June 2012

Case statement for changes to Office of Degree Authorization rules for healthcare programs

Introduction:

As part of healthcare reform efforts in the state the Oregon Health Policy Board convened a Oregon Healthcare Workforce Committee that is staffed by the Office of Health Policy and Research. This committee has membership from all healthcare workforce sectors: industry, community colleges, public and private universities, non-profit agencies, medical schools and organizations representing both urban and rural areas.[1] The mission of the committee is to develop recommendations that will ensure that Oregon has the healthcare workers it needs to meet the goals of healthcare reform and an increasingly diverse patient population.

Need for trained healthcare workers:

Current research indicates that we have shortages in many fields where education beyond a high school diploma is required. Registered nurses, pharmacists, dental hygienists, physical therapists, surgical technologists, and physicians are all in the top ten of 'high demand' identified by the Oregon Employment Department in 2010.[2] Based on current population trends and health care delivery models, the Employment Department forecasts a need for a total of nearly 58,000 additional health care workers in the state by 2018.[3]

Our committee has reviewed the problems and barriers to increasing the pool of health care workers. These include a lack of state funding, shortages of faculty, shortages of clinical training sites, pipeline issues to attract a diverse population to health professions and others. One problem we have identified is the difficulty with the adverse impact provisions of ORS 348.603 and .611, and OAR 583-040-0005(2).

Problem Identified:

The regulations require all publicly funded programs to be subject to review for detrimental duplication or adverse impact by any privately funded institution. Our concern with this provision is that it can have the effect of limiting new public programs in various areas of the state, increasing the cost of training, or overwhelming clinical training sites and has at times meant that no program became available in an area.

For purposes of discussion these are examples of what can happen related to healthcare workforce training:

- A community college has proposed a program in a rural area where there is a demonstrated need. They have done a significant business plan internally including a needs assessment. When the program is noticed through ODA, a proprietary program indicates a potential adverse impact because they are going into this area. The community college then drops the program planning and subsequently the proprietary institution decides that they will not do a program. The net result is that after a significant time, the area is still not served by any program.

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[1] A list of these members is attached

[2] Training Oregonians … for the Right Jobs (2010). Available at: www.qualityinfo.org

[3] Employment Projections by Industry and Occupation, 2008-2018. Available at: www.qualityinfo.org

- Two separate proprietary institutions decide to offer similar programs in the same area. Because the requirements for public notice and review for detrimental duplication or adverse impact do not apply, the two institutions could invest significant time and resources into program development before realizing the overlap.
- A private institution decides to start a new professional program. They have done significant needs assessment and are in the process of getting the program accredited. The public institution who currently offers this program is impacted due to a shortage of clinical training sites, but they do not have the ability to raise this as an issue. The quality of the programs suffers for both as the competition for these sites means less clinical training for all students.
- A proprietary institution begins a program in a technical field that is in high demand. The tuition for this program is considerably higher than the tuition of the public programs in this area. Due to limited positions at a public institution, students either do not go to the proprietary institution due to cost or incur debt beyond their ability to repay.

Proposed Solution:

We would like to propose a “leveling of the playing field” for public, private and proprietary institutions with respect to approval for healthcare workforce training programs only. At the regulatory level, this could be accomplished simply by removing the phase “publicly-funded” from the statute and administrative rules for review of proposed new post-secondary programs and locations (ORS 348.603 and OAR 583-040-0005(2)). As a result, all institutions—public, private and proprietary—would propose programs to be reviewed by others.

As part of this review, we would suggest that:

1. A common format for a business plan, a process for specialized accreditation (if necessary), a needs assessment, a plan for clinical training and a geographic area to be served would be required for all institutions.
2. For any program that is a duplicate, there must be evidence that both the existing institution and the institution proposing the new program have had discussion about clinical training sites, potential students and geographic area to be served. A letter regarding these discussions should be a part of the final application to ODA.