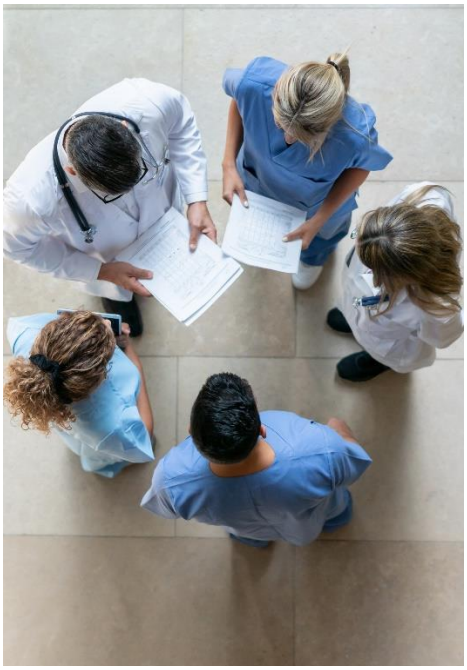
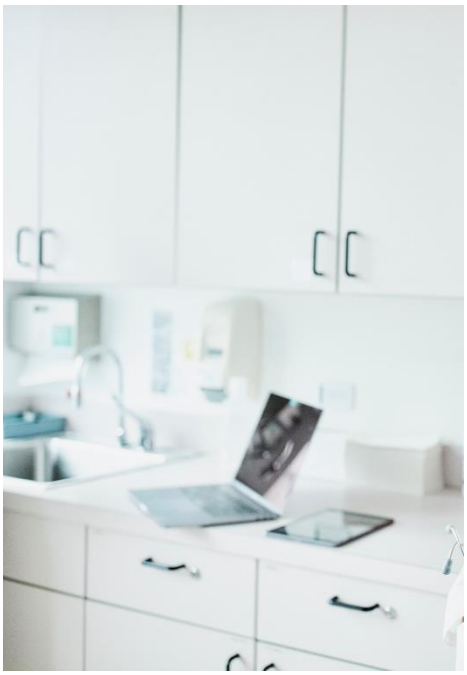
OREGON HEALTH AUTHORITY

Health Policy and Analytics
Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Home Program Impact Report

2024-2025





January 5, 2026

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Executive Summary

The Oregon Health Authority's (OHA) Patient-Centered Primary Care Home (PCPCH) Program continues to serve as a cornerstone of Oregon's health system transformation. Since its inception in 2009, the PCPCH Program has recognized primary care practices that meet rigorous standards for delivering coordinated, comprehensive, and patient-centered care. In 2025, the program introduced a new foundational attribute, Equitable Care, to further embed health equity into every aspect of primary care delivery and strengthen OHA's long-standing commitment to reducing health inequities statewide.

Program reach and participation

About 600 primary care practices across Oregon are recognized as PCPCHs, collectively serving more than 80% of Oregonians and 95% of Medicaid members. Practices represent urban, rural, frontier, Tribal, and school-based communities as well as large systems and small independent clinics. Participation in the program remains voluntary and free.

Practices continue to adopt strategies that deepen the equity and accessibility their care including expanding language access, screening for social needs, integrating traditional health workers, and using data to identify and reduce disparities.

Impact on care delivery and outcomes

Independent evaluation confirms that PCPCH participation is associated with measurable improvements in health outcomes, care experience, and cost savings. Between 2011–2019, PCPCH participation contributed to:

- 6.3% reduction in per-person healthcare expenditures
- $1.3 billion in statewide savings
- $12 reduction in emergency/inpatient spending for every $1 invested in primary care
- $717 million in Medicaid savings

These impacts are especially significant for children and Medicaid members — both populations that are particularly affected by health inequities — demonstrating the model's effectiveness in advancing more equitable outcomes.

Equity and innovation in primary care

Reducing inequities has been a core element of the PCPCH model since 2009. The 2025 PCPCH Standards further embed equity by strengthening expectations for culturally and linguistically appropriate care, trauma-informed practices, and trust-building approaches. Notable advancements include:

- Required training in culturally and linguistically appropriate or trauma-informed care
- Revised standards centered on equity, access, and community partnership
- Increased use of data to identify and address disparities
- Introduction of the Health Equity Designation, with 27 practices having earned the designation in the first year

About 90% of PCPCHs implemented new care processes in the past two years, highlighting their continued commitment to innovation and system transformation.

Support and technical assistance

The PCPCH Program continues to provide comprehensive support to recognized practices through:

- 778 site visits completed since 2012 (123 between January 2024–September 2025)
- Webinars and learning collaboratives reaching more than 2,100 participants
- A statewide resource library with over 120 tools and implementation supports

Practices consistently report that these supports help clarify standards, guide implementation, and strengthen team-based, whole-person care.

Looking ahead

The PCPCH Program remains committed to continuous improvement and alignment with Oregon's broader health system goals. Priorities for 2026 and beyond include:

- Reducing administrative complexity to ease burden on practices
- Expanding learning collaboratives and launching micro-learning modules
- Continuing site visits and Health Equity Designation reviews
- Enhancing tools and resources that support equitable, team-based, whole-person care

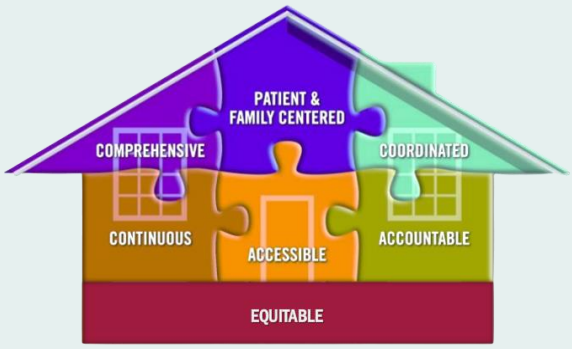
PCPCH Program overview

In 2009, the Oregon Health Authority (OHA) Patient-Centered Primary Care Home (PCPCH) Program was established by the legislature under HB 2009 to set standards for how primary care is delivered so that all Oregonians have access to high-quality care.

The PCPCH is Oregon's version of the "medical home," which is a model of primary care delivery that focuses on coordinating the full scope of patients' preventive care needs, improving the quality of care over time, and building strong relationships with patients and their families to better care for the whole person. The program standards are developed in partnership with a public advisory committee and are revised every few years to reflect the state's health transformation goals, recent clinical evidence and the experience of clinicians and staff who are providing care in practices. The most recent standards were implemented in January 2025.

The PCPCH Model

The PCPCH model is defined by six core attributes and one foundational attribute – Equitable Care – which was added in 2025 (see figure below). Each core attribute has specific standards of care delivery and up to four measures that determine how a practice is implementing that standard. There are three tiers of recognition based on which measures the practice is meeting. In addition, the program started awarding a Health Equity Designation (see page 16) in 2025, which a practice can achieve by meeting specific equity-focused measures.



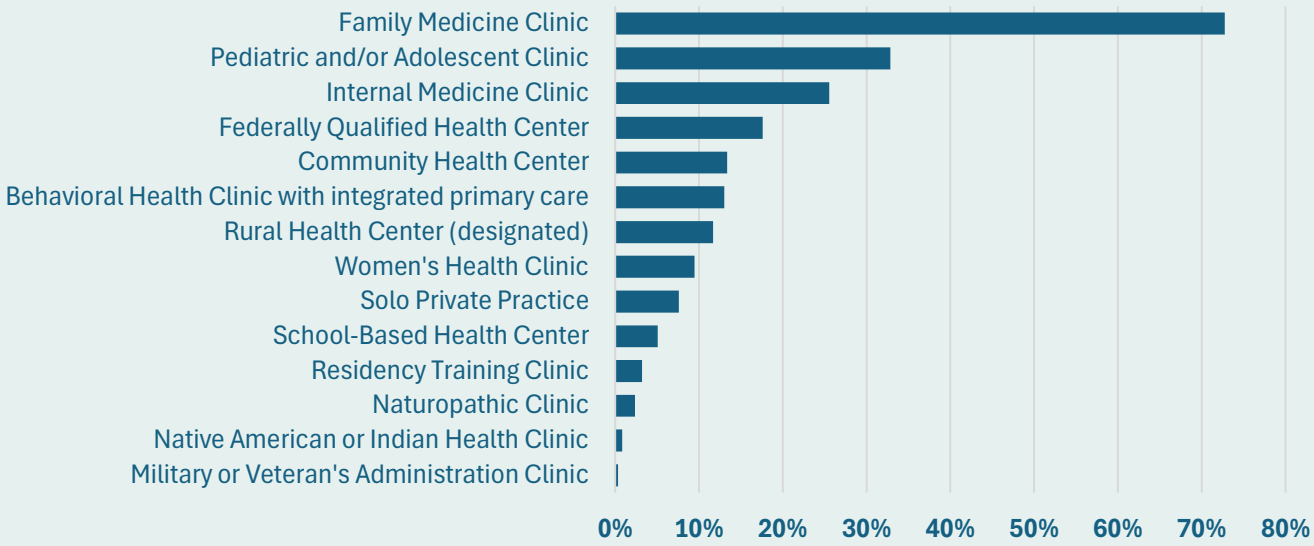
Practices apply to OHA to become a recognized PCPCH by attesting to meeting the standards. Participation in the program is voluntary, and there is no cost to the practice to become a PCPCH. Practices choose to become PCPCHs because of the program's positive impact on patient care. About 600 primary care practices are recognized as PCPCHs serving more than 80% of Oregonians. About 95% of Medicaid Coordinated Care Organization (CCO) members receive care at a PCPCH. Since 2020, CCOs are required by OHA to pay PCPCHs a per-member-per-month payment based on their PCPCH tier level[1] to support this work. In addition, some commercial health plans also pay an enhanced payment based on tier level.

[1] A practice's PCPCH tier level (Tier 3, 4 or 5) is determined by the total point value of the measures they attested to. This tiered recognition structure encourages practices to continue to improve and groups practices that have attested to a similar number of measures into the same tier level.

PCPCH practice characteristics

Many different types of practices participate in the PCPCH Program. Any practice that provides primary care can become recognized as a PCPCH including family medicine clinics, school-based health centers, behavioral health organizations with integrated primary care, pediatric practices, and Federally Qualified Health Centers (Figure 1).

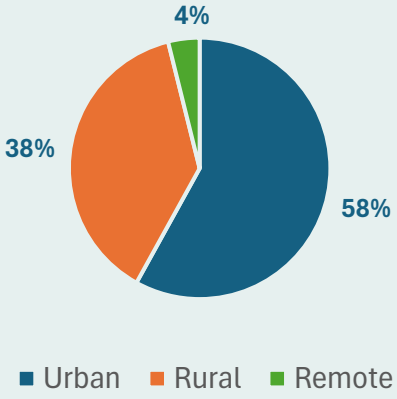
Figure 1. Types of clinics that participate in the PCPCH Program



Source: Self-reported application data from the 591 practices that were recognized as PCPCHs as of 10/1/2025. **Note:** A PCPCH can identify as multiple types of practice on its application (for example as both a Family Medicine Clinic and a Rural Health Center).

PCPCHs can be found throughout Oregon, in 35 out of the 36 counties (see Figure 3 on the following page). They provide care to patients **in urban, rural, and remote areas** (Figure 2). A handful of practices (3%) are in Washington and Idaho serving Oregonians who travel over the border to receive care.

Figure 2. Percent of PCPCHs in urban, rural and remote areas



Source: PCPCH Program application data which includes the 591 practices that were recognized as PCPCHs as of 10/1/25. Geographic designations based on Oregon Office of Rural Health definitions.

Figure 3. PCPCH locations

General PCPCHs

PCPCHs awarded the Health Equity Designation

Source: PCPCH Program data, current as of 11/27/25.

Clinics of all sizes participate in the PCPCH Program, ranging from those with only one primary care provider (PCP) to larger clinics with more than 21 PCPs[2] (Figure 4). **PCPCHs are split in organization structure, with about half operating as an independent clinic unaffiliated with any other practice, and half owned and operated by a larger health system** (Figure 5)**.** Among the independent practices, about 1 in 4 are part of an alliance for shared group purchasing or other economies of scale, such as an Independent Practice Association.

Figure 4. Size of PCPCHs

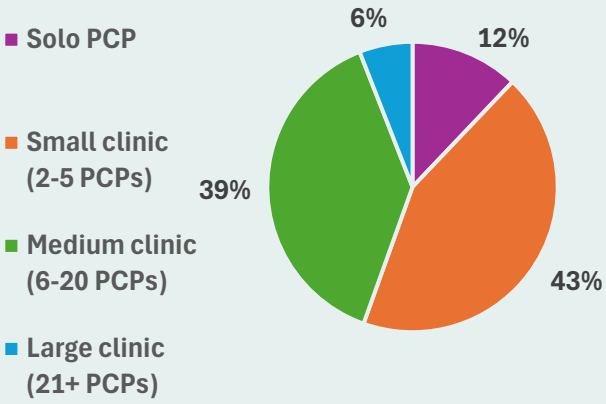
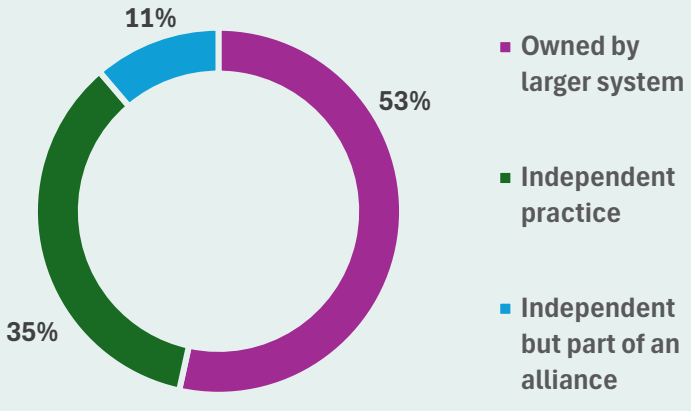


Figure 5. Organizational structure of clinics in the PCPCH Program

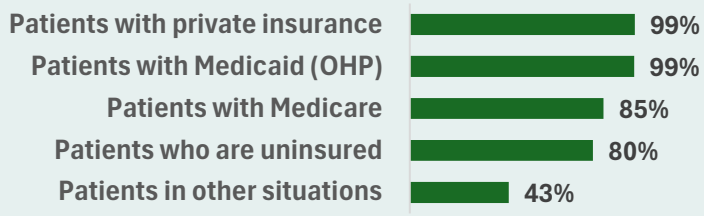


Source: Self-reported application data which includes 436 of the PCPCHs that applied under the 2025 version of the model, current as of 10/1/25.

[2] PCPs refer to clinicians that provide direct patient care, including MDs, DOs, PAs, NPs, and NDs.

Most PCPCHs (83%) have patients with any of the three major forms of insurance: Medicaid (Oregon Health Plan or OHP), Medicare, and private insurance. Most PCPCHs (80%) also have some patients who are uninsured. About 15% of PCPCHs, such as pediatric-only practices, don't have patients on Medicare (Figure 6).

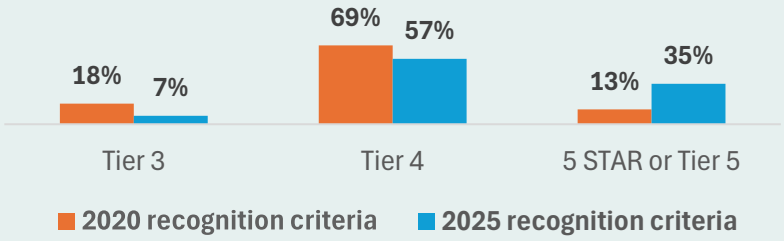
Figure 6. Percent of PCPCHs that serve patients with various types of insurance



Source: Self-reported application data including 430 PCPCHs that applied under the 2025 version of the model, current as of 10/1/25.

A revised version of the PCPCH standards was implemented in January 2025. **While the majority of PCPCHs stayed at the same tier level when re-applying under the updated version, 35% increased their tier level.** As of October 2025**,** the majority of PCPCHs are recognized at Tier 4, with Tier 5 being the second most-common[3].

Figure 7. Percent of PCPCHs recognized at each tier level



Source: PCPCH Program data which includes the 435 practices that had applied under both the 2020 and 2025 model as of 10/1/25.

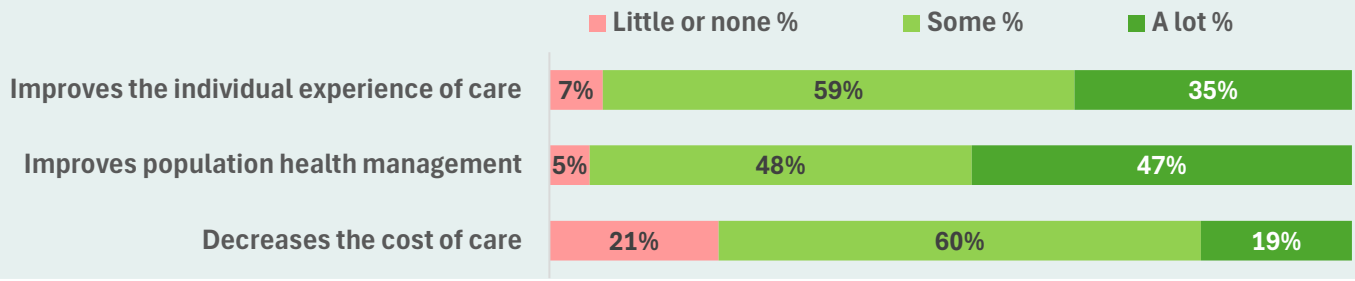
PCPCH Program impact

Changing how practices care for their patients

Oregon implemented the PCPCH Program as part of the state's strategy to achieve the "Triple Aim" of improving Oregonian's individual experiences with healthcare, improving population health management, and decreasing the cost of care. **Most PCPCHs report that the program helps their practice make progress in all three of these goals** either to "some" extent or "a lot," with population management being the most significant area of impact, followed closely by improvements in patients' experience of care (Figure 8).

[3] Tiers 1 and 2 were discontinued as analysis showed that point distributions were disproportionately weighted toward higher tiers, resulting in no Tier 1 or Tier 2 PCPCHs and reduced incentives for ongoing advancement.

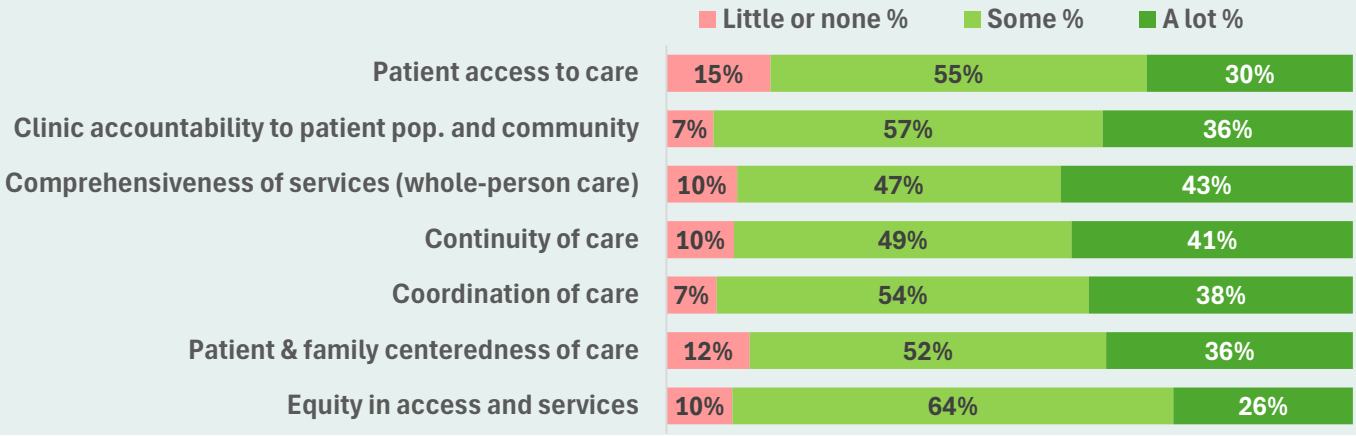
Figure 8. PCPCH Program impact on the triple aim



Source: Self-reported data which includes 437 PCPCHs that applied under the 2025 model, current as of 10/1/25.

Most PCPCHs report that **the program helps their practice address all six core attributes of primary care, as well as equity across these attributes** (Figure 9)**.** The largest areas of impact are in *coordination of care* and *clinic accountability to their patient population and community*, followed closely by *comprehensiveness of services (whole-person care)*.

Figure 9. PCPCH Program impact on core attributes of primary care



Source: Self-reported data which includes 437 PCPCHs that applied under the 2025 model, current as of 10/1/25.

The PCPCH Program is continuing to transform how primary care is delivered. **Most PCPCHs (90%) report having implemented a new type of transformative primary care service or process in the last two years**. For example, 58% of PCPCHs recently began screening their patients for health-related social needs and referring them to community resources. Other new activities include training primary care providers in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care (recently implemented by 50% of PCPCHs) and taking steps to improve the vitality of the providers and staff within the practice (recently implemented by 45%). All three of these activities are the focus of new standards within the PCPCH program model that were rolled out within the last five years.

Transformational activities recently implemented by PCPCHs

The table below shows the percent of PCPCHs that report implementing select primary care services or processes in the last two years, all of which are encouraged and incentivized within the PCPCH model. Those activities highlighted in green were recently added to the model, either in the 2020 or the 2025 version.

58%	Began screening patients for health-related social needs and referring to community resources
50%	Began assuring that their primary care providers are trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care
45%	Began activities to improve the vitality of the providers and staff in their practice
39%	Began identifying and addressing disparities in their practice's patient population based on race, ethnicity, language, disability, gender, gender identity, sexual orientation, or social class
37%	Implemented care management for patients with complex medical and social needs
36%	Began translating clinic documents into languages other than English
36%	Formed a quality improvement team or committee
28%	Initiated a value-based payment arrangement or alternative payment (other than Fee-For-Service) with a Coordinated Care Organization or other payer
27%	Implemented interpretation services for patients whose primary language is not English
27%	Started a partnership with traditional health workers, or traditional health worker services
18%	Formed a patient and family advisory committee
11%	Began substance use disorder care (including medication assisted treatment)

Source: Application data from 437 PCPCHs that applied under the 2025 model as of 10/1/25.

Lower healthcare costs and better utilization

Research demonstrates that OHA's PCPCH Program continues to drive measurable transformation across the state's healthcare system. An Oregon Health & Science University (OHSU) – Portland State University (PSU) School of Public Health study published in 2023, titled "Evaluation of Oregon's Patient Centered Primary Care Homes on Expenditures and Utilization from 2011 to 2019", compared patients who received care at a PCPCH verses a non-PCPCH

and found that by strengthening access to equitable, coordinated, and patient-centered primary care, the program has resulted in significant cost savings and improvements in healthcare utilization. The program's benefits were found to extend to patients, public and private insurance systems, and rural and underserved regions across the state, demonstrating that investing in primary care delivers real value and equity statewide.

PCPCH Program demonstrates powerful return on investment

Between 2012 and 2019:

Improved utilization	Patients received more primary and specialty care and relied less on costly emergency and inpatient care.	For every $1 invested in primary care, an estimated $12 in savings were created in emergency and inpatient services.
Cost savings	Healthcare expenditures per person were reduced by 6.3%, saving $1.3 billion statewide.	Children and youth (18 years or younger) had almost 1.5 times greater rates of expenditure reduction than for adults.
Medicaid savings	Medicaid had almost 1.5 times higher rates of expenditure reduction than private insurers or Medicare (Advantage).	Savings to Medicaid over the first eight years of the program were at least $717 million.

Source: OHSU-PSU School of Public Health. Evaluation of Oregon's Patient Centered Primary Care Homes on Expenditures and Utilization from 2011 to 2019. January 2023.

Technical assistance, education, and engagement

Assistance with applying for PCPCH recognition

Practices typically apply for PCPCH recognition once every two years by attesting to the standards through an online application. Program staff assist individual practices as they are filling out their applications by answering questions about specific standards, providing clarification and examples, offering web support, and sharing additional resources. Program staff respond to 5 to 10 requests for assistance every day.

Site visits to recognized PCPCHs

Program staff conduct site visits to PCPCHs to verify that clinics are meeting the standards they attested to in their applications and to provide support and resources. Oregon Administrative Rule 409-055-0000 requires the program to site visit each practice at least once every five years.

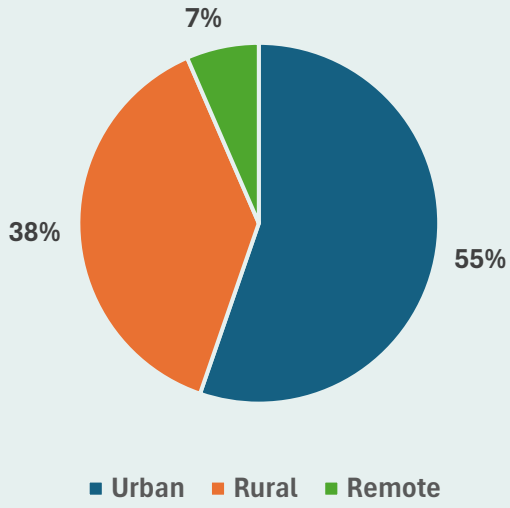
During a site visit, program staff review documentation, interview providers and other staff and conduct a patient focus group interview. **After the site visit, program staff provide a comprehensive report of the findings and offer individualized support to the practice for up to 6 months if needed.** This support is meant to help practices successfully implement standards that were not verified during their site visit. The practice and program staff work together to develop a support plan that can include regular meetings and resources tailored to the practice's unique needs. In addition, some practices receive peer support from a practicing primary care provider serving as a Clinical Transformation Consultant for the PCPCH Program.

There is no cost to practices for a site visit or the subsequent one-to-one coaching, and all technical assistance resources are provided for free. Since 2012, the program has conducted 778 site visits.

PCPCH Program staff conducted 123 site visits between January 2024 and September 2025, either at the clinic site or virtually.[4] Urban, rural, and remote regions were well-represented among practices selected for site visits, with those in remote areas of the state slightly more likely to receive one (Figure 10).

Based on post-visit surveys, most practices (86%) feel well prepared for their site visit and find the PCPCH program site visitors knowledgeable (86%) and courteous (89%). Qualitative feedback centers on their appreciation for the support, collaboration and partnership of PCPCH program staff and how the standards have improved care for their patients (source: PCPCH Site Visit Survey data from 42 practices visited between January 2024 and October 2025).

Figure 10. Percent of recent site visits in urban, rural and remote areas



Source: PCPCH Program data including the 123 PCPCHs that received a site visit between 1/1/24 and 10/1/25.

[4] Note: Site visits were paused from January through April 2025 to give practices time to apply under the updated version of the PCPCH model.

PCPCH feedback on Site Visits

> The instructions and materials provided were clear, concise, and easy to follow. Timelines were well-structured and manageable, and the pre-site visit call offered valuable guidance. I had a clear understanding of the effort required to gather the necessary documentation. Because our team began organizing supporting materials early—during the attestation preparation period—we were well-positioned and efficient when it came time for the site visit.

One Peak Medical
Eugene, OR
October 2025

> I thought the preparation and the frequent check ins set us up for success for the site visit and I think everything went smoothly!

Burket Family Medicine
Medford, OR
May 2025

> I appreciated how the PCPCH program staff made us feel like we were just having a conversation, instead of making us feel like we were being audited. Well done!

One Family Medical Group
Grants Pass, OR
July 2025

> Thank you for your collaboration and support! I feel that PCPCH helps us put the focus on the patient in a way that is meaningful and measurable.

Multnomah County Community Health Centers
November 2025

> We extend our sincere appreciation for an amazing PCPCH Site Visit. From the seamless documentation uploads to the well-organized schedule, every aspect was thoughtfully executed and greatly beneficial to our clinic. We truly appreciate the insights and feedback you provided. This will definitely help us continue delivering high-quality, patient-centered care. Thank you again for your support and collaboration.

Armstrong Wellness
Salem, OR
September 2025

Community partner learning opportunities and resources

The PCPCH program offers a variety of free education and engagement events each year for primary care practice staff and other community partners. Some events focus on implementing specific PCPCH standards, while others provide broader guidance around improving primary care delivery. **These learning opportunities are open to all interested participants at no cost, ensuring that technical assistance is widely accessible.** The following are recent examples of these events.

2025 PCPCH model webinars

To help practices prepare to apply under the newest version of the PCPCH Standards in 2025, the program hosted a bi-monthly webinar series that guided participants through the key updates and revisions. The series included 17 topic areas, providing an opportunity for practices to understand the intent behind the changes, ask questions in real time, and begin planning for successful implementation of the new standards. Topics included providing care in an alternative setting, Health-Related Social Needs (HRSN) screenings and interventions, specialized care setting transitions, meeting patient's language and health literacy needs and integrating traditional workers into the care team. **This webinar series reached over 2,100 participants across Oregon,** reflecting strong statewide engagement and interest in the updated standards and health equity focus areas.

Learning collaboratives

The PCPCH program also hosted two learning collaborative series that provided a forum for peer-to-peer knowledge-sharing as well as **an opportunity for leaders from PCPCH clinics to showcase their best practices and exchange effective strategies for improvement.** The two PCPCH standards chosen for the learning collaboratives (Standards 2.C and 2.F) were based on survey feedback highlighting the areas where practices requested the most assistance. A total of 447 participants joined the series with attendance ranging from 70-153 participants per session, demonstrating strong and continued engagement across sessions.

Engagement with Recent Learning Collaboratives

Topic	Presenting Practices	Sessions and Participants
Patient and Family Involvement in Quality Improvement (Standard 2.C)	Grande Ronde Hospital Clinics – Union One Community Health – Hood River & The Dalles White Oak Medical Center	2 sessions **299 attendees**
PCPCH Staff Vitality (Standard 2.F)	Family Health Associates Evergreen Family Medicine Valley Family Health Care	2 sessions **148 attendees**

PCPCH resource library

The PCPCH program maintains a curated online library of primary care and health equity resources such as toolkits, policies, templates, and case studies. There are over 120 resources available on topics such as Primary Care Clinic Re-Design for Prescription Opioid Management,

Comprehensive Whole-Person Care, the PCPCH Health Equity Designation, Integrating Behavioral Health and Primary Care, Cultural Competency for Behavioral Health, and Early Childhood Mental Health. These resources are used by both PCPCHs and program staff when providing individual technical assistance.

Improving health equity throughout Oregon

The PCPCH Standards have always included measures that support equitable care. The first set of standards developed in 2011 required PCPCHs to provide free interpretation services to all patients in their preferred language, encouraged them to translate all written documents into languages other than English, and supported them in partnering with community organizations to provide equitable access to care. In 2020, the program increased its focus on equity by adding standards around social determinants of health screenings, alternative visit types, substance use disorder treatment, and clinic examples that reflect the diverse patients and communities in Oregon.

2025 PCPCH Standards

Guided by OHA's commitment to eliminate health inequities by 2030, the PCPCH Program conducted listening sessions with more than 30 community-based organizations and primary care practices to identify barriers to care and opportunities for support. Building on this insight, program staff partnered with an advisory committee to revise the PCPCH Standards to ensure that they are actionable, equity-focused, and reflect the feedback from the listening sessions. **The 2025 PCPCH Standards now provide primary care practices with a clear framework for developing the capacity to identify and address inequities in their patient populations.** Holding practices accountable to these standards will improve equity and support OHA in its strategic plan goals. After this version was implemented, the PCPCH program provided a report back to the community-based organizations and practices that participated in the listening sessions which summarized how their feedback influenced changes to the model. Key highlights of 2025 PCPCH Standards include:

- **Equity in all standards:** Nearly all PCPCH Standards were revised to improve equity and align with other OHA initiatives.

- **New required standard:** All PCPCH practices must now ensure that their primary care providers are trained in delivering culturally and linguistically appropriate, trauma-informed, or trust building care.
- **New optional standards:** New equity-focused standards were added, including reducing disparities in screenings and utilization of services and partnering with traditional health workers to deliver culturally and linguistically appropriate care.
- **New Health Equity Designation:** PCPCH practices meeting 15 of the 20 equity-focused measures can receive a special designation, with more information provided in the next section.

Health Equity Designation

Twenty-seven PCPCHs have been awarded the Health Equity Designation since it was introduced in January 2025, including 10 pediatric practices, 12 small practices, and 17 Federally Qualified Health Centers (FQHCs). **This designation is awarded to practices that demonstrate a special commitment to providing high-quality of care to patients from diverse backgrounds and circumstances.** The locations of recipients are included on the map on page 7 of this report.

> "We enjoyed the [site] visit and are proud to hold this designation as it has been a dream of mine to be a Tier 5 with Health Equity Designation!"

Casey Lulay, FNP-C
Santiam Mobile Medicine
Stayton, OR
May 2025

> For me, the Oregon PCPCH Health Equity designation is both an honor and a call to action. It strengthens my purpose as a provider and reminds me that equitable care is not a destination—it is a continual, intentional practice.

Sarah Laiosa, DO
ThriveWell Clinic
Burns, OR
November 2025

What's next for the PCPCH Program?

The PCPCH Program will continue to evolve as a cornerstone of Oregon's primary care system. Upcoming priorities include reducing the administrative complexity of program participation, strengthening support for practices through learning collaboratives and new micro-learning opportunities, and continuing to support practices in their implementation of the PCPCH Standards and pursuit of the Health Equity Designation. Read more about these priorities here:

Reducing administrative complexity for practices

The PCPCH Program has been working to reduce administrative complexity for practices participating in the program as much as possible in ways that still maintain clinic accountability to high-quality care. Efforts will center on streamlining application and site visit preparation, consolidating the supportive documentation required, clarifying measure requirements, and aligning reporting expectations with existing clinic workflows. These changes will be implemented throughout 2026. The goal is for clinics to be able to focus more on team-based patient care than on paperwork for the PCPCH program — allowing for improved clinic efficiency, better success in quality improvement efforts and value based payment, and increased overall effectiveness of the program.

Learning collaboratives and micro-learnings

The PCPCH Program will continue to host learning collaboratives to foster peer-to-peer sharing, problem-solving, and innovation across clinics. These sessions will provide a structured space for clinics to exchange best practices, troubleshoot challenges, and implement evidence-based strategies that improve patient care and clinic operations. Topics may include identifying patient disparities in preventive services, care plans verses plan of care for complex patients, how to operationalize team-based care, and health equity basics. In addition, the program plans to add short, targeted micro-learning modules such as instructional videos to complement virtual learning opportunities. These micro-learnings will provide clinics with quick, actionable guidance on key topics, helping teams efficiently implement best practices and improve performance while minimizing disruption to daily operations.

Site visits and Health Equity Designation reviews

The PCPCH Program site visit team is dedicated to maintaining program accountability and providing individualized coaching to practices. In 2026, the program will continue to prioritize practices that have not received a site visit in over five years, ensuring alignment with updated program standards and expectations. The PCPCH Program site visit team will also conduct Health Equity Designation reviews and offer one-on-one assistance to practices working towards equity-driven care. These efforts have enhanced program consistency, informed technical assistance priorities, and reinforced the PCPCH Program's role in supporting high-quality primary care delivery statewide.

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