2020
The Diversity of Oregon's Licensed Health Care Workforce

Based on data collected from 2014 through January 2020

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Oregon Health Authority
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Health Care Workforce Reporting Program

Contents

About the data in this report:

Oregon's Health Care Workforce Reporting Program (HWRP) was created in 2009. As directed by Oregon Revised Statute 676.410, the HWRP collects and tabulates information from licensees of 17 health licensing boards upon renewal.

Data in this report was collected prior to the onset of the COVID-19 pandemic in the Spring of 2020. At this time, it is uncertain how the pandemic may affect the composition of the licensed health care workforce supply in Oregon.

This report adds data from three licensing boards that were not included in previous reports. It also introduces data on providers who have secondary practice locations in Oregon. For those reasons, data from this report should not be compared with data from earlier reports.

Executive Summary

Report Objectives

This report explores the race, ethnicity, gender, and language makeup of Oregon's licensed health care professionals compared with that of the state.* This report aims to answer the following questions:

- What does the licensed health care workforce look like in Oregon?
- Is the workforce culturally and linguistically representative of the population that it serves?
- How is the workforce composition changing over time?

Why is workforce diversity important?

The National Center for Health Statistics published a report in 2016 documenting health inequities for racial and ethnic groups.[1] Life expectancy, infant mortality and preterm birth rates, as well as prevalence of obesity and hypertension all differ by race and ethnicity. Additionally, differences between racial and ethnic groups in insurance coverage and nonreceipt of needed dental care indicate differences in access to care. COVID-19's disproportionate impact on communities of color, tribal communities, and other historically underrepresented communities has made clear these inequities.

Health inequities also may be dependent on factors other than race and ethnicity. For example, individuals with physical disabilities or cognitive limitations have higher prevalence of chronic conditions compared with individuals with no disabilities.[2] And patients with limited English proficiency were more likely to experience adverse events in six US hospitals (including higher levels of physical harm) compared with patients who spoke English.[3]

Evidence suggests that greater diversity in the health care workforce advances cultural competency and increases access to high-quality health care.[4,5] Accordingly, increasing the proportion of underrepresented US racial and ethnic minorities among health care professionals in the workforce may improve quality of care.

These known health inequities make clear the importance of a workforce that is culturally and linguistically representative of the communities it serves. This report aims to examine the current makeup of the workforce in Oregon and whether it is representative of Oregon's population.

OHA's definition of health equity states: "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, 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 definition recognizes that people are often differentially impacted by the health system depending on their race and ethnicity, languages spoken and/or disability status.

* The Health Care Workforce Reporting Program will be updating demographic survey questions in 2021 to reflect REALD standards. For more information on these standards, see the box on page 7.

Key Insights

- Overall, Oregon's licensed health care workforce is less racially and ethnically diverse than the population being served (Figure 2), with whites and Asians† being overrepresented and Hispanics‡ being underrepresented. However, Hispanics tend to be more represented in fields with fewer barriers to entry (e.g. certified nursing assistants) (Table 1).
- Women are overrepresented in most professions, while men tend to be overrepresented in fields requiring more advanced training (e.g. dentistry and medicine) (Table 1).
- The racial and ethnic makeup of many occupations is changing, and most occupations appear to be becoming more diverse over time (Figure 4). Since 2016, the percentage of white providers has decreased from 83.4 percent to 80.3 percent (a decrease of 3.7%), while most other groups have increased. Over the same time period the white population has decreased by 2.1% (from by 77.6% to 76.0%), suggesting that the differences between the workforce and the state's demographics are decreasing.
- Twenty percent of Oregon's health care professionals reported speaking languages other than English; however, only 11.3% report advanced proficiency or being a native speaker of another language and only 9.4% report using a language other than English with patients (Figure 7). Spanish is the most reported language spoken other than English. While 10.0% of the workforce reports speaking Spanish, only 4.2% report advanced proficiency or being a native speaker of Spanish and 6.8% of the workforce reports using Spanish with patients.
- Similar patterns were seen in the composition of specialty providers (Figure 9). People of color, except for providers of Asian descent, tend to be underrepresented relative to Oregon's population among primary care providers and oral health care professionals. Among behavioral health professionals, Hispanic and non-white health care providers are underrepresented. White health care providers are overrepresented in all of these groups.
- The overrepresentation of white providers is especially pronounced among behavioral health providers, where people of color comprise 13% of licensed behavioral health providers (compared with 24% in the population) (Figure 9).

Explore these data and learn more:
Oregon's licensed health care workforce diversity dashboard

† Asian health care professionals in this report do not include Pacific Islanders. Pacific Islanders are included in a separate group which also includes Native Hawaiians.

‡ Hispanic health care professionals in this report include those who identify as Hispanic and Latino/a/x.

Findings

Race, ethnicity, and gender

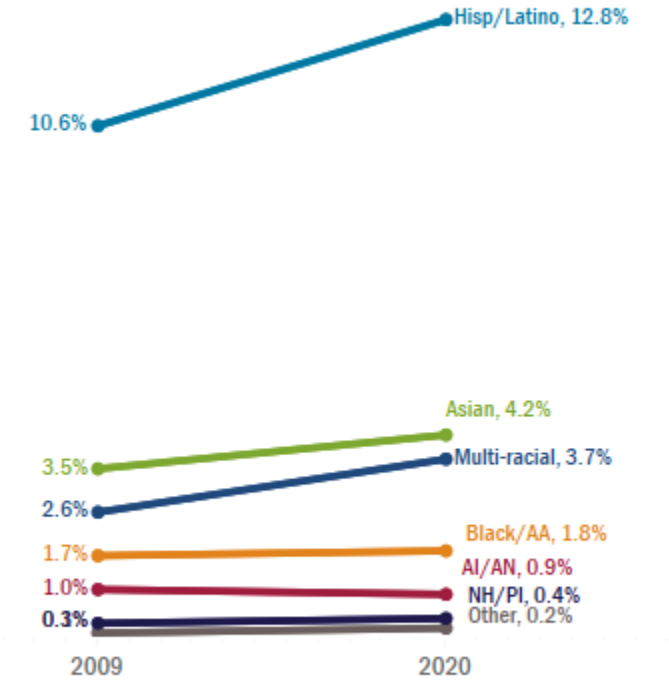
Oregon's population has become more diverse over the last decade. Since 2009, the white population has decreased from 80.4% to 76.0% (ACS; 5-year estimates), while other racial and ethnic populations have increased (**Figure 1**). Overall, Oregon's licensed health care workforce in 2020 is less racially and ethnically diverse than the population being served (**Figure 2**), with whites and Asians being overrepresented and Hispanics being underrepresented. However, this chart masks differences seen among specific occupations.

Table 1 (next page) shows the distribution of each health care profession's race, ethnicity and gender compared with the state's population. Differences are noted at the 0.5 percentage point level. Overall, Hispanic and non-white health care providers are underrepresented, and white health care professionals are overrepresented in almost all professions. However, Hispanics tend to be more represented in fields with fewer barriers to entry (e.g. certified nursing assistants).

Table 1 also shows the breakdown of gender by occupation as compared with the population. (Note: The percentages omit those who declined to answer, 2.2%, and do not show the percent that preferred to self-describe, 0.1%). Women are overrepresented in most professions, while men tend to be overrepresented in fields requiring more advanced training (e.g. dentistry and medicine).

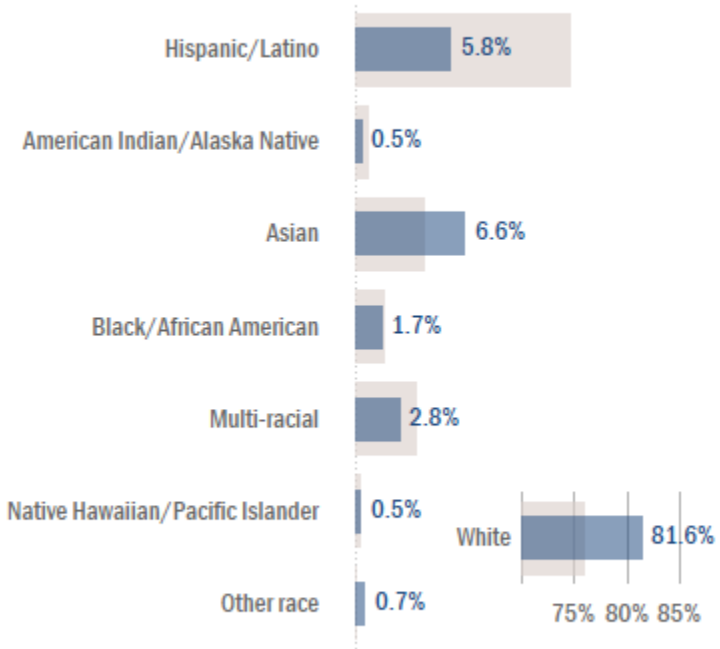
The option to self-describe gender was added to surveys in January 2019. Due to the nature of the renewal cycles, only 59.2% of licensees included in this report saw this option when completing the survey. Of those, 0.2% (n=110) of licensees preferred to self-describe their gender. Most frequently reported self-descriptions included: non-binary (42.7%), transgender (10.0%), and genderqueer (8.2%).

Figure 1: Increasing diversity in Oregon



Note: AA = African American, AI/AN = American Indian or Alaska Native, NH/PI = Native Hawaiian or Pacific Islander

Figure 2: Health care workforce (2020) compared with Population



Note: Providers with missing data were excluded from the analysis. Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity 10.5 percent of the time. Racial categories exclude Hispanics.

Table 1: Race, Ethnicity, and Gender Distribution: 2020 Workforce compared with Population

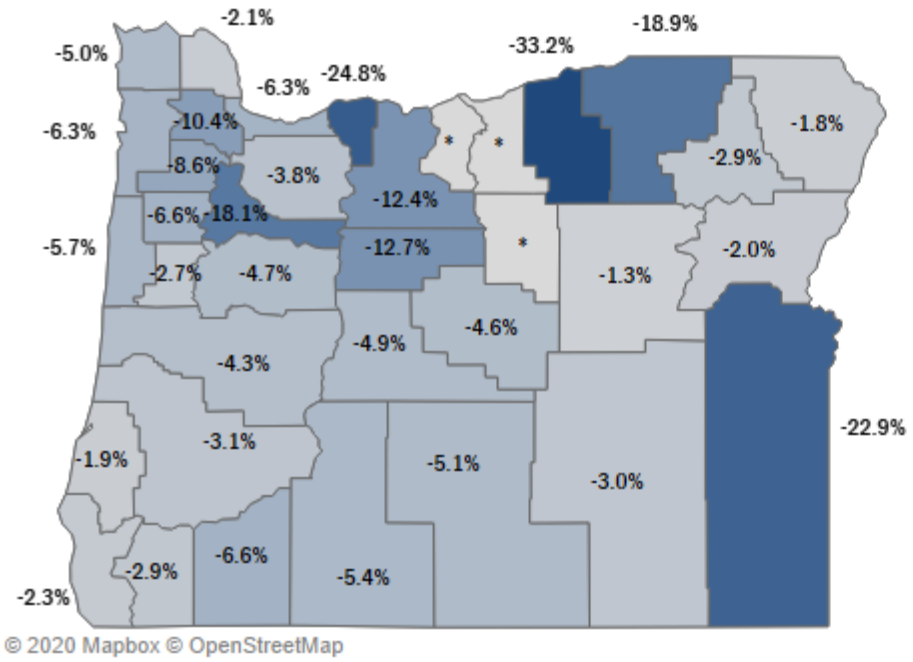
Comparison to state distribution

☐ Similar to state ☐ Below state ☐ Above state

		Hisp/ Latino	White	Black/ AA	AI/AN	Asian	NH/PI	Multi-racial	Other	Fem.	Male
Oregon		12.8%	76.0%	1.8%	0.9%	4.2%	0.4%	3.7%	0.2%	50.4%	49.6%
Chiropractic	Chiropractic physicians	2.5%	89.1%	0.4%	0.3%	4.9%	0.2%	1.9%	0.6%	32.1%	67.8%
	Chiropractic assistants	18.1%	73.1%	0.9%	0.4%	2.8%	0.1%	4.0%	0.5%	87.3%	12.6%
Counseling & therapy	Counselors & therapists	4.4%	88.7%	1.0%	0.5%	2.0%	0.2%	2.4%	0.8%	77.8%	21.7%
Dentistry	Dentists	3.7%	77.5%	0.5%	0.2%	14.4%	0.3%	1.9%	1.6%	27.8%	72.2%
	Dental hygienists	4.9%	85.4%	0.3%	0.6%	4.7%	0.2%	3.0%	0.9%	97.1%	2.9%
Dietetics	Licensed dietitians	3.4%	89.9%	0.2%	0.2%	4.1%	0.0%	2.3%	0.0%	95.6%	4.4%
Massage therapy	Licensed massage therapists	4.4%	86.5%	0.6%	0.5%	3.2%	0.3%	3.5%	0.9%	82.6%	17.0%
Medical	Physicians	3.6%	77.3%	1.4%	0.1%	14.4%	0.2%	1.6%	1.4%	39.7%	60.3%
	Podiatrists	1.2%	83.0%	1.2%	0.0%	11.7%	0.6%	1.8%	0.6%	25.8%	74.2%
	Physician assistants	4.2%	87.4%	1.0%	0.3%	4.4%	0.2%	2.2%	0.4%	64.8%	35.2%
	Acupuncturists	3.2%	81.5%	0.3%	0.0%	10.5%	0.2%	3.2%	1.2%	70.0%	30.0%
Medical imaging	Medical imaging technologists	5.3%	86.9%	0.6%	0.7%	2.8%	0.4%	2.6%	0.5%	65.6%	34.3%
Naturopathy	Naturopathic physicians	4.2%	86.8%	0.3%	0.1%	3.5%	0.0%	3.8%	1.3%	77.4%	22.1%
Nursing	Nurse practitioners	3.8%	86.9%	1.5%	0.4%	3.9%	0.4%	2.4%	0.6%	87.5%	12.4%
	Clinical nurse specialists	0.8%	94.3%	0.0%	0.0%	2.4%	0.0%	2.4%	0.0%	96.2%	3.8%
	Cert. registered nurse anesthetists	3.9%	85.6%	0.8%	0.3%	6.4%	0.6%	2.2%	0.3%	52.7%	47.3%
	Registered nurses	4.3%	85.8%	1.0%	0.5%	4.7%	0.4%	2.9%	0.4%	86.6%	13.3%
	Licensed practical nurses	9.0%	76.3%	4.4%	0.7%	4.6%	0.6%	3.8%	0.5%	87.6%	12.4%
	Certified nursing assistants	16.6%	63.5%	6.6%	1.1%	6.6%	1.2%	3.7%	0.6%	84.8%	15.2%
Occupational therapy	Occupational therapists	2.4%	88.8%	0.6%	0.2%	4.2%	0.2%	3.3%	0.4%	88.9%	11.1%
	Occupational therapy assistants	4.7%	88.7%	0.7%	0.3%	2.0%	0.3%	3.0%	0.3%	88.1%	11.9%
Optometry	Optometrists	2.5%	80.0%	0.3%	0.2%	15.1%	0.3%	1.0%	0.5%	47.3%	52.7%
Pharmacy	Pharmacists	2.8%	70.1%	1.6%	0.4%	21.1%	0.4%	2.8%	0.8%	58.7%	41.3%
	Certified pharmacy technicians	8.6%	76.9%	1.2%	0.8%	7.9%	1.0%	3.0%	0.5%	80.1%	19.9%
Physical therapy	Physical therapists	2.4%	87.7%	0.5%	0.1%	6.9%	0.3%	1.9%	0.2%	65.5%	34.5%
	Physical therapy assistants	2.8%	91.0%	0.5%	0.3%	2.3%	0.3%	2.8%	0.1%	72.6%	27.4%
Psychology	Psychologists	4.1%	87.3%	0.6%	0.1%	4.2%	0.3%	2.5%	0.9%	62.8%	37.1%
Respiratory therapy & polysomnography	Polysomnographic technologists	2.6%	87.9%	2.1%	0.5%	3.2%	0.0%	3.2%	0.5%	55.6%	44.4%
	Respiratory therapists	7.4%	82.3%	1.6%	1.3%	2.8%	0.8%	3.0%	0.7%	62.0%	38.0%
Social work	Licensed clinical social workers	4.0%	88.8%	1.4%	0.5%	2.0%	0.1%	2.4%	0.8%	80.3%	19.4%
	Clinical social work associates	11.8%	74.3%	3.9%	0.4%	3.2%	0.4%	5.3%	0.7%	82.5%	16.2%
	Non-clinical social workers	5.2%	89.6%	0.7%	0.0%	2.2%	0.7%	1.5%	0.0%	88.1%	11.9%
Speech-language pathology & audiology	Audiologists	1.6%	91.6%	0.0%	0.0%	5.2%	0.0%	1.6%	0.0%	74.1%	25.9%
	Speech-language pathologists	3.7%	91.0%	0.3%	0.3%	1.7%	0.1%	2.4%	0.4%	91.8%	7.8%
	Speech-language pathology assts	11.6%	84.1%	0.0%	0.6%	1.8%	0.0%	1.8%	0.0%	97.2%	1.1%
Total	Total	5.8%	81.6%	1.7%	0.5%	6.6%	0.5%	2.7%	0.7%	74.9%	25.0%

Note: Providers with missing data were excluded from the analysis. Workforce records are missing race and ethnicity data because licensees declined to report race or ethnicity 10.5 percent of the time. Racial categories exclude Hispanics. AA = African American, AI/AN = American Indian or Alaska Native, NH/PI = Native Hawaiian or Pacific Islander

Figure 3: Gap in Hispanic/Latino health care professionals compared with county population (2020)



-30.0% 0.0%

* *Suppressed due to small numbers*

A negative value means that the percentage of health professionals who identify as Hispanic/Latino is smaller compared with the Hispanic/Latino population.

For example, 33% of Malheur county's population identify as Hispanic/Latino, while only 10% of the county's health care workforce identify as Hispanic/Latino – a gap of 23%.

The licensed health care workforce in nearly all Oregon counties is less Hispanic than the overall population.[§] **Figure 3** shows the difference between the percentage of Hispanic health care professionals and the Hispanic population by county, with darker blue indicating a bigger gap. Though not evident in this map, counties with a larger-than-average Hispanic population still show the largest gaps, even with a higher number of Hispanic health professionals (See dashboard).

What is REALD?

Data collection currently includes only the five racial groups in accordance with guidelines set by the US Office of Management and Budget. However, data at this level may not capture racial and ethnic identity adequately to determine whether the workforce is representative of the communities that it serves.

REALD is an effort to increase and standardize Race, Ethnicity, Language, and Disability (REALD) data collection across the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA). REALD was advanced through the passage of House Bill 2134 passed by the Oregon legislature in 2013.

The Health Care Workforce Reporting Program will be updating demographic survey questions in 2021 to reflect these standards. **This will allow health care professionals licensed in Oregon to report their demographic identities with more granularity, if they so choose, while also supporting state planning efforts to equitably promote a diverse and culturally responsive workforce for communities across the State.**

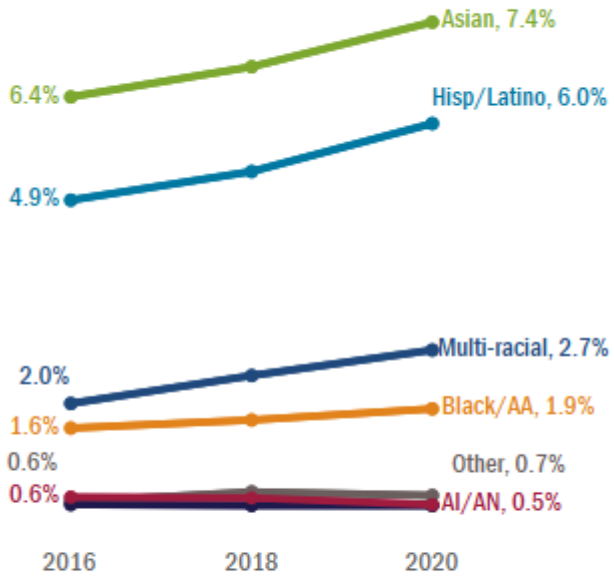
The statutory authority for these rules is codified in the Oregon Revised Statutes (ORS 413.042 and 413.161). In 2014 the administrative rules detailing the data collection standards were completed (OARs 943-070-0000 thru 943-070-0070). Additional information, including an implementation guide, is available on the REALD website.

§ The exception is Gilliam County, which has only 16 providers.

Workforce changes over time

The racial and ethnic makeup of many occupations is changing, and most occupations appear to be becoming more diverse over time. **Figure 4** shows the demographics of the licensed workforce for the boards and occupations that have data available from 2016. Since 2016, the percentage of white providers has decreased from 83.4 percent to 80.3 percent (a decrease of 3.7%), while most other groups have increased. Over the same time period the white population has decreased by 2.1% (from 77.6% to 76.0%), suggesting that the differences between the workforce and the state's demographics are decreasing.

Figure 4: Health care workforce over time
Initial 7 boards only



Note: Includes boards and occupations with data available for 2016, 2018, and 2020: Nursing, Dentistry, Medical (except acupuncturists), Dietetics, Pharmacy, Physical therapy, and Occupational therapy; Native Hawaiian/Pacific Islander remained unchanged at 0.5% from 2016 to 2020.

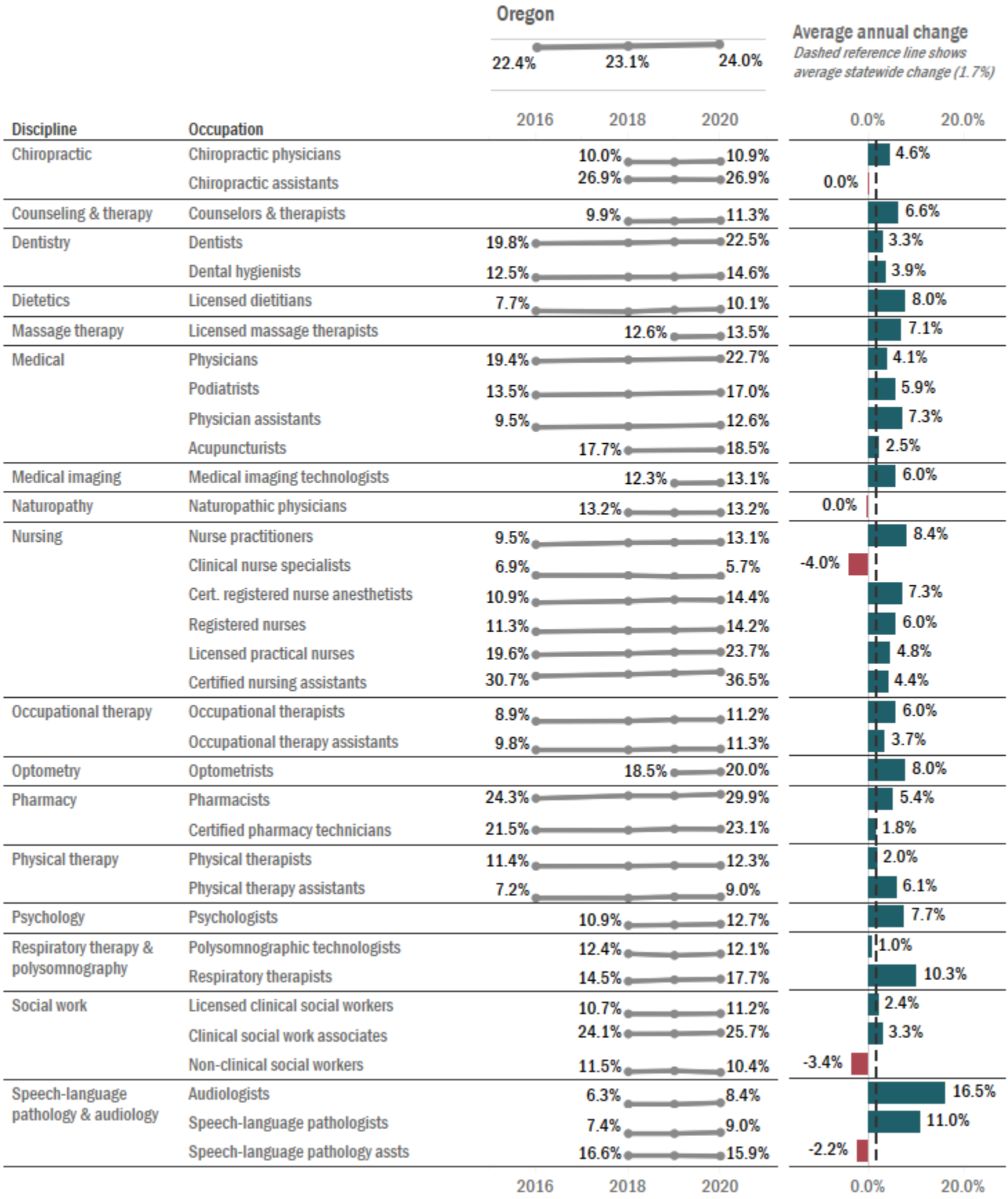
Figure 5 (next page) shows the percentage of providers that identify with tribal communities and communities of color for each occupation (these communities include all racial and ethnic groups other than white). Most occupations show an increase in the percentage of licensees that identify with these groups. The bar chart on the right of the figure shows the average annual change in this percent since data became available. Since 2016, the average annual change in Oregon's population among these populations is 1.7 percent. While the percentage of these communities represented in the workforce is smaller than the statewide percentage for most occupations, most occupations are showing growth in the percentage of licensees that identify with these communities. The average annual growth in most of the occupations is greater than the state's growth. *It is important to note that this measure indicates whether the racial representation of the workforce is changing, but does not capture in which racial or ethnic groups changes may be occurring.* For example, the percentage of providers that identify as members of tribal communities and communities of color may be similar between a specific occupation and the population, but the providers of a specific racial or ethnic group may still be under or overrepresented compared with the population.

It is noteworthy that most of the occupations that show smaller change than the state's change are also occupations that are showing decreasing growth in their supply in the state.[6]

It is possible to look at the changes over time at a more granular level; however, due to small numbers for many of these groups, it may be more difficult to see changes over time at this level. **Figures 6a and b** (page 10-11) show the average annual percent change in these groups since data became available. The average annual percent change for the state is shown at the top for comparison. Overall, most occupations appear to be changing at a similar or greater rate than the population, suggesting that the workforce is becoming more representative of the population it serves (See the dashboard to view these data across time).

Figure 5: Percentage of providers identifying with tribal communities and communities of color

Over time and average annual percent change



Discipline	Occupation	Oregon 2016	Oregon 2018	Oregon 2020	Average annual change
Chiropractic	Chiropractic physicians		10.0%	10.9%	4.6%
	Chiropractic assistants		26.9%	26.9%	0.0%
Counseling & therapy	Counselors & therapists		9.9%	11.3%	6.6%
Dentistry	Dentists	19.8%		22.5%	3.3%
	Dental hygienists	12.5%		14.6%	3.9%
Dietetics	Licensed dietitians	7.7%		10.1%	8.0%
Massage therapy	Licensed massage therapists		12.6%	13.5%	7.1%
Medical	Physicians	19.4%		22.7%	4.1%
	Podiatrists	13.5%		17.0%	5.9%
	Physician assistants	9.5%		12.6%	7.3%
	Acupuncturists		17.7%	18.5%	2.5%
Medical imaging	Medical imaging technologists		12.3%	13.1%	6.0%
Naturopathy	Naturopathic physicians		13.2%	13.2%	0.0%
Nursing	Nurse practitioners	9.5%		13.1%	8.4%
	Clinical nurse specialists	6.9%		5.7%	-4.0%
	Cert. registered nurse anesthetists	10.9%		14.4%	7.3%
	Registered nurses	11.3%		14.2%	6.0%
	Licensed practical nurses	19.6%		23.7%	4.8%
	Certified nursing assistants	30.7%		36.5%	4.4%
Occupational therapy	Occupational therapists	8.9%		11.2%	6.0%
	Occupational therapy assistants	9.8%		11.3%	3.7%
Optometry	Optometrists		18.5%	20.0%	8.0%
Pharmacy	Pharmacists	24.3%		29.9%	5.4%
	Certified pharmacy technicians	21.5%		23.1%	1.8%
Physical therapy	Physical therapists	11.4%		12.3%	2.0%
	Physical therapy assistants	7.2%		9.0%	6.1%
Psychology	Psychologists		10.9%	12.7%	7.7%
Respiratory therapy & polysomnography	Polysomnographic technologists		12.4%	12.1%	1.0%
	Respiratory therapists		14.5%	17.7%	10.3%
Social work	Licensed clinical social workers		10.7%	11.2%	2.4%
	Clinical social work associates		24.1%	25.7%	3.3%
	Non-clinical social workers		11.5%	10.4%	-3.4%
Speech-language pathology & audiology	Audiologists		6.3%	8.4%	16.5%
	Speech-language pathologists		7.4%	9.0%	11.0%
	Speech-language pathology assts		16.6%	15.9%	-2.2%

Figure 6a: Average annual percent change in representation for all occupations

State average annual change is shown for comparison

Occupation	State average annual change: Hisp/Latino 1.4%	AI/AN -1.7%	Asian 2.4%	Black 1.4%
Chiropractic physicians	14.1%	14.6%	6.4%	-7.6%
Chiropractic assistants	2.8%	-31.2%	-14.2%	13.5%
Counselors & therapists	11.3%	8.4%	11.4%	5.1%
Dentists	5.1%	4.2%	3.2%	-6.0%
Dental hygienists	8.8%	2.2%	0.7%	-12.3%
Licensed dietitians	24.1%	-2.0%	1.4%	13.5%
Licensed massage therapists	-0.5%	0.3%	11.0%	9.9%
Physicians	3.3%	-5.6%	3.9%	4.7%
Podiatrists	-12.3%		7.4%	16.8%
Physician assistants	8.1%	-7.9%	6.7%	9.5%
Acupuncturists	-3.4%	-75.0%	1.9%	-7.2%
Medical imaging technologists	11.7%	-16.3%	0.2%	13.3%
Naturopathic physicians	7.6%	-100.0%	0.4%	-36.5%
Nurse practitioners	7.2%	7.1%	8.1%	26.4%
Clinical nurse specialists	-17.5%		4.2%	
Cert. registered nurse anesthetists	0.3%	46.6%	9.4%	47.1%
Registered nurses	6.8%	-4.1%	4.8%	5.6%
Licensed practical nurses	8.4%	-11.3%	0.4%	8.0%
Certified nursing assistants	5.9%	-2.5%	3.6%	1.9%
Occupational therapists	11.7%	-13.3%	0.2%	29.2%
Occupational therapy assistants	8.1%	0.7%	-9.2%	22.2%
Optometrists	3.4%	3.4%	8.3%	
Pharmacists	4.3%	-3.1%	5.3%	14.8%
Certified pharmacy technicians	1.9%	-3.6%	1.6%	5.8%
Physical therapists	-1.5%	-5.1%	3.7%	21.5%
Physical therapy assistants	17.5%	-12.9%	12.5%	-0.8%
Psychologists	5.3%	22.4%	5.0%	-2.1%
Polysomnographic technologists	-21.5%	-100.0%	-1.1%	32.6%
Respiratory therapists	14.5%	16.6%	6.2%	29.9%
Licensed clinical social workers	5.6%	-20.5%	8.1%	5.8%
Clinical social work associates	5.5%	19.2%	9.4%	5.0%
Non-clinical social workers	-6.9%		25.6%	-13.1%
Audiologists	12.3%		3.9%	-50.2%
Speech-language pathologists	11.2%	-12.4%	8.2%	-3.0%
Speech-language pathology assts	0.7%	3.4%	30.0%	

Figure 6b: Average annual percent change in representation for all occupations

State average annual change is shown for comparison

State average annual change:				
Multi-racial	NH/PI	Other	White	
3.5%	1.2%	0.7%	-0.5%	

Occupation					
Chiropractic physicians	4.2%	6.1%	-11.7%	-0.5%	
Chiropractic assistants	10.1%	-44.1%	43.6%	0.0%	
Counselors & therapists	5.9%	32.1%	-12.9%	-0.7%	
Dentists	3.5%	3.9%	5.2%	-0.9%	
Dental hygienists	6.1%	3.1%	5.6%	-0.6%	
Licensed dietitians	27.3%		-83.3%	-0.6%	
Licensed massage therapists	16.7%	14.5%	-1.2%	-1.0%	
Physicians	9.2%	-3.8%	5.9%	-1.1%	
Podiatrists	7.4%	-3.5%	31.8%	-1.0%	
Physician assistants	16.5%	-19.0%	0.1%	-0.9%	
Acupuncturists	5.8%	31.3%	27.1%	-0.5%	
Medical imaging technologists	10.5%	-2.9%	2.8%	-0.8%	
Naturopathic physicians	-2.8%	-100.0%	10.4%	0.0%	
Nurse practitioners	6.1%	-2.3%	14.9%	-1.0%	
Clinical nurse specialists	0.3%			0.3%	
Cert. registered nurse anesthetists	5.6%	100.6%	8.4%	-1.0%	
Registered nurses	10.3%	3.4%	7.2%	-0.8%	
Licensed practical nurses	6.8%	-1.8%	1.0%	-1.3%	
Certified nursing assistants	10.4%	-2.2%	3.5%	-2.1%	
Occupational therapists	11.5%	30.9%	4.1%	-0.6%	
Occupational therapy assistants	28.1%	0.7%	-19.0%	-0.4%	
Optometrists	3.4%	106.8%	-38.0%	-1.8%	
Pharmacists	11.6%	7.9%	-8.1%	-1.9%	
Certified pharmacy technicians	1.8%	-0.4%	17.8%	-0.5%	
Physical therapists	1.5%	6.6%	-11.4%	-0.3%	
Physical therapy assistants	6.8%	-12.9%	-12.9%	-0.5%	
Psychologists	20.9%	13.4%	11.8%	-1.0%	
Polysomnographic technologists	23.9%		-100.0%	0.2%	
Respiratory therapists	0.4%	32.3%	7.5%	-1.8%	
Licensed clinical social workers	1.5%	-28.9%	0.0%	-0.3%	
Clinical social work associates	12.0%	38.7%	-37.0%	-1.0%	
Non-clinical social workers	4.5%	6.0%	-100.0%	0.6%	
Audiologists	112.3%			-1.1%	
Speech-language pathologists	20.5%	-3.0%	20.5%	-0.9%	
Speech-language pathology assts	-18.0%		-50.0%	0.4%	

Offsetting these gaps

Beyond increasing the proportion of health care workers from underrepresented groups, several other methods are being used to provide culturally appropriate care in Oregon.

Traditional health workers (THWs) may help offset some of the gaps between the composition of the workforce and the population. Traditional Health Workers are trusted individuals from their local communities who provide person- and community-centered care by bridging communities and the health systems that serve them. THWs include five primary worker types, including: Community Health Workers, Peer Support Specialists, Peer Wellness Specialists, Personal Health Navigators, and Doulas. Utilization 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.[7] As of October 2020, more than 3,000 THWs are certified by OHA.

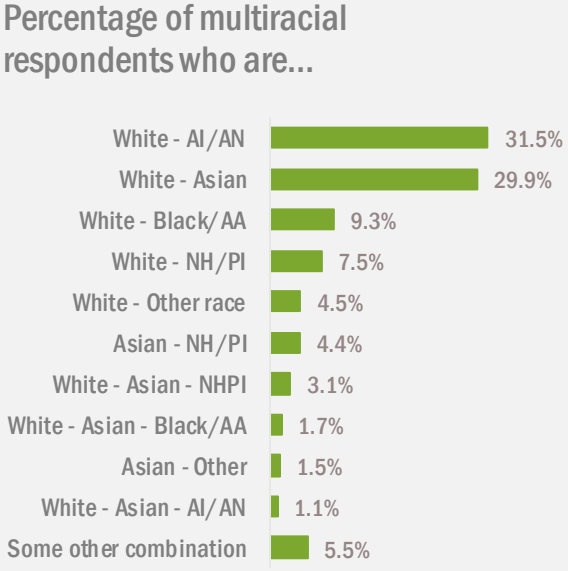
Training in cultural competency may also help build a workforce able to provide culturally appropriate care. OAR 943-090-0000 through 943-090-0020 defined **cultural competency** as: "A lifelong process of examining the values and beliefs and developing and applying an inclusive approach to health practice in a manner that recognizes the content and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families, and communities." With the passage of HB 2011, cultural competency continuing education (CCCE) is now required for the licensed providers covered in this report.[11]

The multiracial workforce

The multiracial population in the US is growing, and if current trends continue, it is expected that the multiracial population in the US will triple by 2060.[8]

Likewise, the percentage of providers identifying as multiracial is increasing for almost all of the licensed occupations included in this report and, it is anticipated that this group will continue to increase. This report defines 'multiracial' licensees as those that select more than one racial group, however this may hide more granular differences. As shown in the chart at right, those who identify as White and American Indian / Alaskan Native multiracial adults are the largest multiracial group in the licensed health care workforce.

REALD will allow providers to identify a primary race or self-identify as multiracial, which will allow us to get a better picture of this segment of the workforce.



[11] The specific requirements are determined by each board and some boards may not require their licensees to complete CCCE approved by the Oregon Health Authority under ORS 413.450.

Language

In 2020, twenty percent of Oregon's health care professionals reported speaking a language other than English (**Figure 7**). Overall, the workforce appears to be more linguistically diverse than the population (represented by the grey bars in the charts), although this does not account for proficiency or training in medical terminology in another language. For example, only 11.3% report advanced proficiency or being a native speaker of another language and only 9.4% report using a language other than English with patients.

Spanish is the most reported language spoken other than English. While 10.0% of the workforce reports speaking Spanish, only 4.2% report advanced proficiency or being a native speaker of Spanish and 6.8% of the workforce reports using Spanish with patients.

After English, the most common languages spoken in Oregon households are Spanish, Chinese (including Mandarin, Cantonese, Teochew and other Chinese languages), Vietnamese, and Russian (ACS; 5-year estimates). **Figure 8** shows the percentage of providers that speak these languages. While the workforce and population appear similar, this may be driven by specific occupations. For example, while 6.5 percent of pharmacists report speaking Vietnamese, only 0.08 percent of licensed counselors and therapists speak Vietnamese. For most occupations, fewer than 0.5 percent of licensees report speaking Vietnamese.

Figure 7: Languages spoken by the workforce
Workforce stratified by proficiency

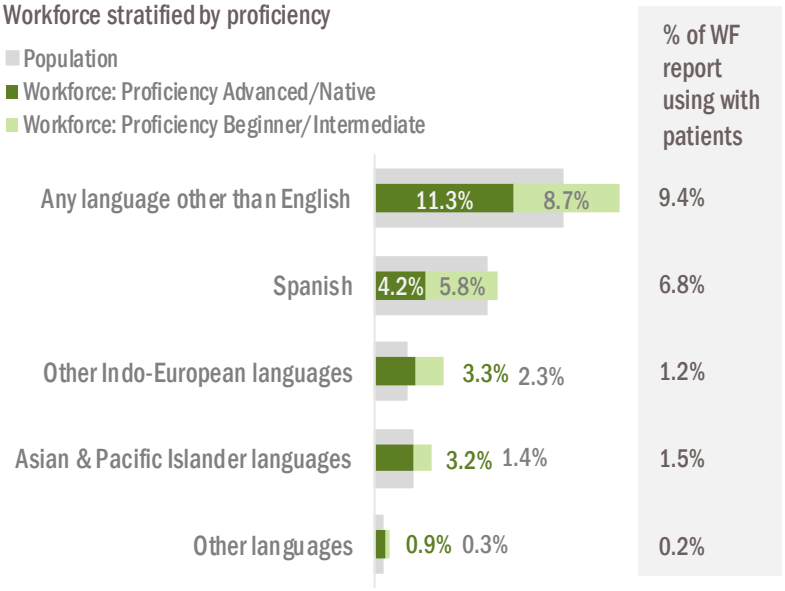
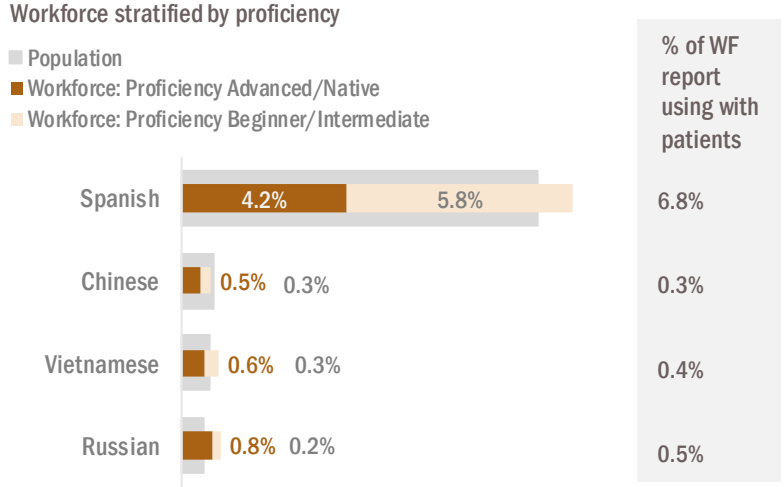


Figure 8: Top Oregon household languages
Workforce stratified by proficiency



Note: Chinese includes Mandarin and Cantonese

The role of health care interpreters

There is no guarantee that a provider who speaks a particular language will be available when a non-English-speaking client needs one. Health care interpreters (HCI) help to fill the gaps. The utilization of language services, such as interpretation by qualified and certified HCIs, has been shown to improve cross-cultural communication, leading to increased compliance with recommended treatment plans, improved health care outcomes, and ultimately, reduction in health disparities.[9] Additionally, increased patient engagement as a result of this improved communication may lead to a reduction in health care cost.[10] Oregon's Health Care Interpreter program is based on Title VI of the federal Civil Rights Act and Oregon law (ORS 413.550). To comply with these laws, OAR 333-002-0000 was implemented to develop an HCI workforce and ensure the availability of quality health care interpretation for patients who are considered Limited English Proficient (LEP).

Certified and qualified interpreters must have formal training and experience and certified interpreters must pass national certification exams. As of October 2020, Oregon has 530 qualified and 173 certified health care interpreters. These numbers have increased from 257 and 91, respectively, since January 2017.

Specialty groups: Primary care, behavioral health care, and oral health care

Figure 9 shows the racial and ethnic distribution of Oregon's primary care, behavioral health, and oral health workforce in 2020 compared with Oregon's population. White health care providers are overrepresented in all of these groups.

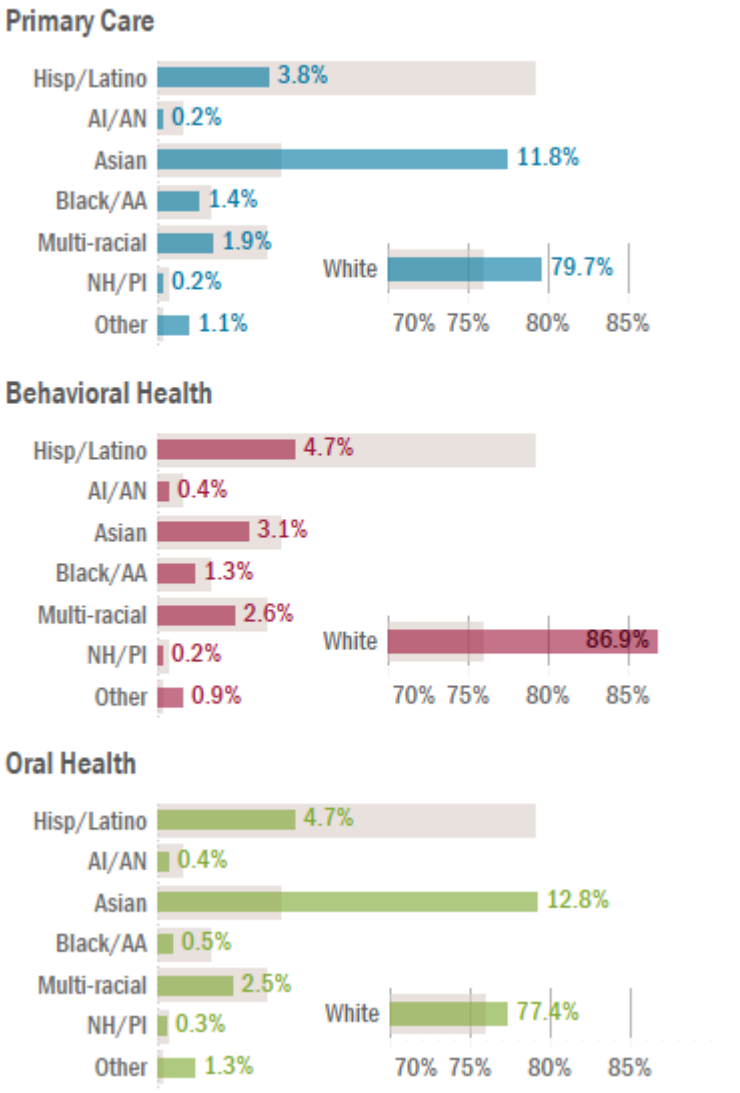
Primary care providers (PCPs), including nurse practitioners, physicians, physician assistants, and naturopathic physicians, makeup approximately 6.0 percent of the health care workforce. Most people of color tend to be underrepresented among PCPs, except for providers of Asian descent.

A similar pattern is seen among oral health care professionals where Asian dentists are overrepresented relative to Oregon's population, while other minority races are underrepresented.

Behavioral health care providers, including psychiatric nurse practitioners, physicians and physician assistants, psychologist examiners, licensed professional counselors and therapists, and licensed clinical social workers, makeup approximately 8.4 percent of the health care workforce. Among all behavioral health professionals, Hispanic and non-white health care providers are underrepresented.

([See the dashboard to view specific occupations within these groups])

Figure 9: Specialty workforce groups compared with population



Language use among specialty groups

Table 2 shows language use and proficiency level for specialty care providers. Thirty-three percent of PCPs and 31% of oral health providers reported speaking a language other than English, suggesting that they are more linguistically diverse than the health care work force as a whole. Primary care providers and oral health providers also report higher levels of proficiency and use with patients compared with the workforce as a whole. In contrast, behavioral health providers were less likely to report speaking a language other than English compared with the workforce as a whole, and only 6.1% of providers reporting using a language other than English with patients.

Table 2: Language use in specialty workforce groups

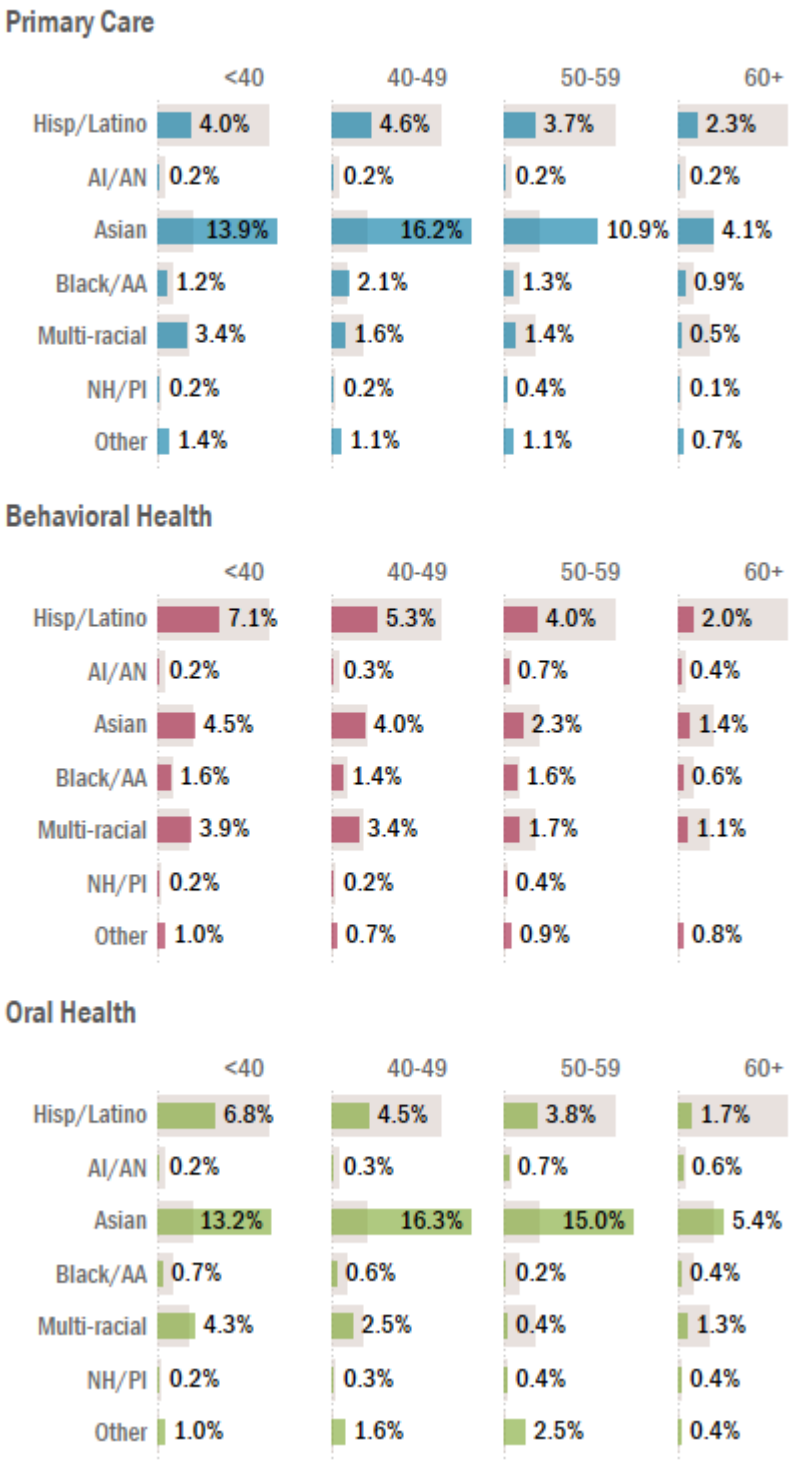
	Speak a language other than English (%)	Advanced/native speaker of language other than English (%)	Use a language other than English with patients (%)
Primary care	32.6%	18.1%	21.2%
Behavioral health	15.7%	8.2%	6.1%
Oral health	31.3%	17.3%	21.2%

Specialty groups' changing demographics

One way to look at how the workforce is changing is to look at cohorts of licensees.¶ **Figure 10** shows the racial and ethnic distribution within each age cohort for the year 2020. In general, within younger age groups there is a larger percentage of non-white health care providers. For example, 7.1 percent of behavioral health professionals under the age of 40 identify as Hispanic/Latino, while only 2.0 percent of behavioral health professionals over the age of 60 identify with this group.

This may be an indication that segments of the workforce are diversifying, however because this data is cross-sectional, it is not possible to ascertain this with certainty and there are alternate explanations. For example, it is possible that providers within some of the ethnic and racial groups leave the workforce earlier (either leaving the occupation or leaving to practice in another state).

Figure 10: Specialty groups compared with population
Stratified by age



¶ Due to changing definitions and lack of longitudinal data, we cannot compare these specialty groups across timepoints.

Supplemental Material

The Health Care Workforce Reporting Program (HWRP)

The HWRP collaborates with 17 health regulatory licensing boards to collect, process, and analyze data for over 35 occupations to understand Oregon's health care workforce; inform public and private educational and workforce investments; and inform policy recommendations for the Governor's Office, legislative leadership and state agencies regarding Oregon's health care workforce (Oregon Revised Statute (ORS) 676.410; Oregon Administrative Rule (OAR) 409-026).

For more information about methodology and results, visit: https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

Participating Licensing Boards
Oregon Board of Chiropractic Examiners
Oregon Board of Dentistry
Oregon Board of Examiners for Speech-Language Pathology and Audiology
Oregon Board of Licensed Clinical Social Workers
Oregon Board of Licensed Dieticians
Oregon Board of Licensed Professional Counselors and Therapists
Oregon Board of Massage Therapists
Oregon Board of Medical Imaging
Oregon Board of Naturopathic Medicine
Oregon Board of Optometry
Oregon Board of Pharmacy
Oregon Board of Physical Therapy
Oregon Board of Psychology
Oregon Medical Board
Oregon Occupational Therapy Licensing Board
Oregon State Board of Nursing
Respiratory Therapist and Polysomnographic Technologist Licensing Board

Limitations

The HWRP collects data on occupations that are licensed in Oregon and covered by Oregon Revised Statute 676.410, so does not represent the entire health care workforce. The program does not currently collect data for many unlicensed health care professionals including traditional health workers, health care interpreters, qualified mental health professionals, addiction counselors, licensed professional counselor interns, lab scientists/technicians, medical assistants, opthalmogist technicians, and more.

Survey data comes only from renewing licensees, so this report assumes that new licensees would respond similarly to renewing licensees. There is a time lag in reporting, so estimates reflect a historical point in time. Length of participation in the HWRP varies by board, so reliable estimates over time vary by occupation. Data is collected for up to two practice locations, so data may not be accurate for health care professionals who have three or more practice locations or who have a mobile practice.

Data do not meet REALD standards (See page 7 for more information). The HWRP will be updating demographic survey questions in 2021 to reflect these standards.

10.5 percent of the licensed workforce declined to provide race and ethnicity data. 2.2 percent declined to provide data on gender. Individuals with missing data are excluded from the charts in this report.

Methodology and definitions

Data sources for this report include workforce data from the Health Care Workforce Reporting Program (HWRP) from 2014 through the first quarter of 2020. HWRP collects workforce-related information directly from health care professionals via a survey embedded in the license renewal process. Health care professionals with an active license in each reporting year (January 2018, 2019 and 2020; month of verification varied by occupation in 2016), were included in this report. Estimates are dependent on licensees who completed the survey. Each licensee can report workforce data for up to two practice locations. Please refer to the HWRP's General Methods documentation on the website for further details.

Population data come from five-year ACS estimates (data collected over 60-month period, 2014–2018). These estimates are not as current as the one-year estimates, but the primary advantage of using multiyear estimates is the data's availability and increased statistical reliability for less populated areas and small population subgroups. Population data reflect the total population (rather than the adult population), as the total population is served by the workforce.

Because not all boards have data available for all years, it is necessary to impute data for missing years to calculate average annual percent change. The average of the year preceding and following the missing year was used for the imputed value.

Data were analyzed and tabulated with SAS 9.4; graphics were produced in Excel and Tableau 2020.

Race & ethnicity: All race/ethnicity categories in the workforce data were coded as mutually exclusive to match the American Community Survey (ACS) race/ethnicity categories and allow comparisons. When a licensee selected Hispanic as his or her ethnicity, the licensee was coded as being Hispanic. If there were other races selected along with Hispanic ethnicity, such as "Black" or "Asian," the licensee would only be counted in the Hispanic category and not in other categories. Of the 6,309 licensees coded as Hispanic, approximately 62.8 percent identified with at least one racial category (White: 53.2%; Multiracial: 4.8%; American Indian/Alaska Native: 2.5%, Black/AA: 1.0%; Asian: 0.7%; Native Hawaiian/Pacific Islander: 0.6%). The remaining 37.2 percent chose "Other" (18.4%), or declined to report a race (18.9%). When a licensee selected a non-Hispanic ethnicity and more than one race, the licensee was coded as "Multiracial" and was not included in the specific race categories. When a licensee selected "Other" as race and no other race was selected, the licensee was coded as "Other."

Language: Regarding languages, ACS coded 381 different languages nationwide. Standard tables separate out 39 languages and the four main language groups used here: Spanish, other Indo-European languages (most languages of Europe and the Indic languages of India, as well as Iranian languages), Asian and Pacific Island languages (among them Chinese, Korean, Japanese, Vietnamese, Hmong, Khmer, Lao, Thai, Tagalog and others) and all other languages (such as Uralic languages, languages of Africa, Native American languages, and more). Some health professionals reporting speaking more than one language may be counted in more than one language group.

Specialty groups definitions

- **Primary care providers** include physicians and physician assistants who specialize in family practice, general practice, geriatric medicine, pediatrics, adolescent medicine, internal medicine, or obstetrics and gynecology; nurse practitioners who specialize in family practice, geriatrics, pediatrics, internal medicine, or OB/GYN/ women's health; and naturopathic physicians who specialize in family medicine, pediatrics, geriatrics or obstetrics.
- **Behavioral health providers** include all psychologists, counselors and therapists, licensed clinical social workers, and clinical social work associates; physicians and physician assistants who specialize in psychiatry (addiction, neurology, child, adolescent, geriatric, or forensic) or psychoanalysis; nurse practitioners who specialize in psychiatry/mental health; and naturopathic physicians who specialize in mental health.
- **Oral health providers** include dentists who specialize in general dentistry, pediatric dentistry or public health; and expanded practice dental hygienists who specialize in general dentistry, pediatric dentistry or public health and who report holding an expanded practice permit.

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Oregon Health Authority

HEALTH POLICY AND ANALYTICS
Office of Health Analytics