

Oregon Healthcare Workforce Committee
AGENDA – June 4th, 2014, 9:30 am – 12:30 pm
Wilsonville Training Center, Wilsonville, OR 97070
29353 SW Town Center Loop, E Room 111/112

Meeting Objectives: Review and discuss charter deliverables to OHPB, membership, updates

#	Time	Agenda Item	Presenter(s)	Action Item
1	9:30 – 9:35 (5')	Welcome	Lisa Dodson	
2	9:35 – 9:40 (5')	Approval: April 2nd meeting summary	Lisa Dodson	x
3	9:40 – 9:50 (10')	Announcement: Lisa Dodson's new role, leadership transition	Lisa Dodson	x
4	9:50 – 10:20 (30')	Workgroup B: Discuss Graduate Medical Education expansion work, share final draft of the policy option memo due to the OHPB on July 1st. Discuss proposal going to Moda Health on June 10 th .	Robyn Dreibelbis, Lisa Dodson	x
5	10:20 – 10:35 (15')	Break		
6	10:35 – 11:05 (30')	Workgroup C: Discuss Financial Incentives draft report due to the OHPB on July 1st.	Lisa Dodson Marc Overbeck	x
7	11:05 – 11:20 (15')	Membership: Discuss membership letter and commitment, suggest new members	Ann Buchele Lisa Dodson	x
8	11:20 – 11:50 (30')	Other Workgroup updates: <ul style="list-style-type: none"> • Workgroup A – Centralized tracking, implementation of rules on clinical placement standards • Workgroup D – Emerging trends in the healthcare workforce 	Cathryn Cushing Ann Buchele	
9	11:50 – 12:15 (25')	General and OHA Updates	All	
10	12:15 – 12:30 (15')	Public Comment	Any	
11	12:30	Adjourn: Next meeting August 6th, 2014	Lisa Dodson	

Meeting Materials

1. Agenda
2. April 2, 2014 draft meeting summary
3. Draft GME Policy Option Memo
4. Matrix of GME Policy Options
5. Draft Situation, Target, Proposal to Moda Health
6. Draft Moda Health proposal budget matrix
7. Draft Financial Incentives report

Oregon Healthcare Workforce Committee
April 2, 2014 from 9:30-12:30
At Wilsonville Training Center
Meeting Summary

Committee Members in Attendance:	Andrew Janssen (By Phone) Daniel Saucy David Pollack Lisa Dodson Lita Colligan	Mary Rita Hurley Sharmila Bose Theresa Mazzaro Carla McKelvey
Committee Members Not in Attendance	Agnes Balassa Ann Buchele David Nardone Jennifer Valentine	Jordana Barclay Mauro Hernandez Michael Reyes Robyn Drebelbis
OHA and OHWI Staff in Attendance	Lisa Angus, OHA Cathryn Cushing, OHA Marc Overbeck, OHA Margie Fernando, OHA	Jo Isgrigg, OHWI Chad Johnson, OHWI
Also in Attendance	Brenda Turner, Occupational Economist with the Oregon Employment Department	

1	Welcome
	Lisa Dodson welcomed everyone to the meeting.
2	Approval: February 5, 2014 meeting summary – Lisa Dodson
	Meeting Summary was approved with the following corrections by David Pollack: Item 12 (2): “David would like to invite either Jennifer Boyd or Judith Bowen, both of whom are directly involved with the planning and implementation of the Inter-Professional Training Initiative at OHSU, to come to the next meeting of Workforce meeting to share the changes happening.”
	<i>Action Steps: Correction made and meeting summary will be posted on website, with no other changes.</i>
3	Presentation: New projections from the Oregon Employment Department – Brenda Turner, Oregon Employment Department
	<u>Objective:</u> Give the committee new information on Oregon’s workforce projections for 2012 – 2022. <u>Background:</u> The Oregon Employment Department updates workforce projections every two years. The most recent update was published on March 12, 2014. Brenda Turner presented the new projections from the Oregon Employment Department on employment in Oregon through 2022. She showed data on employment growth across all industries vs the healthcare industry and gave further refinements for healthcare occupations. The trends show all sectors in healthcare continuing their upward trend.
	<u>Action Steps:</u> Brenda will send the Committee regional employment data.

4	Review : Demographic Profiles of Population and Health Care Workforce: Draft final report to Committee and discussion
	<p><u>Objective</u>: To review the latest draft of the Health Care Diversity Report</p> <p><u>Background</u>: Committee members saw a presentation about the report and the potential content at the last HCWF Committee meeting.</p> <p>Lisa Angus presented the final draft of the report due to the Health Policy Board in May. Lisa reviewed the key areas of the report which include data collection, provider cultural competence, utilizing traditional health workers, and increasing numbers of diverse health professionals. A significant number of professionals lack complete race and ethnicity data, making it difficult to compare between groups.</p> <p>Comments and suggestions from Committee:</p> <ul style="list-style-type: none"> • In the Primary Care Providers diversity scorecard, it was suggested that the 0.5% range of “below, within and above” state population was not very meaningful. • This report did not include gender statistics. Lisa will review the Committee charter to find out what the requirement was from the OHPB and ensure that this report reflects what was asked of the Committee. • Cathryn Cushing added a cover memo to include with this report to the Board that captures the summary and recommendations to the Board. She asked the Committee to review the memo.
	<p><i>Action Steps: Committee members will review the final draft of the report and the cover memo, and provide their feedback to Lisa and Cathryn on the final recommendations by April 23, 2014.</i></p>
6	Discussion : Changes in bylaws; member expectations
	<p><u>Objective</u>: Present draft bylaw changes and solidify expectations of group members</p> <p><u>Background</u>: With new members rotating on the committee, it is an opportune time to clear up any bylaw discrepancies and propose changes.</p> <p>Lisa Dodson reviewed the draft bylaws and highlighted the changes.</p> <p>Comments from Committee:</p> <ul style="list-style-type: none"> • A suggestion was to recruit a person with IT skills to serve on the committee to assist with work around tracking student clinical placement prerequisites. Other members commented that while it would be good to have an IT specialist on the membership, the purview of this committee is to make recommendations to the OHPB, not to do any implementation. • OHA will arrange participation by guest experts if needed.
	<p><i>Action Steps: The Committee voted to accept revised bylaws.</i></p>

7	Discussion: Workgroup B—Residency Expansion: Review and discuss work to date - Lisa Dodson, Robyn Dreibelbis
	<p><u>Objective:</u> Present Committee with options for increasing residencies and for ensuring that the residencies Oregon has are in the areas, both geographic and specialty-related, where they are needed. Receive Committee feedback on the policy options presented.</p> <p><u>Background:</u> Residencies are an important determinant of physician practice decisions. Primary funding for residencies comes from Medicare and, to a lesser extent, Medicaid. Since 1996, there has been a cap on the number of residencies Medicare will fund, resulting in inequities in distribution.</p> <p>Lisa Dodson reviewed the current residency programs in the state. She also reviewed the GME Summit held in Lebanon, Oregon in February and organized by Robyn Dreibelbis and Dr. Dodson. The meeting was successful and well attended with broad representation from across the state. Detailed notes are included in the meeting materials.</p> <p>The general consensus was that we need increased residencies in Oregon, and not just in Family Medicine. There is also a need for Pediatric Residencies, Internal Medicine and Psychiatry in Oregon. The group also recommended forming a Graduate Medical Education (GME) Consortium.</p> <p>Lisa also informed the Committee that she received a call from MODA Health. MODA has funding (around \$1.5m) that they could possibly use as seed money for a primary care residency consortium or to otherwise expand residency options in Oregon. Lisa and Robyn Dreibelbis will be meeting at MODA Health on Tuesday April 8, 2014.</p>
	<p><i>Action Steps:</i></p> <p><i>Lisa is asking the Committee to:</i></p> <ol style="list-style-type: none"> <i>1) consider if a GME consortium is the best way to move forward</i> <i>2) recommend how best to use the funding that may be available from MODA Health</i> <p><i>Lisa Angus will send out the notes from the Summit to the participants.</i></p>
8	Updates: Workgroups A ,C, D - Workgroup Leads and Staff

	<p>Objective: Make the committee aware of the progress of workgroups.</p> <p>Background: The committee determined that appointing workgroups was an efficient use of member time and energy to ensure that the committee meets the objectives set by the Oregon Health Policy Board.</p> <p>Workgroup D: Emerging trends in the health care work force Ann Buchele was not present, so Lisa Angus provided the update. They have identified data and reviewed articles presented at the last meeting. They will be drafting recommendations for the OHPB.</p> <p>Workgroup C: Provider Financial Incentive Programs Marc Overbeck created a grid of award programs, funded by the state and federal governments. The total amount of money involved is large, and it is broken into many different programs across the state. One charge for this workgroup is to suggest ways to evaluate the effectiveness of different programs. This could include assessing the state cost per program, the design of the program, the return on investment, degree to which the program brings resources to locations most in need, and the funding sustainability of the programs.</p> <p>Jack Dempsey is also chairing a separate legislative workgroup around incentive programs and they are waiting to hear this group’s findings to make their recommendations.</p> <p>Each program has different timeframes and goals, and it may not be possible to produce anything as straightforward as a program ranking. The Committee suggested that --given the variety and complexity of the programs-- there can be no one single recommendation that would fit all the programs. An alternative would be to establish a common pool of funding for provider incentive programs, with a flexible strategic plan for distribution.</p>
	<p><i>Action Steps: Workgroup C will send a final draft to the legislative workgroup to review and then bring their final draft to the June Healthcare Workforce Committee meeting before sending it to the OHPB in July 2014.</i></p>
<p>9</p>	<p>Updates: OHA and General – All</p>
	<p>Objective: Ensure that the Committee is up to date on workforce-related issues.</p> <ul style="list-style-type: none"> • Carla McKelvey announced that Bruce Goldberg had resigned as Director of OHA and of Cover Oregon but will stay on in the latter role until a replacement is found. There will be no changes to the work of the OHPB at the present time. • Lisa Angus presented the current Medicaid enrollment numbers: 240,000 Oregonians have been added as new Medicaid enrollees. This is ahead of expectations.

	<i>Action Steps: None</i>
10	Public Comment
	<u>Objective:</u> Give members of the public time to share with the Committee.
	<i>There was no public comment at this meeting.</i>
11	Emerging issues
	<u>Objective:</u> Provide an opportunity for Committee members and staff to give the committee a heads up on issues that are on the horizon.
	<i>Action Steps: Lisa Dodson asked the Committee to think about future assignments they would like to take on.</i>

DRAFT

Graduate Medical Education Policy Options Memo

Approved Charter deliverable #3 (due July 1, 2014):

A policy options memo, developed in consultation with representatives from Oregon Health & Science University and the College of Osteopathic Medicine of the Pacific-Northwest, for increasing the number of family medicine and other primary care medical residencies in Oregon. The memo should consider options including but not limited to: the creation of new community-based primary care residency programs; a GME consortium approach to support regional primary care residencies; and strategies for increasing the proportion of primary care residencies within the current GME residency cap for Oregon.

Section One: Background

The Oregon Health Policy Board charged the Healthcare Workforce Committee with producing a memo outlining options for increasing family medicine and other primary care medical residencies in Oregon. The Board asked the Committee to work in consultation with representatives from Oregon Health & Science University and the College of Osteopathic Medicine of the Pacific-Northwest. The Board asked that the options include a consortium approach to support primary care residencies, the creation of new community-based residency programs and strategies for increasing the proportion of primary care residencies.

To fulfill this charge, the Healthcare Workforce Committee reviewed current literature, met with experts in the field of Graduate Medical Education in Oregon, held a summit to discuss viable options and conducted phone interviews with representatives of GME consortium programs in five states that are using differing approaches to address the shortage of primary care residencies. The memo will outline five separate options and analyze them for administrative and financial feasibility, their potential impact on the problem, whether or not legislative action is needed to establish them and essential partnerships.

The Healthcare Workforce Committee will also make a recommendation on which of the options the Board should endorse and provide an analysis of this option's strengths, weaknesses, opportunities and threats.

I. Brief history of GME nationally

The Accreditation Council for Graduate Medical Education (ACGME) certifies nearly 9,000 medical residency programs in the United Statesⁱ with over 113,000 residents and fellows receiving training.ⁱⁱ According to the 2013 Osteopathic Medical Profession report, the American Osteopathic Association certifies 942 programs training 10,759 residents.ⁱⁱⁱ This number will not meet future needs. The Association of American Medical Colleges (AAMC) estimates a shortage of 45,000

primary care physicians and 46,000 specialists by 2020 as a result of population growth, the aging and longer lifespan of baby boomers, and retiring physicians.^{iv} The American Medical Association predicts that the national primary care workforce would need to grow 24 percent by 2015 to meet projected need.^v There is variation geographically from a projected .7 to 5 percent across states and from 0 to 76 percent across primary care service areas. The variation is due to differing methodologies and to the unpredictability of the outcomes of health reform.

In Oregon, the baseline projection between 2013 and 2020 for physicians, nurse practitioners and physician assistants is 16 percent growth over current demand. There is variability across counties, from, for example, 9.3 percent growth rate in Umatilla County to 28.5 percent in Curry County. Growth in demand is also affected by implementation of health information technologies, team based care and the state's commitment to reducing the growth of Medicaid.^{vi} Although there is variability in the predicted growth in demand for providers across the state, what is clear is that the current demand for providers outpaces the supply.

Even if medical schools can increase the number of medical students choosing a primary care specialty, the number of residency positions in the United States is effectively limited by a cap on federal funding established by the Balanced Budget Act of 1997.^{vii} Most graduate medical education is funded through payments from Medicare which totaled an estimated \$9.5 billion in 2010. Of that amount, \$3 billion was in the form of direct payments (DME) to hospitals for residents' and their supervising physicians' salaries and \$6.5 billion were indirect payments (IME) to hospitals to cover the increased cost of running a teaching hospital.^{viii}

Although the cap does not limit the development of new residency programs or GME programs funded by other means, the Balanced Budget Act cap limits the number of residencies funded by Medicare in established programs to the number being trained in 1997. Furthermore, because most residency programs in 1997 were located on the East Coast, the cap has exacerbated the disparity in available residency positions between the western and eastern United States. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments that took effect on April 1, 2013.^{ix}

Some hospitals provide private funding for residencies in specialties the particular hospital wants to emphasize or for which there is a demand. This funding requires a significant investment by the hospital as, for example, it is estimated to cost \$113,000 per year to train one resident in a primary care specialty.^x

Some states, Oregon included, provide funding to residency programs within their state using Medicaid funds. These funds are not restricted by the cap in the Balanced Budget Act of 1997 but are small in comparison with Medicare funding.

Some hospitals and states are also providing rural rotations for residents, allowing them to practice for a period of time in a rural or underserved community. In Utah, for example, the state offers four week rotations in primary care medical specialties and pharmacy, providing housing, transportation and per diem for the residents. The state is tracking the success of these rotations in attracting physicians to rural Utah and has found that retention of family medicine residents is most successful.

The projected shortage of primary care physicians was addressed in the Affordable Care Act through the Health and Human Services' Primary Care Residency Expansion program. This program provided \$168 million over five years in grant funding to increase the number of residents in primary care by expanding primary care residency programs using community-based health centers, called Teaching Health Centers. In the Teaching Health Centers programs, residents train primarily in community health centers rather than in hospitals. The new GME positions had to be over and above the current number of primary care GME positions even if they then exceeded the Medicare cap. This program expires in 2015.^{xi}

II. Oregon's GME history and current status

The Association of American Medical Colleges' Center for Workforce Studies reported that in 2011, Oregon had 861 residents or 22.3 residents per every 100,000 population. Oregon's ranking among states is 38th in residents per capita.^{xii} The largest number of residencies in Oregon are concentrated at Oregon Health & Science University, however three health systems, Providence Health & Services, Legacy Health Services, and Samaritan Health Services, and one community-based health center, Virginia Garcia, offer residencies.

Oregon's primary care residencies are in even shorter supply. In 2011, there were only 8.4 primary care residencies per every 100,000 in population, putting Oregon at 40th in the nation.^{xiii} According to a report from the Robert Graham Center, by 2030 the need for primary care physicians will rise by 38 percent over 2010 due to the growing and aging population and the expansion of health insurance coverage.^{xiv}

In Oregon, Graduate Medical Education is funded primarily through Medicare DME payments and, to a lesser extent, Medicare IME payments. Oregon also provides \$57 million per biennium in GME funding through Medicaid.

III. Implications of residency programs on recruitment and retention of family medicine providers

The current shortage of residencies in primary care coupled with the projected increase in need of primary care physicians, especially in rural areas and areas designated Health Professional Shortage Areas by the federal Health Resources and Services Administration creates a perfect storm of unmet need resulting in potential poor health outcomes. Increasing residencies in primary care specialties, particularly in family medicine, in rural or underserved parts of the state address this problem in several ways. First, the residents practicing in underserved communities provide much needed access to health care for members of the community. Second, physicians in rural residencies are much more likely to settle in those communities to build their practice.^{xv} Third, increasing residencies in primary care specialties increases opportunities for graduating medical students to practice in those specialties.

Section Two: Policy Options

There are too few primary care physicians in rural and underserved areas in Oregon. Even if medical schools in the state increased the numbers of medical students graduating in these specialties, there aren't sufficient residency slots in which to place them. Insufficient family medicine residency slots results in the loss of Oregon's new physicians to states with available family medicine residency positions.

In addition, rural and underserved parts of Oregon have very few residency programs. This forces most new physicians who want to stay in Oregon and practice in primary care to complete their residencies in urban areas where the majority of them will eventually settle.

To address these problems, the Healthcare Workforce Committee investigated several options to increase the number of family medicine residencies in Oregon located in rural or underserved areas of the state. Options analyzed include:

- Establishing new, individual primary care residency programs: A hospital or health system takes on program development and funding individually
- Creating a consortium: Stakeholders join to share costs and risks depending on the level of stakeholder involvement.
 - Consortium option 1: Voluntary member group that is loosely structured to provide support to residency programs
 - Consortium option 2: Independent nonprofit organization with 501(c)(3) status that can provide a broad range of support, from supplying assistance with accreditation and faculty development to actually developing a residency program or programs.
 - Consortium option 3: Statutorily established consortium with level of authority over funding and operational decisions granted by a state legislature.
- Increasing primary care residencies while staying within the cap: Changing the percentage of primary care residencies in the state
 - Existing residencies option 1: Current residency programs voluntarily increase the percentage of residencies they dedicate to primary care specialties.
 - Existing residencies option 2: Attach accountability or incentive measures to the state's Medicaid GME funding to influence percentage of residencies dedicated to primary care specialties.

The options are analyzed below for impact, feasibility, cost, partners required and whether or not legislative action would be necessary. The Committee asked staff to speak with GME program representatives in other states to determine how they have addressed the problem and identify lessons learned. Information learned from these conversations is detailed below.

I. New individual primary care residency programs – without consortium support

To avoid the constraints of the cap imposed by the Balanced Budget Act of 1997, hospitals without current residency programs can establish new residency programs. The programs then have three years to expand before a cap is placed on the number of residency slots for which they will receive Medicare funding.

- a. *Impact- High, depending on scope:* New family medicine residency programs established in rural or underserved communities could increase the total number of residency slots in family medicine and assist in remedying the health professional shortages in those communities. The overall impact would depend on the number of slots created and the effectiveness of the recruitment effort for graduating medical students.
- b. *Financial and administrative feasibility - Low:* Creating new residency programs entails significant financial and administrative investment. To meet accreditation standards, residency programs must have a high level of appropriate oversight, an education faculty in place, a medical director providing oversight and a structure for receiving and distributing federal funds, to name just a few. Family medicine residency programs are also required to operate or have access to a primary care clinic. These requirements, and high start-up costs, estimated at a minimum of \$2 million by stakeholders exploring establishing an independent family medicine residency in Roseburg, Oregon, make this option unfeasible for most local community hospitals or clinics.

In addition, many rural hospitals are designated by the Centers for Medicare and Medicaid Services (CMS) Sole Community Hospitals. Sole Community Hospitals, which receive Medicare Part A payments under the Inpatient Prospective Payment System (IPPS) rate are not eligible to receive IME payments for their residents.^{xvi}

- c. *Partnerships* – Clinic partner, Medical schools, area hospital
- d. *Legislative action - None required:* Given the high cost of establishing an independent residency program, however, stakeholders may want to ask for funding from the state for start-up costs which would require legislative action.
- e. **Roseburg example**

Consortia and Networks

Many states have taken advantage of the consortium model provided as an option for new program funding through the Balanced Budget Act of 1997 to establish residency programs. The description of a consortium in the Balanced Budget Act follows:

“The Secretary shall establish a demonstration project under which DGME payments would be made to “qualifying consortia.” A qualifying consortium is defined as a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

- *A school of allopathic or osteopathic medicine;*
- *Another teaching hospital, which may be a children’s hospital;*
- *A federally qualified health center;*
- *A medical group practice;*
- *A managed care entity;*
- *An entity furnishing outpatient services; or*
- *Another entity deemed appropriate by the Secretary.*

The members of the consortium must agree to participate in the training programs that are operated by the entities in the consortium, and must agree on a method for allocating the payment among the members. The members also must agree to any additional conditions established by the Secretary. The total payment to a qualifying consortium for a fiscal year cannot exceed the amount that would have been paid to the teaching hospital(s) in the consortium. Payments will be made in proportion from each of the Medicare trust funds as the Secretary specifies.”^{xvii}

There are many variations of this model, a few of which are detailed below.

Some states have created less formal networks or councils that may not have funding authority, but have informal authority over certain aspects of residencies, provide centralized or coordinated operations for multiple residency programs, act as collectors of workforce data, offer trainings or materials and, in some cases, act as advocates for increased funding or attention from their state government, hospitals or medical schools.

II. Option 1: Voluntary member group/ Network

- a. *Impact on problem – Moderate to low, depending on strength of partnerships:*
Although some voluntary partnerships have resulted in an increase of residency slots through advocacy for funding, most networks provide only indirect support of already established residencies.
- b. *Financial and administrative feasibility – High:* Support and coordination can be achieved through established programs such as the state’s Area Health Education Centers (AHEC) or the Office of Rural Health, capitalizing on infrastructure already in place. This reduces the administrative burden and reduces funding needed for start-up.
- c. *Partnerships* – The benefits of a network accrue primarily to members of the network, so the network is improved as partners come to the table. Ideally, all entities with a stake in primary care Graduate Medical Education and increasing family medicine and other primary care physicians in underserved areas would participate. Partners could include FQHC’s, teaching hospitals, other clinic partners, medical schools, and health professional training programs.
- d. *Legislative action – None needed*
- e. *State example – Montana:* The Montana Graduate Medical Education Council (MGMEC)
Montana, with a relatively small population, had only one GME program located in Billings, and a difficult time recruiting physicians. In 2011, the state convened the MGMEC using the resources of the state’s AHEC to administer and staff the Council. The Council is charged with tracking and measuring the health care workforce, coordinating the development of new residency programs and nurturing relationships with providers.

Although the Council has no authority over GME decisions or funding streams, they have been very successful at bringing together influential partners. Council members include the Provost of Montana State University, the Dean of Medical

Education at the University of Montana, representatives from the hospital and health care provider association and the American Medical Association, the residency directors, hospital administrators and representatives from the regional AHECs, state AHEC and Office of Rural Health. These partners successfully lobbied the state legislature for increased funding for new family medicine residency programs located in more rural areas of the state.

The Council has increased available residency slots from six per year in Billings alone to 22 per year in Billings and Missoula. All the residencies are in primary care, including family medicine, with three specifically dedicated to internal medicine. The Council has achieved this with no direct budget for the consortium. The state's AHEC director is hoping for some state funding for at least a .5 FTE to help coordinate the Council and conduct data analysis, for a total funding request of between \$60,000 and \$100,000.

III. Option 2: Independent, Nonprofit (501(c)(3)) Consortium

- a. *Impact on problem – Moderate to high, depending on funding and support from partners and stakeholders* – A consortium approach through a nonprofit organization has the potential to create new residency slots and locate them where the members of the consortium want them, depending on funding and support from partners and stakeholders. This type of approach gives authority to consortium members.
- b. *Financial and administrative feasibility – Moderate (compared to establishing an independent residency program)* – As noted above, start-up costs for new residency programs are high and the administrative burden is great. However, with a consortium approach, these burdens are shared among members. Consortia organized as nonprofit organizations are required to have governance boards with fiduciary and operations accountability and oversight. A nonprofit organization can also function as a financial umbrella organization, receiving funds from various partners and distributing the funds as agreed upon by the Board. Although the burden is still heavy, sharing the cost and administration among partners makes this option much more feasible than establishing a new, independent residency program.
- c. *Partnerships*- All organizations benefitting from the residency program need to be involved in the initial planning and creation of the organization. In some cases, Board members of a 501(c)(3) contribute equally to the organization. In this model, Board membership is often limited to representatives of organizations that have provided funding or who are major stakeholders.
- d. *Legislative action – None needed* - The basic authority to establish a nonprofit entity comes from the state and federal government; however, no legislative action is necessary to establish the consortium Board and bylaws. Legislative action would only be required if the consortium needed additional state funding.
- e. *State example – Modesto, California*: The Valley Consortium for Medical Education The Valley Consortium was developed in response to the closing of the only family medicine residency program in the county. Closing the program meant not only losing the physician recruitment benefits of a residency program, but would leave

70,000 low-income residents of the county without access to the care that had been provided by the residents.

The crisis spurred the formation of a consortium of traditionally competitive partners including a for-profit health center, a not-for-profit health center, the county community health center and a Federally Qualified Health Center look-alike which provided care to the county's very low-income residents. Consortium members provided startup funding through an assessment on all partners. Initial administrative and legal fees were approximately \$70,000. This amount included hiring consultants to work with state and federal partners and facilitate the newly-formed partner group and establishing a nonprofit organization.

Subsequent costs for the establishment of a residency program included the cost of accreditation, hiring faculty and staff, hiring the first residents and further legal and administrative costs. These costs were paid for with a \$200,000 annual investment from each of three partners as well as a \$2.5 million Teaching Health Center grant. It is anticipated that all future costs of running the program will be paid for with federal GME funds; however, consortium partners have committed to contribute in the event of a shortfall.

The result is a consortium that provides 30 family medicine residents to the consortium partners and the community. All business operations of the residency program, and any future residency programs, are run through the consortium, including all Medicare GME payments and any state or grant funding.^{xviii}

IV. Option 3: Statutorily-established consortium

- a. *Impact on problem – Moderate to high, depending on level of authority.* A consortium established in statute could have control over new funding, over any potential accountability and incentive measures tied to state money and could bring influential members to the table. These factors could create an environment where impact on the problem would be high.
- b. *Financial and administrative feasibility - Moderate*
Administrative: Moderate - This option requires establishing a new bureaucratic entity with all of the administrative constraints a government entity imposes. Although this type of structure would not support establishing and running a residency program, it would need to comply with government hiring regulations, oversight measures and other administrative rules and procedures.
Financial: Moderate - The costs for establishing this type of consortium would be restricted to establishing and maintaining the consortium structure as this entity would not be operating the actual residency program.
- c. *Partnerships – Health systems, hospitals and clinics, medical schools*
- d. *Legislative action - Yes*
- e. *State example – Utah – The Utah Medical Council*
The Utah Medical Council was established by statute in 1997 and created as a quasi-public entity. The Board has eight Governor-appointed members including representatives from teaching hospitals, private and public hospitals,

representatives from health insurance plans and three at large members. The Council functions as a neutral body where these potentially competitive members can collaborate.

The Council's charge is three-fold:

- 1) To increase funding to GME and to advise on how to spend those funds,
- 2) To conduct studies on the health care workforce, and,
- 3) To operate a rural rotation program for medical and pharmacy students.

The Council has been successful on all three fronts. By looking closely at every rotation and tracking each resident's time, they were able to increase the reimbursements from Medicare to the teaching hospitals. They have produced workforce reports that have guided GME policy in Utah. The rural rotation program is fully operational and the Council is tracking how many of those residents eventually practice in rural Utah.

The Council is funded at about \$1 million per year, half coming from the state legislature and half coming from the teaching hospitals. The investment by the hospitals is voluntary, so the Council needs to demonstrate value in order to maintain that funding source.

Expanding current family medicine residencies

V. Option 1: Requesting that currently operating GME programs voluntarily allocate more of their residency slots to primary care

- a. *Impact on Problem – Low to moderate* – The impact depends on the willingness of existing programs to commit significant resources. Since the reallocation would be completely voluntary, some institutions may not follow through. In addition, although allocating more slots to primary care would address the need for more primary care residencies, it wouldn't necessarily address the issue of meeting the needs of rural or underserved areas of the state.
- b. *Financial and administrative feasibility – Administratively easy, financially challenging* – Since these programs are already operating, infrastructure is in place, faculty is trained (although additional training in family medicine or other primary care specialty may be needed) and financial systems are functioning. However, an institution receiving significant revenue from residency programs other than primary care may be unwilling to shift residencies into less lucrative specialties.
- c. *Partnerships* – None needed
- d. *Legislative action* – None needed
- e. *State example* - **Needed**

VI. Option 2: Directing state Medicaid Assistance Programs (MAP) funds to programs meeting accountability or incentive measures

Currently Oregon allocates \$57 million per year in Medicaid payments to the state's teaching hospitals.^{xix} Unlike payments from the Medicare program to the teaching hospitals, the state has control over the spending of Medicaid funds and could tie those

funds to measures such as number of residency slots allocated to family medicine, other primary care specialty or located in a rural community.

- a. *Impact on problem – Moderate to high impact* – Although the Medicaid funding is a small part of overall GME funding, it is still a significant amount. Training primary care residents costs approximately \$113,000 per year and Medicaid funding makes a valuable contribution. Tying this money to statewide objectives and appropriate physician workforce development could have high impact on the state.
- b. *Financial and administrative feasibility – Easy* – A process and administrative structure for allocating these funds already exists. Although some investment of time and resources would be needed to develop the new measures and funding formula as well as an evaluation plan, the investment is minimal compared to the other options above.
- c. *Partnerships* – Health policy experts, health system representatives – influential partners would be needed if legislative action is required
- d. *Legislative action* – unclear – needs research
- e. *State example* – Also needs research

Section Three: Recommendation

Based on the analysis above, conversations with other states and GME consultants and the emerging literature, the Healthcare Workforce Committee recommends establishing a consortium that would be used to develop and support new primary care residency programs in Oregon. There are three to five health care institutions and areas of the state that may—with the resources of a consortium—be able to launch new residency programs in the next five years. Although the parameters of the model can only be determined through a rigorous planning process with stakeholders, it is likely that the consortium would establish an independent nonprofit organization for administrative operations, faculty recruitment and development, and receipt and distribution of funds.

The consortium should focus operations in underserved areas of the state and pay particular attention to the potential to recruit and retain primary care physicians in those underserved areas. The consortium would begin by focusing on development of primary care residency programs only, but could grow to encompass other specialties as well. Local hospitals and health systems, federally qualified health centers, county medical centers and Oregon’s two medical schools would be the primary stakeholders for the initial planning phases with the eventual consortium members to be determined.

Strengths: The strength of the consortium model lies primarily in optimizing shared resources. When stakeholders join together to create a residency program, no one institution bears the financial and administrative burden. All stakeholders share the benefits of having residents and increased numbers of physicians practicing in their communities.

Establishing a new residency program allows new GME slots to be built over three years before being capped by the federal government. Creating a new residency program for primary care

allows new physicians increased opportunities to select a primary care practice, filling an urgent need in Oregon. Placing residency programs in rural or underserved parts of the state encourages physicians to build practices in those communities.

Weaknesses: Establishing new residency programs requires a significant investment of resources, whether they are created through a consortium or individual hospitals. Finding sufficient funding until GME payments from Medicare begin is challenging.

Additionally, a consortium established as a nonprofit organization operates under the mission and bylaws created and amended by the stakeholders. Depending on the stakeholders involved and their individual needs, the mission may not reflect the best interests of the state.

Opportunities: Recently, Moda Health approached some individual members of the Healthcare Workforce Committee about the potential of funding for a new primary care residency program serving rural or underserved communities in Oregon. The funding would be enough to cover the planning phase and some of the initial startup costs. A proposal is due to Moda Health on June 10, 2014. This opportunity is time limited and requires immediate action. Since the Healthcare Workforce Committee has been researching the issue of expanding primary care residencies in Oregon since the initial GME Summit in February 2014, the Committee is well prepared to submit a serious proposal to Moda Health.

Other opportunities include Oregon's work on health reform, which has encouraged innovation, and increased emphasis on primary care through the patient-centered primary care home model as well as the work in Roseburg investigating the potential of creating a new individual family medicine residency program. Many partners in that area are already engaged.

Threats: Developing a consortium generally requires the participation and agreement of traditionally competitive institutions, which can be a difficult task. Competing interests of the various stakeholders could threaten the organization.

ⁱ Twenty-first report of the Council On Graduate Medical Education, *Improving Value in Graduate Medical Education August 2013*
<http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentyfirstreport.pdf>

ⁱⁱ The Potential Impact of Reductions in Federal GME Funding in the United States: A Study of the Estimates of Designated Institutional officials, [Thomas J. Nasca](#), MD, MACP, [Rebecca S. Miller](#), MS, and [Kathleen D. Holt](#), Ph.D.J

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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3244335/>

iii American Osteopathic Association. 2013 Osteopathic Medical Profession Report:
<http://www.osteopathic.org/inside-aoa/about/aoa-annual-statistics/Documents/2013-OMP-report.pdf>

iv Physician shortages to worsen without increases in residency training. Association of American Medical Colleges, June 2010. Web accessed 4 Sept. 2013. <https://www.aamc.org/download/286592/data/>

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vi The Projected Demand for Physicians, Nurse Practitioners, and Physician Assistants in Oregon: 2013-2020; February 2014; Prepared for: The Oregon Health Authority; Prepared by: Office for Oregon Health Policy & Research Oregon Health & Science University, Center for Health System Effectiveness Oregon Healthcare Workforce Institute;
<http://www.oregon.gov/oha/OHPR/HCW/Resources/Projected%20Demand%20for%20Physicians,%20Nurse%20Practitioners,%20and%20Physician%20Assistants%20in%20Oregon%20-%202013-2020.pdf>

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ix Budget Control Act, 2011, 112th Congress, 2011-2012 S365: <http://thomas.loc.gov/cgi-bin/query/z?c112:S.365:>

x Wynn, Barbara O.; Smalley, Robert; Cordasco, Kristina M.. *Does It Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs*, 2013, Rand Corporation http://www.rand.org/pubs/research_reports/RR324.html Accessed May 2014

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<http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf>

xii Association of American Medical Colleges Center for Workforce Studies, State Physician Workforce Databook
<https://www.aamc.org/download/152168/data/oregon.pdf>

xiii Association of American Medical Colleges Center for Workforce Studies, State Physician Workforce Databook
<https://www.aamc.org/download/152168/data/oregon.pdf>

xiv Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.

xv American College of Physicians. *Aligning GME Policy with the Nation's Health Care Workforce Needs*. Philadelphia: American College of Physicians; 2011: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

xvi Sole Community Hospitals and Critical Access Hospitals <http://www.osteopathic.org/inside-aoa/Education/OGME-development-initiative/Pages/hospital-types.aspx>

^{xvii} Excerpted from the Balanced Budget Act of 1997, Section 4628. <http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/html/PLAW-105publ33.htm>. Accessed May 15, 2014.

^{xviii} Acad Med. 2012;87:1096–1100. Developing a Community-Based Graduate Medical Education Consortium for Residency Sponsorship: One Community’s Experience, Peter W. Broderick, MD, MEd, and Kiki Nocella, PhD, MHA

^{xix} Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey 2010, Association of American Medical Colleges, https://members.aamc.org/eweb/upload/Medicaid%20Direct_Indirect%20GME%20Payments%20Survey%202010.pdf

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Matrix of GME family medicine/primary care expansion options (* = bullet points)

Approved Charter deliverable #3 (due July 1, 2014): *A policy options memo, developed in consultation with representatives from Oregon Health & Sciences University and the College of Osteopathic Medicine of the Pacific-Northwest, for increasing the number of family medicine and other primary care medical residencies in Oregon. The memo should consider options including but not limited to: the creation of new community-based primary care residency programs; a GME consortium approach to support regional primary care residencies; and strategies for increasing the proportion of primary care residences within the current GME residency cap for Oregon.*

	Description of Option	Administrative feasibility and governance issues - list	Financial feasibility – High, Medium, Low Cost	Impact on problem	Political considerations - list	Partnerships needed - list	Legislative action needed - Yes or No	Minimum time to first residents	Other considerations
New Individual Residency Programs	Hospital or medical center establishes a family medicine residency program.	*Difficult to develop administratively – one institution bears the responsibility of faculty development, relationships with federal partners, accreditation, etc. *Governance easier to establish as one entity is in control	*High cost borne by one institution *Some rural hospitals have Sole Community Hospital designation, making them ineligible for GME IME payments	High impact in one area of the state, if successful	None, since the responsibility is all on one institution.	It would be preferable to involve community partners, but not necessary as the authority rests with one institution.	No – unless the institution wanted to ask for state funds.	2 years	Needs to be some sort of incentive to draw residents and faculty to location.
Consortium to support residencies									
Option #1 – Network or council	Voluntary member group that serves to convene residency programs and other partners, provide educational opportunities and to communicate with members.	*Easy to form *Governance would be voluntary	Low Cost	*Minimal as the group would have no authority to require changes. *Impact is related to the influence of the partners in the network.	None, however, the network could have considerable political influence depending on the partners involved.	All residency programs, hospitals, medical centers, OMA, AHHS, medical schools, AHEC	No	Depends on programs involved – 1 year minimum for accreditation	

Draft V3 (05/27/14): Situation, Target, Proposal for establishing a primary care residency program serving rural and underserved communities in Oregon

Situation: Shortage of primary care physicians and residencies in rural and underserved Oregon

The Accreditation Council for Graduate Medical Education (ACGME) certifies nearly 9,000 medical residency programs in the United Statesⁱ with over 113,000 residents and fellows receiving training.ⁱⁱ According to the 2013 Osteopathic Medical Profession report, the American Osteopathic Association certifies 942 programs training 10,759 residents.ⁱⁱⁱ This number will not meet future needs. The Association of American Medical Colleges (AAMC) estimates a shortage of 45,000 primary care physicians and 46,000 specialists by 2020 as a result of population growth, the aging and longer lifespan of baby boomers, and retiring physicians.^{iv} The American Medical Association predicts that the national primary care workforce would need to grow 24 percent by 2015 to meet projected need.^v Although there is variability in the predicted growth in demand for primary care providers, what is clear is that many more PCPs will be needed in the future.

The Association of American Medical Colleges Center for Workforce Studies reports that in 2011, Oregon had 861 residents or 22.3 residents per every 100,000 population. Oregon's ranking among states is 38th in residents per capita.^{vi} Primary care residencies are in even shorter supply. In 2011, there were only 8.4 primary care residencies per every 100,000 in population, putting Oregon at 40th in the nation.^{vii} According to a report from the Robert Graham Center, by 2030 the need for primary care physicians will rise by 38 percent over 2010 due to the increasing age of the population, the expansion of health insurance coverage and increases in population.^{viii}

Most graduate medical education is funded through payments from Medicare which totaled an estimated \$9.5 billion in 2010. Of that amount, \$3 billion was in the form of direct payments (DME) to hospitals for residents' and their supervising physicians' salaries and \$6.5 billion were indirect payments (IME) to hospitals to cover the increased cost of running a teaching hospital.^{ix}

The Balanced Budget Act of 1997 limits the number of residencies funded by Medicare in established programs to the number being trained in 1997.^x Although the cap does not limit new residency programs or programs funded by other means, it does limit the number of residencies in established programs. Because most residency programs in 1997 were located on the East Coast, the cap has exacerbated the disparity in available residency positions between the western and eastern United States. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments that took effect on April 1, 2013.^{xi}

Some hospitals provide private funding for residencies in specialties the particular hospital wants to emphasize or for which there is a demand. This funding requires a significant investment by the hospital as it costs an estimated \$113,000 per year to train one resident.^{xii}

The current shortage of residencies in primary care or family medicine coupled with the projected increase in need of primary care physicians, especially in rural areas and areas designated Health

Professional Shortage Areas (HPSA) by the Health Resources and Services Administration (HRSA), results in unmet need and potentially poor health outcomes. Increasing residencies in primary care specialties and family medicine and locating them in rural or underserved parts of the state address this problem in several ways. First, the residents practicing in underserved communities provide much needed access to health care for members of the community. Second, when physicians spend their residencies in rural settings, they are much more likely to settle in those communities to build their practices.^{xiii} And third, increasing residencies in primary care specialties creates more opportunity for graduating medical students to practice in those specialties.

An option for establishing a new primary care residency program that spreads the administrative and financial burden among a group of partners is to establish a consortium. Many states have taken advantage of the consortium model provided as an option for new program funding through the Balanced Budget Act of 1997. The description of a consortium in the Balanced Budget Act follows:

“The Secretary shall establish a demonstration project under which DGME payments would be made to “qualifying consortia.” A qualifying consortium is defined as a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

- *A school of allopathic or osteopathic medicine;*
- *Another teaching hospital, which may be a children’s hospital;*
- *A federally qualified health center;*
- *A medical group practice;*
- *A managed care entity;*
- *An entity furnishing outpatient services; or*
- *Another entity deemed appropriate by the Secretary.*

The members of the consortium must agree to participate in the training programs that are operated by the entities in the consortium, and must agree on a method for allocating the payment among the members. The members also must agree to any additional conditions established by the Secretary. The total payment to a qualifying consortium for a fiscal year cannot exceed the amount that would have been paid to the teaching hospital(s) in the consortium. Payments will be made in proportion from each of the Medicare trust funds as the Secretary specifies.”^{xiv}

Target: Encourage more physicians to practice in rural or underserved communities in Oregon by establishing a new primary care residency program in rural Oregon.

Proposal: Primary Care Residency Consortium

The Healthcare Workforce Committee recommends developing the Healthcare Workforce Committee recommends establishing a consortium that would be used to develop and support new primary care residency programs in Oregon. There are 3-5 institutions and areas of the state that may—with the resources of a consortium—be able to launch new residency programs in the next

five years. Although the parameters of the model can only be determined through a rigorous planning process with stakeholders, it is likely that the consortium would establish an independent 501C3 for administrative operations, faculty recruitment and development and receipt and distribution of funds.

The consortium would focus operations in underserved areas of the state and would pay particular attention to retaining primary care physicians in those underserved areas. The consortium would begin with development of primary care residency programs only, but could grow to encompass other specialties as well. Local hospitals and health systems, federally qualified health centers and county medical centers would be the primary stakeholders for the initial planning phases with the eventual consortium members to be determined.

The Committee anticipates that establishing the consortium and launching the first residency program will require four phases of work. The attached budget document outlines more specifically the costs involved in developing a consortium and launching a residency program. Generally:

- 1) Project initiation: In this phase, the Healthcare Workforce Committee completes a proposal to Moda Health and develops a policy option memo and set of recommendations to the Oregon Health Policy Board. A convening organization, such as the Southwest Area Health Education Center (AHEC SW), or Moda Health directly, recruits and hires a GME consultant to begin the planning phase.
- 2) Project planning: Facilitated by the consultant, stakeholders convene to create their vision for the consortium, determine the best business model and invite the appropriate members. The members create a strategic plan for the consortium.
- 3) Consortium development: Based on the strategic plan, consortium members decide on the best business model – anticipated to be an independent not-for-profit 501C3 structure. In that case, consortium members, with assistance from the consultant, will create a Board of Directors, bylaws and establish a system for financial accountability. During this phase, legal counsel will be retained to assist with the set up of the business and financial model.

After Phase 3, there are at least two options. One option is for the new 501C3 Board to develop and operate a new primary care residency program, with the potential for expanding and operating more than one program.

- 4) A) Program development: The Board recruits and hires a Residency Program Director and a Consortium Coordinator. The Residency Program Director and the Consortium Coordinator apply for accreditation, establish faculty and curriculum, recruit residents and develop the consortium infrastructure including human resource functions, payroll, management structure and internet technology. Teaching hospitals would pass through their Medicare DME and IME payments to the consortium and would allocate a portion of the payment to program operations with consortium members committing to making up any shortfall.

Alternatively, the associated teaching hospital or hospitals could develop and operate the new primary care residency programs, relying on the consortium to provide administrative support to create the curriculum, develop faculty, recruit residents and manage the accreditation process.

- B) Program development: The Board recruits and hires a Consortium Coordinator. The Coordinator assists new residency programs to apply for accreditation, recruit residents and establish faculty and curriculum. The Coordinator works with the Board to establish Consortium infrastructure including human resources functions, payroll, management structure and internet technology including human resources functions, payroll, management structure and internet technology. New residency programs recruit and hire Residency Program Directors. In this model, Medicare DME and IME payments stay within the teaching hospitals and the consortium must arrange for separate funding of consortium operations. This could be achieved through a “pay to play” model with each consortium partner being assessed a fee to participate in the consortium and to receive the benefits of the consortium.

In 2011, Oregon ranked 39th among states for primary care residents per capita with 8.2 residents per 100,000 in population. To reach the goal of ranking in the 50th percentile among states with 10.2 residents per 100,000 in population means adding at least 60 primary care residencies. Establishing new primary care residency programs will be essential for the state to achieve this goal.

Sustainability

Medicare DME and IME payments will begin to flow to the teaching hospital (or hospitals) within the consortium three years after hiring the first class of residents. Once a program is training a full complement of residents, it should be largely self-sustaining through Medicare, unless the qualifying hospital is designated a sole community hospital. Sole community hospitals are not eligible to receive Medicare IME payments. In this case, consortium members or government entities would need to make up the remaining amount.

Oregon does currently allocate some funding to Oregon’s teaching hospitals through Medicaid and a portion of that allocation could be paid to the consortium. In addition, according to research in states with established consortia, most consortium Board members commit to a yearly payment from their sponsoring organizations in recognition of the benefit the members are receiving from the consortium.

Ongoing funding for the consortium will come from the consortium Board members through assessments, allocation of portions of Medicare IME payments and through state or federal grant opportunities. The amount of that funding will depend on the scope of the consortium, the FTE needed and the type of business infrastructure decided upon by the original stakeholders.

In conclusion, an investment by Moda Health in establishing new primary care residency programs in rural Oregon communities will have very real benefits for the state. Improved access to primary care will result in better health and better care at a lower cost.

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- ⁱ Twenty-first report of the Council On Graduate Medical Education, [*Improving Value in Graduate Medical Education August 2013*](#)
<http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentyfirstreport.pdf>
- ⁱⁱ The Potential Impact of Reductions in Federal GME Funding in the United States: A Study of the Estimates of Designated Institutional officials , [Thomas J. Nasca](#), MD, MACP, [Rebecca S. Miller](#), MS, and [Kathleen D. Holt](#), Ph.D.J Grad Med Educ. Dec 2011; 3(4): 585–590.doi: [10.4300/JGME-03-04-33](#)
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3244335/>
- ⁱⁱⁱ American Osteopathic Association. 2013 Osteopathic Medical Profession Report:
<http://www.osteopathic.org/inside-aoa/about/aoa-annual-statistics/Documents/2013-OMP-report.pdf>
- ^{iv} Physician shortages to worsen without increases in residency training. Association of American Medical Colleges, June 2010. Web accessed 4 Sept. 2013. <https://www.aamc.org/download/286592/data/>
- ^v Petterson, S.M., Liaw, W.R., Phillips, R.L., Rabin, D.L., Meyers, D.S., and Basemore, A.W. (2012). Projecting US primary care physician workforce needs: 2010-2025, *Annals of Family Medicine*, 10:503-509.
- ^{vi} Association of American Medical Colleges Center for Workforce Studies, State Physician Workforce Databook
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- ^{vii} Association of American Medical Colleges Center for Workforce Studies, State Physician Workforce Databook
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- ^{viii} Petterson, Stephen M; Cai, Angela; Moore, Miranda; Bazemore, Andrew. State-level projections of primary care workforce, 2010-2030. September 2013, Robert Graham Center, Washington, D.C.
- ^{ix} Health Policy Brief: Graduate Medical Education," *Health Affairs*, August 16, 2012. www.healthaffairs.org/Healthpolicybriefs
- ^x Balanced Budget Act Bill Text, 105th Congress (1997-1998), HR2015 enrolled:
<http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/html/PLAW-105publ33.htm>. Accessed May 15, 2014.
- ^{xi} Budget Control Act, 2011, 112th Congress, 2011-2012 S365: <http://thomas.loc.gov/cgi-bin/query/z?c112:S.365>:
- ^{xii} Wynn, Barbara O.; Smalley, Robert; Cordasco, Kristina M.. [Does It Cost More to Train Residents or to Replace Them?](#)A Look at the Costs and Benefits of Operating Graduate Medical Education Programs, 2013, Rand Corporation http://www.rand.org/pubs/research_reports/RR324.html Accessed May 2014
- ^{xiii} American College of Physicians. Aligning GME Policy with the Nation's Health Care Workforce Needs. Philadelphia: American College of Physicians; 2011: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)
- ^{xiv} Excerpted from the Balanced Budget Act of 1997, Section 4628. <http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/html/PLAW-105publ33.htm>. Accessed May 15, 2014.



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Phase/Timeline	Task	Budget	Responsible	Notes
Phase 1: Project initiation May, June 2014	Prepare proposal for Moda Health		HCWF Comm.	HCWF Committee and state staff will develop a proposal as well as policy options for the Oregon Health Policy Board
	Establish list of consultants for AHEC SW to interview for project management		HCWF Comm.	
Total		In-kind		
Phase 2: Planning July 2014 – Sept. 2014	Convene consortium stakeholders	\$20,000	GME Consultant	AHEC Southwest will host the planning process and provide the financial structure and fiduciary accountability until the consortium is established.
	Explore business models		GME Consultant	
	Develop strategic plan		GME Consultant	
	Determine funding, levels of investment by partners		GME Consultant	
Total		\$20,000		AHEC Southwest will host the planning process and provide the financial structure and fiduciary accountability until the consortium is established.
Phase 3: Consortium Development Oct. 2014 – Dec. 2014	Incorporate consortium as a 501C3 or other business entity	\$70,000	Legal	AHEC Southwest will hire the attorneys to develop the structure for the consortium such as a 501C3. When the consortium infrastructure is established, funding can run through it to the consultants and employees.
	Recruit Board members		GME Consultant	
	Finalize strategic plan, funding formula for partners		GME Consultant	
	Develop bylaws		GME Consultant/Legal	

Phase/Timeline	Task	Budget	Responsible	Notes
	Recruit and hire Consortium Coordinator		Board	
			Board	
	Legal consultation by Board/Consortium members		Legal	
Total		\$70,000		This includes \$50,000 in legal fees and \$20,000 in consultant fees
Phase 4 (a): Program Development – consortium creates and manages first residency program Jan. 2015 – Dec. 2015	Recruit and hire Residency Program Director		Board	
	Apply for accreditation		CC and RPD	This process can take up to 18 months for approval.
	Develop consortium infrastructure including payroll, HR, finance, management	\$400,000	RPD	
	Recruit faculty, hire staff		RPD	
	Develop curriculum		RPD	
	Recruit residents		CC	Resident recruitment needs to begin prior to full accreditation for this timeline to be accurate.
Total		\$400,000		This amount includes salaries, operations, application expenses, expert consultation, and any remaining legal fees until Medicare GME payments begin. Medicare payments don't begin until the first residents are in their third year.

Phase/Timeline	Task	Budget	Responsible	Notes
Phase 4 (b): Program Development – consortium supports hospital, FQHC, health system, etc., in development of residency program(s) Jan. 2015 – Dec. 2015	Consortium Coordinator (CC) manages, or assists hospitals to manage application of program(s) for accreditation		CC	
	CC hires consortium staff		CC	
	CC assists residency program(s) in recruiting faculty and developing curriculum	\$200,000 (first year only)	CC	
	CC distributes incentive funds to new residencies for start-up costs – up to \$50,000 per program	\$200,000		
Total		\$400,000		Budget for ongoing consortium expenses determined by scope of consortium responsibility and FTE required. This amount could be funded through a “pay to play” model requiring a yearly assessment for expenses from consortium members.

Total Phase 1 budget: In-kind – Healthcare Workforce Committee, OHA

Total Phase 2 budget: \$20,000 for GME consultant – includes fee plus travel and expenses

Total Phase 3 budget: \$70,000 for legal fees and GME consultant – includes fees plus travel and expenses

Total Phase 4 budget: \$400,000 for primary care residency program start-up costs and first year consortium development support

**Health Care Workforce Committee
Report on Financial Incentives in Oregon**

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I. Introduction

Building a strong health care workforce for Oregon remains a critical task. For several years, the state has faced shortages of health care workers in many, traditionally underserved areas of the state. Now in 2014, some systems are struggling to find an adequate number of providers to serve the large number of Oregonians who have gained health insurance coverage as a result of the Affordable Care Act.

Oregon, like many states, offers an array of various financial incentives to help address existing and anticipated shortages of health care providers. The Oregon Health Policy Board has directed the Health Care Workforce Committee (HCWC) to prepare a report “on the range of incentive programs designed to encourage providers to practice in underserved areas or with underserved populations in Oregon. The report should: a) recommend criteria for monitoring the programs and evaluating their outcomes and effectiveness; and b) suggest strategies for sustaining, expanding, and/or re-targeting the programs as necessary.”

This report will: provide a summary of the evidence on effectiveness of different kinds of incentives; describe the array of financial incentive programs currently available in Oregon; and make recommendations for evaluating and prioritizing these programs in the future.

II. Background on Financial Incentive Programs

The World Health Organization defines incentives as “all the rewards and punishments that providers face as a consequence of the organizations in which they work, the institutions under which they operate and the specific interventions they provide.” Incentives are the factors and/or conditions within health professionals’ work environments that can be used to enable and encourage them to stay in their job location and in their professions. Incentives have been shown to be an important means of attracting and retaining healthcare workers to locations that may be less generally appealing to many professionals.

Incentives can be positive or negative (disincentives) and can be financial or non-financial. Although non-financial incentives (such as work autonomy, schedule flexibility, career development opportunities, and educational and career opportunities for children and spouses) can have a powerful effect, the focus of this report is financial incentives. Financial incentives involve monetary value, such as salaries, pensions, bonuses, allowances, loans, etc. Among the most common types of financial incentives for health care providers are:

- Loan Repayment – through which a provider is offered money to help pay for student loans that have already been incurred, in return for a period of work typically in an underserved location.
- Loan Forgiveness – in most cases, loan forgiveness programs subsidize a student’s educational costs directly in return for future service.
- Tax Credits – through which a provider receives a credit directly against tax liability.
- Insurance Subsidies – through which a portion of a provider’s malpractice insurance premium is covered by an outside source.
- Relocation Costs – through which employers contribute funds toward the cost of a newly hired provider relocating from a different area.
- Signing bonuses – which are one-time payments made by the employer to incentivize acceptance of an offer.
- Employer financial support for continuing education or advanced training.

Financial incentives may be designed to recruit providers to a given area, to retain providers who are already working in an area, and/or to increase the supply of providers in a specific specialty or discipline regardless of where they work. The nature of programs that include a service obligation is that providers face a decision at the end of their required service: whether to remain practicing in the underserved area—at the practice site where they had received their incentive or another site—or to move to another area where pay and other conditions may be more favorable.

Financial incentives are usually directed specifically at the healthcare provider. Whether a provider chooses to stay in an area following the end of the incentive can be influenced by a number of factors, including a clinician’s age, gender, location of the practice, their family situation, sense of belonging in the community, satisfaction with the practice’s administration, and their total compensation package. Other significant factors can include the prevailing workforce availability, economic conditions, availability and quality of local services.

III. Summary Review of Available Evidence

Financial incentive programs to direct providers to underserved areas and populations are widely used (Pathman, 2013). At the federal level, the National Health Service Corps (NHSC) currently provides loan repayment awards to over 11,000 primary care, dental and medical health providers in underserved areas. Nearly every state in the country has health care providers who receive federal NHSC dollars. Most states also have one or more state loan repayment programs (either the federal State Loan Repayment Program [SLRP] or state-funded

loan repayment or both) which are also used to incentivize providers to practice in areas with a low supply of providers.

There are fewer studies of the impact of health care provider incentive programs than might be expected but the published evidence suggests that they can be effective in attracting providers to and keeping them in underserved areas. Physicians who participate in state loan repayment and similar incentive programs are more likely than their peers to practice in needy areas and to serve Medicaid and uninsured patients (48% vs. 28%). They also tend to remain longer in their positions (Pathman, 2004). Participants in loan repayment programs are also more likely than non-participants to continue to practice in underserved areas even after their service obligation expires, although it may not be the same area as their original placement (Barnighausen & Bloom, 2009; Colegrove, 2009). Rural participants in loan repayment programs tend to remain in their service areas longer than their urban counterparts after the obligation period (Pathman, 2012).

Some programs have made concerted efforts to increase provider retention after an obligated service period and have seen clear results. For example, only 26 percent of NHSC providers stayed in their given area more than two months past their service commitment in the 1980s, while in 2012 that number had risen for 71 percent. The Obama Administration funded a nearly \$20 million initiative in the early 2000s to learn how states and communities can expand their ability to retain providers in underserved areas after participation in a financial incentive program concludes. Oregon was one of the states that participated in this effort. Oregon completed its two-year grant with 84 percent of those who had completed their service remaining practicing in underserved areas. (Length of retention ranged from 3 to 18 months at the time of measurement.) The average retention among all states participating in the project was 76%. Oregon's above average results are attributed in large part to outreach efforts to the health care providers serving in the identified cohort, and support and general interest provided for their program participation.

Retention after a service commitment often depends more on general job satisfaction than with compensation. An 11-state collaborative that surveyed more than 1,500 obligated health professionals in 2012 found that relationship with the practice administration, a sense of belonging in the community, and alignment with the mission and goals of the practice all predicted retention more strongly than financial remuneration (Pathman, 2012).

Tax credits are less expensive than loan repayment on an annual basis but there does not appear to be any published evidence regarding the relative effectiveness of tax credits and other incentives. According to a GAO report, states that offer an array of diverse provider incentive programs are more likely to attract providers to areas in need than states with just one or two incentive programs. (US GAO, 1995).

IV. Brief Description of Current Incentive Programs in Oregon

As context for the rest of the report, this section provides brief descriptions of the array of provider financial incentive programs currently available in Oregon.

Programs in Oregon using *state* funding include:

- Rural Medical Practitioners Insurance Subsidy Program
- Medicaid Primary Care Loan Repayment Program
- Scholars for a Healthy Oregon Program (Loan Forgiveness)
- Oregon State Loan Forgiveness Program
- Rural Practitioner Tax Credit
- EMT Tax Credit

Programs in Oregon using *federal* funding include:

- Oregon State Partnership Loan Repayment Program (SLRP)
- National Health Service Corps (NHSC) Loan Repayment
- National Health Service Corps (NHSC) Scholarship Program
- Nurse Corps (NELRP) Loan Repayment Program
- Federal Faculty Loan Repayment Program

Additionally, there are many employer-funded and –specific financial incentive programs designed to recruit and retain health care professionals working within their organizations. Because such programs contribute to employers’ competitive advantage, it is difficult to obtain information about their size and scope.

See Appendix A for a complete matrix of the above programs, including annual funding, number of participants in the program, financial benefit per participant, total annual cost, administrative costs, program performance measures, and other factors.

- **The Rural Medical Practitioners Insurance Subsidy Program** is authorized under ORS Chapters 676.550-676.556, and administered by the Oregon Health Authority (OHA). The program was first established in 2003. The program exists to provide subsidies to qualifying physicians and nurse practitioners in rural areas to offset the cost of medical malpractice insurance. In 2013 there were 655 providers whose insurance premiums were subsidized through the program.
- **The Medicaid Primary Care Provider Loan Repayment Program** was authorized under SB 440 (2013) and established in the Oregon Health Authority (OHA). The impetus for this program was Oregon's 2012 waiver with the Centers for Medicare and Medicaid services, in which Oregon agreed to provide loan repayment for providers serving Medicaid patients to support Oregon's health system transformation and its expansion of Medicaid. It is estimated that approximately 50 providers will receive awards from the funding provided by the legislature. Total funding for the program was \$4 million for 2013-15.
- **The Scholars for a Healthy Oregon Program** was established by the 2013 legislature, to address the high cost of medical education and the mal-distribution of health care providers around the state. The program offers full tuition and fees to 21 OHSU medical, physician assistant, dental and advance practice nursing students who begin in the 2014-15 academic year. Students then have a service obligation for an equivalent number of years, plus one, for each year of support received. Service must be completed in an OHSU approved underserved site. Total funding for the program was \$2.5million for 2013-15, allowing an anticipated 21 students to receive awards.
- **The Oregon State Loan Forgiveness Program** was established in 2010 to meet workforce needs in rural Oregon for the following professions: Primary Care Physician, Physician Assistant, Master of Nursing and Doctor of Nursing Practice, General Surgery and Psychiatry. Students who are enrolled full-time as second or third year students in an approved Oregon rural training track are eligible to apply for up to 3 years of funding. Typical awards are \$35,000 per year. Legislative funding for the 2013-15 biennium is \$700,000, including \$200,000 from the 2014 Session.
- **The Oregon Rural Practitioner Tax Credit** was first established in 1989, to encourage medical providers to serve the health care needs of rural Oregonians. Eligible medical providers, optometrists, and dentists receive a \$5,000 credit annually for maintaining a rural practice. Providers pay a \$45 application fee to the Office of Rural Health to participate in the program. The Oregon Legislative Revenue Office estimates that approximately 1,800 providers use the credit each year, with a revenue impact to the State General Fund of between \$16-17 million per biennium. The program is open to those practicing full-time and part-time, as well as to providers who are not full-time Oregon residents.

- **The Volunteer Rural EMT Tax Credit** was first enacted in 1989 to provide a \$250 tax credit for emergency medical responders in areas 25 miles or more from a population center of 30,000, in recognition of their voluntary service to rural Oregonians. According to the Oregon Department of Revenue, \$300,000 in tax credits were used in the 2011-13 biennium, and approximately 600 rural emergency responders took advantage of the credit.
- **The State Loan Repayment Program** allows primary care providers serving in Health Professional Shortage Areas (HPSAs)¹ to receive financial awards to help offset the cost of their health professional loans. As the program is configured in Oregon, 50 percent of the loan repayment comes from federal sources through the State Office of Rural Health; matching community funds (including clinic funding) provide the additional 50 percent of the funds to the provider. In 2013, there were a total of 15 providers receiving awards under the SLRP.
- **The National Health Service Corps (NHSC) Loan Repayment Program** allows primary care providers at an NHSC-approved site to receive up to \$25,000 annually in loan repayment for at least two years of service. Sites must not deny service to anyone due to an inability to pay, and must offer a sliding fee schedule for those below 200 percent of the Federal Poverty Level. The number of Oregon providers receiving NHSC LRP increased from 124 in 2010 to 192 in 2013. More than \$3.6 million was awarded to clinicians serving in underserved areas within Oregon in 2013.
- **The NHSC Scholarship Program** awards scholarships to students pursuing primary health care professions training in NHSC-eligible disciplines in return for a commitment to provide health care to communities in need, upon graduation and the completion of training. In return for each school year, or partial school year, of financial support received, students agree to provide primary health care services for one (1) year at an NHSC-approved site located in a high-need Health Professional Shortage Area (HPSA). There were 20 NHSC Scholarship participants from Oregon in 2013, and HRSA paid a total of \$1.2 million to these providers that year.
- **The NURSE Corps Loan Repayment Program** eases the student debt burden of registered nurses who work in health centers, rural health clinics, hospitals and other types of facilities currently experiencing a critical shortage of nurses. The program repays 60 percent of the

¹ Health Professional Shortage Areas (HPSAs) are codified in federal statute as the primary means of determining the severity of need of an area or population for health professionals for federal purposes. States analyze provider data and other factors that impact access, and apply for designation of a HPSA to the federal government. HPSA designations and the accompanying scores that show greater or lesser shortage are used to make awards for a variety of state and federal programs related to health care workforce.

outstanding balance in exchange for 2 years of full-time service at an eligible facility. Participants may be eligible to receive an additional 25 percent of the original loan balance for an additional year of full-time service in a critical shortage facility. A funding preference is given to RNs with the greatest financial need. Oregon had 101 nurses participating in the program in 2013, with a federal financial commitment of approximately \$2 million.

- **The Faculty Loan Repayment Program** is a loan repayment program for health professions graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university. In exchange for at least 2 years of service, the Federal government pays up to \$40,000 of the outstanding principal and interest on the individual's health professions education loans. The employing institution matches the loan repayment unless it is determined the matching requirement would impose an undue financial hardship on the institution. Two faculty members in Oregon received awards under this program in 2013, costing \$44,000 in federal revenue.

See Appendix A for a complete matrix of the above programs, including annual funding, number of participants in the program, financial benefit per participant, total annual cost, administrative costs, program performance measures, and other factors.

V. Description of Current Incentive Programs in Selected Other States

Other states offer a variety of levels and types of incentives —ranging from no programs to a diverse and well-funded set of financial incentives. In comparison with other states, Oregon falls in the higher range of both the sheer number of programs as well as investment per capita (of population, not awardees). Some representative samples of state-funded financial incentives, selected based on availability of information are as follows:

Arizona currently operates a State Loan Repayment Program (SLRP) of approximately \$350,000, funded through the Office of Rural Health and Primary Care, which funds about 15 providers annually. Funding for the non-federal portion of the program comes from their State General Fund. Additionally, the office administers a very small Rural Practice Provider Loan Repayment Program (\$150,000 in funding), with about 5 awardees at any one time. Both programs require sites to adhere to the National Health Service Corps (NHSC) standards. A Loan Forgiveness program did exist until 2012, but was defunded due to state budget shortfalls. Payments from this program by providers in default are credited back to the office and are being used to help fund the state share of the SLRP in future years. Behavioral Health providers are not eligible for any of Arizona's programs.

Illinois offers no financial incentive programs for health professionals, outside of the federally funded programs administered by the Bureau of Clinician Recruitment and Service. The state has applied for SLRP funds, which will begin in 2014.

Kansas administers a small state-funded loan repayment program of \$250,000 per year through their State Office of Rural Health and Primary Care. Providers qualify for annual awards of \$25,000 per year for a physician and \$20,000 per year for other disciplines. In the last program year, the state awarded a total of 5 new awards and 3 continued awards to providers who had completed their initial two years of service. Although Kansas has a “clawback” provision requiring heavy penalties from defaulting providers, no provider has defaulted to date, and it has not been used. Additionally, the University of Kansas Medical Center, Rural Health Education and Services (RHES), administers the Kansas Bridging Plan (KBP), a loan forgiveness program (up to \$26,000) offered to physicians in Kansas residency programs of Family Practice, Internal Medicine, Pediatrics and Medicine/Pediatrics in most counties in exchange for 3 years of continued service upon completion of their residency program, a Student Loan Program that allows 30 entering students per year the opportunity to receive tuition, room and board and a stipend in exchange for an equal number of years of service in an underserved area of the state. Finally, the university offers what is known as a “retroactive” loan repayment program, funded from the unspent Student Loan Program dollars whenever students default.

Montana offers two programs for primary care providers: The Montana Rural Physician Incentive Program (MRPIP) administered by the Higher Education Commissioner’s Office which offers medical education loan repayment assistance to approved physicians who practice in rural or medically underserved areas of the state or who serve underserved populations. The maximum amount of education debt repayment a full-time physician may receive is \$100,000 spread over a 5-year period of service. Proportionately reduced repayment amounts are also available for physicians who practice less than full-time. Also, for providers who do not receive an award under MRPIP and who apply unsuccessfully for NHSC, a small State Loan Repayment Program, administered by the Primary Care Office within the State Department of Health, makes available awards to 10 new providers per year. Funding from the State Legislature of \$75,000 per year is matched with \$75,000 in federal funds. Currently, the state has 22 providers participating in the program.

Nebraska offers both a scholarship program and a loan repayment program funded with state dollars. The Nebraska Student Loan Program provides forgivable student loans to Nebraska medical, dental, physician assistant, and graduate-level mental health students who agree to practice an approved specialty in a state-designated shortage area. The Nebraska Loan Repayment Program assists rural communities in recruiting and retaining primary care health professionals by offering state matching funds for repayment of health professionals’ government or commercial educational debt. Awardees receive up to \$40,000 in combined state and matching local funds. As of September 2013 a total of 96 awardees were participating in the two programs combined.

Oklahoma does not administer a SLRP, but does offer a Dental Loan Repayment Program through the State Office for Health, for up to 25 dentists who are eligible to receive \$25,000 per year. Total funding from the legislature is \$750,000.

South Dakota does not offer any loan forgiveness or loan repayment programs or other financial incentives to providers through state government. The University of South Dakota does offer programs that offer direct financial incentives to health care providers practicing in remote areas. One program provides qualifying physicians, dentists, physician assistants, nurse practitioners or nurse midwives an incentive payment in return for three continuous years of practice in an eligible rural community. Physicians and dentists receive \$154,796 for the three year period. The amount of the incentive payment for a qualifying physician assistant, nurse practitioner or nurse midwife is \$35,956. Another program allows other professions (including dietitians and EMT professionals) to receive a one-time \$10,000 payment upon completion of a three year commitment.

Pennsylvania offers a robust state-funded loan repayment program through their State Department of Health using a legislative appropriation of \$600,000. Their program makes available loan repayment of \$64,000 for physicians and dentists over the four-year contract, or \$40,000 for Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives. The state is in the process of re-designing their program and is anticipating a significant state budget increase in the next fiscal biennium to \$2.8 million for the 2014-15 biennium. They will move to a 2 year contract and increase the award for that contract to: \$100,000 for Physicians/Dentists over the 2 years; \$70,000 for PA's, NP's, CNM's and add the following in this category - Dental Hygienist, Licensed Professional Counselors, and Psychologists.

Vermont, a state often compared with Oregon due to its innovative health care system has not had a SLRP, although it applied for one for the first time this year through HRSA. It will be administered by the State Office of Rural Health and Primary Care. Like Oregon, they are taking an approach of asking the local sites to provide the match to the federal SLRP dollars. Where this is not possible the State will match the balance, from its State Education Trust Fund. Vermont also has an annual \$100,000 legislative appropriation, which they subgrant to the Vermont Student Assistance Corp., which goes to dentists, dental hygienists, and nurses. There are currently 12 participants in the program. Finally, the Office receives a legislative appropriation of \$870,000 which is subgranted to the AHEC program office at the University of Vermont to administer the Educational Loan Repayment Program. Approximately 20 awards are made annually, with award amounts varying.

Washington, Oregon's neighbor to the north and sometimes competitor for health professionals has a small State Loan Repayment Program, administered by the Primary Care Financial Incentives Report Draft for Workforce Committee Consideration—5.30.14

Office, (around 20 participants annually) and a much larger Health Professional Loan Repayment Program, which is open to licensed physicians, nurse practitioners, physician assistants, nurse midwives, pharmacists, dentists, dental hygienists and registered nurses. In 2012, awards were made to 120 providers. Total funding for these awards, all from state general funds, was \$4.2 million. The Health Professional Loan Repayment Program is administered by the Washington Student Achievement Council.

Wyoming has a fully-state funded loan repayment program called the Wyoming Healthcare Professional Loan Repayment Program. It provides up to \$90,000 (\$30,000/year for 3 years) for physicians and dentists and up to \$30,000 (\$10,000/year for 3 years) for all other licensed/certified health professions. Total annual funding for the program is \$500,000. Approximately 10 awards across all professions are funded each year. Wyoming is also applying for federal SLRP funds for the first time, and anticipates a total of \$160,000 in federal and state general funds to provide awards for 4 providers for four years each. Physician awards will be \$60,000 in exchange for two years of service, and mid-level awards will be \$20,000 in exchange for two years of service. Additionally, Wyoming has the Wyoming Physician Recruitment Grant Program, also administered by the State Office of Rural Health. This program, the only one of its kind in the nation, provides grants of up to \$80,000 to a hiring entity to reimburse the costs of recruiting an approved physician from outside of Wyoming. The program has been funded at \$400,000 per biennium.

VI. Observations on Financial Incentive Programs in Oregon

Financial incentive programs are not currently designed to complement one another. Historically, provider financial incentive programs have been developed separately to respond to an identified need without always taking other similar programs into account. In Oregon, for example, the Rural Practitioner Tax Credit may be used alongside loan repayment programs as well as the Rural Provider Malpractice Insurance Subsidy. The impact is that a provider may be receiving \$40,000 annually in loan assistance in addition to having a portion of his or her medical insurance premium paid and receiving a \$5,000 tax credit. The broader observation is that because program rules and eligibility criteria are designed and applied independently, the resources of financial incentives may be spread unevenly or inefficiently.

There is a lack of systematized data collection to measure programs' effectiveness. Data on programs' operations and impact are not collected consistently from one program to another nor are they readily obtained, although some can be found upon research. Operational data elements like number of participants, average amount of award, and location of participating

providers are more commonly reported than outcomes such as post-program retention or impact on local workforce capacity. The Oregon Healthcare Workforce Institute (OHWI) has conducted a four-year review of National Health Service Corps participants (along with the participants in the J-1 Physician Waiver Program—a non-financial incentive program for foreign physicians completing residencies in the US.), but this review is somewhat unique among the existing financial incentive programs benefitting Oregon providers (Oregon Healthcare Workforce Institute, 2014). Even where data are available, programs typically do not set and report on their progress against performance targets.

Differing definitions of need may make it hard to compare the benefits of the programs. In Oregon, for instance, we have at least two definitions of need: The legislature has authorized the State Office of Rural Health (ORH) to develop an assessment of need for rural areas and to use these measurements in allocating ORH-controlled funds. The federal government has a distinct system of Health Professional Shortage Area designations, which it uses to allocate federal resources. Other programs assess need based on their specific purposes (e.g. serving Medicaid beneficiaries or ensuring that the cost of malpractice insurance is not a barrier to rural practice).

There is no overarching “review” or governance of the array of provider financial incentive programs. State-funded program responsibilities are spread across various agencies, although the State Office of Rural Health has an administrative role in most. Federally funded programs are managed separately. At the operational level, Oregon has increased coordination over the last several years through an informal Healthcare Workforce Recruitment and Retention Partnership. However, executive review and oversight across programs has been limited to legislative renewal of state funded programs and Congressional allocations.

VII. Recommendations (to be further developed with Healthcare Workforce Committee input)

- 1) *Adopt a set of overarching principles for provider financial incentive programs.* These principles should be applied in any decision-making process sustaining, expanding, and/or re-targeting programs. Potential principles include these:

For program design:

- Seek input from relevant stakeholders in the design phase to help ensure that the program will reach and motivate the target population

- Use all available data to target program to greatest need, and to adjust the design as needs change
- Complement rather than duplicate other incentive programs, contributing to a diverse portfolio of resources to attract, recruit and retain health care providers in areas that need them
- Leverage non-state resources and attempt to limit state investment to areas where funding cannot be found elsewhere
- Size programs appropriately, and size the incentives offered by the programs appropriately.

For program operations

- Maintain reasonable per-capita costs and administrative overhead
- Ensure that program administration is transparent, fair and consistent
- Ensure that organizations overseeing and administering programs have and the resources needed to be successful.

2) *Track program performance and use that information to help ensure program effectiveness.*

Topics for potential measures include:

- Severity of need in the area and among the population benefitting from the program
- Number of providers able to participate
- Number of patients served by participating providers
- Administrative costs of the program (relative to the overall costs of the program as well as per participant)
- Success record of the program in placements and retention over time

Appendix A includes various data points on the current provider incentive programs in Oregon and could provide a starting point for identification of specific measures and collection and analysis of data. See also Recommendation 6 below.

3) *Support the development a consistent and crosscutting methodology all partners can use to identify “need” for health professionals.*

The differing definitions of “need” have emerged over time. Oregon should agree on a common formula for determining need, based on factors which include travel time to available sources of care, population demographics that can predict utilization and access concerns, and provider-to-population ratios that incorporate all relevant provider types and specialties.

4) *Set program performance targets for programs where possible.*

It is recommended that targets be developed with the involvement of both those stakeholders benefiting from the programs as well as those administering and/or accountable for the programs. Consequences for falling short of targets or incentives for exceeding them should also be carefully considered. Examples of targets could include: no program may spend more than a certain, reasonable percentage of its total revenue on administration; or minimal standards for how many patients an obligated service provider is expected to see. Because Oregon does not have the direct ability to set standards for federally funded programs, state officials should work closely with federal partners to maximize alignment.

5) *Evaluate programs on a regular basis for continued effectiveness once measures and targets (where appropriate) are set.*

It is recommended that programs be evaluated on a two-year cycle. However, it is important to note some programs require a longer time period before some of the *benefits* are realized. For example, the Scholars for A Healthy Oregon Program offers tuition assistance to students as they begin their professional study in fields like nursing or medicine. Given the length of training, it will be 4-8 years before the awardees will begin their service obligations and even longer before data will be available on whether participants remain in underserved area after that obligation has been met. (Also, see Recommendation 6 below).

6) *Support system-wide data collection and analysis.*

While agencies currently track various elements of their programs' performance, the lack of consistency and comparability makes it difficult for policymakers and others to consider the suite of programs as a whole. The Oregon Healthcare Workforce Institute (OHWI) is a statewide organization with a track record of cross-program and cross-discipline analysis and could likely perform this task in an objective manner. One potential solution to the challenge of funding data collection could be to earmark a small percentage (e.g., 2 percent) of each program's allocation for measuring performance and effectiveness over time, and authorize data collection and analysis by one agency such as OHWI.

7) *Direct stakeholders who support and administer provider financial incentive programs to meet periodically to compare results and share information.*

This report was created in part because policymakers had expressed the need for an overarching view of financial incentives programs. Many stakeholders have an interest in

seeing how well the individual pieces are working and whether they are supporting or detracting from the effectiveness of the other components. An annual gathering and review could include both sharing of best practices on what is working as well as candid discussion of where efforts are not producing the intended result of an increased supply of workers in areas of need. This would benefit both policy makers and the organizations administering the programs. The Healthcare Workforce Committee or the Oregon Healthcare Workforce Institute could offer a forum for such collaboration.

VIII. Conclusion

Financial incentive programs can offer supports for recruitment and retention of health providers in areas where they are needed and regular “market forces” do not result in an adequate supply of health professionals. In comparison with other states, Oregon offers a reasonable number and diversity of financial incentive programs, although many states make a much larger overall investment.

In terms of making the greatest use of limited funds, there is much more Oregon can do, particularly in the systematic collection of program data to determine ongoing effectiveness of financial incentive programs, the establishment of accepted, system-wide determination of “need” and in the establishment of program and system performance targets to ensure that programs remain accountable and effective.

The Committee appreciates the attention of the Oregon Health Policy Board on this matter, and is happy to continue to work on behalf of the Board in this matter as directed.

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APPENDICES

- A. Matrix of Oregon Financial Incentive Programs--Purposes, Participants, Performance Measures and Costs
- B. Oregon Healthcare Workforce Institute, Oregon's Obligated Service Providers 2013
- C. Links to Oregon Program Administrative Rules and Statutory References
- D. Description and Matrix of Other State Financial Incentive Programs

DRAFT

State and Federally Funded Primary Ca

Program	Entities Responsible:	Description	Purpose	Maximum Award Duration	Who Qualifies:	Requirements
<p style="text-align: center;">Rural Medical Practitioners Insurance Subsidy Program</p>	<p>* OHA/DMAP for Oversight and funding * ORH for administration</p>	<p>Physicians and Nurses working in rural areas of the state are eligible for a subsidy of their professional liability insurance premiums.</p>	<p>Recruitment and Retention of Rural Providers</p>	<p>Annual, Renewable</p>	<p>Physicians and Nurse Practitioners serving Medicare and Medicaid patients in rural Oregon in proportion to their community's percentages</p>	<p>Providers with insurance policies of at least \$1 million per occurrence and \$1 million aggregate.</p>
<p style="text-align: center;">Rural Provider Tax Credit</p>	<p>* ORH for maintaining provider list * OR Department of Revenue also for administering credit</p>	<p>\$5,000 tax credit for providers in rural areas</p>	<p>Recruitment and Retention of Rural Providers</p>	<p>Annual, Renewable</p>	<p>Physician (MD/DO), Podiatrist (DPM), Dentist (DMD/DDS), Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA) and Physician Assistant (PA), Optometrists</p>	<p>Providers at Type A, Type B, certain Type C Hospitals and certain providers whose practice is at least 60% rural patients.</p>

Program	Entities Responsible:	Description	Purpose	Maximum Award Duration	Who Qualifies:	Requirements
Volunteer Rural EMT Tax Credit	* ORH for maintaining provider list * OR Department of Revenue also for administering credit	Tax credit for Emergency Medical Services Providers who volunteer their services to eligible Oregon communities.	Encourage volunteerism of EMS.	Annual, Renewable	Emergency Medical Responder, EMT Basic, Advanced EMT, EMT-Intermediate and Paramedic	Amount of reimbursement for EMS cannot exceed \$3m000 per calendar year or 25% of gross annual income
National Health Service Corp (NHSC) LRP	* HRSA for funding and federal administration; * OHA/PCO for recommendation of approval of sites and outreach within state	Primary care providers working at an NHSC approved site with a HPSA score of 14 or above can receive loan repayment towards qualified education loans. <i>*Minimum HPSA score may vary depending on application cycle.</i>	Recruitment of providers to underserved areas	2 years, with the option to apply for a continuation (up to 7 years). Participants can be full-time; minimum 40 hrs/week, no fewer than 4 days/week or half-time; minimum 20 hrs/week, no fewer than 2 days/week.	Physician (MD/DO), Dentist (DMD/DDS), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Registered Dental Hygienist (RDH), Health Service Psychologist (HSP), Licensed Clinical Social Worker (LCSW), Psychiatric Nurse Specialist (PNS), Marriage and Family Therapist (MFT) and Licensed Professional Counselor (LPC).	US citizen or national, practicing in a qualified discipline, licensed to practice in the state, qualifying education loans and must work in a NHSC approved facility.
National Health Service Corp (NHSC) SP	* HRSA for funding and federal administration; * OHA/PCO for recommendation of approval of sites and outreach within state	Scholarships are awarded to students pursuing primary health care professions training in eligible disciplines in return for a commitment to provide health care to communities in need, upon graduation and completion of training.	Recruitment of providers to severely underserved areas	For each school year, or partial school year of financial support received, students agree to provide primary health services for one year at an approved NHSC site located in a HPSA.	Physician (MD/DO), Dentist (DMD/DDS), Nurse Practitioner (NP), Certified Nurse Midwife (CNM) and Physician Assistant (PA)	US citizen or national enrolled or accepted in the eligible primary care disciplines' degree program at a US accredited school.

Appendix A: Matrix of State and Federally Funded Financial Incentive Programs in Oregon

Program	Entities Responsible:	Description	Purpose	Maximum Award Duration	Who Qualifies:	Requirements
Nursing Education Loan Repayment Program (NELRP)	<ul style="list-style-type: none"> * HRSA for funding and federal administration; * OHA/PCO for recommendation of approval of sites and outreach within state 	<p>NELRP helps to alleviate the critical shortage of nurses by offering loan repayment assistance to RNs and ANPs, in exchange for a commitment to work at a critical shortage facility. Nurse faculty can also receive loan repayment if they work full-time at an accredited school of nursing.</p>	Recruitment of nurses in underserved areas	A minimum of 2 years of service is required, with the option of a third year of service available.	Registered Nurse (RN) and Advanced Nurse Practitioner (ANP)	<p>Must be a licensed RN or ANP, employed full-time (minimum of 32 hrs/week) at a public or private non-profit critical shortage facility. Faculty must be employed as a full-time nurse faculty member at a public or private non-profit school of nursing.</p>

Program	Entities Responsible:	Description	Purpose	Maximum Award Duration	Who Qualifies:	Requirements
<p>Oregon Partnership State Loan Repayment Program (SLRP)</p>	<p>* HRSA for funding to state * OR Office of Rural Health for administration of program</p>	<p>This program is a loan repayment opportunity for health professionals who commit to working in a HPSA for a minimum of 2 years.</p>	<p>Recruitment of providers to underserved areas-- primarily rural</p>	<p>Minimum 2 year service commitment, with the option to apply for a 1 year extension- up to 5 years.</p>	<p>Physician (MD/DO), Nurse Practitioner (NP), Physician Assistant (PA), Dentist (DMD/DDS), Registered Dental Hygienist (RDH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC) and Psychologist (PSY)</p>	<p>US citizen, must work full-time (minimum 40 hrs/week) at an approved site in a HPSA.</p>
<p>Federal Faculty Loan Repayment Program</p>	<p>* HRSA for funding and federal administration; * OHA/PCO for recommendation of approval of sites and outreach within state</p>	<p>Faculty members from disadvantaged backgrounds with a professional health care degree or certificate may receive loan repayment assistance in exchange for teaching at educational institutions that provide training for health care professionals.</p>	<p>Support for nursing faculty with disadvantaged backgrounds</p>	<p>Minimum 2 year contract; participants can apply for sequential contracts.</p>	<p>Physician (MD/DO), Registered Nurse and Nurse Practitioner (RN/NP), Dentist (DMD/DDS), Registered Dental Hygienist (RDH), Physician Assistant (PA), Mental Health professions (Clinical Psychology, Clinical Social Work, Marriage and Family Therapy, Professional Counseling), Audiology, Optometry, Occupational and Physical Therapy (OT/PT), Pharmacy, Podiatry, Speech Language Pathologist (SLP), Medical Laboratory Technology, Radiologic Technology, Dietician, and Veterinary disciplines.</p>	<p>US citizen or national, school produced certification to demonstrate disadvantaged background, full-time or part-time faculty position for a minimum of 2 years.</p>

Appendix A: Matrix of State and Federally Funded Financial Incentive Programs in Oregon

Program	Entities Responsible:	Description	Purpose	Maximum Award Duration	Who Qualifies:	Requirements
<p>Oregon State Loan Forgiveness Program</p>	<p>OR Office of Rural Health</p>	<p>This loan forgiveness program provides loans to students studying to be physicians, nurse practitioners or physician assistants who are committed to working in a rural area. This program focuses on the idea that rural communities may be able to "grow" their own by identifying star students who want to become medical professionals.</p>	<p>Recruitment of providers to rural areas</p>	<p>For each year that loans are received, participants agree to practice in a rural setting in Oregon, at a pre-approved site.</p>	<p>Physicians (MD/DO), Physician Assistant (PA), and Nurse Practitioner (NP)</p>	<p>US Citizen or national, must have completed the first year of education in a qualified discipline, and must complete a service agreement that outlines their commitment to practicing in a rural service following their training and residency.</p>
<p>Primary Care Services Loan Repayment Program (currently unfunded)</p>	<p>OR Office of Rural Health</p>	<p>Program designed to help provide supports for clinicians to serve in underserved areas, particularly rural.</p>	<p>Recruitment of providers to underserved areas</p>	<p>For NP and PA participants, there was a 2 year commitment, with an option of completing up to 4 years. For all other disciplines, there was a minimum of 3 years, with an option of continuing up to 5 years.</p>	<p>Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Dentist (DMD/DDS), Pharmacist (PharmD), and Naturopath (ND)</p>	<p>US citizen or national, practicing in a qualified discipline, licensed to practice in the state, qualifying education loans and must work in health professional shortage area.</p>

Program	Entities Responsible:	Description	Purpose	Maximum Award Duration	Who Qualifies:	Requirements
<p>Scholars for a Health Oregon Initiative</p>	<p>*OHSU</p>	<p>Program established to address the high cost of tuition for students and the maldistribution of providers throughout the state.</p>	<p>Support for OHSU students with high loan debt</p>	<p>Students receiving awards must agree to practice in a rural setting for one year longer than the student received funding.</p>	<p>Students in one of the following clinical degree programs: Physician (MD), Dentist (DMD), Masters of Physician Assistant Studies, Masters of Nursing (MN) in Nurse Anesthesia, Family Nurse Practitioner, Nurse Midwifery, Psychiatric Mental Health Nurse Practitioner.</p>	<p>All students in qualifying programs may apply; priority given to those considered of Oregon heritage under OHSU's admission guidelines; other priorities also apply, including diversity of background, first-generation college student, and rural heritage</p>
<p>Medicaid Primary Care Provider Loan Repayment Program (MPCLRP)</p>	<p>* OHA as accountable state agency * OR Office of Rural Health for daily administration of program</p>	<p>Program designed to meet the goals of Oregon's health care transformation, to provide financial incentives to new providers to serve Medicaid patients</p>	<p>Recruitment of providers to areas most in need of provider capacity to serve Medicaid patients</p>	<p>3 years, with the option to apply for up to an additional two years. Participants can be full-time; minimum 40 hrs/week, no fewer than 4 days/week or half-time; minimum 20 hrs/week, no fewer than 2 days/week.</p>	<p>Physician (MD/DO), Dentist (DMD/DDS), Nurse Practitioner (NP), Physician Assistant (PA), Expanded Practice Dental Hygienist, Psychiatrist, Clinical Social Worker, Marriage and Family Therapist (MFT).</p>	<p>Provider practicing in a qualified discipline, licensed to practice in the state, qualifying education loans, written commitment to serving Medicaid patients.</p>

Appendix A: Matrix of State and Federally Funded Financial Incentive Programs in Oregon

re Financial Assistance Programs Available to Clinicians in Oregon

DRAFT May 28, 2014

Award Information	Number of Participants	Targeted Service Population	State Investment (year)	Federal Investment (year)	Average Annual Award per Participant	Timeframe for Beginning Service Commitment	Data Tracked	Program Monitoring	References
80% of premiums for obstetric physicians or nurse practitioners; 60% of premiums for physicians in family or general practice certified for obstetric services; 40% of premiums for physicians in family practice, general practice, internal medicine, geriatric, pulmonary, pediatric, general surgery or anesthesiology; 15% for all other providers.	655 (2013)	Any	\$2.5 million	\$0	\$3,820	Immediately	# of carriers participating; # of providers receiving awards; amount of money distributed	Legislative Review of Program; for providers, an annual renewal of participation	Oregon Revised Statutes 676.550-676.556; Oregon Administrative Rules 410-500-000 - OAR 410-500-060.
Providers claim tax credit on annual State Income Tax return. Non- and part-year residents receive a portion of the credit.	1,800 (for any given tax year)	Any	\$8.5 million (historic annual average)	\$0	\$4700 ^b	Service Commitment began prior to financial benefit received	# of people receiving credit amount of money distributed	Legislative Review of Tax Credit; for provider, annual report on Income Tax filing	Oregon Revised Statutes 315.613, 315.616, & 315.619; Oregon Administrative Rules 572-090-030.

Award Information	Number of Participants	Targeted Service Population	State Investment (year)	Federal Investment (year)	Average Annual Award per Participant	Timeframe for Beginning Service Commitment	Data Tracked	Program Monitoring	References
Providers claim tax credit on annual State Income Tax return. Non- and part-year residents receive a portion of the credit.	approximately 600 (2012 tax year)	Communities more than 25 miles from a population center of 30,000 or more	\$150,000 (for any given tax year)	\$0	<\$250	Service Commitment began prior to financial benefit received	# of providers receiving credit, number of eligible communities, total amount awarded	Legislative Review of Tax Credit; for provider, annual report on Income Tax filing	Oregon Revised Statute 315.622.
Sites with a HPSA score of 14 or above: Full-time participants can receive up to \$50,000 for a 2 year commitment; half-time participants can receive up to \$50,000 for a 4 year commitment.	192 (2013)	Underserved populations (general population, or specific populations [homeless, low-income, migrant and seasonal farmworker, Medicaid Patients])	\$0	\$4.6 million	\$25,000	Within 60 days of award at latest, otherwise immediately	# of LRP participants overall and by state, # of full-time awardees and part-time awardees; # of continuation applications submitted; cost per site visit for interviews; % of applications received acted on within 12 days.	HRSA Program Compliance, which includes occasional participant interviews, GSA, oversight; 12-day review requirement from HRSA to determine site eligibility;	Section 338B of the Public Health Service Act (42 USC 254I-1)
Tax free payment is made (up to 4 years) for tuition, required fees and other reasonable educational costs. Scholarship recipients also receive a taxable monthly living stipend.	20 (2013)	Underserved populations (general population, or specific populations [homeless, low-income, migrant and seasonal farmworker, Medicaid Patients])	\$0	\$1.1 million (2013)	\$55,000	1-2 years	# of applicants; # of scholars placed; amount of funding	Scholar Placement process, occasional interviews by Program. For provider, submission of financial reports.	Title III, Section 338A of the Public Health Service Act (42 USC 254I)

Appendix A: Matrix of State and Federally Funded Financial Incentive Programs in Oregon

Award Information	Number of Participants	Targeted Service Population	State Investment (year)	Federal Investment (year)	Average Annual Award per Participant	Timeframe for Beginning Service Commitment	Data Tracked	Program Monitoring	References
<p>For RNs and ANPs: Funding preference will be given to nurses based on the greatest financial need, the type of facility, and the HPSA designation of the facility.</p> <p>For faculty: Funding preference is given to faculty with the greatest financial need and to faculty working at nursing schools with at least 50% of students from a disadvantaged background.</p> <p>*NELRP participants will receive 60% of their total outstanding qualifying educational loan balance for a 2 year commitment. Participants may receive an additional 25% of their original loan balance for a third year of service.</p>	101 (2013)	Underserved populations (general population, or specific populations [homeless, low-income, migrant and seasonal farmworker, Medicaid Patients])	\$0	\$1.2 million (2013)	\$1,880	Within 60 days of award at latest, otherwise immediately	# of applicants; # of awardees; amount of money distributed	HRSA Program Compliance, which includes occasional participant interviews, GSA, oversight	Section 846 of the Public Health Service Act (42 United States Code (U.S.C.) section 297n), and 42 Code of Federal Regulations (C.F.R.) section 57.312.

Award Information	Number of Participants	Targeted Service Population	State Investment (year)	Federal Investment (year)	Average Annual Award per Participant	Timeframe for Beginning Service Commitment	Data Tracked	Program Monitoring	References
<p>Participants can receive a maximum award of \$35,000 per year, or 25% of total loan debt, whichever is a smaller amount.</p>	<p>15 (2013-14)</p>	<p>Underserved populations (general population, or specific populations [homeless, low-income, migrant and seasonal farmworker, Medicaid Patients])</p>	<p>\$0</p>	<p>\$300,000 (2013)</p>	<p>\$35,000 total (half of a 2-year award of \$70,000) (Note--federal award is e matched with community dollars to equal a total award to provider. Contribution from Federal SLRP funds is 17,500 annually)</p>	<p>Within 60 days of award at latest, otherwise immediately</p>	<p># of awardees; amount of money distributed; 0% default rate since program began+\$</p>	<p>Financial reports to HRSA, including annual progress report</p>	<p>Public Health Service Act, Title III, Section 3381, 42 U.S.C. 254 q 1(h). Section 10503 of the Affordable Care Act (P.L. 111-148)</p>
<p>Participants can receive up to \$40,000 towards repayment of student loans for a 2 year service commitment.</p>	<p>2 (2013)</p>	<p>Nurses from Disadvantaged Backgrounds; underserved populations with limited access to health care</p>	<p>\$0</p>	<p>\$44,000 (2013)</p>	<p>\$22,000</p>	<p>Within 60 days of award at latest, otherwise immediately</p>	<p># of awardees; amount of money distributed; characteristics of participants</p>	<p>HRSA Program Compliance, which includes occasional participant interviews, GSA, oversight</p>	<p>Section 738(a) of the Public Health Service Act (42 USC 293b(a)</p>

Appendix A. Matrix of State and Federally Funded Financial Incentive Programs in Oregon

Award Information	Number of Participants	Targeted Service Population	State Investment (year)	Federal Investment (year)	Average Annual Award per Participant	Timeframe for Beginning Service Commitment	Data Tracked	Program Monitoring	References
Participants will receive up to \$35,000 annually for expenses related to their medical education.	5 (2013)	Medical students committing to serve rural patients; rural communities and patients	\$1 million (2013-14)	100% State Funding (\$1 million in 2013-15 biennium)	30,000/year for 2 years (2013)	1-2 years	# of participants; distribution of placement; amount of funds distributed	Legislative Oversight, review of application materials and verification of rural track program; financial forms submitted by participant	ORS 442.573
Participants could receive partial loan repayment (1/3 of the outstanding loan balance, or \$25,000), if they participated in a minimum 3 year service commitment.	N/A	Underserved rural populations	\$0 (unfunded)	\$0 (unfunded)	N/A	N/A	N/A	Legislative Oversight when program funded	ORS 442.550 - 442.565 & SB 404

Award Information	Number of Participants	Targeted Service Population	State Investment (year)	Federal Investment (year)	Average Annual Award per Participant	Timeframe for Beginning Service Commitment	Data Tracked	Program Monitoring	References
<p>Participants eligible to receive funding to cover full tuition and fees for 2014-15 student academic year. Stipends are not covered.</p>	<p>Estimates: 6 medical students, 8 nursing students, 4 PA students (total, 18 slots)</p>	<p>Any</p>	<p>\$1.25 million (2013-14)</p>	<p>\$0</p>	<p>Awards likely will range from \$37,000-\$85,000 depending on the discipline</p>	<p>2 - 4 years</p>	<p>Total dollars award; characteristics of participants; number of awards *</p>	<p>Oversight and monitoring from OHSU/Oregon AHEC office</p>	<p>Senate Bill 2 (2013 Session), Chapter 511, Oregon Laws 2013)</p>
<p>Participants eligible to receive 20% annually of unpaid health professional loans, up to \$35,000 per year for three years, with ability to request up to two additional years of service; priority may be given for working in a HPSA with a score of 10 or higher, in a recognized Patient Centered Primary Care Home, and for percentage of Medicaid eligible patients in area and clinic.</p>	<p>50 (estimate for 2014-16)</p>	<p>Medicaid Population (particularly Medicaid Expansion)</p>	<p>\$2 million (2013-14)</p>	<p>\$0</p>	<p>32000*</p>	<p>Immediately, upon award of contract</p>	<p># of awardees; distribution of awardees throughout state; amount of money distributed; average HPSA score for awardees; average difference in Medicaid served from county population.</p>	<p>* Number of awards given</p>	<p>ORS 442.550 - 442.565 OAR 409-037</p>

Sources: Oregon Department of Revenue Tax Expenditure Report, Oregon Office of Rural Health, Oregon AHEC Program, Legislative Revenue Office, HRSA Bureau of C

Oregon Healthcare
Workforce Institute



Oregon's Obligated Service Health Providers: 2008 through 2012

Oregon Healthcare Workforce Institute
February 2014

Acknowledgement

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Oregon's Obligated Service Health Providers: 2008 through 2012

Since the 1960s, the issue of an adequate supply of health professionals to meet the needs of underserved areas and populations has been a part of the national discussion around health care.¹ The establishment of the National Health Services Corps (NHSC) in 1972 was a watershed event, in which the federal government created a concentrated approach to address health care access in underserved areas. To varying degrees, states have followed the lead of the federal government, with many states sponsoring their own loan repayment and loan forgiveness programs to supplement federal resources to recruit health professionals to practice in underserved areas or with underserved populations.

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) has agreements in place with 54 states and territories to coordinate the NHSC and other recruitment and retention programs. In Oregon, the Oregon Primary Care Office (PCO) within the Oregon Health Authority works in partnership with HRSA in administering many federal health care workforce programs to increase the supply of health providers in Oregon's rural and underserved areas.² These HRSA programs include student loan repayment and scholarships, as well as the J-1 physician visa waiver program, for qualified health providers who commit to practicing for a defined service period in communities located in Health Professional Shortage Areas (HPSA).³

The term "obligated service providers" is used in this report to define those health professionals fulfilling a service contract with HRSA in exchange for loan repayment assistance or scholarship, as well as those individuals fulfilling a service contract under a J-1 Visa Waiver for a foreign physician. This report presents information on these obligated service programs and health professions, employing facilities, and retention rates of obligated service providers in Oregon's health care workforce from 2008 through 2012.¹

Obligated Service Programs

Oregon's PCO coordinates four obligated service programs for the state: the National Health Service Corps, NURSE Corps, Faculty Loan Repayment Program, and J-1 Visa Waiver Program.

National Health Service Corps (NHSC) providers serve in federally designated HPSAs in primary care, dentistry, and mental and behavioral health. There are two NHSC programs:

The National Health Service Corps Loan Repayment Program (LRP) offers providers working full-time in HPSAs up to \$60,000 in student loan repayment. The program requires a two-year service commitment with an opportunity to extend service contracts for additional support. Recipients must work in approved worksites in rural, urban and frontier communities.

¹ There exists other state and private programs administered in Oregon that provide similar financial assistance for health care providers; however, information on these programs and providers are not included in this report.

The National Health Service Corps Scholarship Program (SP) offers students pursuing primary health care careers funding for tuition and other educational expenses as well as monthly stipends. In exchange, recipients commit to practicing in a HPSA for a minimum of two and maximum of four years after graduation and licensure.

The NURSE Corps includes licensed registered nurses, advanced practice nurses and nurse faculty who serve at Critical Shortage Facilities (CSF). CSFs are facilities within HPSAs that include non-profit hospitals, inpatient or outpatient nursing facilities, Federally Qualified Health Centers, rural health or public health clinics, and accredited public or private not-for-profit nursing schools. There are two NURSE Corps programs:

The NURSE Corps Loan Repayment Program (NELRP) offers registered nurses and advanced practice registered nurses working in critical nurse-shortage areas loan repayment for up to 60% of eligible school loans. The program requires a two-year service commitment and offers additional 25% repayment for a third-year of service. Recipients must work in approved facilities in rural, urban and frontier communities.

The NURSE Corps Scholarship Program (NSP) offers nursing students funding for tuition and other educational expenses as well as stipends. Recipients commit to working in HPSA facilities with a critical shortage of nurses for a minimum of two and maximum of four years after graduation and licensure.

The Faculty Loan Repayment Program (FLRP) is for health profession program graduates from disadvantaged backgrounds who serve for two years as faculty in qualified health profession education programs at an accredited college or university. Recipients can receive a maximum of \$40,000 in loan repayment to be matched by the employing institution.

J-1 Physician Visa Waiver Program (J-1 Visa Waiver)

To address the U.S. physician shortage, the federal J-1 Physician Visa Waiver Program, also known as the Conrad Program, authorizes Oregon's PCO to sponsor up to 30 international medical graduates per year in full-time employment in federally-designated HPSAs, Medically Underserved Areas, or Medically Underserved Population worksites.⁴⁵

Foreign physicians who obtained their exchange visitor visa to pursue graduate medical education or post-graduate training in the United States are eligible for this program. The J-1 Visa Waiver waives the requirement that foreign physicians return to their home country for two years before applying for permanent residency in the United States. In exchange, the physician agrees to practice full-time for three years in underserved areas or with underserved populations. Once the obligations of the J-1 Visa Waiver have been fulfilled, the physician is eligible to apply for permanent residence or other visa status.

Data and Methods

Data for this report comes from the following sources:

- PCO's 2010 - 2013 National Health Service Corps Field Strength Reports, which includes the loan repayment and scholarship programs, identifies the providers' health profession, employment status, obligated service program type, worksite location, and length of obligation.
- PCO's 2013 J-1 Physician Visa Waiver Database identifies the physicians' practice specialty, gender, country of origin, worksite location, start date, and waiver year. When data elements from the J-1 Physician Visa Database match with data elements in the loan repayment and scholarship database (e.g., worksite location), the data is presented together, otherwise the data is presented separately.
- Oregon Medical Board (OMB) licensing applicant/licensee services website identifies the current license status and worksite location for physicians and physician assistants.⁶
- Oregon State Board of Nursing (OSBN) license verification services website identifies the current license status and worksite location for nurses.⁷
- Oregon Board of Dentistry online licensee directory identifies the current license status and worksite location of dentists and dental hygienists.⁸
- Oregon Board of Licensed Professional Counselors and Therapists online licensee directory identifies the current license status and worksite location for licensed professional counselors and marriage and family therapists.⁹
- Oregon Board of Licensed Clinical Social Workers online license verification and disciplinary records check system identifies the current license status and worksite location for licensed social workers.¹⁰
- Nurse practitioner workforce data from the 2012 OSBN licensing database as submitted to the Oregon Health Care Workforce Licensing Database in February 2012 and cleaned by the Oregon Center for Nursing.¹¹
- Physician and physician assistant workforce data from the 2012 OMB licensing database as submitted to the Oregon Health Care Workforce Licensing Database in January 2012 and cleaned by the Oregon Healthcare Workforce Institute.¹²

The number of obligated service providers in Oregon for 2008, 2009, 2010, 2011, and 2012 was determined by counting obligated service health professionals reported as active in the National

Health Service Corps Field Strength Reports and the J-1 Physician Visa Database for any duration during the specified year.

The primary practice address for obligated service health professionals working in multiple counties was identified as the first reported address. The obligated service providers' rural/non-rural practice status was determined using the Oregon Office of Rural Health's rural/urban zip code designation list.¹³

Retention rates of health providers who have fulfilled their contract obligations were determined using 2013 practice location data from the licensing boards' online directories.

The percentages of obligated service physicians, nurse practitioners, and physician assistants and their non-obligated counterparts working in primary medical care were determined at the county-level using data from the 2012 Oregon Health Care Workforce Licensing Database. For purposes of this report primary medical care providers are defined as physicians, nurse practitioners and physician assistants who reported practicing in the specialties of family medicine, general practice, geriatrics, pediatrics, adolescent medicine, internal medicine, obstetrics and gynecology, or women's health.ⁱⁱ

Section I: Obligated Service Providers in Oregon from 2008 through 2012

Oregon's Obligated Service Providers

There are 14 types of health providers eligible for the obligated service programs identified in this report:¹⁴

Physicians (MD and DO)	Registered Nurses (NUR and Nursing NELRP)
Physician Assistants (PA)	Nurse Faculty (Nursing NELRP)
Dentists (DD)	Psychiatric Nurse Specialists (PNS)
Registered Dental Hygienists (RDH)	Health Service Psychologists (HSP)
Advanced Practice Nurses (Nursing NELRP)	Licensed Clinical Social Workers (LCSW)
Certified Nurse Midwives (CNM)	Licensed Professional Counselors (LPC)
Nurse Practitioners (NP)	Marriage and Family Therapists (MFT)

ⁱⁱ HRSA includes OB/GYN physicians among the definition of primary medical care providers eligible to participate in obligated service programs. Other Oregon Health Authority workforce reports, such as the [Oregon Health Professions: Occupational and County Profiles](#) report, exclude OB/GYN physicians within the definition of primary care providers. For more information on differing definitions of primary care see, for example, the [Institute of Medicine](#), the [American Academy of Family Physicians](#), and the Morehouse School of Medicine's [National Center for Primary Care](#).

The number of obligated service providers in Oregon has increased from 33 in 2008 to 338 in 2012 (see Table 1).

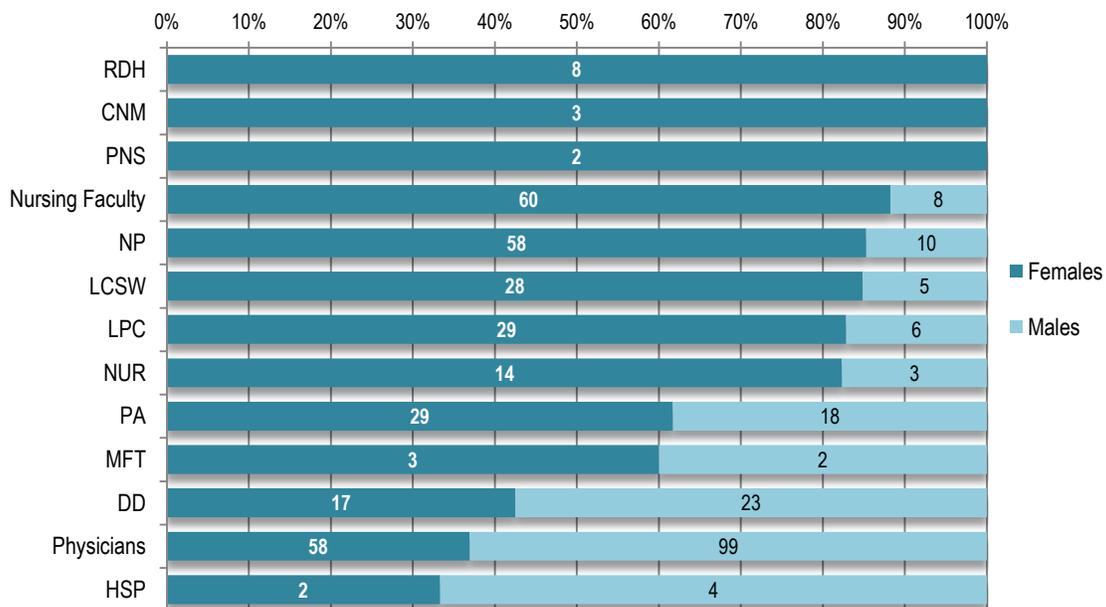
Table 1: Count of Oregon's Obligated Service Health Providers by Year: 2008 - 2012

Profession	2008	2009	2010	2011	2012
Nursing Faculty	0	0	0	0	67
Physicians (MD/DO)	26	36	42	91	78
Nurse Practitioners	1	11	28	49	53
Physician Assistants	1	12	21	38	39
Licensed Clinical Social Workers	0	3	9	21	28
Licensed Professional Counselors	0	5	9	20	29
Dentists	5	14	21	31	30
Registered Nurses	0	0	0	0	17
Health Service Psychologists	0	0	1	4	6
Registered Dental Hygienists	0	0	5	7	5
Marriage and Family Therapists	0	1	2	4	3
Certified Nurse Midwives	0	3	3	3	1
Psychiatric Nurse Specialists	0	1	1	1	1
Total	33	86	142	243	338

Gender of Obligated Service Providers

The number of females (311) in obligated service programs exceeds the number of males (178) (see Figure 1); however, three disciplines have a majority of males: physicians, dentists (DD), and psychologists (HSP).

Figure 1: Gender of Oregon's Obligated Service Providers by Discipline: 2008 - 2012



Oregon's Obligated Service Providers by County

From 2008 through 2012, Oregon's PCO facilitated the placement of 489 obligated service providers in Oregon's rural and underserved areas. Table 2 presents the number of obligated service providers by county of placement over this five-year time period.ⁱⁱⁱ

From 2008 through 2012, the counties with the highest number of obligated service providers are Multnomah (86), Jackson (56), Marion (31), and Washington (28). No obligated service provider identified a practice address in Curry, Sherman, Wallowa, or Wheeler counties during this time period.

ⁱⁱⁱ From 2008 to 2012, eight obligated service providers worked in two or more counties. Two dentists, one physician assistant, and one social worker practiced in both Hood River and Wasco counties. One physician worked in Benton and Linn counties. One dental hygienist worked in Jackson and Josephine counties and one dental hygienist worked in Washington and Yamhill counties. One nurse practitioner worked in three counties: Crook, Deschutes, and Jefferson. For the purpose of this report, only the county associated with the primary practice address of each of these professionals was used to construct Table 2.

Table 2: Distribution of Oregon's Obligated Service Providers by County: 2008 - 2012

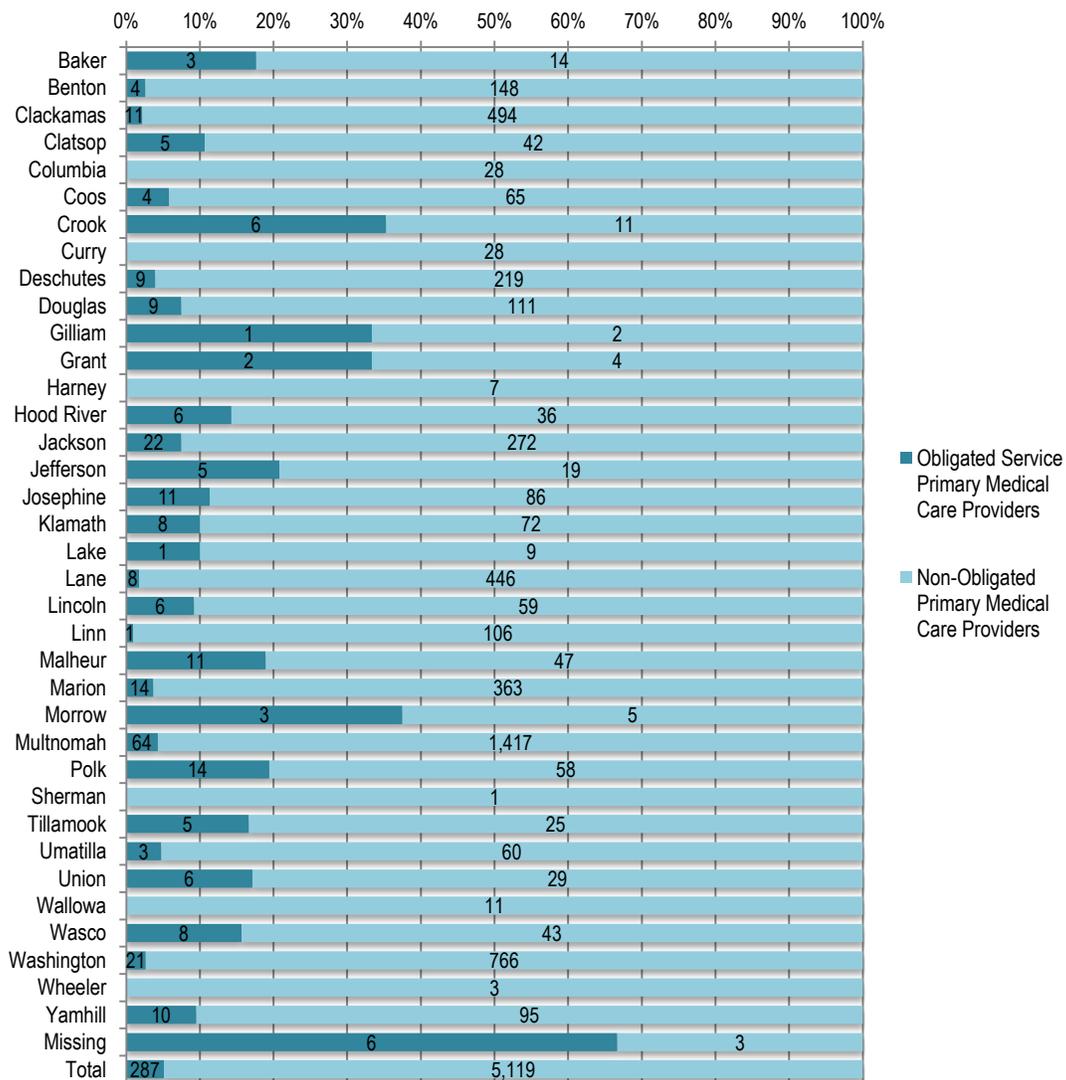
County	Certified Nurse Midwife	Dentist	Health Service Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor	Marriage and Family Therapists	Nurse (NELRP Program)	Nurse Practitioner	Registered Nurse	Physician (MD/DO)	Physician Assistant	Psychiatric Nurse Specialist	Dental Hygienist	Total
Baker	0	0	0	1	1	0	1	0	0	0	1	0	0	4
Benton	0	0	0	0	0	0	0	0	1	1	0	0	0	2
Clackamas	0	1	0	2	2	0	2	4	0	2	1	0	0	14
Clatsop	0	0	0	0	0	0	0	8	0	4	0	0	0	12
Columbia	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Coos	0	0	0	1	3	0	0	4	0	7	0	0	0	15
Crook	0	0	1	0	0	0	0	1	0	2	3	0	0	7
Curry	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Deschutes	0	0	0	0	0	0	1	1	0	6	7	0	0	15
Douglas	0	0	0	2	3	1	0	7	0	9	0	0	0	22
Gilliam	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Grant	0	0	0	0	1	0	0	1	0	2	0	0	0	4
Harney	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Hood River	0	3	0	1	0	0	0	0	0	2	1	0	0	7
Jackson	2	10	0	2	5	0	3	8	2	20	1	0	3	56
Jefferson	0	0	0	1	1	0	1	2	0	2	0	0	0	7
Josephine	0	3	1	3	3	0	1	3	0	7	0	1	1	23
Klamath	0	1	0	1	2	1	1	2	0	9	0	0	1	18
Lake	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Lane	0	1	0	0	0	0	2	3	0	18	0	0	0	24
Lincoln	0	3	0	1	2	1	1	0	0	0	0	0	0	8
Linn	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Malheur	0	6	0	1	0	0	0	0	2	6	1	0	0	16
Marion	0	1	1	0	0	0	4	1	4	15	4	0	1	31
Morrow	0	0	0	1	1	0	0	0	0	0	2	0	0	4
Multnomah	0	2	0	3	2	0	40	12	5	14	6	1	1	86
Polk	0	2	0	3	6	0	0	3	0	1	5	0	0	20
Sherman	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tillamook	0	0	0	1	1	0	0	1	0	1	3	0	0	7
Umatilla	0	0	0	2	0	0	0	2	0	9	0	0	0	13
Union	0	0	0	2	1	0	2	0	0	5	1	0	0	11
Wallowa	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wasco	0	0	0	2	1	0	1	3	0	3	2	0	0	12
Washington	1	3	2	3	0	0	8	1	3	2	4	0	1	28
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yamhill	0	4	1	0	0	0	0	1	0	7	4	0	0	17
Total	3	40	6	33	35	5	68	68	17	157	47	2	8	489

County Distribution of Obligated Service Primary Medical Care Providers

In Figure 2, a comparison is made between the number of obligated service physicians, nurse practitioners, and physician assistants who are primary medical care providers and their non-obligated counterparts by county of practice in 2012. Primary medical care providers are defined as physicians, nurse practitioners, and physician assistants who reported practicing in the specialties of family medicine, general practice, geriatrics, pediatrics, adolescent medicine, or internal medicine, obstetrics and gynecology, or women’s health.

Statewide in 2012, obligated service physicians, nurse practitioners, and physician assistants made up 5% of the statewide primary medical care workforce. There were four counties where more than 25% of the primary medical care workforce consisted of obligated service physicians, nurse practitioners, and physician assistants: Morrow (38%), Crook (35%), Gilliam (33%) and Grant (33%).

Figure 2: Count of Obligated Service Primary Medical Care Providers as Compared to Non-Obligated Primary Medical Care Providers by County (2012)



J-1 Visa Waiver Program

From 2008 through 2012, 105 foreign physicians began their obligated service contracts in Oregon under the J-1 Visa Waiver program. These physicians represent 33 different countries (see Table 3). The most frequently reported home country was India (28) followed by the Philippines (22), Canada (8), and Pakistan (5).

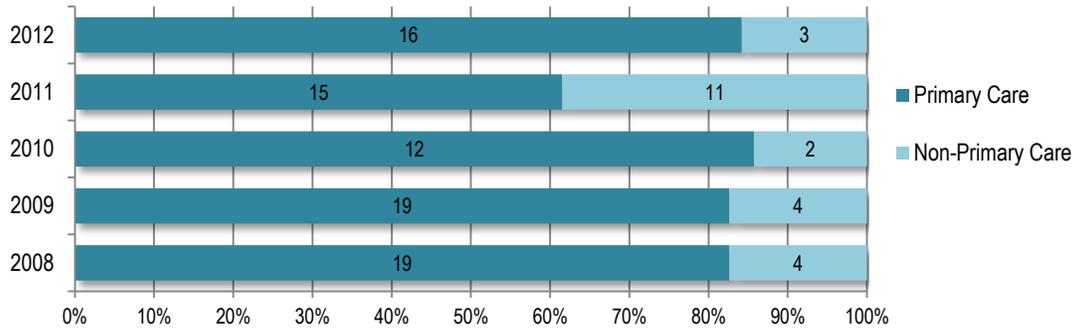
Table 3: Home Country of Oregon's J-1 Visa Waiver Program Physicians by Year Entered: 2008 - 2012

Home Country	2008	2009	2010	2011	2012	Total 2008 - 2012
Argentina	0	0	1	1	0	2
Bangladesh	0	0	1	0	0	1
Barbados	0	0	1	0	0	1
Botswana	0	0	0	0	1	1
Canada	4	1	0	1	2	8
Dominican Republic	2	2	0	0	0	4
Egypt	0	0	0	0	1	1
El Salvador	0	0	0	0	1	1
Germany	0	0	1	0	0	1
Great Britain	0	0	1	0	0	1
India	2	8	5	8	5	28
Kenya	0	0	0	1	0	1
Lebanon	1	0	0	0	1	2
Malaysia	1	0	0	2	0	3
Maldives	0	0	1	0	0	1
Mexico	1	1	0	1	0	3
Moldova	1	0	0	0	0	1
Nepal	0	1	0	1	0	2
New Zealand	0	1	0	0	0	1
Pakistan	2	1	0	1	1	5
Peru	0	0	0	0	1	1
Philippines	6	3	2	8	3	22
Romania	0	0	0	0	1	1
South Korea	0	1	0	0	0	1
Serbia and Montenegro	1	0	0	0	0	1
Slovak Republic	1	0	0	0	0	1
Saint Vincent and the Grenadines	1	0	0	0	0	1
Sudan	0	0	0	0	1	1
Syria	0	1	1	0	0	2
Thailand	0	1	0	0	0	1
Trinidad and Tobago	0	0	0	0	1	1
Turkey	0	1	0	1	0	2
Venezuela	0	0	0	1	0	1
Missing	0	1	0	0	0	1
Total	23	23	14	26	19	105

Primary Care Physicians in the J-1 Visa Waiver Program

From 2008 through 2012, 77% of the 105 J-1 Visa Waiver physicians beginning their 3-year service obligation in Oregon reported practicing in primary care specialties (see Figure 3). These included family medicine, internal medicine, geriatrics, obstetrics and gynecology, and pediatrics

Figure 3: Percentage and Count of Oregon's J-1 Visa Waiver Physicians by Specialty Category by Year Entering: 2008 - 2012



Practice Specialties of Oregon's J-1 Visa Waiver Physicians

There are 20 reported practice specialties of physicians in the J-1 Visa Waiver Program (see Table 4). Internal medicine (56) and family medicine (20) were the most frequently identified specialties reported by those physicians entering the J-1 Visa Waiver program in Oregon from 2008 through 2012.

Table 4: Practice Specialty of Oregon's J-1 Visa Waiver Physicians by Year of Entry: 2008 - 2012

Specialty Type	2008	2009	2010	2011	2012	Total
Bariatric Surgery	0	2	0	0	0	2
Cardiology	1	0	0	1	0	2
Dermatology	1	0	0	1	0	2
Endocrinology	0	0	1	1	0	2
Family Medicine	4	2	3	6	5	20
General Psychiatry	0	0	0	1	0	1
General Surgery	0	0	0	1	1	2
Geriatrics	1	0	0	0	0	1
Hematology	0	0	0	1	0	1
Infectious Diseases	0	0	0	1	0	1
Internal Medicine	14	15	9	8	10	56
Laparoscopic Surgery	0	0	0	1	0	1
Nephrology	1	1	0	0	0	2
Neurological Surgery	0	0	0	0	1	1
Neurology	1	0	0	0	0	1
Obstetrics/Gynecology	0	1	0	1	0	2
Otolaryngologist	0	0	1	0	0	1
Pediatrics	0	1	0	0	1	2
Pulmonology	0	0	0	2	0	2
Rheumatology	0	1	0	0	1	2
Vascular Surgery	0	0	0	1	0	1
Total	23	23	14	26	19	105

Section II: Obligated Service Programs in Oregon from 2008 through 2012

In 2008, only ten obligated service providers in the NHSC loan repayment and scholarship programs were serving in Oregon (see Table 5). In 2012, that number grew to 319 providers in five HRSA loan repayment and scholarship programs.

Table 5: Number of HRSA Obligated Service Providers by Program by Year in Oregon: 2008 - 2012

Program	Count of Obligated Service Providers 2008	Count of Obligated Service Providers 2009	Count of Obligated Service Providers 2010	Count of Obligated Service Providers 2011	Count of Obligated Service Providers 2012
FLRP	0	0	0	0	2
NELRP	0	0	0	0	67
NHSC LRP	9	62	124	208	221
NHSC SP	1	3	4	9	13
NSP	0	0	0	0	13
Total	10	65	128	217	319

The number of J-1 Visa Waiver physicians beginning their terms of service for each year from 2008 through 2012 is seen in Table 6.

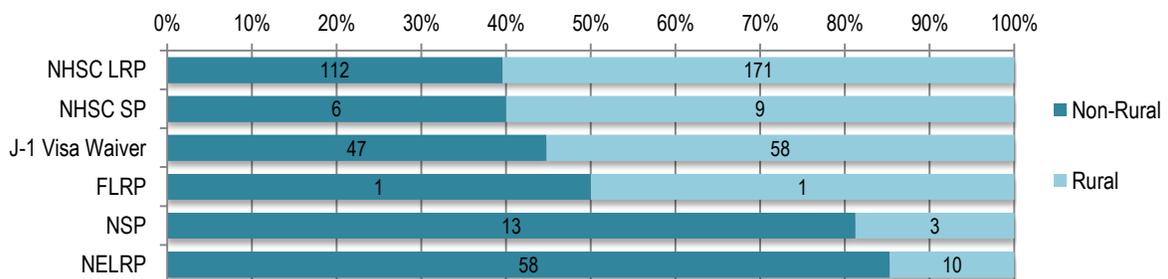
Table 6: Number of J-1 Visa Waiver Physicians in Oregon by Year of Service Entry: 2008 - 2012

Program	2008	2009	2010	2011	2012	Total Entering 2008 - 2012
J-1 Visa Waiver Physicians	23	23	14	26	19	105

Rural/Non-Rural Practice Locations of Obligated Service Providers by Program

From 2008 through 2012, more than 50% of obligated service providers were practicing in Oregon’s rural communities (see Figure 4). Sixty percent (or 171) of NHSC loan repayment obligated service providers were serving in rural communities. Of Oregon’s J-1 Visa Waiver program physicians, 55% (or 58) were practicing in rural communities. The majority of NSP (13) and NELRP (58) obligated service nurses worked in non-rural communities.

Figure 4: Rural/Non-Rural Location of Providers in Obligated Service Programs: 2008 - 2012



Obligated Service Program by County

From 2008 through 2012, health care providers participating in obligated service programs were present in 31 of Oregon's 36 counties.

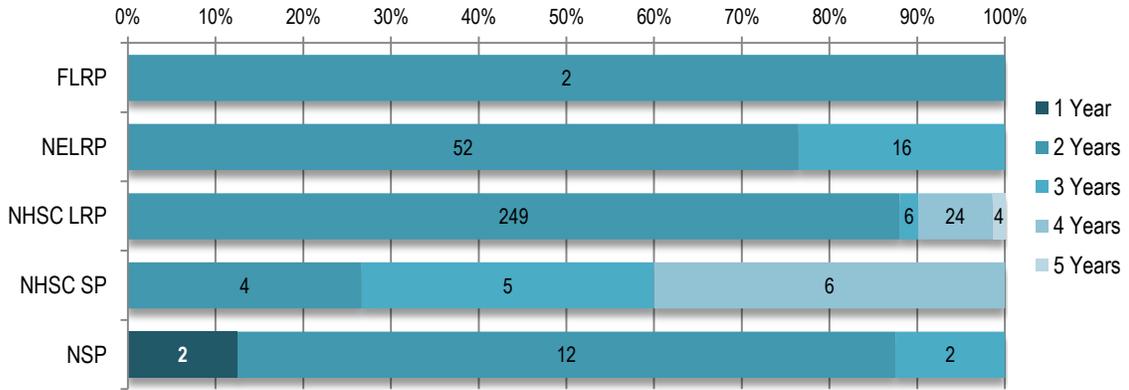
Table 7: Obligated Service Programs by County and Number of Providers: 2008 - 2012

County	FLRP	J-1 Visa	NELRP	NHSC LRP	NHSC SP	NSP	Total
Baker	0	0	1	3	0	0	4
Benton	0	0	0	1	0	1	2
Clackamas	0	1	2	11	0	0	13
Clatsop	0	2	0	10	0	0	10
Columbia	0	1	0	0	0	0	0
Coos	0	7	0	8	0	0	8
Crook	0	0	0	5	2	0	7
Curry	0	0	0	0	0	0	0
Deschutes	0	0	1	11	3	0	15
Douglas	0	8	0	14	0	0	14
Gilliam	0	0	0	1	0	0	1
Grant	0	0	0	4	0	0	4
Harney	0	0	0	1	0	0	1
Hood River	0	0	0	6	1	0	7
Jackson	0	18	3	29	4	2	38
Jefferson	0	0	1	3	3	0	7
Josephine	0	7	1	15	0	0	16
Klamath	0	4	1	12	1	0	14
Lake	0	0	0	1	0	0	1
Lane	0	17	2	5	0	0	7
Lincoln	0	0	1	7	0	0	8
Linn	0	0	0	2	0	0	2
Malheur	0	3	0	11	0	2	13
Marion	0	12	4	11	0	4	19
Morrow	0	0	0	4	0	0	4
Multnomah	1	5	40	36	0	4	81
Polk	0	0	0	20	0	0	20
Sherman	0	0	0	0	0	0	0
Tillamook	1	0	0	6	0	0	7
Umatilla	0	8	0	5	0	0	5
Union	0	5	2	4	0	0	6
Wallowa	0	0	0	0	0	0	0
Wasco	0	1	1	9	1	0	11
Washington	0	0	8	17	0	3	28
Wheeler	0	0	0	0	0	0	0
Yamhill	0	6	0	11	0	0	11
Total	2	105	68	283	15	16	489

Length of Service Obligation

From 2008 through 2012, most of Oregon’s obligated service providers committed to a two-year length of service (see Figure 5). The NHSC loan repayment program has the largest number of obligated service providers serving beyond two years. Twenty-eight providers in the NHSC loan repayment program have served for four or more years. J-1 Visa Waiver physicians have a three year service obligation.

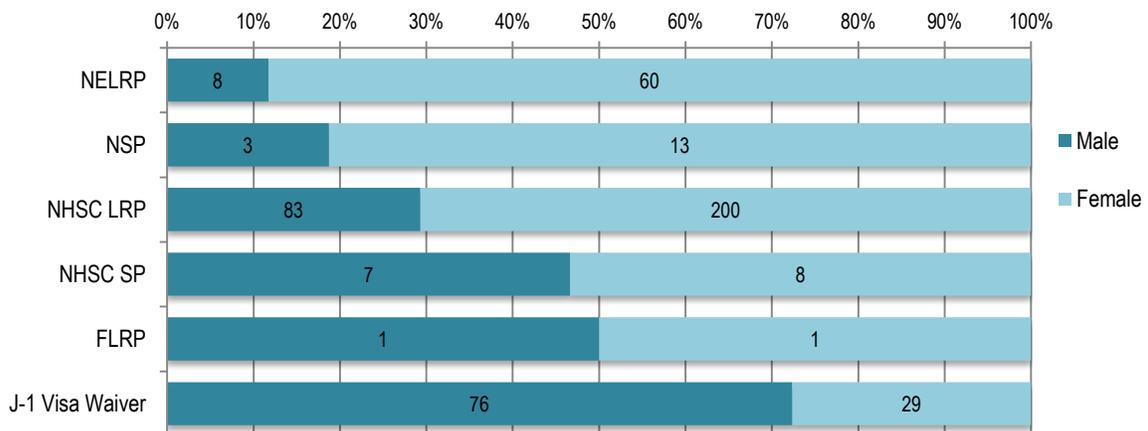
Figure 5: Count and Percentage of Providers by Length of Service Commitment in Obligated Service Program: 2008 -2012



Obligated Service Program Gender Profile

From 2008 through 2012, the majority of Oregon’s obligated service providers were female (see Figure 6). The only program with a majority of males is the J-1 physician visa waiver program with 76 male physicians and 29 female physicians beginning service during this timeframe.

Figure 6: Provider Gender by Obligated Service Program: 2008 - 2012



Section III: Oregon’s Health Care Facilities Employing Obligated Service Providers

Overview of Facilities Employing Obligated Service Providers

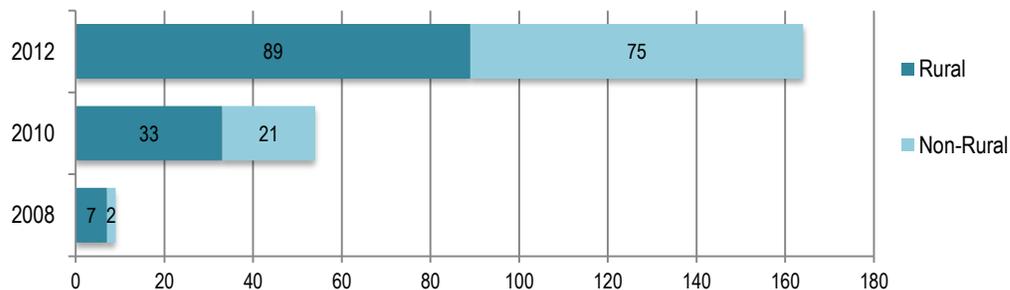
Obligated service providers are employed in federally designated facilities, such as community rural, tribal, or migrant health centers or Federally Qualified Health Clinics, or as faculty in accredited health profession education programs (see Table 8). The most common facility types employing obligated service providers in 2012 were Community and Migrant Health Centers (40) and Federally Qualified Health Centers (26).

Table 8: Type and Count of Facilities Employing Obligated Service Providers (2012)

HRSA Designated Facility Type	Count of Facilities: 2012
Community/Migrant Health Center	40
Federally Qualified Health Center	26
Rural Health Center	6
Hospital Affiliated Primary Care Practice	5
Mental Health/Substance Abuse	2
Prison	2
Certified Rural Health Clinic	1
Compacted Indian Tribe	1
Dental Clinic	1
Group Practices	1
Homeless Shelter	1
Indian Health Service, Tribal Clinic, and Urban Indian Health Clinic	1
Other	21
Missing	56
Total	164

The majority of facilities that employ obligated service providers are located in Oregon’s rural communities, where the number of facilities increased from 7 in 2008 to 89 in 2012 (see Figure 7). The number of facilities that employ obligated service providers in Oregon’s non-rural communities increased from two in 2008 to 75 in 2012.

Figure 7: Rural/Non-Rural Location of Facilities Employing Obligated Service Providers: 2008 - 2012



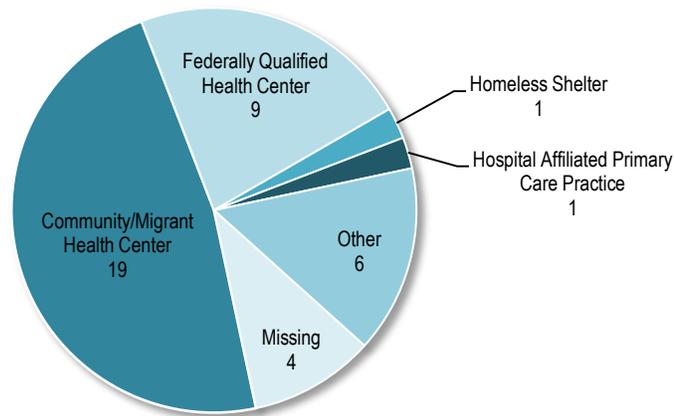
In 2008, there were nine facilities in seven counties employing obligated service providers (see Table 9). By 2012, the number of facilities employing obligated service providers increased to 164 and spread throughout 30 counties in Oregon. The counties experiencing the largest increases in the number of facilities employing obligated service providers from 2008 through 2012 were Multnomah (25), Jackson (13), and Washington (12).

Table 9: Count and County of HRSA Designated Facilities Employing Obligated Service Providers by Year

County	Count of Facilities: 2008	Count of Facilities: 2010	Count of Facilities: 2012
Baker	0	1	3
Benton	0	0	3
Clackamas	0	2	8
Clatsop	0	1	3
Columbia	0	0	0
Coos	0	1	1
Crook	0	2	3
Curry	0	0	0
Deschutes	1	1	3
Douglas	0	2	8
Gilliam	0	0	1
Grant	0	2	1
Harney	0	1	0
Hood River	0	2	2
Jackson	0	6	13
Jefferson	0	1	6
Josephine	1	1	6
Klamath	2	3	5
Lake	0	0	1
Lane	0	3	5
Lincoln	0	0	7
Linn	0	0	1
Malheur	2	4	8
Marion	0	1	9
Morrow	0	1	3
Multnomah	1	7	25
Polk	0	2	6
Sherman	0	0	0
Tillamook	0	1	3
Umatilla	0	1	3
Union	0	1	4
Wallowa	0	0	0
Wasco	0	2	7
Washington	1	3	13
Wheeler	0	0	0
Yamhill	1	2	3
Total	9	54	164

In 2012, most of the 319 obligated service health professionals worked in a single facility. Twenty-three, however, worked in at least two and up to four facilities during their service obligation. These obligated service providers working at multiple facilities included nine nurse practitioners, three licensed clinical social workers, three dentists, three physicians, two physician assistants, two dental hygienists, and a marriage and family therapist. The 23 obligated service health professionals worked in 40 of the 164 active HRSA designated facilities in 2012 (see Figure 8).

Figure 8: Type and Count of Facilities Employing Those Obligated Service Professionals Who Worked in Multiple Locations (2012)



Section IV: Retention of Obligated Service Providers

Retention of Oregon’s Obligated Service Providers

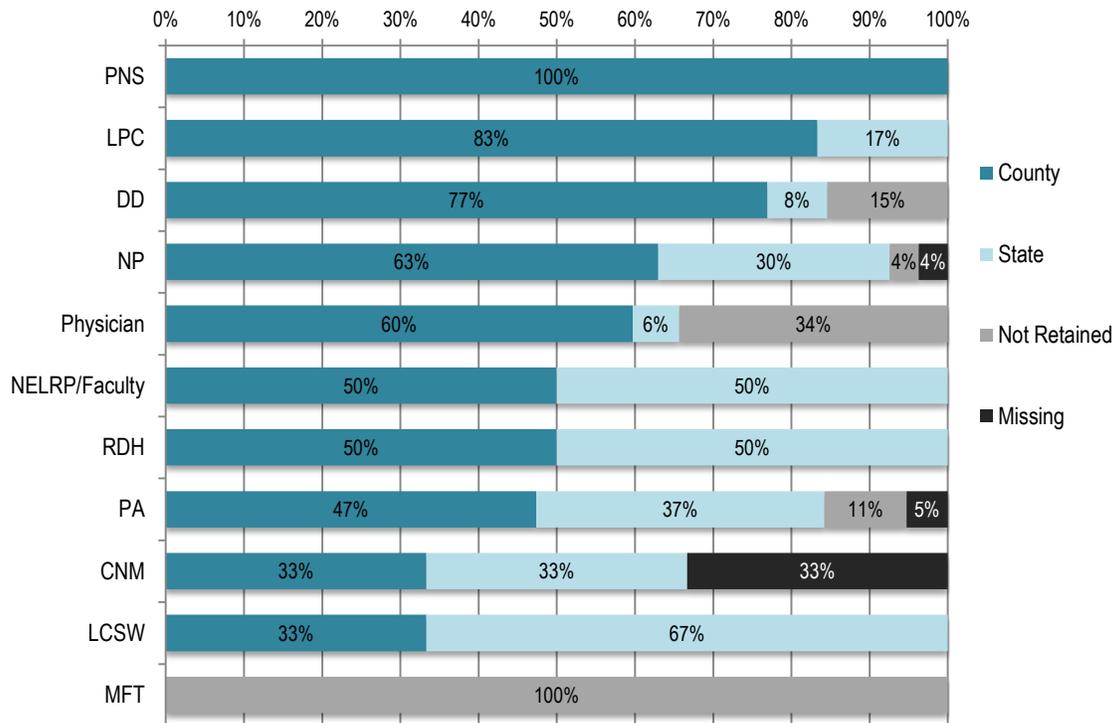
From 2008 through 2013, 142 obligated service providers fulfilled their service contracts in Oregon, including 65 physicians, 27 nurse practitioners, 19 physician assistants, 13 dentists, six licensed professional counselors, three certified nurse midwives, three licensed clinical social workers, two nurse faculty, two dental hygienists, one psychiatric nurse specialist, and one marriage and family therapist. Overall, 78% of these obligated providers completing their service agreement from 2008 through 2013 have remained in Oregon, of which 60% continue to practice in the same county where they served (see Table 10).

Table 10: Percent Retention of Obligated Service Providers (based on service dates): 2008 - 2013

In-County Retention Rate	In-State Retention Rate	Not Retained in Oregon	Missing Data
60%	78%	20%	2%

The provider types with the highest percentage rates of in-county retention include the one psychiatric nurse specialist (100%), licensed professional counselors (83%), dentists (77%), nurse practitioners (63%), and physicians (60%) (see Figure 10).

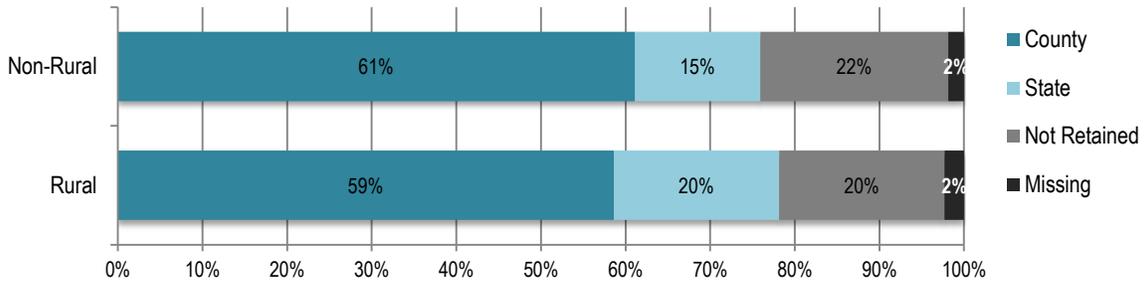
Figure 10: Retention Rates of Oregon's Obligated Service Providers: 2008 - 2013



Retention of Oregon's Obligated Service Providers in Rural and Non-Rural Areas

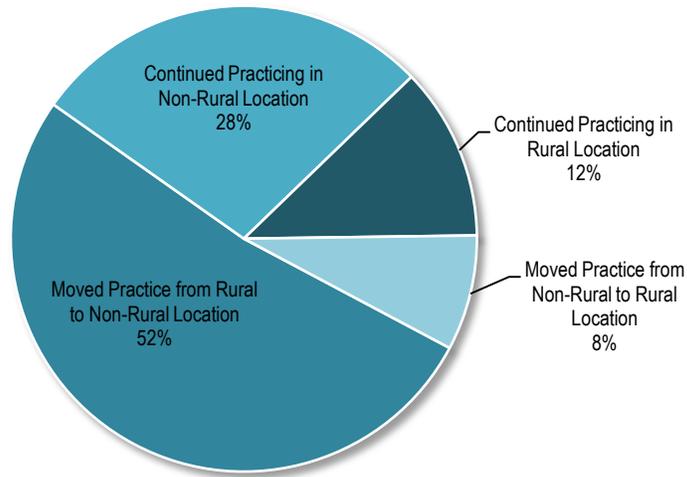
From 2008 through 2013, 61% of non-rural and 59% of rural obligated service providers continued to practice within the same county after completion of their contracts (see Figure 11). Twenty percent of rural and 15% of non-rural providers who completed their service obligations during this time period moved their practice to another county, but remained in Oregon. Twenty-two percent of non-rural and 20% of rural obligated service providers left the state after finishing their service obligations.

Figure 11: Percent Retention of Oregon's Obligated Service Providers by Rural/Non-Rural Practice Location: 2008 - 2013



For obligated service providers who completed their service contracts and remained in Oregon, 80% now practice in non-rural communities (see Figure 12). Of those now practicing in a non-rural setting, 52% percent relocated from a rural Oregon community. Only 8% of obligated service providers moved their practice from a non-rural setting to a rural community.

Figure 12: Post-Service Practice Location of Oregon's Obligated Service Providers Remaining in Oregon: 2008 - 2012



Conclusion

At a time when health insurance coverage for historically underserved groups is expanding at a rate faster than that of the supply of health care providers, and with state and federal health care reforms fully underway, the need for health professionals is greater than ever. Since 2008, the Oregon Primary Care Office has assisted in the promotion of access to care by facilitating the placement of 489 obligated service providers in rural and underserved areas. In 2008, nine facilities in seven of Oregon's counties employed the total of the state's 33 obligated service providers. In 2012, 164 facilities in 30 of Oregon's counties employed the total of the state's 338 obligated service providers.

One crucial measurement of the continued success of these programs is the fulfillment of contracts and subsequent retention of providers. Since 2008, 142 obligated service providers fulfilled their contracts. Seventy-eight percent of these providers have remained in Oregon, of which 60% continue to practice in the same county where they served.

The increases in the numbers of obligated service providers, facilities that employ them and retention rates after contract conclusion show the success of efforts to utilize these programs to their maximum effectiveness. Moreover, the geographic distribution of these providers throughout Oregon's counties and in rural and underserved urban areas has improved. In the face of health reform implementation, provider shortages, and Oregon's growing and aging population, these successes come at a crucial time to meet the workforce demands of a dynamic health care system.

Endnotes

- ¹ Reynolds, P. (2008). A legislative history of federal assistance for health professions training in primary care medicine and dentistry in the United States: 1963-2008. *Academic Medicine*, 83: 1004-1014.
- ² <http://www.hrsa.gov/index.html>
- ³ <http://www.hrsa.gov/shortage/>
- ⁴ U.S. Department of Health and Human Services, Health Resources and Services Administration. *Bureau of Clinician Recruitment and Services*. Available at <http://www.hrsa.gov/about/organization/bureaus/bcrs/>.
- ⁵ U.S. Department of Homeland Security. *Conrad 30 Waiver Program*. Available at <http://www.uscis.gov/working-united-states/students-and-exchange-visitors/conrad-30-waiver-program>
- ⁶ <https://techmedweb.omb.state.or.us/Clients/ORMB/Public/VerificationRequest.aspx>.
- ⁷ <http://osbn.oregon.gov/OSBNVerification/Default.aspx>.
- ⁸ <http://obd.oregonlookups.com/>
- ⁹ <https://hrlb.oregon.gov/oblpct/licenseelookup/index.asp>
- ¹⁰ <https://hrlb.oregon.gov/BLSW/LicenseeLookup/index.asp>
- ¹¹ Oregon Office for Health Policy and Research (2013). *Oregon Health Professions: Occupational and County Profiles (February 2013)*. Available at <http://oregonhwi.org/documents/2012ProfilesReportFINAL1.pdf>
- ¹² Oregon Office for Health Policy and Research (2013). *Oregon Health Professions: Occupational and County Profiles (February 2013)*. Available at <http://oregonhwi.org/documents/2012ProfilesReportFINAL1.pdf>
- ¹³ Oregon Office of Rural Health. *Rural/Urban Designation*. Available at <http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm>
- ¹⁴ U.S. Department of Health and Human Services. (February 2013). National Health Service Corps Loan Repayment Program. Rockville, MD.

Appendix C. Links to Oregon Program Administrative Rules and Statutory Links

Oregon Medicare Primary Care Provider Loan Repayment Program (MCPLRP):

http://www.oregon.gov/oha/OHPR/rulemaking/notices/409-037_Web_Perm.pdf

Oregon Partnership Care Loan Repayment Program (SLRP)

<http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/loan-repayment/slrp.cfm>

Provider Tax Credits

<http://www.ohsu.edu/xd/outreach/oregon-rural-health/providers/provider-tax-credits/index.cfm>

Oregon Rural Medical Practitioners Insurance Subsidy Program

[http://www.dhs.state.or.us/policy/healthplan/rules/temps/500-all\(T\)013112.pdf](http://www.dhs.state.or.us/policy/healthplan/rules/temps/500-all(T)013112.pdf)