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**Oregon Health Authority**  
Office for  
Oregon Health Policy and Research



**Oregon Health Care Workforce Committee**

**Recommendations for the  
Oregon Health Policy Board**

**December 2010**

**Health Care Workforce Committee  
2010 Report**

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## Executive Summary

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee (“Committee”) to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. In response to this charge, the Committee identified three initial priorities for health care workforce development. These priorities reflect the Committee’s desire for action that will address both the current workforce needs and the needs Oregon might have in the future, when health care delivery looks different than it does today. The priorities are:

1. Prepare the current and future workforce for new models of care delivery;
2. Improve the capacity and distribution of the primary care workforce; and
3. Expand the workforce through education, training, and regulatory reform to meet the current projected demand of 58,000 new workers by 2018.

In this report, the Committee recommends five short-term actions and seven longer-term strategies to help Oregon move forward in these priority areas. In the short term, Oregon should:

- Revitalize the state’s primary care practitioner loan repayment program;
- Standardize the administrative aspects of student clinical training;
- Re-interpret an ‘adverse impact’ policy that makes it difficult for educational institutions to offer programs in response to industry and community needs;
- Maintain funding for health professions education programs; and
- Expand health care workforce data collection.

Longer-term recommendations are to:

- Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand
- Define new standards for health care workforce competencies
- Adopt a payment system that encourages the most efficient use of the health care workforce
- Identify barriers that prevent health care professionals from practicing to the full scope of their licenses
- Stimulate local creativity and resource sharing for health care workforce development
- Enhance resources for health professions education programs
- Maintain and enhance resources for K-12 math, science, and health career exposure.

The Committee emphasized that the eventual success of health care workforce development efforts will be strongly influenced by reforms in other parts of the health care system. In that context, the Committee identified these elements of broad-based health care reform as particularly important sources of support for its targeted workforce recommendations: adoption of more comprehensive and/or accountable payment methods; greater emphasis on prevention and population health; and improved data collection.

The Committee has appreciated the opportunity to address the important task of ensuring an adequate health care workforce for Oregon and looks forward to continuing its work.

## I. Introduction

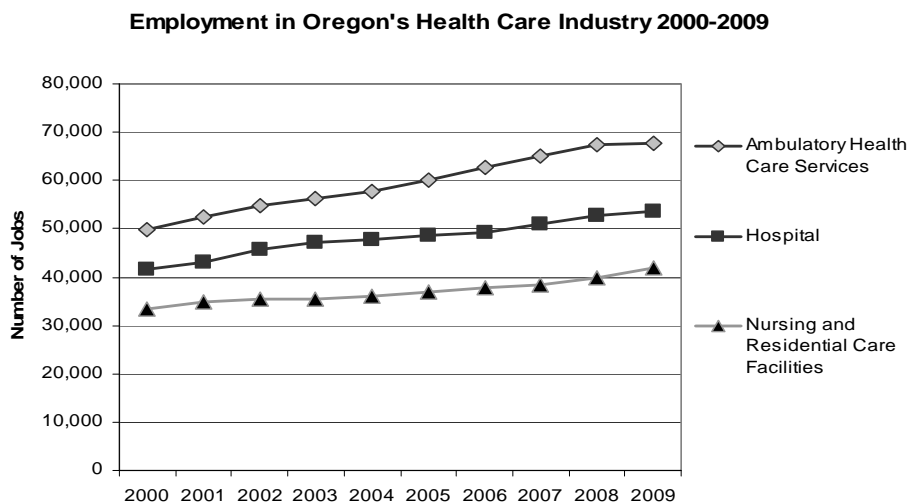
Building a strong health care workforce for Oregon is both an economic and a moral imperative. Our state's unemployment rate is a full percent above the national average. At the same time, Oregon is facing a substantial shortage of health care providers that will only intensify when almost 300,000 people gain access to health insurance coverage in 2014. We have a moral responsibility to ensure that the newly insured can find a health care provider and a unique opportunity to provide stable, living wage jobs for Oregonians in the process.

The likelihood of substantial changes in health care delivery and payment make it difficult to pinpoint the number and kind of health care providers that would be ideal for the future. Some of the changes that are needed to build an appropriate health care workforce for Oregon must be made at the national level. Nevertheless, decisive action can and must be taken in Oregon to create the health care workforce that we need. This report contains the Health Care Workforce Committee's 2010 recommendations for this action.

## II. Background

### *The Challenge*

State and federal health care reforms aim to improve health care for all Oregonians, yet their success depends on access to a health care workforce able to meet the demand for quality services. Reform efforts add to the current demand created by a growing, aging and diversifying population, the increasing number of people living with chronic diseases, advances in medical technology, and an aging health care workforce. To achieve the triple aim of improved population health, increased quality and availability of care, and reduced costs, Oregon needs a health care workforce strategy that addresses all of these factors.



Source: Oregon Employment Department

Increased demand for health care professionals is reflected in industry employment, which comprises a growing share of the state's workforce and accounts for over ten percent of Oregon's total non-farm employment.<sup>1</sup> According to Oregon Employment Department data, employment in Oregon's health care industry grew 31% between 2000 and 2009 (see chart below). The largest job growth occurred in the ambulatory health care services sector, which added 17,800 jobs between 2000 and 2009, representing a 36% increase in employment. Hospital employment grew 29%, adding 12,000 jobs to the labor market. Employment in Oregon's nursing and residential care facilities grew by 8,400, representing a 25% increase in employment in this sector.

Three of the state's top ten sectors projected to add the most jobs are in the health care industry: ambulatory health care, hospitals, and nursing and residential care.<sup>2</sup> Based on current population trends and health care delivery models, the Oregon Employment Department forecasts a need for nearly 58,000 additional health care workers in the state by 2018.<sup>3</sup> Forty-six percent of the projected job openings are to replace those permanently leaving the occupations' labor pool. See Appendix A for a table of the 50 fastest growing health care occupations in Oregon.

These projections, however, are based on market demand rather than population need and do not account for coverage expansions expected to bring almost 280,000 newly insured people into the system by 2014<sup>4</sup> or the significant changes proposed for how health care is delivered and financed. Nurse Practitioners, for example, are likely to be key players in a revitalized primary care system but are not listed in Table 1 because of data collection limitations. Specifically, the U.S. Department of Labor's Standard Occupational Classification (SOC) system puts nurse practitioners in the broad registered nurse category that also includes RNs, staff nurses, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.<sup>5</sup> Similarly, emerging health care occupations, including those associated with new models of health care delivery, are excluded from employment projections since there are no baseline data on which to estimate employment demand.

Furthermore, the aggregate demand figure masks significant variation by geographic region, provider type and specialty. Thirty-two of Oregon's 36 counties have some type of federal primary care health professional shortage area designation.<sup>5</sup> There are 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. Only 38% of Oregon's physicians are practicing in primary care (family medicine, family practice, general practice, general internal medicine, pediatrics, geriatrics, and adolescent medicine).<sup>6</sup> Information about the racial and ethnic diversity of Oregon's health care workforce is currently limited but the state and health professional regulatory boards are collaborating to build a health care workforce data system that will improve the availability and quality of diversity data.

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<sup>1</sup> Beginning in 2011, the U.S. Department of Labor's Standard Occupational Classification (SOC) system creates separate codes for advance practice nurses, nurse midwives and nurse anesthetists

Employment projections also do not reflect the difficulty employers face in filling current job openings. A 2009 statewide vacancy survey by the Oregon Employment Department found that despite the recession, Oregon's health care and social assistance industry had far more vacancies (5,744) than any other industry in the state.<sup>7</sup> Job openings for registered nurses in Oregon represented nearly six percent of all vacancies statewide, ranking the highest of all occupations with job vacancies.<sup>ii</sup> Of the 1,004 reported vacancies for registered nurses, 11% had been open more than 60 days. Of the 457 job openings for nursing assistants, 10% had been vacant more than 60 days. Twenty-nine percent of the 226 reported vacancies for physical therapists and 19% of the 212 vacancies for physicians were open more than 60 days.

Despite these caveats, employment demand projections provide important trend information and are a strong basis for more detailed analyses. The Health Care Workforce Committee has accepted the Oregon Employment Department projections as a reasonable calculation of health care workforce need. Close attention to emerging information on workforce supply and diversity, health care demand, and delivery system changes will be essential for crafting a health care workforce strategy that enables the state to achieve the triple aim.

### *The Oregon Health Care Workforce Committee*

The Oregon Legislature and the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee ("Committee") to coordinate state efforts to recruit and educate health care professionals and retain a quality workforce to meet demand. The Committee is charged with advising the OHPB and developing recommendations and action plans for implementing the necessary changes to train, recruit and retain a health care workforce that is scaled to meet the needs of new systems of care. The Committee is also intended to become the most complete resource for information about the health care workforce in Oregon by improving data collection and assessment of Oregon's health care workforce through regular analysis and reporting of workforce supply and demand.

Committee members include representatives from community colleges, graduate health and medical education, health system and hospital employers, foundations, Area Health Education Centers, and a range of health professions: nursing, dentistry, allied health, behavioral health, and medicine. The Committee is also connected to a broader range of stakeholders and experts via a formal collaborative relationship established this past summer between the Oregon Health Policy Board and the Oregon Workforce Investment Board (OWIB). The OWIB serves as the advisory board to the Governor on workforce matters and is comprised of leaders representing private sector businesses, labor, and state and local governments. One of the chief duties of the OWIB is to assist the Governor by developing a five-year strategic plan for

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<sup>ii</sup> The occupational groupings of the U.S. Department of Labor's Standard Occupational Classification (SOC) system have limitations when analyzing projections for specialty-trained workers within an occupational category. For example, the current SOC for registered nurses includes employment for staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. Similarly, when multiple job titles are grouped within one SOC, such as radiologic, CAT and MRI technologists and technicians, the distinction between levels of training and required certifications is omitted.



Oregon's comprehensive workforce system and building Oregon's health care workforce through job training efforts, which is identified as one of four key initiatives in the plan. The two bodies have agreed to collaborate, seek federal funding opportunities, coordinate recommendations and align efforts to build Oregon's health care workforce. The OWIB has designated the Health Care Workforce Committee as an advisory subcommittee and Oregon Health Policy Board has committed to sharing information, expertise and other resources to support the success of the collaborative relationship.

### *Priorities and Principles*

Committee members started work in Spring 2010 by reviewing health care workforce supply and demand data, considering the impact of health care delivery changes on job roles and training, and analyzing the workforce implications of federal health reform legislation. The Committee identified significant challenges, strengths, barriers, and opportunities for health care workforce development and produced a lengthy list of potential strategic objectives for health care workforce development. First and foremost, the Committee acknowledged the importance of reducing Oregonians' overall need to access health care providers by supporting prevention and health promotion efforts. The Committee recognized the following principles to guide health care workforce development efforts:

1. Build on collaborative and innovative partnerships within and across sectors (education, industry, workforce development, government);
2. Ensure and promote diversity in health profession students, faculty and the health care workforce;
3. Maximize the efficient use of existing and future resources and pursue federal and other non-state funding opportunities that align with the Committee's priorities;
4. Promote the continuation and expansion of successful health profession education initiatives aimed at meeting Oregon's health care workforce needs.

Three priorities emerged from the Committee's careful examination of health care workforce needs. These priorities reflect the Committee's desire for action that will address both our current workforce needs and the needs we might have in the future, when health care delivery looks different than it does today.

1. **Prepare the workforce for new models of care delivery.** If Oregon is to have any chance of solving its health care workforce capacity problems, fundamental changes must be made in how care is provided and how the health care workforce functions. Put simply, the gap between the work that needs to be done and the number of available workers is so big that we have no choice but to do the work differently. Delivery system transformation will prove challenging for a workforce that is already under strain and payment reforms will be necessary to catalyze the needed changes in many cases. But committing to system transformation gives us the opportunity to increase provider satisfaction and retention at the same time that we improve patient health outcomes. Transformation is already underway. Engaging and empowering the health care

workforce to help lead practice transformation is fundamental to the long-term success of health care reform efforts.

2. **Improve the capacity and distribution of the primary care workforce.** There is an urgent need to expand the primary care workforce to meet the anticipated increase in demand for care in 2014 and beyond. Expanding education and training opportunities and increasing the number of health profession graduates is one part of ensuring an adequate workforce, but many health professions require years of training. In the short term, Oregon must take steps to expand the capacity of its existing primary care workforce and to improve its distribution.
3. **Expand Oregon's health care workforce through education, training and regulatory reform to meet the current projected demand for 58,000 additional health care workers.** One of the most straightforward ways to find the estimated 58,000 health care professionals that Oregon needs by 2018 is to “grow our own,” meaning that Oregon must educate more professionals in-state and whenever possible “in-region” to train health care professionals from and in the communities they will serve, to assure both the rural and urban demand is met.

Decisive action in each priority area is needed to ensure that Oregonians have access to appropriate health care providers in their communities when they need care. This document contains the Health Care Workforce Committee’s short- and longer-term recommendations for tackling each priority.

## **II. Short-term Recommendations**

### **1. Revitalize the state’s primary care practitioner loan repayment program.**

*What:* Oregon’s Primary Care Services Program, which provides partial loan repayment to primary care providers in return for service time in rural or underserved areas, should be financed as soon as possible at a level that would reduce at least 5% of the statewide projected need for each professional included in the program every biennium (roughly 30 additional professionals per year).

*Why:* Educational debt combined with the relatively low earning potential of primary care as compared to specialty practice discourages health professionals from entering into primary care, especially in rural or underserved communities where remuneration is typically low. In Oregon, there are 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. Loan repayment programs that tie repayment to a service requirement have been successful in encouraging primary care practice in rural and underserved areas; for example, physicians who participate in state loan repayment and similar financial incentive for service programs are more likely to practice in needy areas and to serve Medicaid and uninsured patients (48% vs 28%) and

remain longer in their positions than their peers.<sup>8</sup> They are more likely than non-participants to continue to practice in underserved areas even when their service obligation expires.<sup>9</sup> Furthermore, bringing health professionals to a community has a ripple economic benefit; it is estimated that a single physician generates 12-48 jobs and between \$60,000 and \$170,000 in state and local taxes in the county where she or he practices.<sup>10</sup>

Federal health reform doubled the size of the national loan repayment program known as the National Health Service Corps, which could bring 100 or more additional primary care practitioners to Oregon. Oregon's program is a good complement to federal programs but has no dedicated funding. This recommendation supports the Committee's second priority of improving the capacity and distribution of the primary care workforce.

*How:*

- Funding mechanisms for a loan repayment program include surcharges on health professional licenses or on student fees in health professional programs, federal matching funds, foundation money, state General Fund, dedicated taxes, and other sources alone or in combination. Workforce Committee leadership will consult with the Office of Rural Health and other partners to outline a range of options for consideration.
- The level of investment required to meet a 5% goal is roughly estimated at \$2M per biennium, if repayment is capped at three years. There is the potential for 1:1 matching funds from the federal Health Resources and Services Administration.
- Eligibility criteria for the Oregon Primary Care Services Program should be reviewed every biennium in collaboration with the Health Care Workforce Committee to ensure that the program can adapt to address new care models and emerging shortages. For example, mental and behavioral health care professionals could be included to support the establishment of robust medical homes in rural and underserved areas.

## **2. Standardize administrative aspects of student clinical training.**

*What:* The Health Care Workforce Committee recommends three actions to streamline and increase capacity for the clinical portion of health profession student preparation:

- Standardize student background requirements for clinical training (drug testing, criminal background check, HIPAA training, etc.) and identify a common vendor (or set of vendors) to perform those checks and issue a student "passport." This standardization would greatly reduce the administrative burden and expense for students, who often pay for a new round of background checks, tests and training for each clinical training site.
- Establish uniform standards for student clinical liability to reduce the time and expense of contractual negotiations between educational institutions and provider organizations.
- Incent more community-based and outpatient practices to serve as clinical training sites through tax incentives or rebates.

*Why:* Clinical experience is a vital and required element of health profession training, yet it can be difficult for students and educational institutions to find placements and burdensome for provider organizations to serve as training sites and to provide preceptors. Additionally, the inconsistencies in student prerequisites for clinical training across and within health care organizations increase students' education expenses and create costly inefficiencies for schools and health care organizations. This recommendation supports the Committee's third priority of expanding the health care workforce through education, training, and regulatory reform and, less directly, the priority of improving workforce distribution.

*How:*

- OHA, in collaboration with the Oregon Workforce Investment Board, the Oregon Department of Community Colleges and Workforce Development, the Oregon Association of Hospitals and Health Systems, the Oregon Area Health Education Center Program Office, the Oregon Healthcare Workforce Institute and the Oregon Center for Nursing, should convene hospital representatives and educators to agree on a standard, uniform set of requirements ("passport") in early 2011.
- OHA should identify statewide vendor(s) for background checks, drug tests and related requirements by RFP or OHA certification.
- OHA should require facilities to accept students' "passports" as proof of student preparedness by Fall 2012.
- The Health Care Workforce Committee should consult with medical liability and contract law experts on options for standardizing student liability (2011).
- OHA should consult with the Oregon Department of Revenue on potential tax credits or other incentives for outpatient practices serving as clinical training sites (2011).

### **3. Enable educational institutions to respond quickly to health care workforce training needs.**

*What:* The state's "adverse impact" policy should be should be revised, interpreted and implemented in a way that enables public educational institutions to respond quickly and appropriately to industry needs while demonstrating appropriate stewardship of public funds.

*Why:* Current interpretation of a state law (ORS 348.603) designed to ensure that public investment does not duplicate or adversely impact private business restricts public educational institutions from offering health occupations training and education programs in direct response to industry or community needs and student demand. The result is that training programs for high-demand health care occupations may not be available or equally available to rural and urban students or to rural or underserved communities. This recommendation supports the Committee's third priority of expanding the health care workforce through education, training, and regulatory reform.

*How:* The OHA should convene stakeholders to redraft the law and/or administrative rules by Spring 2011.

#### **4. Maintain resources for health professions education programs.**

*What:* In spite of the state budget shortfall, the Legislature should avoid making cuts to the health professions education programs, particularly programs that educate those professionals who are important to the establishment of patient-centered medical homes or who are in key shortage occupations (see Appendix A) and programs that reach students in all areas of the state (e.g. distance education). The success of Oregon’s health reform efforts is dependent on the workforce that these programs produce.

*Why:* The most direct and effective way to find the estimated 58,000 health care professionals that Oregon needs by 2018 is to “grow our own,” meaning that Oregon must educate more health professionals in-state. This is particularly important because other states have significantly increased their efforts to retain their health care workforces, limiting the effectiveness of Oregon’s recruitment efforts. Similarly, as Oregon’s population becomes more diverse, Oregon needs to build a health care workforce that reflects the state’s racial and ethnic population. This recommendation supports the Committee’s third priority of expanding the health care workforce through education, training, and regulatory reform.

*How:* While the state’s severe budget challenges make it difficult, the Committee urges the Legislature to maintain funding for health professions education in 2011-13.

#### **5. Expand health care workforce data collection for a more complete picture of Oregon’s health care workforce.**

*What:* The statute that created Oregon’s Health Care Workforce Database should be amended to enable collection of accurate and comparable data for all licensed health care providers in the state.

*Why:* Complete and accurate information about Oregon’s health care workforce is essential for design and evaluation of workforce development strategies, including efforts to increase the diversity of the workforce. Participation in Oregon’s health care workforce database is currently limited to seven professional licensing boards, meaning that the Health Policy Board and other policy makers lack information on key shortage professions such as those providing mental and behavioral health services. Furthermore, legislation governing the database is not flexible enough to include new provider types that may be recognized by professional licensing boards in the future. This recommendation supports all three of the Committee’s priorities.

*How:*

- Participation in the health care workforce database should be extended to all health professional licensing boards in 2011, with actual reporting to be phased in according to data priorities and board readiness.
- Information about licensed mental and behavioral health care professionals is currently lacking, so the boards governing these professions should be prioritized for inclusion in 2011: the Board of Psychologist Examiners; the Board of Licensed Social Workers; and the Board of Licensed Professional Counselors and Therapists.
- The information collected should allow for linkages with Oregon Employment Department data on employment and compensation to enable analysis of workforce development efforts, gaps between supply and demand, and the impact of economic incentives such as loan repayment and rural provider tax credits.
- Also in 2011, the Health Care Workforce Committee should begin to consider how to improve the availability of data on the many certified health care professionals who are not covered by any regulatory board but who make up a substantial portion of Oregon's health care workforce. Examples include: home health aides, qualified mental health professionals, and certified medical assistants.

### **III. Longer-term Recommendations**

#### **1. Use delivery system and payment reform pilots to build evidence for new workforce models and to refine projections of future workforce demand.**

As Oregon leads the way on critical delivery system reform, it should also take leadership in understanding how those reforms will affect the current and future workforce. This recommendation relates to the Committee's first priority of preparing the workforce for new models of care delivery.

OHA should require delivery system reform pilots (primary care homes, behavioral health integration projects, etc.) to include analysis of workforce staffing levels, roles and skills, correlated with level of risk/complexity of patient mix, and population diversity. (Federal health reform legislation includes potential funding for a variety of reform experiments including medical homes and accountable care organizations.) Analysis results and workforce lessons learned should be reported to the Health Care Workforce Committee and the Oregon Employment Department on an ongoing basis to enable sharing of best practices and to help adjust workforce need estimates based on current models of care. The Workforce Committee will consider any available data as part of its 2011 workplan.

#### **2. Define new standards for health care workforce competencies.**

Although health providers are still exploring new models of care and the workforce implications, some of the skills that health care professionals will need are already evident. The Institute of Medicine identified five core competencies for all health care professionals: providing patient-centered care; the ability to work in inter-professional teams; proficiency with informatics or HIT; competence in quality improvement and methods; and evidence-

based practice.<sup>11</sup> Recognizing the importance of addressing health care inequities, the Committee adds cultural competency as a sixth, distinct core skill. Cultural competency is vital not only to improve the quality of care delivered to racially and ethnically diverse patients but also to strength health care professionals' abilities to communicate and collaborate with each other.

Efforts to formalize new competencies in professional practice are already occurring at the national and state levels. For example, the American Board of Medical Specialties has included new requirements regarding interpersonal and communications skills in Maintenance of Certification testing for physicians. The Oregon State Board of Nursing revised the Oregon Nurse Practice Act to include competencies in nursing informatics. Building on current efforts, the OHA should convene representatives from the Oregon's health care industry, academic programs, licensing boards, professional associations, and culturally diverse communities to guide the development of desired competencies and related curricular standards for Oregon's health professions' education programs. As with the previous recommendation, this work would support the Committee's first priority of preparing the workforce for new models of care delivery.

### **3. Adopt a payment system that encourages the most efficient use of the health care workforce.**

A payment environment that restricts who can be reimbursed for service provision encourages practices to use higher-level practitioners to perform functions that could be done just as well—and less expensively—by other qualified providers. This leads to underutilization of existing workforce capacity, with negative consequences for access, quality, and cost. The Committee strongly supports shifting away from this type of payment system to a more comprehensive and/or accountable payment system, as proposed by the Incentives and Outcomes Committee. This recommendation supports the Committee's first and second priorities.

The methods of transitioning to a more integrated payment system should allow practices to build teams that use the best provider for a given function. In primary care, this might mean a base payment sufficient to hire a clinical pharmacist to educate patients about managing their prescriptions or community health workers to serve as bridges between clinical care and population-level prevention. Payment for certified health care interpreter services and the use of telemedicine to make health care more available in rural and remote settings are also strategies that should be considered as components of a comprehensive system.

### **4. Identify barriers that prevent health care professionals from practicing to the full scope of their licenses.**

As new models of care delivery develop, the Committee, OHA and the state's health professional licensing boards should examine payment policies, credentialing standards, organizational structures, and other relevant factors to ensure that there are no barriers to

utilizing the full potential of each professional's license. This recommendation supports the Committee's first and second priorities.

**5. Stimulate local creativity and resource sharing for health care workforce development.**

In the context of increasing interest in regionalization of health care and local accountability, statewide recruitment programs such as the primary care loan repayment program can only be part of the solution. Some communities may need a professional who is not included in the program's scope; others may find that loan repayment is not the right incentive to attract health professionals to their area. At the same time, thousands of dollars are expended by individual employers in health professional recruitment efforts, particularly for rural and underserved areas. The OHA should help increase the efficiency of existing health care workforce development efforts by exploring structures in which health care employers, private industry, government representatives and community leaders can come together (similar to a community health collaborative model) to: identify local health care workforce needs; pool financial resources to recruit professionals; and devise appropriate community recruitment and retention incentives.

As a first step, in 2011 the OHA should convene stakeholders and conduct a feasibility study of mechanisms for and identify barriers (e.g. antitrust laws) to cooperative health care professional recruitment and retention across employers and communities. This work would support the Committee's priority of improving the capacity and distribution of the health care workforce.

**6. Enhance resources for health professions education programs.**

This proposal is the long-term version of short-term recommendation #4. Assuming a more robust state economy in future years, the Committee urges increased investment in health care professions education to help create the estimated 58,000 health care professionals that Oregon needs by 2018. This recommendation relates to the Committee's third priority of expanding the health care workforce through education and training.

**7. Maintain and enhance resources for K-12 math, science, and health career exposure.**

In order to build Oregon's health care workforce of the future, we must invest in the K-12 education pipeline to introduce students, particularly those from Oregon's rural and racial and ethnic minority populations, to and prepare them for health profession careers. Unfortunately, cumulative cuts over several years to Oregon's school districts and Area Health Education Centers budgets have reduced funding for math and science education and exposure to health careers, particularly in rural Oregon. The result has produced students who do not meet minimum qualification standards for admissions to post-secondary health profession education programs. Even though the state's budget challenges make it difficult, the Committee urges the Health Policy Board and the state to maintain now and enhance when possible funding for math, science and health career



experience in Oregon's primary and secondary schools to prepare Oregon's future health care workforce. As above, this recommendation relates to the Committee's third priority of expanding the health care workforce through education and training.

#### **IV. Vision, Context, and Constraints**

The short- and longer-term recommendations in this report are proposed as strategies to create an Oregon health care workforce that is:

- **Diverse and culturally competent.** Oregon's population is becoming increasingly diverse and health care providers in the state should reflect this diversity. Providers should be able to offer services in the patient's preferred language and to provide care in a manner that is appropriate and acceptable for the patient's culture. Improving the diversity and cultural competence of Oregon's health care workforce would produce a range of benefits including increased access to care for vulnerable populations<sup>12</sup>, improved patient-provider communication and quality of care, and expanded availability of living wage careers for racial and ethnic minorities.
- **Comfortable working in inter-professional teams.** Multidisciplinary teams (health care professionals from different fields working together to provide patient-centered care) are a key feature of many models of future primary care and have the potential to increase care coordination, improve quality and efficiency, and enhance job satisfaction and retention for care providers. To work effectively in such teams, health care providers will need a clear understanding of the breadth of knowledge and skills possessed by professionals outside their own disciplines. They will also need training in operational and managerial functions such as team oversight, negotiation, and performance improvement.
- **Practicing in the locations and specialties areas where it is most needed.** All Oregonians should have access to the care they need within a reasonable distance of their own communities. To make this possible, the current trend of decreasing enrollment in primary care disciplines must be reversed and disincentives for practicing in rural and underserved locations must be removed. Recruitment and admissions strategies for health education programs, reimbursement structures, support mechanisms for isolated practitioners, and community incentives should all be examined for their potential to improve the geographic and specialty distribution of the primary care workforce.

The recommendations in this report are strategies proposed by the Oregon Health Care Committee as the most feasible first steps toward creating a workforce that reflects the vision above. However, it is important to note that many of the policies and system changes that would make this workforce vision possible fall outside the traditional arena of workforce development. The Committee recognizes and supports the following elements of broad-based health care reform as necessary context for its more targeted recommendations:

- **Rapid migration away from fee-for-service payment systems.** Paying for units of service or procedures rewards volume and expensive treatments rather than improved health outcomes and superior quality and efficiency. For example, under fee-for-service systems, providers are often not compensated for valuable and time-consuming functions like care coordination, discharge planning, medication management, and other activities that are critical to keeping people healthy. Moreover, restrictions on who can be reimbursed under certain fee-for-service payment systems lead to under-utilization of existing workforce capacity by discouraging mid-level providers and paraprofessionals from providing care within their scopes of practice. Shifting to more integrated or comprehensive payment structures will enable the workforce reconfiguration that is necessary to help Oregon meet its triple aim objectives.
- **Greater emphasis on prevention and population health.** The increasing burden of chronic diseases and poor health at the population level contribute significantly to the demand for health care professionals. In the long-term, investing in public health strategies that prevent or reduce disease and implementing health care reforms that encourage prevention and patient self-management will alleviate some of need to produce additional health care professionals. In the short-term, however, a greater emphasis on prevention and population health would require expanding the capacity of the public health and primary care segments of the workforce.
- **Improved data collection.** Better data and more meaningful measurement of costs and outcomes will be critical to the success of health care reform as a whole. For workforce development, more detailed and accurate information about the characteristics of the current health care practitioners, the projected supply of new professionals, and the future demand for care are obviously key resources for strategic planning. However, reliable data on cost, accessibility, utilization, quality, equity, and efficiency will also be necessary to track and evaluate the impact of workforce development efforts and to adjust those and other reform strategies as needed. Better data on race, ethnicity, language, and other demographic characteristics are critical to assess whether reform efforts are benefitting everyone equally.

Finally, it is important to recognize the limits of state’s role and influence in developing, Oregon’s health care workforce. Education standards, policy decisions and regulatory structures at the national and federal levels affect Oregon’s health care workforce development efforts. These include:

- National health profession education accreditation standards that dictate curriculum and clinical training requirements and limit curricular innovation;
- Higher degree requirements for entry-level clinical occupations, also known as “degree creep,” which exacerbate shortages and impede career pathways;
- Reimbursement policies that incent students, particularly those with significant student loan debt, to enter specialty practices over primary care and health promotion practices; and

- Limitations on expansion of Graduate Medical Education (post-graduate residency programs).

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<sup>1</sup> Oregon Employment Department (2010). *Current Employment Statistics*. Available at: <http://qualityinfo.org/olmisj/CES>.

<sup>2</sup> Oregon Employment Department (2009). *Employment Projections by Industry and Occupation 2008-2018 Oregon Statewide*. Available at <http://qualityinfo.org/pubs/projections/projections.pdf>

<sup>3</sup> Ibid.

<sup>4</sup> Projection based on modeling by Jonathan Gruber, PhD, presented to Oregon Health Policy Board in August 2010.

<sup>5</sup> U.S. Department of Health and Human Services Health Resources and Services Administration (2010). *Health Professional Shortage Areas, 2009*. Available at <http://hpsafind.hrsa.gov>.

<sup>6</sup> Oregon Medical Board data, February 2010

<sup>7</sup> Beleiciks, N. (2009). *Job Vacancies in Oregon*. Oregon Employment Department. Available at: <http://qualityinfo.org>

<sup>8</sup> Pathman et al. (2004). Outcomes of States' scholarship, loan repayment, and related programs for physicians. *Medical Care* 42: 560-568.

<sup>9</sup> Barnighausen & Bloom. (2009). Financial incentives for return of service in underserved areas: a systematic review. *BMC Health Services Research* 9:86.

<sup>10</sup> Oregon Healthcare Workforce Institute (2010). The economic contribution of Oregon's physician practices. Available at: <http://www.oregonhwi.org/resources/reports.shtml>

<sup>11</sup> Institute of Medicine. Preparing the workforce. In: *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press, 2001; 207–223.

<sup>12</sup> Saha & Shipman. (2006). *Rationale for diversity in the health professions*. HRSA. Available at: <http://bhpr.hrsa.gov/healthworkforce/reports/diversity/>

Appendix A

Top Fifty Fastest Growing Health Care Occupations in Oregon 2008-2018

| Occupational Classification                        | Employment |        | Projected Openings Due to |             | Total Projected Openings | Minimum Education | Competitive Education                |
|--|------------|--------|---------------------------|-------------|--------------------------|-------------------|--------------------------------------|
|  | 2008       | 2018   | Job Growth                | Replacement |                          |                   |                                      |
| Registered Nurses                                  | 30,656     | 37,427 | 6,771                     | 5,947       | 12,718                   | Associate         | Bachelor's                           |
| Nursing Aides                                      | 12,842     | 15,950 | 3,108                     | 1,433       | 4,541                    | Short OJT         | Post-sec.                            |
| Physicians & Surgeons                              | 7,456      | 9,278  | 1,822                     | 1,472       | 3,294                    | 1st Prof.         | 1st Prof. + Work Exp.                |
| Home Health Aides                                  | 8,599      | 10,775 | 2,176                     | 965         | 3,141                    | Short OJT         | Post-sec.                            |
| Medical Assistants                                 | 7,113      | 8,948  | 1,835                     | 895         | 2,730                    | Moderate OJT      | Post-sec.                            |
| Dental Assistants                                  | 4,360      | 5,527  | 1,167                     | 928         | 2,095                    | Moderate OJT      | Post-sec.                            |
| Pharmacy Technicians                               | 3,910      | 4,465  | 555                       | 1,056       | 1,611                    | Post-sec.         | Associate                            |
| Dental Hygienists                                  | 3,142      | 4,003  | 861                       | 729         | 1,590                    | Associate         | Bachelor's                           |
| Licensed Practical Nurses                          | 2,582      | 3,172  | 590                       | 900         | 1,490                    | Post-sec.         | Post-sec. + Work Exp.                |
| Child, Family & School Social Workers              | 3,332      | 3,785  | 453                       | 894         | 1,347                    | Bachelor's        | Master's                             |
| Medical & Health Services Managers                 | 3,112      | 3,763  | 651                       | 655         | 1,306                    | Bachelor's        | Master's                             |
| Medical Records & Health Information Technicians   | 2,639      | 3,274  | 635                       | 603         | 1,238                    | Post-sec.         | Associate                            |
| Pharmacists  | 3,180      | 3,649  | 469                       | 757         | 1,226                    | 1st Prof.         | 1st Prof. + Work Exp.                |
| Healthcare Support Workers, All Other              | 3,137      | 3,804  | 667                       | 387         | 1,054                    | Short OJT         | Post-sec.                            |
| Substance Abuse & Behavioral Disorder Counselors   | 2,328      | 2,796  | 468                       | 518         | 986                      | Associate         | Bachelor's                           |
| Radiologic, CAT, & MRI Technologists & Technicians | 2,261      | 2,793  | 532                       | 365         | 897                      | Associate         | Bachelor's                           |
| Medical & Clinical Laboratory Technologists        | 1,947      | 2,392  | 445                       | 412         | 857                      | Post-sec.         | Bachelor's                           |
| Mental Health & Substance Abuse Social Workers     | 1,675      | 2,057  | 382                       | 469         | 851                      | Master's          | Master's and related work experience |
| Emergency Medical Technicians & Paramedics         | 1,768      | 2,155  | 387                       | 400         | 787                      | Post-sec.         | Post-sec. + Work Exp.                |
| Physical Therapists                                | 2,117      | 2,616  | 499                       | 286         | 785                      | Master's          | PhD                                  |
| Mental Health Counselors                           | 1,675      | 2,030  | 355                       | 375         | 730                      | Master's          | Master's and related work experience |
| Rehabilitation Counselors                          | 1,726      | 2,067  | 341                       | 384         | 725                      | Master's          | Master's and related work experience |
| Social Workers, All Other                          | 1,768      | 1,993  | 225                       | 472         | 697                      | Bachelor's        | Master's                             |
| Medical & Public Health Social Workers             | 1,261      | 1,521  | 260                       | 349         | 609                      | Bachelor's        | Master's                             |
| Psychiatric Technicians                            | 444        | 866    | 422                       | 165         | 587                      | Post-sec.         | Associate                            |
| Health Technologists & Technicians, All Other      | 1,303      | 1,592  | 289                       | 295         | 584                      | Post-sec.         | Post-sec. + Work Exp.                |
| Dentists, General                                  | 1,004      | 1,270  | 266                       | 316         | 582                      | 1st Prof.         | 1st Prof. + Work Exp.                |
| Medical Transcriptionists                          | 1,589      | 1,939  | 350                       | 197         | 547                      | Post-sec.         | Associate                            |
| Clinical, Counseling, & School Psychologists       | 1,108      | 1,302  | 194                       | 342         | 536                      | Master's          | Doctorate                            |
| Medical & Clinical Laboratory Technicians          | 1,064      | 1,328  | 264                       | 227         | 491                      | Associate         | Associate + Work Exp.                |
| Surgical Technologists                             | 922        | 1,144  | 222                       | 260         | 482                      | Post-sec.         | Associate                            |
| Respiratory Therapists                             | 1,077      | 1,301  | 224                       | 217         | 441                      | Associate         | Bachelor's                           |
| Psychiatric Aides                                  | 667        | 997    | 330                       | 83          | 413                      | Short OJT         | Work Exp.                            |
| Occupational Therapists                            | 937        | 1,137  | 200                       | 189         | 389                      | Master's          | Master's + Work Exp.                 |
| Opticians, Dispensing                              | 851        | 1,043  | 192                       | 193         | 385                      | Long OJT          | Post-sec.                            |

| Occupational Classification                            | Employment |       | Projected Openings Due to |             | Total Projected Openings | Minimum Education | Competitive Education  |
|--|------------|-------|---------------------------|-------------|--------------------------|-------------------|------------------------|
|  | 2008       | 2018  | Job Growth                | Replacement |                          |                   |                        |
| Healthcare Practitioner & Technical Workers, All Other | 635        | 761   | 126                       | 233         |                          |                   |                        |
| Health Educators                                       | 865        | 1,014 | 149                       | 199         | 348                      | Bachelor's        | Master's               |
| Medical Equipment Preparers                            | 985        | 1,206 | 221                       | 122         | 343                      | Post-sec.         | Post-sec. + Work Exp.  |
| Occupational Health & Safety Specialists               | 725        | 794   | 69                        | 254         | 323                      | Bachelor's        | Master's               |
| Dietitians & Nutritionists                             | 555        | 663   | 108                       | 204         | 312                      | Bachelor's        | Bachelor's + Work Exp. |
| Physician Assistants                                   | 644        | 813   | 169                       | 133         | 302                      | Bachelor's        | Master's               |
| Speech & Language Pathologists                         | 832        | 958   | 126                       | 163         | 289                      | Master's          | PhD                    |
| Massage Therapists                                     | 808        | 965   | 157                       | 118         | 275                      | Post-sec.         | Post-sec. + Work Exp.  |
| Physical Therapist Aides                               | 602        | 757   | 155                       | 98          | 253                      | Short OJT         | Associate              |
| Optometrists   | 354        | 450   | 96                        | 134         | 230                      | 1st Prof.         | 1st Prof. + Work Exp.  |
| Cardiovascular Technologists & Technicians             | 579        | 709   | 130                       | 93          | 223                      | Associate         | Associate + Work Exp.  |
| Physical Therapist Assistants                          | 529        | 661   | 132                       | 86          | 218                      | Associate         | Associate + Work Exp.  |
| Dentists, All Other                                    | 331        | 416   | 85                        | 104         | 189                      | 1st Prof.         | 1st Prof. + Work Exp.  |
| Health Diagnosing & Treating Practitioners, All Other  | 456        | 550   | 94                        | 92          | 186                      | 1st Prof.         | 1st Prof. + Work Exp.  |
| Chiropractors  | 383        | 489   | 106                       | 77          | 183                      | 1st Prof.         | 1st Prof. + Work Exp.  |

Source: Oregon Employment Department