MEMO

To: Oregon Health Policy Board

From: Oregon Healthcare Workforce Committee

Date: March 28, 2013

Action items: Accept attached revised 2012 report from the Workforce Committee; approve or decline to approve specific recommendations; direct or encourage Workforce Committee or other entities to move forward with implementation of approved recommendations.

About the report: The Healthcare Workforce Committee is required by its charter to produce a biennial report for the OHPB with "recommended strategies, actions and policy changes … that support the recruitment, retention and distribution of Oregon's health care workforce, with an emphasis on primary care." The attached report contains the Committee's *revised* 2012 recommendations in response to this charge. Two stakeholder comments on the Committee's draft recommendations are attached in a separate document.

Feedback on first draft of this report: Draft recommendations were presented to the OHPB on February 5, 2013. Board members gave feedback on the draft material and requested that the Committee revise its analysis and recommendations to answer two specific questions:

1. What can the state do now to get ready for 2014? (What three or four key actions could be taken now that will help prepare the workforce for the influx of newly insured?)
2. What key actions should the state be considering for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation?

Board members encouraged the Committee to identify and prioritize actions that would be reasonably achievable and produce the greatest impact, and to focus on workforce needs within a transformed delivery model.

About the new recommendations: The Committee generated a number of recommendations in response to the two questions above. Among those, members prioritized four immediate steps that can increase primary care workforce capacity for 2014, as well as six actions that can be taken over a longer time frame. All the recommendations are listed in priority order in a one-page table and described more fully in the attached revised report.

- The short-term recommendations consist of actions with the potential for an immediate return: strategies for maximizing existing in-state workforce capacity, for recruiting already-trained professionals to Oregon and distributing them appropriately, and for increasing provider retention over the next few critical years.
- The longer-term recommendations are more varied and cover education, recruitment, retention, and data.
- All the recommendations focus on primary care, both because Committee members believe that will be the greatest need in 2014 and because robust primary care is at the heart of the coordinated care model and Oregon's plans to achieve the Triple Aim.

Oregon Healthcare Workforce Committee – Revised Recommendations Summary – April 2, 2013

Short-term recommendations to increase primary care capacity in advance of 2014		Category
1	Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible.	Maximize current capacity
1	Implement new Medicaid loan repayment program for primary care providers	Recruitment
3	Forecast short and longer-term demand for primary care practitioners, accounting for likely effects of new models of care.	Data
4	Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers.	Maximize current capacity
•	Update healthcare workforce need data and healthcare professional shortage area designations to ensure that as many sites and practitioners as possible are eligible for federal recruitment incentives.	Recruitment
•	Increase participation/investment in the Oregon Rural Locum Tenens Collaborative as a means of providing practice support to encourage providers near retirement to stay in the workforce a few years longer	Recruitment / retention
•	Make naturopaths eligible for the new Medicaid state loan repayment program.	Maximize current capacity
•	Support employers and clinics in assessing organizational and/or environmental factors related to clinician retention (including provider engagement, burnout, etc.) and adopting best practices	Retention
•	Continue active outreach for the J-1 visa waiver program, to increase the number of obligated	Recruitment
Administrative and programmatic recommendations for 2014 and beyond		
1	Re-fund the state's Primary Care Loan *Forgiveness* Program	Recruitment
2	Develop occupational training programs to respond to emerging care models and industry demand	Education
3	Ensure that CCOs' required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess	Data
3	Enact workforce data reporting mandate for all health profession licensing boards	Data
5	Develop integrated health careers pathways, with central coordination	Education
6	Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information	Education
•	Revise state's Adverse Impact law and related regulations	Education
•	Maximize opportunities for license reciprocity	Recruitment
•	Ensure exposure to rural practice for health professions students of all kinds, especially primary care practitioners	Recruitment
•	Adopt a uniform credentialing system statewide, in alignment with Health Leadership Council work	Recruitment / retention
•	Develop a system for creating "workforce impact statements (i.e., statements of workforce needs generated by implementation of reform proposals)	Data
Additional recommendations for primary care capacity		
1	Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually.	Education
2	Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.	Education

Oregon Healthcare Workforce Committee

Revised recommendations for the Oregon Health Policy Board

April 2, 2012

Oregon Health Authority

Preface

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee ("Committee") to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. Among other things, the Committee is charged with producing a biennial report for the OHPB outlining "recommended strategies, actions and policy changes … that support the recruitment, retention and distribution of Oregon's health care workforce, with an emphasis on primary care." A draft set of recommendations was presented to the OHPB on February 5, 2013. Board members felt that the recommendations needed more focus and asked the Committee to prepare revised recommendations in answer to two key questions:

1. What can the state do now to get ready for 2014? (What three or four key actions could be taken now that will help prepare the workforce for the influx of newly insured?)
2. What key strategies should the state be considering for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation?

This document contains the Committee's revised recommendations in response to the Board's direction. All the recommendations focus on primary care, both because Committee members believe that will be the greatest need in 2014 and because robust primary care is at the heart of the coordinated care model and Oregon's plans to achieve the Triple Aim.

Because healthcare workforce issues lie at the intersection of education and health care policy, a particularly wide range of actors is implicated in the Committee's recommendations. It is important to note, however, that the Committee's ability to take direct action is limited: it does not have the authority to compel any other body to take action; nor does it have funding to implement ideas that may require financial or other resources beyond staff support. The Committee relies on the OHPB, the Oregon Health Authority, and the Governor's office to carry many of its recommendations forward.

Short-term recommendations to increase primary care capacity in advance of 2014

The OHPB asked the Committee to identify three or four key actions that could be implemented immediately in order to increase Oregon's ability to care for the newly insured in 2014. With 2014 now less than a year away, training any significant number of new primary care providers is out of the question. Consequently, the Committee's revised recommendations focus instead on strategies for maximizing existing in-state workforce capacity, for recruiting already-trained professionals to Oregon and distributing them appropriately, and for increasing provider retention over the critical next few years. In addition, the Committee has included one analytic recommendation in this section: model future primary care workforce demand in the context of new delivery models. This modeling would not result in additional workforce capacity by 2014 but is included in the short-term recommendations

section because the analysis could be done this year and because the results would provide critical guidance for subsequent workforce development efforts.

In order of priority, the Committee's top recommendations for actions that can be taken now are:

1. (Tie) Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible;
1. (Tie) Implement them new Medicaid loan repayment program for primary care providers
3. Forecast short and longer-term demand for primary care practitioners, accounting for likely effects of new models of care; and
4. Make better use of naturopaths as part of the primary care workforce by removing contracting, credentialing, coverage, and payment barriers.

Additional detail for these recommendations can be found in Table 1, beginning on the following page. For each recommendation, the table specifies: the entity (or entities) that the Committee suggests should have responsibility for implementation; the proposed timeframe; and the recommendation's intended impact and relation to the Triple Aim.

In addition to the four primary recommendations above, Committee members identified several other strategies that they believe would have a positive impact on primary care workforce capacity as soon as 2014. These strategies are also listed in Table 1.

Table 1: Short-term recommendations to increase primary care capacity in advance of 2014

What	When	Who*	Intended Impact & Relation to Triple Aim
1. (Tie) Implement flexible, functional, and outcomes-based reimbursement mechanisms, especially for primary care, widely and as soon as possible. (*Category: Maximize existing capacity*)	2014	OHA CCOs Other payers	*Intended impact*: Widespread payment reform would accelerate adoption of new models of care (e.g. PCPCH) and allow practices to use the best, most efficient provider for a given need. *Triple Aim*: Better care, lower costs
1. (Tie) Implement the new Medicaid state loan repayment program for eligible primary care providers. (CMS waiver requirement of $2m annually for 13-15 biennium). (*Category: Recruitment*)	2013	Legislature OHA	*Intended impact*: 50-100 practitioners (depending on provider type mix and loan repayment amounts) obligated to serving Medicaid clients in rural and underserved areas. *Triple Aim*: Better care and health via increased access for underserved groups.
3. Forecast short and longer-term demand for primary care practitioners. (*Category: data*) ▪ Identify uninsured populations (demographic characteristics, geography, etc.) becoming eligible for coverage. ▪ Identify & summarize data on current levels of access to care ▪ Identify and summarize range of potential effects of new models of care/practice redesign on primary care capacity and make-up ▪ Model/forecast demand for primary care practitioners, using input data assembled earlier	June 2013 June 2013 June 2013 October 2013	OHWI and OHA - OHPR, with input from the Workforce Committee and other experts	*Intended impact*: Better, more nuanced projections of workforce demand and capacity will allow for more appropriately focused and scaled action to create the workforce that Oregon needs. *Triple Aim*: An appropriately sized, skilled, and distributed health care workforce supports all three aspects of the Triple Aim.
4. Make better use of naturopaths as part of the primary care workforce: Remove contracting, credentialing, coverage, and payment barriers in CCOs and commercial carriers. (*Category: Maximize existing capacity*)	2013 and 2014	CCOs, health care facilities, commercial plans	*Intended impact*: Immediate increase in primary care workforce, achieved by capitalizing on an existing and in some cases under-utilized provider category.

What	When	Who*	Intended Impact & Relation to Triple Aim
			Triple Aim: Better care via increased access for those interested in naturopathic care.
Update healthcare workforce need data and healthcare professional shortage area designations to ensure that as many sites and practitioners as possible are eligible for federal recruitment incentives. (*Category: Recruitment*)	2013 and 2014	OHA – PCO	*Intended impact*: Increased likelihood that communities, facilities, and providers will be eligible for other recruitment incentive programs (e.g. National Health Service Corps). *Triple Aim*: Better care and health via increased access for underserved groups.
Increase participation/investment in the Oregon Rural Locum Tenens Collaborative as a mechanism to keep providers near retirement in the workforce a few years longer and provide practice support for others. (*Category: Retention*) ▪ Add semi -retired physicians and mid-levels to pool of providers; expand scope of service to include after hours phone coverage for small and remote clinics.	2014	Oregon AHEC	*Intended impact*: Improved physician retention/ reduced burnout due to relief services. Older physicians remain in practice longer by providing locum tenens service, increasing the flexibility of primary care workforce. *Triple Aim*: Better care via provider continuity; lower costs if the expense of new recruitment is avoided.
Make naturopaths eligible for the CMS waiver primary care loan repayment program. (*Category: Recruitment*)	July 2013	OHA in consultation/ negotiation with CMS	*Intended impact*: Expanded range of providers obligated to serving Medicaid clients in rural and underserved areas. *Triple Aim*: Better care via increased access for those interested in naturopathic care.
Support employers and clinics in assessing organizational and/or environmental factors related to clinician retention (including provider engagement, burnout, etc.) and adopting best practices. (*Category: Retention*)	2013	OHA Transformation Center; PCO, ORH, and OPCA, collaboratively; employers,	*Intended Impact:* Improved provider retention, reduced transition time for clinicians, practices, and patients. *Triple Aim:* Better care, potentially reduced costs due to reduction in recruiting services.

What	When	Who*	Intended Impact & Relation to Triple Aim
		practices, and communities	
Continue to do active outreach for J-1 visa waiver program	2013 and 2014	OHA – PCO	*Intended impact*: All available slots for foreign physicians to practice in underserved areas get filled *Triple Aim*: Better care and health via increased access for underserved groups.

*Acronym list:

AHEC – Area Health Education Center
CCO – Coordinated Care Organization
ND – Naturopathic Doctor
OHA – Oregon Health Authority
OHPR – Oregon Health Authority
OHSU – Oregon Health and Sciences University
OHWI – Oregon Healthcare Workforce Institute
OPCA – Oregon Primary Care Association
ORH – Oregon Office of Rural Health
PCO – Oregon Primary Care Office (within OHA)

Administrative and programmatic recommendations for 2014 and beyond

The OHPB's second request was for the Workforce Committee to identify key strategies for the period of 2014-2020 to ensure that Oregon has the workforce it needs given health care transformation. In directing the Committee, Board members emphasized that these recommendations should be "reasonably achievable," even if some were more aspirational than others, and should focus on how workforce needs intersect with a transformed delivery model.

Because the request was for key strategies over a six- or seven-year time period, Workforce Committee members wished to make two cautionary points before offering recommendations:

- It is difficult to forecast future workforce needs when the model of care is changing rapidly and employers are not yet in consensus regarding the types of workers they want to hire. Educational institutions are reluctant to offer training when the likelihood of subsequent employment is not clear. To the extent possible, the Committee suggests framing conversations around the kinds of functions and competencies that providers will need to work within a transformed delivery model,[1] rather than around specific provider types.
- Workforce supply and demand are cyclical and vary by profession, geography, and other factors. For example:
    - Anticipating a looming nursing shortage, many educational institutions increased class sizes in the early and mid 2000s and graduated a much larger number of nurses than in the past. When the recession hit, many incumbent nurses delayed retirement, with the result that new associate and bachelors-degree nurses are reportedly having trouble finding jobs in the Willamette Valley and Portland metro area, but less so in other areas of the state. This situation may change once again as the economy improves and the demand for care increases in 2014.
    - The Committee has heard reports that dental hygienists and x-ray technologists are having difficulty finding employment in Oregon but that there is no shortage of employer demand for physicians, nurse practitioners, or physician assistants.

The Committee's top recommendations for programmatic and administrative action over the next several years span the categories of education, recruitment, retention, and workforce data and are:

1. Re-fund the state's Primary Care Loan Forgiveness Program;
2. Develop occupational training programs to respond to emerging care models and industry demand;

[1] See the Committee's January 2012 report to the Board, entitled Improving Oregon's Health: Recommendations for Building a Healthcare Workforce for New Systems of Care, at: http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_WG1_12.27.11.pdf

3. (Tie) Ensure that CCOs' required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess;
3. (Tie) Enact workforce data reporting mandate for all health profession licensing boards;
4. Develop integrated health careers pathways, with central coordination; and
5. Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information.

For each of these recommendations, Table 2 (following) specifies: the entity (or entities) that the Committee suggests should have responsibility for implementation; the proposed timeframe; and the recommendation's intended impact and relation to the Triple Aim. Additional background information or context for several of the recommendations can be found in Appendix A.

In addition to the six recommendations prioritized above, Committee members identified several other strategies that they believe would help develop Oregon's workforce in the right direction. These strategies are also listed in Table 2.

Table 2. Administrative and programmatic recommendations for 2014 and beyond

What	When	Who*	Intended Impact & Relation to Triple Aim
1. Re-fund Oregon's Primary Care Loan *Forgiveness* Program. (*Category: Recruitment*) Please see Appendix A for more information.	July 2013	Legislature	*Intended impact*: Obligate 5-6 health professions students/year to rural practice in Oregon upon completion of training. *Triple Aim*: Better care and health via increased access for underserved groups.
2. Develop occupational training programs to respond to emerging care models and industry demand, e.g. Oregon Tech's proposed new undergraduate major in Health and Human Behavior, or non-traditional health care worker training programs. (*Category: Education*)	2014	Educational institutions, accrediting organizations, community-based organizations	*Intended Impact:* More Oregon students are prepared to deliver or access services in Coordinated Care Organizations or other new models. *Triple Aim*: Better care and health via relevant training
3. (Tie) Ensure that CCOs' required community health assessments include an assessment of workforce capacity in their service areas/regions and identify areas of anticipated shortage or excess. (*Category: Data*)	2013 and 2014	OHA Transformation Center, CCOs	*Intended impact*: Ensure that CCOs are considering workforce development in their comprehensive planning. *Triple Aim*: Use workforce data to inform policies relevant to all three aspects of the Triple Aim
3. (Tie) Enact workforce data reporting mandate for all health professions boards. (*Category: Data*) Please see Appendix A for more information.	2014	Legislature; licensing boards	*Intended impact*: Create a more complete dataset on the characteristics and practices of Oregon's licensed healthcare workforce. *Triple Aim*: Use data to inform policies relevant to all three aspects of the Triple Aim
5. Develop integrated health careers pathways, with central coordination. (*Category: education*) Please see Appendix A for more information.	2014	Oregon AHEC, CC's, CCWD, OUS, private universities	*Intended Impact*: More Oregon students enter health professions training because the pathway from elementary through professional training is easier to navigate and coordinated statewide, and appropriate resources are available to students at all levels. *Triple Aim*: Better care and health via increased access

What	When	Who*	Intended Impact & Relation to Triple Aim
6. Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information. (*Category: education*) Please see Appendix A for more information.	Beginning of 2014-15 academic year	OHA for admin. rules; Consortium collaboration among schools and clinical sites for tracking system, with input from Workforce Committee	*Intended Impact*: Reduce inefficiencies and costs for student clinical placements to increase capacity. Triple Aim: Improve quality & decrease costs of educational experience; better care via positive adjustments to workforce capacity
Revise state's Adverse Impact law and related regulations. (*Category: Education*) Please see Appendix A for more information.	2013	Higher Education Coordinating Council	*Intended Impact*: A level field exists for program approval between public, private and proprietary institutions, making it easier to "right-size" programs. *Triple Aim*: Improve quality of education experience; better care via positive adjustments to workforce capacity
Maximize opportunities for license reciprocity. (*Category: Recruitment*) ▪ Identify licensing boards' current efforts allowing for reciprocity or expedited licensure for professionals already licensed in other states. ▪ Identify challenges (e.g. laws, regulations) that hinder opportunities for reciprocity.	2013	Healthcare Workforce Committee; Licensing Boards	*Intended impact*: Fewer barriers to recruiting professionals licensed in other states resulting in an increased supply of professionals for Oregon. *Triple Aim:* Better health and care via increased access.
Ensure exposure to rural practice for health professions students of all kinds, especially primary care practitioners. (*Category: Recruitment/Retention*)	2013	All health professional training programs	*Intended impact*: More professionals are better prepared for practice in rural Oregon. *Triple Aim*: Better care
Adopt a uniform credentialing system statewide, in	2014	Health Leadership	*Intended impact*: Fewer barriers to provider affiliation

What	When	Who*	Intended Impact & Relation to Triple Aim
alignment with Health Leadership Council work. (*Category: Recruitment/Retention*)		Council; health plans; health systems; OHA	with plans and hospitals *Triple Aim:* Reduced costs via administrative simplification
Develop a system for creating "workforce impact statements, i.e., statements of workforce needs generated by implementation of reform proposals. (*Category: Data*)	2014	OHWI	*Intended impact*: Build evidence on workforce implications of health care transformation to inform training t and refine projections of future workforce demand. *Triple Aim*: Use data to inform policies relevant to all three aspects of the Triple Aim

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Additional recommendations for increasing primary care workforce capacity

Finally, the Workforce Committee offers two additional recommendations for action after 2014. These are presented separately in Table 3 because they do not fit in the category of "programmatic and administrative" recommendations. The two recommendations are:

1. Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually.
2. Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.

Some knowledge of the structure and funding of graduate medical education (GME) in the U.S. is necessary to fully judge these recommendations; that background is provided in Appendix A.

Table 3. Additional recommendations for increasing primary care workforce capacity

What	When	Who *	Intended Impact & Relation to Triple Aim
1. Increase number of Family Medicine residencies by at least 3 residencies with at least 24 new positions annually. (Oregon ranks 39th in primary care residents/100,000 population at 8.2/100K; US average is 13/100K). (*Category: Education*) Please see Appendix A for more information.	2016	Health systems, Dept. of Family Medicine, OHSU	*Intended impact*: Oregon meets the US average for primary care residents per 100,000. An increased number of physicians are trained locally, increasing the pool from which to recruit. *Triple Aim*: Better care and health via increased access
2. Increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty. (*Category: Education*) Please see Appendix A for more information.	2017	Health systems, OHSU	*Intended impact*: An increased number of physicians are trained locally, increasing the pool from which to recruit. *Triple Aim*: Better care and health via increased access

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Appendix A – Additional Detail for Selected Recommendations

Some of the recommendations in Table 2 and 3 need more context and rationale than is possible to present in table format. Additional detail for those recommendations is provided here.

From Table 2

Recommendation: Re-fund Oregon's Primary Care Loan *Forgiveness* Program

Background: Oregon's primary care loan forgiveness program was created and funded for two years in 2011. It provides 6-8 loans annually to students enrolled in Oregon programs specifically designed to prepare providers for practice in a rural setting. For each year that loans are received, participants agree to practice in a rural setting in Oregon, following their graduate and residency training. Students of medicine, nursing, or physician assisting (a.k.a. "prospective" primary care practitioners) who have completed at least one year of education are eligible. Loan forgiveness differs from loan repayment in that it targets health professions students early in their education, perhaps helping to influence selection of primary care over another specialty. HB 2858, currently under consideration in the 2013 legislative session, would appropriate $1 M for the primary care loan forgiveness program for the 2013-15 biennium.

Recommendation: Enact a workforce data reporting mandate for all health professions licensing boards

Background: The same legislation that created the Health Policy Board and the Oregon Health Authority also directed the Authority to collaborate with 7 health professional licensing boards to collect demographic and practice information from licensed healthcare professionals at the time of license renewal. The 7 Boards were: Oregon Board of Dentistry; Oregon Board of Pharmacy; Oregon Health Licensing Agency for the Oregon Board of Licensed Dieticians; Oregon Medical Board; Oregon Occupational Therapy Licensing Board; Oregon Physical Therapist Licensing Board; and Oregon State Board of Nursing. These boards support database operations via a small per-licensee fee and the overall response rate is very high, since the legislation specifies that the Boards may not renew a license until the workforce information has been collected. Starting in 2012, three additional boards—the Board of Licensed Clinical Social Workers, the Board of Psychologist Examiners, and the Board of Licensed Professional Counselors and Therapists—began to ask their licensees to provide data on a voluntary basis. There are more than 10 other healthcare professional licensing boards that do not currently participate.

To enable collection and analysis of accurate and comparable data for all licensed health care providers in the state, the Workforce Committee recommends that required participation in the Healthcare Workforce Database be extended to all health professional licensing boards in 2014, with actual reporting to be phased in according to data priorities and board readiness. This is a repeat recommendation from the Workforce Committee.

Recommendation: Develop integrated health careers pathways, with central coordination

Background: The Committee made this recommendation at the end of 2012 and noted that it would connect two of the Governor's priorities: healthcare reform and education reform. The overarching recommendation was that Oregon should develop a coherent pipeline to health careers at all levels, beginning with elementary education. The pipeline should organize and connect students to activities and programs that progressively build on student knowledge and experience, and effectively utilize state resources and investments in education from K-12 through higher education and health professional education. Sufficient resources should be available to meet statewide need. More specifically, the Committee recommends:

- Explicitly including health sciences in the "science" category of Oregon's Science, Technology, Engineering and Mathematics (STEM) initiative, since preparation for the health professions requires competency in the same base disciplines.
- Aligning state health care professional education investments with projected Oregon workforce needs, as identified by the Workforce Committee, the Oregon Healthcare Workforce Institute, and others. Data regarding the predicted demand for health professionals should drive education program development and distribution.
- Providing additional funding and support for the development and distribution of health care occupations training to rural communities and underrepresented populations across the K-20 pipeline and increasing incentives to reach diversity goals for the health professional pipeline.
- Encouraging the use of up-to-date delivery modalities, including virtual learning, to increase access to health professions education throughout the state. Distance or distributed learning can help maximize finite resources by aggregating the demand for training but distributing the supply.
- Encouraging inter-institutional cooperation and integration of curricula. All health care professions education should address new models of care in a

consistent way, emphasizing the competencies needed for interprofessional team-based care.

Recommendation: Implement standardized administrative requirements for student clinical placements and create a centralized system/database to track information.

Background: In July 2012, the Health Policy Board approved a set of standard prerequisites for student clinical placement that were developed by the Workforce Committee in consultation with a broad range of stakeholders.[2] Committee members are currently working with the Health Authority and a rules advisory committee to develop administrative rules to implement and enforce the standards.

When approving the standards, the Board strongly advised the Committee and stakeholders to develop a centralized method of tracking students and their prerequisites across clinical placement sites. Committee members are considering options for a centralized system and OHA has issued an RFI to gather more information on the Committee's behalf. Determining the best structure and most appropriate functions of a centralized tracking system is doable; the more challenging implementation task is to determine how such a system might be governed and financed. Stakeholders have stated clearly that they would prefer the state not to administer such a system; for this reason, a not-yet-existing consortium/coalition of schools and clinical placements sites was identified as the responsible party for this part of the recommendation in Table 2.

Recommendation: Revise Oregon's adverse impact laws and regulation

Background: Oregon has a unique policy that requires community colleges to submit a notice of intent at least 30 days prior to seeking Board of Education approval for certain new programs. The Board must then share this notice with private institutions. Private institution officials who feel that the new public program would adversely impact their businesses may file an objection, which sets in motion a proscribed process of negotiation. Notably, the reverse is not true: private institutions are under no obligation to provide notice about planned new programs and publicly-funded programs have no formal opportunity to express objections. The policy can have the effect of delaying or limiting the creation of needed training programs, overwhelming clinical placement sites, or increasing students' costs (because private programs tend to be more expensive for students).

[2] See: http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_SB879_06.29.12.pdf

In 2011 and 2012, members of the Workforce Committee met several times with staff from the Office of Degree Authorization and representatives from public, private, and proprietary schools. At the end of this process, the Committee recommended a small change to statute and administrative rule that would have the effect of requiring *all* institutions—public, private and proprietary—to notify others of proposed new programs and be subject to review for detrimental duplication or adverse impact. A letter recommending this regulatory change was sent to the Higher Education Coordinating Commission, in August 2012. No response has been received to date; however, the 2013 Legislature is considering a bill (HB 3341) that would make some changes to the adverse impact policy and has heard testimony about the Workforce Committee's recommendation.

From Table 3

Recommendations: Increase number of Family Medicine residencies by at least 3, with at least 24 new positions annually; and increase number of community based residencies (Psych, Internal Medicine) by at least 2 residencies in each specialty.

Background: Upon completion of medical school, all new graduates pursue a "residency" in Graduate Medical Education (GME) in a specialty of their choice (the first year of training is sometimes called "internship"). Oregon currently supports more than 800 GME positions in all specialties. Residencies last from three years to more than 5 years. About 275 new positions open up each year. 776 total positions are at OHSU. Providence Health System hosts programs in Family Medicine (7 new positions per year), and Internal Medicine (17 positions per year). The Legacy Health System hosts 15 new Internal Medicine residents per year. In addition, Samaritan Health Services offers 20 first year residency positions, currently open only to DO students, in their Corvallis based residencies in Family Medicine(5), Internal Medicine (6), General Surgery (2), Orthopedic surgery (3), and Psychiatry (4). Residency positions are open on a competitive basis to MD and DO students from all around the US and the world. These training opportunities at OHSU are highly sought after and, through a program called the National Residency Matching Program, students from around the country are "matched" to these residency positions. Each year, some, but not the majority, of the students who become residents are from Oregon.

Studies show a strong correlation between where a new physician completes GME training and where s/he ends up practicing. Expanding GME capacity in Oregon in areas where physicians are most needed could have an immediate and ongoing impact on reversing workforce shortages. OHSU is ranked tenth in the nation for

in-state retention of physicians after GME training, with 52% of residents staying in Oregon to practice. However, only one-third of all licensed Oregon physicians completed all or part of their training in Oregon, making Oregon a longstanding importer of physician workforce.

The federal Medicare dollars that help pay for training of new physicians in teaching hospitals around the country are essential to funding GME programs. However, in 1997 as part of the Balanced Budget Act, the federal government froze the number of GME positions it would support for hospitals *participating at that time*. This is often referred to as the federal "cap" on residents/trainees. However, hospitals that do not yet have an existing GME training program remain eligible to receive federal funding for establishing new programs. Thus, new federal dollars could be available to Oregon hospitals to help support new GME training sites.

The federal dollars that help pay for training of new physicians in teaching hospitals around the country are essential to this advanced training/GME program. However, in 1997 as part of the Balanced Budget Act, the federal government froze the number of GME positions it would support for hospitals *participating at that time*. This is often referred to as the federal "cap" on residents/trainees. However, hospitals that do not yet have an existing GME training program remain eligible to receive federal funding for establishing new programs. Thus, new federal dollars could be available to Oregon hospitals to help support new GME training sites in Oregon.

To qualify, these positions must gain accreditation by the Accreditation Council for Graduate Medical Education and/or the American Osteopathic Association– a multi-year process that involves development of peer-reviewed curriculum that includes an adequate numbers of patients and procedures to gain expertise in the program specialty. GME training in many specialties and sub-specialties requires the programs to be located in large population centers in order to see a sufficient volume of specialty patients. Primary care residencies, especially Family Medicine, are, however, well suited to smaller communities outside the Portland Metro area.

Several smaller Oregon communities have indicated their interest in exploring the option of having GME at their medical centers, such as Salem, Roseburg, Grants Pass, Eugene, Medford, Hood River, and Bend. Currently, the only rurally-based training program in Oregon is the Cascades East Family Medicine Residency Program in Klamath Falls, with 8 new positions per year.

Because the GME programs at community hospitals are necessarily small (typically 2-8 residents per year in each specialty), a GME Consortium approach could support regional programs with common curriculum design, an accreditation umbrella and other program and administrative requirements. This will ensure that hospitals and other community-based sites have a centralized framework for cooperation so Oregon is allotted the maximum number of federally-funded positions and, equally important, that these positions are nationally competitive to attract the highest caliber new physicians to Oregon.

Oregon currently has only one rural Family Medicine training location, *OHSU Cascades East Program in Family Medicine*. Cascades East Family Medicine supports 24 trainees (8 new positions per year) in a three-year program. Started in 1993 at Sky Lakes Medical Center in Klamath Falls, Cascades East Family Medicine Residency is also supported by OHSU Family Medicine Department and Oregon AHEC and has achieved great success. More than 75% of its graduates practice in towns less than 25,000, with many in the smallest communities in Oregon. Providence Family Medicine Residency is in the final stages of adding an additional Rural Training Track position for one resident who will spend the final 2 years of residency in Hood River.

GME programs can become self-sustaining in their 3rd year when federal support becomes available. Startup costs are needed to support administration, faculty, curriculum development and organization, accreditation and related issues. A common structure to help administer established residency programs after the startup phase is complete would also help reduce costs and improve quality.