

## Oregon Health Policy Board

### AGENDA

May 6, 2014

Market Square Building  
1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> floor

9:30 a.m. to noon

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	9:30	Welcome, call to order and roll <b>Action items:</b> <ul style="list-style-type: none"> <li>• 4/1/14 minutes</li> <li>• Approval of Workforce Committee by-law amendments.</li> </ul> <i>Note:</i> <ul style="list-style-type: none"> <li>• <i>Meeting location change (see below)</i></li> </ul>	Chair	X
2	9:35	Director's Report	Leslie Clement, OHA	
3	10:00	Status report of Policy Board Recommendations: <ul style="list-style-type: none"> <li>• Recommendation Two: revised charter, proposed new term: "sustainable health expenditures"</li> <li>• Recommendation Four: proposed charter for work group to spread coordinated care model</li> </ul>	Leslie Clement, OHA Kelly Ballas, OHA	X
4	10:15	OHA Internal Transformation Plan update	Bob Dannenhoffer, Umpqua Health Alliance Leslie Clement, OHA	
5	10:45	CCOs and Early Learning Hubs	Bob Dannenhoffer, Umpqua Health Alliance Helen Bellanca, Health Share of Oregon Dana Hargunani, OHA	
6	11:20	Workforce Committee: Demographic and geographic profile of Oregon's population and current healthcare workforce	Lisa Angus, OHA Cathryn Cushing, OHA	
7	11:45	Public testimony	Chair	
	12:00	Adjourn	Chair	

**Next meeting:**

June 3, 2014  
1:00 to 5:00 p.m.

OHSU Center for Health & Healing  
Floor 3; Room #4  
3303 S.W. Bond Ave.  
Portland, OR 97239

# Oregon Health Policy Board

## DRAFT Minutes

April 1, 2014

1:00 p.m. to 3:15 p.m.

1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> Floor

### Item

#### **Welcome and Call To Order**

Vice Chair Dr. Carla Mckelvey called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.

Tina Edlund and Leslie Clement were present from the Oregon Health Authority (OHA).

#### **Consent Agenda:**

The meeting minutes from March 4, 2014 were unanimously approved.

#### **Director's Report – Tina Edlund**

Tina Edlund reviewed the accomplishments of Dr. Bruce Goldberg's career with the state, who recently resigned from the Oregon Health Authority. Dr. Goldberg worked for the state since 2003. Tina described him as mission driven and passionate with an ultimate goal of caring for the citizens of Oregon and ensuring their access to quality health care.

#### **OHPB recommended actions: Progress report – Jeff Scroggin, OHA**

Jeff Scroggin updated the Board on the progress of the Board's recommended actions to the Governor. For each of the five recommendations, the Board reviewed the recommended actions, the actions taken to this point, and the potential upcoming decisions and actions. The five recommendations were:

1. Measuring the effects;
2. Establish predictable and sustainable rate of growth
3. Focus on primary, preventive and chronic care
4. Spread Coordinated Care Model
5. Enhance & improve rate review

Scroggin asked the Board for the opportunity to come back on May 6 to review the recommendations further, discuss how to have the coordinated care alignment and idea of public/private partnerships come together and review what Legislative Concept would be necessary.

View the OHPB recommended actions [here](#), starting on page 5.

#### **Sustainable Rate of Growth work group update – Mark Whitaker, OHA**

Mark Whitaker presented the proposed draft charter and roster to the Board. The workgroup is charged with providing input to OHPB on the design and implementation of a sustainable health care cost growth benchmark including:

1. A methodology for calculating annual total health care expenditures at various levels, including statewide, regional, and the individual health care entity.
2. A methodology or process for setting an annual growth benchmark for total health care expenditures for the state and individual health care entities.
3. Mechanisms to hold health care entities accountable for cost increases above the annual

growth benchmark.

At a minimum, the workgroup should ensure that its recommended policies and methodologies are transparent, accurate, and feasible.

The Board chose to have the work group focus solely on the first charge for now. The current roster was approved

View the Sustainable Rate of Growth work group update [here](#) , starting on page 14.

#### **Data and Measurement – Lori Coyner, OHA**

Lori provided an update on the progress of the Health Plan Quality Metrics Work Group and when a final report will be distributed.

The incentive metrics reporting and payment schedule was reviewed and can be seen [here](#), starting on page 23.

View The Health Plan Quality Metrics Work Group Update and Incentive Metrics Reporting and Payment Schedule [here](#), starting on page 18.

#### **Coordinated Care Model Spread: PEBB RFP & OEBC Update – Kelly Ballas, OHA; Interim Administrator, PEBB and OEBC**

Kelly provided an update on OEBC and the PEBB Request For Proposal (RFP). Currently PEBB has 130,000 covered lives and OEBC has 130,000 covered lives. Based on HB2279, from 2013 Legislation, there are approximately 43,000 eligible employees from public entities around the state who weren't previously eligible. OEBC contract renewals are also in process.

The goals for PEBB and OEBC are to use state purchasing power and health system transformation momentum to challenge the healthcare community to bring innovation and best practices that will lead to better health, better care and lower costs for all state sponsored healthcare programs.

The RFP strategy is to select health plans that can demonstrate experience and innovative programs around delivery of patient centered, integrated and coordinated care at sustainable costs. The contract renewal strategy is to utilize interest based negotiations each year at contract renewal time to achieve the triple aim.

View Spreading the Coordinated Care Model through PEBB and OEBC presentation [here](#), starting on page 28.

#### **Public Testimony**

**Ty Schwoeffermann from Urban League of Portland and Lizzy Fussell from Oregon Community Health Workers Association** testified on the strategy around workforce development for community health workers. In Oregon's waiver to CMS, Oregon committed to train 300 community workers by 2015. Many community health workers have been trained but are still unemployed due to the lack of attention and development of the workforce. Schwoeffermann and Fussell encouraged OHA to take more leadership in encouraging employment opportunities for community health workers with these suggestions:

- DMAP needs to be able to set reimbursement rates;
- Encourage use of innovation funds at the transformation center to encourage the

employment of Community Health Workers;

- Increase partnership with the Traditional Health Worker Commission.

Both organizations would like to be included in the processes for developing a strategic plan to help this workforce and get them working.

**Adjourn**

**Next meeting:**

May 6, 2014

8:30 a.m. to noon

Market Square Building

1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> floor

**Oregon Health Policy Board**  
*Healthcare Workforce Committee*  
**By-Laws**

**ARTICLE I**

**The Committee and its Members**

- The Healthcare Workforce Committee (“Committee”) is established by the Oregon Health Policy Board (“Board”). The Committee’s function is to investigate, review, discuss, take public comment on and develop coordinated policy options and recommendations to the Board, consistent with the Committee’s scope of work as outlined by its Charter and further determined by the Board.
- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board.
- Members shall serve three year terms and are eligible for reappointment upon completion of their terms, at the discretion of the member, the Committee chairs, and the Board.
- Members of the Committee are not entitled to compensation for services but shall be reimbursed for actual and necessary travel expenses incurred by them by their attendance at committee meetings, in the manner and amount provided in ORS 292.495.

**ARTICLE II**

**Committee Officers and Duties**

- The Board will select the first Chair and Vice Chair of the Committee. After the initial term of office, the Committee shall select a Chair and Vice-Chair from among its members. The Officers will serve for 24-months from the date of their election.
- Duties of the Chair are to:
  - Preside at all meetings of the Committee.
  - Coordinate meeting agendas after consultation with Committee staff.
  - Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
  - Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
  - The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

**ARTICLE III**  
**Committee Members and Duties**

- Duties of Committee members are to:
  - Attend, in person or by phone/electronically, at least three-quarters of Committee meetings annually. Committee members who are unable to attend meetings consistently will be asked to reconsider their membership.
  - Participate in at least one Committee workgroup or specific project per membership term. This may include attending occasional additional meetings or developing and reviewing material outside of Committee meetings.
  - Advise the Committee chairs and staff before representing the Committee or its views publicly.

**ARTICLE IV**  
**Committee Meetings**

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.
- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws.
- The preliminary agenda will be available from the Committee staff and posted on the Committee website <http://www.oregon.gov/oha/OHPR/HCW/Pages/index.aspx> [~~[www.oregon.gov/OHA/OHPR/HPB/Workforce/HealthCareWorkforceCommittee.shtml](http://www.oregon.gov/OHA/OHPR/HPB/Workforce/HealthCareWorkforceCommittee.shtml)~~] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.
- A majority of Committee Members shall constitute a quorum for the transaction of business.
- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members. As a general rule, the Committee will conduct its business through discussion and consensus. In cases where consensus cannot be achieved, a vote may be used. Use of a vote and its results will be recorded in the meeting minutes and those in the minority may prepare a brief minority opinion.

- When voting on motions, resolutions, or other matters, a voice or electronic vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.
- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.
- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.
- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

#### **ARTICLE V**

##### **Amendments to the By-Laws and Rules of Construction**

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

# Coordinated Care Model Alignment Joint Workgroup Draft Charter

Approved by OHPB on May 6, 2014

## I. Authority:

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The Oregon Health Policy Board (Board), through its 2013 recommendations for aligning Affordable Care Act implementation with Oregon's health system reform, directs the Administrator of the Public Employee Benefits Board (PEBB), the Administrator of the Oregon Employee Benefits Board (OEBC) and the Director of the Oregon Health Authority (OHA) to jointly charter a workgroup charged with helping spread Oregon's coordinated care model.

The workgroup will be guided by (1) the Triple Aim of better health, better care and lower costs, (2) the OHPB's Coordinated Care Model Alignment Workgroup report (December, 2013), which outlines coordinated care model attributes and organizational examples and (3) Oregon's coordinated care model principles as listed below:

- Use best practices to manage and coordinate care
- Share responsibility for health
- Measure performance
- Pay for outcomes and health
- Provide information so that patients and providers know price and quality
- Maintain costs at a sustainable level

## II. Membership:

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The director shall appoint workgroup members and a workgroup chair. The workgroup shall include the PEBB and OEBC Administrator, industry stakeholders as determined by the director and a consumer advocate. Workgroup members serve at the pleasure of the director of OHA. Workgroup membership is limited to 2 years. The workgroup's charter shall expire at the discretion of the director after June 2016.

## III. Charge:

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- Conduct and publish an environmental scan assessing broad market needs regarding implementation and spread of coordinated care model principles;
- Develop common contract terms and "tool-kit" (e.g. Coordinated Care Model RFP template) for interested purchasers;
- Develop and adopt a process for organizational alignment and shared learning among public purchasers to foster broad implementation of the coordinated care model and aligned purchasing policies and standards;
- Assist county and local governments with technical assistance to "opt-in" to PEBB and OEBC;
- Collaborate with private purchasers to spread the coordinated care model and support alternative payment methodologies; and
- Provide workgroup progress reports at least bi-annually to the Director of OHA and the Board.

#### IV. Committee Membership:

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- PEBB Administrator
- OEBC Administrator
- Business representatives
- Local gov't purchaser(s)
- Consumer advocate
- Commercial health benefit plan(s)
- CCO(s)
- TBD

#### V. Resources:

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- Executive Sponsor-OHA Chief Financial Officer Kelly Ballas
- Staff support-
  - OHA Director's Office
  - Oregon Health Policy and Research Office
  - PEBB & OEBC
  - Oregon Insurance Division staff, as appropriate
  - HIX staff, as appropriate
  - TA consultation TBD, as appropriate
  - TBD

# **Sustainable Healthcare Expenditures Workgroup CHARTER**

## **Authority**

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In a June 2013 letter, Governor Kitzhaber asked the Oregon Health Policy Board (OHPB) for recommendations to better align Oregon’s implementation of the Affordable Care Act and spread the triple aim goals—better health, better care, and lower costs—across all markets. In addition to other items, the letter charged OHPB with providing recommendations which would move the marketplace toward “growth rates of total health care that are reasonable and predictable.”

In response, OHPB recommended in December 2013 that the Oregon Health Authority (OHA) and Oregon Insurance Division (OID) establish a workgroup to establish a methodology for calculating annual total health care expenditures.

## **Membership**

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The workgroup members are appointed by the Commissioner of OID and the Director of OHA. The workgroup should include and/or consult with stakeholders representing consumers, business, government, insurers, and providers.

## **Responsibility**

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The workgroup is charged with providing input to OHPB on the design and implementation of a methodology for calculating annual total health care expenditures at various levels, including statewide, regional, and the individual health care entity. Some of the key topics the workgroup should consider include:

- Which expenditures should be included or excluded from the calculation?
- Which types of health care entities should be tracked?
- How should expenditures be adjusted for health status or population?
- What are the most appropriate data sources?
- Are there data gaps or additional data that need to be collected?
- What is a feasible timeline for the implementation of the methodology at each reporting level (statewide, regional, and individual health care entity)?

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

## **Principles**

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At a minimum, the workgroup should ensure that its recommended policies and methodologies are transparent, accurate, and feasible.

## **Timing/Schedule**

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The workgroup will hold meetings beginning in April 2014 and conclude in December 2014 or when OHPB determines that the charter has been fulfilled, whichever is sooner. The meeting sessions will serve as an opportunity for the workgroup to review and respond to proposals or alternatives that address the design and implementation considerations outlined in the Responsibility section above.

## **Staff Resources**

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Coordinator:

Mark Whitaker, Senior Financial Policy Analyst, Office of Health Analytics, OHA,  
[Mark.Whitaker@state.or.us](mailto:Mark.Whitaker@state.or.us), (503) 551-5489

Resources:

Gretchen Morley, Director, Office of Health Analytics, OHA

Russell Voth, Research and Data Manager, Office of Health Analytics, OHA

Lisa Angus, Director, Health Policy Development, Oregon Health Policy and Research, OHA

Gayle Woods, Senior Policy Advisor, Oregon Insurance Division

## **OHA's Internal Transformation Plan**

### **Reviewed with CCO CEOs on April 17, 2014**

#### **Rationale**

OHA is committed to transforming as an agency in order to better support the transformation of care through the Coordinated Care Organizations (CCOs). To demonstrate this commitment and ensure greater accountability and transparency in the implementation of the agency's transformation goals, OHA will develop its own transformation plan that reflects the baseline and establishes clear milestones and deliverables, reflective of the transformation plan each CCO was required to submit as part of its contract with OHA.

#### **Strategies**

- 1) The areas of transformation identified in the OHA transformation plan will be developed in collaboration with the CCOs and reflect the priority areas for change already requested by the CCOs.
- 2) Each area of transformation will be developed and implemented by a high-level, cross-functional team ("Tiger Teams").
- 3) "Tiger Teams" (problem-solving teams, including but not limited to technology issues) will be chartered by OHA leadership with the CCO CEO Committee. The Tiger Teams will:
  - Engage CCOs in the development of work plans and timelines.
  - Provide status reports to the OHA leadership and CCO CEO Committee;
  - Be led by an Innovator Agent;
  - Recognize the urgency and importance of the work of the OHA Transformation Plan;
  - Be held accountable for achieving milestones/benchmarks;
  - Break down silos within the agency; and
  - Work collaboratively with CCOs to both incorporate CCO input/feedback and capitalize on CCO expertise.
- 4) There will be a high degree of CCO engagement in the development and implementation of the OHA Transformation Plan. The CCO CEO meetings will be an opportunity for collaboration and shared oversight of the plan.
- 5) OHA will work with CCOs to develop an Operations Bench to include CCOs' Chief Operating Officers in regular communications to foster improved communication within and among the organizations about critical operational issues.
- 6) The OHA Director will establish a new CCO IT Advisory Council for CCO CIOs to provide consultation on key technology issues impacting CCOs, most immediately focusing on issues of eligibility and enrollment.
- 7) As part of OHA's commitment to transparency and accountability, OHA communications methods and tools will be evaluated with CCOs to determine how to improve intra-agency communication alignment and coordination.

## Proposed Initial Areas of Transformation

Draft work plans and accompanying accountabilities due as May CCO CEO meeting

1. Statewide Behavior Health System Strategy and Implementation Plan
2. Rate Setting Policies and Procedures (FFS and CCO rates)
3. Rule Promulgation
4. Eligibility and Enrollment Systems
5. Contract Processes

## Transformation Area 1: Statewide Behavioral Health Strategy and Implementation Plan

### Overview of Approach

- AMH to provide an “as is” description of Oregon’s behavioral health (A&D and MH) system that includes a current inventory of services to provide a baseline that informs stakeholders about existing services, providers, individuals receiving services, and the various funding streams.
- Ensure that existing behavioral health advisory groups are provided the appropriate planning and process information to meet existing requirements for participation in the development of a statewide behavioral health plan.
- Engage a facilitator to engage Oregonians in identifying a common vision of the “to be” behavioral health system.
  - With the facilitator, identify “guiding principles” that will be used to evaluate future policy approaches to ensure the alignment with the vision.
  - Schedule public forums in 5-6 areas of the state to participate in the discussion.
  - Outcome – validation of the “as is” BH system and a draft statewide vision of the desired BH System and guiding principles.
- Use “Tiger Team” approach outlined in Transformation Plan strategies. The team will include the necessary expertise in policy, operations, information technology, rates, and communications to support the development, implementation, monitoring and on-going communication.
- To support transparency, internal operating policies and procedures which are critical to implementation of desired system changes will undergo a similar process, describing the “as is” and “to be” systems. The focus of these internal reviews will specifically address the rule promulgation process and the payment methodology process, including rate development.
- Develop Resource Guides for stakeholders to know who to contact for what information. Educate internal and external customers.
- Refine and finalize the vision and guiding principles document. Draft a work plan that reflects implementation of the BH system changes, including the identification of services managed by CCOs, Counties and the State. Using the existing behavioral health and CCO advisory groups, refine the work plan.
- Finalize and approve the implementation work plan and incorporate the plan into an Oregon Statewide Behavioral Health System Strategic Plan.
- Begin implementation of strategies identified in the finalized plan.

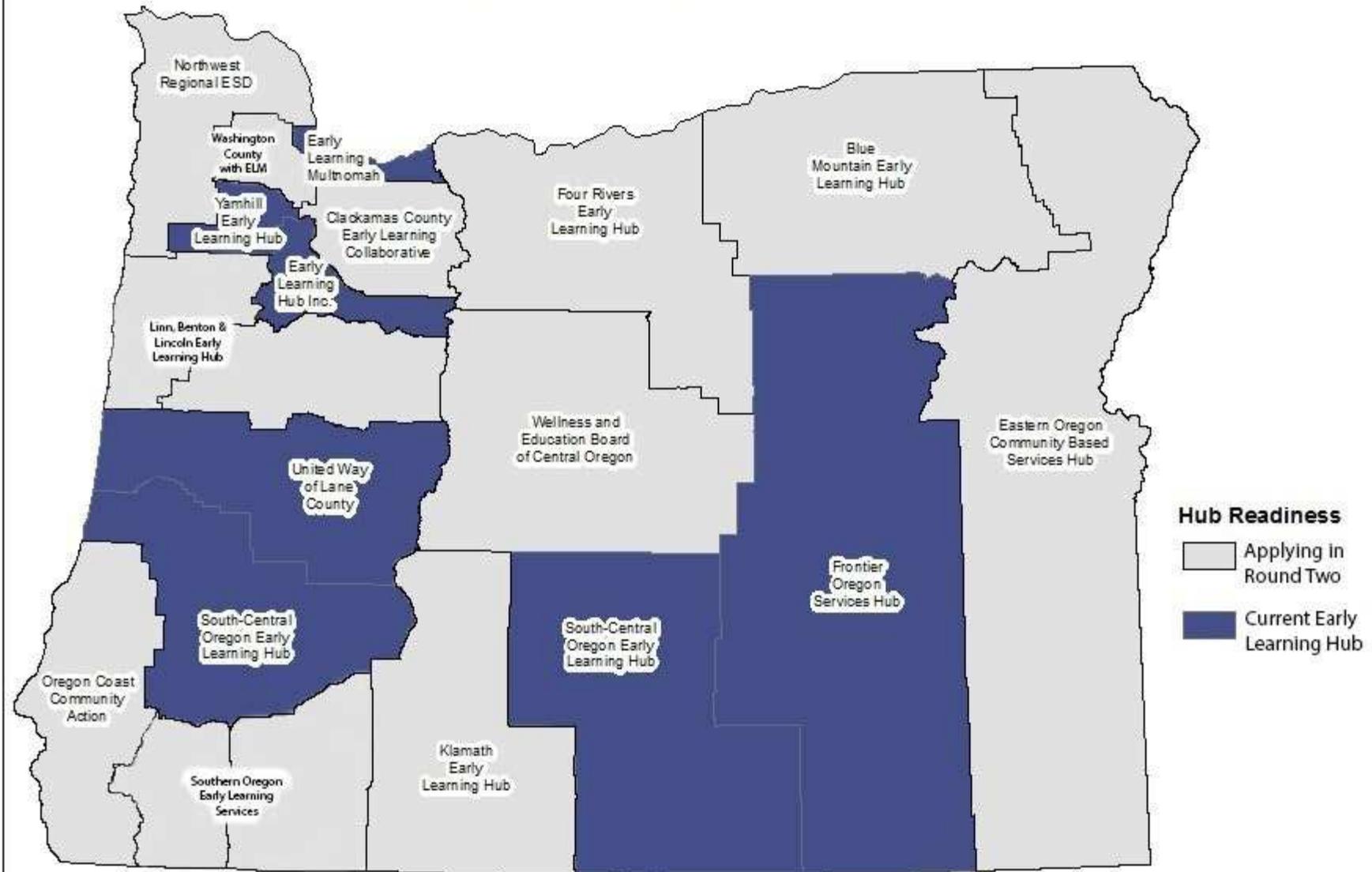
### Behavioral Health System Timeline

OHA Deliverable	Milestones	Due	Accountability	Comment
1. "AS IS" BH System description	A comprehensive inventory of statewide services, description of provider services, needs, funding streams, and identification of key players including those who authorize, assess, deliver, pay for and receive services.	04-30-14 draft 05-15-14 final	Pam Martin	The purpose is to facilitate a common understanding of the existing system
2. Establish cross-functional work teams	Designate Innovator Agent/s and establish teams	05-01-14	Cathy Kaufmann	Ensure that key functional areas are addressed on each team; purpose is to break away from silo'ed approach
3. Continue evaluation and assessment of MH Residential policies	Federal approval establishing new effective date to move MH Residential to CCOs; Policy approach for addressing management of AFHs, Standardized FFS methodology to pay for MH Residential Care	05-30-14;  09-30-14  01-01-15	Leslie Clement	Purpose is to continue to facilitate necessary policy and operational changes in order to move a stable MH residential system with the right payment incentives to CCOs
4. Facilitate statewide discussions regarding the "TO BE" BH System	Community forums will be held in 5-6 areas of the state; existing BH and CCO Advisory Committees will be engaged in the same discussions	07-01-14 *consider extending to 08-01-14	Pam Martin	The objective of the facilitated meetings is to provide a common vision of the "to be" BH system with guiding principles to inform policy and implementation
5. Draft Work Plan	A comprehensive work plan that responds to the vision and guiding principles with evidence-based and best practice approaches	09-01-14	Pam Martin	A 2-5 year plan is drafted for consideration of CCO and BH Advisory Groups review and input
6. Finalize Work Plan	Plan addresses: policies (considers federal authorization, state statutes, rules), operations	10-01-14	OHA Sub-Cabinet	Approves plan based on recommendations received from Advisory Groups

<b>Behavioral Health System Timeline</b>				
<b>OHA Deliverable</b>	<b>Milestones</b>	<b>Due</b>	<b>Accountability</b>	<b>Comment</b>
	(procedures and protocols), payment methodologies and communications) rates, service regulations, and			
7. Placeholder: consider moving UM/CM of MH Residential to CCOs	Move the management of the MH Residential benefit to CCO through the appropriate contract process	TBD; full operational plan developed in consultation with CCO CEOs and Operations Bench	Judy Mohr Peterson	A bridge plan approach for building expertise of managing services prior to adding risk
8. Full risk MH Residential Care contract with CCOs		TBD; full operational plan developed in consultation with CCO CEOs and Operations Bench	Judy Mohr Peterson	Finalize moving MH Residential into CCO global budget

- There will be additional information added to this BH System Transformation timeline once the work plan has been finalized.

# Early Learning Hub Readiness



# **Opportunities for collaboration between Early Learning Hubs and CCOs**

Helen Bellanca, MD, MPH  
Maternal Child Family Program Manager  
Health Share of Oregon

# Understanding our population



## Data

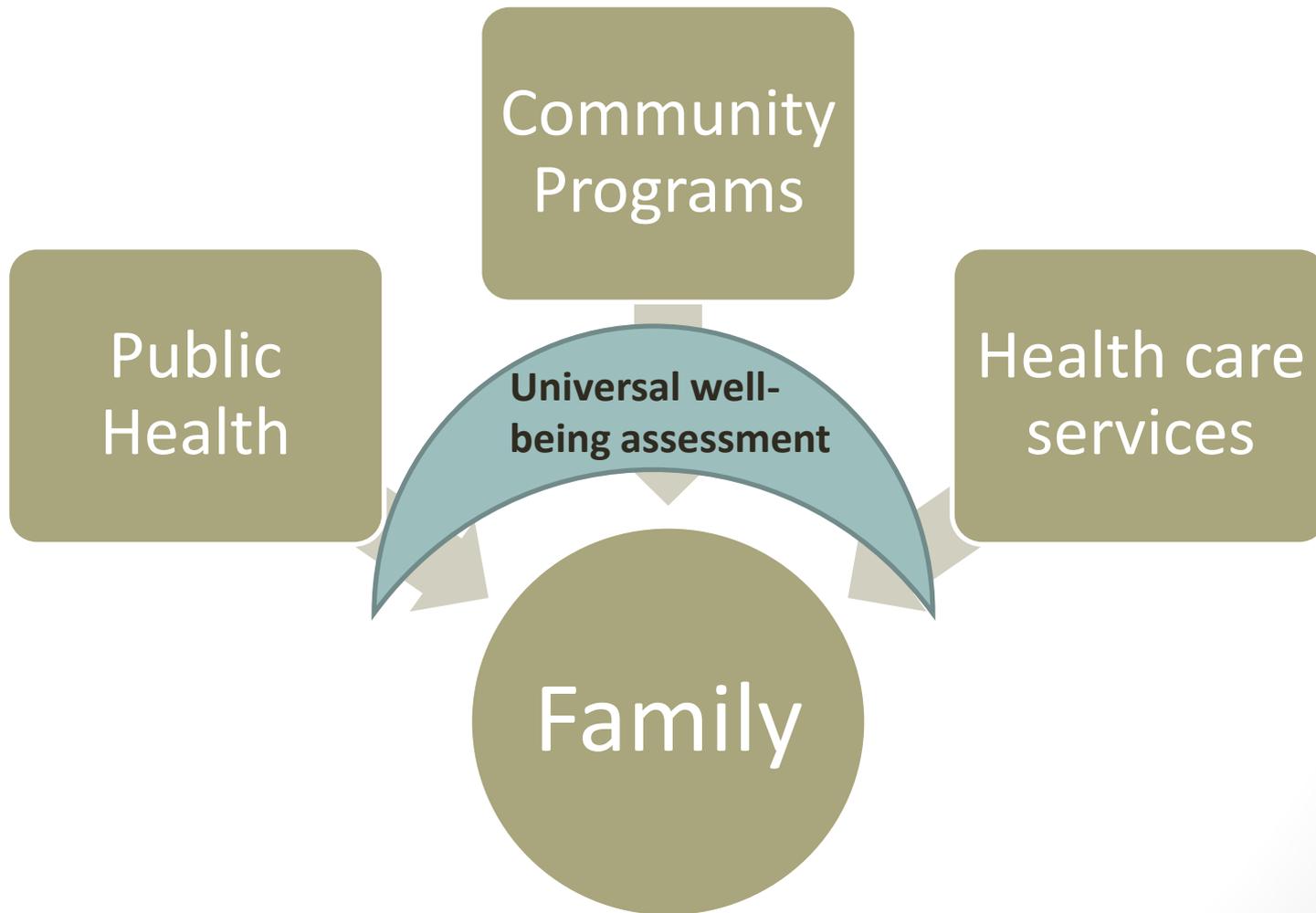
## Metrics

Developmental screening age 0-3

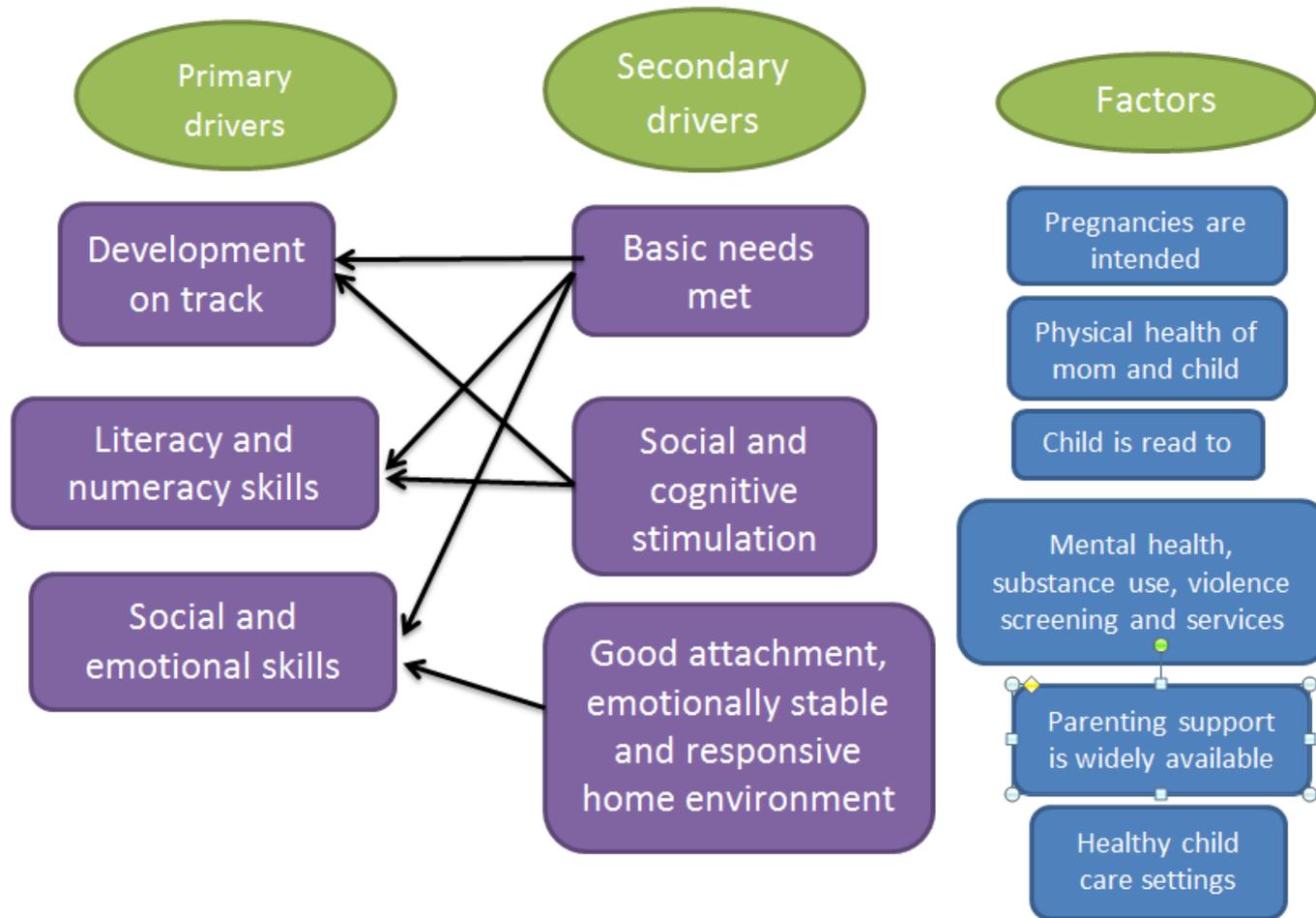
Children age 0-6 enrolled in a PCPCH

Number of children in foster care

# Better meeting the needs of families



# Kindergarten readiness



# Memo

**To:** Oregon Health Policy Board

**From:** Oregon Healthcare Workforce Committee

**Date:** May 6, 2014

In response to the Policy Board's request and to inform recommendations for policy development, public and private investments and strategic plans, the Healthcare Workforce Committee (Committee) asked the Oregon Health Authority (OHA) to develop a report on the diversity of Oregon's health care workforce as compared to the state's population. While the health professions represented by the seven licensing boards in this study reflect only a portion of the state's total health care workforce, the information in this report provides insight into needs, gaps and challenges to improving the diversity of Oregon's health care workforce.

As represented by the licensed health professions in this study, the key findings show:

- The licensed health care workforce is likely less racially and ethnically diverse than Oregon's population as a whole. Missing data makes this impossible to say with certainty.
- Almost 13 percent of the records collected are missing race and ethnicity data. Given the amount of missing data, it is difficult to make accurate comparisons between groups.

It is clear that fostering a more diverse workforce will require action within primary, secondary and professional education as well as in the recruitment and retention of health care professionals and payment reform. Throughout the state, multiple efforts in the health and education policy arenas led by employers, educational institutions, non-profit entities and other organizations are addressing the issues highlighted in this report. For example:

**Improving standardization and consistency in data collection.** On the workforce side, the OHA and the licensing boards engage in ongoing collaboration to improve data collection through technology improvements and standardization in race, ethnicity and language data. On the patient/client side, in 2013 the state legislature passed HB 2134 that standardizes data collected on race, ethnicity, language and disability status by the Oregon Department of Human Services and the OHA.

**Addressing provider cultural competence.** In 2013, the Legislature passed HB 2611 that allows 19 health profession licensing boards to establish rules on cultural competency training for license renewals by 2017.

**Engaging traditional health workers.** The OHA's Traditional Health Worker Commission supports the role, engagement and utilization of traditional health workers (THWs) in part to increase the diversity of the health care workforce in communities across the state. THWs include community health workers, peer support and wellness specialists, personal health navigators and doulas.

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**Increasing the diversity of Oregon's health professionals.** Multiple health care employers, public, non-profit, and private educational institutions, Area Health Education Centers, foundations, non-profit entities, local workforce investment boards, and other organizations are engaged, most often in collaborative efforts, in building the diversity of Oregon's health care workforce. These targeted efforts include (but are not limited to) career exploration, student and faculty recruitment, scholarships and loan repayment programs, student support services, career pathway development, incumbent worker training, supportive employee on boarding, and mentoring programs.

The Committee is committed to increasing the number and capacity of health care professionals to provide the best care possible for Oregonians. This commitment includes encouraging the development of a diverse, culturally competent workforce. One important element in meeting this commitment is realignment of the state's health policy goals, payment methods and worker training. For example, THWs are a racially and ethnically diverse workforce but frequently do not have an accepted mechanism in place for billing and receiving payment. This has resulted in a large number of THWs trained and ready to work, but yet unemployed.

The Committee continues to support efforts to improve data collection and gather research and recommendations on removing the barriers for Oregonians to pursue careers as health professionals in their communities. Improvements in attracting a diverse student body, appropriate and well-timed training, and new methods of payment all play a role in increasing the diversity and capacity of Oregon's health care workforce.

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# 2012–2013

## The Diversity of Oregon’s Health Care Workforce

The Oregon Health Policy Board asked the Oregon Healthcare Workforce Committee to provide a snapshot of the state’s health care workforce diversity. Using information from seven licensing boards required to provide data to the Oregon Health Authority, this report explores the relative distribution of workforce and population by race, ethnicity and language.

It also includes data specifically for primary care providers and information about professionals of color. The licensing boards required to report

include the Oregon Medical Board, Board of Dentistry, State Board of Nursing, Board of Pharmacy, Physical Therapist Licensing Board, Occupational Therapy Licensing Board, and the Board of Examiners of Licensed Dietitians.

Unfortunately, a significant amount of race and ethnicity data about health care professionals is missing, which limits the report’s findings. OHA is working with the licensing boards to improve data collection for future reports.

### Race and ethnicity

It is likely that Oregon’s health care workforce is less racially and ethnically diverse than the state as a whole. However, this cannot be proved because of data limitations. Approximately 13 percent of the workforce records are missing race/ethnicity data because it was not entered by the licensee or it was not collected by the licensing board. Another 4.5 percent of licensees declined to provide race or ethnicity information.

The table on this page shows the number of professionals in different race and ethnicity categories. Percent distribution is not shown because the amount of missing data can create misleading figures for some groups.

The workforce in most Oregon counties is less Hispanic than the overall population. Although

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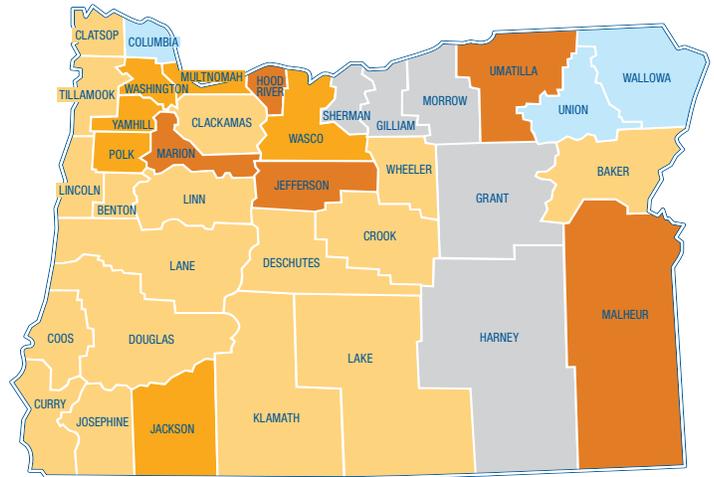
### Oregon health care professionals by race and ethnicity

Board	Total	Non-Hispanic/Latino									Missing (no data)
		Hispanic/Latino	White	Black/African American	American Indian/Alaskan Native	Asian	Native Hawaiian/Pacific Islander	Other	Multi-racial	Refused/declined	
Medical	11,886	333	8,266	95	17	982	16	229	44	509	11.7%
Dentistry	2,655	69	1,914	12	7	177	7	9	40	163	9.7%
Nursing	48,684	1,946	33,079	713	300	1,422	--	618	976	2,140	15.4%
Pharmacy	7,788	1,656	4,648	59	57	616	15	26	174	420	1.5%
Physical therapy	3,465	55	2,902	11	9	128	10	2	43	163	4.1%
Occupational therapy	1,087	13	938	1	3	42	3	12	13	61	0.1%
Licensed dietitians	563	5	315	--	3	16	--	--	4	12	36.9%
<b>Total</b>	<b>76,128</b>	<b>4,077</b>	<b>52,062</b>	<b>891</b>	<b>396</b>	<b>3,383</b>	<b>51</b>	<b>896</b>	<b>1,294</b>	<b>3,468</b>	<b>12.6%</b>

counties with a larger-than-average Hispanic population have a higher number of Hispanic health professionals, those counties tend to have fewer Hispanic health professionals than counties with a smaller Hispanic population. The map at right shows the difference between the percentage of Hispanic health professionals and the Hispanic population by county, with darker orange indicating a broader gap.

Traditional health workers — such as peer wellness specialists, community health workers/promotoras and home care workers — will help correct this disparity. In a survey of 600 traditional health workers conducted in 2011 by the Oregon Health Authority Office of Equity and Inclusion, a majority of respondents reported serving people from the health worker’s same racial or ethnic group.

### Gap in Hispanic/Latino health care professionals compared to county population



A negative value means the percentage of health professionals who identify as Hispanic/Latino is smaller compared to the Hispanic/Latino population. A positive value means the percentage of health professionals who identify as Hispanic/Latino is greater compared to that population.

- Inadequate data
- -23% to -13%
- -12.9% to -5%
- -4.9% to -0.1%
- 0.1% to 4.3%

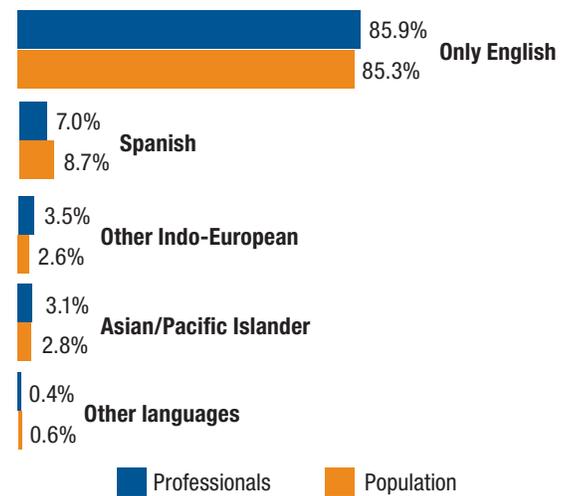
### Language

The proportion of health professionals speaking languages other than English is roughly similar to the state population as a whole (see chart at right). However, there is no guarantee that a provider who speaks a particular language will be available when a non-English-speaking client needs one. In addition, the health professionals’ language proficiency level may not meet the needs of their clients.

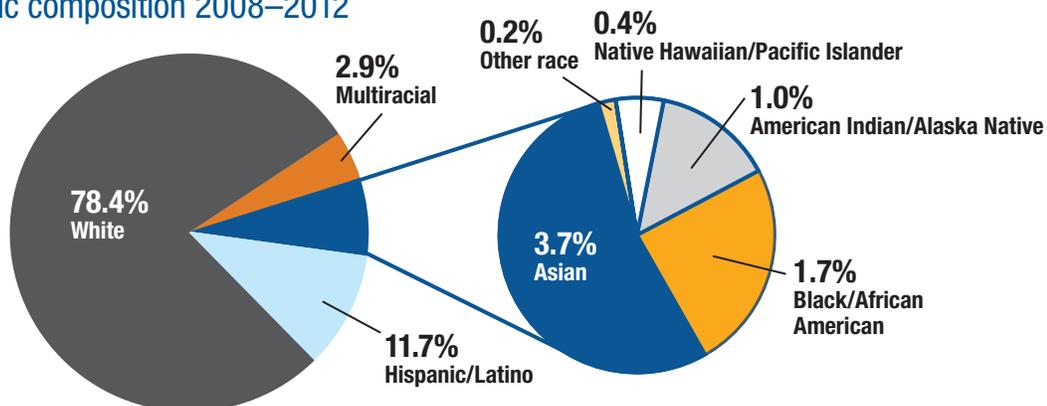
Health care interpreters help to fill the gaps. Oregon offers three levels of health care interpreters including registered, qualified and certified interpreters.

Certified health care interpreters have formal training and experience and must pass both written and oral examinations. Oregon is estimated to have more than 4,500 health care interpreters. Currently, 46 are qualified and 26 are certified health care interpreters.

### Languages in the health care workforce



### Oregon racial/ethnic composition 2008–2012



## Primary care providers<sup>1,2</sup>

Between 35 percent and 45 percent of professionals of color are primary care providers, practicing as physicians, nurse practitioners or physician assistants. (Approximately 40 percent of white licensees practice in primary care specialties.) The scorecard at right shows the diversity of Oregon's primary care providers compared to the diversity of Oregon's population.

As shown in the scorecard, there are more Asian primary care physicians than the percentage of Asians in Oregon's population, while there are fewer African American primary care physicians than the percentage of African Americans in Oregon's population.

Primary care providers are more linguistically diverse than the health care work force as a whole. Spanish is the language most spoken by PCPs, and physicians report the highest percentage speaking more than one language. In fact, only 13 percent of providers overall speak a language other than English, compared with 32 percent of primary care physicians.

## Oregon Primary Care Providers Diversity Scorecard

Race/ethnicity	Oregon population	MD and DO licenses	Physician assistants	Nurse practitioners
White	78.4%			
Black/African American	1.7%			
American Indian/Alaska Native	1.0%			
Asian	3.7%			
Native Hawaiian/Pacific Islander	0.4%		*	*
Hispanic**	11.7%			

Below state population

Similar to state population

Above state population

Note: Providers with missing racial and ethnicity data were excluded from the analysis. Racial categories exclude Hispanics.

\* No providers; \*\* Any race

### Native Hawaiian/Pacific Islander health professionals: N=51

**Important note:** The nursing professions are not represented in this race group due to data collection differences. This contributes to a very small cohort of Native Hawaiian/Pacific Islander health professionals, which makes comparing "top professions" and their characteristics inadvisable.

### Hispanic/Latino health professionals: N=4,077

#### TOP PROFESSIONS:

**Pharmacists: 33.7%**

87.6% female  
47.7% in Portland metro counties  
40.3% aged 55+

**Certified nursing assistants: 25.3%**

83.3% female  
44.9% in Portland metro counties  
7.3% aged 55+

### Asian health professionals: N=3,383

#### TOP PROFESSIONS:

**Medical doctors: 27.0%**      **Registered nurses: 25.1%**

41.6% female      89.3% female  
67.2% in Portland metro counties      76.5% in Portland metro counties  
14.1% aged 55+      17.3% aged 55+

### African American health professionals: N=891

#### TOP PROFESSIONS:

**Certified nursing assistants: 51.7%**      **Registered nurses: 20.9%**

75.7% female      82.3% female  
86.8% in Portland metro counties      81.7% in Portland metro counties  
10.9% aged 55+      21.5% aged 55+

### American Indian/Alaska Native health professionals: N=396

#### TOP PROFESSIONS:

**Registered nurses: 40.9%**      **Certified nursing assistants: 27.0%**

89.5% female      89.7% female  
35.2% in Portland metro counties      24.3% in Portland metro counties  
29.6% aged 55+      12.2% aged 55+

<sup>1</sup> Primary care providers are defined as licensed medical doctors, physicians assistants or doctors of osteopathic medicine whose practice specialties include family medicine, family practice, general practice, internal medicine, geriatrics, pediatrics or adolescent health. Licensed nurse practitioners can also be considered primary care providers if they are certified in adult, family, pediatric, geriatric or women's health practice but do NOT have a practice specialty in anesthesia, critical/care, dermatology, emergency/urgent care, long-term care, management/administration, medical/surgical, neonatology, neurology, nursing education, occupational health, oncology, orthopedics, psychology/mental health, regulatory, rehabilitation or surgery/recovery.

<sup>2</sup> Due to the amount of missing race and ethnicity data, percentages highlighting racial/ethnic workforce makeups should be interpreted with caution.

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## Methods and sources

### Workforce licensing data:

Health professionals are licensees who work in Oregon and renewed or obtained a license from one or more of the following boards during these dates:

- Oregon Medical Board (October through December 2011);
- Oregon State Board of Nursing (renewal dates range between late 2011 and June 2013);
- Oregon Board of Dentistry (Jan. 1 through March 31, 2013 for dentists and July 1 through Sept. 30, 2012 for dental hygienists);
- Oregon Occupational Therapy Licensing Board (March 1 through May 31, 2013);
- Oregon Board of Pharmacy (April 1 through June 30, 2013 for pharmacists and July 1 through Sept. 30, 2012 for certified pharmacy technicians);
- Oregon Physical Therapist Licensing Board (Jan. 1 through March 31, 2013);
- Oregon Board of Licensed Dietitians (May 2012 through June 2013).

Workforce data were extracted from the most recent workforce database. It includes total counts of health professionals from seven health licensing boards. Errors in ZIP codes, state, cities and other address fields were corrected. The Oregon Medical Board and the Oregon State Board of Nursing provided race/ethnicity data collected with their own data system; all the other health professions' race/ethnicity data were collected through a common format workforce survey that licensees must complete as part of their renewal process.

All race/ethnicity categories in the workforce data were coded as mutually exclusive to match the American Community Survey (ACS) race/ethnicity categories and allow comparisons. When a licensee selected Hispanic as his or her ethnicity, the licensee was coded as being Hispanic. If there were other races selected along with Hispanic ethnicity, such as "Black" or "Asian," the licensee would only be counted in the Hispanic category and not in other categories. When a licensee selected a non-Hispanic ethnicity and more than one race, the licensee was only coded as "Multiracial" and was not included in

the specific race categories. When a licensee selected "Other" as race and no other race was selected, the licensee was coded as "Other."

The Primary Care Providers Diversity Scorecard on page three uses a difference of 0.5 as the threshold to identify gaps between provider and population diversity. Using this small difference is essential because of the small population groups described. For example, 1.7 percent of Oregon's population is African American vs. approximately 0.7 percent of primary care providers; using a two- or five-point threshold for difference would result in these figures being shown as roughly equivalent.

The age variable calculates the age of the licensee at the time of his or her license renewal.

Data were analyzed and tabulated with SAS 9.2; graphics were produced in Excel. ArcGIS10 was also used to produce the map.

### Population data from ACS:

- Random sample of all households in Oregon;
- Five-year ACS estimates (data collected over 60-month period, 2008–2012).

ACS five-year combined population estimates were used to present data at the county level. These estimates are not as current as the one-year estimates, but the primary advantage of using multi-year estimates is the data's availability and increased statistical reliability for less populated areas and small population subgroups.

Regarding languages, ACS coded 381 different languages nationwide. Standard tables separate out 39 languages and the four main language groups used here: Spanish, other Indo-European languages, Asian and Pacific Island languages, and all other languages. Language groups are not mutually exclusive; some health professionals reporting speaking more than one language may have been counted twice; 92 percent of the health professionals were coded in only one language group.

*Acknowledgments: This report was a joint effort of these Oregon Health Authority programs: Office of Equity and Inclusion, Program Design and Evaluation Services, the Office of Health Analytics, and the Office of Health Policy and Research.*

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This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact 503-373-1574.

# Resource list

## **Healthcare Workforce Committee resources:**

[www.oregon.gov/oha/OHPR/HCW/Pages/Resources.aspx](http://www.oregon.gov/oha/OHPR/HCW/Pages/Resources.aspx)

Includes:

Oregon Health Professions: Occupational and County Profiles — [www.oregon.gov/oha/OHPR/HCW/Resources/2012%20Oregon%20Health%20Profession%20Profiles.pdf](http://www.oregon.gov/oha/OHPR/HCW/Resources/2012%20Oregon%20Health%20Profession%20Profiles.pdf); and

Projected Demand for Physicians, Nurse Practitioners, and Physician Assistants in Oregon, 2013–2020 — [www.oregon.gov/oha/OHPR/HCW/Resources/Projected%20Demand%20for%20Physicians,%20Nurse%20Practitioners,%20and%20Physician%20Assistants%20in%20Oregon%20-%202013-2020.pdf](http://www.oregon.gov/oha/OHPR/HCW/Resources/Projected%20Demand%20for%20Physicians,%20Nurse%20Practitioners,%20and%20Physician%20Assistants%20in%20Oregon%20-%202013-2020.pdf)

## **Oregon Racial and Ethnic Data and the State of Equity Report, Phase Two, 2013:**

[www.oregon.gov/oha/oei/Pages/soe.aspx](http://www.oregon.gov/oha/oei/Pages/soe.aspx)

## **Traditional Health Workers Report, 2011:**

[www.oregon.gov/oha/oei/Pages/nthw-report.aspx](http://www.oregon.gov/oha/oei/Pages/nthw-report.aspx)

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# Appendix A: Oregon population race and ethnicity, by county

	Total	Hispanic/ Latino		Non-Hispanic													
				White	Percent	Black/AA	Percent	AI/AN	Percent	Asian	Percent	NH/PI	Percent	Other	Percent	Multiracial	Percent
<b>Oregon</b>	<b>3,836,628</b>	<b>449,888</b>	<b>11.7%</b>	<b>3,008,356</b>	<b>78.4%</b>	<b>65,612</b>	<b>1.7%</b>	<b>38,684</b>	<b>1.0%</b>	<b>141,497</b>	<b>3.7%</b>	<b>13,641</b>	<b>0.4%</b>	<b>5,885</b>	<b>0.2%</b>	<b>113,065</b>	<b>2.9%</b>
Baker	16,092	559	3.5%	14,897	92.6%	32	0.2%	240	1.5%	69	0.4%	2	0.0%	-	0.0%	293	1.8%
Benton	85,501	5,486	6.4%	71,390	83.5%	818	1.0%	541	0.6%	4,723	5.5%	303	0.4%	145	0.2%	2,095	2.5%
Clackamas	377,206	29,137	7.7%	318,687	84.5%	2,679	0.7%	1,639	0.4%	13,366	3.5%	801	0.2%	194	0.1%	10,703	2.8%
Clatsop	37,068	2,820	7.6%	32,308	87.2%	204	0.6%	132	0.4%	470	1.3%	51	0.1%	33	0.1%	1,050	2.8%
Columbia	49,317	2,035	4.1%	44,513	90.3%	111	0.2%	675	1.4%	465	0.9%	52	0.1%	19	0.0%	1,447	2.9%
Coos	62,937	3,456	5.5%	54,647	86.8%	200	0.3%	1,399	2.2%	696	1.1%	27	0.0%	133	0.2%	2,379	3.8%
Crook	21,102	1,544	7.3%	18,772	89.0%	46	0.2%	278	1.3%	53	0.3%	8	0.0%	66	0.3%	335	1.6%
Curry	22,344	1,258	5.6%	19,755	88.4%	27	0.1%	291	1.3%	77	0.3%	4	0.0%	-	0.0%	932	4.2%
Deschutes	158,884	11,827	7.4%	140,410	88.4%	458	0.3%	1,209	0.8%	1,766	1.1%	242	0.2%	59	0.0%	2,913	1.8%
Douglas	107,391	5,042	4.7%	96,074	89.5%	339	0.3%	1,816	1.7%	882	0.8%	153	0.1%	99	0.1%	2,986	2.8%
Gilliam	1,904	120	6.3%	1,716	90.1%	15	0.8%	15	0.8%	-	0.0%	5	0.3%	-	0.0%	33	1.7%
Grant	7,366	217	2.9%	6,857	93.1%	16	0.2%	35	0.5%	9	0.1%	2	0.0%	8	0.1%	222	3.0%
Harney	7,359	299	4.1%	6,581	89.4%	16	0.2%	218	3.0%	54	0.7%	6	0.1%	-	0.0%	185	2.5%
Hood River	22,207	6,546	29.5%	14,662	66.0%	105	0.5%	55	0.2%	316	1.4%	50	0.2%	26	0.1%	447	2.0%
Jackson	203,613	21,894	10.8%	170,315	83.6%	1,063	0.5%	1,296	0.6%	2,019	1.0%	506	0.2%	48	0.0%	6,472	3.2%
Jefferson	21,746	4,286	19.7%	13,354	61.4%	146	0.7%	3,343	15.4%	126	0.6%	109	0.5%	35	0.2%	347	1.6%
Josephine	82,636	5,274	6.4%	73,175	88.6%	288	0.3%	1,244	1.5%	521	0.6%	137	0.2%	101	0.1%	1,896	2.3%
Klamath	66,350	6,990	10.5%	53,730	81.0%	419	0.6%	2,301	3.5%	679	1.0%	89	0.1%	59	0.1%	2,083	3.1%
Lake	7,886	560	7.1%	6,860	87.0%	22	0.3%	132	1.7%	39	0.5%	11	0.1%	-	0.0%	262	3.3%
Lane	351,794	26,125	7.4%	297,479	84.6%	3,125	0.9%	3,227	0.9%	8,358	2.4%	813	0.2%	518	0.1%	12,149	3.5%
Lincoln	45,992	3,662	8.0%	38,730	84.2%	129	0.3%	1,269	2.8%	588	1.3%	87	0.2%	71	0.2%	1,456	3.2%
Linn	116,871	9,097	7.8%	101,743	87.1%	496	0.4%	1,998	1.7%	1,054	0.9%	233	0.2%	65	0.1%	2,185	1.9%
Malheur	31,057	9,793	31.5%	19,735	63.5%	293	0.9%	144	0.5%	373	1.2%	35	0.1%	-	0.0%	684	2.2%
Marion	315,391	76,429	24.2%	215,437	68.3%	2,865	0.9%	2,928	0.9%	5,685	1.8%	1,996	0.6%	1,838	0.6%	8,213	2.6%
Morrow	11,146	3,515	31.5%	7,196	64.6%	16	0.1%	54	0.5%	70	0.6%	10	0.1%	-	0.0%	285	2.6%
Multnomah	737,110	79,791	10.8%	532,082	72.2%	40,843	5.5%	4,758	0.6%	48,384	6.6%	4,500	0.6%	1,227	0.2%	25,525	3.5%

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Appendix A: Oregon population race and ethnicity, by county

	Total	Hispanic/ Latino		Non-Hispanic													
				White	Percent	Black/AA	Percent	AI/AN	Percent	Asian	Percent	NH/PI	Percent	Other	Percent	Multiracial	Percent
<b>Oregon</b>	<b>3,836,628</b>	<b>449,888</b>	<b>11.7%</b>	<b>3,008,356</b>	<b>78.4%</b>	<b>65,612</b>	<b>1.7%</b>	<b>38,684</b>	<b>1.0%</b>	<b>141,497</b>	<b>3.7%</b>	<b>13,641</b>	<b>0.4%</b>	<b>5,885</b>	<b>0.2%</b>	<b>113,065</b>	<b>2.9%</b>
<b>Polk</b>	75,448	9,122	12.1%	60,811	80.6%	313	0.4%	1,185	1.6%	1,580	2.1%	281	0.4%	26	0.0%	2,130	2.8%
<b>Sherman</b>	1,865	112	6.0%	1,676	89.9%	2	0.1%	25	1.3%	1	0.1%	-	0.0%	-	0.0%	49	2.6%
<b>Tillamook</b>	25,254	2,262	9.0%	21,904	86.7%	153	0.6%	195	0.8%	183	0.7%	12	0.0%	41	0.2%	504	2.0%
<b>Umatilla</b>	75,846	17,966	23.7%	52,782	69.6%	545	0.7%	1,364	1.8%	668	0.9%	105	0.1%	85	0.1%	2,331	3.1%
<b>Union</b>	25,670	1,016	4.0%	23,284	90.7%	84	0.3%	94	0.4%	233	0.9%	215	0.8%	12	0.0%	732	2.9%
<b>Wallowa</b>	6,938	157	2.3%	6,553	94.5%	38	0.5%	45	0.6%	13	0.2%	6	0.1%	7	0.1%	119	1.7%
<b>Wasco</b>	25,113	3,784	15.1%	19,442	77.4%	88	0.4%	1,095	4.4%	247	1.0%	107	0.4%	-	0.0%	350	1.4%
<b>Washington</b>	531,818	83,085	15.6%	371,106	69.8%	8,883	1.7%	2,405	0.5%	46,446	8.7%	2,458	0.5%	699	0.1%	16,736	3.1%
<b>Wheeler</b>	1,287	24	1.9%	1,225	95.2%	-	0.0%	8	0.6%	1	0.1%	-	0.0%	-	0.0%	29	2.3%
<b>Yamhill</b>	99,119	14,598	14.7%	78,468	79.2%	735	0.7%	1,031	1.0%	1,283	1.3%	225	0.2%	271	0.3%	2,508	2.5%

Source: American Community Survey five-year file, 2008–2012

# Appendix B: Oregon health care workforce, by race and ethnicity, by county

	Total	Hispanic/ Latino	Non-Hispanic								
			White	Black/AA	AI/AN	Asian	NH/PI	Other	Multiracial	Refused/ declined	Missing (no data)
<b>Oregon</b>	<b>76,056</b>	<b>4,073</b>	<b>52,007</b>	<b>890</b>	<b>396</b>	<b>3,381</b>	<b>51</b>	<b>894</b>	<b>1,294</b>	<b>3,466</b>	<b>9,604</b>
Baker	269	9	193	-	1	3	-	4	3	15	41
Benton	1,834	74	1,353	11	7	58	2	14	41	75	199
Clackamas	6,555	391	4,381	91	26	407	4	84	107	301	763
Clatsop	681	39	494	3	2	18	2	8	7	20	88
Columbia	260	22	173	1	2	10	-	3	4	11	34
Coos	1,276	64	894	1	18	37	-	7	32	55	168
Crook	168	10	126	-	-	2	-	-	2	8	20
Curry	241	13	175	-	2	3	-	-	6	7	35
Deschutes	3,132	129	2,377	10	14	43	-	22	40	120	377
Douglas	1,709	79	1,238	3	14	46	1	13	29	54	232
Gilliam	12	1	6	-	-	-	-	-	-	3	2
Grant	108	4	72	1	1	2	-	-	1	6	21
Harney	99	4	76	-	3	1	-	-	2	5	8
Hood River	473	31	353	-	1	10	-	3	6	21	48
Jackson	4,118	231	2,897	13	27	94	3	42	80	213	518
Jefferson	195	12	135	-	6	2	-	1	3	11	25
Josephine	1,337	70	954	2	3	29	-	12	28	56	183
Klamath	950	66	657	4	12	18	-	13	16	48	116
Lake	92	6	67	-	1	-	-	-	2	6	10
Lane	6,963	329	4,872	30	48	181	6	64	136	330	967
Lincoln	771	34	561	1	7	25	-	6	11	33	93
Linn	1,486	74	1,016	5	6	24	-	13	20	72	256
Malheur	582	60	388	2	2	17	-	4	7	30	72
Marion	7,069	434	4,875	57	48	238	4	122	125	322	844
Morrow	49	3	38	-	-	-	-	-	-	2	6
Multnomah	21,263	1,046	13,944	491	75	1,315	20	303	345	1,004	2,720

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*Appendix B: Oregon health care workforce, by race and ethnicity, by county*

	Total	Hispanic/ Latino	Non-Hispanic								
			White	Black/AA	AI/AN	Asian	NH/PI	Other	Multiracial	Refused/ declined	Missing (no data)
<b>Oregon</b>	<b>76,056</b>	<b>4,073</b>	<b>52,007</b>	<b>890</b>	<b>396</b>	<b>3,381</b>	<b>51</b>	<b>894</b>	<b>1,294</b>	<b>3,466</b>	<b>9,604</b>
Polk	587	40	413	2	6	19	-	1	6	25	75
Sherman	5	-	4	-	-	-	-	-	-	-	1
Tillamook	307	15	226	1	1	8	-	1	3	11	41
Umatilla	994	58	697	9	12	13	1	8	13	47	136
Union	450	23	338	1	1	7	-	11	5	17	47
Wallowa	124	5	97	-	-	1	-	1	2	4	14
Wasco	683	36	518	-	3	11	-	6	7	24	78
Washington	9,818	569	6,428	145	42	707	7	112	181	440	1,187
Wheeler	12	-	8	-	-	-	-	-	-	3	1
Yamhill	1,384	92	963	6	5	32	1	16	24	67	178

Health care workforce missing county information: 72

Source: Health Care Workforce Database, Oregon Health Authority, 2013

# Appendix C: Oregon population and health care workforce, Hispanic/Latino ethnicity, by county

County		Total	Hispanic/ Latino	
Oregon	Health care workforce	76,056	4,073	5.4%
	Population	3,836,628	449,888	11.7%
Baker	Health care workforce	269	9	3.3%
	Population	16,092	559	3.5%
Benton	Health care workforce	1,834	74	4.0%
	Population	85,501	5,486	6.4%
Clackamas	Health care workforce	6,555	391	6.0%
	Population	377,206	29,137	7.7%
Clatsop	Health care workforce	681	39	5.7%
	Population	37,068	2,820	7.6%
Columbia	Health care workforce	260	22	8.5%
	Population	49,317	2,035	4.1%
Coos	Health care workforce	1,276	64	5.0%
	Population	62,937	3,456	5.5%
Crook	Health care workforce	168	10	6.0%
	Population	21,102	1,544	7.3%
Curry	Health care workforce	241	13	5.4%
	Population	22,344	1,258	5.6%
Deschutes	Health care workforce	3,132	129	4.1%
	Population	158,884	11,827	7.4%
Douglas	Health care workforce	1,709	79	4.6%
	Population	107,391	5,042	4.7%
Gilliam	Health care workforce	12	1	8.3%
	Population	1,904	120	6.3%
Grant	Health care workforce	108	4	3.7%
	Population	7,366	217	2.9%
Harney	Health care workforce	99	4	4.0%
	Population	7,359	299	4.1%
Hood River	Health care workforce	473	31	6.6%
	Population	22,207	6,546	29.5%

County		Total	Hispanic/ Latino	
Oregon	Health care workforce	76,056	4,073	5.4%
	Population	3,836,628	449,888	11.7%
Jackson	Health care workforce	4,118	231	5.6%
	Population	203,613	21,894	10.8%
Jefferson	Health care workforce	195	12	6.2%
	Population	21,746	4,286	19.7%
Josephine	Health care workforce	1,337	70	5.2%
	Population	82,636	5,274	6.4%
Klamath	Health care workforce	950	66	6.9%
	Population	66,350	6,990	10.5%
Lake	Health care workforce	92	6	6.5%
	Population	7,886	560	7.1%
Lane	Health care workforce	6,963	329	4.7%
	Population	351,794	26,125	7.4%
Lincoln	Health care workforce	771	34	4.4%
	Population	45,992	3,662	8.0%
Linn	Health care workforce	1,486	74	5.0%
	Population	116,871	9,097	7.8%
Malheur	Health care workforce	582	60	10.3%
	Population	31,057	9,793	31.5%
Marion	Health care workforce	7,069	434	6.1%
	Population	315,391	76,429	24.2%
Morrow	Health care workforce	49	3	6.1%
	Population	11,146	3,515	31.5%
Multnomah	Health care workforce	21,263	1,046	4.9%
	Population	737,110	79,791	10.8%
Polk	Health care workforce	587	40	6.8%
	Population	75,448	9,122	12.1%
Sherman	Health care workforce	5	-	0.0%
	Population	1,865	112	6.0%

County		Total	Hispanic/ Latino	
Oregon	Health care workforce	76,056	4,073	5.4%
	Population	3,836,628	449,888	11.7%
Tillamook	Health care workforce	307	15	4.9%
	Population	25,254	2,262	9.0%
Umatilla	Health care workforce	994	58	5.8%
	Population	75,846	17,966	23.7%
Union	Health care workforce	450	23	5.1%
	Population	25,670	1,016	4.0%
Wallowa	Health care workforce	124	5	4.0%
	Population	6,938	157	2.3%
Wasco	Health care workforce	683	36	5.3%
	Population	25,113	3,784	15.1%
Washington	Health care workforce	9,818	569	5.8%
	Population	531,818	83,085	15.6%
Wheeler	Health care workforce	12	-	0.0%
	Population	1,287	24	1.9%
Yamhill	Health care workforce	1,384	92	6.6%
	Population	99,119	14,598	14.7%

Health care workforce missing county information: 72

Sources: Health Care Workforce Database, Oregon Health Authority, 2013; American Community Survey five-year file, 2008–2012

# Appendix D: Oregon population and health care workforce: languages spoken other than English

SPEAK A LANGUAGE OTHER THAN ENGLISH		Total	Only English speakers	Percent	Spanish or Spanish Creole	Percent	Other Indo-European languages	Percent	Asian and Pacific Island languages	Percent	Other languages	Percent
<b>Oregon</b>	<b>Health care workforce</b>	76,056	65,332	85.9%	5,342	7.0%	2,680	3.5%	2,394	3.1%	308	0.4%
	<b>Population</b>	3,601,649	3,071,950	85.3%	314,426	8.7%	92,658	2.6%	102,474	2.8%	20,141	0.6%
<b>Baker</b>	<b>Health care workforce</b>	269	244	90.7%	15	5.6%	7	2.6%	2	0.7%	1	0.4%
	<b>Population</b>	15,292	14,784	96.7%	355	2.3%	88	0.6%	61	0.4%	4	0.0%
<b>Benton</b>	<b>Health care workforce</b>	1,834	1,618	88.2%	113	6.2%	52	2.8%	44	2.4%	7	0.4%
	<b>Population</b>	81,692	72,048	88.2%	3,792	4.6%	1,907	2.3%	2,931	3.6%	1,014	1.2%
<b>Clackamas</b>	<b>Health care workforce</b>	6,555	5,505	84.0%	456	7.0%	268	4.1%	291	4.4%	35	0.5%
	<b>Population</b>	356,026	314,785	88.4%	19,365	5.4%	10,209	2.9%	10,008	2.8%	1,659	0.5%
<b>Clatsop</b>	<b>Health care workforce</b>	681	611	89.7%	33	4.8%	17	2.5%	16	2.3%	4	0.6%
	<b>Population</b>	35,097	32,324	92.1%	1,821	5.2%	513	1.5%	303	0.9%	136	0.4%
<b>Columbia</b>	<b>Health care workforce</b>	260	223	85.8%	14	5.4%	15	5.8%	6	2.3%	2	0.8%
	<b>Population</b>	46,534	44,304	95.2%	1,198	2.6%	542	1.2%	234	0.5%	256	0.6%
<b>Coos</b>	<b>Health care workforce</b>	1,276	1,127	88.3%	83	6.5%	38	3.0%	25	2.0%	3	0.2%
	<b>Population</b>	59,767	57,102	95.5%	1,614	2.7%	682	1.1%	299	0.5%	70	0.1%
<b>Crook</b>	<b>Health care workforce</b>	168	156	92.9%	9	5.4%	-	0.0%	3	1.8%	-	0.0%
	<b>Population</b>	20,023	19,074	95.3%	711	3.6%	188	0.9%	24	0.1%	26	0.1%
<b>Curry</b>	<b>Health care workforce</b>	241	216	89.6%	14	5.8%	8	3.3%	3	1.2%	-	0.0%
	<b>Population</b>	21,457	20,363	94.9%	727	3.4%	240	1.1%	51	0.2%	76	0.4%
<b>Deschutes</b>	<b>Health care workforce</b>	3,132	2,822	90.1%	212	6.8%	66	2.1%	23	0.7%	9	0.3%
	<b>Population</b>	149,386	139,529	93.4%	7,483	5.0%	1,483	1.0%	825	0.6%	66	0.0%
<b>Douglas</b>	<b>Health care workforce</b>	1,709	1,551	90.8%	72	4.2%	40	2.3%	40	2.3%	6	0.4%
	<b>Population</b>	101,906	97,853	96.0%	2,158	2.1%	1,108	1.1%	571	0.6%	216	0.2%
<b>Gilliam</b>	<b>Health care workforce</b>	12	11	91.7%	1	8.3%	-	0.0%	-	0.0%	-	0.0%
	<b>Population</b>	1,801	1,685	93.6%	100	5.6%	16	0.9%	0	0.0%	0	0.0%
<b>Grant</b>	<b>Health care workforce</b>	108	99	91.7%	5	4.6%	2	1.9%	2	1.9%	-	0.0%
	<b>Population</b>	7,030	6,917	98.4%	74	1.1%	22	0.3%	9	0.1%	8	0.1%
<b>Harney</b>	<b>Health care workforce</b>	99	87	87.9%	8	8.1%	2	2.0%	1	1.0%	1	1.0%
	<b>Population</b>	6,965	6,805	97.7%	77	1.1%	29	0.4%	26	0.4%	28	0.4%
<b>Hood River</b>	<b>Health care workforce</b>	473	373	78.9%	80	16.9%	16	3.4%	2	0.4%	2	0.4%
	<b>Population</b>	20,763	14,735	71.0%	5,713	27.5%	210	1.0%	105	0.5%	0	0.0%

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Appendix D: Oregon population and health care workforce: languages spoken other than English

SPEAK A LANGUAGE OTHER THAN ENGLISH		Total	Only English speakers	Percent	Spanish or Spanish Creole	Percent	Other Indo-European languages	Percent	Asian and Pacific Island languages	Percent	Other languages	Percent
Oregon	Health care workforce	76,056	65,332	85.9%	5,342	7.0%	2,680	3.5%	2,394	3.1%	308	0.4%
	Population	3,601,649	3,071,950	85.3%	314,426	8.7%	92,658	2.6%	102,474	2.8%	20,141	0.6%
Jackson	Health care workforce	4,118	3,594	87.3%	305	7.4%	124	3.0%	82	2.0%	13	0.3%
	Population	191,672	173,541	90.5%	14,103	7.4%	2,060	1.1%	1,649	0.9%	319	0.2%
Jefferson	Health care workforce	195	180	92.3%	11	5.6%	3	1.5%	1	0.5%	-	0.0%
	Population	20,183	16,516	81.8%	3,012	14.9%	51	0.3%	123	0.6%	481	2.4%
Josephine	Health care workforce	1,337	1,176	88.0%	91	6.8%	43	3.2%	25	1.9%	2	0.1%
	Population	78,426	74,898	95.5%	1,951	2.5%	1,126	1.4%	335	0.4%	116	0.1%
Klamath	Health care workforce	950	826	86.9%	72	7.6%	30	3.2%	16	1.7%	6	0.6%
	Population	62,454	57,277	91.7%	3,835	6.1%	748	1.2%	389	0.6%	205	0.3%
Lake	Health care workforce	92	89	96.7%	2	2.2%	1	1.1%	-	0.0%	-	0.0%
	Population	7,594	7,216	95.0%	321	4.2%	20	0.3%	20	0.3%	17	0.2%
Lane	Health care workforce	6,963	6,214	89.2%	415	6.0%	198	2.8%	112	1.6%	24	0.3%
	Population	333,659	302,766	90.7%	16,941	5.1%	6,331	1.9%	6,021	1.8%	1,600	0.5%
Lincoln	Health care workforce	771	691	89.6%	42	5.4%	18	2.3%	18	2.3%	2	0.3%
	Population	43,739	40,836	93.4%	2,118	4.8%	355	0.8%	344	0.8%	86	0.2%
Linn	Health care workforce	1,486	1,367	92.0%	71	4.8%	19	1.3%	27	1.8%	2	0.1%
	Population	109,257	101,880	93.2%	5,428	5.0%	1,088	1.0%	640	0.6%	221	0.2%
Malheur	Health care workforce	582	503	86.4%	58	10.0%	13	2.2%	7	1.2%	1	0.2%
	Population	28,833	21,704	75.3%	6,630	23.0%	217	0.8%	218	0.8%	64	0.2%
Marion	Health care workforce	7,069	6,131	86.7%	550	7.8%	192	2.7%	167	2.4%	29	0.4%
	Population	292,013	219,175	75.1%	58,626	20.1%	8,203	2.8%	5,075	1.7%	934	0.3%
Morrow	Health care workforce	49	45	91.8%	3	6.1%	1	2.0%	-	0.0%	-	0.0%
	Population	10,350	7,417	71.7%	2,836	27.4%	56	0.5%	41	0.4%	0	0.0%
Multnomah	Health care workforce	21,263	17,748	83.5%	1,527	7.2%	973	4.6%	919	4.3%	96	0.5%
	Population	690,968	555,741	80.4%	57,689	8.3%	31,011	4.5%	38,903	5.6%	7,624	1.1%
Polk	Health care workforce	587	503	85.7%	55	9.4%	14	2.4%	12	2.0%	3	0.5%
	Population	70,758	62,467	88.3%	6,090	8.6%	1,000	1.4%	1,025	1.4%	176	0.2%
Sherman	Health care workforce	5	5	100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	Population	1,753	1,668	95.2%	72	4.1%	12	0.7%	1	0.1%	0	0.0%
Tillamook	Health care workforce	307	265	86.3%	23	7.5%	9	2.9%	6	2.0%	4	1.3%
	Population	23,951	22,301	93.1%	1,450	6.1%	147	0.6%	42	0.2%	11	0.0%

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Appendix D: Oregon population and health care workforce: languages spoken other than English

SPEAK A LANGUAGE OTHER THAN ENGLISH		Total	Only English speakers	Percent	Spanish or Spanish Creole	Percent	Other Indo-European languages	Percent	Asian and Pacific Island languages	Percent	Other languages	Percent
Oregon	Health care workforce	76,056	65,332	85.9%	5,342	7.0%	2,680	3.5%	2,394	3.1%	308	0.4%
	Population	3,601,649	3,071,950	85.3%	314,426	8.7%	92,658	2.6%	102,474	2.8%	20,141	0.6%
Umatilla	Health care workforce	994	873	87.8%	79	7.9%	26	2.6%	13	1.3%	3	0.3%
	Population	70,290	55,741	79.3%	13,162	18.7%	667	0.9%	470	0.7%	250	0.4%
Union	Health care workforce	450	407	90.4%	27	6.0%	11	2.4%	4	0.9%	1	0.2%
	Population	24,081	22,765	94.5%	843	3.5%	213	0.9%	257	1.1%	3	0.0%
Wallowa	Health care workforce	124	114	91.9%	9	7.3%	-	0.0%	1	0.8%	-	0.0%
	Population	6,608	6,375	96.5%	136	2.1%	70	1.1%	19	0.3%	8	0.1%
Wasco	Health care workforce	683	619	90.6%	45	6.6%	10	1.5%	7	1.0%	2	0.3%
	Population	23,552	19,945	84.7%	2,996	12.7%	232	1.0%	231	1.0%	148	0.6%
Washington	Health care workforce	9,818	8,133	82.8%	724	7.4%	427	4.3%	488	5.0%	46	0.5%
	Population	493,829	378,887	76.7%	60,444	12.2%	20,155	4.1%	30,218	6.1%	4,125	0.8%
Wheeler	Health care workforce	12	9	75.0%	3	25.0%	-	0.0%	-	0.0%	-	0.0%
	Population	1,243	1,224	98.5%	16	1.3%	2	0.2%	1	0.1%	0	0.0%
Yamhill	Health care workforce	1,384	1,197	86.5%	115	8.3%	37	2.7%	31	2.2%	4	0.3%
	Population	92,697	79,239	85.5%	10,582	11.4%	1,677	1.8%	1,005	1.1%	194	0.2%

Health care workforce missing county information: 72

Sources: Health Care Workforce Database, Oregon Health Authority, 2013; American Community Survey five-year file, 2008–2012

Health care workforce data includes languages other than English; these were classified into the four ACS language groups. Some health care workers were classified in more than one language group. English-only speaking health care workers did not report any other language besides English.

NOTE: Columns are mutually exclusive for population data; they are not for health care workforce data because one health care worker may have been classified in more than one language group.