

Primary Care Strategy Committee

September 17, 2026, Meeting Minutes

Attendance

Attended	Name
Yes	Betsy Boyd-Flynn
Yes	Carly Hood-Ronick
No	Cathy Merz
Yes	Danielle Sobel
No	Deb Patterson
No	Deborah Cohen
Yes	Douglas Lincoln
Yes	Elise Phelps
Yes	Erik Vanderlip
Yes	Grant Kennon
Yes	Linda Lang
Yes	Lisa Reynolds
Yes	Lorenzo Perez
Yes	Nicolas Powers
Yes	Raffaella Betza
Yes	Ricardo Palazuelos
Yes	Shelby Lee Freed
No	Steve Fritz
No	Tracy Muday
Yes	Claire Pierce-Wrobel, ex officio
Yes	Jesse O'Brien, ex officio

In addition, Tony Germann, OHPB Vice-Chair and liaison to the committee, was in attendance.

Meeting start, agenda review

Chair Raffaella Betza welcomed the committee and reviewed the agenda.

Public comment

There was no public comment.

Health System Sustainability Group primary care recommendations

Betsy Boyd-Flynn presented the Health System Sustainability Group's primary care recommendations, highlighting alignment with committee objectives and discussing immediate, mid-term, and long-term strategies for payment reform, administrative simplification, and access. She explained that the Health System Sustainability Group was convened by former Governor Kitzhaber at Governor Kotek's request. The group's work is under active consideration by the governor's office.

Participants discussed the flaws of the Relative Value Unit (RVU)-based payment system for primary care, noting its misalignment with preventive and cognitive care. Doug Lincoln emphasized the need for increased total investment in primary care and highlighted the importance of risk adjustment and population-based payments. Carly Hood-Ronick agreed, noting that payment has consistently had one foot in fee-for-service (FFS) / RVU and one foot in value-based payment (VBP). Senator Lisa Reynolds said she and Representative Ben Bowman (Oregon House Majority Leader) are looking at operationalizing some issues included in the Health System Sustainability Group's primary care recommendations in 2027 bills.

Carly said it is important to talk about the ideal team structure and to make sure it's focused on services given limited resources; health care can't solve housing, poverty, etc. Betsy agreed, noting that what impacts health the most isn't within the health care system; however, making clinics responsible for health-related social needs hasn't worked. She emphasized that better and more effective connections are critical, but that doesn't have to mean pulling the work into clinics.

Raff highlighted the importance of counting the cognitive load required of clinics to take on the screening for health-related social needs and the possible moral injury from screening for social problems the clinic cannot solve. Tony Germann agreed, noting the need to focus on resource allocation to meet community needs, which could be related to social determinants of health; resources to meet these

needs could reduce costs for the health system but it's not clear who is best to allocate those resources. He noted that new providers are often not equipped for this work.

Linda spoke about the need for two layers, a core clinical team and a connected community network, which could include non-profits; public health; providers of housing, food, transportation, and legal aid services; schools; and other community organizations. These entities could be the “connective tissue” for funded coordination, shared accountability, closed-loop referrals, and appropriate information exchange.

Jesse O'Brien pointed out that the Oregon Health Plan is not subject to the Department of Consumer and Business Services (DCBS). He asked for more details about the Health System Sustainability Group's recommendation to increase DCBS authority, including markets. Betsy responded that the ideas include following other states that regulate the insurance under one agency. She referenced the rate review authority Rhode Island has and the need for a community discussion to explore possibilities. She noted that this not happening in Oregon is not a failure of DCBS.

Doug asked if we are using the right funds. He stated that if all spending is decreased the primary care spend of 12% will also decrease.

Objective: Understanding administrative burden

Raffaella led a discussion on administrative burden in primary care, focusing on the proliferation and limitations of quality metrics, their impact on small practices, and the need for radical simplification.

Nic Powers agreed noting that his team lives these every day. He pointed out that much work goes into trying to achieve process measures that don't really capture what patients and clinicians need. He said they measure and report per current requirements, but separately (and relatively unreported), they seek and achieve outcomes that matter.

Danielle Sobel informed members that she is aware of work that is happening in a legislative coalition, sponsored by Representative Hai Pham, to draft legislation on quality metrics and streamlined solutions.

Erik Vanderlip agreed with 95% of Raffaella's presentation and noted that the system isn't designed to manage chronic disease. He disagreed with completely disregarding quality reporting, noting that what you measure gets attention. He emphasized the need for accountability, that guidelines don't tell you how to keep someone out of the ER. He pointed to some good quality metrics such as measuring HbA1c (measuring blood sugar levels) and PHQ9 (a 9-question standard tool used to screen, diagnose, and measure the severity of depression), highlighting the failure to visualize what a team-based chronic care system looks like. Doug agreed with the need to be careful about misaligned or perverse incentives.

Objective: Big, bold solutions

Raffaella initiated a conversation on transformative solutions for primary care, including regulatory consolidation, value-based payment models, and potential pathways toward single payer or universal primary care.

Raffaella noted that she doesn't know what is possible, given federal and state regulation. Jesse offered to set up a future presentation to educate the group.

Raffaella noted that the Oregon Insurance Dashboard shows that the commercial market in Oregon covers about 45% of Oregonians, with about 50% of these in ERISA plans, leaving a pretty big chunk of lives in commercial plans regulated by DCBS whose health insurance the committee could influence to do some of what the PCSC wants to see in primary care.

Erik expressed a desire for PCSC to foster innovative models that will allow for freedom of exploration of different pathways with outcomes reporting and other ways to show that something is working better for Oregonians. He noted the importance of not assuming that PCSC knows what's best for widely different communities and widely different people.

Raffaella agreed and noted that she likes the Patient-Centered Primary Care Home (PCPCH) model, but that doesn't have to be the one. The focus needs to be on helping patients and not trying to control day-to-day clinic operations.

Tony voiced support for bold, out-of-the-box thinking to improve quality and increase simplicity

Doug commented that the committee should think about the health of the "system" – access, capacity, workforce – as what defines quality, instead of a bunch of process metrics that encourages box checking with no evidence they make people healthier.

Possible products

Raffaella provided the group with a list of possible products PCSC could create to advise OHPB.

Closing comments and adjourn

OHA staff will send a follow-up email to committee members sharing the links from the chat and asking members what topics they would like to learn more about.

Raffaella said the next meeting is Thursday, October 15, noon to 2 p.m.