

# Oregon Healthcare Workforce Committee

## AGENDA

October 28, 2010

Wilsonville Training Center, Room 111-112  
29353 SW Town Center Loop E Wilsonville, Oregon 97070  
1 – 4 pm

#	Time	Item and related material	Presenter(s)	Action Item
1	1:00	Welcome	Chairs	
2	1:05	Approval of September 29 meeting summary	Chairs	X
3	1:10	Update from the Health Policy Board / expectations for Workforce Committee draft recommendations	Dr. Joe Robertson, Health Policy Board Member	
4	1:40	Feedback from the Health Equity Policy Review Committee (HEPRC)	Tricia Tillman, Office of Multicultural Health & Services, and HEPRC members	
5	2:10	Break		
6	2:25	Discussion and revision of draft Committee report	Chairs	
7	3:30	Approval of draft Committee report	Chairs	X
8	3:40	Public comment	Chairs	
9	3:55	Adjourn		

### Meeting materials:

1. Draft agenda
2. Draft September 29 meeting summary
3. Draft September 29 breakout group summary
4. HEPRC input document
5. Latest draft Committee report (10-25-10)

**Next meeting: Wednesday, December 8<sup>th</sup> at 9am, Portland State Office Building Room 1 C.**

**Oregon Healthcare Workforce Committee  
Meeting Summary**

September 29 2010  
1 – 4 pm

Committee Members in Attendance

Ann Malosh (Vice-Chair)  
Lita Colligan  
June Chrisman  
Paula Crone  
Lisa Dodson  
Terri Johanson  
Donna Larson  
Marcus Mundy

Kelly Morgan (by phone)  
David Nardone  
David Pollack  
Mark Richardson (by phone)  
Karen Sanders  
Daniel Saucy  
Kristin Simmons  
Jennifer Valentine

OHPR and OWHI Staff in Attendance

Jo Isgrigg (OHWI)  
Jennifer Swendsen (OHWI)

Sean Kolmer (OHPR)  
Lisa Angus (OHPR)

Committee Members not in Attendance

John Moorhead (Chair)  
Bonnie Bender  
Kris Campbell  
Sara Hopkins-Powell

Dan Lange  
Kathyleen Tomlin  
Judith Woodruff

Meeting Summary (Committee actions or decisions in bold)

Ann Malosh convened the meeting at 1:05pm.

**Minutes from the August 18<sup>th</sup> meeting were approved.**

Updates

Lisa Angus gave a few updates on Health Policy Board, Committee, and OHA activities:

- All Committees are working to finish at least draft recommendations for the Health Policy Board. The Board's October full-day meeting and its two November meetings will be busy with Committee presentations. All Committee recommendations will also be fed into the "Blueprint"/comprehensive plan document that the Board OHA must deliver to the Legislature by the end of the year.
- The Workforce Committee is scheduled to present draft recommendations to the Board on November 9<sup>th</sup> and return with final recommendations on December 16th.
- Two groups are currently reviewing Committees' draft recommendations or plans for their impact on particular groups: the Health Equities Policy Review Committee,

convened by the Office of Multicultural Health and Services, and the Safety Net Advisory Council, an existing state advisory body. Both groups will produce an official set of comments from their review processes but, in the meantime, staff notes from the groups' reviews of the Workforce Committee's draft recommendations are included in the meeting materials.

- The state was unfortunately not successful in its application for HRSA state healthcare workforce planning funding, which would have put some additional staff resources into analysis and strategic planning.

There was a brief discussion of Committee membership, since the HRSA grant would have added three new members (representing the state Department of Education, the recognized state federation of labor, and a labor organization, respectively). There are no immediate plans to change or expand Committee membership but the OHA Director's Office maintains a list of interested parties for various Committees.

### Recommendation Development

Ann Malosh noted that the intent of today's meeting is for the group to come to agreement on a set of recommendations that reflect the Committee's priorities and respond to the requests outlined in the 9-13-10 memo from Bruce Goldberg. Committee discussion of the memo included the following key points:

- There was concern that the Committee's charge as given in the memo was much larger than they had understood – that the Committee was being asked to recommend an ideal healthcare delivery model rather than steps for staffing that model. However, it was also noted that the Committee's current working documents contain many background assumptions about the bigger picture of reform and where the delivery system should be heading that may need to be articulated more clearly.
- Some members saw the memo's request for boldness as disconnected from previous indications that the Committee should be reasonable about the availability of resources. Others felt the request was to be more aggressive, despite the lack of resources, or at least to give the Board some more and less aggressive options to consider. It was suggested that perhaps the Committee's concern about reasonableness had led it to prematurely limit the strategies proposed to the Board and that, if compromises were necessary, the Board might prefer to make those decisions themselves.
- Several members felt that the request to recommend scope of practice changes was inappropriate for the Committee but that the Committee might want to strengthen existing statements about supporting/removing barriers for professionals to work to the top of their licenses. A few felt there may be future possibilities for collaborative work in this area.
- The group agreed that there was a need to tie all their work back to the triple aim and to point out where its recommendations could be expected to move the dial.

The Committee broke into three small groups to continue development of its recommendations. Please note: audio recording of the small workgroup conversations is not available but each group's report to the full Committee was recorded.

*Summaries of the breakout conversations are in a separate document, called "9-29 Breakout Summary DRAFT.doc."*

### Next steps

Staff will translate the August and September Committee small group and full Committee discussions into a first draft Committee report Committee members' consideration. Members asked that they receive this draft in about two weeks. Committee members will have a week or so to provide feedback and staff will bring a revised version to the October 28<sup>th</sup> Committee for another round of review. The result will be sent to the Board Planning Committee on November 1 as requested and will form the basis of the Committee's presentation to the Board on November 9<sup>th</sup>.

Committee members stated that the report should incorporate relevant input and feedback that the Committee had received from other groups including the Commonwealth/Quality safety net medical home group, the Health Equities Policy Committee, and others. They also made the following suggestions for report organization and content:

1. Describe where we are going - the vision of what the Committee thinks the workforce should look like.
2. Include some preamble material and/or assumptions that describe the larger context in which the Committee intends its recommendations to be considered and possibly implemented. Included in this should be a statement that the ultimate goal is more health, not more healthcare, since recommendations on workforce can feel like they are about building systems rather than health.
3. Tell the story – give an example of what each recommendation might look like when effective.

### Public Comment

Members of the public who were present did not wish to offer comment.

Ms. Malosh adjourned the meeting at 3:50pm.



Action Step(s)	Time Frame (Specify unit of time, e.g. year, biennium, etc.)	Actor (Who should be doing the identified action steps?)
<p>programs, licensing boards, professional discipline organizations to guide the development of competency and curricular standards with specific reference to PCPCH development and implementation.</p> <ul style="list-style-type: none"> <li>* Set competency standard but allow flexibility in method of attaining it.</li> <li>* Request information from healthcare professional educational programs on current training provided in each identified competency area.</li> </ul>		
<p><b><i>Create market conditions for the health system to respond to transformation</i></b> through appropriate reimbursement strategies, in coordination with Health Incentives and Outcomes committee and the Payment Reform Subcommittee.</p>		
<p>Link Health Authority data on workforce (Oregon Healthcare Workforce Database) with Employment Dept. data on compensation to enable analysis of salary and potential economic incentives.</p> <p>Collaborate with Incentives &amp; Outcomes and Payment Reform Committees to create and ensure that quality and payment reforms include a wide range of current and future workforce roles and functions, especially those that are aligned with the emerging PCPCHs. This would specifically involve reducing/eliminating barriers and constructing appropriate incentives to facilitate the adoption of such reforms.</p>	<p>2010</p> <p>Ongoing</p>	<p>OHPR and Employment Dept.</p> <p>Workforce Committee Chairs</p>

**Priority 2: Build the size and capacity of the health care workforce, particularly primary care, to help meet the anticipated increase in demand for health care services.**

Action Step(s)	Time Frame (Specify unit of time, e.g. year, biennium, etc.)	Actor (Who should be doing the identified action steps?)
<p><b><i>Revitalize the state's primary care practitioner loan repayment program</i></b></p>		
<p>Fund program to address 5-10% of gap. Explore innovative program financing options to achieve this.</p> <p>Require biennial review of occupations eligible for program participation biennially to allow adaptation for new care models and</p>	<p>2011-13</p> <p>Ongoing</p>	<p>Legislature → Office of Rural Health</p>

<b>Action Step(s)</b>	<b>Time Frame</b> (Specify unit of time, e.g. year, biennium, etc.)	<b>Actor</b> (Who should be doing the identified action steps?)
changing workforce shortages.		
<b><i>Alternative community workforce recruitment program</i></b>		
Provide funds to communities to use as incentives (not just loan repayment) for health care workforce recruitment. Require assessment of need and community match. Engage business and economic development sectors. Communities then provide funds to the practitioners they really need, with requirements for years of community service.	Longer-term	OHA, Office of Rural Health
<b><i>Explore interests in and barriers to cooperative (multi-community) health care professional recruitment efforts</i></b> with Oregon's rural and underserved communities.		
Establish a non-profit cooperative recruitment program to attract primary care providers to rural communities for less cost. * Follow model of Oregon rural locum tenens program or national 3RNet ( <a href="http://www.3RNet.org">www.3RNet.org</a> ): voluntary participation, small fees for both job seekers and employers fund operation.	2011-13	Oregon AHEC or Office of Rural Health
<b><i>Increase Oregon's primary care training capacity</i></b> for current and future health care workforce needs.		
Make investments in training professionals that would enhance the operation of medical homes. Require that some component of training be inter-professional.  Provide tax credit or other incentives to increase the number of community clinical training sites, particularly outpatient and individual practices.	2011-13	Not yet specified
<b><i>Support professionals working to the top of their licenses by providing reimbursement for care provided by underutilized professionals</i></b>		
Professionals or professional roles should include care coordinator, RNs, dental hygienists, dieticians, and evidence-based alternative care	?	Not yet specified

### **Priority 3: Expand Oregon's health care workforce through education, training and regulatory reform to meet the projected demand for 58,000 additional health care workers**

*Maintain resources for health professions education programs* despite state budget cuts.

<b>Action Step(s)</b>	<b>Time Frame</b> (Specify unit of time, e.g. year, biennium, etc.)	<b>Actor</b> (Who should be doing the identified action steps?)

<b><i>Enhance resources for health professions education programs despite state budget cuts.</i></b>		
Demonstrate the business case for investment in healthcare workforce (e.g. current vs. required capacity, cost to maintain and expand workforce, ROI if shortages were filled – all by region).	90 days total	OHWI, Hosp. Assoc., Employment Department, Workforce Committee
<b><i>Create a favorable policy and regulatory environment for the expansion of health care professional training and placement and the development new of new training models</i></b>		
<ul style="list-style-type: none"> <li>• Revise application of the state’s adverse impact policy and detrimental duplication process to develop new health care education programs.</li> <li>• Minimize administrative delays for qualified health professionals from other states and countries applying for licensure in Oregon. <ul style="list-style-type: none"> <li>* Survey Boards to identify areas for improvement</li> <li>* Prepare recommendations to Health Authority &amp; Boards</li> </ul> </li> <li>• Standardize student clinical liability requirements</li> <li>• Standardize and aggregate student background check functions for clinical training (the “student passport”). <ul style="list-style-type: none"> <li>* Convene facilities, educators, and insurers to agree on what tests are required, by discipline</li> <li>* Require students to use accepted vendor(s) (chosen by RFP or certified by OHA) for tests</li> <li>* Require facilities to accept “passport” from vendors as proof of tests</li> </ul> </li> </ul>	<p>2011</p> <p>2011</p> <p>2011</p> <p>2011-12</p>	<p>CCWD?</p> <p>OHWI → Workforce Committee → OHA and Licensing Boards</p> <p>Medical Liability Committee?</p> <p>CCWD, OHA, all stakeholders</p>

# Health Equity Policy Review Committee

## Major Recommendations for the Health Care Workforce Committee

### Cross-cutting issues that the Oregon Health Policy Board, Oregon Health Authority and OHPB Committees should consider:

- Use race/ethnicity-conscious metrics and language to demonstrate the high priority given to equity and ending health disparities. Integrate and define equity language:
  - throughout committee charters, missions, presentations, etc.
  - to define aspirations, what success looks like and to ensure health equity is prioritized even after staffing/committee membership changes.
  - to avoid general phrases like, “all Oregonians”
    - when such statements do not reflect the specific status and needs of racially/ethnically diverse communities.
    - when population-based programs do not actually reach all people due to political limitations. For example, avoid the use of “all” and “everyone” from program/policy language when not accurate as in the case of the Healthy Kids program which states that it insures “all” of Oregon’s children, when undocumented children are ineligible for the program.
- Include ongoing substantial community representation from racially and ethnically diverse backgrounds on all boards, commissions and government bodies in order to both ensure accountability for achieving health equity outcomes for all communities and avoid tokenism.
  - Build-in and institutionalize community feedback in the development, evaluation and implementation processes.
  - Develop stronger leadership roles for community health care centers, safety net clinics and practitioners of traditional medicine who are currently working effectively with culturally-diverse communities.
- Collect, compile and analyze accurate and granular demographic data in order to effectively address health inequity.
  - Oregon’s “aging” population has a very different demographic than Oregon’s “diversifying” population. Care should be used to clarify the differences in these two population shifts.
  - Collect data at the most granular levels of race, ethnicity, national origin, language, ability, sexual orientation and occupation in order to ensure an accurate understanding of the need for tailored policy strategies.
  - Engage racially and ethnically diverse communities in the development of data-sharing agreements, including the collection, analysis and dissemination of data.
  - Use data to assure accountability for health equity outcomes and incentivize provider payments to address health disparities.

- Incentivize and adequately reimburse prevention and patient-centered primary care, since effective preventative care can often reduce emergencies and avoid hospital admissions.
- Develop a proactive communications strategy that continually advocates for health care reform and health equity, realizing that not all segments of society are currently committed to equitable health outcomes for all Oregonians.

**Recommendations for the Health Care Workforce Committee:**

- Support healthcare workforce development programs to recruit and retain a racially and ethnically diverse workforce as this is essential to equitable health practices and outcomes. As Oregon faces a shortage in healthcare providers, diversifying our workforce will lead to higher quality, more efficient services and access to care for underrepresented populations and will meet the demand of a rapidly changing health care system for all Oregonians.
  - Inventory, evaluate and expand educational and mentorship programs for culturally diverse elementary, middle, high school and 2 year/4 year college students to create and formalize a pipeline for entering healthcare fields.
    - Institutionalize these programs to create leadership positions for people from historically under-served communities in order to ensure racial and ethnic diversity across all occupational spectrums.
    - Create targeted and culturally-specific outreach campaigns that connect with racially and ethnically diverse community and faith-based organizations and communities.
    - The Oregon University System must work to better serve the needs of students transitioning from community colleges to universities and health career training programs.
- Identify issues and strategies related to the retention of a diverse healthcare workforce and assure that working environments, acknowledge and respect the perspectives and contributions of people from racially and ethnically diverse backgrounds.
  - Licensed health care providers of color are in high demand and the Health Care Workforce Committee is uniquely poised to assure that the state of Oregon can compete for a diverse and qualified workforce.
  - Identify the factors, organizational practices and policies that contribute to a collaborative and equitable work community and create a more culturally accepting environment. This will lead to higher team performance for all employees.
  - Require a cultural competency training module within the workplace that provides employees with the specific skill set that is necessary for working on a professionally, culturally and economically diverse team. Eliminate hierarchial biases based on perceived, rather than real, differences in order to maximize the benefit of the team-to-client relationship.
- Require cultural competency training as a condition of re-licensure and/or establish a cultural competency certification (that results in pay-differential) for providers who effectively address the ways in which issues of cultural competence and patients' values,

beliefs, religion, language communication styles and perspectives impact health and the delivery of services.

- Assure and sustain Health Care Interpreters as a critical member of the health care workforce.
  - Design, commission and incorporate best practices for a statewide reimbursement policy for Health Care Interpreters.
  - Require that all interpreters working in healthcare settings be certified in order to promote health equity for non-English speaking patients.
  - Provide differential pay for bilingual providers commensurate with the additional skills required and demands placed on them.
  - Ensure adequate gender, religious and cultural representation so as to ensure cultural competency in the interpretation process and match patient needs.
  - Explore opportunities to draw-down federal funds to ensure an adequately trained Health Care Interpreter workforce.
- Assure and sustain Community Health Workers as a critical member of the health care workforce as this is both cost-effective and central to addressing the health care needs of under-served communities.
  - Develop and utilize a reimbursement policy for Community Health Workers from culturally diverse backgrounds
- Require adequate geographic distribution of the healthcare workforce in order to meet the needs of all Oregonians
  - Provide healthcare training across Oregon to avoid solely urban-centered care at the expense of rural communities.
  - Provide bilingual/cultural support to non-English speaking students in rural areas in order to adequately recruit and retain a racially and ethnically diverse workforce throughout Oregon.
  - Implement a targeted match-making system to identify under-served communities and connect health care workers to these areas.
  - Provide payment incentives for providers working in under-served areas (ie/loan reimbursement).
- Expedite re-licensing process for health care professionals who are licensed out-of-state/country. This is an opportunity for Oregon to both equalize opportunities for individuals who have already been trained, while culturally expanding its health workforce in order to meet the needs of racially and ethnically diverse Oregonians.
- Expand data collection to incorporate mental and behavioral health, as these fields are vital to the wellbeing of under-served communities. Collaborate with racially and ethnically diverse communities in the processes of data collection, analysis and dissemination, including the development of data-driven policy recommendations.

**Oregon Health Care Workforce Committee  
DRAFT 2010 Report to the Oregon Health Policy Board**

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**The health care workforce and delivery system of today are stretched to the maximum to meet the growing demands of Oregon’s population, yet too many Oregonians are not able to access health care when and where it is needed. At the same time, health care delivery is rapidly moving away from the model of single practitioners focused on units of service to inter-professional teams responsible for health outcomes. These important trends demand bold action for health care workforce development.**

**Sweeping changes planned for health care delivery and payment make it difficult to pinpoint the number and kind of health care providers ideal for the future. Some of the changes that are needed to build an appropriate health care workforce for Oregon must be made at the national level. Nevertheless, decisive action can and must be taken in Oregon to create the health care workforce that we need. This report contains the Health Care Workforce Committee’s 2010 recommendations for this action.**

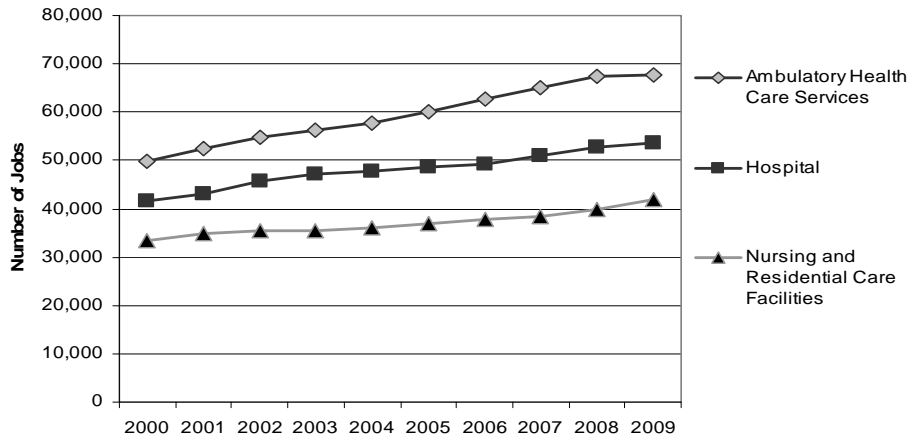
**I. Background**

*The Challenge*

State and federal health care reforms aim to improve health care for all Oregonians, yet their success depends on access to a health care workforce able to meet the demand for quality services. Reform efforts add to the current demand created by a growing, aging and diversifying population, the increasing number of people living with chronic diseases, advances in medical technology, and an aging health care workforce. To achieve the triple aim of improved population health, increased quality and availability of care, and reduced costs, Oregon needs a health care workforce strategy that addresses all of these factors.

Increased demand for health care professionals is reflected in industry employment, which comprises a growing share of the state’s workforce and accounts for over ten percent of

**Employment in Oregon’s Health Care Industry 2000-2009**



Source: Oregon Employment Department

Oregon’s total non-farm employment.<sup>1</sup> According to Oregon Employment Department data, employment in Oregon’s health care industry grew 31% between 2000 and 2009 (see chart below). The largest job growth occurred in the ambulatory health care services sector, which added 17,800 jobs between 2000 and 2009, representing a 36% increase in employment. Hospital employment grew 29%, adding 12,000 jobs to the labor market. Employment in Oregon’s nursing and residential care facilities grew by 8,400, representing a 25% increase in employment in this sector.

Three of the state’s top ten sectors projected to add the most jobs are in the health care industry: ambulatory health care, hospitals, and nursing and residential care.<sup>2</sup> Based on current population trends and health care delivery models, the Oregon Employment Department forecasts a need for nearly 58,000 additional health care workers in the state by 2018.<sup>3</sup> Forty-six percent of the projected job openings are to replace those permanently leaving the occupations’ labor pool.

**Top 20 Fastest Growing Health Care Occupations in Oregon 2008-2018**

Occupational Classification	Employment		Projected Openings Due to		Total Projected Openings	Minimum Education Requirement	Competitive Education Level
	2008	2018	Job Growth	Replacement			
Registered Nurses	30,656	37,427	6,771	5,947	12,718	Associate	Bachelor’s
Nursing Aides	12,842	15,950	3,108	1,433	4,541	Short OJT	Post-Secondary
Physicians & Surgeons	7,456	9,278	1,822	1,472	3,294	1st Prof.	1st Prof. + Work Exp.
Home Health Aides	8,599	10,775	2,176	965	3,141	Short OJT	Post-Secondary
Medical Assistants	7,113	8,948	1,835	895	2,730	Moderate OJT	Post-Secondary
Dental Assistants	4,360	5,527	1,167	928	2,095	Moderate OJT	Post-Secondary

Revised draft for Committee review – 10.25.10

Pharmacy Technicians	3,910	4,465	555	1,056	1,611	Post-Secondary	Associate
Dental Hygienists	3,142	4,003	861	729	1,590	Associate	Bachelor's
Licensed Practical Nurses	2,582	3,172	590	900	1,490	Post-Secondary	Post-sec. + Work Exp.
Child, Family & School Social Workers	3,332	3,785	453	894	1,347	Bachelor's	Master's
Medical & Health Services Managers	3,112	3,763	651	655	1,306	Bachelor's	Master's
Medical Records & Health Information Technicians	2,639	3,274	635	603	1,238	Post-Secondary	Associate
Pharmacists	3,180	3,649	469	757	1,226	1st Prof.	1st Prof. + Work Exp.
Healthcare Support Workers, All Other	3,137	3,804	667	387	1,054	Short OJT	Post-Secondary
Substance Abuse & Behavioral Disorder Counselors	2,328	2,796	468	518	986	Associate	Bachelor's
Radiologic, CAT, & MRI Technologists & Technicians	2,261	2,793	532	365	897	Associate	Bachelor's
Medical & Clinical Laboratory Technologists	1,947	2,392	445	412	857	Post-Secondary	Bachelor's
Mental Health & Substance Abuse Social Workers	1,675	2,057	382	469	851	Master's	Master's + Work Exp.
Emergency Medical Technicians & Paramedics	1,768	2,155	387	400	787	Post-Secondary	Post-sec. + Work Exp.
Physical Therapists	2,117	2,616	499	286	785	Master's	PhD

Source: Oregon Employment Department

These projections, however, are based on market demand rather than population need and do not account for coverage expansions expected to bring almost 280,000 newly insured people into the system by 2014<sup>4</sup> or the significant changes proposed for how health care is delivered and paid for. Emerging health care occupations, including those associated with new models of health care delivery, are excluded from employment projections since there are no baseline data on which to estimate employment demand.

Furthermore, the aggregate demand figure masks significant variation by geographic region, provider type and specialty. Thirty-two of Oregon's 36 counties have some type of federal primary care health professional shortage area designation.<sup>5</sup> There are seven counties with ten or fewer physician practices, including two counties with only one physician each and twelve counties with fewer than ten dentists, including four counties with no dental practice. Only 38% of Oregon's physicians are practicing in primary care (family medicine, family practice, general practice, general internal medicine, pediatrics, geriatrics, and adolescent medicine).<sup>6</sup>

Employment projections also do not reflect the difficulty employers face in filling current job openings. A 2009 statewide vacancy survey by the Oregon Employment Department found that despite the recession, Oregon's health care and social assistance industry had far more vacancies (5,744) than any other industry in the state.<sup>7</sup> Job openings for registered nurses in Oregon represented nearly six percent of all vacancies statewide, ranking the highest of all

occupations with job vacancies.<sup>i</sup> Of the 1,004 reported vacancies for registered nurses, 11% had been open more than 60 days. Of the 457 job openings for nursing assistants, 10% had been vacant more than 60 days. Twenty-nine percent of the 226 reported vacancies for physical therapists and 19% of the 212 vacancies for physicians were open more than 60 days.

Despite these caveats, employment demand projections provide important trend information and are a strong basis for more detailed analyses. The Health Care Workforce Committee has accepted the Oregon Employment Department projections as a reasonable calculation of health care workforce need. Close attention to emerging information on workforce supply, health care demand, and delivery system changes will be essential for crafting a health care workforce strategy that enables the state to achieve the triple aim.

### *The Oregon Health Care Workforce Committee*

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee (“Committee”) to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. The Workforce Committee is charged with advising the OHPB and developing recommendations and action plans for implementing the necessary changes to train, recruit and retain a health care workforce that is scaled to meet the needs of new systems of care. The Committee is also intended to become the most complete resource for information about the health care workforce in Oregon by improving data collection and assessment of Oregon’s health care workforce through regular analysis and reporting of workforce supply and demand.

Committee members include representatives from community colleges, graduate health and medical education, health system and hospital employers, foundations, Area Health Education Centers, and a range of health professions: nursing, dentistry, allied health, behavioral health, and medicine. The Committee is also connected to a broader range of stakeholders and experts via a formal collaborative relationship established this past summer between the Oregon Health Policy Board and the Oregon Workforce Investment Board (OWIB). The OWIB serves as the advisory board to the Governor on workforce matters and is comprised of leaders representing private sector businesses, labor, and state and local governments. One of the chief duties of the OWIB is to assist the Governor by developing a five-year strategic plan for Oregon's comprehensive workforce system and building Oregon’s health care workforce through job training efforts is identified as one of four key initiatives in the plan. The two bodies have agreed to collaborate seek federal funding opportunities, coordinate

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<sup>i</sup> The occupational groupings of the U.S. Department of Labor’s Standard Occupational Classification (SOC) system have limitations when analyzing projections for specialty-trained workers within an occupational category. For example, the current SOC for registered nurses includes employment for staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Similarly, when multiple job titles are grouped within one SOC, such as radiologic, CAT and MRI technologists and technicians, the distinction between levels of training and required certifications is omitted.

recommendations and align efforts to build Oregon's health care workforce. The OWIB has designated the Health Care Workforce Committee as an advisory subcommittee and Oregon Health Policy Board has committed to sharing information, expertise and other resources to support the success of the collaborative relationship.

### *Priorities and Principles*

Committee members started work in Spring 2010 by reviewing health care workforce supply and demand data, considering the impact of health care delivery changes on job roles and training, and analyzing the workforce implications of federal health reform legislation. The Committee identified significant challenges, strengths, barriers, and opportunities for health care workforce development and produced a lengthy list of potential strategic objectives for health care workforce development. First and foremost, the Committee acknowledged the importance of reducing Oregonians' overall need to access health care providers by supporting prevention and health promotion efforts. The Committee recognized the following principles to guide health care workforce development efforts:

1. Build on collaborative and innovative partnerships within and across sectors (education, industry, workforce development, government);
2. Ensure and promote diversity in health profession students, faculty and the health care workforce;
3. Maximize the efficient use of existing and future resources and pursue federal and other non-state funding opportunities that align with the Committee's priorities;
4. Promote the continuation and expansion of successful health profession education initiatives aimed at meeting Oregon's health care workforce needs.

Three priorities emerged from the Committee's careful examination of health care workforce needs:

1. **Prepare the workforce for new models of care delivery.** If Oregon is to have any chance of solving its health care workforce capacity problems, fundamental changes are needed in how care is provided and how the workforce is deployed to provide that care. The push for health care systems to provide better quality care at a lower cost is also prompting calls for significant changes in the way health care is delivered. Delivery system transformation will challenge the already over-burdened workforce but it also an opportunity to improve conditions by making care delivery more efficient and increasing provider satisfaction. Engaging and empowering the health care workforce to lead practice transformation is fundamental to the long-term success of health care reform efforts.
2. **Improve the capacity and distribution of the primary care workforce.** There is an urgent need to expand the primary care workforce to meet the anticipated increase in demand for care in 2014 and beyond. Expanding education and training opportunities and increasing the number of health profession graduates is one part of ensuring an adequate workforce, but many health professions require years of training. In the short

term, Oregon must take steps to expand the capacity of its existing primary care workforce and to improve its distribution.

3. **Expand Oregon's health care workforce through education, training and regulatory reform to meet the projected demand for 58,000 additional health care workers.** One of the most straightforward ways to find the estimated 58,000 health care professionals that Oregon needs by 2018 is to “grow our own,” meaning that Oregon must educate more professionals in-state and whenever possible “in-region” to train health care workforce where they are needed to assure both the rural and urban demand is met.

Decisive action in each priority area is needed to ensure that Oregonians have access to appropriate health care providers in their communities when they need care. This document contains the Health Care Workforce Committee's short-term and longer-term recommendations for tackling each priority.

## II. Short-term Recommendations

### 1. Revitalize the state's primary care practitioner loan repayment program.

*What:* Educational debt combined with the relatively low earning potential of primary care as compared to specialty practice discourages health professionals from entering into primary care, especially in rural or underserved communities where remuneration is typically low. Loan repayment programs that tie repayment to a service requirement have been successful in encouraging primary care practice in rural and underserved areas.<sup>8</sup>

Federal health reform doubled the size of the national loan repayment program known as the National Health Service Corps, which could bring 100 or more additional primary care practitioners to Oregon. Oregon's own primary care loan repayment program is a good complement to federal programs but has no dedicated funding. The program should be financed as soon as possible at a level that would reduce 5% [placeholder goal] of the projected need for each professional included in the program every biennium (roughly 30 additional professionals per year).

*How:*

- Funding mechanisms for a loan repayment program include state General Fund, dedicated taxes, surcharges on health professional licenses or on student fees in health professional programs, federal matching funds, foundation money, and other sources alone or in combination. **QUESTION TO THE COMMITTEE: WHO IS WILLING TO WORK WITH STAFF TO FLESH OUT FINANCING OPTIONS?**
- The level of investment required to meet the 5% goal is roughly estimated at \$2M per biennium, if repayment is capped at three years.
- Eligibility criteria for the Oregon Primary Care Services Program should be reviewed every biennium in collaboration with the Health Care Workforce Committee to

ensure that the program can adapt to address new care models and emerging shortages.

**2. Extend rural provider tax credit to urban practitioners providing behavioral health services to rural Oregonians via telemedicine. [New item for Committee consideration]**

*What:* Oregon currently offers a \$5,000 tax credit to encourage health care professionals to provide services in rural areas.<sup>ii</sup> Eligibility for this tax credit should be extended to behavioral health professionals who provide a certain amount of services to rural Oregonians via telemedicine. Mental health services are prioritized in this recommendation because evidence suggests that remote delivery can be effective<sup>9</sup> and because mental health services are a pressing need in rural communities.

*How:*

- Health Care Workforce Committee members and OHA staff should consult with experts on the technical details such as an appropriate minimum number of hours and definitions of eligible behavioral health professionals and services. These details will strongly influence the financial and service impacts of the proposal. Expert opinion is that 20-40 individuals would be eligible for the credit. At that level of participation and assuming a 1- hours/week service minimum, the state's tax revenue would be \$100,000 - \$200,000 less and 800 – 1,600 hours/month of mental health services would be made available to rural Oregonians.
- The rural provider tax credit statute should be amended in the 2011 legislative session.

**3. Standardize administrative aspects of student clinical training.**

*What:* Clinical experience is a vital and required element of health profession training, yet it can be difficult for students and educational institutions to find placements and burdensome for provider organizations to serve as training sites and to provide preceptors. Additionally, the inconsistencies in student prerequisites for clinical training across and within health care organizations increase students' education costs and create costly inefficiencies for schools and health care organizations. The Health Care Workforce Committee recommends three steps to streamline this stage of health profession preparation and expand the range of clinical training sites:

- Standardize student background requirements (drug testing, criminal background check, HIPAA training, etc.), identify a common vendor (or set of vendors) to perform those checks appropriate to each health occupation, and issue a student "passport." This standardization would greatly reduce the administrative burden and expense for students, who often pay for a new round of background checks, tests and training for each clinical training site.

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<sup>ii</sup> Oregon's current rural practitioner state income tax credit, authorized by ORS 315.613 – 315.622, allows up to \$5,000 in personal income tax credits to eligible MDs, DOs, DPMs, DDSs, DMDs, NPs, PAs and CRNAs.

- Establish uniform standards for student clinical liability to reduce the time and expense of contractual negotiations between educational institutions and provider organizations.
- Incent more community-based and outpatient practices to serve as clinical training sites through tax incentives or rebates.

*How:*

- OHA, in collaboration with the Oregon Workforce Investment Board, the Oregon Department of Community Colleges and Workforce Development, the Oregon Association of Hospitals and Health Systems, the Oregon Area Health Education Center Program Office, the Oregon Healthcare Workforce Institute and the Oregon Center for Nursing, should convene hospital representatives and educators to agree on a standard, uniform set of requirements (“passport”) in early 2011.
- OHA should identify statewide vendor(s) for background checks, drug tests and related requirements by RFP or OHA certification.
- OHA should require facilities to accept students’ “passports” as proof of student preparedness by Fall 2012.
- The Health Care Workforce Committee should consult with medical liability and contract law experts on options for standardizing student liability (2011).
- OHA should consult with the Oregon Department of Revenue on potential tax credits or other incentives for outpatient practices serving as clinical training sites (2011).

**4. Enable educational institutions to respond quickly to health care workforce training needs.**

*What:* Current interpretation of a state law (ORS 348.603) designed to ensure that public investment does not duplicate or adversely impact private business restricts public educational institutions from offering health occupations training and education programs in direct response to industry and community needs and student demand. The adverse impact policy should be revised, interpreted and implemented in such a way as to enhance student access to health profession education and improve public educational institutions’ responsiveness to industry needs while maintaining appropriate stewardship of public funds.

*How:*

The OHA should convene stakeholders to redraft the law by Spring 2011.

**5. Expand health care workforce data collection for a more accurate picture of Oregon’s health care workforce. QUESTION TO THE COMMITTEE: WHAT ARE THE PRIORITY BOARDS AND WHAT IS THE TIMELINE TO BEGIN DATA COLLECTION?**

*What:* Complete and accurate information about Oregon’s health care workforce is essential for design and evaluation of workforce development strategies, including efforts

to increase the diversity of the workforce. Participation in Oregon’s health care workforce database is currently limited to seven professional licensing boards, meaning that the Health Policy Board and other policy makers lack information on key shortage professions such as those providing mental and behavioral health services. Furthermore, legislation governing the database is not flexible enough to include new provider types that may be recognized by professional licensing boards in the future. The language in the statute should be expanded to allow collection of comparable, consistent workforce-related data about all licensed health care providers in the state.

*How:*

- Participation in the health care workforce database should be extended to all health professional licensing boards in 2011, with actual reporting to be phased in according to data priorities and board readiness.
- The information collected should allow for linkages with Oregon Employment Department data on employment and compensation to enable analysis of workforce development efforts, gaps between supply and demand, and the impact of economic incentives such as loan repayment and rural provider tax credits.

### **III. Longer-term Recommendations**

#### **1. Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand**

##### **QUESTION FOR THE COMMITTEE: SHOULD THIS BE ADDED TO THE COMMITTEE’S 2011 WORK PLAN?**

As Oregon leads the way on critical delivery system reform, it should also take leadership in understanding how those reforms will affect the current and future workforce. OHA should require delivery system reform pilots (primary care homes, behavioral health integration projects, etc.) to include analysis of workforce staffing levels, roles and skills, correlated with level of risk/complexity of patient mix, and population diversity. (Federal health reform legislation includes potential funding for a variety of reform experiments including medical homes and accountable care organizations.) Analysis results and workforce lessons learned should be shared with the Health Care Workforce Committee and the Oregon Employment Department on an ongoing basis to enable sharing of best practices and to help adjust workforce need estimates based on current models of care.

#### **2. Define new standards for health care workforce competencies**

##### **QUESTION FOR THE COMMITTEE: CAN WE PRIORITIZE TOP THREE WORKFORCE COMPETENCIES? WHAT ARE THEY?**

Although health providers are still exploring new models of care and the workforce implications, some of the new skills that health care professionals will need are already evident. These include: the ability to work in diverse, patient-centered, inter-professional teams; proficiency with health information technology (HIT); cultural competence; competence in quality improvement methods; and familiarity with prevention, evidence-

based clinical and public health practices, among others. Efforts to formalize these new competencies in professional practice are already occurring at the national and state levels. For example, the American Board of Medical Specialties has included new requirements regarding interpersonal and communications skills in Maintenance of Certification testing for physicians. The Oregon State Board of Nursing revised the Oregon Nurse Practice Act to include competencies in nursing informatics.

Building on current efforts, the OHA should convene representatives from the Oregon's health care industry, academic programs, licensing boards, and professional associations to guide the development of desired competencies and related curricular standards for Oregon's health professions' education programs.

**3. Adopt a payment system that encourages the most efficient use of the health care workforce. QUESTION TO THE COMMITTEE: IS THE COMMITTEE RECOMMENDING THAT PRIMARY CARE BE REIMBURSED MORE GENEROUSLY THAN IT CURRENTLY IS?**

A payment environment that restricts who can be reimbursed for service provision encourage practices to use higher-level practitioners to perform functions that could be done just as well—and less expensively—by other qualified providers. This leads to underutilization of existing workforce capacity, with negative consequences for access, quality, and cost. The Committee strongly supports shifting away from this type of payment system to a more comprehensive and/or accountable payment system, as proposed by the Incentives and Outcomes Committee.

For example, in primary care, the transition to a more integrated payment system should allow practices to build teams that use the best provider for a given function, e.g.: clinical pharmacists to educate patients about managing their prescriptions and check for drug interactions; certified medical assistants to provide uncomplicated chronic disease management care and coordination; and community health workers to serve as bridge between clinical care and population-level prevention.

**4. Adjust scope of practice when needed to enable delivery of high quality, efficient health care. QUESTION TO COMMITTEE: IS A MORE SYSTEMATIC EXAMINATION OF SCOPE OF PRACTICE SOMETHING THAT THE COMMITTEE WANTS TO ADD TO THE 2011 WORKPLAN?**

As new models of care delivery develop, OHA and the state's health professional licensing boards should examine providers' scopes of practice to ensure that there are no unnecessary barriers to implementation of promising practices, provided that patient safety and quality of care standards are maintained.

**5. Stimulate local creativity and resource sharing for health care workforce development.**

A statewide loan repayment program is unlikely to meet the needs of every community. Some communities may need a professional who is not included in the program's scope; other communities may find that loan repayment is not the right incentive to attract health

professionals to their area. At the same time, thousands of dollars are expended by individual employers in health professional recruitment efforts, particularly for rural and underserved areas. The OHA should help increase the efficiency of existing health care workforce development efforts by exploring structures in which health care employers, private industry, government representatives and community leaders can come together (similar to a community health collaborative model) to: identify local health care workforce needs; pool financial resources to recruit professionals; and devise appropriate community recruitment and retention incentives.

As a first step, in 2011 the OHA should convene stakeholders and conduct a feasibility study of mechanisms for and identify barriers (e.g. antitrust laws) to cooperative health care professional recruitment and retention across employers and communities.

#### **6. Enhance resources for health professions education programs**

One of the most straightforward ways to find the estimated 58,000 health care professionals that Oregon needs by 2018 is to “grow our own,” meaning that Oregon must educate more health professionals in-state. This is particularly important issue as other states have significantly increased their efforts to retain their health care workforces, limiting the effectiveness of Oregon’s recruitment efforts. Similarly, as Oregon’s population becomes more diverse, Oregon needs to build a health care workforce that reflects the state’s racial and ethnic population. While the state’s severe budget challenges make it difficult to consider increasing funding for health professions education programs in 2011, the Committee urges the Health Policy Board and the state to keep this strategy in mind as the most direct and effective way to build a health care workforce to meet the needs of Oregonians. **QUESTION TO THE COMMITTEE: WHAT ARE THE SPECIFIC HEALTH PROFESSIONS THAT THE COMMITTEE WOULD LIKE TO PRIORITIZE?**

#### **7. Enhance resources for K-12 math, science, and health career exposure.**

In order to build Oregon’s health care workforce of the future, we must invest in the K-12 education pipeline to introduce students, including those from Oregon’s rural and racial and ethnic minority populations, to and prepare them for health profession careers. Unfortunately, cumulative cuts over several years to Oregon’s school districts and Area Health Education Centers budgets have reduced funding for math and science education and exposure to health careers, particularly in rural Oregon. The result has produced students who do not meet minimum qualification standards for admissions to post-secondary health profession education programs. Even though the state’s budget challenges make it difficult, the Committee urges the Health Policy Board and the state to enhance funding for math, science and health career experience in Oregon’s primary and secondary schools to prepare Oregon’s future health care workforce.

#### IV. Vision, Context, and Constraints

The short- and longer-term recommendations in this report are proposed as strategies to create an Oregon health care workforce that is:

- **Diverse and culturally competent.** Oregon’s population is becoming increasingly diverse and health care providers in the state should reflect this diversity. Providers should be able to offer services in the patient’s preferred language and to provide care in a manner that is appropriate and acceptable for the patient’s culture. Improving the diversity and cultural competence of Oregon’s health care workforce would produce a range of benefits including increased access to care for vulnerable populations<sup>10</sup>, improved patient-provider communication and quality of care, and expanded availability of living wage careers for racial and ethnic minorities. **QUESTION TO THE COMMITTEE: WHAT SPECIFIC ACTIVITIES (WITHIN OR IN ADDITION TO EXISTING RECOMMENDATIONS) ARE PROPOSED TO HELP ACHIEVE THIS?**
- **Comfortable working in inter-professional teams.** Multidisciplinary teams (health care professionals from different fields working together to provide patient-centered care) are a key feature of many models of future primary care and have the potential to increase care coordination, improve quality and efficiency, and enhance job satisfaction and retention for care providers. To work effectively in such teams, health care providers will need a clear understanding of the breadth of knowledge and skills possessed by professionals outside their own disciplines. They will also need training in operational and managerial functions such as team oversight, negotiation, and performance improvement.
- **Practicing in the locations and specialties areas where it is most needed.** All Oregonians should have access to the care they need within a reasonable distance of their own communities. To make this possible, the current trend of decreasing enrollment in primary care disciplines must be reversed and disincentives for practicing in rural and underserved locations must be removed. Recruitment and admissions strategies for health education programs, reimbursement structures, support mechanisms for isolated practitioners, and community incentives should all be examined for their potential to improve the geographic and specialty distribution of the primary care workforce.

The recommendations in this report are strategies proposed by the Oregon Health Care Committee as the most feasible first steps toward creating a workforce that reflects the vision above. However, it is important to note that many of the policies and system changes that would make this workforce vision possible fall outside the traditional arena of workforce development. The Committee recognizes and supports the following elements of broad-based health care reform as necessary context for its more targeted recommendations:

- **Rapid migration away from fee-for-service payment systems.** Paying for units of service or procedures rewards volume and expensive treatments rather than improved health outcomes and superior quality and efficiency. For example, under fee-for-

service systems, providers are often not compensated for valuable and time-consuming functions like care coordination, discharge planning, medication management, and other activities that are critical to keeping people healthy. Moreover, restrictions on who can be reimbursed under certain fee-for-service payment systems lead to under-utilization of existing workforce capacity by discouraging mid-level providers and paraprofessionals from providing care within their scopes of practice. Shifting to more integrated or comprehensive payment structures will enable the workforce reconfiguration that is necessary to help Oregon meet its triple aim objectives.

- **Greater emphasis on prevention and population health.** The increasing burden of chronic diseases and poor health at the population level contribute significantly to the demand for health care professionals. In the long-term, investing in public health strategies that prevent or reduce disease and implementing health care reforms that encourage prevention and patient self-management will alleviate some of need to produce additional health care professionals. In the short-term, however, a greater emphasis on prevention and population health would require expanding the capacity of the public health and primary care segments of the workforce.
- **Improved data collection.** Better data and more meaningful measurement of costs and outcomes will be critical to the success of health care reform as a whole. For workforce development, more detailed and accurate information about the characteristics of the current health care practitioners, the projected supply of new professionals, and the future demand for care are obviously key resources for strategic planning. However, reliable data on cost, accessibility, utilization, quality, equity, and efficiency will also be necessary to track and evaluation the impact of workforce development efforts and to adjust those and other reform strategies as needed.

Finally, it is important to recognize the limits of state's role and influence in developing, Oregon's health care workforce. Education standards, policy decisions and regulatory structures at the national and federal levels affect Oregon's health care workforce development efforts. These include:

- National health profession education accreditation standards that dictate curriculum and clinical training requirements and limit curricular innovation;
- Higher degree requirements for entry-level clinical occupations, also known as "degree creep," which exacerbates shortages and impedes career pathways;
- Reimbursement policies that incent students, particularly those with significant student load debt, to enter specialty practices over primary care and health promotion practices; and
- Limitations on expansion of Graduate Medical Education (post-graduate residency programs).

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<sup>1</sup> Oregon Employment Department (2010). *Current Employment Statistics*. Available at: <http://qualityinfo.org/olmisj/CES>.

<sup>2</sup> Oregon Employment Department (2009). *Employment Projections by Industry and Occupation 2008-2018 Oregon Statewide*. Available at <http://qualityinfo.org/pubs/projections/projections.pdf>.

<sup>3</sup> Ibid.

<sup>4</sup> Projection based on modeling by Jonathan Gruber, PhD, presented to Oregon Health Policy Board in August 2010.

<sup>5</sup> U.S. Department of Health and Human Services Health Resources and Services Administration (2010). *Health Professional Shortage Areas, 2009*. Available at <http://hpsafind.hrsa.gov>.

<sup>6</sup> Oregon Medical Board data, February 2010

<sup>7</sup> Beleiciks, N. (2009). *Job Vacancies in Oregon*. Oregon Employment Department. Available at <http://qualityinfo.org>.

<sup>8</sup> Barnighausen & Bloom. (2009). Financial incentives for return of service in underserved areas: a systematic review. *BMC Health Services Research* 9:86, need page numbers

<sup>9</sup> Garcia-Lizana & Munoz-Mayorga. (2010). What about telepsychiatry? A systematic review. *Primary Care Companion to the Journal of Clinical Psychiatry* 12(2): need page numbers

<sup>10</sup> Saha & Shipman. (2006). *Rationale for diversity in the health professions*. HRSA.