Oregon Healthcare Workforce Committee

AGENDA

October 10, 2012

Wilsonville Training Center
29353 SW Town Center Loop E, Wilsonville, Oregon 97070
Room 111/112
1 – 4 p.m.

#	Time	Agenda Item	Presenter(s)	Action Item
1	1:00	Welcome	Chairs	
2	1:05	Approval of August 8 meeting summary	Chairs	X
3	1:10	Updates	All	
4	1:30	New loan repayment program required by Medicaid waiver – initial discussion of design options	Staff, All	
5	2:00	Review and feedback on latest draft of strategic plan for primary care provider recruitment (HB 2366)	Lisa Dodson, Jo Isgrigg, Marc Overbeck	
6	2:30	Public Comment	Chairs	
	2:45	Break		
7	3:00	Refine recommendations for 2012 report to the Health Policy Board • Review current recommendations (2010 recommendations + changes made at August meeting) • Breakout discussions – small groups – prioritize and flesh out top 2 recommendations • Synthesis and next steps	All	
8	3:50	Select December meeting date: 5th, 13th, 14th, or 18th		
9	4:00	Adjourn		

DRAFT

Meeting Materials

1. Agenda
2. August 8, 2012 draft meeting summary
3. Legislative Concept 342 – new loan repayment program
4. Information on existing Oregon loan repayment programs
5. Design considerations for loan repayment
6. Latest HB 2366 plan draft
7. Potential recommendations for 2012 – discussion document

Oregon Healthcare Workforce Committee
Meeting Summary

August 8, 2012
9 a.m. - noon

Committee Members in Attendance

John Moorhead (Chair)
Peter Angstadt (via phone)
Lita Colligan
Lisa Dodson
Sara Hopkins-Powell (via phone)
Andrew Janssen (via phone)
Terri Johanson
Donna Larson (via phone)
David Nardone
David Pollack
Michael Reyes
Daniel Saucy
Kristen Simmons
Jennifer Valentine
Judith Woodruff

OHA and OWHI Staff in Attendance

Jo Isgrigg (OHWI)
Tina Edlund (OHA)
Lisa Angus (OHPR)

Committee Members not in Attendance

Ann Malosh (Vice-Chair)
June Chrisman
Paula Crone
Saige Gracie
Mauro Hernandez
Mary-Rita Hurley
Susan Kirchoff
Kelly Morgan
Mark Richardson
Sergio Vasquez

John Moorhead convened the meeting and introductions were made.

The June 6, 2012 meeting summary was approved.

Updates

Tina Edlund gave an update on the Medicaid waiver that was approved by CMS on July 5, 2012. Workforce-related elements in the waiver include:

- Requirement to establish a primary care loan repayment program, funded at $2M annually, by July 2013.
- Interest in the non-traditional workforce and commitment to train 300 additional community health workers by 2015.

She noted that some specifics remained to be negotiated in the 120 days following the waiver approval, notably:

- Details for calculating the 2 percentage point Medicaid PMPM cost trend reduction that the state has committed to achieving by year 2 of

- Design of a quality incentive pool intended to start moving CCO payments from volume to value. CMS expects that an increasing portion of CCO payments will be through that incentive pool, rather than in the traditional capitation rate.

In response to a question about next steps for Coordinated Care Organizations, Tina explained that the hope is to offer one or more CCOs as a coverage choice to PEBB members in the future. CCOs could also potentially be an option on the Health Insurance Exchange but there are many details that would have to be worked out. Some CCOs seem to be interested in that potential and others less so.

There was some discussion of the Community Health Worker (CHW) training commitment in the waiver and a related meeting convened by the Governor's Office on August 1st. Committee members made points about the importance of keeping training connected to the community, since it is a community-based model of care, and of ensuring that training is standardized and has clear articulation points with additional educational opportunities, to create career ladders. One member suggested using the model of OHWI's HIT brain trust—which engaged individuals from multiple sectors to create a strategic plan—to continue planning for CHW curriculum development and training. Questions that were raised at the Governor's Office August 1 meeting included: where will the jobs be? Do we have any data about employer demand for CHWs? How will CHWs get paid? How will CHWs be integrated into existing systems?

Committee Leadership

John Moorhead announced that he would be stepping down from the Committee to take on other responsibilities. Tina Edlund thanked him for leadership and commitment to the Committee and congratulated all members on their work to date.

The Committee's by-laws call for the Chair and Vice-Chair to be elected by the membership every 2 years.

Donna Larson nominated Ann Malosh to continue as Vice-Chair; Kristen Simmons seconded. The motion was approved.

David Nardone nominated Lisa Dodson to assume the Chair position; David Pollock seconded. The motion was approved.

Discussion of Current Projects

Adverse Impact. Sara Hopkins-Powell reminded members about the state's adverse impact law and the Committee's 2010 recommendation to revise it. She noted that the issue is politically charged and there are strong feelings on both sides but the Committee has had some productive meetings with stakeholders, in context of recent changes in higher education structure and leadership. The proposal is to send a letter to the Higher Education Coordinating Commission requesting the statutory and regulatory change; a draft letter is included in the meeting materials for the Committee's approval.

In discussion, it was noted that the request is to change the regulation for health professional training programs only, as our Committee has no position on other programs. The Higher Education Coordinating Commission may choose to address the issue more broadly.

Terri Johanson said that the group deserves a huge hand for finding a way to open this door in a positive manner and **moved to approve the letter. Dan Saucy seconded and the motion was approved.**

Strategic Plan for Primary Care Provider Recruitment (HB 2366). Lisa Dodson gave an overview of the work to date, which included a SWOT analysis and several meetings. The group is currently at the stage of proposing recommendations and steps and would appreciate the Committee's input. Points from the subsequent discussion included:

- Recruitment is a nationally competitive process. Neighboring states dedicate more to recruitment that Oregon does, so matching their resources may be an appropriate benchmark.
- It's important to make sure that the definition of primary care provider in the document is broad and includes mental health professionals, even if just those working in a patient-centered primary care home, for example.
- Several members noted the importance of health care as an economic driver in communities and suggested approaching the economic development community to find resources for the plan in different communities and statewide.
- Local WIBs (workforce investment boards) see the economic connection but tend—at least in Oregon—to focus on training that gives fairly immediate returns. Incumbent worker training might be one area to bridge the gap, as it can generate workforce capacity and higher wage job placements in a shorter time frame.
- The pipeline for training physicians and nurses and other professionals is long but motivating those already in training to take up primary care has a quicker return – expanding the rural health scholars program is one potential recommendation.
- The state Workforce Investment Board is another potential partner and/or resource. Perhaps, with some education about the economic benefit, the OWIB might be willing to provide resources for a kind of co-op marketing plan – something with a statewide strategy and goals but also templates and other tools for communities to use, since recruitment is very community-specific?
- There was some discussion of a recommendation to expand the number of primary care residency position in Oregon but the issue of graduate medical education (GME) allocation is complex and controlled federally. The up-front investment is significant.
- One member suggested connecting the health care workforce capacity issue to the Governor's education agenda and the 40:40:20 goal.

Standards for student clinical placements (SB 879). Terri Johanson reported that the Committee's recommendations on SB 879 were presented to the Health Policy Board in July and that the Board was very receptive. They encouraged us to be more specific and prescriptive about centralizing the student passport, whether in paper or electronic format. That discussion will continue as part of administrative rule development in the fall.

Discussion of this topic included these points:

- The administrative rule process is good for definitional issues but not for working through operational questions. It may be better to make those decisions up front. The Committee could continue the centralization and automation discussion with stakeholders before beginning rule development.
- The Committee should solicit students' input on operational issues.
- One way to advance the discussion might be to be to explain the programmatic/ operational need and invite a handful of businesses (e.g. StudentMax, others) to: 1) propose what kind of technology would best fit that need and; 2) suggest the business model for supporting the solution.
- The Committee has recommended a long phase-in period for the standards, to allow contractual changes to be made, but the degree of synergy/agreement around the list may mean that the standards get adopted sooner.

Public Testimony

No members of the public wished to offer testimony.

Inventory of Healthcare Professional Training Programs

Jo Isgrigg introduced the inventory, an update to one that OWHI prepared for the Committee in 2010. She noted that the data source was a national one, so not 100% up-to-date and that, since 2010, Oregon had a net loss of 12 high-school health professional preparation programs. She requested that Committee members check the inventory and send any updates or corrections. Subsequent discussion included:

- There is interest in inviting Western Governor's University (online programming, non-profit, started by NGA) to offer degrees in Oregon to meet the 40-40-20 goal. Their job and graduation success rates are not great and many of the programs are health professions but training is generally faster and cheaper than both public and private. Would this institution go through the same adverse impact process? Would need to add them to the inventory.
- Items to check: health administration, management line; medical informatics line.

Many members expressed interest in an inventory that would show current capacity, as well as past graduation numbers, to inform strategic action at the state level. It would be ideal to have an ongoing system, a parallel to what has been started for licensed professionals from some boards. It is no longer feasible to operate without an ability to centralize data and support analyses. Data points should include:

- Current capacity
- % filled
- Recent graduation numbers
- Future plans (how much could capacity change / what do you think need is)
- (It was noted that this is all still supply data, not demand)

OHWI and OCN are charged with this kind of work (in support of the OWIB) but time and funding are needed. It could be done with student labor on a one-time basis, but not ongoing.

Hawaii just received a Dept. of Labor grant for similar kind of database, but it's not limited to health professions. The suggestion was made to add this database and analysis idea as a short-term recommendation for the 2012 report.

2012 Report Building

Members discussed recommendations for the 2012 report to the Health Policy Board. Lisa Angus reviewed comments that had been received from Committee members about updates needed to the 2010 recommendations, as a starting place. Discussion included these points:

- Add in a short-term recommendation about tracking training capacity (see previous item)
- Add in specific enrollment or graduate targets and funding amounts for health education training programs, if that recommendation still stands
- For the new loan repayment program, consider options for scenario in which there are not enough interested candidates or eligible sites to fully expend the funds each year
- Keep emphasizing the importance of payment reform occurring and reinforcing the practice changes that the Committee wants to see.
- Take the opportunity to connect healthcare reform (workforce specifically) with education reform. E.g. STEM initiative for K-12 should include science and math as preparation for healthcare professional careers.

Dr. Moorhead adjourned the meeting at noon.

LC 342
2013 Regular Session
44300-002
9/5/12 (LHF/ps)

D R A F T

SUMMARY

Establishes primary care provider loan repayment program in Oregon Health Authority. Requires authority to adopt rules for eligibility and participation in program.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to primary care provider loan repayment program; appropriating money; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) There is created in the Oregon Health Authority the primary care provider loan repayment program for the purpose of assisting primary care providers who have committed to serving medical assistance recipients in rural or medically underserved areas of the state.

(2) The authority shall prescribe by rule:

(a) Participant eligibility criteria, including the types of primary care providers who may participate in the program;

(b) The terms and conditions of participation in the program;

(c) The types of loans for which payments may be provided;

(d) The priority for distribution of funds available under subsection (4) of this section if the funds are insufficient to provide assistance to all of the applicants who are eligible to participate in the program; and

(e) Any other requirements necessary to ensure federal financial participation in the costs of the program.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(3) The authority may enter into contracts with one or more public or private entities to administer the program or parts of the program.

(4) There is created the Primary Care Provider Loan Repayment Fund in the State Treasury, separate and distinct from the General Fund. Interest earned by the Primary Care Provider Loan Repayment Fund is credited to the fund. The fund consists of moneys appropriated from the General Fund and federal moneys received for the purpose of operating the primary care provider loan repayment program. Moneys in the Primary Care Provider Loan Repayment Fund are continuously appropriated to the authority to be used to implement and operate the primary care provider loan repayment program.

SECTION 2. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Primary Care Loan Repayment and Forgiveness Programs Available to Clinicians in Oregon

Program	Administered By:	Description	Program Length	Who Qualifies (Disciplines):	Requirements	Loan Repayment Funding	Program Financing	References
National Health Service Corp (NHSC) LRP	HRSA	Primary care providers working at an NHSC approved site with a HPSA score of 14 or above can receive loan repayment towards qualified education loans. **Minimum HPSA score may vary depending on application cycle.*	2 years, with the option to apply for a continuation (up to 7 years). Participants can be full-time; minimum 40 hrs/week, no fewer than 4 days/week or half-time; minimum 20 hrs/week, no fewer than 2 days/week.	Physician (MD/DO), Dentist (DMD/DDS), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Registered Dental Hygienist (RDH), Health Service Psychologist (HSP), Licensed Clinical Social Worker (LCSW), Psychiatric Nurse Specialist (PNS), Marriage and Family Therapist (MFT) and Licensed Professional Counselor (LPC).	US citizen or national, practicing in a qualified discipline, licensed to practice in the state, qualifying education loans and must work in a NHSC approved facility.	**Sites with a HPSA score of 14 or above**: Full-time participants can receive up to $60,000 for a 2 year commitment; half-time participants can receive up to $60,000 for a 4 year commitment. **Sites with a score of 13 or below:** Full-time participants can receive up to $40,000 for a 2 year commitment, half-time participants can receive up to $40,000 for a 4 year commitment.	100% Federal Funding	Section 338B of the Public Health Service Act (42 USC 254l-1)
National Health Service Corp (NHSC) SP	HRSA	Scholarships are awarded to students pursuing primary health care professions training in eligible disciplines in return for a commitment to provide health care to communities in need, upon graduation and completion of training.	For each school year, or partial school year of financial support received, students agree to provide primary health services for one year at an approved NHSC site located in a HPSA.	Physician (MD/DO), Dentist (DMD/DDS), Nurse Practitioner (NP), Certified Nurse Midwife (CNM) and Physician Assistant (PA)	US citizen or national enrolled or accepted in the eligible primary care disciplines' degree program at a US accredited school.	Tax free payment is made (up to 4 years) for tuition, required fees and other reasonable educational costs. Scholarship recipients also receive a taxable monthly living stipend.	100% Federal Funding	Title III, Section 338A of the Public Health Service Act (42 USC 254l)

Program	Administered By:	Description	Program Length	Who Qualifies (Disciplines):	Requirements	Loan Repayment Funding	Program Financing	References
Nursing Education Loan Repayment Program (NELRP)	HRSA	NELRP helps to alleviate the critical shortage of nurses by offering loan repayment assistance to RNs and ANPs, in exchange for a commitment to work at a critical shortage facility. Nurse faculty can also receive loan repayment if they work full-time at an accredited school of nursing.	A minimum of 2 years of service is required, with the option of a third year of service available.	Registered Nurse (RN) and Advanced Nurse Practitioner (ANP)	Must be a licensed RN or ANP, employed full-time (minimum of 32 hrs/week) at a public or private non-profit critical shortage facility. Faculty must be employed as a full-time nurse faculty member at a public or private non-profit school of nursing.	**For RNs and ANPs:** Funding preference will be given to nurses based on the greatest financial need, the type of facility, and the HPSA designation of the facility. **For faculty:** Funding preference is given to faculty with the greatest financial need and to faculty working at nursing schools with at least 50% of students from a disadvantaged background. *NELRP participants will receive 60% of their total outstanding qualifying educational loan balance for a 2 year commitment. Participants may receive an additional 25% of their original loan balance for a third year of service. All awards are taxable.	100% Federal Funding	Section 846 of the Public Health Service Act (42 United States Code (U.S.C.) section 297n), and 42 Code of Federal Regulations (C.F.R.) section 57.312.
Oregon Partnership State Loan Repayment Program (SLRP)	OR Office of Rural Health	This program is a loan repayment opportunity for health professionals who commit to working in a HPSA for a minimum of 2 years.	Minimum 2 year service commitment, with the option to apply for a 1 year extension- up to 5 years.	Physician (MD/DO), Nurse Practitioner (NP), Physician Assistant (PA), Dentist (DMD/DDS), Registered Dental Hygienist (RDH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC) and Psychologist (PSY)	US citizen, must work full-time (minimum 40 hrs/week) at an approved site in a HPSA.	Participants can receive a maximum award of $35,000 per year, or 25% of total loan debt, whichever is a smaller amount.	The program is funded through a grant from the Bureau of Health Professions, National Health Service Corps, with a 1:1 dollar match from the practice site.	Public Health Service Act, Title III, Section 3381, 42 U.S.C. 254 q-1(h). Section 10503 of the Affordable Care Act (P.L. 111-148)

Program	Administered By:	Description	Program Length	Who Qualifies (Disciplines):	Requirements	Loan Repayment Funding	Program Financing	References
Federal Faculty Loan Repayment Program	HRSA	Faculty members from disadvantaged backgrounds with a professional health care degree or certificate may receive loan repayment assistance in exchange for teaching at educational institutions that provide training for health care professionals.	Minimum 2 year contract; participants can apply for sequential contracts.	Physician (MD/DO), Registered Nurse and Nurse Practitioner (RN/NP), Dentist (DMD/DDS), Registered Dental Hygienist (RDH), Physician Assistant (PA), Mental Health professions (Clinical Psychology, Clinical Social Work, Marriage and Family Therapy, Professional Counseling), Audiology, Optometry, Occupational and Physical Therapy (OT/PT), Pharmacy, Podiatry, Speech Language Pathologist (SLP), Medical Laboratory Technology, Radiologic Technology, Dietician, and Veterinary disciplines.	US citizen or national, school produced certification to demonstrate disadvantaged background, full-time or part-time faculty position for a minimum of 2 years.	Participants can receive up to $40,000 towards repayment of student loans for a 2 year service commitment.	100 % Federal Funding	Section 738(a) of the Public Health Service Act (42 USC 293b(a)
Oregon Loan Forgiveness	OR Office of Rural Health	This loan forgiveness program will provide loans to students studying to be physicians, nurse practitioners or physician assistants who are committed to working in a rural area. This program focuses on the idea that rural communities may be able to "grow" their own by identifying star students who want to become medical professionals.	For each year that loans are received, participants agree to practice in a rural setting in Oregon, at a pre-approved site.	Physicians (MD/DO), Physician Assistant (PA), and Nurse Practitioner (NP)	US Citizen or national, must have completed the first year of education in a qualified discipline, and must complete a service agreement that outlines their commitment to practicing in a rural service following their training and residency.	Participants will receive up to $35,000 annually for expenses related to their medical education.	100% State Funding; $525,000	ORS 442.573

Program	Administered By:	Description	Program Length	Who Qualifies (Disciplines):	Requirements	Loan Repayment Funding	Program Financing	References
Primary Care Services Loan Repayment Program (currently unfunded)	OR Office of Rural Health	This program provided partial loan repayment in return for service time in a rural or underserved area. This program lost funding in the 2011-2013 biennium.	For NP and PA participants, there was a 2 year commitment, with an option of completing up to 4 years. For all other disciplines, there was a minimum of 3 years, with an option of continuing up to 5 years.	Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Dentist (DMD/DDS), Pharmacist (PharmD), and Naturopath (ND)	US citizen or national, practicing in a qualified discipline, licensed to practice in the state, qualifying education loans and must work in health professional shortage area.	Participants could receive partial loan repayment (1/3 of the outstanding loan balance, or $25,000), if they participated in a minimum 3 year service commitment.	100% State Funded	ORS 442.550 - 442.565 & SB 404

Workforce Training Loan Reimbursement
Discussion Document

CMS WAIVER LANGUAGE ON WORKFORCE LOAN REPAYMENT:
"To ensure that DSHP funds promote the development of workforce training to benefit the Medicaid population and improve access, the State shall commit to funding a primary care provider loan repayment program, with the following conditions:

By July 1, 2013, the State shall establish an annual funding level of $2,000,000 to provide assistance to providers who make written commitments to serving Medicaid populations in rural and underserved areas. If the State is unable to establish funding for this program at the amount specified in this term, the State's Workforce Development state designated health program expenditure authority must be reduced. The DSHP Workforce Development funding must be reduced by 25 percent of the difference between the $2,000,000 and the amount that the State is able to reinstate for the loan repayment program for Demonstration Years 12 and 13."

DECISION POINT #1: DEFINING PRIMARY CARE.

- How do we define primary care?
- Should the definition include mental health services? Dental? Advanced dental hygienists? General surgeons?
- Should there be a preference for minorities? People from disadvantaged backgrounds? Native Oregonians?

Example

- The National Health Service Corp (NHSC) makes a special consideration for people from disadvantaged backgrounds, including providers with a mental or physical impairment, ESL students, and providers from low-income families.

DECISION POINT #2: DEFINING "UNDERSERVED" AND "RURAL" POPULATIONS.

- How should we define "underserved" and "rural" populations?

Examples

- The Health Resources Services Administration (HRSA) uses Health Professional Shortage Areas (HPSAs) to identify areas that are lacking appropriate health care workforce capacity in three different ways:
    - A geographical area
    - A population
    - A facility

- HRSA draws its definition for rural populations from one of the following organizations:
    - U.S. Consensus Bureau
    - Office of Management and Budget Definition
    - Office of Rural Health Policy

DECISION POINT #3: PROMOTING GOALS OF TRANSFORMATION.

- Should there be a preference for clinics that are recognized as a Patient-Centered Primary Care Homes (PCPCHs)?
- Should there be incentives for innovation?

DECISION POINT #4: DEFINING THE COMMITMENT.

- How long is the commitment to Medicaid?
- How should the commitment be operationalized? It could be a simple attestation, or could be defined in a number of ways: relative to the number of Medicaid patients served, percentage of the population served, the percentage FTE of a clinician that is used to serve Medicaid-funded patients, or other.

DECISION POINT #5: DEFINING THE AMOUNT OF REPAYMENT.

- What is the amount of repayment?
- How do you determine the amount of repayment? Should the amount of repayment be tied to actual debt accrued?
- How many years are you eligible for repayment?
- What are the required years of service? What are permitted years of service (i.e. is continuation available, following completion of an initial obligation?

DECISION POINT #6: PRIORITIZING FUNDS.

- How should funds be prioritized?
- How should funds be prioritized in case of a shortfall?

Examples

- Senate Bill 608, regarding subsidized medical liability insurance, includes language that specifies the allocation of funds generally and in the case of a shortfall, including a tiered list of prioritized providers.
- HRSA has approved an Oregon-developed definition of rural and frontier areas. Should clinicians in "rural" and "frontier" areas have a specific priority? Should clinicians in "frontier" areas receive extra consideration? Should there be a "set-aside" for rural and/or frontier counties for either the percentage of funds awarded, or the number of awards?

DECISION POINT #7: ENFORCEMENT AND COMPLIANCE.

- How should the program encourage compliance?
- Should there be penalties for defaulting on the contract?

Example

- Various programs penalize providers for breaching their contract and leaving the site before the duration of the service period is complete, including a $7,500 per-month fee for early departure and/or complete loan repayment with an additional 10% fee.

5-Year Strategic Plan for Primary Care Provider Recruitment in Oregon

** WORKING DRAFT **

October 2012

Placeholder for Executive Summary

I. Introduction

About this Plan

The Oregon Legislature has long recognized that a robust health care workforce contributes not only to the health of Oregonians, but to the economic health of the state--particularly our rural and underserved communities. Like many western states, Oregon has many counties and populations within the state that suffer from an identified shortage of health care provider availability—complicating efforts to improve the health of a population and promote economic growth. These include areas with a high concentration of Medicaid-eligible or other low-income individuals, and other populations, including the migrant and seasonal farmworkers, homeless individuals, and communities of color. In some parts of rural Oregon, there simply is not a sufficient health care workforce to meet the needs of the population as a whole.

In 2011, the Legislature enacted HB 2366, tasking the Oregon Health Policy Board's Health Care Workforce Committee to work with interested parties to develop a "strategic plan for recruiting primary care providers to Oregon"

Lawmakers specified that the plan should address:

1) Best recruitment practices and existing recruitment programs;
2) Development of materials and information promoting Oregon as a desirable place for primary care physicians to live and work;
3) Development of a pilot program to promote coordinated visiting and recruitment opportunities for primary care physicians;
4) Potential funding opportunities; and
5) The best entities to implement the strategic plan.[1]

These recommendations are particularly (but not exclusively) targeted toward geographic areas and populations within the state that are underserved currently by the health care workforce. Underserved populations include low income individuals, migrant and seasonal farmworkers, homeless individuals, and Medicaid recipients. Underserved geographic areas include both

[1] Enrolled HB2366, 2011 Legislative Assembly

areas that currently have a shortage of physicians, but whose remoteness makes it difficult to retain a robust health care workforce.

In developing the plan described in this document, the Committee completed a thorough literature review and an environmental scan of other state strategic plans for primary care recruitment and consulted with stakeholders from professional societies, health systems and plans, state agencies, educational institutions, and provider groups. Committee members also consulted individually with representatives from Business Oregon and Travel Oregon and incorporated community input on health care workforce priorities from regional forums in Roseburg and Lincoln City and Pendleton convened by the state's Primary Care Office for a separate but topically related project.

For the purposes of this report and plan, primary care is defined as *an initial point of entry into the health care system where patients can receive diagnosis and/or treatment.* This definition is intended to include medical, dental and mental health care.

II. Background

Current Primary Care Capacity in Oregon

Primary care provider shortages continue to persist in many parts of Oregon. Thirty-two of Oregon's 36 counties have some type of federal primary care health professional shortage area designation. In 2010, there were 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. There were four counties where no dentist or pharmacist registered a practice address, three counties where no dental hygienist, physician assistant, or licensed practical nurse listed a practice address, two counties where no nurse practitioner or physical therapist listed an address, and one county with no registered nurses (OHA, 2011).

The Oregon Employment Department forecasts the need for slightly more than 76,000 additional health care workers in the state between 2010 and 2020, a 48% increase. Forty-three percent of the projected job openings are to replace those permanently leaving the occupations' labor pool. The projected demand is largest in settings that employ the most primary care providers: a 34% increase for ambulatory health care services sector and 35% increase for nursing and residential care facilities (35%). Hospital employment is projected to grow more slowly, by 25% (Oregon Employment Department, 2012).

There were 10,822 active licensed physicians practicing in Oregon in 2010; however, only 38% of those physicians were practicing in primary care (OHPR, 2011). In this case, primary care physicians are those who listed practice specialties in family medicine/practice, general practice, geriatrics, pediatrics, adolescent medicine, (general) internal medicine, or internal medicine with a subspecialty in geriatric medicine. Over the past two decades, a larger percentage of medical school graduates have chosen specialty care over primary care and metropolitan over rural practice sites, and tend to place a higher value on a work/life balance than previous generations (American College of Physicians, 2008).[2]

The Oregon Employment Department projects that the number of employed physicians and surgeons will increase by 28.3% between 2010 and 2020, meaning that the state would need to add an additional 3,700 physicians in that time period.[3]

The population-to- primary care physician ratio in Oregon in 2010 was 930:1 (OHA, 2011). This statewide ratio is below the "gold-standard" figure of 1,500:1 that was first used by Kaiser in the 1980s and that continues to be referenced today. Many areas of the state do not meet this population-to-provider standard. Counties such as Multnomah have low ratios (e.g. 630:1 in 2010) whereas a number of less populated counties have much higher ratios, e.g. 2,471:1 in Crook County (OHA, 2011). A majority of providers continue to choose urban or suburban practice; out of the estimated 10,822 active licensed physicians in Oregon in 2010, only 1,100 were actively practicing in rural areas (OHWI, 2010). Reasons for this include availability of employment for spouses, opportunities for entertainment and cultural activities, availability of specialists and collaboration with other physicians and peers. The shortage of providers in rural areas contributes to health care access and health disparities seen between rural and urban populations (Oregon Rural Health Association, xxxx).

Oregon's Primary Care Office, located within the Oregon Health Authority, is responsible for providing analysis and determining which areas and special populations within the state qualify for a Health Professional Shortage Area (HPSA) designation. As of July 2012, Oregon was XXX

[2] It should be noted that not all physicians in primary care specialties are providing primary care. For example, some physicians in traditional primary care specialties have taken on new roles as hospitalists, providing care exclusively to in-patients in acute care hospitals. In Oregon's rural areas, it is not uncommon to find a family practice physician staffing a hospital emergency department.

[3] The Oregon Employment Department numbers represent only employed physicians, may include naturopathic physicians, and will exclude contracted, self-employed and some locum tenens physicians. The numbers represent the labor market demand versus the social demand to provide access to all Oregonians

primary care physicians "short" of removing all the federal designations. The Oregon Office for Rural Health provides a sophisticated model to determine "unmet need" beyond simple FTE.

In addition to physicians, advanced registered nurse practitioners (NP) and registered nurses (RN) are vital to the primary care workforce in Oregon. Unlike some other states, Oregon has granted NPs substantial autonomy to provide care without physician oversight. In 2010, the number of licensed NPs in the state was 2,422; it is estimated that 1,955 were actively practicing in Oregon. In 2010, Oregon had 45,946 licensed RNs (which includes NPs), with an estimated 35,849 actively working (OHA, 2011). The Employment Department forecasts that Oregon will need an additional 14,499 registered nurses by 2020, due to industry growth and replacement of current nurses who will retire or change careers. Nurse practitioners and RNs are heavily concentrated in the metropolitan counties in the state. Multnomah, Washington and Clackamas Counties have the highest number of NPs.

The limited number of nursing faculty significantly impacts the ability of schools to increase their nursing student capacity. Nursing graduates primarily choose clinical settings over academic professions because of the significant difference in compensation; only one third of nursing faculty report feeling satisfied with their salary (Oregon Center for Nursing, 2009).

In 2010, there were 918 active licensed physician assistants practicing in Oregon, of which 45% identified a practice associated with a primary care specialty. Physician assistants (PA) are more equitably distributed between the Portland Metropolitan Area and the rest of the state, compared with primary care physicians (25% of PAs statewide practice within Multnomah, Washington and Clackamas Counties, compared with 35% of physicians statewide (OHWI, 2010). The number of PAs and ratio of PAs-to-physicians varies widely in different parts of the state. Only 13 PAs are practicing in Linn County—a ratio of 8 PAs for every 100 primary care physicians, while in Crook County, the ratio is 29 per one hundred (OHWI, 2010).

Demand for new health care professionals is expected to continue to increase in the coming years. Contributing to this demand is the aging of the existing primary care workforce. According to 2010 licensing data, approximately 30% of Oregon's active workforce in 15 licensed health care professions is 55 years of age or older. Among nurses, the figure is higher: more than 45% of nurse practitioners, certified nurse specialists, and licensed practical nurses are 55 years of age or older (OHA, 2011). The current economy has forced many to postpone their plans for retirement but the aging of professionals is expected to have a large impact on workforce capacity in the next 5-10 years. In 2010, pharmacists, physical therapists, dentists,

and occupational therapists were most likely to report that they were considering a practice change that could impede access to care (e.g. retiring, reducing practice hours, moving out of state, or leaving the field) (OHA, 2011). Combined with an aging population (by 2030, one fifth of Americans will be over the age of 65), an increase in the number of individuals with chronic medical conditions, and XXX who will be newly eligible for medical insurance coverage in 2014 as a result of national health care reform, demand for primary care providers shows no sign of abating.

Best Practices in Primary Care Provider Recruitment

As specified in the HB 2366, the Committee undertook an environmental scan of best practices and existing recruitment plans, drawing on local, state, and multi-state/regional plans and strategies used throughout the country. The full scan is contained in Appendix XX. Notable findings from this scan include:

- There is incredible variation in level of industry and governmental resources and programs for recruitment initiatives by state.
- While the stakeholders involved in recruitment are numerous and diverse, and often has competing interests or market share, there is growing recognition that geographies and organizations are working to recruit and retain the same limited pool of applicants. In some cases, people are capitalizing on awareness of this shared need to motivate collaboration among stakeholders.
- Most recruitment plans emphasize the key importance of pipelines, beginning at the elementary school level, for creating interest in and availability of local health care training programs. Most plans also tie retention strategies into recruitment, since many of the same factors play a role.
- Many plans highlight the need to create incentives targeted by provider type: loan repayment may be more attractive to dentists and physicians and others with high debt burdens; incentives like salary, benefits, or sign-on bonuses could be of greater impact for other providers.
- Adequate funding for recruitment is a perennial problem.
- Many of the publicly-available plans focus on rural access and spend little to no time discussing urban pockets of inaccessibility. Very few plans include alternative care providers or newly emerging roles such as Community Health Workers.

Existing Tools for Recruitment in Oregon

The primary recruitment tools available statewide in Oregon are federal and state loan repayment and forgiveness programs, a small state tax credit for rural providers, and an Oregon

DRAFT

rural medical liability subsidy program. A full description of these programs can be found in Appendix XX; however, more than one of these programs is currently unfunded. In addition to programs financed by the state or the federal government, private health systems, hospitals, and other entities have their own recruitment incentive tools; a few of these are also described in Appendix XX.

III. Vision

Oregon will be a model for efficient, coordinated primary care recruitment and retention efforts in the United States. All areas serving all populations in Oregon will be competitive with other states and regions for recruiting primary care providers in order to stabilize and increase Oregon's primary care workforce and ensure access to high quality health care for all Oregonians.

IV. Strengths, Weaknesses, Opportunities, and Threats

Oregon has not historically educated a sufficient quantity of physicians to meet its needs, particularly in the area of primary care residencies, and has been and continues to be an importer of trained physicians [cite.] Physicians and other health care providers are in high demand throughout the country, increasing the competition for these scarce and expensive resources. The relative strengths and weaknesses of Oregon's health care recruitment environment include factors related to the medical climate, such as medical liability, as well as general livability measures such as cost of living, quality of education and climate.

Strengths for primary care provider recruitment in Oregon include:

- An educational community committed to innovation has reduced silos between institutions. For example, the Oregon Consortium for Nursing Education (OCNE) collaborative, the community colleges' distance learning platform, and newly forming inter-professional curricula at many institutions will help attract students to health care careers and will increase availability of training in communities across the state, helping to ease the geographic maldistribution of health care providers.
- A well-developed Oregon AHEC (Area Health Education Centers) system addresses the K-16 pipeline to create an in-state pool from which to recruit. Programs such as the Oregon Department of Education's ASPIRE, which helps middle-and high school students access education and training beyond high school by providing information and support to students and their families can be adapted for health career support for disadvantaged students.

DRAFT

- The Oregon Rural Scholars program developed by Oregon AHEC at OHSU provides enhanced educational opportunities for medical students interested in rural practice, increasing their likelihood of choosing a specialty in high need (such as family medicine or general surgery). This program could be expanded to include students from other primary care disciplines such as osteopathic physicians, physician assistants, advance practice nurses, dentists and pharmacists.
- Oregon is a national leader in health care reform with large-scale delivery and financing changes underway. If these reforms and measures appropriately and consistently value primary care providers, and provide adequate financial incentives for care, Oregon will improve its attractiveness to progressive primary care providers;
- Oregon's Medical and Nursing Practice Acts provide progressive scopes of practice for nurse practitioners and physician assistants, as compared to other states, which create a recruitment incentive for non-physician health care providers. Nurse practitioners may practice without physician oversight and with full prescribing authority, and Physician Assistants may practice under non-direct supervision, extending their ability to provide services into more remote rural areas.
- Oregon has several outstanding examples of communities and organizations mobilizing and coordinating (instead of competing) for providers. The Rimrock Health Alliance and the Klamath Falls Partnership are two examples. Promotion of these models to other communities could increase recruitment and retention success.
- The Oregon Locum Tenens Cooperative assists rural communities, facilities and medical practices to acquire temporary or short-term coverage for primary care providers (primarily physicians but also nurse practitioners and physician assistants), and has been helpful in recruiting providers to rural locations.
- An Oregon tax credit of $5,000 for rural providers provides a recruitment incentive for some rural communities, although it sunsets in 2014.

Oregon also has several weaknesses with respect to primary care provider recruitment:

- Oregon's tax structure is a disincentive for high-wage earners.
- Oregon offers relatively few provider recruitment incentives and those are underfunded as compared to other states. The state primary care provider loan repayment program has been unfunded since 2009. However, a loan forgiveness program for students focused on rural health was created in 2011 and the state's 2012 Medicaid waiver

DRAFT

requires $2 million to be dedicated to primary care provider loan repayment as of July 2013 (see opportunities).

- High educational debt is a deterrent to students selecting primary care specialties and to locating in areas of high need such as rural and underserved communities cite. OHSU has among the highest tuition and graduate debt load of any state supported medical school in the U.S. Cite. Western University's College of Osteopathic Medicine of the Pacific opened a branch campus in Lebanon, Oregon in 2010, but, as a private institution also has relatively high tuition and students are likely to graduate with significant debt.
- Oregon has historically low Medicare and Medicaid reimbursement compared to other states, reducing income potential for physicians serving those populations and reducing access for patients covered by those programs.
- Recruitment into Oregon's large rural and frontier areas and more urban underserved populations is historically more difficult. Oregon's weakened K-12 education system is a liability when trying to recruit and retain providers with families. This is particularly pronounced in rural areas, where most schools operate on a 4-day school week as a cost-saving measure and have fewer, if any, advanced placement courses, International Baccalaureate programs and/or extracurricular activities.

Opportunities for recruitment include:

- The expansion of the insured population in 2014. Under federal health reform more than XXX Oregonians are anticipated to acquire health care coverage. This creates a significant pool of potential patients but is also a threat, as there is currently inadequate capacity to absorb this many individuals into the current provider system.
- Oregon is a leader in health reform. Building on momentum of health care reform and primary care renewal can energize providers toward achieving a more efficient, effective, well organized and satisfying health care system. Oregon's innovation efforts may attract younger physicians, and those willing to provide care in new ways, in addition to non-traditional disciplines, and may provide openings for emerging health professionals such as community health workers.
- New media and technologies exist for contacting and targeting potential health care practitioner recruits from a wider audience, at lower cost.
- The current bump in Medicaid and Medicare reimbursement for primary care providers (a time-limited provision of the federal Affordable Care Act) may lead to an increase in the number of health career students considering primary care careers.

DRAFT

- Expansion and increased support for National Health Service Corps from the Affordable Care Act may increase the number and improve the distribution of loan repayment positions in Oregon.
- Additionally, a new loan repayment program funded at $2M annually for primary care clinicians who commit to serving Medicaid patients holds promise for recruiting clinicians to areas that are traditionally underserved.
- A strong trend toward physician employment by large health systems (see also threats), has resulted less physician time engaged in practice management, which may increase productivity and improve career satisfaction. Larger systems may be able to engage in enhanced retention activities.

Threats to effective recruitment include:

- Uncertainty regarding development of Coordinated Care Organizations and other novel health care system reforms at both the state and federal level. Many practitioners and others are wary in this time of transition.
- Anticipated expansion of insured population in 2014 (also an opportunity) will increase income potential for physicians, but may also bring low reimbursement rate for publicly-covered individuals and increasing provider workload. There could be detrimental effects if payment reform lags behind eligibility expansion and other necessary delivery system reforms.
- Strong trend toward physician employment (see also opportunities) requires changes in recruitment and retention strategies, as well as changes in support needed for physicians who remain in independent practice.
- Inadequate State budget has a direct effect on recruitment via health care facility reimbursement and budgets, and therefore hiring capacity, as well as an indirect effect through funding for health care education programs.

DRAFT

V. Strategic Objectives and Plan

Objective	Tactics	Timeline	Potential Funding Sources	Best entities to implement the strategic plan
Increase by X% the number of primary care practitioners in rural and underserved communities in Oregon who were educated in-state by [DATE]; and increase by Y% the number of primary care practitioners practicing in rural and underserved communities (over a 2012 baseline).	Increase funding for existing primary care educational programs by X% in order to increase admissions capacity and expand the pipeline of primary care practitioners.	2013 2015 2017		Oregon State Legislature Oregon Health & Science University
	Expand funding by at least $X annually for loan repayment to clinicians serving underserved areas and populations.	2013 2015 2017		Oregon State Legislature Oregon Office of Rural Health
	Increase funding by at least $X for the Rural Scholars Program to allow an increase in the annual number of students in the program. Open the program to a variety of students in programs throughout the state.	2013 2015 2017		Oregon Area Health Education Center Program (OR AHEC)
	Expand funding for training programs by at least $X for "new" health care workers that will be part of the primary care delivery team, (e.g. Community Health Workers and others).	2013 2015 2017		Oregon State Legislature OHA Office of Equity and Inclusion
	Support an additional $X to fund programs like AHEC that develop and encourage more high school students and undergraduates choosing primary health care careers.	2013 2015 2017		AHEC Public health profession education programs (K-16)

DRAFT

Objective	Tactics	Timeline	Potential Funding Sources	Best entities to implement the strategic plan
Empower communities and increase capacity in at least X Oregon communities to recruit primary care providers, particularly into rural and underserved areas	Consider the need for additional loan repayment funding beyond the recent $2M for providers committed to serving Medicaid patients.	2013		Oregon Health Authority Office of Rural Health Health Resources and Services Administration (HRSA)
	Review federal Health Professional Shortage Area (HPSA) scores to increase the state's ability to access federal loan repayment funding and other financial incentive programs.	By X Date		
	Increase involvement of local business, economic development organizations, and others in recruiting primary care practitioners, by promoting a (Rimrock Alliance-type) community engagement approach in X number of communities throughout Oregon	X by 2013 Y by 2015 Z by 2017		
	Encourage inclusion of health care professional recruitment incentives when enterprise zones are negotiating tax abatement with large businesses - Work with local business to fund required community match for the HRSA state loan repayment program (SLRPP).			Business Oregon Local economic development organizations Office of Rural Health
	Foster collaboration among local business and economic development constituencies to address local issues that affect the community's ability to recruit (education system, tax structure, etc.) in X number of communities.	X by 2013 Y by 2015 Z by 2017		Might be Governor's CERT Team for Health Care??? Business Oregon? Governor's Office? OHA? Office of Rural Health?

DRAFT

Objective	Tactics	Timeline	Potential Funding Sources	Best entities to implement the strategic plan
	Develop a recruitment tool kit for communities, that includes marketing and promotion material, proven recruitment strategies, information about Locum Tenens and other programs, templates/best practice resources/links to relevant recruitment programs, etc.	2013 2015 2017		Primary Care Office
Expand successful out-of-state recruitment efforts for primary care providers	Increase and coordinate marketing efforts to link organizations and candidates to the available resources.	2013 2015 2017		Primary Care Office Office of Rural Health
	Encourage investment by health care organizations (clinics and hospitals) in the Oregon Locums Tenens Cooperative (OLTC) to ensure community access to locum tenens in at least X number of communities throughout Oregon (Potentially conduct coordinated clinician visitation opportunities through this method that can be used to introduce clinicians to rural communities and help communities make sound hiring decisions.)	2013 2015 2017		Oregon Locum Tenens Cooperative
	Provide staffing for or designate one or more individuals to watch for potential funding opportunities (e.g. Community Development Block Grants that can be used for health-related capital projects) on an ongoing basis.	By X date		

DRAFT

Objective	Tactics	Timeline	Potential Funding Sources	Best entities to implement the strategic plan
	Market Oregon as a "career destination state" for the primary care providers: • Coordinate with Travel Oregon and Business Oregon to access marketing resources useful for local community's recruitment efforts. • Using input from Oregon's rural primary care providers and clinics, build a robust candidate recruitment website or network that includes practice information and loan repayment resources.	2013 2015 2017		Oregon Health Authority Office of Rural Health Oregon AHEC Business Oregon Travel Oregon Oregon Primary Care Association Oregon Healthcare Workforce Institute
Support successful clinical practice transformation to enable Oregon to be a "career destination state" for primary care providers.	• Accelerate payment reform efforts • Enactment of tort or malpractice reform • Implement administrative simplification for providers and plans (e.g. simplification of billing) • Continue implementation of Patient Centered Primary Care Homes (PCPCH) and other initiatives that enable coordinated patient care and improve practice processes.	By X date?		Oregon Health Authority Community Health Centers Oregon Department of Justice Oregon Legislature Centers for Medicare and Medicaid Services

DRAFT

VI. References[forthcoming]

VII. Appendices

- HB 2366
- Environmental scan of best practices
- Existing recruitment tools in Oregon
- Summary of December 2011 stakeholder meeting
- Other ….

DRAFT

Oregon Healthcare Workforce Committee
2012 recommendations for Oregon Health Policy Board

Discussion Document for Committee Meeting October 10, 2012

At the August 2012 meeting, Committee members began a discussion about which of the group's 2010 recommendations might still be relevant and what new recommendations might be needed. The material below summarizes that initial discussion, including comments received from some members in advance of the meeting. Committee members also expressed a desire for the 2012 report to be more focused and ambitious than the former report. To that end, we will do some work in smaller groups at the October meeting to prioritize among the recommendations currently proposed and to strengthen and add specificity to the few that rise to the top.

Summary of initial discussion and/or comments on recommendations

FROM 2010 -- Revitalize the state's primary care practitioner loan repayment program (short-term)
Discussion/Comments:

- Revise this, in light of new loan repayment program to be created through Medicaid waiver agreement with CMS.
- Should not be a stand-alone recommendation but instead one element of a broader community recruitment strategy; include in the Committee's HB 2366 report (strategic plan for primary care provider recruitment) rather than in report of recommendations to the Health Policy Board?
- For new program, consider options for scenario in which there are not enough interested candidates or eligible sites to fully expend the funds each year

FROM 2010 -- Standardize administrative aspects of student clinical training (short-term)
Discussion/Comments:

- Keep the work going. Standards have been approved, now need implementation strategy and administrative rules.

FROM 2010 -- Revise adverse impact regulations (short-term)

- Monitor this issue. Letter proposing statutory and administrative rule change has been sent to the Higher Education Coordinating Commission.

FROM 2010 -- Maintain resources for health professions education programs (short-term); Enhance resources (long-term)
Discussion/Comments:

- Revise these recommendations - add in specific enrollment or graduate targets and funding amounts for priority health education training programs
- Take the opportunity to connect healthcare reform (workforce specifically) with education reform. E.g. STEM initiative for K-12 should include science and math as preparation for healthcare professional careers.

FROM 2010 -- Expand health care workforce data collection for a more complete picture of Oregon's health care workforce (short-term)
Discussion/Comments:

- Keep working to include more licensing boards and professions in licensing database.

NEW – (Perhaps combined with above) create a centralized data file of healthcare professional *education* capacity in Oregon
Discussion/Comments:

- Data elements should include: current capacity; % of capacity that is filled; recent graduation numbers (as in 2010 and 2012 inventories created by OHWI); and future plans for expanding or contracting capacity. See 8-8-12 meeting summary for more details.

FROM 2010 -- Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand (long-term)
Discussion/Comments:

- Limited comments/discussion on this but some feeling among members that this is still relevant? Suggestions to contract with a neutral body to gather evidence and refine projections and to work with BOLI, licensing boards, Employment Department and others to make sure projections are based on new models of care.

FROM 2010 -- Define new standards for health care workforce competencies
Discussion/Comments:

- Discussion of this recommendation largely pertained to NTHW competencies. Suggestions emphasizing the importance of aligning work, perhaps by having a neutral body take the next step to translate competencies into education programs that will be recognized in the labor market and provide pathways for future educational advancement.

FROM 2010 -- Adopt a payment system that encourages the most efficient use of the health care workforce

- Keep emphasizing the importance of payment reform occurring and reinforcing the practice changes that the Committee wants to see.

FROM 2010 -- Identify barriers (payment policies, credentialing standards, organizational structures, etc.) that prevent health care professionals from practicing to the full scope of their licenses.

- No discussion of specific recommendation(s).

FROM 2010 -- Stimulate local creativity and resource sharing for health care workforce development

- No discussion of specific recommendation(s) for the 2012 OHPB report. However, topic is addressed in strategic plan for primary care provider recruitment under development in response to HB 2366.

FROM 2010 -- Maintain and enhance resources for K-12 math, science, and health career exposure

- Include health occupations in the definition of STEM and support investment in STEM education networks by the OEIB, Governor and Legislature