2017-2018

The triple aim and clinic engagement with NMPCA

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EXECUTIVE SUMMARY

The New Mexico Primary Care Association (NMPCA) participated in the 2017-2018 Evaluation Lab to determine whether available administrative records might be used to assess whether the organization is meeting its mission to promote best practices among the clinic organizations it serves. Following the Evaluation Lab model, NMPCA staff and a UNM student supervised by an experienced evaluator collaborated to create a logic model and to design and implement an evaluation plan. In a departure from the usual composition of an evaluation team, the UNM student was also a staff member at NMPCA. This dual role provided an insider level of familiarity with the issues facing NMPCA, and an enhanced opportunity to embed useful evaluation practices into the organization.

Using NMPCA records, the team was able to measure clinic organization performance using the Triple Aim measures of cost per patient, patient experience, and health outcomes. The team identified as top performers those organizations with scores above average in at least 2 of the 3 areas of the Triple Aim. These top performers were then compared with their level of participation in the training and technical assistance offerings of the NMPCA.

The analysis revealed a statistically significant relationship between the top performers in the Triple Aim and those organizations' utilization of the NMPCA as a resource. This suggests that organizations benefit from engaging in NMPCA activities. As with any observational study, we cannot be sure that the relationship is causal, and it is also possible that organizations that are already effective are more able to spend the time and effort to participate in NMPCA activities. Even under this explanation, though, increased attendance suggests that these organizations value the NMPCA, and the NMPCA should look for ways to engage the less enthusiastic organizations.

Going forward, the evaluation team recommends looking at Joy of Practice as the additional piece that transforms the Triple Aim into the Quadruple Aim. To evaluate Joy of Practice, the evaluation team recommend conducting interviews and focus groups at FQHCs around the state.

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1. Introduction

The New Mexico Primary Care Association (NMPCA), a non-profit 501 (c) (3) corporation, represents 19-member organizations that operate more than 160 primary care, dental, school-based and behavioral health clinics throughout New Mexico. NMPCA has a full-time staff of 30 employees, 20 located in Albuquerque and 10 in Farmington, Gallup, Las Cruces, and Santa Fe. Founded in 1980, NMPCA serves as a liaison between its members and State and Federal agencies and works on behalf of the member health centers to develop and provide:

- Professional education and technical assistance for the development of staff and Boards of Directors, which are composed of at least 51% of patients from the health center;
- Outreach and enrollment training and support to assist members and other community organizations to enroll consumers in Medicaid and Health Insurance Exchange coverage;
- Clinical quality improvement support services to enable members to improve both the quality of their services and the health status of their patients;
- Critical health information technology services, including network management, electronic health record hosting, and data analytics;
- Avenues for member organizations, clinics and staff to network and share best practices;
- Assistance to communities to build infrastructure and secure resources for new primary care clinics; and
- Information and data to inform and educate policy makers and legislators.

Through training, technical assistance, facilitation, data storage, coaching and other services, NMPCA assists the Federally Qualified Health Centers (FQHCs) to provide accessible and high-quality healthcare for all New Mexicans, focusing on vulnerable populations.

NMPCA participated in the 2017-2018 Evaluation Lab to determine whether available administrative records might be used to assess whether the organization is meeting its mission to promote best practices among the clinic organizations it serves. Following the Evaluation Lab model, NMPCA staff, an NMPCA client (clinic organization) representative, and a UNM student supervised by an experienced evaluator collaborated to create a logic model and to design and implement an evaluation plan. In a departure from the usual composition of an evaluation team, the UNM student was also a staff member at NMPCA. This dual role provided an insider level of familiarity with the issues facing NMPCA, and an enhanced opportunity to embed useful evaluation practices into the organization.

The Evaluation Team members were:

- Sonia Bettez, Associate Director of the Evaluation Lab

- Audrey Cooper, Evaluation Lab Fellow and NMPCA Staff Evaluation Coordinator
- Eileen Goode, CEO, NMPCA
- Karen Sakala, Director of Quality and Data, NMPCA
- Terry Schleder, Clinical Quality Specialist, NMPCA
- Brandi Peres, FQHC Representative from Albuquerque Healthcare for the Homeless

Upon deliberation and thoughtful discussions, the evaluation team created a logic model. (See Appendix A.) Together, the team decided to evaluate the first outcome in the logic model: increased embodiment of the spirit of the Patient Centered Medical Home (PCMH) model in New Mexico's FQHCs and look-alikes.

The PCMH model provides a framework intended to improve the organization and implementation of heath care in clinical settings (AHRQ 2017). Part of the design of the PCMH model resulted from an evaluation of high functioning practices already in existence. Qualities and characteristics from these practices formed the basis for the PCMH model and resulted in the implementation of practice transformations and measurable outcomes. That National Committee for Quality assurance (NCQA), a private nonprofit focused on quality improvement in healthcare, has assembled criteria for Practice transformation to implement PCMH:

1. Team-Based Care and Practice Organization
2. Knowing and Managing Your Patients
3. Patient-Centered Access and Continuity
4. Care Management and Support
5. Care Coordination and Care Transitions, and
6. Performance Measurement and Quality Improvement

NCQA uses a checklist approach to certify that a clinic meets the definition of a PCMH. The checklist, however, renders PCMH as a one-dimensional concept—either an organization has achieved a certain aspect of the checklist or it has not.

The team chose the Triple Aim (population health, patient experience and cost of care) as the framework for the evaluation of the FQHC's embodiment of the PCMH model. The Triple Aim framework informs the PCMH model and seeks to address the need of healthcare to be stewarded in a conscientious, effective, and efficient manner where quality is high, and outcomes are excellent (IHI 2017). Additionally, clinics that embody the PCMH model perform at a high level in the Triple Aim.

2. Measuring the Triple Aim and Engagement with NMPCA

The evaluation team chose measured each element of the Triple Aim as follows:

Population Health

For the population health indicators, the evaluation team chose diabetes and hypertension out of the 16 reported measures in the Uniform Data System (UDS), to which all FQHCs and look-a-likes report. Diabetes and hypertension are the main chronic diseases in New Mexico. The hypertension measure consists of the rate of patients ages 18-85 at a particular FQHC with a diagnosis of hypertension and with blood pressure of less than 140/90. This signifies how well the FQHC is doing to keep people with hypertension controlled or without signs and symptoms of hypertension. This is important because people with controlled blood pressure have lower risk of heart attack, stroke, and deterioration of their cardiovascular system.

The diabetes indictor consists of the rate of patients in an FQHC ages 18-75 with a diagnosis of diabetes who have a Hemoglobin A1C greater than 9 or who have a diagnosis but have not received a hemoglobin A1C test. The Hemoglobin A1C test measures the attachment of glucose to hemoglobin which reflects a person's glucose levels over the past three months. The A1C diagnostic test measures blood glucose maintenance. For patients with a diagnosis of diabetes, the hemoglobin A1C is used to measure whether the diabetes is controlled. For the purposes of this evaluation, the diabetes measure was inverted to match with the hypertension measure in that both measures refer to controlled patients. For the analysis, the evaluation team used data from 2015-2016 which produced two diabetes rates and two hypertension rates per FQHC and created a Health Outcomes indicator by averaging the two. (See Figure 1.)

Patient Experience

The evaluation team used 2015 and 2016 data from the Patient Experience survey administered twice annually by the NMPCA to most of the FQHCs in New Mexico. The NMPCA sends surveys, in electronic and paper form, depending on the preference of the FQHC, to each FQHC in the months of April and October for administration to patients. In paper form, each clinic is given 50 surveys per site to distribute. The electronic version is implemented by the health center over the course of the month, and the health center will collect as many responses as they can. The clinic staff offers the survey at random over the course of month. The survey consists of 12 core questions. The patient may choose from a Likert Scale of Always, Usually, Sometimes, Never. Some questions are also in a Yes/No response format. The NMPCA analyzes the completed surveys and sends results to the FQHCs. From the survey, the evaluation team chose the following 5 questions:

1. When you phoned this clinic to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?

2. Wait time includes time spent in the waiting room and exam room. How often did you see this provider within 15 minutes of your appointment?
3. How often did this provider explain things in a way that was easy to understand?
4. When this provider ordered a blood test, x-ray, or other tests for you, how often did someone from the clinic follow up to give you the results?
5. Did you and anyone in this clinic talk about a personal problem, family problem, alcohol use, drug use, or mental or emotional issue?

The evaluation team chose the 5 questions above because they addressed themed areas of the PCMH model:

- Access (Questions 1 & 2)
- Communication (Question 3)
- Coordination of Care (Question 4)
- Comprehensiveness (Question 5)

On four of the five questions, we used the percentage of respondents who chose "Always." On one question regarding Access, the evaluation team decided to use the percentage of respondents who chose "Always" and "Usually" because it was a question on wait times. Patient wait times are often greater than 15 minutes in the clinical setting, so we chose to include "Always" and "Usually" because those represent reasonably high quality service. For each of the five questions during 2015-2016, we averaged the percentages to achieve one number for the Patient Experience indicator. (See Figure 2.)

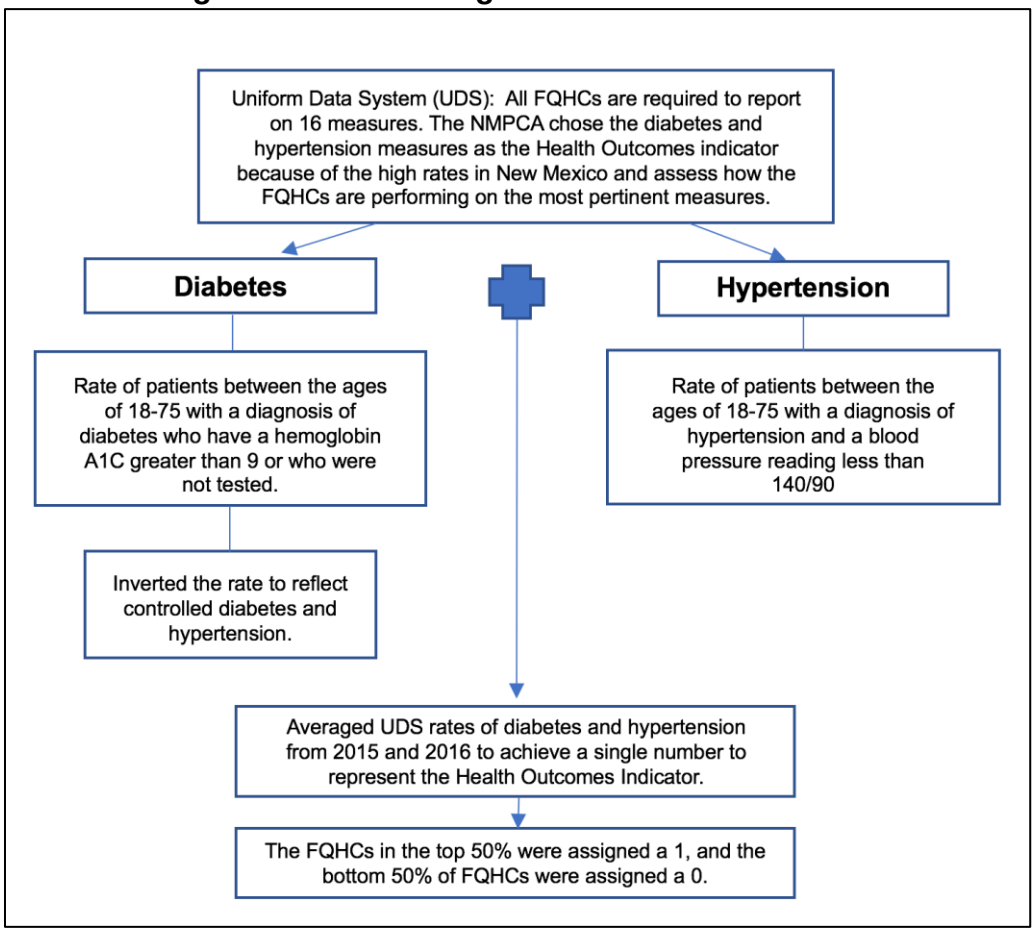
Cost of Care

For the final indicator in the Triple Aim, the evaluation team used cost per patient as reported by each FQHC annually to the UDS for the years of 2015 and 2016. This number is the average of all costs for care services provided to each patient. We averaged the costs for both years to achieve the Cost per Patient indicator for each FQHC. (See Figure 3.)

The NMPCA offers trainings, meetings, conferences, peer learning groups, and special projects to assist the FQHCs to improve their performance. The evaluation team decided to compile existing data on attendance at NMPCA offerings to find out whether attendance was correlated with performance on the Triple Aim indicators.

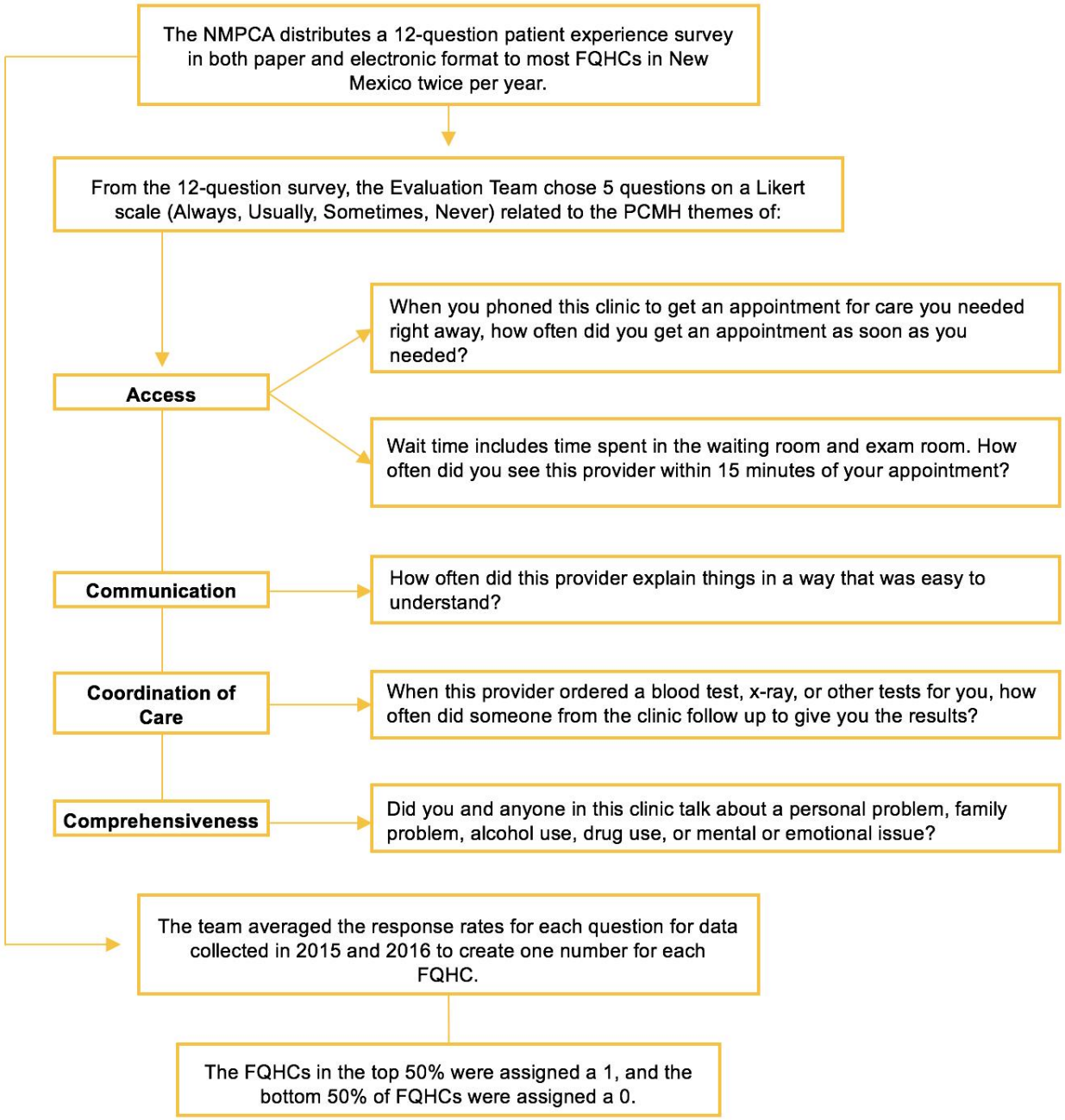
The compilation of attendance data entailed combing through files in various locations in the NMPCA server to find scanned copies of attendance sheets, totaling the numbers of attendees from each FQHC for each offering, and entering all the data in a spreadsheet on Excel. Members of the NMPCA evaluation team chose the offerings relevant for the analysis. Each FQHC had an opportunity to participate in all the offerings.

6. **Figure 1: Determining the Health Outcomes Indicator**



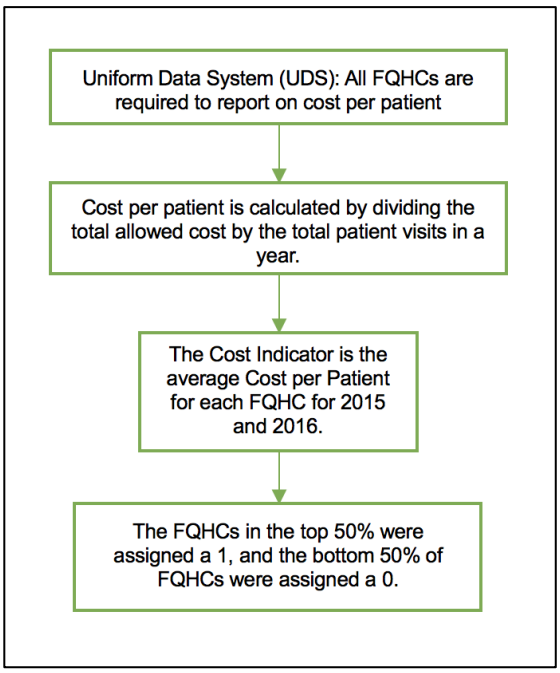
Source: Created by evaluation team based on Based on UDS information.

Figure 2: Determining the Patient Experience Indicator



Source: Created by evaluation team based on Patient Experience Survey created by the Clinical Performance Improvement Committee at the NMPCA

Figure 3: Determining the Cost Indicator



Source: Created by the evaluation team based on UDS information.

3. Data Analysis and Results

Once we compiled all the data, we took the averages of the Triple Aim measures. In the case of cost per patient, we averaged the 2015 and 2016 costs. For patient experience, we averaged the 5 question percentages for 2015 and 2016, respectively, and then we averaged the years together to get a single percentage for each organization. Finally, we averaged the hypertension and diabetes measures for each year respectively, and then we averaged the years. That created one number in the form of a percentage for each Triple Aim measure that yielded a single percentage per organization as indicator of health outcomes.

Two FQHCs were missing either the patient experience indicator because they conduct their own patient experience surveys and do not share their data with the NMPCA.

We excluded the cost indicator for two organizations. One organization, a FQHC Look-Alike, does not receive federal funding. Therefore, that organization does not have the federal funding to spend more on its patients, resulting in much lower costs. A second organization includes non-health services in its patient count, which artificially lowers the cost.

We then sorted each organization into whether they were a high or low performer based on whether they were in the top 50% percent or the bottom. If they were in the top for one measure, they were assigned a 1. If they were in the bottom, they were assigned a 0. Then we sorted the clinics by total number of measures for which they received a 1. This left some clinics achieving top performance in 0

measures, 1 measure, 2 measures, and one clinic with 3 top achievements. Missing or compromised data by some organizations resulted in exclusion for that measure when calculating top performance. No organization was missing more than 1 measure.

The Triple Aim framework used by the evaluation team defines a high performing practice as being a top performer in two or more of the Triple Aim indicators. Eight FQHCs rated as high performing practices, and the remaining 10 rated in the low performing group.[1] (See Appendix B.)

The second portion of the analysis compared the top and bottom performers against their participation in the NMPCA offerings. The one FQHC that ranked as a top performer for all three measures attended 30 offerings. FQHCs ranked as top performers in two measures attended an average of 26 offerings. Those in the top group for one measure attended an average of 23 offerings. And those with no top ranking attended an average of 16 offerings. (See Figure 4 and Appendix B.)

We ran a t-test to see if differences between high and low performers in offerings attended and the total number of people attending were statistically significant. The results showed that high performers in the Triple Aim attended more offerings than low performers, and that the difference was statistically significant.

Higher performers also sent more people in total to offerings, but the difference was not statistically significant. We also ran regressions of Triple Aim performance rank on offerings attended and total attendance, with and without controls for whether the clinic served rural populations, the homeless and Native populations, with similar results.

We also explored several other questions.

Drive time and distance: A question arose that is especially pertinent in a rural and frontier state: Does distance to the NMPCA or the drive time to the NMPCA correlate to achievement in the Triple Aim framework? There was no statistically significant relationship between either drive time or distance and performance outcomes of the FQHCs and participation.

Urban/Rural: Patient experience scores were higher in rural areas as compared to urban areas.

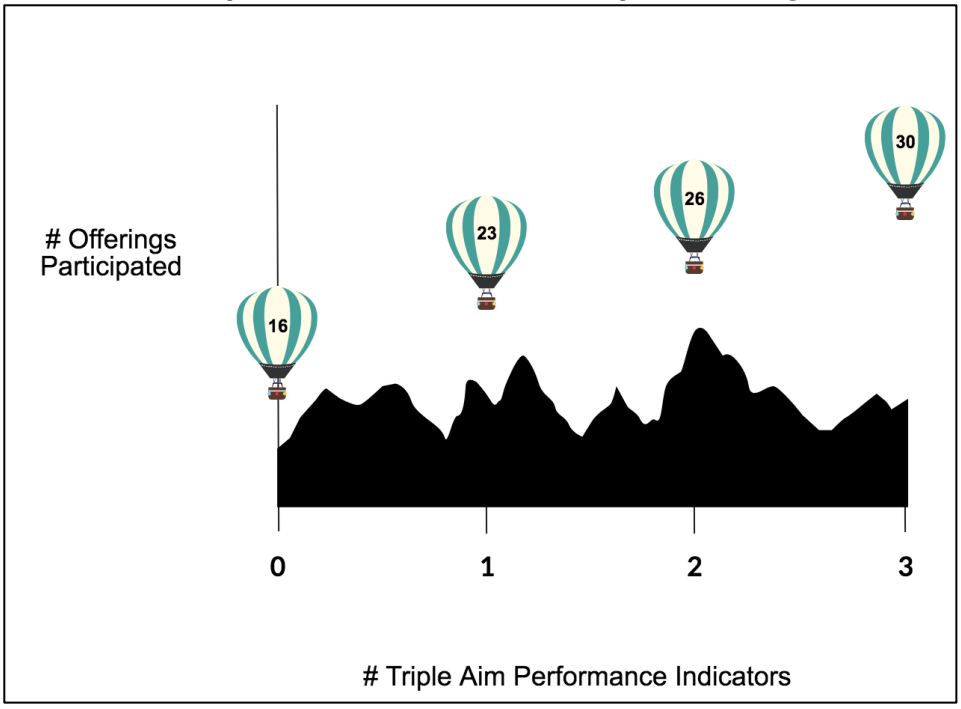
At risk populations: By labeling the clinics in terms of at risk populations, we looked at whether having a majority of patients at an FQHC come from an at-risk population, such as Native Americans or the homeless, correlated to performance outcomes in the Triple Aim framework. We found a direct

[1]One of the organizations with missing cost data could potentially be considered a high performing practice because they have met at least one high performance indicator. Neither of the two organizations with no patient experience data would have the ability to be considered high performing practices because they did not score high performance in other two indicators the evaluation team measured.

relationship between performance outcomes and at-risk populations being that the at-risk populations correlated to low performance outcomes.

Number of attendees versus simply attending the NMPCA offerings: In examining the participation data, the evaluation team wanted to know if there was a significance to sending more people from an FQHC vs simply sending representation of any kind. There was a slight relationship between sending higher numbers of attendees, but there was much stronger relationship to the Triple Aim performance indicators with simply sending representation no matter the quantity.

Figure 4: Relationship Between NMPCA Participation & FQHC Performance



Source: Created by evaluation team based on NMPCA data.

4. Recommendations

To embed evaluation into the NMPCA, the UNM team recommends implementation of an annual or biannual evaluation that replicates the data collection methods and analysis of this evaluation. To make this as easy as possible, organizing all sign- in sheets into Excel documents after a meeting, conference, or training takes place would be quite helpful. Finally, to ensure a complete data set to give each organization full opportunity to have their achievements in the Triple Aim reflected in the data, it would be useful to encourage organizations with missing patient experience data to share or use the NMPCA's survey. For example, since the NMPCA administers the patient experience survey, it would be helpful to encourage clinics who opt out of the survey to participate or share data that corresponds with the 5 questions that

compose the Patient Experience Indicator. Regarding to the Cost per Patient Indicator, it would be useful to address the importance of accurate reporting of cost per patient to the UDS by educating clinics on calculating the data correctly.

5. Next Steps

For continued evaluation, the NMPCA may want to measure the next dimension of the Quadruple aim, Joy of Work. The Quadruple Aim adds Joy of Work which as an important component because clinician burnout directly and measurably impacts the three indictors of the Triple Aim (Bodenheimer 2014). Clinician burnout is a symptom of an absence of Joy of Work.

Joy of Work may be measured by interviewing staff in a couple of FQHCs and/or conducting focus groups and using the information to develop a survey for all the clinics. Joy of Work can be difficult to measure because it is a feeling or experience and therefore is very subjective. However, the Patient Experience Indicator is largely derived from a series of subjective questions, so it stands to reason that Joy of Work can also be measured.

References

AHRQ – Agency for Healthcare Research and Quality. 2017. “Defining the PCMH.”. Accessed November 6th, 2017. https://www.pcmh.ahrq.gov/page/defining-pcmh

Bodenheimer, Tom. “The 10 building blocks of high-performing primary care.” *National Center for Biotechnology Information*. 2014. Accessed September 25th, 2017. https://www.ncbi.nlm.nih.gov/pubmed/24615313

IHI – Institute for Health Improvement. 2017. “The IHI Triple Aim.” Accessed November 6th, 2017 http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Appendix A: NMPCA Logic Model

Logic Model

Inputs	Activities	Outputs	Outcomes	Impacts
330 Grant	Uniform Data Set Data Collection and Reporting	Number of participants at New Mexico Primary Care Association meetings, trainings, technical assistance offerings	Increase Federally Qualified Health Center embodiment of the spirit of the Patient Centered Medical Home model	Staff is satisfied with the care they provide to patients.
New Mexico Primary Care Association Staff	Clinical Performance Improvement Committee Meetings (5X year), Training, Peer Learning Opportunity	Number of patients completing the patient experience survey	Federally Qualified Health Centers will clearly demonstrate improved efficiency in their care delivery systems.	Patients are satisfied with the care they receive.
Federally Qualified Health Center Staff	Training and Technical Assistance		Federally Qualified Health Centers will clearly demonstrate improved quality in their care delivery systems.	Individual staff members are happy to go to work.
Patient Centered Medical Home Best Practice Model	Projects to further implementation of PCMH model (i.e. Cancer/Diabetes/Heart Disease with Department of Health)		Increase in the number of unique patients.	Federally Qualified Health Centers recognize the New Mexico Primary Care Association as a valuable resource.
New Mexico Primary Care Association Environment that facilitates shared learning and problem solving	Development of staff satisfaction measurement		Increase in the patient satisfaction measurement.	
Contract Funding				

Beliefs	The Federally Qualified Health Centers are using the check box method of Patient Centered Medical Home, but they are not applying the principals of Patient Centered Medical Home. Clinics with strong leadership are more likely to embody Patient Centered Medical Home model. When the Patient Centered Medical Home model is fully implemented, the health center operates more efficiently and with greater staff satisfaction, and patients have more access to care, better quality of care, and continuity of care.
Barriers	Clinics find changes to be difficult. Rural areas have less access to robust hiring pool of leadership. Capacity to implement model--lack of skills, time, people. The only encounters that are tracked are with billable providers.

Appendix B: Clinic Triple Aim Measures, Performance, and Attendance at NMPCA Offerings

Clinic Code	Triple Aim Measures			Clinics in Top Half of Distribution			Measures in Top Half of Distribution	Participation at NMPCA	
	Health Outcomes	Cost per Patient	Patient Experience	Highest Health	Lowest Cost	Best Patient Experience		Number of Offerings Attended	Average Gross Attendance
9	.704	$884	.826	X	X	X	3	30	152
3	.730	805	.750	X	X		2		
4	.725	1,047	.775	X		X	2		
13	.649	901	.822		X	X	2		
8	.693	686	.742	X	X		2	26	127
10	.678	1,321	.762	X		X	2		
14	.721	1,059	.824	X		X	2		
17	.669	1,294	.805	X		X	2		
2	.478	1,531	.797			X	1		
5	.656	NA	.708	X	NA		1		
18	.620	NA	.757		NA	X	1		
12	.798	1,347	.685	X			1	23	121
15	.651	675	.728		X		1		
7	.599	859	.747		X		1		
11	.642	831	NA		X	NA	1		
6	.649	1,038	.752				0		
16	.545	2,471	NA			NA	0	16	65
1	.431	1,642	NA			NA	0		

Note: Each clinic is assigned a code to ensure confidentiality. Each clinic is grouped based on # of High Performance Indicators from high to low. 5 clinics are missing data in a single category. The Evaluation Team omitted the Cost per Patient data for clinics 5 and 18. Clinic 5 was removed because of the way they receive federal funding which gives them an unusually low cost value. Clinic 18 was removed because the Evaluation Team did not trust the cost due to the clinic's addition of services to the cost calculation outside of the prescribed criteria of inclusion. Clinics 11, 16, and 1 either did not collect or share their data with the NMPCA.