

Detailed Ambulatory CDS/QI Worksheet [Sample data for blood pressure control in rollover text for blank cells]

Target =	
Current Performance on Target =	

		Optimal State (sample activities to optimize performance)			Current State (Your current CDS/QI configuration)					Potential Enhancements			
Decision Support Opportunity		Care Activities	Examples of Care Activities	Notes	CDS 5 Rights					Notes	Proposed Enhancements (locally or by EHR vendor)	Notes	
					Who? (people)	What? (information)	Where? (channels)	How? (Formats)	When? (Workflow)				
Patient-specific Activities	Not Visit-Related	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									
	Before Patient Comes to Office	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									
	Daily Care Team Huddle	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 2. Preparing for care transitions 3. Planning/scheduling tests/treatments needed during each visit	Support staff can prepare orders for needed interventions during these discussions with the provider									
	During Office Visit	Check-in	Review/verify/update patient information	1. Review insurance information to help determine formularies/coverage to minimize patient out-of pocket expenses and enhance adherence 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.								
		Waiting	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								
		Rooming	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).								
		Provider Encounter	History and Physical	1. Review and discuss previous encounter records/consultation notes/medications/test results/patient-submitted information (e.g., health status forms) 2. Discuss symptoms, adherence/barriers to jointly developed care plan, response to treatment, other patient issues 3. Provider physical exam, including assessing key target-related findings									
			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								
			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									
	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									
Procedures	In-office immunizations, lab testing, other clinical interventions - especially those related to target												

			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

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Links:

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