

**BEHAVIORAL HEALTH SCREENING IN
PRIMARY CARE SETTINGS
2016**

**U.S. Department of Health and Human Services
Indian Health Service
Office of Public Health Support: Division of Planning, Evaluation, and Research
National Government Performance and Results Act Support Team**

Executive Summary

In FY 2007, the Indian Health Service (IHS) initiated a study of qualitative and quantitative data to identify and analyze factors contributing to high-quality behavioral health preventive care screening, as measured by performance on selected GPRA measures.

The study team, which included staff from the Division of Planning, Evaluation, and Research (DPER) and the IHS National GPRA Support Team (NGST), selected three GPRA behavioral health screening measures to analyze: Depression Screening, Alcohol Screening, and Domestic/Intimate Partner Violence Screening. They examined FY 2007 performance results and identified sites that were “higher performing” (performance on selected measures one or more standard deviations above the mean) or “lower performing” (performance on selected measures one-half or more standard deviations below the mean). Nine federal sites and seven tribal sites agreed to participate in the study. Twelve of these sites met the definition of higher performing clinics and four sites met the definition of lower performing clinics.

The study team analyzed contextual quantitative data from master planning documents, funding information, and demographic and workload data from the IHS National Data Warehouse. The study team also conducted in-depth, qualitative focus groups at each participating site to:

- determine factors that contributed to higher performance on selected measures;
- identify barriers to achieving higher performance on selected measures; and,
- elicit recommendations from sites on how to improve behavioral health screening.

Key Findings

1. Universal Screening, Staff Core Competency, and Coordination of Care were the three primary attributes found at all higher performing sites.

Higher performing sites screened all patients for behavioral health conditions, provided access to training for providers and staff and/or had staff who felt competent to screen for behavioral health conditions, and encouraged communication and coordination among all staff members involved in delivering behavioral health care and documenting screening.

2. Universal Screening, Staff Core Competency and Coordination of Care were supported by secondary factors found at most higher performing sites.

Secondary factors included making multiple attempts at screening, using standardized behavioral health screening tools, using Electronic Health Record (EHR) reminders, and providing patient education. Higher performing sites reported that they made multiple attempts at screening patients, either during the same appointment or at subsequent appointments.

3. Higher performing sites did not report significant barriers to screening, but did report barriers that affected their ability to provide full-service behavioral health care.

Higher performing sites reported challenges such as high staff turnover and lack of training for new or temporary staff, lack of time for screening, patient transportation issues, patient trust in providers, and community tolerance of drug and alcohol use... Some sites also reported problems with getting patients into treatment programs, data documentation issues or difficulty getting GPRA “credit” for screenings. However, higher performing sites did not consider these factors to be significant barriers to screening, and none of these factors were mentioned by all sites.

4. Lower performing clinics did not perform universal screening and reported problems related to staff training and competency, coordination of care, and access to resources.

Lower performing clinics did not report any of the primary or secondary attributes reported by higher performing clinics. Lower performing sites lacked policies or procedures regarding universal screening, and reported problems with staff training, coordination of care, documentation, and access to resources that greatly hindered their ability to screen. Lower performing sites also reported many of the same barriers as higher-performing sites, particularly staffing shortages, time constraints, documentation, and access to resources, but, unlike higher performing sites, reported that these barriers directly affected their ability to screen patients.

5. Higher performing sites recommended their primary attributes as best practices for other sites to follow.

Higher performing sites recommended universal screening of all patients, staff training, good communication among all providers and staff, and collaboration and coordination among departments and outside agencies. Other recommendations included many of the secondary factors that supported these attributes, including using EHR reminders, patient education, and community education and outreach campaigns.

Conclusion

This study identified practices that contribute to higher rates of behavioral health screening among higher performing clinics. The best practices found at all higher performing sites included Universal Screening, Staff Core Competency, and Coordination of Care. All higher performing sites made behavioral health screenings a high priority within their primary care clinics. They reported that staff training and competency, as well as coordination among staff and providers, contributed to higher screening rates. Secondary factors such as patient education, collaboration with other

agencies to provide services, use of EHR reminders, and patient and community education and outreach also contributed to higher rates of screenings. The practices and policies of higher performing sites in this study provide an adaptable and achievable model for clinics working to improve their behavior health screening rates.

Recommendations

- Develop and implement universal screening policies and procedures;
- Provide training for all staff to improve core competency and documentation processes;
- Improve care coordination and staff communication;
- Make full use of the features available in EHR, including clinical reminders; and
- Educate patients on available services, distribute patient brochures, conduct community education and outreach campaigns, and work with outside agencies to improve coordination and availability of resources.

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Section I: Purpose and Research Goals of Study

The Indian Health Service (IHS) began collecting and reporting performance measures in 1998, as required by the Government Performance and Results Act (GPRA) of 1993 (P.L. 103-62) and the GPRA Modernization Act (GPRAMA) of 2010 (P.L. 111-352). These performance measures reflect the health services IHS provides to American Indian and Alaska Native patients. Performance on GPRA/GPRAMA measures varies among programs, but no studies to date have aimed at identifying factors that contribute to clinics reporting higher performance.

In 2007, IHS initiated a project to identify and analyze factors contributing to higher performance on behavioral health preventive care, as measured by performance on selected GPRA measures. This project was the first attempt to examine characteristics of selected Indian health programs from across the U.S with the intent of identifying promising practices that could be replicated by other programs. The study focused on comparing higher and lower performing clinics' performance on a set of related GPRA measures. The intent of the study was to identify potential structural, administrative, and clinical variables that contribute to higher performance and assess barriers to achieving higher performance in selected clinic settings. The Division of Planning, Evaluation and Research (DPER), the IHS Office of Public Health Support (OPHS), the IHS National GPRA Support Team (NGST), and other staff worked together to define the project's focus and scope and manage its implementation including data collection and analysis. Members of the initial study team were Elaine Brinn, Amy Patterson, Janae Price, Francis Frazier, Phillip Smith and Lucie Vogel. Other major contributors included Christine Brennan, Wendy Blocker, Rachel Harvey, Diane Leach, and James L. Ward Associates.

Section II: Background

1. *The Indian Health Service*

The Indian Health Service (IHS) is the agency within the Department of Health and Human Services that provides comprehensive health services for approximately 2.2 million American Indians and Alaska Natives (AI/AN). The Indian health system of federally and tribally operated serves members of 566 federally recognized Tribes in 36 states.

IHS services are administered through 12 Area Offices and tribally and federally-managed service units. Health care services are provided directly to AI/AN people through a network of hospitals and outpatient clinics located primarily on or near Indian reservations with supplemental services purchased from other sources for care beyond what that network can provide.¹

2. *IHS Performance Measurement*

The Government Performance and Results Act (GPRA) of 1993 required Federal agencies to demonstrate that they were using their appropriated funds effectively and to develop and report performance measures that reflected progress toward achieving the agency mission. The law required agencies to have a five-year Strategic Plan in place and to submit Annual Performance Plans and Reports with their budget requests. The GPRA Modernization Act (GPRAMA) of 2010 strengthened GPRA by requiring federal agencies to use performance data to drive decision making. By 2007, IHS had developed a comprehensive set of clinical and non-clinical performance measures that assessed the provision of essential health services throughout the Agency

3. *Collection of GPRA data*

The Indian Health Service uses the in-house Resource and Patient Management System (RPMS) to collect and retain patient care data. In 2003, the IHS implemented the Clinical Reporting System (CRS), an application within RPMS designed for local and Area-level monitoring of clinical GPRA measures, and national data reporting. CRS collects the clinical performance results that are reported to the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and Congress. Prior to this study, IHS had not conducted a study of sites that had higher or lower performance on GPRA measures. The implementation of CRS in 2003 standardized and automated the collection of clinical performance measure information, which enabled a database to support this study.

4. *Selection of Behavioral Health measure set*

¹ The IHS budget also provides limited funding for approximately 33 urban Indian health programs which began reporting of GPRA measures in 2006.

The study team opted to select a subset of GPRA measures for analysis to limit the number of confounding variables. The team ultimately decided to focus on behavioral health measures, which form an important subset of clinical GPRA measures and represent one of the agency's highest clinical priorities.

Another factor in choosing these GPRA measures was their relatively low cost, since no laboratory tests, special equipment, or services from private providers are required. Behavioral health screening requires no additional costs above staff time.

IHS has five GPRA measures related to behavioral health: Depression Screening, Alcohol Screening, Intimate Partner/Domestic Violence Screening, Suicide Surveillance, and Tobacco Cessation Intervention. The IHS selected three of these measures: Depression Screening, Alcohol Screening, and Intimate Partner/Domestic Violence Screening, for this study. These are screening measures performed in the primary care setting and had not undergone any significant changes since they became GPRA screening measures.

The Alcohol Screening measure aims to reduce the prevalence of Fetal Alcohol Syndrome within the AI/AN population. The measure denominator includes female Active Clinical patients age 15-44 (childbearing age) and the numerator includes all such patients who have been screened for alcohol use, had an alcohol-related diagnosis or procedure (procedures include counseling/rehabilitation, and detoxification), or received alcohol-related patient education, in the report period (a one year period that starts on July 1 of every calendar year).

The Domestic Violence/Intimate Partner Violence Screening measure denominator includes female Active Clinical patients age 15-40. The measure numerator includes all such patients who have been screened for or diagnosed with intimate partner (domestic) violence or have received intimate partner (domestic) violence education or counseling during the report period.

The Depression Screening measure denominator is all Active Clinical patients age 18 and over of both genders. The numerator includes patients who have been screened for depression within the report period. It also includes anyone diagnosed with a mood disorder in the same period, but does not include patients who only received education for depression, but did not receive a diagnosis.

For additional description of the GPRA data collection process, including brief definitions and explanations of terms such as active patients, measure logic, and information sources, see Appendix D.

5. Importance of behavioral health measures to Indian health programs

Behavioral health screening, treatment, and follow-up are high priorities for the IHS. American Indians and Alaska Natives have some of the highest rates of Depression, Domestic Violence, and Alcohol Abuse of all racial and ethnic groups.

Studies report alcohol consumption rates among AI/AN women of childbearing age to be higher than the national average for all races. One study of alcohol consumption in Alaska found that the prevalence of heavy drinking among AI/AN women was 32 percent, compared to 15 percent of non-AI/AN women.² AI/AN women were also found to have less knowledge of the harmful effects of alcohol on developing fetuses than non-AI/AN women.³ Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome Disorder (FASD), a range of conditions affecting children and adults whose mother drank alcohol while pregnant. Fetal Alcohol Syndrome (FAS) is the most severe end of the FASD spectrum, and is the leading known cause of mental retardation. Children with FAS often have difficulties in school and trouble getting along with others.⁴ One study showed that children diagnosed with FAS performed significantly worse on seven cognitive and behavioral tests and measures.⁵

Rates of FAS are higher among AI/AN people compared to the general population. FAS cases have been reported at a rate of 9.8 per 1000 live births among southwestern Plains Indians living on reservations.⁶ Another study found an AI/AN FAS rate of 5.6 per 1000 in Alaska, and 2.5 per 1000 in Arizona, well above that of any other race or ethnicity in those states.⁷ Estimates of the prevalence of FAS in the general US population ranges from 0.5 to 2 cases per 1000 live births.⁸ [Recent studies using in-person assessment of school-aged children in several U.S. communities estimate that the incidence of FAS is closer to 6 to 9 out of 1,000 children.⁹]

Additional screening and education efforts could attempt to prevent more cases of FAS and thus reduce the incidence and resulting burdens of this permanent condition.¹⁰ Studies have shown that brief intervention with counseling significantly reduces the rate of alcohol use during pregnancy among women with a history of heavy drinking.¹¹ Researchers have begun to explore on how successful interventions may be tailored to fit

² Prevalence and characteristics of alcohol consumption and fetal alcohol syndrome awareness--Alaska, 1991 and 1993. *MMWR. Morbidity and Mortality Weekly Report*. 1994 Jan 14; 43(1):3-6.

³ Prevalence and characteristics of alcohol consumption and fetal alcohol syndrome awareness--Alaska, 1991 and 1993. *MMWR. Morbidity and Mortality Weekly Report*. 1994 Jan 14; 43(1):3-6.

⁴ CDC. Fetal Alcohol Spectrum Disorders web page. Information retrieved on 5/5/2015 at <http://www.cdc.gov/ncbddd/fasd/facts.html>

⁵ May, et al. Prevalence and Characteristics of Fetal Alcohol Spectrum Disorders. *Pediatrics* 2014; 134:5 855-866.

⁶ May PA, Hymbaugh KJ, Aase JM, Samet JM. Epidemiology of fetal alcohol syndrome among American Indians of the Southwest. *Social Biology*. 1983 Winter; 30(4):374-87.

⁷ Fetal alcohol syndrome: Alaska, Arizona, Colorado, and New York, 1995-1997: *MMWR. Morbidity and Mortality Weekly Report*. 2002 May 24;51(20) 433-5.

⁸ May PA, and Gossage JP. Estimating the prevalence of Fetal Alcohol Syndrome: A Summary. *Alcohol Research & Health*. 2001;25(3):159-67.

⁹ May, et al. Prevalence and Characteristics of Fetal Alcohol Spectrum Disorders. *Pediatrics* 2014; 134:5 855-866.

¹⁰ CDC. Alcohol Screening and Brief Intervention Efforts web page. Information retrieved on 5/5/2015 at <http://www.cdc.gov/ncbddd/fasd/alcohol-screening.html>

¹¹ Hankin, JR. Fetal Alcohol Syndrome Prevention Research. *Alcohol research & health : the journal of the National Institute on Alcohol Abuse and Alcoholism*. 2002;26(1):58-65

the needs of AI/AN populations.¹²

Millions of adult American women of all races are abused by their spouse or partner each year. More than 1 in 3 women (35.6%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.¹³ While men also experience abuse from partners, women are 7 to 14 times more likely to suffer a severe physical injury from an intimate partner than men.¹⁴ Symptoms of domestic violence may appear as injuries or chronic conditions related to stress. Intimate partner violence is usually chronic and repetitive.¹⁵ Women who experience domestic violence are more often victims of nonconsensual sex and have higher rates of smoking, chronic pain syndromes, depression, generalized anxiety, substance abuse, and Post-Traumatic Stress Disorder.¹⁶

Forty-six percent of AI/AN women reported that they have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime, higher than the national average of 35.6%, and nearly half reported sexual violence other than rape in their lifetime.¹⁷ A survey of Navajo women seeking routine care at an IHS facility revealed that 13.5 percent had experienced physical abuse in the past year, and 41.9 percent had experienced physical abuse from a male partner at least once in their lives.¹⁸ A study of the San Carlos Apache tribe reservation found that 75 percent of women reported violence in their current relationship.¹⁹

An epidemiological study of American adults of all races found that 1 in 20 or approximately 5 percent had experienced a major depressive disorder within the previous year and over 13 percent had experienced major depression in their lifetime. One study found that almost nine percent of Native Americans suffered a major depressive disorder within the previous year and over 19 percent had experienced a major depression in their

¹² Montag, A., Clapp, D., Calac, D., Gorman, J., Chambers, C. A review of evidence-based approaches for reduction of alcohol consumption in Native women who are pregnant or of reproductive age. *Am J Drug Alcohol Abuse*. 2012 September; 38(5): 436–443

¹³ Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

¹⁴ Muelleman RL, Lenaghan PA, Pakieser RA. Battered women: injury locations and types. *Annals of Emergency Medicine* 1996;28(5):486-92.

¹⁵ Barrier PA. Domestic violence. *Mayo Clinic Proceedings*. 1998 Mar;73(3):271-4.

¹⁶ Ganley A, Warshaw C, eds. *Improving the Health Care Response to Domestic Violence: A resource manual for health care providers*. Family Violence Prevention Fund. 1995.

¹⁷ Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

¹⁸ Fairchild D, Fairchild M, Stoner S. Prevalence of adult domestic violence among women seeking routine care in a Native American health care facility. *American Journal of Public Health*. 1998;88:1515-7.

¹⁹ Hamby S, Skupien M. Domestic violence on the San Carlos Apache reservation: Rates, associated psychological symptoms, and current beliefs. *IHS Provider* 1998, August.

lifetime.²⁰ A 2006 survey by SAMHSA found that among U.S. adults ages 18 and over who reported only one race, AI/ANs had the highest rate of a serious psychological distress within the last year (25.9 percent), and the highest rate of a major depressive episode (MDE) within the last year (12.1 percent).²¹

Depression frequently increases the risk of suicidal behavior. A major literature review by Harris and Barraclough concluded that the overall risk for suicide among all patients with depressive disorders is elevated 12- to 20-fold compared to the general population.²² Primary care providers and other clinicians, through routine screening, can diagnose depression and provide treatment which can decrease the risk of suicide. According to the “Surgeon General’s Call to Action to Prevent Suicide,” the first step in preventing suicide is to identify and understand the risk factors. One major risk factor is a history of mental illness, particularly depression. The Surgeon General’s report urged health agencies to “improve [the] ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk.”²³ Other studies have noted that the vast majority of suicide victims also have a major psychiatric illness, with depression being the most common diagnosis.²⁴

²⁰ Hasin DS, Goodwin RD, Stinson FS, Grant BF. Epidemiology of Major Depressive Disorder: Results From the National Epidemiologic Survey on Alcoholism and Related Conditions *Archives of General Psychiatry*. 2005;62(10):1097-1106.

²¹ Substance Abuse and Mental Health Services Administration. (2007). Results from the 2006 National Survey on Drug Use and Health: National Findings. Rockville, MD.

²² Harris EC, Barraclough B. Suicide as an outcome for mental disorders. A meta-analysis *Br J Psychiatry*. 1997. 170: 205-228

²³ DHHS: *Surgeon General’s Call to Action to Prevent Suicide* (1999)

²⁴ Rihmer, Z. Can better recognition and treatment of depression reduce suicide rates? A brief review. *European Psychiatry* Vol. 15, Issue 7. November 2001 (406-409).

Section III: Methodology

The goal of the study was to analyze differences in administration and practice within IHS programs based on GPRA measures using a mixed qualitative and quantitative research method.

The study team examined existing quantitative data, including the National Data Warehouse (NDW) and the Service Unit Master Plans prepared for the IHS Division of Facilities Planning and Construction. The study team identified six sources of information that could explain differences in performance between sites: information from the IHS Federal Disparity Index model of level of need; use of an electronic health record; staffing levels; behavioral health service availability; performance on other GPRA measures; and status as either an IHS or Tribally operated facility. The team also used two major studies as a framework for comparison: *Crossing the Quality Chasm: A New Health System for the 21st Century*; and the Chronic Care Model developed by the MacColl Institute for Health Care Innovation.

In addition to the quantitative information and model comparisons, the study team used qualitative methods to collect more in-depth information to help explain differences in GPRA results among sites. The study team developed a standardized questionnaire to be used in focus group discussions with staff at each site. This allowed for more substantive responses from respondents, follow-up and clarifying questions by the facilitator, introduction of new and unanticipated topics by respondents, and interaction and more detailed discussion among respondents.

1. Site selection methodology and criteria

The study team examined GPRA FY 2007 results for three selected behavioral health measures (Depression Screening, Alcohol Screening, and Domestic/Intimate Partner Violence Screening.) All IHS and tribal clinics²⁵ that reported GPRA results for FY 2007 were ranked in order of performance, from highest to lowest, on each of the three behavioral health screening measures by calculating the mean result for each measure across all clinics reporting data for that measure. The higher performing sites selected for consideration were at least one standard deviation above the mean for each of three behavioral health measures; lower performing sites were at least one-half standard deviation below the mean for each of the three measures. Each of the three measures was analyzed individually and only those sites meeting the selection criteria for all three measures were considered for participation in the study.

²⁵ All IHS-operated clinics reported GPRA data. Although use of RPMS (required for GPRA reporting) and participation in GPRA is voluntary for tribal clinics, most tribal sites reported GPRA data. In FY 2007, IHS and tribal clinics that reported GPRA results served approximately 86% of the IHS user population. Urban clinics were not included in the site selection process. Urban clinics began reporting GPRA data in FY 2006. In FY 2007, only a small percentage of urban programs were reporting GPRA via CRS, and of those, only a small number met the selection criteria, leaving an unrepresentative sample from which to include in the study.

In order to have a greater variety of site characteristics represented, clinics meeting the criteria for the study were then categorized according to size, type (IHS or Tribal) and IHS Area. Clinics with fewer than 30 patients in the denominator for each of the three measures were excluded to ensure a representative sample at each facility.

Following the identification of sites, formal invitations to participate in this evaluative study were prepared and sent to prospective sites. For sites that were tribally operated, tribal leaders were also contacted to identify any specific approval processes that were required. Nine federal sites and seven tribal sites agreed to participate. This sample included more higher than lower performing sites to identify more promising practices.

2. Focus groups

The study team developed focus group questions to elicit information among the group participants. The questions asked about factors that contributed to their success in behavioral health screening, barriers that impeded screening, and recommendations to other clinics to improve screening. Separate sets of questions were developed for four different groups to be convened at each clinic: an administrator/manager group, a medical provider group, a behavioral health professional group, and a data entry staff group. Early versions of the guides were reviewed by a number of additional IHS headquarters and Area clinical and behavioral health staff members and a pre-test focus group was convened at the California Area Indian Health Service Office to test the draft focus group discussion guides. A contractor with previous experience in Indian health programs and behavioral health conducted the focus group discussions.

In addition to the pre-test, two of the Federal sites selected to participate in the study were contacted and asked to serve as the study pilot sites. Members of the study team traveled with the focus group moderator to observe the participant reactions and responses to the questions and identify any necessary changes or modifications to the guides. Based on the focus group results from these pilots, the study team made revisions to the focus group guides and produced the final version of the guides for use at the other Federal and Tribal facilities. A partial list of the discussion questions appears in Appendix C.

Focus groups conducted at tribal clinics (which have non-federal employees) were subject to the provisions of the Paperwork Reduction Act. Therefore, Office of Management and Budget (OMB) review and approval of the focus group study guides was required. Final OMB approval for the guides was given on April 20, 2009. This was in addition to the formal request sent to each site for administrative and Tribal approval.

Preparation and protocol for focus groups

Prior to visiting each participating clinic, the contractor contacted the Chief Executive Officer (CEO) to ask a series of background questions about the clinic. CEOs were provided with an information sheet organized in a question and answer format, to be

distributed to each individual participating in the focus groups to provide background on the study. At each clinic, the contractor convened both an Administrator/Manager group, and a Provider group. At clinics with co-located behavioral health services, the contractor convened a Behavioral Health group. In clinics that used data entry staff to enter screening information into patient health records or to assist providers in making correct entries into electronic health records, the contractor convened a Data Entry group. Each focus group was scheduled to meet from one and a half to two hours.

Verification of site transcripts and reports

The contractor recorded each session to assure that the group's discussion was captured in its entirety and to allow the contractor to concentrate his or her attention on facilitating the discussion rather than on extensive note taking. All of the recordings were professionally transcribed. The study team received both the audio recording and the written transcript of every focus group meeting. Team members compared the audio recordings with the transcripts of focus groups at all of the clinics to verify their accuracy and corrected the transcripts as needed.

The study team also reviewed individual site reports submitted by the contractor. Contents were cross-referenced with transcripts, and the contractor was contacted when clarifications were required. Each participating site received its own report, but site reports were not further distributed, as agreed during the original site contacts. In addition to individual site reports, the contractor prepared a final summary report with the contractor's interpretation of findings and the sites' recommendations.

Analysis of focus group results and contextual information

Using the transcripts, site reports and final summary report, the study team analyzed the findings of the focus groups to identify the most significant qualitative findings.

Section IV: Site Characteristics

Nine federal and seven Tribal sites in six IHS Areas participated in the study between November 2007 and October 2009. Combined, these sixteen participating sites serve over 100,000 AI/AN patients annually.

Twelve of the sixteen sites (seven federal and five Tribal) were classified as “higher performers” based on FY 2007 GPRA results on the three behavioral health screening measures. Four sites, two federal and two Tribal, were classified as “lower performers” based on GPRA results.

In order to identify structural factors that might contribute to higher or lower performance on behavioral health screening in the primary care setting, the study team gathered six types of data about participating sites.

1. *Level of Need Funded:*

The Indian Health Service developed a Federal Disparity Index (FDI) model in 2000 to assess comparative funding levels and needs among IHS and Tribal health programs. Each IHS or Tribal site is scored according to its level of need funded (LNF) on a scale from 0 to 100 percent. A score of 50% means the site has one half of the resources from the IHS that would be necessary to provide health services comparable to those in the benchmark federal employee health benefits nationwide service benefit plan (FEHBP), standard option (operated by Blue Cross/Blue Shield). A 100% score means the unit has achieved funding parity with the FEHBP benchmark, not that all necessary or desirable services are readily available. Congress authorized a special Indian Health Care Improvement Fund (IHCIF) in 1988 to reduce funding disparities and resource deficiencies.²⁶ When Congress appropriates funds to the IHCIF, IHS uses the FDI to allocate funds to qualifying sites in proportion to funding deficiency.

The study team reviewed the publicly-available 2008 Federal Disparity Index of all sixteen participating sites to determine whether funding disparities were factors impacting performance. According to the index, five of eight higher performing sites that were specifically listed in the tables were funded at between 60% and 100% LNF (no more precise breakdown is provided), and three were funded between 50 and 60%. The remaining three higher performing sites could not be specifically identified because funding was distributed directly to Tribes operating multiple sites... Of the four lower performing sites, two were funded at between 60 and 100%, one was funded at between 50 and 60%, and one was funded between 35 and 40%. In 2008, Congressional appropriations to the Indian Health Care Improvement Fund raised the lowest funded IHS and Tribal sites to

²⁶ Indian Health Care Improvement Act. (1988) The Fund was created as per Title 25, Chapter 18, Subchapter II, 1621

40% of their LNF, which impacted only one of the twelve sites in the study for which information was available.

Based on this limited information, there does not appear to be a meaningful relationship between higher or lower performance and funding levels. In this study's sample, higher-performers were no more likely to be fully or highly funded compared to lower-performers from IHS appropriations. Information about funds from other sources such as third party collections or funds provided directly by Tribes to support facilities they operate was not available to the study team and it is unknown whether differences in total funding from all sources exist and, if so, what their distribution might be among higher and lower performing study sites.

2. *Use of Electronic Health Record:*

Six of the twelve higher performing sites were using the Electronic Health Record (EHR) at the time of the study; only 1 out of 4 lower performing sites were using EHR. The IHS Electronic Health Record includes reminders to perform screenings and allows the immediate documentation of screenings. These features provide a built-in support of the screening process that other versions of the Resource Patient Management System (RPMS), the IHS information management system, do not. EHR appeared to be a factor contributing to higher screening rates and GPRA scores.

The implementation schedule of EHR at Indian health clinics has favored sites that are "ready" to move toward an electronic health record system and it is probable that higher performing sites are more likely to have the EHR because they are higher performing in general. None of the higher performing sites using EHR attributed their success to the system, although they did acknowledge that EHR facilitated the screening and documentation process. One lower performing site with EHR indicated that their providers needed additional training on the system.

3. *Staffing:*

Lower performing sites were more likely to report staff shortages and that they relied heavily on temporary staff members. Higher performing sites were more likely to report their staff had been with the clinic for a long time. Lower performing sites considered staff shortages and lack of time as significant barriers. While some higher performing federal sites participating in this study reported significant shortfalls in staffing, they were still performing well above average with regard to behavioral health screenings.

4. *Behavioral Health Service Availability:*

Eleven of the twelve higher performing sites had some type of behavioral health services available on site; three of the eleven noted that the services were only available part-time. The one higher performing site that did not have behavioral health services on site stated that the behavioral health service was “off-site but nearby”. This contrasts somewhat with the lower performing sites, where three of four had behavioral health services available off site. The only lower performing site that had co-located behavioral health services noted that the behavioral health program was “separate.” Although located at the IHS-operated facility, the behavioral health program was tribally operated and the two programs did not coordinate services.

While the study revealed differences in terms of proximity, all sites reported that they had some access to behavioral health services. The more significant differences concerned the degree of coordination and collaboration between behavioral health and primary care services. Three of four lower-performing clinics indicated no coordination of primary care with behavioral health.

5. Performance on other GPRA measures:

Higher performing sites performed better than the lower performing sites on 15 of the 17 non-behavioral health GPRA measures in FY 2007. Of the remaining two measures, higher and lower performing sites performed equally on dental access and lower performing sites had a slightly smaller, though not statistically significant, percentage of patients with diabetes who had poor glycemic control.

The reason for this performance difference on other non-behavioral health measures cannot be determined from the information gathered for this study. Many of the higher performing sites indicated they had policies and/or procedures that required screenings, and these policies were not limited to behavioral health screenings. Factors that supported higher performance on behavioral health screening measures may also contribute to higher performance on other GPRA measures.

6. IHS vs. Tribal Sites:

The study team included a mix of both IHS and tribally operated sites. Tribal clinics have more flexibility in how they operate and provide services. Consequently, significant differences might exist between IHS and Tribal sites in terms of practices and procedures. The focus group findings, however, did not reveal significant differences between IHS and tribal sites with respect to clinic operations and service delivery.²⁷

²⁷ Although this section is primarily a discussion of structural (external) factors impacting performance, data from the study focus groups has been included here because it relates to these external factors, and is not discussed elsewhere in the report.

There were major differences in the physical facilities. The average age of IHS facilities included in the study was 30 years while the average age of tribal facilities was 10 years. However, this facility age difference was not associated with differences in performance among higher and lower performing clinics.

Because of the limited scope of this study, the goal of gathering contextual information was not to draw conclusions about specific, structural differences between all higher and lower performing sites but instead to identify groups of factors associated with higher and lower performance within the constraints of the limited sample in this study.

Overall, a review of site characteristics reveals some differences between higher and lower performers in this study: use of EHR systems, staffing, and availability of behavioral health services, performance on other GPRA measures, and whether the facility was an IHS or tribal site. Coupled with the findings from the focus groups, however, staffing appeared to be the only characteristic to impact performance.

Comparison with Existing Models

One objective of this study was to compare characteristics of the higher performing clinics with characteristics of quality care identified by major studies and reports. Two established models were used as a framework for comparison: 1) *Crossing the Quality Chasm: A New Health System for the 21st Century*, prepared by the Institute of Medicine (IOM); and 2) the Chronic Care Model, developed by the MacColl Institute for Healthcare Innovation.

Both models identify and describe components of a complete system of care, including prevention and treatment. This study focused on preventive screening measures, with limited attention given to what treatments may have been provided to patients who screened positive. Certain aspects of these models were reported by higher performing clinics. These included the IOM's principles of providing timely, equitable, and patient-centered care and the six elements of the Chronic Care Model: the community, the health system, self-management support, delivery system design, decision support and clinical information systems.

Overall, the higher performing clinics participating in the study reflected many of the goals identified in both the IOM and Chronic Care Models. Higher performing sites met the IOM model goals of timely and equitable care by providing universal behavioral health screening. Because the study did not address treatment, it is unclear whether these sites also fulfill the IOM goal to provide patient-centered care. Higher performing sites reflected many of the goals of the Chronic Care Model, including community involvement, a health system that encourages high-quality care, a decision support system that integrates primary and specialist care, and the use of a comprehensive clinical information system (RPMS) to manage performance.

Section V: Focus Group Findings

A total of 39 focus groups were conducted at the 16 participating federal and tribal health organizations in six IHS Areas between November 2007 and October 2009. For examples of specific focus group questions, see Appendix C. This section briefly summarizes and analyzes successful practices at higher performing sites, and summarizes and analyzes reported barriers at both higher performing and lower performing sites.

Focus group questions were designed to elicit both open-ended responses and closed-ended responses. Some questions asked participants to offer examples of clinic processes that respondents felt contributed to success (or served as barriers) in behavioral health screening. Other questions were more specific, and closed-ended; e.g. the focus group moderator asked whether a clinic distributed patient education on behavioral health topics.

A. Summary of Successful Practices at Higher Performing Sites

The study team sought to identify the characteristics and attributes of higher performing sites that contributed to high performance on GPRA behavioral health measures. A number of common successful *characteristics, practices and attributes* at higher performing sites emerged. The most common practices and attributes can be grouped into three overall categories: Universal Screening, Staff Core Competency, and Coordination of Care. The most successful sites screened all patients for behavioral health conditions at every visit, provided access to at least a minimum amount of training for their staff, and encouraged good communication and coordination among all staff members involved in delivering behavioral health care and documenting screening.

Primary Characteristics of Higher Performing Sites:

Primary characteristics are characteristics that a majority of sites identified in response to open-ended questions.

Universal Screening

- Policies and procedures (both formal and informal) are in place requiring staff members to perform behavioral health screenings.
- Providers attempt to screen patients during every appointment, no matter how frequently the patient receives care, and often as part of the triage process. As a result, patients expect the screening as part of a clinical visit and do not feel “singled out.”
- Providers attempt to screen all patients, even those who are not included in the GPRA population (e.g., children, men, elders, non-native spouses).
- Patients are screened whether referral resources are available or not.

Staff Core Competency

- Primary care staff members feel qualified to administer the screenings, and are comfortable in handling the process of screening, and if necessary, referral and follow-up.
- Staff members have some training on screening and documentation, and in some cases, GPRA reporting.
- At sites where providers do not do direct data entry, the data entry staff is well trained and has access to primary care providers; at sites where providers do direct data entry, there are staff members who monitor the quality of the data entered and provide the primary care staff with training and technical support to improve.
- Many sites review their GPRA results, discuss them with providers, and hold providers accountable for screening their patients.

Coordination of Care

- Staff members working within and between primary care and behavioral health departments communicate and coordinate with each other. Some sites reported that the primary care and behavioral health staff met regularly to review patient care.
- At sites where there is demonstrated coordination of care with the behavioral health department, referrals are made as quickly as possible after a positive screen; some sites reported “walking” the patients directly to the behavioral health department.
- Sites collaborate with Tribes and with the community to identify and provide resources.
- Patient care is handled as a team approach; while the specific form may vary, higher performing sites report that coordination of care is a high priority. Two sites even reported they had developed patient care teams. One site said that Behavioral Health and Primary Care are “interwoven.”
- Transportation is sometimes provided by Community Health Representatives, the clinic, or the tribes so that patients can come to the clinic for the screening or follow-up appointment.

Secondary Characteristics of Higher Performing Sites

In addition to the three primary characteristic categories discussed above, the focus group discussions revealed some additional characteristics of higher performing sites. These factors were mentioned frequently as contributing to successful behavioral health screening, but were not necessarily practiced at most or all higher performing sites. Also, these characteristics include factors that focus group participants *confirmed* as common practices in response to specific questions asked by the focus group moderator; they were not necessarily offered as examples of successful practices spontaneously. Although these additional characteristics may not all directly impact a clinic’s screening rates, they help to support the screening and documentation process, and support the three primary characteristics outlined above. Moreover, they are factors that contribute to a comprehensive approach to behavioral health screening, treatment and follow-up, and suggest that higher performing sites use a multi-faceted approach in order to provide

high-quality behavioral health care. The following factors were frequently mentioned as successful practices at higher performing sites:

Multiple attempts at screening (Supports Universal Screening)

- Medical staff make multiple attempts at screening, either during the same appointment, or through a follow-up screening.
- Follow up questions are asked during the exam to verify screening during triage.
- A patient may also be re-screened if a lab result suggests the initial screening result was not accurate.

Standardized behavioral health screening tools (Supports Staff Competency)

- Some providers use standardized screening tools such as the CAGE, PHQ2, and PHQ9 or in-house tools, to make the screening process easier and more consistent. These same forms are used at all clinics at high- performing sites with multiple locations and departments. While not all higher performing sites reported using standardized screening tools, most were familiar with them and the majority used them for at least some behavioral health screenings. These sites also reported being relatively happy with the usefulness of such tools.

Electronic Health Record

- Half of higher performing sites use the Electronic Health Record (EHR) rather than paper charts.
- Participants who used the EHR reported that this had improved screening rates, as it made documentation of screening more consistent and easier to complete, and provided reminders to providers to screen.

Patient Education (Supports Universal Screening and Coordination of Care)

- Staff are provided patient education on behavioral health topics in the form of handouts, through one-on-one conversations during the screenings, or both.
- Patient education is made available in bathrooms and other areas where patients can find it privately. This was particularly important for materials on domestic violence.
- Sites do community outreach to increase awareness about behavioral health issues and educate patients.

Additional Characteristics of Higher Performing Site

Other factors were mentioned by those working in higher performing sites as contributing to success on screenings or behavioral health care; however, these factors were not universal among sites nor mentioned by a majority of focus groups. These were generally factors mentioned by only one or two sites, but are factors which these sites felt were significant.

- The clinic tests blood alcohol and uses other lab tests to confirm a positive behavioral health screening.
- Patients fill out self-report questionnaires.
- Patients see the same providers at each visit.

- The clinic has low staff turnover, which helps to maintain continuity of care.
- Providers and support staff perform chart audits or other reviews to see if behavioral health screenings are due, and contact patients to come in if a screening is due.
- Attempts to address the issue of “stigma” associated with behavioral health conditions by putting the behavioral health office in the primary care department. One participant reported: *This whole area around here is so relaxed and casual about that whole thing. Most of the time people are joking about coming to see [the behavioral health provider].*

B. Summary of Barriers to Screening Reported at Higher Performing Sites

Despite having policies and procedures that require universal screening, even the highest-performing sites did not record a screening rate over 92% for any measure, and the average rate among high performers on the measures was 71% for Domestic/Intimate Partner Violence Screening, 71% for Alcohol Screening, and 62% for Depression Screening. Higher Performing sites were asked to identify barriers to screening at their facilities. There were fewer common themes, and many barriers identified were specific to a facility’s staff, location, or community.

The reported barriers with the greatest effect on screening rates included lack of training for new or temporary staff, high staff turnover and use of temporary providers, lack of time for screening, and patient transportation issues.

Sites with higher staff turnover rates mentioned that new or temporary providers were not prepared to perform and address behavioral health screenings, so screening did not occur. A lack of training for new or temporary providers about documentation requirements (e.g. where to record screenings on patient charts) was also mentioned as a barrier. This lack of training means that screenings performed are not always recorded, or recorded correctly, and therefore would not count toward GPRA results.

A number of facilities mentioned having problems with documentation or obtaining GPRA “credit” for screenings they perform. Some staff reported the GPRA logic was a barrier; the GPRA logic definitions did not include the right patients or GPRA logic definitions allowed patients who should not be included to be “counted against” the clinic’s results. While all IHS, Tribal and Urban clinics use the same GPRA definitions, concern over GPRA logic and definitions is common among sites striving for a 100% universal screening rate.

Other barriers mentioned related to the provision of treatment and follow up. For example, sites reported that they believed patients did not always respond to screening questions truthfully, or that the community tolerated a high degree of domestic violence or alcohol abuse. As a result, some patients needing treatment were screened as negative. Sites reported difficulties with finding treatment programs for patients that did screen positive which prevented them from being able to provide help to those identified as needing it. While these barriers do not necessarily hinder screening, they do impact the

ability of a site to correctly identify needs and to provide treatment and follow-up. Similarly, lack of access to referral resources does not in itself limit the ability to screen patients in the primary care setting, but does make treatment difficult and burdensome. While these factors limit the provision of comprehensive behavioral health care, they do not serve as barriers to the initial screening process. However, because higher performing sites are often those that also do well on the provision of this comprehensive care, many higher performing sites do consider these factors as important barriers to that process.

The first set of factors below are barriers reported by sites impacting their ability to screen patients in the primary care setting. The second set of factors includes barriers reported by sites limiting the provision of comprehensive behavioral health care. This second group also includes factors that higher performing sites reported prevented them from obtaining “credit” in GPRA for their work in behavioral health. While the GPRA logic may prove frustrating for providers and staff, it does not in itself present an actual “barrier” to the screening process.

Primary Barriers to Screening at Higher Performing Sites

Training

- New and temporary staff members often do not receive adequate training in behavioral health screening or documentation.

Time and Staff

- Not enough staff to complete behavioral health screenings.
- Lack of time or staff for screenings impacted the overall quality of care and made patients unhappy with the clinic.

Patient Transportation

- Lack of patient transportation sometimes prevents people from being able to use the medical department on a regular basis, which impacts screening rates.
- Referral resources were limited or too far away.

Although some higher performing sites reported providing transportation for patients as a successful practice, patient transportation difficulties often were reported at other successful sites as a significant barrier. Many of the sites were extremely rural and had a large geographical service area. A number of these higher performing sites reported that lack of transportation options for patients, insufficient money for gas, and issues related to geography (e.g., large distance to travel, inclement weather, etc.) all impacted their ability to screen eligible patients as well as to provide services.

Secondary Barriers Reported by Higher Performing Sites

Accuracy of Documentation

- Providers did not always enter data into the correct places on a chart, or did not fill out forms completely or correctly.

GPRA Logic

- CRS/GPRA logic is written to include all active patients who meet a basic definition of two visits within three years to various clinics, there are patients within this population that do not have regular contact with a clinic's medical department. Some sites mentioned that these infrequent patients are "counted against them."

Community Context

- Patients that did not want to be screened.
- Difficulty getting answers to screening questions because people were afraid or reluctant to discuss their issues with the staff due to the shame or stigma associated with behavioral health issues. This was true at some clinics where the community was small and staff members were part of the community, and conversely, at some larger sites where the staff members were not part of the community.
- Differing standards of normal or unacceptable behavior among community members compared to providers, e.g. not regarding drinking beer as drinking "alcohol."

Higher performing sites reported few actual barriers to the screening process. Training issues appear to be related mainly to new or temporary staff members, while longer-term staff members are well-trained and understand the importance of the screening and documentation process at their facility. Although there are a number of community factors that may limit the clinic's ability to identify and treat those patients in need, higher performing clinics still see the value in universal screening and using all the resources available for treatment and follow-up. Also, while many higher performing sites reported shortfalls in staffing, they were still performing well above average with regard to behavioral health screenings.

C. Summary of Barriers Reported at Lower Performing Sites

Many of the barriers identified at lower performing sites were the reverse of factors identified as successful practices at higher performing sites. While higher performing sites identified universal screening, staff core competency, and coordination of care as successful practices, lower performing sites lacked all of these attributes. Lower performing sites did not have any policies or procedures regarding universal screening, and reported that problems with staff training, coordination, documentation, and access to resources greatly hindered their ability to screen.

Primary Barriers for Lower Performing Sites:

Lack of Universal Screening Policy and Procedures

- Did not have standardized process in place to screen their patients.
- Did not regularly screen for behavioral health conditions.

Lack of Training/Staff Core Competency

- Provider staff did not receive adequate training to ask the screening questions and were uncomfortable screening their patients.
- Staff was not adequately trained on documenting screenings.
- Patients did not trust the primary care staff and/or the tribal behavioral health department due to confidentiality concerns, lack of staff continuity, or worries about staff qualifications.
- Providers are not held accountable when they do not perform screenings.

Lack of Coordination

- Referral resources were limited, too far away, or providers did not know what resources existed in the community.
- Do not collaborate or coordinate with the tribally-operated health department.

Secondary Barriers noted by Lower Performing Sites

Lower performing sites reported few of the secondary successful practices reported at higher performing sites such as standardized screening tools, multiple attempts at screening, patient education, and use of the Electronic Health Record. In some cases, they reported that the lack of these factors served as another barrier. Unlike high-performers, lower performing sites did not generally use standardized screening tools, and did not report any significant attempts at providing patient education. Only one lower performing site was using the Electronic Health Record at the time of the study.

Some respondents at lower performing sites did report that they made more than one attempt at screening patients. The multiple attempts represent the most significant “successful” practice at lower performing sites by individual providers. While the lower performing clinics did not have any policy regarding universal screening or did not hold providers accountable for screening, these providers had taken it upon themselves to try to screen their patients on a regular basis.

Lack of Standardized Screening Tools

- Behavioral health screening tools were inadequate or hard to use.
- Did not use standardized screening tools at all.

Lack of Electronic Health Record (EHR)

- Do not have EHRs.

Other Barriers to Screening Reported by Lower Performing Sites

In addition to reporting that they did not have many of the secondary factors that supported high performance on screenings, lower performing sites also mentioned many of the *barriers* to screening that were also mentioned by high performers, including time constraints and staff turnover and transportation. They also shared many of the same

perceived barriers to screening, including community norms and accurate documentation. However, in the case of lower performing sites, these factors appear to be more significant, particularly with regard to staffing shortages and time constraints.

Time and Staff

- Not having enough staff or time to complete behavioral health screenings.
- Severe overcrowding leading to implementing policy specifically designed to limit the amount of time a provider spends with a patient.
- Very high staff turnover and many temporary providers.

Transportation

- Did not provide any patient transportation to their clinic or to treatment
- Referral resources were limited or too far away.
- Some patients were unable to come into the clinic due to transportation issues.

As with higher performing sites, lower performing sites identified factors that did not necessarily hinder the screening process, but limited their ability to provide behavioral health care. These factors include documentation issues, community standards, and lack of referral sources. GPRA logic, however, was not mentioned as a significant barrier by lower performing sites.

Accuracy of Documentation

- Providers do not document correctly or data is just not entered into RPMS.
- Did not have a standard way to document completed screenings.

Community Context

- Patients that did not want to be screened and were afraid or reluctant to discuss their issues with the staff because of privacy concerns.
- Communities had heavy alcohol use and episodes of domestic violence less frequently reported to medical providers.

Lower performing sites shared many of the same barriers (both actual and perceived) reported by higher performing sites, including training and transportation problems, documentation problems, and community/patient compliance issues. Such issues seem to be endemic across sites, regardless of how well a clinic is performing on behavioral health screening. The main factors that led lower performing sites to have lower behavioral health screening rates were the same factors that contributed to success at higher performing sites. Many of the factors confirmed or volunteered less frequently as factors contributing to success by respondents at higher performing sites also were lacking at lower performing sites. However, higher performing sites had managed to compensate for these barriers by focusing on universal screening, maintaining staff core competency, and encouraging coordination of care.

D. Recommendations

The recommendations made by higher performing sites mirrored the successful practices and barriers reported. Higher performing sites recommended universal screening of all patients, staff training, good communication among all providers and staff, and collaboration and coordination among departments and outside agencies.

Implement Universal Screening Policies and Procedures

- Perform universal screening of all patients (whether part of the GPRA denominator or not) at every visit.
- Require staff to screen, either by official or unofficial policy.
- Develop standardized processes and procedures for behavioral health screening.
- Screen as part of the triage process.
- Use self-report questionnaires for patients.

Train all staff to improve core competency and documentation processes

- Train staff on the behavioral health screening and documentation process.
- Train primary care staff on data entry, and train data entry staff on medical terminology.
- Have screening data in one place for accurate entry and stay current on data entry.
- Check before appointments to see if patients need screening and if possible, use EHR reminders.
- Hold providers accountable for screening rates/give feedback to providers on performance.
- Retain staff to maintain continuity of care.

Implement Good Coordination and Communication

- Improve staff communication and working relationships.
- Have data entry staff communicate with providers regularly, and improve teamwork between medical records and primary care.
- Plan for follow-up to positive screens.
- Standardize the screening process, so that the screening is the same, regardless of who does it or where it is done
- Create opportunities for the data entry and primary care staffs to collaborate.
- Foster relationships with other departments and agencies, especially with the behavioral health department and community treatment programs, and between the clinic and the tribes.
- Develop patient care teams to improve care and communication.
- Identify resources for patients and make sure providers are aware of them.
- Follow up with patients who screen positive for behavioral health conditions.
- Educate patients on acceptable/community norms and available services, distribute patient brochures.
- Conduct community education and outreach campaigns, and work with agencies to improve awareness.

Relatively few themes emerged in the recommendations made by the lower performing sites, and the focus group facilitators generally noted that these sites had a difficult time identifying solutions to the barriers they experienced at their facilities. The following recommendations were made by more than one lower performing site.

Training

- Increase training for primary care and data entry on how to deliver and document the screenings.
- Create self-report questionnaires for patients to complete prior to the exam.

Coordination

- Improve coordination between primary care and other departments, especially behavioral health.
- Improve patient access to referral resources.
- Add or expand onsite mental health services.

Other recommendations reflected the barriers identified by lower performing sites, including lack of time. These recommendations included:

- Increase the amount of time providers can spend with their patients.
- Develop a consistent screening approach for all providers.
- Provide screening tools and have all staff use the same tools.
- Use RPMS/CRS/EHR tools to identify patients that need screening.

However, one recommendation that lower performing sites did not make was to perform universal screening. This may be due to the fact that universal screening involves a commitment on the part of the facility to require staff to screen all patients and to take the time to perform these screenings.

E. Summary of Findings

Overall, the most common successful *practices and attributes* at higher performing sites were Universal Screening, Staff Core Competency, and Coordination of Care. The most successful sites screened all patients for behavioral health conditions at every visit, provided access to training for their staff, and encouraged communication and coordination among all staff members involved in delivering behavioral health care and documenting screening. Secondary characteristics of higher performing sites included patient education, multiple attempts at screening, use of standardized behavioral health tools, and use of the Electronic Health Record.

Barriers reported by higher performing sites included lack of training for new or temporary staff, high staff turnover and use of temporary providers, lack of time for screening, and patient transportation issues. Other barriers mentioned that did not function as barriers to the screening process, but detracted from the provision of treatment and follow up included a lack of trust in providers on the part of patients, or having a community that tolerated a high degree of domestic violence or alcohol abuse.

Sites also reported problems with enrolling patients into treatment programs. However, these other barriers did not directly impact a site's ability to screen, but to provide comprehensive behavioral health care. Additionally, quite a few facilities mentioned problems with documentation or obtaining GPRA "credit" for screening.

The recommendations made by higher performing sites mirrored the successful practices and barriers reported. Higher performing sites recommended universal screening of all patients, staff training, good communication among all providers and staff, and collaboration and coordination among departments and outside agencies. Among lower performing sites, the main recommendations were for training and better coordination.

Section VI: Lessons Learned from the Study Design for Replicating This Study

On a substantive level, the relatively small sample size of this study means the findings should be used with caution in terms of their potential applicability to other sites for the GPRA behavioral health screening measures studied. Other sites may find it useful to replicate aspects of this study for their own purposes. Additionally, there may be utility in conducting similar studies for other GPRA measures. With these future possibilities in mind, some procedural challenges emerged during the course of designing and carrying out this study. These challenges fall into three principal categories: complying with the requirements of the Paperwork Reduction Act, arranging for participation and then scheduling focus group meetings at IHS and tribal health programs, and finding sources of comparable contextual information on all participating sites.

A. Paperwork Reduction Act:

Under the Paperwork Reduction Act, if a Federal agency plans to administer a questionnaire to 9 or more non-Federal individuals, Office of Management and Budget (OMB) approval is required. Because Tribal clinic employees are non-Federal, the focus group discussion guide and evaluation plan were subject to the Act. While the study team believes the inclusion of Tribal clinics in the study added an important dimension to the study, the approval process was lengthy. The preparation of the submission package was more complex and time consuming than anticipated. In addition, the approval process under the Act, which requires a minimum of six months to complete, took longer in this case. As a result, completion of all of the site visits, focus group discussions, and subsequent analyses and report writing all took substantially longer than initially estimated. The delay in being able to schedule the tribal site visits also resulted in some increase in travel costs due to rising airline fares and gasoline prices for auto travel.

B. Scheduling Challenges

The study team realized from the outset that Tribal permission would be required if Tribal sites were included in the study. While the team believes that their inclusion was important, including tribal sites in the study did involve additional steps to identify the appropriate Tribal officials to contact and to follow up by providing additional supporting documentation that some requested beyond the basic background material initially provided to them. This process took far more time and effort than was anticipated. On average, 2 to 3 months passed between the initial contact with a Tribal clinic to identify appropriate Tribal officials and final receipt of approval to participate. In one case, despite multiple contacts, the study team was never able to arrange for participation and ultimately had to reduce the number of study sites by one, as there was not enough time to start the process over to include an alternate tribal site.

While the study team expected that scheduling Tribal sites would be challenging, it was also more difficult than anticipated to schedule IHS-operated sites in a number of instances. The team was unable to include one Federal site because of staffing issues at that location; recent high turnover among the leadership and providers meant there was not a core staff with any depth of experience at the clinic to participate. Fortunately, this happened early enough in the study that there was time to identify and include another IHS-operated site as a replacement that met the study criteria. In other instances, lack of a permanent chief executive officer, staff changes, and various other delays in responses to team contacts resulted in difficulty trying to establish contact with an individual who could make a commitment to participate and schedule a visit.

Other operational issues at some sites resulted in focus group participants not being available when the focus group moderator arrived on site, despite prior arrangements being made. These resulted primarily in meeting delays or last minute substitutions of staff, although in one instance, a focus group had to be convened by teleconference.

C. Contextual Information Sources

While the primary source of information regarding successful practices and barriers was always expected to be the focus groups, the study team intended to compare a variety of other site characteristics using data from other, existing systems and sources. However, in many instances, information sources did not include all of the same data elements for all of the sites. In some cases, no information at all was available on certain participating sites.

There are several reasons for this situation. First, under Public Law 93-638 (Indian Self-Determination and Education Assistance Act) Indian Tribes can obtain health care for their members directly from the federal government (IHS) or through a contract or a compact with the IHS to assume tribal control over administration and funding for various health care programs and services the IHS would otherwise provide. All of the tribal sites participating in this study operate at least some of their health care programs under such compacts or contracts and thus have greater flexibility in how they operate than IHS directly-operated sites. The fact that Tribes have latitude to operate their clinics differently than federal sites is significant. For instance, with respect to Level of Need Funded (LNF), in some instances Tribes that operate multiple facilities accept funding without providing a breakdown of that funding to the individual facility level. Thus, the study team was unable to do a complete comparison of site funding based on LNF.

A second reason is a lack of standardization in gathering and reporting certain types of information among Indian Health Service Areas. For instance, the study team initially believed that Area Master Plans would be a rich source of comparative information. However, as these were collected and reviewed, the team found that some Areas used different contractors, and those reports did not include the same

information or look at the same base timeframe. In addition, Tribal facilities were permitted to opt out of the Master Plan process in their Area, preparing their own plan instead of utilizing the contractor's services. In those cases, very limited information was available and was not prepared according to the same metrics as others within that Area. Finally, Area policies about data sharing vary. Thus, the study team had access to complete workload reports (provided for calculating a particular performance measure) for most Areas. However, several Areas provided only a summary of information rather than the base report. As a result, detailed staffing information that would have provided an interesting basis of comparison was not available for all sites.

Section VII: Final Observations from the Study and Implications for the Future

The key findings of this study suggest that higher performing sites have three main successful practices, all of which can be adopted by other clinics. Moreover, these practices may be adaptable to other screening measures, particularly those that involve screening large groups of patients, although cost/benefit considerations may produce different screening policies better suited to other health conditions.

1. IHS Areas and/or national and local tribal organizations may want to consider:
 - a. how to identify lessons learned from their own experiences with behavioral health and/or other screening measures (see Appendix A: Quick Guide to improve behavioral health screening rates, as a potential basis for discussion);
 - b. how to develop model policies and procedures that could be adapted to local needs and circumstances; and matching of higher performing sites as technical advisors to lower performing sites;
 - c. how to replicate some or all of this study or adapt it to assess other performance measures.

This study did not examine behavioral health treatment in a systematic way. However, the repeated mentions, by both higher and lower performing sites, of the lack of sufficient treatment resources suggests that the Indian Health Service may want to explore cost-effective ways to address this limitation with new authorities and organizational priorities.

Appendix A: Quick Guide to Improving Behavioral Health Screening Rates

1. Implement Universal Screening
 - a. Attempt to screen everyone, at every visit, regardless if they meet a GPRA definition (exceptions may include small children).
 - b. Make multiple attempts to screen; if someone has a child or other adult with them try to make a follow up appointment where they can be screened privately to encourage honest replies.
 - c. Develop a standardized process for screening. Consider doing the screening during the triage process or via patient questionnaire, filled out before the appointment starts.
 - d. Consider making an official clinic policy requiring providers to screen patients for behavioral health conditions.

2. Support Staff Competency
 - a. Offer training opportunities for staff members, especially new or temporary staff, on behavioral health screening and documentation.
 - b. Train primary care staff on data entry, train data entry staff on medical terminology, and provide everyone with information about GPRA.
 - c. Encourage staff to utilize training opportunities provided by IHS or other agencies.
 - d. Review GPRA results with providers and other staff and offer incentives for improvement.
 - e. Consider making a policy to use standardized screening tools.
 - f. Have policies supporting staff retention.
 - g. At sites with the Electronic Health Record, encourage staff to attend training and learn to use all the features, including reminders.

3. Encourage and Support Coordination of Care
 - a. Encourage communication between departments. Encourage departments to meet often to review patient care and coordinate services; one possibility is to create patient care “teams.”
 - b. Standardize the screening, referral, and treatment process so that all staff know their role; always make referrals as quickly as possible.
 - c. Offer patient education promoting understanding of the need for behavioral health screening. If necessary, offer outreach programs to the community to help address community acceptance of drinking, intimate partner violence, and depression.
 - d. Identify community resources for patients, make sure providers are aware of them and encourage staff to use all services available.
 - e. Collaborate with tribes and other community groups to identify and provide resources for patients. Foster relationships with other departments, agencies and community treatment programs.

- f. If possible, provide patient transportation to appointments and referral resources, and consider partnering with tribes and community groups to provide transportation.

Appendix B: Characteristics of Higher Performing Sites

Primary Characteristics	Secondary Characteristics	Tertiary Characteristics
<ul style="list-style-type: none"> • Universal Screening <ul style="list-style-type: none"> ○ Staff screen all patients at every appointment ○ Many sites have policies or procedures requiring universal screening • Staff Core Competency <ul style="list-style-type: none"> ○ Primary care staff feel qualified doing screenings ○ Staff have training on screening/documentation ○ Data entry quality procedures are in place ○ GPRA results are reviewed with providers and providers are held accountable • Coordination of Care <ul style="list-style-type: none"> ○ Primary care and BH staff communicate and coordinate care ○ Site collaborates with tribe and community to provide care 	<ul style="list-style-type: none"> • Multiple Screening Attempts <ul style="list-style-type: none"> ○ Medical staff make multiple attempts during same or follow-up appointment ○ Follow-up questions asked in exam to verify responses from triage ○ Patient may be re-screened if lab result indicates inaccurate screen • Patient Education <ul style="list-style-type: none"> ○ Sites provide handouts, oral information during screenings ○ Patient handouts provided in discreet areas ○ Sites conduct community outreach to increase awareness • Standardized BH Screening Tools <ul style="list-style-type: none"> ○ Use standard, well-accepted, or in-house tools ○ Same tools used at all locations • Electronic Health Record (EHR) <ul style="list-style-type: none"> ○ 6 of 12 sites use EHR ○ Advantages include: <ul style="list-style-type: none"> ▪ Improved screening rates ▪ Easier/more consistent documentation ▪ Provider reminders to screen 	<ul style="list-style-type: none"> • Miscellaneous Other Factors <ul style="list-style-type: none"> ○ Lab tests used to confirm positive behavioral health screen ○ Patients fill out self-report questionnaire ○ Patients see same provider at each visit ○ Low staff turnover helps maintain continuity of care ○ Staff review charts and contact patient if screening due ○ One site put behavioral health office in primary care department

Appendix C: Sample of Focus Group Questions (Provider Questions)

Behavioral Health Overview:

1. When performing behavioral health screenings, do you usually screen just the patients who fit the GPRA definition for a measure, or do you screen others who do not meet the GPRA definition?
2. Why or why not?
3. EHR Sites: How useful is EHR in documenting the results of Behavioral health screenings?
4. Do you use any EHR reminders to identify patients who need screening?
5. Do you have any suggestions for how documentation could be improved in EHR?
6. Non EHR Sites: How do you document behavioral health screenings in RPMS?
7. Do you think this is the best way to document results?
8. Do you have any suggestions for improvement?
9. Do you use the RPMS health maintenance reminders or depression screening reports to determine which patients need to be screened?
10. Do you provide behavioral health patient education?
11. Who receives this education?
12. How is patient education documented?
13. Has your site undertaken any initiatives recently to improve behavioral health screening rates?
14. What are they?
15. Have you ever received training on behavioral health screening best practices?
16. What kind of training?
17. How useful was the training?
18. What role do the CHRs play at your site in identifying patients who need a clinical behavioral health screening? *Prompt: CHRs perform and document BH screenings; make informal referrals; transport patients, etc.*

DOMESTIC VIOLENCE

Section A: Screening Process and Tools

1. What screening tools or guidelines do you use when you screen for DV? *Prompt: a question on a health questionnaire, a standardized IPV screening tool such as HITS or WAST, or the IHS Family Violence Prevention guidelines.*
2. On a five-point scale, where one is very dissatisfied and five is very satisfied, how satisfied are you with the tools or guidelines you are using?
3. Why?
4. Please describe your usual process for screening for DV. *Try to guide the discussion to encompass the beginning and end of the process or processes they perform, from initial identification to data entry.*
5. Do you use any other processes to screen for DV?
6. What do you do when you get a positive screen?
7. What do you do when children who can speak or other adults are present with a patient who requires a BH screening?
8. How do you follow up on patients who can't be screened because others are present?

Section B: Referrals and Resources

1. Do you have a set of referrals or resources available for patients who screen positive for DV?
2. What are some examples of resources you would use?
3. Have you received any training on the DV resources available to your patients?
4. Is the availability or quality of referral resources ever a factor in your decision to screen?
5. Why or why not?

Section C: Final Questions

6. What are the factors that you think contribute to your facility's success in screening for DV?
7. What factors do you think might limit your ability to screen for DV?
8. What would you recommend to improve DV screening rates?
9. What would you recommend as DV screening best practices for other facilities?

ALCOHOL SCREENING TO PREVENT FAS

Section A: Screening Process and Tools

1. Do you use any screening tools for alcohol screening? *Ask about tools such as CRAFFT, CAGE, AUDIT, etc. if not mentioned*
2. On a five-point scale, where one is very dissatisfied and five is very satisfied, how satisfied are you with the tools?
3. Why?
4. What is your usual alcohol screening process? *Try to guide the discussion to encompass the beginning and end of the process or processes they perform, from initial identification to data entry.*
5. Do you ever use any other processes to screen for alcohol use?
6. What do you do when you get a positive screen?
7. What do you do when children who can speak or other adults are present with a patient who requires a BH screening?
8. How do you follow up on patients who can't be screened because others are present?

Section B: Referrals and Resources

1. Do you have a set of referrals or resources available for patients who screen positive for alcohol use?
2. What are some examples of resources you would use?
3. Have you received any training on the substance abuse resources available to your patients?
4. Is the availability or quality of referral resources ever a factor in your decision to screen?
5. Why or why not?

Section C: Final Questions

6. What are the factors that you think contribute to your facility's success in screening for alcohol use?

7. What factors do you think might limit your ability to screen female patients of childbearing age for alcohol use?
8. What would you recommend to improve alcohol screening rates?
9. What would you recommend as alcohol screening best practices for other facilities?

DEPRESSION SCREENING

Section A: Screening Process and Tools

1. Which depression screening tools do you use? *Ask about PHQ2 and PHQ9 if not mentioned, also Beck's Depression Inventory.*
2. On a five-point scale, where one is very dissatisfied and five is very satisfied, how satisfied are you with the tools?
3. Why?
4. What is your usual depression screening process? *Try to guide the discussion to encompass the beginning and end of the process or processes they perform, from initial identification to data entry.*
5. Do you ever use any other process to screen for depression?
6. What do you do when you get a positive screen?
7. What do you do when children who can speak or other adults are present with a patient who requires a BH screening?
8. How do you follow up on patients who can't be screened because others are present?

Section B: Referrals and Resources

1. Do you have a set of referrals or resources available for patients who screen positive for depression?
2. What are some examples of resources you would use?
3. Have you received any training on depression resources available to your patients?
4. Is the availability or quality of referral resources ever a factor in your decision to screen?
5. Why or why not?

Section C: Final Questions

6. What are the factors that you think contribute to your facility's success in screening for depression?
7. What factors do you think might limit your ability to screen?
8. What would you recommend to improve depression screening rates?
9. What would you recommend as depression screening best practices for other facilities?

CONCLUSION

1. Do you have any other comments about behavioral health screening in the primary care setting that you would like to add?

Appendix D: Description of GPRA Data Collection Process

GPRA performance data has been collected by CRS since 2003. (Prior to 2003, data for IHS GPRA reporting on clinical measures was manually reported.) Federal (IHS) facilities are required to use RPMS and report GPRA data via CRS. Tribal facilities are not required to use RPMS or CRS and submit GPRA reports on a voluntary basis. Some urban facilities have been required to use CRS and some have not, but all must report GPRA data in order to receive funding. Urban GPRA data is not combined with Federal or tribal data. Although IHS accepts GPRA reports from tribal sites that do not use RPMS, this data is not aggregated with RPMS/CRS data. Therefore all aggregate clinical GPRA data reported to HHS, OMB and Congress is from RPMS/CRS tribal and federal sites only.

GPRA data is collected and reported on an annual cycle that begins on July 1st and ends on June 30th. This timetable allows for data to be collected, aggregated, and analyzed for the annual budget submission. Data runs occur on a quarterly basis, although sites are not required to submit 1st quarter reports. All quarterly reports are cumulative from July 1st. Second and third quarter reports are reviewed internally; only the 4th quarter report is used to compile IHS national performance measure rates for all clinical GPRA measures and to report official national results for a given fiscal year.

CRS calculates measure results by calculating an aggregate denominator and numerator for each measure. The denominator consists of the patient population eligible for the measure. Different measures have different denominators. The numerator consists of the patients from the denominator who meet the logic criteria for a performance measure. For example, the denominator for Adult Influenza Immunization is “Active Clinical patients age 65 or older” and the numerator for Adult Influenza Immunization is “Active Clinical patients age 65 or older who have received an influenza immunization during the Report Period.”

Generally all GPRA measures use some variation of the “Active Clinical” definition for each measure denominator, with specific age (and in some cases gender) definitions. To be considered Active Clinical, a patient must have two visits to medical clinics in the past three years with at least one of those visits to a core medical clinic such as internal medicine, family practice, or pediatrics (thus eliminating patients who may only visit a dentist or an emergency room, for instance). They also must be alive on the last day of the report period, must be American Indian/Alaska Native (AI/AN), and must reside in a community specified in the site’s GPRA community taxonomy. Two measures do not use an Active Clinical denominator; the Diabetes Diagnosed Ever contextual measure, and the Dental Access measure both use the User Population as a denominator. The User Population includes all patients who have been seen at least once in the three years prior to the end of the reporting period; patients also must be AI/AN, alive on the last day of the report period, and reside in a community specified in the site’s GPRA community taxonomy.

Collection of GPRA data occurs at the clinic level and therefore relies on accurate data entry both by staff and providers. Some clinics use the Electronic Health Record (EHR),

which generally involves direct provider entry of data. Other clinics have support staff enter data into RPMS. All clinics have the flexibility to use the CRS software to monitor and improve their performance by running reports more frequently, running reports by provider, and running lists to identify patients who need screenings or preventive care.

After a GPRA quarterly report is run at a clinic, the Area GPRA Coordinator runs an Area report consisting of all CRS reports from clinics in their Area. These aggregated Area files are sent to the National GPRA Support Team (NGST) at the California Area Office where they are reviewed and validated by the NGST and combined with data from other Areas to produce national results. The NGST does provide some general analysis of data trends, but its primary role is to report data. National data is reported to HHS, OMB and Congress in the annual performance report. This data also becomes part of the annual budget submission.

In each fiscal year, the IHS must meet specific performance targets for each measure. Targets are negotiated with and ultimately set by OMB, based on agency funding and prior performance. These targets become part of the annual budget justification. Generally, IHS has done well in meeting annual performance targets, although there is considerable variation across Areas and among individual sites.