2017-2018

Evaluation Plan for The New Mexico Primary Care Association

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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 over 160 primary care, dental, school-based and behavioral health clinics throughout New Mexico. NMPCA has a full-time staff of 20 employees located in Albuquerque and 10 employees 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, boards, and community members;
- 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.

(New Mexico Primary Care Association, 2017)

Through training, technical assistance, facilitation, data storage, coaching and other services NMPCA's primary goal is to assist the Federally Qualified Health Centers to provide accessible and high quality healthcare for all New Mexicans, focusing on vulnerable populations. See appendix A for more information about the health centers that NMPCA supports.

2. Purpose of Evaluation

Upon deliberation and thoughtful discussions, key stakeholders of the New Mexico Primary Care Association and the UNM Evaluation team created a logic model and decided to evaluate the Patient Centered Medical Home Model as realized by the FQHCs in New Mexico and the NMPCA's involvement in helping the FQHCs to achieve the embodiment of the model.

3. **Logic Model**

The New Mexico Primary Care Association (NMPCA) seeks to understand its impact on the implementation of the Patient Centered Medical Home (PCMH) on the seventeen Federally Qualified Health Centers (FQHCs) in the State of New Mexico. PCMH is a framework intended to improve the organization and implementation of health care in clinical settings (AHRQ, 2017).

Key literature informs the PCMH model frameworks for FQHCS and evidence exists to support the PCMH model in achieving the Triple Aim: cost savings, patient experience and improved population health. 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.

While the evidence demonstrates improved outcomes in relation to the Triple Aim, some uncertainty remains. For example, it is unclear if early adopters of the PCMH model were already highly functioning organizations. Also, PCMH is a model of ideals and values but is measured by NCQA in the form of a checklist. It is doubtful that the checklist fully encompasses the true intent behind PCMH. In addition, the checklist does not include Joy of Practice, which has been identified as part of the Quadruple Aim and an important factor in preventing clinician burnout, and NCQA recognition does not capture patient experience. See Appendix B for a review of the literature.

Figure 1. 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.

4. Context

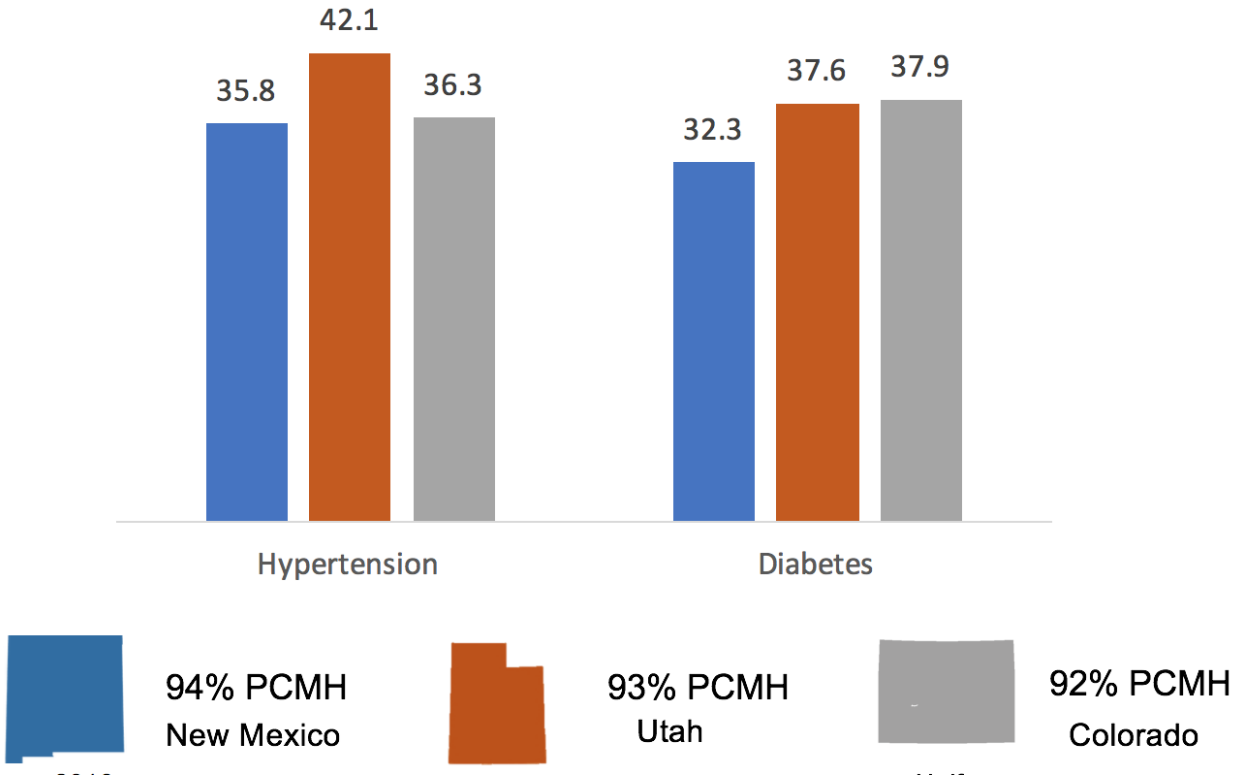
FQHCs exist in every state as do federally funded organizations, such as the NMPCA, which provide training and technical assistance to the FQHCs. Therefore, we chose Utah and Colorado for comparison with New Mexico as neighboring states with large rural areas and some overlap in population demographics.

The Uniform Data Set (UDS) is a collection of data on the 16 health measures each FQHC is required to report to Health Resources and Services Administration. From the UDS we chose uncontrolled hypertension and uncontrolled diabetes as the measures to compare between states, as they are both prominent healthcare issues in all three states.

New Mexico has a significantly lower rate of uncontrolled diabetes compared with its neighbors, Utah and Colorado. In New Mexico, the uncontrolled diabetes rate is 32%, compared with 38% in Utah and Colorado. The rate of uncontrolled hypertension is slightly lower in New Mexico, at 36%, compared with 38% rates in Utah and Colorado. (See Figure 1.)

More than 90% of the FQHCs in the three states have achieved the designation of PCMH. (See Figure 1.)

Figure 1. PCMH Adoption and Rates of Uncontrolled Hypertension and Uncontrolled Diabetes within the FQHCs



Sources: 2016 Uniform Data System, New Mexico Primary Care Association, Colorado Community Health Network, Association for Utah Community Health.

5. Evaluation Team and Other Stakeholders

The stakeholders in the New Mexico Primary Care Association who are participating in the evaluation are:

- Eileen Goode, CEO
- Karen Sakala, Director of Clinical Programs and Data
- Terry Schleder, Clinical Quality Specialist
- Brandi Peres, FQHC Representative from Albuquerque Healthcare for the Homeless

The UNM team consists of Team Lead Sonia Bettez, Senior Fellow Amy Hawkins, and Fellow Audrey Cooper.

The Clinical Quality Team at the NMPCA along with Eileen Goode, CEO, have demonstrated their commitment to the FQHCs and the organization itself through the pursuit of this evaluation. In seeking to understand the impact of the Clinical Quality Team's work with the FQHCs, the NMPCA is actively trying to understand how to better serve the communities of New Mexico. Additionally, in adding a representative from an FQHC, the NMPCA shows dedication to an open and honest process, and includes a voice from the clinics' side. The NMPCA has put together a dedicated group that has committed time and energy through regular meetings and discussions with the evaluation team.

6. Evaluation Activities and Timeline

The 2017-2018 Evaluation will entail identifying data that is already being collected by the NMPCA and data that is publically assessable to the NMPCA that can be used to start answering the evaluation questions using the Triple Aim as a framework. The NMPCA administers a biannual patient experience survey to most of the FQHCs in the state and analyses the data on behalf of the FQHCs. From these 16 measures, we chose uncontrolled diabetes and uncontrolled hypertension because they represent two major health indicators for New Mexico. The evaluation team will also look at cost per patient at each FQHC.

Additionally, the NMPCA keeps record of all FQHCs and their representatives who attend NMPCA trainings, conferences, meetings, and other functions. The evaluation team will use this information to see if there is a relationship between the achievements of patient experience survey data, key UDS measures, and cost per patient with the level of participation each organization engages in with the NMPCA.

As mentioned earlier, the key evaluation questions are:

- Are the Federally Qualified Health Centers truly embodying the Patient Centered Medical Home Model?
- And if so, is the NMPCA instrumental in the embodiment of the model?

To answer the evaluation questions, the UNM team will:

A. Review Patient Experience Questions to discern which ones can be identifiers of patient satisfaction as indicators of embodiment of the PCMH model
B. Collect or compile existing data regarding Joy of Work and staff satisfaction of employees and staff at the FQHCs because of practicing the PCMH model
C. Analyze data about FQHCs regarding the utilization of NMPCA resources and services by aggregating attendance records such as sign in sheets from the trainings, conferences, peer groups, and technical assistance visits from 2015 and 2016.
D. Identify possible additions to NMPCA processes of data collection to include the gathering of data on a regular basis that can be evaluated and tracked for Joy of Work within the FQHCs.
E. Compile existing data from the Uniform Data Set for cost per patient, uncontrolled diabetes, and uncontrolled hypertension to be used to compare with FQHCs' utilization of NMPCA as a resource

Timeline for 2018 Evaluation Activities

January
Meet with the NMPCA & UNM full Evaluation Team to look at the data that has been aggregated to date. These data include the complete attendance record for participation by the FQHCs, cost per patient, patient experience questions, and Uniform Data System measures on uncontrolled hypertension and diabetes.

February
Review and analyze data.

Meet with NMPCA & UNM full Evaluation Team to discuss data analysis thus far and possibly present initial data analysis findings. Determine next steps for data analysis and any questions that arose from the findings that are not yet answerable.

March
Complete data analysis.

April 13
Complete draft of report shared with NMPCA.

April 27
Evaluation Lab Workshop at UNM – NMPCA project shared with other Evaluation Lab partners and community members.

May
Complete final text of report incorporating NMPCA feedback.

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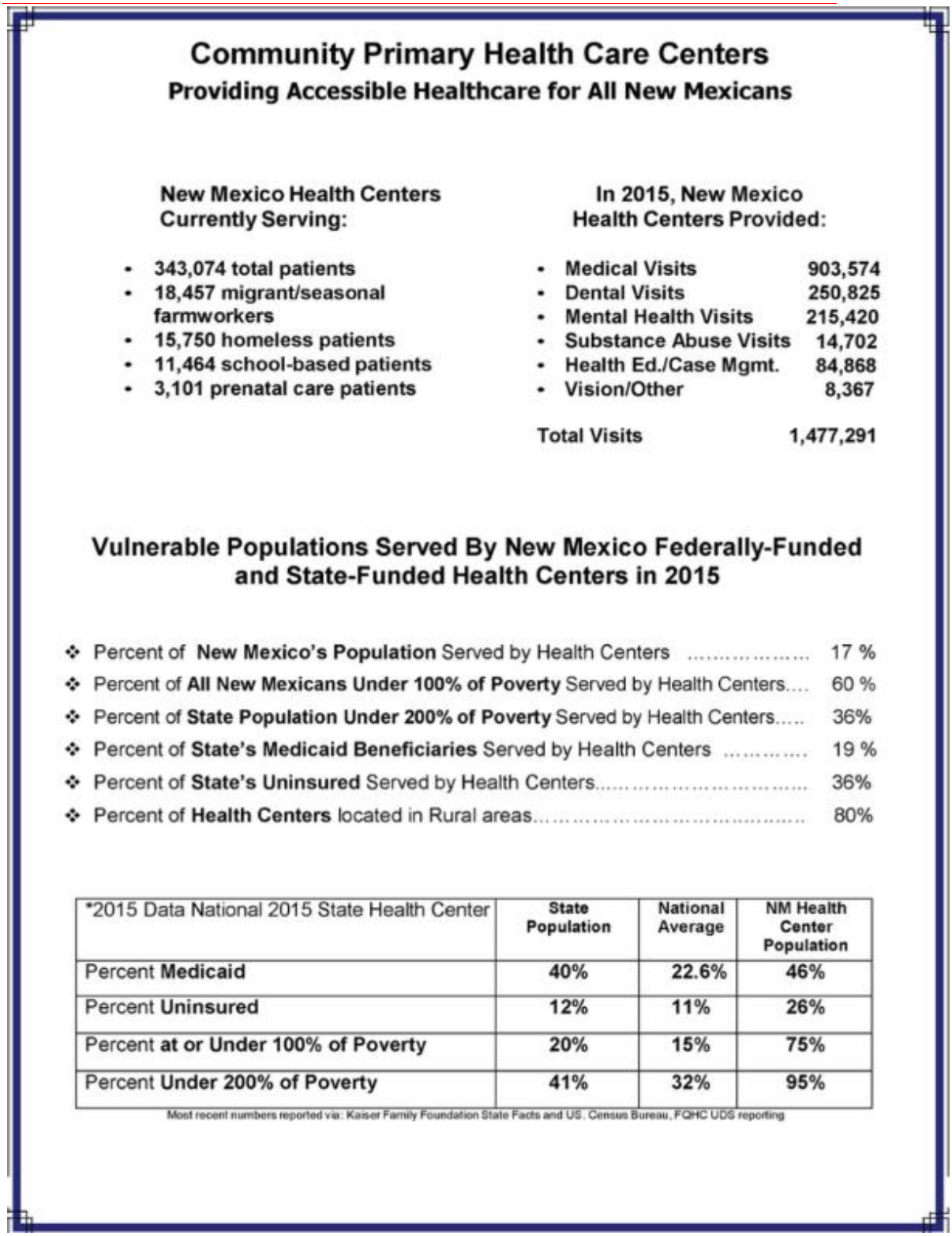
Appendix A: Community Primary Health Care Centers Fact Sheet



Community Primary Health Care Centers

Providing Accessible Healthcare for All New Mexicans

New Mexico Health Centers Currently Serving:

- 343,074 total patients
- 18,457 migrant/seasonal farmworkers
- 15,750 homeless patients
- 11,464 school-based patients
- 3,101 prenatal care patients

In 2015, New Mexico Health Centers Provided:

Medical Visits	903,574
Dental Visits	250,825
Mental Health Visits	215,420
Substance Abuse Visits	14,702
Health Ed./Case Mgmt.	84,868
Vision/Other	8,367
Total Visits	1,477,291

Vulnerable Populations Served By New Mexico Federally-Funded and State-Funded Health Centers in 2015

- Percent of **New Mexico's Population** Served by Health Centers ..... 17 %
- Percent of **All New Mexicans Under 100% of Poverty** Served by Health Centers.... 60 %
- Percent of **State Population Under 200% of Poverty** Served by Health Centers..... 36%
- Percent of **State's Medicaid Beneficiaries** Served by Health Centers ..... 19 %
- Percent of **State's Uninsured** Served by Health Centers..... 36%
- Percent of **Health Centers** located in Rural areas..... 80%

*2015 Data National 2015 State Health Center	State Population	National Average	NM Health Center Population
Percent **Medicaid**	40%	22.6%	46%
Percent **Uninsured**	12%	11%	26%
Percent **at or Under 100% of Poverty**	20%	15%	75%
Percent **Under 200% of Poverty**	41%	32%	95%

Most recent numbers reported via: Kaiser Family Foundation State Facts and US. Census Bureau, FQHC UDS reporting

Source: New Mexico Primary Care Association. (2017). Fact sheet. Retrieved November 9, 2017, from http://www.nmpca.org/fact-sheet.html.

Appendix B: Literature Review

INTRODUCTION

The New Mexico Primary Care Association (NMPCA) seeks to understand its impact on the implementation of the Patient Centered Medical Home (PCMH) on the seventeen Federally Qualified Health Centers (FQHCs) in the State of New Mexico. PCMH is a framework intended to improve the organization and implementation of health care in clinical settings (AHRQ, 2017). Understanding the recent history of the health care landscape within the United States as well as how the PCMH model was identified and implemented in the clinical setting helps clarify the evolution of the model itself.

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.

This review examines the literature on high functioning practices and practice transformation, and considers other themes and frameworks that inform the narratives in health care improvement.

THE ROAD TO THE PATIENT CENTERED MEDICAL HOME

PCMH is a framework intended to improve the organization and implementation of health care in the primary care clinical setting. The framework identifies five core functions and attributes: patient-centered, comprehensive, coordinated, accessible, and committed to quality and safety (AHRQ, 2017). Where do these attributes come from?

In the 1990s, a medical doctor named Edward Wagner began looking at the model of health care in the United States and characterized primary care systems as:

> designed to provide ready access and care to patients with acute, varied problems, with an emphasis on triage and patient flow; short appointments; diagnosis and treatment of symptoms and signs; reliance on laboratory investigations and prescriptions; brief, didactic patient education; and patient-initiated follow-up. (Wagner 1998; p. 2)

This approach to care presumed that patients would not be coming back unless their acute illness or injury worsened. However, with the rise of endemic chronic illnesses such as diabetes and heart disease, the acute care model was falling short in meeting patient needs. Wagner proposed a Chronic Care model to address areas that were lacking such as quality visits, patient education, and coordinated care. Wagner's model helped to lay the groundwork for PCMH.

Along with the Chronic Care model, PCMH was also informed by the Triple Aim. This term was coined by the Institute for Healthcare Improvement which is headed by Don Berwick, another critical thinker and architect of today's health systems. The Triple Aim is itself a framework purposed 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). The Triple Aim has three components:

1. Population health,
2. Patient experience, and
3. Per capita cost of care.

THE HIGH PERFORMING PRACTICE

The NMPCA often cites the work of doctors Tom Bodenheimer and Christine Sinsky as foundational theorists in the work of high performing practices. Bodenheimer (2014) writes about the need for one more element to move from the Triple Aim to the Quadruple Aim; this element is Joy in Practice. Bodenheimer argues that the Triple Aim falls short in the key problem area of clinician burnout. Because clinician discontent is linked to poor outcomes in each of the elements of the Triple Aim, Joy of Practice must be considered a critical element. Bodenheimer's analysis is observational, as he quotes oft heard physician complaints, and he presents evidence that burnout is associated with worse health outcomes and poor patient experience to make the common-sense case that clinician burnout is part of addressing the Triple Aim.

Based on Bodenheimer's assessment of the healthcare landscape and newly coined concept of the Quadruple Aim, Sinksy conducted site visits to 23 high-functioning primary care practices meeting at least one of the Triple Aims. Sinksy used the following criteria to define her choice of practices:

1. The majority were recently PCMH recognized,
2. They exhibited good use of their electronic health record systems, and
3. They engaged in quality reporting to Medicare using the Physician Quality Reporting System (Sinsky, 2013).

Most of the observations consisted of a day's worth of shadowing clinical care teams including clinicians and staff. Sinsky's team also met with administrative staff and managers.

Sinsky discovered three main characteristics of high functioning practices:

1) Team based care,
2) Pre-visit planning, and
3) Work-flow mapping.

Team based care requires that the provider, medical assistant, nurse, front desk, or any combination of clinical staff work together with the patient to plan the patient care for the visit, arrange for the patient to receive all intended services, and ensure that the patient has strong follow up with the staff. Team based care increases quality and efficiency.

Pre-visit planning requires the team to assemble to review the patient health record and care plan and determine what the patient needs for services for that given day's visit.

Work-flow mapping is the way the team determines what needs to be done for the day's visits, who will perform which tasks, and how the tasks will be performed. Sinsky's findings point to redistribution of human capital: By taking the pressure off the clinician to handle all the patients' needs, staff have more equitable and satisfying work and support a clinician who is not overburdened with responsibility.

Bodenheimer used an iterative process to pull common themes from Sinskey's notes about each practice to create ten building blocks of high performing practices. Bodehneimer also compared the observational findings to nationally recognized emerging research and publications around concepts such as PCMH. The ten building blocks are:

1. Engaged leadership,
2. Data-driven improvement,
3. Empanelment,
4. Team-based care,
5. Patient-team partnership,
6. Population management,
7. Continuity of care,
8. Prompt access to care,
9. Comprehensiveness and care coordination, and
10. Template of the future—a means of scheduling patients for just the right amount of time to do justice to their needs.

The NMPCA staff and community partners often promote the ten building blocks in trainings and as components of community projects in the clinic setting.

IMPLEMENTATION OF THE PATIENT CENTERED MEDICAL HOME MODEL & PRACTICE TRANSFORMATION

When a primary care clinic goes through the process of becoming a PCMH, they describe the process as Practice Transformation. As PCMH became a standard framework for clinics across the country, the National Committee for Quality Assurance (NCQA) assembled criteria for PCMH. The criteria are:

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 is a private nonprofit focused on quality improvement in health care. NCQA offers a service to evaluate and bestow a nationally honored recognition of PCMH to individual health centers. Level 3 PCMH is the highest level a practice can attain and encompasses excellent infrastructure and outcomes geared at meeting the Triple Aim (NCQA, 2017). NCQA was the first organization to formally designate PCMH.

However, NCQH uses a checklist approach to certifying that a clinic is a PCMH. The main concern with the checklist is that it renders PCMH as a one-dimensional concept—either an organization has achieved a certain aspect of the checklist or it has not. This limits the art of management and clinical practice and does not allow for nuance or the difficulty of pinning down elements of PCMH such as the feeling when walking into an organization. The checklist approach ignores Joy of Practice. How can a checklist measure such a strong feeling as joy?

Kern (2016) conducted a prospective cohort study between the years 2008-2012 of the PCMH model in terms of quality of care and the different uses of electronic health records and paper charting for 226 practices in the Hudson Valley region of New York State. Kern used three groups in the study: 12 practices with NCQA Level 3 PCMH using electronic health records, 45 practices without PCMH recognition using electronic health records, and the 169 practices with paper records and not PCMH. The groups were then compared on 7 utilization measures, for example primary care visits, emergency room visits, diagnostic tests ordered, and 8 quality measures such as breast and colorectal cancer screenings.

Kern found that practices with Level 3 PCMH recognition scored higher on 2 of the 7 of the utilization measures, and on 2 of the 8 quality measures.

Kern's study provides some evidence for the effectiveness of the PCMH, but the evidence is tempered by the fact that the NCQA checklist does not necessarily capture the true embodiment of PCMH. It is possible that the results would have been more dramatic had Kern been able to identify when the PCMH model was implemented in value and mission rather than just by the checklist.

In another study, Friedberg (2015) aimed to assess whether PCMH-recognized practices performed better in cost savings, patients' use of emergency, hospital, and clinical outpatient services, and the quality of care related to diabetes and preventative screenings. 27 practices volunteered to pursue PCMH designation through the NCQA. These newly designated practices were compared with 29 practices that did not pursue the PCMH designation.

Two commercial health plans provided data related to costs and care. Friedberg found that the 27 pilot organizations had better outcomes in diabetes and preventative care than the 29 comparison practices. PCMH practices also had lower costs as demonstrated by lower utilization of hospital and emergency services. Friedberg's study does not discuss how clinics were assigned to which groups, and that begs the question: Did clinics with more motivation sign up to be in the pilot group? Presumably, the pilot clinics experienced practice transformation during the NCQA recognition process, but it is also possible that the clinics in the pilot group were already practicing in the framework of PCMH. This leaves uncertainty about whether adopting the PCMH model through the NCQA recognition process is responsible for improved outcomes.

CONCLUSION

As is discussed above, several theorists have put together thoughtful frameworks to organize the PCMH model into something that is useful, comprehensive, and transformative. Understanding the Triple Aim, Quadruple Aim, and Bodenheimer's building blocks clarifies what PCMH seeks to achieve beyond the NCQH PCMH checklist-based recognition. For the NMPCA, the utility and accessibility of resources around the theory and implementation of PCMH helps the NMPCA inform and coach FQHCs in the how to implement PCMH effectively.

Existing research provides some support for the association between PCMH and improvements in the elements of the Triple Aim. This is exciting news for the NMPCA and the FQHCs because it suggests that the PCMH model works. However, there are lingering questions: Do clinics that pilot PCMH already have excellent practice models? Are there better ways to measure success such as randomly assigning clinics to PCMH practice? Is it too late to assess practice transformation if clinics are already recognized by an organization such as NCQA?

Arguably, if you read Bodenheimer's work or Sinsky, the heart and soul is what drives excellent practices. Joy of Practice is hardly achieved through a checklist.

Recommendations for the NMPCA include constructing an evaluation around outcomes measures of Joy of Practice for staff and clinicians and comparing patient experience and patient satisfaction to clinical outcomes and utilization. These measures go beyond the checklist, and understanding their impact on the other Quadruple Aim outcomes such as cost per patient and Uniform Data Set health measures could have a profound influence on how the NMPCA helps train FQHC staff on how to maximize quality of patient care. If high measures of Joy of Practice and patient experience correlate to high measures of UDS and cost per patient, the NMPCA's focus could shift to coaching on increasing joy and satisfaction of the staff and patients.

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