NNPTC National Evaluation

Grant Year 2 and First Half of Grant Year 3

April 1, 2015 – September 30, 2016

Agenda

- Highlights of Grant Year 2 and first half of Grant Year 3 data
  - Registration
  - Evaluation
- Successes
- Challenges
- Key questions from findings

Overview

- Registration system launched April 1, 2015 using HPAT + Reach questions
- Evaluation system launched in mid-July, 2015
  - Standard questions reflecting common learning objectives
  - Focus on 2015 STD Treatment Guidelines
  - Approximately 15 different evaluation instruments based on content available

HPAT Registration Data

Grant Year 2

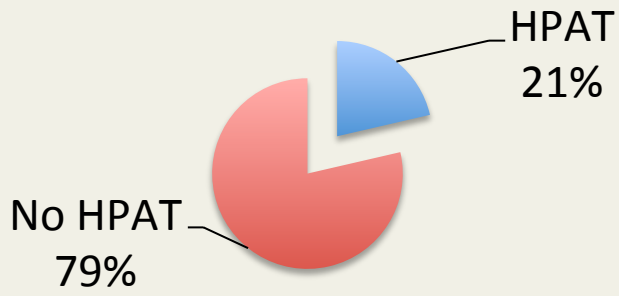
- In GY 2: Approximately 25,270 participants in 260 classes and 249 training events
- PTCs collected registration data on 5,405 participants (**21.4**%)

Grant Year 3 (6 months)

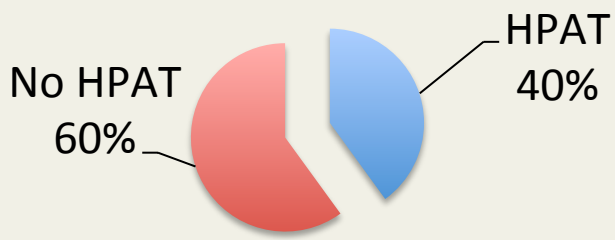
- In GY 3: Approximately 9,037 participants in 139 classes and 93 training events
- PTCs collected registration data on 3,618 participants (**40.0**%)

Participants with Registration Data

GY 2 Proportion of Participants with Registration Data



GY 3 Proportion of Participants with Registration Data



The proportion of participants for whom HPAT data is being collected has increased in GY 3. **Whoohoo!!**

But … there is still a gap for collecting data from clinic-based trainings and for short didactic trainings.

Evaluations by Course Type

Grant Year 2

- Class types (class codes) with evaluations attached ranged from 100% - 50%
- 804 and 805 non-webinar short didactic courses were the least evaluated

Grant Year 3 (6 months)

- Class types with evaluations attached ranged from 100% to 0%
- 805 non-webinar short didactic, 813 short didactic for clinic, and 814 webinar conference presentations were the least evaluated

We are still not evaluating some courses and TEs where we probably should.

Registrant 'Audiences'

- HPAT data coded to identify audiences based on FOA considerations
  1. Primary care clinicians, non-expert
  2. 2. Expert STD clinicians
  3. Administrators in settings likely to provide STD care
  4. Non-clinicians who see STD patients/clients
- All in audiences 1-4 work in high morbidity counties and serve at least 1 of 4 key groups at risk for STDs
- Those not falling in audiences 1 – 4 are 'other'

Trainee Audiences

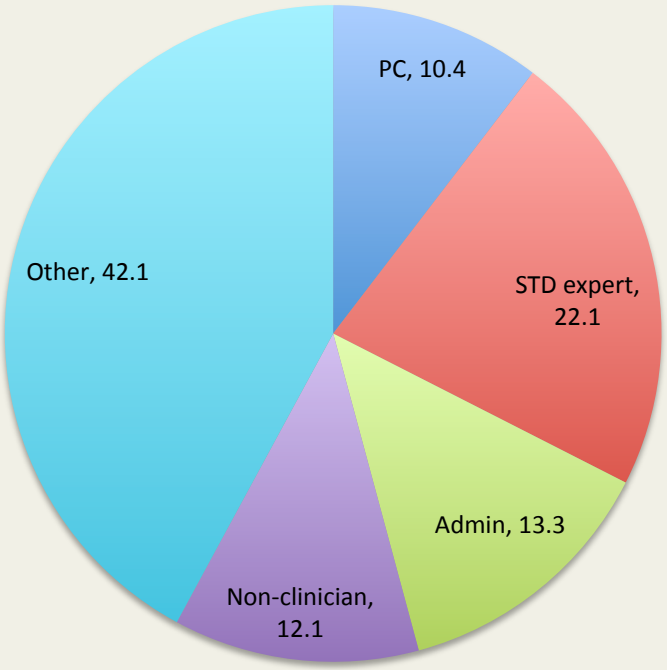
Audiences by Grant Year		
	Grant Year 2	Grant Year 3 (half)
1-Primary Care	563 (10.4%)	327 (9.0%)
2-STD Expert	1,192 (22.1%)	920 (25.4%)
3-Administrators in likely settings	719 (13.3%)	554 (15.3%)
4-Non-clinicians serving STD pops	655 (12.1%)	603 (16.7%)
Others	2,276 (42.1%)	1,214 (33.6%)
Total HPAT	5,405 (100%)	3,618 (100%)

Primary care providers are ~10% of trainees who complete HPATs; percentage of "others" has decreased. Whoohoo!!

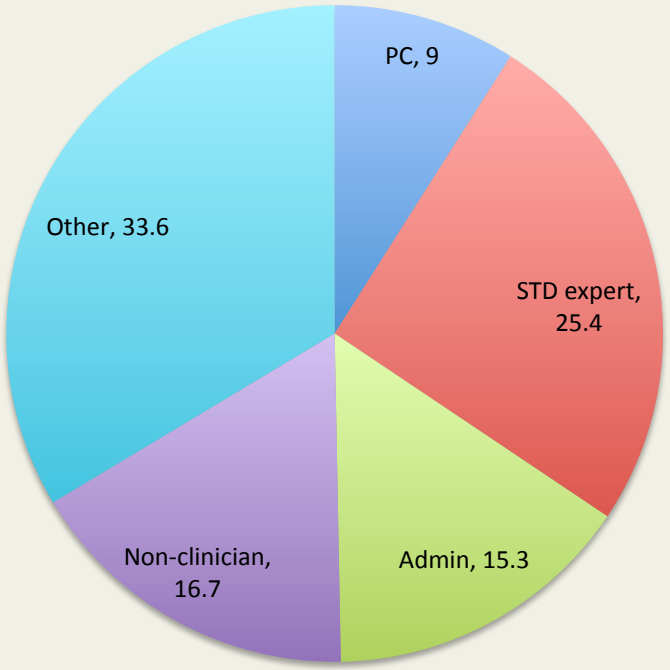
Can we improve on reach to audiences 1 and 2?

Trainee Audiences

Grant Year 2



Grant Year 3 (6 months)



Fewer than 35% of trainees fall into the top 2 audiences.

Professional Roles of Registrants

Grant Year 2

- 47.8% clinicians (including interns/residents/ fellows)
- 17.9% administrators
- 18.4% other providers such as case managers, mental health providers, etc.
- 8.0% health professional students
- 75.7% of all trainees work in high morbidity counties

GY 3 (6 months)

- 46.4% clinicians (including interns/residents/fellows)
- 20.2% administrators
- 21.3% other providers such as case managers, mental health providers, etc.
- 4.8% health professional students
- 74.4% of all trainees work in a high morbidity area

Percentages of registrant professional roles and work locations are similar in both grant years.

Why ‘others’ not in Audiences 1-4

Grant Year 2

- Others = 2,276 (42.1%) did not fall within audiences 1-4 for one or more of the following reasons
  - 57.7% do not work in a high morbidity area
  - 46.1% do not serve one of four priority risk populations
  - 18.3% do not provide direct service to patients/clients

Grant Year 3 (6 months)

- Others = 1,214 (33.6%) did not fall within audiences 1-4 for one or more of the following reasons
  - 76.1% do not work in a high morbidity area
  - 23.0% do not serve one of four priority risk populations
  - 13.8% do not provide direct service to patients/clients

Should NNPTC *not* train in non-high morbidity areas? Not train non-clinicians who do not provide direct service? Should NNPTC better target participants?

Response Rates

- Response rates are in line with literature
- % of courses evaluated increased in GY 3

Courses and Response Rates – Total NNPTC						
# (%) Classes Evaluated	Post Course Response Rate			90 Day Response Rate		
	Evaluations Submitted	Evaluations Sent	%	Evaluations Submitted	Evaluations Sent	%
Grant Year 2						
163/194 (84%)	1,579	2,693	**59%**	661	2,229	**30%**
Grant Year 3						
126/139 (91%)	1,859	3,279	**57%**	556	1,982	**28%**

Satisfaction

Satisfaction

- Mean satisfaction overall and by audience

Mean Satisfaction					
Grant Year 2					
Satisfaction with …	Total	Aud 1	Aud 2	Aud 3	Aud 4
Overall learning	4.39	4.48	4.32	4.31	4.41
Quality of content	4.41	4.47	4.34	4.34	4.40
Trainers	4.41	4.43	4.36	4.36	4.39
Teaching methods	4.33	4.37	4.25	4.25	4.34
Grant Year 3 (6 months)					
Satisfaction with …	Total	Aud 1	Aud 2	Aud 3	Aud 4
Overall learning	4.43	4.49	4.45	4.39	4.41
Quality of content	4.46	4.54	4.49	4.42	4.41
Trainers	4.48	4.52	4.52	4.44	4.44
Teaching methods	4.40	4.46	4.42	4.34	4.37

Intent to Change/Actual Change

Grant Year 2

- Intent to change = **66.6**% immediately post
- Actual change = **59.3**%

  90 days post

Grant Year 3 (6 months)

- Intent to change = **47.2**% immediately post
- Actual change = **52.0**%

  90 days post

As might be expected, self-reported actual change was stronger in more intensive courses than in less intensive courses (71.8%/58.9%, $p<.001$) in Grant Year 2. **Should there be a focus on more intensive courses?**

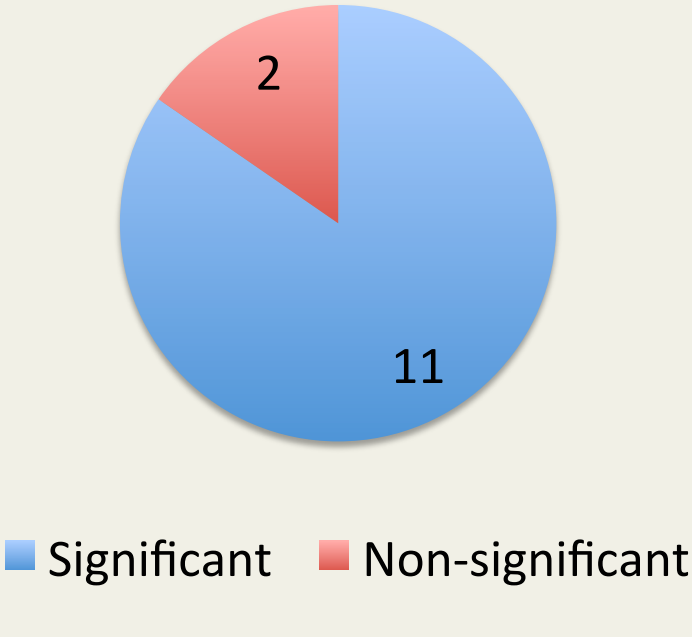
Use of Guidelines

Use of CDC Guidelines Occasionally or Consistently Before and 90 Days After Training			
	All Trainees	Aud 1	Aud 2
Grant Year 2			
Before training	74.2%	54.5%	91.8%
90 days after training	78.0%	73.1%	87.0%
Grant Year 3			
Before training	76.6%	58.7%	90.5%
90 days after training	87.1%	79.6%	94.5%

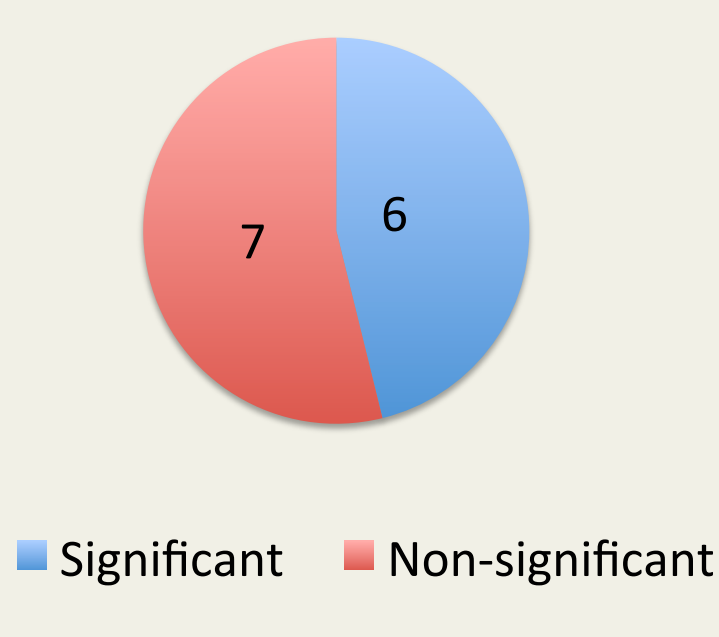
The percentage of trainees using the CDC Guidelines increased 90 days after training except in audience 2 in Grant Year 2.

Practice Patterns

Grant Year 2



Grant Year 3 (6 months)



All non-significant changes were already at highest measurement level except 1.

Knowlege

Percentage of Correct Answers – Total and Audience 1 and 2						
	Grant Year 2			Grant Year 3 (6 months)		
	All Trained	Aud 1	Aud 2	All Trained	Aud 1	Aud 2
Immediate post course						
Treatment of uncomplicated gonorrhea	83.9	86.2	96.2	88.1	93.2	94.8
3 month retest after diagnosis of CT, GC, trichomonas	64.6	47.1	75.8	64.2	68.3	64.4
STD screening test for HIV-negative MSM	64.8	66.2	73.2	54.0	63.4	55.6
3 month retest after diagnosis of gonorrhea	61.3	77.7	71.9	76.9	70.0	81.7
Treatment primary and secondary syphilis, adult not HIV+ or pregnant	90.3	87.7	94.7	91.0	83.3	96.7
90 days post course						
Treatment gonorrhea	86.1	89.1	97.7	92.5	88.2	96.8
3 month retest after diagnosis of CT, GC, trichomonas	70.1	52.2	82.6	78.0	52.9	84.9
STD screening for MSM oral and receptive anal multiple partners	62.5	50.0	72.0	71.5	58.8	76.3

% wrong answers below 85% in red. Opportunities for improving tested knowledge.

Successes

- Development and implementation of national registration and evaluation systems
- Response rates for post- and follow-up evaluations in line with literature
- Satisfaction is good
- Training influences self-reported practice intention *and* reported actual change rates
- Reported use of Guidelines usually increases after training

Challenges

- Adoption and use of systems vary by PTC
- Turnover in PTC staff requires ongoing training for use of registration and evaluation systems
- Adding questions to accommodate CE process (addressing in GY 3)
- Knowledge of follow-up after treatment of STDs and screening for MSM are lower than desired even among some who say they use the Guidelines consistently

Questions

1. Should there be **process requirements for use of the registration and/or evaluation system**, e.g., types of courses or minimum number of courses by type?
2. Should there be **process requirements for types/ intensity of courses to be delivered**? We see more change with more intense courses, but fewer numbers of trainees. Do we want depth or breadth?
3. **Who should be trained**? Should primary care (audience 1) be primary training target?
    1. Instead, perhaps, consider how to target audiences 1-4 and reduce 'others'?
    2. What about people in states with low morbidity ('others')?
4. How should the PTCs **address low knowledge** for changes in Guidelines?