An MCO's Perspective on Access to Care in the State of Oregon

April 2024

Prepared by:

Ann Klein, President
aklein@majorishealthsystems.com

Lisa Johnson, Chief Operating Officer
ljohnson@majorishealthsystems.com

Majoris Health Systems Oregon, Inc.
PO Box 1728, Lake Oswego, OR 97035
(503) 639-6080

Overview

Oregon has a statewide medical provider access issue that impacts many patient populations, including those served by workers' compensation. Insufficiencies are concentrated in a subset of geographies and specialties. The COVID 19 pandemic and its aftermath continue to stress the system. For the workers' compensation population, Majoris utilizes its unique position as a managed care organization to actively mitigate provider shortages. Despite the challenges in adequate provider resources, within the workers' compensation space, Oregon outperforms most states based on reported premium ratings.[1] Past successes and new technologies like telemedicine provide opportunities to address unmet needs and maintain national leadership.

Challenges are not evenly distributed throughout the state. Oregon's rural and frontier communities do not have a physician population sufficient to meet community demands. As physicians retire, they are not always replaced, exacerbating the shortage. Clinic consolidation[2] and the reduction of occupational medicine clinics[3] also impact worker access. The supply of neurology, cardiology, pulmonology, and mental health specialties are insufficient to meet the demands of many patient populations.

Majoris actively mitigates access issues for the workers' compensation patient population. As not all providers are equally suited or available to the injured worker population, Majoris develops solutions designed to efficiently utilize the best suited provider resources. One core approach Majoris successfully utilizes is extensive educational outreach to help providers find treatment within the workers' compensation system approachable and help clinics meet administrative demands efficiently. Another key approach is ongoing innovation in care delivery informed by medical best practices. This provides flexibility in provider utilization while maintaining high quality care standards.

Moving forward, Majoris continues to develop, test, and manage novel solutions to the evolving access challenges. Key initiatives include:

- Expanding our mid-level expander program for broader, medically appropriate utilization.
- Developing a framework to leverage telemedicine as an integrated tool to the overall care delivered to workers.
- Exploration of non-traditional attending providers.
- Continued partnership with clinics to ease administrative burdens and achieve greater bandwidth with existing resources.

Oregon's workers' compensation redesign in the 1990's moved medical care decisions squarely back into the hands of the medical professionals. This redesign resulted in the state becoming one of the best performing systems in the nation. Past successes demonstrate provider access challenges are best solved by empowering our medical professionals to efficiently deliver care. Majoris' collaborative approach with Oregon's medical professionals and other stakeholders has served Oregon workers well. We strongly advocate establishment of a working group with SAIF, private and self-insureds, providers and other engaged stakeholders to strategize how to best address ongoing medical care accessibility challenges.

[1] https://www.oregon.gov/DCBS/reports/cost/Pages/oregon-vs-nation.aspx

[2] Jeff Manning, "Optum, buyer of Eugene's Oregon Medical Group, tells patients to seek care elsewhere as physicians leave," *The Oregonian/OregonLive*, March 27, 2024, www.oregonlive.com/business/2024/03/shedding-physicians-buyer-of-eugene-clinic-chain-tells-patients-to-seek-care-somewhere-else.html

[3] Majoris has a total of 20 partnerships with clinics dedicated to occupational medicine for the entire state. This is representative of nearly all such clinics existing in Oregon, excluding those affiliated with Kaiser Permanente.

WITHIN THIS REPORT

Majoris has been aware of the ongoing and changing access issues and has dedicated resources to address them. This paper shares our knowledge with other vested parties looking at the access issue from both a workers' compensation perspective as well as the viewpoint of the general population of Oregon. This paper provides the following:

- Background on medical care accessibility in Oregon and the reasons those involved in the care of injured workers should be paying attention to the issues and collaborating to resolve them.
- Definition of access to care.
- Outline of areas in Oregon experiencing unmet healthcare needs addressed first geographically, and then by specialty.
- Majoris MCO network coverage.
- Analysis of MCO network utilization data, addressing:
    - Network vs. Non-Network Services
    - Initial Wait Times
    - COVID 19 Impact
- MCO Impact on the injured worker's experience, reviewing challenges and solutions for:
    - Geography
    - Specialty
    - COVID 19
- Takeaways.
- Plans for moving forward.

BACKGROUND

Appropriate access to timely medical care is an important component of ensuring a worker returns to work and life as fully and quickly as possible. Although not all Oregon injured workers experience barriers to care, historically it has been a challenge for certain communities (generally rural and often remote) and within certain subsets of specialty care. These workers face greater risk that their treatment will be delayed, be limited in options, or require considerable travel. While access challenges are not new, the COVID 19 pandemic pressures further exacerbated the issues.

In the rural areas of the state where many of these challenges are concentrated, it is common to have primary care physicians decline to schedule workers' compensation patients because they do not have bandwidth. When required to choose where to focus, these providers prefer to practice general primary care. This results in many workers' compensation patients being funneled to a small handful of providers or through urgent care clinics that are often not structured to effectively provide ongoing longitudinal care. Some communities solve the issue by having a provider travel between towns, typically coming from a more populated area to the rural setting a few times a week or month.[4] This can compromise the quality of care and workers' compensation expertise, especially for injured workers with more complicated care needs. Community resiliency is also impacted, with a single provider change presenting the potential for meaningful reduction to access.

[4] Examples of this include larger health systems along the I-5 corridor that send providers out to coastal towns or up to the Hood River/The Dalles area, or specialists with two or more clinics they rotate between.

Access to certain specialty care is also challenging. Neurology options have been limited for nearly a decade, with physicians scheduling months in advance even for straightforward consultations. Demand for behavioral health has increased in recent years, particularly for those workers who qualify for the Post Traumatic Stress Disorder presumption passed in 2019. Care in this area is commonly scheduled far in advance and options for injured workers are limited to a few providers who have made the intentional decision to reserve a portion of their practice for workers' compensation. Pre-COVID 19, cardiology and pulmonology were rarely needed in the workers' compensation space, and when they were, scheduling issues were rare. Post-COVID 19, the overall demand for these specialties is up in both the general and workers' compensation spaces, translating to new resource limitations and care delays.

In addition to the pressures placed on specialty care, the pandemic impacted the entire workforce, creating tight labor markets for both licensed medical providers and administrative support staff.

As the question of access to care for injured workers is a subset of a larger conversation regarding the challenges facing the general population, this report first reviews the overall state of healthcare access in Oregon before drilling down into the workers' compensation subsector and then the Managed Care Organization experience.

DEFINING ACCESS TO CARE

Identifying potential solutions for access to care requires defining a standard for what constitutes appropriate access and the barriers to achieving that standard.

There are no universally accepted ratios for provider to population counts. This makes it difficult to set standards or identify gaps. A key challenge to establishing targets is that the desirable ratio of provider to population is driven by demand, which fluctuates based on population demographics and the specific specialty in question.

Key components that should be considered when defining access are:

- Reasonable travel requirements.
- Wait times for urgent care services.
- Wait times for standard/primary care physician care.
- Wait times for specialty care.
- Adequate choice.
- Affordability.

Reasonable targets for these standards vary based on community location. Urban areas will provide greater choice and a broader range of specialty care options without requiring significant travel or wait.

While there is not a universally accepted ratio of providers to population, there are several entities who have developed assessments of unmet need. The Health Resources and Services Administration (a federal agency) and the Oregon Office of Rural Health (a state agency) are two such entities. Both developed frameworks to designate areas with shortages of primary care physicians. These approaches assess the general patient population care demand, and do not consider the additional workers' compensation needs that often reduce options. As such, the provider ratios offer insight but may not consistently translate into an equivalent provider ratio for the workers' compensation patient subset.

The following quantitative and qualitative data sets provide insight into the current state of available medical resources, inform appropriate goals for future improvements, and offer a framework for innovation. Due to data constraints, the comparative data in this report is limited to providers licensed as a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO).

AREAS OF UNMET HEALTH CARE NEED

General Population

There are now a limited number of medical practices dedicated to occupational medicine in Oregon so most care for injured workers draws from the same resources as the general population. Referencing the available assessments on the state's overall primary care coverage sets a baseline for care potentially available to workers' compensation patients. Review of the reports issued by the Health Resources and Service Administration (HRSA) and the Oregon Office of Rural Health (ORH) show that the state has on average a ratio of 0.98, representing an exact balance of supply to estimated general population demands. Importantly, when looking at the breakdown across the state, both also reveal imbalanced distribution of primary care resources between urban and rural communities.

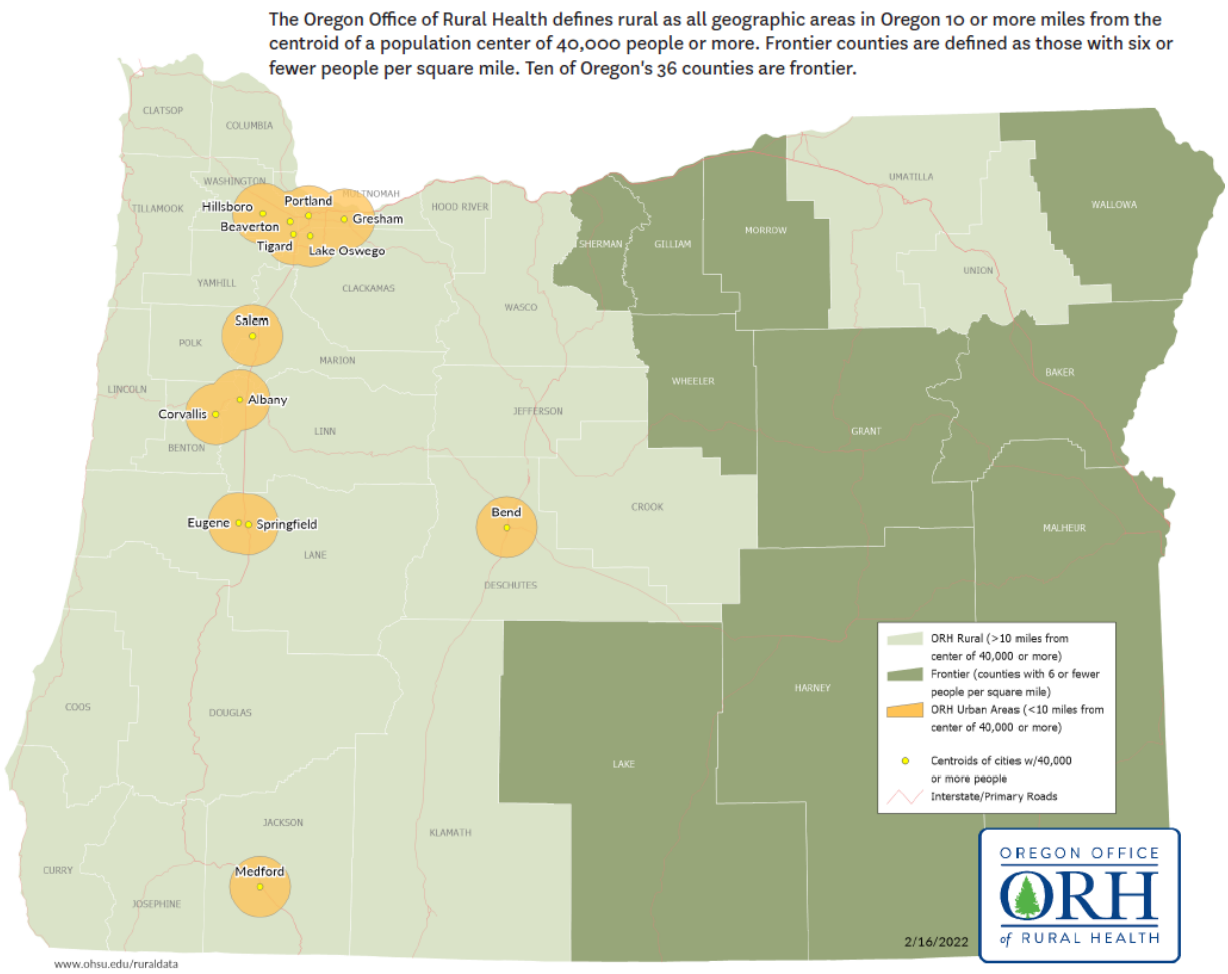
HRSA identifies areas with shortages of primary care physicians utilizing three core scoring criteria[5]. Under that methodology, Oregon has 9 counties identified as experiencing physician shortages for their community needs, considered federally recognized Health Professional Shortage Areas (HPSA).

- Benton
- Columbia
- Gilliam
- Wheeler
- Baker
- Lane
- Morrow
- Sherman
- Washington

ORH developed the Areas of Unmet Health Care Need Report (AUHCN) in 1998. This report assesses available medical resources and identifies areas that are "medically underserved" utilizing nine variables that measure access to and utilization of primary physical, mental, and oral health care. The state is broken into 128 geographical service areas and grouped into the categories of urban, rural and frontier.[6] Each area is scored, with zero being the worst possible score and 90 being the best possible score. The scores are then used to inform which areas should be designated as underserved.

[5] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring

[6] Urban <10 miles from the center of 40,000+ population, Rural > 10 miles from the center of 40,000+ population, and Frontier are counties with 6 or fewer people per square mile.



Map 1

The below table shows the scores for the last three years for the state and each of the above categories.

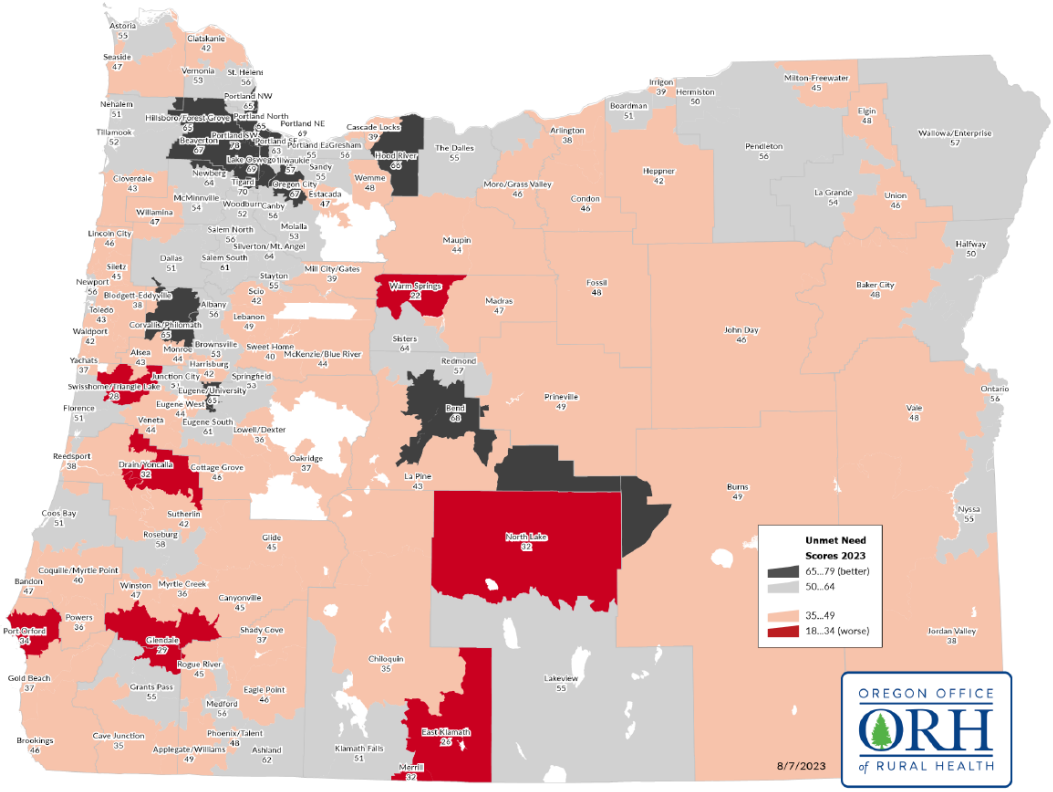
Mean (Average) Score by Geographic Area	**2023**	**2022**	**2021**
Oregon	49.1	49.4	49.4
Urban	61.6	62.1	62.6
Rural (without Frontier)	46.1	45.9	46.0
Rural (including Frontier)	46.2	46.4	46.4
Frontier	46.9	48.9	48.0

Table 1

The disparity between urban and rural or frontier is demonstrated by comparing the top 13 areas with greatest unmet need to the top 13 with the least unmet need.

Greatest Unmet Need Areas	**2023**	**2022**	***Least Unmet Need Areas***	**2023**	**2022**
Warm Springs	22	18	*Portland SW*	78	79
East Klamath	26	24	*Tigard*	70	70
Swisshome/ Triangle Lake	28	27	*Portland NE*	69	70
Glendale	29	27	*Lake Oswego*	69	70
North Lake	32	40	*Bend*	68	69
Drain/Yoncalla	32	31	*Oregon City*	67	68
Merrill	32	33	*Beaverton*	67	67
Port Ortford	34	26	*Hood River*	66	68
Cave Junction	35	33	*Portland NW*	65	67
Chiloquin	35	32	*Portland North*	65	65
Lowell/Dexter	36	35	*Hillsboro/Forest Grove*	65	66
Myrtle Creek	36	38	*Eugene/University*	65	65
Powers	36	29	*Corvallis/Philomath*	65	66

Table 2



Map 2

Highlights from the September 2023 report include:

- The average travel time to the nearest Patient Centered Primary Care Home (PCPCH)[7] in Oregon is 12.6 minutes. In 21 rural or frontier service areas where no PCPCH is available, the average drive time is 26 minutes.
- Rural and frontier regions have a lower average ratio of 0.72, indicating a higher demand than supply. Urban areas have a ratio of 1.13, indicating they have surplus for the local need, though reduced compared to 2022. Notably, 10 primary care service areas, all rural or frontier, have zero primary care provider Full Time Equivalent (FTE).[8] The overall ratio of estimated primary care visits existing providers in Oregon can accommodate is 0.98.

Primary Care Capacity Ratio (higher is better)	**2023**	**2022**
Oregon	0.98	1.21
Urban	1.13	1.38
Rural (without Frontier)	0.70	0.88
Rural (including Frontier)	0.72	0.91
Frontier	1.01	1.31

Table 3

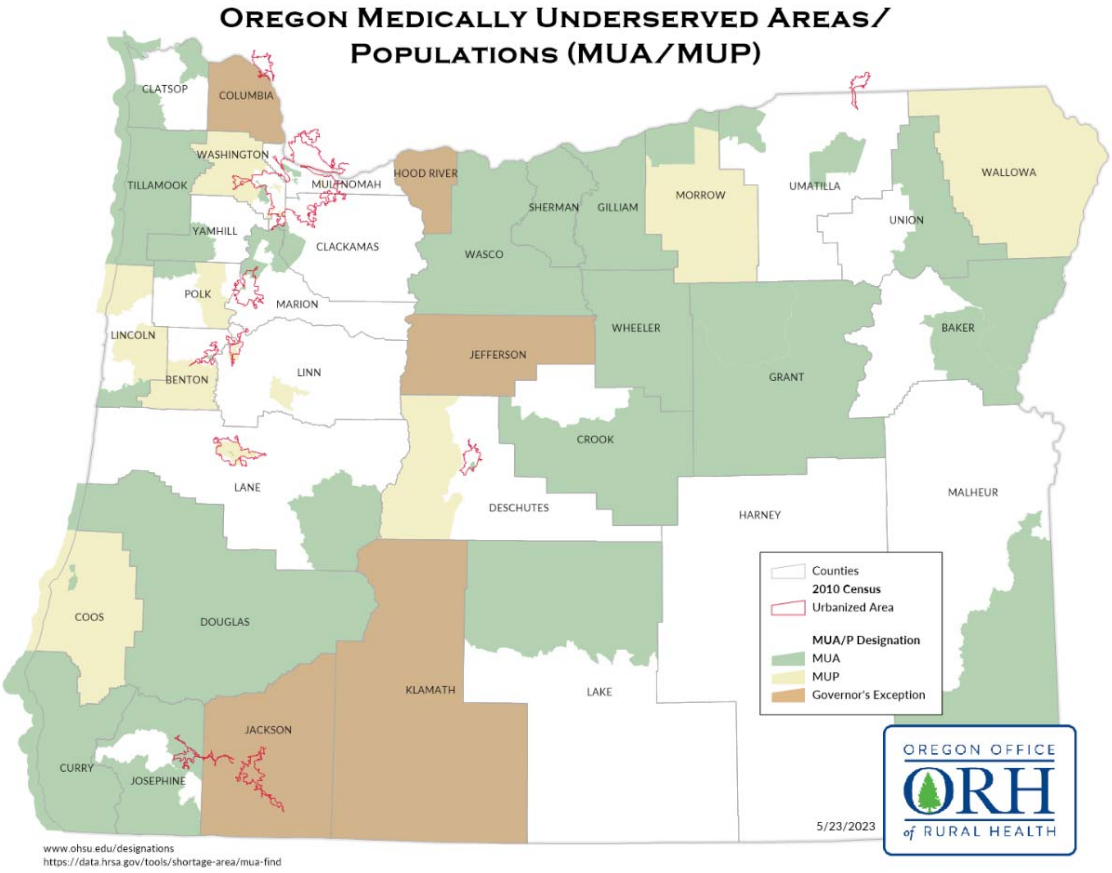
  - A ratio of 1.0 signifies a balance between supply and demand, *assuming uniform access and affordability*.
  - The 10 service areas, all rural, that do not have any primary care provider FTEs are Alsea, Blodgett-Eddyville, Cascade Locks, East Klamath, Harrisburg, Jordan Valley, Lowell/Dexter, Merrill, Powers, and Swisshome/Triangle Lake.
- The state has 1.15 mental health care provider FTEs per 1,000 people; however, rural and frontier areas only provide 0.52 FTE on average. All 26 primary care service areas without mental health provider FTE are found in rural or frontier areas.
- Oregon's three-year (2020-2022) average preventable hospitalization/ASCS rate is 5.8 per 1,000 people yearly. Rural and frontier areas show a higher average rate of 7.0 per 1,000. Warm Springs, Reedsport, Clatskanie & Bandon all exhibit rates over double the state average.
- Oregon has an average Unmet Need Score of 49.1 out of 90. 70 of the 128 service areas fall below that score: Urban: 2 out of 24 (8%); Rural (without frontier): 56 out of 86 (65%); Frontier: 12 out of 18 (67%)

The Oregon Health Authority Primary Care Office uses this information to request federal designation for certain areas of the state as Medically Underserved Areas (MUA) and/or Medically Underserved

[7] Note, a Patient Centered Primary Care Home (PCPCH) is a health care clinic that has been officially recognized by the Oregon Health Authority (OHA) for providing high quality, patient centered care. All PCPCHs must possess a minimum of 11 criteria. The lack of a PCPCH does not always mean there are no primary care providers in that community, but any that do exist have not met those quality standards.

[8] FTE is calculated using the OHA's Healthcare Workforce Reporting Program Database, using primary and secondary work locations. It includes Physician, Physician Assistant and Nurse Practitioner Surveys as of January 2023. It does not include first time licensees or those with a mobile practice or work in an outcall capacity, which may skew the data.

Populations (MUP). Additional areas receive a designation of "Governor's Exception", which are areas that do not meet the standard federal designation but are recognized as shortage areas using a federally approved state-based certification process.[9]



Map 3

As demonstrated by the ORH Report and Underserved Area designations, access to providers is regionally sensitive, with wide swaths of the state experiencing significant unmet need. The urban areas' estimated supply excess is absorbed when allocated across the entire state's estimated need. The physician search firm Merritt Hawkins' Survey of Physician Wait Times showed that average wait times nationally for patients increased to 22 days in 2022; in the Portland metro area it is an average of 45.6 days.[10] All of these data points consider the general population. For individuals seeking to access care for a work injury, provider availability can vary compared to the population at large. As shown on Graph 6, MCO enrollment can mitigate this. The initial wait time for workers enrolled in the Majoris MCO in the Portland metro area is 22.8 days – much closer to the nationwide average reported by Merritt Hawkins.

[9] https://www.ohsu.edu/oregon-office-of-rural-health/health-care-need-designations
[10] Long waits to see a doctor are a public health crisis. Oliver Kharraz. May 2023 Phillip Miller. https://www.statnews.com/2023/05/02/doctor-appointment-wait-times-solutions/
Note: Merritt Hawkins is now AMN Healthcare Physician Solutions

AREAS OF UNMET HEALTH CARE NEED

Workers' Compensation

The standard treatment of work-related injury and disease involves a subset of the overall licensed medical community. For example, the number of obstetricians in a community will have minimal to zero impact on that population's ability to receive care for their on-the-job injuries. Therefore, when assessing access to medical care for the injured worker population, it is appropriate to refine the selection of specialties included in analysis. As referenced earlier in this report, to support effective comparative analysis, Majoris has limited review to licensed MDs and DOs. Analysis is further refined to focus on MDs and DOs specializing in the care most used in the treatment of work injuries and disease. These are not exhaustive of all specialties utilized in the treatment of work injuries; they are representative of the core specialties utilized regularly and expansively.[11] [12] [13] [14] For the purposes of this report and effective analysis, those specialties are categorized into the use types outlined in Table 4.

Workers' Compensation Core Specialties

Specialty Use-Type Category	***Description***	***Specialties included***
Often Attending	Specialties calibrated to the treatment of work injuries. Physicians practicing in one of these generally assume the role of attending physician when caring for an injured worker. Physicians with this specialty can be considered a likely resource for work injuries.	Occupational Medicine; Pain Management; Physical Medicine & Rehabilitation; Sports Medicine

[11] Specialties are self-reported by physicians to the Oregon Medical Board (OMB) and descriptors are not controlled or standardized. To support analysis, Majoris consolidated specialties into consistent formats and made assumptions on the most likely primary specialty based on the wording the physician selected when reporting their specialty.

[12] OMB data is not a direct correlation to the number of physicians actively practicing in Oregon. The licensee listing includes those who maintain an active Oregon license but: are retired from active practice, have relocated without updating their address with the Board, practice in another state full-time (multi-licensed), or focus on work outside hands-on treatment. As such, numbers are inflated from actual available Oregon physicians. Some profiles are also incomplete or outdated, with partial or omitted practice addresses. Spot validation of the data also demonstrates that addresses are not always reflective of a physician's current practicing location. Majoris made best attempts at educated assumptions based on the data available.

[13] Because Oregon workers' compensation has defined Geographical Service Areas (GSA) set out by statute and are used to assign coverage by Managed Care Organizations, data has been organized within those defined areas. While it is common for physicians to treat at multiple locations, including different towns, counties or even across state lines, OMB data is limited to a single practice location per physician.

[14] Because of the difficulty in assessing certain specialties' true availability to the workers' compensation population, the counts are inflated, though the exact inflation factor is difficult to accurately ascertain (e.g., a physician with a declared primary specialty of internal medicine may be found practicing in an occupational medicine clinic or in an oncology clinic).

Specialty Use-Type Category	***Description***	***Specialties included***
Common Attending	Specialties that commonly treat injured workers, but many physicians practicing in one of these specialties limit how or if they will treat workers' compensation patients. For example, a family physician may choose to limit care to individuals who had already established care prior to the work injury. Physicians with this specialty can be considered a possible resource for work injuries.	Family Medicine; General Practice; Osteopathic/Neuromusculoskeletal Medicine
Surgical	Surgical specialties that commonly treat injured workers, but care will be limited to injuries requiring surgical intervention. The role of attending physician is often limited to the global surgery period.	General Surgery; Hand Surgery; Head & Neck Surgery; Foot & Ankle Surgery; Neurological Surgery; Orthopedic Surgery
Consulting	Specialties required to assess or address a facet of the overall work-injury. Rarely used for longitudinal care, overall treatment management or the role of attending physician.	Critical Care; Neurology
Sometimes Ancillary	Specialties that span different care levels. Physicians practicing in one of these specialties could often serve as the attending physician, or never. For example, an emergency medicine specialist could practice in an occupational medicine clinic or an emergency department. In the first scenario they are a core resource, in the second they are highly limited.	Anesthesiology; Emergency Medicine; Internal Medicine
Limited Scope	Necessary specialty for the treatment of work injuries, narrowly limited treatment scope.	Radiology, Psychiatry

Table 4

There are 9,201 physicians licensed with the OMB with one of the workers' compensation related specialties.

26125
All OMB Physicians

20458
OMB Physicians with non-limiting license type

19818
OMB Oregon Jurisdiction Physicians

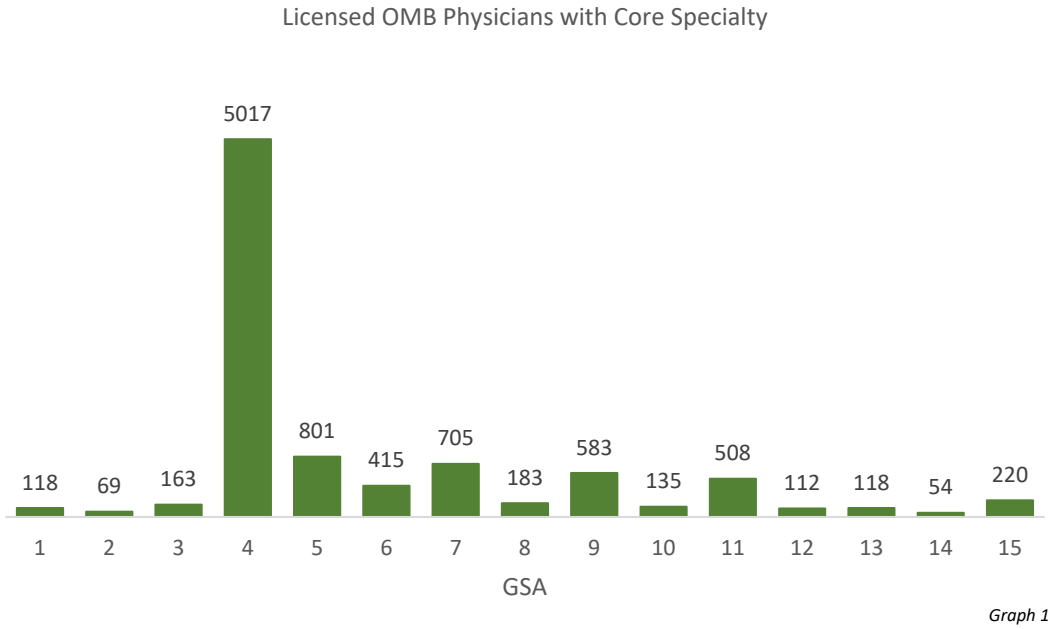
16683
OMB Physicians with a Relevant Specialty

9201
OMB Physicians with a Core Specialty

OMB Oregon Licensed Physicians with a Core Specialty

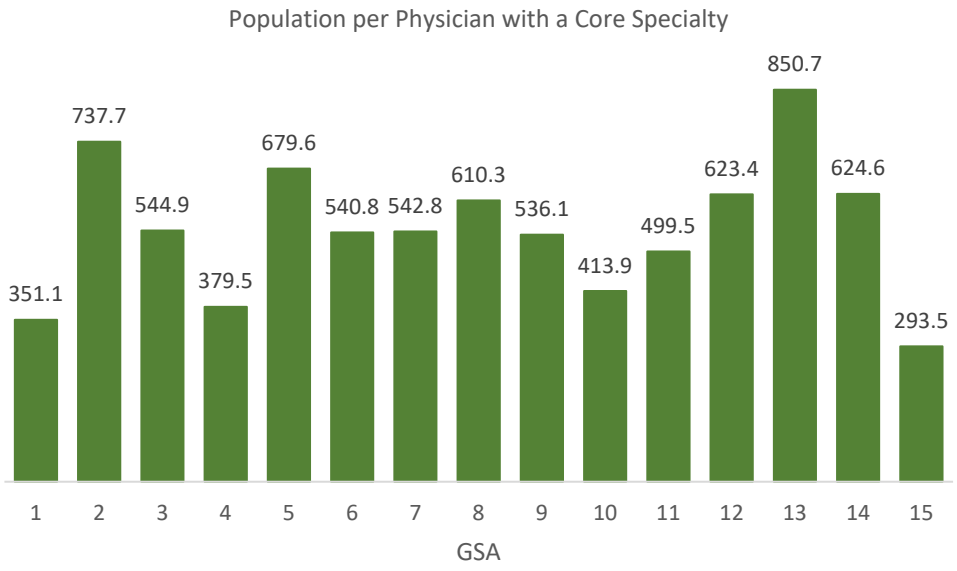
SPECIALTY	Count
INTERNAL MEDICINE	2355
GENERAL & FAMILY PRACTICE	2342
EMERGENCY MEDICINE	1037
ANESTHESIOLOGY	733
PSYCHIATRY	550
ORTHOPEDICS	497
RADIOLOGY	470
GENERAL SURGERY	452
NEUROLOGY	248
NEUROSURGERY	116
PHYSICAL MEDICINE & REHAB	107
PAIN MANAGEMENT	96
SPORTS MEDICINE	74
OCCUPATIONAL MEDICINE	46
HAND SURGERY	41
OSTEOPATH	37
Total	**9201**

Per Graph 1 there is a wide disparity of licensed physicians between GSAs depending on their location in the state.



Graph 1

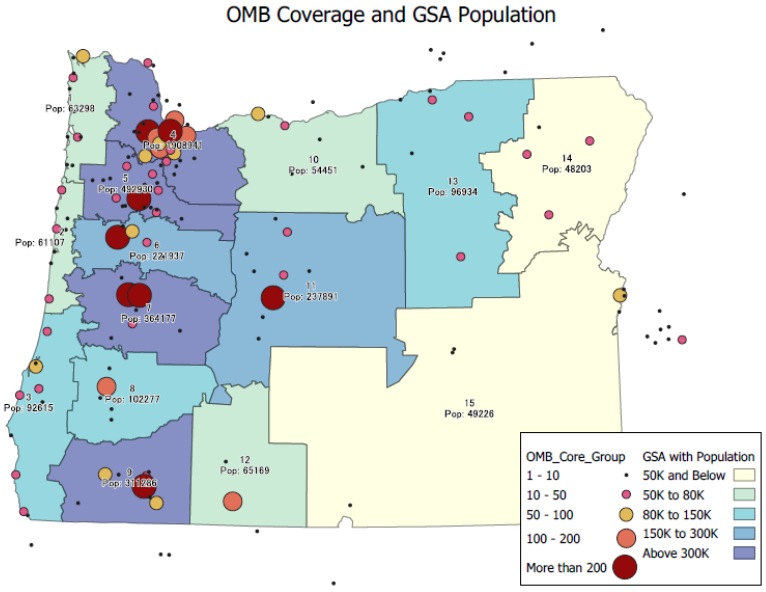
Graph 2 calculates the population per physician by GSA.[15][16]



Graph 2

When broken out by GSA, physician count compared to general population demonstrates that availability shifts based on geographic location. However, as each GSA's square mileage and distance between towns varies significantly, it does not completely demonstrate actual physician accessibility.

The impact of geographical considerations on physician accessibility is better visualized by Map 4, "OMB Coverage and GSA Population". For example, GSA 15 has more physicians per capita than every other GSA, but because of the distance those physicians must cover, medical accessibility will be impacted depending on where an individual resides.



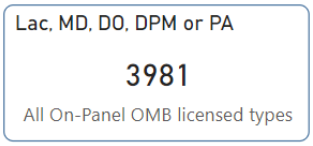
Map 4

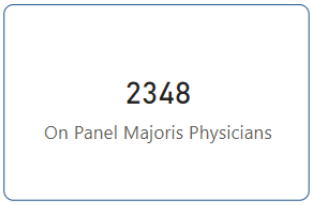
[15] This data does not adjust for part-time physicians, reporting each as if they are a full-time equivalent.
[16] GSA reference list and map are found in Appendix A.

MAJORIS MCO NETWORK PHILOSOPHY

Majoris has dedicated resources for network credentialing, recredentialing, and education. Our curated network consists of over 7,000 individual providers representing 80 different specialties. Nearly 4,000 of those individuals are practitioners licensed by the OMB, and 2,345 of those have a core workers' compensation specialty as defined in the prior section. Majoris' network strategy selectively contracts with providers best suited for treatment of workers' compensation patients. This includes factors such as relevant specialty, treatment history and credentials, experience navigating work injury care, and openness to collaborating with other stakeholders (insurer, employer and MCO). Provider engagement and experience is a strong indicator for quality care and outcomes. Majoris avoids contracting with providers unwilling to focus assessment on the work-related condition(s) or provide a treatment plan that incorporates progressive return to function and work duties. Treatment in this context can translate to elongated recovery timelines and potentially reduced overall recovery. When possible, Majoris also avoids contracting with providers who overly limit their availability for injured workers so that the members listed in the MCO directory are an accurate representation of options for the worker population. Our philosophy of selective contracting enables Majoris to build strong relationships with treating providers and provide effective education and support. This translates into quality care for injured workers.

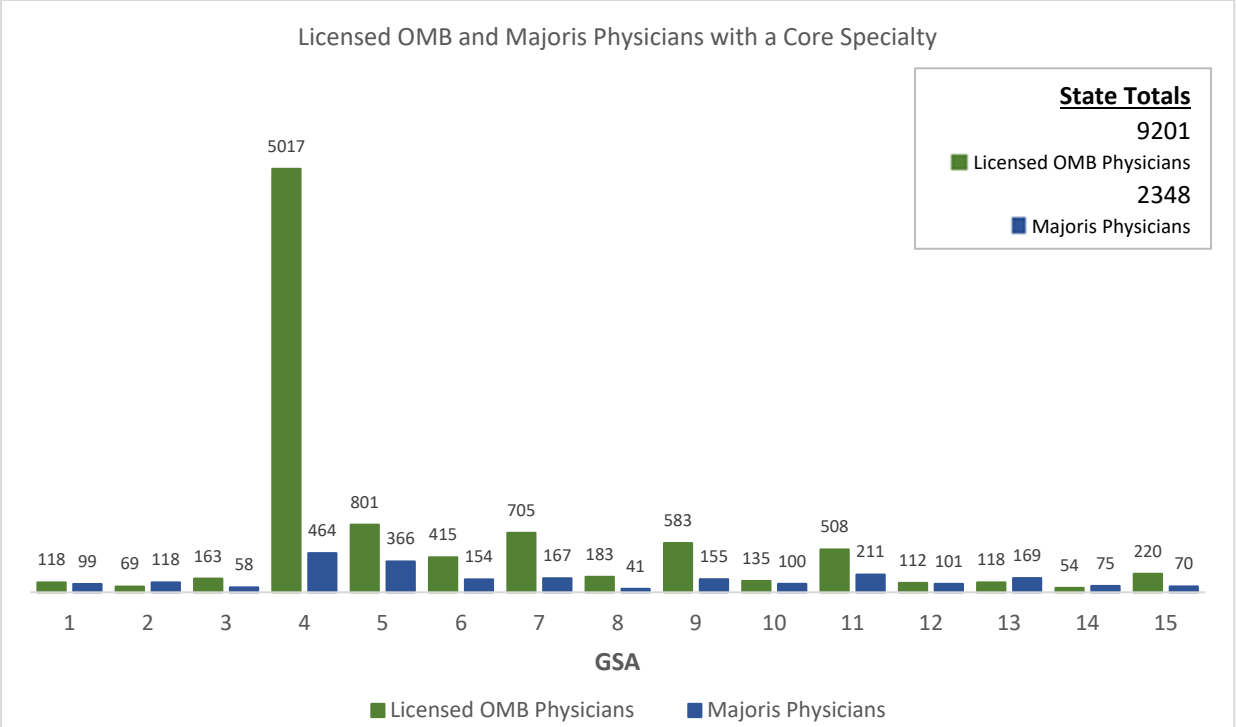
There are 2,348 physicians on the Majoris network with one of the core workers' compensation related specialties. Graph 3 on the following page compares overall Oregon licensed physicians versus Majoris' network.





Majoris On Panel Physicians with a Core Specialty

SPECIALTY	Count
ANESTHESIOLOGY	121
EMERGENCY MEDICINE	179
GENERAL & FAMILY PRACTICE	644
GENERAL SURGERY	253
HAND SURGERY	2
INTERNAL MEDICINE	277
NEUROLOGY	58
NEUROSURGERY	63
OCCUPATIONAL MEDICINE	48
ORTHOPEDICS	279
OSTEOPATH	34
PAIN MANAGEMENT	16
PHYSICAL MEDICINE & REHAB	66
RADIOLOGY	304
SPORTS MEDICINE	4
Total	**2348**



NOTE: If a Majoris Physician practices in multiple GSAs only one was chosen

Graph 3

Graph 3 demonstrates how provider volume is not a standalone indicator for provider adequacy in meeting a specific patient population demand. For example, if looking at the percentage of available OMB licensed physicians to contracted MCO physicians, Majoris' GSA 4 access appears deficient. However, GSA 4 has some of the best network adequacy in the state. The average days from enrollment to first visit on Graph 6 shows that workers are accessing care in GSA 4 more readily than nearly all other areas of the state.[17]

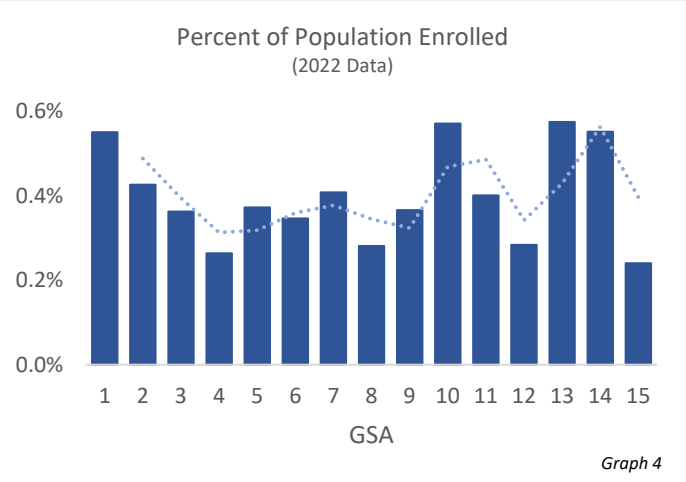
Physician composition and additional healthcare demands outside the workers' compensation population influence accessibility of physician resources, as does delivery method. If a clinic is positioned to dedicate most of its physician resources to treat injured workers, the number of physicians required to meet demand is significantly lower than if the clinic is also attempting to field additional patient population types or is focused on a different set of healthcare needs. If the community has overall higher healthcare needs, that further strains available medical resources.

The more populated areas of the state have more hospitals and specialty clinics. This results in a larger subset of physicians with a specialty relevant to the workers' compensation patient, but utilized in a setting that is not (e.g., hospitalists, emergency departments, cancer centers, etc.) [GSA's 04, 07, 09]. This overstates the number of estimated physicians available to workers' compensation patients. Conversely, these areas often have occupational medicine clinics dedicating physician resources for more efficient worker care [GSA's 04, 06, 07, 09].

[17] This graph reflects the data quality issues disclosed in the prior section. Spot validation found that a material portion of providers reported by OMB as actively practicing in one area in reality have retired, relocated or practice in a setting not directly relevant to workers' compensation. At times that results in the Majoris network appearing to have a lower percentage of physicians than reality, and in others more physicians than OMB reports exist.

Less populated areas of the state have fewer physicians overall, and those physicians are required to serve the full suite of healthcare needs. Majoris' experience has determined that access is often more readily solved by identifying a few resources willing to dedicate most of their time to workers' compensation patients, rather than attempting to add more numbers overall. Majoris utilizes both methods [GSA's 01, 02, 03, 08, 12, 14, 15]. For GSA's 08, 12, 14, 15, both approaches present challenges due to the physical distance between communities.

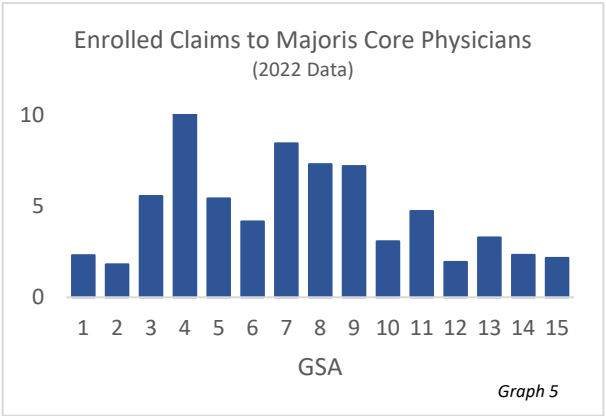
Community demographics influence the mix and volume of physician required to effectively meet demand for care. For example, a community with a high concentration of seniors will likely demand more neurological care than a community with a younger population. Communities with a high concentration of retirees will require fewer occupational medicine resources than those where most individuals are engaged in the workforce. Just as with the general population, demographics for the active workforce subset and the area's industry influence physician specialty and volume demand.



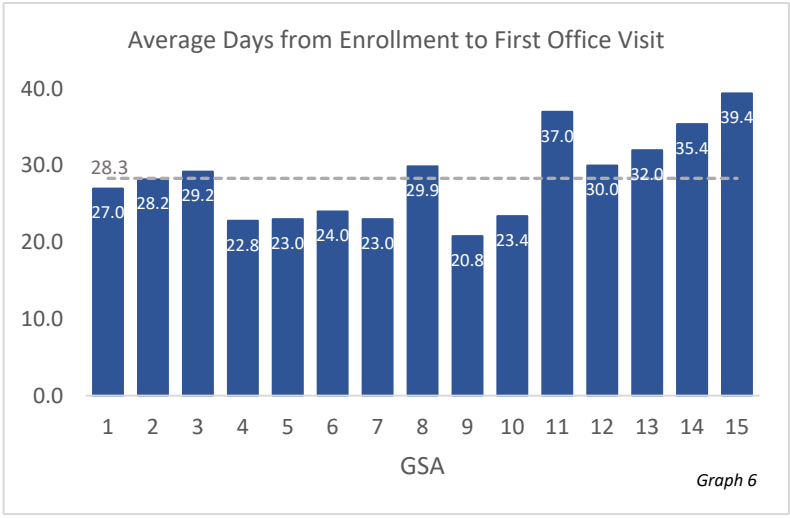
Graph 4

Percent of total population enrolled into the MCO serves as a representation of overall workers' compensation care demands for the GSA. Graph 4 demonstrates how this fluctuates depending on the area of the state.

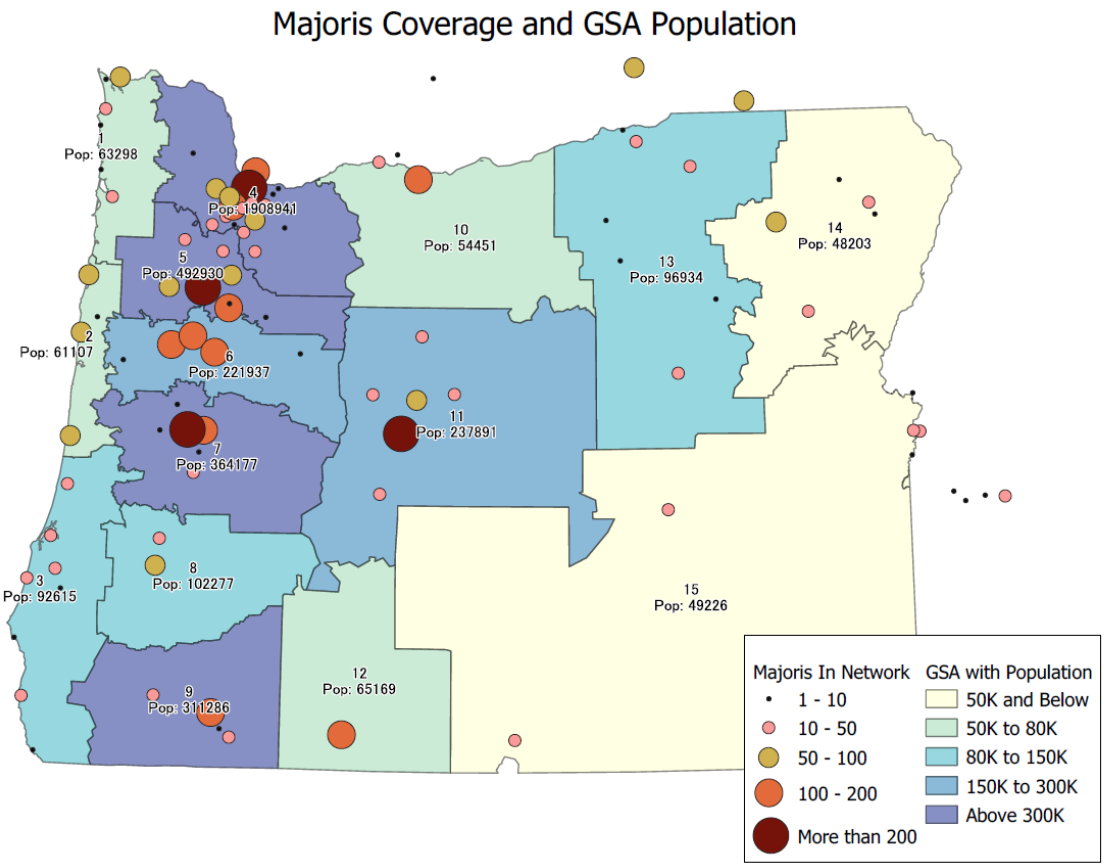
Time to care is a measure of accessibility. For enrolled claims, the average number of days from enrolled to first visit measures the ease of worker access. The ratio of physicians to population is not a sufficient measure of accessibility on its own. Graph 5 shows the ratio of Majoris "core specialty" physicians to total enrolled claims by GSA. Graph 6 shows the average number of days from enrollment to visit by GSA. The lack of correlation between these two charts demonstrates how the volume of providers does not consistently indicate accessibility.



Graph 5



Graph 6



Map 5

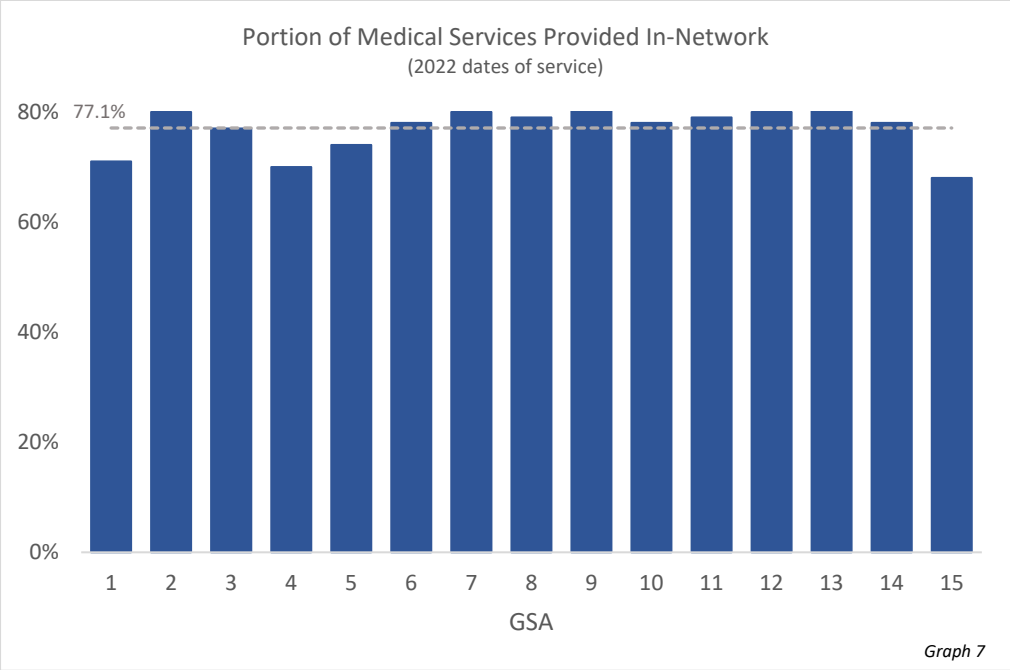
ANALYSIS

Resource limitations do not consistently impact injured workers, and physician volume does not translate into an exact correlation of resource accessibility. This section outlines this through review of utilization statistics demonstrating actual worker experience within the MCO framework. We will address:

- Network access and initial wait times.
- Provider volume compared to outcome.
- Impact of Covid 19.

Network vs Non-Network Services

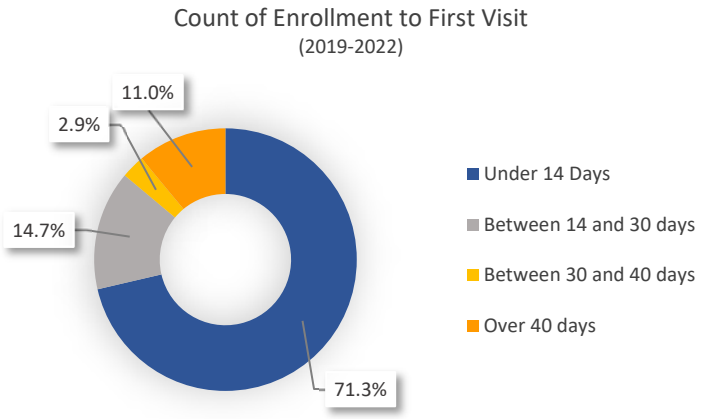
If MCO resources are insufficient, the system is designed to safeguard the worker by allowing non-MCO treatment when medically appropriate alternatives exist. Additionally, statutory requirements allow non-network care with an injured worker's established primary care physician even if there are sufficient MCO options. This feature of Oregon's MCO framework protects workers' access to care. On average, 77.1% of care provided to Majoris enrolled workers is provided via network options (Graph 7), demonstrating that Majoris network coverage meets most worker needs without requiring use of non-network options. The 22.9% of non-MCO care represents instances of workers utilizing their right to treat with their non-network primary care physician and instances of MCO resource limitations.



Graph 7

Initial Wait Times

Another access assessment is how quickly an individual can be scheduled. As referenced previously, the Merritt Hawkins' survey of key metropolitan centers reports that the national wait time for major urban centers is 22 days, with the Portland metropolitan area at 45 days. As highlighted in the previous section, Majoris statistics show that on average enrolled workers see a provider 26.7 days from date of enrollment (Graph 6), with 71.3% of workers seen within 14 days from enrollment, and 86% seen within 30 days (Graph 8). [18] This is closer to national averages and much faster than the experience of the Portland, OR general population as measured by the Merritt Hawkins' survey.

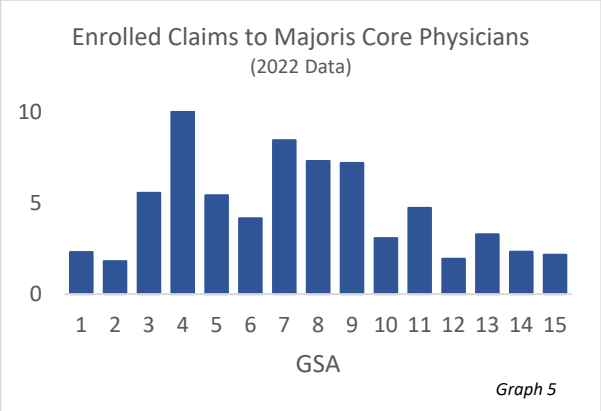


Graph 8

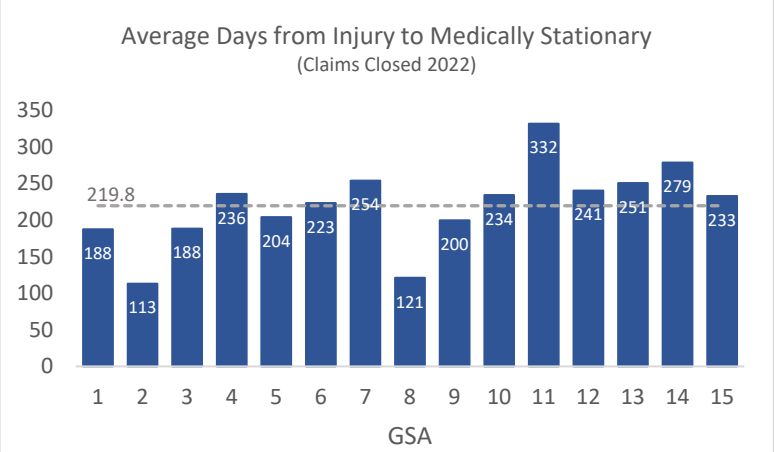
[18] Since many workers have treated prior to enrollment, most do not need to be seen immediately at time of enrollment. Rather, expectation is that most should be seen within 30 days of enrollment. The Hawkins survey is assessing overall scheduling, which may include initial visits.

Provider Volume vs Outcomes

While it is a common assumption that more providers will translate to better care, Majoris has not found that to be true. As referenced in the previous section, utilization patterns demonstrate that higher provider volume to enrolled claims does not correlate to workers being seen more quickly. Similarly, stronger provider ratios do not consistently translate into improved injury resolution timeframes (Graphs 5 & 9).



Graph 5



Graph 9

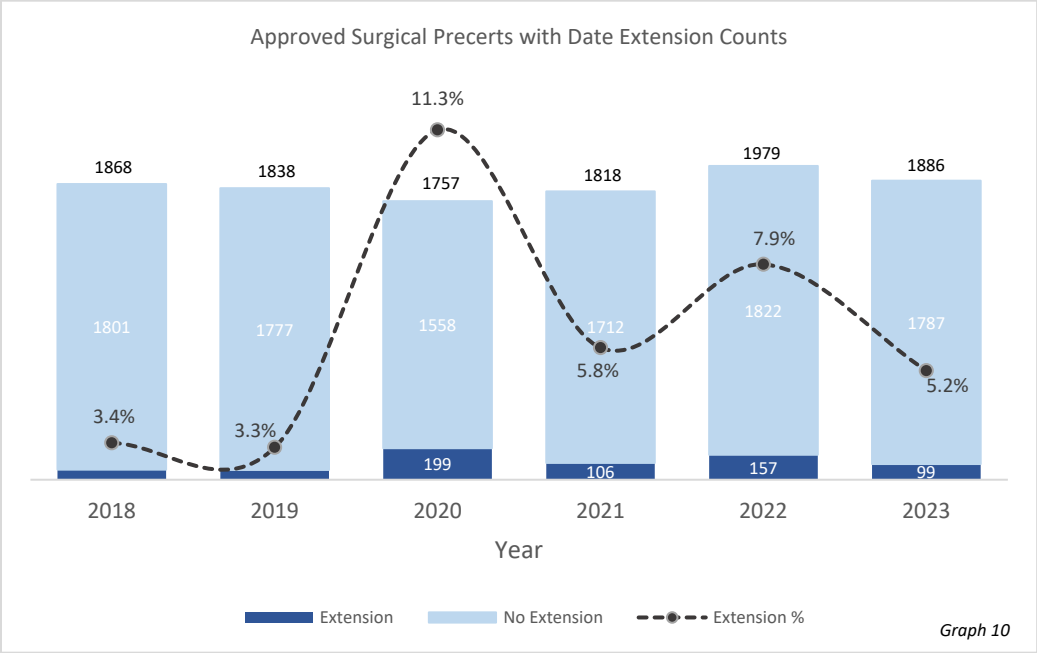
Review of the physician data compared to utilization statistics offers three key insights:

1. Areas of the state designated rural and frontier have limited overall medical care resources. Even when the majority are engaged by the MCO, non-workers' compensation care demands and insufficient physician volume prevent injured worker demands from being as readily met as the other areas.
    a. Geographical distance and concentration of medical practitioners means some workers face longer drives to access the available resources.
    b. These communities typically share the same subset of physicians for all patient populations, rather than having certain physicians dedicated to the workers' compensation population.
    c. A common solution to the issue is to "borrow" resources from another area. The coastal communities often have a partnership with a larger health center along the I-5 corridor, providing them part-time access through physician travel.
2. Higher volume of physicians does not definitively translate into greater access for workers. The physicians need to also be fully available and practicing in a setting suited for workers' compensation treatment. For example:
    a. GSA 4 has a higher ratio of enrolled workers (and population) to Majoris physicians, yet utilization statistics show it has one of the lowest average days from enrollment to first visit. Also, the portion of medical services provided in-network is not significantly reduced compared to other GSAs with higher network participation. Additionally, it is one of the GSAs with the highest concentration of clinics dedicated to occupational medicine. This demonstrates that how care is made available to workers is just as important as how many providers are available to provide care.
    b. Conversely, GSA 12 is one of the more challenging areas of the state when it comes to finding an attending physician yet has one of the stronger physician to enrolled worker ratios.

3. Access to care is not an issue for most injured workers. Overall, workers are seen regularly and readily access MCO options. However, for the subset of workers in certain geographical areas or requiring certain specialty care, challenges to accessing care are greater.

COVID 19 Impact

COVID 19 impacted access to care across many sectors of healthcare, which impact is not easily quantified. Approved surgical procedure data offers a quantifiable example of how COVID 19 delayed care, and how those delays remain. Graph 10 tracks the frequency of surgical extensions that result when an approved surgery is not scheduled within 60 days[19]. 2020 had a dramatic uptick in extensions, largely driven by state moratoriums on elective surgery. After those moratoriums and other restrictions were lifted extensions in 2021 to 2023 lessened but are greater than pre-pandemic levels. Surveying orthopedic clinics, the barriers are due to too few anesthesiologists and surgical scheduling slots, reducing their surgeons' capacity. Majoris has fielded similar reports from other specialties and clinics.



Graph 10

WORKER EXPERIENCE AND THE MCO IMPACT

The following sections provide examples of how these challenges play out across the state, and the various solutions Majoris has explored in addressing them. While some of these solutions are unique to MCO capabilities, they all offer valuable insight into how access to care can be positively impacted with the right tools and approach.

GSA 3: South Coast / Coos Bay

The south coast of Oregon has historically experienced limited choice for injured workers, with North Bend Medical Center (NBMC) one of the main resources for care. Most of their providers are only willing to treat their established patients. This resulted in only two physicians being available for new injuries if

[19] As a part of quality care oversight, Majoris guidelines require procedures be scheduled within 60 days from date of approval.

the individual did not have a primary care physician. In 2016, Majoris met with NBMC leadership to discuss avenues to increase access. NBMC reported it was not able to require any of their physicians to accept workers' compensation. The urgent care clinic did not feel equipped to follow workers beyond an initial visit, and the primary care physicians felt they had too large a patient load to absorb any ad-hoc work injury demands.

Then options were then further reduced to a single nurse practitioner willing to oversee workers' compensation cases. Majoris partnered with her to develop a set of protocols that extended her attending authority while maintaining quality oversight and ensuring timely escalation to other specialties. The partnership translated into timely care for workers and robust collaboration with the attending.

Subsequently, NBMC explored opening an occupational medicine clinic but did not. When the original nurse practitioner announced retirement in 2023, Majoris moved swiftly to provide data to NBMC substantiating the business case for replacing her and reinforced MCO availability to provide the workers' compensation training. Once recruited, Majoris played a key role in supporting the onboarding of the new provider to achieve a smooth transition from one occupational medicine provider to the other.

GSA 15: Baker City

Options for care within Baker City are limited and people in the community often travel to the Boise, Idaho area for many of their care needs. For injured workers specifically, Baker City has not had a dedicated occupational medicine resource for over a decade. The community has two medical clinics, both extensions of Boise, ID based medical centers (St. Alphonsus and St. Luke's). Majoris has worked extensively with both organizations to find a way to bring occupational medicine options closer to the community. Leadership groups at both have consistently expressed openness to the concept but difficulty in identifying enough provider availability to successfully commit. After several years of collaboration, Majoris and St. Alphonsus launched a program in 2020 that leveraged a local physician assistant with a Fruitland based occupational medicine physician to provide occupational medicine services in Baker City. Unfortunately, one year later that physician assistant relocated out of state and St. Alphonsus was unable to recruit a replacement. Because of its frontier location, Majoris views Baker City as a good candidate for trialing new telemedicine concepts. Utilizing the MCO's ability to oversee utilization, there is potential to leverage telemedicine as a component of the overall care without losing the quality derived from in-person care. One possible approach is to establish more expansive guidelines on when and how telemedicine should be utilized in conjunction with in-person care. Another possibility is to leverage other healthcare resources like physical therapists as part of the telemedicine setting.

GSA 12: Klamath Falls

The Klamath Falls community solves its overall access issues in part through a family medicine residency clinic via a joint partnership between the local medical center and the Oregon Health & Science University located in Portland. As residents are not yet fully licensed physicians and treat under the supervision of rotating attendings, this changed the landscape of choice for workers' compensation patients. Majoris partnered with the clinic to identify new protocols that allowed them to utilize the residents while maintaining the required elements of workers' compensation regulations.

The partnership helped meet the community need, with occasional disruptions due to the natural turnover of residents. Ultimately, additional adjustments resulted in a shift to mid-level practitioners as the official attending physician to further reduce disruptions for injured workers while maintaining access levels for the community as a whole.

This approach was successful until COVID 19 created significant disruption in the area's medical community. Now, as with Baker City and other rural communities, people often travel to larger towns to meet their needs. In scenarios like this, Majoris focuses on providing medical oversight to identify which needs are most critical, facilitating transferring care outside the community when appropriate, and maintaining monitoring for those that currently do not have regular access to care.

Neurology

Neurology has been a limited specialty for years, regardless of patient population. Demand has increased due to advances in medicine and an aging population, but the number of physicians specializing in neurological care has not.[20] While only a small subset of workers require neurologic care, for those that do, care can be delayed months waiting on a consultation or diagnostic testing. These delays elongate recovery timelines and can reduce overall recovery outcomes.

With shortages across the state, Majoris concentrates efforts in canvassing available options and facilitating scheduling to overcome these barriers.

Behavioral Health

Demand for behavioral health has increased in response to regulation changes impacting compensability decisions and increased openness to mental health intervention. When canvassing its available network, Majoris found that many providers are open to treating workers' compensation but have limited availability to offer. Clinics also reported difficulty dedicating resources for workers' compensation because it is more short-term, limited in scope, and more complicated to treat compared to other patient populations. Treating injured workers is less desirable for providers when they can fill their schedule with the more reliable set.

Majoris has found greatest success with practitioners who have carved out a significant portion of their practice to fielding workers' compensation needs, and who offer care via the telehealth setting. Even with these successes, care may be delayed due to limited supply, and workers have few choices when selecting a provider.

COVID 19

The COVID 19 pandemic had wide ranging impacts to the healthcare system, many still in force at the beginning of 2024.

[20] Majersik JJ, Ahmed A, Chen IA, Shill H, Hanes GP, Pelak VS, Hopp JL, Omuro A, Kluger B, Leslie-Mazwi T. A Shortage of Neurologists - We Must Act Now: A Report From the AAN 2019 Transforming Leaders Program. Neurology. 2021 Jun 14;96(24):1122-1134.

Pre-COVID 19, physicians specializing in pulmonology and cardiology were infrequently required for workers' compensation care. They are now regularly needed for workers with a compensable COVID 19 infection or Long-COVID syndrome. This new demand is mirrored by non-workers' compensation patient populations. Potential for an immediate influx of new physicians to respond to this increased demand is low. Neurology is similarly impacted, overlaid onto the limitations already in play before the pandemic.

Following the pandemic, the healthcare system experienced a significant shift in its workforce. Licensed medical professionals retired or made relocation decisions, creating gaps clinics have struggled to fill. The tighter labor market also translated to medical support staff turnover and shortages. These roles are necessary to efficient, effective care. Shortages or limitations in administrative support staff often translate to care delivery barriers.

Whether directly tied to pandemic considerations or merely a timing factor, shortages in anesthesiology have increasingly impacted timely surgical intervention for workers. As with the other specialties, the Oregon workers' compensation system mirrors the challenges of the general healthcare system.[21]

Majoris is a partner for providers, and we are well positioned to be responsive to the consistently evolving challenges providers face. COVID 19 left providers struggling to navigate new unknowns with fewer resources. Majoris actively partners with them to identify solutions and offer resources, including developing new guidance, offering man hours to help workers get appointments scheduled, and training new staff in workers' compensation protocols. This collaborative approach gives providers a committed resource and keeps them active in the workers' compensation system.

TAKEAWAYS

Access to care is a systemic problem and demands a multi-faceted solution. The challenges faced by the Oregon workers' compensation system are a product of the state's healthcare system, demographics and geography. These are most acutely felt in the rural areas and require solving the overall physician shortage. All requirements to support efficient care delivery must be considered, not just those directly related to licensed medical providers. Ability to deliver healthcare requires a full spectrum of resources and the tight labor market will continue to impact medical offices' ability to serve workers' compensation demands. Our plans must anticipate future needs and provide the resilience required to meet both current and future Oregon worker care demands.

The subset of physicians most likely to be relevant for injured workers is a smaller subset of the total licensed physicians, influenced by specialty, clinical setting and practice philosophy. Understanding which physicians are best suited to meet the workers' compensation demands helps refine potential solution considerations. Likewise, the overall issue of access is a set of access challenges, each with unique nuance and corresponding solution potentials.

While a systemic issue, the challenges are limited to a small subset of the overall worker population. The Oregon workers' compensation system is one of the highest performing in the nation.[22] Existing solutions

[21] AAMC Report Reinforces Mounting Physician Shortage. AAMC Press Release. 2021 Jun 11. https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage

[22] https://www.oregon.gov/DCBS/reports/cost/Pages/oregon-vs-nation.aspx

such as the managed care organization and telemedicine provide tools that can be responsive to the unique and changing healthcare demands. As such, any new initiatives should align with existing solutions.

Access to Care Is Nuanced & Multi-Faceted

As demonstrated throughout this report, the concept of access has multiple layers and is sensitive to the types of demand. When discussing access to care, defining it as a multi-faceted problem positions stakeholders to understand that it will best be solved through a range of solutions specific to each facet is important, rather than a single comprehensive cure-all. This includes looking at the overall framework for care delivery, in addition to increasing the number of available medical providers.

Leverage Existing Resources in New Ways

Redefining existing resources via structured, controlled frameworks can expand access without requiring new providers or undermining quality. Successes in Baker City & South Coast demonstrate that appropriately leveraging mid-level practitioners can solve recruitment challenges without reducing care, though they also show the fragility of relying on a single sourced solution. Communities with occupational medicine clinics similarly demonstrate the efficiency potential generated by dedicating a smaller subset of providers wholly on workers' compensation demands. These models allow for a higher worker-to-provider ratio without a dramatic impact to utilization and outcome statistics.

Telemedicine

Telemedicine must be leveraged to help solve the shortage problem in rural and frontier areas. This should be done thoughtfully, focusing on where it is best suited to alleviate pressure from the situations where in-person is necessary. As even urban areas are experiencing shortage issues, this will need to be done alongside other measures for true improvement.

MOVING FORWARD

Majoris continues to partner with communities across the state to address a range of medical care access challenges. In the short term, innovating to do less with more is critical. In the long term, growing the base of medical providers to meet demand remains essential. Majoris remains committed to supporting coordinated partnerships with engaged stakeholders in achieving both the short- and long-term goals.

Majoris Plans to: Find New Dedicated Provider Resources

Majoris is shifting to seeking fewer but more dedicated provider resources from clinics. As demonstrated by the pilot programs implemented in Baker City and Coos Bay, a single dedicated resource often improves coverage more effectively than multiple partial resources. Majoris is also exploring consultative approaches that leverage specialist input without requiring full care engagement for increased access without increased provider count.

Continued investment in already robust MCO outreach dispels common misconceptions about workers' compensation that can alienate physicians and supports streamlining clinic processes so that treating injured workers is a profitable, sustainable revenue center for clinics.

Majoris Plans to: Expand Existing Extender Solutions

Majoris will expand utilization of the nurse practitioner and physician assistant extender programs where available resources exist. These programs offer clinics expanded recruitment opportunities while maintaining structure through MCO oversight to ensure care options remain medically appropriate.

Majoris Plans to: Develop Workers' Compensation Focused Telehealth

Majoris is exploring how to integrate telehealth with in-person care for expanded bandwidth from virtual care without undermining care quality. One concept is an integrated care program between telehealth-based physicians and in-person based physical therapists. This type of approach would provide virtual physicians real-time physical assessments to inform their treatment plans. It would also retain the critical elements of routine and reduced home isolation that in-person visits create. Clinic operations could be streamlined by reducing the amount of exam rooms and administrative staff required.

Majoris Plans to: Explore the Use of Non-traditional Attendings

Majoris is considering other license types that could be structured to fill the role of attending physician in a medically appropriate way. As with existing Majoris extender programs, this concept requires clear parameters and oversight to maintain proper levels of care.

An example is the Doctor of Physical Therapy (DPT) license. DPTs are authorized to develop treatment plans and make referrals that go beyond physical medicine prescriptions yet are not authorized to direct care in the workers' compensation space. They are not an equivalent replacement to a D.O. or M.D. However, with the correct parameters they could be a care bridge, reducing demand on physician resources and expanding options for workers where appropriate. Other license types may exist with similar opportunities.

Majoris Plans to: Maintain Flexibility

Majoris maintains focus on the evolving provider access challenge. Solutions must be flexible to be sustainable. A recent shift in resources reiterates that point. Providence, a longstanding resource for occupational medicine, announced the closure of two of its occupational medicine clinics in the first quarter of 2024. They cited inability to employ sufficient providers and administrative staff. Their available providers are unwilling to travel between clinics long term. Majoris quickly moved to identify alternatives for impacted workers and began collaborating with Providence to identify a path forward.

We seek support and engagement from all stakeholders within the workers' compensation system in this endeavor, especially in the space of innovation and flexibility.

Appendix A

Geographical Service Areas

01. North Coast
02. Central Coast
03. South Coast
04. Portland Metro
05. Salem
06. Linn-Benton
07. Eugene
08. Roseburg
09. Jackson-Josephine
10. The Dalles
11. Bend
12. Klamath Falls
13. Pendleton
14. La Grande
15. Burns-Ontario