

AAPPS Program Outcome Measures (POM): Report Back and the Next Submission

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Webinar outline

- ❑ **Part I: March POM report-back**
 - Syphilis screening of MSM in HIV care settings
 - GC treatment verification
 - Partner services outcomes for women with early syphilis

- ❑ **Part II: Update on short reports**
 - Quick poll

- ❑ **Part III: Overview of guidance for next submission**
 - Main additions
 - Other changes

PART I: POM REPORT BACK

March POM

- ❑ **Three POM domains requested, all for the entire 2014 time period**
- ❑ **Better guidance + better data = More we could do with these data**
 - Compared to Sept 2014 data
- ❑ **For each we will present today:**
 - Summary statistics
 - Data limitations noted
 - Some group comparisons, e.g., by groups based on case report load
 - No individual project area comparisons presented at this time

**POM 2: SYPHILIS SCREENING
AMONG MSM IN HIV CARE**

What we asked for

- ❑ **Annual syphilis screening rate:**
 - Number of clients (unduplicated) seen by high priority HIV care providers who were screened for syphilis at least once in the measurement year
 - Not restricted to Ryan White care providers
 - Denominator: MSM or All males

- ❑ **“Developmental” measure (2-D): Percent of those tested or screened for syphilis who were identified a new case of syphilis**
 - Duplicated clients (maybe tested > 1 time)
 - New syphilis cases diagnosed (not positive tests)

POM2: Data submitted

- ❑ 13 did not submit a numerator and denominator for POM 2 (screening rate)**
- ❑ 24 did not for POM 2-D (new syphilis cases identified)**
- ❑ 3 reported data quality of 1 (very poor)**
- ❑ 3 did not report for specified time period**

Top reason for not submitting:

- ❑ Data not available (at all, or not yet)**

POM 2: Data and reporting issues raised among those that did report

❑ Concerns about data accuracy due to e.g.:

- Data entry lags
- Data management within CareWare
- Inability to independently assess aggregate data provided to STD program

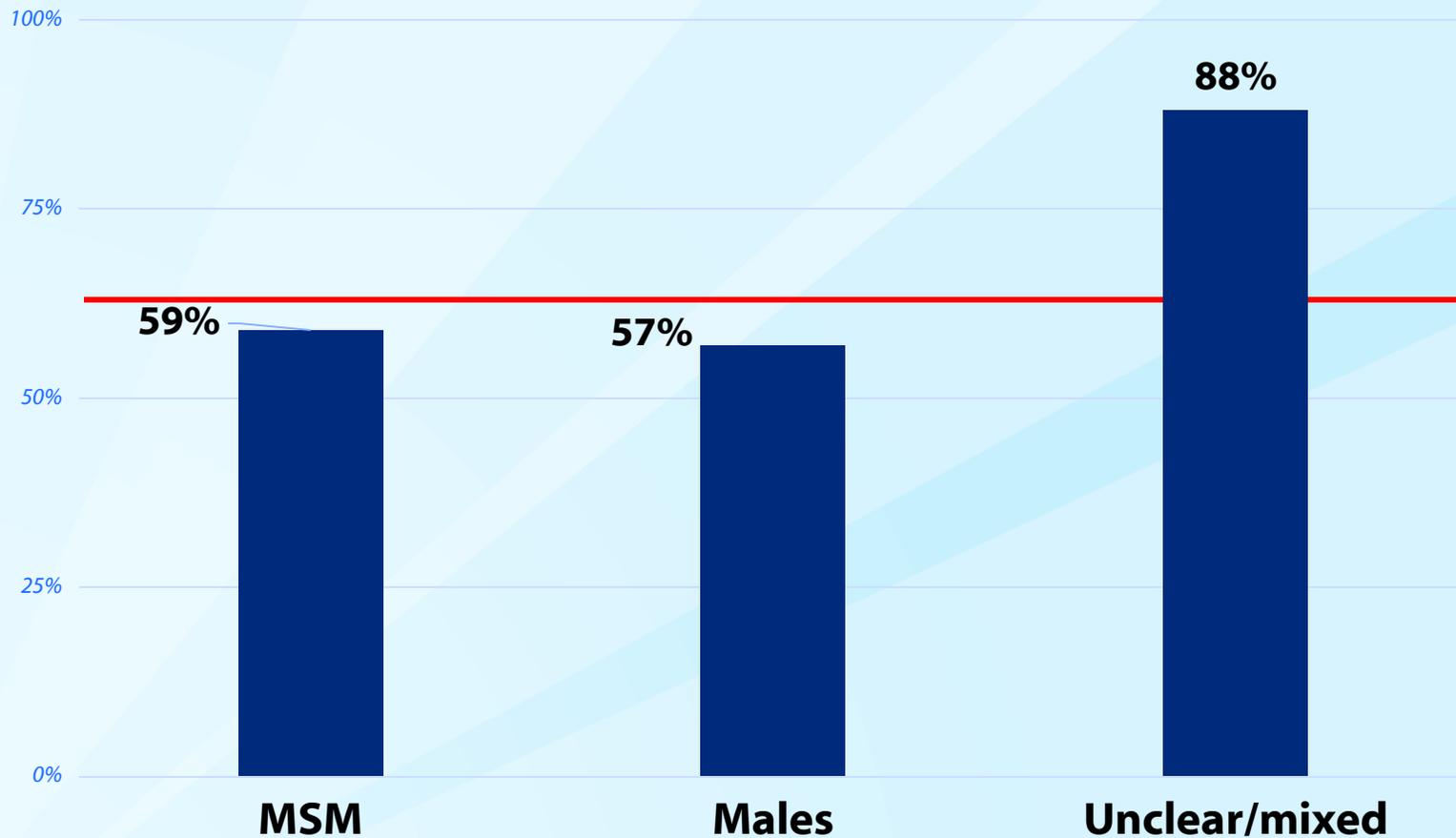
❑ Concerns about completeness/representativeness, e.g.:

- Reporting under Ryan White program being voluntary
- Syphilis testing not being reimbursed
- Limited number of providers providing data by deadline

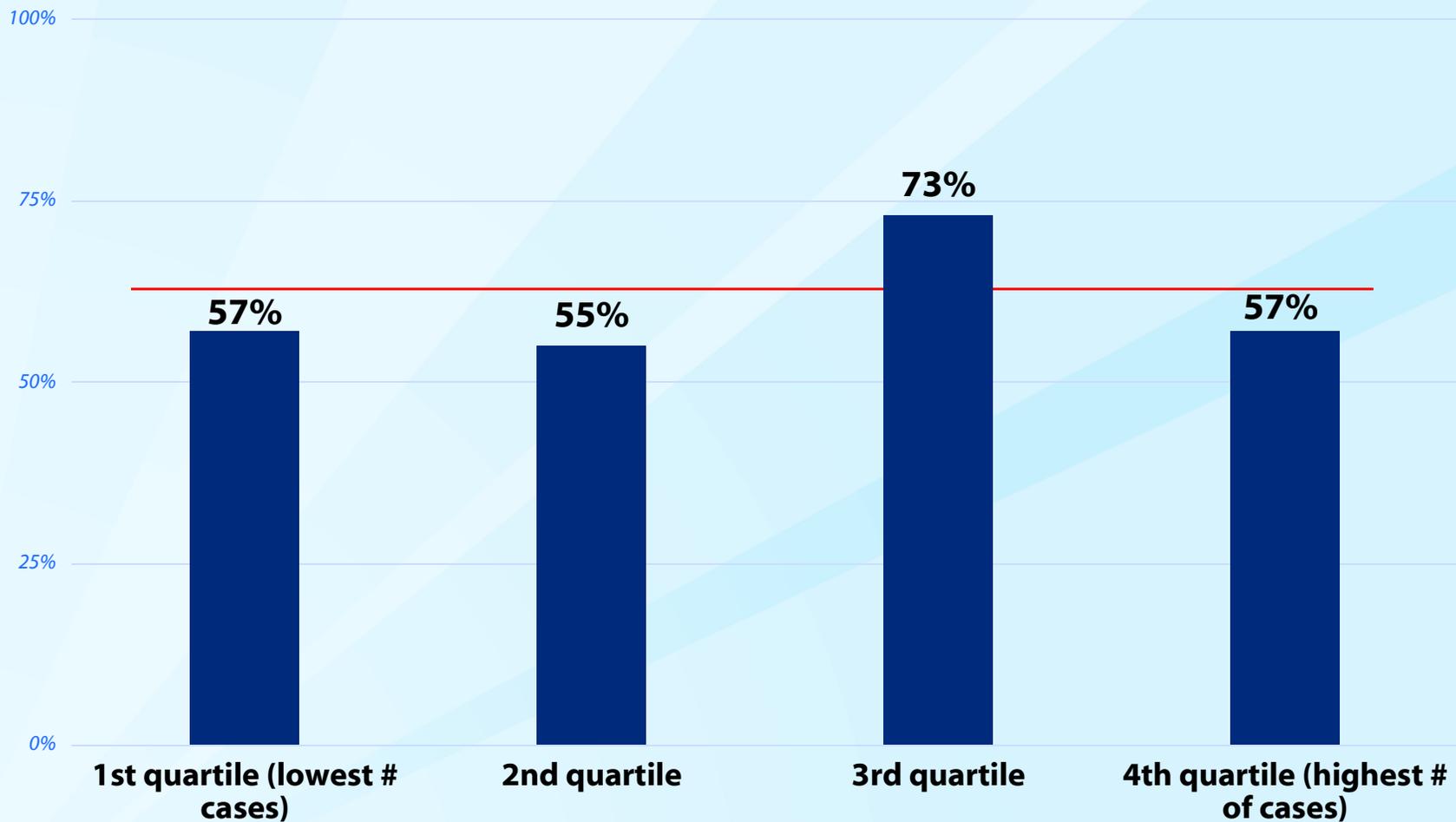
POM2 parameters: Overall

	Medians (range)
# of areas included	41
# of providers included	3 (Range 1-49)
# of clients/patients reported on	1135 (Range 35-17,699)
Denominator reported on	MSM, n=23 All males, n=16 Unclear or mix, n=2
Annual syphilis screening rate	60% (Range 1%-100%)

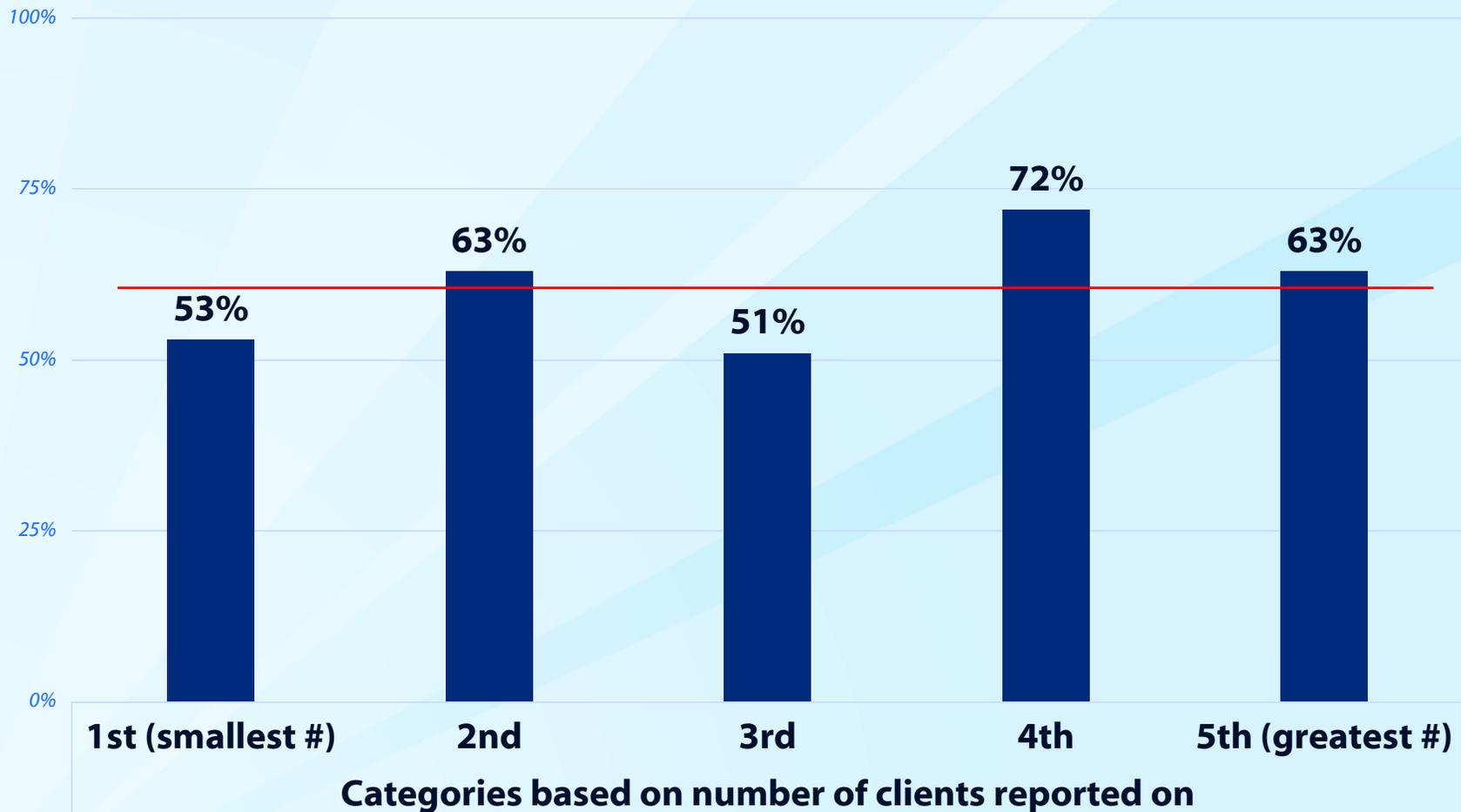
Median annual syphilis screening among MSM seen by HIV care providers, by type of denominator used



Median annual syphilis screening rate among MSM seen by HIV care providers, by number of early syphilis cases among males reported in 2014 in STDNet



Median annual syphilis screening among MSM seen by HIV care providers, by groups based on number of patients reported on



Syphilis screening among MSM in HIV care: Summary

- ❑ **Majority of areas reported data for POM 2**
 - Given barriers to obtaining data and time needed to forge this, we were impressed
- ❑ **Reported screening rates and scale ranged widely**
- ❑ **No evident patterns in screening rates reported, in exploratory analysis**
- ❑ **These findings:**
 - Not surprising, given variation in approaches taken to working on this issue and data limitations
 - Even so, most areas reported screening rates that showed significant room for growth, or at least good rationale for continued work on this issue with that sector

POM 2: Developmental

- ❑ **Many areas reported on positive syphilis tests, not new syphilis cases**
 - Great deal of work involved in matching syphilis case reports with select HIV care providers
- ❑ **Many areas seemed to report on a rather different population base than that used for POM 2**
 - Scale was very different in many cases: median difference between the two denominators was 329, range 2-9658
 - Of 39 areas reporting on POM2D, the denominator for POM 2D was greater than that for POM2 (as we would expect) in only 6 areas
- ❑ **POM2D – needs further clarification and consideration**

POM 5: GC TREATMENT VERIFICATION

GC treatment: What we asked for

- ❑ Total # of GC cases reported in 2014**
- ❑ % of those cases with any medication information**
- ❑ % of those with dual therapy documented**
 - Ceftriaxone + (Azithro or Doxy)
 - Recommended therapy as of 2012 STD TX guidelines

(*Recently changed in 2015 TX guidelines*)

GC treatment: Data submitted

- ❑ **56 of 59 awardees reported complete data on this POM**
- ❑ **1 awardee self-identified their data as of “very poor” quality**
 - = 55 areas’ data reported
- ❑ **The data source was the STD surveillance system (e.g., STD*MIS, MAVEN, PRISM)**
- ❑ **3 areas reported on a subset of their total GC cases**

GC treatment: Data concerns raised

- ❑ **Extent of missing data**
- ❑ **Information on dual therapy may have been lost during data entry or merger, due to constraints in the data system**
 - e.g. Only one medication name could be entered in to the field, even if the case report noted two
- ❑ **Data analysis procedures made identifying dual therapy difficult**
 - E.g., Information was spread across various data fields

POM5 parameters: Overall

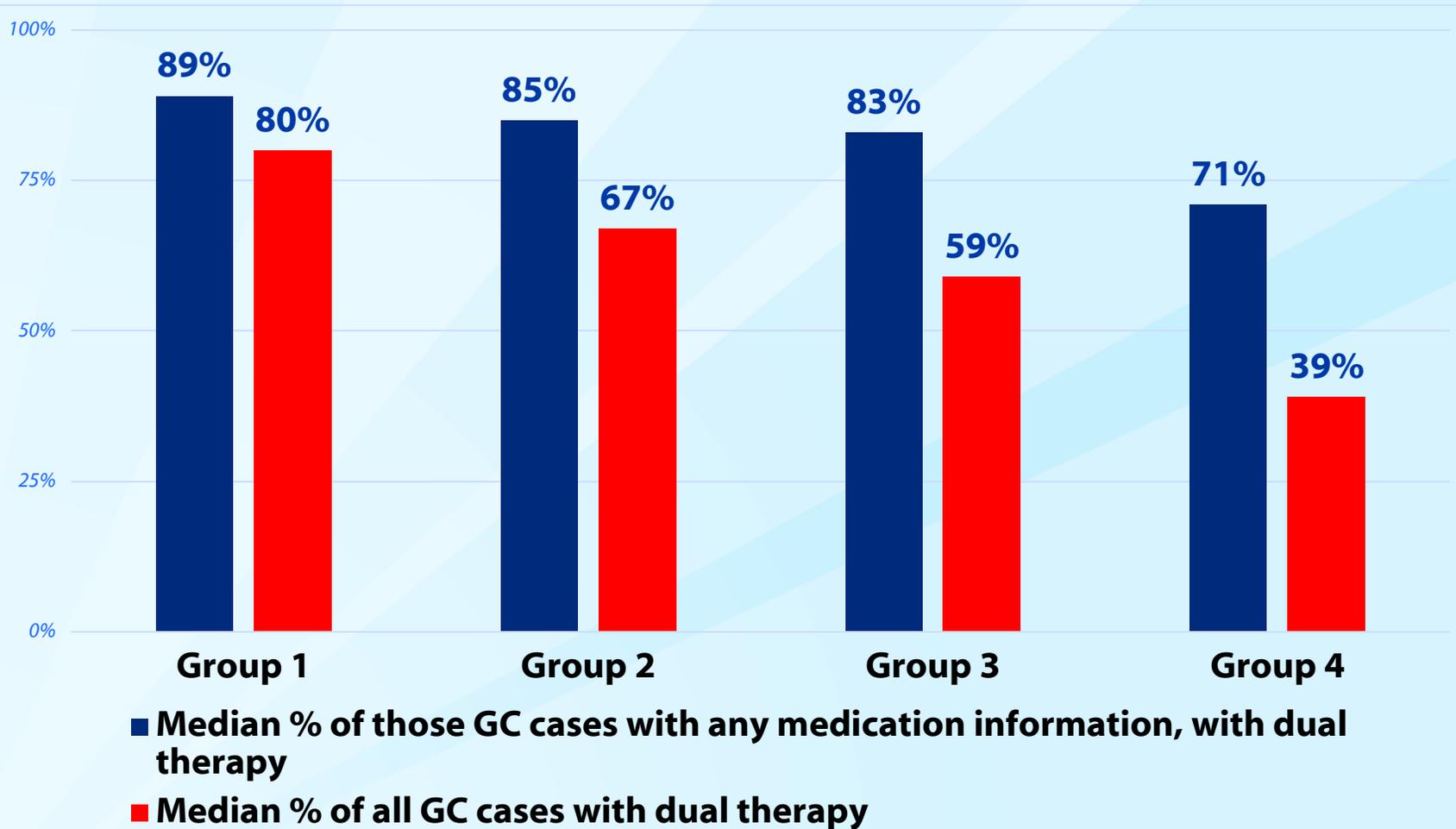
	Median (ranges)
# of areas included	55
# of GC cases reported	4167 (81 - 34,787)
% of cases with any medication information	84% (24% -100%)
% of GC cases with any medication information, with dual therapy	83% (36% - 100%)
POM5: % of all GC cases with dual therapy	60% (12% - 99%)

GC treatment: Morbidity groups

* Quartiles *

	Group 1: Lowest # of GC cases	Group 2: 2nd lowest # of GC cases	Group 3: 2nd highest # of cases	Group 4: Highest # of cases
# of areas	15	12	15	13
Those included	RI, SD, WV, ID, HI, WY, MT, VI, DE, NE, VT, PR, NH, ND, ME	CO, Baltimore, NV, DC, MD, UT, NM, IA, KS, San Francisco, OR, MN	AZ, OK, MS, WI, KY, PA, NJ, AR, Philadelphia, IN, IL, NY, TN, WA, MO	Chicago, GA, MI, VA, NYC, LA, OH, NC, AL, Los Angeles, FL, CA, TX
Median # of GC cases	434	2435	6236	14020

GC treatment outcomes, by morbidity group



GC treatment verification summary

- ❑ **Many awardees lacked medication information on a sizeable proportion of their reported GC cases**
- ❑ **Among GC cases with medication information, dual therapy documentation was generally high**
- ❑ **Awardees with higher numbers of reported GC cases had:**
 - Lower rates of cases with any medication information, &
 - Lower rates of dual therapy documented, among cases with medication information
- ❑ **However, we know that these data do not necessarily reflect provider practices, given various data reporting issues**
 - Shows limited ability of many health departments to be able to assure GC treatment
 - Must work a lot on reporting and systems if all project areas are going to be major players in monitoring and addressing this

**POM 6: PARTNER SERVICES FOR
FEMALES WITH EARLY SYPHILIS**

POM6: Female early syphilis cases with 1+ contact treated

□ POM 6 components:

- Total number of ES cases among females of reproductive age
- # of ES cases interviewed
- # of contacts initiated for partner services
- # of contacts examined (tested)
- # of contacts treated, by disposition: (Dispo E) (Dispo A) (Dispo C)
- The POM: % of cases among females of reproductive age with Early Syphilis (ES) with at least one partner treated for syphilis (disease intervention rate) within 30 days

POM6: Data submitted

- ❑ 53 Project Areas submitted complete data (numerator and denominator)**
- ❑ 4 reported no female syphilis**
- ❑ 1 reported poor data quality**
- ❑ 1 could not obtain POM6 (but provided all other data points)**

POM6 parameters: Overall

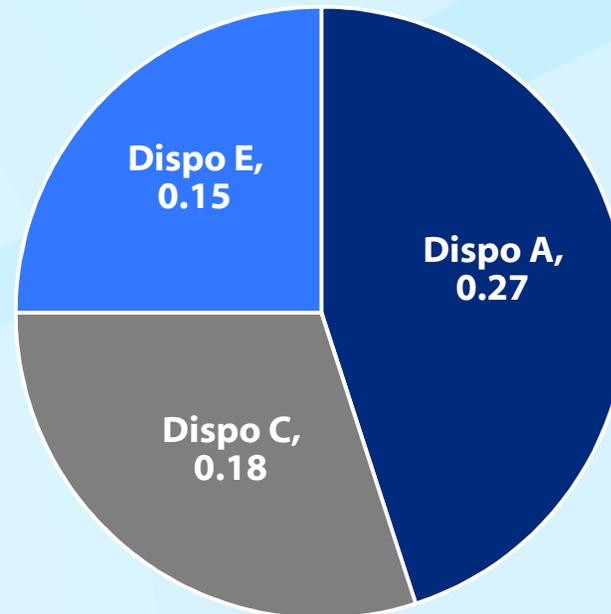
	Median (ranges)
# Areas included	54
# of ES cases among women	40 (1-596)
% cases interviewed	95.9% (69-100%)
# contacts initiated	63.5 (1-1525)
# contacts examined	35.5 (1-726)
Contact index	1.35 (0.63-5.31)
Exam rate	70% (33-100%)

*POM 6 and DI rate include data from 53 project areas

POM6 parameters: Overall, continued

	Median (ranges)
Treatment index – overall	0.6 (0.16-2.0)
Treatment index – Dispo A	0.27 (0.04-1.5); n=50
Treatment index – Dispo C	0.18 (0.02-1.0); n=49
Treatment index – Dispo E	0.15 (0.004-1.0); n=47

**Median Treatment Index by
Disposition Code**
(Median for total Treatment index= 0.6)



POM6 Summary Data

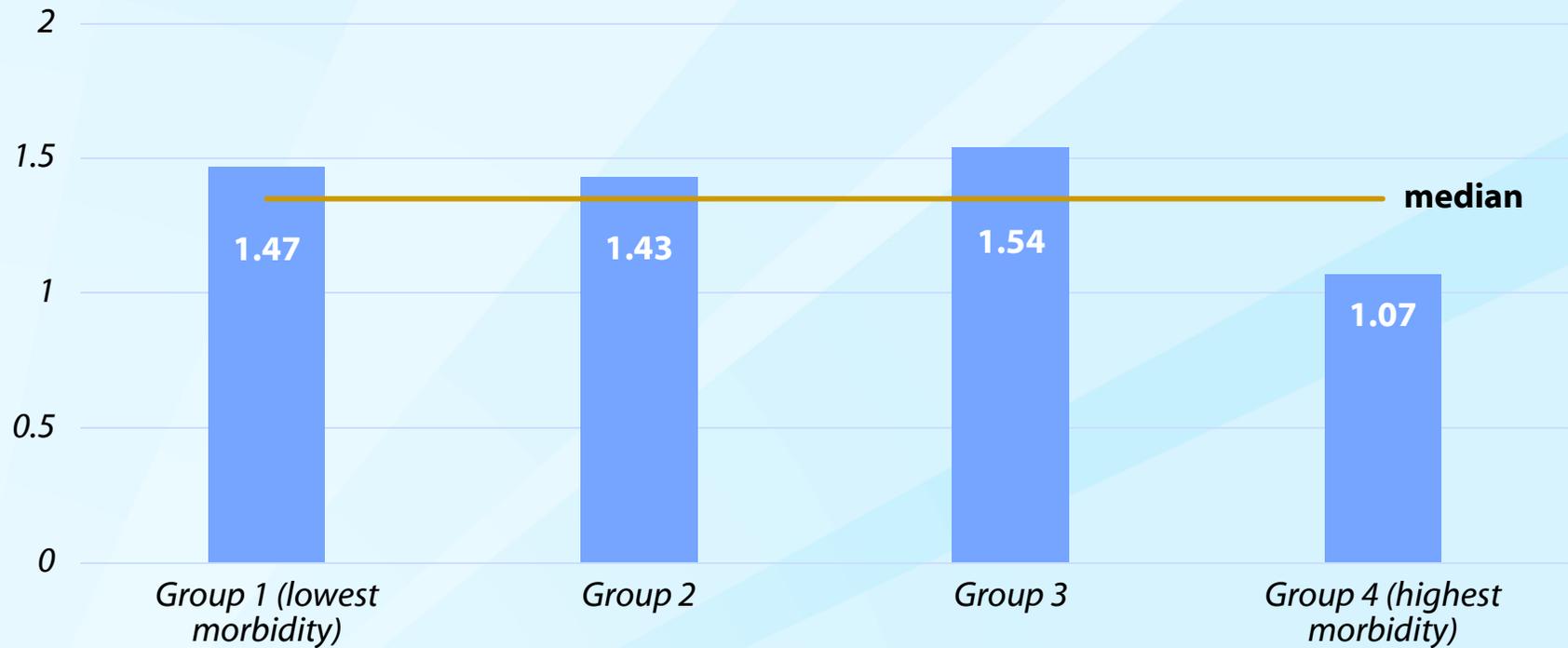
	Median (ranges)
Total # of cases w/ at least 1 partner treated*	20 (1-365)
POM 6: Disease intervention rate*	52% (13-100%)

Females with ES: Morbidity groups

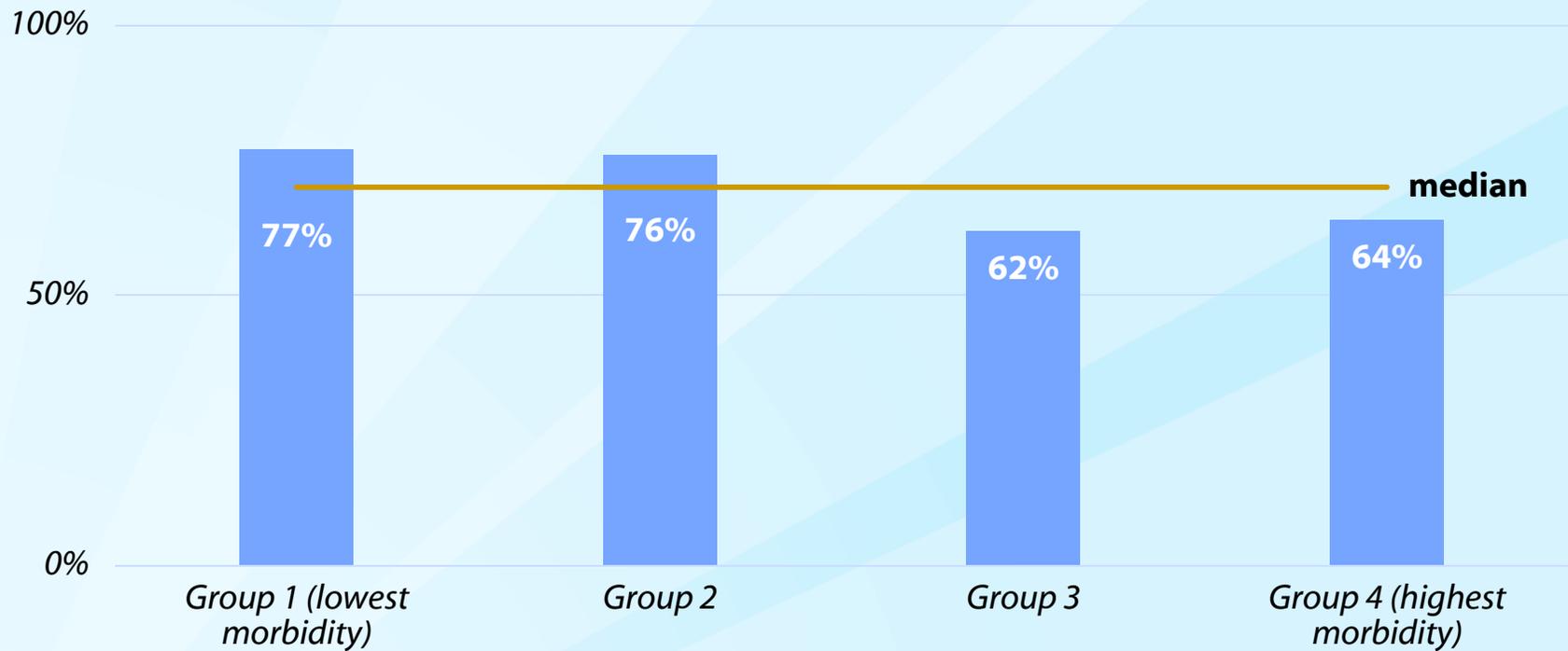
* Quartiles *

	Group 1: Lowest # of females with ES	Group 2: 2nd lowest # female with ES	Group 3: 2nd highest # of females with ES	Group 4: Highest # of females with ES
# of areas	14	14	13	13
Those included	AK, CO, DE, HI, ME, MT, ND, NE, NH, NJ, RI, San Francisco, UT, WI	AL, CT, DC, IA, IN, KS, MN, NM, NY, OR, SD, VA, WA, WV	AR, Baltimore, IL, KY, MA, MD, MI, MO, NV, OK, PA, Philadelphia, TN	AZ, CA, Chicago, FL, GA, LA, Los Angeles, NC, New York City, OH, PR, SC, TX
Median # of females of reproductive age with ES in 2014	7.5	30	56	129

Median Contact Index By morbidity groups



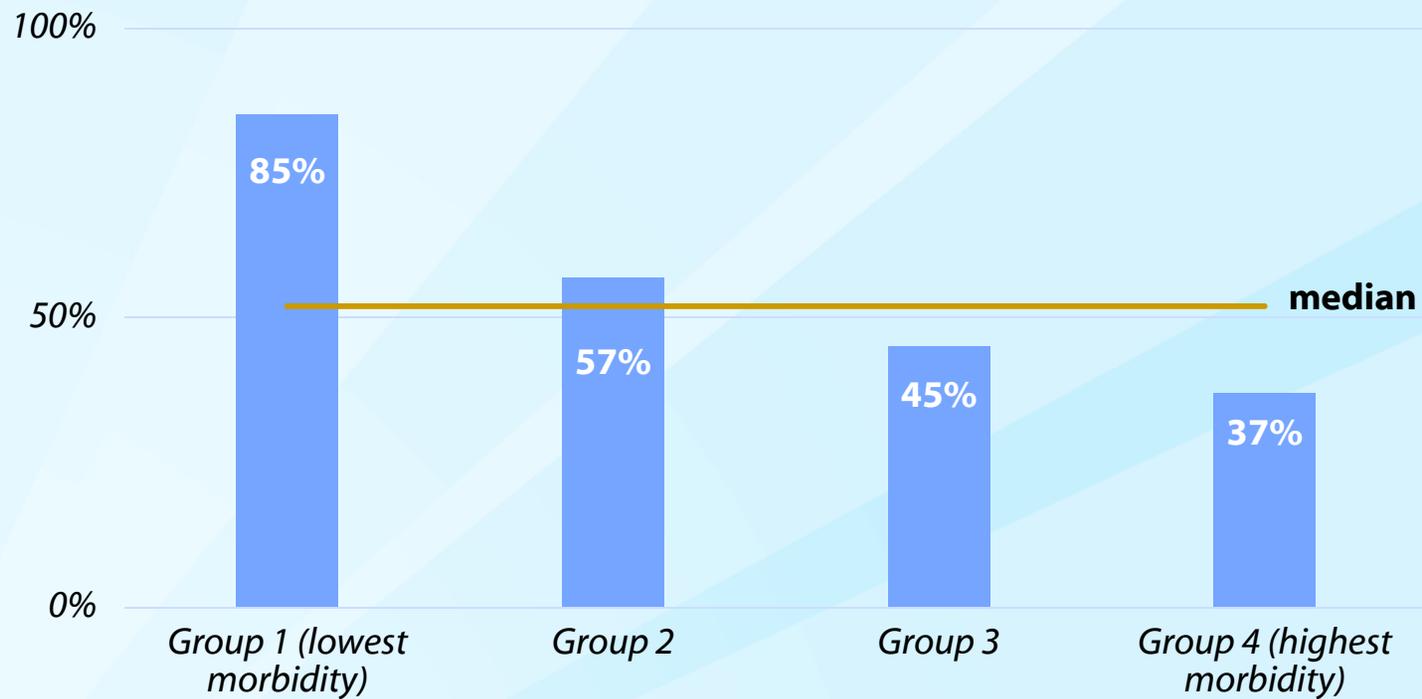
Median Exam Rate By morbidity groups



Median Treatment Index By morbidity groups



Median Disease Intervention Rate By morbidity groups



Disease intervention for women with early syphilis: Summary

- ❑ The vast majority of project areas were able to report all components of POM6 with high confidence in their data and relative ease
- ❑ Lower morbidity project areas generally were above the median, whereas higher morbidity areas generally were below the median, especially in disease intervention rates
- ❑ Except for the interview rate, there is significant room for growth and program enhancement across all measures of the partner services cascade

Questions or comments on Part I

PART II: UPDATE ON SHORT REPORTS

Coming soon: Short reports

- ❑ **Our own version of the “Rapid Feedback Report” many are familiar with**
 - Brand new format needs a lot of vetting inside and outside Division
- ❑ **Purpose is to allow project area staff see their areas’ data in comparative context to inform discussion about:**
 - Value of the POM
 - Program’s direction
- ❑ **Primary audience:**
 - Awardees
 - DSTDP staff that support them
- ❑ **Priority values: Simplicity, clarity, & timeliness**
- ❑ **Content: Like what was presented today with more detail**

Coming soon: Short reports

❑ **Two reports in the works now**

- GC treatment verification
- Partner services outcomes for females with ES

❑ **Reviewed to date by**

- Some NCSD POW members
- DSTDP health communications staff
- Program consultants & program evaluation staff

❑ **Goal: Both reports will be issued before the end of July to all awardees**

- Vetting will continue after that
- Format will continue to be improved over time, as we jointly figure out what's most useful

Key question: Should we put identifiers in the short reports?

Should DSTDP list project areas' names in the short reports that all project areas will receive?

For example, are you ok with our sharing tables or figures like this?

Imagine your project area listed clearly on here with all others



Project area	# of GC cases	POM 5: % of all GC cases with dual therapy
New Hampshire	234	87%
Iowa	1622	84%
New Mexico	2236	84%
San Francisco	3285	83%
ETC . . .		

**POLL #1 for awardee representatives
who are on the webinar:
Regarding DSTDP's general policy**

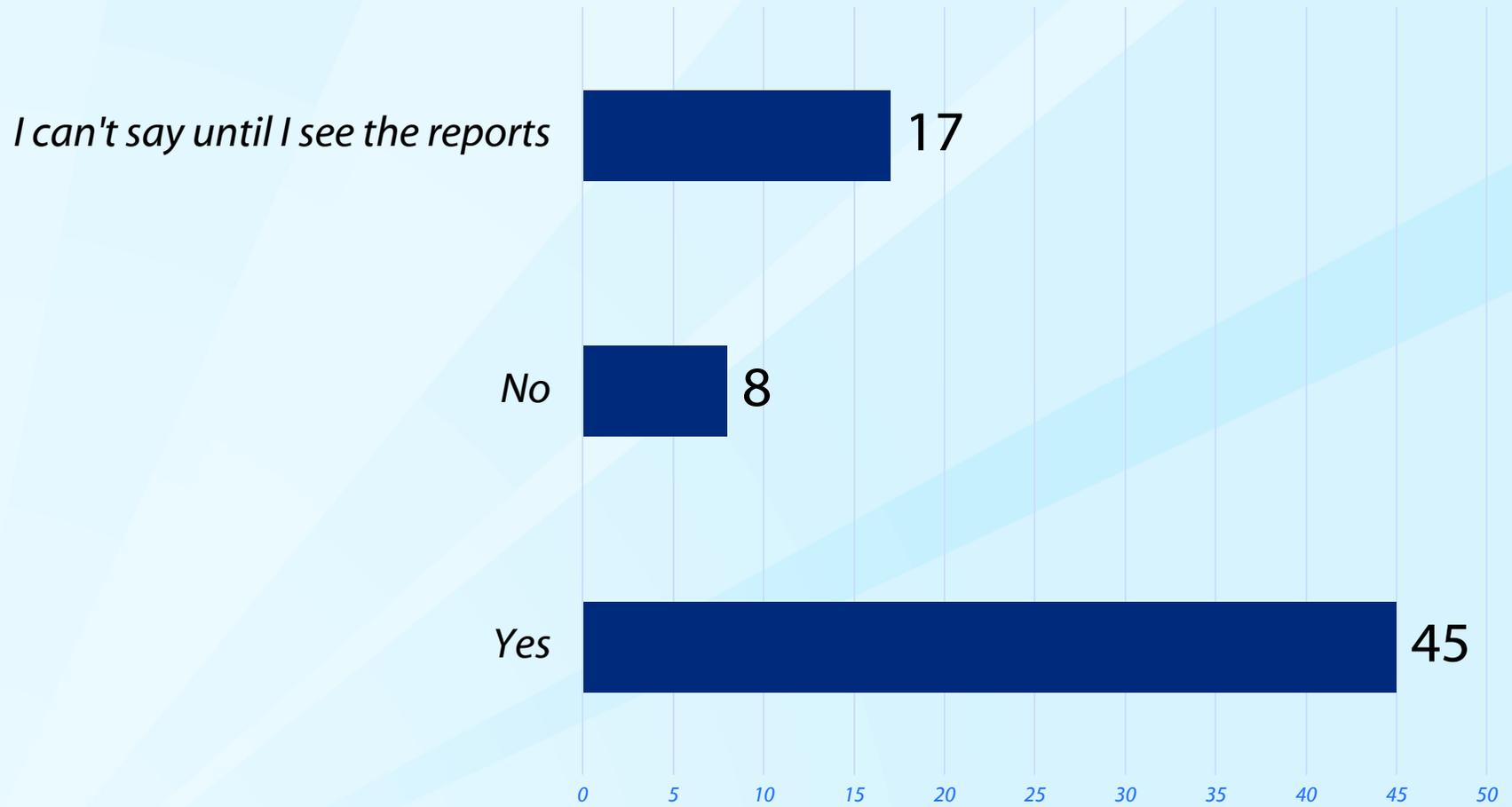
Poll question 1:

- As a general policy, should DSTDP list project areas' names (i.e., identifiers) in the short reports that all project areas receive?**

Response options:

- Yes**
- No**
- I can't say until I see the reports**

Poll 1 Results



**POLL #2 for awardee representatives
who are on the webinar:
Regarding the first set of short reports**

Poll question 2:

- Are you comfortable with DSTDP issuing this first set of short reports with identifiers?**

Response options:

- Yes**
- No**

Poll 2 Results

No

10

Yes

55

0

10

20

30

40

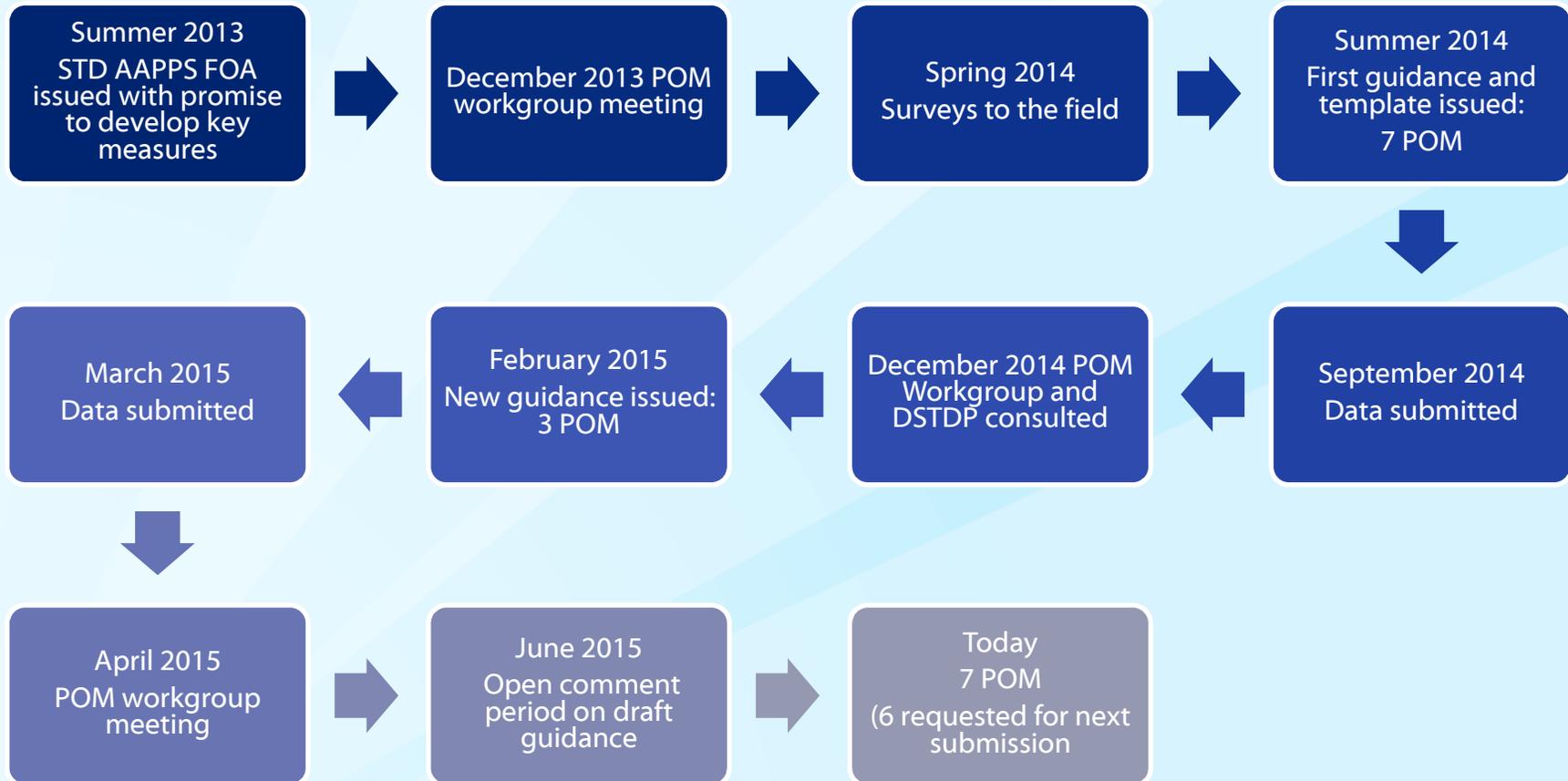
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60

Questions or comments on Part II

PART III: GUIDANCE FOR NEXT POM SUBMISSION

Review of the POM development pathway



POM: What you're familiar with already (March 2015)

Assessment and Policy

Assurance: Screening and treatment

- Syphilis screening among MSM in HIV care
- GC treatment

Assurance: Partner services and linkage to care

- Disease intervention among females

Assurance: Health promotion and prevention education

POM: Main additions

Assessment and Policy

- No POM
- APR standardized reporting forms

Assurance: Screening and treatment

- Syphilis screening among MSM in HIV care
- GC treatment
- CT screening among young women

Assurance: Partner services and linkage to care

- Disease intervention among females and males with female contacts
- HIV testing, new dx, and linkage to HIV care among initiated cases

Assurance: Health promotion and prevention education

- No POM

Why these main additions?

- ❑ **CT screening among young women**
 - A high priority across project areas and at CDC
 - An area of substantial effort and change (beyond IPP)
- ❑ **Disease intervention among males with early syphilis and female contacts**
 - Help round out picture related to congenital syphilis
 - Data fairly accessible
- ❑ **HIV testing, new dx, and linkage to HIV care among initiated GC and syphilis cases**
 - A high priority across project areas and at CDC
 - Helps shed light on some STD program contributions towards HIV outcomes

CT screening among young women: Key points

- ❑ **Measure reported should be on par with the effort you are making to increase CT screening**
 - Statewide effort? Report a state-wide CT screening rate.
 - 3 FQHC effort? Report for those 3 FQHC.
 - 1 health plan effort? Report for that 1 health plan.
- ❑ **We understand that as a result, the data will not be comparable across areas**
 - Less valuable to report back out in comparative short reports
 - But perhaps more valuable to tracking and understanding what each of you is doing in this regard

CT screening among young women: Key points

- ❑ **Focus on annual screening rate**
 - Not asking for positivity, treatment, or other aspects of CT prevention and control continuum
- ❑ **Asking for annual 2014 rate, if you have it**
 - If you don't, focus on working on getting relevant 2015 data
- ❑ **Denominator can be either:**
 - 1) sexually active young women seen by those providers/orgs or
 - 2) all young women seen by those providers/orgs
 - (Like we did for syphilis screening among MSM in HIV care)
- ❑ **Contextual information**
 - How much of your jurisdiction's CT burden comes from the area those providers/orgs serve

HIV testing, new dx, and linkage to care among initiated cases: Key points

- ❑ **HIV testing within 30 days and new HIV dx that result are requested now, for Jan-June 2015 time period**
 - Linkage to care for those newly –diagnosed cases will not be requested now
- ❑ **Focus on cases**
 - Not their partners or contacts
- ❑ **Focus on your initiated syphilis and GC cases**
 - Initiate = assigned to DIS for interview
 - Should include various stages of syphilis but mostly early
 - If you didn't initiate any GC cases, only report on syphilis cases
 - If you didn't initiate many syphilis cases, then you might report on mostly GC cases

HIV testing, new dx, and linkage to care among initiated cases: Key points

- ❑ **We want data from your STD program database**
 - Documentation of HIV status, testing, test result, and linkage to care, as evident in your field services database -- whatever the original source.
 - Hopefully measures will be more accessible and more useful to you all as STD programs running field services
- ❑ **We will ask for information on missing data**
 - Need a sense of how well your field services databases are tracking these outcomes

Disease intervention among males with early syphilis with female contacts: Key points

- ❑ **Mirror image of what was requested in March for females of reproductive age with early syphilis**
 - New exam rate, contact index, disease intervention rate ...
- ❑ **Focus on males who had 1+ female contacts**
 - Males with only female contacts & males with female and male contacts
 - Not asking for data on males who report only male contacts
 - Reporting will focus on the female contacts only, however

Other changes and additions

- ❑ **Additional context field for GC treatment**
 - Gonorrhea cases with only Ceftriaxone documented as treatment
 - Allows more of the “probable” top recommended treatment to come through in your data
- ❑ **Not asking for information on annual syphilis screening among MSM in HIV care (already submitted 2014 data)**
- ❑ **Space of report your 2016 work plan objectives**
 - Pasting in your proposed 2016 work plan objective that is relevant to each POM
 - Helps trace the link between your work plan and the POM

Other changes and additions

❑ **Space to interpret your POM**

- Rating of how acceptable each reported POM outcome is to you, and a brief explanation of that rating
- You report POM X as at 65% -- do you see that as Great? Troubling? Fine? Why?

❑ **Workbook has the same look/feel but streamlined**

- Fewer open text fields
- Reformatted to be easier to navigate and print

What next? Short-term

We will issue the final POM guidance and Excel template within 2 weeks of today

- ❑ Please review guidance document**
- ❑ Do not rely only on the Excel workbook**

Please send questions and queries to Dayne Collins

- ❑ We will post FAQ's to everyone if needed**

Big news: Postponing the POM deadline

POM are not longer due by August 27

- ❑ Awardees need more time**
- ❑ Revised guidance saying this from PGO is coming out shortly**
- ❑ New due date will likely be mid-October**

Deadline for a new 2016 Targeted Evaluation Plan (TEP) also will be moved to this date

- ❑ Progress report on current TEP should still be submitted by August 27, however**

What next? Medium-term

- ❑ **No additional POM development is planned**
 - Work with what we have on the table
 - Refine, clarify, improve as needed
 - Stabilize them
- ❑ **See if we can disseminate these well**
- ❑ **See if we can use these well**
- ❑ **Start moving from Excel to a web-based data platform**
 - For improved data submission, data visualization, and use

Questions or comments on Part III

POM Workgroup members (past and present)

- Beth Butler, PA
- Jennifer Vandavelde, KS
- Jeff Stover, VA
- Jeff Hitt, LA
- Brad Beasley, TN
- Erin Fratto, UT
- Robin Hennessy, NYC
- Heidi Bauer, CA
- Andrea Radford, IL
- Daniel Daltry, VT
- Charlie Rabins, NCSD

Thank you!

Thank you also to

- Various project area staff who responded to the POM open comment period (MN, IL, CA, NC, NYC, IA, DE)
- Our DSTDP colleagues: Marta Bornstein, Brandy Maddox, Shaunta Wright, and Darlene Davis

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

