

Oregon Healthcare Workforce Committee
AGENDA - April 2, 2014, 9:30 am – 12:30 pm
Wilsonville Training Center, Wilsonville, OR 97070
29353 SW Town Center Loop, E Room 111/112

Meeting Objectives:

- Approve summary of February meeting
- Advance work on Health Policy Board deliverables
- Discuss topics relevant to Committee charter

#	Time	Agenda Item	Presenter(s)	Action Item
1	9:30 – 9:35 (5')	Welcome	Lisa Dodson	
2	9:35 – 9:40 (5')	Approval: February 5th meeting summary	Lisa Dodson	x
3	9:40 – 10:10 (30')	Presentation: New projections from the Oregon Employment Department	Brenda Turner	
4	10:10 – 10:35 (25')	Review: Demographic Profiles of Population and Health Care Workforce: Final report to Committee and discussion	Lisa Angus	x
5	10:35 – 10:45 (10')	Break	All	
6	10:45 – 11:00 (15')	Discussion: Changes in bylaws; member expectations	Lisa Dodson Ann Malosh	
7	11:00 – 11:30 (30')	Discussion: Workgroup B—Residency Expansion: Review and discuss work to date	Robyn Dreibelbis Lisa Dodson	
8	11:30 – 11:50 (20')	Updates: Workgroups A, C, and D	Workgroup Leads and Staff	
9	11:50 – 12:10 (20')	Updates: OHA and General	All	
11	12:10 – 12:20 (10')	Public Comment	Any	
12	12:20 – 12:30 (10')	Emerging Issues	Committee Members	
13	12:30	Adjourn: Next meeting June 4, 2014	Lisa Dodson	

Meeting Materials

1. Agenda
2. February 5, 2014 draft meeting summary
3. Employment Department Projections presentation
4. Draft final analysis – workforce diversity
6. Committee by-law potential edits
7. GME material s
9. Legislative Wrap Up

**Oregon Healthcare Workforce Committee
at the Wilsonville Training Centre
Meeting Summary
February 5, 2014, 9:30-12:30**

Committee Members in Attendance

Sharmila Bose (By Phone)	Ann Malosh
Lisa Dodson	David Nardone
Robyn Dreibelbis	David Pollack
Andrew Janssen (By Phone)	Michael Reyes
Teresa Mazarro	Daniel Saucy
Carla McKelvey, (representing the OHPB)	Jennifer Valentine

Committee Members not in Attendance

Agnes Balassa	Mauro Hernandez
Jordana Barclay	Mary Rita Hurley
Lita Colligan	Michael Kirshner
	Donna Larson

OHA and OHWI Staff in Attendance

Lisa Angus	Jo Isgrigg
Margie Fernando	Marc Overbeck

Also in Attendance

Rebekah Gould, OHA Health Analytics	Dana Drum, Oregon Public Health
Suzanne Yusem, OHA Health Analytics	

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1. Lisa Dodson welcomed everyone to the meeting. She especially welcomed Dr. Carla McKelvey, who will be the liaison to the Committee from the Oregon Health Policy Board.
 2. The meeting summary of the December 11, 2013 was accepted with no changes.
 3. OHA Updates
 - **Medicaid Primary Care Loan Repayment**--Marc reported that the first application cycle of the Medicaid Primary Care Provider Loan Repayment Program ended with nearly 50 applications. Of these, 20 were MD/DOs; 10 PAs; 9 NPs; 8 Psychologists; 3 Dentists. Marc noted that about 45 of these applications were from existing providers; the administrative rules for the program state that no more than 20% of the awardees may be currently serving providers.

Lisa Dodson expressed concern that these incentive programs have rules that may leave out a group of students whose qualifications fall in between programs and are unable to receive the benefits of these programs.

- **Medicaid Enrollment numbers for 2014**--Lisa Angus reported that the latest enrollment numbers are:
 - Over 180,000 new Medicaid enrollees covered through the Oregon Health Plan
 - Around 122,000 came in through the Fast-track Program
 - Approximately 58,000 came into Oregon Health Plan through Cover Oregon
 - Around 32,000 have enrolled in private insurance through Cover OregonThis brings the total newly enrolled to approximately 212,000.

- **2014 Legislative Session**--Lisa Angus updated the committee on three bills in this session that are noteworthy for this committee:
 - HB 4137 is looking to increase funding for the loan forgiveness program.
 - SB 1566 Oregon Workforce Investment Board (OWIB) has a new bill that will enable them to play a larger role in advising the employment department.
 - SB 1548 adds the words "Physician Assistants" and "Nurse Practitioners" to a myriad of statutes related to physician practice. The intent of the bill is to bring Oregon laws up-to-date with current practices.

- **New HCWC Website**--Marc announced that the website for the Healthcare Workforce is live. Thanks were offered to Zarie Haverkate, the OHPR Web Liaison, who revamped the site to make it look better. Marc will send this link to all the committee members to check out the new site: <http://www.oregon.gov/oha/OHPR/HCW/Pages/index.aspx>. Members who saw it commented that the site was well organized.

4. Other updates

- **Community Health Worker Training**--Ann Malosh reported that the Dept. of Community Colleges and Workforce Development (CCWD) Deputy Commissioner convened a meeting of community colleges, employers, and community health workers (CHWs) on January 31, 2014 to discuss how to help employers train incumbent workers. The state has provided approximately \$600,000 in the education budget to help train CHWs.

- **Membership of the Healthcare Workforce Committee**--Lisa Dodson announced that Terri Johanson had resigned from the committee. Lisa asked the Committee to consider some issues to standardize and update membership:
 - Should we have a term limit for membership?
 - Are we representing the right balance?
 - Consequences of missing meetings regularly?
 - Plan for dealing with changes in circumstances of members?

Committee staff will draw up some draft suggestions after receiving comments and will share this at the next meeting.

5. Discussion: Workgroup C – Financial Incentive Programs Recommendation

A report on the range of incentive programs designed to encourage providers to practice in underserved areas or with underserved populations in Oregon.

Lisa Dodson prepared a draft white paper on Incentive Programs. Marc prepared a list of all the current State and Federally Funded Primary Care Financial Assistance programs available to clinicians in Oregon. Both were distributed to members.

Concurrent with the work to develop the report to the OHPB, a Legislative workgroup chaired by Jack Dempsey would also like to have the Committee's input on how to assess the effectiveness of all state and federally funded provider incentive programs.

Some of the issues that the Workforce discussed surrounding this report are:

- Some programs are federally funded, some are state funded. Some have existed for a long time and may not be relevant now.
- The impact of tax credits and malpractice subsidies is less visible than direct monetary awards. Surveying recipients of tax credits about the value of that incentive is not possible because tax returns are private and so participants cannot be easily identified.
- Some programs have an immediate effect and the results are clear year by year. Other programs have a workforce impact only after many years of training, so data would only be available to view 7-10 years in the future.
- Recruitment and retention need to be separated. It is easier to recruit than to retain workers once the programs are over.
- State and Federal seed money is available for recruitment but communities must provide resources and motivation for retention.
- Survey of recently hired or relatively new professionals to ask about reasons they are likely to stay or leave might be useful.

Lisa Dodson added that she would like to recommend that Oregon Health Care Workforce Institute be given more funding in order to do the kind of data analysis that is needed on these programs.

Lisa would appreciate any feedback or suggested metrics that the group can use to complete this report on the effectiveness of these programs.

6. Review of Demographic Profiles of Population and Health Care Workforce

Suzanne Yusem and Rebekah Gould from OHA Health Analytics and Lisa Angus presented on the Oregon Healthcare Workforce Diversity profile. This is the first draft of the work done thus far, and a final working draft will be available at the April 2, 2014 meeting for the Committee to review before submitting to the OHPB at the end of April. The Committee provided comments on the report including additions requested.

- If there is missing data, it is better to not draw any conclusions. In the next report the Appendices will identify missing data.
- In the Diversity Table, Registered Nurses appear twice, under the Oregon Medical Board and also under the Oregon State Board of Nursing. Rebekah will correct this.
- The final draft should differentiate providers versus all health care professionals
- Suzanne confirmed that the data of Spanish speakers did not show their level of proficiency. Their new surveys will start collecting this proficiency data.

8. Discussion: Workgroup D – Industry Trends

An analysis of health care industry trends in emerging employment categories and new workforce roles, accompanied by an audit of Oregon's training capacity for those jobs and roles.

Ann Malosh provided a list of reports relevant to industry trends and employment of the health care workforce. The plan is to start with a review of these articles and other reports published recently, then to assess the remaining information gaps and solicit information from Oregon employers, possibly via forums convened with the help of CCWD. The underlying task is to look at the trend of the existing jobs in healthcare and to gauge where the industry is heading with new jobs and the changes required.

Among the questions that Ann would like to review about potentially emerging jobs are:

- What are the high priority areas?
- Are the new positions people who can practice independently, or do they need supervision?
- Do the jobs require a degree or certification? Is training typically in the education setting or on the job?
- Barriers to employment
- To what degree do particular jobs or roles overlap with one another?
- (How) does the new job or role support health systems transformation?

Lisa Angus will send out to members a recent article about the concept of "Primary Care Technicians". Members who would like to assist with the literature review were asked to let Ann Malosh know by Friday, Feb 7, 2014 at the latest.

7. Presentation from Dana Drum, Oregon Public Health Division

Danna Drum from the Performance Management Program of OHA's Public Health Division presented information about Oregon's Public Health Workforce Gaps and Training Needs. This report focused on the anticipated gaps in Public Health workforce and the results of a workforce training needs assessment results for the existing Public Health workforce.

The report emphasized the urgency of workforce training, recruitment and retention in Oregon within the public health system. Danna and others anticipate building a broad public health workforce development plan for Oregon, with multiple stakeholders participating. Danna will share this with the Committee when it is completed. Danna suggested having a member of this effort serve on the Healthcare Workforce Committee would be a good way to tie efforts together.

10. Brief Updates on Other Workgroups

Workgroup A: A business plan, developed in consultation with OHA and all relevant stakeholders, for a centralized tracking system and document repository for student clinical placement prerequisites in Oregon.

Lisa Angus reported that there are two areas of work related to the student clinical placement prerequisites:

1. The requirements have been outlined under Oregon Administrative Rules 409-030-0100, effective July 1, 2014. These rules are a universal set of standardized administrative requirements that health profession students will need to meet in order to reduce the administrative burden for all concerned. The administrative rules were already distributed to over 500 interested parties. Lisa also shared three outreach/communication products that will be sent to students, schools, and clinical sites in the coming month.
2. Business plan for a centralized tracking system. An RFI went out to potential vendors in spring of 2013 but only two responses were received. OHPR staff have been proactively contacting additional potential vendors, who could present options to a workgroup. With Terri Johanson's resignation, new Committee leadership is needed for this project.

Workgroup B: A policy options memo, for increasing the number of family medicine and other primary care medical residencies in Oregon.

Robyn Dreibelbis reminded members that the memo to OHPB is due July 1, 2014. A retreat with stakeholders is scheduled for February 25, 2014. At this meeting, discussions will begin concerning the expansion of primary care medical residencies in Oregon. There will be a second meeting to include a larger group of individuals involved in this topic.

There are currently many models of resident education. One goal is to gather what is currently available and see what is missing or what we can learn from other states and their

residency training programs. This group will also look at the current federal funding system for residencies and the barriers and/or changes that are a part of that.

Projections of primary care provider demand in Oregon after implementation of ACA coverage expansions, with appropriate adjustments for the estimated impact of health systems transformation on primary care workforce roles and capacity.

Lisa Angus and Jo Isgrigg reported on the presentation that they made along with Peter Graven at the Oregon Health Policy Board on February 4, 2014 and the feedback they received from OHPB. The group received positive feedback from the Board and also a request from OHPB to lay out more specific strategies for the 2015-2017 Budget.

This draft report will be posted on the website.

11. Public Comment

Michael Latteri, a second year medical student from OHSU, commented that he is trying to get other students also to attend meetings of the Committee, as he finds them useful and informative.

12. Emerging Issues

David Pollack had two issues to share with the group.

1. OHSU School of Medicine Undergraduate Curriculum Transformation
David is on the committee that is transforming the current curriculum at OHSU. The current curriculum is changing radically to integrate all the basic type of courses into a series of blocks and clusters. He will share more on these changes as they move along.
2. Inter-Professional Training Initiative
David reported that every first-year student in all the disciplines at OHSU will have four half-days when they will come together to share and learn about each other's disciplines. David will arrange for one of these students to come to this Committee to talk about this change.

Meeting adjourned at 4:00pm.

Job Growth in Oregon

Industry and Occupational Employment
Projections Through 2022

Oregon Healthcare Workforce Institute

April 2, 2014

The projected growth will take us far beyond our pre-recession employment levels.

Oregon to Add 258,000 Jobs by 2022



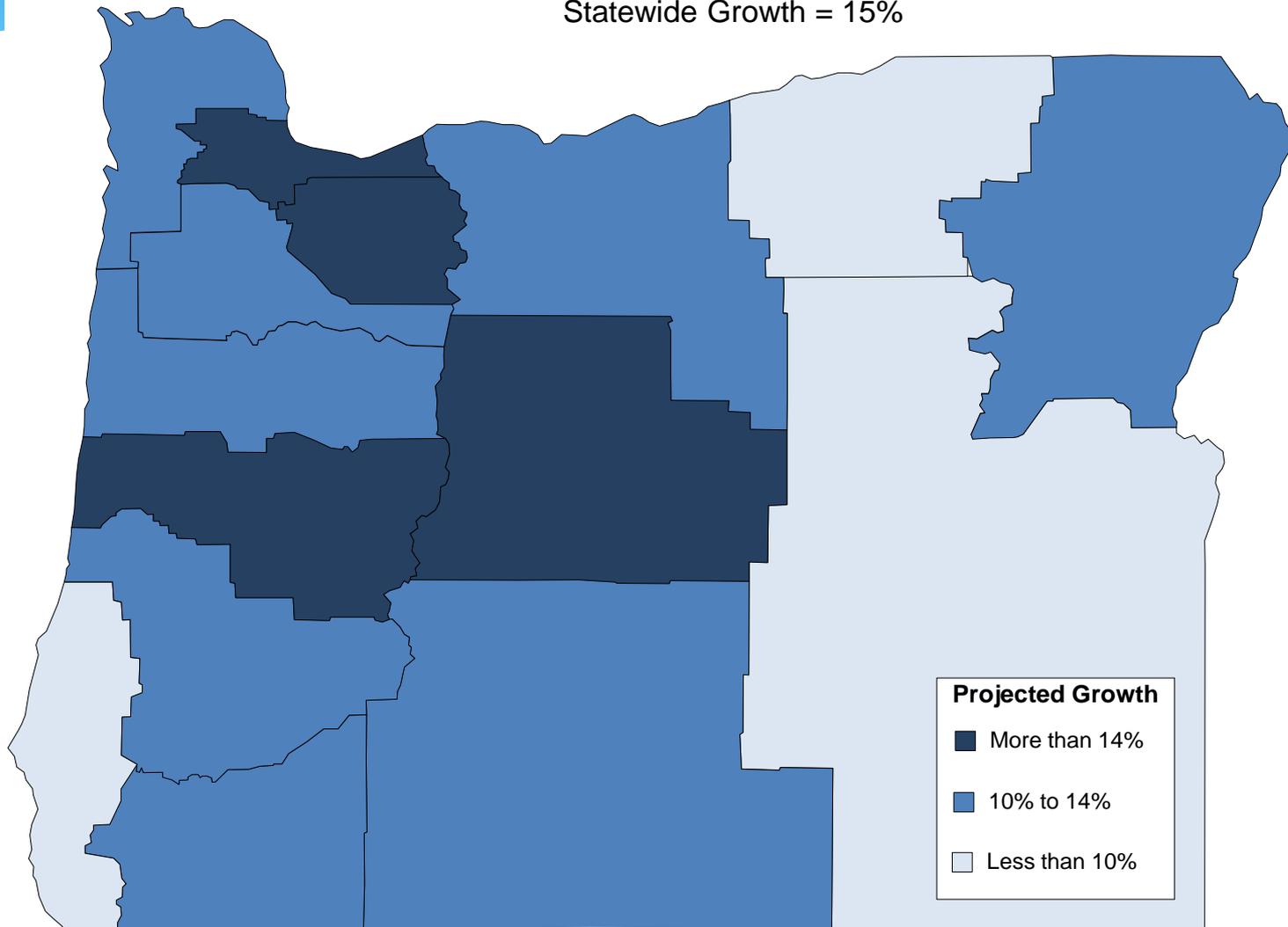
- * 258,000 jobs over ten years is well above the 100,000 jobs added in the past 10 years.
- * 15% growth over ten years is stronger than the 6% growth seen over the past decade

Key Factors

- * Continuing population growth.
- * The need to replace baby boom retirees (even though many will work longer than planned).
- * Continued growth in health care, in part because of those aging baby boomers.
- * Strong growth in construction, recovering from large recession losses.

Some very rural areas have super-slow growth.

Faster Job Growth Projected in Portland Area and Central Oregon, 2012-2022
Statewide Growth = 15%



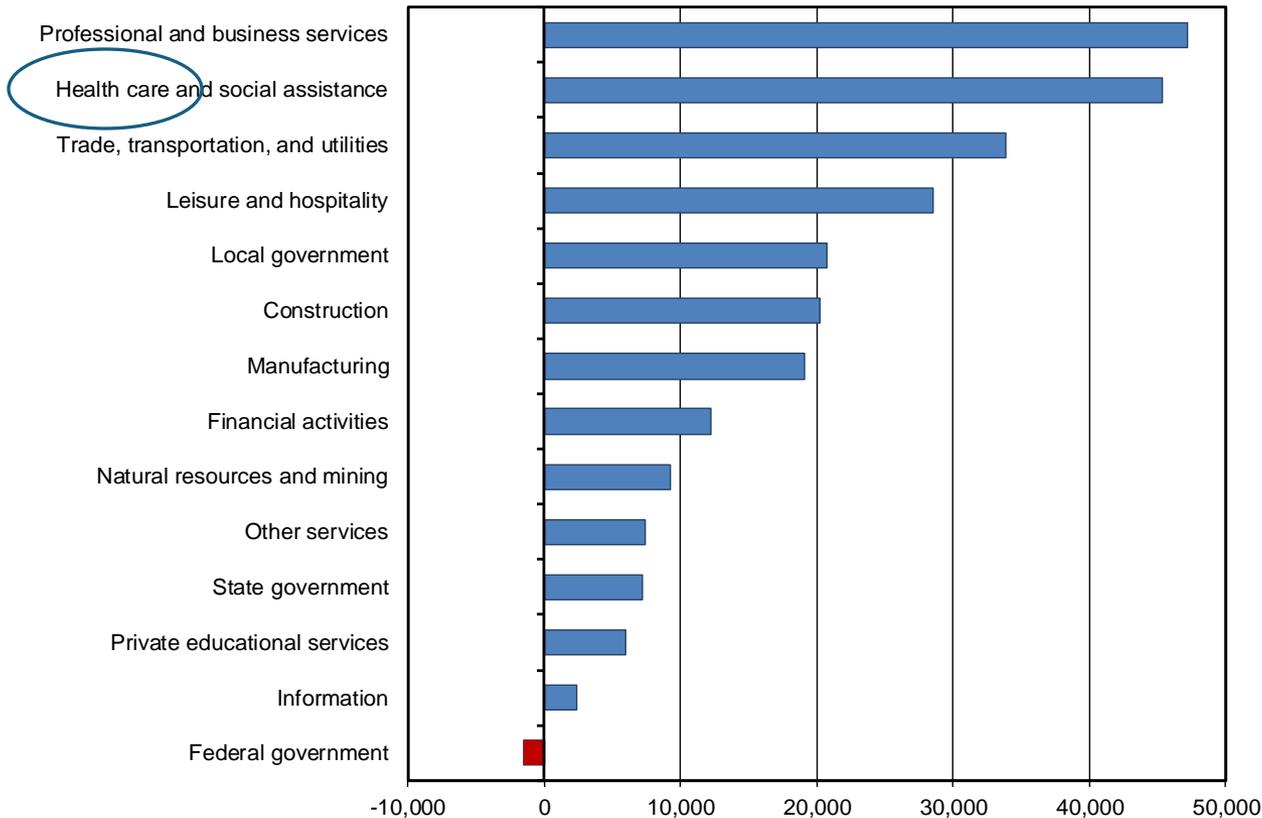
“Industry” vs “Occupation”

- * “Healthcare industry” includes ALL workers in the industry
 - * A hospital employs nurses, baristas and janitors...
- * “Healthcare occupations” are those occupations that are directly healthcare related
 - * Podiatrists, audiologists, phlebotomists, nurses...

Starting with Industry data....

Computer systems design, nursing and residential care facilities, and ambulatory care facilities drive the growth in the professional/business and health industry sectors.

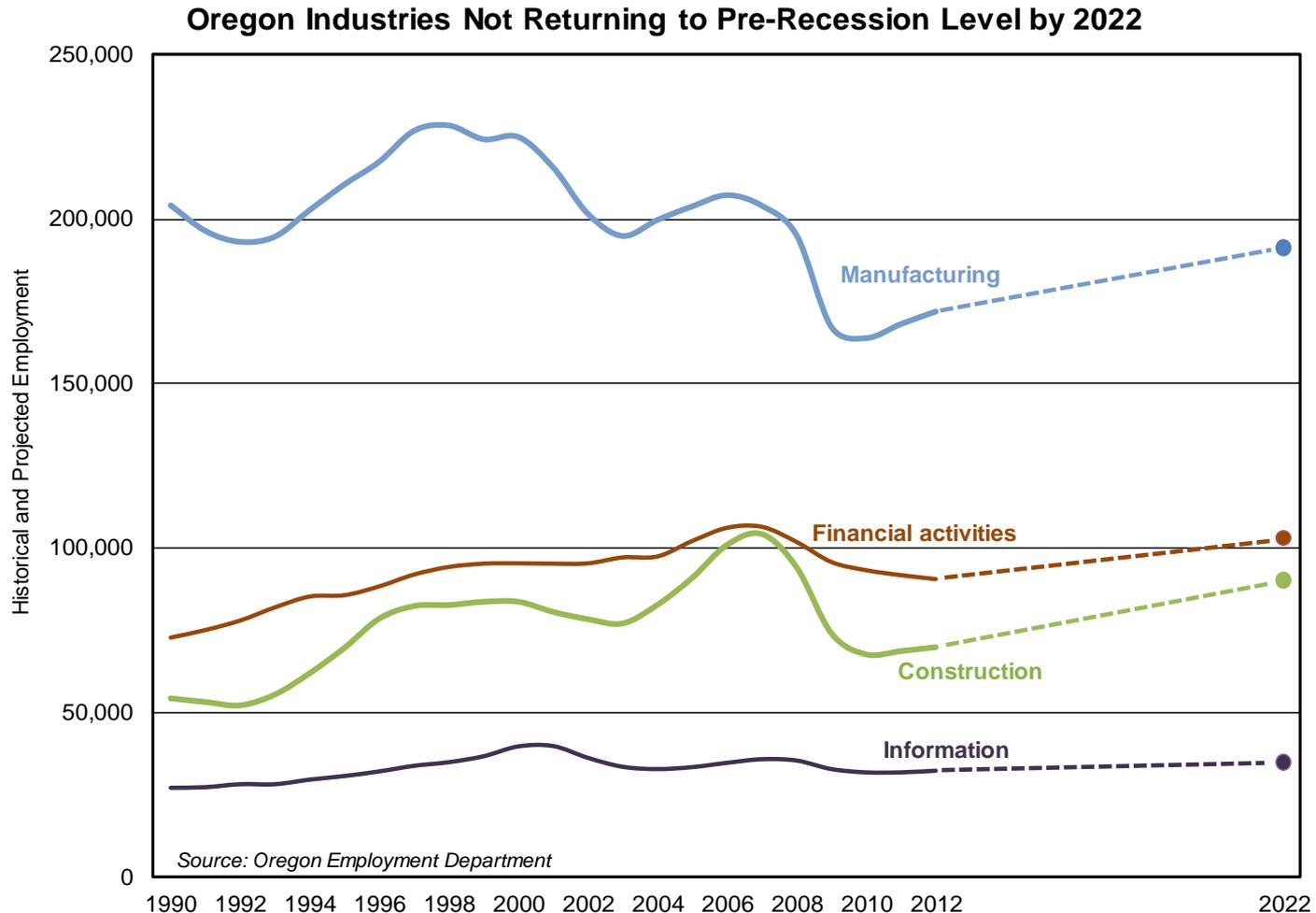
All Oregon Private Industry Sectors Expected to Add Jobs, 2012-2022



Source: Oregon Employment Department

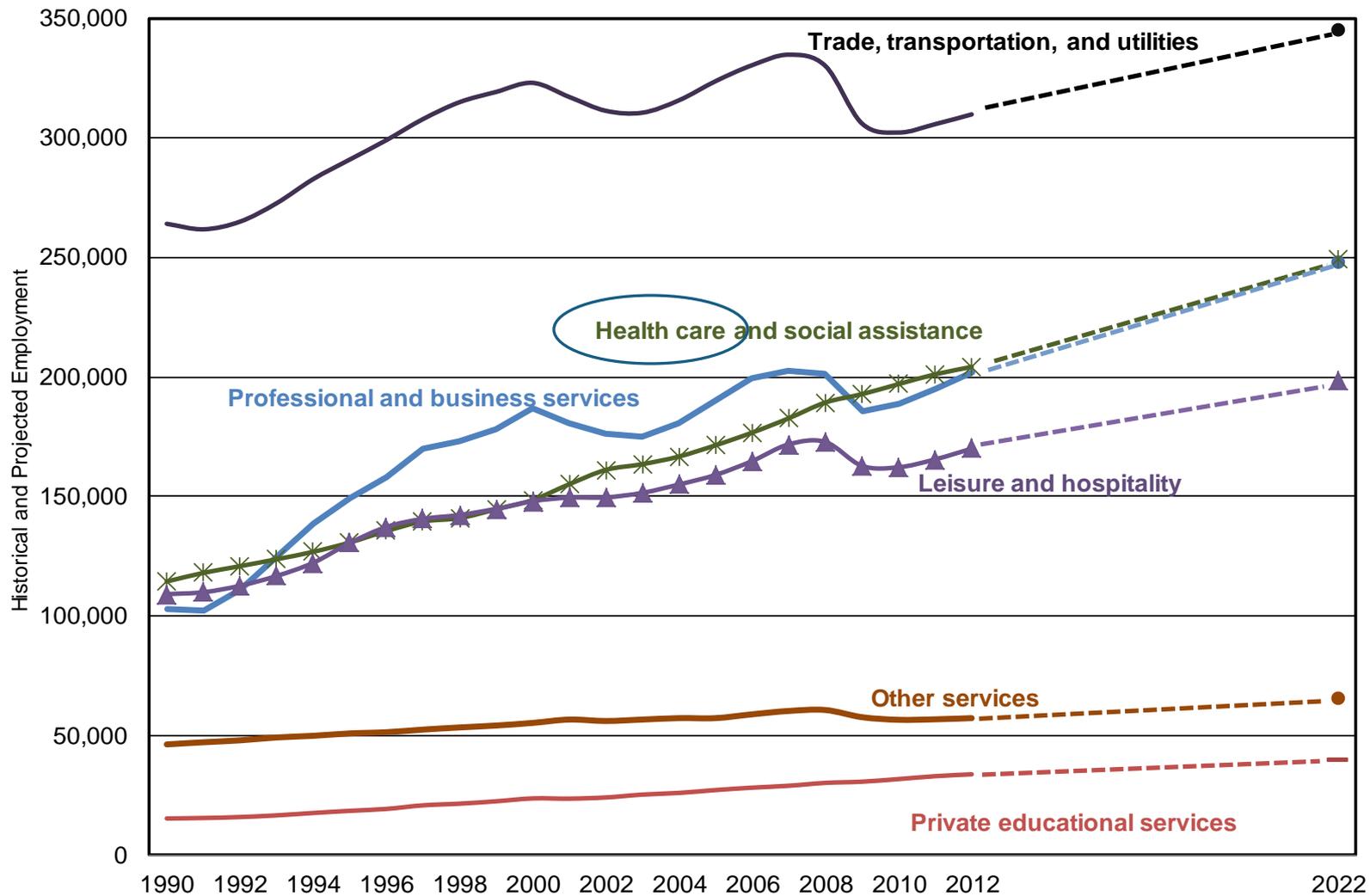
* Federal government is the only industry projected to decline, largely due to losses in postal employment

Despite its strong growth, construction will not return to its pre-recession employment level by 2022. Nor will manufacturing, financial activities, or information.



On a brighter note, many industries will regain and surpass their pre-recession employment levels.

Oregon Industries Growing Past Pre-Recession Level by 2022



Health care and private educational services never really had a recessionary slump.

Source: Oregon Employment Department

All sectors in healthcare continuing their upward trend

- Growth above statewide average of 15%
- Hospital growth expected to be slightly below statewide average
 - Shift to care in offices of physicians and away from hospitals

	2012	2022	Change	% Change
Health care and social assistance	204,100	249,400	45,300	22%
Ambulatory health care services	74,000	93,100	19,100	26%
Hospitals	53,500	61,100	7,600	14%
Nursing and residential care facilities	44,100	55,900	11,800	27%
Social assistance	32,500	39,300	6,800	21%

Switching to Occupations....

Healthcare
occupations
found in variety
of industries

	2012 Employment
General Medical and Surgical Hospitals	41,472
Offices of Physicians	21,652
Offices of Dentists	11,751
Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly	9,226
Nursing Care Facilities (Skilled Nursing Facilities)	7,784
Outpatient Care Centers	7,452
Colleges and Universities	6,720
Executive, Legislative and General Government Administration of Human Resource Programs	3,948
Veterinary Services	3,796
Individual and Family Services	3,651
Residential Intellectual & Developmental Disability, Mental Health, & Substance Abuse Facilities	3,383
Offices of Physical, Occupational, and Speech Therapists, and Audiologists	3,282
Federal Government, Excluding Post Office	3,189
Home Health Care Services	2,700
Pharmacies and Drug Stores	2,353
Medical and Diagnostic Laboratories	2,295
Offices of Chiropractors	2,217
Management of Companies and Enterprises	2,053
Offices of All Other Health Practitioners	2,051
Employment Services	1,794
Psychiatric and Substance Abuse Hospitals	1,518
Other General Merchandise Stores	1,353
Offices of Optometrists	1,268
Offices of Mental Health Practitioners (except Physicians)	1,237
Ambulance Services	1,168
	1,144

Industries, cont.

From
education
to retail,

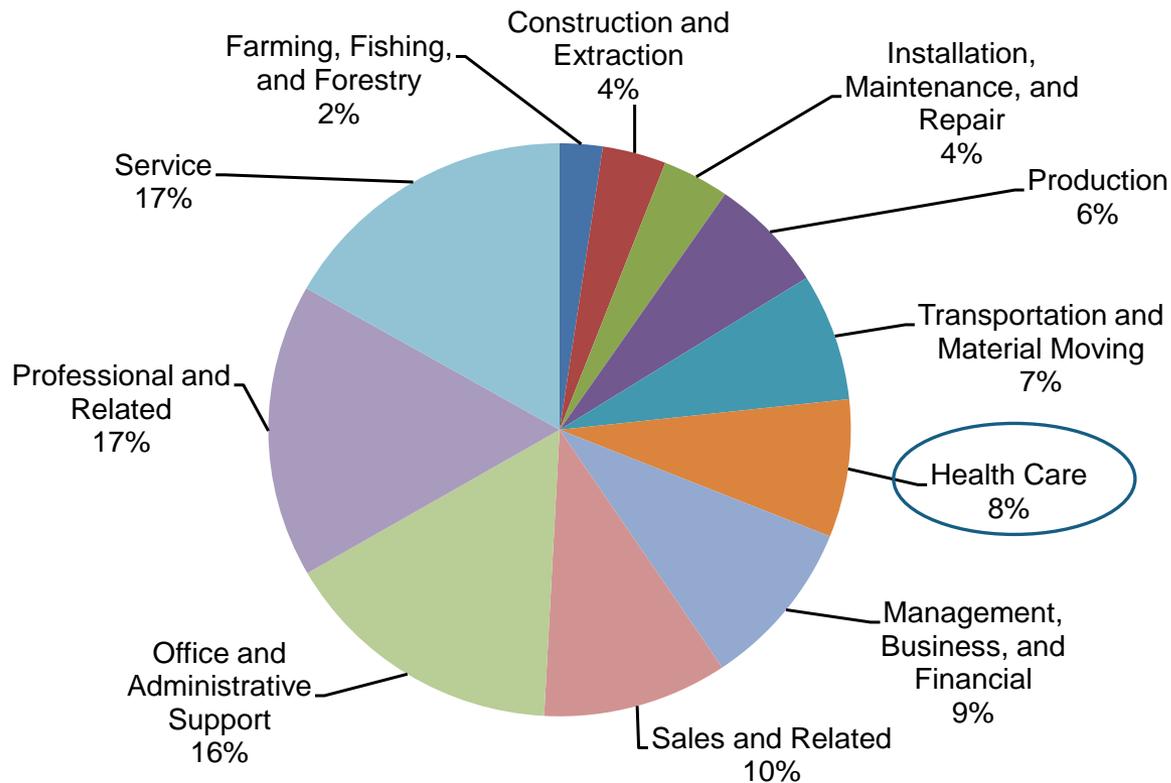
and

insurance
to child care

	2012 <u>Employment</u>
Elementary and Secondary Schools	896
Medical Equipment and Supplies Manufacturing	851
Department Stores	834
Grocery Stores	795
Justice, Public Order, and Safety Activities	743
All Other Professional, Scientific, and Technical Services	717
Insurance Carriers	696
Vocational Rehabilitation Services	656
Personal Care Services	618
Blood and Organ Banks	618
Specialty (except Psychiatric and Substance Abuse) Hospitals	605
Other Residential Care Facilities	569
Electronic Shopping and Mail Order Houses	438
Management, Scientific, and Technical Consulting Services	420
Optical Goods Stores	400
Community Food and Housing, and Emergency and Other Relief Services	387
Child Day Care Services	304
Colleges, Universities, and Professional Schools	267
All Other Health and Personal Care Stores	254
Offices of Podiatrists	251
Computer Systems Design and Related Services	228
Document Preparation Services	209
Telemarketing Bureaus and Other Contact Centers	182
Other Support Services	175
Scientific Research and Development Services	164

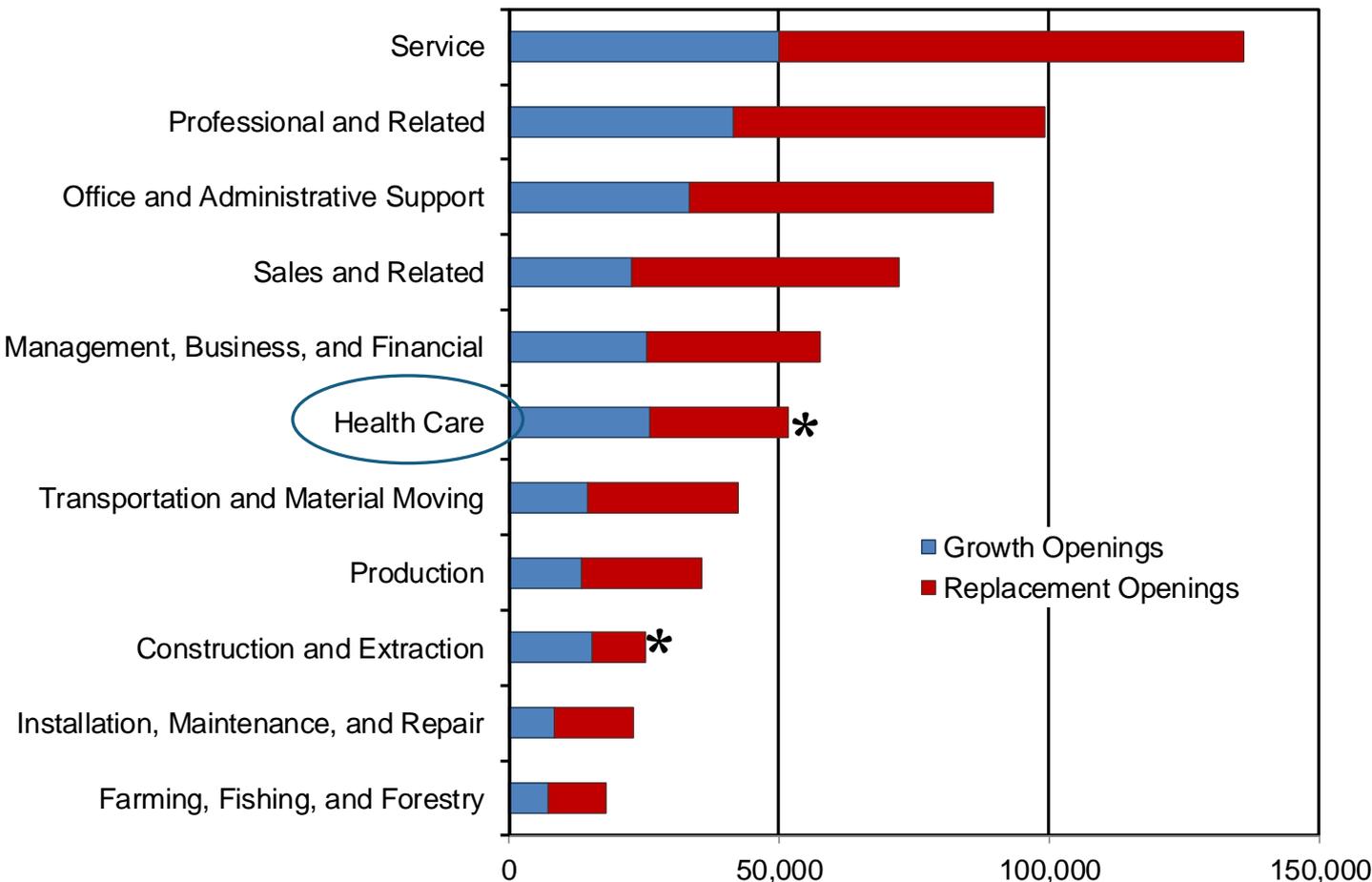
One out of 12 jobs in Oregon are healthcare jobs

Oregon Employment by Broad Occupational Group, 2012



Healthcare and construction only sectors with more job openings due to growth than replacement needs

Growth Openings vs. Replacement Openings in Oregon, 2012-2022



Top two occupations with most openings in services:

- * Combined Food Prep and Serving Workers
- * Waiters and Waitresses

Top two occupations with most openings in professional:

- * Teacher Assistants
- * Postsecondary Teachers

Healthcare occupations among the fastest growing in the state

20 Fastest Growing Occupations in Oregon, 2012-2022

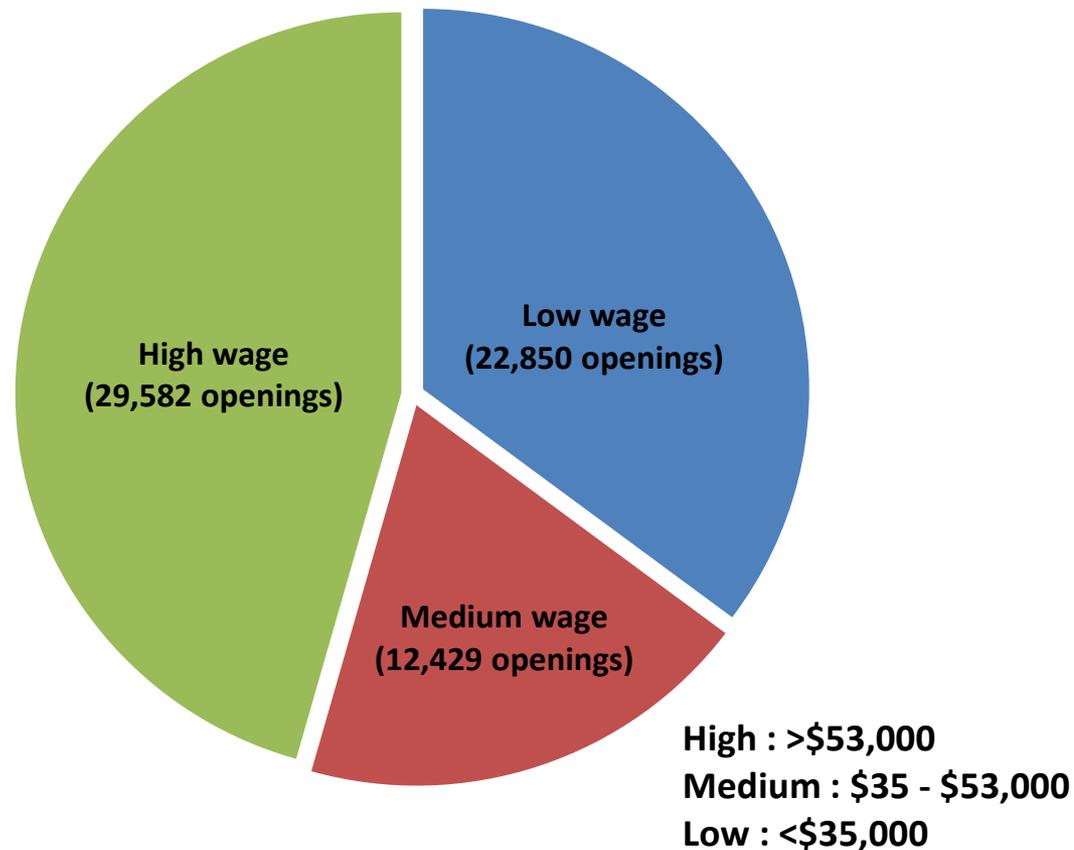
Standard Occupational Classification Title	2012 Employment	Percent Change
Skincare Specialists	297	57.2%
Numerical Tool and Process Control Programmers	462	47.2%
Survey Researchers	177	44.6%
Gaming Service Workers, All Other	36	41.7%
Choreographers	237	40.9%
Roofers	1,963	39.5%
Anthropologists and Archeologists	226	39.4%
Podiatrists	64	39.1%
Brickmasons and Blockmasons	460	38.9%
Physician Assistants	931	38.7%
Insulation Workers, Floor, Ceiling, and Wall	450	38.7%
Fence Erectors	415	38.3%
Travel Guides	235	38.3%
Stonemasons	34	38.2%
Diagnostic Medical Sonographers	469	38.2%
Animal Trainers	152	38.2%
Market Research Analysts and Marketing Specialists	2,390	37.8%
Nurse Midwives	171	37.4%
Mason's and Tile and Marble Setter's Helpers	273	37.4%
Geographers	43	37.2%
Roofers' Helpers	97	37.1%
Plasterers and Stucco Masons	235	37.0%
Painters, Construction and Maintenance	3,306	37.0%
Painter's, Paperhanger's, Plasterer's, and Stucco Mas	142	36.6%
Physical Therapist Aides	605	36.5%

Fastest growing healthcare occupations

	2012 Employment	2022 Employment	Employment Change	Percent Change
Podiatrists	64	89	25	39.1%
Physician Assistants	931	1,291	360	38.7%
Diagnostic Medical Sonographers	469	648	179	38.2%
Nurse Midwives	171	235	64	37.4%
Physical Therapist Aides	605	826	221	36.5%
Medical Equipment Repairers	592	807	215	36.3%
Optometrists	404	550	146	36.1%
Home Health Aides	7,101	9,502	2,401	33.8%
Audiologists	220	293	73	33.2%
Physical Therapist Assistants	582	768	186	32.0%
Medical Secretaries	12,382	16,167	3,785	30.6%
Health Diagnosing and Treating Practitioners, All Other	383	499	116	30.3%
Occupational Therapy Assistants	180	233	53	29.4%
Orthotists and Prosthetists	106	137	31	29.3%
Marriage and Family Therapists	458	591	133	29.0%

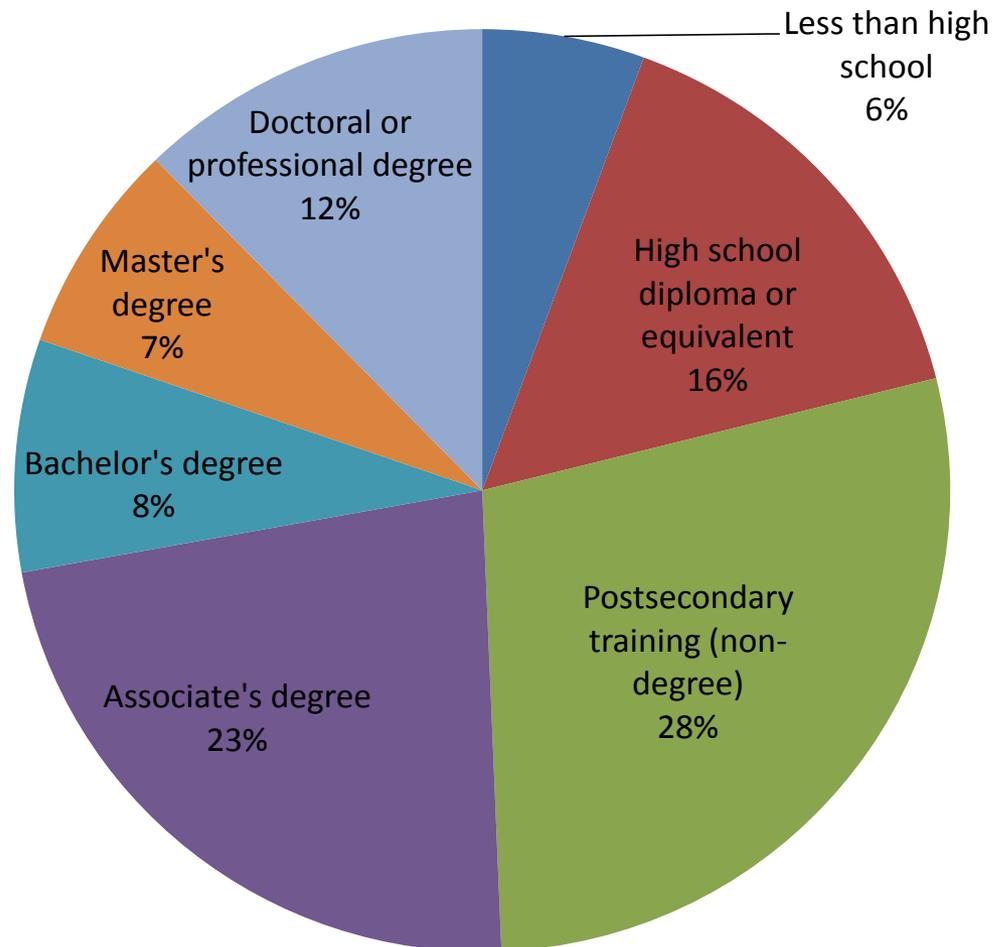
Almost half of healthcare job openings will be high wage

Healthcare Occupational Job Openings, 2012-2022



A degree is the typical entry level education for half of healthcare job openings

Healthcare Occupational Job Openings, 2012-2022



To summarize:

- * Healthcare...
 - * Made it through the recession with flying colors
 - * Occupations found in a variety of industries
 - * Growing faster than the statewide average of 15%
 - * Has a larger share of openings due to growth than replacement
 - * Openings are good paying jobs and most require higher levels of education

Brenda Turner, Occupational Economist

Oregon Employment Department

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Oregon Healthcare Employment Projections by Detailed SOC, 2012-2022

Oregon Employment Department, Workforce and Economic Research
 Brenda.P.Turner@state.or.us, 503-947-1233

Standard Occupational Classification Code and Title	2012		2022		Employment Change	Percent Change	Growth Openings	Replacement Openings	Total Openings	Typical Entry Level Education	Competitive Education	Work Experience	On-the-Job Training
	Employment	Employment	Employment	Employment									
Management													
11-9111 Medical and Health Services Managers	3,434	4,070	636	18.5%	636		834	1,470	Bachelor's degree	Master's degree	None	None	
Social Scientists and Related Workers													
19-3031 Clinical, Counseling, and School Psychologists	1,147	1,375	228	19.9%	228		312	540	Master's degree	Doctoral or professional degree	None	Internship/residency	
Counselors, Social Workers, and Other Community and Social Service Specialists													
21-1011 Substance Abuse and Behavioral Disorder Counselors	1,527	1,862	335	21.9%	335		325	660	High school diploma or equivalent	Master's degree	None	Moderate-term on-the-job training	
21-1013 Marriage and Family Therapists	458	591	133	29.0%	133		97	230	Master's degree	Master's Degree	None	Internship/residency	
21-1014 Mental Health Counselors	1,916	2,282	366	19.1%	366		407	773	Master's degree	Master's Degree	None	Internship/residency	
21-1015 Rehabilitation Counselors	1,397	1,598	201	14.4%	201		297	498	Master's degree	Master's Degree	None	None	
21-1019 Counselors, All Other	224	259	35	15.6%	35		48	83	Master's degree	Master's Degree	None	None	
21-1021 Child, Family, and School Social Workers	3,448	3,888	440	12.8%	440		730	1,170	Bachelor's degree	Master's Degree	None	None	
21-1022 Healthcare Social Workers	1,328	1,559	231	17.4%	231		281	512	Bachelor's degree	Master's degree	None	None	
21-1023 Mental Health and Substance Abuse Social Workers	2,172	2,555	383	17.6%	383		460	843	Master's degree	Master's Degree	None	None	
21-1029 Social Workers, All Other	1,573	1,767	194	12.3%	194		333	527	Bachelor's degree	Master's Degree	None	None	
21-1091 Health Educators	760	879	119	15.7%	119		199	318	Bachelor's degree	Master's Degree	None	None	
21-1094 Community Health Workers	287	328	41	14.3%	41		75	116	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	Short-term on-the-job training	
Healthcare Practitioners and Technical Occupations													
29-1011 Chiropractors	459	566	107	23.3%	107		90	197	Doctoral or professional degree	Doctoral or professional degree	None	None	
29-1021 Dentists, General	1,167	1,296	129	11.1%	129		285	414	Doctoral or professional degree	Doctoral or professional degree	None	None	
29-1029 Dentists, All Other Specialists	296	325	29	9.8%	29		72	101	Doctoral or professional degree	Doctoral or professional degree	None	Internship/residency	
29-1031 Dietitians and Nutritionists	586	684	98	16.7%	98		70	168	Bachelor's degree	Bachelor's degree	None	Internship/residency	
29-1041 Optometrists	404	550	146	36.1%	146		117	263	Doctoral or professional degree	Doctoral or professional degree	None	None	
29-1051 Pharmacists	3,506	4,144	638	18.2%	638		837	1,475	Doctoral or professional degree	Doctoral or professional degree	None	None	
29-1060 Physicians and Surgeons	8,185	9,862	1,677	20.5%	1,677		2,049	3,726	Doctoral or professional degree	Doctoral or professional degree	None	Internship/residency	
29-1071 Physician Assistants	931	1,291	360	38.7%	360		167	527	Master's degree	Master's degree	None	None	
29-1081 Podiatrists	64	89	25	39.1%	25		13	38	Doctoral or professional degree	Doctoral or professional degree	None	Internship/residency	
29-1122 Occupational Therapists	1,084	1,336	252	23.3%	252		147	399	Master's degree	Doctoral or professional degree	None	None	
29-1123 Physical Therapists	2,362	3,025	663	28.1%	663		581	1,244	Doctoral or professional degree	Doctoral or professional degree	None	None	
29-1124 Radiation Therapists	166	193	27	16.3%	27		34	61	Associate's degree	Bachelor's degree	None	None	
29-1125 Recreational Therapists	131	160	29	22.1%	29		27	56	Bachelor's degree	Bachelor's degree	None	None	
29-1126 Respiratory Therapists	1,175	1,333	158	13.5%	158		170	328	Associate's degree	Bachelor's degree	None	None	
29-1127 Speech-Language Pathologists	952	1,133	181	19.0%	181		144	325	Master's degree	Doctoral or professional degree	None	None	
29-1128 Exercise Physiologists	37	38	1	2.7%	1		4	5	Bachelor's degree	Bachelor's degree	None	None	
29-1129 Therapists, All Other	99	121	22	22.2%	22		12	34	Bachelor's degree	Master's Degree	None	None	
29-1131 Veterinarians	1,069	1,288	219	20.5%	219		343	562	Doctoral or professional degree	Doctoral or professional degree	None	None	
29-1141 Registered Nurses	30,677	35,636	4,959	16.2%	4,959		5,948	10,907	Associate's degree	Bachelor's degree	None	None	
29-1151 Nurse Anesthetists	178	225	47	26.4%	47		35	82	Master's degree	Master's degree	None	None	
29-1161 Nurse Midwives	171	235	64	37.4%	64		33	97	Master's degree	Master's degree	None	None	
29-1171 Nurse Practitioners	958	1,215	257	26.8%	257		186	443	Master's degree	Master's degree	None	None	
29-1181 Audiologists	220	293	73	33.2%	73		45	118	Master's degree	Doctoral or professional degree	None	None	
29-1199 Health Diagnosing and Treating Practitioners, All Other	383	499	116	30.3%	116		79	195	Doctoral or professional degree	Doctoral or professional degree	None	None	
Health Technologists and Technicians													
29-2011 Medical and Clinical Laboratory Technologists	1,683	1,899	216	12.8%	216		441	657	Bachelor's degree	Bachelor's degree	None	None	
29-2012 Medical and Clinical Laboratory Technicians	1,098	1,376	278	25.3%	278		288	566	Postsecondary training (non-degree)	Associate's degree	None	None	
29-2021 Dental Hygienists	3,356	3,975	619	18.4%	619		859	1,478	Associate's degree	Bachelor's degree	None	None	
29-2031 Cardiovascular Technologists and Technicians	630	796	166	26.4%	166		89	255	Associate's degree	Associate's degree	None	None	
29-2032 Diagnostic Medical Sonographers	469	648	179	38.2%	179		66	245	Associate's degree	Bachelor's degree	None	None	
29-2033 Nuclear Medicine Technologists	170	203	33	19.4%	33		24	57	Associate's degree	Bachelor's degree	None	None	
29-2034 Radiologic Technologists	1,979	2,323	344	17.4%	344		279	623	Associate's degree	Bachelor's degree	None	None	
29-2035 Magnetic Resonance Imaging Technologists	222	262	40	18.0%	40		31	71	Associate's degree	Associate's degree	Less than 5 years	None	
29-2041 Emergency Medical Technicians and Paramedics	1,841	2,156	315	17.1%	315		502	817	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None	
29-2051 Dietetic Technicians	175	211	36	20.6%	36		17	53	High school diploma or equivalent	Postsecondary training (non-degree)	None	None	
29-2052 Pharmacy Technicians	4,699	5,550	851	18.1%	851		465	1,316	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	Moderate-term on-the-job training	
29-2053 Psychiatric Technicians	478	586	108	22.6%	108		47	155	Postsecondary training (non-degree)	Associate's degree	None	Short-term on-the-job training	
29-2055 Surgical Technologists	990	1,204	214	21.6%	214		98	312	Postsecondary training (non-degree)	Associate's degree	None	None	
29-2056 Veterinary Technologists and Technicians	1,429	1,723	294	20.6%	294		141	435	Associate's degree	Associate's degree	None	None	
29-2057 Ophthalmic Medical Technicians	243	304	61	25.1%	61		24	85	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None	
29-2061 Licensed Practical and Licensed Vocational Nurses	2,705	3,242	537	19.9%	537		660	1,197	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None	
29-2071 Medical Records and Health Information Technicians	3,014	3,630	616	20.4%	616		797	1,413	Postsecondary training (non-degree)	Associate's degree	None	None	
29-2081 Opticians, Dispensing	1,030	1,316	286	27.8%	286		296	582	High school diploma or equivalent	Postsecondary training (non-degree)	None	Long-term on-the-job training	
29-2091 Orthotists and Prosthetists	106	137	31	29.3%	31		10	41	Bachelor's degree	Bachelor's degree	None	Internship/residency	
29-2092 Hearing Aid Specialists	116	136	20	17.2%	20		11	31	High school diploma or equivalent	High school diploma or equivalent	None	None	
29-2099 Health Technologists and Technicians, All Other	1,546	1,873	327	21.2%	327		153	480	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None	
Other Healthcare Practitioners and Technical Occupations													
29-9011 Occupational Health and Safety Specialists	946	1,057	111	11.7%	111		257	368	Bachelor's degree	Bachelor's degree	None	Short-term on-the-job training	
29-9012 Occupational Health and Safety Technicians	65	70	5	7.7%	5		18	23	Bachelor's degree	Bachelor's degree	None	Moderate-term on-the-job training	
29-9091 Athletic Trainers	207	250	43	20.8%	43		56	99	Bachelor's degree	Master's Degree	None	None	
29-9099 Healthcare Practitioners and Technical Workers, All Other	811	964	153	18.9%	153		221	374	Associate's degree	Associate's degree	None	None	
Nursing, Psychiatric, and Home Health Aides													
31-1011 Home Health Aides	7,101	9,502	2,401	33.8%	2,401		1,351	3,752	Less than high school	Postsecondary training (non-degree)	None	Short-term on-the-job training	

Oregon Healthcare Employment Projections by Detailed SOC, 2012-2022

Oregon Employment Department, Workforce and Economic Research
 Brenda.P.Turner@state.or.us, 503-947-1233

Standard Occupational Classification Code and Title		2012	2022	Employment	Percent	Growth	Replacement	Total	Typical Entry Level Education	Competitive Education	Work Experience	On-the-Job Training
		Employment	Employment	Change	Change	Openings	Openings	Openings				
31-1013	Psychiatric Aides	1,099	1,308	209	19.0%	209	209	418	High school diploma or equivalent	High school diploma or equivalent	None	Short-term on-the-job training
31-1014	Nursing Assistants	13,546	16,308	2,762	20.4%	2,762	2,576	5,338	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None
Occupational Therapy and Physical Therapist Assistants and Aides												
31-2011	Occupational Therapy Assistants	180	233	53	29.4%	53	45	98	Associate's degree	Associate's degree	None	None
31-2012	Occupational Therapy Aides	18	21	3	16.7%	3	5	8	High school diploma or equivalent	Postsecondary training (non-degree)	None	Short-term on-the-job training
31-2021	Physical Therapist Assistants	582	768	186	32.0%	186	129	315	Associate's degree	Associate's degree	None	None
31-2022	Physical Therapist Aides	605	826	221	36.5%	221	134	355	High school diploma or equivalent	Associate's degree	None	Short-term on-the-job training
Other Healthcare Support Occupations												
31-9011	Massage Therapists	1,689	2,126	437	25.9%	437	179	616	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None
31-9091	Dental Assistants	4,476	4,962	486	10.9%	486	928	1,414	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None
31-9092	Medical Assistants	7,691	9,744	2,053	26.7%	2,053	1,467	3,520	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None
31-9093	Medical Equipment Preparers	1,207	1,381	174	14.4%	174	230	404	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	Moderate-term on-the-job training
31-9094	Medical Transcriptionists	1,237	1,365	128	10.4%	128	236	364	Postsecondary training (non-degree)	Associate's degree	None	None
31-9096	Veterinary Assistants and Laboratory Animal Caretakers	1,222	1,473	251	20.5%	251	233	484	High school diploma or equivalent	Postsecondary training (non-degree)	None	Short-term on-the-job training
31-9097	Phlebotomists	1,096	1,288	192	17.5%	192	209	401	Postsecondary training (non-degree)	Postsecondary training (non-degree)	None	None
31-9099	Healthcare Support Workers, All Other	2,108	2,487	379	18.0%	379	402	781	High school diploma or equivalent	Postsecondary training (non-degree)	None	None
Office and Administrative Support												
43-4111	Interviewers, Except Eligibility and Loan	3,069	3,579	510	16.6%	510	580	1,090	High school diploma or equivalent	High school diploma or equivalent	None	Short-term on-the-job training
43-6013	Medical Secretaries	12,382	16,167	3,785	30.6%	3,785	1,490	5,275	High school diploma or equivalent	Postsecondary training (non-degree)	None	Moderate-term on-the-job training
Installation, Maintenance, and Repair												
49-9062	Medical Equipment Repairers	592	807	215	36.3%	215	165	380	Postsecondary training (non-degree)	Associate's degree	None	Moderate-term on-the-job training
Production												
51-9081	Dental Laboratory Technicians	806	920	114	14.1%	114	272	386	High school diploma or equivalent	Postsecondary training (non-degree)	None	Moderate-term on-the-job training
51-9082	Medical Appliance Technicians	95	109	14	14.7%	14	32	46	High school diploma or equivalent	Postsecondary training (non-degree)	None	Long-term on-the-job training
51-9083	Ophthalmic Laboratory Technicians	373	425	52	13.9%	52	126	178	High school diploma or equivalent	High school diploma or equivalent	None	Moderate-term on-the-job training

THE DIVERSITY OF OREGON'S HEALTHCARE WORKFORCE 2012—2013

Oregon's Healthcare Workforce Committee was asked by the Oregon Health Policy Board to provide a snapshot of the diversity of the healthcare workforce. Using information from seven licensing Boards required to provide workforce related data to the Oregon Health Authority, this report explores the relative distribution of workforce and population by race, ethnicity and language. It also includes data specifically for primary care providers and information about professionals of color. The licensing Boards required to report include the Oregon Medical Board, Board of Dentistry, State Board of Nursing, Board of Pharmacy, Physical Therapist Licensing Board, Occupational Therapy Licensing Board, and the Board of Examiners of Licensed Dietitians.

Unfortunately, the findings in the report are limited by a significant amount of missing data on race and ethnicity of health care professionals. OHA is working with the licensing Boards to improve data collection for future reports.

RACE & ETHNICITY

It is likely that Oregon's healthcare workforce is less racially and ethnically diverse than the state as a whole, but given the limitations of the data collected, that is impossible to say with certainty.

Almost 13% of the workforce records are missing race/ethnicity data (either it was not entered by the licensee or

it was not collected by the licensing board). The Oregon Medical Board and the Oregon State Board of Nursing provided race/ethnicity data collected with their own data system; all the other health professions' race/ethnicity data were collected through a common format workforce survey that licensees must complete as part of their renewal process.

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

Asian Health Professionals: N=3,383

- 90% practice in 9 counties
- Among race groups, has the highest proportion working in Washington County (21%) and Clackamas County (12%)
- 27% are practicing as physicians

Native Hawaiian/Pacific Islander Health Professionals: N=51

- 25 % practicing as physicians, however, NH/PI professionals only reported as practicing in 11 counties
- 40% practicing in Multnomah County

Note: Due to the amount of missing race and ethnicity data, percentages highlighting racial/ethnic workforce makeup should be interpreted with caution.

RACE & ETHNICITY, CONTINUED

In most counties in Oregon, the workforce is less Hispanic than the overall population. Counties with a larger than average Hispanic population have a higher number of Hispanic health professionals, however, there tends to be an even greater gap in those counties between number of Hispanic health professionals and the size of the Hispanic population. The map at right shows the difference between the percentages of Hispanic health professionals to Hispanic population, with darker orange indicating a broader gap.

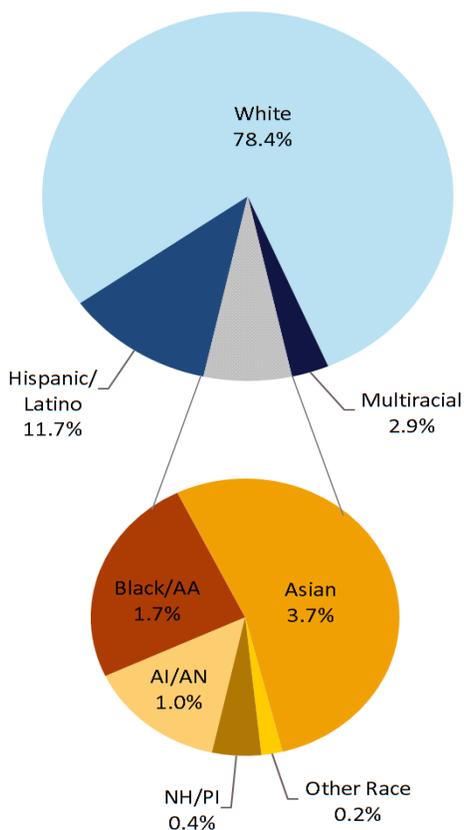
Traditional health workers who provide services to clients as, for example, peer wellness specialists, peer support specialists, community health workers/promotoras, personal health navigators and homecare workers will help to fill gaps. In a survey of 600 traditional health workers conducted in 2011 by Oregon's Office of Equity and Inclusion, a majority of respondents reported that they served people who were from the same racial or ethnic group.

Gap in Hispanic/Latino Representation within Healthcare Health professionals Compared to County



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

Oregon's Racial/Ethnic Composition 2008 - 2012



Hispanic/Latino Health Professionals: N=4,077

- 9% of all CNAs – the highest proportion of non-white racial/ethnic groups
- 45% of all Pharmacists – the highest proportion of all racial/ethnic groups, including white
- 20% aged 30 years or younger – second-highest proportion of all racial/ethnic groups

African American Health Professionals: (N=891)

- 40% plan on increasing practice hours compared to only 15% of white and 17% of Hispanic/Latino health professionals.
- Only 5% plan on retiring in the next two years.

American Indian/Alaska Native Health Professionals: N=396

- Only 19% practice in Multnomah County compared to 26% of Hispanic/Latinos and 55% of African-Americans.
- There is a larger proportion of AI AN health professionals in Lane and Marion counties than any other race group.

LANGUAGE

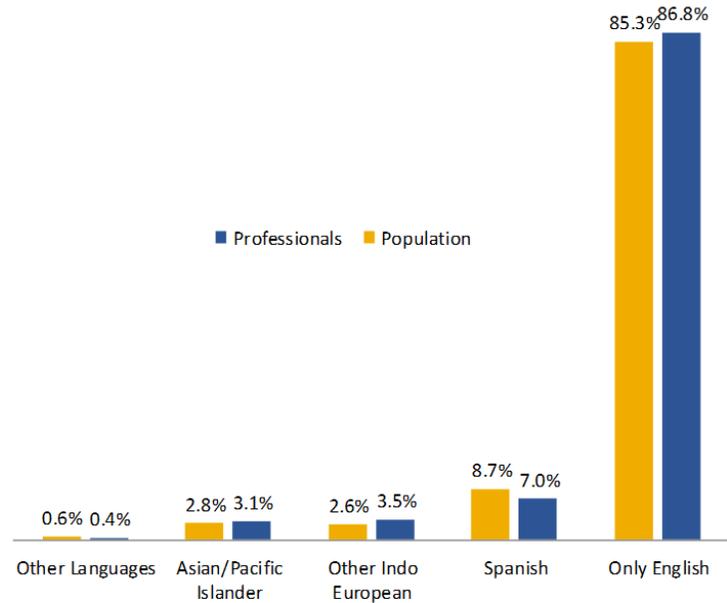
The proportion of health professionals speaking languages other than English is roughly similar to the population as a whole. However, there is no guarantee that a provider who speaks a particular language will be available when needed by a non-English speaking client, nor that their proficiency level will meet the needs of their clients. This is due to the lack of standardized testing currently required for practitioners to report out their proficiency in any particular language(s) they may speak.

Health care interpreters help to fill the gaps. Health care interpreters are individuals who are readily able to communicate with a person with limited English proficiency.

Health care interpreters (HCI) may register with the state of Oregon in three ways: as a registered interpreter; qualified interpreter; or certified interpreter. Certification for a HCI is the highest level of credential available from the State of Oregon, and is achieved by oral and written examination, along with formal training and experience.

Certification establishes interpreting skills and medical knowledge as well as language proficiency. It is estimated that there are more than 4,500 interpreters in Oregon.

Languages in Healthcare Workforce



PRIMARY CARE PROVIDERS^{1,2}

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

Primary care providers are more linguistically diverse than the healthcare workforce as a whole. Spanish is the language most spoken by PCPs and MDs report the highest percentage speaking more than one language. In fact, 87 percent of all providers speak only English but only 68 percent of physicians speak only English.

Oregon Primary Care Providers Diversity Scorecard

	Oregon Population	DO Licensees	MD Licensees	Physician Assistants	Nurse Practitioners
White	78.4%				
Black/AA	1.7%				
AI/AN	1.0%				
Asian	3.7%				
NH/PI	0.4%	*		*	*
Hispanic**	11.7%				

Legend

- below state population by more than 0.5%
- within 0.5% of state population
- above state population by more than 0.5%

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

*No providers

**Any race

¹Primary care providers are defined as MD, PA, DO licensees whose practice specialties are in family medicine, family practice, general practice, internal medicine, geriatrics, pediatrics, and adolescent health; NP licensees with specialty certification in adult, family, pediatric, geriatric, or women health's practice but practice specialty is NOT in anesthesia, critical/care, dermatology, emergency/urgent care, long term care, management/administration, medical/surgical, neonatology, neurology, nursing education, occupational health, oncology, orthopedics, psychology/mental health, regulatory, rehabilitation, or surgery/recovery.

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

METHODS & SOURCES

Workforce data were extracted from the most recent workforce database. The dataset includes total counts of health professionals from seven health licensing boards. Zip codes, state, and cities and other address fields were corrected and standardized where errors were identified.

All race/ethnicity categories in the workforce data were coded to be mutually exclusive to match the ACS race/ethnicity categories and allow for comparisons. When a licensee selected Hispanic as their ethnicity, the licensee was coded as being Hispanic. If there were other races selected along with Hispanic ethnicity, such as “Black” or “Asian”, the licensee would only be counted in the Hispanic category, and not in other categories. When a licensee selected a non-Hispanic ethnicity and more than one race, the licensee was only coded as “Multiracial” and was not included in the specific race categories. When a licensee selected “Other” as race and then no other race was selected, the licensee coded as “Other”.

The age variable is a calculation of the age of the licensee at the time of their license renewal.

Data were analyzed and tabulated with SAS 9.2; graphics were produced in Excel.

American Community Survey (ACS) 5-year combined population estimates were used in order to present data at the county level. These estimates are not as current as the one-year estimates, but the primary advantage of using multiyear estimates is the availability and increased statistical reliability of the data for less populated areas and small population subgroups.

Nationwide, 381 languages are coded. Standard tables separate out 39 languages and four main language groups as used here.

Languages from ACS data are reported as 4 general language groups: Spanish, Other indo-European languages, Asian and Pacific Island languages, and all other languages. Language groups are not mutually exclusive as some health professionals reporting more than one language may have been coded in more than one language group; 92% of the health professionals were coded in only one language group.

Workforce Licensing Data: Health professionals are licensees who are working in Oregon and who have renewed or obtained a license from the following Boards:

Oregon Medical Board (renewal period: October-December 2011)

Oregon State Board of Nursing (renewal dates range between late 2011 and June 2013)

Oregon Board of Dentistry (January 1-March 31 2013 for dentists, July 1-September 30 2012 for dental hygienists)

Oregon Occupational Therapy Licensing Board (March 1-May 31 2013)

Oregon Physical Therapist Licensing Board (January 1-March 31 2013)

Oregon Board of Pharmacy (April 1-June 30 2013 for pharmacists, July 1-September 30 2012 for certified pharmacy technicians)

Oregon Board of Licensed Dietitians (renewals May 2012 through June 2013)

Population Data: from the American Community Survey

Random sample of all households in Oregon

5-year ACS estimates (data collected over 60-month period 2008-2012)

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

List of possible appendices:

- References & resources (incl. link to 2012 workforce profiles report, State of Equity report, etc.)
- Detailed *population* race distribution table by county
- Detailed *population & provider* ethnicity and language distribution tables by county
- Detailed tables for characteristics of workforce in specific race or ethnicity groups

Draft - Diversity Report Cover Memo

April 2nd, 2014

From: Oregon's Healthcare Workforce Committee

To: Oregon Health Policy Board

The Healthcare Workforce Committee asked Oregon Health Authority staff to develop a report on the diversity of the state's healthcare workforce. The seven licensing Boards required by statute to gather and submit workforce data ask questions of their renewing licensees about their profession, location and practice hours and retirement plans. Licensees also answer general demographic questions including race, ethnicity and language. Using this licensing data, OHA produced the following short report.

Key findings include:

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

Throughout the state, efforts are being made to address the issues highlighted in this report.

Data collection: OHA and the licensing Boards are collaborating to improve data collection, through technology improvements and standardization of how and when race & ethnicity data are collected. In addition, in 2013 the Legislature passed HB 2134 which standardizes, based on best practices, the collection of data on race, ethnicity, language and disability status by the Oregon Department of Human Services and the Oregon Health Authority. This will provide consistency and will improve our understanding of racial and ethnic diversity in Oregon.

Provider cultural competence: In 2013, the Legislature passed HB 2611 which allows 19 licensing Boards to establish rules requiring cultural competency training for license renewals by 2017. Boards are also required to document their licensees' participation in approved trainings.

Utilizing traditional health workers: The Oregon Health Authority's Traditional Health Worker Commission will support the role, engagement and utilization of traditional health workers (THWs). THWs include Community Health Workers, Peer Support and Wellness Specialists, Personal Health Navigators and Doulas. The Commission's support of THWs is in part to increase the diversity of the healthcare workforce in communities across the state.

Increasing numbers of diverse health professionals: Oregon's Area Health Education Centers (AHEC) are charged with developing career pathways leading to sustainable, accessible healthcare in Oregon's communities. Programs such as MedStars, a career mentoring program targeted to rural, underserved high school seniors, expose young people from diverse backgrounds to careers as health professionals. AHECs also provide support to K-12 teachers, offering shadowing opportunities, materials and technology for their young students.

In addition, in 2013, Oregon's Legislature passed HB 2636 which authorized the development of a STEM Council that will encourage investment in science, technology, engineering and mathematics education.

Oregon's Healthcare Workforce Committee is committed to increasing the number and capacity of healthcare professionals to provide the best care possible for Oregonians. This commitment includes encouraging a diverse, culturally competent workforce. The Committee will continue to support efforts to improve data collection and gather research and recommendations on removing the barriers for all Oregonians to pursue careers as health professionals in their communities.

Oregon Health Policy Board
Healthcare Workforce Committee
By-Laws

ARTICLE I

The Committee and its Members

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

ARTICLE II

Committee Officers and Duties

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

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

ARTICLE III
Committee Members and Duties

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

ARTICLE IV
Committee Meetings

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

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

ARTICLE V

Amendments to the By-Laws and Rules of Construction

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

GME Background



- **FUNDING SOURCES**
- **OTHER STATES**
- **MODELS**

Review of GME funding



- Overall funding for Graduate Medical Education comes from patient care revenues.
- However, the current single largest funder of GME is the Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (CMS)

- Fifteenth Report: *Financing Graduate Medical Education in a Changing Health Care Environment*, Council on Graduate Medical Education, December 2000.
- *Health Policy Brief: Graduate Medical Education*. Health Affairs, August 16, 2012.

Review of GME funding



- GME is primarily funded with more than \$13 billion of public money, with the largest portion paid by Medicare.
- Approximately \$9.5 billion in Medicare funds and approximately \$2 billion in Medicaid dollars to help pay for GME.
- Additional funding is provided by the Department of Defense, the Department of Veterans Affairs and the U.S. Public Health Service.

- Council of Graduate Medical Education. Twenty-first report: improving value in graduate medical education [Internet]. Rockville (MD): COGME; 2013 Aug [cited 2013 Oct 4]. Available from: <http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentyfirstreport.pdf>
- *Physician Education Advancing Community Health Brief*, AOA Division of State Government Affairs, January 2013.

GME funding: continued



- There are two mechanisms in which Medicare and Medicaid **distribute** GME funding:
 - 1) Direct Medical Education (DME): payments are based on resident salaries, supervision and other educational costs
 - 2) Indirect Medical Education (IME): payments are based on additional operating costs of a hospital with a GME program.
- *Medicare Direct Graduate Medical Education (DGME) Payments*, Association of American Medical Colleges.
https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html

Aligning GME funding with Health Policy Priorities



- States continue to look to align GME funding with other health policy goals.
- This can include increased funding for training in certain specialties, addressing workforce shortages in rural and underserved areas and increasing faculty positions to train new physicians.

Utah



- In 1997, Utah created the Utah Medical Education Council (UMEC) to address the state's physician shortage and coordinate GME funding that would be better aligned with the state's workforce needs.
- UMEC is a quasi-governmental body whose responsibilities include assessing the physician workforce demands, developing and suggesting policy, finding and disbursing GME funds, addressing physician shortages in rural locations and managing the GME funds from CMS

Kansas and Florida



- In an effort to promote accountability in the use of GME funds, Kansas and Florida link Medicaid GME payments to stated state policy goals.
- Kansas applied to both fee-for-service and managed care Medicaid programs, while Florida GME payments focus on fee-for-service payments.
- Like most states, Kansas and Florida have focused on encouraging training in primary care specialties, rural and medically underserved areas.

Texas



- Texas lawmakers have authorized state-formula funding to expand GME. In 2007, the Texas legislature authorized an additional \$62.8 million in state funding for GME positions and for faculty costs.
- However, the additional funding was not enough to pay for the growth necessary to keep up with the physician shortage.
- Texas also provides supplemental funding for approved medical residency training programs.

Minnesota



- Governor proposed using Health Care Access Fund, funded by provider tax, to establish the Medical Education and Research Cost (MERC) fund:
 - This single, annual distribution is funded using a portion of the state's medical assistance program, the cigarette tax and a federal match.
 - The formula used to distribute the money to teaching hospitals and clinics is based on the number of patients on public health insurance programs, not on how many students are being trained.
 - The program was set up this way to maximize the benefit of federal matching dollars

Maryland



- Maryland currently has an all-payor system where the Health Services Cost Review Commission sets hospital rates for all payers.
- Maryland has built costs associated with GME funding into its rate-setting system.
- GME rates are reviewed on an annual basis based on financial and resident count reports.
- Maryland also has a Medicare waiver in which the federal government pays more in Maryland than anywhere else. In return, Maryland has to keep its Medicare costs below national growth.

New York



- New York’s all-payor system was created through the “Professional Education Pool” which collects and distributes money for GME.
- New York requires all payors to contribute to the fund, including:
 - Blue Cross and Blue Shield
 - commercial insurers
 - health maintenance organizations (non-Medicaid and non-Medicare)
 - businesses
 - self-insured funds
 - third party administrators.

Review of Models



- Health Care Provider Model
- Education Model
- Performance Model
- Planning Model

Health Care Provider Model



- Medicare pays for GME through a health care provider model.
- This approach links payments for clinical training to patient care activities.
- Because the indirect payment adjustment is intended to reflect the impact of teaching activity on a hospital's patient care costs, this model is particularly appropriate for IME payment.

Education Model



- Under this approach, payment would be made to a program sponsor, which would be held accountable for the way funds are allocated and expended. Sponsors could be :
 - universities, medical schools, colleges of osteopathic medicine, hospitals, consortia
- Any other entity whose primary purpose is providing education and/or health care services:
 - a health department, public health agency, organized health care delivery system or hospital system

Performance Model



- This model links payment to the achievement of specific performance measures or objectives.
- Funding could also be used to support specific projects or demonstrations on infrastructure development or particular workforce goals.
- While this approach encourages innovation and quality enhancement, it is more suitable as a supplemental funding mechanism than as a primary source of GME payment.

Planning Model



- Under this approach, funding would be channeled through planning or coordinating bodies such as GME consortia, state GME, physician workforce commissions or task forces.
- The primary function of these bodies would be to assess the health care needs of their communities and to allocate funds based on local workforce considerations.

Planning Model: continued



- Because this approach ties training and funding decisions to local health care needs, it could provide the states, payers and consumers a stronger role in allocating funds to meet workforce objectives.
- According to the Council on Graduate Medical Education, however, existing evidence tends to suggest that reliance on consortia to assume such a role may be premature.

Planning Model: continued



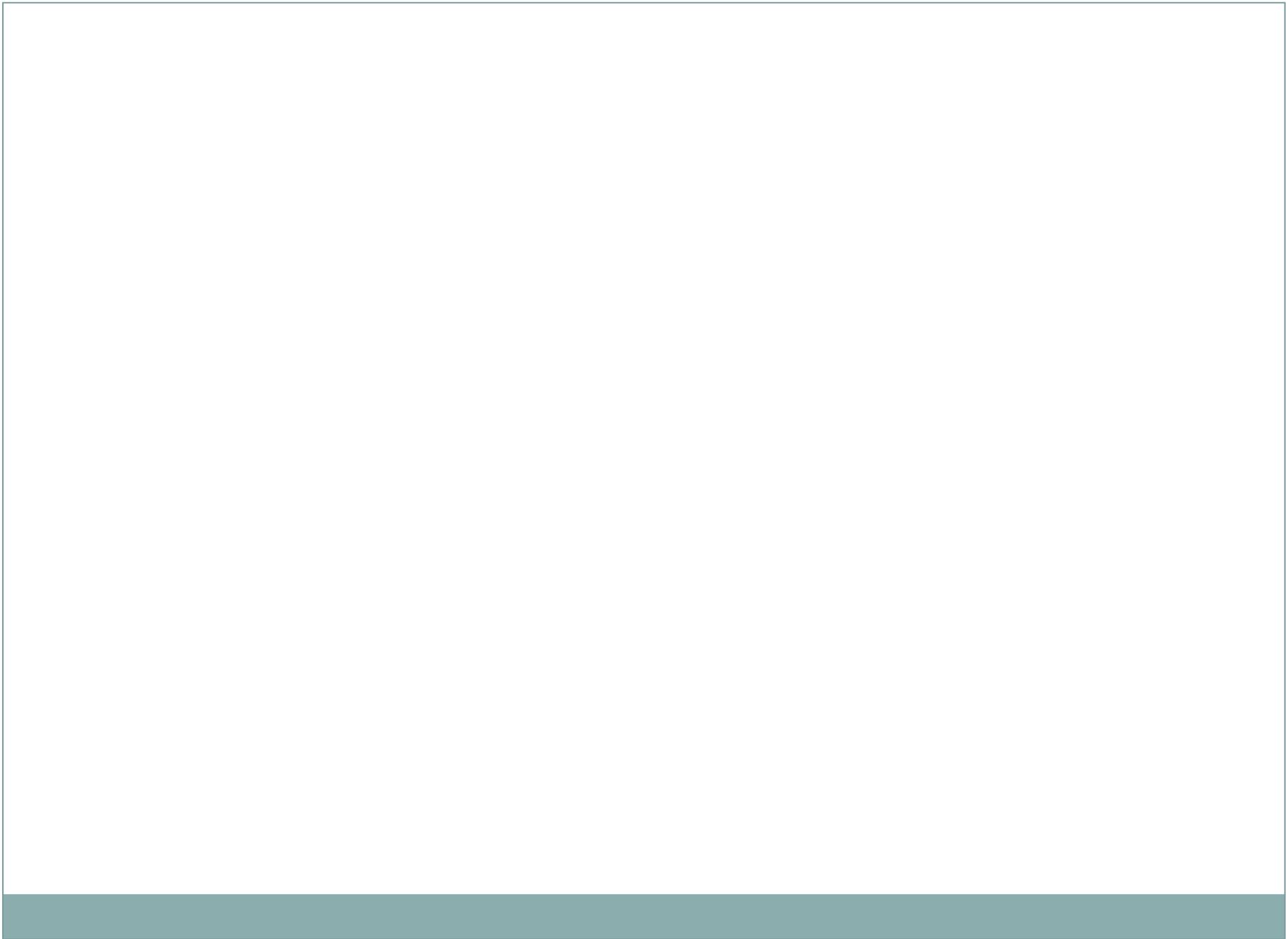
- Adopting this model would also require development of a new regulatory mechanism to assure accountability.
- Payment to state entities or consortia provides *little incentive* to nonteaching hospitals to initiate new GME programs.

An Assessment of Family Medicine Residency Networks in the United States

Brett White, MD; Patricia A. Carney, PhD; Roger Garvin, MD



- **Introduction:** Residency networks, comprising groups of residency programs organized as collaborative ventures or consortia, have existed in the United States for more than 30 years. At the same time, there have been no comparative assessments of their structures and functions.
- **Objectives:** We conducted a survey of residency networks to assess their organizational structures and activities.
- **Results:** Of the 9 networks, 5 provided data, with 32 of a possible 51 residency programs (62.8%) responding. Respondents reported predominantly functioning as affiliated networks (76.3%) rather than collaborative ventures or consortia. The networks have a variety of funding streams and share resources.
- **Conclusions:** A major function of residency networks is the sharing of resources, particularly in the area of faculty development, with 97.1% of respondents sharing faculty development resources. In addition, all residency networks were actively involved in research, and they participated in political advocacy and in enhancing the engagement of medical students. Networks have been successful at obtaining grants to support their infrastructure.



**Residency Expansion (Workgroup B) Meeting
February 25, 2014
COMP NW, Lebanon Oregon**

Participants (see roster for titles and affiliations)

Nancy Bell	Katherine Fisher	David Pollack
Patrick Brunet	Roger Garvin,	Mari Ricker
Douglas Carr	Gary Halvorson	David E. Schmidt
Lisa Dodson	Joyce Hollander-Rodriquez	Chris Swide
Robyn Dreibelbis	Edward Junkins	Chris Traver
Robert Dannenhoffer	Lance McQuillan	
Brian G Eichman	David Nardone	

Welcome and Purpose

Dr. Robyn Dreibelbis opened the meeting and welcomed participants. She gave a little background about the Oregon Health Policy Board's (OHPB) Healthcare Workforce Committee and reviewed the task that the Committee has been given with respect to residency expansion: to describe and recommend policy options for increasing the number of family medicine and other primary care medical residencies in Oregon. The Committee has been asked to examine options including but not limited to: a) the creation of new community-based primary care residency programs; b) a GME consortium approach to support regional primary care residencies; and c) strategies for increasing the proportion of primary care residencies within the current GME residency cap for Oregon.

Dr. Dreibelbis noted that this initial meeting and conversation was intended to:

- Focus on family medicine for now, with the possibility of expanding the conversation and participants to other primary care disciplines at a later date;
- Include representatives from established as well as emerging or potential residency programs;
- Address the overall request from the OHPB rather than delving into the details of any one options in particular.

Dr. Dreibelbis reviewed Oregon data on distribution of population and primary care physicians, and on the location of current and potential family medicine residency programs. Dr. Dreibelbis' slides are embedded here. One program is not shown on the maps: Virginia Garcia is hosting two residents as part of a multi-state residency program under a HRSA Teaching Health Center grant funded by the ACA.



Final_GME Expansion
Retreat_Dreibelbis In

History of GME in Oregon

Dr. Lisa Dodson reviewed Oregon's history with graduate medical education (GME) and provided state and national statistics about ratio of residents to population and retention rates for Oregon Medicaid students and residents. Her slides are embedded here:



Oregon Primary Care
GME retreat - Dodsor

Key points and comments raised during Dr. Dodson's presentation included:

- A family medicine residency at Eastmoreland Hospital that ran from the mid-1990s to mid-2000s is not shown on the Oregon timeline.
- New hospitals do not start with a residency cap but acquire one within 5 years; ACA Teaching Health Center grants and split programs or rural training tracks are other ways in which to get around the cap.
- Looking at all specialties combined, Oregon’s ratio of residencies to undergraduate medical education spots is not bad but that does not hold true for primary care specialties specifically.
- It may not cost much less to recruit a new physician who had done his or her residency in Oregon (as opposed to out of state). It’s assumed that employers would not need to pay for a recruitment visit or for significant moving expenses, but other typical recruitment costs (e.g. signing bonus, loan repayment, etc.) would still apply.
- There is not a widely accepted number for the correct ratio of primary care physicians to population. The minimum threshold for rural areas might be higher than one would expect for two reasons:
 - Primary care physicians in rural areas typically provide services that would be performed by specialists in more populated areas (deliveries, ED coverage, etc.);
 - A minimum capacity is necessary so that a single person leaving does not destabilize the entire primary care infrastructure in the community.
- Telemedicine may help in some areas (e.g. psychiatry especially) but is not a panacea.
- Regulations on residency caps are arcane and difficult for hospitals to interpret. New hospitals or those starting residency programs (e.g. general surgery in Coos Bay) need technical assistance to make sure they submit the proper cost reports and don’t end up with a low cap just because of reporting issues.

Dr. Dodson concluded her presentation with a straw proposal for discussion:

- All residencies should be dually accredited
- Oregon should be, at minimum, at the 50th percentile for primary care residents/100K population, and the growth should be in FM
- Broaden funding for FM residency expansion:
 - Don’t rely exclusively on Federal funding
 - Per capita residency fund from state
 - Pay or play: spread costs from just the participating Health Systems
 - Recruitment fee
 - “tax” or fee
- Consortium-based

Novel approaches to GME expansion

Dr. Ed Junkins reviewed some literature on workforce demand and the cost of residency training and described some novel approaches in other states. In particular, he outlined four models for GME financing: a health care provider model; an education model; a performance model; and a planning model. His slides are embedded here:



Oregon_Expansion_
GME 022514 Junkins I

In response to questions about the OHPB’s desired product, Lisa Angus reported that the OHPB had heard that primary care residency slots were a limiting factor for workforce development in Oregon and was seeking expert recommendations on how to address that issue. As a policy advisory and oversight

body, the Board itself is not in a position to take direct action but can provide feedback, endorse recommendations, and help implement the policies by working through the Legislature, the Governor's Office, OHA, and partners.

Dr. Junkins' presentation led to a broad discussion of different options for Oregon. Key points and questions included these:

- CMS funding was never intended to be the primary source of support for GME. GME has expanded well beyond the residency cap at many institutions in many states, but only where the line of service is profitable. That is the reason there are so many sub-specialty programs.
- The U.S. relies on foreign medical graduates to backfill several hundred residency positions each year. These graduates and fully trained foreign physicians participating in the J-1 visa waiver program fulfill an important need and often serve in locations that are difficult to recruit to, so efforts to expand residency training should not undercut the pathway for foreign trained individuals to practice.
- Any effort going forward should be designed collaboratively with advanced practice providers.
- A pay-or-play option held appeal for several participants as way of diversifying funding for GME. Health systems could pay in as a part of the cost of doing business in the state. A pay-or-play system should certainly not penalize and potentially even reward existing programs.
- The idea of a cap-and-trade system was raised in conjunction with pay-or-play but it was also noted that such an arrangement could contribute to further mal-distribution of physician training and supply in the state.
- One participant felt that it could take years to get the necessary buy-in for either a group-financed consortium or a pay-or-play model (or combination). Starting smaller might be more feasible and a small amount of funding (e.g. \$1M each for the next 5 primary care residency programs to start in Oregon) could tip the balance.
- GME financing should be separated from hospitals. If the funding came directly to the educational side rather than going through the hospital first, that would provide an incentive for new program development.

A great deal of discussion centered around the idea of a GME consortium. Participants identified these potential advantages and disadvantages:

Advantages of a GME consortium

- Could help jump-start new residencies by providing technical or other support to hospitals and health systems interested in establishing new programs
- Could enable economies of scale for new and existing programs, which spend an enormous amount of what could otherwise be academic time on accreditation and evaluation activities. This is a benefit for the 5 states participating in the WWAMI partnership (Washington, Alaska, Idaho, Montana, Wyoming), almost all of whom are single program institutions.
- Participating programs offer mutual support and guidance; a consortium could help all

Disadvantages of a GME consortium

- Potential loss of autonomy for programs, depending on structure and requirements
- Risk of financial requirement / ask for additional investment for participation
- Potential loss of competitive advantage for some programs
- Has the potential to be just another meeting without sufficient power, funds, or clout
- Potential internal conflict for participating organizations if the consortium recommends action that another arm of the participating organization does not support
- Could be fragile if based too much on voluntary

Advantages of a GME consortium

programs with barriers they face (financing, regulatory, infrastructure, etc.)

- Standardization of residency practices can be a benefit (e.g. to ensure quality of training)
- A consortium approach could make it easier to offer shared programs or 1-2 models.
- Can provide faculty development support, and support for program directors, who can be very difficult to recruit
- Could serve as a public-private partnership, balancing interests and financing. A consortium could also act as a general advisory board for GME in Oregon.
- Could potentially serve as the institutional sponsor for residences not based at a hospital or health system. In that case, however, the consortium itself would have to be accredited.
- A consortium could 'raise all ships' via shared ideas and cross-pollination of personnel.
- A consortium could help attract residents to Oregon (other states with consortiums like CO and MN get a lot of interest from medical school graduates)
- Oregon could use a consortium to build a primary care training cachet much like Oregon wine or the Ducks

Disadvantages of a GME consortium

participation

- Could increase competition for clinical sites, educational opportunities, faculty preceptors, etc.
- Structure would have to be balanced to avoid the perception of bias toward one health system or another
- Uncertainty about continuation funding and sustainability, especially in conjunction with potential changes in DME and IME in the future, could make institutions reluctant to participate
- Not clear what the business case would be for existing, larger programs – the benefits are more evident for new programs, single program institutions, and communities or the state as a whole
- Consortium model in and of itself doesn't really enable the re-distribution of residency slots, since the cap and DME & IME funding are tied to the primary institution is institutional and Medicare GME funding. Would have to combine programs or move away from reliance on Medicare financing.

Participants also raised a number of questions about what functions a consortium model might have and how it would operate. Questions, comments, and suggestions included:

- A consortium could run the gamut from an informal coordinating body to a very centralized entity with financing and authority for approving new programs and allocating slots. What point on this continuum would make the most sense for Oregon?
 - Would/should seed money for new programs come through the consortium?
 - Perhaps a consortium could have some authority and *new* funds for starting new programs, without being given authority over existing ones
 - Perhaps a consortium could offer no-interest loans: new programs could receive something like \$1M for start-up but have to pay it back in 5-10 years
 - Perhaps the state could contribute matching funds
 - Perhaps a consortium just around primary care residencies would be most feasible?
- One participant suggested that the value of a consortium was more about the connections it supports and less about financing.
- Minnesota's consortium is interesting – it's more than just an administrative body and it is well connected to other professions
- In some states, the state AHEC (Area Health Education Center) or state Primary Care Office serves as the convener or host of a consortium.

- A group of Oregon institutions approached the Foundation of Medical Excellence several years ago about hosting a consortium but the Foundation’s Board decided it wasn’t the right fit for them. Potential participant institutions also felt that they didn’t have the funding available to participate.
- The start-up costs for a new residency program are thought to be in the ballpark of \$1M. DO-only programs that are accredited by the American Osteopathic Association (AOA) have slightly lower costs. Samaritan’s pro-forma for starting four new programs (family medicine, internal medicine, psychiatry, and general surgery) had an estimate of \$2.8M.
- Some residency programs are DO-only and some are dually accredited. A consortium approach would have to address this issue up-front, because MD programs would have less incentive to participate in a consortium if only a portion of the residency positions were open to their students.
 - Note: the day following the meeting, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) announced that they had agreed to a single accreditation system for graduate medical education (GME) programs in the United States, to be phased in over the next several years. See: <https://www.acgme.org/acgmeweb/portals/0/PDFS/Nasca-Community/SingleAccreditationRelease2-26.pdf>
- There is a loose, informal Oregon Council of GME (meets once/year for lunch). It’s a communication and education-based group with no funding, but could be a useful connection point for this work. Glenn Rodriguez—who was invited to this meeting but could not attend—is the past president.

At the end of the discussion, there was tentative interest in the idea of a consortium, depending on its structure and functions. Meeting attendees suggested that Workforce Committee members review the consortium arrangements in other states, explore sustainability issues, and clarify the potential participants and governance/representation.

Next steps

In response to the question of who else should be involved in the larger conversation about expanding primary care residencies in Oregon, participants suggested:

- State or local entities (if the consortium is intended to be a public-private partnership)
- Health systems that do not yet have residency programs
- Philanthropy
- Specialties other than family and internal medicine – the idea would need support from the entire community of program care
- (Post-meeting additional suggestions from Lisa A.: OAHHS should be looped in, as well as the major professional organizations like OMA, OAFP, etc.)

The group agreed on the following next steps:

1. A subset of today’s participants (particularly Drs. Dreibelbis and Dodson, along with any others interested) would distill the information from this meeting, propose some options or recommendations (what, who, how much would it cost), and run those by the OHPB Healthcare Workforce Committee at its next meeting on April 2nd.
2. An online or phone-based follow-up meeting of this group would be convened after that, with a draft set of options or recommendations distributed ahead of time.

2014 Oregon Legislative Session Update -- Health Care Workforce Policy-Related Bills

Prepared for the Oregon Healthcare Workforce Committee

March 10, 2014

Bills that passed

Bill number	Description	Background / Explanation	Status
HB4009	<p>Establishes the Pediatric Nursing Facility Account in State School Fund.</p> <p>Continuously appropriates moneys in account for costs of educational services to students in pediatric nursing facilities.</p> <p>Provides that Department of Education is responsible for provision of educational services to students admitted to pediatric nursing facilities and for payment of costs for those services.</p>	<p>Providence Child Center is a residential pediatric nursing facility that offers educational services. It is located in Portland and can accommodate a maximum of 58 residents. The measure results from stakeholder group meetings during the 2013-14 Interim.</p> <p>Portland Public Schools has been serving these students, however, is not legally able to seek reimbursement for students whose parents do not reside in the district. This bill requires the Department of Education (ODE) to provide educational services for students with disabilities. Portland Public Schools (PPS) will continue to serve these students through contract with ODE. In addition, the bill establishes the Pediatric Nursing Facility Account with the State School Fund (SSF) and annual transfers will be made to this fund from the SSF.</p> <p>Currently, PPS receives an additional \$500,000 per year to support the additional costs incurred by students in the Pediatric Nursing Facility. This bill would provide \$35,838 per student up to a maximum of 58 students or \$2,076,612 per year in 2014-15 and \$2,577,479 per year in the 2015-17 biennium. This amount would be a carve out within the SSF and would not require an increase in GF allocated to the SSF.</p>	Passed, awaiting Governor's signature
HB4074B	<p>Authorizes the Board of Medical Imaging to waive requirements for individual who has substantial experiences, as determined by the Board, and who is a medical imaging employee of a rural hospital.</p> <p>Specifies any health care practitioner may order or interpret medical imaging procedures if such procedures are within the practitioner's scope of authority as</p>	<p>In 2009, the Legislative Assembly required that all technologists under the Board of Medical Imaging become nationally recognized, which is the highest standard of licensure. The statute went into effect January 2014. As a result, the licensure change will have a negative impact for the Nuclear Medicine Program at Grande Ronde Hospital and potentially other rural hospitals. The national certification requires a minimum of 8,000 hours of clinical experience over a four year span and this can be difficult for technologists in rural hospitals because these hospitals do not have the necessary patient volumes to sustain or garner the required hours required.</p>	Passed, signed into law

2014 Oregon Legislative Session Update -- Health Care Workforce Policy-Related Bills

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	determined by the agency that licensed the licensee.		
HB4109A	Requires Oregon Health Authority (OHA) to commission an independent study of costs and impacts of operating a basic health program in Oregon. Specifies the parameters of the study. Requires the report be submitted to the Legislative Assembly by November 30, 2014.	Requires Oregon Health Authority (OHA) to commission an independent study of costs and impacts of operating a basic health program in Oregon. Specifies the parameters of the study. Requires the report be submitted to the Legislative Assembly by November 30, 2014.	Passed, awaiting Governor's signature
SB1542B	Requires the Home Care Commission to establish and administer the Private Pay Consumer program to enable private individuals to purchase in-home care services from the Commission through the Home Care Registry. The bill directs the Home Care Commission to create a subcommittee of the commission to define and establish new classifications of in-home care workers.	<p>In 2000, the citizens of Oregon voted to amend the State Constitution to create the Oregon Home Care Commission. The Commission is responsible for ensuring the quality of home care services that are funded by the Department of Human Services for seniors and people with disabilities. Additionally, the Commission is responsible for addressing the needs of persons with developmental disabilities, mental illnesses, their family members, and personal support workers. The Commission facilitates filing workers' compensation claims for both home care workers and personal support workers.</p> <p>Prior to the passage of this bill, only individuals covered by Medicaid could purchase care through the Home Care Worker registry.</p>	Passed, awaiting Governor's signature
SB1548A	Amends certain statutes referencing "physician" to include "physician assistant" and "nurse practitioner." Deletes language referencing tanning facilities and certain statutes relating to health care insurance. Adds physician assistant language for purposes relating to assistive telecommunication for persons with disabilities. Deletes "physician" and replaces with "provider" in two locations.	<p>Oregon law allows physician assistants (PAs) to perform a medical service if their supervising physician approves it, unless PAs are specifically excluded. In several other places in state law the language is vague about which providers may perform certain medical functions, often referring only to "physicians" or "physicians and nurse practitioners." Without explicit mention or direct cross-reference to ORS 677.515, these individual statutes give the impression that PAs are not allowed to perform normal functions related to their profession.</p> <p>The Oregon Society of Physician Assistants and Oregon Nurses Association seek to clarify Oregon statutes regarding the types and settings of medical care where PAs and Nurse Practitioners are</p>	Passed, signed into law

2014 Oregon Legislative Session Update -- Health Care Workforce Policy-Related Bills

Prepared for the Oregon Healthcare Workforce Committee

March 10, 2014

		authorized to provide medical services.	
SB1566A	Declares state public policy to promote coordinated provision of education, employment, economic development, and job training services. Mandates inclusion of community colleges and public and private universities. Mandates that Governor appoint one member to State Workforce Investment Board who represents a local workforce investment board. Clarifies expectations delivery from state to agencies and local boards. Details requirements of local plan submitted to Governor. Describes appropriate labor market information activities. Assigns new duties to State Workforce Investment Board. Abolishes regional workforce committees	<p>In 2013, a Workforce System Redesign Work Group (Work Group) was formed, consisting of leadership from the state workforce agencies, the Governor’s office, and representatives from local workforce investment boards. Public Financial Management (PFM) was contracted to identify and address barriers to achieving the mandates in the OWIB plan. PFM made 16 separate findings regarding the current state of the workforce system resulting in 20 recommendations. The Work Group adopted 15 recommendations to refer to OWIB to improve services for jobseekers and businesses.</p> <p>Senate Bill 1566-A addresses PFM findings that the current workforce system suffers from a lack of clear governance by clarifying the role of OWIB as an oversight body for employment and other workforce development services. The measure provides the board the ability to enter into compacts for performance with the local service delivery system and eliminates long standing confusion regarding the difference between local and regional workforce investment boards.</p>	Passed, signed into law

Bills that did not pass

Bill number	Description	Background	Status
HB 4002	Removed the requirement that an institution granting a doctoral degree in psychology be accredited by the American Psychological Association.	This bill was introduced at the urging of Walden University, a primarily on-line institution not accredited by the APA.	In House Committee on Health Care, public hearing held
HB4070	Provided that an individual disciplined by the Board of Dentistry could request that all documentation of the action be removed after ten years if certain requirements were met.	Testimony against this bill was provided by the Board of Dentistry and the Oregon Trial Lawyers.	In House Committee on Health Care
HB4082	Appropriates moneys from General Fund to Department of Community Colleges and Workforce Development for Back To Work	No amount specified	In Joint Ways and Means

2014 Oregon Legislative Session Update -- Health Care Workforce Policy-Related Bills

Prepared for the Oregon Healthcare Workforce Committee

March 10, 2014

	Oregon program.		
HB4137	Appropriates \$2.5 million to Oregon Department of Administrative Services for Primary Health Care Loan Forgiveness Program.	The Primary Care Loan Forgiveness Program is authorized by ORS 442.573-442.574 and is funded through June 2015. Students must be enrolled in an approved rural Oregon training program to apply for available loans under this program	In Joint Ways and Means
HB4152	Specifies conditions for coordinated care organization or entity contracting with or participating in coordinated care organization to employ health care practitioners. Requires hospital and hospital system to disclose on website its relationship with physicians employed by or compensated by hospital or hospital system.	This bill was intended to shed light on the relationships CCOs have with physicians, hospitals and health systems. It would have made public the policies governing the hospitals and health care systems to which CCOs may make referrals.	In House Committee on Health Care, no hearings
SB1560	Modifies requirements for health plan coverage of telemedical services.	In this bill, health benefits plans must reimburse for a service delivered telemedically using the same code as for a service delivered in person. Chair Monnes Anderson and the Senate Health Care Committee asked that a workgroup be convened during the interim to discuss coverage of telemedicine services (SB 1560). OHA has agreed to participate in this workgroup that may look to introduce a bill in 2015.	In Senate Committee on Health Care and Human Services, Public Hearing and Work Session held
SB1561	Exempts establishment where practitioner dispenses drugs from laws and rules related to regulation of drug outlets if establishment and practitioner meet certain criteria.	Would allow practitioners who are allowed to dispense drugs to do so from their office.	In Senate Committee on Health Care and Human Services, Public Hearing held