

Oregon Healthcare Workforce Committee

AGENDA May 8, 2013

OIT Wilsonville Campus
27500 SW Parkway Ave., Wilsonville, OR 97070
Room 402
1 – 4 pm

Meeting Objectives:

- Approve summaries of prior meetings
- Inform Committee members on relevant activity
- Members develop and adopt a work plan for 2013-14

| # | Time | Agenda Item | Presenter(s) | Action Item |
|---|------|--|----------------------------|-------------|
| 1 | 1:00 | Welcome | Ann Malosh | |
| 2 | 1:05 | Approval of February 12 meeting summary | Ann Malosh | X |
| 3 | 1:10 | Legislative Update | Lisa Angus, Others | |
| 4 | 1:30 | Update and Discussion on SB 879 | Terri Johanson, Lisa Angus | |
| 5 | 1:45 | Other Updates--Members | All | |
| 6 | 2:00 | Break | | |
| 7 | 2:15 | Committee Workplan Development <ul style="list-style-type: none">• Discuss Health Policy Board feedback on revised recommendations• Develop next steps for priority recommendations and for Committee work• Propose timetable for Committee activity | Ann Malosh, All | X |
| 8 | 4:00 | Adjourn | Ann Malosh | |

Meeting Materials

1. Agenda
2. February 12 draft meeting summary
3. Legislative Update
4. Next steps / Committee workplan development document
5. HB2366 Strategic Plan

**Oregon Healthcare Workforce Committee
Meeting Summary**

February 12, 2013
1:00 – 4:00

Committee Members in Attendance

Lisa Dodson (Chair)

Ann Malosh (Vice-Chair)

Paula Crone (via phone)

Mary Rita Hurley

Terri Johanson

David Nardone (via phone)

David Pollack

Daniel Saucy

Jennifer Valentine (via phone)

OHA and OWHI Staff in Attendance

Jo Isgrigg (OHWI)

Lisa Angus (OHPR)

Marc Overbeck

Margie Fernando

Committee Members not in Attendance

June Chrisman

Saige Gracie

Mauro Hernandez

Andrew Janssen

Susan Kirchoff

Michael Reyes

Mark Richardson

Sergio Vasquez

Judith Woodruff

Donna Larson

Other

Agnes Balassa (Governor's office) via phone

Meeting summary (Committee actions or decisions in bold)

Dr. Dodson convened the meeting.

The Dec 12, 2012 meeting summary was accepted with no changes.

Updates

- Ann Malosh asked if the Community Healthcare Workers Employment surveys were completed. Jo Isgrigg and Lisa Angus reported that the Office of Equity and Inclusion (OEI) would like to attend a future Workforce Committee meeting and are expected to bring the results of their survey to the committee then.
- Mary Rita Hurley stated that OEI's Cultural Competence Continuing Education Committee report should be available by the end of February.

Notes from 12.14.12 Workforce Meeting

- David Pollack commented on HB 2611 that directs certain health regulatory boards to adopt requiring licensees to document participation in continuing education opportunities relating to cultural competency approved by OHA. He is interested to know how OHA is going to define cultural competency. Mary Rita Hurley will be attending the first hearing on Feb 15, 2013 and will have more details after this.
- Lisa Dodson testified on Loan Repayment bill, SB 440 on Mon Feb 11, 2013. She thinks that the testimonies were well received by the Legislature.
- David Pollack and Lisa Dodson completed their presentation on Healthcare Workforce development to the 2nd year medical students. David will email this presentation to the committee.
- Lisa Dodson shared with the committee that AHEC has set aside Feb 22, 2013 and Apr 4, 2013 for a pilot project with St Charles for an Inter-professional Education conference, where students from all 8 disciplines and 7 schools will be coming together. All students in training programs on rotation in the St Charles system are invited. She also invited the committee to attend if possible. She will provide a report to the committee once this is over.
- David Pollack and Lisa Dodson also shared that the Provost of OHSU has approved the use of a common academic calendar for all the programs in OHSU starting next year.

2012 Oregon Health Professionals Profiles report: presentation and discussion of data by Jo Isgrigg and Mary Rita Hurley

Jo Isgrigg and Mary Rita Hurley presented an update to the first Oregon Health Professions: Occupational and County Profiles report published in April 2011. This report identifies the trends in the geographic distribution, demographics and future careers plans of health professionals represented by the 21 health care occupations.

The highlights of the report are:

- Since 2010, the majority of health professions experienced an increase in the number of licensees, however three professions, dentists, physicians and certified nursing assistants experienced a decrease.
- A 2.9% overall reduction between 2010 and 2012 in primary care practitioners (Physicians, PAs and NPs)
- Registered nurses continue to be a large portion of the health care workforce, with a slight increase of male registered nurses.
- Ten of Oregon's 36 counties have health professionals representing all 21 occupations profiled in this report.
- Aging of the health care workforce is still a concern with an alarming rate of retirements and/or planning to retire within the next 10 years

Notes from 12.14.12 Workforce Meeting

This report is critical and timely because it provides workforce data that will inform the committee in its efforts to formulate a response back to the Oregon Health Policy Board. The data is important to address Oregon's health care workforce needs for the future and provide for better modeling.

The committee discussed at length how these data can be fine-tuned or explored further to address the future workforce needs and the higher demand anticipated in 2014. Some of the questions/comments raised were:

- How to trace the professionals who have left the workforce, why did they leave? Can the Licensing Boards provide a survey of the reasons why these professionals left?
- Is there a way of trending the data for the future?
- What categories of professionals are needed for the Primary Care Homes of the future?
- What kind of jobs will be required to implement the care model?
- Where do the new health occupations, like the community health workers and non-traditional workers, fit into the CCOs? Lita Colligan noted that the OIT has already introduced a new Medical Sociology program as a minor in anticipation of the demand from the industry.
- Will the traditional ways of defining the health professions work?
- Is there an opportunity to revise this data collection to better model what the CCOs and Primary Care Homes are going to need?

2012 recommendations and 2013 Committee work: Feedback from Health Policy Board and discussion

The Workforce committee presented its 2012 recommendations to the Health Policy Board on Feb 5, 2013. The video recording of this presentation by Lisa Dodson and Ann Malosh was sent by email to the committee by Lisa Angus. The Board was very interested in the recommendations and had many questions that require a follow up by the committee.

Lisa Dodson handed out a draft document that outlines the format for the revised recommendations to address their concerns. Lisa reminded the committee that their charge and scope in the charter are to provide recommendations only. The Workforce committee has no budget and no statutory authority to do anything else.

The draft response is in two parts, Part 1 targets 2014, and Part 2, targets 2014-2020. The committee is asked to prioritize the recommendations.

The Health Policy Board wanted to know what the best recommendation is for the amount of dollars available, what is achievable, who is accountable and who can do it. Specifically, they would like the committee to recommend what needs to happen before 2014 to align with the Triple Aim around workforce. The committee discussed how best to present the recommendations, perhaps with a visual diagram of what the care model team should look like. The committee would like to see the transformation plans of the CCOs.

Notes from 12.14.12 Workforce Meeting

Some suggestions to include in the draft document of revised recommendations:

- Concentrate and define the primary care aspect only for now
- Expand the utilization of Naturopaths for primary care
- Have a mix of providers in the primary care setting
- Provide the building blocks of what the CCO workforce should look like but leave the details to the individual CCO
- Since we cannot produce new workforce between now and 2014, use the current workforce more efficiently by prolonging careers or expanding locums and accelerating current programs
- Enhance the skill set of new graduates
- Find out what other states are doing to expand the workforce

Lisa and staff will revise the document and send it around for the committee to view before sending a draft to the Health Policy Board.

Medicaid waiver loan repayment program design recommendation for OHA

Lisa Angus presented the draft Committee recommendations for the Medicaid waiver loan repayment program design, based on discussion from the previous two Committee meetings.

Committee members present approved the draft document with the following to be added:

1. Add Naturopaths to Provider Eligibility list
2. Loan repayment will only apply to health profession debt

Because there was not a quorum of members present, Lisa will circulate this via email in order to obtain official committee approval.

Lisa will then make the changes and send to the Health Policy Board

Public Testimony

There was no public testimony at this meeting.

Meeting Adjourned at 3:44pm.

Next Meeting - TBD

2013 Oregon Legislative Session Update -- Health Care Workforce Policy-Related Bills

Prepared for the Oregon Healthcare Workforce Committee

May 8, 2013

| Bill | Description | Status |
|----------|---|---|
| HB 2037A | <p>Licensing reciprocity for spouses of military personnel posted to Oregon.</p> <p><i>Bill summary:</i> Requires, under specified circumstances, certain professional regulatory boards to issue authorization to practice profession to spouse or domestic partner of active member of Armed Forces who is subject of military transfer to Oregon. Requires Teacher Standards and Practices Commission to establish by rule expedited process by which military spouse or domestic partner who is licensed to teach in another state may apply for and obtain teaching license.</p> | <p>Passed House. In Senate Health Care Committee with Public Hearing and Possible Work Session scheduled 05/07/13.</p> |
| HB 2636A | <p>STEM Investment Council.</p> <p><i>Bill summary:</i> Establishes STEM Investment Grant Program for purpose of providing funding to school districts, community colleges and public universities and other entities to advance educational goals related to science, technology, engineering and mathematics. Establishes STEM Investment Grant Account. Appropriates moneys in account to council for purpose of awarding grants under grant program. Appropriates moneys from General Fund to council for purpose of awarding grants under grant program. Declares emergency, effective July 1, 2013.</p> | <p>House Higher Ed & Workforce Development Committee recommended passage and referred to Ways & Means on 03/12/13. No action since.</p> |
| HB 2858 | <p>Funding for primary care provider loan <i>forgiveness</i> program</p> <p><i>Bill summary:</i> Appropriates money to Oregon Department of Administrative Services for deposit in Primary Health Care Loan Forgiveness Program Fund. Declares emergency, effective July 1, 2013.</p> | <p>House Health Care recommended do pass and referred to Ways & Means by prior reference on 3/13/13.</p> |
| HB 2902A | <p>Pay parity for NPs and PAs in independent practice.</p> <p><i>Bill summary:</i> Requires insurers to reimburse physician assistants and nurse practitioners {in independent practices} at same rate as physicians for same services. Declares emergency, effective on passage.</p> | <p>Passed House on 4/17/13 and referred to Senate Health Care Committee. Public Hearing and Possible Work Session scheduled 05/09/13.</p> |
| HB 2997A | <p>Licensure requirement for direct entry midwifery</p> <p><i>Bill summary:</i> Requires person to obtain license to practice direct entry midwifery. Grants State Board of Direct Entry Midwifery certain powers related to rulemaking, investigations and discipline, including power to impose</p> | <p>In Ways & Means Subcommittee on Education with Public Hearing scheduled 05/08/13.</p> |

| | | |
|----------|---|--|
| | civil penalties. Establishes Direct Entry Midwifery Account and continuously appropriates moneys in account to board. Declares emergency, effective on passage, | |
| HB 2999 | <p>Would have been coverage mandate for naturopathic services.</p> <p><i>Bill summary:</i> Requires health benefit plan to cover services of naturopath that are covered by plan if provided by physician. Requires coordinated care organization to ensure members have access to services of naturopath.</p> | Dead |
| HB 3341 | <p>Adverse Impact bill.</p> <p><i>Bill summary:</i> Exempts public universities and community colleges from requirement to enter into agreement with for-profit institutions of higher education before implementing potentially duplicative new post-secondary programs. Directs Higher Education Coordinating Commission to report to Seventy-eighth Legislative Assembly on methods to avoid duplication of facilities and to leverage public and private education facilities and faculty resources in state post-secondary education system.</p> | Passed House 4/25/13 and was referred to Senate Education and Workforce Development on 05/01/13. |
| HB 3407A | <p>Advisory committee on (non) traditional health workers</p> <p><i>Bill summary:</i> Establishes Traditional Health Workers Commission within Oregon Health Authority advise authority on adoption of criteria and descriptions for coordinated care organizations to use with respect to certain health workers who are not licensed by this state and training and education requirements for those workers.</p> | Passed House Health Care Committee and was referred to Ways & Means by prior reference on 04/17/13. |
| SB 2 | <p>OHSU scholarships for health care providers who agree to practice in underserved locations.</p> <p><i>Bill summary:</i> Establishes Scholars for a Healthy Oregon Initiative to provide free tuition and fees for certain students in health care disciplines in exchange for student commitment to work in underrepresented locations after graduation. Appropriates moneys to Oregon Department of Administrative Services for Oregon Health and Science University for purposes of initiative.</p> | Passed Senate Health Care Committee on 3/29 and was referred to Ways and Means by prior reference. No action since then. |
| SB 325A | <p>Extend rural practitioner tax credit.</p> <p><i>Bill summary:</i> Extends sunset for tax credit for practice of rural medicine. Provides that, to be eligible for credit, individual must be engaged in rural practice of medicine for at least 20 hours per week, averaged over month, and must remain willing to serve certain percentage of Medicare and medical assistance patients. Limits eligibility to individuals</p> | Passed Senate Health Care Committee on 4/24/13 and was referred to Senate Tax Credits Committee by prior reference. |

| | | |
|---------|---|---|
| | with adjusted gross income of \$250,000 or less for single return, or \$500,000 or less for joint return. Applies to tax years beginning on or after January 1, 2014. Takes effect on 91st day following adjournment sine die. | |
| SB 440B | <p>Medicaid primary care provider loan repayment program.</p> <p><i>Bill summary:</i> Creates primary care provider loan repayment program and establishes Primary Care Provider Loan Repayment Fund. Requires Oregon Health Authority to transfer moneys from Oregon Health Authority Fund to Primary Care Provider Loan Repayment Fund for purpose of operating primary care provider loan repayment program. Declares emergency, effective on passage.</p> | Passed the Senate. Referred to Ways & Means by the House on 05/01/13. |

Healthcare Workforce Committee 2013-14 Work Plan Document – **DRAFT**

Last Update: 5-3-13

| Recommendation | Actor(s) | Timeframe -- | Notes on potential next steps / resources needed / barriers |
|--|---|----------------|--|
| PRIORITIZED RECS from April 2, 2013 presentation to Health Policy Board – IMMEDIATE FOR 2014 | | | |
| Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible. | OHA CCOs Other payers | 2013 & forward | <ul style="list-style-type: none"> ▪ Explore more what role Workforce Committee could play ▪ OHA Transformation Center actively planning for technical assistance to CCOs and alignment with other payers around alternative/accountable payment methods |
| Implement the new Medicaid state loan repayment program for eligible primary care providers. | Legislature OHA | 2013 | <ul style="list-style-type: none"> ▪ Little action needed – bill is moving and Workforce Committee has already made recommendations for program design ▪ Committee should receive information on program administrative rules when they are drafted, hoping for June ▪ Regular updates to Committee on progress of program, applicants, etc. |
| Forecast short and longer-term demand for primary care practitioners. | OHWI and OHA - OHPR, with input from WFC | 2013 | <ul style="list-style-type: none"> ▪ OHA and OHWI are in the process of scoping the modeling work and getting other expert input ▪ Depending on the level of detail, could bring some of the scope and parameter questions to Committee for input ▪ Progress reports and detailed presentation/discussion of results with Committee, potentially at Oct. meeting? |
| Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers. | CCOs, health care facilities, commercial plans | 2013 and 2014 | <ul style="list-style-type: none"> ▪ Need to hear more specifically about what the barriers are and hear examples of solutions people have already developed. ▪ Staff or assigned Committee members could be asked to do other background research? |

| Recommendation | Actor(s) | Timeframe -- | Notes on potential next steps / resources needed / barriers |
|---|--|------------------------|--|
| <i>“Strike force for recruiting” suggestion from Dr. Robertson at 4/4 Board meeting</i> | | | <ul style="list-style-type: none"> ▪ Committee could discuss feasibility and utility of this suggestion and/or follow-up with Dr. Robertson for more information about what he had in mind ▪ Refer to HB 2366 report for actionable strategies that are NOT already represented in following recommendations. |
| PRIORITIZED RECS from April 2, 2013 presentation to Health Policy Board – LONGER TERM (2013-2017) | | | |
| Re-fund the state’s Primary Care Loan Forgiveness Program | Legislature | July 2013 | <ul style="list-style-type: none"> ▪ Wait to see whether the Legislature will take action. As of 3/13, funding bill (HB 2858) is in Ways & Means. ▪ HB 2366 report recommended expanding program – is there a need to work up specific steps/costs/etc. for that? |
| Develop occupational training programs to respond to emerging care models and industry demand – for new AND incumbent workers | Educational institutions, accrediting organizations, community-based organizations | 2014 | <ul style="list-style-type: none"> ▪ Committee could perhaps plan & convene a focused forum/discussion between employers and educators? ▪ Bring in employers with successful up-training programs for existing workers to educate Committee? |
| Ensure that CCOs’ required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess | OHA Transformation Center, CCOs | 2013 and (early?) 2014 | <ul style="list-style-type: none"> ▪ Bring in representatives from OHA, CCOs, and partners to educate Committee about what community health assessment work is currently happening, and about network adequacy reports and related requirements of CCOs ▪ Ask/assign OHA staff or contractors to assemble currently available workforce data or resources in a way that is useful for CCOs (e.g. by CCO area rather than county, etc.) ▪ Make sure that output from projections analytic project (see page 1) will be in a format that is useful to CCOs as well as statewide |
| Enact workforce data reporting mandate for all health profession licensing boards | Legislature; licensing boards | 2014 | <ul style="list-style-type: none"> ▪ A mandate would require legislation – would need to find sponsor for either short 2014 session or 2015. Support from affected Boards would be important. |

| Recommendation | Actor(s) | Timeframe -- | Notes on potential next steps / resources needed / barriers |
|---|--|------------------------------------|--|
| Develop integrated health careers pathways, with central coordination | Oregon AHEC, CC's, CCWD, OUS, private universities | 2014 | <ul style="list-style-type: none"> More work needed to identify next steps and role (if any) for Workforce Committee in this area. |
| Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information | OHA for admin. rules; Consortium collaboration among schools and clinical sites for tracking system, with input from Workforce Committee | Beginning of 2014-15 academic year | <ul style="list-style-type: none"> Administrative rules are in progress Potential barrier: Level of flexibility for clinical facilities is currently a point of disagreement Resources needed: For a centralized system to really move forward, would need working agreement from key players on financing and governance |
| Increase number of Family Medicine residencies by at least 3 residencies with at least 24 new positions annually. | Health systems, Dept. of Family Medicine, OHSU | 2016 | <ul style="list-style-type: none"> More work needed to identify next steps and role (if any) for Workforce Committee - Lisa Dodson a good resource (along with others) for how to advance this issue. |
| Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty. | Health systems, OHSU | 2017 | <ul style="list-style-type: none"> More work needed to identify next steps and role (if any) for Workforce Committee - Lisa Dodson a good resource (along with others) for how to advance this issue. |
| PAST recommendations with loose ends | | | |
| Revise state's Adverse Impact law and related regulations. | Higher Education Coordinating Council, Legislature | 2013 | <ul style="list-style-type: none"> Wait to see outcome of 2013 legislation (HB 3341) |
| NON-PRIORITIZED RECS from April 2, 2013 presentation to Health Policy Board – Short term. Question for Committee: Are these on a “back burner” list unless we have time available? | | | |

| Recommendation | Actor(s) | Timeframe -- | Notes on potential next steps / resources needed / barriers |
|--|---|---------------|--|
| Update healthcare workforce need data and healthcare professional shortage area designations to ensure that as many sites and practitioners as possible are eligible for federal recruitment incentives. | OHA – PCO | 2013 and 2014 | <ul style="list-style-type: none"> ▪ PCO is doing this/has done a lot recently. Perhaps what is needed is just status updates from time to time, unless/until HRSA comes out with new methodology for determining shortage areas? |
| Increase participation/investment in the Oregon Rural Locum Tenens Collaborative as a mechanism to keep providers near retirement in the workforce a few years longer and provide practice support for others. | Oregon AHEC | 2014 | <ul style="list-style-type: none"> ▪ Next steps: Add semi -retired physicians and mid-levels to pool of providers; expand scope of service to include after hours phone coverage for small and remote clinics. ▪ Is there a role or task for the Committee here? |
| Make naturopaths eligible for the CMS waiver primary care loan repayment program. | OHA in consultation/ negotiation with CMS | July 2013 | <ul style="list-style-type: none"> ▪ OHA should consider this (along with Committee’s other program design recommendations) as part of administrative rules development for the program. |
| Support employers and clinics in assessing organizational and/or environmental factors related to clinician retention (including provider engagement, burnout, etc.) and adopting best practices | OHA Transformation Center; PCO, ORH, and OPCA, collaboratively; employers, practices, and communities | 2013 | <ul style="list-style-type: none"> ▪ Staff or assigned Committee members could be asked to do background research on best practices etc.? Sergio Vasquez a good resource (along with others) for how to advance this issue; Oregon PCO office has relevant resources. ▪ Bring in current employers, clinicians, anyone who has done focused work around retention to educate Committee? ▪ |
| Continue active outreach for the J-1 visa waiver program, to increase the number of obligated professionals working in underserved areas | OHA – PCO | 2013 and 2014 | <ul style="list-style-type: none"> ▪ PCO is doing this/has done a lot recently. Perhaps what is needed is just status updates from time to time? |

| Recommendation | Actor(s) | Timeframe -- | Notes on potential next steps / resources needed / barriers |
|--|--|--------------|---|
| NON-PRIORITIZED RECS from April 2, 2013 presentation to Health Policy Board – Longer term. Question to Committee: Are these on a “back burner” list unless we have time available? | | | |
| Maximize opportunities for license reciprocity: identify licensing boards’ current efforts allowing for reciprocity or expedited licensure for professionals already licensed in other states; identify challenges (e.g. laws, regulations) that hinder opportunities for reciprocity. | Healthcare Workforce Committee; Licensing Boards | 2013 | <ul style="list-style-type: none"> ▪ Staff or assigned Committee members could be asked to do some other background research on current status and best practices? ▪ Bring in licensing board representatives to educate Committee about opportunities and constraints? |
| Ensure exposure to rural practice for health professions students of all kinds, especially primary care practitioners. | All health professional training programs | 2013 | <ul style="list-style-type: none"> ▪ Is there a role or task for the Committee here? |
| Adopt a uniform credentialing system statewide, in alignment with Health Leadership Council work. | Health Leadership Council; health plans; health systems; OHA | 2014 | <ul style="list-style-type: none"> ▪ A couple of very relevant bills this session (e.g. SB 604, HB 2020); recommend waiting to see where they end up before planning next steps |
| Develop a system for creating “workforce impact statements, i.e., statements of workforce needs generated by implementation of reform proposals. | OHWI | 2014 | <ul style="list-style-type: none"> ▪ This did not get a high number of votes from members, but is an intriguing idea. Is this worth pursuing, and if so, who has ideas? |

Oregon Healthcare Workforce Committee

***Revised* recommendations for the
Oregon Health Policy Board**

April 2, 2012



Preface

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee (“Committee”) to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. Among other things, the Committee is charged with producing a biennial report for the OHPB outlining “recommended strategies, actions and policy changes ... that support the recruitment, retention and distribution of Oregon’s health care workforce, with an emphasis on primary care.” A draft set of recommendations was presented to the OHPB on February 5, 2013. Board members felt that the recommendations needed more focus and asked the Committee to prepare revised recommendations in answer to two key questions:

1. What can the state do now to get ready for 2014? (What three or four key actions could be taken now that will help prepare the workforce for the influx of newly insured?)
2. What key strategies should the state be considering for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation?

This document contains the Committee’s revised recommendations in response to the Board’s direction. All the recommendations focus on primary care, both because Committee members believe that will be the greatest need in 2014 and because robust primary care is at the heart of the coordinated care model and Oregon’s plans to achieve the Triple Aim.

Because healthcare workforce issues lie at the intersection of education and health care policy, a particularly wide range of actors is implicated in the Committee’s recommendations. It is important to note, however, that the Committee’s ability to take direct action is limited: it does not have the authority to compel any other body to take action; nor does it have funding to implement ideas that may require financial or other resources beyond staff support. The Committee relies on the OHPB, the Oregon Health Authority, and the Governor’s office to carry many of its recommendations forward.

Short-term recommendations to increase primary care capacity in advance of 2014

The OHPB asked the Committee to identify three or four key actions that could be implemented immediately in order to increase Oregon’s ability to care for the newly insured in 2014. With 2014 now less than a year away, training any significant number of new primary care providers is out of the question. Consequently, the Committee’s revised recommendations focus instead on strategies for maximizing existing in-state workforce capacity, for recruiting already-trained professionals to Oregon and distributing them appropriately, and for increasing provider retention over the critical next few years. In addition, the Committee has included one analytic recommendation in this section: model future primary care workforce demand in the context of new delivery models. This modeling would not result in additional workforce capacity by 2014 but is included in the short-term recommendations

section because the analysis could be done this year and because the results would provide critical guidance for subsequent workforce development efforts.

In order of priority, the Committee's top recommendations for actions that can be taken now are:

1. (Tie) Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible;
1. (Tie) Implement the new Medicaid loan repayment program for primary care providers
3. Forecast short and longer-term demand for primary care practitioners, accounting for likely effects of new models of care; and
4. Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers.

Additional detail for these recommendations can be found in Table 1, beginning on the following page. For each recommendation, the table specifies: the entity (or entities) that the Committee suggests should have responsibility for implementation; the proposed timeframe; and the recommendation's intended impact and relation to the Triple Aim.

In addition to the four primary recommendations above, Committee members identified several other strategies that they believe would have a positive impact on primary care workforce capacity as soon as 2014. These strategies are also listed in Table 1.

Table 1: Short-term recommendations to increase primary care capacity in advance of 2014

| What | When | Who* | Intended Impact & Relation to Triple Aim |
|---|--|---|--|
| <p>1. (Tie) Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible. (<i>Category: Maximize existing capacity</i>)</p> | 2014 | OHA CCOs Other payers | <p><i>Intended impact:</i> Widespread payment reform would accelerate adoption of new models of care (e.g. PCPCH) and allow practices to use the best, most efficient provider for a given need.</p> <p><i>Triple Aim:</i> Better care, lower costs</p> |
| <p>1. (Tie) Implement the new Medicaid state loan repayment program for eligible primary care providers. (CMS waiver requirement of \$2m annually for 13-15 biennium). (<i>Category: Recruitment</i>)</p> | 2013 | Legislature OHA | <p><i>Intended impact:</i> 50-100 practitioners (depending on provider type mix and loan repayment amounts) obligated to serving Medicaid clients in rural and underserved areas.</p> <p><i>Triple Aim:</i> Better care and health via increased access for underserved groups.</p> |
| <p>3. Forecast short and longer-term demand for primary care practitioners. (<i>Category: data</i>)</p> <ul style="list-style-type: none"> ▪ Identify uninsured populations (demographic characteristics, geography, etc.) becoming eligible for coverage. ▪ Identify & summarize data on current levels of access to care ▪ Identify and summarize range of potential effects of new models of care/practice redesign on primary care capacity and make-up ▪ Model/forecast demand for primary care practitioners, using input data assembled earlier | <p>June 2013</p> <p>June 2013</p> <p>June 2013</p> <p>October 2013</p> | OHWI and OHA - OHP, with input from the Workforce Committee and other experts | <p><i>Intended impact:</i> Better, more nuanced projections of workforce demand and capacity will allow for more appropriately focused and scaled action to create the workforce that Oregon needs.</p> <p><i>Triple Aim:</i> An appropriately sized, skilled, and distributed health care workforce supports all three aspects of the Triple Aim.</p> |
| <p>4. Make better use of naturopaths as part of the primary care workforce: Remove contracting, credentialing, coverage, and payment barriers in CCOs and commercial carriers. (<i>Category: Maximize existing capacity</i>)</p> | 2013 and 2014 | CCOs, health care facilities, commercial plans | <p><i>Intended impact:</i> Immediate increase in primary care workforce, achieved by capitalizing on an existing and in some cases under-utilized provider category.</p> |

| What | When | Who* | Intended Impact & Relation to Triple Aim |
|---|---------------|--|--|
| | | | <i>Triple Aim:</i> Better care via increased access for those interested in naturopathic care. |
| Update healthcare workforce need data and healthcare professional shortage area designations to ensure that as many sites and practitioners as possible are eligible for federal recruitment incentives. (<i>Category: Recruitment</i>) | 2013 and 2014 | OHA – PCO | <i>Intended impact:</i> Increased likelihood that communities, facilities, and providers will be eligible for other recruitment incentive programs (e.g. National Health Service Corps). <i>Triple Aim:</i> Better care and health via increased access for underserved groups. |
| Increase participation/investment in the Oregon Rural Locum Tenens Collaborative as a mechanism to keep providers near retirement in the workforce a few years longer and provide practice support for others. (<i>Category: Retention</i>) <ul style="list-style-type: none"> ▪ Add semi-retired physicians and mid-levels to pool of providers; expand scope of service to include after hours phone coverage for small and remote clinics. | 2014 | Oregon AHEC | <i>Intended impact:</i> Improved physician retention/ reduced burnout due to relief services. Older physicians remain in practice longer by providing locum tenens service, increasing the flexibility of primary care workforce. <i>Triple Aim:</i> Better care via provider continuity; lower costs if the expense of new recruitment is avoided. |
| Make naturopaths eligible for the CMS waiver primary care loan repayment program. (<i>Category: Recruitment</i>) | July 2013 | OHA in consultation/ negotiation with CMS | <i>Intended impact:</i> Expanded range of providers obligated to serving Medicaid clients in rural and underserved areas. <i>Triple Aim:</i> Better care via increased access for those interested in naturopathic care. |
| Support employers and clinics in assessing organizational and/or environmental factors related to clinician retention (including provider engagement, burnout, etc.) and adopting best practices. (<i>Category: Retention</i>) | 2013 | OHA Transformation Center; PCO, ORH, and OPCA, collaboratively; employers, | <i>Intended Impact:</i> Improved provider retention, reduced transition time for clinicians, practices, and patients. <i>Triple Aim:</i> Better care, potentially reduced costs due to reduction in recruiting services. |

| What | When | Who* | Intended Impact & Relation to Triple Aim |
|--|---------------|----------------------------|---|
| | | practices, and communities | |
| Continue to do active outreach for J-1 visa waiver program | 2013 and 2014 | OHA – PCO | <p><i>Intended impact:</i> All available slots for foreign physicians to practice in underserved areas get filled</p> <p><i>Triple Aim:</i> Better care and health via increased access for underserved groups.</p> |

*Acronym list:

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Administrative and programmatic recommendations for 2014 and beyond

The OHPB's second request was for the Workforce Committee to identify key strategies for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation. In directing the Committee, Board members emphasized that these recommendations should be "reasonably achievable," even if some were more aspirational than others, and should focus on how workforce needs intersect with a transformed delivery model.

Because the request was for key strategies over a six- or seven-year time period, Workforce Committee members wished to make two cautionary points before offering recommendations:

- It is difficult to forecast future workforce needs when the model of care is changing rapidly and employers are not yet in consensus regarding the types of workers they want to hire. Educational institutions are reluctant to offer training when the likelihood of subsequent employment is not clear. To the extent possible, the Committee suggests framing conversations around the kinds of functions and competencies that providers will need to work within a transformed delivery model,¹ rather than around specific provider types.
- Workforce supply and demand are cyclical and vary by profession, geography, and other factors. For example:
 - Anticipating a looming nursing shortage, many educational institutions increased class sizes in the early and mid 2000s and graduated a much larger number of nurses than in the past. When the recession hit, many incumbent nurses delayed retirement, with the result that new associate and bachelors-degree nurses are reportedly having trouble finding jobs in the Willamette Valley and Portland metro area, but less so in other areas of the state. This situation may change once again as the economy improves and the demand for care increases in 2014.
 - The Committee has heard reports that dental hygienists and x-ray technologists are having difficulty finding employment in Oregon but that there is no shortage of employer demand for physicians, nurse practitioners, or physician assistants.

The Committee's top recommendations for programmatic and administrative action over the next several years span the categories of education, recruitment, retention, and workforce data and are:

1. Re-fund the state's Primary Care Loan Forgiveness Program;
2. Develop occupational training programs to respond to emerging care models and industry demand;

¹ See the Committee's January 2012 report to the Board, entitled Improving Oregon's Health: Recommendations for Building a Healthcare Workforce for New Systems of Care, at: http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_WG1_12.27.11.pdf

3. (Tie) Ensure that CCOs' required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess;
3. (Tie) Enact workforce data reporting mandate for all health profession licensing boards;
4. Develop integrated health careers pathways, with central coordination; and
5. Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information.

For each of these recommendations, Table 2 (following) specifies: the entity (or entities) that the Committee suggests should have responsibility for implementation; the proposed timeframe; and the recommendation's intended impact and relation to the Triple Aim. Additional background information or context for several of the recommendations can be found in Appendix A.

In addition to the six recommendations prioritized above, Committee members identified several other strategies that they believe would help develop Oregon's workforce in the right direction. These strategies are also listed in Table 2.

Table 2. Administrative and programmatic recommendations for 2014 and beyond

| What | When | Who* | Intended Impact & Relation to Triple Aim |
|---|---------------|--|---|
| <p>1. Re-fund Oregon’s Primary Care Loan <i>Forgiveness</i> Program. (<i>Category: Recruitment</i>)</p> <p>Please see Appendix A for more information.</p> | July 2013 | Legislature | <p><i>Intended impact:</i> Obligate 5-6 health professions students/year to rural practice in Oregon upon completion of training.</p> <p><i>Triple Aim:</i> Better care and health via increased access for underserved groups.</p> |
| <p>2. Develop occupational training programs to respond to emerging care models and industry demand, e.g. Oregon Tech’s proposed new undergraduate major in Health and Human Behavior, or non-traditional health care worker training programs. (<i>Category: Education</i>)</p> | 2014 | Educational institutions, accrediting organizations, community-based organizations | <p><i>Intended Impact:</i> More Oregon students are prepared to deliver or access services in Coordinated Care Organizations or other new models.</p> <p><i>Triple Aim:</i> Better care and health via relevant training</p> |
| <p>3. (Tie) Ensure that CCOs’ required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess. (<i>Category: Data</i>)</p> | 2013 and 2014 | OHA Transformation Center, CCOs | <p><i>Intended impact:</i> Ensure that CCOs are considering workforce development in their comprehensive planning.</p> <p><i>Triple Aim:</i> Use workforce data to inform policies relevant to all three aspects of the Triple Aim</p> |
| <p>3. (Tie) Enact workforce data reporting mandate for all health professions boards. (<i>Category: Data</i>)</p> <p>Please see Appendix A for more information.</p> | 2014 | Legislature; licensing boards | <p><i>Intended impact:</i> Create a more complete dataset on the characteristics and practices of Oregon’s licensed healthcare workforce.</p> <p><i>Triple Aim:</i> Use data to inform policies relevant to all three aspects of the Triple Aim</p> |
| <p>5. Develop integrated health careers pathways, with central coordination. (<i>Category: education</i>)</p> <p>Please see Appendix A for more information.</p> | 2014 | Oregon AHEC, CC’s, CCWD, OUS, private universities | <p><i>Intended Impact:</i> More Oregon students enter health professions training because the pathway from elementary through professional training is easier to navigate and coordinated statewide, and appropriate resources are available to students at all levels.</p> <p><i>Triple Aim:</i> Better care and health via increased access</p> |

| What | When | Who* | Intended Impact & Relation to Triple Aim |
|---|------------------------------------|---|---|
| <p>6. Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information. <i>(Category: education)</i></p> <p>Please see Appendix A for more information.</p> | Beginning of 2014-15 academic year | OHA for admin. rules; Consortium collaboration among schools and clinical sites for tracking system, with input from Workforce Committee | <p><i>Intended Impact:</i> Reduce inefficiencies and costs for student clinical placements to increase capacity.</p> <p>Triple Aim: Improve quality & decrease costs of educational experience; better care via positive adjustments to workforce capacity</p> |
| <p>Revise state’s Adverse Impact law and related regulations. <i>(Category: Education)</i></p> <p>Please see Appendix A for more information.</p> | 2013 | Higher Education Coordinating Council | <p><i>Intended Impact:</i> A level field exists for program approval between public, private and proprietary institutions, making it easier to “right-size” programs.</p> <p><i>Triple Aim:</i> Improve quality of education experience; better care via positive adjustments to workforce capacity</p> |
| <p>Maximize opportunities for license reciprocity. <i>(Category: Recruitment)</i></p> <ul style="list-style-type: none"> ▪ Identify licensing boards’ current efforts allowing for reciprocity or expedited licensure for professionals already licensed in other states. ▪ Identify challenges (e.g. laws, regulations) that hinder opportunities for reciprocity. | 2013 | Healthcare Workforce Committee; Licensing Boards | <p><i>Intended impact:</i> Fewer barriers to recruiting professionals licensed in other states resulting in an increased supply of professionals for Oregon.</p> <p><i>Triple Aim:</i> Better health and care via increased access.</p> |
| <p>Ensure exposure to rural practice for health professions students of all kinds, especially primary care practitioners. <i>(Category: Recruitment/Retention)</i></p> | 2013 | All health professional training programs | <p><i>Intended impact:</i> More professionals are better prepared for practice in rural Oregon.</p> <p><i>Triple Aim:</i> Better care</p> |
| Adopt a uniform credentialing system statewide, in | 2014 | Health Leadership | <i>Intended impact:</i> Fewer barriers to provider affiliation |

| What | When | Who* | Intended Impact & Relation to Triple Aim |
|---|------|--|--|
| alignment with Health Leadership Council work. (<i>Category: Recruitment/Retention</i>) | | Council; health plans; health systems; OHA | with plans and hospitals <i>Triple Aim:</i> Reduced costs via administrative simplification |
| Develop a system for creating “workforce impact statements, i.e., statements of workforce needs generated by implementation of reform proposals. (<i>Category: Data</i>) | 2014 | OHWI | <i>Intended impact:</i> Build evidence on workforce implications of health care transformation to inform training t and refine projections of future workforce demand. <i>Triple Aim:</i> Use data to inform policies relevant to all three aspects of the Triple Aim |

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Additional recommendations for increasing primary care workforce capacity

Finally, the Workforce Committee offers two additional recommendations for action after 2014. These are presented separately in Table 3 because they do not fit in the category of “programmatic and administrative” recommendations. The two recommendations are:

1. Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually.
2. Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.

Some knowledge of the structure and funding of graduate medical education (GME) in the U.S. is necessary to fully judge these recommendations; that background is provided in Appendix A.

DRAFT

Table 3. Additional recommendations for increasing primary care workforce capacity

| What | When | Who * | Intended Impact & Relation to Triple Aim |
|--|------|--|--|
| <p>1. Increase number of Family Medicine residencies by at least 3 residencies with at least 24 new positions annually. (Oregon ranks 39th in primary care residents/100,000 population at 8.2/100K; US average is 13/100K). (<i>Category: Education</i>)</p> <p>Please see Appendix A for more information.</p> | 2016 | Health systems, Dept. of Family Medicine, OHSU | <p><i>Intended impact:</i> Oregon meets the US average for primary care residents per 100,000. An increased number of physicians are trained locally, increasing the pool from which to recruit.</p> <p><i>Triple Aim:</i> Better care and health via increased access</p> |
| <p>2. Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty. (<i>Category: Education</i>)</p> <p>Please see Appendix A for more information.</p> | 2017 | Health systems, OHSU | <p><i>Intended impact:</i> An increased number of physicians are trained locally, increasing the pool from which to recruit.</p> <p><i>Triple Aim:</i> Better care and health via increased access</p> |

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Appendix A – Additional Detail for Selected Recommendations

Some of the recommendations in Table 2 and 3 need more context and rationale than is possible to present in table format. Additional detail for those recommendations is provided here.

From Table 2

Recommendation: Re-fund Oregon’s Primary Care Loan *Forgiveness* Program

Background: Oregon’s primary care loan forgiveness program was created and funded for two years in 2011. It provides 6-8 loans annually to students enrolled in Oregon programs specifically designed to prepare providers for practice in a rural setting. For each year that loans are received, participants agree to practice in a rural setting in Oregon, following their graduate and residency training. Students of medicine, nursing, or physician assisting (a.k.a. “prospective” primary care practitioners) who have completed at least one year of education are eligible. Loan forgiveness differs from loan repayment in that it targets health professions students early in their education, perhaps helping to influence selection of primary care over another specialty. HB 2858, currently under consideration in the 2013 legislative session, would appropriate \$1 M for the primary care loan forgiveness program for the 2013-15 biennium.

Recommendation: Enact a workforce data reporting mandate for all health professions licensing boards

Background: The same legislation that created the Health Policy Board and the Oregon Health Authority also directed the Authority to collaborate with 7 health professional licensing boards to collect demographic and practice information from licensed healthcare professionals at the time of license renewal. The 7 Boards were: Oregon Board of Dentistry; Oregon Board of Pharmacy; Oregon Health Licensing Agency for the Oregon Board of Licensed Dietitians; Oregon Medical Board; Oregon Occupational Therapy Licensing Board; Oregon Physical Therapist Licensing Board; and Oregon State Board of Nursing. These boards support database operations via a small per-licensee fee and the overall response rate is very high, since the legislation specifies that the Boards may not renew a license until the workforce information has been collected. Starting in 2012, three additional boards—the Board of Licensed Clinical Social Workers, the Board of Psychologist Examiners, and the Board of Licensed Professional Counselors and Therapists—began to ask their licensees to provide data on a voluntary basis. There are more than 10 other healthcare professional licensing boards that do not currently participate.

To enable collection and analysis of accurate and comparable data for all licensed health care providers in the state, the Workforce Committee recommends that required participation in the Healthcare Workforce Database be extended to all health professional licensing boards in 2014, with actual reporting to be phased in according to data priorities and board readiness. This is a repeat recommendation from the Workforce Committee.

Recommendation: Develop integrated health careers pathways, with central coordination

Background: The Committee made this recommendation at the end of 2012 and noted that it would connect two of the Governor’s priorities: healthcare reform and education reform. The overarching recommendation was that Oregon should develop a coherent pipeline to health careers at all levels, beginning with elementary education. The pipeline should organize and connect students to activities and programs that progressively build on student knowledge and experience, and effectively utilize state resources and investments in education from K-12 through higher education and health professional education. Sufficient resources should be available to meet statewide need. More specifically, the Committee recommends:

- Explicitly including health sciences in the “science” category of Oregon’s Science, Technology, Engineering and Mathematics (STEM) initiative, since preparation for the health professions requires competency in the same base disciplines.
- Aligning state health care professional education investments with projected Oregon workforce needs, as identified by the Workforce Committee, the Oregon Healthcare Workforce Institute, and others. Data regarding the predicted demand for health professionals should drive education program development and distribution.
- Providing additional funding and support for the development and distribution of health care occupations training to rural communities and underrepresented populations across the K-20 pipeline and increasing incentives to reach diversity goals for the health professional pipeline.
- Encouraging the use of up-to-date delivery modalities, including virtual learning, to increase access to health professions education throughout the state. Distance or distributed learning can help maximize finite resources by aggregating the demand for training but distributing the supply.
- Encouraging inter-institutional cooperation and integration of curricula. All health care professions education should address new models of care in a

consistent way, emphasizing the competencies needed for interprofessional team-based care.

Recommendation: Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information.

Background: In July 2012, the Health Policy Board approved a set of standard prerequisites for student clinical placement that were developed by the Workforce Committee in consultation with a broad range of stakeholders.² Committee members are currently working with the Health Authority and a rules advisory committee to develop administrative rules to implement and enforce the standards.

When approving the standards, the Board strongly advised the Committee and stakeholders to develop a centralized method of tracking students and their prerequisites across clinical placement sites. Committee members are considering options for a centralized system and OHA has issued an RFI to gather more information on the Committee's behalf. Determining the best structure and most appropriate functions of a centralized tracking system is doable; the more challenging implementation task is to determine how such a system might be governed and financed. Stakeholders have stated clearly that they would prefer the state not to administer such a system; for this reason, a not-yet-existing consortium/coalition of schools and clinical placements sites was identified as the responsible party for this part of the recommendation in Table 2.

Recommendation: Revise Oregon's adverse impact laws and regulation

Background: Oregon has a unique policy that requires community colleges to submit a notice of intent at least 30 days prior to seeking Board of Education approval for certain new programs. The Board must then share this notice with private institutions. Private institution officials who feel that the new public program would adversely impact their businesses may file an objection, which sets in motion a proscribed process of negotiation. Notably, the reverse is not true: private institutions are under no obligation to provide notice about planned new programs and publicly-funded programs have no formal opportunity to express objections. The policy can have the effect of delaying or limiting the creation of needed training programs, overwhelming clinical placement sites, or increasing students' costs (because private programs tend to be more expensive for students).

² See: http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_SB879_06.29.12.pdf

In 2011 and 2012, members of the Workforce Committee met several times with staff from the Office of Degree Authorization and representatives from public, private, and proprietary schools. At the end of this process, the Committee recommended a small change to statute and administrative rule that would have the effect of requiring *all* institutions—public, private and proprietary—to notify others of proposed new programs and be subject to review for detrimental duplication or adverse impact. A letter recommending this regulatory change was sent to the Higher Education Coordinating Commission, in August 2012. No response has been received to date; however, the 2013 Legislature is considering a bill (HB 3341) that would make some changes to the adverse impact policy and has heard testimony about the Workforce Committee’s recommendation.

From Table 3

Recommendations: Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually; and increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.

Background: Upon completion of medical school, all new graduates pursue a “residency” in Graduate Medical Education (GME) in a specialty of their choice (the first year of training is sometimes called “internship”). Oregon currently supports more than 800 GME positions in all specialties. Residencies last from three years to more than 5 years. About 275 new positions open up each year. 776 total positions are at OHSU. Providence Health System hosts programs in Family Medicine (7 new positions per year), and Internal Medicine (17 positions per year). The Legacy Health System hosts 15 new Internal Medicine residents per year. In addition, Samaritan Health Services offers 20 first year residency positions, currently open only to DO students, in their Corvallis based residencies in Family Medicine(5), Internal Medicine (6), General Surgery (2), Orthopedic surgery (3), and Psychiatry (4). Residency positions are open on a competitive basis to MD and DO students from all around the US and the world. These training opportunities at OHSU are highly sought after and, through a program called the National Residency Matching Program, students from around the country are “matched” to these residency positions. Each year, some, but not the majority, of the students who become residents are from Oregon.

Studies show a strong correlation between where a new physician completes GME training and where s/he ends up practicing. Expanding GME capacity in Oregon in areas where physicians are most needed could have an immediate and ongoing impact on reversing workforce shortages. OHSU is ranked tenth in the nation for

in-state retention of physicians after GME training, with 52% of residents staying in Oregon to practice. However, only one-third of all licensed Oregon physicians completed all or part of their training in Oregon, making Oregon a longstanding importer of physician workforce.

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

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

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

Several smaller Oregon communities have indicated their interest in exploring the option of having GME at their medical centers, such as Salem, Roseburg, Grants Pass, Eugene, Medford, Hood River, and Bend. Currently, the only rurally-based training program in Oregon is the Cascades East Family Medicine Residency Program in Klamath Falls, with 8 new positions per year.

Because the GME programs at community hospitals are necessarily small (typically 2-8 residents per year in each specialty), a GME Consortium approach could support regional programs with common curriculum design, an accreditation umbrella and other program and administrative requirements. This will ensure that hospitals and other community-based sites have a centralized framework for cooperation so Oregon is allotted the maximum number of federally-funded positions and, equally important, that these positions are nationally competitive to attract the highest caliber new physicians to Oregon.

Oregon currently has only one rural Family Medicine training location, *OHSU Cascades East Program in Family Medicine*. Cascades East Family Medicine supports 24 trainees (8 new positions per year) in a three-year program. Started in 1993 at Sky Lakes Medical Center in Klamath Falls, Cascades East Family Medicine Residency is also supported by OHSU Family Medicine Department and Oregon AHEC and has achieved great success. More than 75% of its graduates practice in towns less than 25,000, with many in the smallest communities in Oregon. Providence Family Medicine Residency is in the final stages of adding an additional Rural Training Track position for one resident who will spend the final 2 years of residency in Hood River.

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

**Oregon Health Policy Board
Oregon Healthcare Workforce Committee**

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

January 2013

Prepared in response to HB 2366



**Oregon Healthcare Workforce Committee
Strategic Plan for Primary Care Provider Recruitment
January 2013**

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Executive Summary

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

The Committee engaged a number of interested parties in developing the strategic plan and articulated this vision to guide the process: *Oregon will be a model for efficient, coordinated primary care recruitment and retention efforts in the United States. All areas serving all populations will be competitive with other states and regions for the recruitment of primary care providers in order to ensure access to high quality health care for all Oregonians.*

Based on its assessment of Oregon’s strengths weaknesses, upcoming opportunities and threats, and stakeholder input, the Committee identified three overarching goals for primary care provider recruitment, along with strategies to achieve these goals:

“Grow Our Own”: produce more primary care professionals in Oregon in order to increase the size of the recruitment pool

- Increase the output of primary care educational programs, particularly training programs for physicians, nurse practitioners, and physician assistants.
- Increase the capacity of Oregon’s Rural Scholars Program
- Invest in programs that develop and encourage high school and undergraduate students to choose primary care careers
- Study the need for training programs for emerging health workers who will be part of the service delivery teams of the future

Increase Oregon’s effectiveness at external recruitment

- Increase and coordinate efforts to link employers and primary care providers to each other and to available recruitment resources
- Market Oregon as a “career destination state” for the practice of primary care
- Support clinical practice transformation, to increase the attractiveness of primary care practice
- Encourage investment in/expansion of Oregon’s Locum Tenens Cooperative
- Designate one or more entities to track and alert stakeholders of funding opportunities with relevance for primary care provider recruitment and retention

Support Communities: Empower rural and underserved communities in their own efforts to recruit and retain primary care providers

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

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

I. Introduction

About this Plan

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

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

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

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

Information about best practices for recruitment and descriptions of existing recruitment efforts can be found Sections II and III, as well as in the environmental scan in Appendix B. Suggestions regarding promotional materials and practitioner visiting opportunities are included with other recommendations under Strategic Objectives and Plan (Section IV), where

¹ Enrolled HB2366, 2011 Legislative Assembly

funding resources and suggestions for implementation are also addressed. In addition, adequacy of undergraduate and graduate medical education is addressed in Section IV with further details outlined in Appendix E.

Because the *distribution* of health professionals is just as important as total numbers for ensuring an adequate workforce², recommendations in this report are particularly (but not exclusively) targeted toward Oregon's underserved geographic areas and populations. Underserved populations include low income individuals, migrant and seasonal farmworkers, homeless individuals, and Medicaid recipients. Underserved geographic areas include both areas that currently have a shortage of physicians, and those whose remoteness makes it difficult to retain a robust health care workforce.

For the purposes of this report and plan, primary care is defined as *an initial point of entry into the health care system where patients can receive diagnosis and/or treatment*. While parts of HB 2366 specifically address physicians, this report operates with a broader definition of primary care workforce, including advance practice nurses, physician assistants, dentists, pharmacists and, to a limited extent, emerging health professions such as Community Health Workers. This definition is intended to include medical, community based dental and mental health care services across professions.

II. Background

Current Primary Care Capacity in Oregon

OVERALL: Primary care provider shortages persist in many parts of Oregon. Thirty-two of Oregon's 36 counties have some type of federal primary care health professional shortage area (HPSA) designation, based on population-to-provider ratio, population demographics, travel time to nearest provider, and community health status characteristics. (See maps of HPSA designations provided in Appendix G.) In 2010, there were seven counties with ten or fewer physician practices, including two counties with only one physician each and twelve counties with fewer than ten dentists, including four counties with no dental practice. There were four counties where no dentist or pharmacist registered a practice address, three counties where no dental hygienist, physician assistant, or licensed practical nurse listed a practice address, two

² Dower & O'Neil. 2011. *Primary health care workforce in the United States*. The Robert Wood Johnson Foundation. Research Synthesis Report no. 22. Available at: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/07/primary-care-health-workforce-in-the-united-states0.html>

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

The Oregon Employment Department forecasts the need for slightly more than 76,000 additional health care workers in the state between 2010 and 2020, a 48% increase. Forty-three percent of the projected job openings are to replace those permanently leaving the occupations' labor pool. The projected demand is largest in settings that employ the most primary care providers: a 34% increase for ambulatory health care services sector and 35% increase for nursing and residential care facilities. Hospital employment is projected to grow more slowly, by 25%.⁴

Using a model based on five factors (percentage of primary care visits to need; rate of ambulatory care sensitive conditions; travel time to nearest hospital; comparative mortality ratio, and low birthweight rate) the Oregon Office for Rural Health finds that 59 of the state's 105 rural service areas have unmet need.⁵ Oregon's Primary Care Office, located within the Oregon Health Authority, is responsible for providing analysis and determining which areas and special populations within the state qualify for a health professional shortage area (HPSA) designation. As of July 2012, Oregon would require at least 80 primary care physicians, working full time, properly distributed to shortage areas, in order to remove all the federal primary care medical designations.⁶

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

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

⁴ Oregon Employment Department (2009). *Employment Projections by Industry and Occupation 2010-2020 Oregon Statewide*. Available at <http://qualityinfo.org/pubs/projections/projections.pdf>

⁵ Oregon Office of Rural Health. *2011-12 Area of Unmet Health Care Need in Oregon*. Available online at: <http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf>

⁶ Current federal methodology only considers the number of physicians (not other primary care provider types) when determining primary care medical shortage areas.

considering a practice change that could impede access to care (e.g. retiring, reducing practice hours, moving out of state, or leaving the field).³ Combined with an aging population (by 2030, one fifth of Americans will be over the age of 65), an increase in the number of individuals with chronic medical conditions, and the almost 400,000 individuals who will be newly eligible for health insurance coverage in 2014 as a result of the Affordable Care Act,⁷ demand for primary care providers shows no sign of abating.

PHYSICIANS: There were 10,822 active licensed physicians practicing in Oregon in 2010; however, only 38% of those physicians were practicing in primary care³. In this case, primary care physicians are those who listed practice specialties in family medicine/practice, general practice, geriatrics, pediatrics, adolescent medicine, (general) internal medicine, or internal medicine with a subspecialty in geriatric medicine. Barbara Starfield and other primary care leaders have called for the U.S. to move toward the goal of having of having 50 percent of active patient care clinicians (physicians, nurse practitioners, and physician assistants) in primary care practice.⁸

The population-to-primary care physician ratio in Oregon in 2010 was 930:1.³ This is well inside the most commonly cited U.S. “standard” of 1,500 people per primary care physician^{9,10} but the statewide average masks considerable variation. Counties such as Multnomah are relatively well-supplied with primary care physicians (1 for every 630 residents in 2010) whereas a number of less populated counties have much higher ratios (e.g. Crook County had 2,471 residents for every primary care physician in 2010).³ A majority of providers continue to choose urban or suburban practice; out of the estimated 10,822 active licensed physicians in Oregon in 2010, only approximately 1100 (10%) were actively practicing in rural areas, where 37% of the population resides.³ Reasons for this include a perceived lack of availability of employment for spouses, opportunities for entertainment and cultural activities, quality of K-12 education, a perception of being “on call” at any time, a lack of availability of specialists and fewer opportunities for collaboration with other physicians and peers. The shortage of providers in rural areas may contribute to health care access and health disparities seen between rural and urban populations.⁵

⁷ Urban Institute (2011), *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid*. Available at <http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf>

⁸ Sandy, Bodenheimer, Pawlson, & Starfield. (2009). The Political Economy Of U.S. Primary Care. *Health Affairs*, 28(4): 1136-1145.

⁹ Ricketts et al. (2007). Designating Places & Populations as Medically Underserved: A Proposal for a New Approach. *Journal of Health Care for the Poor and Underserved*, 18:567-589.

¹⁰ Goodman, Fisher, Bubolz, et al. (1996). Benchmarking the US physician workforce. An alternative to needs-based or demand-based planning. *JAMA*, 276(22):1811- 7. [See comments, published erratum appears in *JAMA* 1997 Mar 26;277(12):966.]

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

Over the past two decades, a larger percentage of medical school graduates have chosen specialty care over primary care and metropolitan over rural practice sites. Specialization is increasingly common even among primary care residents; more than 50% of individuals in internal medicine residency programs report that they are planning a subspecialty care career.¹² This trend has been attributed to a number of factors, including increasing student educational indebtedness, higher reimbursement for specialists and urban physicians, lower prestige for primary care, scope of practice concerns, decreasing percentages of rural and other underrepresented students at elite institutions, and a generational trend to place a higher value on a work/life balance than previous generations.^{13,14}

NURSES: Advanced registered nurse practitioners (NP) and registered nurses (RN) are also vital to the primary care workforce in Oregon. Unlike some other states, Oregon has granted NPs substantial autonomy to provide care without physician oversight. In 2010, the number of NPs with an Oregon license was 2,422; it is estimated that 1,955 were actively practicing in the state. In 2010, Oregon had 45,946 licensed RNs (which includes NPs), with an estimated 35,849 actively working.³ The Employment Department forecasts that Oregon will need an additional 14,499 registered nurses by 2020, due to industry growth and replacement of current nurses who will retire or change careers.⁴ Nurse practitioners and RNs are concentrated in the metropolitan counties in the state: a full 53 percent of NPs practicing statewide are practicing

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

¹² West and Dupras. (2012). General Medicine vs Subspecialty Career Plans Among Internal Medicine Residents. *JAMA*. 308(21):2241-2247.

¹³ American College of Physicians (2008) *The Case for Young Physician Leaders*. Available at: http://www.acponline.org/meetings/internal_medicine/2011/handout

¹⁴ It should be noted that not all physicians in primary care specialties are providing primary care. For example, some physicians in traditional primary care specialties have taken on new roles as hospitalists, providing care exclusively to in-patients in acute care hospitals. In Oregon's rural areas, it is not uncommon to find a family practice physician staffing a hospital emergency department.

in Multnomah, Washington and Clackamas Counties, where approximately 43% of the state's population resides.³

A limited number of nurse educators significantly impacts the ability of schools to increase their nursing student capacity. Nursing graduates primarily choose clinical settings over academic professions because of the significant difference in compensation; only one third of nursing faculty report feeling satisfied with their salary. Nursing faculty are significantly older than the general population and an increased rate of retirement is expected to cause further stress to nursing education in the next decade.¹⁵

PHYSICIAN ASSISTANTS: In 2010, there were 918 active licensed physician assistants practicing in Oregon, 45% of whom identified a practice associated with a primary care specialty. As with NPs, Oregon's Physician assistants (PAs) enjoy relatively more autonomy in practice than in many other states. However, PAs are somewhat more equitably distributed between the Portland Metropolitan Area and the rest of the state than primary care physicians and nurse practitioners (44% of PAs statewide practice within Multnomah, Washington and Clackamas Counties, compared with 50% of primary care physicians and 53% of NPs. The number of PAs and ratio of PAs-to-physicians varies widely in different parts of the state. Only 13 PAs are practicing in Linn County—a ratio of 8 PAs for every 100 primary care physicians, while in Crook County, the ratio is 29 per one hundred.³

Best Practices in Primary Care Provider Recruitment

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

- There is incredible variation in level of industry and governmental resources and programs for recruitment initiatives by state.
- While the stakeholders involved in recruitment are numerous and diverse, and often have competing interests or market share, there is growing recognition that geographies and organizations are working to recruit and retain the same limited pool of applicants. In some cases, people are capitalizing on awareness of this shared need to motivate collaboration among stakeholders.

¹⁵ Oregon Center for Nursing. (2009). *Oregon's Nurse Faculty Workforce*. Available at: <http://www.oregoncenterfornursing.org/documents/OCN%20Nurse%20Faculty%20Workforce%20Report%202009.pdf>

- Most recruitment plans emphasize the key importance of pipelines, beginning as early as elementary school level and continuing through college and university education, for creating interest in and availability of local health care training programs.
- Most plans also tie retention strategies into recruitment, since many of the same factors play a role. Retention is increasingly recognized as a valuable tool that reduces cost of recruitment and increases stability in the health care sector.
- Many plans highlight the need to target incentives by provider type. Loan repayment may be more attractive to dentists, physicians and others with high debt burdens; incentives like salary, benefits, or sign-on bonuses could be of greater impact for other providers. Loan forgiveness and repayment programs—as well as scholarship programs—can effectively address student concerns about entering primary care careers with high levels of indebtedness.
- Adequate funding for coordinated recruitment and retention initiatives is a perennial problem.
- Many of the publicly available plans focus on rural access and spend little to no time discussing urban pockets of inaccessibility. Very few plans include alternative care providers or newly emerging roles such as Community Health Workers.

Existing Incentives for Recruitment in Oregon

The primary recruitment incentives available statewide in Oregon include federal and state loan repayment or forgiveness programs, a small state tax credit for rural providers, and Oregon’s rural medical liability subsidy program. A full description of these programs can be found in Appendix C; however, more than one of these programs is currently unfunded. In addition to programs financed by the state or the federal government, private health systems, hospitals, and other entities have their own recruitment incentives and tools; a few of these are also described in Appendix C.

III. Vision

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

IV. Strengths, Weaknesses, Opportunities, and Threats

Physicians and other health care providers are in high demand throughout the country, increasing the competition for these scarce and expensive resources. The relative strengths and

weaknesses of Oregon's health care recruitment environment include factors related to the medical climate (e.g. medical liability) as well as general livability measures such as cost of living, quality of education and climate.

Strengths for primary care provider recruitment in Oregon include:

- An educational community committed to innovation has reduced silos between institutions. For example, the Oregon Consortium for Nursing Education (OCNE) collaborative, the community colleges' distance learning platform, and newly forming inter-professional curricula at many institutions will help attract students to health care careers and will increase availability of training in communities across the state, helping to ease the geographic maldistribution of health care providers.
- A well-developed Oregon AHEC (Area Health Education Centers) system addresses the K-16 pipeline to create an in-state pool of students preparing for health careers from which to recruit. Oregon AHEC reaches 34 of 36 Oregon counties, delivering health careers education to more than 12,000 rural students and teachers in 2011-12. Oregon AHEC programs include: health careers occupations clubs and camps; In-A-Box Science curriculum; college student Day in the Life experiences; Health Career exploration days; and Health Career Opportunity programs.
- Programs such as the Oregon Department of Education's ASPIRE, which helps middle- and high school students access education and training beyond high school by providing information and support to students and their families, can be adapted for health career support for disadvantaged students.
- The Oregon Rural Scholars program developed by Oregon AHEC at OHSU provides enhanced educational opportunities for medical students interested in rural practice, increasing their likelihood of choosing a specialty in high need in underserved areas (such as family medicine or general surgery). This program could be expanded to include students from other primary care disciplines such as osteopathic physicians, physician assistants, advance practice nurses, dentists and pharmacists.
- Oregon is a national leader in health care reform with large-scale delivery and financing changes underway. Oregon's Coordinated Care Organizations (CCOs) lead the nation in innovative healthcare delivery models for Medicaid populations. If these reforms appropriately and consistently value primary care providers, and provide adequate financial incentives for care, Oregon will improve its attractiveness to progressive primary care providers.

- Oregon’s Medical and Nursing Practice Acts provide progressive scopes of practice for nurse practitioners and physician assistants, as compared to other states; this creates a recruitment incentive for non-physician health care providers. Nurse practitioners may practice without physician oversight and with full prescribing authority, and Physician Assistants may practice under non-direct supervision, extending their ability to provide services into more remote rural areas.
- Oregon has several outstanding examples of communities and organizations mobilizing and coordinating (instead of competing) for providers. The Rimrock Health Alliance and the Klamath Falls Partnership are two examples. Promotion of these models to other communities could increase recruitment and retention success.
- The Oregon Locum Tenens Cooperative assists rural communities, facilities and medical practices to acquire temporary or short-term coverage for primary care providers (primarily physicians but also nurse practitioners and physician assistants), and has been helpful in recruiting providers to rural locations. Since November 2011, the OLTC has more than doubled its membership—from 10 members to 22, and has increased its capacity for coverage by 500%.
- An Oregon tax credit of \$5,000 for rural providers provides both a recruitment and retention incentive for some rural communities, although it sunsets in 2014.

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

- Oregon’s tax structure is a disincentive for high-wage earners when compared to neighboring states.
- Oregon offers relatively few provider recruitment incentives and those are underfunded as compared to other states. The state primary care provider loan repayment program has been unfunded since 2009. However, a loan forgiveness program for students focused on rural health was created in 2011 and the state’s 2012 Medicaid waiver requires \$2 million to be dedicated to primary care provider loan repayment as of July 2013 (see opportunities).
- High educational debt is a deterrent to students selecting primary care specialties and to locating in areas of high need such as rural and underserved communities.¹⁶ OHSU has among the highest tuition and graduate debt load of any state-supported medical

¹⁶ Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices, 2009, The Robert Graham Center, Washington DC

school in the U.S.¹⁷ Western University's College of Osteopathic Medicine of the Pacific opened a branch campus in Lebanon, Oregon in 2010, but, as a private institution also has relatively high tuition and students are likely to graduate with significant debt.

- Oregon has historically low Medicare and Medicaid reimbursement rates compared to other states, reducing income potential for physicians serving those populations and potentially reducing access for individuals covered by those programs.
- Recruitment into Oregon's large rural and frontier areas and more urban underserved populations is historically more difficult. Oregon's weakened K-12 education system is a liability when trying to recruit and retain providers with families. This is particularly pronounced in rural areas, where most schools operate on a 4-day school week as a cost-saving measure and have fewer, if any, advanced placement courses, International Baccalaureate programs and/or extracurricular activities.

Opportunities for recruitment include:

- The expansion of the insured population in 2014. Under federal health reform, close to 400,000 Oregonians are anticipated to acquire health care coverage⁷. This creates a significant pool of potential patients but is also a threat to system capacity.
- Oregon is a leader in health reform. Building on momentum of health care reform and primary care renewal can energize providers toward achieving a more efficient, effective, well organized and satisfying health care system. Oregon's innovation efforts may attract younger physicians and those willing to provide care in new ways, in addition to non-traditional disciplines, and may provide openings for emerging health professionals such as community health workers.
- Internet and social media technologies may be used to contacting and engage potential health care practitioner recruits from a wider audience than with traditional methods, at lower cost.
- The current bump in Medicaid and Medicare reimbursement for primary care providers (a time-limited provision of the federal Affordable Care Act) may increase providers' willingness to serve individuals with public coverage.
- Expansion and increased support for National Health Service Corps from the Affordable Care Act may increase the number and improve the distribution of loan repayment positions in Oregon. From January 2011 through October 2012, Oregon saw the number

¹⁷ <http://www.ohsu.edu/xd/education/schools/school-of-medicine/about/school-of-medicine-news/education-news/lcme-update-71112.cfm>

of National Health Service Corps clinicians increase from 124 to 192. Further, work that has been done to analyze health professional shortages has enabled an additional 300 clinicians to be eligible for the program, beginning in January 2013.

- A new loan repayment program for primary care clinicians who commit to serving Medicaid patients, funded at \$2M annually, holds promise for recruiting clinicians to areas that are traditionally underserved. (Note: The positive effect of this program will be reduced if it entirely replaces existing incentives such as the Loan Forgiveness program established in the 2011 Session.)
- A strong trend toward physician employment by large health systems (see also threats), may reduce the amount of time physicians spend on practice/business management, which may increase productivity and improve career satisfaction. Larger systems may be able to engage in enhanced retention activities with physician employees.
- Oregon's commitment to train 300 Community Health Workers may also increase practice resources available to current clinicians, provided that training and incentives are available to encourage widespread and appropriate use of CHWs.

Threats to effective recruitment include:

- Uncertainty regarding development of Coordinated Care Organizations and other novel health care system reforms at both the state and federal level. Practitioners may be wary in this time of transition, reducing the ability to recruit new clinicians and threatening retention of others.
- An anticipated expansion of insured population in 2014 (also an opportunity) will increase income potential for some providers, but may also bring low reimbursement rates for publicly-covered individuals and increasing provider workload. There could be detrimental effects if payment reform lags behind eligibility expansion and other necessary delivery system reforms.
- A strong trend away from independent practice toward physician employment (see also opportunities) requires different changes in recruitment and retention strategies, as well as additional practice supports for physicians who remain in independent practice.
- An inadequate state budget has a direct effect on recruitment via reduced health care facility reimbursement and budgets, which impact hiring capacity. It also has an indirect effect through reduced funding for health care education programs.

V. Strategic Goals and Plan

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

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

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|--|---|---|---|--|
| | Increase access to primary care provided by Naturopathic Physicians (NDs) by removing coverage and credentialing barriers. In some locations, NDs are an underutilized and immediately available primary care workforce. | 2013-14 | Not applicable | Health systems and insurance plans |
| | Study the need for training programs for emerging health care workers who will be part of the primary care delivery team (e.g. Community Health Workers, peer wellness specialists, navigators, and others). | 2013; report back to Workforce Committee by end of 2013 | Done within existing resources | Oregon AHEC |
| | Invest in or maintain programs that that develop and encourage high school and undergraduate students to choose primary health care careers (basic science and math education, high-school health professions programs, Area Health Education Centers, etc.). | Ongoing | STEM initiative; private and/or foundation funding; General Fund educational appropriations | Oregon AHEC; Public and private education programs (K-16) |
| Increase Oregon's effectiveness at external recruitment | Increase and coordinate efforts to link organizations and candidates to the available resources, including meeting with recruitment groups. | Ongoing | Use existing funding | Oregon Primary Care Office; Oregon Office of Rural Health; Oregon Primary Care Association |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|------|---|----------|---------------------------|---|
| | <p>Market Oregon as a “career destination state” for the primary care providers:</p> <ul style="list-style-type: none"> • Coordinate with Travel Oregon and Business Oregon to access marketing resources useful for local community’s recruitment efforts. • Using input from Oregon’s rural primary care providers and clinics, build a robust candidate recruitment website or network that includes practice information and loan repayment resources. | Ongoing | Oregon Legislature | <p>Oregon Health Authority; Office of Rural Health; Oregon AHEC; Business Oregon; Travel Oregon</p> <p>Oregon Primary Care Association; Office of Rural Health; Oregon Healthcare Workforce Institute</p> |
| | <p>Encourage investment by health care organizations (rural and underserved clinics and hospitals) in the Oregon Locums Tenens Cooperative (OLTC) to ensure community access to affordably priced locum tenens services in 50% of eligible rural and underserved sites, or at least 30 communities throughout Oregon</p> <p>Promote the OLTC as a means to conduct coordinated clinician visitation opportunities that can be used to introduce clinicians to rural communities and help communities make sound hiring decisions. The OLTC Loan to Practice (L2P) program coordinates with the Primary Care Office to recruit potential NHSC eligible providers (see Appendix F for details).</p> | By 2014 | Clinics and Hospitals | Oregon Locum Tenens Cooperative; Oregon AHEC; Oregon Primary Care Office |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|--|---|--|---|---|
| | <p>Support clinical practice transformation to help make Oregon a “career destination state” for primary care providers.</p> <ul style="list-style-type: none"> • Accelerate payment reform efforts • Implement administrative simplification for providers and plans (e.g. simplification of billing) • Continue implementation of Patient Centered Primary Care Homes (PCPCH) and other initiatives that enable coordinated patient care and improve practice processes. • Implement malpractice reform | Ongoing | CMS; Oregon Legislature; other federal entities and private sources as appropriate. | Oregon Health Authority; Health care professional associations; Community Health Centers; Rural Health Clinics; Health Systems; Hospitals, and all other delivery system entities |
| | Designate an entity to track and notify stakeholders of potential funding opportunities (e.g. Community Development Block Grants that can be used for health-related capital projects) on an ongoing basis. | Immediately | Use existing resources | Oregon Primary Care Office |
| Support Communities: Empower rural and underserved communities to recruit and retain primary care providers | Increase involvement of local business, economic development organizations, and others in recruiting primary care practitioners, by promoting a community engagement approach (e.g. Rimrock Health Alliance) | 4 communities in 2013 8 by 2015 12 by 2017 | Local chambers; city and county funding; hospital districts; | Local communities, with help from: Regional economic development entities; Oregon Primary Care Office; AHECs; Office of Rural Health; Oregon Primary Care Association |
| | Encourage inclusion of health care professional recruitment incentives when enterprise zones are negotiating tax abatement with large businesses (e.g. work with incoming businesses to fund required community match for the HRSA state loan repayment program). | Ongoing | Not applicable | Business Oregon; local economic development organizations; Office of Rural Health |

| Goal | Strategies | Timeline | Potential Funding Sources | Best entities to implement the strategy |
|------|--|---------------------------|--|--|
| | Foster collaboration among business (including health care) and economic development constituencies to address issues that affect the community's ability to recruit (e.g. education system, tax structure, physical infrastructure, etc.) | Ongoing | Not applicable | Business Oregon; Office of Economic Development; Governor's Office; Office of Rural Health; local communities and businesses |
| | Develop a recruitment tool kit for communities, which includes marketing and promotion material, proven recruitment strategies, information about Locum Tenens and other programs, templates/best practice resources, links to relevant recruitment programs, etc. | By 2014; update annually | Unknown; may or may not require additional resources | Oregon Primary Care Office and partners |
| | Review federal Health Professional Shortage Area (HPSA) scores to increase the state's ability to access federal loan repayment funding and other financial incentive programs. | by February 2013, ongoing | Not applicable | Oregon Primary Care Office |

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

Appendices

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

Enrolled
House Bill 2366

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

CHAPTER

AN ACT

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

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

Whereas retirement of primary care providers is outpacing replacement; and

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

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

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

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

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

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

Passed by House April 21, 2011

Repassed by House June 6, 2011

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Ramona Kenady Line, Chief Clerk of House

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Bruce Hanna, Speaker of House

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Arnie Roblan, Speaker of House

Passed by Senate June 1, 2011

.....
Peter Courtney, President of Senate

Received by Governor:

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

Approved:

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

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

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

.....
Kate Brown, Secretary of State

Environmental Scan—Provider Recruitment Strategies

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

Summary Findings

Common themes throughout recruitment plans:

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

Noted differences in recruitment plans:

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

Additional Findings: Multi-state/collaborative work

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

Recruitment and Retention Best Practices Model, 2005

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

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

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

Physician Recruitment Plan: Steps for Recruiting Success

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

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

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

New England Regional Collaborative:

New England Regional Healthcare Workforce Collaboration (Sept. 2008)

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

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

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

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

<http://www.NWRPCA.org>

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

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

Additional Findings: State-specific work

Connecticut:

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

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

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

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

Idaho:

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

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

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

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

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

Louisiana:

Primary Care Recruitment and Retention Services Unit:

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

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

Massachusetts:

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

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

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

Michigan:

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

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

Primary Health Care Profile of Michigan (Oct. 2008)

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

- BCBSM Physician Group Incentive Program (PGIP)

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

Mississippi:

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

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

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

Montana:

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

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

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

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

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

North Dakota:

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

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

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

South Carolina:

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

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

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

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

Virginia:

Health Care Workforce Annual Report, (June 2010)

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

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

Vermont’s Plan:

Primary Care Workforce Development Strategic Plan (May 2011)

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

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

Washington:

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

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

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

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

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

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

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

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

Existing Recruitment Programs in Oregon

Loan Forgiveness

Primary Health Care Loan Forgiveness Program

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

Loan Repayment

Oregon Partnership State Loan Repayment Program (SLRP)

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

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

The program is funded through a grant from the Bureau of Health Professions, National Health Service Corps, with a 1:1 dollar match from the practice site.

The National Health Service Corps (NHSC) Loan Repayment Program

This loan repayment program is administered by the federal Health Resources and Services Administration, with assistance from the state's Primary Care Office. Primary care providers working at an NHSC approved site (a Health Professional Shortage Area with an appropriate score; see below) can receive loan repayment towards qualified education loans. Award amounts for this year's program have been modified to help ensure communities with the greatest need – those with the highest HPSA scores – receive recruitment support to fill much needed clinical positions. Initial awards amounts are as follows:

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

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

Federal Faculty Loan Repayment Program

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

Nursing Education Loan Repayment Program

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

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

given to individuals with the greatest financial need and those working at schools of nursing with at least 50 percent enrollment of students from a disadvantaged background.

Primary Care Services Loan Repayment Program – currently unfunded

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

Tax credits and Liability Subsidy

Rural Provider Malpractice Subsidy

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

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

From 2003 to 2011, the medical liability insurance premium subsidy program was funded by a partnership between the State Accident Insurance Fund Corporation (SAIF), the Department of Consumer and Business Services (DCBS), and the Office of Rural Health (ORH). In 2011, the program was moved to the Oregon Health Authority, in collaboration with the ORH but the funding mechanism no longer exists. However, the Governor's Balanced Budget for 2013-15 proposes \$4.6M in General Fund to support the program.

Rural Provider Income Tax Credit

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

Private System Options (Large Healthcare Systems in Oregon)

Health System #1:

1) Traditional Physician Recruitment Option

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

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

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

- 3) Employment Loan Option (makes payments to Student's/Resident's Lender to Partially Offset Student Loans). Same as 2) above but instead of loaning money during the schooling/residency of the recruit, System agrees in a letter to the specified physician that if certain standards/conditions are met by said physician (e.g., graduate on time with specified GPA, match into appropriate residency and complete said residency within specified time, ready willing and able to begin employment at System within certain timeframe, enter into employment agreement with System and meet all applicable employment conditions as of the effective date of the employment agreement, etc.), then System will employ the physician and in said employment agreement, in addition to the compensation payable to the employed physician thereunder, commit to pay certain monies directly to the student's/resident's lender for each full year of employment at System completed (such loan payments may be of any amount provided the overall compensation payable to the physician and to lender on physician's behalf is consistent with fair market value). Any such payments will be deemed comp. to the physician employee for IRS purposes and the employed physician's total compensation (actual monies paid to him/her by System plus monies paid to his/her lender) must be consistent with the FMV of the employment services.

Health System #2:

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

Health System #3:

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

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

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

Brainstorming discussions

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

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

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

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

- Improve the practice environment by reducing documentation needs and the range of responsibilities that clinicians now have

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

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

Strategy development and prioritization

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

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

Issues that arose during the small group discussions included these:

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

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

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

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

In brief:

- Graduate Medical Education (GME) training in primary care specialties provides an immediate and ongoing new source of physicians for Oregon without recruiting out of state.
- Federal funding helps support new GME programs, thus, the Consortium will not require ongoing state support.
- A statewide strategic approach to GME would help ensure Oregon maximizes workforce and federal funding benefits. By contrast, a hospital-by-hospital uncoordinated approach may diminish these benefits to Oregon.
- After a five-year phase-in, a community based GME consortium program could support training of about 130 primary care physicians each year in 5 or more community based programs – in the areas where physicians are most needed.

Summary:

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

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

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

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

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

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

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

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

The Need for a Rural Locum Tenens Program in Oregon

What is locum tenens?

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

Why is a rural locum tenens program needed?

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

Why an academic health center based model?

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

What are the benefits of a rural locum tenens program?

For rural physicians:

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

For locum tenens physicians:

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

For rural communities:

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

For OHSU:

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

How will a rural locum tenens program be funded?

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

Why is technical support included in this program?

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

What is the expected demand for these services?

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

Oregon rural locum tenens program partners

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

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OREGON LOCUM TENENS COOPERATIVE (OLTC)

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

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

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

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

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

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

Program Summary

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

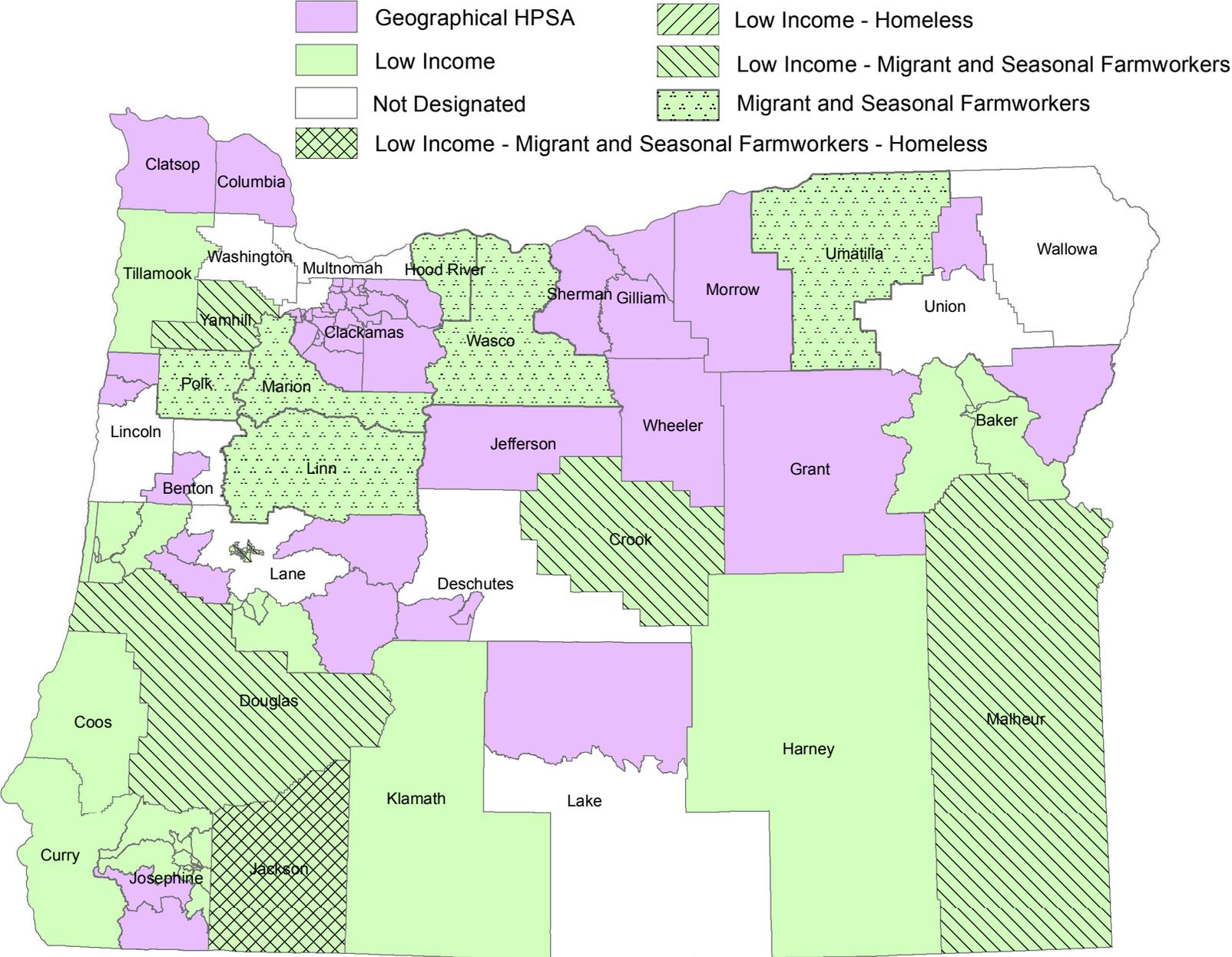
Who are the members? The founding members are composed of several Oregon critical access hospitals and rural practices. Expansion of membership can be to any health facility or physician practice in a rural or underserved community, through approval of the OLTC governing board. Members pay an annual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

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

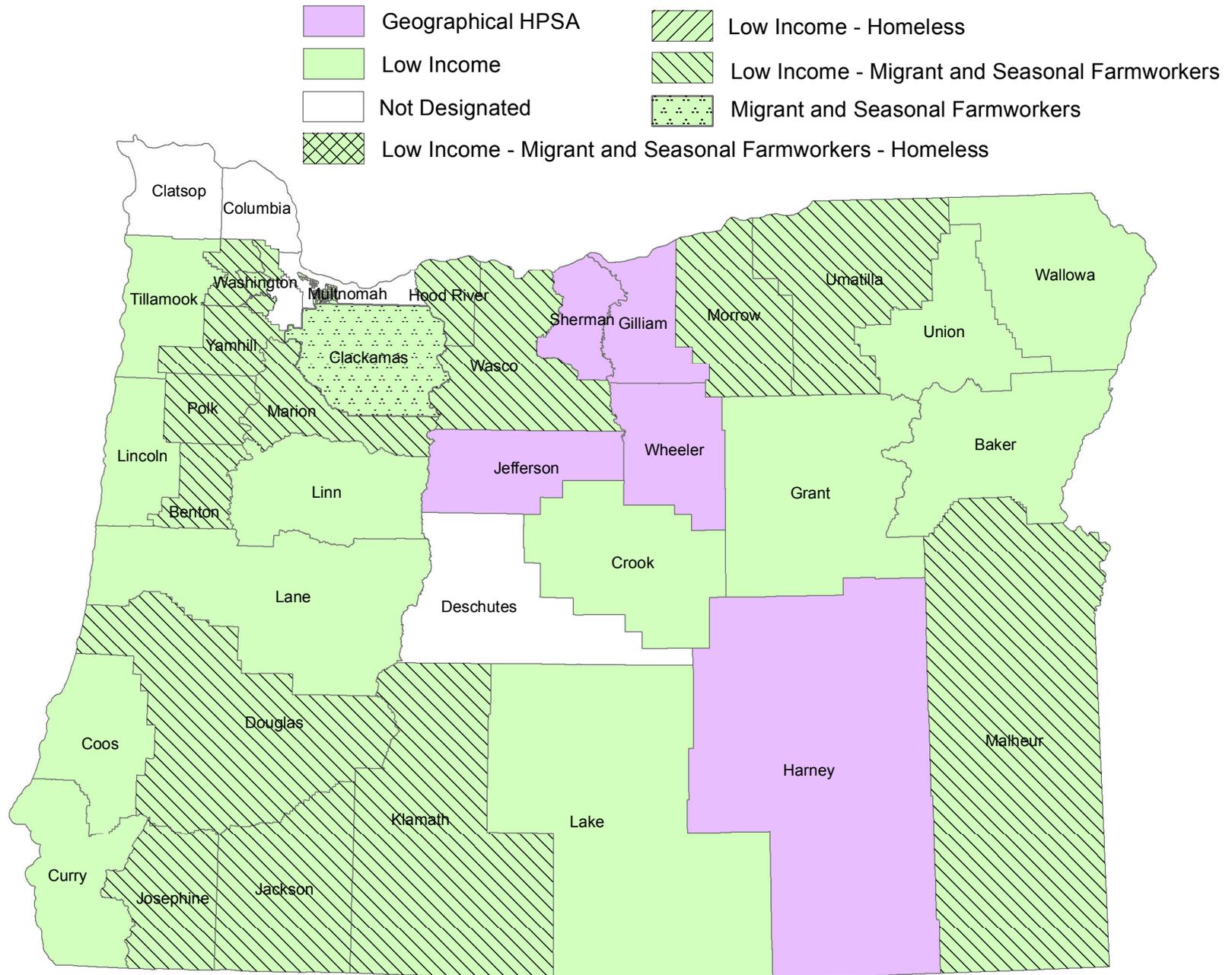
Program Development and Administration

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

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



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



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

