HIV/STI measures

- 1 GPRA (Prenatal HIV)
- 3 others added
  - HIV screening 13-64 y.o.
  - STI screening
  - Chlamydia screening
    - All based on national recommendations
    - 2 of the above needed modification

Prenatal HIV lessons learned

- Visited sites doing the best, worst
- Data issues present, had to be solved to obtain buy-in for identifying clinical gaps
- Best sites had and clear responsibility for 1) identifying patient due for HIV test, 2) getting test ordered, 3) getting test into RPMS

Examples

- Bundle HIV in prenatal panel ordered in QuickPik in HER
- Use of electronic clinical reminder
- Order HIV test at initial HCG+

- Essential to visit sites to talk to providers, do the chart reviews, give site-specific results
- Now replicating Prenatal HIV methods with new ONMs and B+C Cancer screening

Modifications

- STI screening
  - Needed to remove one code (false positive for CT)
  - Need to tell sites not to use ‘venereal disease screening’ code, it isn’t in the logic
  - Need to re-tool measure for syphilis
  - HIV Screening of 13-64 y.o.
    - Adding 5 year and ‘ever’ intervals

Challenges

- Choose a new GPRA measure for HIV/STIs?
- How get sites to care about these new measures

Technical challenges (opportunities)

- New measures (newly HIV+, total STI incidence, CD4 count) validity
- Outcomes, not just outputs

GPRA Best Practices

Lessons Learned from 9 sites meeting 19/19 GPRA targets

NEJM article 2011

EHR only showing effective gains in organizations with

-decades of experience

-in-house expertise/modification

Kaiser, Cleveland Clinic, VA

GPRA champion sites

- 2 in AK
  - KANA (Kodiak), BBAHC (Bristol Bay)
- 4 in NAS
  - Micmac, Catawba, Oneida Nation, Passamaquoddy Indian Township
- 3 in OK
  - Stigler, Wilma P Mankiller, Muskogee

Summary

- GPRA made an internal priority
- GPRA data locally available
- GPRA data regularly shared and discussed
- Delegation of services away from Provider
- Local innovation
  - Use of information technology

GPRA was an internal priority

- GPRA measures embraced as measurement for quality of care

- Sites self-accountable to GPRA, rather than performing well for external reporting:

  7 of 9 sites were tribal and don’t need to report GPRA scores

GPRA data shared (1 of 4)

- GPRA scores available at regular intervals (usually monthly)
- Low scores identified early in GPRA year
- Allows identification and troubleshooting on data issues (taxonomies, codes, etc.)
- Generates patients lists to determine who is overdue for what immunizations/screenings (via CRS or iCare)

GPRA data shared (2 of 4)

- Data widely shared by GPRA coordinator or CAC with:

  -Health Director/CEO, Clinical director, Medical Practitioners, Quality Improvement Staff, Data Entry/Medical Records, Behavioral Health Staff, Dental Staff, Diabetes and Immunization Coordinators and other specialized staff members)

GPRA data shared (3 of 4)

- All sites had at least one scheduled and regular interaction to share GPRA numbers, and get input and ideas from staff on new taxonomies, follow up with hard-to-reach patients, and targeting lagging indicators

- Examples include:
  - morning huddle
  - weekly medical meeting
  - GPRA coordination committee

GPRA data shared (4 of 4)

- At provider team level within facility
- At Area level across facilities

Allows rapid identification and sharing of best practices, reinforced by awards and recognition from Area level

Delegation of Services away from Provider Level (1 of 3)

- Responsibility for meeting GPRA measures divided among staff, both medical and non-medical

- Clear responsibility by individuals for each measure

Delegation (2 of 3)

- Shared but clearly defined responsibility makes targets feel more attainable and includes entire facility

- Allows providers to spend more time discussing issues with patients rather than checking off screenings, resulting in better provider-patient encounter

Delegation (3 of 3)

- Examples:
  - Nurses identify and complete most of preventive care

  -Chief Nursing Assistant responsible for her staff completing screenings for depression, alcohol use, domestic violence

  -Contract health representative makes follow up calls to make appts. for patients overdue for preventive care

Local Innovation (1 of 4)

- Local solution examples:
  - Diabetes clinic that provides all aspects of diabetes care, includes incentives for some patients to keep appointments
  - Data management: medical records is lead responsible on prenatal HIV screening because most tests done outside the tribal clinic. Enters external tests into RPMS, identifies patients who have not been tested

Local Innovation (2 of 4)

- Use of information technology
  - iCare for comprehensive check of community members who are overdue for care
  - RCIS package to capture services provided by referral sites
  - Use of electronic clinical reminders (or standing protocols)
  - Monitoring state immunization registries

Local Innovation (3 of 4)

- Provider and facility level friendly competitions
  - Facility level: incentives and awards for facilities in an Area that meet certain goals and improvements
  - Provider level: using iCare to chart provider and provider teams' progress on GPRA measures. These data spur teams to do better, and help identify best practices worth sharing

Local Innovation (4 of 4)

- Indicator-specific innovation examples:
  - Colorectal Cancer Screening: care team surveyed patients about FOBT kits, found out instructions were confusing and there was not follow up from clinic staff. They updated the instructions and established a process for follow up (CHR/RN call patient 2 weeks after receiving FOBT kit)
  - Transport to mammogram services for hard-to-reach patients
  - Dental Services for youth delivered via strong relationship with local school

Summary

- GPRA needs to be prioritized by leadership for entire facility as internal benchmark of quality
- GPRA data needs to be regularly available and utilized
- Patient lists needed to identify data issues and non-screened/immunized patients