

# CHLAMYDIA SCREENING QUALITY IMPROVEMENT PROJECT (CHL QIP)

Summary of DVHA's informal quality improvement project 2018-2019  
to improve chlamydia screening rates for women ages 16-24

## **Contents**

Team Members .....	2
Problem/Opportunity Statement .....	2
Project Scope .....	2
Learning Collaborative.....	2
Project Goal .....	3
Project Interim Indicators & Results.....	4
Indicator 1 .....	4
Indicator 2: .....	4
Indicator 3: .....	5
Replication/Next Steps .....	5
Appendix A: Project Charter .....	6
Appendix B: Fishbone Diagram.....	8
Appendix C: Learning Collaborative Schedule.....	9
Appendix D: Provider Sustaining & Replicating Interventions .....	11
Appendix E: Provider Reflections on Collaborative .....	13
Appendix F: Provider PDSA Slides.....	15

## **Summary of Chlamydia (CHL) Quality Improvement Project (QIP)**

### **Team Members**

<b>Team Sponsor:</b>	Dr. Scott Strenio, Medical Director
<b>Team Champion:</b>	Sandi Hoffman, Director QICIU
<b>Team Lead:</b>	Aletta Powel, Quality Assurance Manager QICIU
<b>DVHA:</b>	Kristy Allard, COU; Alexandra Frey, Blueprint; Brianna Nalley, Blueprint; Jaclyn Holden, Blueprint; Tony Kramer, Data Unit
<b>VDH:</b>	Daniel Daltry, VDH Health Surveillance Division; Nathaniel Waite, Maternal & Child Health Division

### **Problem/Opportunity Statement**

During Medicaid's regular performance measure analysis, the Quality Committee, Managed Care Medical Committee and Clinical Utilization Review Board (CURB) reviewed the HEDIS measure "Chlamydia Screening in Women (CHL)" which looks at the 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. As Vermont is currently performing below the Medicaid national 50<sup>th</sup> percentile, the CHL measure was chosen as the topic for a quality improvement project.

### **Project Scope**

The project team reviewed chlamydia screening data, research, and evidence-based interventions. The team developed a charter ([Appendix A](#)) and completed a fishbone analysis ([Appendix B](#)) diagramming the possible barriers to women receiving screening and heard from several subject matter experts on the topic. A learning collaborative was then chosen as the primary intervention for the project.

When completing the initial barrier analysis, the team identified a gap for Medicaid members in the targeted demographic who entered into custody of the Department of Corrections. Many of the admissions were Medicaid members prior to admission or after release. As a result of this project, the Health Care Director from the DOC increased screening practices for members admitted to correctional facilities in Vermont.

### **Learning Collaborative**

The team offered the learning collaborative through the Blueprint's Women's Health Initiative from April through November 2019. The collaborative was a combination of:

- Web-based learning sessions: 1.5-hour sessions that included a combination of didactic content on best practices, case studies of strategies being implemented, and practice teams sharing the work they are doing
- Action/measurement Periods: during action periods practice teams met regularly to set goals, identify strategies, implement those strategies, and measure whether they had been successful.

#### **Five practices registered for the collaborative:**

- CVMC Women's Health Clinic
- NVRH Women's Wellness Center
- Porter Women's Health
- St Albans Primary Care
- White River Family Practice

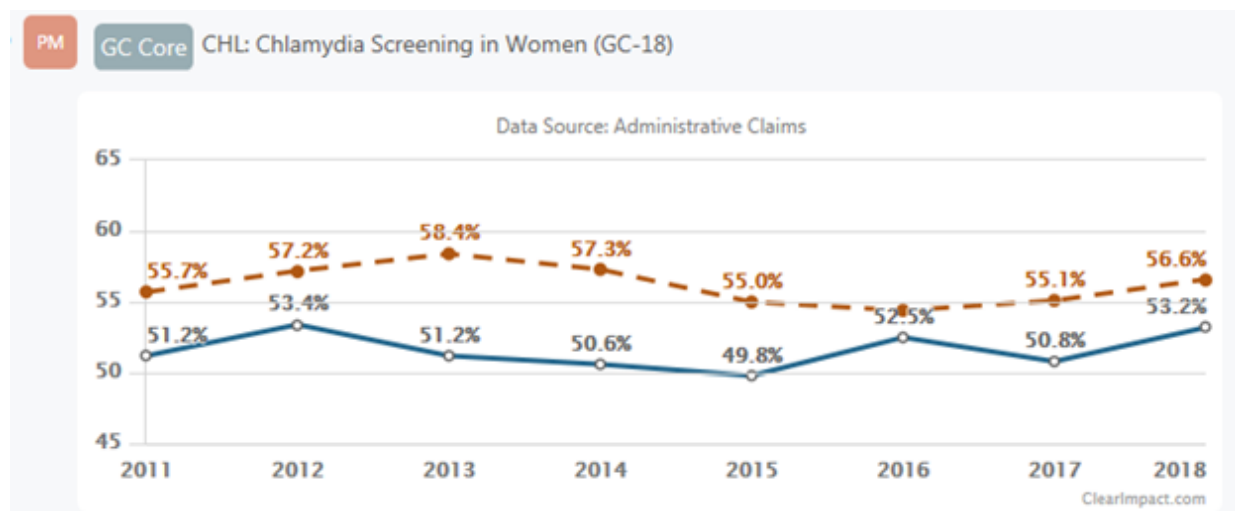
The team recruited a variety of subject matter experts to speak on topics related to chlamydia screening and quality improvement. Please see [Appendix C](#) for the detailed schedule and speakers.

**Here is an overview of the content of the sessions:**

- Collaborative layout, overview of chlamydia screening, and root cause analysis using the fishbone diagram
- Effective and efficient clinic workflows and how to use process mapping in quality improvement work
- Shared-decision approaches for screening, inclusivity, and cultural sensitivity
- Confidentiality history, screening & billing with a focus on confidentiality at an adolescent well-care visit
- Adolescent friendly practices, including pediatric setting & family medicine settings and adolescent well-visits
- Trauma based approaches & leveraging Electronic Health Records (EHRs)
- Protocols for Appropriate and Timely Treatment for CHL & expedited partner therapy (EPT)
- Strategies to sustain improvement, group reflections, practices shared 1-page PDSA documents & a 2-minute pitch summarizing their improvement efforts

**Project Goal**

The project goal was to increase the chlamydia screening rate of sexually active female Medicaid beneficiaries between the ages of 16-24.



The red dashed trend line above is the 50th percentile national benchmark for Medicaid programs. The blue solid trend line is Vermont Medicaid's actual values. The formal goal of the project was to increase the statewide Medicaid HEDIS rate.

However, as the collaborative got underway, the team understood that an intervention with only 5 practices would not move the needle in a statistically significant way on a statewide measure. Three interim indicators were developed to assess the impact of the collaborative on the 5 participating practices.

## **Project Interim Indicators & Results**

### **Indicator 1:**

To increase the % of sexually active female Medicaid beneficiaries ages 16-24, attributed to the practices in the learning collaborative, who receive a CHL screen in a 12-month period.

#### **Action:**

The DVHA Data Unit identified members who fit denominator criteria and then populated panels for 4 of the 5 practices participating in the collaborative. One practice did not receive a panel due to attribution challenges. Over the course of the collaborative, approximately 1/3 of members in the original denominator were excluded due to factors out of our control such as attribution, eligibility, etc. The Data Unit calculated and adjusted CHL screening rate pre & post collaborative for the members who met measure criteria and remained attributed to the practices from April 2019 through October 2019.

#### **Results:**

The pre-collaborative rate was 50.9% and the post-collaborative rate was 54.5% for an increase of 3.6%. While these numbers show a slight increase in screening compliance, the Data Unit believes the result does not demonstrate dependency or infer causality between the collaboration activities and screening rates. However, the slight increase in screening is encouraging and any lack of statistical significance does not warrant discontinuation of best practices implemented during the CHL screening collaborative.

### **Indicator 2:**

Measure change in skills, knowledge & competencies by asking all practice team members to complete a pre and post self-assessment

#### **Action:**

Team members from each practice were invited to complete a pre & post self-assessment of knowledge, skills, and competency relating to the learning collaborative objectives. The rating scale was low, medium low, medium, medium high, and high. Nine pre self-assessments and 9 post self-assessments were completed; however, not by the same 9 people.

#### **Results:**

##### **Q1: Please rate your level of knowledge/skill with quality improvement strategies.**

- Practices rating themselves at the high or medium high level went from 69.4% to 94.3%; an increase of 24.9%.

##### **Q2: Please rate your level of knowledge of clinical protocols for screening and treating Chlamydia.**

- Practices rating themselves at the high or medium high level went from 53.3% to 97.8%; an increase of 44.5%.

##### **Q3: Please rate your level of competency with patient centered approaches for chlamydia screening.**

- Practices rating themselves at the high or medium high level went from 59.3% to 85.2%, an increase of 25.9%.

##### **Q4: Please rate your level of skill in using electronic health records in the chlamydia screening workflow.**

- Practices rating themselves at the high or medium high level went from 69.4% to 97.2%, an increase of 27.8 %.

**Indicator 3:**

Practices self-report on their experience both quantitatively and qualitatively.

**Action:**

Prior to the closing session, participating practices were asked to pull together:

- 1) Their team's thoughts on the sustainability/replication of your interventions
- 2) Their team's reflections on what could have been better and what worked well for the collaborative
- 3) A 2 minute "elevator pitch" on your project with a 1-page handout showing the PDSA

**Results:**

- 1) Please see [Appendix D](#) for provider thoughts on sustainability.
- 2) Please see [Appendix E](#) for provider feedback on the collaborative.
- 3) Please see [Appendix F](#) for providers' PDSA slides.

**Replication/Next Steps**

Based on the results of the 3 interim indicators above, DVHA believes that the practices who participated in the collaborative benefitted from the experience and were able to improve both their knowledge & screening rate on chlamydia.

So that other practices may benefit from the expertise pulled together for this collaborative, DVHA is working to turn the 8 session slide decks into an E-learn course for the OneCare Learning Management System.

DVHA and OneCare Vermont have a Quality Management Workgroup that meets quarterly to share successes and challenges related to performance measures and performance improvement. This report will be presented in an upcoming meeting. This report will also be shared with the AHS Quality Committee.

## **Appendix A: Project Charter**

### **QI Project Team Charter Improving the Medicaid Chlamydia Screening Rate (CHL)**

4/1/2018 to 11/30/2019

WSOC, 280 State Drive, Waterbury VT

#### **Team Members**

**Team Sponsor:** Dr. Scott Strenio, Medical Director

**Team Champion:** Sandi Hoffman, Director QICI Unit

**Facilitator:** Aletta Powel, Quality Assurance Manager QICI Unit

**Internal DVHA:** Kristy Allard, COU, Alexandra Frey, Blueprint, Tony Kramer, Data Unit

**Internal AHS:** Daniel Daltry, VDH Health Surveillance Division

#### **Problem/Opportunity Statement**

During Medicaid's regular performance measure analysis, the Quality Committee, Managed Care Medical Committee and Clinical Utilization Review Board (CURB) reviewed the HEDIS measure "Chlamydia Screening in Women (CHL)" which looks at the 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. As Vermont is currently performing below the Medicaid national 50<sup>th</sup> percentile, the CHL measure was chosen as the topic for a quality improvement project.

#### **Project Scope**

The project team will review chlamydia screening data, research, and evidence-based interventions. The team will complete a barrier analysis, choose interventions, identify indicators and develop a project implementation plan to improve the chlamydia screening rate.

The team may choose to focus on one of the two age ranges or the total. The size of the denominator will be taken into consideration when making that choice.

DVHA anticipates the project will last 12-16 months.

#### **Goal:**

To increase the chlamydia screening rate of sexually active female Medicaid beneficiaries between the ages of 16-24.

### Performance Measures/Key Performance Indicators

Description	Current	Goal
See baseline data below.		
Interim indicators may be developed with the assistance of the Data Unit.		

### Baseline Data

The CHL HEDIS measure has two age stratifications and a total rate:

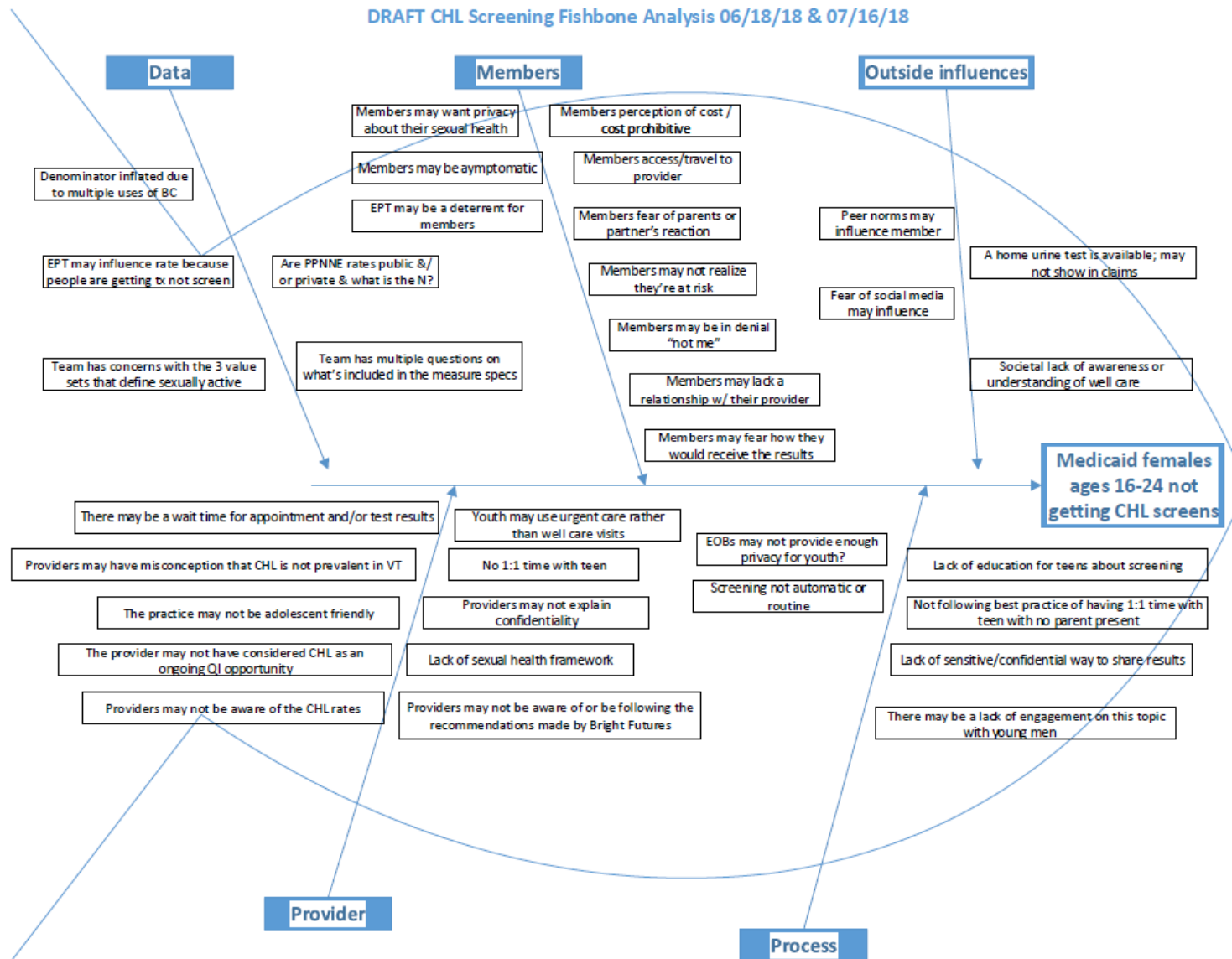
HEDIS CHL Rate					
Description	2015	2016	2017	2018 (DRAFT)	Goal
Chlamydia Screening in Women: 16-20	44.8%	49.6%	47.5%	49.1%	TBD
Chlamydia Screening in Women: 21-24	57.3%	56.3%	55.6%	57.5%	TBD
Chlamydia Screening in Women: Total Rate	49.8%	52.5%	50.8%	52.3%	TBD
Medicaid 50 <sup>th</sup> percentile	55.0%	54.4%	55.1%	Unknown	

2017			
Age Range	Numerator	Denominator	2017 Rate
16-20	1,977	4,162	47.5%
21-24	1,586	2,852	55.6%
Total	3,563	7,014	50.8%

2018 (DRAFT)			
Age Range	Numerator	Denominator	2017 Rate
16-20	1,991	4,059	49.5%
21-24	1,482	2,576	57.5%
Total	3,473	6,635	52.3%
*TK notes there is a < in Medicaid enrollment for the 21-24 age range			



## Appendix B: Fishbone Diagram



## Appendix C: Learning Collaborative Schedule

CHL Screening Learning Collaborative		
Topic	Minutes	Speaker
<b>CHL Learning Collaborative Kick-off Session: 04/05/19 from 11:30-2:00PM</b>		
Welcome & Layout of LC	25	Erin Just
Overview of Chlamydia	15	Daniel Daltry
Sexual health promotion; strengths based approach	15	Daniel Daltry
Root Cause Analysis (QI Tool: Fishbone)	15	Aletta Powell
Review of HEDIS Measure & Intro to panel report	15	Tony Kramer
Overview of strategies to improve CHL screening rates & tx	10	Erin Just
Break	10	
Staff education and provider education materials	10	Daniel Daltry
Model for Improvement (QI Tool)	50	Christie Allen
Next steps	10	Erin Just
<b>Total time</b>	<b>150</b>	
<b>CHL Learning Collaborative Session 2: 05/03/19 from 11:30-1PM</b>		
Effective and efficient clinic workflows: *Team-based care approaches *Pre-visit Planning *Huddles *Standing orders	30	Dr. Erica Gibson
Break	5	
Process mapping (QI Tool)	20	Erin Just
Practices report out / questions	30	
Next steps	5	
<b>Total time</b>	<b>90</b>	
<b>CHL Learning Collaborative Session 3: 05/31/19 from 11:30-1PM</b>		
Shared-decision approach for screening	15	Artie Seelig, C4BHI
Inclusive approaches to screening and discussing sexual and risk behaviors Including: sex positivity, gender inclusivity, LGBTQ inclusivity	15	Taylor Small, Pride Center
Cultural sensitivities as they relate to STIs/CHL	20	Mercedes Avila
Break	5	
Practices report out / questions	30	Erin Just
Next steps	5	
<b>Total time</b>	<b>90</b>	
<b>CHL Learning Collaborative Session 4: 06/28/19 from 11:30-1PM</b>		
Confidentiality: history, screening, and billing	30	Dr. Barb Frankowski
Adolescent confidentiality	20	
Break	5	
Practices report out / questions	30	Erin Just
Next steps	5	
<b>Total time</b>	<b>90</b>	

CHL Learning Collaborative Session 5: 08/02/19 from 11:30-1PM		
Adolescent friendly practices, including pediatric setting & family medicine setting	30	Dr. Erica Gibson
Adolescent well-visit		
Quality Improvement strategies for patient & family engagement	20	Jaclyn Holden
Break	5	
Practices report out / questions	30	Jaclyn Holden
Next steps	5	
Total time	90	
CHL Learning Collaborative Session 6: 09/06/19 from 11:30-1PM		
Trauma based approaches	25	Hannah Holbrook
Leveraging EMRs	25	Practices
Break	5	
Practices report out / questions	30	Jaclyn Holden
Next steps	5	Erin Carmichael
Total time	90	
CHL Learning Collaborative Session 7: 10/04/19 from 11:30-1PM		
Protocols for Appropriate and Timely Treatment for CHL *Re-screening 90-120 days once treatment is provided	10	Daniel Daltrey
*EPT: Expedited Partner Therapy	30	Dr. Erica Gibson
Break	5	
Practices report out / questions	35	Jaclyn Holden
Next steps	10	
Total time	90	
CHL Learning Collaborative Session 8: 11/01/19 from 11:30-1PM		
Strategies to sustain improvements (QI Tool)	20	Jaclyn Holden
Practice thoughts on replicability/sustainability of interventions	20	Jaclyn Holden
Group reflections on what went well, could have been better	10	Aletta Powel
Break	5	
Practices share 1 pg PDSA & 2 minute elevator speech	25	Aletta Powel
Close out & farewell	10	Jaclyn & Aletta
Total time	90	

## Appendix D: Provider Sustaining & Replicating Interventions

### CVMC: Sustainability/Replication of Interventions

- ▶ Is your practice planning on sustaining any of the interventions implemented in the immediate future?
  - ▶ Yes
    - ▶ CVMC Women's Health hopes to sustain the work that's been done on standardizing the EHR reporting process
  - ▶ Why or why not?
    - ▶ We need to transfer changes to the new EHR rolling out next week to improve documentation and data collection going forward
- ▶ Would you recommend other practices replicate any of your intervention(s)?
  - ▶ Yes
  - ▶ Why or why not?
    - ▶ We plan to replicate these changes within CVMC Family and Pediatric practices and leverage what we've learned during the collaborative to improve the screening numbers across our HSA, which are lower than that of our practice
  - ▶ Did you encounter any barriers you would share with a practice who was replicating your intervention(s)?
    - ▶ Yes, management and provider engagement was our biggest barrier

### NVRH: Sustainability/Replication of Interventions

- ▶ Is your practice planning on sustaining any of the interventions implemented in the immediate future?
  - ▶ Yes, we will continue to indicate if a patient should receive a chlamydia screening during our pre-visit planning.
- ▶ Would you recommend other practices replicate any of your intervention(s)?
  - ▶ We recommend indicating if a patient should be screened for chlamydia during pre-visit planning. This is indicated on a printout of the RN/Provider's schedule at the beginning of each day.

## St. A: Sustainability/Replication of Interventions

- ▶ Is your practice planning on sustaining any of the interventions implemented in the immediate future?
  - ▶ The practice will continue using the changes made in the EMR for pre-visit planning and continue to use the workflow implemented for 16-24 year old patients.
  - ▶ Education regarding chlamydia will continue to be sent through the portal.
  - ▶ The changes made to the EMR allow for more efficient pre-visit planning and running reports.
- ▶ Would you recommend other practices replicate any of your intervention(s)?
  - ▶ The workflow that was implemented can help with pre-visit planning and should help with missed opportunities. If practices can use their EMR to assist with this process, we would recommend this.
  - ▶ There were several iterations before the EMR was adjusted for benefit of the provider and for pre-visit planning.
  - ▶ The practice still has some work to do on missed opportunities. Provider buy-in across the practice is not universal.
  - ▶ It would be helpful to have standing orders for screening

## WRFP: Sustainability/Replication of Interventions

- ▶ Is your practice planning on sustaining any of the interventions implemented in the immediate future?
  - ▶ Why or why not?
  - ▶ Yes, making chlamydia the "standard of care" for 16-24 years old females has increased our screening rates for this age group.
- ▶ Would you recommend other practices replicate any of your intervention(s)?
  - ▶ Why or why not?
  - ▶ Would recommend meeting with entire staff and getting buy-in for a process that becomes the standard of care.
  - ▶ Did you encounter any barriers you would share with a practice who was replicating your intervention(s)?
  - ▶ Plan ahead on how to contact minors (where to note in the patient record, etc.)

## Appendix E: Provider Reflections on Collaborative

### Reflections on Learning Collaborative: What could have been better?

- > We could have used assistance in engaging more practices, and in getting more buy-in from management and providers from the beginning; not sure what would have helped with this?
- > The webex format was helpful to accommodate schedules, but pre-recorded webinars might have been even better for our practice...difficult to have several people 'off' at the same time; although that precludes discussion and questions
- > 90 minutes is too long to pull staff away from patient care (suggest max of 60 minutes)
- > Guest speakers presenting clinical information on the subject shouldn't be at 11:30 (providers still seeing patients). Needs to be during lunch time.
- > Report outs done too much/taking too much valuable time
- > Stick to the "subject". Example, didn't need to learn about process flow maps when we just wanted to utilize the time on how to improve chlamydia screening (information pertaining directly to the subject). Again, staff time is limited.

### Reflections on Learning Collaborative: What could have been better?

- > This practice likes to spend time with other practices in-person if possible (very challenging)
- > The length of the LC was a bit too long
- > We would have liked to spend more time talking with the other practices
- > Few practices participated
- > This practice has a lot of experience with QI and did not need the QI 101
- > It would be great to include males

### Reflections on learning collaborative: what worked well?

- > Sharing information and getting feedback from other practices involved in the collaborative
- > The information presented was excellent and practical, and covered a lot of opportunities that we hadn't previously thought about assessing or changing
- > The webex format made the sessions more accessible for more staff
- > Changing our language and destigmatizing
- > Collecting urine samples on all patients
- > A more preventative focus
- > Staff/nursing pre-visit planning and making indicators of who should be screened.
- > Informative talks/presentations (but unfortunately the appropriate people that should have listened were still seeing patients in the morning)

### Reflections on learning collaborative: what worked well?

- > The practice was able to devote time using this structure to make some changes
- > We were able to take some good resources to use
- > Treatment information was extremely valuable (i.e. treating partners without the need to bring them in for appointment.
- > This collaborative prompted us to move forward with making chlamydia a standard of care, rather than a choice which many declined. We were always sensitive to cost but learned in this collaborative that most insurances were covering the screening. This had been our greatest barrier.
- > There were a lot of great presenters



## Appendix F: Provider PDSA Slides

Practice: NVRH Women's Wellness Center  
Team Members:

### Plan: Identify an opportunity & plan for improvement / Why did you choose this project / What was your baseline data telling you?

We initially chose to improve chlamydia screening rates for all women ages 16-24 who have identified as being sexually active. After getting our data we learned that we were screening 80% of women ages 16-24 who were sexually active.

### Do: What ideas for improvement did you test?

We focused on providing education to staff and patients on chlamydia and the importance of screening. We also focused on pre-visit planning and making sure it was indicated that all patients age 16-24 that were coming in for a visit were due for a screening.

### Study: What were the results of your test(s)? What is your final post-change data compared to the baseline data?

After making some minor changes to workflow and pre-visit planning we were able to increase our screening rate to 85%.

### Act: What lessons did you learn from the process? How will this change be sustained?

We learned that we do well with screening for chlamydia but will continue to do pre-visit planning and also work to destigmatize chlamydia and educate more patients on the importance of being screened.



## AHS Chlamydia Screening Learning Collaborative

Practice: St. Albans Primary Care

Team Members: Dr. Toby Sadkin, Sarah Owen, NP, Renee Trombley, LPN, Medical Office Administrator, Jill Davis, Blueprint QI Facilitator

**Plan: Identify an opportunity & plan for improvement / Why did you choose this project / What was your baseline data telling you?**

- The baseline data was telling us that just over ½ of the women ages 16-24 were being screened annually for chlamydia and we needed to increase the rate of screening

**Do: What ideas for improvement did you test?**

- EMR modifications to assist with pre-visit planning, easier documentation for providers and running reports
- Implementing a new workflow to include roomers obtaining a urine for all patients due for a screening ages 16-24 as well as providing hand-outs and education
- Education was sent out through the portal

**Study: What were the results of your test(s)? What is your final post-change data compared to the baseline data?**

- From June through September our missed opportunities rate remained steady and did not decline
- We need the claims data we received prior to beginning the collaborative to determine our post-change data.

**Act: What lessons did you learn from the process? How will this change be sustained?**

- ▶ A lot of time was spent on developing a new workflow that is streamlined and can be successful
- ▶ Adding prompts in the EMR was very helpful
- ▶ Using the EMR to collect data worked well
- ▶ We have room for improvement for missed opportunities

## AHS Chlamydia Screening Learning Collaborative

**Practice:** White River Family Practice

**Team Members:** Dr. Jill Blumberg, Lisa Paquette, RN, Deb Patenaude, CMA, Laurie Needham, billing specialist, Tammy Gray, referral coordinator/front staff & Joanne Arey, Practice Manager

**Plan: Identify an opportunity & plan for improvement / Why did you choose this project / What was your baseline data telling you?**

Our screening rates were well below the State average of 54.2% (this number is based only on Medicaid and our numbers are on all patients). Our goal was to exceed the State average and address our systems to see where we were falling short. Our baseline was 44%.

**Do: What ideas for improvement did you test?**

1. Discussing the process of screening all 16-24 year old females at an "all staff" meeting for staff buy-in
2. Changing how we presented to patients, not an option but a standard of care
3. Displayed education about chlamydia on all of our exam room bulletin boards
4. Pre-visit planning templates for rooming these patients, portal messages reminding them they will be asked to leave a urine specimen upon arrival to their appointment and why, created instructions to hand-out at check-in on how to obtain accurate u/a specimen (different from standard collection)
5. Communication between provider, patient/family & medical assistant that test will be run (unless otherwise indicated)

**Study: What were the results of your test(s)? What is your final post-change data compared to the baseline data?**

Our goal was to increase our screening rates by 20% when we completed the collaborative sessions. Our % of 16-24 year old female patients seen during this time increased to 71%. This was a significant improvement during a short time (less than a year)

**Act: What lessons did you learn from the process? How will this change be sustained?**

How testing is presented to the patient makes a difference ("would you like to be test" vs. standard of care for this age group)

Buy-in from all providers and staff is critical

We will apply this process/approach to other areas of our practice. We will make an internal decision on whether to test males as well.

With success like this we will not turn back, we will celebrate!

## AHS Chlamydia Screening Learning Collaborative

Practice: **UVM-HN Central Vermont Medical Center Women's Health**  
Team Members: **Angela Shea, Beverly Coon, Elisa Vandervoort**

**Plan: Identify an opportunity & plan for improvement / Why did you choose this project / What was your baseline data telling you?**

- Our baseline data showed good screening numbers overall, but opportunities for improvement included raising the screening rates of a few specific providers to match the overall high numbers
- We chose process mapping and workflow comparison to understand where variation was occurring and attempt to standardize parts of the process and share best-practices between providers

**Do: What ideas for improvement did you test?**

- We reviewed & documented screening processes & protocols
- We interviewed providers to determine where variations were occurring
- We began assessing EHR documentation to ensure measurement was accurate

**Study: What were the results of your test(s)? What is your final post-change data compared to the baseline data?**

- We discovered variation in what appointment types included screening, how providers were asking about sexual activity/status, and how this was being documented in the EHR
- Post-change data hasn't been reported yet. With all of the practices switching to a different EHR, it was decided that a measure of change would be more meaningful after the transition and after further opportunities for standardization and improved data reporting

**Act: What lessons did you learn from the process? How will this change be sustained?**

- We learned that mapping a process from multiple staff viewpoints is important
- We learned that variation between providers existed at multiple levels which needed to be addressed differently
- We learned that the new EHR will have greater capability for more accurate documentation and data tracking; following up on the process transition for the new EHR will help sustain & replicate