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**HEALTH**  
AUTHORITY

# Primary Care Strategy Committee

October 15, 2026

Oregon Health Policy Board  
Health Policy and Analytics Division

# Welcome to the Primary Care Strategy Committee meeting

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- The meeting will begin shortly.
- This meeting is being recorded.
- Please mute yourself when not speaking.
- The chat is public.
- If you'd like to provide public comment, please send a message using the chat function on your Teams toolbar by 12:10pm, the time set aside in the agenda for public comment.
  - Public comments are limited to two minutes.



# Welcome

# Agenda

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- Agenda review, meeting goals
- Public comment (12:10 p.m.)
- Reflections from September 17, 2026, meeting presentation on administrative burdens and big, bold solutions
- Break (12:45 p.m.)
- Defining whole-person care
- Oregon Patient-Centered Primary Care Home Program
- Solutions and strategies to achieve whole-person care
- Possible committee products
- Next steps

# Review draft meeting minutes

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A draft summary from our September 17 meeting is included in the materials for today's meeting.

The Committee doesn't have to vote to approve, but please review and flag any needed changes.



# Guiding principles

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A Primary Care Strategy Committee action should...

1. Support patient access in all areas of the state.
2. Protect and support primary care's ability to provide whole person care, including preventative care, across all areas of the state.
3. Increase workforce wellbeing for all members of the primary care team.
4. Decrease administrative burden for providers.
5. Be aligned with other efforts to improve primary care.
6. Have the greatest impact on the health of the most people in their own environment.
7. Not increase complexity for patients.
8. Increase investment in team-based primary care.
9. Not increase the cost of care for patients and ideally lower total the cost of care.

# PCSC timeline

| Month     | Activities                                                                                                                                                                                                      |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| April     | <i>Clarified charge; established group agreements and decision-making process; discussed leadership roles; approved a process for prioritization; learned about legislative concept (LC) and possible ideas</i> |
| May       | <i>Agreed on vision and objectives; conducted initial discussion on the straw proposal, focused on the LC</i>                                                                                                   |
| June      | <i>Decide on ideas to include in the LC; begin discussing guiding principles</i>                                                                                                                                |
| July      | <i>Possibly refine LC based on OHPB feedback and finalize LC for OHPB 8/4 meeting vote; finalize guiding principles; supporting a strong, local, team-based workforce</i>                                       |
| Aug       | <i>Objective(s) presentations</i>                                                                                                                                                                               |
| Sep - Dec | <b>Objectives presentations; develop actions</b>                                                                                                                                                                |



# Public comment



# **Reflections on understanding administrative burdens and big, bold solutions**

# Opportunities: *administrative burden*

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Big, bold solutions

- Pursue radical simplicity of quality measures and go all in on the PCPCH program.
  - Require all payers to participate and hold accountable payers that add on additional measures.
  - Adjust the PCPCH program as needed
- Pay for primary care with true value-based contracts that prioritize reduction of avoidable spending and unplanned care with appropriate risk sharing. No individual quality measures set by outside entities. Completely move away from fee for service.
  - PCSC should support any ongoing national efforts to repeal Merit-based Incentive Payment System (MIPS).

\* This and the next four slides are repeats from the 9/17/26 PCSC meeting.

# Big, bold solutions (1 of 4)

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Many payers, one standard

- Update DCBS statutory authority over commercial insurance lines.
- Draft legislation to unify health insurer oversight in one agency (DCBS or other).
- Ensure that paying for whole person primary care is a core principle of this one agency.
- Ensure that an explicit founding principle of this one agency is the pursuit of administrative simplicity.

# Big, bold solutions (2 of 4)

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Many payers, one standard

- The standard should include:
  - Primary care spending targets with enforcement power.
  - Direct payments for whole person care, a minimum PMPM payment.
- Value based contracts w/ flexible payments - capitation, with rates set by a central authority.
- Very streamlined quality metrics - such as use PCPCH as one unifying quality indicator and scrap individual measures.

# Big, bold solutions (3 of 4)

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Many payers, one standard

- In this situation, all payers share the savings from stronger primary care and better health.
- These savings should be re-invested into the healthcare system as much as possible, and/or drive cost reduction overall.

# Big, bold solutions (4 of 4)

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Another option: Reduce the number of payers

- Pass comprehensive Universal Primary Care legislation enabling a unified payment model.
- Involves many of the solutions on the previous slide, main difference is who pays.

# Discussion

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What additional questions do you have?

What kinds of actions feel meaningful?

Do you feel like you have enough information to make decisions on some of these solutions?





# Break



# Defining whole-person care

# Whole-person care: straw definitions (1 of 2)

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- Whole-person care means helping and **empowering** individuals, families, communities, and populations to improve their health in multiple **interconnected biological, behavioral, social, and environmental areas**.\*
- Whole person health is a **person-centered, integrated** approach to health care that focuses on **health creation** and **well-being** by **incorporating patients' goals** into their health care.\*\*

\* U.S. Department of Health and Human Services. National Institutes of Health [Whole Person Health: What It Is and Why It's Important](#)

\*\* National Academies of Sciences, Engineering, and Medicine [Transforming Health Care to Create Whole Health: Strategies to Assess, Scale, and Spread the Whole Person Approach to Health](#).

# Whole-person care: straw definitions (2 of 2)

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- A whole-person approach to primary care **integrates conventional medicine** with **healthy lifestyle promotion, evidence-based complementary approaches and self-care** to holistically address an individual's health. It **promotes better health** both **through conventional means**, such as taking medications to treat disease and surgical interventions, and **complementary approaches**, such as managing stress and sleep, coaching around nutrition, and practices like yoga and acupuncture.\*
- Whole person health focuses on **well-being rather than the absence of disease** and accounts for the **mental, physical, emotional and spiritual** health and the **social determinants of health** of a person.\*\*

\* Primary Care Collaborative. [Moving Toward Whole-Person Primary Care](#)

\*\* American Academy of Family Physicians. [Family Physicians: Leaders in Whole Health](#)



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# PATIENT CENTERED

## PRIMARY CARE HOME PROGRAM

# Patient-Centered Primary Care Home Program

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- Established in 2009 by the Oregon Legislature to set standards of care for primary care practices and advance the Triple Aim.
- PCPCH standards are developed in partnership with an advisory committee; revised five times, most recently in January 2025.
- The program certifies practices that meet those standards.
  - Over 600 PCPCHs in 33 of 34 Oregon counties
  - 96% of CCO members get their care at a PCPCH
- The program provides 1:1 practice coaching, webinars, learning collaboratives and other technical assistance support to PCPCHs .

# Oregon's PCPCH model

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- Six core attributes and one foundational attribute — equitable care
- 13 required measures, all others optional
- Practices apply to become a PCPCH by attesting to measures
  - Any type of practice can be a PCPCH
- Three tiers of recognition based on which measures a clinic meets
- Health Equity Designation
  - 49 clinics have this distinction



# Required PCPCH Measures (1 of 3)

| Standard                       | PCPCH Must Pass Measure                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Telephone Access               | 1.C.0 – PCPCH assures that its patients have continuous access to clinical advice by telephone.                                                                                                                                                                                                                                                                          |
| Performance & Clinical Quality | 2.A.0 – PCPCH tracks and reports to OHA three primary care quality measures.                                                                                                                                                                                                                                                                                             |
| Medical Services               | 3.B.0 – PCPCH routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support. |
| Behavioral Health Services     | 3.C.0 – PCPCH has a routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.                                                                                                                                                                                                                 |

# Required PCPCH Measures (2 of 3)

| Standard                                            | PCPCH Must Pass Measure                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Personal Clinician Assignment and Continuity</b> | <b>4.A.0</b> – PCPCH reports the percent of active patients assigned to a personal clinician or team and has a process for considering patient choice in assignment. PCPCH also reports the percent of visits in which a patient saw their assigned clinician or team.                                                                                                                                                |
| <b>Organization of Clinical Information</b>         | <b>4.C.0</b> – PCPCH uses an electronic health record (EHR) technology that is certified by the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record. |
| <b>Hospital Setting Transitions</b>                 | <b>4.E.0</b> – PCPCH has a documented process for transitions of care with its usual hospital providers or directly provides routine hospital care.                                                                                                                                                                                                                                                                   |
| <b>Planning for Continuity</b>                      | <b>4.F.0</b> – PCPCH has a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available.                                                                                                                                                                                                                                                            |

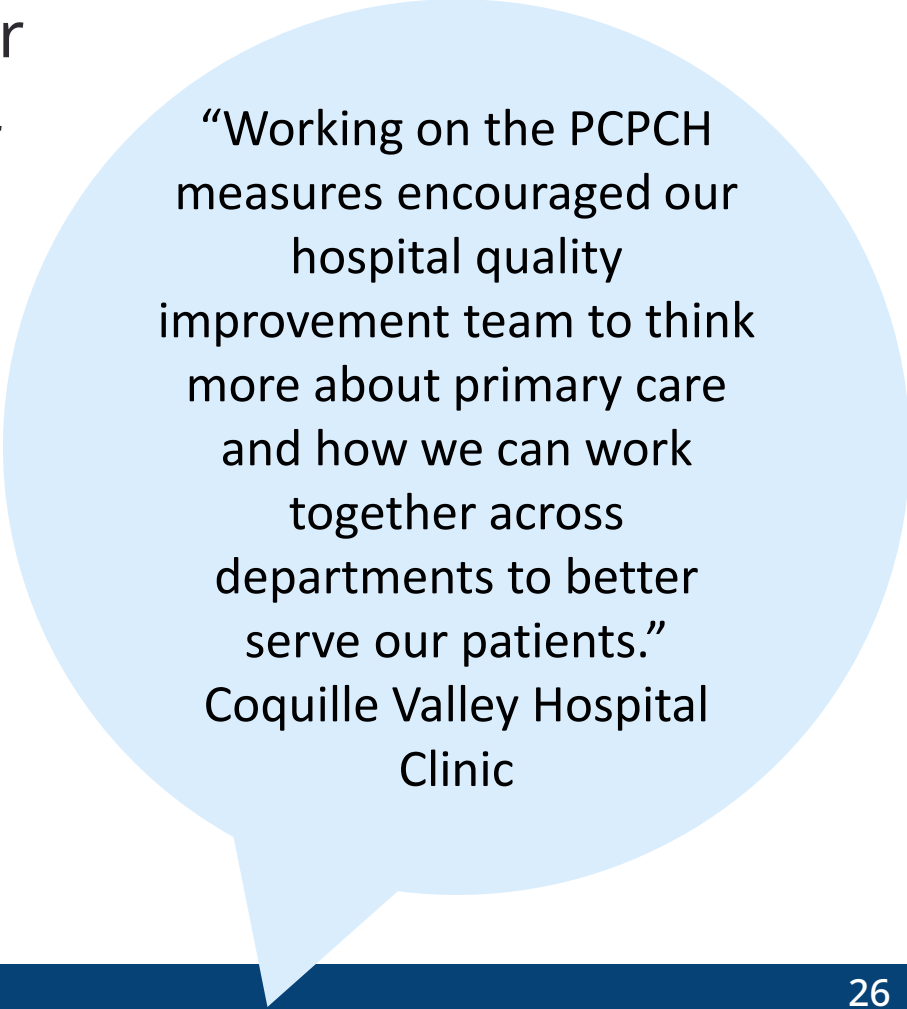
# Required PCPCH Measures (3 of 3)

| Standard                                         | PCPCH Must Pass Measure                                                                                                                                                                                                                                                            |
|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| End of Life Planning                             | <b>5.F.0</b> – PCPCH has a process for offering or coordinating hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.                                                                                              |
| Meeting Language & Health Literacy               | <b>6.A.0</b> – PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their primary language.                                                                                                                                        |
| Experience of Care                               | <b>6.C.0</b> – PCPCH surveys a sample of its population on their experiences with specific areas of care and shares results with clinic staff. PCPCH also meets a survey completion benchmark or has a strategy to increase the number of completed surveys                        |
| Communication of Rights, Roles, Responsibilities | <b>6.D.0</b> – PCPCH has a written document or other educational materials that outlines PCPCH and patient rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship. |
| Cultural Responsiveness of Workforce             | <b>6.E.0</b> – PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.                                                                                                                           |

# Site visits and technical assistance

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- Staff conduct site visits to ~100 PCPCHs a year
  - Verify clinic is meeting the measures and offer support and other resources
  - Provide 1:1 practice coaching for up to six months following a site visit if needed (at no cost!)
- Webinars, learning collaboratives, online resource library
- Help from program staff by email or phone



“Working on the PCPCH measures encouraged our hospital quality improvement team to think more about primary care and how we can work together across departments to better serve our patients.”  
Coquille Valley Hospital  
Clinic

# PCPCH program impact on care delivery

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Among PCPCH clinics that completed a PCPCH application in 2025 ...

- 93% report the program helps them improve the individual experience of care
- 95% report the program helps them improve population health management
- 90% report having implemented a new type of transformative primary care service or process in the last two years
- 85% report the program positively impacts patient access to care
- 92% report the program positively impacts coordination of care
- 90% report the program positively impacts equity in access and services

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

# PCPCHs lower costs and impact utilization

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OHSU-PSU School of Public Health; published in January 2023

- Evaluation of PCPCH's impact on health care expenditures and utilization of service from 2012-2019
- The study compared patients who received care at a PCPCH vs a Non-PCPCH and found that among PCPCH practices:
  - Total health care expenditures per person were reduced by 6.3% or \$76 per person per quarter. Resulted in an estimated \$1.3B in savings from 2012-2019
  - For every \$1 in primary care expenditures, an estimated \$12 in savings in other services were created, including emergency department and inpatient care
  - Patients utilized more primary care and specialty services, and less emergency department, pharmacy and inpatient care services.

# Actions to reduce administrative burden

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- This past year the program made operational changes to reduce burden
  - Changes based on clinic feedback obtained during site visits, 1:1 coaching and a survey fielded in fall 2025
- Site visits
  - Reduced or eliminated the documentation required for 38 out of 84 measures. For 23 measures, no documentation is required
  - Shortened the overall site visit day to four hours by streamlining clinical/staff interviews and making the patient focus group interview optional

# Actions to reduce administrative burden cont.

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- Standards and measure requirements / technical assistance guide
  - Updated the technical specifications for certain measures to align more closely with current clinic operations, reduce administrative burden and make some measures easier to meet.
  - Revised the PCPCH 2025 Recognition Criteria Technical Specification and Reporting Guide (TA Guide) format for clarity and to reduce overall length. Revised TA Guide will be published by November 2026.
- Future revisions to the standards
  - PCPCH model has been revised every few years since 2012
  - requires an advisory committee, comprehensive partner feedback, public meetings and rulemaking

# Additional information

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- OHA PCPCH program [website](#)
- [PCPCH 2025 Recognition Criteria Technical Specification and Reporting Guide](#) that provides detailed specifications, documentation requirements and examples for each measure.
- [PCPCH Program Impact Report 2024-2025](#)
- PSU-OHSU School of Public Health PCPCH program evaluations from [2016](#) and [2023](#)



# Solutions and strategies to achieve whole-person care



# Sharing committee recommendations and input with OHPB

# Preparing recommendations for OHPB

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- Set statewide primary care goals as required in the PCSC charter:
  - *Establish and Monitor Statewide Goals: Define statewide primary care goals for payment and affordability, workforce, and the delivery system, including integrating behavioral and oral health. Monitor and publicly report progress toward these goals, including workforce and investment indicators.*
- Roadmap for achieving and monitoring committee goals

# Next meeting

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Thursday, November 19, 2026

Noon–2 p.m.

[Primary Care Strategy Committee](#)

# Alternate format and contacts

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You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Primary Care Strategy Committee at [OHPB.PrimaryCare@oha.oregon.gov](mailto:OHPB.PrimaryCare@oha.oregon.gov) or 503-753-9688. We accept all relay calls.

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