech	$104	$116	$110
CT Tech	$101	$105	$103
Medical Lab Tech	$65	$83	$74
MRI Tech	$86	$106	$96
Nuclear Medicine Tech	$108	$112	$110
Pharmacy Tech	$82	$84	$83
Radiology Tech	$44	$58	$51
Respiratory Therapist	$82	$88	$85
Sterile Processing Tech	$89	$97	$93
Surgical Tech	$82	$84	$83
Ultrasound Tech	$77	$101	$89
Occupational Therapist	$45	$61	$53
Physical Therapist	$55	$81	$68
Speech Therapist	$84	$106	$95

REGIONAL CONTRACT LABOR BILL RATES

Western Region

Western bill rates in Q2 2026 reflected a generally stable regional profile, with stronger pricing concentrated in specialty, technical, and therapy roles rather than across the full labor mix. Physician rates continued to be led by Anesthesiology, Radiology, Emergency Medicine, and OB/GYN, while advanced practice pricing remained firmest in CRNA, NP Hospitalist, NP Psychiatric, PA Emergency Medicine, and PA Surgical roles.

Nursing rates showed the clearest strength in Cath Lab, Radiology, L&D, PACU, and OR, while broader acute-care categories remained more moderate. Allied health followed a similar pattern, with Cath Lab Tech, Nuclear Medicine Tech, CT Tech, MRI Tech, Ultrasound Tech, Radiology Tech, and therapy roles such as Physical Therapy and Speech Therapy sitting at the higher end of the regional range.



Q2 2026 WESTERN BILL RATES

Physician	Low	High	Average
Anesthesiology	$360	$490	$425
Emergency Medicine	$315	$415	$365
Family Medicine	$190	$240	$215
Hospitalist	$225	$295	$260
Internal Medicine	$200	$250	$225
OB/GYN	$280	$390	$335
Psychiatry	$250	$340	$295
Radiology	$345	$475	$410
Advanced Practice			
CRNA	$305	$355	$330
NP – Emergency Medicine	$155	$185	$170
NP – Family Medicine	$142	$178	$160
NP – Hospitalist	$190	$230	$210
NP – Psychiatric	$170	$210	$190
PA – Emergency Medicine	$155	$185	$170
PA – Internal Medicine	$140	$180	$160
PA – Surgical	$185	$235	$210
Nursing			
Case Manager - HH	$83	$107	$95
Cath Lab	$100	$126	$113
CNA	$38	$52	$45
ER	$88	$90	$89
ICU	$91	$95	$93
L&D	$101	$107	$104
Long Term Care	$68	$84	$76
LPN	$52	$70	$61
MA	$38	$50	$44
Med Surg/Tele	$85	$91	$88
OR	$92	$98	$95
PACU	$94	$110	$102
Psych	$78	$98	$88
Radiology	$96	$120	$108
Allied Health			
Anesthesia Tech	$48	$62	$55
Cath Lab Tech	$109	$121	$115
CT Tech	$105	$111	$108
Medical Lab Tech	$68	$86	$77
MRI Tech	$90	$112	$101
Nuclear Medicine Tech	$112	$116	$114
Occupational Therapist	$84	$88	$86
Pharmacy Tech	$47	$61	$54
Physical Therapist	$85	$91	$88
Radiology Tech	$93	$101	$97
Respiratory Therapist	$85	$87	$86
Speech Therapist	$80	$106	$93
Sterile Processing Tech	$48	$64	$56
Surgical Tech	$58	$84	$71
Ultrasound Tech	$88	$110	$99

REGIONAL CONTRACT LABOR BILL RATES

California State

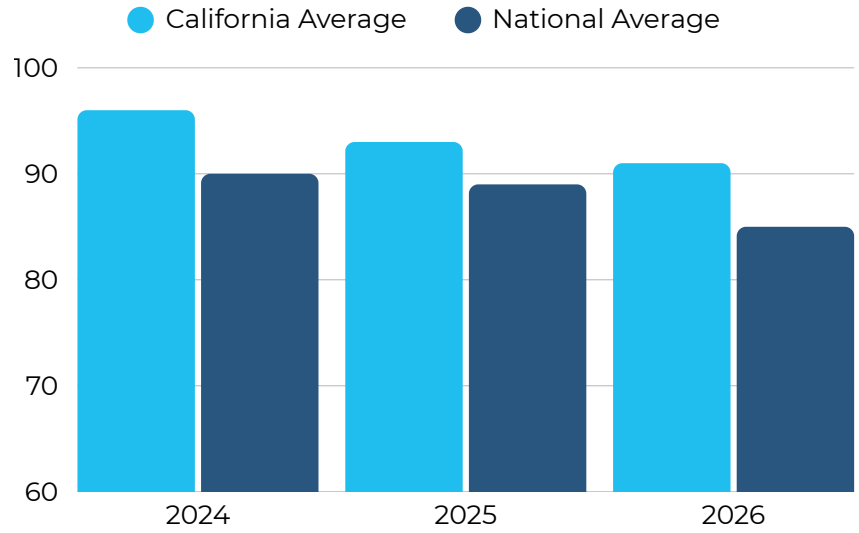
California bill rates remained among the strongest regional benchmarks in Q2 2026, with higher pricing concentrated in specialized physician, nursing, advanced practice, allied technical, and therapy roles. Physician rates continued to be led by Anesthesiology, Radiology, Emergency Medicine, and OB/GYN, while advanced practice pricing was firmest in CRNA, NP Hospitalist, NP Psychiatric, PA Emergency Medicine, and PA Surgical roles.

Nursing rates showed particular strength in L&D, OR, ICU, Cath Lab, Radiology, and PACU, reflecting continued demand for specialized clinical coverage. Allied health rates followed a similar pattern, with stronger pricing in Cath Lab Tech, Nuclear Medicine Tech, CT Tech, MRI Tech, Ultrasound Tech, Radiology Tech, and therapy roles. As with New York, California statewide averages should be read as a blended view across distinct submarkets, but the Q2 data continues to show a premium-rate environment where specialized coverage needs drive the clearest pricing pressure.

2024
California: $96
National: $90

2025
California: $93
National: $89

Q1-Q2 2026
California: $91
National: $85



Q2 2026 CAIFORNIA BILL RATES

Physician	Low	High	Average
Anesthesiology	$427	$557	$492
Emergency Medicine	$358	$499	$429
Family Medicine	$200	$251	$226
Hospitalist	$230	$310	$270
Internal Medicine	$195	$265	$230
OB/GYN	$320	$430	$375
Psychiatry	$286	$386	$336
Radiology	$370	$550	$460
Advanced Practice			
CRNA	$315	$365	$340
NP – Emergency Medicine	$160	$190	$175
NP – Family Medicine	$150	$186	$168
NP – Hospitalist	$195	$235	$215
NP – Psychiatric	$175	$215	$195
PA – Emergency Medicine	$160	$190	$175
PA – Internal Medicine	$145	$185	$165
PA – Surgical	$190	$240	$215
Nursing			
Case Manager - HH	$88	$112	$100
Cath Lab	$106	$132	$119
CNA	$40	$54	$47
ER	$101	$105	$103
ICU	$106	$112	$109
L&D	$115	$127	$121
Long Term Care	$54	$72	$63
LPN	$55	$73	$64
MA	$40	$52	$46
Med Surg/Tele	$90	$98	$94
OR	$115	$121	$118
PACU	$99	$115	$107
Psych	$82	$102	$92
Radiology	$101	$125	$113
Allied Health			
Anesthesia Tech	$50	$64	$57
Cath Lab Tech	$114	$126	$120
CT Tech	$107	$113	$110
Medical Lab Tech	$71	$89	$80
MRI Tech	$93	$115	$104
Nuclear Medicine Tech	$114	$118	$116
Occupational Therapist	$86	$90	$88
Pharmacy Tech	$49	$63	$56
Physical Therapist	$87	$93	$90
Radiology Tech	$96	$104	$100
Respiratory Therapist	$86	$90	$88
Speech Therapist	$83	$109	$96
Sterile Processing Tech	$50	$66	$58
Surgical Tech	$61	$87	$74
Ultrasound Tech	$91	$113	$102

WORKFORCE BRIEFING

HEALTHCARE LEGISLATION, POLICY, AND MARKET SIGNALS

Rural Emergency Hospitals Move from Policy Concept to Practical Strategy
Healthcare Deals Enter a More Structure-Sensitive Era
Gig Nursing Platforms: Familiar Model, Unsettled Rules
Nurse Labor Activity Becomes More Frequent, Not Just Larger
Workplace Violence Continues to Command Workforce Attention

RURAL EMERGENCY HOSPITALS MOVE FROM POLICY CONCEPT TO PRACTICAL STRATEGY

Rural Emergency Hospitals Reframe the Sustainability Question

Rural Emergency Hospitals (REHs) remain an early-stage model, but their expansion to 51 hospitals signals that the designation is becoming a serious strategic option for some rural communities. Created as a new Medicare provider type and effective in 2023, the REH designation allows eligible rural hospitals to discontinue inpatient acute care while preserving 24/7 emergency services, observation care, and outpatient services.

For small rural hospitals facing low inpatient volumes, persistent workforce shortages, and difficult service-line economics, the model reframes the sustainability question. The issue is not always how to preserve the hospital exactly as it has operated in the past, but how to preserve the services the community cannot safely lose.

Key REH Benefits Include

- **Enhanced Medicare outpatient payment:** OPPS payment plus 5% for qualifying Medicare outpatient services
- **Monthly facility payment:** REHs receive a fixed monthly facility payment in addition to reimbursement for covered services. In 2025, CMS listed the payment at $285,625.90 per month for each REH, with the amount increasing annually based on the hospital market basket update.
- **Operational flexibility:** more flexibility around staffing and services, subject to state licensure requirements
- **Technical assistance:** support through the REH Technical Assistance Center

Early Adoption Remains Limited, But Worth Watching

Adoption remains relatively limited, which is part of what makes the designation notable. Rural Emergency Hospitals are not yet a mainstream rural hospital model, but early conversions are beginning to show how some small hospitals may redesign their role around emergency access, outpatient care, transfer relationships, and financial sustainability.

Uneven adoption also tells its own story. Some states have multiple REHs, while others currently have none. That absence does not necessarily mean rural hospitals in those states are less challenged. It may indicate that hospitals are pursuing other sustainability strategies, including Critical Access Hospital models, affiliation, service-line restructuring, state support, or workforce stabilization before considering the more significant step of giving up inpatient acute care.

RURAL EMERGENCY HOSPITALS MOVE FROM POLICY CONCEPT TO PRACTICAL STRATEGY

New York Example: Clifton-Fine Hospital

Clifton-Fine Hospital in Star Lake, New York, offers a useful early example of REH conversion as rural redesign rather than simple retrenchment. The hospital began discussing the designation publicly in 2024 and announced its transition in 2025 after evaluating the model through the REH Technical Assistance Center's financial modeling process. Facing low inpatient volumes, insufficient revenue, and a shrinking rural population, Clifton-Fine gave up inpatient care while preserving 24/7 emergency services, observation care, primary care, behavioral health, lab, radiology, and therapy services. It also added a walk-in convenient care clinic as part of the transition.
The experience also shows how REH conversion can reshape both facilities and staffing. Hospital leadership said the emergency department would remain fully operational, but staffing patterns would shift toward more ED-focused coverage. In 2026, Clifton-Fine also opened a new emergency department supported by grant funding, with expanded emergency, diagnostic imaging, observation, triage, radiology, and CT capacity. For a community roughly an hour from the nearest alternative hospital, the model highlights the central REH tradeoff: inpatient services are reduced, but emergency stabilization, outpatient access, and transfer readiness are preserved.

Strategic Takeaway

Workplace violence continues to draw attention because it touches multiple parts of hospital operations at once: staff safety, retention, labor relations, patient access, behavioral health capacity, compliance readiness, and public trust. The policy trend is not limited to punishing perpetrators after an incident. Increasingly, states and health systems are focusing on whether healthcare organizations have the prevention systems, reporting structures, staff supports, security infrastructure, and documentation needed to address violence as an ongoing workforce and operational risk.

HEALTHCARE DEALS ENTER A MORE STRUCTURE-SENSITIVE ERA

A Blocked Staffing Merger Gives Way to a Private Sale

Cross Country Healthcare, whose planned combination with Aya Healthcare collapsed under FTC scrutiny in December 2025, agreed on May 8 to be taken private by private equity firm Knox Lane for $437 million, a 31% premium over its pre-announcement share price. Where the Aya deal would have combined two of the largest healthcare staffing platforms, the Knox Lane transaction moves Cross Country out of public markets rather than consolidating it with a direct competitor. That structure appears less likely to draw the same antitrust concern. The deal is expected to close in Q3, pending regulatory review.

Notable alongside the sale: Cross Country reported Q2 revenue down 18% year over year, with a $4.3 million net loss. CEO John Martins also stepped down shortly after the Aya deal fell apart, with co-founder Kevin Clark returning as chairman. Taken together, the sequence shows how a blocked competitor tie-up can redirect a company's strategic path, from sector consolidation to private ownership.

USAP Antitrust Case Moves Toward Resolution

The FTC's long-running case against U.S. Anesthesia Partners has reached its settlement phase. On April 23, 2026, FTC and USAP reached an agreement in principle to settle the antitrust suit first filed in 2023, bringing one of the more closely watched roll-up cases in hospital-based physician services closer to resolution after nearly three years in court.

Terms remain confidential, but reporting points to structural limits on future acquisitions rather than a monetary penalty. FTC settled separately with Welsh Carson in early 2025; this agreement reaches USAP directly. A related patient class action continues, with trial set for January 2028.

The Concern: Market Power

The FTC alleged Welsh Carson created USAP in 2012 specifically to consolidate Texas anesthesia practices, not through a single transaction but through serial acquisitions, price-setting arrangements, and a market-allocation agreement, ultimately reaching market shares as high as 70% in major Texas metro areas. The case was notable because it challenged the roll-up strategy itself, not only a single transaction.

Strategic Takeaway

Across both accreditation and state-level regulation, staffing is being treated less as a flexible operational input and more as a compliance function that must be defined, documented, and defensible. As a result, the ability to document staffing decisions consistently across systems and sources is becoming more important to survey readiness and regulatory resilience.

GIG NURSING PLATFORMS: THE CLASSIFICATION GAP

Familiar Model, Unsettled Rules

Gig nursing platforms aren't new, but the regulatory questions around them still are. For hospital leaders, the issue is no longer whether app-based staffing can help fill open shifts. It's what sits behind the shift. Digital scheduling, rapid shift matching, and mobile payments look similar across platforms, but the employment model underneath can differ significantly. Some platforms hire nurses as W-2 employees. Others classify them as 1099 independent contractors. Still others use a hybrid structure that shifts depending on the state, the client agreement, or the role. That distinction isn't a technicality. It determines who pays overtime and payroll taxes, who carries workers' compensation and professional liability, who owns credentialing and onboarding, and ultimately who is accountable when a shift turns into a compliance, wage-and-hour, or patient safety issue.

State Policy Continues to Draw New Lines

Policymakers have been grappling with gig nursing for several years, and state approaches remain uneven. A recent AI Now Institute report identified activity in at least 17 states since 2022 involving bills that would recognize gig nursing platforms as distinct from healthcare staffing agencies. The report also noted that several states have already created carveouts for certain platform-based work, while others are moving toward greater inclusion of platforms within existing staffing oversight structures.

New York offers one notable counterexample. Rather than treating digital healthcare staffing platforms as wholly separate from temporary healthcare staffing agencies, New York included digital health care service platforms within its temporary healthcare services agency framework, including registration and reporting requirements.

Strategic Takeaway

Gig nursing may offer useful flexibility, especially for short-notice or low-volume staffing needs. But the app is not the strategy. Hospitals using or evaluating these platforms should look past the technology interface and assess the underlying employment model, credentialing controls, insurance coverage, timekeeping process, rate-setting practices, incident reporting, and contractual allocation of risk.

NURSE LABOR'S NEW NORMAL: SHORT, SHARP, STRATEGIC

Nurse Labor Activity Becomes More Frequent, Not Just Larger

Second-quarter nurse labor activity reflected ongoing pressure across the healthcare labor environment. Large walkouts still draw attention, including the Brigham and Women's/Mass General Brigham strike that moved from Q2 planning into a July walkout, while the long-running Henry Ford Genesys strike in Michigan shows how unresolved disputes can create sustained operational pressure. But the broader signal is frequency: shorter walkouts, strike authorizations, and staffing-centered disputes are becoming a more regular part of the operating environment. Nurse.org's strike tracker shows confirmed RN walkouts rising sharply from pre-pandemic levels, with approximately 15 to 16 confirmed or underway by mid-2026. Cornell's Labor Action Tracker and BLS data point in the same direction, showing healthcare strike activity and worker involvement rising sharply in 2025.

The pattern is also becoming more tactical. More than four in ten RN strikes tracked by Nurse.org lasted a single day, allowing unions to create operational pressure while limiting lost wages. For hospitals, even short walkouts can trigger broader coverage, cost, scheduling, and communications challenges, particularly when replacement staffing agreements carry multiday minimums.

Staffing Wins Are Common, Ratios Are Rare

Nurse.org's review of 48 settled RN strikes found:

- 43 of 48 produced some form of staffing improvement
- 6 resulted in enforceable staffing ratios

Most staffing wins involved targeted provisions, such as::

- Staffing committees
- Staffing plans
- Break relief
- Charge nurse protections
- Penalty pay

The Bigger Picture

Nurse labor activity is becoming a more regular feature of the workforce environment rather than an episodic disruption. The strategic signal is frequency and leverage: more bargaining units are using short strikes, authorization votes, and staffing-centered demands to press operational issues into contract language. For hospital leaders, the labor landscape is less about isolated wage disputes and more about how staffing models, safety infrastructure, retention practices, and day-to-day clinical operations are being negotiated into the structure of care delivery.

WORKPLACE VIOLENCE CONTINUES TO COMMAND WORKFORCE ATTENTION

State Policy Continues to Broaden

A 2026 Health Affairs Scholar review found that, as of June 2024, 48 states had enacted at least one law addressing workplace violence in healthcare settings. Earlier state activity focused largely on penalties for perpetrators, but newer approaches place more emphasis on prevention and remediation. Forty-five states had penalty laws, while 27 had enacted prevention laws and 23 had enacted remediation laws, with 17 states covering all three categories. The scope of these laws has also widened, with more recent legislation applying across healthcare settings rather than focusing primarily on emergency departments or EMS.

The Response Model Is Expanding

Policy: Penalties, prevention plans, reporting requirements, nonretaliation protections

Operations: Staff training, security protocols, visitor controls, risk assessment, incident review

Technology: Wearable alerts, panic buttons, response-time tracking, location-based escalation tools

Support: Post-incident relief, counseling, paid leave, documentation, organizational follow-up

When Safety Becomes Wearable

WellSpan Health offers a practical example of how workplace violence prevention is being translated into frontline security infrastructure, with the Central Pennsylvania health system reporting a two-thirds reduction in workplace violence-related injuries after outfitting frontline healthcare staff with wearable safety devices from Canopy, a platform originally developed with Jefferson Health to support faster emergency response through systemwide alerts. The technology allows staff to discreetly signal for help when a situation begins to escalate, addressing a common gap in clinical settings where workers may be away from a phone, wall button, or immediate colleague support. WellSpan framed the initiative as part of a broader investment in safety, training, and technology, with the goal of preventing incidents rather than simply responding after harm occurs.

The Bigger Picture

Workplace violence continues to draw attention because it touches multiple parts of hospital operations at once: staff safety, retention, labor relations, patient access, behavioral health capacity, compliance readiness, and public trust. The policy trend is not limited to punishing perpetrators after an incident. Increasingly, states and health systems are focusing on whether healthcare organizations have the prevention systems, reporting structures, staff supports, security infrastructure, and documentation needed to address violence as an ongoing workforce and operational risk.

Adaptive Workforce Solutions

When the Talent Search is Already Over

For many hospitals, the best staffing solution is not always a new search. Sometimes, it's creating a better structure for temporary workers who are already known, already trained, and a good organizational fit. This could be agency staff coming off assignment, a trusted referral, or a project-based professional already familiar with the organization. In each case, the challenge is not finding the worker. It's finding the right way to engage and support that worker without defaulting to a traditional staffing model that may no longer fit the need.

That's where Nikia Elam, Adaptive Workforce Solutions' Employer of Record Manager, plays a central role.

As Adaptive's Employer of Record Manager, Nikia works closely with hospital teams to help move known workers into a cleaner, more cost-effective employment structure. She helps coordinate the practical details, including worker communication, onboarding, payroll, documentation, credentialing, and compliance, so hospitals can preserve continuity without adding disruption.

Two current projects show how flexible the model can be. In New York, Adaptive is helping a hospital transition approximately 30 long-term agency allied health providers into an EOR model, preserving experienced workers while reducing cost and administrative friction. In Alabama, another hospital needs EOR support for multistate IT staff, showing how the model can also support non-clinical, distributed, or specialized roles without requiring the hospital to build that employment infrastructure internally.

How Employer of Record Works

- Adaptive serves as the W-2 employer
- Worker receives pay, benefits, and employment support
- Hospital keeps day-to-day direction
- Adaptive handles the employment administration
- Same worker, cleaner structure, lower cost

Nikia Elam

Employer of Record Manager

"Most hospitals know what to do when they need an agency to find someone, and they know what direct hire looks like. What often gets missed is the situation in between: the hospital already knows the worker, but needs a cleaner, more cost-effective way to employ and support them. That is where EOR can be a very practical option."

Keep the Worker and Lower the Cost

Scan the QR code to connect with Adaptive Workforce Solutions and learn whether Employer of Record could help your hospital retain known workers, reduce unnecessary cost, and create a cleaner employment structure. Check out our dedicated Vizient Member Portal with access to program details, service guides, and requisition forms.

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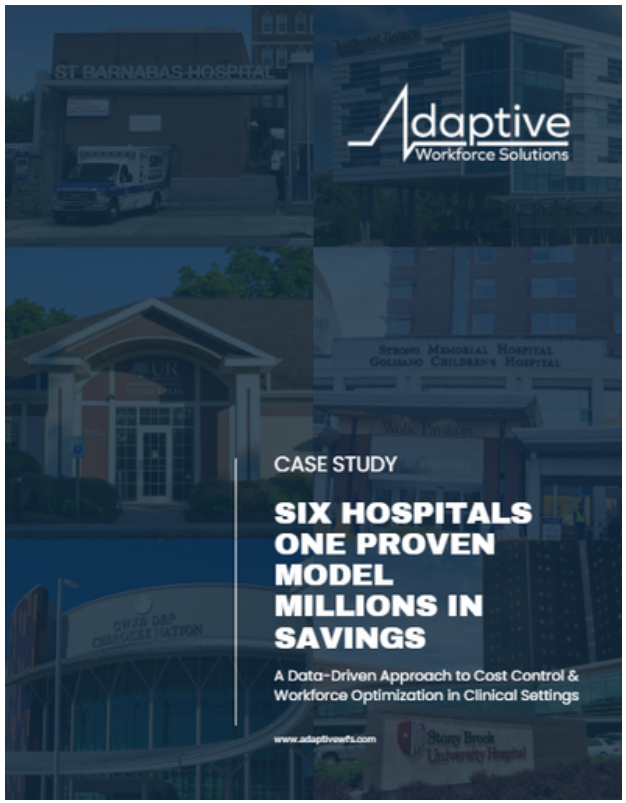
Awarded Supplier SV8315

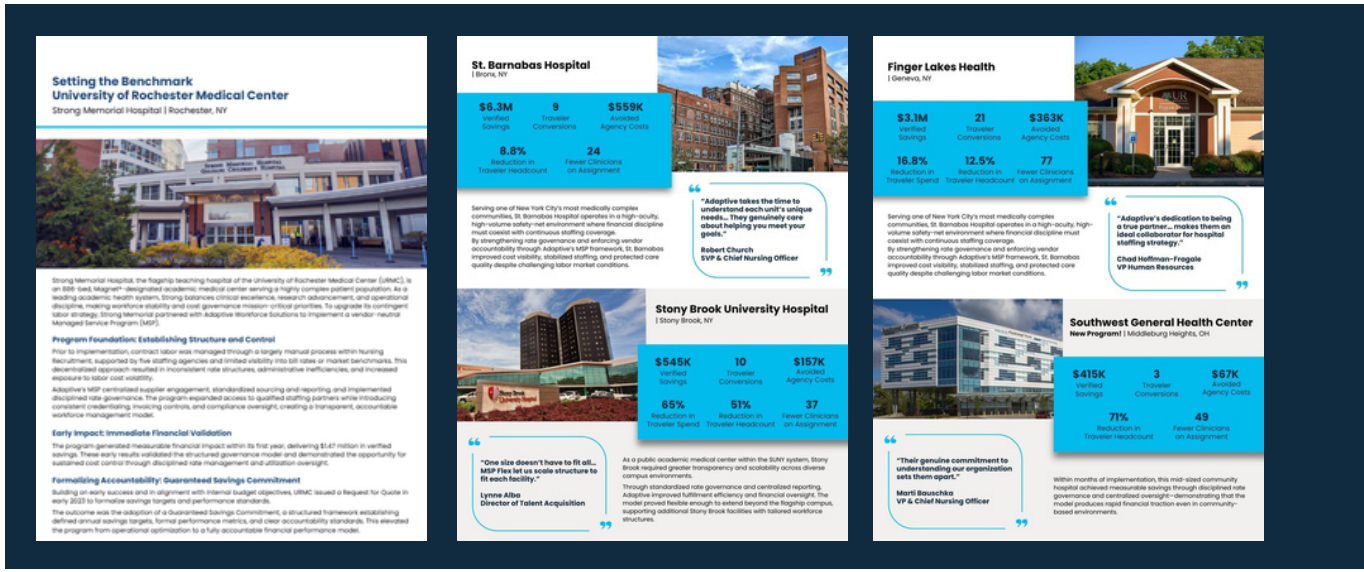
Adaptive
Workforce Solutions

SIX HOSPITALS. ONE PROVEN MODEL. MILLIONS IN SAVINGS.



This case study showcases results from six hospitals that implemented structured workforce strategies to improve transparency, strengthen accountability, and drive millions in verified savings. From academic medical centers to community hospitals, the findings demonstrate how disciplined governance can translate into measurable financial and operational impact.

Click Here to Download The Full Case Study



Here's what six different hospitals and health systems have achieved under Adaptive's Guaranteed Savings Programs:

University of Rochester Medical Center
886 Licensed Beds
$82M
Total Program Savings

St. Barnabas Hospital
422 Licensed Beds
$6.3M
Total Program Savings

Cherokee Nation Health Services
52 Licensed Beds
$13.2M
Total Program Savings

Stony Brook University Hospital
695 Licensed Beds
$545,544
Total Program Savings

Finger Lakes Health
623 Licensed Beds
$3.1M
Total Program Savings

Southwest General Hospital
354 Licensed Beds
$415,000
Total Program Savings

Adaptive Workforce Solutions

The Adaptive Workforce Solution

Adaptive Workforce Solutions is a workforce management company supporting hospitals and health systems nationwide. Adaptive is not a staffing agency; it operates as an independent, vendor-neutral partner, managing workforce programs that connect hospitals to a network of more than 300 independent staffing agencies.

Managed Service Programs

Vendor-neutral workforce management programs for nursing, allied health, and locums, combining advanced technology with centralized oversight and greater visibility into contingent labor.

MSP Flex™

A right-sized, flexible recruitment solution designed to help smaller, rural, and community hospitals address staffing needs without a full program transition.

Direct Hire

Permanent placement services that identify, recruit, and secure full-time talent for hard-to-fill and leadership roles, reducing vacancy time and long-term reliance on contract labor.

Employer of Record

Administrative employment infrastructure including payroll, benefits, compliance, and workforce administration support.

Consulting Services

Workforce assessments, market rate analyses, and strategic guidance focused on improving workforce efficiency and cost discipline.

Our Partners

Ohio Hospital Association

AzHHA Arizona Hospital and Healthcare Association

HANYS Marketplace™ Curated Healthcare Solutions®

vizient® Awarded Supplier

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