



Oregon Health Policy and Analytics Division
Clinical Supports, Integration, and Workforce Unit

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Oregon Health Care Workforce Needs Assessment – V3 Draft

**Prepared for the Oregon Health Policy
Board**

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



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1. Executive Summary

Sufficient supply of a well-supported health care workforce is necessary as part of the broader systematic goal of ensuring equitable population health outcomes. As such, and in accordance with House Bill (HB) 3261 in 2017, a health care workforce needs assessment is conducted every two years and submitted to the legislature by the Oregon Health Policy Board, in collaboration with the Oregon Health Authority to support the goal of ensuring access to necessary health care for every Oregonian.

This is the sixth report since HB 3261 (2017) passed. Building on past assessments and guidance from the Oregon Health Policy Board's Health Care Workforce Committee, this report specifically focuses on three workforce groups: the primary care workforce, the oral health workforce, and the behavioral health workforce. Specifically, this report:

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

Methods

To assess Oregon's workforce needs, we reviewed multiple Oregon-specific reports and engaged in an extensive literature review. In-depth information on the primary care, oral health, and behavioral health workforce groups in Oregon is mainly based on data analyses from the Oregon Health Care Workforce Reporting Program (HWRP), managed by the Oregon Health Authority Office of Health Analytics. All HWRP data are statewide estimates calculated from 2026 Health Care Workforce Survey data of state-licensed health care workers. We supplemented this with additional state-specific and national data sources on the health workforce as well as population health. Combined, this information supports a comprehensive examination of Oregon's primary care, oral health, and behavioral health workforce and associated needs.

The report is organized into the following sections, each of which are summarized below: Social Determinants of Work, The Health Care Workforce Landscape, the Primary Care Workforce, The Oral Health Workforce, The Behavioral Health Workforce, Population Need and Capacity Across Oregon, and Recommended Areas of Focus.

Social determinants of work

- **The Social Determinants of Work (SDW) are structural conditions that shape an individual's ability to find, keep, and thrive in a job.** The SDW are factors such as housing, childcare, school quality, and broadband access which can impact access to, as well as the strength and sustainability of, the health care workforce.
- **Housing and childcare shortages are substantial:** To meet overall housing demand, Oregon needs about 30,000 additional housing units annually. Currently, 34 of 36 counties in Oregon are childcare deserts.
- **Rural communities face longer travel distances,** limited transportation and broadband, and greater unmet health care needs than urban areas.
- **Oregon has implemented several workforce-supportive policies,** including Medicaid expansion, paid family and medical leave, and protections for lesbian, gay, bisexual, trans, queer, intersex, asexual, and two-spirit (LGBTQIA2S+) workers.

Health care workforce landscape

- **The full impact of Medicaid cuts resulting from the federal HR1 is unclear but will likely impact both provider revenue as well as shift demand** to emergency rooms and urgent care as well as federally qualified health centers and rural health centers.
- **Complex credentialing can impede workforce entry.** To address this, Oregon has pursued reimbursement, supervision, administrative and other credentialing reforms to address these concerns in the behavioral health workforce but has not done the same for primary care or oral health.
- **Oregon provides significant opportunities for health workforce occupations to work at the top of their scope, an important strategy for retention.** Multiple occupations can practice independently in Oregon, including nurse practitioners and clinical nurse specialists, with physician associates able to practice under a collaborative practice agreement with a physician.
- **Oregon has a range of policies supportive of the health workforce.** To support recruitment and retention, particularly in underserved areas, Oregon has instituted several policies and programs, including expedited licensure for physicians, telehealth flexibility, and financial incentives for providers in underserved communities.

Primary care workforce

- **Primary care workforce growth has been driven largely by non-physician providers.** Recent growth in Oregon's primary care workforce was concentrated among nurse practitioners (NPs), physician associates/physician assistants (PAs), and

naturopathic physicians (NDs) while growth among physicians (MD/DOs) was comparatively limited.

- **Clinician supply is increasing faster than direct patient care capacity.** Between 2024 and 2026, Oregon's primary care workforce grew by 6.1%, while estimated direct patient care capacity increased by 4.0%. This gap suggests that growth in the number of practicing clinicians does not necessarily translate into proportional increases in patient care availability. Just under a quarter of clinicians report working more than 40 hours per week.
- **The primary care workforce remains concentrated in urban areas.** Although workforce supply has increased statewide, geographic distribution remains uneven, with many rural and frontier communities continuing to experience workforce shortages and access challenges.
- **Most NPs, PAs, and NDs report working in clinic settings, with MD/DOs spread more evenly across hospital and clinic settings.** Similarly, while most NPs, NDs, and PAs report specializing in family medicine, MD/DOs tend to be spread across family medicine, internal medicine, and pediatrics.
- With respect to practice characteristics, **access to primary care is supported through telehealth and Medicaid provision**, with 84% of primary care workers providing telehealth services and over 75% of MD/DOs seeing Medicaid patients.
- **Workforce demand is expected to increase across most primary care occupations.** Growth is projected to be strongest among NPs, with continued demand for RNs, MAs, PAs, and community-based workers.
- **Workforce diversity remains an opportunity area.** The primary care workforce remains less racially and ethnically diverse than Oregon's population, which may have implications for culturally responsive care and workforce equity goals. However, approximately one quarter report speaking a language other than English.

Oral health workforce

- **Growth in Oregon's oral health workforce has been modest (0.8%), with similar increases among dentists and dental hygienists (DHs).** From 2024 to 2026, the number of actively practicing dentists increased 1.0% and the number of DHs increased 0.6%. Direct patient care capacity grew slightly faster (1.3%), reaching 4,196 FTEs statewide, driven by increases among dentists, DHs, and expanded practice dental hygienists (EPDHs). EPDHs experienced the largest growth, increasing 14.0% in supply and 4.5% in direct patient care FTEs.
- **Workforce distribution is uneven and is concentrated along the I-5 corridor, with ongoing rural access gaps**, with only about one-quarter of the oral health workforce working in rural areas (the lowest levels existing in Gilliam and Sherman counties). Dental therapists remain concentrated in the Portland metropolitan area, with limited

representation in many rural and underserved communities, suggesting opportunities to expand the geographic distribution of this workforce across the state.

- **Relative to the Oregon population, the oral health workforce is less racially and ethnically representative.** One-quarter of the licensed oral health workforce speak a language other than English, but Black or African American and American Indian or Alaska Native populations are under-represented.
- **Medicaid capacity is limited.** Over 35% of Oregon dentists accept Medicaid, with the number of claims increasing by 12.8% from 2023 to 2025. Still, Medicaid dental care seems to be concentrated among a small set of providers, with almost half of all Oregon dentists reporting that less than 50% of their patients carry Medicaid coverage.
- **Training output and retention may not meet future demand.** Dental hygiene and dentistry completions have remained relatively stable, but dental assisting completions have declined over time. Workforce demand is projected to grow along with significant turnover expected among dental assistants reflective of a high number of replacement positions (e.g., workers retiring, changing occupations, or leaving the workforce).

Behavioral health workforce

- **Modest growth of the behavioral health (BH) workforce** is driven by increases in the number of licensed psychiatric nurse practitioners (NPs), licensed clinical social workers (LCSWs), and licensed counselors and therapists (LPCs/LMFTs) over the past two years.
- **Direct patient care capacity remains lower than overall workforce supply.** Between 2024 and 2026, Oregon's behavioral health workforce grew 18.0%, while direct patient care capacity increased 17.5%. Although growth in workforce supply largely translated into additional patient care capacity, there were still considerably fewer direct patient care FTEs (10,825) than actively practicing behavioral health professionals (19,569) in 2026, reflecting variation in time spent providing direct patient care.
- **The distribution of the BH workforce continues to be uneven.** The workforce is concentrated in urban counties. Psychiatric NPs are the most likely to work in rural areas, with a proportion approximately double that of rural psychiatrists.
- **Relative to the Oregon population, the BH workforce is less racially and ethnically diverse.** BH workers are predominantly white, while most other racial and ethnic groups are underrepresented. Clinical social work associates (CSWAs) are the most diverse licensed BH occupation, with higher percentages of Black and Hispanic workers. Certified-only BH workers are younger and more racially diverse than the

licensed BH workforce. A smaller proportion of certified-only BH workers identify as female than in the licensed BH workforce.

- **Telehealth and Medicaid are major components of BH care delivery;** over three-quarters of licensed BH providers offer telehealth services to Oregon residents and just over half of licensed BH providers serve Medicaid-covered patients – mostly by PAs and CSWAs.
- **There are multiple pathways into the BH workforce, but completions from the over 25 BH training programs have decreased across several occupations,** including social work and psychologists. Educational programs are concentrated in the Portland Metro area, which may contribute to regional BH workforce disparities across the state.
- **The BH workforce is projected to grow over the next decade,** with the greatest increase in employment demand expected to be for substance abuse, behavioral disorder, and mental health counselors. However, demand projections are majorly due to future workforce turnover and replacement openings, rather than the creation of new positions.

Population need and capacity across Oregon

- **Birth outcomes are better than the U.S. average in Oregon, while mortality is slightly higher.** Oregon's birth and fertility rates are declining, while low birthweight and infant mortality remain below national averages. All-cause mortality and suicide rates in Oregon are slightly higher than the U.S. average.
- **Oregon's population is slowly becoming more racially and ethnically diverse,** particularly through growth in the Hispanic or Latino/a/x/e population.
- **Approximately one-third of Oregon's population is covered by Medicaid,** while poverty, SNAP participation, and uninsured rates vary across counties and are highest in several rural areas.
- **Structural capacity in Oregon is varied, with more access concentrated on the west side of the state.** There are three counties without a hospital and two with only one documented federally qualified health center or rural health center. Every county has at least one health professional shortage designation, with uneven access to emergency departments and behavioral health services.
- **There has been little change in unmet need overall in Oregon, despite some improvement in underlying measures.** The overall Unmet Need for Health Care score for Oregon is 49.6 out of 90. Lower scores indicate areas with greater unmet need: rural (46.4) and remote (48.8) areas have greater unmet needs compared to urban areas of the state (62.5). Since 2025, Oregon has seen increases in the number of Primary Care Service Areas without any primary care capacity and rates of preventable hospitalizations and dental ED visits. Over the same period, Primary Care

Service Areas without any mental health providers have decreased and the rates of ED visits for mental health and substance use are unchanged.

Recommended areas of focus

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

Recommended areas of focus: Primary care workforce

There are existing supports and work underway to increase capacity of the primary care workforce, including provider incentives such as the Healthy Oregon Workforce Training Opportunity (HOWTO) Grant and loan repayment programs, Patient Centered Primary Care Home program, and actions recommended by the Oregon Health Policy Board's Primary Care Strategy Committee. The following recommended areas of focus build on this work:

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

Recommended areas of focus: Oral health workforce

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

- **Examine reasons for low use of Expanded Practice Dental Hygienist (EPDH) permits.** About a third of dental hygienists hold an EPDH permit, but few use it; understanding why could facilitate greater capacity for preventive oral health care.
- **Continue to track dental therapists and monitor completions from the new dental therapy school in Oregon.** Because dental therapists were only recently approved for licensure, available data are currently insufficient to evaluate workforce trends and needs. Continued monitoring is needed along with the inclusion of dental therapists in future workforce needs assessments. This includes tracking entrants to and graduates of Pacific University's dental therapy program, which enrolled its inaugural class in fall 2026.
- **Facilitate use of expanded function dental assistants,** which can improve efficiency, productivity, and access, especially where shortages exist.
- **Facilitate growth of the DA workforce through apprenticeships and on-the-job training,** an approach employers see as effective for recruitment.
- **Address decreasing completions apparent among the DA workforce** by expanding entry pathways and examining the root causes of this, alongside recruitment outreach and stronger partnerships between DA programs and dental practices.
- **Continue supporting, and potentially grow, incentive programs** targeting oral health, such as with HOWTO and the Health Care Provider Incentive Program loan repayment.
- **Implement targeted work to better track the DA workforce,** including statewide data collection, evaluation of advancement pathways, and cross-agency coordination.

Recommended areas of focus: Behavioral health workforce capacity

The BH workforce continues to grow, supported by provider incentive programs and initiatives such as HB 4083 in 2026 (centralizing credentialing, expanding supervision eligibility, reducing Medicaid credentialing burden). Recommendations here build on this progress:

- **Further examine underlying reasons for the gap between the number of actively practicing BH occupations and reported direct care FTE.** Exact reasons for this are

unknown and deserve further examination, though current research has identified that the emotional demand of the work and administrative load could be contributors. Specific strategies to address this gap include:

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

Broad issues to address

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

- **Address maldistribution of the health workforce through continued investment in grow-your-own programs and rural clinical placements.** Some improvements have occurred (e.g., every county now has a dentist), but gaps persist, particularly in eastern and remote counties. There are many existing supports to build on, including the 2023 telehealth law (Senate Bill 232), rural pathway programs, MA apprenticeships, employer/community-based training programs, provider incentive programs, and the Area Health Education Center Scholars Program. Additional evidence-based models worth considering include:
 - Targeted grow-your-own programs.
 - Further investment in rural clinical placement initiatives.
 - Examining the feasibility of stackable credential pathways (programs where students can obtain a sequential set of credentials or certificates that build toward higher qualifications).

- **Continue efforts to promote achievement of workforce demographics that represent the Oregon population.** Representation varies by occupation; Black/African American, American Indian/Alaska Native, and Hispanic/Latino populations remain underrepresented in several groups, and gender imbalances persist in higher-paying roles. Beyond provider incentive programs, opportunities include:
 - Continue and expand K-12 health career pathway programs in addition to Oregon's Health and Biomedical Sciences career and technical education pathways.
 - Conduct further research into which dimensions of diversity most affect access and outcomes, including intersectional data analyses.
- **Address Social Determinants of Work needs, particularly childcare and housing.** Oregon's childcare assistance programs are not fully funded to meet demand. Other states offer models worth considering, including employer tax credit funds, private-public partnerships to facilitate cost-splitting for childcare, and discounted mortgage/homebuyer programs for health professionals.
- **Seek continued funding and support of strategies to facilitate retention, including supporting the wellbeing of the health workforce.** High replacement openings are expected for DHs, NPs, therapists/counselors, social workers, MAs, and DAs. Effective strategies to support retention require organizational-level policy change (flexible scheduling, career advancement opportunities) and attention to workforce wellbeing, which can be facilitated alongside state-level policy levers (reimbursement improvements, telehealth flexibility, and reduced administrative burden).
- **Assess the workforce and access impacts of Rural Health Transformation Program funding** that addresses needs identified in this assessment, including community-based care programs, workforce development pathways, K-12 career pathways, a new family medicine residency, and preceptor payment initiatives in Eastern Oregon.
- **Continue focusing on robust data collection for Oregon's health care workforce.** Oregon's licensure survey and tracking systems are a notable strength compared to other states. Opportunities to expand include:
 - Standardize additional licensure survey questions to include information on if educated in Oregon and Medicaid acceptance to the nursing surveys; and align future employment plans between MD/DO and PA surveys with others.
 - Consider use of practice setting in addition to specialty to more accurately measure the primary care workforce.

- Continue to build data on the certified workforce (MAs, DAs, and traditional health workers [THWs]), including use of national data sources and partnering with professional organizations to collect data.
- Identify opportunities to further improve tracking of the certified behavioral health workforce across licensure/certification types.
- Add skills-related questions to licensure renewal surveys to help assess skill gaps across experience levels and occupations.
- Add questions to better assess the wellbeing of the health workforce.
- **Establish and track measurable goals over time as decisions are made with where to focus with respect to the above recommendations.** Setting and accomplishing realistic goals will require collaborative efforts across partnering organizations, including governmental representatives, legislators, educational institutions, and health care workforce organizations, to develop appropriate measures, identify relevant data sources, and hold each other accountable in progressing toward desired outcomes.

Conclusion

The findings and recommendations presented in this report highlight the ongoing work in Oregon to support and sustain a thriving health care workforce that provides culturally responsive care. Recommendations provide specific suggestions for expansion of current work or additional areas of focus. Ongoing collaborative work will be needed to prioritize recommendations and establish measurable goals that are tracked over time. This additional work is an important part of moving forward in Oregon's goal of ensuring everyone has local access to the health care they need.

2. Background

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

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

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

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

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

3. Methods

To assess Oregon's workforce needs, we (the report authors) reviewed multiple Oregon-specific reports and engaged in an extensive literature review. In-depth information on the primary care, oral health, and behavioral health workforces in Oregon is mainly based on data analyses from the Oregon Health Care Workforce Reporting Program (HWRP), managed by the Oregon Health Authority Office of Health Analytics. This data contains information on each workforce group's supply, distribution, and population

density across the state, as well as workforce demographics, practice characteristics, and retention factors. HWRP data is collected from state-licensed health care workers when they complete the Health Care Workforce Survey at the time of their license renewal from one of the 17 participating health professional licensing boards. Survey data is then used to estimate the full size and characteristics of the workforce in Oregon.

When describing the supply and distribution of each health workforce, two key variables are used:

1. **Number of actively practicing** = the number of those licensed in Oregon who are also currently working (including volunteers)
2. **Number of Full-time Equivalents (FTEs) dedicated to direct patient care**, where 1 FTE = 40 hours per week of direct patient care

One FTE does not equal one person in that most respondents are engaging in a mix of work that includes direct care, administrative activities, research, education, and other types of work. In addition, some health care workers work part-time and for others, full-time may be 36 hours instead of 40. However, direct care FTE information does provide information on the hours of direct care being provided overall in each workforce group.

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

4. Social determinants of work

The Social Determinants of Work (SDW) recognize that the conditions in which health care workers are educated, recruited and supported shape the strength and sustainability of the health care workforce. These conditions influence factors such as the types of jobs available, the ability to find employment, and opportunities for career

advancement.⁵ Although the primary responsibility for most of the SDW fall outside of OHA's scope, OHA can shape some of the impact of these determinants through health policy reforms, such as through Medicaid payment policies,⁶ workforce incentive programs,⁷ housing stipends, relocation assistance, and related initiatives.^{8,9}

Housing stability and affordability

Oregon has faced a longstanding housing shortage, particularly for low- and moderate-income households, which has contributed to sustained increases in home prices and rental costs across much of the state.^{10,11} State analyses estimate that Oregon will need to add approximately 30,000 new housing units annually over the next two decades to meet current and future demand.¹² Nationally, Oregon ranks as the sixth least affordable state for housing, with one third of households spending more than the recommended 30% of their income on housing.¹³ Regionally, this proportion ranges from 12.9% to 46.3% and is most notable among counties in the western region of the state (see **Error! Reference source not found.** for regional categories by county). In addition, rural communities, communities recovering from the 2020 wildfires, low-income households, and communities of color may face additional barriers.^{11,14}

Transportation

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

Childcare

According to a 2025 assessment, 34 of Oregon's 36 counties are considered child care deserts for households with infants and toddlers, reflecting continuing shortages in licensed childcare capacity.¹⁸ Although availability for preschool-aged children has improved, largely because of expanded public investments through publicly funded early learning initiatives, access remains uneven across rural and underserved communities and is particularly severe in central Oregon.¹⁸⁻²⁰ Affordability also continues to present

barriers for many working families, while limited provider capacity and daycare workforce shortages have contributed to waitlists for Oregon's Employment Related Day Care subsidy program.^{19,21}

School quality

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

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

Digital access

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

Food security

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

Policies supportive of the workforce overall

Oregon has adopted several policies and official positions that provide important support to the workforce. This includes the statewide Paid Leave Oregon program, which

provides eligible employees with paid family, medical, and safe leave, and statewide sick leave protections for most workers.^{32,33} Oregon also has a relatively high minimum wage, with rates ranging from \$14.55 per hour in nonurban counties to \$16.80 in the Portland metro area as of July 2026, and annual adjustments tied to inflation.³⁴ Other workforce-supportive policy include Oregon being a Medicaid expansion state, a refundable Earned Income Tax Credit program, and protections for LGBTQIA2S+ workers.³⁵ Further, the OHA has a dedicated Equity and Inclusion Division to support culturally responsive care, including language access and workforce diversity.³⁶

5. Health care workforce landscape

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

Federal policy changes affecting the health care workforce

Changes to insurance coverage: Federal budget cuts to Medicaid

Recent federal policy changes will likely cause an estimated 200,000 Oregon residents to lose Medicaid coverage, according to a state analysis, which could in turn increase the amount of uncompensated care hospitals provide to uninsured patients.^{37,38} Approximately 1,460,889 Oregonians are currently enrolled in Medicaid, representing about 34% of the state's population.³⁹ Changes to Medicaid reimbursement may have workforce implications, given that hospitals and clinics rely heavily on public insurance reimbursement. When coverage drops, facilities see a decline in revenue, financial margins decline, and hiring freezes or layoffs become more likely.⁴⁰

Rural hospitals may be especially vulnerable to Medicaid reductions given that rural communities tend to have higher poverty rates, less access to employer-sponsored insurance, and poorer overall health outcomes, making Medicaid a disproportionately important source of coverage. Nationally, approximately 25% of people under age 65 who live in rural areas are covered by Medicaid, as well as 22% of people dually enrolled in Medicaid and Medicare.^{41,42}

Some mitigating factors may help offset the potential workforce impacts of Medicaid reductions. In anticipation of federal Medicaid changes, Oregon received approximately \$197 million in federal Rural Transformation funds in 2026 with the potential to receive more in following years.⁴³ The state has also responded to stabilize the workforce given Medicaid cuts: Medicaid insurers received approximately 10.2% higher payments per enrollee in 2026 to stabilize access.⁴⁴

Federal changes to student loans and health professions education

Recent federal student loan changes may affect the health care workforce pipeline. Beginning July 1, 2026, federal borrowing limits are generally capped at \$20,500 annually and \$100,000 in aggregate for graduate students and \$50,000 annually and \$200,000 in aggregate for students in programs classified as professional degrees.⁴⁵ New Graduate PLUS loans, which previously allowed borrowing up to the cost of attendance, have also been eliminated.⁴⁵ Given this, students may need to rely more heavily on scholarships, institutional aid, private loans, or other funding.

Federal changes to affirmative action

Federal policy changes may also affect efforts to diversify Oregon's health care workforce. The 2023 U.S. Supreme Court decision to restrict consideration of race in college admissions, followed by federal actions in 2025 to eliminate or restrict diversity, equity and inclusion (DEI) programs and preferences in federal programs and contracting, may affect recruitment, admissions, and workforce diversity initiatives.^{46,47} These changes may be particularly relevant in Oregon, where workforce diversity and culturally responsive care remain priorities.

Behavioral health Medicaid reimbursement

Although compensation is frequently identified as a barrier to behavioral health workforce recruitment and retention, Oregon has made substantial investments in behavioral health Medicaid reimbursement. For example, House Bill 5202 (2022) appropriated \$42.5 million in state General Fund dollars to increase Medicaid behavioral health provider reimbursement rates by an average of 30%.⁴⁸ With federal Medicaid matching funds, this translated into approximately \$154.5 million in total funding for a rate increase.^{48 49} A 2023 analysis ranked Oregon ninth among U.S. states in Medicaid fee-for-service reimbursement for a common set of mental health services, prior to the new reimbursement rate increase.⁵⁰ Additionally, House Bill 4083 (2026) aimed to reduce non-financial barriers by streamlining credentialing, lowering administrative burden, expanding access to clinical supervision, and reducing delays in Medicaid billing and patient care initiation.⁵¹ Expanding access to supervision is important because many behavioral health professionals must complete supervised clinical experience for independent licensure, and limited access to qualified supervisors can delay career advancement for workforce growth.

Regulatory factors

Credentialing barriers and facilitators

Oregon has standardized certification pathways for THWs, which include community health workers, peer support specialists, peer wellness specialists, personal health navigators, birth doulas, and Tribal THWs.^{52,53} However, other occupations have multiple credentialing pathways with different training requirements, supervision expectations, and scopes of practice. For example, Oregon recognizes at least three types of medical assistant (MA) credentials, each with distinct qualifications and responsibilities.^{54,55} Because MAs are not overseen by a centralized regulatory body, employers are responsible for determining whether candidates are qualified to perform required duties.⁵⁵ These variations can make it difficult to assess whether applicants have comparable skills and competencies. This is similar for other certified occupations, where there is often the option to be trained on-the-job, with competencies verified by the employer (e.g., dental assistants).

Oregon's behavioral health career pathway is similarly complex, with 14 certifying or licensing boards offering 60 credentials and licenses.⁵⁶ The Oregon Higher Education Coordinating Commission notes that navigating this landscape can create barriers to career advancement, particularly when progression between credentials requires additional education, training, or supervised experience.⁵⁶

Scope of practice for advanced practice and other key providers

Expanding health professionals' ability to practice to the full extent of their education and training has been identified as one strategy for improving access to care, particularly in rural and underserved communities.⁵⁷ A large number of occupations can independently practice in Oregon, in addition to physicians.

- **Nurse Practitioners** (NPs, inclusive of Psychiatric Mental Health Nurse Practitioners [PMHNPs]) have full practice authority in Oregon, allowing them to independently evaluate patients, diagnose, treat, prescribe medications, and manage patient care within their population focus and competencies.^{58,59}
- **Physician associates** (PAs) (previously physician assistants) practice and prescribe under written collaboration agreements.⁶⁰⁻⁶²
- **Psychologists, professional counselors, marriage and family therapists, and clinical social workers** can practice independently but do not have prescriptive authority.^{63,60}

Compact licensure agreements

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

complicate state oversight of professional competencies, and create new participation requirements that can create barriers for some professionals. Oregon participates in the physical therapy compact.⁶⁴ However, Oregon is not a compact state for most other major health care professions – cited reasons include different licensure standards in other states, financial and administrative costs, and limited evidence it would substantially contribute to health workforce growth.⁶⁵ Legislation has been considered for nursing, physician associates, social workers, counselors, and psychologists, but has not advanced.⁶⁶⁻⁷² Oregon currently license out-of-state nurses through endorsement, with the number of licenses issued by endorsement now exceeding those issued by examination.⁷³ In addition, Oregon allows out-of-state nurses to practice under temporary 90-day licensure exceptions to address staffing shortages, with the option for employers to request an additional 90 days.⁷⁴

Facilitators for workforce capacity

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

Regulatory strategies

Oregon has pursued targeted regulatory and funding strategies to expand workforce capacity and reduce barriers to practice. For example, expedited licensure by endorsement allows eligible MDs and DOs licensed in other states to obtain Oregon licensure without primary source verification of core credentials, reducing administrative burden and shortening the licensure process.⁷⁵ This is true for nurse practitioners and nurses as well.⁶⁷

Oregon has also taken steps to address supervision barriers in the behavioral health workforce, including HB 2949 in 2021 which allocated \$80 million to address critical behavioral health workforce shortages.⁷⁶ More information on these impacts can be found in the 2027 Provider Incentives Evaluation Report. More recently, HB 4083 (2026) expanded the pool of professionals eligible to supervise Clinical Social Work Associates (CSWAs), which may address ongoing barriers to licensure among this workforce.^{56,77-80} Other initiatives that passed in 2026 include HB 4069 which requires behavioral health employers to establish workplace safety policies and plans and HB 4115 which streamlines background checks by extending their duration and allowing greater portability across care settings.⁷⁸

Expanded telehealth regulations

Oregon's 2023 telehealth law (SB 232) expands pandemic-era flexibilities by allowing certain out-of-state physicians (MDs and DOs) and PAs to provide care with established

patients in Oregon via telemedicine without obtaining an Oregon license in certain situations.^{75,81} The regulation has the potential to help mitigate workforce shortages by extending provider services and improving rural access.⁸²

Area Health Education Centers (AHECs)

Area Health Education Centers (AHECs) provide important infrastructure supporting Oregon's health workforce education and training pipeline for all health care occupations, particularly in rural and underserved communities.⁸³ Oregon's AHECs were established in 1990; the program consists of a central program office at Oregon Health and Science University (OHSU) and five regional AHECs covering the state. Its workforce development activities span the training pipeline, including introducing middle and high school students to health careers, supporting interprofessional education and clinical training, and promoting workforce recruitment and retention.⁸³

Provider incentives programs

Provider incentive programs offer a key strategy for addressing workforce recruitment and retention challenges, particularly in rural and underserved communities where economic and community conditions may make it difficult to attract and retain health professionals. Oregon's Health Care Provider Incentive Program (HCPIP) uses state-funded financial incentives to offset some of these barriers and encourage students and practicing providers to serve populations and communities with greater workforce needs.⁸⁴ The program consolidates multiple funding streams into a single OHA-managed fund to strengthen the workforce and has supported at least 3,585 students and health professionals between 2018 and 2022.^{84,85} Indicators of need relevant to these programs are discussed elsewhere in this report.

Technology and AI

Studies suggest that health IT and automation can improve efficiency and decrease administrative burden, allowing clinicians to focus on patient care (e.g., electronic health records and AI-assisted documentation).⁸⁶⁻⁸⁸ Oregon has taken a cautious approach to AI implementation. In February 2025, Oregon's statewide Artificial Intelligence Action Plan was released which calls for privacy protections, cybersecurity safeguards, workforce training, and ethical oversight of AI across state government, including health care.⁸⁹

Workforce well-being and retention

Employee well-being is an important factor for reducing burnout and supporting health care workforce retention. National research suggests that addressing high workloads, organizational support, and challenging working conditions may reduce burnout, improve job satisfaction, and strengthen workforce retention.^{90,91} As part of the work to support the health care workforce in Oregon, the Oregon Wellness Program offers free,

confidential mental health counseling, education, and research focused on workforce well-being.⁷³

6. The primary care workforce in Oregon

Background

The primary care workforce includes a range of occupations that contribute to the delivery of comprehensive, coordinated, and person-centered care supporting prevention, health promotion, chronic disease management, patient education, and connections to community-based services.^{92,93} They work in a wide variety of settings, helping to ensure access to care for rural and medically underserved populations.^{94,95} Stronger primary care systems are associated with improved population health outcomes, lower mortality rates, greater health equity, and lower health care spending.^{95,96} The following section provides an overview of the supply, distribution, and characteristics of the primary care workforce in Oregon.

Primary care occupations licensed and certified in Oregon

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

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

Primary Care Occupation	Primary Care Area of Practice	Scope of Practice	Minimum Education Required for Licensure
Physicians (MD/DO)	Those who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology.	Independent practitioner	Completion of, at minimum, postgraduate training (internship, residency, or fellowship), following medical school.
Physician Associates (PAs)	Those who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology.	Collaborative Practice Agreement required	Completion of an accredited master's degree PA training program.

Naturopathic physicians (NDs)	Those who specialize in family medicine, pediatrics, geriatrics or obstetrics.	Independent practitioner	Completion of a doctoral naturopathic medical program, optional post-graduate residency program.
Nurse practitioners (NPs)	Those who specialize in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/ gynecology/women's health.	Independent practitioner	Completion of a master's degree in nursing (MSN), or Doctor of Nursing Practice (DNP).
Clinical Nurse Specialist (CNSs)	Those who work in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/gynecology/women's health.	Independent practitioner	Completion of a master's degree in nursing program (MSN), a Doctor of Nursing Practice (DNP), or a post-master's certificate, and must have, or have applied for, an RN license in Oregon.
Registered Nurses (RNs)	Those who work in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/gynecology/women's health.	Supervision required	Completion of an associate degree in nursing (ADN) or a bachelor's degree in nursing (BSN).
Licensed Practical Nurses (LPNs)	Those who work in family practice, geriatrics, pediatrics, internal medicine, or obstetrics/ gynecology/women's health.	Supervision required	Completion of an Oregon State Board of Nursing-approved Practical Nursing program following a high school diploma or GED.

See Methods appendix for definitions independent practitioner and collaborative practice agreement.

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

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

Primary Care Occupation	Primary Care Area of Practice	Scope of Practice	Minimum Education Required for Certification
Medical assistants (MAs)	Health care professionals who support other physicians, physician associates, nurse practitioners, and others through performing clinical and administrative tasks (e.g., scheduling, recording vital signs, drawing blood).	Supervision required*	Completion of an accredited MA program post-high school degree/GED.

Traditional health workers (THWs)	Public health workers certified by the Oregon Health Authority. Six THW types are recognized: community health workers (CHWs), peer support specialists (PSS), peer wellness specialists (PWS), personal health navigators (PHNs), birth doulas, and Tribal traditional health workers (THWs).	Supervision required	Training and certification requirements vary by THW type but require completion of an OHA-approved training program.
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*MAs are not licensed by the State of Oregon and function as supervised unlicensed health care personnel. Some employers may require national certification.

Supply and distribution of Oregon’s primary care workforce

As of 2026, there were an estimated 13,054 licensed independent-practice primary care professionals in Oregon, among which 10,166 were estimated to be actively practicing in Oregon (23.6 per 10,000 population) (**Table 6-3**). These totals only include primary care occupations that can practice independently in Oregon (MD/DOs, NDs, NPs, and PAs) to more accurately estimate the availability of primary care providers in the state. While RNs are important to the primary care workforce, including them in total estimates would lead to overestimations of the workforce. A majority of the actively practicing primary care licenses were MDs/DOs, with 14.8 actively practicing per 10,000 population and NPs (5.3 per 10,000 population). Total FTEs dedicated to direct care were 17.3 per 10,000 population (7,441 total FTEs). Per 10,000 population, direct patient care FTEs were highest among MDs/DOs (10.8), followed by NPs (3.9) and PAs (2.1).

An estimated 13,357 RNs were licensed in 2026 among which 9,964 (75%) were estimated to be actively practicing (**Table 6-3**). An estimated 5,461 RN FTEs provided direct patient care (12.7 per 10,000 population).

Among the certified primary care workforce, there were an estimated 10,603 MAs in Oregon in 2024, and a total of 9,190 active certifications among 7,824 registered THWs. Among active THW certifications, there were 2,392 CHWs, 4,457 Peer Support Specialists, 1,648 Peer Wellness Specialists, 127 Personal Health Navigators, and 566 birth doula certifications (**Appendix Figure 14-1**).

Supply changes over time: Since 2024, Oregon’s primary care workforce has grown by 6.1%, from 9,584 to 10,166 actively practicing primary care professionals in 2026 (**Figure 6-1**). NPs experienced the largest increase in workforce supply, growing by 18.8% (1,936 to 2,300), followed by PAs at 13.7% (1,015 to 1,154) and NDs at 8.9% (336 to 366). The number of actively practicing MD/DOs remained relatively stable, increasing by 0.8% (6,297 to 6,346). Estimated direct patient care capacity increased more modestly, with total direct patient care FTEs rising 4.0%, from 7,124 in 2024 to 7,411 in 2026. Across occupations, NP direct patient care FTEs increased by 17.3% (1,439 to 1,688), followed by NDs at 9.2% (207 to 226) and PAs at 11.3% (794 to 884). In contrast, physician direct patient care FTEs decreased slightly by 0.9%, from 4,684 to 4,643.⁹⁷

Most primary care professionals work in urban locations in Oregon (75.1%; **Figure 6-2**). The highest percentages of professionals working in rural areas were among NPs (36.1% of licensees and 37.6% of direct patient care FTEs) and PAs (32.7% of licensees and 33.1% of direct patient care FTEs). In contrast, NDs (17.2% of direct patient care FTEs) and RNs (19.4% of direct patient care FTEs) were among the lowest. Very few actively licensed primary care occupations also report a practice address in a border state (3.6% of physicians, 0.3% of NDs, 2.1% of PAs; **Appendix Table 14-1**). However, the Oregon State Board of Nursing specifically asks NPs about also being licensed in other states and whether they are actively practicing in those states. Just under one quarter (20.6%) of surveyed NPs who specialize in primary care, and 12.0% of RNs, are licensed and working in Washington in addition to Oregon (**Appendix Table 14-2**).

The distribution of the primary care workforce is concentrated in the western half of the state, with highest total number of licensed primary care professionals in Multnomah County (**Appendix Figure 14-2**). **Figure 6-3** and **Figure 6-4** demonstrate broadly similar county-level patterns of primary care workforce availability, with **Figure 6-3** accounting for direct patient care FTEs and providing a measure of workforce capacity available for patient services. Geographic distribution of workforce capacity is similar across the two maps. However, several counties show notable differences between total clinician supply and direct patient care capacity. For example, Malheur County has one of the highest clinician-to-population ratios in the state (69 clinicians per 10,000 population, **Figure 6-3**) but ranks much lower when adjusted to direct patient care FTEs (18.5 per 10,000 population, **Figure 6-4**), suggesting that a substantial share of clinician effort may be dedicated to activities other than direct patient care. In contrast, Lake County's ranking improves relative to many other counties after adjustment for patient care FTEs, indicating a larger proportion of clinician time devoted to direct patient care.

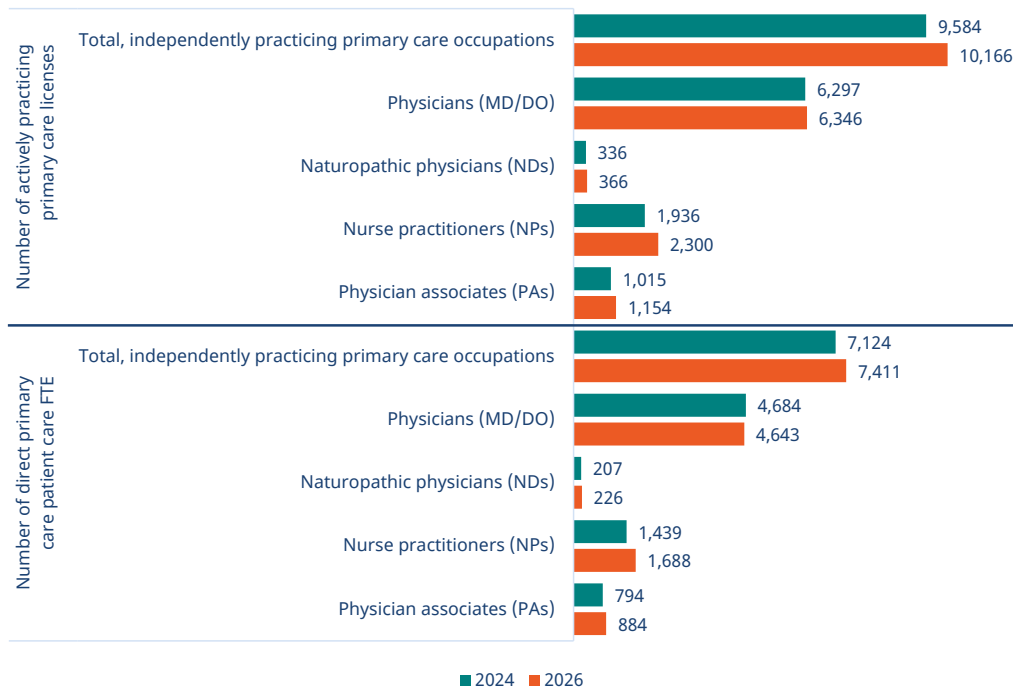
Family medicine represents the largest clinical focus area within Oregon's primary care workforce, particularly among NDs (86.1%), NPs (77.5%), and PAs (69.8%) (**Table 6-4**). Geriatric medicine and pediatric/adolescent medicine were common focus areas among PAs and physicians, and obstetrics and gynecology/women's health represented a substantial area of practice for NDs and RNs.

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

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

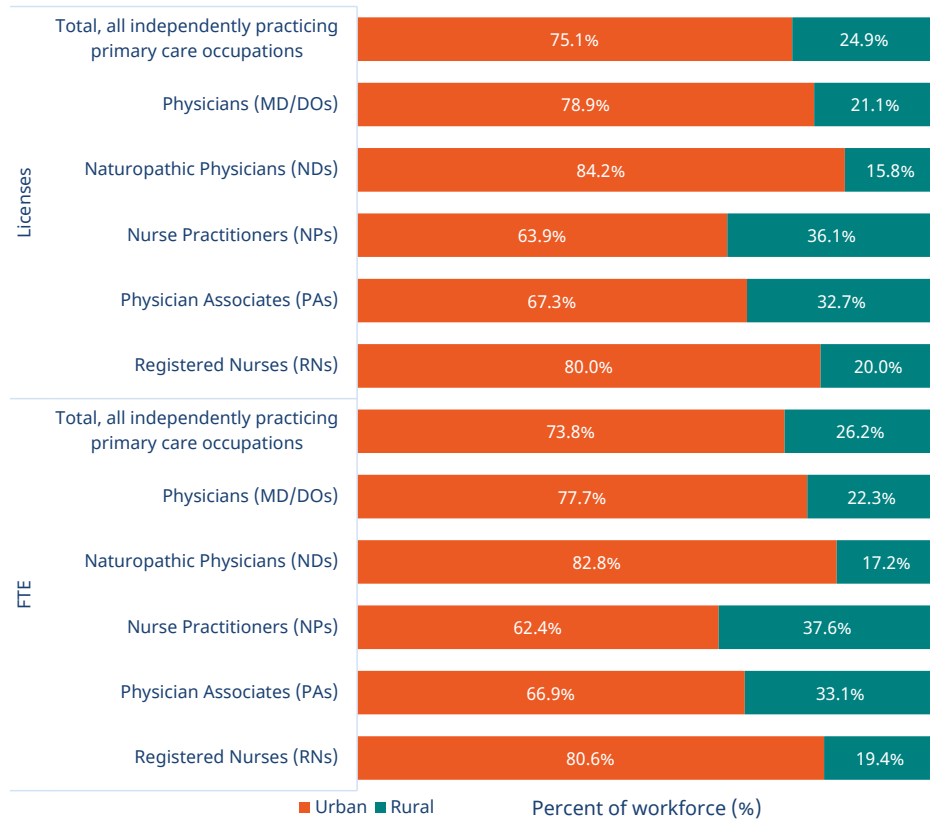
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details, including detailed descriptions of included primary care specialties and FTE calculations. Totals only include occupations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

Figure 6-1. Changes in the estimated supply and direct patient care FTE of the actively practicing primary care workforce licensed in Oregon, 2024–2026



Data Source: Oregon Health Authority, *Oregon Primary Care Workforce: 2024 Data Report (2025)*; Oregon Health Care Workforce Reporting Program, 2024–2026.

Figure 6-2. Estimated supply and direct patient care FTE of the actively practicing primary care workforce licensed in Oregon by rural/urban practice location, 2024-2026



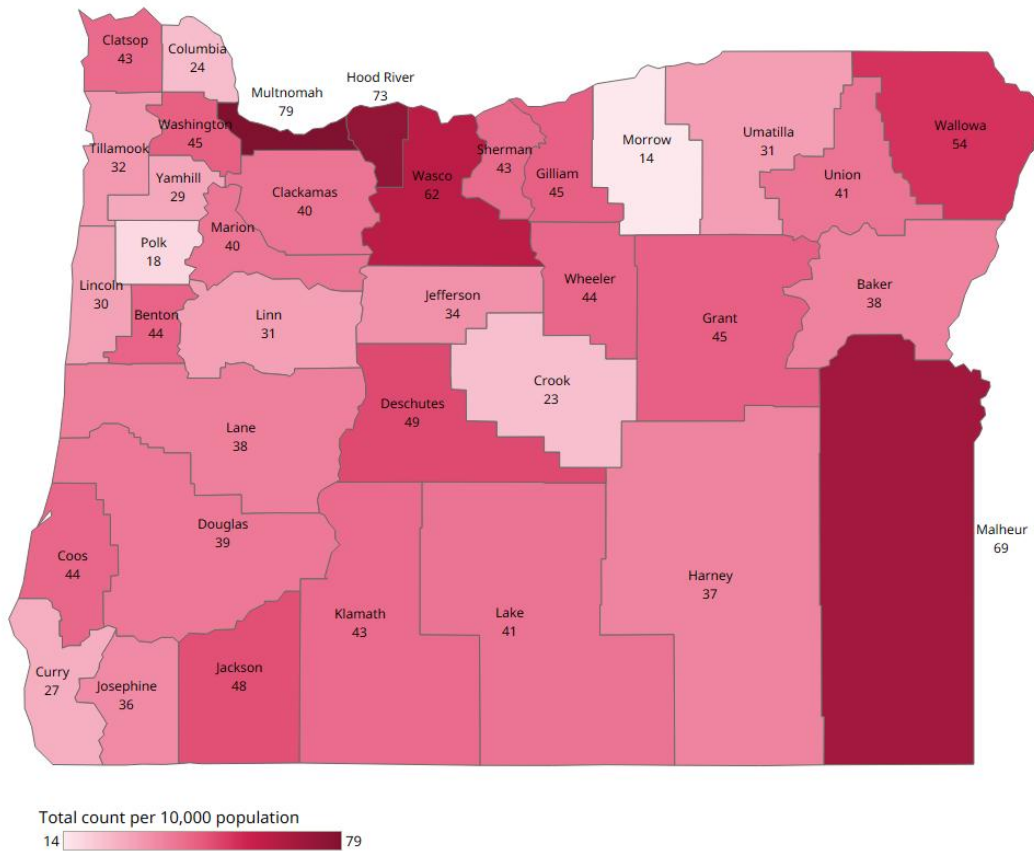
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details (descriptions of primary care specialties, FTE calculations, and rural/urban designation). Totals only include occupations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

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

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

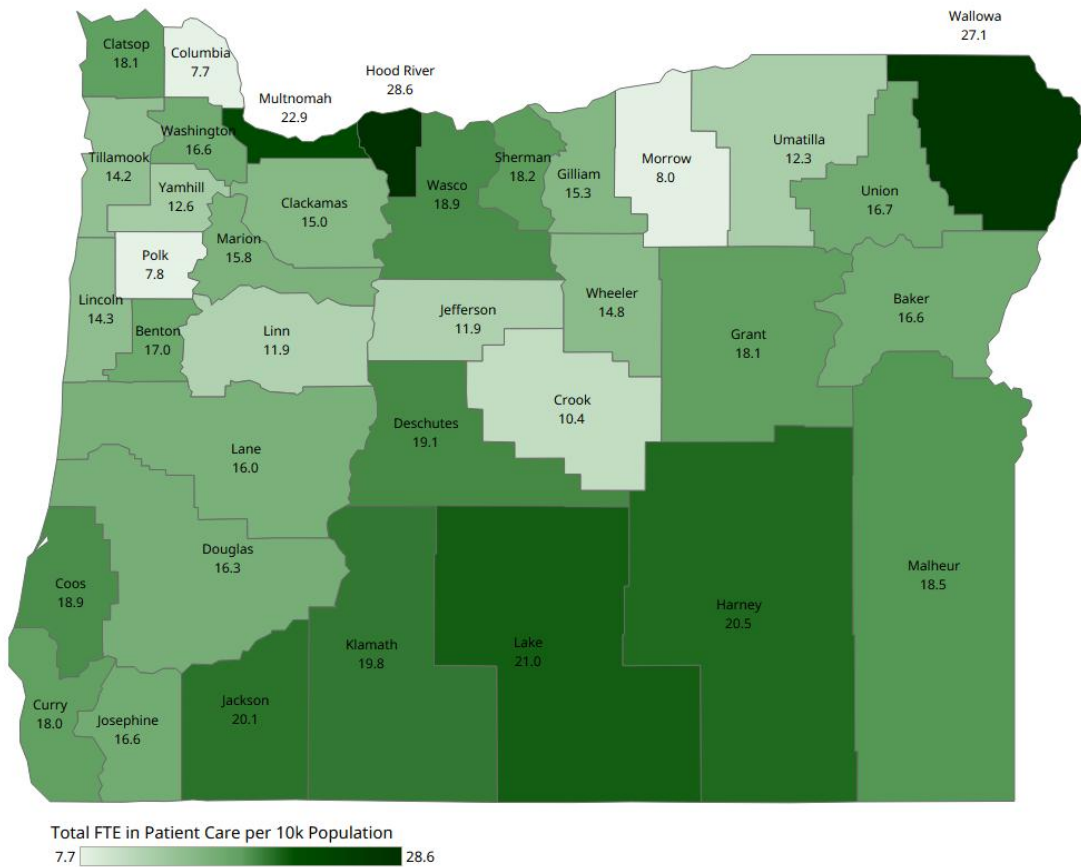
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. "N/A" indicates specialty not available; these occupations are excluded from total calculations. See Methods appendix for more details. Column percentages do not add to 100% as workers can practice in multiple clinical focus areas/specialties. Totals only include occupations that can practice independently to more accurately estimate availability of primary care providers: MD/DOs, NDs, NPs, and PAs.

Figure 6-3. Estimated county-level supply of the actively practicing primary care workforce licensed in Oregon per 10,000 population, 2024-2026



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

Figure 6-4. Estimated county-level direct patient care FTE in the actively practicing primary care workforce licensed in Oregon per 10,000 population, 2024-2026



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

Demographics of Oregon's primary care workforce

Characteristics of the approximately 20,000 actively practicing primary care workforce are detailed in **Table 6-5**. Among all occupations in the licensed primary care workforce, the average age was 45.8 years, ranging from 41.5 years among PAs to 49.4 years among MD/DOs. The average age at original licensure among primary care occupations in Oregon ranged from 30.0 years among RNs to 37.5 years among primary care NPs. Licensed primary care workers in Oregon are more female overall (76.0%). Female representation is greatest among RNs and NPs, whereas physicians have more even distribution between female and male practitioners.

Consistent with statewide workforce trends, Oregon's primary care workforce is predominantly white (65%), although with a slightly lower white population compared to the state. Most other racial and ethnic groups are underrepresented in the primary care workforce.⁹⁸ Asian workers are slightly overrepresented in the primary care workforce (8.6% compared to 4.9% of the state), but are particularly overrepresented among MD/DOs (16.1%). Among NPs, 4.9% are estimated to be Black or African American, compared with 1.9% of the estimated Oregon population. The racial diversity of the primary care workforce overall is similar to the diversity of this group reported in 2024, although not directly comparable as the previous diversity report excluded respondents who reported "Decline" or "Unknown" when reporting their race. Overall, an estimated 24.0% of the primary care workforce speaks a language other than English. Among the specific occupations, this ranges from 16.5% among RNs to 37.5% among MD/DOs.

Estimates for highest level of education among the licensed primary care occupations in Oregon align with what is required for licensure: all MD/DOs and NDs hold doctoral degrees, and most PAs are master's prepared (92.9%). NPs have more variation in their highest level of education, with 78.9% estimated to have a master's and 20.4% estimated to have a doctorate. This is true for RNs as well, with 7.0% estimated to have master's degrees, 65.0% to have bachelor's degrees, and 26.7% to have associate degrees.

Just over half of the primary care workforce is estimated to be in the Portland Metro area (51.6%), largely driven by NDs (67.8%) and MD/DOs (51.6%). Southern Oregon (19.5%) and the Willamette Valley/North Coast (13.7%) regions have the next highest concentrations of the workforce. NPs and PAs are more likely to be in Eastern (5.3% and 4.9%) and Central (11.8% and 12.5%) Oregon compared to other occupations.

Relative to the certified primary care workforce, MAs are estimated to be slightly younger on average (36.6 years) and to have a higher proportion of the workforce identifying as female (84.1%) and as white (71.4%) compared to the licensed primary care workforce and compared to Oregon overall (**Table 6-6**). An estimated 23% identify as Hispanic or Latino/a/x/e, which is higher than overall Oregon population estimates. One in five MAs

(20.0%) is estimated to speak a language other than English (compared to 24.0% of the licensed primary care workforce) and 11.5% reported having a disability (compared to 2.1% of the licensed primary care workforce). However, ACS data includes more questions about disability than the Oregon HWRP data and therefore are expected to show higher rates. Educational attainment was concentrated below the bachelor's level, with most reporting some college education (38.3%), a high school diploma or equivalent (22.3%), or an associate degree (23.1%).

The THW workforce reflects substantial racial/ethnic diversity, with 55.0% identifying as white, 15.2% as Hispanic or Latino/a/x/e, 8.7% as American Indian or Alaska Native, and 7.9% as Black or African American (**Appendix Figure 14-4**).^{99,100}

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

	Total, practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon	20,130	6,346	366	2,300	1,154	9,964
Age at original licensure (years), mean (SD)	32.7 (9.0)	34.9 (7.5)	32.3 (5.6)	37.5 (9.2)	32.47 (7.8)	30.0 (9.3)
Current age (years), mean (SD)	45.8 (12.2)	49.4 (11.7)	46.7 (11.7)	46.4 (10.9)	41.5 (10.6)	43.5 (12.4)
Gender identity						
Female	76.0%	54.3%	72.7%	84.2%	68.3%	88.9%
Male	22.1%	45.6%	22.7%	12.5%	31.5%	8.2%
Other/Self describe	0.4%	0.1%	1.4%	0.6%	0.2%	0.4%
Decline to answer	1.9%	0%	3.3%	2.8%	0%	2.4%
Race/Ethnicity						
American Indian or Alaska Native	0.6%	0.2%	0.3%	1.0%	0.5%	0.8%
Asian	8.6%	16.1%	3.8%	4.9%	6.5%	5.3%
Black/African American	2.4%	1.7%	1.4%	4.9%	1.7%	2.3%
Native Hawaiian/Pacific Islander	0.2%	0.2%	0%	0.1%	0.2%	0.3%
Middle Eastern/North African	0.5%	1.3%	0.6%	0.1%	0.4%	0.2%
White	65.0%	58.5%	69.7%	67.2%	65.4%	68.4%

	Total, practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Hispanic or Latino/a/x/e	4.1%	2.0%	4.1%	4.1%	3.2%	5.5%
Other race	1.3%	2.0%	1.9%	1.0%	1.5%	0.8%
Multi race	4.7%	4.3%	7.7%	4.0%	5.7%	4.9%
Decline or Unknown	12.5%	13.8%	10.7%	12.8%	15.1%	11.5%
Language						
Speaks language other than English	24.0%	37.5%	20.5%	19.5%	25.5%	16.5%
Disability						
Disabled	2.1%	—	2.5%	2.0%	—	3.7%
Highest level of education						
High School	0.3%	0%	0%	0%	0%	0.6%
Associate	13.2%	0%	0%	0%	0%	26.7%
Bachelor's	32.4%	0%	0%	0.5%	3.5%	65.0%
Master's	17.8%	0%	0%	78.9%	92.9%	7.0%
Doctorate	35.8%	99.8%	100%	20.4%	0%	0.4%
None of the above	0.2%	0%	0%	0.1%	0%	0.3%
Missing	0.3%	0.2%	0%	0%	3.6%	0%
Practice distribution by region in Oregon						
Portland Metro	51.6%	51.6%	67.8%	37.7%	44.5%	54.8%
Willamette Valley & North Coast	13.7%	14.4%	12.8%	13.8%	16.4%	12.9%
Central Oregon	9.1%	8.6%	6.6%	11.7%	12.5%	8.6%
Southern Oregon	19.5%	19.2%	11.7%	26.4%	19.9%	18.3%
Eastern Oregon	3.5%	2.8%	0.5%	5.3%	4.9%	3.5%
Missing	2.6%	3.3%	0.5%	4.2%	1.8%	1.9%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Individuals in the primary care workforce were not asked all of the disability questions gathered for population level disability data. See Methods appendix for more details (descriptions of included primary care specialties, definitions of disability and regional distribution). For detailed REALD race/ethnicity standard reporting categories see Appendix Table 14-3.

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

	Medical assistants in Oregon
Estimated total number of MAs in Oregon (weighted)	10,603
Current age (years), mean (SE)	36.6 (1.5)
Gender identity	

	Medical assistants in Oregon
Female	84.1%
Male	15.9%
Race	
American Indian or Alaska Native	1.2%
Asian/Pacific Islander	5.9%
Black/African American	0.0%
White	71.4%
Other/Mixed Race	21.5%
Ethnicity	
Hispanic origin	23.0%
Language	
Speaks language other than English	20.0%
Disability	
Disabled	11.5%
Highest level of education	
Less than high school	3.2%
High School or equivalent	22.3%
Some college	38.3%
Associate degree	23.1%
Bachelor's degree	10.3%
Master's degree	1.3%
Professional school/Doctorate degree	1.4%

Data Source: American Community Survey 2024 1-year estimates. See Methods appendix for more details.

Practice characteristics of Oregon's primary care workforce

Work patterns were similar across the primary care workforce, with actively practicing licensed primary care occupations working from 34.6 (RNs) to 37.9 hours per week (MD/DOs; **Table 6-7**). The share of those working more than 40 hours per week ranged from 14.3% among RNs to 28.3% among physicians. Telehealth use was common among NDs and NPs, with more than 80% reporting providing telehealth services to Oregon residents, compared with 20% of RNs.

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

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

Annual wages varied considerably across primary care occupations and generally reflected differences in education, training requirements, and scope of practice (**Table 6-9**). Family medicine and general internal medicine physicians reported the highest median wages, exceeding \$239,000 annually, over four times greater than the Oregon overall median wage of \$54,662 per year. NPs and PAs had median wages around \$150,000, while RNs earned a median wage of approximately \$127,000. MAs and CHWs had lower median wages of about \$51,000 and \$57,000, respectively.

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

	Total, all independently practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon	10,166	6,346	366	2,300	1,154	9,964
Average hours worked per week, mean (SD)	37.6 (16.5)	37.9 (16.8)	35.9 (13.9)	37.4 (14.3)	37.1 (10.9)	34.5 (12.1)
Worked over 40 hours weekly	26.3%	28.3%	27.0%	26.1%	15.4%	14.3%
Telehealth practice serving Oregon residents*	84.0%	—	87.7%	83.4%	—	20.3%
Sees patients covered by Medicaid at primary or secondary practice**	80.4%	80.4%	61.2%	—	86.1%	—
Medicaid patients seen at primary practice	6,322	5,103	224	—	994	—
0–25% of patients	22.0%	23.4%	20.1%	—	15.3%	—
26–50%	21.5%	21.3%	25.4%	—	21.6%	—
51–75%	13.8%	12.0%	25.4%	—	20.7%	—

	Total, all independently practicing primary care occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
76–100%	7.4%	5.8%	23.2%	—	12.0%	—
Unknown	33.7%	35.9%	4.5%	—	28.9%	—

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Dashes indicate unavailable data. See Methods appendix for more details.
 *Out of only those asked about telehealth, excluding RNs (n=2,666).
 **Out of only those asked about Medicaid (n=7,866).

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

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

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

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

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

Primary Care Occupation	2025 Annual Median Wage
Community Health Workers	\$57,034

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

Education program completions of Oregon’s primary care workforce

Oregon's primary care education and training pipeline varies considerably by occupation (**Table 6-10**). In 2024, there were 31 institutions in Oregon with programs preparing students for primary care occupations (**Figure 6-4**). RN programs produced the largest number of completions annually, with 1,260 completions across 18 institutions in 2024, and generally maintained stable output over the past six years despite fluctuations during the COVID-19 pandemic. MA and LPN programs also contributed substantial numbers of graduates to the primary care workforce in Oregon, although both experienced declines earlier in the period before rebounding in 2024. PA programs have shown modest growth, increasing from 94 graduates in 2018 to 116 across three institutions in 2024. In contrast, MD, ND, and NP programs produce substantially fewer graduates each year than RN, MA, and LPN programs. MD completion counts have remained relatively stable, while ND completions declined from 87 in 2018 to 39 in 2024. NP completions fluctuated and totaled 82 completions in 2024. Physician completions reflect those from Oregon’s single MD-granting medical school (OHSU School of Medicine). Oregon also hosts Western University of Health Sciences' osteopathic medical program (COMP-Northwest), but IPEDS reports completions at the institutional level and thus, completions information likely understate Oregon's MD/DO training pipeline. This is likely true for NPs and RNs as well, as many nursing students from online and out-of-state institutions also complete clinical training in Oregon.^{101,102}

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

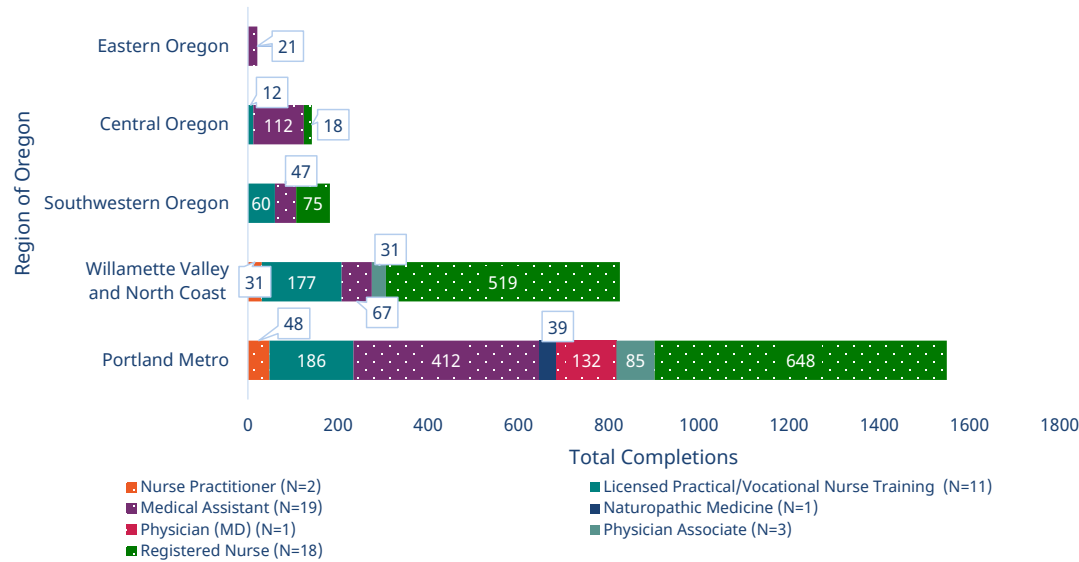
Table 6-10. Education program completions, by academic year, of the actively practicing primary care workforce in Oregon, 2018-2024

Occupation	2018	2019	2020	2021	2022	2023	2024
Physician (MD)	147	126	151	158	149	166	132
Naturopathic Medicine	87	73	67	61	38	49	39
Nurse Practitioner	79	77	97	58	62	62	82

Physician Associate	94	95	97	101	97	118	116
Registered Nurse	1,295	1,276	1,377	999	1,225	1,207	1,260
Licensed Practical/Vocational Nurse Training	498	412	370	377	355	367	435
Medical Assistant	804	757	470	737	586	522	659

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

Figure 6-4. Primary care education programs in Oregon with at least one completion by occupation and region, 2024



Note: Values in parentheses in the legend (N=X) indicate the number of Oregon educational institutions reporting program completions in 2024.

Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. Number of Oregon institutions in 2024 indicated in parentheses. See Methods appendix for mapping of CIP codes by occupation and award level.

Demand and reported vacancies of Oregon's primary care workforce

Demand for Oregon's primary care workforce is projected to grow over the next decade, with the largest increases expected among NPs, PAs, RNs, MAs, and community health workers (**Table 6-11**). By 2034, Oregon is projected to need an additional 1,269 NPs, 643 PAs, 4,214 RNs, 2,341 MAs, and 240 CHWs to meet projected employment growth. NPs are projected to experience strong growth, with employment increasing by nearly 50% between 2024 and 2034. RNs and MAs are expected to have the largest increase in the number of job openings due to the size of their respective workforces and ongoing replacement needs. Across most occupations, replacement job openings account for a

substantial share of projected demand, with the highest replacement openings among MAs and community health workers, highlighting the importance of maintaining training pipelines while also addressing retirements and workforce turnover. Family medicine physicians, PAs, and NPs are all projected to see growth in both employment and annual job openings.

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

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

Data sources: Oregon Wage Information, Oregon Occupations in Demand, and Oregon Occupational Employment Projections prepared by the Oregon Employment Department (OED), Workforce and Economic Research Division. Primary care occupations listed are ordered from most to least entry-level education required, then most to least competitive education level, where appropriate. See Methods appendix for more details.

Retention and turnover of Oregon's primary care workforce

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

Available workforce planning data suggest relatively strong retention among Oregon's primary care workforce (**Table 6-12**). Among NPs and RNs, about two-thirds expect to remain in the workforce for more than 10 years (**Appendix Table 14-4**). Most clinicians expect to maintain their current work hours (over 75% across professions), and the large majority plan to continue working at their current practice location (over 80% across

professions). Relatively few anticipate leaving Oregon to practice elsewhere or leaving their profession altogether.

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

	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Registered Nurses (RNs)
Estimated number of actively practicing primary care licenses in Oregon	6,346	366	2,300	1,154	9,964
Completed educational program or medical residency in Oregon	25.8%	86.1%	N/A	36.0%	N/A
Average years since original licensure (as of 2026), mean (SD)	14.5 (11.1)	14.4 (10.3)	8.9 (8.0)	9.0 (7.1)	13.5 (10.6)
Anticipated change in future work hours					
Increase practice hours	1.6%	11.2%	5.1%	1.8%	6.8%
Maintain practice hours	89.4%	75.4%	82.2%	89.3%	82.3%
Reduce practice hours	4.5%	12.0%	11.3%	3.2%	9.4%
Other	0.8%	1.4%	1.4%	0.5%	1.5%
Anticipated change in future career plans in the next two years					
Continue working at my current location(s)	N/A	88.8%	85.8%	N/A	85.9%
Leave Oregon to practice out of state	N/A	1.4%	2.1%	N/A	2.2%
Leave the field (intend to work in a different field)	0.1%	2.2%	0.7%	0.3%	0.7%
Move to Oregon to practice in the field	0.0%	0.0%	0.3%	0.0%	0.2%
Move to another practice location in Oregon	1.1%	3.6%	6.0%	3.4%	5.4%
Other	—	2.5%	2.6%	—	3.2%
Retire	1.8%	1.6%	2.5%	0.3%	2.6%

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

7. The oral health workforce in Oregon

Background

Oral health is an essential part of overall health and wellbeing. Poor oral health, including untreated tooth decay and gum disease, is associated with a range of chronic conditions, including diabetes, cardiovascular disease, adverse pregnancy outcomes, and certain cancers.^{103,104} Historically, oral health care has been financed, delivered, and managed separately from physical and behavioral health care, resulting in missed opportunities for comprehensive primary care.^{105,106} In Oregon, coverage for diagnostic and preventive oral health services is included as part of the Oregon Health Plan, with many of the 33 Federally Qualified Health Centers in Oregon offering dental services along with primary care and behavioral health services. Still, access to care requires a sufficient workforce to meet population needs. The following section provides an overview of the supply, distribution, and characteristics of the oral health workforce in Oregon.

Oral health care occupations licensed and certified in Oregon

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

Oregon is considered a national leader in allowing DHs to practice more independently in community-based settings as compared to other states.¹⁰⁷ Under Oregon law, DHs may perform many dental hygiene procedures under general supervision, meaning a dentist is not required to be physically present.¹⁰⁸ DHs with Expanded Practice Permits (EPP) may provide dental hygiene services without on-site dentist supervision for specified underserved populations and in approved community settings, such as nursing homes, schools, community or correctional facilities.¹⁰⁹ The EPP does not expand the clinical scope of dental hygiene practice; rather, it increases where and for whom dental hygienists may provide services. A comparison of activities is listed in **Appendix Table 15-1**.

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

Oral Health Occupation	Definition and Area of Practice	Scope of Practice	Minimum Education Required for Licensure
Dentist	Those who can diagnose oral health diseases, interpret x-rays, monitor the growth and development of teeth and jaws, and perform surgical procedures on teeth.	Independent Practitioner	Completion of a CODA-accredited dental school program resulting in a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree, and successful completion of required national licensure examinations.
Dental hygienist	Paraprofessional that works under the supervision of a licensed dentist to provide preventive and therapeutic oral prophylaxis and educate patients in dental hygiene.	Supervision required	Completion of a CODA-accredited dental hygiene program resulting in an associate or bachelor's degree, and successful completion of required national and clinical licensure examinations.
Expanded practice dental hygienist (EPDH)	A licensed dental hygienist who has obtained an Expanded Practice Permit (EPP) and is authorized to provide dental hygiene services without on-site dentist supervision for specified patient populations and in approved community-based settings. The EPP does not expand the clinical scope of dental hygiene practice but allows hygienists to provide services in settings such as community health clinics, nursing homes, schools, correctional facilities, and other locations authorized in ORS 680.200.	Independent practice in select settings (e.g. nursing homes, schools, community clinics, or correctional facilities) or Collaborative agreement with a dentist, as required for certain services.	Completion of dental hygiene licensure requirements plus either (1) 2,500 hours of supervised dental hygiene practice and 40 hours of approved continuing education coursework, or (2) completion of a board-approved course of study that includes at least 500 hours of dental hygiene practice with qualifying patient populations.
Dental therapist	A newer provider type allowed by House Bill 2528 (2021) to be licensed and practice in Oregon. This dental provider offers preventive and routine restorative care, including filling cavities, placing temporary crowns, and extracting badly diseased or loose teeth.	Collaborative agreement	Completion of a CODA-accredited or board-approved dental therapy program that includes didactic and clinical training in dental therapy procedures, plus successful completion of required board examinations.

Oral Health Occupation	Definition and Area of Practice	Scope of Practice	Minimum Education Required for Licensure
Denturist	A licensed professional who is trained to provide removable dentures directly to the public without being supervised by a dentist. They construct, adjust, repair, reline, and alter full or partial dentures and other removable non-orthodontic dental appliances, and they take impressions and bite registrations as part of treatment.	Independent practitioner	Completion of an associate degree or equivalent denture technology program that meets state-approved curriculum requirements, including extensive coursework and supervised clinical training in denture construction and patient care.

See Methods appendix for definitions independent practitioner and collaborative practice agreement.

There are three occupations in Oregon's certified oral health workforce (**Table 7-2**). **Dental assistants (DAs)** and **Expanded function dental assistants (EFDAs)**. Both work under the supervision of a dentist. DAs in Oregon are not licensed and may be trained on the job for basic assisting duties. However, certification is required for radiography and a range of expanded functions, including preventive, restorative, orthodontic, and certain anesthesia-related procedures. Oregon also permits appropriately certified anesthesia dental assistants to perform specialized functions such as initiation of intravenous (IV) lines pursuant to OAR 818-042-0117. While certified DAs are recorded through Oregon's certification processes, Oregon lacks comprehensive licensure-based workforce data on all DAs. EFDAs, certified through the Dental Assisting National Board (DANB), can perform specialized tasks in addition to those of a dental assistant, such as removal of temporary crowns and fitting for new crowns.¹¹⁰ DANB administers other DA certification programs on behalf of the Oregon Board of Dentistry, including credentials such as Radiologic Proficiency, Expanded Function Orthodontic Dental Assistant, and Expanded Function Preventive Dental Assistant. **Community dental health coordinators** provide oral health education and support with navigating oral health services. This certification requires Community Dental Health Coordinator Program.

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

Oral Health Occupation	Definition	Minimum Education Required for Certification
Dental assistant (DA)	Unlicensed professional that helps with infection control by sterilizing and disinfecting instruments, setting up instrument trays, and assisting with dental procedures.	No formal educational degree, certification, or licensure is required to work as a DA in Oregon. Training may be obtained through on-the-job experience or through high school Career and Technical Education (CTE) and postsecondary dental assisting

		programs, including those offered by community colleges.
Expanded function dental assistant (EFDA)*	In addition to the duties of a dental assistant, and defined under OAR 818-042-0070, EFDAs are allowed to perform the following tasks after certification under the supervision of a dentist: coronal polishing; removing temporary crowns; preliminarily fit crowns; place temporary restorative material, polish amalgam or composite restorations with a slow-speed handpiece; remove excess supragingival cement from crowns, bridges, bands, or brackets; fabricate temporary crowns and bridges and temporarily cement them; re-cement temporary or permanent crowns with temporary cement in limited situations.	Completion of an approved education or certification pathway through the Dental Assisting National Board (DANB) or the applicable dental assisting credential, which may include coursework, examination, and/or documented clinical experience depending on the function being certified.
Community dental health coordinator	Provides oral health education, helps patients navigate the oral health system, coordinates appointments and follow-up care, assists with case management, and supports prevention efforts.	Completion of a 12-month Community Dental Health Coordinator (CDHC) training program that includes didactic instruction, community-based experience, case management training, and preventive oral health education.

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

*In addition to general expanded functions performed by EFDAs, DAs can perform expanded orthodontic functions (EFODA), preventive functions (EFPDA), and certain anesthetic functions through additional certification via the Dental Assisting National Board. More information can be found at <https://www.danb.org/state-requirements/detail/oregon-state-requirements>.

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

Supply and distribution of Oregon's oral health care workforce

As of 2026, there were an estimated 7,136 licensed oral health workers in Oregon, of which roughly 80% were actively practicing (**Table 7-3**). Direct care FTE was relatively similar between dentists (4.8 per 10,000 population) and DHs (5 per 10,000 population). As of January 2026, there were 22 dental therapists licensed in Oregon, with 16 having completed the Health Care Workforce survey. As such, limited data on dental therapists is included where applicable. Total direct care FTE provided by dental therapists was approximately 0.04 per 10,000 population (data not tabled). There are 7,586 DAs in Oregon, although it is unknown what percent are actively practicing.¹¹¹

Of the 30.4% of DHs who hold an expanded practice permit, an estimated 31.5% are active permit users and 61.8% of these permit users have a collaborative agreement with a dentist (**Table 7-4**).

Supply changes over time: From 2024 to 2026, the size of Oregon's actively practicing oral health workforce grew modestly, increasing 0.8% from 5,658 to 5,704 professionals (**Figure 7-1**). The number of actively practicing dentists increased 1.0% (2,403 to 2,428), while DHs by 0.6% (3,255 to 3,276). The number of EPDHs increased 14.0%, from 874 to 996. Morrow County was the only county with no estimated oral health professionals in 2024, was estimated to have five oral health professionals in 2026. Total direct patient care capacity increased 1.3%, from 4,143 to 4,196 FTEs, reflecting increases among dentists (2.0%), dental hygienists (0.6%), and EPDHs (4.5%, from 604 to 631 FTEs). Previous supply estimates for dental therapists are not available.

Just over a quarter of the actively practicing oral health workforce in Oregon (26.8%) is estimated to be working in rural areas, with similar proportions of direct care FTE in rural areas (26.9%; **Figure 7-2**). A slightly higher percentage of dental therapists work in rural areas (29% vs. 71% urban). Very few actively practicing oral health professionals have a practice address in a bordering state (1%; see **Appendix Table 15-2**).

The highest total number of the licensed practicing oral health workforce in Oregon is concentrated in the western region of the state in counties with large cities (**Appendix Figure 15-1**).

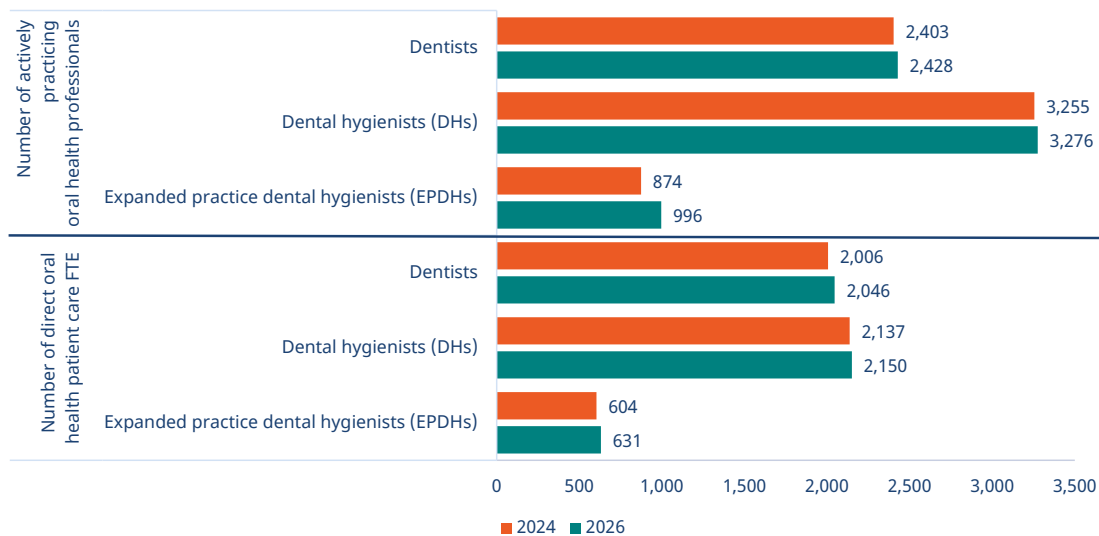
Figures 7-3 and **7-4** demonstrate broadly similar county-level patterns of oral health workforce availability, with **Figure 7-4** accounting for direct patient care FTEs and providing a measure of workforce capacity available for patient services. Among dental therapists, 56% practice in the Portland metro area (Multnomah, Clackamas, and Washington counties; data not mapped). There were two counties, Gilliam and Sherman, with no estimated dental hygienists; all counties had at least one dentist. Overall oral health workforce density ranged from 5 providers per 10,000 population in Gilliam County to 39 in Wheeler County (**Figure 7-3**). However, several counties showed notable differences between workforce supply and direct patient care capacity. Wheeler County had the highest overall workforce density but a more moderate direct patient care FTE density (11.8 per 10,000 population), while Hood River County had the highest direct patient care FTE density (15.6 per 10,000 population) despite ranking below Wheeler County in overall workforce supply. Gilliam (0.6) and Sherman (1.4) counties had the lowest direct patient care FTE densities (**Figure 7-4**).

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

	Total practicing oral health occupations	Dentists	Dental Hygienists	Dental Therapists
Estimated number of active oral health Oregon licenses	7,136	3,024	4,090	22
Estimated number of actively practicing oral health licenses in Oregon	5726	2428	3276	22
Estimated number of actively practicing oral health licenses per 10,000 population	133	5.6	7.6	N/A
Estimated amount of direct oral health patient care FTE	4,213	2,046	2,150	17
Estimated amount of direct oral health patient care FTE per 10,000 population	9.8	4.8	5.0	N/A
Estimated amount of other oral health FTE (research, admin, teaching, other)	337	63	270	4

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Density calculation not provided for dental therapists due to the small number. See Methods appendix for more details.

Figure 7-1. Changes in the estimated supply and direct patient care FTE of the actively practicing oral health workforce licensed in Oregon, 2024-2026



Data Source: Oregon Health Authority, *Oregon Primary Care Workforce: 2024 Data Report* (2025); Oregon Health Care Workforce Reporting Program, 2024–2026. Note: Total oral health workforce numbers cannot be provided due to differences in measurement in 2024.

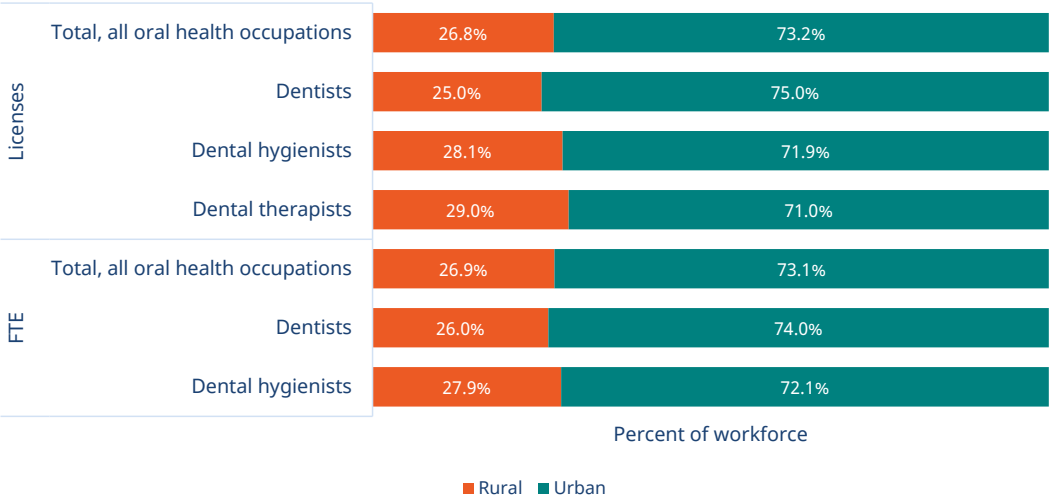
Table 7-4. Estimated supply of actively practicing expanded practice dental hygienists (EPDHs)* in Oregon, 2024-2026

	Dental Hygienists
Estimated number of actively practicing dental hygienists licensed in Oregon	3,276
Estimated supply of dental hygienists that hold an EPDH permit in Oregon	30.4%
Estimated direct care FTEs of dental hygienists that hold an EPDH permit in Oregon	631
Estimated number of EPDH permit holders	996
Estimated supply of active EPDH permit users among all EPDH permit holders	31.5%
Estimated supply of active EPDH permit users in a collaborative agreement with a dentist	61.8%

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

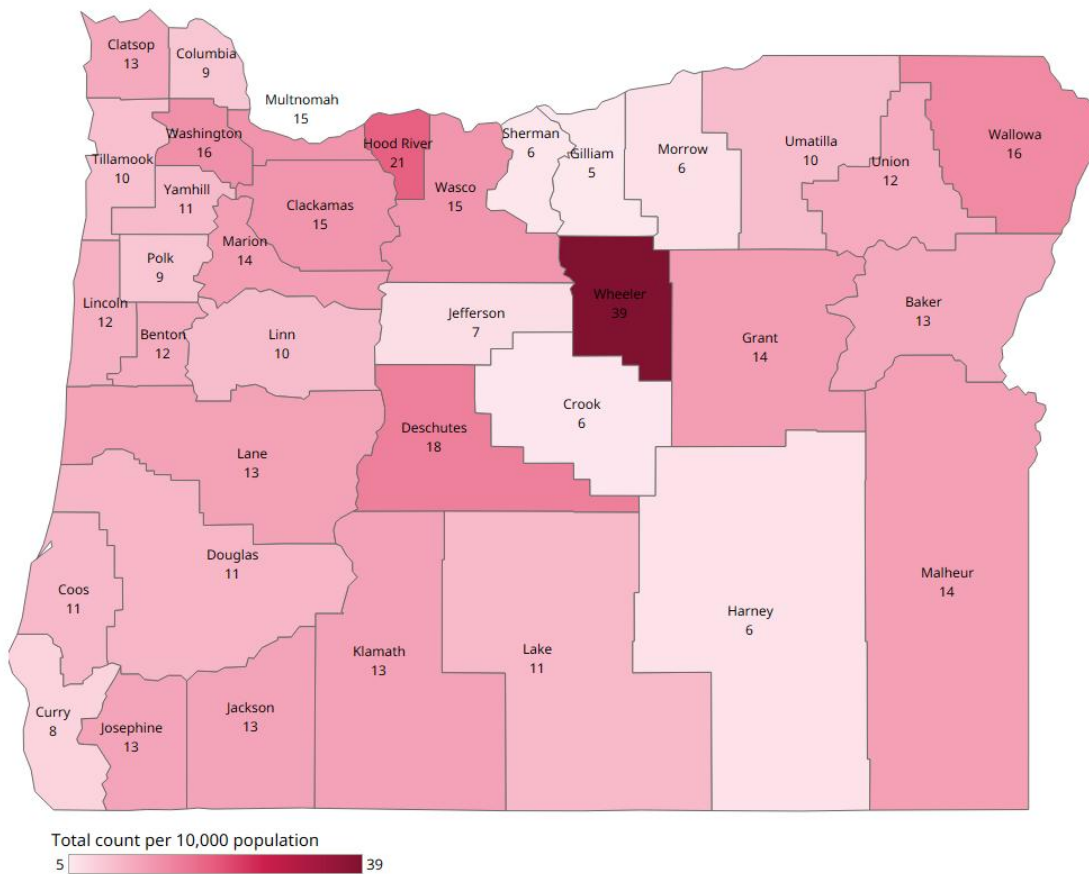
*EPDHs hold a special permit in the state of Oregon allowing them to provide preventative care independently, without direct supervision from a dentist. See Appendix Table 15-1 and Appendix Table 15-2.

Figure 7-2. Estimated supply and direct patient care FTE of the actively practicing oral health workforce licensed in Oregon by rural/urban practice location, 2024-2026



Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. Rural/urban FTE data not available for dental therapists due to small numbers. See Methods appendix for more details (missing counts, FTE calculations and rural/urban designation).

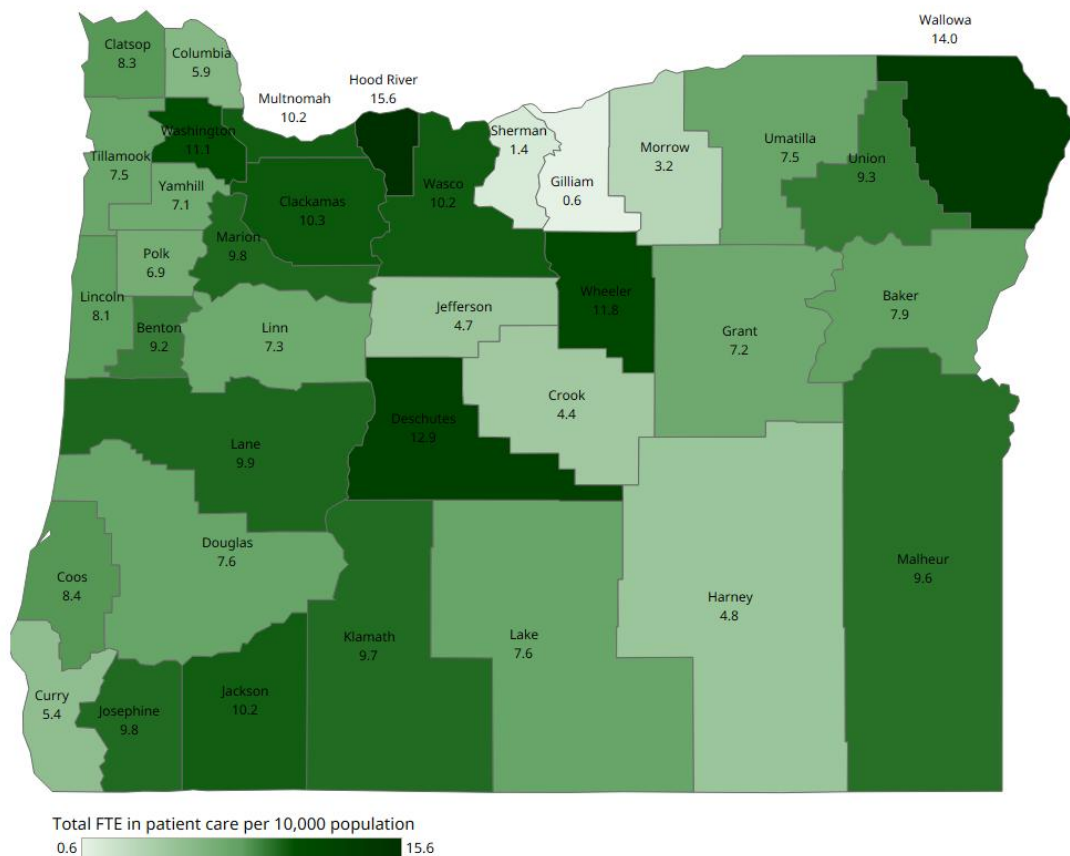
Figure 7-3. Estimated county-level supply of the actively practicing* oral health workforce licensed in Oregon per 10,000 population, 2024-2026



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

*County-level estimates of the actively practicing oral health workforce exclude dental therapists because the number of dental therapists is too small to support reliable county-level estimates.

Figure 7-4. Estimated county-level direct patient care FTE of the actively practicing* oral health workforce licensed in Oregon per 10,000 population, 2024-2026



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

*County-level estimates of the actively practicing oral health workforce exclude dental therapists because the number of dental therapists is too small to support reliable county-level estimates.

Demographics of Oregon's oral health workforce

Characteristics of the 5,704 oral health workers in Oregon (excluding dental therapists, due to small numbers) are detailed in **Table 7-5**. The average age at initial licensure and the current average age for DHs (26.79 and 44.18 years, respectively) is slightly younger than that of dentists (28.83 and 47.89 years, respectively) (**Table 7-5**). Most licensed oral health workers identify as female (68.2%), mainly due to most DHs identifying as female

(94%) compared to approximately one-third of dentists (33.3%), as is consistent with previous reports.¹¹² Approximately 60% of oral health occupations identify as white and 11.3% as Asian (12.9% declined to report their race). Dentists identify as Asian at a higher rate (17.2%) than DHs (6.9%), although both are overrepresented compared to the Oregon population (4.4%).⁹⁸ Only 0.4% of the licensed oral health workforce identify as Black or African American and 4.7% as Hispanic or Latino/a/x/e, and both are underrepresented compared to the Oregon population (1.8% and 14.7%, respectively). This is similar to estimates in 2024, although not directly comparable as the previous diversity report excluded respondents who reported “Decline” or “Unknown” when reporting their race. Overall, 24.0% of the licensed oral health workforce is estimated to speak a language other than English; this is higher among dentists (32.0%) compared to DHs (18.1%).

Educational backgrounds align with credentialing requirements: most dentists (97.8%) hold a doctorate, while DHs hold either an associate (54.4%) or bachelor’s (43.5%) degree as their highest level of education.

Geographically, the workforce is concentrated in the Portland Metro (47.3%) and Southern Oregon regions (21.8%), with the smallest proportion reporting working in Eastern Oregon. Distribution among dentists and DHs is similar.

Most DAs identify as female (96.6%) and white (82.4%), which is higher than licensed oral health workers (**Table 7-6**). This workforce also skews slightly younger (36.7 years) than the licensed oral health workforce. No American Indian or Alaska Native DAs were reported in this data. Ethnicity is asked separately from race in the data of DAs, so the higher percentage of Hispanic DAs cannot be compared to other data. An estimated 13.7% of DAs speak a language other than English, which is less than estimated for dentists and DHs. Most DAs are estimated to have a high school or some college as their highest level of education, although 16.9% are estimated to have an associate degree.

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

	Total, practicing oral health occupations	Dentists	Dental hygienists
Estimated number of actively practicing oral health licenses in Oregon	5,704	2,428	3,276
Age at original licensure (years), mean (SD)	27.65 (6.35)	28.83 (5.63)	26.79 (6.72)
Current age (years), mean (SD)	45.75 (11.99)	47.89 (11.98)	44.18 (11.74)
Gender identity			
Female	68.2%	33.3%	94.0%
Male	28.9%	63.3%	3.4%

	Total, practicing oral health occupations	Dentists	Dental hygienists
Other/ Prefer to self-describe	0.3%	0.1%	0.5%
Don't want to answer/Decline	2.5%	3.2%	2.0%
Race/Ethnicity			
American Indian or Alaska Native	1.0%	0.5%	1.3%
Asian	11.3%	17.2%	6.9%
Black/African American	0.4%	0.7%	0.2%
Native Hawaiian or Pacific Islander	0.3%	0.3%	0.3%
Middle Eastern/ North African	1.7%	3.1%	0.8%
White	60.6%	57.2%	63.2%
Hispanic or Latino/a/x/e	4.7%	2.7%	6.1%
Other Race	0.9%	0.6%	1.2%
Multi Race	3.7%	3.9%	3.5%
Decline	12.9%	12.8%	13.0%
Unknown	2.5%	1.2%	3.5%
Language			
Speaks language other than English	24.0%	32.0%	18.1%
Disability			
Disabled	1.6%	1.2%	1.9%
Highest level of education			
High School	0.0%	0.0%	0.0%
Associate	31.2%	0.0%	54.4%
Bachelor's	25.0%	0.0%	43.5%
Master's	0.4%	0.9%	0.0%
Doctorate	41.6%	97.8%	0.0%
None of the above	1.8%	1.3%	2.2%
Missing	0.0%	0.0%	0.0%
Practice distribution by region in Oregon			
Portland Metro	47.3%	50.3%	45.1%
Willamette Valley & North Coast	16.5%	16.1%	16.7%
Central Oregon	10.4%	10.0%	10.8%
Southern Oregon	21.8%	20.0%	23.1%
Eastern Oregon	3.7%	3.3%	3.9%
Missing	0.3%	0.2%	0.4%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details (definitions of disability and regional distribution). For detailed REALD race/ethnicity standard reporting categories see Appendix Table 15-3.

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

Dental assistants in Oregon	
Estimated number of DAs in Oregon (weighted)	7,586
Current age (years), mean (SE)	36.7 (1.6)
Gender identity	
Female	96.6%
Male	3.4%
Race	
American Indian or Alaska Native	0%
Asian/Pacific Islander	3.1%
Black/African American	0.1%
White	82.4%
Other/Mixed Race	13.6%
Ethnicity	
Hispanic origin	13.4%
Language	
Speaks language other than English	13.7%
Disability	
Disabled	0.9%
Highest level of education	
Less than high school	2.0%
High School or equivalent	25.1%
Some college	53.4%
Associate degree	16.9%
Bachelor's degree	1.9%
Master's degree	0.8%
Professional school/Doctorate degree	0%

Data Source: American Community Survey 2024 1-year estimates. See Methods appendix for more details.

Practice characteristics of Oregon's oral health workforce

On average, dentists work more hours per week than DHs (35.7 vs. 29.9 hours weekly, respectively) with 16% of dentists reporting working over 40 hours per week compared to 7% of DHs (**Table 7-7**). The oral health workforce primarily works in private group dental offices (48.1% of dentists and 53.1% of DHs) and private solo dental offices (35.8% of dentists and 34.4% of DHs; data not tabled). Dentists also reported practicing in community and school-based clinics (5.6%). Although less common than among other health care occupations, 11.0% of dentists reported providing some telehealth services. Dentists also reported receiving an average of 32.2 hours per week of assistance from DHs and 36.9 hours from DAs, including EFDAs.

An estimated 37.6% of actively practicing licensed dentists see patients covered by Medicaid at their primary or secondary practice, compared to 81.3% of licensed dental therapists in the state (data not tabled). Among these dentists, approximately one-third (32.5%) report that 76–100% of their patients are Medicaid-covered, while 29.1% report that fewer than 25% of their patients carry Medicaid coverage. DHs were not included in Medicaid-related survey questions, limiting cross-occupation comparisons. A 2024 evaluation of Oregon Health Plan dental provider enrollment found that 32 of 36 Oregon counties lack adequate Medicaid dental provider capacity, and that approximately 96 additional Medicaid dental FTEs would be needed statewide to meet OHP member needs.¹¹³ While the Medicaid coverage is lower for dentists than primary care and BH occupations, Medicaid claims analyses demonstrate a 12.8% increase in the number of dentists accepting Medicaid from 2023 to 2025, with an overall increase in the number of claims as well (from 787,855 in 2023 to 978,431 in 2025), the largest increase in Medicaid coverage in over two decades (**Appendix Table 15-4**).¹¹⁴

The Oregon Employment Department estimates the 2025 annual median wage for actively practicing DHs in Oregon at \$121,514 compared to \$190,840 for dentists (**Table 7-8**). These are both well above Oregon’s overall median wage of \$54,662 per year. DAs have an annual median wage of \$59,363 per year, just slightly higher than Oregon’s overall median wage.

Table 7-7. Estimated practice characteristics of the actively practicing oral health workforce licensed in Oregon, 2024-2026

	Total, practicing oral health occupations	Dentists	Dental hygienists
Estimated number of actively practicing oral health licenses in Oregon	5,704	2,428	3,276
Average hours worked per week, mean (SD)	32.4 (11.1)	35.7 (10.6)	29.9 (10.7)
Worked over 40 hours weekly	10.6%	16.0%	7.0%
Telehealth practice serving Oregon residents	6.6%	11.0%	3.4%
Average hours of assistance received from DHs per week at primary location, mean (SD)	—	32.2 (22.2)	—
Average hours of assistance received from Chairside Assistants (DAs, EFDAs) per week at primary location, mean (SD)	—	36.9 (17.5)	—
Sees patients covered by Medicaid at primary or secondary practice	—	37.6%	—
Medicaid patients seen at primary practice		914	
0-25% of patients	—	29.1%	—
26-50%	—	10.6%	—
51-75%	—	13.1%	—
76-100%	—	32.5%	—

Unknown	—	10.2%	—
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Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details. Note: the DH survey does not include Medicaid questions.

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

Oral Health Occupation	2025 Annual Median Wage
Dentists, General	\$190,840
Dental Hygienists	\$121,514
Dental Assistants	\$59,363

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

Education program completions of Oregon’s oral health workforce

Oregon's oral health education pipeline shows modest and, in some cases, declining output relative to workforce demand. As of 2024, there were 19 institutions with oral health education programs in Oregon. Dental hygiene completions increased slightly between 2018 and 2024 (149 to 160 completions), while dental completions, including specialties, remained relatively stable over the same period (87 to 84 completions) from Oregon's sole dental school (**Table 7-9**). Completions from dental assisting programs in Oregon (11 programs in 2024) declined by 18.1% between 2018 and 2024 (387 to 317 completions), despite projected increases in DA job openings (**Table 7-10**). Oral health education programs are concentrated in the northwest part of the state, with some representation in southern and central Oregon, but no oral health education programs are located in eastern Oregon (**Figure 7-4**).

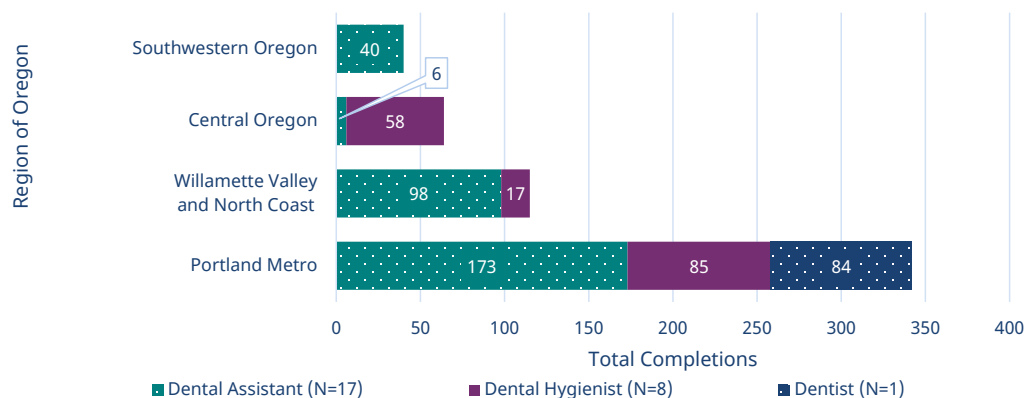
DA training pathways do include an option for on-the-job training, although there is no source of reliable data to capture the number of DAs who choose this option and there are limited resources available to educate those interested about this as an option. Oregon's formal dental assisting education pathway is primarily delivered through programs located at public community colleges, many of which are CODA-accredited, along with an expanding number of private vocational programs and high school CTE programs.

Table 7-9. Education program completions of the oral health workforce in Oregon, 2018-2024

Oral Health Occupation	2018	2019	2020	2021	2022	2023	2024
Dental Assistant	387	369	223	394	360	325	317
Dental Hygienist	149	141	110	191	146	149	160
Dentist	87	91	87	85	84	89	84

Data Sources: Integrated Postsecondary Education Data System (IPEDS), 2023-2024 and the Oregon Higher Education Coordinating Commission (HECC). See Methods appendix for more details of CIP codes by occupation and award level.

Figure 7-4. Oral health education programs in Oregon with at least one completion by occupation and region, 2024¹¹⁵



Note: Values in parentheses in the legend (N = X) indicate the number of Oregon educational institutions reporting program completions in 2024.

Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024 and Oregon Higher Education Coordinating Commission (HECC). Number of Oregon institutions in 2024 indicated in parentheses. See Methods appendix for mapping of CIP codes by occupation.

Demand and reported vacancies of Oregon's oral health workforce

The Oregon Employment Department projects an increase in new job openings for all dental occupations by 2034. To meet projected workforce growth, Oregon is expected to need an additional 115 dentists, 455 DHs, and 642 DAs between 2024 and 2034 (**Table 7-10**). The greatest increase will be among DAs (642 new job openings, an 11.6% increase) and the least among dentists (115 new openings, an 8.6% increase). Replacement job openings for DAs are expected to be very high (7,492), approximately 35.6% higher than the estimated employment in 2024 and 21.5% higher than the projected employment in 2034, highlighting potentially high turnover for this occupation. Replacement job openings for DHs also signal a higher expected rate of turnover,

although reports from licensure survey data do not indicate this happening in the short-term.

Table 7-10. Projected employment of and demand for the oral health workforce in Oregon, 2024-2034

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

Data sources: Oregon Wage Information, Oregon Occupations in Demand, and Oregon Occupational Employment Projections prepared by the Oregon Employment Department, Workforce and Economic Research Division. See Methods appendix for more details.

Retention and turnover of Oregon’s oral health workforce

With respect to future stability of the workforce, DHs are more likely to have trained in-state (77%) compared to dentists (48.4%), with dentists having been in the workforce slightly longer than DHs, on average (19.23 years vs. 17.39 years for hygienists; **Table 7-11**). In both occupational groups, most report plans to maintain their current hours and practice location, with roughly 11-12% planning to reduce hours in the next two years (slightly lower than previous reports). Retirement intentions are low overall – slightly higher among dentists (4.0%) compared to DHs (2.4%), with very few planning to leave Oregon or the field entirely.

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

Recent information on the DA workforce in Oregon notes concerns with turnover and unfilled positions among DAs, with national research stating that dentists report difficulties filling positions for both DAs and DHs, resulting in lower capacity to fill open appointments.^{116,117} Other research reports that less than half (40%) of entry-level DAs (those with less than two years of experience) report planning to stay in the field for five or more years, further signaling concerns with retention.¹¹⁷

Table 7-11. Workforce retention and future career plans of the licensed practicing oral health workforce in Oregon, 2024-2026

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

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

8. The behavioral health workforce in Oregon

Background

Behavioral health (BH) care is crucial in addressing the emotional and mental well-being of Oregonians. BH services are available across the state in a wide range of settings, including outpatient programs, community clinics such as Certified Community Behavioral Health Clinics, crisis centers, inpatient psychiatric hospitals, and residential treatment facilities. However, improving access to quality BH care for Oregon's population has been a large focus over the past few years following the \$1.35 billion funding allocated by the Oregon legislature in 2021.¹¹⁸ Part of this investment focused on improving recruitment and retention of the BH workforce. The BH workforce prevents, treats, and provides ongoing support and management for mental health conditions like anxiety and depression, substance use disorders, and addictive behaviors.¹¹⁹ The following section provides an overview of the supply, distribution, and characteristics of the BH workforce in Oregon.

Behavioral health occupations licensed and certified in Oregon

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

Most of the licensed BH workforce require an advanced post-graduate degree and supervised clinical training hours. LPCs and LMFTs working towards the supervised direct

client contact hours required for full licensure must first register as an associate with the Oregon Board of Licensed Professional Counselors and Therapists. Professional counselor associates and marriage and family therapist associates must complete the experience requirements to obtain full licensure within five years.¹²⁰ Data on registered associates are not available for analysis in this report.

A large portion of the BH workforce in Oregon is composed of certified BH occupations, credentialed by the Mental Health and Addiction Certification Board of Oregon (MHACBO). As detailed in **Table 8-2**, these include **certified alcohol and drug counselors** (CADCs), **certified recovery mentors** (CRMs), **certified gambling recovery mentors** (CGRMs), **certified gambling addiction counselors** (CGACs), **certified prevention specialists** (CPSs), **qualified mental health associates** (QMHAAs), **qualified mental health professionals** (QMHPs), **peer support specialists** (PSSs), and **peer wellness specialists** (PSWs). Most of the certified BH workforce require supervision to practice, usually by an approved clinical supervisor.¹²¹ LPCs and LMFTs can qualify to be supervisors through a multi-step process.

Individuals in the BH workforce may hold a state license in addition to being MHACBO-certified or be certified only. Licensed and/or certified BH workers can also have multiple certifications, resulting in three groups of workers in the BH workforce: those that are licensed without any additional certifications, those that are licensed and certified, and those that are certified only (not licensed). To more accurately account for all BH workers, we focus on the certified-only group, in addition to the state-licensed BH occupations. The Methods Appendix contains more details about this data.

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

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

Licensed Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Minimum Education Required for Licensure ¹²²
Licensed Clinical Psychologist (PhD/PsyD)	Those who give therapy services to individuals to diagnose or treat behavioral, emotional, or mental disorders.	Independent practitioner	Completion of a Doctor of Psychology (PsyD) and/or Doctor of Philosophy in Psychology (PhD), and at least 1 year or 1,500 hours of supervised post-doctoral work experience.*
Licensed Professional Counselor (LPC)	LPCs assess, diagnose and treat individuals with mental, emotional or behavioral disorders using counseling services.	Independent practitioner Supervision required – professional counselor associate	Completion of a master's degree (MA) in counseling or related mental health degree from an accredited school and at least 3 years of clinical counseling experience as a professional counselor associate, including at least 1,900 supervised direct client contact hours.*

Licensed Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Minimum Education Required for Licensure ¹²²
Licensed Marriage and Family Therapist (LMFT)	LMFTs assess, diagnose, and treat mental, emotional, and behavioral disorders involving individuals, couples, children, and families.	Independent practitioner Supervision required – marriage and family therapist associate	Completion of an MA in marriage and family therapy or related mental health degree and at least 3 years of clinical counseling experience as a marriage and family therapist associate, including at minimum 1,900 supervised direct client contact hours, including 750 working with couples and families in the same session.*
Licensed Clinical Social Worker (LCSW)	LCSWs counsel and aid individuals and families requiring mental health related social service assistance.	Independent practitioner	Completion of a master's degree in social work (MSW), minimum 2 years working as a Clinical Social Work Associate (CSWA) under supervision by an OR LCSW or equivalent to earn a minimum of 100 hours of LCSW supervision and 3500 hours of total work experience, with 2,000 being direct client hours.*
Non-clinical Social Worker	Non-clinical social workers support individuals, families, and communities through case management, consultation, and advocacy, but do not provide therapy or diagnose mental health conditions.	N/A – do not work in a clinical setting	Registered Baccalaureate Social Workers: Completion of a Bachelor of Social Work (BSW) degree; 'Exam Candidate' license available if they have BSW but have not passed the exam. Licensed Master Social Workers: Completion of an MSW.*
Psychiatrist (MD or DO)	Allopathic (MD) or osteopathic (DO) physicians trained to practice in the specialty of psychiatry, focusing on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders.	Independent practitioner	Completion of, at minimum, 3-year postgraduate training (internship, residency, or fellowship), following medical school.*
Psychiatric Mental Health Nurse Practitioner (PMHNP)	Advanced practice registered nurses specializing in providing mental health care.	Independent practitioner	Completion of a MA in nursing (MSN) or doctorate in nursing practice (DNP) in psychiatric/mental health and verification of national certification for license type/population focus. Must have active RN license in OR.

Licensed Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Minimum Education Required for Licensure ¹²²
Psychiatric Physician Associate (PA)	Psychiatric PAs diagnose mental health conditions, manage medications, and develop treatment plans under physician collaboration.	Collaborative practice agreement required	Completion of an accredited master's degree PA training program.*
Naturopathic Physician (ND) with a specialty in Mental Health	Physicians who use natural and functional therapies to treat behavioral health conditions holistically.	Independent practitioner	Completion of a doctoral naturopathic medical program, optional post-graduate residency program.

See Methods appendix for definitions independent practitioner and collaborative practice agreement.

*Licensure requirements also require passage of a board-approved national competency exam (all provider types), and either the Oregon Jurisprudence Exam (licensed clinical psychologists, NDs), the Oregon Laws and Rules Exam (LPCs, LMFTs, LCSWs, non-clinical social workers), or the Medical Practice Act Exam (psychiatrists, PAs).

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

Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Minimum Education Required for Certification
Certified Alcohol and Drug Counselor (CADC-R, I, II, III)	Counselors who treat people with substance use disorders (SUD).	Independent practitioner - CADC II, III Supervision required - CADC I	CADC I: Completion of a high school diploma/GED, plus 150 hours of Alcohol/Drug/Addictions education, and at least 1,000 hours of supervised SUD work experience. CADC II: Completion of a bachelor's degree (BA) or equivalent, plus 300 hours of Alcohol and Drug Specialty Education and 4,000 hours of supervised SUD work experience.* CADC III: Completion of a Master's degree (MA) in a BH field plus 300 Alcohol/Drug/Addictions education and 6,000 cumulative hours of supervised SUD work experience.*
Qualified Mental Health Associate (QMHA-R, I, II)	Behavioral health worker who is qualified to work at state-approved mental health programs.	Supervision required - consults with senior clinician	QMHA-R: Completion of a BA in counseling or related BH field or 3 years of education/work experience and a supervisor's assessment confirming readiness. QMHA I: Completion of 1,000 supervised experience hours after becoming QMHA-R.* QMHA II: Completion of 4,000 hours of supervised work experience as a QMHA-R or QMHA I.*
Qualified Mental Health Professional (QMHP-R, C)	A certified mental health practitioner that can assess and treat patients and provide psychotherapy.	Independent practitioner	QMHP-R: Completion of an MA in behavioral science, or a Bachelor of Science in nursing or occupational therapy (OT) as well as an active Oregon nursing or OT license, and a supervisor's assessment of clinical readiness. QMHP-Certified: Completion of 1,000 hours of post-graduate clinical experience while registered as a QMHP-R.*
Certified Recovery Mentor (CRM I, II)	Provides non-clinical addiction peer support at Peer Recovery Centers or under OHA-certified SUD provider organizations.	Supervision required	CRM I: Completion of 40 hours of OHA-approved peer and oral health training, in recovery from SUD for at least 2 years, successful background check, completion of ethics quiz, and a signed code of conduct. CRM II: Completion of a high school diploma/GED, plus 80 hours of peer support training and 500 supervised hours, and an existing certification as a CRM I or an Adult Addiction Peer Support Specialist or an Adult Addition Peer Wellness Specialist.*

Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Minimum Education Required for Certification
Certified Gambling Recovery Mentor (CGRM)	Provides non-clinical gambling addiction recovery peer support.	Supervision required	Completion of 40-hours of OHA-approved gambling addiction peer training and oral-health training.
Certified Gambling Addiction Counselor (CGAC-R, I, II)	A counselor who provides entry-level and advanced-level problem-gambling counseling in state-certified programs.	Supervision required	CGAC-R: Completion of a BA or a combination of at least 3 years of relevant education and work experience in problem addiction or mental health. CGAC I: Completion of a BA or equivalent in a BH field plus 30 hours of problem/compulsive gambling education, and 500 hours of supervised clinical experience in gambling addiction counseling. CGAC II: Completion of a BA or equivalent in a BH field, plus 60 hours of problem/compulsive gambling education, and 2,000 hours of supervised experience in gambling addiction counseling.
Certified Prevention Specialist (CPS)	Substance-use prevention professional.	Supervision required	Completion of 150 hours of prevention-specific education aligned with the International Certification and Reciprocity Consortium Prevention Domains, and 2,000 hours (120 direct) of supervised prevention work.
Peer Support Specialist (PSS)	An individual providing services to others who share similar life experiences (addiction, mental health, youth support, or family support).	Supervision required	Completion of an OHA-approved Traditional Health Worker ⁸⁹ training program, and personal experience with the subject matter of focus, in recovery from addiction or having ever received mental health or addiction services.
Peer Wellness Specialist (PWS)	An individual with lived experience of mental health or substance use conditions that provides support services to others with similar life experiences (adult addictions, adult mental health, youth support, or family support), focusing on well-being and prevention and maintain recovery.	Supervision required	Completion of an OHA-approved Traditional Health Worker ⁸⁹ training program, or having 3000 hours of prior work experience within the past 5 years, or transferring a reciprocal PWS certification from another state.
Clinical Social Work Associate (CSWA)	Individuals practicing as clinical social workers under the supervision of an	Supervision required	Completion of Master of Social Work degree with plan of clinical supervision toward licensure submitted.

Behavioral Health Providers	Definition/ Area of Practice	Scope of Practice	Minimum Education Required for Certification
	Oregon LCSW while completing the required clinical practice hours to become a LCSW.		

BA: Bachelor’s degree; MA: Master’s degree; R: Registrant status. See Methods appendix for more details and definitions.
 *Licensure requirements also require passage of a national competency exam (all provider types), and the Oregon Jurisprudence Exam (CADC II, III).

Supply and distribution of Oregon's behavioral health workforce

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

Supply changes over time: From 2024 to 2026, Oregon's behavioral health workforce grew 18.0%, from 16,582 to 19,569 actively practicing professionals (**Figure 8-1**). The largest increases occurred among nurse practitioners (43.9%; 1,223 to 1,760), licensed clinical social workers (21.4%; 5,211 to 6,325), counselors and therapists (16.0%; 5,673 to 6,578), and clinical social work associates (15.6%; 1,478 to 1,709). Smaller increases were observed among psychologists (8.3%; 1,995 to 2,161) and physicians (3.2%; 857 to 884), while the number of naturopathic physicians declined from 106 to 96. Direct patient care capacity increased 17.5%, from 9,214 to 10,825 FTEs. The largest gains occurred among nurse practitioners (39.8%; 831 to 1,162 FTEs), licensed clinical social workers (20.1%; 2,811 to 3,375), and counselors and therapists (16.2%; 2,964 to 3,443). Most other occupations experienced modest increases in direct patient care FTEs, while naturopathic physician FTEs declined from 55 to 46.

The majority of the BH workforce in Oregon is in urban areas of the state (84.2%; **Figure 8-2**). NPs have the highest percentage of rural workers when compared to the other BH occupations, with 18.3% in rural, compared to only 7.4% of NDs who specialize in mental health. LPCs and LMFTs, LCSWs, and CSWAs also have higher rates of rural workers (roughly 17%) compared to MD/DOs, psychologists, and psychiatric PAs (about 9%). Similar rural/urban percentages are observed when comparing direct patient care FTE by BH occupation. Very few actively licensed BH occupations also have a practice address in a border state (1%; **Appendix Table 16-1**), although the Oregon State Board of Nursing specifically asks NPs where else they are licensed to practice and if they are actually practicing in that state. Over one-quarter (27.4%) of surveyed NPs who specialize in BH are licensed and working in Washington in addition to Oregon (**Appendix Table 16-2**).

The distribution of the BH workforce is concentrated in the western half of the state, with the majority of the workforce in Multnomah County (94 licensed BH workers per 10,000 population; **Figure 8-3**). Counties in the northern central part of the state had the least amount of licensed BH professionals, although the supply of occupations per 10,000

population is not as low, given the relatively low populations in these counties. For example, despite only having two estimated BH workers in Wheeler County, this is equivalent to a density of 17 providers per 10,000 population. The density of direct patient care FTE provided by the BH workforce follows a similar distribution across the state (**Figure 8-4**). Multnomah County and Deschutes County have the highest density of FTE per capita (48.3 FTE and 32.3 FTE per 10,000 population, respectively). Gilliam County has the lowest density of direct patient FTE from a BH professional (3.0 FTE per 10,000 population).

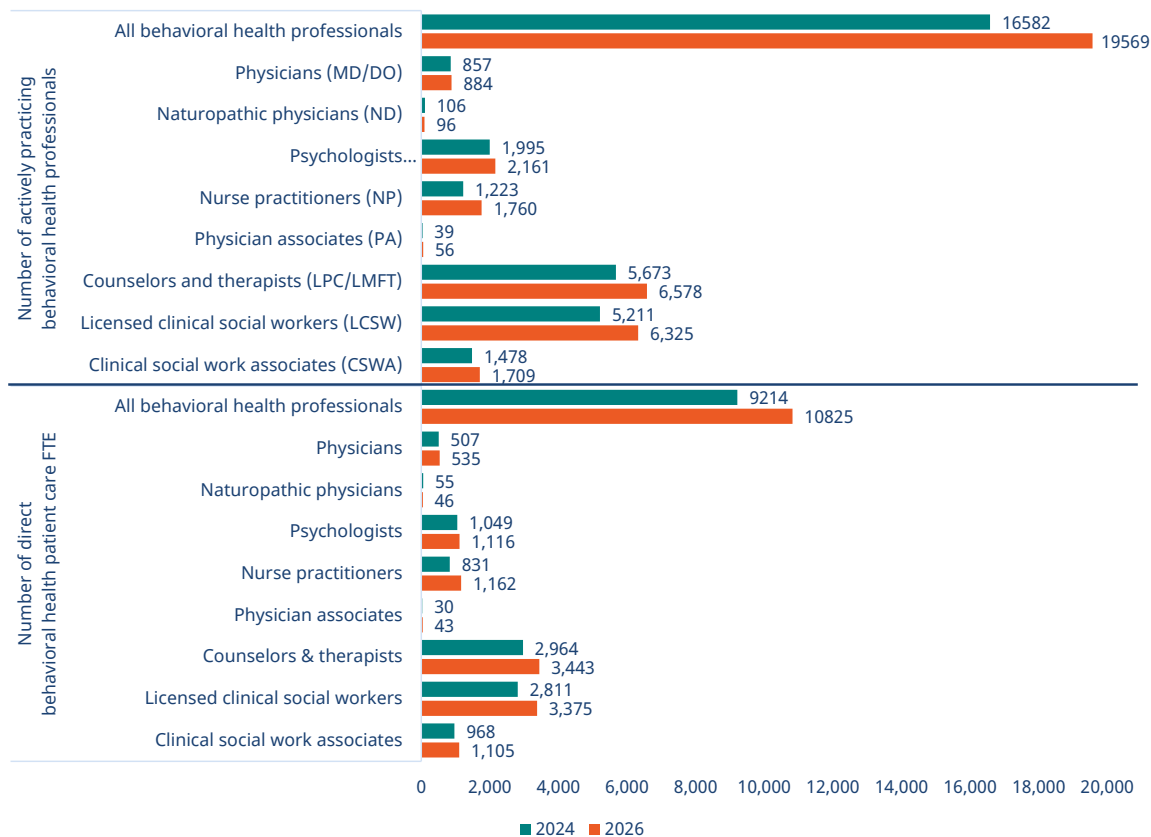
There are currently 1,855 certified-only individuals in Oregon, meaning they do not also hold a state-issued license to practice a BH occupation (**Table 8-5**). Density and FTE data for the certified BH workforce are not available.

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

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

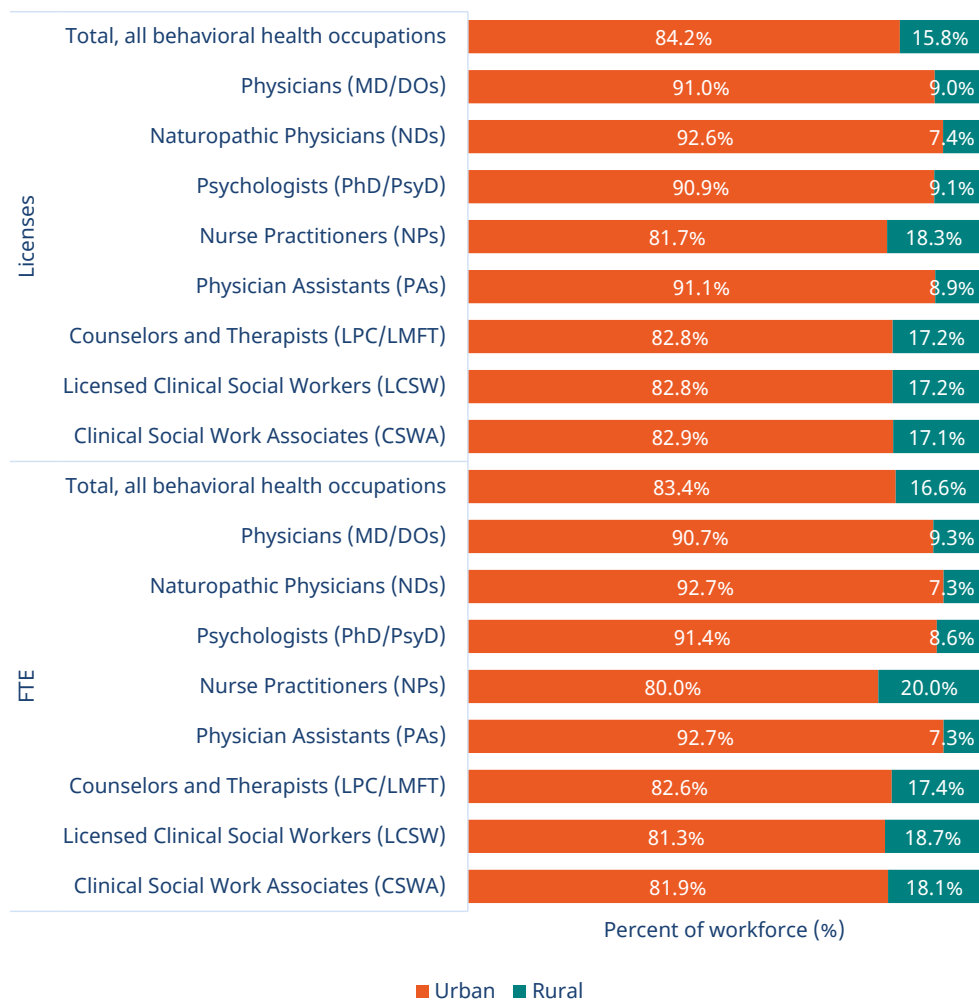
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details.

Figure 8-1. Changes in the estimated supply and direct patient care FTE of the actively practicing behavioral health workforce licensed in Oregon, 2024–2026



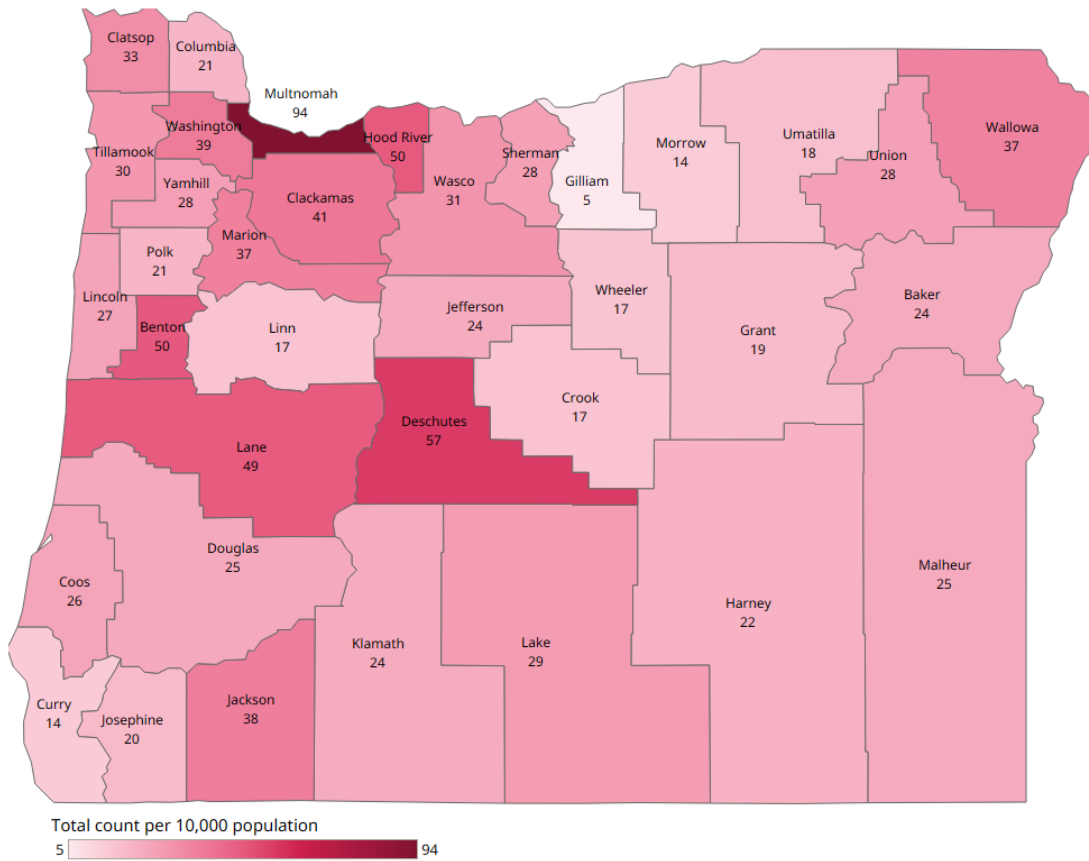
Data Source: Oregon Health Authority, *Oregon Primary Care Workforce: 2024 Data Report* (2025); Oregon Health Care Workforce Reporting Program, 2024–2026.

Figure 8-2. Estimated supply and direct patient care FTE of the actively practicing behavioral health workforce licensed in Oregon by rural/urban practice location, 2024-2026



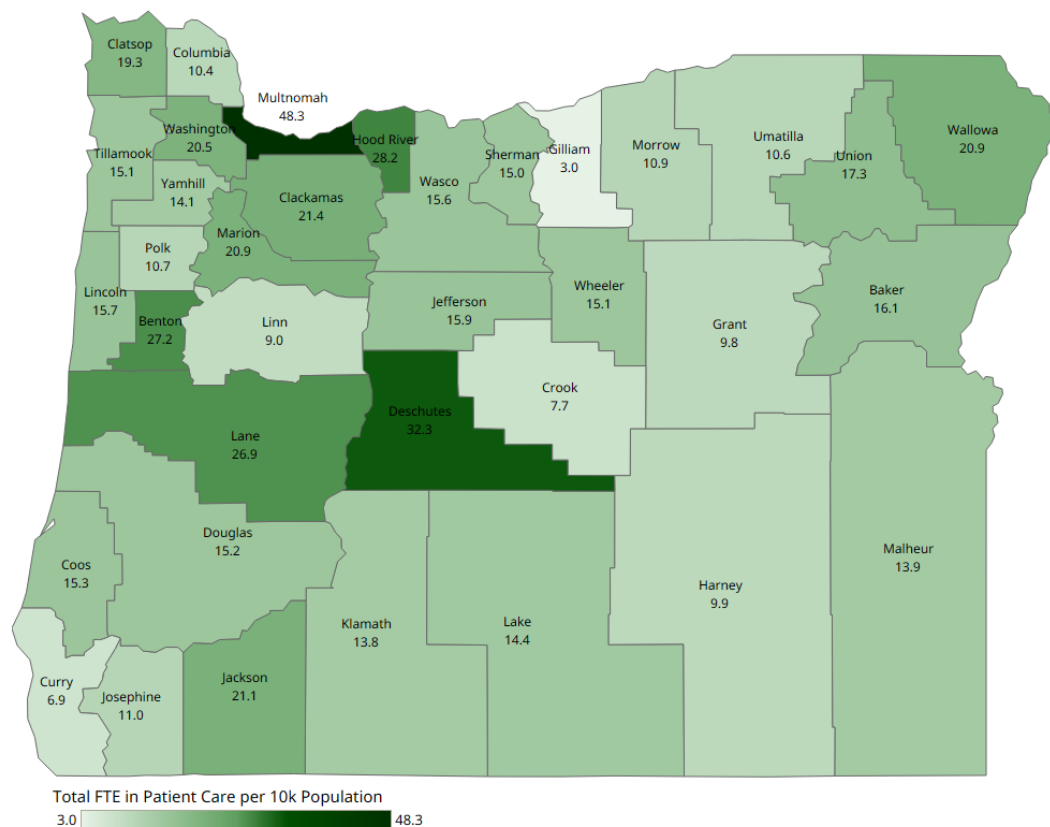
Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details (missing counts, FTE calculations, and rural/urban designations).

Figure 8-3. Estimated county-level supply of the actively practicing behavioral health workforce licensed in Oregon per 10,000 population, 2024-2026



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

Figure 8-4. Estimated county-level direct patient care FTE in the actively practicing behavioral health workforce licensed in Oregon per 10,000 population, 2024-2026



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

Demographics of Oregon's licensed behavioral health workforce

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

Like the overall racial diversity of Oregon, the licensed BH workforce is estimated to be predominantly white (71.1%). All other racial and ethnic groups are underrepresented in the BH workforce though there are some outliers among specific occupations. Asian MD/DOs specializing in psychiatry (13.4%) and Black and African American psychiatric NPs (12.3%) are well-represented in the state, though above parity in the state population. CSWAs are the most diverse occupation, with higher estimated percentages of Black (7.0%) and Hispanic (10.9%) workers than in most other BH occupations.⁹⁸ The racial diversity of the BH workforce overall is similar to the diversity of this group reported in 2024, although not directly comparable as the previous diversity report excluded respondents who reported “Decline” or “Unknown” when reporting their race. Overall, an estimated 14.1% of the BH workforce speaks a language other than English. Among the specific occupations, one-quarter of MD/DOs are estimated to speak a language other than English compared to only 11.1% of LPCs and LMFTs.

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

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

Demographics of Oregon’s certified-only behavioral health workforce

This section details the demographics of Oregon’s certified-only behavioral health workforce. Demographic information for traditional health workers (THWs), including peer support specialists and peer wellness specialists who contribute to the BH workforce, is presented in the primary care workforce section because available THW data were limited and reported as a combined workforce group.

There are 14,992 total credentials held by the 11,855 unique individuals in the certified-only BH workforce (**Table 8-6**). Among all unique individuals with at least one BH certification, 21.7% (2,567) hold two or more credentials (**Table 8-5**). Overall, the certified BH workforce skews slightly younger on average (43.2 years) and is generally not as female (63.6%) as the licensed BH workforce. The certified BH workforce has slightly more racial diversity, with about 10% of workers identifying as Hispanic or Latino/a/x/e, 6.5% identifying as Black and African American, and 3.0% identifying as American Indian

or Alaska Native. Only 1.4% of the BH active certified workforce identifies as Asian and less than 1% are Native Hawaiian or Pacific Islander, and Middle Eastern or North African. An estimated 16.3% of certified individuals speak a language other than English, compared to only an estimated 14.1% of the overall licensed BH workforce. The highest education levels among the certified workforce are high school (33.9%) and bachelor's level (31.0%). Certified BH workers are also more spread out across the state, with only 40.8% in the Portland Metro area and 26.5% in the Willamette Valley/North Coast region.

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

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

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

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

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

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

	Total, all behavioral health occupations	Physicians (MD/DOs)	Naturopathic Physicians (NDs)	Psychologists (PhD/PsyD)	Nurse Practitioners (NPs)	Physician Associates (PAs)	Counselors and Therapists (LPC/LMFT)	Licensed Clinical Social Workers (LCSW)	Clinical Social Work Associates (CSWA)
Master's	79.3%	0%	0%	0.6%	74.3%	94.6%	95.2%	97.7%	99.2%
Doctorate	20.1%	96.5%	99.0%	98.9%	23.5%	0%	4.4%	1.5%	0.5%
None of the above	0.6%	3.4%	1.0%	0.5%	0.2%	1.8%	0.4%	0.7%	0.1%
Missing	0%	0.1%	0%	0%	0%	1.8%	0%	0%	0%
Practice distribution by region in Oregon									
Portland Metro	57.1%	62.7%	85.4%	62.8%	52.6%	44.6%	54.2%	58.1%	58.3%
Willamette Valley & North Coast	13.3%	16.6%	2.1%	13.8%	14.7%	1.8%	12.9%	13.0%	13.0%
Central Oregon	8.6%	4.5%	9.4%	5.0%	8.5%	10.7%	10.8%	8.2%	8.1%
Southern Oregon	17.9%	13.6%	1.0%	17.0%	16.9%	30.4%	19.6%	17.6%	17.3%
Eastern Oregon	2.0%	1.5%	0.0%	0.6%	4.5%	3.6%	1.5%	2.2%	2.9%
Missing	1.3%	5.9%	2.1%	0.7%	2.8%	8.9%	1.0%	0.9%	0.3%

Data Source: Oregon Health Care Workforce Reporting Program, 2024-2026. All counts are estimates, calculated for each occupation separately. See Methods appendix for more details (definitions of disability and regional distribution). For detailed REALD race/ethnicity standard reporting categories see Appendix Table 16-3.

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

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

	Total certified-only individuals in the BH workforce
Outside Oregon	6.8%

Data Source: Mental Health and Addiction Certification Board of Oregon, 2026. Data represents all unique individuals with a MHACBO certification only and no additional state BH licenses. See Methods appendix for more details (full certified credential list, regional distribution). This data source does not ask respondents about disability.

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

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

	Total Credentials held by certified-only BH workforce	Certified Alcohol and Drug Counselors	Qualified Mental Health Associates	Qualified Mental Health Professionals	Certified Recovery Mentors	Certified Gambling Addiction Counselors	Certified Prevention Specialists	Certified Gambling Recovery Mentor
Education level								
High School	34.0%	32.5%	24.3%	0.1%	72.4%	24.6%	12.7%	48.5%
Associate	16.4%	21.5%	17.4%	0.1%	15.6%	22.5%	16.4%	30.3%
Bachelor's	29.9%	27.9%	51.0%	6.2%	9.7%	29.8%	32.7%	12.1%
Master's	18.6%	17.2%	6.9%	89.3%	2.0%	20.9%	32.7%	9.1%
Doctorate	1.1%	1.0%	0.4%	4.4%	0.4%	2.1%	5.5%	0%
Distribution by region in OR								
Portland Metro	40.7%	38.7%	38.3%	42.8%	47.7%	40.3%	18.2%	39.4%
Willamette Valley & North Coast	26.7%	28.8%	26.8%	24.0%	25.1%	27.2%	21.8%	21.2%
Central Oregon	8.4%	7.8%	9.8%	8.1%	6.4%	11.0%	27.3%	12.1%
Southern Oregon	12.4%	10.8%	14.2%	9.4%	13.3%	8.9%	14.5%	12.1%
Eastern Oregon	5.2%	5.4%	5.6%	4.1%	4.4%	6.3%	9.1%	9.1%
Outside Oregon	6.5%	8.6%	5.2%	11.6%	3.1%	6.3%	9.1%	6.1%

Data Source: Mental Health and Addiction Certification Board of Oregon (MHACBO), 2026. Data represents all MHACBO credentials held by a certified-only individual (no additional state BH license), not the unique individual. Individuals may be double counted if they hold more than one credential. See Methods appendix for more details and full list of included credentials. This data source does not ask respondents about disability.

Practice characteristics of Oregon's behavioral health workforce

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

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

According to the Oregon Employment Department, most BH occupations make above the Oregon median wage, \$58,260 per year (**Table 8-9**). Clinical and counseling psychologists have the highest median yearly wage (\$136,157/year), while psychiatric aides have the lowest (\$47,986/year). Median wages generally follow the trend that more education requirements correlate to a higher median wage; however this does not apply to rehabilitation counselors (\$54,059/year) and child, family and school social workers (\$64,480/year), who appear to earn less per year than their counterparts in similar roles (i.e. mental health and substance abuse social workers, \$73,778/year).

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

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

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

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

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

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

Table 8-9. Annual median wage of select behavioral health occupations in Oregon, 2025

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

Behavioral Health Occupation	2025 Annual Median Wage
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$71,552
Psychiatric Aides	\$47,986

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

Education program completions of Oregon’s behavioral health workforce

There are many routes to becoming a certified or licensed BH professional in Oregon (**Table 8-10**). As of 2024, there were approximately 25 education institutions offering BH-related education programs that trained and graduated students to work in BH. Social work programs contributed the largest number of graduates to the workforce in 2024 (524 graduates across 10 institutions), followed by therapist programs (302 graduates across 12 institutions) and psychologist programs (218 graduates across 6 institutions). Oregon only has one education program each for producing psychiatrists and psychiatric NPs.

After an initial decline in completions during the COVID-19 pandemic, completions increased across several BH occupations through 2022 and 2023. However, completion counts declined from 2023 to 2024 across nearly all occupation categories. Particularly notable decreases occurred among therapists (361 to 302 graduates), social workers (575 to 524 graduates), psychologists (260 to 218 graduates), psychiatry programs (166 to 132 graduates), addiction specialists (116 to 88 graduates), and mental health specialists (47 to 14 graduates). The available data do not provide information on the factors contributing to these declines. Although these data show the number of education program completions from Oregon institutions, it is unknown what proportion of graduates subsequently enter the behavioral health workforce in Oregon.

BH programs are concentrated in the Portland Metro area, with the largest number of completions coming from that area (**Figure 8-1**). However, there are other education institutions along the Willamette Valley producing BH professionals, including social workers, psychologists, therapists, addiction specialists, and mental health specialists, as well as smaller numbers of programs located in Southern and Eastern Oregon.

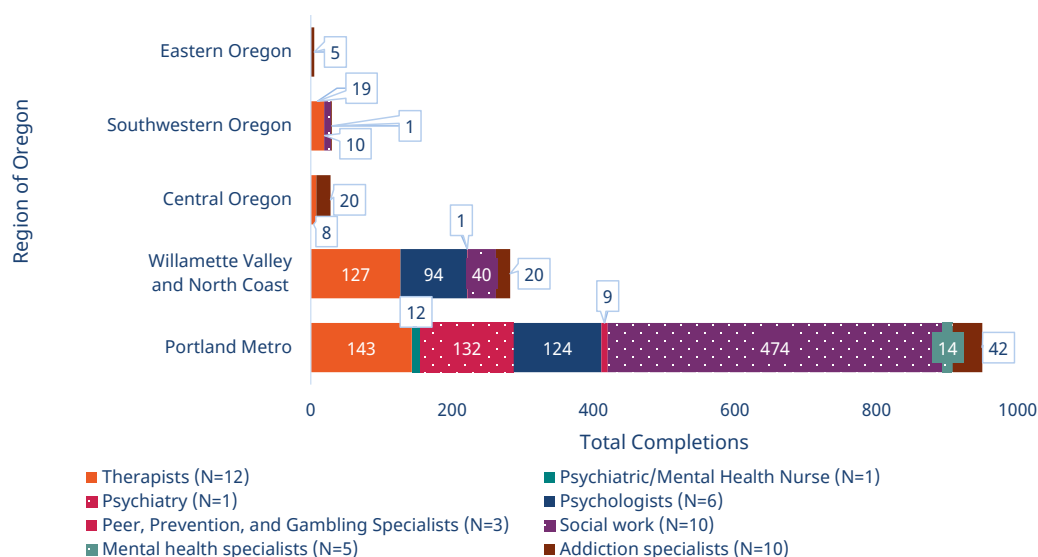
Table 8-10. Education program completions of the behavioral health workforce in Oregon, 2018-2024

Occupation	2018	2019	2020	2021	2022	2023	2024
Addiction specialists	84	95	60	80	139	116	88
Mental health specialists	37	46	43	26	61	47	14
Social work	598	557	555	542	546	575	524

Occupation	2018	2019	2020	2021	2022	2023	2024
Peer, Prevention, and Gambling Specialists	14	21	14	161	10	16	10
Psychologists	231	230	228	262	288	260	218
Therapists	275	280	269	271	319	361	302
Psychiatry	147	126	151	158	149	166	132
Psychiatric/Mental Health Nurse	9	11	15	1	12	16	12

Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. See Methods appendix for more details of CIP codes by occupation and award level. See Appendix Table 16-4 for the full list of programs and completion counts.

Figure 8-1. Behavioral health education programs in Oregon with at least one completion, by occupation and region, 2024



Note: Values in parentheses in the legend (N = X) indicate the number of Oregon educational institutions reporting program completions in 2024.

Data Source: Integrated Postsecondary Education Data System (IPEDS), 2023-2024. Number of Oregon institutions in 2024 indicated in parentheses. See Methods appendix for mapping of CIP codes by occupation.

Demand and reported vacancies of Oregon's behavioral health workforce

According to data from the Oregon Employment Department's Workforce and Economic Research Division, the BH workforce in Oregon is projected to grow over the next decade (**Table 8-11**). To meet projected workforce growth, Oregon is expected to need an additional 1,629 substance abuse, behavioral disorder, and mental health counselors, 324

child, family, and school social workers, 312 marriage and family therapists, 311 mental health and substance abuse social workers, and 295 social workers in other specialties between 2024 and 2034. The largest growth expected to be seen is among substance abuse, behavioral disorder, and mental health counselors (1,629 projected new job openings 2024-2034; 758 job openings annually). Most of the total projected openings are comprised of replacement openings due to retirement, changing occupations, or leaving the workforce, rather than new openings. Along with the relatively small projected employment increases for all other BH occupations over the 10-year period, this indicates projected increases in turnover among this workforce. While not directly comparable due to differences in the structures of the data, the projected increases in the demand data align with ongoing growth seen in the supply of the licensed BH workforce over time. Demand data on psychiatric NPs is unavailable from this dataset.

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

Behavioral Health Occupation	2024 Employment	2034 Projected Employment	Average Annual Job Openings, 2024-2034	Projected Replacement Openings, 2024-2034	Projected New Job Openings, 2024-2034	Total Projected Openings, 2024-2034
Psychiatrists	391	437	15	105	46	151
Clinical and Counseling Psychologists	461	541	32	243	80	323
School Psychologists	697	731	43	399	34	433
Psychologists, All Other	1,392	1,509	105	932	117	1,049
Marriage and Family Therapists	1,252	1,564	145	1,142	312	1,454
Rehabilitation Counselors	1,932	2,087	229	2,137	155	2,292
Counselors, All Other	212	245	24	205	33	238
Mental Health and Substance Abuse Social Workers	2,346	2,657	244	2,125	311	2,436
Child, Family, and School Social Workers	6,354	6,678	573	5,403	324	5,727
Health care Social Workers	2,270	2,468	220	2,002	198	2,200
Social Workers, All Other	3,651	3,946	336	3,061	295	3,356
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	6,945	8,574	758	5,954	1,629	7,583
Psychiatric Aides	1,325	1,430	201	1,907	105	2,012

Data sources: Oregon Wage Information, Oregon Occupations in Demand, and Oregon Occupational Employment Projections prepared by the Oregon Employment Department (OED), Workforce and Economic Research Division.

Behavioral health occupations listed are ordered from most to least entry-level education required, then most to least competitive education level, where appropriate. See Methods appendix for more details.

Retention and turnover of Oregon’s behavioral health workforce

Just over one-third (34.3%) of the 1,036 actively practicing BH MD/DOs, NDs, and PAs completed their education program or medical residency in Oregon (**Table 8-12**). As such, the BH workforce averages about 10 years since initial Oregon licensure (mean of 9.7 years), ranging from 3.1 years (CSWAs) to almost 14 years (psychologists).

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

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

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

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

9. Population needs and capacity across Oregon

Background

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

Population health outcomes across Oregon

Birth and mortality

Oregon's birth and mortality indicators vary substantially across counties (**Table 9-1**). The statewide birth rate is 9.1 births per 1,000 population, below the U.S. rate of 10.1.¹²³ Both birth and fertility rates have been declining, with birth rates in 17 counties below the state average.^{124,125} The statewide birth rate is 9.1 births per 1,000 population, below the U.S. rate of 10.1.¹²³ Both birth and fertility rates have been declining, with birth rates in 17 counties below the state average.^{124,125}

Oregon compares favorably with the nation on low birthweight births (7.0% vs. 8.5%) and infant mortality (4.93 vs. 5.6 deaths per 1,000 live births). Among counties with reported data, Klamath has the highest low birthweight rate (9.9%) and Yamhill the lowest (6.2%).¹²³

Oregon's all-cause mortality rate is slightly higher than the national rate (980.6 vs. 903.4 deaths per 100,000), with substantial county variation, from 592.3 in Gilliam to 1,978.9 in Curry.¹²⁶ These county-level crude rates should be interpreted cautiously because they are not age-adjusted. Chronic disease mortality, a key indicator of population health and primary care need, was 608.8 deaths per 100,000 population statewide and ranged from 389.1 in Washington County to 1,193.3 in Curry County. Oregon's suicide rate, an indicator closely related to behavioral health needs, is 20.0 per 100,000, up from 19.4 in 2023. The highest county suicide rates are in Tillamook (43.8), Curry (42.9), Josephine (39.9), and Douglas (34.7).¹²⁷

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

County	Birth rate, per 1,000 population (2025)	Fertility rate, births per 1,000 age 15-44 female population (2025)	Low birthweight births, per 100 live births (2024)	Infant mortality rate, per 1,000 live births (2024)	All-cause mortality rate, per 100,000 population (2024)	Chronic disease mortality rate, per 100,000 population (2024)	Suicide rate, per 100,000 population (2024)
Baker	7.8	60.6	2.8%	DS	1,484.2	881.0	DS
Benton	5.6	26.9	5.8%	DS	718.4	420.6	17.4
Clackamas	8.7	48.4	6.0%	4.1	947.8	526.7	16.3
Clatsop	7.8	45.0	5.4%	DS	1,223.8	712.9	DS
Columbia	9.5	53.4	9.0%	DS	1,109.9	651.4	18.6
Coos	8.1	52.4	8.6%	DS	1,767.6	1,020.1	28.0
Crook	9.6	66.8	7.2%	DS	1,139.1	612.2	DS
Curry	6.5	54.7	2.4%	DS	1,978.9	1,193.3	42.9
Deschutes	9.2	52.3	4.6%	DS	859.4	457.5	21.6
Douglas	8.6	56.8	7.7%	DS	1,681.0	969.4	34.7
Gilliam	5.2	66.2	DS*	DS	592.3	0.0	DS
Grant	7.5	62.7	21.9%	DS	1,441.4	512.8	DS
Harney	10.9	68.3	6.1%	DS	1,263.4	537.6	DS
Hood River	8.6	48.2	7.8%	DS	741.2	408.5	DS
Jackson	8.9	53.2	6.9%	4.4	1,278.7	675.4	23.6
Jefferson	10.7	68.1	9.8%	DS	1,096.1	605.0	DS
Josephine	9.5	59.4	6.9%	DS	1,672.7	889.3	39.9
Klamath	10.0	61.9	8.3%	DS	1,445.7	847.1	35.7
Lake	9.8	71.7	9.7%	DS	1,483.2	590.9	DS
Lane	7.5	39.5	8.6%	4.7	1,177.7	647.5	25.7
Lincoln	6.4	49.9	6.1%	DS	1,487.6	928.7	27.5
Linn	10.7	59.9	5.2%	DS	1,215.2	715.6	23.6
Malheur	13.3	72.7	7.6%	DS	1,101.6	614.8	DS
Marion	11.1	57.8	7.8%	3.7	987.2	532.7	15.9
Morrow	13.1	75.4	6.8%	DS	853.5	455.2	DS
Multnomah	8.6	38.3	8.4%	4.2	868.1	452.5	18.9
Polk	9.6	49.4	6.5%	DS	1,007.7	553.4	16.7
Sherman	9.0	76.7	10.0%	DS	0.0	0.0	DS
Tillamook	8.1	55.2	6.0%	DS	1,407.9	890.0	43.8
Umatilla	13.0	64.2	6.3%	DS	1,025.6	577.1	17.5
Union	10.8	53.9	3.5%	DS	1,337.5	693.8	DS
Wallowa	9.2	59.2	4.2%	DS	1,264.0	599.4	DS
Wasco	9.4	56.1	9.1%	DS	1,378.5	744.3	DS
Washington	9.6	47.3	6.2%	3.8	705.3	389.1	15.2

County	Birth rate, per 1,000 population (2025)	Fertility rate, births per 1,000 age 15-44 female population (2025)	Low birthweight births, per 100 live births (2024)	Infant mortality rate, per 1,000 live births (2024)	All-cause mortality rate, per 100,000 population (2024)	Chronic disease mortality rate, per 100,000 population (2024)	Suicide rate, per 100,000 population (2024)
Wheeler	8.9	53.2	DS	DS	0.0	0.0	DS
Yamhill	9.5	50.5	5.6%	DS	1055.7	610.3	18.4
Total	9.1	45.0	7.0	4.93	980.6	608.8	20.0

*DS: Data suppressed.

Data sources: 2024 Area Health Resources Files, Health Resources and Services Administration; Oregon Health Authority Vital Statistics, 2025. See Methods appendix for details of data sources and calculations.

Population growth and demographic change

Oregon’s overall population has by 25.7% grown since 2000, increasing from 3.4 million to 4.3 million residents in 2025 (**Figure 9-1**) with an estimated 50.6% identifying as female, while its demographic composition has shifted substantially. The population is aging: adults ages 65 and older increased from 16.4% of the population in 2015 to approximately 20% in 2025, while the proportion of children ages 0–17 declined from 21.6% to about 18% over the same period (**Figure 9-2**). Oregon has also become more racially and ethnically diverse (**Figure 9-3**). The proportion of the population identifying as white has declined since 2000, while the Hispanic or Latino population has increased. In contrast, the proportions identifying as Black or African American and American Indian or Alaska Native have remained relatively stable. In 2025, approximately 71% of Oregonians identified as white and nearly 15% as Hispanic or Latino, with smaller proportions identifying as two or more races, Asian, Black or African American, American Indian or Alaska Native, or Native Hawaiian or Other Pacific Islander (**Figure 9-3**).

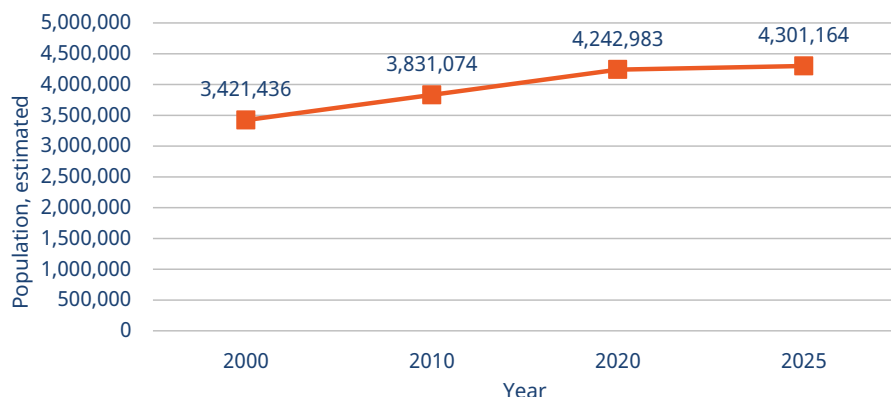
Linguistic diversity

Reflecting Oregon’s changing demographics, approximately 15.1% of Oregon households speak a language other than English at home, mostly commonly Spanish, Chinese (Mandarin/Cantonese), and Vietnamese.¹²⁸

Oregon generally requires health care providers receiving public funds to use health care interpreters listed on the OHA Health Care Interpreter (HCI) Registry when providing services to patients with limited English proficiency, with limited exceptions.¹²⁹ OHA recognizes 3,603 active Oregon HCI interpreters in good standing covering approximately 120 languages. In addition, Oregon has 92 bilingual providers who self-report as proficient or have taken proficiency exams in 30 languages, and two American

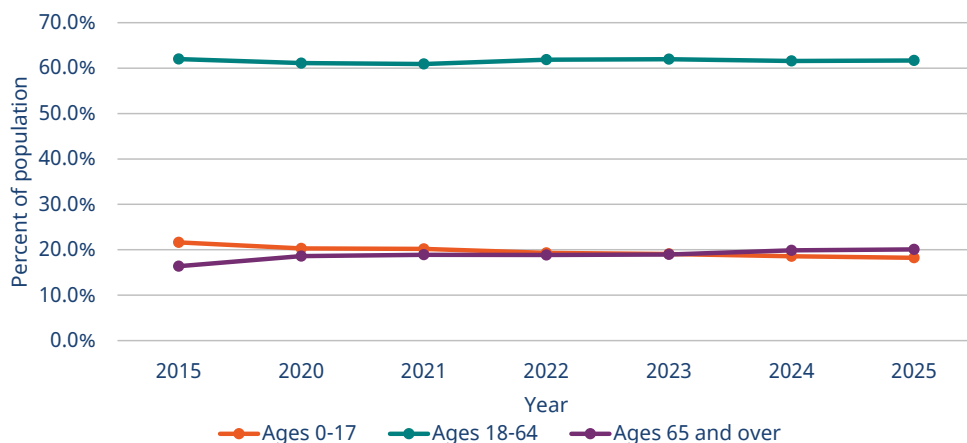
Sign Language (ASL)-proficient providers. Despite this registry, access remains uneven and finding interpretation for less commonly spoken languages across the state is difficult. Along with this, smaller clinics can struggle with interpretation costs, and rural clinics face challenges due to lower availability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

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



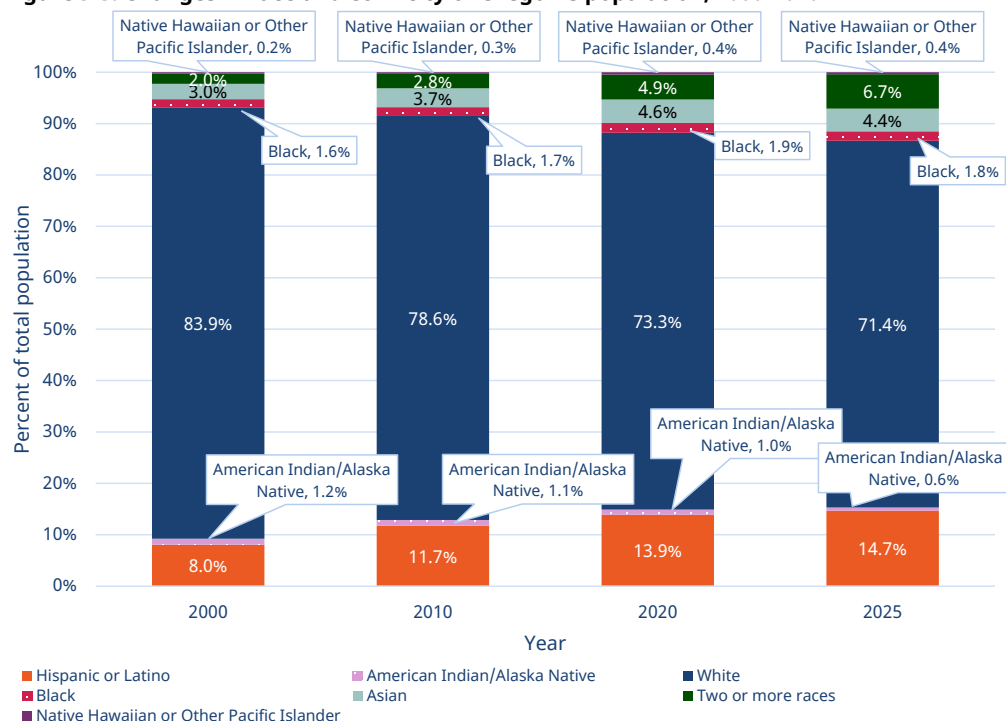
Data Source: Portland State University Population Research Center, Population Estimate Reports.

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



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

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



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

Socioeconomic status

Socioeconomic conditions vary substantially across Oregon counties, with some areas experiencing multiple indicators of economic disadvantage (**Table 9-2**). Statewide, 13.9% of residents lived below the poverty level in 2023, per capita income was \$59,653, and approximately 20% participated in SNAP. Poverty was highest in Malheur, Klamath, and Wheeler counties, although counties with the highest percent in deep poverty were Klamath, Gilliam, and Benton while per capita income was lowest in Malheur, Jefferson, and Wheeler counties. SNAP participation exceeded 25% in Coos, Douglas, Jefferson, Josephine, Klamath, and Malheur counties. Insurance coverage is high statewide, with an uninsured rate of 2.7% in 2024 (**Table 9-3**), although rates were higher in Marion County (4.4%), North Central Oregon (4.0%), Northeast Oregon (3.9%), Jackson County (3.8%), and Southwest Oregon (3.7%). Approximately one-third of Oregon residents were enrolled in Medicaid as of June 2026.

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

County	Adults without a high school diploma (2022)	Unemployment rate (2023)	Per capita income (2023)	Population below poverty level (2023)	Population in deep poverty (2023)	SNAP participation (2022)
Baker	6.3%	1.8%	\$52,392	16.2%	6.4%	23.0%
Benton	2.4%	1.5%	\$60,307	16.2%	11.2%	11.5%
Clackamas	4.0%	1.8%	\$80,269	6.9%	3.8%	11.4%
Clatsop	5.8%	1.8%	\$60,930	15.3%	6.1%	17.4%
Columbia	6.7%	2.0%	\$59,020	9.8%	4.0%	16.9%
Coos	7.6%	1.9%	\$59,838	16.0%	7.7%	26.4%
Crook	6.7%	2.3%	\$57,968	12.8%	4.8%	20.0%
Curry	7.3%	1.8%	\$57,405	15.8%	4.6%	22.5%
Deschutes	4.0%	1.8%	\$81,025	8.7%	4.9%	11.6%
Douglas	6.4%	2.0%	\$52,684	16.0%	6.8%	25.4%
Gilliam	7.4%	1.9%	\$71,618	11.8%	9.2%	19.1%
Grant	8.5%	2.2%	\$54,969	15.3%	6.8%	20.1%
Harney	6.5%	2.0%	\$53,228	15.2%	5.4%	23.3%
Hood River	11.2%	1.8%	\$71,946	10.0%	3.1%	12.4%
Jackson	6.5%	2.1%	\$62,541	12.6%	5.4%	21.6%
Jefferson	8.1%	1.9%	\$46,111	13.9%	5.9%	27.7%
Josephine	6.7%	2.1%	\$55,038	15.1%	7.0%	28.4%
Klamath	7.4%	2.2%	\$51,246	19.3%	9.7%	28.6%
Lake	9.6%	2.2%	\$50,163	17.0%	7.9%	23.5%
Lane	5.0%	1.9%	\$61,634	14.7%	7.9%	19.6%
Lincoln	5.5%	1.8%	\$59,715	15.4%	7.7%	21.0%
Linn	6.3%	1.9%	\$57,016	14.2%	5.6%	22.2%
Malheur	11.9%	1.5%	\$40,360	19.7%	7.2%	27.3%
Marion	9.5%	1.8%	\$58,470	14.1%	5.3%	20.0%
Morrow	14.6%	1.7%	\$58,480	13.2%	5.7%	19.5%
Multnomah	5.8%	2.1%	\$75,772	12.8%	6.0%	18.1%
Polk	5.2%	1.8%	\$55,086	11.8%	4.9%	17.1%
Sherman	8.3%	1.9%	\$66,483	14.5%	6.4%	24.4%
Tillamook	7.0%	1.7%	\$61,950	11.5%	5.1%	17.9%
Umatilla	10.3%	2.0%	\$53,253	16.5%	6.3%	20.9%
Union	4.9%	1.8%	\$53,469	13.6%	5.4%	22.3%
Wallowa	4.9%	2.1%	\$59,576	13.0%	4.2%	14.5%
Wasco	9.7%	2.0%	\$56,865	13.6%	5.1%	21.0%
Washington	5.0%	1.8%	\$79,139	8.1%	4.1%	10.2%
Wheeler	6.4%	1.5%	\$49,563	18.4%	2.2%	15.3%
Yamhill	6.8%	1.8%	\$61,974	10.6%	5.1%	15.5%
Oregon	7.1%	1.9%	\$59,653	13.9%	6.0%	19.9%

Data source: 2024 Area Health Resources Files, Health Resources and Services Administration. See Methods appendix for details.

Table 9-3. Uninsured population by Oregon county/region, 2024

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

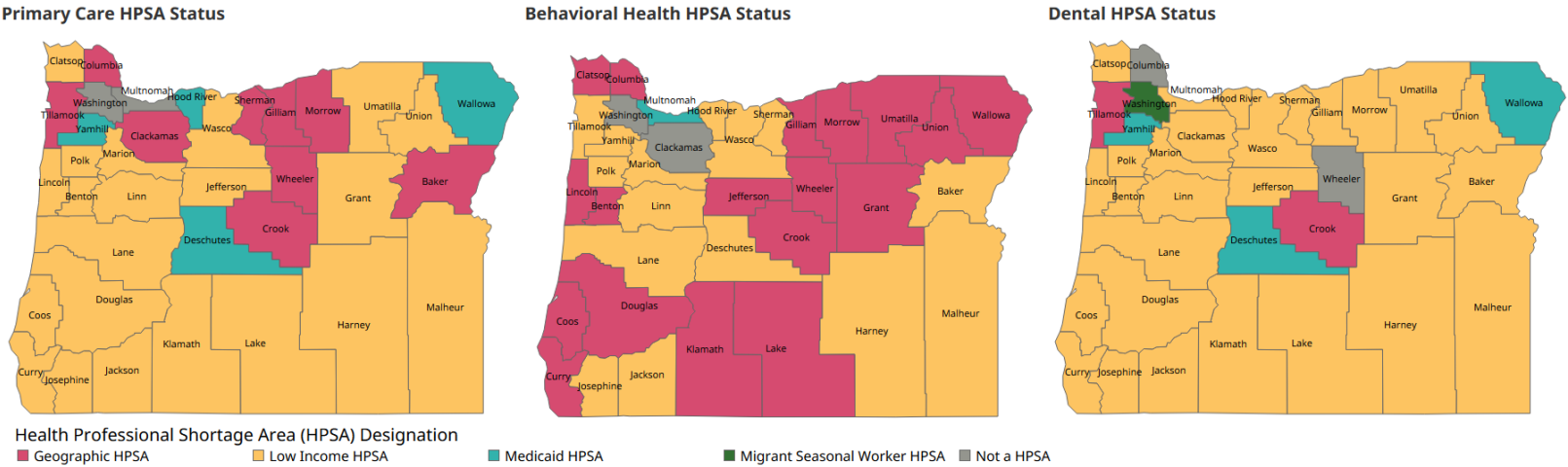
Data Source: Oregon Health Insurance Survey Coverage Dashboard, 2024.

*May be statistically unreliable; interpret with caution

Structural capacity

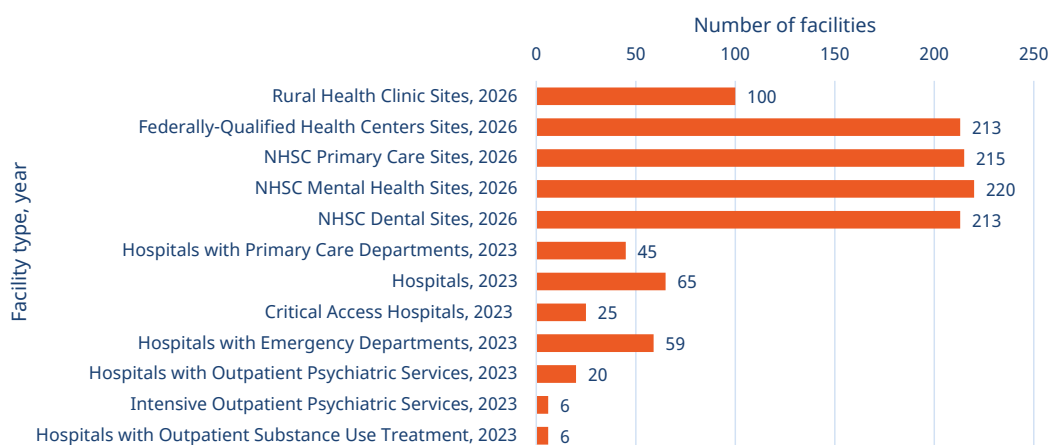
Most counties in Oregon are designated as a geographic or population Health Professional Shortage Area (HPSA) for primary care, behavioral health, and oral health (**Figure 9-4**). A HPSA is a federally designated area, population, or facility that lacks sufficient primary care, dental health, or mental health providers to meet the needs of the population. Nine counties are designated as full Primary Care HPSAs, two as full Dental HPSAs, and 19 as full Mental Health HPSAs. Shortages also overlap across service areas: Crook County is designated as a geographic HPSA for all three types of care, and five additional counties have geographic HPSA designations for two of the three types.

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



Data source: 2026 Health Resources and Services Administration (HRSA) Data Warehouse. ¹³⁰ See Methods appendix for HPSA definitions.

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



Data source: 2026 Oregon Certified FQHC and RHC data.^{131,132} 2024 Area Health Resources Files (AHRF), Health Resources and Services Administration (HRSA). HRSA National Health Service Corps (NHSC) Sites Data Explorer accessed August 2026. NHSC-approved site information includes participating clinical sites serving Health Professional Shortage Areas (HPSAs). NHSC sites are HRSA-approved health care facilities in underserved areas that provide clinical services and are eligible to recruit clinicians through NHSC workforce programs.

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

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

Oregon’s Patient-Centered Primary Care Home (PCPCH) Program supports both access to culturally responsive care and the health care workforce. Recognized practices must meet standards for coordinated, comprehensive, patient-centered, and equitable care, including culturally and linguistically appropriate care.¹³³ The model also promotes

integrated services, including behavioral health and primary care, and includes standards aimed at improving provider and staff well-being.¹³³

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

Behavioral health infrastructure: Oregon's behavioral health infrastructure includes a mix of hospital- and community-based services. In 2023, the most recent data available, 20 hospitals offered outpatient psychiatric services, while only six offered intensive outpatient psychiatric services and six offered outpatient substance use treatment (**Figure 9-5**). The state also includes numerous National Health Service Corps (NHSC) sites, which are HRSA-approved facilities located in federally designated HPSAs. NHSC site approval enables facilities to recruit clinicians through federal scholarship and loan repayment programs, helping underserved communities attract and retain behavioral health, primary care, and oral health providers. The state also has three psychiatric hospitals: Oregon State Hospital, located in Salem, with a satellite center in Junction City, PeaceHealth in Eugene, and Cedar Hills Hospital in Portland.

Beyond hospital-based care, every county has a Community Mental Health Program, and Behavioral Health Resource Networks (BHRNs) support substance use disorder services statewide. A second round of BHRN funding began in July 2025 which provided grants to the Nine Federally Recognized Tribes and organizations in every county in Oregon related to providing substance use disorder services.¹³⁴ Substance Abuse and Mental Health Services Agency (SAMHSA) data identify 212 mental health facilities in Oregon, including 104 outpatient facilities, although these data exclude private practitioners and facilities that do not primarily provide specialty mental health treatment.

Population-level outcomes related to health care access

According to 2024 Behavioral Risk Factor Surveillance System estimates (BRFSS; see Methods appendix for details), 72.1% of Oregon adults reported visiting a doctor for a check-up in the last year, and 82.3% reported having at least one personal health care provider (**Table 9-4**). Overall, 79.9% of respondents reported good, very good, or excellent health, while 20.1% reported fair or poor health. The most commonly reported disability domain was cognition (16.1%), followed by mobility (10.9%) and independent living (9.8%). Additionally, 12.7% of Oregon adults reported being unable to afford a

doctor's visit when needed during the previous 12 months. These are estimated rates for the state – experiences may differ regionally.

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

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

Data source: Oregon Behavioral Risk Factor Surveillance System, 2024. See Methods appendix for details.

Table 9-5 summarizes selected chronic health conditions among Oregonians and common preventive health measures, used here as measures specific to primary care needs and utilization. An estimated one-quarter of adults reported having been told by a doctor that they had arthritis, while less than 4% had been diagnosed with angina or coronary heart disease (3.5%). Use of common preventive health measures was relatively high: over two-thirds of Oregon women aged 40 and over reported having a mammogram in the past two years, and almost 77% of adults aged 65 and older reported having received a pneumonia vaccination. In comparison to national estimates, Oregon's chronic disease prevalence estimates are generally lower compared to national estimates, with screening estimates being mixed (lower than national for mammogram,

higher than national prevalence for blood stool test). Data from Oregon's All Payer All Claims database indicate that primary care accounts for a substantial share of health care utilization and spending in the state. On average, approximately 14% of total health care expenditures are spent on primary care, with individual payers ranging from 5.9% to 17.1%, exceeding Oregon's primary care spending benchmark of 12%.¹³⁵

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

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

Table 9-5. Age-adjusted indicators of primary care, oral health, and behavioral health care access in Oregon, 2024

Indicators of health care access	Age-adjusted estimated percentage of adults in Oregon
Primary Care	
Adults aged 18+ who have been told they have arthritis	25.5%
Adults aged 18+ who have been told they currently have asthma	14.5%
Adults aged 18+ who have ever been told they have COPD*	6.0%
Adults aged 18+ who have ever been told they have angina or coronary heart disease	3.5%
Adults aged 18+ who have ever been told by a doctor they have diabetes	10.8%
Adults aged 45-75 who had a blood stool test within the past year to screen for colorectal cancer	11.2%
Women aged 40+ who had a mammogram within the past two years	67.7%
Adults aged 65+ who have ever had a pneumonia vaccination	76.9%
Calculated variable for meeting USPSTF lung cancer screening guidelines, [†] among eligible respondents	15.2%
Oral Health	
Adults aged 65+ who have had all their natural teeth extracted	11.0%

Adults aged 18+ that have had any permanent teeth extracted	36.7%
Visited the dentist within the past year (2022)	65.4%
Behavioral Health	
Adults aged 18+ who have ever been told they have a form of depression	28.4%
Number of days during the past 30 days when mental health status was considered not good among adults aged 18+	
0 days	48.0%
1-13 days	31.9%
14+ days	20.1%

Data source: Oregon Behavioral Risk Factor Surveillance System, 2024. See Methods appendix for details.

*COPD: Chronic obstructive pulmonary disease

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

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

Indicator	Estimated annual percentages
Mental health measures	
Any mental illness	31.6%
Received mental health treatment (2024 only)	28.6%
Major depressive episodes	11.9%
Had serious thoughts of suicide	7.0%
Attempted suicide	0.7%
Substance use disorder measures	
Substance use disorder in the past year	21.8%
Illicit drug use in the past month	26.0%
Prescription opioid misuse in the past year	2.9%
Opioid misuse in the past year	3.0%
Cigarette use in the past month	14.9%
Nicotine vaping in the past month	10.2%

Data source: National Survey on Drug Use and Health Data. See Methods appendix for details.

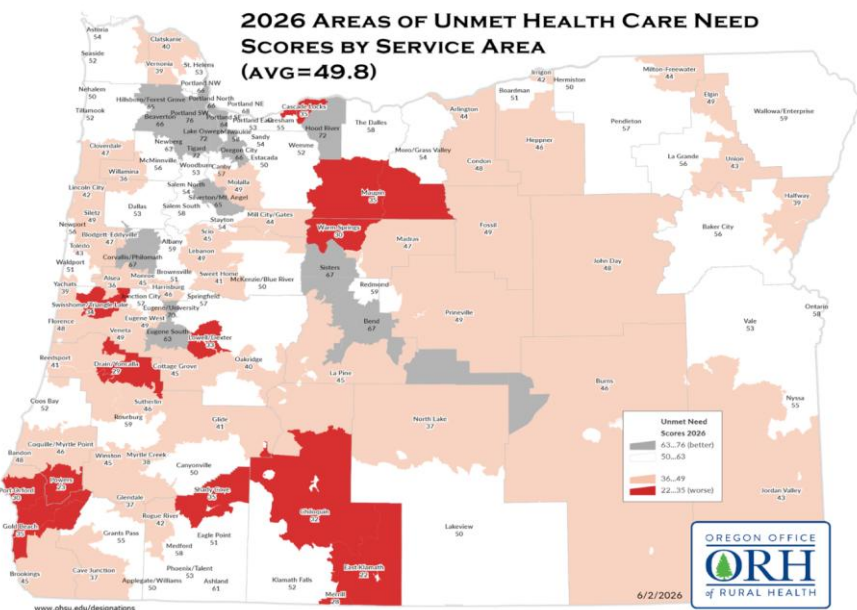
Areas of Unmet Health Care Need

Areas of Unmet Health Care Need are measured within primary care service areas (N=128) by the Oregon Office of Rural Health.¹³⁶ The overall Unmet Health Care Need score is a composite measure of nine variables representing primary, behavioral health, and oral health care availability as well as affordability and utilization. Lower scores indicate greater unmet health care need. It should be noted that these are sub-county areas and cannot be directly compared to the county-level data provided elsewhere in this report. Workforce supply are direct measures of FTE, rather than the estimates

provided in previous sections. However, these do provide a closer examination of areas of Oregon with higher primary care, behavioral health, and oral health care needs.

Oregon's overall unmet need score is 49.8, a slight increase from 49.6 in 2025, with service-area scores ranging from 22 to 76 (**Figure 9-6**). The overall greatest unmet need was concentrated in rural and remote areas, where scores averaged 46.4 and 48.8, respectively, compared to urban areas (62.5). There were 13 rural service areas with an overall unmet need score 35 and below, whereas the lowest score in an urban area was 49 (Eugene West) and 37 (North Lake) in a remote area. Portland Southwest, which includes OHSU, had the highest score, while East Klamath had the lowest score (22, compared with 23 last year). East Klamath has no primary care capacity and no dentists or mental health providers; it also has the fourth-worst prenatal care measure and a high poverty rate. In total, 62 service areas scored below the Oregon average, down slightly from 65 last year.

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



Data Source: Oregon Office of Rural Health, 2026.

Primary Care - Unmet Needs

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

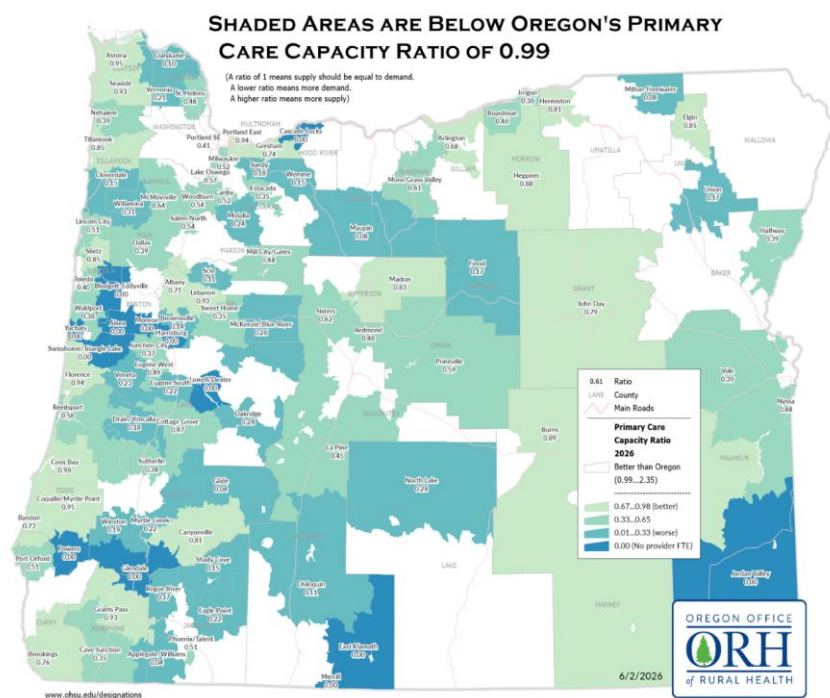
Primary care capacity: The statewide primary care capacity was 0.99 and ranged from 0.0-2.35 – this is measured as the proportion of estimated primary care visits that available providers could meet (higher proportions indicate better capacity). Ninety-six service areas had lower capacity (13 with 0.0,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

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

Preventable hospitalizations for ambulatory care sensitive conditions (ACSCs):

ACSCs are conditions such as asthma and diabetes which hospitalization may sometimes be avoided through timely and effective primary care. ACSC rates per 1,000 population were calculated as a three-year average of hospital discharges identified using ICD diagnosis codes in Oregon (2023-2025) and Washington (2018-2020) data. Rates ranged from 1.9 to 22.2 per 1,000 population, with a statewide rate of 7.1, up from 6.7 in the previous report. Average ACSC hospitalization rates were 8.9 in rural areas, 7.0 in remote areas, and 6.4 in urban areas.

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



Data Source: Oregon Office of Rural Health, 2026.

Oral Health Care - Unmet Needs

Unlike the primary care section, maps are not presented for oral health care and behavioral health care unmet need measures because provider availability and geographic workforce distribution are already described in the corresponding workforce

sections. To avoid duplication, this section focuses on summary measures of unmet need across primary care service areas.

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

Behavioral Health Care – Unmet Needs

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

10. Recommended areas of focus

Before and since the 2025 Health Care Workforce Needs Assessment was released in January 2025, Oregon has undertaken significant efforts to address health care workforce needs such as maldistribution, representation, barriers to entry, and risk of turnover. Findings in this 2027 Health Care Workforce Needs assessment reflect some positive changes related to these prior efforts, particularly growth in the BH workforce (Section 8) and primary care NPs and PAs (Section 6).

This report also identifies areas where more concentrated efforts are needed. Growth has been more limited in the oral health workforce (Section 7) and across all physician types (Sections 6 and 8). In addition, there are ongoing needs related to lower workforce supply in rural and remote areas, fewer educational completions for some occupational groups, expected high levels of replacement job openings for certified occupations, and inadequate access to childcare and housing. Along with needs specific to the health care workforce, findings highlight population health indicators that underscore the importance of ensuring access to high-quality primary care, oral health care, and behavioral health services.

The following recommendations respond to the health care workforce needs identified in this report. Recommendations also highlight opportunities for continued investment and tracking, as well as expansion of current Oregon policies and programs, and provide evidence-based examples of potential approaches. Recommendations specific to each health workforce group are presented first, followed by recommendations addressing needs that cut across primary care, oral health, and behavioral health workforces. Citations provide supporting evidence and examples of initiatives where applicable.

Recommended areas of focus: Primary care workforce

Oregon has ongoing efforts to support the primary care workforce that should be sustained and, where appropriate, expanded. These include funding for Oregon's provider incentive programs (e.g., Healthy Oregon Workforce Training Opportunity [HOWTO] Grant, Health Care Loan Repayment Program, and Primary Care Loan Forgiveness), support and funding for PCPCHs, and the work of OHPB's Primary Care Strategy Committee. While there has been growth in the primary care workforce since the 2025 assessment, there are ongoing concerns related to primary care capacity as evidenced by the 24.2% reporting working more than 40 hours per week, the limited growth in the number of direct care FTEs per 10,000 population, and the increasing number of primary care service areas with 0 primary care capacity. As such, the recommendations below are meant to complement ongoing work and to emphasize specific opportunities to maximize capacity of the existing primary care workforce.

- **Explore opportunities to facilitate adoption and incorporation of team-based care models**, although more evidence is needed regarding their effectiveness. A recent study highlights one potential model emphasizing greater team integration, clear role delineation between occupational types, and staffing aligned with both community needs and the mix of clinicians within a practice. This approach may enable smaller panel sizes, more efficient use of staff, and greater reach in underserved areas.¹³⁷
- **Provide informational and financial support to preceptors for NPs.** While there has been growth over time among primary care NPs in Oregon, the state has only two NP programs, with available data showing minimal growth in educational completions over time (See "Education program completions" in Section 6). National concerns related to clinical placements and availability of preceptors, particularly in rural areas, may be one explanatory factor contributing to this decline in Oregon.¹³⁸⁻¹⁴⁰ In addition to the informational support provided by Oregon Health Science University School of Nursing on becoming a preceptor,¹⁴¹ funding is needed to facilitate payment of preceptors. A recent Rural Health Transformation Plan grant is providing some support for this via the Northeast Oregon Area Health Education Center. Additional funding could be helpful in expanding preceptor access, along with efforts to

strengthen organizational support for precepting, including activities in productivity metrics and providing sufficient compensation.^{142,143}

- **Support RNs to function in primary care at the top of their scope.** RNs encompass a large part of the primary care workforce and when they are working at the top of their license (e.g., providing dedicated nurse visits, engaging in complex care coordination, supporting social determinants of health), they can expand services, reduce service gaps, and support physicians, PAs and NPs.^{57,144,145} Current findings demonstrate a significant gap between the number of primary care RNs and their reported direct patient care FTE, highlighting the need to better understand how RNs are being utilized in these settings. Given broader gaps in understanding RNs' contribution to primary care, additional education for practices and data collection could help assess and strengthen the use of RNs in primary care in Oregon.
- **Explore opportunities to expand medical assistant (MA) roles,** as this may support greater primary care capacity, although research on long-term effects on MA retention and supply remains limited. Examples of expanded team-based care models from Kaiser Permanente, and Washington and Minnesota primary care clinics demonstrate improvements in workflow, efficiency, preventive care delivery, and team functioning.¹⁴⁶⁻¹⁴⁸ Career ladders, professional development, and compensation progression may also support MA workforce stability by providing structured pathways from entry-level positions into advanced clinical, care coordination, or leadership roles.^{149,150}

Recommended areas of focus: Oral health workforce

As noted in the findings, Oregon's oral health workforce has experienced little overall growth, evidencing a need for targeted efforts to grow and stabilize this workforce. Oregon has a number of policies and initiatives in place to support this workforce, including regulations allowing a broader scope of practice for dental hygienists, eligibility for state incentive programs (e.g., HOWTO), and a recent report examining ways to support the dental assistant (DA) workforce. The latter is part of a Health Resources and Services Administration grant focused on addressing oral health workforce needs. The recommendations below offer specific, actionable strategies that complement and build on these existing efforts. These approaches may be particularly relevant because a substantial share of dental care is delivered in solo and small-group practices, where staffing shortages and turnover can disproportionately affect practice operations and patient capacity.¹⁵¹

- **Examine reasons for low use of Expanded Practice Dental Hygienist permits.** Data examined in this report demonstrate that while approximately a third of DHs report having an EPDH permit, only a small proportion use these permits in practice. Further

work is needed to understand barriers to utilization and identify opportunities to expand capacity for preventive oral health care.

- **Continue to track dental therapists and monitor completions from the new dental therapy school in Oregon.** Because dental therapists were only recently approved for licensure, insufficient data are available to assess workforce trends and needs. Continued tracking is warranted along with their inclusion in future needs assessments. This includes tracking of entrants to and completions from the recent dental therapy program started at Pacific University, which has its first class in Fall 2026.
- **Facilitate use of expanded function dental assistants (EFDAs).** Studies suggest that EFDAs can improve practice efficiency, increase provider productivity, and expand access to dental services, particularly in settings experiencing workforce shortages.¹⁵²⁻¹⁵⁵
- **Facilitate growth of the DA workforce through apprenticeships and other on-the-job training,** which employers have identified as effective strategies for recruitment and may support career progression into dental hygiene.¹⁵⁶ However, apprenticeship utilization appears limited in Oregon, with only one registered dental assistant apprenticeship currently identified.
- **Address decreasing educational completions among the DA workforce.** Available data demonstrates a decrease in DA program completions. In addition to expanding pathways into the profession through apprenticeships and on-the-job training, further exploration of the factors contributing to decreasing DA completions is needed to support continued growth of this workforce. A recent report on the DA workforce highlights the importance of outreach and recruitment into DA programs, partnering with the OHSU School of Dentistry, and increased partnerships between DA training programs and dental practices.¹¹⁶
- **Explore Oregon-specific rural dental training models.** Programs such as the University of Washington's Rural/Regional Initiatives in Dental Education (RIDE)¹⁵⁷ and the Yakima Valley Farm Workers Clinic's Northwest Dental Residency Program¹⁵⁸ demonstrate approaches to increasing training opportunities in rural and underserved communities. Oregon could consider adapting similar approaches to strengthen recruitment and retention of dentists in rural areas.
- **Continue support of, and potentially grow, incentive programs targeting the oral health workforce** such as the HOWTO and HCPIP loan repayment programs. These programs have shown promise in retaining health care workers in rural and underserved areas, and in increasing access to care. This may also be an important part of increasing oral health Medicaid coverage, as current data suggests that Medicaid dental care is concentrated among a relatively small subset of high-volume providers.

- **Improve tracking of the DA workforce** by collaborating with state and community partners to collect statewide DA workforce data, supporting evaluation of workforce pathway and advancement strategies, and maintaining cross-agency coordination on oral health workforce issues as proposed by the Dental Assistant Workforce Shortage Advisory Committee.¹¹⁶

Recommended areas of focus: Behavioral health workforce capacity

The behavioral health workforce continues to grow in Oregon and numerous initiatives and policies are underway to strengthen it, including the recent signing of HB 4083 (2026), which centralizes credentialing, expands eligibility for supervision of early-career providers, such as through cross-license supervision, and reduces administrative requirements for Medicaid credentialing.¹⁵⁹ The recommendations below focus on opportunities to build on and expand existing efforts.

- **Continue examining underlying reasons for the gap between the number of actively practicing BH occupations and the available direct care FTE.** The BH workforce also on average works less than 35 hours per week, although 18% are estimated to work over 40 hours per week. Reasons for the direct care FTE/license number gap, and lower average weekly hours, are not fully understood, although the emotional demands and administrative burden related to the work have been identified as potential contributing factors. As such, there may be opportunities to address this gap through:
 - **Organizational strategies** that facilitate manageable caseloads, offer emotional and peer support, encouraging use of available vacation time, and foster a workplace culture that addresses burnout and secondary traumatic stress.¹⁶⁰⁻¹⁶²
 - **Telehealth and flexible work arrangements**, which may strengthen workforce capacity by improving flexibility, autonomy, work-life balance, and self-care.^{163,164} Telehealth does appear to be a major component of BH care delivery in Oregon; continued support and expansion of ability to do this could be warranted. Greater use of video visits among mental health clinicians has been associated with lower turnover and greater job satisfaction.¹⁶³
- **Address decreasing educational completions apparent in current data, which may reflect barriers to entry.** Strengthening Oregon's BH workforce pipeline may involve interventions from early career exposure through education, training, supervision, and licensure.
 - **Increase early exposure to BH careers.** Introducing high school students to BH career pathways, particularly those from underserved communities, may help

build the workforce pipeline, as recommended in the recent Behavioral Health Talent Assessment report.^{49,165}

- **Reduce the financial burden of BH education and training.** Costly educational pathways can create barriers to entering BH professions. Strategies include tuition assistance, scholarships, clinical-training stipends, paid internships, and loan repayment.^{166,167} Oregon has already made substantial investments through OHA's BH workforce initiatives and 2025 legislation providing educational incentive grants and other financial supports to graduate BH students.¹⁶⁸
- **Expand access to clinical supervision.** In addition to expanding the pool of professionals eligible to provide supervision via HB 4083, barriers remain for clinicians who must pay for required supervision out of pocket.^{77,80,120,169} Strategies include strengthening supervision grant programs and leveraging existing supervisors and local expertise to expand access and accelerate licensure.⁸⁰
- **Facilitate entry of qualified out-of-state providers.** Oregon facilitates entry of some out-of-state BH providers through profession-specific pathways, including reciprocity for LPCs and LMFTs, endorsement for psychologists, and recognition of qualifying supervised experience completed elsewhere.¹⁷⁰ However, requirements vary across professions.¹⁷¹ Opportunities include more consistent recognition of out-of-state licenses, education, examinations, and supervised experience.
- **Facilitate simplification and alignment of BH certification pathways.** Oregon's behavioral health career pathway is complex, with 14 certifying or licensing boards offering 60 credentials and licenses.⁵⁶ In addition to addressing this complexity in HB 4083 (2026), a centralized guide, as discussed in the recent Behavioral Health Talent Report and being developed by the HECC in partnership with OHA, could provide a more immediate way to help individuals interested in BH careers understand and navigate available career pathways.

Broad issues to address

The following recommendations address needs identified among all the health care workforce groups examined in this needs assessment. These are not new concerns nor are they unique to the Oregon health care workforce. Oregon has already engaged in substantial efforts to address these needs, and the findings in this report suggest progress in response to these efforts. The recommendations below highlight ongoing work which should continue to be supported, along with examples of additional approaches to build on these efforts.

Address maldistribution of the health workforce through continued and expanded investment in targeted grow-your-own programs and clinical placements in rural areas. Findings from this needs assessment demonstrate ongoing maldistribution of the

health workforce in Oregon, with lower per-capita supply in counties on the east side of the state and in rural and remote areas. There has been some improvement since the last needs assessment. For example, the average Unmet Need for Health Care score in remote areas increased from 46.1 to 48.7 and every county now has at least one dentist, whereas Sherman County previously had none. However, ongoing efforts are needed to further improve access. Existing programs and policies in Oregon that show promise for improving access to the health workforce include:

- Oregon's 2023 telehealth law (SB 232) which helps to extend provider services and improve rural access.^{75,81,82}
- "Grow your own" rural pathway programs such as The Healthy Rural Oregon project, which establishes accessible training and employment opportunities for community-based workers.¹⁷²
- Medical assistant apprenticeships which are available in approximately 20 Oregon counties.¹⁷³⁻¹⁷⁵
- Employer- and community-based dental assistant, traditional health worker, and community health worker training programs.¹⁷⁶⁻¹⁷⁸
- Multiple provider incentive programs, including HOWTO grant program which has supported growth in the rural nursing and medical assistant workforces.¹⁷⁷
- The Oregon AHEC Scholars Program, which supports health workforce training in rural settings.^{179,180}

Evidence-based approaches implemented elsewhere in the U.S. which could fit well with existing work in Oregon to address maldistribution include:

- **Additional targeted grow-your-own programs**, such as the University of Illinois Rural Medical Education (RMED) Program, which recruits students with rural backgrounds and provides a rural-focused medical curriculum¹⁸¹; the University of New Mexico Combined BA/MD Program, an integrated undergraduate-to-medical-school pathway with rural training¹⁸²; the Colorado Center for Nursing Excellence's "Grow Your Own Primary Care Nurse Practitioner" model that supports RNs already living in rural communities¹⁸³ along with the Rural Psychiatric Mental Health Nurse Practitioner program that extends this approach to RNs in Colorado, New Mexico, and Wyoming.¹⁸⁴
- **Further investment in clinical placements in rural areas** such as the University of Washington's Rural Nursing Health Initiative (RNHI) that supported rural clinical placements for DNP students, paid postgraduate fellowships for advanced practice nurses, and financial support for preceptors and rural clinical sites.^{185,186}
- **Examining the feasibility of building stackable credential programs.** Stackable credential programs – programs where students can obtain a sequential set of credentials or certificates that build toward higher qualifications - have the potential

to grow the workforce over time and address issues related to supply and distribution. However, this approach requires significant coordination with community colleges with well-defined stackable credential pathways, targeted funding and state-level articulation policies, such as those in Ohio and Florida.¹⁸⁷⁻¹⁸⁹

Continue efforts to promote achievement of workforce demographics that are representative of the population. Representation of the health care workforce relative to the population varies by occupation, with more diversity among the certified (i.e., non-licensed and typically lower paid) occupations. There have been improvements in racial and ethnic representativeness in some occupations, such as within the BH workforce. However, Black or African American and American Indian/Alaska Native populations continue to be underrepresented in the primary care and oral health workforces, with Hispanic or Latino/a/x/e populations also underrepresented across all three workforces. Representation is also important with respect to other demographics, including geography, age, and gender. For example, while females make up the majority of the health workforce, males remain more highly represented in higher-paying occupations, such as dentistry and psychiatry. Continued work is needed to promote culturally responsive and equitable care. The provider incentive programs, already highlighted with respect to addressing maldistribution, also play an important role in increasing representation of the health care workforce. In addition, two additional areas present opportunities for continued or expanded efforts:

Continue to provide support, and consider expansion of, K-12 health career pathway programs.^{190,191} Oregon currently supports these efforts through its statewide Health and Biomedical Sciences Career and Technical Education (CTE) pathway.¹⁹² These programs provide exposure through classroom instruction, work-based learning, job shadowing, internships, industry certifications, and dual-credit opportunities. Although evidence on the long-term workforce impacts of Oregon's programs is limited, participation data indicate that Health Sciences CTE programs serve a diverse student population and represent a potential strategy for broadening pathways into health professions.¹⁹³ Additional examples of K-12 health career pathway programs which could build on or expand CTE programming include the Health Sciences and Technology Academy in West Virginia, Florida State University's Science Students Together Reaching Instructional Diversity and Excellence (SSTRIDE) program, and the University of Chicago's Health Professions Recruitment and Exposure Program.^{190,194,195} These programs have reported strong outcomes related to college enrollment, pursuit of health-related fields, and participation by students from underrepresented, rural, low-income, and first-generation backgrounds.

Consider expansion of scholarship programs to support enrollment in health care workforce education programs. The current Scholars for a Health Oregon Initiative

currently provides full tuition to a limited number of health career students, including MD, dental, and NP, at Oregon Health Science University. This is funded as part of the broader set of provider incentive programs in Oregon and is an important part of expanding representation of the health care workforce.

Consider engaging in additional research to better understand which dimensions of workforce diversity are most important for improving access to care and meeting the needs of Oregon's diverse communities. Studies have shown better health outcomes with provider-patient racial/ethnic concordance, but other aspects of concordance (e.g., age, gender) are not as well studied.^{196,197} Intersectional data analyses of language and race/ethnicity, race/ethnicity and sexual orientation and gender identity, and geography and race/ethnicity should also be considered.

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

Addressing these needs may be critical to recruiting and retaining key health care workers especially in rural areas.¹⁹⁸ Broader workforce initiatives that support workers more broadly, including health care workers, may also be important to consider. Oregon has several childcare assistance programs, but these are not all adequately funded to meet current demand.¹⁹ Oregon has also offered one-time housing stipends and childcare assistance through the Community Mental Health Provider grants and the Behavioral Health Workforce Bonus and Housing Stipend (B&HS) Program. Other states have implemented approaches that may have promise for longer-term solutions to address childcare access as well as housing stability, which could be considered in Oregon, including:

- **Tax incentives for childcare.** Massachusetts's Employer Child Care Innovation Fund, offers tax credits for employers and Massachusetts's The Commonwealth Cares for Children tax cuts or funding to childcare providers.^{199,200}
- **Private-public partnerships for childcare.** States including Michigan, Kentucky, Missouri, and Ohio have implemented Tri-Share programs, which split the cost of childcare between the state, the employer, and the employee and provide a promising model for public-private partnerships. Michigan's Tri-Share program and Vermont's Child Care Financial Assistance program are income-restricted, whereas New Mexico is the only state in the country to offer universal, no-cost childcare regardless of income.²⁰¹⁻²⁰³
- **Housing initiatives for health care workers.** Ohio Heroes is a discounted mortgage interest rate program for certain occupations including physicians, nurse practitioners, RNs and LPNs. While not state-run, there are opportunities to potentially partner with nonprofit programs, such as Nurses Next Door, which provides one-time grants to first time homebuyers who are nurses.²⁰⁴

Continue funding and supporting strategies to facilitate retention, including strategies to address and support the wellbeing of the workforce.

Available information on short-term intentions regarding future employment plans among surveyed, licensed occupations indicates relative stability, while employment demand data appear to expect a high level of replacement openings for dental hygienists, nurse practitioners, therapists and counselors, and social workers, along with MAs and DAs (for whom detailed data on turnover and future employment plans are not available). As such, continued support for strategies known to facilitate retention is warranted. Some strategies are addressed elsewhere in this report (e.g., addressing SDW needs, team-based models of care), while others require organizational-level policy changes (e.g., flexible scheduling, mentoring, career advancement opportunities). These efforts can be complemented by state-level policy levers such as health care provider incentive programs, increased reimbursement, reimbursement for peer support services, telehealth flexibility, addressing administrative load for Medicaid credentialing, and investing in pathway programs.²⁰⁵⁻²⁰⁷ Each of these can work together to better support the wellbeing of the health care workforce, a key part of retention.

Assess the workforce and access impacts of Rural Health Transformation Program funding²⁰⁸ that address the concerns identified in this assessment and which may need future funding or other supports to continue. These include:

- Programs designed to expand community-based care (e.g., Connected Care for Older Adults, School Nurse Access Pilot, and Nursing Home Visiting)
- Workforce development programs (e.g., Medical Assistant Workforce Pathway, Advancement of Rural Provider Education)
- K-12 Career Pathways program through the Oregon AHEC and also through "OnTrack OHSU!".²⁰⁹
- A new family medicine residency at Virginia Garcia Memorial Health Center. This investment is particularly relevant given evidence that family medicine residents often remain in the state where they complete residency. It may also help address the longstanding constraints on expanding Medicare-funded residency positions resulting from the Balanced Budget Act of 1997 which capped the number of Medicare-funded residency positions.^{210,211}
- Payment for health care preceptors in Eastern Oregon through the Healthcare Preceptor Initiative.^{141,212}

Increase attention to collecting robust data on the health care workforce in Oregon. Oregon collects a significant amount of valuable health care workforce data, particularly through two efforts: 1) a compulsory survey completed at license renewal for most licensed health care workers and via other tracking systems, such as with MHACBO, and 2) evaluation data from provider incentive programs. Oregon has also engaged in

additional qualitative assessments such as the recent 2026 Dental Assisting Workforce in Oregon report and the 2026 Behavioral Health Talent Assessment. This is a distinct achievement compared to many other states, where licensure data serve as the primary source of information on workforce supply and distribution. Building on this foundation, there are several opportunities to further expand efforts to improve data collection in the state:

- **Standardize additional questions in licensure surveys.** As stated above, the compulsory survey completed by licensed health care workers upon license renewal in Oregon provides key information on health care workforce supply, distribution, demographics, practice characteristics and future employment plans. Most questions are standardized across the surveys for different occupations; however, we identified four key areas where further standardization or additional questions are warranted.
 - **Identify details about education.** Questions regarding whether an individual was educated in Oregon are asked only of MDs, DOs, NDs, and PAs. Adding similar questions to other workforce surveys would facilitate comparability across occupations and help identify which occupational groups are more likely to practice in the state where they are educated.
 - **Inquire about participation in insurance programs.** Adding a question regarding Medicaid acceptance to the nursing survey would provide a more complete picture of access to care and support workforce planning about where increased coverage is needed, particularly for primary care nurse practitioners.
 - **Align future planning questions.** Questions regarding future employment plans are currently asked differently in the surveys for MDs/DOs and PAs than for other licensed occupations, limiting comparisons across occupations, such as intentions to remain in or leave the workforce.
 - **Add secondary location information.** Specific to the OMB survey for MDs/DOs, we recommend collecting the number of days per year spent at secondary locations, in addition to the hours worked, to better identify physicians operating as locums. This information may be particularly important for understanding primary care workforce capacity.
 - **Add a question regarding clinician supervision and precepting responsibilities.** As was identified previously, barriers to program completion for some health workforce groups, such as social workers and nurse practitioners, can relate to difficulty with clinical placements or completing required clinical supervision hours. Increased information on who in the workforce is providing clinical supervision and/or operating as a preceptor would provide greater insight

as to the current workforce capacity for training and support targeted work to address barriers.

- **Consider both specialty and practice setting when measuring the primary care workforce given,** as specialty alone may overestimate the supply of professionals providing primary care. This may be particularly relevant for NPs (e.g., more physicians may split time between hospital and clinic settings versus NPs). The potential impact of practice setting is illustrated by differences between the 2020 Primary Care Nursing report and Health Care Workforce Reporting data.²¹³ While there were several differences in methodology, a key difference was the use of practicing setting in defining the primary care workforce. The 2020 nursing report, by using setting, estimated 745 actively practicing primary care nurse practitioners while in that same year, the Health Care Workforce Reporting program—which didn’t include practice setting—estimated this actively practicing number to be 1,347.
- **Continue to build on existing efforts to collect data on the certified health care workforce.** Previous needs assessments have highlighted persistent gaps in data for the certified workforce, particularly MAs, DAs, and THWs. Oregon has made progress in addressing these gaps, including through data from MHACBO on the certified BH workforce and improved information on THWs and health care interpreters, all of which are included in this report. However, there are continued opportunities to expand on this work, as the lack of comparable data (e.g., FTE, future employment plans) leaves a considerable gap in identifying which issues to prioritize through funding and policy initiatives. These opportunities include:
 - **Continue to include national data sources** such as the American Community Survey (ACS) to better understand overall state-level trends of the certified health care workforce. ACS data on the DA and MA workforce groups are included in this report and could be included in future assessments.
 - **Align questions across existing data sources.** Where possible, align questions on the certified behavioral health workforce with those in licensure surveys, particularly questions related to employment characteristics and future career plans.
 - **Continue building partnerships with professional organizations** in the state to collect additional information on certified occupations such as DAs for whom certification is not required and thus may not appear in other state-level system data. This builds on work facilitated by the Health Resources and Services Administration 2022-2026 grant focused on addressing oral health workforce needs.

- **Identify opportunities to more clearly track the certified behavioral workforce** to better capture time spent using different types of certifications. The certified BH workforce includes several groups: those who are licensed, those who are both licensed and certified, and those who are certified only. Individuals may hold more than one certification, making it difficult to determine how often each type of certification is used in practice, thus hindering the assessment of ongoing workforce gaps. In addition, those who do not hold licenses that qualify them to begin the certification process have two options: their qualifications can be verified by employers or by MHACBO. This further complicates workforce tracking, as MHACBO data may not capture the entire certified workforce.
- **Examine opportunities to add questions about skills to licensure renewal surveys.** It can be challenging to assess skill gaps across health care workforce groups, including differences between newer versus more experienced and differences in skills between occupational types. The current best proxy is job tenure, but this does not provide information on skills required for the job or potentially transferable skills. This represents an opportunity for future data collection, particularly when comparing occupations with overlapping roles such as dental hygienists and dental therapists.
- **Examine opportunities to add questions related to provider wellbeing.** In line with previous recommendations from the Health Care Workforce Committee made in 2024,²¹⁴ more data is needed regarding the wellbeing of the health care workforce in Oregon. There is an opportunity to add questions regarding burnout, using a standardized burnout assessment tool.
- **Establish and track measurable goals over time as decisions are made with where to focus with respect to the above recommendations.** Setting and accomplishing realistic goals will require collaborative efforts across partnering organizations, including governmental representatives, legislators, educational institutions, and health care workforce organizations, to develop appropriate measures, identify relevant data sources, and hold each other accountable in progressing toward desired outcomes.

11. Conclusion

The findings and recommendations presented in this report highlight the ongoing work in Oregon to support and sustain a thriving health care workforce that provides culturally responsive care. Our recommendations provide specific suggestions for expanding current work or additional areas of focus. To prioritize and advance these

Commented [NG1]: Suggest adding a citation to the workforce wellness paper.

Commented [NG2R1]: Also - a recommendation from the paper also included expansion of the Oregon Wellness Program. To Chris's earlier point, could some content be added on wellbeing that would tie to a recommendation?

Commented [PK3R1]: here is the report:
https://uwnetid.sharepoint.com/:b:/r/sites/og_dfm_chws-P-OHAHealthNeedsandIncentivesEval/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fog%5Fdfm%5Fchws%2DP%2DOHAHealthNeedsandIncentivesEval%2FShared%20Documents%2FP%2DOHA%20Health%20Needs%20and%20Incentives%20Eval%2FNeeds%20Assessment%2FBackground%20and%20Literature%2FFORMATTED%20Workforce%20Wellness%20and%20Resiliency%20Strategy%20Page%20v2%5B42%5D%2Epdf&parent=%2Fsites%2Fog%5Fdfm%5Fchws%2DP%2DOHAHealthNeedsandIncentivesEval%2FShared%20Documents%2FP%2DOHA%20Health%20Needs%20and%20Incentives%20Eval%2FNeeds%20Assessment%2FBackground%20and%20Literature&p=true&share=cQpYTIw%2DsDRKSrgccxeVYSZkEgUCPwFsOWPUZFOn1P7UEsltg

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recommendations, we also recommend establishing measurable goals to be tracked over time, an endeavor that extends beyond the scope of this report. This work will be an important part of advancing Oregon’s goal of ensuring that everyone has local access to the health care they need.

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- Members of the Oregon Health Policy Board
- Members of the 2027 Health Care Workforce Needs Assessment Advisory Committee

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