



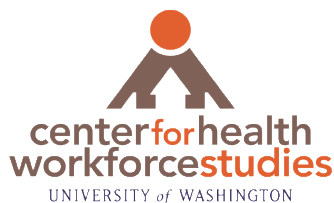
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DRAFT - Oregon Health Care Workforce Needs Assessment

**Prepared for the Oregon Health Policy
Board**

**Prepared by the University of Washington Center for Health
Workforce Studies and WWAMI Rural Health Research Center**



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1. Executive Summary

Sufficient supply of a well-supported health care workforce is necessary as part of the broader systematic goal of ensuring equitable population health outcomes. As such, and in accordance with House Bill 3261, a health care workforce needs assessment is conducted every two years and submitted to the legislature by the Oregon Health Policy Board, in collaboration with the Oregon Health Authority.

This is the sixth report since HB 3261 was passed. Building on past assessments, this report specifically focuses on three health care workforce groups: the primary care workforce, the oral health workforce, and the behavioral health workforce. Specifically, this report:

- Describes key factors impacting the demand for, access to, and availability of the health workforce in Oregon, including Social Determinants of Work.
- Describes the demographics, education, supply, distribution, demand, retention, and turnover risk of the three health care workforce groups of focus.
- Examines population health outcomes, measures of need, and access to care.
- Provides recommendations for addressing identified needs.

Methods

To assess Oregon's workforce needs, we reviewed multiple Oregon-specific reports and engaged in an extensive literature review. In-depth information on the primary care, oral health, and behavioral health workforce groups in Oregon is mainly based on data analyses from the Oregon Health Care Workforce Reporting Program (HWRP), managed by the Oregon Health Authority Office of Health Analytics. We supplemented this with additional state-specific and national data sources on the health workforce as well as population health. All together this supports a more comprehensive examination of Oregon's primary care, oral health, and behavioral health workforce and associated needs.

Social determinants of work

- **The Social Determinants of Work (SDW) can impact access to the health care workforce.** The SDW are factors such as housing, childcare, school quality, and broadband access which can impact access to, as well as the strength and sustainability of, the health care workforce.
- **Housing and childcare shortages are substantial:** Oregon needs about 30,000 additional housing units annually, and 34 of 36 counties are childcare deserts.
- **Rural communities face longer travel distances,** limited transportation and broadband, and greater unmet healthcare needs than urban areas.

- **Oregon has implemented several workforce-supportive policies**, including Medicaid expansion, paid family and medical leave, and protections for LGBTQ+ workers.

Health care workforce landscape

- **The full impact of Medicaid cuts is unclear but will likely impact both provider revenue as well as shift demand** to emergency rooms and urgent care as well as federally qualified health centers and rural health centers.
- **Complex credentialing can impede workforce entry**, although Oregon has pursued reimbursement, supervision, credentialing, and administrative reforms to address these concerns in the behavioral health workforce.
- **Oregon provides significant opportunities for health workforce occupations to work at the top of their scope, an important strategy for retention.** Multiple occupations can practice independently in Oregon, including nurse practitioners and clinical nurse specialists, with physician associates able to practice under a collaborative practice agreement with a physician.
- **Oregon has instituted a range of policies supportive of the health workforce.** To support recruitment and retention, particularly in underserved areas, Oregon has instituted several policies and programs, including expedited licensure for physicians, telehealth flexibility, and financial incentives for providers in underserved communities.

Primary care workforce

- **Primary care workforce growth has been driven largely by non-physician providers.** Recent growth in Oregon's primary care workforce was concentrated among nurse practitioners (NPs), physician associates/physician assistants (PAs), and naturopathic physicians (NDs) while growth among physicians was comparatively limited.
- **Clinician supply is increasing faster than direct patient care capacity.** The supply of practicing primary care clinicians increased from 22.3 to 23.6 per 10,000 population from 2024 to 2026. However, direct patient care capacity increased more modestly, from 17.0 to 17.3 FTEs per 10,000 population, indicating that increases in workforce headcounts do not necessarily translate into proportional increases in patient care availability.
- **The primary care workforce remains concentrated in urban areas.** Although workforce supply has increased statewide, geographic distribution remains uneven, with many rural and frontier communities continuing to experience workforce shortages and access challenges.

- **Demand expected to increase across most primary care occupations.** Growth is projected to be strongest among NPs, with continued demand for RNs, MAs, PAs, and community-based workers.
- **Workforce diversity remains an opportunity area.** The primary care workforce remains less racially and ethnically diverse than Oregon's population, which may have implications for culturally responsive care and workforce equity goals.

Oral health workforce

- **Growth among the oral health workforce has been minimal (1%), with relatively even distribution between dentists and dental hygienists.** The number of dentists grew slightly faster than dental hygienists, with a total of 9.8 direct care FTEs per 10,000 population. Direct care FTEs among dental hygienists with an expanded practice permit grew by 4.5%.
- **Workforce distribution is uneven, with rural access gaps.** About one-quarter of the oral health workforce works in rural areas. Oral health workforce density varies across counties, with the lowest levels in Gilliam and Sherman counties.
- **Relative to the Oregon population, the oral health workforce is less racially and ethnically representative.** 25% of the licensed oral health workforce speak a language other than English, but African American or Black and American Indian or Alaska Native populations are under-represented.
- **Medicaid capacity is limited.** About 31% of Oregon dentists accept Medicaid, with the number of claims increasing from 2023 to 2025. Still, Medicaid dental care seems to be concentrated among a small set of providers, with almost all having reported that less than 50% of their patients carry Medicaid coverage.
- **Training output and retention may not meet future demand.** Dental hygiene and dentistry completions have remained relatively stable, but dental assisting completions have declined over time. Demand is projected to grow along with significant churn expected among dental assistants reflective of a high number of replacement positions.

Behavioral health workforce

- **Modest growth of the behavioral health (BH) workforce** is driven by increases in the number of licensed psychiatric nurse practitioners (NPs), licensed clinical social workers (LCSWs), and licensed counselors and therapists (LPCs/LMFTs) over the past two years.
- **There is a significant gap between overall supply and direct patient care capacity.** While there has been growth among the overall number of BH workers, the growth in direct patient care FTE has been smaller, with a notably lower number of direct patient care FTEs compared to actively practicing individuals.

- **The distribution of the BH workforce continues to be uneven.** The workforce is concentrated in urban counties. Among the workforce, psychiatric NPs are the most likely to work in rural areas, double the number of rural psychiatrists.
- **Relative to the Oregon population, the BH workforce is less racially and ethnically diverse.** BH workers are predominantly White, while most other racial and ethnic groups are underrepresented. Clinical social work associates (CSWAs) are the most diverse licensed BH occupation, with higher percentages of Black and Hispanic workers. Certified-only BH workers are younger, less female, and more racially diverse than the licensed BH workforce.
- **Telehealth** is a major component of BH care delivery; over three-quarters of licensed BH providers offer telehealth services to Oregon residents. Just over half of licensed BH providers serve Medicaid-covered patients – mostly by PAs and CSWAs.
- **There are multiple pathways into the BH workforce**, but completions from the over 60 BH training programs have decreased across all occupations. Educational programs are concentrated in the Portland Metro area, which may contribute to regional BH workforce disparities across the state.
- **Increase in employment demand** is projected to be largest for substance abuse, behavioral disorder, and mental health counselors over the next decade among BH occupations. Projections indicate future workforce turnover and replacement openings due to workers retiring, changing occupations, or leaving the workforce, rather than the creation of new positions.

Measures of need and capacity

- **Birth outcomes are better than the U.S. average in Oregon, while mortality is slightly higher.** Oregon's birth and fertility rates are declining, while low birthweight and infant mortality remain below national averages. All-cause mortality is slightly higher than the U.S. average as are suicide rates.
- **Oregon's population is slowly becoming more racially and ethnically diverse**, particularly through growth in the Hispanic or Latino/a/x population.
- **Approximately one-third of Oregon's population is covered by Medicaid**, while poverty, SNAP participation, and uninsured rates vary across counties and are highest in several rural areas.
- **Structural capacity in Oregon is varied, with more access concentrated on the west side of the state.** There are three counties without a hospital and two with only one documented federally qualified health center or rural health center. Every county has at least one health professional shortage designation, with uneven access to emergency departments and behavioral health services.
- **There has been little change in unmet need overall in Oregon, despite some improvement in underlying measures.** The overall Unmet Need score for Oregon is

49.6. Since 2025, the number of Primary Care Service Areas without any primary care capacity and rates of preventable hospitalizations and dental ED visits have increased; Primary Care Services Areas without any mental health providers have decreased; and the rates of ED visits for mental health/substance use are unchanged.

Recommended areas of focus

Since the 2025 Health Care Workforce Needs Assessment, Oregon has made progress to address needs in the health workforce such as maldistribution, representation, barriers to entry, and turnover risk. The 2027 findings show growth in the behavioral health (BH) workforce and among primary care NPs and PAs, but minimal growth in the oral health workforce and across all physician types. Other ongoing needs identified include rural/remote supply gaps, declining educational completions in some fields, high expected replacement openings, and access to childcare and housing. The suggested recommendations below are meant to build upon existing work in Oregon, organized first by workforce group (primary care, oral health, behavioral health), then by cross-cutting issues.

Recommended areas of focus: Primary care workforce

In addition to existing supports and work underway, including provider incentives such as the Healthy Oregon Workforce Training Opportunity (HOWTO) Grant and loan repayment programs, Patient Centered Primary Care Homes, and initiatives recommended by the Oregon Health Policy Board's Primary Care Strategy Committee, the following recommend key areas of focus to increase the capacity of the current primary care workforce.

- **Explore opportunities to facilitate adoption and incorporation of team-based care models.** Team-based models with clear role delineation can yield smaller panel sizes, more efficient staffing, and greater reach in underserved areas.
- **Examine and address decreasing educational completions among nurse practitioners.** With only two NP programs in Oregon and declining completions, further examination of this is needed, along with continued funding for the nurse preceptor grant and stronger organizational support for preceptors is needed.
- **Support RNs to function in primary care at the top of their scope.** RNs can expand services and support physicians, PAs, and NPs when practicing at full scope. A gap between RN counts and reported direct-care FTE suggests a need to better understand and strengthen RN utilization in primary care.
- **Explore opportunities to expand medical assistant (MA) roles.** Expanded team-based models elsewhere show workflow and care-delivery improvements; career ladders and compensation progression may also support MA workforce stability.

Recommended areas of focus: Oral health workforce

Little overall growth in supply and in direct patient care FTEs point to a need for targeted work in growing and supporting the oral health workforce. Oregon already supports this workforce through expanded dental hygienist scope of practice, provider incentive program eligibility, and recent HRSA-funded work to address needs in Dental Health Provider Shortage Areas, including a report focused on growing and sustaining the dental assistant (DA) workforce. Additional targeted recommendations are:

- **Examine reasons for low use of Expanded Practice Dental Hygienist (EPDH) permits.** About a third of dental hygienists hold an EPDH permit, but few use it; understanding why could facilitate greater capacity for preventive oral health care.
- Continue to track dental therapists and explore the feasibility of a dental therapy school in Oregon. As more data is available, continued tracking of this workforce is warranted along with their inclusion in future needs assessments. In addition, further exploration of the feasibility of starting a dental therapy program is needed.
- **Facilitate use of expanded function dental assistants (EFDAs),** which can improve efficiency, productivity, and access, especially where shortages exist.
- **Facilitate growth of the DA workforce through apprenticeships and on-the-job training,** an approach employers see as effective for recruitment, though currently potentially underutilized based on available data.
- **Address decreasing completions apparent among the DA workforce** by expanding entry pathways and examining root causes, alongside recruitment outreach and stronger partnerships between DA programs and dental practices.
- **Continue supporting, and potentially grow, incentive programs** targeting oral health, such as with HOWTO and the Health Care Provider Incentive Program loan repayment.
- **Targeted work to better track the DA workforce,** including statewide data collection, evaluation of advancement pathways, and cross-agency coordination.

Recommended areas of focus: Behavioral health workforce capacity

The BH workforce continues to grow, supported by provider incentive programs and initiatives such as HB 4086 (centralizing credentialing, expanding supervision eligibility, reducing Medicaid credentialing burden). Recommendations here build on this progress:

- **Further examine underlying reasons for the gap between the number of actively practicing BH occupations and reported direct care FTE.** Exact reasons for this are unknown and deserve further examination. Current research has identified that the emotional demand of the work and administrative load could contribute – specific strategies to address this are:

- Organizational strategies that facilitate manageable caseloads, offer peer support, and foster a workplace culture to support burnout prevention.
- Telehealth and flexible work arrangements, linked to lower turnover and higher job satisfaction.
- **Address decreasing educational completions**, which may reflect barriers to entry:
 - Increase early exposure to BH careers, especially for underserved communities.
 - Reduce the financial burden of BH education through tuition assistance, stipends, and loan repayment.
 - Expand access to clinical supervision, including addressing out-of-pocket supervision costs.
 - Facilitate entry of qualified out-of-state providers through more consistent recognition of licenses and experience.
- **Facilitate simplification and alignment of BH certification pathways.** With 14 boards and 60 credentials, a centralized guide providing detailed information on career pathways and credentialing would offer more immediate clarity for prospective BH professionals.

Broad issues to address

These cross-cutting recommendations apply across all workforce groups and build on substantial existing Oregon efforts.

- **Address maldistribution of the health workforce through continued investment in grow-your-own programs and rural clinical placements.** Some improvements have occurred (e.g., every county now has a dentist), but gaps persist, particularly in eastern and remote counties. There are many existing supports to build on, including the 2023 telehealth law (Senate Bill 232), rural pathway programs, medical assistant apprenticeships, employer/community-based training programs, provider incentive programs, and the Area Health Education Center Scholars Program. Additional evidence-based models worth considering include:
 - Additional targeted grow-your-own programs.
 - Further investment in rural clinical placement initiatives.
 - Examining the feasibility of stackable credential pathways.
- **Continue efforts to promote workforce demographics that are representative of the population.** Representativeness varies by occupation; Black/African American, American Indian/Alaska Native, and Hispanic/Latino populations remain underrepresented in several groups, and gender imbalances persist in higher-paying roles. Beyond provider incentive programs, opportunities include:
 - Continuing and potentially expanding K-12 health career pathway programs in addition to Oregon's Health and Biomedical Sciences CTE pathway.

- Further research into which dimensions of diversity most affect access and outcomes.
- **Address Social Determinants of Work needs, particularly childcare and housing.** Oregon's childcare assistance programs are not fully funded to meet demand. Other states offer models worth considering, including employer tax credit funds, private-public partnerships to facilitate cost-splitting for childcare, and discounted mortgage/homebuyer programs for health professionals.
- **Continued funding and support of strategies to facilitate retention.** High replacement openings are expected for DHs, NPs, therapists/counselors, social workers, MAs, and DAs. Many strategies require organizational-level policy change (flexible scheduling, career advancement opportunities) which can be facilitated alongside state-level policy levers (reimbursement improvements, telehealth flexibility, and reduced administrative burden).
- **Highlight and consider tracking Rural Health Transformation Program funding** that addresses needs identified in this assessment, including community-based care programs, workforce development pathways, K-12 career pathways, a new family medicine residency, and preceptor payment initiatives in Eastern Oregon.
- **Continued attention toward collecting robust data on the health care workforce in Oregon.** Oregon's licensure survey and tracking systems are a notable strength compared to other states. Opportunities to expand include:
 - Standardizing additional licensure survey questions including information on if educated in Oregon, adding information on Medicaid acceptance to the nursing surveys, and future plans alignment between MD/DO and PA survey with others.
 - Consider use of practice setting in addition to specialty to more accurately measure the primary care workforce.
 - Continuing to build data on the certified workforce (MAs, DAs, THWs), including use of national data sources and partnering with professional organizations to collect data.
 - Identify opportunities to further improve tracking of the certified behavioral health workforce across licensure/certification types.
 - Consider adding skills-related questions to licensure renewal surveys to help assess skill gaps across experience levels and occupations.

Conclusion

The findings and recommendations presented in this report highlight the ongoing work in Oregon to support and sustain a thriving health care workforce that provides culturally responsive care. Recommendations provide specific suggestions for expansion of current work or additional areas of focus. To accomplish these, ongoing collaborative work will be needed to prioritize recommendations and create measurable goals. This additional work

is an important part of moving forward in Oregon's goal of ensuring everyone has local access to the health care they need.

2. Background

Oregon has engaged in a significant amount of work to ensure a thriving, stable, and culturally responsive health care workforce that can be accessed locally when needed, which is a foundation for equitable population health outcomes. As part of this, the Oregon Legislature passed House Bill (HB) 3261 in 2017, which requires the Oregon Health Policy Board, in collaboration with the Oregon Health Authority, to submit a Health Care Workforce Needs Assessment to the Oregon Legislature every two years. This is the sixth Health Care Workforce Needs Assessment completed in accordance with HB 3261. This assessment is required to include information on the health workforce needed to address health disparities in Oregon, on the impacts of insurance coverage changes, and health workforce needs in rural areas.

Sufficient supply of a well-supported health care workforce is necessary as part of the broader systematic goal of ensuring equitable population health outcomes.^{1,2} In 2017, the Oregon Health Policy Board established the Health Equity Committee with the aim of coordinating and developing policy that promotes the achievement of health equity for residents of Oregon.³ In 2019, the OHA set a goal of eliminating health inequities by 2030, and the Oregon Health Policy Board adopted a formal definition of health equity focused on addressing disadvantages created by socially determined circumstances.^{3,4} This report takes a health equity lens in its approach, giving particular attention to health care workforce needs to address current inequities.

Previous health care workforce needs assessments have highlighted the need to address the maldistribution of the health workforce in Oregon, to grow a health workforce that demographically reflects the Oregon population, and to implement initiatives focused on workforce development. Building on these past assessments, this report specifically focuses on three health care workforce groups: the primary care workforce, the oral health workforce, and the behavioral health workforce. Specifically, this report:

- Describes key factors impacting the demand for, access to, and availability of the health workforce in Oregon, including Social Determinants of Work.
- Describes the demographics, education, supply, distribution, demand, retention, and turnover risk of the three health care workforce groups of focus.
- Examines population health outcomes, measures of need, and access to care.
- Provides recommendations for addressing identified needs.

Due to the lack of an agreed upon measure or specific recommendations for how many providers are needed in different types of communities, this report cannot make recommendations to that effect. However, it is feasible to make recommendations to address identified gaps and areas of inequities. Oregon is already engaged in a significant amount of work in this area – recommendations will highlight opportunities to both sustain, as well as build on, current endeavors.

3. Methods

To assess Oregon's workforce needs, we reviewed multiple Oregon-specific reports and engaged in an extensive literature review. In-depth information on the primary care, oral health, and behavioral health workforce groups in Oregon is mainly based on data analyses from the Oregon Health Care Workforce Reporting Program (HWRP), managed by the Oregon Health Authority Office of Health Analytics. This data contains information on each workforce group's supply, distribution, and population density across the state, as well as workforce demographics, practice characteristics, and retention factors. HWRP data is collected from all state-licensed health care workers when they complete the Health Care Workforce Survey at the time of their license renewal. Survey data is then used to estimate the full size and characteristics of the workforce in Oregon.

We supplemented HWRP state data with workforce data from several other state and national sources. Briefly, we also include information on the certified BH workforce from the Mental Health and Addiction Certification Board of Oregon; educational data from the Integrated Postsecondary Education Data System of the U.S. Department of Education's National Center for Education Statistics and Higher Education Coordinating Commission; workforce demand data from several Oregon Employment Department Workforce and Economic Research Division datasets; and data on Oregon's overall population from the 2024 American Community Survey, the Area Health Resource File, and the Behavioral Risk Factor Surveillance System. Together, these data sources provide a full look into the primary care, oral health, and behavioral workforces of Oregon. We also used previous HWRP health workforce supply and diversity reports, along with their supply dashboard, to examine workforce trends in Oregon over time. Full descriptions of all sources, data, and analyses are in the

4. Social determinants of work

The Social Determinants of Work (SDW) recognize that the conditions in which health care workers are educated, recruited and supported shape the strength and sustainability of the health care workforce as these conditions influence factors such as the types of jobs available, the ability to find employment, and opportunities for career advancement.⁵ OHA can shape some of the impact of these determinants through health policy reforms, such as through Medicaid payment policies,⁶ workforce incentive programs,⁷ housing stipends, relocation assistance, and related initiatives.^{8,9}

Housing stability and affordability

Oregon has faced a longstanding housing shortage, particularly for low- and moderate-income households, which has contributed to sustained increases in home prices and rental costs across much of the state.^{10,11} State analyses estimate that Oregon will need to add approximately 30,000 new housing units annually over the next two decades to meet current and future demand.¹² Nationally, Oregon ranks as the sixth least affordable state for housing, with one third of households spending more than the recommended 30% of their income on housing.¹³ Regionally, this proportion ranges from 12.9% to 46.3% and is most notable among counties on the west side of Oregon (see

Methods appendix). In addition, rural communities, communities recovering from the 2020 wildfires, low-income households, and communities of color may face additional barriers.^{11,14}

Transportation

Transportation influences residents' access to employment, education, health care, and community participation.¹⁵ Although Oregon's urban areas offer relatively robust transportation systems, rural communities face longer travel distances and greater reliance on private vehicles, creating barriers to accessing essential services and employment.^{15,16} To address these concerns, Oregon established the Statewide Transportation Improvement Fund (STIF) in 2017, which expanded transit routes, increased service frequency, reduced-fare programs and improved intercommunity connections.¹⁷ Recent data shows that STIF generated 34.8 million transit rides, up from 18.4 million in the prior 2-year reporting period. These improvements have increased access to essential destinations such as health care and employment, although growing demand and operational costs continue to challenge the state's ability to meet transportation needs.¹⁷

Childcare

According to a 2025 assessment, 34 of Oregon's 36 counties are considered child care deserts for households with infants and toddlers, reflecting continuing shortages in licensed childcare capacity.¹⁸ Although availability for preschool-aged children has improved, largely because of expanded public investments through publicly funded early learning initiatives, access remains uneven across rural and underserved communities and is particularly severe in central Oregon.¹⁸⁻²⁰ Affordability also continues to present barriers for many working families, while limited provider capacity and daycare workforce shortages have contributed to waitlists for Oregon's Employment Related Day Care subsidy program.^{19,21}

School quality

The Oregon Department of Education reports multiple indicators of school quality, including academic achievement, student growth, graduation rates, regular attendance, English learner progress.²² Although Oregon's four-year graduation rate has recovered since the COVID-19 pandemic, reaching 81.8% in the 2023-24 academic year, it is still below its record 82.6% rate in the 2019-20 school year and the U.S. average of 87% for the 2021-2022 school year.²³ With respect to academic achievement, Oregon ranks 46th and 48th in fourth-grade reading and mathematics and 31st and 38th in eighth-grade reading and math in 2024.^{24,25}

District-level data within Oregon indicate substantial geographic variation in these outcomes, with educational challenges affecting both rural communities and some lower-income urban and suburban districts.^{26,27} These differences may have health workforce implications by decreasing the pipeline of students prepared for health professions and may also influence where health care workers choose to move.

Digital access

An estimated 92.4% of Oregon households have broadband internet, however, significant disparities in high-speed internet access persist in many rural communities.²⁸ This, among other concerns, can affect ability to deliver, and access, telehealth services. Oregon is addressing these urban-rural disparities through a \$689 million federal broadband initiative that is expected to expand reliable high-speed internet service to approximately 104,000 underserved locations statewide.²⁹

Food security

Approximately 599,460 Oregonians (14.2%) experienced food insecurity in 2023, including 145,060 children.³⁰ Approximately 40% of food-insecure Oregonians lived in households with incomes above Oregon's Supplemental Nutrition Assistance Program (SNAP) eligibility threshold, indicating that food insecurity extends beyond eligibility for federal nutrition assistance programs.³¹ SNAP-related socioeconomic variables are provided in Section 9 of the report in "Socioeconomic status."

Policies supportive of the workforce overall

Oregon has adopted several policies and official positions which provide important support to the workforce. This includes the statewide Paid Leave Oregon program, which provides eligible employees with paid family, medical, and safe leave, and statewide sick leave protections for most workers.^{32,33} Other workforce-supportive policy include Oregon being a Medicaid expansion state, a refundable Earned Income Tax Credit program, and protections for LGBTQIA+ workers.³⁴ Further, the OHA has a dedicated Equity and Inclusion Division to support culturally responsive care, including language access, and workforce diversity.³⁵

5. Health care workforce landscape

The following section provides an overview of the changing health care landscape in Oregon and underlying factors that may influence workforce capacity, supply, distribution, and sustainability of the health care workforce in Oregon.

Changes to insurance coverage: Federal budget cuts to Medicaid

Recent federal policy changes may cause some Oregon residents to lose Medicaid coverage, according to a state analysis, which could in turn increase the amount of uncompensated care hospitals provide to uninsured patients.³⁶ Approximately 1,460,889 Oregonians are enrolled in Medicaid, representing about 34% of the state's population.³⁷ Changes to Medicaid reimbursement may have workforce implications, given that hospitals and clinics rely heavily on public insurance reimbursement. When coverage drops, facilities see a decline in revenue, financial margins decline, and hiring freezes or layoffs become more likely.³⁸

Rural hospitals may be especially vulnerable to Medicaid reductions given that rural communities tend to have higher poverty rates, less access to employer-sponsored insurance, and poorer overall health outcomes, making Medicaid a disproportionately important source of coverage. Nationally, approximately 25% of people under age 65 who live in rural areas are covered by Medicaid, as well as 22% of people dually enrolled in Medicaid and Medicare.^{39,40}

Some mitigating factors may help offset the potential workforce impacts of Medicaid reductions. In anticipation of federal Medicaid changes, Oregon received approximately \$197 million in federal Rural Transformation funds in 2026 with the potential to receive more in following years.⁴¹ The state has also responded to stabilize workforce given Medicaid cuts: Medicaid insurers will receive approximately 10.2% higher payments per enrollee in 2026 to stabilize access.⁴²

Behavioral health Medicaid reimbursement

Although compensation is frequently identified as a barrier to behavioral health workforce recruitment and retention, Oregon has made substantial investments in behavioral health Medicaid reimbursement. For example, House Bill 5202 (2022) appropriated \$42.5 million in state General Fund dollars to increase Medicaid behavioral health provider reimbursement rates. With federal Medicaid matching funds, this translated into approximately \$154.5 million in total funding for rate increase.⁴³ Additionally, House Bill 4083 (2026) aimed to reduce non-financial barriers by streamlining credentialing, lowering administrative burden, expanding access to clinical supervision, and reducing delays in Medicaid billing and patient care initiation.⁴⁴ A 2023 analysis ranked Oregon ninth among U.S. states in Medicaid fee-for-service reimbursement for a common set of mental health services.⁴⁵

Regulatory factors

Credentialing barriers and facilitators

Oregon has standardized certification pathways for some health care occupations, including community health workers, peer specialists and traditional health workers.^{46,47} However, other occupations have multiple credentialing pathways with different training requirements, supervision expectations, and scopes of practice. For example, Oregon recognizes at least three types of medical assistant credentials, each with distinct qualifications and responsibilities.^{48,49} Because medical assistants are not overseen by a centralized regulatory body, employers are responsible for determining whether candidates are qualified to perform required duties.⁴⁹ These variations can make it difficult to assess whether applicants have comparable skills and competencies. This is similar for other certified occupations, where there is often the option to be trained on-the-job, with competencies verified by the employer (e.g., dental assistants).

Oregon's behavioral health career pathway is similarly complex, with 14 certifying or licensing boards offering 60 credentials and licenses.⁵⁰ The Oregon Higher Education Coordinating Commission notes that navigating this landscape can create barriers to career advancement, particularly when progression between credentials requires additional education, training, or supervised experience.⁵⁰

Scope of practice for advanced practice and other key providers

Expanding health professionals' ability to practice to the full extent of their education and training has been identified as one strategy for improving access to care, particularly in rural and underserved communities.⁵¹ A large number of occupations can independently practice in Oregon, in addition to physicians.

- **Nurse Practitioners** (NPs, inclusive of Psychiatric Mental Health Nurse Practitioners [PMHNPs]) have full practice authority in Oregon, allowing them to independently evaluate patients, diagnose, treat, prescribe medications, and manage patient care within their population focus and competencies.^{52,53}
- **Physician associates** (PAs) (previously physician assistants) practice and prescribe under written collaboration agreements.⁵⁴⁻⁵⁶
- **Psychologists, professional counselors, marriage and family therapists, and clinical social workers** can practice independently, but do not have prescriptive authority.^{57,60}

Compact licensure agreements

Interstate licensure compacts can reduce barriers to practice and improve workforce mobility, but may also involve substantial implementation and administrative costs,

complicate state oversight of professional competencies, and create new participation requirements that can create barriers for some professionals. Oregon participates in the physical therapy compact,⁵⁸ however, Oregon is not a compact state for most other major health care professions – cited reasons include different licensure standards in other states, financial and administrative costs, and limited evidence it would substantially contribute to health workforce growth.⁵⁹ Legislation has been considered for nursing, physician associates, and psychologists, but has not advanced.⁶⁰⁻⁶⁶ Oregon does currently license out-of-state nurses through endorsement, with these now exceeding licenses issued by examination.⁶⁷

Facilitators for workforce capacity

The following section highlights key strategies and supports intended to expand workforce capacity and improve access to care, particularly in rural and underserved communities.

Regulatory strategies

Oregon has pursued targeted regulatory and funding strategies to expand workforce capacity and reduce barriers to practice. For example, expedited licensure by endorsement allows eligible MDs and DOs licensed in other states to obtain Oregon licensure without primary source verification of core credentials, reducing administrative burden and shortening the licensure process.⁶⁸ This is true for nurse practitioners and nurses as well.⁶⁷

Oregon has also taken steps to address supervision barriers in the behavioral health workforce, including House Bill (HB) 2949 in 2021 which allocated \$80 million to address critical behavioral health workforce shortages.⁶⁹ More recently, House Bill 4083 (2026) expanded the pool of professionals eligible to supervise Clinical Social Work Associates (CSWAs), which may address ongoing barriers to licensure among this workforce.^{50,70-73} Other initiatives in 2026 include HB 4069 which requires behavioral health employers to establish workplace safety policies and plans and HB 4115 which streamlines background checks by extending their duration and allowing greater portability across care settings.⁷¹

Expanded telehealth regulations

Oregon's 2023 telehealth law (SB 232) expands pandemic-era flexibilities by allowing certain out-of-state physicians (MDs and DOs) and PAs to provide care with established patients in Oregon via telemedicine without obtaining an Oregon license in certain situations.^{68,74} The regulation has the potential to help mitigate workforce shortages by extending provider services and improving rural access.⁷⁵

Area Health Education Centers (AHECs)

Area Health Education Centers (AHECs) provide important infrastructure supporting Oregon's health workforce education and training pipeline for all health care occupations,

particularly in rural and underserved communities.⁷⁶ Oregon's AHECs were established in 1990 and consists of a central program office at OHSU and five regional AHECs covering the state. Its workforce development activities span the training pipeline, including introducing middle and high school students to health careers, supporting interprofessional education and clinical training, and promoting workforce recruitment and retention.⁷⁶

Provider Incentives programs

Provider incentive programs offer a key strategy for addressing workforce recruitment and retention challenges, particularly in rural and underserved communities where economic and community conditions may make it difficult to attract and retain health professionals. Oregon's Health Care Provider Incentive Program (HCPIP) uses financial incentives to offset some of these barriers and encourage students and practicing providers to serve populations and communities with greater workforce needs.⁷⁷ The program consolidates multiple funding streams into a single OHA-managed fund to strengthen the workforce and has supported at least 3,585 students and health professionals between 2018 and 2022.^{77,78} Indicators of need relevant to these programs are discussed elsewhere in this report.

Technology and AI

Studies suggest that health IT and automation can improve efficiency and decrease administrative burden, allowing clinicians to focus on patient care (e.g., electronic health records and AI-assisted documentation).⁷⁹⁻⁸¹ Oregon has taken a cautious approach to AI implementation. In February 2025, Oregon's statewide Artificial Intelligence Action Plan was released which calls for privacy protections, cybersecurity safeguards, workforce training, and ethical oversight of AI across state government, including health care.⁸²

6. The primary care workforce in Oregon

Background

The primary care workforce includes a range of occupations that contribute to the delivery of comprehensive, coordinated, and person-centered care supporting prevention, health promotion, chronic disease management, patient education, and connections to community-based services.^{83,84} They work in a wide variety of settings, helping to ensure access to care for rural and medically underserved populations.^{85,86} Stronger primary care systems are associated with improved population health outcomes, lower mortality rates, greater health equity, and lower health care spending.^{86,87} The following section provides

an overview of the supply, distribution, and characteristics primary care workforce in Oregon.

Primary care occupations licensed and certified in Oregon

Oregon's licensed primary care workforce spans seven provider types (Table 6-1). These include **Medical Doctors/Doctors of Osteopathic Medicine (MDs/DOs)**, **Naturopathic Doctors (NDs)**, **Nurse Practitioners (NPs)**, and **Clinical Nurse Specialists (CNSs)**, who are fully independent practitioners in Oregon. **Physician Associates (PAs)** provide primary care services via a collaborative agreement with physicians. MDs, DOs, and NDs are all doctorally-prepared; NPs and CNSs can be master's or doctorally-prepared and PAs are master's-prepared. **Registered Nurses (RNs)** work under supervision and can have an associate or bachelor's degree in nursing. **Licensed Practical Nurses (LPNs)** work under supervision and must complete an approved practical nursing program.

Table 6-1. Licensed primary care occupations in Oregon: Definition, scope of practice, and minimum education required

Primary Care Occupation	Definition/Area of Practice	Scope of Practice	Minimum Education Required for Licensure
Physicians (MD/DO)	Those who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology.	Independent practitioner	Completion of, at minimum, postgraduate training (internship, residency, or fellowship), following medical school.
Physician Associates (PAs)	Those who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology.	Collaborative Practice Agreement required	Completion of an accredited master's degree PA training program.
Naturopathic physicians (NDs)	Those who specialize in family medicine, pediatrics, geriatrics or obstetrics.	Independent practitioner	Completion of a doctoral naturopathic medical program, optional post-graduate residency program.
Nurse practitioners (NPs)	Those who specialize in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/gynecology/women's health.	Independent practitioner	Completion of a master's degree in nursing (MSN), or Doctor of Nursing Practice (DNP).
Clinical Nurse Specialist (CNSs)	Those who work in family practice, geriatrics, pediatrics, internal medicine, or	Independent practitioner	Completion of a master's degree in nursing program (MSN), a Doctor of Nursing

	obstetrics/gynecology/women's health.		Practice (DNP), or a post-master's certificate, and must have, or have applied for, an RN license in Oregon.
Registered Nurses (RNs)	Those who work in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/gynecology/women's health.	Supervision required	Completion of an associate degree in nursing (ADN) or a bachelor's degree in nursing (BSN).
Licensed Practical Nurses (LPNs)	LPNs who work in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/gynecology/women's health.	Supervision required	Completion of an Oregon State Board of Nursing-approved Practical Nursing program following a high school diploma or GED.

See

Methods appendix for definitions independent practitioner and collaborative practice agreement.

Oregon's certified primary care workforce includes two occupations (

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Table 6-2). **Medical Assistants (MAs)** provide administrative and clinical support services under the supervision of licensed health care professionals and typically complete a certificate or associate degree program. **Traditional Health Workers (THWs)** are community-based workers who support health education, navigation, outreach, and culturally responsive care and are certified through Oregon-approved training pathways. Training for THWs is largely provided by community-based organizations and health systems.

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Table 6-2. Certified primary care occupations in Oregon: Definition, scope of practice, and minimum education required.

Primary Care Occupation	Definition/Area of Practice	Scope of Practice	Minimum Education/Training Required for Certification
Medical assistants (MAs)	Health care professionals who support other physicians, physician associates, nurse practitioners, and others through performing clinical and administrative tasks (e.g., scheduling, recording vital signs, drawing blood).	Supervision required*	Completion of an accredited MA program post-high school degree/GED.
Traditional health workers (THWs)	Public health workers, of which there are six types certified by the Oregon Health Authority: Community health workers (CHWs), Peer Support Specialists (PSS), Peer Wellness Specialists (PWS), Personal Health Navigators (PHN), Birth Doulas, Tribal Traditional Health Workers.	Supervision required	Training and certification requirements vary by THW type but require completion of an approved training program.

*MAs are not licensed by the State of Oregon and function as supervised unlicensed health care personnel.

Supply and distribution of the primary care workforce in Oregon

As of 2026, there were an estimated 13,054 licensed independent-practice primary care professionals in Oregon, among which 10,166 were estimated to be actively practicing in Oregon (23.6 per 10,000 capita) (

Table 6-3). A majority of these were MDs/DOs, with 14.8 actively practicing per 10,000 capita and NPs (5.3 per 10,000 capita). Total FTEs dedicated to direct care were 17.3 per 10,000 capita (N=7,441). Per 10,000 capita direct patient care FTEs were highest among MDs/DOs (10.8), followed by NPs (3.9) and PAs (2.1).

An estimated 13,357 RNs in were licensed in 2026 among which 9,964 (75%) were estimated to be actively practicing (

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Table 6-3). 5,461 FTEs provided direct patient care (12.7 per 10,000 capita).

Among the certified primary care workforce, there were an estimated 10,603 MAs in Oregon in 2024, and a total of 9,190 active certifications among 7,824 registered THWs. Among active certifications, there were 2,392 CHW, 4,457 Peer Support Specialist, 1,648 Peer Wellness Specialist, and 127 Personal Health Navigator certifications.

Supply changes over time: Since 2024, the primary care workforce grew by 6.1%, from 9,584 in 2024 to 10,166 in 2026. During this time, NPs had the largest supply increase with 18.8% growth in actively practicing licenses (1936 to 2300), followed by 13.7% among PAs (1,015 to 1,154) and 8.9% among NDs (336 to 466). There was very little change among practicing physicians (0.8%). Direct patient care FTEs increased by 4.4% (7,124 to 7,441), with little change in direct patient care FTEs per 10,000 capita (17.0 to 17.3). Among the separate occupations, physicians experienced a slight decline of 0.9%, while PAs increased by 9.2%, NPs by 17.3%, and NDs by 11.3%.

Most professionals work in urban locations in Oregon (75.1%;

Figure 6-1). The highest percentages of professionals working in rural areas were among NPs (36.1% of licensees and 37.6% of direct patient care FTEs) and PAs (32.7% of licensees and 33.1% of direct patient care FTEs). In contrast, NDs (17.2% of direct patient care FTEs) and RNs (19.4% of direct patient care FTEs) were among the lowest. Very few actively licensed primary care occupations also practice in a border state (3.6% of physicians, 0.3% of NDs, 2.1% of PAs; Appendix Table 14-1 **Error! Reference source not found.**). However, the Oregon State Board of Nursing specifically asks NPs where else they are licensed to practice and if they are actually practicing in that state. Just under one quarter (20.6%) of surveyed NPs who specialize in primary care, and 12.0% of RNs, are licensed and working in Washington in addition to Oregon.

The distribution of the primary care workforce is concentrated in the western half of the state, with highest total number of licensed primary care professionals in Multnomah County (Appendix Table 14-2). Counties with the fewest primary care professionals were located mainly on the northeast side of the state, although the per capita supply was not as low, given the low population of these counties (Figure 6-2). For example, while Gilliam

County had only 7 primary care professionals in the state, this was estimated to be 33 per 10,000 capita. All counties had at least one physician and an NP, however Grant and Wheeler counties did not have a PA. The highest estimated density of direct patient care FTE was concentrated in north central Oregon along with Wallowa County (

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Figure 6-3). Counties with the lowest estimated direct patient care FTE per 10,000 population were Columbia (7.7), Polk (7.8), and Morrow (8.0).

Family medicine represents the largest clinical focus area within Oregon's primary care workforce, particularly among NDs (86.1%), NPs (77.5%), and PAs (69.8%) (

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Table 6-4). Geriatric medicine and pediatric/adolescent medicine were common focus areas among PAs and physicians, and obstetrics and gynecology/women's health represented a substantial area of practice for NDs and RNs.

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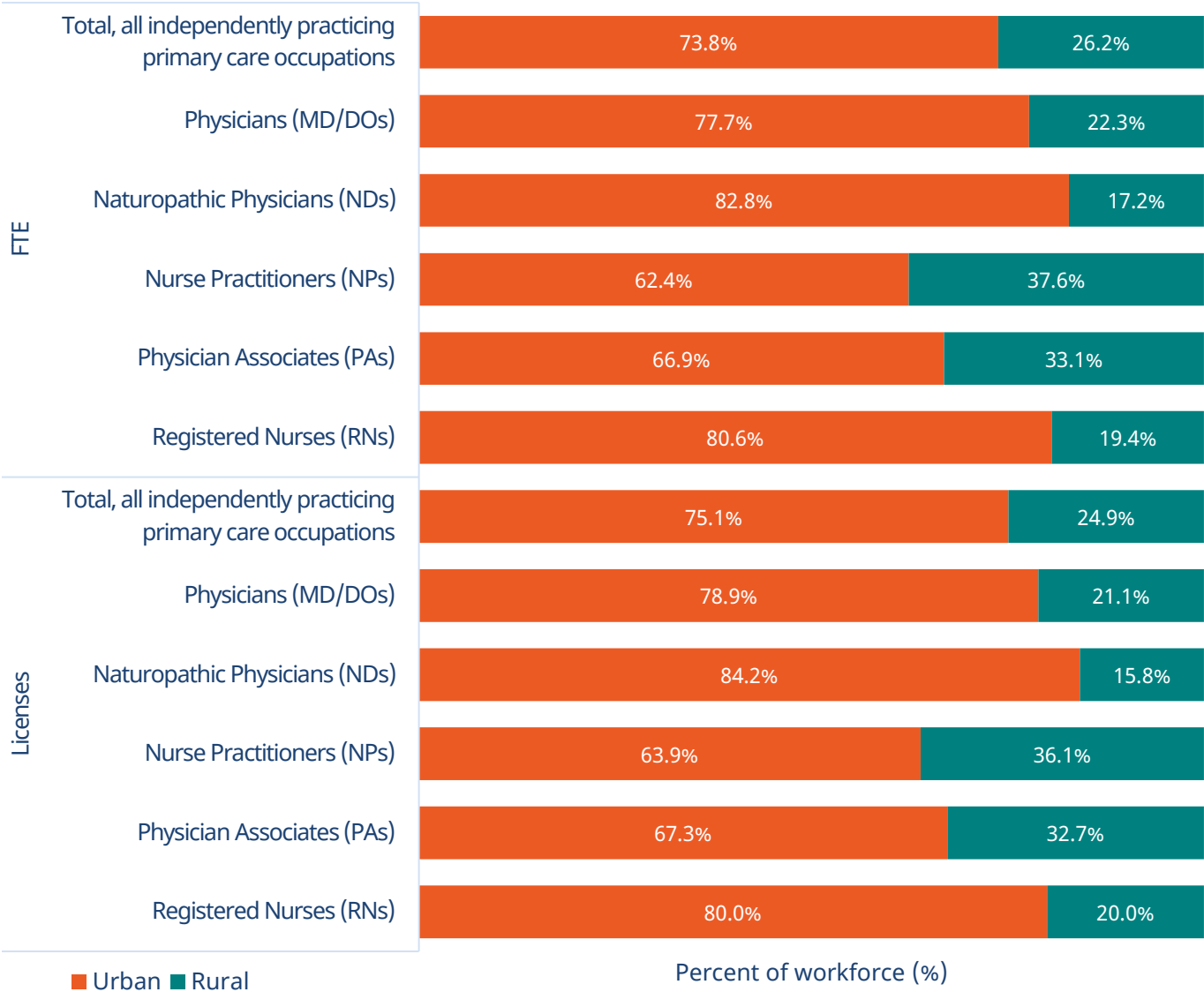
Table 6-3. Estimated supply of the licensed practicing primary care workforce in Oregon, 2024-2026

	Total, independently practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associate (PAs)	Registered Nurses (RNs)
Estimated total number of active primary care licenses in Oregon, N	13,054	8,188	466	3,146	1,254	13,357
Estimated number of actively practicing primary care Oregon licenses, n	10,166	6,346	366	2,300	1,154	9,964
Estimated number of active primary care licenses per capita, n per 10,000 Oregon population	23.6	14.8	0.9	5.3	2.7	23.2
Estimated amount of direct patient care FTE	7,441	4,643	226	1,688	884	5,461
Estimated amount of direct patient care FTE per capita, n per 10,000 population	17.3	10.8	0.5	3.9	2.1	12.7
Estimated amount of other FTE (research, admin, teaching, other)	1,345	846	76	304	119	2,682

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details, including detailed descriptions of included primary care specialties and FTE calculations. Totals only include occupations that can practice independently to more accurately estimate availability of primary care providers: MD/DOs, NDs, NPs, and PAs.

Figure 6-1. Estimated supply and direct patient care FTE of the actively practicing primary care workforce in Oregon by rural/urban practice location, 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

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Methods appendix for more details (descriptions of primary care specialties, FTE calculations, and rural/urban designation). Totals only include occupations that can practice independently to more accurately estimate availability of primary care providers: MD/DOs, NDs, NPs, and PAs.

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Table 6-4. Supply estimates of the actively practicing primary care workforce in Oregon by primary care clinical focus area, 2024-2026

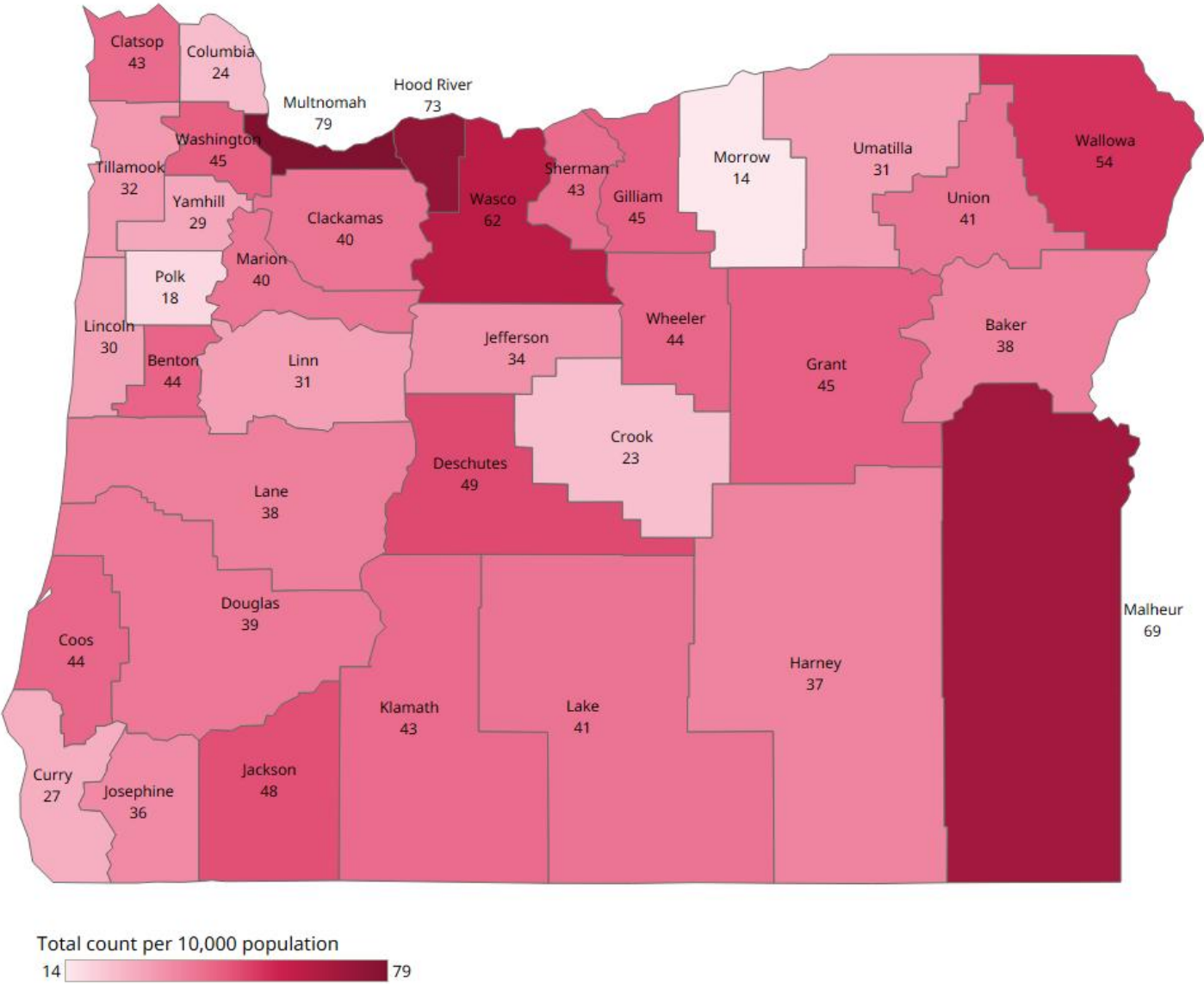
	Total, all independently practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon, N	10,166	6,346	366	2,300	1,154	9,964
Family Medicine	52.8%	38.8%	86.1%	77.5%	69.8%	15.0%
General Medicine	5.3%	4.2%	N/A	N/A	11.6%	N/A
Geriatric Medicine	47.8%	57.9%	0.3%	11.8%	78.8%	25.0%
Pediatric and Adolescent Medicine	36.5%	42.8%	6.6%	8.4%	67.0%	29.5%
Internal Medicine	27.8%	37.4%	N/A	12.0%	15.3%	10.1%
Obstetrics and Gynecology/ Women's Health	15.0%	17.9%	31.7%	4.9%	13.7%	25.5%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. "N/A" indicates specialty not available; these occupations are excluded from total calculations. See

Methods appendix for more details. Column percentages do not add to 100% as workers can practice in multiple clinical focus areas/specialties. Totals only include occupations that can practice independently to more accurately estimate availability of primary care providers: MD/DOs, NDs, NPs, and PAs.

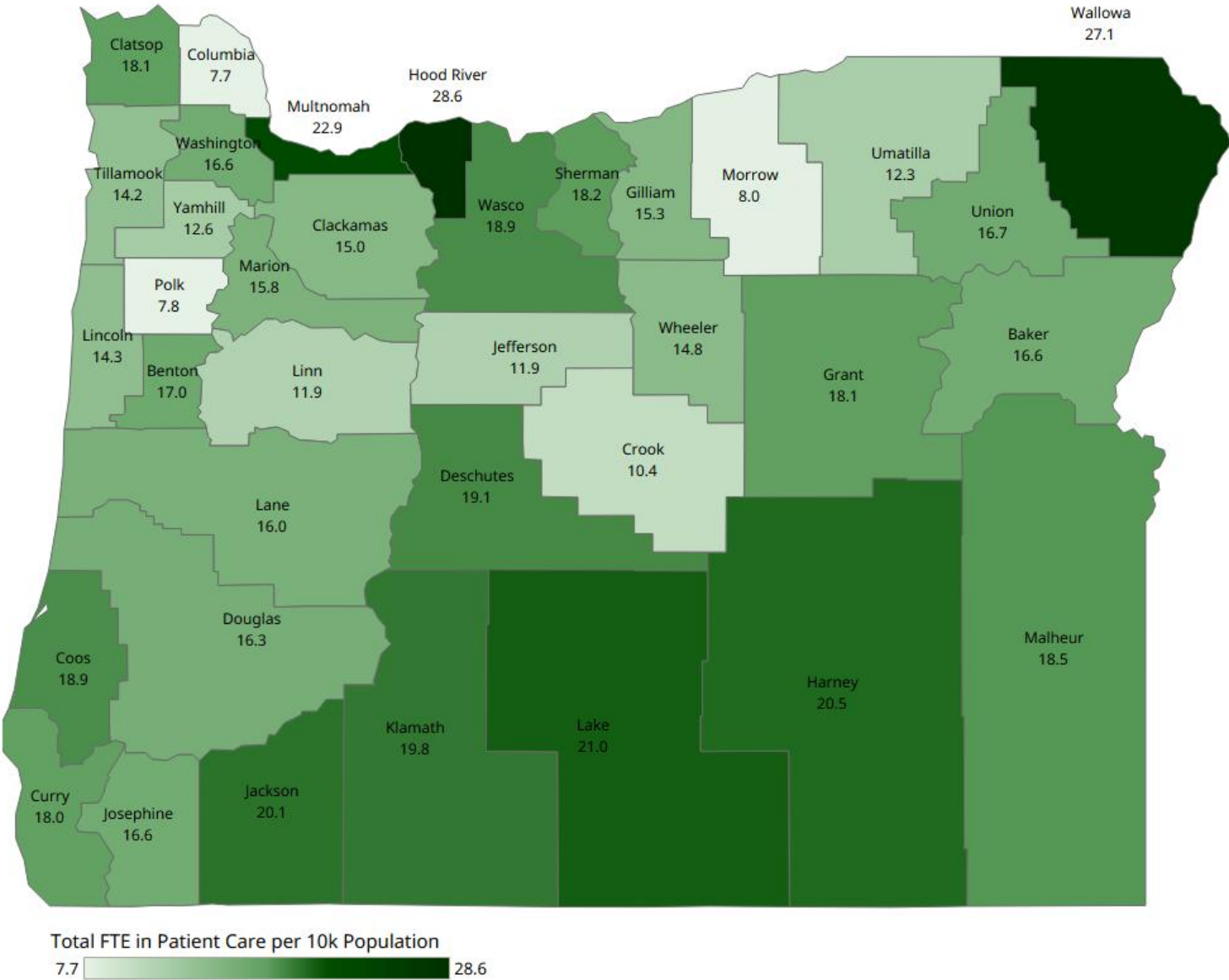
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Figure 6-2. Estimated supply per capita of the actively licensed oral health workforce in Oregon (per 10,000 population), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details. Totals only include occupations that can practice independently to more accurately estimate availability of primary care providers: MD/DOs, NDs, NPs, and PAs.

Figure 6-3. Direct patient care FTE per capita of the actively licensed independently practicing primary care workforce by county in Oregon (per 10,000 population), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details. Totals only include occupations that can practice independently to more accurately estimate availability of primary care providers: MD/DOs, NDs, NPs, and PAs.

Demographics of the primary care workforce in Oregon

The primary care workforce in Oregon was predominantly female, with women representing more than three-quarters (76.0%) of all actively practicing primary care licensees (Table 6-5). Female representation was greatest among RNs and NPs, whereas physicians showed the most even distribution between female and male practitioners. The average age across all primary care occupations was 45.8 years, ranging from 41.5 years among PAs to 49.4 years among physicians.

Consistent with statewide workforce trends, Oregon's primary care workforce remains less racially and ethnically diverse than the state's population.⁸⁸ White clinicians continue to comprise the majority of providers across all primary care professions, while Hispanic/Latino, Black/African American, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander populations remain underrepresented. Asian clinicians remain an exception, particularly among physicians, where they account for 16.1% of the workforce. Compared with 2024, overall patterns of representation are largely unchanged.

Educational attainment aligns with professional training requirements: MD/DOs and NDs almost universally hold doctoral degrees, while NPs and PAs are primarily master's-prepared. RNs have a higher proportion of bachelor's degrees than other primary care occupations, although a substantial share also hold associate degrees.

Among the certified occupations, MAs had an average age of 36.6 years and identified as predominately female (84.1%) and white (71.4%; Table 6-6). One in five MAs (20.0%) reported speaking a language other than English and 11.5% identified as having a disability; educational attainment was concentrated below the bachelor's level, with most reporting some college education (38.3%), a high school diploma or equivalent (22.3%), or an associate degree (23.1%).

THWs are more racially diverse than the MA occupation and Oregon overall, with 55.0% identifying as White, 15.2% as Hispanic or Latino/a/x, 8.7% as American Indian or Alaska Native, and 7.9% as Black or African American.^{89,90}

Table 6-5. Estimated demographics of the actively practicing primary care workforce licensed in Oregon, 2024-2026

	Total, all primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
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Estimated number of actively practicing primary care licenses in Oregon, N	20,130	6,346	366	2,300	1,154	9,964
Average age at original licensure (years), Mean (SD)	32.7 (9.0)	34.9 (7.5)	32.3 (5.6)	37.5 (9.2)	32.47 (7.8)	30.0 (9.3)
Average age (years), Mean (SD)	45.8 (12.2)	49.4 (11.7)	46.7 (11.7)	46.4 (10.9)	41.5 (10.6)	43.5 (12.4)
Gender identity						
Female	76.0%	54.3%	72.7%	84.2%	68.3%	88.9%
Male	22.1%	45.6%	22.7%	12.5%	31.5%	8.2%
Other/Self describe	0.4%	0.1%	1.4%	0.6%	0.2%	0.4%
Decline to answer	1.9%	0%	3.3%	2.8%	0%	2.4%
Race/Ethnicity						
American Indian or Alaska Native	0.6%	0.2%	0.3%	1.0%	0.5%	0.8%
Asian	8.6%	16.1%	3.8%	4.9%	6.5%	5.3%
Black/African American	2.4%	1.7%	1.4%	4.9%	1.7%	2.3%
Native Hawaiian/Pacific Islander	0.2%	0.2%	0%	0.1%	0.2%	0.3%
Middle Eastern/North African	0.5%	1.3%	0.6%	0.1%	0.4%	0.2%
White	65.0%	58.5%	69.7%	67.2%	65.4%	68.4%
Hispanic or Latino/a/x/e	4.1%	2.0%	4.1%	4.1%	3.2%	5.5%
Other race	1.3%	2.0%	1.9%	1.0%	1.5%	0.8%
Multi race	4.7%	4.3%	7.7%	4.0%	5.7%	4.9%
Decline or Unknown	12.5%	13.8%	10.7%	12.8%	15.1%	11.5%
Speaks language other than English	24.0%	37.5%	20.5%	19.5%	25.5%	16.5%
Identifies as having a disability	2.1%	—	2.5%	2.0%	—	3.7%
Highest level of education						
High School	0.3%	0%	0%	0%	0%	0.6%
Associate degree	13.2%	0%	0%	0%	0%	26.7%
Bachelor's degree	32.4%	0%	0%	0.5%	3.5%	65.0%
Master's degree	17.8%	0%	0%	78.9%	92.9%	7.0%
Doctorate degree	35.8%	99.8%	100%	20.4%	0%	0.4%
None of the above	0.2%	0%	0%	0.1%	0%	0.3%
Missing	0.3%	0.2%	0%	0%	3.6%	0%
Practice distribution by region in Oregon						
Portland Metro	51.6%	51.6%	67.8%	37.7%	44.5%	54.8%

Willamette Valley & North Coast	13.7%	14.4%	12.8%	13.8%	16.4%	12.9%
Central Oregon	9.1%	8.6%	6.6%	11.7%	12.5%	8.6%
Southern Oregon	19.5%	19.2%	11.7%	26.4%	19.9%	18.3%
Eastern Oregon	3.5%	2.8%	0.5%	5.3%	4.9%	3.5%
Missing	2.6%	3.3%	0.5%	4.2%	1.8%	1.9%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

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Methods appendix for more details, including descriptions of included primary care specialties, and definitions of disability and regional distribution. For detailed REALD race/ethnicity standard reporting categories see Appendix Table 14-3.

Table 6-6. Demographics of the medical assistant (MA) workforce in Oregon, 2024

	Proportion of estimated MAs in Oregon (%)
Estimated total number of medical assistants in Oregon, N (weighted)	10,603
Average age (years), Mean (<i>Standard Error</i>)	36.6 (1.5)
Gender identity	
Female	84.1%
Male	15.9%
Race	
American Indian or Alaska Native	1.2%
Asian/Pacific Islander	5.9%
Black/African American	0.0%
White	71.4%
Other/Mixed Race	21.5%
Ethnicity	
Hispanic origin	23.0%
Speaks language other than English	20.0%
Identifies as having a disability	11.5%
Highest level of education	
Less than high school	3.2%
High School or equivalent	22.3%
Some college	38.3%
Associate degree	23.1%
Bachelor's degree	10.3%
Master's degree	1.3%
Professional school/Doctorate degree	1.4%

Data Source: American Community Survey 2024 1-year estimates. See

Methods appendix for more details.

Practice characteristics of the primary care workforce in Oregon

Work patterns were similar across provider types, with primary care workers reporting an average of 35-38 hours worked per week (Table 6-7). The share of those working more than 40 hours per week ranged from 14% among RNs to 28% among physicians. Telehealth use was common among NDs and NPs, with more than 80% reporting providing telehealth services to Oregon residents, compared with 20% of RNs.

Many primary care professionals reported seeing Medicaid-covered patients in their practice. Among physicians, NDs, and PAs, most reported serving at least some Medicaid patients (61.2% for NDs, 80.4% for physicians, and 86.1% for PAs). Among those who reported the proportion of Medicaid patients at their primary practice site, the largest share of physicians and PAs indicated that Medicaid beneficiaries comprised 0%-50% of their patient panel, while NDs were more evenly distributed across Medicaid patient-share categories.

Primary care services are delivered in a variety of settings, and practice settings varied by profession (

Table 6-8). Physicians, NDs, and PAs commonly practiced in private clinics or office-based settings, while the highest proportion of RNs reported working in hospital settings. Community and public health settings represented an important practice location for PAs and physicians, and skilled nursing or long-term care settings appeared among the most common settings for NPs and RNs.

Annual wages varied considerably across primary care occupations and generally reflected differences in education, training requirements, and scope of practice (

Table 6-9). Family medicine and general internal medicine physicians reported the highest median wages, exceeding \$239,000 annually. NPs and PAs had median wages around \$150,000, while RNs earned a median wage of approximately \$127,000. Medical assistants and community health workers had lower median wages of about \$51,000 and \$57,000, respectively.

Table 6-7. Estimated practice characteristics of the actively practicing primary care workforce in Oregon, 2024-2026

	Total, all independently practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon, N	10,166	6,346	366	2,300	1,154	9,964
Average hours worked per week, mean (SD)	—	37.9 (16.8)	35.9 (13.9)	37.4 (14.3)	37.1 (10.9)	34.5 (12.1)
Worked over 40 hours weekly	—	28.3%	27.0%	26.1%	15.4%	14.3%
Telehealth practice serving Oregon residents	—	—	87.7%	83.4%	—	20.3%
Sees patients covered by Medicaid at primary or secondary practice*	80.4%	80.4%	61.2%	—	86.1%	—
Percentage of Medicaid patients seen at primary practice, n	6,322	5,103	224	—	994	—
0–25%	22.0%	23.4%	20.1%	—	15.3%	—
26–50%	21.5%	21.3%	25.4%	—	21.6%	—
51–75%	13.8%	12.0%	25.4%	—	20.7%	—
76–100%	7.4%	5.8%	23.2%	—	12.0%	—
Unknown	33.7%	35.9%	4.5%	—	28.9%	—

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Dashes indicate unavailable data. See

Methods appendix for more details.

*Out of only those asked about Medicaid (n=7,866).

Table 6-8. Top three primary practice settings of the actively practicing primary care workforce in Oregon, 2024-2026

	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon, N	6,346	366	2,300	1,154	9,964
Primary practice setting Rank 1	Private clinic or office (47.7%)	Private outpatient practice/clinic (87.2%)	Office/clinic (68.6%)	Private clinic or office (56.4%)	Hospital (44.1%)
Primary practice setting Rank 2	Hospital (30.2%)	Community/ school health center (5.2%)	Other (13.3%)	Community/ public health clinic (28.2%)	Office/clinic (24.7%)
Primary practice setting Rank 3	Community/ public health clinic (12.5%)	Educational/ research institution (3.3%)	Skilled nursing facility/long term care (2.6%)	Other (9.1%)	Skilled nursing facility/long term care (7.4%)

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details. Practice setting wording reflects exact wording used on each professional board's workforce survey.

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Table 6-9. Annual median wage of select actively practicing primary care professionals in Oregon, 2025

Occupation Title	2025 Annual Median Wage
Family Medicine Physicians	Over \$239,200
General Internal Medicine Physicians	Over \$239,200
Pediatricians, General	\$186,930
Nurse Practitioners	\$148,533
Physician Associates	\$153,192
Registered Nurses	\$127,358
Medical Assistants	\$51,314
Community Health Workers	\$57,034

Data source: Oregon Wage Information prepared by the Oregon Employment Department, Workforce and Economic Research Division. Primary care occupations listed reflect those with data collected by the Oregon Employment Department and include both licensed and certified occupations, ordered from most to least education required. See

Methods appendix for more details.

Education program completions of the primary care workforce in Oregon

Oregon's primary care education and training pipeline varies considerably by occupation (Table 6-10). RN programs produced the largest number of graduates annually, with just under 1,300 graduates in 2024 and generally stable output over time despite fluctuations during the COVID-19 pandemic. MA and LPN programs also contributed substantial numbers of graduates, although both experienced declines earlier in the period before rebounding in 2024. PA programs have shown modest growth, increasing from 94 graduates in 2018 to 116 in 2024. In contrast, MD, ND, and NP programs produce substantially fewer graduates each year. MD completion counts have remained relatively stable, while ND and NP programs have experienced declines since 2018. Oregon's training capacity across key primary care occupations is summarized below.

It should be noted that Oregon has one MD-granting medical school (OHSU School of Medicine) and these are the completions reflected. Oregon hosts Western University of Health Sciences' osteopathic medical program (COMP-Northwest), but IPEDS reports completions at the institutional level and thus, completions information likely understate Oregon's MD/DO training pipeline. This is likely true for NPs and RNs as well, as many nursing students from online and out-of-state institutions also complete clinical training in Oregon.^{91,92}

Oregon's primary care training programs are concentrated in the Portland metropolitan area, with smaller numbers of programs and graduates distributed across the Willamette Valley, Central Oregon, Southern Oregon, and Eastern Oregon (Figure 6-4). RN programs account for the largest number of annual completions and are geographically the most widespread, while MD, ND, NP, and PA training programs are concentrated in a smaller number of locations.

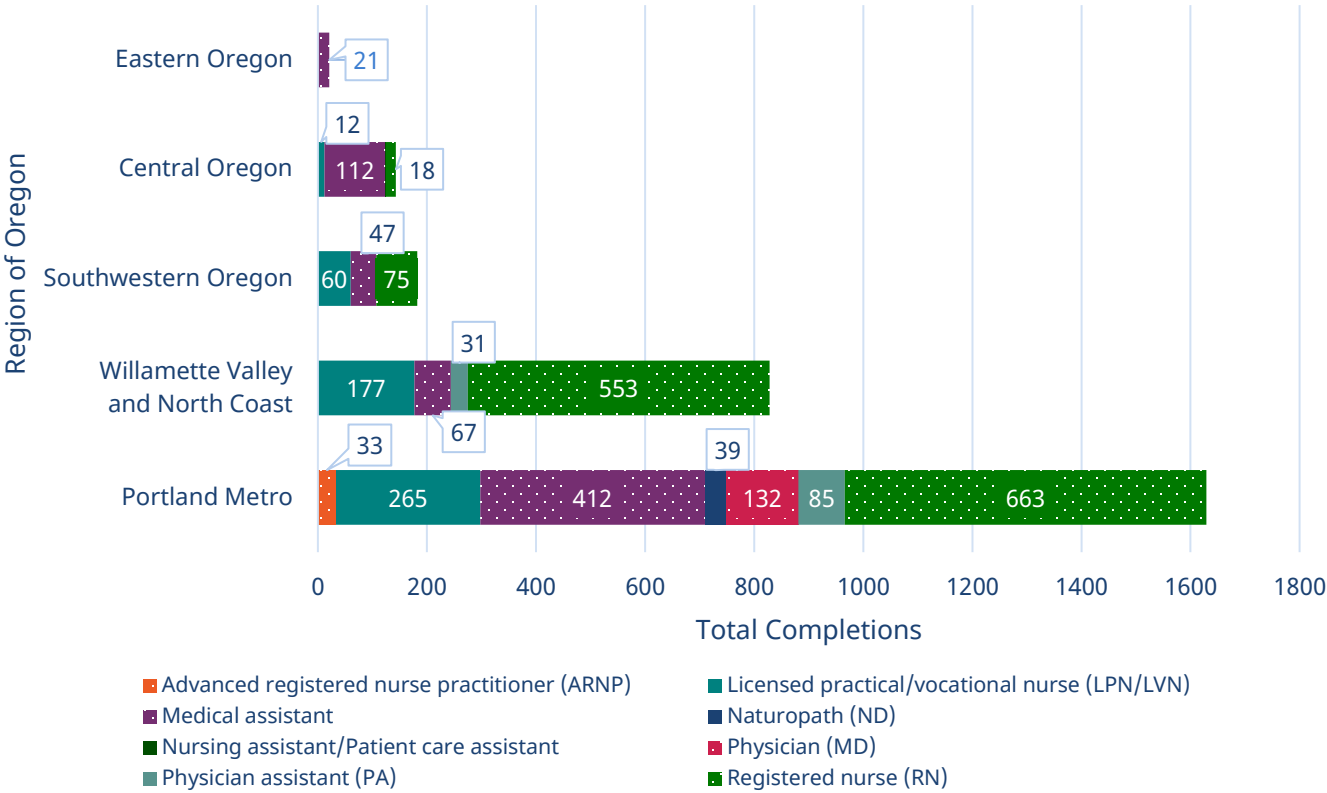
Table 6-10. Education programs and total number of completions, by academic year, of the actively practicing primary care workforce in Oregon, 2018-2024

Occupation (number of education institutions in Oregon, 2024)	2018	2019	2020	2021	2022	2023	2024
Physician (MD) (N=1)	147	126	151	158	149	166	132
Naturopathic Medicine (ND) (N=1)	87	73	67	61	38	49	39
Nurse Practitioner (N=2)	110	118	122	79	60	53	44
Physician Associate (N=3)	94	95	97	101	97	118	116
Registered Nurse (N=18)	1,303	1,279	1,383	1,002	1,243	1,219	1,299
Licensed Practical/Vocational Nurse Training (LPN/LVN) (N=11)	512	430	392	379	363	367	438

Medical Assistant (N=19)	804	740	470	737	586	522	648
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Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See Methods Appendix for more details of CIP codes by occupation and award level.

Figure 6-4. Primary care training programs in Oregon with at least one completion by number of completions, 2024



Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See

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Demand and reported vacancies of the primary care workforce in Oregon

Demand for Oregon's primary care workforce is projected to grow over the next decade, with the largest increases expected among NPs, PAs, RNs, MAs, and community health workers (Table 6-11). NPs are projected to experience strong growth, with employment increasing by nearly 50% between 2024 and 2034. RNs and MAs are expected to have the largest increase in the number of job openings due to the size of their respective workforces and ongoing replacement needs. Across most occupations, replacement job openings account for a substantial share of projected demand, with the highest replacement openings among MAs and community health workers, highlighting the importance of maintaining training pipelines while also addressing retirements and workforce turnover. Family medicine physicians, PAs, and NPs are all projected to see growth in both employment and annual job openings.

Table 6-11. Projected employment of and demand for the primary care workforce in Oregon, 2024-2034

Occupation Title	2024 Employment	2034 Projected Employment	Average Annual Job Openings, 2024-2034	Projected Replacement Openings, 2024-2034	Projected New Job Openings, 2024-2034	Total Projected Openings, 2024-2034
Family Medicine Physicians	1,952	2,143	71	516	191	707
General Internal Medicine Physicians	447	491	16	118	44	162
Obstetricians and Gynecologists	334	361	12	88	27	115
Pediatricians, General	896	901	23	226	5	231
Nurse Practitioners	2,642	3,911	269	1,418	1,269	2,687
Physician Associates	2,096	2,739	182	1,173	643	1,816
Registered Nurses	46,378	50,592	2,828	24,068	4,214	28,282
Medical Assistants	12,343	14,684	1,837	16,025	2,341	18,366
Community Health Workers	1,646	1,886	207	1,825	240	2,065

Data sources: Oregon Wage Information, Oregon Occupations in Demand, and Oregon Occupational Employment Projections prepared by the Oregon Employment Department (OED), Workforce and Economic Research Division. Primary care occupations listed reflect those with data collected by the OED and include both licensed and certified occupations. See

Methods appendix for more details.

Retention and turnover of the primary care workforce in Oregon

Oregon's primary care workforce reflects varying levels of in-state training and retention across professions (Table 6-12). More than 80% of NDs reported completing their education in Oregon, compared with 36% of PAs and 25.8% of physicians, indicating that a substantial share of the physician and PA workforce is trained outside the state. Physicians and NDs have been licensed for an average of approximately 14 years, while NPs and PAs average about nine years since initial licensure, suggesting continued entry of newer providers into Oregon's primary care workforce.

Available workforce planning data suggest relatively strong retention among Oregon's primary care workforce (Table 6-12). Among NPs and RNs, about two-thirds expect to remain in the workforce for more than 10 years. Most clinicians expect to maintain their current work hours (over 75% across professions), and the large majority plan to continue working at their current practice location (over 80% across professions). Relatively few anticipate leaving Oregon to practice elsewhere or leaving their profession altogether.

Table 6-12. Workforce retention and future career plans of the actively practicing primary care workforce in Oregon, 2024-2026

	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon, N	6,346	366	2,300	1,154	9,964
Completed PA educational program or medical residency in Oregon (%)	25.8%	86.1%	N/A	36.0%	N/A
Average years since original licensure (as of 2026), mean(SD)	14.5 (11.1)	14.4 (10.3)	8.9 (8.0)	9.0 (7.1)	13.5 (10.6)
Anticipated change in future work hours (%)					
Increase practice hours	1.6%	11.2%	5.1%	1.8%	6.8%
Maintain practice hours	89.4%	75.4%	82.2%	89.3%	82.3%
Reduce practice hours	4.5%	12.0%	11.3%	3.2%	9.4%
Other	0.8%	1.4%	1.4%	0.5%	1.5%
Anticipated change in future career plans over the next two years (%)					
Continue working at my current location(s)	N/A	88.8%	85.8%	N/A	85.9%
Leave Oregon to practice out of state	N/A	1.4%	2.1%	N/A	2.2%
Leave the field (intend to work in a different field)	0.1%	2.2%	0.7%	0.3%	0.7%
Move to Oregon to practice in the field	0.0%	0.0%	0.3%	0.0%	0.2%

Move to another practice location in Oregon	1.1%	3.6%	6.0%	3.4%	5.4%
Other	—	2.5%	2.6%	—	3.2%
Retire	1.8%	1.6%	2.5%	0.3%	2.6%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

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7. The oral health workforce in Oregon

Background

Oral health is an essential part of overall health and wellbeing. Poor oral health, including untreated tooth decay and gum disease, is associated with a range of chronic conditions, including diabetes, cardiovascular disease, adverse pregnancy outcomes, and certain cancers.^{93,94} Historically, oral health care has been financed, delivered, and managed separately from physical and behavioral health care, resulting in missed opportunities for comprehensive primary care.^{95,96} In Oregon, coverage for diagnostic and preventive oral health services is included as part of the Oregon Health Plan, with many of the 33 Federally Qualified Health Centers in Oregon offering dental services along with primary care and behavioral health services. Still, access to care requires a sufficient workforce to meet need – the following provides an overview of the supply, distribution, and characteristics of the oral health workforce in Oregon.

Oral health care occupations licensed and certified in Oregon

Oregon’s licensed oral health workforce spans five provider types (**Table 7-1**). **Dentists** practice independently and are doctorally-prepared (DDS or DMD). **Dental hygienists (DHs)** work under the supervision of dentists and require an associate degree at minimum. **Expanded Practice Dental Hygienists (EPDHs)**, once permitted, can provide preventive care independently or via a collaborative agreement with a dentist. **Dental therapists**, authorized in 2021, work under collaborative agreements as well and are required to complete a dental therapy program. **Denturists** practice independently and are required to have, at minimum, an associate degree.

Oregon is considered a national leader in allowing DHs to practice more independently in community-based settings as compared to other states.⁹⁷ DHs without an EPDH permit can perform many hygiene procedures under general supervision (dentists not required to be physically present).⁹⁸ DHs with EPDH permits can perform an additional set of independent tasks, including assessing and treating qualifying patients without dentist supervision, operating an independent hygiene practice, and providing dental care in nursing homes, schools, community clinics, or correctional facilities.⁹⁹ A comparison of activities is listed in Appendix Table 16-1.

Table 7-1. Licensed oral health occupations in Oregon: definition, scope of practice, and minimum education required

Oral Health Providers	Definition	Scope of Practice	Minimum Education/ Training Required for Licensure
Dentist	Those who can diagnose oral health diseases, interpret x-rays, monitor the growth and development of teeth and jaws, and perform surgical procedures on teeth.	Independent Practitioner	Completion of a CODA-accredited dental school program resulting in a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree, and successful completion of required national licensure examinations.
Dental hygienist	Paraprofessional that works under the supervision of a licensed dentist to provide preventive and therapeutic oral prophylaxis and educate patients in dental hygiene.	Supervision required	Completion of a CODA-accredited dental hygiene program resulting in an associate or bachelor's degree, and successful completion of required national and clinical licensure examinations.
Expanded practice dental hygienist (EPDH)	Hygienist with the training and experience to qualify for an expanded practice permit who can operate independently without the direct supervision of a dentist and render preventive services via tele-dentistry; authorized to work in specific settings such as community health clinics, nursing homes, and other locations described in ORS 680.200.	Independent practitioner in select settings (e.g. nursing homes, schools, community clinics, or correctional facilities) or Collaborative agreement	Completion of dental hygienist licensure requirements plus additional education and clinical experience requirements including 2500 hours supervised practice plus 40 hours of coursework OR completed course of study that includes 500 hours dental hygiene practice.
Dental therapist	A newer provider type allowed by House Bull 2528 (2021) to be licensed and practice in Oregon. This dental provider offers preventive and routine restorative care, including filling cavities, placing temporary crowns, and extracting badly diseased or loose teeth.	Collaborative agreement	Completion of a CODA-accredited or board-approved dental therapy program that includes didactic and clinical training in dental therapy procedures, plus successful completion of required board examinations.

Denturist	A licensed professional who is trained to provide removable dentures directly to the public without being supervised by a dentist. They construct, adjust, repair, relin, and alter full or partial dentures and other removable non-orthodontic dental appliances, and they take impressions and bite registrations as part of treatment.	Independent practitioner	Completion of an associate degree or equivalent denture technology program that meets state-approved curriculum requirements, including extensive coursework and supervised clinical training in denture construction and patient care.
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There are three occupations in Oregon’s certified oral health workforce (Table 7-2). **Dental assistants (DAs)** and **Expanded function dental assistants (EFDAs)** both operate under a dentists’ supervision. DAs are not required to be certified and can be trained on the job in Oregon. EFDAs, certified through the Dental Assisting National Board (DANB), can perform specialized tasks in addition to those of a dental assistant, such as removal of temporary crowns and fitting for new crowns. functions.¹⁰⁰ DANB administers other DA certification programs on behalf of the Oregon Board of Dentistry, including credentials such as Radiologic Proficiency, Expanded Function Orthodontic Dental Assistant, and Expanded Function Preventive Dental Assistant. **Community dental health coordinators** provide oral health education and support with navigating oral health services. This certification requires Community Dental Health Coordinator Program.

Table 7-2. Certified oral health occupations in Oregon: Definition and minimum education required

Oral Health Providers	Definition	Minimum Education/ Training Required for Certification
Dental assistant	Unlicensed professional that helps with infection control by sterilizing and disinfecting instruments, setting up instrument trays, and assisting with dental procedures.	No formal educational degree, certification, or licensure is required to work as a dental assistant in Oregon. Training may be obtained through on-the-job experience or completion of a dental assisting certificate program.
Expanded function dental assistant (EFDA)	In addition to the duties of a dental assistant, and defined under OAR 818-042-0070, EFDAs are allowed to perform the following tasks after certification under the supervision of a dentist: coronal polishing; removing temporary crowns; preliminarily fit crowns; place temporary restorative material, polish amalgam or composite restorations with a slow-speed handpiece; remove excess supragingival cement from crowns, bridges, bands, or brackets; fabricate temporary crowns and bridges and temporarily cement them; re-cement	Completion of a CODA-accredited dental assisting program and additional state certification requirements to perform expanded dental assisting functions (EFDA), including radiographic proficiency and successful completion of approved examinations.

	temporary or permanent crowns with temporary cement in limited situations.	
Community dental health coordinator	Provides oral health education, helps patients navigate the oral health system, coordinates appointments and follow-up care, assists with case management, and supports prevention efforts.	Completion of a 12-month Community Dental Health Coordinator (CDHC) training program that includes didactic instruction, community-based experience, case management training, and preventive oral health education.

Scope of Practice Note: supervision is required for all certified oral health occupations in Oregon.

The following sections of the report will focus on the oral health professions involved in the delivery of primary oral health care, as data is available: dentists, dental hygienists, and dental assistants.

Supply and distribution of the oral health care workforce in Oregon

As of 2026, there were an estimated 7,114 licensed oral health professionals in Oregon, of which roughly 80% (N=5,704) were actively practicing (

Table 7-3). Direct care FTE was relatively similar between dentists (4.8 per 10,000 capita) and DHs (5 per 10,000 capita). As of January 2026, there were 22 dental therapists licensed in Oregon, with 16 having completed the Health Care Workforce survey (data not tabled). There are 7,586 DAs in Oregon, although it is unknown what percent are actively practicing.¹⁰¹

Of the 30.4% of DHs (N=996) who hold an expanded practice permit, an estimated 31.5% are active permit users (n=314) and 61.8% of permit users have a collaborative agreement with a dentist (

Table 7-4).

Supply changes over time: From 2024 to 2026, the size of the actively practicing licensed oral health workforce grew 0.8% overall. Actively practicing dentists grew by 1% (2,403 to 2,428) and DHs by 0.6% (3,255 to 3,276), with Morrow County now estimated to have five oral health professionals (previously was zero). Oral health direct patient care FTEs increased by 1.3% (4,143 to 4,196). Previous per capita estimates only included EPDH holders and are not comparable to current estimates. The number of EPDH holders increased by 14.0% (874 to 996).

Just under a quarter of actively practicing oral health professionals in Oregon (24.9%) are estimated to be working in rural areas, with similar proportions of direct care FTE in rural areas (25.2%) (

Table 7-3). Very few actively practicing oral health professionals have a practice address in a bordering state (1%; see Appendix Table 16-2).

The highest total number of licensed practicing oral health professionals in Oregon was on the west side of the state in counties with large cities (Appendix Table 15-2). There were two counties – Gilliam and Sherman - with 0 estimated DHs; all counties had at least 1 dentist. Overall oral health workforce density ranged from 5 per 10,000 capita in Gilliam County to 39 in Wheeler County (

Figure 7-2).

The lowest direct patient care FTE per 10,000 capita was generally in the central part of the state, with the western side of the state having high FTE density overall. Hood River (15.6) and Wallowa (14.0) counties had the highest direct patient care FTE per 10,000 capita and Gilliam (0.6) and Sherman (1.4) had the lowest (

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Figure 7-3).

Table 7-3. Estimated supply of the licensed practicing oral health workforce in Oregon, 2024-2026

	All Oral Health Occupations	Dentists	Dental Hygienists
Estimated number of active oral health Oregon licenses, N	7,114	3,024	4,090
Estimated number of actively practicing oral health licenses in Oregon, n	5704	2428	3276
Estimated number of actively practicing oral health licenses per capita, n per 10,000 population	13.3	5.6	7.6
Estimated amount of direct patient care FTE	4,196	2,046	2,150
Estimated amount of direct patient care FTE per 10,000 population	9.8	4.8	5.0
Estimated amount of other FTE (research, admin, teaching, other)	333	63	270

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

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Table 7-4. Estimated supply of actively practicing expanded practice dental hygienists (EPDHs)* in Oregon, 2024-2026

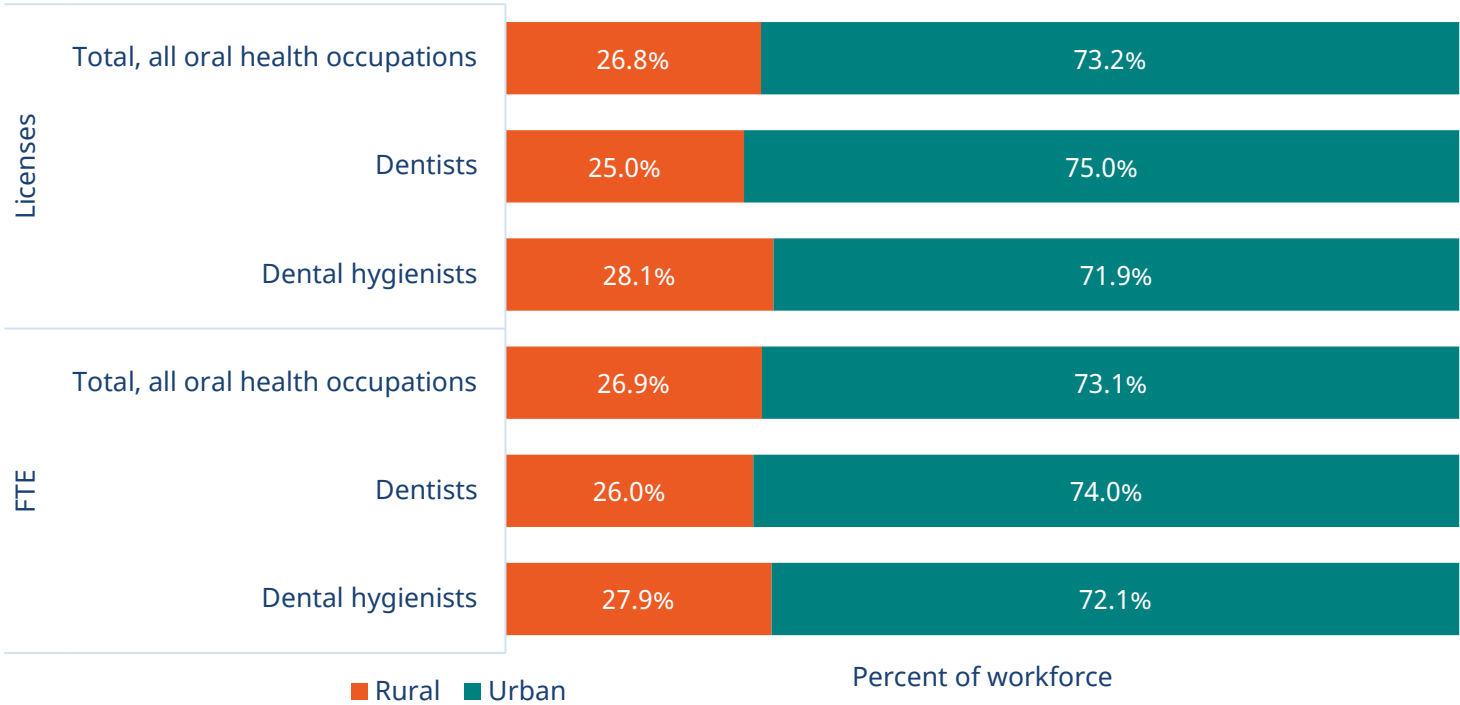
	Dental Hygienists N=3,276
Estimated supply of dental hygienists that hold an EPDH permit in Oregon, N(%)	996 (30.4%)
Estimated direct care FTEs of dental hygienists that hold an EPDH permit in Oregon, N	631
Estimated supply of active EPDH permit users among all EPDH permit holders, N(%)	314 (31.5%)
Estimated supply of active EPDH permit users in a collaborative agreement with a dentist, N(%)	194 (61.8%)

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

*EPDHs hold a special permit in the state of Oregon allowing them to provide preventative care independently, without direct supervision from a dentist. See Appendix Table 16-1 and **Error! Reference source not found.**

Figure 7-1. Estimated supply and direct patient care FTE of the actively practicing oral health care professionals in Oregon by rural/urban practice location, 2024-2026

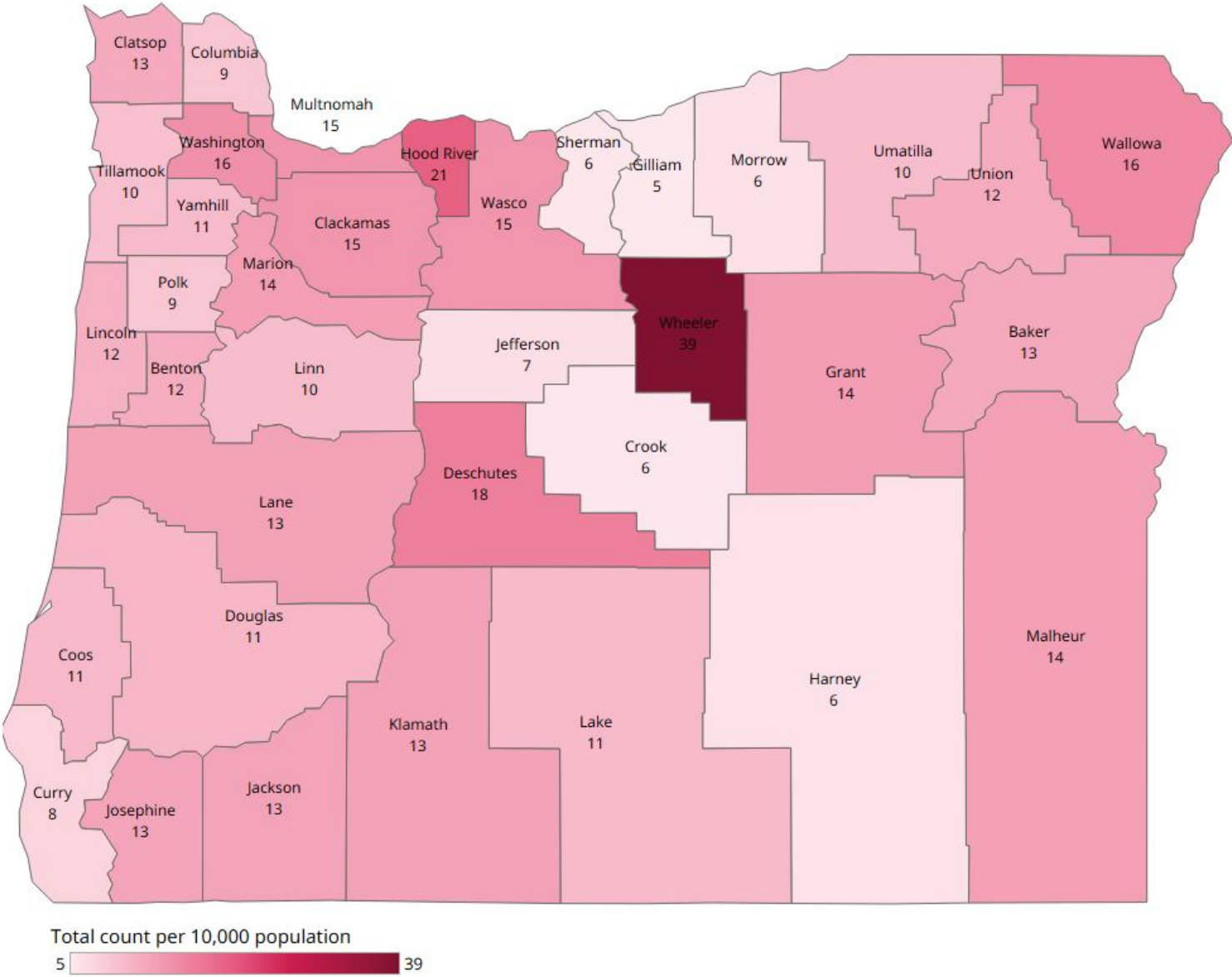


Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details (missing counts, FTE calculations and rural/urban designation).

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Figure 7-2. Estimated supply per capita of the actively licensed oral health workforce in Oregon (per 10,000 population), 2024-2026

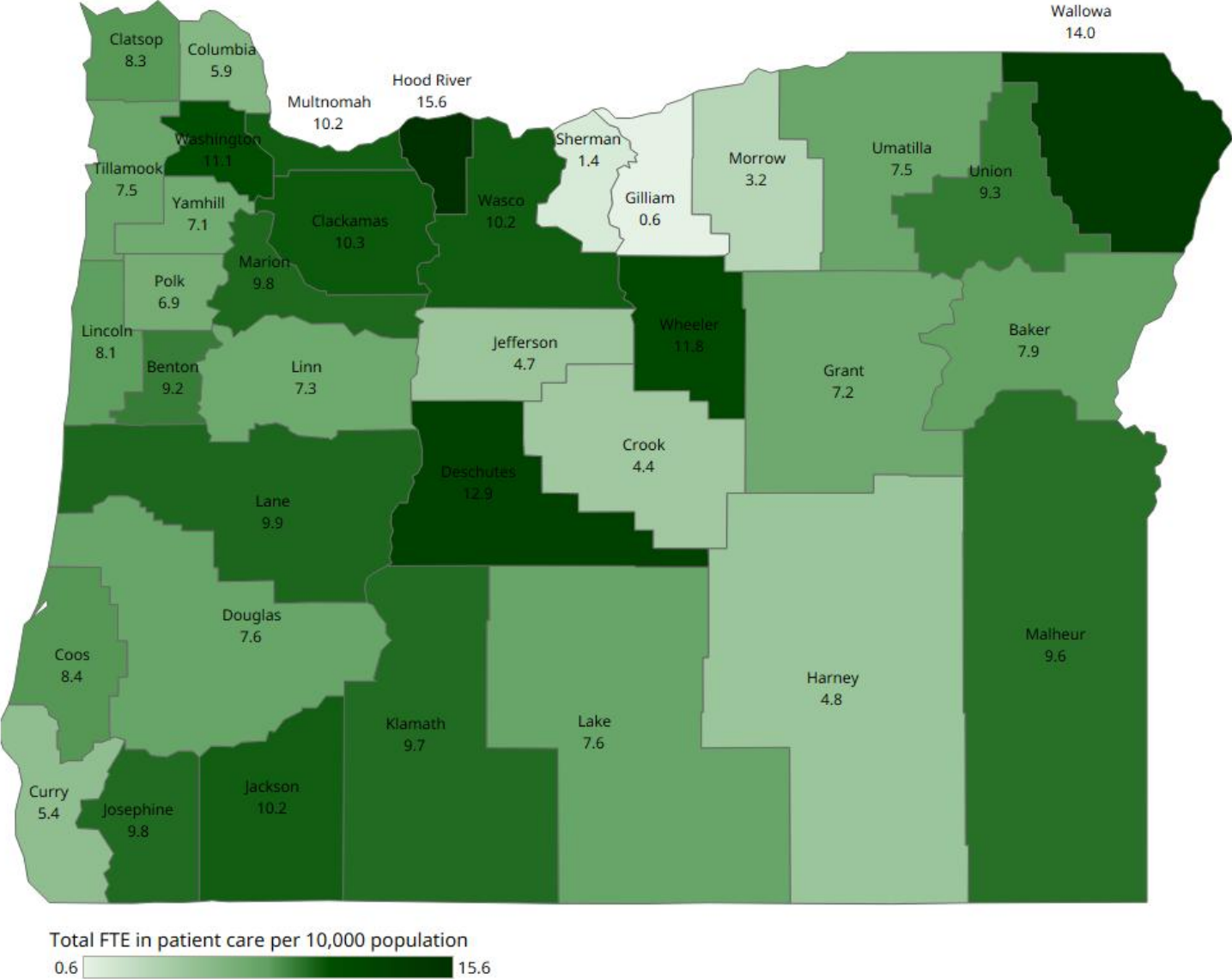


Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

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Figure 7-3. Estimated direct patient care FTE of the actively licensed oral health workforce in Oregon (per 10,000 population), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

Demographics of the oral health care workforce in Oregon

The average age at initial licensure and the current average age for DHs (26.79 and 44.18 years, respectively) is slightly younger than that of dentists (28.83 and 47.89 years, respectively) (

Table 7-5). Most oral health professionals identify as female (68.2%), mainly due to most DHs identifying as female (94%) compared to approximately one-third of dentists (33.3%), as is consistent with previous reports.⁸⁸ Approximately 60% of oral health occupations identify as white and 11.3% as Asian (12.9% declined to report their race). Dentists identify as Asian at a higher rate (17.2%) than DHs (6.9%), although both are overrepresented compared to the Oregon population (4.4%). Only 0.4% of the oral health workforce identify as Black or African American, 1.0% American Indian or Alaska Native, 0.3% as Native Hawaiian or Pacific Islander, and 4.7% as Hispanic or Latino/e/x, with Black or African American and Hispanic or Latino/e/x underrepresented compared to the Oregon population (1.83% and 14.68%, respectively). This is similar to estimates in 2024, although those identifying as American Indian or Alaska Native or as African American or Black have decreased.

Educational backgrounds align with scope of practice: nearly all dentists (97.8%) hold a doctorate, while DHs hold either an associate (54.4%) or bachelor's (43.5%) degree as their highest level of education. Just under one quarter of oral health workers report speaking a language other than English, with dentists more likely to report this than hygienists (32.0% 18.1%, respectively). Geographically, the workforce is concentrated in the Portland Metro (47.3%) and Southern Oregon regions (21.8%), with the smallest proportion reporting working in Eastern Oregon, underscoring ongoing rural access challenges.

Most DAs, similar to DHs, identify as female and White (

Table 7-6). A higher percent identify as Hispanic (13.4%) or “Other/mixed race” (13.6%) compared to other oral health occupations. 13.7% of DAs are estimated to speak a language other than English, which is less than estimated for dentists and DHs. Most DAs are estimated to have a high school or some college as their highest level of education, although 16.9% are estimated to have an associate degree.

Table 7-5. Estimated demographics of the licensed practicing oral health workforce in Oregon, 2024-2026

	Total, all oral health occupations	Dentists	Dental hygienists
Estimated number of actively practicing oral health licenses in Oregon, N	5,704	2,428	3,276
Average age at original licensure (years), Mean (SD)	27.65 (6.35)	28.83 (5.63)	26.79 (6.72)
Average age (years), Mean (SD)	45.75 (11.99)	47.89 (11.98)	44.18 (11.74)
Gender identity (%)			
Female	68.2%	33.3%	94.0%
Male	28.9%	63.3%	3.4%
Other/ Prefer to self-describe	0.3%	0.1%	0.5%
Don't want to answer/Decline	2.5%	3.2%	2.0%
Race/Ethnicity (%)			
American Indian or Alaska Native	1.0%	0.5%	1.3%
Asian	11.3%	17.2%	6.9%
Black or African American	0.4%	0.7%	0.2%
Native Hawaiian or Pacific Islander	0.3%	0.3%	0.3%
Middle Eastern/ North African	1.7%	3.1%	0.8%
White	60.6%	57.2%	63.2%
Hispanic or Latino/a/x/e	4.7%	2.7%	6.1%
Other Race	0.9%	0.6%	1.2%
Multi Race	3.7%	3.9%	3.5%
Decline	12.9%	12.8%	13.0%
Unknown	2.5%	1.2%	3.5%
Speaks language other than English (%)	24.0%	32.0%	18.1%
Identifies as having a disability (%)	1.6%	1.2%	1.9%
Highest level of education (%)			
High School	0.0%	0.0%	0.0%
Associate	31.2%	0.0%	54.4%
Bachelor's	25.0%	0.0%	43.5%
Master's	0.4%	0.9%	0.0%
Doctorate	41.6%	97.8%	0.0%
None of the above	1.8%	1.3%	2.2%
Missing	0.0%	0.0%	0.0%

Practice distribution by region in Oregon (%)			
Portland Metro	47.3%	50.3%	45.1%
Willamette Valley & North Coast	16.5%	16.1%	16.7%
Central Oregon	10.4%	10.0%	10.8%
Southern Oregon	21.8%	20.0%	23.1%
Eastern Oregon	3.7%	3.3%	3.9%
Missing	0.3%	0.2%	0.4%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details (definitions of disability and regional distribution). For detailed REALD race/ethnicity standard reporting categories see Appendix Table **15-3**.

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Table 7-6. Estimated demographics of the dental assistant (DA) workforce in Oregon, 2024

Proportion of estimated DAs in Oregon (%)	
Estimated total number of dental assistants in Oregon, N (weighted)	7,586
Average age (years), Mean (<i>Standard Error</i>)	36.7 (1.6)
Gender identity (%)	
Female	96.6%
Male	3.4%
Race (%)	
American Indian or Alaska Native	0%
Asian/Pacific Islander	3.1%
Black/African American	0.1%
White	82.4%
Other/Mixed Race	13.6%
Ethnicity (%)	
Hispanic origin	13.4%
Speaks language other than English (%)	13.7%
Identifies as having a disability (%)	0.9%
Highest level of education (%)	
Less than high school	2.0%
High School or equivalent	25.1%
Some college	53.4%
Associate degree	16.9%
Bachelor's degree	1.9%
Master's degree	0.8%
Professional school/Doctorate degree	0%

Data Source: American Community Survey 2024 1-year estimates. See

Methods appendix for more details.

Practice characteristics of the oral health workforce

On average, dentists reported a higher number of hours per week (35.71) compared to DHs (29.87), with 16% of dentists reporting working over 40 hours per week compared to 7% of DHs (

Table 7-7). With respect to hours of assistance, dentists report an average of 32.21 hours per week from DHs and 36.92 hours from DAs, including EFDAs. The annual median wage for actively practicing DHs is estimated to be \$121,514, compared to \$190,840 for dentists and \$59,363 for DAs (the median wage for Oregon is \$54,662.40 per year).

With respect to patient population, an estimated 37.6% of actively practicing dentists report seeing patients covered by Medicaid at their primary or secondary practice. Among those who do (n=914), approximately one-third (32.5%) report that 76–100% of their patients are Medicaid-covered, while 29.1% report that fewer than 25% of their patients carry Medicaid coverage — suggesting that Medicaid dental care is concentrated among a relatively small subset of high-volume providers. DHs were not included in Medicaid-related survey questions, limiting cross-occupation comparisons. A 2024 evaluation of Oregon Health Plan dental provider enrollment found that 32 of 36 Oregon counties lack adequate Medicaid dental provider capacity, and that approximately 96 additional Medicaid dental FTEs would be needed statewide to meet OHP member needs.¹⁰²

Medicaid claims data offers a complementary picture to the self-report HWRP data.¹⁰³ As of 2025, it is estimated that 3,236 dentists were practicing in Oregon, with 31.1% accepting Medicaid (n=1006), a slight increase from 2023 (N=892) and closely aligned HWRP Medicaid coverage reports (N=914). Overall Medicaid dental claims grew from 787,855 in 2023 to 978,431 in 2025 and claims per FTE rising from 197.0 to 244.6. The proportion of dentists accepting more than 600 Medicaid claims per year increased slightly (12.2% to 12.8%).

Table 7-7. Estimated hours worked and hours of assistance for the actively practicing oral health workforce in Oregon, 2024-2026

	Total, all oral health occupations	Dentists	Dental hygienists
Estimated number of actively practicing oral health licenses in Oregon, N	5,704	2,428	3,276
Average hours worked per week, mean (SD)	32.35 (11.06)	35.71 (10.63)	29.87 (10.71)
Worked over 40 hours weekly (%)	10.6%	16%	7%
Average hours of assistance received from DHs per week at primary location, Mean (SD)	—	32.21 (22.23)	—

Average hours of assistance received from Chairside Assistants (DAs, EFDAs) per week at primary location, Mean (SD)	—	36.92 (17.53)	—
Sees patients covered by Medicaid at primary or secondary practice (%)	—	37.6%	—
Percentage of Medicaid patients seen at primary practice (%)		n=912	
0-25%	—	29.1%	—
26-50%	—	10.6%	—
51-75%	—	13.1%	—
76-100%	—	32.5%	—
Unknown	—	10.2%	—

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details. Note: the DH survey does not include Medicaid questions.

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Table 7-8. Annual median wage of the actively practicing oral health workforce in Oregon, 2025

Occupational Title	2025 Annual Median Wage
Dentists, General	\$190,840
Dental Hygienists	\$121,514
Dental Assistants	\$59,363

Data source: Oregon Wage Information prepared by the Oregon Employment Department, Workforce and Economic Research Division.

Table 7-9. Estimated Medicaid dental coverage in Oregon, 2023 and 2025

	Dentists, 2023	Dentists, 2025
Total Dentists in OR, N	3,043	3,236
Dentists accepting Medicaid (%)	29.3%	31.1%
Medicaid claims, N	787,855	978,431
FTEs (number of Medicaid claims/4000)	197.0	244.6
Dentists accepting over 600 Medicaid claims per year (%)	12.2%	12.8%

Data Source: Jon McElfresh, Oral Health Workforce Coordinator, Health Policy & Analytics Division, Oregon Health Authority. Oregon Health Analytics Data from the Medicaid Management Information System (MMIS), accessed on March 21, 2026.

Education program completions of the oral health workforce in Oregon

Oregon's oral health education pipeline shows modest and, in some cases, declining output relative to workforce demand (

Table 7-10). Dental hygiene completions have slightly increased from 149 in 2018 to 160 in 2024 across eight programs. Dentistry completions (including specialties) have remained relatively flat, holding near 84–91 per year across the same period from Oregon's sole dental school. Dental assisting programs (11 programs in 2024) produced 316 completions in 2018 but only 227 in 2024, despite projected increases in DA job openings (Table 7-11). Programs tend to be concentrated in the northwest part of the state, with some additional education access southwest and none located on the east side of Oregon.

DA training pathways do include an option for on-the-job training, although there is no source of reliable data to capture the number of DAs who choose this option and there are limited resources available to educate those interested about this as an option. Oregon's formal dental assisting education pathway is primarily delivered through CODA-accredited programs located at public community colleges, including Portland Community College, Chemeketa Community College, Lane Community College, and Central Oregon Community College.

Table 7-10. Education programs and number of completions by academic year for oral health occupations in Oregon, 2018-2024

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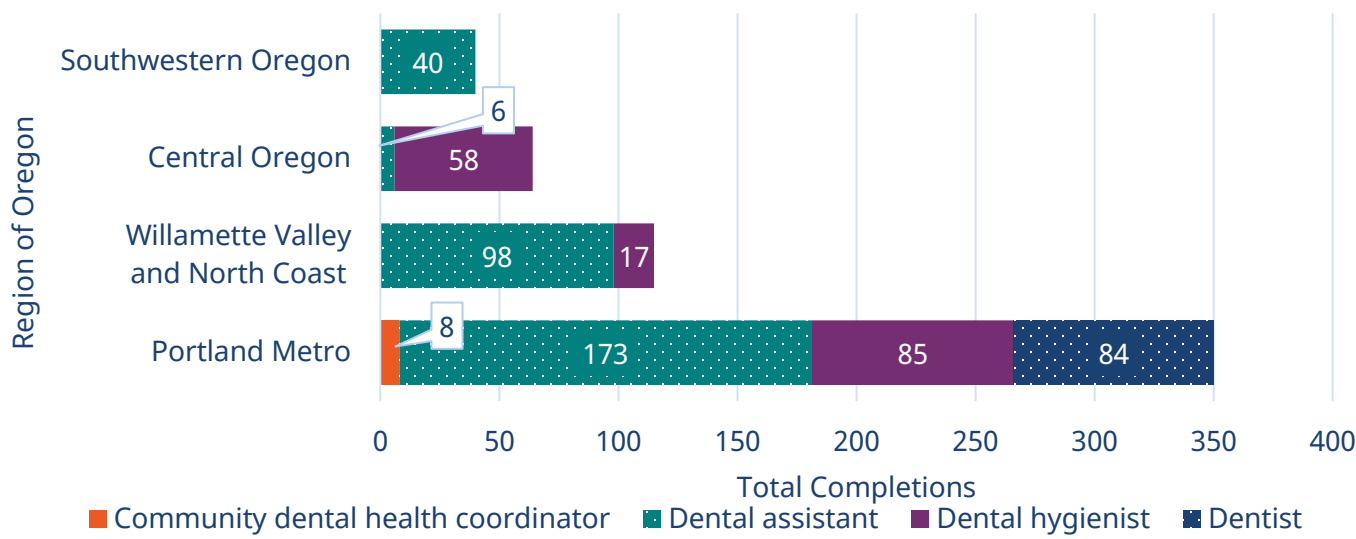
Education program	2018	2019	2020	2021	2022	2023	2024
Dental assisting/assistant (N=11, 2024)	316	302	162	335	304	262	227
Dental hygiene/hygienist (N=8, 2024)	149	141	110	191	146	149	160
Dentistry (N=1, 2024)	87	91	87	85	84	89	84

Data Sources: Integrated Postsecondary Education Data System (IPEDS), 2023-2024 and the Oregon Higher Education Coordinating Commission (HECC). See

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Methods appendix for more details of CIP codes by occupation and award level.

Figure 7-4. Oral health training programs in Oregon with at least one completion by number of completions, 2024¹⁰⁴



Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024 and the Oregon Higher Education Coordinating Commission (HECC). See

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Methods appendix for mapping of CIP codes by occupation.

Demand and reported vacancies of the oral health care workforce in Oregon

The Oregon Employment Department projects an increase in new job openings for all dental occupations by 2034. The greatest increase will be among DAs (642 new job openings, an 11.6% increase) and the least among dentists (115 new openings, an 8.6% increase). Replacement job openings for DAs are expected to be very high (7,492), approximately 35.6% higher than the estimated employment in 2024 and 21.5% higher than the projected employment in 2034, highlighting potentially high turnover for this occupation. Replacement job openings for DHs also signal a higher expected rate of turnover, although reports from licensure survey data don't signal this near-term (Table 7-11).

Table 7-11. Projected employment of and demand for the oral health workforce in Oregon, 2024-2034

Occupation Title	2024 Employment	2034 Projected Employment	Average Annual Job Openings, 2024-2034	Projected Replacement Openings, 2024-2034	Projected New Job Openings, 2024-2034	Total Projected Openings, 2024-2034
Dentists, General	1,339	1,454	47	356	115	471
Dental Hygienists	3,662	4,117	278	2,323	455	2,778
Dental Assistants	5,525	6,167	813	7,492	642	8,134

Data sources: Oregon Wage Information, Oregon Occupations in Demand, and Oregon Occupational Employment Projections prepared by the Oregon Employment Department, Workforce and Economic Research Division as of 07/10/2026. See

Methods appendix for more details.

Retention and turnover of the oral health workforce

With respect to future stability of the workforce, DHs are more likely to have trained in-state (77%) compared to dentists (48.4%), with dentists having been in the workforce slightly longer than DHs, on average (19.23 years vs. 17.39 years for hygienists;

Table 7-12). In both occupational groups, most report planning to maintain their current hours and practice location, with roughly 11-12% planning to reduce hours in the next two years (slightly lower than previous reports). Retirement intentions are low overall – slightly higher among dentists (4.0%) compared to dental hygienists (2.4%), with very few planning to leave Oregon or the field entirely.

However, it should be noted that information from the 2024 Evaluation of Oregon Health Plan Dental Provider Enrollment report highlights difficulties with recruiting and retaining oral health occupations, particularly in rural areas. This report highlights challenges with retention related to reimbursement, workload, and lack of adequate staffing.¹⁰²

Recent information on the DA workforce in Oregon notes concerns with turnover and unfilled positions among DAs, with national research stating that dentists report difficulties filling positions for both DAs and DHs, resulting in lower capacity to fill open appointments.^{105,106} Other research reports that less than half (40%) of entry-level DAs (those with less than two years of experience) report planning to stay in the field for five or more years, further signaling concerns with retention.¹⁰⁶

Table 7-12. Workforce retention and future career plans of the licensed practicing oral health workforce in Oregon, 2024-2026

	Total, all oral health occupations	Dentists	Dental hygienists
Estimated number of actively practicing oral health professionals in Oregon, N	5,704	2,428	3,276
Active oral health professionals who graduated from an Oregon educational program (%)	64.8%	48.4%	77.0%
Average years since original licensure, mean (SD)	18.10 (11.59)	19.23 (11.93)	17.39 (11.27)
Anticipated change in future work hours (%)			
Increase practice hours	5.3%	4.9%	5.6%
Maintain practice hours as is	81.4%	82.4%	80.7%
Reduce practice hours	11.9%	11.2%	12.4%
Other	1.4%	1.4%	1.4%
Anticipated career plans in the next two years (%)			
Continue working at my current location(s)	89.8%	88.3%	90.8%
Leave Oregon to practice out of state	1.2%	1.6%	1.0%
Leave the field (with intention to work in a different field)	0.9%	0.3%	1.4%
Move to Oregon to practice in the field	0.1%	0.1%	0.0%
Move to another practice location in Oregon	3.0%	3.7%	2.5%
Other	1.9%	2.0%	1.9%
Retire	3.0%	4.0%	2.4%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

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8. The behavioral health workforce in Oregon

Background

Behavioral health (BH) care is crucial in addressing the emotional and mental well-being of Oregonians. BH services are available across the state in a wide range of settings, including outpatient programs, community clinics such as Certified Community Behavioral Health Clinics, crisis centers, inpatient psychiatric hospitals, and residential treatment facilities. However, improving access to quality BH care for Oregon's population has been a large focus over the past few years following the \$1.35 billion funding allocated by the Oregon legislature.¹⁰⁷ Part of this investment focused on improving recruitment and retention of the BH workforce. The BH workforce prevents, treats, and provides ongoing support and management for mental health conditions like anxiety and depression, substance use disorders, and addictive behaviors.¹⁰⁸ The following section provides an overview of the supply, distribution, and characteristics of the BH workforce in Oregon.

Behavioral health occupations licensed and certified in Oregon

Oregon has two main categories of BH workers, state-licensed occupations, and certified occupations. The licensed workforce is credentialed to practice in the state by their professional boards (Table 8-1). Licensed BH occupations in Oregon include **clinical psychologists** licensed by the Oregon Board of Psychology; **professional counselors** (LPCs) and **marriage and family therapists** (LMFTs) licensed through the Oregon Board of Licensed Professional Counselors and Therapists; as well as **licensed clinical social workers** (LCSWs) and **non-clinical social workers** licensed by the Oregon Board of Licensed Social Workers. There are also licensed occupations in which the provider has a specialty in mental or behavioral health, including **psychiatrists** (MD/DOs) and **psychiatric physician associates** (PAs) licensed by the Oregon Medical Board; **naturopathic physicians** (NDs) licensed by the Oregon Board of Naturopathic Medicine; and **psychiatric mental health nurse practitioners** (NPs) licensed by the Oregon State Board of Nursing. Licensed BH occupations are independent practitioners (meaning they can diagnose, treat, and prescribe without physician oversight), apart from psychiatric PAs, who require a collaborative practice agreement. **Clinical social work associates** (CSWAs) are certified by the Oregon Board of Licensed Social Workers to practice under supervision while working towards becoming a LCSW. CSWAs appear in tables below with the licensed BH workforce as they are credentialed through a state professional board. Most of the licensed BH workforce require an advanced post-graduate degree and clinical training hours.

A large portion of the BH workforce in Oregon is composed of certified BH occupations, credentialed by the Mental Health and Addiction Certification Board of Oregon (MHACBO). As detailed in Table 8-2, these include **certified alcohol and drug counselors** (CADCs), **certified recovery mentors** (CRMs), **certified gambling recovery mentors** (CGRMs), **certified gambling addiction counselors** (CGACs), **certified prevention specialists** (CPSs), **qualified mental health associates** (QMHAAs), **qualified mental health professionals** (QMHPs), and **peer support specialists** (PSSs). Most of the certified BH workforce require supervision to practice, usually by an approved clinical supervisor.¹⁰⁹ LPCs and LMFTs can qualify to be supervisors through a multi-step process. Individuals in the BH workforce may hold a state license in addition to being MHACBO-certified or be certified only. Licensed and/or certified BH workers can also have multiple certifications, resulting in three groups of workers in the BH workforce: those that are licensed without any additional certifications, those that are licensed and certified, and those that are certified only (not licensed). To more accurately account for all BH workers, we focus on the certified-only group, in addition to the state-licensed BH occupations. The Methods Appendix contains more details about this data.

There are other BH adjacent occupations in Oregon, including case managers who work with people from vulnerable populations and help connect them to other BH support and services, and crisis managers that work with individuals and communities to provide mental health crisis interventions, such as those provided by county-led Community Mental Health Programs.

Table 8-1. Licensed behavioral health occupations and occupations with a specialty in behavioral health in Oregon: definition, scope of practice, and minimum education required

Licensed Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Education/Training Required for Licensure ¹¹⁰
Licensed Clinical Psychologist (PhD/PsyD)	Those who give therapy services to individuals to diagnose or treat behavioral, emotional, or mental disorders.	Independent practitioner	Completion of a Doctor of Psychology (PsyD) and/or Doctor of Philosophy in Psychology (PhD), and at least 1 year or 1,500 hours of supervised post-doctoral work experience.*
Licensed Professional Counselor (LPC)	LPCs assess, diagnose and treat individuals with mental, emotional or behavioral disorders using counseling services.	Independent practitioner	Completion of a master's degree (MA) in counseling or related mental health degree from an accredited school and at least 3 years of supervised clinical counseling experience, including at least 1,900 direct client contact hours.*
Licensed Marriage and Family Therapist (LMFT)	LMFTs assess, diagnose, and treat mental, emotional, and behavioral disorders involving individuals, couples, children, and families.	Independent practitioner	Completion of an MA in marriage and family therapy or related mental health degree and at least 3 years of supervised clinical counseling experience, including at minimum 1,900 direct client contact hours, including 750 working with couples and families in the same session.*
Licensed Clinical Social Worker (LCSW)	LCSWs counsel and aid individuals and families requiring mental health related social service assistance.	Independent practitioner	Completion of a master's degree in social work (MSW), minimum 2 years working as a Clinical Social Work Associate (CSWA) under supervision by an OR LCSW or equivalent to earn a minimum of 100 hours of LCSW supervision and 3500 hours of total work experience, with 2000 being direct client hours.*
Non-clinical Social Worker (NonCI_SW)	Non-clinical social workers support individuals, families, and communities through case management, consultation, and	N/A – do not work in a clinical setting	Registered Baccalaureate Social Workers: Completion of a Bachelor of Social Work (BSW) degree; 'Exam Candidate' license available if they have BSW but have not passed the exam.

	advocacy, but do not provide therapy or diagnose mental health conditions.		License Master Social Workers: Completion of an MSW.*
Psychiatrist (MD or DO)	Allopathic (MD) or osteopathic (DO) physicians trained to practice in the specialty of psychiatry, focusing on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders.	Independent practitioner	Completion of, at minimum, 3-year postgraduate training (internship, residency, or fellowship), following medical school.*
Psychiatric Mental Health Nurse Practitioner (PMHNP)	Advanced practice registered nurses specializing in providing mental health care.	Independent practitioner	Completion of a MA in nursing (MSN) or doctorate in nursing practice (DNP) in psychiatric/ mental health and verification of national certification for license type/population focus. Must have active RN license in OR.
Psychiatric Physician Associate (PA)	Psychiatric PAs diagnose mental health conditions, manage medications, and develop treatment plans under physician collaboration.	Collaborative practice agreement required	Completion of an accredited master's degree PA training program.*
Naturopathic Physician (ND) with a specialty in Mental Health	Physicians who use natural and functional therapies to treat behavioral health conditions holistically.	Independent practitioner	Completion of a doctoral naturopathic medical program, optional post-graduate residency program.

See

Methods appendix for definitions independent practitioner and collaborative practice agreement.

*Licensure requirements also require passage of a national competency exam (all provider types), and the Oregon Jurisprudence Exam (licensed clinical psychologists and licensed clinical social workers).

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Table 8-2. Certified behavioral health occupations in Oregon: definition, scope of practice, and minimum education required

Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Education/Training Required for Certification
Certified Alcohol and Drug Counselor (CADC-R, I, II, III)	Counselors who treat people with substance use disorders.	Independent practitioner - CADC II, III Supervision required - CADC I	CADC I: Completion of a high school diploma/GED, plus 150 hours of Alcohol/Drug/Addictions education, and at least 1,000 hours of supervised substance use disorder (SUD) work experience. CADC II: Completion of a bachelor's degree (BA) or equivalent, plus 300 hours of Alcohol and Drug Specialty Education and 4,000 hours of supervised SUD work experience.* CADC III: Completion of a Master's degree (MA) in a behavioral health field plus 300 Alcohol/Drug/Addictions education and 6,000 cumulative hours of supervised SUD work experience.*
Qualified Mental Health Associate (QMHA-R, I, II)	Behavioral health worker who is qualified to work at state-approved mental health programs.	Supervision required - consults with senior clinician	QMHA-Registrant: Completion of a BA in counseling or related behavioral health field or 3 years of education/work experience and a supervisor's assessment confirming readiness. QMHA I: Completion of 1,000 supervised experience hours after becoming QMHA-R.* QMHA II: Completion of 4,000 hours of supervised work experience as a QMHA-R or QMHA I.*
Qualified Mental Health Professional (QMHP-R, C)	A certified mental health practitioner that can assess and treat patients and provide psychotherapy.	Independent practitioner	QMHP-Registrant: Completion of an MA in behavioral science, or a Bachelor of Science in nursing or occupational therapy (OT) as well as an active Oregon nursing or OT license, and a supervisor's assessment of clinical readiness. QMHP-Certified: Completion of 1,000 hours of post-graduate clinical experience while registered as a QMHP-R.*
Certified Recovery Mentor (CRM I, II)	Addiction peer support (non-clinical, lived-experience) at Peer Recovery Centers or	Supervision required	CRM I: Completion of 40 hours of OHA-approved peer and oral health training, in recovery from SUD for at least 2 years, successful background check, completion of ethics quiz, and a signed code of conduct.

	under OHA-certified SUD provider organizations.		CRM II: Completion of a high school diploma/GED, plus 80 hours of peer support training and 500 supervised hours, and an existing certification as a CRM I or an Adult Addiction Peer Support Specialist or an Adult Addiction Peer Wellness Specialist.*
Certified Gambling Recovery Mentor (CGRM)	Gambling addiction recovery peer support (non-clinical)	Supervision required	Completion of 40-hours of OHA-approved gambling addiction peer training and oral-health training.
Certified Gambling Addiction Counselor (CGAC-R, I, II)	CGACs provide entry-level and advanced-level problem-gambling counseling in state-certified programs.	Supervision required	CGAC–Registrant: Completion of a BA or a combination of at least 3 years of relevant education and work experience in problem addiction or mental health. CGAC I: Completion of a BA or equivalent in a behavioral health field (e.g., psychology, clinical social work), plus 30 hours of problem/compulsive gambling education, and 500 hours of supervised clinical experience in gambling addiction counseling. CGAC II: Completion of a BA or equivalent in a behavioral health field, plus 60 hours of problem/compulsive gambling education, and 2,000 hours of supervised experience in the gambling addiction counselor domains.
Certified Prevention Specialist (CPS)	Substance-use prevention professional	Supervision required	Completion of 150 hours of prevention-specific education aligned with the International Certification and Reciprocity Consortium Prevention Domains, and 2,000 hours (120 direct) of supervised prevention work.
Peer Support Specialist (PSS)	An individual providing services to another individual who shares similar life experience (addiction, mental health, youth support, or family support).	Supervision required	Completion of an approved Traditional Health Worker ⁸⁹ training program, and personal experience with the subject matter of focus, in recovery from addiction or having ever received mental health or addiction services.
Clinical Social Work Associate (CSWA)	Individuals practicing as clinical social workers	Supervision required	Completion of Master of Social Work degree with plan of clinical supervision toward licensure submitted.

	under the supervision of an Oregon LCSW while completing the required clinical practice hours to become a LCSW.		
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BA: Bachelor’s degree; MA: Master’s degree; R: Registrant status. See

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Methods appendix for more details and definitions.

*Licensure requirements also require passage of a national competency exam (all provider types), and the Oregon Jurisprudence Exam (CADC II, III).

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Supply and distribution of the behavioral health workforce in Oregon

As of 2026, there were an estimated 23,099 licensed BH professionals in Oregon, among which 19,569 (84.7%) were estimated to be actively practicing in Oregon (Table 8-3). LPCs/LMFTs, and LCSWs comprise approximately two-thirds of the actively practicing BH workforce, about 15 active licenses per capita. Among the BH workforce, LPCs and LMFTs delivered the highest amount of total direct patient care in 2026, 3,443 FTE and have the highest total number of actively practicing, 6,578. Psychologists (2,161 active licenses; 5.0 per capita) were the next largest group of BH professionals, although their total amount of direct patient care FTE (1,116) is roughly the same as NPs (1,760 active licenses; 4.1 per capita; 1,162 FTE), and CSWAs (1,709 active licenses; 4.0 per capita; 1,105 FTE).

Supply changes over time: There was an 18.0% increase in the actively practicing BH workforce, from 16,582 in 2024 to 19,569 in 2026. Among the separate licensed BH occupations, there was very little change in supply of physicians, NDs, psychologists, and PAs, and much larger increases in active LPC/LMFT, LCSW, and NP licenses. NPs had the largest supply increase from 2024 to 2026 with 43.9% growth in actively practicing licenses (1,223 to 1,760 licenses). Active LCSW licenses grew 21.4% over the past two years, followed by LPCs/LMFTs (16.0% growth). With respect to direct patient care FTE, there was a similar increase over time at 17.5%, with an overall per capita increase in estimated direct care FTE as well, from 20.4 in 2024 to 25.1 in 2026. There were increases in direct patient care FTEs across all BH occupations, with the largest increases among NPs (39.8%; 831 to 1,162), LCSWs (20.1%; 2,811 to 3,375) and LPCs/LMFTs (16.2%; 2,964 to 3,443).

The majority of the BH workforce in Oregon is in urban areas of the state (84.2%;

Figure 8-1). NPs have the highest percentage of rural workers when compared to the other BH occupations, with 18.3% in rural, compared to only 7.4% of NDs who specialize in mental health. LPCs and LMFTs, LCSWs, and CSWAs also have higher rates of rural workers (roughly 17%) compared to MD/DOs, psychologists, and psychiatric PAs (about 9%). Similar rural/urban percentages are observed when comparing direct patient care FTE by BH occupation. Very few actively licensed BH occupations also practice in a border state (1%; see Appendix Table 16-1), although the Oregon State Board of Nursing specifically asks NPs where else they are licensed to practice and if they are actually practicing in that state. over one-quarter (27.4%) of surveyed NPs who specialize in BH, are licensed and working in Washington in addition to Oregon (Appendix Table 16-2).

The distribution of the BH workforce is concentrated in the western half of the state, with the majority of the workforce in Multnomah County (94 licensed BH workers per 10,000 population;

Figure 8-2). Counties in the northern central part of the state had the least amount of licensed BH professionals, although the supply of occupations per capita is not as low, given the relatively low populations in these counties. For example, despite only having two estimated behavioral health workers in Wheeler County, this is equivalent to a density of 17 providers per capita. The density of direct patient care FTE provided by the behavioral health workforce follows a similar distribution across the state (

Figure 8-3). Multnomah County and Deschutes County have the highest density of FTE per capita (48.3 FTE and 32.3 FTE per 10,000 population, respectively). Gilliam County has the lowest density of direct patient FTE from a BH professional (3.0 FTE per 10,000 population).

There are currently 1,855 certified-only individuals in Oregon, meaning they do not also hold a state-issued license to a practice a BH occupation (Table 8-5). Density and FTE data for the certified BH workforce are not available.

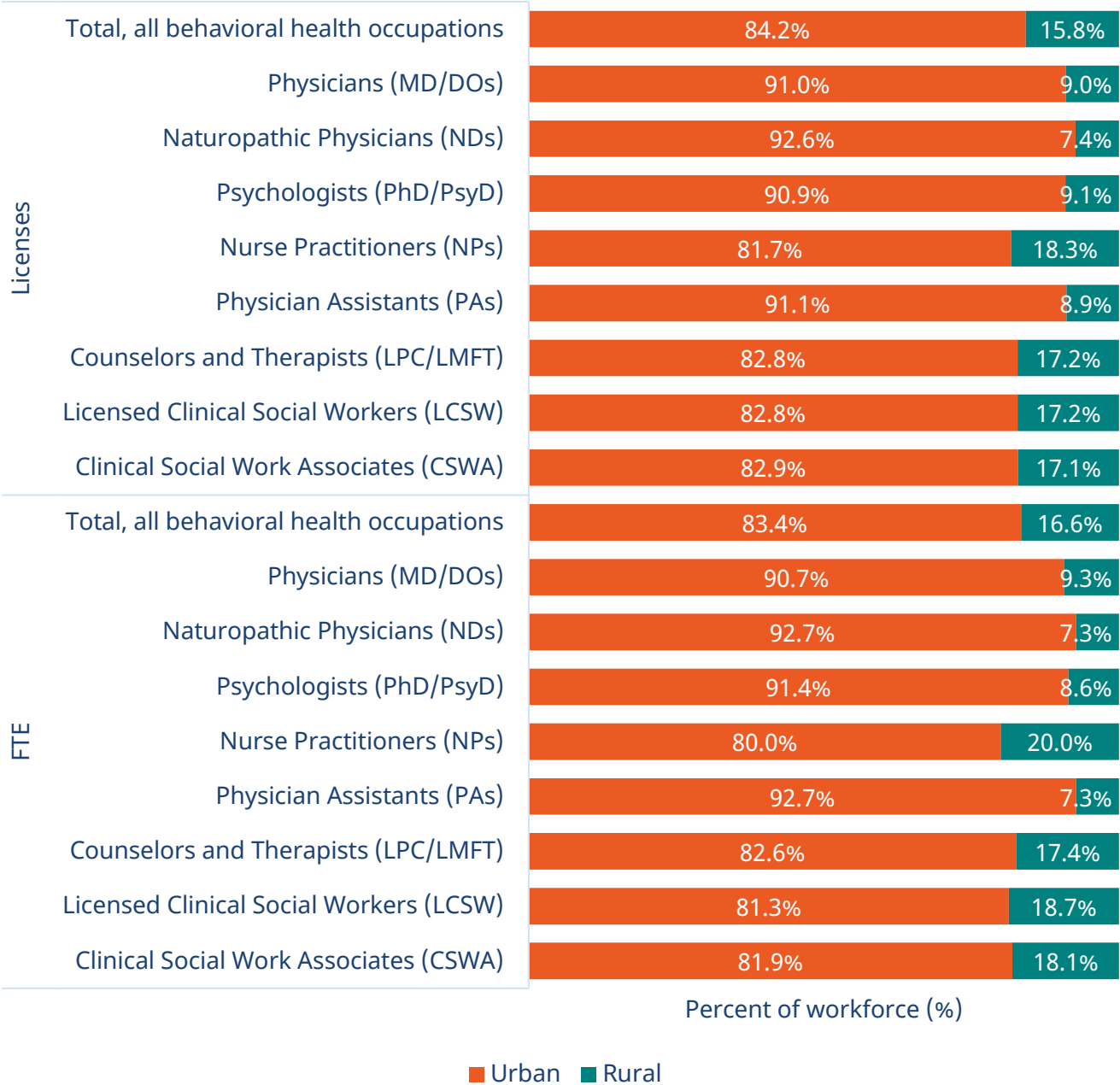
Table 8-3. Estimated supply of the behavioral health (BH) care workforce licensed in Oregon, 2024-2026

	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Estimated total number of active BH licenses in Oregon, N	23,099	1,141	117	2,513	2,408	61	7,688	7,394	1,777
Estimated number of actively practicing BH licenses in Oregon, n	19,569	884	96	2,161	1,760	56	6,578	6,325	1,709
Estimated number of active BH licenses per capita, n per 10,000 Oregon population	45.5	2.1	0.2	5.0	4.1	0.1	15.3	14.7	4.0
Estimated amount of direct BH patient care FTE	10,825	535	46	1,116	1,162	43	3,443	3,375	1,105
Estimated amount of direct patient care FTE per capita, n per 10,000 Oregon population	25.1	1.2	0.1	2.6	2.7	0.1	8.0	7.8	2.6
Estimated amount of other BH FTE (research, admin, teaching, other)	4,837	166	21	580	274	6	1,566	1,775	449

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

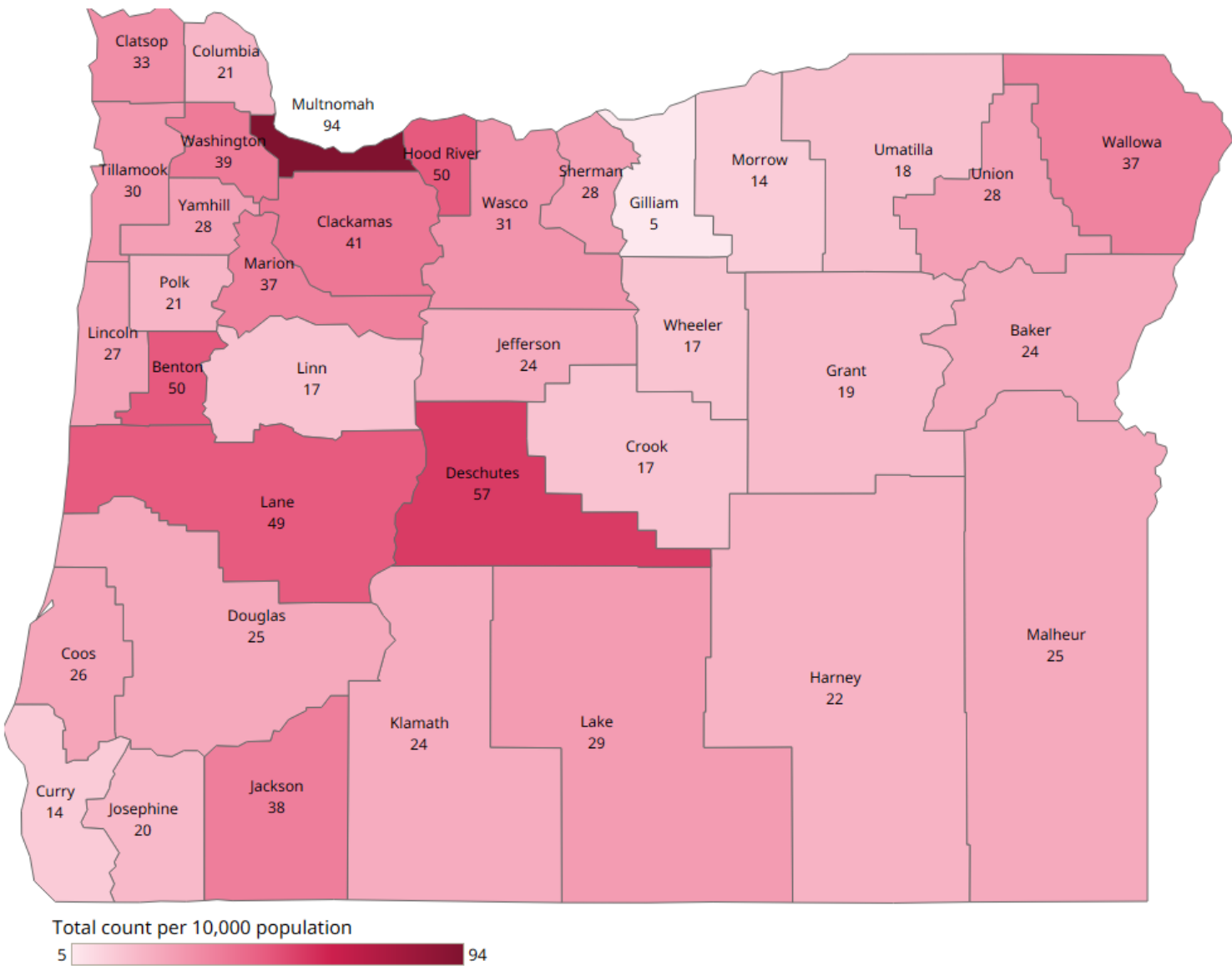
Figure 8-1. Estimated supply and direct patient care FTE of the actively practicing behavioral health workforce licensed in Oregon by rural/urban practice location, 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details (missing counts, FTE calculations, and rural/urban designations).

Figure 8-2. Estimated supply per capita of the actively practicing licensed behavioral health workforce by county in Oregon (per 10,000 population), 2024-2026

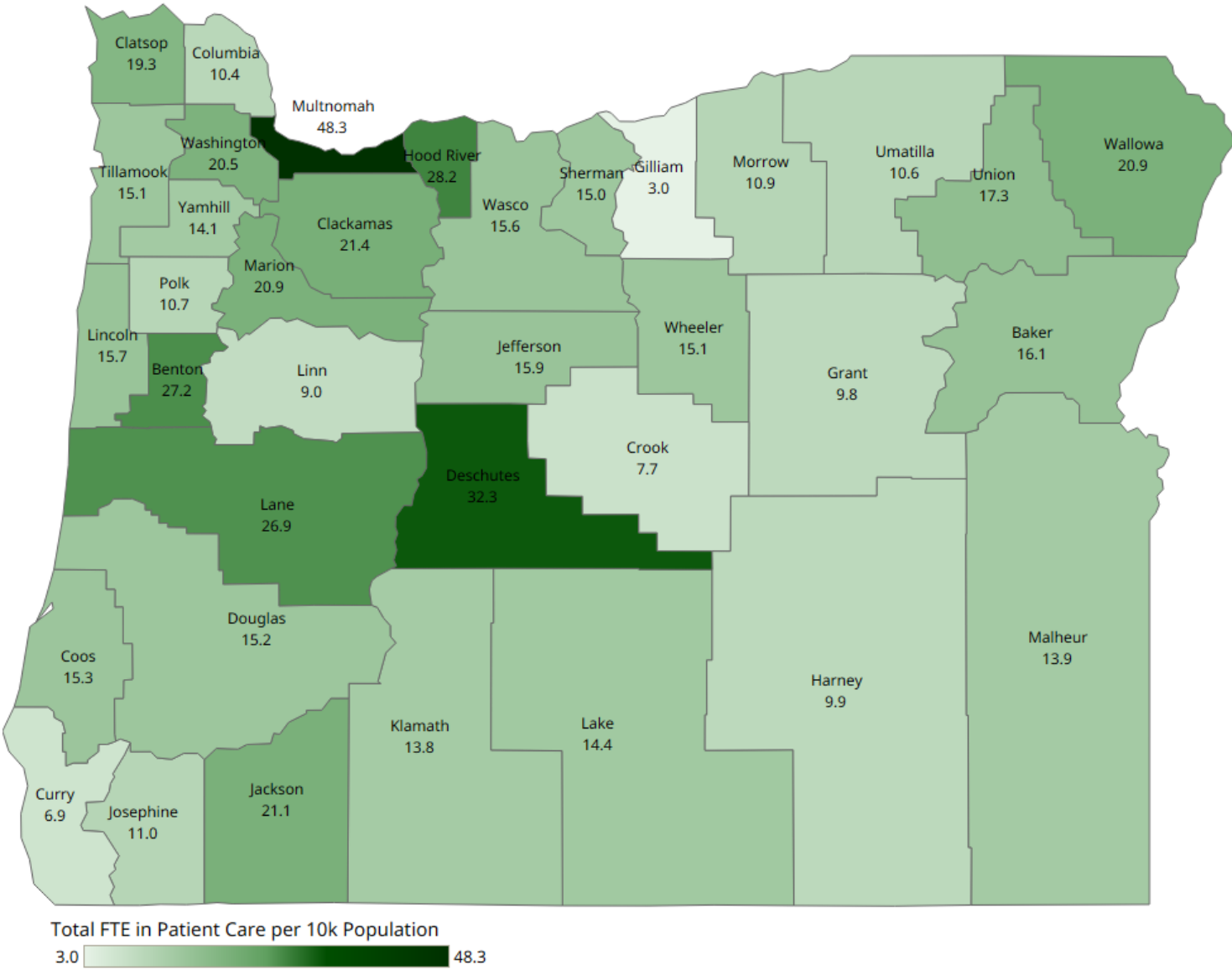


Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

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Figure 8-3. Direct patient care FTE per capita of the actively practicing licensed behavioral health workforce by county in Oregon (per 10,000 population), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

Demographics of the behavioral health workforce in Oregon

Characteristics of the almost 20,000 actively practicing licensed BH workers in Oregon are detailed in Table 8-4. Among all occupations in the licensed BH workforce, the average age is 47.9 years, with MD/DOs (51.2 years) and psychologists (50.3 years) averaging over a decade older than CSWAs (average age 38.3 years). The average age at original licensure in Oregon was in the mid to late thirties among all BH occupations. Licensed BH workers in Oregon are more female overall (73.8%), although MD/DOs are slightly more male (56.2%).

Like the overall racial diversity of Oregon, the licensed BH workforce is predominantly white (71.1%). Most other racial and ethnic groups are underrepresented in the BH workforce, with some notable exceptions. There are three times more Asian MD/DOs specializing in psychiatry (13.4%) compared to Asians in the state (4.9%), and there are almost seven times the number of Black/African Americans represented among psychiatric NPs (12.3%) as there are Black Oregonians (1.9%). CSWAs are the most diverse occupation, with higher percentages of Black (7.0%) and Hispanic (10.9%) workers than in most other BH occupations.¹¹¹ The racial diversity of the BH workforce overall is similar to the diversity of this group reported in 2024, although not directly comparable as the previous diversity report excluded respondents who reported “Decline” or “Unknown” when reporting their race. One-quarter of MD/DOs speak a language other than English compared to only 11.1% of LPCs and LMFTs.

Licensed BH occupations in Oregon generally require a graduate degree at the Master’s (PAs, LPC/LMFTs, LCSWs, and CSWAs; range from 94.6% - 99.2% individually) or Doctoral level (MDs, DOs, and PhD/PsyDs). NPs have more variation in their highest level of education; about three-quarters of licensed NPs have a master’s degree (74.3%) and one-quarter have a Doctorate (23.5%).

Over half of the BH workforce in Oregon is in the Portland Metro area (57.1%), largely driven by higher concentrations of MD/DOs (62.7%), NDs (85.4%), and psychologists (62.8%). Southern Oregon (17.9%) and the Willamette Valley/North Coast (13.3%) regions have the next highest concentrations of the workforce. NPs (4.5%) and PAs (3.6%) are more likely to be in Eastern Oregon compared to the other BH occupations.

There are 14,992 total credentials among the 11,855 unique individuals in the certified-only BH workforce (Table 8-6). Among all unique individuals with at least one BH certification, 21.7% (2,567) hold two or more credentials (Table 8-5). Overall, the certified BH workforce skews slightly younger on average (43.2 years) and is generally not as female (63.6%) as the licensed BH workforce. The certified workforce is also much more racially diverse, with 65.7% of credential holders identifying as non-Hispanic white. 16.3% of certified individuals speak a language other than English, compared to only an estimated 14.1% of the overall

licensed BH workforce. The highest education levels among the certified workforce are high school (33.9%) and bachelor's level (31.0%). Certified BH workers are also more spread out across the state, with only 40.8% in the Portland Metro area and 26.5% in the Willamette Valley/North Coast region.

As individuals can hold multiple credentials from MHACBO, Table 8-6 details the characteristics of each certified occupation by credential rather than unique individual. Certified BH workers predominantly hold certifications as QMHAs (5,596 credentials) and CADCs (4,424 credentials), followed by CRMs (2,974 credentials) and QMHPs (1,649 credentials). Those with a QMHA credential are the youngest among the certified BH workforce (average age 40.7 years) while CPS are the oldest (51.1 years) most female. They have the highest percentage of female credential holders (81.8%) followed by QMHPs (71.9%). All credential types are majority female, except 71.0% of the 33 CGRM credentials are held by males.

The certified BH workforce is majority white across all credential types (65.7% on average across all credentials), ranging from 56.8% (CGACs) to 68.5% white (CADCs). Multi racial credential holders are the next most prevalent category (average amongst all credentials, 11.6%). The highest percentage of Hispanic/Latino credential holders is among CGACs (18.6%) and CGRMs (18.2%), almost double the overall average among all credentials (9.9%). There is a relatively high percentage of American Indian/Alaskan Native credential holders among CPSs (14.5%) compared to the other credential types (range from 1.1% to 9.1%). Across all certifications, there is low representation of Asian, Native Hawaiian/Pacific Islander, and Middle Eastern credential holders (1.4%, 0.5%, 0.2%, average among all credentials, respectively).

Highest education level varies by credential type depending on certification requirements (see

Table 8-2). Overall, very few of the credential holders have a Master's (18.6%) or Doctorate degree (1.1%), while about one-third (34.0%) of all credentials have a high school degree. Almost three-quarters of those with a CRM have a high school education, compared to the QMHP credential that is predominantly held by individuals with a master's degree (89.3%).

The geographic distribution of certified BH occupations across the state is similar to the distribution of the licensed BH workforce. The majority of credentials are concentrated in the Portland Metro (40.7%) and Willamette Valley (26.7%) regions, although the certified BH workforce is much more geographically diverse than the licensed BH workforce.

Table 8-4. Estimated demographics of the actively practicing behavioral health (BH) workforce licensed in Oregon, 2024-2026

	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Estimated number of actively practicing BH licenses in Oregon, N	19,569	884	96	2,161	1,760	56	6,578	6,325	1,709
Average age at original licensure (years), Mean (SD)	38.2 (9.8)	37.1 (8.7)	32.8 (6.6)	36.6 (9.2)	39.2 (9.3)	34.0 (8.4)	39.7 (10.5)	37.8 (9.2)	35.3 (9.3)
Average age (years), Mean (SD)	47.9 (12.3)	51.2 (13.2)	44.0 (10.7)	50.3 (13.4)	46.9 (10.8)	43.1 (12.3)	47.6 (12.0)	49.5 (11.9)	38.3 (9.7)
Gender identity (%)									
Female	73.8%	48.2%	77.1%	64.8%	74.6%	58.9%	75.0%	78.9%	74.5%
Male	21.2%	56.2%	14.6%	31.1%	20.9%	39.3%	19.0%	16.2%	17.6%
Other/Self describe	1.7%	0.2%	6.3%	1.5%	1.0%	1.8%	2.0%	1.4%	3.2%
Decline to answer	3.5%	0%	2.1%	2.5%	3.5%	0%	4.0%	3.4%	4.7%
Race/Ethnicity(%)									
American Indian or Alaska Native	0.8%	0.4%	2.1%	0.4%	0.5%	0%	0.8%	0.9%	1.5%
Asian	3.3%	13.4%	3.1%	4.7%	3.1%	0%	2.4%	2.4%	3.8%
Black/African American	3.5%	2.0%	1.0%	1.1%	12.3%	5.6%	2.2%	2.4%	7.0%
Native Hawaiian/Pacific Islander	0.2%	0.5%	0%	0.2%	0.3%	0%	0.2%	0.2%	0.4%
Middle Eastern/North African	0.5%	1.6%	1.0%	0.7%	0.2%	0%	0.5%	0.2%	0.5%
White	71.1%	59.5%	63.6%	74.9%	61.8%	68.5%	73.4%	75.4%	58.6%
Hispanic or Latino/a/x/e	4.3%	3.2%	2.1%	2.8%	2.8%	1.9%	3.9%	4.0%	10.9%
Other race	1.1%	1.7%	5.2%	0.8%	0.8%	0%	1.0%	1.0%	1.6%
Multi race	6.2%	4.7%	6.3%	7.6%	5.7%	3.7%	6.4%	5.7%	7.1%
Decline or Unknown	9.1%	12.9%	15.6%	7.1%	12.6%	20.4%	9.4%	7.8%	8.7%
Speaks language other than English (%)	14.1%	25.0%	21.9%	13.0%	17.3%	19.6%	11.1%	12.9%	22.7%
Identifies as having a disability(%)	4.9%	—	9.4%	5.6%	3.4%	—	5.3%	4.8%	6.8%
Highest level of education (%)									
High School	0%	0%	0%	0%	0%	0%	0%	0%	0%
Associate	0%	0%	0%	0%	0.1%	0%	0%	0%	0.1%

Bachelor's	0.2%	0%	0%	0%	1.9%	1.8%	0%	0%	0%
Master's	79.3%	0%	0%	0.6%	74.3%	94.6%	95.2%	97.7%	99.2%
Doctorate	20.1%	96.5%	99.0%	98.9%	23.5%	0%	4.4%	1.5%	0.5%
None of the above	0.6%	3.4%	1.0%	0.5%	0.2%	1.8%	0.4%	0.7%	0.1%
Missing	0%	0.1%	0%	0%	0%	1.8%	0%	0%	0%
Practice distribution by region in Oregon (%)									
Portland Metro	57.1%	62.7%	85.4%	62.8%	52.6%	44.6%	54.2%	58.1%	58.3%
Willamette Valley & North Coast	13.3%	16.6%	2.1%	13.8%	14.7%	1.8%	12.9%	13.0%	13.0%
Central Oregon	8.6%	4.5%	9.4%	5.0%	8.5%	10.7%	10.8%	8.2%	8.1%
Southern Oregon	17.9%	13.6%	1.0%	17.0%	16.9%	30.4%	19.6%	17.6%	17.3%
Eastern Oregon	2.0%	1.5%	0.0%	0.6%	4.5%	3.6%	1.5%	2.2%	2.9%
Missing	1.3%	5.9%	2.1%	0.7%	2.8%	8.9%	1.0%	0.9%	0.3%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details (definitions of disability and regional distribution). For detailed REALD race/ethnicity standard reporting categories see Appendix Table 16-3.

Table 8-5. Demographics of the active certified-only behavioral health workforce in Oregon, 2026

	Total Certified-Only Individuals in the BH Workforce
Total unique individuals with a BH certification in Oregon, N	11,855
Percent with 1 certification	78.3%
Percent with 2 certifications	17.5%
Percent with 3 or more certifications	4.1%
Average age at first certification, mean (SD)	39.8 (11.4)
Average age, mean (SD)	43.2 (12.4)
Gender identity (%)	
Female	63.6%
Male	33.0%
Trans, Intersex, Other	3.4%
Race/Ethnicity (%)	
American Indian/Alaska Native	3.0%
Asian	1.6%
Black/African American	6.5%
Hispanic/Latino	9.9%
Native Hawaiian/Pacific Islander	0.5%
Middle Eastern/North African	0.2%
Multi racial	11.4%
White (non-Hispanic)	65.7%
Other	1.1%
Speaks language other than English (%)	16.3%
Veteran Armed Forces (%)	6.7%
Education level (%)	
High School	33.9%
Associate	14.9%
Bachelor's	31.0%
Master's	19.1%
Doctorate	1.2%
Distribution by region in OR (%)	
Portland Metro	40.8%
Willamette Valley & North Coast	26.5%
Central Oregon	8.0%
Southern Oregon	12.8%
Eastern Oregon	5.1%

Outside Oregon	6.8%
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Data Source: Mental Health and Addiction Certification Board of Oregon, 2026. Data represents all unique individuals with a MHACBO certification only and no additional state BH licenses. See

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Methods appendix for more details (full certified credential list, regional distribution).

Table 8-6. Demographics of the active certified-only behavioral health (BH) workforce in Oregon, 2026, by credential

	Total Credentials held by certified-only BH workforce	Certified Alcohol and Drug Counselors	Qualified Mental Health Associates	Qualified Mental Health Professionals	Certified Recovery Mentors	Certified Gambling Addiction Counselors	Certified Prevention Specialists	Certified Gambling Recovery Mentor
Total BH credentials (not including licensed individuals), N	14,922	4,424	5,596	1,649	2,974	191	55	33
Average age at first certification, mean (SD)	40.5 (11.4)	40.9 (11.0)	38.4 (11.7)	42.4 (11.9)	42.2 (10.4)	44.6 (11.3)	40.9 (10.7)	47.5 (10.2)
Average age, mean (SD)	43.6 (12.3)	45.6 (12.6)	40.7 (12.3)	45.6 (12.7)	44.5 (10.8)	47.8 (12.3)	51.1 (11.8)	50.3 (10.9)
Gender identity (%)								
Female	63.5%	62.6%	67.2%	71.9%	54.0%	54.8%	81.8%	22.6%
Male	33.3%	34.6%	28.6%	25.6%	43.5%	44.1%	18.2%	71.0%
Trans, Intersex, Other	3.2%	2.8%	4.3%	2.5%	2.5%	1.1%	0.0%	6.5%
Race/Ethnicity (%)								
American Indian/Alaska Native	3.1%	3.3%	1.7%	1.1%	6.1%	3.3%	14.5%	9.1%
Asian	1.4%	1.1%	1.9%	3.0%	0.2%	2.2%	0%	0%
Black/African American	6.5%	6.0%	5.8%	8.2%	7.5%	8.2%	0%	6.1%
Hispanic/Latino	9.9%	8.8%	10.6%	8.6%	10.4%	18.6%	0%	18.2%
Native Hawaiian/Pacific Islander	0.5%	0.3%	0.7%	0.6%	0.4%	0.5%	0%	0%
Middle Eastern/North African	0.2%	0.2%	0.2%	0.6%	0.1%	0.0%	0%	0%
Multi racial	11.6%	10.7%	12.1%	9.3%	13.6%	9.3%	18.2%	3.0%
White (non-Hispanic)	65.7%	68.5%	66.1%	67.8%	60.4%	56.8%	67.3%	57.6%
Other	1.1%	1.2%	0.9%	0.9%	1.3%	1.1%	0%	6.1%
Speaks language other than English (%)	16.0%	14.7%	17.5%	18.2%	14.0%	21.6%	9.1%	21.2%
Veteran Armed Forces (%)	6.6%	6.7%	6.8%	7.0%	6.0%	8.1%	3.6%	9.1%
Education level (%)								
High School	34.0%	32.5%	24.3%	0.1%	72.4%	24.6%	12.7%	48.5%
Associate	16.4%	21.5%	17.4%	0.1%	15.6%	22.5%	16.4%	30.3%
Bachelor's	29.9%	27.9%	51.0%	6.2%	9.7%	29.8%	32.7%	12.1%
Master's	18.6%	17.2%	6.9%	89.3%	2.0%	20.9%	32.7%	9.1%
Doctorate	1.1%	1.0%	0.4%	4.4%	0.4%	2.1%	5.5%	0%

Distribution by region in OR (%)

Portland Metro	40.7%	38.7%	38.3%	42.8%	47.7%	40.3%	18.2%	39.4%
Willamette Valley & North Coast	26.7%	28.8%	26.8%	24.0%	25.1%	27.2%	21.8%	21.2%
Central Oregon	8.4%	7.8%	9.8%	8.1%	6.4%	11.0%	27.3%	12.1%
Southern Oregon	12.4%	10.8%	14.2%	9.4%	13.3%	8.9%	14.5%	12.1%
Eastern Oregon	5.2%	5.4%	5.6%	4.1%	4.4%	6.3%	9.1%	9.1%
Outside Oregon	6.5%	8.6%	5.2%	11.6%	3.1%	6.3%	9.1%	6.1%

Data Source: Mental Health and Addiction Certification Board of Oregon (MHACBO), 2026. Data represents all MHACBO credentials held by a certified-only individual (no additional state BH license), not the unique individual. Individuals may be double counted if they hold more than one credential. See

Methods appendix for more details and full list of included credentials.

Practice characteristics of the behavioral health workforce in Oregon

Actively practicing licensed BH workers work from 31.7 (LPC/LMFTs) to 38.0 hours weekly (PAs, Table 8-7). Among all BH occupations, 18.0% work over 40 hours weekly across their primary and secondary practice locations. Telehealth practice is very common across the BH workforce; 81.0% of occupations provide telehealth that serves Oregon residents (excluding MD/DOs and PAs). Seeing patients covered by Medicaid is less common. A little over half of the licensed BH workforce (excluding NPs) see such patients (53.7%), with PAs seeing the highest percentage of Medicaid-covered patients (85.7%), followed by CSWAs (79.3%). Among the BH workforce who reported serving Medicaid-covered patients at their primary practice site, the percentage of patients covered by Medicaid varies across occupations. Of the providers that see Medicaid patients, relatively high percentages of psychiatrists (30.2%), psychologists (16.9%), and PAs (31.0%) answered “Unknown” about the percentage of patients they see who are covered by Medicaid, making it difficult to accurately assess this question.

The most common practice setting across all licensed BH occupations was a private office, clinic, or outpatient practice (Table 8-8). Other common settings include community and school health centers, public health clinics, and hospitals.

According to the Oregon Employment Department, most BH occupations make above the Oregon median wage, \$58,260 per year (

Table 8-9). Clinical and counseling psychologists have the highest median yearly wage (\$136,157/year), while psychiatric aides have the lowest (\$47,986/year). Median wages generally follow the trend that more education requirements correlate to a higher median wage, however this does not apply to rehabilitation counselors (\$54,059/year) and child, family and school social workers (\$64,480/year), who appear to earn less per year than their counterparts in similar roles (i.e. mental health and substance abuse social workers, \$73,778/year).

Table 8-7. Estimated practice characteristics of the actively practicing behavioral health (BH) workforce licensed in Oregon, 2024-2026

	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Estimated number of actively practicing BH licenses in Oregon, N	19,569	884	96	2,161	1,760	56	6,578	6,325	1,709
Average hours worked per week, mean (SD)	33.3 (13.9)	34.4 (15.6)	31.8 (13.8)	33.0 (14.6)	35.6 (15.8)	38.0 (12.0)	31.7 (13.5)	33.8 (13.5)	37.3 (11.6)
Worked over 40 hours weekly (%)	18.0%	22.4%	24.0%	20.3%	24.5%	19.6%	14.9%	18.2%	17.3%
Telehealth practice serving Oregon residents (%)	81.0%	—	97.9%	85.7%	85.3%	—	88.8%	73.6%	67.2%
Sees patients covered by Medicaid at primary or secondary practice (%)	53.7%	53.6%	68.8%	35.3%	—	85.7%	50.2%	56.3%	79.3%
Percentage of Medicaid patients seen at primary practice, n	9,568	474	66	762	—	48	3,305	3,558	1,356
0-25%	21.1%	10.9%	17.2%	36.7%	—	11.9%	24.5%	21.5%	7.0%
26-50%	17.5%	16.0%	23.4%	19.0%	—	11.9%	18.6%	19.3%	9.4%
51-75%	20.8%	21.5%	28.1%	16.6%	—	19.0%	20.6%	22.3%	19.1%
76-100%	27.6%	21.5%	25.0%	10.8%	—	26.2%	28.0%	24.5%	46.7%
Unknown	13.0%	30.2%	6.3%	16.9%	—	31.0%	8.3%	12.4%	17.7%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Dashes indicate unavailable data. See Methods Appendix for more details.

Table 8-8. Top three primary practice settings of the actively practicing behavioral health (BH) workforce licensed in Oregon, 2024-2026 (column %)

	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Estimated number of actively practicing BH licenses in Oregon, N	884	96	2,161	1,760	56	6,578	6,325	1,709
Primary practice setting Rank 1	Private clinic or office (43.6%)	Private outpatient practice/clinic (93.8%)	Private outpatient practice/clinic (68.8%)	Office/clinic (69.3%)	Private clinic or office (60.7%)	Private outpatient practice/clinic (65.7%)	Private outpatient practice/clinic (49.7%)	Private outpatient practice/clinic (35.6%)
Primary practice setting Rank 2	Community/public health clinic (17.8%)	Community/school health center (2.1%)	Other (12.0%)	Hospital (7.3%)	Community/public health clinic (30.4%)	Phone or online (11.3%)	Other (15.9%)	Other (19.0%)
Primary practice setting Rank 3	Hospital (30.8%)	Other (2.1%)	Educational/research institution (6.4%)	Community/public health (4.7%)	Hospital (5.4%)	Other (6.7%)	Hospital (8.5%)	Community/school health center (17.2%)

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Practice setting wording reflects exact wording used on each board's workforce survey. See

Methods appendix for more details.

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Table 8-9. Annual median wage of select actively practicing behavioral health professionals licensed in Oregon, 2025

Occupation Title	2025 Annual Median Wage
Psychiatrists	Suppressed
Clinical and Counseling Psychologists	\$136,157
School Psychologists	\$116,251
Psychologists, All Other	\$85,197
Marriage and Family Therapists	\$82,056
Rehabilitation Counselors	\$54,059
Counselors, All Other	\$78,166
Mental Health and Substance Abuse Social Workers	\$73,778
Child, Family, and School Social Workers	\$64,480
Health care Social Workers	\$87,464
Social Workers, All Other	\$65,083
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$71,552
Psychiatric Aides	\$47,986

Data source: Oregon Wage Information prepared by the Oregon Employment Department (OED), Workforce and Economic Research Division. BH occupations listed reflect those with data collected by the OED and include both licensed and certified BH professionals, ordered from most to least education required.

Education program completions of the behavioral health workforce in Oregon

There are many routes to becoming a certified or licensed BH professional in Oregon (

Table 8-10). As of 2024, there were approximately 60 education institutions offering BH-related education programs that trained and graduated students to work in BH (see

Appendix Table 16-3 for the full list of programs and completion counts). Social work programs contributed the largest number of graduates to the workforce in 2024 (482 graduates across 8 institutions), followed by psychologist education programs (408 graduates across 9 institutions). Oregon only has one education program each for producing psychiatrists and psychiatric NPs.

After an initial decline in completions during the COVID-19 pandemic, several BH occupations experienced growth through 2022 and 2023. However, completion counts declined from 2023 and 2024 across all occupation categories, with particularly notable decreases among psychologists (560 to 408 graduates), social workers (513 to 482 graduates), addiction specialists (100 to 49 graduates), and psychiatry programs (332 to 264 graduates). Although data show the number of education program completions from Oregon institutions, it is unknown what percentage of these graduates enter the workforce in Oregon.

BH programs are concentrated in the Portland Metro area, with the largest number of completions coming from that area (

Figure 8-1). However, there are other institutions along the Willamette Valley producing BH professionals, including social workers, psychologists, therapists, addiction specialists, and mental health specialists, as well as smaller numbers of programs located in Southern and Eastern Oregon.

Table 8-10. Education programs and number of program completions, by academic year, of the actively practicing behavioral health workforce in Oregon, 2018-2024

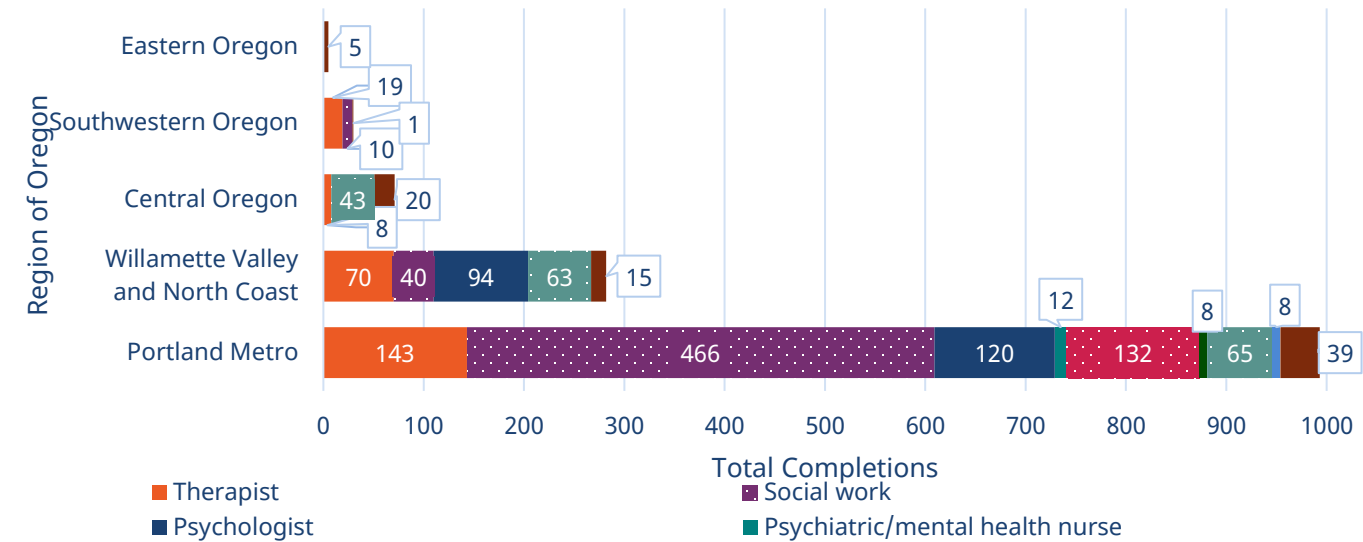
Occupation (total number of education institutions in Oregon (2024))	2018	2019	2020	2021	2022	2023	2024
Addiction specialists (N=7)	32	39	57	61	123	100	49
Mental health specialists (N=9)	172	137	123	133	136	159	157
Social work (N=8)	498	481	500	466	506	513	482
Peer, Prevention, and Gambling Specialists (N=1)	52	56	29	37	21	46	22
Psychologists (N=9)	323	365	369	414	542	560	408
Therapists (N=24)	122	137	118	125	99	142	116
Psychiatry (N=1)	294	252	302	316	298	332	264
Psychiatric/Mental Health Nurse/Nursing (N=1)	9	11	15	4	12	16	2

Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See

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Methods appendix for more details of CIP codes by occupation and award level.

Figure 8-1. Behavioral health training programs in Oregon with at least one completion, by number of completions, 2024



Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See

Demand and reported vacancies of the behavioral health workforce in Oregon

According to data from the Oregon Employment Department's Workforce and Economic Research Division, the BH workforce in Oregon is projected to grow over the next decade (Table 8-11). The largest growth expected to be seen is among substance abuse, behavioral disorder, and mental health counselors (1,629 projected new job openings 2024-2034; 758 job openings annually). Most of the total projected openings are comprised of replacement openings rather than new openings. Along with the relatively small projected employment increases for all other BH occupations over the ten-year period, this indicates projected increases in turnover among this workforce. While not directly comparable due to differences in the structures of the data, the projected increases in the demand data align with ongoing growth seen in the supply of the licensed BH workforce over time. Demand data on psychiatric NPs is unavailable.

Table 8-11. Projected employment of and demand for the behavioral health workforce in Oregon, 2024-2034

Occupation Title	2024 Employment	2034 Projected Employment	Average Annual Job Openings, 2024-2034	Projected Replacement Openings, 2024-2034	Projected New Job Openings, 2024-2034	Total Projected Openings, 2024-2034
Psychiatrists	391	437	15	105	46	151
Clinical and Counseling Psychologists	461	541	32	243	80	323
School Psychologists	697	731	43	399	34	433
Psychologists, All Other	1,392	1,509	105	932	117	1,049
Marriage and Family Therapists	1,252	1,564	145	1,142	312	1,454
Rehabilitation Counselors	1,932	2,087	229	2,137	155	2,292
Counselors, All Other	212	245	24	205	33	238
Mental Health and Substance Abuse Social Workers	2,346	2,657	244	2,125	311	2,436
Child, Family, and School Social Workers	6,354	6,678	573	5,403	324	5,727

Health care Social Workers	2,270	2,468	220	2,002	198	2,200
Social Workers, All Other	3,651	3,946	336	3,061	295	3,356
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	6,945	8,574	758	5,954	1,629	7,583
Psychiatric Aides	1,325	1,430	201	1,907	105	2,012

Data source: Oregon Wage Information, Oregon Occupations in Demand, and Oregon Occupational Employment Projections prepared by the Oregon Employment Department (OED), Workforce and Economic Research Division. BH occupations listed reflect those with data collected by the OED and include both licensed and certified BH professionals, ordered from most to least entry-level education required, then most to least competitive education level, where appropriate.

Retention and turnover of the behavioral health workforce in Oregon

Just over one-third (34.3%) of the 1,036 actively practicing BH MD/DOs, NDs, and PAs completed their education program or medical residency in Oregon (

Table 8-12). As such, the BH workforce averages about 10 years since initial Oregon licensure (mean of 9.7 years), ranging from 3.1 years (CSWAs) to almost 14 years (psychologists).

When anticipating their future career plans, the majority of the BH workforce wished to maintain their current practice hours and continue working at their current work location (

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Table 8-12). This is highest amongst BH MD/DOs (92.4%). Only about 10% of the licensed BH workforce said they wanted to either increase or decrease their current practice hours, and this is even less common amongst the MD/DOs and PAs. The majority of the BH workforce indicated intent to continue working at their current location (88.2% overall), and very few said they intend on leaving OR to work in another state (1.5%), move to another practice within OR (4.9%), or retire (2.3%). Among NPs, 2.2% said they planned to retire in the next two years (see Appendix Table 16-5). These results illustrate satisfaction within the careers of licensed BH occupations, and do not align with the demand data above, which indicate a period of high turnover due to many replacement openings over the next ten years.

Table 8-12. Workforce retention and future career plans of the actively practicing behavioral health (BH) workforce licensed in Oregon, 2024-2026

	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Estimated number of actively practicing BH licenses in Oregon, N	884	96	2,161	1,760	56	6,578	6,325	1,709
Completed educational program or medical residency in OR (%)	29.9%	88.5%	—	—	10.7%	—	—	—
Average years since original licensure (as of 2026), mean(SD)	14.1 (11.9)	11.2 (9.2)	13.6 (10.7)	7.7 (7.1)	9.1 (7.5)	7.8 (6.6)	11.7 (9.0)	3.1 (1.9)
Anticipated change in future work hours (%)								
Increase practice hours	2.4%	21.9%	7.4%	13.1%	2.6%	12.3%	7.6%	15.8%
Maintain practice hours	92.4%	63.5%	79.5%	74.6%	91.9%	76.3%	80.3%	77.3%
Reduce practice hours	5.0%	13.5%	12.2%	10.2%	5.0%	10.2%	10.9%	5.6%
Other	1.0%	1.0%	0.9%	2.2%	1.2%	1.2%	1.2%	1.3%
Anticipated change in future career plans over the <i>next two</i> years (%)								
Continue working at my current location(s)	—	81.3%	88.7%	83.9%	—	89.0%	88.7%	87.6%
Leave OR to practice out of state	0.6%	3.1%	1.5%	2.0%	0.5%	1.5%	1.3%	1.2%
Leave the field (intend to work in a different field)	0%	2.1%	0.3%	0.7%	0%	0.6%	0.5%	0.5%
Move to OR to practice in the field	0.1%	0%	0.2%	1.9%	0.1%	0.4%	0.1%	0.1%
Move to another practice location in OR	1.1%	8.3%	4.0%	6.8%	1.2%	4.5%	4.3%	7.8%
Retire	2.0%	2.1%	3.3%	1.6%	1.9%	1.7%	3.4%	0%
Other	—	3.1%	2.0%	3.1%	—	2.2%	1.6%	2.8%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Column percentages sum to 100% across both categories of questions for MD/DOs and PAs. See

9. Measures of current needs and available resources

The following section provides an overview of population health in Oregon, outcomes related to accessing oral health, primary, and behavioral health care, along with structural capacity related to these areas of health care. Finally, this section ends with providing an overview of unmet health care needs in the state according to information from the Oregon Office of Rural Health.

Population health outcomes

Birth and mortality

Oregon's birth and mortality indicators vary substantially across counties (Table 9-1). The statewide birth rate is 9.1 births per 1,000 population, below the U.S. rate of 10.1.¹¹² Both birth and fertility rates have been declining, with birth rates in 17 counties below the state average.^{113,114}

Oregon compares favorably with the nation on low birthweight births (7.0% vs. 8.5%) and infant mortality (4.93 vs. 5.6 deaths per 1,000 live births). Among counties with reported data, Klamath has the highest low birthweight rate (9.9%) and Yamhill the lowest (6.2%).¹¹²

Oregon's all-cause mortality rate is slightly higher than the national rate (980.6 vs. 903.4 deaths per 100,000), with substantial county variation, from 592.3 in Gilliam to 1,978.9 in Curry.¹¹⁵ These county-level crude rates should be interpreted cautiously because they are not age-adjusted. Oregon's suicide rate is 20.0 per 100,000, up from 19.4 in 2023. The highest county rates are in Tillamook (43.8), Curry (42.9), Josephine (39.9), and Douglas (34.7).¹¹⁶

Table 9-1. Oregon county-level birth and mortality indicators, 2024-2025

County	Birth rate, per 1,000 population (2025)	Fertility rate, births per 1,000 age 15-44 female population (2025)	Low birthweight births, per 100 live births (2024)	Infant mortality rate, per 1,000 live births (2024)	All-cause mortality rate, per 100,000 population (2024)	Chronic disease mortality rate, per 100,000 population (2024)	Suicide rate, per 100,000 population (2024)
Baker	7.8	60.6	2.8%	DS	1484.2	881.0	DS
Benton	5.6	26.9	5.8%	DS	718.4	420.6	17.4
Clackamas	8.7	48.4	6.0%	4.1	947.8	526.7	16.3

County	Birth rate, per 1,000 population (2025)	Fertility rate, births per 1,000 age 15-44 female population (2025)	Low birthweight births, per 100 live births (2024)	Infant mortality rate, per 1,000 live births (2024)	All-cause mortality rate, per 100,000 population (2024)	Chronic disease mortality rate, per 100,000 population (2024)	Suicide rate, per 100,000 population (2024)
Clatsop	7.8	45.0	5.4%	DS	1223.8	712.9	DS
Columbia	9.5	53.4	9.0%	DS	1109.9	651.4	18.6
Coos	8.1	52.4	8.6%	DS	1767.6	1020.1	28.0
Crook	9.6	66.8	7.2%	DS	1139.1	612.2	DS
Curry	6.5	54.7	2.4%	DS	1978.9	1193.3	42.9
Deschutes	9.2	52.3	4.6%	DS	859.4	457.5	21.6
Douglas	8.6	56.8	7.7%	DS	1681.0	969.4	34.7
Gilliam	5.2	66.2	DS	DS	592.3	0.0	DS
Grant	7.5	62.7	21.9%	DS	1441.4	512.8	DS
Harney	10.9	68.3	6.1%	DS	1263.4	537.6	DS
Hood River	8.6	48.2	7.8%	DS	741.2	408.5	DS
Jackson	8.9	53.2	6.9%	4.4	1278.7	675.4	23.6
Jefferson	10.7	68.1	9.8%	DS	1096.1	605.0	DS
Josephine	9.5	59.4	6.9%	DS	1672.7	889.3	39.9
Klamath	10.0	61.9	8.3%	DS	1445.7	847.1	35.7
Lake	9.8	71.7	9.7%	DS	1483.2	590.9	DS
Lane	7.5	39.5	8.6%	4.7	1177.7	647.5	25.7
Lincoln	6.4	49.9	6.1%	DS	1487.6	928.7	27.5
Linn	10.7	59.9	5.2%	DS	1215.2	715.6	23.6
Malheur	13.3	72.7	7.6%	DS	1101.6	614.8	DS
Marion	11.1	57.8	7.8%	3.7	987.2	532.7	15.9
Morrow	13.1	75.4	6.8%	DS	853.5	455.2	DS
Multnomah	8.6	38.3	8.4%	4.2	868.1	452.5	18.9
Polk	9.6	49.4	6.5%	DS	1007.7	553.4	16.7
Sherman	9.0	76.7	10.0%	DS	0.0	0.0	DS
Tillamook	8.1	55.2	6.0%	DS	1407.9	890.0	43.8
Umatilla	13.0	64.2	6.3%	DS	1025.6	577.1	17.5
Union	10.8	53.9	3.5%	DS	1337.5	693.8	DS
Wallowa	9.2	59.2	4.2%	DS	1264.0	599.4	DS
Wasco	9.4	56.1	9.1%	DS	1378.5	744.3	DS
Washington	9.6	47.3	6.2%	3.8	705.3	389.1	15.2
Wheeler	8.9	53.2	DS	DS	0.0	0.0	DS
Yamhill	9.5	50.5	5.6%	DS	1055.7	610.3	18.4
Total	9.1	45.0	7.0	4.93	980.6	608.8	20.0

Data sources: 2024 Area Health Resources Files, Health Resources and Services Administration; Oregon Health Authority Vital Statistics, 2025. See

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Methods appendix for details of data sources and calculations.

Population growth and demographic change

Oregon's overall population has grown since 2000 (

Figure 9-1) with an estimated 50.6% identifying as female, while its demographic composition has shifted substantially. The population is aging: adults ages 65 and older increased from 16.4% of the population in 2015 to approximately 20% in 2025, while the proportion of children ages 0–17 declined from 21.6% to about 18% over the same period (

Figure 9-2). Oregon has also become more racially and ethnically diverse (

Figure 9-3). The proportion of the population identifying as White has declined since 2000, while the Hispanic or Latino population has increased. In contrast, the proportions identifying as Black or African American and American Indian or Alaska Native have remained relatively stable. In 2025, approximately 71% of Oregonians identified as White and nearly 15% as Hispanic or Latino, with smaller proportions identifying as two or more races, Asian, Black or African American, American Indian or Alaska Native, or Native Hawaiian or Other Pacific Islander (

Figure 9-3).

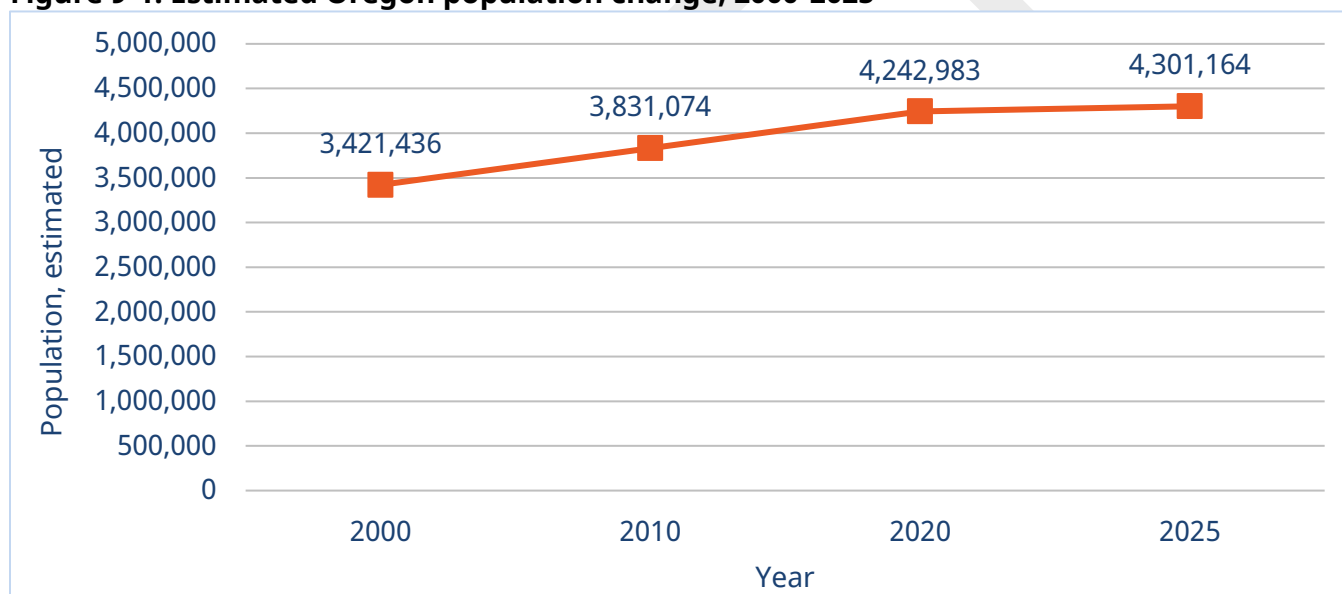
Linguistic diversity

In reflection of Oregon's changing demographics, approximately 15.1% of Oregon households speak a language other than English at home, mostly commonly Spanish, Chinese (Mandarin/Cantonese), and Vietnamese.¹¹⁷

Oregon generally requires health care providers receiving public funds to use health care interpreters listed on the OHA Health Care Interpreter (HCI) Registry when providing services to patients with limited English proficiency, with limited exceptions.¹¹⁸ OHA recognizes 3,603 active Oregon HCI interpreters in good standing covering approximately 120 languages. In addition, Oregon has 92 bilingual providers who self-report as proficient or have taken proficiency exams in 30 languages, and two ASL-proficient providers.

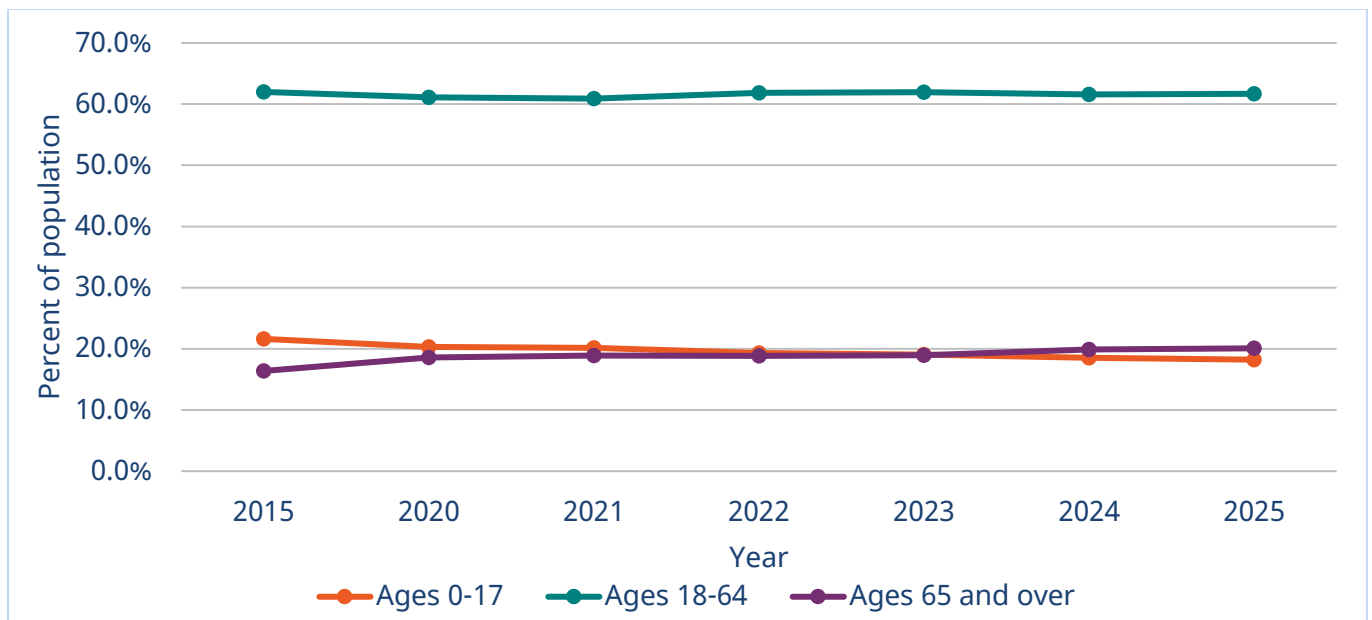
Despite this registry, access remains uneven and finding interpretation for less commonly spoken languages across the state is difficult. Along with this, smaller clinics can struggle with interpretation costs and rural clinics face challenges due to lower availability of HCIs and/or bilingual or ASL-proficient providers are available.

Figure 9-1. Estimated Oregon population change, 2000-2025



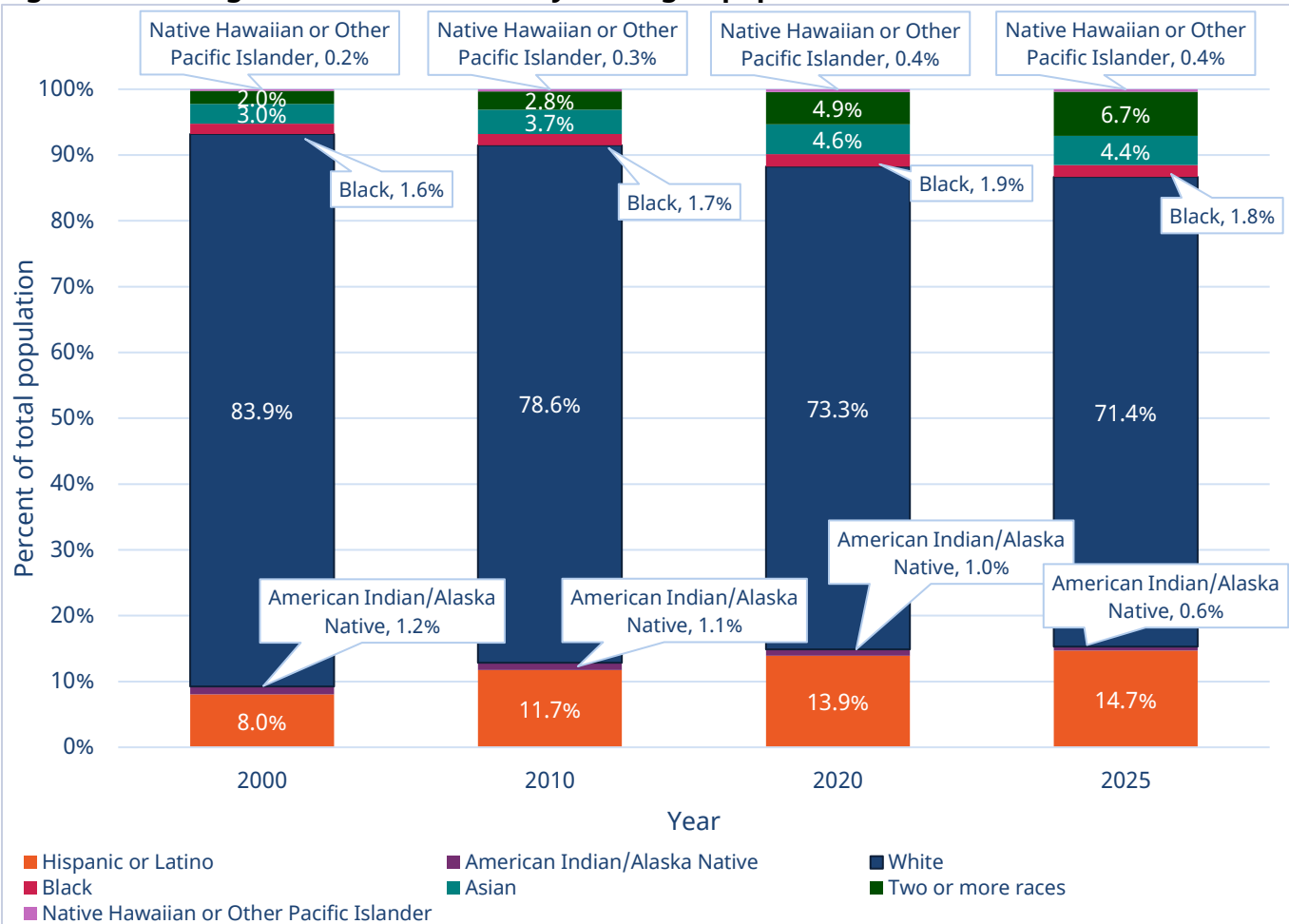
Data Source: Portland State University Population Research Center, Population Estimate Reports.

Figure 9-2. Shifts in age distribution in Oregon, 2015-2025



Data Source: Portland State University Population Research Center, Population Estimate Reports.

Figure 9-3. Changes in race and ethnicity of Oregon population, 2000-2020



Data source: 2000, 2010, and 2020 U.S. Decennial Census and 2024 American Community Survey (ACS) 5-year estimates.

Socioeconomic status (SES)

Socioeconomic conditions vary substantially across Oregon counties, with some areas experiencing multiple indicators of economic disadvantage (Table 9-2). Statewide, 13.9% of residents lived below the poverty level in 2023, per capita income was \$59,653, and approximately 20% participated in SNAP. Poverty was highest in Malheur, Klamath, and Wheeler counties, although counties with the highest percent in deep poverty were Klamath, Gilliam, and Benton while per capita income was lowest in Malheur, Jefferson, and Wheeler counties. SNAP participation exceeded 25% in Coos, Douglas, Jefferson, Josephine, Klamath, and Malheur counties. Insurance coverage is high statewide, with an uninsured rate of 2.7% in 2024 (

Table 9-3), although rates were higher in Marion County (4.4%), North Central Oregon (4.0%), Northeast Oregon (3.9%), Jackson County (3.8%), and Southwest Oregon (3.7%). Approximately one-third of Oregon residents were enrolled in Medicaid as of June 2026.

Table 9-2. Oregon county-level socioeconomic status indicators, 2022-2023

County	Adults without a high school diploma (2022)	Unemployment rate (2023)	Per capita income (2023)	Population below poverty level (2023)	Population in deep poverty (2023)	SNAP participation (2022)
Baker	6.3%	1.8%	\$52,392	16.2%	6.4%	23.0%
Benton	2.4%	1.5%	\$60,307	16.2%	11.2%	11.5%
Clackamas	4.0%	1.8%	\$80,269	6.9%	3.8%	11.4%
Clatsop	5.8%	1.8%	\$60,930	15.3%	6.1%	17.4%
Columbia	6.7%	2.0%	\$59,020	9.8%	4.0%	16.9%
Coos	7.6%	1.9%	\$59,838	16.0%	7.7%	26.4%
Crook	6.7%	2.3%	\$57,968	12.8%	4.8%	20.0%
Curry	7.3%	1.8%	\$57,405	15.8%	4.6%	22.5%
Deschutes	4.0%	1.8%	\$81,025	8.7%	4.9%	11.6%
Douglas	6.4%	2.0%	\$52,684	16.0%	6.8%	25.4%
Gilliam	7.4%	1.9%	\$71,618	11.8%	9.2%	19.1%
Grant	8.5%	2.2%	\$54,969	15.3%	6.8%	20.1%
Harney	6.5%	2.0%	\$53,228	15.2%	5.4%	23.3%
Hood River	11.2%	1.8%	\$71,946	10.0%	3.1%	12.4%
Jackson	6.5%	2.1%	\$62,541	12.6%	5.4%	21.6%
Jefferson	8.1%	1.9%	\$46,111	13.9%	5.9%	27.7%
Josephine	6.7%	2.1%	\$55,038	15.1%	7.0%	28.4%
Klamath	7.4%	2.2%	\$51,246	19.3%	9.7%	28.6%
Lake	9.6%	2.2%	\$50,163	17.0%	7.9%	23.5%
Lane	5.0%	1.9%	\$61,634	14.7%	7.9%	19.6%
Lincoln	5.5%	1.8%	\$59,715	15.4%	7.7%	21.0%
Linn	6.3%	1.9%	\$57,016	14.2%	5.6%	22.2%
Malheur	11.9%	1.5%	\$40,360	19.7%	7.2%	27.3%
Marion	9.5%	1.8%	\$58,470	14.1%	5.3%	20.0%
Morrow	14.6%	1.7%	\$58,480	13.2%	5.7%	19.5%
Multnomah	5.8%	2.1%	\$75,772	12.8%	6.0%	18.1%
Polk	5.2%	1.8%	\$55,086	11.8%	4.9%	17.1%
Sherman	8.3%	1.9%	\$66,483	14.5%	6.4%	24.4%
Tillamook	7.0%	1.7%	\$61,950	11.5%	5.1%	17.9%
Umatilla	10.3%	2.0%	\$53,253	16.5%	6.3%	20.9%
Union	4.9%	1.8%	\$53,469	13.6%	5.4%	22.3%
Wallowa	4.9%	2.1%	\$59,576	13.0%	4.2%	14.5%
Wasco	9.7%	2.0%	\$56,865	13.6%	5.1%	21.0%

Washington	5.0%	1.8%	\$79,139	8.1%	4.1%	10.2%
Wheeler	6.4%	1.5%	\$49,563	18.4%	2.2%	15.3%
Yamhill	6.8%	1.8%	\$61,974	10.6%	5.1%	15.5%
Oregon	7.1%	1.9%	\$59,653	13.9%	6.0%	19.9%

Data source: 2024 Area Health Resources Files, Health Resources and Services Administration. See

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Methods appendix for details.

Table 9-3. Uninsured population by Oregon region

Region/County	Percentage of uninsured population in Oregon (2024)
Central Oregon (Deschutes)	1.6%
Clackamas County	2.1%
Douglas County*	1.7%
Jackson County	3.8%
Lane County	2.0%
Linn and Boston Counties	2.7%
Marion County	4.4%
Multnomah County	2.5%
North Central Oregon (Morrow, Gilliam, Sherman, Wasco, Hood River, Jefferson, Wheeler, Grant, Crook)	4.0%
Northeast Oregon (Umatilla, Wallowa, Union, Baker)	3.9%
Northwest Oregon (Lincoln, Tillamook, Clatsop, Columbia)*	1.5%
Polk and Yamhill Counties	2.5%
Southeast Oregon (Malheur, Harney, Lake, Klamath)	3.2%
Southwest Oregon (Josephine, Curry, Coos)	3.7%
Washington County	2.0%
Oregon	2.7%

Data Source: Oregon Health Insurance Survey Coverage Dashboard, 2024.

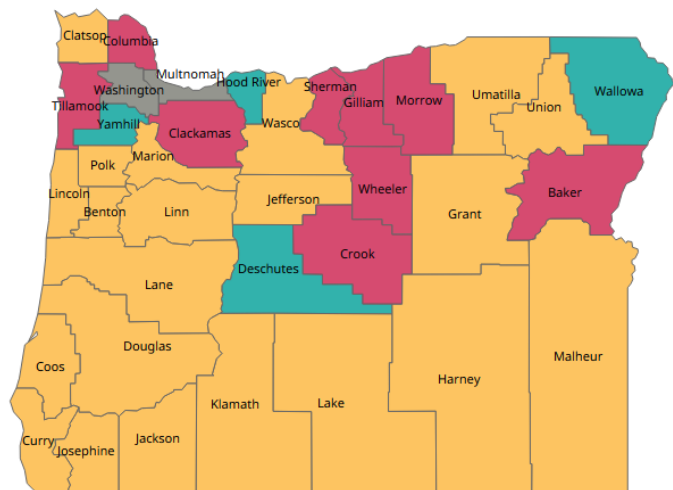
*May be statistically unreliable; interpret with caution

Structural capacity

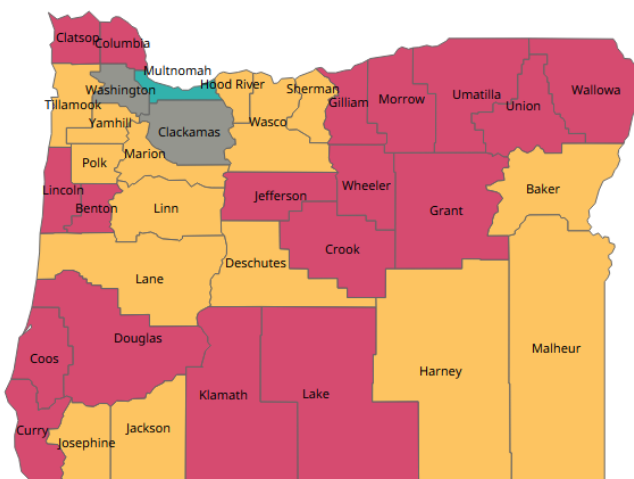
Most counties in Oregon are designated as a geographic or population shortage area for primary care, behavioral health, and oral health (Figure 9-4). Nine counties are designated as full Primary Care HPSAs, two as full Dental HPSAs, and 19 as full Mental Health HPSAs. Shortages also overlap across service areas: Crook County is designated as a geographic HPSA for all three types of care, and five additional counties have geographic HPSA designations for two of the three types.

Figure 9-4. Oregon Counties by Health Professional Shortage Area (HPSA) Status

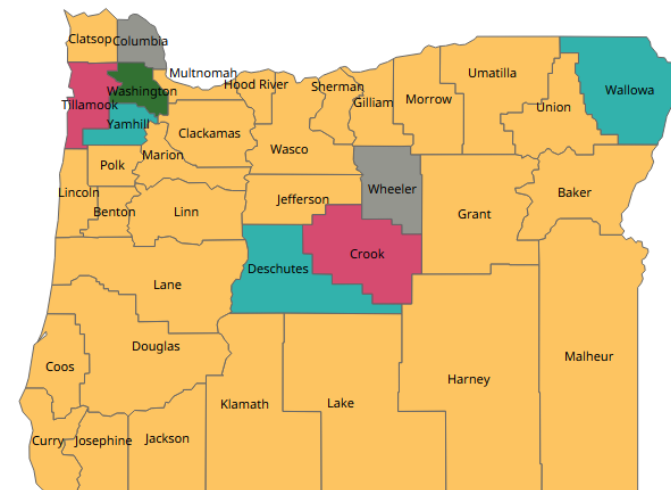
Primary Care HPSA Status



Behavioral Health HPSA Status



Dental HPSA Status



Health Professional Shortage Area (HPSA) Designation

■ Geographic HPSA

■ Low Income HPSA

■ Medicaid HPSA

■ Migrant Seasonal Worker HPSA

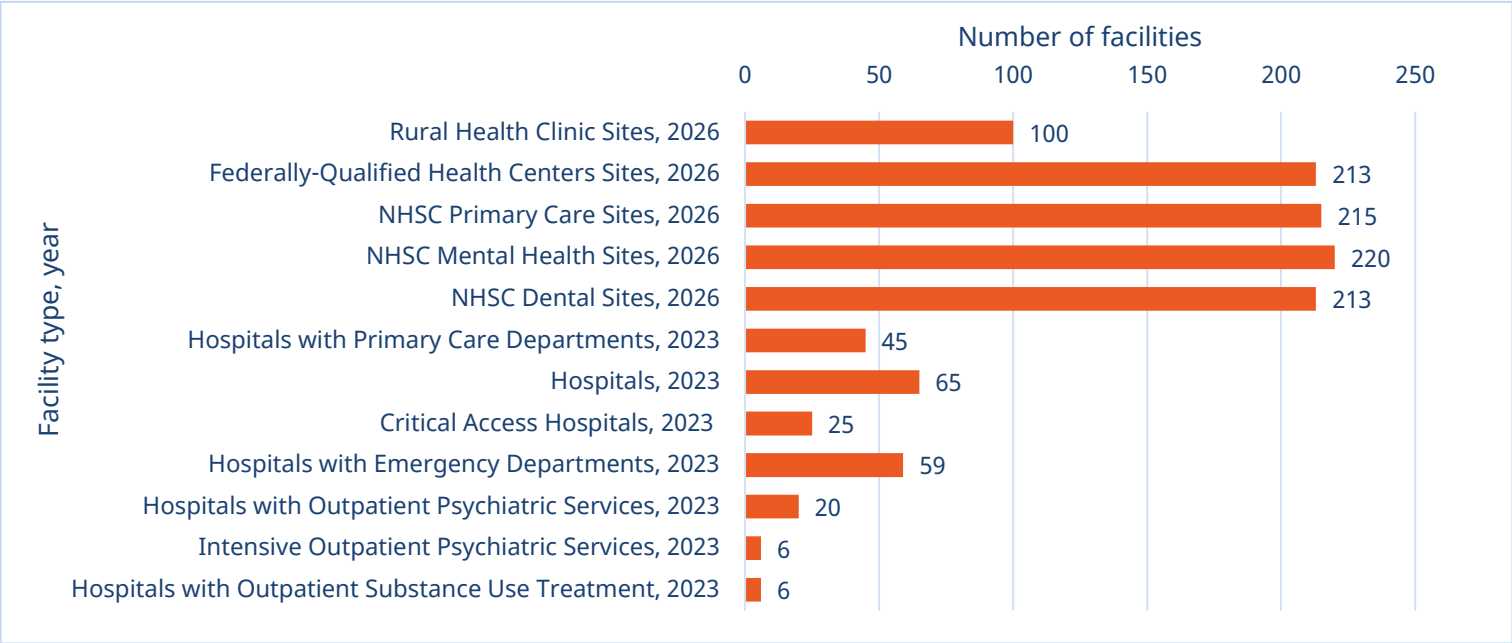
■ Not a HPSA

Data source: 2026 Health Resources and Services Administration (HRSA) Data Warehouse.¹¹⁹ See

Methods appendix for HPSA definitions.

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Figure 9-5. The count of hospital, behavioral health, and primary care facilities in Oregon, 2026



Data source: 2026 Oregon Certified FQHC and RHC data.^{120,121} 2024 Area Health Resources Files (AHRF), Health Resources and Services Administration (HRSA). HRSA National Health Service Corps (NHSC) Sites Data Explorer accessed August 2026. NHSC-approved site information includes participating clinical sites serving Health Professional Shortage Areas (HPSAs).

Primary Care access: Oregon’s primary care infrastructure includes 100 Rural Health Clinics (RHCs), 213 Federally Qualified Health Center (FQHC) sites, and 45 hospitals with primary care departments statewide (Appendix Table 17-1). Access to these facilities varies considerably by county. Seven counties have no FQHC sites and 7 have no RHCs, although no county lacks both types of facilities. Several counties are reliant on just one (Sherman, Gilliam) or two (Lake, Jefferson) RHCs or FQHCs. Six of the 7 counties without FQHC sites are designated as frontier counties, and all have populations under approximately 16,000. Five of the 7 counties with no RHCs, include large urban centers (exceptions are Klamath and Wheeler counties).

Compared with 2023 AHRF data, the number of RHCs statewide declined from 117 to approximately 100 by 2026, with several counties losing their only RHC. In contrast, the number of FQHC sites increased from 191 to 213, with some of the growth occurring in and around Portland, including Multnomah and Clackamas counties.

Oregon’s Patient-Centered Primary Care Home (PCPCH) Program supports both access to culturally responsive care and the health care workforce. Recognized practices must meet standards for coordinated, comprehensive, patient-centered, and equitable care, including culturally and linguistically appropriate care.¹²² The

model also promotes integrated services, including behavioral health and primary care, and includes standards aimed at improving provider and staff well-being.¹²²

Hospital infrastructure: Oregon's hospital infrastructure varies considerably across counties. The 2023 AHRF data identify 65 hospitals statewide, with 25 Critical Access Hospitals and 59 hospitals with emergency departments (Appendix Table 17-2). Four counties with small populations (Columbia, Gilliam, Sherman, and Wheeler) had no hospital or emergency department, although a new hospital is scheduled to open in Columbia County in August 2026. Hospital capacity is concentrated in more populous areas, with Multnomah, Washington, and Lane counties having among the largest numbers of hospitals and emergency departments.

Behavioral health infrastructure: Oregon's behavioral health infrastructure includes a mix of hospital- and community-based services. In 2023, the most recent data available, 20 hospitals offered outpatient psychiatric services, while only six offered intensive outpatient psychiatric services and six offered outpatient substance use treatment (Figure 9-5). The state also has three psychiatric hospitals: Oregon State Hospital, located in Salem, with a satellite center in Junction City, PeaceHealth in Eugene, and Cedar Hills Hospital in Portland.

Beyond hospital-based care, every county has a Community Mental Health Program, and Behavioral Health Resource Networks (BHRNs) support substance use disorder services statewide. A second round of BHRN funding began in July 2025 which provided grants to tribes and organizations in every county in Oregon related to providing substance use disorder services.¹²³ Substance Abuse and Mental Health Services Agency (SAMHSA) data identify 212 mental health facilities in Oregon, including 104 outpatient facilities, although these data exclude private practitioners and facilities that do not primarily provide specialty mental health treatment.

Population-level outcomes related to health care access

According to the 2024 Behavioral Risk Factor Surveillance System (BRFSS; see

Methods appendix for details) Oregonians have high rates of health care access: roughly three-quarters said they had visited a doctor for a check-up in the last year (72.1%), and over 82% said they had at least one personal health care provider (

Table 9-4). Eighty percent of Oregonians surveyed indicated they had good or better health compared to 20.1% with fair or poor health. The highest disability prevalence was cognitive impairment; 16.1% of those surveyed said they had serious difficulty concentrating, remembering, or making decisions.

Table 9-4. Age-adjusted population health indicators: health status, disability prevalence, and indicators if health care access/coverage, Oregon 2024

Health Indicator	Age-adjusted estimated percentage of adults in Oregon
Health Status	
Fair or Poor Health	20.1%
Good or Better Health	79.9%
Disability Status	
Vision impairment	4.5%
Difficulty doing errands alone	9.8%
Difficulty dressing or bathing	3.6%
Serious difficulty concentrating, remembering, or making decisions	16.1%
Serious difficulty walking or climbing stairs	10.9%
Adults aged 18+ who reported being deaf	6.2%
Adults aged 18+ who could not afford to see a doctor when needed in the past 12 months	12.7%
Time since last visited a doctor for a routine check-up	
Within the past year	72.1%
Within the past 2 years	12.8%
Within the past 5 years	8.1%
5 or more years ago	6.1%
Never	0.8%
Has only one personal health care provider	50.0%
Has more than one personal health care provider	32.3%

Data source: Oregon Behavioral Risk Factor Surveillance System, 2024. See

Methods appendix for details.

Table 9-5 summarizes selected chronic health conditions among Oregonians and common preventive health measures, used here as measures specific to primary care needs and utilization. An estimated one-quarter of adults reported having been told by a doctor that they had arthritis, while less than 4% had been diagnosed with angina or coronary heart disease (3.5%). Use of common preventive health measures was relatively high: over two-thirds of Oregon women aged 40 and over reported having a mammogram in the past two years, and almost 77% of adults aged 65 and older reported having received a pneumonia vaccination. In comparison to national estimates, Oregon’s chronic disease prevalence estimates are generally lower compared to national estimates, with screening estimates being mixed (lower than national for mammogram, higher than national prevalence for blood stool test). All Payer All Claims data does seem to indicate that there is use of primary care in the state, with the percent of total health care spending that is spent on primary care in Oregon averaging about 14%, with plans ranging from 5.9%-17.1% spending (Oregon’s benchmark is 12%).¹²⁴

In terms of oral health indicators, the 2024 Oregon BRFSS asks respondents about teeth extractions. Almost 40% of surveyed adults reported having a permanent tooth extracted, while 11% of older adults have had all their teeth extracted (Table 9-5). Data from the 2022 survey estimated that 65.4% of adults had seen a dentist in the past year. Compared to national prevalence estimates, more adults in Oregon are estimated to have seen a dentist and fewer have had any teeth extracted.

With respect to behavioral health, 28.4% of Oregon adults are estimated to have been told they have a form of depression, and just over half said they had at least one or more days in the past month where they did not have good mental health (including stress, depression, or problems with emotions; Table 9-6). In addition, according to data from the National Survey on Drug Use and Health, 31.6% of those surveyed report any mental illness, with 11.9% reporting a major depressive episode and 0.7% reporting attempted suicide in the past year. These prevalence rates are all higher than national prevalence estimates.

Table 9-5. Age-adjusted indicators of primary care, oral health, and behavioral health care access in Oregon, 2024¹²⁵

Primary Care	Age-adjusted estimated percentage of adults in Oregon
Adults aged 18+ who have been told they have arthritis	25.5%
Adults aged 18+ who have been told they currently have asthma	14.5%
Adults aged 18+ who have ever been told they have COPD*	6.0%
Adults aged 18+ who have ever been told they have angina or coronary heart disease	3.5%

Adults aged 18+ who have ever been told by a doctor they have diabetes	10.8%
Adults aged 45-75 who had a blood stool test within the past year to screen for colorectal cancer	11.2%
Women aged 40+ who had a mammogram within the past two years	67.7%
Adults aged 65+ who have ever had a pneumonia vaccination	76.9%
Calculated variable for meeting USPSTF lung cancer screening guidelines, [†] among eligible respondents	15.2%
Oral Health	
Adults aged 65+ who have had all their natural teeth extracted	11.0%
Adults aged 18+ that have had any permanent teeth extracted	36.7%
Visited the dentist within the past year (2022)	65.4%
Behavioral Health	
Adults aged 18+ who have ever been told they have a form of depression	28.4%
Number of days during the past 30 days when mental health status was considered not good among adults aged 18+	
0 days	48.0%
1-13 days	31.9%
14+ days	20.1%

Data source: Oregon Behavioral Risk Factor Surveillance System, 2024. See

Methods appendix for details.

*COPD: Chronic obstructive pulmonary disease

†USPSTF: United States Preventive Services Task Force. Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years are recommended to be screened yearly for lung cancer with a CAT/CT chest scan.

Table 9-6. Mental health measures and substance use disorder among people aged 18 or older in Oregon, 2023-2024

Indicator	Estimated annual percentages
Mental Health Measures	
Any Mental Illness	31.6%
Received Mental Health Treatment (2024 only)	28.6%
Major Depressive Episodes	11.9%
Had Serious Thoughts of Suicide	7.0%
Attempted Suicide	0.7%
Substance Use Disorder Measures	
Substance use disorder in the past year	21.8%
Illicit drug use in the past month	26.0%
Prescription opioid misuse in the past year	2.9%
Opioid misuse in the past year	3.0%
Cigarette use in the past month	14.9%
Nicotine vaping in the past month	10.2%

Data source: National Survey on Drug Use and Health Data. See

Methods appendix for details.

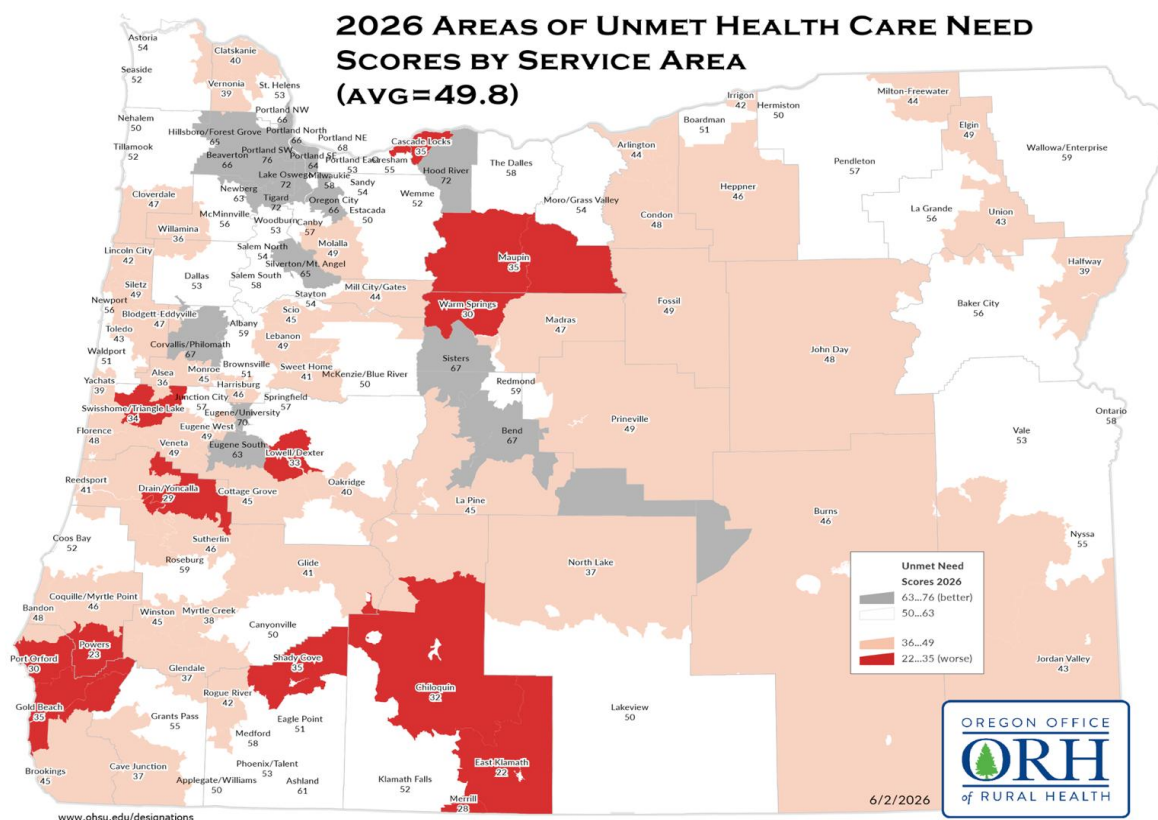
Areas of Unmet Health Care Need

Areas of Unmet Health Care Need are measured within primary care service areas by the Oregon Office of Rural Health (N=128). The overall Unmet Health Care Need score is a composite measure of nine variables representing primary, behavioral health, and oral health care availability as well as affordability and utilization. Lower scores indicate greater unmet health care need. It should be noted that these are sub-county areas and cannot be directly compared to the county-level data provided elsewhere in this report. Workforce supply are direct measures of FTE, rather than the estimates provided in previous sections. However, these do provide a closer examination of areas of Oregon with higher primary care, behavioral health, and oral health care needs.

Oregon's overall unmet need score is 49.8, a slight increase from 49.6 in 2025, with service-area scores ranging from 22 to 76 and overall greatest unmet need concentrated in rural and remote areas (

Figure 9-6). Portland Southwest, which includes OHSU, had the highest score, while East Klamath had the lowest score (22, compared with 23 last year). East Klamath has no primary care capacity and no dentists or mental health providers; it also has the fourth-worst prenatal care measure and a high poverty rate. In total, 62 service areas scored below the Oregon average, down slightly from 65 last year.

Figure 9-6. Areas of Unmet Health Care Need in Oregon State, 2026



Data Source: Oregon Office of Rural Health, 2026.

Primary Care - Unmet Needs

Travel time: The average travel time to the nearest Patient-Centered Primary Care Home (PCPCH) in Oregon was 13 minutes, compared to 14 in 2025. The 13 service areas with no primary care capacity (all rural or remote) had an average travel time of 24.1 minutes.

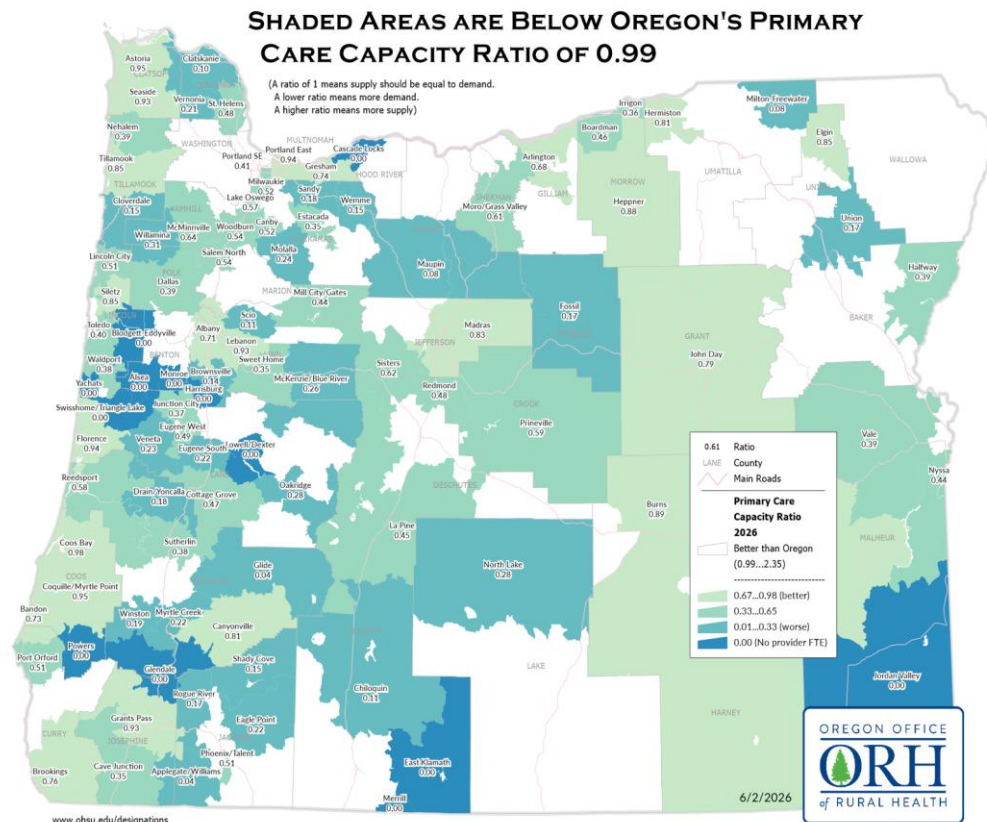
Primary care capacity: The statewide primary care capacity was 0.99 and ranged from 0.0-2.35 – this is measured as the proportion of estimated primary care visits that available providers could meet (higher proportions indicate better capacity). Ninety-six service areas had lower capacity (13 with 0.0, up from 11 in 2025). Rural and remote areas had an average capacity ratio of 0.78, an improvement from 0.71 in the previous year.

Prenatal care: Oregon had 62.5 cases of inadequate prenatal care per 1,000 births, defined as care beginning in the third trimester or involving fewer than five prenatal visits, compared with 62.2 in the previous report. Rates ranged widely from 0 to 335.7 per 1,000 births, with 60 service areas exceeding the statewide rate. Average rates were particularly high in remote (86.7) and rural (70.2) areas.

Preventable hospitalizations for ambulatory care sensitive conditions (ACSCs): ACSCs are conditions such as asthma and diabetes which hospitalization may sometimes be

avoided through timely and effective primary care. ACSC rates per 1,000 population were calculated as a three-year average of hospital discharges identified using ICD diagnosis codes in Oregon (2023-2025) and Washington (2018-2020) data. Rates ranged from 1.9 to 22.2 per 1,000 population, with a statewide rate of 7.1, up from 6.7 in the previous report. Average ACSC hospitalization rates were 8.9 in rural areas, 7.0 in remote areas, and 6.4 in urban areas. Jordan Valley had the lowest rate, while Warm Springs had the highest.

Figure 9-7. Primary Care Capacity for Oregon, 2025



Data Source: Oregon Office of Rural Health, 2026.

Oral Health Care – Unmet Needs

Emergency department (ED) visits for non-traumatic dental conditions ranged from 0 to 16.4 visits per 1,000 population. The statewide rate was 3.7 per 1,000, up slightly from 3.5 in the previous report, with 53 service areas reporting rates below the statewide average. Rural areas had the highest average rate (5.2), followed by remote areas (4.1) and urban areas (3.1). Compared with the previous report, rates increased in rural and urban areas but declined in remote areas. Jordan Valley had the lowest rate, while Warm Springs had the highest.

Behavioral Health Care – Unmet Needs

ED visits for mental health and substance use conditions, ranged from 0 to 109.2 visits per 1,000 population, based on a three-year average. The statewide rate was 16.4 per 1,000, unchanged from the previous report. Average rates were highest in urban areas (16.9), followed by rural (15.9) and remote areas (10.2); the rate in remote areas declined from 12.6 in the previous report. Warm Springs had the highest rate among service areas. Differences may reflect access to emergency care: service areas with a hospital had an average rate of 17.7 visits per 1,000, compared with 13.5 in areas without a hospital, suggesting that lower ED use in some areas may reflect differences in hospital availability as well as underlying need.

10. Recommended areas of focus

Prior to, and since the 2025 Health Care Workforce Needs Assessment was released in January 2025, Oregon has engaged in significant work to address needs in the health care workforce such as maldistribution, representation, barriers to entry, and risk of turnover. Findings in this 2027 health care workforce needs assessment reflect some positive changes related to these prior efforts, particularly with growth in the BH workforce (Section 8) and primary care NPs and PAs (Section 6). This report highlights other areas that need more targeted work. There has been less growth in the oral health workforce (Section 7) and across all physician types (Sections 6 and 8). In addition, there are ongoing needs related to lower supply in rural and remote areas, fewer educational completions for some occupational groups, expected high levels of replacement job openings for certified occupations, and inadequate access to childcare and housing. Along with needs specific to the health care workforce, findings highlight population health indicators that underscore the importance of access to high-quality primary care, oral health care, and behavioral health services. The following recommendations are made in light of these identified health care workforce needs. Recommendations also highlight opportunities for continued investment and tracking, as well as expansion of current Oregon policies and programs, with evidence-based examples of how this could be done. Recommendations specific to each health workforce group will be detailed first, followed by recommendations to address needs that cut across primary care, oral health, and behavioral health workforce groups. Citations included provide evidence for these recommendations as well as examples of initiatives where applicable.

Recommended areas of focus: Primary care workforce

There is ongoing work in the state oriented towards supporting the primary care workforce which should be sustained and potentially expanded including funding of

Oregon's provider incentive programs (e.g., Healthy Oregon Workforce Training Opportunity [HOWTO] Grant. Primary Care Loan Repayment Program), support and funding of Patient Centered Primary Care Homes, and the work of OHPB's Primary Care Strategy Committee. The recommendations below are meant to be in addition to this work and emphasize several specific opportunities to maximize capacity of the current primary care workforce.

- **Explore opportunities to facilitate adoption and incorporation of team-based care models**, although more evidence is needed regarding the success of these models. A recent study highlights one potential model which emphasizes greater team integration, clear role delineation between occupational types, and staffing aligned with both community needs and the combination of clinicians in the practice. This approach results in smaller panel sizes, more efficient use of staff, and greater reach in underserved areas.¹²⁶
- **Examine and address decreasing educational completions among nurse practitioners (NP)**. While there has been growth over time among primary care NPs in Oregon, there are only two nurse practitioner programs in Oregon and current available data show a decreasing number of educational completions over time (See "Education program completions" in Section 6). There are known national concerns related to clinical placements and availability of preceptors, particularly in rural areas, which could be one explanatory factor for decreasing completions in this occupation in Oregon.¹²⁷⁻¹²⁹ Continued funding for the nurse preceptor grant in Oregon is needed, along with emphasizing the role of organizational support, including counting preceptor activities in productivity metrics and providing sufficient compensation.^{130,131}
- **Support RNs to function in primary care at the top of their scope**. RNs encompass a large part of the primary care workforce and when they are working to the top of their license (e.g., providing dedicated nurse visits, engaging in complex care coordination, supporting social determinants of health), they can help to expand services, reduce service gaps, and support physicians, PAs & NPs.^{51,132,133} Current findings demonstrate a significant gap between the number of primary care RNs and their reported direct patient care FTE, which highlights a need for further exploration of how RNs in this setting are being used. In addition, there are known gaps in knowledge regarding how important RNs are to primary care and as such, additional education for practices and data collection could help assess and strengthen use of RNs in primary care in Oregon.
- **Explore opportunities to expand medical assistant (MA) roles**, as this may support greater capacity, although research on long-term effects on MA retention and supply remains limited. Examples of expanded team-based care models from Kaiser Permanente, and Washington and Minnesota primary care clinics demonstrate

improvements in workflow, efficiency, preventive care delivery, and team functioning.¹³⁴⁻¹³⁶ Career ladders, professional development, and compensation progression may also support workforce stability among MAs by providing structured pathways from entry-level MA positions into advanced clinical, care coordination, or leadership roles.^{137,138}

Recommended areas of focus: Oral health workforce

As noted in the findings, there has been very little overall growth in the size of the oral health workforce and a decrease in FTEs dedicated to direct patient care, evidencing a need for targeted work focused on growing and stabilizing this workforce. Oregon has a number of policies and initiatives in place supportive of this workforce, including regulations supporting a broader scope of practice for dental hygienists, eligibility for state incentives programs, and a recent report examining ways to support the dental assistant (DA) workforce, which is part of a grant from the Health Services and Resources Administration to address needs in the oral health workforce. The recommendations detailed below offer specific, actionable suggestions in addition to sustaining work already taking place. The approaches detailed below may be particularly relevant because a substantial share of dental care is delivered through solo and small-group practices, where staffing shortages and turnover can have a disproportionate effect on practice operations and patient capacity.¹³⁹

- **Examine reasons for low use of Expanded Practice Dental Hygienist permits.** Data examined in this report demonstrate that while approximately 1/3 of DHs report having an EPDH permit, only a small proportion use these permits in their practice. Work is needed to examine the reasons for this and whether there are opportunities to grow use of these permits to support additional capacity for preventive oral health care.
- **Continue to track dental therapists and explore the feasibility of a dental therapy school in Oregon.** Due to dental therapists only recently being approved for licensure, there is not sufficient data to assess trends and needs in this workforce and continued tracking is warranted along with their inclusion in future needs assessments. In addition, the lack of a dental therapy school in Oregon could make it difficult to grow this workforce and further exploration of the feasibility of starting a dental therapy program is needed.¹⁴⁰
- **Facilitate use of expanded function dental assistants.** Studies have found that EFDAs can improve practice efficiency, increase provider productivity, and support greater access to dental services, particularly in settings experiencing workforce shortages.¹⁴¹⁻¹⁴⁴
- **Facilitate growth of the DA workforce through apprenticeships and other on-the-job training,** which employers have identified as effective for recruitment, in addition

to supporting career progression to dental hygiene.¹⁴⁵ However, apprenticeship utilization appears limited in Oregon, with only one registered dental assistant apprenticeship currently identified.

- **Address decreasing completions apparent among the DA workforce.** Available data demonstrates decreasing completions for the DA workforce. In addition to expanding opportunities for entry through apprenticeships and on-the-job training, exploration of the reason for decreasing DA completions is needed to ensure continued expansion of this workforce. The recent report on the DA workforce also highlights the importance of outreach for recruitment into DA programs, partnering with the OHSU School of Dentistry, and increased partnerships between DA training programs and dental practices.¹⁰⁵
- **Continue support of, and potentially grow, incentive programs targeting the oral health workforce** such as the HOWTO and HCIP loan repayment programs. These have shown promise in retaining health care workers in rural and underserved areas, and in increasing access to care.
- **Improve tracking of the DA workforce** by partnering with stakeholders to collect statewide DA workforce data, supporting evaluation of workforce pathway and advancement strategies, and maintaining cross-agency coordination on oral health workforce issues as proposed by the Dental Assistant Workforce Shortage Advisory Committee.¹⁰⁵

Recommended Areas of focus: Behavioral health workforce capacity

The behavioral health workforce continues to grow in Oregon and numerous initiatives and policies are already underway to strengthen it, including the recent signing of HB 4086, which centralizes credentialing, expands eligibility for supervision of early-career providers, and reduces administrative requirements for Medicaid credentialing.¹⁴⁶ The recommendations here focus on opportunities to build on and expand existing efforts.

- **Continue examining underlying reasons for the gap between the number of actively practicing BH occupations and the available direct care FTE.** Reasons for this gap are not fully known, although have been theorized to be related to the emotional demand of the work and administrative load and as such, there could be some opportunities to address this through:
 - **Organizational strategies** that facilitate manageable caseloads, offer emotional and peer support, encouraging use of available vacation time, and foster a workplace culture that addresses burnout and secondary traumatic stress.¹⁴⁷⁻¹⁴⁹
 - **Telehealth and flexible work arrangements**, which may strengthen workforce capacity by improving flexibility, autonomy, work-life balance, and self-care.^{150,151}

Greater use of video visits among mental health clinicians has been associated with lower turnover and greater job satisfaction.¹⁵⁰

- **Address decreasing educational completions apparent in current data, which may reflect barriers to entry.** Strengthening Oregon’s BH workforce pipeline may involve interventions from early career exposure through education, training, supervision, and licensure.
 - **Increase early exposure to BH careers.** Introducing high school students, particularly those from underserved communities, to BH career pathways may help build the workforce pipeline, as recommended in the recent Behavioral Health Talent Assessment report.^{152,153}
 - **Reduce the financial burden of BH education and training.** Costly educational pathways can create barriers to entering BH professions. Strategies include tuition assistance, scholarships, clinical-training stipends, paid internships, and loan repayment.^{154,155} Oregon has already made substantial investments through OHA’s BH workforce initiatives and 2025 legislation providing educational incentive grants and other financial supports to graduate BH students.¹⁵⁶
 - **Expand access to clinical supervision.** In addition to expanding who is eligible to provide supervision, there are additional needs related to requirements for some clinicians to pay for supervision out of pocket.^{73,157,158} Strategies include strengthening supervision grant programs and leveraging existing supervisors and local expertise to expand access and accelerate licensure.⁷³
 - **Facilitate entry of qualified out-of-state providers.** Oregon facilitates entry of some out-of-state BH providers through profession-specific pathways, including reciprocity for LPCs and LMFTs, endorsement for psychologists, and recognition of qualifying supervised experience completed elsewhere.¹⁵⁹ However, requirements vary across professions.¹⁶⁰ Opportunities include more consistent recognition of out-of-state licenses, education, examinations, and supervised experience.
 - **Facilitate simplification and alignment of BH certification pathways.** Oregon’s behavioral health career pathway is complex, with 14 certifying or licensing boards offering 60 credentials and licenses.⁵⁰ In addition to addressing this in HB 4086, a centralized guide, as discussed in the recent Behavioral Health Talent Report, would be a more immediate opportunity to provide those interested in a BH career in Oregon with clarity regarding career pathway options.

Broad issues to address

The following are recommendations to address needs identified among all the health care workforce groups examined in this needs assessment. These are not new concerns nor are they unique to the Oregon health care workforce. Oregon has already engaged in a

significant amount of work to address these needs and findings in this report seem to indicate some response to that work. Recommendations below briefly identify work in this area which should continue to be supported, followed by examples of additional approaches to build on this work.

Address maldistribution of the health workforce through continued and expanded investment in targeted grow-your-own programs and clinical placements in rural areas. Findings from this needs assessment demonstrate ongoing maldistribution of the health workforce in Oregon, with lower per capita supply in counties on the east side of the state and in general in rural and remote areas. There has been some improvement since the last needs assessment - for example, the average unmet need for health care score in remote areas increased (46.1 to 48.7) and every county now has at least one dentist, whereas Sherman County was previously without a dentist. However, ongoing work is needed. Existing programs and policies in Oregon with promise to improve access to the health workforce include:

- Oregon's 2023 telehealth law (SB 232) which helps to extend provider services and improve rural access.^{68,74,75}
- "Grow your own" rural pathway programs such as The Healthy Rural Oregon project, which establishes accessible training and employment opportunities for community-based workers.¹⁶¹
- Medical assistant apprenticeships are available in approximately 20 Oregon counties.¹⁶²⁻¹⁶⁴
- Employer- and community-based dental assistant, traditional health worker, and community health worker training programs.¹⁶⁵⁻¹⁶⁷
- Multiple provider incentives programs, including The Healthy Oregon Workforce Training Opportunity (HOWTO) Grant which has supported growth in the rural nursing and medical assistant workforces.¹⁶⁶
- The Oregon AHEC Scholars Program, which supports health workforce training in rural settings.^{168,169}

Other evidence-based examples which could fit well with existing work in Oregon to address maldistribution include:

- **Additional targeted grow-your-own programs**, such as the University of Illinois Rural Medical Education (RMED) Program, which recruits students with rural backgrounds and provides a rural-focused medical curriculum¹⁷⁰; the University of New Mexico Combined BA/MD Program, an integrated undergraduate-to-medical-school pathway with rural training¹⁷¹; the Colorado Center for Nursing Excellence's "Grow Your Own Primary Care Nurse Practitioner" model that supports RNs already living in rural communities¹⁷² along with the Rural Psychiatric Mental Health Nurse Practitioner program that extends this approach to RNs in Colorado, New Mexico, and Wyoming.¹⁷³

- **Further investment in clinical placements in rural areas** such as the University of Washington's Rural Nursing Health Initiative (RNHI) that supported rural clinical placements for DNP students, paid postgraduate fellowships for advanced practice nurses, and financial support for preceptors and rural clinical sites.^{174,175}
- **Examining the feasibility of building stackable credential programs.** Stackable credentials have the potential to grow the workforce over time and thus address issues related to supply and distribution, but this approach requires significant coordination with community colleges with well-defined stackable credential pathways, targeted funding and state-level articulation policies, such as those in Ohio and Florida.¹⁷⁶⁻¹⁷⁸

Continue efforts to promote workforce demographics that are representative of the population. Representativeness of the health care workforce relative to the population varies by occupation, with more diversity among the certified (i.e., non-licensed and typically lower paid) occupations. There have been improvements in racial and ethnic representativeness in some occupations, such as within the BH workforce. However, there continues to be underrepresentation of Black or African American, American Indian/Alaska Native, and Hispanic or Latino/a/x/e populations in the primary care and oral health workforce groups, with underrepresentation of Hispanic or Latino/a/x/e populations among all three occupational groups. Representativeness is also important with respect to other demographics, including geography, age, and gender. For example, while women make up the majority of the health workforce, certain higher paying occupations, such as dentists and psychiatrists, have higher proportions of men. Continued work is needed in this area to support provision of culturally responsive and equitable care. The provider incentives programs, already highlighted with respect to addressing maldistribution, also play an important role in increasing representation of the health care workforce. In addition, there are two other opportunities for continued and/or expanded work:

- **Continue to provide support, and consider expansion of, K-12 health career pathway programs.**^{179,180} Oregon currently supports efforts to this effect, through the statewide Health and Biomedical Sciences Career and Technical Education (CTE) pathway.¹⁸¹ These programs provide exposure through classroom instruction, work-based learning, job shadowing, internships, industry certifications, and dual-credit opportunities. Although evidence on the long-term workforce impacts of Oregon's programs is limited, participation data indicate that Health Sciences CTE programs serve a diverse student population and represent a potential strategy for broadening pathways into health professions.¹⁸² Additional examples of K-12 health career pathway programs which could build on or expand CTE programming include the Health Sciences and Technology Academy in West Virginia, Florida State University's SSTRIDE program, and the University of Chicago's Health Professions Recruitment and Exposure Program.^{179,183,184} These all have reported strong outcomes related to college

enrollment, pursuit of health-related fields, and participation by students from underrepresented, rural, low-income, and first-generation backgrounds.

- **Consider engaging in additional research** to better understand which dimensions of workforce diversity are most important for improving access to care and meeting the needs of Oregon's diverse communities. Studies have shown better health outcomes with provider-patient racial/ethnic concordance, but other aspects of concordance (e.g., age, gender) are not as well studied.^{185,186}

Address Social Determinants of Work needs, particularly childcare and housing.

Addressing these may be a key part of both recruiting and retaining key health care workforce occupations, especially for workers in rural areas.¹⁸⁷ With this, it may be important to consider initiatives that support workers more broadly, inclusive of those in health care. Oregon currently has several childcare assistance programs, but these are not all adequately funded to meet current demand.¹⁹ Oregon has also offered one-time housing stipends and childcare assistance through the Community Mental Health Provider grants and the Behavioral Health Workforce Bonus and Housing Stipend (B&HS) Program. Other states have implemented approaches that may have promise for longer-term solutions to address childcare access as well as housing stability, which could be considered in Oregon:

- **Provide tax incentives for childcare.** Massachusetts's Employer Child Care Innovation Fund, offers tax credits for employers and Massachusetts's The Commonwealth Cares for Children tax cuts or funding to childcare providers.^{188,189}
- **Explore private-public partnerships for childcare.** States like Michigan, Kentucky, Missouri, and Ohio have implemented Tri-Share programs, which splits the cost of childcare between the state, the employer, and the employee and is a good example of a successful public-private partnership to address needs in the state. Michigan's Tri-Share program and Vermont's Child Care Financial Assistance program are both income-restricted, whereas New Mexico is the only state in the country to offer universal, no-cost childcare regardless of income.¹⁹⁰⁻¹⁹²
- **Prioritize healthcare workers in housing initiatives.** Ohio Heroes is a discounted mortgage interest rate program for certain occupations including physicians, nurse practitioners, RNs and LPNs. While not state-run, there are opportunities to potentially partner with nonprofit programs like Nurses Next Door provide one-time grants to first time homebuyers who are nurses.¹⁹³

Continue funding and supporting strategies to facilitate retention. Available information on short-term intentions regarding future plans among surveyed, licensed occupations indicates relative stability, while employment demand data appear to expect a high level of replacement openings for dental hygienists, nurse practitioners, therapists and counselors, and social workers, along with MAs and DAs (for whom we do not have

access to detailed turnover/future plans data). As such, we would point to supporting or engaging in strategies known to facilitate better retention, some of which are detailed elsewhere (e.g., addressing SDW needs, team-based models of care) and many of which require organizational-level policy change (flexible scheduling, mentoring, career advancement opportunities), but which can be supported by and done alongside state policy levers such as health care provider incentive programs, increasing reimbursement along with reimbursement of peer support services, telehealth flexibility, addressing administrative load for Medicaid credentialing, and investing in pathway programs.¹⁹⁴⁻¹⁹⁶

Highlight and consider tracking Rural Health Transformation Program¹⁹⁷ funding that is addressing the concerns identified in this assessment and which may need future funding or other supports to continue. These include:

- Programs oriented toward increasing community-based care (e.g., Connected Care for Older Adults, School Nurse Access Pilot, and Nursing Home Visiting)
- Workforce development programs (e.g., Medical Assistant Workforce Pathway, Advancement of Rural Provider Education)
- K-12 Career Pathways program through the Oregon AHEC
- A new family medicine residency at Virginia Garcia Memorial Health Center (high rates of family medicine residents stay in the state in which they complete their residency). This is important in light of the difficulties of paying for additional residency slots due to a previous law (the Balanced Budget Act of 1997), which capped the number of Medicare-funded residency positions.^{198,199}
- Payment for health care preceptors in Eastern Oregon through the Healthcare Preceptor Initiative

Increase attention toward collecting robust data on the health care workforce in Oregon. Oregon collects a significant amount of valuable health care workforce data, particularly through two efforts: 1) a compulsory survey completed upon renewal for most in the licensed health care workforce and via other tracking systems, such as with MHACBO, and 2) evaluation data related to provider incentive programs. Oregon has also engaged in additional qualitative assessments such as with the recent 2026 Dental Assisting Workforce in Oregon report and the 2026 Behavioral Health Talent Assessment. This is a distinct achievement compared to most other states, where licensure data are often relied upon as the main source of information on supply and distribution. There are opportunities to expand on existing efforts to improve data collection in the state:

- **Standardize additional questions in licensure surveys.** As stated above, the compulsory survey licensed health care workforce occupations complete upon renewing their license in Oregon provides key information on health care workforce supply, distribution, demographics, practice characteristics and future plans. Most questions are standardized across the surveys for different occupations; however,

there are four key areas where further standardization or additional questions are recommended.

- **Identify details about education.** Questions regarding whether an individual was educated in Oregon is only asked of MDs, DOs, NDs, and PAs. It is recommended this type of question be added to other surveys to facilitate comparability as well as understanding of which occupational groups tend to work where they are educated.
- **Inquire about participation in insurance programs.** Adding a question regarding Medicaid acceptance to the nursing survey would support more accurate planning about where increased coverage is needed, particularly for primary care nurse practitioners.
- **Align future planning questions.** Questions regarding future plans are currently asked in different ways in the survey for MDs/DOs and PAs versus other licensed occupations, making it difficult to compare, for example, intention to leave or stay across occupations.
- **Add secondary location information.** Specific to the OMB survey for MDs/DOs, it is recommended that the number of days per year spent at a secondary location be added in addition to the hours spent to better identify those operating as locums (particularly important for those in primary care).
- **Consider use of setting when measuring the primary care occupation** as there is potential to overestimate the size of the primary care workforce when using specialty only to measure. This may be particularly true among NPs (e.g., more physicians may split time between hospital and clinic settings versus NPs). This is demonstrated in the 2020 Primary Care Nursing report – while there were several differences in methodology, the use of setting is a major one that may be contributing to significant differences in the estimated number of nurse practitioners in primary care (actively practicing estimated at 745 in 2020 nursing report, estimates from the same year in Health Care Workforce Reporting data were 1,347).
- **Continue to build on existing efforts to collect data on the certified health care workforce.** Previous needs assessments have highlighted ongoing needs for better data regarding the certified workforce, particularly MAs, DAs, and THWs. There has been work done in this area to address this need, including data from MHACBO on the certified BH workforce as well as information on THWs and health care interpreters – all of this data are included in this report. However, there are continued opportunities to expand on this work as the lack of comparable data (e.g., FTE, future plans) leaves a considerable gap with respect to what issues to focus on/target via funding and policy. These opportunities are:
 - **Continue to include national data sources** such as the American Community Survey to help with understanding overall state-level trends of the certified health

care workforce when possible. ACS data on the DA and MA workforce groups was included in this report and could be included in the future.

- **Align questions across existing data** being collected on the certified behavioral health workforce with licensure surveys, where possible, such as with respect to employment characteristics and future plans.
- **Continue building partnerships with professional organizations** in the state to collect additional information on certified occupations such as DAs for whom certification is not required and thus may not appear in other state-level system data. This builds on work facilitated by the grant from the Health Resources and Services Administration focused on addressing oral health workforce needs.
- **Identify opportunities to more clearly track the certified behavioral workforce** to better capture time spent using different types of certifications. There are several different groups within the certified BH workforce, including those who are licensed, those who are licensed and certified, and those who are certified only. Those with certifications can have more than one, making it difficult to know how often each type of certification is being applied in their practice and hindering subsequent ability to assess ongoing gaps. In addition, those who do not have licenses which would qualify them to begin the certification process have two options – their qualifications can be verified by employers or verified by MHACBO, further complicating the tracking process as MHACBO data may not be capturing all of the certified workforce.
- **Examine opportunities to add data questions on skills to licensure renewal surveys.** It can be challenging to assess the extent of skill gaps across health care workforce groups, both related skill gaps between those newer versus more experienced in the workforce as well as differences in skills between occupational types. The current best proxy is tenure on the job, but this doesn't provide information on skills needed for the job or potentially transferable skills. This is an opportunity for future data collection, particularly when comparing similar roles such as dental hygienists and dental therapists.

11. Conclusion

The findings and recommendations presented in this report highlight the ongoing work in Oregon to support and sustain a thriving health care workforce that provides culturally responsive care. Recommendations provide specific suggestions for expansion of current work or additional areas of focus. To prioritize and accomplish these, measurable goals should be created and tracked over time, an endeavor that goes beyond the scope of this report. Setting and accomplishing realistic goals requires a collaborative effort across stakeholder organizations (e.g., governmental representatives, legislators, educational

institutions, health care workforce organizations) as work is needed to develop those measures, identify data sources relevant to the measures, and enforce the outcomes. This additional work is an important part of moving forward in Oregon's goal of ensuring everyone has local access to the health care they need.

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13. Methods appendix

Data sources

Oregon Health Care Workforce Reporting Program (HWRP), Oregon Health Authority Office of Health Analytics²⁰⁰

Supply, demographics, practice characteristics, retention and future career planning data on the primary care, oral health, and behavioral health (BH) workforces are from the HWRP 2026 database of all licensed health care workers in Oregon. Data are collected at time of license renewal from the Health Care Workforce Survey between January 2024 and January 2026, depending on the specifics of the individual licensing board's renewal cycles and periods (Appendix Table 13-1). All occupations complete the same survey except for those licensed by the Oregon Medical Board or the Oregon State Board of Nursing; these are noted in the body of the report when applicable. Previous HWRP health workforce supply and diversity reports, along with their supply dashboard were used to examine workforce trends in Oregon over time.

Table 13-1. Oregon licensing boards' renewal cycle information for occupations analyzed in the 2027 Oregon Health Care Workforce Needs Assessment

Oregon Licensing Board	Occupation(s) credentialed relevant to this report	Renewal Period	Renewal Cycle
Board of Licensed Professional Counselors and Therapists	Licensed Professional Counselors, Licensed Marriage and Family Therapists	Ongoing [*]	2-year
Board of Dentistry	Dentists	Jan-Mar 31 [†]	2-year
	Registered dental hygienists	July-Sept [†]	2-year
Medical Board	Physicians (MDs and DOs) Physician Associates	Dec of odd years	2-year
Board of Naturopathic Medicine	Naturopathic physicians	Nov 1-Dec 31	1-year

State Board of Nursing	Nurse practitioners	Ongoing	2-year
	Registered nurses		
Board of Psychology	Psychologists	Ongoing [‡]	2-year
Board of Licensed Social Workers	Licensed Clinical Social Workers,	Ongoing	2-year
	Clinical Social Work Associates	Ongoing	1-year

*Even-numbered licenses will renew in even-numbered years, and odd-numbered licenses will renew in odd-numbered years.

†Those licensed in even-numbered years renew in even-numbered years and those licensed in odd-numbered years renew in odd-numbered years.

‡Even-numbered licensees renew in odd years, and odd-numbered licensees renew in even years.

Integrated Postsecondary Education Data System (IPEDS)

Data on institution counts and education program completions in Oregon come from the U.S. Department of Education’s National Center for Education Statistics IPEDS database. The most recent year of complete data used is from the 2023-2024 academic year. IPEDS may not capture completions from programs that do not receive federal funding, or individuals who may have entered the profession through on-the-job training or apprenticeship arrangements. Completions are reported by award level and Classification of Instructional Programs (CIP) code. Graduates’ specialty certifications, practice settings, or state of practice are not included in this data. We grouped CIP codes into broader occupational categories for these analyses (Appendix Table 13-2). An institution counted as “program” if at had least one completion listed in IPEDS for that academic year.

For analyzing the educational pathways of the primary care workforce, we focused on the award levels associated with preparation for the primary care occupations included in this study. Related CIP programs that did not prepare individuals for direct primary care practice were excluded (e.g. programs for specialty, leadership, administrative, research, or educational roles). Where multiple award levels existed, only those commonly associated with entry into practice were retained, noted in Appendix Table 13-2. In contrast, the oral health and behavioral health occupations examined in this study generally mapped more directly to a limited set of educational pathways.

Table 13-2. Classification of Instructional Programs (CIP) codes associated with occupations in the 2027 Oregon Health Care Workforce Needs Assessment

Workforce	Occupation/ practice area	CIP code and award level
Behavioral Health	Addiction specialists	51.1501
Behavioral Health	Mental health specialists	51.1508; 51.1599
Behavioral Health	Social work	44.0701; 44.0799

Behavioral Health	Peer, prevention, and gambling specialists	51.1504; 44.0702
Behavioral Health	Psychologists	42.2801; 42.2802; 42.2803; 42.2805; 42.2807; 42.2812; 42.2813; 42.2814; 42.2899 (including Masters, Doctoral, and Post-baccalaureate certificate)
Behavioral Health	Therapists	51.1505; 51.1506; 51.1513
Behavioral Health	Psychiatrists (MDs)	51.1201
Behavioral Health	Psychiatric/mental health nurse/nursing	51.3810
Primary Care	Physicians	51.1201 (Doctor's degree-professional practice)
Primary Care	Naturopathic Medicine physicians	51.3303 (Doctor's degree-professional practice)
Primary Care	Nurse Practitioners	51.3805 Family Practice Nurse/Nurse Practitioner (Master's and Doctor's degree-professional practice); 51.3807 Nurse Midwife/Nursing Midwifery (Master's and Doctor's degree-professional practice); 51.3809 Pediatric Nurse/Nursing (Master's and Doctor's degree-professional practice); 51.3818 Nursing Practice (Doctor's degree-professional practice)
Primary Care	Physician Associates	51.0912 (Master's degree)
Primary Care	Registered Nurses	51.3801 (Associate's degree); 52.3801 (bachelor's degree); 54.3801 (Graduate certificate); 56.3801 (Postbaccalaureate certificate)
Primary Care	Licensed Practical/Vocational Nurses	51.3901 (Associate's degree, Certificate <1 year, Certificate 1-<2 years, Certificate 2-<4 years, and Graduate certificate)
Primary Care	Medical Assistants	51.0801 (Associate's degree); 52.0801 (Certificate <1 year); 53.0801 (Certificate 1-<2 years)
Oral Health	Dentistry	51.0401; 51.0506; 51.0508; 51.0510

		(Includes endodontic, orthodontic, and periodontic dentistry specialties)
Oral Health	Dental Assisting	51.0601
Oral Health	Dental Hygiene	51.0602

Oregon Higher Education Coordinating Commission (HECC) Private Career Schools Student Data Dashboard²⁰¹

Completion and institution counts for dental assisting private career school programs are from data compiled by the HECC. IPEDS does not capture data from institutions that do not receive federal funding, so state higher education agency data from HECC was used to supplement the IPEDS oral health education data.

Mental Health and Addiction Certification Board of Oregon Registry (MHACBO)²⁰²

Supply and demographics of the certified-only BH workforce are from the MHACBO registry of credentialed BH workers in Oregon. Individuals can be licensed with a state board and certified by MHACBO simultaneously. We focused on the certified-only workforce to approximate an account of the unduplicated BH workforce in Oregon. Individuals can also hold multiple certifications with MHACBO, so the total number of certifications is greater than the total number of discrete individuals with at least one certification. This is noted where appropriate in the report.

Historically, there have also been employer-qualified BH workers (primarily QMHAs and QMHPs), but as these were not publicly verified, they were not considered among the certified BH workforce. If they are not already licensed through the state licensing board, most of these employer-verified mental health workers now register with MHACBO as a QMHA-R or QMHP-R to indicate that they have met Oregon Administrative Rule requirements to function as a QMHA or QMHP. As these “R” credentials track un-licensed individuals that would have previously been considered employer-verified, the number of non-certified BH workers in Oregon is very low.

American Community Survey (ACS)²⁰³

We used cross-sectional data from the 2024 1-year ACS to add demographic data on dental assistants (DAs) and medical assistants (MAs) working in Oregon, two occupations that are not licensed in the state, and thus not available in the HWRP database. The ACS is an annual national survey of over 3.3 million households conducted by the U.S. Census Bureau. The dataset was extracted for analysis through the Integrated Public Use Microdata Series (IPUMS).

All values are weighted estimates based on self-reported survey responses. We included all MAs and DAs in the labor force, defined as employed and unemployed workers in Oregon aged 16 years and older. Occupational counts reflect respondents who reported MA or DA

as their current occupation (if employed) or most recent occupation (if unemployed), regardless of practice setting, age, or employment status. The ACS is not designed specifically to produce occupation-level estimates, so results may be subject to sampling error and may not be fully representative of the MA workforce or DA workforces in Oregon. Data from 2024 5-year ACS estimates was used for comparing the race/ethnicity of the workforce to the overall Oregon population.²⁰⁴

Behavioral Risk Factor Surveillance System (BRFSS)²⁰⁵

We used age-adjusted estimated prevalence data from the 2024 Behavioral Risk Factor Surveillance System (BRFSS), a survey of health behaviors, risk factors, chronic health conditions, and use of preventive services by U.S. residents, to indicate the current health of Oregon residents. BRFSS is nationally coordinated by the U.S. Centers for Disease Control and Prevention but implemented by each state's health department. The Oregon Health Authority surveys a random sample of all adults aged 18 years and older living in a private residence in Oregon annually. The survey results are then used to estimate health statistics of Oregon's adult population.

In the BRFSS data used in the report, mental health (Table 9-6) includes stress, depression, and problems with emotions. Forms of depression may include depression, major depression, dysthymia, or minor depression. Other variables used in the report are BRFSS-derived from one or more survey questions. The following statistics in

Table 9-4 and Table 9-5 have been calculated from multiple BRFSS questions:

- Health status
- Adults aged 18+ who have been told they have arthritis
- Adults aged 18+ who have been told they currently have asthma
- Adults aged 45-75 who had a blood stool test within the past year to screen for colorectal cancer,
- Women aged 40+ who had a mammogram within the past two years,
- Adults aged 65+ who have ever had a pneumonia vaccination
- Adults aged 65+ who have had all their natural teeth extracted
- Adults aged 18+ that have had any permanent teeth extracted
- Number of days during the past 30 days when mental health status was considered not good

Oregon Employment Department (OED) Workforce and Economic Research Division

For tracking employment projections, current employment demand, and occupational wages, we accessed OED's Occupations in Demand 2024-2034, Oregon Occupational Employment Projections 2024-2034, and Oregon Wage Information.²⁰⁶ See the OED's website for more information on data sources used in calculating employment

projections.²⁰⁷ Other projection data came from the U.S. Bureau of Labor Statistics and the ACS.

Area Health Resource File (AHRF), Health Resources and Services Administration

The 2024 AHRF was used to provide for county-level mortality measures (infant mortality, all-cause mortality, chronic disease mortality, and suicide mortality rates; Table 9-1). AHRF is a publicly available dataset managed by the U.S. Health Resources and Services Administration, Bureau of Health Workforce. It contains information on health professions, health facilities, population characteristics, economics, and hospital utilization at the county, state, and national level.

Oregon Health Authority Vital Records and Statistics²⁰⁸

Oregon Vital Records and Statistics provided data on county-level birth and mortality indicators. Data included counts of births, low birthweight births, and deaths used to calculate birth rate, fertility rate, and percent low birthweight births (Table 9-1). Oregon State law requires all live births and deaths to have complete records. 2024 was the most recent year of finalized death data available for analysis, and 2025 the most recent year for finalized birth data. Specific definitions of calculated birth and death statistics are below. All-cause mortality rate, chronic disease mortality rate, and suicide rates are all calculated per 100,000 population.

Oregon Health Insurance Survey (OHIS) Coverage Dashboard, 2024²⁰⁹

We used OHIS data to include statistic of the uninsured population in Oregon by region (Table 13-1). The OHIS is a survey conducted every two years of households in Oregon about health insurance types and coverage, and results are used to produce estimates of the Oregon population.

National Survey on Drug Use and Health (NSDUH)²¹⁰

Estimates of mental health indicators and rates of substance use disorder in Oregon came from the Substance Abuse and Mental Health Services Administration's 2023-2024 NSDUH, a national survey conducted annually of a sample of people aged 12 and older in the U.S. about their use of tobacco, drugs, and alcohol, mental health issues, and treatment received. We limited included data to adults aged 18 or older in Oregon. For some small counties in Oregon, estimates were calculated using small area estimation approaches and based on pooled 2023-2024 data. More detail can be found on their website (<https://www.samhsa.gov/data/report/2023-2024-nsduh-state-specific-tables>).

2026 Health Resources and Services Administration (HRSA) Data Warehouse

Health Professional Shortage Areas (HPSAs) are federally designated shortage areas for primary care, dental, or behavioral health providers. Geographic HPSAs indicate shortages affecting an entire service area (i.e., full HPSAs); population HPSAs indicate shortages for specific populations; and facility HPSAs indicate shortages at specific facilities.

Portland State University (PSU) Population Research Center – Population Estimate Reports²¹¹

Oregon county population estimates used as the denominator for creating per capita calculations and density maps came from PSU's annual County Population Estimate. The Population Research Center releases a certified estimate at the end of the year followed by supplemental reports quarterly reflecting population revisions. The 2025 population estimate of Oregon used in our workforce analyses (4,300,464) was pulled January 2026 prior to the release of any supplemental reports with adjusted population information.

Analyses of population indicators (Table 9-1, Figure 9-1, Figure 9-2) use supplemental population estimates from April 2026, where the 2025 population of Oregon was revised to 4,301,164.

Analyses

Workforce Definitions

Actively practicing. All workforce definitions in this report define an actively practicing Oregon health care worker as one who is currently employed in the field, self-employed in the field and/or volunteering AND reported a primary or secondary practice location in Oregon.

Licensed primary care workforce. Available HWRP data on primary care occupations includes those who practice in the following primary care clinical focus areas (aka specialties), which vary slightly by occupation type: family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology/women's health. For example, NDs and nursing professions (NPs and RNs) do not have a 'General Medicine' specialty and NDs do not have an 'Internal Medicine' specialty option; these occupations are excluded from the total calculation for these clinical areas. Professionals can be included in more than one specialty/clinical focus area.

When included in tables, totals of the actively practicing primary care workforce exclude RNs to prevent over-estimation of the overall primary care workforce. That is, totals only include those that can practice independently to more accurately estimate availability of primary care providers. Independently practicing primary care occupations include MD/DOs, NDs, NPs, and PAs.

Oral health workforce. Data from HWRP on the workforce practicing primary oral health includes all dentists and dental hygienists reporting a specialty in general dentistry, pediatric dentistry, or public health. Dental therapists are not currently represented in HWRP because they do not complete the Oregon Health Care Workforce survey. This may reflect the very small number of practicing dental therapists in Oregon and/or the absence of in-state dental therapy education and training programs.

Licensed behavioral health workforce. Data from HWRP includes MD/DOs and PAs who specialize in psychiatry (addiction, neurology) or psychoanalysis; NPs who specialize in psychiatry/mental health; NDs who specialize in mental health; and all psychologists, LPC/LMFTs, LCSWs, and CSWAs.

Certified-only behavioral health workforce. As shown in Table 8-5 and Table 8-6 data on the certified-only BH workforce from MHACBO includes the following occupations and associated credentials: Certified Alcohol and Drug Counselors (CADC-R, I, II, III); Qualified Mental Health Associates (QMHA-R, I, II); Qualified Mental Health Professionals (QMHP-R, C); Certified Recovery Mentors (CRM, CRM II); Certified Gambling Addiction Counselors (CGAC-R, I, II); Certified Prevention Specialists, and Certified Gambling Recovery Mentors.

'R' credentials indicate a non-licensed individual has been verified as meeting Oregon Administrative Rule requirements to practice as a QMHA or QMHP in Oregon. Registration is required for certificate candidates before proceeding with testing and completion of other requirements to earn full MHACBO certification (CADC, QMHA, QMHP, CGAC).

Estimation of the number practicing in Oregon

All counts from the HWRP database are estimates, as only individuals renewing their license complete the Health Care Workforce Survey (e.g., new licensees do not complete this survey). Estimates are calculated by the HWRP, with detailed information available in the "OHA-General Methods" document.²¹² Briefly, the estimated number of actively practicing health care workers in Oregon is based on the *percentage of survey respondents with active Oregon licenses who report they are actively practicing in Oregon multiplied by the total number of active licenses in Oregon*.

The total number of active licenses is provided by each licensing board; estimates for each occupation are calculated separately. The estimated number of each occupation practicing in Oregon is then used to calculate subsequent estimates, including total direct patient care FTE (see further explanation below).

Definitions of Measures

Birth rate. The percentage of births per 1,000 population (Table 9-1).

Border state practice address. Having a reported primary or secondary practice address in Washington, Idaho, California, or Nevada.

Border state practice address of nursing occupations. The Oregon State Board of Nursing Health Workforce Survey specifically asks respondents to: "Indicate the states you are currently licensed," and "Indicate the states where you are currently practicing." Border state practice address defined as report of a primary or secondary practice address in Washington, Idaho, or California (Appendix Table 14-2. Active Oregon primary care nursing

licenses that are also licensed and employed in a border state, 2024-2026 Appendix Table 14-2, Appendix Table 15-2, and Appendix Table 16-2).

Chronic diseases. As used in calculation of Oregon chronic disease mortality rate, these include deaths attributed to cancer, heart disease, stroke, chronic lower respiratory disease (COPD), and diabetes (Table 9-1).

Collaborative practice agreements: written agreements with a physician or dentist which define the services the clinician (e.g., physician assistant, dental therapist) can perform.

Deep poverty. The percentage of individuals with household incomes below 50% of the federal poverty level (poverty threshold), based on U.S. Census Bureau data reported through the Area Health Resources Files (AHRF).

Direct patient care FTE.²¹² HWRP defines direct patient care FTE based on total hours worked and time spent providing direct patient care. Occupation-level direct patient care FTE is calculated for each occupation from the Health Care Workforce Survey data. Estimated FTE for all FTE categories is calculated by multiplying the average reported FTE (total, direct patient care, other) for that occupation by the estimated N of that occupation. County-level estimate of direct patient care FTE is calculated via workforce survey data by using the *percentage of observed direct patient care FTE in the county multiplied by the estimated total direct patient care FTE for the state.*

The state-level estimate for total direct patient care FTE of a given health care occupation is calculated as: *average direct patient care FTE for an occupation multiplied by the estimated number practicing in Oregon.*

For dentists only, direct patient care FTE was weighted based on the number of auxiliaries reported (e.g., chairside assistants, hygienists, etc.) and age, according to HRSA Procedures for Shortage Designations.

Disability. Data from HWRP defines individuals who identify as having a disability as those who answered yes to at least one of the following questions regarding: deaf/serious difficulty hearing; blind/serious difficulty seeing; serious difficulty walking or climbing stairs; difficulty dressing or bathing; difficulty running errands alone; limited activity due to physical, mental, or emotional condition. The Oregon Medical Board (who surveys MD/DOs and PAs) does not collect disability data.

Educational program completion. Residency program completion only refers to physicians (MD/DOs) completing their residency in Oregon.

The Oregon Board of Nursing collects county of educational program, not state; so nursing licenses (NPs and RNs) are excluded from total calculations (Table X.X, Table X.X, Table Z).

Fertility Rate. The percentage of births per 1,000 population of females aged 15-44 years.

Future career plans. The Oregon Medical Board survey uses a single combined future plans/future hours question that is not directly comparable to the separate future plans and future hours questions used by other professional boards.

Independent practitioners: those who can diagnose, treat, and prescribe without physician oversight or sign-off.

Infant mortality rate. The percentage of deaths among infants under 1 year of age per 1,000 live births.

Low Birthweight Births. Births of babies weighing less than 2,500 grams. Low birthweight birth rate calculated as percentage of births less than 2,500 grams per 100 live births.

Mortality rates. All-cause, chronic disease, suicide rates from AHRF are all calculated per 100,000 population.

Per capita (provider-to-population) ratios.²¹² Estimated county direct patient care FTE per county population are calculated from the estimated statewide direct patient care FTE multiplied by the percentage observed direct patient care FTE in the county.

Practice characteristics. In all workforce sections, calculations for average hours worked per week and the percentage of actively practicing occupations working over 40 hours a week are based on total working hours reported at both an individual's primary and secondary practice locations. The Oregon Medical Board survey does not include telehealth questions, so data is unavailable for MD/DOs and PAs. Data is unavailable regarding Medicaid coverage for RNs and NPs as the Oregon Board of Nursing survey does not include Medicaid questions.

Primary care clinical focus area. Primary and secondary clinical focus areas are used to identify primary care licenses, so professionals may practice in multiple primary care clinical focus areas/specialties. As such, column percentages in Table 6.4 showing the breakdown of clinical focus area by occupation adds to greater than 100%. Physicians and PAs can select primary and secondary specialties at both their primary and secondary practice locations, allowing them to specify up to four specialty options. Occupations without General Medicine (NDs, NPs, RNs) and Internal Medicine (NDs) clinical focus areas are excluded from total calculations.

Race/Ethnicity: HWRP data has been collapsed into race/ethnicity groups from REALD ("Race, Ethnicity and Language, Disability") standard reporting categories. Respondents selecting Hispanic ethnicity of any race are only counted in the Hispanic category. Non-Hispanic respondents selecting multiple races are included in the "Multi race" category and not the individual race category.

Certified BH workers in the MHACBO data selecting more than one race/ethnicity (including Hispanic/Latino) are categorized as multi racial. MHACBO data are collapsed

based on collected data, not REALD categories. For detailed REALD race/ethnicity standard reporting categories see each workforce section's associated Appendix.

Rural/urban. Rurality of workforce supply is based off all actively practicing workers with a practice ZIP code in Oregon. Primary practice address ZIP codes were used to assign rural/urban designation, according to the Oregon Office of Rural Health.²¹³ If primary address ZIP code was missing, secondary address ZIP code was used if available.

Regional distribution. HWRP data of the licensed primary care, oral health, and behavioral health workforces categorizes Oregon counties into the following five geographic regions, using practice address county (see Table 6-6, Table 7-5, and Table 8-4):

- *Portland Metro:* Clackamas, Multnomah, Washington;
- *North coast/Willamette Valley:* Benton, Clatsop, Columbia, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill;
- *Central Oregon:* Crook, Deschutes, Gilliam, Hood River, Jefferson, Klamath, Lake, Sherman, Wasco, Wheeler;
- *Southwest Oregon:* Coos, Curry, Douglas, Jackson, Josephine, Lane;
- *Eastern Oregon:* Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, Wallowa.

MHACBO data of the certified-only BH workforce uses an individual's home address ZIP code to identify county in Oregon. Counties are then categorized into geographic regions: (see Table 8-5 and Table 8-6):

- *Portland Metro:* Clackamas, Multnomah, Washington, Hood River;
- *Willamette Valley/North Coast:* Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill;
- *Southern Oregon:* Coos, Curry, Douglas, Jackson, Josephine;
- *Central Oregon:* Crook, Deschutes, Gilliam, Jefferson, Klamath, Lake, Sherman, Wasco, Wheeler;
- *Eastern Oregon:* Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, Wallowa.

Educational program regions were derived from the Oregon Department of Transportation. Statewide Transportation Improvement Fund. Available at <https://www.oregon.gov/odot/rptd/pages/statewide-transportation-improvement-fund.aspx?utm>. Accessed June 2026.

Vision impairment. From the 2024 BRFSS data, is based on the question: "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" (

Table 9-4)

Analyses

Summary statistics. All HWRP workforce data uses the estimated count of all actively practicing licenses. All totals are estimates and rounded to the nearest whole number. As such, may add up to higher than the total N for a category.

Maps. Maps of workforce density by county were created using count per capita and direct patient care FTE per capita for all occupations in the specific workforce mapped. Maps were created with Tableau (Tableau 2026.1, Seattle, WA).

Missing data

Figure 6-1. Estimated supply and direct patient care FTE of the actively practicing primary care workforce in Oregon, by rural/urban practice location: Missing data due to lack of primary or secondary practice site ZIP code preventing rural/urban designation are excluded from calculations. Missing counts: total estimated licenses, 724; total direct patient FTE, 463.

Figure 7-1. Estimated supply and direct patient care FTE of the actively practicing oral health care professionals in Oregon, by rural/urban practice location: Missing data due to lack of primary or secondary practice site ZIP code preventing rural/urban designation are excluded from calculations. Missing counts: total estimated licenses, 402; direct patient care FTE, 263.

Figure 8-1. Estimated supply and direct patient care FTE of the actively practicing behavioral health workforce licensed in Oregon, by rural/urban practice location: Missing data due to lack of primary or secondary practice site ZIP code preventing rural/urban designation are excluded from calculations. Missing counts: total estimated licenses: 4,842; direct patient FTE, 2,845.

14. Primary care appendix

Appendix Table 14-1. Percentage of the estimated actively practicing primary care workforce licensed in Oregon with a practice address in a border state, 2024-2026

	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Registered Nurses (RNs)
Total estimated actively practicing primary care licenses in Oregon, n	6,346	366	2,300	1,154	9,964
Washington	2.5%	0.3%	1.1%	1.2%	0.6%
Idaho	0.4%	0%	0.3%	0.5%	0.1%
California	0.6%	0%	0.2%	0.4%	0.1%
Nevada	0.1%	0%	0.04%	0.0%	0.0%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See

Methods appendix for more details.

Appendix Table 14-2. Active Oregon primary care nursing licenses that are also licensed and employed in a border state, 2024-2026

	Total, all primary care nursing occupations	Nurse Practitioners (NPs)	Registered Nurses (RNs)
Total estimated actively practicing Oregon nursing licenses, n	12,264	2,300	9,964
Licensed in Washington	21.1%	28.7%	19.4%
Licensed and practicing in Washington	13.6%	20.6%	12.0%
Licensed in California	9.5%	15.1%	8.2%
Licensed and practicing in California	4.9%	9.3%	4.0%
Licensed in Idaho	5.0%	10.2%	3.7%
Licensed and practicing in Idaho	3.5%	7.8%	2.4%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Table 14-3. Detailed REALD race and ethnicity information of all active primary care occupations licensed in Oregon, 2024-2026

Grouped race/ethnicity	REALD race/ethnicity reporting categories	Total, all primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Registered Nurses (RNs)
	Total estimated actively practicing primary care licenses in Oregon, n	10,166	6,346	366	2,300	1,154	9,964
American Indian or Alaska Native	American Indian	0.5%	0.2%	0	1.0%	0.4%	0.7%
	Alaska Native	0.03%	0	0	0.1%	0	0.1%
	Canadian Inuit, Metis, or First Nation	0.02%	0	0.3%	0	0	0
	Indigenous Mexican, Central or South American	0.03%	0.02%	0	0	0.1%	0
Asian	Asian Indian	1.78%	4.7%	1.4%	0.7%	1.0%	0.3%
	Cambodian	0.04%	0	0	0	0	0.1%
	Communities of Myanmar	0.01%	0	0	0	0	0
	Chinese	1.6%	3.5%	0.6%	0.7%	1.6%	0.7%
	Filipino/a	1.8%	1.8%	0.3%	1.5%	0.7%	2.0%
	Hmong	0.1%	0.02%	0	0	0	0.1%
	Japanese	0.5%	0.7%	0.3%	0.2%	0.4%	0.4%
	Korean	0.8%	1.4%	0.8%	0.9%	0.5%	0.4%
	Laotian	0.1%	0.02%	0	0.1%	0	0.1%
	South Asian	0.5%	1.4%	0	0.2%	0.3%	0.1%
	Vietnamese	0.9%	1.3%	0.3%	0.4%	1.7%	0.8%

Grouped race/ethnicity	REALD race/ethnicity reporting categories	Total, all primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Registered Nurses (RNs)
Total estimated actively practicing primary care licenses in Oregon, n		10,166	6,346	366	2,300	1,154	9,964
Black or African American	Other Asian	0.6%	1.4%	0.3%	0.1%	0.4%	0.2%
	African (Black)	0.01%	0.02%	0	0	0.1%	0
	African American	1.3%	0.7%	1.1%	2.8%	1.4%	1.3%
	Afro-Caribbean	0.2%	0.3%	0.3%	0.3%	0	0.1%
	Ethiopian	0.1%	0	0	0.2%	0	0.2%
	Other African (Black)	0.7%	0.7%	0	1.1%	0.2%	0.6%
	Other Black	0.2%	0.02%	0	0.5%	0	0.2%
Native Hawaiian or Pacific Islander	Guamanian or Chamorro	0.04%	0.04%	0	0.1%	0	0
	Communities of the Micronesia Region	0.01%	0	0	0	0	0
	Native Hawaiian	0.1%	0.1%	0	0	0.2%	0.1%
	Samoan	0.01%	0.02%	0	0	0	0
	Marshallese	0.01%	0	0	0	0	0
	Other Pacific Islander	0.1%	0.04%	0	0.1%	0	0.2%
Middle Eastern/ North African	Middle Eastern	0.5%	1.1%	0.6%	0.1%	0.3%	0.2%
	Northern African	0.1%	0.1%	0	0.1%	0.1%	0
White	Slavic	1.1%	1.0%	1.9%	1.3%	1.1%	1.1%
	Eastern European	8.9%	6.9%	12.3%	10.6%	6.2%	9.9%
	Western European	34.3%	39.3%	40.2%	31.6%	38.1%	31.2%
	Other White	20.8%	11.3%	15.3%	23.7%	20.0%	26.2%
Hispanic or Latino/a/x/e	Mexican	2.3%	0.9%	1.6%	1.3%	1.7%	3.6%
	Central American	0.4%	0.3%	0.6%	0.4%	0.6%	0.3%
	South American	0.5%	0.4%	0.8%	0.6%	0.6%	0.4%
	Other Hispanic or Latino/a/x	1.0%	0.4%	1.1%	1.8%	0.3%	1.2%
	Other Race	1.3%	2.0%	1.9%	1.0%	1.5%	0.8%
	Multi Race	4.7%	4.3%	7.7%	4.0%	5.7%	4.9%
	Decline	9.4%	9.7%	9.6%	11.3%	7.8%	8.9%
	Unknown	3.2%	4.1%	1.1%	1.5%	7.3%	2.6%

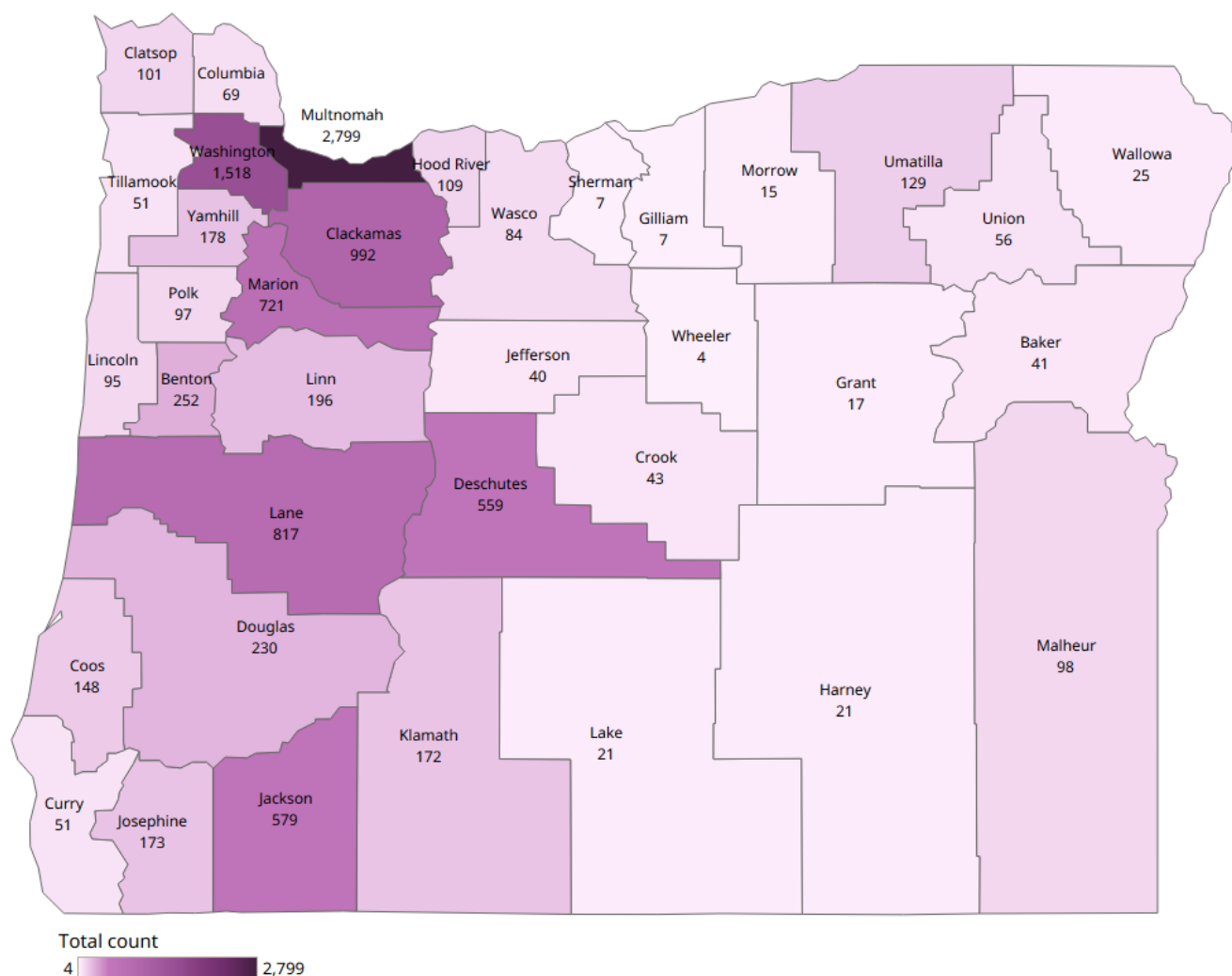
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Table 14-4.Expected years until retirement among actively practicing primary care naturopathic physicians, nurse practitioners, and registered nurses in Oregon, 2024-2026

	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Registered Nurses (RNs)
Total estimated actively practicing primary care licenses in Oregon, N	366	2,300	9,964
Expected years until retirement			
Within the next 2 years	—	3.2%	3.5%
Within the next 3-5 years	—	7.7%	7.2%
Within the next 6-10 years	—	11.6%	10.3%
More than 10 years from now	—	66.0%	67.5%
Don't know	—	9.1%	9.5%
Missing	—	2.4%	2.0%

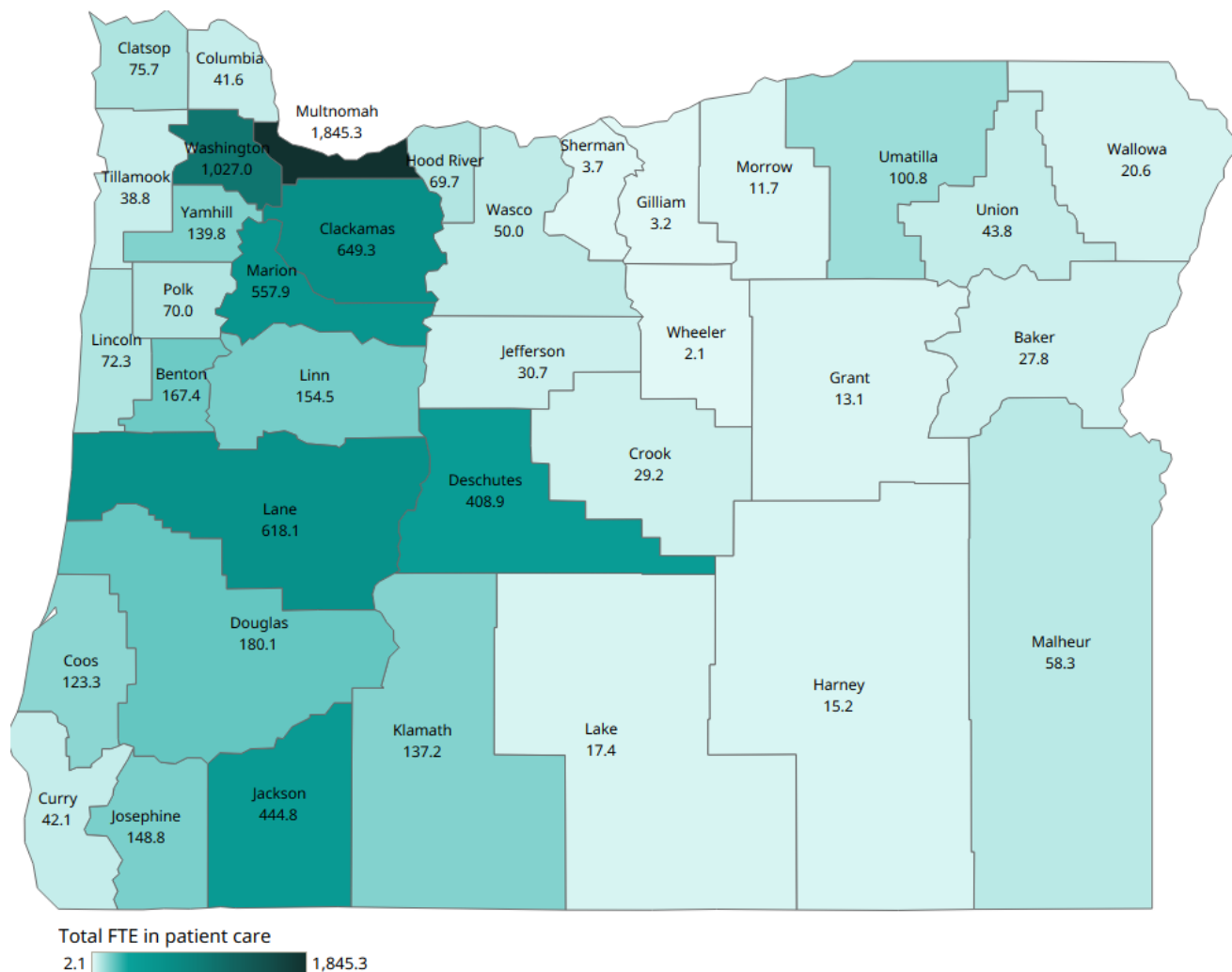
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Dashes indicate unavailable data. See Methods Appendix for more details.

Appendix Figure 14-1. Estimated supply of the actively practicing primary care workforce licensed in Oregon (count), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Figure 14-2. Direct patient care FTE of the actively practicing primary care workforce licensed in Oregon (count), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

15. Oral health appendix

Appendix Table 15-1. Comparing dental hygiene (DH) and expanded practice dental hygiene (EPDH) scope of practice in Oregon

Activity	Regular Oregon DH	Oregon EPDH
Clean teeth	Yes	Yes
Scale and root plane	Yes	Yes
Take X-rays	Yes	Yes
Administer local anesthesia (with required credentials)	Yes	Yes
Work without dentist <i>physically</i> present in many situations	Often	Yes
Open an independent practice serving qualifying underserved populations	No	Yes
Treat nursing home residents without dentist supervision	No	Yes
Develop and manage care plans as an independent provider under EPDH law	No	Yes
Prescribe prophylactic antibiotics/NSAIDs under collaborative agreement	No	Yes

Data source: Oregon Revised Statutes (ORS) 680.205 and Oregon Administrative Rule (OAR) 818-035-0065. See Methods Index for more details.

Appendix Table 15-2. Percentage of the estimated actively practicing oral health workforce licensed in Oregon with a practice address in a border state, 2024-2026

	Total, all primary oral health occupations	Dentists	Dental Hygienists
Estimated number of actively practicing oral health licenses in Oregon, N	5,704	2,428	3,276
Washington	0.4%	0.6%	0.3%
Idaho	0.1%	0.1%	0.0%
California	0.1%	0.1%	0.1%
Nevada	0.0%	0.0%	0.0%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Table 15-3. Detailed REALD race and ethnicity information of all active oral health occupations licensed in Oregon, 2024-2026

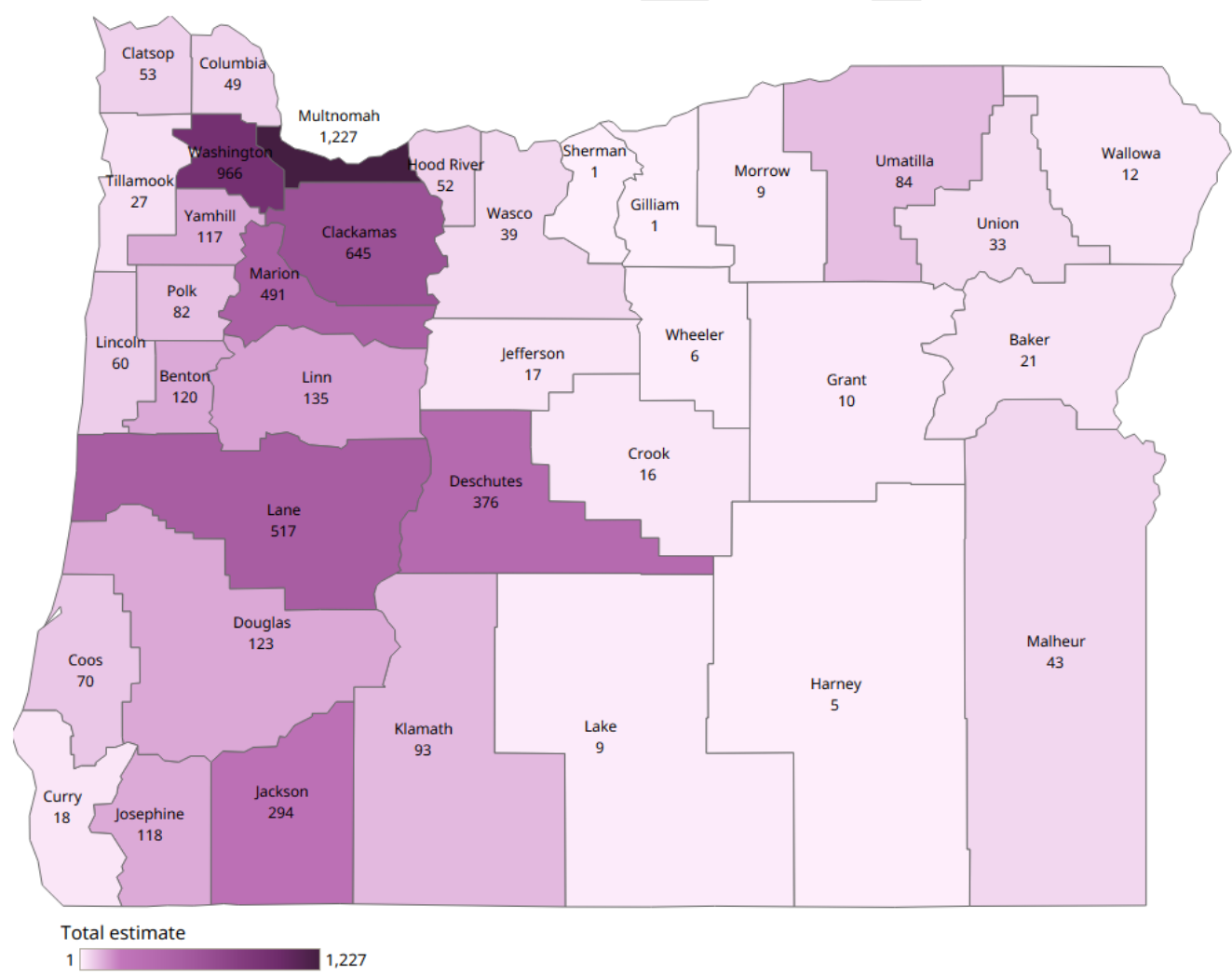
Grouped race/ethnicity	REALD race/ethnicity reporting categories	Total, all primary oral health occupations	Dentists	Dental Hygienists
	Total estimated actively practicing oral health licenses in Oregon, N	5,704	2,428	3,276
American Indian or Alaska Native	American Indian	0.1%	0.1%	0.1%

Grouped race/ethnicity	REALD race/ethnicity reporting categories	Total, all primary oral health occupations	Dentists	Dental Hygienists
	Total estimated actively practicing oral health licenses in Oregon, N	5,704	2,428	3,276
	Alaska Native	0.8%	0.2%	1.2%
	Canadian Inuit, Metis, or First Nation	0	0	0
	Indigenous Mexican, Central or South American	0.1%	0.1%	0
Asian	Asian Indian	1.2%	2.3%	0.3%
	Cambodian	0.1%	0	0.1%
	Communities of Myanmar	0	0.1%	0
	Chinese	1.6%	3.0%	0.6%
	Filipino/a	1.0%	0.9%	1.0%
	Hmong	0	0	0
	Japanese	0.9%	1.3%	0.6%
	Korean	2.2%	4.1%	0.8%
	Laotian	0.1%	0	0.2%
	South Asian	0.3%	0.6%	0.1%
	Vietnamese	3.4%	4.1%	2.8%
	Other Asian	0.5%	0.7%	0.3%
Black or African American	African (Black)	0	0	0
	African American	0.3%	0.4%	0.2%
	Afro-Caribbean	0.1%	0.1%	0
	Ethiopian	0	0.1%	0
	Other African (Black)	0	0.1%	0
	Other Black	0	0.1%	0
Native Hawaiian or Pacific Islander	Guamanian or Chamorro	0	0.1%	0
	Communities of the Micronesian Region	0	0	0
	Native Hawaiian	0.1%	0.1%	0.1%
	Samoan	0	0.1%	0
	Marshallese	0	0.0	0
	Other Pacific Islander	0.1%	0.1%	0.1%
Middle Eastern/ North African	Middle Eastern	1.7%	3.0%	0.7%
	Northern African	0.1%	0.1%	0
White	Slavic	1.2%	0.9%	1.5%
	Eastern European	8.6%	6.7%	10.0%
	Western European	30.7%	37.7%	25.4%
	Other White	20.2%	12.0%	26.3%
Hispanic or Latino/a/x/e	Mexican	2.8%	1.1%	4.0%
	Central American	0.6%	0.4%	0.8%
	South American	0.3%	0.3%	0.3%
	Other Hispanic or Latino/a/x	0.9%	0.9%	0.9%
	Other Race	0.9%	0.6%	1.2%

Grouped race/ethnicity	REALD race/ethnicity reporting categories	Total, all primary oral health occupations	Dentists	Dental Hygienists
	Total estimated actively practicing oral health licenses in Oregon, N	5,704	2,428	3,276
	Multi Race	3.7%	3.9%	3.5%
	Decline	12.9%	12.8%	13.0%
	Unknown	2.5%	1.2%	3.5%

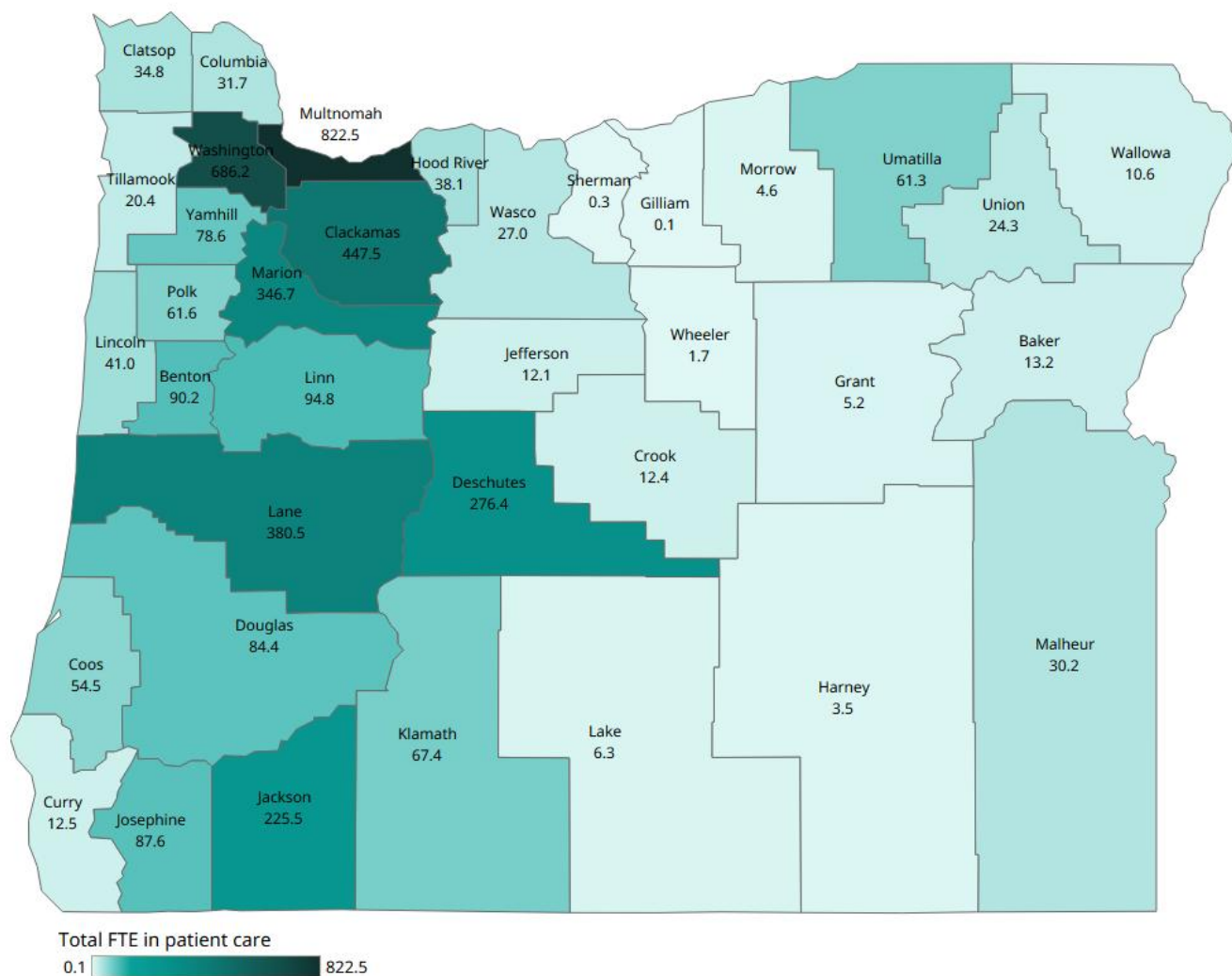
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Figure 15-1. Estimated supply of the actively practicing oral health workforce licensed in Oregon (count), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Figure 15-2. Direct patient care FTE of the actively practicing oral health workforce licensed in Oregon (count), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

16. Behavioral health appendix

Appendix Table 16-1. Percentage of the estimated actively practicing behavioral health workforce licensed in Oregon with a practice address in a border state, 2024-2026

	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Total estimated actively practicing behavioral health licenses in Oregon, N	19,569	884	96	2,161	1,760	56	6,578	6,325	1,709
Washington	0.9%	1.5%	2.1%	1.0%	1.9%	1.8%	0.7%	0.6%	0.4%
Idaho	0.1%	0.1%	0%	0.05%	0.5%	0%	0.1%	0.2%	0%
California	0.4%	1.1%	0%	0.5%	0.7%	5.4%	0.5%	0.3%	0%
Nevada	0.04%	0%	0%	0%	0.2%	0%	0%	0%	0%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Table 16-2. Active licensed Oregon psychiatric nurse practitioners that are also licensed and practicing in a border state, 2024-2026

	Nurse Practitioners (NPs)
Total estimated actively practicing Oregon nursing licenses, n	1,769
Licensed in Washington	35.8%
Licensed and practicing in Washington	27.4%
Licensed in California	13.5%
Licensed and practicing in California	8.0%
Licensed in Idaho	5.6%
Licensed and practicing in Idaho	4.1%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Table 16-3. Detailed REALD race and ethnicity information of the actively practicing behavioral health (BH) workforce licensed in Oregon, 2024-2026

Grouped race/ethnicity	REALD race/ethnicity categories	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
	Total estimated actively practicing BH licenses in Oregon, N	19,569	884	96	2,161	1,760	56	6,578	6,325	1,709
American Indian or Alaska Native	American Indian	0.6%	0.3%	2.1%	0.4%	0.4%	0.0%	0.7%	0.7%	1.0%
	Alaska Native	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.03%	0.1%	0.0%
	Canadian Inuit, Metis, or First Nation	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.02%	0.0%
	Indigenous Mexican, Central or South American	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.1%	0.5%
Asian	Asian Indian	0.6%	4.5%	0.0%	0.9%	0.4%	0.0%	0.4%	0.2%	0.6%
	Cambodian	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.02%	0.2%
	Communities of Myanmar	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
	Chinese	0.7%	3.4%	0.0%	1.3%	0.4%	0.0%	0.5%	0.3%	0.7%
	Filipino/a	0.4%	0.6%	1.0%	0.3%	0.6%	0.0%	0.4%	0.3%	0.5%
	Hmong	0.1%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.02%	0.3%
	Japanese	0.3%	0.5%	0.0%	0.5%	0.3%	0.0%	0.3%	0.4%	0.1%
	Korean	0.5%	0.6%	1.0%	0.7%	0.8%	0.0%	0.4%	0.6%	0.3%
	Laotian	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.04%	0.1%
	South Asian	0.2%	1.5%	1.0%	0.3%	0.1%	0.0%	0.2%	0.1%	0.3%
	Vietnamese	0.3%	1.2%	0.0%	0.3%	0.4%	0.0%	0.1%	0.2%	0.4%
	Other Asian	0.2%	1.1%	0.0%	0.3%	0.2%	0.0%	0.1%	0.2%	0.4%
Black or African American	African (Black)	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	African American	2.6%	1.6%	1.0%	0.9%	8.0%	3.7%	1.8%	2.1%	4.9%
	Afro-Caribbean	0.2%	0.1%	0.0%	0.2%	0.9%	0.0%	0.1%	0.1%	0.8%
	Ethiopian	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%
	Somali	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.02%	0.4%
	Other African (Black)	0.4%	0.1%	0.0%	0.1%	2.6%	1.9%	0.1%	0.1%	0.4%
	Other Black	0.2%	0.0%	0.0%	0.0%	0.6%	0.0%	0.1%	0.2%	0.4%
Native Hawaiian or Pacific Islander	Guamanian or Chamorro	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.02%	0.0%	0.1%
	Communities of the Micronesian Region	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native Hawaiian	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.1%	0.04%	0.2%
	Samoa	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.03%	0.0%	0.0%
	Marshallse	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Other Pacific Islander	0.1%	0.4%	0.0%	0.1%	0.2%	0.0%	0.02%	0.1%	0.0%
Middle Eastern/ North African	Middle Eastern	0.5%	1.6%	1.0%	0.7%	0.2%	0.0%	0.5%	0.2%	0.5%
	Northern African	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.02%	0.0%	0.0%
White	Slavic	1.1%	1.6%	2.1%	1.3%	1.2%	1.9%	0.9%	1.1%	1.0%
	Eastern European	11.5%	9.1%	15.6%	12.7%	10.1%	7.4%	11.3%	12.4%	9.6%
	Western European	43.6%	39.3%	40.6%	50.9%	33.5%	42.6%	45.9%	46.0%	29.8%
	Other White	15.0%	9.6%	5.2%	10.0%	17.0%	16.7%	15.3%	15.9%	18.3%

Grouped race/ethnicity	REALD race/ethnicity categories	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Assistants (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
	Total estimated actively practicing BH licenses in Oregon, N	19,569	884	96	2,161	1,760	56	6,578	6,325	1,709
Hispanic or Latino/a/x/e	Mexican	2.4%	1.1%	1.0%	1.6%	1.3%	1.9%	1.9%	2.4%	7.6%
	Central American	0.4%	0.4%	0.0%	0.3%	0.1%	0.0%	0.4%	0.3%	1.0%
	South American	0.5%	1.0%	0.0%	0.3%	0.3%	0.0%	0.6%	0.4%	0.9%
	Other Hispanic or Latino/a/x	1.0%	0.8%	1.0%	0.7%	1.1%	0.0%	1.0%	0.9%	1.4%
	Other Race	1.1%	1.7%	5.2%	0.8%	0.8%	0.0%	1.0%	1.0%	1.6%
	Multi Race	6.2%	4.7%	6.3%	7.6%	5.7%	3.7%	6.4%	5.7%	7.1%
	Decline	7.7%	9.8%	13.5%	6.2%	11.1%	11.1%	8.1%	6.6%	6.7%
	Unknown	1.4%	3.1%	2.1%	0.8%	1.4%	9.3%	1.2%	1.1%	2.0%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Table 16-4. Education programs and number of completions, by academic year, of the actively practicing behavioral health workforce in Oregon, 2018-2024

Occupation (number of education institutions in Oregon, 2024)	2018	2019	2020	2021	2022	2023	2024
Addiction specialists (Total programs 2024, N=18)	84	95	60	80	139	116	88
Applied Behavioral Analysis (n=4)	7	4	2	7	12	13	26
Substance Abuse/Addiction Counseling (n=10)	32	39	57	61	123	100	49
Trauma Counseling (n=1)				1	1	0	5
Mental health specialists (Total programs 2024, N=6)	37	46	43	26	61	47	14
Clinical, Counseling and Applied Psychology, Other (n=2)	29	26	37	17	52	42	6
Community Psychology (n=2)	6	19	6	9	9	5	8
Mental and Social Health Services and Allied Professions, Other (n=2)	2	1				0	2
Social work (Total programs 2024, N=19)	598	557	555	542	546	575	524
Social Work (n=16)	558	521	527	519	525	545	510
Youth Services/Administration (n=1)	28	16	14	7	11	14	6
Community Health Services/Liaison/Counseling (n=1)	12	20	14	16	10	16	8
Peer, Prevention, and Gambling Specialists (Total programs 2024, N=14)	46	60	71	77	133	116	59
Mental and Social Health Services and Allied Professions (n=3)	2	1				0	2
Community Health Services/Liaison/Counseling (n=1)	12	20	14	16	10	16	8
Psychologists (Total programs 2024, N=18)	231	230	228	262	288	260	218
Clinical Child Psychology (n=1)						8	0

Occupation (number of education institutions in Oregon, 2024)	2018	2019	2020	2021	2022	2023	2024
Clinical Psychology (n=5)	154	156	140	161	169	169	146
Forensic Psychology (n=3)	2	5	6	13	19	20	13
School Psychology (n=6)	31	39	48	57	55	60	49
Psychology, general (n=3)	44	30	34	31	45	3	10
Therapists (Total programs 2024, N=24)	275	280	269	271	319	361	302
Mental Health Counseling/Counselor (n=9)	109	96	102	92	117	127	129
Marriage and Family Therapy/Counseling (n=8)	122	136	118	123	97	142	106
Trauma Counseling (n=1)				1	1	0	5
Counseling Psychology (n=6)	44	47	49	55	104	92	62
Psychiatry (Total programs 2024, N=1)	147	126	151	158	149	166	132
Psychiatric/Mental Health Nurse/Nursing (N=1, 2024)	9	11	15	1	12	16	12

Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See Methods Appendix for more details of CIP codes by occupation and award level.

Note: 1 completion from a Clinical Pastoral Counseling/Patient Counseling program was counted toward total Therapist completions in 2019, although there is not a current program in 2024. There is 1 new Social Work, Other program in 2024, with 0 completions in that year.

Appendix Table 16-5. Distribution of behavioral health education program completions in Oregon by region and occupation, 2024

Occupation	Portland Metro	Willamette Valley and North Coast	Central Oregon	South western Oregon	Eastern Oregon
Addiction specialist	39	15	20	1	5
Community health worker	8	0	0	0	0
Mental health specialist	65	63	43	0	0
Peer, prevention, and gambling specialist	8	0	0	0	0
Physician (MD)	132	0	0	0	0
Psychiatric/mental health nurse	12	0	0	0	0
Psychologist	120	94	0	0	0
Social work	466	40	0	10	0
Therapist	143	70	8	19	0

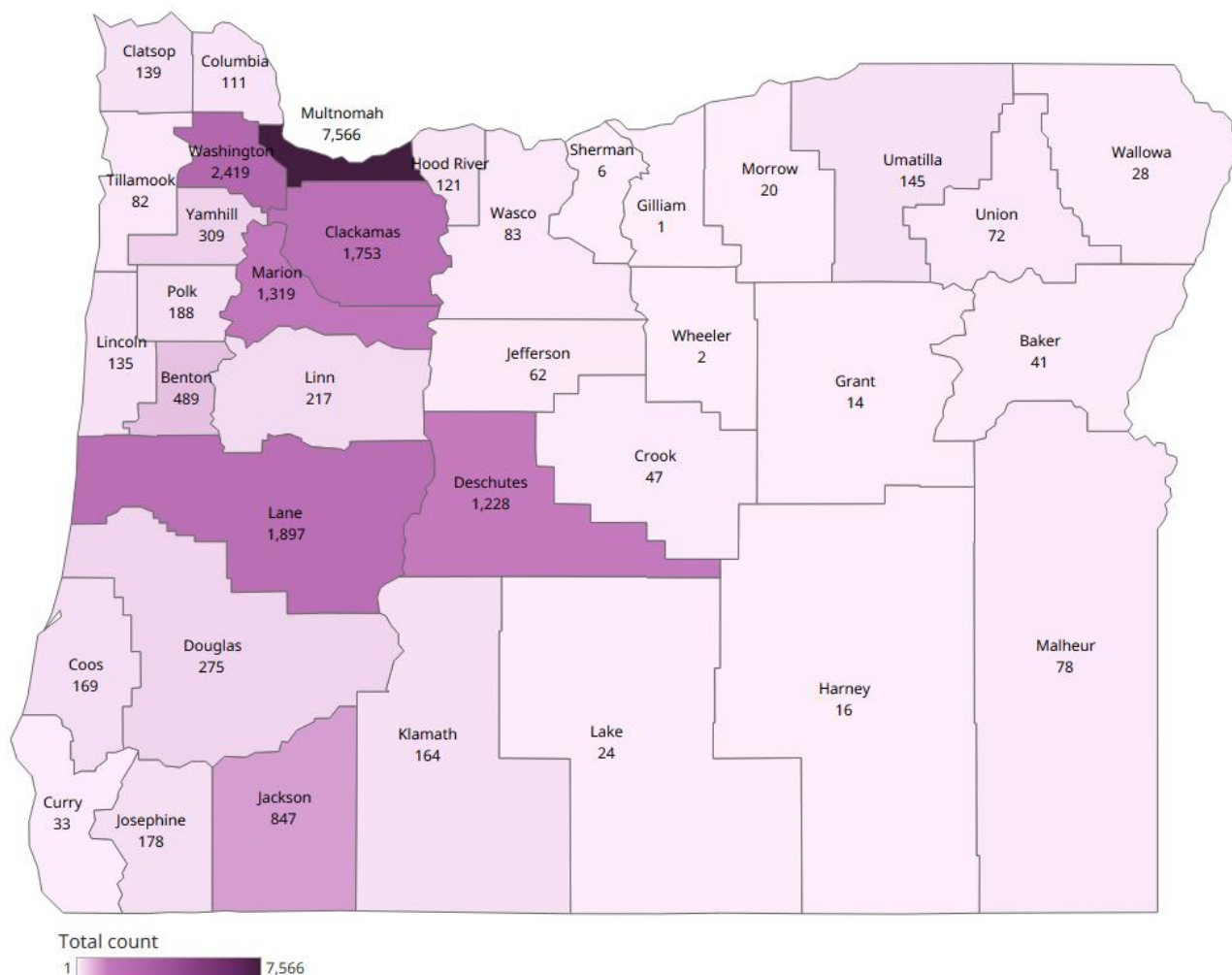
Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See Methods Appendix for more details of CIP codes by occupation and award level.

Appendix Table 16-6. Expected years until retirement of actively practicing behavioral health nurse practitioners licensed in Oregon, 2024-2026

	Total estimated actively practicing Oregon behavioral health nurse practitioners, N=1,760
Expect to retire within the next 2 years	2.2%
Expect to retire within the next 3-5 years	6.3%
Expect to retire within the next 6-10 years	9.8%
Expect to retire more than 10 years from now	68.2%
Don't know when will retire	11.9%
Missing	1.6%

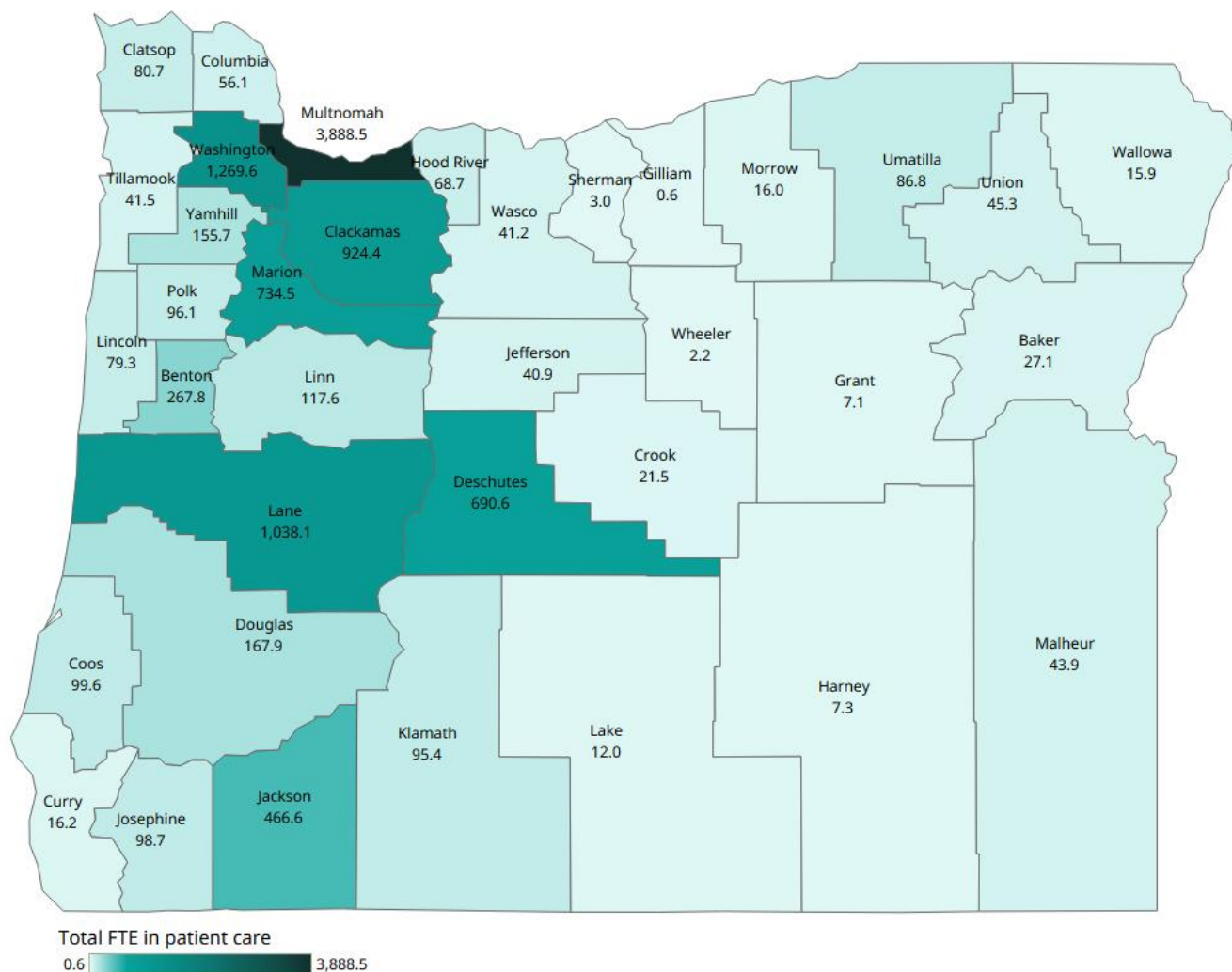
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Figure 16-1. Estimated supply of the licensed actively practicing behavioral health workforce by county in Oregon (count), 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

Appendix Figure 16-2. Direct patient care FTE of the actively practicing behavioral health workforce by county in Oregon, 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods Appendix for more details.

17. Measures of need appendix

Appendix Table 17-1. Number of primary care infrastructure and population-based facility availability in Oregon, by county

County	Number of Rural Health Clinic (RHC) Sites (2026)	Number of Federally-Qualified Health Centers (FQHC) Sites (2026)	Number of Hospitals with Primary Care Departments (2023)
Baker	3	0	1
Benton	0	4	1
Clackamas	3	16	2
Clatsop	6	2	2
Columbia	3	3	0
Coos	2	6	1
Crook	2	1	1
Curry	3	1	1
Deschutes	0	8	2
Douglas	5	12	1
Gilliam	1	0	0
Grant	2	0	1
Harney	3	0	1
Hood River	2	1	1
Jackson	0	26	2
Jefferson	1	1	1
Josephine	1	2	0
Klamath	0	6	1
Lake	2	0	1
Lane	4	10	3
Lincoln	7	9	2
Linn	11	3	2
Malheur	1	5	1
Marion	8	4	1
Morrow	3	1	1
Multnomah	0	59	4
Polk	1	4	1
Sherman	1	0	0
Tillamook	4	5	1
Umatilla	6	1	2
Union	5	0	1
Wallowa	4	4	1
Wasco	3	3	1

Washington	0	9	4
Wheeler	0	3	0
Yamhill	3	4	0
Oregon	100	213	45

Data source: 2026 Oregon Certified FQHC and RHC data; 2024 Area Health Resources Files, Health Resources and Services Administration.

Appendix Table 17-2. Number of hospitals in Oregon, by county

County	Number of Hospitals (2023)	Number of Critical Access Hospitals (2023)	Number of Hospitals with Emergency Departments (2023)
Baker	1	1	1
Benton	1	0	1
Clackamas	3	0	3
Clatsop	2	2	2
Columbia	0	0	0
Coos	3	2	3
Crook	1	1	1
Curry	1	1	1
Deschutes	2	0	2
Douglas	3	1	2
Gilliam	0	0	0
Grant	1	1	1
Harney	1	1	1
Hood River	1	1	1
Jackson	3	0	3
Jefferson	1	1	1
Josephine	1	0	1
Klamath	1	0	1
Lake	1	1	1
Lane	5	2	5
Lincoln	2	2	2
Linn	2	1	2
Malheur	1	0	1
Marion	4	0	3
Morrow	1	1	1
Multnomah	9	0	6
Polk	1	1	1
Sherman	0	0	0
Tillamook	1	1	1
Umatilla	2	2	2
Union	1	1	1

Wallowa	1	1	1
Wasco	1	0	1
Washington	5	0	4
Wheeler	0	0	0
Yamhill	2	0	2
Oregon	65	25	59

Data source: 2024 Area Health Resources Files, Health Resources and Services Administration.

Appendix Table 17-3. Number of behavioral health facilities in Oregon by county, 2023

County	Number of Hospitals Offering Outpatient Psychiatric Services	Number of Hospitals Offering Intensive Outpatient Psychiatric Services	Number of Hospitals Offering Outpatient Substance Use Treatment
Baker	0	0	0
Benton	1	0	0
Clackamas	2	1	0
Clatsop	1	0	0
Columbia	0	0	0
Coos	0	0	0
Crook	0	0	0
Curry	0	0	0
Deschutes	1	0	0
Douglas	0	0	0
Gilliam	0	0	0
Grant	0	0	0
Harney	1	0	0
Hood River	1	0	1
Jackson	0	0	0
Jefferson	0	0	0
Josephine	0	0	0
Klamath	0	0	0
Lake	0	0	1
Lane	4	2	0
Lincoln	1	0	0
Linn	0	0	0
Malheur	0	0	0
Marion	0	0	1
Morrow	0	0	0
Multnomah	2	2	1
Polk	0	0	0
Sherman	0	0	0

Tillamook	1	0	1
Umatilla	0	0	0
Union	1	0	0
Wallowa	1	0	0
Wasco	1	0	0
Washington	2	1	1
Wheeler	0	0	0
Yamhill	0	0	0
Oregon	20	6	6

Data source: 2024 Area Health Resources Files, Health Resources and Services Administration.

Appendix Table 17-4. Number of National Health Service Corps (NHSC) Sites in Oregon by county, 2026

County	Number of NHSC Primary Care Sites	Number of NHSC Mental Health Sites	Number of NHSC Dental Sites
Baker	2	2	2
Benton	3	3	2
Clackamas	11	11	11
Clatsop	4	4	4
Columbia	2	2	2
Coos	11	11	11
Crook	3	3	3
Curry	18	18	18
Deschutes	13	13	12
Douglas	1	1	1
Gilliam	1	1	1
Grant	4	4	4
Harney	22	22	22
Hood River	5	5	4
Jackson	5	5	5
Jefferson	7	7	7
Josephine	1	1	1
Klamath	8	8	8
Lake	3	3	3
Lane	3	3	1
Lincoln	8	8	8
Linn	8	8	8
Malheur	2	2	2
Marion	33	38	38
Morrow	6	6	6
Multnomah	2	2	2

Polk	1	1	1
Sherman	3	3	2
Tillamook	6	6	5
Umatilla	2	2	2
Union	11	11	11
Wallowa	6	6	6
Wasco	2	2	2
Washington	3	3	2
Wheeler	11	11	11
Yamhill	4	4	4
Oregon	215	220	213

Data source: HRSA National Health Service Corps (NHSC) Sites Data Explorer, accessed August 2026. NHSC-approved site information includes participating clinical sites serving Health Professional Shortage Areas (HPSAs).

