



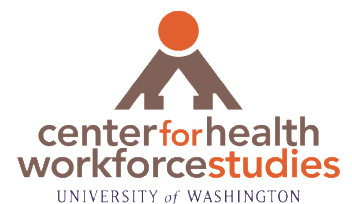
Health Policy and Analytics Division
Health Care Provider Incentive Program

2027

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

**Prepared for the Oregon Health Policy
Board**

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



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List of Abbreviations

Abbreviation	Definition
AHEC	Area Health Education Center
ARPA	American Rescue Plan Act
ASWB	Association of Social Work Boards
AUHCN	Areas of Unmet Health Care Need
BH	Behavioral Health
BHLRP	Behavioral Health Loan Repayment Program (HCPIP program)
BHWI	Behavioral Health Workforce Incentives
BLSW	(Oregon) Board of Licensed Social Workers
CADC	Certified Alcohol and Drug Counselor
CEU	Continuing Education Unit
CHW	Community Health Worker
CMHP	Community Mental Health Program
CNA	Certified Nursing Assistant
COVID-19	Coronavirus (2019)
CRM	Certified Recovery Mentor
CRNA	Certified Registered Nurse Anesthetist
CSIW	Clinical Supports, Integration and Workforce (Unit)
DDS	Doctor of Dental Surgery
DMD	Doctor of Dental Medicine
DNP	Doctor of Nursing Practice
DO	Doctor of Osteopathic Medicine
DPM	Doctor of Podiatric Medicine
EMS	Emergency medical services
EOC	End-of-Contract
EOY	End-of-Year
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
GED	General Educational Development (credential)
HB	House Bill
HCPIF	Health Care Provider Incentive Fund
HCPIP	Health Care Provider Incentive Program
HCPLRP	Health Care Provider Loan Repayment Program
HCWF	Health Care Workforce
HOWTO	Healthy Oregon Workforce Training Opportunity
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HWRP	Health Care Workforce Reporting Program

Abbreviation	Definition
IHS	Indian Health Service
LPN	Licensed Practical Nurse
MD	Doctor of Medicine
MHACBO	Mental Health and Addiction Certification Board of Oregon
MPAS	Master of Physician Associate Studies
ND	Doctor of Naturopathic Medicine
NP	Nurse Practitioner
OBHLRP	Oregon Behavioral Health Loan Repayment Program (BHWI program)
OHA	Oregon Health Authority
OHPB	Oregon Health Policy Board
OHSU	Oregon Health & Science University
OMA	Oregon Medical Association
ORH	Oregon Office of Rural Health
ORS	Oregon Revised Statutes
PA	Physician Associate
PCLF	Primary Care Loan Forgiveness
PRISM	Provider Retention & Information System Management
PSLF	Public Service Loan Forgiveness
QMHA	Qualified Mental Health Associate
QMHP	Qualified Mental Health Professional
REALD SOGI	Race, Ethnicity, Language, Disability, Sexual Orientation, and Gender Identity
RHC	Rural Health Clinic
RMPIS	Rural Medical Practitioners Insurance Subsidy
RN	Registered Nurse
RPTC	Rural Practitioner Tax Credit
SD	Standard deviation
SHOI	Scholars for a Healthy Oregon Initiative
SLRP	State Partnership Loan Repayment Program

Executive Summary

This report evaluates Oregon’s health care provider incentives, which are designed to grow the state’s health care workforce and increase access to culturally responsive care in urban and rural underserved areas.

Oregon began offering financial incentives to support health care provider recruitment and retention in the 1980s. Initial efforts included a rural practitioner tax credit and medical liability insurance premium subsidies to physicians and nurses in rural parts of the state. During the 2010s, Oregon policymakers recognized that health care systems transformation efforts, including expanded insurance coverage and increased access to care, required investments to strengthen the state’s health care workforce.

In 2017, the Oregon Legislature passed House Bill 3261 to create the Health Care Provider Incentive Fund (HCPIF), which combined these earlier provider incentives into a single pool. HCPIF is administered by the Oregon Health Authority (OHA) in collaboration with the Oregon Office of Rural Health (ORH) at Oregon Health & Science University (OHSU) and under the direction of the Oregon Health Policy Board (OHPB).

House Bill 3261 (2017) requires OHPB, through OHA and its partners, to evaluate the effectiveness of state financial incentive programs in recruiting and retaining health care providers to practice in rural and medically underserved areas and report its findings to the Oregon Legislature every two years. This is the fifth such report. This report covers incentives from HCPIF’s inception in 2018 through June 30, 2026, unless otherwise noted, and summarizes data on the following financial incentive programs per House Bill 3261:

- **Health Care Provider Incentive Program (HCPIP)**, created by House Bill 3261 (2017) and codified in Oregon Revised Statutes (ORS) 676.460 (now ORS 676.454)
- **Healthy Oregon Workforce Training Opportunity Grant Program (HOWTO)**, created by House Bill 3261 (2017) and codified in ORS 676.467
- **Rural Practitioner Tax Credit Program (RPTC)**, created by Senate Bill 438 (1989) and codified in ORS 315.613

Behavioral Health Workforce Incentives (BHWI), created by House Bills 2949 (2021) and 4071 (2022) and codified in ORS 675.650 to 675.658

Between 2018 and 2026, Oregon operated at least 20 distinct health care workforce incentives across 11 incentive types, administered by three HCPIF umbrella initiatives within OHA (HCPIP, HOWTO, and BHWI) and by ORH (RPTC).

Together these incentives supported students in grades eight through 12, students in professional degree programs, pre-licensed and certified workers, licensed clinicians, and health care interpreters.

About This Evaluation

Findings are organized according to data elements specified in House Bill 3261 and informed by two established frameworks: the Donabedian Structure-Process-Outcome model and the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework. This approach responds to the Health Care Workforce (HCWF) Committee's request for greater attention to how process indicators (e.g., award rates) differ from outcome indicators (e.g., provider supply). All findings are descriptive. Because recipients were not randomly assigned and no non-recipient comparison group was available, findings describe patterns associated with participation rather than causal effects. Counts are reported separately by program because reporting units differ and individuals may receive more than one incentive. Data sources, methods, and small-numbers reporting rules are described in Appendix B.

Key Findings

- **Provider types, discipline, and specialty.** Oregon's incentives reach every stage of the workforce pathway, from students in grades 8 through 12 to practicing clinicians, certified behavioral health workers, and health care interpreters. Reach ranged from 13 State Partnership Loan Repayment Program (SLRP) recipients to 4,043 RPTC recipients, and fee waivers covered 4,082 behavioral health certification registrations (Table 1).
- **Demographic characteristics.** Where data were available, many recipients identified with a race or ethnicity other than white alone, and many used a language other than English. Fewer than half of Behavioral Health Loan Repayment Program (BHLRP) recipients (46.0 percent) identified as white, and two in five Health Care Provider Loan Repayment Program (HCPLRP) recipients (40.1 percent) used a language other than English. Categories differ by program and are not directly comparable.
- **Location.** Programs reached their intended settings. Nearly all recipients of programs requiring rural practice served rural communities, while loan repayment programs reached safety-net sites in both rural and urban areas.
- **Contribution to direct patient care.** Recipients reported close to full-time clinical schedules, averaging roughly 32 to 38 hours of direct patient care or clinical work per week.
- **Services provided through telemedicine.** Most HCPLRP (57.8 percent) and BHLRP (86.0 percent) recipients with available data delivered some care by

telehealth, although telehealth made up a small percentage (2.6 percent) of HCPLRP survey respondents' outpatient visits.

- **Applications and awards.** Among incentives that collect applicant data, demand grew fastest for HCPLRP and HOWTO and appeared to outpace available awards. Eligible HCPLRP applicants tripled between 2018 and 2025 and eligible HOWTO proposals grew from 9 in Round 1 to 103 in Round 6.
- **Retention.** Most recipients remained in Oregon after their service obligation ended; fewer remained in the same county. HCPLRP, Primary Care Loan Forgiveness (PCLF), and Scholars for a Healthy Oregon Initiative (SHOI) were the only incentives with sufficient data to assess retention through five years. Across all measured intervals, at least 70 percent of recipients remained in practice in Oregon.
- **Evidence by incentive type.** National research provides the strongest evidence for loan repayment and loan forgiveness, particularly for recruiting providers to rural and underserved areas. Evidence for scholarships, career pathways, bonuses, and stipends is more limited, and no published evaluations of fee waiver programs were identified. Published evaluations of rural tax credits and malpractice insurance subsidies are limited to Oregon's 2016 evaluation and, for malpractice subsidies, studies of a North Carolina program from the early 1990s.
- **Data.** Programs collect different data in different formats. This prevents counting unique individuals across programs and tracking certified and pre-licensed workers over time.

Incentive Reach

Between 2018 and 2026, Oregon's provider incentives supported students, practicing professionals, and health care workers across every incentive type and in most parts of the state (Table 1). Counts are reported by incentive and by the measurement unit applicable to each program (e.g., recipients vs. registrations).

Table 1. Number of individuals reached by Oregon health care provider incentives, by incentive program, 2018-2026

Incentive	Number reached	Unit*, reporting period
Health Care Provider Loan Repayment Program (HCPLRP) for practicing professionals in primary care, oral health, and behavioral health†	322	Recipients, 2018-2026
Behavioral Health Loan Repayment Program (BHLRP) for licensed, pre-licensed, and certified professionals‡	113	Recipients, 2018-2022 and 2024-2026

Incentive	Number reached	Unit*, reporting period
State Partnership Loan Repayment Program (SLRP)†	13	Recipients, 2022-2023‡
Primary Care Loan Forgiveness (PCLF) for students in training†	117	Recipients, 2018-2026
Scholars for a Healthy Oregon Initiative (SHOI) at OHSU	152	Recipients, 2018-19 to 2025-26§
Health Care Workforce Scholarship	371	Recipients, 2019-2025
Health Care Workforce Pathways scholarships for students in grades 8-12	468	Recipients, 2025
Healthy Oregon Workforce Training Opportunity (HOWTO) Grant Program	At least 1,728	Unduplicated participants trained, 2019-2025, across 53 grantee projects
Health Care Interpreter Retention Incentives	102	Recipients, 2025
Behavioral Health Retention Incentives (certification and examination fee waivers)	4,082 registrations 481 examinations	Recipients, June-December 2025
Rural Medical Practitioner Insurance Subsidy (RMPIS)	978	Recipients, 2018-2026
Rural Practitioner Tax Credit (RPTC)	4,043	Unique provider recipients, tax years 2018-2025

Counts are not additive. Programs report in different units (e.g., unique providers, awards, and fee waivers) and individuals may hold more than one incentive. Reporting periods differ by program. The table does not include incentives funded through BHWI, which are summarized in Appendix A.

***Units include recipients (individuals who directly received an incentive from a loan repayment, loan forgiveness, scholarship, subsidy, tax credit, or fee waiver program) and participants (individuals who did not receive direct incentive funding but participated in an education program funded through a grantee organization).**

†Loan repayment and loan forgiveness recipients include those who are currently completing or have completed their service obligation and exclude those who were initially awarded an incentive but withdrew before completing their service obligation.

‡The evaluation of SLRP from 2022-2023, when HCPIF provided one-time match funding.

§SHOI counts include students who have been dismissed, withdrew from the academic program, or breached their service commitment.

Findings by House Bill 3261 Reporting Element

Location of Service

Recipients' practice locations corresponded to each program's eligibility criteria. Rural practice is a condition of the PCLF service obligation and all 70 PCLF recipients with a recorded service obligation site (100 percent) practiced rurally. Rural practice is also an eligibility condition for the RPTC and RMPIS programs: 99.1 percent of RPTC recipients reported a rural or remote primary

practice site, and 98.1 percent of RMPIS recipients reported a rural primary or secondary practice site.

Loan Repayment Program recipients are required to serve underserved populations in both rural and urban safety-net settings. Among recipients with practice site information, 55.8 percent of HCPLRP recipients and 45.1 percent of BHLRP recipients completed or are completing their service obligation in a rural area. Federally qualified health centers (FQHCs) and rural health clinics (RHCs), two types of safety-net settings, accounted for nearly half (45.2 percent) of HCPLRP practice site types and about one-quarter (23.0 percent) of BHLRP recipients' practice sites.

Because programs differ in size and eligibility criteria, these counts are not comparable across programs. Among HCPLRP, BHLRP, PCLF, RMPIS, and RPTC recipients, at least half practiced in Service Areas with higher need for their specialty than the state average, based on 2026 Areas of Unmet Health Care Need (AUHCN) measures.

Contribution to Direct Patient Care

HCPLRP recipients reported an average of 34.3 to 36.4 hours of direct patient care or clinical work each week, depending on data source (Health Care Workforce Reporting Program [HWRP] licensure data or the Provider Retention & Information System Management [PRISM] survey). PCLF recipients reported 34.0 to 37.5 hours, and BHLRP recipients reported 32.4 to 33.7 hours. RMPIS recipients reported an average of 37.5 weekly hours, 97.0 percent of which were at rural practice sites.

Services Provided Through Telemedicine

Among HCPLRP recipients with HWRP telehealth data, 57.8 percent delivered at least some care via telehealth, as did 86.0 percent of BHLRP recipients. Telehealth use among HCPLRP recipients ranged from 95.5 percent of licensed behavioral health providers to 32.3 percent of dentists. Telehealth accounted for 2.6 percent of outpatient visits among HCPLRP survey respondents and 21.3 percent among BHLRP respondents. HWRP does not collect telehealth data from physicians and physician associates, so these estimates exclude both groups.

Demographic Characteristics of Recipients

Race/ethnicity data were collected for most HCPIP incentives. Hispanic or Latino/a/x/e recipients accounted for 10.3 percent of PCLF, 11.5 percent of HCPLRP, 18.6 percent of BHLRP, 23.7 percent of SHOI, 25.7 percent of Health Care Workforce Pathways, and 38.7 percent of Health Care Interpreter Retention Incentives recipients. Fewer than half of BHLRP recipients (46.0

percent) and Health Care Workforce Pathways recipients (47.6 percent) identified as white, and 38.0 percent of Health Care Workforce Scholarship recipients identified a primary race or ethnicity other than white.

The percentage of recipients who use a language other than English ranged from 5.1 percent among PCLF recipients to 40.1 percent among HCPLRP recipients and 86.8 percent among health care interpreters. Spanish was the most common language used in every program that reported specific languages. Women made up the majority of recipients in every incentive that collected gender data. Three HCPIP incentives (Health Care Workforce Scholarship, Health Care Workforce Pathways, and Health Care Interpreter Retention Incentives) collect Race, Ethnicity, Language, and Disability and Sexual Orientation and Gender Identity (REALD SOGI) data using OHA's standard instrument. Other incentives used program-specific or Office of Management and Budget categories. REALD SOGI collection for these programs began in 2025-2026. Demographic data were not collected for SLRP, RPTC, HOWTO, or RMPIS before 2024.

Applications and Awards

Eligible HCPLRP applicants rose from 76 in 2018 to 231 in 2025, the most recent full year, and the percentage of eligible applicants awarded fell from 42.1 percent in 2018 to 15.2 percent in 2025. Across 2018 to 2026, 361 of 1,260 eligible applicants (28.7 percent) received an award. For BHLRP, the percentage of eligible applicants receiving an award rose from 15.8 percent in 2021 to 26.9 percent in 2024. For PCLF, 90 of 129 applicants (69.8 percent) received awards between 2019 and 2026. HOWTO funded 53 of 215 eligible proposals (24.7 percent) across six rounds, and the percentage funded fell to 12.6 percent in Round 6.

Retention

Retention was measured for incentives with service obligations and individual records that could be linked to the HWRP. Among HCPLRP, PCLF, and SHOI recipients, 70 percent or more were practicing in Oregon at every interval measured (Table 2). Retention in the county of service was slightly lower but remained above half (70.4 percent of HCPLRP and 66.7 percent of PCLF recipients at five years). Among HCPLRP and PCLF recipients who completed their obligation at a rural site, 83.7 percent and 84.1 percent, respectively, were practicing in rural Oregon one year later. BHLRP retention could be examined for only 18 recipients and only through two years, given the program's relatively recent implementation and the inclusion of certified rather than licensed providers. Estimates at five years post obligation are based on smaller samples and should be considered preliminary.

Table 2. Retention of HCPIP loan repayment, loan forgiveness, and SHOI recipients after completion of the service obligation

Incentive and interval	In Oregon	In the same county
Loan repayment (HCPLRP), 1 year (n = 170)	90.6%	83.5%
Loan repayment (HCPLRP), 3 years (n = 101)	85.1%	73.3%
Loan repayment (HCPLRP), 5 years (n = 27)	77.8%	70.4%
Loan forgiveness (PCLF), 1 year (n = 44)	93.2%	79.5%
Loan forgiveness (PCLF), 3 years (n = 36)	100.0%	80.6%
Loan forgiveness (PCLF), 5 years (n = 18)	94.4%	66.7%
SHOI, 1 year (n = 48)	100.0%	N/A
SHOI, 3 years (n = 34)	91.2%	N/A
SHOI, 5 years (n = 17)	70.6%	N/A

Abbreviations: HCPIP – Health Care Provider Incentive Program; HCPLRP – Health Care Provider Loan Repayment Program; SHOI – Scholars for a Healthy Oregon Initiative. **Denominators differ by interval and decrease as follow-up increases because recent recipients have not yet reached later intervals. Recipients who no longer appeared in HWRP licensing data were counted as not retained in Oregon. Retention could not be reliably measured for other incentives because of limited data or small numbers.**

Key Takeaways by Incentive Program

The following takeaways summarize findings unique to each incentive. Detailed findings for each program appear in the body of the report. Findings for BHWI-funded incentives appear in Appendix A.

Loan Repayment

Health Care Provider Loan Repayment Program (HCPLRP)

- HCPLRP awarded \$26.5 million through 361 awards between 2018 and 2026, and 322 recipients completed or are completing their service obligation. Primary care (41.9 percent) and oral health providers (32.0 percent) made up a majority of recipients.
- Eligible applicants tripled between 2018 (76) and 2025 (231), and the percentage of eligible applicants awarded fell from 42.1 percent in 2018 to 15.2 percent in 2025. OHA staff reported a 40 percent increase in loan repayment applications in the most recent cycle while funding and staffing remained limited.
- Retention in Oregon declined from 90.6 percent at one year to 77.8 percent at five years after the service obligation.

Behavioral Health Loan Repayment Program (BHLRP)

- BHLRP awarded \$4.8 million to 113 recipients, divided roughly evenly among licensed (33.6 percent), pre-licensed (35.4 percent), and certified (31.0 percent) providers. Mental health facilities accounted for 69.9 percent of recipients' practice sites.
- BHLRP recipients reported the highest telehealth use of any program measured (86.0 percent).
- BHLRP paused awards from 2022 until July 2024 (when behavioral health loan repayment funding was available through BHWI instead of HCPIP). The percentage of eligible applicants awarded was 15.8 percent in 2021 and 26.9 percent in 2024, and the average award rose from \$34,575 (2021) to \$50,595 (2025).

Loan repayment recipient survey (HCPLRP and BHLRP)

- Among 21 survey respondents (7.3 percent response rate), 85.7 percent reported that the program significantly influenced their decision to stay at their current practice site, and 61.9 percent reported that it influenced their decision to practice in a rural or underserved area.
- Respondents identified the three-year service commitment as the main deterrent to enrollment among otherwise eligible colleagues, and 70.0 percent requested a larger award.

State Partnership Loan Repayment Program (SLRP)

- SLRP supported 13 recipients with \$584,091 in 2022-2023, disbursing approximately 97.3 percent of available federal and HCPIP match funds. More than three-quarters of recipients practiced at a rural primary site.
- Federal SLRP funding paused after 2023 and was restored in early 2026. ORH received a new grant, HCPIP committed matching funds, and awards resumed in July 2026. Continuation depends on federal funding.

Loan Forgiveness

Primary Care Loan Forgiveness (PCLF)

- PCLF supported 117 students, most commonly physician associates (47.9 percent). All 70 recipients with a recorded service site practiced in a rural area.
- PCLF had the highest five-year retention in Oregon of any incentive measured (94.4 percent), and 72.2 percent of recipients remained in rural practice five years after their service obligation.

- PCLF awarded 69.8 percent of applicants between 2019 and 2026, the highest award rate of any incentive with applicant data, although applicant numbers were small (7 to 24 per year).

Scholarships

Scholars for a Healthy Oregon Initiative (SHOI)

- SHOI provided full-tuition scholarships to 152 OHSU students between 2018-19 and 2025-2026 (\$21.1 million). The proportions of nurse practitioners in each cohort rose from 29.2 percent to 47.1 percent, while the proportion of medical students fell from 29.2 percent to 11.8 percent.
- More than half of recipients with a known place of origin came from a rural community (54.0 percent), and 83.5 percent of recipients in service (from all cohorts since 2014-15) practiced family medicine or general practice.
- All SHOI recipients (100.0 percent) were practicing in Oregon one year after their service obligation, and 70.6 percent were practicing in Oregon at five years.

Health Care Workforce Scholarship

- The number of students supported grew from 14 (2019-2021) to 201 (2023-2025), while total funding fell from \$1,345,711 to \$687,950. The average award fell from \$9,919 (2021-2023) to \$3,474 (2023-2025) as the program expanded to more institutions, including community colleges, and provided smaller awards to more students.
- Thirty-eight percent of recipients identified a primary race/ethnicity other than white, and 26.9 percent used a language other than English at home. Educational and workforce outcomes are not yet tracked.

Career Pathways and Training Initiatives

Health Care Workforce Pathways Program

- In its first cycle (June to December 2025), six organizations awarded \$551,496 to 468 students in grades 8 through 12, an average of \$1,178 per student. Three in four recipients were served by rural (34.4 percent) or mixed rural and urban (41.0 percent) programs.
- One in four respondents identified as Hispanic or Latino/a/x/e (25.7 percent), and one in four reported a disability (25.6 percent).

Healthy Oregon Workforce Training Opportunity (HOWTO) Grant Program

- HOWTO awarded \$34.3 million to 48 organizations for 53 projects across six rounds, training at least 1,728 participants. Traditional Health Workers made up the largest percentage of new workers trained (51.4 percent).
- Eligible proposals grew more than tenfold, from nine in Round 1 to 103 in Round 6. The percentage funded fell from 64.0 percent in Round 4 to 12.6 percent in Round 6.
- HOWTO funds organizations to develop new training programs, so participant counts do not fully capture its impact. Program continuation after grant funding ends is not systematically tracked, although some have continued, including a psychiatric mental health nurse practitioner program with a distance-learning component in Eastern Oregon.

Fee Waivers

Health Care Interpreter Retention Incentives

- In its first period (June to December 2025), the program supported 102 recipients, with an average award of \$621 toward required continuing education.
- Most recipients (86.8 percent) used a language other than English at home. Spanish, Russian, and Ukrainian were the most common certified languages.

Behavioral Health Retention Incentives (MHACBO, HCPIP-funded)

- A \$1.35 million award to the Mental Health and Addiction Certification Board of Oregon (MHACBO) covered 4,082 certification registrations and 481 examinations from June to December 2025. Half of registrants with a recorded education level (50.8 percent) held a high school credential or associate degree as their highest level of education.
- Among examinees who tested, 90.0 percent passed. Practice locations are not collected, so geographic reach cannot be assessed.

Insurance Subsidy

Rural Medical Practitioner Insurance Subsidy (RMPIS)

- RMPIS supported 978 physicians and nurse practitioners, and 97.0 percent of their reported practice hours were at rural sites. More than two-thirds of primary care recipients (69.5 percent) practiced in Service Areas with lower primary care capacity than the state overall.
- Survey respondents were more likely to report that the subsidy helped them remain at their current practice (65.2 percent) than influenced their decision to practice rurally (21.7 percent), suggesting that the subsidy may be more

effective for retention than recruitment. Most respondents (81.0 percent) requested a larger subsidy, noting that it has not kept pace with premium increases.

- Participation has declined every year since 2020, from 619 recipients in 2018 to 327 in 2026, continuing a decline observed in earlier Oregon evaluations.

Tax Credit

Rural Practitioner Tax Credit (RPTC)

- RPTC provided \$63.3 million in credits to 4,043 providers in tax years 2018 through 2025. Recipients practiced in 91.3 percent of rural and 94.4 percent of remote Service Areas.
- Participation was stable from 2018 to 2023 (2,015 to 2,091 recipients per year). Recipients claimed the credit for an average of 3.9 years, and 37.3 percent claimed it for five or more years. Demographic and practice-hours data are not collected, so equity and effectiveness cannot be assessed.

Behavioral Health Workforce Incentives (BHWI)

- BHWI included \$60 million in one-time funding for incentives including loan repayment, scholarships, tuition assistance, hiring and retention bonuses, housing stipends, clinical supervision grants, fee waivers, peer workforce development, and a Tribal set-aside. Programs were implemented rapidly under American Rescue Plan Act (ARPA) timelines without a prospective data plan, which limits evaluation. The BHWI-funded Oregon Behavioral Health Loan Repayment Program (OBHLRP) concludes in October 2026.
- Among concluded BHWI programs, fee waivers reached the largest number of participants. The MHACBO fee waiver covered certification costs for 16,341 recipients from July 2022 to June 2024 (\$3.7 million, about \$220 per recipient), more than all other BHWI programs combined. The BLSW and ASWB programs covered 2,843 social work license applications and renewals and 505 social work exam registrations. Among ASWB-supported first-time test takers, pass rates were 80.2 percent for those whose primary language was English, compared with 26.9 percent for those whose primary language was not English.
- Peer Support Services grants (\$5.0 million to 53 organizations, 2023-2024) funded 1,190 hiring and retention bonuses and training for 533 peers; 86.0 percent of funding went to urban-designated organizations. OBHLRP, Behavioral Health Scholarships, Graduate Tuition Assistance and Stipends, CMHP grants, and the Bonus and Housing Stipend Program continued past this evaluation's data window and will be evaluated in the next report.

Program Perspectives

In a July 2026 focus group, OHA staff from HCPIP, HOWTO, BHWI, and the Oral Health Workforce program described common challenges, including limited capacity for data collection and analysis, difficulty tracking participants over time, and funding timelines that are shorter than the time needed to observe workforce outcomes. Staff noted that programs relying on providers or organizations to apply have limited ability to direct resources to communities with the greatest need, and that incentives cannot, by themselves, address barriers such as housing, childcare, reimbursement, and working conditions.

Data Completeness and Infrastructure

Data coverage limited what could be assessed for most programs. ORH participant records for loan repayment and loan forgiveness are overwritten when a recipient's status changes, so findings from this source are a point-in-time snapshot. Retention, patient care hours, and telehealth use come from HWRP licensure data, which do not include certified and pre-licensed professions, Traditional Health Workers, or health care interpreters. Between 16.8 and 54.0 percent of loan repayment, loan forgiveness, and SHOI recipients who completed their obligation could be included in retention analyses. Several programs provided pre-aggregated summaries rather than individual records, and small numbers limited reporting for many findings.

Evidence on Effectiveness by Incentive Type

This evaluation specifically evaluated different types of provider incentive programs. The literature review (Appendix F) summarized national evidence on the effectiveness of provider incentives on recruitment and retention. Table 3 provides a brief summary of that evidence alongside findings from Oregon's provider incentive programs. Existing evidence on provider incentive programs focuses largely on a few federal programs, most notably the National Health Service Corps (NHSC), and selected state programs. These studies rely almost entirely on observational or self-reported data, limiting comparisons of effectiveness across program types. Oregon's findings are also descriptive, and incentive types serve different populations at different career stages (e.g., high school students and practicing clinicians), so their outcomes cannot be directly compared.

Table 3. Summary of national evidence and Oregon findings on the effectiveness of provider incentives, by incentive type and program

Incentive type	Oregon incentive program	National evidence	Oregon findings
Loan repayment	HCPLRP, BHLRP, SLRP, OBHLRP	Strongest evidence of any incentive, especially for recruitment; retention after the obligation ends is mixed	Consistent with national evidence. HCPLRP retained 90.6 percent at one year and 77.8 percent at five years
Loan forgiveness	PCLF	Shares the loan repayment evidence base	94.4 percent retained at five years; 72.2 percent in rural practice
Scholarships	SHOI, Health Care Workforce Scholarship, BHWI scholarships and tuition assistance	Increase graduates; limited evidence on shortages, diversity, or retention	SHOI retained 70.6 percent at five years; scholarships without a service obligation are not tracked; see Appendix A for BHWI scholarships and tuition assistance
Career pathways and training	HOWTO, Health Care Workforce Pathways, Peer Support Services	Positive short-term effects; long-term workforce effects unclear	Reach and participation only
Clinical supervision grants	CMHP Grants (BHWI)	Limited but promising	Supervisee licensure progression not reported
Fee waivers	Health Care Interpreter Retention Incentives, Behavioral Health Retention Incentives, BHWI-MHACBO, ASWB, BLSW	No published evaluations	90.0 percent exam pass rate; retention cannot be measured; see Appendix A for BHWI programs
Hiring and retention bonuses	CMHP Grants, Bonus and Housing Stipend Program, Peer Support Services	Few studies; wages matter more than one-time bonuses	See Appendix A
Stipends (housing, childcare, relocation)	Bonus and Housing Stipend Program, CMHP Grants	Promising but effects not isolated	See Appendix A
Insurance subsidies	RMPIS	Few, dated evaluations; mainly retention effects	Supports staying more than choosing rural practice; participation appears to be declining

Incentive type	Oregon incentive program	National evidence	Oregon findings
Tax credits	RPTC	Limited evidence; Oregon's 2016 evaluation is the only published estimate of effects on provider supply (mainly retention)	Broadest reach; effectiveness cannot be assessed with current data

Note: See Table 79 for more detail of national evidence and Oregon evaluation findings. Sources for national evidence are cited in the Evidence on Effectiveness by Incentive Type section of this report, Table 79, and in the literature review (Appendix F). Oregon findings are descriptive and do not include a comparison group.

Oregon's findings for loan repayment, loan forgiveness, and SHOI are consistent with national evidence: most recipients remained in Oregon after their service obligation ended; many remained at/near their obligation sites. Findings for RMPIS and RPTC are consistent with prior Oregon evaluations describing them as retention and cost-offset tools for providers already in rural practice. For the remaining incentives, neither national research nor current Oregon data can yet establish effectiveness, a gap the following recommendations are designed in part to address.

Recommended Areas of Focus for Incentive Planning

The report closes with five areas of focus for the design and targeting of Oregon's incentive portfolio, drawn from the findings and the literature.

- **Focus Area A. Prioritize incentive programs with robust evidence of effectiveness.** Among the provider incentives assessed, loan repayment and loan forgiveness have the strongest national evidence of effectiveness, consistent with Oregon's retention findings for these programs. Continued investment in these programs could be paired with stronger evaluation of newer approaches, such as bonuses, stipends, and fee waivers.
- **Focus Area B. Adopt a single program structure to support consistency.** Behavioral health loan repayment operated under two programs with separate rules and data systems. With OBHLRP concluding in October 2026, a single structure under HCPIP would support consistent eligibility, obligations, and data collection.
- **Focus Area C. Explore contributing factors to decline in incentive program participation.** RMPIS participation has declined since 2020, and the available data do not indicate why. Direct examination is warranted, particularly because few states offer such programs and published evaluations of them are limited.
- **Focus Area D. Consider incentives in the context of broader environmental and situational factors.** Housing, childcare,

reimbursement, and working conditions affect recruitment and retention. Continued investment in clinical supervision, housing stipends, and other supports, including childcare, should be considered. This would likely require collaboration across state agencies and with local partners.

- **Focus Area E. Review alignment between incentive program offerings and current delivery of care.** A periodic review of eligible disciplines and site types, informed by applicant and award data, would confirm whether eligibility criteria reflect team-based care in rural and underserved communities.

Recommendations for Future Evaluations

The report also recommends steps to strengthen data for future evaluation cycles, many of which were identified by OHA staff and several of which are already underway:

- **Recommendation 1.** Adopt minimum data standards for every incentive, including persistent identifiers to track unique individuals across programs, practice site ZIP codes, need designations recorded at the time of award, and REALD SOGI data.
- **Recommendation 2.** Extend workforce data to certified and non-licensed workers through data sharing with certification boards such as MHACBO and the Traditional Health Worker Registry.
- **Recommendation 3.** Include data expectations in contracts and funding announcements before the first award.
- **Recommendations 4 .** Standardize definitions (e.g., awards vs. unique individuals, and obligated vs. disbursed dollars) so programs can be described consistently.
- **Recommendation 5.** Measure retention consistently across incentive programs, using nested geographic levels, a defined starting point, and set follow-up timepoints, so that results can be compared across programs.
- **Recommendation 6.** Add measures of the work environment, such as supervision access and intent to remain.
- **Recommendation 7.** Establish standing longitudinal tracking of recipients in partnership with ORH and consider a staggered schedule that rotates programs through in-depth evaluation each biennium.

Implementing these improvements will require additional funding and analytic capacity.

Next Steps

Oregon has invested in a range of incentives to recruit and retain providers in rural and underserved communities, from career exploration for high school

students to loan repayment and tax credits for practicing clinicians. Most recipients with available data remained in Oregon after completing their service obligation, and programs reached the rural and safety-net settings they were designed to serve. However, applications to HCPLRP and proposals to HOWTO have grown faster than available awards, and the effectiveness of newer incentive types cannot yet be assessed with current data. Strengthening data collection across all incentives will allow future evaluations to describe not only who programs reach, but whether they change where providers practice and how long they stay.

Background

Oregon began offering financial incentives to support health care provider recruitment and retention in the 1980s. Initial efforts included a rural practitioner tax credit, followed by liability insurance premium subsidies for providers serving rural communities. As health care coverage expanded in the 2010s and more people became eligible for care, Oregon policymakers recognized the state needed resources to build a robust health care workforce. In 2017, the Oregon Legislature passed House Bill 3261 to create the Health Care Provider Incentive Fund (HCPIF), which combined these earlier provider incentives into a single pool. HCPIF is administered by the Oregon Health Authority (OHA) under the direction of the Oregon Health Policy Board (OHPB). OHA administers several HCPIF incentives, including loan repayment, loan forgiveness, and the rural medical practitioner insurance subsidy, in partnership with the Oregon Office of Rural Health (ORH) at Oregon Health & Science University (OHSU) through an intergovernmental agreement. ORH also administers the RPTC in partnership with the Oregon Department of Revenue. The OHA's Clinical Supports, Integration and Workforce (CSIW) Unit conducts this evaluation on behalf of OHPB, as directed by House Bill 3261 (2017). The legislation requires OHA to evaluate the effectiveness of state financial incentive programs in recruiting health care providers to practice in rural and medically underserved areas and retaining them in those areas (ORS 676.463). HB 3261 identified financial incentive programs for inclusion in this evaluation, including (but not limited to) the following:

- **Health Care Provider Incentive Program (HCPIF)**, created by House Bill 3261 (2017) and codified in Oregon Revised Statutes (ORS) 676.46 (now ORS 676.454)
- **Healthy Oregon Workforce Training Opportunity Grant Program (HOWTO)**, created by House Bill 3261 (2017) and codified in ORS 676.467

- **Rural Practitioner Tax Credit Program (RPTC)**, created by Senate Bill 438 (1989) and codified in ORS 315.613.
- **Behavioral Health Workforce Incentives (BHWI)**, created by House Bills 2949 (2021) and 4071 (2022) and codified in ORS 675.650 to 675.658

HB 3261 also requires the collection of information about participants in these programs. This information may include participants' dates of program entry; locations and duration of service; discipline and specialty; hours of direct patient care; the proportion of services provided through telemedicine; and other demographic information deemed useful for evaluating program effectiveness. OHA is required to report its findings to the interim committees of the Legislative Assembly related to health every two years.

Health Care Provider Incentive Program

HCPIP supports access to care for underserved communities throughout Oregon by strengthening recruitment and retention of high-quality providers in these communities. HCPIP offers incentives, including loan repayment, loan forgiveness, scholarships, and insurance subsidies, to health care students and practicing professionals who commit to serving patients in underserved and rural areas of Oregon. HCPIP is overseen by OHA and administered in partnership with the ORH.

Healthy Oregon Workforce Training Opportunity Grant Program (HOWTO)

The HOWTO Grant Program works to expand health professional training in Oregon to address current and future shortages in the health care workforce. The program provides grants to support innovative, community-based training initiatives that work to address local health care workforce shortages and expand the diversity of the health professional workforce. The HOWTO grant program began in 2019 and is administered under the direction of OHPB in partnership with OHA and Oregon Health & Science University (OHSU).

Rural Practitioner Tax Credit

The Rural Practitioner Tax Credit (RPTC) was created by Senate Bill 438 in 1989 and provides qualifying health care professionals practicing in rural areas a tax credit on their state income tax returns. The RPTC is administered by ORH, in partnership with the Oregon Department of Revenue (DOR).

Behavioral Health Workforce Incentives (BHWI)

BHWIs were created by OHA following the passage of House Bill 2949 (2021) and House Bill 4071 (2022), with the goal of increasing the recruitment and retention of the behavioral health workforce and “increase access to services that are peer- and community-driven and that provide culturally specific and

culturally responsive services for people of color, tribal communities, and persons with lived behavioral health experiences.” The initiative included \$60 million in one-time funding that was placed in a Behavioral Health Incentive Subaccount within HCPIF. This investment was to develop a diverse licensed and non-licensed behavioral health workforce through scholarships, loan repayment, retention bonuses, and peer workforce development.

Tribal Behavioral Health Workforce Incentives

Both HB 2949 (2021) and HB 4071 (2022) directed OHA to focus the behavioral health workforce incentive funding to support a number of specific populations and communities, including “Tribal members and Tribal communities.” As a result, a Tribal set-aside was established for the Nine Federally Recognized Tribes of Oregon. Some Tribes elected to share a portion of this funding with the Native American Rehabilitation Association of the Northwest, the only Urban Indian Health Program (UIHP) in the state, which provides health services for American Indians and Alaska Natives in the Portland metro region.

Program Typology

Incentive types vary in whether they require a return-of-service obligation and whether funding is provided directly to individual providers and students or to health care organizations. Several incentive types require a committed period of service at an eligible practice site in exchange for funds, including loan repayment, loan forgiveness, and some scholarships that require a service obligation. A smaller set of programs, including the RPTC program, insurance subsidies, and other scholarships, do not require a service obligation. Funds under most incentive types flow directly to individual providers or students (e.g., loan repayment, loan forgiveness, scholarships), while others fund organizations to develop and administer local recruitment and retention efforts (e.g., hiring and retention bonuses, stipends, clinical supervision grants).

The mechanism by which each incentive type aims to strengthen the workforce also varies considerably, ranging from directly reducing providers’ educational debt burden (loan repayment, loan forgiveness) to building organizational capacity for clinical supervision and staff support (clinical supervision grants, career pathways and training initiatives).

Table 4 describes Oregon’s provider incentive programs, grouped by type. Note that some programs offer multiple types of incentives and are thus listed in multiple rows.

Table 4. Typology of Oregon provider incentive programs

Incentive type	Programs	Description
Loan repayment programs	<ul style="list-style-type: none"> • Health Care Provider Loan Repayment Program (HCPLRP)* • Behavioral Health Loan Repayment Programs (BHLRP)* • Oregon Behavioral Health Loan Repayment Program (OBHLRP)† • State Partnership Loan Repayment Program (SLRP)* 	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.
Loan forgiveness programs	<ul style="list-style-type: none"> • Primary Care Loan Forgiveness (PCLF)* 	Students in eligible health care training programs can receive coverage of tuition and fees in exchange for a return-of-service obligation at an eligible rural or underserved practice site upon graduation.
Scholarship programs	<ul style="list-style-type: none"> • Scholars for a Healthy Oregon Initiative (SHOI) at Oregon Health & Science University (OHSU)*‡ • Health Care Workforce Scholarship at non-OHSU Education Programs (formerly known as “SHOI-Like”)*‡ • Behavioral Health Scholarships† • Graduate Tuition Assistance and Stipends† • Community Mental Health Program (CMHP) Grants (Set-Aside)† 	Provides funding to institutions to develop and award scholarships (towards tuition, fees, and/or stipends) to students pursuing future health care careers. SHOI and some Health Care Workforce Scholarship recipients were required to complete a service obligation.
Career pathways and training initiatives	<ul style="list-style-type: none"> • Healthy Oregon Workforce Training Opportunity (HOWTO) Grants§ • Health Care Workforce Career Pathways* • Peer Support Services§ 	Provides funding and partnerships to develop programs and support services aimed at helping students and practicing professionals, particularly those from underrepresented backgrounds, to enter, advance and remain in health care careers. These programs can focus on supporting people across various education levels, from K-12 to career and technical education to community college and undergraduate to post-graduate and professional education.
Fee waiver programs	<ul style="list-style-type: none"> • Health Care Interpreter Retention Incentives* • Behavioral Health Retention Incentives* 	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, intended to promote staff retention.

Incentive type	Programs	Description
	<ul style="list-style-type: none"> • Mental Health and Addiction Certification Board of Oregon (MHACBO)† • Association of Social Work Board (ASWB) Program† • Oregon Board of Licensed Social Workers (BLSW) Program† • CMHP Grants† 	
Hiring and retention bonuses	<ul style="list-style-type: none"> • CMHP Grants † • Oregon Behavioral Health Workforce Bonus and Housing Stipend (B&HS) Program† • Peer Support Services§ 	Provides funding to health care organizations to provide monetary incentives to recruit and/or retain staff.
Clinical supervision grants	<ul style="list-style-type: none"> • CMHP Grants† 	Provides funding to behavioral health organizations to support clinical supervision for behavioral health 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.
Stipends	<ul style="list-style-type: none"> • Oregon Behavioral Health Workforce B&HS Program† • CMHP Grants† 	Provides funding to health care organizations to recruit and/or retain staff by providing cost-of-living supports (housing, relocation, childcare, etc.).
Insurance subsidy	Rural Medical Practitioner Insurance Subsidy*	Subsidies to offset the malpractice insurance costs for providers practicing in rural areas, with subsidies disbursed to insurers.
Tax credits	Rural Practitioner Tax Credit§	Eligible practicing health care providers who work in rural areas can receive a tax credit on their state tax return.
Other	Tribal Set-Aside§	Provides funding to support Tribal behavioral health workforce initiatives, administered by OHA Behavioral Health in partnership with OHA's Office of Tribal Affairs.

Abbreviations: HCPIP – Health Care Provider Incentive Program; BHWI – Behavioral Health Workforce Incentives.

***Program managed or administered by HCPIP.**

†Program managed or administered by BHWI.

‡All SHOI and some Health Care Workforce scholarship recipients (all those in biennium 2019-2021 and those in biennium 2021-2025 who receive \$35,000 or more) were required to

complete a return-of-service obligation of one year per year of funding received. All other scholarship programs did not require a service obligation.

§Program managed by entity other than HCPIP or BHWI.

||Program supports a range of recruitment and retention incentives and is therefore listed under several types.

Evaluation Approach

Conceptual Model

This evaluation is grounded in a conceptual model in which health care provider incentive programs reduce financial and structural barriers to practice (e.g., educational debt), thereby influencing provider decisions about practice location and retention. These decisions, in turn, shape workforce distribution and capacity in underserved areas and, over time, access to care and health equity. This evaluation assesses the steps in this pathway for which data were available (participation, practice location, and retention), recognizing that effects may vary across populations and geographic contexts.

Theoretical framework

Two established frameworks provide the structure for this evaluation, addressing the absence of explicit theoretical grounding identified in prior evaluation cycles. First, Donabedian's Structure-Process-Outcome model supplies the causal logic, framing the evaluation around the conditions that enable programs (context and structure), the activities through which they operate (process), and the results they produce (outcome). This framing responds directly to Health Care Workforce (HCWF) Committee feedback from the 2025 evaluation, which called for greater attention to how OHA prioritizes resources and how process indicators such as award rates differ from outcome indicators such as changes in provider supply. Second, the RE-AIM framework supplies the evaluative lens, operationalizing what success looks like across five dimensions (Reach, Effectiveness, Adoption, Implementation, and Maintenance). This framework allows the evaluation to address not only whether outcomes are achieved, as well as for whom, under what conditions, and whether effects are sustained over time.

The two frameworks are complementary: Donabedian explains the mechanisms by which structures and processes produce outcomes, while RE-AIM organizes the presentation of findings for a legislative and policy audience.

Data Sources

This evaluation draws on multiple data sources that vary in structure, source, and completeness, ranging from individual-level administrative records to pre-

aggregated program dashboards and qualitative focus group data. Detailed descriptions of each source, including reporting periods, variables, methods, and known limitations, appear in Appendix B.

ORH participant data. Administrative participant records maintained by the Oregon Office of Rural Health (ORH) were available for six programs, including loan repayment (HCPLRP, BHLRP, SLRP), loan forgiveness (PCLF), RMPIS, and RPTC. Reporting periods for most of these programs were from April 2018 to June 2026, with the exceptions of BHLRP (April 2018 to April 2022 and restarted June 2024 to June 2026), SLRP (December 2022 to 2023), and the tax credit (tax years 2018 to 2025). The data for most programs include individual-level data on recipients, including their discipline, credential type, award or credit amount, year of award/participation, and service obligation or eligible practice site location. Data on SHOI was provided to the evaluation team as pre-aggregated tables, rather than individual-level data. The ORH participant data contains demographic information, including data on race/ethnicity, languages used, and disability status, but REALD SOGI data was not available. Included in the participant data for HCPLRP, BHLRP, and PCLF were summary tables that described the application volume, award activity, and funding allocations over their reporting periods. Participant data from the RPTC Program is considered less reliable for tax years after 2023 because taxpayers may amend prior-year returns. Data for 2024 and 2025 are reported with this limitation noted. Collectively, the participant data provides information on most Reach, Adoption, and Implementation domains for these programs, though the coverage of this data source differs across programs.

Health Care Workforce Reporting Program (HWRP) data. Location and retention outcomes and some current provider characteristics are drawn from the HWRP through linking ORH participant data to HWRP data for three loan repayment and forgiveness (HCPLRP, BHLRP, and PCLF) programs. Records on providers' primary and secondary practice locations were provided for 2016-2026, and provider characteristics, including hours of direct patient care, and telehealth usage, were available for the current year, 2026. Because administrative records were not complete, some recipients' records could not be linked to HWRP data, and data on some certified and pre-licensed professions eligible under HCPLRP and BHLRP are not collected by the HWRP (e.g., certified alcohol and drug counselors, social work associates, etc.). Only providers who completed their service obligation by 2025 were included in retention analyses. Approximately 16.8-54.0 percent of loan repayment and forgiveness recipients were linked for retention analyses, and 42.5-85.1 percent of recipients were linked to provider characteristics. Details on rates of data linkage to the HWRP are described in Table 2 in Appendix B. The HWRP collects data annually from health care providers when they renew their licenses with their respective state licensing boards; therefore, it does not include

information on providers who choose not to maintain their Oregon licensure. Additionally, data on telehealth usage is not collected for physicians (MDs/DOs) or physician associates in the HWRP. (Note, this data source differs from the workforce assessment reports published by the HWRP, which are released biennially.)

ORH Areas of Unmet Health Care Need. The Areas of Unmet Health Care Need (AUHCN) is a score 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.⁽¹⁾ The AUHCN total score uses nine variables to create a composite total score.

In this evaluation, three variables were used from the 2026 AUHCN scores to classify Service Areas as areas of higher need for provider availability by specialty:

- **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 overall supply: 1.40 mental health provider FTE per 1,000 population), and
- **Oral Health:** *Dentists FTE per 1,000 population* (Oregon overall supply: 0.47 dentist FTE per 1,000).⁽²⁾

ORH Rural-Urban Designation. ORH uses the following definitions to classify rural areas within Oregon:

- *Rural* indicates any geographic area in Oregon ten 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. This corresponds with ORH's frontier designation.

Rural areas include those classified as remote; urban areas include any areas not classified as rural or remote. We used the Service Area-to-ZIP code crosswalk developed by ORH to assign practice location and organization ZIP codes as "urban," "rural" or "remote" (May 2026 version).⁽³⁾

Provider Retention & Information System Management (PRISM) survey.

The PRISM survey is administered to loan repayment (HCPLRP and BHLRP) and loan 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), at the completion of their service obligation (end-of-contract survey), and annually thereafter (alumni survey). This survey provides wide-ranging self-reported data on provider characteristics (provider discipline, demographics), their current work hours, recipient experiences and satisfaction in their programs, and their anticipated intentions to remain in practice. The exact coverage of variables differs by survey. The response rates for the survey ranged from 20.0 to 53.7 percent for HCPLRP recipients, 15.7 to 46.0 percent for BHLRP recipients, and 15.6 to 76.9 percent for PCLF recipients depending on survey. The alumni survey had the lowest response rates among all programs (15.6 - 27.8 percent). Because of low response rates, findings are subject to nonresponse bias and may not represent the entire population of recipients.

ORH survey. A supplemental qualitative survey was 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 about their perceptions and experiences with each program, including perceived benefits and recommendations for improvement. The surveys were open to responses from May 20, 2026 to June 8, 2026. Respondents received two reminders and had response rates of 7.3 percent (HCPLRP/BHLRP) to 15.1 percent (RMPIS). Because of low response rates, findings are subject to nonresponse bias and may not represent the entire population of recipients.

Grantee data reporting. Grantee data reporting was provided for five programs: Health Care Workforce Scholarships, Career Pathways, HOWTO, Health Care Interpreter Retention Incentives, and Behavioral Health Retention Incentives. Data availability varied greatly by program. Four programs (Health Care Workforce Scholarships, Career Pathways, Health Care Interpreter Retention Incentives, and Behavioral Health Retention Incentives) reported biennial individual-level recipient data to OHA. This data included individual-level data on recipient grantee organization, discipline/prospective educational program, and award amount. HOWTO provided pre-aggregated data, rather than individual recipient-level data. Only the Health Care Workforce Scholarships, Career Pathways, and Health Care Interpreter Retention programs collected individual REALD SOGI data on recipients. Grantee reporting data for the other programs provide some variable demographic information on recipients and participants.

BHWI dashboard. BHWI programs are represented by pre-aggregated dashboard data maintained by the BHWI team and the Office of Health Analytics, with reporting periods ranging from May 2022 through July 2026 depending on the program. Summary data was extracted from the dashboard

on August 22, 2026, with subsequent updates made in September 2026. BHWI program data are summarized in Appendix A.

Focus group with OHA staff. Qualitative data was collected during a focus group with OHA program staff on July 30, 2026. OHA staff who administer 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. Findings from this focus group are detailed in the Program Perspectives section of this report.

Literature review. A review of national evidence on the effectiveness of provider incentive programs, organized by incentive type and RE-AIM domain, was completed in April 2026 to inform this evaluation. Its findings are summarized in the section “Evidence on Effectiveness by Incentive Type” and Table 79 below, and the full review appears in Appendix F.

Structure of This Report

This evaluation addresses programs at varying levels of depth. The following programs outlined in HB 3261 were comprehensively evaluated as available data allows:

- Health Care Provider Incentive Program
- Healthy Oregon Workforce Training Opportunity (HOWTO) Grant Program
- Rural Practitioner Tax Credit

Findings from the evaluation for these programs are presented in the body of this report, summarized by incentive type.

Programs administered under BHWI received a descriptive review of program structure and focused evaluation, when possible, relying upon publicly available data. Depth of evaluation varies across BHWI programs according to the data available. Principal findings for each BHWI program, tables, and figures are presented together in Appendix A. Additionally, a narrative describing the Tribal Behavioral Health (Set-Aside) program is presented in Appendix A.

To conserve report length, sub-headers were retained only if data were available to examine outcomes. For example, if the sub-header “Locations of Service” is not present, this indicates that data were not available to examine this outcome for the incentive program of interest at this time.

Terminology

This report uses several terms to describe different types of beneficiaries of incentive programs:

- *Recipients* are individuals who directly received an incentive from a loan repayment, loan forgiveness, scholarship, subsidy, tax credit, or fee waiver program. For loan repayment, loan forgiveness, and scholarships that

require a service obligation, "recipients refers to individuals who are completing or have completed their service obligation, excluding individuals who later withdrew from their program before completing their obligation.

- *Awards* or *awardees* include all individuals who were awarded a loan repayment, loan forgiveness, or scholarship with a service obligation requirement. This term includes individuals who may have later withdrawn or been dismissed before completing their service obligation.
- *Grantees* are organizations that were awarded funding to disburse to individual recipients (e.g., Health Care Workforce Scholarships, Behavioral Health Retention Incentives), or to develop and provide training programs to individual participants (e.g., HOWTO).
- *Participants* are individuals who were not awarded direct incentive funding but participated in an education program funded through a grantee organization.

Loan Repayment Programs

Background

Loan repayment programs provide eligible health care professionals with tax-free funds to repay qualifying educational loans in exchange for two to three years of service at an eligible practice site, where they provide care to patients regardless of insurance type or ability to pay.

The following three loan repayment programs were evaluated in this report:

- Health Care Provider Loan Repayment Program (HCPLRP)
- Behavioral Health Loan Repayment Program (BHLRP)
- State Partnership Loan Repayment Program (SLRP)

A fourth program, the Oregon Behavioral Health Loan Repayment Program (OBHLRP), is administered by BHWI. Both BHLRP and OBHLRP serve behavioral health providers but operate under separate funding sources, administrative rules, and reporting. This report presents findings separately for each, with BHLRP in this section and OBHLRP findings in Appendix A.

Note: Abbreviations for the behavioral health loan repayment programs have varied over time. In this report, BHLRP refers to the HCPIP program, and OBHLRP refers to the BHWI program.

Eligible provider types differ by loan repayment program and are described within each program subsection below. See Appendix E for additional retention findings for loan repayment and forgiveness programs.

Health Care Provider Loan Repayment Program (HCPLRP)

HCPLRP is a state-funded component of Oregon's HCPIP, established to help rural and underserved communities recruit and retain qualified health care professionals. HCPLRP has been overseen by OHA since 2018 under HB 3261. The program provides tax-free loan repayment assistance to eligible providers in exchange for a minimum three-year commitment to practice at a qualifying site.

Currently, eligible providers include the following professionals providing primary care in outpatient, clinic-based settings:

- Dentists in general or pediatric practice;
- Expanded Practice Dental Hygienists;
- Dental Assistants;
- Dental Therapists;
- Pharmacists;
- Physicians (MD, DO, or ND) who practice in the specialties of family medicine or general practice, general internal medicine, geriatrics, pediatrics, or obstetrics and gynecology;
- Nurse Practitioners who practice in the specialties of adult primary care, women's health care, geriatrics, pediatrics, family practice, mental health, or nurse midwifery;
- Physician Associates who practice in the specialties of family medicine or general practice, general internal medicine, geriatrics, pediatrics, mental health, or obstetrics and gynecology;
- Licensed Clinical Social Workers;
- Licensed Marriage and Family Therapists;
- Licensed Professional Counselors;
- Psychiatrists;
- Psychologists;
- Psychiatric Mental Health Nurse Practitioners; and
- Certified Alcohol and Drug Counselor IIIs.

Additional provider types, including pre-licensed and certified behavioral health providers, were eligible for HCPLRP prior to the start of the BHLRP being funded through HCPIP.

Eligible practice sites must meet one of the following criteria:

- Be located in a Health Professional Shortage Area (HPSA) or Facility HPSA, serve an underserved area or area of unmet need, or
- Serve Medicaid and Medicare patients at or above the county average, or
- Provide essential health care services to an underserved population, as determined by OHA.

In exchange for a minimum three-year service commitment, full-time providers may receive 70 percent of qualifying educational loan debt, up to \$50,000 per service year. Part-time providers may receive 35 percent, up to \$25,000 per service year (three-year service commitment required). Providers may apply for additional assistance in exchange for additional three-year award periods up to nine years, providing a maximum of 100 percent loan repayment for full-time providers and 50 percent for part-time providers.

Key Takeaways

- HCPLRP awarded \$26.5 million through 361 awards between 2018 and 2026, and 322 recipients completed or are completing their service obligation. Primary care (41.9 percent) and oral health providers (32.0 percent) made up most recipients.
- Eligible applicants tripled between 2018 (76) and 2025 (231), and the share of eligible applicants awarded fell from 42.1 percent in 2018 to 15.2 percent in 2025 while the average award amount rose by more than half. OHA staff reported a 40 percent increase in loan repayment applications in the most recent cycle while funding and staffing remained limited.
- Retention in Oregon was 90.6 percent at one year and 77.8 percent at five years after the service obligation.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

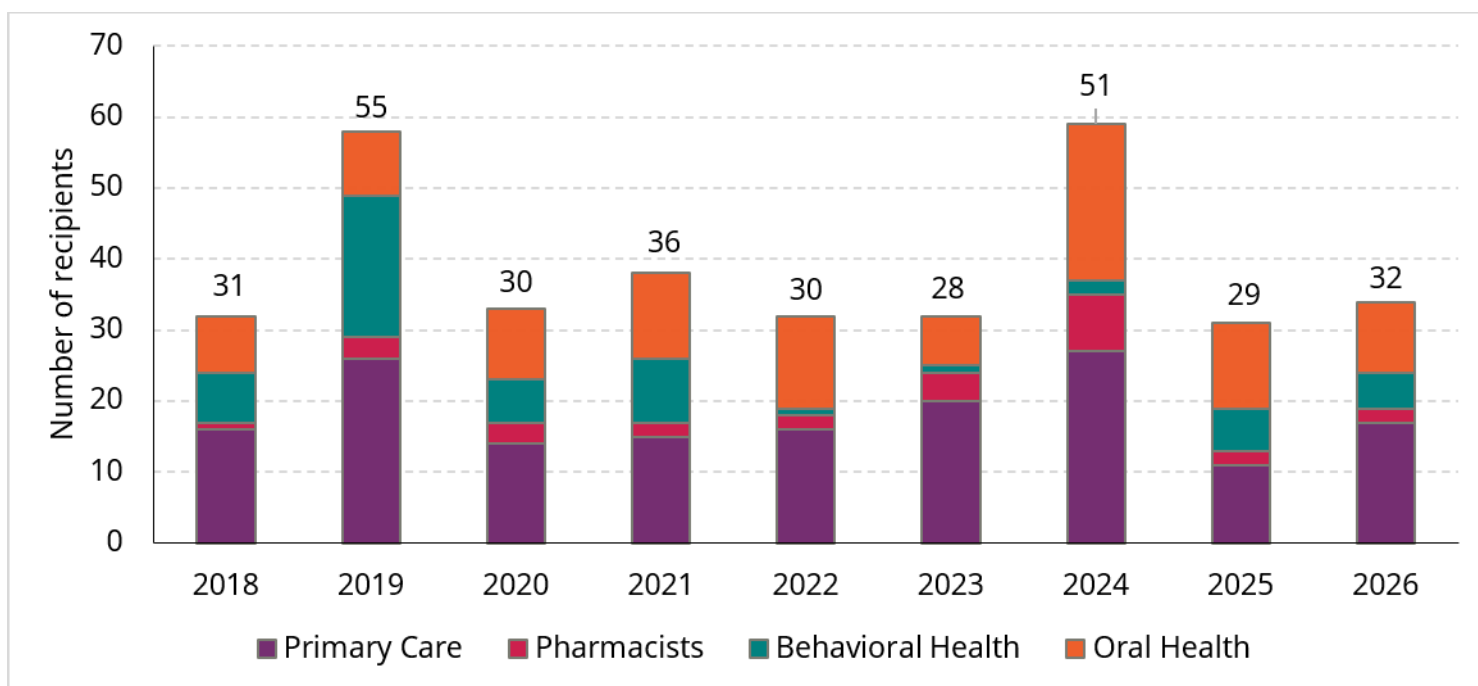
There were 361 HCPLRP awards between 2018 and 2026 . Among those awarded, 322 recipients are completing or have completed their service obligation. Thirty-nine awardees withdrew or declined participation before completing their obligation.

Among the recipients who are completing or have completed their service obligation, annual cohorts ranged from 28 (2023) to 55 (2019) recipients, and their composition shifted over time (Figure 1). Overall, two in five recipients were primary care providers (n = 135, 41.9 percent), roughly a third were oral health providers (n = 103, 32.0 percent), 17.7 percent were behavioral health providers (n = 57), and 8.4 percent were pharmacists (n = 27). Dentists were the largest single occupational group, comprising 70.9 percent of all oral health providers and 22.7 percent overall (n = 73). Physicians comprised 15.5 percent

of all providers and 37.0 percent of primary care providers (n = 50), followed by NPs (12.4 percent overall, 29.6 percent of primary care, n = 40), and PAs (10.2 percent overall, 24.4 percent of primary care, n = 33). No behavioral health discipline exceeded 3.4 percent of recipients. Details of HCPLRP recipients by cohort year and detailed provider type are available in Appendix C.

Overall, the majority of HCPLRP recipients practice full-time (87.1 percent); only 12.9 percent practice part-time. Part-time practice was most common among physicians (24.0 percent) and least common among behavioral health providers (5.3 percent), none of whom were pre-licensed associates practicing part-time.

Figure 1. HCPLRP recipients by discipline and award year, 2018-2026



Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026. Recipients include those who are completing or have completed their service obligation (n = 322) and exclude 39 awardees who withdrew from the program before completing their obligation. Primary care includes physicians (MD, DO, and ND), physician associates, and nurse practitioners. Behavioral health includes licensed and pre-licensed behavioral health providers. Oral health includes dentists, expanded practice dental hygienists, and dental assistants.

The relative proportion of HCPLRP recipients who were behavioral health providers fell from 36.4 percent of the cohort in 2019 to 3.7 percent of awards made during 2022 through 2024 combined, then recovered to 20.7 percent in 2025 and 15.6 percent in 2026 (Figure 1).

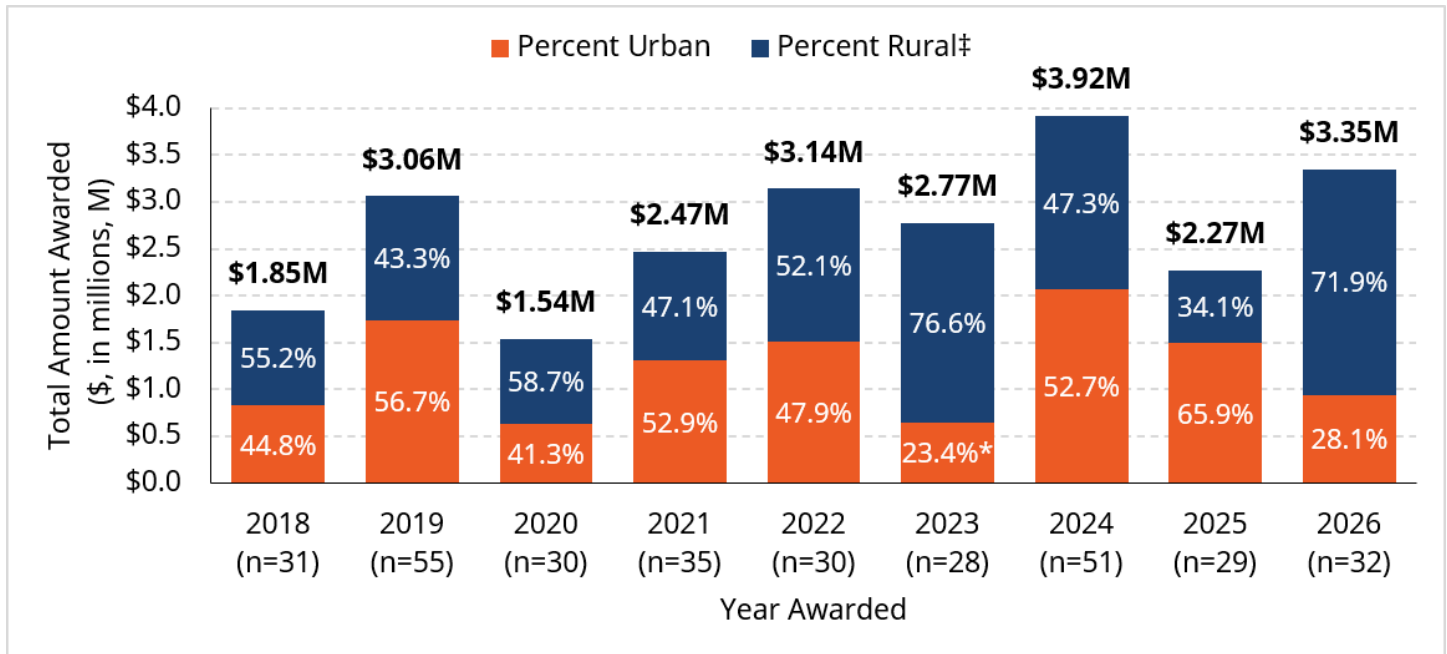
Locations of Service

Among the 321 recipients with a recorded primary practice site for their service obligation (one recipient was missing location data), 172 (53.6 percent)

practiced in a rural ZIP code, including 17 (5.3 percent) who practiced in a remote ZIP code. Counting all obligation practice sites (n = 349 sites, reflecting 26 recipients with two obligation sites and two recipients with three sites), 55.8 percent of recipients report working in a rural practice (including 5.3 percent reporting a remote practice). The total rural proportion of each annual cohort varied, ranging from 38.2 percent in 2019 to 75.0 percent in 2023, and was 71.9 percent in 2026 (Figure 2).

Over the program period, recipients completed or were completing their service obligation in 79 of Oregon's 128 Service Areas as defined by ORH's Areas of Unmet Health Care Need reporting. Nearly all urban Service Areas were covered (23 of 24). Half (53.8 percent) of the 104 rural Service Areas and half (50.0 percent) of the 18 remote Service Areas had recipients.

Figure 2. Total amounts awarded (in thousands of U.S. dollars) to HCPLRP recipients (n = 322) and percent of funding by recipients' primary practice site urban-rural designation†, 2018-2026



Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. **Data Source:** ORH participant data for reporting period 04/01/2018-06/30/2026; ORH urban-rural ZIP code designations, May 2026.

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

†Based on the ZIP code urban-rural designation of recipients' primary service obligation practice location. Excludes one recipient missing designation of primary practice site.

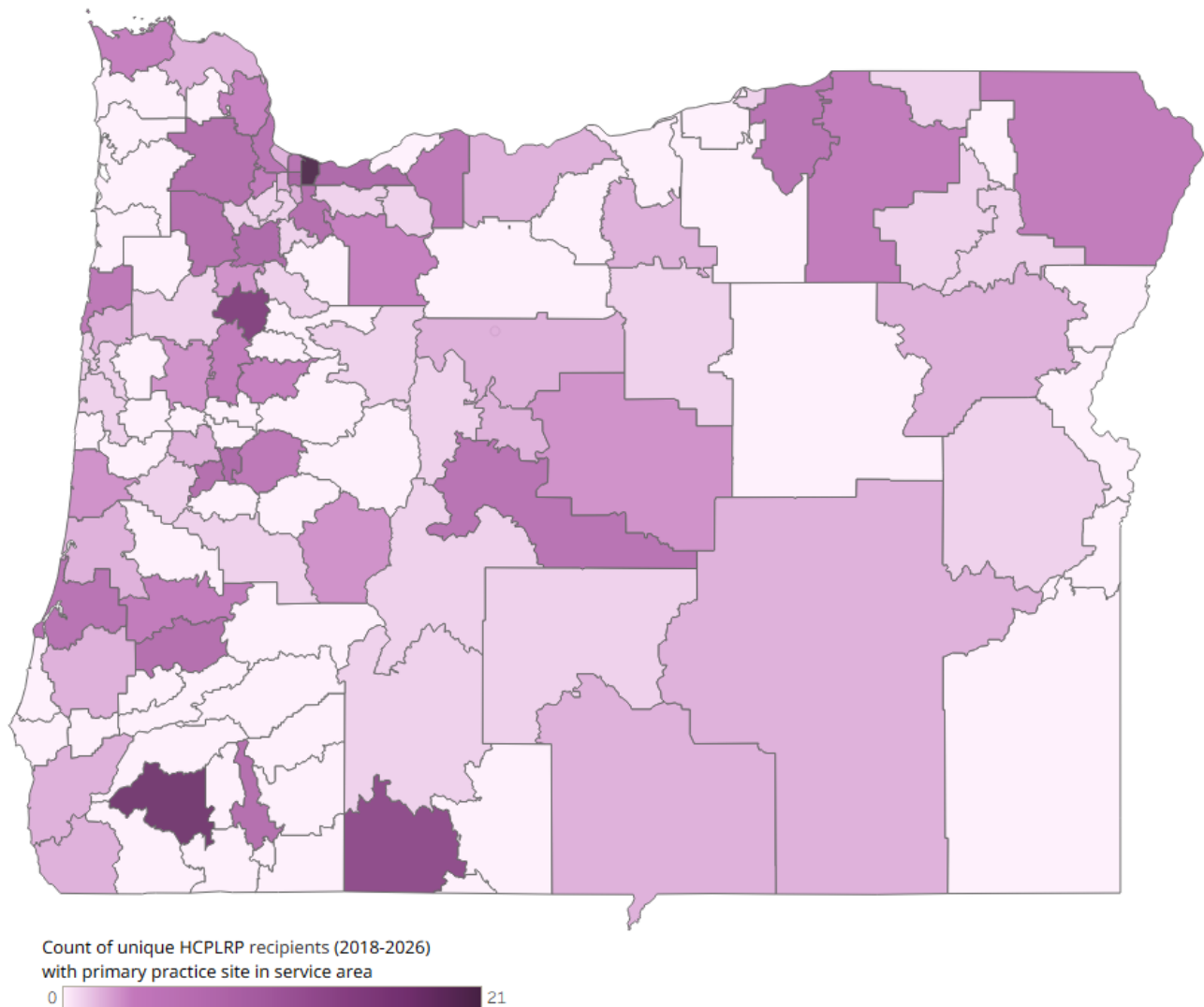
‡Rural includes recipients with rural and remote primary practice sites.

Figure 3 shows the geographic distribution of HCPLRP recipients across Oregon's Service Areas. Components of the Areas of Unmet Health Care Need (AUHCN) scores relating to primary care, behavioral health, and oral health need were used to assess the proportion of recipients who completed their service obligation in areas of high need for their specialty.

Across primary care, behavioral health, and oral health specialties, over half of HCPLRP recipients were completing their service obligation in areas of higher need for their specialty than the state average. The primary care capacity ratio (or percent of primary care visits able to be met) is used to measure the supply of primary care compared to the demand in a Service Area, with a score less than 1 indicating there is insufficient supply of primary care to meet demand.

Among HCPLRP recipients in primary care (MDs, DOs, NDs, NPs, and PAs only, n = 135), over half (57.0 percent) were practicing in Service Areas with a primary care capacity ratio less than the state overall ratio (0.99). Similarly, over half (50.9 percent) of recipients in behavioral health (n = 57) were working in Service Areas with lower mental health providers per capita compared to the state supply (≤ 1.4 mental health provider FTE per 1,000 population), and over half (56.9 percent) of oral health recipients (n = 102) were working in Service Areas with fewer dentists per capita than the state supply (≤ 0.47 dentist FTE per 1,000 population). AUHCN score components used in this analysis reflect 2026 conditions of need, while awards were made from 2018 onward. Scores may therefore not reflect the level of unmet need at the time of award.

Figure 3. Geographic distribution of HCPLRP recipients by Service Area*, 2018-2026



Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026; ORH Oregon Service Areas from the Areas of Unmet Health Care Need, 2026.

***Based on the Service Area of their primary practice location.**

Provider Practice Sites

Recipients' obligated practice sites were concentrated in safety-net settings. Among recipients, 325 practice setting types were reported: 24 recipients reported two site types, and two recipients reported 3 types. Federally qualified health centers (FQHCs) were most common (n = 107, 32.9 percent), followed by dental facilities (n = 65, 20.0 percent), clinics (n = 51, 15.7 percent), rural health clinics (RHCs; n = 40, 12.3 percent), mental health facilities (n = 37, 11.4 percent), and pharmacies (n = 9, 2.8 percent). FQHCs and RHCs together accounted for 45.2 percent of sites. Remaining settings included Tribal Clinics, critical access hospitals, correctional facilities, and naturopathic clinics, each with fewer than 5 recipients (16 facility types combined, 4.9 percent).

Duration of Service

Most recipients completed four years of service with HCPLRP (n = 228; 75.0 percent). This includes current recipients, applicants for continuation, recipients with continuation, and completed recipients. Duration of service obligation was not available for 18 recipients. Fifty-seven (18.8 percent) recipients completed one to three years, and 19 (6.3 percent) completed five or more years.

Evaluation of Program Adoption

Organizational Participation

The following types of organizations hosted the majority of HCPLRP recipients between 2018 and 2026: FQHCs (n = 107 recipients), dental facilities (n = 65), clinics (n = 51), rural health clinics (n = 40), and mental health organizations (n = 37). There were fewer than 12 recipients at the following practice sites (counts suppressed): pharmacies, Tribal organizations, critical access hospitals, corrections agencies, naturopathic clinics, and other practice sites.

Demographic Characteristics of Recipients

Slightly over half of HCPLRP recipients identified as white (53.7 percent), 13.0 percent identified as Asian, and 11.5 percent identified as Hispanic or Latino/a/x/e (Table 5). Two in five recipients (n = 129, 40.1 percent) reported using a language other than English, most commonly Spanish, which accounted for 63.6 percent of reported languages (Table 6). Approximately one in nine recipients (n = 38, 11.8 percent) reported a disability (Table 7). HCPLRP data used OMB minimum race/ethnicity reporting categories and are not REALD SOGI.

Table 5. Race/ethnicity of HCPLRP recipients, 2018-2026 (N = 322)

Race/ethnicity	Number of Recipients	Percent of Recipients
White	173	53.7%
Asian	42	13.0%
Hispanic or Latino/a/x/e	37	11.5%
Black or African American	17	5.3%
Multiracial	12	3.7%
American Indian or Alaska Native*	8*	2.5%*
Middle Eastern or North African‡	-‡	-‡
Native Hawaiian or Pacific Islander†	-†	-†
Declined/unknown	25	7.8%

Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. **Data Source:** ORH participant

data for reporting period 04/01/2018-06/30/2026.

***Estimate 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).

Table 6. Languages used by HCPLRP recipients, 2018-2026 (N = 322)

Languages used†	Number of recipients	Percent of recipients
Uses a language other than English	129	40.1%
Spanish‡	82	63.6%
Other‡	37	28.7%
Vietnamese‡	12	9.3%
Russian*	7*	5.4%*

Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. **Data Source:** ORH participant data for reporting period 04/01/2018-06/30/2026.

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

†Languages used among recipients who use a language other than English. Percentages do not sum to 100 as some recipients use multiple languages other than English.

Table 7. Disability status of HCPLRP recipients, 2018-2026 (N = 322)

Disability status*	Number of recipients	Percent of recipients
Nondisabled	284	88.2%
Disabled	38	11.8%

Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. **Data Source:** ORH participant data for reporting period 04/01/2018-06/30/2026.

***Disability was measured by asking about the limitations to daily living activities: hearing, seeing, mobility, cognition, self-care (dressing/bathing), learning, communicating, independent living (doing errands), and mental health. Not all recipients were asked about each limitation listed above, and some limitations are underrepresented. Not all people with disabilities choose to report limitations or are represented using these disability questions; interpret with caution.**

Evaluation of Program Effectiveness

Contribution to Direct Patient Care

Weekly clinical hours were available from two sources, which differed in their coverage and reporting of hours. Estimates are presented separately below.

Using HWRP data (data available for n = 258; 80.1 percent of all 322 recipients), HCPLRP recipients reported an average of 34.3 (SD [standard deviation] 10.4) total hours of direct patient care per week across primary and secondary practice locations. Weekly hours were similar across most provider types (Table 8), ranging from 32.3 hours (SD 8.4) among expanded practice dental

hygienists to 36.9 hours (SD 9.3) among nurse practitioners. Licensed behavioral health providers reported the fewest hours, at 25.1 (SD 15.9), and showed the greatest variability. Differences in weekly patient care hours across provider types were statistically significant (one-way analysis of variance, $p < .05$, with lower hours among behavioral health providers than other provider types).

Table 8. Average and standard deviation of total weekly hours spent on direct patient care among 2018-2026 HCPLRP recipients, overall and by provider type

Provider type	Average	Standard deviation
Total HCPLRP Recipients (n = 258)	34.3	10.4
Physicians (MDs/DOs) (n = 48)	35.7	10.8
Physician associates (n = 29)	34.7	7.9
Nurse practitioners (n = 37)	36.9	9.3
Naturopathic physicians (n = 11)*	35.7*	9.0*
Pharmacists (n = 24)	34.7	12.4
Licensed behavioral health providers (n = 22)	25.1	15.9
Dentists (n = 62)	35.1	7.9
Expanded practice dental hygienists (n = 25)	32.3	8.4

Abbreviations: HCPLRP – Health Care Provider Loan Repayment Program; MD – doctor of medicine; DO – doctor of osteopathic medicine. **Data Source:** HWRP database on HCPLRP recipients, 2026. Data is from the current year (2026) HWRP database providing responses for HCPLRP recipients from 2016-2026.

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

PRISM end-of-year and end-of-contract survey questionnaires completed by HCPLRP recipients provided weekly clinical hours by provider type and practice setting (n = 195) (Table 9; Table 10). Recipients in federally qualified health centers (FQHCs) and community and migrant health centers, the most common setting (37.4 percent of reporting recipients), reported 35.9 hours (SD 5.7), as did those in rural health clinics (SD 7.1). Note that PRISM estimates refer to weekly clinical hours, not specifically direct patient care.

Table 9. Average reported weekly clinical hours among HCPLRP PRISM survey respondents, by provider type, 2018-2026 (N = 195 survey respondents)

Provider type	Average	Standard deviation
All HCPLRP Recipients (n = 195)	36.4	5.6
Physicians (MDs/DOs) (n = 44)	36.0	7.2
Physician associates (n = 22)	38.0	4.3
Nurse practitioners (n = 24)	36.6	5.2
Dentists (n = 46)	36.9	4.3
Other dental care providers (n = 9)	37.1	3.0
Behavioral health clinicians (n = 26)	35.6	4.7
Other provider disciplines (n = 18)	34.3	7.6

Provider type	Average	Standard deviation
Missing (n = 6)	-	-

Abbreviations: HCPLRP – Health Care Provider Loan Repayment Program; MD – Doctor of Medicine; DO – Doctor of Osteopathic Medicine. **Data Source:** PRISM end-of-year & end-of-contract surveys for reporting period 04/01/2018 - 03/31/2026.

Table 10. Average reported weekly clinical hours among HCPLRP PRISM survey respondents, by practice setting, 2018-2026 (N = 195 survey respondents)

Practice setting	Average	Standard deviation
All HCPLRP Recipients (n = 195)	36.4	5.6
FQHC, community and migrant health centers (n = 73)	35.9	5.7
Office based clinic or practice (n = 54)	37.5	4.6
Rural health clinic (n = 32)	35.9	7.1
Mental health and substance use disorder facility (n = 13)	33.4	6.3
Missing practice setting (n = 10)*	38.6*	2.2*
IHS or Tribal Health System (n<5)†	-†	-†
Prison (n<5)†	-†	-†
Other (n = 7)*	36.9*	3.4*

Abbreviations: HCPLRP – Health Care Provider Loan Repayment Program. FQHC – federally qualified health center; IHS – Indian Health Service. **Data Source:** PRISM end-of-year & end-of-contract surveys for reporting period 04/01/2018 - 03/31/2026.

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

† Estimates suppressed due to small numbers; statistically unreliable.

Services Provided Through Telemedicine

Data on telemedicine or telehealth use were available from three sources (ORH, HWRP, and PRISM), which differ in coverage and measurement. Estimates are presented separately below.

In ORH participant data, data on telehealth status was tracked as a distinct data point for recipients starting in 2025 and was recorded for 64 of the 322 (20.0 percent) HCPLRP recipients from 2018-2026. Among those with a recorded response, 16 (25.0 percent) reported seeing at least some patients via telehealth.

In HWRP data, 274 of the 322 recipients (85.1 percent) linked to HWRP records, and telehealth responses were available for 180 (55.9 percent of all recipients). Telehealth items are not administered to physicians and physician associates in HWRP, resulting in the exclusion of 77 linked recipients. An additional 17 linked recipients were missing telehealth data. Among these 180 recipients, 104 (57.8 percent) reported delivering care via telehealth at their current primary or secondary practice location. All 104 recipients who report delivering care via telehealth reported serving Oregon clients via telehealth (100.0 percent).

Utilization varied by provider type, from 95.5 percent among licensed behavioral health providers to 32.3 percent among dentists (Table 11).

Table 11. Percent of 2018-2026 HCPLRP recipients who report using telehealth at their current primary or secondary practice location, overall and by provider type

Provider type	Total recipients	Number reporting telehealth	Percent reporting telehealth
Total Recipients	180	104	57.8%
Nurse practitioners	36	32	88.9%
Naturopathic physicians*	11	10	90.9%*
Pharmacists*	24	9	37.5%*
Licensed behavioral health providers	22	21	95.5%
Dentists	62	20	32.3%
Expanded practice dental hygienists	25	12	48.0%

Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program.

Data Source: HWRP database on HCPLRP recipients, 2026. Data are from the current-year (2026) HWRP database, providing responses for HCPLRP recipients from 2018-2026.

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

Among HCPLRP recipients who completed the PRISM end-of-year survey (n = 54), telehealth accounted for an average of 2.6 percent (SD 5.4) of outpatient visits. This proportion varied by provider type, from 0.0 percent among other dental care providers to 7.5 percent among nurse practitioners. However, each provider-type subgroup included between six and 11 respondents, so these estimates may be statistically unreliable due to small numbers and should be interpreted with caution.

Estimates from HWRP linked data and PRISM are not directly comparable: the ORH and HWRP figures describe the proportion of recipients delivering any telehealth, measured among different subsets of the cohort, whereas the PRISM figure describes the proportion of outpatient visits delivered via telehealth.

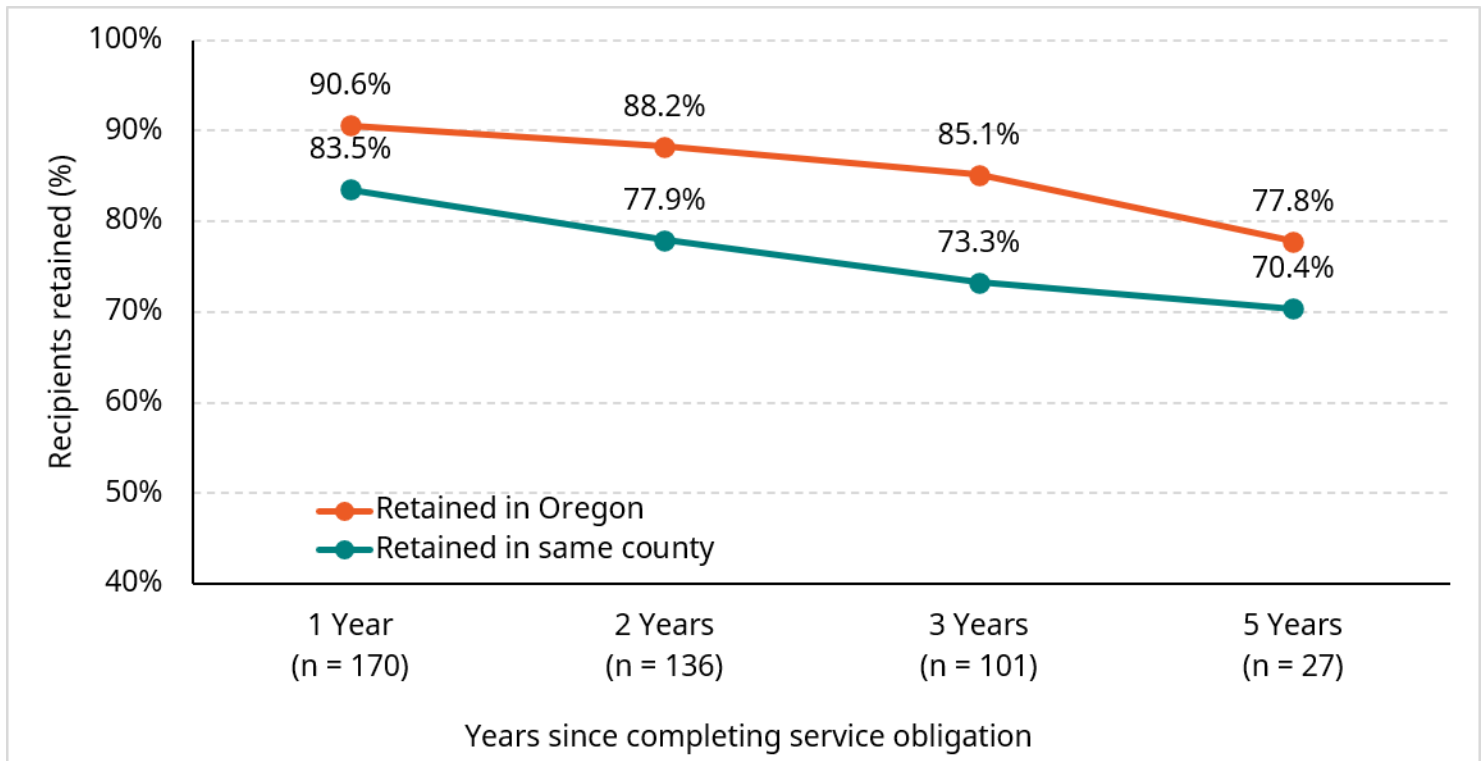
Post-Service Retention

Retention analyses were conducted using practice location (from licensing data via 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 after completing service, 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 HWRP data primarily includes licensed providers in Oregon, a provider who no longer appeared in HWRP data in a given year was counted as not retained in Oregon.

Retention within Oregon was highest, declining from 90.6 percent at one year to 77.8 percent at five years (Figure 4). County-level retention was slightly

lower, starting at 83.5 percent at one year and declining to 70.4 percent at five years.

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

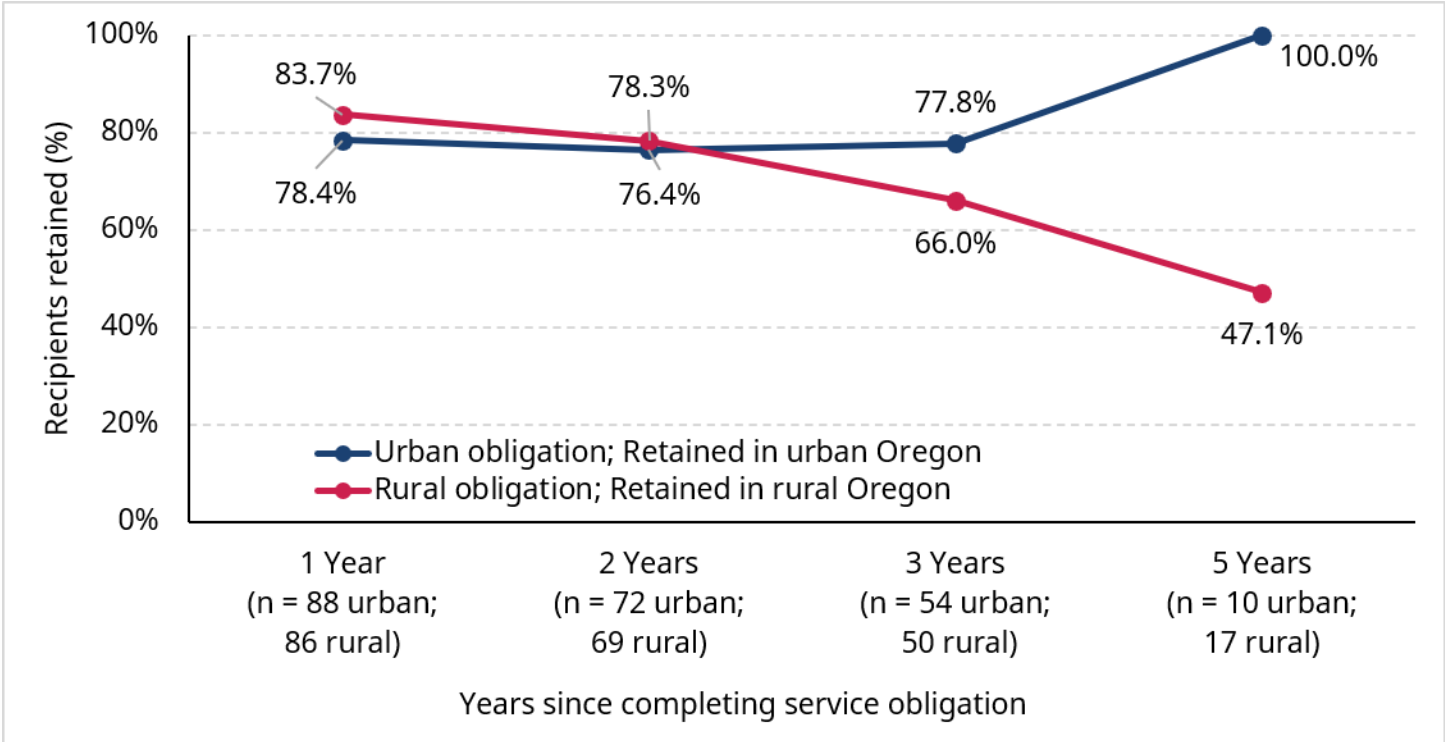


Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. Data Source: HWRP database on HCPLRP recipients’ licensure-associated practice locations, 2018-2026.

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 practice location in the same state, county, or Service Area at follow-up.

Retention analyses by rurality and provider type were also conducted for recipients who had completed their service obligation by 2025 (Figure 5). Retention in a rural-urban setting in Oregon was evaluated separately for recipients with an urban service obligation site (n = 88) and those with a rural or remote site (n = 86). Urban recipients remained in urban practice locations in Oregon at consistently high rates, at 78.4 percent (69 of 88) at one year, 76.4 percent at two years, 77.8 percent at three years, and 100.0 percent (10 of 10) at five years. Retention in rural practice in Oregon was also high, but declined more over time, from 83.7 percent (72 of 86) at one year to 78.3 percent at two years, 66.0 percent at three years, and 47.1 percent (8 of 17) at five years.

Figure 5. Retention of 2018-2026 HCPLRP recipients in urban and rural areas of Oregon at one, two, three, and five years after service obligation completion



Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. **Data Source:** HWRP database 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 in an urban/rural area was defined as having at least one practice location in an urban/rural area at follow-up.**

Retention was examined separately for primary care (n = 85), behavioral health (n = 34), and oral health (n = 51) recipients. As with the overall retention analysis, analytic samples decreased with follow-up time; therefore, five-year retention estimates may be statistically unreliable due to small numbers and are not reported. Through the first three years, retention within Oregon was high across all provider categories. Primary care recipients were retained within Oregon at 90.6 percent, 89.2 percent, and 84.6 percent at one, two, and three years, respectively. Oral health recipients were retained in Oregon at higher percentages at each time point: 100 percent, 97.3 percent, and 96.0 percent at one, two, and three years, respectively. Behavioral health recipients’ retention within Oregon was also steady across time points at 76.5 percent, 76.5 percent, and 75.0 percent at one, two, and three years, respectively.

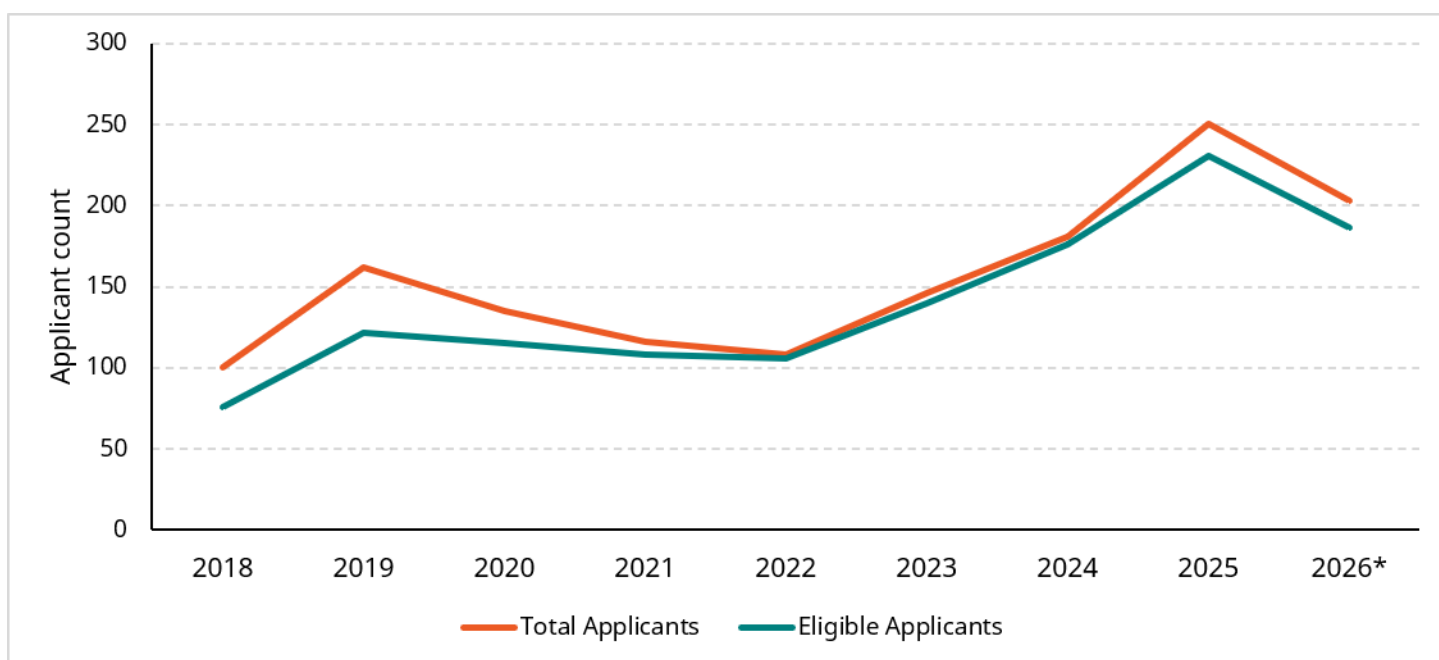
County-level retention by provider type was lower than statewide retention but remained high and relatively stable through three years. Most primary care recipients remained in the same county at each interval: 88.2 percent, 83.1 percent, and 76.9 percent at one, two, and three years, respectively. Oral health recipients showed minimal variation across intervals, at 80.4 percent, 83.8

percent, and 80.0 percent across one, two, and three years. Behavioral health recipients were retained within county at 76.5 percent, 61.8 percent, and 58.3 percent across one, two, and three years. Across all three categories, most recipients remained in their county of service at every measured interval.

Evaluation of Program Implementation

Across Oregon's 128 Service Areas, 79 (61.7 percent) had at least one HCPLRP recipient; 49 (38.3 percent) had none. The number of applicants (total and eligible) steadily increased from 100 total (76 eligible) in 2018 to 250 (231 eligible) in 2025 (most recent full year) (Figure 6).

Figure 6. Total HCPLRP applicants and eligible applicants by application year, 2018-2026

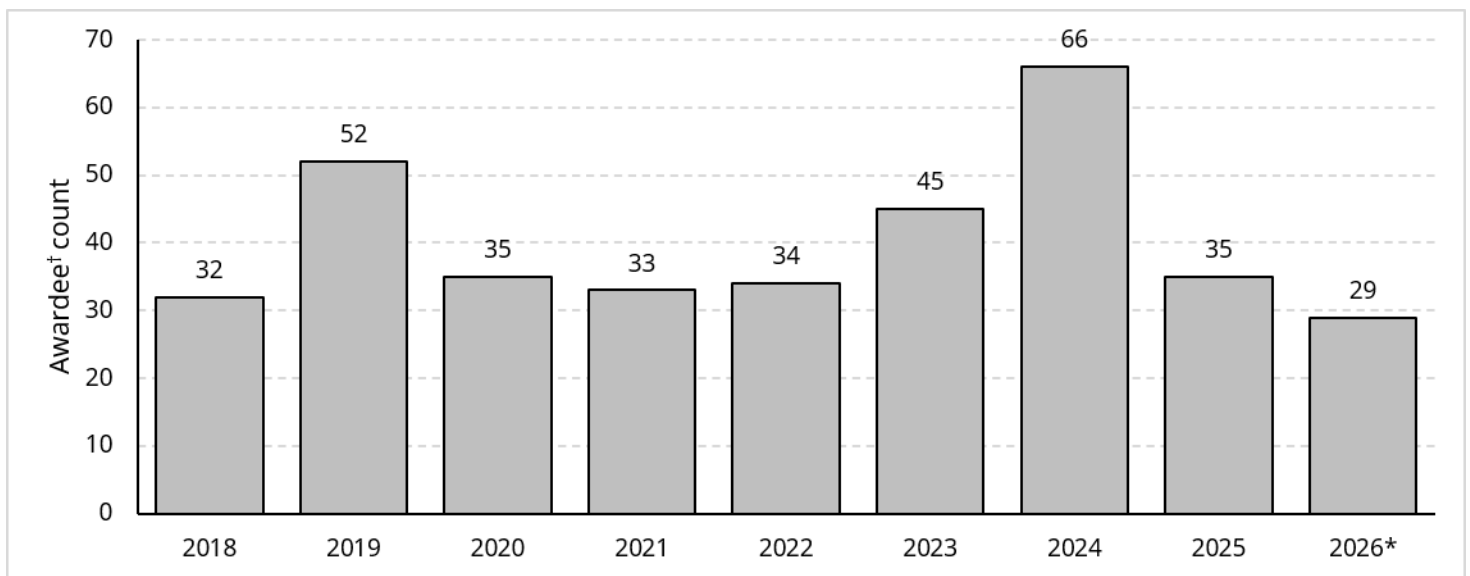


Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

***Data for 2026 represents a partial year, as the data included at time of evaluation goes through June 30, 2026.**

From 2018 to 2026, a total of 1,260 eligible applicants applied to HCPLRP, and a total of 361 awards were distributed (Figure 7). These include 322 recipients who are currently completing or have completed their service commitment, and 39 recipients who were awarded funding but later withdrew before completing their service.

Figure 7. Awarded HCPLRP applicants by application year, 2018-2026



Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

***Data for 2026 represents a partial year, as the data included at time of evaluation goes through June 30, 2026.**

†Awarded applicants in this figure include those who are completing their obligation, have completed their service obligation, and those who withdrew from the program before completing their obligation.

Across application years, the total dollars awarded generally increased over the period and peaked in 2024 (Table 12). During this time, annual dollars awarded ranged from \$1,812,260 (2020) to \$4,786,501 (2024).

Annual recipient counts ranged from 27 (2022) to 61 (2024) between 2018 and 2026. From 2018 to 2024, the percent of applicants awarded ranged from 32.1 percent (2022) to 42.6 percent (2019). In 2025, the percent of awarded applicants decreased to 15.2 percent with an increase in the number of eligible applicants (Table 12).

Table 12. HCPLRP eligible applicants, awards, percent of applicants awarded, and recipients by application year, 2018-2026

Application year	Total eligible applicants	Total awardst	Percent of applicants awarded	Total dollars awarded	Total recipients†
2018	76	32	42.1%	\$1,892,859	29
2019	122	52	42.6%	\$2,660,571	46
2020	115	35	30.4%	\$1,812,260	28
2021	108	33	30.6%	\$1,968,081	24
2022	106	34	32.1%	\$3,178,808	27
2023	140	45	32.1%	\$3,885,501	43
2024	176	66	37.5%	\$4,786,501	61

Application year	Total eligible applicants	Total awards†	Percent of applicants awarded	Total dollars awarded	Total recipients‡
2025	231	35	15.2%	\$3,450,174	35
2026*	186*	29*	15.6%*	\$2,882,149	29*
Total	1260	361	28.7%	\$26,516,904	322

Abbreviation: HCPLRP – Health Care Provider Loan Repayment Program. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

***Data for 2026 represents a partial year, as the data included at time of evaluation goes through June 30, 2026.**

†Total awards includes recipients who are currently completing or have completed their service obligation, and individuals awarded who later withdrew from program prior to completing service obligation.

‡Total Recipients includes only recipients who are currently completing or have completed their service obligation.

Evaluation of Program Sustainability (Maintenance)

From 2018 to 2026, applicant interest in HCPLRP increased: the number of total and eligible applicants per application year rose from roughly 76-100 in 2018 to 231-250 in 2025 and 186-203 from the first half (January-June) of 2026. Over the same period, the number of awards issued fluctuated and did not match the growth in applications. Across the full period, 1,401 total applicants were recorded, of whom 1,260 were eligible. Of these, 361 received an award. Total dollars awarded also increased, from \$1,892,859 in 2018 to \$3,450,174 in 2025, with a peak of \$4,786,501 in 2024. The average amount per award rose as well, from \$54,828 across 2018-2021 to \$85,006 across 2022-2025. Because individual awards were larger, the increase in funding did not produce a matching increase in the number of awards. The percent of eligible applicants awarded fell from 37.5 percent in 2024 to 15.2 percent in 2025. Funding for HCPLRP is subject to the legislature’s biennial appropriation to HCPIF.

Behavioral Health Loan Repayment Program (BHLRP)

BHLRP is a component of HCPIF, established to help rural and underserved communities recruit and retain behavioral health providers. The program provides tax-free loan repayment assistance to eligible providers in exchange for a minimum three-year commitment to practice at a qualifying site. The program is intended to strengthen the behavioral health workforce by reducing educational debt and expanding access to behavioral health services in underserved communities.

Eligible providers include the following behavioral health professionals:

- Licensed provider types
 - Psychiatric Nurse Practitioners

- Psychiatrists (General, Child and Adolescent, or Geriatric)
- Clinical Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Pre-licensed provider types
 - Clinical Social Workers
 - Counseling or Clinical Psychologists
 - Professional Counselors
 - Marriage and Family Counselors
- Associates, bachelor's, or master's level provider types:
 - Qualified Mental Health Associates (QMHA's)
 - Qualified Mental Health Professionals (QMHPs)
 - Certified Alcohol and Drug Counselors Level I
 - Certified Alcohol and Drug Counselors Level II

Eligible practice sites must meet one of the following three criteria:

- Be located in a Health Professional Shortage Area (HPSA) or Facility HPSA, serve an underserved area or area of unmet need, or
- Serve Medicaid and Medicare patients at or above the county average, or
- Provide essential health care services to an underserved population, as determined by OHA.

In exchange for a minimum three-year service commitment, full-time providers may receive 70 percent of qualifying educational loan debt, up to \$50,000 per service year. Part-time providers may receive 35 percent, up to \$25,000 per service year (three-year service commitment required). Providers with less than \$15,000 in qualifying loan debt may be eligible for repayment of up to 100 percent of their loan balance, subject to program limits, in exchange for three years of service at an eligible site.

The BHLRP was operational under HCPIP from July 2021 to January 2022. Following the passage of HB 2949, the program transitioned to being operated by the Behavioral Health Workforce Incentives program using one-time funding (additional details in Appendix A). During the 2023 session, the legislature allocated additional funding to HCPIP to address the behavioral health workforce shortage, and HCPIP resumed awards for the BHLRP in 2024. This evaluation covers the reporting period that this program was administered under HCPIP from July 2021- January 2022 and July 1, 2024- June 30, 2026.

Key Takeaways

- BHLRP awarded \$4.8 million to 113 recipients, divided roughly evenly among licensed (33.6 percent), pre-licensed (35.4 percent), and certified (31.0 percent) providers. Mental health facilities accounted for 69.9 percent of recipients' practice sites.
- BHLRP recipients reported the highest telehealth use of any program measured (86.0 percent).
- BHLRP paused awards from 2022 until July 2024, while behavioral health loan repayment was funded through BHWI. The share of eligible applicants awarded was 15.8 percent in 2021, 26.9 percent in 2024, and 23.9 percent in 2025.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

The BHLRP made 113 awards in 2021-2022 and 2024-2026, with roughly equal distributions across licensed (33.6 percent), pre-licensed (35.4 percent), and certified providers (31.0 percent). The most represented provider types were Licensed Clinical Social Workers, Clinical Social Worker Associates, Professional Counselor Associates, and Qualified Mental Health Associates (Table 13). All award recipients are currently completing or have completed their service obligation. Annual cohorts of recipients ranged from one recipient (2022) to 55 recipients (2025).

Table 13. Number and percent of BHLRP recipients by provider type, 2021-2022 and 2024-2026

License Category	Provider Type	Number	Percent of subtotal
All license categories (Total recipients)	All provider types (Total Recipients)	113	-
Licensed	All Licensed Provider Types	38	33.6% of Total
Licensed	Licensed clinical social workers	17	44.7%
Licensed	Licensed professional counselors*	9*	23.7%*
Licensed	Psychiatric mental health NPs†	-†	-†
Licensed	Psychologists†	-†	-†
Licensed	Licensed marriage and family therapists†	-†	-†
Licensed	Mental Health Nurses (RN or LPN) †	-†	-†
Pre-Licensed	All Pre-Licensed Provider Types	40	35.4% of Total
Pre-Licensed	Clinical social worker associates	23	57.5%
Pre-Licensed	Professional counselor associates	14	35.0%
Pre-Licensed	Psychology (clinical or counseling) †	-†	-†
Pre-Licensed	Marriage and family therapist associates†	-†	-†

License Category	Provider Type	Number	Percent of subtotal
Certified	All Certified Provider Types	35	31.0% of Total
Certified	Qualified mental health associates	19	54.3%
Certified	Qualified mental health professionals & other certified providers	16	45.7%

Abbreviations: BHLRP - Behavioral Health Loan Repayment Program; NP - nurse practitioner; RN - registered nurse; LPN - licensed practical nurse. Data Source: ORH participant data for reporting periods 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026.

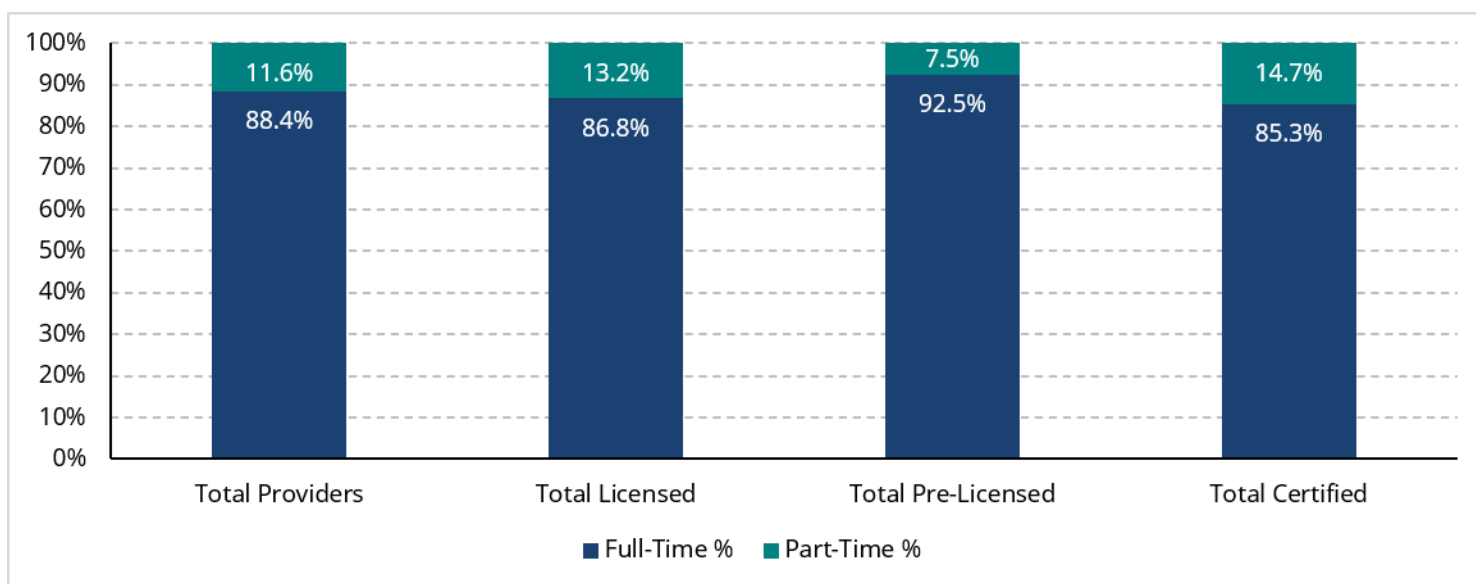
***Estimate may be statistically unreliable due to small numbers; interpret with caution.**

†Estimate suppressed due to small numbers; statistically unreliable.

The distribution of provider types across recipients is consistent across both the ORH Participant Data and the PRISM alumni survey data. For example, the most common provider type among recipients who completed the PRISM alumni survey was Social Workers, followed by Licensed Professional Counselors. However, small analytic samples of the PRISM data limit reporting of specific estimates.

Most BHLRP recipients worked full-time (88.4 percent overall), and this held consistent across the three license categories, with 85.3 percent of Certified providers, 86.8 percent of Licensed providers, and 92.5 percent of Pre-Licensed providers reporting full-time work (Figure 8). Full-time/part-time status could not be reliably reported by individual provider type due to small numbers of recipients.

Figure 8. Full-time/part-time status of BHLRP recipients, by provider type, 2021-2022 and 2024-2026



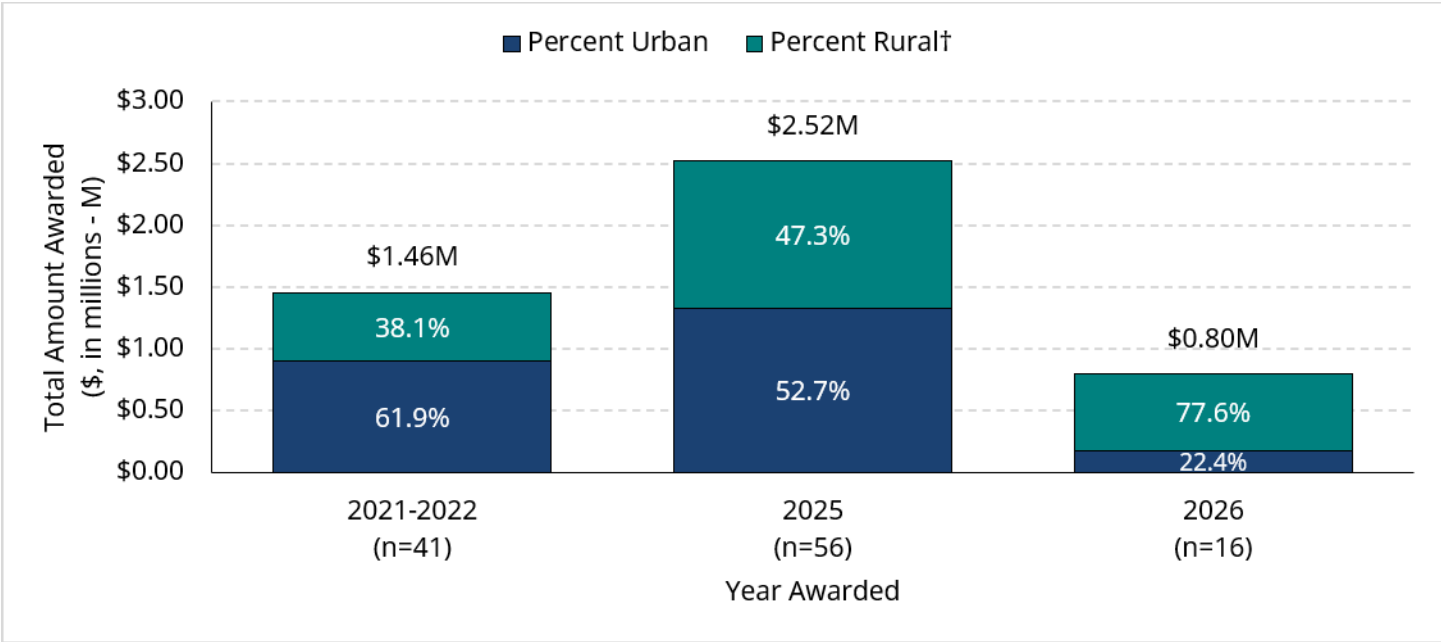
Abbreviation: BHLRP - Behavioral Health Loan Repayment Program. Data Source: ORH participant data for reporting periods 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026.

Locations of Service

Across the 113 BHLRP recipients, 51 (45.1 percent) practiced in a rural or remote ZIP code, and 64 (56.6 percent) practiced in an urban ZIP code (based on all obligated practice sites, which include six recipients with two service sites). Across all program years, the total rural or remote share increased, from 14.3 percent of recipients at rural service sites in 2021-2022 to 20.2 percent in 2025-2026. Among recipients in 2018-2022 and 2024-2026, about half of the total \$4,773,976 in funding was awarded to providers with a rural primary practice location (49.5 percent, \$2,364,495). Figure 9 shows the total amounts awarded and percent awarded to providers in urban and rural primary practice sites.

Over the program period, BHLRP recipients completed or were completing their service obligation in 43 of Oregon’s 128 Service Areas. Most urban Service Areas had at least one recipient (17 of 24), while only 25.0 percent of rural or remote Service Areas had at least one recipient (26 of 104).

Figure 9. Total amounts awarded (in millions) to BHLRP recipients (n = 113) and percent of recipient funding by practice site urban-rural designation* by year awarded, 2021-2022 and 2024-2026



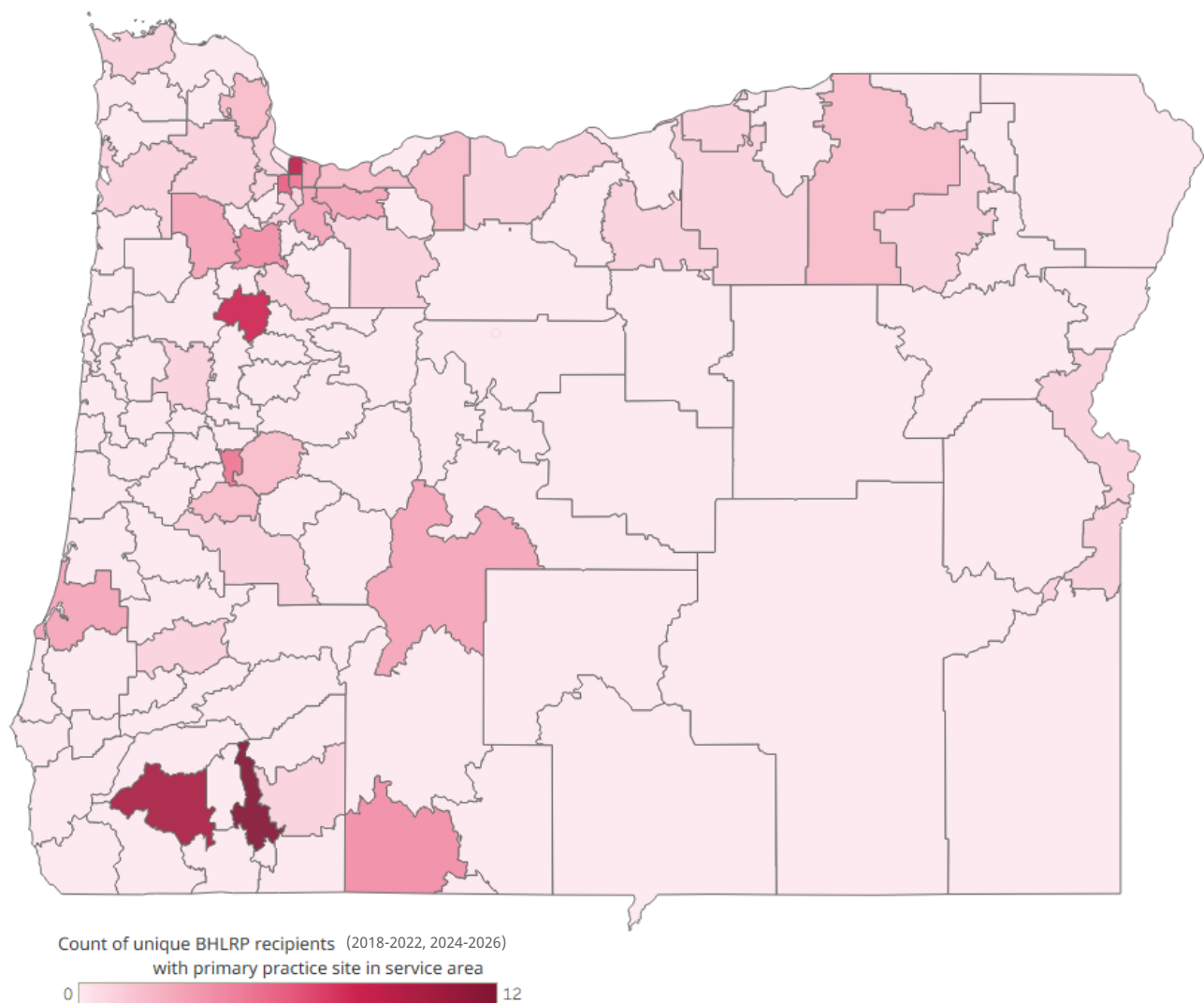
Abbreviations: BHLRP - Behavioral Health Loan Repayment Program; M – million dollars. Data Source: ORH participant data for reporting periods 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026; ORH Service Area urban-rural designations from the Areas of Unmet Health Care Need data, 2026.

***Based on the urban-rural designation of recipients' primary service obligation practice location ZIP code.**

†Rural includes recipients with rural and remote primary practice sites.

Figure 10 shows the geographic distribution of BHLRP recipients across Oregon's Service Areas. One component of the Areas of Unmet Health Care Need (AUHCN) scores, the per capita supply of mental health providers in a Service Area, was used to examine the distribution of BHLRP recipients' obligation practice location in Service Areas of higher need. Over half of BHLRP recipients (50.4 percent) were completing or had completed their service obligation in Service Areas with lower mental health provider FTE per capita than the state average (≤ 1.4 mental health providers FTE per 1,000 population). The per capita supply of mental health providers FTE used in this analysis reflects 2026 conditions of need, while awards were made from 2018 onward. Scores may therefore not reflect the level of unmet need at the time of award.

Figure 10. Geographic distribution of BHLRP recipients across Service Area* locations, 2021-2022 and 2024-2026



Abbreviation: BHLRP - Behavioral Health Loan Repayment Program. Data Source: ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026; ORH Oregon Service Areas from the Areas of Unmet Health Care Need, 2026.

***Based on the Service Area of BHLRP recipients' primary practice location.**

Provider Practice Sites

BHLRP recipients' obligated practice sites were concentrated in the safety-net delivery system. Mental health facilities comprised the largest group (n = 79, 69.9 percent), followed by federally qualified health centers (FQHCs) (n = 21, 18.6 percent), and rural health clinics (n = 5, 4.4 percent). Other facility types could not be reliably reported, due to small numbers of recipients (<5).

Duration of Service

Most recipients completed four to five years of service with BHLRP (n = 76; 73.1 percent). This includes current recipients, applicants for continuation, recipients with continuation, and completed recipients. Duration of service obligation was not available for nine recipients.

Evaluation of Program Adoption

Organizational Participation

The types of practice sites for BHLRP recipients are shown in Table 14. Mental health organizations were the most common site (n = 79 recipients), followed by FQHCs (n = 21).

Table 14. Number and percent of BHLRP recipients by site type across all practice sites

Site type	Number of recipients	Percent of recipients
Mental health	79	69.9%
Federally Qualified Health Center	21	18.6%
Residential facility, clinic, corrections agency, or other practice site*	8*	7.1%*
Rural Health Clinic*	5*	4.4%*

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026.

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

Demographic Characteristics of Recipients

Less than half of BHLRP recipients identified as white (46.0 percent) and 18.6 percent identified as Hispanic or Latino/a/x/e (Table 15). One in four recipients (n = 29, 25.7 percent) reported using a language other than English, most commonly Spanish, which accounted for 69.0 percent of reported languages (Table 16). Nineteen (16.8 percent) recipients reported a disability (Table 17). Note that the BHLRP data from ORH comprise demographic data only and are not REALD SOGI.

Table 15. Race/ethnicity of BHLRP recipients, 2021-2022 and 2024-2026 (n = 113)

Race/ethnicity	Number of Recipients	Percent of Recipients
White	52	46.0%
Hispanic or Latino/a/x/e	21	18.6%
Asian*	9*	8.0%*
American Indian or Alaska Native*	7*	6.2%*
Black or African American*	6*	5.3%*
Native Hawaiian or Pacific Islander†	-†	-†
Multiracial†	-†	-†

Race/ethnicity	Number of Recipients	Percent of Recipients
Declined/Unknown	14	12.4%

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. **Data Source:** ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026.

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

†Estimates suppressed due to small numbers; statistically unreliable.

Table 16. Languages used by BHLRP recipients, 2021-2022 and 2024-2026 (n = 113)

Languages used‡	Number of recipients	Percent of recipients
Uses a language other than English	29	25.7%
Spanish	20	69.0%
Other languages*	9*	31.0%*

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. **Data Source:** ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026.

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

‡Languages used among recipients using a language other than English, including Mien, German, Portuguese, Romanian, American Sign Language, Burmese, Hmong, and Punjabi. Unable to report these languages individually due to small numbers.

Table 17. Disability status of BHLRP recipients, 2021-2022 and 2024-2026 (n = 113)

Disability status*	Number of recipients	Percent of recipients
Nondisabled	94	83.2%
Disabled	19	16.8%

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. **Data Source:** ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026.

***Disability was measured by asking about the limitations to daily living activities: hearing, seeing, mobility, cognition, self-care (dressing/bathing), learning, communicating, independent living (doing errands), and mental health. Not all recipients were asked about each limitation listed above, and some limitations are underrepresented. Not all people with disabilities choose to report limitations or are represented using these disability questions; interpret with caution.**

Evaluation of Program Effectiveness

Contribution to Direct Patient Care

Information about providers' direct patient care or clinical hours was available from two sources, which differ in coverage and in how hours were reported. Estimates are presented separately below.

Using HWRP data, BHLRP recipients (data available for n = 43; 38.1 percent of all 113 recipients) reported an average of 32.4 (SD 10.9) total hours of direct patient care per week across primary and secondary practice locations. Weekly hours are not reportable across most provider types due to small sample sizes. Available data are shown in Table 18.

Table 18. Average reported weekly hours spent on direct patient care among BHLRP recipients, by provider type (reportable subgroups only)

Provider type	Average	Standard deviation
Overall (n = 43)†	32.4	10.9
Licensed clinical social workers (n = 13)	31.4	13.5
Licensed professional counselors (n = 8)*	29.0*	13.6*
Pre-licensed (n = 18)	32.8	6.3

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: HWRP database on BHLRP recipients, 2026. Data is from current year (2026) HWRP database providing responses for BHLRP recipients from 2021-2022 and 2024-2026.

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

†Includes 43 BHLRP recipients with HWRP data available on direct patient care hours.

PRISM end-of-year and end-of-contract survey questionnaires submitted by BHLRP recipients provide weekly clinical hours overall, by provider type, and by practice setting (n = 45). Recipients reported an average of 39.1 (SD 8.0) total hours per week, of which 33.7 (SD 5.9) hours were reported as clinical hours. Available data by provider type and practice setting are shown in Table 19 and Table 20. Note that these estimates refer to clinical hours, not necessarily direct patient care.

Table 19. Average reported weekly clinical hours among BHLRP survey respondents, by provider type (reportable subgroups only)

Provider type	Average	Standard deviation
Overall (n = 44)	33.7	5.9
Behavioral health clinicians (n = 18)	34.2	3.8
Other provider disciplines (n = 25)	33.4	7.2

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: PRISM end-of-year & end-of-contract surveys for reporting period 04/01/2021 - 03/31/2026.

Table 20. Average reported weekly clinical hours among BHLRP survey respondents, by practice setting (reportable subgroups only)

Practice setting	Average	Standard deviation
Overall (n = 44)	33.7	5.9
Mental health and substance use disorder facility (n = 23)	33.3	6.6
Office-based clinic or practice (n = 8)*	34.6*	2.8*

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: PRISM end-of-year & end-of-contract surveys for reporting period 04/01/2021 - 03/31/2026.

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

Services Provided Through Telemedicine

Data on telemedicine or telehealth use among recipients were available from three sources (ORH, HWRP, and PRISM), which differ in coverage and measurement. Estimates are presented separately below.

In ORH participant data, data on telehealth status was collected starting in 2025 and was recorded for 52.2 percent of recipients (n = 59). Among the recipients with telehealth data from this source, 13 (22.0 percent) report seeing at least some patients via telehealth.

A total of 48 BHLRP recipients were matched to HWRP Data, which reports delivery of care via telehealth. Five of the linked recipients were missing telehealth data. The sample for this telehealth analysis with HWRP data includes 43 BHLRP recipients, among whom 86.0 percent (n = 37) reported delivering care via telehealth at their current primary or secondary practice location. Across these 37 recipients who provide telehealth care, all reported serving Oregon clients via telehealth (100.0 percent). Telehealth use varied little across provider types (Table 21).

Table 21. Percent of BHLRP recipients reporting using telehealth at their current primary or secondary practice location, by provider type (reportable categories only)

Provider type	Total Recipients	Number Reporting Telehealth	Percent Reporting Telehealth
Total recipients	43	37	86.0%
Licensed clinical social workers*	12	11*	91.7%*
Licensed professional counselors*	8*	7*	87.5%*
Psychologists†	-†	-†	-†
Psychiatric mental health nurse practitioner†	-†	-†	-†
Mental health RNs†	-†	-†	-†
Licensed marriage and family therapists†	-†	-†	-†
Pre-licensed BH providers	14	12	85.7%

Abbreviations: BHLRP – Behavioral Health Loan Repayment Program; BH – behavioral health; RNs – registered nurses. Data Source: HWRP database on BHLRP recipients, 2026. Data is from current-year (2026) HWRP database providing responses for BHLRP recipients from 2018-2022 and 2024-2026.

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

†Estimates suppressed due to small numbers; statistically unreliable.

Among BHLRP recipients who completed the PRISM end-of-contract survey (n = 12), the percent of outpatient visits delivered via telehealth averaged 21.3

percent (SD 19.1). This proportion is not reportable by provider type due to small numbers.

Post-Service Retention

Retention was assessed using practice location reported through HWRP licensing data 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, 18 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 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 (analytic 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 and two years after completing their service obligation was highest within Oregon (Table 22). A smaller proportion of recipients remained in the same county one and two years after their service obligation.

Table 22. Retention of BHLRP recipients after completion of the service obligation

Time after service completion	In Oregon	In the same county
1 year (n = 18)	77.8%	72.2%
2 years (n = 15)	93.3%	72.2%

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: HWRP database on BHLRP recipients’ licensure-associated practice locations, 2016-2026. 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 practice state and county at either their primary or secondary locations are the same at follow-up.

Retention was examined separately for BHLRP recipients with an urban service obligation location (n = 12) and those with a rural or remote service obligation location (n = 8) using HWRP Data. After excluding recipients with missing location data or a follow-up window not yet reached, the analytic sample for these comparisons ranged from five to six recipients per group at each follow-up point, which is below the sample size needed to report the retention rate. Failed linkage to HWRP (including missing license information and professions not collected by HWRP) and inadequate follow-up time excluded roughly a fifth to a third of the eligible cohort, representing a limitation of the analysis.

PRISM survey data also collected self-reported measures of anticipated and actual retention among BHLRP participants while they were still completing their service obligation and at the end of their contract. Recipients who had

completed their service obligation reported shorter anticipated time remaining in their community, state, and rural or underserved practice settings than participants still active in the program, with one exception: those who completed their service reported longer anticipated time remaining in their current practice specifically (6.8 years) than end-of-year survey respondents (5.5 years; Table 23).

Table 23. Average* anticipated years of retention among BHLRP recipients, by survey

Provider type	Years anticipated remaining in current practice	Years anticipated remaining in current community	Years anticipated remaining in rural practice	Years anticipated remaining in medically underserved area	Years anticipated remaining in Oregon
Currently in service obligation†	6.2 (5.9)	13.6 (12.4)	12.5 (9.5)	15.5 (10.9)	16.3 (12.8)
At completion of service obligation‡	6.8 (6.5)	8.7 (5.6)	12.4 (9.1)	11.8 (6.7)	12.3 (7.8)

Abbreviations: BHLRP – Behavioral Health Loan Repayment Program. **Data Source:** PRISM end-of-year & end-of-contract surveys for reporting period 04/01/2018 - 03/31/2026.

*Values indicate means, standard deviations are reported in parentheses.

†This survey includes responses collected annually from recipients while they are still in their service obligation.

‡This survey includes responses collected from recipients at the completion of their service obligation.

Among alumni tracked over time following contract completion (n = 29), state-level retention remained high through 84 months post-completion (75 percent), even as retention at the specific service site (13 percent) and employing organization (13 percent) declined substantially over the same period (Table 24).

Table 24. Percent of BHLRP alumni reporting continued practice in the same service site, same organization, in Oregon, and a HPSA, state-designated shortage area, or safety net setting, by follow-up period (n = 29)

	End of Service	12 months	36 months	60 months	84 months
Current Service Site	100.0%	67.9%	63.6%	18.2%	12.5%
Same organization	100.0%	71.4%	72.7%	27.3%	12.5%
Oregon	100.0%	96.4%	100.0%	81.8%	75.0%
At a HPSA, state-designated shortage area, or safety net organization	100.0%	75.0%	82.0%	82.0%	75.0%

Abbreviations: BHLRP – Behavioral Health Loan Repayment Program. Data Source: PRISM alumni survey for reporting period 04/01/2018 - 03/31/2026.

Among PRISM survey respondents with retention data available (n = 45), most anticipated staying within a HPSA, state-designated shortage area, or safety net organization up to seven years after service obligation. Among PRISM end-of-year and end-of-contract respondents, anticipated years remaining varied somewhat by race/ethnicity, though sample sizes for most subgroups were too small to report (seven of nine race/ethnicity categories are suppressed per small-numbers guidance, Table 25).

Table 25. Average* (standard deviation)† anticipated years of retention among BHLRP recipients, by provider type (reportable subgroups only)

Race/ethnicity	Years anticipated remaining in current practice	Years anticipated remaining in current community	Years anticipated remaining in rural practice	Years anticipated remaining in medically underserved area	Years anticipated remaining in Oregon
White (n = 23)	7.8 (6.7)	15.1 (12.3)	11.4 (8.6)	13.0 (10.4)	17.9 (11.9)
Hispanic or Latino/a/x/e (n = 10)*	5.4 (6.1)	15.6 (13.4)	-	-	22.0 (14.4)

Abbreviations: BHLRP – Behavioral Health Loan Repayment Program. Data Source: PRISM end-of-year & end-of-contract surveys for reporting period 04/01/2018-03/31/2026.

***Estimates may be statistically unreliable due to small numbers; interpret with caution. Number of years anticipated remaining in rural practice and medically underserved area are suppressed within this subgroup due to small numbers.**

†Values indicate means, standard deviations are reported in parentheses.

Evaluation of Program Implementation

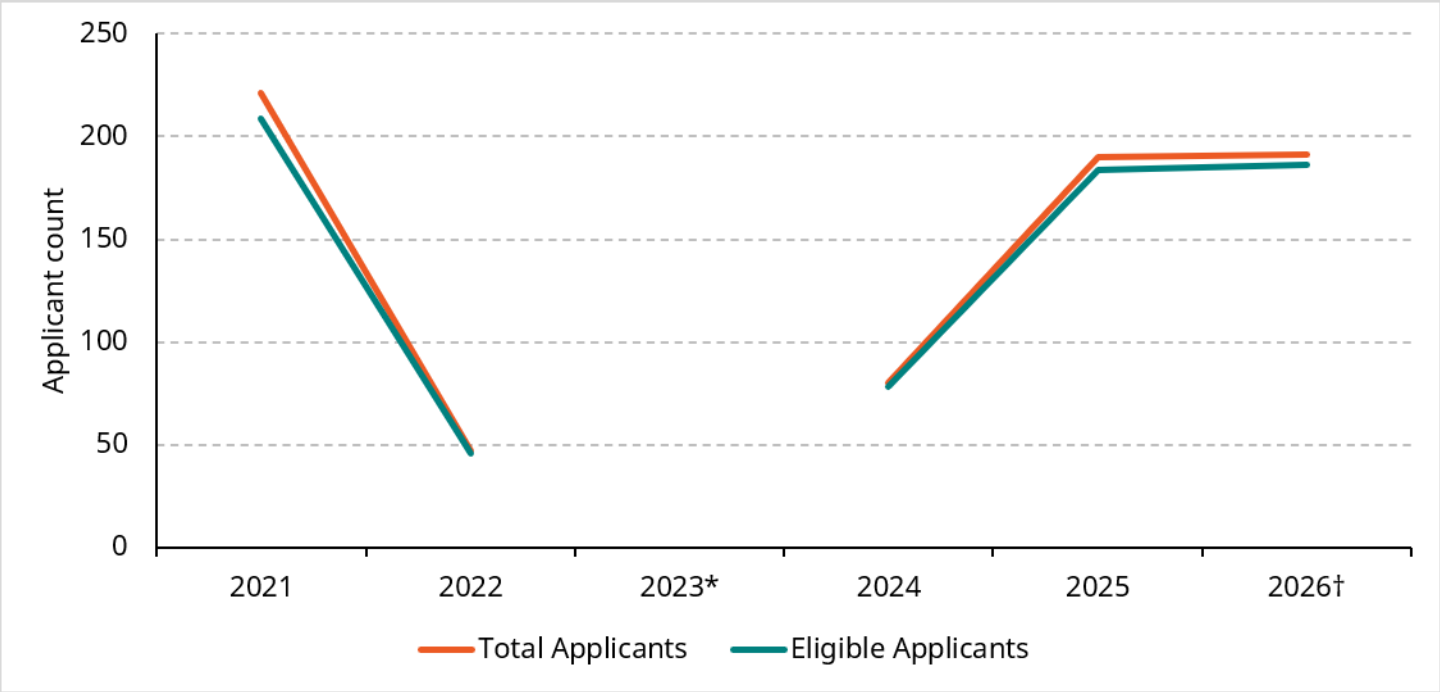
Across Oregon’s 128 Service Areas, 43 (33.6 percent) had at least one BHLRP recipient who completed their service obligation, while 85 (66.4 percent) had none.

The total number of applicants and eligible applicants were similar from the first application year in 2021 with 209 eligible applicants to 184 eligible applicants in 2025 (the most recent complete application year for which data is available). There was a decline in applications in 2022 and 2024, the years before and after the program was not operational in 2023. Reporting data from 2026 represents a partial year, ending on June 30.

The number of recipients also fluctuated over periods of program implementation (Table 26). In total, BHLRP awarded a total of \$4,773,976 to 113 recipients. Data from 2026 represents a partial year ending on June 30 with 15 recipients at time of evaluation. Across complete application years with awards,

funding ranged from \$803,718 (2024) to \$2,226,163 (2025). Awards in the first half of 2026 totaled \$603,108.

Figure 11. BHLRP total and eligible applicants and recipients by application year early implementation years (2021-2022) and recent years (2024-2026)



Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026. *In 2023, the program was not in operation, so there were no applicants in that year. †Data for 2026 represents a partial year, as the data included at time of evaluation goes through June 30, 2026.

Table 26. Eligible applicants, awards, percent of applicants awarded, recipients, and total dollars awarded by application year, early implementation years (2021-2022) and recent years (2024-2026)

Application year*	Total eligible applicants	Total awardst	Percent of applicants awarded	Total amount awarded (dollars)
2021	209	33	15.8%	\$1,140,987
2022*	46	0	0.0%	\$0
2024	78	21	26.9%	\$803,718
2025	184	44	23.9%	\$2,226,163
2026†	186	15	8.1%	\$603,108
Total	703	113	16.1%	\$4,773,976

Abbreviation: BHLRP – Behavioral Health Loan Repayment Program. Data Source: ORH participant data for reporting period 07/01/2021-1/31/2022 and 07/01/2024-06/30/2026. *In 2023, the program was not in operation, so there were no applicants or awards in that year. No awards were made in application year 2022.

†Data for 2026 represents a partial year, as the data included at time of evaluation goes through June 30, 2026.

Evaluation of Program Sustainability (Maintenance)

BHLRP operated three award periods from March to December 2021, followed by a gap with no awards due to BHWI resources beginning in 2022. Since the legislature allocated one-time funding to BHWI, BHLRP resumed in July 2024 through June 2026, following a legislative addition of for behavioral health workforce incentive funds to HCPIP during the 2023 session.

Eligible applicants numbered 209 in 2021, 78 in 2024 (when awards resumed midyear), and 184 in 2025. In the first half of 2026 there were 186 eligible applicants, already more than in all of 2025. This suggests demand may be increasing, although the gap between the 2021 and 2024 cycles limits comparison of the two periods.

Loan Repayment (HCPLRP and BHLRP) Survey Findings

A supplemental survey was administered to current HCPLRP and BHLRP recipients between May 20 and June 8, 2026, collecting self-reported perceptions of program benefits and recommendations for improvement. Responses could not be disaggregated by program and are reported together. Of the 287 current HCPLRP and BHLRP participants surveyed, 21 completed the survey (response rate: 7.3 percent).

Key Takeaways

- Among 21 survey respondents (7.3 percent response rate), 85.7 percent reported that the program significantly influenced their decision to stay at their current practice site, and 61.9 percent reported that it influenced their decision to practice in a rural or underserved area.
- Respondents identified the three-year service commitment as the main deterrent to enrollment among otherwise eligible colleagues, and 70.0 percent requested a larger award.

Recipient-Reported Program Impact

Impact on Decision-Making and Retention

Most respondents (61.9 percent, $n = 13$) indicated that the program influenced their decision to practice in a rural or underserved area, with one third reporting that the loan repayment program significantly influenced their decision to take a position in a medically underserved or rural area. The program helped nearly half remain in Oregon (47.6 percent, $n = 10$). Notably, the program significantly influenced the decision of 85.7 percent ($n = 18$) of respondents to stay at their current practice site.

Impact on Providers' Lives

Most respondents reported that the program reduced financial stress related to student loan debt (85.7 percent, n = 18), and 57.1 percent (n = 12) reported that the program improved their overall well-being or work-life balance.

Impact on Providers' Service

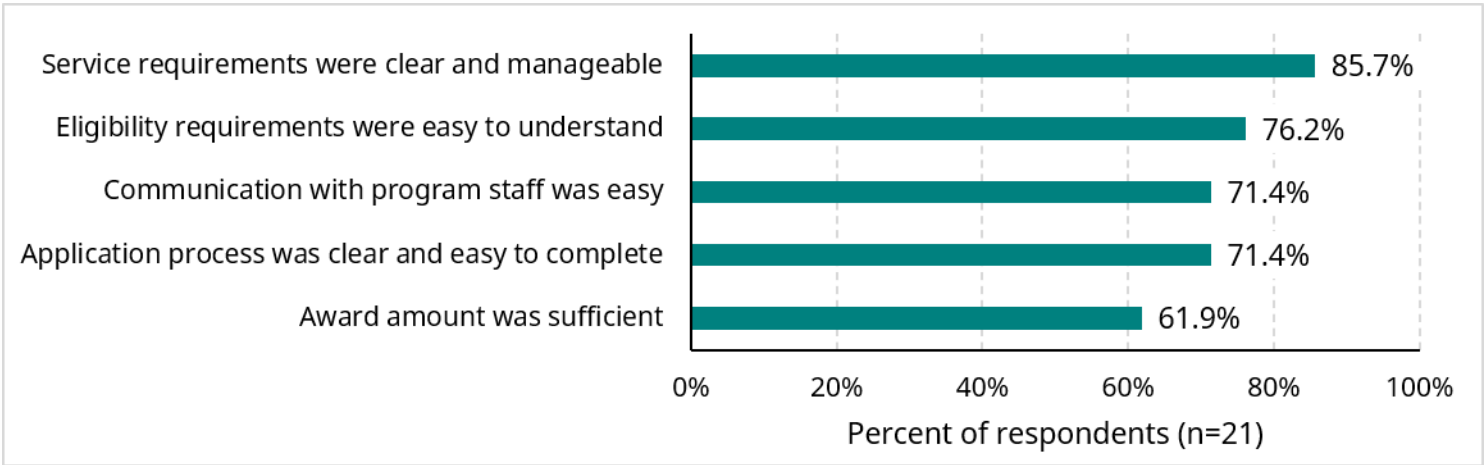
A total of nine (42.9 percent) respondents indicated that the loan repayment program allowed them to focus more on patient care.

Participant Assessment of the Program

Respondents generally viewed program administration positively (Figure 12; Figure 13). Most reported that service requirements were clear and manageable (85.7 percent), eligibility requirements were easy to understand (76.2 percent), and the application process was clear and easy (71.4 percent). Half wanted reduced reporting or administrative burden, and 70.0 percent identified increasing the award amount as a desired change, with one respondent noting the following:

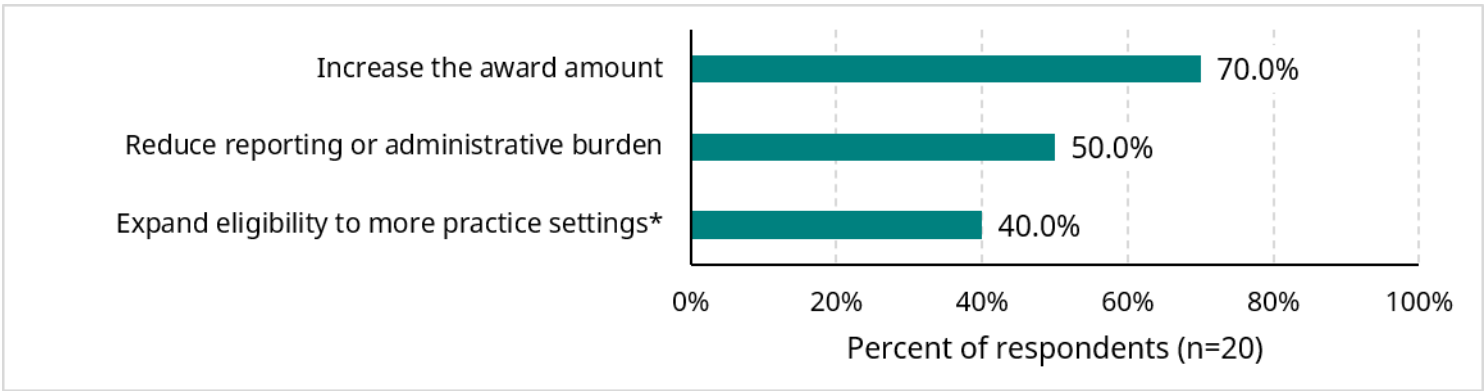
*With the
to revisit the award amount for physicians in very rural/frontier practices.*

Figure 12. Percent of survey respondents with feedback on aspects of the loan repayment programs (HCPLRP and BHLRP) that worked well, 2026



Data Source: Loan repayment participant online survey, May 20, 2026 to June 8, 2026 (7.3 percent response rate).

Figure 13. Percent of survey respondents with requested improvements to the loan repayment programs (HCPLRP and BHLRP), 2026



Data Source: Loan repayment participant online survey, May 20, 2026 to June 8, 2026 (7.3 percent response rate).

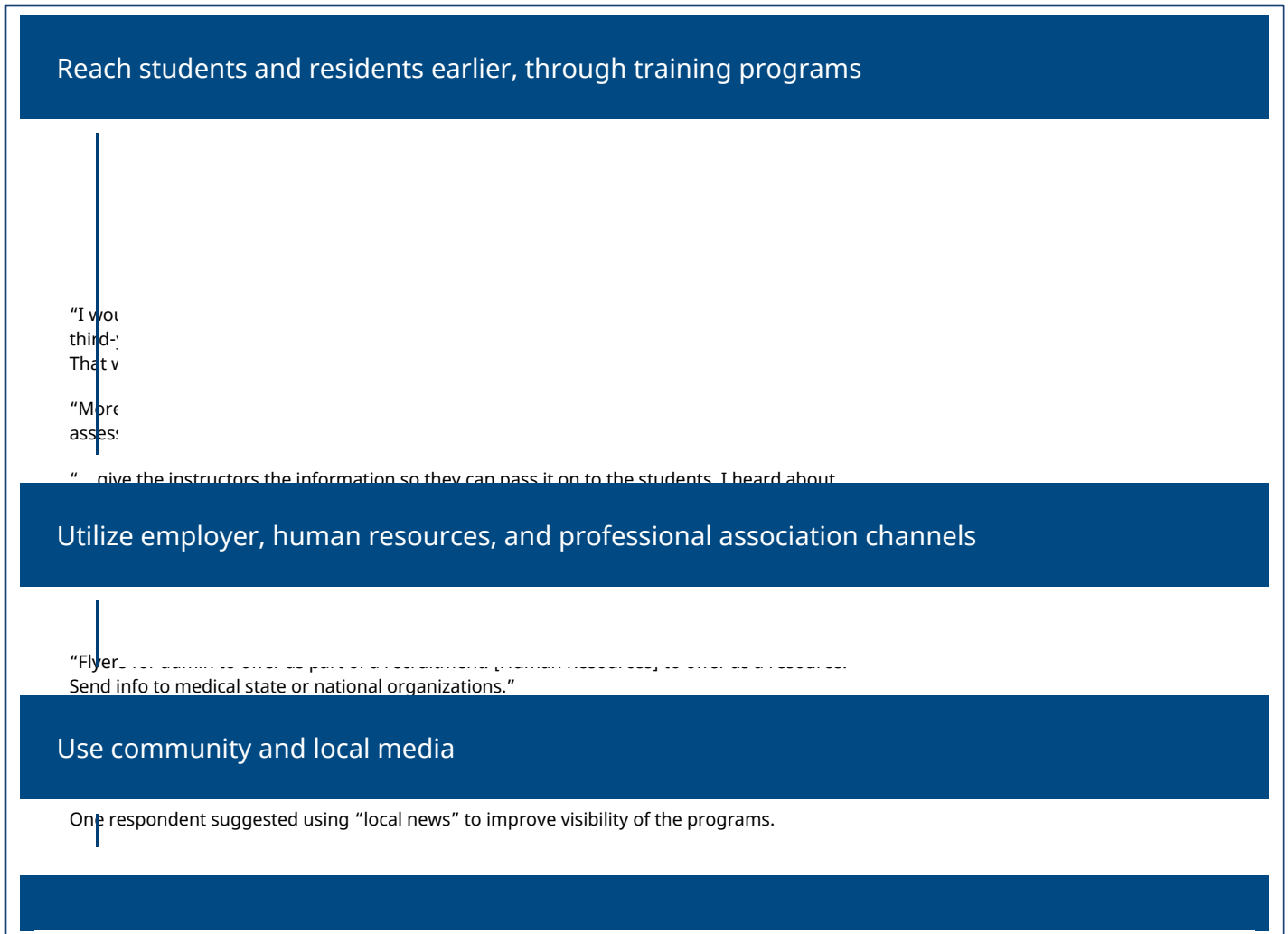
***Estimates may be statistically unreliable due to small numbers; interpret with caution.**

Among respondents who provided qualitative responses, the three-year service commitment was identified as the most challenging aspect of the loan repayment programs and the main deterrent to enrollment for colleagues who were otherwise eligible and willing to participate. One respondent noted,

Two respondents described staying in positions that were a poor fit or reclassifying current positions to avoid repayment penalties. One respondent proposed a three-year maximum enrollment period with a prorated, no-penalty exit.

Participants recommended several approaches to improve the program’s reach and increase awareness among potential applicants (Figure 14).

Figure 14. Suggestions for improving visibility of and recruitment for HCPIP loan repayment programs, 2026



Data Source: Loan repayment participant online survey, May 20, 2026 to June 8, 2026. N = 21 respondents (7.3 percent response rate).

State Partnership Loan Repayment Program (SLRP)

SLRP provides educational loan repayment assistance to health care professionals in exchange for a service commitment at an approved practice site. SLRP is funded by the federal government through an ORH grant from the Health Resources and Services Administration (HRSA), with matching funds provided by OHA's HCPIP. The program is intended to support recruitment and retention of health care professionals in underserved communities.

Eligible providers include a broad range of health care professionals, including the following:

- Physicians (allopathic and osteopathic)
- Primary care nurse practitioners and physician associates
- Certified nurse-midwives

- Dentists
- Dental therapists
- Expanded practice dental hygienists
- Clinical and counseling psychologists
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Psychiatric nurse specialists
- Registered nurses
- Pharmacists
- Certified alcohol and drug counselors holding a master's degree
- Registered dietitians holding a master's degree

Key Takeaways

- SLRP supported 13 recipients with \$584,091 in 2022-2023. More than three-quarters of recipients practiced at a rural primary site.
- Federal SLRP funding paused after 2023 and was restored in early 2026. ORH received a new grant, HCPIP committed matching funds, and awards resumed in July 2026.

SLRP Eligibility, Service Requirements, and Awards

To qualify for SLRP, physicians, nurse practitioners, and physician associates must practice in specified primary care specialties, including family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, women's health, and psychiatry/mental health. Providers must be U.S. citizens or nationals, hold a current unrestricted license, have qualifying educational loan debt, and be in good standing with federal debt obligations.

Eligible practice sites must be nonprofit public or private organizations located in a Health Professional Shortage Area (HPSA) and provide outpatient primary medical, mental, and behavioral health, and/or dental services. Sites must offer free or reduced-fee services to individuals at or below 200 percent of the federal poverty level, serve patients regardless of ability to pay, accept applicable public insurance programs, and meet OHA nondiscrimination requirements.

In exchange for a minimum two-year service commitment, full-time physical health providers may receive up to \$75,000 in loan repayment assistance (\$37,500 per year). Full-time dental and behavioral health providers may receive

up to \$50,000 (\$25,000 per year). Half-time physical health providers may receive up to \$37,500 (\$18,750 per year), and half-time dental and behavioral health providers may receive up to \$25,000. Awards are capped at the lesser of 50 percent of qualifying educational loan debt or the applicable federal maximum.

This evaluation of SLRP covers the reporting period of December 21, 2022, through December 31, 2023. Awards from this period were funded federally through a HRSA grant awarded to the ORH and from OHA through a \$300,000 matching grant. After this one-time grant, federal SLRP grants were not available until a new funding opportunity was released in early 2026.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

Thirteen providers received SLRP awards during the reporting period from December 2022 to 2023. One additional provider was awarded but declined. Five disciplines are represented among those 13 awarded recipients. Pharmacists are the largest single discipline (38.5 percent of total). All other disciplines fall below the suppression threshold for reporting small numbers individually and cannot be disaggregated (n = 8, 61.5 percent; includes MDs, NPs, RNs, and dentists). The cohort included no behavioral health professionals, physician associates, certified nurse-midwives, dental therapists, expanded practice dental hygienists, or registered dietitians. Whether this reflects application volume, award decisions, or site availability cannot be determined, because applicant-level data were not supplied. The majority (76.9 percent) of recipients reported working full-time (n = 10).

Locations of Service

Across all SLRP recipients, over three-quarters had a primary practice site in a rural ZIP code (data suppressed due to small numbers). This pattern remained the same when examining geographic reach across all recipient service obligation sites, rather than at the primary practice site only.

Twelve of Oregon's 128 service areas contained at least one SLRP recipient during the reporting period (Table 27). Overall, 16.7 percent of urban service areas contained a recipient, compared to 7.7 percent of rural service areas (including remote). None of the eighteen remote service areas contained a recipient.

Table 27. Number and percent of Oregon Service Areas containing at least one SLRP recipient, 2022-2023

Service area designation	Total Service Areas in Oregon	Service Areas with a recipient*	Percent of Service Areas
All Service Areas	128	12	9.4%
Urban	24	4	16.7%
Rural (including remote)	104	8	7.7%
Rural (excluding remote)	86	8	9.3%
Remote	18	0	0.0%

Abbreviation: SLRP – State Partnership Loan Repayment Program. Data Source: ORH participant data for reporting period 12/21/202–12/31/2023.

***Accounts for recipients reporting primary and secondary practice locations. Recipients with practice sites in distinct service areas designations will be counted multiple times.**

Overall, \$584,091 was distributed through SLRP from 2022-2023. Table 28 shows funding distribution by rurality. Funding distribution is reported against the rural-urban classification of the primary service obligation site. Funding is distributed to rural ZIP Codes in similar proportions to the distribution of recipients: 75.4 percent of funding went to recipients at rural ZIP codes.

Table 28. SLRP Total amount awarded by rural-urban location of primary service obligation site, 2022-2023

Location	Total funding	Percent of funding
Total	\$584,091	100.0%
Rural	\$440,564	75.4%
Urban	\$143,527	24.6%

Abbreviation: SLRP – State Partnership Loan Repayment Program. Data Source: ORH participant data for reporting period 12/21/2022–12/31/2023.

Provider Practice Sites

Of the 13 recipients, eight (61.5 percent) practiced at FQHCs and five (38.5 percent) at clinics or Rural Health Clinics. Other practice site counts are suppressed because of small numbers.

Duration of Service

At the end of the reporting period, over four-fifths of recipients had either completed an initial or continuation award (exact percentage suppressed to prevent backward calculation).

Evaluation of Program Adoption

The available data did not support assessment of the program adoption, including organizational participation and demographic characteristics of recipients. Counts of SLRP recipients by type of practice site suppressed due to small numbers. Demographic data was not collected on SLRP recipients.

Evaluation of Program Effectiveness

Services Provided Through Telemedicine

Data on telemedicine or telehealth utilization were available based on recipients' reports of whether they provided care to at least some patients via telehealth. No SLRP recipients reported providing patient care via telehealth during the reporting period.

Data on SLRP retention and direct patient care hours could not be reported due to small numbers, requiring suppression.

Evaluation of Program Implementation

Total disbursement for the cohort was \$584,091. Program documentation records \$300,000 in federal funds per grant year and a one-time HCPIP match of \$300,000 covering one year of awards, giving an indicative available total of \$600,000 for the award year covered by this reporting period. On that basis, approximately 97.3 percent of available funds were disbursed.

Data completeness and infrastructure

Data on SLRP recipients was limited to ORH participant data. Due to the small number of SLRP recipients, many findings from the ORH data were suppressed, including retention, patient care hours, and organizational participation. No data sources were available to assess demographic characteristics.

Evaluation of Program Sustainability (Maintenance)

This evaluation covered a short reporting period for SLRP, from December 21, 2022, through December 31, 2023, when a one-time, \$300,000 matching grant from the Health Care Provider Incentive Fund was provided to ORH, which limits the evaluation of program maintenance beyond this period.

Following the one-time funding match, federal funding for SLRP was unavailable until a new notice of funding was announced in early 2026. ORH applied for and received a new SLRP grant, which resumed funding in July 2026. With this new federal grant, HCPIP has committed matching funds for the grant's first three years from its 2025-2027 program budget, depending on continued federal funding availability. Several potential factors may compromise the future maintenance of SLRP, including unpredictability of potential federal budget cuts, future budget approval for OHA matching funds, and ORH's capacity to continue to apply for and manage HRSA grants.

Loan Forgiveness Programs

Primary Care Loan Forgiveness (PCLF) (HCPIP)

Background

The Primary Care Loan Forgiveness (PCLF) program provides tax-free financial support to eligible students while they are enrolled in an eligible academic program or residency. Awards may cover tuition and fees during one or more years of an eligible academic program. In exchange, recipients commit to providing primary care in an approved rural Oregon practice after completing their training. OHA began administering the PCLF program under HB 3261 on April 1, 2018. PCLF is ongoing, and awards are distributed annually.

Eligible participants include students pursuing training to become physicians, physician associates, nurse practitioners, dentists, and pharmacists in specified primary care specialties. Eligible specialties include family medicine, general internal medicine, pediatrics, geriatrics, obstetrics/gynecology, general surgery, community psychiatry, psychiatric mental health, general dentistry, and general or psychiatric pharmacy. Applicants must be participating in the Oregon AHEC Scholars Program or an approved Oregon rural training track and remain enrolled full-time and in good academic standing.

Eligible practice sites must be in a rural Oregon community and meet one of the following criteria:

- Be located in a Health Professional Shortage Area (HPSA) or Facility HPSA, serve an underserved area or area of unmet need, or
- Serve Medicaid and Medicare patients at or above the county average, or
- Provide essential health care services to an underserved population, as determined by OHA.

Students must begin practicing full-time at an eligible site within 90 days of graduation or residency completion and provide at least 32 hours per week of direct patient care. The service obligation is one year of clinical primary care service for each year of PCLF funding received, with at least 45 weeks of service required during each 52-week service year. Awards may cover full tuition and fees but cannot exceed the highest resident tuition rate at publicly funded health professional training programs in Oregon.

Data from this evaluation covers a reporting period of April 1, 2018 to June 30, 2026. Included in this analysis are all PCLF awardees who had an active contract on and after April 1, 2018, including recipients who were awarded prior to OHA assuming management of the PCLF program on April 1, 2018.

Key Takeaways

- PCLF supported 117 students, most commonly physician associates (47.9 percent), and all 70 recipients with a recorded service site practiced in a rural area.
- PCLF had high five-year retention (94.4 percent), and 72.2 percent of recipients remained in rural practice five years after their service obligation.
- PCLF awarded 69.8 percent of applicants between 2019 and 2026, although applicant numbers were small (7 to 24 per year).

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

Between 2018 and 2026, the PCLF program had 117 recipients. Because PCLF awards are provided while recipients are still in school, 29.1 percent (n = 34) were still in school or residency, while 70.9 percent (n = 83) were completing or had completed their obligation.

Across the 117 PCLF recipients, PAs were the largest discipline (n = 56; 47.9 percent), followed by physicians (MDs and DOs; n = 29; 24.8 percent), and pharmacists (n = 16; 13.7 percent) (Table 29). The numbers of NPs and dentists were suppressed due to small numbers. Recipient counts by specialty and types of services provided were not available.

Table 29. PCLF recipients by provider discipline, 2018-2026 (N = 117)

Provider discipline	Number of recipients	Percent of recipients
Total recipients	117	100.0%
Physician associates	56	47.9%
Physicians – MDs & DOs	29	24.8%
Pharmacists	16	13.7%
Nurse practitioners‡	-‡	-‡
Dentists†	-†	-†

Abbreviations: PCLF – Primary Care Loan Forgiveness; MD – Doctor of Medicine; DO – Doctor of Osteopathic Medicine. **Data Source:** ORH participant data for reporting period 04/01/2018-06/30/2026.

†Estimates suppressed due to small numbers; statistically unreliable.

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

PRISM survey data show a similar discipline mix among end-of-contract respondents (n = 20) and alumni respondents (n = 14). Data are not presented because most cells contain fewer than five respondents.

Locations of Service

The service obligation practice site location is available only for the 70 recipients (59.8 percent of 117) who are completing or have completed their service obligation and are not missing service location information. Among 70 recipients with known service location data, 70 (100.0 percent) practiced in a rural or remote ZIP code.

Among Oregon's 128 Service Areas, 32 (25.0 percent) had at least one PCLF recipient completing or currently in their service obligation; 96 Service Areas had none (Table 30). Coverage was 0.0 percent of urban Service Areas, 30.8 percent of rural Service Areas including remote (32 of 104), and 16.7 percent of remote Service Areas (three of 18).

Table 30. Number and percent of Oregon Service Areas containing at least one PCLF recipient*

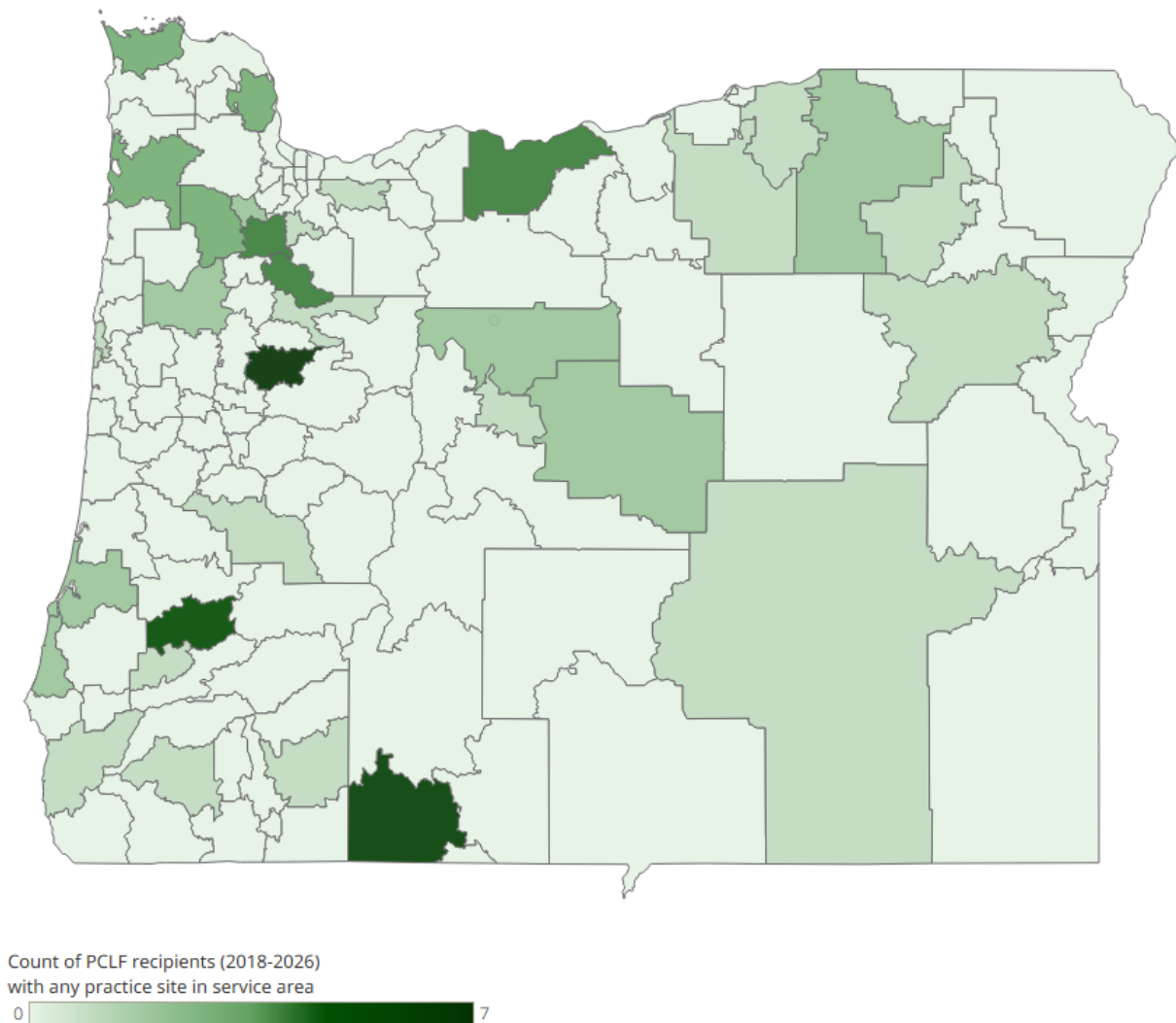
Rurality	Total number of Service Areas in Oregon	Number of Service Areas with a PCLF recipient*	Percent of Service Areas with a PCLF recipient
Total	128	32	25.0%
Urban	24	0	0.0%
Rural (including remote)	104	32	30.8%
Rural (excluding remote)	86	29	33.7%
Remote	18	3	16.7%

Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

***Includes only 70 recipients who are currently completing or had completed their service obligation from 2018-2026. An additional 13 recipients who are currently completing or had completed their obligation were excluded because the rural-urban designation of their obligation practice site was unavailable.**

Figure 15 shows the geographic distribution of recipient practice sites across Service Areas. The Service Area primary care capacity ratio (or percent of primary care visits able to be met) was used to examine the distribution of PCLF recipients' practice locations in areas of higher primary care need (n = 66, including only physician, NP, and PA recipients with service practice location information). A ratio less than one indicates there is insufficient supply of primary care to meet demand. Over half of included PCLF recipients (56.1 percent) were completing or have completed their service obligation in Service Areas with lower primary care capacity ratios than the state ratio (≤ 0.99). The primary care capacity ratio used in this analysis reflects 2026 conditions of need, while awards were made from 2018 onward. Scores may therefore not reflect the level of unmet need at the time of award.

Figure 15. Geographic distribution of PCLF recipients across Service Area locations, 2018-2026 (n = 70)*



Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026; ORH Oregon Service Areas from the Areas of Unmet Health Care Need, 2026.

***Based on the Service Area of recipients’ primary practice location. Includes only 70 recipients completing their service obligation or who had completed their obligation from 2018 to 2026 with a known practice location. Practice location was missing for 13 PCLF recipients who were completing or had completed their service obligation. Practice site location was unavailable for 34 recipients from 2018-2026 who are currently still in school or residency.**

Duration of Service

Most recipients had a one-year (n = 77; 65.8 percent of 117 total recipients) or two-year (n = 19, 16.2 percent) service obligation. Eight recipients (6.8 percent) had a three-year service obligation, although this estimate may be statistically unreliable due to small numbers and should be interpreted with caution. The

mean obligation length was 1.3 years (SD 0.6) among the 104 recipients with length of service information available (13 recipients missing years of service, 11.1 percent of all recipients). By discipline, mean obligation length was 2.1 years (SD 0.73) for physicians, 1.5 years (SD 0.5) for NPs, and 1.0 year (SD 0) for PAs and pharmacists. Dentist estimates are suppressed due to small numbers.

Evaluation of Program Adoption

Organizational Participation

The types of organizations in which recipients complete their service obligations are not systematically collected or readily available.

Among PRISM end-of-contract survey respondents (n = 20), rural health clinics were the most common practice setting (12 respondents; 60.0 percent). Counts for FQHC/community and migrant health centers, office-based clinics, and other settings were fewer than five. No respondents reported practicing at IHS/Tribal sites, mental health and substance use disorder facilities, or prisons.

Demographic Characteristics of Recipients

Across 117 recipients, the largest group (n = 50, 42.7 percent) identified as white. Table 31 provides a breakdown of recipient race/ethnicity. Six recipients (5.1 percent) reported using a language other than English (Table 32). The languages other than English used by recipients and the number of recipients reporting a disability are suppressed due to small numbers. Gender identity is not available in the supplied data. Most recipients were from Oregon (40.2 percent), California (18.8 percent), or Washington (8.5 percent). Less than one-third were from another U.S. state or another country (Table 33).

Table 31. Race/ethnicity of PCLF recipients (N = 117 recipient records)

Race/ethnicity	Number of recipients	Percent of recipients
White	50	42.7%
Hispanic or Latino/a/x/e	12	10.3%
Asian*	11*	9.4%*
Middle Eastern and North African	0	0.0%
Multiracial	0	0.0%
American Indian or Alaska Native†	-†	-†
Black or African American†	-†	-†
Native Hawaiian or Pacific Islander†	-†	-†
Declined/Unknown	38	32.5%

Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

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

†Estimates suppressed due to small numbers; statistically unreliable.

Table 32. PCLF recipients who use a language other than English (N = 117 recipient records)

Uses a language other than English†	Number of recipients	Percent of recipients
No	111	94.9%
Yes*	6*	5.1%*

Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

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

†Estimates for which languages used other than English are suppressed due to small numbers; statistically unreliable.

Table 33. Home state of PCLF recipients (N = 117 recipient records)

Home state (n = 117 reporting)	Number of recipients	Percent of recipients
Oregon	47	40.2%
Other U.S. states/international	38	32.5%
California	22	18.8%
Washington*	10*	8.5%*

Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

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

As a student pathway program, PCLF participation operates through four educational institutions: OHSU, Pacific University, Western University of Health Sciences' Heatherington College of Osteopathic Medicine (DO program), and Frontier Nursing University (NP program) (Table 34). Recipients were mostly concentrated at two institutions: OHSU (n = 52; 44.4 percent) and Pacific University (n = 51; 43.6 percent), together accounting for 103 of 117 recipient records (88.0 percent) (Table 34). OHSU recipients included providers from all five disciplines (17 physicians, 15 PAs, 11 NPs, and six pharmacists; NP and pharmacist counts may be statistically unreliable due to small numbers). Counts for dentists were suppressed due to small numbers. Disciplines of recipients at Pacific University included PAs (n = 41) and pharmacists (n = 10; may be statistically unreliable due to small numbers).

Table 34. PCLF recipients and amounts awarded by school (N = 117 recipient records)

School	Number of recipients	Percent	Total awarded*	Average award
OHSU	52	44.4%	\$2,730,462	\$54,609
Pacific University	51	43.6%	\$2,268,503	\$48,266

School	Number of recipients	Percent	Total awarded*	Average award
Western University (DO program)‡	-‡	-‡	-‡	-‡
Frontier Nursing University (NP program)†	-†	-†	-†	-†
Total	117		\$6,021,665	\$55,245

Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

***Dollar amounts include awards associated with any recipient participating in PCLF from 2018-2026, including 27 recipients who were awarded prior to 2018 and completed their service obligation in this time period. Thus, the total amount awarded in this table exceeds the 2019-2026 total in the ORH summary below (\$4,945,100).**

†Estimates suppressed due to small numbers; statistically unreliable.

‡Estimates suppressed to prevent backward calculation of other suppressed estimates.

Evaluation of Program Effectiveness

Contribution to Direct Patient Care

Weekly hours were available from two sources that differ in coverage and measurement. Estimates are presented separately.

Using HWRP data (n = 60 recipients with data), PCLF recipients reported an average of 34.0 hours (SD 9.5) of direct patient care per week across primary and secondary practice locations (Table 35). Averages were similar for physicians, PAs, and NPs (no statistically significant difference in reported average weekly patient care hours by provider type).

Table 35. Average total weekly hours spent on direct patient care (at primary and secondary practice locations) by PCLF recipients, overall and by provider type

Provider type	Number of recipients	Average	Standard deviation
All PCLF recipients with data	60	34.0	9.5
Physicians (MDs/DOs)	17	35.2	12.0
Physician associates	30	34.1	6.2
Nurse practitioners*	7*	34.9*	9.5*
Pharmacists†	-†	-†	-†
Dentists†	-†	-†	-†

Data Source: HWRP database on PCLF recipients, 2026. Data is from current year (2026)

HWRP database providing responses for PCLF recipients from 2018-2026. 72 recipient records were linked to HWRP provider characteristics; 12 additional records were missing weekly-hours data.

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

†Estimates suppressed due to small numbers; statistically unreliable.

Using PRISM end-of-contract survey data (n = 20 respondents; 76.9 percent response rate), recipients reported an average of 37.5 weekly clinical hours (SD

Rural health clinics were the most common practice setting (12 of 20 respondents; 60.0 percent), with an average of 37.3 clinical hours (SD 5.2). Estimates for all other settings are suppressed due to small numbers. PRISM measures weekly clinical hours, rather than direct patient care hours.

Telehealth data for PCLF recipients are limited. Telehealth questions were not available in HWRP data for physician and PA recipients (52 of the 72 linked records), and 8 additional records were missing telehealth variables, leaving 12 recipients with telehealth data (10.3 percent of 117). Estimates are therefore not reported here due to small numbers. Variation in telemedicine use by rural versus urban location also cannot be assessed.

Among the 72 current PCLF participants surveyed, five responded, for a response rate of 6.9 percent. Given the small number of responses, findings should be interpreted as illustrative rather than representative. Four respondents reported reduced financial stress, and three reported that the program influenced their decision to practice in a rural or underserved area. One respondent described the award as an enabler for a rural-practice

Another respondent, however, stated that state-level awards cannot offset the scale of medical education debt, particularly given uncertainty about federal Public Service Loan Forgiveness. "I don't think a reform and a fundamental redesign of medical education will make a difference."

Participant assessment of the program. Four of the five respondents reported that the application process and eligibility requirements were easy to understand, and all five reported that service requirements were clear and

manageable. The most commonly requested program change was an increase in the award amount (four of five respondents), followed by expanded eligibility to additional practice settings (three of five). In qualitative responses, one respondent requested that the award amount be re-scaled to current tuition and cost of living and proposed an optional larger award tied to a longer commitment, including post-graduation support.

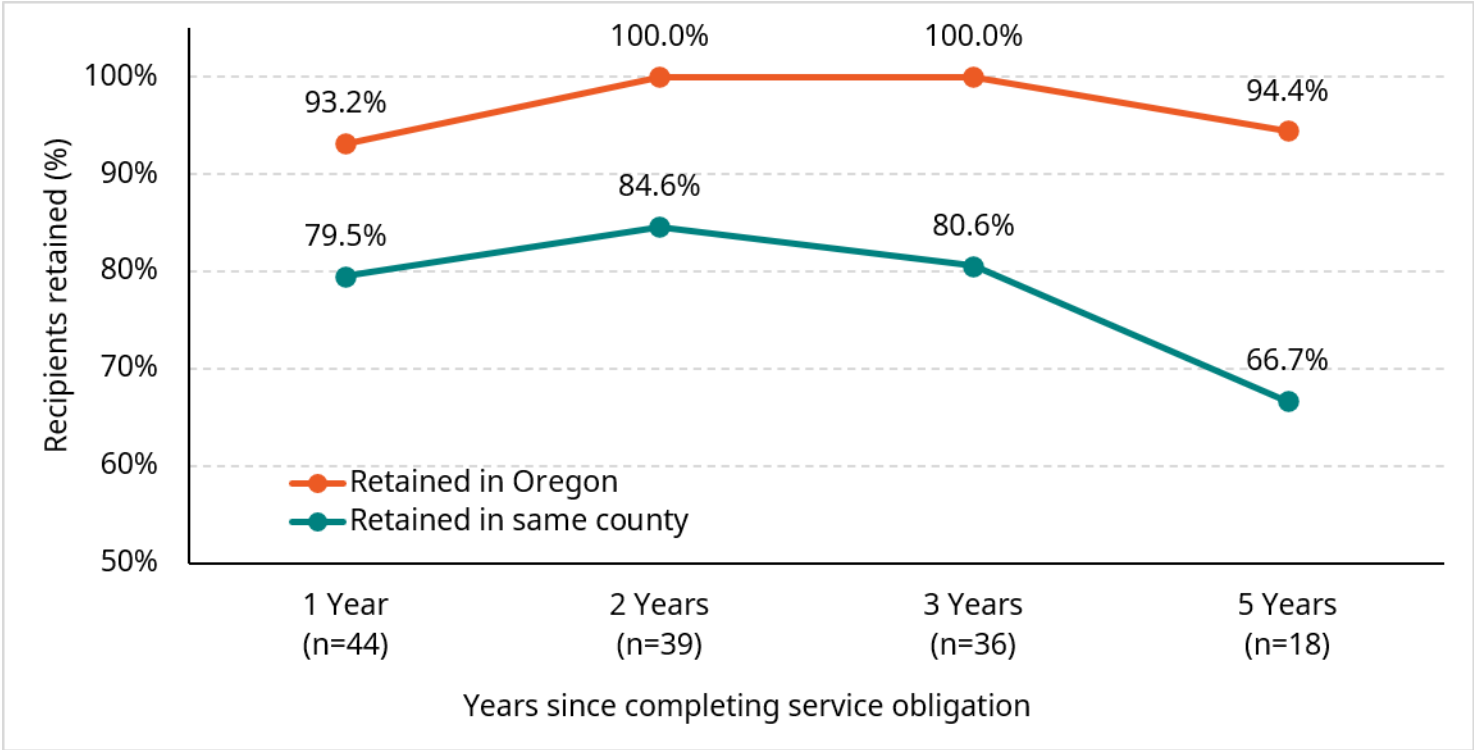
Respondents most commonly learned about the program through schools or training programs and the AHEC Scholars Program. They suggested continuing to work with educational institutions and related organizations, including rural tracks, AHEC programs, and other national and state specialty organizations, as the primary channel for increasing awareness about the program.

Post-Service Retention

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 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.

PCLF recipients' retention within Oregon remained high at each time period (93.2 percent at one year, 100 percent at two and three years, and 94.4 percent at 5 years). Retention in the same county was 79.5 percent at one year, 84.6 percent at two years, 80.6 percent at three years, and 66.7 percent at five years (Figure 16).

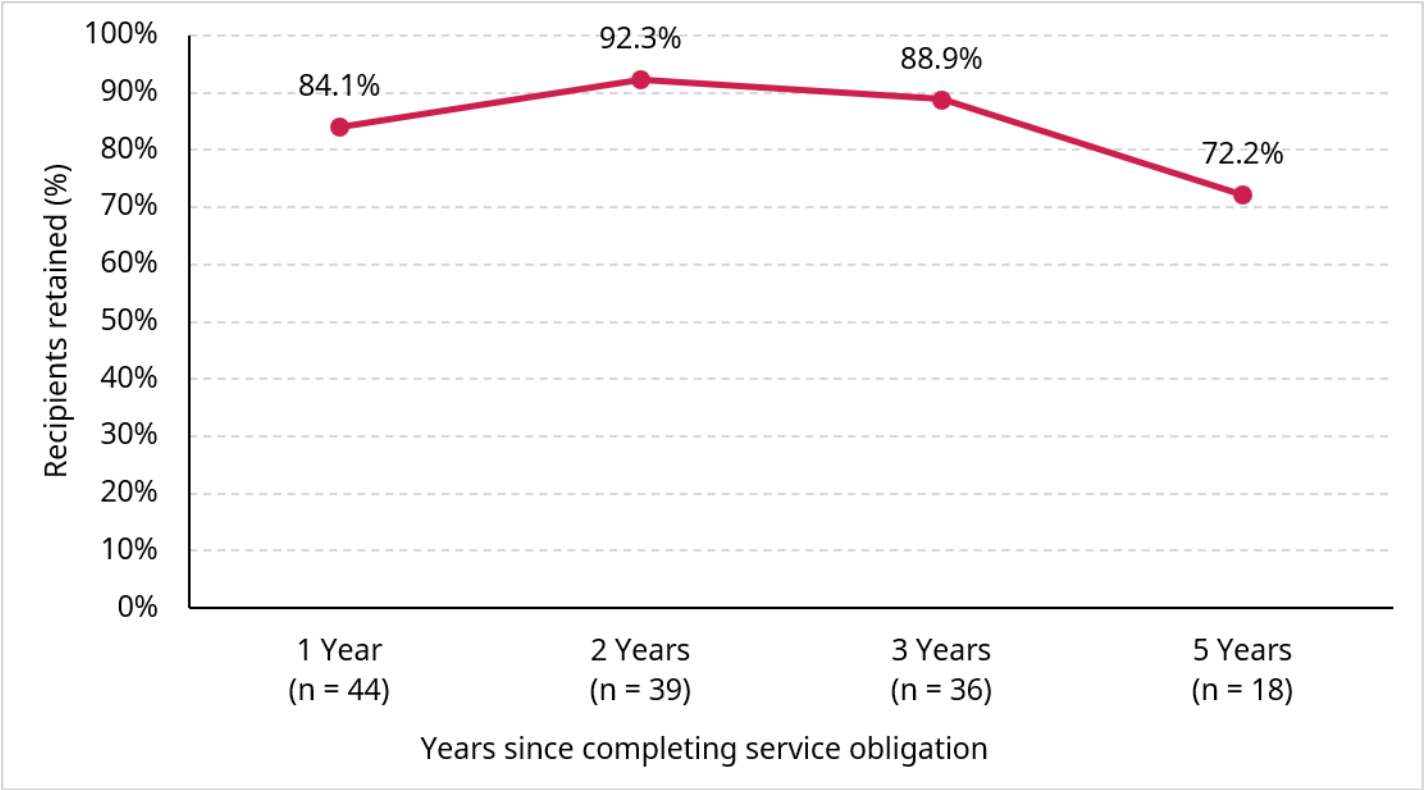
Figure 16. Retention of PCLF recipients in Oregon and the same county at one, two, three, and five years after service obligation completion



Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: HWRP database on PCLF recipients’ licensure-associated practice locations, 2016-2026. Denominators differ by interval (n = 44, 39, 36, and 18) and may comprise different recipient cohorts. Includes only PCLF recipients from 2018-2026 who completed their service obligation by 2025.

Retention in rural practice following completion of service obligation was also examined because all PCLF recipients completed service obligation in rural practice (Figure 17). PCLF recipients remained in rural practice locations at high rates: 84.1 percent at one year (37 of 44 included), 92.3 percent at two years (36 of 39), 88.9 percent at three years (32 of 36), and 72.2 percent at five years (13 of 18).

Figure 17. Retention of PCLF recipients in rural areas of Oregon at one, two, three, and five years after service obligation completion



Abbreviation: PCLF – Primary Care Loan Forgiveness. **Data Source:** HWRP database on PCLF recipients’ licensure-associated practice locations, 2016-2026. **Denominators differ by interval (n = 44, 39, 36, and 18) and may comprise different recipient cohorts. Includes only PCLF recipients from 2018-2026 who completed their service obligation by 2025. Rural retention only shown because all PCLF recipients completed their service in a rural practice site.**

Self-reported intent to remain in practice from PCLF recipients in PRISM data are directionally consistent with HWRP retention results. End-of-contract survey respondents (n = 20 of 26 eligible; 76.9 percent response rate) reported anticipating remaining a mean of 10.0 additional years (SD 10.4) in their current practice, 13.8 years (SD 13.5) in their current community, 15.6 years (SD 11.7) in rural practice, 16.7 years (SD 10.9, one response missing) in a medically underserved area, and 19.5 years (SD 13.6) in Oregon. Among alumni survey respondents (n = 14 of 90; 15.6 percent response rate), 92.9 percent reported remaining in Oregon 12 months after contract completion (Table 36). Because PRISM estimates are derived from a small sample of respondents, estimates may be statistically unreliable and should be interpreted with caution.

Table 36. Percent of PCLF recipients responding to PRISM alumni survey (n = 14) who reported remaining in each setting after contract completion*

Setting	12 months	36 months
Current service site	57.1%	58.3%

Setting	12 months	36 months
Same organization	71.4%	75.0%
Oregon	92.9%	83.3%
HPSA	42.9%	41.7%
HPSA or state-designated shortage area	50.0%	50.0%
HPSA, state-designated shortage area, or safety-net organization	71.4%	66.7%

Abbreviations: PCLF – Primary Care Loan Forgiveness; HPSA – Health Professional Shortage Area. **Data Source:** PRISM alumni survey for reporting period 04/01/2018 - 03/31/2026.

***Estimates in this table may be statistically unreliable due to small numbers and potential response bias (n = 14 respondents; 15.6% response rate); interpret with caution.**

To examine retention by recipient characteristics, only self-reported data from PRISM is available, and most subgroups are too small to report. Among end-of-contract survey respondents, physicians (n = 6) anticipated remaining a mean of 13.0 years (SD 10.9) in their current practice and 27.0 years (SD 11.9) in Oregon. PAs (n = 11) anticipated 6.9 years (SD 9.3) in their current practice and 14.3 years (SD 14.4) in Oregon. NP estimates are suppressed. Estimates for physicians and PAs may be statistically unreliable due to small numbers (interpret with caution).

To examine retention by race/ethnicity, estimates are reportable only for white respondents (n = 18), who anticipated remaining a mean of 10.8 years (SD 10.6) in their current practice and 21.1 years (SD 13.4) in Oregon. All other race/ethnicity groups had none (American Indian or Alaska Native, Asian, Black or African American, Middle Eastern or North African, Native Hawaiian or Pacific Islander) or fewer than five respondents (Hispanic or Latino/a/x/e).

Evaluation of Program Implementation

Among Oregon’s 128 Service Areas, 32 (25.0 percent) had at least one PCLF recipient completing (or in) their service obligation, while 96 Service Areas did not.

The PCLF participant data included a summary table describing the number of applicants, number of recipients awarded, and total dollars awarded from 2019 to 2026. From this summary table, PCLF made 90 awards from 2019 through 2026. These awards were made under OHA administration and exclude 27 recipients awarded before April 1, 2018, who are included in the 117 recipients described above. Annual recipient counts ranged from six (2021) to 17 (2025), and annual dollars awarded ranged from \$339,800 (2021) to \$978,500 (2025), with a decrease in both recipients and dollars awarded in 2021 (Table 37). Total dollars awarded for 2019-2026 were \$4,945,100 and the average award (computed as annual dollars divided by annual recipients) ranged from \$49,821 (2020) to \$58,333 (2019), with an overall average of \$54,946.

Evaluation of Program Sustainability (Maintenance)

Applications and awards fluctuated year-to-year without a consistent trajectory due to unpredictable applicant numbers (Table 37). Total PCLF applicants ranged from 7 (2021) to 24 (2025), and recipients from 6 (2021) to 17 (2025). Across all program years, 90 of 129 applicants (69.8 percent) received awards. In complete years (2019-2025), the annual percent awarded ranged from 57.1 percent (2022) to 85.7 percent (2019 and 2021). In the first half of 2026, 9 of 18 applicants (50.0 percent) received awards. Annual dollars awarded ranged from \$339,800 (2021) to \$978,500 (2025). The two most recent complete years (2024-2025) had the highest applicant counts (22 and 24) and the largest dollar totals (\$764,700 and \$978,500). Funding for PCLF is subject to biennial appropriation to HCPIF.

Table 37. PCLF applications, awards, and dollars awarded by award year, 2019-2026

Year	Total applicants	Recipients	Percent of applicants awarded	Total dollars awarded	Average award
2019	14	12	85.7%	\$700,000	\$58,333
2020	18	14	77.8%	\$697,500	\$49,821
2021	7	6	85.7%	\$339,800	\$56,633
2022	14	8	57.1%	\$434,500	\$54,313
2023	12	10	83.3%	\$566,900	\$56,690
2024	22	14	63.6%	\$764,700	\$54,621
2025	24	17	70.8%	\$978,500	\$57,559
2026	18	9	50.0%	\$463,200	\$51,467
Total	129	90	69.8%	\$4,945,100	\$54,946

Abbreviation: PCLF – Primary Care Loan Forgiveness. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026. Counts are from an ORH summary of PCLF applications and awards made under OHA administration, beginning with the first OHA award cycle in 2019 (n = 90 awards). The 117 PCLF recipients reported elsewhere in this section also include 27 recipients who were awarded before OHA assumed administration of the program on April 1, 2018, and who had an active contract on or after that date. Applicant data are not available for these earlier awards. Average award computed as total dollars awarded divided by recipients for each year. ORH reporting period ends 06/30/2026, so 2026 row reflects a partial year.

Scholarship Programs

Background

Scholarship programs provide funding to students pursuing future health care careers that can be used towards tuition, fees, and/or stipends.

The following two scholarship programs were evaluated in this report:

- Scholars for a Healthy Oregon Initiative at OHSU
- Health Care Workforce Scholarships

Other scholarships administered by BHWI, including the Behavioral Health Scholarship programs, the Graduate Tuition Assistance and Stipends, and the Community Mental Health Program (CMHP) Grants are described further in Appendix A.

Scholars for a Healthy Oregon Initiative (SHOI) at OHSU

SHOI was established in 2013 under ORS 348.303, provides students in specific clinical degree programs at Oregon Health & Science University (OHSU) a scholarship covering the entire cost of tuition and fees, in exchange for a service obligation of one year longer than the number of years of funding received. SHOI was created by a separate statute prior to the establishment of HCPIF and was incorporated into the Fund's biennial allocation through House Bill 3261 (2017). HCPIF provides passthrough funding to OHSU for administration of this incentive. OHSU adopted the program's administrative policies and procedures and selects recipients. ORH approves the practice sites where recipients complete their service obligation.

Eligible students are Oregon residents or Oregon Heritage students who have been admitted to OHSU, but have not yet begun, an eligible program: Doctor of Medicine (MD), Doctor of Dental Medicine (DMD), Master of Physician Associate Studies (MPAS), and the adult gerontology acute care, family, nurse anesthesia, nurse-midwifery, pediatric, and psychiatric mental health nurse practitioner Doctor of Nursing Practice (DNP) tracks. Priority consideration is given to students who live in or graduated from a high school in an underserved Oregon community, students who attended Eastern Oregon University, Oregon Institute of Technology, Southern Oregon University, or Western Oregon University, first-generation college students, and students from diverse or underrepresented communities.

Recipients must practice at an ORH-approved site in a rural or urban underserved community immediately upon completing their degree, residency, or training, and must see all patients regardless of ability to pay. Approved sites include FQHCs, critical access hospitals, certified rural health clinics, Tribal Clinics, community mental health clinics, and other facilities serving medically underserved populations. A recipient who does not complete the service obligation must repay the amount received, plus a 25 percent penalty, reduced *pro rata* for each full year of service completed.

Data for the evaluation of this incentive program were provided by ORH and OHSU.

Key Takeaways

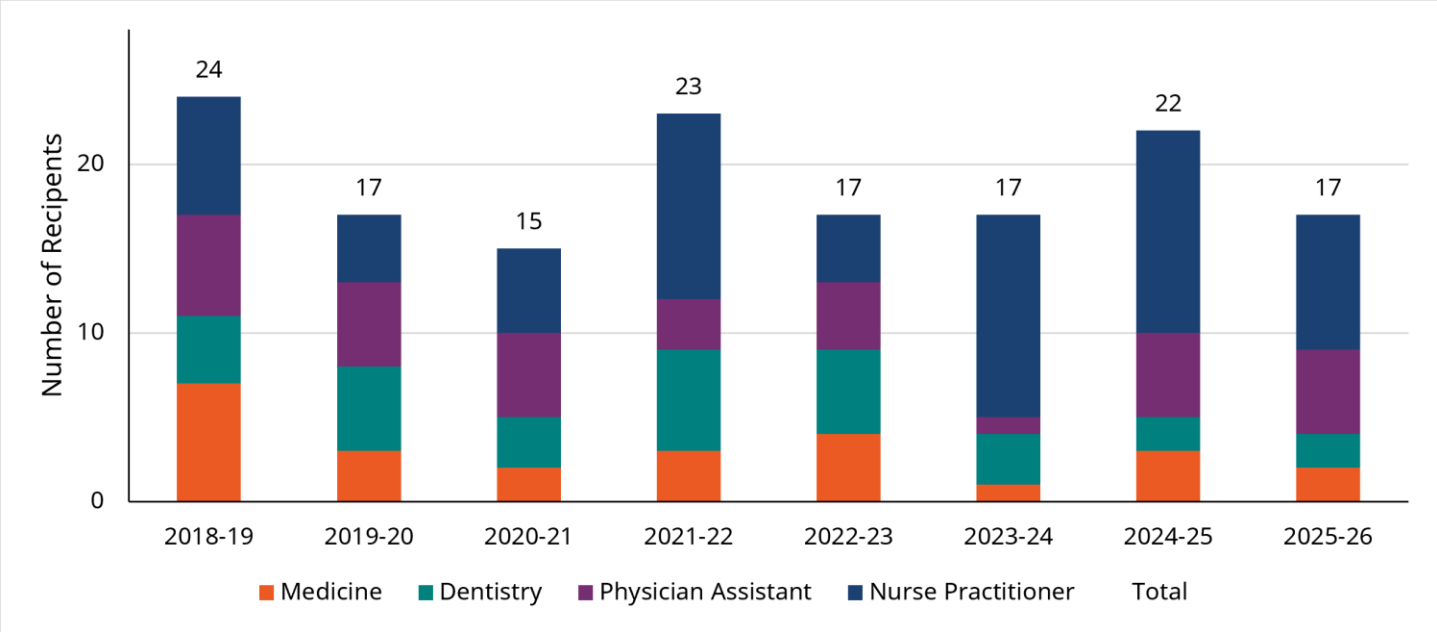
- SHOI provided scholarships to 152 OHSU students between 2018-19 and 2025-2026 (\$21.1 million). The nurse practitioner share of each cohort rose from 29.2 percent to 47.1 percent, while the medical student share fell from 29.2 percent to 11.8 percent.
- More than half of recipients with a known place of origin came from a rural community (54.0 percent), and 83.5 percent of recipients in service (from all cohorts since 2014-15) practiced family medicine or general practice.
- All SHOI recipients (100 percent) were practicing in Oregon one year after their service obligation, and 70.6 percent were practicing in Oregon after five years.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

SHOI made 152 awards between 2018-2019 and 2025-2026 academic years (Table 38), comprising 25 MD, 30 DMD, 34 MPAS, and 63 NP recipients. Annual cohorts ranged from 15 to 24 recipients. Cohort composition shifted over the period, with NP and MPAS recipients accounting for a larger portion of later cohorts (Figure 18). The NP proportion of the cohort rose from 29.2 percent in 2018-2019 to 47.1 percent in 2025-2026, a relative increase of 61.3 percent, and the MPAS proportion rose from 25.0 percent to 29.4 percent, a relative increase of 17.6 percent. Over the same period, the MD proportion fell from 29.2 percent to 11.8 percent, and the DMD proportion fell from 16.7 percent to 11.8 percent, relative decreases of 59.6 percent and 29.3 percent. Year-to-year proportion varied within these endpoints. The NP proportion peaked at 70.6 percent in 2023-2024, and the DMD proportion reached 29.4 percent in both 2019-2020 and 2022-2023 (Table 38).

Figure 18. SHOI award recipients* by professional degree and award year, 2018-2019 to 2025-2026 academic years



Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. **Data Source:** Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019–2025/2026 academic years. Counts are reported as provided by OHSU and were not suppressed.

***Total award recipients include students who have been dismissed, withdrew from the academic program, or breached their service commitment.**

Table 38. Distribution of SHOI award recipients by professional degree, 2018-2019 to 2025-2026 academic years

Award Year	Medicine (n)	Cohort percent	Dentistry (n)	Cohort percent	PA (n)	Cohort percent	NP(n)	Cohort percent
2018-2019	7	29.2%	4	16.7%	6	25.0%	7	29.2%
2019-2020	3	17.6%	5	29.4%	5	29.4%	4	23.5%
2020-2021	2	13.3%	3	20.0%	5	33.3%	5	33.3%
2021-2022	3	13.0%	6	26.1%	3	13.0%	11	47.8%
2022-2023	4	23.5%	5	29.4%	4	23.5%	4	23.5%
2023-2024	1	5.9%	3	17.6%	1	5.9%	12	70.6%
2024-2025	3	13.6%	2	9.1%	5	22.7%	12	54.5%
2025-2026	2	11.8%	2	11.8%	5	29.4%	8	47.1%
Total*	25		30		34		63	
Mean annual cohort percent	-	16.0%	-	20.0%	-	22.8%	-	41.2%

Award Year	Medicine (n)	Cohort percent	Dentistry (n)	Cohort percent	PA (n)	Cohort percent	NP(n)	Cohort percent
Percent change, 2018-19 to 2025-26	-	-59.6%	-	-29.3%	-	+17.6%	-	+61.3%

Abbreviations: SHOI – Scholars for a Healthy Oregon Initiative; PA – physician associate; NP – nurse practitioner. **Data Source:** Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019–2025/2026 academic years. Counts are reported as provided by OHSU in pre-aggregated program reporting and were not suppressed. Counts below five in some award years should be interpreted with caution. ***Total award recipients include all SHOI recipients who have been awarded from academic years 2018-2019 to 2025-2026 including those who have been dismissed, withdrew from the academic program, or breached their service commitment.**

Specialty is collected from recipients after they begin their service commitment. Specialty was reported for 139 SHOI recipients who graduated and entered or completed their service obligation as of April 6, 2026. These 139 recipients were drawn from all 229 awards made since the program’s first cohort in 2014-2015, a distinct group from the 152 awards made from 2018-19 onward (described in Figure 18 and Table 38). Recipients from earlier cohorts are included because service commitment specialty is observable only after graduation, and recipients from more recent cohorts remain in training.

Family medicine or general practice specialties accounted for 116 recipients (83.5 percent) who are in service obligation or completed service obligation as of April 6, 2026. All 25 MD recipients and all 26 DMD recipients were placed in family medicine or general practice, as were 35 of 40 MPAS recipients (87.5 percent) and 30 of 48 NP recipients (62.5 percent). The remaining 23 recipients were distributed across 11 specialties, including anesthesiology, midwifery, obstetrics and gynecology, psychiatric mental health, and substance use disorder. Detailed counts by specialty are not reported because each cell contained fewer than five recipients. Because specialty data are reported only for recipients in service, the data exclude MD recipients completing residency requirements, recipients within the 90-day grace period for placement, and recipients on approved leave from their service site. Because the interval between award and service entry varies by program length, disciplines with longer training are underrepresented among recipients currently in service. The 25 MD recipients are largely recipients from cohorts preceding 2018-19.

Locations of Service

Service location is reported for the same 139 SHOI recipients in service as of April 6, 2026 (from those awarded from 2014-2015 to 2025-2026 academic years and not a subset of recipients from Table 38). Recipients were placed at sites in 44 distinct Oregon communities. Portland accounted for 24 recipients (17.3 percent) and Roseburg for 12 (8.6 percent). No other community accounted for more than 10. Thirty-five communities had fewer than five recipients each, together accounting for 56 recipients (40.3 percent).

Evaluation of Program Adoption

Organizational Participation

Funds are received and distributed by a single organization, OHSU.

Demographic Characteristics of Recipients

REALD SOGI data collection for SHOI began in 2026. REALD SOGI data reporting is anticipated for the next evaluation.

Sex, race, and ethnicity were reported for all 152 SHOI recipients from 2018-19 through 2025-2026 (Table 39). Ninety-seven recipients (63.8 percent) were female and 52 (34.2 percent) were male. Fewer than five recipients declined to respond or reported a category not listed. Thirty-six recipients (23.7 percent) identified as Hispanic or Latino/a/x/e and 115 (75.7 percent) as not Hispanic or Latino/a/x/e (Table 41). Ninety-nine recipients (65.1 percent) identified as white, 15 (9.9 percent) as another race, 12 (7.9 percent) as more than one race, and seven (4.6 percent) as Black or African American; 12 recipients (7.9 percent) did not report race (Table 40). Among the 140 recipients who reported race, 41 (29.3 percent) identified with a race other than white alone. Counts for American Indian or Alaska Native and Asian categories are not reported because there were fewer than five recipients, and there were no Native Hawaiian or Pacific Islander recipients. Annual counts by sex, ethnicity, and race are not reported because most annual cells contained fewer than five recipients.

Table 39. Sex of SHOI recipients, 2018-2019 to 2025-2026 academic years (N = 152)

Gender	Number	Percent
Female	97	63.8%
Male	52	34.2%
No Response†	-†	-†
Not listed†	-†	-†

Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. **Data Source:** Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019 – 2025/2026 academic years. Demographic data is voluntarily provided by recipients.
†Estimates suppressed due to small numbers; statistically unreliable.

Table 40. Race of SHOI recipients, 2018-2019 to 2025-2026 academic years (N = 152)

Race	Number	Percent
White‡	99	65.1%
Multiracial	12	7.9%
Black or African American*	7*	4.6%*
Native Hawaiian and Pacific Islander	0	0.0%
American Indian or Alaska Native†	-†	-†
Asian†	-†	-†
Another race	15	9.9%
No response	12	7.9%

Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. **Data Source:** Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019 – 2025/2026 academic years. Demographic data is voluntarily provided by recipients.
*Estimates may be statistically unreliable due to small numbers; interpret with caution.
†Estimates suppressed due to small numbers; statistically unreliable.
‡White includes Middle Eastern and Eastern European.

Table 41. Ethnicity of SHOI recipients, 2018-2019 to 2025-2026 academic years (N = 152)

Ethnicity	Number	Percent
Not Hispanic or Latino/a/x/e	115	75.7%
Hispanic or Latino/a/x/e	36	23.7%
No Response†	-†	-†

Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. **Data Source:** Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019 – 2025/2026 academic years. Demographic data is voluntarily provided by recipients.
†Estimates suppressed due to small numbers; statistically unreliable.

Place of origin was available for 126 SHOI recipients (82.9 percent of 152 SHOI recipients). SHOI recipients originated from 94 distinct Oregon communities representing 124 distinct ZIP codes, including metropolitan communities in the Portland region and Willamette Valley, as well as rural and frontier communities in eastern, central, and southern Oregon and along the coast. ORS 348.303 directs OHSU to give preference to SHOI applicants of rural heritage. Over half of SHOI recipients had a rural place of origin (54.0 percent), including eight recipients who had a remote place of origin.

Table 42. Rural-Urban designation of SHOI recipients' place of origin, 2018-2019 to 2025-2026 academic years (N = 126).

Designation†	Number	Percent
Urban	58	46.0%

Designation†	Number	Percent
Rural (including remote)	68	54.0%
Remote*	8*	6.3%*

Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. Data Source: Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019 – 2025/2026 academic years.

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

†Designation classified based on the reported ZIP code of each recipients’ reported place of origin.

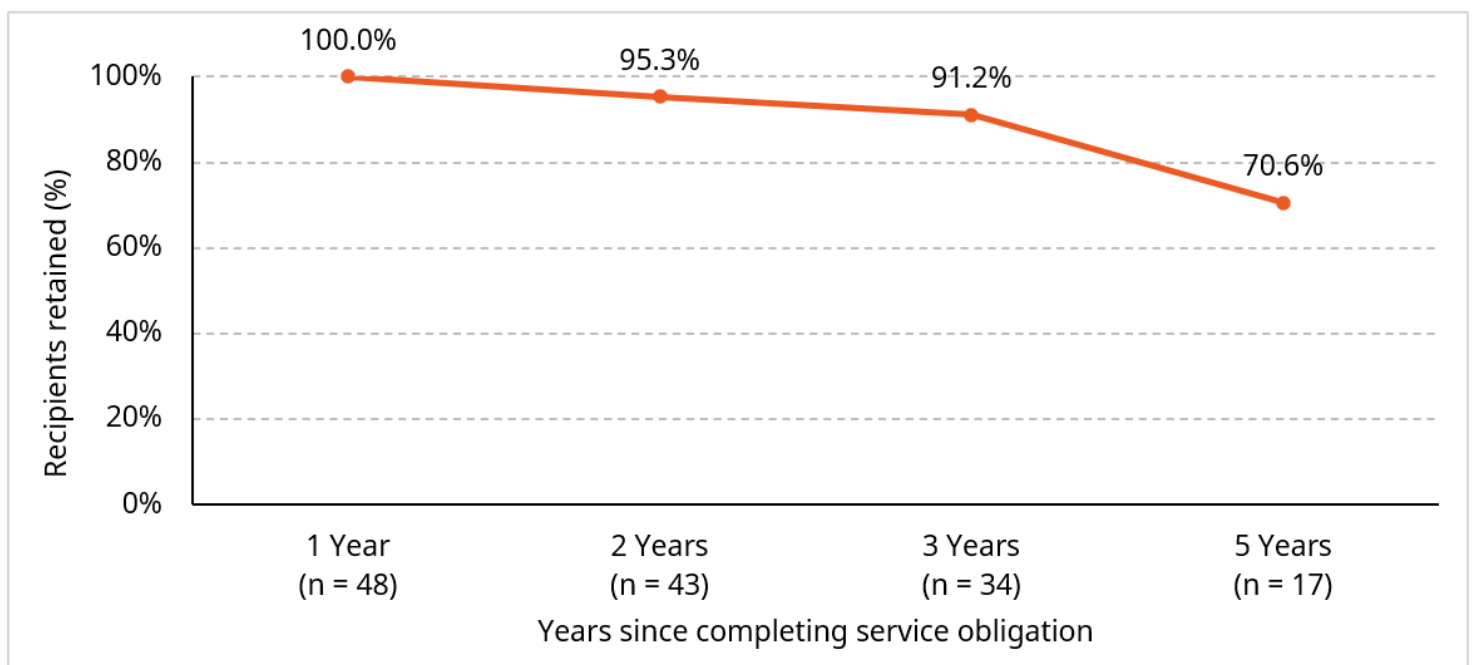
Evaluation of Program Effectiveness

Post-Service Retention

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 within Oregon was high at each observed time point: 100.0 percent at one year, 95.3 percent at two years, 91.2 percent at three years, and a decrease to 70.6 percent at five years (Figure 19).

Figure 19. Retention of SHOI recipients in Oregon at one, two, three, and five years after service obligation completion



Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. Data Source: HWRP 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 SHOI recipients from all cohorts since 2014-15 who completed their service obligation by 2025.

Evaluation of Program Implementation

SHOI disbursed \$21,123,146 across the 2018-2019 through 2025-2026 academic years, averaging \$2,640,393 annually (Table 43). Annual disbursements ranged from \$1,782,801 in 2020-2021 to \$3,325,890 in 2021-2022 and did not follow a consistent direction over the period. Total disbursement in 2025-2026 was 18.3 percent below the 2018-19 level in nominal terms. The distribution of dollars awarded across degree programs was not proportional. For example, dentistry accounted for \$7,244,690 (34.3 percent) of total disbursements, but 19.7 percent of awards made during the period, while nurse practitioner programs accounted for \$5,241,445 (24.8 percent) of disbursements but 41.4 percent of awards. These differences are consistent with variation in tuition costs and program length across degrees. Disbursements to NP programs rose from \$311,274 in 2018-19 to \$860,775 in 2025-2026, and from 10.2 percent to 34.4 percent of annual disbursement, consistent with the increasing percentage of nurse practitioner recipients as documented in Table 38. Disbursements to medicine declined from \$1,300,776 (42.5 percent) to \$463,808 (18.5 percent) over the same period. Because SHOI funds each scholar for the duration of their program, annual disbursements reflect payments to all enrolled scholars rather than to that year's recipients, and disbursement totals are not comparable to annual award counts.

Table 43. Total amount awarded by professional degree and award year, 2018-2019 to 2025-2026 academic years

Award Year*	Medicine	Dentistry	Physician Associate	Nurse Practitioner	Total
2018-2019	\$1,300,776	\$826,808	\$625,278	\$311,274	\$3,064,136
2019-2020	\$576,519	\$1,179,323	\$532,890	\$281,201	\$2,569,933
2020-2021	\$211,182	\$724,554	\$545,435	\$301,630	\$1,782,801
2021-2022	\$609,311	\$1,512,648	\$324,489	\$879,442	\$3,325,890
2022-2023	\$834,225	\$1,296,106	\$442,928	\$266,877	\$2,840,136
2023-2024	\$227,078	\$578,430	\$117,990	\$1,243,621	\$2,167,119
2024-2025	\$670,361	\$547,063	\$554,336	\$1,096,625	\$2,868,385
2025-2026	\$463,808	\$579,758	\$600,405	\$860,775	\$2,504,746
Total	\$4,893,260	\$7,244,690	\$3,743,751	\$5,241,445	\$21,123,146

Abbreviation: SHOI – Scholars for a Healthy Oregon Initiative. **Data Source:** Grantee reporting data in the form of pre-aggregated tables from OHSU reporting for the 2018/2019 – 2025/2026 academic years.

***In SHOI, students are awarded at a single point in time, and funds are dispersed over academic year(s). Data in this table represents the academic year when total *anticipated* funding was awarded to student recipients, not when funds were received. Data includes actual expenditures to date and estimated future expenditures through 2027-28. Data**

includes disbursements for students who breached their service agreement and have not paid back the SHOI fund. Values reported in U.S. dollars.

Evaluation of Program Sustainability (Maintenance)

SHOI operates under ORS 348.303 with ongoing passthrough funding from HCPIP and is not supported by one-time or time-limited appropriations. Awards were made in each year of the reporting period, including 2025-2026. SHOI is therefore anticipated to continue beyond 2026, subject to biennial appropriation to the Health Care Provider Incentive Fund.

Annual cohorts ranged from 15 to 24 recipients across the eight award years, averaging 19. Cohort size varied over time, as did annual disbursements. Cohort composition shifted over the period, with NP recipients accounting for an increasing percentage of awards and MD recipients a decreasing percentage.

Health Care Workforce Scholarships

The Health Care Workforce Scholarship, formerly known as the Scholars for a Healthy Oregon Initiative-Like (SHOI-Like) Scholarship, provides funding to health professional training programs at institutions of higher education to award scholarships to students. Institutions that receive funding work in partnership with OHA to develop an application and distribution process for awarding scholarships to their students. This evaluation includes data on scholarship recipients from the 2019-2021, 2021-2023, and 2023-2025 biennia.

In the 2019-2021 biennium, students were selected from three graduate health education programs, who were awarded through a competitive solicitation process. In the 2019-2021 biennium, all students who were awarded scholarships were required to complete a service obligation. During the 2021-2023 and 2023-2025 biennia, the program expanded to include a broader range of health care training programs and educational organizations. In the 2021-2023 and 2023-2025 biennia, only students who received more than \$35,000 were required to complete a service obligation. Table 45 below includes the educational programs funded during each biennium.

Key Takeaways

- The number of students supported through the Health Care Workforce Scholarship Program grew from 14 (2019-2021) to 201 (2023-2025), while total funding fell from \$1,345,711 to \$687,950.
- The average award fell from \$9,919 (2021-2023) to \$3,474 (2023-2025) as the program expanded to more institutions.

- Thirty-eight percent of recipients identified a primary race or ethnicity other than white, and 26.9 percent spoke a language other than English at home. Educational and workforce outcomes are not yet tracked.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

Across the three biennia, the Health Care Workforce Scholarship Program provided funding to 371 students pursuing health care degrees, including 14 students in the 2019-2021 biennium, 156 in the 2021-2023 biennium, and 201 students in the 2023-2025 biennium. Across these three funding periods, 32.3 percent of students were pursuing nursing (certified nursing, licensed practical and registered nursing, nurse practitioners), 31.0 percent were pursuing dental care (dental assisting and hygiene), and 14.0 percent were pursuing behavioral health degrees (associates and master's level, Table 44). Less than 10 percent were pursuing medical degrees (7.8 percent including DO, ND, and PA degrees), medical assisting/technical degrees (9.4 percent), and other degree programs (5.4 percent).

Table 44. Number and percent of Health Care Workforce Scholarship recipients by prospective degree, 2019-2025

Prospective Degree Category	Prospective Degree	Number of recipients	Percent of Recipients
Medical	Physicians - DO & ND	15	4.0%
Medical	Physician Associate	14	3.8%
Nursing	Nursing (RN or LPN)	100	27.0%
Nursing	CNA	14	3.8%
Nursing	Nurse Practitioners*	6	1.6%
Behavioral Health	Master's degree	28	7.5%
Behavioral Health	Associate's degree	24	6.5%
Dental Care	Dental Assisting	95	25.6%
Dental Care	Dental Hygiene	20	5.4%
Medical Assisting/ Technical Degrees	All Medical Assisting/Technical Degrees†	35	9.4%
Other	All Other Degrees‡	20	5.4%
All Categories (Total Recipients)	All Prospective Degrees (Total Recipients)	371	-

Abbreviations: DO – Doctor of Osteopathic Medicine; ND –Doctor of Naturopathic Medicine; RN – registered nurse; LPN – licensed practical nurse; CNA – certified nursing assistant. **Data Source:** Grantee data reporting for reporting period 01/01/2019-12/31/2025.

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

†Medical assisting/technical degree programs include medical assisting, EMT/paramedicine, pharmacy technician, and phlebotomy.

‡ Other degree programs include speech-language pathology, public health, physical health, and health care administration.

Duration of Service

All recipients in the 2019-2021 biennium and recipients in later biennia who were awarded a scholarship amount more than \$35,000 were required to complete a service obligation in a rural or underserved community upon graduation. There were 13 recipients in the 2019-2021 biennium who completed a service obligation (one recipient withdrew before completing their obligation), and 10 recipients in the 2021-2023 biennium completed a service obligation. Most recipients completed a two-year service obligation (64.2 percent, n = 15). Other recipients completed one or three years of service (exact numbers suppressed due to small numbers).

Evaluation of Program Adoption

Organizational Participation

The number of grantee organizations in the Health Care Workforce Scholarship program increased from the 2019-2021 to 2023-2025 biennium (Table 45). In its first biennium, the program awarded scholarships to students of three graduate-level educational programs directly. In 2021-2023, the program was changed to a grant-making program, and funds were awarded to education and training programs to award scholarships to their students. In the 2021-2023 biennium, the program awarded funding to six educational programs to administer scholarships, including three private universities, two community colleges, and one dental assistant training program. In 2023-2025, the program expanded to eight educational programs, including four community colleges, two public universities, and two nursing training programs.

Table 45. Educational institutions, number of recipients, and total dollar amounts awarded in the Health Care Workforce Scholarship by biennium, 2019-2025

Biennium	Educational institution	Number and types of educational programs supported	Number of recipients	Total amount awarded to recipients
2019-2021	All Educational Institutions in 2019-2021 Biennium	3 program types	14	\$1,345,711

Biennium	Educational institution	Number and types of educational programs supported	Number of recipients	Total amount awarded to recipients
2019-2021	COMP-Northwest*	Doctor of Osteopathy (DO)	5	\$588,000
2019-2021	National University of Natural Medicine†	Naturopathic Doctor (ND)	-†	\$382,711
2019-2023	Pacific University‡	Physician Associate (PA)	-‡	\$375,000
2021-2023	All Educational Institutions in 2021-2023 Biennium	8 program types	156	\$1,547,312
2021-2023	Umpqua Community College	Dental Assistant, Phlebotomy Certificate, Pharmacy Technician	58	\$184,383
2021-2023	Chemeketa Community College	Dental Assistant, Nursing (RN), Emergency Medical Technician, Speech Language Pathology	47	\$204,896
2021-2023	Capitol Dental	Dental Assistant	36	\$300,600
2021-2023	Pacific University*	Physician Associate (PA)	6	\$400,000
2021-2023	National University of Natural Medicine‡	Naturopathic Doctor (ND)	-‡	\$57,433
2021-2023	George Fox University†	Physician Associate (PA)	-†	\$400,000
2023-2025	All Educational Institutions in 2023-2025 Biennium	14 program types	201	\$687,950
2023-2025	Chemeketa Community College	Dental Assistant, Nursing (RN), Emergency Medical Technician, Speech Language Pathology, Behavioral Health (AS)	45	\$101,867
2023-2025	Umpqua Community College	Dental Assistant, Phlebotomy Certificate, Nursing (RN, LPN, CNA), Pharmacy Technician	35	\$115,374
2023-2025	Central Oregon Community College	Behavioral Health (AS), Nursing (RN, CNA), Dental Assistant, Medical Assistant, Public Health	34	\$124,459
2023-2025	Nurse Re-Entry	Nursing	32	\$100,000
2023-2025	Rogue Community College	Dental Hygiene	20	\$50,000
2023-2025	Southern Oregon University	Behavioral Health (MS)	16	\$100,000
2023-2025	Eastern Oregon University	Behavioral Health (MS)	12	\$26,250
2023-2025	Merrit Health and Wellness*	Nurse Practitioner (NP)	7*	\$70,000

Abbreviations: AS – associate’s degree; MS – master’s degree. **Data Source:** Grantee data reporting for reporting period 01/01/2019-12/31/2025.

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

†Estimate suppressed due to small numbers; statistically unreliable.

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

Demographic Characteristics of Recipients

The Health Care Workforce Scholarship program began collecting REALD SOGI data from recipients in the 2021-2023 biennium. Table 46 describes the primary race/ethnicity of scholarship recipients, with approximately 40 percent of recipients from 2021-2025 identifying as American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino/a/x/e, Multiracial, or Native Hawaiian or Pacific Islander.

Table 46. Health Care Workforce Scholarship recipients by primary race/ethnicity, 2021-2025

Primary race/ethnicity‡	Number of recipients	Percent of recipients
White	132	48.9%
Hispanic or Latino/a/x/e	49	18.1%
Multiracial	39	14.4%
Asian*	9*	3.3%*
Black or African American*	6*	2.2%*
American Indian or Alaska Native†	-†	-†
Native Hawaiian or Pacific Islander†	-†	-†
Another race†	-†	-†
Don’t Know/Don’t want to answer	32	11.9%

Data Source: Grantee data reporting for 2021-2023 and 2023-2025 biennium recipients only.

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

†Estimate suppressed due to small numbers; statistically unreliable.

‡Out of 371 Health Care Workforce Scholarship recipients from 2021-2025, 295 recipients provided REALD SOGI data (79.5%). 25 were missing responses on primary race/ethnicity. This table reports the race or ethnicity respondents said they primarily identify with. For this table, respondents are assigned to a single broad race or ethnic category based on their response.

About one-fourth of scholarship recipients (26.9 percent, n = 60) reported using a language other than English at home, most commonly Spanish (78.3 percent, n = 47). Other languages include Russian, Ukrainian, French, Somali, Vietnamese, Mien, Arabic, Bisaya, Tagalog, Urdu, and Punjabi.

Data on gender identity was only collected in 2023-2025. Most recipients in these years were women (85.4 percent). About 7 percent of recipients reported men, and about 6 percent reported all other gender identities, including non-

binary and genderqueer. Among 2021-2025 scholarship recipients, 7.5 percent (n = 22) reported having a disability.

The number and types of educational institutions represented among Health Care Workforce Scholarship recipients have expanded since the program's first biennium. By expanding the range of participating educational institutions, the program has also broadened the types of students supported, including those pursuing licensed and certified professions in medicine, nursing, behavioral health, dental care, and other technical and assistant occupations, including medical assistant, pharmacy technician, and emergency medical technician programs.

Evaluation of Program Effectiveness

Because scholarship recipients were still students, services provided in future practice (e.g., telemedicine utilization and direct patient care hours) and other program effectiveness outcomes could not be assessed.

Evaluation of Program Implementation

Table 45 (page 103) describes the number of awards and total amount of funding provided by grantee educational programs. From the 2019-2021 to the 2023-2025 biennium, the amount of funding awarded to all institutions decreased, while the number of educational institutions and students supported through scholarships increased. In the 2021-2023 biennium, the average amount awarded per recipient was \$9,919, while in the 2023-2025 biennium the average amount awarded per recipient was \$3,474.

Evaluation of Program Sustainability (Maintenance)

From the initial 2019-2021 biennium to the 2023-2025 biennium, the program has expanded to award funding to more educational institutions and a wider range of educational programs, supporting a greater spectrum of students seeking different pathways into the health care workforce. Because of this, the number of students provided scholarships has grown across the biennia from 14 in the 2019-2021 biennium to 201 in the 2023-2025 biennium. At the same time, the total amounts awarded across the biennia have decreased from \$1,345,711 in 2019-2021 to \$687,950 in the 2023-2025 biennium, largely by providing smaller awards to a greater number of students. The Health Care Workforce Scholarship program is expected to continue into the next biennium, subject to biennial appropriation to the Health Care Provider Incentive Fund.

Career Pathways and Training Initiatives

Background

Career pathways and training initiatives provides funding and partnerships to develop programs and support services aimed at helping students and practicing professionals, particularly those from underrepresented backgrounds, to enter, advance and remain in health care careers. These programs can focus on supporting recipients and/or participants across various education levels, from K-12 to career and technical education to community college and undergraduate to post-graduate and professional education.

The following two such programs were evaluated in this report:

- Health Care Workforce Pathways
- Healthy Oregon Workforce Training Opportunity (HOWTO) Program

The Health Care Workforce Pathways program is administered under HCPIP, while the HOWTO program is administered by OHPB in partnership with OHA and OHSU. Another training initiative administered by BHWI, the Peer Support Services program, is described further in Appendix A.

Health Care Workforce Pathways Program

The Health Care Workforce Pathways Program (also referred to as Health Care Workforce Pathways Scholarships) is administered under HCPIP. The program provides funding to organizations to administer a secondary school scholarship program aimed at increasing diversity and representation in the physical health, oral health, and behavioral health workforce. Health Care Workforce Pathways Scholarships are awarded to organizations serving students in grades 8 through 12 and graduating seniors to participate in a secondary education, Career and Technical Education (CTE), mentorship, health career exploration camps, or other health care-related pathway program. The first grant cycle for this program began March 1, 2025, and is ongoing. Data available for this evaluation comprises grantee data reporting to HCPIP from June 30, 2025, to December 31, 2025.

Key Takeaways

- In its first cycle (June to December 2025), six organizations awarded \$551,496 to 468 students in grades 8 through 12, an average of \$1,178 per student. Three in four recipients were served by rural (34.4 percent) or mixed rural and urban (41.0 percent) programs.
- One in four respondents identified as Hispanic or Latino/a/x/e (25.7 percent), and one in four reported a disability (25.6 percent).

Evaluation of Program Reach

Recipients and Grantee Organizations

In total, 468 students received scholarships through the Health Care Workforce Pathways Program, totaling \$551,496 (average scholarship award per student recipient was \$1,178; standard deviation \$1,001). A total of six organizations received funding through the program (Table 47).

Table 47. Distribution of recipients, amount awarded, and average amount awarded per recipient across organizations participating in the Health Care Workforce Pathways Program, June 30, 2025-December 31, 2025

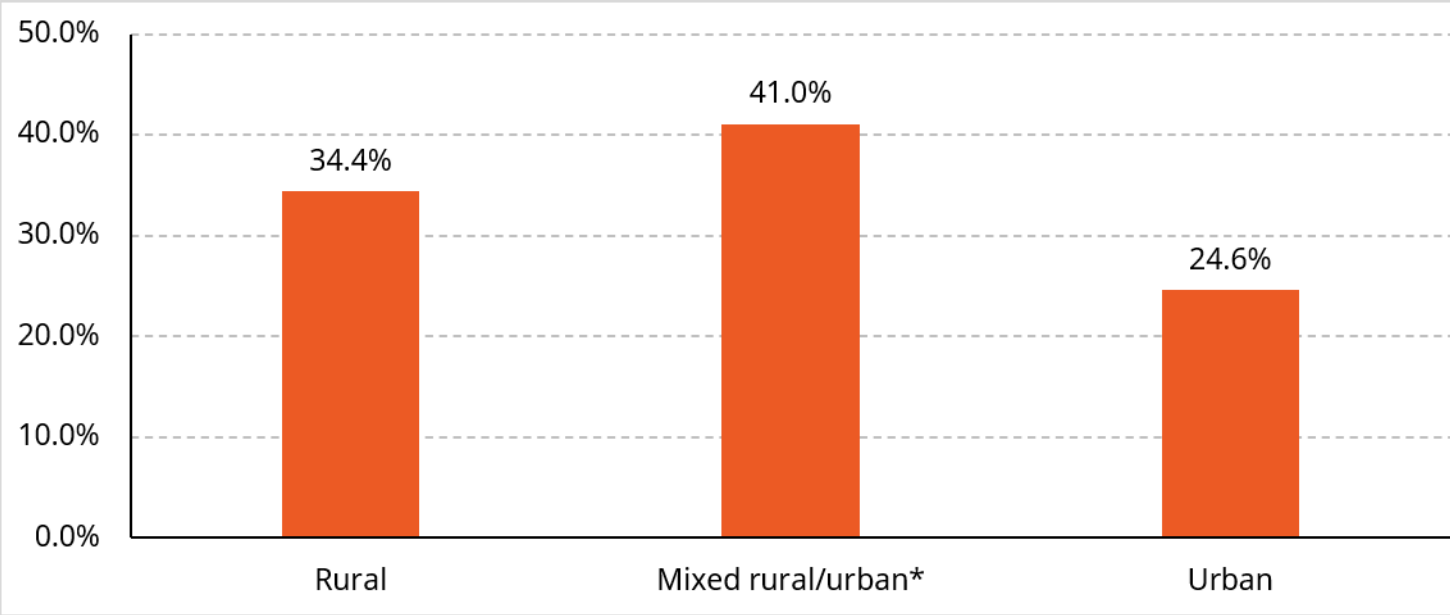
Organizations	Number of recipients	Percent of Pathways recipients	Total amount awarded to recipients	Average award amount per recipient
Jefferson County School District	10	2.1%	\$37,500	\$3,750
Lane County Educational Service District (2 programs)	102	21.8%	\$149,885	\$1,469
Northeast Oregon Area Health Education Center (6 programs)	93	19.9%	\$149,885	\$1,612
Oregon Area Health Education Center (3 programs)	132	28.2%	\$57,075	\$432
Willamette Career Academy (2 programs)	115	24.6%	\$95,976	\$835
Sky Lakes Medical Center Foundation	16	3.4%	\$86,560	\$5,410

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

Location of Grantee Organizations

Location data was not available for individual scholarship recipients; therefore, recipient location was classified based on the rural/urban status of the grantee organization that awarded the scholarship. Of the 468 recipients, at least 161 (34.4 percent) were associated with clearly rural programs and 115 (24.6 percent) with clearly urban programs. The remainder were associated with programs serving a mix of rural and urban locations (Figure 20).

Figure 20. Distribution of recipients of the Health Care Workforce Pathways Program by rural-urban designation of awarding organizations and their associated programs, June 30, 2025-December 31, 2025



Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

Note: Rural-urban classification is based on the location(s) served by the associated program’s ZIP code, not the individual recipient’s location/ZIP code.

***Two grantees** (Lane County Educational Service District, which contains both rural and urban ZIP codes, and Oregon Area Health Education Center, specifically the High School Health Care Career Exploration Camps located both in Bend and Klamath Falls) were located in both rural and urban locations as classified by ZIP code.

Evaluation of Program Adoption

Organizational Participation

All institutions participating in the Health Care Workforce Pathways Program are educational or education-adjacent organizations, reflecting the program’s K-12 and pre-professional pathway focus (Table 48).

Table 48. Types of organizations participating in the Health Care Workforce Pathways Program

Institution	Organization type
Jefferson County School District	K-12 school district
Lane County Educational Service District	Educational service district (regional K-12 support agency)
Northeast Oregon AHEC (NEOAHEC)	Area Health Education Center
Oregon AHEC (ORAHEC)	Area Health Education Center
Willamette Career Academy	Career & technical education academy
Sky Lakes Medical Center Foundation	Hospital-affiliated foundation

Four types of organizations received awards through the Health Care Workforce Pathways Program: K-12 school districts and education service districts, regional Area Health Education Centers, a career-and-technical-education academy, and a hospital-affiliated foundation.

Demographic Characteristics of Recipients

The Health Care Workforce Pathways Program collects REALD SOGI data. Of 468 total recipients, 364 (77.8 percent) completed a REALD SOGI questionnaire, but response rates varied by question. Most scholarship recipients reported belonging to one race or ethnicity (n = 270, 76.1 percent). When asked about their primary race or ethnicity, almost half of recipients identified as white (n = 150, 47.6 percent) and one quarter identified as Hispanic or Latino/a/x/e (n = 81, 25.7 percent) (Table 49).

Of the recipients who responded to questions about languages used, 59 recipients (18.3 percent) reported using a language other than English at home, while 263 (81.7 percent) reported English only, and 42 (11.5 percent) did not respond (Table 50). Among recipients who reported using a language other than English at home, 57 (96.6 percent) reported using Spanish. The remaining recipients reported using Russian or various Indigenous or Native American languages (estimates suppressed due to small numbers).

Among the recipients who completed questionnaire questions on gender identity, the majority of recipients identified as a woman/girl (n = 251, 75.6 percent); 41 (12.3 percent) as man/boy, and 46 (13.9 percent) as all other gender identities or declined to answer (Table 51). Among recipients who completed questionnaire questions related to disability, 34 (25.6 percent) reported a disability, of whom 22 (16.5 percent of respondents) reported one disability and 12 (9.0 percent of respondents) reported two or more. The most commonly reported disability was difficulty concentrating, remembering, or making decisions (n = 18, 4.9 percent of all respondents). Each of the other disability limitations were reported by 10 or less recipients.

Table 49. Primary race or ethnicity of Health Care Workforce Pathways Program recipients (who completed REALD SOGI questionnaire), June 30, 2025-December 31, 2025 (n = 315)

Primary race/ethnicity	Number	Percent
White	150	47.6%
Hispanic or Latino/a/x/e	81	25.7%
Asian	14	4.4%
Multiracial	14	4.4%
American Indian or Alaska Native	0	0.0%
Black or African American†	-†	-†

Primary race/ethnicity	Number	Percent
Native Hawaiian or Pacific Islander†	-†	-†
Don't Know	9	2.9%
Don't want to answer	44	14.0%

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025. Estimates based on the number of respondents who responded to the questionnaire and did not have missing data for these items (n = 315).

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

†Estimate suppressed due to small numbers; statistically unreliable.

Table 50. Language other than English used at home of Health Care Workforce Pathways Program recipients who completed REALD SOGI questionnaire, June 30, 2025-December 31, 2025 (n = 322)

Language other than English used at home	Number	Percent
No - I only speak English at home	263	81.7%
Yes*	59	18.3%

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

*Among recipients who report using a language other than English at home, 57 (96.6%) report using Spanish.

Table 51. Gender identity of Health Care Workforce Pathways Program recipients who completed REALD SOGI questionnaire, June 30, 2025-December 31, 2025 (n = 332)

Total reported gender identities - alone or in combination*	Number	Percent
Woman/Girl	251	75.6%
Man/Boy	41	12.3%
All other gender identities/Did not want to answer	46	13.9%

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

*Respondents could select multiple gender identities, so the counts of identities may sum to more than the total number of responses.

Table 52. Disability status reported by Health Care Workforce Pathways Program recipients who completed REALD SOGI questionnaire, June 30, 2025-December 31, 2025 (n = 133)

Disability status†	Number	Percent*
Nondisabled /no reported limitation	99	74.4%
Disabled	34	25.6%
Disabled: 1 disability	22	16.5%
Disabled: 2 or more disabilities	12	9.0%

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

*There were 133 responses to the disability-related questions on the REALD-SOGI questionnaire. The percentages of the reported disability and number of disabilities are out of the 133 total respondents who completed the questionnaire.

†Disability was measured by asking about the limitations to daily living activities: hearing, seeing, mobility, cognition, self-care (dressing/bathing), learning, communicating,

independent living (doing errands), as well as a question about mental health. Not all programs asked about each limitation and some limitations are underrepresented. Not all people with disabilities choose to report limitations or are represented using REALD SOGI disability questions; interpret with caution.

Participation is spread across six institutions, with no single institution accounting for a majority of recipients. Each institution accounted for approximately 20-30 percent of all participants, except for Jefferson County School District (n = 10, 2.1 percent of total) and Sky Lakes Medical Center Foundation (n = 16, 3.4 percent).

Evaluation of Program Effectiveness

The program effectiveness evaluation questions could not be assessed using the available data. Funding is awarded to organizations, which then distribute funds to individual scholarship recipients, and scholarship recipients are students in grades 8-12, so data on their future practice (e.g., patient care hours, etc.) cannot yet be collected. Because the recipients of this program are secondary students, tracking recipients post-graduation will remain challenging.

Evaluation of Program Implementation

In its first biennium of funding, the Health Care Workforce Pathways Scholarship program has disbursed a total of \$551,496 of funding through six grantee organizations to support 468 students in grades 8-12 exploring health care careers. Most recipients were associated with grantee programs in rural (34.4 percent) or mixed rural/urban locations (41.0 percent).

Evaluation of Program Sustainability (Maintenance)

In its first biennium of funding, the Health Care Workforce Pathways Scholarship Program reached 468 students in grades 8-12 across both rural and urban areas of Oregon exploring and pursuing health care careers through a wide range of pathways (e.g., career exploration, experiential learning, scholarship funding for higher education, etc.). Because this evaluation only includes data covering its first biennium of funding, evaluation of program maintenance (changing trends in number of supported participants over time) is limited but may be explored in future evaluations. The Health Care Workforce Pathways program is expected to continue into the next biennium, subject to biennial appropriation to HCPIF.

Healthy Oregon Workforce Training Opportunity (HOWTO) Program

The HOWTO program provides grants to organizations and institutions to support the development of innovative, transformative, community-based

training initiatives with the ultimate goal of addressing health care workforce shortages and expanding the diversity of the health care workforce in Oregon. The program began in 2019 and is currently administered by OHPB in partnership with OHA and OHSU. HOWTO is funded through the OHSU-OHA partnership, and \$12 million was earmarked to support the program over the 2023-2025 biennium. HOWTO is an ongoing program, and OHA plans to release a seventh request for grant proposals in early 2027.

HOWTO differs from most programs in this evaluation. Rather than providing awards directly to individual providers or participants, HOWTO funds organizations to build and sustain new training programs. Participant counts are one output of this work, but they do not capture the training programs and curricula built with HOWTO funds, which are intended to be sustained after the grant period ends.

Six rounds of grantmaking have been completed. As recorded in the grantee summary data, award start dates ranged from March 1, 2019 (Round 1) to June 16, 2025 (Round 6), and grant periods for the most recent awards extend into 2027 and 2028. Across Rounds 1-6, 53 grantee projects were funded.

Data sources for this evaluation include two pre-aggregated tables provided by OHA: a grantee summary covering Rounds 1-6 (dated April 2026), consisting of one record per grantee project (n = 53) with organization name, award dates and amount, completion status, and project description; and a metrics table (dated May 2026) consisting of pre-aggregated counts of new workers trained, incumbent workers trained with additional skills, and high school career experiences, by category and grant round, covering March 2019 through December 2025. OHA program staff also provided the number of eligible proposals received in each round.

Key Takeaways

- HOWTO awarded \$34.3 million to 48 organizations for 53 projects across six rounds, training at least 1,728 participants. HOWTO funds organizations to build new training programs, so participant counts may understate its impact. Traditional Health Workers made up the largest share of new workers trained (51.4 percent).
- Eligible proposals grew more than tenfold, from 9 in Round 1 to 103 in Round 6, and the percent awarded ranged from 64.0 percent in Round 4 to 12.6 percent in Round 6.
- Whether funded programs continue after the grant ends is not tracked, although some are known to have continued, including a psychiatric mental health nurse practitioner program with a distance component in Eastern Oregon.

Evaluation of Program Reach

Program Participants

HOWTO grantees reported participants in three categories: new workers trained, incumbent workers trained with additional skills, and high school career experiences. Overall, 1,728 participants were reported across Rounds 1-6. The overall total counts each participant only once, but unduplicated counts were not available for every category and round, so the three categories add up to more than 1,728. These counts include participants trained through December 2025, or through the end of the grant for completed projects, and do not include later cohorts.

New workers trained represented the largest reported participant group, with 1,511 participants trained across Rounds 1-6 (Table 53). Traditional Health Workers accounted for the largest category of newly trained workers (776, 51.4 percent), followed by various certified professionals (411), additional behavioral health roles (140), behavioral health graduate education (114), and primary care residency/internship programs (70).

Participant counts by round reflect the timing of program development. For example, the nine Round 1 participants in behavioral health graduate education completed a psychiatric mental health nurse practitioner (PMHNP) training program, with a distance education component in Eastern Oregon, that was built with HOWTO funding. Because the first one to two years of a HOWTO project may focus on building curriculum, partnerships, and accreditation, these nine participants represent the first two cohorts that completed the program before the grant ended. The program has continued since HOWTO funding ended in 2023.

Table 53. New workers trained through the HOWTO Program, by category and round, March 2019-December 2025

Category	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Total
Traditional Health Workers	158	-	303	304	-	11	776
Behavioral health graduate education	9	-	75	19	9	2	114
Additional behavioral health roles	-	34	17	55	12	22	140
Various certified professionals	-	70	84	255	-	2	411
Primary care residency/internship programs	-	30	11	29	-	-	70
New workers trained	167	134	490	662	21	37	1,511

Abbreviation: HOWTO - Healthy Oregon Workforce Training Opportunity (HOWTO) program.
Data Source: HOWTO metrics table (OHA) from grantee data reporting for reporting period 3/1/2019-12/31/2025.

Note: The total number of new workers trained (1,511) is an unduplicated total. "-" indicates that the category did not apply to projects funded in that round. Counts within each category reflect trainings rather than individuals, so a participant who completed more than one training may be counted more than once.

HOWTO grantees also provided trainings to incumbent workers, who were already working in the field and developing additional skills. Across Rounds 1-6, grantees recorded 1,532 behavioral health trainings, 1,202 interprofessional health care trainings, and smaller numbers of other trainings (Table 54).

Because individual workers could complete multiple trainings, these counts should not be summed to estimate the number of unique incumbent workers trained. Unduplicated counts were reported for Rounds 2, 3, and 5 only, totaling 187 participants.

Table 54. Incumbent workers trained with additional skills and the overall unduplicated total in the HOWTO Program, by round, March 2019-December 2025

Incumbent Workers	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Total
Behavioral health trainings	-	-	1,395	107	24*	6	1,532
Interprofessional health care trainings	1,202	-	-	-	-	-	1,202
CEUs for community health workers	-	55*	-	309	-	28	392
CHW trainings for dental assistants	-	-	76*	-	-	-	76
PA behavioral health fellowship	-	-	32*	-	-	-	32
Unduplicated total	†	55	108	†	24	†	187

Abbreviations: CEU – continuing education units; CHW – community health worker, HOWTO - Healthy Oregon Workforce Training Opportunity (HOWTO) program. **Data Source:** HOWTO metrics table (OHA) from grantee data reporting for reporting period 3/1/2019-12/31/2025.

Note: "-" indicates that the category did not apply to projects funded in that round. The Unduplicated total row reflects counts reported by OHA and is not a sum of the rows above. The total of 187 includes only the rounds for which an unduplicated count was reported.

* Category count already unduplicated.

† Unduplicated subtotal not provided.

HOWTO also provided 188 high school career experiences without certifications: 82 in Round 3, 76 in Round 4, and 30 in Round 5. Counts for Rounds 3 and 4 represent experiences, and a student may have participated in more than one; the number of unique participants was not available for these rounds. The Round 5 count represents unduplicated participants.

HOWTO does not collect individual-level data from grantees, so the demographic characteristics of participants could not be described.

Evaluation of Program Adoption

Demand for HOWTO Funding

Demand for HOWTO funding has grown substantially across grant rounds. The number of eligible proposals increased from 9 in Round 1 to 103 in Round 6 (Table 55), and proposals more than doubled between Round 5 (40) and Round 6 (103). The number of awards in each round depends on available funding, so awards did not keep pace with proposals, and the percentage of proposals funded declined from 64.0 percent in Round 4 to 12.6 percent in Round 6. Across all six rounds, 53 of 215 eligible proposals (24.7 percent) were funded. This growth suggests increasing awareness of HOWTO and demand among Oregon organizations for funding to build health care training programs.

Table 55. Number of eligible proposals, awards, and percent of proposals awarded for HOWTO grants by round, Rounds 1-6 (March 2019-December 2025)

Round	Number of eligible proposals	Number of awards	Percent awarded
1	9	3	33.3%
2	17	6	35.3%
3	21	9	42.9%
4	25	16	64.0%
5	40	6	15.0%
6	103	13	12.6%
Total	215	53	24.7%

Abbreviation: HOWTO - Healthy Oregon Workforce Training Opportunity (HOWTO) program.

Data Source: Proposal and award counts provided by OHA HOWTO program staff. Percent awarded calculated by the evaluation team.

Grantee Organizations

Across Rounds 1-6 of the HOWTO Program, 48 grantee organizations received 53 awards totaling \$34,300,437 in funding. As of April 2026, 29 projects were complete, and 24 projects were ongoing. All projects in Rounds 1-3 were complete.

HOWTO grantee organizations represented a range of organization types, including Local Workforce Development Boards, FQHCs, community colleges, Tribal health organizations, public and private universities, hospitals and health systems, K-12 school districts, professional and membership associations, culturally specific community-based nonprofits, for-profit dental organizations, and a national consulting firm.

Forty-three (89.6 percent) of the 48 grantee organizations received one award. Five organizations received two awards each, accounting for the remaining 10 of 53 awards (18.9 percent).

Evaluation of Program Effectiveness

HOWTO is a program-building grant, so its effectiveness cannot be measured in the same way as incentive programs that provide awards directly to individual providers. The intended outcomes of HOWTO include new training programs that continue to train Oregon's health care workforce after the grant period ends. The data available for this evaluation describes awards and participant counts but does not include measures of whether funded training programs were sustained or what workforce outcomes they produced, so effectiveness could not be assessed for this evaluation.

Developing specific effectiveness metrics for HOWTO would allow future evaluations to assess program outcomes. Potential measures include whether funded programs continue to enroll participants after HOWTO funding ends and how many cohorts complete after the grant period; completion and credentialing rates among participants; employment of program completers in Oregon, including in rural and underserved communities; and partnerships and additional funding leveraged to sustain programs.

Evaluation of Program Implementation

Program-Building Activities

HOWTO grantee project activities extend beyond training individual workers. HOWTO awards fund organizations to build new training programs, and innovation and plans for sustainability beyond the funding period are part of the award selection criteria. Funds cannot be used to maintain existing workforce development programs as they are. Grantees use HOWTO funds for staffing, curriculum development, partnerships and consortia, accreditation, and hands-on clinical learning opportunities, including simulation experiences, supplies, and equipment such as dental mannequins. HOWTO funds also provide direct support to participants, including tuition, fees, and transportation and childcare stipends that reduce barriers to participation. These program-building uses distinguish HOWTO from the Health Care Workforce Pathways Scholarships, which organizations distribute directly to participants.

Projects typically follow a three-year implementation timeline. The first one to two years may focus on building curriculum, partnerships, and accreditation before the first participants enroll. No-cost extensions are common because implementation often takes longer than planned, and project timelines in Rounds 1 and 2 were particularly affected by COVID-related changes. Grantees

submit semi-annual progress and expenditure reports, which are required before OHA pays semi-annual invoices.

The depth of these program-building activities is difficult to capture with participant counts alone. Project descriptions for all 53 funded projects, provided in Appendix D, show the range of training programs that grantees have developed.

Opportunities to Strengthen Future Evaluation

Participant counts were the primary measure available for this evaluation, and they do not capture the training programs and curricula built with HOWTO funds. In addition to the effectiveness measures described above, several data elements would help future evaluations describe HOWTO's program-building work: (1) an inventory of the training programs, curricula, and accreditations developed by each project; (2) expenditures by category (e.g., staffing, curriculum development, clinical learning, participant supports), which could be drawn from existing semi-annual expenditure reports; and (3) project location by county or region, which OHA has compiled for a recent project dashboard and which could be linked to participant counts. A brief data dictionary describing how unduplicated totals are calculated and how categories that do not apply to a round are recorded would also help future evaluation teams interpret the data consistently.

Evaluation of Program Sustainability (Maintenance)

As of April 2026, 24 of 53 grantee projects were ongoing, with grant end dates of July 31, 2026 (four projects), January 31, 2027 (5 projects), July 31, 2027 (four projects), and July 31, 2028 (11 projects). Because funds are disbursed through semi-annual invoices across each project's timeline, funding commitments already in place extend into 2027 and 2028.

Sustainability is also built into HOWTO project selection. Awards are made partially based on plans to sustain training programs beyond the funding period, and some programs have continued after their grants ended. As noted above, the PMHNP training program developed with a Round 1 award has continued since its HOWTO funding ended in 2023. Information on how many funded programs continued after their grant periods was not available for this evaluation.

HOWTO is an ongoing program funded through the OHSU-OHA partnership, and OHA plans to release a seventh request for grant proposals in 2027. Beyond the existing grant commitments and planned seventh round, information about future appropriations or funding levels was not available; therefore, future-year funding cannot be projected.

Fee Waiver Programs

Background

Fee waiver programs provide funding to current or prospective health care providers to cover the costs of examination courses, examinations, licensure or certification fees, and/or license/certification renewal fees with the goal of retaining these providers in the health care workforce.

The following two fee waiver programs, administered by HCPIP, were evaluated in this report:

- Health Care Interpreter Retention Incentive
- Behavioral Health Retention Incentive

Other fee waiver programs administered by BHWI, including the Association of Social Work Board (ASWB) and the Oregon Board of Licensed Social Workers (BLSW) programs, are described further in Appendix A.

Health Care Interpreter Retention Incentives (HCPIP)

The Health Care Interpreter Retention Incentives, part of HCPIP, provide funding to health care interpreter training programs to offer continuing education training to health care interpreters at no cost. In Oregon, Qualified and Certified health care interpreters must renew their certification every four years and complete at least 24 hours of continuing education credits. This program encourages health care interpreters to renew their certification by eliminating the cost of this continuing education requirement. The Health Care Interpreter Retention program funding started June 30, 2025 during the 2023-2025 biennium.

Key Takeaways

- In its first period (June to December 2025), the program supported 102 recipients, with an average award of \$621 toward required continuing education.
- Most recipients (86.8 percent) spoke a language other than English at home. Spanish, Russian, and Ukrainian were the most common certified languages.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

Available grantee data provides information about the credential or clinical position category for each Health Care Interpreter Retention Incentives recipient and the language(s) in which interpreter participants are certified.

Among the 102 recipients from June 2025 to July 2026, most were either currently enrolled (n = 39, 38.2 percent) or had completed their training (n = 38, 37.3 percent). Smaller proportions had withdrawn (Table 56).

Table 56. Number of Health Care Interpreter Retention Incentives recipients by program status, June – December 2025 (n = 102)

Program status	Number of recipients	Percent of recipients
Currently enrolled	39	38.2%
Completed	38	37.3%
Withdrew*	8*	7.8%*

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025. **Note:** Table does not include 17 (16.7%) recipients with program status classified as “NA” in the available data; these are incorporated into the percentage.

***The number of recipients who withdrew (n = 8) may be statistically unreliable due to small numbers; interpret with caution.**

The clinical position was recorded for 47 of 94 recipients (50.0 percent, excluding eight recipients who withdrew from the program) (Table 57). Among these recipients, 15 (16.0 percent) were health care interpreters in training enrolled in the 60-hour training program, 17 (18.1 percent) were certified health care interpreters completing 24 hours of continuing education units, and 15 (16.0 percent) were current health care providers comprised of medical assistants and other health care providers.

Table 57. Health Care Interpreter Retention Incentive recipients by clinical position category, June – December 2025

Clinical position category	Number of recipients*	Percent of recipients* (n = 94)	Percent of recipients with clinical position data (n = 47)
Certified health care interpreters (24-hour CEU)	17	18.1%	36.2%
Health care interpreters in training (60-hour training program)	15	16.0%	31.9%
Current health care providers	15	16.0%	31.9%
Missing clinical position information	47	50.0%	n/a
Total recipients overall	94		
Total (excluding missing clinical position)	47		

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

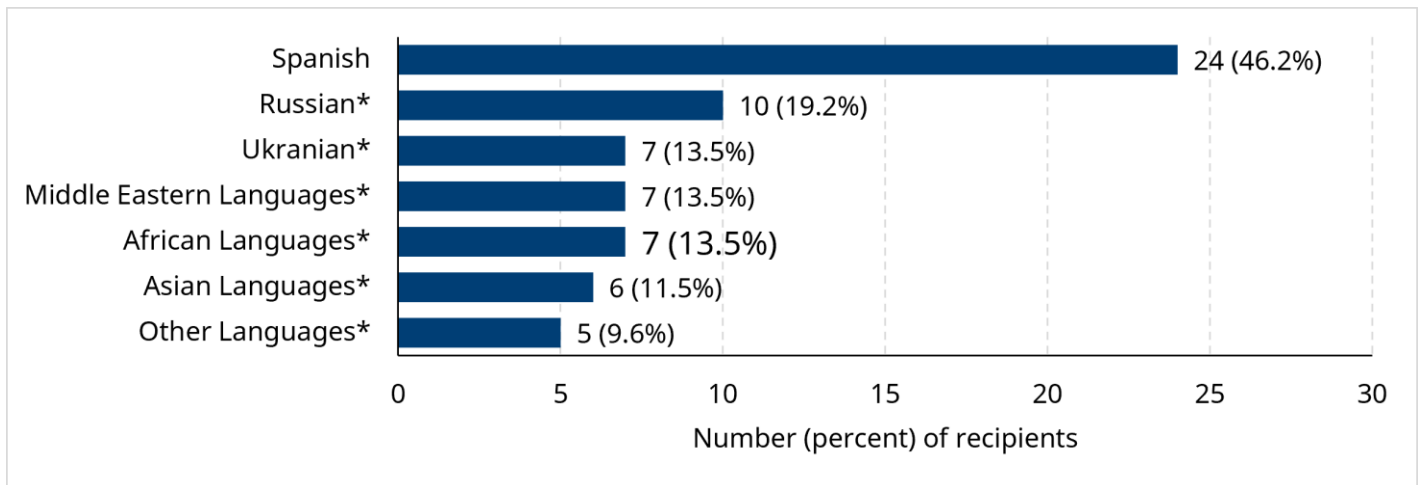
***Excludes 8 recipients who withdrew from the program before completing.**

Subcategories of current health care providers include medical assistants (n = 5) and other current health care providers (n = 10).

Fifty-two recipients were health care interpreters in training or certified health care interpreters. Among these recipients, Spanish was the most frequently reported language certification (n = 24, 46.2 percent), followed by Russian (n =

10, 19.2 percent) and Ukrainian (n = 7, 13.5 percent) (Figure 21). Recipients could be certified in more than one language: 41 recipients (78.8 percent) were certified in one language, and 11 recipients (21.2 percent) were certified in two or more languages. Individual languages within the aggregated groups are footnoted in Figure 21. Each had fewer than 5 recipients and were not reported separately due to small numbers.

Figure 21. Certified languages of Health Care Interpreter Retention Incentives recipients, June – December 2025 (n = 52 health care interpreters in training and certified health care interpreters)



Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025. Because individuals can be certified in more than one language, percentages do not sum to 100 percent. Middle Eastern languages include Arabic, Dari, Kurdish, and Pashto. African languages include Swahili, Somali, Shona, Mandingo, and Maay Maay. Asian languages include Vietnamese, Mandarin, Burmese, and Chuukese. Other languages include French, Haitian Creole, and Urdu. Individual languages within these groups are not reported because each has fewer than 5 recipients.

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

Evaluation of Program Adoption

Organizational Participation

All grantee organizations participating in the Health Care Interpreter Retention Incentives are OHA-registered health care interpreter training programs. Nine such programs were awarded for the 2023-2025 biennium:

- AMN Healthcare Language Services, Inc.
- Linguava Interpreters Inc.
- Linguistics Global Associates Inc.
- Medical Interpreting Training School
- Oregon Health Care Interpreter Association

- Svetlana’s Training, LLC
- The Cross-Cultural Health Care Program
- The Immigrant and Refugee Community Organization
- UIO Language Logistics, LLC

Demographic Characteristics of Recipients

REALD SOGI data are available for the Health Care Interpreter Retention Incentives program and are summarized in tables below. REALD SOGI responses were recorded for 76 of 102 recipients (74.5 percent). Percentages in tables use denominators specific to each category; these denominators differ from one another and from the recipient totals used elsewhere.

Among the 75 recipients included in the race/ethnicity analysis, nearly two in five (n = 29, 38.7 percent) identified as Hispanic or Latino/a/x/e alone or in combination and one-third (n = 25, 33.3 percent) identified as white (Table 58). Among the 76 recipients with language data, 66 (86.8 percent) reported using a language other than English at home (Table 59). The remaining 10 responses are suppressed to prevent backward calculation of a suppressed value. Among those using another language at home, 31 (47.0 percent) use Spanish, 12 (18.2 percent) Russian, and 9 (13.6 percent) Ukrainian. Fifty recipients (65.8 percent) reported a gender identity of woman and 22 (28.9 percent) reported man (Table 60). The number of recipients reporting any disability was fewer than five and is suppressed.

Table 58. Race/ethnicity of Health Care Interpreter Retention Incentives recipients, June – December 2025 (n = 75)

Race/ethnicity, alone or in combination	Number of recipients	Percent
Hispanic or Latino/a/x/e	29	38.7%
White	25	33.3%
Asian	11	14.7%
Black or African American*	9*	12.0%*
Middle Eastern or North African*	5*	6.7%*
Native Hawaiian or Pacific Islander	0	0.0%
American Indian or Alaska Native†	-†	-†
Declined to answer/missing†	-†	-†

Data Source: Grantee data for reporting period 06/30/2025-12/31/2025. Race/ethnicity categories are reported alone or in combination and, as a result, counts do not sum to the denominator.

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

†Estimate suppressed due to small numbers; statistically unreliable.

Table 59. Languages used at home by Health Care Interpreter Retention Incentives recipients, June – December 2025

Languages used at home other than English used at home	Number of recipients	Percent	Denominator
Language other than English used at home† (n = 66)	66	86.8%	76
Spanish	31	47.0%	66
Russian	12	18.2%	66
Ukrainian*	9	13.6%	66

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025.

Denominators differ by category. Languages used at home are reported among recipients who use a language other than English at home. Individuals may report more than one language. Counts do not sum to the denominator.

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

†Estimate suppressed due to small numbers; statistically unreliable.

Table 60. Gender identity of Health Care Interpreter Retention Incentives recipients, June – December 2025

Gender identity, alone or in combination	Number of recipients	Percent
Woman	50	65.8%
Man	22	28.9%
All other gender identities, declined, or missing*	7*	9.2%*

Data Source: Grantee data reporting for reporting period 06/30/2025-12/31/2025. A total of 76 recipients responded to REALD SOGI responses (74.5% of 102 total recipients). Gender identity was collected as a select-all-that-apply item, and therefore numbers of recipients tabulated here do not sum to 76.

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

Evaluation of Program Effectiveness

Program effectiveness could not be assessed using the available data.

Evaluation of Program Implementation

All 94 recipients and the full \$58,390 awarded were accounted for by three organizations offering interpreter training programs (Table 61).

Table 61. Recipients, total amount awarded, and average award by organizations offering interpreter training programs, Health Care Interpreter Retention Incentives, June – December 2025 (n = 94 recipients)

Interpreter training program	Number of recipients	Percent of recipients	Total amount awarded
Medical Interpreting Training School	48	51.1%	\$27,840
Oregon Health Care Interpreter Association	32	34.0%	\$17,040

Interpreter training program	Number of recipients	Percent of recipients	Total amount awarded
The Immigrant and Refugee Community Organization	14	14.9%	\$13,510
Total	94	100.0%	\$58,390

Data Source: Grantee data for reporting period 06/30/2025-12/31/2025. Total recipients exclude 8 participants who withdrew from the program. Recipient counts and award amounts are reported directly in the source table. Percentages are calculated against the reported totals of 94 recipients and \$58,390.

Evaluation of Program Sustainability (Maintenance)

In its first biennium of funding, the Health Care Interpreter Retention Incentives program made 102 awards; however, because this evaluation only includes data covering its first biennium of funding, evaluation of program maintenance (changing trends in number of supported participants over time) is limited but may be explored in future evaluations. The Health Care Interpreter Retention Incentives program is expected to continue into the next biennium, subject to biennial appropriation to HCPIF.

MHACBO Incentives administered by HCPIF (Behavioral Health Retention Incentives)

The Behavioral Health Retention Incentives program, part of HCPIF, provides funding to the Mental Health and Addiction Certification Board of Oregon (MHACBO) to cover registration and advanced examination costs for certain behavioral health certifications. HCPIF refers to this program as the Behavioral Health Care Retention Scholarship; this report uses Behavioral Health Retention Incentives because the program is a fee waiver. The full award of \$1,350,000 was made to MHACBO, which applies the funding to individual registration and examination costs. Individuals do not receive funds directly and incur no service obligation. During the reporting period for this evaluation, the program covered examination costs for Certified Alcohol and Drug Counselors (CADC) II and III, Qualified Mental Health Associates (QMHA) II, and Certified Recovery Mentors (CRM) II, and registration costs for CADC, QMHA, Qualified Mental Health Professionals (QMHP), and CRM registrants.

HCPIF funding continued fee waivers that MHACBO first offered through BHWI, a program funded with part of Oregon’s federal American Rescue Plan Act (ARPA) allocation. The BHWI-funded MHACBO program was a \$3.7 million award that covered four certification types between July 2022 and June 2024, and it is reported with other BHWI-funded incentives in Appendix A. The two programs share an administering organization but differ in funding source, award amount, period, and data, so they are reported separately.

Data evaluating the MHACBO program were provided on two separate groups of recipients. “Registration recipients” include individuals whose certification registration fees were waived. “Examination recipients” include individuals whose certification examination fees were waived. Because these data sources could not be linked, the evaluation cannot determine how many distinct individuals received only one or both fee waivers.

Key Takeaways

- A \$1.35 million award to MHACBO covered 4,082 certification registrations and 481 examinations from June to December 2025. Half of registrants with a recorded education level (50.8 percent) held a high school credential or associate degree as their highest level of education.
- Among examinees who tested, 90.0 percent passed. Practice locations are not collected, so geographic reach cannot be assessed.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

The program supported 4,082 registration recipients and 481 examination recipients between June 30 and December 31, 2025 (Table 62). QMHA-R was the most common registration type (n = 1,353, 33.1 percent), followed by CADC-R (n = 1,154, 28.3 percent), CRM (n = 952, 23.3 percent), and QMHP-R (n = 623, 15.3 percent). Education level was recorded for 3,915 registrants (95.9 percent). Half of registrants with a recorded education level held a high school credential or associate degree (50.8 percent).

Educational attainment varied across credential types, which is consistent with the requirements of each certification pathway. Nearly all QMHP-R registrants held a master’s or doctoral degree (94.8 percent), and none held a high school credential or associate degree alone. CRM registrants were predominantly at high school or GED level (74.3 percent). QMHA-R registrants clustered at bachelor’s level (47.8 percent), and CADC-R registrants were the most evenly distributed across all four education levels.

Table 62. Registration recipients by certification type and education level, MHACBO Behavioral Health Retention Incentives (HCPIP), June-December 2025 (N = 4,082).

Certification type	Number of recipients	Percent of recipients	HS/GED	Associate	Bachelor	Master or higher
All registration recipients	4,082	100.0%	38.5	12.3	24.8	24.4
CADC-R	1,154	28.3%	42.8	13.3	23.3	20.6
QMHA-R	1,353	33.1%	25.8	16.3	47.8	10.1
QMHP-R	623	15.3%	0.0	0.0	5.2	94.8

Certification type	Number of recipients	Percent of recipients	HS/GED	Associate	Bachelor	Master or higher
CRM	952	23.3%	74.3	14.1	9.6	2.0

Abbreviations: MHACBO - Mental Health and Addiction Certification Board of Oregon; CADC - Certified Alcohol and Drug Counselor; QMHA - Qualified Mental Health Associate; QMHP - Qualified Mental Health Professional; CRM - Certified Recovery Mentor. **Data Source:** ORH Grantee Data Reporting (MHACBO) for reporting period 06/30/25-12/31/2025.

Education level percentages are row percentages among registrants with a recorded education level (n = 3,915); 167 registrants (4.1 percent) were missing education level and are excluded. Missing counts by credential: CADC-R 24, QMHA-R 129, QMHP-R 13, CRM 1.

Locations of Service

The MHACBO data provided for this evaluation contained no geographic variables. The proportion of recipients or funding located in rural areas or Areas of Unmet Need could not be determined. However, this is reflective of the program's structure: funding is directed to a statewide certification board, and certification is not tied to a practice site.

Evaluation of Program Adoption

Organizational Participation

MHACBO is the sole partner organization for this program. The entire award of \$1,350,000 was made to MHACBO, the sole certification organization for these credentials in Oregon.

Demographic Characteristics of Recipients

Just over two-thirds of registration recipients identified as white (69.3 percent), 13.7 percent identified as Hispanic or Latino/a/x/e, 12.0 percent as multi-racial, and 10.1 percent as Black or African American (Table 63). Approximately one in six registrants (n = 697, 17.1 percent) reported using a language other than English at home, most commonly Spanish, which accounted for 64.7 percent of reported languages (Table 64). American Sign Language was the second most frequently reported (n = 50, 7.2 percent). Nearly two-thirds of registrants identified as a woman or girl (62.9 percent; Table 65). Approximately one in 20 registrants (n = 208, 5.1 percent) reported any disability (Table 66). Note that the MHACBO data comprise demographic data only and are not collected using the OHA REALD SOGI instrument.

Among registrants who reported any disability, the most frequently reported limitations were difficulty concentrating, remembering, or making decisions (n = 81, 38.9 percent), difficulty walking or climbing stairs (n = 70, 33.7 percent), and deafness or difficulty hearing (n = 42, 20.2 percent). Data on examinees are suppressed due to small numbers.

Table 63. Race/ethnicity of MHACBO registration recipients and passed examinees, MHACBO Behavioral Health Retention Incentives (HCPIP), June-December 2025

Race/ethnicity	Number of registrants who received an award	Percent of registrants who received an award	Number of passed examinees who received an award	Percent of passed examinees who received an award
White	2,822	69.3%	290	82.4%
Hispanic or Latino/a/x/e	558	13.7%	36	10.2%
Multiracial	489	12.0%	42	11.9%
Black or African American	413	10.1%	14	4.0%
American Indian or Alaska Native	302	7.4%	27	7.7%
Asian	148	3.6%	5*	1.4%*
Native Hawaiian or Pacific Islander	54	1.3%	-†	-†
Declined/unknown	50	1.2%	-‡	-‡
Middle Eastern or North African	28	0.7%	0	0.0%

Abbreviation: MHACBO - Mental Health and Addiction Certification Board of Oregon. **Data**

Source: ORH Grantee Data Reporting (MHACBO) for reporting period 06/30/25-12/31/2025.

Race/ethnicity are reported alone or in combination; categories are not mutually exclusive and do not sum to 100%. Denominators vary by column: registrants n = 4,074; passed examinees n = 352. MHACBO demographic items are not REALD SOGI-aligned and are not comparable to REALD SOGI data reported for other programs.

*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).

Table 64. Languages other than English used at home by MHACBO registration recipients and passed examinees, MHACBO Behavioral Health Retention Incentives (HCPIP), June-December 2025

Languages other than English Used at Home	Number of registrants who received an award	Percent of registrants who received an award	Number of passed examinees who received an award	Percent of passed examinees who received an award
Uses a language other than English at home*	697	17.1%	40	11.4%
Spanish	451	64.7%	30	75.0%
American Sign Language	50	7.2%	0	0.0%
French	36	5.2%	0	0.0%
Somali or Cushitic	28	4.0%	0	0.0%
German	22	3.2%	0	0.0%
Arabic	17	2.4%	0	0.0%
Japanese	15	2.2%	0	0.0%
Russian	15	2.2%	0	0.0%
Vietnamese	12	1.7%	0	0.0%

Languages other than English Used at Home	Number of registrants who received an award	Percent of registrants who received an award	Number of passed examinees who received an award	Percent of passed examinees who received an award
Other	59	8.5%	13	32.5%

Abbreviation: MHACBO - Mental Health and Addiction Certification Board of Oregon. **Data Source:** ORH Grantee Data Reporting (MHACBO) for reporting period 06/30/25-12/31/2025. Denominators vary by item: registrants n = 4,082; passed examinees n = 352. MHACBO demographic items are not REALD SOGI-aligned and are not comparable to REALD SOGI data reported for other programs.

*Languages used are among those using a language other than English at home. Percentages do not sum to 100 as some recipients report multiple languages. Individual language counts were not reported for passed examinees other than Spanish and other.

Table 65. Gender identity of MHACBO registration recipients and passed examinees, MHACBO Behavioral Health Retention Incentives (HCPPI), June-December 2025

Gender Identity	Number of registrants who received an award	Percent of registrants who received an award	Number of passed examinees who received an award	Percent of passed examinees who received an award
Woman/girl	2,539	62.9%	238	67.8%
Man/boy	1,316	32.6%	105	29.9%
Intersex	185	4.6%	-†	-†
Transgender	178	4.4%	-†	-†
Nonbinary	-‡	-‡	-†	-†
Transgender, intersex, or nonbinary§	-†	-†	8*	2.3%*

Abbreviation: MHACBO - Mental Health and Addiction Certification Board of Oregon. **Data Source:** ORH Grantee Data Reporting (MHACBO) for reporting period 06/30/2025-12/31/2025. Gender identity is reported alone or in combination; categories are not mutually exclusive and do not sum to 100%. Denominators vary by item: registrants n = 4,036; passed examinees n = 351. MHACBO demographic items are not REALD SOGI- aligned and are not comparable to REALD SOGI data reported for other programs.

*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).

§Gender identity categories were reported separately for registrants and as a single combined category for passed examinees.

Table 66. Disabilities reported by MHACBO registration recipients and passed examinees, MHACBO Behavioral Health Retention Incentives (HCPIP), June-December 2025

Disability*	Number of registrants who received an award	Percent of registrants who received an award	Number of passed examinees who received an award	Percent of passed examinees who received an award
Any disability reported	208	5.1%	22	6.9%
One disability	177	4.4%	-†	-†
Two or more disabilities	31	0.8%	-†	-†

Abbreviation: MHACBO - Mental Health and Addiction Certification Board of Oregon. **Data Source:** ORH Grantee Data Reporting (MHACBO) for reporting period 06/30/25-12/31/2025.

Denominators vary by item: registrants n = 4,061; passed examinees n = 317. MHACBO demographic items are not REALD SOGI- aligned and are not comparable to REALD SOGI data reported for other programs.

*Disability was measured by asking about the limitations to daily living activities: hearing, seeing, mobility, cognition, self-care (dressing/bathing), learning, communicating, independent living (doing errands), and mental health. Not all recipients were asked about each limitation listed above, and some limitations are underrepresented. Not all people with disabilities choose to report limitations or are represented using these disability questions; interpret with caution.

†Estimates suppressed due to small numbers; statistically unreliable.

Evaluation of Program Effectiveness

Certification Attainment

While retention and telehealth usage data are unavailable, certification attainment data can be used to evaluate program effectiveness. Among the 481 examination recipients from June-December 2025, 352 (73.2 percent) passed, 39 (8.1 percent) failed, and 90 (18.7 percent) had registered but had not yet taken the examination as of December 31, 2025. Among those who completed the examination (i.e., both those who had passed and those who had failed, for a total of 391), the overall pass rate was 90.0 percent (352 of 391). Pass rates varied by examination type (Table 67), from 73.2 percent for the Jurisprudence Ethics Examination to 100.0 percent for CADC II and CADC III.

CADC II and CADC III pass rates shown in Table 67 should be interpreted with caution. Both examinations had large numbers of recipients who registered but had not yet taken the test (63 of 127 CADC II recipients and 27 of 48 CADC III recipients), so the reported pass rates reflect 64 and 21 test-takers, respectively, rather than the full supported cohort. Outcomes for the remaining candidates are not yet available.

Table 67. Examination support recipients and examination outcomes, MHACBO Behavioral Health Retention Incentives (HCPIP), June-December 2025 (N = 481)

Examination	Total examination support recipients	Passed	Failed	Registered, not taken	Total exams taken*	Pass rate (%)
All examination recipients	481	352	39	90	391	90.0%
CADC II	127	64	0	63	64	100.0%
CRM II	118	107	11	0	118	90.7%
QMHA II	106	100	6	0	106	94.3%
Jurisprudence†	82	60	22	0	82	73.2%
CADC III	48	21	0	27	21	100.0%

Abbreviations: MHACBO - Mental Health and Addiction Certification Board of Oregon, CADC – Certified Alcohol and Drug Counselor; QMHA – Qualified Mental Health Associate; QMHP – Qualified Mental Health Professional; CRM - Certified Recovery Mentor. **Data Source:** ORH Grantee Data Reporting (MHACBO) for reporting period 06/30/25-12/31/2025.

***The denominator for the pass rate is the number of recipients who passed plus failed (a total of 391 in this table) and excludes recipients who registered but had not yet taken the examination.**

†The Jurisprudence examination is an ethics requirement for prospective CADC II and CADC III candidates, taken after completion of required coursework, supervised experience hours, and the MAC National Certification examination.

Evaluation of Program Implementation

A total of \$1,350,000 was provided to MHACBO to implement this incentive as the sole grantee organization. Because individual or summary data on total funding disbursed were not provided, evaluation of funding disbursement could not be assessed. Other domains of implementation, including patient care hours provided by recipients, could not be assessed using available data collected from recipients.

Evaluation of Program Sustainability (Maintenance)

Because the program was newly established in 2025, with data only available from its first biennium of funding, changes in the number of supported participants over time cannot be determined with available data. This may be explored in future evaluations.

Rural Medical Practitioner Insurance Subsidy (RMPIS)

Background

The Rural Medical Practitioner Insurance Subsidy (RMPIS) Program was created by House Bill 3630 (2003) to provide partial malpractice premium subsidy payments to insurance carriers intended to stabilize and support Physicians and Nurse Practitioners in rural and remote Oregon. These practicing professionals provide essential services, such as obstetric care and certain specialties at a site that meets OHA's definition of a rural practice. Originally codified by ORS 676.550, the program is now administered by HCPIP under ORS 676.460, in partnership with ORH. Subsidies are available to providers who practice at least 60 percent of the time in rural areas and who attest to serve Medicare and Medicaid patients in the same proportion as the Medicare and Medicaid population percentage in their county. The amount of the subsidy is related to the provider's specialty, with the highest subsidies offered to obstetrics (80 percent); family medicine/general practice offering obstetrics services (60 percent); anesthesiology, family medicine/general practice without obstetrics, general surgery, geriatrics, internal medicine, pediatrics, and pulmonary medicine (40 percent). All other eligible physicians and nurse practitioners receive up to 15 percent subsidies.

Key Takeaways

- RMPIS supported 978 physicians and nurse practitioners, and 97.0 percent of their reported practice hours were at rural sites. More than two-thirds of primary care recipients (69.5 percent) practiced in Service Areas with lower primary care capacity than the state overall.
- Survey respondents more often reported that the subsidy helped them remain at their current practice (65.2 percent) than that it influenced their decision to practice rurally (21.7 percent), which suggests the subsidy functions more as a retention tool than a recruitment tool. Most respondents (81.0 percent) requested a larger subsidy, noting that it has not kept pace with premium increases.
- Participation has declined each year since 2020, from 602 recipients in 2020 to 372 in 2025.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

The RMPIS program provided insurance subsidies to 978 unduplicated health care providers from 2018-2026 (Table 68). Most recipients were physicians (78.4 percent, n = 767), and about one-fifth of recipients were nurse practitioners (21.6 percent, n = 211). Among both physician and nurse practitioner recipients, the most common specialty was family medicine without obstetrics (28.2 percent of physicians, n = 216, and 55.0 percent of nurse practitioners, n = 116). About 10 percent (n = 73) of physician recipients practice obstetrics, including 22 family physicians who practice obstetrics, and about 14 percent (n = 29) of nurse practitioner recipients practice obstetrics.

Table 68. Number and percent of unduplicated Rural Medical Practitioner Insurance Subsidy recipients by provider type and credit percentage, 2018-2026

Provider Type	Credit Percentage	Specialties Included	Number	Percent
All Provider Types	-	All Specialties	978	
Physicians - MDs & Dos	-	All Specialties	767	78.4%
Physicians - MDs & DOs	80% credit	Obstetric physicians	51	5.2%
Physicians - MDs & DOs	60% credit	Family physicians with obstetrics	22	2.2%
Physicians - MDs & DOs	Up to 40% credit	Family medicine (without obstetrics), internal medicine, pediatrics, anesthesiology, general surgery, geriatrics, and pulmonary medicine physicians	442	45.2%
Physicians - MDs & DOs	Up to 15% credit	Other medical/surgical physicians	252	25.8%
Nurse Practitioners	-	All Specialties	211	21.6%
Nurse Practitioners	60-80%* credit	Obstetrics/midwifery nurse practitioners	29	3.0%
Nurse Practitioners	Up to 40% credit	Family medicine, internal medicine, pediatrics, and other nurse practitioner specialties	182	18.6%

Abbreviations: MD – Doctor of Medicine; DO – Doctor of Osteopathic. Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026.

***Nurse practitioners (NPs) who practice obstetrics or midwifery in Ashland receive a 60% credit percentage. There were <5 nurse practitioner recipients in Ashland from 2018-2026**

who practiced obstetrics, included in this total (estimate suppressed due to small numbers). All other NPs who practice obstetrics received an 80% credit percentage.

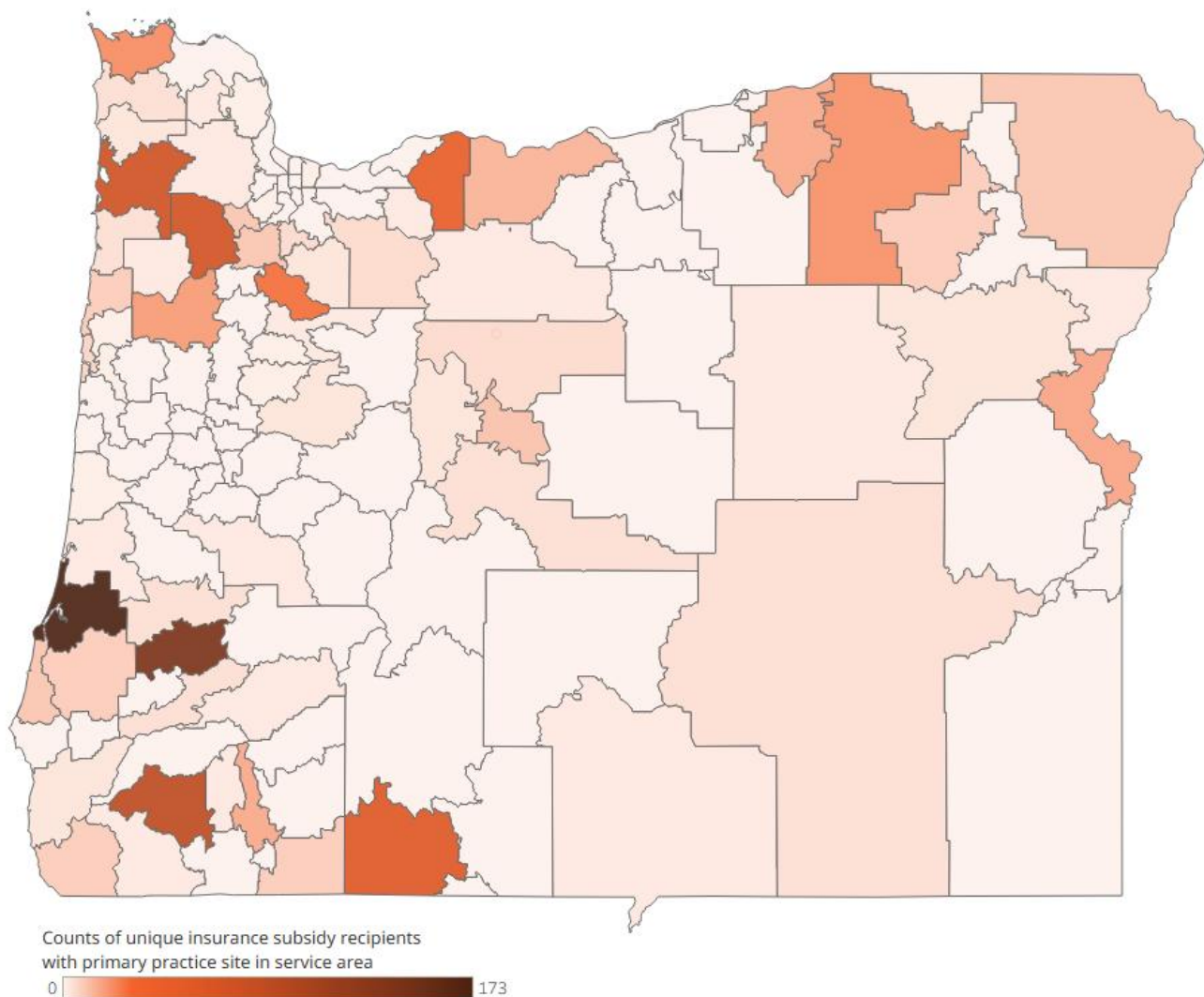
Locations of Service

Due to program eligibility requirements, the overwhelming majority of RMPIS recipients reported a primary or secondary practice location in a rural ZIP code (98.1 percent, n = 958), including 42 recipients (4.3 percent) who report working in a remote county. However, some recipients worked in both rural and urban ZIP codes across their primary and secondary practice sites; 42 recipients (4.3 percent) worked in an urban ZIP code. Based on weekly hours reported at each recipient's primary and secondary practice site, 97.0 percent of total reported FTE was in rural practice sites and only 3.0 percent was in urban practice site. About 3.0 percent of reported FTE was at remote practice sites.

Subsidy recipients from 2018-2026 reached 62 of Oregon's 104 rurally designated Service Areas (59.6 percent), including half of the 18 remote Service Areas. Figure 22 describes the counts of RMPIS recipients in each Service Area.

ORH identifies the level of unmet need by Service Area using "Areas of Unmet Health Care Need (AUHCN)" scores, which include a primary care capacity ratio that measures primary care supply versus demand in a particular area. A ratio less than 1 indicates that demand for primary care exceeds supply (unmet need). Among recipients working in primary care specialties (general practice, family medicine, internal medicine, geriatrics, pediatrics, and obstetrics and gynecology), the primary care capacity ratio of recipient's practice location service area was used to determine the distribution of subsidy recipients in areas of unmet need. Over two-thirds (69.5 percent) of subsidy recipients practice in a Service Area with a primary care capacity ratio less than the state overall ratio (≤ 0.99). The primary care capacity ratio used in this analysis reflects 2026 conditions of need, while awards were made from 2018 onward. Scores may therefore not reflect the level of unmet need at the time of award.

Figure 22. Geographic distribution of Rural Medical Practitioner Insurance Subsidy recipients across Oregon Service Area locations*, 2018-2026



Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026; ORH Oregon Service Areas from the Areas of Unmet Health Care Need, 2026.

***Based on the Service Area of their primary practice location.**

Duration of Service

ORH participant data tracks the number of years each participant remained eligible for and received the subsidy. Among 2018-2026 recipients, about one-third of recipients received the subsidy for one to two

years (34.0 percent, n = 334). About one-fourth received the subsidy for three to four years (22.8 percent, n = 218), and a similar proportion received it for five to seven years (24.0 percent, n = 234). Less than one-fifth of recipients received the subsidy for eight years or more (19.7 percent, n = 192). While providers may lose eligibility for reasons other than leaving rural practice or reducing their proportion of time in rural practice (e.g., not renewing their eligibility status

with ORH), duration of eligibility is an imperfect proxy for duration in rural practice.

Evaluation of Program Adoption

Given the limited information available on RMPIS recipients’ practice organizations, we were unable to characterize organizational participation of RMPIS recipients.

Demographic Characteristics of Recipients

Demographic data were collected from RMPIS recipients from October 2024 to March 2026 and were available for 423 of 477 recipients (88.7 percent). Because some participants had missing data or declined to provide demographic information, these findings may not be representative of all recipients. Among 2024-2026 recipients who reported race/ethnicity information, about 16 percent identified as American Indian or Alaska Native, Asian, Multiracial, Black or African American, Hispanic or Latino/a/x/e, or Middle Eastern or North African as shown in Table 69. About 5 percent of RMPIS recipients (n = 18) reported using a language other than English, with Spanish most commonly reported. Information on disability was collected, but results were suppressed due to small numbers.

Table 69. Rural Medical Practitioner Insurance Subsidy (RMPIS) Recipients by race/ethnicity, 2024-2026 (n = 423)

Race/ethnicity	Number of recipients	Percent of recipients
White	270	63.8%
Asian	48	11.3%
Hispanic or Latino/a/x/e*	5*	1.2%*
Multiracial*	5*	1.2%*
American Indian or Alaska Native†	-†	-†
Black or African American†	-†	-†
Middle Eastern or North African†	-†	-†
Another race	35	8.3%
Don't Know/Unknown	51	12.1%

Data Source: ORH participant data for reporting period October 2024 - March 2026.

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

†Estimate suppressed due to small numbers; statistically unreliable.

Evaluation of Program Effectiveness

Contribution to Direct Patient Care

ORH participant data provides the average hours worked by RMPIS recipients at their primary and secondary (if applicable) practice sites. While the data do

not specify whether these hours represent direct patient care, hours worked at practice sites are a reasonable proxy for direct patient care hours.

Among all RMPIS recipients from 2018-2026, recipients reported spending an average of 37.5 hours per week at their reported practice sites. Average weekly hours reported by physician and nurse practitioner recipients were similar (37.5 hours vs 37.3 hours, respectively).

Providers must work at least 60 percent of their reported hours in a rural practice site to maintain program eligibility. Among RMPIS participants from 2018-2026, the average percent of weekly hours reported in a rural practice location was 99.1 percent. Average percent of weekly reported hours in rural practice was similar between physicians (98.8 percent) and nurse practitioners (100.0 percent).

Recipient-Reported Program Impact

Among the 152 current RMPIS program participants surveyed, 23 responded (response rate: 15.1 percent).

Impact on Decision-Making and Retention. Respondents most commonly reported that the subsidy reduced financial stress (82.6 percent, n = 19) and helped them remain at their current practice site (65.2 percent, n = 15). Seven (30.4 percent) respondents noted that the program significantly influenced their decision to remain at their current practice site. In contrast, only 21.7 percent (n = 5) reported that the program influenced their decision to practice in a rural or underserved area, and 39.1 percent (n = 9) reported that the program did “not at all” influence their decision to take a position in a medically underserved or rural area. This suggests the subsidy had a greater influence on respondents’ choice to remain at their current rural practice than in attracting them to rural practice in the first place.

[The subsidy] began after I began working in [rural community], so did not influence my decision to practice in a rural setting but it has been greatly appreciated.

One respondent stated,

Participant Assessment of the Program. Most respondents viewed the application process (78.3 percent, n = 18) and eligibility requirements (73.9 percent, n = 17) positively (Table 70 - Table 72). Fewer respondents (34.8 percent) selected communication with program staff as something that worked well. The most frequently reported challenge was reliance on renewal reminders and the associated risks of coverage lapses (78.9 percent). The most commonly requested improvement to the program was an increase in the subsidy amount (81.0 percent, n = 17). This aligned with qualitative feedback, which noted that the subsidy has not kept pace with premium increases. One respondent noted:

Table 70. Participant feedback on what worked well regarding the Rural Medical Practitioners Insurance Subsidy (RMPIS) Program, 2026

Unfortunately, the subsidy has simply not kept up with rapidly rising

Aspects of the RMPIS program that worked well (n = 23)	Number of respondents	Percent of respondents
Application process was clear and easy to complete	18	78.3%
Eligibility requirements were easy to understand	17	73.9%
Communication with program staff was easy	8	34.8%
Insurance subsidy amount was sufficient	5	21.7%

Data Source: Current RMPIS participant online survey, administered by email, May 20, 2026 to June 8, 2026. N = 23 respondents (15.1% response rate). Respondents could select more than one response; therefore, percentages do not sum to 100.0%.

Table 71. Participant feedback on challenges experienced regarding Rural Medical Practitioners Insurance Subsidy (RMPIS) Program, 2026

Challenges in participating in the RMPIS program (n = 19)	Number of respondents	Percent of respondents
Reliance on renewal reminders and potential for lapses	15	78.9%
Risk of losing subsidy when switching carriers or practice sites	6	31.6%
Rigid quarterly application and eligibility timing	3	15.8%

Data Source: Current RMPIS participant online survey, administered by email, May 20, 2026 to June 8, 2026. N = 23 respondents (15.1% response rate) although response rates vary by survey question with 19 respondents to this question. Respondents could select more than one response; therefore, percentages do not sum to 100.0%.

Table 72. Participant feedback on improvements regarding Rural Medical Practitioners Insurance Subsidy (RMPIS) Program, 2026

Most requested improvements to the RMPIS program (n = 21)	Number of respondents	Percent of respondents
Increase the subsidy amount	17	81.0%
Simplify the application process	8	38.1%
Improve communication from program staff	7	33.3%

Data Source: Current RMPIS participant online survey, administered by email, May 20, 2026 to June 8, 2026. N = 23 respondents (15.1% response rate), although response rates vary by survey question, with 21 respondents to this question. Respondents could select more than one response; therefore, percentages do not sum to 100.0%.

Survey respondents were asked about reasons they had or might consider changing liability insurance carriers. Respondents consistently reported that carrier changes were driven almost entirely by disruption in the Oregon Medical Association’s (OMA) carrier relationship. These included the end of the OMA discount, a move from one carrier to another to stay in the OMA program,

and a coverage gap when no successor carrier was in place at renewal. The remaining respondents cited cost.

Respondents offered several suggestions for improving the program in addition to increasing the subsidy amount noted above. The suggestions included approaches to improve the program's reach and inform more potential applicants about the program (Figure 23).

Figure 23. Suggestions for improving Rural Medical Practitioners Insurance Subsidy (RMPIS) Program, 2026



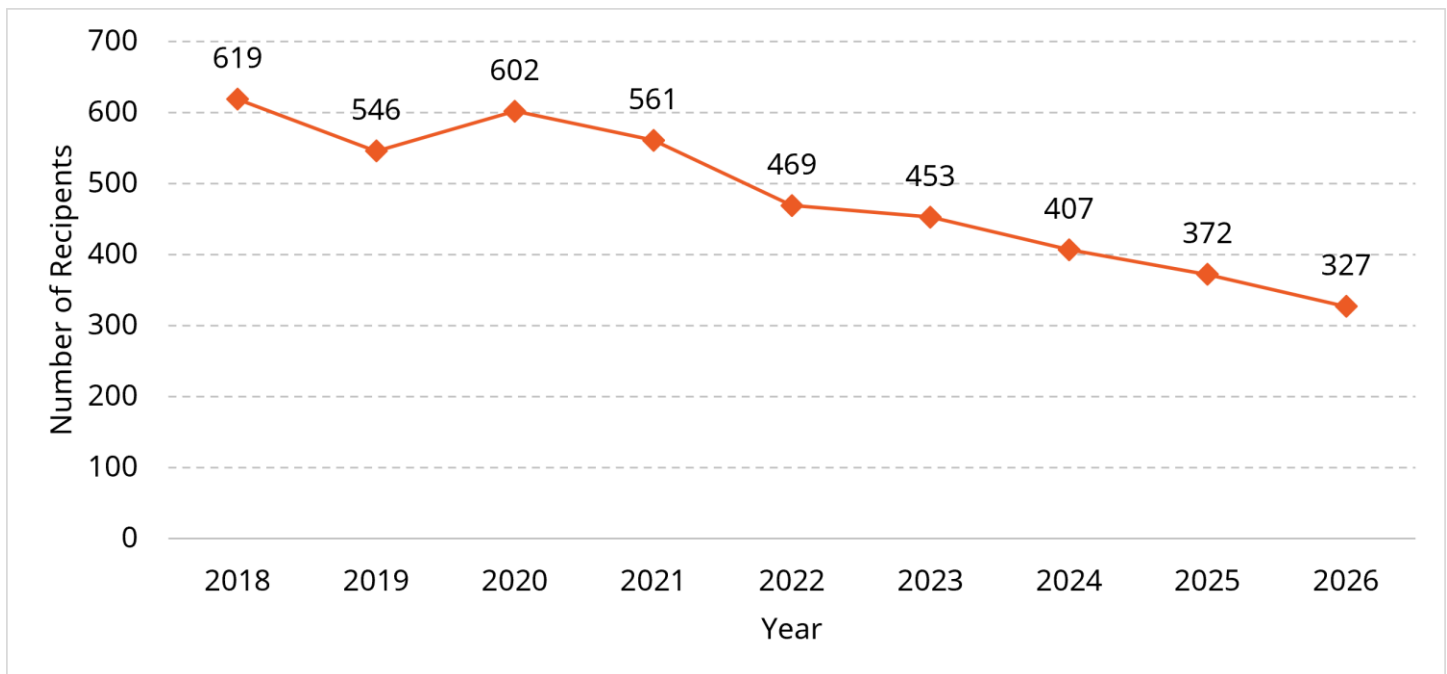
Data Source: RMPIS participant online survey, administered May 20, 2026, to June 8, 2026. N = 23 respondents (15.1% response rate).

Evaluation of Program Implementation

ORH participant data does not provide information on individual-level funding amounts, limiting our ability to compare funding amounts with levels of workforce need.

Between 2018 and 2026, the number of RMPIS recipients has decreased (Figure 24). Participation was highest in 2018 and increased slightly from 2019 to 2020. Since 2020, the number of recipients has declined each year.

Figure 24. Rural Medical Practitioner Insurance Subsidy (RMPIS) Recipients by year, 2018-2026



Data Source: ORH participant data for reporting period 04/01/2018-06/30/2026. Recipients may qualify for multiple non-consecutive years.

Evaluation of Program Sustainability (Maintenance)

Between 2020 and 2026, the number of RMPIS recipients has declined. Similar declines in RMPIS participation were observed in prior provider incentive evaluations, going back to 2010-2015, as noted in the 2016 evaluation report by the Lewin Group.⁽⁴⁾ This suggests sustained declines in participation in RMPIS over the past decade.

RMPIS provides funding to insurance carriers on behalf of recipients on a monthly or quarterly basis (depending on carrier). Funding for RMPIS is subject to biennial appropriation to HCPIF.

Tax Credit

Rural Practitioner Tax Credit (RPTC)

Background

The Rural Practitioner Tax Credit (RPTC) was created by Senate Bill 438 (1989) and administered by ORH under ORS 315.613. RPTC is an eligibility-based

program that allows qualifying health care professionals practicing in rural areas to receive state income tax credit through an application and certification process. Providers must apply to the ORH, which reviews eligibility and submits approved provider information to the Oregon Department of Revenue (DOR). The program does not include a service obligation, competitive award process, or capped funding allocation. Eligible practitioners may participate in consecutive or non-consecutive years, up to a lifetime maximum of 10 eligible tax years and may concurrently participate in loan repayment programs. Data for the RPTC program evaluation was obtained from ORH. Eligible professionals include physicians (MDs, DOs), podiatrists, NPs, PAs, dentists, certified registered nurse anesthetists, and optometrists.

Key Takeaways

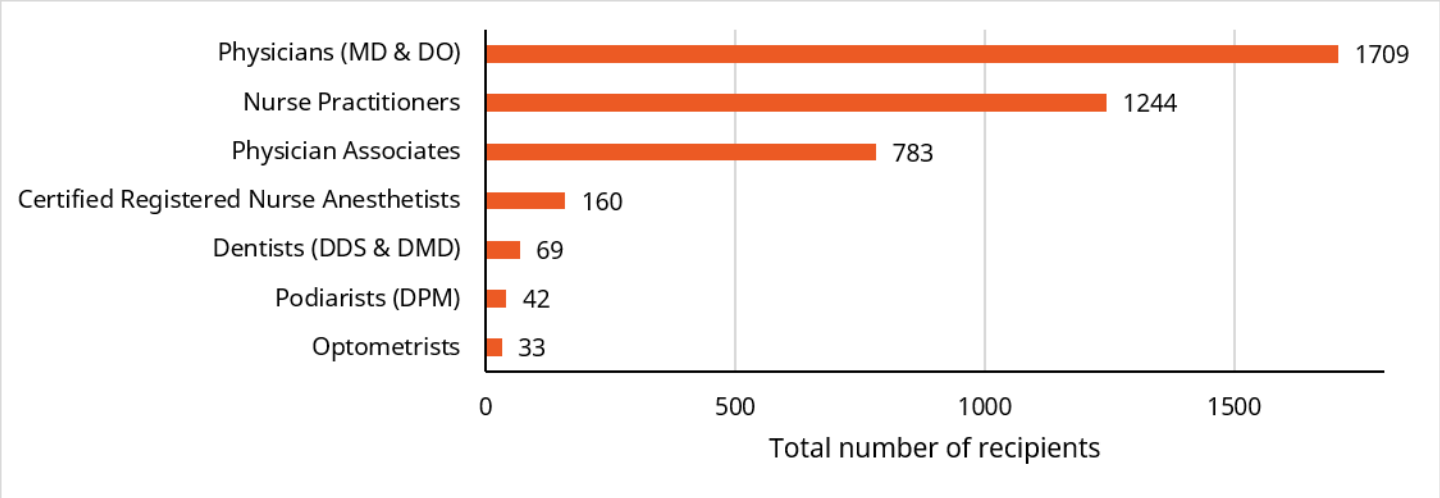
- RPTC provided \$63.3 million in credits to 4,043 providers in tax years 2018 through 2025. Recipients practiced in 91.3 percent of rural and 94.4 percent of remote Service Areas.
- Participation was stable from 2018 to 2023 (2,015 to 2,091 recipients per year), though physicians fell from 46.3 to 38.5 percent of recipients. Recipients claimed the credit for an average of 3.9 years, and 37.3 percent claimed it for five or more years. Demographic and practice-hours data are not collected, so equity and effectiveness cannot be assessed.

Evaluation of Program Reach

Provider Type, Discipline, and/or Specialty

The RPTC program reached 4,043 unique providers across tax years 2018 through 2025 (Figure 25). Physicians comprised the largest single discipline (42.3 percent), followed by NPs (30.8 percent) and PAs (19.4 percent). Together, these three disciplines accounted for 92.4 percent of recipients. Certified registered nurse anesthetists (4.0 percent), dentists (1.7 percent), podiatrists (1.0 percent), and optometrists (0.8 percent) accounted for the remainder. Discipline was missing for three recipients (0.1 percent).

Figure 25. Unique tax credit recipients by provider type*, Rural Practitioner Tax Credit, 2018-2025



Data Source: ORH participant data for reporting period covering tax years 2018-2025. Tax years 2024 and 2025 are not complete at the time of data extraction because amended returns may be filed in subsequent years. Counts for these years are provisional and understate final participation by an unknown amount.

***Three providers with missing discipline data are not shown.**

Annual RPTC participation ranged from 1,620 recipients (2025) to 2,091 (2021) (Table 73). Individual providers may be represented in multiple years because they can participate in the RPTC program for more than one year. Recipient counts in 2024 and 2025 are provisional, as providers may amend their previous tax returns up to three prior tax years from the original filing deadline. As such, the 2024 and 2025 tax years are amendable until the tax filing deadline in 2027 and 2028, respectively.(5)

Although the total number of recipients was stable from 2018 to 2023, the mix of disciplines changed. Physician recipients declined from 962 in 2018 to 776 in 2023 (19.3 percent fewer), while physician associate recipients increased from 365 to 431 (18.1 percent more) and nurse practitioner recipients increased from 592 to 648 (9.5 percent more). Physicians made up 46.3 percent of recipients in 2018 and 38.5 percent in 2023. The available data do not indicate whether this shift reflects changes in the rural workforce, in eligibility, or in claiming behavior.

Table 73. Tax credit recipients by discipline and tax year, Rural Practitioner Tax Credit Program, 2018-2025

Provider type	2018	2019	2020	2021	2022	2023	2024*	2025*
All recipients	2,080	2,052	2,090	2,091	2,057	2,015	1,943	1,620
Physicians (MD/DO)	962	892	901	875	842	776	727	544
Nurse practitioners	592	616	646	662	649	648	630	567
Physician associates	365	381	381	393	404	431	445	408

Provider type	2018	2019	2020	2021	2022	2023	2024*	2025*
CRNAs	86	84	80	80	87	77	61	43
Dentists (DDS/DMD)	29	33	30	37	31	32	31	21
Podiatrists (DPM)	26	24	30	22	22	25	23	16
Optometrists	20	22	22	22	21	25	24	21

Data Source: ORH participant data for reporting period covering tax years 2018-2025.

Annual columns are person-years and do not sum to the total of 4,043 unique providers because recipients may claim the credit annually for up to 10 years. Counts for providers with missing discipline (one in 2022, one in 2023, two in 2024) are included in annual totals but not shown separately.

***Tax years 2024 and 2025 are not complete at the time of data extraction because amended returns may be filed in subsequent years. Counts for these years are provisional and understate final participation by an unknown amount.**

Locations of Service

Rural practice is a condition of eligibility for the RPTC Program; 4,008 of 4,043 recipients (99.1 percent) practiced at a rural or remote primary practice site. Remote sites accounted for 331 recipients (8.2 percent), and 33 recipients (0.8 percent) reported an urban primary practice site, which may reflect providers holding qualifying rural sites alongside an urban primary location. Practice urban-rural location was missing for four recipients (0.1 percent). Current practice location data on RPTC recipients only included a primary practice site. Practice locations were classified as urban or rural using the ZIP code of their primary practice site.

Remote practice varied substantially by provider type (Table 74). More than half of dentists practiced at remote sites (n = 36, 52.2 percent), compared with 8.2 percent of recipients overall. Optometrists and certified registered nurse anesthetists also practiced remotely at above-average rates, while physicians and nurse practitioners, the two largest disciplines, were less likely to do so. Because credit amounts increase with distance from a population center, disciplines concentrated in remote areas receive proportionally larger individual credits.

Table 74. Tax credit recipients by rural-urban location of reported primary practice site and provider type, Rural Practitioner Tax Credit Program, 2018-2025 (N = 4,045)

Provider type	Total	Urban	Rural	Remote	Percent Rural or Remote
All recipients	4,033	33	3,669	331	99.2%
Dentists (DDS/DMD)	69	0	33	36	100.0%
Optometrists	33	0	25	-†	100.0%
CRNAs	160	0	140	20	100.0%
Physician associates	781	-†	711	-‡	99.5%
Podiatrists (DPM)	42	-‡	39	-†	-†

Physicians (MD/DO)	1,709	11*	1,582	116	99.4%
Nurse practitioners	1,239	18	1,139	82	98.5%

Data Source: ORH participant data for reporting period covering tax years 2018-2025. Tax years 2024 and 2025 are not complete at the time of data extraction because amended returns may be filed in subsequent years.

Excludes 10 recipients (seven recipients with missing practice location ZIP code and three with missing discipline).

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

†Estimates suppressed due to small numbers; statistically unreliable.

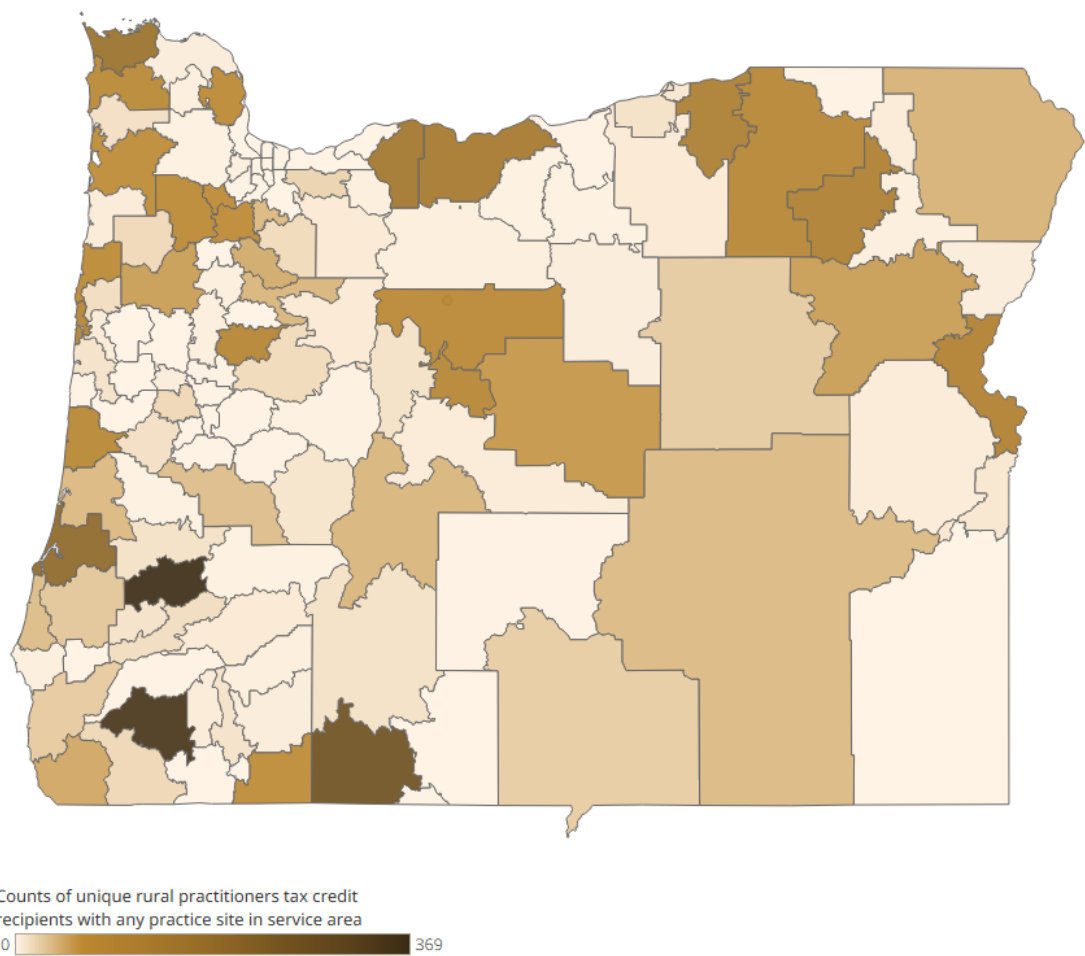
‡Estimates suppressed to prevent backward calculation of other suppressed estimate(s).

Over the RPTC Program period 2018-2025, recipients practiced in 106 of Oregon's 128 Service Areas (82.8 percent), the broadest geographic distribution of any program in this evaluation. Coverage of rural Oregon was near-complete: 95 of 104 rural Service Areas (91.3 percent) and 17 of 18 remote Service Areas (94.4 percent) contained at least one recipient, compared with 11 of 24 urban Service Areas (45.8 percent). Remote Service Areas had the highest coverage rate of any category, consistent with credit amounts scaling upward with distance from a population center. Figure 26 describes the counts of tax credit recipients in each Service Area.

Components of the Areas of Unmet Health Care Need (AUHCN) scores relating to primary care, behavioral health, and oral health need were used to assess the proportion of RPTC recipients practicing in areas of high need for their specialty.

Across primary care, behavioral health, and oral health specialties, the majority of RPTC recipients were practicing in areas of higher need for their specialty than the state average. The primary care capacity ratio was used to measure primary care supply versus demand in a particular area, with a ratio less than one indicating that demand for primary care exceeds supply (unmet need). Among RPTC recipients in primary care (MDs, DOs, NPs, and PAs only, n = 2,387), over half (58.3 percent) were practicing in Service Areas with a primary care capacity ratio less than the state overall ratio (≤ 0.99). Similarly, over three-quarters (79.8 percent) of recipients in behavioral health specialties (n = 178) were working in Service Areas with lower mental health provider FTE per capita compared to the state average (≤ 1.4 provider FTE per 1,000 population), and just over half (50.7 percent) of dentist recipients (n = 69) were working in Service Areas with fewer dentists per capita than the state average (≤ 0.47 dentist FTE per 1,000 population). AUHCN score components used in this analysis reflect 2026 conditions of need, while awards were made from 2018 onward. Scores may therefore not reflect the level of unmet need at the time of award.

Figure 26. Geographic distribution of Rural Practitioner Tax Credit Recipients across Oregon Service Area locations*, 2018-2025



Data Source: ORH participant data for reporting period covering tax years 2018-2025; ORH Oregon Service Areas from the Areas of Unmet Health Care Need, 2026.

***Based on the service area of their primary practice location.**

Duration of Service

The RPTC Program imposes no service obligation; however, duration of participation can be measured as the number of tax years in which a provider claimed the credit. Average participation in the program was 3.9 years. Table 75 reports the full distribution of recipients by years of participation. The distribution appears bimodal: 758 recipients (18.7 percent) claimed in a single year only, while 526 (13.0 percent) claimed in all eight years of the period.

Table 75. Number of tax years in which recipients claimed the Rural Practitioner Tax Credit, 2018-2025 (N = 4,043)

Years claimed	Number of recipients	Percent of recipients
1 year	758	18.7%
2 years	702	17.4%

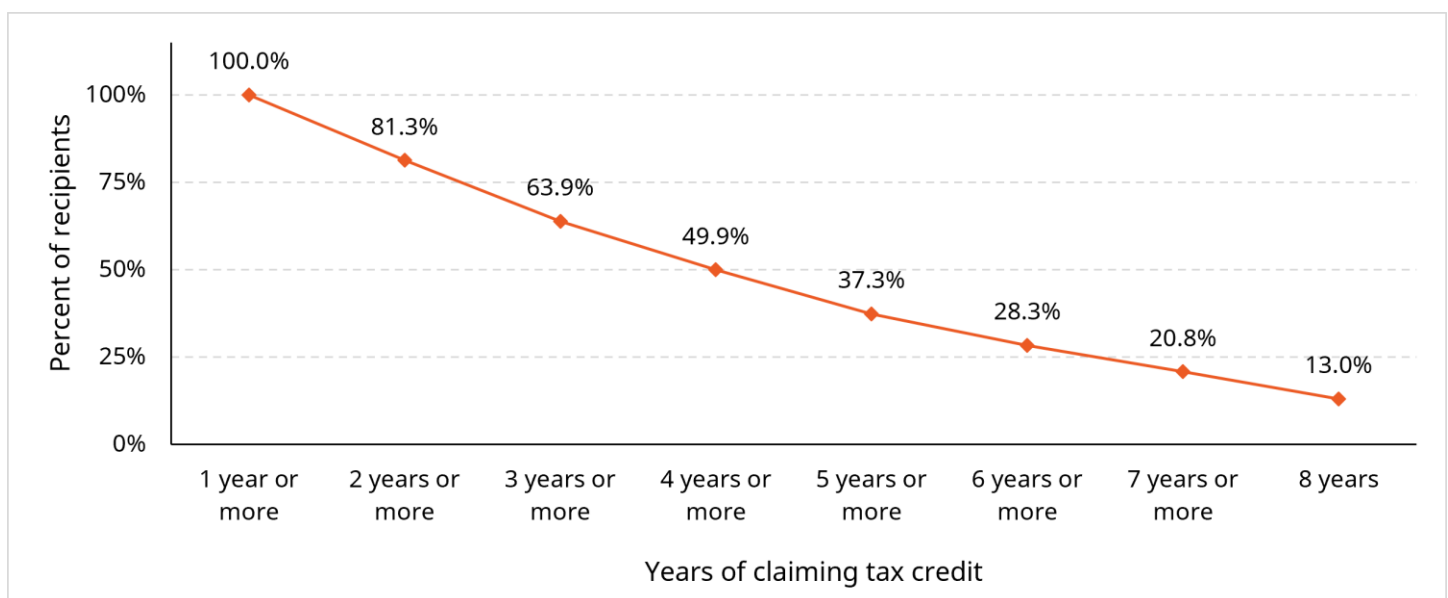
Years claimed	Number of recipients	Percent of recipients
3 years	564	14.0%
4 years	511	12.6%
5 years	363	9.0%
6 years	306	7.6%
7 years	313	7.7%
8 years	526	13.0%
Total	4,043	100.0%

Data Source: ORH participant data for reporting period covering tax years 2018-2025. Data do not distinguish consecutive from non-consecutive years. Counts of recipients for tax years 2024 and 2025 are provisional at the time of data extraction because amended returns may be filed in subsequent years.

Cumulatively, participation declined steadily with each additional year (Figure 27). About half of recipients (49.9 percent) claimed the credit in four or more years, and 37.3 percent claimed the credit for five or more years.

This measure has two caveats of note. First, it counts years claimed, not years at a single site. Providers who move between qualifying rural sites continue to be counted, while providers who stay at one site but practice fewer than the 20-hour threshold (or become otherwise ineligible) do not. The measure also does not distinguish consecutive from non-consecutive years. Second, the cumulative percentages shown in Figure 27 likely understate participation in later years because providers entered the program at different times during the eight-year study period. Those who joined later had less opportunity to accumulate years of participation before the study ended. For example, a provider who first claimed in 2024 could have at most two years of observed participation, even if they continue claiming in future years.

Figure 27. Cumulative percent of Rural Practitioner Tax Credit recipients claiming the credit by number of tax years, 2018-2025 (N = 4,043)



Data Source: ORH participant data for reporting period covering tax years 2018-2025. Note: Data do not distinguish consecutive from non-consecutive years

Note: Percentages are cumulative across the eight-year observation window and do not account for differences in recipients’ length of follow-up. Recipients entering the program in later years had fewer opportunities to accumulate multiple years of claims. Data do not distinguish consecutive from non-consecutive years. Counts of recipients for tax years 2024 and 2025 are provisional at the time of data extraction because amended returns may be filed in subsequent years.

Evaluation of Program Adoption

The types of organizations participating in the program could not be identified because the credit is claimed by an individual on a personal income tax return, and no employing organization, practice site name, or facility type is recorded.

REALD SOGI data are not collected for the RPTC Program, and the demographic composition of recipients could not be described.

Evaluation of Program Effectiveness

Measures of program effectiveness (e.g., contribution to direct patient care or retention) could not be assessed based on available data.

Evaluation of Program Implementation

The program credited \$63,321,820 across tax years 2018 through 2025. Across the six tax years for which data are complete, funding and participation were stable (excluding 2024 and 2025). Recipients ranged from 2,015 to 2,091 annually, and total credited amounts per year ranged from \$8.01 million to \$8.41 million. Providers received an average of \$15,655 from the RPTC across all years of their participation.

The average credit per recipient was stable across all eight years, ranging from \$3,929 to \$4,022. Because credit amounts are determined by a provider’s distance from an urban center, this stability suggests that the mix of recipients across different urban-rural distances did not change much over the study period (consistent with participation data described above).

Table 76. Recipients, total amount credited, and average credit per recipient by tax year, Rural Practitioner Tax Credit Program, 2018-2025

Measure	2018	2019	2020	2021	2022	2023	2024*	2025*
Recipients	2,080	2,052	2,090	2,091	2,057	2,015	1,943	1,620
Total credited (\$M)	8.19	8.18	8.30	8.41	8.08	8.01	7.70	6.45
Average credit (\$)	3,938	3,987	3,970	4,022	3,929	3,975	3,965	3,981

Data Source: ORH participant data.

Total credited across all eight tax years is reported by the source as \$63,327,320. Annual figures sum to \$63,321,820, a difference of \$5,500. Average credit is calculated as total credited divided by recipients for each tax year.

***Tax years 2024 and 2025 are not complete at the time of data extraction and are provisional. The average credit in these years remains within the range observed in all prior years, consistent with incomplete observation of the same population rather than a change in participation.**

Evaluation of Program Sustainability (Maintenance)

Across the tax years with complete data coverage at the time of evaluation (2018-2023), total participation in the RPTC remained steady (2,015 to 2,091 recipients per year), while the share of recipients who were physicians declined and the shares of physician associates and nurse practitioners increased. A higher proportion of providers have claimed the credit for only one to two years compared to providers who have participated for all eight years observed. This suggests the program is reaching new rural health providers and supporting providers who have remained in rural practice. Average tax credit amounts across the years of evaluation remained steady. Because the RPTC is established in statute (ORS 315.613) rather than funded through appropriation, its continuation depends on legislative action; repeal, expiration, or changes to eligibility would directly affect participation.

Other Incentives

Hiring and Retention Bonuses

Hiring and retention bonuses provide one-time payments to recruit or retain staff. Funding is directed to health care organizations, which determine how bonuses are distributed among eligible workers. See Appendix A for information about Oregon's provider incentive programs that involve hiring and retention bonuses.

Clinical Supervision Grants

Clinical supervision grants provide funding to behavioral health organizations to support supervision for providers pursuing licensure. Licensure in counseling, social work, marriage and family therapy, and substance use treatment commonly requires several hundred to several thousand hours of supervised post-degree clinical experience. Access to qualified supervisors may affect how quickly pre-licensed clinicians can complete those requirements. Funds may be used to contract or employ clinical supervisors, to train clinicians to become qualified supervisors, or to hire supervisees and ensure they receive supervision. See Appendix A for information about Community Mental Health

Program (CMHP) Grants, administered under BHWI, which support clinical supervision, among other incentives.

Stipends

Stipends provide funding to health care organizations to offer cost-of-living supports, including housing, relocation, and childcare assistance, as a recruitment and retention strategy. These supports help offset expenses beyond compensation that may affect a worker's ability to accept or remain in a position, particularly in higher-cost and rural communities. See Appendix A for information about Oregon provider incentive programs that offer stipends.

Tribal Set-Aside

Both HB 2949 (2021) and HB 4071 (2022) directed OHA to focus the behavioral health workforce incentive funding to support a number of specific populations and communities, including “Tribal members and Tribal communities”. As a result, a Tribal set-aside was established for the Nine Federally Recognized Tribes of Oregon.

Some Tribes elected to share a portion of this funding with the Native American Rehabilitation Association of the Northwest, the only Urban Indian Health Program in the state, which provides e health services for American Indians and Alaska Natives in the Portland metro region. Program activities are described narratively in Appendix A.

Program Perspectives

A focus group with OHA staff from HCPIP, HOWTO Grant Program, Oral Health Workforce/HRSA grants, and BHWI was conducted on July 30, 2026. The purpose of the discussion was to identify implementation challenges, program sustainability, and issues not captured by quantitative data.

Health Care Provider Incentive Program (HCPIP)

HCPIP staff identified challenges related to defining and measuring program success, particularly across programs with different purposes. Staff noted that upstream career pathway programs and downstream loan repayment programs have different expected outcomes and raised questions about how to assess success when participants do not ultimately enter health care careers. Staff also described limitations in tracking scholarship recipients after participation, including difficulty determining where students ultimately practice.

HCPIP staff also described constraints on program reach and targeting. Retention-focused programs largely depend on providers who apply, which

limits the program's ability to direct providers to areas with the greatest need. Staff reported a 40 percent increase in loan repayment applications in the most recent cycle while funding and staffing remained limited, creating pressure to balance outreach with program capacity.

Staff also identified changes in health care delivery that may not be fully reflected in existing program definitions. They described changes in primary care and team-based care, including the role of urgent care and physical therapy, and raised questions about whether current eligibility criteria encompass the settings and disciplines now contributing to care, particularly in rural and frontier communities.

The Oral Health Workforce representative, who manages HRSA grants outside HCPIP, emphasized the importance of tailoring incentives to individual providers and their circumstances. Staff indicated that loan repayment and loan forgiveness may be more effective when recipients have experience or ties to the communities being targeted or when programs are designed to meet individual provider needs. This discussion also highlighted limitations of a one-size-fits-all approach to incentives. This evaluation does not provide quantitative findings on retention or other outcomes for the Oral Health Workforce/HRSA programs.

HOWTO Grant Program

HOWTO staff described substantial limitations in longitudinal tracking. Data collection generally extends through grant closeout, including no-cost extensions. HOWTO selects projects that create new training programs and have a plan to be sustained beyond the funding period. Staff noted that implementing a new program often takes longer than the three-year grant period and that, particularly for grantees creating new programs, the first cohort of participants may only be completing training as funding ends. Staff described informal follow-up with some grantees after funding ends, but HOWTO does not have the structure or dedicated staffing to systematically track whether funded training programs continue after the grant, or whether participants are employed and retained in the health care workforce.

HOWTO collects summary-level information from grantees rather than individual-level data. Staff described considerable variation in grantee organizations' data capacity, ranging from large clinical organizations to very small teams, making standardized data collection difficult.

Staff also described a tension between reporting participation and assessing longer-term outcomes. They noted that programs are often pushed to report participant numbers, even though getting people trained is only one piece of the pathway to employment and retention. Staff emphasized the need to agree on a definition of success and to tell both the numbers and the impact of

grantees' work. In addition, reliance on organizations to apply for funding may limit targeting of communities with the greatest need, particularly where organizations have limited capacity to develop applications.

Behavioral Health Workforce Incentives (BHWI)

BHWI staff described data infrastructure as having developed largely reactively. The programs were implemented rapidly during the COVID-19 period using American Rescue Plan Act (ARPA) funding, without a prospective data plan. Staff reported that data requirements evolved during implementation in response to leadership requests, and that REALD SOGI data requirements were added after programs were already underway. Staff also described limited capacity to conduct detailed data analyses.

BHWI staff provided examples of measures that had to be identified or reconstructed after implementation. For example, the total number of retention bonuses paid was not available until shortly before the focus group, and turnover among hiring-bonus recipients was derived from final surveys administered at the end of the incentive period rather than from prospective tracking.

Staff also described repeated changes in program requirements and limited lead time for implementation. The time required to establish programs and achieve workforce outcomes was viewed as difficult to reconcile with ARPA funding timelines and legislative expectations. Staff emphasized that workforce development requires more time than many funding cycles allow.

BHWI staff additionally raised concerns about the tension between spending time-limited funds within required deadlines and ensuring that funds are deployed strategically.

Cross-Program Findings

Across the programs represented in the focus group, staff identified several common issues. These included limited capacity for data collection and analysis, difficulty tracking participants over time, and challenges aligning program timelines with the time required to observe workforce outcomes. Staff also emphasized that provider incentives operate within a broader workforce environment and cannot, by themselves, address barriers such as housing, childcare, reimbursement, and working conditions.

Staff further emphasized the importance of sustained funding and the ability to adapt programs over time. At the same time, the discussion identified program-specific differences in how success is defined, who can be reached, and what outcomes can realistically be observed. These differences should be considered when interpreting findings across OHA's provider incentive programs.

Data Completeness and Infrastructure

ORH Participant Data (Loan Repayment, Loan Forgiveness, Insurance Subsidy, and Tax Credit)

ORH participant data provided the most complete data source on all loan repayment (HCPLRP, BHLRP, SLRP), loan forgiveness (PCLF), insurance subsidy (RMPIS), and tax credit (RPTC) recipients, providing information on recipient discipline, specialty, and practice locations for service obligation (loan repayment and forgiveness), though data coverage varied across programs, as described below.

One major limitation of the participant data for loan repayment and forgiveness programs is that this data is maintained in such a way that it overwrites each time a participant has a change in status (e.g., from applicant to recipient, completion of a service obligation, application for a continuation award, withdrawal, application to another incentive program, or change in practice site). This mainly impacts accurate tracking of changes to applicant status and practice site locations, as changes occur over time. This limitation did not apply to the RMPIS and RPTC programs.

Some key variations in data coverage were noted in the ORH participant data:

Location of Service or Practice. ORH participant data contained provider practice locations for service obligation (loan repayment and forgiveness) and program eligibility (insurance subsidy and tax credit), including practice site name, address, city, state, county, and ZIP code. HCPLRP and BHLRP provided up to three obligation practice sites, RMPIS provided two practice sites, and PCLF and RPTC data provided only a primary site. Because of this, recipients with more than these numbers of practice sites will not have all their practice locations accurately represented in this evaluation. For the PCLF program, 13 recipients who were currently in their service obligation or had completed their service obligation were missing data on their service obligation practice location (15.7 percent of 83 PCLF recipients who were in or completed obligation).

Incentive amounts awarded. ORH participant data included amounts awarded to individual recipients for the loan repayment, loan forgiveness, and tax credit programs. Individual amounts on insurance subsidy recipients were not available.

SLRP. Due to the small number of SLRP recipients in the ORH participant data (total 13 recipients from 2022-2023), many findings on SLRP recipients by various characteristics could not be reported due to small numbers.

Health Care Workforce Reporting Program (Loan Repayment, Loan Forgiveness, and SHOI)

HWRP provided supplemental data for loan repayment and forgiveness recipients from licensed professions, including information on longitudinal practice location (for retention), reported clinical hours, and telehealth usage.

Because HWRP primarily tracks the licensed health care workforce in Oregon, recipients who are pre-licensed, certified, Traditional Health Workers, Health Care Interpreters, or licensed providers who do not renew their Oregon license (move out of state, leave practice, etc.) are not documented in HWRP. The BHLRP is one program with several eligible pre-licensed and certified professions that had limited data coverage in HWRP. Additionally, linkage to HWRP requires adequate collection of Oregon licensure numbers from recipients, which were inconsistently collected from loan repayment and loan forgiveness recipients in the ORH participant data and not provided for tax credit or insurance subsidy recipients. Response rates to questions collected in HWRP vary, leading to varying data coverage:

- **Retention:** 54.0 percent of HCPLRP (n = 174), 16.8 percent of BHLRP (n = 19), 40.2 percent of PCLF (n = 47), and 34.5 percent of SHOI recipients (n = 48) who had completed obligation had sufficient data for inclusion in retention analyses.
- **Weekly patient care hours:** 80.1 percent of HCPLRP recipients (n = 258), 38.1 percent of BHLRP recipients (n = 43), and 51.3 percent of PCLF recipients (n = 60) had data coverage of weekly patient care hours.
- **Telehealth usage:** 55.9 percent of HCPLRP recipients (n = 180), 38.1 percent of BHLRP recipients (n = 43), and 10.3 percent (n = 12) had data coverage on telehealth usage.

PRISM Survey

Supplementary data on loan repayment (HCPLRP and BHLRP only) and PCLF recipients were available from the PRISM survey, providing self-reported data on provider characteristics (demographics), current work practice and characteristics, work hours and patient visits, and their anticipated plans to remain in various aspects of practice after their service obligation. Response rates to these surveys varied by type of survey and program but were generally low: 15.7-19.9 percent for the end of year (conducted annually while recipients are in service obligation), 46.0-76.9 percent for end of contract (collected at end of service completion), and 15.6-27.8 percent for alumni (conducted at least annually following obligation completion).

REALD SOGI and Demographic Data

Demographic categories used in data collection tools varied between programs and within programs over time. REALD SOGI data was collected for three HCPIP incentives: the Health Care Workforce Scholarship, the Health Care Workforce Career Pathways, and the Health Care Interpreter Retention Incentives programs. Race/ethnicity data was collected in institutional categories using OMB standards rather than REALD SOGI categories for the remaining HCPIP programs including loan repayment (HCPLRP and BHLRP only), PCLF, SHOI, RMPIS, and Behavioral Health Retention Incentives (MHACBO) programs. REALD SOGI collection for these programs began in 2025-2026, with some variation in implementation across programs. REALD SOGI reporting is anticipated in the next evaluation, though future evaluations that include recipient data from years prior to REALD SOGI implementation will be required to reconcile reporting of non-REALD SOGI aligned data. No demographic data was provided on SLRP or tax credit recipients.

Contributions to Direct Patient Care

Data on weekly hours of reported clinical care were primarily available from HWRP on licensed incentive recipients only, with varying response rates.

Average weekly hours worked were only collected in ORH participant data for insurance subsidy recipients, to determine recipients program eligibility (at least 60 percent of their reported hours must be in a rural practice location). However, this data on hours worked from RMPIS recipients did not specify what amount or proportion of their hours were dedicated to direct patient care. This was also the only program that collected hours worked data tied to practice location, allowing for describing the distribution of weekly reported hours by rural-urban practice.

Data on reported weekly hours in direct patient care were not provided for the following programs that served current health care providers: tax credit, SHOI, Health Care Interpreters, and Behavioral Health Retention Incentives.

Services Provided Through Telemedicine

ORH participant data recently began collecting data on telemedicine usage from loan repayment (HCPLRP, BHLRP, and SLRP) recipients in 2025. Because this was recently implemented, only a portion of HCPLRP and BHLRP recipients had telemedicine data available (19.9 percent of HCPLRP recipients, 52.2 percent of BHLRP recipients). This source did not collect data on types of services or proportion of patients served through telemedicine.

Supplementary data on telemedicine usage was provided for licensed recipients in HWRP data for loan repayment (HCPLRP and BHLRP only) and

PCLF. HWRP also does not collect data on telemedicine usage from physicians and physician associates, which highly impacted data availability for this topic.

Data on telehealth usage was not available at time of evaluation for the following programs that served current health care providers: insurance subsidy, tax credit, SHOI, Health Care Interpreters and Behavioral Health Retention Incentives.

Grantee Reporting Data on Scholarship Programs

Grantee reporting data on scholarship programs, including the Health Care Workforce Scholarships and Health Care Career Pathways, provided sufficient individual records of scholarship recipients to report data on recipient program/school, prospective degree, and amount of award, and also allowed for analysis by grantee organization that awarded the scholarships. REALD SOGI data were also available on many recipients (79.5 percent of Health Care Workforce Scholarship recipients and 77.8 percent of Health Care Pathways Scholarship recipients).

The available data does not currently support several evaluation questions that could provide important insights into scholarship program success, including whether scholarship recipients pursue educational pathways toward health careers, how outcomes change over time or across award rounds, and how awards align with areas of greatest unmet workforce needs.

Grantee Reporting on Fee Waiver Programs

Available data for the Health Care Interpreters and Behavioral Health Retention Incentives support description of recipients, credential and program status, award amounts, and REALD SOGI characteristics.

However, the data did not provide information on recipients' practice locations, so the distribution of recipients across Oregon, in rural or underserved areas, or by areas of greatest need could not be described. Baseline practice setting and post-award activity and employment are not recorded and are not available from HWRP given the providers served by these incentives are not licensed. Retention is therefore not reported for these programs.

Summary of Findings

Between 2018 and 2026, Oregon operated at least 20 distinct health care workforce incentives across eleven incentive types, administered by three umbrella initiatives (HCPIP, HOWTO, and BHWI) and by other entities. All findings in this report are descriptive. The evaluation includes no comparison group of providers who did not receive an incentive, and findings describe who was reached, where recipients practiced, and what could be observed following

the incentive period. This section consolidates findings across all incentives, organized by the data elements specified in House Bill 3261. See Appendix F for a literature review of evidence on the effectiveness of provider incentives.

Provider Types, Discipline, and Specialty

Oregon's incentives reach every stage of the workforce pathway, from students in grades 8 through 12 to practicing clinicians and certified behavioral health workers.

Fee waivers for behavioral health certification reached the largest number of individuals. The BHWI-funded MHACBO program recorded 16,341 recipients between July 2022 and June 2024 (Appendix A), and the HCPIP-funded Behavioral Health Retention Incentives covered 4,082 registrations and 481 examinations. The Rural Practitioner Tax Credit reached the next largest number (4,043 unique providers). Between 2018 and 2026, loan repayment supported 322 recipients through HCPLRP, 113 through BHLRP, and 13 through SLRP; loan forgiveness supported 117 recipients; scholarship and career pathways programs supported 152 SHOI recipients, 371 Health Care Workforce Scholarship recipients, and 468 Career Pathways recipients; and the Health Care Interpreter Retention Incentives supported 102 interpreters. Because recipients could participate in more than one program and deduplication is not possible across all programs, counts are presented by program rather than combined.

Demographic Characteristics of Recipients

Where data were available, many incentive recipients identify with a race or ethnicity other than white alone, and many use a language other than English, but differing categories prevent direct comparison across programs.

Among incentive programs that collected race/ethnicity data, the percentage of recipients identifying as American Indian or Alaska Native, Asian, Multiracial, Black or African American, Hispanic or Latino/a/x/e, or Middle Eastern or North African, or Native Hawaiian or Pacific Islander ranged by program (Table 77).

Table 77. Distribution of recipients by race/ethnicity by incentive, where collected

Incentive	Distribution of recipients by race/ethnicity	Data source
Health Care Provider Loan Repayment Program (HCPLRP)	11.5% Hispanic or Latino/a/x/e, 5.3% Black or African American, 3.7% Multiracial, 2.5% American Indian or Alaska Native	Program demographic data, 2018-2026
Behavioral Health Loan Repayment Program (BHLRP)	18.6% identify as Hispanic or Latino/a/x/e; 6.2% American Indian or	Program demographic data,

Incentive	Distribution of recipients by race/ethnicity	Data source
	Alaska Native; 5.3% Black or African American.	2018-2022 and 2024-2026
State Partnership Loan Repayment Program (SLRP)	Data not available/not collected	
Primary Care Loan Forgiveness (PCLF)	10.3% of all recipients identify as Hispanic or Latino/a/x/e	Program demographic data, 2018-2026
Scholars for a Healthy Oregon Initiative (SHOI)	23.7% of all recipients identify as Hispanic or Latino/a/x/e	Program demographic data, 2018-2019 to 2025-2026
Health Care Workforce Scholarships	38.0% identify as American Indian or Alaska Native, Asian, Hispanic or Latino/a/x/e, Black or African American, Middle Eastern or North African, Native Hawaiian or Pacific Islander as primary race or ethnicity	REALD SOGI, 2021-2025
Health Care Workforce Pathways Program	25.7% Hispanic or Latino/a/x/e; 47.6% white	REALD SOGI primary identity, 2025
Healthy Oregon Workforce Training Opportunity (HOWTO) Program	Data not available/not collected	
Health Care Interpreter Retention Incentives	38.7% Hispanic or Latino/a/x/e and 33.3 percent white, alone or in combination. Total number of individuals is not available due to reporting method.	REALD SOGI, 2025
MHACBO Incentives administered by HCPIP (Behavioral Health Retention Incentives)	69.3% white, 13.7% Hispanic or Latino/a/x/e, 12.0% multiracial, 10.1% Black or African American, alone or in combination. Total number of individuals is not available due to reporting method.	Program demographic data, 2025
Rural Medical Practitioner Insurance Subsidy (RMPIS)	1.2% Hispanic or Latino/a/x/e; 1.2% multiracial; 63.8% white	Program demographic data, 2024-2026
Rural Practitioner Tax Credit (RPTC)	Data not available/not collected	

Note: Where a percentage is shown, it is computed as recipients reporting a race or ethnicity other than white alone, excluding those who declined to answer or whose response was not recorded, except where the program reports the measure directly. Some programs/incentives collect race/ethnicity “alone or in combination,” resulting in

overlapping categories; for these programs, the largest categories are listed. Categories are not consistent across incentive programs and are not directly comparable.

Diversity among other dimensions, including languages used, disability, and gender, varied across programs.

- Two in five HCPLRP recipients (40.1 percent) reported using a language other than English, most commonly Spanish (63.6 percent of languages reported), as did 26.9 percent of Health Care Workforce Scholarship recipients and 17.1 percent of Behavioral Health Retention Incentive registrants.
- Among health care interpreter participants, 86.8 percent reported using a language other than English at home.
- Women comprised the majority of recipients across incentives collecting gender data, including 75.6 percent of Career Pathways recipients, 65.8 percent of interpreter participants, 63.8 percent of SHOI recipients, and 62.9 percent of Behavioral Health Retention Incentive registrants.
- Programs either reported gender data or binary sex data (male/female). This summary refers to this data as "gender," acknowledging that some of the programs collected or reported sex data, and may have conflated gender and sex. Gender and sex are not binary, so this data may not represent the diversity of program recipients' genders.
- Reported disability was reported by 11.8 percent of HCPLRP recipients, 25.6 percent of Career Pathways recipients, and 7.5 percent of Health Care Workforce Scholarship recipients.

HCPIP incentive programs now collect REALD SOGI-aligned data, and SHOI began REALD SOGI collection in 2026. Other incentives collect race/ethnicity in institutional or program-specific categories, which are not directly comparable across programs.

Locations of Service

Programs reached the settings they were designed to reach: nearly all recipients practiced rurally where rural practice is required, and loan repayment recipients served in both rural and urban safety-net settings.

Where rural practice is a condition of receiving the incentive, nearly all recipients practiced rurally, as expected (99.1 percent of tax credit recipients; 98.1 percent of insurance subsidy recipients). Where rural practice is a condition of the service obligation, all 70 loan forgiveness (PCLF) recipients with a recorded practice site (100.0 percent) practiced in a rural or remote area. For programs in which eligible sites must serve underserved populations, a criterion encompassing both rural and urban safety-net settings, the rural

proportion was 55.8 percent among HCPLRP recipients and 45.1 percent among BHLRP recipients.

Tax credit recipients practiced in 106 of Oregon's 128 Service Areas. Recipients currently serving or who had completed service obligations practiced in 79 Service Areas for HCPLRP, 43 for BHLRP, 32 for PCLF, and 12 for SLRP. The number of Service Areas reached varies with program size and eligibility criteria, and the magnitude of these counts is not comparable across programs.

Contribution to Direct Patient Care

Recipients reported close to full-time clinical schedules, averaging roughly 32 to 38 hours of direct patient care or clinical work per week.

HCPLRP recipients reported an average of 34.3 weekly hours (SD 10.4) across primary and secondary practice sites (based on HWRP data). Average weekly hours were slightly higher using self-reported PRISM survey data for HCPLRP (36.4 weekly hours, SD 5.6). Weekly hours were similar across most provider types within HCPLRP, ranging from 32.3 hours among expanded practice dental hygienists to 36.9 hours among nurse practitioners.

PCLF recipients had, on average, 34.0 hours (SD 9.5) of direct patient care weekly in HWRP data. As with HCPLRP, average weekly hours reported by PRISM survey respondents were slightly higher (37.5 hours, SD 9.5).

BHLRP recipients had an average of 32.4 hours (SD 10.9) of direct patient care from HWRP data. In PRISM data, behavioral health clinicians reported slightly higher average weekly clinical hours than other provider disciplines (34.2, SD 3.8 vs. 33.4, SD 7.2). Survey-reported (PRISM) average estimates for BHLRP were slightly higher (33.7, SD 5.9).

Insurance subsidy recipients reported 37.5 average weekly hours, on average 99.1 percent of reported weekly hours were reported at a rural practice site.

Services Provided Through Telemedicine

Among recipients asked about telehealth in licensing data, most delivered some care by telehealth, but telehealth made up a small share of HCPLRP visit.

Telehealth estimates differed by data source. In HWRP licensing data, 57.8 percent of HCPLRP recipients (104 of 180) and 86.0 percent of BHLRP recipients (37 of 43) reported delivering some care via telehealth at their current primary or secondary practice location. HWRP does not ask physicians or physician associates about telehealth, so these estimates exclude the 25.8 percent of HCPLRP recipients in those disciplines. In ORH participant data, which began recording telehealth in 2025, 25.0 percent of HCPLRP recipients (16 of 64) and 22.0 percent of BHLRP recipients (13 of 59) reported seeing at least some patients via telehealth. Within HWRP data, telehealth use varied by discipline,

from 95.5 percent among licensed behavioral health providers and 88.9 percent among nurse practitioners to 48.0 percent among expanded practice dental hygienists and 32.3 percent among dentists.

Where measured, telehealth accounted for an average of 2.6 percent of outpatient visits among HCPLRP survey respondents and 21.3 percent among BHLRP respondents (n = 12).

Applications and Awards

Demand for HCPLRP and HOWTO has grown faster than available awards.

Applicant data are collected by the HCPIP loan repayment (HCPLRP and BHLRP) and loan forgiveness (PCLF) incentives. Applications for HCPLRP rose from 76 in 2018 to 231 in 2025 (most recent full year of data), while annual award counts ranged from 32 to 66 over the same period. For BHLRP, the percentage of eligible applicants receiving an award was 15.8 percent in 2021 and 23.9 percent in 2025. For PCLF, the percentage of eligible applicants awarded was 85.7 percent in 2019 and 70.8 percent in 2025.

Retention

Most recipients remained in Oregon after their service obligation ended; fewer remained in the same county.

Post-service retention at one through five years was measured for HCPLRP, PCLF, and SHOI, incentives with individual records linkable to HWRP and with sample sizes sufficient to report. Retention within Oregon was at or above 70 percent or higher at every interval measured through one to five years following completion of the service obligation (Table 78). Retention within the county of service was 83.5 percent at one year and 70.4 percent at five years for HCPLRP recipients, and 79.5 percent at one year and 66.7 percent at five years for PCLF recipients. Among HCPLRP recipients with a rural or remote obligation practice site, 83.7 percent remained in rural practice in Oregon at one year. Among PCLF recipients with available data, 84.1 percent stayed in rural areas of Oregon one year after completing service (37 of 44 included, not tabled).

The number of recipients available for analysis decreased at longer follow-up periods because fewer recipients had reached those time points; therefore, retention estimates at later follow-up periods are based on smaller sample sizes and should be considered preliminary. Retention analyses of BHLRP recipients were also conducted but could only be examined for one to two years because the program is newer, reporting data going back only to 2022, and some BHLRP recipients are not tracked by HWRP because they are certified but not licensed professionals. Future evaluations may have additional years of data to examine more BHLRP recipients.

Table 78. Retention of HCPIP loan repayment, loan forgiveness, and SHOI recipients after completion of the service obligation

Incentive	In Oregon	In the same county
Loan repayment (HCPLRP), 1 year (n = 170)	90.6%	83.5%
Loan repayment (HCPLRP), 3 years (n = 101)	85.1%	73.3%
Loan repayment (HCPLRP), 5 years (n = 27)	77.8%	70.4%
Loan forgiveness, 1 year (n = 44)	93.2%	79.5%
Loan forgiveness, 3 years (n = 36)	100.0%	80.6%
Loan forgiveness, 5 years (n = 18)	94.4%	66.7%
SHOI, 1 year (n = 48)	100.0%	N/A
SHOI, 3 years (n = 34)	91.2%	N/A
SHOI, 5 years (n = 17)	70.6%	N/A

Abbreviations: HCPIP – Health Care Provider Incentive Program; HCPLRP – Health Care Provider Loan Repayment Program; SHOI – Scholars for a Healthy Oregon Initiative. **Denominators differ by interval and decrease as follow-up increases (because recent recipients have not yet reached later intervals). Retention could not be reliably measured for other incentive types due to limited data availability or sample sizes that did not meet the small-numbers reporting threshold.**

Evidence on Effectiveness by Incentive Type

This section summarizes national evidence from the literature review prepared for this evaluation (Appendix F) and compares it with evaluation data reported above.

Table 79 summarizes the comparison, and the sections that follow describe the evidence for each incentive type.

National evidence on provider incentives comes largely from federal programs such as the National Health Service Corps (NHSC), relies on observational or self-reported data, and rarely follows providers after their service obligation ends.(6–8) Like these studies, this evaluation had no comparison group, and because Oregon’s incentives serve populations ranging from high school students to practicing clinicians, outcomes are not directly comparable across incentive types.

Table 79. National evidence and Oregon findings on the effectiveness of provider incentives, by incentive type

Incentive type	Oregon incentives	National evidence	Oregon findings
Loan repayment	HCPLRP, BHLRP, SLRP, OBHLRP	<p>Strongest evidence, particularly for recruitment. Evidence on retention after the obligation ends is mixed and depends on how retention is defined.</p> <p>State programs (14 states): safety-net administrators reported that loan repayment and forgiveness made recruiting easier (81.7%) and quicker (65.4%).(9)</p> <p>State programs (1996 cohort): 93% of physicians in loan repayment, direct incentive, and resident programs completed their service; 66% of loan repayment physicians were still at their service site 8 years after starting.(10)</p> <p>NHSC loan repayment and forgiveness (behavioral health): over 80% of 2012-2020 participants were still practicing in underserved areas in 2021.(11)</p> <p>IHS loan repayment: 76% still working at an I/T/U site four years after the service obligation.(12)</p> <p>Oregon 2016 evaluation: 75-79% of added FTE-years for primary care physicians and 88-90% for NPs and PAs came from recruitment.(4)</p>	<p>Consistent with national evidence.</p> <p>HCPLRP retention overall: 83.5% retained within county at one year; 70.4% at five years.</p> <p>HCPLRP retention for behavioral health providers: 76.5% in county at one year; 58.3% at three years.</p> <p>BHLRP retention: 72.2% in county at one and two years. On average, recipients anticipate about 12 years remaining in rural practice.</p> <p>Insufficient data for SLRP and OBHLRP.</p>
Loan forgiveness	PCLF	<p>Studied together with loan repayment in most national research and shares the same evidence base.</p> <p>State service-option loan programs (forgivable students loans): 44.7% of physicians completed</p>	<p>Retention is high, but comparison with national findings is limited because Oregon does not track service completion or buyouts.</p>

Incentive type	Oregon incentives	National evidence	Oregon findings
		<p>their service and 49.2% bought out of their obligation.(10)</p> <p>Rural-focused training during professional education or residency is associated with future rural practice.(13,14)</p>	<p>PCLF retention in Oregon: 93.2% at one year; 94.4% at five years.</p> <p>PCLF retention in county: 79.5% at one year; 66.7% at five years.</p> <p>PCLF retention in rural practice: 84.1% at one year; 72.2% at five years.</p>
Scholarships	SHOI, Health Care Workforce Scholarship, BHWI scholarships and tuition assistance	<p>Increase the number of graduates; limited evidence on reducing shortages or diversifying the workforce.</p> <p>State scholarship programs: 66.5% of physicians completed their service and 27.2% bought out; scholarship recipients had shorter retention than loan repayment, loan, and direct incentive recipients (HR for leaving 1.96).(10)</p> <p>Across state service programs: 71% of obligated physicians remained at their sites at four years and 55% at eight years, compared with 61% and 52% of non-obligated physicians.(10)</p>	<p>SHOI retention in Oregon: 100% at one year, 91.2% at three years, and 70.6% at five years. 83.5% of SHOI recipients in service practiced family medicine or general practice.</p> <p>Health Care Workforce Scholarship: 23 of 371 recipients completed a service obligation (awards of \$35,000 or more); outcomes for scholarships without a service obligation are not tracked.</p> <p>See Appendix A for BHWI scholarships and tuition assistance</p>
Career pathways and training	HOWTO, Health Care Workforce Pathways, Peer Support Services	<p>Positive short-term effects on career awareness and enrollment; most studies too small to assess long-term workforce effects.(15)</p> <p>HPOG randomized trial (health care training for low-income adults): six years after enrollment, 36.9% of participants worked in a health care occupation, compared with 32.0% of the control group.(16)</p>	<p>Health Care Workforce Pathways: 468 students in the first cycle.</p> <p>HOWTO: At least 1,728 participants trained, including 1,511 new workers.</p> <p>Limited data on credentialing, employment, or retention.</p>

Incentive type	Oregon incentives	National evidence	Oregon findings
Clinical supervision grants	Community Mental Health Program Grants (Set-Aside) (BHWI)	Supervised hours are a documented licensure barrier. May increase the supply of supervisors; no published effect estimates on licensure or retention were identified.	See Appendix A. CMHP grants run through September 2026.
Fee waivers	Health Care Interpreter Retention Incentives, Behavioral Health Retention Incentives, BHWI-MHACBO, ASWB, BLSW	No published evaluations identified. Comparable programs exist (e.g., Massachusetts waived application fees for 13 behavioral health licenses, 2024-2026; California peer support certification fee waivers). Licensing costs and requirements are recognized barriers to workforce entry; among EMTs, more burdensome licensing requirements offset entry associated with increased demand.(17)	Effectiveness measures are challenging to track. See Appendix A.
Hiring and retention bonuses	CMHP Grants, Bonus and Housing Stipend Program, Peer Support Services	Few studies and no published effect estimates identified. Long-term retention may depend more on competitive wages than on one-time bonuses.(18)	Peer Support Services: 1,103 retention bonuses and 87 hiring bonuses. Bonus and Housing Stipend Program (preliminary): 1,292 retention bonuses and 304 hiring bonuses. Retention of bonus recipients is not tracked. See Appendix A.
Stipends (housing, childcare, relocation)	Bonus and Housing Stipend Program, CMHP Grants	Viewed as promising, but no studies isolate their independent effects; no effect estimates identified.	Bonus and Housing Stipend Program (preliminary findings): 100 housing stipends of \$3,000, used mainly to recruit workers from out of state. See Appendix A.
Insurance subsidies	RMPIS	Several states have offered malpractice premium assistance for rural, underserved, or obstetric	65.2% of survey respondents report that the subsidy helped them remain at their

Incentive type	Oregon incentives	National evidence	Oregon findings
		<p>providers (e.g., Maine, New Mexico, Arizona, Georgia, North Carolina); status varies.</p> <p>North Carolina (1988 onward; up to \$6,500 per physician per year): participating counties maintained or increased access to obstetric care, and participating physicians increased obstetric care for Medicaid patients relative to other physicians.(19,20)</p> <p>Oregon 2016 evaluation: the subsidy added 459 FTE-years for primary care physicians, all through retention, and 111 FTE-years for NPs and PAs, about half through recruitment.(4)</p>	<p>practice; 21.7% said it influenced their decision to practice rurally.</p> <p>The number of recipients decreased from 619 in 2018 to 327 in 2026.</p> <p>81.0% of respondents requested a larger subsidy.</p>
Tax credits	RPTC	<p>At least five states currently offer rural provider tax credits.</p> <p>Oregon 2016 evaluation: the credit added 736 FTE-years for primary care physicians, all through retention, and 600 FTE-years for NPs and PAs, 85% through retention.(4)</p> <p>New Mexico: Tax credit program could not be evaluated with the data the state retained.(21)</p>	<p>4,043 providers received \$63.3 million in credits (2018-2025).</p> <p>Recipients claimed the credit for 3.9 years on average; 49.9% claimed it in four or more years and 37.3% in five or more.</p> <p>Broad geographic reach (106 of 128 Service Areas). Effectiveness cannot be assessed with current data.</p>

Note: Sources for national evidence are cited above and in the literature review (Appendix F). Oregon findings are descriptive and do not include a comparison group.

Abbreviations: ASWB - Association of Social Work Boards; BHLRP - Behavioral Health Loan Repayment Program; BHWI - Behavioral Health Workforce Incentives; BLSW - Oregon Board of Licensed Social Workers; CMHP - Community Mental Health Program; EMT - emergency medical technician; FTE - full-time equivalent; GAO - U.S. Government Accountability Office; HCPLRP - Health Care Provider Loan Repayment Program; HOWTO - Healthy Oregon Workforce Training Opportunity Grant Program; HPOG - Health Profession Opportunity Grants; HR - hazard ratio; IHS - Indian Health Service; I/T/U - Indian

Health Service, Tribal, and Urban Indian health programs; MHACBO - Mental Health and Addiction Certification Board of Oregon; NHSC - National Health Service Corps; NM LFC - New Mexico Legislative Finance Committee; NP - nurse practitioner; OBHLRP - Oregon Behavioral Health Loan Repayment Program; PA - physician associate; PCLF - Primary Care Loan Forgiveness; RMPIS - Rural Medical Practitioner Insurance Subsidy; RPTC - Rural Medical Practitioner Tax Credit; SHOI - Scholars for a Healthy Oregon Initiative; SLRP - State Loan Repayment Program.

Loan Repayment

Of the incentive types reviewed, loan repayment has the most extensive national research. Past studies loan repayment programs to easier recruitment, and many participants stay in underserved settings after their service obligation ends.(9–12) Findings on longer-term retention vary with how retention is defined.(6,22) In Oregon, most HCPLRP recipients remained in the same county five years after their obligation, which is consistent with national findings. Same-county retention was somewhat lower among behavioral health providers. Among loan repayment survey respondents, most reported that the program significantly influenced their decision to stay at their practice site, although the response rate was low. BHLRP recipients anticipated about 12 more years in rural practice on average, but retention data were limited to two years. Data were not sufficient to assess SLRP or OBHLRP.

Loan Forgiveness

Most national studies combine loan forgiveness with loan repayment (therefore, they share much of the same evidence base).(9,23) One multistate study found that about half of physicians with forgivable loans bought out of their service obligation prior to serving the full commitment.(10) PCLF data do not record service completion or buyouts, so Oregon's experience cannot be compared with this finding. Among PCLF recipients who completed their obligation and could be linked to HWRP data, 94.4 percent were practicing in Oregon, and 72.2 percent were practicing in a rural area five years later (n = 18). Rural-focused training during professional education or residency is consistently linked to later rural practice.(13,14) PCLF requires applicants to participate in the Oregon AHEC Scholars Program or an approved rural training track, so every recipient had this type of training before receiving an award. This requirement may help explain the high retention. It also means these outcomes cannot be attributed to the award alone, because recipients may already have been inclined toward rural practice.

Scholarships

National evaluations show that scholarships increase the number of health program graduates.(24,25) They work best when awards are large enough to cover fees and living expenses and come with supports such as mentoring and tutoring.(25) Evidence that scholarships reduce shortages or diversify the workforce is more limited. Scholarships that carry a service obligation have a clearer link to workforce outcomes. In one multistate study, scholarship recipients with a service obligation had higher buyout rates and shorter retention than loan repayment recipients.(10) SHOI results in Oregon are encouraging. All recipients remained in the state one year after their obligation and most remained at three and five years, and most practiced in family

medicine or general practice, in line with the program's primary care focus. Most Health Care Workforce Scholarship awards have no service obligation. These awards lower financial barriers for students entering health professions, but their workforce outcomes are not tracked.

Career Pathways and Training Initiatives

Pathway programs show positive short-term effects, including greater awareness of health careers and higher college and medical school enrollment.⁽¹⁵⁾ Long-term workforce effects are harder to study, because outcomes may not appear until years after participation. One of the few randomized trials in this area found that health care training for low-income adults increased health care employment six years after enrollment.⁽¹⁶⁾ Community colleges train a large share of the practical nursing and allied health workforce. They can also open routes into higher-wage roles.⁽²⁶⁾ In Oregon, HOWTO trained at least 1,728 participants, including 1,511 new workers. The Health Care Workforce Pathways Program reached 468 students in its first cycle. These programs are building the early stages of the workforce pipeline.

Supervision Grants

Required supervised hours are among the commonly cited barriers to behavioral health licensure.^(27,28) Supervision grants address this barrier directly. Early evidence from Nebraska suggests they can expand the number of available supervisors.⁽²⁹⁾ Tracking supervisees through licensure would add to a small evidence base.

Fee Waivers

Fee waivers reduce a recognized barrier to entering the workforce.^(17,30) Other states, including Massachusetts and California, have recently adopted them.^(31,32) No published evaluations were identified. In Oregon, fee waiver programs, like Behavioral Health Retention Incentives, have covered thousands of certification registrations, and most examinees passed. Collecting certification renewal data would show whether fee waivers support continued practice.

Hiring and Retention Bonuses

Bonuses are widely used and can help employers fill positions quickly and keep them filled. Few studies have measured their effects.⁽³³⁾ Evidence from nursing suggests they may work best alongside competitive wages.⁽¹⁸⁾ Oregon has issued thousands of hiring and retention bonuses through BHWI-funded programs. Tracking whether recipients stay with their employers (and for how long) would make Oregon one of the few states able to measure the effects of bonuses.

Housing, Childcare, and Relocation Stipends

Stipend supports for costs that rural workforce research often identifies as barriers to recruitment and retention may have an impact on recruitment or retention.(34,35) No studies were identified that isolate their specific effects.

Insurance Subsidies

Evaluations of malpractice insurance subsidies are few but generally favorable. North Carolina's program helped maintain obstetric access in participating counties.(19,20) Oregon's 2016 evaluation found the subsidy added provider FTE-years, mainly through retention.(4) Current findings appear to be consistent with this evidence. Survey respondents most often said RMPIS helped them stay in practice. Declining participation and requests for larger subsidies suggest the program's value may depend on keeping pace with premium costs.

Tax Credits

Published evaluations are limited. Oregon's 2016 evaluation is one of the few to find that a rural provider tax credit added provider FTE-years, mainly through retention.(4) RPTC reaches more of Oregon's Service Areas than any other incentive, and many recipients claim it year after year, which suggests ongoing commitment to rural practice. Linking RPTC records to HWRP data would allow future evaluations to measure retention directly and track recipients over time.

Conclusions Across Incentive Types

Retention findings for HCPLRP, PCLF, and SHOI are in line with national studies showing that most recipients remain in state or in underserved practice after their obligation ends. Oregon cannot yet compare service completion or buyout rates with national studies of loan forgiveness and scholarship programs. Findings for RMPIS and RPTC are consistent with Oregon's 2016 evaluation, which describes these programs as retention and cost-offset tools for providers already in rural practice. For scholarships without service obligations, career pathways and training grants, fee waivers, bonuses, and stipends, neither national research nor current Oregon data can yet establish effectiveness. Several of these incentive types have little or no national research, so outcome data collected in Oregon would contribute evidence that does not yet exist elsewhere.

Recommended Areas of Focus for Health Care Workforce Incentive Planning in Oregon

The following areas of focus follow from the findings above and from the literature reviewed. They concern the design and targeting of Oregon's incentive portfolio; recommendations concerning future evaluations follow in the next section.

Focus Area A. Prioritize incentive programs with robust evidence of effectiveness.

The literature provides the strongest evidence for loan repayment and forgiveness programs, particularly for recruiting providers to rural and medically underserved communities.(6,9,22,36) Oregon could consider prioritizing continued investment in these programs while strengthening evaluation of newer approaches, such as retention bonuses, stipends, and fee waivers, to better understand their effectiveness and inform future funding decisions.

National evidence is strongest for loan repayment and loan forgiveness, and Oregon's retention findings for HCPLRP, PCLF, and SHOI are consistent with that evidence (see section entitled Evidence on Effectiveness by Incentive Type). Evidence is limited for scholarships without service obligations, career pathway programs, hiring and retention bonuses, and housing and childcare stipends, and no published evaluations of fee waiver programs were identified. Published evaluations of rural tax credits and malpractice insurance subsidies are limited; existing evaluations found that both programs function mainly as retention tools. Identifying and integrating outcome measures into future incentives at the time of award (see Recommendations below) would generate evidence where national research is lacking.

Focus Area B. Adopt a single program structure to support consistency.

Behavioral health loan repayment operated under two programs (HCPIP and BHWI) during the evaluation period, with separate eligibility rules, service obligation lengths, and data systems. With OBHLRP concluding in October 2026 (see Appendix A) and BHLRP continuing under HCPIP, a single program structure would support consistent eligibility criteria, obligation requirements, and data collection, and would allow behavioral health loan repayment to be described as one program area in future evaluations.

Focus Area C. Explore contributing factors to decline in incentive program participation.

The RPTC and RMPIS Programs reduce the cost of practice for providers already working in rural areas, and are best understood as retention and cost-offset instruments. Insurance subsidy participation has declined since 2020, consistent with patterns observed in earlier Oregon evaluations, and the available data do not indicate the reason; direct examination of this trend would be informative, particularly because few states offer such programs and published evaluations of them are limited.(4) Data elements that would support these analyses are described in Recommendation 1 below.

Focus Area D. Consider incentives in the context of broader environmental and situational factors.

OHA program staff noted that incentives operate within a broader environment of housing, childcare, reimbursement, and working conditions. Oregon supports several of these conditions through clinical supervision grants, housing stipends, and locally determined needs, and the supervision investment is consistent with documented licensure requirements and with evidence that funded supervision increases supervisor availability.(27–29,37) Continued investment in these and other supports, including childcare, should be considered to strengthen recruitment and retention in rural and medically underserved areas. Because several of these factors, including housing and childcare, fall outside OHA’s scope, progress would likely require collaboration across state agencies and local partners.

Focus Area E. Review alignment between incentive program offerings and current delivery of care.

OHA program staff described changes in primary care and team-based delivery and noted questions about whether current eligibility criteria encompass the settings and disciplines contributing to care in rural and medically underserved communities. A periodic review of eligible disciplines and site types against current delivery patterns, informed by applicant as well as award data, would confirm whether eligibility criteria reflect current practice.

Recommendations for Future Evaluations

Oregon's provider incentive programs have expanded substantially since 2018, and several were implemented rapidly in response to urgent workforce needs. The recommendations below reflect opportunities to strengthen the data available for future evaluation cycles as these programs continue to mature.

Many were identified by OHA staff themselves during the focus group conducted for this evaluation, and several are already underway, including the expansion of REALD SOGI data collection across health care workforce incentives.

Recommendation 1. Consider adopting a minimum data standard applying to every incentive, regardless of incentive type or administering entity.

Programs currently collect data appropriate to their individual purposes and reporting requirements. A shared minimum set of elements would allow findings to be described consistently across *all incentives* and would broaden the questions future evaluations can address. Five elements would be most useful:

- A persistent, non-identifying evaluation identifier assigned to each individual at the point of award or support, stable across *all programs and years*, so that unique reach can be counted and multiple incentives held by the same person can be identified.
- Discipline, credential, or role, recorded in a controlled vocabulary that includes non-licensed and certified roles alongside licensed disciplines.
- Practice or training site(s) ZIP Code(s) at award and at each follow-up point, so that geographic and need classifications can be evaluated consistently *across all incentives*. For recipients who are current health care providers, a minimum of a primary and secondary practice site ZIP codes should be collected.
- The AUHCN score, HPSA designation, and rural classification of the award site, recorded at the time of award rather than reconstructed at evaluation.
- REALD SOGI collected using OHA's standard instrument, with non-response recorded explicitly.

Data for all programs should be maintained in a way that collects and retains historical data on recipients as they progress through status changes in programs. Ensuring existing records are not overwritten will allow for tracking participants over time as changes occur to their program status and reduce analyst burden in conducting future evaluations.

Recommendation 2. Extend workforce observability to the certified and non-licensed workforce.

Oregon's recent behavioral health investments have supported a workforce that is not currently represented in statewide licensure data, which is consistent with a national gap in workforce data systems.⁽¹¹⁾ Oregon is well positioned to address this, and several approaches could be considered: data-sharing

agreements with certification boards such as MHACBO, which certifies CADC, QMHA, QMHP, and CRM credentials and demonstrated in this evaluation that it maintains detailed individual-level records; linkage to the Traditional Health Worker Registry maintained by OHA, which covers community health workers, peer wellness and peer support specialists, doulas, and personal health navigators (38) and reporting of employment status and practice location by organizational grantees at award and at 12 and 24 months.

Recommendation 3. Include data expectations in contracts and funding opportunity announcements.

Program staff described data requirements that were introduced after programs were operating, and measures that were assembled retrospectively, largely reflecting the speed at which programs were implemented to meet immediate needs. Establishing data elements, definitions, and reporting templates before the first award, and including them in contract language, would reduce this burden on program staff in future cycles. Because grantee data capacity ranges from large clinical organizations to very small teams, templates would benefit from being simple, tested in advance, and accompanied by technical assistance. Reserving a modest percentage of program funds for grantee data capacity would support this. Providing evaluation teams with grantee reports and program data early in the evaluation cycle would also allow more time for analysis.

Recommendation 4. Standardize definitions so that programs can be described consistently.

Several differences in reporting could be resolved without additional data collection:

- Use consistent measures of telemedicine and direct patient care across programs where possible.
- Distinguish awards, supports, and unique individuals in every count reported, including in aggregate reporting.
- Distinguish obligated, allocated, disbursed, and expended dollars.
- Record an explicit zero in reporting templates rather than leaving a cell blank, so that no activity can be distinguished from no report.

Recommendation 5. Apply a consistent retention construct across programs.

Retention can be reported at several nested levels, including the same practice site, Service Area, county, and within Oregon. Applying this approach across programs, measured from a defined starting point (e.g., service obligation

completion, or final incentive receipt for programs without an obligation) at defined timepoints (e.g., one, three, and five years), would allow retention to be measured and compared consistently *across all incentives*. Reporting the denominator, the number not yet eligible for follow-up, and the number missing location data alongside each estimate also supports interpretation.

Recommendation 6. Add measures of the work environment.

Published evidence indicates that organizational conditions, including supervisory support, job resources, role clarity, and technical assistance, are associated with retention in underserved practice.(22,34,35) OHA staff described a similar view, noting that incentives operate within a broader environment of housing, childcare, reimbursement, and working conditions. A short instrument for employers or organizational recipients covering supervision access, caseload, role clarity, and intent to remain, administered at the same intervals as the retention measure, would allow future evaluations to describe the conditions associated with retention rather than retention alone. Reporting the number of supervisees supported and their licensure progression would allow existing supervision investments to be described in future evaluations.

Recommendation 7. Establish a standing method of longitudinal tracking of incentive recipients.

A robust data system that collects longitudinal data from incentive recipients, in partnership with ORH, across the various incentive programs would benefit future evaluations.

For licensed professions, some longitudinal data may be supplemented with a linkage with the HWRP database, ideally keyed to the persistent evaluation identifier described in Recommendation 1. This would allow regular measurement of provider retention and potentially reduce data collection of elements already collected by HWRP, such as demographic, direct patient care hours, and telehealth usage information for some providers. To support this, more complete collection of Oregon license numbers will be required when providers apply for an incentive, with records updated when they obtain their Oregon license. However, because HWRP primarily tracks providers while they remain licensed in Oregon, additional longitudinal data collection of providers who leave Oregon or are certified professionals, Traditional Health Workers, and students will still be required to track all participants. Additional funding and analytic staff capacity will be required to implement a new data system.

Recommendation 8. Consider a staggered schedule for in-depth program evaluation.

Oregon's incentive portfolio has grown substantially since 2018 and now includes that least 20 distinct incentives administered by multiple entities. A staggered approach for evaluation would maintain consistent baseline reporting for all incentives every cycle, including reach, awards, funding, and recipient characteristics, while designating a subset of programs for in-depth evaluation in each biennium. Programs would rotate through the in-depth component on a defined schedule set by OHA in consultation with the HCWF Committee.

This approach would allow more complete examination of the programs selected in each cycle, including outcome measures that require additional data assembly, and could align the depth of evaluation with the timeframes over which different programs produce observable results. Programs supporting individuals still in training, for example, may be most informative when examined at longer intervals, while programs serving practicing professionals may warrant more frequent biennial review.

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