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

Electronic Health Record (EHR) Quality Measure Dataflow Tool #1

Understanding CQM Data Documentation in Your Practice

Provided By:
The National Learning Consortium (NLC)

Developed By:
Health Information Technology Research Center (HITRC)

The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. 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. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.

NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs (*REC*, *Beacon*, *State HIE*) and through the *Health Information Technology Research Center (HITRC)* Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

Dataflow Tool #1 (Understanding CQM Data Documentation in Your Practice) and Dataflow Tool #2 (Creating a CQM Data Documentation Plan for Your Practice) are intended to help providers think about and plan for Clinical Quality Measure (CQM) documentation. This worksheet – for Tool #1 – is meant to be used by providers who are thinking about the who, what, where, and when of CQM data documentation. It can be used to determine how data elements that are captured before, during, or after the patient visit are entered into the EHR. It also includes discussion questions and links to other tools that can help providers think about how to modify their workflow, training, computer terminal locations, and CQM data documentation responsibilities as needed. This worksheet is meant to augment, not replace, other workflow analysis that the provider might be doing for EHR implementation.

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Understanding Clinical Quality Measure (CQM) Data Documentation in Your Practice

Date Completed: _____

For each of your selected Clinical Quality Measures (CQMs) use this worksheet to determine how the data elements needed to calculate that CQM flow from the point of capture (before, during, or after the patient visit) by your staff into your EHR.

CQM(s) for this worksheet:

_____
_____
_____

Data elements required for CQM(s):

_____

In the table on the following page, describe what, where, and when each staff member in your practice currently documents or will document each of the data elements required for this CQM. The columns in the table below include the following topics:

- **Role:** May be to collect data on forms, enter data into the computer, supervise the overall data collection process, check the data for accuracy, or other roles. Fill in a name if you choose. Consider how different clinical teams in your practice may organize staff roles in different ways.
- **What:** What data elements does or will this staff member document in the EHR for this CQM? (May be more than one data element or none at all.)
- **Where:** Where in the practice does this staff member document these data elements for the EHR? (May be more than one place.) Is there a hand-off of data to another person, such as a form or checklist that goes from one person to another and is then entered into the EHR?
- **When:** At what point in the process of the patient visit does this staff member complete their documentation of these data elements for the EHR? Is it before the patient visit, during the visit, or after the visit. Is it at the end of the day when all of the patient visits are over and there is more time for entering data in the EHR? (May also be more than one time period.)

As needed revise this worksheet by shortening or expanding it for the needs of your practice. For example, some types of staff listed below may not be involved in your practice. Or, expand the list of staff by adding additional types of staff or names of staff members.

QUALITY MEASURE DATA DOCUMENTATION ROLES AND TASKS BY STAFF MEMBER

CQM for this Worksheet: _____

Complete 1 row for each role. Some may share roles: Physician, Physician Assistant, Nurse Practitioner, Nurse, Medical Assistant, Office Staff, Billing Staff, etc.	What data elements for this CQM are documented by this staff member?	Where in the practice are the data documented for the EHR by this staff member?	When during a patient visit or a day are the data documented by this staff member?

Source: Adapted from DOQ-IT. "A Systems Approach to Operational Redesign Workbook." MassPro. Web. 27 Mar. 2011. <http://www.masspro.org/docs/tools/DOQIT%20WB%20for%20WEB.pdf>

QUESTIONS FOR DISCUSSION AMONG PRACTICE STAFF MEMBERS

- Do all staff with data documentation responsibilities for this CQM's data elements have access to EHR terminals or computer workstations?
- Are EHR terminals or computer workstations currently placed in locations that make documentation in the EHR easy – for example, right after taking a blood pressure reading?

- Can you consider shifting documentation responsibilities from one staff member to another, to create efficiencies in staff workloads or to better ensure data accuracy?

Consider the following related tools that may assist your practice staff with completing this worksheet and addressing these discussion questions. These tools are available for free, through the Stratis Health Regional Extension Center at http://www.stratishealth.org/expertise/healthit/clinics/clinictoolkit.html[1]

- Optimization Strategies for Point of Care Charting (Section 2.2).[2] This 3-page resource describes several strategies that a practice can use to determine where staff are encountering roadblocks to documenting data elements for CQMs.
- Training Plan (Section 2.1).[3] This 4-page document offers a template for creating a training plan for all staff, along with special considerations for training staff and types of training that could be applied to using EHRs for CQM documentation
- Space Planning (Section 2.1).[4] When using the table above to identify where data elements are documented, refer to this 5-page space planning tool. This tool includes more detail on space considerations for a wide range of equipment that support EHR implementation. It also provides an illustrated diagram that can be used to map patient flow and equipment through an office.

[1] "Clinics - HIT." *Stratis Health*. Stratis Health, 2010. Web. 27 Mar. 2011. <http://www.stratishealth.org/expertise/healthit/clinics/>.

[2] MargretA Consulting LLC. "Optimization Strategies for Point of Care Charting." *Stratis Health*. Stratis Health, 2009. Web. 27 March 2011. <http://www.stratishealth.org/documents/HITToolkitclinic/2.Utilize/2.2Effective%20Use/2.2Optimization_Strategies_for_POC_Charting.doc>.

[3] MargretA Consulting LLC. "Training Plan." *Stratis Health*. Stratis Health, 2009. Web. 27 Mar. 2011. <http://www.stratishealth.org/documents/HITToolkitclinic/2.Utilize/2.1Implement/2.1Training_Plan.doc>.

[4] MargretA Consulting LLC. "Space Planning." *Stratis Health*. Stratis Health, 2009. Web. 27 Mar. 2011. <http://www.stratishealth.org/documents/HITToolkitclinic/2.Utilize/2.1Implement/2.1Space_Planning.doc>.