

Report on a QI Project Eligible for Part IV MOC

Improving Chlamydia Screening Rates for Women Ages 18-24 in General Medicine Population Through Use of Point of Care Decision Support

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [ocpd.med.umich.edu], click on “Part IV Credit Designation,” and review sections 1 and 2. Complete and submit a “QI Project Preliminary Worksheet for Part IV Eligibility.” Staff from the UMHS Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

Completing the report. The report documents completion of each phase of the QI project. Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font and answers should be in regular font (generally immediately below the questions). To check boxes electronically, either put an “X” in front of a box or copy and paste “ ” over the blank box.

For further information and to submit completed applications, contact either:

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Report Outline

Section	Items
A. Introduction	1-6. Current date, title, time frame, project leader, specialties/subspecialties involved, funding
B. Plan	7-10. General goal, patient population, IOM quality dimensions addressed, experimental design 11-12. Baseline measures of performance, specific performance objectives 13. Data review and identifying underlying (root) causes
C. Do	14-16. Intervention(s), who is involved, initiated when
D. Check	17-18. Post-intervention performance measurement, data collection, performance level
E. Adjust – Replan	19. Review, continuing/new underlying causes,
F. Redo	20. Second intervention
G. Recheck	21-22. Post-adjustment performance measurement, data collection, performance level
H. Readjust plan	23. Review, continuing/new underlying causes to address
I. Future plans	24-26. Subsequent PDCA cycles, standardize processes, “spread” to other areas
J. Physician involvement	27-30. Physician’s role, requirements, reports, reflections, participation, number
K. Project Organization	31-33. Part of larger initiative, organizational structure, resources, oversight, Part IV opportunity

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date:** 6/17/15

2. **Title of QI project:** Improving Chlamydia Screening Rates for Women Ages 16-24 in General Medicine Through Use of Point of Care Decision Support

3. **Time frame**

- a. **Date physicians begin participating (may be in design phase):** 5/21/14
- b. **End date:** 5/31/15

4. **Key individuals**

- a. **QI project leader** *[also responsible for attesting to the participation of physicians in the project]*

Name: Susan Blitz MD

Title: Clinical Assistant Professor

Organizational unit: UMHS Division of General Medicine

Phone number: 615 8084

Email address: sblitz@umich.edu

Mailing address: NCRC

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Building 16, Room 430W
Ann Arbor, MI 48109-2800

- b. **Clinical leader to whom the project leader reports regarding the project** *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*

Name: Laurence McMahon MD

Title: Division Chief

Organizational unit: UMHS Division of General Medicine

Phone number: 936-5216

Email address: lmcmahon@umich.edu

Mailing address: NCRC

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5. **Approximately how many physicians were involved in this project categorized by specialty and/or subspecialty?** 30 General Internists and 1 APP (See attachment E)

6. **Will the funding and resources for the project come only from internal UMHS sources?**

Yes, only internal UMHS sources

No, funding and/or resources will come in part from sources outside UMHS,
which are: _____

The Multi-Specialty Part IV MOC Program requires that projects engage in change efforts over time, including at least three cycles of data collection with feedback to physicians and review of project results. Some projects may have only three cycles while others, particularly those involving rapid cycle improvement, may have several more cycles. The items below are intended to provide some flexibility in describing project methods. If the items do not allow you to reasonably describe the methods of your specific project, please contact the UMHS Part IV MOC Program office.

B. Plan

7. General goal**a. Problem/need. What is the “gap” in quality that resulted in the development of this project? Why is this project being undertaken?**

Undiagnosed, unrecognized, and untreated chlamydia leads to significant morbidity among women, including infertility and higher risk for ectopic pregnancy. Current UMHS performance for annualized Chlamydia Screening, based on HEDIS definition of appropriate patients¹ was 29% as of May, 2014. This is well below HEDIS 75th percentile performance and below the 90thtile goal for UMHS of 59% of patients screened. Given UMHS' low performance, improving rates of chlamydia screening was identified as a priority for our patients' safety.

¹The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

b. Project goal. What outcome regarding the problem should result from this project?

Improved rates of annual Chlamydia screening for all women aged 18-24

8. Patient population. What patient population does this project address?

All women aged 18-24 seen for at least one clinical appointment in the Division of General Medicine during the study period. Note: General Medicine does not typically provide medical care for women under age 18.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Safety | <input type="checkbox"/> Equity | <input checked="" type="checkbox"/> Timeliness |
| <input checked="" type="checkbox"/> Effectiveness | <input checked="" type="checkbox"/> Efficiency | <input type="checkbox"/> Patient-Centeredness |

10. What is the experimental design for the project?

- Pre-post comparisons (baseline period plus two or more follow-up measurement periods)
 Pre-post comparisons with control group
 Other: _____

11. Baseline measures of performance:**a. What measures of quality are used? If rate or %, what are the denominator and numerator?**

Screening Rate: Rate of Chlamydia Screening in women ages 18-24 seen for a clinic visit.

Denominator: Women seen, ages 18-24 for a clinic visit as above.

Numerator: Number of these women, with a chlamydia test completed within the past 365 days.

Response to Point of Care Decision Support (Best Practice Alert, or BPA): Rate of responding to BPA that is triggered during a clinic visit

Denominator: Clinic visits where the BPA fired (women aged 18-24 years old, no Chlamydia screen within the past 365 days)

Numerator: Number of BPAs that are addressed (Chlamydia test obtained + assessment overridden (patient not sexually active, testing done elsewhere, or declined testing))

b. Are the measures nationally endorsed? If not, why were they chosen?

For this project we developed a measure of screening that is based on, but broader than the national HEDIS criteria of annual screening for all sexually active women aged 16-24. For the HEDIS measure, “sexually active” is defined as women with a birth control prescription, a urine pregnancy test without a radiologic study within 7 days, or prior sexually transmitted infection testing. Because young women are not always comfortable disclosing sexual activity, this definition will likely miss some women who are at risk of exposure to Chlamydia. Importantly, many young women are on birth control medications without being sexually active. Thus we felt that adhering to this definition would not accurately identify young women at risk. Therefore, our broader measure applies universal screening unless the patient was documented as not sexually active within the

past 6 months. This broader definition makes testing easier to accomplish in the context of providing confidential care.

The measure of response to a point of care decision support was developed locally, based on a best practice alert (BPA) available in our electronic medical record.

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?

Electronic medical records

d. What methods were used to collect the data (e.g., abstraction, data analyst)?

Data abstraction through automated reporting developed by programmers specifically for this project.

e. How reliable are the data being collected for the purpose of this project?

Very reliable

f. How are data to be analyzed over time, e.g., simple comparison of means, statistical test(s)?

Simple comparison of performance rates

g. For what time period was the sample collected for baseline data?

Baseline data was collected from 9/1/14-9/30/14

12. Specific performance objectives

a. What was the overall performance level(s) at baseline? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

Screening rate The screening rate at baseline was 43%, ranging from 29% to 55% within health centers. See Table 1 (on next-to-last page of this report), left side, for screening rates by individual health center.

Response to BPA. The response to the BPA was 40%, ranging from 21% to 100% within individual health centers. See Table 2 (on last page of this report), left side, for response rates by individual health center.

b. Specific aim: What was the target for performance on the measure(s) and the timeframe for achieving the target?

By the conclusion of the post- adjustment period for this project (4/30/15) our specific aims for these measures are :

Screening rate: From a baseline rate of 43%, 59% (90thtile goal for UMHS performance) of women 18-24 who are seen for an office visit will have a Chlamydia screen done either at the visit or within the past 365 days.

Response to BPA: From a baseline rate of 40%, 75% of BPAs will be addressed during the office visit.

c. How were the performance targets determined, e.g., regional or national benchmarks?

The University of Michigan Medical Group's specific aim for screening rate reflects the reasonably expected increase beyond the number of women aged 16-24y assigned to each primary care site who have had a Chlamydia screening test performed within the past 365 days (whether or not they have been seen in the clinic during that year). This aim is 59% for women 16-24 years old, which was the 90thtile of the prior rates for all clinics at UMHS. Because not all women assigned to a primary care site are actually seen for a clinic visit each year, we set performance targets for the patients who are actually seen in clinic at levels higher than the University of Michigan Medical Group goal. HEDIS metrics were not used as a target since our definition of women who are

candidates for chlamydia testing differ from HEDIS, in that we target all women 16-24 years of age while HEDIS focuses only on women with claims for contraception, prior STI's, or pregnancy testing absent of proximate radiologic studies.

The specific aim for addressing the BPA for Chlamydia was set at a level (75%) higher than the average baseline level. At the outset, two clinics exceeded this rate but most fell below 75%. For the locations addressing the BPA greater than 75%, the goal would be to maintain addressing the BPA at this rate since no improvement was required. Because some patients will decline the screening when offered, the level for addressing the BPA was set higher than for actually obtaining a Chlamydia screen.

13. Data review and identifying underlying (root) causes.

a. Who was involved in reviewing the baseline data, identifying underlying (root) causes of the problem(s), and considering possible interventions ("countermeasures") to address the causes? Briefly describe:

• Who was involved?

Project lead team. Project Facilitator (Grant Greenberg MD), Project Managers (Cecilia Sauter, Megan Moore), Ambulatory Care Administrator (Elly Samuels). Physician leads for each of the clinical areas (Fam Med: Allison Ursu MD, Pediatrics Heather Burrows MD, Gen Med Susan Blitz MD, Ob-Gyn Roger Smith MD, UHS Rob Ernst MD).

General Medicine. Susan Blitz then reviewed baseline data with participating physicians in General Medicine.

• How? (e.g., in a meeting of clinic staff)

Project lead team. This group met initially on 5/21/14 monthly to review the UMHS annualized data on chlamydia screening rates and discuss initial project planning/coordination.

General Medicine. General Medicine faculty reviewed baseline data at the monthly General Medicine Clinical Council meeting and then site directors shared at monthly divisional meetings. For faculty who were unable to attend the meeting, the data was shared electronically.

b. What were the primary underlying/root causes for the problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately. How the intervention(s) address each primary underlying cause will be explained in #14.c.)

Potential root causes identified in May 2014 prior to baseline data collection included:

Physician Factors:

- Lack of recognition of the need to screen the patient given the many other clinical tasks that occur at any given patient encounter
- Discomfort with the topic
- Lack of knowledge on the evidence-based recommendation for Chlamydia screening
- Lack of recognition of less invasive options for screening beyond pelvic exam

Patient Factors:

- Discomfort raising topic to physician/embarrassment
- Unwilling to undergo pelvic exam

Process/Staff Issues:

- Lack of standard mechanism to address STD screening in a sensitive manner
- No routine practice to obtain urine samples
- Different process for urine collection (dirty sample) than for screening for urinary tract infections (clean catch)
- Patient Self Swab product for chlamydia testing not present in all clinical areas

When the General Medicine Clinical Council met in December 2014 to discuss baseline data and identify underlying causes, they confirmed that this list accurately reflected the challenges in implementing appropriate Chlamydia screening. They felt that there were certain issues that were most relevant to address, and gave priority to the following root causes for lower Chlamydia screening:

- Discomfort of staff in bringing up this issue with discussing STD screening in a sensitive manner
- Lack of recognition of the need to screen the patient based on the many other clinical tasks during an appointment
- Lack of standard mechanism to address adolescent visits in a confidential manner
- No routine practice to obtain urine samples
- No standard mechanism to obtain patient self-swabs

C. Do

14. Intervention(s). Describe the interventions implemented as part of the project.

An Electronic Health Record (MiChart) point of care "Best Practice Advisory (BPA)" was initiated on 9/1/14 to remind physicians to screen patients who meet criteria for screening (female, age 18-24, no screening within last 365 days, not otherwise excluded due to lack of sexual activity). During the baseline data collection period, physicians tended to address the BPA during HME visit encounters only. As an intervention related to the BPA, physicians and staff were educated further on the use of the BPA and agreed and were prompted to address the BPA during all eligible visits.

Physician and staff education was provided to address concerns about sensitivity issues around screening. Educational materials and patient communication scripts were developed to explain this initiative.

Workflows were developed, and training was provided for office support staff to allow medical assistants to obtain urine specimens from young women during the check-in process. Self-swab vaginal specimens were also available, but rarely utilized.

A process for documenting phone numbers specifically to facilitate sensitive communication of this test result was programmed into the EHR.

15. Who was involved in carrying out the intervention(s) and what were their roles?

Project Facilitator (Grant Greenberg MD)

Project Manager (Cecilia Sauter)

Ambulatory Care Administrator (Elly Samuels)

Physician leads for each of the clinical areas (Fam Med: Allison Ursu MD, Pediatrics Heather Burrows MD PhD, Gen Med Susan Blitz MD, Ob-Gyn Roger Smith MD, UHS Rob Ernst MD).

--- this team met monthly starting 5/21/14 to develop project, BPA, educational materials, and discuss project planning

General Medicine Physician Lead Susan Blitz, MD also prepared data for presentation at General Medicine Clinical Council and asked General Medicine site leadership to communicate and overview with participating physicians to track clinical interventions.

Participating Physicians participated in data review, self-reflection on specific clinic data, and participated in educational discussions on the importance and utilization of the BPA. Physicians also agreed to address the BPA at non-well visit encounters.

Other Clinical Staff and Clerical staff provided information to patients about screening intervention, Medical Assistants obtained urine specimens at many clinical sites. Health Center Managers supported these workflow changes within the clinics.

16. The intervention was initiated when? (For multiple interventions, initiation date for each.)

Interventions to improve utilization of the BPA after review of baseline data were implemented on 2/1/15.

D. Check

17. Post-intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?

Yes ___

18. Performance following the intervention.

a. The collection of the sample of performance data following the intervention occurred for the time period: 2/1/15-2/28/15

b. What was post-intervention performance level? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

Screening rate. The post-intervention screening rate was 52%, ranging from 35% to 71% within health centers. See Table 1 (on next-to-last page of this report), middle column, for screening rates by individual health center.

Response to BPA. The post-intervention response to the BPA was 49%, ranging from 31% to 78% within individual health centers. See Table 2 (on last page of this report), middle column, for response rates by individual health center.

c. Did the intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?

Screening rate. The increase from the baseline rate of 43% to 52% is more than half-way to achieving our aim of 59%.

Response to BPA. The increase from the baseline rate of 40% to 49% is only one-fourth of the change needed to achieve our aim of 75%.

E. Adjust – Replan

19. Review of post-intervention data and identifying continuing/new underlying causes.

a. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of the continuing/new problem(s), and considering possible adjustments to interventions ("countermeasures") to address the causes? Briefly describe:

- **Who was involved?** Participating physicians and general medicine project lead Susan Blitz, MD
- **How?** All faculty had the opportunity to reflect on data provided at a regular clinic site meetings in March 2015. At these meetings, faculty discussed issues impacting responses to the BPA and workflow issues around support staff assistance with obtaining urine specimens.

b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately. How the intervention(s) address each primary underlying cause will be explained in #20.c.)

Physician Factors:

-Some physicians not clear on how to utilize the BPA within the chart to obtain screening or document lack of sexual activity

Patient Factors:

-Some patients continue to decline testing despite education on the importance of chlamydia screening.

Process/Staff Issues:

- Time not available to discuss screening during all general medicine visits
- Staff didn't follow standard process to obtain urine specimen

F. Redo

20. Second intervention.

a. **The second intervention was initiated when?** (For multiple interventions, initiation date for each.)
4/1/15

b. **What interventions were implemented?**

- Additional training on use of BPA
- Additional workflow training and standard scripts to explain the need for training
- Additional workflow training provided to support staff.

G. Recheck

21. **Post-second intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?**

Yes No – If no, describe how this data collection

22. Performance following the second intervention.

a. **The collection of the sample of performance data following the intervention(s) occurred for the time period: 4/1/15-4/30/15**

b. **What was the performance level?** (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

Screening rate. The post-adjustment screening rate was 60%, ranging from 33% to 92% within health centers. See Table 1 (on next-to-last page of this report), right column, for screening rates by individual health center.

Response to BPA. The post-adjustment response to the BPA was 54%, ranging from 33% to 100% within individual health centers. See Table 2 (on last page of this report), right, for response rates by individual health center.

c. **Did the second intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?**

Screening rate. The increase from the baseline rate of 43% to 60% slightly surpassed our aim of 59%.

Response to BPA. The increase from the baseline rate of 40% to 54% is less than half of the change needed to achieve our aim of 75%.

H. Readjust

23. **Review of post-second intervention data and identifying continuing/new underlying causes.**

a. Who was involved in reviewing the data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe:

- **Who was involved?** General Medicine physicians were involved via site faculty meetings throughout the entire project and participated in reviewing the final data
- **How?** (e.g., in a meeting of clinic staff) Final Data Analysis was discussed at the General Medicine Clinical Council meeting and data was distributed to all General Medicine physicians and APPs via their site Medical Director or Pod Lead in May 2015.

b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)

Physician Factors:

- Physicians are now aware of how to access the BPA, but do not always remember to look for it. Rate of BPA usage may be artificially low as recording of the data requires the BPA to be “clicked” on directly, while often the BPA is viewed and acted upon without “clicking” directly on the BPA.

Patient Factors:

- Some patients continue to decline testing.

Process/Staff Issues:

- Time available for visits continues to be a challenge
- Staff continue sporadically to forget or miss obtaining a urine specimen when rooming patients

I. Future Plans

24. How many subsequent PDCA cycles are to occur, but will not be documented as part of the “project” for which Part IV credit is designated?

Ongoing data surveillance is planned on a quarterly basis, reviewing monthly process data on the interventions developed as part of this project. As warranted based on performance, additional interventions and/or adjustments to process will be developed.

25. How will the project sustain processes to maintain improvements?

The BPA generated during this project will continue to be active for appropriate office encounters. Detailed, monthly reports documenting which physicians and support staff have viewed each BPA, by clinic and department, will continue to be available and accessible which will be shared with clinical leadership and as needed, individual physicians. Quarterly meetings of the multi-disciplinary team are planned as an ongoing effort to insure sustaining of improvement and to facilitate further adjustments as warranted.

26. Do other parts of the organization(s) face a similar problem? If so, how will the project be conducted so that improvement processes can be communicated to others for “spread” across applicable areas?

This project has been a joint project with involvement of all service areas that provide care for young women aged 16-24 (Pediatrics, Family Medicine, Internal Medicine, OB/Gyn, and University Health Services). All areas have worked together to develop this project as well as the various interventions.

27. What lessons (positive or negative) were learned through the improvement effort that can be used to prevent future failures and mishaps or reinforce a positive result??

Developing a collaborative, team-based, multi-disciplinary approach led to a very robust and positive environment to promote improvement. This also allowed for broader engagement at a local level. Integrating the intervention with operational leadership to help disseminate, educate, and reinforce workflow for this project was extremely helpful. This project has served as a model for other projects to build from given the success of the overall effort.

As with any large project, local variation, and potentially less engagement with some leadership and/or physicians around the topic may lead to pockets of sub-optimal results. Ensuring engagement occurs at a local level is essential for similar large efforts in the future.

J. Physician Involvement

28. Physician's role. What were the minimum requirements for physicians to be actively involved in this QI effort? *(What were physicians to do to meet each of the basic requirements listed below? If this project had additional requirements for participation, also list those requirements and what physicians had to do to meet them.)*

- a. Interpreting baseline data and planning intervention:
Attendance at division meetings in December 2014 and January 2015 for educational material on Chlamydia screening, review of BPA utilization, and analysis of baseline data.
- b. Implementing intervention:
Incorporating BPA into daily practice, supporting clinical workflows to promote screening starting by 2/1/15.
- c. Interpreting post-intervention data and planning changes:
Attendance at site faculty meetings in March 2015 and involvement in discussion
- d. Implementing further intervention/adjustments:
Further modifications to clinical workflows as indicated, starting by 4/1/15.
- e. Interpreting post-adjustment data and planning changes:
Attendance at clinic site faculty meetings in May 2015 and involvement in discussion

29. How were reflections of individual physicians about the project utilized to improve the overall project?

Suggestions made by individual faculty at site meetings were incorporated into the process development. This input was utilized to facilitate development of workflows within the individual clinics.

30. How did the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?

All faculty were required to demonstrate active longitudinal participation by attending all site meetings where educational sessions were provided as well as meetings where data was discussed and further interventions planned. The general medicine project lead monitored the participation of all faculty. Although improvement varied among sites, physicians at all sites demonstrated their awareness and endorsement of the project and felt that even though their numbers may not demonstrate improvement they felt their practice patterns were impacted by the improvement project. The Division of General Medicine as a whole improved in both outcomes (screening rates and response rates). In a small minority of clinic sites the rates slightly declined, but this is likely due to unstable numbers from a short outcome monitoring time frame.

K. Project Organizational Role and Structure

31. UMHS QI/Part IV MOC oversight – this project occurs within:

University of Michigan Health System

- Overseen by what UMHS Unit/Group? Faculty Group Practice Quality Focus Measure, Division of General Medicine

• Is the activity part of a larger UMHS institutional or departmental initiative?

- No Yes – the initiative is Faculty Group Practice QMP Quality Focus Measure

Veterans Administration Ann Arbor Healthcare System

• **Overseen by what AAVA Unit/Group?**

• **Is the activity part of a larger AAVA institutional or departmental initiative?**

No Yes – the initiative is:

An organization affiliated with UMHS to improve clinical care

• **The organization is:**

• **The type of affiliation with UMHS is:**

Accountable Care Organization type (*specify which*):

BCBSM funded, UMHS lead Collaborative Quality Initiative (*specify which*):

Other (*specify*):

**Table 1. Screening Rates at General Medicine Clinics
for Chlamydia in Women Aged 18-24 Years**

Clinic	# Women Seen Aged 18-24y, % with Annual Chlamydia Test *					
	Baseline 9/1–10/31/14		Post-Intervention 2/1–28/15		Post-Adjustment 4/1–30/15	
Clinic A	73	47%	54	61%	73	70%
Clinic B	30	43%	22	55%	35	71%
Clinic C	23	43%	19	42%	15	33%
Clinic D	88	35%	69	38%	81	56%
Clinic E	24	29%	17	41%	27	44%
Clinic F	50	46%	42	71%	49	63%
Clinic G	22	45%	13	54%	25	52%
Clinic H	31	48%	20	35%	17	53%
Clinic I	6	50%	15	40%	12	58%
Clinic J	28	43%	26	62%	19	58%
Clinic K	22	55%	13	54%	13	92%
All Clinics	397	43%	310	51%	366	60%

* Annual Chlamydia test done either during visit or in the past 365 days. (Does not include those documented as not sexually active or those who refused.)

Table 2. Response Rates at General Medicine Clinics to Point of Care Decision Support (Best Practice Alert, or BPA)

Clinic	# Clinic Visits Where BPA Fired, % of BPAs Addressed		
	Baseline 9/1–31/14	Post-Intervention 2/1–28/15	Post-Adjustment 4/1–30/15
Clinic A	52 31%	32 69%	35 83%
Clinic B	19 21%	15 53%	17 47%
Clinic C	15 33%	14 36%	11 36%
Clinic D	65 23%	52 31%	58 40%
Clinic E	18 22%	13 23%	21 33%
Clinic F	44 45%	29 62%	31 48%
Clinic G	18 44%	8 38%	15 100%
Clinic H	23 91%	17 65%	9 44%
Clinic I	4 100%	11 36%	6 50%
Clinic J	19 42%	16 56%	10 50%
Clinic K	15 73%	9 78%	3 100%
All Clinics	292 40%	216 49%	216 54%

* BPA addressed = screening obtained or BPA because documented as not sexually active in past 6 months, testing done elsewhere, or patient refused test.