Report on a QI Project Eligible for Part IV MOC

Improving Chlamydia Screening Rates for Women Ages 18-24 in a College Health Service 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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R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 763-1425, rvh@umich.edu
Ellen Patrick, UMHS Part IV Program Administrator, 763-936-9771, ellpat@umich.edu

Report Outline

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date: 10/15/15

2. Title of QI project: Improving Chlamydia Screening Rates for Women Ages 16-24 at the University Health Service 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: 6/30/15

4. Key individuals

   a. QI project leader [also responsible for attesting to the participation of physicians in the project]
      Name: Robert Ernst MD
      Title: Associate Executive Director and Medical Director
      Organizational unit: University Health Service, University of Michigan
      Phone number: (734) 763-2495
      Email address: robernst@med.umich.edu
      Mailing address: 207 Fletcher St.
                      Ann Arbor, MI 48109

   b. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/"sponsoring" the project within the specific clinical setting]
      Name: Robert Winfield MD
      Title: Executive Director
      Organizational unit: University Health Service, University of Michigan
      Phone number: (734) 763-6880
      Email address: rwinf@med.umich.edu
      Mailing address: 209 Fletcher St., Ann Arbor, MI 48109

5. Approximately how many physicians were involved in this project categorized by specialty and/or subspecialty?
   General Internal Medicine – 8
   Family Medicine – 5
   Obstetrics/Gynecology – 1
   Physician Assistant - 2

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. As of September 2014, performance for annualized Chlamydia Screening at UHS, based on HEDIS definition of appropriate patients was: 32% for the Clinic A, 25% for the Clinic B and 65% for the Clinic C. Overall, this is well below HEDIS 75th percentile performance of 59% of patients screened. Given the demonstrated low performance at UHS, the comparatively high number of qualifying visits to our ambulatory care clinics, and the applicability of this important practice to our predominant patient population, improving rates of chlamydia screening was identified as a priority for patient 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. Sexually active is defined as women with a birth control prescription, a urine pregnancy test without a radiologic study within 7 days, or sexually transmitted infection testing.

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

Improved rates of annual Chlamydia screening for all eligible women at UHS, aged 18-24

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

UHS criteria: all women ages 16-24 who were seen in the clinic during the project time frame.

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

- Safety
- Effectiveness
- Timeliness
- Efficiency

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 (EPIC).

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 (given the high number of qualifying visits a single month of data was felt to be adequate to accurately assess the baseline rate of screening).

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 overall chlamydia screening rate for qualified visits at baseline at UHS (during the month of September, 2014) was 37%. See Table 1 (on page of this report), left side, for screening rates by individual clinical departments at UHS.

   **Response to BPA.** The response to the BPA was 19%, ranging from 8% to 53% within individual clinics at UHS. See Table 2 (on last page of this report), left side, for response rates by individual clinics.

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 (6/30/15) our specific aims for these measures are:

   **Screening rate:** From a baseline overall screening rate of 37%, the target rate was established at 59% (90th%tile goal for UMHS performance) of women 18-24 who are seen for an eligible visit to have a Chlamydia screen done either at the visit or within the past 365 days.

   **Response to BPA:** From a baseline rate of 19%, 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 16-24yr 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). As an affiliated University of Michigan campus partner and participating member of the Project Planning Team, the University Health Service has
accepted this same target of 59% of eligible patients screened for this Quality Improvement Project done in parallel with the similar project conducted at UMHS. This aim is 59% for women 16-24 years old, which was the 90%ile 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, the performance targets were set 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. 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).
        - University Health Service: Robert Ernst served as the point person and then reviewed baseline data with participating physicians and physician assistants at UHS.

      • 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.
        - University Health Service: The Medical Staff at UHS reviewed baseline data at a weekly staff meeting to discuss baseline rates and monthly performance during the study period. For providers 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.)

      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, particularly outside the Clinic C
      - 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 the topic to physician/embarrassment
      - Unwilling to undergo pelvic exam

      Process/Staff Issues:
      - Discomfort of staff in bringing up this issue with discussing STD screening in a sensitive manner
      - Lack of standard mechanism to address STD screening in a sensitive manner
      - No routine practice to obtain urine samples
University of Michigan Health System Part IV Maintenance of Certification Program

- Different process for urine collection (dirty sample) than for screening for urinary tract infections (clean catch)
- No standard mechanism to obtain patient self-swabs
- No standard workflow to address the issue of chlamydia screening outside the clinician visit
- Limited standardized MA intake process to address screening issues

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 to remind physicians and other providers 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 (September 1 – 30, 2014, the BPA was active in the Electronic Health Record, but physicians and other providers had not been oriented to the change.

As an intervention related to the BPA, physicians and staff were educated further on the use of the BPA (which fires as a bright yellow flag on the record for eligible visits) at a Medical Staff meeting on October 1, 2014. Tip sheets were also shared. The group was then prompted to address the BPA during all eligible visits.

At that same staff meeting physicians, PA’s and other clinical staff were provided education to address concerns about sensitivity issues around screening. Educational materials and patient communication scripts were developed to explain this initiative.

Self-swab vaginal specimens were also made available at the UHS lab upon order from a provider.

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

University Health Service Physician Lead Robert Ernst, MD also prepared data for presentation at Medical Staff Meetings and asked Women’s Health, Medical Clinic and Clinic B Service Chiefs (Mike Corrigan MD and Susan Ernst MD) to communicate and review the intervention with participating providers at their clinic locations and to track clinical interventions.

Participating Providers participated in data review, self-reflection on specific clinic data, and participated in educational discussions on the importance and utilization of the BPA.

Physicians, PA’s and other clinic providers also agreed to address the BPA at non-well visit encounters.

Other Clinical Staff and Clerical staff provided information to patients about screening intervention. The UHS Nursing Supervisor 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 10/1/15.

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: 11/1/2014 – 11/30/2014.

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 at UHS remained relatively unchanged at 39%, ranging from 29% to 70% within individual clinic areas. See Table 1 (on last page of this report), middle column, for screening rates by individual health center. The lower rates are seen at the Clinic B where patients generally present with urgent issues. The significantly higher rate of 70% was seen in Clinic C where sexual health issues are routinely addressed.

**Response to BPA.** The post-intervention response to the BPA was also unchanged at 19%, ranging from 12% to 53% within individual clinical areas. See Table 2 (on last page of this report), middle column, for response rates by individual health center. Again, the highest rate was seen in the dedicated Clinic C.

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

**Screening rate.** The overall screening rate of 39% remained relatively unchanged from the baseline rate 37% and was still well below the target of 59%. The screening rate for patients seen at the dedicated Clinic C improved from 65% to 70%, and represented the only clinical area at or above the target.

**Response to BPA.** The rate of 19% remained unchanged and well below the aim of 75%.

E. Adjust – Replan


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?** The UHS Project Lead (Robert Ernst, MD), UHS Clinic Service Chiefs (Mike Corrigan MD and Susan Ernst MD), the UHS Nursing Supervisor (Anne McLeod) and other UHS clinical providers.

- **How?** All participating providers had the opportunity to reflect on data provided monthly clinical staff meetings, initially conducted on November 5, 2014. At these meetings, clinicians, service chiefs, and the nursing supervisor and discussed issues impacting responses to the BPA and workflow issues around support staff assistance with addressing the BPA at the time of intake and with obtaining urine specimens (or assisting with vaginal self-collect).

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
-Some providers, particularly male providers, expressed clumsiness addressing reproductive health issues at visits, particularly urgent visits, to address unrelated issues

**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
- Support staff did not follow a standard process at intake to initially address the BPA or collect urine specimens

**F. Redo**

20. **Second intervention.**
   a. **The second intervention was initiated when?**  (For multiple interventions, initiation date for each.)
   4/20/2015
   b. **What interventions were implemented?**
      - Additional training on use of BPA
      - Workflows were developed, and training was provided for office support staff to allow medical assistants to initially address the BPA at the time of intake in all clinical areas and to obtain urine specimens from young women during the check-in process.

**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:** 5/1/2015 - 5/31/15
   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 overall chlamydia screening rate at UHS was 58%, ranging from 46% to 82% within individual clinical areas. See Table 1 (on 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 32%, ranging from 9% to 72% within individual clinical areas. 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 37% to 58% nearly achieved our overall target of 59%.

   **Response to BPA.** The increase from the baseline rate of 19% to 32% remained well below the change needed to achieve our aim of 75%.
H. Readjust


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?** The UHS site lead (Rob Ernst MD), the individual clinic service chiefs (Mike Corrigan MD and Susan Ernst MD), and all participating providers were involved via clinical staff meetings throughout the entire project and participated in reviewing the final.

- **How?** (e.g., in a meeting of clinic staff) Final Data Analysis was discussed at the Medical staff meeting on June 11, 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:**
- Providers are now more aware of how to access the BPA, but there is still considerable room to improve the utilization rate. This 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
- The BPA is somewhat limited in that MA’s are restricted from having patients decline testing (either because they have had it done elsewhere, because they are not sexually active, or because they are not interested in testing at the time of the current visit)
- There is still some inconsistency in terms of support staff addressing the BPA at the time of check in, particularly in areas where there has been turn over of staff
- Staff 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 location, will continue to be available and accessible which will be shared with Clinic Service Chiefs and as needed, individual providers. 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 Service). 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 providers 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 Medical Staff meetings in September and October of 2014 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 October 2014.

   c. Interpreting post-intervention data and planning changes:
      Attendance at medical staff meetings in December 2014 and involvement in discussions between December 2014 and April 2015 as additional workflow and standardized intake processes were developed.

   d. Implementing further intervention/adjustments:
      Further modifications to clinical workflows as indicated, starting by 4/20/2015.

   e. Interpreting post-adjustment data and planning changes:
      Attendance at weekly medical staff meetings in June 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 providers at staff meetings were incorporated into the process development. These meetings included the UHS Clinic Service Chiefs, the UHS Nursing Supervisor and Lead MA so that this input could be 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 providers were required to demonstrate active longitudinal participation by attending Medical Staff meetings where educational sessions were provided as well as meetings where data was discussed and further interventions planned. The UHS project lead monitored the participation of all participating providers. Although improvement varied among clinic areas, providers at all clinics demonstrated their awareness and endorsement of the project and felt that even though their numbers may not demonstrate dramatic improvement they felt their practice patterns were impacted by the improvement project. The University Health Service as a whole improved in both outcomes (screening rates and response rates).
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?
     • 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 University Health Service
     • The type of affiliation with UMHS is:
       □ Accountable Care Organization type *(specify which)*:
       □ BCBSM funded, UMHS lead Collaborative Quality Initiative *(specify which)*:
       ✔ Other *(specify)*: Affiliated University clinical partner organization on campus.
### Table 1. Screening Rates at University Health Service for Chlamydia in Women Aged 18-24 Years

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<tbody>
<tr>
<td>Clinic A</td>
<td></td>
<td>909 32%</td>
<td>826 34%</td>
<td>576 49%</td>
</tr>
<tr>
<td>Clinic B</td>
<td></td>
<td>943 25%</td>
<td>932 29%</td>
<td>136 46%</td>
</tr>
<tr>
<td>Clinic C</td>
<td></td>
<td>544 65%</td>
<td>409 70%</td>
<td>266 82%</td>
</tr>
<tr>
<td>All Clinics</td>
<td></td>
<td>2396 37%</td>
<td>2167 39%</td>
<td>978 58%</td>
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Note: Aim is 59% (90th%tile at UMHS) of eligible women screened for chlamydia.

* 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)

<table>
<thead>
<tr>
<th>Clinic</th>
<th># Clinic Visits Where BPA Fired, % of BPAs Addressed</th>
<th>Baseline 9/1/2014 – 9/30/14</th>
<th>Post-Intervention 11/1/2014 – 11/30/14</th>
<th>Post-Adjustment 5/1/2015 – 5/31/15</th>
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<tbody>
<tr>
<td>Clinic A</td>
<td></td>
<td>706 12%</td>
<td>627 13%</td>
<td>351 17%</td>
</tr>
<tr>
<td>Clinic B</td>
<td></td>
<td>768 8%</td>
<td>751 12%</td>
<td>81 9%</td>
</tr>
<tr>
<td>Clinic C</td>
<td></td>
<td>403 53%</td>
<td>264 53%</td>
<td>171 72%</td>
</tr>
<tr>
<td>All Clinics</td>
<td></td>
<td>1877 19%</td>
<td>1642 19%</td>
<td>603 32%</td>
</tr>
</tbody>
</table>

Note: Aim is 75% of BPAs addressed during the office visit.

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