Oregon's Health Care Workforce Needs Assessment 2025

Third Draft

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Executive Summary

2025 Oregon Health Care Workforce Needs Assessment

This Biennial Health Care Workforce Needs Assessment Informs Oregon's Efforts to Achieve Equity and Access to Care for All.

OHA's goal of eliminating health inequities requires the preparation, recruitment, and retention of a workforce qualified to deliver culturally and linguistically responsive health care. House Bill 3261, passed in 2017, directs the Oregon Health Policy Board (OHPB) and Oregon Health Authority (OHA) to produce a biennial assessment of the health care workforce needed to meet the needs of patients and communities throughout Oregon. This is the fifth such report that provides insights into workforce needs in communities across Oregon and general guidance on how to expand and diversify the workforce. The report also informs the distribution of health care provider incentives.

This Assessment Compiles Information and Recommendations from Various Sources to Determine Progress on Expanding and Diversifying Oregon's Health Care Workforce.

The report is anchored in OHA's commitment to health equity and its strategic goal of eliminating health inequities by the year 2030. The report also builds on the Health Care Workforce Committee's Strategic Framework (see Appendix A), which was developed as a next step to the 2023 biennial assessment report and sets a vision of a robust, diverse, and resilient health care workforce. The committee created strategy papers released in January 2024 on workforce diversity, workforce wellness and resiliency, and workforce development and retention. The Social Determinants of Work initiative describes barriers which should be addressed that prevent diverse workers from entering, advancing, and remaining in the health care labor market.

The main data source for this report is the OHA Health Care Workforce Reporting Program's supply and diversity information. This report includes additional data and information on COVID-19 impacts and health care workforce shortages, education and career pathways, workforce wellness and resiliency, telehealth, and the Health Care Provider Incentive Program and other state-funded provider incentives. This report outlines data and recommendations for 10 provider workforces from existing reports, surveys, project advisory committees, and subject matter experts. Ensuring these provider workforces reflect their patient populations and are robustly represented across the state is critical to make progress towards Oregon's goal of achieving health equity. Lastly, the report includes continued or new recommendations since the previous assessment on increasing access to culturally and linguistically responsive care.

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Social Determinants of Work in Health Care Workforce

The Social Determinants of Work framework (Figure 2.1) describes an interconnected web of challenges workers must navigate to arrive and thrive at their workplaces and achieve economic mobility. These barriers faced by workers can be addressed through program and policy efforts to impact employer and system-level change. Reasons for health care workforce shortages can include the social determinants of work.

Figure 2.1: Social Determinants of Work and Examples

Image adapted from the United Way of Greater Cleveland

Health care occupations are highly female dominated and racially/ethnically diverse in low-paid, fast-growing health care support jobs in which occupational segregation occurs. For example, needs assessments affirm that lack of affordable housing impacts recruitment and retention, especially in rural areas. Lack of reliable and affordable childcare and transportation are also barriers to employment in the health care workforce. Addressing these social determinants for workers experiencing inequities is important to health care career entry, advancement, and retention.

Investments in Workforce Development

Oregon has made concerted efforts in the past two years to invest in the expansion, retention, and diversity of the health care workforce using multiple strategies:

- Federal support to address workforce shortages and increase access to care.
- State legislative actions in behavioral health workforce, nurse and hospital staffing, and long-term care.
- Coordinated Care Organization (CCO) grantmaking to address regional workforce shortages.
- Future Ready Oregon strategic initiatives administered by the Higher Education Coordinating Commission to increase opportunities for a diverse workforce.
- Oregon Health & Science University (OHSU) initiative to increase the number of clinicians graduated by 30% and increase student diversity to 30% by 2030.

OHA's Health Care Provider Incentive Program offers financial incentives to increase workforce diversity and capacity in rural and medically underserved regions of Oregon. With a $25.2 million budget for the 2023-2025 biennium, the program offers loan repayment, loan forgiveness, scholarships and career pathways, and rural medical practitioners insurance subsidy incentives. As of June 30, 2024, the program has a total of 7,735 recipients across all incentives since 2018 (Table 3.1). The number has doubled since the 2023 report.

Health Care Workforce Trends and Data

This section provides a snapshot into health care workforce trends by reviewing data and information from various sources. Data is presented on workforce supply, workforce diversity, and unmet needs and geographic distribution of the workforce. Health care labor market information outlines the impact of COVID-19 on workforce shortages. Additionally, information about education and career pathways, workforce wellness and resiliency, and telehealth is provided.

Health Care Workforce Reporting Program and Areas of Unmet Health Care Needs Data

- An estimated total of 209,188 licensed providers and 103,482 full-time equivalents (FTE) of direct patient care are currently in Oregon.
- There was a 5% increase in primary care provider direct patient care FTE from 2022 to 2024.
- More than 13% of licensed health care professionals planned to reduce the number of hours they work in the next two years, while over 10% planned to increase their work hours.

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- Female providers are overrepresented in most health care professions, though men tend to be overrepresented in fields requiring more years of formal training, such as physicians and dentists.
- Latino/a/x providers are underrepresented in most health care professions.
- Spanish is the most common language spoken, other than English, among licensed providers (about 9%). The next most common spoken languages are Chinese (including Mandarin and Cantonese), Vietnamese, Tagalog, French, and Russian.
- On average, rural and remote areas have greater unmet health care need than urban areas in Oregon.

Health Care Workforce Shortages and Impacts of COVID-19

- Oregon Employment Department (OED) data shows strong job growth in health care and social assistance in the past year, gaining over 15,000 jobs.
- Despite this growth, employers report experiencing vacancies and difficulties filling positions particularly in certain occupations and industries. Oregon health care and social assistance businesses had over 18,800 job vacancies or accounted for almost one-third of all job openings in the state.
- Personal care aides had the most vacancies (2,700 vacancies), followed by nursing assistants (1,731 vacancies) and registered nurses (1,643 vacancies). Dental hygienists (416 vacancies), physical therapists (292 vacancies), nurse practitioners (248 vacancies), and family medicine physicians (206 vacancies) had 100% "difficult to fill" vacancies, meaning a job that an employer has troubling staffing over a sustained period (Table 5.3).
- OED estimated the fastest growing health care practitioner and health care support occupations over the next 10 years, with nurse practitioners' employment projected to increase by more than half in 2032, followed by an over 35% increase for physical therapist assistants and physician associates (Table 5.6).
- Employment in social service and behavioral health occupations is expected to be more than 15% higher in 2032 than in 2022, while employment of substance abuse, behavioral disorder, and mental health counselors is expected to increase by over 27% (Table 5.7).
- It is also important to account for replacement openings (e.g., workers who leave the occupation due to burnout, retirement, career changes, or other reasons) when analyzing future workforce needs. Between 2022-2032, home health aides and personal care providers and registered nurses were projected to have a total of over 70,000 and 29,000 job openings, respectively (Figure 5.8).

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Education and career pathways

- The health care sector relies on a highly educated and skilled workforce. OED estimates that 56% of jobs in health care require some form of postsecondary education, compared to 40% for all industries in Oregon (Figure 6.1).
- In 2023, over 70% of “difficult-to-fill” health care job vacancies required education beyond high school (Figure 6.1).

Workforce wellness and resiliency

- Burnout has been a long-standing issue for health care workers. A national survey found a dramatic increase in physician burnout during the first two years of the COVID-19 pandemic. Over 60% of participants reported at least one manifestation of burnout in 2021 compared with 38% in 2020. Physicians’ satisfaction with work-life integration declined from 46% in 2020 to 30% in 2021.
- Health care workforce burnout was exacerbated during the COVID-19 pandemic, as workers experienced increased workload and shortages in resources, anxiety and fear related to working conditions, and extreme mental and physical fatigue.
- Data suggest strategies to improve health workers’ well-being helped reduce workforce burnout. A recent national survey showed that physician burnout rate had dropped below 50% for the first time since 2020, compared to about 63% in 2021. Job stress rate decreased from about 56% in 2022 to around 51% in 2023, while job satisfaction rate increased from 68% to 72%. More physicians reported feeling valued by their organization (50.4% in 2023 vs 46.3% in 2022).
- Despite the burnout rate dropping from its record-high during the pandemic, the extent of the problem remains a reality that demands attention.

Telehealth

- Telehealth can potentially increase access to care—thus addressing Oregon’s health care workforce shortages—by allowing patients to connect with providers outside their home city or region.
- While telehealth use by Oregon Health Plan (OHP) members rose very sharply at the start of the COVID-19 pandemic and peaked as a percentage of claims in September 2020, the telehealth proportion subsequently fell.
- Oregon has taken action to continue post-pandemic access to telehealth, but future policy could focus on measuring and addressing potential equity concerns. While the similarity of OHP telehealth utilization rates across racial/ethnic groups

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is favorable, lower utilization by rural and frontier OHP members suggests that the full potential of telehealth to mitigate geographic workforce shortages is not being realized.

Health Care Workforce in Oregon

Oregon has been a leader in health care transformation for decades. An equitable health care system requires a robust workforce for the 10 specific provider types in this report to make progress towards Oregon's goals of achieving health equity; integrating physical, behavioral and oral health; and ensuring access to care. Updates since the last report are provided for eight provider types (Traditional Health Workers, Health Care Interpreters, primary care, nursing, long-term care, behavioral health, oral health, and public health). Two provider types (school health and gender affirming care providers) are new to this report. Each provider type is examined below.

Traditional Health Workers

- Traditional Health Workers (THWs) are trusted individuals from their local communities who provide person-and community-centered care by bridging communities and the health systems they serve.
- As of October 2024, there were more than 6,500 THWs (which include Community Health Workers, Peer Wellness Specialists, Peer Support Specialists, Personal Health Navigators, and Birth Doulas) registered and certified with the OHA THW program, which has doubled since the 2023 assessment.

Health Care Interpreters

- Health Care Interpreters (HCIs) provide high-quality health care interpretation at in-person medical appointments or over the phone or video, as crucial partners to reduce communication barriers and health care disparities. The HCI program at OHA was established in 2010 to help develop a well-trained workforce of HCIs to address language and communication barriers to access health care services.
- To increase the supply of certified spoken and Sign Language HCIs in Oregon, in 2021, the Oregon legislature passed HB 2359 which mandated that health care providers who are reimbursed with public funds work with a qualified or certified HCI who is listed on the central registry.

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- Since the passage of HB 2359, the numbers of credentialed HCIs on the central Registry has more than tripled. There are now over [2,200 Qualified and Certified Interpreters in the Oregon central Registry]
- Although the number of certified and qualified HCIs has increased statewide, there is still a gap in meaningful language access for culturally responsive health care services. Many CCOs and providers are still not working with certified or qualified HCI on Oregon's central registry.

Primary Care Providers

- Primary care is foundational to improve health and advance health equity for Oregonians.
- National data shows the number of primary care physicians per capita has declined over time from a high of 68.4 per 100,000 people in 2012 to 67.2 PCPs per 100,000 people in 2021.
- While the rate of total clinicians in primary care, inclusive of nurse practitioners and physician associates, has grown over the past several years, it is still insufficient to meet the demands of overall population growth, a rapidly aging population with higher levels of chronic disease, and workforce losses during the pandemic. In Oregon—with a primary care capacity ratio of 1.0 being the average—the primary care capacity ratio in urban areas increased from 1.13 in 2023 to 1.16 in 2024. However, rural and remote areas had a primary care capacity ratio of 0.69, indicating that the number of health care providers was insufficient to meet the demand for primary care health delivery as calculated.
- Oregon's primary care workforce is less racially and ethnically diverse than the general population with Latino/a/x, African American/Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander providers being underrepresented.
- There are shortages of primary care workforce across the U.S and in Oregon's graduate medical education pathway to prepare physicians to enter the field.

School Health Providers

- School-based health practitioners are critical to ensure the overall well-being and academic success of students.
- Despite school nurse FTE increasing from 279 in the 2017-18 school year to about 408 in 2023-24 school year, student health needs still exceed the capacity of available school nurses and Licensed Practical Nurses in most school districts.
- Oregon has an average of one school psychologist for every 3,393 students, one school social worker for every 8,831 students, and one school counselor for every 461 students. This is well below the recommended ratio for each provider type.

Nursing Workforce

- Nurses practice in almost all Oregon health care settings, including primary and specialty outpatient care, inpatient and post-acute care, home health, schools, public health, and behavioral health.
- The proportion of Licensed Practical Nurses (LPNs), Registered Nurses (RNs), and Advanced Practice Registered Nurses (APRNs) who are Hispanic or Latino/a/x is lower than among the overall Oregon population.
- Oregon nursing students are more diverse than practicing RNs, with 40% of bachelor of science in nursing (BSN) students being White, 18% Asian, and 18% Hispanic or Latino/a/x.
- Geographically, nurses are not evenly distributed across Oregon's 36 counties, with many rural counties having fewer nurses than would be expected based on their population.
- Nurse compensation in Oregon is higher than in most other states. Wages also vary geographically, being highest in the Portland metro area and lowest in eastern Oregon.
- Although Oregon's nursing workforce is currently growing, a vacancy crisis in clinical settings and high workplace stress persist.
- Oregon's nursing education programs graduate the 3rd lowest number of nurses per capita of any state.
- Oregon's inadequate nursing education capacity has two main causes: difficulty in recruiting nursing faculty members, and there are too few opportunities for the clinical placements that nurses in training must complete.

Long-Term Care Workforce

- The population needing long-term services and supports is growing rapidly.
- Employee turnover among the direct care workforce is extraordinarily high.
- Relative to the population of older adults, the number of direct care workers is much lower in rural areas than in urban areas.
- The number of staff in Oregon long-term care facilities dropped dramatically in 2020 and 2021. By June 2024, it was still below the pre-pandemic trend.

Gender Affirming Care Providers

- It is estimated in Oregon that 0.70% youth ages 13 to 17 (5,250 youth) and 0.65% (or 19,750) adults ages 18 and older identify as transgender.
- Essential gender affirming care (GAC) from providers should be welcome and inclusive to transgender and gender-diverse (TGD) patients and create a gender-affirming clinical environment.

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- Despite the clear needs of TGD patients, relatively few clinicians have received formal training in GAC.
- Systematic provider-level data about GAC capacity and quality are not available nationally or in Oregon.
- Growing demand will require Oregon to expand its GAC workforce.

Behavioral Health Providers

- Oregon ranked 47 out of 51 on a national ranking that reflects overall mental health prevalence and access to care, indicating higher prevalence of mental illness and lower rates of access to care.
- The statewide behavioral health provider FTE per 1,000 people increased from 1.15 in 2023 to 1.25 in 2024.
- Behavioral health providers are unevenly distributed across the state. Multnomah County has the highest density of behavioral health providers at 38.4 providers per 10,000, while one county had no licensed behavioral health providers. Rural and remote areas had 0.56 FTE per 1,000 population, slightly higher than last year's rate of 0.52 but lower than 1.60 FTE per 1,000 population in urban areas.
- People of color are underrepresented in Oregon's licensed behavioral health workforce.
- Mental Health and Addiction Counseling Board of Oregon data (Figure 15.6) shows that about 31% of unlicensed behavioral health providers and 67% of substance use disorder providers were people of color.

Oral Health Providers

- Approximately one million Oregonians in 33 of the 36 state's counties live in a Dental Health Professional Shortage Area.
- In 2024, there were 3,735 licensed dentists, 4,209 licensed hygienists, and 874 actively practicing expanded practice dental hygienists.
- The active practice rate for dentists, which includes the number of hours worked per week and the amount of time spent on direct patient care, has remained relatively steady between 2016-2024.
- Oregon had a rate of 0.47 dentist patient care FTE per 1,000 people in 2024, which was the same as last year. Rural and remote areas had a lower rate of 0.31 FTE per 1,000 population, compared to 0.55 FTE per 1,000 population in urban areas.
- Oregon's oral health providers are less racially and ethnically diverse than the general population with Latino/a/x, African American/Black, American

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Indian/Alaska Native, and Native Hawaiian/Pacific Islander providers being underrepresented.

Public Health Workforce

- The public health workforce in the United States performs foundational services such a chronic disease prevention, community disease prevention and control, environmental public health, and maternal, child, and family health to improve the health of the community.
- Before the COVID-19 pandemic, the public health workforce was significantly understaffed and in decline.
- Many public health agencies increased hiring in the early years of the pandemic, but, by 2023, the number of positions had returned to pre-pandemic levels.

Conclusions/Recommendations

The report synthesizes information from previous sections into priority policy recommendations across Oregon's health care workforce by considering workforce investments, wellness and resiliency, diversity, and specific workforces critical to achieving health equity. **Since the previous report, there has been progress towards expanding and diversifying the workforce. However, continued work is still needed.** Priority recommendations to create a culturally and linguistically responsive workforce are summarized around four broad themes – funding; diversity of the workforce; shortages, especially in rural areas; and evaluation of these initiatives – and organized by continued or new recommendations since the previous report.

Sustain Funding Levels to Sustain Momentum in Workforce Development and Retention

Oregon has provided funding for initiatives and programs to recruit, train, diversify, and maintain the workforce who can provide culturally and linguistically responsive care and who reach rural communities. This level of funding should be continued to maintain the progress achieved and to continue to diversify and expand the workforce.

Continued recommendations include:

- Continue investment in early career development and continuing-education opportunities for people from underrepresented communities to promote their entry and advancement in health care careers.

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- Increase funding to increase wage floors, recruiting and relocation bonuses, and assistance with social determinants of work such as housing and childcare.
- Continue to reduce barriers to certification and registration processes.
- Continue to fund financial incentives to increase opportunities for training and education, such as those in the OHA Health Care Provider Incentive Program and Behavioral Health Workforce Incentives.

New recommendations include:

- Explore Medicaid strategies to invest in the health care workforce, such as New York's Section 1115 Waiver's career pathways and loan repayment programs.
- Support reimbursement models based on the true cost of providing services.
- Increase training slots, internship opportunities, and funding to support preceptor and teaching faculty.
- Provide retention and recruitment bonuses as direct salary and/or housing allowances or stipends or childcare subsidies to recruit and retain the workforce.

Maintain Progress in Improving the Diversity of Health Care Providers to Provide Culturally Responsive Care to All

Oregon must have a more diverse workforce to achieve the strategic goal of eliminating health inequities. Community-based health care providers such as THWs, HCIs, and school-based providers are types of providers that may better reflect the communities' lived experiences and serve as trusted sources to provide culturally responsive care.

Continued recommendations include:

- Improve outreach to all counties across the state, and deploy strategies to recruit, train and employ providers of color and from other underrepresented communities in these fields,
- Continue using the Health Care Workforce Committee's Health Equity Framework and strategies to support a diverse health care workforce.
- Support training to providers to offer culturally and linguistically responsive care.
- Promote entry into the workforce and advancement for people from underrepresented communities through early career development and continuing-education opportunities.

New recommendations include:

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- Reduce barriers for internationally educated health care professionals to practice in Oregon. Senate Bill 849 (2023) would have provided career guidance and support services to internationally educated state residents if it had passed. The University of California, Los Angeles's International Medical Graduate Program is another example that helps physician-trained legal immigrants pass their licensing exams and obtain residency training in family medicine.
- Investigate licensure reciprocity agreements. In addition, licensing examinations and continuing education requirements could incorporate knowledge about social determinants of health and the importance of addressing social needs in the health care setting.
- Use an equity approach to develop wellness programs and provide culturally responsive support to workforce seeking care.
- Expand use of community partners in mental health service including faith-based partners.
- Initiate and promote visible role models and affinity groups for providers of color.
- Increase compensation and promote healthy work environments for home care workers and community-based facility staff.

Seek Multipronged Solutions to Address the Shortage and Improve the Distribution of the Health Care Workforce

Current data shows rural and remote areas have greater unmet health care need than urban areas in Oregon. Improving the distribution of the health care workforce requires multipronged solutions, such as enhancing education pipelines for recruitment and career advancement; increasing compensation, incentives, and bonuses for working in rural areas; offering transportation, childcare, and housing stipends to offset the social determinants of work; reducing administrative and documentation burdens; and continuing to support workforce wellness and resiliency to promote retention.

Continued recommendations include:

- Increase training opportunities in underserved areas to improve recruitment and retention of health care workers from rural and underrepresented populations.
- Continue expanding opportunities and funds to support pipeline programs in middle and high schools to attract more students into health care professions.

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- Continue to expand the Oregon Wellness Program to provide prevention, acute intervention, and chronic management support for all health care workforce members, especially in rural areas.
- Make workplaces more welcoming for diverse health care professionals, such as providing frequent implicit bias and cultural responsiveness training for all staff and conducting climate surveys on a regular basis for employees to provide feedback on their working experience.
- Increase training slots and internship opportunities for more oral and behavioral health providers and to support more preceptors.
- Test new training pathways to increase dental therapists, assistants, and hygienists.
- Create and sustain positive work environments and culture to improve work-life balance, such as implementing flexible work schedules.

New recommendations include:

- Increase compensation and benefits and offer housing, childcare, and/or transportation stipends or assistance.
- Support training of rural health care and behavioral health providers to provide gender-affirming care.
- Use the Health Care Workforce Committee's strategy paper to guide collective actions to improve the wellness and resiliency of the health care workforce.
- Intentionally partner with K-12 education to support health care education and career pathways programs.
- Increase remote work and telehealth opportunities.

Enhance Data Collection to Identify Successes, Challenges, and Priorities of the Workforce and Promote Evidence-Informed Strategies

To achieve the goals of improving development, diversity and wellness of the health care workforce requires strategies informed by evidence. Enhancing data collection is imperative to help evaluate and understand challenges and priorities of the workforce, and ensure strategies are relevant and specific. Since the previous report, several evaluations and needs assessments have been completed on progress made, as well next steps to address workforce issues and achieve health equity.

Continued recommendations include:

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- Survey health care workers to evaluate burnout and identify their challenges and priorities for wellness and resiliency improvement.
- Use REALD (race, ethnicity, language, and disability) and SOGI (sexual orientation and gender identity) data to help develop workforce wellness programs that provide culturally responsive support to workforce members.
- Improve data collection and accessibility to support health care employers for demand planning.

New recommendations include:

- Investigate the benefits of licensure reciprocity to accept credentials from other states.
- Invest in data collection and research to improve the understanding of whether benefits to support housing, childcare, or transportation influence workforce diversity, recruitment and retention, and wellness and resiliency.
- Evaluate the benefits and unintended consequences of workforce initiatives, funding, and incentive programs, which requires funding for external evaluators.

Conclusion

Since the release of the 2023 Health Care Workforce Needs Assessment, Oregon has made progress in expanding, retaining, and diversifying the health care workforce, but problems like workforce shortages, lack of diversity, and provider burnout still exist. OHPB's Health Care Workforce Committee adopted the Strategic Framework and prioritized three goals of **workforce diversity**, **wellness and resiliency**, **and development and retention**. This current assessment report provides recommendations on achieving the vision of "*a robust, diverse, and resilient health care workforce that provides culturally and linguistically responsive care, eliminates health inequities, and meets the local health care needs of everyone in Oregon.*" The report's recommendations are interrelated and warrant collaborative and coordinated actions among government, legislature, education institutions, health care organizations, local communities, and even interested groups out of the health care sector to ensure Oregon has the workforce it needs.

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Background

Why a Health Care Workforce Needs Assessment?

Oregon has long been working to transform its health care system to achieve health equity, expand access to care, improve population health outcomes, and ensure a financially sustainable and high-quality health care system. The foundation of health care delivery is a provider interacting with a patient. Thus, Oregon must have the workforce needed to effectively deliver high-value care to patients across the state.

House Bill 3261, passed in 2017, provides guidance and requirements associated with Oregon's incentive programs aimed at attracting and retaining health care providers to work in underserved areas of the state. It also directs the Oregon Health Policy Board (OHPB), its Health Care Workforce Committee, and Oregon Health Authority (OHA) to produce an assessment of the health care workforce needed to meet the needs of patients and communities throughout Oregon. The assessment must consider:

1. The workforce needed to address health disparities among medically underserved populations in Oregon.
2. The workforce needs that result from continued expansion of health insurance coverage in Oregon.
3. The need for health care providers in rural communities.

The needs assessment informs proposals for using the Health Care Provider Incentive Fund to improve the diversity and capacity of Oregon's health care workforce.

This is the fifth report OHA has published in accordance with House Bill 3261. As stated in previous reports, it is not feasible to develop recommendations on care providers required in each Oregon community to serve its health care needs (see Figure 1.1).

Figure 1.1. Barriers to Determining Specific Numbers of Providers Needed to Serve a Community

- There are no consensus recommendations for how many health care providers of different types a community needs based on its population size, demographics, and health status.
- Development of such recommendations is complicated by the evolution of team-based health care delivery, the increasing use of telehealth services, and the ability of different types of practitioners to serve a patient's needs.
- Population health care needs can vary considerably, even within a county or within a community. This makes it challenging to create quantifiable target provider-to-population ratios that account for unique community characteristics and ensure equitable access to health care.

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However, these reports can provide insights into the workforce needs in communities across Oregon, identify needed provider types, and provide general guidance for distributing health care provider incentives.

Current Context: Health Equity

OHA has adopted health equity as one of its core values and committed to its strategic goal of eliminating health inequities by the year 2030 (Figure 1.2).

Figure 1.2. OHA/OHPB Health Equity definition, Updated October 2020

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

This focus on equity includes the training, recruitment, and retention of a diverse workforce that can deliver culturally and linguistically appropriate care, supported by:

- 2020-2024 Healthier Together Oregon State Health Improvement Plan goals.
- Health Care Workforce Committee's Equity Framework , which guides the committee's efforts to center equity in discussions and decision-making through a set of questions to ensure that Oregon's health care workforce development efforts advance opportunities for communities experiencing inequities.

Current Context: Health Care Workforce Committee Strategic Framework

The Health Care Workforce Committee adopted a Strategic Framework (see Appendix A) as a next step to the 2023 Health Care Workforce Needs Assessment report. The committee developed the framework by prioritizing and grouping the report's recommendations into three broad areas requiring attention to make progress toward creating a culturally and linguistically responsive health care workforce in Oregon. For each broad area identified in the framework, the committee created strategy papers released January 2024. The papers may be accessed by clicking on the links below:

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- Workforce diversity
- Workforce wellness and resiliency
- Workforce development and retention

The framework sets a vision of a robust, diverse, and resilient health care workforce that provides culturally and linguistically responsive care, eliminates health inequities, and meets the local health care needs of everyone in Oregon.

Methods

This report complies data, information, and recommendations from various sources to determine progress on expanding and diversifying Oregon's health care workforce to reflect the patients they serve. It is anchored in OHA's commitment to health equity and its strategic goal of eliminating health inequities by the year 2030. The report also builds on the Health Care Workforce Committee's Strategic Framework (Appendix A). The Health Care Workforce Committee provided input on the report over several months. Following the committee's approval, OHPB also reviewed and accepted the report.

The main data source is the Health Care Workforce Reporting Program's supply and diversity information. This report includes additional data and information on the impacts of COVID-19 and health care workforce shortages, education and career pathways, workforce wellness and resiliency, telehealth, and the Health Care Provider Incentive Program and other state-funded provider incentives. This report also outlines data and recommendations for 10 provider workforces from existing reports, surveys, project advisory committees, and subject matter experts. These provider workforces are critical to make progress towards Oregon's goals of achieving health equity; integrating physical, behavioral and oral health; and ensuring access to care. Lastly, the report synthesizes the data and information presented in earlier sections to offer four main themes with recommendations on increasing access to culturally and linguistically responsive care.

Social Determinants of Work in Health Care Workforce

The Social Determinants of Work framework (Figure 2.1) describes an interconnected web of challenges that workers must navigate daily to arrive and thrive at their workplaces. These factors can be reduced through programmatic and policy efforts through employer-level change and system-level change.

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Figure 2.1: Social Determinants of Work and Examples

Image adapted from the United Way of Greater Cleveland

The social determinants also include occupational segregation which occurs when one demographic group is overrepresented or underrepresented in a certain job category and often impacts people of color and female workers. People of different races and genders are unevenly represented in different kinds of jobs, which have very different wages, benefits and working conditions. For instance, Black workers are concentrated in low-wage jobs and underrepresented in higher-paying occupations relative to their share of the labor force. They are also paid less than white workers on average within the same occupational categories, especially in managerial and leadership roles.

According to national data, health care occupations are highly female dominated and racially/ethnically diverse in low paid, fast growing health care support jobs in which occupational segregation occurs. These jobs include nursing assistants, home health aides, home and personal care aides, medical assistants, pharmacy aides, dental assistants, and physician assistants. Women, people of color, immigrants and other workers experiencing inequities are overrepresented in these jobs that require little education, are lower skill level, have low pay, and tend to have high turnover rates.

In Oregon, female providers are overrepresented in most professions, though men tend to be overrepresented in fields requiring more years of formal training, such as physicians and dentists. Latino/a/x providers are underrepresented in most health care professions. Personal care and home health aides and medical assistants are among the fastest growing health care occupations in percentages and numbers over the next 10 years according to labor market data. In addition, the most difficult to fill positions include personal care aides, registered nurses, nursing assistants medical assistants,

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and dental assistants. For more information, refer to the Health Care Workforce Reporting Program Data and Health Care Workforce Shortages and Impact of COVID-19 sections.

Reasons for shortages in the health care workforce can include the social determinants of work. Needs assessments from behavioral health, oral health, and public health providers all affirm that lack of affordable housing impacts recruitment and retention especially in rural areas. Lack of reliable and affordable childcare and transportation are also barriers to employment in the health care workforce.

Subsidies or on-site childcare have been implemented or suggested to improve retention and reduce burnout among the health care workforce. A study by Braddock et. al surveyed health care workers during the COVID-19 pandemic about the importance of childcare. Health care workers described how childcare influenced their ability to stay in the workforce, including hours or times they could work. Lack of childcare prevented job growth and influenced many to leave the health care industry. Availability of childcare related to health care workers staying longer at their job. In Oregon, nurses have access to referrals for emergency childcare. Some nurses may be eligible for a subsidy depending on their income.

Employer assistance housing programs have emerged to support frontline workers which include the health care workforce. Some health care systems have started purchasing housing complexes for their staff. Examples include workforce housing established in Seattle and Rose Haven who offer occupation-specific housing for those who work with homeless Portlanders. In April 2024, Oregon Congresswoman Val Hoyle secured $4 million in funding for the project from the House Committee on Appropriations. This funding would support a workforce housing project in North Bend for 72 affordable workforce housing units aimed at critical workers such as those in health care.

OHA has initiated a housing incentive program intended to support the behavioral health care workforce. As part of its Behavioral Health Workforce Initiative, OHA established the Oregon Behavioral Health Workforce Bonus and Housing Stipend Program that offers funding for behavioral health organizations to provide incentives to recruit and retain a diverse behavioral health workforce including housing stipends. In 2023, the Oregon Behavioral Health Workforce Bonus and Housing Stipend Program received 88 applications and funded 20 organizations to provide bonus and housing stipends to their workforce. OHA is currently advocating for more funding to be made available for this program.

Investments in Workforce Development

State and National Workforce Investments

Oregon has invested in the expansion, retention, and diversity of the health care workforce using multiple strategies. Several programs have been expanded or introduced since the last report to achieve these goals across a variety of health care professions. In addition, there are ongoing national investments supporting health care professionals to practice in Oregon. These investments are summarized in Appendix B and throughout the report.

Health Care Provider Incentive Program

Oregon has invested in state-funded financial incentives to address workforce shortages and expand diversity for the health care workforce serving Oregon Health Plan and Medicare patients. In 2017, the passage of House Bill 3261 established the Health Care Provider Incentive Program and the Health Care Provider Incentive Fund with the intent of building health care workforce capacity in rural and medically underserved parts of Oregon and pooling existing incentive programs into one flexible program. As of June 30, 2024, the program has a total of 7,735 recipients since 2018 (Table 3.1). Table 3.2 details the allocation for each incentive for the 2023-2025 biennium.

Table 3.1. Oregon's Health Care Program Financial Incentive Recipients 2018-2024 (as of June 30, 2024)

Incentive	Number of Recipients
Primary care loan forgiveness for students in training	72
Loan repayment for practicing professionals in primary care, behavioral health, and oral health	335
Rural medical practitioner insurance subsidies for practicing primary care professionals in rural areas	920
Scholars for a Healthy Oregon Initiative (SHOI) scholarships for OHSU students	89
Scholarships for non-OHSU students	82
HOWTO Grant Program for community-based training initiatives	1,135
Behavioral Health Workforce incentives for practicing licensed and certified professionals	1,425
Rural Medical Practitioner Tax Credit for practicing primary care professionals in rural areas	3,677

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Total	7,735

Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Table 3.2. Incentive Allocation for the 2023-2025 Biennium

Incentives	2023-2025 allocation
Loan Repayment for practicing professionals in primary care, behavioral health and oral health	**$8.1M**
Primary Care Loan Forgiveness for students in training	**$1.0M**
SHOI for student scholarships	**$5.0M**
Scholarships, Health Care Workforce Pathways, and Retention Incentives	**$5.35M**
Rural Medical Malpractice Insurance Subsidy for practicing primary care professionals in rural areas	**$2.8M**
Administrative Costs	**$2.95M**
Total	**$25.2M**

Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Primary Care Loan Forgiveness

Loan Forgiveness is an incentive for students to receive funding during their education in exchange for a future service obligation in an underserved rural community that qualifies as a Health Professional Shortage Area and serves the same percentage of Medicaid and Medicare patients that exist in the county in which the clinic is located. Students may receive a loan equal to the cost of their post-graduate training for each year they choose to practice in a qualified Health Professional Shortage Area for up to three years. Eligible providers include certain specialties of physicians, physician associates, dentists, pharmacists, and nurse practitioners. Table 3.3 shows award distribution by school and discipline from 2018 to 2024. Applicants received an average award of $54,235 through the Primary Care Loan Forgiveness incentive.

Table 3.3. Primary Care Loan Forgiveness Award Distribution by School and Discipline, 2018-2024

School and Discipline	Average Award Amount
Oregon Health & Science University (OHSU)	**$ 52,832**
School of Medicine (MD)	$82,537
Physician Associate (PA)	$47,833
School of Nursing (DNP/NP)	$65,200
School of Dentistry (DMD)	$52,200
OSU/OHSU School of Pharmacy	$35,200

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Pacific University	$48,031
Physician Associate (PA)	$50,992
School of Pharmacy (PharmD)	$35,200
Western University of Health Sciences College of Osteopathic Medicine of the Northwest (COMP-NW)	**$84,488**
Total	**$54,235**

Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Loan Repayment Program

The Loan Repayment Program was designed to help support underserved communities in the recruitment and retention of health care providers. Providers receive funds to repay student loan debt based on the balance owed upon joining the Loan Repayment Program and must be practicing at a qualifying site. Qualifying sites must be in a Health Professional Shortage Area, serve at a minimum the same percentage of Medicaid and Medicare patients that exist in the county in which the clinic is located, and be approved by the Oregon Office of Rural Health. Eligible providers include a range of health care professionals across primary care, dental, and behavioral health. Table 3.4 shows the Loan Repayment Program has allocated since 2018 more than $21.4 million in loan repayment to 335 participants. Between July 1,2023 to July 1, 2024, 22% of loan repayment applicants were awarded.

Table 3.4. Loan Repayment Award Distribution by Discipline (2018-2024)

Provider Type	Number of Awards	Total Awarded	Average Awarded
Primary Care			
Doctor of Nursing Practice (DNP)	33	$ 1,726,182	$ 52,309
Pharmacist (PharmD)	23	$ 1,701,537	$ 73,980
Physician Associate (PA)	30	$ 2,006,261	$ 66,875
Doctor of Osteopathic Medicine (DO)	14	$ 1,439,586	$ 102,828
Medical Doctor (MD)	38	$ 3,262,209	$ 85,848
Naturopathic Doctor (ND)	12	$ 892,749	$ 74,396
Subtotal	**150**	**$ 11,028,524**	**$ 73,523**
Behavioral Health			
Certified Alcohol and Drug Counselor (CADC) II	1-5*	†	†
Case Manager	1-5*	†	†
Clinical Psychologist	1-5*	†	†
Licensed Clinical Social Worker (LCSW)	21	$ 657,311	$ 31,301

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Licensed Marriage and Family Therapist (LMFT)	1-5*	†	†
Licensed Professional Counselor (LPC)	7	$ 301,947	$ 43,135
Professional Counselor	1-5*	†	†
Psychiatric Nurse Practitioner (NP)	7	$ 280,737	$ 40,105
Doctor of Psychology (PsyD)	1-5*	$ 71,088	$ 71,088
Qualified Mental Health Associate (QMHA)	6	$ 108,323	$ 18,054
Qualified Mental Health Professional (QMHP)	9	$ 284,431	$ 31,603
Registered Nurse (RN)	1-5*	†	†
Unlicensed Clinical Social Worker	21	$ 603,209	$ 28,724
Unlicensed Counseling or Clinical Psychologist	1-5*	$ 127,062	$ 42,354
Unlicensed Marriage and Family Counselor	1-5*	$ 132,426	$ 66,213
Unlicensed Professional Counseling	14	$ 586,905	$ 40,494
Subtotal	**104**	**$ 3,694,383**	**$ 35,523**
Oral Health			
Doctor of Dental Surgery (DDS)/Doctor of Dental Medicine (DMD)	62	$ 6,158,580	$ 99,332
Expanded Practice Dental Hygienist	19	$ 520,854	$ 27,413
Subtotal	**81**	**$ 6,679,434**	**$ 82,462**
Total	**335**	**$21,402,341**	**$ 63,888**

*Exact value was suppressed for confidentiality.
†Numbers were suppressed to prevent backward calculation.

Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Rural Medical Insurance Subsidy

OHA provides subsidies for provider malpractice insurance premiums for physicians and nurse practitioners serving in rural areas of Oregon that they would otherwise pay in full. Reimbursement varies by specialty with providers in obstetric care receiving the highest reimbursement at 80% of the cost. Family or general practice providers that offer obstetrical services can receive 60% reimbursement. Providers in anesthesiology, family practice, general practice, general surgery, geriatrics, internal medicine, pediatrics, and pulmonary medicine can receive 40% reimbursement. Providers of other practices not previously listed can receive up to 15% reimbursement. Table 3.5 shows

452 and 407 providers were eligible for Rural Medical Insurance Subsidy Program in 2023 and 2024, respectively.

Table 3.5. Number of Eligible Providers for Rural Medical Insurance Subsidy Program per Year by Practice Type, 2018-2024

Year	80%	60%	40%	15%	Total
2018	44	19	353	203	619
2019	36	18	325	167	546
2020	52	21	355	178	606
2021	47	19	335	163	564
2022	30	16	282	143	471
2023	35	12	279	126	452
2024	31	12	254	110	407
Total	275	117	2,183	1,090	3,665

Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Scholarships and Scholars for a Healthy Oregon Initiative (SHOI)

SHOI provides full tuition for Oregon Health & Science University (OSHU) students that agree to practice as a health care provider in a rural or underserved community in Oregon upon graduation using the Health Care Provider Incentive Fund. SHOI awardees must agree to practice in an underserved Oregon community for a minimum of one year longer than the total years SHOI funding was received. As of March 1, 2024, over $13 million has been distributed to 89 providers (Table 3.6).

Table 3.6. SHOI Recipients by Discipline, March 1, 2019-March 1, 2024

Discipline	Recipients	Award Amount
Medical Doctor (MD)	13	$2,524,751
Dentist (DMD/DDS)	22	$6,565,470
Physician Associate (PA)	18	$1,963,826
Nurse Practitioner (DNP)	36	$1,957,480
Total	**89**	**$13,011,527**

Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Other Oregon universities also established scholarships programs funded by the Health Care Provider Incentive Program. Table 3.7 shows that 68 awardees received a total of $782,202 scholarships for the 2021-2023 Biennium.

Table 3.7. HCWF Scholarship Recipients by School and Discipline, 2019-2023

Educational Institution	2019-2021 Biennium	2021-2023 Biennium

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	Awardees	Scholarship Awarded	Awardees	Scholarship Awarded
Capitol Dental Dental Assistant Certificate			16	$133,600
Chemeketa Community College Dental Assistant Certificate Registered Nurse (RN) Program Emergency Medical Technician (EMT) Certificate Speech Language Pathology			25	$48,684
Western University of Health Sciences College of Osteopathic Medicine of the Northwest (COMP-NW) Doctor of Osteopathic Medicine	5	$588,000		
George Fox University Physician Associate			>5	$200,000
National University of Natural Medicine (NUNM) Naturopathic Doctor	>5[x]	$382,711	5	$80,000
Pacific University Physician Associate	>5[x]	$375,000	>5	$300,000
Umpqua Community College Dental Assistant Certificate Phlebotomy Certificate Pharmacy Technician			21	$99,918
Total	**14**	**$1,345,711**	**68**	**$782,202**

[x] One withdrawal from each institution since the last evaluation report.
Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Healthy Oregon Workforce Training Opportunity (HOWTO) Grant Program

The HOWTO Grant Program was established in 2018 as a partnership between OHSU and OHA under the direction of OHPB. HOWTO supports innovative, transformative, and community-based training initiatives to address health care workforce shortages across the state and expand the diversity of the health professional workforce. OHSU initially housed the program administration, which was transferred to OHA in August 2021.

HOWTO has awarded five rounds of funding for a total of $25.8 million across 40 projects. Maximum awards are limited to $1 million total for up to a three-year project timeframe, though grantees can request no-cost-extensions when needed for

completion of spending and grant objectives. The average grant amount in Rounds 1-5 is $643,801.

HOWTO grantee projects include those that are increasing health care workforce capacity by recruiting new trainees into the field, as well as projects that are offering skill-building and other approaches to increase retention. Training supported by HOWTO funds address wide-ranging health care workforce roles across medical, oral, and behavioral health fields, such as Behavioral Health Aides, Certified Alcohol and Drug Counselors, Community Health Workers, Dental Assistants, Family Medicine Residents, Medical Assistants, Nurse Practitioners, Peer Support Specialists, Pharmacy Technicians, and Qualified Mental Health Professionals.

Twenty-six of the 40 HOWTO projects are still ongoing and are in various stages of implementation. With an emphasis on building innovative programs that can be sustained long-term, the training curricula, residency and internship programs, training and employer consortia, and other partnerships developed through these projects will continue to increase health care workforce capacity beyond the duration of their HOWTO funding.

Rural Medical Practitioner Tax Credit Program

Rural practitioner tax credits are also available to providers for practicing in areas that meet the requirements of a designated rural area and whose individual adjusted gross income does not exceed $300,000. Certified registered nurse anesthetists, dentists, doctors of medicine (MD), doctors of osteopathic medicine (DO), nurse practitioners, optometrists, physician associates, and podiatrists are eligible for participation. Tax credit amounts are tiered based on distance from city centers with a population of more than 40,000 people. Providers at practices 10-20 miles away from an urban center receive $3,000, 20-50 miles away receive $4,000, and 50+ miles away receive $5,000. A separate rural tax credit is also offered to emergency medical services providers who serve in rural areas. Figure 3.8 shows the tax credit recipients decreased from around 3,000 in 2018 to less than 2,000 in 2023.

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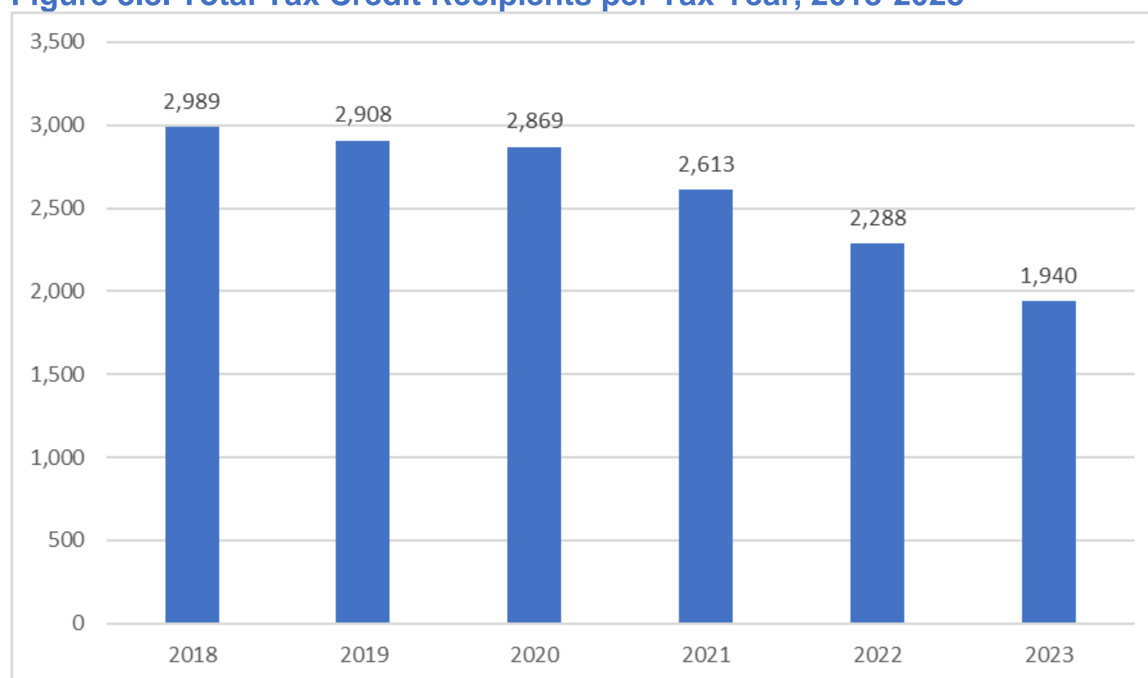
Figure 3.8. Total Tax Credit Recipients per Tax Year, 2018-2023



Source: Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, Oregon Health Authority

Health Care Workforce Trends and Data

This section provides a snapshot into health care workforce trends by reviewing data and information from various sources. Data is presented on workforce supply, workforce diversity, and unmet needs and geographic distribution of the workforce. Health care labor market information outlines the impact of COVID-19 on workforce shortages. Additionally, information about education and career pathways, workforce wellness and resiliency, and telehealth is provided.

Health Care Workforce Reporting Program Data

Oregon was one of the first states in the country to legislatively mandate data collection on licensed health care professionals through OHA's Health Care Workforce Reporting Program. The program was created in 2009 with the passage of House Bill 2009, which required OHA to collaborate with seven health profession licensing boards to collect health care workforce data during the license renewal processes. During the 2015 Oregon Legislative session, Senate Bill 230 added 10 licensing boards to the program. Oregon's licensing boards participating in this data collection are outlined in Table 4.1, along with the occupations that they license. The program releases two reports every two years on licensed health care workforce supply and diversity. This data is used to

understand Oregon's health care workforce, inform public and private educational and workforce investments, and inform policy recommendations for state agencies and the Legislative Assembly regarding Oregon's health care workforce.

Table 4.1. Oregon Health Care Licensing Boards that Participate in the Health Care Workforce Reporting Program

Board	Occupations
Oregon Board of Chiropractic Examiners	Chiropractic physicians Chiropractic assistants
Oregon Board of Dentistry	Dentists Dental hygienists
Oregon Board of Examiners for Speech-Language Pathology and Audiology	Speech-language pathologists Audiologists Speech-language pathology assistants
Oregon Board of Licensed Social Workers	Licensed clinical social workers Clinical social work associates Non-clinical social workers
Oregon Board of Licensed Dieticians	Licensed dieticians
Oregon Board of Licensed Professional Counselors and Therapists	Licensed professional counselors Licensed marriage and family therapists
Oregon Board of Massage Therapists	Licensed massage therapists
Oregon Board of Medical Imaging	Medical imaging technologists Radiation therapists
Oregon Board of Naturopathic Medicine	Naturopathic physicians
Oregon Board of Optometry	Optometrists
Oregon Board of Pharmacy	Pharmacists Certified pharmacy technicians
Oregon Board of Physical Therapy	Physical therapists Physical therapy assistants
Oregon Board of Psychology	Psychologists
Oregon Medical Board	Physicians Physician associates Podiatrists Acupuncturists
Oregon Occupational Therapy Licensing Board	Occupational therapists Occupational therapy associates

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Oregon State Board of Nursing	Certified nursing assistants Licensed practical nurses Registered nurses Nurse practitioners Certified registered nurse anesthetists Clinical nurse specialists
Respiratory Therapist and Polysomnographic Technologist Licensing Board	Respiratory therapists Polysomnographic technologists

Source: OHA Office of Health Analytics, 2024 Oregon's Licensed Health Care Workforce Supply

The Health Care Workforce Reporting Program 2024 estimated there were 209,188 licensed providers and 103,482 full-time equivalents (FTE) of direct patient care in Oregon. The direct patient care FTE by occupation and the annual average percent change from 2020-2024 are shown in Figure 4.2. The nursing and social work occupations have grown significantly over the past five years. Noteworthy average annual increases in direct patient care FTE were observed for speech language pathology assistants (18.1%), non-clinical social workers (15.9%), clinical social work associates (11.9%), and nurse practitioners (10.9%).

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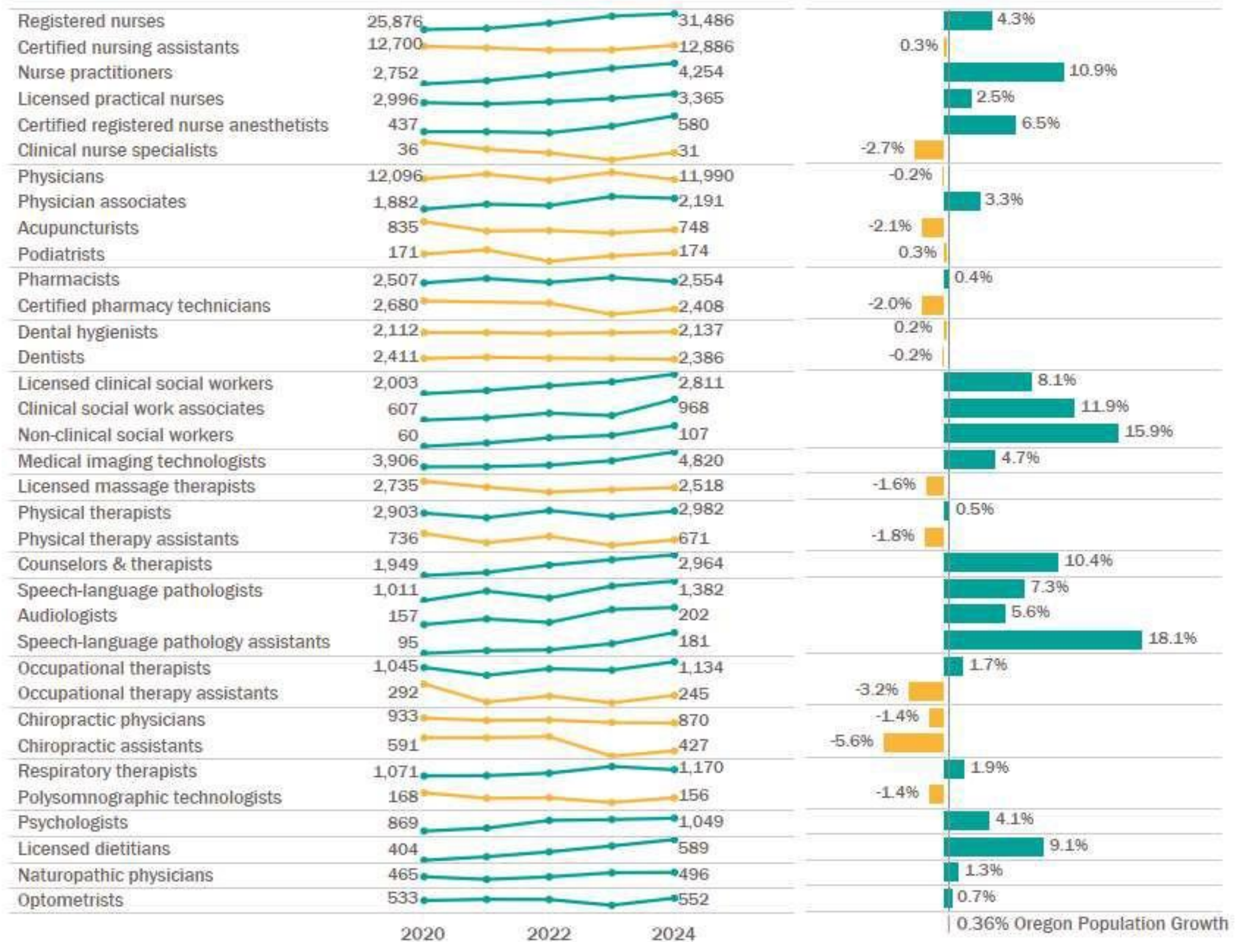
Figure 4.2. Average Annual Percent Change in Direct Patient Care FTE Varies by Occupation, 2020-2024



Source: OHA Office of Health Analytics, [2024 Oregon's Licensed Health Care Workforce Supply]().

Table 4.3 shows primary care provider direct patient care FTE changes by occupation over five years. Nurse practitioners and physician associates' direct patient care FTE increased by 16% and 14%, respectively. Overall, there is a 5% increase in primary care provider direct patient care FTE from 2022 to 2024 (Table 4.3).

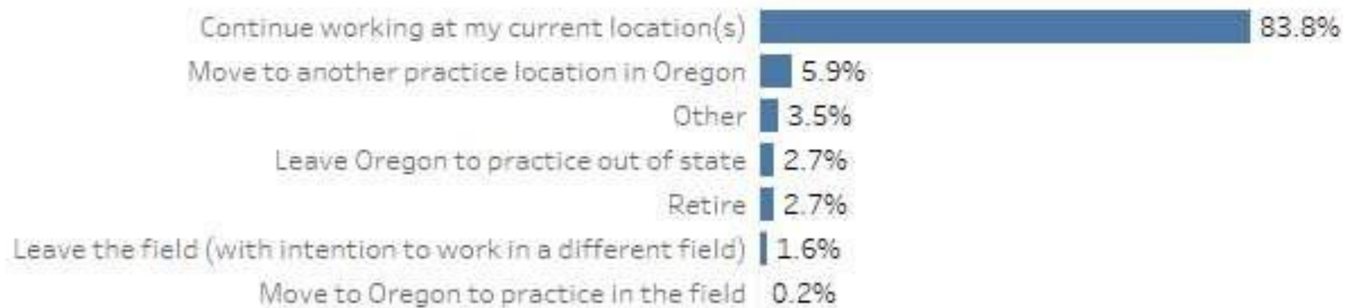
Table 4.3 Primary Care Provider Direct Patient Care FTE Changes by Occupation

Occupation	2020	2022	2024	Change from 2022 to 2024
Physicians	4,716	4,638	4,684	1 %
Nurse practitioners	1,020	1,241	1,439	16%
Physician associates	685	694	794	14%
Naturopathic Physicians	220	206	207	0.5%
TOTAL	6,641	6,779	7,124	5%

Source: OHA Office of Health Analytics, 2024 Oregon's Licensed Health Care Workforce Supply.

Figure 4.4 shows plans for working over the next two years. Around 90% of respondents indicated that they would continue or begin practice in Oregon. About 6% of respondents reported planning to retire or to leave Oregon and practice out of state. About 2% planned to leave their profession.

Figure 4.4. Licensed Health Care Professions' Plans for Working



Source: OHA Office of Health Analytics, 2024 Oregon's Licensed Health Care Workforce Supply.

As shown in Figure 4.5, 13.4% of licensed health care professionals planned to reduce the number of hours they work in the next two years, while 10.2% planned to increase their work hours.

Figure 4.5. Licensed Health Care Professions' Planned Changes to Work Hours

Source: OHA Office of Health Analytics, 2024 Oregon's Licensed Health Care Workforce Supply.

Starting in 2021, the Health Care Workforce Reporting Program's survey of providers began using the REALD tool. REALD outlines how to collect data on race, ethnicity, language, and disability with more granularity. The tool can be used to more accurately identify inequities and subpopulations that may benefit from focused interventions, and help address unique inequities that occur at the intersections of race, ethnicity, language, and disability.

The gender and race/ethnicity breakdown for health care providers compared with Oregon's general population is shown in Table 4.6. Female providers are overrepresented in most professions, though men tend to be overrepresented in fields requiring more years of formal training, such as physicians and dentists. Latino/a/x providers are underrepresented in most health care professions. See The Health Care Workforce in Oregon section for more detail on provider specialty groups.

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Table 4.6. Health Care Workforce Compared to Oregon Population by “Parent”* Race/Ethnicity and Gender, 2024

Comparison to state distribution
Below state | Similar to state | Above state | None

		AI/AN	Asian	Black /AA	Latino /a/x/e	NH/PI	Other race	White	Female	Male
Oregon		3.2%	5.8%	3.0%	12.4%	0.9%	0.2%	74.4%	50.2%	49.8%
Chiropractic	Chiropractic assistants	2.8%	5.1%	1.0%	17.3%	1.2%	0.6%	72.0%	82.3%	12.9%
	Chiropractic physicians	2.0%	6.7%	1.1%	3.6%	0.9%	1.1%	84.7%	31.7%	62.5%
Counselors and t..	Counselors & therapists	3.0%	3.4%	2.3%	4.6%	0.5%	0.7%	85.4%	75.3%	19.7%
Dentistry	Dental hygienists	2.9%	7.7%	0.7%	6.9%	0.7%	1.1%	80.1%	93.5%	3.3%
	Dentists	1.3%	19.9%	0.9%	4.2%	1.1%	1.2%	71.6%	30.4%	65.7%
Dietetics	Licensed dietitians	1.5%	6.8%	0.8%	4.6%	0.1%	0.4%	85.8%	92.8%	4.4%
Massage therapy	Licensed massage therapists	3.9%	5.2%	1.6%	4.7%	0.7%	1.5%	82.5%	77.3%	15.9%
Medical	Acupuncturists	0.5%	13.2%	0.6%	2.2%	0.2%	2.8%	80.6%	71.6%	27.9%
	Physician associates	1.1%	8.6%	2.2%	6.4%	0.6%	1.6%	79.5%	66.0%	33.0%
	Physicians	0.2%	19.1%	2.0%	2.7%	0.2%	2.5%	73.3%	42.1%	57.8%
	Podiatrists	0.0%	14.0%	1.5%	0.0%	0.0%	3.7%	80.9%	21.8%	78.2%
Medical imaging	Medical imaging technologists	2.5%	5.8%	0.8%	6.2%	0.9%	0.8%	83.0%	62.6%	31.9%
Naturopathy	Naturopathic physicians	3.0%	5.9%	1.1%	5.3%	0.7%	1.3%	82.8%	73.0%	20.8%
Nursing	Certified nursing assistants	3.4%	7.9%	10.0%	18.2%	1.9%	1.5%	57.1%	83.7%	14.2%
	Certified registered nurse anest..	0.8%	7.8%	0.3%	4.8%	0.3%	1.1%	84.9%	47.3%	46.2%
	Clinical nurse specialists	0.0%	4.9%	1.2%	2.5%	1.2%	0.0%	90.1%	90.1%	4.4%
	Licensed practical nurses	2.9%	6.5%	7.1%	9.9%	1.2%	0.8%	71.6%	84.7%	13.3%
	Nurse practitioners	2.1%	6.2%	4.3%	4.5%	0.4%	0.9%	81.7%	83.5%	12.9%
	Registered nurses	2.1%	7.3%	2.4%	5.4%	0.8%	0.9%	81.2%	83.1%	13.8%
Occupational therapy	Occupational therapists	1.4%	7.2%	0.9%	3.3%	0.4%	0.7%	86.2%	85.3%	11.8%
	Occupational therapy assistants	3.4%	4.9%	2.7%	4.5%	0.8%	0.4%	83.3%	82.9%	12.7%
Optometry	Optometrists	0.5%	22.2%	0.3%	2.1%	0.7%	0.5%	73.7%	48.4%	47.6%
Pharmacy	Certified pharmacy technicians	2.7%	10.9%	2.0%	10.5%	2.2%	1.1%	70.6%	76.2%	20.4%
	Pharmacists	1.6%	27.8%	2.3%	2.8%	1.2%	0.9%	63.4%	57.0%	38.7%
Physical therapy	Physical therapists	1.1%	9.3%	0.7%	3.2%	0.7%	0.4%	84.5%	62.6%	34.8%
	Physical therapy assistants	1.3%	3.3%	1.3%	4.7%	0.1%	0.3%	89.1%	66.7%	29.1%
Psychology	Psychologists	1.6%	6.4%	1.3%	4.8%	0.2%	1.0%	84.6%	63.3%	32.6%
Respiratory therapy and polys..	Polysomnographic technologists	3.9%	3.9%	2.2%	2.8%	1.1%	0.0%	86.0%	48.9%	45.7%
	Respiratory therapists	2.5%	5.2%	3.3%	8.1%	0.8%	1.2%	79.0%	59.7%	35.8%
Social work	Clinical social work associates	3.1%	5.0%	6.1%	13.7%	1.0%	1.6%	69.4%	75.9%	17.0%
	Licensed clinical social workers	2.5%	3.2%	2.4%	4.9%	0.4%	0.8%	85.7%	79.0%	16.8%
	Non-clinical social workers	1.9%	5.7%	2.5%	8.2%	0.6%	0.6%	80.4%	81.5%	16.1%
Speech-language pathology and audiology	Audiologists	0.9%	6.1%	0.5%	3.3%	0.9%	0.5%	87.9%	74.7%	17.4%
	Speech-language pathologists	2.0%	4.5%	0.6%	5.1%	0.2%	0.6%	86.9%	88.9%	7.5%
	Speech-language pathology as..	2.7%	3.3%	0.5%	12.6%	1.1%	1.1%	78.7%	95.3%	2.4%
Grand Total		2.1%	9.1%	2.9%	6.4%	0.8%	1.1%	77.6%	72.9%	24.0%

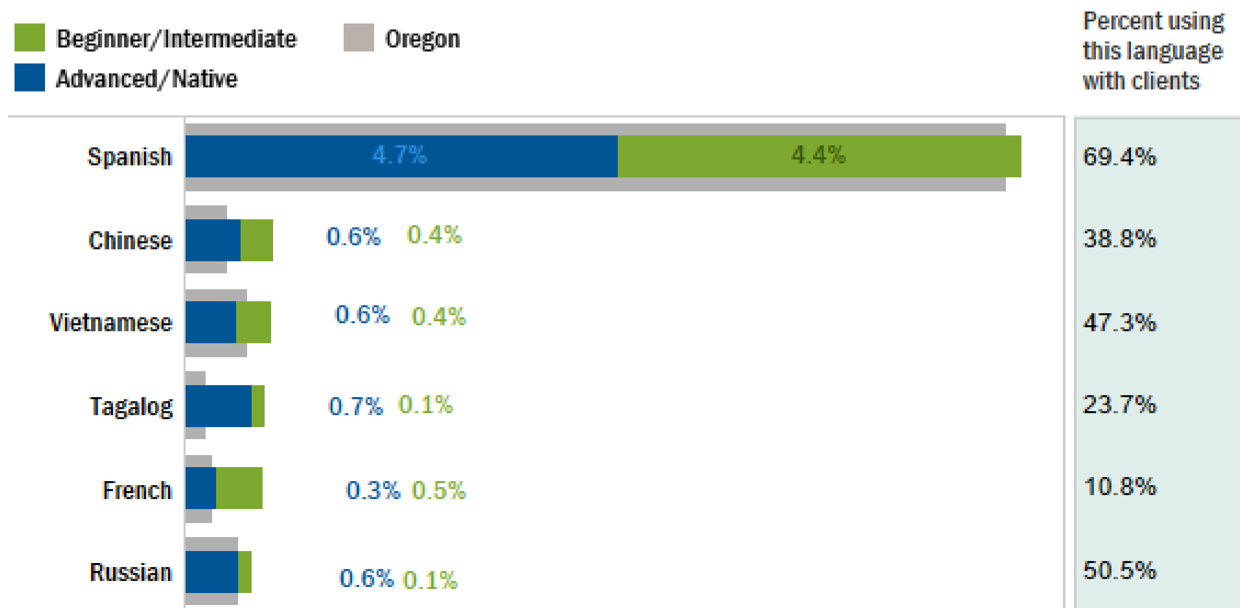
Note: Highlight threshold is 2.0% difference from state population baseline. Providers with missing data were excluded from the analysis. Some Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity. Individuals reporting multiple races are recategorized using rarest race methodology. AA = African American, AI/AN = American Indian or Alaska Native, NH/PI = Native Hawaiian or Pacific Islander

* More information regarding race/ethnicity “parent” category can be found in the [REALD Implementation Guide](#).
Source: OHA Office of Health Analytics, [Oregon’s Health Care Workforce Reporting Program](#)

As shown in Figure 4.7, Spanish is the most common language spoken other than English among licensed providers (about 9%). The next most common languages spoken are Chinese (including Mandarin and Cantonese), Vietnamese, Tagalog, French, and Russian. Less than 1% of the licensed health care providers are native speakers or have advanced proficiency in each of those languages. Thus, many patients who speak a language other than English need the assistance of a Health Care Interpreter (see the [Health Care Interpreters section](#)).

Figure 4.7. Top Languages Spoken by the Workforce, 2024

Workforce stratified by proficiency, compared to Oregon Population



Note: Chinese includes Mandarin and Cantonese.

Source: OHA Office of Health Analytics, [Oregon’s Health Care Workforce Reporting Program](#)

Areas of Unmet Health Care Needs Data

The Oregon Office of Rural Health at Oregon Health & Science University (OHSU) produces a report annually on Oregon Areas of Unmet Health Care Need, presenting community-level data on access to care and health care workforce capacity in 128 primary care service areas. The Office of Rural Health defines primary care service areas using zip code data, with at least 800 people in each service area. Generally, service areas are defined considering topography, social and political boundaries, and travel patterns, and health resources are located within 30 minutes travel time in any given service area.

It is important to note that the report does not assess unmet health care needs by race/ethnicity, language, disability, sexual orientation, or gender identity. Equitable health care access is dependent on the diversity and language abilities of providers, and the intersectionality of urban/rural geography with these demographic characteristics in the health care workforce is an important consideration.

Nine variables of access to primary physical, behavioral, and oral health care are included in the report. A composite score of unmet need is calculated from these measures, ranging from 0 to 90, with lower scores indicating greater unmet need. Scores are calculated for each primary care service area in the state.

For 2024, the unmet health care need scores ranged from 21 (worst) to 78 (best), with a statewide average of 49.7 (Figure 4.8). Rural and remote areas comprise all but two of the 69 service areas that fall below the statewide average score.

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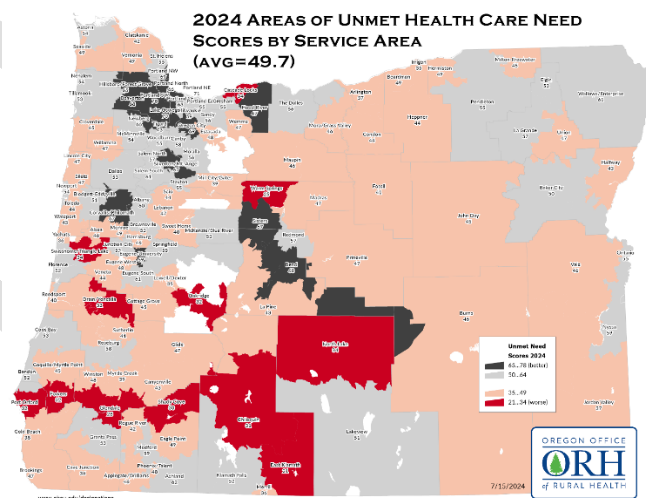
Figure 4.8. Unmet Health Care Needs Scores by Service Area



Source: The Oregon Office of Rural Health. The 2024 Areas of Unmet Health Care Need Report.

Table 4.9 shows scores for unmet health care need by geographic area. From 2022 to 2024, rural and remote areas consistently have greater unmet health care need than urban areas in Oregon. See the Health Care Workforce in Oregon section for more detail on provider specialty groups.

Table 4.9. Average Unmet Health Care Need Score by Geographic Area

	Unmet Health Care Need Score *Lower numbers indicate more unmet need*		
	2024	**2023**	**2022**
Oregon	49.7	49.1	49.4
Urban	62.7	61.6	62.1
Rural (without Remote)	46.7	46.1	45.9
Rural (including Remote)	46.5	46.2	46.4
Remote	45.7	46.9	48.9

Source: Oregon Office of Rural Health. 2024 Areas of Unmet Health Care Need Report.

Health Care Workforce Shortages and Impacts of COVID-19

Oregon Employment Department (OED) data shows strong job growth in health care and social assistance over the past year (see Figure 5.1) gaining over 15,000 jobs from June 2023 to June 2024 with average pay of $63,998. However, employers report experiencing vacancies and difficulties filling positions particularly in certain occupations and industries.

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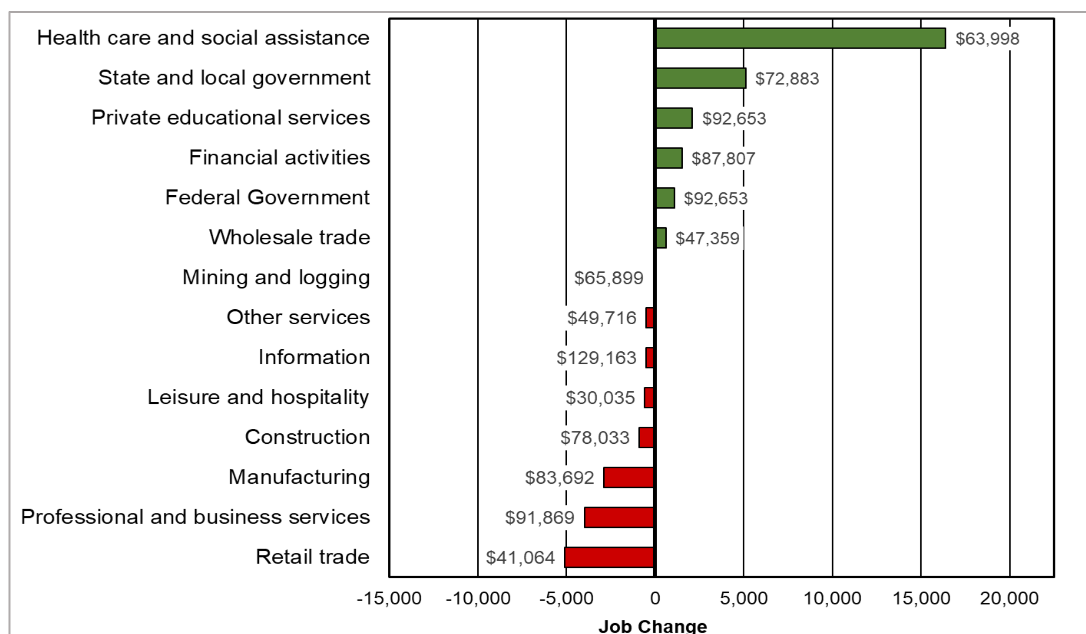
Figure 5.1. June 2023 - June 2024 job change, 2023 average pay



Source: OED, Current Employment Statistics

Despite the strong growth, health care and social assistance had the most job vacancies of any industry in Oregon. According to OED, Oregon health care and social assistance businesses had over 18,800 job vacancies or accounted for almost one-third of all job openings. Table 5.2 shows major indicators from Oregon health care job vacancies by vacancy type in 2023. Nealy 80% of health care vacancies were "difficult to fill" with a higher average hourly wage ($33.51) than for "not-difficult-to-fill" positions ($21.30). Over 70% of "difficult-to-fill" positions required education beyond high school, compared to nearly 30% of "not-difficult-to-fill" ones. "Difficult-to-fill" positions had higher requirements for previous experience than "not-difficult-to-fill" ones (57% vs 31%).

Table 5.2 Major indicators from Oregon health care* job vacancies by vacancy type, 2023

	All Health Care Vacancies	Not Difficult to Fill	Difficult to Fill
Vacancies	9,915	2,193	7,722
Average Hourly Wage	$31.17	$21.30	$33.51
Full-Time Positions	76%	76%	77%
Permanent Positions	99%	97%	100%

Requiring Education Beyond High School	64%	29%	73%
Requiring Previous Experience	51%	31%	57%
Difficult to Fill	78%	0%	100%

Source: OED, Oregon Job Vacancy Survey

Note: * In this context, “health care” refers to job vacancies found in businesses in the health care and social assistance industry (NAICS 62) for health care occupations (SOC 29 and 31).

Table 5.3 lists occupations with highest number of vacancies reported as difficult to fill. Personal care aides had most vacancies (2,700 vacancies), followed by nursing assistants (1,731 vacancies) and registered nurses (1,643 vacancies). Although the following occupations showed a smaller numbers of vacancies, dental hygienists (416 vacancies), physical therapists (292 vacancies), nurse practitioners (248 vacancies), and family medicine physicians (206 vacancies) had 100% vacancies as “difficult to fill”.

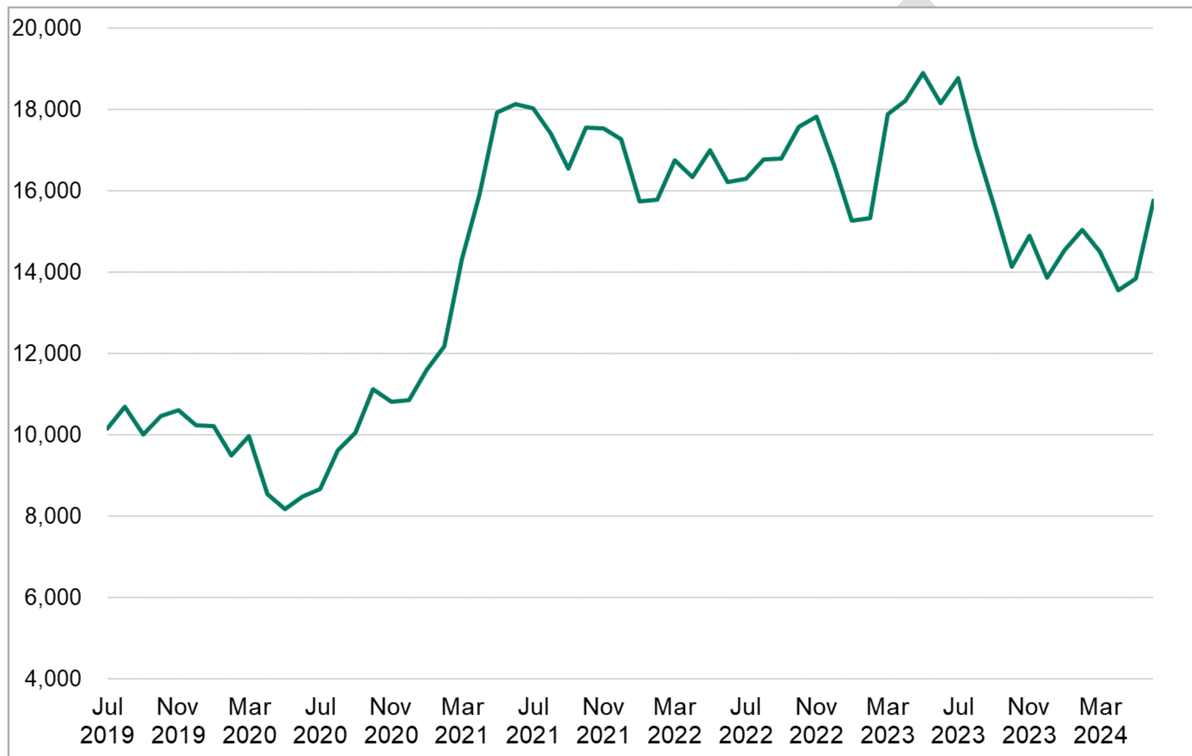
Table 5.3 Top health care occupations in Oregon with highest number of vacancies reported as difficult to fill, 2023

Occupation	Vacancies	Difficult to Fill	Share of Total
Personal Care Aides	2,700	1,662	62%
Registered Nurses	1,643	1,382	84%
Nursing Assistants	1,731	1,005	58%
Medical Assistants	933	674	72%
Dental Assistants	608	581	96%
Mental Health Counselors	925	488	53%
Dental Hygienists	416	416	100%
Social and Human Service Assistants	1,200	353	29%
Physical Therapists	292	292	100%
Rehabilitation Counselors	321	289	90%
Nurse Practitioners	248	248	100%
Medical and Health Services Managers	403	248	62%
Family Medicine Physicians	206	206	100%

Source: OED

The Help Wanted OnLine program measures the demand for labor using advertised online job vacancies and reflects trends in employment opportunities across the United States. Figure 5.4 shows the number of monthly online health care occupational job postings in Oregon analyzed by OED. There were nearly 16,000 health care job postings in June 2024, which was around 15% below the peak in May 2023 (18,896).

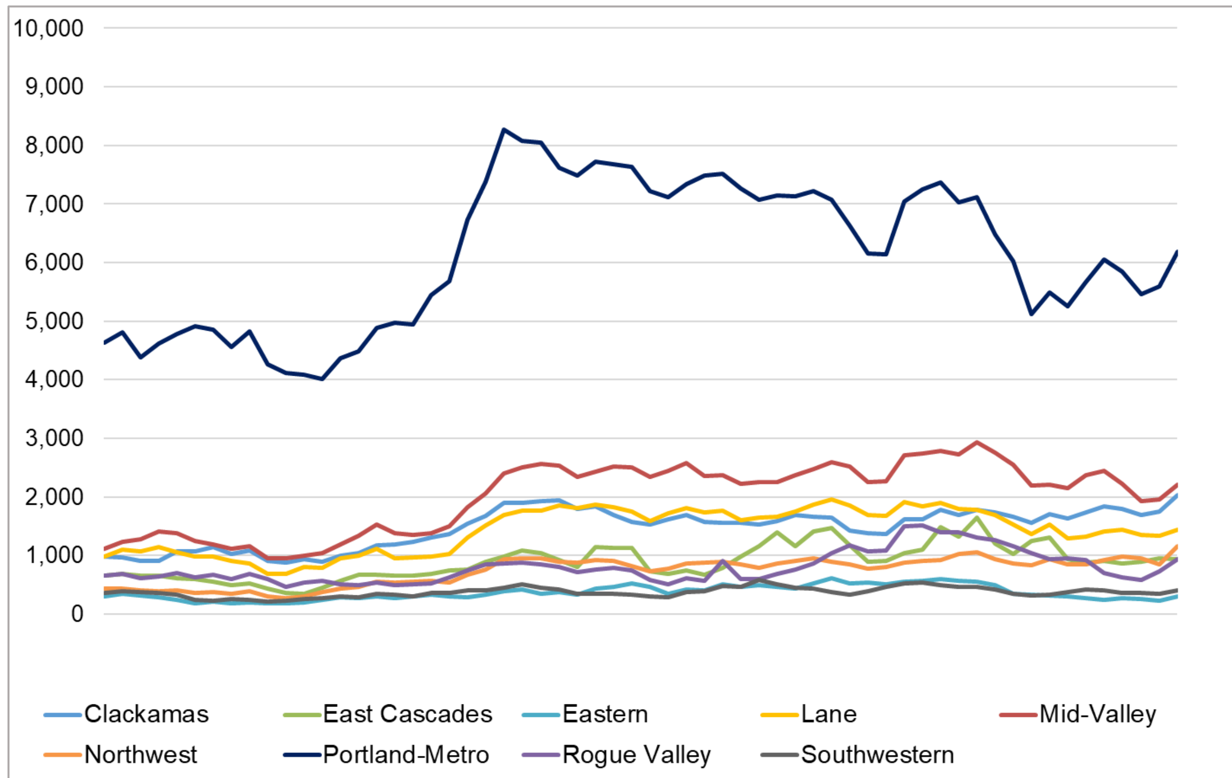
Figure 5.4. Monthly online health care occupational job postings in Oregon



Source: OED, the Conference Board's Help Wanted OnLine (HWOL)

There have been consistent increases in health care job postings since the pandemic across the state. As shown in Figure 5.5, Portland-metro had a 50% increase in online job postings from June 2020 to June 2024. Although the Eastern region had only about 300 online job postings, it was still 55% more than four years ago. The Portland-metro had the largest number of online job postings (6,179 postings) in June 2024, followed by Mid-Valley (2,213 postings) and Clackamas (2,025 postings).

Figure 5.5. Monthly online health care job postings in Oregon by region, June 2020 - June 2024



Source: OED, the Conference Board's Help Wanted OnLine (HWOL)

Moving forward, OED projected health care occupations that will grow faster over the next 10 years than the statewide average, partly due to recovery from pandemic and changes in technology and health care delivery. Table 5.6 lists the fastest growing health care practitioner and health care support occupations compared with employments in 2022. Nurse practitioners' employment was projected to increase by more than half in 2032, followed by over 35% increase for physical therapist assistants and physician associates. As another strong point of interest, OED expected employments in social service and behavioral health occupations would be more than 15% higher in 2032 than in 2022, while employments of substance abuse, behavioral disorder, and mental health counselors would increase by over 27% (Table 5.7).

Table 5.6. Projected 2022-2032 fastest growing health care practitioner and health care support occupations

Occupation Title	Employment 2022	Projected Employment 2032	Employment Change	Percent Change

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Nurse Practitioners	2,244	3,424	1,180	52.6%
Physical Therapist Assistants	836	1,155	319	38.2%
Physician Associates	1,419	1,934	515	36.3%
Veterinary Assistants and Laboratory Animal Caretakers	2,745	3,620	875	31.9%
Veterinarians	1,898	2,485	587	30.9%
Veterinary Technologists and Technicians	1,451	1,897	446	30.7%
Speech-Language Pathologists	1,959	2,492	533	27.2%
Orthotists and Prosthetists	135	169	34	25.2%
Home Health and Personal Care Aides	36,897	46,165	9,268	25.1%
Physical Therapists	3,106	3,847	741	23.9%
Nurse Anesthetists	384	473	89	23.2%
Massage Therapists	2,282	2,800	518	22.7%
Medical Assistants	11,955	14,523	2,568	21.5%

Source: OED, Occupational Employment Projections 2022-2032

Table 5.7. Projected 2022-2032 growth of social service and behavioral health occupations

Occupation Title	Employment 2022	Projected Employment 2032	Employment Change	Percent Change
Overall Community and Social Service Occupations	46,174	53,344	7,170	15.5%
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	7,487	9,541	2,054	27.4%

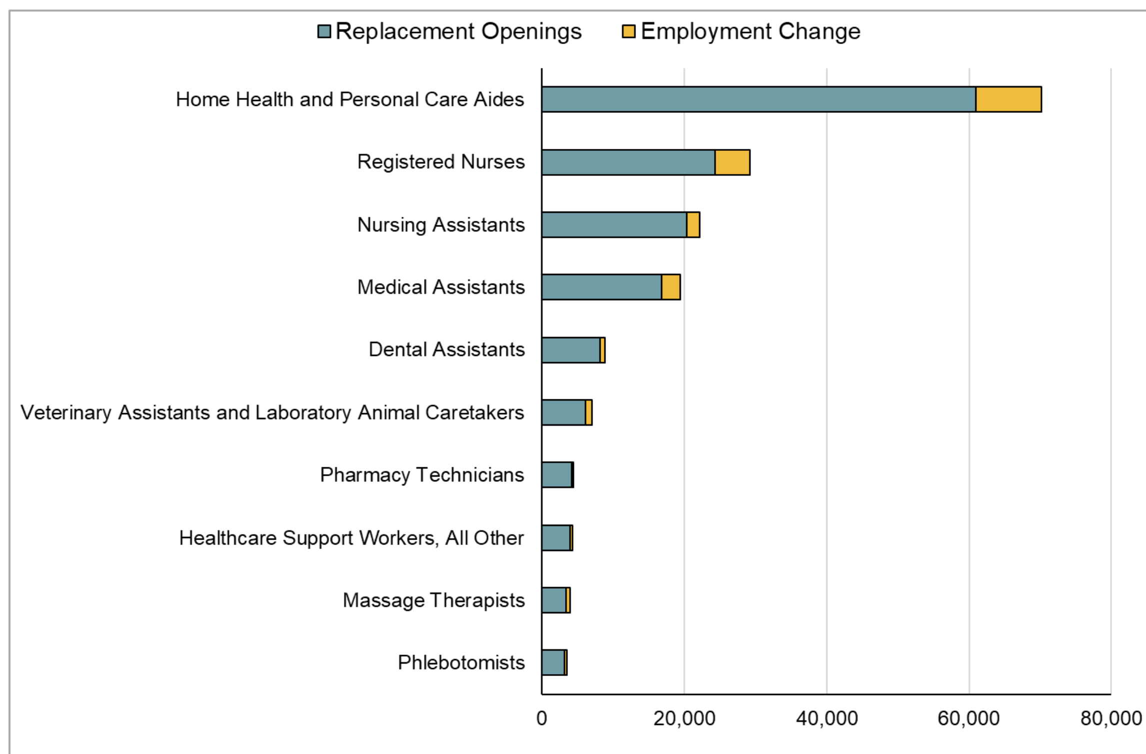
Community Health Workers	996	1,188	192	19.3%
Rehabilitation Counselors	3,998	4,754	756	18.9%
Mental Health and Substance Abuse Social Workers	2,103	2,436	333	15.8%
Community and Social Service Specialists, All Other	2,065	2,376	311	15.1%
Health Education Specialists	749	856	107	14.3%
Health care Social Workers	1,984	2,261	277	14.0%
Social Workers, All Other	3,071	3,469	398	13.0%
Social and Human Service Assistants	6,611	7,469	858	13.0%
Child, Family, and School Social Workers	5,190	5,853	663	12.8%
Probation Officers and Correctional Treatment Specialists	2,230	2,476	246	11.0%
Educational, Guidance, and Career Counselors and Advisors	2,688	2,878	190	7.1%

Source: OED, Occupational Employment Projections 2022-2032

In addition to growth from new jobs, it is also important to account for replacement openings (e.g., workers who leave the occupation due to burnout, retirement, change careers, or other reasons) when analyzing future workforce needs. This is particularly important for the workforce who have high burnout risks or turnover rates. Figure 5.8 illustrates projections of health care occupations with most replacement openings. Home health and personal care aides and registered nurses were projected to have a total of over 70,000 and 29,000 job openings, respectively. The large number of replacement openings in these occupations may be in part due to their high turnover

rates and a rebound from pandemic. OED projected over 230,000 total openings in health care practitioner and support occupations between 2022 and 2032.

Figure 5.8. Health care occupations with most openings of employment projections 2022-2032



Source: OED, Occupational Employment Projections 2022-2032

The [2024 Commonwealth Fund National Survey of Federally Qualified Health Centers] (FQHCs) suggests the workforce shortages have become significantly worse for all provider types since 2018. According to the survey, 77% of community health centers reported shortages of mental health providers in 2024, increasing from 70% in 2018. For primary care providers, 70% of community health centers reported shortages in 2024 compared to 65% in 2018. There was an even bigger increase in the shortage of nurses, increasing from 54% in 2018 to 70% in 2024.

Oregon Primary Care Association conducted a survey about how the COVID-19 has impacted the workforce. Respondents reported that the pandemic has reshaped the landscape of primary care, emphasizing the well-being of health care providers. Health care workers are more focused on self-care and work-life balance, recognizing the importance of time and flexibility for personal pursuits. The COVID-19 pandemic also limited the number of patients who had access to dental services, and many support

staff, including dental hygienists and dental assistants, left the field, causing a ripple effect of delayed patient treatments, lapsed hygiene and recall exams, and currently, long waits for patient appointments. Currently, FQHC responders find themselves in a "catch up" period for patient treatments, exacerbated by lack of support staff, which further burdens dental providers. For FQHC behavioral health providers, ongoing issues include risk assessment difficulties and a need for children to improve social skills.

Future Ready Oregon, established under Senate Bill 1545 (2022), is a $200 million package of investments that work together to advance a more equitable workforce system and increase opportunities for diverse workers (see Appendix B). Future Ready Oregon's focus groups of health care employers suggested that "*The health care industry is recovering from the COVID pandemic impact*" and "*The full employee lifecycle has experienced unprecedented challenges resulting from the pandemic and employee expectations.*" Employers found it particularly difficult to fill positions for nurses, behavioral health workers, technicians (e.g. lab, imaging, respiratory therapists), dental hygienists, primary care providers and specialists, doulas, patient navigators, and other non-credentialed workforce (e.g. housekeepers, dietary aides). To address workforce needs, the focus groups recommended enhancing working relationships and communications among Oregon health care employers and higher education institutions in areas including curriculum development, career pathway definition and promotion, and student preparation and exposure to future workplaces and positions (see Education and Career Pathway section).

Recommendations to address health care workforce shortages

The Oregon Health Care Workforce Committee's Workforce Development and Retention subcommittee has comprehensive recommendations to address workforce shortages that are combined with feedback from the health care workforce into four broad areas:

- Increase investment in education and training programs to improve skilled and culturally competent health care workforce.
- Develop strategies to increase recruitment, such as increasing access to health care careers and improving compensation and social factors.
- Develop strategies to increase retention, such as providing wellness support and improving community integration and belonging.
- Improve data collection and accessibility to support health care employers for demand planning.

Examples in each of these areas to address health care workforce shortages are provided in Appendix C.

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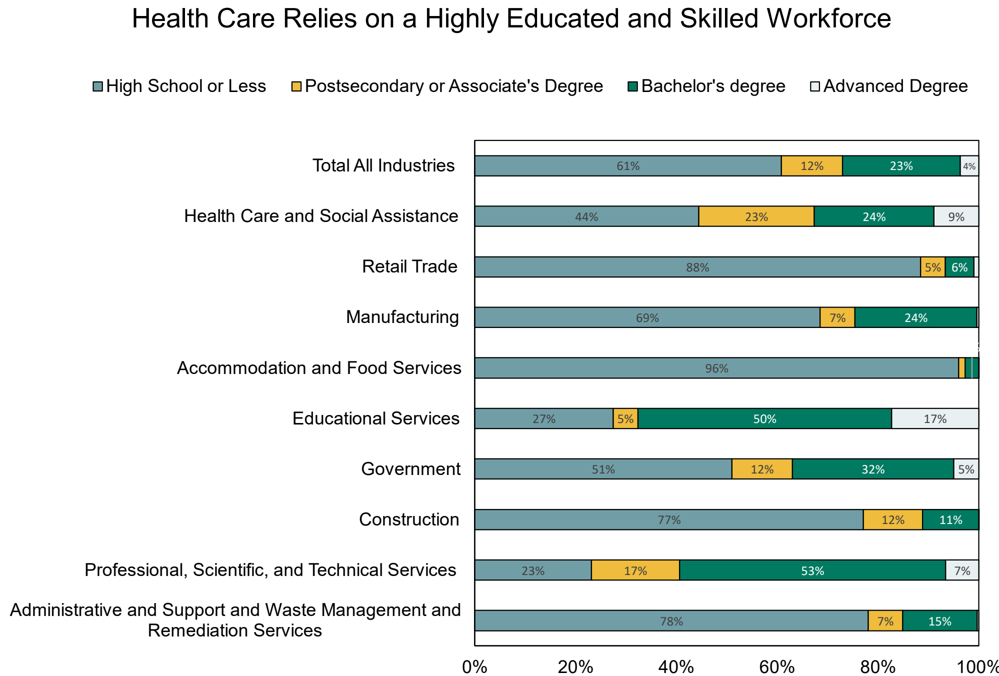
Education and career pathways

The health care sector relies on a highly educated and skilled workforce. OED estimates that 56% of jobs in health care require some form of postsecondary education, compared to 40% for all industries in Oregon (Figure 6.1).. In 2023, over 70% of "difficult-to-fill" health care job vacancies required education beyond high school.

Figure 6.1. Education requirement for industries in Oregon



Source: Oregon Employment Department, Occupational Employment Projections 2022-2032
Chart based on the distribution of 2022 sector employment by typical entry-level education.

The 2023 U.S Supreme Court decision ending race-conscious admission programs at colleges and universities across the country may negatively impact pathways into health care professions. There will need to be greater innovation to support diverse learning environments that can help students "*sharpen their critical thinking and analytical skills, prepare all students to succeed in an increasingly diverse and interconnected world, break down stereotypes and reduce bias, and enable schools to fulfill their role in opening doors for students of all backgrounds*" (U.S. Department of Education).

As the health care sector relies on a highly educated workforce, it can be vulnerable to bottlenecks in the education pipeline. Oregon has invested in supporting education pipelines to attract students into health care professions.

Recommendations to support education and career pathways

The Oregon Health Care Workforce Committee's Workforce Development and Retention subcommittee provided recommendations to improve education pipeline and

pathways for career advancement that are combined with feedback from the health care workforce into five broad areas:

- Expand opportunities to support pipeline programs in middle and high schools.
- Coordinate efforts for health care education and career advancement.
- Increase access to health care careers for people from diverse, underserved, and rural communities.
- Increase training slots to train more providers
- Increase incentives for academic positions.

Examples of education and career pathways programs in each of these areas are provided in Appendix D.

Workforce wellness and resiliency

Burnout has been a long-standing issue for health care workers. Complex challenges at organizational, system, and socio-cultural levels contribute to health care workforce burnout. The literature suggests, "*Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs.*" Burnout has been long noted as a reason for the health care workforce to exit the profession even before the pandemic. The resulting workforce shortage would cause ripple effects and further place burden and increase risk of burnout on remaining health workers.

Health care workforce burnout was exacerbated during the COVID-19 pandemic, as they experienced increased workload and shortages in resources, anxiety and fear for working conditions, and extreme mental and physical fatigue (see Health Care Workforce Shortages and Impacts of COVID-19 section). A national survey found a dramatic increase in physician burnout during the first two years of the COVID-19 pandemic. Over 60% of participants reported at least one manifestation of burnout in 2021 compared with 38% in 2020. Physicians' satisfaction with work-life integration declined from 46% in 2020 to 30% in 2021. The 2022 U.S. Surgeon General's Advisory Addressing Health Worker Burnout pointed out that "*health worker burnout harms all of us,*" as "*the health worker burnout crisis will make it harder for patients to get care when they need it, cause health costs to rise, hinder our ability to prepare for the next public health emergency, and worsen health disparities*."

National strategies have been taken to improve health workers well-being and address burnout at multiple levels. The U.S. Department of Health and Human Services awarded $103 million in the American Rescue Plan Funds to reduce burnout and to promote mental health among the health workforce. The U.S. Surgeon General's

Advisory Addressing Health Worker Burnout and the National Plan for Health Workforce Well-Being called on multi-sectoral leaders to develop systemic approach to support care providers and optimize their well-being. The National Plan listed priority areas including creating and sustaining positive work and learning environments and culture; investing in measurement, assessment, strategies, and research; supporting mental health and reducing stigma; addressing compliance, regulatory, and policy barriers for daily work; engaging effective technology tools; institutionalizing well-being as a long-term value; and recruiting and retaining a diverse and inclusive health workforce. The National Academy of Medicine also launched the Action Collaborative on Clinician Well-Being and Resilience, which is a network of health professional organizations and health systems, to raise the visibility and improve understanding of challenges to clinician well-being, and to advance evidence-based, multidisciplinary solutions. The American Medical Association recently summarized its efforts to reduce physician burnout, such as supporting physicians to seek care for wellness and burnout and making efforts to ensure confidentiality protections.

Data suggested these strategies helped reduce workforce burnout. A recent national survey showed that physician burnout rate had dropped below 50% for the first time since 2020, compared to about 63% in 2021. Job stress rate decreased from about 56% in 2022 to around 51% in 2023, while job satisfaction rate increased from 68% to 72%. Regarding systemic factors, more physicians reported feeling valued by their organization to a great extent or moderately (50.4% in 2023 vs 46.3% in 2022). Despite the burnout rate dropping from its record-high during the pandemic, as the survey report pointed out, "*the extent of the problem remains a startling reality that demands ongoing attention, especially among those who are at highest risk.*"

Recommendations to support workforce wellness and resiliency

The Oregon Health Care Workforce Committee's Workforce Wellness and Resiliency subcommittee recommends strategies to reduce workplace burdens and support workforce wellness that are combined with feedback from the health care workforce into five broad areas:

- Collect data on wellness to inform evidence-based strategies.
- Expand and fund the Oregon Wellness Program.
- Create a statewide system to recognize and reward employers that improve employee well-being.
- Create and sustain positive work environments and culture to improve work-life balance.
- Increase compensation and benefits and improve social factors.

More discussion in each of these areas is provided in Appendix E.

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Telehealth

Telehealth comprises means or methods for enhancing health care, public health, and health education using telecommunications technologies. Telehealth includes:

- Live audio and/or video conference between patient and clinician (e.g., by telephone or Internet)
- Store and forward (e.g., specialist reviewing x-rays at a remote location)
- Telementoring or teleconsultation between clinicians. (e.g., clinician getting advice from an offsite specialist to support care of a patient, using technology such as video conference)
- Remote patient monitoring (e.g., devices that monitor blood glucose levels at home and transmit to a physician)
- Mobile health (e.g., use of mobile applications to track health information)

Telehealth can potentially address health care workforce shortages and increase access to care in underserved areas by allowing patients to connect with providers outside their home city or region. For example, telehealth could improve access in health care provider shortage areas, such as many rural areas of Oregon. Patients who speak languages other than English can also benefit if a local in-person interpreter is not available. Telehealth can also enhance access for patients who have transportation barriers or limited access to childcare.

Telehealth holds the potential either to mitigate or to worsen health inequities. It may improve access for patients from disadvantaged populations, who disproportionately face transportation challenges and live in neighborhoods with fewer specialty clinicians. On the other hand, many patients in rural regions or low-income households lack the broadband internet access that enables video telehealth, which also requires a camera, video display, and digital literacy that many older or low-income patients may not have. Lack of privacy can also prevent patients from using telehealth for sensitive discussions. Patients with limited English proficiency may also not benefit from telehealth if interpreters are unavailable or patients have difficulty hearing them. Finally, visits that require a physical examination or procedure cannot be conducted via telehealth.

Prior to the COVID-19 pandemic, payers often restricted coverage of telehealth, including lower reimbursement rates for telehealth versus in-person visits. Federal regulations limited the communication modalities that could be used for telehealth, and Oregon Health Plan (OHP) required patients to be at a clinic or other remote site (not their own home) to participate in telehealth for physical health services.

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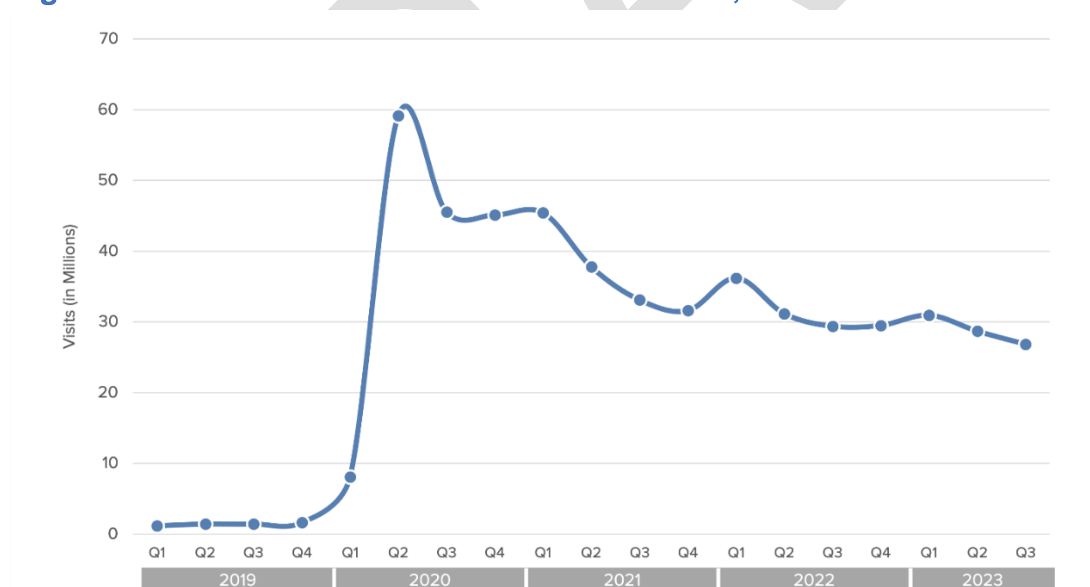
Demand for telehealth visits increased dramatically at the beginning of the COVID-19 pandemic, driven by the risk of Coronavirus exposure, shortages of personal protective equipment (PPE), and the absence of vaccines. Commercial payers, Medicare, and Medicaid rapidly adopted policy changes in 2020 that improved access to and reimbursement for telehealth services. In June 2021, House Bill 2508 made many of these changes permanent in Oregon, and subsequent OHP regulations made most of the pandemic telehealth policies permanent. Medicare also instituted telehealth policy flexibilities under the COVID-19 Public Health Emergency, which ended in January 11, 2023. Legislation extended federal telehealth flexibilities (except those allowing prescription of controlled substances) through 2024. In September 2024, the US House passed a bill that would extend federal telehealth flexibilities through 2026.

Telehealth use increased dramatically during the COVID-19 pandemic, from less than 1% of commercial health insurance claim lines to 13.0% in April 2020, although telehealth use was approximately one-third lower for rural patients than urban patients. The quarterly volume of commercial health insurance claims has dropped by more than half since the 2020 peak (Figure 7.1), and behavioral health now accounts for 2 in 3 commercial telehealth claims. In July 2024, 6.4% of commercial insurance claims were telehealth in the western states of the US.

Figure 7.1. Commercial telehealth visit volumes, 2019- 2023



Source: Trilliant Health

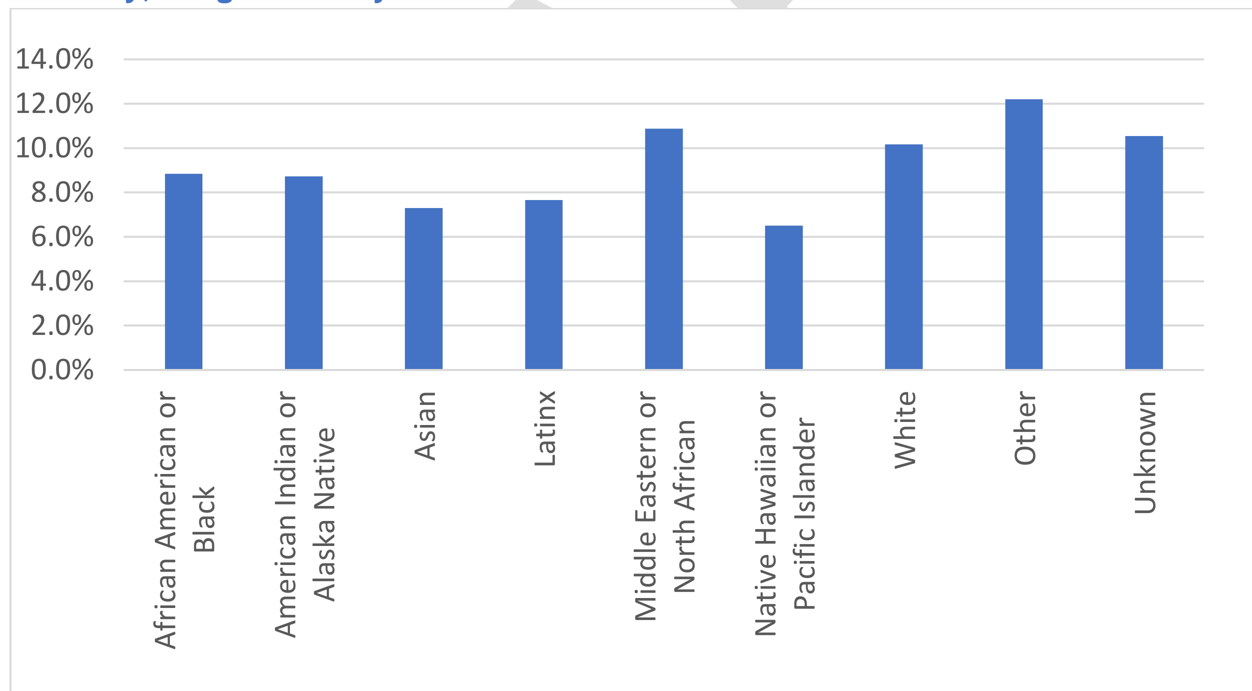
At the end of 2023, more than 1 in 10 traditional Medicare beneficiaries was using telehealth. Telehealth utilization was higher for disabled beneficiaries and for those

dually enrolled in Medicaid. However, rural residents were less likely to use telehealth than urban residents.

Telehealth use by OHP members rose very sharply (from a starting level less than 1%) at the start of the COVID-19 pandemic and peaked as a percentage of claims in September 2020. The telehealth proportion subsequently fell, and 9.9% of OHP ambulatory claims were telehealth in Oregon state fiscal year (SFY) 2023 (July 2022-June 2023). OHP telehealth utilization data are not available after June 2023.

Figure 7.2 shows the proportion of OHP ambulatory care claims for each major racial ethnic/group that were provided via telehealth during SFY 2023. The proportion of telehealth visits is between 7% and 10% for African-American, American Indian, Asian, Latino/a/x, and White members. Other racial/ethnic groups in these data are quite small; and race/ethnicity was Unknown for a fifth of claims.

Figure 7.2. Percentage of OHP ambulatory claims that are telehealth, by race and ethnicity, Oregon fiscal year 2023



Proportion of total claims by race/ethnicity:

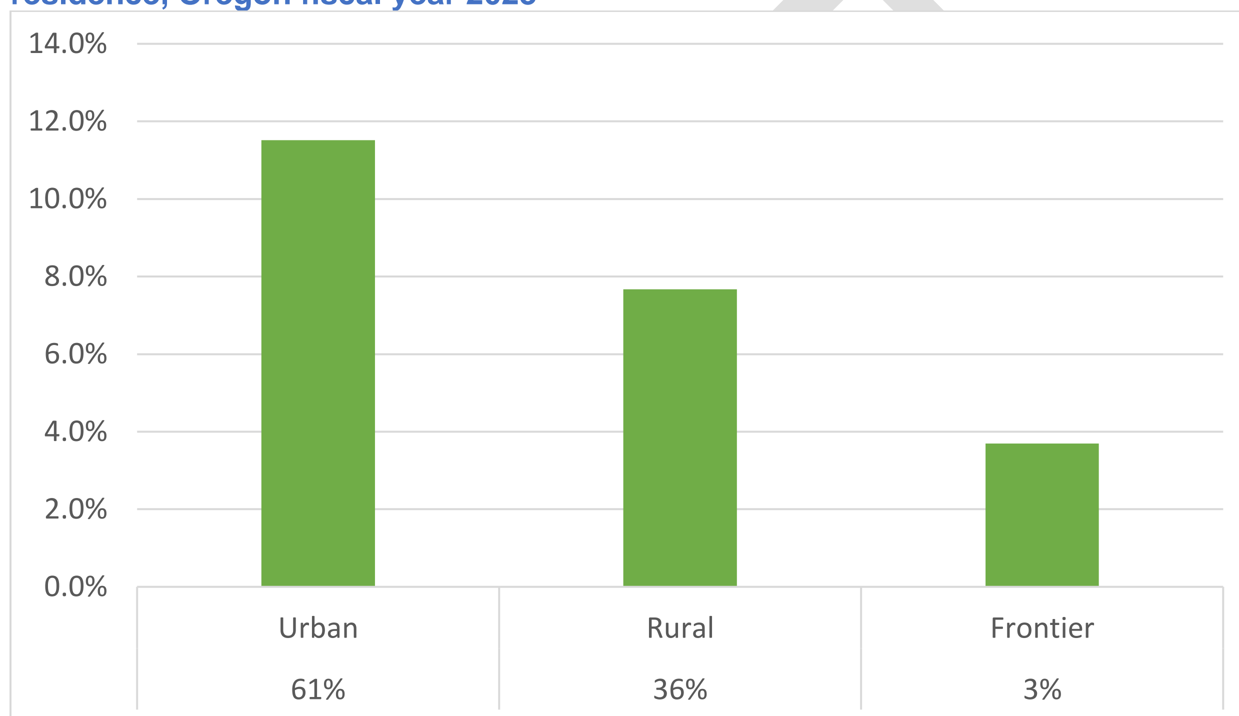
4%	3%	2%	9%	<1%	1%	59%	1%	20%

Source: Oregon Health Authority. Excludes inpatient, dental, and pharmacy claims.
Note: State fiscal year 2023 is July 2022 – June 2023.

In SFY 2022 (ended June 2022), 62% of OHP telehealth claims were for behavioral health and 25% for primary care, proportions which mirrored national data at that time. The specialty distribution of OHP claims data after SFY 2022 is not available.

Figure 7.3 shows the proportion of SFY 2023 OHP ambulatory care claims that were provided via telehealth, by rurality of the member's residence. The proportion of telehealth visits is highest in urban areas (12%), lower in rural areas (8%), and lowest in frontier areas of the state.

Figure 7.3. Percentage of OHP ambulatory claims that are telehealth, by rurality of residence, Oregon fiscal year 2023



Source: Oregon Health Authority. Excludes inpatient, dental, and pharmacy claims.
Notes: Proportion of total claims by race/ethnicity is shown below each bar.
State fiscal year 2023 is July 2022 – June 2023.

Future of Telehealth in Oregon

Oregon has taken action to continue post-pandemic access to telehealth, but future policy should focus on measuring and addressing potential equity concerns. The similarity of OHP telehealth utilization rates across racial/ethnic groups is favorable. However, lower utilization by rural and frontier OHP members suggests that the full potential of telehealth to mitigate geographic workforce shortages is not being realized. Potential causes of this disparity, such as limited broadband internet access in rural areas, should be investigated. Also, as discussed in the Health Care Interpreter section

below, telehealth by itself does not ensure adequate language access. OHP members' preferences for and satisfaction with telehealth services could be assessed, as well as potential provider concerns about telehealth or barriers to using it.

Health Care Workforce in Oregon

Oregon has been a leader in health care transformation for decades. An equitable health care system requires a robust workforce for the 10 specific provider types in this report to make progress towards Oregon's goals of achieving health equity; integrating physical, behavioral and oral health; and ensuring access to care. Updates since the last report are provided for eight provider types (Traditional Health Workers, Health Care Interpreters, primary care, nursing, long-term care, behavioral health, oral health, and public health). Two provider types (school health and gender affirming care providers) are new to this report. Each provider type is examined below.

Traditional Health Workers

Background on Traditional Health Workers in Oregon

Traditional Health Workers (THWs) are trusted individuals from their local communities who provide person-and community-centered care by bridging communities and the health systems they serve. THW roles were defined in the original bill that created Oregon's coordinated care organizations (CCOs) in 2011, House Bill 3650. As listed in ORS 414.665, there are five specialty types of THWs in Oregon:

- Community Health Workers (CHWs) share ethnicity, language, socioeconomic status, and life experiences of the community they serve. They assist individuals and their community to achieve positive health outcomes, including facilitating linkages between health/social services and the community; and improve the quality and cultural competence of service delivery.
- Peer Wellness Specialists are informed by their own experiences with recovery and assist with recovery from addiction, mental health, and physical conditions by helping to integrate behavioral health and primary care and help individuals achieve well-being.
- Peer Support Specialists provide services to individuals who share a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition). Types of peer support specialists include recovery peers, mental health peers, family support specialists, and youth support specialists.

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- Personal Health Navigators provide information, assistance, tools, and support to enable a patient to make the best health care decisions.
- Birth Doulas are birth companions who provide personal, nonmedical support to women and families throughout a person's pregnancy, childbirth, and postpartum experience.

OHA's Traditional Health Worker Program, housed in OHA's Equity & Inclusion Division, assists THWs in becoming trained and certified to meet current standards and provide high-quality, culturally competent care. The Traditional Health Worker Commission advises and makes recommendations to OHA, to ensure the program is responsive to consumer and community health needs. House Bill 2088, passed in 2021, requires the OHA to adopt qualification criteria for Tribal THWs as a sixth THW specialty type. A Tribal THW Program Analyst is working with the Nine Federally Recognized Tribes of Oregon to request CMS approve Tribal THW as a reimbursable provider.

As of October 2024, there were more than 6,500 THWs registered and certified with the OHA THW program, which has doubled since the 2023 assessment. There are more than 7,700 certifications which indicates that some THWs are certified for multiple positions. Table 8.1 lists the number and distribution by type of THW certification.

Table 8.1. Traditional Health Worker Certifications by Type, October 2024

Traditional Health Worker Specialty Type	Number	Percentage
Birth Doula	368	5%
Community Health Worker (CHW)	1624	21%
Peer Support Specialist (PSS) Adult Addictions	2253	29%
Peer Support Specialist (PSS) Adult Mental Health	1434	18%
Peer Support Specialist (PSS) Family Support	290	4%
Peer Support Specialist (PSS) Youth Support	310	4%
Peer Wellness Specialist (PWS) Adult Addictions	569	7%
Peer Wellness Specialist (PWS) Adult Mental Health	718	9
Peer Wellness Specialist (PWS) Adult Addictions & Mental Health	115	2%
Peer Wellness Specialist (PWS) Family Support and Youth Support	6	1%
Personal Health Navigator (NAV)	85	5%

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Total	7,772	9%

The THW Commission conducted listening sessions with members in the September 2024 meeting to document the needs of the workforce. Community health workers and personal health navigators described needs around mentorship, paid internships, and onboarding; focus on self-care; advocacy for higher paying wages and for higher salary compensation for lived experiences and space to share their perspectives about the work.

People seeking to become a THW need to meet the training requirements for their worker type in order to qualify for state certification. Community Health Workers, Peer Wellness Specialists, Personal Health Navigators, and Peer Support Specialists, including the subtypes of Family Support Specialist and Youth Support Specialist, must complete an OHA-approved training program for that worker type. Birth Doula's who are seeking to become certified and be added to the registry, and who have yet to take a 28-hour Birth Doula foundational training, must take and complete an OHA-approved Training Program for Birth Doulas. As such, OHA offers these required trainings statewide and remotely.

A 2024 Traditional Health Worker Program Training Gap Analysis was presented in September 2024 to the THW Commission (See Figures 8.2 and 8.3). The analysis revealed that there have been 59 trainings, nearly twice as many since 2018, with an increase in trainings for Peer Support Specialists on Adult Addictions. Nearly half of trainings served the Portland Metro region. Over one-third of trainings were offered statewide. There were significant increases in the number of virtual or distance-learning options offered with only one-third of trainings limited to in-person (other trainings were offered as hybrid or distance learning). Training gaps in certain regions of the state included Central Oregon, coastal Oregon, Columbia Gorge and rural and frontier regions. In order to improve the distribution of THWs to reach all areas of the state, trainings should be targeted for regions with current training gaps.

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Figure 8.2. Traditional Health Worker Trainings by Type, 2024

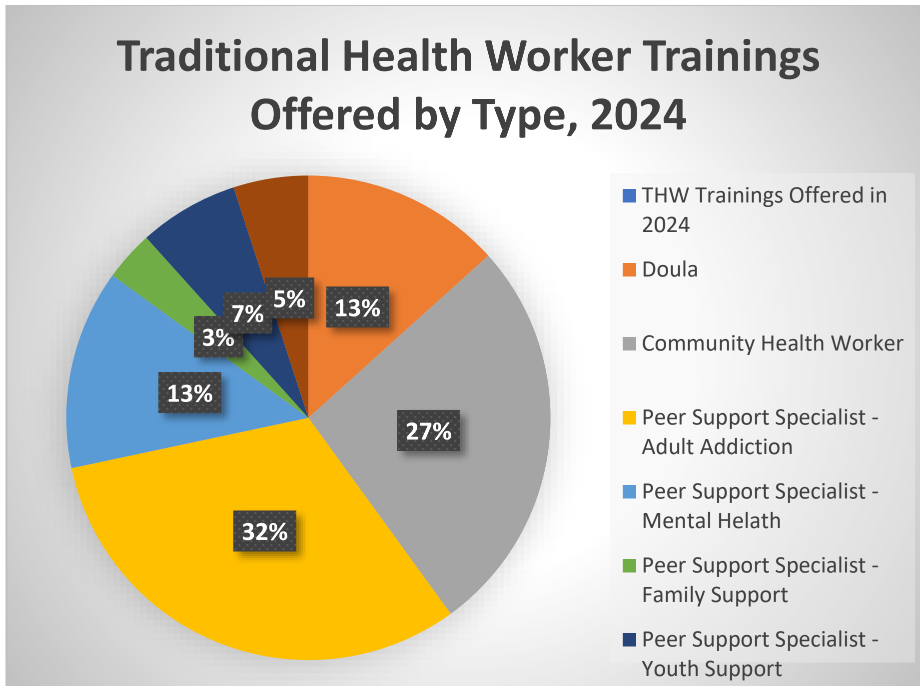
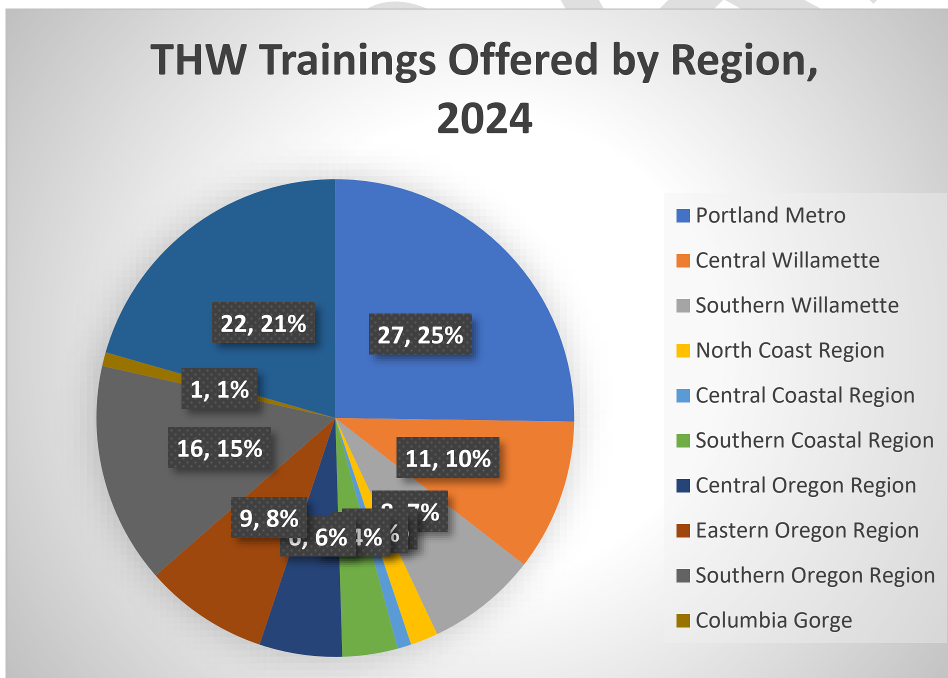


Figure 8.3. Traditional Health Worker Trainings by Region, 2024



Traditional Health Workers are integrated into service delivery. OHA requires contracted CCOs to develop an annual THW Integration and Utilization Plan. CCO-reported data

from 2023 show the number of THWs by worker type employed by each CCO and the ratio of THW to CCO member (See Table 8.4 below). Only 14 out of 16 CCOs reports were available online. Not all data were consistently reported by all CCOs. 12 out of 14 CCOs (87%) reported that they conducted member assessments for satisfaction with THW services in 2023 Table 8.4 provides the average number of THW by provider type and the range (minimum and maximum) employed with CCO. There were higher numbers of Peer Support Specialists and Community Health Workers than other types of THW. Some CCOs did not report any Peer Wellness Specialists and Patient Health Navigators.

Table 8.4. Average Number of Traditional Health Worker Employed at Coordinated Care Organizations (CCO) by Type, 2023

	Average Number of THW employed at CCOs	Range of THW employed at CCOs (min, max)	Average Ratio of THW: Number of CCO members
Birth Doula	22.5	(1, 146)	1 :6826
Community Health Worker	49.9	(7, 247)	1: 2459
Peer Support Specialist	89.4	(24, 239)	1: 870
Peer Wellness Specialist	8.9	(0, 51)	1: 17,700
Patient Health Navigator	5.1	(0, 36)	1: 12,422
Total Traditional Health Worker	175.9	(62, 719)	1: 451

Data in this table are averaged data tabulated from the 2023 CCO self-reported annual THW Integration and Utilization Plans. Employed was defined as either full or less than full-time, employed by the CCO or a provider, and employed in the clinic or in the community. Only 14 out of 16 CCOs reports were available online. Not all data were consistently reported by all CCOs. For instance, one CCO did not include their number of members and was not included in the ratio of THW workers to CCO members.

Recommendations on Future Workforce of Traditional Health Workers

The THW listening sessions and training gaps analysis reports proposed the following recommendations to advance the THW workforce:

- Increase pay and sustained funding for the workforce.
- Invest and expand THW trainings in rural and frontier counties (Southern and Eastern Oregon), coastal regions and the Columbia Gorge to increase the distribution of the THW to regions outside of Portland Metro.
- Develop strategies to improve onboarding, flexibility in schedules, and self-care.
- Conduct surveys with THW to provide more accurate on demographics, compensation, work environments, and training needs.
- Evaluate the impact of THWs with CCOs including number of members served, types of services provided, member satisfaction, and workforce demographics, trainings, and certification.

Examples of programs expanding the THW workforce are described below.

- Oregon Office of Rural Health has partnered with OHA to coordinate a CDC grant-funded program that will support the capacity of Oregon's public health agencies and Critical Access Hospitals by growing the Community Health Worker workforce in rural Oregon. Northeast Oregon Network or Oregon State University will provide training to 25 CHWs by spring of 2023. ORH will support a peer-to-peer network for CHW students.
- In 2024 and 2025, Community Health Worker apprenticeship hybrid programs were offered through OCHIN with HRSA funding. OCHIN will recruit culturally diverse participants in partnership with high schools and community-based organizations and support job placement following an internship. The first cohort started October 2024; a second cohort is planned for January 2025.
- OHA plans to expand the THW registry to be available in Spanish, test different payment models with CCOs and they included proposed funds in their 2025-2027 Agency Request Budget to invest in hubs to support doula work.

Health Care Interpreters

The Importance of Health Care Interpreters

Health Care Interpreters (HCIs) are specialized interpreters trained for the health care setting who are proficient in English and one or more other languages. They provide high-quality health care interpretation for people with limited English proficiency or provide signed language interpretation services. HCIs provide high-quality health care interpretation at in-person medical appointments or over the phone or video, as crucial partners to reduce communication barriers and health care disparities.

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The two national HCI certifying organizations are the National Board of Certification for Medical Interpreters and the Certification Commission for Health care Interpreters, which together offer exams for seven languages: Arabic, Cantonese, Korean, Mandarin, Russian, Spanish, and Vietnamese. As of 2023, there were 3,364 active certifications with the National Board of Certification for Medical Interpreters and over 5,000 certified interpreters nationwide through the Certification Commission for Health care Interpreters. The Registry of Interpreters for the Deaf lists around 10,000 certified American Sign Language interpreters in the United States.

Health Care Interpreters (HCIs) in Oregon

The HCI program at OHA was established in 2010 to help develop a well-trained workforce of HCIs to address language and communication barriers to access health care services. The Oregon Council on Health Care Interpreters advises OHA on administrative rules and policy standards for the HCI Program. Oregon Revised Statute (ORS) 413.550 health care providers work with Oregon certified or qualified HCIs.

The requirements for becoming a Qualified or Certified HCI in Oregon include 60 hours of formal health care interpreter training from an OHA-approved training program, and completing an equivalent language proficiency exam in English and a target non-English language. Certified HCIs in Oregon must also have passed a national certification exam from a recognized organization (mentioned above). Language proficiency can also be demonstrated degrees from their country of origin. Many interpreters do not have to prove English language proficiency if they attended high school and graduated in an English language country.

To increase the supply of certified spoken and Sign Language HCIs in Oregon, In 2021, the Oregon legislature passed HB 2359 which mandated that health care providers who are reimbursed with public funds work with a qualified or certified HCI who is listed on the central registry. The law went into effect on July 1, 2022. The program has developed training standards, curricula, and an HCI central registry enrollment process. OHA reduced barriers to the HCI application process by: 1) eliminating the application fee; 2) removing the background check requirement; 3) removing the previous work experience requirement; and 4) removing the requirement that upon renewal, qualified interpreters in languages that are certifiable must become certified, making this optional and permitting them to remain qualified.

Since the passage of HB2359, the numbers of credentialed HCIs on the central Registry has more than tripled. There are now over 2,200 Qualified and Certified Interpreters in the Oregon central Registry. (Table 9.1). The diffusion of languages has increased with over 50 languages representing African, Asian, Arabic, and Persian languages. The

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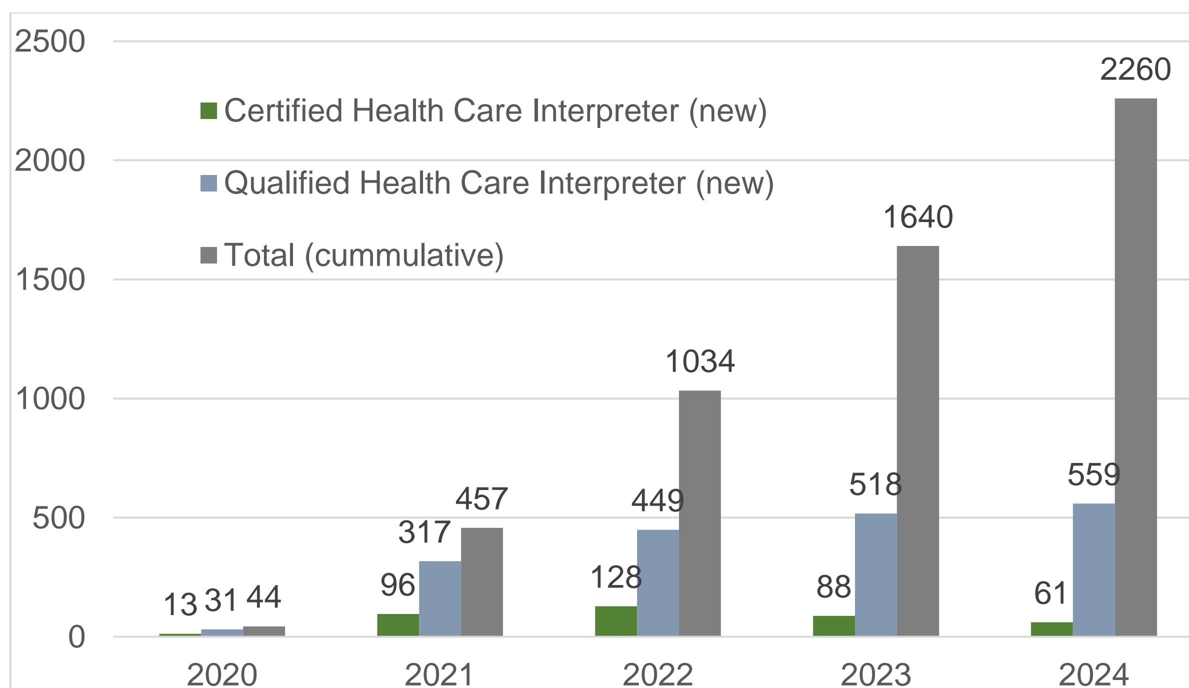
most common language represented in the central Registry is Spanish at 56%; approximately 15% of HCI on Oregon's central registry used American Sign Language.

Table 9.1. The number of new and cumulative qualified and certified interpreters on Oregon's HCI registry since 2020.



Data are from Oregon's Health Care Interpreter Registry as of September 29, 2024.

Although the number of certified and qualified HCIs has increased statewide, there is still a gap in meaningful language access for culturally responsive health care services. From the assessment of Oregon substance use disorder services updated in 2024, interpretation and translation services were rarely available in languages other than Spanish during sessions for substance use disorders. To achieve meaningful language access to culturally responsive health care, utilization of qualified and certified HCIs was adopted as a CCO incentive metric. In 2022, CCOs reported the percentage of visits with high-quality language services for members with interpreter needs for a random sample of members. From 2022 to 2023, CCO statewide performance increased from 5.6% to 10.7%. However, CCO statewide performance remained well below the 75% benchmark. Only four CCOs met their improvement target. Ongoing work is needed to improve access to HCI services, as well as data collection and reporting.

Recent data has been collected from OHP claims data of encounters of Oregon CCO members who needed interpreter services between 2020-2023. This ongoing study from a doctoral student at OSU uses data from OHA and analyzes 3.7 million encounters of Oregon CCO members with an identified interpreter need between

January 2020-December 2023. From 2020 through mid-2020, only around 5% of OHP members needing interpretation services met state standards. In 2021, HB 2359 mandated that health care providers who are reimbursed with public funds work with a qualified or certified HCI. Preliminary findings from these analyses were presented at the Oregon Public Health Association conference in October of 2024. Data provided below are personal communication with Felicity Ratway, doctoral student at OSU and Certified Medical Interpreter. Figures 9.2 below show the percentage of encounters with certified or qualified interpreters that are is listed on OHA's HCI central registry.

From analysis of the encounter data between 2020-2023, there is no shortage of interpreters, but access to interpreters varied by language. Most LEP/SL CCO appointments had no interpreter present. Approximately 1,036 interpreters on the OHA registry (OHA Qualified and OHA Certified interpreters) covered 2,401 CCO appointments during the study period. A large section of the interpreters who have worked in these encounters do not appear on the HCI central registry and may not be certified or qualified interpreters. When there is an interpreter present, they generally do not have state credentials. Remote appointments are less likely to have a credentialed interpreter. Most interpreters work other jobs because the median rate for credentialed interpreters was $25/hour, one-hour minimum, which translates to a median income of less than $19,000 per year. At the current median pay rate and hour minimum, there are not enough CCO appointments for interpreters on the registry to make a living wage.

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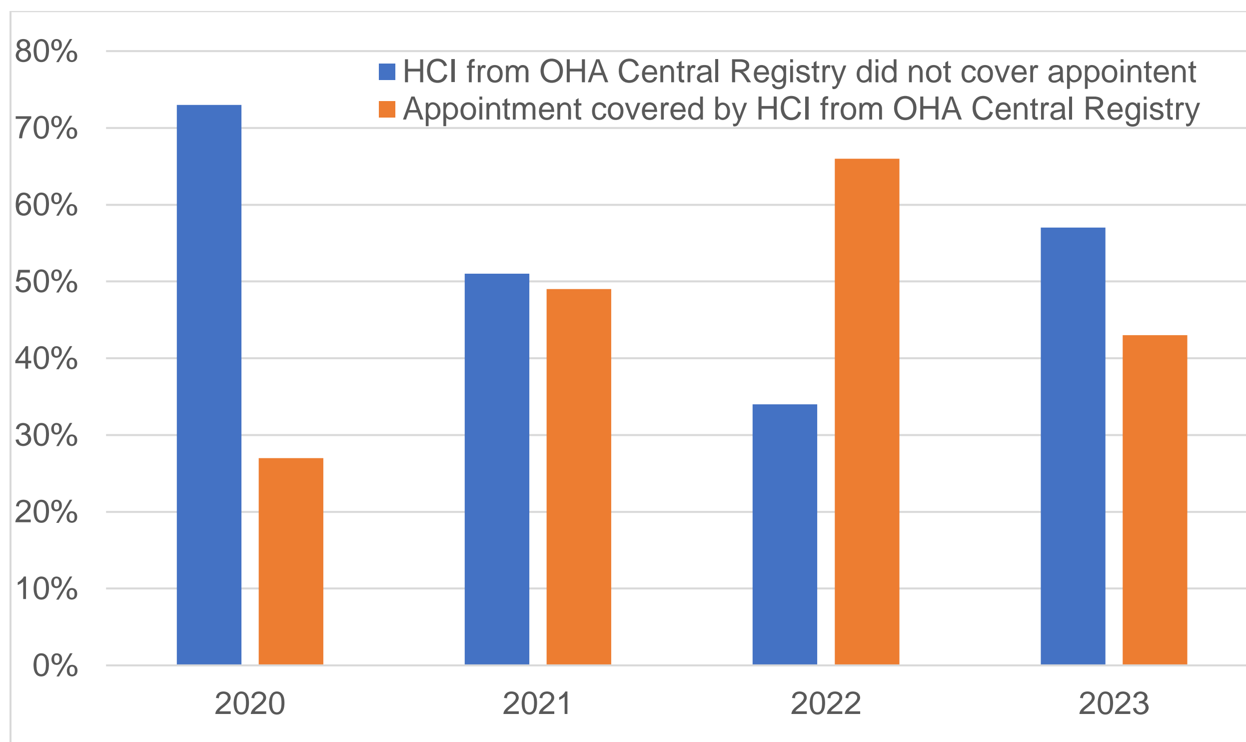
Figure 9.2. The percentage of CCO appointments for LEP/SP patients who received interpretation service by whether the services was covered by a HCI on OHA's central registry, 2020-2023



Recommendations for Future Workforce of Health Care Interpreters

Although the number of certified and qualified HCIs has increased statewide, there is still a gap in meaningful language access for culturally responsive health care services. Many CCOs and providers are still not working with certified or qualified HCI on Oregon's central registry. Recommendations for the future of the HCI workforce come from survey data, ongoing analyses, and from conversations with OHA staff and expert members:

- Continue to provide free HCI 60-hour training and CEUs, as legislatively mandated, and reduce barriers to Oregon's certification and registration process;
- Improve compensation (e.g., pay for a two-hour minimum and patient no-shows);
- Invest in expanding HCI training in rural communities experiencing growth in language access needs;
- Continue to promote or publicize HCIs available on the Oregon central registry to assist HCIs with being hired;

- Provide technical assistance for providers and health care systems to improve their language access plans for forecasting language access needs and auditing the quality of language access services; and
- Evaluate the process and compliance of working with qualified or certified HCIs including benefits and challenges to working with companies who provide language services versus hiring individual interpreters and compensation, recruitment and retention.

Primary Care Providers

The Importance of Primary Care Providers

Primary care is foundational to improve health and advance health equity for Oregonians. According to the American Academy of Family Physicians, "*A primary care practice serves as the patient's entry point into the health care system and as the continuing focal point for all needed health care services.*" Primary care professionals may include physicians and physician associates specializing in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine or obstetrics and gynecology; nurse practitioners specializing in family practice, geriatrics, pediatrics, internal medicine, obstetrics/gynecology/women's health; and naturopathic physicians specializing in family medicine, pediatrics, geriatrics or obstetrics.

National data from the Health of US Primary Care 2024 Scorecard Report shows the number of primary care physicians per capita has declined over time from a high of 68.4 per 100,000 people in 2012 to 67.2 PCPs per 100,000 people in 2021.While the rate of total clinicians in primary care, inclusive of nurse practitioners and physician associates, has grown over the past several years, it is still insufficient to meet the demands of overall population growth, a rapidly aging population with higher levels of chronic disease, and workforce losses during the pandemic.

Primary Care Providers in Oregon

The 2024 Licensed Health Care Workforce Supply report by OHA estimated there were 9,584 primary care providers actively practicing in Oregon, the majority (66%) of which were physicians (Table 10.1).

Table 10.1. Primary care providers supply estimates in Oregon, 2024

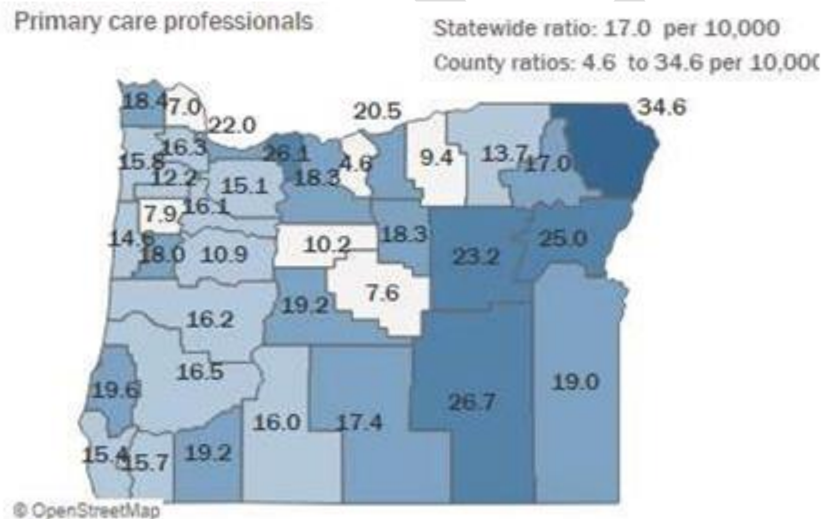
Occupation	Direct patient care FTE	Actively practicing professionals
Physicians	4,684	6,297
Nurse practitioners	1,439	1,936

Physician associates	794	1,015
Naturopathic Physicians	207	336
TOTAL	**7,124**	**9,584**

Source: OHA Office of Health Analytics. 2024 Oregon's Licensed Health Care Workforce Supply.

Figure 10.2 shows the direct patient care FTE for primary care professional to population ratios at state and county levels. The statewide ratio was 17.0 FTE per 10,000 Oregonians. The county ratios varied widely, ranging from 4.6 per 10,000 (Sherman) to 34.6 per 10,000 (Wallowa).

Figure 10.2. Primary Care Professional FTE per 10,000 Population, 2024

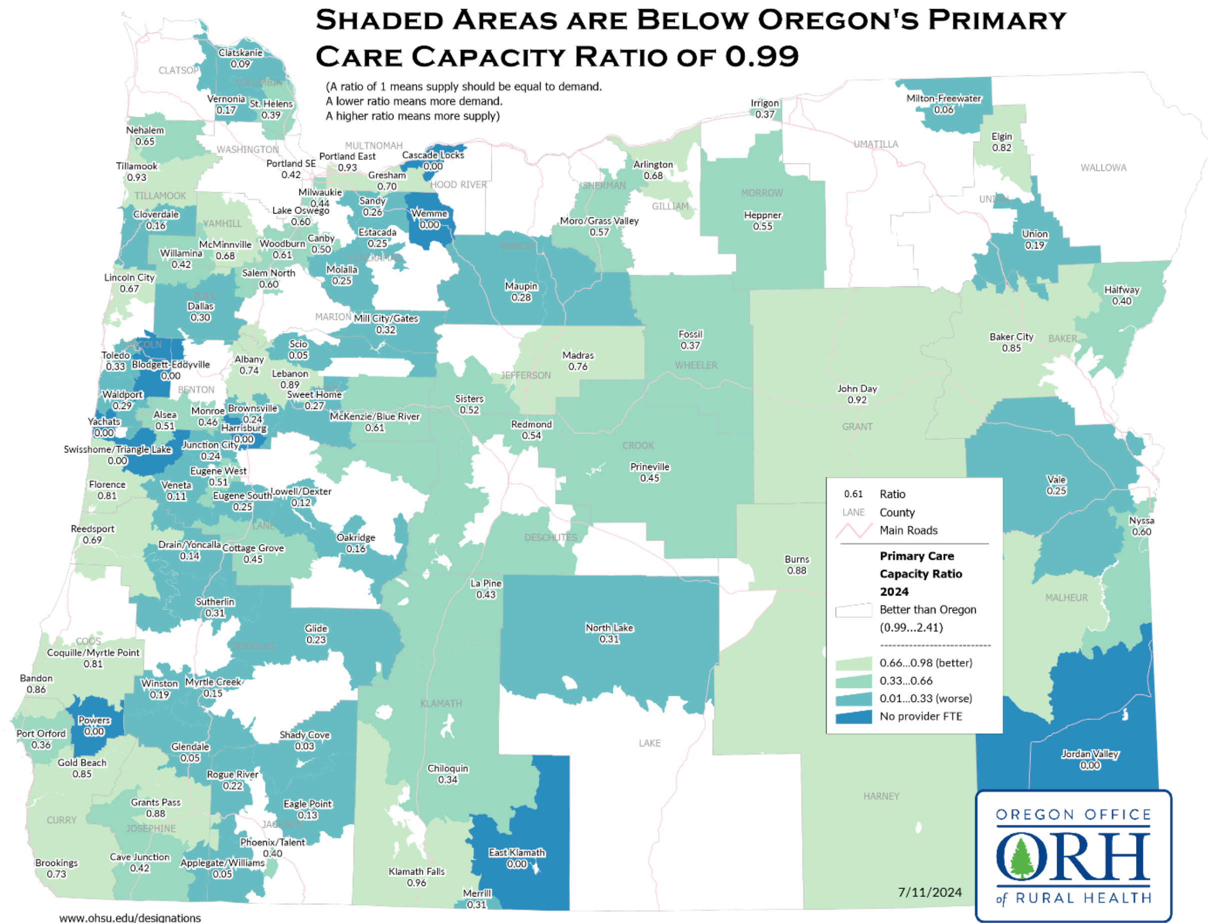


Source: OHA Office of Health Analytics. 2024 Oregon's Licensed Health Care Workforce Supply.

Figure 10.3 shows the primary care capacity by service area, with the shaded areas being below the statewide primary care capacity ratio. A primary care capacity ratio of 1.00 means that primary care supply should be equal to demand if access and affordability were equal for everyone. A ratio less than 1.00 means that there is more demand for primary care visits than supply. The estimated statewide primary care capacity ratio in 2024 was 0.99, meaning that with even distribution of providers across the state, there should be sufficient primary care capacity to meet patient needs. The primary care capacity ratio in urban areas increased from 1.13 in 2023 to 1.16 in 2024. However, rural and remote areas had a primary care capacity ratio of 0.69, indicating

that the number of health care providers was insufficient to meet the demand for primary care health delivery as calculated.

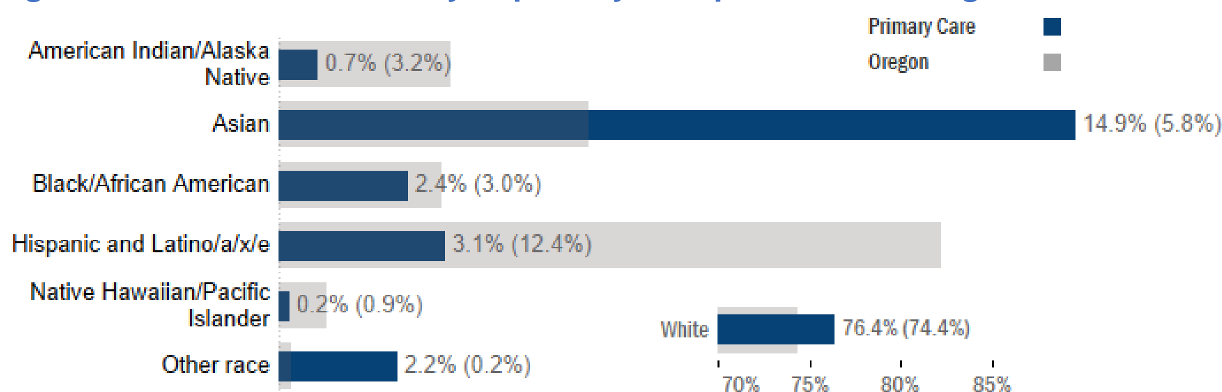
Figure 10.3. Primary Care Capacity by Service Area



Source: The Oregon Office of Rural Health. The 2024 Areas of Unmet Health Care Need Report.

As illustrated in Figure 10.4, Oregon's primary care workforce is less racially and ethnically diverse than the general population with Latino/a/x, African American/Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander providers being underrepresented (see the Health Care Workforce Reporting Program Data section for details by occupation).

Figure 10.4. Race and ethnicity of primary care providers in Oregon



Source: OHA Office of Health Analytics, Oregon's Health Care Workforce Reporting Program

There are shortages of primary care workforce across the U.S and in Oregon's graduate medical education pathway. The National Center for Health Workforce Analysis estimates that from 2021 to 2036, the demand of primary care workers will increase by 14%, while primary care workers supply will increase by only 9%. OED data indicates that family medicine physician positions are difficult to fill. The Health of US Primary Care 2024 Scorecard Report shows that Oregon had a smaller proportion of primary care medical residents (family medicine, internal medicine, geriatrics, and pediatrics) at 11.7 per 100,000 as compared to nationwide at 17 per 100,000. In addition, Oregon had a slightly higher percentage of primary care physicians trained in community-based settings (16.6%) compared to the national proportion (15.2%).

Recommendations for Future Workforce of Primary Care Providers

To achieve high-quality primary care and rebuild a strong foundation for the U.S. health care system, the Health of US Primary Care 2024 Scorecard Report and other data **suggest the following recommendations:**

- Diversify the primary care workforce and create culturally and linguistically responsive team-based care to meet the needs of the populations served.
- Expand educational pathway models and improve financial incentives.
- Increase primary care residencies in community and interprofessional settings.
- Address staff wellness and resiliency.

Examples of Oregon's efforts to advance primary care workforce are described below:

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- Aviva Health partnered with Mercy Medical Center to develop the Roseburg Family Medicine Residency supported by HRSA's Teaching Health Center grant and HOWTO Grant Program.
- The Oregon legislature passed Senate Bill 490 in 2023 to fund the Oregon Residency Collaborative Alliance for Family Medicine, which provides residents with networking and collaboration opportunities and scholarships for professional development, and supports faculty development and cultivation.
- OHA facilitates National Health Service Corps loan repayment and scholarships for primary care providers to practice in Health Professional Shortage Areas (also see Investments in Workforce Development section).
- OHA's Health Care Provider Incentive Program helps support underserved communities in their recruitment and retention of high-quality providers who serve patients regardless of their source of coverage or ability to pay (also see Investments in Workforce Development section).
- OHA's Patient-Centered Primary Care Home (PCPCH) Program, which promotes a model of high-quality, equitable primary care, has included a new standard in 2025 on cultural responsiveness of the health care workforce. This standard has two measures: 1) PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care and 2) PCPCH partners with one or more THWs or THW services.
- A total of 43 current PCPCHs, or 7%, have attested to the provision of oral health services by dental providers. A total of 383 current PCPCHs, or 62%, have attested to provision of integrated behavioral health services including population-based, same-day consultations by behavioral health providers.
- The PCPCH program has a standard on staff vitality to promote the safety, well-being, work satisfaction, growth, and the overall morale of PCPCH staff.

National programs to advance primary care workforce are summarized in Appendix G. In addition, recommendations on addressing workforce shortages and improving wellness and resiliency, and education and career pathways (see relevant sections) support development and retention of primary care workforce in Oregon.

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School Health Providers

The importance of school health and mental health providers

School-based health practitioners are critical to ensure the overall well-being and academic success of students. The Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973 require that school districts provide these services if needed by a student to access their public education. The requirement for school districts to ensure every student access to a Free Appropriate Public Education (FAPE), ensures that students with disabilities have access to an education that is both free of charge and designed to meet their unique learning requirements. These medical professionals support not only students receiving special education but also the general student population and school- and district-wide education initiatives.

School Health Providers in Oregon

School nursing is a highly challenging environment where nurses provide complex care to students, including seizure and diabetes management, tracheostomy care, catheterization, and specialized cardiac support. Beyond direct care, school nurses are the only qualified staff who can train and supervise others in administering nursing services, as required by the Oregon Nurse Practice Act. They also oversee health promotion and disease prevention for the entire student population, ensuring students can safely participate in their education. Two types of professional nurses, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), may practice in the school setting.

As shown in the below table, school nurse FTE increased from 279 in 2017-18 school year to about 408 in 2023-24 school year. Total nurse FTE also increased from around 310 to 483 during the same period. Despite the increasing nurse FTE, student health needs still exceed the capacity of available school nurses and LPNs in most school districts. In school year 2023-24, the statewide school nurse-to-student ratio (1:2,267 for general population students) is almost three times higher than the recommended ratio, with only 19 school districts (10%) meeting this recommended ratio. Out of the 151 school districts that reported medically fragile, medically complex, and/or nursing dependent students enrolled in their district, five reported no nurse FTE. A total of 44 school districts (22%) did not report any school nurse FTE.

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Table 11.1. Nurse FTE and Nurse to Student Ratios in Schools

School year	2017-18	2018-19	2019-20	2020-21	2021-22 *	2023-24
Registered Nurse/School Nurse FTE	279.2	295.6	311.92	329.67	363.59	407.55
Licensed Practical Nurse FTE	30.44	44.4	64.57	49.98	63.33	75.89
Total Nurse FTE in Schools	309.64	340	376.49	379.65	426.92	483.44
Statewide Ratio of school nurses to General Population Students (recommended ratio 1:750) **	1:5,481	1:5,565	1:4,572	1:3,346	1: 2,843	1:2,267.24

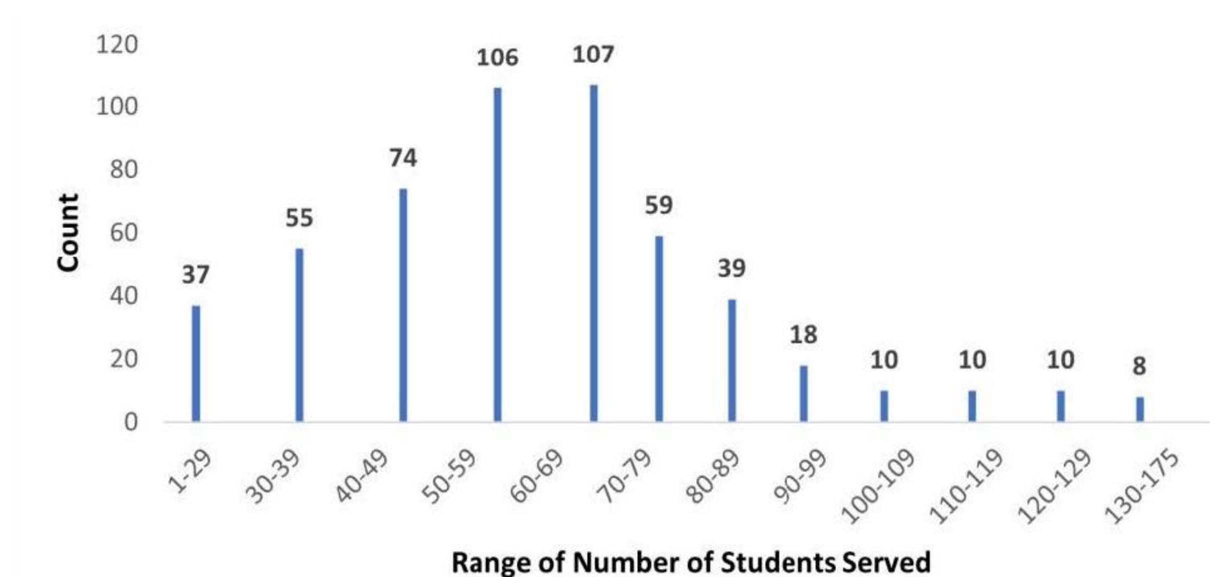
Source: Oregon Department of Education. School Nurses Annual Report.

* The State Board of Education paused data collection for the 2022-23 school year per legislative directive

**This ratio represents the nurses' FTE (of those who are not already designated for students with medical needs) to remaining students after subtracting those with medical needs from the total population.

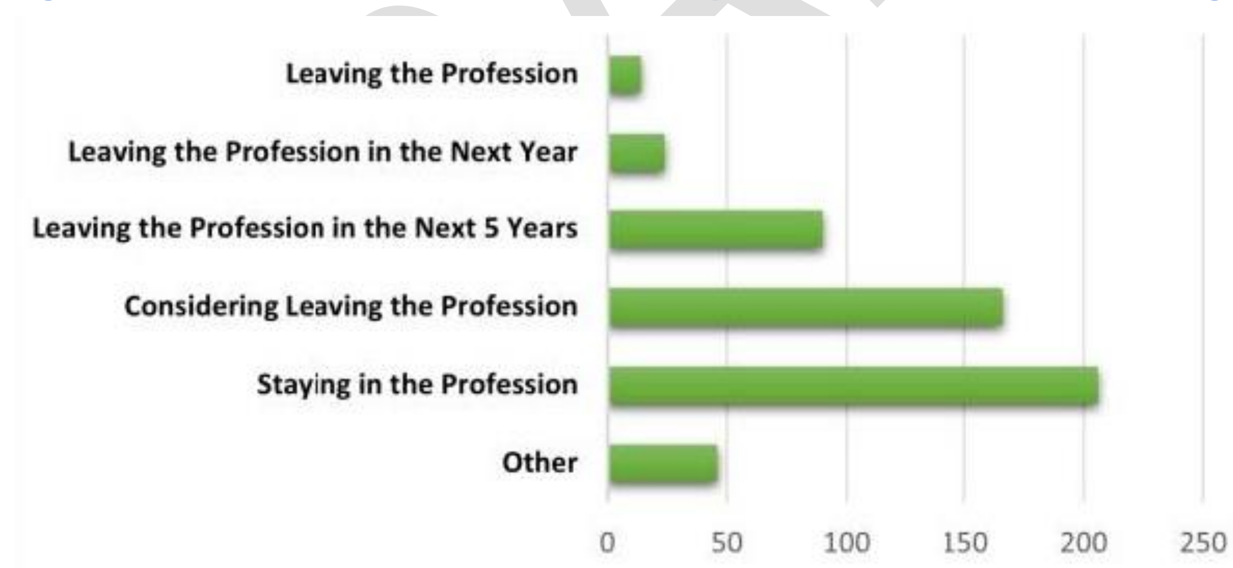
In addition to nurses, there is a wide variety of licensed health care professionals practicing in Oregon schools including Occupational Therapists (OT), Physical Therapists (PT), and Speech-Language Pathology (SLP) therapists. The Oregon Department of Education reported that OT, PT, and SLP services in schools are critical to ensure the overall well-being and holistic development of students. ODE recently conducted a study on school-based OTs, PTs, and SLPs in accordance with House Bill 2618 (2023). The study received 548 responses from these practitioners, more than 60% of whom serve over 50 students with Individualized Education Programs and Section 504 plans (Figure 11.2).. Approximately 70% of the respondents in the study work at multiple locations. Over 80% of licensed practitioners responded that their workload impacted their ability to provide services to students. Only 38% of the licensed practitioners definitively indicated that they were planning to stay in the education field (Figure 11.3)..

Figure 11.2. Students served with Individualized Education Programs and Section 504 plans per OT, PT, SLP practitioner



Source: Oregon Department of Education (2024). HB 2618 Report.

Figure 11.3. Professional outlook for licensed practitioners in the school setting



Source: Oregon Department of Education (2024). HB 2618 Report.

Table 11.4 shows adjusted FTE data on staff members at a public school, district, or education service districts for at least 20 consecutive days over a school year. FTE for school health services in Oregon has been increasing over the last five school years.

Special education speech pathology services had the largest adjusted FTE, while special education audiology services had only around 12 adjusted FTE in a school year.

Table 11.4. Adjusted FTE for school health services *

School year	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Nurse, Non-Special Education	208.57	227.03	261.79	281.88	282.74
Special Education Medical and Nursing Staff	81.03	80.51	95.81	102.33	123.13
Special Education Audiologist	13.75	11.75	12.2	10.35	11.59
Special Education Speech Pathologist	933.62	968.85	979.36	977.54	1027.63
Special Education Occupational Therapist	179.39	189.2	191.44	196.11	215.9

Source: Oregon Department of Education.

*The FTE shown is adjusted to reflect staff that worked a short school year. Adjusted FTE = FTE * Contract Length / Full Contract Length

School Mental Health Providers in Oregon

Youth in Oregon have consistently reported some of the highest mental health needs in the country and are among those least likely to receive psychological services. One of the major contributing factors to this lack of available services rests in a chronic shortage of licensed and qualified mental health providers. Examples of school mental and behavioral health providers include but are not limited to School Counselors, School Psychologists, School Social Workers, and Other Qualified School Personnel.

Table 11.5 shows adjusted FTE data on staff members at a public school, district, or education service districts for at least 20 consecutive days over a span of time that includes December 1st of a given school year. FTE for school mental health services in Oregon has been increasing over the last five school years.

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Table 11.5. Adjusted FTE for school health services

School year	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Social Worker, Non-Special Education	(No data)	(No data)	(No data)	158.46	189.17
Special Education School Social Workers	12.93	38	22.02	23.76	38.27
Psychologist, Non-Special Ed	65.75	53.69	63.12	70.65	85.44
Special Education Psychologist	303.14	341.75	328.38	326.96	344.74
Guidance Counselor, Non-Special Ed	1315.1	1449.45	1615.76	1630.14	1639
Special Education Counselors and Rehab Counselors	48.03	52	20.2	16.59	20.36

According to the America's school mental health report card, the state has an average of one school psychologist for every 3,393 students, one school social worker for every 8,831 students, and one school counselor for every 461 students. This is well below the recommended ratio for each provider type illustrated below. In addition to board-licensed mental health providers (e.g. psychiatrists, psychologists, clinical social workers, professional counselors, marriage and family therapists, and registered nurses), there are mental and behavioral health providers unique to the school setting, such as school counselors, school psychologists, and school social workers. Table 11.6 below shows school mental health professionals to Student Ratios in Oregon Schools.

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Table 11.6. School mental health professionals to Student Ratios in Oregon Schools

	School psychologists	School social workers	School counselors
Statewide ratio of school mental health professionals to students	1:3,393	1:8,831	1:461
Recommended Ratio	1:500	1:250	1:250

Source: Hopeful Future Campaign (2022). America's school mental health report card

Recommendations on the future of school health providers

A recent ODE report concluded that "*Oregon schools are experiencing significant staffing shortages across all school health service providers,*" and "*this shortage has led to increased workload concerns.*" The 2023 Oregon School Nurse Survey conducted by the OHA Adolescent and School Health unit proposed the following recommendations to improve and help the school nursing role to better serve students:

- Better staffing of school health teams, and more time for school nurses to focus on priority work;
- Greater understanding and utilization of the school nurse role;
- Increasing time and better materials for training school staff for student support;
- Enhancing school nurse training and support, such as better health professional leadership and opportunities for school nurse professional development;
- Improving resources for school health work, including funding, documentation systems, functional workspace, and partnerships with community providers;
- Improving equitable access to health services and education, particularly for under-resourced populations.

ODE recommends establishing a workload methodology for occupational therapists, physical therapists, and speech-language pathologists in a school setting:

- Include any additional workload elements and considerations that are specific to Early Intervention / Early Childhood Special Education contractors.
- Include school Medicaid billing, which help fund additional health services staff, purchase health supplies and assistive technology, teaching materials, etc.

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- Require state-level infrastructure to facilitate standardized practices, promote consistency, and foster collaboration across education institutions.
- Invest in statewide technology systems to help reduce workload constraints.

ODE and partners at OHA and Oregon Department of Human Services are implementing innovative strategies to scaffold the mental health workforce, which are summarized in Appendix H. This workforce is not included in school workforce counts or ratios. Consistent funding for this and other emerging youth mental health workforce solutions, will help to ease the mental health workforce burden in Oregon.

Nursing Workforce

The Importance of the Nursing Workforce

Nurses practice in almost all Oregon health care settings, including primary and specialty outpatient care, inpatient and post-acute care, home health, schools, public health, and behavioral health. Different levels of nursing licensure reflect increasing clinical responsibilities and independence that require higher levels of training:

- Certified nursing assistants (CNAs) work under the direction of licensed nurses to provide care such as assistance with activities of daily living. In Oregon, CNAs must complete at least 155 hours of classroom instruction and supervised clinical practice.
- Licensed practical nurses (LPNs) provide basic nursing care such as medication administration or dressing changes. LPNs must complete a community college or vocational education program and pass a national licensing exam.
- Registered nurses (RNs) provide advanced nursing services such as patient assessment, care planning, patient education, and care coordination. RNs must obtain an associate or bachelor's degree and pass a national licensing exam.
- Advanced practice registered nurses (APRNs) must complete a master's or doctoral degree. The most numerous APRNs are nurse practitioners (NPs), who can practice independently and are often primary care providers. Nurse midwives, nurse anesthetists, and clinical nurse specialists are also APRNs.

Oregon's Nursing Workforce

In the United States, nurses are licensed at the state level. Oregon State Board of Nursing (OSBN) works within the requirements of the Oregon Nurse Practice Act and other state legislation. Oregon Center for Nursing (OCN) analyzes data from OSBN and other sources to characterize the demographics, education, and practice patterns of Oregon nurses.

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Seven in 10 of Oregon's approximately 109,000 licensed nurses are RNs. Table 12.1 shows the number of nurses at each level of licensure and the estimated proportion practicing in Oregon in 2023. Although the number of practicing CNAs was unchanged from 2020 to 2023, the number of practicing LPNs, RNs, and APRNs grew by over 25%. The proportion of licensed nurses in each category who were actively practicing was very similar in 2023 and 2020.

Table 12.1. Licensed and practicing nurses in Oregon

	CNAs	LPNs	RNs	APRNs
Licensed	18,530	6,150	75,188	8,638
Practicing	16,100	5,150	56,200	6,590
Percent practicing	86.9%	83.7%	74.7%	76.3%
Change from 2020	-1%	+9%	+20%	+34%

Source: OCN analysis of OHA 2023 Public Use Nursing Workforce Data File

Oregon community colleges offer four LPN programs and 17 associate degree of nursing (ADN) programs. There are also eight bachelor of science in nursing (BSN) programs, including five Oregon Health & Science University (OHSU) campuses. In the past decade, Oregon BSN programs have produced an increasing number of graduates, while the number of ADN graduates has remained relatively flat and the number of Oregon LPN graduates has decreased.

RN program graduates who successfully complete the national licensing exam in Oregon are licensed via "examination." RNs who are licensed in other states can also apply to OSBN to be licensed in Oregon via "endorsement." The number of RNs licensed by endorsement began to increase very rapidly in about 2010, and now exceeds licenses via examination. However, OCN estimates that only about one in three RNs licensed via endorsement from 2010 to 2018 actually practice in Oregon. Importantly, RNs licensed via endorsement are more likely to practice in Oregon's small, rural communities.

The Nursing Licensure Compact is active in 42 states (not including Oregon) and allows nurses licensed in one Compact state to practice in any other participating state. Joining the Compact would make it easier for nurses to move to Oregon, or to provide telehealth services across state lines. However, this would also reduce OSBN revenue and could hinder accurate tracking of the nursing workforce.

Across all license types, 80% of practicing Oregon nurses are female. Among Oregon RNs, 84% are female compared to 88.5% nationally. The age distribution of Oregon

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nurses has shifted: the largest age cohort of RNs was 55-60 years in 2012 but was younger (35-44) in 2023.

Table 12.2 shows that Oregon CNAs and LPNs are more racially and ethnically diverse than RNs and APRNs. The proportion of LPNs, RNs, and APRNs who are Hispanic or Latino/a/x is lower than among the overall Oregon population. Oregon nursing students are more diverse than practicing RNs, with 40% of BSN students being White, 18% Asian, and 18% Hispanic or Latino/a/x.

Table 12.2. Race and ethnicity of Oregon's nursing workforce and population

Race/Ethnicity	CNA	LPN	RN	APRN	Oregon Population
African American or Black	9%	6%	3%	5%	2.0%
American Indian/Alaska Native	2%	1%	1%	1%	1.1%
Asian	7%	5%	5%	5%	5.0%
Hispanic or Latinx	16%	8%	4%	3%	13.6%
Native Hawaiian/Pacific Islander	1%	<1%	<1%	<1%	0.4%
White	47%	60%	67%	68%	73.5%
Multiple race	5%	5%	4%	4%	4.3%
Other	1%	1%	1%	1%	0.0%
Unknown/Declined	13%	12%	14%	14%	0.0%

Source: OCN analysis of OHA 2023 Public Use Nursing Workforce Data File and US Census Bureau (2020)

Geographically, nurses are not evenly distributed across Oregon's 36 counties, with many rural counties having fewer nurses than would be expected based on their population. In addition to the nurse recruiting and retention challenges that all health care settings face, OCN research has identified additional barriers in rural areas, including housing availability and limited spouse/partner employment opportunities.

The setting in which Oregon nurses practice varies by type of license (Figure 12.3). The majority of CNAs practice in long-term care facilities (47%) or hospitals (39%). Most LPNs practice in long-term (39%) or outpatient (24%) care. Over half (54%) of RNs practice in hospitals, while over half (53%) of APRNs practice in outpatient care.

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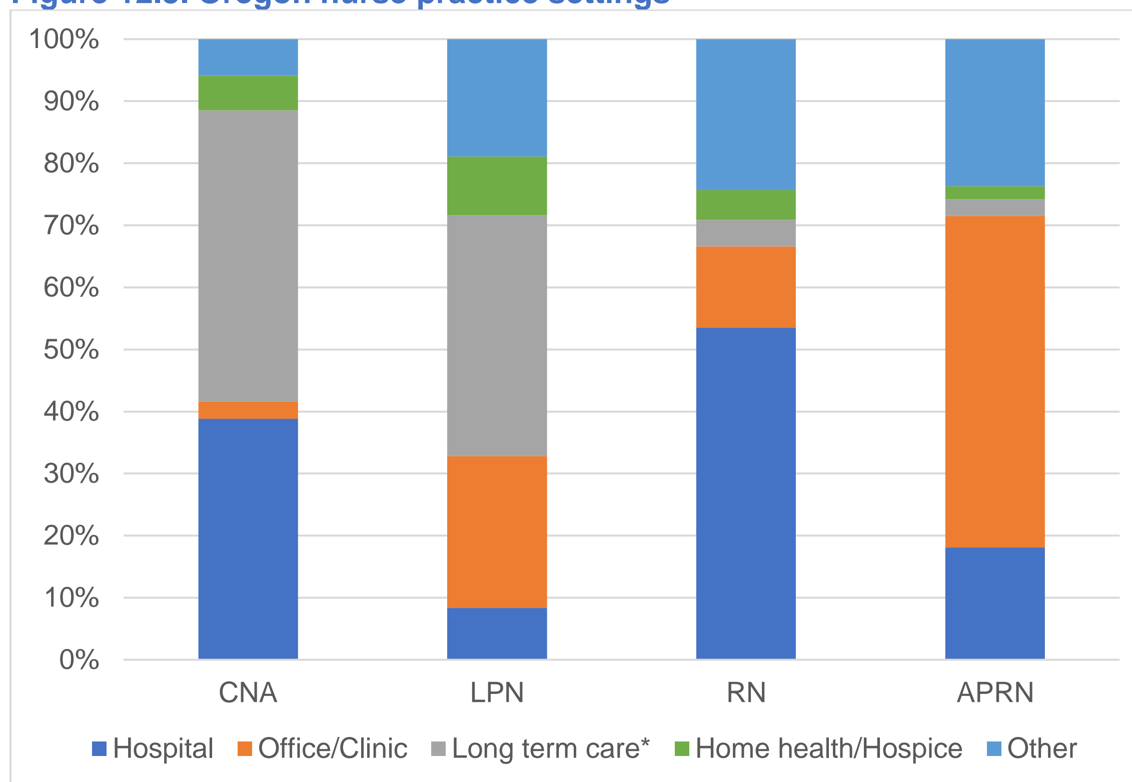
Figure 12.3. Oregon nurse practice settings



Source: OCN analysis of OHA 2023 Public Use Nursing Workforce Data File
* Long-term care includes Skilled nursing facilities, Assisted living, Residential care, Adult foster homes

Demand for nurses is driven by the number and acuity of patients who need inpatient, outpatient, and long-term care, and also depends on nurse workload in each care setting.[1] Oregon skilled nursing facilities (SNFs) are currently required to meet minimum staffing requirements for CNAs and RNs. New national staffing rules become effective between 2026 and 2029, with the earliest implementation in urban areas. The nursing facility industry has vigorously opposed these new rules as infeasible, especially the requirement to have an RN on duty 24 hours every day.

Oregon and California are the only states that mandate nurse-to-patient ratios in multiple hospital units. HB 2697 mandates maximum ratios that depend on the type of unit and the shift. These inpatient ratios become effective June 1, 2024, superseding previous Oregon law requiring each hospital to develop and implement a nurse staffing plan, approved by the hospital nurse staffing committee. Hospitals that fail to meet the required ratios can face civil penalties beginning in June 2025.

[1] See Appendix I for more details on required SNF and inpatient staffing ratios.

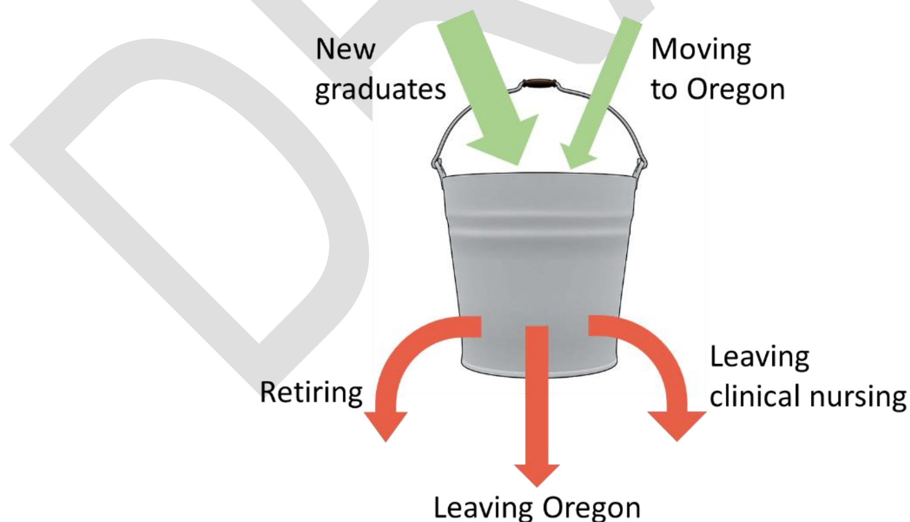
Nurse compensation in Oregon is higher than in most other states. Oregon wages for CNAs are slightly (1%) higher than for other entry-level jobs, a level that is 9th highest among states. Oregon has the 3rd highest average RN wage of any state. On average, Oregon RNs earn $55/hour, with variation across practice settings: RNs in public health, residential care, and school settings earn less than $50/hour, while those in hospital earn over $58/hour. Wages also vary geographically, being highest in the Portland metro area and lowest in eastern Oregon. Nevertheless, as described further below, pay alone does not appear to be sufficient to ameliorate nurses' concerns about their work environments.

Future of the Nursing Workforce

Although Oregon's nursing workforce is currently growing, a vacancy crisis in clinical settings and high workplace stress persist. This complex landscape (further described in Appendix I) calls for sustained policy action as outlined in the policy recommendations below.

The size of Oregon's nursing workforce depends on both the *inflow* of newly licensed nurses and the *outflow* of nurses leaving clinical. OCN describes this challenge as a "leaky bucket," where high outflow makes it very difficult to maintain an adequate inflow (Figure 12.4). Policy solutions should therefore aim both to increase inflow, especially by **strengthening Oregon's nursing education pipeline**, and stemming outflow by **increasing retention of nurses in clinical roles**.

Figure 12.4. "Leaky Bucket" model of Oregon Nursing workforce



Strengthen Oregon's Nursing Education Pipeline. Oregon's nursing education programs graduate the 3rd lowest number of nurses per capita of any state. OCN

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estimates that only about 72% of Oregon's annual demand for new RNs is met by graduates of the state's nursing education programs, with the balance made up by an increasing number of RNs from other states gaining Oregon licenses by endorsement.

An in-depth report by the Oregon Longitudinal Data Collaborative (OLDC) described the shortcomings of the state's nursing education system as well as the underlying causes. Oregon's RN education programs have the capacity to enroll only one in four qualified applicants. This capacity would have to be increased by almost 70% (approximately 1,000 additional graduates per year) the meet the state's demand for new RNs.

Oregon's inadequate nursing education capacity has two main causes. First, difficulty in recruiting nursing faculty members, primarily because pay for nurse educators is low compared to what they can earn in clinical settings. Second, there are too few opportunities for the clinical placements that nurses in training must complete.

OLDC recommends the following steps to increase Oregon's nursing education capacity:

- Identify statewide approaches to increase pay for nursing faculty
    - The Legislature moved toward this goal by providing $5M for the Retaining and Elevating the Nurse Education Workforce (RENEW) initiative, which is conducting research on recruiting and retaining nurse educators and will provide grants to test solutions at public education programs.
- Expand clinical placement capacity. One potential approach is a centralized statewide clinical placement system that would reduce unproductive competition for placements among education programs and hospitals.
- Fund expansion of lab and simulation facilities at nursing education programs
- Conduct additional research into other barriers that nursing students—especially those from underrepresented groups who can increase the diversity of Oregon's nursing workforce—face in enrolling in and completing nursing degree programs.
- Conduct additional research about how to increase retention of nursing graduates, especially during their first few years of clinical practice.

Increase Retention by Promoting Health Work Environments. Researchers and labor organizations are making increasingly clear that improving retention in clinical settings is essential to maintain an adequate nursing workforce. Several key factors affect nursing retention:

- The concern that nurses raise most often is inadequate staffing. This contributes to burnout and is associated with worse patient outcomes. The new HB 2697 requirements described above should improve nurse staffing in Oregon hospitals. The impact of these new requirements on patient outcomes, non-nurse staffing

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levels, and nurse satisfaction should be systematically evaluated when they are fully implemented.

- Another prevalent concern is workplace violence or abuse. Eight in ten nurses report being subject to verbal or physical abuse, discrimination, or sexual harassment at work in 2021. Health care organizations should take affirmative steps to protect all employees from abuse, discrimination, and harassment.
- The American Association of Critical-Care Nurses has promulgated Healthy Work Environment (HWE) standards that, in addition to Appropriate Staffing, include dimensions such as True Collaboration, Meaningful Recognition, and Authentic Leadership. The comprehensive Magnet model, which incorporates multiple HWE dimensions, can also dramatically lower nurse turnover.
- Other surveys confirm the high value that nurses place on having employers listen to their concerns and value their contributions. A Nurse Staffing Think Tank listed HWE as the highest priority solution to the nurse staffing crisis. OCN's RN Well-Being Project outlines structural changes to the nursing work environment that can be implemented in Oregon.
- Wellness and resilience programs help to mitigate burnout within existing work situations. For example, the Oregon Wellness Program provides free counseling and education to health care professionals including nurses. However, nurses have a clear preference for structural work environment changes.

Although few employers have systematically implemented HWE interventions, RNs' work satisfaction is much higher in units that have. A major barrier implementing HWE is that Medicare and Medicaid reimbursement models do not adequately support the necessary organizational changes. Nevertheless, evidence shows that systematic work environment changes reduce burnout and enhance retention of nurses.

Long-Term Care Workforce

Oregon's Long-term Care Workforce

Many older adults and people with physical or mental disabilities need long-term services and supports (LTSS). Oregon offers LTSS in beneficiaries' homes and a continuum of residential care settings described in Appendix J. Oregon leads the nation in home and community-based LTSS, with fewer than 10% of Medicaid beneficiaries receiving LTSS only in skilled nursing facilities.

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The direct care workers who provide LTSS in Oregon must meet different levels of certification, depending on the setting in which they work:

- Home care workers, including personal support workers and personal care attendants, must have eight hours of orientation and training (with four additional hours if they administer medications) and complete six hours of continuing education annually.
- Staff at community-based care (CBC) facilities such as assisted living or residential care must complete a training program at their facility and demonstrate proficiency in topics such as resident care services, safety, and dementia needs. Twelve hours of annual continuing education are required.
- Certified Nursing Assistants (CNAs) in skilled nursing facilities must complete 155 hours of training, pass an examination, and complete 12 hours of continuing education annually.

Because training for direct care work is relatively limited, it offers opportunities to workers who could also work in other entry-level jobs such as hospitality, retail, or food service. Direct care workers must also pass background checks, which vary in effectiveness and may pose equity barriers.

PHI, a national direct care workforce research and advocacy organization, produces annual estimates of each state's direct care workforce. Oregon had 46,720 direct care workers in 2023, including 33,060 personal care or home health aides and 13,660 CNAs[2]. Although there is significant variability in PHI's annual estimates, it appears that the size of Oregon's direct care workforce was relatively flat from 2028 to 2023, despite steadily increasing demand for LTSS.

Among Oregon's direct care workforce:

- Eight in 10 are female
- One in three is a person of color
- One in six is an immigrant
- Two in 10 hold an Associate's degree or higher level of education
- Two in five have household incomes below 138% of the FPL
- One in three receives public food or nutrition assistance
- More than one in four is insured by Medicaid, and one in 10 (three times the statewide average for employed individuals) is uninsured

[2] CNAs, including those who do not work in long term care, were also counted in the Nursing section of this report.

The population needing LTSS is growing rapidly: the number of Oregonians age 85 and older (who are most likely to require LTSS) is expected to grow 29% by 2030 compared to 2023. As a result, PHI estimates that Oregon's direct care workforce will grow by 22% in 2032 (compared to 2022).

Recruiting, retention, and compensation challenges in long-term care.

Employee turnover among the direct care workforce is extraordinarily high. Only half of direct care staff at Oregon ALFs and RCFs work at the same facility for more than a year. Nationwide, staff turnover at SNFs is over 50%. Annual turnover among home care workers has historically been very high, and remained at almost 80% in 2023.

Vacancy rates are less precisely measured but remain high. SNFs across the country report great difficulty in hiring staff, with total employment still below pre-pandemic levels and almost half of SNFs limiting admissions due to staff shortages. Most assisted living facilities also report significant difficulty in hiring staff. One in four referrals for home care is denied because of insufficient staff at home care agencies. And relative to the population of older adults, the number of direct care workers is much lower in rural areas than in urban areas.

The COVID-19 pandemic led to an acute long-term care staffing crisis nationwide and in Oregon. Before vaccines became available, half of COVID-19 deaths were among long-term care facility residents and staff, and home care workers with limited access to personal protective equipment were at very high risk of COVID-19 exposure. The number of staff in Oregon long-term care facilities dropped dramatically in 2020 and 2021, and by June 2024 was still somewhat below the pre-pandemic trend (Figure 13.1).

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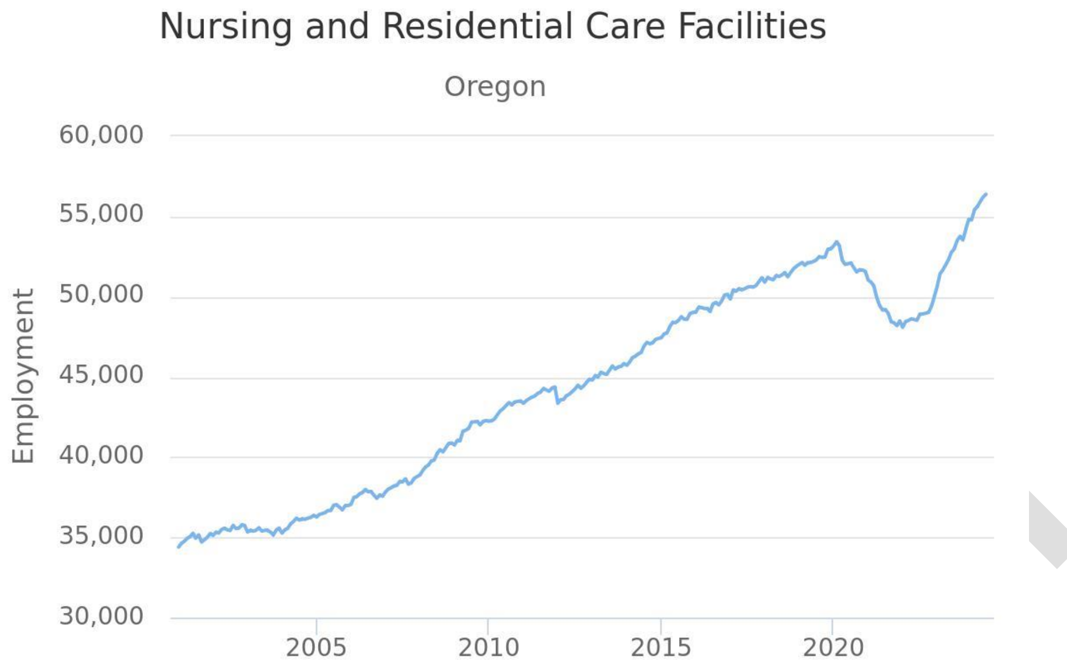
Figure 13.1. Total employment in Oregon long term care facilities



Long-term care facilities responded in part by increased hiring of agency or contract staff. The nationwide proportion of SNFs using contract CNAs doubled from 2019 to 2022, and was associated with lower quality care for residents. Greater use of agency staff also significantly increased costs for Oregon long term care facilities. HB 2665, enacted in 2023, directed OHA to set maximum rates for temporary nursing and direct care staff. OHA has conducted an environmental scan of wage levels and temporary staffing rate caps in other states, developed a rate setting methodology, and plans to finalize rules maximum wage rates effective January 2025.

Staffing shortages at SNFs and CBC facilities led to hospital “boarding,” or extremely long lengths of stay, for patients who could not be discharged. A February 2023 OHA analysis showed that over 40% of Oregon hospitals’ discharge referrals to long term care facilities were denied. In June 2023, the Legislature approved HB 3396, which established a Joint Task Force on Hospital Discharge Challenges charged with developing recommendations to address Oregon hospitals’ challenges in discharging patients to post-acute care. The Task Force’s final report was to be submitted to the Legislature by November 2024.

A wide range of analyses have identified several causes of longstanding high turnover and vacancy rates among direct care workers. The most important are low pay and

limited benefits, but other reasons (described in more detail in Appendix J) include poor working conditions, limited training, few career advancement opportunities, and a widespread undervaluation of direct care work.

A comprehensive report by the Assistant Secretary for Planning and Evaluation (ASPE) in the US Department of Health & Human Services (HHS) documented that wages for direct care workers are lower than for other entry-level jobs in every state. In Oregon, median wages for home health and personal care aides were 83% of those for other entry-level positions, a proportion that is actually the 10th highest among states. Oregon wages for CNAs are slightly (1%) higher than for other entry-level jobs, a proportion that is 9th highest among states. Other research showed that direct care workers in long-term care are generally paid less than those working in hospitals.

In addition to low hourly wages, many direct care workers are employed part time, and often juggle work for multiple employers. Many direct care workers in Oregon depend on overtime hours, when available, to earn a living wage. Nevertheless, PHI ranks Oregon 3rd in the nation on an index that comprises wages, benefits, housing costs, and state labor laws and policies to protect LGBTQIA2S+ workers.

Numerous reports, including by the National Governors Association, the Bipartisan Policy Center, and the Kaiser Family Foundation (KFF) have highlighted that long-term care facilities' and home care agencies' ability to raise direct care workers' pay and benefits is limited by low Medicaid reimbursement levels as well tight family budgets for home care. For SNFs, new federal staffing standards (described in the Nursing section of this report) will magnify this challenge in future years.

Pursuant to SB 703, Portland State University (PSU) measured direct care worker wages, total costs, and Medicaid reimbursement at Oregon ALFs, RCFs, and MCCs. They found that for a typical ALF or RCF, Medicaid reimburses 75% to 88% of operating costs. There was wide variation across facilities, with a third of RCFs having Medicaid reimbursement less than 60% of costs, but a quarter of ALFs and more than a quarter of MCCs or facilities having Specific Needs contracts receiving Medicaid reimbursement greater than operating costs.

Pursuant to SB 5506, ODHS funded a "rate and wage" study that examined direct care worker pay and Medicaid reimbursement rates in a wide range of Oregon home care and residential care settings. This highly complex study developed detailed rate models intended to cover service providers' costs and based on a standardized acuity assessment system for individuals receiving services. Compared to current Medicaid reimbursement, these rate models would result in estimated average rate increases of

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14% for ALFs, 75% for RCFs, 16% for AFHs serving residents with intellectual or developmental disabilities, and 76% for other AFHs.

Recommendations for the Long-Term Care Workforce

Oregon has taken or is considering many important steps to strengthen its long-term care workforce, but most have been tightly focused or reactive to events such as the COVID-19 pandemic. Sustainable solutions to make direct care work an attractive profession will require coordinated action by Oregon's Legislature, ODHS, OHA, and other state agencies, labor organizations, and long-term care employers:

- The Joint Task Force on Hospital Discharge Challenges has prepared a draft report of its findings and recommendations (see Appendix J) focused on the challenges of finding immediate post-hospital residential placements for patients that many long term care facilities find difficult to accept due to their complex care needs, especially severe mental illness, substance abuse, and/or housing insecurity.
  The Task Force also recommended that:
  - AFH payment models be updated, which would increase the number of AFH owner/operators (who are long term care workforce members) and allow them to hire additional staff to house residents with complex care needs
  - Future Ready Oregon and the Health Care Workforce Committee develop policies to support steps such as promoting career pathways, developing a centralized nursing clinical placement system, increasing nurse educator salaries, student loan forgiveness, and streamlining background check processing for direct care workers

- Other ongoing programs are described in more detail in Appendix J, including the RISE Partnership, Future Ready Oregon grants, Oregon Care Partners training, and Oregon Home Care Commission pay increases for training.

- Oregon should systematically review the range of options for improving direct care workers' compensation and select policies that will ensure compensation levels that attract enough workers to the direct care profession. States have taken different approaches to pursue this objective:
  - Wage floors. States including California and New York require that direct care workers be paid a specified amount above the state's minimum wage
  - Wage pass-throughs. Other states including Minnesota require that long term care employers pay a minimum percentage of their Medicaid LTSS reimbursement to direct care workers. In April 2024, CMS has published

a rule that, within six years, home and personal care providers pay at least 80% of their Medicaid reimbursement to direct care workers.
  - Workforce development. Oregon and other states offer increased wages to workers who complete additional training or certification.
  - Rate increases. Most states have also increased LTSS providers' Medicaid reimbursement rates with the goal of increasing direct care workers' compensation. The approach recommended by the Oregon Rate and Wage study described above would, if implemented, would support better pay and benefits for direct care workers.

- Oregon should explore ways to provide enhanced training and career pathways to more direct care workers. As described in more detail in Appendix J, non-licensed workers in home or residential care settings can benefit from, and be compensated for, completing additional training in general aspects of care provision as well as caring for individuals with specific conditions such as dementia, mental illness, or developmental disability.

- The Legislature, ODHS, OHA, and other state agencies should explore approaches to promoting implementation of health work environments at Oregon's long-term care employers. Components of such environments (described in Appendix J) include: high-quality supervision that supports direct care workers and their professional growth; task delegation from nurses to trained direct care workers; greater integration of direct care workers into multidisciplinary care teams; and ensuring culturally inclusive work environments.

- Oregon should consider appointing a multi-sector group to synthesize recommendations from experts and other states, develop a comprehensive direct care workforce strategy, collect data on that workforce, and evaluate the effectiveness of policies that are implemented. Important examples of this approach (see Appendix J) are Wisconsin, Washington, and Colorado. Appendix J also describes comprehensive visions of a future direct care workforce that is well trained, fairly compensated, highly valued, and works in health organizational environments.

Gender Affirming Care Providers

The Importance of Gender Affirming Care

Gender affirming care (GAC) refers to the full spectrum of health care services—physical, behavioral, and oral—received by people who identify as transgender and gender diverse (TGD). This includes transgender men and women (whose current

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gender identity is different from the sex assigned to them at birth) and nonbinary or gender non-conforming people who do not primarily identify as either male or female. TGD people are part of the larger LGBTQIA2S+ community, but sexual orientation is not clearly predicted by gender identity. TGD people may identify as straight, lesbian, gay, bisexual, pansexual, or queer, for example.

It is estimated in Oregon that 0.70% youth ages 13 to 17 (5,250 youth) and 0.65% (or 19,750) adults ages 18 and older identify as transgender. The World Professional Association for Transgender Health (WPATH) publishes evidence-based standards of care for GAC, including: hormone therapy; gender affirming surgery; primary care; reproductive and sexual health care; and behavioral health care. OHP covers GAC services in accordance with the WPATH standards of care, and Oregon law requires private health insurers to cover all medically necessary GAC services. In 2023, HB 2002 expanded those requirements to include some gender transition procedures, such as electrolysis.

It is important to emphasize that GAC includes a welcoming environment that does not deter TGD people from seeking needed health care. This means that organizational policies (for example, restroom access, patient room assignment, or welcoming members of "families of choice") must be gender affirming, and all staff must be trained to interact with TGD patients (for example, pronoun usage and avoidance of inappropriate questions).

To promote cultural responsiveness and inclusivity, workforce policy should consider that TGD people experience greater inequities in health care than cisgender people due to individual and systemic discrimination and mistreatment, stigma, violence, and social and economic factors. TGD people have poorer self-reported health status (1 in 3 rate it as fair or poor) and higher rates of disability. A recent meta-analysis suggests that TGD people have elevated rates of cardiovascular disease. Four in 10 TGD people nationwide and in Oregon experienced serious psychological distress in the prior month. TGD people also have dramatically higher rates of suicidal ideation and attempted suicide. TGD people, especially those who are gender nonconforming, are much more likely to be unhoused. Three in 10 TGD Oregonians reported incomes below the poverty level in 2015, and more than 1 in 3 had been homeless at least once in their life. In California (where the health insurance system has many similarities to Oregon), transgender people are far more likely to be covered by Medicaid.

Oregon's Gender Affirming Care Workforce

The GAC workforce includes providers described in other sections of this report: adult and pediatric primary care; behavioral health and substance use disorder clinicians;

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specialty medical care and oral health care; other licensed professionals such as nurses and pharmacists; gender affirming surgeons; and unlicensed clinical and nonclinical staff. Essential GAC from those providers should be welcome and inclusive to TGD patients and be provided in a gender-affirming clinical environment.

Relatively few clinicians have received formal training in GAC. GAC is not a standardized or required component of medical or nursing education. Beyond the WPATH standards of care, specialty-specific competencies or guidelines for GAC appear to be limited. Primary care GAC guidelines from the University of California San Francisco (UCSF) are frequently cited. The Endocrine Society has published guidelines for hormone therapy, and the American Psychological Association has published guidelines for treating TGD patients. But few other clinical professional associations have published evidence-based GAC guidelines.

Workforce policy should address barriers TGD people face in accessing health care, which include:

- A recent study summarized access barriers, including: poor acceptability (e.g., discrimination, deadnaming[3], and misgendering[4]); inadequate accommodation (e.g., provider not trained in GAC); limited availability (e.g., of hormone therapy); and inadequate accessibility (i.e., no GAC providers in local area)
- Among Oregon respondents to the 2015 US Transgender Survey (USTS), more than 2 in 10 avoided needed health care in the past year for fear of mistreatment, and more than 1 in 3 who sought health care had at least one negative experience related to being transgender
- Early national results from the 2022 USTS show similar patterns of health care access persisting among TGD people. In the past year, 1 in 4 did not see a doctor when they needed to for fear of mistreatment; and half who did receive health care had at least one negative experience because they were transgender
- The 2016-2018 TransPop survey found that fewer than 6 in 10 TGD people had a transgender-related health care provider, and fewer than 7 in 10 felt that their health care provider was sufficiently knowledgeable about transgender care
- The California Health Interview Survey (CHIS) found that TGD people were less likely to have received preventive care and more likely to have delayed or not received needed health care or prescribed medications in the past year.

[3] Continued use of a name a TGD person no longer uses.

[4] Not using a TGD person's pronouns

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- In the 2023 Washington Post/KFF survey, almost half of TGD adults report that their providers know "not too much" or "nothing at all" about GAC, and almost 4 in 10 that it is somewhat or very difficult to find a provider who treats them with dignity and respect. Three in 10 report they have had to teach a provider about TGD people or been asked unnecessary or invasive questions about their gender identity. TGD adults were almost twice as likely as cisgender adults to report not receiving needed behavioral health care or medications in the past year.
- A study of rural TGD adults in 5 northeastern states found that 1 in 3 did not have access to gender affirming primary care.

Systematic provider-level data about GAC capacity and quality are not available nationally or in Oregon. There are no large studies of GAC training or competence levels among health care providers, nor are there studies of how many health care provider organizations can provide a welcoming environment for TGD patients. Studies of access to gender affirming bottom surgery found that half of US states had no surgeons offering such care, and fewer than 3 surgeons in states that did. A study of the availability of GAC to TGD youth found limited geographic access (driving time of 2 to 6 hours) in rural areas nationwide, including southern and eastern Oregon. A few sources have examined GAC access in Oregon. In a qualitative study, transgender women in Oregon still faced barriers to accessing the full range of needed GAC. Another study found significant room for improvement in TGD people's experience in an Oregon hospital emergency department, but that providers who had received training in GAC felt more competent in treating TGD patients.

Other provider-level data about GAC access in Oregon are not systematically available. The largest number of primary care, specialty, and behavioral health practices that welcome TGD people are in the Portland metro area, followed by the Willamette Valley. Anecdotal evidence indicates that Oregonians face several barriers to GAC: access is much more limited in rural areas; gender affirming surgery is offered in Portland, but waiting lists can be as long as three years; and electrolysis is required before bottom surgery, but few electrolysis providers in Oregon accept health insurance reimbursement. Oregon health systems or providers may analyze their GAC demand and capacity, but OHP, Coordinated Care Organizations (CCOs), or other insurers do not systematically collect or summarize such data.

Recommendations on the Future Gender Affirming Care Workforce

Four broad recommendations on creating a welcoming, affirming, and culturally responsive GAC workforce are provided below.

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- **Growing demand will require Oregon to expand its GAC workforce.** Nationwide, commercial insurance claims for hormone therapy grew dramatically from 2016 to 2019, and utilization of gender-affirming surgeries almost tripled from 2016 to 2020. Because the proportion of TGD people is higher among adolescents and young adults, total GAC demand will inherently grow as the population ages. Oregon may also experience more in-migration of TGD people if other states restrict access to GAC for adults.

- **Oregon must expand its capacity to train clinicians and staff in GAC.** OHSU offers several GAC training opportunities: continuing medical education for licensed providers, staff training for physical and behavioral health provider organizations, training in hormone therapy prescribing, and an elective rotation for medical students. However, OHSU is not funded to provide as much training as Oregon provider organizations require to meet the needs of TGD patients. Some GAC training resources are available online for reproductive health providers or hospitals, or in person, for example at the annual Advancing Excellence in Transgender Health conference.

- **Oregon should investigate how best to prioritize and adequately fund GAC training.** Training in urban areas could initially focus on the subset of providers who treat the highest volume of TGD patients. However, in rural areas with few providers, all of them may need to be trained. Federally qualified health centers (FQHCs), rural health centers (RHCs) and certified community behavioral health clinics (CCBHCs) should be able to access GAC training. OHA could also partner with TGD advocacy organizations to identify provider organizations that should receive priority for training. GAC training could also be part of broader effort to ensure care is inclusive for patients in racial/ethnic minorities, language, disability, sexual orientation, or gender identity.

- **Oregon should explore policies to address workforce gaps and expand access to GAC.** Most GAC will probably continue to be provided by existing providers of primary, specialty, behavioral, and oral health care. The number of gender-affirming surgery providers will likely remain small, and so it may be best to establish a limited number of centers of excellence that can meet TGD Oregonian's needs for such care.

Behavioral Health Providers

The Importance of Behavioral Health Providers

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Behavioral health services, including mental health treatments and substance use disorder services, are an important component of whole-person care. Behavioral health services are provided by a variety of both licensed and unlicensed practitioners. Licensed providers include psychologists, counselors and therapists, clinical social workers, clinical social worker associates, and other licensed professions when the provider has a specialty in behavioral health (e.g., MDs with a specialty in psychiatry). There are other health care professionals who may not have a specialty in behavioral health that are licensed to provide prescription-based treatment for behavioral health conditions. This group generally includes medical doctors, doctors of osteopathy, nurse practitioners, and physician assistants. Unlicensed providers include trained or certified addiction specialists, traditional health workers, crisis counselors, case managers, and community support personnel.

In the US in 2023, nearly half of people age 12 and older with any mental illness did not receive any treatment and less than one-quarter who needed substance use treatment received any treatment. The HRSA's National Center for Health Workforce Analysis projects shortages in behavioral occupations including addiction counselors, mental health counselors, psychologists, marriage and family counselors, and school counselors based on the current need. These estimates do not account for the unmet need for people not yet diagnosed. Nationally, the behavioral health provider workforce is primarily female and non-Hispanic White. The behavioral health system has been faced with a workforce shortage, a lack of racial and ethnic diversity, and uneven distribution across and within states.

Behavioral Health in Oregon

In 2023, the KFF analysis showed that 35% of adults in Oregon reported anxiety and/or depressive disorder, compared to 32% of adults in the U.S. Approximately 10% of adults in Oregon reported an unmet need for mental health treatment in the past year which was 3% higher than the national average and the 5th highest in the country. According to Mental Health America, Oregon ranked 47th out of 51 which indicated higher prevalence of mental illness and lower rates of access to care. Two-thirds of substance use disorder service organizations in Oregon have inadequate staffing to meet current demands for service.

Since 2021, the Oregon Legislature made significant investments totally over $1.35 billion to recruit, retain, and diversify the behavioral health workforce. Other incentive streams allowed for tuition assistance and graduate stipends, childcare and housing stipends, and fee waiver programs to cover examination and licensing costs for licensed and certified providers in Oregon. Please refer to the section in this report on Investment in Workforce Development.

Behavioral Health Providers in Oregon

The 2024 Licensed Health Care Workforce Supply report by OHA)showed behavioral health professionals were the largest specialty group with 16,582 licensees actively practicing which is a 19% increase from 2022 (Table 14.1). Around 75% of behavioral health professionals were counselors and therapists and licensed clinical social workers. From 2020-2024, direct patient care FTE of psychologists increased 4%, counselors and therapists increased almost 12% annually, licensed clinical social workers FTE increased 12% annually, and non-clinical social work associates FTE is increasing almost 16% annually. For counselors and therapists, the number of licensed professionals, actively practicing professionals, and direct patient care FTE has increased 60-80% since 2016.

Table 14.1. Licensed behavioral health providers FTE by occupation in Oregon

Occupation	Direct patient care FTE	Actively practicing professionals
Counselors and therapists	2,964	5,673
Licensed clinical social workers	2,811	5,211
Psychologists	1,049	1,995
Psychiatrists		
Clinical social work associates	968	1,478
Non-clinical social work associates	107	
Nurse practitioners		1,223
Physicians		857
Naturopathic physicians		106
Physician associates		39
TOTAL	**7,899**	**16,582**

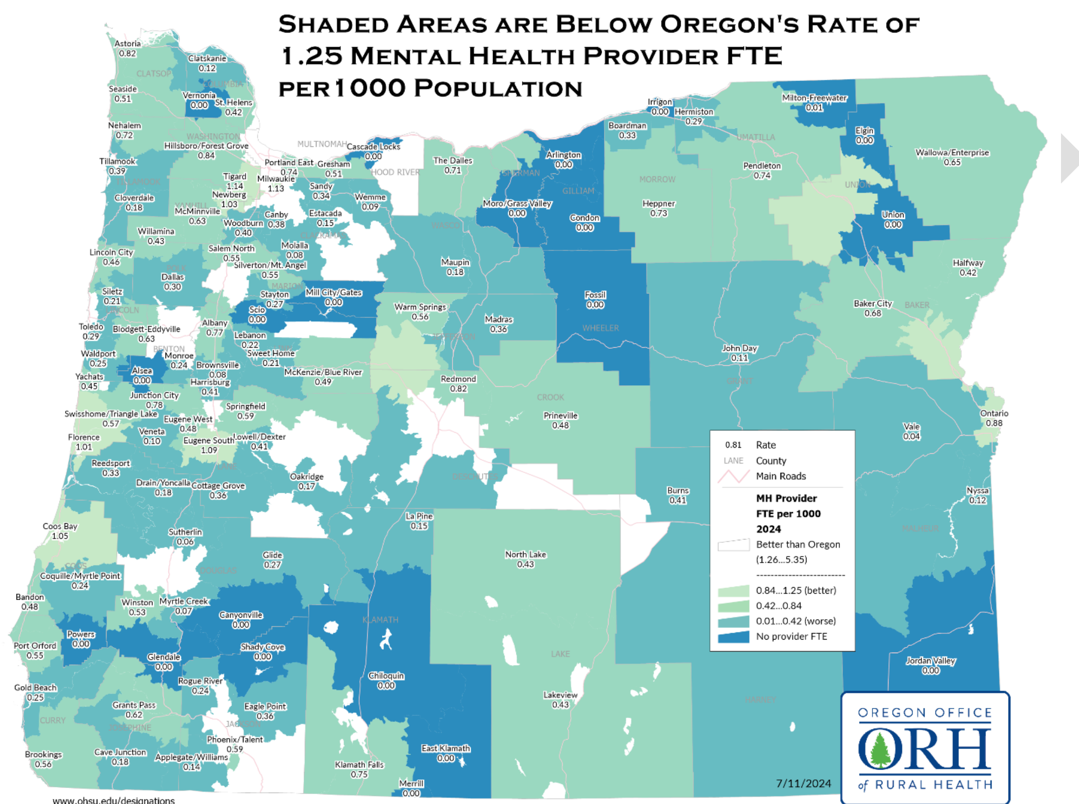
Source: 2024 Licensed Health Care Workforce Supply report

Licensed behavioral health providers can be integrated into primary care through the Patient-Centered Primary Care Homes (PCPCHs) in Oregon. A PCPCH encouraged to have an integrated licensed behavioral health clinician (i.e., MD, PhD, PsyD, PMHNP, LCSW, LPC, LMFT) trained to work in a primary care setting. A total of 383 current

PCPCHS have attested to provision of integrated behavioral health services including population-based, same-day consultations by behavioral health providers (62% of total recognized PCPCHs). Refer to the section in this report describing Primary Care.

Figure 14.2 shows the licensed behavioral health provider FTE per 1,000 population by service area. The statewide behavioral health provider FTE per 1,000 people increased from 1.15 in 2023 to 1.25 in 2024. Rural and remote areas had 0.56 FTE per 1,000 population, which was slightly higher than last year's rate of 0.52, but still much lower than 1.60 FTE per 1,000 population in urban areas.

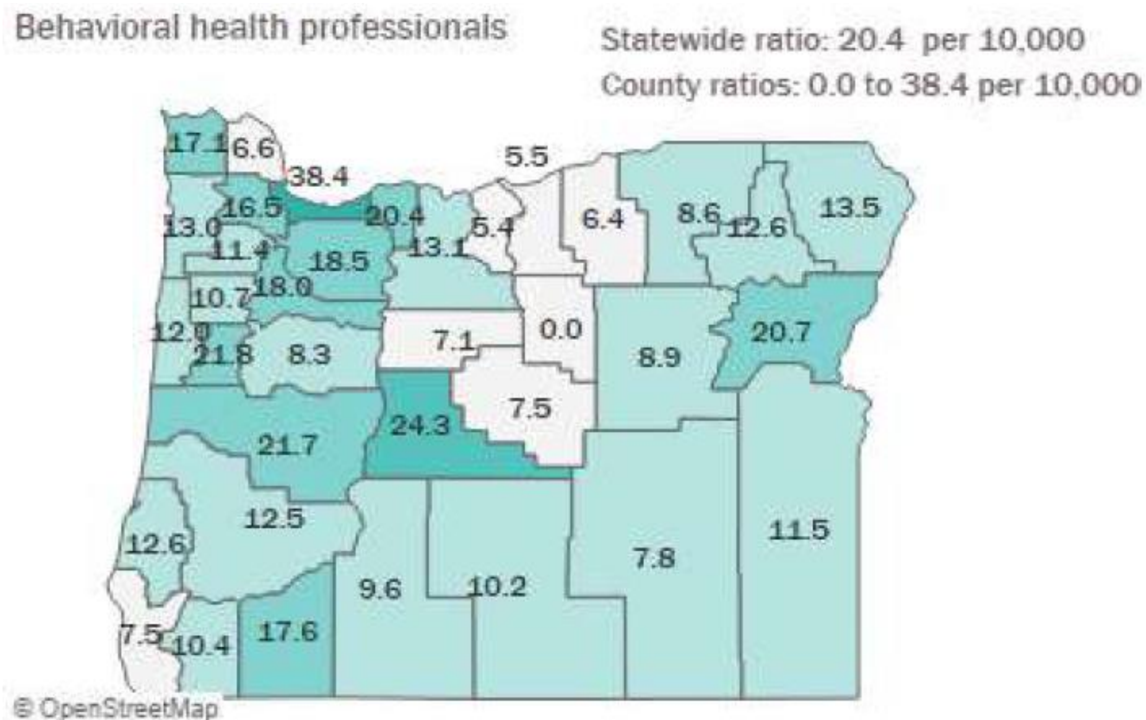
Figure 14.2 Behavioral health provider FTE per 1,000 population by service area



Source: Oregon Office of Rural Health. 2024 Areas of Unmet Health Care Need Report.

Figure 14.3. lists the number of licensed behavioral health providers per 10,000 people by county. The statewide average is 20.4 behavioral health providers per 10,000 people in Oregon. Behavioral health providers are unevenly distributed across the state. Multnomah County has the highest density of behavioral health providers at 38.4 providers per 10,000. One county had no licensed behavioral health providers.

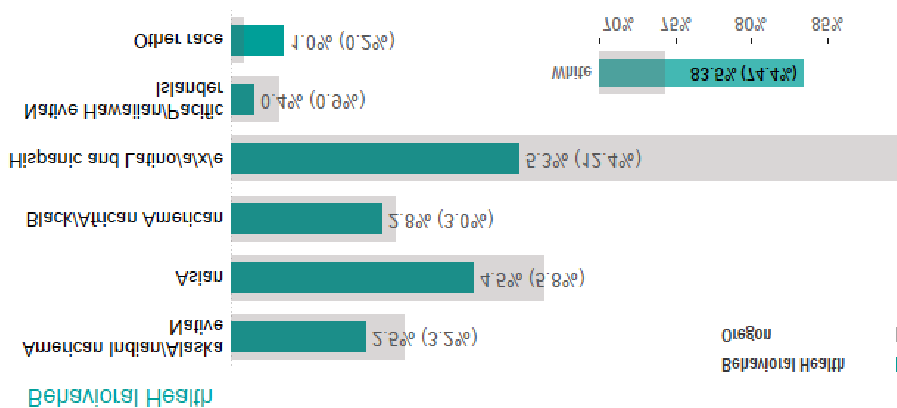
Figure 14.3. Distribution of licensed behavioral health provider in Oregon



Source: [2024 Licensed Health Care Workforce Supply report]()

As illustrated in Figure 14.4, people of color are underrepresented in Oregon's licensed health care workforce. (see [Health Care Workforce Trends and Data]() section for detail by occupation). Oregon's Health Care Workforce Reporting Program showed that people of color comprise approximately 25% of the licensed behavioral health provider workforce which is relatively stable since the last needs assessment.

Figure 14.4. Race and ethnicity of behavioral health providers in Oregon



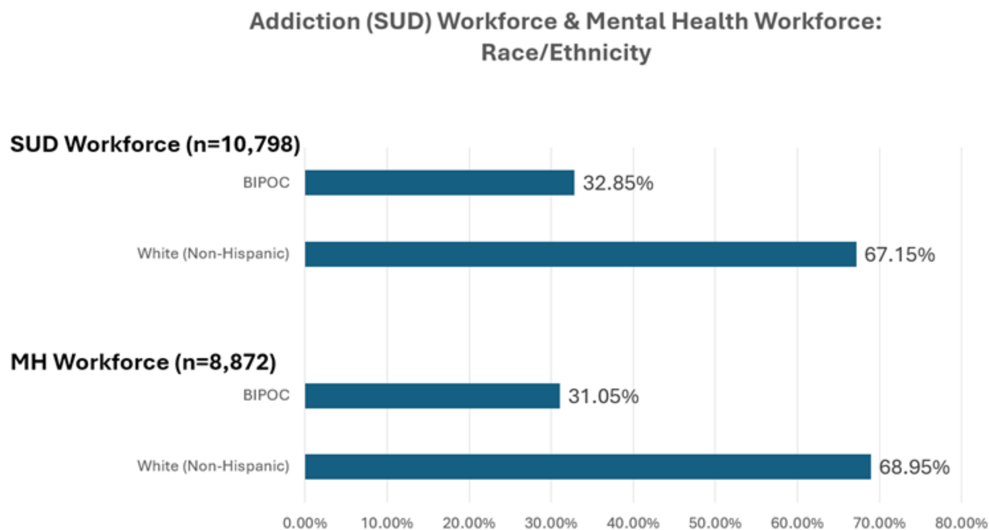
Source: OHA Office of Health Analytics, [Oregon's Health Care Workforce Reporting Program]()

This year's report expanded details about the certified behavioral health providers who may or may not also be licensed. The Mental Health & Addiction Certification Board of Oregon (MHACBO) tracks the certified behavioral health and substance use disorder workforce in Oregon. Table 14.5 details the types of providers included in MHACBO and enrollment numbers in May 2024. The majority of substance use disorder service organizations employ peer support specialists. Certified Recovery Mentors were most frequently employed. Oregon offers some reciprocity with other states if they use CADC reciprocity with all states who utilize the NAADAC or IC&RC National Psychometric Exams for their addiction counselors. Statewide, Oregon averages one CADC for every 810 residents, one CRM for every 1,307 residents, one QMHA for every 814 residents, and one QMHP for every 2,044 residents (this position does not include LPC, LMFTs, or LCSWs). It should be noted that QMHPs and CADSx could be licensed (i.e., LCSW, psychologist, etc)., but still hold this credential. Refer to the Appendix K Figures 14.8 - 14.13 which depict the number of certified but not licensed behavioral health providers by 1,000 persons at the county level and by provider type. Data from the Mental Health and Addiction Counseling Board of Oregon are shown in Figure 14.6 and report that about 31% of unlicensed behavioral health providers and 67% of the substance use disorder providers were people of color.

Table 14.5. Certified behavioral health providers FTE by occupation in Oregon

Provider type	Number of registrations in MHACBO as of May 2024
Certified Alcohol and Drug Counselors (CADC)	5,229
Certified Recovery Mentors (CRM)	3,171
Certified Gambling Addiction Counselors (CGAC)	312
Certified Prevention Specialists (CPS)	58
Qualified Mental Health Associates (QMHA)	5,201
Qualified Mental Health Professionals (QMHP)	2,071
Total	16,042

Figure 14.6. Race and ethnicity of the certified behavioral health and substance use disorder providers in Oregon



Source: Mental Health and Addiction Counseling Board of Oregon as of November 25, 2024

Oregon has invested in the behavioral workforce through the Behavioral Health Workforce Incentive program and the Health Care Provider Incentive Program's loan repayment program. Between 2018 and June 2024, there has been a total of 1,425 recipients of Behavioral Health Workforce incentives for practicing licensed and certified professionals. OHA facilitates National Health Service Corps loan repayment and scholarships for behavioral health providers to practice in Health Professional Shortage Areas. Refer to the section of Investments in Workforce Development.

Future workforce of behavioral health providers

Recommendations to improve the behavioral health workforce are summarized under several domains and integrated from multiple reports including the Behavioral Health Workforce Report, the Evaluation of the Oregon Certified Community Behavioral Health Clinic Program, the Evaluation of the Oregon Certified Community Behavioral Health Clinic (CCBHC) Program, the Future Ready Oregon's Health Care Industry Consortium findings, the Oregon Health Authority Behavioral Health Residential + Facility Study, the Oregon Substance Use Disorder Services Inventory and Gap Analysis, the OHA Behavioral Health Workforce Initiatives Audit, and the National Council of Mental Wellbeing report.

Multi-pronged approaches are needed to increase the number, racial and ethnic diversity, and reach of providers. Recommendations include:

- Increase direct salary compensation and decrease the wage differentials between behavioral health and other sectors affected decisions to enter or retain positions in the behavioral health field. Low wages in behavioral health create incentives to enter other fields with higher earning potential. Consider "wage add-on" programs which effectively increase wages for eligible providers.
- Invest in a multilingual and multicultural behavioral health workforce for training, licensing, hiring, retaining, and compensating plus provide mentorship, visible role models, affinity groups for providers representing diverse races and ethnicities.
- Provide retention and recruitment bonuses as direct salary and/or housing allowances or stipends or childcare subsidies including sustaining the Oregon Behavioral Health Workforce Bonus and Housing Stipend Program.
- Reduce administrative barriers, streamline application, certifying, and reporting processes for both individual providers and grantees.
- Develop reciprocity agreements that allow for transferability of providers with other states; and
- Work with partners who are developing and expanding the facility capacity to understand staffing needs. As stated by Ebony Clarke, Behavioral Health Director, OHA in their September 2024 to the Oregon Senate Interim Committee on Health, "Growing the behavioral workforce in tandem with executing capital projects is critical for increasing access – a bed built is not a bed filled if there is no one to staff it."

Recommendations for innovation and investment in the current and future behavioral health workforce include:

- Continue to invest in new or enhanced behavioral health workforce incentives (such as salaries, loan repayment, educational support, etc). to augment the workforce in underserved areas, providers of color, and providers who focus on mental health services for children.
- Develop administrative models for integrated care (such as through the Patient-Centered Primary Care Homes) to increase payment rates for licensed and non-licensed providers and remove restrictions on organizational staffing requirements in order to increase use of all types of behavioral health providers (licensed and non-licensed) in integrated care.

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- Licensed behavioral health providers can be integrated into primary care through the Patient-Centered Primary Care Homes (PCPCHs) in Oregon. A PCPCH encouraged to have an integrated licensed behavioral health clinician (i.e., MD, PhD, PsyD, PMHNP, LCSW, LPC, LMFT) trained to work in a primary care setting. A total of 383 current PCPCHS have attested to provision of integrated behavioral health services including population-based, same-day consultations by behavioral health providers (62% of total recognized PCPCHs).
- Enhance efforts to reach rural and frontier communities by having a more effective communication and outreach plan for incentives.
- Expand and sustain funding to the CCBHC program to support a program in every county.
- Increase training and better prepare providers for the levels of care needed to meet the high acuity needs of patients in Oregon today.
- Expand the peer behavioral services through persons with lived experiences as key components in residential behavioral health and substance use disorder treatment settings to improve trust.
- Increase dually credentialed staff for substance use treatment and co-occurring mental health disorders which is supported by increased pay.
- Incentivize CCO requirements to incentivize increased payments for mental health and SUD services.
- Expand billable services and reimbursement for social and case complexity.
- Provide education and mentorship to improve transparencies of career trajectories; and
- Improve pipeline for early educational exposure of health care career opportunities to engage priority populations.

Community-based approaches have been recommended and specific strategies could include:

- Identify opportunities to intentionally build upon or partner with other community-based initiatives.
- Expand use of expanding community partners in mental health service including faith-based partners; and
- Establish coordination between mental health and substance use disorder services as well as primary and behavioral care coordination and integration.

There are several recommendations to better support data collection of both the providers and organizations.:

- Establish a central data resource website include number, demographics, and population trends for the behavioral workforce
- Expand performance and outcome metrics to track impact of investing including leveraging existing data (e.g. REALD demographics, licensure/certification, years of experience, employment setting or area of practice, and occupational role). Conduct mixed-method evaluation integrating existing data with listening sessions or focus groups with grantees and communities affected to better understand the strengths, challenges, and needs of the workforce. OHA proposes a program evaluation process of behavioral health workforce incentive programs in their 2025-2027 agency request budget to highlight the progress and increase transparency. This request would require legislative approval to hire staff or contractors to complete the evaluation.
- Review licensing and credentialing databases for providers with multiple credentials to remove duplicates, avoid double-counting or over-estimating the supply of providers.
- Need for more specific and timely assessment tools for estimating the need for services. Some of the current tools do not use metrics detailed or nuanced enough to capture change at county-level to determine gaps in service or change that would be influenced by the investments in the behavioral health workforce.

OHA successfully allocated 98% of funds allocated under the Behavioral Health Workforce Incentive (BHWI) program. Statewide behavioral health provider FTE increased between 2023 and 2024. BHWI funding went to the Nine Federally Recognized Tribes in Oregon to increase behavioral health services. Five scholarship grants were awarded to higher education and community-based programs to increase individuals pursuing education in behavioral health. However, staffing shortages persist in rural areas and among providers of color. Oregon's health care workforce does not represent the demographics of the state. Gaps in workforce and funding exist for providers of children's mental health services. OHA requested funds in their agency request budget for the 2025-2027 biennium to close Oregon's shortage in behavioral health and substance use treatment capacity, to expand Medicaid Certified Community Behavioral Health Clinics (CCBHC), which integrate behavioral with physical health care, and to increase and diversify Oregon's behavioral health workforce to eliminate health inequities. Governor Kotek's 2025-2027 budget request includes $25.7 million in behavioral health education and training programs, wrap-around supports for students, tuition assistance, and scholarships ; $24.3 million towards graduate stipends, loan repayment, and peer and manager support for the community mental health workforce;

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$130 million for maintaining and expanding provider rate increases for behavioral health services included in the Oregon Health Plan and increase inpatient psychiatric rates; and $1.25 million to streamline and improve state licensing and certification boards.

Oral Health Providers

The Importance of Oral Health Providers

Oral health is critical to overall health. More than 57 million American reside in areas with a shortage of oral health professionals with rural areas experiencing significant health inequities. The Health Resources and Services Administration's National Center for Health Workforce Analysis projects that the demand for general dentists, periodontists, and dental hygienists will grow faster than their availability by 2036. Nationwide, the oral health industry is facing a shortage of dental assistants.

Oral Health Providers in Oregon

Approximately one million Oregonians live in a Dental Health Professional Shortage Area (Dental HPSA). One of the key goals of Oregon's coordinated care model is to integrate physical, oral, and behavioral health care to treat the whole person. Recognizing the importance of oral health across the lifespan, Oregon is one of only 23 states that offer extensive dental benefits to all adults with Medicaid, as well as children.

There are four main types of dental health providers in Oregon:

- **Dentist (DMD/DDS)** – Doctor of Medicine in Dentistry (DMD) or Doctor of Dental Surgery (DDS) who can diagnose oral health disease, interpret x-rays, monitor the growth and development of the teeth and jaws, and perform surgical procedures on the teeth.
- **Dental Hygienist** – Paraprofessional that works under the supervision of a licensed dentist to provide preventive and therapeutic oral prophylaxis and educate patients in dental hygiene.
- **Expanded Practice Dental Hygienist (EPDH**) – Hygienist with the training and experience to qualify for an expanded practice permit who can operate independently without the direct supervision of a dentist and render preventative services via teledentistry; authorized to work in specific settings such as community health clinics, nursing homes, and other locations described in ORS 680.200.
- **Dental Assistant** – Unlicensed professional that helps with infection control by sterilizing and disinfecting instruments, setting up instrument trays, and assisting with dental procedures.

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There is significant variation across the U.S. in the scope of activities of dental hygienists. As of 2019, Oregon allows one of the broadest scopes of practice for dental hygienists compared with other states. Dental hygienists can formulate treatment plans within the dental hygiene scope; prescribe, administer, and dispense fluoride, topical medications, and chlorohexidine; and administer local anesthesia with authorization from a dentist. Dental hygienists working in a public health setting can provide sealants and prophylaxis without prior examination by a dentist.

In 2024, there were 3,735 licensed dentists, 4,209 licensed hygienists, and 874 actively practicing expanded practice dental hygienists. The active practice rate, which includes the number of hours worked per week and the amount of time spent on direct patient care, has remained relatively steady for dentists between 2016-2024. The amount of direct patient care FTE has remained stable for both dentists and dental hygienists in Oregon between 2020-2024. Figure 15.1 reports the ratio of licensed oral health professionals per 10,000 people by county. There are 6 licensed oral health professions per 10,000 people in Oregon. At the county level, county ratios ranged from 0 to 9.6 providers per 10,000 people with highest rates in Hood River and Wallowa Counties and no licensed oral health providers in Morrow County. Licensed oral health providers can be integrated into primary care through the Patient-Centered Primary Care Homes (PCPCHs) in Oregon. A total of 43 current PCPCHS have attested to provision of oral health services by dental providers (7% of total recognized PCPCHs). Refer to the section in this report describing Primary Care.

Figure 15.1. Oregon Licensed Health Care Workforce Supply, 2024

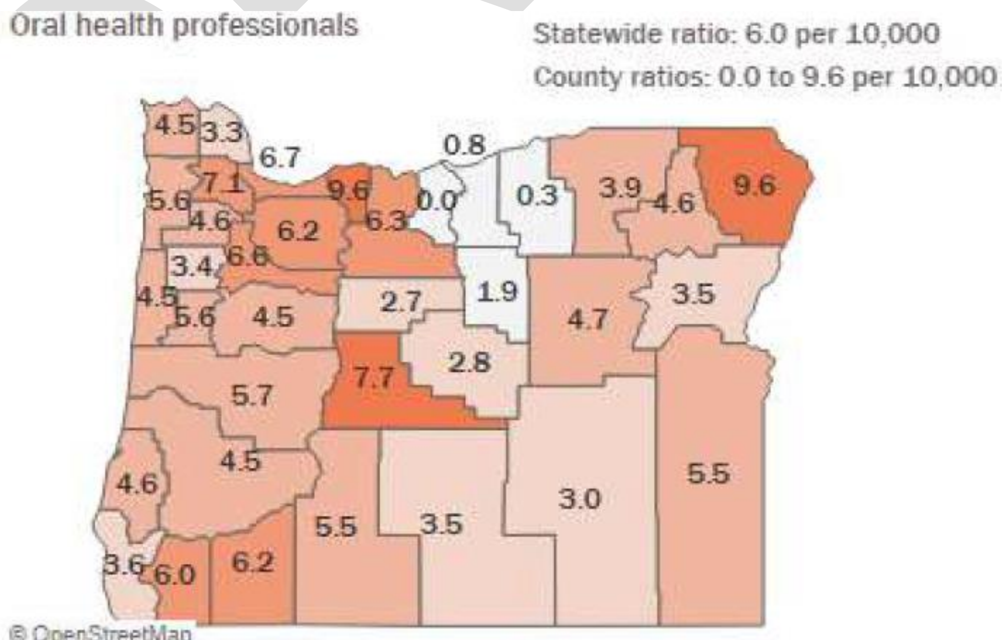

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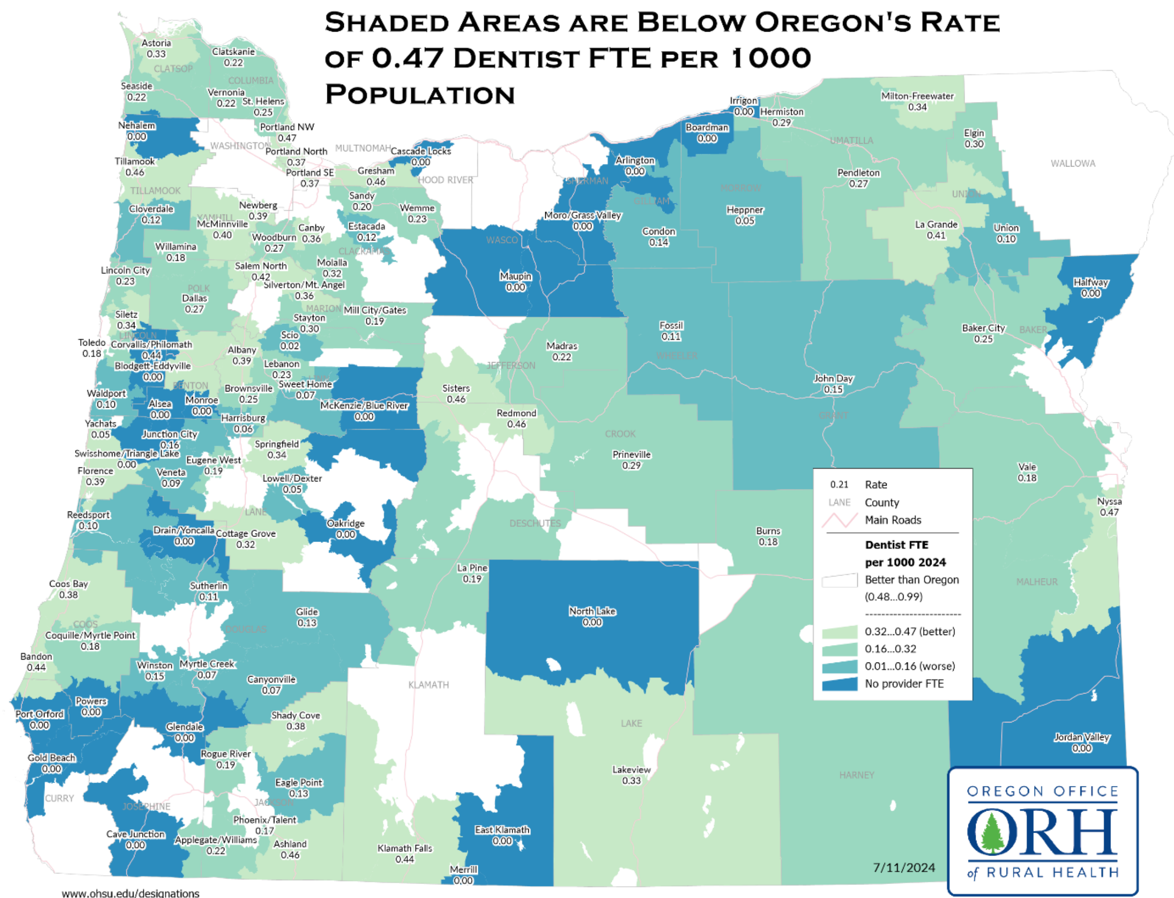
Figure 15.2. Dentist patient care FTE per 1,000 population by service area



Source: Oregon Office of Rural Health. 2024 Areas of Unmet Health Care Need Report.

Figure 15.2 shows the dentist patient care FTE per 1,000 population by service area. Oregon had a rate of 0.47 dentist patient care FTE per 1,000 people in 2024, which was the same as last year. Rural and remote areas had a lower rate of 0.31 FTE per 1,000 population, compared to 0.55 FTE per 1,000 population in urban areas.

As illustrated in Figure 15.3, Oregon's oral health providers are less racially and ethnically diverse than the general population with Latino/a/x, African American/Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander providers being underrepresented. (see Health Care Workforce Trends and Data section for detail by occupation)

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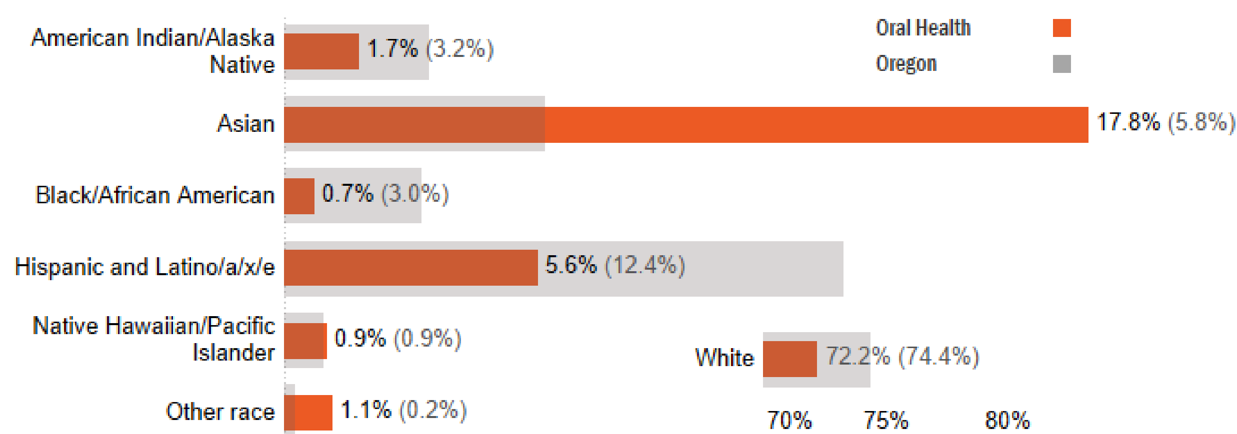
Figure 15.3. Race and ethnicity of oral health providers in Oregon



Source: OHA Office of Health Analytics, Oregon's Health Care Workforce Reporting Program

According to the American Dental Association, over three-quarters of dentists in Oregon identify as White and 17% identity as Asian, and 3% identify as Hispanic. Approximately one-third of dentists are female. The demographics of oral health providers in Oregon do not match the demographics of Oregonians.

Over half of Oregon dentists do not accept OHP. The Evaluation of Oregon Health Plan Dental Provider Enrollment conducted key informant and dental practice interviews and summarized policy and process barriers to enrolling more dental providers to accept Medicaid patients and lists recommendations to mitigate these barriers. Thirty-two of Oregon's 36 counties (89 percent) lack adequate Medicaid dental full-time equivalents to meet the needs of enrolled patients. Higher needs are concentrated in urban/metro areas. Workforce recruitment and retention are a common challenge for dental practices, particularly in rural areas.

Oregon's oral health providers are eligible for workforce development programs including loan forgiveness, loan repayment programs, and tax credits which provide the benefit to providers in underserved areas of the state who work with underserved patients such as those on Medicaid and Medicare. OHA facilitates National Health Service Corps loan repayment and scholarships for oral health providers to practice in Health Professional Shortage Areas. Please refer to the Investments in Workforce Development section in this report for more details.

As of August 2024, OHA has made progress on the HRSA Oral Health Workforce activities:

- OHSU faculty administered the first cohort of didactic sessions hosted via the Extension for Community Health care Outcomes (ECHO) platform which focused on expanding the capacity of existing and potential preceptors.

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- Capitol Dental Care's mobile dental van has expanded to additional sites within Lane County and has hired additional staff to help coordinate preventive and comprehensive dental services and decrease no show rates.

- Grant funds have been used to subsidize the costs associated with integrating a new dental clinic into a Federally Qualified Health Center in Brookings, Oregon. Medicaid patients will have access to comprehensive and preventive dental services in person or via teledentistry.

OHA's Dental Pilot Project Program encourages the development of innovative practices in oral health care delivery systems to improve care to populations with the least access to dental care and the highest disease rates. Dental pilot projects are community driven and intentionally designed to increase access to dental care for communities of color and other populations which evidence-based studies have shown to have the highest dental disease rates and the least access to dental care. Two examples are described. Northwest Portland Area Indian Health Board plans to launch an Oregon Tribes Dental Health Aide Therapist (DHAT) program. Select tribal communities in Oregon will send 5-7 trainees to train with the DHAT program in Alaska and complete a preceptorship with his or her tribe. Willamette Dental Group and Pacific University will investigate the feasibility and cost-effectiveness of adopting a dental therapist model as a new category of dental care provider. This pilot project will also evaluate the efficacy of a unique one-year dental therapy education program that will allow dental hygienists to complete dental therapy education while they maintain their current employment as a dental hygienist.

Future of the Oral Health Workforce

Following approval of House Bill 3223 in 2023, the Oregon Board of Dentistry was asked to convene an advisory committee to study the dental assistant workforce shortage and make recommendations to address the shortage as well as to conduct a workforce study. Draft recommendations from the Oregon Board of Dentistry and the Dental Assistant Workforce Shortage Advisory Committee include:

- Streamline, simplify, and expedite the certification process;
- Create alternative pathways for certifications such as competency-based assessments to promote diversity,
- Promote financial support through scholarship, grants and loan forgiveness programs to diversify the workforce;
- Expand scope of practice to perform a broader range of services to increase their value and contribution;
- Provide support for continuing education;
- Implement reciprocity agreements with other states;

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- Educate the public about role of dental assistance to increase the pipeline; and
- Break down barriers within the profession to ensure that dental assistants are valued and viewed as critical to the oral health care team.

Recommendations are summarized from national and state reports to address the shortage and diversity of the oral health workforce in general and include:

- Increased compensation and reimbursement rates
- Recruit oral health care professionals who identify as Hispanic/Latino, Asian Indian/Alaska Native, and Black/African American;
- Incentivize and reduce administrative burdens for providers who serve OHP patients;
- Sustain funding, improve communication and eligibility to increase the reach of loan repayment programs;
- Offer stipends or subsidies for living costs such as housing, childcare, and transportation;
- Implement new pathways to increase dental therapists, assistants, and hygienists;
- Support dental schools to expand curriculum and recruit students to represent Oregonians from diverse backgrounds and/or rural communities; and
- Increase student engagement into oral health education programs.

Public Health Workforce

Importance of the Public Health Workforce

The public health workforce in the United States performs foundational services such a chronic disease prevention, community disease prevention and control, environmental public health, and maternal, child, and family health to improve the health of the community. Before the COVID-19 pandemic, the public health workforce was significantly understaffed and in decline. Many public health agencies increased hiring in the early years of the pandemic, but, by 2023, the number of positions had returned to pre-pandemic levels. Many of the financial investments during the COVID-19 pandemic have ended because they were one-time, temporary allocations; concerns exist about maintaining the staffing and progress of the public health workforce. While federal funding is dwindling the work of the public health workforce is increasing as new legislation passes that increases the work assigned to public health but often does not come with additional financial investment to carry out that work.

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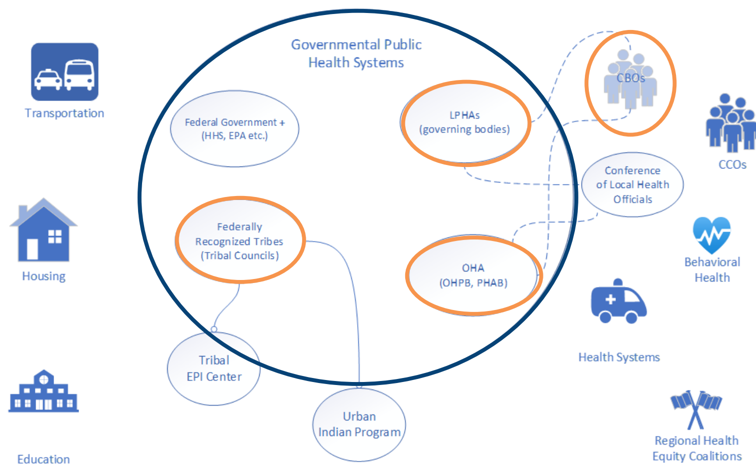
Public Health Workforce in Oregon

Figure 16.1. The public health system in Oregon

Oregon's Public Health System



Source: OHA, Public Health Division

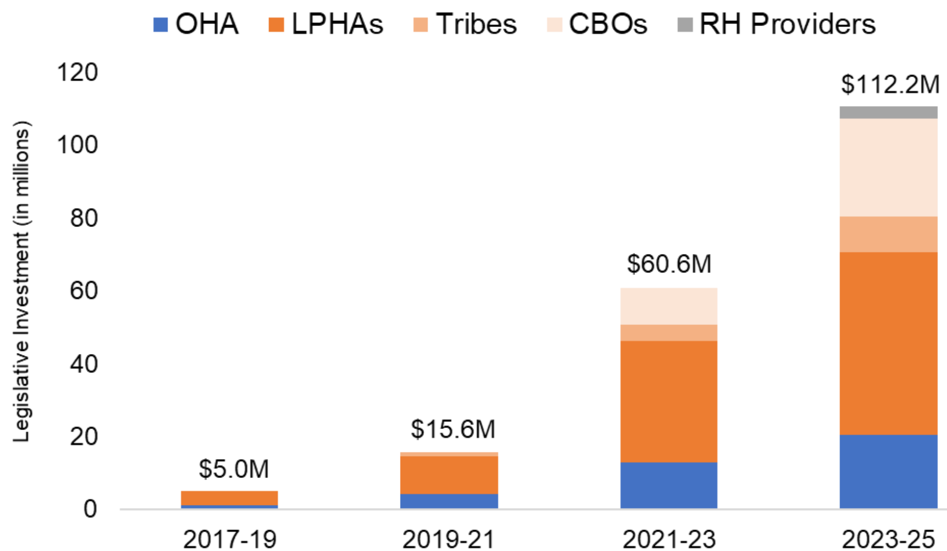
Note: abbreviations in the figure includes CBO (community-based organizations), RHEC (regional health equity coalitions), LPHA (local public health authority), and OHA:

The Oregon public health system includes federal, state, Tribal and local agencies, private organizations and other diverse partners working together to protect and promote the health of all communities where they live, work, play and learn. Governmental public health is a network of federal, state and local health authorities, and government-to-government relationships with federally recognized Tribes. Oregon has a decentralized public health system, which means that local health departments have authority over most public health functions in their jurisdictions. Tribes have authority over all public health functions on Tribal lands.

- In 2017, the Oregon legislature began to invest in public health through Public Health Modernization funding and increased investments to LPHAs, Tribes, and CBOs. Figure 17.2 below provides details of this funding from 2017-2025. Since the last report, OHA has conducted significant evaluation of public health modernization for investments during the 2021-2023 biennium. With this funding, more than 300 positions in local public health authorities were funded across all 33 local public health authorities (LPHAs) in Oregon. OHA has increased the number of CBOs directly funded since the last report from 130 to almost 200 unique organizations that support culturally, and

linguistically responsive services and foundational programs centered around health equity. Oregon has Nine Federally Recognized Tribes. OHA Public Health Division (PHD) provides technical assistance and supports Tribes with Public Health Modernization funding. Since the previous report, Northwest Portland Area Indian Health Board (NPAIHB) received a grant from the Centers for Disease Control and Prevention's National Public Health Improvement Initiative program to increase trained staff and to provide education, technical assistance, and support to Tribally-based health departments and programs.

Figure 16.2. Legislative investment in public health modernization by partner type, 2017-2025 (in millions)



The following reports are anticipated to be released in in the near future::

OHA is conducting an expanded evaluation for public health workforce needs using data from modernization funding reports, focus groups, and key informant interviews that will be released in June 2025.

The Oregon Public Health Modernization Capacity and Cost Assessment will assess the staffing need within Oregon's state and local public health authorities

The Public Health Workforce Interests and Needs Survey (PH WINS) is the only national survey that reflects workforce interests and needs nationally, at the state level public health as well as for participating local level governmental public health workforce.

The second edition of the Coalition of Local Health Officials (CLHO) Workforce Report reflecting staffing at LPHAs post the COVID-19 pandemic.

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Recommendations for Future of the Public Health Workforce

In 2024, OHA Public Health Division and the Oregon Public Health Advisory Board (PHAB) contracted with the Wyoming Survey & Analysis Center (WYSAC) to complete an analysis of Oregon-specific public health workforce assessments conducted between 2017-2024. Simultaneously, PHAB convened a public health system workforce workgroup to identify and prioritize workforce recommendations. The recommendations from the WYSAC summaries, the 2023-2025 Public Health Modernization Evaluation Preliminary Findings Presentation, and several national workforce reports are summarized below.

- Resolve administrative barriers in hiring that require multiple levels of approval and long-turnaround times making it difficult to hire staff quickly.
- Establish a clearinghouse for position descriptions, implement recruitment and retention strategies that address rural workforce challenges.
- Increase salaries and compensation including reimbursement for continued education, and loan repayments.
- Attract and retain skilled and diverse talent to support foundational public health services including emergency preparedness and response.
- Offer targeted recruitment, training, and support for public health staff working in rural and underserved areas, either through home-grown candidates or incentivized relocation benefits for jobs in rural areas.
- Equip public health staff with skills and resources to effectively engage with diverse communities, including data collection, partnership building, and cultural competency.
- Approve budgets that ensure training and professional development to implement core programs and skills.
- Provide flexible ongoing funding to tailor foundational public health services to a community's needs and preferences that allows for pivots to address emerging health issues.
- Support staff mental health to reduce burnout and increase retention.
- Create mentorship and sponsorship programs for public health leaders from historically marginalized and underrepresented backgrounds and populations.
- Support mechanisms to surge the workforce as part of ongoing emergency preparedness and response planning.
- Increase staffing levels for critical emergency response positions, such as community health workers, community navigators, and call center staff.

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- Leverage partnerships with universities to increase the pipeline and provide real world public health work experience to students to the public health field.

After the official end to the COVID-19, public health advocates are experiencing or anticipating budget cuts. In 2022, U.S. Congress passed new legislation to support the Public Health Workforce Loan Repayment Program; however, Congress did not appropriate any funding to this program. Concerns exist for maintaining staff following the loss of post-COVID funding.

Conclusions/Recommendations

The report synthesizes information from previous sections into priority policy recommendations across Oregon's health care workforce by considering workforce investments, wellness and resiliency, diversity, and specific workforces critical to achieving health equity. **Since the previous report, there has been progress towards expanding and diversifying the workforce. However, continued work is still needed.** Priority recommendations to create a culturally and linguistically responsive workforce are summarized around four broad themes – funding; diversity of the workforce; shortages, especially in rural areas; and evaluation of these initiatives – and organized by continued or new recommendations since the previous report.

Sustain Funding Levels to Sustain Momentum in Workforce Development and Retention

Oregon has provided funding for initiatives and programs to recruit, train, diversify, and maintain the workforce who can provide culturally and linguistically responsive care and who reach rural communities. This level of funding should be continued to maintain the progress achieved and to continue to diversify and expand the workforce. Examples of progress made since the last report:

- Oregon allocated funds to increase recruitment and retention of behavioral health providers who are people of color, tribal members, or residents of rural areas The Oregon Behavioral Health Workforce Bonus and Housing Stipend Program funded 20 organizations to provide bonus and housing stipends to their workforce.
- HB 3396 (2023) provides funds to support apprenticeships and on-the-job training for health care workers and support clinical placements for students.
- Oregon has invested in supporting education pipelines for high school and middle school students to explore careers in the health care field.

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- OHA provides free Health Care Interpreter training needed for certification and reduced barriers such as application fees, background check, and previous work experience.
- OHA provides supplemental medical assistance payments to health care providers and labor-management training trusts to enhance apprenticeship and training programs.

Continued recommendations include:

- Continue investment in early career development and continuing-education opportunities for people from underrepresented communities to promote their entry and advancement in health care careers.
- Increase funding to increase wage floors, recruiting and relocation bonuses, and assistance with social determinants of work such as housing and childcare.
- Continue to reduce barriers to certification and registration processes.
- Continue to fund financial incentives to increase opportunities for training and education, such as those in the OHA Health Care Provider Incentive Program and Behavioral Health Workforce Incentives.

New recommendations include:

- Explore Medicaid strategies to invest in the health care workforce, such as New York's Section 1115 Waiver's career pathways and loan repayment programs.
- Support reimbursement models based on the true cost of providing services.
- Increase training slots, internship opportunities, and funding to support preceptor and teaching faculty.
- Provide retention and recruitment bonuses as direct salary and/or housing allowances or stipends or childcare subsidies to recruit and retain the workforce.

Maintain Progress in Improving the Diversity of Health Care Providers to Provide Culturally Responsive Care to All

Oregon must have a more diverse workforce to achieve the strategic goal of eliminating health inequities. Community-based health care providers such as THWs, HCIs, and school-based providers are types of providers that may better reflect the communities' lived experiences and serve as trusted sources to provide culturally responsive care. There has been progress in developing a more diverse health care workforce in Oregon:

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- New graduates of Oregon nursing education programs are more ethnically and racially diverse than the existing workforce.
- OHA has increased importance and documentation of the role of certified behavioral health workforce who may better represent the community in terms of lived experience.
- Oregon's public health system has expanded public health modernization to community-based organization and expanded voting membership on the Public Health Advisory Board to include members from community organizations.

Continued recommendations include:

- Improve outreach to all counties across the state, and deploy strategies to recruit, train and employ providers of color and from other underrepresented communities in these fields,
- Continue using the Health Care Workforce Committee's Health Equity Framework and strategies to support a diverse health care workforce.
- Support training to providers to offer culturally and linguistically responsive care.
- Promote entry into the workforce and advancement for people from underrepresented communities through early career development and continuing-education opportunities.

New recommendations include:

- Reduce barriers for internationally educated health care professionals to practice in Oregon. Senate Bill 849 (2023) would have provided career guidance and support services to internationally educated state residents if it had passed. The University of California, Los Angeles's International Medical Graduate Program is another example that helps physician-trained legal immigrants pass their licensing exams and obtain residency training in family medicine.
- Investigate licensure reciprocity agreements. In addition, licensing examinations and continuing education requirements could incorporate knowledge about social determinants of health and the importance of addressing social needs in the health care setting.
- Use an equity approach to develop wellness programs and provide culturally responsive support to workforce seeking care.
- Expand use of community partners in mental health service including faith-based partners.

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- Initiate and promote visible role models and affinity groups for providers of color.
- Increase compensation and promote healthy work environments for home care workers and community-based facility staff.

Seek Multipronged Solutions to Address the Shortage and Improve the Distribution of the Health Care Workforce

Current data shows rural and remote areas have greater unmet health care need than urban areas in Oregon. Improving the distribution of the health care workforce requires multipronged solutions, such as enhancing education pipelines for recruitment and career advancement; increasing compensation, incentives, and bonuses for working in rural areas; offering transportation, childcare, and housing stipends to offset the social determinants of work; reducing administrative and documentation burdens; and continuing to support workforce wellness and resiliency to promote retention. Examples of progress made since the last report:

- Oregon supported the ECHO knowledge-sharing network to conduct virtual training cohorts with community dental providers in underserved areas.
- The Health Care Workforce Committee adopted the Strategic Framework in 2023 and prioritized workforce wellness and resiliency.
- The Oregon Wellness Program provides wellness support for health care workers through confidential counseling, education, and research.
- The Oregon legislature passed House Bill 2235 (2023) requiring OHA to convene a workgroup to focus on reducing administrative and other burdens that affect behavioral health workforce.
- OHA convened a public health workforce workgroup to prioritize recommendations to build and enhance skills in culturally responsive engagement, communication, promotion of health equity, emergency preparedness, data analysis and data justice.

Continued recommendations include:

- Increase training opportunities in underserved areas to improve recruitment and retention of health care workers from rural and underrepresented populations.
- Continue expanding opportunities and funds to support pipeline programs in middle and high schools to attract more students into health care professions.

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- Continue to expand the Oregon Wellness Program to provide prevention, acute intervention, and chronic management support for all health care workforce members, especially in rural areas.
- Make workplaces more welcoming for diverse health care professionals, such as providing frequent implicit bias and cultural responsiveness training for all staff and conducting climate surveys on a regular basis for employees to provide feedback on their working experience.
- Increase training slots and internship opportunities for more oral and behavioral health providers and to support more preceptors.
- Test new training pathways to increase dental therapists, assistants, and hygienists.
- Create and sustain positive work environments and culture to improve work-life balance, such as implementing flexible work schedules.

New recommendations include:

- Increase compensation and benefits and offer housing, childcare, and/or transportation stipends or assistance.
- Support training of rural health care and behavioral health providers to provide gender-affirming care.
- Use the Health Care Workforce Committee's strategy paper to guide collective actions to improve the wellness and resiliency of the health care workforce.
- Intentionally partner with K-12 education to support health care education and career pathways programs.
- Increase remote work and telehealth opportunities.

Enhance Data Collection to Identify Successes, Challenges, and Priorities of the Workforce and Promote Evidence-Informed Strategies

To achieve the goals of improving development, diversity and wellness of the health care workforce requires strategies informed by evidence. Enhancing data collection is imperative to help evaluate and understand challenges and priorities of the workforce, and ensure strategies are relevant and specific. Since the previous report, several evaluations and needs assessments have been completed on progress made, as well next steps to address workforce issues and achieve health equity.

Continued recommendations include:

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- Survey health care workers to evaluate burnout and identify their challenges and priorities for wellness and resiliency improvement.
- Use REALD (race, ethnicity, language, and disability) and SOGI (sexual orientation and gender identity) data to help develop workforce wellness programs that provide culturally responsive support to workforce members.
- Improve data collection and accessibility to support health care employers for demand planning.

New recommendations include:

- Investigate the benefits of licensure reciprocity to accept credentials from other states.
- Invest in data collection and research to improve the understanding of whether benefits to support housing, childcare, or transportation influence workforce diversity, recruitment and retention, and wellness and resiliency.
- Evaluate the benefits and unintended consequences of workforce initiatives, funding, and incentive programs, which requires funding for external evaluators.

Conclusion

Since the release of the 2023 Health Care Workforce Needs Assessment, Oregon has made progress in expanding, retaining, and diversifying the health care workforce, but problems like workforce shortages, lack of diversity, and provider burnout still exist. OHPB's Health Care Workforce Committee adopted the Strategic Framework and prioritized three goals of **workforce diversity**, **wellness and resiliency**, **and development and retention**. This current assessment report provides recommendations on achieving the vision of "*a robust, diverse, and resilient health care workforce that provides culturally and linguistically responsive care, eliminates health inequities, and meets the local health care needs of everyone in Oregon.*" The report's recommendations are interrelated and warrant collaborative and coordinated actions among government, legislature, education institutions, health care organizations, local communities, and even interested groups out of the health care sector to ensure Oregon has the workforce it needs.

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List of Abbreviations

- AFHs, Adult Foster Homes
- ADN, Associate Degree of Nursing
- AHRQ, Agency for Healthcare Research and Quality's resource
- ALFs, Assisted Living Facilities
- APDs, Aging and People with Disabilities
- APRNs, Advanced Practiced Registered Nurses
- ASL, American Sign Language
- ASPE, Assistant Secretary for Planning and Evaluation
- BHWi, Behavioral Health Workforce Initiative
- BRFSS, Behavioral Risk Factor Surveillance System
- BSN, Bachelor's Degree of Nursing
- CADC, Certified Alcohol & Drug Counselor
- CBC, Community-Based Care
- CBO, Community-Based Organization
- CCBHC, Certified Community Behavioral Health Clinics
- CCO, Coordinated Care Organization
- CHIS, California Health Interview Survey
- CHLO, Coalition of Local Health Officials
- CHW, Community Health Workers
- CMS, Centers for Medicare & Medicaid Services
- CNA, Certified Nursing Assistant
- DDS, Doctor of Dental Surgery
- DHAT, Dental Health Aide Therapist
- DMD; Doctor of Medicine in Dentistry

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- DO, Doctor of Osteopathy
- EPDH, Expanded Practice Dental Hygienist
- FAPE, Free Appropriate Public Education
- FCC, Federal Communications Commission
- FFS, Fee-For-Service
- FTE, Full-time Equivalent
- FQHC, Federally Qualified Health Centers
- GAC, Gender Affirming Care
- GARE, Government Alliance on Race and Equity
- HCI, Health Care Interpreters
- HHS, Health and Human Services
- HOWTO, Healthy Oregon Workforce Training Opportunity
- HPRD, Hours Per Resident Day
- HRSA, Health Resources and Services Administration
- HWE, Health Work Environment
- IDEA, Individuals with Disabilities Education Act
- KFF, Kaiser Family Foundation
- LEP, Limited English Proficiency
- LPHA, Local Public Health Authority
- LPNs, Licensed Practical Nurses
- LTSS, Long-Term Services and Supports
- MACPAC, Medicaid and CHIP Payment and Access Commission
- MCCs, Memory Care Communities
- MD, Medical Doctor
- NHSC, National Health Services Corps
- NP, Nurse Practitioner
- OBHLRP, Oregon Behavioral Health Loan Repayment Program
- OCHCI, Oregon Council on Health Care Interpreters
- OCN, Oregon Center for Nursing
- ODDS, Office of Developmental Disability Services
- ODHS, Oregon Department of Human Services
- OED, Oregon Employment Department
- OHA, Oregon Health Authority
- OHCA, Oregon Health Care Association
- OHP, Oregon Health Plan
- OHPB, Oregon Health Policy Board
- OHSU, Oregon Health & Science University
- OLDC, Oregon Longitudinal Data Collaborative
- ORS, Oregon Revised Statutes
- OSBN, Oregon State Board of Nursing
- OT, Occupational Therapists

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- PA, Physician Assistant
- PCPCH, Patient-Centered Primary Care Home
- PHD, Public Health Division
- PHEC, Post-Hospital Extended Care
- PH WINS, Public Health Workforce Interests and Needs Survey
- PSU, Portland State University
- PT, Physical Therapists
- QMHA, Qualified Mental Health Associate
- RCFs, Residential Care Facilities
- REALD, Race, Ethnicity, Language and Disability
- RENEW, Retaining and Elevating the Nurse Education Workforce
- RHC, Rural Health Center
- RHEC, Regional Health Equity Coalitions
- RID, Registry of Interpreters for the Deaf
- RNs, Registered Nurses
- RTFs, Residential Treatment Facilities
- RTHs, Residential Treatment Homes
- SFY, State Fiscal Year
- SHARE, Supporting Health for All through Reinvestment
- SHOI, Scholarships and Scholars for a Healthy Oregon Initiative
- SLP, Speech-Language Pathology therapists
- SNFs, Skilled Nursing Facilities
- SOGI, Sexual Orientation and Gender Identity
- TGD, Transgender and Gender Diverse
- WPATH, World Professional Association for Transgender Health
- WYSAC, Wyoming Survey & Analysis Center
- YRBS, Youth Behavioral Risk System

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Appendix A: Background

Health Care Workforce Committee Strategic Framework

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Appendix B: Investments in Workforce Development

Oregon Workforce Investments

Behavioral Health Investment

Since 2021, the Oregon Legislature made significant investments totaling over $1.35 billion to recruit, retain, and diversify the behavioral health workforce.

- House Bill 2949 (2021) and House Bill 4071 (2022) created the Behavioral Health Workforce Incentive program (BHWI) to recruit and retain providers who

are people of color, tribal members, or residents of rural areas in this state and who can provide culturally specific behavioral health services. BHWI supports:
  - $60 million for scholarships, loan repayment, and retention activities
  - $20 million to provide supervised clinical experience to associates or other individuals so they may obtain a license or certificate to practice.

- House Bill 5202 (2022) includes a Special Purpose Appropriation by Committee recommendation for $42.5 million in state general funds for OHA to increase fee-for-service (FFS) and coordinated care organization (CCO) behavioral health provider rates by an average of 30 percent.

- House Bill 2235 (2023) requires OHA to convene a workgroup to study barriers to workforce recruitment and retention in Oregon's publicly financed behavioral health system and formalize recommendations for improvement in 2025.

- The 2025-2027 Governor's Recommended Budget focuses on increasing the supply and distribution of a diverse and culturally responsive behavioral health workforce by investing $25.7 million in behavioral health education and training programs, wrap-around supports for students, and tuition assistance and scholarships, and investing $24.3 million in graduate stipends, loan repayment, and peer and manager support for the community mental health workforce.

Additional funding outside of the Oregon legislature funding include:

- The Opioid Settlement Board allocated $450,000 to support Oregon Coalition of Prevention Professionals/Oregon Council for Behavioral Health to train and certify two cohorts of 25 Certified Prevention Specialists per year to relieve gaps in certified/credentialed workforce with training in primary prevention.

- United We Heal Oregon creates behavioral health career advancement opportunities through completion of advanced certifications gained in apprenticeship and training programs. OHA announced November 1, 2024 that they will amend Medicaid State Plan to add supplemental payments for behavioral health providers. United We Heal Supplemental Payments Program will provide supplemental medical assistance payments to eligible behavioral health care providers to enhanced apprenticeship and training programs.

Hospital and Health Facility Staffing

The Oregon Legislature made investments in programs to address shortages and stabilize the state's workforce:

- House Bill 3396 (2023) provides funds to support clinical education at hospitals and health care facilities, and support two labor/management training trusts (Shirely Ware Education Center and RISE Partnership) to expand on-the-job training, apprenticeship opportunities and other programs that support the development of health care professionals. It also established a Joint Task Force on Hospital Discharge Challenges charged with developing recommendations to address Oregon hospitals' challenges in discharging patients to post-acute care.

- House Bill 2665 (2023), directed OHA to set maximum rates for temporary nursing and direct care staff. OHA conducted an environmental scan of wage levels and temporary staffing rate caps in other states, developed a rate setting methodology, and plans to finalize rules maximum wage rates effective January 2025.

Coordinated Care Organization (CCO) Investments

The Supporting Health for All through REinvestment (SHARE) Initiative comes from a legislative requirement for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on efforts to address health inequities and social determinants of health and equity. Examples of health care workforce projects CCOs have funded via SHARE include:

- Yamhill Community Care CCO awarded more than $4.84 million in grant funding to 19 local Traditional Health Workers (THW) organizations to increase the number of certified THWs and provide continuing education for existing THWs.
- Yamhill Community Care CCO partnered with Willamette Workforce Partnership to launch the Workforce Supports for Yamhill County Future Clinician Behavioral Health Practitioners Training Program to boost the behavioral health workforce within the county.
- Eastern Oregon CCO supported the creation of the Master of Science in Clinical Mental Health Counseling and Master of Science in Social Work program at Eastern Oregon University in 2023, which will train 150 students per academic year, and over $400,000 will be provided in scholarships by Eastern Oregon CCO to Eastern Oregon University students. Eastern Oregon CCO also committed $1,070,000 to train individuals to become Qualified or Certified interpreters and provide interpreter services to its members.

Future Ready Oregon

Future Ready Oregon, established under Senate Bill 1545 (2022), is a $200 million package of investments that work together to advance a more equitable workforce system and increase opportunities for diverse workers. In the 2022-2023 program year, the Higher Education Coordinating Commission (HECC):

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- Awarded approximately $87 million in **Workforce Ready Grants** via three rounds of competitive funding awards (March 2022 – December 2024). Sixteen projects totaling approximately $10.8 million will advance healthcare career pathways, connecting participants with regionally identified high-demand occupations in fields such as community health, behavioral health, surgical tech, phlebotomy, and dentistry.
- Convened three statewide, sector-specific **Industry Consortia** in 2023—representing the health care, manufacturing, and technology sectors.
- **Workforce Benefits Navigators**: Oregon's nine local workforce development boards (LWDBs) have launched their Future Ready Oregon Workforce Benefits Navigators (WBN) projects to increase access to benefits and services available through workforce programs. These benefits and services are geared towards helping marginalized and underserved communities access workforce education and training opportunities, career coaching, and comprehensive wraparound supports. Future Ready Oregon (Senate Bill 1545, 2022) allocated $10 million for the HECC to develop a WBN program in partnership with the LWDBs to implement pilot projects in their respective regions to ensure equitable access to workforce services and wraparound supports to meet basic needs. The LWDBs are piloting a variety of strategies designed to connect community members with workforce training opportunities and related benefits via WorkSource Oregon (WSO) and local partners, including culturally specific CBOs.

Students and learners, particularly individuals who have been historically marginalized, face barriers to access and the successful completion of education and training that leads to high-wage, high-demand jobs. Through grant-funded programs and strategic initiatives Future Ready Oregon aims to close gaps in educational attainment and employment and strengthen Oregon's economic competitiveness. In the first two years of implementation (March 2022 – December 2023), Future Ready Oregon has served nearly 12,000 participants. Ninety-two percent of participants (92%) identified with one or more of the priority populations. Nearly two-thirds of participants (62%) identified with at least two priority populations, and Future Ready Oregon participants were more diverse than the labor force overall, when considering race/ethnicity, gender, and geography. Thirty-one percent of education and training participants (31%) engaged with wraparound supports; and participants indicated a 96% completion rate for services, including intentional support services, career coaching, workforce development training, and early career skills.

Consortia are bringing together education, industry, and community partners to assess critical workforce needs, skills standards, and career pathways and identify barriers to equitable workforce participation. Recently, the consortia heard from Jensen Strategies, the consulting group that conducted focus groups with employers in the health care, manufacturing, and technology industry sectors across the state in summer 2024 to

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better understand their workforce and talent development needs. The focus group findings include the experiences and needs of Oregon's employers related to workforce planning, training, development, and retention and will inform the Health care Consortium's discussions and recommendations. Jensen Strategies presented preliminary findings and recommendations at the Healthcare Industry Consortium's September 24, 2024 meeting. A full report is expected in December 2024.

Oregon Health & Science University (OHSU) 30-30-30 Plan

OHSU's 30-30-30 initiative was developed to help address health care workforce shortages and health care inequities that worsened during the COVID-19 pandemic and have disproportionately affected underserved communities. OHSU 30-30-30 goal is to increase graduates from certain OHSU health care programs by at least 30% and increase student diversity to at least 30% by 2030. In 2022, under House Bill 5202, the Oregon Legislature invested $45 million in OHSU 30-30-30:

- $20 million in annually recurring funds to expand class sizes for certain health care professional programs and to increase student body diversity.
- $25 million in one-time funding toward programs to help recruit and retain a more diverse student body at OHSU through scholarships. Over $6.5 million in student scholarships has been awarded since the start of the 30-30-30 initiative.

To meet its 30-30-30 goals, OHSU has funded over 35 initiatives focused on building the academic and student services infrastructure necessary to support larger class sizes in certain health profession programs and to recruit and retain a more diverse student body. OHSU also initiated new scholarship programs that help to overcome the significant cost barriers associated with seeking a health profession education, aiding recruitment growth and increasing the rate of degree completion.

National Workforce Investments

National Health Services Corps (NHSC) Program

The NHSC is part of the US Department of Health and Human Services and administered by the Health Resources and Services Administration, Bureau of Clinician Recruitment and Service. NHSC offers loan repayment incentives and scholarships to students and providers in qualifying primary health care professions who provide services in federally designated Health Professional Shortage Areas (HPSA). There are more than 200 NHSC-approved sites across Oregon. Licensed primary care medical, dental, and mental and behavioral health providers practicing at a NHSC-approved site with a HPSA score of 14 or above in return for a two-year, full-time commitment can be awarded up to $50,000 for loan repayment.

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Physician Visa Waiver Program

The Physician Visa Waiver Program (also called the J-1 Visa Waiver Program, Conrad Program, and Exchange Visitor Program) allows international medical graduates who have completed residencies or fellowships in the United States to remain in this country to practice in federally designated shortage areas. Each state may submit up to 30 waivers per fiscal year (October 1 through September 30). The Oregon Primary Care Office examines each application for accuracy and completeness before sending it to the U.S. Department of State. Annual summary shows that the Oregon program placed a total of 525 physicians in 40 cities throughout the state between 2002 and 2023.

Appendix C: Health Care Workforce Shortages and Impacts of COVID-19

Recommendations to Address Health Care Workforce Shortage

Increase investment in education and training programs to improve skilled and culturally competent health care workforce. The Workforce Development and Retention subcommittee recommends health-related education and training programs be aligned with the needs of the health care sector, reflect the diversity of the state, and incorporate practical training experience. (See Education and Career Pathway section) The subcommittee also recommends developing a sustainable funding strategy to support health care workforce development, recruitment, and retention efforts. (See Investment in Workforce Development section)

- To address workforce shortages in rural areas, the Oregon Office of Rural Health helps match primary care providers (physicians, nurse practitioners, physician assistants, dentists, and more) with organizations that provide primary care services throughout Oregon's rural and urban underserved health care communities. The Physician Visa Waiver Program allows Oregon to sponsor 30 waiver applications of international medical graduates per federal fiscal year (October 1 to September 30) to remain in the United States if they work in a federally designated shortage area. To retain health care professionals, OHA offers state-funded incentives toward workforce retention such as loan repayment from the Health Care Provider Incentive Program and Behavioral Health Workforce Initiative (see Investment in Workforce Development section).

- The New York state's recently approved Medicaid 1115 Waiver includes $48 million of student loan repayment for psychiatrists with a priority on child and

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adolescent psychiatrists (up to $300,000 per provider); primary care physicians and dentists (up to $100,000 per provider); and nurse practitioners and pediatric clinical nurse specialists (up to $50,000 per provider). Health care professionals will make a four-year commitment to maintain a personal practice panel or work at an organization that includes at least 30 percent Medicaid and/or uninsured members. Award criteria include geographic distribution of applicants, regional need, commitment to working in underserved communities, and linguistic and cultural competency.

Develop strategies to increase recruitment, such as increasing access to health care careers and improving compensation and social factors. The Workforce Development and Retention subcommittee suggests expanding youth health care day camp opportunities to increase health care workforce recruitment. (See Education and Career Pathway section) To increase health care workforce from diverse communities, the subcommittee recommends providing application process support for underrepresented groups, and "*outreach efforts should be taken to ensure recruitment is reaching underrepresented and minority groups across Oregon."*. The subcommittee also recommends providing relocation assistance, such as financial incentives and cultural orientation programs, to increase the recruitment and retention of diverse health care providers. Improving compensation and other social factors (see Social Determinants of Work in Health Care Workforce section) can support workforce recruitment and retention, which would be particularly important in rural and remote areas.

Develop strategies to increase retention, such as providing wellness support and improving community integration and belonging. The Workforce Development and Retention subcommittee recommended promoting providers' connection to the local communities, such as recruiting rural and local students for rural positions, establishing mentorship programs to pair new health professionals with experienced practitioners, encourage community engagement initiatives, and offer cultural sensitivity training. The subcommittee highlights the importance of providing a supportive and fulfilling work environment and providing employees wellness programs designed by employees. (See Workforce Wellness and Resiliency section). The Future Ready Oregon focus groups recommended similar strategies on improving work environment and work-life balance to increase retention, including providing education to health care employer leadership and staff on cultural competency, enabling and supporting onsite childcare, enabling and supporting employee housing assistance. The focus groups also recommended "*investing in workplace violence prevention and reduction through training, education, and legislation that holds people accountable for their violent actions.*"

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Improve data collection and accessibility to support health care employers for demand planning. According to the Future Ready Oregon's focus groups study, workforce- demand planning was short-term for nearly all health care employers, focusing on addressing immediate needs. Changing expectations and unpredictable staffing supply made it challenging to conduct long-term planning. It is important to improve collection of state and/or national data, such as demographic and population trends, retention levels (e.g. by position, category and/or sector), Medicaid participants, position vacancy statistics, wages, cost of care, etc. The focus groups also recommended establishing a central data resource website that is accessible to all health care employers.

Appendix D: Education and Career Pathways

Recommendations to support education and career pathways

Expand opportunities to support pipeline programs in middle and high schools.

- **Northeast Oregon Area Health Education Center** provides **pathway programs for middle and high school students**, like the MedQuest camp for high school students to explore health care careers and the Investigators of Science Day Camp, held in partnership with Eastern Oregon University to explore health care workforce careers.
- **The Tribal Health Scholars program** is a **paid externship program that supports and inspires American Indian and Alaska Native high school students** to pursue careers in health care. The program works as a partnership between tribal communities, the Northwest Native American Center of Excellence, and the Northwest Portland Area Indian Health Board. Students receive 14-week online courses, 12-hour clinical shadowing, and education and career mentorship. As of October 2024, 132 scholars have completed the Tribal Health Scholars programs since 2018. Oregon also has many incentive

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The Workforce Development and Retention subcommittee and the Future Ready Oregon focus groups of health care employers recommended continuing and enhancing health care career programs in middle and high schools to support students who are passionate about the health professions. The Workforce Development and Retention subcommittee suggested the programs should "*focus on health care experiences or shadowing, exam training, career counseling, and mentorship*."

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programs to support education pipeline and reduce educational debt burden for practicing professionals. (See Investment in Workforce Development section)

Oregon also has growing funding for **apprenticeships and training to offer career ladders for health care workers**. Below are a few examples:

- House Bill 3396 (2023) provides funds to:
    - Support clinical education at hospitals and health care facilities.
    - Support two labor/management training trusts (Shirely Ware Education Center and RISE Partnership) to expand on-the-job training, apprenticeship opportunities and other programs that support the development of health care professionals.
- Senate Bill 1545 (2022) established Future Ready Oregon , which provided investments that "*strategically leverage state General Fund and federal American Rescue Plan Act (ARPA) resources to promote collaboration and innovation in workforce and talent development*". (See Investment in Workforce Development section)
- Long-Term CareWorks is an Oregon-registered, Certified Nursing Assistant Apprenticeship delivered by RISE Partnership. It provides workers in Oregon long-term care settings with classroom instruction, on-the-job experience, and career mentorship. In 2023 it trained 87 apprentices across the state. (see Long-Term Care Workforce section).
- United We Heal provides behavioral health apprenticeships. The programs offer classroom learning, on-the-job training, and financial stipends depending on individual needs. As of August 2024, 178 health care professionals participated in the programs, 40 Qualified Mental Health Associate or Certified Alcohol and Drug Counselor graduated, and over 80% of apprentices were identified as a member of an underrepresented population. (See Behavioral Health Workforce section).
- The Northwest Native American Center of Excellence at OHSU provides multiple post-baccalaureate health education pathway programs for American Indian and Alaska Native learners to pursue health professional careers, including Wy'east Medicine, Wy'east Nursing, and Wy'east Dentistry. The pathways provide a holistic, culturally specific framework to promote health professional careers among American Indians and Alaska Natives. The Northwest Native American Center of Excellence also offers Health Pathway Coaching through text mentoring, newsletter, visual stories, and applicant workshop.

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Coordinate efforts for health care education and career advancement. New York's Career Pathways Training Program can be an example of supporting people to enter a career pathway, have advancement opportunities and remain in the health care field.

- The **New York Health Equity Reform 1115 Waiver includes $646 million for the Career Pathways Training Program** "*to provide holistic educational and professional placement supports for those newly entering the workforce and those seeking to advance in their careers*." Career training will be organized to support New Careers in Health care Pipeline and Health care Career Advancement Pipeline Three high-performing Workforce Investment Organizations were created to manage the Career Pathways Training Program. These Workforce Investment Organizations must have deep connections to their respective regions, have demonstrated success in operationalizing workforce training programs, and have capacity to rapidly and effectively stand up the Career Pathways Training program in their region. To coordinate education and training activities, these Workforce Investment Organizations will:
    - Conduct outreach to recruit prospective students and providers
    - Form partnerships with educational institutions, social care networks, and providers
    - Coordinate educational programs for new and current health care workers
    - Provide meaningful support for participants to assure successful completion of programs, including case management, tutoring, and other academic support (e.g., apprenticeship and mentorship programs)
    - Make payments for books, academic fees, and backfill for current employees' time spent in training programs
    - Aid in job placement to meet service commitments
    - Perform data collection and reporting on performance metrics, spending, and other information.

  Adopting a similar strategy to enhance collaboration with education partners, health care employers and other interested groups in Oregon can help coordinate efforts to support health care education and career pathways programs. The Future Ready Oregon focus group participants also recommended "*establishing a state level position charged with coordinating dialogue between health care employers and Oregon's educational system*".

Increase access to health care careers for people from diverse communities. Investments should focus on early career development for high school students and career advancement for health care workforces from underrepresented communities. The Future Ready Oregon focus groups of health care employers also recommended

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expanding access to education and training programs in rural areas and areas with significant priority populations. Creating training opportunities in underserved areas is particularly important to recruit and retain rural and underrepresented populations to the field.

Health care provider comments:

"I would suggest creating opportunities for individuals to be trained near their hometown. Apprenticeship programs in rural and underserved communities would increase workforce retention."

Increase training slots to train more providers, and increase incentives for academic positions.

- The "Resident Physician Shortage Reduction Act of 2023" would provide 2,000 new Medicare-supported graduate medical education positions per fiscal year from FY2025-FY2031, for a total of 14,000 new positions over seven years. The bill particularly requires the Government Accountability Office to "*report on strategies to increase the diversity of the health professional workforce, including with respect to representation from rural, low-income, and minority communities.*"

- The New York Health Equity Reform 1115 Waiver provides career training for participants newly entering the health care workforce and for those looking to advance in their careers. It is estimated to provide about 7,000 slots for nursing workforce (e.g. licensed practical nurse, associate registered nurse, etc)., 8,400 slots for professional technical workforce (e.g. physician assistant, licensed mental health counselor, credentialed alcohol and substance abuse counselor, etc)., and over 3,000 slots for frontline public health workers. Increasing training slots and funding to training more providers is an essential solution to the workforce crisis. It is also important to "*support professional growth opportunities (e.g., credentialling) for employees by providing onsite training and/or financial support for living expenses" as recommended by* the Future Ready Oregon focus groups of health care employers.

Increase academic position compensation to meet the increasing demand for faculty and teachers, since a significant gap exists between faculty and teaching position salaries and community salaries for health care professionals. The Future Ready Oregon focus groups of health care employers suggested increasing pay for

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higher education instructors who are training highly needed credentialed positions. Examples of programs include:

- The Health Resources and Services Administration's (HRSA) Nurse Faculty Loan Program, which provided low interest loans for individuals studying to be nurse faculty and loan cancelation for those who then go on to work as faculty to increase the number of qualified nursing faculty nationwide.

- House Bill 3396 (2023) requires OHA to provide grants to Oregon Center for Nursing (OCN) to work with Oregon's public nursing education programs to develop programs to recruit and retain nurse educators.

Despite this progress in investments and initiatives, the Future Ready Oregon focus groups of health care employers suggested that accessibility to health care education remained limited by geography and financial resources. The study highlighted challenges, such as lack of career path definitions and clarity, lack of job seeking coaching to assist employment candidates, and lack of early educational exposure of health care career opportunities and accessibility to engage priority populations.

Appendix E: Workforce Wellness and Resiliency

Recommendations to support workforce wellness and resiliency

Collect data on wellness to inform evidence-based strategies.

The Workforce Wellness and Resiliency subcommittee recommends surveying the health care workforce to evaluate their wellness and identify the leading factors contributing to their burnout. Survey findings can "*ensure that interventions are relevant, specific, and ultimately achieve an improvement in wellness outcomes*".

- The Health Center Workforce Well-being survey is an example for survey development to collect data on workforce wellness. The Health Resources & Services Administration conducted the Health Center Workforce Well-being survey to capture baseline data on workforce well-being, job satisfaction, and burnout of health workers. From November 2022 to early February 2023, nearly 700 health centers participated and more than 52,000 staff responded. The survey questions included sixteen "domains" and four "outcome measures"

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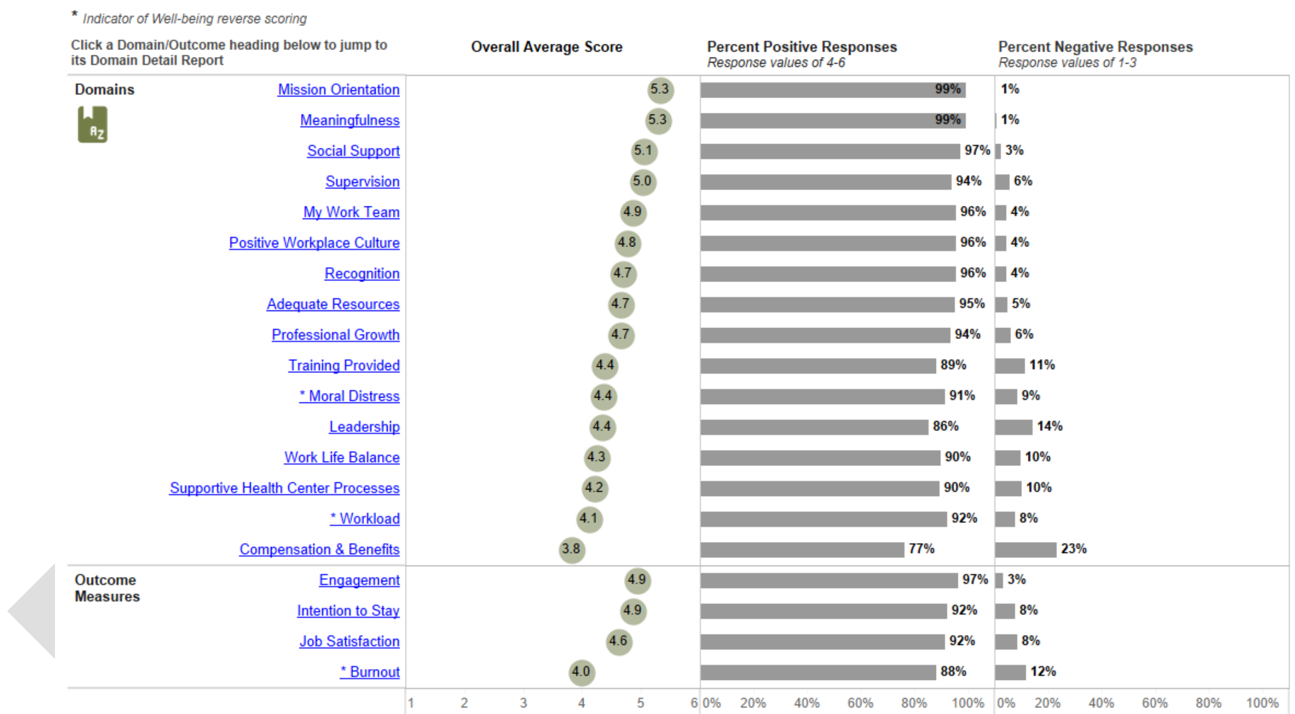
(Figure Appendix E.1).. The survey showed that "compensation and benefits" domain was the leading concern that had negative impacts on workforce well-being, with an overall 23% negative responses. For example, about 36% of respondents disagreed with the question "*I am well paid given my training and experience*", with 12% strongly disagreed. It also showed that 92% and 88% of responses were favorable to well-being when asked questions about "job satisfaction" and "burnout", respectively. Using the Health Center Workforce Well-being survey as model for developing the Oregon survey can improve comparability with national findings.

Figure Appendix E.1. Health Center Workforce Well-being survey domain summary overview



Source: The Health Resources & Services Administration. [Health Center Workforce Well-being Survey Dashboard]

Expand and fund the Oregon Wellness Program.

The [Oregon Wellness Program] provides wellness support for physicians, nurses, and other health care professionals in Oregon. The program promotes health care professionals' well-being through confidential counseling, education, and research. The Workforce Wellness and Resiliency subcommittee recommends

funding and expanding the Oregon Wellness Program to provide prevention, acute intervention, and chronic management support for all health care workforce members in Oregon. Supporting the Oregon Wellness program is particularly important for workforce in rural areas.

Health care provider comments:

"*Oregon's support for the Oregon Wellness Program deserves recognition, as it provides critical mental health resources for health care providers. This support is essential, especially in rural areas where such resources are scarce.*"

Create a statewide system to recognize and reward employers that improve employee well-being.

The Workforce Wellness and Resiliency subcommittee recommend OHA create a statewide system to "reward employers that take steps to understand the needs of their employees and implement wellness programs that address these needs". Employees have varying needs to improve their well-being and reduce burnout. Therefore, before developing and implementing employee wellness programs, employers should conduct evaluation and collect data to understand the needs of their employees and identify leading risk factors of stress and burnout. The Workforce Development and Retention subcommittee recommends that employee wellness programs be "*designed by employees rather than developed through a top-down approach or human resources decision-making program development*". The subcommittee provided a list of employee wellness activities, such as engaging in healing conversations to promote positive coping and resilience, talking about emotional experience to reduce isolation and despair, providing onsite healing spaces, and incorporating actions in a strategic plan.

It is also important to use an equity approach to employee wellness programs and provide culturally responsive support to workforce members seeking care. The workforce wellness survey should collect data on demographic characteristics such as Race, Ethnicity, Language and Disability (REALD), Sexual Orientation and Gender Identity data (SOGI), and practice location and setting. These data can support the development of workforce wellness programs that provide culturally responsive solutions to unique symptoms, and risk and resilience factors. To recognize and reward employers for providing

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culturally responsive wellness programs, OHA should develop a standardized evaluation rubric consistent with the Health Care Workforce Committee's Health Equity Framework.

Create and sustain positive work environments and culture to improve work-life balance.

Health care staff are more focused on self-care and work-life balance, recognizing the importance of time and flexibility for personal pursuits. There is a high demand for flexible schedules and innovative patient care models with remote and telemedicine options. The Oregon legislature passed House Bill 2235 (2023) requiring OHA to convene a workgroup to focus on reducing administrative and other burdens that affect health care workforce. To improve work-life balance, recommendations included employers implementing flexible work schedules, offering sabbaticals and paid time off benefits, improving remote work and telehealth opportunities, and providing mental health support and employee education on stress management. (Also see Nursing Workforce section)

Health care provider comments:

"*I think the pandemic was the catalyst for various workforce to examine that home/life balance. Many initially liked remote options for employment. I think four years later, the workforce changed, and this workforce demands more flexibility in where and how they work.*"

Increase compensation and benefits and improve social factors.

The Health Center Workforce Well-being survey showed that "compensation and benefits" was the leading concern that had negative impacts on workforce well-being (Figure above). About 36% of respondents disagreed with the question "*I am well paid given my training and experience,*" with 12% strongly disagreed. Comparing rural and urban areas, 66% of respondents in rural areas reported they were well paid given their training and experience (12% strongly agreed), which was higher than 63% in urban areas (11% strongly agreed). Therefore, in addition to improving compensation, it is important to improve other social factors to support wellness and resiliency for workforce in rural areas. (see Social Determinants of Work in Health Care Workforce section) This also requires improving data collection and evaluation, as recommended above, to identify

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leading social factors contributing workforce stress and burnout, and inform evidence-based interventions to improve wellness and resiliency.

Appendix F: Traditional Health Workers

Background on Traditional Health Workers in Oregon

Traditional Health Workers (THWs) are trusted individuals from their local communities who provide person-and community-centered care by bridging communities and the health systems they serve. Utilizations of THWs helps assure delivery of high-quality, culturally competent care which is instrumental in achieving Oregon's Triple Aim of better health, better care, and lower costs. THW roles were defined in the original bill that created Oregon's coordinated care organizations (CCOs) in 2011, House Bill 3650.

In February 2021, a survey as distributed via email to 3,070 THWs on OHA's THW registry described the demographics of those registered. THWs identified as primarily female and White. CHWs identified with more as persons of color than the other THW types. Females represented the overwhelming proportion of doulas and CHW; however, approximately one-third of peer support specialists and peer wellness specialists identified as male. Language use varied greatly between groups, with CHWs being most likely to use a language other than English at home (42.6%) as compared to doula (12.5%). The survey has not been conducted again since the previous needs assessment report in 2023.

A 2024 Traditional Health Worker Program Training Gap Analysis was presented in September 2024 to the THW Commission. See Figures 10.2 and 10.3. This analysis look at THW trainings in Oregon approved through June 2024. There have been 59 trainings nearly twice as many trainings done than in the 2018 report. With funding from Measure 110, there was an increase in trainings for Peer Support Specialists on Adult Addictions. Nearly half of all trainings served the Portland Metro region which may be an oversaturation unless dedicated for culturally-specific trainings. Over one-third of training were offered statewide. Significant increases in number of virtual or distance learning options offered with only one-third of trainings limited to in-person (other trainings offered as hybrid or distance learning). Gaps of trainings in certain regions of the state include Central Oregon, Coastal Oregon, Columbia Gorge and rural and frontier regions. Lack of Peer Support Specialists in the Willamette Valley Region.

Appendix G: Primary Care Providers

Examples of programs to support primary care providers

The U.S. Department of Health and Human Services (HHS) has taken the following actions to strengthen primary care:

- National Health Service Corps supports more than 18,000 primary care medical, dental, and behavioral health providers nationwide through scholarships and loan repayment programs, in exchange for serving in Health Professional Shortage Areas.
- The Teaching Health Center Graduate Medical Education Program awarded over $175 million during the 2023-24 academic year support the training of over 1,096 residents in 81 community-based residency programs. CMS awarded new Medicare-funded physician residency slots to fund additional positions in hospitals serving the underserved communities.
- To retain and recruit physicians in underserved and rural areas, HHS invested over $43 million in the Rural Residency Planning and Development program from fiscal year 2019-2022. In 2023, HHS awarded nearly $11 million to establishing new residency programs in rural communities.
- The Community Health Worker and Health Support Worker Training Program funded projects to increase the number of CHWs and Health Support Workers.
- The Advanced Nursing Education Nurse Practitioner Residency and Fellowship Program also provided funding to train nurses and nurse practitioners to effectively deliver primary care, mental health and maternal health care.
- HRSA awarded $103 million to reduce burnout and promote mental health and wellness among the health care workforce. The Agency for Health care Research and Quality's (AHRQ) resource provided guidance for primary care administrators, leaders, and clinicians to address burnout in primary care.

HHS announced over $8 million through 18 awards in 2023 to train primary care medical and physician associate students, and medical residents in providing culturally and linguistically appropriate care.

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Appendix H: School Health Providers

Programs to support School Mental Health Providers

The Oregon Department of Education, and partners at the Oregon Health Authority and Oregon Department of Human Services are implementing several innovative strategies to scaffold the mental health workforce. These efforts focus on providing youth and their families with fundamental resources to support their primary health and mental health needs. For example, in the Community Care Demonstration Project, Community Care Specialists, who are embedded in schools, provide emotional support and mental health and health navigation services to students and families. This often involves connecting families with local systems of care to ensure that identified health and mental health needs are met as rapidly as possible. Wraparound support often includes referrals to mental health services, health, vision and dental care, housing/shelter, food, clothing, and childcare. Specialists either provide warm handoffs or accompany families to services.

Similarly, ODHS Family Preservation teams, some of whom are co-located in schools, increase family access to necessary services and supports to increase health and well-being, and decrease family stress that often increases the risk for chronic absenteeism, and student mental health challenges. In focusing on providing Tier 1 preventative services and supports to students and their families, these two initiatives are intended to decrease the burden on qualified, licensed and credentialed mental health providers, allowing them to focus on students at greater need for psychological services.

Appendix I: Nursing Workforce

Oregon's Nursing Workforce

Nurse staffing ratios:
Oregon skilled nursing facilities (SNFs) are required to meet minimum staffing requirements for CNAs and RNs. They must provide at least 2.45 hours per resident day (HPRD) of CNA care and one hour of RN care per week. Other requirements include CNA-to-patient ratios and facility-level RN staffing levels. In 2024, CMS finalized new national staffing rules for SNFs that include 0.55 HPRD of RN care, 2.45 HPRD of CNA care, and 3.48 total HPRD of nursing care (including CNAs, LPNs, and RNs). In addition, a RN must be present in the facility 24 hours a day, 7 days per week. The new rules become effective between 2026 and 2029, with the earliest implementation in urban areas.

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In 2023, average RN HPRD was similar for Oregon and the rest of US, at 0.66 and 0.71, respectively. Average CNA HPRD was higher for Oregon (2.90) compared to the rest of US (2.11). Almost seven in 10 Oregon SNFs met the 0.55 HPRD RN staffing requirement, and nine in ten met the 2.45 HPRD CNA staffing requirement. Data on 24/7 RN staffing are not currently available.

Oregon HB 2697 mandates nurse-to-patient ratios in multiple hospital units maximum ratios that range from: 1 patient per nurse in settings such as active labor and delivery or emergency department trauma; to 2 patients per nurse in intensive care; and 4 patients[5] per nurse in medical/surgical units. One CNA can be assigned a maximum of seven patients on the day shift and eleven on the night shift. Hospital nurse staffing committees may adopt different ratios only if they implement innovative care models that include other clinical staff.

Future of the Nursing Workforce

Nursing shortage—or Vacancy crisis?

A national nursing shortage is widely discussed. HRSA has projected a nationwide shortage of almost 80,000 RNs in 2025, although it projects the national shortage to be ameliorated by 2035. Another recent analysis projects that the decrease in the nursing workforce during the COVID-19 pandemic was temporary, and that the number of RNs nationwide will be more than one-third larger in 2035 than in 2022. However, the HRSA projections indicate that nursing shortages will persist in several states by 2035, with four of the six states with the greatest shortages being Washington (26%), California (18%), Oregon (16%), and Idaho (15%).

Hospitals nationwide report high vacancy rates for nursing positions and difficulty in hiring nurses. In late 2023, 69% of hospital nursing leaders cited "staff recruitment and retention" as their most pressing challenging, up from 47% in mid-2021. The pandemic exacerbated hospital staffing challenges, with one effect being that over 5% of RNs were travel nurses in 2022, compared to 1% in 2018. SNFs also report severe difficulty in hiring nursing staff, with nearly half of facilities having to limit admissions as a result. OCN has described this situation as a "vacancy crisis," where increasing the number of nurses does not automatically decrease open nursing positions, particularly in direct patient care settings

Many nurses contend that working conditions deter them from taking available positions. Burnout affects many nurses, and was dramatically exacerbated by the pandemic. By late 2021, half of nurses nationwide reported emotional exhaustion, with

nurses reporting a higher rate than physicians or other health care professionals both before and during the pandemic. OCN measured very high levels of workplace stress among Oregon nurses in 2022.

Concern is widespread that burnout may lead nurses to leave practice. More than one in four nurses surveyed in 2022 said they planned to leave the profession in the following five years. However, the number of nurses who actually left clinical practice during the pandemic may not have been as large as feared. Nurses' attitudes improved somewhat as the pandemic waned, with a smaller proportion reporting that they planned to leave their current position or plan to leave the profession in 2023 than in 2022. Nevertheless, nurses continue to face high levels of workplace stress, for reasons that predate the pandemic.

Appendix J: Long-Term Care Workforce

Oregon's Long-term Care Workforce

Long-term services and supports (LTSS) include: assistance with instrumental activities of daily living such as housekeeping, shopping, and meal preparation; assistance with activities of daily living such as bathing, dressing, or transferring from bed to chair; medication management or assistance with other medical needs; and rehabilitative services.

Oregon offers LTSS in a continuum of long-term care settings that include:

- Home care, primarily for assistance with instrumental activities of daily living and activities of daily living. This assistance is often provided by family members or other informal caregivers, but many Oregonians also receive assistance from paid caregivers.
- Residential treatment homes (RTHs) and residential treatment facilities (RTFs) that provide a supportive residential environment for individuals with mental or emotional disorders, including serious mental illness.
- Group homes that house and support residents with intellectual or developmental disabilities
- Community-based care (CBC) facilities that include assisted living facilities (ALFs), residential care facilities (RCFs), and adult foster homes (AFHs). Community-based care residents may require more assistance with activities of daily living than in-home consumers, and often with medication management.
    - Memory care communities (MCCs) are RCFs or ALFs with specialized facilities and an additional endorsement to care for residents with advanced dementia.

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- Skilled nursing facilities (SNFs) that serve residents needing more intensive nursing services in addition to activities of daily living assistance. In Oregon, skilled nursing facilities emphasize post-acute care, often including physical, occupational, or speech therapy, for residents recently discharged from hospitals.

LTSS policies are mostly administered by the Oregon Department of Human Services (ODHS) through it Aging and People with Disabilities (APD) division and Office of Developmental Disability Services (ODDS). OHA's Behavioral Health Division funds RTHs, RTFs, and some AFHs.

The Oregon Health Care Association (OHCA) estimates that over 30,000 Oregonians received LTSS in CBCs or SNFs in 2023, and at least 30,000 others received home care. Approximately half of those care recipients were Medicaid beneficiaries.

Recruiting, retention, and compensation challenges in long-term care.

In addition to low pay and limited benefits, other causes of the longstanding high turnover and vacancy rates among direct care workers include:

- **Poor working conditions**. Although direct care work often pays less than other entry-level jobs, direct care workers also have higher injury rates than most other occupations. Direct care work also requires a large amount of emotional labor to interact with clients facing severe illness or disability, often in home settings where colleagues are not available for support.
- **Limited training and few career advancement opportunities**. These challenges are related to the existing structure of long term care jobs and organizations. Home care workers and CBC facility staff often receive limited training, despite the complexity of caring for individuals with serious conditions and high needs for assistance. Unpredictable work schedules and poor quality supervision further add to the stress of direct care work. Career advancement opportunities are limited by the narrow definition of most direct care workers' jobs.
- **Undervaluation of direct care work**. Although it is essential for recipients, direct care work remains undervalued by funders, policy makers, and much of the public. For example, many people do not understand that paid care provided in homes is as essential as that provided on hospitals or long term care facilities. The multiple dimensions of skill required to provide direct care are also often not recognized. Most people underestimate the probability that they will require direct care as they age, and overestimate how much direct care workers are paid. In economic terms, insufficient capacity for paid direct care imposes greater caregiving burdens on families and reduces labor force participation. The

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low pay and difficult working conditions of direct care work are also linked to the fact that direct care workers are disproportionately female, members of racial/ethnic minorities, low income, and/or immigrants.

Despite the many challenges of direct care, workers overwhelmingly want to continue in the profession. Nine in ten Oregon CNAs working in long term care want to continue that work in future years. In a recent survey of Idaho direct care workers, the most common reason for choosing to do direct care work is "I like helping people."

Recommendations for the Long-Term Care Workforce

Sources and details supporting specific recommendations:

- **Joint Task Force on Hospital Discharge Challenges.** SNFs and CBC facilities may not have staff adequately trained to accept patients with their complex care needs, especially severe mental illness, substance abuse, and/or housing insecurity; AFHs, although better able to meet such patients' care needs, may be unable to do so at current reimbursement rates. The Task Force's main recommendations were to: streamline LTSS eligibility determinations, for example by establishing presumptive Medicaid eligibility for LTSS; promote innovative care models such as medical respite care; and coordinate better with managed care entities such as CCOs, as well as extend the Medicaid Post-Hospital Extended Care (PHEC) benefit to fund up to 100 days of SNF care.

- **Ongoing Oregon programs**
    - The RISE Partnership sponsors several programs that benefit direct care workers, including:
        - Subsidized health insurance, paid time off, and other benefits to over 30,000 independent home care and personal care workers
        - Online and in-person training for home care workers
        - Subsidized health insurance via the Essential Health care Worker Trust
        - CNA apprenticeships that include stipends and wraparound supports during training
    - Future Ready Oregon will provide grants for career pathway programs in nursing or other workforce segments identified by Oregon communities. Grants are expected to be awarded by the end of 2024.
    - Oregon Care Partners provides free training to family caregivers and direct care workers

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- The Oregon Home Care Commission provides modest pay increases for home care workers who complete 25 hours of enhance certification training

- **Enhanced training and clear career pathways**. Non-licensed workers in home or residential care settings can benefit from, and be compensated for completing additional training in general aspects of care provision as well as caring for individuals with specific conditions such as dementia, mental illness, or developmental disability. California, for example, has funded a range of programs that provide enhanced training, in some cases with supportive stipends, to direct care workers. PHI helps to develop advanced direct care roles that include expertise in caring for specific conditions, peer mentoring and coaching, or care coordination. Career pathways can support direct care workers who want to move into licensed roles or attain a more advanced license. Oregon's RISE Partnership CNA apprenticeship is one example, and Washington state has created a financially supported apprenticeship program for CNAs to become LPNs.

- **Healthy work environments**. Several resources outline key aspects of healthy work environments, including PHI's 5 Pillars of Direct Care Job Quality, career advancement suggestions from Leading Age, examples of empowered direct care teams from the Commonwealth Fund, and guidelines for culturally inclusive environments form PSU.

- **State-level policy options and recommendations**.
  - Example sets of policy options relevant to Oregon have been developed by Idaho, Maine, and Michigan.
  - The Medicaid and CHIP Payment and Access Commission (MACPAC) also provides a useful inventory of Medicaid policies to strengthen the direct care workforce.
  - The National Governors Association suggests that states pursue a multi-sector, multi-agency strategy to develop coordinated direct care workforce policies
    - In Wisconsin, for example, a Governor's Task Force developed a coordinated set of recommendations to support family caregivers and strengthen the direct care workforce. Washington state has an ongoing Long Term Care Workforce Initiative, and Colorado has convened a multi-stakeholder collaborative to develop direct care workforce recruitment and retention strategies.

- **Vision for the direct care workforce**. Several organizations have laid out a comprehensive vision of a future direct care workforce that is well trained, fairly

compensated, highly valued, and works in health organizational environments. PHI has outlined this broad vision as well as detailed policies for the nation and for Oregon. Leading Age has outlined a very similar approach for professionalizing the LTSS workforce, and the Milbank Memorial Fund has produced a detailed policy toolkit with examples from many states.

Appendix K: Behavioral Health Providers

Behavioral health providers in Oregon

This year's report expanded details about the certified but not licensed behavioral health providers. The Mental Health & Addiction Certification Board of Oregon (MHACBO) tracks the certified behavioral health and substance use disorder workforce in Oregon. Table 14.4 details the types of providers included in MHACBO and enrollment numbers in May 2024. Most of the substance use disorder service organizations employ peer support specialists. Certified Recovery Mentors were most frequently employed. Oregon offers some reciprocity with other states if they use CADC reciprocity with all states who utilize the NAADAC or IC&RC National Psychometric Exams for their addiction counselors. Statewide Oregon averages one CADC for every 810 residents, one CRM for every 1,307 residents, one QMHA for every 814 residents, and one QMHP for every 2,044 residents (this position does not include LPC, LMFTs, or LCSWs). It should be noted that QMHPs and CADSx could be licensed (i.e., LCSW, psychologist, etc)., but still hold this credential. Refer to the Appendix Figures 14.8 -14.13 which depict the number of certified but not licensed behavioral health providers by 1,000 persons at the county level and by provider type.

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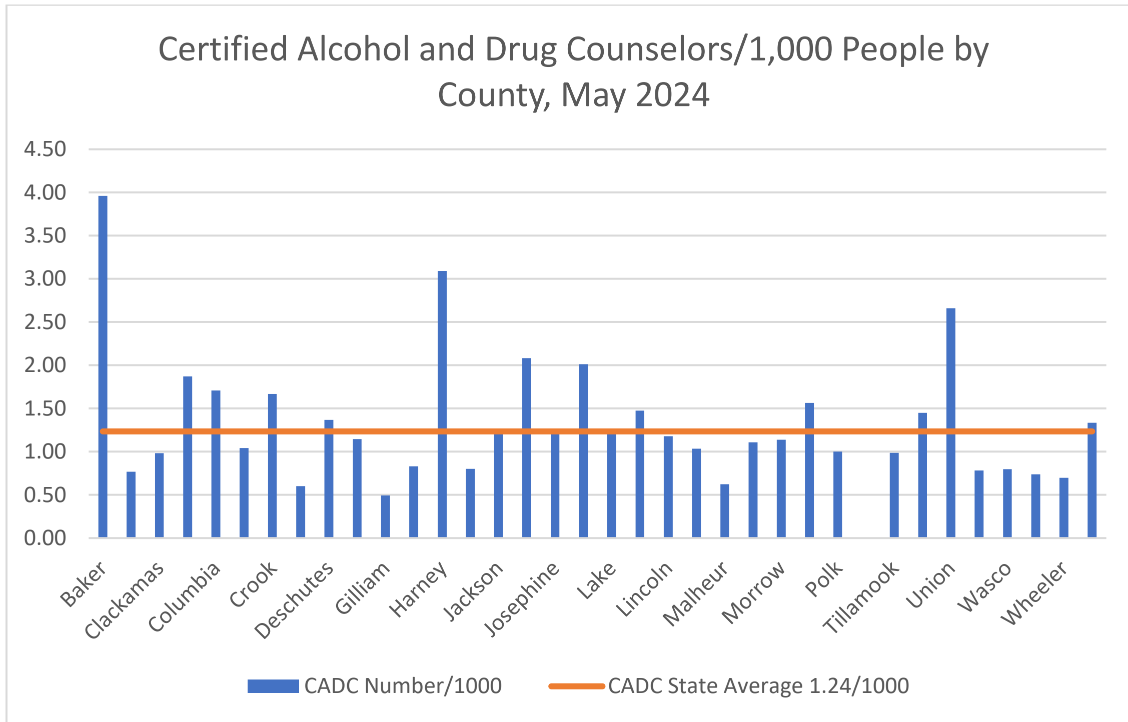
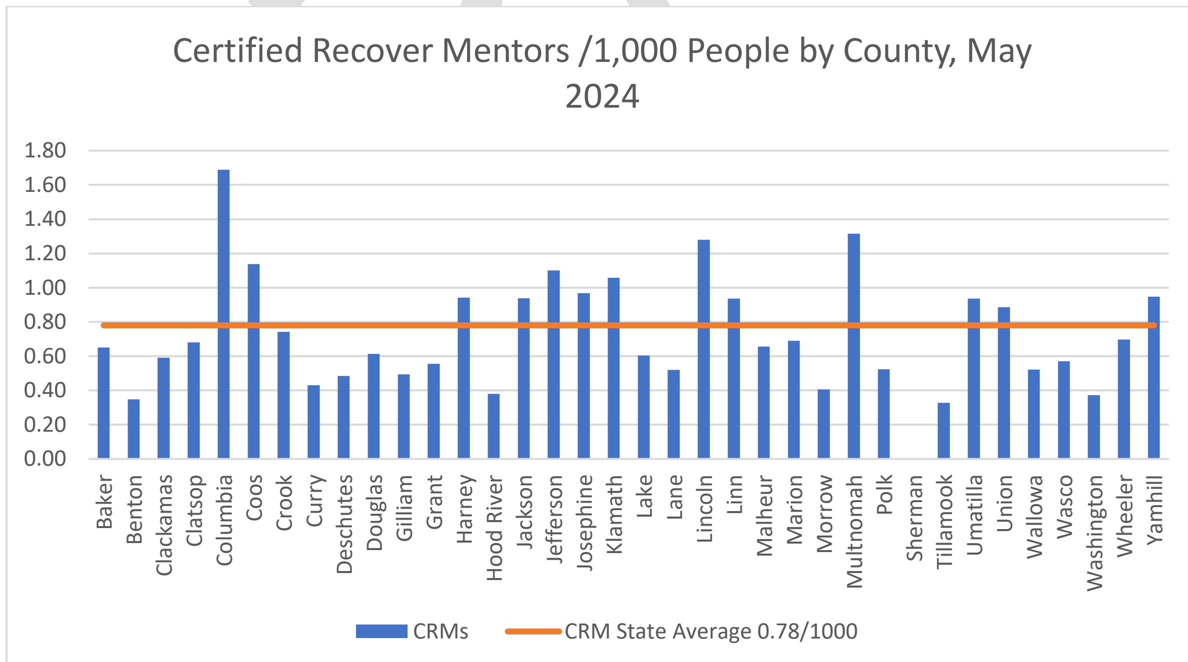
Figure 14.8. The number of Certified Alcohol and Drug Counselor per 1,000 people by county, May 2024



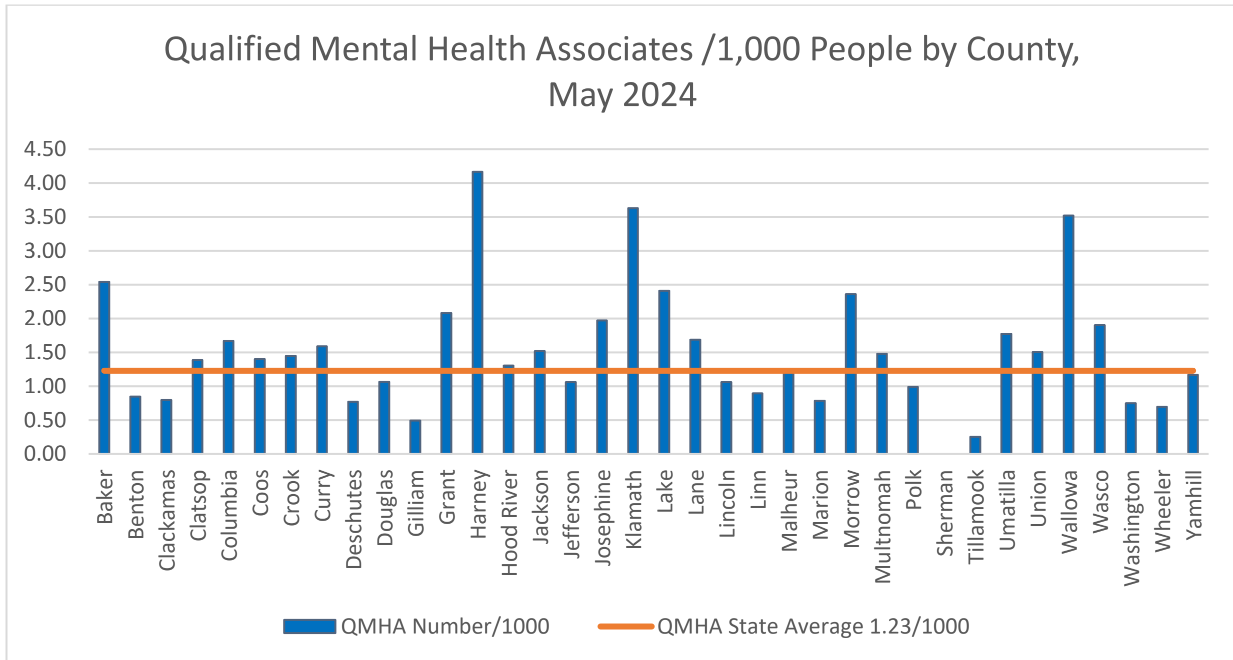
Source: Mental Health and Addiction Certification Board of Oregon

Figure 14.9. The number of Certified Recovery Mentors per 1,000 people by county, May 2024



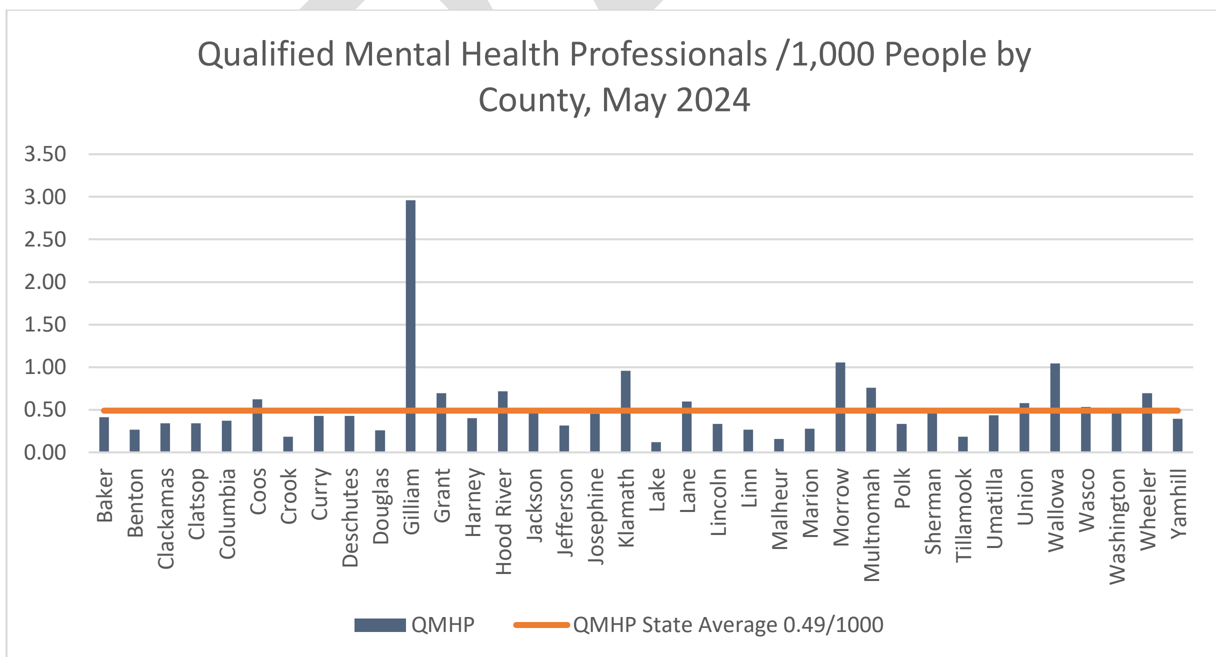
Source: Mental Health and Addiction Certification Board of Oregon

Figure 14.10. The number of Qualified Mental Health Associates per 1,000 people by county, May 2024



Source: Mental Health and Addiction Certification Board of Oregon

Figure 14.11. The number of Qualified Mental Health Professionals per 1,000 people by county, May 2024



Source: Mental Health and Addiction Certification Board of Oregon

Figure 14.12. The number of Certified Prevention Specialists per 1,000 people by county, May 2024

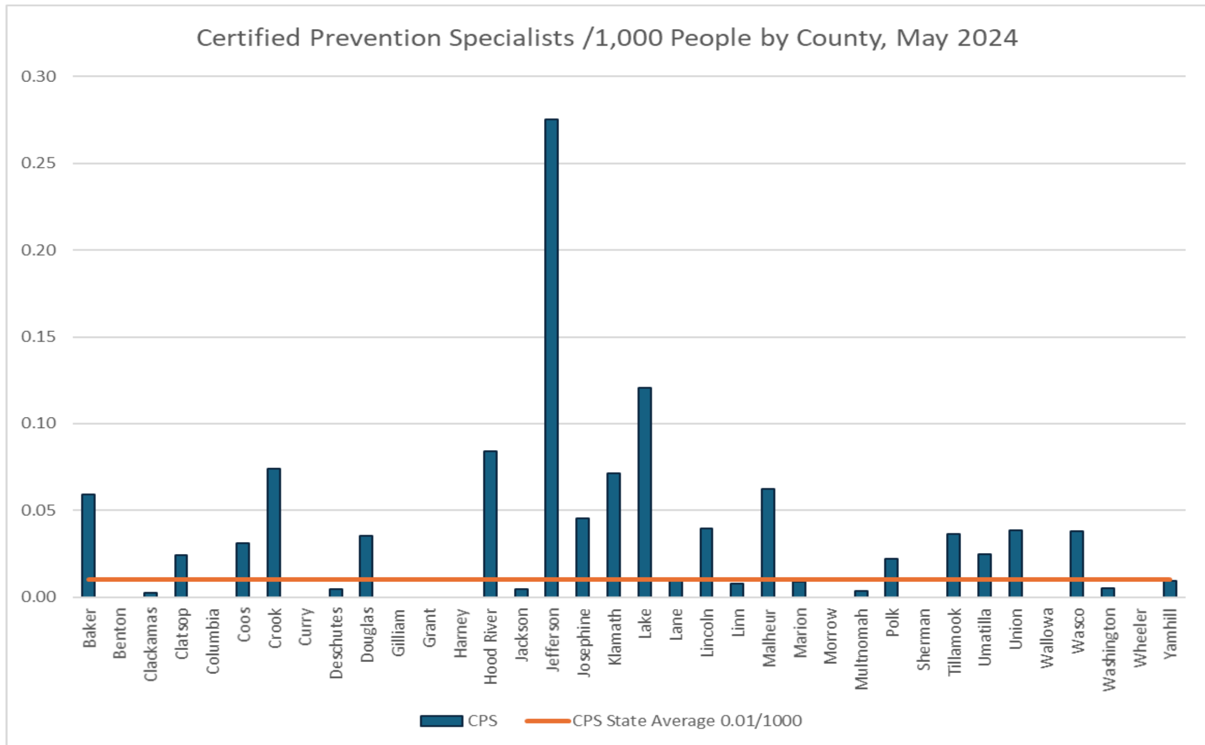
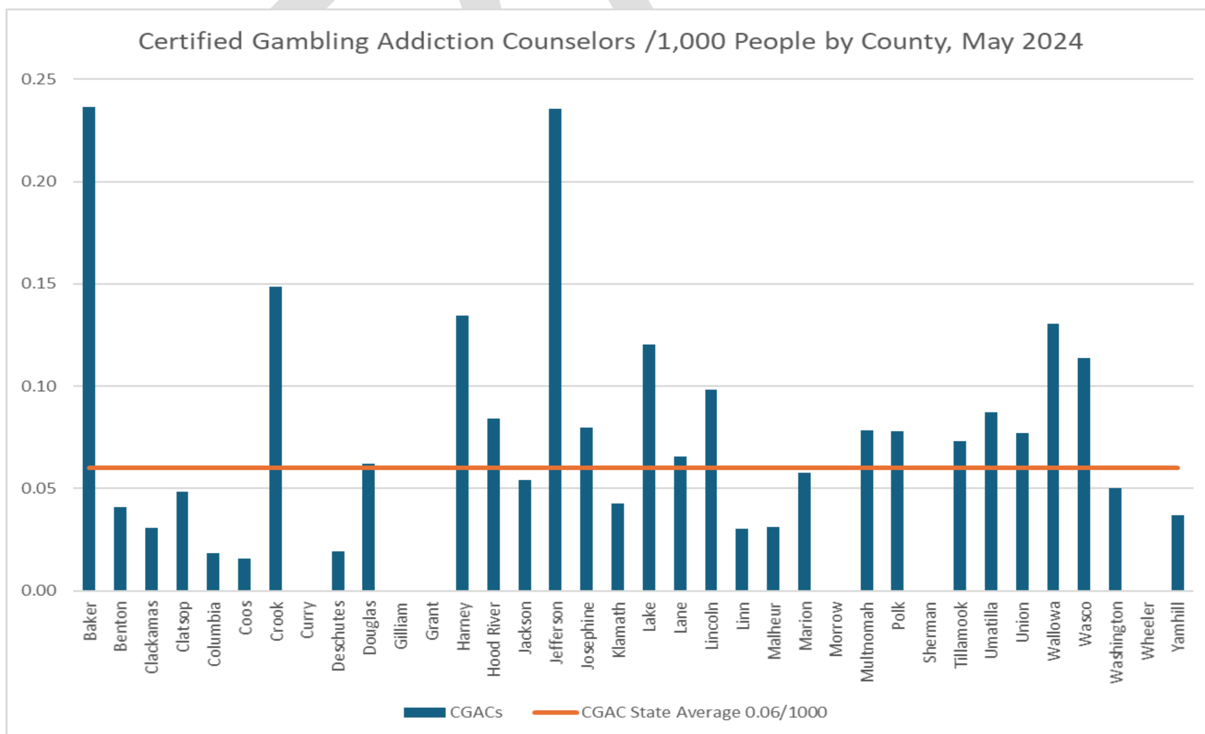


Figure 14.13. The number of Certified Gambling and Addiction Counselors per 1,000 people by county, May 2024



Future Workforce of Behavioral Health Providers

Pending Updates

National Recommendations

The National Academies recommended strategies to expand the behavioral health care workforce participating in Medicare, Medicaid, and Marketplace plans: 1) Increase the workforce by reducing credentialing and licensing barriers and increase training programs; 2) develop guidance for states on funding mechanisms and provide models for developing, implementing, and operating a single state-wide platform for care provider credentialing and enrollment through CMS; 3) provide guidance on setting Medicare and Medicaid fee-for-service reimbursement rates accounting for the actual costs of care and adjusting for past and current undervaluation of work efforts of behavioral health care providers; and 4) increase support and sustained use of telehealth to improve access to geographically underserved communities.

Appendix L: Oral Health Providers

Oral Health Providers in Oregon

Recognizing the importance of oral health across the lifespan, Oregon is one of only 23 states that offer extensive dental benefits to all adults with Medicaid, as well as children. Dental benefits for Medicaid adults are not required by federal law, but can be offered as a state option, and most states provide limited coverage, such as only extractions or emergency services. Extensive coverage includes a comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; and a per-person annual expenditure cap of at least $1,000.

According to the CCO Performance 2023 Final Report, CCO statewide performance on Preventive Dental or Oral Health Services for children ages 1-5 has gradually improved each year. In 2023, 15 out of 16 CCOs met the benchmarks for preventive dental or oral health services for children ages 1-5 and ages 6-14.

Over half of Oregon dentists do not accept OHP. The Evaluation of Oregon Health Plan Dental Provider Enrollment conducted key informant and dental practice interviews and summarized policy and process barriers to enrolling more dental providers to accept Medicaid patients and lists recommendations to mitigate these barriers. Thirty-two of Oregon's 36 counties (89 percent) lack adequate Medicaid dental full-time equivalents

to meet the needs of enrolled patients. Higher needs are concentrated in urban/metro areas. Workforce recruitment and retention are a common challenge for dental practices, particularly in rural areas. Many providers or managers shared constraints related to recruitment and retention such as clinics located in undesirable locations, lack of applicants, or competitive pay. Administrative burdens were associated with billing and filing insurance claims on behalf of patients which takes time and resources away from direct patient care. Reimbursements rates have not kept pace with rapidly rising costs for materials and staffing, and OHP reimbursements are lower in comparison to rates offered by private insurance. Providers who accept OHP shared that they were "in the red" – not making money – for any service beyond routine dental exams.

Appendix M: Public Health Workforce

Public Health Workforce in Oregon

The Oregon public health system includes federal, state, Tribal and local agencies, private organizations and other diverse partners working together to prevent disease, protect people from harm, and promote actions that make us health. Oregon has a decentralized public health system, which means that local health departments have authority over most public health functions in their jurisdictions. Tribes have authority over all public health functions on Tribal lands. The public health system works daily with community-based organizations to ensure that communities are at the forefront of efforts to improve health and that public health interventions are reaching those who experience a disproportionate burden of death and disease. OHA's Public Health Division (PHD) achieves its mission through programmatic work organized in three centers - the Center for Prevention and Health Promotion, the Center for Health Protection, and the Center for Public Health Practice. Finally, the Office of the State Public Health Director provides business operations, fiscal, equity and data science leadership, as well as coordination of policy and partnership activities across the public health system. The OHA Public Health Division's Policy and Partnerships unit provides technical assistance and consultation to local public health authorities (LPHAs) and Tribes, and coordinates local public health authority compliance reviews. Oregon's Public Health Advisory Board (PHAB) serves as an advisory body to the Oregon Health Authority.

Tribal Public Health

Oregon has 9 federally recognized Tribes. Tribal governments are separate sovereign nations with powers to protect the health, safety and welfare of their members and to govern their lands.-PHD provides technical assistance and supports Tribes with Public

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Health Modernization and other program-specific funding. Since the previous healthcare needs assessment, the Northwest Portland Area Indian Health Board (NPAIHB) received a grant from the Centers for Disease Control and Prevention's National Public Health Improvement Initiative program to increase the number of trained staff and to provide education, technical assistance, and support to Tribally-based health departments and programs.

Oregon's Local Public Health Authorities

Local public health authorities are responsible for public health functions within their local jurisdiction. Each local public health authority can tailor the programs and services to their community's priorities and preferences. There are 33 local public health authorities (LPHAs), 28 are county governments, 1 is a public health district that serves two counties, 3 are a 501c(3), 1 is a public-private partnership. Some LPHAs have additional public-private partnerships to deliver non-governance related public health services. Two county governments previously relinquished their LPHA to OHA.

During the COVID-19 pandemic, local public health authorities augmented staffing by re-assigning non-communicable disease staff and staff from other county governments, working with CBOs to assist with contact tracing, and partnering with colleges to include student workers in clinical/nursing and public health academic degree programs to support the work. The Coalition of Local Health Officials (CLHO) represents LPHAs in Oregon with one of the areas of focus on workforce recruitment and retention. CLHO completed a workforce report in 2021 which showed that the workforce had increased during the COVID-19 pandemic. CLHO will release their updated workforce report later in 2024.

Community-Based Organizations

OHA recognizes the essential role of community-based organizations (CBOs) addressing the public health needs of our communities. OHAs has increased the number of CBOs they directly fund since the last health care needs assessment report from 130 to almost 200 unique organizations that support culturally, and linguistically responsive services and foundational programs centered around health equity.

Public Health Modernization

In 2017, the Oregon legislature started investing in public health through the Public Health Modernization funding. This funding was for Public Health Modernization to expand each accomplishment in public health into long-term systems change. Since this initial investment, the Oregon legislature has increased the funding amounts with increased investments in LPHAs, Tribes, and CBOs. Figure 16.3 below for details of Public Health Modernization funding from 2017-2025.

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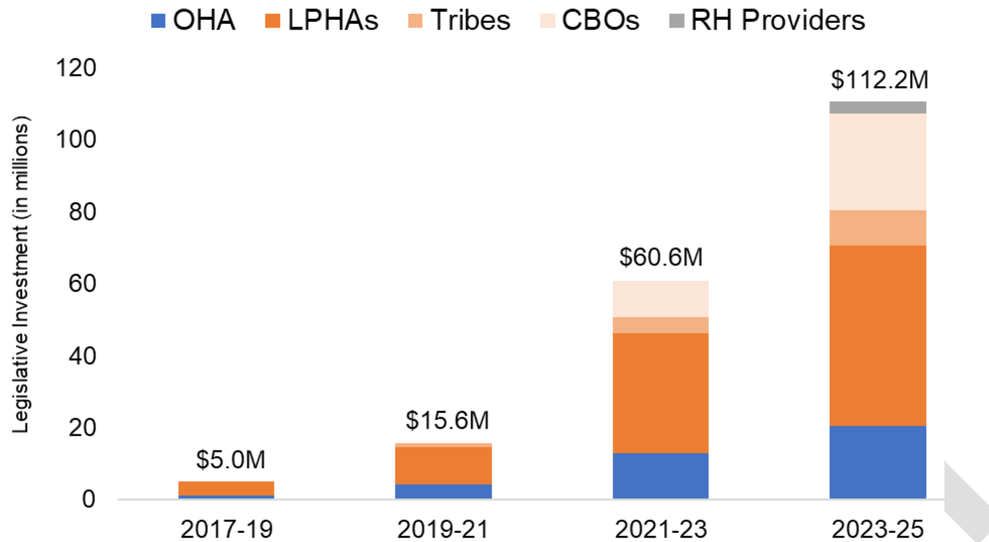
Figure 16.3. Legislative investment in public health modernization by partner type, 2017-2025 (in millions)



Since the last healthcare workforce report, OHA has conducted significant evaluation of public health modernization for investments during the 2021-2023 biennium. With this funding, more than 300 positions in local public health authorities were funded across all counties in Oregon. This number includes full and partial positions as well as new and ongoing positions and represent all foundational capabilities and programing - more than 80 positions related to communicable disease control (80+ positions), environmental public health (30+ positions), health equity and cultural responsiveness (14 positions), communications (12 positions), policy and planning (12 positions), and community partnership development (12 positions).

OHA is conducting an expanded evaluation around the public health workforce needs using data from modernization funding reports, focus groups, and key informant interviews. This 2023-2025 Public Health Modernization Evaluation report will be released in June 2025.

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