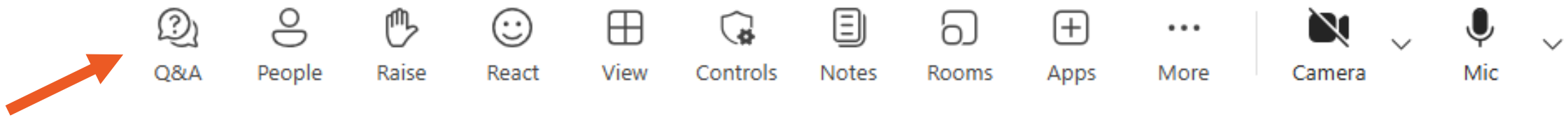
Primary Care Strategy Committee

July 16, 2026

Oregon Health Policy Board
Health Policy and Analytics Division

Welcome to the Primary Care Strategy Committee meeting

- The meeting will begin shortly.
- This meeting is being recorded.
- Please mute yourself when not speaking.
- If you'd like to provide public comment, please send us a message using the Q&A function on your Teams toolbar (see below) by 12:15pm, the time set aside in the agenda for public comment.
  - Public comments are limited to 2 minutes.



Welcome

Agenda review

Goals:

- Discuss and respond to the Oregon Health Policy Board (OHPB) legislative concept (LC) input.
- Discuss and decide on guiding principles.
- Learn about strategies to support a strong, local, team-based primary care workforce.

Agenda

- Agenda review, meeting goals, April meeting summary
- Public comment (12:15 p.m.)
- OHPB LC input
- Break (12:50 p.m.)
- Guiding principles
- Supporting a strong, local, team-based workforce
- Next steps

Review draft meeting minutes

A draft summary from our June 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.

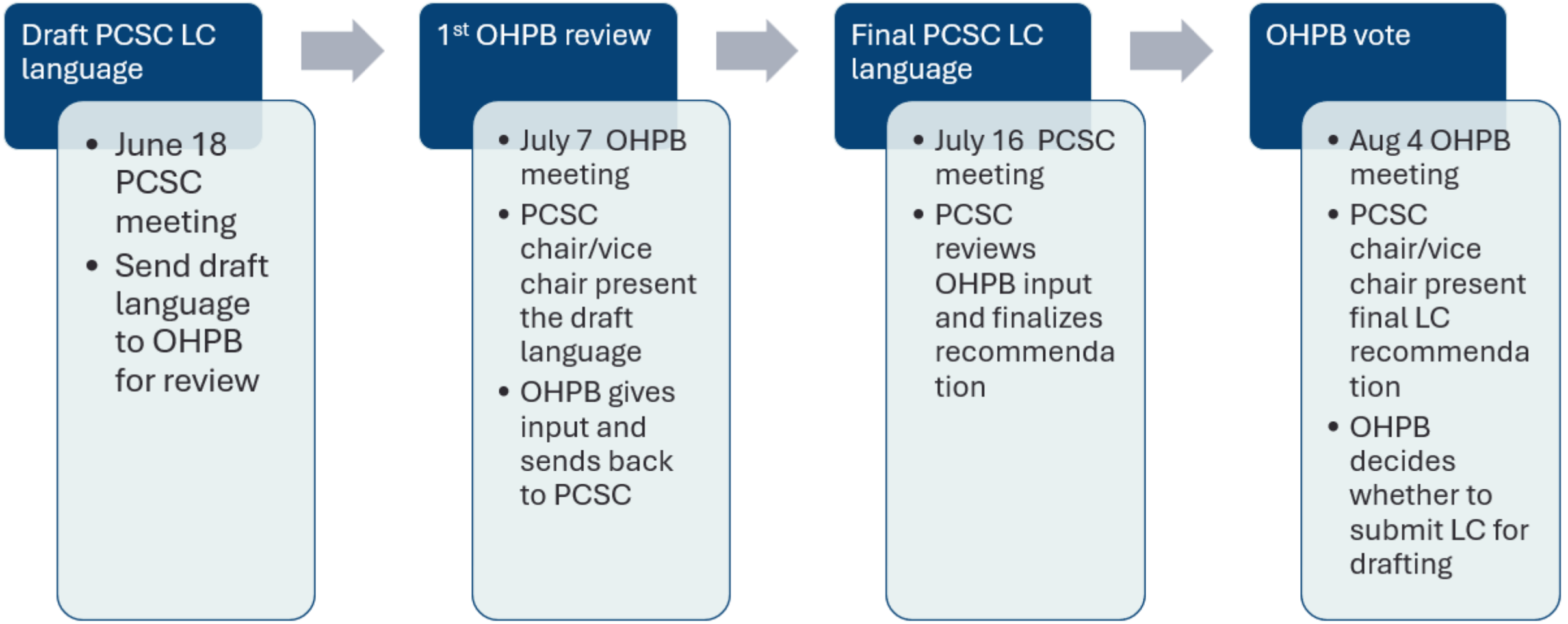
PCSC timeline

Month	Activities
April	*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*
May	*Agreed on vision and objectives; conducted initial discussion on the straw proposal, focused on the LC*
June	*Decide on ideas to include in the LC; begin discussing guiding principles*
July	**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**
Aug	Objective(s) presentations
Sep - Dec	Objectives presentations; develop actions

Public comment

OHPB Legislative Concept Input

OHPB Legislative Concept timeline



Per member per month payment for Patient-Centered Primary Care Homes

Problem

- Increased demands on primary care providers and lack of sufficient funding to support approaches, such as expanding the primary care “team”

Proposed solution

- Require all payers to pay a PMPM to PCPCHs in their network to sustain PCPCH practices through, for example, being able to hire additional staff for the primary care team.
- PMPM would be tiered based on the tier-status of the PCPCH clinic.
- Does not legislate a recommended PMPM amount that payers should provide to PCPCHs in their network.

OHPB input: PCPCH PMPM

- Agreement that increasing payment is important.
- Input on whether PCPCH PMPM needs to be the required payment model.
  - One member noted that, for example, higher fee-for-service payments could have the same impact.
  - Another member noted the payment mechanism mattered and supported a PMPM payment.
- Concern that the requirement only applies to commercial payers regulated by the state, which does not include self-funded plans (which is the case for any legislation related to “all payers”).

Discussion: PCPCH PMPM payment

- Reactions to the OHPB input?
- Are there any changes we want to make to the recommendation?

Vote (if needed): Per member per month payment for Patient-Centered Primary Care Homes

1	2	3	4	5	6	7	8
Whole-hearted endorsement *"I really like it"*	Agreement with a minor point of contention *"Not perfect, but it's good enough"*	Support with reservations *"I can live with it"*	Abstain *"This issue does not affect me"*	More discussion needed *"I don't understand the issues well enough yet"*	Don't like but will support *"It's not great, but I don't want to hold up the group"*	Serious disagreement *"I am not on board with this – don't count on me"*	Veto *"I block this proposal"*

Stabilizing primary care via timely value-based payment funding

Problem

- There is often a significant delay in practices receiving flexible funding associated with VBP that can support team-based care.

Proposed solution

- Create a more sustainable cashflow for primary care practices by requiring all Oregon payers prospectively disburse value-based payment (VBP)-related quality measure performance payments on a quarterly cadence, at a minimum (with a retroactive adjustment if needed)
- Payments should equal at least 50% of what a practice is eligible for during the payment timeframe.

OHPB input: Timely VBP funding

- Concern was raised about the value of quality metrics and tying payments to them, and a suggestion that the committee explore this much broader issue in the future.

- As a follow up to an OHPB meeting discussion, there was an ask for PCSC to connect with the Industry Advisory Committee to the Affordability Committee (another OHPB committee) which is discussing the administrative burden and value of quality metrics

Discussion: Timely VBP funding

- Reactions to the OHPB input?
- Reactions to the proposal to change the requirement to payers must offer the option to all the primary care practices they contract with and practices decide?
- Are there any changes we want to make to the recommendation?

***Vote (if needed)*: Timely VBP funding**

1	2	3	4	5	6	7	8
Whole-hearted endorsement *"I really like it"*	Agreement with a minor point of contention *"Not perfect, but it's good enough"*	Support with reservations *"I can live with it"*	Abstain *"This issue does not affect me"*	More discussion needed *"I don't understand the issues well enough yet"*	Don't like but will support *"It's not great, but I don't want to hold up the group"*	Serious disagreement *"I am not on board with this – don't count on me"*	Veto *"I block this proposal"*

Changes to the Primary Care Spending in Oregon Report

Problem

- OHA has heard from many partners they do not use the report for its intended purpose of informing policy because they do not agree with 1) the restrictive, outdated definition of primary care that is written in statute and 2) the exclusion of prescription drugs from the total medical expenditures.
- The statute also prescribes a Report deadline that does not align with the data collection and processing timeline.

Proposed solution

- Move the definition of primary care from statute to administrative rule, which would support a more robust community engagement process to create the definition; and allow the definition to be changed over time.
- Remove from statute the exception for prescription drugs from total medical expenditures, which would support a more robust community engagement process to inform the methodology; and allow the methodology to be changed over time.
- Shift the Report deadline from February 1 to September 30 to align with the data processing timeline.

Break

Guiding principles

Draft guiding principles

A primary care action should…

- Support patient access in all areas of the state.
- Protect and support primary care's ability to provide whole person care, including preventative care, across all areas of the state.
- Increase workforce wellbeing for all members of the primary care team.
- Decrease administrative burden for providers.
- Be aligned with other efforts to improve primary care.
- Have the greatest impact on the most people.
- Not increase complexity for patients.
- Increase investment in team-based primary care.

Supporting a strong, local, team-based primary care workforce

A comparative analysis of staffing models and per-member-per-month (PMPM) targets

Deborah J. Cohen, PhD; July 2026

Thank you

- **Funders** – Commonwealth Fund and Healing Works Foundation
- **Team** – Tamar Wyte-Lake, Leah Gordon, Stephan Lindner, Julia Heinlein
- **Advisors** – Kevin Grumbach, Lauren Hughes, Bob Phillips, Barbra Rabson, Russell Phillips, Kim Yu, Diane Rittenhouse, Rebecca Etz, Michael Balit
- Practices and staff who participated

The Primary Care Investment Gap

Global Lag

Despite recognized value of primary care, the U.S. continues to lag other wealthy nations in relative investment and pre-capita spending

Need for Standardization

- State and federal metrics to track core investment
- Articulated models for interdisciplinary team care
- Clear transparency on the actual cost to provide care that is comprehensive with continuity

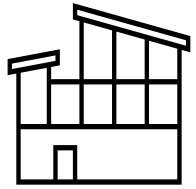
Research is needed to address primary care questions that advance interprofessional team-based care.[1]

[1]National Academies of Sciences, Engineering, and Medicine. 2025. Building a workforce to develop and sustain interprofessional primary care teams..

Study Aims and Methodology (1 of 2)

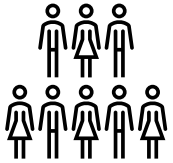
- Identify the team roles, functions and staffing ratios that exist in primary care today
- Identify what is needed to deliver interdisciplinary team-based primary care
- Estimate the cost to deliver this care

Study Aims and Methodology (2 of 2)



Data Collection

FTE surveys, interviews, BLS/MGMA data



12 practices

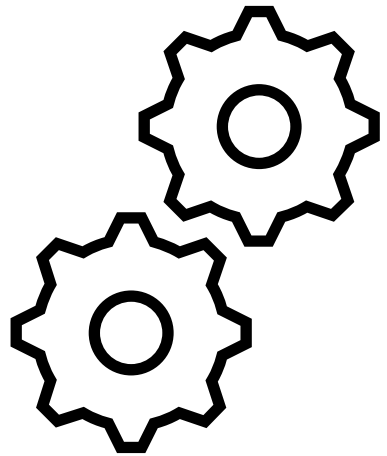
Selected via iterative, maximally varied sampling

Analysis

Comparative analysis and modeling against the AHRQ[2] workforce configurations study

[2]Meyers D, LeRoy L, Bailit M, Schaefer J, Wagner E, Zhan C. Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices; 2018. J Gen Intern Med 33(10):1774–9.

The key functions of primary care have not changed



Primary Care Critical Functions

- Comprehensive care with continuity
- Care Coordination / referral management
- Self-management support
- Population management
- Complex care / Care transitions
- Administrative support
- Community linkages
- Behavioral health
- Medication management
- Practice QI Leadership

Primary Care Critical Functions (1 of 2)

Function	Definition	Who does it
Comprehensive care with continuity	Integrated, whole person care with continuity	Clinicians, MA/LPN, RN
Self-management support	Support that enables patients to care for themselves	Clinicians, RN, MA/LPN
Care Coordination/referral management	Making and following-up on referral for care outside practice	MA/LPN; admin
Population Management	Proactive outreach to patients to engage in care	MA/LPN; RN; SW; admin
Complex care / care transitions	Helping patients with complex care needs manage their health	RNs, SW, MA/LPN
Practice leadership	Clinical Leadership; QI	MD

Primary Care Critical Functions (2 of 2)

Function	Definition	Who does it
Administrative support	Check-in, phones, paperwork	Admin; MA
Community linkages	Identify social needs, connect to community resources	CHW, patient navigators, peers, SW
Behavioral health	Work with patients and families, using evidence-based approaches to provide patient centered care screening and short- and longer-term therapy	LCSW, LMFT, Psychologists, Psychiatric NP
Medication management	Helping patients understand medications they are on, know how to take them, and assess if they are working	Clinical Pharmacist

Shifts in interdisciplinary professional role and staffing

There are fewer physicians

AHRQ

Index Model:

- 0.33 FTE NP/PA for every 1.0 MD/DO FTE

High Social Need Model:

- 1.0 FTE NP/PA for every 1.0 MD/DO FTE

Our Study

Index Model:

- Two practices employ all MDs/DOs
- Four range from having 1.3 to 1.6 FTE NP/PAs for every 1.0 MD FTE

High Social Need Model:

- Practice have between 2.0 to 4.6 FTE NP/PA for every 1.0 MD/DO FTE

Clinician Mix: Why it matters

NPs/PAs

- Smaller panels
- See fewer patients in a clinical session
- May be directed to
  - see patients with less complexity
  - acute care visits; enhance access (extender); can impact continuity
- Clinics provide additional training / mentorship to develop clinical experience of these professionals

There are fewer Registered Nurses

AHRQ

Index Model:

- 4.0 RN FTE

High Social Need Model:

- 7.0 RN FTE

Our Study

Index Model:

- 3 practices have no RNs
- 2 practices had < 0.75 FTE RN

High Social Need Model:

- 2 practices have no RNs
- 1 practices had 2.27 FTE RN
- 1 practices 5.8 RN FTE

Fewer Nurses: Why it matters (1 of 2)

Self Management Support

- Clinicians and RNs focus on complex management and education.
  - Clinicians provide support directly during visits
  - RNs can conduct dedicated nursing visits
    - monitoring conditions (e.g., blood pressure, HbA1c),
    - providing education
    - adjust medications based on clinician orders
  - MAs and LPNs typically handle straightforward tasks and clinical monitoring

Fewer Nurses: Why it matters (2 of 2)

Complex Care and Care Transitions

- **Clinical assessment and management** - medical safety, clinical monitoring and enabling the patients plan of care
- **Care transition support and continuity** - ensuring a smooth transition between care settings, such as between the hospital or other care settings and the home
- **Self-management support** - educating and empowering the patient and family to manage the care at home
- **Support and navigation with social determinants** - assisting patients with the non-medical barrier to complex care and assessing community resources, as needed

Right Task, Right Person, Right Training

Rising Panel Demands (1.0 FTE)

	MD/DO	NP/PA
AHRQ Target (Index; high social need)	1300; 1000	1000; 900
Study Practices	1566	1,194

Practice are Coming up Short

	Index Model		High Social Need Model	
	AHRQ	Study - **Actual**	AHRQ	Study - **Actual**
Total on-site Staff	36.8 FTE	26.7 FTE	50.3 FTE	30.5 FTE
Total Salary PMPM	$40	$32	$58	$35
Operations PMPM	$22	$17	$31	$19
Total cost PMPM	$62	$49	$89	$54

PMPMs are adjusted for inflation (2026). All numbers shown are for 10,000 lives.

Staffing Suggestions

10,000 lives

Staffing suggestions with FTE

Clinicians	9.0 FTE; 10.2 FTE (3.6–4.1 MD/DO FTE; 5.4–6.1 NP/PA FTE)
RNs	1 RN for every 2.0 clinician FTE
MAs	1.5 MAs for every 1.0 clinician FTE
Administrative	1.0 admin for every 1.0 clinician FTE
Practice manager	1.0 FTE
BHC – LCSW, Psychologists;	2 BHC; 1.0 FTE for every 2.0 to 3.0 clinician FTE; 1.0 FTE to 1.0 FTE for FQHCs
Psychiatry (NP)	Varies; at least 0.75 and up to 4.5 for CHCs
Clinical Pharmacist	1.0 FTE to 5.0 - 6.0 clinicians FTE or 10,000 lives
Dietician/nutritionist	2.0 per 10,000 lives
Social worker/CHW	1.0-2.0 FTE for 10,000; 6.0-7.0 FTE for in high Medicaid*
Dentistry	1.0 FTE for 10,000; for rural practices and high social need

FTE, Costs, PMPM: Index Model (10,000 lives)

	AHRQ	Our Study
Total on-site Staff	36.8 FTE	48.75 FTE
Total Salary PMPM	$41	$48
Operations PMPM	$22	$27
Total cost PMPM	$63	$75

This is a status quo access model

PMPMs are adjusted for inflation (2026). All numbers shown are for 10,000 lives.

FTE, Costs, PMPM: High Social Need Model (10,000 lives)

	AHRQ	Our Study
Total on-site Staff	50.3 FTE	68.9 FTE
Total Salary PMPM	$58	$72
Operations PMPM	$31	$39
Total cost PMPM	$89	$111

This is a status quo access model

PMPMs are adjusted for inflation (2026). All numbers shown are for 10,000 lives.

The Triple Double Framework

10%
Double Investment

Reach $100 PMPM target through 10% national spend allocation

2X
Double Reach

Expand CHC capacity to serve medically underserved areas

2x
Double Clinicians

Reduce burnout through smaller panels and team integration

Contextualizing the Investment

- U.S. is expected to reach a total health care spend of $5.42 trillion this year
- The projected U.S. population is 342,000,000
- **Monthly Per-Capita Personal Healthcare Spending : $1,133.00 PMPM**
- 10% of that is $113

The Triple Double is conservative.

To move beyond the status quo, we need to…(1 of 2)

Encourage more professionals to choose primary care

- Reduce clinician burden
  - Pay for primary care team that people need
  - Reduce panel size
- Increase compensation to align with demand, moving toward pay parity with hospitalists and specialists
- Pay a "transformation premium" for the knowledge and effort required to develop advanced primary care practices

To move beyond the status quo, we need to…(2 of 2)

Invest in…

- Loan repayment policies
- Technical assistance to support change
- Data systems to better identify / address community needs and reduce work burden
- Infrastructure to expand team space
- New practices to meet community need for access

Questions and discussion

Connection to PCSC prioritized strategies: Support and pay for whole-person team-based care, including requiring minimum expenditure

Require all payers to pay sufficiently through:

- A PMPM for PCPCH
- Medicare Advanced Primary Care Management and Behavioral Health Integration codes
- Increasing Medicaid payment rates to at least 100% of the Medicare
- Adequately reimburse practices to support staff capacity and technology for screening and referral of health-related social needs
- CCOs reimburse practices for using interpreters with only national health care interpreter certification for Medicare compliance

Provide educational opportunities on topics beyond the PCPCH Program standards, such as:

- Clinic leadership and management, administrative processes like billing for services
- Team-based care
- How to ensure providers can serve at the "top of their license."

Objectives presentations

Framework for objective presentations

1. **Background**

   Share information about why your topic matters

2. **What is Oregon doing already?**

   Work with OHA staff to share what work is ongoing already around your topic

3. **Strategies**

   Which of our prioritized strategies may tie in directly with your topic and how?

4. **Opportunities**

   What opportunities exist to address this topic – you can use opportunities from the Committee Framework or share other opportunities you're aware of or thought up yourself

Draft objectives (1 of 2)

Overarching

Identify gaps and drive bold solutions – Erik Vanderlip
Assess where Oregon is falling short of its primary care vision and recommend concrete, enforceable policy actions to close those gaps.

Simplify and align the primary care system – Raffaella Betza
Reduce fragmentation, simplify payments, decrease administrative burden, and create a system that is easier for patients and providers to navigate.

Establish and monitor statewide goals *(from the charter) – full committee*
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.

Draft objectives (2 of 2)

Workforce

Support a strong, local, team-based workforce – Deb Cohen
Making Oregon a place where primary care providers want to work, including by reducing administrative complexity, expanding recruitment and retention pathways, and increasing provider wellness and resiliency.

Delivery system

Advance whole-person, integrated, community-based care – Ricardo Palazuelos support but not lead
Ensure everyone living in Oregon has access to a high-quality primary care practice that provides coordinated, continuous, comprehensive and personalized whole-person care.

Payment and affordability

Ensure financial sustainability – Betsy Boyd-Flynn and Carly Hood-Ronick
Enforce (or strengthen) minimum primary care investments, adopt site neutral payments, and explicitly protect independent, rural, and pediatric practices from consolidation pressures.

Next meeting

Thursday, August 20, 2026

Noon–2 p.m.

Primary Care Strategy Committee

Alternate format and contacts

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 or 503-753-9688. We accept all relay calls.

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https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Primary-Care-Strategy-Committee.aspx

OREGON HEALTH AUTHORITY