

## Oregon Healthcare Workforce Committee

**AGENDA – May 4, 2016**

**Health Care Workforce Committee Meeting 9:00 – 11:40 am**  
**Behavioral Health Subcommittee Meeting 11:45 am – 1:00 pm**

**Wilsonville Training Center, Wilsonville, OR 97070**  
**29353 SW Town Center Loop, E Room 111/112**

**Meeting Objectives: 1) Advance the work of the Committee’s deliverables around: a) Recommendations on Provider Incentives in Oregon and b) Steps to advance Behavioral Health Integration in Oregon; 2) Identify other items of importance to members for future consideration**

#	Time	Agenda Item	Presenter(s)	Action Item
1	9:00 – 9:02 (2')	<b>Convene HCWF Committee, Welcome</b>	David Pollack	
2	9:02 – 9:05 (3')	<b>Approval:</b> March 2, 2016 Meeting Summary	David Pollack	X
3	9:05 – 9:15 (10')	<b>OHPB and OHA Updates</b> <ul style="list-style-type: none"> <li>• OHPB update</li> <li>• OHA updates</li> </ul>	Carla McKelvey, OHPB Stephanie Jarem, OHA Marc Overbeck, OHA	
4	9:15 – 10:50 (95')	<b>Update on HB3396:</b> Provider Incentives Study <ul style="list-style-type: none"> <li>A) Task 4 Stakeholder Engagement</li> <li>B) Lewin Group Deliverables               <ul style="list-style-type: none"> <li>a. Task 1 Data Analysis</li> <li>b. Task 2 Evaluation of Oregon Incentive Programs</li> </ul> </li> </ul>	Jeff Papke, HCWF Committee  Paul Hogan, Lewin Group Sebastian Negrusa, Lewin Group	X
5	10:50 – 11:00 (10')	<b>Break</b>		
6	11:00 – 11:20 (20')	<b>Behavioral Health Update</b>	Alisha Moreland Sheldon Levy Maria Lynn Kessler	
7	11:20 – 11:30 (10')	<b>Other Items from Members</b> —Current and Relevant, Future Topics for HCWF Committee	All	
8	11:30 – 11:40 (10')	<b>Public Comment</b>	Any	
9	11:40	<b>Adjourn:</b> Next Meeting July 6, 2016	David Pollack	

## BEHAVIORAL HEALTH SUBCOMMITTEE

#	Time	Agenda Item	Participating	Action Item
1	11:45 am – 1:00 pm (75')	<b>Meetings on Behavioral Health Integration Deliverables:</b> <ul style="list-style-type: none"><li>• <b>Environmental Scan</b></li><li>• <b>Taking Behavioral Health Pilots to Scale</b></li><li>• <b>Identification of Barriers to Integration and Solutions</b></li></ul>	Any Committee Member, plus Invited Subject Matter Experts	

### Meeting Materials

1. Agenda
2. March 2, 2016 Meeting Summary
3. Plan for Listening Sessions for HB 3396
4. Lewin Group Materials on HB 3396
5. BHI Subcommittee Progress Summary

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**Oregon Healthcare Workforce Committee**  
**March 2, 2016 9:30 am – 12:30 pm**  
**at Wilsonville Training Center**  
**DRAFT - Meeting Summary**

<b>Committee Members in Attendance:</b>	Patrick Brunett (by phone) Jeff Clark Jeff Papke Robyn Dreibelbis (by phone) Janus Maybee Alisha Moreland	David Pollack Daniel Saucy Annette Fletcher Kate Lee Troy Larkin Shilena Battan
<b>Committee Members not in Attendance:</b>	Tawna Sanchez	David Nardone
<b>OHA staff, OHWI, OCN</b>	Stephanie Jarem, OHA Marc Overbeck, OHA Margie Fernando, OHA Oliver Droppers, OHA	Mike Morris, OHA Chad Johnson, OHWI Jana Bitton, OCN
<b>Others</b>	Carla McKelvey, Oregon Health Policy Board liaison	

<b>1</b>	<b>Welcome</b>
	David welcomed everyone to the meeting.
<b>2</b>	<b>Approval: Jan 6, 2016 Meeting Summary</b>
	The meeting summary of Jan 6, 2016 was accepted without changes.
<b>3</b>	<b>Updates</b>
	<p><u>OHPB Updates</u></p> <p>Carla McKelvey reported on the March Oregon Health Policy Board meeting, noting the Quality Metrics Mid-Year Transformation Report presented at the Oregon Health Policy Board meeting on Mar 1, 2016. Very good data appears in this mid-year report, especially data on vulnerable population data and mental health data. Quality metrics like this will help in the future as we work on behavioral health integration.</p> <p>Steph updated the Committee on the OHPB retreat that took place in February. The Board identified the following topic areas that will be discussed in 2016-2017:</p> <ul style="list-style-type: none"> <li>• Behavioral health improvement</li> <li>• Integration of health systems (physical health, behavioral health, oral health)</li> </ul>

- Alternative payment methodologies (APMs) (i.e. value-based payments)
- Pharmacy
- SB 440 (strategic plan for data use and collection; 2017 Metrics Committee)

*Steph will send out a summary of the topics they discussed to the group.*

The next OHPB meeting will be on April 6, 2016 where the Medicaid Waiver renewal will be discussed.

Carla added that at the retreat OHPB also looked at the various sub-committees of the Board. The Workforce Committee stood out as a model of how they would like to see committees run. They are very pleased with the work of this committee. Likewise David Pollack said that having Carla at the Workforce meeting as a representative of the Oregon Health Policy Board is very productive for this committee.

Legislative update:

Senate Bill 5701 allocated another \$2 million to the **Medicaid Primary Care Loan Repayment Program** for the remainder of this biennium. Meanwhile HB 3396 directs the OHPB to study the various incentive programs in the state and report to the legislature by September 2016.

HB 1503 repeals the sunset on requirement that insurer reimburse licensed physician assistants and certified nurse practitioners for primary care services that are reimbursed by insurer if provided by licensed physician.

Marc thanked everyone for sending in their biographies and photos for the web. It is now online for public viewing.

*David asked the committee to look at Relational Map and Margie will send this map out to the committee to comment on.*

**4 OHA update**

David Simnitt introduced himself as the Head of the Policy and Analytics Unit. He was hired as the Medicaid Director a year ago and is now the Head of the Policy and Analytics unit, under the new OHA structure. He is responsible for Behavioral Health policy, Medicaid policy and Oral health policy, specifically changes and federal requirements that affect the state.

Marc informed the committee that the **National Health Service Corps** has opened its Loan Scholarship program which will run through April 28, 2016.

	<p><a href="https://nhsc.hrsa.gov/scholarships/index.html">https://nhsc.hrsa.gov/scholarships/index.html</a> Marc asked the committee members to encourage clinicians to apply.</p> <p>Marc also reminded the committee that <b>Oregon J1 Visa program</b> allows 30 waiver applications each year and applications are also available through our website, <a href="http://www.oregon.gov/oha/OHPR/PCO/Pages/J1.aspx">http://www.oregon.gov/oha/OHPR/PCO/Pages/J1.aspx</a></p> <p>Patrick Brunett updated the committee on the <b>GME consortium</b>. They are working on a draft institutional sponsorship application that will go to the GME for accreditation. They are trying to model their application on other national GME's in the country. It is also possible that they will be considered for a small grant from the Rural Hospitals Sustainability group so that they can continue for the next few years while they continue to build their structure. The next meeting is on March 28, 2016.</p>
<b>5</b>	<b>Update on Behavioral Health Integration</b>
	<p>Alisha Moreland updated the Committee on the meeting held by the Behavioral Health Integration subcommittee before this meeting. The subcommittee is working on three specific deliverables:</p> <ol style="list-style-type: none"> <li>1. Bringing successful behavioral health integration pilots statewide</li> <li>2. Addressing any gaps in education and curriculum needed to train physical health and behavioral health providers to work in a team-based system</li> <li>3. Policy changes needed to overcome barriers to behavioral and physical health integration faced by providers</li> </ol> <p>Steph spoke about how the scope of work around this topic has expanded slightly; everyone is working on elements of Behavioral Health, but it's clear that there is a need to bring these elements together. It was suggested that this venue will be the right place to come up with a combined report.</p> <p>Carla indicated that from her perspective it's also important to find out why integration has failed where it has failed. Some groups have tried and failed and it will be important to find out why. Alisha responded that the survey will capture this in the first round.</p> <p>Regarding the second deliverable, Sheldon contacted various institutions of higher education to gather information about their training programs. He noted that in many cases, it was difficult to obtain good information.</p> <p>Janus reported out on the third deliverable, and noted that the group wants to first get back the results of the initial survey and then examine those and consider past presentations to identify the primary issues to address in this component of the Committee's work.</p>

	<p>Mike Morris updated the committee on the Behavioral Planning grant, called Oregon Certified Community Behavioral Health Clinic Planning Grant (<b>CCBHC</b>). Oregon is one of 24 states to receive this planning grant; eight states will be selected out of the 24 for grants to develop this model. He is hopeful that Oregon will be selected.</p> <p>Mike also updated the Committee on the <b>Behavioral Health Mapping Initiative</b> which is under development. The mapping tool will display, by county, data such as age groups, economic growth rate, poverty rate, proportion of population on OHP, prevalence of behavioral health conditions, and other variables. The data will also include penetration rates and utilization of a range of behavioral health services, organized by intensity. In addition, the tool will include outcomes measured for CCOs and for regional contractors. A review of this population, service and outcome data will inform policy and funding decisions by enabling OHA to develop a full picture of the need, resources, and outcomes for Oregon’s behavioral health system and to better understand the return on investment related to these services.</p>
<b>6</b>	<b>Lewin Group presentation on HB 3396</b>
	<p>Sebastian Negrusa and Projesh Ghosh from the Lewin Group joined the Committee via telephone to talk about their timeline and the progress they have made to date.</p> <p>Members of the Committee asked questions about the collection and use of data. Lewin shared some of the challenges with obtaining and analyzing data in a project like this. Committee members also provided feedback to the Lewin group on the project.</p>
<b>7</b>	<b>Public Comment</b>
	<p>Scott Ekblad from the Oregon Office of Rural Health spoke to address two concerns he had--one of which was the definition to be used in the report of “medically underserved” area, essentially how should “high need” be determined. Scott noted his office publishes an annual report on unmet need which could be useful.</p> <p>Scott also addressed the issue of what is the “right” level at which to assess need. The Office of Rural Health has identified rural service delivery areas, which are arguably better to use than a whole county in places—for example, looking at all of the providers in Lane County against the population will not tell you if Florence, Oakridge, or Cottage Grove are well served.</p> <p>Scott also offered his strong opinion that the incentive programs should be available for both rural and non-rural underserved areas.</p>

**8.**

**Adjourn**

The meeting was adjourned at 12:35. The next meeting will be on May 4, 2016

DRAFT



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - WITH REAL-WORLD PERSPECTIVE.

# Evaluation of Health Care Workforce Incentives in Oregon - Task 1 Summary

Prepared for Oregon Healthcare Workforce Committee Meeting

**May 4, 2016**

# Background

## ■ Objectives:

- ▶ Estimate the effectiveness of current provider incentive programs in:
  - attracting and retaining health workforce within the state
  - ensuring an appropriate workforce distribution across urban and rural areas
- ▶ Consider new programs (if feasible and necessary), scale up or down current programs, and leverage resources to complement current programs
- ▶ Recommend ways to improve data collection to serve policy-making decisions meant to optimize health care workforce within the state

## ■ Lewin team and capabilities:

- ▶ Extensive experience with:
  - workforce issues
  - health legislation provisions
  - empirical methods needed for incentive program evaluation
  - required health care data

# Proposed Approach

- Task 1: Research and Data Analysis
  - ▶ Descriptive statistics on: health workforce in OR, distribution of providers, participation in programs, patient population by location, and high need areas
  - ▶ Inventory of factors related to incentive programs (funding, program design, lit search on previous estimates showing effectiveness of such programs)
- Task 2: Evaluation of Program Effectiveness
  - ▶ Regression-based models and other methods to measure effectiveness of programs
    - Focus on high priority/larger programs
- Task 3: Develop Policy and Program Recommendations
  - ▶ Ensure systematic data collection
  - ▶ Consider new programs or improve existing ones
  - ▶ Optimally allocate resources to maximize access to providers in OR
- Task 4: Stakeholder Engagement
- Task 5: Comprehensive Reports
- Task 6: Presentation Materials

# Questions Addressed Under Task 1

## ■ Oregon Health Care Market

- ▶ What is the demographic and geographical distribution of the Oregon population?
- ▶ How does provider-to-population ratios vary by county, rural, poor populations?
- ▶ What is the growth rate in the number of providers by major type and discipline?
- ▶ How are the supply and demand for providers projected to change through 2020?

## ■ Provider Incentive Programs in Oregon

- ▶ How do programs compare in terms of purpose, criteria, funding, costs, and population?
- ▶ How did funding and scope of programs change over time?

## ■ Descriptive Assessment of the Provider Incentive Programs

- ▶ How many providers are enrolled in multiple programs and how does that change the cumulative amount of benefits?
- ▶ How are participants distributed and do they respond to program changes?

## ■ Literature Review

- ▶ Document the design and effectiveness of past similar programs
- ▶ Determine relevant program performance measures

# Oregon Health Care Market: Main Findings

- Categories of the population that are projected to increase (ACS data):
  - ▶ Individuals insured through Medicaid
  - ▶ Individuals with no employer-provided insurance
  - ▶ Individuals over the age of 65
  - ▶ Insured individuals overall
  - ▶ Hispanic population
- Demand for health care services (measured as visits) and providers are projected to increase (APAC data) relative to previous years
- Supply of PC physicians is projected to increase at lower rates than the increase in the demand for PC physicians (AHRF, P360 and Oregon data)
- If same trends, future S and D for PAs, NPs, RNs appear to be close to each other
  - ▶ Caveat: visits per population are much lower in rural areas than in urban areas; this may not reflect lower demand in rural areas, but rather provider shortage
  - ▶ Taking this into account, results into a much larger demand than supply

# Oregon Health Care Market: Main Findings

## Baseline Scenario

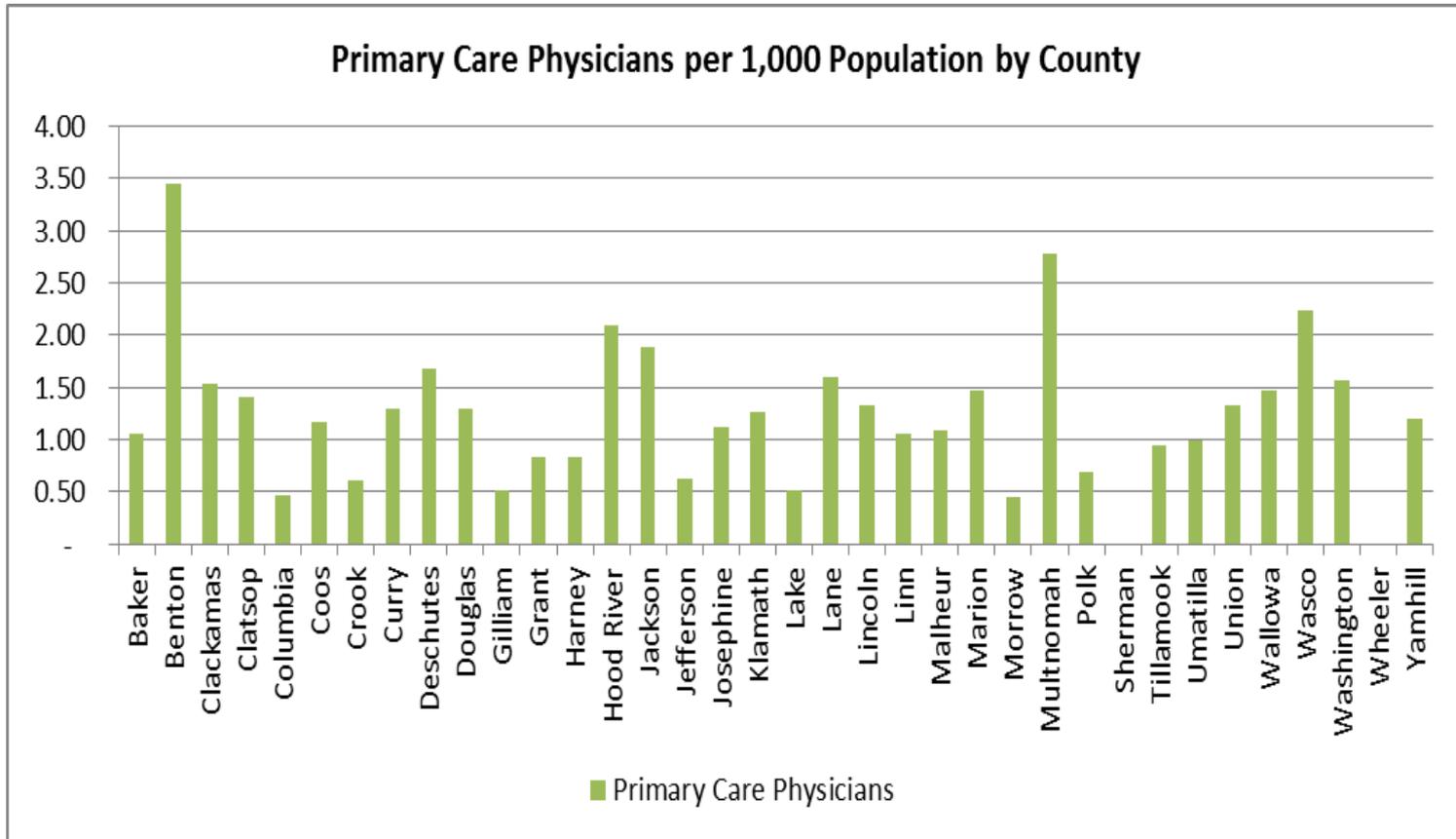
Provider Type	Projected Demand						Projected Supply					
	2015	2016	2017	2018	2019	2020	2015	2016	2017	2018	2019	2020
Primary Care Physicians	7,094	7,146	7,250	7,358	7,469	7,580	6,883	6,917	6,952	6,987	7,022	7,057
Specialty Care Physicians	4,689	4,736	4,823	4,906	4,995	5,088	4,505	4,631	4,761	4,894	5,031	5,172
Behavioral Health	5,487	5,484	5,521	5,549	5,587	5,618	5,291	5,317	5,344	5,371	5,398	5,425
Dentist	2,963	2,985	3,028	3,068	3,115	3,156	2,856	2,857	2,858	2,859	2,859	2,860
Physician Asst.	1,495	1,512	1,535	1,557	1,582	1,608	1,455	1,497	1,541	1,585	1,631	1,679
Nurse Practitioner	2,337	2,348	2,376	2,407	2,435	2,465	2,261	2,381	2,507	2,640	2,780	2,927
Clinical Nurse Specialist	68	69	69	69	70	70	62	61	60	58	57	56
Adv. Practice Mid-wife	221	221	222	224	224	227	216	222	228	234	240	247
Registered Nurse	39,436	39,833	40,522	41,241	41,975	42,722	38,717	39,298	39,887	40,486	41,093	41,709
Licensed Practical Nurse	240	242	244	248	252	255	234	240	247	253	260	267
Nurse Anesthetist	359	364	371	379	386	396	335	336	338	339	340	342

## Scenario 1: Urban Utilization Throughout

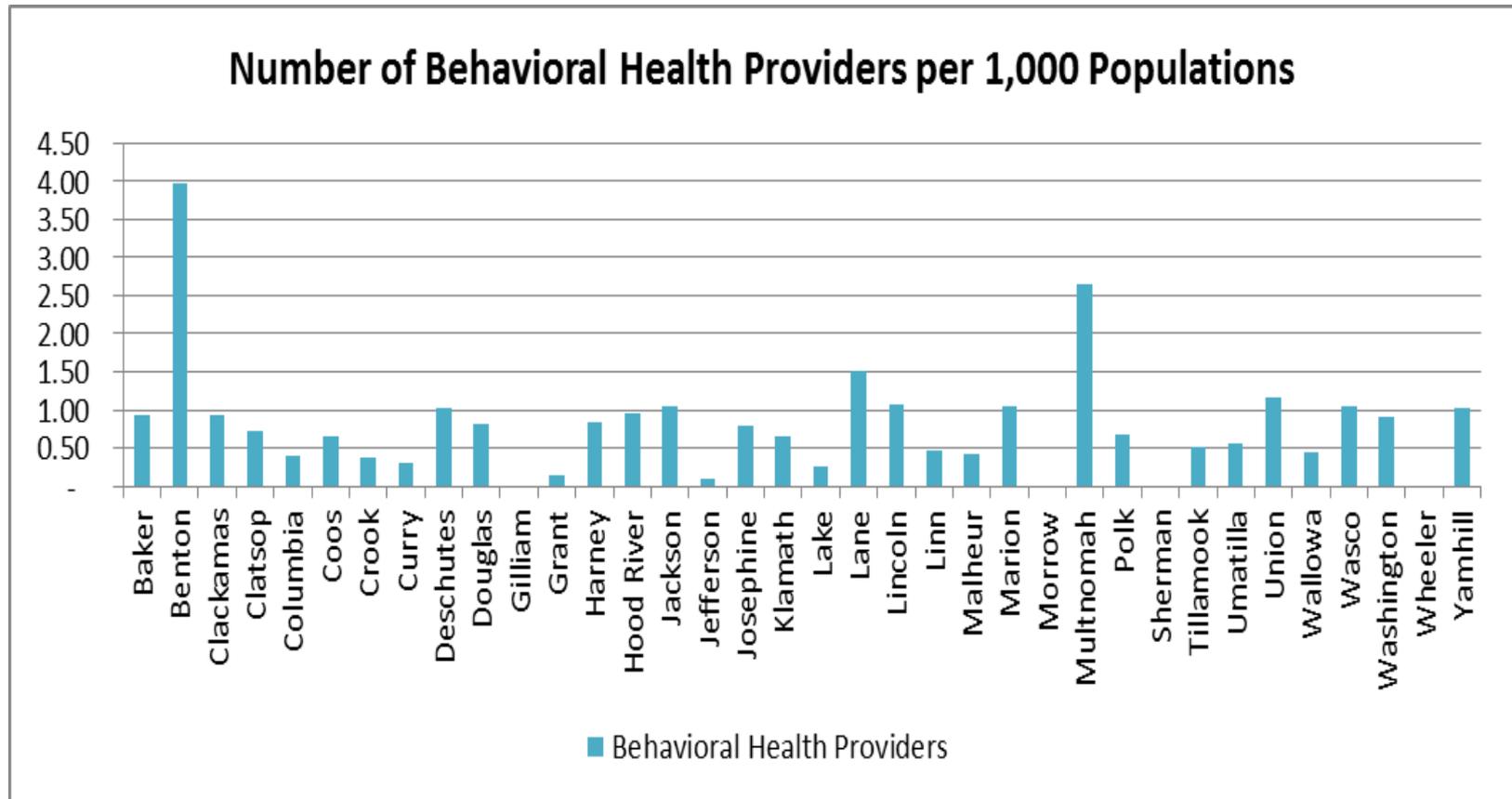
Provider Type	Projected Demand					
	2015	2016	2017	2018	2019	2020
Primary Care Physicians	7,695	7,715	7,790	7,871	7,949	8,030
Specialty Care Physicians	4,913	4,926	4,975	5,026	5,078	5,128
Behavioral Health	6,444	6,460	6,528	6,590	6,654	6,725
Dentist	4,292	4,305	4,348	4,393	4,436	4,479
Physician Asst.	1,705	1,710	1,729	1,748	1,763	1,780
Nurse Practitioner	2,488	2,496	2,522	2,549	2,573	2,598
Clinical Nurse Specialist	159	160	161	162	164	165
Adv. Practice Mid-wife	330	333	337	341	344	350
Registered Nurse	51,077	51,214	51,724	52,239	52,759	53,291
Licensed Practical Nurse	795	798	804	814	825	832
Nurse Anesthetist	619	620	626	636	643	650

- Projected demand is obtained by assuming provider productivity remains the same as in 2015
- Projected supply is obtained by applying historic growth rates to provider population in 2015
- Scenario 1 assumes that utilization of services in rural areas is the same as in urban areas

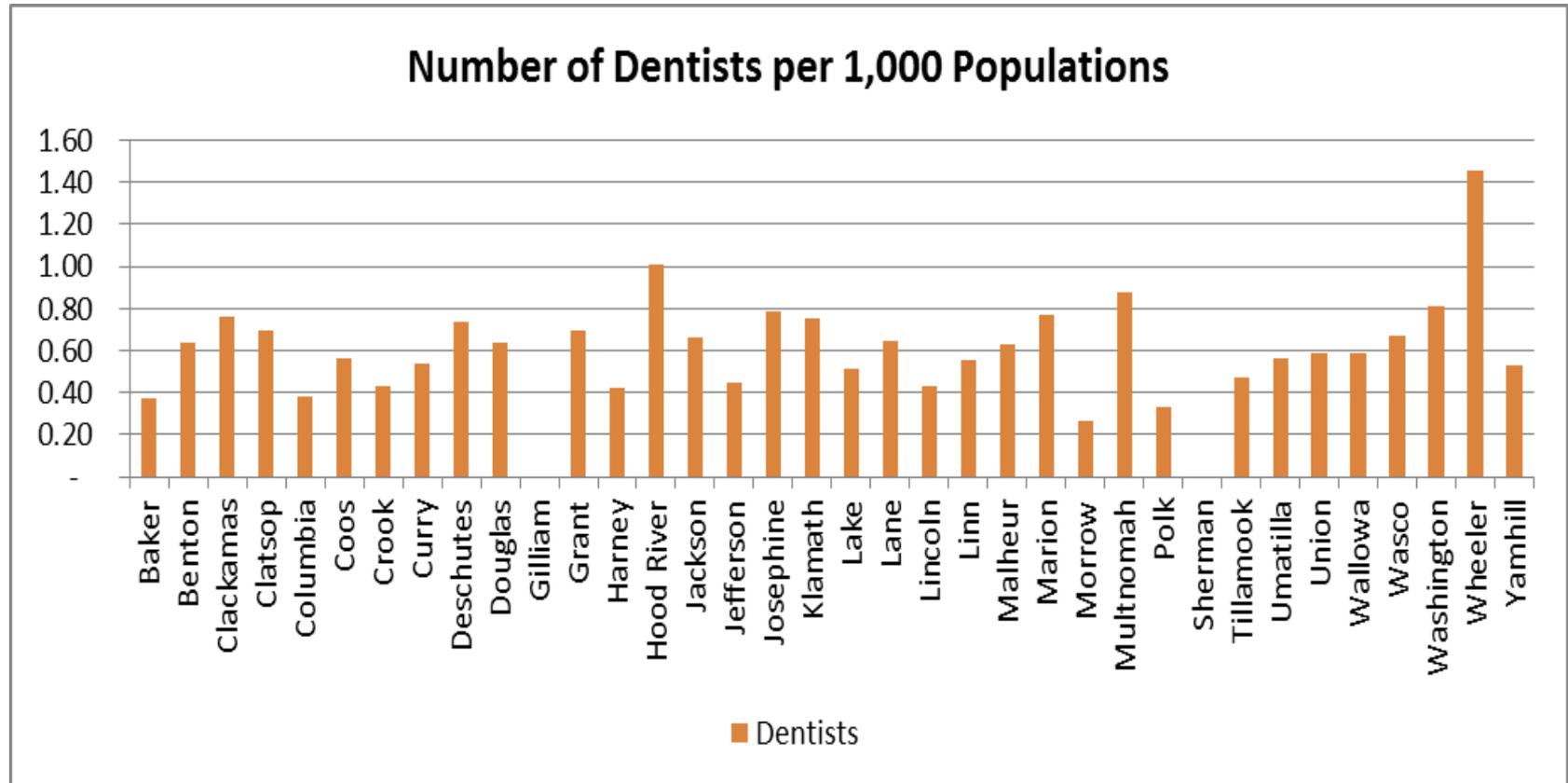
# Oregon Health Care Market: PC Physicians per Population (2015)



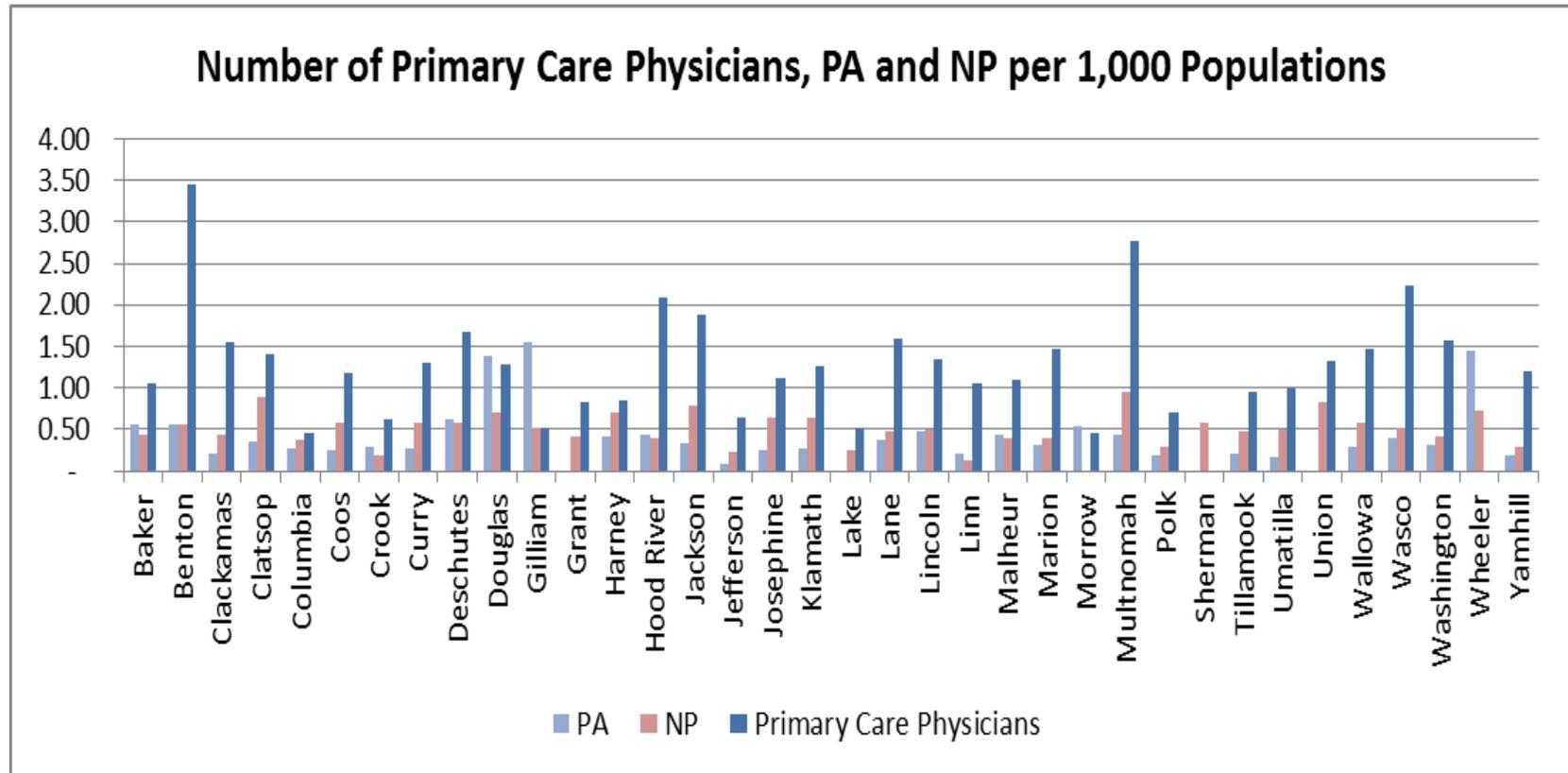
# Oregon Health Care Market: Behavioral Health Providers per Population (2015)



# Oregon Health Care Market: Dentists per Population (2015)



# Oregon Health Care Market: PAs, NPs and PC Physicians per Population (2015)



# Oregon Health Care Market: Main Findings

## Pct Providers in Rural and Urban Areas

Provider Type	Rural	Urban	Unknown
Physicians	19.3	79.1	1.6
Primary Care Physicians (PCP)	20.1	78.5	1.4
Non-Primary Care Physicians	18.1	80.1	1.8
Behavioral Health Providers (BHP)	15.1	82.2	2.6
Dentists	24.9	73.0	2.2
PAs	30.6	68.7	0.8
NPs	25.9	72.1	1.9
Clinical Nurse Specialists (CNS)	12.5	84.4	3.1
Advanced Practice Midwives (APN)	17.4	81.3	1.4
Licensed Practical Nurses (LPN)	19.0	77.7	3.3
Nurse Anesthetists (NA)	27.4	70.3	2.3

## Providers per 1,000 People

Provider Type	Rural	Urban
All Providers	9.53	19.69
Physicians	1.60	3.76
Primary Care Physicians (PCP)	1.00	2.25
Behavioral Health Providers (BHP)	0.59	1.84
Dentists	0.52	0.87
PAs	0.32	0.41
NPs	0.43	0.68

- There are 1.76 PC providers, 1.37 BH providers and 0.73 dentists per 1,000 people in OR
- Notable heterogeneity by county in availability of PC, BH providers, dentists and non-physicians
- Percent of Oregonians living in rural vs urban areas is 36.5% in rural and 63.5% in urban areas.
- Only about one fifth of all physicians who serve in Oregon actually practice in rural areas
- This pronounced imbalance in the distribution of medical providers across rural and urban areas actually translates into smaller provider-to-population ratios in rural areas relative to urban areas

# Provider Incentive Programs: Main Facts

- We considered the following loan repayment programs:
  - ▶ Medicaid Primary Care Loan Repayment Program (MPC-LRP), Primary Health Care Loan Forgiveness Program (PCLFP), Primary Care Services Loan Repayment Program (PCS-LRP), Behavioral Health Loan Repayment Program (BH-LRP), Scholars for a Healthy Oregon Program (Loan Forgiveness) (SHOI), Oregon State Partnership Loan Repayment Program (SLRP), Federal Faculty Loan Repayment Program (FF-LRP), National Health Service Corps Loan Repayment (NHSC LRP), Nursing Education Loan Repayment Program (NE-LRP)
- The tax credit and insurance subsidy programs that we considered are:
  - ▶ The Oregon Rural Practitioner Tax Credit (RPTC) and The Volunteer Rural Emergency Medical Service Tax Credit (EMS-TC), Rural Medical Practitioners Insurance Subsidy Program (RMPIS)
- These programs differ:
  - ▶ in generosity, from \$250 (EMS-TC), \$5,000 (RPTC) to \$20,000 (BH-LRP) or \$50,000 (NHSC-LRP)
  - ▶ by the provider types that are eligible to apply (e.g., MPC-LRP)
  - ▶ by the population served (e.g., BH-LRP)
- Program changes over the 2010-2015 period
  - ▶ RPTC and RMPIS - changes took effect at the end of the study period
  - ▶ NHSC - major increases in awards and number of eligible positions

# Descriptive Assessment of the Provider Incentive Programs: Main Findings

Participants by Year and Program

Programs	2010	2011	2012	2013	2014	2015
RPTC	2,137	2,164	2,203	2,214	2,216	104*
RMPIS	861	822	769	702	687	639
EMS-TC	557	565	572	562	520	269*
J1-VW	66	64	59	74	75	84
MPC-LRP	-	-	-	-	17	42
BH-LRP	-	-	-	-	-	14
SLRP	0	6	6	6	6	6
NHSC	127	185	321	257	262	346
LRP	122	179	222	240	237	316
SP	5	6	13	17	25	27
Others	0	0	86	0	0	3
<b>Total</b>	<b>3,119</b>	<b>3,186</b>	<b>3,338</b>	<b>3,262</b>	<b>3,208</b>	<b>1,477*</b>

Multiple Participants in 2014

	RPTC	RMPIS	EMS TC	J1-VW	SLRP	NHSC	MPC-LRP
RPTC	1648	465	3	16	1	75	5
RMPIS	-	216	0	2	0	1	0
EMS-TC	-	-	517	0	0	0	0
J1-VW	-	-	-	55	0	0	0
MPC-LRP	-	-	-	-	0	0	12
SLRP	-	-	-	-	4	0	-
NHSC	-	-	-	-	-	185	-
RPTC + RMPIS	-	-	0	2	0	1	0

- About 5% of the entire OR health workforce participates in at least one program
- Most multiple participants are in RPTC and RMPIS or in RPTC and NHSC
- Participation in RPTC and EMS-TC remained stable, while participation in RMPIS declined
- NHSC participation increased, especially among nurse practitioners and physician assistants
- Majority of NHSC participants are serving in FQHCs; 18 percent of them are in Community Mental Health Centers (CMHCs)

# Distribution of Incentive Program Participants by County in 2014

County	Total Participants	Participants State-Specific Programs							Participants in NHSC Program		
		State-Specific Programs	RPTC	RMPIS	VR EMSTC	J-1	MPC LRP	SLRP	NHSC	NHSC LRP	NHSC SP
Baker	74	73	43	3	31	-	-	-	2	2	-
Benton	6	3	3	-	-	-	-	-	4	3	1
Clackamas	57	49	41	8	6	-	1	-	8	8	-
Clatsop	140	140	98	18	34	1	2	-	5	4	1
Columbia	57	57	36	-	21	-	-	-	-	-	-
Coos	228	222	164	101	35	5	-	-	8	8	-
Crook	37	37	25	1	12	-	-	-	1	-	1
Curry	56	56	45	8	8	-	-	-	-	-	-
Deschutes	88	78	50	11	23	-	-	-	15	12	3
Douglas	342	335	271	98	47	4	1	-	15	14	1
Gilliam	14	14	3	-	11	-	-	-	-	-	-
Grant	34	34	19	1	15	-	-	1	2	2	-
Harney	20	20	18	2	1	-	-	-	-	-	-
Hood River	99	97	76	24	19	-	-	-	5	5	-
Jackson	88	52	48	8	-	-	-	-	38	34	4
Jefferson	38	38	32	5	6	-	1	-	4	1	3
Josephine	238	224	219	76	-	4	1	-	20	18	2
Klamath	149	136	54	49	40	-	-	-	15	14	1
Lake	47	45	15	3	31	-	-	-	2	2	-
Lane	105	100	85	1	13	2	1	-	5	5	-
Lincoln	144	141	109	20	26	-	-	-	5	5	-
Linn	72	72	70	2	1	-	-	-	1	1	-
Malheur	113	111	87	21	20	-	-	1	11	11	-
Marion	99	93	60	36	2	-	2	1	8	8	-
Morrow	24	23	13	-	10	-	-	-	6	6	-
Multnomah	38	5	-	-	1	-	4	-	33	30	3
Polk	64	56	55	13	-	-	-	-	9	8	1
Sherman	13	13	1	-	12	-	-	-	-	-	-
Tillamook	85	84	63	35	17	-	1	-	4	4	-
Umatilla	184	182	155	43	20	2	-	-	2	2	-
Union	92	89	72	17	14	1	-	-	3	3	-
Wallowa	19	19	17	11	-	-	-	-	-	-	-
Wasco	152	146	107	17	38	-	-	-	16	14	2
Washington	9	1	-	-	-	-	1	-	8	7	1
Wheeler	7	7	3	-	4	-	-	-	1	-	1
Yamhill	109	105	54	55	-	1	-	-	6	6	-
Unknown	67	67	5	-	2	55	2	3	-	-	-
<b>Total</b>	<b>3,208</b>	<b>3,024</b>	<b>2,216</b>	<b>687</b>	<b>520</b>	<b>75</b>	<b>17</b>	<b>6</b>	<b>262</b>	<b>237</b>	<b>25</b>

# Main Findings from Literature Review

- Performance Metrics for Provider Incentive Programs:
  - ▶ Number of providers serving in a high-need area who would *not* have served there in the absence of the incentive program
  - ▶ Retention metrics:
    - By time in high need area measured from the beginning or end of contract
    - By location: provider keeps working in the same site as during contract, or a similar, high-need area site
    - Large variation in the length of period chosen and degree of geographic inclusion
  - ▶ Cost of attracting an additional provider in a high need area
  - ▶ Amount of services provided by participating providers (defined as patients or visits)
  - ▶ Reduction of provider shortage in a given area
  - ▶ Number of provider-years generated by the program
- Program Effects:
  - ▶ Most evaluations focused on NHSC; very few evaluations of state incentive programs
    - An increase in NHSC tuition subsidies of by \$5,000 per enrollee, would result in a 1.7 percent increase in the long term physician supply (Holmes, 2004)
    - Lewin 2014: 49% of primary care NHSC participants were in the same HPSAs after 1 year of obligation completion and 35% of the participants were located in the same HPSAs 6 years after obligation

# Proposed Performance Metrics

- The overall measure of program impact is the increase in access to health care services provided in the area targeted by the program
- This will be approximated by:
  - ▶ The increase in providers attracted to targeted areas
  - ▶ The increase in time served in those areas
- This will be summarized by the change in full time equivalent (FTE) providers in targeted areas over a specific period
- In addition, we will consider the cost of the program
- An important overall measure of success is the change in provider FTE per change in cost
  - ▶ Also defined as the marginal cost per added FTE

# Next Steps

## ■ Key questions to be addressed in Task 2:

- ▶ How do performance measures vary by provider type and discipline?
- ▶ What are the key factors that drive the program performance?
- ▶ How do a clinician's individual characteristics affect retention rates?
- ▶ Does the effectiveness of the programs differ in the short run vs. in the long run?
- ▶ How is the supply of providers by specialty (primary care, behavioral, and oral health providers) affected by different incentive programs?
- ▶ How do programs compare in terms of effectiveness measures and costs?

## ■ Key questions to be addressed in Task 3:

- ▶ Determine if data anomalies are present and identify steps to address them
- ▶ Explore consolidating multiple years of data to bolster evaluation research
- ▶ Assess if programs need be scaled up, down, removed or consolidated
- ▶ Provide insights into how resizing of programs may address county level shortages
- ▶ Compare program costs and benefits and return on investments

# Back-Up Slides

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# Data for Task 1

## OR Health Care Market

- American Community Survey (**ACS**) : *individual level micro data*
- Area Health Resource File (**AHRF**): *county Level Aggregate data*
- OR All Payer All Claims (**APAC**) Data: *claims level micro data*



- Use ACS and AHRF to develop detailed demographic profiles, health insurance and income status of patient population and geographic distribution by county, urban vs rural, HPSA vs non-HPSA
- Supplement ACS and AHRF with OR APAC to analyze health care utilization by service type and providers and examine the demand for health care services

- AHRF County Level Data
- Provider Level Datasets:
  - *Provider360*
  - *Physician Compare*
  - *AMA Master Files*
  - *NHSC data*
  - *Oregon Medical Board*
- Provider Participation data in OR incentive programs
- OR APAC Data



- Use AHRF and provider level datasets to analyze the size, composition and the geographic distribution of the health care workforce in the state
- Use APAC utilization data to understand the productivity of health care workforce by type of services and provider discipline (primary care, dental, and mental care);
- Develop models to project future supply of health care workforce by discipline and by geography

# Data for Task 1 - continued

## OR Incentive Programs for Health Care Providers

- OR incentive program datasets and documentation:
  - *Program-specific historical administrative data (NHSC, data from OHA and Office of Rural Health) on program participation*
  - *Program-specific documentation on eligibility, benefits/award, cost, funding*



- Study program documentation to understand objectives, eligibility criteria, and targeted population; examine historical trend in funding, scope, and costs;
- Link administrative data to track multiple program participation
- Perform descriptive analysis to examine demographic and clinic profiles of participants and their geographic distribution
- Determine whether program changes over time (in terms of funding, scope and costs) are correlated with changes in the number of program participants

## Assessment of Incentive Programs

- Program Specific Datasets:
  - NHSC Data
  - Data from OHA and Office of Rural Health
- Provider Level Datasets:
  - *Provider360*
  - *Physician Compare*
  - *AMA Master Files*
  - *Oregon Medical Board*



- Examine program performance measures: recruitment, retention, costs and the number of patients served
- Estimate number of program participants in RHCs, FQHCs and critical access hospitals and other delivery settings
- Study the variation in program performance measures by program, provider discipline and by organization setting
- Evaluate performance measures before/after program was implemented, or when program changes took place
- Assess program effectiveness in terms of providing care services to rural and high need areas

# Data for Task 2

## Quantitative evaluation of the effectiveness of incentive programs

### **Qualitative:**

- Inputs from OHA, OHWC and Stakeholders; Reviews of peer-reviewed journals, reports, white papers, research projects, and other unpublished literature

### **Quantitative:**

- Analytic database by linking program specific administrative datasets with other provider level databases



- Identify and summarize findings related to the measures of effectiveness of various types of incentive programs for providers practicing in high need areas.
- Discuss with OHA and OHWC members and Stakeholders to determine key program performance metrics
- Develop statistics to analyze trends in program participation including participation in multiple programs
- Evaluate trends after the introduction of new programs or when changes in the scope and funding of the existing programs occur.
- Analyze the characteristics of program participants (provider type, discipline, rural location, age, gender, race) and compare their profile to that of non-participating providers
- Develop econometric models to estimate the impact of key programs on recruitment of providers and their retention in underserved and rural areas.

# Number of Providers by Type

Provider type	Number of Providers	
	Total	per 1,000 Population
All Health Care Providers	72,766	18.33
Physicians	11,567	2.91
Primary Care Physicians (PCP)	6,981	1.76
Non-Primary Care Physicians	4,586	1.16
Behavioral Health Providers (BHP)	5,434	1.37
Dentists	2,914	0.73
Physician Assistants (PA)	1,466	0.37
Nurse Practitioners (NP)	2,305	0.58
Clinical Nurse Specialists (CNS)	64	0.02
Advanced Practice Midwives (APN)	219	0.06
Registered Nurses (RN)	38,832	9.78
Licensed Practical Nurses (LPN)	242	0.06
Nurse Anesthetists (NA)	343	0.09
Population (2014)	3,970,239	

# Distribution of Providers per 1,000 Populations by Discipline and County

County	Population	Providers per 1,000 Populations				
		Physicians	Primary Care Physicians	Non-PC Physicians	Behavioral Health	Dentists
Baker	16,059	1.81	1.06	0.75	0.93	0.37
Benton	86,316	5.33	3.45	1.88	3.99	0.64
Clackamas	394,972	2.58	1.54	1.04	0.92	0.76
Clatsop	37,474	2.54	1.41	1.12	0.72	0.69
Columbia	49,459	0.71	0.47	0.24	0.40	0.38
Coos	62,475	1.90	1.17	0.74	0.66	0.56
Crook	20,998	1.05	0.62	0.43	0.38	0.43
Curry	22,335	1.93	1.30	0.63	0.31	0.54
Deschutes	170,388	2.88	1.67	1.21	1.02	0.73
Douglas	106,972	2.41	1.29	1.12	0.81	0.64
Gilliam	1,932	0.52	0.52	-	-	-
Grant	7,180	0.97	0.84	0.14	0.14	0.70
Harney	7,126	0.98	0.84	0.14	0.84	0.42
Hood River	22,885	3.63	2.10	1.53	0.96	1.01
Jackson	210,287	3.01	1.88	1.13	1.05	0.66
Jefferson	22,192	0.68	0.63	0.05	0.09	0.45
Josephine	83,599	1.81	1.12	0.68	0.79	0.79
Klamath	65,455	2.32	1.27	1.05	0.64	0.75
Lake	7,838	0.51	0.51	-	0.26	0.51
Lane	358,337	2.60	1.59	1.01	1.52	0.64
Lincoln	46,406	2.26	1.34	0.93	1.08	0.43
Linn	119,356	1.52	1.06	0.45	0.47	0.55
Malheur	30,359	1.58	1.09	0.49	0.43	0.63
Marion	326,110	2.42	1.47	0.94	1.04	0.77
Morrow	11,187	0.45	0.45	-	-	0.27
Multnomah	776,712	4.82	2.77	2.04	2.65	0.88
Polk	77,916	0.89	0.69	0.19	0.68	0.33
Sherman	1,710	-	-	-	-	-
Tillamook	25,342	1.85	0.95	0.91	0.51	0.47
Umatilla	76,705	1.43	0.99	0.44	0.55	0.56
Union	25,691	2.26	1.32	0.93	1.17	0.58
Wallowa	6,820	1.61	1.47	0.15	0.44	0.59
Wasco	25,515	3.92	2.23	1.69	1.06	0.67
Washington	562,998	2.47	1.57	0.91	0.91	0.81
Wheeler	1,375	-	-	-	-	1.45
Yamhill	101,758	1.74	1.21	0.53	1.02	0.53
Total	3,970,239	2.91	1.76	1.16	1.37	0.73

# Programs Using State Funding

Programs in Oregon	Description
Rural Medical Practitioners Insurance Subsidy Program	<ul style="list-style-type: none"> <li>Administered by OHA (since 2003)</li> <li>Provides subsidies to qualifying physicians and NPs in rural areas to offset cost of medical malpractice insurance</li> <li>Funding: \$2.5 million/year</li> </ul>
Medicaid Primary Care Loan Repayment Program	<ul style="list-style-type: none"> <li>Administered by OHA (since 2013)</li> <li>Provides loan repayment for providers serving Medicaid patients in Oregon</li> <li>Funding: \$4 million (2013-2015)</li> </ul>
Scholars for a Healthy Oregon Program (Loan Forgiveness)	<ul style="list-style-type: none"> <li>Administered by OHSU (established in 2013)</li> <li>Offers full tuition and fees to 21 OHSU medical, PA, Dental and APN students in exchange for obligation to serve in a OHSU approved underserved site for a stipulated period</li> <li>Funding: \$2.5 million (2013-2015)</li> </ul>
The Oregon State Loan Forgiveness Program	<ul style="list-style-type: none"> <li>Administered by Office of Rural Health (established in 2010)</li> <li>Provides loan repayment to 2<sup>nd</sup>/3<sup>rd</sup> year students who are enrolled in Oregon rural training track for funding up to 3 years</li> <li>Funding: \$700,000 (2013-2015); typical awards are \$35,000/year</li> </ul>
Primary Care Services Loan Repayment Program	<ul style="list-style-type: none"> <li>Administered by Office of Rural Health</li> <li>Provides loan repayment to providers offering primary care services in exchange for at least 3-years of service in underserved and rural areas (2-years for PA/NPs)</li> <li>Funding: currently unfunded</li> </ul>
Rural Practitioner Tax Credit	<ul style="list-style-type: none"> <li>Administered by Office of Rural Health and Oregon Department of Revenue (since 1989)</li> <li>Provides \$5,000 tax credit annually to eligible providers, optometrists, and dentists</li> <li>Funding: \$8.5 million/year</li> </ul>
The Volunteer Rural Emergency Medical Service (EMS) Tax Credit	<ul style="list-style-type: none"> <li>Administered by the Office of Rural Health and Oregon Department of Revenue (since 1989)</li> <li>Provides a \$250 tax credit for emergency medical respondents in rural areas (25 or more miles away from population centers)</li> <li>Funding: \$150,000/tax year</li> </ul>
Behavioral Health Loan Repayment Program	<ul style="list-style-type: none"> <li>Administered by the Office of Rural Health</li> <li>Offers loan repayment to behavioral health workers in exchange for at least 1 year of service in Mental Health Professional Shortage Areas</li> <li>Typical award is up to \$20,000 per participant per year of obligatory service</li> </ul>

# Programs Using Federal Funding

Programs using Federal Funding	
Oregon State Partnership Loan Repayment Program (SLRP)	<ul style="list-style-type: none"> <li>Provides loan repayment in exchange for a 2-year service obligation in Health Professional Shortage Areas</li> <li>Funding (HRSA): \$300,000/year and typical awards are up to \$35,000/year</li> </ul>
National Health Service Corps (NHSC) Loan Repayment	<ul style="list-style-type: none"> <li>Provides loan repayment to primary care providers in exchange for service obligation in Health Professional Shortage Areas</li> <li>Funding (HRSA): \$4.6 million/year and typical awards are up to \$50,000 for a 2-year commitment</li> </ul>
National Health Service Corps (NHSC) Scholarship Program	<ul style="list-style-type: none"> <li>Provides scholarship to pursue primary care and commit to serve in Health Professional Shortage Areas</li> <li>Funding (HRSA): \$1.1 million (2013)</li> </ul>
Nursing Education (NELRP) Loan Repayment Program	<ul style="list-style-type: none"> <li>Provides loan repayment to Registered Nurses and Advanced Nursing Practitioners in exchange for a minimum of a 2-year service in Health Professional Shortage Areas</li> <li>Funding (HRSA): \$1.2 million (2013)</li> </ul>
Federal Faculty Loan Repayment Program	<ul style="list-style-type: none"> <li>Provides loan repayment to health professions graduates from disadvantaged backgrounds who serve as faculty at an eligible health profession college or university</li> <li>Pays up to \$40,000 in exchange for at-least 2-year service in Health Professional Shortage Areas</li> <li>Funding (HRSA): \$44,000 (2013)</li> </ul>

This survey is being administered on behalf of the Oregon Health Policy Board (OHPB)'s Healthcare Workforce Committee. It is designed to collect information about how primary care providers and behavioral health providers work together at practices in Oregon. It should take no longer than 5 minutes to complete.

**Your answers are confidential and will not be reported in a way that identifies you or your practice.** Instead, they will be combined with answers from other practices to help the OHPB understand how primary care providers and behavioral health providers are working together. Your feedback will help the OHPB recommend program improvements to assist practices in the future.

## SURVEY

- Please indicate whether your organization includes access to each of the following types of providers.

<b>Type of Provider</b>	<b>Access on-site (co-located)</b>	<b>Referral available within organization (different site)</b>	<b>External referral available</b>	<b>Not available</b>	<b>Other</b>
<i>Mental Health Providers</i>					
Psychiatrist, (MD)					
Psychiatric Mental Health Nurse Practitioner (PMHNP)					
Licensed Clinical Social Worker (LSCW)					
Licensed Professional Counselor (LPC)					
Psychologist (PhD)					
Qualified Mental Health Provider (QMHP)					
Qualified Mental Health Associate (QMHA)					
Another type of mental or behavioral health provider (please write in)					
<i>Physical Health Providers</i>					
Primary care physicians (MD)					
Naturopathic Physicians (ND)					
Registered Nurse (RN)					

Nurse Practitioner (NP)					
Other Physical Health Provider					
Addiction Services Providers					
Certified Alcohol and Drug Abuse Counselor (CADC)					
Qualified Mental Health Associate (QMHA)					
Peer Support Services					
Peer Recovery services					
Peer wellness services					

- Integration, coordination, and collaboration between behavioral health providers, physical health providers, addiction providers, and peer wellness services in order to provide higher quality care and a patient-centered experience can occur in many different ways and usually requires multiple incremental steps to achieve. We are interested in understanding ways in which your organization is currently working towards the integration of health services.

Please indicate the degree to which your organization participates in each of the following activities or efforts towards achieving integration.

Activity	Description	My organization currently does this	My organization will do this within 6 months	My organization is not currently doing this	Other
Co-location of services	Behavioral health providers and physical health providers are all located in and provide services in the exam room area of the clinic				
Shared appointment systems	There is one system for making both primary care and behavioral health appointments				
Chart note integration	Behavioral health and primary care chart notes are placed in the same location				
Shared assessment and management tools	Behavioral health providers and physical health providers use shared screens, visit templates, and outcomes instruments that are readily available (e.g., electronically or in a wall hanger folder)				

Curbside consultation	Physical health providers and behavioral health providers routinely discuss patient care issues together prior to and after same-day handoffs or prior to a scheduled visit.				
Team membership	Behavioral health providers are regarded as core members of the primary care team and attend all primary care meetings.				
Routine screening and referral for Psych issues	Patients are routinely screened prior to or during medical exams for behavioral health problems such as depression, PTSD, anxiety, alcohol or drug abuse.				

3. What have been the three biggest challenges your organization has experienced in helping primary care providers and behavioral health providers work together?

4. What is your job description?

- Executive management
- Administrative staff
- Primary care medical provider
- Specialist medical provider
- Mental health provider
- Substance abuse and addictions provider
- Other [fill-in]

5. Which of the following describes your organization (check all that apply)?

- Hospital
- Medical clinic
- Behavioral health clinic
- Small, independent practice
- Larger group practice
- Integrated health system
- Long-term care or residential facility
- Other

6. If there are multiple practice sites within your organization, please write in the number of sites:

7. Please write in the number of clinicians at this site. *Please do not count pharmacists, medication assistants, or general administrative support staff.*
8. Please write in the average number of unduplicated clients served in January 2016. *If you are unsure, please write in your best guess.*
9. Is your practice a certified (Patient Centered Primary Care Home (PCPCH)?
- Yes
  - No
  - Unsure
  - (if no) Is your practice interested in being recognized as a PCPCH?
10. Is your organization employing providers who are currently receiving state- or federally-funded incentives (e.g., National Health Service Corps or Oregon Medicaid Loan Repayment, etc.)?
- Yes
  - No
  - If no, would you be interested in doing so?
  - Unsure
  - Other
11. Please describe the area surrounding your organization:
- Rural
  - Urban
  - Frontier
  - Other
12. Does your organization participate in a CCO network?
- Yes
    - i. If yes, please list which CCO(s):
  - No
13. OHA may be interested in understanding more detail about some responses. If you would be open to follow-up, please provide your name, email address or phone number:
- [Fill in]

Thank you! The Oregon Health Policy Board's Health Care Workforce Committee will be using the results of this study to provide recommendations in November 2016 that support behavioral health integration efforts in Oregon. For more information, please visit our website here:

<http://www.oregon.gov/oha/OHPR/HCW/Pages/index.aspx>

Oregon Health Policy Board  
Healthcare Workforce Committee  
Behavioral Health Integration Subcommittee  
Preliminary Survey Results

## Background

The Healthcare Workforce Committee (HCWF)'s Behavioral Health Integration subcommittee distributed an online survey to gather feedback and input on one of the deliverables requested by the OHPB:

*Deliverable #1: Identification of activities and processes necessary to achieve a foundational level of behavioral and physical health integration; highlighting of best practices seen in Oregon that are scalable.*

The survey consisted of 15 questions, broken into three major sections: 1) demographics of the survey participant's organization, 2) level of access to various types of providers within the organization (on-site, referral within the organization, external referral, or not available); and 3) status of integration based on seven elements that are foundational to successful integration of care.

## Demographics of survey respondents:

The targeted respondents were physical and behavioral health care practitioners or administrators.

Survey participants self-reported as the following types of organizations (multiple responses allowed):

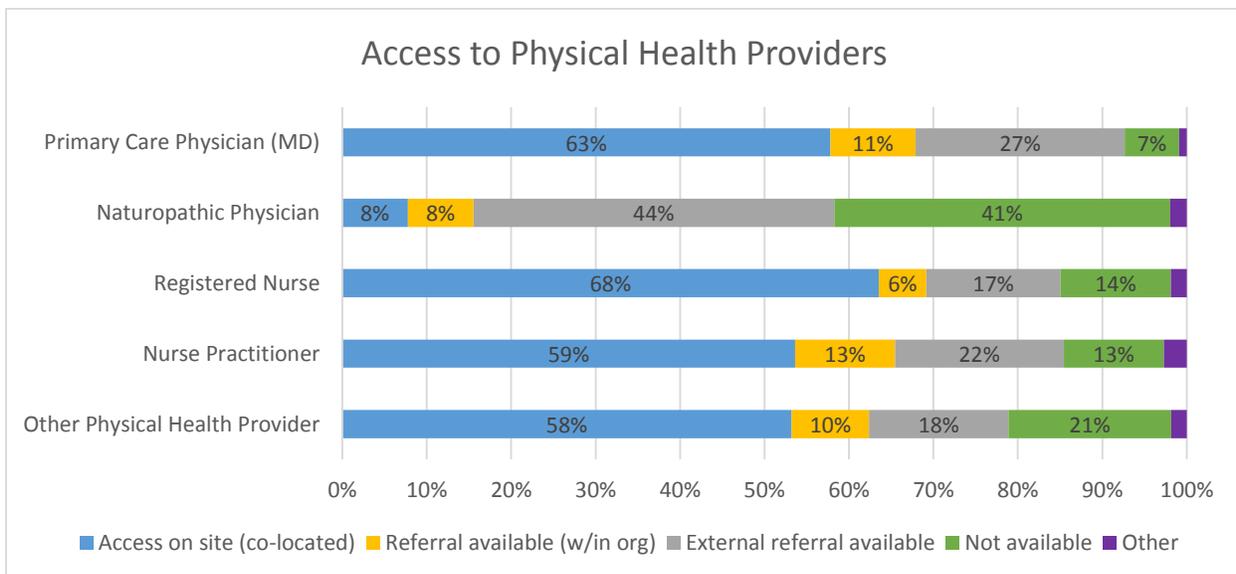
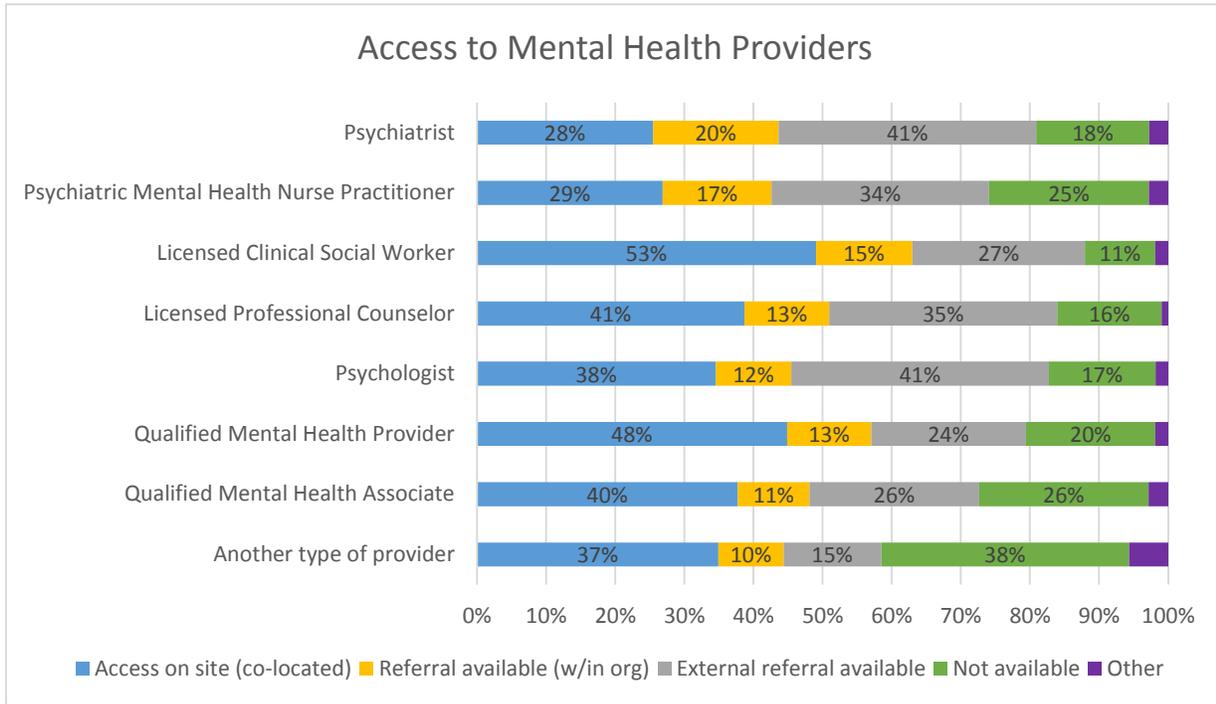
- 71 medical clinics
- 46 behavioral health clinics
- 30 small, independent practices
- 23 integrated health systems
- 15 hospitals
- 13 larger group practices
- 6 long-term care or residential facility
- 25 other (tribal; non-profit org; CCO; health district; FQHC)

## Other items of note:

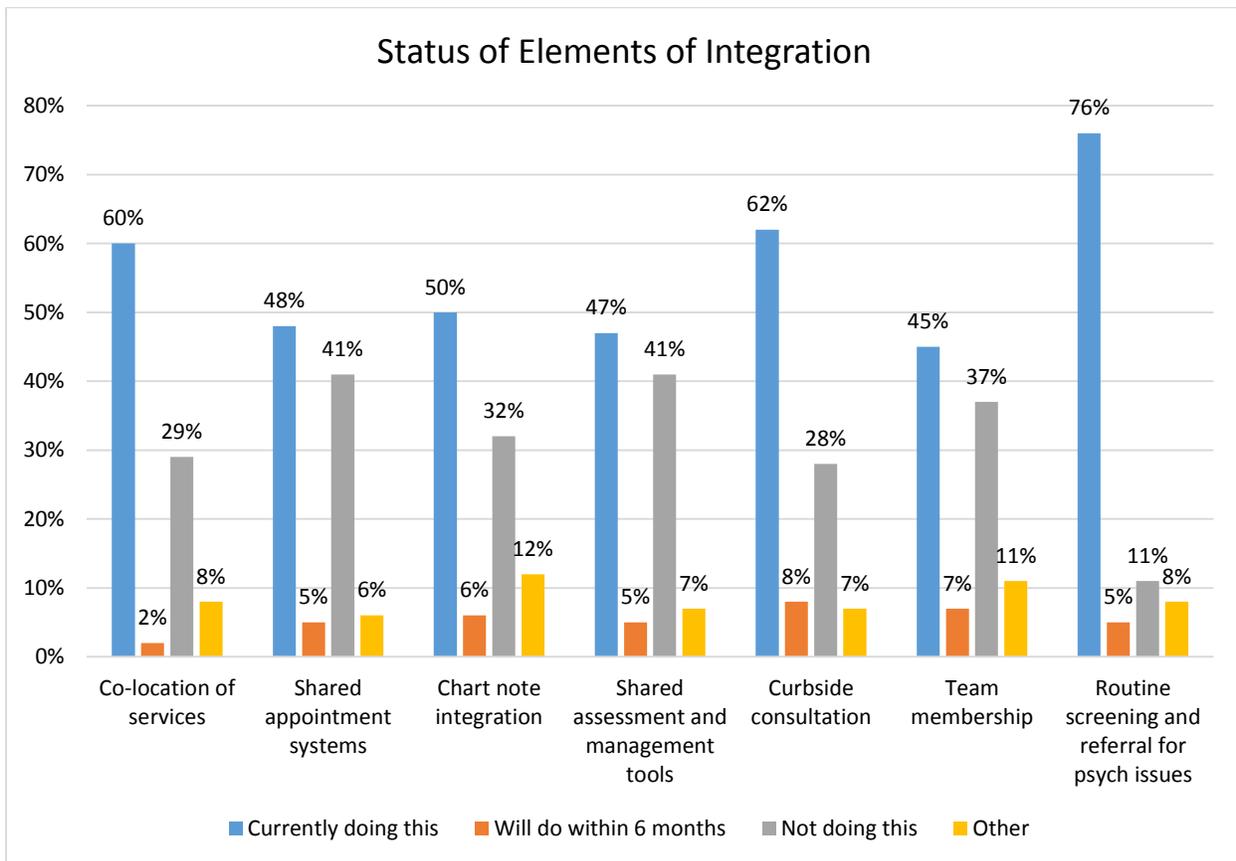
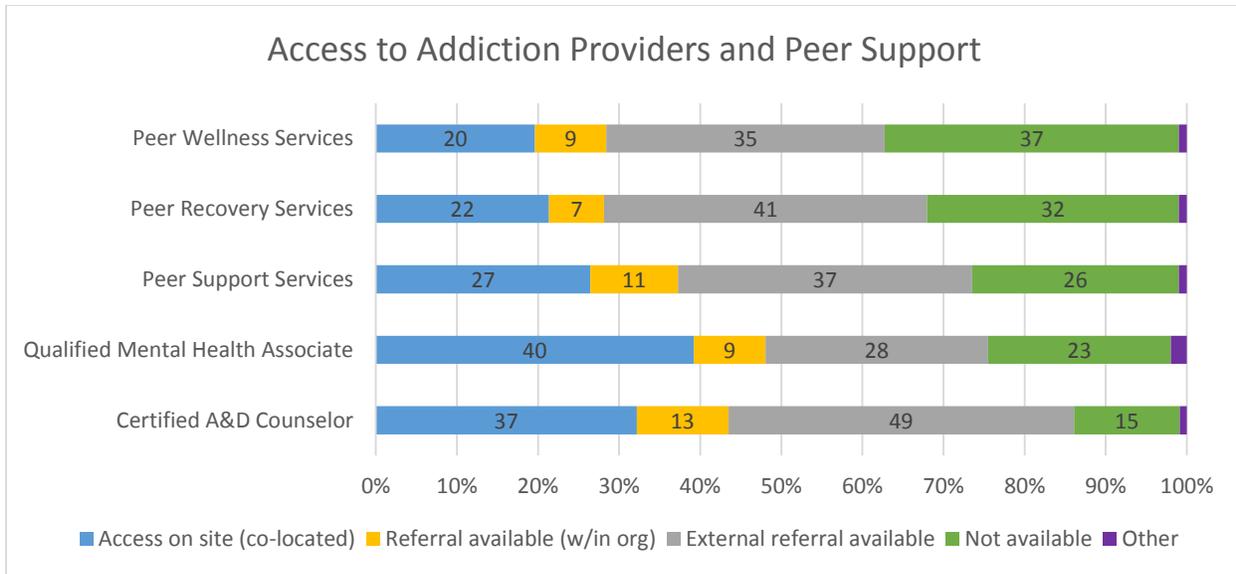
- 54.3% reported as being a recognized PCPCH; 34.8% were not a PCPCH; 11.6% were unsure of their PCPCH status; and 5.5% were interested in becoming a PCPCH
- 43% defined the area surrounding their organization as rural; 47% urban; 4% frontier; 6% other
- 84% participated in CCO network(s)
- 25% employ providers who are currently receiving state- or federally-funded incentives (e.g., NHSC); 46% do not; 25% are unsure; 11% are interested in doing so
- Number of clinicians at the site ranged from 2 to 600 (multiple sites)
- Number of patients seen in January 2016 ranged from 20 to 35,000 (integrated health system)

## Access to Providers

Approximately one-third of respondents had **on-site** access to physical, mental, and addiction service providers (any type of provider). Nearly two-thirds reported having **on-site** access to both physical and mental health providers. Just under half of respondents had access to addictions services.



*\*Note: "Other physical health provider" was most commonly a Physician's Assistant*





4. Billing (not compensated for integrated care)
5. Lack of space for co-location
6. Sharing records
  - a. Majority: IT incompatibility, EMR issues
  - b. Some: privacy/confidentiality concerns
7. Lack of time (to see more patients, for huddles, etc.), including:
  - a. Scheduling (long wait times)
8. Insurance challenges (authorizations, network)
9. Funding issues (cost of BH provider, charges to clients, low or no reimbursement)