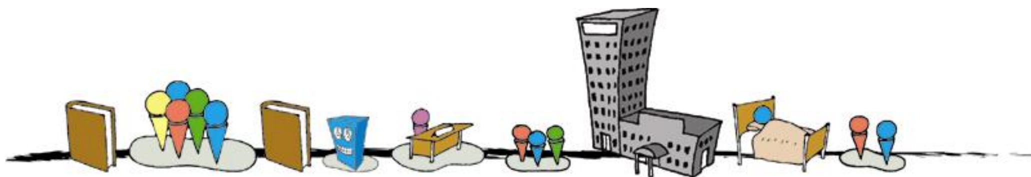

Division of Sexually Transmitted Disease Prevention
Business Process Management Modeling Initiative

SUB TASK 2

DELIVERABLE
2C

CONTRACT
GS-10F-0087N

CAP GEMINI ERNST & YOUNG

DELIVERABLE 2C GS-10F-0087N	• Summary of organizational assessments, and interviews relative to the development of STD Prevention objectives and guiding principles

Organizational Assessment and Recommendations

Overview

The aim of this initiative is to examine and redefine the STD Prevention work of CDC-funded project areas and inform the development of technology to support that work. During the initial assessment, however, the majority of the interviewees and facilitated session participants represented DSTDP. As a result many of the findings reflect the work of DSTDP, in the context of its interaction with grantees. As this initiative continues, the team recognizes that additional input and representation will be required from state and local grantees. Nonetheless, this feedback will be integral to a comprehensive understanding of issues facing all grantees, as well as an understanding of how the CDC can support the grantees in their development and the implementation of a common but flexible model for STD Prevention.

The organizational assessment and recommendations listed below are based on the interview summaries and activities that occurred in the facilitated session. Interviews yielded significant information about the work of State and Local Health Departments: What key challenges they face, what support mechanisms they seek and how they envision technology helping them to overcome some of these obstacles. Session participants synthesized common themes, summarized issues facing stakeholders and developed recommendations for improvement.

In addition, although the goal of the initiative is to derive a series of common STD Prevention processes over the next 18 months, stakeholders were also encouraged to identify shorter-term solutions. Therefore, two outputs are presented within each section:

1) Observations of STD Prevention activities within DSTDP and State and Local Health Departments, including issues to be considered during the development of the common framework and the long term technology solution

2) Recommendations that are immediately actionable with minimal process changes or technology requirements

Recommendations offered here aim for immediate positive impact and require limited resources for implementation. Examples include communication plans, stakeholder meetings, Question and Answer databases, centrally located contact sheets, searchable Question and Answer databases, and lists of current resources (e.g. training programs, software programs). Longer-term recommendations requiring more significant resources, including technology, staff, and funding and are central to the BPMM initiative, and will be addressed in the future state design of later deliverables.

Observations

Stakeholders cite much success in meeting STD Prevention goals and collaborating with partners. They believe that STD Prevention services are effective, even in this era of decreased funding, and they detail the excellent work of the CDC and State and Local Health Departments. Although much of the text below is focused on issues and recommendations, this material reflects participants' commitment to improvement in STD Prevention practices and their desire to provide the input necessary to drive the initiative.

It should also be noted some of the recommendations below restate work that is already being considered or already in progress. Again, this is indicative of the commitment of participants, who aim to reinforce ideas and communicate current work. Discussion of some existing work is included here to present a comprehensive summary of all improvement opportunities identified during interviews.

Observations – CDC-funded Project Areas

Resources
Grantees have received approximately level funding for the last ten years. As new monies are channeled to bio-terrorism efforts, away from current initiatives, there is valid concern that it will be difficult to maintain current STD Prevention activities, let alone augment them as needs arise. DSTDP and grantees recognize the need to further secure alternative funding sources, identify external partners and instill an understanding of program needs with the public and government entities.

They also recognize that decreased funding, along changing public health needs that require programs to address alternate populations and different diseases, will force grantees to prioritize activities, potentially discarding some current activities. Grantees and DSTDP staff struggle to define these priorities. Stakeholders seek help in identifying a flexible set of protocols that will guide them in making program decisions. They seek to draw from a variety of research findings and best practices, to knowledgably evaluate the trade offs and make concrete decisions.

Communication
The grantees interviewed appear to be in close communication with DSTDP about program and research activities. However, they cite a lack of formal communication about the full range of activities at DSTDP and technical assistance offerings. They also state that surveillance results are often not timely or specific enough to facilitate program decisions. In parallel, stakeholders recognize a need improve communication of similar information between state and local health departments.

Both internal and external stakeholders believe that enhanced analysis capability for state and local health departments would circumvent the need to rely on the CDC (or State Health Departments) for detailed, rapid surveillance feedback. However, they also acknowledge a need to better communicate the technical assistance offerings and research outcomes to grantees and Local Health Departments.

Technology
Grantees state that technology is often quite basic, particularly at local health departments. Local staff and field investigation staff often do not even have access to computers. In addition, in many circumstances, cumbersome processes are used to

circumvent lacking technology. Cases are reported on paper, sent to a central location and manually entered, often in more than one system. Data is then exported to external programs for analysis. Some grantees seem limited by STD*MIS, as they have difficulty sharing data with local health departments and difficulty creating needed reports to inform programs.

Like internal stakeholders, grantees express a desire to better understand the workings and implications of NEDSS and the STD PAM. In addition they cite concern that there are no additional monies being allocated for the STD PAM implementation and maintenance, Funding for NEDSS and the PAMs is to be drawn from Bio-Terrorism monies, and from existing grants from the various CDC Centers. However, the transition to a centralized, browser-based surveillance system will require significant transformation – not only the purchase and development of technology, but also organizational re-structuring, training, communication, etc within each Department. Grantees and DTSTDP staff are unclear how they will afford this transformation and how to prepare for a centralized initiative, that crosses funding streams.

Training

Grantees and DSTDP staff cite a desire to improve capabilities at state and local health departments. Although those grantees interviewed have the ability to collect and analyze their own data, they relay that other grantees and local health departments struggle more significantly. They state that many lack the ability to examine and analyze their own data, due to the complexity of the applications. Interviewees cite a need for technical assistance particularly with data analysis, planning and program implementation.

Program Development

Most interviewees suggest that providing better data definitions, case definitions and consistent protocols for reporting and collection would be beneficial to both grantees and DSTDP. Stakeholders recognize that even the most sophisticated users are often uncertain about the purpose of certain fields, and that reported information is often inconsistent even across local collection sites, within one state.

There is also significant discussion about expanding the data elements to be collected, particularly through the new interview record, to standardize the collection of contextual and risk behavior information to inform research and investigation. However, there is recognition that some of the data already collected is not used for analysis and some is not accurate. Therefore, stakeholders suggest rigorously examining current data, improving current collection protocols, reviewing the need for more data and identifying how new data will be used, prior to expanding the interview record and data requests.

DSTDP aims to instill a culture of outcomes measurement and to tie programs, technical assistance and funding to prevention outcomes. However, the method is elusive, as it is neither beneficial to reward states that are unable to show progress, nor to punish states that are unable to meet goals. Staff recognizes that there will have to be flexible funding and technical assistance structure, which can meet the varying needs of grantees, yet they must also meet the President's Performance Measurement Guidelines. Some grantees have participated in the development of the outcomes measurements. However, others appear to resist the implementation of the proposed standard measures for reporting.

More broadly, there are significant differences in the structure of grantee operations that must be considered during program development and planning. States employ varying levels of centralization: some states investigate cases and conduct intervention services locally, while others conduct these activities centrally, at the State Health Department. Protocols for investigation vary: Some states investigate the full range of diseases, while others focus on syphilis and antimicrobial-resistant gonorrhea. Some states follow-up on all positive lab reports and case reports, while others are only able to investigate case reports from providers. These inconsistencies are indicative of the variation in resources, state support, local priorities and legislation. They also reflect the lack of compliance in provider and lab reporting, one of the most complex issues facing health departments. Grantees recognize that differences in structure may be necessary due to resources, and local public health need. However, they seek a consistent set of processes that will guide program activities and allow for effective prevention and thorough research and across the states.

Recommendations – CDC-funded Project Areas

Many of the complex issues presented must be addressed through thorough process changes and technology augmentation. However, the following table represents some immediate actionable recommendations.

Recommendation	Action Steps
1. Identify and document funding sources	Request funding information through the annual Guidance, and document findings. Disseminate funding possibilities to grantees. Inform policy development and partnership strategy
2. Communicate CDC activities, TA capability and research to stakeholders	Create database of all services that CDC offers as well as key contact names and brief examples of the work. Consider augmenting the PDSB newsletter, or creating a new newsletter, to include program and research activity summaries.
3. Identify and communicate full range of training programs offered to providers and grantees/DIS. Ensure consistent content.	Continue creating searchable spreadsheet of all known available classes in 2004 (THCB, SAIC, PTCs), where they are being held, a brief description of the class, and the main contact. Create educational framework by key stakeholder to help identify which courses to take, where those courses are offered
4. Detail training needs and develop in-house analysis capability for decision-making at State and Local Health Departments.	Identify training needs with grantees and update training offerings. Potentially conduct training on analysis functions of STD*MIS and/or offer TA or classes on SAS/SPSS, in coordination with training being conducted through HIV program
5. Ensure that training is reaching priority targets, based on demographics, areas of need, STD prevalence data, and other related program variables	Conduct review of training needs and PTC programs. Information could be gathered to review whether training programs offered through PTCs or through other resources are addressing areas of greater need.
6. Create consistent case definitions and data definitions for all grantees	Continue reviewing and revising case definitions, as is currently in process. Create materials and training to facilitate consistent collection of data across grantees. QA data to ensure measures are consistent
7. Communicate plan for	Disseminate summary materials and the full transition plan to

transition from NETSS to NEDSS	grantees. Communicate the timeline for transitioning to the new system, including any overlap of systems, and contacts for implementation activities. Identify potential issues that may arise during the NETSS to NEDSS transition and develop plans to address these issues.
8. Increase the level of understanding about NEDSS and the STD PAM	Continue to hold trainings and meetings on NBS and PAMs. Create Question and Answer document for users that can be sorted and searched. Allow users to submit questions regularly that will be posted to a website.
9. Revise data elements collected to reflect field as well as research needs	First identify data elements necessary to promote field investigation, then consider if other elements necessary for research/surveillance. Identify the owner for each additional data element, and document how data will be used prior to solidifying interview record.
10. Identify standard measures for grantees to use to analyze for performance. Allow for flexible benchmarks, based on local needs	Solidify prevention program outcome goals as identified in Performance Measurement initiative. Pilot and train grantees on definitions of outcome goals and measurement methods. Incorporate measures into program guidance and status reports to measure progress and identify TA needs
11. Many programs are nearly stagnant while others are highly innovative. Innovative-nature of programs should be encouraged from a Division level	Create portion of grant response that requests 'marks of innovation' from programs that will encourage them to think of how they have adapted their programs based on data, areas of need, etc. Encourage sharing of these innovations via a communication mechanism such as a newsletter. More innovative programs will see a greater need for real-time analysis of data, which will help drive STD PAM use and interest
12. Increase mutual understanding of roles and responsibilities between DSTDP and CDC-funded project-areas	Create one-page 'customer satisfaction survey' to evaluate CDC's work with funded project areas. Review CSPS guidance/response for CDC action steps and track for completion and level of satisfaction. Outline roles and responsibilities and TA programs on DSTDP web-site. Build cross-training and/or orientation programs to give project areas opportunity to learn about CDC branches, programs and contacts

Recommendations Summary

Just as collaboration with a variety of stakeholders is necessary for success, so is accountability for implementation. It is imperative that each short and long-term recommendation has an owner and a time frame for completion. One person must be responsible for implementation, including all necessary communication with stakeholders, completion of each milestone and consistent progress reports to leadership to ensure problems are addressed quickly.

Therefore, CDC-funded project areas should first validate the observations and recommendations presented above and then the Steering Committee should prioritize the recommendations. Once selections are made, it is essential that leadership assigns accountability, outlines a schedule for milestones and deliverables and then monitors progress to ensure completion.

Conclusion

Stakeholders recognize that health departments must become nimble. They must be able to prioritize and update activities as resources shift and public health outcomes change. They seek to break from traditional silos and examine comprehensive goals across programs and funding structures. Yet, they acknowledge difficulty adapting prevention activities and breaking from the traditional paradigm of surveillance and investigation toward a new model based on measurable STD Prevention outcomes.

The Division of STD Prevention understands that adopting a new paradigm requires a comprehensive initiative that is applicable and adaptable to all grantees. Moreover, DSTDP acknowledges that CDC-funded project areas often mimic the organizational and funding structures of the CDC. Consequently, they must not only support the grantees in developing a new public health model, but also look inwardly to ensure they are facilitating the necessary changes through their own behavior.

NEDSS and the STD PAM present a wonderful opportunity for DSTDP and grantees to plan for the new paradigm. By the very structure of NEDSS, the Division, State Health Departments and Local Health Departments will have to evolve quickly in order to accommodate a central database along with functions and data shared with other disciplines. The collaborative development of the Vision for STD Prevention and the assessment of stakeholder prevention activities is a bold first step, setting a tone of partnership between DSTDP and CDC-funded project-areas. Stakeholders must be committed to collaboration as it not only results in superior outcomes, but it precisely models the behavior necessary for them to implement successfully in the new paradigm.

The next steps for DSTDP and grantees are two fold: 1) Consider recommendations presented here. They are immediately actionable, presenting benefit without significant resource or technology requirements, 2) Continue developing the new business process model to address the obstacles facing stakeholders and ultimately support the development and implementation of appropriate technology. The Steering Committee must decide where to focus resources to obtain the largest impact for both the Division and for stakeholders, and how to move forward to foster collaboration, communication, and to achieve the Vision for STD prevention. The challenge is great, but DSTDP’s demonstrated commitment to involving stakeholders and iterative work will help ensure success.

STD Prevention Recommendation Grid

The grid below presents recommendations identified by DSTDP staff, grantees and external stakeholders during interviews, meetings and sessions as part of the Business Process Modeling Initiative for STD Prevention. The recommendations are mapped according to perceived Level of Effort and resulting Benefit, as estimated by stakeholders:

1. Level of Effort considers time required to implement, cost of implementation, and staff availability
2. Benefit, considers the value to the stakeholders affected by the recommendation

This grid should be considered a working tool for future Division efforts.