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The Initiative for Child Healthcare Quality

To envision what can be and to create the highest quality healthcare for children in New Mexico

Envision NM

School-based Health Care Quality Improvement Project End of Year Data Summary Report 2011/2012

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UNM SCHOOL of MEDICINE
Department of Pediatrics

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Background

Adolescents are typically the most medically underserved population in any state. The healthcare needs of adolescents are related to their developmental stage, and tend to be a combination of both physical and mental health concerns. The New Mexico Department of Health (DOH) sponsored School Based Health Centers (SBHCs) provide medical and behavioral health services to this underserved population. New Mexico SBHCs operators include five Federally Qualified Health Centers (FQHCs)[1], four Regional Education Collaboratives[2], the University of New Mexico, the Southern New Mexico Community Foundation, and private medical providers. The Community Foundation of Southern New Mexico and the University of New Mexico are the single largest contractors, i.e. serve the largest numbers of students enrolled in schools served by SBHCs. Both of these organizations serve 21% of the total students served by SBHCs. Five FQHC contractors serve 36% of all students served by DOH funded SBHCs; Presbyterian Medical Services serves 49% of students served by FQHCs. In addition to DOH funding, SBHC funding comes from tribes, private foundations, and Medicaid reimbursements.

Since 2008, DOH has contracted with Envision NM (ENM) to work with SBHCs to improve the quality of healthcare delivered to New Mexico students. ENM is a healthcare quality improvement (QI) program of the Department of Pediatrics, University of New Mexico Health Sciences Center. ENM provides training, development and evaluation services to improve the quality of health services for children and youth throughout the state. ENM has been partnering with the NM Departments of Health Office of School and Adolescent Health (OSAH) and Human Services (HSD), the New Mexico Pediatric Society, Indian Health Service, NM Alliance of School-Based Health Centers, NM Salud Managed Care Organizations, and other healthcare organizations around the state for over seven years.

ENM's work is based on established models for creating improvements in clinical practices and delivery systems developed by the Institute for Healthcare Improvement (IHI). Conceptually, these developments are embodied in the Model for Improvement[3], developed by Associates in Process Improvement, a tool for implementing improvement in health care quality. ENM

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[1] Federally Qualified Health Centers (FQHCs) are non-profit clinics located in rural and urban medically underserved areas. FQHCs focus on improving the health of underserved, low-income and uninsured communities and populations in order to eliminate health disparities. FQHCs receive federal funds to help cover the costs of providing services for people who are uninsured.

[2] Regional Education Cooperatives provide support and services to school districts to improve student outcomes and meet local districts' needs. Regional Education Cooperatives also play a role in the delivery and implementation of core services and major statewide education initiatives (such as school based health services, Child Find programs, etc. http://hprec.org/NMRECA/RECA%202010-2011%20final%20rev%203.pdf

[3] The Improvement Guide: A Practical Approach to Enhancing Organization Performance, *Gerald Langley, Kevin Nolan, Thomas Nolan, Clifford Norman, Lloyd Provost*. San Francisco, Jossey-Bass Publishers, 1996

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employs this model and method to teach providers in SBHCs to identify practice changes that will lead to improved patient care and help reduce health care costs. ENM utilizes on-site visits, webinars, email, and phone coaching for QI work. All DOH-funded SBHCs are required to implement healthcare Quality Improvement (QI) initiatives as part of their contract and may work on their own or choose QI work with ENM.

ENM provides three SBHC QI programs:

- Demonstration Quality Improvement (DQI),
- Advanced Quality Improvement (AQI), and
- Children's Health Insurance Program Reauthorization Act (CHIPRA).

This report focuses on numbers 1 & 2 above. The CHIPRA program activities are reported separately.

ENM provided QI technical support to a total of 25 sites during 2011/2012, compared to 40 SBHCs in 2010/2011. This reduction was due to decreased funding as well as an increased attention to the participating sites. Not all sites submitted data, and some sites participated in more than one program during the year. Specifically:

- 16 SBHCs submitted data under DQI
- 4 sites submitted data under AQI
- 3 Behavioral Health AQI
- 1 Sexually Transmitted Infections AQI
- 2 sites participated in DQI before moving into AQI
- 2 sites participated in ENM DQI or AQI prior to moving into the CHIPRA project
- 3 sites participated in DQI (site visits and/or Teamwork/Perception surveys) but did not submit medical record review data, either due to a late start or staffing shortages

The 16 DQI sites serve a total of 16,720 students (Appendix 1).

Building on last year's Early Intervention, Screening, Diagnosis, and Treatment (EPSDT) DQI program, the 2011/2012 DQI focused on improving EPSDT documentation. SBHCs that met the ENM established EPSDT proficiency standard, had the option of participating in AQI to work on improving other SBHC clinical practices. There were two AQI content areas this year: Behavioral Health (BH AQI) and Sexually Transmitted Infection (STI AQI). Three sites were involved in the BH AQI and one in STI. One of the BH AQI sites transferred to CHIPRA effective December 1, 2011.

In 2011 ENM also began providing enhanced services to four SBHCs as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) demonstration project. The project goals include: improving the quality of care delivered in SBHCs, integrating SBHCs into the medical home approach, and engaging youth in their own health care decisions. ENM staff

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provides staff coaching, including a focus on patient-centered medical homes. Under contract to DOH, APEX Education[4] provides additional support in utilizing electronic medical information and records. The CHIPRA program is evaluated in a separate document. ENM does not use Medicaid funds to support the CHIPRA program; the project is fully funded by a federal CHIPRA Children's Medical Services Grant.

ENM technical support includes site visits from ENM staff, participation in improvement activities, and webinar sessions. ENM maintains an expert staff, utilizes up-to-date information technology, and draws upon the resources of the UNM Health Sciences Center to train and support health care providers in employing "best practices"[5] to ensure effective and efficient health care services for children and youth. In 2011/2012, the equivalent of four full-time ENM staff were assigned to serve the SBHC sites. In addition, at weekly ENM QI meetings, all ENM staff, with expertise in primary care, nutrition, behavioral health, and SBHC administration, provided input on SBHC QI issues.

Each section of this report includes a presentation of data, followed by examples of performance measures that support ongoing monitoring and improvement of SBHC services. Some suggested performance measures are specific to ENM operations. Other measures can best be monitored and acted upon by a collaboration of SBHC partners. SBHC partners include:

- NM Alliance of School Based Health Centers
- NM Department of Health, Office School and Adolescent Health
- NM Human Services Department
- Parent Teacher's Association
- School Based Health Centers Partner's Team
- School Health Advisory Committees
- School and District Administrators
- UNM Envision Program

To support a collaborative approach to improving SBHC outcomes, in 2012, with the support of DOH OSAH, the SBHC Partner's Team began to implement a collaborative "Results Based Accountability" (RBA) initiative.

Throughout this report, ENM SBHCs refers to the SBHCs that participated in the 2011/2012 ENM SBHC DQI and AQI Programs. CHIPRA refers to SBHCs in the CHIPRA program. If ENM SBHCs are not specified, then the data reflects data for all DOH funded SBHCs.

[4] Apex Education is a private consulting firm that coordinates data collection and conducts evaluation for New Mexico SBHCs.

[5] Best Practice" refers here to both quality improvement best practice methods as well as best practices in the clinical areas included in the SBHC QI.

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SBHC Utilization

Overall Visits/Encounters

Each DOH-funded SBHC submits monthly data on patient visits to Apex Education[6]. These data provide a very valuable resource for developing and implementing ongoing SBHC and ENM performance monitoring protocols. The nine SBHCs that utilize electronic medical records provide monthly summary information to Apex on Microsoft Excel spreadsheets, typically by the 7th day of the following month. Other SBHCs utilize the Welligent Electronic Health Record Software System to continuously enter data; these sites are directed by DOH to enter the last month's data by the 5th of the following month. For the purposes of this evaluation, the SBHC data provided by DOH funded sites is identified as "Welligent Data". Apex compiles monthly "Level of Operations" reports, which include information on overall visits by type of office visit, race, gender, and unduplicated students. These data are critical for performance monitoring and well as for developing effective strategies to maximize the positive impact of ENM technical assistance on patient care at SBHCS.

There was a 26% decrease in SBHC visits in the last two years (Figure 1). Four major factors contributed to this decrease:

- Mandatory re-organization of the DOH contracts with SBHCs resulted in many contracts not being finalized until October, which is typically the month with the highest utilization (Figure 2).
- The re-organization also meant that SBHC staff had considerable uncertainty about their jobs and SBHCs experienced high levels of provider turnover, again impacting productivity.
- Five SBHCs that had DOH contracts to provide services in 2010/2011 did not have contracts in 2011/2012: Gadsden Middle School, Belen High School, Career Prep, Deming High, and Socorro High.
- Finally, the budget for the OSAH SBHC program has decreased over the past few years, resulting in fewer SBHC staff hours.

[6] Apex is under contract to NMDOH to collect, compile, and analyze monthly SBHC statistics

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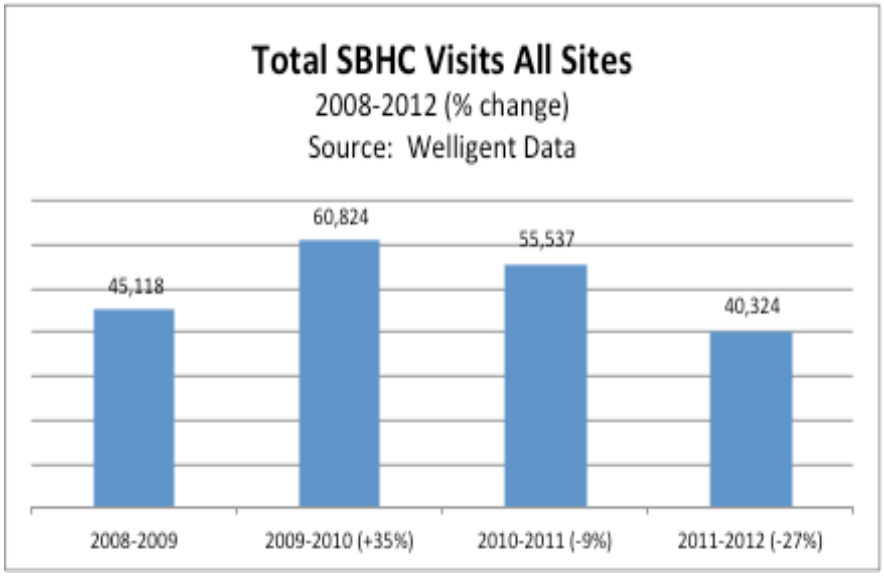
Figure 1 - Total SBHC Visits 2008-2012



Note: June 2012 numbers are estimated

% Change in SBHC Visits 2012/2011	
Jul-11	-68%
Aug-11	-34%
Sep-11	-34%
Oct-11	-30%
Nov-11	-21%
Dec-11	-31%
Jan-12	-30%
Feb-12	7%
Mar-12	-34%
Apr-12	-11%
May-12	-58%

It is important to monitor monthly utilization and to identify factors impacting monthly variations, such as the number of days in operation and provider availability. These data can be used on an ongoing basis to identify potential problem areas and develop strategies to maximize the use of SBHCs throughout the year. Figure 2 presents monthly SBHC visits from 2008 – 2012.

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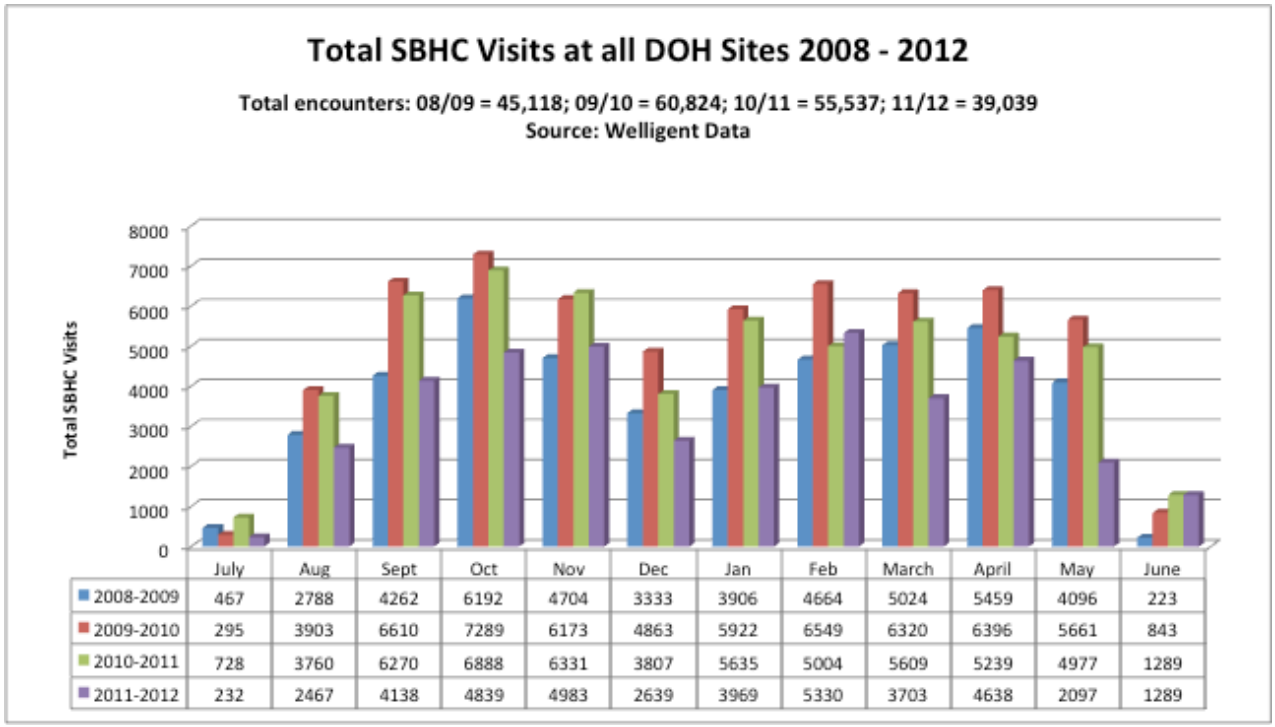
Figure 2 - Monthly SBHC Visits at DOH Funded SBHCs 2008 - 2012.



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
2008-2009	467	2788	4262	6192	4704	3333	3906	4664	5024	5459	4096	223
2009-2010	295	3903	6610	7289	6173	4863	5922	6549	6320	6396	5661	843
2010-2011	728	3760	6270	6888	6331	3807	5635	5004	5609	5239	4977	1289
2011-2012	232	2467	4138	4839	4983	2639	3969	5330	3703	4638	2097	1289

Note: June 2012 Visits are estimated

Data highlights:

- With the exception of February, SBHC utilization in 2012 was lower each month than in the previous three years.
- Low utilization months offer opportunities to serve more students, and in particular increase the number of EPSDTs completed.
- By the end of October 2011, 28% of all SBHC visits were completed.

SBHC Utilization by Visit Type and EPSDTs Provided

SBHC staff categorizes the presenting issue for each appointment by DOH defined "visit categories". The visit type is the reason the patient came to the clinic (Figure 3), although the patient may receive services for additional reasons.

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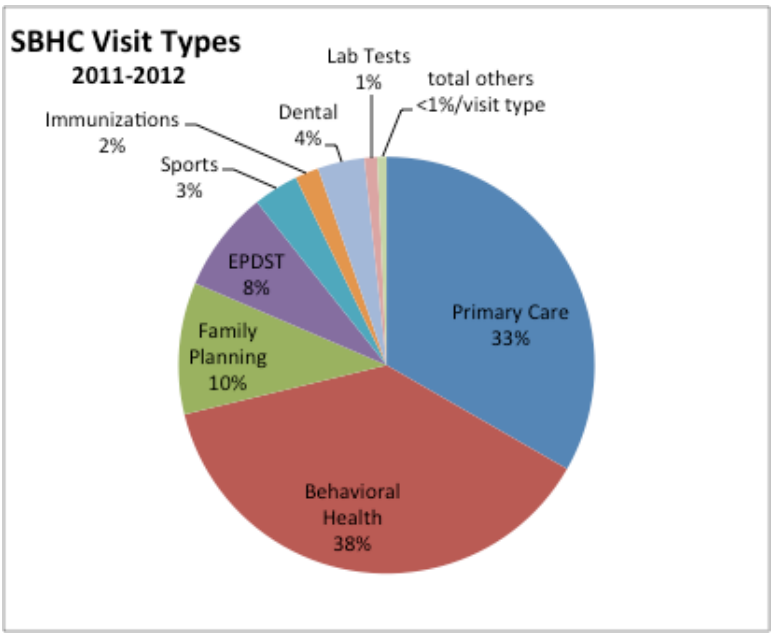
Figure 3 - SBHC Visits by Type 2011/2012



Data highlights:

- In 2011/2012, the most common reported reasons for students to come to DOH-funded SBHCs were primary care (33%) and behavioral health (38%).
- Eight percent of appointments were scheduled specifically to give students an Early Intervention, Prevention, Screening, Diagnosis, and Treatment (EPSDT).

DOH is very interested in increasing the number of students that receive an EPSDT or comparable well-child screening. The EPSDT has a standard set of 18 required components and is more labor-intensive than a regular child exam. To increase the number of EPSDTs provided, ENM is working with SBHC staff to identify other opportunities, such as sports physical visits, to perform EPSDTs. Figure 4 presents monthly visits at DOH SBHCs with and without EPSDTs for 2011 and 2012.

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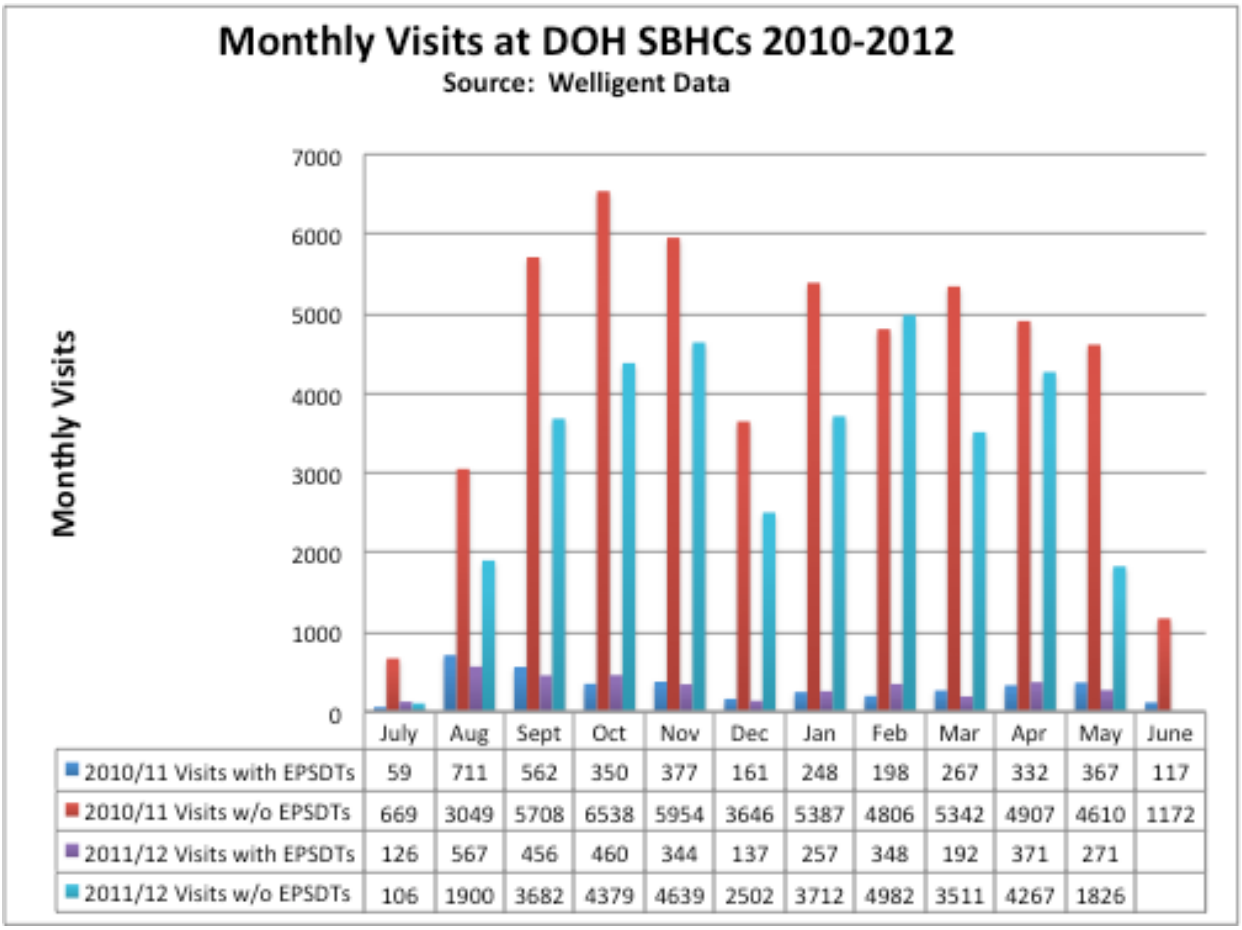
Figure 4 - Monthly Visits and EPSDTs at DOH Sites



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
2010/11 Visits with EPSDTs	59	711	562	350	377	161	248	198	267	332	367	117
2010/11 Visits w/o EPSDTs	669	3049	5708	6538	5954	3646	5387	4806	5342	4907	4610	1172
2011/12 Visits with EPSDTs	126	567	456	460	344	137	257	348	192	371	271	
2011/12 Visits w/o EPSDTs	106	1900	3682	4379	4639	2502	3712	4982	3511	4267	1826	

Data highlights:

- The highest SBHC utilization in 2011/2012 was in February of 2012, followed by November 2011, October 2011 and April 2012.
- Typically the highest utilization rates are in the Fall, from September through November. However, the late contracts resulted in late clinic opening days and made it difficult for clinics to be fully staff during these important months.
- There were 3529 SBHC EPSDTs from July 2011 through May 2012; 60% of all the EPSDTs were completed by the end of the first semester.
- Typically lower monthly SBHC utilization from January through May provides an opportunity for increasing the number of EPSDTs with existing staff levels by maximizing provider time.

SBHC Saturation Rates by Site Type

Figure 5 presents SBHC saturation rates at SBHCs served by 1) the ENM CHIPRA program, 2) other ENM SBHCs, and 3) the rest of the DOH-funded schools. Table 1 presents aggregate

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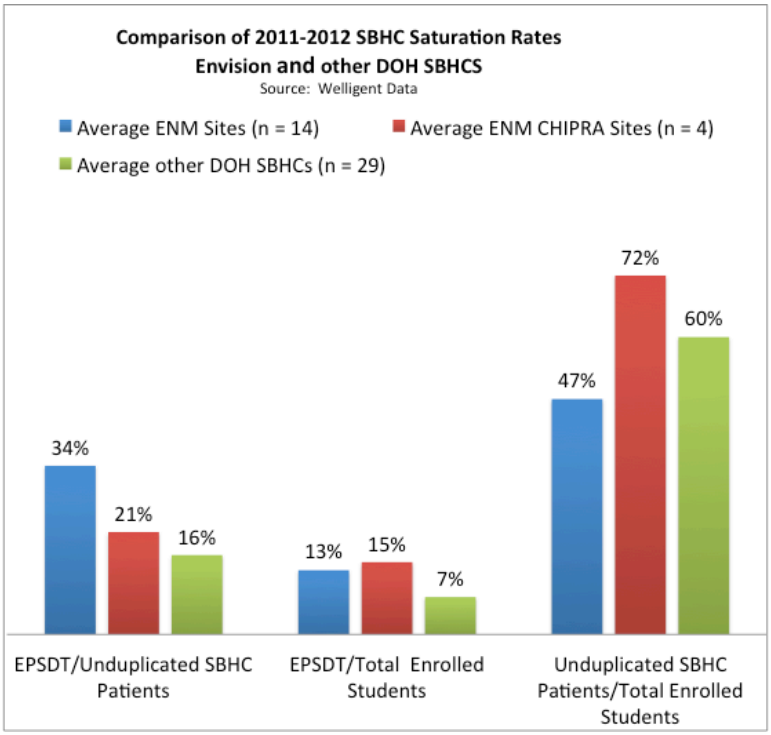
saturation rates for the SBHCs served by each contractor. The data demonstrate that ENM is having a positive impact on increasing the number of students receiving EPSDTs, a DOH priority.[7]

Figure 5 - Comparison of Saturation Rates Among DOH Sites



Data highlights:

- To give each school equal weight in the average, the average of the ratios of the individual SBHCs was calculated for all schools in a cohort.
- The "ENM sites" and "CHIPRA sites" completed about twice as many EPSDTs/enrolled students as the other DOH sites.
- The "ENM sites" were the most successful in providing EPSDTs to unduplicated SBHC patients; i.e. 34% of all students that accessed SBHC services, received an EPSDT.
- Data limitations are described in footnote 7.

[7] Theses analyses were limited by the following:

Student enrollment was not available for San Felipe Pueblo, Native American Community Academy, or Navajo Prep SBHCs; the total student population served excludes these SBHCs.

Some SBHCs also serve members of the community who are not students enrolled in the SBHCs. Data is not currently available to distinguish students and non-students. However, in 2011/2012 there were 314 visits by young children aged 1 to 4. Adult community members, including school staff may also be utilizing the site.

Contractors for Native American Community Academy and Navajo Prep were not available for this analysis

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Table 1 – SBHC Utilization by SBHC Contractors

Contractor	Students Enrolled in Contractor SBHC(s)	% of Students Enrolled in SBHC schools	Undupli-cated SBHC patients/ Enrolled Students	Total EPSDT 2011-12	EPSDTs/# of Enrolled Students	EPSDTS/ Undupli-cated Patients
REC V	388	1%	31%	60	15%	50%
Community Foundation of Southern NM	7,253	22%	15%	516	7%	49%
UNM	6,619	20%	26%	533	8%	31%
La Clinica del Pueblo de Rio Arriba	1,095	3%	94%	282	26%	27%
El Centro Family Health	3,748	12%	37%	326	9%	24%
REC IX	1,138	4%	29%	69	6%	21%
Las Clinicas del Norte	120	0%	66%	11	9%	14%
Presbyterian Medical Services	6,030	19%	34%	225	4%	11%
Hidalgo Medical Services	1,289	4%	66%	88	7%	10%
REC IV	1,005	3%	42%	38	4%	9%
JASSH - Casa de Salud	499	2%	23%	10	2%	9%
Eastern New Mexico University	2,902	9%	23%	37	1%	6%
Dance Expose Productions	153	0%	86%	1	1%	1%
REC VI	132	0%	42%	0	0%	0%
Union County Health & Wellness Network	74	0%	77%	0	0%	0%
	32,445	100%				17%

Data highlights:

- The Community Foundation of Southern New Mexico (CFSNM) SBHCs serves the greatest number of students at SBHCs; 7,253 students were enrolled in the schools that they serve in 2011/2012, followed by UNM, serving 6,619 students.
- These two contractors serve 42% of all students enrolled at schools that are served by SBHCs.
- For all contractors, 17% of unduplicated patients received an EPSDT in 2011/2012.
- REC V, which serves 388 students from the Mountainair SBHC, had the highest percent,

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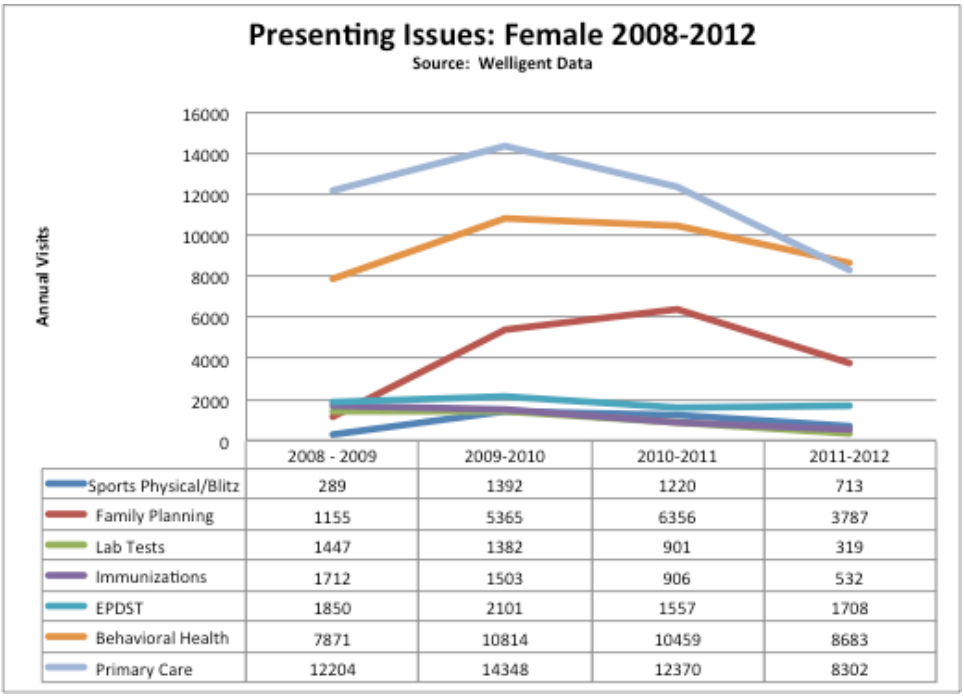
50%. Mountainair is an ENM DQI site.

- CFSNM also had a relatively high rate of EPSDTS; CFSNM SBHCs provide EPSDTs to 49% of its unduplicated patients. All of the four SFSNM SBHC sites were ENM DQI sites this past year.
- Data limitations are described in footnote 7.

Utilization by Gender

Male students are under-represented at SBHCs. While 51% of New Mexico students are male, from 2011/2012 only 42% of SBHC visits were by males. This under-utilization tracks with national trends on adolescent utilization of health services. Figures 6 and 7 show the reasons (presenting issues) that female and male students access SBHCs.

Figure 6 - Female Students Presenting Issues 2008-2012



	2008 - 2009	2009-2010	2010-2011	2011-2012
Sports Physical/Blitz	289	1392	1220	713
Family Planning	1155	5365	6356	3787
Lab Tests	1447	1382	901	319
Immunizations	1712	1503	906	532
EPDST	1850	2101	1557	1708
Behavioral Health	7871	10814	10459	8683
Primary Care	12204	14348	12370	8302

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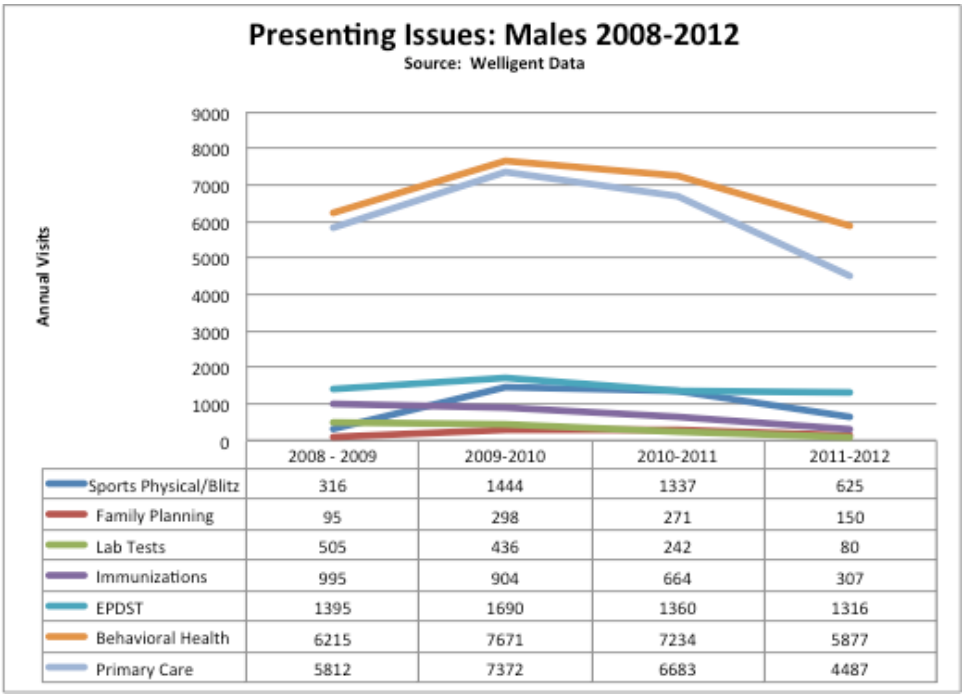
Figure 7 - Male Students Presenting Issues 2008-2012



	2008 - 2009	2009-2010	2010-2011	2011-2012
Sports Physical/Blitz	316	1444	1337	625
Family Planning	95	298	271	150
Lab Tests	505	436	242	80
Immunizations	995	904	664	307
EPDST	1395	1690	1360	1316
Behavioral Health	6215	7671	7234	5877
Primary Care	5812	7372	6683	4487

Data highlights:

- From 2008-2010 the most common reasons for female and male students to visit an SBHC was for primary care.
- In 2011/2012 primary care continued to be the most common reason for male students, however, female students made a few hundred more behavioral health than primary care visits.

Figure 8 presents changes in the percent of visits by gender over the past two years.

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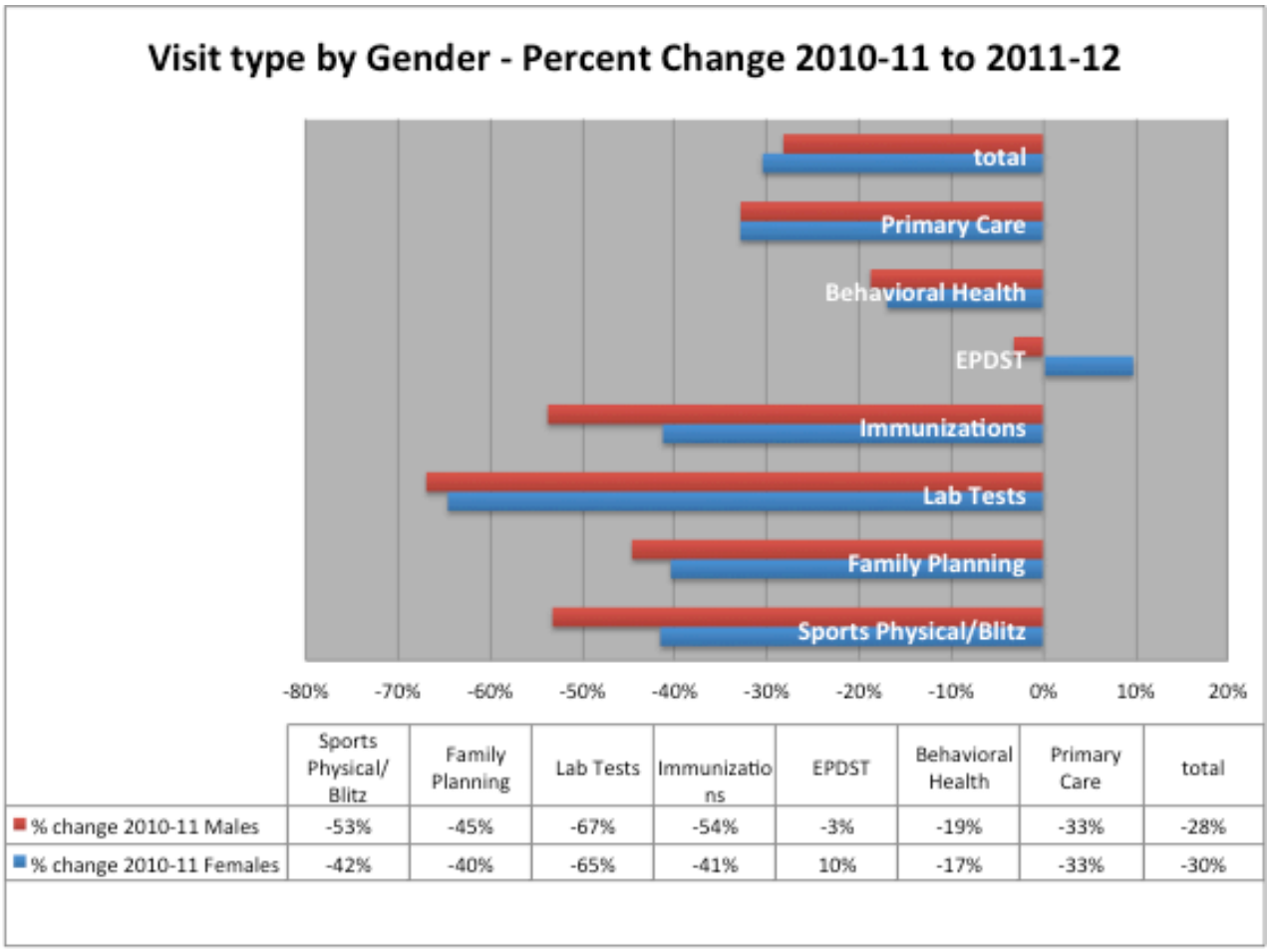
Figure 8 - Visit Type by Gender



	Sports Physical/ Blitz	Family Planning	Lab Tests	Immunizations	EPDST	Behavioral Health	Primary Care	total
% change 2010-11 Males	-53%	-45%	-67%	-54%	-3%	-19%	-33%	-28%
% change 2010-11 Females	-42%	-40%	-65%	-41%	10%	-17%	-33%	-30%

Data highlights:

- With the exception of EPSDTs for females, there was a substantial decrease in visit type by gender between the 2010 to 2011 school years for all the major SBHC visit types.
- EPSDTs increased by 10% for females, while they decreased by 3% for males.
- There was a 40% decrease in female family planning visits over the past two years.
- There was 53% decrease in sports physicals (include sports blitz visits) for males and a 42% decrease for females. This is likely related to the late DOH contracts as sports physicals are mostly conducted in the early fall months.

The NM 2008 Adolescent Health Report compared seven risk factors for male and female students. Two risk factors were substantially higher for male students: the prevalence of obesity was 17.3% for males compared to 6.5% for females (Youth Risk and Resiliency Survey)[8]. The

8 http://nmhealth.org/erd/HealthData/yrrs.shtml, The New Mexico Youth Risk and Resiliency Survey is a survey of public high school students (grades 9 - 12) and public middle school students (grades 6 - 8). The survey includes questions about risk behaviors (behaviors contributing to unintentional injury; behaviors associated with violence; mental health, suicidal ideation and suicide attempts; alcohol, tobacco and drug use; sexual activity; and physical activity, nutrition, and body weight) and resiliency (protective) factors.

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reported suicide rates for males were 6.6 times higher than for females. This information helps inform OSAH and ENM regarding where to target services. ENM staff has the expertise to provide SBHCs with technical expertise to increase the number of male students accessing services, as well as to improve delivery of healthy weight and behavioral health services and referrals.

In the following sections of this report, performance measures that are specific to ENM operations are highlighted in orange. Measures that need to be monitored and acted upon by a SBHC partners are highlighted in blue.

Table 2 presents sample performance measures and recommended actions related to SBHC utilization.

Table 2 - Performance Measures and Actions: SBHC Utilization and EPSDT Rates

Performance Measures and Actions: SBHC Utilization		
	Sample Performance Measures	**Recommended actions**
SBHC Partners	***SBHC Utilization*** a) Quarterly visits/visits in previous year quarter b) Total monthly visits/total students served c) Percent utilization by gender d) Total EPSDTs/total students served	a) Identify a few (2 or 3) high priority performance measures for quarterly network monitoring. b) Modify "Monthly SBHC Operating Reports" to include comparative date for "high-priority" measures from previous year and month. c) Develop campaign to increase SBHC utilization.
Envision	a) Adapt partner performance measures (above) to site-specific measures. b) Envision utilization tracking and intervention.	a) Conduct monthly review of each ENM SBHC based on "high-priority" performance measures identified by the network. b) Develop site intervention protocols that are responsive to changes in high-priority performance measure. For example, if there is a drop of over 10% in SBHC utilization compared to the previous year or month, contact SBHC coordinator to identify problems and develop plan of action.

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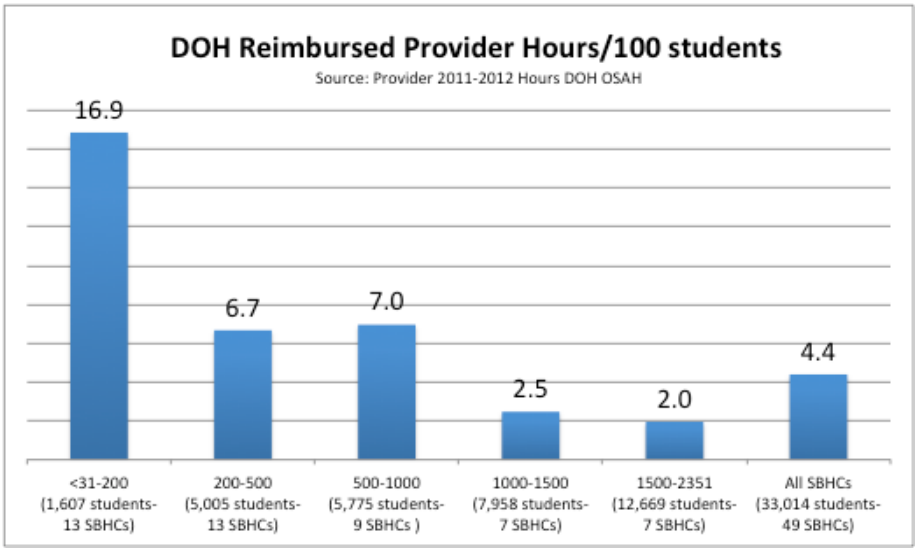
SBHC Staffing and Operations

SBHC Staffing

Primary care providers, behavioral health providers, and program administrators staff SBHCs. DOH provides funding for behavioral health and primary care providers at each site with which they contract. In addition, tribes, foundations, FQHCs fund supplemental provider hours. Foundation funding provided additional provider hours for SBHCs in the Elev8 SBHC Program, including 40 hours/week of behavioral health hours for Grant and Wilson Middle Schools. Elev8 also provided funding for Acoma/Laguna SBHCs. FQHCs may also have supplemented DOH funding at the sites that they serve; however, those data were not available for this analysis.

Figure 9 presents DOH provider hours/100 students by the number of students served by each SBHC. Small schools get substantially more DOH funded provider hours/enrolled students than larger schools.

Figure 9 - DOH-Reimbursed Provider Hours/Student by School Size



Note: This data does not include non-DOH funding sources.

Data highlights:

- The ratio of providers/students served at each SBHC ranges from 1.4 at the Las Cruces High School SBHC, which serves 2351 students to 51.6 at the Lake Arthur Middle School with 26 students (Appendix 1).
- The 13 SBHCs with 31 – 200 students had a total of 16.9 provider hours/student.
- The 7 SBHCs with 1500 – 2351 students had only 2 provider hours/student.

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At the end of the school year ENM staff provided anecdotal assessments of staffing conditions and other circumstances that limited the ability of the clinic staff to complete QI activities, which are listed in Table 3.

Table 3 - Impact of SBHC Staffing on QI Activities 2010-2012

Perceived Barriers to QI work
Distance. Face to face contact is better than by phone.
SBHC lack of knowledge of QI and unfamiliarity with ENM. Engagement improved as sites got to know our program better.
Site attitudes towards ENM had a direct impact on the level of work. Those who saw QI as helpful were able to fully engage even when feeling overburdened. Sites who saw QI as a burden carried that attitude into their work and their outcomes reflected this attitude.
The changing healthcare environment wore the providers down.
There was lack of investment in the QI process.
There was lack of follow through in the QI process.
Clinic staff was too busy with clinical care and changes within the practice to work on the QI tasks.
Electronic Health Record (EHR) transition and implementation was a burden on staff time.
Differing priorities of the team limited the impact of the QI work.
Lack of teamwork and communication limited the impact of the QI work.
Providers tried to make changes individually rather than using QI methodology,
The lack of QI champions at the SBHCs negatively impacted communication between ENM and SBHC staff.

SBHC Staff Perceptions

At the beginning of the school year SBHC staff served by the ENM program were asked to participate in a staff perception survey. There were a total of 72 responses; five staff members responded from four CHIPRA SBHC sites, and from 1 to 5 staff members responded from the other sites served by ENM.

SBHC staff responded to two questions regarding team communication and participation:

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1) On a scale of 1 to 5 (with 5 representing very well) how well do your team members communicate?[9]

2) On a scale of 1-5 (with 5 representing full team participation), how well does your site function as a team?

Table 4 - Team Communication

SBHC	Average of Communicate	Average of Team Function Rate	Total Team Cohesion	Responses
Average CHIPRA sites	3.7	3.8	7.5	20
Average other sites	3.9	4.1	8.5	52
AVERAGE ALL SITES	3.9	3.9	7.7	72

- The perception of the quality of team functioning ranged from a low of 2.0 to a high of 5.0.
- The average perception of team communication and overall team functioning were both 3.9.

Clinic staff members were asked how their clinic team resolves work-related differences among team members. The most common response was through group discussion.

Table 5 - Conflict Resolution

Item	#	%
We usually resolve issues through group discussion	31	42%
Leader or supervisor meets with those involved to reach solution	21	28%
We leave it up to the parties involved to work out their differences	17	23%
I think we need to have a process	10	14%
Other	3	4%
Respondents	74	

[9] Appendix 3 presents reasons cited by staff members regarding the quality of their team's communication.

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Table 6 presents performance measures and actions related to SBHC staffing.

Table 6 - Performance Measures and Actions: SBHC Staffing

Performance Measures and Actions: SBHC Staffing		
	Sample Performance Measures	**Recommended actions**
SBHC Partners	***SBHC staffing levels*** a) Students served/behavioral health provider hours b) Students served/primary care provider hours ***SBHC staff stability*** a) Percent staff turnover from previous year	a) Develop SBHC target-staffing levels. b) Develop NM SBHC Staffing Plan, including criteria for prioritizing SBHC sites for increased staffing levels. c) Prepare quarterly staffing level reports of all SBHC sites (student/provider ratios); include in monthly monitoring reports.
OSAH		a) Require monthly staffing level updates, i.e. hours/provider type, as part of monthly reporting. This information should be actual, not budgeted time. b) If feasible, integrate this data entry into Welligent data entry system.
Envision	Adapt SBHC partners' performance measures (above) to site-specific measures.	a) Continue to gather information on staffing capacity issues as part of school year initial assessment. b) Develop criteria for selecting ENM SBHC sites for preparation of site-specific staffing capacity plans.

SBHC Equipment and Supplies

At the beginning of the school year, ENM staff recorded "missing" equipment and supplies based on conversations with SBHC staff. Based on anecdotal information from some of the sites, it is apparent that clinic staff is not necessarily aware of what they have, what is missing, and the condition of the equipment. Regardless, it is evident from the data gathered that some critical equipment and supplies are missing. A list of items reported as "missing" is presented below.

- Oxygen (10 sites)
- Defibrillator (7 sites)
- Rapid strep tests (6 sites)
- Group a strep cultures (5 sites)
- Microscope (3 sites)

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- Hemocue (3 sites)
- Nebulizer (2 sites)
- Scanner (1 site)
- Dental equipment (1 site)

Table 7 - Performance Measures and Actions: SBHC Medical Equipment

Performance Measures and Actions: SBHC Medical Equipment		
	Sample Performance Measures	**Recommended actions**
SBHC Partners	***Equipment and physical capacity*** The selected measures should be directly related to the SBHC standards of care described in the NM DOH OSAH "School Based Health Center Standards and Benchmarks, updated April 2010".	a) Verify equipment and facility needs at non-ENM SBHCs within 30 days of the 2011/2012 school year and 30 days before the end of the school year. b) Develop statewide strategies to address unmet equipment needs. c) Add an inventory of equipment and supplies to the new OSAH Operational Plan form (which all DOH funded SBHCs will be required to complete at the beginning of the school year).
Envision		a) Verify equipment and facility needs at each ENM SBHC within 30 days of the 2011/2012 school year and 30 days before the end of the school year. b) Develop site-specific plans to address unmet equipment needs, such as sharing equipment used by school nurses or the results of school nurse conducted medical examinations (such as hearing and vision screenings).

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Envision Operations

The ENM staff is very experienced and multidisciplinary. The staff includes nine skilled medical professionals, including a pediatrician, a registered dietician, social workers, nurse practitioners, a physician assistant, a psychiatrist, and support staff. In 2011/2012 ENM provided the equivalent of four full-time staff members (FTEs) to support DQI and AQI SBHC initiatives. Each site was assigned a lead; one additional team member attended each site visit. All ENM QI staff attended weekly meetings to provide input and technical support to the SBHC staff members responsible for serving the ENM QI SBHC sites.

These ENM staff members provide a wide range of support to SBHCs including site visits, emails, phone calls/coaching calls, webinars and written materials. Some of this support is site-specific, and other support, such as webinars, is for all SBHCs. ENM staff made 20 site visits in the 2011/2012 school year, including two visits to two sites. The purposes of the visits were:

- Developing or renew relationships with SBHC staff
- Updating SBHC staff on the current year QI protocols
- Providing PDSA training
- Assisting in developing site specific PDSA
- Medical Record Review training and technical assistance

In 2011 each ENM QI staff member began tracking all contacts he/she made with each site, in person, by email, or by telephone. Table 8 presents the months that ENM staff sent emails, and made phone calls and site visits. This data can be used to develop strategies to improve the timeliness and effectiveness of ENM interventions.

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Table 8 - ENM Staff Contacts with SBHC Sites

Contact Month	Emails	Phone Calls	Total Email and Phone Contacts	Cumulative % of email & phone contacts	1st site visit	2nd site visit	Cumulative % of all site visits
Sep-11	0	1	1	0%			0
Oct-11	4	5	9	2%	1		5%
Nov-11	44	38	82	16%	6		33%
Dec-11	39	27	66	27%	6	2	71%
Jan-11	59	51	110	46%	3		86%
Feb-11	86	33	119	66%	1		95%
Mar-11	75	32	107	85%			95%
Apr-11	30	14	44	92%	1		100%
May-11	23	22	45	100%			
Total	360	223	583		18	2	
% of Contacts	62%	38%					

Data highlights:

- ENM was not able to begin the QI process until a SBHC had a signed DOH contract. Consequently, there was only one site contract in September and 9 in October. By November most of the contracts were in place and ENM staff made 82 phone and email contacts.
- The number of email/phone contacts ranged from 12 to 73.
- Some of the variation is related to late contract start-up dates
- Some of the variation is due to different coaching styles by ENM staff.
- Site visits began in October 2011. The last site visit wasn't completed until April 2012 due to a late contract initiation date.
- By the end of November 2011, only 33% of the sites had at least one visit.
- 71% of the sites had at least one ENM site visit by the end of December; by that time 41% of all of the SBHC visits were completed.
- The email/phone contacts peaked in January, February, and March, as ENM staff worked closely with SBHCs to meet QI goals during a compressed clinic year.

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Table 9 - Performance Measures and Actions: SBHC Staff Time

Performance Measures and Actions: Envision Staff Time		
	Sample Performance Measures	**Recommended actions**
Envision	***Site-specific technical assistance.*** a) ENM technical assistance staff contacts/site. b) Percent of SBHC sites visited within 30 days of SBHC opening.	a) Establish SBHC contact and site visit scheduling targets to maximize the impact that ENM services can have on SBHC operations.
OSAH		a) Require SBHCs to select whether or not they will participate in the ENM QI program before the end of the previous school year.

Plan Do Study Act Tool

The Plan Do Study Act (PDSA) tool provides a framework for developing, testing and implementing changes that will lead to improvement. ENM staff is trained to utilize this tool and to provide PDSA technical assistance to SBHCs. Documenting the quality and outcomes of PDSAs is a critical component of evaluating a SBHC QI program. More importantly, sharing high quality PDSAs with SBHC staff throughout the state would be a useful training tool.

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Table 10 - PDSA Topic Areas

Topic	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site J	Site K	Site L	Site M	Site N	Site O	Site P	Grand Total
BH Registry			4		2											6
BMI%									1				1		1	3
BP%		1						1				1				3
Communication - students									1							1
EPSDT documentation				2		1								1		4
EPSDT increase	1															1
Hearing & Lab tests							2							1		3
Hemocue			1													1
Imm	1	1	1		1							1				5
Lab documentation											1		1			2
Staff Communication					4		1							1		6
Telehealth							3									3
WCDx	1				2			1								4
Scheduling appts										1						1
Grand Total	**3**	**2**	**6**	**2**	**9**	**1**	**6**	**2**	**2**	**1**	**1**	**2**	**2**	**3**	**1**	**43**

Data highlights:

- The most common PDSA topic was to improve BMI/Weight category diagnosis documentation (7 PDSAs), followed by immunizations (five sites).
- Four other PDSAs focused on improving other specific EPSDT items.
- Four PDSAs focused on overall EPSDT documentation.
- One site selected to work on increasing the number of EPSDTs.
- Three sites selected to work on staff communication, and one site on communication with students

Table 11 presents a performance measure and recommended actions related to PDSAs.

Table 11 - Performance Measures and Actions: PDSAs

Performance Measures and Actions: PDSAs		
	Sample Performance Measures	**Recommended actions**
Envision	Percent of PDSAs that meet ENM criteria for quality and outcomes.	Develop criteria and protocols for assessing the quality and outcomes of SBHC PDSAs.

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Medical Record Reviews

EPSDT and the Proficiency Model Overview

Quality improvement (QI) depends on data to signify improvement, but the numbers do not usually speak for themselves. The goals of Quality Improvement (QI) are

1. Simple operational change;
2. Short cycle evaluation of change; and
3. Sustainable after change is made.

The steps to successful QI are:

1. Define the best care that can be provided in this setting based on evidenced-based medicine;
2. Identify the gap between current practice and best practice, and;
3. Participate in closing that gap.

The medical record review (MRR) process is a standard QI tool that helps measure progress towards established goals that are evidenced by changes in the content of medical records around specific practice guidelines. Since 2007, when ENM first began providing technical assistance to SBHCs, MRRs have been an integral part of the program evaluation. MRRs in the DQI work with SBHCs include an assessment of the accuracy of Early Prevention, Screening, Diagnosis and Treatment (EPSDTs) documentation. EPSDTs are Medicaid defined annual child-wellness exams.

ENM's DQI work with SBHCs focuses on improving the delivery of EPSDT examinations. QI does not rely on large statistically powerful samples of data to demonstrate change, however data must be specific to the goals to be achieved and the processes that are affected. Complex QI processes and results lessen the motivational impact that the information can provide.

Completing numerous MRRs is perceived by SBHC staff as an overly burdensome process, consuming substantial amounts of SBHC staff time. Each year it has been a challenge to collect a sufficient number of MRRs to demonstrate reliable site-specific improvements in EPSDT documentation. To address this problem, this year ENM adopted an "EPSDT Proficiency Level" model. The model focuses attention on the core functions of the clinic and staff before moving on to more complex elements of providing care in the SBHC. Required components of the EPSDT exam, documented in each student's medical record, were categorized into three levels – basic, near proficiency, and proficient. In addition, three "best practice" items are included in the model, which are not required by Medicaid.

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The levels were established based on the assumption that core elements of comprehensive health care occur at Level 1 and the more complex elements that require expertise and integration of the entire SBHC occur in Level 4 (Table 12). Level 4 items are not required for a Medicaid reimbursed EPSDT in New Mexico, however they improve the quality of the exam and provide a potential stepping-stone for AQI work.

Every staff member at every SBHC has good ideas about how to improve care. The strategy of the ENM Proficiency Model is to move from the most intuitive functions of the clinic process and provider experience to the more complex, making incremental progress to achieve proficiency and support sustainable changes in service delivery. The framework of the proficiency model guides ENM QI coaches as they guide SBHCs in systems improvement.

SBHC staff complete paper medical record reviews, based on protocols established by ENM. The medical records are randomly selected. ENM staff enters the data into a Microsoft Excel database and provides feedback quickly in graphic form, on a single page, to identify areas in need of improvement. This report back to the sites is called a Fast Feedback Form (FFF). To receive a "pass" for a level, 75% of charts in a sample must include 100% of the items in the level. For example, even if all elements of Level 4 were documented, if there were incomplete elements at Level 1, the site would be classified as "Basic" (Level 1), until the cut-point of 75% is met. ENM staff members were instructed to continue to work with SBHC staff on elements in the Basic Level until at least 75% of the elements in the Basic Level were completed correctly 100% of the time. Once the 75% threshold was met, ENM staff began to provide technical support on items in the next level.

Feedback from coaches and SBHC staff was positive regarding the utility of the Proficiency Model and the FFF for focusing QI efforts. The higher number of PDSAs and topics, coupled with improved MRR data suggest this model impacted the quantity and quality of QI work.

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Table 12 - EPSDT Documentation Proficiency Levels

PROFICIENCY LEVEL	EPSDT MEDICAL RECORD REVIEW ITEM
Level 1 Basic	Blood Pressure
	Height, Weight, BMI# & BMI%
	Immunization Status
	Physical Exam
	Review of Systems
	SHQ 1st visit
Level 2 Nearing Proficiency	Hct/Hgb
	Urine Analysis
	Hearing Screen
	Vision Screen
	Dental Counseling
	SHQ Reviewed
Level 3 Proficient	Anticipatory Guidance
	Medical Risk Factors
	Behavioral Risk assessed
	Additional Diagnoses
	Follow-up appointments
	Referrals
Level 4 Best Practice	Student Confidential Consent
	Weight Category Diagnosis
	Blood Pressure % recorded if BMI ≥85%

EPSDT Medical Record Review Findings

Figure 10 presents the overall proficiency for ***individual EPSDT items*** achieved during the baseline (334 MRRs) and final reviews (233 MRRs). The items are grouped by the ENM established proficiency levels. The items included in the "basic" level are essential for providing the background information needed to properly assess items in the more complex, "proficiency level". For example, it isn't possible to complete a comprehensive assessment of "medical risk factors", included in the "proficiency level", without completing all of the items in the basic and near proficiency levels. Based on this "pass" protocol, the "proficiency level" was aggregated for all schools for the baseline, short cycles, and final evaluations for the 4 Proficiency Levels.

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A comparison of MRR proficiency between 2010/2011 and 2011/2012 was also conducted to assess the impact that the new Proficiency Model had on EPSDT proficiency, compared to the more traditional MRR approach utilized in past years Figure 11. In 2010/2011 356 Baseline MRRs were conducted, followed by 223 “first follow-up” MRRs. Final “MRRs” were also planned. However it was too burdensome for SBHC staff to complete a final set of MRRs, and the “follow-up” MRRs served as the “Final” review.

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Figure 10 - EPSDT Medical Record Reviews by Item

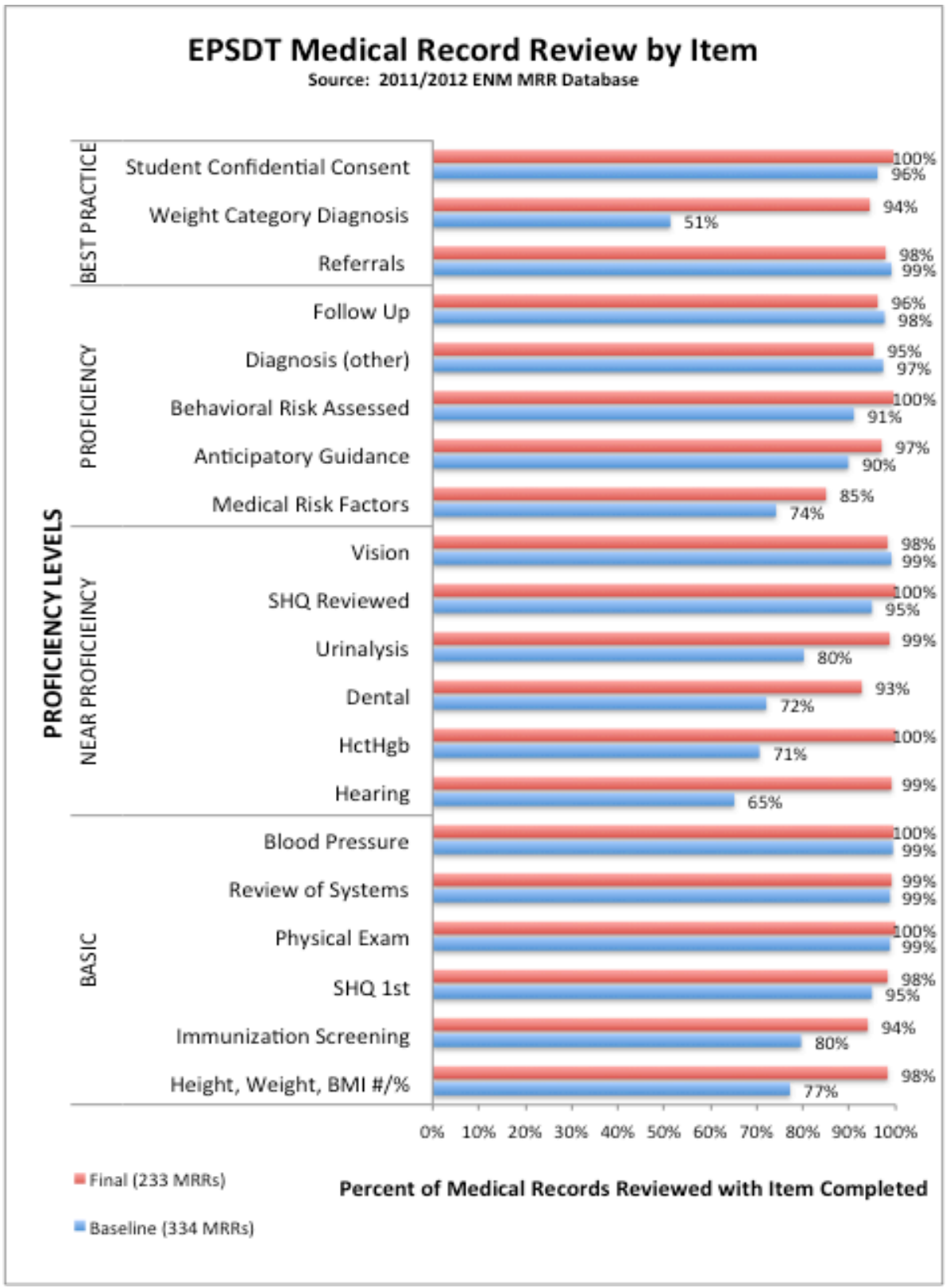

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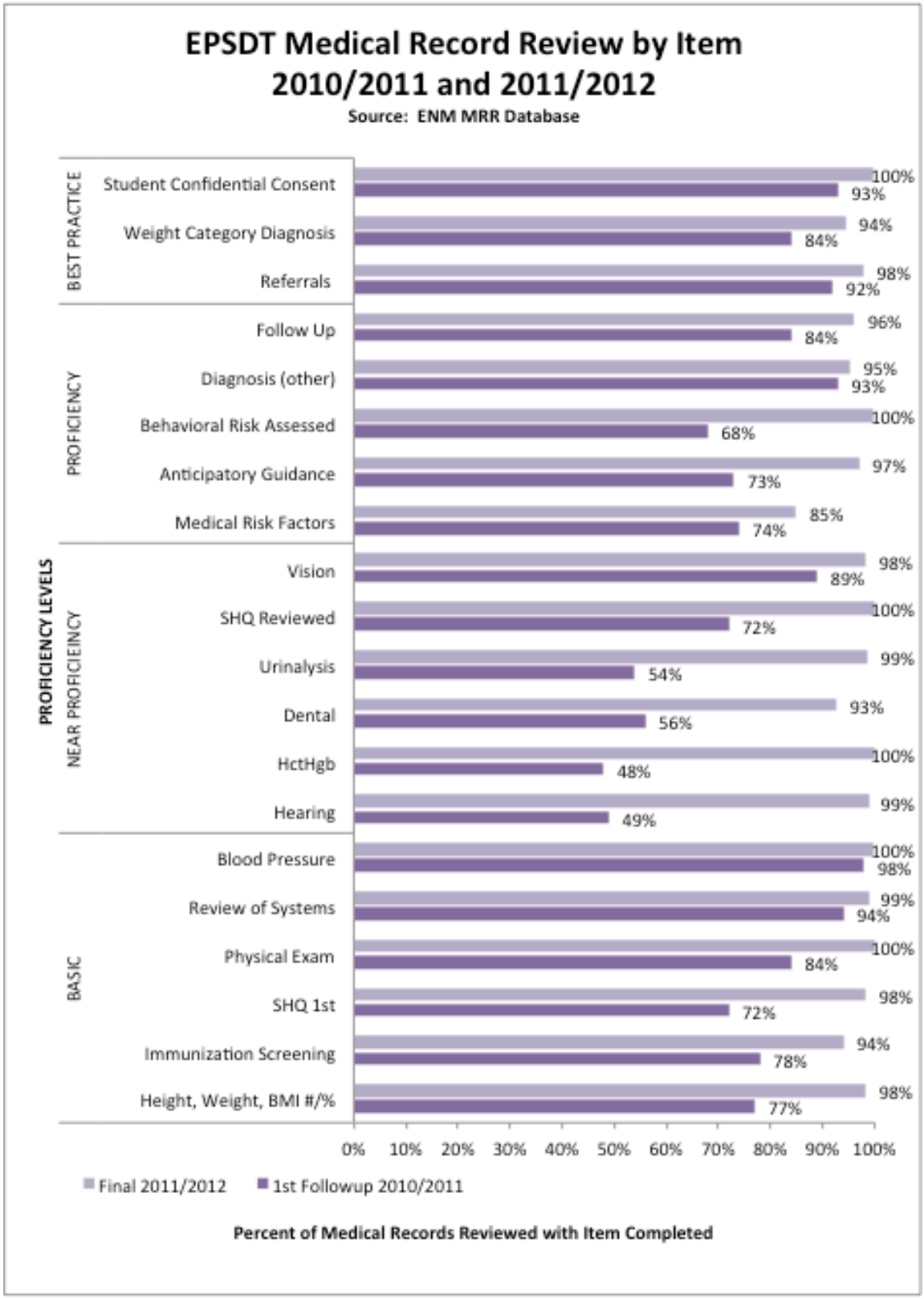
Figure 11 - EPSDT Medical Reviews 2010/2011 and 2011/2012



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Data highlights (Figures 11 and 12):

Figure 11– 2011/2012 MRRs

- At baseline, there were three items in the "Near Proficiency" level (hearing screening, dental screening, and Hct/Hgb) that were completed at a lower rate than the "medical risk factors" in the "Proficiency Level".
- At the final review, all of the items in the "Near Proficiency" level were completed at a higher rate than the "medical risk factors".
- These findings demonstrate that ENM's approach to focus on "Basic" items in order to support better overall student health assessments has positively impacted the EPSDT process.

Figure 12– Comparison of 2010/2011 MRRs and 2011/2012 MRRs

- The change between the two years was calculated as:

  % correct per item in 2010/2011 - % correct per item in 2011/2012.

- The percent of MRRs with correct documentation was higher for every EPSDT item in 2010/2011 compared to this year.
- In the Basic Proficiency Level, the greatest improvement was documentation of SHQs on the first visit (an increase of +26%), followed by Height, Weigh, BMI #/% (+21%).
- In the Near Proficiency Level, there were substantial improvements in five of the six EPSDT elements, ranging from +28% for "SHQ Reviewed" to +52% for "Hct/Hgb".
- In the Proficiency Level, the largest gain was for "Behavioral Risk Assessed" (32%), followed by "Anticipatory Guidance" (+24%).
- The most modest gains were in "Best Practice" items, which were high in both years.

Ten DQI SBHCs submitted baseline and final medical record reviews. This information was analyzed to assess the positive impact that ENM coaching had on EPSDT proficiency over the course of the year (Figure 12).

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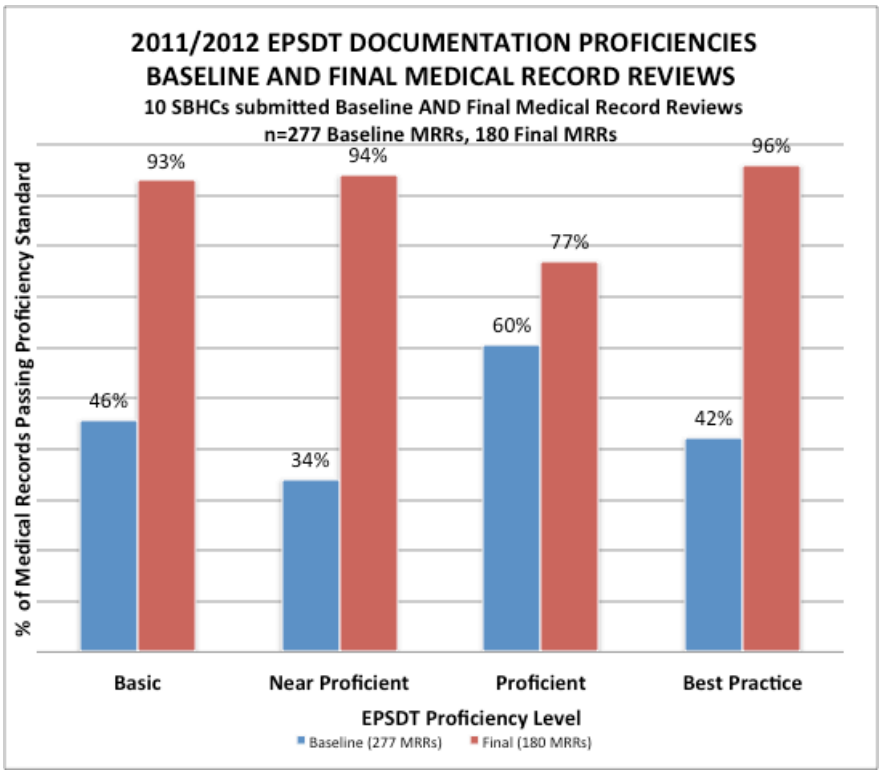
Figure 12 - EPSDST Medical Record Reviews - SBHCs with Baseline and Final MRRs



Data highlights:

- The "percent pass" is the percent of the medical records reviewed that had all elements in a level documented correctly.
- The "percent pass" is the average "pass" rate for the ten sites; i.e. the "percent pass" for a site with 20 MRRs has the same weight as the "percent pass" for a site with 10 MRRs.
- The "percent pass" was substantially lower in the Baseline than in the final reviews for all Proficiency Levels.
- At baseline, 60% of the SBHCs received a "pass" for proficiency but only 46% received a "pass" for basic proficiency.
- It is interesting to note that at the end of the year, 96% of the sites passed the "Best Practice" level, while only 60% passed the "Proficient Level".
- The biggest change was in the "near proficiency" level, which increased from 34% to 94%.
- This data provides further evidence that the new EPSDT Proficiency Model is an effective model to improve EPSDT proficiency.

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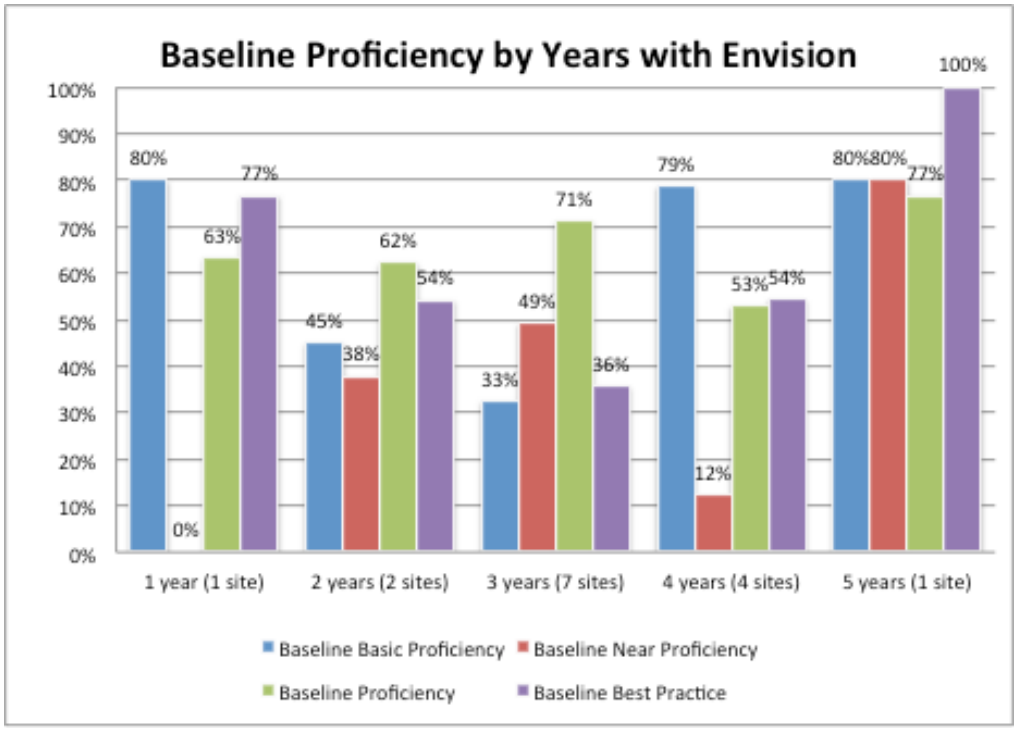
This year's ENM sites have received ENM technical support from 1 to 5 years. Figure 13 summarizes MRR baseline proficiency by the number of years SBHCs have been served by ENM.

Figure 13 - Baseline Proficiency by Years with Envision



Data highlights:

- Fourteen of the fifteen SBHCs that submitted baseline MRRs, worked with ENM for at least one year **before** the 2011/2012 school year.
- In reviewing this data it is important to keep in mind that due to substantial SBHC staff turnover, even though ENM may have worked at a SBHC for multiple years, many of the individual staff members have not received ongoing ENM coaching and QI training.
- As discussed in the previous section, there appears to be a very positive impact on SBHC EPSDT proficiency in a given year. However, there is no apparent relationship between the number of years an SBHC has worked with Envision and EPSDT baseline proficiency.
- This finding, along with high SBHC staff turnover, changes in SBHC standards, benchmarks, and billing protocols, emphasizes the need for ongoing QI training for all SBHCs.

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Advanced Quality Improvement

There were two additional AQI content areas this year: Behavioral Health (BH AQI) and Sexually Transmitted Infection (STI AQI). Three sites were involved in the BH AQI and one in STI. One of the BH AQI sites transferred to CHIPRA effective December 1, 2011.

One common and new program element in the AQI sites this year is the introduction of patient registries. The utilization of patient registries in managing patients with chronic illness is a central part of Patient-Centered Medical Home, and has been identified as a best practice in healthcare reform.

Behavioral Health AQI

Studies indicate that one in five children/youth have some sort of mental, behavioral, or emotional problem, and that one in ten may have a serious emotional problem. Among adolescents, one in eight may suffer from depression. Of all these children and teens struggling with emotional and behavioral problems, a mere 30% receive any sort of intervention or treatment. SBHC teams are uniquely suited to identify and address student depression and related crises, including suicidality. Envision NM behavioral health QI staff worked with participating SBHCs to develop and review the Behavioral Health Registry as a tool to enable SBHC staff to identify and track each of their students who are at risk of, or experiencing, depression and/or anxiety.

Two sites began using the BH registry. One site submitted two registry reviews and the other site submitted four registry reviews. The behavioral health registry and review is a complex process. The current BH AQI registry review tool (Appendix 4) includes seven items as proxies for behavioral health best practice. The registry for this year was hard-copy forms in a binder. A positive screen on the SHQ was the entry point for entry into the BH registry. SBHC staff were educated on the use of evidence-based assessment tools valid for use in this population. The seven items were:

- Risk Level (medium or high)
- Screening (depression or anxiety)
- Assessment Tools Used (PHQ-9 or SCARED)
- Team Conference Done?
- Comprehensive Assessment Done?
- Treatment Received?
- Discharged?

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Sites were asked to review their registry once a month and submitted their reviews when completed.

Lessons Learned

Revisions for next year include encouraging use of electronic health records as a registry. A key aspect of registry development involves differentiating between information needed for clinical management and that needed for quality improvement. This will involve enhanced training up-front for sites using registries for management of their at-risk, behavioral health populations.

Sexually Transmitted Infections AQI

The STI AQI was in development this year; one site served as a pilot. The STI AQI involved establishing a registry. A positive screen on the SHQ for sexually activity was the entry point into the STI registry. Ten items on the STI review serve as best practice proxies for providing screening, diagnosis and treatment for sexually transmitted infections.

- Was a syphilis test ordered?
- Was an HIV test ordered?
- Was a pregnancy test ordered?
- Rubella immunization up to date?
- Current and signed confidential consent form?
- Was a Chlamydia/Gonorrhea test ordered?
    - If a CT/GC test was ordered, was the test positive?
    - If the test result was positive, was there expedited partner treatment?
    - Was there a retesting appointment scheduled?
    - Was the case reported to the Health Department?

The protocol specifies that the site initially collect data on the prevalence of sexual activity in their county for a similar age group served by their SBHC as a way of framing their concern about this population. The next step involved looking specifically at the rate of infection for chlamydia and gonorrhea in their county and the state as a whole. Baseline data collection involved identifying target ICD9 codes to compare incidence of infection with state and county rates.

Their rates were similar to state and county rates but lower than what was expected. The site created an initial registry of positive screens and completed one medical record review using the registry review tool. The information was submitted electronically to ENM and the results have been discussed with the site. ENM is continuing to develop the report format and

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procedures along with the revised protocol for sites that choose to work in this clinical area next year.

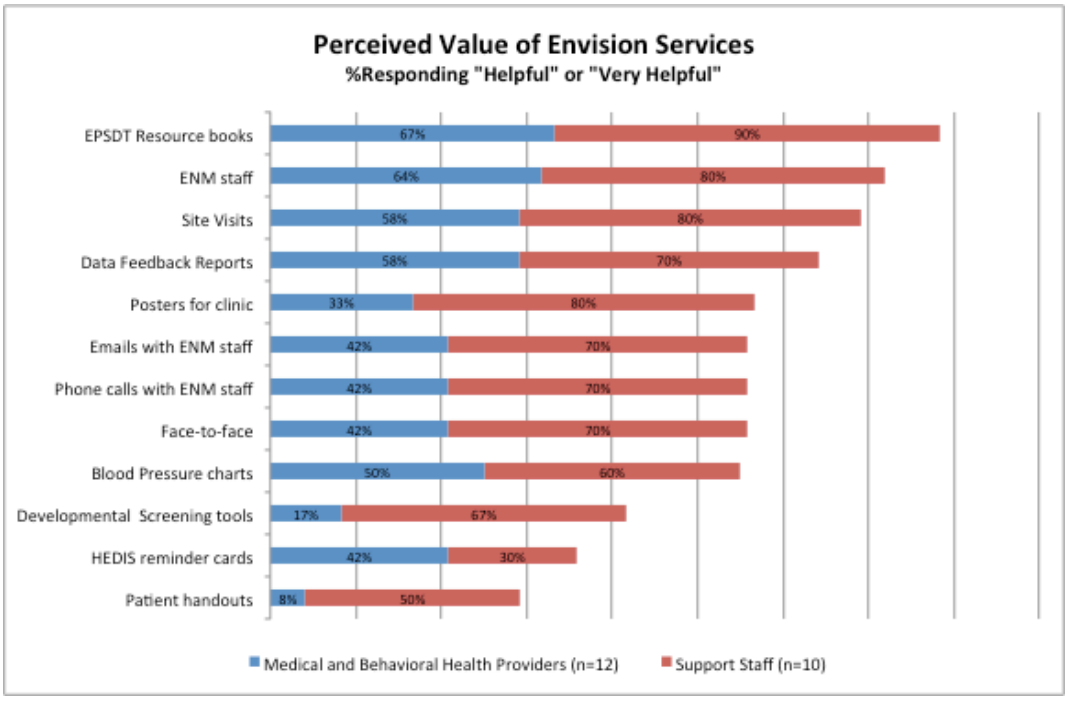
Lessons Learned

It is extremely important that sites spend the time up front to gather information about their community and population. This enables sites to be assured that they are accurately capturing the expected rate of at-risk students.

2011-2012 SBHC Participant Satisfaction Survey

ENM conducted a Participant Satisfaction Survey of SBHC staff in May 2012. SBHC staff includes behavioral health and medical providers, health educators and administrative staff. Twenty-five SBHC staff members completed the surveys. The data are aggregated into two groups - medical and behavioral health providers and support staff. Support staff includes medical assistants. Survey highlights are presented below. Figure 14 describes the perceived value of SBHC services; Figure 15 presents interest in Webinar topics; Figures 17 and 18 describe perceived value and participation in PDSAs (Plan Do Study Act).

Figure 14 - Perceived Value of SBHC Services



Data highlights:

- EPSDT Resource books were considered the most valuable by both support staff (90%

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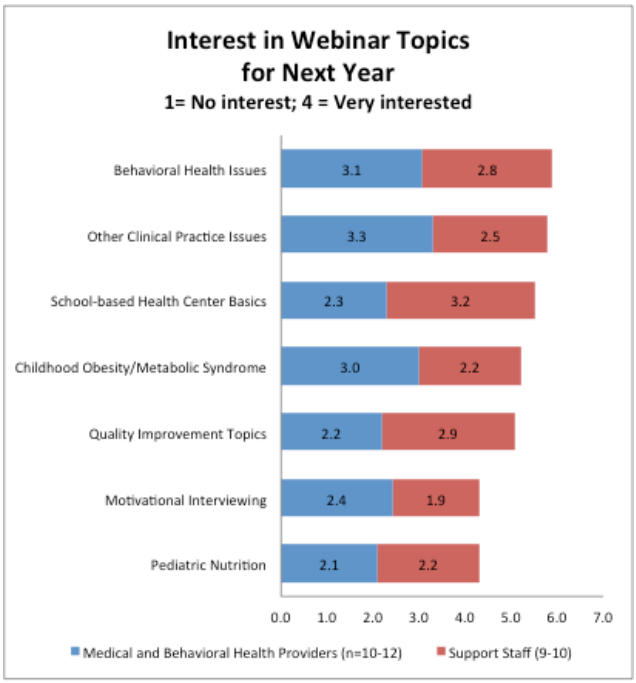
of respondents), and providers (67%).

- With the exception of HEDIS reminder cards, support staff felt that ENM services were more helpful as compared to the medical and behavioral health providers.

Figure 15 - Interest in Webinar Topics



Data highlights:

- Medical providers expressed the most interest in webinars on "other clinical practice issues".
- Support staff expressed the most interest in webinars on SBHC basics.

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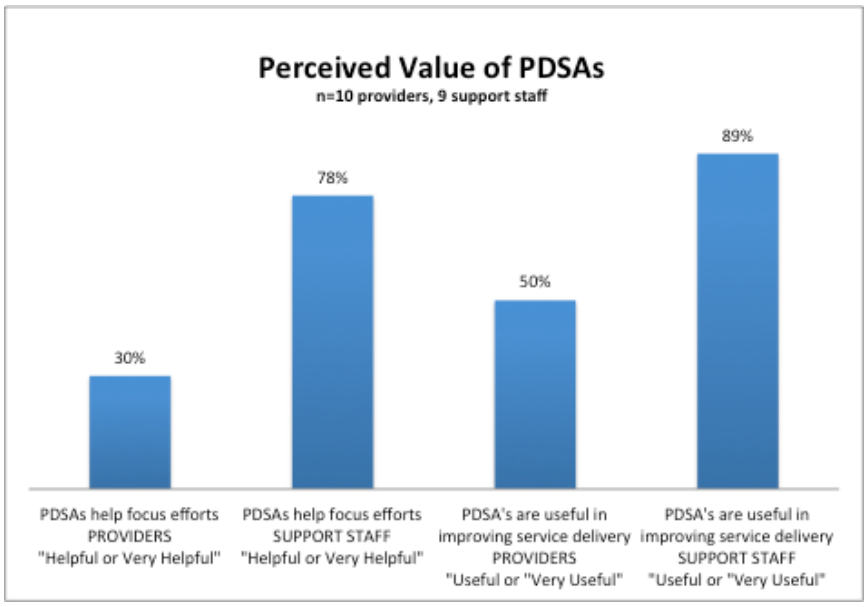
Figure 16 - Perceived Value of PDSAs



Data highlights:

- In general, support staff feels that PDSAs are more valuable than did the medical and behavioral health providers.
- 89% of support staff feels that PDSAs are useful in improving service delivery, compared to 50% of providers.
- 78% of support staff feels that PDSAs help focus clinic efforts, compared to 30% of providers.
- Since of the PDSAs focused on clinical processes, the difference in perceptions between providers and support staff may be because support staff is more directly impacted by PDSAs results.

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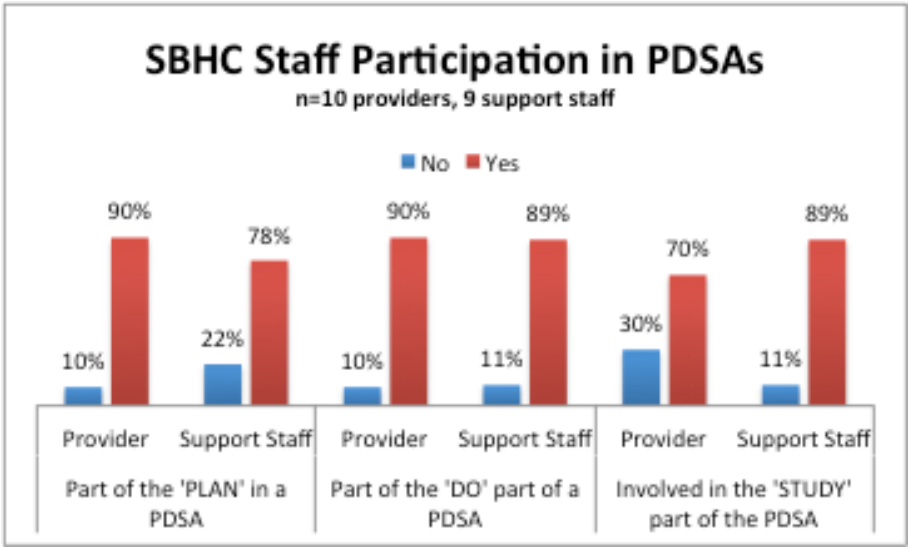
Figure 17 - SBHC Staff Participation in PDSAs



Data highlights:

- Both providers and support staff reported high participation in developing and implementing the PDSA action items.

Table 13 - Performance Measures and Actions: Participant Satisfaction

Performance Measures and Actions: Participant Satisfaction		
	Sample Performance Measures	**Recommended actions**
Envision	***Perceived quality of ENM services.*** a) Percent of skilled medical professionals and percent of support staff that rate ENM overall services as "very helpful". ***Perceived impact of QI on patient care.*** a) Percent of skilled medical professionals and percent of support staff that feel that QI has a moderate or extensive positive impact on patient care.	a) Develop and implement an assessment tool to determine reasons for relatively low QI support by skilled medical professionals. b) Develop and implement provider MI intervention to increase perceived value of QI by SBHC skilled medical professionals.

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Summary and Conclusions

- During the 2011/2012 school year, sixteen SBHCs participated in the ENM Demonstration Quality Improvement (DQI) program. Building on last year's Early Intervention, Screening, Diagnosis, and Treatment DQI program, the 2011/2012 DQI focused on improving EPSDT documentation. SBHCs that met the ENM established EPSDT proficiency standard, had the option of participating in AQI to work on improving other SBHC clinical practices.
- There were two AQI content areas this year: Behavioral Health (BH AQI) and Sexually Transmitted Infection (STI AQI). Three sites were involved in the BH AQI and one in STI. Both AQIs utilized patient registries to document student needs. Patient registries are a "best practice" in healthcare and a central component of Medicaid healthcare reform. The information learned from these pilot AQIs will be used to support future ENM SBHC QI initiatives.
- There was a 35% decrease in student utilization of SBHCs from 2010/2011 to 2011/2012. Due to new contract requirements, DOH SBHC contracts weren't finalized until October, which is normally the highest utilization month. Even once the contracts were in place, it was difficult for SBHCs to reach full staffing levels in a timely manner. Even with the substantial overall decrease in overall utilization, there was a 10% in EPSDTs for female students.
    - The ENM sites completed about twice as many EPSDTs/enrolled students as the other DOH sites.
    - The ENM DQI sites were also the most successful in providing EPSDTs to unduplicated SBHC patients. 34% of all students that accessed ENM SBHC, received an EPSDT, compared to 17% for all SBHC patients in DOH funded SHBCs.
- Utilization patterns for the past four years indicate that lower monthly SBHC utilization from January through May provides an opportunity for increasing the number of SBHC services, with existing staff levels.
- During the 2011/2012 school year, sixteen SBHCs participated in the ENM Demonstration Quality Improvement (DQI) program. Building on last year's EPSDT DQI program, the 2011/2012 DQI focused on improving EPSDT documentation.
- This year ENM implemented initiatives to monitor ENM staff contacts at each DQI SBHC (phone calls, emails, and site visits). This information will be used to help maximize the impact of QI on SBHC operations; establishing internal performance measures is a useful tool that should be considered. Relevant performance measures include those related to allocation of staff time and establishing timelines to maximize the impact of QI on SBHC operations. The data collected this year will support that effort.

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- 71% of the ENM DQI sites had at least one ENM site visit by the end of December; by that time 41% of all of the SBHC visits were completed. Contractual delays impacted timely site visits.
- This year ENM began cataloguing and categorizing PDSAs, a critical component of successful QI initiatives. The most common PDSA aim was to improve BMI/Weight Category documentation (six sites), followed by immunizations (five sites). This information will be useful in helping SBHCs learn from each other's successes and to fine-tune ENM technical assistance.
- To improve ENM's SBHC program effectiveness, a new ENM EPSDT Proficiency Model was implemented. The model was designed to reduce the burden of a large number of medical record reviews, and to focus attention on strengthening the core functions of the clinic and staff before moving on to more complex elements of providing care. The sixteen required components of the EPSDT exam were categorized into three levels – basic, near proficiency, and proficient. In addition, "best practice" items were included as a fourth level.
    - Feedback from coaches and SBHC staff was positive regarding the utility of the Proficiency Model and the "Fast Feedback Form", which provided quick feedback to both ENM and SBHC staffs. The higher number of PDSAs and topics, coupled with improved MRR data suggest this model impacted the quantity and quality of QI work.
    - A comparison of last year's MRRs with this year's revealed that the ENM SBHC sites improved documentation for each EPSDT element; many of the improvements were substantial.
    - The data indicate that there is a very positive impact on SBHC EPSDT proficiency in a given year. However, there is no apparent relationship between the number of years an SBHC has worked with Envision and EPSDT baseline proficiency. In reviewing this information it is important to keep in mind that due to substantial SBHC staff turnover, even though ENM may have worked at a SBHC for multiple years, many of the individual staff members have not received ongoing ENM coaching and QI training.
    - This finding, along with high SBHC staff turnover, changes in SBHC standards, benchmarks, and billing protocols, emphasizes the need for ongoing QI training for all SBHCs.
- Inadequate SBHC staffing and equipment levels continue to limit the effectiveness of SBHC services. ENM can support these efforts by providing technical assistance to SBHCs interested in utilizing QI tools to tackle these issues. Strategies should be implemented to collect the information necessary to assess the impact of staffing and

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equipment on SBHC utilization.

- SBHC support staff rated ENM services and QI in general, much higher than did SBHC skilled medical professionals. Opportunities exist to enhance engagement of medical and behavioral health providers in quality improvement. Examples of potential strategies are:
    - Use motivational interviewing skills to increase SBHC skilled medical professionals' support for QI.
    - Use QI processes to improve ENM internal operations, such as scheduling of staff hours and site visits.
    - Use QI to work with SBHCs on system changes to address SBHC staffing and equipment needs.
    - Use QI to work with the SBHC partners to improve SBHC utilization and the number of students receiving regular EPSDTs.
- To improve overall SBHC utilization and services, and consequently the impact that ENM QI services can have on improved student health, requires a collaborative effort by all SBHC partners. To support collaboration, the SBHC Partner's Team, with the support of DOH, began a Results Based Accountability (RBA)[10] Initiative in Spring 2012. ENM is playing an active role in this collaborative process designed to address three important questions: "What did we do?" "How well did we do it?"; "What is the impact?"
- The RBA process requires partners to decide on performance measures to direct their collaborative work. Data is utilized on an ongoing basis to measure the impact of this collaborative effort. The Welligent data continues to improve the data available on SBHC utilization and will be a valuable resource during this effort. However, it is challenging to pull together data on SBHC overall capacity (e.g. provider hours, staff turnover, equipment needs). These capacity indicators impact the ability of SBHCs to complete QI initiatives.
- The OSAH 2012/2013 "School Based Health Center Operations Plan" documentation form, will help the RBA data collection effort and will also help ENM target its technical assistance. In addition to the questions currently on the form, it would be useful to include an inventory of equipment availability and condition, as well as funding sources available for SBHC operations.

[10] http://www.resultsaccountability.com/

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Appendices

Appendix 1 - SBHC DOH Hours/Students Served

SBHC	2011/ 2012 Envision Program	Enrolled Students*				DOH funded provider hours			
		Elem students	Middle students	High School students	Total Served by SBHC	DOH funded Primary Care hrs	DOH funded Behavioral Health hrs	Total DOH Hrs	Total Hrs/100 Student
Albuquerque High School	DQI			1678	1678	16	16	32	1.9
Capital High School				1111	1111	24	36	60	5.4
Carlos Vigil Middle School			560		560	16	16	32	5.7
Carlsbad High School				1610	1610	14	14	28	1.7
Chaparral High School	DQI			1078	1078	8	8	16	1.5
Cobre High School	CHIPRA			361	361	16	8	24	6.6
Cuba Schools Wellness			115	304	419	8	8	16	3.8
Des Moines High School	DQI late entry	37	NA	37	74	8	8	16	21.6
Dulce High School	DQI/AQI			197	197	16	16	32	16.2
East San Jose Elementary		580			580	8	8	16	2.8
Escalante High School				120	120	12	12	24	20.0
Espanola Valley High School	CHIPRA			1018	1018	16	16	32	3.1
Ft. Sumner High School			75	101	176	8	8	16	9.1
Gadsden High School	DQI			1715	1715	16	16	32	1.9
Gallup High School				1161	1161	8	8	16	1.4
Goddard High School	DQI (combined site)			1098	1098	7	8	15	1.4
Grant Middle School			728		728	24	YDI	24	3.3
Highland High	DQI/AQI			1667	1667	16	16	32	1.9
Jemez Valley Public Schools	DQI		79	125	204	8	8	16	7.8
Laguna Middle School	DQI/CHIPRA		58		58	9	16	25	43.1
Laguna-Acoma High School				305	305	10	16	26	8.5
Lake Arthur Middle School			31		31	8	8	16	51.6
Las Cruces High	DQI			2351	2351	16	16	32	1.4
Lordsburg High School				198	198	8	14	22	11.1
Lovington High School	DQI			561	561	40	40	80	14.3
Maxwell Wellness		52	16	17	85	8	8	16	18.8
Mesa Middle School (Roswell)	DQI (combined site)		450		450	14	12	26	5.8
Mescalero Apache School		NA			0	8	8	16	NA
Mesta Vista HS	DQI	168	124	93	385	12	12	24	6.2
Mora Independent School		189	just have 2	148	337	24	24	48	14.2
Mountainair Middle/High School	DQI		84	100	184	8	8	16	8.7
Navajo Prep						8	8	16	
Onate High School	DQI			2109	2109	16	16	32	1.5
Pojoaque Valley High School	AQI/CHIPRA			710	710	24	24	48	6.8
Quemado School		23	58	78	159	16	8	24	15.1
Raton High School				379	379	8	8	16	4.2
RFK Charter/South Valley Academy				21.48148	499	18	40	58	11.6
Roosevelt Middle School			390		390	8	0	8	2.1
Roswell High School	DQI (combined site)			1354	1354	14	12	26	1.9
Roy High School		16		24	40	8	8	16	40.0
Ruidoso High School	DQI		508	630	1138	16	16	32	2.8
San Felipe Pueblo ES		NA			0	8	8	16	NA
San Jon Schools		51	29	52	132	8	8	16	12.1
Santa Fe High School				1539	1539	24	36	60	3.9
Santa Rosa High School	DQI		116	173	289	16	16	32	11.1
School on Wheels				153	153	16	16	32	20.9
Silver High School	CHIPRA			730	730	32	34	66	9.0
Taos High School				728	728	16	16	32	4.4
Taos Middle School			529		529	16	16	32	6.0
To'Hajilee Teen Center		NA			0	6	16	22	NA
Van Buren Middle School	DQI		589		589	16	24	40	6.8
Washington Middle School			489		489	8	8	16	3.3
West Las Vegas SC			286	502	788	16	16	32	4.1
Wilson Middle School			498		498	24		24	4.8

* NM Public Education Department 40 day enrollment

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Appendix 2 - SBHC Contractors Overview

CONTRACTOR	SBHCs Served	Students Served	% of Students Served
Community Foundation of Southern NM	Chaparral High School	**7,253**	**21.5%**
	Gadsden High School		
	Las Cruces High		
	Onate High School		
Dance Expose Productions	School on Wheels	**153**	**0.5%**
De Baca Family Practice Clinic	Ft. Sumner High School	**176**	**0.5%**
Dulce Independent Schools	Dulce High School	**197**	**0.6%**
Eastern New Mexico University - R	Goddard High School	**2,902**	**8.6%**
	Mesa Middle School (Roswell)		
	Roswell High School		
El Centro Family Health	Carlos Vigil Middle School	**3,748**	**11.1%**
	Espanola Valley High School		
	Maxwell Wellness		
	Roy High School		
	Taos High School		
	Taos Middle School		
	West Las Vegas SC		
Hidalgo	Cobre High School	**1,289**	**3.8%**
	Lordsburg High School		
	Silver High School		
JASSH - Casa de Salud	RFK Charter/South Valley Academy	**499**	**1.5%**
La Clinica del Pueblo de Rio Arriba	Mesta Vista HS	**1,095**	**3.2%**
	Pojoaque Valley High School		
Las Clnicas del Norte	Escalante High School	**120**	**0.4%**
Nor-Lea Hospital	Lovington High School	**561**	**1.7%**

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CONTRACTOR	SBHCs Served	Students Served	% of Students Served
Presbyterian Medical Services	Capital High School	**6,030**	**17.9%**
	Carlsbad High School		
	Cuba Schools Wellness		
	Gallup High School		
	Lake Arthur Middle School		
	Quemado School		
	Santa Fe High School		
REC IV	Mora Independent School	**1,005**	**3.0%**
	Raton High School		
	Santa Rosa High School		
REC IX	Ruidoso High School	**1,138**	**3.4%**
REC V	Jemez Valley Public Schools	**388**	**1.1%**
	Mountainair Middle/High School		
REC VI	San Jon Schools	**132**	**0.4%**
San Felipe Pueblo	San Felipe Pueblo ES		
Union County Health and Wellness Network	Des Moines High School	**74**	**0.2%**
University of New Mexico	Laguna Middle School	**6,982**	**20.7%**
	Laguna-Acoma High School		
	Mescalero Apache School		
	To'Hajiilee Teen Center		
	Albuquerque High School		
	East San Jose Elementary		
	Grant Middle School		
	Highland High		
	Roosevelt Middle School		
	Van Buren Middle School		
	Washington Middle School		
	Wilson Middle School		
TOTAL		**33,742**	**100.0%**

Data Note: School enrollment data was not available for BIA SBHC sites.

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Appendix 3- Team Communication

Less than average communication (responded 1 or 2)
Team leader is to busy with other things to have any time.
Little or no communication, miscommunication
Little or no communication, miscommunication.
We are not here all on same day.
It depends on which team members are communicating with who or whom in what context.
There are a lot of grudges being carried for some of the challenges over the last year
Too much conflict
Attitude
Average communication (responded 3)
It depends on which members. I can't speak for the problem people. There is a top down management style in which MA is under nurse supervisor who is somewhere else.
Reassignments throughout the agency have affected SBHC operations
I chose that answer because the team communicates well enough to do the job; but not necessarily outstanding or extra good. Our communication is adequate.
We have variable schedules and are individually very busy. Monthly meetings help. Email is also helpful but lapses occur.
It is a very busy clinic, supporting primary care, behavioral health, and dental; two of the three providers have part-time, with varying, ever-changing schedules... not to mention a funder on-site with integration expectations, all within a very dynamic school administration schedule.
Unsure. Personally, I share any useful information I have gained with others. For some reason, coordinators don't end up on same page.
Different work schedules
Very open environment, friendly, team-oriented environment
The social workers and the clinic staff are located in two different places. We have meeting every other week, but they are often canceled with something comes up. The main form of communication is via email.
Coordinator is not always available to communicate with.
Good to very good communication (responded 3 or 4)
Team is able to communicate well by being provided with several modes of communication, i.e., staff meetings, email, and face-to-face communication.
I think that we all know that communication is very important in order to keep the clinic running smoothly.
With a small staff and small clinic as long as everyone gets along communicating is easy. Most of the time there is not a problem.
Once in awhile with a busy day we don't always get a chance to pass along information
I think as a team we work well but sometimes communication gets lost.
We are a small group in a small space and get along well. Unfortunately clinic manager is not on site & mental health is only once a week.
I think we are great informal communicators but don't always use consistent formal lines of communication which can sometimes be important in terms of follow-through and accountability
I think for the most part communication has improved. It is helpful that the medical and behavioral health staff are in the clinic on the same days.

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We all have the same goal, which is to provide a high level of service/quality of care to the students. With this common purpose we all do what it takes for this to occur and we know that communication and teamwork is a key component.
Limited time
Communication is desired, expected, camaraderie is fostered.
I only work one day of the week at this site, I leave notes to my peers, I don't get to much feed back of what's happening. Maybe lack of time, I really don't know why?
Interaction in clinic and through email. Our clinical assistant is a constant so provides a great deal of continuity to the clinic
We are on good talking terms.
We have different members on different days. We have started a communication log.
We are a small clinic and work closely together
Different schedules
We are in a small building and see each other all day.
Positive relationships and years of working together.
We communicate but everyone is so busy sometimes information is miscommunicated.
Smallest of our sites, independent of school so fewer distractions; smaller group.
Frequently speak over phone or in person
We are all comfortable with each other and are all here with the same goal of helping our youth.
Small office setting, amiable relationships, emphasis on being a team.
We just all get along so well. Everyone is always willing to help one another.
Very open environment, friendly, team-oriented environment
Small school, use of electronics
Because we talk
We are few in number, We schedule a meeting time each week to check in and assess clinic issues. This is necessary since we are open only once a week.
We have a team meeting every Tuesday morning and then throughout the day when the need arises.
Easy access
Great rapport with each other
We have a good relationship among the team
Regular meetings, close proximity of offices.
Small building, team attitude
There are only two of us.
work very closely together
Setting, systems, sense of responsibility
Collaborative teamwork to enhance the best health outcome for the students.
We are a small team
Communication is the key to being successful. Work together well with the school.

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Appendix 4 - Behavioral Health Registry

This table presents the number of patients in the registry:

Review Number	Starting Number	Number Screened *(either medium or high risk)*	Number Added	Number in Registry
One	0	4	4	4
Two	4	4	4	8

The next table presents the counts and percentages of each of the review items:

Category	Item	First Review		Second Review	
		%	#	%	#
Risk Level	Medium	75%	3	50%	2
	High	100%	4	75%	3
Screen Results	Depression	75%	3	--	--
	Anxiety	100%	4	--	--
Assessment Tools	PHQ-9	50%	2	50%	2
	SCARED	100%	4	50%	2
	Both	50%	2	50%	2
Team Conferences and Comprehensive Assessments	Team Conferences	100%	4	75%	3
	Comprehensive Assessments	75%	3	50%	2
Treatment and Discharge	Receiving Treatment	50%	2	25%	1
	Declined	25%	1	25%	1
	Discharged	0%	0	75%	3
	EPSDT	0%	0	0%	0
Notes	*The 3 cases that were medium risk for depression were also among the 4 that were high risk for anxiety.*			*BH provider stopped seeing new pts as of Mid-April; patients referred for counseling in community*	

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Appendix 5 - Recommended Performance Measures and Actions

	Sample Performance Measures	Recommended actions
SBHC Utilization		
SBHC Partners	***SBHC Utilization*** a) Quarterly visits/visits in previous year quarter b) Total monthly visits/total students served c) Percent utilization by gender d) Total EPSTDs/total students served	a) Identify a few (2 or 3) high priority performance measures for quarterly network monitoring. b) Modify "Monthly SBHC Operating Reports" to include comparative date for "high-priority" measures from previous year and month. c) Develop campaign to increase SBHC utilization.
Envision	a) Adapt partner performance measures (above) to site-specific measures. b) Envision utilization tracking and intervention.	a) Conduct monthly review of each ENM SBHC based on "high-priority" performance measures identified by the network. b) Develop site intervention protocols that are responsive to changes in high-priority performance measure. For example, if there is a drop of over 10% in SBHC utilization compared to the previous year or month, contact SBHC coordinator to identify problems and develop plan of action.
SBHC Staffing		
SBHC Partners	***SBHC staffing levels*** a) Students served/behavioral health provider hours b) Students served/primary care provider hours ***SBHC staff stability*** a) Percent staff turnover from previous year	a) Develop SBHC target-staffing levels. b) Develop NM SBHC Staffing Plan, including criteria for prioritizing SBHC sites for increased staffing levels. c) Prepare quarterly staffing level reports of all SBHC sites (student/provider ratios); include in monthly monitoring reports.
OSAH		a) Require monthly staffing level updates, i.e. hours/provider type, as part of monthly reporting. This

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		information should be actual, not budgeted time. b) If feasible, integrate this data entry into Welligent data entry system.
Envision	Adapt SBHC partners' performance measures (above) to site-specific measures.	a) Continue to gather information on staffing capacity issues as part of school year initial assessment. b) Develop criteria for selecting ENM SBHC sites for preparation of site-specific staffing capacity plans.
SBHC Medical Equipment		
SBHC Partners	***Equipment and physical capacity*** The selected measures should be directly related to the SBHC standards of care described in the NM DOH OSAH "School Based Health Center Standards and Benchmarks, updated April 2010".	a) Verify equipment and facility needs at non-ENM SBHCs within 30 days of the 2011/2012 school year and 30 days before the end of the school year. b) Develop statewide strategies to address unmet equipment needs.
Envision Staff Time		
Envision	***Site-specific technical assistance.*** a) ENM technical assistance staff contacts/site. b) Percent of SBHC sites visited within 30 days of SBHC opening.	a) Establish SBHC contact and site visit scheduling targets to maximize the impact that ENM services can have on SBHC operations.
OSAH		a) Require SBHCs to select whether or not they will participate in the ENM QI program before the end of the previous school year.

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PDSAs		
Envision	Percent of PDSAs that meet ENM criteria for quality and outcomes.	Develop criteria and protocols for assessing the quality and outcomes of SBHC PDSAs.
Participant Satisfaction		
Envision	***Perceived quality of ENM services.*** a) Percent of skilled medical professionals and percent of support staff that rate ENM overall services as "very helpful". ***Perceived impact of QI on patient care.*** a) Percent of skilled medical professionals and percent of support staff that feel that QI has a moderate or extensive positive impact on patient care.	a) Develop and implement an assessment tool to determine reasons for relatively low QI support by skilled medical professionals. b) Develop and implement provider MI intervention to increase perceived value of QI by SBHC skilled medical professionals.

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