

Envision NM 2008/2009

Assessing the Capacity of SBHCs for Participation in a Quality Improvement Initiative Report #1: Selection of Sites

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Overview

Envision New Mexico (ENM), in partnership with the NM Department of Health, Office of School and Adolescent Health (NM DOH/OSAH), is engaging School-based Health Centers (SBHCs) in New Mexico in a Quality Improvement Initiative (QII). The objective of Envision NM is to improve pediatric healthcare through use of the Model for Improvement (MFI) to promote systems change and utilization of best practices around a variety of pediatric healthcare issues. Quality improvement builds upon providers' current knowledge base and interest in improvement, and provides training and skill development to implement changes that result in sustainable improvements in care. The ENM QII is a multi-year process to enhance knowledge of specific pediatric best practices, and to build capacity for improved pediatric care for Medicaid-eligible children and youth throughout the state. Specific QII initiatives offered this school year include: 1) Pediatric Obesity Prevention and Treatment, 2) Teen Lifestyle Change (TLC) program, 3) Behavioral Health, 4) Improved Clinical Practice, and 5) Community Collaboration.

This report covers the initial contact and assessment for capacity for all OSAH supported sites throughout New Mexico, and describes the process of bringing together the data gathered from the sites with decision making about what and how the data could be used to guide selection of the site for quality improvement.

Based on the experiences of the 2007/2008 QII, it was clear that not all SBHCs have the same capacity to successfully engage in the intensive QI initiatives provided by Envision NM. Since quality improvement activities are time intensive, staffing levels and other resources were thought to be the key factors that would differentiate sites. Moreover, Envision NM has the resources to support QI in approximately two dozen sites. This recognition led to a structured process to assess capacity of sites and use this information in recruitment decisions for 2008-2009. Envision NM incorporates the use of both *Model for Improvement*¹ and *Motivational Interviewing*² as tools for QI in our initiatives. We utilized the principles of both of these tools to guide the screening and recruitment process.

The assessment strategy leading to the identification of a sub-set of sites for QII was based on a series of steps:

- 1) Initial assessment of site characteristics and capacities (telephone survey; see Attachment A)
- 2) Review and prioritization of sites by key capacities (especially provider resources)
- 3) Assessment of site readiness and QII preferences (telephone survey; see Attachment B)
- 4) Final selection and assignment of sites to specific initiatives

The Model for Improvement

The Model for Improvement is a simple yet powerful tool for accelerating improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes. The model has two parts:

- Three fundamental questions:
 - What are we trying to accomplish? (What is the AIM?)
 - How will we know that a change is an improvement?
 - What changes can we make that will result in an improvement?

¹ Gerald Langley, K.N., Thomas Nolan, Clifford Norman, Lloyd Provost, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 1996, San Francisco: Jossey-Bass

² Miller, W. R. & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change*. The Guilford Press: New York.

- The Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.

PDSA cycles are a data-driven, fluid process and the information gained in one cycle feeds the development of the next cycle. Attachment C provides a detailed outline of the steps taken in this process of screening sites for participation in the QII.

The AIM: Using the tools of QI, we aim to identify indicators that increase the likelihood of success of SBHCs participating in a QII with Envision NM.

Use of Motivational Interviewing (MI) Readiness Scale

Motivational Interviewing is a communication technique designed to facilitate behavior change. Envision NM offers training in MI as a part of the QII. One tool used in MI is the “Readiness Scale.” We used this scale in the site screening process (Attachment B) to assess sites’ readiness to engage in QI, readiness to participate in QI with Envision NM, and confidence in ability to participate successfully in the QI process. Sites that indicated some level of readiness to change were identified as amenable to the practice change process of the QII

Capacity in SBHCs related to QII at ENM

The purpose of any quality improvement initiative is to improve performance in the targeted area. Critical to the accomplishment of this purpose is the capacity of those involved to participate and respond to the ongoing process of quality improvement. Experience suggested that not all SBHCs were equally prepared to successfully engage in quality improvement. Moreover, limits of program capacity at Envision NM meant that not all SBHCs could be included in intensive quality improvement initiatives this year. The objective of screening and assessment was to best match the potential for quality improvement within the SBHCs to the opportunities available through Envision NM.

From review of our previous work with NM SBHCs, two features of capacity emerged:

- capacity to actually function fully as a SBHC with all the applicable operating procedures in place, and
- capacity (or potential ability) to move beyond basic operations towards ‘best practice’ performance.

The goal for performance is clinical care and operations that include implementation and consistent use of evidenced-based “best practices”.

In an attempt to identify those SBHCs that provide basic medical care and possess the capacity to move toward “performance” as measured by “best practice” outcomes, Envision NM developed an iterative process of screening and selection based on measures of capacity. Initial screening via a telephone survey was designed to assess components of capacity that included:

- Compliance with select ‘standards of practice’ defined by the New Mexico Department of Health
- Measures of resources or assets available within each site (funding, staffing, scheduled availability of services)

A follow up call focused on more subjective elements of capacity such as interest (since participation was voluntary) and more specific measures of “Readiness to Change” and “Confidence” in ability to succeed with the initiative.

OSAH Standards

OSAH provides standards and guidelines for the establishment and development of an SBHC. A complete listing of these standards can be found in a publication called “*Opening a School-based Health Center, A How-to Guide for New Mexico SBHC Coordinators*”, produced in 2005 by the NM Department of Health, Office of School Health and the NM Assembly on School-based Healthcare.³ Envision NM reviewed these standards and selected 27 that would provide a snapshot of the current standard of practice at a given site. These items were included in the initial telephone survey.

Step 1: Initial Assessment of NM DOH Supported SBHCs

A total of 59 State supported SBHCs were identified for an initial interview about their operations and capacities. While all 59 sites received financial support from OSAH, 7 sites are also affiliated with Indian Health Service facilities, 10 with universities, and 17 with federally qualified health centers. From the initial list of 59 sites that could potentially participate with ENM, contact was made and surveys were completed with 55 sites. The 4 sites not included in the survey results were not active and/or did not respond to repeated attempts to contact them. These 55 SBHCs are located throughout New Mexico in 47 communities and 29 counties. Table 1 (attached) lists these sites by community, county, and zip code.

Staffing: Administrative

Each SBHC has a designated Coordinator in addition to varying medical, behavioral health, and other support staff. We asked about the on-site hours, number, and types of providers for each group of Center staff.

Table 2 (attached) provides the number of administrative and other support staff reported by each site, including the site coordinator, billing clerks, and medical assistants.

Among the 55 sites reported, the average number of on-site hours for the Coordinator was approximately 19 hours, with total administrative time averaging almost 35 hours. Half of the sites had 16 or more hours of Coordinator time on-site each week; 9 sites reported none. Only one in four sites reported more than 30 hours for the Coordinator, while one in four had 8 hours of Coordinator time, or less.

Staffing: Medical

The count of Medical providers included physicians, physician assistants, and nurse practitioners. Hours for these providers were combined into an overall Medical staffing measure. Table 3 (attached) shows the number, type and hours of service available for each SBHC surveyed.

Total medical hours for all 55 sites reporting ranged from 4 hours to 80. The average was 16.5 hours, with 25% having 8 hours or less, and 25% having 24 or more hours of Medical service per week.

Staffing: Behavioral Health

Behavioral health providers reflect a variety of disciplines, including social workers, counselors, PhDs and MDs. Table 4 (attached) lists the number, type, and hours reported for each site.

Sites averaged 20 hours of combined behavioral health services per week, with the upper 25% having 24 hours or more. The lower quartile had 10 hours or less with only 3 sites reporting less than 8 hours. Seven sites had 40 hours or more.

³ *Opening a School-Based Health Center: A How-To Guide for New Mexico SBHC Coordinators*, first edition (2005). Produced by the New Mexico Department of Health, Office of School Health, and the New Mexico Assembly on School-Based Health Care

Additional Services

In addition to the core staff for these SBHCs, 10 sites reported that services were also provided by staff employed by the school. Twenty-eight sites reported other kinds of service providers; the list includes a wide variety of roles including dental and vision screening, health educators, nutritionists, and counselors for substance abuse and smoking cessation. On average these other providers together contributed 20 hours per week to services available in the sites.

Site Operations

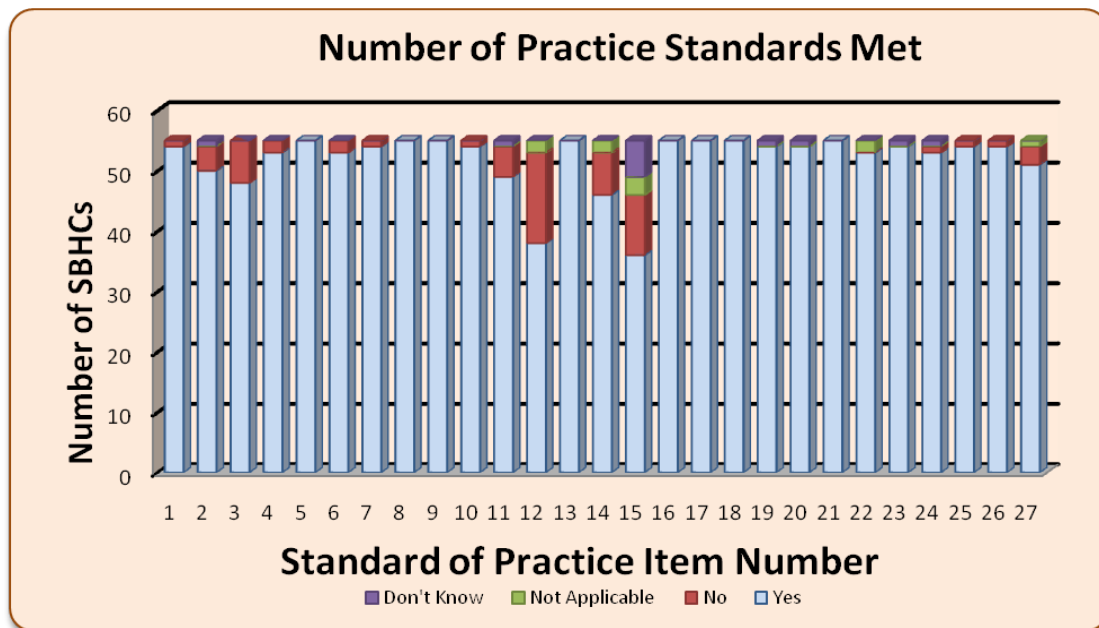
SBHCs are open from 9 to 12 months per year with most open for 10 months or more (93%) and one in five open 12 months. Sites maintain various weekly schedules ranging from 1 to 5 days, with the average being 3.3 days. Forty-five percent are open 4 or more days.

Envision NM utilizes the internet for both communication and training. Sites were asked about access and experience. All but 2 sites reported existing internet access (1 site undergoing installation), all but one was high speed service, and 37 of the 55 sites reported having had a successful experience previously participating in a web-based, e-meeting (web conferencing).

Standards of Practice

One potential indicator of the capacity of sites is the degree to which they have been able to achieve specific standards of practice defined by OSAH. As part of this assessment sites were surveyed regarding 27 standards of practice in the operation of a school based facility. The “standards of practice” items ranged from the availability of a sound proof treatment room to the use of an appointment system. The complete list of questions with corresponding item numbers can be found in Attachment A. With only a few exceptions, these SBHCs reported compliance with nearly all of these standards. Results are shown in shown in Graph 1, below.

Graph 1: Number of SBHCs Meeting Selected Practice Standards



Looking at specific standards where 5% or more of the sights fell short, the findings included sites:

- that lacked a “no-show” management system (Item #27 – 6%)
- lacking a sound proof room for patient encounters (Item #18 – 7%)
- where providers did not display current licenses and/or nametags (Item #11 – 9%)
- with facilities that lacked private phone, fax and/or email dedicated to the site (Item #3 – 12%)
- that could not verify compliance with CLIA standards (Item # 14 – 13%)
- lacking written policy and procedure for management of psychotropic medication (Item #15 – 22%)
- lacking verified compliance with New Mexico pharmacy regulations (Item #12 – 27%)

Deficiencies tended to be clustered in a limited number of sites. Two-thirds of the sites had 1 or fewer unmet standards. Table 5 (below) shows the distribution of total standards met for these 55 sites.

Table 5: Number of Standards Met in Screening for Capacity

Number of Standards Met	Number of Sites	Percent
19	1	1.8 %
20	2	3.6 %
22	1	1.8 %
23	4	7.3 %
24	4	7.3 %
25	8	14.5 %
26	12	21.8 %
27	23	41.8 %

Overall, these relatively new programs report considerable progress to establishing operations in compliance with a number of complex standards. However, these findings point to some areas for improvement. Because the great majority of sites comply with all, or nearly all, standards these measures will not be particularly useful in differentiating sites for participation in QII.

Step 2: Use of Screening Results for Site Selection

The descriptive information resulting from the first round of telephone surveys was employed to narrow the number of sites under consideration for QII this year. The process involved two discrete steps where decisions were reached in response to the data about the sites. These steps included:

- 1) Site response to the initial contact and interview. Some sites self-selected out of consideration.
- 2) Sites were prioritized by key capacities.

Based on initial responses to the survey, 12 sites were removed from consideration. The reasons are summarized in Table 6.

Table 6: Reasons for Exclusion in Phase 1

Reason for Initial Exclusion	Number of Sites	Percent
Personnel or staffing issues (e.g., no provider)	6	10.9 %
Answered “No” to 3 or more capacity questions	3	5.5 %
Not interested	3	5.5 %
Total Excluded in Phase 1	12	21.8 %

Six of these sites had vacancies in basic provider and/or coordinator positions. For this year there was simply no one to work with regarding QI at these sites, but these sites can be considered for participation in future years. Three sites answered “No” to 3 or more of the capacity screening questions, which we interpreted to mean that site did not have sufficient capacity to participate in an intensive QII. And 3 sites indicated that they were

otherwise not interested in participating at this time. This step in the selection process resulted in 43 sites remaining under consideration for the QII this year.

Prioritization of Sites by Key Capacities

Step 1, above, resulted in a pool of 43 sites for inclusion in the QII. The target, based on ENM resources, was 24-25 sites. Similar to the findings for all 55 sites, these 43 sites are typically open 3 days per week, with 7% open only 1 day each week. Most sites operated for either 10 or 11 months, with 3 open for 9 months and 10 open for 12 months. Upon review, these measures of site operations did not help to differentiate the capacity of the 43 sites to participate in QII, and were not used in subsequent analysis.

Further review of elements of 'capacity' was undertaken to narrow the range of sites prior to the second round of contacts. Information relating to capacity that could be used to prioritize sites included:

- Site Coordinator (hours on-site)
- Medical Providers (number and hours of service)
- Behavioral Health Providers (number and hours of service)
- Other Support Staff
- Number/Hours of School Staff Service Contribution

Site Coordinator

From an organization development perspective, past experience had demonstrated the importance of the Site Coordinator in serving as the focal point for QII efforts by promoting participation and organizing activities in the SBHC. Reported on-site hours per week ranged from 0 (5 sites) to 45 (1 site), with half of the sites reporting 16 or more hours.

Medical Providers

Medical provider numbers ranged from 1 to 3 per site, with nearly 2/3 of sites having 1 medical provider, 1 in 4 with 2 providers, and only 6 sites with 3 medical providers. Total hours of service for medical providers ranged between 6 and 80 hours. The median hours of service was 16. Moreover, total medical provider hours was not directly a result of number of providers, since 4 out of 5 providers were available 16 hours or less. Only 3 medical providers worked 30 hours or more.

Behavioral Health Providers

The number of Behavioral Health providers per site ranged from "0" (1 site) to "4" (1 site), with 50% having one provider. Hours of service per week ranged from "0" to "80" (1 site), with half having 16 hours or less. Again, the pattern was that sites with more hours tend to have multiple providers rather than single providers offering more hours. The median hours per provider was 10.

Other Support Staff/School Staff

Most sites have 2 administrative support staff (60%) who provide, together, approximately 36 hours per week to SBHC operations. Only 10 sites reported school staff who worked in the SBHC.

Capacity-Based Selection of Sites

Given that QII is a training program, key staff resources (Coordinator, Medical, and Behavioral Health) are conceptually most relevant to accomplishing the objectives of the program. The measures of days and months of operation, and compliance with OSAH standards either do not vary much among sites or apply to only a small number of the 43 sites under consideration.

Staff hours tend to be allocated in 8 hour blocks, meaning that providers are grouped in clusters of 8, 16, 24, etc., hours of service. Since half of the sites reported 16 hours or more of time for the Coordinator, Medical and Behavioral Health providers, this number was used to stratify sites. The QII involves extensive ongoing interaction between Envision NM staff and the staff of each SBHC. In most cases this interaction is channeled through the Site Coordinator, but it is recognized that other support staff at the site can play an important role in making things work, as well. So, a combined measure of Coordinator time plus other administrative staff time was computed. The results are in Table 7, below.

Table 7: Hours per Week (less than/greater than 16) for Each Staffing Category

Description		Number of Sites	Percent
Coordinators	< 16 hours/week	16	37.2 %
	≥ 16 hours/week	27	62.8 %
Support Staff	< 16 hours/week	4	9.3 %
	≥ 16 hours/week	39	90.7 %
Medical Providers	< 16 hours/week	12	27.9 %
	≥ 16 hours/week	31	72.1 %
Behavioral Health Providers	< 16 hours/week	12	27.9 %
	≥ 16 hours/week	31	72.1 %

Of the 39 sites with 16 or more hours of combined staff support, 29 also had 16 hours or more of Medical provider time each week. Table 8 (attached) shows the sites and related staff hours for the 29 sites. Similarly, when associated with Behavioral Health providers a group of 28 sites was identified. For Coordinator hours alone, the result would be 24 sites.

Target Group for Recruitment

The list of 29 sites (with support staff and medical providers ≥ 16 hours per week) was thought to have the best capacity to participate in QII and was viewed as a practical working list of sites to take to the recruitment phase of the QII project. Table 9 (next page) summarizes the use of SBHC screening data to prioritize sites to be included in a second telephone survey to assess the self-perceived readiness of the site to be part of QII, and to identify site preferences for program areas offered by ENM. It was expected that not all of these sites would choose to participate and that the resulting number of sites would be within the capacity of ENM to support this year.

Table 9: Screening Results: First Removed, Second Removed, and Final Group for Assessment of Readiness

Group Description	Number of Sites	Support Staff hours per week	Coordinator on-site hours per week	Medical provider hours per week	Behavioral Health hours per week	How many months open	How many days of the week	Avg Number of Capacity Standards Met
1 st Removed Group	12	29.58	18.67	10.00	19.50	10.33	3.75	24.33
2 nd Removed Group	14	25.43	11.21	10.43	18.14	10.64	2.79	25.93
Inclusion Group	29	40.97	21.66	22.62	21.90	10.48	3.41	25.76

This summary of the characteristics of the three groups formed in the selection process suggests that the key differences were few:

- First Removed Group: These sites are characterized by lower average medical provider hours, somewhat fewer behavioral health hours, but reported a larger number of support staff hours and more days of operation each week. Half of these sites were removed from consideration because of too few medical provider hours while the other half chose not to participate for reasons of their own.
- Second Removed Group: These sites had similar levels of medical provider hours and fewer behavioral health hours when compared to the Final Group. Most importantly, these 14 sites had many fewer Coordinator and total support staff hours, the primary reason they were not included in the Final Group.
- Final Inclusion Group: By definition these sites have the qualifying combination of at least 16 hours of both medical provider and coordinator time. They also have considerably more behavioral health hours.

Interestingly, these groups did not differ in any meaningful way on meeting OSAH standards. While issues around standards tend to be clustered in certain sites, those sites were equally likely to be in each of these three groups.

The following table 10 shows a breakdown of these same measures of the final group of 29 that was then given the second survey on readiness and preferences, plus the average measure of their readiness scores.

Table 10: Comparison of Final Selected and Not-selected groups by Capacity Measures and Readiness

Group Description	Number of Sites	Support Staff hours per week	Coordinator on-site hours per week	Medical provider hours per week	Behavioral Health hours per week	How many months open	How many days of the week	Avg Number of Capacity Standards Met	Avg Readi-Index
Not Selected	7	37.14	23.43	19.14	18.57	10.14	3.5	25.43	5
Selected for participation	22	42.18	21.09	23.72	22.96	10.59	3.38	25.86	24.36

The remarkable difference is in their average “Readi-index,” which is simply the readiness scores added together. This provided a clear measurement of interest in participation.

Step 3: Assessment of Site Readiness and QII Preferences

A second telephone survey was used to invite participation, assess the perceived readiness of the site to be part of QII, and to identify site preferences for program areas offered by Envision NM. It was expected that not all of these sites would choose to participate and that the resulting number of sites would be within the capacity of Envision to support this year.

These 29 sites received descriptive information about available content areas and expectations for the tasks and responsibilities of each QII initiative, along with a letter of invitation to participate in the program. This document asked sites to review the information and consider their preferences for specific initiatives, and indicated that a follow-up phone call will provide an opportunity for further discussion, for confirmation of interest, and to identify which initiatives will best suit their needs.

The brief (15 minute) interview was based on 4 questions, three of them utilizing the “Readiness” scale. That is, *“on a scale of zero to ten, with zero being not ready and ten being very ready.”*

- 1) How ready is your SBHC to participate in a quality improvement initiative?
- 2) How confident are you that your SBHC can participate in a quality improvement initiative?
- 3) How ready is your SBHC to participate in a quality improvement initiative with Envision NM?

The fourth question was: “What is your preference for QI Initiatives, in order of priority?” The choices, as indicated earlier, are 1) Pediatric Obesity Prevention and Treatment, 2) Teen Lifestyle Change (TLC) program, 3) Behavioral Health, 4) Improved Clinical Practice, and 5) Community Collaboration. The target was 5 sites per content area.

Envision NM staff reviewed the resulting data regarding site preferences and readiness, along with other commentary from the sites, and assigned sites to QII content areas. These assignments were communicated to each site, any further discussions or negotiations were completed, and a final confirmation of assignment and consent agreement was provided by written letter (postal or email) to the site.

Table 11 (attached) shows the individual responses of the 29 sites to the 3 “readiness” questions, along with an additive index that combines the three scores. This index makes the distinction among sites (Selected, Not Selected) more apparent.

For the most part, the ‘Not Selected’ sites chose to opt out of the QII, expressed in the low ‘readiness’ values of their own self-assessment. Based on the index scores there was a clear distinction between the two groups of sites. These two groups do not differ substantially on average medical, behavioral health or support staff hours. The assessment of ‘readiness’, as intended, appears to be independent of underlying staff capacity in the sites. This assessment of ‘readiness’ leaves 22 potential participants in the QII.

Step 4: Final Selection and Assignment of Sites to Specific QII Initiatives

With only a few exceptions, sites were assigned QII initiatives consistent with their first preferences. Two sites were assigned to their second choice because of Envision NM capacity. At the request of the Site Coordinator two sites were re-assigned to ICP to create a group of 4 sites with a common QII that are served by the same team of providers. The Community Collaboration content area had only 1 site assigned due to: 1) the lack of sites expressing interest in participating in CC as a QII content area, and 2) the apparent need for community development in other areas which Envision NM can foster. Table 12 (attached) shows the preferences and content area assigned for each site. Table 13 (attached) shows the locations of QII sites by city, county, and QII initiative.

Next Steps: Lessons Learned and Process Assessment

We are in the process of reviewing data collected that may indicate success in the QII. This includes:

- Aggregate chart review data
- Attendance rates at trainings
- Satisfaction Survey results
- Qualitative Assessment by Content Area QII Leaders

Summary

Considering that most of these SBHCs have only been on the map since 2005, it is clear that they have made great strides in meeting OSAH standards and overcoming operational hurdles in their clinics and schools. This survey provides information about SBHCs as reported by participating staff. The information collected was used to recruit sites into the Envision New Mexico Quality Improvement Initiative for 2008-2009. In the end, 22 sites began this multi-year, intensive, quality improvement program. Participating sites are involved in initiatives on Pediatric Obesity Prevention and Treatment (5 sites); Teen Lifestyle Change (3 sites); Behavioral Health (4 sites); Improved Clinical Practice(9); and Community Collaboration (1 site). Envision NM will continue to work directly with these and other SBHCs to assess their strengths, needs, and opportunities to become the best possible resource for students in New Mexico.

Attachment A: Screening for Capacity and Standards Met

Screening for DOH-funded SBHCs					
Name of Site:			Date		
Staff-person Making Call:					
Name of on-site Coordinator:					
If present, name of primary care provider:					
If present, name of behavioral health provider:					
<p>Script: <i>Talk with the SBHC coordinator, and preferably, both primary care and behavioral health providers.</i> Hello, My name is..... and I am calling from _____. We are working with the DOH Office of School and Adolescent Health to support sites with the Quality Improvement Contract Deliverables. We are calling each SBHC to try to ascertain where your strengths and needs will place you within our QI plan this coming year. I would like to take just a few minutes to ask you some questions and get your feedback. Is now a good time to talk, or would you like to schedule another time to talk? <i>If now is a good time to talk, follow up with:</i> Please do your best to answer each question accurately. If there are some questions that puzzle you, perhaps you can direct me to another staff member who might be able to answer them. These questions are for quality improvement purposes only and will not in any way influence your funding or your standing with OSAH. After we interview all of the SBHCs, we will randomly select 20 SBHCs for follow-up visits, to check the reliability of our screening tool. Thanks in advance for participating with us!</p>					
1	How much is your funding from OSAH?	\$		Don't Know	
2	How many hours do you (as the coordinator) work on-site each week?				
3	Do you have a medical provider?	Yes	No	Don't Know	N/A
4	If yes, what type of medical provider do you have?	MD	PA		NP
	Other				
5	How many hours does the medical provider offer services per week?				
6	Do you have a behavioral health provider?	Yes	No	Don't Know	N/A
7	If yes, what type of behavioral health provider do you have?	MD	PhD	LPCC/ LPC	MSW
	Other				
8	If so, how many hours does the behavioral health provider offer services per week?				
9	What other regular staff does your site have (e.g., Clerk, Medical Assistant)?				
	List other regular staff:				
10	What other services and providers do you have? chiropractor, substance abuse counselor, dental hygienist, etc...?				
	List other services or providers:				
11	What hours do these other staff members work?				
12	What months does your site operate?	Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul			
13	What days of the week is your SBHC open? M T W Th F				
14	Does your site have Internet access?	Yes	No	Don't Know	N/A
15	If yes, does it have dial-up or broadband internet access?	Dial-up		Broadband	
16	If yes, has your site ever successfully signed-on to an e-meeting before?	Yes	No	Don't Know	N/A

ITEM #	Screening form #	Phase 1: Basic Operations				
		Script: We would like to go through a check list to assess your current operations.				
		Phase 1 Physical Site Standards				
1	17	Accessible (ADA compliant) entrance ramp, water fountain and restroom available	Yes	No	Don't Know	N/A
2	18	Exam and counseling rooms built with soundproof walls	Yes	No	Don't Know	N/A
3	19	Dedicated and private phone, fax and email account in place	Yes	No	Don't Know	N/A
4	20	Medical charts inaccessible to the public, school personnel and behind double locks	Yes	No	Don't Know	N/A
5		Phase 1 Operations and Policy Standards				
5	21	Healthcare provided to all clients regardless of ability to pay	Yes	No	Don't Know	N/A
6	22	Appointment system in place that is responsive to emergency and unscheduled appointments and includes reminder of appointments	Yes	No	Don't Know	N/A
7	23	Internal and external referrals/consultations for primary and mental health provided, as indicated (forms used, log present)	Yes	No	Don't Know	N/A
8	24	Clients provided confidential services, or referred out, in accordance with NM state law	Yes	No	Don't Know	N/A
9	25	Private medical information transferred in accordance with the HIPAA regulations, with measures to ensure confidentiality, privacy, and security of personal health information	Yes	No	Don't Know	N/A
10	26	Confidentiality of all client information and medical records maintained and confidential progress notes identified as such	Yes	No	Don't Know	N/A
		Phase 1 Clinical Standards				
11	27	Treatment providers have current license and wear nametags that contain their name, licensure, and title	Yes	No	Don't Know	N/A
12	28	Compliance verified with NM Board of Pharmacy Regulations (Pharmacy License present and current)	Yes	No	Don't Know	N/A
13	29	Basic medical equipment in place (exam table, lab equipment, nebulizer, otoscope, PB cuffs, scale).	Yes	No	Don't Know	N/A
14	30	Compliance assured for Clinical Laboratory Improvement Amendments (CLIA-waived certificate present)	Yes	No	Don't Know	N/A
15	31	Written policy and procedure in place to address prescription of psychotropic medications.	Yes	No	Don't Know	N/A
16	32	Direct patient care personnel trained in infection control, emergency care, identifying suicide/homicide ideation, and in reporting child abuse.	Yes	No	Don't Know	N/A
17	33	Emergency kit available OR process in place to handle emergencies	Yes	No	Don't Know	N/A
18	34	Disposable needle containers present and labeled appropriately	Yes	No	Don't Know	N/A
19	35	Infectious materials disposed of separately with appropriate labels	Yes	No	Don't Know	N/A
20	36	Standard (universal) precautions observed and signs posted for hand washing	Yes	No	Don't Know	N/A
21	37	Parent and/or client consent for treatment signed and on record in chart, including confidential services	Yes	No	Don't Know	N/A
22	38	Prescription pads not pre-signed AND inaccessible to the public	Yes	No	Don't Know	N/A
		Phase I Medical record standards				
23	39	Client charts maintained as per OSAH standards (standardized chart format utilized and chart securely bound)	Yes	No	Don't Know	N/A
24	40	HIPAA notification signature page present in medical chart	Yes	No	Don't Know	N/A
25	41	Vital signs completed at first visit and as indicated.	Yes	No	Don't Know	N/A
26	42	Treatment plan consistent with the diagnosis.	Yes	No	Don't Know	N/A
27	43	No show and/or cancellation system in place that documents in medical chart when client does not keep appointment	Yes	No	Don't Know	N/A

Attachment C: Outline of PDSA Cycles

AIM: Using the tools of QI, we aim to identify indicators that increase the likelihood of success of SBHCs participating in a QII with Envision NM.

- 1) Develop screening procedure
 - a) Define and assess **capacity**
 - i) Operational Function
 - (1) Identify resources, assets, and barriers
 - ii) Define and assess “readiness”
 - (1) Ability to move beyond basic operations towards ‘**best practice**’ performance.
 - (2) Interest:
 - (a) In Content Area
 - (b) In participating in QI
 - (3) Confidence of success
 - (a) Past experience with QI
 - (b) Less tangible factors:
 - (i) desire/willingness of staff
 - (ii) Presence of team leader
 - b) Develop screening tool to assess both operational and “readiness” aspects of capacity

CYCLE 1 PLAN

- c) Test screening tool
 - i) Pilot with known sites

C1 DO

- ii) Analyze results
 - (1) Takes too long
 - (2) Insufficient/unhelpful information
- iii) Further define capacity

C1 STUDY

- (1) Key operational standards of practice
- d) Revise screening tool
 - i) Add standards measures
 - ii) Remove questions about experience with QI
 - iii) Break process into 2 phases:
 - (1) Operations and standards
 - (2) Readiness, confidence and interest

C1 ACT

AND

Cycle 2 PLAN

- e) Screen sites Phase 1
 - i) 55 of 59 sites contacted

C2 DO 1

- f) Analyze results
 - i) Tabulate and compare
 - (1) Number of staff in each role
 - (2) Hours of each staff
 - (3) Number of standards met
 - (4) Other factors examined, not found to be significant differentiators

C2 STUDY 1

- ii) Elimination phase 1
 - (1) 3 sites declined to be considered for participation
 - (2) 3 sites had “no” to 3 or more standards questions
 - (3) 6 sites had significant staffing shortages

C2 ACT 1

g) Still more than target: re-analyze results

C2 STUDY 2

i) Elimination phase 2

- (1) Hours of medical provider and support staff < 16/week probably don't have sufficient time to participate

C2 ACT 2

h) Screen sites phase 2

i) Survey of:

- (1) 3 readiness questions
- (2) Ranking of interest in Content Areas offered

C2 DO 2

ii) Tabulate and compare

- (1) 3 sites not interested
- (2) 3 sites very low interest
- (3) 1 site moderate interest
 - (a) This site coordinator also works at another site that is included (in CC)
 - (b) Discussed with this coordinator, agreed that only the one site would be included since Content Area = CC, actually involves both
- (4) 22 sites interested
- (5) Note average "Readi-index" for not selected = 5, and for selected = 24

C2 STUDY 3

i) Assign selected to Content Area

- i) Most assigned to 1st choice
- ii) Some moved due to providers same at multiple sites
- iii) Ended up with 9 in ICP; 4 = 1 in LC, 2 = 1 in Taos
- iv) CC only 1, due to interest by sites and recognition that CC does not really fit SBHC QII, but still plenty of other things to be done in community development.

C2 ACT 3

Attachment D: Large-format Tables

Table 1: SBHCs for Initial Interview

SBHC Site Name	School Name	City	County	Zip
Laguna-Acoma Teen Center	ACL Laguna Acoma HS	Casa Blanca	Cibola	87038
To'Hajiilee Teen Center	ACL To'Hajiilee K-12	To'Hajiilee	Cibola	87026
Albuquerque HS SBHC	Albuquerque HS	Albuquerque	Bernalillo	87102
Belen HS SBHC	Belen HS	Belen	Valencia	87002
Spartan Health Center	Bernalillo HS	Bernalillo	Sandoval	87004
Teen Health Ctr @ Capitol HS	Capital HS	Santa Fe	Santa Fe	87505
Career Prep SBHC	Career Prep Alternative HS	Shiprock	San Juan	87420
Carlos Vigil MS SBHC	Carlos Vigil MS	Espanola	Rio Arriba	87532
The CAVE Health Center	Carlsbad HS	Carlsbad	Eddy	88220
Chaparral HS SBHC	Chaparral HS	Chaparral	Dona Ana	88001
Cobre Wellness Center	Cobre HS	Bayard	Grant	88023
Cuba Schools Wellness Center	Cuba Independent Schools	Cuba	Sandoval	87013
Deming Wildcat Health Center	Deming HS	Deming	Luna	88030
Dexter MS SBHC	Dexter MS	Dexter	Chavez	88230
Des Moines SBHC	Des Moines	Des Moines	Union	88418
Dulce Teen Health Center	Dulce HS	Dulce	Rio Arriba	87528
East San Jose SBHC	East San Jose Elementary	Albuquerque	Bernalillo	87102
Teen Wellness Center at Escalante HS	Escalante HS	Tierra Amarilla	Rio Arriba	87575
Espanola High SBHC	Espanola HS	Espanola	Rio Arriba	87532
Ft. Sumner SBHC	Ft. Sumner HS	Ft. Sumner	De Baca	88119
Gadsden HS SBHC	Gadsden HS	Anthony	Dona Ana	88021
Gallup Teen Life Center	Gallup HS	Gallup	McKinley	87305
Goddard HS SBHC	Goddard HS	Roswell	Chavez	88201
Hagerman SBHC	Hagerman	Hagerman	Chavez	88232
Highland HS SBHC	Highland HS	Albuquerque	Bernalillo	87109
Jemez Valley SBHC	Jemez Valley HS	Jemez Pueblo	Sandoval	87024
Lake Arthur SBHC	Lake Arthur	Lake Arthur	Chavez	88253
Las Cruces HS SBHC	Las Cruces HS	Las Cruces	Dona Ana	88001
Lordsburg Municipal SBHC	Lordsburg HS	Lordsburg	Hidalgo	88045
Lovington Student Healthcare Center	Lovington Schools	Lovington	Lea	88260
Maxwell Wellness Center	Maxwell Municipal School	Maxwell	Colfax	87729
Mesa MS SBHC	Mesa MS	Roswell	Chavez	88203
Mesa Vista SBHC	Mesa Vista Consolidated Schools	Ojo Caliente	Taos	87549
Mescalero Apache School Based Health Center	Mescalero Apache School	Mescalero	Otero	88340
Mora SBHC	Mora Schools	Mora	Mora	87732
Mustang Health Center	Mountainair HS	Mountainair	Torrance	87036
McKenzie SBHC	Navajo Prep School	Farmington	Rio Arriba	87401
Ocate HS SBHC	Ocate HS	Las Cruces	Dona Ana	88011
PB & J Preschool SBHC	PB & J	Albuquerque	Bernalillo	87105
Pojoaque Valley HS SBHC	Pojoaque Valley HS	Pojoaque	Santa Fe	87506
Quemado SBHC	Quemado Schools	Quemado	Catron	87829
Tiger Den Wellness Center	Raton High School	Raton	Colfax	87740
RFK SBHC	RFK Charter School	Albuquerque	Bernalillo	87106
Roosevelt MS SBHC	Roosevelt MS	Tijeras	Bernalillo	87059
Roswell SBHC	Roswell HS	Roswell	Chavez	88201
Roy High School SBHC	Roy Municipal Schools	Roy	Harding	87743
Ruidoso SBHC	Ruidoso HS	Ruidoso	Lincoln	88345
San Felipe Pueblo EL SBHC	San Felipe Pueblo Elem	Pueblo of San Felipe	Sandoval	87001
San Jon School Based Center	San Jon	San Jon	Quay	88434
Santa Fe HS SBHC	Santa Fe HS	Santa Fe	Santa Fe	87505
Lion Care Health Center	Santa Rosa Schools	Santa Rosa	Guadalupe	88435
School on Wheels SBHC	School on Wheels	Albuquerque	Bernalillo	87105
Silver Schools Health Center	Silver City Consolidated School	Silver City	Grant	88061
Socorro HS SBHC	Socorro HS	Socorro	Socorro	87801
Taos HS Wellness Center	Taos HS	Taos	Taos	87571
Taos MS Wellness Center	Taos MS	Taos	Taos	87571
Van Buren MS SBHC	Van Buren MS	Albuquerque	Bernalillo	87108
Washington MS SBHC	Washington MS	Albuquerque	Bernalillo	87102
West Las Vegas Student Health Center	West Las Vegas High School	Las Vegas	San Miguel	87701

Table 2: SBHC Administrative Support

ID Number	Coordinator On-site Hours Per Week	Number of Support Staff	Support Staff Hours Per Week
8001	10	2	45
8002	37.5	1	37.5
8003	36	2	42
8004	8	2	16
8005	4	3	16
8006	36	2	52
8007	24	2	32
8008	36	2	66
8009	not reported	not reported	not reported
8010	25	1	25
8011	not reported	not reported	not reported
8012	15	1	15
8013	40	2	80
8014	16	1	16
8015	8	2	14
8016	20	1	20
8017	20	2	36
8018	not reported	not reported	not reported
8019	0	1	40
8020	0	2	24
8021	0	2	not reported
8022	0	1	16
8023	5	3	47
8024	not reported	not reported	not reported
8025	20	1	20
8026	8	2	16
8027	24	1	24
8028	30	1	30
8029	1	2	6
8030	20	3	52
8031	40	1	40
8032	32	2	72
8033	16	2	32
8034	0	1	16
8035	32	1	32
8036	0	2	not indicated
8037	20	2	60
8038	20	2	60
8039	0	1	16
8040	4	2	44
8041	16	3	40
8042	40	1	40
8043	24	2	36
8044	40	2	80
8045	16	3	56
8046	20	2	60
8047	8	2	16
8048	40	2	80
8049	20	2	40
8050	0	2	32
8051	40	1	40
8052	45	2	55
8053	24	1	24
8054	36	1	36
8055	8	2	40
8056	16	2	32
8057	16	2	16
8058	8	2	8
8059	8	1	8

Table 3: SBHC Medical Providers

ID Number	Number of Medical Providers	Type of Medical Providers	Medical Provider Hours Per Week
8001	0	none currently	40 (when filled)
8002	4	PA, NP, DOx2	7
8003	3	1 NP & 1 NP/PhD	24
8004	1	NP	8
8005	3	MD	12
8006	2	1CNS, 1NP	16
8007	2	MD,2PA	20
8008	3	NP/PhD	24
8010	1	NP	8
8012	3	PA, NP	16
8013	3	PA, 2-NP	12
8014	1	NP	4
8015	3	PA, 2NP	30
8016	1	MD	16
8017	1	NP	16
8019	1	CFNP	10
8020	1	PA	16
8021	1	NP	24
8022	1	PA	16
8023	1	NP	18
8024	2	FNP	9
8025	3	MD, PA	24
8026	2	NP	16
8027	1	NP	8
8028	1	NP	16
8029	1	not reported	8
8030	2	NP	32
8031	1	NP	8
8032	2	MD x 2	4
8033	1	NP	16
8034	1	PA	16
8035	1	NP	4
8036	1	NP	24
8037	2	PA, RN	80
8038	2	2 NP	24
8039	1	NP	16
8040	1	CFNP	6
8041	1	PA	16
8042	1	NP	24
8043	1	PA	24
8044	1	NP	40
8045	1	NP	20
8046	1	NP	8
8047	1	MD	8
8048	1	CNP	16
8049	2	MD	16
8050	2	PA	24
8051	1	NP	30
8052	2	MD	24
8053	1	NP	8
8054	2	NP/PhD, & nurse midwife	16
8055	1	NP	8
8056	1	NP	16
8057	2	NP	16
8058	2	NP	8

Table 4: SBHC Behavioral Health Providers

ID Number	Number of Behavioral Health Providers	Types of Behavioral Health Providers	Behavioral Health Hours Per Week
8001	1	LPCC	40
8002	2	LSAA	12
8003	1	Masters in Counseling	8
8004	1	LPCC	8
8005	1	LPCC	12
8006	2	2 Masters in Counseling	16
8007	3	MD,LPCC	24
8008	1	Masters in psych	12
8010	1	LPCC	10
8012	1	LISW	16
8013	2	Psych	40
8014	1	LPCC	8
8015	2	LPCC,LMHC	38
8016	1	LMHC	16
8017	2	LPCC,LPC	16
8019	2	LMSW, MD	36
8020	2	LPCC, Psych Fellow	16
8021	2	not reported	30
8022	1	MSW	16
8023	1	LPCC	8
8024	1	LISW	10
8025	1	not reported	4
8026	1	LPCC	16
8027	2	MSW & contract Counseling	8
8028	2	LISW	24
8029	2	LPCC	22
8030	0	new BH provider	40
8031	2	PhD	12
8032	1	LPCC	40
8033	1	MSW	16
8034	1	MSW	18
8035	1	LPCC	8
8036	2	not reported	30
8037	3	LPCC, LMHC, SAC	72
8038	3	LPC,LISW	24
8039	1	LPCC	8
8040	2	LMSW, MD	36
8041	2	MSW, LISW	16
8042	1	LPC	16
8043	2	LISW/LPCC	24
8044	1	LPCC	40
8045	2	LPCC	80
8046	1	LISW	16
8047	1	LMHC	8
8048	2	LPCC & LPC	50
8049	1	PhD	16
8050	1	LPCC	8
8051	1	LISW	21
8052	2	LPCC & LPC	24
8053	0	not reported	0
8054	2	NP w/Masters in counseling	12
8055	4	1 LPCC,2 LISW, 1 SAC	16
8056	1	LPC	16
8057	2	MSW	16
8058	8	MSW	8

Table 8: Number of Hours per Week by Staffing Category at Selected Sites

Site ID	Number of Hours Per Week		
	Support Staff	Medical Provider	Behavior Health Provider
8003	42	24	8
8006	52	16	16
8007	32	20	24
8008	66	24	12
8016	20	16	16
8017	36	16	16
8020	24	16	16
8022	16	16	16
8023	47	18	8
8025	20	24	4
8028	30	16	24
8030	52	32	40
8033	32	16	16
8034	16	16	18
8037	60	80	72
8038	30	24	24
8041	40	16	16
8042	40	24	16
8043	36	24	24
8044	80	40	40
8045	56	20	80
8048	80	16	16
8049	40	16	16
8050	32	24	8
8051	40	30	21
8052	55	24	24
8054	36	16	12
8056	32	16	16
8057	16	16	16

Table 11: Site Readiness for QII

	<i>Site ID</i>	<i>Ready for QI</i>	<i>Ready for ENM</i>	<i>Confident</i>	<i>Readi-Index</i>
Not Selected	8007	0	0	0	0.00
	8023	5	5	5	15.00
	8028	0	0	0	0.00
	8034	0	0	0	0.00
	8042	3	3	3	9.00
	8049	3	3	3	9.00
	8052	1	1	0	2.00

	<i>Site ID</i>	<i>Ready for QI</i>	<i>Ready for ENM</i>	<i>Confident</i>	<i>Readi-Index</i>
Selected	8003	10	8	10	28.00
	8008	10	8	10	28.00
	8016	5	8	6	19.00
	8017	8	9	10	27.00
	8020	8	8	10	26.00
	8022	8	10	10	28.00
	8025	4	6	8	18.00
	8026	10	8	10	28.00
	8030	8	10	8	26.00
	8033	8	10	8	26.00
	8037	9	7	6	22.00
	8038	8	9	9	26.00
	8041	5	8	8	21.00
	8043	9	9	9	27.00
	8044	10	10	10	30.00
	8045	9	9	9	27.00
	8045	10	8	10	28.00
	8048	7	8	4	19.00
	8050	6	8	9	23.00
	8051	5	5	8	18.00
8056	5	8	9	22.00	
8057	7	8	4	19.00	

Table 12: Site Preference and Assignment to QII Content Area

School Identifier	Preference 1	Preference 2	Preference 3	Area Assigned
8003	ICP	TLC	POW	ICP
8006	BH	TLC	POW	ICP
8008	POW	TLC	CC	ICP
8016	ICP	TLC	BH	ICP
8017	ICP	TLC	none	ICP
8020	BH	none	none	BH
8022	POW	BH	ICP	POW
8025	POW	ICP	CC	POW
8030	ICP	BH	none	BH
8033	TLC	POW	BH	TLC
8037	CC	none	none	CC
8038	ICP	TLC	none	ICP
8041	TLC	ICP	BH	TLC
8043	TLC	ICP	BH	TLC
8044	BH	TLC	ICP	BH
8045	BH	POW	TLC	BH
8048	POW	BH	ICP	POW
8050	ICP	none	none	ICP
8051	ICP	BH	none	ICP
8054	ICP	POW	TLC	ICP
8056	TLC	POW	none	POW
8057	POW	BH	TLC	POW

Table 13: Final Sites, QII Assignments by City and County

County	City	Content Area Assigned
Bernalillo	Albuquerque	BH
	Albuquerque	ICP
Chavez	Roswell	POW
	Roswell	POW
Dona Ana	Chaparral	ICP
	Gadsden	ICP
	Las Cruces	ICP
	Las Cruces	ICP
Eddy	Carlsbad	POW
Grant	Silver City	CC
Guadalupe	Santa Rosa	POW
Lea	Lovington	BH
McKinley	Gallup	BH
Rio Arriba	Espanola	TLC
	Tierra Amarilla	POW
	Espanola	TLC
Sandoval	Bernalillo	ICP
Santa Fe	Pojoaque	TLC
Socorro	Socorro	ICP
Taos	Ojo Caliente	BH
	Taos	ICP
	Taos	ICP