Oregon Health Policy Board
Oregon Healthcare Workforce Committee

5-Year Strategic Plan for Primary Care Provider Recruitment in Oregon

January 2013

Prepared in response to HB 2366

Oregon Health Authority

Oregon Healthcare Workforce Committee
Strategic Plan for Primary Care Provider Recruitment
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TABLE of CONTENTS

EXECUTIVE SUMMARY I

I. INTRODUCTION 1

About this Plan 1

II. BACKGROUND 2

Current Primary Care Capacity in Oregon 2

Overall 2

Physicians 4

Nurses 5

Physician Assistants 6

Best Practices in Primary Care Provider Recruitment 6

Existing Incentives for Recruitment in Oregon 7

III. VISION 7

IV. STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS 7

V. STRATEGIC GOALS AND PLAN 12

Executive Summary

In 2011, the Legislature adopted HB 2366, tasking the Workforce Committee to develop a "strategic plan for recruiting primary care providers to Oregon." The plan was to address best recruitment practices and existing recruitment programs, development of materials promoting Oregon as a desirable place for primary care physicians to live and work, pilot visiting programs, potential funding opportunities, and entities best suited to implement the plan.

The Committee engaged a number of interested parties in developing the strategic plan and articulated this vision to guide the process: *Oregon will be a model for efficient, coordinated primary care recruitment and retention efforts in the United States. All areas serving all populations will be competitive with other states and regions for the recruitment of primary care providers in order to ensure access to high quality health care for all Oregonians.*

Based on its assessment of Oregon's strengths weaknesses, upcoming opportunities and threats, and stakeholder input, the Committee identified three overarching goals for primary care provider recruitment, along with strategies to achieve these goals:

"Grow Our Own": produce more primary care professionals in Oregon in order to increase the size of the recruitment pool

- Increase the output of primary care educational programs, particularly training programs for physicians, nurse practitioners, and physician assistants.
- Increase the capacity of Oregon's Rural Scholars Program
- Invest in programs that develop and encourage high school and undergraduate students to choose primary care careers
- Study the need for training programs for emerging health workers who will be part of the service delivery teams of the future

Increase Oregon's effectiveness at external recruitment

- Increase and coordinate efforts to link employers and primary care providers to each other and to available recruitment resources
- Market Oregon as a "career destination state" for the practice of primary care
- Support clinical practice transformation, to increase the attractiveness of primary care practice
- Encourage investment in/expansion of Oregon's Locum Tenens Cooperative
- Designate one or more entities to track and alert stakeholders of funding opportunities with relevance for primary care provider recruitment and retention

Support Communities: Empower rural and underserved communities in their own efforts to recruit and retain primary care providers

- Increase involvement of local businesses, economic development and others in recruiting providers by promoting a community engagement approach
- Encourage inclusion of health care professional recruitment incentives when enterprise zones are negotiating tax abatement
- Develop a recruitment “tool kit” for communities that includes marketing material, information on workforce programs, and proven strategies for successful recruitment and retention
- Ensure continued analysis of federal Health Professional Shortage Area (HPSA) scores to maximize access to federal resources for loan repayment and other financial incentive programs.

The Committee anticipates that a five-year time frame is needed to accomplish the work in the strategic plan and that a number of different entities must take coordinated action to achieve the Committee’s vision for primary care provider recruitment.

I. Introduction

About this Plan

The Oregon Legislature has long recognized that a robust health care workforce contributes not only to the health of Oregonians, but to the economic health of the state, particularly our rural and underserved communities. Like many western states, Oregon has counties and populations within the state that suffer from an identified shortage of health care provider availability, complicating efforts to improve population health of a population and promote economic growth. These include areas with a high concentration of Medicaid-eligible or other low-income individuals, and other populations, including migrant and seasonal farmworkers, homeless individuals, and communities of color. In some parts of rural Oregon, there simply is not a sufficient health care workforce to meet the needs of the population as a whole.

In 2011, the Legislature enacted HB 2366, tasking the Oregon Health Policy Board's Health Care Workforce Committee to work with interested parties to develop a "strategic plan for recruiting primary care providers to Oregon." Lawmakers specified that the plan should address:

1) Best recruitment practices and existing recruitment programs;
2) Materials and information promoting Oregon as a desirable place for primary care physicians to live and work;
3) A potential pilot program to promote coordinated visiting and recruitment opportunities for primary care physicians;
4) Potential funding opportunities; and
5) The best entities to implement the strategic plan.[1]

In developing the plan described in this document, the Committee completed a thorough literature review and an environmental scan of other state strategic plans for primary care recruitment and consulted with stakeholders from professional societies, health systems and plans, state agencies, educational institutions, and provider groups. Committee members also consulted individually with representatives from Business Oregon and Travel Oregon and incorporated community input on health care workforce priorities from regional forums in Roseburg and Pendleton convened by the state's Primary Care Office for a separate but topically related project.

Information about best practices for recruitment and descriptions of existing recruitment efforts can be found Sections II and III, as well as in the environmental scan in Appendix B. Suggestions regarding promotional materials and practitioner visiting opportunities are included with other recommendations under Strategic Objectives and Plan (Section IV), where

[1] Enrolled HB2366, 2011 Legislative Assembly

funding resources and suggestions for implementation are also addressed. In addition, adequacy of undergraduate and graduate medical education is addressed in Section IV with further details outlined in Appendix E.

Because the *distribution* of health professionals is just as important as total numbers for ensuring an adequate workforce[2], recommendations in this report are particularly (but not exclusively) targeted toward Oregon's underserved geographic areas and populations. Underserved populations include low income individuals, migrant and seasonal farmworkers, homeless individuals, and Medicaid recipients. Underserved geographic areas include both areas that currently have a shortage of physicians, and those whose remoteness makes it difficult to retain a robust health care workforce.

For the purposes of this report and plan, primary care is defined as *an initial point of entry into the health care system where patients can receive diagnosis and/or treatment.* While parts of HB 2366 specifically address physicians, this report operates with a broader definition of primary care workforce, including advance practice nurses, physician assistants, dentists, pharmacists and, to a limited extent, emerging health professions such as Community Health Workers. This definition is intended to include medical, community based dental and mental health care services across professions.

II. Background

Current Primary Care Capacity in Oregon

OVERALL: Primary care provider shortages persist in many parts of Oregon. Thirty-two of Oregon's 36 counties have some type of federal primary care health professional shortage area (HPSA) designation, based on population-to-provider ratio, population demographics, travel time to nearest provider, and community health status characteristics. (See maps of HPSA designations provided in Appendix G.) In 2010, there were seven counties with ten or fewer physician practices, including two counties with only one physician each and twelve counties with fewer than ten dentists, including four counties with no dental practice. There were four counties where no dentist or pharmacist registered a practice address, three counties where no dental hygienist, physician assistant, or licensed practical nurse listed a practice address, two

[2] Dower & O'Neil. 2011. *Primary health care workforce in the United States*. The Robert Wood Johnson Foundation. Research Synthesis Report no. 22. Available at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/07/primary-care-health-workforce-in-the-united-states0.html

counties where no nurse practitioner or physical therapist listed an address, and one county with no registered nurses.[3] (See maps of HPSA Designations in Appendix G.)

The Oregon Employment Department forecasts the need for slightly more than 76,000 additional health care workers in the state between 2010 and 2020, a 48% increase. Forty-three percent of the projected job openings are to replace those permanently leaving the occupations' labor pool. The projected demand is largest in settings that employ the most primary care providers: a 34% increase for ambulatory health care services sector and 35% increase for nursing and residential care facilities. Hospital employment is projected to grow more slowly, by 25%.[4]

Using a model based on five factors (percentage of primary care visits to need; rate of ambulatory care sensitive conditions; travel time to nearest hospital; comparative mortality ratio, and low birthweight rate) the Oregon Office for Rural Health finds that 59 of the state's 105 rural service areas have unmet need.[5] Oregon's Primary Care Office, located within the Oregon Health Authority, is responsible for providing analysis and determining which areas and special populations within the state qualify for a health professional shortage area (HPSA) designation. As of July 2012, Oregon would require at least 80 primary care physicians, working full time, properly distributed to shortage areas, in order to remove all the federal primary care medical designations.[6]

Demand for new health care professionals is expected to continue to increase in the coming years. Contributing to this demand is an aging population as well as aging of the existing primary care workforce itself. According to 2010 licensing data, approximately 30% of Oregon's active workforce in 15 licensed health care professions is 55 years of age or older. Among nurses, the figure is higher: more than 45% of nurse practitioners, certified nurse specialists, and licensed practical nurses are 55 years of age or older. The current economy has forced many to postpone their plans for retirement but the aging of professionals is expected to have a large impact on workforce capacity in the next 5-10 years. In 2010, pharmacists, physical therapists, dentists, and occupational therapists were most likely to report that they were

[3] Oregon Health Policy and Research (2011) *Oregon Health Professions: Occupational and County Profiles*. Available at http://www.oregon.gov/OHA/OHPR/RSCH/docs/Workforce/Final_2010_Oregon_Health_Profession_Profiles.pdf

[4] Oregon Employment Department (2009). *Employment Projections by Industry and Occupation 2010-2020 Oregon Statewide.* Available at http://qualityinfo.org/pubs/projections/projections.pdf

[5] Oregon Office of Rural Health. *2011-12 Area of Unmet Health Care Need in Oregon*. Available online at: http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf

[6] Current federal methodology only considers the number of physicians (not other primary care provider types) when determining primary care medical shortage areas.

considering a practice change that could impede access to care (e.g. retiring, reducing practice hours, moving out of state, or leaving the field).[3] Combined with an aging population (by 2030, one fifth of Americans will be over the age of 65), an increase in the number of individuals with chronic medical conditions, and the almost 400,000 individuals who will be newly eligible for health insurance coverage in 2014 as a result of the Affordable Care Act,[7] demand for primary care providers shows no sign of abating.

PHYSICIANS: There were 10,822 active licensed physicians practicing in Oregon in 2010; however, only 38% of those physicians were practicing in primary care[3]. In this case, primary care physicians are those who listed practice specialties in family medicine/practice, general practice, geriatrics, pediatrics, adolescent medicine, (general) internal medicine, or internal medicine with a subspecialty in geriatric medicine. Barbara Starfield and other primary care leaders have called for the U.S. to move toward the goal of having of having 50 percent of active patient care clinicians (physicians, nurse practitioners, and physician assistants) in primary care practice.[8]

The population-to-primary care physician ratio in Oregon in 2010 was 930:1.[3] This is well inside the most commonly cited U.S. "standard" of 1,500 people per primary care physician[9,10] but the statewide average masks considerable variation. Counties such as Multnomah are relatively well-supplied with primary care physicians (1 for every 630 residents in 2010) whereas a number of less populated counties have much higher ratios (e.g. Crook County had 2,471 residents for every primary care physician in 2010).[3] A majority of providers continue to choose urban or suburban practice; out of the estimated 10,822 active licensed physicians in Oregon in 2010, only approximately 1100 (10%) were actively practicing in rural areas, where 37% of the population resides.[3] Reasons for this include a perceived lack of availability of employment for spouses, opportunities for entertainment and cultural activities, quality of K-12 education, a perception of being "on call" at any time, a lack of availability of specialists and fewer opportunities for collaboration with other physicians and peers. The shortage of providers in rural areas may contribute to health care access and health disparities seen between rural and urban populations.[5]

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[7] Urban Institute (2011), *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid.* Available at http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf

[8] Sandy, Bodenheimer, Pawlson, & Starfield. (2009). The Political Economy Of U.S. Primary Care. Health Affairs, 28(4): 1136-1145.

[9] Rickets et al. (2007). Designating Places & Populations as Medically Underserved: A Proposal for a New Approach. Journal of Health Care for the Poor and Underserved, 18:567-589.

[10] Goodman, Fisher, Bubolz, et al. (1996). Benchmarking the US physician workforce. An alternative to needs-based or demand-based planning. JAMA, 276(22):1811- 7. [See comments, published erratum appears in JAMA 1997 Mar 26;277(12):966.]

Oregon has not historically educated a sufficient quantity of practitioners to meet its needs, particularly in the area of primary care residencies, and has been and continues to be an importer of trained physicians, according to 2012 Licensing Board data. Oregon has only 27 first year resident positions per year in three Family Medicine programs. By comparison, Washington, with a population less than double that of Oregon (3,871,859 vs. 6,830,038) has more than 100 new Family Medicine residency positions annually. Idaho, with a population less than half that of Oregon, has 22 new positions each year. [11]

Over the past two decades, a larger percentage of medical school graduates have chosen specialty care over primary care and metropolitan over rural practice sites. Specialization is increasingly common even among primary care residents; more than 50% of individuals in internal medicine residency programs report that they are planning a subspecialty care career.[12] This trend has been attributed to a number of factors, including increasing student educational indebtedness, higher reimbursement for specialists and urban physicians, lower prestige for primary care, scope of practice concerns, decreasing percentages of rural and other underrepresented students at elite institutions, and a generational trend to place a higher value on a work/life balance than previous generations.[13,14]

NURSES: Advanced registered nurse practitioners (NP) and registered nurses (RN) are also vital to the primary care workforce in Oregon. Unlike some other states, Oregon has granted NPs substantial autonomy to provide care without physician oversight. In 2010, the number of NPs with an Oregon license was 2,422; it is estimated that 1,955 were actively practicing in the state. In 2010, Oregon had 45,946 licensed RNs (which includes NPs), with an estimated 35,849 actively working.[3] The Employment Department forecasts that Oregon will need an additional 14,499 registered nurses by 2020, due to industry growth and replacement of current nurses who will retire or change careers.[4] Nurse practitioners and RNs are concentrated in the metropolitan counties in the state: a full 53 percent of NPs practicing statewide are practicing

[11] National Resident Matching Program, Results and Data: 2011 Main Residency Match. National Resident Matching Program, Washington, DC. 2011.

[12] West and Dupras. (2012). General Medicine vs Subspecialty Career Plans Among Internal Medicine Residents. *JAMA*. 308(21):2241-2247.

[13] American College of Physicians (2008) *The Case for Young Physician Leaders*. Available at: http://www.acponline.org/meetings/internal_medicine/2011/handout

[14] It should be noted that not all physicians in primary care specialties are providing primary care. For example, some physicians in traditional primary care specialties have taken on new roles as hospitalists, providing care exclusively to in-patients in acute care hospitals. In Oregon's rural areas, it is not uncommon to find a family practice physician staffing a hospital emergency department.

in Multnomah, Washington and Clackamas Counties, where approximately 43% of the state's population resides.[3]

A limited number of nurse educators significantly impacts the ability of schools to increase their nursing student capacity. Nursing graduates primarily choose clinical settings over academic professions because of the significant difference in compensation; only one third of nursing faculty report feeling satisfied with their salary. Nursing faculty are significantly older than the general population and an increased rate of retirement is expected to cause further stress to nursing education in the next decade.[15]

PHYSICIAN ASSISTANTS: In 2010, there were 918 active licensed physician assistants practicing in Oregon, 45% of whom identified a practice associated with a primary care specialty. As with NPs, Oregon's Physician assistants (PAs) enjoy relatively more autonomy in practice than in many other states. However, PAs are somewhat more equitably distributed between the Portland Metropolitan Area and the rest of the state than primary care physicians and nurse practitioners (44% of PAs statewide practice within Multnomah, Washington and Clackamas Counties, compared with 50% of primary care physicians and 53% of NPs. The number of PAs and ratio of PAs-to-physicians varies widely in different parts of the state. Only 13 PAs are practicing in Linn County—a ratio of 8 PAs for every 100 primary care physicians, while in Crook County, the ratio is 29 per one hundred.[3]

Best Practices in Primary Care Provider Recruitment

As specified in HB 2366, the Committee undertook an environmental scan of best practices and existing recruitment plans, drawing on local, state, and multi-state/regional plans and strategies from across the country. The full scan is contained in Appendix B. Notable findings include:

- There is incredible variation in level of industry and governmental resources and programs for recruitment initiatives by state.
- While the stakeholders involved in recruitment are numerous and diverse, and often have competing interests or market share, there is growing recognition that geographies and organizations are working to recruit and retain the same limited pool of applicants. In some cases, people are capitalizing on awareness of this shared need to motivate collaboration among stakeholders.

[15] Oregon Center for Nursing. (2009). *Oregon's Nurse Faculty Workforce*. Available at: http://www.oregoncenterfornursing.org/documents/OCN%20Nurse%20Faculty%20Workforce%20Report%202009.pdf

- Most recruitment plans emphasize the key importance of pipelines, beginning as early as elementary school level and continuing through college and university education, for creating interest in and availability of local health care training programs.
- Most plans also tie retention strategies into recruitment, since many of the same factors play a role. Retention is increasingly recognized as a valuable tool that reduces cost of recruitment and increases stability in the health care sector.
- Many plans highlight the need to target incentives by provider type. Loan repayment may be more attractive to dentists, physicians and others with high debt burdens; incentives like salary, benefits, or sign-on bonuses could be of greater impact for other providers. Loan forgiveness and repayment programs—as well as scholarship programs—can effectively address student concerns about entering primary care careers with high levels of indebtedness.
- Adequate funding for coordinated recruitment and retention initiatives is a perennial problem.
- Many of the publicly available plans focus on rural access and spend little to no time discussing urban pockets of inaccessibility. Very few plans include alternative care providers or newly emerging roles such as Community Health Workers.

Existing Incentives for Recruitment in Oregon

The primary recruitment incentives available statewide in Oregon include federal and state loan repayment or forgiveness programs, a small state tax credit for rural providers, and Oregon's rural medical liability subsidy program. A full description of these programs can be found in Appendix C; however, more than one of these programs is currently unfunded. In addition to programs financed by the state or the federal government, private health systems, hospitals, and other entities have their own recruitment incentives and tools; a few of these are also described in Appendix C.

III. Vision

Oregon will be a model for efficient, coordinated primary care recruitment and retention efforts in the United States. All areas serving all populations in Oregon will be competitive with other states and regions for recruiting primary care providers in order to ensure access to high quality health care for all Oregonians.

IV. Strengths, Weaknesses, Opportunities, and Threats

Physicians and other health care providers are in high demand throughout the country, increasing the competition for these scarce and expensive resources. The relative strengths and

weaknesses of Oregon's health care recruitment environment include factors related to the medical climate (e.g. medical liability) as well as general livability measures such as cost of living, quality of education and climate.

Strengths for primary care provider recruitment in Oregon include:

- An educational community committed to innovation has reduced silos between institutions. For example, the Oregon Consortium for Nursing Education (OCNE) collaborative, the community colleges' distance learning platform, and newly forming inter-professional curricula at many institutions will help attract students to health care careers and will increase availability of training in communities across the state, helping to ease the geographic maldistribution of health care providers.
- A well-developed Oregon AHEC (Area Health Education Centers) system addresses the K-16 pipeline to create an in-state pool of students preparing for health careers from which to recruit. Oregon AHEC reaches 34 of 36 Oregon counties, delivering health careers education to more than 12,000 rural students and teachers in 2011-12. Oregon AHEC programs include: health careers occupations clubs and camps; In-A-Box Science curriculum; college student Day in the Life experiences; Health Career exploration days; and Health Career Opportunity programs.
- Programs such as the Oregon Department of Education's ASPIRE, which helps middle- and high school students access education and training beyond high school by providing information and support to students and their families, can be adapted for health career support for disadvantaged students.
- The Oregon Rural Scholars program developed by Oregon AHEC at OHSU provides enhanced educational opportunities for medical students interested in rural practice, increasing their likelihood of choosing a specialty in high need in underserved areas (such as family medicine or general surgery). This program could be expanded to include students from other primary care disciplines such as osteopathic physicians, physician assistants, advance practice nurses, dentists and pharmacists.
- Oregon is a national leader in health care reform with large-scale delivery and financing changes underway. Oregon's Coordinated Care Organizations (CCOs) lead the nation in innovative healthcare delivery models for Medicaid populations. If these reforms appropriately and consistently value primary care providers, and provide adequate financial incentives for care, Oregon will improve its attractiveness to progressive primary care providers.

- Oregon's Medical and Nursing Practice Acts provide progressive scopes of practice for nurse practitioners and physician assistants, as compared to other states; this creates a recruitment incentive for non-physician health care providers. Nurse practitioners may practice without physician oversight and with full prescribing authority, and Physician Assistants may practice under non-direct supervision, extending their ability to provide services into more remote rural areas.
- Oregon has several outstanding examples of communities and organizations mobilizing and coordinating (instead of competing) for providers. The Rimrock Health Alliance and the Klamath Falls Partnership are two examples. Promotion of these models to other communities could increase recruitment and retention success.
- The Oregon Locum Tenens Cooperative assists rural communities, facilities and medical practices to acquire temporary or short-term coverage for primary care providers (primarily physicians but also nurse practitioners and physician assistants), and has been helpful in recruiting providers to rural locations. Since November 2011, the OLTC has more than doubled its membership—from 10 members to 22, and has increased its capacity for coverage by 500%.
- An Oregon tax credit of $5,000 for rural providers provides both a recruitment and retention incentive for some rural communities, although it sunsets in 2014.

Oregon also has several weaknesses with respect to primary care provider recruitment:

- Oregon's tax structure is a disincentive for high-wage earners when compared to neighboring states.
- Oregon offers relatively few provider recruitment incentives and those are underfunded as compared to other states. The state primary care provider loan repayment program has been unfunded since 2009. However, a loan forgiveness program for students focused on rural health was created in 2011 and the state's 2012 Medicaid waiver requires $2 million to be dedicated to primary care provider loan repayment as of July 2013 (see opportunities).
- High educational debt is a deterrent to students selecting primary care specialties and to locating in areas of high need such as rural and underserved communities.[16] OHSU has among the highest tuition and graduate debt load of any state-supported medical

[16] Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices, 2009, The Robert Graham Center, Washington DC

school in the U.S.[17] Western University's College of Osteopathic Medicine of the Pacific opened a branch campus in Lebanon, Oregon in 2010, but, as a private institution also has relatively high tuition and students are likely to graduate with significant debt.

- Oregon has historically low Medicare and Medicaid reimbursement rates compared to other states, reducing income potential for physicians serving those populations and potentially reducing access for individuals covered by those programs.
- Recruitment into Oregon's large rural and frontier areas and more urban underserved populations is historically more difficult. Oregon's weakened K-12 education system is a liability when trying to recruit and retain providers with families. This is particularly pronounced in rural areas, where most schools operate on a 4-day school week as a cost-saving measure and have fewer, if any, advanced placement courses, International Baccalaureate programs and/or extracurricular activities.

Opportunities for recruitment include:

- The expansion of the insured population in 2014. Under federal health reform, close to 400,000 Oregonians are anticipated to acquire health care coverage[7]. This creates a significant pool of potential patients but is also a threat to system capacity.
- Oregon is a leader in health reform. Building on momentum of health care reform and primary care renewal can energize providers toward achieving a more efficient, effective, well organized and satisfying health care system. Oregon's innovation efforts may attract younger physicians and those willing to provide care in new ways, in addition to non-traditional disciplines, and may provide openings for emerging health professionals such as community health workers.
- Internet and social media technologies may be used to contacting and engage potential health care practitioner recruits from a wider audience than with traditional methods, at lower cost.
- The current bump in Medicaid and Medicare reimbursement for primary care providers (a time-limited provision of the federal Affordable Care Act) may increase providers' willingness to serve individuals with public coverage.
- Expansion and increased support for National Health Service Corps from the Affordable Care Act may increase the number and improve the distribution of loan repayment positions in Oregon. From January 2011 through October 2012, Oregon saw the number

[17] http://www.ohsu.edu/xd/education/schools/school-of-medicine/about/school-of-medicine-news/education-news/lcme-update-71112.cfm

of National Health Service Corps clinicians increase from 124 to 192. Further, work that has been done to analyze health professional shortages has enabled an additional 300 clinicians to be eligible for the program, beginning in January 2013.

- A new loan repayment program for primary care clinicians who commit to serving Medicaid patients, funded at $2M annually, holds promise for recruiting clinicians to areas that are traditionally underserved. (Note: The positive effect of this program will be reduced if it entirely replaces existing incentives such as the Loan Forgiveness program established in the 2011 Session.)
- A strong trend toward physician employment by large health systems (see also threats), may reduce the amount of time physicians spend on practice/business management, which may increase productivity and improve career satisfaction. Larger systems may be able to engage in enhanced retention activities with physician employees.
- Oregon's commitment to train 300 Community Health Workers may also increase practice resources available to current clinicians, provided that training and incentives are available to encourage widespread and appropriate use of CHWs.

Threats to effective recruitment include:

- Uncertainty regarding development of Coordinated Care Organizations and other novel health care system reforms at both the state and federal level. Practitioners may be wary in this time of transition, reducing the ability to recruit new clinicians and threatening retention of others.
- An anticipated expansion of insured population in 2014 (also an opportunity) will increase income potential for some providers, but may also bring low reimbursement rates for publicly-covered individuals and increasing provider workload. There could be detrimental effects if payment reform lags behind eligibility expansion and other necessary delivery system reforms.
- A strong trend away from independent practice toward physician employment (see also opportunities) requires different changes in recruitment and retention strategies, as well as additional practice supports for physicians who remain in independent practice.
- An inadequate state budget has a direct effect on recruitment via reduced health care facility reimbursement and budgets, which impact hiring capacity. It also has an indirect effect through reduced funding for health care education programs.

V. Strategic Goals and Plan

Based on its review of best practices and assessment of Oregon's current strengths and weaknesses, the Committee proposes the following three strategic goals for primary care provider recruitment in Oregon: 1) produce more primary care professionals in state; 2) improve Oregon's competitiveness for recruiting professionals from out of state; and 3) support planning and recruitment at the local level, where professionals will live and work. Recommendations for specific strategies in each of these areas are listed below, along with suggested timelines, potential funding sources, and ideas about which groups or institutions are best suited to implement a particular strategy.

Goal	Strategies	Timeline	Potential Funding Sources	Best entities to implement the strategy
Grow Our Own: produce more primary care professionals in Oregon	Increase volume output of Oregon primary care practitioners educated through Oregon's health care professional training programs (particularly MD/DO, PA, and NP programs)	2016	Tuition; educational institution investments & endowments; General Fund support	Oregon State Legislature Educational institutions with MD/DO, NP, and PA training programs
	Increase the number of Oregon primary care residencies.	2015	Health systems; Medicare after first three years; private foundations	Oregon Area Health Education Center Program (OR AHEC); Health systems
	Expand Oregon's Primary Health Care Loan Forgiveness program by at least 10 participants.	2014	General Fund support; Educational Institutions; private or community foundations	Oregon State Legislature; Oregon Office of Rural Health
	Increase capacity of the Oregon Rural Scholars Program to 10% of the OHSU medical school class; open the program to nursing, physician assistant, osteopathic, pharmacy and dental students equal to up to 10% of class size at schools throughout the state.	2014	Oregon Educational Institutions; private or community foundations	Oregon AHEC

Goal	Strategies	Timeline	Potential Funding Sources	Best entities to implement the strategy
	Increase access to primary care provided by Naturopathic Physicians (NDs) by removing coverage and credentialing barriers. In some locations, NDs are an underutilized and immediately available primary care workforce.	2013-14	Not applicable	Health systems and insurance plans
	Study the need for training programs for emerging health care workers who will be part of the primary care delivery team (e.g. Community Health Workers, peer wellness specialists, navigators, and others).	2013; report back to Workforce Committee by end of 2013	Done within existing resources	Oregon AHEC
	Invest in or maintain programs that that develop and encourage high school and undergraduate students to choose primary health care careers (basic science and math education, high-school health professions programs, Area Health Education Centers, etc.).	Ongoing	STEM initiative; private and/or foundation funding; General Fund educational appropriations	Oregon AHEC; Public and private education programs (K-16)
Increase Oregon's effectiveness at external recruitment	Increase and coordinate efforts to link organizations and candidates to the available resources, including meeting with recruitment groups.	Ongoing	Use existing funding	Oregon Primary Care Office; Oregon Office of Rural Health; Oregon Primary Care Association

Goal	Strategies	Timeline	Potential Funding Sources	Best entities to implement the strategy
	Market Oregon as a "career destination state" for the primary care providers: • Coordinate with Travel Oregon and Business Oregon to access marketing resources useful for local community's recruitment efforts. • Using input from Oregon's rural primary care providers and clinics, build a robust candidate recruitment website or network that includes practice information and loan repayment resources.	Ongoing	Oregon Legislature	Oregon Health Authority; Office of Rural Health; Oregon AHEC; Business Oregon; Travel Oregon Oregon Primary Care Association; Office of Rural Health; Oregon Healthcare Workforce Institute
	Encourage investment by health care organizations (rural and underserved clinics and hospitals) in the Oregon Locums Tenens Cooperative (OLTC) to ensure community access to affordably priced locum tenens services in 50% of eligible rural and underserved sites, or at least 30 communities throughout Oregon Promote the OLTC as a means to conduct coordinated clinician visitation opportunities that can be used to introduce clinicians to rural communities and help communities make sound hiring decisions. The OLTC Loan to Practice (L2P) program coordinates with the Primary Care Office to recruit potential NHSC eligible providers (see Appendix F for details).	By 2014	Clinics and Hospitals	Oregon Locum Tenens Cooperative; Oregon AHEC; Oregon Primary Care Office

Goal	Strategies	Timeline	Potential Funding Sources	Best entities to implement the strategy
	Support clinical practice transformation to help make Oregon a "career destination state" for primary care providers. • Accelerate payment reform efforts • Implement administrative simplification for providers and plans (e.g. simplification of billing) • Continue implementation of Patient Centered Primary Care Homes (PCPCH) and other initiatives that enable coordinated patient care and improve practice processes. • Implement malpractice reform	Ongoing	CMS; Oregon Legislature; other federal entities and private sources as appropriate.	Oregon Health Authority; Health care professional associations; Community Health Centers; Rural Health Clinics; Health Systems; Hospitals, and all other delivery system entities
	Designate an entity to track and notify stakeholders of potential funding opportunities (e.g. Community Development Block Grants that can be used for health-related capital projects) on an ongoing basis.	Immediately	Use existing resources	Oregon Primary Care Office
Support Communities: Empower rural and underserved communities to recruit and retain primary care providers	Increase involvement of local business, economic development organizations, and others in recruiting primary care practitioners, by promoting a community engagement approach (e.g. Rimrock Health Alliance)	4 communities in 2013 8 by 2015 12 by 2017	Local chambers; city and county funding; hospital districts;	Local communities, with help from: Regional economic development entities; Oregon Primary Care Office;, AHECs; Office of Rural Health; Oregon Primary Care Association
	Encourage inclusion of health care professional recruitment incentives when enterprise zones are negotiating tax abatement with large businesses (e.g. work with incoming businesses to fund required community match for the HRSA state loan repayment program).	Ongoing	Not applicable	Business Oregon; local economic development organizations; Office of Rural Health

Goal	Strategies	Timeline	Potential Funding Sources	Best entities to implement the strategy
	Foster collaboration among business (including health care) and economic development constituencies to address issues that affect the community's ability to recruit (e.g. education system, tax structure, physical infrastructure, etc.)	Ongoing	Not applicable	Business Oregon; Office of Economic Development; Governor's Office; Office of Rural Health; local communities and businesses
	Develop a recruitment tool kit for communities, which includes marketing and promotion material, proven recruitment strategies, information about Locum Tenens and other programs, templates/best practice resources, links to relevant recruitment programs, etc.	By 2014; update annually	Unknown; may or may not require additional resources	Oregon Primary Care Office and partners
	Review federal Health Professional Shortage Area (HPSA) scores to increase the state's ability to access federal loan repayment funding and other financial incentive programs.	by February 2013, ongoing	Not applicable	Oregon Primary Care Office

Readers will note a number of different groups and institutions listed in the right-hand column as the best entities to implement specific recruitment strategies for Oregon. The Committee feels that coordination among these potential actors—and among the strategies themselves—is most critical at the community or regional level. Communities and local employers are in the best position to identify the need for particular providers, and to judge which recruitment strategies would be most useful in their area. The Committee also believes that cooperation between private and public employers is most feasible at the local level. The best entity to keep track of the range of primary care provider recruitment strategies being implemented across the state, and to consolidate information about progress toward the goals outlined in this plan, is the Workforce Committee itself.

Appendices

A. HB 2366
B. Environmental scan of best practices
C. Existing recruitment tools in Oregon
D. Summary of December 2011 stakeholder meeting
E. Graduate medical education "white paper"
F. Oregon Locum Tenens information
G. Health Professional Shortage Area maps

Enrolled
House Bill 2366

Sponsored by Representative NATHANSON; Representatives BARKER, DEMBROW, DOHERTY, GELSER, HOYLE, THOMPSON, Senators DEVLIN, MONNES ANDERSON (Presession filed.)

CHAPTER .....

AN ACT

Relating to recruitment of primary care physicians; and declaring an emergency.

Whereas Oregon's population is growing faster than the number of licensed, active and practicing primary care providers in Oregon; and

Whereas retirement of primary care providers is outpacing replacement; and

Whereas there is an acute shortage of primary care providers, particularly in rural communities; and

Whereas stabilizing and increasing Oregon's health care workforce is a top priority for the Oregon Health Authority and the Oregon Health Policy Board; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. The Oregon Health Authority, through the Health Care Workforce Committee created pursuant to ORS 413.017, shall work with interested parties, which may include Travel Oregon, the State Workforce Investment Board, medical schools, physician organizations, hospitals, county and city officials, local chambers of commerce, organizations that promote Oregon or local communities in Oregon, and organizations that recruit health care professionals, to develop a strategic plan for recruiting primary care providers to Oregon. The strategic plan must address:

(1) Best recruitment practices and existing recruitment programs;

(2) Development of materials and information promoting Oregon as a desirable place for primary care providers to live and work;

(3) Development of a pilot program to promote coordinated visiting and recruitment opportunities for primary care providers;

(4) Potential funding opportunities; and

(5) The best entities to implement the strategic plan.

SECTION 2. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.

Passed by House April 21, 2011

Repassed by House June 6, 2011

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Ramona Kenady Line, Chief Clerk of House

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Bruce Hanna, Speaker of House

.....
Arnie Roblan, Speaker of House

Passed by Senate June 1, 2011

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2011

Approved:

.....M.,....., 2011

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2011

.....
Kate Brown, Secretary of State

Environmental Scan—Provider Recruitment Strategies

In response to House Bill 2366, an environmental scan of best practices and existing recruitment plans was undertaken, drawing on local, state, and multi-state/regional plans and strategies used throughout the country. The information was compiled and analyzed for common themes as well as notable differences. In addition to presenting summary findings, this document identifies and describes promising practices from specific plans that may be applicable to the work at hand in the State of Oregon.

Summary Findings

Common themes throughout recruitment plans:

- The number of stakeholders is very large and diverse, with often competing interests or market share.
- The growing recognition, among cities and towns, as well as organizations, that each one is competing against the other to recruit and retain the same limited pool of applicants. The theme of the plans attempts to capitalize on creating the awareness of this shared need and getting stakeholders to work together.
- Most plans discuss the key importance of pipelines, beginning at the elementary level, of feeding the interest in and availability of locally-available healthcare training programs.
- Most call out the difficulty in establishing common data parameters around all of the data available. The example of what is a full-time FTE alone varying tremendously among providers.
- Importance of adequate funding sources, without which most of the initiatives will either not even get off of the ground, or fail once initiated.
- Many focus on rural access and spend little to no time discussing urban pockets of inaccessibility.
- Most plans tie retention into the recruitment plan/initiative.
- Many highlight the need to create incentives targeted by provider type: loan repayment more attractive to dentists and physicians than to those providers with less intensive and expensive training, where things like salary, benefits, sign-on bonuses could be of greater impact.

Noted differences in recruitment plans:

- There is incredible variation in level of industry v. governmental resources and programs for recruitment initiatives by state. This includes access to "Office of…"s as well as loan repayment programs.
- There are some plans that call for changing the scope of various providers (i.e. dental hygienists/physician assistants/nurse practitioners) in order to address the need. Some do not even touch on this as a possible source of additional primary care resources.
- Some plans/groups discuss engagement in regional marketing to recruit and retain health professionals. Others have minimal discussions around shared marketing initiatives.
- Some of the 'plans' act more as sample process and procedure manuals, explaining best practices and even offering templates for pieces of the recruitment process (i.e. site visit sample itineraries, sample recruitment contracts, etc.)
- Plans varied from being solely physician focused, to including Advanced Practice Providers, to being very generally healthcare focused and wrapping in technicians and nursing staff. Very few had any focus on approaches with alternative care providers.

Additional Findings: Multi-state/collaborative work

Arizona/Illinois/Mississippi/Virginia (state primary care associations collaborative):
Recruitment and Retention Best Practices Model, 2005
http://www.nachc.org/client/documents/Recruitment%20%20Retention%20Best%20Practices%20Model.pdf

- This document has many useful procedures outlines and a number of sample checklists, document drafts, job descriptions, etc.
- This plan also had a number of best practices in retention, largely aimed at individual organizational initiatives, rather than regional or statewide initiatives.

CHAMPS (Community Health Assn. of Mt/Plains States):
Physician Recruitment Plan: Steps for Recruiting Success
http://www.champsonline.org/ToolsProducts/RRResources/PhysicianRecruitmentPlan.html

- This plan talks about strategic use of the NHSC (National Health Service Corps) vacancy lists, as rural and CHCs have great appeal to these healthcare professionals.
- These organizations have pooled resources and created a Job Opportunities Bank to advertise all opportunities of member organizations within their geographic area (http://www.champsonline.org/JobBank/JobOpportunitiesBank.html)

- This association has a created a webcast and printable handouts highlighting community-based recruitment strategies and tactics, entitled, "Successful Recruitment in Challenging Times: A Community-Based Approach to Keeping your Edge with Limited Candidates and Shrinking Funds".

New England Regional Collaborative:

New England Regional Healthcare Workforce Collaboration (Sept. 2008)

http://www.nosorh.org/resources/files/NE_RegionalHealthcareWorkforceCollaboration.pdf

- Part of this plan focused in good detail on pipeline expansion initiatives in getting adequate healthcare resources. They also examine scope of practice, and recommend forums, resulting in redesign and change in scope.
- They offered the following initiatives:
    - Engage in group purchasing of headhunter firms.
    - Explore job redesign to keep older staff working
    - Development of regional website as locus of regional information on best practices
- Plan development included a stakeholder survey that may be useful source of questions for a similar effort in Oregon

NW Regional Primary Care Assn (AK, OR ID, WA):

Strategic Recruitment Planning: What's in your Medical Staff Recruitment ToolBox?

http://www.NWRPCA.org

http://www.nwrpca.org/images/stories/2010/workforce/direct_recruitment/General-Strategic_Recruitment_Planning.pdf

- This organization has a toolkit available online to aid individual groups in recruitment initiatives, as well as a job bank that appears to be underutilized and appears somewhat difficult to navigate.

Additional Findings: State-specific work

Connecticut:

Averting Crisis: Ensuring Healthcare for Future Generations in Connecticut CT Hospital Association (April 2007)

http://www.chime.org/hospital_issues/workforce/pdf/Averting_Crisis-HCWorkforceReport.pdf

- The state hospital association has initiated several workplace development initiatives. One of the more creative is to offer educational opportunities to the healthcare workforce,

providing over 100 educational and leadership development programs, reaching more than 4,500 healthcare providers each year

Idaho:

The Community Apgar Project: A Validated Tool for Improving Rural Communities' Recruitment and Retention of Physicians (Dec. 2010)

http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/120110_apgar_assessment.pdf

Idaho Rural Family Physician Workforce Study: the Community Apgar Questionnaire (July 2011)

http://www.rrh.org.au/publishedarticles/article_print_1769.pdf

- Idaho appears to have focused much effort around family medicine physician recruitment. Their Community APGAR profiling has been extensively written about and appears to be spreading to other states. The Community APGAR test assesses attributes and capabilities of communities based on historical trends within that community. The assessment is designed to allow real-time identification of factors that need to be addressed in order to positively influence recruitment outcomes.

Louisiana:

Primary Care Recruitment and Retention Services Unit:

http://www.dhh.state.la.us/offices/page.asp?id=88&detail=3818

- Offers a state loan repayment program midlevel providers, in addition to physicians: (http://www.dhh.state.la.us/offices/page.asp?ID=88&Detail=4986)

Massachusetts:

Health Workforce Issues in Massachusetts, The Massachusetts Health Policy Forum (June, 2000)

http://masshealthpolicyforum.brandeis.edu/publications/pdfs/09Jun00/IBHealthWorkfrcIssues%209.pdf

- Provides good recommendations and guidance in data collection, analysis and dissemination of labor market and utilization information

Michigan:

Addressing the Primary Care Workforce Crisis—Together (Sept. 2009)

http://apps02.crosstechpartners.com/dpm/Client/MPCA/FilesStage/9-29-09%20Primary%20Care%20Workforce%20Meeting.pdf

Primary Health Care Profile of Michigan (Oct. 2008)

http://www.mpca.net/Client/MPCA/Files/profiles%20introduction.pdf

- BCBSM Physician Group Incentive Program (PGIP)

- State Loan Repayment Programs are expanded here to include: PCPs, extenders, nurse midwives, mental health and dentists

Mississippi:

Mississippi's Physician Labor Force: Current Status and Future Concerns (Oct. 2003)
http://www.healthpolicy.msstate.edu/publications/laborforcereport.pdf

- Recommends that data concerning recruitment of physicians who have graduated from medical schools outside the state of Mississippi be gathered and analyzed. Previously implemented Mississippi recruitment programs should be evaluated, in addition to the needs of potential physician recruits. Mississippi residents attending out-of-state medical schools should be tracked.
- Recommends looking at policies and programs throughout the country in order to recruit and retain more female and minority physicians. More than any other plan encountered, this one highlighted the importance of diversity in the providers being recruited.
- Recommends looking at malpractice climate and premiums as a possible deterrent to recruitment and recommends that mitigating this may benefit both recruitment and retention.
- Offers a comprehensive look at the particular challenges of rural recruitment.

Montana:

Montana Healthcare Workforce Plan—Recruiting Strategy (Aug. 2011)
http://healthinfo.montana.edu/mthwac.html

- Montana has a robust workforce plan, broken into many different strategies and sub-strategies. There is also a Montana Recruitment Collaborative that has come together and owns a list of specific strategies. This is housed in a robust document which appears to be 'living', which includes not only the strategies, but also measures and outcomes (one of these is built off of the ID APGAR) associated with each one:

  (http://healthinfo.montana.edu/MTHWAC/Recruiting%20Health%20Professionals%20to%20Montana.docx)
- Several robust loan repayment programs available from the State as well.
- "Come Back to Montana" marketing campaign (for those who left the state for training)

North Dakota:

North Dakota Health Care Workforce: Planning Together to Meet Future Health Care Needs, Center for Rural Health, University of North Dakota, (April 2007)
http://ruralhealth.und.edu/projects/nursing/pdf/HealthCareWorkforcePolicyBrief2.pdf,

- Calls out need to educate legislators and voters about the 'perfect storm' of the aging workforce and needs of an aging population

South Carolina:

Maximizing your Primary Care Recruitment Plan: Tapping into Current Federal and State Programs and Resources, March 2010

http://scorh.net/services.php?pid=10

http://www.scorh.net/Maximizing Primary Care Recruitment

- State grant program for primary care physicians that is up to $40,000 over a four-year period.
- Highly innovative primary care regional locums tenens program in place, that has four FPs and 1 pediatrician on staff. They charge significantly less than firms, and provide malpractice.
- Offers a provider recruitment database to organizations, and run an opportunities website where postings can be placed by organizations throughout the state

Virginia:

Health Care Workforce Annual Report, (June 2010)

http://www.vahealth.org/irb/documents/2011/pdf/RD227.pdf

- Legislation requires that the State Health Commissioner submit an annual report regarding activities of the Virginia DOH in recruiting and retaining health care providers, to include success metrics as well as recommendations for new programs, activities and strategies.
- Monitors use and efficacy of national rural recruitment website, 3RNet (www.3rnet.org) in the state
- Established Rural Workforce Awards, recognizing the efforts of individuals and organizations in their efforts to improve and expand the health workforce in the rural areas of Virginia. During the Workforce Summit, there were five awards given to individuals and organizations that have significantly contributed to rural communities through initiatives designed to address Virginia's healthcare workforce shortage.
- Sponsors a "Choose Virginia" conference for medical students that is subsidized and focuses on career building and clinical sessions (http://www.vafp.org/PDF-Files/2011%20Choose%20VA%20Student%20Brochure_Layout%201.pdf)

Vermont's Plan:

Primary Care Workforce Development Strategic Plan (May 2011)

http://dvha.vermont.gov/budget-legislative/primary-care-workforce-strategic-plan-with-correction-06-13-11.pdf

- Set a measurable and time-bound goal of increased practitioners within their strategic plan (X number of providers by Y date)
- One of the only plans to call out naturopathic primary care
- Discusses the role of partner/spouse employment in recruitment and retention
- The state employs a "Physician Placement Specialist" who connects employers to residents and practicing providers.
- Created a "Top Ten Reasons to Practice Medicine in Vermont" marketing piece that offers compelling information for prospective providers.
- The report contains good detail on the impact of healthcare reform on primary care workforce needs overall.

Washington:

Rural Health Care: A Strategic Plan for Washington State (Summer 2009)
http://www.wsha.org/files/1st%20Edition%20-%20Rural%20Health%20Plan%20-%20WA.pdf

- Recommends utilizing new technology in order to improve support to practitioners in rural areas in access to continuing education and in addressing professional isolation issues

Washington State Legislature: Rural and Underserved Areas-Health Care Professional Recruitment and Retention (Chapter 70.185 RCW)
http://apps.leg.wa.gov/rcw/default.aspx?cite=70.185&full=true

- The state has charged University of Washington with the development of a robust primary care physician shortage plan, targeting underserved and rural areas.
- Washington has legislated a 'Health Professional Recruitment and Retention Clearinghouse', charged with:
    - Inventory and classification of current public and private health professional recruitment and retention efforts
    - Identification of recruitment and retention program models having the greatest success rates as well as gaps in recruitment and retention program gaps
    - Working with existing recruitment and retention programs to better coordinate statewide activities and to make such services more widely known and broadly available
    - Providing general information to communities, health care facilities, and others about existing available programs
    - Working in cooperation with private and public entities to develop new recruitment and retention programs
    - Identification of needed recruitment and retention programming for state institutions, county public health departments and districts, county human service

agencies, and other entities serving substantial numbers of public pay and charity care patients, and may provide these services to eligible entities, including:

- Assistance in establishing or enhancing recruitment of health care professionals
- Recruitment on behalf of sites unable to establish their own recruitment program
- Assistance with retention activities in practices with eligible practitioners of the health professional loan repayment and scholarship program

Existing Recruitment Programs in Oregon

Loan Forgiveness

Primary Health Care Loan Forgiveness Program

This is one of the few new programs started and funded by the legislature in 2011. The loan forgiveness program, funded with $525,000, will provide loans to students studying to be physicians, nurse practitioners or physician assistants who are committed to work in a rural area. Loans of up to $35,000 per year, administered by the Office of Rural Health, will be awarded to students beginning in their second year of training. One year of loan will be forgiven for each year spent practicing in a rural Oregon community upon completion of the student's training.

Loan Repayment

Oregon Partnership State Loan Repayment Program (SLRP)

Government and commercial loans incurred for the purpose of obtaining a health professional education are eligible. Qualifying commercial lending institutions are those that are subject to examination and supervision, in their capacity as lenders, by an agency of the United States or of the State in which the institutions have their principal place of business.

To be eligible, practice sites must be a public or private non-profit organization, located in a Health Professional Shortage Area (HPSA) and willing to provide 50% of the award amount. Participants sign a contract for a minimum two-year practice commitment. They must work full-time (40 hours per week), with no more than 35 days vacation per year. There are severe penalties for default on contracts.

The program is funded through a grant from the Bureau of Health Professions, National Health Service Corps, with a 1:1 dollar match from the practice site.

The National Health Service Corps (NHSC) Loan Repayment Program

This loan repayment program is administered by the federal Health Resources and Services Administration, with assistance from the state's Primary Care Office. Primary care providers working at an NHSC approved site (a Health Professional Shortage Area with an appropriate score; see below) can receive loan repayment towards qualified education loans. Award amounts for this year's program have been modified to help ensure communities with the greatest need – those with the highest HPSA scores – receive recruitment support to fill much needed clinical positions. Initial awards amounts are as follows:

Providers	2 Years Full-time	4 Years Half-time	2 Years Half-time
Providers at Sites with HPSA Score 14+	Up to $60,000	Up to $60,000	Up to $30,000
Providers at Sites with HPSA Score 0-13	Up to $40,000	Up to $40,000	Up to $20,000

Physicians (MD/DO), Dentists (DMD/DDS), Nurse Practitioners (NP), Certified Nurse Midwives (CNM), Physician Assistants (PA), Registered Dental Hygienists (RDH), Health Service Psychologists (HSP), Licensed Clinical Social Workers (LCSW), Psychiatric Nurse Specialists (PNS), Marriage and Family Therapists (MFT) and Licensed Professional Counselors (LPC) are all eligible. Minimum service requirement is two years, with an option to continue up to 7 years for additional loan repayment.

Federal Faculty Loan Repayment Program

The Faculty Loan Repayment Program helps eligible health professions faculty from disadvantaged backgrounds to repay their student loans. The program provides as much as $20,000 a year to eligible faculty members who apply to and are selected to receive funding from the program in return for a 2-year service commitment. Participants should also receive matching funds from their employing educational institution. In addition, Faculty Loan Repayment Program participants receive a tax liability benefit.

Nursing Education Loan Repayment Program

The Nursing Education Loan Repayment Program is a selective program of the U.S. Government that helps alleviate the critical shortage of nurses by offering loan repayment assistance to registered nurses and advanced practice registered nurses, in return for working in a Critical Shortage Facility and to nurse faculty in return for working full time at an accredited school of nursing. In exchange for a 2-year service commitment, participants receive 60 percent of their total qualifying nursing education loan balance. For an optional third year of service, participants may receive 25 percent of their original total qualifying nursing education loan balance. Participants also receive the salary and benefits they have negotiated with their employing facility.

Eligibility is restricted to nurses who have completed training, who are licensed and employed full time (at least 32 hours per week) at a public or private, non-profit that is designated as, located in or primarily serving a designated primary care or mental health professional shortage area. Funding preference for nursing loan repayment is based on financial need and type of facility in which the nurse will be employed; funding preference in faculty loan repayment is

given to individuals with the greatest financial need and those working at schools of nursing with at least 50 percent enrollment of students from a disadvantaged background.

Primary Care Services Loan Repayment Program – currently unfunded

Oregon's existing (but currently unfunded) program is called the Primary Care Services Loan Repayment Program. It began in 1993 but funding was lost in the 2009-11 biennium. Historically, the program was open to physicians, physician assistants, nurse practitioners, dentists, pharmacists, and naturopaths and provided partial loan repayment (1/3 of the outstanding loan balance annually, up to an annual maximum of $25,000) in return for service time in a rural or underserved area. Service commitment was a minimum of three years, maximum of 5 (2 and 4 for Nurse Practitioners and Physician Assistants.

Tax credits and Liability Subsidy

Rural Provider Malpractice Subsidy

The program provides medical liability insurance premium subsidies to physicians and nurse practitioners working in underserved rural communities. Subsidies cover a percentage of a provider's actual insurance premium and are offered at varying rates based on the provider's practice type. The highest subsidies are given to practitioners providing obstetric care, which is the highest priority group addressed by the program. The subsidies are as follows:

- 80% of the premium for physicians specializing in obstetrics and nurse practitioners certified for obstetric care;
- 60% of the premium for physicians specializing in family or general practice who provide obstetrical services;
- 40% of the premium for physicians and nurse practitioners engaging in family practice without obstetrical services, general practice without obstetrical services, internal medicine, geriatrics, pulmonary medicine, pediatrics, general surgery, or anesthesiology;
- 15% of the premium for other physicians and nurse practitioners.

From 2003 to 2011, the medical liability insurance premium subsidy program was funded by a partnership between the State Accident Insurance Fund Corporation (SAIF), the Department of Consumer and Business Services (DCBS), and the Office of Rural Health (ORH). In 2011, the program was moved to the Oregon Health Authority, in collaboration with the ORH but the funding mechanism no longer exists. However, the Governor's Balanced Budget for 2013-15 proposes $4.6M in General Fund to support the program.

Rural Provider Income Tax Credit

This program grants up to $5,000 in personal income tax credits to eligible physicians, nurse practitioners and nurse anesthetists, and physician assistants working in eligible rural facilities or whose caseloads consist of a majority of rural patients. The tax credit is authorized by Oregon Revised Statutes 315.613 – 315.622 and implemented through Oregon Administrative rules 572-090-030.

Private System Options (Large Healthcare Systems in Oregon)

Health System #1:

1) Traditional Physician Recruitment Option
   Requires documented community need, signed recruitment agreement, in general limited to no more than a loan amount equal to 5-10% of the MGMA median for the physician's specialty/years in specialty, and in no event more than 15% of the MGMA median for the physician's specialty/years in specialty (said amount could be paid directly to the physician or a specified lender to reduce outstanding medical school loans) which would be provided in advance of the recruited physician's relocation to the hospital's service area (may also provide for subsequent recruitment incentives such as income guaranties and relocation assistance provided the aggregate financial assistance is consistent with fair market value).

2) Employment Loan Option (loans $ to Student/Resident during Schooling/Residency)
   Same as 1) above but enter into an employment agreement (or loan agreement) with the student/resident (instead of recruitment agreement), in general advance/loan funds equal to 5-10% of the MGMA median for the physician's specialty/years in specialty, and in no event more than 15% of the MGMA median for the physician's specialty/years in specialty, to the student/resident during schooling/residency, those funds are subsequently forgiven as part of his/her compensation under the employment agreement once he/she begins working at System. The employed physician's total compensation (actual monies paid to him/her by System plus monies forgiven) must be consistent with the FMV of the employment services. *Should not be offered until physician's last year in medical school and if then only subject to the physician satisfying certain standards (e.g., success in school, "matched" to right residency program, quality of student and dedication to community etc.). Strong preference to limit this option to those physicians who are already in a residency program and likely would start employment at System within 12 months of loan.*

3) Employment Loan Option (makes payments to Student's/Resident's Lender to Partially Offset Student Loans). Same as 2) above but instead of loaning money during the schooling/residency of the recruit, System agrees in a letter to the specified physician that if certain standards/conditions are met by said physician (e.g., graduate on time with specified GPA, match into appropriate residency and complete said residency within specified time, ready willing and able to begin employment at System within certain timeframe, enter into employment agreement with System and meet all applicable employment conditions as of the effective date of the employment agreement, etc.), then System will employ the physician and in said employment agreement, in addition to the compensation payable to the employed physician thereunder, commit to pay certain monies directly to the student's/resident's lender for each full year of employment at System completed (such loan payments may be of any amount provided the overall compensation payable to the physician and to lender on physician's behalf is consistent with fair market value). Any such payments will be deemed comp. to the physician employee for IRS purposes and the employed physician's total compensation (actual monies paid to him/her by System plus monies paid to his/her lender) must be consistent with the FMV of the employment services.

Health System #2:

No repayment in Oregon (offer in other states where they are located where it is 'harder' to recruit). Offers a low interest loan (1% above prime) to pay down high interest debt/loans. Not specific to student loan repayment.

Health System #3:

No repayment, though signing bonuses are typically geared towards recruitment, up to $25,000. Some contracts also have retention bonuses that are geared to this purposes (i.e. after contract renewal or first / second year, $X dollar bonus).

Primary Care Provider Recruitment Strategy / HB 2366
Stakeholder Meeting Summary
12-14-11

The Oregon Healthcare Workforce Committee convened approximately 25 participants from a range of organizations (professional societies, health systems and plans, state agencies, educational institutions, and provider groups) to generate and prioritize potential strategies for primary care provider recruitment across the state. This was the first of several anticipated stakeholder conversations; the Committee plans a larger meeting/symposium in the spring of 2012.

Brainstorming discussions

Participants first identified existing recruitment activities or initiatives in Oregon that have shown success or promise. This list included:

- Incentives for students to enter educational programs
- Incentives for practitioners to enter critical practice shortage areas
- Rural medical liability subsidy
- Rimrock Health Alliance (a co-op in Prineville, includes health and civic leaders)
- Forthcoming payment and delivery system reforms (CCOs, ACOs, etc.)
- New training capacity in state, e.g. 1st pharmacy class at Pacific University (with a note that training capacity is important – don't forget about creating a larger pool from which to recruit)
- Enhanced reimbursement for rural health
- Education about value of different practitioners (e.g. the Oregon Association of Naturopathic Physicians is working with the Oregon Primary Care Association to educate community health centers about using naturopathic physicians)
- J-1 visa program to bring foreign-trained providers to the state (with a note that the program has a little extra capacity and a suggestion to explore a statewide network to re-place visa holders in new locations in Oregon after their 3-year service period)
- Rural rotation opportunities for students
- Cross-disciplinary rotations or experience for students
- Existence of Oregon schools (e.g. OHSU) helps with recruitment
- Expedited (for out of state physicians) or more flexible (e.g. for PAs) licensure processes

Next, participants brainstormed other steps that could be taken to help recruit primary care practitioners:

- Make it more desirable for physicians and others to do part-time retirement, rather than full-time
- Expand training capacity (e.g. residency slots)
- Consistent, collaborative marketing (e.g. Brand Oregon)
- Reducing workforce need by increasing prevention and individual health management skills
- Scope of practice improvements (e.g. allowing pharmacists to do cholesterol testing) and making sure everyone can work to top of license.
- Marketing the scope of practice breadth/flexibility that Oregon already has in comparison to many other states.
- Improve the practice environment by addressing state and private carriers' reimbursement policies (for retention as much as recruitment)
- Payment reform, not just insurance reform (for retention as much as recruitment)
- Increase responsiveness to interested professionals (when one Oregon person doesn't respond to an interested candidate, word gets around that Oregon as a whole is not responsive)

- Improve the practice environment by reducing documentation needs and the range of responsibilities that clinicians now have

Participants also identified other groups or individuals that should contribute to the development of a strategic plan for primary care provider recruitment in Oregon:

- Insurance companies
- Practicing primary care practitioners and their spouses / families
- State (re: reimbursement rates)
- Students, residents, and recent residents – people who can speak about the decision to stay or go
- Health administration, public health, and other non-clinicians (in some cases, these professionals may be better candidates for some of the managerial and population health management functions that clinicians are doing now and could free up clinicians for patient care)
- Mental health providers and agencies
- People involved with medical home models
- Veterans
- Consumers
- Business leaders

<u>Strategy development and prioritization</u>

Finally, participants broke into groups and reviewed a long list of potential strategies for primary care provider recruitment, which was developed from an environmental scan of best practices and existing recruitment plans at the local, state, multi-state/regional and national levels. Meeting participants were asked to categorize the strategies into four quadrants based on their rating of the **impact** that strategy could have in Oregon and the **effort** (financial, personnel, barriers) required to implement it. Participants also added some potential strategies of their own to the environmental scan list. The results of this discussion are shown in the table on the next page.

At the end of the small group discussion, the entire group did some informal voting to identify strategies that the Workforce Committee and its staff should explore in more detail. Votes are shown in parentheses after each strategy on the table.

Issues that arose during the small group discussions included these:

- A variety of recruitment and retention efforts are already happening through the state, the Office or Rural Health, or other groups with a statewide purview. However, the private sector often does not know how to access services/participate in efforts. There was general support and encouragement for more collaboration between state-level and private groups and a request for more frequent cross-sector conversations like the current one. However, another participant noted that there was too much duplication of effort between state-level agencies.
- Group members spent considerable time noting the problems with state funding (lack thereof) and the need to focus on the structural changes associated with health reform (e.g. payment).

	Low Effort	**High Effort**
High Impact	• Fund existing loan programs (7 votes) • State-run APGAR testing (7 votes) • Use Social Media for marketing (6 votes) • Look at what other states are doing, especially states with large rural populations. Use their efforts and/or steal their providers (4 votes) • State website—Job Bank (4 votes) • Targeted marketing to students who left state for training (4 votes) • State recruitment program; FTE recruiter available; State working with entities to develop recruitment programs. State recruiting collaborative (3 votes) • Share Best Practices (Web or other methods) (3 votes) • State-coordinated (employed or not) locum tenens program – clear online tool with opportunities and potentially interested clinicians. Market to R3s. (2 votes) • Student conference focused on career building ("how to pick a practice") – panels by specialty or profession that discuss what it's like to work where, transparency (2 votes) • Annual Workforce Summit (share best practices) (2 votes) • CME initiatives added to existing and more robust telemedicine programs • Provide recruitment database to organizations • Rural grand rounds • Legislative education re: need for PCPs • Direct marketing current Oregon students (events/website) • Data collection around new recruits. • Monitor user efficacy of 3RNet. • Provide marketing support for recruiting organizations. • Group purchasing headhunters; negotiated discount. • Awareness/spread of monetary incentive programs	• Payment reform (23 votes) and payment transparency (re: standard contractual clause that prevents one provider from discussing reimbursement). Equal pay for equal work. • Care redesign. Fuller use of scope of practice (PA/NPs/NDs/etc) (10 votes) • Community health-focused town halls (e.g. a tech-enabled primary care grand rounds) – include clinical and policy topics, all providers. Creates community engagement as well as virtual professional support. (7 votes) • Address malpractice climate (7 votes) • Increase number of primary care residencies and training opportunities statewide Increase size of pool of providers; train in Oregon Increase supply (training capacity) (5 Votes). • Statewide job bank/website (4 votes) • Develop Common messaging and workforce definitions (4 votes) • Ensure quality student experiences statewide (4 votes) • Community engagement models and best practices (4 votes) • Increased educational funding for local students - stipend during residency to return to Oregon. Creation of monetary incentive programs (4 votes) • Increased Data analysis (with interpretation of what to do, not just numbers) (3 votes) • State-employed locum tenens available (2 votes) • Develop creative job models to improve clinician satisfaction (job sharing, PCMH) (2 votes) • Creative marketing best practices; Cohesive branding and marketing (2 votes) • Lower income tax for PCPs* (competition with WA State (2 Votes) • Reduce burnout stressors (retention) (2 votes) • Reform in general /progressive environment – will help attract socially conscious students • Annual workforce summit—spread of best practices • State recruitment program (with FTE recruiter) • Increased recruiting of local students • Support for community APGAR assessment or similar / community involvement • Rural workforce awards

		• CCO's role in recruiting /structure.
Low Impact	• Annual workforce summit – spread of recruitment and retention best practices • Marketing piece on top 10 reasons to practice in Oregon • Look into non-compete clauses … are they disincentives in some places? • State website with best practices • Marketing assessment and Provide Support to private groups • State working with entities to develop recruitment programs • Provider education about existing resources and policies • Student focused conference on career building • Increased use of telemedicine for provider support • Rural workforce awards/recognition • Annual workforce summit – spread of recruitment and retention best practices • Marketing piece on top 10 reasons to practice in Oregon • Look into non-compete clauses … are they disincentives in some places?	• Provide marketing support for recruiting organizations – one person commented that this works in AK but not OR • Support options for PCPS (MAs, EMTs, scribes, etc.) • Support/sponsor national clinical conferences coming to Portland as recruitment tool • State employed PCP locum tenens or LT pool (MD/DO/PA/NP)

Primary Care Graduate Medical Education: Training physicians where they are needed

In brief:

- Graduate Medical Education (GME) training in primary care specialties provides an immediate and ongoing new source of physicians for Oregon without recruiting out of state.
- Federal funding helps support new GME programs, thus, the Consortium will not require ongoing state support.
- A statewide strategic approach to GME would help ensure Oregon maximizes workforce and federal funding benefits. By contrast, a hospital-by-hospital uncoordinated approach may diminish these benefits to Oregon.
- After a five-year phase-in, a community based GME consortium program could support training of about 130 primary care physicians each year in 5 or more community based programs – in the areas where physicians are most needed.

Summary:
Upon completion of medical school, all new graduates pursue a "residency" in Graduate Medical Education (GME) in a specialty of their choice. Oregon currently supports more than 800 GME positions in all specialties. 776 positions are at OHSU, and about 275 open up each year and are open on a competitive basis to students from all around the US and the world. These training opportunities at OHSU are highly sought after and are nationally "matched" to new graduates from all over the country, some of them 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, thus, could have an immediate and ongoing impact on reversing workforce shortages. Already, OHSU is ranked tenth in the nation for in-state retention of physicians after GME training, with 52% 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 an importer of physician workforce.

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.

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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. Corvallis has recently added several small Osteopathic residencies in affiliation with the Western University College of Osteopathic Medicine of the Pacific campus in Lebanon, Oregon.

Because the GME programs at community hospitals are necessarily small, 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 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.

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 to help administer established residency programs after the startup phase is complete.

The Need for a Rural Locum Tenens Program in Oregon

***What is locum tenens*?**
Taken from the Latin "to substitute for", locum tenens are physicians who provide temporary medical services for a specific length of time. This can vary from a few days to allow for vacation or continuing medical education, to several months for medical leave or interim coverage between providers.

Why is a rural locum tenens program needed?
Rural practices and hospitals have difficulty covering the needs of their community on a 24 hour, 7 day per week basis due to the limited numbers of providers present in the community. Many rural communities do not have sufficient medical staff to allow physicians time away for vacation, continuing education and other important activities to prevent burnout and increased turnover. In addition, the broad scope of practice inherent in rural practice can make finding temporary coverage difficult or prohibitively expensive. Commercial locum tenens agencies charge fees substantially higher than can be afforded by rural physicians, whose incomes and practice revenues are not sufficient to support those costs.

Why an academic health center based model?
As the only academic health center in Oregon, OHSU holds much of the responsibility for training physicians to meet the needs of all Oregonians. Faculty, fellows and residents can participate as locum tenens providers on a part-time temporary basis as part of their regular duties, or as extra income producing work. Because OHSU already verifies credentials of its physicians, communities do not sustain any extra expense to perform these essential tasks. Academic health center based programs exist in other areas, such as University of Kansas and University of New Mexico.

What are the benefits of a rural locum tenens program?
For rural physicians:

- Affordable practice relief for vacation, continuing education or illness
- Supplemental assistance during busy times
- Ability to keep office open and staff employed
- Revenue produced when office would otherwise be closed
- Recruitment

For locum tenens physicians:

- Opportunity to experience rural practice without having to commit long term to one location
- Income to relieve financial burden
- Skill enhancement
- Flexible scheduling and part time work availability\

For rural communities:

- Ability to obtain 24 hour/7 day medical services
- Recruitment
- Economic development, keeping medical care in the community
- Opportunity to showcase community to potential physicians
- Infrastructure development

For OHSU:

- Support for rural communities
- Training opportunities for faculty, fellows and residents
- Academic faculty skill enhancement and maintenance
- Support for community physicians who provide teaching service to OHSU

How will a rural locum tenens program be funded?

Fees generated by the program will provide the majority of the funding. To keep fees low enough to be helpful, however, there is a need for additional support. The Area Health Education Center at OHSU has applied for grant funding to seek support for start up costs, administrative overhead, and technical assistance for communities seeking locum tenens services. These funds, if obtained, can be used to sustain the first 2-3 years of start up for the program. Additional funds will be sought from the Oregon State Legislature to provide a program subsidy designated for physicians in Health Professions Shortage Areas. A sliding scale fee will be developed in order to keep the costs low enough to be feasible.

Why is technical support included in this program?

Technical support from the Oregon Office of Rural Health field specialists is crucial to assisting communities in planning for recruitment and retention. Rural communities and hospitals frequently lack the resources to engage in the complex task of health workforce planning. The locum tenens program will be one component of an overall recruitment and retention plan for communities. Additional field specialists will be needed to assist communities, physicians and Critical Access Hospitals with the assessment needed for successful health workforce planning.

What is the expected demand for these services?

In a survey conducted by the Oregon Office of Rural Health in December, 2006, more than half of physicians eligible for the Oregon Rural Provider Tax Credit indicated desire to utilize locum tenens services, but report difficulty obtaining coverage through existing means. Most report that they would utilize a high quality, affordable service, if available.

Oregon rural locum tenens program partners

- ***Oregon Health and Science University***
  - ***Oregon Area Health Education Center***
  - ***Oregon Office of Rural Health***
  - ***OHSU Department of Family Medicine***
- ***Oregon Association of Hospitals and Healthcare Systems***
- ***Oregon Healthcare Workforce Institute***

For additional information, contact:

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Oregon Locum Tenens Cooperative (OLTC)

In July of 2009, OHSU's Area Health Education Center (AHEC) began exploring alternative methods of locum tenens provision, ensuring temporary or short-term primary care access to rural communities, facilities and medical practices. Many communities recognized commercial options of locum tenens, or short-term coverage, as unaffordable and often providing care that was not compatible with the needs of rural populations. Our mission, in partnering with rural communities to address these issues, led us to a cooperative model of locums provision, the Oregon Locum Tenens Cooperative (OLTC), launched in January, 2011. The primary benefits of this model include:

Community-based and Membership Directed. The cooperative model allows facilities and communities to build a program that best suits their needs using locums to address both long and short-term health system goals.

Centralized Posting and Direct Contracting. The OLTC office centrally posts openings, reaching a wide audience of potential locums physicians. The cost of locums services remains low through permitting each member to maintain the individual contract and compensation arrangements.

Physicians familiar with rural practice, scope of care and available resources. The rural nature of our State requires practitioners comfortable with patient care in settings of limited local resources. The OLTC uses Oregon physicians who understand the territory.

No-cost recruitment for practices. As a program service, should a site be successful in recruiting a locums provider to a permanent position, the OLTC looks upon that as a success. Over the next year, the OLTC will be investigating Federal and State loan repayment options for locums service to designated areas.

Building Primary Care Workforce. Through connections with OHSU, OAFP, Oregon AHEC and national recruitment capacity with the central OLTC office, optimal connections can be made with potential locums providers. Locums options can be used to help draw recruits to Oregon and experience multiple communities.

Program Summary

Functions the OLTC program office. As a central point to post locum tenens openings, the program office maintains and manages the coverage requests of OLTC members. Its primary asset is the locum tenens workforce built via social networks and affiliated organizations. Each participating provider will have primary verification completed to assure his or her qualifications. Members can access this credentialing data and past placement satisfaction surveys to more quickly make decisions on providers electing to take assignments.

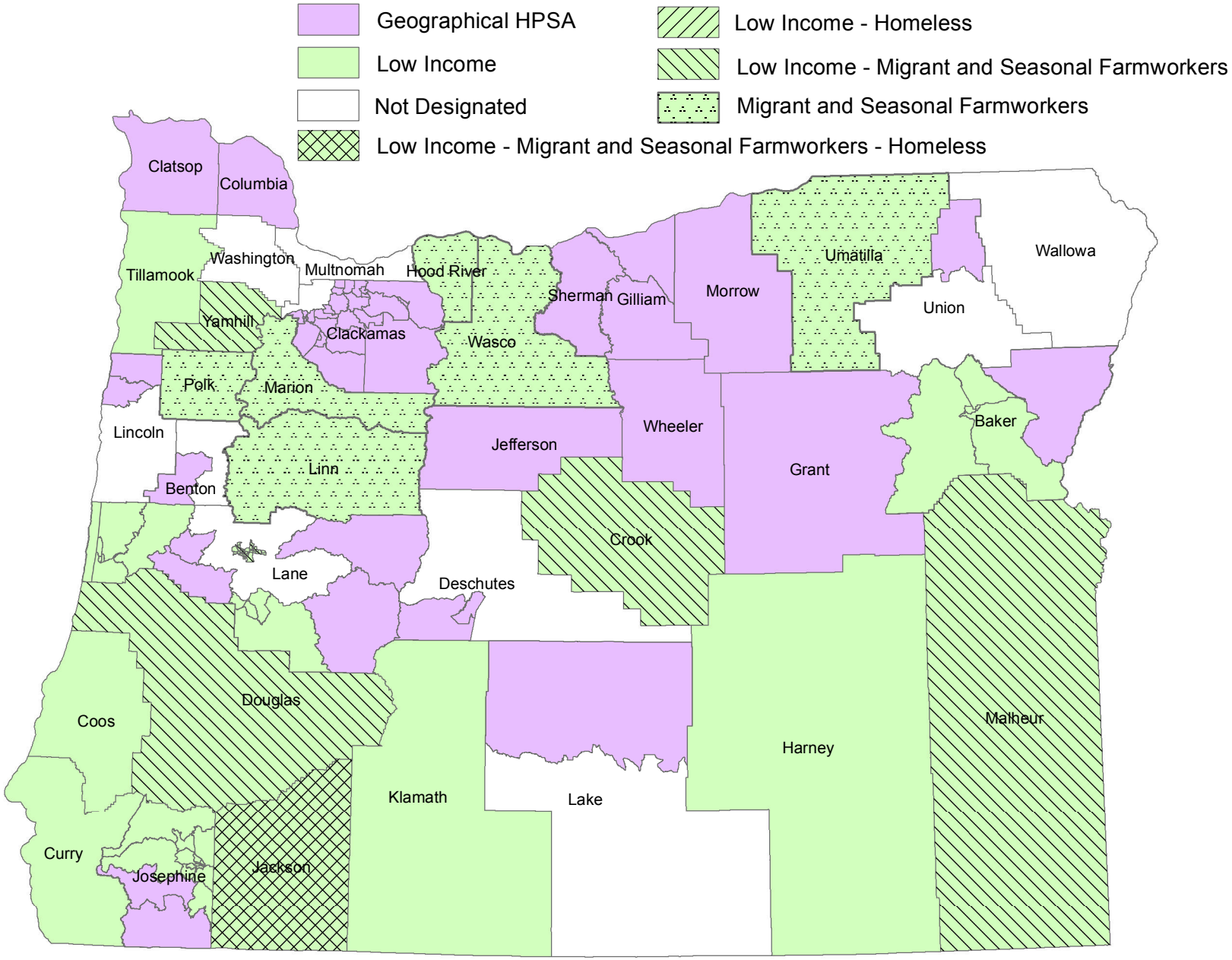
Who are the members? The founding members are composed of several Oregon critical access hospitals and rural practices. Expansion of membership can be to any health facility or physician practice in a rural or underserved community, through approval of the OLTC governing board. Members pay an annual membership fee based upon practice or facility size to access OLTC services. Medical malpractice for locums is typically covered through a member's existing policies or by negotiating a per-diem with their representatives.

How does it work? Up to three months in advance, any member site can request coverage through the OLTC program office. Postings include location, type of coverage, scope of care, dates of coverage and total compensation. Locum tenens providers can view available openings through regular postings (web-enablement in development) and request dates to provide needed coverage. Once a provider indicates interest in a coverage location and date(s), the program office connects the site with the individual's name and credentials. After the work is completed, the site submits provider satisfaction surveys for use by future OLTC members. All compensation for direct care services is completed between the site and physician.

Program Development and Administration

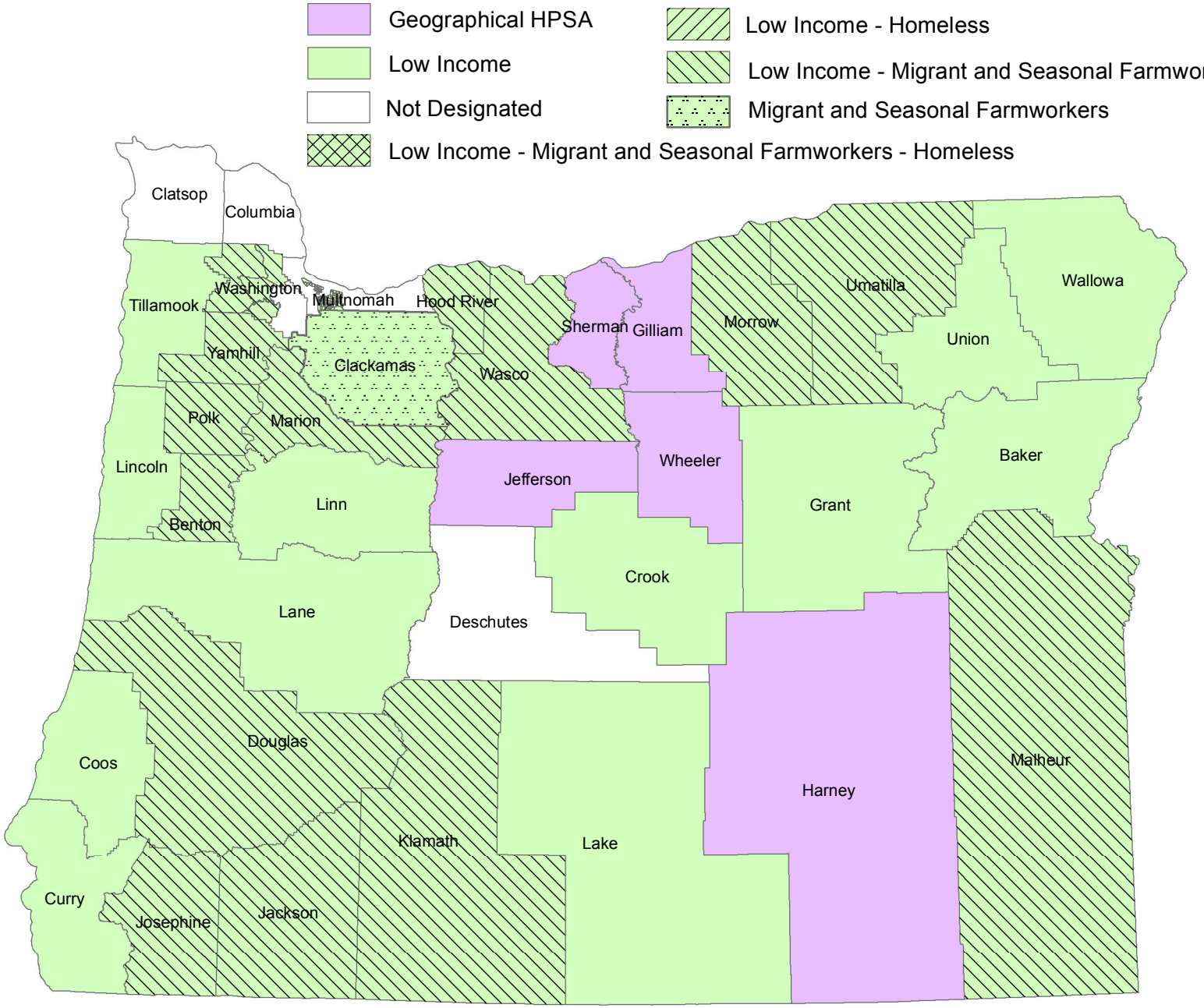
Initial funding for development was provided through the Oregon Community Foundation and continued through AHEC and OHSU support. Although the program will be self-sustaining based on membership fees, we are actively seeking rate relief and subsidy partners in our mission to address temporary practice coverage needs and expand rural Oregon's primary care workforce capacities.

Oregon Primary Medical Care Health Professional Shortage Area (HPSA) Designations as of 9/28/2012



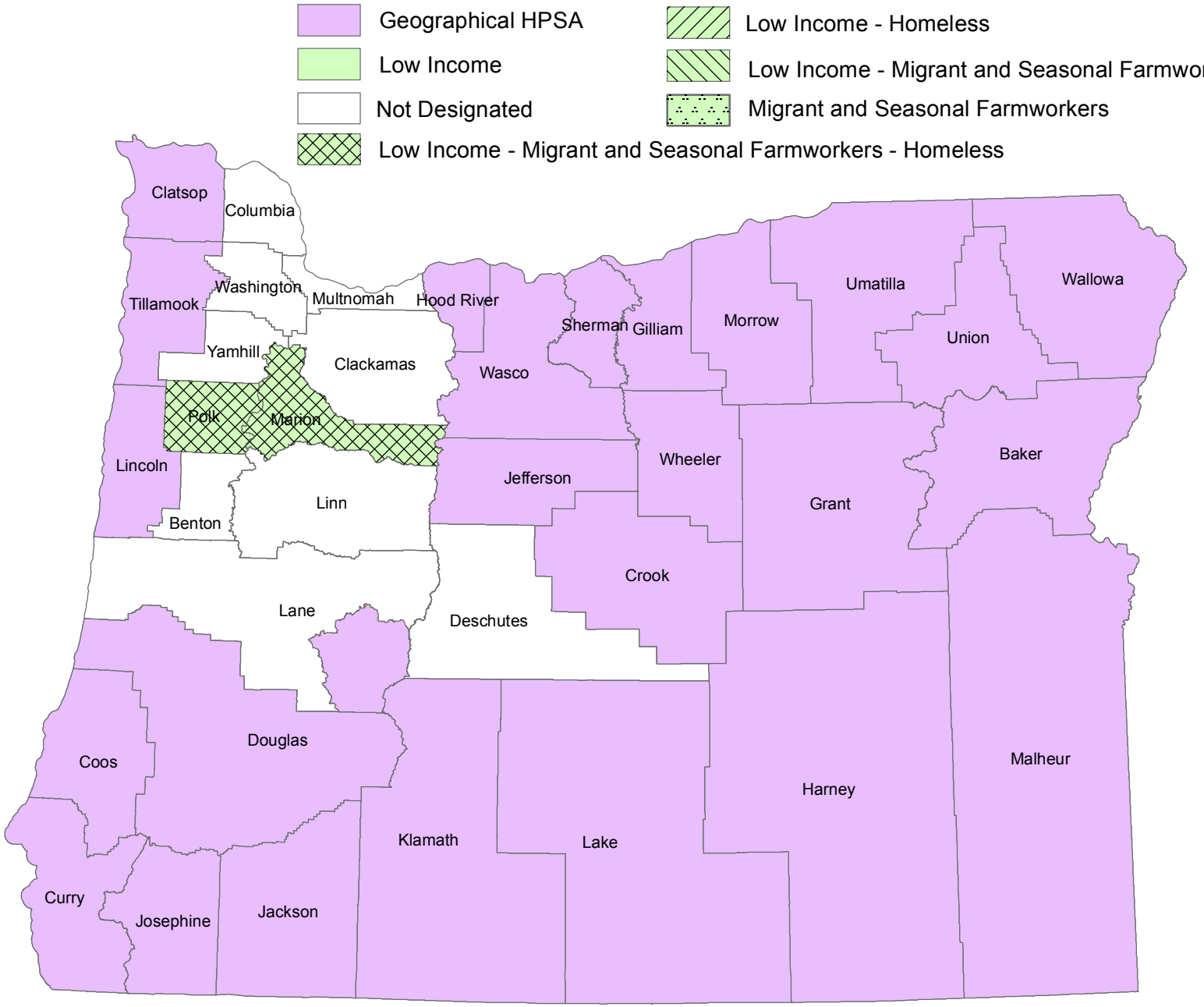
Created by Sata Hackenbruck, Oregon Health Policy and Research, 9/28/2012

Oregon Dental Care Health Professional Shortage Area (HPSA) Designations as of 9/28/2012



Created by Sata Hackenbruck, Oregon Health Policy and Research, 9/28/2012

Oregon Mental Care Health Professional Shortage Area (HPSA) Designations as of 9/28/2012



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