

		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' 2. Provide supplemental educational materials to help them understand and manage their condition	Consider patient language, culture and health literacy in providing education; e.g. using engaging material in the appropriate language, reading level, and with diagrams/videos as appropriate to optimize value									
	Encounter Closing	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.) 2. Schedule next office visit/referrals, schedule appropriate labs or imaging studies - address prior authorization										
	After Patient Leaves Office	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) 2. Verify completion of scheduled lab/consult/imaging studies and that results are entered in EHR; respond appropriately to abnormalities										
Population-oriented Activities	Outside Patient-specific Encounters	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 2. Use patient lists generated from registry to identify prevention and chronic care management gaps for individual patients 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/address implications of Payer condition management outreach to patients									

Acknowledgements This worksheet version is developed under the ONC CDS4MU project to support the National Learning Consortium, building on work of the CDS/PI Collaborative (supported by the California Healthcare Foundation), which builds, in turn, on the HIMSS CDS Guidebook Series.

Links: [ONC Clinical Decision Support for Meaningful Use \(CDS4MU\) Project](#)
[CDS Collaborative for Performance Improvement](#)
[California HealthCare Foundation](#)
[HIMSS Guidebook Series](#)