



**Health Policy and Analytics Division**  
Health Care Provider Incentive Program

**2027**

# **V3 DRAFT - Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon**

**Appendices A through F**

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## Appendix A: Supporting Program Detail for the Behavioral Health Workforce Incentives

### Appendix A - List of Abbreviations

| Abbreviation    | Definition                                                             |
|-----------------|------------------------------------------------------------------------|
| <b>ARPA</b>     | American Rescue Plan Act                                               |
| <b>ASWB</b>     | Association of Social Work Boards                                      |
| <b>B&amp;HS</b> | (Oregon Behavioral Health Workforce) Bonus and Housing Stipend Program |
| <b>BHLRP</b>    | Behavioral Health Loan Repayment Program (HCPIP program)               |
| <b>BHWI</b>     | Behavioral Health Workforce Incentives                                 |
| <b>BIPOC</b>    | Black, Indigenous, or people of color                                  |
| <b>BLSW</b>     | (Oregon) Board of Licensed Social Workers                              |
| <b>CMHP</b>     | Community Mental Health Program                                        |
| <b>CSWA</b>     | Clinical Social Work Associate                                         |
| <b>DNP</b>      | Doctor of Nursing Practice                                             |
| <b>FQHC</b>     | Federally Qualified Health Center                                      |
| <b>HB</b>       | House Bill                                                             |
| <b>HCPIP</b>    | Health Care Provider Incentive Program                                 |
| <b>HPSA</b>     | Health Professional Shortage Area                                      |
| <b>HRSA</b>     | Health Resources and Services Administration                           |
| <b>LCSW</b>     | Licensed Clinical Social Worker                                        |
| <b>LMSW</b>     | Licensed Master Social Worker                                          |
| <b>LPC</b>      | Licensed Professional Counselor                                        |
| <b>MA</b>       | Master of Arts                                                         |
| <b>MD</b>       | Doctor of Medicine                                                     |
| <b>MHACBO</b>   | Mental Health and Addiction Certification Board of Oregon              |
| <b>MS</b>       | Master of Science                                                      |
| <b>MSW</b>      | Master of Social Work                                                  |
| <b>NP</b>       | Nurse Practitioner                                                     |
| <b>OBHLRP</b>   | Oregon Behavioral Health Loan Repayment Program (BHWI program)         |
| <b>OHA</b>      | Oregon Health Authority                                                |
| <b>ORH</b>      | Oregon Office of Rural Health                                          |

| Abbreviation | Definition                               |
|--------------|------------------------------------------|
| <b>PhD</b>   | Doctor of Philosophy                     |
| <b>PSS</b>   | Peer Support Specialist                  |
| <b>PsyD</b>  | Doctor of Psychology                     |
| <b>REALD</b> | Race, Ethnicity, Language, Disability    |
| <b>RN</b>    | Registered Nurse                         |
| <b>SD</b>    | Standard deviation                       |
| <b>SLRP</b>  | State Partnership Loan Repayment Program |
| <b>SOGI</b>  | Sexual Orientation and Gender Identity   |
| <b>THW</b>   | Traditional Health Worker                |
| <b>USD</b>   | United States dollars                    |

## Background: Behavioral Health Workforce Incentives

The Behavioral Health Workforce Incentives (BHWI) program was created following the passage of House Bills 2949 (2021) and 4071 (2022) to increase the recruitment and retention of behavioral health providers in Oregon, particularly in communities disproportionately impacted by the COVID-19 pandemic.(1,2)

This evaluation of programs funded under the BHWI was conducted utilizing data pulled from the interactive BHWI dashboard in August 2026.(3) This evaluation includes the following programs that have concluded at the time of this evaluation:

- Peer Support Services,
- Mental Health and Addiction Certification Board of Oregon (MHACBO),
- Association of Social Work Boards (ASWB) Program, and
- Oregon Board of Licensed Social Workers (BLSW) Program.

Additional data on the ASWB and BLSW programs were included from narrative reports provided by BHWI. Some BHWI programs will continue beyond the evaluation period covered by this year's report, with data collection ongoing. As such, these programs, listed below, will only be briefly described in this year's evaluation:

- Oregon Behavioral Health Loan Repayment Program (OBHLRP)
- Behavioral Health Scholarships Program
- Graduate Tuition Assistance and Stipends
- Community Mental Health Program (CMHP) Grants
- Oregon Behavioral Health Workforce Bonus and Housing Stipend (B&HS) Program

Evaluations of these ongoing programs will be explored in future evaluation reports.

An additional narrative describing the Tribal milestones in the behavioral health workforce with funding from HB 2949 was provided to the evaluation team and is also included in this appendix.

## Peer Support Services

In alignment with House Bill 4071, this peer support services incentive program provided grant funding to 53 different Peer Support Organizations from June 22, 2023-September 30, 2023 (one non-renewing funding cycle). Funding was provided for workforce retention bonuses, workforce training and professional development, hiring incentives, employee engagement activities, training and

certification for Peer Support Services and Traditional Health Worker, and the creation of a cross-trained perinatal peer support workforce across five counties. All contracts ended on January 31, 2024 (contract periods ranged from 133 to 223 days; median 216 days). Total contracted funding across all 53 subrecipients was \$4,979,774.

The Peer Support Services program includes activities that align with two incentive typologies. This section reports the program's career pathways and training activity: peers trained and training programs created. Due to considerable overlap in organizations, findings for all activities are reported here. The subrecipients' organizations determined locally which activities to fund, and some organizations offered both training and bonus activities. Of the 53 subrecipients, 32 reported training activities, 41 reported bonus activities, 22 reported both, and two reported neither training nor bonus activities.

Findings in this section rely on Peer Support Subrecipient tracking data provided by OHA, comprising one record per subrecipient (n = 53) with subrecipient name, project county, county designation (urban, rural, or frontier), contract start and end dates, contract amount, and counts of five reported activities. No individual-level recipient records, REALD SOGI data, expenditure or invoice data, or post-award follow-up data were available for this program. Small-number reporting follows the approach described in Appendix B.

## Evaluation of Program Reach

**Recipient Organizations.** Across 53 subrecipients awarded Peer Support Services funding, the program recorded 1,190 bonuses: 1,103 retention bonuses and 87 hiring bonuses (Table 1). Retention bonuses were both the most common funded activity and the dominant one by volume, with 37 of 53 subrecipients (69.8 percent) reporting distributing them. Among the 37 subrecipients reporting retention bonuses, the median number distributed was 18 (range 3-292). Hiring bonuses were reported by only 9 subrecipients (17.0 percent), with a median of five per reporting subrecipient (range 1-30). Five subrecipients reported distributing both bonus types, and four reported hiring bonuses but no retention bonuses.

**Table 1. Reported retention and hiring bonuses distributed by subrecipients, Peer Support Services Program, June 2023-January 2024 (N = 53 subrecipients).**

| Activity          | Subrecipients reporting activity, n (%) | Total bonuses reported | Median number of bonuses among reporting subrecipients (range) | Mean number of bonuses per reporting subrecipient |
|-------------------|-----------------------------------------|------------------------|----------------------------------------------------------------|---------------------------------------------------|
| Retention bonuses | 37 (69.8%)                              | 1,103                  | 18 (3-292)                                                     | 29.8                                              |
| Hiring bonuses    | 9 (17.0%)                               | 87                     | 5 (1-30)                                                       | 9.7                                               |

**Data Source:** OHA 2026 Peer Support Subrecipient tracking workbook, contract period 6/22/2023-1/31/2024. Blank cells in the source workbook were treated as reports of no activity for that subrecipient organization.

In total, nearly half of subrecipients (47.2 percent, n = 25) reported training 533 peers (Table 2). Two subrecipients reported peers trained in the BIPOC category only, and 21 reported peers trained in the “white alone or unknown” category, and two reported training peers in both categories.

**Table 2. Reported peers trained by subrecipients, Peer Support Services Program, June 2023-January 2024 (N = 53 subrecipients total).**

| Activity                               | Subrecipients providing training, n (%) | Total trained | Median number trained among subrecipients (range) | Mean number trained among subrecipients |
|----------------------------------------|-----------------------------------------|---------------|---------------------------------------------------|-----------------------------------------|
| Peers trained (white alone or unknown) | 23 (43.4%)                              | 413           | 15 (1-65)                                         | 18.0                                    |
| Peers trained (BIPOC)                  | 4 (7.5%)                                | 120           | 28 (20-44)                                        | 30.0                                    |
| Peers trained (overall)                | 25 (47.2%)                              | 533           | 18 (1-65)                                         | 19.7                                    |

**Abbreviations:** BIPOC – Black, Indigenous, and People of Color. **Data Source:** OHA 2026 Peer Support Subrecipient tracking workbook, contract period 6/22/2023-1/31/2024. **Note:** Blank cells in the source workbook were treated as reports of no activity for that subrecipient organization.

Eleven subrecipients (20.8 percent) reported creating one Traditional Health worker/Peer Support Services (THW/PSS) training program, generating 11 new training programs statewide. Among subrecipients reporting creating a TWH/PSS training program, four also reported training peers.

**Locations of Service and Communities Served.** Subrecipients were located in 16 of 36 Oregon counties (44 percent). One additional subrecipient was Clark County, Washington (\$450,000; 9.0 percent of program funding).

Using the county rurality designations recorded in the workbook, 43 subrecipients (81.1 percent) were designated as urban, 7 (13.2 percent) as rural, and 3 (5.7 percent) as frontier (Table 3). Funding followed the same

distribution: urban-designated subrecipients held \$4,281,532 (86.0 percent), rural-designated subrecipients \$479,750 (9.6 percent), and frontier-designated subrecipients \$218,492 (4.4 percent). Rural- and frontier-designated subrecipients together held 10 contracts (18.9 percent) and \$698,242 (14.0 percent) of program funding. Median contract amounts varied across designations (\$61,282 urban, \$40,000 rural, and \$82,000 frontier), suggesting that the greater concentration of funding among urban subrecipients may reflect, at least in part, the larger number of urban subrecipients rather than differences in typical contract amounts.

**Table 3. Subrecipients and contracted funding by county designation, Peer Support Services Program, June 2023-January 2024**

| County designation         | Subrecipients, n (%) | Total contracted | Percent of total funding | Median contract | Range              |
|----------------------------|----------------------|------------------|--------------------------|-----------------|--------------------|
| Urban                      | 43 (81.1%)           | \$4,281,532      | 86.0%                    | \$61,282        | \$5,519-\$450,000  |
| Rural (including frontier) | 7 (13.2%)            | \$479,750        | 9.6%                     | \$40,000        | \$10,000-\$169,000 |
| Frontier                   | 3 (5.7%)             | \$218,492        | 4.4%                     | \$82,000        | \$4,200-\$132,292  |
| Total                      | 53 (100%)            | \$4,979,774      | 100%                     | \$61,282        | \$4,200-\$450,000  |

**Data Source:** OHA 2026 Peer Support Subrecipient tracking workbook, contract period 6/22/2023-1/31/2024. **Note:** County rurality designation provided in data workbook. The designation is internally inconsistent for Clackamas County, which appears as both rural and urban (program treated as it was classified in the workbook). One subrecipient is recorded in Clark County, which is a Washington county, but is classified as urban in the data workbook.

Reported activity was concentrated among urban-designated subrecipients (Table 4). Urban subrecipients accounted for 957 of 1,103 retention bonuses (86.8 percent), 65 of 87 hiring bonuses (74.7 percent), 334 of 413 peers trained in the white-alone-or-unknown category (80.9 percent), 84 of 120 peers trained in the BIPOC category (70.0 percent), and 10 of 11 training programs created (90.9 percent). None of the three frontier-designated subrecipients reported any bonuses.

**Table 4. Number of activities and subrecipients reporting activity by county designation, Peer Support Services Program, June 2023-January 2024**

| Category                              | Number in Urban County<br>(Number of subrecipients reporting activity, N = 43) | Number in Rural County<br>(Number of subrecipients reporting activity, N = 7) | Number in Frontier County<br>(Number of subrecipients reporting activity, N = 3) | Total Number of Bonuses<br>(Number of subrecipients reporting activity) |
|---------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Retention bonuses                     | 957 (31 subrecipients)                                                         | 146 (6 subrecipients)                                                         | 0 (0 subrecipients)                                                              | 1,103 (37 subrecipients)                                                |
| Hiring bonuses                        | 65 (6 subrecipients)                                                           | 22 (3 subrecipients)                                                          | 0 (0 subrecipients)                                                              | 87 (9 subrecipients)                                                    |
| Peers Trained: White alone or unknown | 334 (18 subrecipients)                                                         | 75 (4 subrecipients)                                                          | 4* (1 subrecipients)                                                             | 413 (23 subrecipients)                                                  |
| Peers Trained: BIPOC                  | 84 (3 subrecipients)                                                           | 36 (1 subrecipients)                                                          | 0 (0 subrecipients)                                                              | 120 (4 subrecipients)                                                   |
| THW/PSS training programs created     | 10 (10 subrecipients)                                                          | (0 subrecipients)                                                             | 1* (1 subrecipients)                                                             | 11 (11 subrecipients)                                                   |

**Data Source:** OHA 2026 Peer Support Subrecipient tracking workbook, contract period 6/22/2023-1/31/2024. **Note:** County rurality designation provided in data workbook. The designation is internally inconsistent for Clackamas County, which appears as both rural and urban (program treated as it was classified in the workbook). One subrecipient is recorded in Clark County, which is a Washington county, but is classified as urban in the data workbook and treated as such here.

\*Estimates may be statistically unreliable due to small numbers; interpret with caution.

## Evaluation of Program Adoption

Subrecipients were predominantly community-based organizations. Participation was broadly distributed by organization count and concentrated by dollars. The five largest contracts accounted for \$1,750,920 (35.2 percent) of program funding and the ten largest for \$2,594,739 (52.1 percent), while the 26 smallest contracts together accounted for \$790,250 (15.9 percent). Reported activity was similarly concentrated: a single subrecipient reported 292 retention bonuses, 26.5 percent of all retention bonuses recorded in the program.

## Evaluation of Program Implementation

Fifty-three subrecipient organizations received Peer Support Services contracts totaling \$4,979,774. Contract amounts ranged from \$4,200 to \$450,000, with a median of \$61,282 (interquartile range \$33,660-\$115,100) and a mean of \$93,958. Sixteen subrecipients (30.2 percent) held contracts of \$100,000 or more, and 11 (20.8 percent) held contracts under \$25,000.

## Evaluation of Program Sustainability (Maintenance)

The Peer Support Services program was a one-time investment and concluded on January 31, 2024. All 53 contracts share that end date, and no successor funding, subsequent cycle, or continuation mechanisms are expected.

## Mental Health and Addiction Certification Board of Oregon (MHACBO)

This section describes MHACBO fee waivers funded by BHWI from July 2022 to June 2024. After BHWI funding ended, HCPIP continued funding MHACBO fee waivers through the Behavioral Health Retention Incentives, which are reported in the main report.

Previously as part of the BHWI, the Mental Health and Addiction Certification Board of Oregon was provided approximately \$3.7 million in funding to cover the fees for initial certification registration, registration renewals, certification exams, and exam preparation courses to reduce the costs for individuals entering the behavioral health workforce. These fee waivers were provided to individuals seeking certification/recertification or registration as a Certified Recovery Mentor, Qualified Mental Health Professional or Associate, Certified Alcohol and Drug Counselor, and Certified Prevention Specialist from July 2022 through June 2024.

## Evaluation of Program Reach

OHA and MHACBO committed \$3.7 million between July 2022 and June 2024 to cover initial certification registrations, renewals, certification examinations, and examination preparation courses across four certification types: Certified Recovery Mentor, Qualified Mental Health Associate, Certified Alcohol and Drug Counselor, and Certified Prevention Specialist. The program reached 16,341 recipients, more than all other BHWI programs combined, at an average of \$220 per recipient. Approximately 10,000 registrations were covered; registrations and recipients are distinct units and are not comparable.

## Evaluation of Program Adoption

MHACBO reports the largest demographic sample of any BHWI program (Table 5). Non-response was 7.1 percent, substantially lower than other programs.

**Table 5. Race/ethnicity of MHACBO program recipients, July 2022-June 2024 (N = 16,341).**

| Race/ethnicity            | Number of responses | Percent |
|---------------------------|---------------------|---------|
| White                     | 10,278              | 61.5%   |
| Hispanic or Latino/a/x/e  | 1,445               | 8.6%    |
| Multiracial               | 1,320               | 7.9%    |
| Black or African American | 1,091               | 6.5%    |

| Race/ethnicity                      | Number of responses | Percent     |
|-------------------------------------|---------------------|-------------|
| American Indian or Alaskan Native   | 671                 | 4.0%        |
| Asian                               | 311                 | 1.9%        |
| Native Hawaiian or Pacific Islander | 79                  | 0.5%        |
| Middle Eastern or North African     | 48                  | 0.3%        |
| Another race                        | 319                 | 1.9%        |
| Not Available                       | 1,154               | 6.9%        |
| <b>Total responses</b>              | <b>16,716</b>       | <b>100%</b> |

**Data Source: OHA BHWI Dashboard. Recipients may select more than one race or ethnicity; responses (16,716) therefore exceed recipients (16,341). Percentages are of total responses.**

## Evaluation of Program Implementation

MHACBO expenditures were allocated as follows: renewal fees \$1,403,000 (39 percent), registration costs \$883,000 (24 percent), testing fees \$553,000 (15 percent), training fees \$360,000 (10 percent), salaries and related costs \$240,000 (7 percent), and administrative costs \$164,000 (5 percent). More was expended on renewal of existing credentials than on new registrations, suggesting that the program principally sustained the existing certified workforce rather than expanding it.

MHACBO cumulative registrations increased steadily across the full program period and had not plateaued when funding concluded in June 2024.

## Evaluation of Program Sustainability (Maintenance)

The MHACBO program, as part of the BHWI program, provided fee waivers to 16,341 recipients for examination or registration fees. Fee waivers for some professions certified by MHACBO have continued as part of the Behavioral Health Retention Incentives in the HCPIP.

## Association of Social Work Boards (ASWB) Program

As part of the BHWI, OHA partnered with the Association of Social Work Boards (ASWB) to provide one-time funding to provide financial relief to individuals working to become licensed social workers by covering the costs of ASWB examination registration fees from January 2023 to February 2024 with the goal of increasing the pass and licensure rates of social workers in Oregon. The program was funded with \$130,000 from House Bills 2949 and 4071 through funding from the American Rescue Plan Act (ARPA).

## Evaluation of Program Reach

The program covered 505 ASWB examination registrations between January 2023 and February 2024, totaling \$129,910 in funds spent. These registrations included 464 clinical exams (91.9 percent), 39 Master's exams (7.7 percent), and two were for excused absence exams. Exam fees were \$230 per exam for

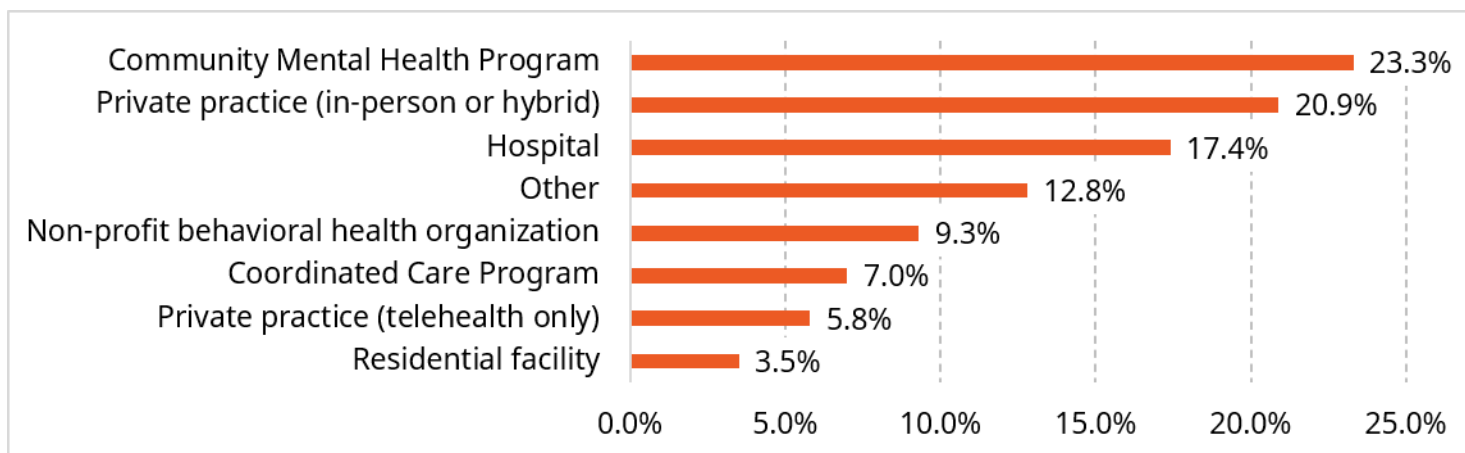
Bachelor's or Master's exams (required to become Registered Baccalaureate or Licensed Master Social Workers [LMSW], respectively), \$260 for the Clinical Exam (required to become a Licensed Clinical Social Worker [LCSW]), and \$150 for excused absence exams.

After the end of the program, an optional survey to understand how this exam fee voucher program impacted those that received the incentive was administered through an email sent by ASWB. Of all the program participants emailed, 99 (22 percent) responded to the survey. Some respondents did not respond to all the questions.

Most of the 88 survey respondents who took the Clinical Exam (65.9 percent, N=58) reported an intention to provide direct behavioral health services in Oregon for 10 years or more. Five reported an intention to provide direct behavioral health services in Oregon for between seven and nine years, 13 between four and six years, and nine between one and three years.

Those currently employed in the behavioral health field were asked about workplace setting, with the a "Community Mental Health Program (CMHP)" selected most often at 23.3 percent and a "Residential Facility" selected least at 3.5 percent (Figure 1).

**Figure 1. Workplace setting reported by ASWB program recipients who completed post-participation survey, (n=99)**



**Abbreviation: ASWB – Association of Social Work Boards. Data Source: ASWB Profile, Behavioral Health Workforce Incentives, Oregon Health Authority.**

## Evaluation of Program Adoption

The overall pass rate for all first-time exam takers was 73.9 percent (total of 441 first-time test takers). Data on languages used, race, ethnicity, and gender were collected from all test takers prior to examination. Test takers whose primary language was English (n = 389) outnumbered test takers whose primary language was not English (n = 52). Test takers whose primary language was not

English had a pass rate of 26.9 percent, compared with a pass-rate of 80.2 percent for test takers whose primary language was English.

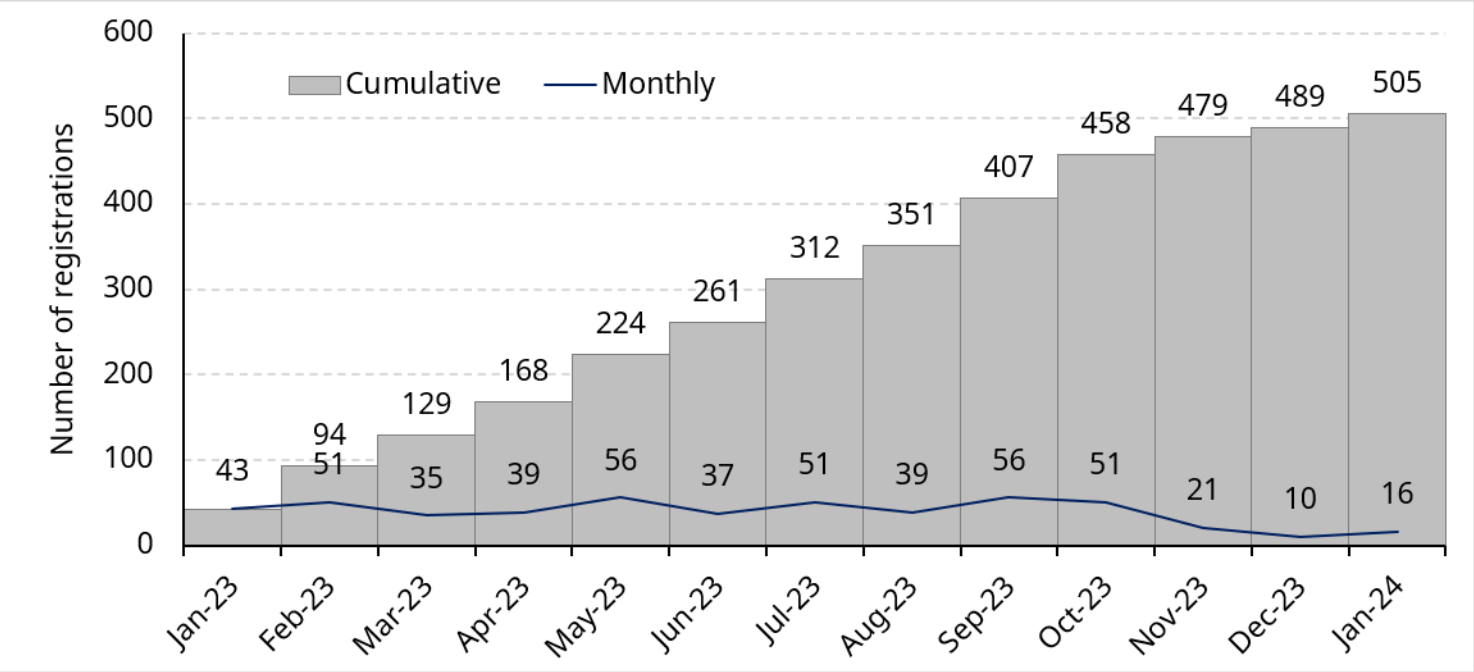
REALD SOGI data were not collected. However, race/ethnicity data collected by the ASWB and provided to BHWI indicated first-time pass rates were 88 percent among individuals who identified as white, and ranged from 80-90 percent for those who identified as Multiracial. Those who identified as Black or African American had the lowest first-time pass rate at 28 percent. To protect confidentiality, pass rates for groups with 30 or fewer individuals were reported as ranges. Both language and pass rates are consistent with the [ASWB's pass rate analysis](#), and the exams have been investigated due to these racial disparities and their availability only in English.(4)

The majority (80.5 percent, n = 355) of test-takers were female, 16 percent (n = 71) of test takers were male, and fifteen test-takers identified as neither male nor female or preferred not to say. Females had a higher pass rate on their first attempt (76 percent) than males (68 percent) or those who identified as neither male nor female or who preferred not to say (50-60 percent, reported as a range to protect confidentiality).

## **Evaluation of Program Implementation**

Registrations accrued monthly throughout the program, reaching a cumulative total of 505 by January 2024 (Figure 2). Growth was strongest through the middle of the program and slowed over the final two recorded points (December 2023 and January 2024). This monthly pattern suggests that exam-fee uptake held steady across most of the program's duration before tapering off in the final two recorded months.

**Figure 2. Monthly and cumulative total registrations covered by the ASWB program, January 2023-January 2024.**



Data Source: [Behavioral Health Workforce Incentives \(2025\). Interactive display](#) accessed [08/22/2026]. Salem, OR: Oregon Health Authority. [https://www.oregon.gov/oha/HSD/AMH/Pages/BHWI-Dashboard.aspx].

**Evaluation of Program Sustainability (Maintenance)**

Monthly registration totals indicate a decrease in participation towards the end of the program, with the lowest numbers observed in the final two months. Since ASWB was a one-time initiative, this decline reflects the conclusion of funding rather than any changes in eligibility or administrative processes. The conclusion of the ASWB program means that social workers resumed paying examination registration fees in 2024.

**Oregon Board of Licensed Social Workers (BLSW) Program**

As part of the BHWI, OHA partnered with the Oregon Board of Licensed Social Workers (BLSW) to create a one-time, year-long program to waive licensure application and renewal fees for social workers in Oregon from December 2022 to December 2024. This program was funded through House Bills 2949 and 4071 using American Rescue Plan Act funds and aimed to reduce financial barriers, support provider retention, and expedite the licensure process for clinical social work associates (CSWAs), LCSWs, and LMSWs in Oregon.

**Evaluation of Program Reach**

The BLSW fee waiver program was available to all social workers seeking to enter the behavioral health workforce in Oregon and was automatically applied to all applications and renewals. Application and renewal fees were waived

regardless of applicant location, with the intent of encouraging more social workers to practice in the state.

Licensure application and renewal fees were between \$200 and \$460. The program funded 2,843 social work applications and renewals, spending a total of \$638,872. The most frequent use of the waiver was for CSWA renewals (n = 1,092, \$72k), followed by CSWA applications (n = 666, \$173k), LCSW applications (n = 621, \$286k), and CSWA to LCSW applications (n = 340, \$88k). LMSW applications received by far the fewest number of waivers with only 124 (\$20k).

**Table 6. BLSW incentives funded and expenditures, by license type, December 2022-December 2024**

| License type      | Number funded | Percent | Amount    |
|-------------------|---------------|---------|-----------|
| CSWA renewals     | 1,092         | 38.4%   | \$72,000  |
| CSWA applications | 666           | 23.4%   | \$173,000 |
| LCSW applications | 621           | 21.8%   | \$286,000 |
| CSWA to LCSW      | 340           | 12.0%   | \$88,000  |
| LMSW applications | 124           | 4.4%    | \$20,000  |
| Total             | 2,843         | 100%    | \$639,000 |

Abbreviations: CSWA - Clinical Social Work Associate; LCSW - Licensed Clinical Social Worker; LMSW - Licensed Master Social Worker. Data Source: BHWI dashboard (2025). Interactive display accessed [08/22/2026]. The BSLW program was implemented on 12/2022 and ran from 01/01/2023 to 12/31/2023.

Amounts are rounded in OHA source reporting; the sum of \$639,000 differs from reported program expenditure of \$638,872 due to rounding.

## Evaluation of Program Implementation

All allocated funds were spent, totaling \$638.9k, representing a 100 percent total allocation.

CSWA renewals (n = 1,092) used the most fee waivers, allowing practicing CSWA to maintain their ability to practice in Oregon. The next largest group consisted of LCSW applicants either directly (n = 621) or through the CSWA to LCSW pathway (n = 340), supporting entry into LCSWs practice. LMSWs had the smallest number of applications.

## Evaluation of Program Sustainability (Maintenance)

BLSW fee waiver program was a one-time program that concluded in February 2024 and provided fee waivers for 2,843 licensure fees for social workers, dispersing 100 percent of the \$638,872 allocated funding. Following the conclusion of the BLSW program in 2024, social workers have resumed paying licensure registration fees. No further legislation has allocated additional funding for this program.

## Oregon Behavioral Health Loan Repayment Program (OBHLRP)

The OBHLRP was established under House Bill 4071 (2022) and began awarding loan repayment in April 2022, initially administered under HCPIP's existing loan repayment administrative rules before transitioning to BHWI's own administrative rules effective September 2022.(5,6) OBHLRP provides loan repayment assistance to behavioral health care workers serving underserved communities in exchange for a two-year service commitment. The program is intended to increase access to behavioral health services for people of color, Tribal members, and rural residents, while supporting providers who serve patients regardless of insurance coverage or ability to pay.

Eligible providers must be currently employed and provide at least 16 hours of behavioral health services per week for part-time and 32+ hours for full-time, including direct or telehealth patient/client care, care coordination, case management, charting, and clinical supervision. Eligible provider types include licensed behavioral health providers, certified behavioral health providers, and registered traditional health workers. OHA gives priority in scoring and awards to applicants who represent or identify with underserved communities, provide behavioral health services to underserved populations, have lived experience with underserved communities, speak a second language in a behavioral health setting, work at a Community Mental Health Program, or practice in a rural or frontier community.

In exchange for a two-year service commitment, full-time providers (32 or more hours per week) may receive 70 percent of qualifying educational loan debt, up to \$50,000 per obligation year. Part-time providers (16-31 hours per week) may receive 50 percent, up to \$25,000 per obligation year. Recipients who did not apply their award toward the repayment of student loan debt were required to repay the portion of the award in question.

All recipient service commitments will be completed by October 2026 which is after the data collection window for this report. A final analysis will be used for the next program evaluation. It is expected that these data will include prioritization criteria, demographics, retention rates during service commitments, practice patterns, and satisfaction of recipients during their time in the program. A publicly accessible dashboard displays a subset of the data collected to date.(3)

As of June 30, 2026, OBHLRP is not accepting new applications, with any future cycles contingent on additional legislative funding. Behavioral health loan repayment remains available to new applicants through the Behavioral Health Loan Repayment Program administered by HCPIP.

## Behavioral Health Scholarships Program

The Behavioral Health Scholarships Program, part of the BHWI, provided funding to community colleges and other low-barrier training programs, with the goal of lowering barriers to entering pathways to behavioral health careers for students from diverse and underrepresented backgrounds. Five schools and programs ranging from Peer Wellness Specialist certification training to Doctor of Psychology training received approximately \$2 million in funding to operate this grant from April 2023 to September 2026. Grantees worked in partnership with OHA to develop an application and distribution process for awarding scholarships to their students which prioritized students from communities that are underserved.

Data is collected yearly. Final reporting will not be evaluated until it is collected in September 2026, which is after the cutoff for the current evaluation. At this time, counts show that at least 286 students and trainees have been awarded at least one scholarship with 200 who have surpassed their graduation date. These numbers and confirmations of graduation and completion are expected to rise as final reporting is collected and analyzed. This information will be included in a subsequent evaluation, and much of it is expected to be available on BHWI's public facing dashboard.

## Graduate Tuition Assistance and Stipends

As part of the BHWI, the Graduate Tuition Assistance and Stipend Program provided funding to eight institutions of higher education to provide graduate-level students pursuing degrees in behavioral health with tuition assistance and stipends to lower the financial barriers of completing their programs. Institutions worked in partnership with OHA to develop an application and distribution process for awarding scholarships to their students, prioritizing students with culturally or linguistically diverse or underrepresented backgrounds. This program is active from January 2024 to September 2026. Current counts indicate that at least 224 students have received either tuition assistance or stipends across all awarded institutions with these numbers projected to rise once final reporting is received in October 2026. Data collection, analysis, and synthesis will occur after the data collection period for the current evaluation but will be included in a subsequent evaluation report. There is currently a public dashboard where progress for this program can be viewed, and it will be updated regularly as new data are collected and metrics displayed.

## Community Mental Health Program (CMHP) Grants (Set-Aside)

As part of the BHWI, the Community Mental Health Program (CMHP) grants provided funding to local county mental health centers to support recruitment and retention of behavioral health providers. The grants are intended to

strengthen the behavioral health workforce in communities with the greatest need, with a particular focus on increasing access to culturally specific, culturally responsive, rural, and high acuity services. CMHP grant funding supports a wide range of workforce incentives, including clinical supervision, tuition and training, housing assistance, bonuses and stipends, subsidized dual certification, childcare support, wellness incentives, recruitment, and relocation incentives. Funding may also support clinical supervisors, who provide experience required for licensure in certain behavioral health professions.

Funding was distributed in April 2023 and all CMHP grant agreements will be completed by September 30, 2026, which is after the data collection window for this evaluation report. A final analysis will be used for the next program evaluation. It is expected that this data will include prioritization criteria, demographics, retention rates during the program by incentives, and satisfaction of recipients during their time in the program. A publicly available dashboard displays some of the data collected to date and will continue to be updated to include new metrics as data is synthesized.

## **The Oregon Behavioral Health Workforce Bonus and Housing Stipend (B&HS) Program**

The Oregon Behavioral Health Workforce Bonus and Housing Stipend (B&HS) Program is a workforce recruitment and retention initiative established by OHA as part of BHWI and funded through BHWI's time-limited American Rescue Plan Act (ARPA) funding. The program provided funding to behavioral health organizations from December 2022 through March 2026, with all contracts ending by June 30, 2026, to offer hiring bonuses, retention bonuses, and housing stipends to behavioral health workers who deliver direct care services, particularly in underserved communities. Organizations used the funds to employ or contract with behavioral health care workers who hold an associate's, bachelor's, master's, or doctoral degree, or other recognized behavioral health certifications or credentials, and who provided direct behavioral health care to underserved communities. Organizations could not award retention bonuses alone and were required to also offer hiring or housing bonuses. Housing stipends of \$3,000 each were used primarily as a recruitment tool to help workers relocate to Oregon from out of state.

According to program staff, 20 organizations awarded 1,292 retention bonuses, 304 hiring bonuses, and 100 housing stipends (approximately \$300,000); these counts are preliminary, and organizations did not report bonuses in a consistent way. Final reporting data were not available for the current evaluation. A publicly accessible dashboard displays preliminary data current through June 30, 2026, and the program will be included in a subsequent evaluation.

## **Tribal Set-Aside: House Bill 2949 (2021) Tribal Milestones in the Behavioral Health Workforce**

The Nine Federally Recognized Tribes in Oregon and the Urban Indian Health Program (UIHP) face unique challenges recruiting, training, and retaining qualified behavioral health providers. Investments from House Bill 2949 (2021) have helped strengthen behavioral health systems in ways that are both foundational and equity centered. From hiring psychiatric nurse practitioners, counselors and substance use disorder professionals to offering sign-on and retention incentives, these resources help stabilize staffing and expand access to care. At the same time, Tribes are building internal capacity by supporting staff as they pursue licensure, certification, and advanced credentials, ensuring that services can be sustained and expanded from within their own communities.

Many Tribes have leveraged funding to secure licensed clinical supervisors, creating opportunities to mentor and advance the skills of counselors, peer support specialists, and substance use disorder providers. Clinical supervision plays a critical role in strengthening quality of care while supporting workforce development and creating pathways for professionals to continue serving communities with significant behavioral health needs. Funding has also helped Tribes establish and expand behavioral health services with appropriate clinical oversight, increasing access to care in rural and underserved areas while reducing workforce burnout and supporting long-term retention.

Culturally responsive training has been another key area of investment. Tribes have implemented trauma-informed care training, professional development opportunities, certification programs, and specialized instruction in areas such as suicide prevention, substance use treatment, and emerging therapeutic practices. Staff participation in conferences and advanced training opportunities has expanded clinical expertise while reinforcing culturally grounded approaches that reflect the values, strengths, and experiences of Tribal communities. Some Tribes have paired these workforce investments with practical supports such as housing and travel assistance, helping providers consistently deliver services in geographically remote areas.

These investments are supporting long-term, sustainable workforce growth by addressing immediate staffing needs while building resilient and culturally grounded behavioral health systems for the future. The milestones achieved through House Bill 2949 demonstrate that workforce investments do more than fill vacancies. They help strengthen systems of care, expand access to services, and support the health and well-being of Tribal communities for generations to come.

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## Appendix B: Evaluation Data Sources and Methods

### Appendix B - List of Abbreviations

| Abbreviation  | Definition                                                |
|---------------|-----------------------------------------------------------|
| <b>3RNet</b>  | National Rural Recruitment and Retention Network          |
| <b>AUHCN</b>  | Areas of Unmet Health Care Need                           |
| <b>BHLRP</b>  | Behavioral Health Loan Repayment Program                  |
| <b>BHWI</b>   | Behavioral Health Workforce Incentives                    |
| <b>CADC</b>   | Certified Alcohol and Drug Counselor                      |
| <b>CRNA</b>   | Certified Registered Nurse Anesthetist                    |
| <b>DDS</b>    | Doctor of Dental Surgery                                  |
| <b>DMD</b>    | Doctor of Dental Medicine                                 |
| <b>DO</b>     | Doctor of Osteopathic Medicine                            |
| <b>DPM</b>    | Doctor of Podiatric Medicine                              |
| <b>EOC</b>    | End of Contract                                           |
| <b>EOY</b>    | End of Year                                               |
| <b>FQHC</b>   | Federally Qualified Health Center                         |
| <b>HCPIP</b>  | Health Care Provider Incentive Program                    |
| <b>HCPLRP</b> | Health Care Provider Loan Repayment Program               |
| <b>HOWTO</b>  | Healthy Oregon Workforce Training Opportunity             |
| <b>HPSA</b>   | Health Professional Shortage Area                         |
| <b>HRSA</b>   | Health Resources and Services Administration              |
| <b>HWRP</b>   | Health Care Workforce Reporting Program                   |
| <b>IHS</b>    | Indian Health Service                                     |
| <b>MD</b>     | Doctor of Medicine                                        |
| <b>MHACBO</b> | Mental Health and Addiction Certification Board of Oregon |
| <b>ND</b>     | Doctor of Naturopathic Medicine                           |
| <b>NP</b>     | Nurse Practitioner                                        |
| <b>OAR</b>    | Oregon Administrative Rule                                |
| <b>OD</b>     | Doctor of Optometry                                       |
| <b>OHA</b>    | Oregon Health Authority                                   |
| <b>OHSU</b>   | Oregon Health & Science University                        |
| <b>OMB</b>    | Office of Management and Budget                           |

| Abbreviation      | Definition                                                                    |
|-------------------|-------------------------------------------------------------------------------|
| <b>ORH</b>        | Oregon Office of Rural Health                                                 |
| <b>PA</b>         | Physician Associate                                                           |
| <b>PCLF</b>       | Primary Care Loan Forgiveness                                                 |
| <b>PRISM</b>      | Provider Retention & Information System Management                            |
| <b>REALD SOGI</b> | Race, Ethnicity, Language, Disability, Sexual Orientation and Gender Identity |
| <b>RMPIS</b>      | Rural Medical Practitioner Insurance Subsidy                                  |
| <b>RPTC</b>       | Rural Practitioner Tax Credit                                                 |
| <b>SHOI</b>       | Scholars for Healthy Oregon Initiative                                        |
| <b>SLRP</b>       | State Partnership Loan Repayment Program                                      |

## ORH Participant Data

The Office of Rural Health (ORH) maintains individual-level administrative participant records for the following six programs, for the applicable reporting periods:

- Health Care Provider Loan Repayment Program (HCPLRP), 4/1/2018-6/30/2026
- Behavioral Health Loan Repayment Program (BHLRP), 7/1/21-1/31/22 and 7/1/24-6/30/26
- Primary Care Loan Forgiveness (PCLF), 4/1/2018-6/30/2026
- State Loan Repayment Program (SLRP), 12/21/22-12/31/23
- Rural Medical Practitioner Insurance Subsidy (RMPIS), 4/1/2018-6/30/2026) and
- Rural Medical Practitioner Tax Credit Program (RPTC), Tax Years 2018-2025.

These records include recipient discipline, credential type, award or credit amount, and service obligation practice site location (loan repayment and forgiveness programs only), current practice site (tax credit and insurance subsidy only).

## Loan Repayment and Forgiveness

### Methods

Loan repayment and forgiveness (HCPLRP, BHLRP, SLRP, PCLF) participant data was obtained from OHA. The following analytic variables were created from the participant data:

**Status.** Status of award variables were included in the data provided:

- **Applicant:** An individual who applied for the program but was not selected, or whose application was deemed incomplete at the close of the application cycle.
- **Applicant for Continuation:** A previous program participant who completed their prior service commitment and applied to be considered for a continuation award.
- **Awardee:** A current program participant who has been selected to receive an award.
- **Completed:** A former program participant who successfully fulfilled their service obligation and completed the program.
- **Continuation:** A previous program participant who completed their prior service commitment, applied for a continuation award, and was

awarded additional funding, making them a current program participant again.

- **Declined:** An individual who applied for the program was selected to receive an award but chose not to accept it.
- **Ineligible:** An individual who applied for the program, but whose application was determined to be ineligible according to program Oregon Administrative Rules (OARs).
- **Withdrawal:** A program participant who withdrew from the program before completing their service obligation.

In this evaluation, “**recipients**” included those who had one of the following statuses: awardee, completed, applicant for continuation, or continuation, unless otherwise specified. In the HCPLRP program, some additional awarded applicants received funding but later withdrew from the program prior to completing their service obligation. These individuals were determined by the “received” variable, which contained the amount of funding awarded to recipients. Those with any recorded funding amount were considered an awarded applicant, regardless of status. Current PCLF recipients (status “Recipient”) were further categorized as either “in school or residency” or “in service obligation” based on recorded service obligation start and end dates. Recipients without service obligation dates were considered in school or residency. Recipients were considered in service obligation if they had a service end date after June 30, 2026.

**Application year.** Application year was determined from the year of their date of application.

**Award year.** Year awarded is the year in which an applicant was awarded an incentive. This is distinct from the years of service obligation. PCLF recipients are awarded while still in school; therefore, their award year can precede the start of their service obligation by several years.

**Provider discipline.** Providers were assigned discipline categories (primary care, behavioral, health, oral health) which were created using provider type and specialty variables. Primary care includes physicians (medical doctors [MDs], Doctor of Osteopathic Medicine [DOs], and naturopathic doctors [NDs]), nurse practitioners (NPs), and physician associates (PAs), who reported a primary care specialty (family medicine or general practice, general internal medicine, geriatrics, pediatrics, or obstetrics and gynecology) per program eligibility. Pharmacists were analyzed separately from primary care in the HCPLRP and PCLF analyses by specialty. Behavioral health includes all licensed (licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, psychiatrists, psychologists, psychiatric mental health nurse practitioners, and certified alcohol and drug counselors

[CADC] III), pre-licensed (clinical social work associates, professional counselor associates, marriage and family therapy associates, and clinical or counseling psychology), and certified professions (qualified mental health associates, qualified mental health professionals, and CADC I-II), depending on program eligibility. Oral health professions included dentists, expanded practice dental hygienists, and dental assistants.

**Provider full- or part-time status.** Providers applying for loan repayment (HCPLRP, BHLRP, and SLRP only) reported their work status in the following categories:

- **Full-time:** minimum of 32 hours per week of direct patient care.
- **Part-time:** minimum of 16 hours per week of direct patient care.
- **Split full-time:** minimum of 32 hours per week of direct patient care, distributed across multiple approved practice sites.
- **Split part-time:** Minimum of 16 hours per week of direct patient care, distributed across multiple approved practice sites.

In our analysis, full-time and split full-time recipients were combined into a “full time” category of all recipients who reported a minimum of 32 hours per week of direct patient care. Part-time and split part-time recipients were combined into a “part-time” category of all recipients who reported a minimum of 16 hours per week of direct patient care.

**Provider location(s) Service Area rural-urban designations.** The street address, city, state, ZIP code, and county were provided on recipients’ primary (and if applicable second and third) practice location where they were completing their service obligation for program eligibility. Practice location zip codes were linked to Service Area using a ZIP code-to-Service Area crosswalk from ORH (version from May 2026).(1) This dataset included a “designation variable” that assigned each ZIP code as “urban”, “rural” or “Frontier” (referred to in the evaluation as remote) based on their ZIP code, and the Service Area of the ZIP code. The Service Area variable was also used to link provider locations to the Areas of Unmet Health Care Need Variables. See additional details below on the ORH rural-urban designation & AUHCN. Because some program recipients work in both rural and urban designated ZIP codes, the percent of recipients in urban and rural practice sites, when accounting for all practice sites reported, will not add up to 100%. Table 7 describes the number of practice sites reported by loan repayment and forgiveness recipients.

**Table 7. Number of service obligation practice sites reported by loan repayment and forgiveness recipients, 2018-2026**

| Number of Service Obligation Practice Sites        | HCPLRP     | BHLRP      | PCLF      |
|----------------------------------------------------|------------|------------|-----------|
| Total recipients reporting practice site locations | 321‡       | 113        | 75‡       |
| Total number of practice site reported             | <b>349</b> | <b>119</b> | <b>70</b> |

**Abbreviations:** HCPLRP – Health Care Provider Loan Repayment Program; BHLRP – Behavioral Health Loan Repayment; PCLF – Primary Care Loan Forgiveness. **Data Source:** ORH participant data for reporting period 4/1/2018-6/30/2026

\*Estimates may be statistically unreliable due to small numbers; interpret with caution.

‡Estimates suppressed due to small numbers; statistically unreliable.

‡One HCPLRP recipient missing any practice location information. Only 83 PCLF recipients from 2018-2026 were in their service obligation or completed service obligation, and among these, 8 were missing information on their service obligation practice site. All PCLF recipients only reported a primary practice site.

**Practice site type.** A variable on practice site type was provided in the participant data for HCPLRP and BHLRP recipients only. Categories of practice site type included Federally Qualified Health Care Centers (FQHCs), dental facility, clinic, rural health clinic (RHC), mental health, pharmacy, Tribal, Critical Access Hospital (CAH), corrections, naturopathic clinic, and other.

**Duration of service obligation.** For HCPLRP and BHLRP recipients, years of service obligation were calculated from dates of start of service obligation and end of service obligation variables. For continuation recipients, the year of ending service was the final year of the continuation. PCLF recipient data had a variable provided with the number of years of service.

**Demographic variables.** Demographic variables provided included race/ethnicity, languages used, and disability. Categories of race/ethnicity collected from applicants changed over time with changing REALD SOGI data collection requirements, requiring harmonization of responses from recipients that were collected over time. For example, in 2018, applicants were only asked 6 race/ethnicity categories and asked to check all that apply. Recipients were categorized using the 10 Race/ethnicity categories in the current application, using categories that aligned with the Office of Management and Budget (OMB) minimum race/ethnicity reporting categories:

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino/a/x/e
- Middle Eastern or North African

- Native Hawaiian or Pacific Islander
- White
- Multiracial
- Other
- Declined/Don't Know/Unknown

Because no data on primary race/ethnicity was available, individuals reporting multiple races were assigned to a biracial/multiracial category. Tables in the REALD SOGI Implementation Guide published by OHA was consulted for harmonizing responses from earlier applicants that had different categories compared with more recent race/ethnicity categories.(2) The reported languages used variable was used to determine which recipients reported using a language other than English, and the frequency of languages used among recipients. A single binary variable of “self-reported functional limitations” (true/false) was provided to indicate disability status.

**Total award amounts.** Award amounts (in dollars) were provided for all individual recipients. Continuation recipients also had an award for their continuation award. Total award amounts were calculated by summing the initial award amount and the amount of continuation awards (if applicable).

**Qualifying debt amounts.** Loan repayment applicants report their total qualifying debt when they first apply, and again if they apply for continuation. The amount of qualifying debt is used to calculate their award amount. However, data provided on qualifying debt was missing for over a third of HCPLRP recipients (38.8%, n = 125) and the majority of BHLRP recipients (93%, n = 105), so it was excluded from the report.

**Telemedicine utilization.** Beginning in 2025, loan repayment applicants were asked whether they provide care via telehealth and what proportion of their time was spent delivering telehealth services. However, the data provided for this evaluation included only a binary indicator of reported telehealth use (yes/no), indicating whether applicants provided at least some care via telehealth. Because these questions were introduced recently, telehealth data were available for only a subset of recipients (19.9 percent of HCPLRP recipients and 52.2 percent of BHLRP recipients). Given the lower coverage of responses, additional telehealth data was obtained from the HWRP. See details below.

## Limitations

For the loan repayment and forgiveness programs, ORH participant data provides the most complete source of information on program recipients. However, how this data are maintained introduces limitations for this evaluation. Individual participant data overwrites each time a participant's status changes with ORH (e.g., from applicant to recipient, completion of a

service obligation, application for a continuation award, or withdrawal) or applies to another ORH managed incentive program, rather than preserving data of participants over time. This practice results in the loss of historical data, limiting the ability to track changes in participants' status, practice site locations, and reported outstanding debt over time. It also complicates analysis by requiring analysts to account for different versions of the data and limits comparability across evaluation periods. Given this, findings based on this data should be interpreted as a point-in-time snapshot rather than directly compared with findings from previous evaluations that used prior versions of the data used.

Rural practice site eligibility (PCLF obligation practice sites must be in a rural area) may differ slightly from the rural definition used in this evaluation, which used area ZIP code based rural-urban designation using a ZIP code crosswalk obtained from ORH.<sup>(1)</sup> However, Oregon's rural definition, *any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more*, may not perfectly align with ZIP code boundaries, causing potential misclassification. The data included a "Community Type" variable indicating the urban-rural location of practice sites. However, this variable was missing for 27 out of 83 (32.5%) of PCLF recipients who were completing or had completed their service obligation. Given the extent of missing data and the need for a consistent approach to rural-urban designation throughout the evaluation, this variable was not used.

Only data on a primary site was provided for PCLF recipients. Data on up to three practice sites was provided for HCPLRP and BHLRP recipients. Providers with more than one or three practice sites respectively will not have those additional sites accounted for in this analysis. None of the loan repayment or loan forgiveness programs collected data on hours of direct patient care.

ORH participant data also did not include Race, Ethnicity, Language, Disability, and Sexual Orientation and Gender Identity (REALD SOGI) variables data for most programs; however, it does include other demographic variables, including race/ethnicity, languages used, and disability status.

## Rural Medical Practitioner Insurance Subsidy

### Methods

RMPIS participant data was obtained from OHA covering a reporting period of 4/1/2018-6/30/2026. A separate datafile which included demographic data collected from recipients from October 2024 – March 2026 was also provided.

Data on recipients was available for each year they were eligible for the subsidy. An analytic data file was created using anonymized recipient IDs to identify unique recipients and calculate the total number of years each was eligible. Separate indicator variables were created to identify eligibility for each

year between 2018-2026. The most recent response for discipline, practice site location, and weekly hours worked was selected for each unique recipient.

The following analytic variables were created from the participant and demographic data:

**Provider type.** Recipient provider types were classified using discipline and specialty variables. The discipline variable (MD, DO, NP) grouped physicians (MD and DO) and NP categories. Data on provider specialty was merged with data on credit percentages awarded by specialty to assign each recipient to their expected credit percentage based on their reported specialty.

**Provider location(s).** The street address, city, state, ZIP code, and county were provided on recipients' primary (and if applicable second) practice location reported for program eligibility. Provider ZIP codes were classified as rural using a ZIP code-to-Service Area crosswalk from ORH that assigned each ZIP code as "urban", "rural", or "frontier" (referred to as remote in this evaluation).(1) About one in ten recipients (12.2%, n = 119) reported a secondary practice location.

**Reported average weekly hours/rural weekly hours.** Recipients reported the average weekly hours they worked at their primary (and if applicable secondary) practice site(s). For recipients who worked at two practice sites, average weekly hours were calculated by summing the average weekly hours reported at both practice sites. Rural average weekly hours were calculated for each participant was calculated by summing the average weekly hours worked only at practice sites that were designated rural or remote. This variable did not specify if these reported hours were for direct patient care only.

**Demographic variables.** Demographic data was collected on recipients from October 2024 – March 2026 and included responses from 423 recipients (88.7% of 477 recipients from 2024-2026, 43.3% of 978 recipients from 2018-2026). Because recipients appear to have responded multiple times to the demographic survey (multiple responses per unique recipient ID numbers), the most recent response from each recipient ID was selected for analysis. Available race/ethnicity variables included an open-ended race/ethnicity question, a select-all-that-apply racial and ethnic category question with subcategories (Which of the following describes your racial or ethnic identity? Select all that apply), and a question asking respondents who selected multiple categories whether they identified with one category as their primary racial or ethnic identity. Using the responses from the select-all-that-apply race/ethnicity category variable, respondents were aggregated into the following categories:

- **American Indian or Alaska Native** (includes American Indian, Alaska Native, Canadian Inuit, Métis, or First Nation, Indigenous Mexican, and other American Indian/Alaska Native)

- **Asian** (includes Asian Indian, Chinese, Filipino/a, Hmong, Japanese, Korean, Laotian, South Asian, Vietnamese, Other Asian, and other Asian)
- **Black or African American** (includes African American, African (Black), Caribbean (Black), Other Black, and other Black/African American)
- **Hispanic or Latino/a/x/e** (includes Mexican, Central American, South American, Other Hispanic or Latino/a/x, and other Hispanic/Latino/a/x/e)
- **Middle Eastern or North African** (includes Middle Eastern, Northern African, and other Middle Eastern/North African)
- **Native Hawaiian or Pacific Islander** (includes Native Hawaiian, Guamanian or Chamorro, Micronesian, Samoan, Tongan, Other Pacific Islander, and other Native Hawaiian/Pacific Islander)
- **White** (includes Eastern European, Slavic, Western European, Other White, and other White)
- **Other** (includes Other Categories and any race, ethnicity, or identity not captured above)
- **Don't Know/Unknown** (includes Don't Know, Unknown, Prefer Not to Answer, and missing responses, if applicable)

The primary race/ethnicity indicator variable, those who responded “No. I identify as Biracial or Multiracial” were categorized into the “Multiracial” group.

Responses to the question “What language(s) do you use at home?” were used to identify recipients who reported speaking a language other than English at home and to calculate the frequency of languages reported. Variables on recipients reported disability/functional limitation were available and frequencies were calculated, but the results of these analyses were suppressed due to small numbers.

## Limitations

Data on RMPIS recipients is collected annually at the time an individual initially applies or reapplies for program eligibility. When providers stop reapplying for this program, they are no longer tracked in the participant data. This limits the ability to track provider retention in rural areas, and the reasons individuals no longer continue to reapply (e.g. leaving an eligible rural practice location versus choosing not to reapply while remaining in rural practice). Available data was limited to subsidy credit percentages, not the subsidy amounts applied for individual recipients. This also limits the ability to track changes in the total amounts credited in the program data. Oregon license numbers are not collected from applicants, so linkage to the HWRP data was not available for

this program. Reported hours at each practice site did not specify the proportion of reported hours that were direct patient care hours. Rural practice site eligibility may differ from the rural definition used in this evaluation, which used the ZIP code based rural-urban designation. Additionally, only a primary and secondary practice site were provided in the data. Providers with more than two practice sites will not have all practice locations accurately accounted for in this evaluation and our determination of rural eligibility. This data also did not include current REALD SOGI variables, but the demographic data collected starting in October 2024 provides a more comprehensive collection of race, ethnicity, language, and disability variables than loan repayment or forgiveness.

## Rural Practitioner Tax Credit

### Methods

RPTC participant data was obtained from OHA covering a reporting period of 1/1/2018-12/31/2025 (tax years 2018-2025). Data are collected from recipients each year they apply/reapply to receive the tax credit. More than five recipients associated with tax year 2026 were included in the data provided to the evaluators but were excluded from the analysis.

The following analytic variables were created from the participant data:

**Years of participation.** Each recipient had one row of data for each year they received the tax credit. Number of years and each year (2018-2025) a recipient received the credit was calculated for each recipient based on the tax year variable.

**Provider discipline.** Provider discipline (MD, DO, DPM, DDS, DMD, NP, PA, OD, CRNA) was provided. Physicians (MD and DO) and dentists (DDS and DMD) were grouped into single physician and dentist categories.

**Provider location.** Provider's primary practice site name, street address, city, and county were included in the participant data only. ZIP codes were matched to addresses using the U.S. Census Geocoder, and unresolved addresses were searched using Google Maps.(3,4) Provider ZIP codes were linked to a rural-urban variable using a ZIP code-to-Service Area crosswalk from ORH to assign practice ZIP codes as "urban", "rural", or "remote".(1) Provider locations from their most recent eligible tax year were used to calculate the counts and providers by geographic variables.

**Amounts credited.** A variable with the dollar amount credited to each provider each year they received the credit was used to calculate the total amount credited to each provider over the time of their participation in the program, over each year, and total over the entire reporting period.

## Limitations

Data from the RPTC is considered less reliable for tax years after 2023 because taxpayers may still amend prior returns, though 2024 and 2025 figures will be reported with this limitation noted. Rural practice site eligibility may differ from the rural definition used in this analysis, which used a ZIP code-based rurality definition. Available data only included a primary practice site. Providers with more than one practice site do not have all their practice locations accurately described in this data, in particular the sections on rural program eligibility. The data on this program did not include any REALD SOGI variables.

## Scholars for Healthy Oregon Initiative

OHA provided the evaluation team with pre-aggregated data on the Scholars for Healthy Oregon Initiative (SHOI) covering a reporting period from the 2018/2019 to 2025/2026 academic years. These tables included data on awards across disciplines, specialty of recipients by discipline, service commitment location, place of origin, total funding to awardees by year and discipline, sex (male, female, no response/unknown), ethnicity (Hispanic or Latino, Not Hispanic or Latino, unknown), race (Black or African American, White, American Indian or Native Alaskan, Native Hawaiian or other Pacific Islander, Korean, Vietnamese, more than one race, unknown, other), and counts of withdrawals/dismissals/defaults from the program. Data from these pre-aggregated tables were summarized and presented in the main evaluation report. Retention analyses on SHOI recipients were conducted by OHA with HWRP data and presented in the main evaluation report.

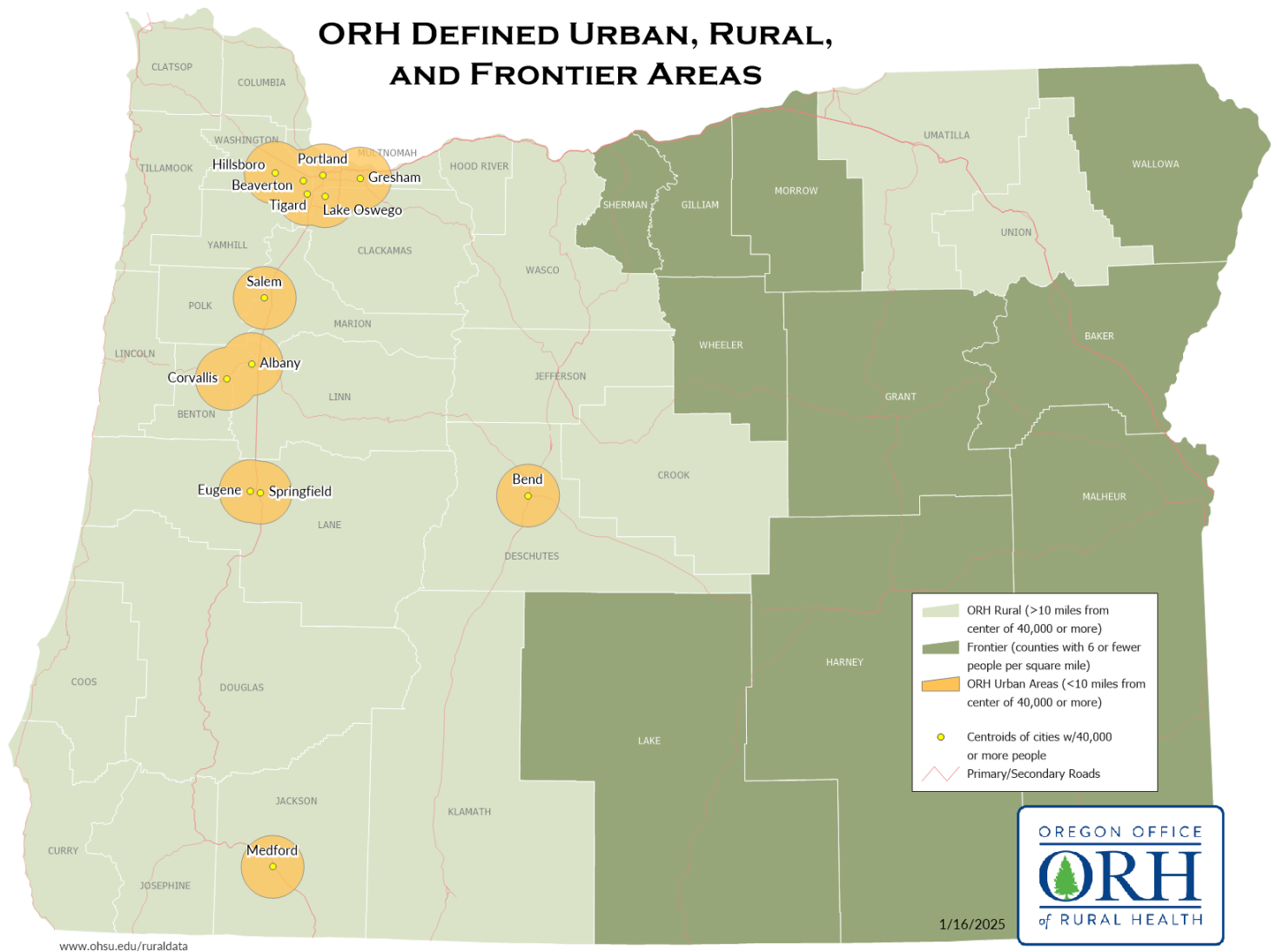
## Oregon Rural-Urban Designation

ORH uses the following definitions to classify rural areas within Oregon:

- **Rural** indicates any geographic area in Oregon 10 or more miles from the centroid of a population center of 40,000 people or more.
- **Remote** indicates any county with six or fewer people per square mile. Ten Oregon counties are considered remote (also referred to as “frontier” by ORH).

Rural areas include remote areas (shown in light and dark green in Figure 3), while urban areas encompass all areas not classified as rural or remote (shown in yellow in Figure 3). In this analysis, the collective term “rural” was used to refer to all rural areas including the remote counties, unless otherwise specified.

**Figure 3. Map of ORH Designated Urban, Rural, and Frontier Areas, January 2025.**



**Data Source: Oregon Office of Rural Health, version 1/16/2025. “Frontier” areas in this map were referred to as “remote” in this evaluation.**

We used a ZIP code-to-Service Area crosswalk developed by ORH (version from May 2026).(1). The crosswalk contained a “designation” variable that classified ZIP codes as “urban”, “rural” or “frontier” (which we referred to as remote to conform with terminology used in the 2026 AUHCN data). Recipient practice site location(s) ZIP code(s) were linked to a designation using the crosswalk.

## Limitations

Programs that require rural practice for eligibility (PCLF, RMPIS, RPTC) utilize the Oregon rural definition of any geographic area in Oregon ten or more miles from the centroid of a population center of 40,000 people or more; however, these areas may not completely align with ZIP code boundaries that were used

in this analysis to classify providers location as urban or rural, so some misclassification of rural and urban providers is possible.

## Health Care Workforce Reporting Program (HWRP) Data

The Health Care Workforce Reporting Program (HWRP) data was used to describe characteristics and retention of recipients of HCPLRP, BHLRP, and PCLF, and SHOI. The HWRP collects data annually from licensed health care providers during license renewal. Licensure information, including Oregon license numbers and National Provider Identifiers (NPIs), for all loan repayment and forgiveness recipients was provided to HWRP, which subsequently provided the evaluation team with two data files:

- A data file that included longitudinal data (dated 2016-2026) of providers primary (and secondary if applicable) practice address, city, county, state, and ZIP code in each year.
- A current year (2026) data file containing variables on direct patient care hours and telehealth utilization among HWRP respondents.

HWRP data could not be linked to some program recipients who were missing their license numbers or who were pre-licensed or certified professionals. The HWRP does not collect data on certified professions or professionals before obtaining licensure. Details on data coverage available from the HWRP are described in Table 8.

**Table 8. Percent of HCPLRP, BHLRP, and PCLF recipients included in HWRP data analyses**

| HWRP Analyses                             | HCPLRP | BHLRP | PCLF  |
|-------------------------------------------|--------|-------|-------|
| Total Recipients                          | 322    | 113   | 117   |
| Retention analyses*                       | 54.0%  | 16.8% | 40.2% |
| Provider characteristics, overall linkage | 85.1%  | 42.5% | 65.8% |
| Characteristic: Weekly patient care hours | 80.1%  | 38.1% | 51.3% |
| Characteristic: Telehealth usage          | 55.9%  | 38.1% | 10.2% |

**Abbreviations:** HCPLRP – Health Care Provider Loan Repayment Program; BHLRP – Behavioral Health Loan Repayment Program; PCLF – Primary Care Loan Forgiveness. **Data Source:** Health Care Workforce Reporting Program (HWRP) data practice location data, 2016-2026; HWRP current year data on provider characteristics, 2026.

\*Excludes recipients who did not complete their program’s service obligation by 2025 to be eligible for the minimum 1-year retention analyses.

†Response rates to individual fields in the provider characteristics varied.

## Methods

**Retention analyses.** For each provider, a baseline, one-year, two-year, three-year, and five-year follow up year was calculated based on the year recipients completed their service obligation (baseline). Only providers who had completed their service obligation by 2025 were included in the retention

analysis to allow for at least one year of follow-up after completion of their service obligation. Baseline practice locations were determined from the service locations provided in the ORH participant data. Provider practice location ZIP codes were assigned as “urban” or “rural” and assigned to their Service Area using a ORH ZIP code-to-Service Area crosswalk, previously described. Retention was evaluated at one-, two-, three-, and five-year intervals following completion of the participant's service obligation. For each follow-up interval, annual practice locations were matched to primary and secondary baseline locations using an “any-location match” approach. Participants were classified as retained if any baseline practice location matched any follow-up practice location for the geographic unit under evaluation. Retention was assessed at three geographic levels:

- State retention: retained in Oregon compared to baseline.
- County retention: retained in the same county as baseline.
- Service Area retention: retained in the same Service Area as baseline (results described in appendix E).

Because the HWRP primarily tracks the health care workforce licensed in Oregon, retention at the county, service area, and rural/urban levels were interpreted as retention measures within Oregon’s healthcare workforce. For each year of HWRP data, a match flag variable was included with practice location information that indicated if for a particular year the provider’s practice location was:

- 1 = matched
- 2 = unmatched.

The data dictionary noted that for a particular year, some recipients may have a match flag = 1 (matched) but having missing location data, which indicated that their license number, but not their location data, was found in the HWRP database.

Using a combination of the comparison of baseline to follow-up location and the match\_flag variables, a retention variable for each participant was coded as the following:

- Not retained (0): Baseline & comparison location different
- Retained (1): Baseline & comparison location the same.
- Not linked to OR licensure data (2): Match Flag = 2
- Linked but location unknown (3): Match Flag = 1 but location information missing
- Follow-up not yet observable (4): Year needed for follow up beyond 2026 (latest year of HWRP data available).

Because location information was unknown or not yet available for comparison, individuals with retention variables coded as 3 or 4 were excluded from the retention analyses at each follow-up point. Because recipients who could not be linked to HWRP data (coded as 1) likely no longer held Oregon licensure (required to practice in Oregon), they were grouped with recipients whose practice locations differed between baseline and follow-up (coded as 0). Together, these recipients were classified as “Not Retained. This was done with the rationale that providers observed no longer practicing in Oregon could also no longer be retained within their baseline Oregon county, Service Area, or Oregon rural/urban designation.

Retention rates were calculated as:

$$\text{Percent Retained} = \frac{\text{Retained (coded as 1)}}{\text{Not Retained (coded as 0 or 2) + Retained (coded as 1)}}$$

Retention results at the state (within Oregon) and county level are presented in the main report. Results at the Service Area level are presented in Appendix E.

Retention rates were also calculated distinctly for recipients with baseline rural and urban practice locations. Recipients baseline practice location (at the end of service obligation) ZIP Code was classified as urban or rural (including rural and remote ZIP codes). Practice location ZIP codes at one, two, three, and five years were similarly classified. Rural-origin retention assessed whether providers with at least one baseline rural practice location maintained at least one rural practice location at each follow-up interval. Urban-origin retention assessed whether providers with at least one baseline urban practice location maintained at least one urban practice location follow-up.

Retention was again evaluated at one-, two-, three-, and five-year follow-up intervals using the any-location match approach. Similarly, providers with both rural/remote and urban follow-up locations were considered retained if they maintained at least one practice location within their original practice setting. As a result, rural-origin retention reflects maintenance of any rural/remote practice location, while urban-origin retention reflects maintenance of any urban practice location.

**Provider characteristics.** Current year HWRP data was also used to provide supplementary information on provider characteristics, namely reported average weekly clinical hours and telehealth usage. In the HWRP, providers report the average weekly hours spent in direct patient care at their primary and secondary practice sites. The total weekly hours spent on direct patient care summed the clinical hours spent at the primary and secondary practice sites. Overall average and standard deviation of weekly hours on direct patient care, and by provider type (based on the provider type variable linked from the ORH participant data) were calculated.

This report includes two variables about telehealth usage, derived from the following reporting questions:

- 1) Licensee utilizes tele practice at their primary/secondary practice location (Yes, No)
- 2) Describe your telehealth practice (at primary/secondary practice location): Does your telepractice provide care for Oregon clients? (yes/no)

This second variable was calculated from four follow-up questions:

- 1) Describe your telehealth practice: Based in Oregon, care for Oregon clients.
- 2) Describe your telehealth practice: Based in Oregon, care for clients outside of Oregon.
- 3) Describe your telehealth practice: Based outside of Oregon, care for Oregon clients.
- 4) Describe your telehealth practice: Based outside of Oregon, care for clients outside of Oregon.

Participants who selected either the response option 1 (“Based in Oregon, care for Oregon clients”) or option 3 (“Based outside of Oregon, care for Oregon clients”) were classified as providing care for clients in Oregon, regardless of the provider’s location. Variables on telehealth usage are not collected by the HWRP from physicians or physician associates.

## **Limitations and Data Gaps**

The HWRP data provided some key supplementary data for the evaluation of loan repayment and forgiveness programs. It was a key source of provider’s location information to follow post-service obligation retention and information on clinical hours and telehealth usage.

However, this data source has some key limitations. First, the HWRP will only have location information on recipients for as long as they are annually renewing their licenses in Oregon. Providers who move out of state and no longer maintain their Oregon licensure will not be tracked in HWRP data. In this analysis, it was assumed that individuals no longer matched to the HWRP data were likely no longer in the Oregon health care workforce, and therefore, not retained in Oregon or their county or service area of origin. Using the `match_flag` variable, we attempted to distinguish providers who are no longer licensed in Oregon from those who are licensed but are missing location data. However, this likely is a conservative estimate of true retention because it includes providers who may not have data in HWRP for another reason. HWRP also does not track pre-licensed or certified professions, particularly in behavioral health, which are eligible for loan repayment programs. Rates of

linkage of incentive recipients to the HWRP data varied by program. The BHLRP program had low rates of linkage to HWRP data because it has many pre-licensure and certified professions eligible for this incentive. It is also recently resumed program, and many recipients were excluded from the retention analyses because they had not completed their obligation by 2025. HWRP also does not collect data on telehealth usage from physicians and physician associates, which are a large portion of loan repayment and forgiveness recipients.

## ORH Areas of Unmet Health Care Need (AUHCN) Maps

The AUHCN is a score that is used to rank the availability, affordability and utilization of primary physical, dental and mental health care in each of Oregon's 128 primary care Service Areas. The score is updated and published in a report each year by the ORH.<sup>(5)</sup> The AUHCN total score uses nine variables that measure primary, dental and mental health care availability, affordability and utilization to rank each Service Area. The lowest and worst total score possible is zero. The highest and best score possible is 90. *A lower score means an area has greater unmet need.*

This evaluation used three of the nine component variables from the 2026 AUHCN scores to classify Service Areas into categories of need based on different provider disciplines (primary care, behavioral health, oral health). These variables were chosen because they related to the availability of providers in the Service Area. For each variable, the 2026 overall score for Oregon was used to create binary variables:

- **Primary Care:** *Primary care capacity ratio or the percent of primary care visits able to be met.* A ratio less than 1 indicates the supply of primary care providers is insufficient to meet demand while a score greater than 1 indicates the supply of primary care providers exceeds demand. (Oregon overall ratio: 0.99)
- **Behavioral Health:** *Mental health provider FTE per 1,000 population* (Oregon: 1.40 mental health provider FTE per 1,000 population)
- **Oral Health:** *Dentists FTE per 1,000 population* (Oregon overall: 0.47 dentist FTE per 1,000)

## Limitations

The AUHCN score provides a composite score that ranks Oregon Service Areas by the availability, affordability and utilization of primary physical, dental and mental health in a single year, and scores for each Service Area change over time as measurements of unmet need change. Data for this evaluation only used the 2026 AUHCN scores to compare the distribution of recipients who were awarded incentives from 2018-2026. Most programs have preferred

placement or retention of recipients in areas of unmet health care need, but the placement or retention of these providers in these areas will have effects on the scores of unmet need in future years.

## Provider Retention & Information System Management (PRISM)

The Provider Retention & Information System Management (PRISM) surveys are administered to loan repayment (HCPLRP and BHLRP only) and forgiveness (PCLF) recipients. The survey is developed and managed by 3RNET in partnership with Cecil G. Sheps Center for Health Services Research at University of North Carolina. Recipients are surveyed multiple times: at the beginning of their service obligation (start of service survey), at the end of each service year (end of year survey - EOY), at the completion of their service obligation (end of contract survey - EOC), and annually thereafter (alumni survey). This survey provides wide-ranging self-reported data on provider characteristics (provider discipline, demographics), financial/loan information, their current work practice and characteristics, their work hours and patient visits, the patient population they serve, recipient satisfaction and wellbeing, and their anticipated plans to remain in various aspects of practice as their service obligation. The exact coverage of variables differs by survey.

Summary reports and abbreviated data files were provided to the evaluation team, covering a reporting period of 4/1/2018-3/31/2016. These files included the EOY, EOC, and alumni surveys. Some demographic variables originally obtained from the start-of-service surveys were included in the EOY/EOC and alumni datafiles, but the entire original start-of-service survey could not be analyzed due to time and resource constraints. The evaluation team was also provided a distribution response report that provides insights into the rates of responses for various PRISM surveys. Response rates to the PRISM surveys were calculated by the evaluation team are described in Table 9. Response rates to individual survey questions vary from entire survey response rates.

**Table 9. Response rates to PRISM surveys by program, 4/1/2018 - 3/31/2026.**

| PRISM Survey             | Number of Responses* | Number of Surveys Sent† | Response Rate |
|--------------------------|----------------------|-------------------------|---------------|
| HCPLRP – End of Year     | 93                   | 464                     | 20.0%         |
| HCPLRP – End of Contract | 102                  | 190                     | 53.7%         |
| HCPLRP – Alumni          | 55                   | 198                     | 27.8%         |
| BHLRP – End of Year      | 22                   | 140                     | 15.7%         |
| BHLRP – End of Contract  | 23                   | 50                      | 46.0%         |
| BHLRP – Alumni           | 29                   | 169                     | 17.2%         |
| PCLF – End of Contract   | 20                   | 26                      | 76.9%         |
| PCLF – Alumni            | 14                   | 90                      | 15.6%         |

**Abbreviations: HCPLRP – Health Care Provider Loan Repayment Program; BHLRP – Behavioral Health Loan Repayment Program; PCLF – Primary Care Loan Forgiveness. Data Source: PRISM**

distribution response report from a reporting period of 4/1/2018 - 3/31/2026.

\*Obtained from the number of unique clinician IDs in the applicable PRISM data files and summary reports.

†Obtained from the “total first sent” column from distribution report, which includes all individuals sent the initial invite to participate in the survey, excluding those who could not be contacted to participate.

## Methods

Due to time and analytic constraints, most PRISM data utilized in the evaluation was obtained from the summary reports downloaded by OHA from the PRISM portal. Some additional by variable analyses were run using the raw data files downloaded from the PRISM portal.

**Provider type.** Provider type variable (discipline\_category\_id) was included in the EOY, EOC, and alumni survey data. Clinicians were classified into the following categories by PRISM:

- Physician
- Physician associate
- Nurse practitioner
- Dentist
- Other dental
- Mental health
- Other
- Undefined

Provider type variable was used to calculate responses to other variables, such as years anticipated remaining in various practice domains, by provider type.

**Practice setting.** Provider practice setting type (practice\_category\_id) was included in the EOY, EOC, and alumni survey data. Practice settings were classified into the following categories by PRISM:

- FQHC, community and migrant health center
- Rural health clinic
- IHS or Tribal site
- Health department
- Prison
- Mental health and substance use disorder facility
- Office based clinic or practice
- Another practice type

- Undefined

The practice setting variable was used to calculate responses to other variables, such as years anticipated remaining in various practice domains, by practice setting.

**Race/ethnicity.** A race/ethnicity category variable (RaceEthnicityId) was included in the EOY, EOC, and alumni survey data. This variable was originally surveyed from respondents at the start of service survey. race/ethnicity were pre-aggregated and classified into the following categories by PRISM:

- American Indian or Alaska Native
- Asian
- Black or African American/Black
- Hispanic or Latino/Latina (referred to as Hispanic or Latino/a/x/e in the report)
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- White
- Other
- Multiracial

This race/ethnicity category variable was used to calculate responses to other variables, such as years anticipated remaining in various practice domains, by race/ethnicity. In reporting these results, the race/ethnicity category names created by PRISM were replaced by the preferred category names used by OHA, in REALD SOGI reporting guidelines.(2)

**Average weekly clinical hours.** The EOY and EOC PRISM survey included a question that asked respondents to report their “average hours per week spent on clinical work (excluding on-call).” Means and medians of this variable were calculated overall and by provider characteristics.

**Anticipated years remaining in practice by various domains.** The EOY and EOC surveys included questions asking respondents to self-report a single best-estimate of the number of years they anticipated remaining in the following:

- Current practice
- Current community
- Rural practice (only asked if current practice in rural areas)
- A medically underserved area
- Oregon

Means and medians of this variable were calculated overall and by provider characteristics.

**Alumni reported retention following service obligation completion.** Alumni surveys included various questions on current practice following completion of obligation that assist with tracking recipient reported retention in various ways. Alumni were asked to provide information on their current practice site, whether it was the same practice site, the same organization but a different site, in the same state, in a federally designated Health Professional Shortage Area (HPSA), in a state designated shortage area, and/or in a safety net organization compared to their obligation practice site. Alumni are asked these questions at repeated intervals, allowing for tracking of reported retention of program alumni by these domains.

The limited alumni survey data files provided to the evaluation team did not include the exact current practice locations of alumni, or the variables of retention at various time points. Summary results of these variables were obtained from summary tables describing alumni survey results for each program from the PRISM portal. Because these were pre-calculated results from the PRISM portal, further sub-analyses could be calculated.

## Limitations and Data Gaps

PRISM surveys are a rich data source that collects key data from HCPIP loan repayment and forgiveness recipients at multiple time points during and after their participation in their programs. However, the number of questions asked in each of these surveys likely also impacts the response rates and representativeness of their results. Most of the PRISM surveys have calculated response rates <50% (Table 9), so they are subject to non-response bias if the individuals who did not respond to the surveys differ from respondents on key characteristics analyzed. Some questions, such as the anticipated years they expect to remain in various domains of practice, may also be subject to desirability bias. Only end of contract and alumni survey data are available for primary care loan forgiveness, not providing any data on current PCLF awardees in service obligation.

## ORH Survey

A supplemental qualitative survey fielded in 2026 for the loan repayment (HCPLRP, BHLRP), loan forgiveness (PCLF) and Insurance Subsidy (RMPIS) Programs. The online surveys collected insights from current program recipients and recipients about their perceptions and experiences with each program, including perceived benefits and recommendations for improvement. The surveys were open to responses from 5/20/2026 to 6/8/2026, respondents received two reminders and had response rates of 7.3% from HCPLRP and BHLRP recipients, 6.9% from PCLF recipients, and 15.1% from RMPIS recipients.

Because of low response rates, findings are subject to nonresponse bias and may not represent the entire population of recipients.

## Grantee Data Reporting

OHA provided reporting data from the grantee educational institutions and community-based organizations who received funding for the following programs (and covering the following reporting periods):

- Healthy Oregon Workforce Training Opportunity (HOWTO, March 2019 – December 2025),
- Health Care Workforce Scholarships program (January 2019-December 2025),
- Health Care Workforce Career Pathways program (June 30-December 31, 2025),
- Health Care Interpreters Retention Incentives (June 30-December 31, 2025), and
- Behavioral Health Retention Incentives (June 30-December 31, 2025).

The evaluation team received grantee reporting data at the individual recipient-level for the Health Care Workforce Scholarships, Health Care Workforce Career Pathways program, the Health Care Interpreters Retention incentives, and the MHACBO incentives. Data for two programs, SHOI and HOWTO, were provided to the evaluation team as pre-aggregated reporting data, rather than individual-level data. Only the Health Care Workforce Scholarships, Career Pathways, Health Care Interpreter Retention programs collected individual-level REALD SOGI data on recipients, though some of these programs only collected REALD SOGI data for limited reporting periods.

## Methods

Because of heterogeneity between grantee reporting data provided to evaluators, data methods for each program are described individually. Methods that were similar across program are noted.

**HOWTO.** Grantee reporting data on HOWTO grantees and participants was provided to the evaluation team as pre-aggregated, pre-calculated tables. The SHOI reporting data covered a reporting period from the 2018-2029 to 2025-2026 school years. The HOWTO reporting data covered a reporting period of 3/1/2019-12/31/2025. These tables included an awards summary (providing the grantee organizations, start and end dates, amounts awarded per grantee, and project descriptions for six rounds of funding), and a summary metrics table (providing summary counts of three categories of HOWTO participants served – new workers trained, incumbent workers training for additional skills, and high

school student opportunities – overall and by category). For both programs, grantee reporting data was summarized in tables and charts.

**Health Care Workforce Scholarships.** Grantee reporting data for the Health Care Workforce Scholarships provided individual-level recipient data for the 2019-2021, 2021-2023, and 2023-2025 biennia separately. Grantee data varied across the biennia.

Because the program from 2019-2021 required recipients to complete a service obligation, similar to the SHOI program, the 2019-2021 data included each recipient's prospective degree, their school, their program status (awardee, completed, withdrawal), the start & end dates of their service obligation period, and obligation practice site information (name, city, ZIP code, county, and facility type, community type). No individual level award amount data was provided for the 2019-2021 biennium recipients.

The 2021-2023 and 2023-2025 data included each recipient's input date, their school, their educational program, any certifications they will be obtaining, graduation date, scholarship amount, and award date. Recipients receiving more than \$35,000 were required to complete a service obligation in the 2021-2023 and 2023-2025 biennia, so years of service obligation were summarized for these recipients. Descriptive statistics (counts and percentages of recipients) were calculated for all years overall, by prospective degree program, and school, and summary statistics were calculated for total and average award amounts, overall, by school, and by degree program.

REALD SOGI data was collected on scholarship recipients only in the 2021-2023 and 2023-2025 biennia. There were a total 295 responses with REALD SOGI demographic data, covering 79.5% of all recipients in those years (N = 371). Using the responses from the select all that apply race/ethnicity category variable, the distribution of total reported races, alone or in combination, was calculated. Using a variable that allowed responded to select their primary race/ethnicity was used to calculate a primary race/ethnicity distribution. A third, primary race/ethnicity indicator variable, was used to categorize those who responded "No. I identify as Biracial or Multiracial" were categorized into a "Multiracial" group in the primary race/ethnicity distribution. In both analyses, responses were aggregated into the following categories:

- **American Indian or Alaska Native** (includes American Indian, Alaska Native, Canadian Inuit, Métis, or First Nation, Indigenous Mexican, and other American Indian/Alaska Native)
- **Asian** (includes Asian Indian, Chinese, Filipino/a, Hmong, Japanese, Korean, Laotian, South Asian, Vietnamese, Other Asian, and other Asian)
- **Black or African American** (includes African American, African (Black), Caribbean (Black), Other Black, and other Black/African American)

- **Hispanic or Latino/a/x/e** (includes Mexican, Central American, South American, Other Hispanic or Latino/a/x, and other Hispanic/Latino/a/x/e)
- **Middle Eastern or North African** (includes Middle Eastern, Northern African, and other Middle Eastern/North African)
- **Native Hawaiian or Pacific Islander** (includes Native Hawaiian, Guamanian or Chamorro, Micronesian, Samoan, Tongan, Other Pacific Islander, and other Native Hawaiian/Pacific Islander)
- **White** (includes Eastern European, Slavic, Western European, Other White, and other White)
- **Other** (includes Other Categories and any race, ethnicity, or identity not captured above)
- **Don't Know/Unknown** (includes Don't Know, Unknown, Prefer Not to Answer, and missing responses, if applicable)

The variable “what language(s) do you use at home?” was used which recipients reported speaking a language other than English at home, and the frequency of languages used at home among recipients.

Variables on recipients reported disability/functional limitations were available for the 2021-2023 and 2023-2025 biennia. Frequencies of total disabilities reported, alone or in combination, were calculated, but the results of these individual disability analyses were suppressed due to small numbers. The number of individuals reporting any disability and the frequencies of the number of disabilities reported were calculated for respondents.

Data on gender identities was only collected from 2023-2025 recipients, including 140 responses, 69.7% of scholarship recipients from 2023-2025. Distribution of gender identities reported, alone or in combination, were calculated.

**Health Care Workforce Career Pathways.** Grantee reporting data for the Health Care Workforce Scholarships provided individual-level recipient data covering reporting period 6/30/25-12/31/2025. This data included variables on each recipients' academic institution, sub-program, post-secondary school acceptance/plans for future (only for one grantee's recipients), anticipated graduation (if applicable), scholarship amount, and award date. Summary statistics were calculated with these variables include total number of recipients and the number of recipients, total and average amount awarded overall and by grantee organization and sub-program, total amount awarded.

REALD SOGI data was collected on pathways scholarship recipients during the full reporting period and includes 364 responses (77.8% of a total of 468 recipients). Analysis of REALD SOGI variables was the same as the Health Care Workforce Scholarship program, see above for detailed methods.

**Health Care Interpreters Retention Incentives.** Grantee reporting data for the interpreters retention incentive provided individual-level recipient data covering reporting period 6/30/25-12/31/2025. The data provided for this program covered three grantee organizations:

- Medical Interpreting Training School,
- Oregon Health Care Interpreters Association, and
- The Immigrant and Refugee Community Organization.

This data included variables on each incentive recipients' academic institution, clinical position and license type (if applicable), certification languages (certified health care interpreters only), status (completed, enrolled, withdrew, "N/A"), anticipated completed date, scholarship amount, and award date. Summary statistics were calculated including the total number of recipients overall and by status, clinical position, and certified languages. Summary statistics of the total number of participants, total amount awarded, and the average amount awarded by grantee organization was also calculated.

REALD SOGI data was collected on recipients during the full reporting period and includes 76 responses (80.9% of a total of 94 incentive recipients). Analysis of REALD SOGI variables was the same as the Health Care Workforce Scholarship program, see above for detailed methods.

**Behavioral Health Retention Incentives.** Grantee reporting data for the MHACBO retention incentive provided individual-level recipient data covering reporting period 6/30/25-12/31/2025. The data provided by MHACBO was divided into two data files:

- **Registrant data**, which includes the number of individuals who received registration fee waivers.
- **Examination data**, which includes the number of individuals who received examination fee waivers.

Unique individuals could be counted more than once between the two data sources if they received both types of fee waivers over the reporting period, because a unique recipient ID number, connecting the two data sources was not provided. The registrant data included variables on certification type, certification status, date of first certification, date of last certification, and education level, and location information associated with registration (address, city, state, ZIP code).

Data on examination fee waiver recipients' exam type, date of exam registration, exam date, exam status, and certification number. For individuals in the examination data that passed their exams, there was additional information on certification title (type of certification), date of first certification,

date of last certification, due date of certification, education-level, and location information associated with exam registration.

Both the registrant data and the examination data included demographic data. The examination data only included demographic information from individuals who passed their examination. Demographic data was collected during the full reporting period and includes 4074 responses from registration fee waiver recipients (99.8% of 4082 total registration recipients) and all 352 passed examination recipients (72.3% of all exam fee waiver recipients,  $n = 481$ ). Only total reported races and ethnicities, alone or in combination, were reported due to limited response rates to the primary race/ethnicity variables.

## **Limitations and Data Gaps**

Data collection methods and reporting varied across programs, primarily due to differences in program goals and target recipients.

Limited geographic data was available on grantee organizations, limiting geographic analyses of recipient organizations. Location information was provided on individual registration recipients and examination recipients who passed their exams; however, information on practice locations on individual recipients was not provided or clarified.

Three programs out of six collected REALD SOGI data; however, REALD SOGI data for one out of these four programs were limited to a subset of recipients due to recent implementation of REALD SOGI data collection (Health Care Workforce Scholarships). Demographic data on MHACBO exam fee waiver recipients was only provided for individuals who passed their examinations, limiting comparisons of demographic data across individuals who passed examinations vs. those who did not pass.

## **Focus Group**

Qualitative data was collected during a focus group with OHA program staff in July 2026. OHA staff that administer the HCPIP, HOWTO, BHWI, and Oral Health/HRSA programs and grants participated, providing context about implementation and areas for program improvement that the quantitative sources cannot supply. The discussion focused on implementation challenges, program sustainability, and issues not captured by quantitative data.

## **Methods**

A qualitative one-hour long focus group was conducted on July 30, 2026, with OHA program staff over Zoom. The focus group was conducted following a semi-structured interview guide that covered questions related to program implementation, program maintenance, and recommendations for the future of these programs. One member of the evaluation team facilitated the focus

group following the guide, while a second member of the evaluation team took notes. Prior to starting the focus group, ground rules and consent for recording were obtained from participants. Participants' additional thoughts on focus group questions were also collected from the Zoom chat log. Focus group notes, recordings, transcripts, and chat were summarized by the evaluation team.

## Small-Number Reporting

Reporting of small numbers was adapted from the OHA Office of Health Analytics Small Numbers Reporting Guidelines (version 2.2, September 2025). For counts and percentages of individual recipients drawn from program records (ORH participant data, HWRP-linked data, and individual-level grantee data), values based on fewer than five recipients were suppressed and values based on five to 11 recipients were flagged as potentially statistically unreliable. Where a suppressed value could be calculated from other values in the same table, an additional value was suppressed or categories were combined. Counts of trainings, programs, or organizations, summary tables provided in aggregate by program partners (e.g., OHSU for SHOI and the BHWI dashboard), and survey responses (PRISM and the ORH survey) were reported as provided, with denominators shown; estimates from small denominators should be interpreted with caution. Dollar amounts were not suppressed unless they reveal a suppressed count.

## Appendix B References

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5. [Oregon Office of Rural Health. Healthcare Need Designations](https://www.ohsu.edu/oregon-office-of-rural-health/healthcare-need-designations) [Internet]. Oregon Health & Science University; 2026 [cited 2026 Aug 10]. Available from: <https://www.ohsu.edu/oregon-office-of-rural-health/healthcare-need-designations>



**Oregon Health Policy and Analytics Division**  
Health Care Provider Incentive Program

## **Appendix C: Health Care Provider Loan Repayment Recipients by Provider Type, Overall, and by Award Year, 2018-2026**

**Table 10. Health Care Provider Loan Repayment Program recipients by discipline category, overall and by award year, 2018–2026 (N = 322)**

| Discipline Category       | Total recipients | Percent of recipients§ | 2018      | 2019      | 2020      | 2021      | 2022      | 2023      | 2024      | 2025      | 2026      |
|---------------------------|------------------|------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| <b>All</b>                | <b>322</b>       |                        | <b>31</b> | <b>55</b> | <b>30</b> | <b>36</b> | <b>30</b> | <b>28</b> | <b>51</b> | <b>29</b> | <b>32</b> |
| <b>Primary Care</b>       | 135              | 41.9%                  | 16        | 26        | 14        | 15        | 16        | 20        | 27        | 11*       | 17        |
| <b>Pharmacists †</b>      | 27               | 8.4%                   | - †       | - †       | - †       | - †       | - †       | - †       | - †       | - †       | - †       |
| <b>Behavioral Health‡</b> | 57               | 17.7%                  | -‡        | -‡        | -‡        | -‡        | -‡        | -‡        | -‡        | -‡        | -‡        |
| <b>Oral Health</b>        | 103              | 32.0%                  | 8*        | 9*        | 10*       | 12        | 13        | 7*        | 22        | 12        | 10*       |

\*Estimates may be statistically unreliable due to small numbers; interpret with caution.

†Estimates suppressed due to small numbers; statistically unreliable.

‡Estimates suppressed to prevent backward calculation of other suppressed estimate(s).

§Column percentages are of all 322 recipients, which includes all individuals who were awarded loan repayment and are either currently completing, continuing to complete, or have completed a service obligation, excluding recipients who later withdrew before completing their service obligation. Year columns give the number of recipients in each award cohort; row totals equal the sum across award years. Discipline totals match values in the corresponding category rows.

**Table 11. Health Care Provider Loan Repayment Program recipients and percent of recipients reporting full-time hours by discipline, 2018–2026 (N = 322)**

| Discipline Category                 | Discipline                               | Total recipients | Percent of recipients‡ | Percent full time |
|-------------------------------------|------------------------------------------|------------------|------------------------|-------------------|
| <b>All</b>                          | <b>All</b>                               | <b>322</b>       |                        | <b>88.5%</b>      |
| <b>Primary Care</b>                 | <b>All Primary Care Disciplines</b>      | <b>135</b>       | <b>41.9%</b>           | <b>85.8%</b>      |
| <b>Primary Care</b>                 | Physicians - MDs/DOs                     | 50               | 15.5%                  | 76.0%             |
| <b>Primary Care</b>                 | Physician Associates                     | 33               | 10.2%                  | 87.9%             |
| <b>Primary Care</b>                 | Nurse Practitioners                      | 40               | 12.4%                  | 92.5%             |
| <b>Primary Care</b>                 | Naturopathic Physicians                  | 12               | 3.7%                   | 100.0%            |
| <b>Pharmacy</b>                     | <b>Pharmacists</b>                       | <b>27</b>        | <b>8.4%</b>            | <b>85.2%</b>      |
| <b>Behavioral Health (All)</b>      | <b>All Behavioral Health Disciplines</b> | <b>57</b>        | <b>17.7%</b>           | <b>94.7%</b>      |
| <b>Behavioral Health (Licensed)</b> | <b>All Licensed BH Disciplines</b>       | <b>38</b>        | <b>11.8%</b>           | <b>92.1%</b>      |
| <b>Behavioral Health (Licensed)</b> | Psychiatric Mental Health NPs*           | 11*              | 3.4%                   | 100.0%            |
| <b>Behavioral Health (Licensed)</b> | Psychologists†                           | -†               | -†                     | -†                |

| Discipline Category                     | Discipline                               | Total recipients | Percent of recipients‡ | Percent full time |
|-----------------------------------------|------------------------------------------|------------------|------------------------|-------------------|
| <b>Behavioral Health (Licensed)</b>     | Licensed Clinical Social Workers*        | 11*              | 3.4%                   | 90.9%             |
| <b>Behavioral Health (Licensed)</b>     | Licensed Professional Counselors*        | 9*               | 2.8%                   | 77.8%             |
| <b>Behavioral Health (Licensed)</b>     | Licensed Marriage and Family Therapists† | -†               | -†                     | -†                |
| <b>Behavioral Health (Licensed)</b>     | Other Licensed BH Providers†             | -†               | -†                     | -†                |
| <b>Behavioral Health (Pre-Licensed)</b> | <b>Pre-Licensed BH Disciplines</b>       | <b>19</b>        | <b>5.9%</b>            | <b>100.0%</b>     |
| <b>Oral Health</b>                      | <b>All Oral Health Disciplines</b>       | <b>103</b>       | <b>32.0%</b>           | <b>89.3%</b>      |
| <b>Oral Health</b>                      | Dentists                                 | 73               | 22.7%                  | 91.8%             |
| <b>Oral Health</b>                      | Expanded Practice Dental Hygienists      | 25               | 7.8%                   | 84.0%             |
| <b>Oral Health</b>                      | Dental Assistants*                       | 5*               | 1.6%                   | 80.0%             |

\*Estimates may be statistically unreliable due to small numbers; interpret with caution.

†Estimates suppressed due to small numbers; statistically unreliable.

‡ Column percentages are of all 322 recipients, which includes all individuals who were awarded loan repayment and are either currently completing, continuing to complete, or have completed a service obligation, excluding recipients who later withdrew before completing their service obligation. Year columns give the number of recipients in each award cohort; row totals equal the sum across award years. Discipline totals match values in the corresponding category rows.



**Oregon Health Policy and Analytics Division**  
Health Care Provider Incentive Program

## **Appendix D: Healthy Oregon Workforce Training Opportunity Grant Program Awards Summary, March 2019 – June 2025**

**Table 12. Healthy Oregon Workforce Training Opportunity Grant Program Awards Summary, March 2019-June 2025**

| Round          | Organization                                  | Start date | End date                 | Amount     | Project Description                                                                                                                                                                                                                                                                                  |
|----------------|-----------------------------------------------|------------|--------------------------|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Round 1</b> | George Fox University                         | 3/1/2019   | 7/31/2023<br>(Complete)  | \$998,606  | Establishes the Interprofessional Primary Care Institute to leverage interdisciplinary care teams to deliver Continuing Medical Education to primary care clinicians, behavioral health clinicians, nurses, and clinical pharmacists by providing intensive events for emergency primary care roles. |
| <b>Round 1</b> | Northeast Oregon Area Health Education Center | 3/1/2019   | 6/30/2023<br>(Complete)  | \$971,871  | Creates a distance education Psychiatric Mental Health Nurse Practitioner (PMHNP) program to increase the mental health workforce in Eastern Oregon by recruiting, advancing, and retaining nurses already embedded in the region.                                                                   |
| <b>Round 1</b> | Oregon Community Health Worker Association    | 3/1/2019   | 6/30/2022<br>(Complete)  | \$877,727* | Develops and supports Community Health Worker (CHW) training statewide in multiple communities experiencing health inequities and health workforce shortage areas, and advocates for increased funding for CHW positions and actively support CHWs to obtain employment.                             |
| <b>Round 2</b> | Aviva Health                                  | 10/1/2019  | 3/31/2023<br>(Complete)  | \$988,000  | Establishes the Roseburg Family Medicine Residency Program with Mercy Medical Center to address the burgeoning physician and broader clinical health care workforce shortage in Douglas County and rural Oregon.                                                                                     |
| <b>Round 2</b> | Clackamas Workforce Partnership               | 10/1/2019  | 7/31/2024<br>(Complete)  | \$500,000  | Expands, develops, and increases local health workforce diversity by supporting and enrolling Clackamas County residents, with a focus on the immigrant and refugee populations, into programs such as certified nursing assistants, dental assistants, medical billing, and pharmacy technicians.   |
| <b>Round 2</b> | NW Portland Area Indian Health Board          | 10/1/2019  | 1/31/2024<br>(Complete)  | \$955,844  | Establishes the Behavioral Health Aide Education Program for Tribal communities in Oregon, Washington and Idaho to increase access to local Tribal Behavioral Health Practitioners throughout Indian Country.                                                                                        |
| <b>Round 2</b> | Oregon Washington                             | 10/1/2019  | 10/31/2023<br>(Complete) | \$480,670  | Establishes a medical assisting program in partnership with Blue Mountain Community College to address the growing                                                                                                                                                                                   |

| Round          | Organization                                | Start date | End date             | Amount      | Project Description                                                                                                                                                                                                                                                                                                                |
|----------------|---------------------------------------------|------------|----------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                | Health Network                              |            |                      |             | health care workforce shortage in Umatilla County and other areas of rural Oregon.                                                                                                                                                                                                                                                 |
| <b>Round 2</b> | Samaritan Health Systems                    | 10/1/2019  | 9/30/2023 (Complete) | \$366,436*  | Establishes the Samaritan Pacific Communities Hospital Rural Training Track, a rural medical residency training track that will place residents in Newport, Oregon to address physician shortages along Oregon's coastal region.                                                                                                   |
| <b>Round 2</b> | The Next Door Inc.                          | 10/1/2019  | 3/31/2023 (Complete) | \$500,000   | Develops the Valle Verde program, a culturally specific 11-week Mental Health Promotion training series designed to expand CHW and other provider training by providing Continuing Education Units, and to provide specific skills to CHWs and mental health providers specific to local Latinx community members.                 |
| <b>Round 3</b> | DentaQuest, LLC (formerly Advantage Dental) | 1/1/2021   | 1/31/2024 (Complete) | \$1,000,000 | Establishes an internal Dental Assistance Training Program to address statewide shortages while increasing the diversity of this workforce to train dental assistants for dual roles as patient navigators, through THW education.                                                                                                 |
| <b>Round 3</b> | Clackamas Community College                 | 1/1/2021   | 7/31/2025 (Complete) | \$436,544   | Develops a new dental program to offer alongside existing Career and Technical Education Day Camps for high school students at Clackamas Community College to increase workforce diversity by offering oral health program scholarships for camp students to attend college.                                                       |
| <b>Round 3</b> | East Cascades Works                         | 1/1/2021   | 7/31/2024 (Complete) | \$1,000,000 | Establishes the Central Oregon Behavioral Health Consortium, a collaborative of local agencies increasing access to behavioral health care by providing centralized, coordinated, and systemic workforce development and retention training to address behavioral health workforce shortages in central Oregon.                    |
| <b>Round 3</b> | Grain Integrated Health                     | 1/1/2021   | 1/31/2024 (Complete) | \$275,000   | Establishes a naturopathic primary care residency program in Cascade Locks that includes a diversity, equity, and inclusion training curriculum and provides experiential learning to Career and Technical Education high school students to address health disparities and diversity, equity, and inclusion in rural health care. |

| Round          | Organization                                       | Start date | End date                | Amount      | Project Description                                                                                                                                                                                                                                                                                                                        |
|----------------|----------------------------------------------------|------------|-------------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Round 3</b> | Lutheran Community Services NW                     | 1/1/2021   | 1/31/2026<br>(Complete) | \$946,063   | Expands behavioral health training pathways for refugees by supporting entry-level trainings to be certified as a Peer Support Specialist currently working in behavioral health and residencies for newly graduated clinicians focused on working with refugees.                                                                          |
| <b>Round 3</b> | Northwest Oregon Works                             | 1/1/2021   | 1/31/2024<br>(Complete) | \$737,847   | Establishes a Behavioral Health Work-Based Learning Career Pathway that includes three levels, Peer Recovery Support Specialist/Community Health Worker to master's prepared Behavioral Health Clinicians, to address workforce shortages and prioritize recruitment from the Latinx community.                                            |
| <b>Round 3</b> | Oregon Child and Family Services (Oregon Alliance) | 1/1/2021   | 1/31/2024<br>(Complete) | \$499,903   | Develops and provides two statewide training series for behavioral health providers to improve workforce retention and address the root cause of ongoing underrepresentation of racial and ethnic minorities.                                                                                                                              |
| <b>Round 3</b> | Pacific University                                 | 1/1/2021   | 1/31/2025<br>(Complete) | \$985,753   | Establishes a certificate program and a Physician Assistant Behavioral Health Fellowship programs to be innovative team-based training opportunities that will focus on increasing the knowledge and skills of diverse health care providers to work effectively with patients dealing with behavioral health and substance use disorders. |
| <b>Round 3</b> | St Charles Health System                           | 1/1/2021   | 7/31/2025<br>(Complete) | \$1,000,000 | Establishes a new Family Medicine Rural Training Track program in central Oregon in partnership with Oregon Health & Science University that includes an experience in a culturally congruent Indian Health Service/Tribal site and prioritizes Native American medical students.                                                          |
| <b>Round 4</b> | Bridges to Change                                  | 7/1/2022   | 1/31/2026<br>(Complete) | \$180,000   | Establishes an in-house Peer Wellness Specialist (PWS) training to prepare peers for credentialing and working in Oregon that will be trauma informed and culturally responsive.                                                                                                                                                           |
| <b>Round 4</b> | Clackamas Workforce Partnership                    | 7/1/2022   | 7/31/2026               | \$296,920   | Establishes the Behavioral Health Consortium of Clackamas that will help identify and address key challenges in the behavioral health system, with an emphasis on education and training                                                                                                                                                   |

| Round          | Organization                         | Start date | End date                | Amount      | Project Description                                                                                                                                                                                                                                                                                                                                                                          |
|----------------|--------------------------------------|------------|-------------------------|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                |                                      |            |                         |             | pathways, worker retention, workforce diversification, and access to care.                                                                                                                                                                                                                                                                                                                   |
| <b>Round 4</b> | La Clinica                           | 7/1/2022   | 7/31/2025<br>(Complete) | \$1,000,000 | Expands workplace learning programs to create workforce training pipeline for the Latine community focusing on medical, dental, and behavioral health workforce.                                                                                                                                                                                                                             |
| <b>Round 4</b> | Lane Community College               | 7/1/2022   | 7/31/2027               | \$1,000,000 | Focuses Medical Assistants (MA), Community Health Workers (CHW), and Peer Support Specialists (PSS) to create a multifaceted educational program which integrates an expansion of existing programs for MAs, a bilingual CHW program, and a new program that includes a continuing education component for PSS.                                                                              |
| <b>Round 4</b> | Lane Workforce Partnership           | 7/1/2022   | 7/31/2025<br>(Complete) | \$999,956   | Develops a perinatal lounge, a multicultural hub for perinatal support and professional community building, that will include Doula certification training, Doula workforce inclusion (equity and inclusion training), and Doula workforce sustainability through two pathways, community-based self-employment, and hospital-based employment to include workshops, mentoring classes, etc. |
| <b>Round 4</b> | Latino Network                       | 7/1/2022   | 1/31/2026<br>(Complete) | \$331,230   | Provides OHA-certified Spanish language and culturally specific continuing education courses for CHWs in Oregon and assists CHWs in obtaining continuing education credits to maintain their OHA CHW certification.                                                                                                                                                                          |
| <b>Round 4</b> | Lines for Life                       | 7/1/2022   | 1/31/2026<br>(Complete) | \$298,874   | Recruits and trains Rural Mental Health Crisis Responders statewide, equipped with advanced crisis response and telehealth competencies, and provides a virtual learning collaborative to nurture inter-organizational partnership, professional development, and peer support.                                                                                                              |
| <b>Round 4</b> | NW Portland Area Indian Health Board | 7/1/2022   | 7/31/2027               | \$1,000,000 | Establishes the Northwest Community Health Aide (CHA) Education Program of Oregon that will provide a culturally specific framework to diversify the health care workforce through designing and implementing accessible health care educational pathways for future CHA providers, academic                                                                                                 |

| Round          | Organization                                   | Start date | End date             | Amount      | Project Description                                                                                                                                                                                                                                                      |
|----------------|------------------------------------------------|------------|----------------------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                |                                                |            |                      |             | enrichment, and mentorship for high school and undergraduate students.                                                                                                                                                                                                   |
| <b>Round 4</b> | Oregon Academy of General Dentistry Foundation | 7/1/2022   | 7/31/2026            | \$297,301   | Develops a Dental Assistant Training Program that provides two condensed and accelerated pathways into the field of dental assisting, one focused on high school seniors and the second on community members.                                                            |
| <b>Round 4</b> | Oregon Council for Behavioral Health           | 7/1/2022   | 7/31/2025 (Complete) | \$561,191   | Creates a network of equity-focused vocational sites that will sustainably train and develop diverse credentialed behavioral health employees within the workforce. These vocational sites will meet in a learning collaborative for support and continuous improvement. |
| <b>Round 4</b> | Oregon Social Learning Center                  | 7/1/2022   | 7/31/2026            | \$299,181   | Expansion of Adolescent and Family Services and Students with Involved Families and Teachers programs in Lane County to increase the behavioral health workforce supporting rural communities.                                                                           |
| <b>Round 4</b> | Southwestern Oregon Workforce Investment Board | 7/1/2022   | 1/31/2026 (Complete) | \$935,166   | Develops and implements a Traditional Health Worker (THW) integration and utilization plan in Coos, Curry and Douglas counties that will hire THW supervisors and train the community as CHWs, PSSs, Youth Support Specialists (YSS) and birth Doulas.                   |
| <b>Round 4</b> | Virginia Garcia Memorial Health Center         | 7/1/2022   | 7/31/2025 (Complete) | \$1,000,000 | Expands workforce diversity in health care by covering the cost for staff, patients, and community members to become certified medical assistants, dental assistants, and pharmacy technicians, and providing paid positions in the clinics while they are students.     |
| <b>Round 4</b> | Willamette Dental Group                        | 7/1/2022   | 7/31/2025 (Complete) | \$750,000   | Establishes a Dental Assistant (DA) and uptraining DA training program that will recruit and prepare non-clinical staff and community members to be trained as DAs with Expanded                                                                                         |

| Round          | Organization                                | Start date | End date             | Amount      | Project Description                                                                                                                                                                                                                                                                                  |
|----------------|---------------------------------------------|------------|----------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                |                                             |            |                      |             | Function, Restorative Dental Assistant Capacity, and other certification specialties.                                                                                                                                                                                                                |
| <b>Round 4</b> | Willamette Workforce Partnership            | 7/1/2022   | 7/31/2025 (Complete) | \$299,999   | Develops and launches the Mid-Willamette Behavioral Health Consortium to increase access to and retain behavioral health workers focusing on those positions with the highest turnover.                                                                                                              |
| <b>Round 4</b> | Yamhill Valley Community Doulas             | 7/1/2022   | 1/31/2026 (Complete) | \$152,756   | Develops and expands upon the Yamhill Valley Doulas, Inc. Mentorship program which recruits, educates, and retains Doulas through training, an intensive birth practicum, and certification.                                                                                                         |
| <b>Round 5</b> | Center for Family Development               | 1/31/2024  | 7/31/2026            | \$69,000    | Supports the training of 15 Perinatal to Five therapists in the Perinatal Child Parent Psychotherapy program, which is a validated relationship-based, trauma-informed treatment and preventive intervention that begins during pregnancy and continues after the baby's birth.                      |
| <b>Round 5</b> | Liberty House                               | 1/31/2024  | 1/31/2027            | \$300,000   | Develops a new training program that will recruit pre-licensed mental health providers to train and support while they work toward professional licensure. The program includes an emphasis on Spanish-speaking or rural-focused providers.                                                          |
| <b>Round 5</b> | Klamath Community College                   | 1/31/2024  | 1/31/2027            | \$274,262   | The Community Health Worker (CHW) capacity building program's goal is to increase the number of CHWs supporting rural healthcare infrastructure and systems in the Klamath Basin, throughout the region, and across the state.                                                                       |
| <b>Round 5</b> | Morrison Child & Family Services            | 1/31/2024  | 1/31/2027            | \$187,208   | Supports student intern through high quality clinical training in a supportive team-based environment as well as opportunities to engage in culturally and linguistically specific consultation and support while increasing access to care for clients.                                             |
| <b>Round 5</b> | Northwest Portland Area Indian Health Board | 1/31/2024  | 1/31/2027            | \$1,000,000 | Develops the Northwest Dental Health Aide Program (DHAP) in Oregon. The DHAP provides a culturally-specific framework to diversify the oral healthcare workforce in Oregon through accessible oral healthcare educational pathways for future Dental Health Aide providers, academic enrichment, and |

| Round          | Organization                             | Start date | End date  | Amount    | Project Description                                                                                                                                                                                                                                                                                                                |
|----------------|------------------------------------------|------------|-----------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                |                                          |            |           |           | mentorship for American Indian and Alaska Native high school and undergraduate students.                                                                                                                                                                                                                                           |
| <b>Round 5</b> | United We Heal Training Trust            | 1/31/2024  | 1/31/2027 | \$998,748 | Supports the Behavioral Health Careers Pathway program. Pre-apprentice, Baccalaureate and Master' s degree support programs aim to provide more advanced career pathways while simultaneously addressing the demand for diverse trained professionals in the behavioral health care sector.                                        |
| <b>Round 6</b> | African Youth and Community Organization | 6/16/2025  | 7/31/2028 | \$995,597 | AYCO's SHIFA (Somali for "healing") Healing Workforce Development Project will guide individuals through internship to gain relevant health care experiences and certifications. Roles will include Qualified Mental Health Associate, Community Health Worker, Peer Support Specialist, and Certified Alcohol and Drug Counselor. |
| <b>Round 6</b> | BCT Partners LLC                         | 6/16/2025  | 7/31/2027 | \$999,040 | Expands capacity of the Emergency Medical Services (EMS) workforce and improves the ability to serve across urban and rural Oregon by offering paid training, educational support, career coaching, and employment opportunities to 125 community members in rural areas.                                                          |
| <b>Round 6</b> | Black Parent Initiative                  | 6/16/2025  | 7/31/2028 | \$283,177 | Supports the Clinical Lactation Education Program to address the lack of culturally responsive perinatal health care access and supports for underserved communities. Financial assistance, mentorship, and career coaching help trainees as they work towards certifications and living wage jobs.                                |
| <b>Round 6</b> | Chemeketa Community College              | 6/16/2025  | 7/31/2028 | \$123,962 | Establishes the Health Care Interpreter program, which includes integrated academic and language supports and requires a healthcare workplace practicum so trained students are directly placed with employers to assure complete training and inclusive onboarding occurs.                                                        |

| Round          | Organization                          | Start date | End date  | Amount    | Project Description                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------|---------------------------------------|------------|-----------|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Round 6</b> | Empower Therapy                       | 6/16/2025  | 7/31/2028 | \$74,990  | Provides clinical supervision to clinicians-in-training and provides continuing education opportunities for clinicians and clinical supervisors to provide culturally-responsive services, reduce burnout, and improve clinician retention in rural communities.                                                                                                                                              |
| <b>Round 6</b> | Familias en Acción                    | 6/16/2025  | 7/31/2028 | \$867,157 | Supports the Recreando Alianza y Oportunidad de Salud (RAYOS) program to expand the healthcare workforce in Oregon, providing skill building and employment/income opportunities for Community Health Workers (CHWs). This project includes: 1) training and support to secure CHW certification; 2) continuing education opportunities; and 3) career coaching and job placement support.                    |
| <b>Round 6</b> | Friends of the Children-Klamath Basin | 6/16/2025  | 7/31/2027 | \$997,766 | Focuses on expanding the behavioral health workforce by supporting 45+ behavioral health professionals that will increase access to care for children who have significant adverse childhood experiences. Roles include Qualified Mental Health Associates, Qualified Mental Health Professionals, Peer Support Specialists, and additional clinical supervisor positions.                                    |
| <b>Round 6</b> | Insight Counseling and Therapy        | 6/16/2025  | 7/31/2028 | \$944,211 | Provides a structured pathway for aspiring clinicians to achieve licensure through paid work experience and includes comprehensive training, mentorship, and clinical supervision to address behavioral health workforce shortages in rural Oregon.                                                                                                                                                           |
| <b>Round 6</b> | La Clinica                            | 6/16/2025  | 7/31/2028 | \$667,844 | Creates clear, sustainable career pathways for high school students and addresses critical workforce shortages in Southern Oregon, particularly in entry-level roles like Patient Services Representatives. Through a partnership with South Medford High School and Rogue Community College, the initiative provides academic preparation, hands-on training, mentorship, and paid internship opportunities. |

| Round   | Organization                | Start date | End date  | Amount    | Project Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------|-----------------------------|------------|-----------|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Round 6 | Portland State University   | 6/16/2025  | 7/31/2028 | \$904,772 | Building on Salem-Keizer School District's existing Behavioral Health and Human Services Career Technical Education Center (CTEC) curriculum, the program integrates targeted workforce activities, including dual-credit courses, Traditional Health Worker training, simulation-based skill-building, expert-led workshops, and supervised practicum placements to ensure students graduate with the skills, certification pathways, and experience needed to address behavioral health needs in schools and communities. |
| Round 6 | Portland Workforce Alliance | 6/16/2025  | 7/31/2028 | \$406,868 | The Health Care Fellows Program creates pathways for individuals (focused on young adults aged 17-24) to gain experience, certifications, and employment opportunities that open doors to higher-paying career paths.                                                                                                                                                                                                                                                                                                       |
| Round 6 | Reynolds School District #7 | 6/16/2025  | 7/31/2028 | \$287,143 | Creates a Dental Assistant training program guided by an integrated career technical education program design and includes internships and paid summer clinical experiences to help address financial barriers for students.                                                                                                                                                                                                                                                                                                |
| Round 6 | United We Heal              | 6/16/2025  | 7/31/2028 | \$995,852 | Supports a partnership with Juntos NW and Fresh Out Community Based Reentry Program to implement culturally responsive and linguistically specific curricula and supportive services for training pathways in Qualified Mental Health Associate (registered apprenticeship), Peer Support Specialist, Certified Alcohol and Drug Counselor, Certified Recovery Mentor, and Community Health Worker in Addictions roles.                                                                                                     |

**Notes: \$33,056,274 total awarded across 53 grantee projects**

**Project timelines in Rounds 1 and 2 were particularly impacted by COVID-related changes. Grantees can request no-cost-extensions when needed for completion of spending and grant objectives.**

**\*Adjusted amount reflected differs from initial award.**



**Oregon Health Policy and Analytics Division**  
Health Care Provider Incentive Program

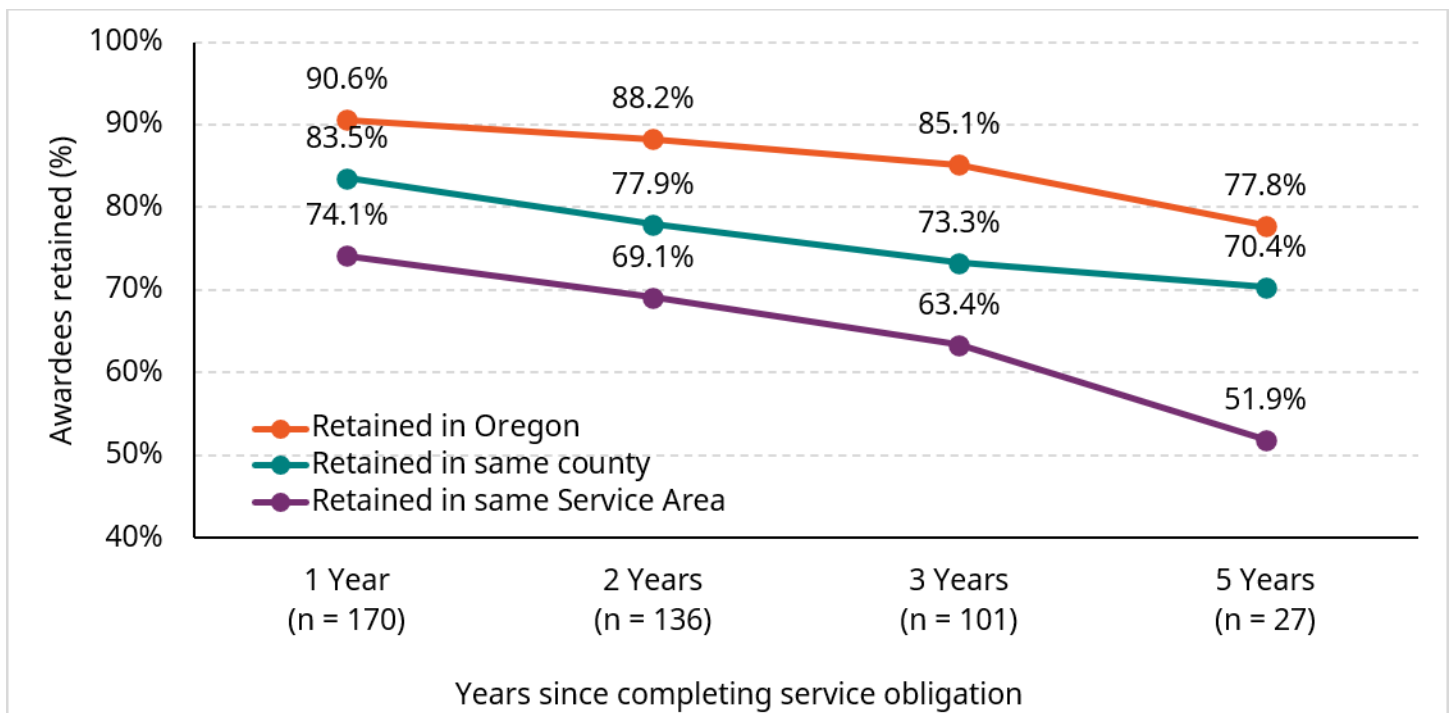
## **Appendix E: Service Area Retention Results for Loan Repayment, Loan Forgiveness, and Scholars for Healthy Oregon Initiative Programs**

## Health Care Provider Loan Repayment Program (HCPLRP)

Retention analyses were conducted using practice location (from licensing data via the HWRP) at one, two, three, and five years post-service for 170 recipients who had completed their HCPLRP service obligation by 2025. Follow-up data are incomplete by definition: 34 recipients had not yet reached two years, 69 had not reached three years, and 143 had not reached five years, and location data were missing for an additional two to four recipients per interval. Analytic samples therefore declined from n = 170 at one-year post-service to n = 27 at five years post-service. Because the HWRP data primarily includes licensed providers in Oregon, we assumed that if a provider initially licensed was no longer available in the HWRP data starting at a certain year, they were no longer considered retained in Oregon.

Service-area retention also declined steadily (80.6 percent at one year to 63.6 percent at five years) (Figure 4).

**Figure 4. Retention of 2018-2026 HCPLRP recipients in Oregon, the same county, and the same Service Area at one, two, three, and five years after service obligation completion**



**Abbreviation:** HCPLRP – Health Care Provider Loan Repayment Program. **Data Source:** Health Care Workforce Reporting Program data on HCPLRP recipients’ licensure-associated practice locations, 2018-2026. Denominators differ by interval and may comprise different recipient cohorts. For recipients with multiple practice locations reported at baseline and follow-up, retention was defined as having at least one baseline practice location in the same state, county, or Service Area at follow-up.

## Behavioral Health Loan Repayment Program (BHLRP)

Retention was assessed using practice location reported through licensing data in HWRP at one and two years following completion of a BHLRP service obligation (no recipients have yet reached the three- or five-year follow-up window). As of 2025, 19 BHLRP recipients (all from the 2021-2022 award cohorts) had completed their service obligation and were therefore eligible for retention follow-up (69 recipients were still completing obligation or had not completed their obligation by 2025 and 25 could not be linked to the HWRP data). Within this pool of 19 recipients, the analytic sample varied by follow-up year: one recipient was missing location data at one year (n = 18). At two years, one recipient had not yet reached that follow-up point while four were missing location data (n = 15).

Among the small number of BHLRP recipients eligible for retention analyses, retention at one year and two years after completing their service requirement, retention within Oregon was highest (Table 13). A smaller proportion of recipients remained in the same county one and two years after their service requirement. About half remained in the same Service Area one and two years after their service requirement.

**Table 13. Retention of BHLRP recipients after completion of the service obligation in the same Service Area**

| Time after service completion | In the same Service Area |
|-------------------------------|--------------------------|
| 1 year (n = 18)               | 55.6%                    |
| 2 years (n = 15)              | 50.0%                    |

**Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: Health Care Workforce Reporting Program data on BHLRP recipients’ licensure-associated practice locations, 2021-2022. Denominators differ by interval and may comprise different recipient cohorts.**

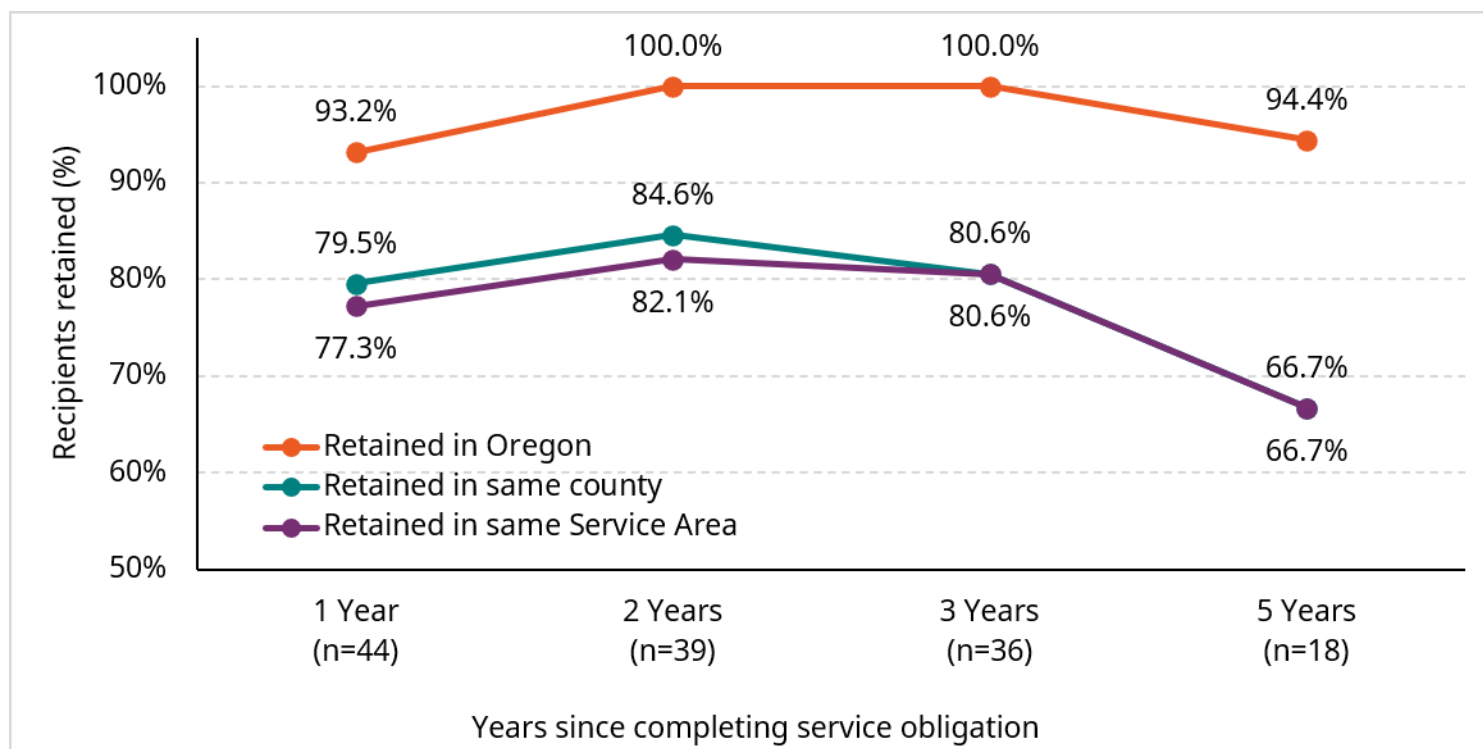
**Recipients with multiple practice locations reported at baseline and at follow-up years were considered retained if their baseline Service Area at either their primary or secondary locations are the same at follow-up.**

## Primary Care Loan Forgiveness (PCLF)

Retention was measured using licensure-associated reported practice locations at one, two, three, and five years following service obligation completion, among the 52 recipients who completed their service obligation by 2025 and could be linked in the HWRP data. Denominators shrink at longer intervals because follow-up years fall in the future for recent completers or location data are missing (44, 39, 36, and 18 recipients were included at one, two, three, and five years, respectively). For recipients with multiple practice locations, retention counts as a match at either the primary or secondary location.

Retention in the same Service Area was 77.3 percent, 82.1 percent, 80.6 percent, and 66.7 percent at the same intervals (Figure 5).

**Figure 5. Retention of PCLF recipients in Oregon, the same county, and the same Service Area at 1, 2, 3, and 5 years after service obligation completion**



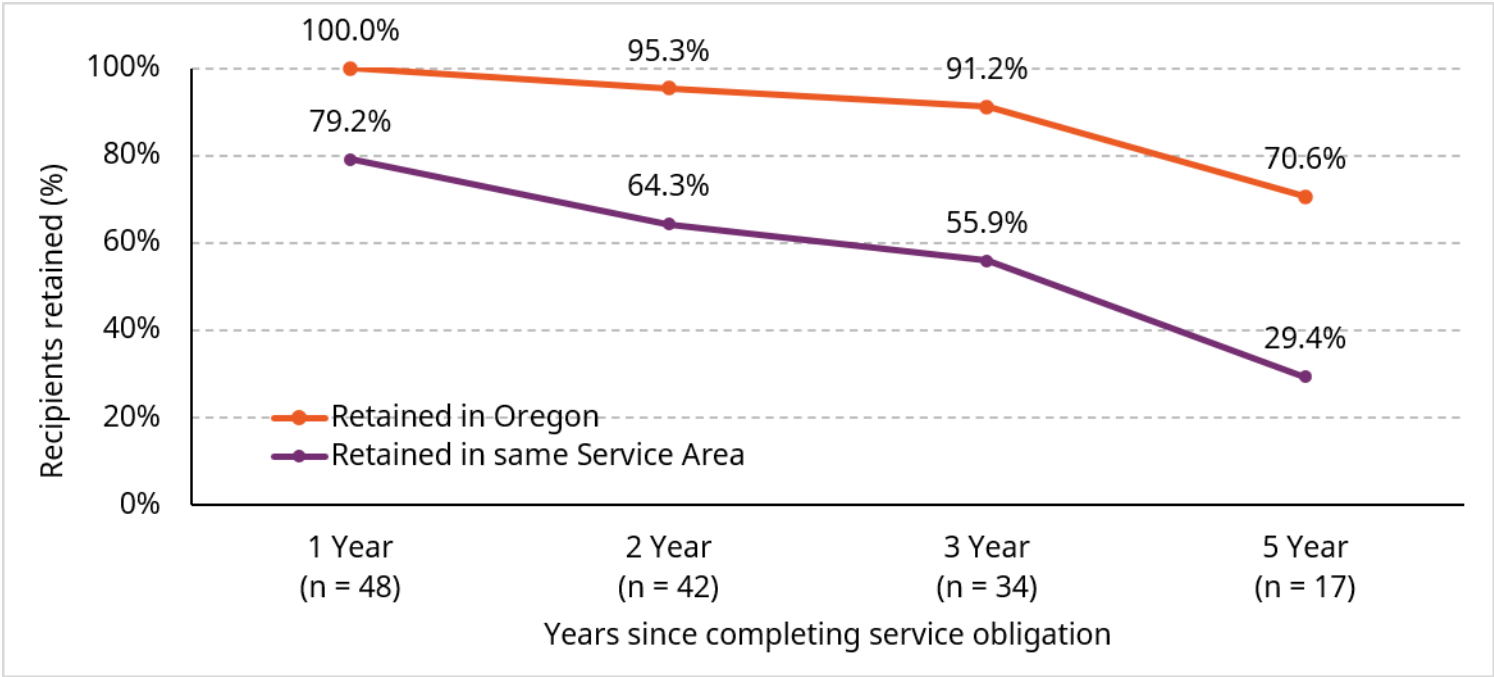
**Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: Health Care Workforce Reporting Program data on PCLF recipients’ licensure-associated practice locations, 2018-2026. Denominators differ by interval (n = 44, 39, 36, 18) and may comprise different recipient cohorts. Includes only PCLF recipients from 2018-2026 who completed their service obligation by 2025.**

## Scholars for Healthy Oregon Initiative (SHOI)

Retention was measured using licensure-associated reported practice locations at one, two, three, and five years following service obligation completion, among the 48 SHOI recipients who completed their service obligation by 2025 and could be linked in the HWRP data. Denominators shrink at longer intervals because follow-up years fall in the future for recent completers or location data are missing (48, 43, 34, and 17 recipients were included at one, two, three, and five years, respectively).

Retention in the same Service Area declined gradually from 79.2 percent in one year to 29.4 percent in five years following service obligation (Figure 6).

**Figure 6. Retention of SHOI recipients from 2018-2019 to 2025-2026 academic years in Oregon and the same Service Area at one, two, three, and five years after service obligation completion**



**Abbreviation:** SHOI – Scholars for a Healthy Oregon Initiative. **Data Source:** Health Care Workforce Reporting Program data on SHOI recipients’ licensure-associated practice locations, 2018-2026. Denominators differ by interval (n = 48, 43, 34, and 17) and may comprise different recipient cohorts. Includes only SHOI recipients from 2018-2026 who completed their service obligation by 2025.



**Oregon Health Policy and Analytics Division**  
Health Care Provider Incentive Program

## **Appendix F: Literature Review: Evidence of the Effectiveness of Provider Incentives**

## A. Background and Typology

### Rationale for Provider Incentive Policies

Across the United States, and in Oregon, the health workforce is unevenly distributed, with rural and underserved areas facing persistent shortages of health care professionals in primary care, dental care, and mental health.(1-3) To identify and address these workforce gaps, the Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs), which identify geographic areas, populations, or facilities with provider shortages and help determine eligibility for federal incentive programs. In Oregon, the state uses Areas of Unmet Health Care Need, as defined by the Oregon Office of Rural Health, to determine eligibility for state incentive programs.(3)

Provider incentive programs are designed to ease health worker shortages by offering prospective health professionals a financial reward in exchange for committing to work for a set number of years in underserved areas, ultimately improving equitable access to health care services.(4-7) These incentive programs are structured to encourage health care professionals to both seek employment and remain in underserved and rural areas (although the specific definitions of “underserved” may vary across federal and state programs).

This literature review focuses on the types of financial incentive programs used for providers in Oregon and compares federal programs and, where available, Oregon-specific provider incentive programs. Using the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework,(8) we examine how provider incentive programs are designed to address health workforce shortages. In the context of this evaluation, “Reach” refers to the providers who receive the incentive and the populations that ultimately benefit. “Effectiveness” focuses on provider recruitment and retention, particularly in underserved and rural areas. “Adoption” assesses potential participants’ awareness of and engagement with the program. Where available, “Implementation,” reflecting how a program is delivered, and “Maintenance,” reflecting programs’ sustainability over time, are also described.

## B. Evidence on Reach

In the RE-AIM framework, “Reach” refers to the proportion and characteristics of the intended population who participate in a program. Specifically, Reach measures how many providers receive incentives and how many patients and communities ultimately benefit from the program.

## Provider Reach

The National Health Service Corps (NHSC) is the most well-documented federal incentive program for provider reach. Approximately 18,335 active NHSC participants were serving in fiscal year (FY) 2023 across 21,641 approved sites, with 38.2 percent of placements in rural areas.(9) The composition of participants in service-based programs like NHSC also appears unique: compared to family physicians participating in the Public Service Loan Forgiveness (PSLF) program (with no obligation to serve disadvantaged communities), NHSC participants were more likely to belong to underrepresented groups and to serve in rural areas with underserved populations.(10)

## Program Type

Reach varies by provider incentive program type. Loan repayment programs, for example, typically target newly graduated or practicing providers with existing debt, while scholarship and loan forgiveness programs reach students earlier in their training. Career pathway programs aim to engage prospective students from underrepresented and rural backgrounds early in their careers. Programs targeting behavioral health providers, including Oregon's Behavioral Health Loan Repayment Program and behavioral health fee waiver programs, are intended to incentivize service specifically in the behavioral health workforce.

## Population Reach

Provider incentive programs are often designed to improve access to care in underserved areas. Han and colleagues (2021) found that NHSC primary care provider staffing was associated with expanding capacity at rural community health centers without significantly increasing medical care costs, thereby potentially improving access.(11) Mapping existing incentive programs against HPSA designations (or Areas of Unmet Health Care Need) may help identify whether programs are reaching areas with the greatest need; however, it remains difficult to ascertain the volume of patients served.(5) Quigley (2022) proposed an approach using new measures of medical need, low income, rural location, and population-to-provider ratios to capture data on the patients ultimately served by provider incentive programs in Maryland;(12) however, similar approaches have not been widely used in other states.

## Gaps in Reach Data

Systematic data on who does not apply or is not reached by incentive programs are limited.

## C. Evidence on Effectiveness

In the RE-AIM framework, "Effectiveness" refers to the proportion of incentive recipients who remain at their designated practice setting or county, or within Oregon's workforce, after their service obligation is completed. Below, we compare and synthesize evidence on the effectiveness of provider incentive programs, highlighting design features associated with positive outcomes in underserved areas.

### Incentive Program Effectiveness by Program Type

#### Loan Repayment Programs

**Recruitment.** Among existing incentive programs, the strongest evidence for supporting initial recruitment is associated with loan repayment and return-of-service initiatives.(12-16) For example, in a 14-state study of 26 state service programs, safety-net administrators reported that loan repayment and loan forgiveness programs made recruiting clinicians easier (81.7 percent) and quicker (65.4 percent).(15) Additionally, HRSA reported in 2025 that increasing NHSC loan repayment amounts led to a 30 percent rise in primary care applications, suggesting that greater financial support may strengthen recruitment to serve in primary care.(16)

**Retention beyond the obligation period.** Loan repayment and forgiveness programs may also be effective in retaining providers beyond their obligation period, although the data are mixed and depend on how retention is defined (for example, remaining at the same site versus remaining in any underserved area).(17-20) In an 11-state analysis of NHSC survey data from loan payment participants between 2009 and 2012, the share who *anticipated* remaining at their site five years after service ranged from 36.7 percent (California) to 66.7 percent (Delaware and Nebraska).(21) A 2022 report found that over 80 percent of behavioral health providers who participated in NHSC loan repayment and forgiveness programs between 2012 and 2020 continued practicing in underserved areas as of 2021.(22) Similarly, an evaluation of retention patterns for clinicians participating in the Indian Health Service (IHS) Loan Repayment Program found that 76 percent of participants were still working at an Indian, Tribal, or urban Indian health site (I/T/U site) four years after completing their service obligation.(18)

**Evidence from comparison designs.** One unpublished working paper comparing U.S. counties with and without state or local loan repayment programs estimated that rural counties with programs had about 5 percent more physicians, with differences persisting for up to 10 years.(23) Peer-reviewed studies using comparison designs were not identified.

**Recruitment versus retention.** Oregon's 2016 evaluation estimated that most of the rural FTE-years added by loan repayment programs came from recruiting clinicians who would not otherwise have practiced in rural Oregon. Recruitment accounted for 75 percent to 79 percent of added FTE-years for physicians and 88 percent to 90 percent for nurse practitioners and physician associates, although estimates for the state-funded programs were not statistically significant.(17)

**Completion of the service obligation.** Loan repayment participants complete their obligations at high rates. In a 2004 study of 69 state programs in 40 states, 93 percent of participants in loan repayment and similar programs completed service requirements, compared with 66.5 percent of scholarship recipients and 44.7 percent of service-option loan recipients.(24) Completion was 90 percent in Wyoming's loan repayment program, about 93 percent in Nebraska's, and 96 percent in the federal Nurse Corps programs.(25-27) A systematic review of 43 studies published in 2009 found that 71 percent of participants across program types had fulfilled or were fulfilling their obligations.(28)

**Retention in underserved settings.** National data show that most participants remain in underserved practice after their obligation, but many leave their original site. In a 2004 national study of state programs, 66 percent of loan repayment physicians remained at their service site eight years after starting, the longest retention of any program type. Across all state service programs, 71 percent of obligated physicians remained at their sites at four years and 55 percent at eight years, compared with 61 percent and 52 percent of physicians without service obligations.(24) Among NHSC primary care alumni, 79 percent to 82 percent were practicing in any HPSA one year after service, compared with 43 percent to 49 percent in the same county HPSA (note: evaluations from 2014 and 2016).(29, 30) HRSA reports that 81 percent of clinicians completing NHSC service in FY 2022 remained in underserved areas two years later.(31) Among family physicians, participation in NHSC or state loan repayment was associated with about twice the odds of rural practice.(32) The share of NHSC family physicians practicing in medically underserved settings declined from 85.0 percent three years after residency to 60.7 percent at six years.(33) Among Nurse Corps alumni, 84 percent of loan repayment recipients remained in rural areas, underserved communities, or schools of nursing up to six years after their commitment.(25, 34)

**State program retention.** Published state data vary widely in method and results. In Kansas, a 2011 telephone survey showed that 44.6 percent of loan repayment and NHSC participants remained at their original site after their obligation.(35) In Colorado, health care providers who participated in loan repayment programs between 1992 and 2007 indicated that 55 percent remained at their original site. Fewer providers completing their service in rural

areas were still practicing rurally (64 percent) compared to urban completers who remained in urban practice (96 percent).(36) In North Dakota, 59 percent of physicians and 83 percent of advanced practice registered nurses and physician assistants [associates] awarded loan repayment between 2010 and 2014 remained in underserved areas after their contracts.(37) In Wyoming, 66 percent of loan repayment recipients (awarded between fiscal years 2005 and 2016) were practicing in the state in 2019.(26) In Vermont, retention among loan repayment recipients varied by discipline, with more than 50 percent of physicians, 60 percent of physician assistants [associates], 65 percent of registered nurses, and 80 percent of nurse practitioners remaining in practice in the state.(38)

**Behavioral health loan repayment programs.** Evidence for behavioral health loan repayment programs is limited. A scoping review found that federal loan repayment programs attract behavioral health providers to shortage areas in the short term, but that the literature is small and concentrated on the NHSC.<sup>19</sup> Among behavioral health clinicians finishing federal loan repayment terms in 33 states, 42 percent anticipated remaining in their practice for at least five more years. Supportive administration and fair compensation were the strongest predictors.(39)

### **Loan Forgiveness Programs**

**Completion of the service obligation.** Forgivable loans and service-option loans, which support students during training and are forgiven through later service, have lower completion rates than loan repayment programs. Many of these programs allow recipients to “buy out” their service obligation by repaying the funds in lieu of completing their service obligation. In a 2004 national study, 49.2 percent of service-option loan recipients repaid their loans rather than completing service.(24) Programs that set buyout penalties at three times the support amount had higher completion (80.3 percent vs. 48.6 percent).(15) Nebraska’s forgivable student loan program had an average buyout rate of 39.2 percent across five award years.(27)

**Retention among those who complete service.** Among clinicians who complete service, retention can be high. Minnesota’s loan forgiveness programs, in which loans are repaid after each year of qualifying service (after education is completed), reported that 88.9 percent of rural physicians and 100 percent of rural nurse practitioners and physician assistants [associates] in the FY 2010-2014 cohort were practicing at a qualifying site five years after completing program requirements.(40) Safety-net administrators were less likely to expect clinicians in forgivable loan programs to stay longer than clinicians in loan repayment programs (62.3 percent vs. 78.8 percent overall).<sup>15</sup>

**Forgiveness without a location requirement.** Unlike the programs above, the federal Public Service Loan Forgiveness program forgives remaining federal student loans after 10 years of payments while the borrower works for a government or nonprofit employer, with no rural or shortage-area requirement. This program applies to all types of public service, not only health care. In national survey data on early-career family physicians, 24.2 percent of Public Service Loan Forgiveness participants worked in medically underserved settings, close to the 19.5 percent of all family physicians and far below the 82.2 percent of NHSC participants.<sup>10</sup> Additional research supports evidence that participants were less likely than nonparticipants to practice in rural areas.(32)

**Data availability.** Several states that operate forgivable loan programs publish limited completion or retention data. North Carolina's Program Evaluation Division found that the state could not verify whether its education loan programs encourage employment in fields with critical shortages.(41)

### **Career Pathways and Training Initiatives**

These programs include a wide variety of strategies designed to support students in pursuing health care careers across the educational continuum, from K-12 and career and technical education to community college, undergraduate, and postgraduate training.(42) Evaluations of K-16 pathway programs suggest positive short-term impacts, including increased awareness of health care careers, improved standardized test performance, and higher college and medical school enrollment; however, most studies have been too small to evaluate long-term impacts.(43) Community colleges train a substantial share of the health care workforce, particularly in practical nursing, allied health, and laboratory sciences and can create pathways that support advancement into higher-skilled, higher-wage jobs.(44) More is known about how post-graduate and professional training supports recruitment and retention in rural and underserved areas: physicians and dentists who receive rural-focused training during medical school, dental school, or residency are more likely to choose rural practice.(45, 46) Behavioral health trainees with more rural training experience are more likely to anticipate staying in rural practice, though less is known about their long-term retention.(47)

Few studies of career pathway programs have used a comparison group. One rigorous study, a randomized trial of the federal Health Profession Opportunity Grants, paired health care training with tuition assistance and support services for low-income adults. Six years after award, 36.9 percent of participants worked in a health care occupation compared with 32.0 percent of comparison adults.(48)

Programs that recruit students with rural ties and connect them to professional training report the largest impact on rural practice. In Alabama, 48.1 percent of

Rural Medical Scholars participants, a program focused on recruiting rural students and promoting rural family practice careers, practiced in rural Alabama compared with 11.2 percent of their peers.(49) The Scholars in Rural Health program at the University of Kansas School of Medicine found that among the 150 practicing clinicians who were supported through the program, 56 percent worked in rural counties.(50)

While postbaccalaureate premedical programs show promise in increasing educational attainment among disadvantaged students,(51) it is challenging for pipeline programs to track participants into practice. A survey of Area Health Education Centers in 19 states found limited capacity to follow participants beyond one year.(52) It is possible to match participants to National Student Clearinghouse records, an approach that has been used to show higher health professions degree completion among pipeline participants.(53) However, this approach will not capture licensing, employment, or workforce impacts.

## **Scholarships**

Scholarships aid students seeking health care careers by reducing the burden of educational debt, which often disproportionately burdens students from underrepresented and low-income backgrounds.(54) Some scholarships require a return-of-service obligation, while others do not. Evaluations show that scholarship programs increase the number of health program graduates, but provide limited evidence on whether they reduce workforce shortages or improve workforce diversity.(55, 56) Scholarships' effectiveness on maintaining a student through the course of their education and training can depend on the amount of tuition coverage, duration of support, assistance with expenses such as fees and stipends, and the provision of wraparound services such as mentorship, exam preparation, tutoring, and counseling.(56)

Scholarships with service obligations place clinicians in underserved areas, but fewer recipients complete service than in loan repayment programs. In a 2004 national study of state programs, an average of 66.5 percent of scholarship recipients completed service.(24) In the same study, 27.2 percent of scholarship recipients bought out of their obligation, and scholarship recipients left their service sites sooner than loan repayment, loan, and direct incentive recipients.(24) Similarly, 66.3 percent of surveyed nursing scholarship recipients in Virginia reported completing their obligation.(57)

Evidence suggests that scholarship recipients change sites but remain in underserved practice. The NHSC scholarship program provides tuition, fees, and living expenses for students in primary care professions and requires a service commitment in an underserved area after completing their education. Among NHSC scholars, one year after service, 41.4 percent remained at their service site compared with 70.1 percent of loan repayment participants, but

similar shares of both groups (72.5 percent and 71.0 percent) remained in underserved practice.(29, 30) Among alumni recipients of the national Nurse Corps Scholarship Program, 72 percent remained in rural areas, underserved communities, or schools of nursing up to six years after completion of their service commitment.(25)

Programs that recruit rural-origin students report high rural retention among completers; in Mississippi, 84 percent of Mississippi Rural Physicians Scholarship Program recipients who completed their service commitment were still practicing rurally (duration of post-service completion service not reported).(58) For scholarships without service obligations, there is little evidence to suggest that the scholarships alone significantly improve recruitment or retention of the health care workforce in rural or underserved areas, especially in higher income countries.(59)

### **Clinical Supervision Grants**

Completing required clinical supervision hours is a well-documented pipeline barrier for pre-licensed clinicians, particularly in counseling, social work, marriage and family therapy and substance use treatment, where licensure often requires hundreds to thousands of supervised post-degree clinical hours.(60-62) As a result, clinical supervision grants and stipend programs have emerged as a workforce strategy to reduce this barrier. Evidence from a Nebraska study suggests that supervision grants increase the supply of supervisors and improve trainees' ability to enter the workforce.(61)

### **Fee Waiver Programs (exam, licensure, and certification fees)**

To the best of our knowledge, no published evaluations have directly assessed fee waiver programs as a standalone recruitment and retention strategy. However, licensure and certification costs are recognized barriers to workforce entry and mobility, particularly for new graduates and clinicians entering underserved areas. Some employers and state systems have incorporated payment or reimbursement of initial and renewal licensure fees into broader recruitment packages.(63-65) States have also implemented similar targeted fee waiver programs. Massachusetts waived initial application fees for 13 behavioral health licenses and certifications from September 2024 through June 2026.(66) The California Mental Health Services Authority (CalMHSA) offers fee waivers for Medi-Cal (California's Medicaid program) peer support specialist certification, including application, examination, training, and renewal fees.(67) Although these programs address upfront costs, their effects on workforce retention and recruitment have not been established.

Related research suggests that licensing requirements may influence workforce entry. A study of emergency medical technicians found that more stringent

state licensing requirements offset increases in entry associated with expanded insurance coverage,(68) although findings were suggestive rather than definitive and did not evaluate fee waivers specifically. In a 2025 survey of Minnesota mental health graduates, 61 percent identified examination or study-material costs, and 58 percent identified application costs as moderate or significant problems.(32) An early evaluation of California’s peer support specialist certification program also cited training and exam costs as barriers.(69) Together, these findings suggest that fee waiver programs may address a recognized potential barrier to education and practice, but whether they increase workforce entry or improve retention, particularly in underserved areas, has not been established.

### **Hiring and Retention Bonuses**

Although sign-on and retention bonuses are commonly used to recruit and retain providers, few studies have evaluated their effectiveness.(70, 71) A recent scoping review of nursing recruitment and retention strategies suggests that long-term retention may depend more on competitive wages, rather than one-time bonuses as a short-term solution.(72) Research from Australia suggests that financial incentives, including retention payments, positively influence rural primary care providers’ interest in remaining in rural practice, although actual effects on retention were not examined.(73)

### **Housing, Childcare, and Relocation Stipends**

These supports are viewed as promising recruitment and retention strategies in rural and underserved workforce policy,(74, 75) but direct causal studies isolating their independent effects are limited.

### **Insurance Subsidies**

Insurance subsidies reduce the cost of malpractice insurance for rural providers. These costs have been identified by rural family physicians as a barrier to providing higher-liability services, such as obstetric care.(76) Beyond Oregon, several states have offered malpractice premium assistance for rural, underserved, or obstetric providers. Maine’s Rural Medical Access Program assists physicians who provide prenatal and delivery care in underserved areas.(77) New Mexico’s Birthing Workforce Retention Fund, created in 2008, provides awards of \$5,000 to \$10,000 toward malpractice premiums for certified nurse-midwives and physicians whose obstetric practice is at least half Medicaid or low-income patients.(78) Arizona law authorizes premium assistance of up to \$5,000 or \$10,000 for physicians and advanced practice providers who deliver babies in rural areas, in exchange for one year of continued practice.(79) Georgia has previously offered malpractice premium grants to physicians and dentists in underserved rural areas,(80) North Carolina

subsidized insurance premiums for rural obstetric providers through its Rural Obstetrical Care Incentive program beginning in 1988,(81) and Pennsylvania fully abated required malpractice fund assessments for obstetricians and other high-risk specialists statewide from 2003 to 2005.(82)

Despite the existence of these programs, published evaluations are limited. Evaluations from 1992 and 1993 of North Carolina's Rural Obstetrical Care Incentive program found that participating counties maintained or increased access to obstetric care, participating physicians increased obstetric care for Medicaid patients relative to physicians elsewhere in the state, and inadequate prenatal care declined in participating counties while increasing in other rural counties.(81, 83) To our knowledge, evaluations of the Maine, New Mexico, Arizona, or Georgia programs were not identified. Oregon is the only state described here with a published evaluation estimating the association between its Rural Medical Practitioner Insurance Subsidy and provider supply. A broader evaluation of Oregon's provider incentive programs attributed effects on physician supply to retention, while recruitment also contributed to estimated effects for nurse practitioners and physician associates.(17) In that evaluation, the subsidy's effect for physicians came entirely through retention, while about half of its effect for nurse practitioners and physician associates came from recruitment.17 After Oregon introduced its rural malpractice subsidy in 2003, the proportion of rural physicians who stopped providing maternity care fell from 25.0 percent to 9.6 percent, although the subsidy's effect was not measured directly (study from 2006).(84) Overall, evidence on malpractice premium subsidies is limited and mixed, and their effects on provider recruitment or retention remain unclear.

### **Tax Credits**

Currently, at least five states (Oregon, Alabama, Georgia, Louisiana, and New Mexico) offer tax credits to rural health care providers.(3, 85-89) These programs vary by eligible professions, definitions of rural practice, and duration limits. Oregon is the only state for which an evaluation has estimated effects on provider recruitment and retention.(17) The 2016 Lewin Group report estimated that Oregon's Rural Provider Tax Credit contributed to increased retention among rural primary care physicians, nurse practitioners, and physician associates.(17) However, a 2021 review by Oregon's Legislative Revenue Office found that, although most surveyed tax credit recipients considered the credit as important to their decision to remain in rural practice, available data could not establish its independent effect on recruitment or retention.(90) Similarly, a review by New Mexico's Legislative Finance Committee noted that insufficient data limited assessment of the state's rural health care practitioner tax

credit.(91) No evaluations of the Alabama, Georgia, or Louisiana credits were identified.

## Summary of Evidence of Effectiveness

Evidence is strongest for loan repayment programs, which generally improve recruitment in underserved areas, although findings on retention after service obligations end are mixed.(13, 14, 17, 28) Scholarships and forgivable loans also support recruitment, but some recipients repay rather than fulfill service obligations. Estimates from individual programs suggest that about one-quarter of scholarship recipients and one-half of loan recipients repay rather than serving in some programs, although those who complete service often remain in underserved practice.(15) Evidence for sign-on bonuses, housing or relocation assistance, and fee waivers is more limited. No published evaluations of fee waivers were identified, and evaluations estimating effects of malpractice insurance subsidies and rural provider tax credits have been limited to Oregon.(17) Overall, evidence remains uneven across incentive types.

## Potential Impacts of Incentive Programs on Workforce Supply

**Change in HPSA status.** Recruiting additional providers can improve an area's provider-to-population ratio, potentially lowering its HPSA score or leading to loss of designation. Because some incentives depend on HPSA status, this change may affect eligibility for future incentive programs, including certain NHSC loan repayment opportunities.(1, 92) This creates a potential tension: successful recruitment may reduce eligibility for incentives that help sustain the local workforce.

**Provider migration driven by incentives.** Incentives may redistribute providers across communities rather than increase the overall supply of providers, particularly when they move from one underserved area to another to qualify for incentives.(15, 93) For example, providers may relocate from a nearby community to a HPSA-eligible site to qualify for loan repayment, potentially improving access in the receiving community without improving access across the region and leaving the other community with new, persistent, or worsening workforce shortages.

**Short-term retention.** Because many incentives require only a short service commitment, providers often leave once the incentive period ends,(17-20) resulting in communities experiencing rotating workforces and sites that need to constantly re-recruit to maintain staffing.

**Provider type substitution.** Service obligation programs often prioritize specific provider types, most commonly physicians,(94) which can overlook other provider types, such as nurse practitioners and physician associates, who

may be equally eligible to provide care in underserved communities. Depending on local needs, these providers may offer an alternative or complementary approach to addressing workforce shortages. Incentive programs that focus narrowly on physicians may therefore miss opportunities to strengthen and build a more sustainable workforce.

## Factors that May Moderate the Effectiveness of Provider Incentive Programs

In addition to service obligation and incentive type described above, several additional features moderate the effectiveness of provider incentive programs, especially regarding initial recruitment versus longer-term retention.

**Work environment.** Evidence from the NHSC loan repayment program suggests that technical assistance and job resources accessible within the clinician's work environment were more influential on intentions to remain in a position compared to individual- or community-level characteristics.(20)

**Type of provider.** The association between provider type and incentive program effectiveness varies across programs and outcomes. For example, the 2016 Lewin report found that physicians working in IHS sites had the lowest retention rates within the same I/T/U organization compared with other provider types.(18) In contrast, a study of the Bureau of Clinician Recruitment and Service found the highest retention rates among physicians and the lowest for physician associates.(95) Research on NHSC loan repayment programs also found improved recruitment of primary care physicians, but had larger effects on nurse practitioners and physician associates.(17)

**Geography.** Provider incentive programs are often designed specifically to recruit clinicians to rural or underserved areas because shortages are geographically concentrated. Recent workforce data show that over 60 percent of primary care HPSAs are in rural areas.(1) Evidence suggests that provider incentives (loan repayment, loan forgiveness) generally increase the number of clinicians practicing in rural and underserved areas, although retention after the obligation period is variable.(10, 94, 96) Of note, the same geographic barriers that increase the need for rural incentive programs can make long-term retention more difficult once service obligations end.

## Gaps in Effectiveness Data

Important gaps remain in the effectiveness of provider incentive programs. Recent research indicates that the literature is relatively limited and concentrated in a few programs, most notably the NHSC loan repayment and forgiveness programs, and that few studies directly compare categories such as financial incentives, education programs, regulatory approaches, and broader

support strategies.(19, 97) Long-term retention after the service obligation remains understudied, largely because many programs do not consistently report retention outcomes.(19, 33) Exceptions include a non-peer-reviewed working paper comparing counties with and without state or local loan repayment programs,(23) a randomized trial of financial support for health care training,(48) and an older national comparison of obligated and nonobligated physicians.(24) As a result, the comparative effectiveness of different program models is not well understood.(19, 33) Many states also lack the data needed to track outcomes. Several states with large loan repayment programs publish no post-obligation retention data, and recent state reviews in Washington, Maryland, and Alabama reported that data systems could not track recipients' workforce outcomes.(98-100)

## **D. Evidence on Adoption**

Within the RE-AIM framework, "Adoption" refers to the proportion and representativeness of settings and individuals willing to participate in a program. For this evaluation, Adoption considers whether eligible providers and practice sites are aware of, interested in, and able to engage with incentive programs. Evidence on the adoption of provider incentive programs is limited. A fundamental precondition for adoption is awareness, yet fragmentation across myriad programs offered by federal, state, and institutional entities may create barriers in awareness.(101) Additionally, physician-focused programs have historically dominated the loan repayment and incentive landscape, and thus, awareness of such programs targeted to other provider groups may be limited.

## **E. Evidence on Implementation**

"Implementation" within RE-AIM refers to the fidelity and consistency with which a program is delivered, including administrative processes, service obligation monitoring, and data collection. Data on implementation are limited. Federal programs, such as the NHSC, follow standardized application cycles and systems, and service obligation requirements have been consistent over the years. However, state programs and new program types (beyond loan repayment, such as clinical supervision grants, housing stipends, or fee waivers) vary considerably in terms of structure and components.(5) State loan repayment and forgiveness programs can also vary over time due to budget fluctuations.(9) A persistent implementation challenge is data quality and consistency, and the lack of standardized outcome reporting across programs limits comparisons or monitoring.(19) As noted above, evidence from NHSC suggests that implementation is characterized by the organizational context where providers work, namely that job resources and technical assistance had a greater impact on retention intentions than individual or community

characteristics alone.(20) Finally, it appears that multidimensional aspects of program implementation may increase effectiveness compared to standalone incentives.(102)

## **F. Evidence on Maintenance**

In the context of this evaluation, “Maintenance” refers to the degree to which a program is sustained over time at the program level (continued funding and operation). Limited data exists on the long-term maintenance of provider incentive programs as evaluated interventions. The NHSC's field strength declined from 20,215 participants in FY 2022 to approximately 18,335 in FY 2023 following a significant reduction in federal appropriations.(103) Further declines were observed in FY 2024 (field strength 17,415), after which there was a slight increase in FY 2025 (field strength 18,596), though still less than FY 2022.(104) Beyond funding stability, evidence as to whether and how provider incentive programs are sustained, adapted, or discontinued over time is largely absent from the published literature.(14)

## **G. Prior Evaluations of Oregon’s Provider Incentive Programs: Key findings and limitations**

The 2016 Lewin Group report (17) found that Oregon’s incentive programs (loan repayment, tax credits, and insurance subsidies) increased provider FTE years in rural areas, with some programs functioning mainly as recruitment tools and others supporting retention of existing rural clinicians. The report also suggested that nurse practitioners and physician associates generated additional FTE years at lower cost than physicians, indicating a cost-effective strategy for addressing shortages, though data limitations constrained the evaluation.

The 2023 Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon (89) showed that financial incentives supported at least 3,585 students and professionals from 2018 to 2022, expanding access to care in underserved communities and generating an estimated 1.1 million service hours for nearly 440,000 patients. The 2023 report also found that incentives contributed to workforce diversity (34 percent of recipients identifying as non-White or Tribal members for incentives that collected race/ethnicity data), though persistent shortages, incomplete demographic data, and limited time for assessing long-term retention remained challenges.

The 2025 Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon (105) reported that Oregon’s incentive programs supported 7,208 students and professionals from 2018 to 2024, improving recruitment and retention in medically underserved communities. Retention outcomes in 2025 were strong, with 89 percent of students and 92 percent of

practicing professionals remaining in Oregon for up to five years, and participating clinicians expected to deliver 1.2 million hours of care annually to about 1.5 million patients. The 2025 report highlighted continued gains in workforce diversity (39 percent identifying as people of color or Tribal members for incentives that collected race/ethnicity data) and identified opportunities for expanded behavioral health and nursing incentives, clearer career pathways, and employer supports such as housing and childcare.

The primary limitations in the three prior evaluations stem from incomplete or inconsistent data, particularly missing applicant information, limited provider-level or demographic details, and reliance on administrative or proprietary datasets. Each report also lacked sufficient time or tracking capacity to fully assess long-term retention or the sustained impact of newer incentive programs. As a result, the evidence base remains constrained, and future evaluations would benefit from stronger data collection systems and longer follow-up periods.

**Table 14. Types of incentive programs with comparison of Oregon incentive programs and similar national or state-level programs.**

| Program Type            | Description                                                                                                                                                                                                                 | Oregon Programs                                                                                                                                                                                                                                                                                               | Similar National or State Programs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Loan Repayment</b>   | Eligible practicing providers receive tax-free awards to pay off educational debt in exchange for return-of-service obligation at an eligible practice site in a rural or underserved area.                                 | <ul style="list-style-type: none"> <li>• HCPIP - Health Care Provider Loan Repayment Program</li> <li>• HCPIP - Behavioral Health Loan Repayment Program (BHLRP)</li> <li>• HCPIP - State Loan Repayment Program (SLRP)</li> <li>• BHWI - Oregon Behavioral Health Loan Repayment Program (OBHLRP)</li> </ul> | <p><u>National:</u></p> <ul style="list-style-type: none"> <li>• National Health Service Corps (NHSC) Loan Repayment Programs (LRPs)</li> <li>• Nurse Corps LRP</li> <li>• Indian Health Service (IHS) LRP</li> <li>• Substance Use Disorder Treatment and Recovery LRP</li> </ul> <p><u>State:</u></p> <ul style="list-style-type: none"> <li>• Currently 46 states, the District of Columbia, and 3 US territories offer state loan repayment programs that are jointly funded with the federal government.(106)</li> </ul> |
| <b>Loan Forgiveness</b> | Students in eligible health care training programs can receive coverage of tuition, fees, and/or stipends in exchange for a return-of-service obligation at an eligible rural or underserved practice site upon graduation. | <ul style="list-style-type: none"> <li>• HCPIP - Primary Care Loan Forgiveness</li> </ul>                                                                                                                                                                                                                     | <p><u>State:</u></p> <ul style="list-style-type: none"> <li>• Colorado Health Service Corps Scholarship Program for Addiction Counselors(107)</li> <li>• Illinois Rural Nurse Practitioner Scholarship Program(108)</li> <li>• Mississippi Rural Physicians Scholarship Program(58)</li> </ul>                                                                                                                                                                                                                                |
| <b>Scholarships</b>     | Provides funding to institutions to develop and award scholarships (towards tuition, fees, and/or stipends) to students pursuing future health care careers.                                                                | <ul style="list-style-type: none"> <li>• HCPIP - Health Care Workforce Scholarship</li> <li>• HCPIP - Scholars for a Healthy Oregon Initiative (SHOI)</li> <li>• BHWI - Behavioral Health SHOI-Like Scholarships</li> <li>• BHWI - Graduate Tuition Assistance and Stipends</li> </ul>                        | <p><u>National:</u></p> <ul style="list-style-type: none"> <li>• NHSC Scholarship Program</li> <li>• Nurse Corps Scholarship Program</li> <li>• IHS Scholarship Program</li> <li>• Native Hawaiian Health Scholarship Program</li> <li>• HRSA Behavioral Health Workforce Education and Training (BHWET) Program for Professionals(109)</li> </ul>                                                                                                                                                                            |

| Program Type                                    | Description                                                                                                                                                                                                                                                                                                                                                                                                   | Oregon Programs                                                                                                                                                                                                                | Similar National or State Programs                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                 |                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>• HRSA Scholarships for Disadvantaged Students</li> </ul> <p><u>State:</u></p> <ul style="list-style-type: none"> <li>• Doctors for Maine's Future Scholarship(110)</li> <li>• New Jersey Midwifery Education Project (NJ-MEP)(55)</li> </ul>                                                     |
| <b>Career Pathways and Training Initiatives</b> | Provides funding and partnerships to develop programs and support services aimed to help students, particularly those from underrepresented backgrounds, to advance towards health care careers. These programs focus on supporting students across various education levels, from K-12 to career and technical education to community college and undergraduate to post-graduate and professional education. | <ul style="list-style-type: none"> <li>• HCPIP - Health Care Workforce Pathways Scholarships</li> <li>• Healthy Oregon Workforce Training Opportunity Grant Program (HOWTO)</li> <li>• BHWI - Peer Support Services</li> </ul> | <p><u>State:</u></p> <ul style="list-style-type: none"> <li>• Various states: Area Health Education Centers Pathways and Scholar Programs(111)</li> <li>• New Mexico: Forward NM Pathways to Health Careers(112)</li> </ul>                                                                                                              |
| <b>Clinical Supervision Grants</b>              | Provides funding to behavioral health (BH) organizations to support clinical supervision for BH providers pursuing licensure. Funds may be used to contract or employ clinical supervisors, train clinicians to become qualified supervisors, or hire supervisees and ensure they receive supervision.                                                                                                        | <ul style="list-style-type: none"> <li>• BHWI - Community Mental Health Program Grants</li> </ul>                                                                                                                              | <p><u>National:</u></p> <ul style="list-style-type: none"> <li>• HRSA Behavioral Health Workforce Education and Training (BHWET) Program for Professionals(109, 113)</li> </ul> <p><u>State:</u></p> <ul style="list-style-type: none"> <li>• Nebraska: Behavioral Health Education Center, Supervision Incentive Program(61)</li> </ul> |

| Program Type                           | Description                                                                                                                                                                                                                                      | Oregon Programs                                                                                                                                                                                                                                                                                                                                                                  | Similar National or State Programs                                                                                                                                                                                                                          |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>Massachusetts: Behavioral Health Supervising Clinicians Incentive Program (established in June 2025)(114)</li> <li>Washington: Behavioral Health Workforce Pilot Program and Training Grants Program(115)</li> </ul> |
| <b>Fee waiver programs</b>             | Provides funding to cover the costs of examination courses, examinations, licensure or certification fees, and/or license/certification renewal fees to encourage health care providers to complete and continue licensure and/or certification. | <ul style="list-style-type: none"> <li>HCPIP - Behavioral Health Retention Incentives</li> <li>HCPIP - Health Care Interpreter Retention Incentives</li> <li>BHWI - Mental Health &amp; Addiction Certification Board of Oregon (MHACBO)</li> <li>BHWI - Association of Social Work Board (ASWB) Programs and Oregon Board of Licensed Social Workers (BLSW) Programs</li> </ul> | <u>State:</u> <ul style="list-style-type: none"> <li>Massachusetts one-time behavioral health license application fee waivers(66);</li> <li>California Medi-Cal peer support specialist certification fee waivers(67)</li> </ul>                            |
| <b>Sign-on &amp; Retention Bonuses</b> | Provides funding to health care organizations to provide one-time monetary incentives to recruit and/or retain staff.                                                                                                                            | <ul style="list-style-type: none"> <li>BHWI - Community Mental Health Program Grants</li> <li>BHWI - Oregon Behavioral Health Workforce Bonus and Housing Stipend Program</li> <li>BHWI - Peer Support Services</li> </ul>                                                                                                                                                       | <u>State:</u> <ul style="list-style-type: none"> <li>New York State Health Care and Mental Hygiene Worker Bonus (HWB) Program(116)</li> </ul>                                                                                                               |
| <b>Stipends</b>                        | Provides funding to health care organizations to recruit and/or retain staff by providing cost-of-living supports (housing/relocation, childcare, etc.)                                                                                          | <ul style="list-style-type: none"> <li>BHWI - Oregon Behavioral Health Workforce Bonus and Housing Stipend Program</li> <li>BHWI - Community Mental Health Program Grants</li> </ul>                                                                                                                                                                                             | <u>State:</u> <ul style="list-style-type: none"> <li>North Dakota: Workforce Retention Funding for Critical Access Hospitals (starting in 2026 through ND's Rural Health Transformation Program)(117)</li> </ul>                                            |
| <b>Insurance Subsidies</b>             | Subsidies to offset malpractice insurance costs for providers practicing in rural areas, with subsidies disbursed to insurers.                                                                                                                   | <ul style="list-style-type: none"> <li>HCPIP - Rural Medical Practitioner Insurance Subsidy</li> </ul>                                                                                                                                                                                                                                                                           | <u>State:</u> <ul style="list-style-type: none"> <li>Maine Rural Medical Access Program(77);</li> <li>New Mexico Birthing Workforce Retention Fund(78);</li> </ul>                                                                                          |

| Program Type      | Description                                                                                                           | Oregon Programs                                                                   | Similar National or State Programs                                                                                                                                                                                                                                                                                                                                                         |
|-------------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                   |                                                                                                                       |                                                                                   | <ul style="list-style-type: none"> <li>• Arizona rural obstetric malpractice premium assistance(79).</li> <li>• Previously: Georgia, North Carolina, and Pennsylvania (among others)(80, 81, 118)</li> </ul>                                                                                                                                                                               |
| <b>Tax Credit</b> | Eligible practicing health care providers who work in rural areas can receive a tax credit on their state tax return. | <ul style="list-style-type: none"> <li>• Rural Practitioner Tax Credit</li> </ul> | <u>State:</u> <ul style="list-style-type: none"> <li>• Georgia: Rural Health Care Professional Tax Credit and Rural Physician Credit(86)</li> <li>• New Mexico: Rural Health Care Professional Tax Credit Program(88)</li> <li>• Alabama: Rural Physicians Tax Credit(87)</li> <li>• Louisiana: Small Town Health Professionals Credit(85)</li> <li>• Montana (phased out 2007)</li> </ul> |

**Abbreviations: BHWI - Behavioral Health Workforce Incentives; HCPIP - Health Care Provider Incentive Program; HOWTO - Healthy Oregon Workforce Training Opportunity Grant Program; HRSA - Health Resources & Services Administration; IHS - Indian Health Service; LRP - loan repayment program; SHOI - Scholars for Healthy Oregon Initiative**

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