

Oregon Healthcare Workforce Committee

AGENDA

December 14, 2012

Wilsonville Training Center

29353 SW Town Center Loop E, Wilsonville, Oregon 97070

Room 111/112

9 a.m. – noon

| # | Time | Agenda Item | Presenter(s) | Action Item |
|---|-------|---|---|-------------|
| 1 | 9:00 | Welcome | Chairs | |
| 2 | 9:05 | Approval of October 10 meeting summary | Chairs | X |
| 3 | 9:10 | Updates | All | |
| 4 | 9:20 | Primary care loan repayment program required by 2012 Medicaid Waiver: discussion of design options <ul style="list-style-type: none">• Expert and public testimony• Committee discussion | <i>Anticipated testimony from:</i> Oregon Office of Rural Health; Oregon Association of Naturopathic Physicians; Oregon Academy of Family Physicians; Nurse Practitioners of Oregon; other individuals and organizations may also testify | |
| | 10:15 | Break | | |
| 5 | 10:30 | Final review and approval - strategic plan for primary care provider recruitment (HB 2366) | Lisa Dodson | X |
| 6 | 10:45 | Final development of recommendations for 2012 report to the Health Policy Board | All | X |
| 7 | 11:45 | General Public Comment | Chairs | |
| 8 | Noon | Adjourn | | |

Meeting Materials

1. Agenda
2. October 10, 2012 draft meeting summary
3. Loan repayment program discussion document
4. Final draft: Strategic Plan for Primary Care Provider recruitment (HB 2366)
5. Shell for 2012 recommendations and report

**Oregon Healthcare Workforce Committee
Meeting Summary**

October 10, 2012
1:00 – 4:00 pm

Committee Members in Attendance

Lisa Dodson (Chair, via phone)
Ann Malosh (Vice-Chair)
Peter Angstadt (via phone)
Lita Colligan
Paula Crone
Mauro Hernandez
Mary-Rita Hurley
Andrew Janssen (via phone)
Terri Johanson (via phone)
Mark Richardson

Donna Larson (via phone)
David Nardone
David Pollack
Michael Reyes
Daniel Saucy
Jennifer Valentine
Sergio Vasquez (via phone)
Kristen Simmons (via phone)

OHA and OWHI Staff in Attendance

Jo Isgrigg (OHWI)
Lisa Angus (OHP)
Marc Overbeck

Hilary Gossler
Margie Fernando

Committee Members not in Attendance

June Chrisman
Saige Gracie
Sara Hopkins-Powell
Judith Woodruff

Susan Kirchoff
Kelly Morgan

Ann Malosh convened the meeting and introductions were made.

Lisa Angus pointed out two typos that will be corrected. With that, **meeting summary of August 8, 2012 was approved.**

Updates

- Jo Isgrigg reported that OHWI and OCN are working on the 2012 report from the Oregon Healthcare Workforce Database, going through the licensing data. The report is due at the end of the year.
- Lisa Angus informed the group that the State applied for a State Innovation Model grant that may provide support for testing and extending Oregon's health system transformation work. A key component of the grant request was to establish a Transformation Center to provide a wide range of support and technical assistance to the CCOs, including workforce topics. Maximum award amount is \$60 million; funding is

Notes from 10.10.12 Workforce Meeting

being provided by the Center for Medicare and Medicaid Innovation (CMMI). Awards should be announced in December.

- Mark Richardson gave an update on the new Collaborative Life Sciences building at OHSU. The objective of this center is to focus on collaborative care between the Nursing, Dental, Pharmacy and Medical School and also PSU and Medical graduates. The curriculum for the medical school is also undergoing revision. The building is expected to open in the fall of 2013 and be fully occupied by fall of 2014.

Loan repayment program required by Medicaid waiver

Lisa Angus reminded members about the loan repayment program that OHA is required to set up as part of the CMS waiver by 2013. The amount of this loan repayment program will be \$2 million for providers serving Medicaid populations in rural and underserved areas. Committee members had initial discussion of several design options for the program including eligibility, terms and conditions, and priority for distribution; further discussion and additional opportunities for stakeholder input are planned for the December Committee meeting. Key points made or questions raised in the initial discussion included:

- Primary care should be defined widely (including mental health and dental).
- Should ability to provide services directly be a requirement for provider eligibility for loan repayment? That would translate most directly to access but may preclude some new models of care (e.g. using psychiatrist in a consulting role). What about providing tele-health services (e.g. psychiatry in John Day)?
- Could look at amount of loan debt as factor for prioritizing among applicants.
- Think about this program in the context of other recruitment initiatives and with a long-term vision – if it is temporary, it should be used to plug holes in existing programs (e.g. fill needs not met by the National Health Service Corps), rather than to supplant them.
- Rather than specifying criteria very finely in advance, the program could request applications that specify and demonstrate the particular need in their area. It's more unwieldy but recognizes the fact that need for a given kind of practitioner may vary. Many committee members expressed support for this idea. To tie to transformation, CCOs could act as the applicants for loan repayment funds on behalf of their communities.
- Retention of clinicians is just as important as recruitment. Could prioritize applicants from organization that have a clear retention plan, or minimum staff retention rate.

Staff will bring additional information and options back for discussion at the December meeting.

Latest draft strategic plan for primary care provider recruitment (HB 2366)

Marc Overbeck gave an overview of the latest draft of the 5-year Strategic Plan for Primary Care Provider Recruitment in Oregon (HB 2366). The major objectives of the plan have been organized as follows:

- 1) Expand and improve the pipeline of health care workforce development from within Oregon (“Growing Our Own”)

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- 2) Increase our effectiveness in recruiting primary care providers from outside of Oregon, through recruitment programs, marketing of Oregon as a “destination state” for the practice of primary care, and by bolstering by successful clinical practice transformation (i.e., PCPCH, CCOs, other health care reform, liability reform, etc.)
- 3) Empower communities to increase their skill and capacity in recruiting and retaining primary care providers.

Many points were raised in this discussion, including:

- With the number of entities suggested as candidates for implementing different tactics, there was a concern that implementation would be fragmented. Members suggested having a single entity (e.g. OHA) be responsible for implementation or at least act as a central tracking and reporting body for implementation.
- There was a fair amount of discussion of potential funding sources, something that HB 2366 requires the plan to address. Comments included:
 - Who are the primary beneficiaries of this plan? They should provide support.
 - Consider the state economic development department for some funds, as the healthcare sector brings a significant amount of funding to the state? A 3-legged stool of employers, communities, and economic development might be appropriate.
 - Can some additional funding come from community engagement, tax abatement, creating designations.
 - There is the need to get more creative with funding ideas. Yes, government and health systems would benefit from recruitment but money is scarce at both levels. Think about potential revenue generated from plan activities that might serve as a resource.

Ann Malosh asked committee members to review the plan, including filling in potential targets and to submit comments to Marc, Jo, and/or Lisa by the end of October.

Public Comment

Scott Ekblad from the Office of Rural Health testified that their office administers 3 loan repayment programs in Oregon and has many years of experience. They also have good data available from all their years of administering these programs and are very willing to assist the state with this \$2m grant from the CMS waiver. Mr. Ekblad made several observations about loan repayment programs:

- Contrary to the generally accepted idea that loan repayment money can be easily spent, sometimes the dollar amount is too small to persuade candidates to move to rural areas and sometimes candidates with school age children do not move to rural areas easily.
- The definition of “rural” is not straightforward; some communities are excluded depending on the definition so it’s important match the definition to the program purpose and to do a reality check with a map
- Rural upbringing is a predictor of willingness to practice in a rural area.
- Mark Richardson noted research suggesting that physicians in couples are more likely to settle where the female member of the couple grew up.

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- Redefining primary care as essential care helps keep the definition broad and allows for differences in urban and rural areas (e.g. psychiatry and general surgery are needs in rural areas).
- A minimum work hour requirement could be considered.
- One way to address the question of retention is to require third-party exit interviews.

Mr. Ekblad urged the Committee to tweak the existing but unfunded Primary Care Services loan repayment program, rather than creating a new one and offered to assist with writing legislative language. He would be willing to come to the December meeting, if his help is needed.

Refining recommendations for 2012 report to the Health Policy Board

Committee members reviewed the document summarizing the past meeting's discussion on 2012 recommendations to the Health Policy Board. The high-level discussion identified a few recommendations to be combined and a few others to be put on hold, and a few Committee members volunteered to draft additional language for some recommendations.

Staff will update the list of potential recommendations based on the discussion and distribute it to the Committee. Ann Malosh asked Committee members to review the revised list and identify the top 2 or 3 priorities for further development.

December meeting date

Group agreed to switch the December meeting date to Friday, Dec 14, 2012. Lisa will confirm time once room has been booked.

Meeting adjourned at 4:00pm.

Loan Repayment--Additional Considerations

At the October meeting, Committee members discussed design options for the primary care provider loan repayment program that that state has committed to as part of its 2012 Medicaid waiver renewal. This is intended as a discussion document for the Committee's continued consideration.

Working Principles:

(Based on Committee discussion in October; to be confirmed, revised, and/or supplemented)

- Complement, rather than supplant, existing programs
- Keep program eligibility criteria broad; ask for additional specification and demonstration of need in program applications (note: CMS will need to approve)
- Support Oregon's health care reforms
- Incorporate requirements for retention planning into program application
- Others?

| Issue & Context | Options (not mutually exclusive in every case) | Pros / Cons |
|--|--|--|
| <p>How many clinicians will be able to receive awards?</p> <p>NHSC currently offers \$30,000 per year for to years for federal loan repayment. A smaller award size would allow more clinicians to receive funds.</p> | A. Offer \$30,000 per year for up to three years—min. 40 clinicians | <p>Pro: This is the same amount of money as offered by NHSC, and likely attractive to clinicians</p> <p>Con: Smaller awards would allow more clinicians to receive funds</p> |
| | B. Offer smaller awards (\$20,000 per year) to more clinicians—min. 60 clinicians | <p>Pro: Smaller award allows more to participate</p> <p>Con: May not be as attractive to clinicians with higher debt loads</p> |
| | C. Offer very small awards (\$10,000 per year) to a large number of clinicians—min. 120 clinicians | <p>Pro: Small award allows multiple awards</p> <p>Con: Small award likely not of interest to many clinicians; may not be the motivator anticipated by the program</p> |
| | D. Construct the program to allow a fixed percentage of debt (e.g., 20% of total loan amount), up to a fixed amount (e.g., \$30,000) | <p>Pro: May allow for more awards to be made</p> <p>Con: May make it more difficult to identify the number up front</p> |
| <p>Where should funds be targeted/what is the service area eligibility?</p> | A: Only offer awards in designated geographic Federal Health Professional Shortage Areas (HPSAs), where the need has been determined for the area's entire population. | <p>Pro: Easy to categorize and allows for awards to go where need has been determined for a whole population</p> <p>Con: May not be appropriately targeted to Medicaid patients.</p> |

| Issue & Context | Options (not mutually exclusive in every case) | Pros / Cons |
|--|--|--|
| | <p>B: Offer awards in designated geographic OR population-based Federal Health Professional Shortage Areas (HPSAs), which includes areas where only a particular population (e.g., low income individuals) suffers a shortage of available health care providers</p> | <p>Pro: Use of existing HPSA designations allows for coordination of resources with other major healthcare workforce programs in Oregon (e.g., J-1 Waiver, NHSC)</p> <p>Con: May be other methodologies to better determine need</p> |
| | <p>C: Offer awards ONLY designated low-income HPSAs (not geographic or other population HPSAs)</p> | <p>Pro: Allows prioritization of resources to low-income, and potentially Medicaid-eligible populations</p> <p>Con: Could leave out other areas of the state with ability to use the program</p> |
| | <p>D: Make awards available for any clinician in a HPSA or a Medically Underserved Area/Population</p> | <p>Pro: Provides for maximum flexibility</p> <p>Con: Does not sharply target resources on the Medicaid population</p> |
| <p>Rural communities are disadvantaged when it comes to their workforce capacity to meet the health care needs of rural communities. According to OHA's 2011 report, only 10% of active, licensed physicians are practicing in rural communities. Yet, rural communities contain 37% of Oregon's population.ⁱ</p> | <p>A: Identify a set number (e.g. 50%) of awards to be made available to clinicians who agree to practice in rural areas</p> | <p>Pro: Supports goal of increasing access to care for rural Oregonians</p> <p>Con: May prevent qualified, deserving clinicians in non-rural areas from taking advantage of the awards.</p> |
| | <p>B: Make no distinction between rural and urban areas, and prioritize awards all areas based on HPSA score or some other agreed upon methodology.</p> | <p>Pro: Allows awards to areas where need is seen as greatest, regardless of rural/urban designation</p> <p>Con: May allow rural areas to fall further behind non-rural areas in developing health care workforce capacity.</p> |
| <p>People of color are underrepresented in some health care professions in Oregon;ⁱⁱ evidence suggests that minorities are more likely to work in underserved areasⁱⁱⁱ</p> | <p>A: Offer priority consideration for clinicians from communities of color.</p> | <p>Pro: Provides an opportunity for qualified health professionals of color to serve who otherwise would not.</p> <p>Con: May allocate resources where need is not determined to be greatest overall.</p> |
| | <p>B: Do not offer any priority consideration for clinicians of color</p> | <p>See above, only reverse</p> |
| <p>Method of application for funds</p> <p>The traditional model for a loan repayment program involves the</p> | <p>A: Clinicians, with the support of their (intended) practice sites</p> | <p>Pro: Clinicians are the ones who assume legal responsibility for the commitment to practice;</p> <p>Con: May not be the optimal way to distribute finite</p> |

| Issue & Context | Options (not mutually exclusive in every case) | Pros / Cons |
|--|---|---|
| <p>clinician applying directly to the grantor of funds. In programs where a “match” is required, the clinician may apply in conjunction with a practice site which guarantees certain contributions. The Workforce Committee expressed interest in having Coordinated Care Organizations potentially play a role in the application process.</p> | <p>B: Clinics, which would apply to the program and identify specific positions in their organization for which loan repayment would be used as a recruitment (or retention?) incentive</p> | <p>resources in conjunction with local need</p> <p>Pro: Clinics have flexibility to allocate resources as necessary</p> <p>Con: Different clinics may use different criteria to identify which positions would be offered loan repayment</p> |
| | <p>C: CCOs, which would collect applications from their service area, conduct pre-review of applications, and apply to the program</p> | <p>Pro: Promotes health system transformation work and acknowledges leading role of CCOs</p> <p>Con: Not clear how this would interact with geographic eligibility (not all CCOs operate in underserved areas) or eligibility for Medicaid providers outside the CCO.</p> |

Additional discussion question: How should the program be marketed to encourage a high volume of qualified applicants?

ⁱ Oregon Health Authority (2011.) *Oregon Health Professions: Occupational and County Profiles*. Available at http://www.oregon.gov/OHA/OHPR/RSCH/docs/Workforce/Final_2010_Oregon_Health_Profession_Profiles.pdf

ⁱⁱ Derksen, Daniel, and Ellen-Marie Whelan (2009.), “Closing the Health Care Workforce Gap: Reforming Federal Health Care Workforce Policies to Meet the Needs of the 21st Century.” Available at http://www.americanprogress.org/issues/2010/01/pdf/health_care_workforce.pdf

ⁱⁱⁱ Saha & Shipman. (2006). *Rationale for diversity in the health professions*. HRSA. Available at: <http://bhpr.hrsa.gov/healthworkforce/reports/diversity/>

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

** WORKING DRAFT **

12-10-12

Executive Summary

In 2011, the Legislature adopted HB 2366, tasking the Workforce Committee to develop a “strategic plan for recruiting primary care providers to Oregon.” The plan was to address best recruitment practices and existing recruitment programs, development of materials promoting Oregon as a desirable place for primary care physicians to live and work, pilot programs, potential funding opportunities, and entities best suited to implement the plan. The Committee engaged a number of interested parties in developing the strategic plan.

The Workforce Committee set out a vision that *Oregon will be a model for efficient, coordinated primary care recruitment and retention efforts in the United States. All areas serving all populations will be competitive with other states and regions for the recruitment of primary care providers in order to ensure access to high quality health care for all Oregonians.* The Committee developed three overarching goals as the focus of the strategic plan, along with strategies to achieve these goals:

“Grow Our Own”: produce more primary care professionals in Oregon

- Increase the output of primary care educational programs
- Increase the capacity of the Rural Scholars Program
- Invest in programs that develop and encourage high school and undergraduate students to choose primary care careers
- Study the need for training programs for emerging health workers who will be part of the service delivery teams of the future

Increase Oregon’s effectiveness at external recruitment

- Increase and coordinate efforts to link organizations and candidates to the available resources
- Market Oregon as a “career destination state” for the practice of primary care
- Encourage investment in the Locum Tenens program
- Support clinical practice transformation
- Designate one or more individuals to watch for potential funding opportunities

Support Communities: Empower rural and underserved communities to recruit and retain primary care providers

- Increase involvement of local businesses, economic development and others in recruiting providers by promoting a community engagement approach
- Encourage inclusion of health care professional recruitment incentives when enterprise zones are negotiating tax abatement
- Foster collaboration among business and economic development to support a community's ability to recruit
- Develop a recruitment "tool kit" for communities, that includes marketing material , information on workforce programs and proven strategies for successful recruitment and retention
- Ensuring continued analysis of federal Health Professional Shortage Area (HPSA) scores to maximize access to federal resources for loan repayment and other financial incentive programs.

The Committee anticipates that a five-year time frame is needed to accomplish the work in the strategic plan and that a number of different entities must take coordinated action to achieve the Committee's vision for primary care provider recruitment.

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 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

Information about best practices for recruitment and descriptions of existing recruitment efforts can be found Sections II and III, as well as in the environmental scan in Appendix B. Suggestions regarding promotional materials and practitioner visiting opportunities are included with other recommendations under Strategic Objectives and Plan (Section IV), where funding resources and suggestions for implementation are also addressed. In addition, adequacy of undergraduate and graduate medical education is addressed in Section IV with further details outlined in Appendix E.

Because the distribution of health professionals is just as important as total numbers for ensuring an adequate workforce², recommendations in this report are particularly (but not

¹ Enrolled HB2366, 2011 Legislative Assembly

exclusively) targeted toward Oregon’s underserved geographic areas and populations. Underserved populations include low income individuals, migrant and seasonal farmworkers, homeless individuals, and Medicaid recipients. Underserved geographic areas include both areas that currently have a shortage of physicians, and those 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 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*. While parts of HB 2366 specifically address physician workforce, this report references a more classification of primary care workforce, including advance practice nurses, physician assistants, dentists, pharmacists and, to a limited extent, emerging health professions such as Community Health Workers. This definition is intended to include medical, community based dental and mental health care services across professions.

I. Background

Current Primary Care Capacity in Oregon

Primary care provider shortages 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

² Dower & O’Neil. 2011. *Primary health care workforce in the United States*. The Robert Wood Johnson Foundation. Research Synthesis Report no. 22.

practitioner or physical therapist listed an address, and one county with no registered nurses.³ (See maps of HPSA Designations in Appendix G.)

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. Hospital employment is projected to grow more slowly, by 25%.

There were 10,822 active licensed physicians practicing in Oregon in 2010; however, only 38% of those physicians were practicing in primary care³. 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. Many experts cite an ideal ratio of approximately 50% primary care providers as the optimal workforce target.⁴ Using this target further increases the relative deficit of primary care providers in the workforce.

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. This trend has been attributed to a number of factors, including increasing student educational indebtedness, higher reimbursement for specialists and urban physicians, lower prestige for primary care, scope of practice concerns, decreasing percentages of rural and other underrepresented students at elite institutions, and a generational trend to place a higher value on a work/life balance than previous generations.^{5 6}

The population-to-primary care physician ratio in Oregon in 2010 was 930:1.3 This statewide ratio is well below the highly cited figure of 1,500:1 that continues to be referenced by experts

³ Oregon Health Policy and Research (2011) *Oregon Health Professions: Occupational and County Profiles*. Available at http://www.oregon.gov/OHA/OHPR/RSCH/docs/Workforce/Final_2010_Oregon_Health_Profession_Profiles.pdf

⁴ Lasser, Daniel H., MD (2012), *UMASSMed Now*, University of Massachusetts Medical School

⁵ American College of Physicians (2008) *The Case for Young Physician Leaders*. Available at http://www.acponline.org/meetings/internal_medicine/2011/handout

⁶ 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.

today.⁷ Many areas of the state, however, do not meet this population-to-primary care physician 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.³ 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 approximately 1100 (10%) were actively practicing in rural areas³. A full 37 percent of the population resides in these areas³. Reasons for this include a perceived lack of availability of employment for spouses, opportunities for entertainment and cultural activities, quality of K-12 education, a perception of being “on call” at any time, a lack of availability of specialists and fewer opportunities for 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 populations⁸

Using a model based on five factors (percentage of primary care visits to need; rate of ambulatory care sensitive conditions; travel time to nearest hospital; comparative mortality ratio, and low birthweight rate) the Oregon Office for Rural Health finds that 59 of the state’s 105 rural service areas have unmet need.⁸ 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 would require at least 88 primary care physicians, working full time, properly distributed to shortage areas, in order to remove all the federal primary care medical designations.

Advanced registered nurse practitioners (NP) and registered nurses (RN) are also 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.³ 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

⁷ Centers for Disease Control and Prevention (2012), *National Ambulatory Medical Care Survey*. Available online at www.cdc.gov/nchs/namcs.htm

⁸ Oregon Office of Rural Health. *2011-12 Area of Unmet Health Care Need in Oregon*. Available online at: <http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf>

concentrated in the metropolitan counties in the state: a full 53 percent of the total number of NPs practicing statewide are practicing in Multnomah, Washington and Clackamas Counties.⁹

A limited number of nurse educators 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). Nursing faculty are significantly older than the general population and an increased rate of retirement is expected to cause further stress to nursing education in the next decade.

In 2010, there were 918 active licensed physician assistants practicing in Oregon, 45% of whom identified a practice associated with a primary care specialty. As with NPs, Oregon's Physician assistants (PAs) enjoy relatively more autonomy in practice than in many other states, but 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 (and 53% of NPs).³ 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 hundred³.

Demand for new health care professionals is expected to continue to increase in the coming years. Contributing to this demand is an aging population as well as aging of the existing primary care workforce itself. 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)³. 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 close to 400,000 who will be newly

⁹ OHPR OHWI(2011)

eligible for medical insurance coverage in 2014 as a result of national health care reform¹⁰, 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 B. 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 have 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 as early as elementary school level and continuing through college and university education, 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. Retention is increasingly recognized as a valuable tool that reduces cost of recruitment and increases stability in the health care sector.
- Many plans highlight the need to create incentives targeted by provider type: loan repayment may be more attractive to dentists, physicians and others with high debt burdens; incentives like salary, benefits, or sign-on bonuses could be of greater impact for other providers. Loan forgiveness and repayment programs--as well as scholarship programs--effectively address student concerns about entering primary care careers with high levels of indebtedness.
- Adequate funding for coordinated recruitment and retention initiatives 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.

¹⁰ Urban Institute (2011), *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid* Available at <http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf>

Existing Incentives for Recruitment in Oregon

The primary recruitment incentives available statewide in Oregon are federal and state loan repayment or forgiveness programs, a small state tax credit for rural providers, and an Oregon rural medical liability subsidy program. A full description of these programs can be found in Appendix C; 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 incentives and tools; a few of these are also described in Appendix C.

II. 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 ensure access to high quality health care for all Oregonians.

III. Strengths, Weaknesses, Opportunities, and Threats

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.

With respect to physicians, Oregon has not historically educated a sufficient quantity of practitioners to meet its needs, particularly in the area of primary care residencies, and has been and continues to be an importer of trained physicians, according to 2012 Licensing Board data. Oregon has only 27 first year resident positions per year in 3 Family Medicine programs. By comparison, Washington, with a population less than double that of Oregon (3,871,859 vs 6,830,038) has more than 100 new Family Medicine residency positions annually.¹¹ Idaho, with a population less than half that of Oregon, has 22 new positions each year.

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)

¹¹ National Resident Matching Program, Results and Data: 2011 Main Residency Match. National Resident Matching Program, Washington, DC. 2011.

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 of students preparing for health careers from which to recruit. Oregon AHEC reaches 34 of 36 Oregon counties, delivering health careers education to more than 12,000 rural students and teachers in 2011-12. Oregon AHEC programs include health careers occupations clubs and camps, In-A-Box Science curriculum, college student Day in the Life experiences, Health Career exploration days, and Health Career Opportunity programs
- 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.
- 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. Oregon's Coordinated Care Organizations (CCOs) lead the nation in innovative healthcare delivery models for Medicaid populations. If these reforms 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; this creates 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. Since November 2011, the OLTC has more than doubled its membership—from 10 members to 22, and has increased its capacity for coverage by 500% since November 2011.
- An Oregon tax credit of \$5,000 for rural providers provides both a recruitment and retention 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 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.¹² OHSU has among the highest tuition and graduate debt load of any state-supported medical school in the U.S.¹³ 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.

¹² Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices, 2009, The Robert Graham Center, Washington DC

¹³ <http://www.ohsu.edu/xd/education/schools/school-of-medicine/about/school-of-medicine-news/education-news/lcme-update-71112.cfm>

- 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, close to 400,000 Oregonians are anticipated to acquire health care coverage¹⁰. This creates a significant pool of potential patients but is also a threat to system capacity.
- 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.
- 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. Between the beginning of 2011 through October 2012, Oregon has seen the number of National Health Service Corps clinicians increase from 124 to 192. Further, work that has been done to analyze health professional shortages has enabled an additional 300 clinicians to be eligible for the program, beginning in January 2013.
- 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. (Note: The positive effect of this program will be reduced if it entirely replaces existing incentives such as the Loan Forgiveness program established in the 2011 Session.)

- A strong trend toward physician employment by large health systems (see also threats), may lessen 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 with physician employees.
- Oregon's commitment to train 300 Community Health Workers may also increase practice resources available to clinicians can practice, provided that adequate training and incentives are available to encourage widespread and appropriate use of CHWs in the new healthcare system.

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 physicians and other practitioners are wary in this time of transition, reducing the ability to recruit new clinicians and threatening retention of others.
- An anticipated expansion of insured population in 2014 (also an opportunity) will increase income potential for some providers, 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.
- A strong trend toward physician employment (see also opportunities) requires changes in recruitment and retention strategies, as well as changes in support for physicians who remain in independent practice.
- An inadequate state budget has a direct effect on recruitment via reduced health care facility reimbursement and budgets and therefore hiring capacity in many health care professions, as well as an indirect effect through reduced funding for health care education programs. Uncertainty in budgets creates an environment not conducive to willingness to engage in the changes necessary for health reform.

IV. Strategic Goals and Plan

Based on its review of best practices and assessment of Oregon’s current strengths and weaknesses, the Committee proposes the following three strategic goals for primary care provider recruitment in Oregon: 1) produce more primary care professionals in state; 2) improve Oregon’s competitiveness for recruiting professionals from out of state; and 3) support planning and recruitment at the local level, where professionals will live and work. Recommendations for specific strategies in each of these areas are listed below, along with suggested timelines, potential funding sources, and ideas about which groups or institutions are best suited to implement a particular strategy.

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|--|---|----------|--|---|
| Grow Our Own: produce more primary care professionals in Oregon | Increase output of Oregon primary care educational practitioners educated through Oregon’s health care professional training programs (particularly MD/DO, PA, and NP programs) | 2016 | Tuition; educational institution investments & endowments; General Fund support | Oregon State Legislature Educational institutions with MD/DO, NP, and PA training programs |
| | Increase number of Oregon residencies. | 2015 | Health systems; Medicare after first three years; private foundations | AHEC; Health systems; |
| | Expand Oregon’s Primary Health Care Loan Forgiveness program by at least 10 participants. | 2014 | General Fund support; Educational Institutions; private or community foundations | Oregon State Legislature Oregon Office of Rural Health |
| | Increase capacity of the Oregon Rural Scholars Program to 10% of the OHSU medical school class; open the program to nursing, physician assistant, osteopathic, pharmacy and dental students equal to up to 10% of class size at schools throughout the state. | 2014 | Oregon Educational Institutions; private or community foundations | Oregon Area Health Education Center Program (OR AHEC) |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|--|---|---|---|--|
| | Study the need for training programs for emerging health care workers who will be part of the primary care delivery team, (e.g. Community Health Workers, peer mental health counselors, social workers and others). | 2013; report back to Workforce Committee by end of 2013 | Done within existing resources | Oregon AHEC |
| | Invest in or maintain programs that that develop and encourage high school and undergraduate students to choose primary health care careers (basic science and math education, high-school health professions programs, Area Health Education Centers, etc.). | Ongoing | STEM initiative; private and/or foundation funding; Educational GF appropriations | AHEC; Public and private education programs (K-16) |
| Increase Oregon’s effectiveness at external recruitment | Increase and coordinate efforts to link organizations and candidates to the available resources, including meeting with recruitment groups. | Ongoing | Use existing funding | Oregon Primary Care Office Oregon Office of Rural Health Oregon Primary Care Association |
| | Market Oregon as a “career destination state” for the primary care providers: <ul style="list-style-type: none"> • 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. | Ongoing | Oregon Legislature | Oregon Health Authority Office of Rural Health Oregon AHEC Business Oregon Travel Oregon Oregon Primary Care Association Oregon Healthcare Workforce Institute |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|------|--|-------------|---|---|
| | <p>Encourage investment by health care organizations (rural and underserved clinics and hospitals) in the Oregon Locums Tenens Cooperative (OLTC) to ensure community access to affordably priced locum tenens services in 50% of eligible rural and underserved sites, or at least 30 communities throughout Oregon</p> <p>Promote the OLTC as a means to conduct coordinated clinician visitation opportunities that can be used to introduce clinicians to rural communities and help communities make sound hiring decisions. The OLTC Loan to Practice (L2P) program coordinates with the Primary Care Office to recruit potential NHSC eligible providers (see Appendix F for details)</p> | By 2014 | Clinics and Hospitals | Oregon Locum Tenens Cooperative; Oregon Area Health Education Center; Oregon Primary Care Office |
| | <p>Support clinical practice transformation to help make Oregon a “career destination state” for primary care providers.</p> <ul style="list-style-type: none"> • 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. | Ongoing | CMS; Oregon Legislature; other federal entities and private sources as appropriate. | Oregon Health Authority; Health care professional associations; Community Health Centers, Rural Health Clinics, Health Systems, Hospitals, and all other delivery system entities |
| | 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. | Immediately | Use existing resources | Oregon Primary Care Office |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|--|---|--|--|---|
| Support Communities: Empower rural and underserved communities to recruit and retain primary care providers | Increase involvement of local business, economic development organizations, and others in recruiting primary care practitioners, by promoting a (Rimrock Alliance-type) community engagement approach | 4 communities in 2013 8 by 2015 12 by 2017 | Local chambers; city and county funding; hospital districts; | Local communities, with help from: Oregon Primary Care Office, AHECs, Office of Rural Health, Oregon Primary Care Association, Regional economic development entities |
| | Encourage inclusion of health care professional recruitment incentives when enterprise zones are negotiating tax abatement with large businesses - E.g. Work with local business to fund required community match for the HRSA state loan repayment program (SLRPP). | Ongoing | Not applicable | Business Oregon Local economic development organizations Office of Rural Health |
| | Foster collaboration among business (including health care) and economic development constituencies to address issues that affect the community's ability to recruit (education system, tax structure, physical infrastructure, etc.) | Ongoing | Not applicable | Business Oregon; Office of Economic Development; Governor's Office; Office of Rural Health; Local communities and businesses |
| | Develop a recruitment tool kit for communities which 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. | By 2014; update annually | Unknown; may or may not require additional resources | Oregon Primary Care Office and partners |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|-------------|---|---------------------------|----------------------------------|--|
| | 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 February 2013, ongoing | Not applicable | Oregon Primary Care Office |

DRAFT

Readers will note a number of different groups and institutions listed in the right-hand column as the best entities to implement specific recruitment strategies for Oregon. The Committee feels that coordination among these potential actors—and among the strategies themselves—is most critical at the community or regional level. Communities and local employers are in the best position to identify the need for particular providers, and to judge which recruitment strategies would be most useful in their situations. The Committee also believes that cooperation between private and public employers is most feasible at the local level. The best entity to keep track of the range of primary care provider recruitment strategies being implemented across the state, and to consolidate information about progress toward the goals outlined in this plan is the Workforce Committee itself.

V. Appendices

- A. HB 2366
- B. Environmental scan of best practices
- C. Existing recruitment tools in Oregon
- D. Summary of December 2011 stakeholder meeting
- E. Graduate medical education “white paper”
- F. Oregon Locum Tenens information
- G. Health Professional Shortage Area maps

Enrolled
House Bill 2366

Sponsored by Representative NATHANSON; Representatives BARKER, DEMBROW, DOHERTY, GELSER, HOYLE, THOMPSON, Senators DEVLIN, MONNES ANDERSON (Presession filed.)

CHAPTER

AN ACT

Relating to recruitment of primary care physicians; and declaring an emergency.

Whereas Oregon’s population is growing faster than the number of licensed, active and practicing primary care providers in Oregon; and

Whereas retirement of primary care providers is outpacing replacement; and

Whereas there is an acute shortage of primary care providers, particularly in rural communities; and

Whereas stabilizing and increasing Oregon’s health care workforce is a top priority for the Oregon Health Authority and the Oregon Health Policy Board; now, therefore,

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

SECTION 1. The Oregon Health Authority, through the Health Care Workforce Committee created pursuant to ORS 413.017, shall work with interested parties, which may include Travel Oregon, the State Workforce Investment Board, medical schools, physician organizations, hospitals, county and city officials, local chambers of commerce, organizations that promote Oregon or local communities in Oregon, and organizations that recruit health care professionals, to develop a strategic plan for recruiting primary care providers to Oregon. The strategic plan must address:

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

SECTION 2. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.

Passed by House April 21, 2011

Repassed by House June 6, 2011

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Ramona Kenady Line, Chief Clerk of House

.....
Bruce Hanna, Speaker of House

.....
Arnie Roblan, Speaker of House

Passed by Senate June 1, 2011

.....
Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2011

Approved:

.....M,....., 2011

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M,....., 2011

.....
Kate Brown, Secretary of State

Environmental Scan—Provider Recruitment Strategies

In response to House Bill 2366, an environmental scan of best practices and existing recruitment plans was undertaken, drawing on local, state, and multi-state/regional plans and strategies used throughout the country. The information was compiled and analyzed for common themes as well as notable differences. In addition to presenting summary findings, this document identifies and describes promising practices from specific plans that may be applicable to the work at hand in the State of Oregon.

Summary Findings

Common themes throughout recruitment plans:

- The number of stakeholders is very large and diverse, with often competing interests or market share.
- The growing recognition, among cities and towns, as well as organizations, that each one is competing against the other to recruit and retain the same limited pool of applicants. The theme of the plans attempts to capitalize on creating the awareness of this shared need and getting stakeholders to work together.
- Most plans discuss the key importance of pipelines, beginning at the elementary level, of feeding the interest in and availability of locally-available healthcare training programs.
- Most call out the difficulty in establishing common data parameters around all of the data available. The example of what is a full-time FTE alone varying tremendously among providers.
- Importance of adequate funding sources, without which most of the initiatives will either not even get off of the ground, or fail once initiated.
- Many focus on rural access and spend little to no time discussing urban pockets of inaccessibility.
- Most plans tie retention into the recruitment plan/initiative.
- Many highlight the need to create incentives targeted by provider type: loan repayment more attractive to dentists and physicians than to those providers with less intensive and expensive training, where things like salary, benefits, sign-on bonuses could be of greater impact.

Noted differences in recruitment plans:

- There is incredible variation in level of industry v. governmental resources and programs for recruitment initiatives by state. This includes access to “Office of...”s as well as loan repayment programs.
- There are some plans that call for changing the scope of various providers (i.e. dental hygienists/physician assistants/nurse practitioners) in order to address the need. Some do not even touch on this as a possible source of additional primary care resources.
- Some plans/groups discuss engagement in regional marketing to recruit and retain health professionals. Others have minimal discussions around shared marketing initiatives.
- Some of the ‘plans’ act more as sample process and procedure manuals, explaining best practices and even offering templates for pieces of the recruitment process (i.e. site visit sample itineraries, sample recruitment contracts, etc.)
- Plans varied from being solely physician focused, to including Advanced Practice Providers, to being very generally healthcare focused and wrapping in technicians and nursing staff. Very few had any focus on approaches with alternative care providers.

Additional Findings: Multi-state/collaborative work

Arizona/Illinois/Mississippi/Virginia (state primary care associations collaborative):

Recruitment and Retention Best Practices Model, 2005

<http://www.nachc.org/client/documents/Recruitment%20%20Retention%20Best%20Practices%20Model.pdf>

- This document has many useful procedures outlines and a number of sample checklists, document drafts, job descriptions, etc.
- This plan also had a number of best practices in retention, largely aimed at individual organizational initiatives, rather than regional or statewide initiatives.

CHAMPS (Community Health Assn. of Mt/Plains States):

Physician Recruitment Plan: Steps for Recruiting Success

<http://www.champsonline.org/ToolsProducts/RRResources/PhysicianRecruitmentPlan.html>

- This plan talks about strategic use of the NHSC (National Health Service Corps) vacancy lists, as rural and CHCs have great appeal to these healthcare professionals.
- These organizations have pooled resources and created a Job Opportunities Bank to advertise all opportunities of member organizations within their geographic area (<http://www.champsonline.org/JobBank/JobOpportunitiesBank.html>)

- This association has created a webcast and printable handouts highlighting community-based recruitment strategies and tactics, entitled, “Successful Recruitment in Challenging Times: A Community-Based Approach to Keeping your Edge with Limited Candidates and Shrinking Funds”.

New England Regional Collaborative:

New England Regional Healthcare Workforce Collaboration (Sept. 2008)

http://www.nosorh.org/resources/files/NE_RegionalHealthcareWorkforceCollaboration.pdf

- Part of this plan focused in good detail on pipeline expansion initiatives in getting adequate healthcare resources. They also examine scope of practice, and recommend forums, resulting in redesign and change in scope.
- They offered the following initiatives:
 - Engage in group purchasing of headhunter firms.
 - Explore job redesign to keep older staff working
 - Development of regional website as locus of regional information on best practices
- Plan development included a stakeholder survey that may be useful source of questions for a similar effort in Oregon

NW Regional Primary Care Assn (AK, OR ID, WA):

Strategic Recruitment Planning: What’s in your Medical Staff Recruitment ToolBox?

<http://www.NWRPCA.org>

http://www.nwrpca.org/images/stories/2010/workforce/direct_recruitment/General-Strategic_Recruitment_Planning.pdf

- This organization has a toolkit available online to aid individual groups in recruitment initiatives, as well as a job bank that appears to be underutilized and appears somewhat difficult to navigate.

Additional Findings: State-specific work

Connecticut:

Averting Crisis: Ensuring Healthcare for Future Generations in Connecticut CT Hospital Association (April 2007)

http://www.chime.org/hospital_issues/workforce/pdf/Averting_Crisis-HCWorkforceReport.pdf

- The state hospital association has initiated several workplace development initiatives. One of the more creative is to offer educational opportunities to the healthcare workforce,

providing over 100 educational and leadership development programs, reaching more than 4,500 healthcare providers each year

Idaho:

The Community Apgar Project: A Validated Tool for Improving Rural Communities' Recruitment and Retention of Physicians (Dec. 2010)

http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/120110_apgar_assessment.pdf

Idaho Rural Family Physician Workforce Study: the Community Apgar Questionnaire (July 2011)

http://www.rrh.org.au/publishedarticles/article_print_1769.pdf

- Idaho appears to have focused much effort around family medicine physician recruitment. Their Community APGAR profiling has been extensively written about and appears to be spreading to other states. The Community APGAR test assesses attributes and capabilities of communities based on historical trends within that community. The assessment is designed to allow real-time identification of factors that need to be addressed in order to positively influence recruitment outcomes.

Louisiana:

Primary Care Recruitment and Retention Services Unit:

<http://www.dhh.state.la.us/offices/page.asp?id=88&detail=3818>

- Offers a state loan repayment program midlevel providers, in addition to physicians:
(<http://www.dhh.state.la.us/offices/page.asp?ID=88&Detail=4986>)

Massachusetts:

Health Workforce Issues in Massachusetts, The Massachusetts Health Policy Forum (June, 2000)

<http://masshealthpolicyforum.brandeis.edu/publications/pdfs/09Jun00/IBHealthWorkfrclissues%209.pdf>

- Provides good recommendations and guidance in data collection, analysis and dissemination of labor market and utilization information

Michigan:

Addressing the Primary Care Workforce Crisis—Together (Sept. 2009)

<http://apps02.crosstechpartners.com/dpm/Client/MPCA/FilesStage/9-29-09%20Primary%20Care%20Workforce%20Meeting.pdf>

Primary Health Care Profile of Michigan (Oct. 2008)

<http://www.mpca.net/Client/MPCA/Files/profiles%20introduction.pdf>

- BCBSM Physician Group Incentive Program (PGIP)

- State Loan Repayment Programs are expanded here to include: PCPs, extenders, nurse midwives, mental health and dentists

Mississippi:

Mississippi’s Physician Labor Force: Current Status and Future Concerns (Oct. 2003)

<http://www.healthpolicy.msstate.edu/publications/laborforcereport.pdf>

- Recommends that data concerning recruitment of physicians who have graduated from medical schools outside the state of Mississippi be gathered and analyzed. Previously implemented Mississippi recruitment programs should be evaluated, in addition to the needs of potential physician recruits. Mississippi residents attending out-of-state medical schools should be tracked.
- Recommends looking at policies and programs throughout the country in order to recruit and retain more female and minority physicians. More than any other plan encountered, this one highlighted the importance of diversity in the providers being recruited.
- Recommends looking at malpractice climate and premiums as a possible deterrent to recruitment and recommends that mitigating this may benefit both recruitment and retention.
- Offers a comprehensive look at the particular challenges of rural recruitment.

Montana:

Montana Healthcare Workforce Plan—Recruiting Strategy (Aug. 2011)

<http://healthinfo.montana.edu/mthwac.html>

- Montana has a robust workforce plan, broken into many different strategies and sub-strategies. There is also a Montana Recruitment Collaborative that has come together and owns a list of specific strategies. This is housed in a robust document which appears to be ‘living’, which includes not only the strategies, but also measures and outcomes (one of these is built off of the ID APGAR) associated with each one:

(<http://healthinfo.montana.edu/MTHWAC/Recruiting%20Health%20Professionals%20to%20Montana.docx>)

- Several robust loan repayment programs available from the State as well.
- “Come Back to Montana” marketing campaign (for those who left the state for training)

North Dakota:

North Dakota Health Care Workforce: Planning Together to Meet Future Health Care Needs, Center for Rural Health, University of North Dakota, (April 2007)

<http://ruralhealth.und.edu/projects/nursing/pdf/HealthCareWorkforcePolicyBrief2.pdf>,

- Calls out need to educate legislators and voters about the ‘perfect storm’ of the aging workforce and needs of an aging population

South Carolina:

Maximizing your Primary Care Recruitment Plan: Tapping into Current Federal and State Programs and Resources, March 2010

<http://scorh.net/services.php?pid=10>

<http://www.scorh.net/Maximizing Primary Care Recruitment>

- State grant program for primary care physicians that is up to \$40,000 over a four-year period.
- Highly innovative primary care regional locums tenens program in place, that has four FPs and 1 pediatrician on staff. They charge significantly less than firms, and provide malpractice.
- Offers a provider recruitment database to organizations, and run an opportunities website where postings can be placed by organizations throughout the state

Virginia:

Health Care Workforce Annual Report, (June 2010)

<http://www.vahealth.org/irb/documents/2011/pdf/RD227.pdf>

- Legislation requires that the State Health Commissioner submit an annual report regarding activities of the Virginia DOH in recruiting and retaining health care providers, to include success metrics as well as recommendations for new programs, activities and strategies.
- Monitors use and efficacy of national rural recruitment website, 3RNet (www.3rnet.org) in the state
- Established Rural Workforce Awards, recognizing the efforts of individuals and organizations in their efforts to improve and expand the health workforce in the rural areas of Virginia. During the Workforce Summit, there were five awards given to individuals and organizations that have significantly contributed to rural communities through initiatives designed to address Virginia's healthcare workforce shortage.
- Sponsors a “Choose Virginia” conference for medical students that is subsidized and focuses on career building and clinical sessions (http://www.vafp.org/PDF-Files/2011%20Choose%20VA%20Student%20Brochure_Layout%201.pdf)

Vermont’s Plan:

Primary Care Workforce Development Strategic Plan (May 2011)

<http://dvha.vermont.gov/budget-legislative/primary-care-workforce-strategic-plan-with-correction-06-13-11.pdf>

- Set a measurable and time-bound goal of increased practitioners within their strategic plan (X number of providers by Y date)
- One of the only plans to call out naturopathic primary care
- Discusses the role of partner/spouse employment in recruitment and retention
- The state employs a “Physician Placement Specialist” who connects employers to residents and practicing providers.
- Created a “Top Ten Reasons to Practice Medicine in Vermont” marketing piece that offers compelling information for prospective providers.
- The report contains good detail on the impact of healthcare reform on primary care workforce needs overall.

Washington:

Rural Health Care: A Strategic Plan for Washington State (Summer 2009)

<http://www.wsha.org/files/1st%20Edition%20-%20Rural%20Health%20Plan%20-%20WA.pdf>

- Recommends utilizing new technology in order to improve support to practitioners in rural areas in access to continuing education and in addressing professional isolation issues

Washington State Legislature: Rural and Underserved Areas-Health Care Professional Recruitment and Retention (Chapter 70.185 RCW)

<http://apps.leg.wa.gov/rcw/default.aspx?cite=70.185&full=true>

- The state has charged University of Washington with the development of a robust primary care physician shortage plan, targeting underserved and rural areas.
- Washington has legislated a ‘Health Professional Recruitment and Retention Clearinghouse’, charged with:
 - Inventory and classification of current public and private health professional recruitment and retention efforts
 - Identification of recruitment and retention program models having the greatest success rates as well as gaps in recruitment and retention program gaps
 - Working with existing recruitment and retention programs to better coordinate statewide activities and to make such services more widely known and broadly available
 - Providing general information to communities, health care facilities, and others about existing available programs
 - Working in cooperation with private and public entities to develop new recruitment and retention programs
 - Identification of needed recruitment and retention programming for state institutions, county public health departments and districts, county human service

agencies, and other entities serving substantial numbers of public pay and charity care patients, and may provide these services to eligible entities, including:

- Assistance in establishing or enhancing recruitment of health care professionals
- Recruitment on behalf of sites unable to establish their own recruitment program
- Assistance with retention activities in practices with eligible practitioners of the health professional loan repayment and scholarship program

Attachment C

Existing Recruitment Programs in Oregon

Loan Forgiveness

Primary Health Care Loan Forgiveness Program

This is one of the few new programs started and funded by the legislature in 2011. The loan forgiveness program, funded with \$525,000, will provide loans to students studying to be physicians, nurse practitioners or physician assistants who are committed to work in a rural area. Loans of up to \$35,000 per year, administered by the Office of Rural Health, will be awarded to students beginning in their second year of training. One year of loan will be forgiven for each year spent practicing in a rural Oregon community upon completion of the student's training.

Loan Repayment

Oregon Partnership State Loan Repayment Program (SLRP)

Government and commercial loans incurred for the purpose of obtaining a health professional education are eligible. Qualifying commercial lending institutions are those that are subject to examination and supervision, in their capacity as lenders, by an agency of the United States or of the State in which the institutions have their principal place of business.

To be eligible, practice sites must be a public or private non-profit organization, located in a Health Professional Shortage Area (HPSA) and willing to provide 50% of the award amount. Participants sign a contract for a minimum two-year practice commitment. They must work full-time (40 hours per week), with no more than 35 days vacation per year. There are severe penalties for default on contracts.

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.

The National Health Service Corps (NHSC) Loan Repayment Program

This loan repayment program is administered by the federal Health Resources and Services Administration, with assistance from the state's Primary Care Office. Primary care providers working at an NHSC approved site (a Health Professional Shortage Area with an appropriate score; see below) can receive loan repayment towards qualified education loans. Award amounts for this year's program have been modified to help ensure communities with the

greatest need – those with the highest HPSA scores – receive recruitment support to fill much needed clinical positions. Initial awards amounts are as follows:

| Providers | 2 Years Full-time | 4 Years Half-time | 2 Years Half-time |
|---|-------------------|-------------------|-------------------|
| Providers at Sites with HPSA Score 14+ | Up to \$60,000 | Up to \$60,000 | Up to \$30,000 |
| Providers at Sites with HPSA Score 0-13 | Up to \$40,000 | Up to \$40,000 | Up to \$20,000 |

Physicians (MD/DO), Dentists (DMD/DDS), Nurse Practitioners (NP), Certified Nurse Midwives (CNM), Physician Assistants (PA), Registered Dental Hygienists (RDH), Health Service Psychologists (HSP), Licensed Clinical Social Workers (LCSW), Psychiatric Nurse Specialists (PNS), Marriage and Family Therapists (MFT) and Licensed Professional Counselors (LPC) are all eligible. Minimum service requirement is two years, with an option to continue up to 7 years for additional loan repayment.

Federal Faculty Loan Repayment Program

The Faculty Loan Repayment Program helps eligible health professions faculty from disadvantaged backgrounds to repay their student loans. The program provides as much as \$20,000 a year to eligible faculty members who apply to and are selected to receive funding from the program in return for a 2-year service commitment. Participants should also receive matching funds from their employing educational institution. In addition, Faculty Loan Repayment Program participants receive a tax liability benefit.

Nursing Education Loan Repayment Program

The Nursing Education Loan Repayment Program is a selective program of the U.S. Government that helps alleviate the critical shortage of nurses by offering loan repayment assistance to registered nurses and advanced practice registered nurses, in return for working in a Critical Shortage Facility and to nurse faculty in return for working full time at an accredited school of nursing. In exchange for a 2-year service commitment, participants receive 60 percent of their total qualifying nursing education loan balance. For an optional third year of service, participants may receive 25 percent of their original total qualifying nursing education loan balance. Participants also receive the salary and benefits they have negotiated with their employing facility.

Eligibility is restricted to nurses who have completed training, who are licensed and employed full time (at least 32 hours per week) at a public or private, non-profit that is designated as, located in or primarily serving a designated primary care or mental health professional shortage area. Funding preference for nursing loan repayment is based on financial need and type of

facility in which the nurse will be employed; funding preference in faculty loan repayment is given to individuals with the greatest financial need and those working at schools of nursing with at least 50 percent enrollment of students from a disadvantaged background.

Primary Care Services Loan Repayment Program – currently unfunded

Oregon's existing (but currently unfunded) program is called the Primary Care Services Loan Repayment Program. It began in 1993 but funding was lost in the 2009-11 biennium. Historically, the program was open to physicians, physician assistants, nurse practitioners, dentists, pharmacists, and naturopaths and provided partial loan repayment (1/3 of the outstanding loan balance annually, up to an annual maximum of \$25,000) in return for service time in a rural or underserved area. Service commitment was a minimum of three years, maximum of 5 (2 and 4 for Nurse Practitioners and Physician Assistants).

Tax credits and Liability Subsidy

Rural Provider Malpractice Subsidy

The program provides medical liability insurance premium subsidies to physicians and nurse practitioners working in underserved rural communities. Subsidies cover a percentage of a provider's actual insurance premium and are offered at varying rates based on the provider's practice type. The highest subsidies are given to practitioners providing obstetric care, which is the highest priority group addressed by the program. The subsidies are as follows:

- 80% of the premium for physicians specializing in obstetrics and nurse practitioners certified for obstetric care;
- 60% of the premium for physicians specializing in family or general practice who provide obstetrical services;
- 40% of the premium for physicians and nurse practitioners engaging in family practice without obstetrical services, general practice without obstetrical services, internal medicine, geriatrics, pulmonary medicine, pediatrics, general surgery, or anesthesiology;
- 15% of the premium for other physicians and nurse practitioners.

From 2003 to 2011, the medical liability insurance premium subsidy program was funded by a partnership between the State Accident Insurance Fund Corporation (SAIF), the Department of Consumer and Business Services (DCBS), and the Office of Rural Health (ORH). In 2011, the program was moved to the Oregon Health Authority, in collaboration with the ORH but the funding mechanism no longer exists.

Rural Provider Income Tax Credit

This program grants up to \$5,000 in personal income tax credits to eligible physicians, nurse practitioners and nurse anesthetists, and physician assistants working in eligible rural facilities or whose caseloads consist of a majority of rural patients. The tax credit is authorized by Oregon Revised Statutes 315.613 – 315.622 and implemented through Oregon Administrative rules 572-090-030.

Private System Options (Large Healthcare Systems in Oregon)

Health System #1:

1) Traditional Physician Recruitment Option

Requires documented community need, signed recruitment agreement, in general limited to no more than a loan amount equal to 5-10% of the MGMA median for the physician's specialty/years in specialty, and in no event more than 15% of the MGMA median for the physician's specialty/years in specialty (said amount could be paid directly to the physician or a specified lender to reduce outstanding medical school loans) which would be provided in advance of the recruited physician's relocation to the hospital's service area (may also provide for subsequent recruitment incentives such as income guaranties and relocation assistance provided the aggregate financial assistance is consistent with fair market value).

2) Employment Loan Option (loans \$ to Student/Resident during Schooling/Residency)

Same as 1) above but enter into an employment agreement (or loan agreement) with the student/resident (instead of recruitment agreement), in general advance/loan funds equal to 5-10% of the MGMA median for the physician's specialty/years in specialty, and in no event more than 15% of the MGMA median for the physician's specialty/years in specialty, to the student/resident during schooling/residency, those funds are subsequently forgiven as part of his/her compensation under the employment agreement once he/she begins working at System. The employed physician's total compensation (actual monies paid to him/her by System plus monies forgiven) must be consistent with the FMV of the employment services. *Should not be offered until physician's last year in medical school and if then only subject to the physician satisfying certain standards (e.g., success in school, "matched" to right residency program, quality of student and dedication to community etc.). Strong preference to limit this option to those physicians who are already in a residency program and likely would start employment at System within 12 months of loan.*

3) Employment Loan Option (makes payments to Student's/Resident's Lender to Partially Offset Student Loans). Same as 2) above but instead of loaning money during the

schooling/residency of the recruit, System agrees in a letter to the specified physician that if certain standards/conditions are met by said physician (e.g., graduate on time with specified GPA, match into appropriate residency and complete said residency within specified time, ready willing and able to begin employment at System within certain timeframe, enter into employment agreement with System and meet all applicable employment conditions as of the effective date of the employment agreement, etc.), then System will employ the physician and in said employment agreement, in addition to the compensation payable to the employed physician thereunder, commit to pay certain monies directly to the student's/resident's lender for each full year of employment at System completed (such loan payments may be of any amount provided the overall compensation payable to the physician and to lender on physician's behalf is consistent with fair market value). Any such payments will be deemed comp. to the physician employee for IRS purposes and the employed physician's total compensation (actual monies paid to him/her by System plus monies paid to his/her lender) must be consistent with the FMV of the employment services.

Health System #2:

No repayment in Oregon (offer in other states where they are located where it is 'harder' to recruit). Offers a low interest loan (1% above prime) to pay down high interest debt/loans. Not specific to student loan repayment.

Health System #3:

No repayment, though signing bonuses are typically geared towards recruitment, up to \$25,000. Some contracts also have retention bonuses that are geared to this purposes (i.e. after contract renewal or first / second year, \$X dollar bonus).

Attachment C

Primary Care Provider Recruitment Strategy / HB 2366 Stakeholder Meeting Summary 12-14-11

The Oregon Healthcare Workforce Committee convened approximately 25 participants from a range of organizations (professional societies, health systems and plans, state agencies, educational institutions, and provider groups) to generate and prioritize potential strategies for primary care provider recruitment across the state. This was the first of several anticipated stakeholder conversations; the Committee plans a larger meeting/symposium in the spring of 2012.

Brainstorming discussions

Participants first identified existing recruitment activities or initiatives in Oregon that have shown success or promise. This list included:

- Incentives for students to enter educational programs
- Incentives for practitioners to enter critical practice shortage areas
- Rural medical liability subsidy
- Rimrock Health Alliance (a co-op in Prineville, includes health and civic leaders)
- Forthcoming payment and delivery system reforms (CCOs, ACOs, etc.)
- New training capacity in state, e.g. 1st pharmacy class at Pacific University (with a note that training capacity is important – don't forget about creating a larger pool from which to recruit)
- Enhanced reimbursement for rural health
- Education about value of different practitioners (e.g. the Oregon Association of Naturopathic Physicians is working with the Oregon Primary Care Association to educate community health centers about using naturopathic physicians)
- J-1 visa program to bring foreign-trained providers to the state (with a note that the program has a little extra capacity and a suggestion to explore a statewide network to re-place visa holders in new locations in Oregon after their 3-year service period)
- Rural rotation opportunities for students
- Cross-disciplinary rotations or experience for students
- Existence of Oregon schools (e.g. OHSU) helps with recruitment
- Expedited (for out of state physicians) or more flexible (e.g. for PAs) licensure processes

Next, participants brainstormed other steps that could be taken to help recruit primary care practitioners:

- Make it more desirable for physicians and others to do part-time retirement, rather than full-time
- Expand training capacity (e.g. residency slots)
- Consistent, collaborative marketing (e.g. Brand Oregon)
- Reducing workforce need by increasing prevention and individual health management skills
- Scope of practice improvements (e.g. allowing pharmacists to do cholesterol testing) and making sure everyone can work to top of license.
- Marketing the scope of practice breadth/flexibility that Oregon already has in comparison to many other states.
- Improve the practice environment by addressing state and private carriers' reimbursement policies (for retention as much as recruitment)
- Payment reform, not just insurance reform (for retention as much as recruitment)

- Increase responsiveness to interested professionals (when one Oregon person doesn't respond to an interested candidate, word gets around that Oregon as a whole is not responsive)
- Improve the practice environment by reducing documentation needs and the range of responsibilities that clinicians now have

Participants also identified other groups or individuals that should contribute to the development of a strategic plan for primary care provider recruitment in Oregon:

- Insurance companies
- Practicing primary care practitioners and their spouses / families
- State (re: reimbursement rates)
- Students, residents, and recent residents – people who can speak about the decision to stay or go
- Health administration, public health, and other non-clinicians (in some cases, these professionals may be better candidates for some of the managerial and population health management functions that clinicians are doing now and could free up clinicians for patient care)
- Mental health providers and agencies
- People involved with medical home models
- Veterans
- Consumers
- Business leaders

Strategy development and prioritization

Finally, participants broke into groups and reviewed a long list of potential strategies for primary care provider recruitment, which was developed from an environmental scan of best practices and existing recruitment plans at the local, state, multi-state/regional and national levels. Meeting participants were asked to categorize the strategies into four quadrants based on their rating of the **impact** that strategy could have in Oregon and the **effort** (financial, personnel, barriers) required to implement it. Participants also added some potential strategies of their own to the environmental scan list. The results of this discussion are shown in the table on the next page.

At the end of the small group discussion, the entire group did some informal voting to identify strategies that the Workforce Committee and its staff should explore in more detail. Votes are shown in parentheses after each strategy on the table.

Issues that arose during the small group discussions included these:

- A variety of recruitment and retention efforts are already happening through the state, the Office of Rural Health, or other groups with a statewide purview. However, the private sector often does not know how to access services/participate in efforts. There was general support and encouragement for more collaboration between state-level and private groups and a request for more frequent cross-sector conversations like the current one. However, another participant noted that there was too much duplication of effort between state-level agencies.
- Group members spent considerable time noting the problems with state funding (lack thereof) and the need to focus on the structural changes associated with health reform (e.g. payment).

| | Low Effort | High Effort |
|--------------------|---|---|
| High Impact | <ul style="list-style-type: none"> • Fund existing loan programs (7 votes) • State-run APGAR testing (7 votes) • Use Social Media for marketing (6 votes) • Look at what other states are doing, especially states with large rural populations. Use their efforts and/or steal their providers (4 votes) • State website—Job Bank (4 votes) • Targeted marketing to students who left state for training (4 votes) • State recruitment program; FTE recruiter available; State working with entities to develop recruitment programs. State recruiting collaborative (3 votes) • Share Best Practices (Web or other methods) (3 votes) • State-coordinated (employed or not) locum tenens program – clear online tool with opportunities and potentially interested clinicians. Market to R3s. (2 votes) • Student conference focused on career building (“how to pick a practice”) – panels by specialty or profession that discuss what it’s like to work where, transparency (2 votes) • Annual Workforce Summit (share best practices) (2 votes) • CME initiatives added to existing and more robust telemedicine programs • Provide recruitment database to organizations • Rural grand rounds • Legislative education re: need for PCPs • Direct marketing current Oregon students (events/website) • Data collection around new recruits. • Monitor user efficacy of 3RNet. • Provide marketing support for recruiting organizations. • Group purchasing headhunters; negotiated discount. • Awareness/spread of monetary incentive programs | <ul style="list-style-type: none"> • Payment reform (23 votes) and payment transparency (re: standard contractual clause that prevents one provider from discussing reimbursement). Equal pay for equal work. • Care redesign. Fuller use of scope of practice (PA/NPs/NDs/etc) (10 votes) • Community health-focused town halls (e.g. a tech-enabled primary care grand rounds) – include clinical and policy topics, all providers. Creates community engagement as well as virtual professional support. (7 votes) • Address malpractice climate (7 votes) • Increase number of primary care residencies and training opportunities statewide Increase size of pool of providers; train in Oregon Increase supply (training capacity) (5 Votes). • Statewide job bank/website (4 votes) • Develop Common messaging and workforce definitions (4 votes) • Ensure quality student experiences statewide (4 votes) • Community engagement models and best practices (4 votes) • Increased educational funding for local students - stipend during residency to return to Oregon. Creation of monetary incentive programs (4 votes) • Increased Data analysis (with interpretation of what to do, not just numbers) (3 votes) • State-employed locum tenens available (2 votes) • Develop creative job models to improve clinician satisfaction (job sharing, PCMH) (2 votes) • Creative marketing best practices; Cohesive branding and marketing (2 votes) • Lower income tax for PCPs* (competition with WA State (2 Votes) • Reduce burnout stressors (retention) (2 votes) • Reform in general /progressive environment – will help attract socially conscious students • Annual workforce summit—spread of best practices • State recruitment program (with FTE recruiter) • Increased recruiting of local students • Support for community APGAR assessment or similar / community involvement • Rural workforce awards • CCO’s role in recruiting /structure. |

| | | |
|--------------------------|---|---|
| | | |
| <p>Low Impact</p> | <ul style="list-style-type: none"> • Annual workforce summit – spread of recruitment and retention best practices • Marketing piece on top 10 reasons to practice in Oregon • Look into non-compete clauses ... are they disincentives in some places? • State website with best practices • Marketing assessment and Provide Support to private groups • State working with entities to develop recruitment programs • Provider education about existing resources and policies • Student focused conference on career building • Increased use of telemedicine for provider support • Rural workforce awards/recognition • Annual workforce summit – spread of recruitment and retention best practices • Marketing piece on top 10 reasons to practice in Oregon • Look into non-compete clauses ... are they disincentives in some places? | <ul style="list-style-type: none"> • Provide marketing support for recruiting organizations – one person commented that this works in AK but not OR • Support options for PCPS (MAs, EMTs, scribes, etc.) • Support/sponsor national clinical conferences coming to Portland as recruitment tool • State employed PCP locum tenens or LT pool (MD/DO/PA/NP) |

Appendix E

Primary Care Graduate Medical Education: Training physicians where they are needed

In Brief:

Graduate Medical Education (GME) training in primary care specialties provides an immediate and ongoing new source of physicians for Oregon without recruiting out of state.

- Federal funding helps support new GME programs, thus, the Consortium will not require ongoing state support.
- A statewide strategic approach to GME would help ensure Oregon maximizes workforce and federal funding benefits. By contrast, a hospital-by-hospital uncoordinated approach may diminish these benefits to Oregon.
- After a five-year phase-in, a community based GME consortium program could support training of about 130 primary care physicians each year in 5 or more community based programs – in the areas where physicians are most needed.

Summary:

Upon completion of medical school, all new graduates pursue a “residency” in Graduate Medical Education (GME) in a specialty of their choice. Oregon currently supports more than 800 GME positions in all specialties. 776 positions are at OHSU, and about 275 open up each year and are open on a competitive basis to students from all around the US and the world. These training opportunities at OHSU are highly sought after and are nationally “matched” to new graduates from all over the country, some of them from Oregon.

Studies show a strong correlation between where a new physician completes GME training and where s/he ends up practicing. Expanding GME capacity in Oregon in areas where physicians are most needed, thus, could have an immediate and ongoing impact on reversing workforce shortages. Already, OHSU is ranked tenth in the nation for in-state retention of physicians after GME training, with 52% staying in Oregon to practice. However, only one-third of all licensed Oregon physicians completed all or part of their training in Oregon, making Oregon an importer of physician workforce.

The federal dollars that help pay for training of new physicians in teaching hospitals around the country are essential to this advanced training/GME program. However, in 1997 as part of the Balanced Budget Act, the federal government froze the number of GME positions it would support for hospitals *participating at that time*. This is often referred to as the federal “cap” on residents/trainees. However, hospitals that do not yet have an existing GME training program remain eligible to receive federal funding for establishing new programs. Thus, new federal dollars could be available to Oregon hospitals to help support new GME training sites in Oregon.

To qualify, these positions must gain accreditation by the Accreditation Council for Graduate Medical Education and/or the American Osteopathic Association— a multi-year process that involves development of peer-reviewed curriculum that includes an adequate numbers of patients and procedures to gain expertise in the program specialty. GME training in many specialties and sub-specialties requires the programs to be located in large population centers in order to see a sufficient volume of specialty patients. Primary care residencies, especially Family Medicine, are, however, well suited to smaller communities outside the Portland Metro area.

Several smaller Oregon communities have indicated their interest in exploring the option of having GME at their medical centers, such as Salem, Roseburg, Grants Pass, Eugene, Medford, Hood River, and Bend. Corvallis has recently added several small Osteopathic residencies in affiliation with the Western University College of Osteopathic Medicine of the Pacific campus in Lebanon, Oregon.

Because the GME programs at community hospitals are necessarily small, a GME Consortium approach could support regional programs with common curriculum design, an accreditation umbrella and other program and administrative requirements. This will ensure that hospitals and other community-based sites have a centralized framework for cooperation so Oregon is allotted the maximum number of federally-funded positions and, equally important, that these positions are nationally competitive to attract the highest caliber new physicians to Oregon.

Oregon currently has only one rural Family Medicine training location, *OHSU Cascades East Program in Family Medicine*. Cascades East Family Medicine supports 24 trainees in a three-year program. Started in 1993 at Sky Lakes Medical Center in Klamath Falls, Cascades East Family Medicine Residency is also supported by OHSU Family Medicine Department and Oregon AHEC and has achieved great success. More than 75% of its graduates practice in towns less than 25,000, with many in the smallest communities in Oregon.

GME programs can become self sustaining in their 3rd year when federal support becomes available. Startup costs are needed to support administration, faculty, curriculum development and organization, accreditation and related issues. A common to help administer established residency programs after the startup phase is complete.



OREGON
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OREGON LOCUM TENENS COOPERATIVE (OLTC)

In July of 2009, OHSU's Area Health Education Center (AHEC) began exploring alternative methods of locum tenens provision, ensuring temporary or short-term primary care access to rural communities, facilities and medical practices. Many communities recognized commercial options of locum tenens, or short-term coverage, as unaffordable and often providing care that was not compatible with the needs of rural populations. Our mission, in partnering with rural communities to address these issues, led us to a cooperative model of locums provision, the Oregon Locum Tenens Cooperative (OLTC), launched in January, 2011. The primary benefits of this model include:

Community-based and Membership Directed. The cooperative model allows facilities and communities to build a program that best suits their needs using locums to address both long and short-term health system goals.

Centralized Posting and Direct Contracting. The OLTC office centrally posts openings, reaching a wide audience of potential locums physicians. The cost of locums services remains low through permitting each member to maintain the individual contract and compensation arrangements.

Physicians familiar with rural practice, scope of care and available resources. The rural nature of our State requires practitioners comfortable with patient care in settings of limited local resources. The OLTC uses Oregon physicians who understand the territory.

No-cost recruitment for practices. As a program service, should a site be successful in recruiting a locums provider to a permanent position, the OLTC looks upon that as a success. Over the next year, the OLTC will be investigating Federal and State loan repayment options for locums service to designated areas.

Building Primary Care Workforce. Through connections with OHSU, OAFP, Oregon AHEC and national recruitment capacity with the central OLTC office, optimal connections can be made with potential locums providers. Locums options can be used to help draw recruits to Oregon and experience multiple communities.

Program Summary

Functions the OLTC program office. As a central point to post locum tenens openings, the program office maintains and manages the coverage requests of OLTC members. Its primary asset is the locum tenens workforce built via social networks and affiliated organizations. Each participating provider will have primary verification completed to assure his or her qualifications. Members can access this credentialing data and past placement satisfaction surveys to more quickly make decisions on providers electing to take assignments.

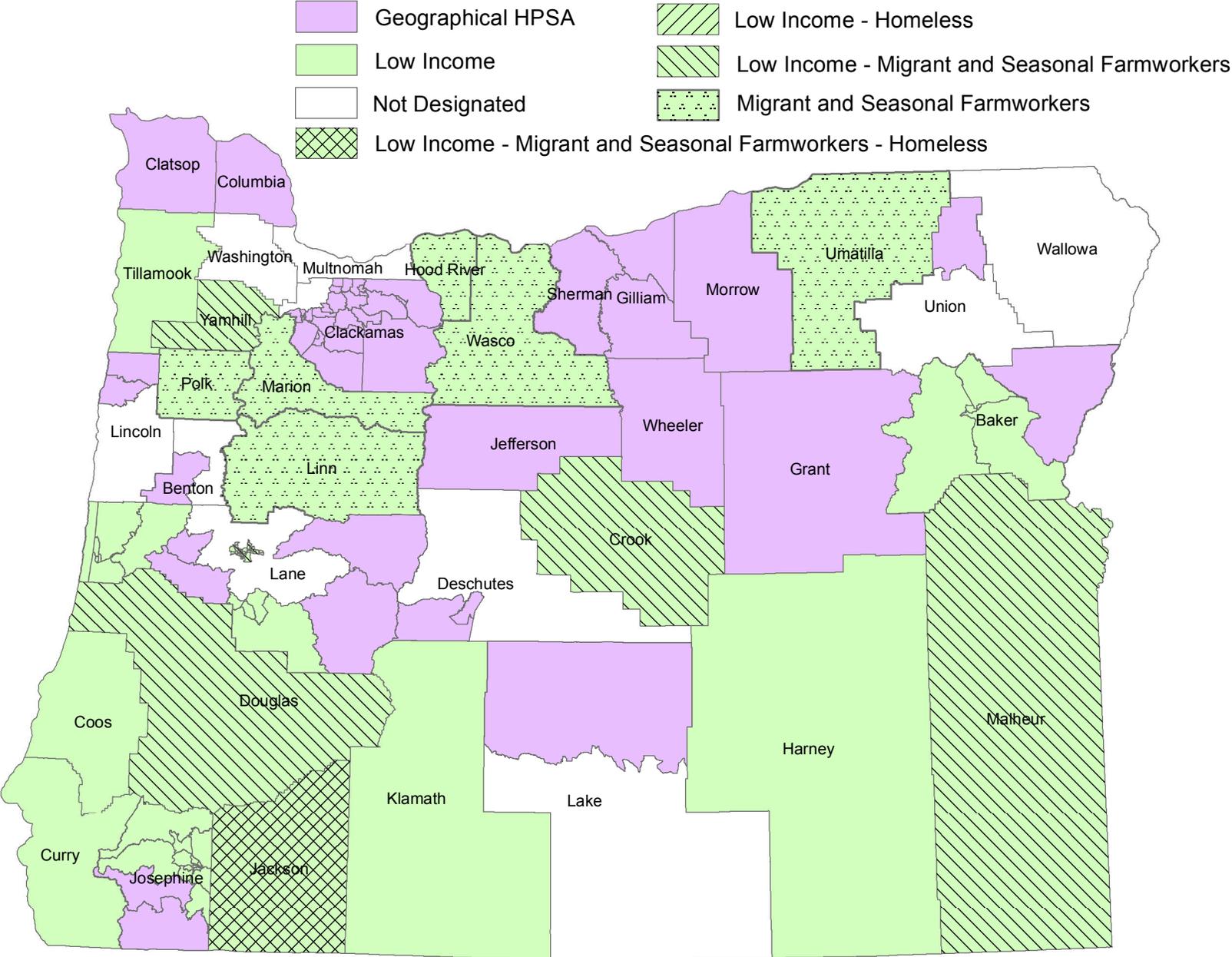
Who are the members? The founding members are composed of several Oregon critical access hospitals and rural practices. Expansion of membership can be to any health facility or physician practice in a rural or underserved community, through approval of the OLTC governing board. Members pay an annual membership fee based upon practice or facility size to access OLTC services. Medical malpractice for locums is typically covered through a member's existing policies or by negotiating a per-diem with their representatives.

How does it work? Up to three months in advance, any member site can request coverage through the OLTC program office. Postings include location, type of coverage, scope of care, dates of coverage and total compensation. Locum tenens providers can view available openings through regular postings (web-enablement in development) and request dates to provide needed coverage. Once a provider indicates interest in a coverage location and date(s), the program office connects the site with the individual's name and credentials. After the work is completed, the site submits provider satisfaction surveys for use by future OLTC members. All compensation for direct care services is completed between the site and physician.

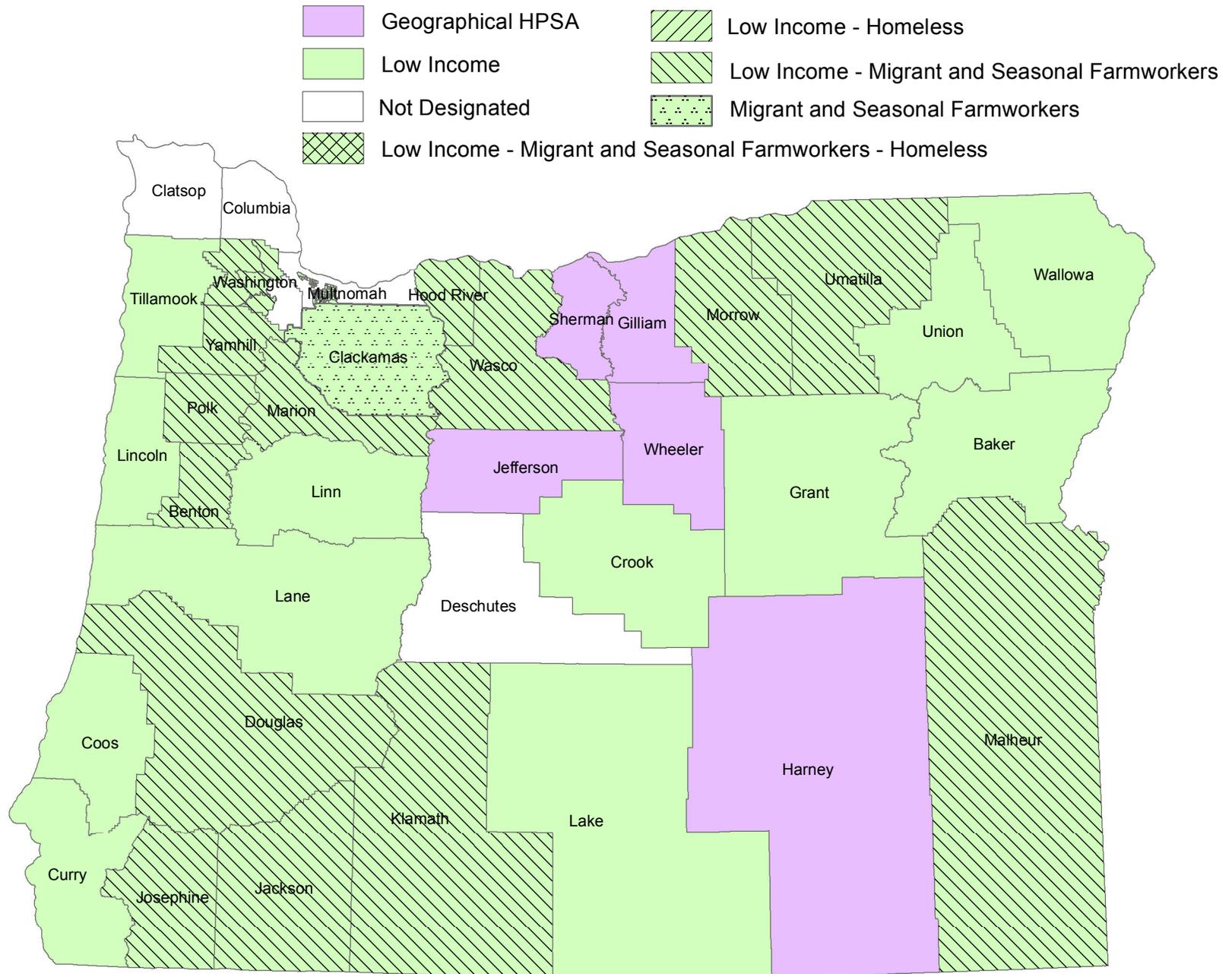
Program Development and Administration

Initial funding for development was provided through the Oregon Community Foundation and continued through AHEC and OHSU support. Although the program will be self-sustaining based on membership fees, we are actively seeking rate relief and subsidy partners in our mission to address temporary practice coverage needs and expand rural Oregon's primary care workforce capacities.

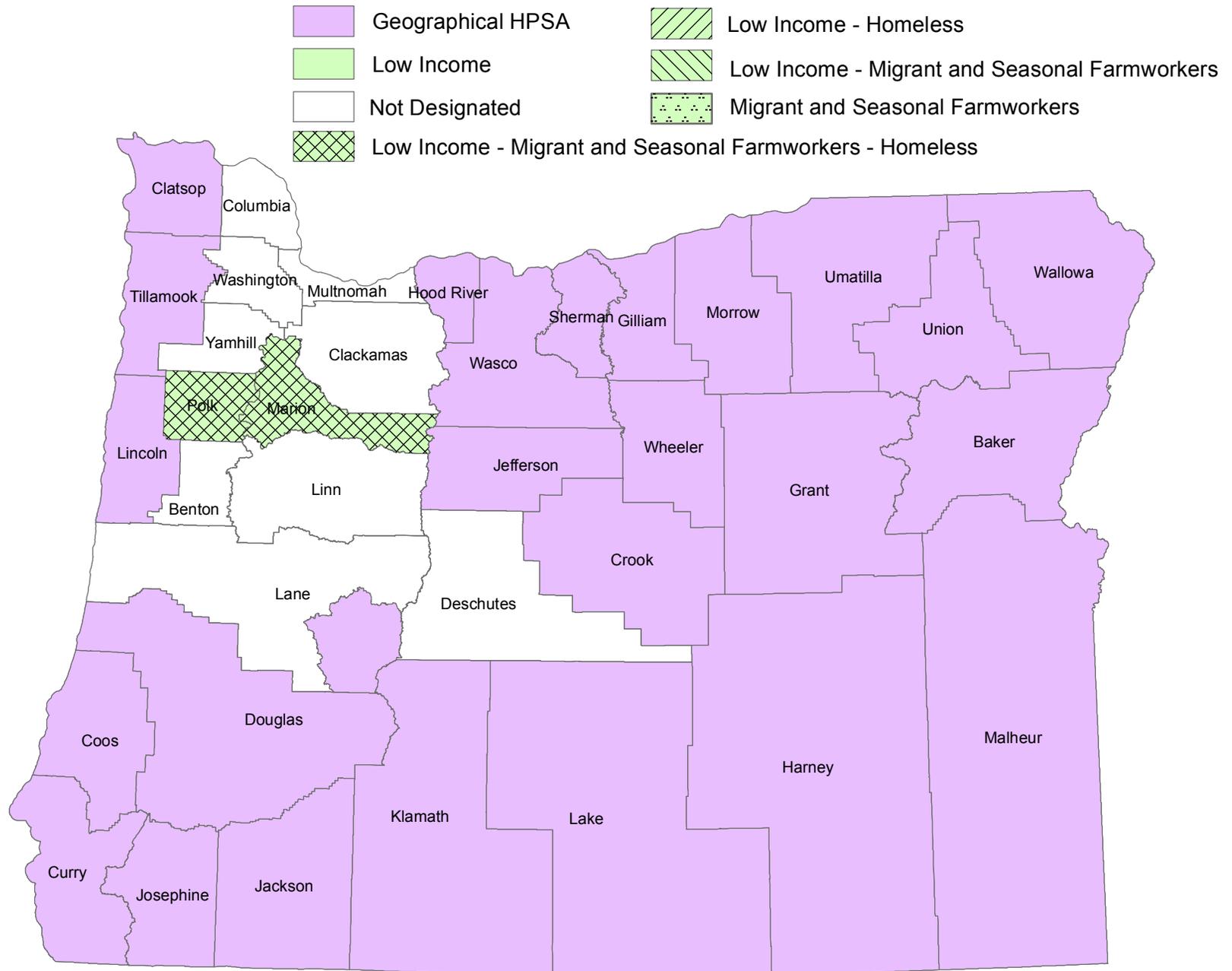
Oregon Primary Medical Care Health Professional Shortage Area (HPSA) Designations as of 9/28/2012



Oregon Dental Care Health Professional Shortage Area (HPSA) Designations as of 9/28/2012



Oregon Mental Care Health Professional Shortage Area (HPSA) Designations as of 9/28/2012



The Need for a Rural Locum Tenens Program in Oregon

What is locum tenens?

Taken from the Latin “to substitute for”, locum tenens are physicians who provide temporary medical services for a specific length of time. This can vary from a few days to allow for vacation or continuing medical education, to several months for medical leave or interim coverage between providers.

Why is a rural locum tenens program needed?

Rural practices and hospitals have difficulty covering the needs of their community on a 24 hour, 7 day per week basis due to the limited numbers of providers present in the community. Many rural communities do not have sufficient medical staff to allow physicians time away for vacation, continuing education and other important activities to prevent burnout and increased turnover. In addition, the broad scope of practice inherent in rural practice can make finding temporary coverage difficult or prohibitively expensive. Commercial locum tenens agencies charge fees substantially higher than can be afforded by rural physicians, whose incomes and practice revenues are not sufficient to support those costs.

Why an academic health center based model?

As the only academic health center in Oregon, OHSU holds much of the responsibility for training physicians to meet the needs of all Oregonians. Faculty, fellows and residents can participate as locum tenens providers on a part-time temporary basis as part of their regular duties, or as extra income producing work. Because OHSU already verifies credentials of its physicians, communities do not sustain any extra expense to perform these essential tasks. Academic health center based programs exist in other areas, such as University of Kansas and University of New Mexico.

What are the benefits of a rural locum tenens program?

For rural physicians:

- Affordable practice relief for vacation, continuing education or illness
- Supplemental assistance during busy times
- Ability to keep office open and staff employed
- Revenue produced when office would otherwise be closed
- Recruitment

For locum tenens physicians:

- Opportunity to experience rural practice without having to commit long term to one location
- Income to relieve financial burden
- Skill enhancement
- Flexible scheduling and part time work availability\

For rural communities:

- Ability to obtain 24 hour/7 day medical services
- Recruitment
- Economic development, keeping medical care in the community
- Opportunity to showcase community to potential physicians
- Infrastructure development

For OHSU:

- Support for rural communities
- Training opportunities for faculty, fellows and residents
- Academic faculty skill enhancement and maintenance
- Support for community physicians who provide teaching service to OHSU

How will a rural locum tenens program be funded?

Fees generated by the program will provide the majority of the funding. To keep fees low enough to be helpful, however, there is a need for additional support. The Area Health Education Center at OHSU has applied for grant funding to seek support for start up costs, administrative overhead, and technical assistance for communities seeking locum tenens services. These funds, if obtained, can be used to sustain the first 2-3 years of start up for the program. Additional funds will be sought from the Oregon State Legislature to provide a program subsidy designated for physicians in Health Professions Shortage Areas. A sliding scale fee will be developed in order to keep the costs low enough to be feasible.

Why is technical support included in this program?

Technical support from the Oregon Office of Rural Health field specialists is crucial to assisting communities in planning for recruitment and retention. Rural communities and hospitals frequently lack the resources to engage in the complex task of health workforce planning. The locum tenens program will be one component of an overall recruitment and retention plan for communities. Additional field specialists will be needed to assist communities, physicians and Critical Access Hospitals with the assessment needed for successful health workforce planning.

What is the expected demand for these services?

In a survey conducted by the Oregon Office of Rural Health in December, 2006, more than half of physicians eligible for the Oregon Rural Provider Tax Credit indicated desire to utilize locum tenens services, but report difficulty obtaining coverage through existing means. Most report that they would utilize a high quality, affordable service, if available.

Oregon rural locum tenens program partners

- ***Oregon Health and Science University***
- ***Oregon Area Health Education Center***
- ***Oregon Office of Rural Health***
- ***OHSU Department of Family Medicine***
- ***Oregon Association of Hospitals and Healthcare Systems***
- ***Oregon Healthcare Workforce Institute***

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Workforce Committee 2012 Report

**** DRAFT FOR DISCUSSION ****



To be filled in – staff work



For Committee to develop and/or review

Introduction

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

Committee members include representatives from community colleges, graduate health and medical education, health system and hospital employers, foundations, Area Health Education Centers, and a range of health professions: nursing, dentistry, allied health, behavioral health, and medicine.

Among other deliverables, the Committee is charged with developing a “biennial report to the Board of recommended strategies, actions and policy changes, including statutory changes if required, that support the recruitment, retention and distribution of Oregon’s health care workforce, with an emphasis on primary care.” The strategies and actions should include licensure strategies for a 21st century health care workforce as needed. This document contains the Committee’s 2012 recommendations for the Board’s consideration.

Summary

TBD for final version of document – key findings and recommendations.

Background for policy recommendations

In its 2010 report to the Board, the Committee described a variety of population and labor market factors contributing to the demand for qualified health care professionals in Oregon. Those factors remain influential today: Oregon’s growing, aging and diversifying population, the increasing number of people living with chronic diseases, advances in medical technology, and

an aging health care workforce all contribute to a growing need for health care professionals. Previously, the Committee reported that the Oregon Employment Department was projecting a need for nearly 58,000 additional health care workers in the state by 2018; the Department has since updated their projections and now anticipates that approximately 76,00 additional professionals will be needed by 2020 (approximately 43,000 due to employment growth and 33,000 to replace professionals leaving the field)¹. These projections do not account for the large number of Oregonians expected to gain health coverage in 2014 through potential Medicaid expansion or via the individual mandate and the availability of tax credits from Cover Oregon, the state's Health Insurance Exchange. On the other hand, they also do not reflect changing models of care delivery, which will affect provider capacity and therefore workforce demand in ways as yet unknown.

In a 2011 report on the primary care workforce in the United States, the Robert Wood Johnson Foundation observed that "the maldistribution of primary care providers appears to be a more significant problem than an overall shortage."² Oregon also suffers from uneven distribution of providers; the supply of health care professionals varies significantly by geographic region, provider type and specialty. [Insert brief data from 2012 Profiles report.]

As it did in 2010, the Committee envisions a health care workforce for Oregon that is diverse and culturally competent, comfortable providing inter-professional, team-based care, and practices in the locations and disciplines where it is most needed. Given the consistency of this vision and the fact that the population and labor market factors affecting workforce demand have not changed substantially over the past few years, the Workforce Committee feels that the three priorities it identified in 2010 are still relevant:

- **Prepare the workforce for new models of care.** This is particularly important given the work Oregon has done since 2010 to transform health care delivery in Medicaid and beyond. The state has recognized XX patient-centered primary care homes (PCPCHs) to date and several private and public purchasers are now reimbursing differently for care provided at recognized PCPCHs. A PCPCH Institute is already providing practice transformation support to these clinics. Fifteen Coordinated Care Organizations (CCOs) are now serving almost 90% of Oregon Health Plan clients. The state recently submitted an application for federal grant funding which would be used in part to create a Transformation Center to provide technical assistance to CCOs and facilitate learning

¹ Oregon Employment Department (2009). *Employment Projections by Industry and Occupation 2010-2020 Oregon Statewide*. Available at <http://qualityinfo.org/pubs/projections/projections.pdf>

² Primary care workforce in the United States. By Sarah Goodell, M.A., Catherine Dower, J.D. and Edward O'Neil, Ph.D., M.P.A., F.A.A.N., based on a research synthesis by Dower and O'Neil,

and adoption of best practices in delivery system and payment reform across all markets. Engaging and empowering the health care workforce to help lead practice transformation is fundamental to the long-term success of health care reform efforts.

- **Improve capacity and distribution of primary care workforce.** Programs like loan repayment or forgiveness that provide incentives for primary care providers to practice in rural and underserved areas are one tool for equalizing distribution; increasing training opportunities in underserved areas of the state is another. Payment reform, technology developments like telemedicine, and practice changes that encourage professionals to work to the top of their licenses can help expand the capacity of the existing workforce.

In response to HB 2366 from the 2011 legislative session, the Workforce Committee recently produced a 5-year strategic plan for primary care provider recruitment in Oregon. The plan articulates three major goals for growing the state's primary care workforce and describes tactics and actions to achieve those goals. For an overview of that plan and link to the full plan, see [SIDEBAR to be created after Committee approval of HB 2366 plan]. The current document has a broader scope than the HB 2366 strategic plan but the recommendations are well aligned, particularly in relation to this priority of improving the capacity and distribution of primary care workforce. The Workforce Committee fully endorses the 2366 strategic plan and encourages the Health Policy Board to act on the recommendations within its purview.

- **Expand the workforce through education, training and regulatory reform to make progress toward the projected need in 2020.** One of the most straightforward ways to find the additional health care professionals that Oregon needs is to “grow our own,” i.e., to educate more professionals from Oregon in Oregon. The Committee's 5-year strategic plan for primary care provider recruitment (see SIDEBAR) also addresses this priority.

The Committee's 2010 report to the Health Policy Board contained five short-term and seven long-term recommendations for action at a variety of levels, from specific changes in administrative rule to general support for delivery system redesign. Substantial progress has been made on many of those recommendations and work is continuing on a few, see SIDEBAR/SECTION X. For this 2012 report, the Committee has focused on three key actions that the Committee thinks would have a substantial impact system-wide and would provide a foundation for a host of other more targeted workforce development efforts.

2012 Recommendations

1. **Align resources for health care professional education with investments in K-12 and higher education.**

- Include health occupations in the definition of STEM and support investment in STEM education networks by the OEIB, Governor and Legislature
- Support development and distribution of health care occupations training to rural and underserved areas
- Ensure that educational institutions have the funds available to respond to changing workforce needs

FOR COMMITTEE DISCUSSION:

- *What steps are needed to get health occupations included in the STEM definition and initiative? Would it be problematic if the Oregon STEM definition differs from the federal one?*
- *What specific training programs need better distribution?*
- *What are the priority rural and underserved areas, and what schools or training programs already exist in those areas?*
- *What exactly does the 3rd bullet mean – is it a recommendation for overall funding, or a strategic pot of funds/expedited approval process/something similar for healthcare professional training programs when needs are identified?*

2. **Continue to push for payment reforms that support practice change; use information from payment and/or delivery system reforms to build evidence for new workforce models and refine projections of future workforce demand.**

- Payment reforms should encourage the most efficient use of the health care workforce, based on the competencies that workers exhibit.
- In order to assure that workforce implications of potential healthcare system changes (new initiatives, grant projects, other OHA committee recommendations, etc.) are identified, the responsible authority for any new project or proposal should be required to consider and report on the workforce impacts/needs in the development and implementation of such projects/proposals. This could even be formalized into a required "healthcare workforce impact study" or its equivalent.
- Develop mechanisms to share information about best practices in workforce development and deployment related to new models of care.

FOR COMMITTEE DISCUSSION:

- *Are there particular payment reforms or alternative payment models that the Committee thinks should be prioritized (either within Medicaid/for CCOs or in other markets)? One member suggestion: “This should include an emphasis on increased reimbursement for providers meeting Meaningful Use criteria and becoming certified as Patient Centered Primary Care Homes.”*
- *Any suggestions for operationalizing the second bullet?*
- *What mechanism(s) does the Committee think would be most useful/most successful in disseminating best practices related to workforce development or deployment for new models of care?*

3. Expand health care workforce data collection for a more complete picture of Oregon’s health care workforce: (1) expand Oregon Healthcare Workforce Database to include data from all health care licensing boards; (2) create a centralized data file of healthcare professional education capacity in Oregon.

- Required participation in Oregon’s health care workforce database should be extended to all health professional licensing boards in 2013, with actual reporting to be phased in according to data priorities and board readiness.
- Data elements for educational capacity should include: current school and program capacity; % of capacity that is filled; recent graduation numbers; and future plans for expanding or contracting capacity.

FOR COMMITTEE DISCUSSION:

- *Any particular priorities for board participation in Workforce Database? In 2010, the Committee prioritized three behavioral health professional boards, all of whom are now participating voluntarily. Remaining boards include: Naturopaths; Chiropractic Examiners; Medical Imaging; Optometry; Speech-Language Pathology; Respiratory Therapy, EMTs, Direct Entry Midwifery; Massage, Denture Technology; and Nursing Home Administrators.*
- *What would the committee recommend about non-licensed practitioners (e.g. medical assistants, or health management/administrators, addiction counselors, etc.) How would this connect to potential registry of CHWs? To Home Care Commission’s registry?*
- *Any recommendations regarding the use of the data (e.g. one member suggested Oregon-specific predictive modeling)*

Conclusions

TBD for final version of document

Committee next steps

- Describe the Committee’s role in next steps for ongoing work (e.g. SB 879/student passport work, CHW development, design of new loan repayment program funded by Medicaid waiver, etc.)
- Identify any projects or policy questions the Committee would suggest to the Board for Committee work in 2013.

Draft Sidebar:

Status of 2010 Oregon Healthcare Workforce Committee recommendations to the Health Policy Board

Short-term recommendations from 2010

Recommendation: Revitalize the state’s primary care practitioner loan repayment program.

Status: Ongoing. A bill to re-fund the Primary Care Services Program was introduced in 2011 but did not pass. However, as a part of the recent Medicaid waiver agreement with the Centers for Medicare and Medicaid Services (CMS), the state has committed to establishing a primary care loan repayment program, funded at \$2M annually, by July 2013. The Committee discussed design options for this loan repayment program at its October and December 2012 meetings.

Recommendation: Standardize administrative aspects of student clinical training.

Status: Ongoing. In July 2012, the Health Policy Board approved [a set of standard prerequisites for student clinical placement](#) that were developed by the Committee in consultation with a broad range of stakeholders. Committee members are working with OHA staff (and a rules advisory committee to be convened in early 2013) to develop administrative rules to implement and enforce the standards. When approving the standards, the Board strongly advised the Committee and stakeholders to develop a centralized method of tracking students and their prerequisites across clinical placement sites. Committee members are considering options and stakeholder appetite for such a centralized system.

Recommendation: Revise or re-interpret the state’s “adverse impact” policy.

Status: Referred to Higher Education Coordinating Committee (HECC) for consideration and action. In consultation with staff from the (former) Office of Degree Authorization and representatives from public, private, and proprietary schools, the Committee recommended a small change to statute and administrative rule that would have the effect of requiring all institutions—public, private and proprietary—to notify others of proposed new programs and be subject to review for detrimental duplication or adverse impact. A letter recommending this regulatory change was sent to the HECC in August 2012.

Recommendation: Maintain resources for health professions education programs.

Status: Not accomplished. This was a recommendation to the Oregon Legislature for the 2011 session. Because of budget constraints, the 2011 session resulted in some funding reductions for health care professional training programs at publicly-funded educational institutions in Oregon.

***Recommendation:* Expand health care workforce data collection for a more complete picture of Oregon's health care workforce.**

Status: Partially accomplished. The Committee recommended that the statute for Oregon's Health Care Workforce Database should be amended to enable collection of accurate and comparable data for all licensed health care providers in the state. HB 3560 (2011) directed OHA to work with all licensing boards to populate the database but did not explicitly require boards or their licensees to participate, or to support database operations via a small fee as the original seven participating boards do. Starting in 2012, three additional boards (the Board of Licensed Clinical Social Workers, the Board of Psychologist Examiners, and the Board of Licensed Professional Counselors and Therapists) began to ask their licensees to provide data on a voluntary basis.

Long-term recommendations from 2010

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

Status: Not undertaken.

***Recommendation:* Define new standards for health care workforce competencies.**

Status: The Committee has produced two sets of recommendations related to new workforce competencies: 1) a [report](#) identifying individual competencies that will help health care professionals work successfully in new ways, as well as organizational competencies needed to implement new models of care; and 2) via a short-term Subcommittee, [recommended professional competencies and training requirements](#) for community health workers, peer wellness specialists, and personal health navigators, as required by HB 3650. The Health Policy Board approved the non-traditional health worker recommendations in January 2012 and OHA's Office of Equity & Inclusion recently convened a Non-Traditional Health Worker Steering (NTHW) Committee, whose first task will be to help develop administrative rules for the recommended training standards and a process for certification.

***Recommendation:* Adopt a payment system that encourages the most efficient use of the health care workforce.**

Status: The Oregon Health Authority has made major strides in moving from volume-based payments to value-based payments with the establishment of global budgets for CCOs and alternative payments for recognized patient-centered primary care homes. A variety of private-sector initiatives are also ongoing.

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

Status: Not undertaken directly but the Committee's [report](#) on individual and organizational competencies necessary for new models of care delivery has some relevant content and recommendations.

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

Status: Not undertaken directly but the Committee's recent strategic plan for primary care provider recruitment has some relevant content and recommendations.

Recommendation: **Enhance resources for health professions education programs.**

Status: This recommendation was intended for a future in which the state economy was more robust than in 2010 when the recommendation was made. The Committee has a related recommendation in this year's report.

Recommendation: **Maintain and enhance resources for K-12 math, science, and health career exposure.**

Status: This was a recommendation to the Oregon Legislature for the 2011 session and was not accomplished due to budget constraints. Between 2010 and 2012, Oregon had a net loss of 12 high-school health professional preparation programs. The Committee has a related recommendation in this year's report.

Appendices

- Committee Roster
- *Other?*