HealthIT.gov
National Learning Consortium
Advancing America's Health Care

# Health IT-enabled Quality Improvement [eCQI] Worksheet (Ambulatory, Enhanced Version)

***INTRODUCTION:***

***Description:***

This tool can help users document and analyze current approaches to specific quality improvement targets and plan enhancements. It is part of the ONC eCQI Resources [1] that provide guidance on planning and implementing improved care processes [2]. There is also a tutorial on using this worksheet among those eCQI Resources [3].

You should select quality improvement targets based on evidence, including quality measures results that show current performance gaps, and on practice guidelines recognized by relevant professional societies or expert advisory panels such as the USPSTF. Your REC, QIN-QIO, or other QI partners can help you prioritize improvement targets relevant to your practice. Your REC or health IT vendor can help with implementing tools to support process changes identified by this worksheet. The CDC/Million Hearts Hypertension Control Change Package [4] is an example of evidence-based tools and guidance for supporting target-focused quality improvement efforts.

***Version:*** Version 2.0; May 22, 2015

***Table of Contents:***



**Sample Completed Worksheet:** Hypertension control case study [5]


**Acknowledgements**

Worksheet Provided By:
Jerome A. Osheroff, MD, TMIT Consulting, LLC

*This tool has been refined based on experience using the eCQI worksheets in quality improvement (QI) projects. It builds on QI tools sponsored by the Office of the National Coordinator for Health IT (ONC)[1]. Those ONC tools were based on work of the CDS/PI Collaborative [6] (supported by the California Healthcare Foundation [7]), which builds, in turn, on the HIMSS CDS Guidebook Series [8]. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within.*


**References**


1. eCQI Resources
2. Planning and implementing improved care processes
3. Enhanced eCQI worksheet tutorial
4. CDC/Million Hearts Hypertension Control Change Package
5. Hypertension control case study - CHC, Inc.
6. CDS Collaborative for Performance Improvement
7. California Healthcare Foundation
8. HIMSS CDS Guidebook Series

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## Start Page: Using the Detailed Ambulatory eCQI Worksheet

**Overview**

To access the worksheet, click the tab at the bottom of this window that says "Amb Worksheet with HTN example"

Note: Roll cursor over the worksheet headings to see guidance on what the headings mean. Worksheet cells in the Current State columns include Hypertension examples that can be viewed as rollover text. (In the PDF version table cell rollovers are now text; see heading Comments, last page.)

**Tip**: Imagine that you are a patient not meeting the target when you are populating the worksheet; i.e., consider what is and isn't happening that's causing the suboptimal result.

**Step 1: Target**

* Enter the clinical measure to be improved and current performance on this measure (rows 4-5)

**Step 2: Optimal State Activities (see Columns D-F)**

* Review the pre-populated sample key care activities and modify them to fit the target. Consider evidence-based guidelines, and other best practice resources to guide these entries.

**Step 3: Current State Information Flow (see Columns H-M)**

* Relative to the activity in the Optimal State, document current information flows at each support opportunity
* Document in Column M key factors underpinning the Current State information flow that might influence enhancements
* Merge the cells to combine dimensions such as 'what, where, how' if desired

**Step 4: Potential Enhancements (see Columns O-P)**

* Document in Column O how information flow could be improved to increase performance
* Note in Column P considerations for implementing the potential enhancement

Use this completed worksheet with the QI team to help prioritize and implement high-yield enhancements to current workflows and information flows; consider beginning with those that will yield the greatest benefits with the least effort and resources. (see ONC eCQI Process Improvement page for further details)

# Detailed Ambulatory eCQI Worksheet [Sample data for blood pressure control in rollover text for blank cells]

## What Are We Trying To Improve? How Are We Doing Today?

| | |
|---|---|
| **Target* =** | *** |
| **Current Performance on Target** =** | **** |

## eCQI Approach Details

| | | Optimal State [a] (sample activities to optimize | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | CDS 5 Rights[5 | | | | | | | |
| **Decision Support Opportunity [1]** | | **Care Activities [2]** | **Examples of Care Activities[3]** | **Notes[4]** | **Who?[6] (people)** | **What?[7] (information)** | **Where?[8] (channels)** | **How?[9] (Formats)** | **When?[10] (Workflow)** | **Notes[11]** | **Proposed Enhancements (locally or by EHR vendor)[12]** | **Notes[13]** |
| **Patient-specific Activities[14]** | **Not Visit-Related[15]** | Patient understands condition and treatment; follows care plan developed in collaboration with care team | Patient addresses agreed-upon lifestyle changes (diet, exercise, etc.), takes medications, keeps appointments, documents key clinical information (weight, blood sugar, blood pressure, food diary, etc.), understands resources available for care including help line & clinic locations for urgent care | Consider opportunities to support patients at home, grocery store/restaurants, etc., where their decisions/actions influence the target | Comment: Patient | Comment: Health status questionnaires (e.g., home BPs, diet/exercise logs), education about conditions/medications (HTN, BP meds, non-drug HTN management), reminders about medications/testing/follow-up (e.g., follow-up appointment for BP checks, lab tests ordered to follow meds or underlying triggers for uncontrolled HTN) | Comment: Smartphone, PHR, mail, e-mail, patient portal | Comment: Documentation tools, reference materials, flowsheets, text messages, reminders | Comment: Patients may access this material during various daily activities such as grocery shopping, or time set aside to monitor and learn about their condition. | Comment: Consider all the ways the practice supports patient target-related decisions/actions outside of encounters. Consider also increasing decision support outreach from Payers to patients, and relation to practice's efforts. | Comment: Consider using more robust channels (e.g., patient portal, text messages) and information/formats (e.g., electronic health status monitoring for ready incorporation into EHR) | Comment: Collaborate with EHR/portal vendors and others to help with data integration |
| **Patient-specific Activities[14]** | **Before Patient Comes to Office[16]** | Patient reviews/updates /submits pertinent health status data. Remind patient about visit | Patient helps create 'pre-visit summary' that provides/validates key data such as allergies, medications, problems, self-monitoring results (BP, blood sugar, etc.). Remind patient to keep appointment and prepare as needed | EHR portals that enable patients to interact with information in their record help enable patient data review and submission | Comment: Who is receiving/providing the information? For example: Doctors; Nurses; Pharmacists; Other care team members/staff; Patients! (and their caregivers) | Comment: What information is being exchanged/processed? | Comment: How is the information getting to/from the targeted individual? For example, via:; EHR modules (ordering, documentation, results review); Registries; Clinician/Patient portals; Mobile devices (patient and clinician); Smart home devices (BP/blood sugar monitors, etc.); Paper (e.g., patient handout); | Comment: In what format is the information flowing? For example: ; Documentation Templates ; Order sets; Reference information; Patient Lists/Provider Scorecards; Flow sheets and Graphs; Dashboards; Alerts and reminders; | Comment: When exactly in the workflow is the information flowing? | See above. | See above | See above |

| | | Optimal State [a] (sample activities to optimize | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | CDS 5 Rights5 | | | | | | | |
| Decision Support Opportunity [1] | | Care Activities [2] | Examples of Care Activities[3] | Notes[4] | Who?[6] (people) | What?[7] (information) | Where?[8] (channels) | How?[9] (Formats) | When?[10] (Workflow) | Notes[11] | Proposed Enhancements (locally or by EHR vendor)[12] | Notes[13] |
| Patient-specific Activities[14] | Daily Care Team Huddle[17] | List visit action items and preparations for each patient to be seen during the day | 1. Gathering key data such as reports from recent tests and consultations<br>2. Preparing for care transitions<br>3. Planning/ scheduling tests/ treatments needed during each visit | Support staff can prepare orders for needed interventions during these discussions with the provider | Comment: Provider, clinical support staff | Comment: see 'Examples of Care Activities" cell in this row | Comment: EHR data review, order entry pages, dashboard page and flowcharts highlighting needed interventions; HIE; printed reports from outside sources | Comment: EHR data review, order entry pages, dashboard page and flowcharts highlighting needed interventions; HIE; printed reports from outside sources | Comment: Can be prior to the next day's visits or the morning of the clinic day | Comment: Protocols to establish when and how the huddle happen | Comment: Consider automating the data gathering process (e.g., through technologies and processes to ensure pertinent data is readily accessible in EHR) and patient-specific summary dashboards to optimize huddle efficiency/effectiveness. | |
| Patient-specific Activities[14] | During Office Visit[18] Check-in[19] | Review/verify/ update patient information | 1. Review insurance information to help determine formularies/coverage to minimize patient out-of pocket expenses and enhance adherence<br>2. Verify demographic and clinical information (Allergies, Medications, Problem list), e.g., by providing patient a 'pre-visit summary' to review | There are different tools, channels, workflows for handling this information flow, e.g., front desk staff gives paper forms that staff later enters into EHR. | Comment: Patient, front desk staff | Comment: see 'Examples of Care Activities" cell in this row | Comment: EHR, kiosks, tablets, written materials/paper forms | Comment: Summary data displays, documentation tools | Comment: Patient arrives at office | | Comment: Consider tools that further automate data review/updating, and incorporation into EHR | |
| Patient-specific Activities[14] | During Office Visit[18] Waiting[20] | Gather patient data, provide educational info | Patient completes pre-visit health form, reviews educational materials and clinical resources related to their health issues | Can be a continuation of activities started during check-in; e.g., reviewing pre-visit summary | Comment: Patient (with tools provided by staff) | Comment: General health and condition-specific educational resources. Health status questionnaires | Comment: Kiosks, tablets, written materials (posters, pamphlets) and forms | Comment: Education tools (including audio/video) and documentation forms | Comment: After check-in, before clinical encounter | | Comment: Consider opportunities to better utilize waiting time to enhance shared goals | |

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| Patient-specific Activities[14] | During Office Visit[18] | Rooming[21] | Clinical support staff documents/reviews key information with patient before provider encounter | 1. Obtain and document vital signs (e.g., blood pressure [repeat if abnormal], height, weight, BMI, smoking status), chief complaint in patient's words and brief details; 2. Review and compare with EHR data patient-reported allergies (reaction/severity) and medications (dose, route, frequency, pharmacy), including non-prescription medications and supplements (to help identify potential drug-drug interactions) ; 3. Note needed medication refill orders; 4. Execute standing orders (e.g., testing before provider encounter) | Clinician/practice-developed protocols help ensure data is collected and entered into EHR properly (e.g., appropriate technique for recording blood pressure, responding to abnormal values, and documenting results). | Comment: Rooming staff (e.g., nurse, medical assistant) | Comment: see 'Examples of Care Activities" cell in this row | Comment: EHR data entry/documentation forms and data review pages | | Comment: Before Provider encounter | Comment: see 'Notes' cell earlier in this row | | |
| Patient-specific Activities[14] | During Office Visit[18] | Provider Encounter[22] | History and Physical | 1. Review and discuss previous encounter records/consultation notes/medications/test results/patient-submitted information (e.g., health status forms)<br>2. Discuss symptoms, adherence/barriers to jointly developed care plan, response to treatment, other patient issues<br>3. Provider physical exam, including assessing key target-related findings | | Comment: Provider, patient | Comment: EHR modules for results review and clinical documentation providing tools such as smart forms (prompts for key data - see documentation below), and access to pertinent data such as consultation reports, test results, patient-submitted health status forms, etc. | Comment: EHR modules for results review and clinical documentation providing tools such as smart forms (prompts for key data - see documentation below), and access to pertinent data such as consultation reports, test results, patient-submitted health status forms, etc. | Comment: EHR modules for results review and clinical documentation providing tools such as smart forms (prompts for key data - see documentation below), and access to pertinent data such as consultation reports, test results, patient-submitted health status forms, etc. | Comment: Data gathering during provider encounter (data gathering and documentation often intertwined) | | Comment: Seek to ensure optimal support for efficiently gathering all information needed from patient and records to optimize care decisions/actions related to the target | |

| Optimal State [a] (sample activities to optimize | | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Decision Support Opportunity [1] | Care Activities [2] | Examples of Care Activities[3] | Notes[4] | CDS 5 Rights5 | | | | | Notes[11] | Proposed Enhancements (locally or by EHR vendor)[12] | Notes[13] |
| | | | | Who?[6] (people) | What?[7] (information) | Where?[8] (channels) | How?[9] (Formats) | When?[10] (Workflow) | | | |
| Patient-specific Activities[14] During Office Visit[18] Provider Encounter[22] | Documentation | Document key information needed to support appropriate decision making and action (e.g., history and physical results, care plan, patient education) | Documentation is called out separately in this worksheet row to highlight the use of tools that help ensure key information is documented appropriately | Comment: Provider/patient/ others on care team | Comment: 'Smart' documentation tools such as problem specific templates that prompt for key data needed for target-related assessment (pertinent history and exam findings) and management. For example, HTN templates that ensure that pertinent data needed to assess poor BP control are gathered, such as barriers to medication adherence (including depression, drug costs, side effects). | * Diagnostic decision support tools (integrated into EHR or stand-alone)<br>* Clinician reference on diagnosis/treatment and medications (e.g., integrated into EHR workflow via info buttons)<br>* Data review tools such as target related graphs/flowsheets/dashboards (BP, weight, blood sugar, meds, etc.) to support shared clinician/patient review<br>* templates for problem-specific care plans. | Comment: Data entry items, forms and pages in the EHR | Comment: During patient-provider encounter, as well as other interactions with a patient and with data in the EHR (e.g., when new results are entered and reviewed outside a patient visit) | Comment: Documentation templates combine evidence-based guidance and clinical best practice to optimize practice workflow | Comment: Use EHR capabilities and workflow refinements to ensure that critical data needed for decisions and actions is captured as seamlessly as possible within care workflows. To accomplish this, think through who should be documenting what, and where and how this should happen. | |
| Patient-specific Activities[14] During Office Visit[18] Provider Encounter[22] | Assessment/ Diagnosis and Care Plan | Provider assesses clinical data, formulates condition management recommendations and engages patient in shared decision making to create a care plan | | Comment: Provider/patient | Comment: * Diagnostic decision support tools (integrated into EHR or stand-alone)<br>* Clinician reference on diagnosis/treatment and medications (e.g., integrated into EHR workflow via info buttons)<br>* Data review tools such as target related graphs/flowsheets/dashboards (BP, weight, blood sugar, meds, etc.) to support shared clinician/patient review<br>* templates for problem-specific care plans. | | Comment: * Diagnostic decision support tools (integrated into EHR or stand-alone)<br>* Clinician reference on diagnosis/treatment and medications (e.g., integrated into EHR workflow via info buttons)<br>* Data review tools such as target related graphs/flowsheets/dashboards (BP, weight, blood sugar, meds, etc.) to support shared clinician/patient review<br>* Templates for problem-specific care plans | Comment: During assessment/planning phase of patient-provider encounter | | Comment: Seek to make the right diagnosis and management decisions and actions the 'easy thing to do.' | |

| | | | Optimal State [a] (sample activities to optimize | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
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| Patient-specific Activities[14] | During Office Visit[18] | Provider Encounter[22] | Ordering | Write orders/prescriptions for meds, labs/diagnostic tests, follow-up visits, referrals, other interventions appropriate to address shared patient/provider care goals | Insurance information gathered earlier can support prior authorization, minimize out-of-pocket patient expenses and hassles | Comment: Provider | Comment: * Problem-specific order sets, including built in information on quality measures (ideally with ability to document patient exclusions for measure-indicated interventions ), guidance on investigating and managing complex situations (e.g., medication escalation and evaluation for secondary causes in resistant hypertension), drug dosage adjustments for renal impairment * Order checking for drug contraindications * Specialist/consult communications (e.g., smart consultation forms for patients with multi-drug-resistant HTN) * Interruptive alerting used only as a 'safety net' supporting other intervention approaches; especially avoiding interruptive alerting about needed orders outside ordering workflow (e.g., interruptive alert on chart open about overdue mammogram ), or after the order session is closed | Comment: * Problem-specific order sets, including built in information on quality measures (ideally with ability to document patient exclusions for measure-indicated interventions ), guidance on investigating and managing complex situations (e.g., medication escalation and evaluation for secondary causes in resistant hypertension), drug dosage adjustments for renal impairment * Order checking for drug contraindications * Specialist/consult communications (e.g., smart consultation forms for patients with multi-drug-resistant HTN) * Interruptive alerting used only as a 'safety net' supporting other intervention approaches; especially avoiding interruptive alerting about needed orders outside ordering workflow (e.g., interruptive alert on chart open about overdue mammogram ), or after the order session is closed | Comment: * Problem-specific order sets, including built in information on quality measures (ideally with ability to document patient exclusions for measure-indicated interventions ), guidance on investigating and managing complex situations (e.g., medication escalation and evaluation for secondary causes in resistant hypertension), drug dosage adjustments for renal impairment ; * Order checking for drug contraindications; * Specialist/consult communications (e.g., smart consultation forms for patients with multi-drug-resistant HTN); * Interruptive alerting used only as a 'safety net' supporting other intervention approaches; especially avoiding interruptive alerting about needed orders outside ordering workflow (e.g., interruptive alert on chart open about overdue mammogram ), or after the order session is closed; | Comment: During ordering process within patient-provider encounter | Comment: Order sets and related tools combine evidence-based guidance and clinical best practice to optimize practice workflow | Comment: Make it as easy as possible to do the right thing - e.g., safely order all indicated interventions. | |
| Patient-specific Activities[14] | During Office Visit[18] | Provider Encounter[22] | Procedures | In-office immunizations, lab testing, other clinical interventions - especially those related to target | | Comment: Provider, clinical staff, patient | Comment: Reference information, documentation tools, relevant data display provided via EHR to help ensure that the interventions are provided and documented appropriately. | Comment: Reference information, documentation tools, relevant data display provided via EHR to help ensure that the interventions are provided and documented appropriately. | Comment: Reference information, documentation tools, relevant data display provided via EHR to help ensure that the interventions are provided and documented appropriately. | Comment: During office visit, either before, during, or after provider encounter | | | |

| Decision Support Opportunity [1] | | Optimal State [a] (sample activities to optimize | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | CDS 5 Rights5 | | | | | | | |
| | | Care Activities [2] | Examples of Care Activities[3] | Notes[4] | Who?[6] (people) | What?[7] (information) | Where?[8] (channels) | How?[9] (Formats) | When?[10] (Workflow) | Notes[11] | Proposed Enhancements (locally or by EHR vendor)[12] | Notes[13] |
| Patient-specific Activities[14] | During Office Visit[18] | Provider Encounter[22] | Patient Education | 1. Ensure patient (and care-givers) understand and are engaged with care plan, e.g., by providing and discussing 'after visit summary' with patient 'teach back'<br>2. Provide supplemental educational materials to help them understand and manage their condition | Comment: Provider/clinical staff, patient | Comment: * Information as per 'Examples of Care Activities' cell earlier in this row (e.g., low sodium diet and guidance on reading fool labels for HTN) and in Assessment/Diagnosis and Care Plan above (e.g., data presentation for joint provider/patient review)<br>* After Visit Summary (with patient teach back) helps ensure patient understands and agrees with care plan, and has documentation after they leave office<br>* Can leverage electronic channels (EHR, internet, tablets, portal) and paper channels (handouts/pamphlets stored in filing cabinets, wall racks, etc.)<br>* Formats can include reference information, After Visit Summary, audio/video materials, quizzes and interactive tools, etc. | Comment: * Information as per 'Examples of Care Activities' cell earlier in this row (e.g., low sodium diet and guidance on reading fool labels for HTN) and in Assessment/Diagnosis and Care Plan above (e.g., data presentation for joint provider/patient review)<br>* After Visit Summary (with patient teach back) helps ensure patient understands and agrees with care plan, and has documentation after they leave office<br>* Can leverage electronic channels (EHR, internet, tablets, portal) and paper channels (handouts/pamphlets stored in filing cabinets, wall racks, etc.)<br>* Formats can include reference information, After Visit Summary, audio/video materials, quizzes and interactive tools, etc. | | Comment: Various stages within and beyond the office visit | Comment: Select, manage and maintain paper-based tools (e.g., obtain and stock brochures) as well as electronic tools (e.g., vet/obtain material, integrate into EHR) | Comment: Try to manage this information via EHR to optimize workflow and content maintenance. Consider involving non-provider clinical staff more in routine patient education activities. Include more engaging multimedia education materials (e.g., illustrating how modifiable cardiovascular risks lead to heart attacks) to help patients understand and address these factors. | |
| Patient-specific Activities[14] | During Office Visit[18] | Encounter Closing[23] | Additional education and Checkout | 1. Provide detailed guidance on diet, training on use of devices such as glucometers, home blood pressure monitors, inhalers (e.g., by dietician, nurse educator, etc.)<br>2. Schedule next office visit/referrals, schedule appropriate labs or imaging studies - address prior authorization | Provider | * Problem-specific order sets, including built in information on quality measures (ideally with ability to document patient exclusions for measure-indicated interventions ), guidance on investigating and managing complex situations (e.g., medication escalation and evaluation for secondary causes in resistant hypertension), drug dosage adjustments for renal impairment<br>* Order checking for drug contraindications<br>* Specialist/consult communications (e.g., smart consultation forms for patients with multi-drug-resistant HTN)<br>* Interruptive alerting used only as a 'safety net' supporting other intervention approaches; especially avoiding interruptive alerting about needed orders outside ordering workflow (e.g., interruptive alert on chart open about overdue mammogram ), or after the order session is closed | * Problem-specific order sets, including built in information on quality measures (ideally with ability to document patient exclusions for measure-indicated interventions ), guidance on investigating and managing complex situations (e.g., medication escalation and evaluation for secondary causes in resistant hypertension), drug dosage adjustments for renal impairment<br>* Order checking for drug contraindications<br>* Specialist/consult communications (e.g., smart consultation forms for patients with multi-drug-resistant HTN)<br>* Interruptive alerting used only as a 'safety net' supporting other intervention approaches; especially avoiding interruptive alerting about needed orders outside ordering workflow (e.g., interruptive alert on chart open about overdue mammogram ), or after the order session is closed | * Problem-specific order sets, including built in information on quality measures (ideally with ability to document patient exclusions for measure-indicated interventions ), guidance on investigating and managing complex situations (e.g., medication escalation and evaluation for secondary causes in resistant hypertension), drug dosage adjustments for renal impairment ; * Order checking for drug contraindications; * Specialist/consult communications (e.g., smart consultation forms for patients with multi-drug-resistant HTN); * Interruptive alerting used only as a 'safety net' supporting other intervention approaches; especially avoiding interruptive alerting about needed orders outside ordering workflow (e.g., interruptive alert on chart open about overdue mammogram ), or after the order session is closed | During ordering process within patient-provider encounter | Order sets and related tools combine evidence-based guidance and clinical best practice to optimize practice workflow | Make it as easy as possible to do the right thing - e.g., safely order all indicated interventions. | |

| | | Optimal State [a] (sample activities to optimize | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| Patient-specific Activities[14] | After Patient Leaves Office[24] | Ensure care plan is executed appropriately | 1. Follow-up (via various methods as appropriate) to verify patient understanding and adherence to treatment plan (e.g., medications and appointments)<br>2. Verify completion of scheduled lab/consult/imaging studies and that results are entered in EHR; respond appropriately to abnormals | | Provider/clinical staff, patient | Similar to 'Not visit related' row above | Similar to 'Not visit related' row above | Similar to 'Not visit related' row above | Similar to 'Not visit related' row above | | | |
| Population-oriented Activities[25] | Outside Patient-specific Encounters[26] | Identify/address care gaps across the patient panel | 1. Identify evidence-based guidelines related to target and build order sets, documentation templates, flowsheets, etc. accordingly - collaborating with EHR vendor, REC, others as appropriate<br>2. Use patient lists generated from registry to identify prevention and chronic care management gaps for individual patients<br>3. Address gaps, e.g., contact patients overdue for indicated visits/interventions and arrange appropriate action | Build needed capabilities for addressing gaps broadly across patients. For example: new/enhanced activities such as group visits for diabetes patients, more robust materials such as diet/exercise/BP/ weight logs and plans for weight/HTN/DM management. Understand/addre ss implications of Payer condition management outreach to patients | Care manager, patients, payers | See 'Examples of Care Activities' cell in this row. For example, identify and address patients whose blood pressure remains above the target threshold ( e.g., >=140/90) through interventions such as calling the patient in for a follow-up visit to seek causes for resistant hypertension (see Documentation row above) escalate medications, intensify approaches outlined in 'Not visit related' and Patient Education' rows above, etc. | Using a manual registry/log to identify HTN patients, and the EHR to pull the records of the patients, see when the last visits were, and if their BP was in control or not. Then using the EHR to create an action list for the care manager to call/email/mail/text the patients to come in for an appointment. | Using a manual registry/log to identify HTN patients, and the EHR to pull the records of the patients, see when the last visits were, and if their BP was in control or not. Then using the EHR to create an action list for the care manager to call/email/mail/text the patients to come in for an appointment. | | Established workflows to create and maintain the manual registry/log. Established workflows/protocols for the 'care manager' role to conduct the data review and patient outreach (identify patient contact preferences). | Try to deeply automate and integrate these separate steps (manual registry/log, EHR data extraction, etc.) by procuring/customizing a registry, and using it to drive the data extraction and creation/presentation of patient lists (e.g., highlighting items needing attention) enhance workflows driving these processes. | Must carefully validate that all the data in the registry is always reliably accurate. Will need to work closely with vendor on these processes. |

| | Optimal State [a] (sample activities to optimize | | | Current State [b] (Your current CDS/QI configuration) | | | | | | Potential Enhancements [c] | |
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| | | | | Who?[6] (people) | What?[7] (information) | Where?[8] (channels) | How?[9] (Formats) | When?[10] (Workflow) | | | |
| Foundational Work[27] Broadly Supporting Care Activities | Ensure infrastructure, capabilities and other essentials for the target are in place | Staff training, EHR/Health IT tools, policies and procedures, and other essentials in place to support excellent performance on the target | These capacities and tools underpin current performance on the target and usually need to be refined to support enhancements identified in earlier rows of this worksheet | | | | | | | | |

**Comments / Notes**

*Target Comment: List the specific care process/outcome measure on which your improvement effort is focused. Consider including both the narrative measure description and the targeted improvement goal. For Meaningful Use Stage 2 measures, consider listing the CMS eMeasure number and/or the NQF measure number, as well as the measure domain.

**Current Performance on Target. Comment: Document information available about your current performance on the target measure.

***Comment: BP< 140/90 in 85% of patients within 2 years (CMS eMeasure 165v1, NQF #0018, Domain= Clinical Process/ Effectiveness) Process/Effectiveness)

****Comment: As of July 1, 2013 performance on this measure is 68%

a Optimal State. Comment: Use this section to describe activities that should occur to optimize results related to the target for both patients and the practice. Edit the content below to reflect your practice

b Current State. Comment: Use this section to describe how information relevant to the improvement target currently is flowing through the practice

c Potential Enhancements. Comment: Use this section to describe information flow enhancements that could help to achieve targeted improvements

1 Decision Support Opportunity. Comment: Phases in the care of individual patients - and a organization's full patient panel - where information flow can be enhanced to improve clinical decisions, actions and outcomes

2 Care Activities Comment: Types of tasks that support high performance on the improvement target

3 Examples of Care Activities Comment: More specific task examples than the broader activities listed in previous column

4 Notes Comment: Use this column to record additional information about achieving the desired state, such as where the activity typically occurs

5 CDS 5 Rights Comment: Use these columns to document the 5 key information flow dimensions (see roll-over text for each box below for more details). Merge cells in each row as needed to clarify/simplify the description, but make sure each of the 5 dimensions is considered

6 Who? People Comment: Who is receiving/providing the information? For example: Doctors; Nurses; Pharmacists; Other care team members/staff; Patients! (and their caregivers)

7 What (Information) Comment: What information is being exchanged/processed?

8 Where? (channels) Comment: How is the information getting to/from the targeted individual? For example, via:; EHR modules (ordering, documentation, results review); Registries; Clinician/Patient portals; Mobile devices (patient and clinician); Smart home devices (BP/blood sugar monitors, etc.); Paper (e.g., patient handout);

9 How? Formats. Comment: In what format is the information flowing? For example: ; Documentation Templates ; Order sets; Reference information; Patient Lists/Provider Scorecards; Flow sheets and Graphs; Dashboards; Alerts and reminders;

10 When? (Workflow) Comment: When exactly in the workflow is the information flowing?

11 Notes. Comment: Use this column to document key factors related to how you achieved this information flow; focus particularly on factors that might influence your selection of potential enhancements

12 Proposed Enhancements (locally or by EHR vendor). Comment: Specific opportunities to improve upon 'Current State' information flow, and related care decisions, actions and outcomes. After considering these for each step, prioritize and execute highest value enhancements.

13 Proposed Enhancements, Notes. Comment: Considerations for implementing the proposed enhancements

14 Patient Specific Activities. Comment: These rows address interactions between the practice and individual patients

15 Not Visit Related. Comment: Not related to a patient's visit to the office/clinic or just before or after that visit

16 Before Patient Comes to Office. Comment: After a patient has an office visit scheduled but before they arrive for that appointment

17 Daily Care Team Huddle. Comment: Provider team preparations for all patient visits scheduled for the day

18 During Office Visit. Comment: Events during individual patient office visit. Visit components are listed in the next column

19 Check-In. Comment: Interactions between patient and front office staff that initiate the office visit

20 Waiting. Comment: After patient checks in, before encounter with clinical team

21 Rooming. Comment: Preparation for provider encounter

22 Provider Encounter. Comment: Main encounter with Provider

23 Encounter Closing. Comment: After main provider encounter, but before patient leaves the office

24 After Patient Leaves Office. Comment: The particular encounter has concluded and the patient is no longer in the office

25 Population-oriented Activities. Comment: How the practice monitors and manages health status across all patients for which it is responsible

26 Outside Patient-specific Encounters. Comment: Activities focused on the entire patient panel

27 Foundational Work. Comment: How the practice ensures it has the capabilities and infrastructure to be successful with the patient-focused and population management activities