Question and Answers with Webinar Speakers

Questions and Answers with Dr. Evan Saulino, MD, PhD, Clinical Advisor, Patient-Centered Primary Care Home Program, Oregon Health Authority

Question: Interested in outcomes....both those that are required from OHA as well as some of your own.

Answer: I'm not sure how to answer this question. I think looking at the Portland State University (PSU) Evaluation of PCPCH paper would be a good first step – there is SO MUCH there to dig through, at so many levels. In terms of other "quality indicators" – Quality Corporation in Oregon has included some of these data about relative effects of getting care through a PCPCH in their annual "State of Oregon Health Care Quality" report – see this link for most recent full report (2015) with these data.

Question: Any population health measures? Are people healthier or using services more efficiently?

Answer: The PSU Evaluation does show that people ARE using health services more "efficiently" – there are a number of aspects to this statement addressed in the PSU Evaluation, but for example when people get their care through a PCPCH, they visit the ER less, they are hospitalized less, they are re-hospitalized less, they have fewer visits to specialists, and even when they are hospitalized the cost of each hospitalization is LESS than if they get their care through a clinic that is not recognized as a PCPCH. There have NOT been more in-depth analyses of outcomes such as looking at mortality rate, or self-reported health or other population health measures such as equity – but these would be very interesting to evaluate in the future.

Question: What quality measures were evaluated in the evaluation & what are some of the evidence gaps that need to be examined to understand the effectiveness of PCPCP certification?

Answer: There are many question we have left to answer, and many areas where we recognize the PCPCH work is just "scratching the surface" of what is possible. The main "evidence gaps" that we see are in demonstrating the sustainability of the model of care over time, and being able to pick out or predict or track the variability in clinics – in other words, it is possible (a hypothesis) that some of the more high performing PCPCHs are "creating" most of the cost/care improvement effects, and less-high-performing clinics are not demonstrating the same or similar improvements. What we DO know from the PSU Evaluation data is that clinic size or location alone were not reliable predictors of efficacy. There is much more for us to study and learn across our state.

Question: You stated the individual attributes alone didn't impact outcomes (costs), but when all 6 were present, they did have an impact. Did any of the individual attributes have a larger impact on quality than others? What were your quality measures?

Answer: Please see PSU Evaluation paper for more details about which cost/utilization measures were evaluated. Performance on other "quality metrics" were not evaluated in this PSU study –

see above for the Quality Corporation report that did address some of these "quality metrics" in PCPCHs vs. non-PCPCHs.

According to the PSU data/evaluation, the "Coordination and Integration" PCPCH core attribute (which has standards/measures like risk stratification, complex care management, care planning, end-of-life care) had the strongest and really the only "statistically significant", "independent" effect. The other Core Attributes did not demonstrate a similarly significant effect.

Question: In the evaluation, it seems that the early adopting clinics may have already been well performing clinics who wanted to improve. Not that a majority of PC clinics are in the program, are their plans to look more deeply at the benefits and challenges and value-added outcomes for clinics?

Answer: Agree that "early adopters" may have affected some positive benefits in the PSU evaluation. However, the study looked over 3 years, and at the end of those 3 years, there were well over 400 recognized PCPCHs in Oregon – about ½ of all of the primary care clinics in the state. It is highly unlikely that over ½ of the state's primary care clinics were "early adopters" – instead, it is more likely that a small percentage of those clinics recognized the first year were "early adopters" and the others were in the large part of the "bell curve" of change adoption. The evaluators also looked at clinics that were recognized in year 1, year 2, and year 3 of the program and saw similar effects for clinics recognized their first year. Therefore, given the large population scale and timeline of the evaluation, the various "cuts" of data for different time periods of model adoption, and the very large "market share" of clinics adopting PCPCH model of care during this time period, it is unlikely that the results would have been compromised significantly by an "early adopter" effect.

Please look at the **qualitative** arm of the PSU evaluation – that has answers to the benefits and challenges for "high performing" clinics in Oregon. There are numerous learnings both on the "positive" and "negative" sides.

Yes, there is a desire to look more deeply at these issues moving forward.

Questions and Answers with Jane Conley, Administrator, Springfield Family Physicians

Question: Jane, a question about the phone in calls to your original behavioral health, did you have previous appt made with them to take the phone call?

Answer: This was done without appointments. Our arrangement with our local BH organization was that they would provide a QMHA or QMHP (Qualified Mental Health Associate/Professional) during working hours who was available to answer the phone whenever it rang. These calls were not intended to be actual therapy sessions; rather, they were intended to engage the patient and make the idea of therapy less intimidating. The QMHA listened empathetically, made a quick assessment of the patient's issues, then scheduled an appointment with a therapist in their organization who would be a good fit. We found that this connection between the patient and BH increased the patient's likelihood of following through with therapy.

A secondary benefit was that the physician was able to hand the phone to the patient and move on to the next appointment.

Question: how do the Behavioral health personnel bill- separately than the clinic since it sounds like they freelance in your space?? Is the initial phone consult free?

Our process has evolved. When we were using the initial phone consult, there was no charge to the patient. At that time, the patients were seen at another location by the BH organization. As that evolved into on-site therapists, we no longer used the phone and instead warm hand-offs were done in person in the office. For a while, this was done as a free-lance situation; we provided free space in our office, and they billed under their own tax id number. Today, we have two variations. We lease two therapists from our BH organization partner. Those therapists engage patients who are expected to require "short term therapy" (i.e., 1-6 visits). We bill for those services under our tax id number and they chart in our EHR. Additionally, we provide space for two more therapists who are seeing patients that need longer, "traditional" therapy. Those services are billed by the BH organization under their tax id number and the notes are recorded in a separate EHR, with a follow-up note sent to the PCP. Patients report they enjoy being able to see their therapists in an office where they are already comfortable. It greatly increases the chances that they will engage in needed therapy.

Question: Does your behavioral health provider provide all necessary services for your practice? Drug rehab, etc.

Answer: Yes, one of the reasons we chose to work with a community partner, rather than develop our own stand-alone program, was that we realized we would likely not be able to provide all the additional support services. Our patients have access to a wide variety of BH services and group meetings through this partnership. For example, our BH partner provides group yoga classes for pain management in one of our locations and has conducted group visits for tobacco cessation at our main office. Many other services are available at their locations.

Question: I am looking to develop partnerships with regional hospitals and OHSU and have been unsuccessful finding the right person to talk to. Suggestions? We are very rural, only medical care in an hour any direction. Have part time BHC--would like more hours, but no one we have talked with are willing to come out here

Answer: I asked our psychologist for help with your question, and here is her response:
"It seems anyone who works in Maupin could be eligible for loan repayment given the location. She/he could also connect to local training programs throughout the state to see if they want to send trainees or recent graduates (UO clinical psych, Pacific University clinical psych, George Fox clinical psych, PSU clinical social work)."

Question: Jane, how do you recruit new providers for your group? What resources specifically do you use?

Answer: We post openings on our website, have written letters to residency programs and placed ads in professional magazines. But I find that working with recruiters is the most effective way by far. Recruiters are constantly searching for candidates and can align candidates interested in your particular location and type of practice. They provide a name and CV to me, and I make contact with the candidate. It's my role to figure out if they might be a good fit and excite them about what we have to offer. I arrange the interviews (which include providers and staff), hotel accommodations, and a real estate tour if they are interested.