Blueprint CMP Implementation Guide for Practice Facilitators

Systematic Patient Reminders of Tests Due

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Quick Start Guide

A summary of the essential steps to set up and enhance post-visit follow up by non-clinicians for improved diabetes care management. Click here for guide

Practice Facilitator Guide

Purpose of This Guide

The Blueprint Care Management Process (CMP) Guides for Practice Facilitators are designed to assist practice improvement facilitators (PIFs) and primary care providers (PCPs) in implementing key CMPs shown to contribute to improved care quality and health outcomes for patients living with diabetes.

How to Use This Guide

The Blueprint CMP guides can be used by various stakeholders in the implementation of key CMPs in primary care. Practice facilitation program directors can use these guides **to develop training** to introduce PIFs to key CMPs. PIFs can utilize the guides **as a roadmap while working with practices**, drawing on the content and adapting to the needs of the specific practices with which they are working to implement or enhance the target CMP. Finally, PCPs and their quality improvement (QI) teams can consult these guides to assist them in planning implementation or improvement of different CMPs at their practice.

CMP Description

Systems for finding and reminding patients due for testing help practices prompt patients to take proactive steps to complete necessary testing and manage their health. Unlike recall systems which focus on notifying patients of abnormal results or missed appointments, reminders for tests due are about keeping patients on track with regular recommended preventive care and health maintenance tests. For individuals living with diabetes, this includes routine A1C testing, lipid testing, kidney function monitoring, annual comprehensive eye exams, and flu and covid vaccinations.

The term **systematic** refers to a structured, organized, and consistent approach to delivering reminders. It means the process of sending reminders is done in a planned, repeatable, and

methodical way, often integrated into the practice's workflow or technology systems. Systematic reminders are not ad-hoc or random but are designed to ensure all patients due for preventive services and tests are identified and consistently reminded when their tests are due based on clinical data and established protocols—reducing the likelihood of gaps in care.

Systematic reminder systems can be **fully automated, manual, or a hybrid** process that combines both automation and manual tracking and reminder delivery. A fourth option, which may or may not be available to the practices you are working with, is **outsourcing reminders** to their ACO, IPA, or health plans.

If this is your first time helping a PCP implement or enhance a patient reminder system, this demo video by eClinicalWorks provides a good example of the types of functionalities that are available in EHR-based reminder systems. Or you can run a search for systematic patient reminders of tests due on your own and find other sample videos.

Rationale for Selection of CMP

Systematic patient reminders for tests due was selected as a Blueprint CMP for improving diabetes care quality and outcomes based on the findings of the UNITED study. The study identified three out of 64 CMPs evaluated as contributing to the majority of the improved care quality and health outcomes for patients living with diabetes.

These high-impact CMPs were:

1. A systematic approach to identify and remind patients of tests due
2. Guideline-based clinician reminders for preventive services during a clinic visit
3. After-visit follow-up by a non-clinician

These processes were found to significantly enhance diabetes care quality and outcomes accounting for 47% of the total improvement in overall optimal diabetes care and 68% of the decrease in A1C levels.

> From: Peterson, K. A., Carlin, C. S., Solberg, L. I., Normington, J., & Lock, E. F. (2023). Care management processes important for high-quality diabetes care. *Diabetes Care, 46*(10), 1762–1769. https://doi.org/10.2337/dc22-2372

Benefits of This CMP

The benefits to PCPs and patients of implementing systematic patient reminders for tests include:

- Improved patient completion rates for labs and annual eye exams

- Enhanced quality and content of patient visits
- Improved patient outcomes
- Reduced need for rescheduled appointments and manual reminder calls saving staff time and associated costs

What "Good" Looks Like for This CMP

Case Examples and PEARLS

As a practice facilitator or a primary care provider implementing or enhancing CMPs in a practice, knowing what "good" looks like can help you implement CMPs more effectively and efficiently, and can give you helpful ideas for making enhancements. Pearls are shorter real-world examples, submitted by practice facilitators and primary care providers as "helpful hints and tips" for implementing and using the CMP. Click the link below to review examples and tips that have been submitted or to submit your own.

https://www.lanetpbrn.net/patient-reminders

Key Tasks

Engage leadership

A first step in implementing a new CMP at a practice is always to engage practice leadership to confirm their buy-in, determine their goals for the CMP, and identify resources the practice has (and will need) to implement the new process.

Meet with leadership to review these issues, and to identify who will be the "champion" for the CMP at the practice. This individual should have sufficient authority to be able to assure implementation of the processes at the practice, and a personal interest or passion for the CMP or the practice's goals for implementing it.

Form a CMP project team

Before embarking on this work with a practice, be sure they have identified the person or team who can make these decisions and carry out this work. This may be a special project team created by the practice for purposes of implementing or enhancing this CMP, the practice's QI team, or in a small practice, the office manager in consultation with the practice owner and lead physician.

Regardless of who or which group is charged with working through these tasks to implement or enhance this CMP, ideally the group involved includes representatives from staff and clinicians

who will be involved in the new or redesigned workflows and can provide input on their design to enhance the effectiveness of these changes.

These individuals are not always obvious, so work with the practice to make sure their voices and ideas are included in the conversations—either directly as a member of a team or through outreach to them for input. For example:

- The front desk clerk or whomever oversees scheduling
- MAs who may be charged with educating the patients about reminders
- The front office clerk who will be collecting intake data, updating phone numbers, and filling gaps in this information

Use the Project Team Table in the worksheet section to help the practice think about and select their project team.

Project team table worksheet

Task 1. Assess the current state of the CMP at the practice

Work with the practice to conduct a brief assessment of its "rent state" for sending test reminders for its patients living with diabetes.

Use the Current State Assessment Worksheet for this CMP below with the practice to assess the current state of their patient reminders or create your own tool.

Current State Assessment Worksheet for Patient Reminders

Task 2. Set goals for implementing or enhancing the CMP

The first step in implementing or enhancing any CMP is to clearly define the practice's goals for its adoption or improvements.

Work with the practice to determine their goals for this CMP for their patients living with diabetes.

Use the Goal Sheet below to record the practice's goals and objectives for this CMP, how they will know when they've achieved them, and their timeline.

Goal Sheet for Patient Reminders of Tests Due

Task 3. Assess EHR and HIT systems' patient reminder capabilities & select approach

Step 1. Evaluate the practice EHR and related HIT for automating reminders

Help the practice determine the capabilities of their existing EHR and related systems for delivering automated patient reminders for tests.

Work with the practice to assess the resources they have available for sending patient reminders for tests due. Automating as many of the steps in the reminder process as possible can make sending patient reminders more feasible for practices.

Help the practice assess the capabilities of its EHR and other health information technology (HIT) for automating patient reminders for tests due.

Identify the practice's EHR and HIT systems lead and engage them to assist you and the team in connecting with their vendors and reviewing their systems' capabilities for providing systematic patient reminders for tests due to their focus patients for this CMP.

Use the EHR Assessment Worksheet below for Patient Reminders to conduct an initial informal assessment of their systems.

EHR Assessment for Patient Reminders of Tests Due

Step 2. Assess purchasing a 3rd party service or platform if EHR not sufficient

If the practice's EHR does not support automating patient reminders, work with the practice to evaluate feasibility of purchasing services from a third-party patient-engagement platforms.

If the practice's EHR system does not offer patient reminders for tests, or the module is too costly, work with the practice to evaluate use of a third-party platform.

Many of these platforms integrate with practice EHRs and offer similar functionalities

To generate a list of options, conduct an online search of patient engagement and reminder platforms, and ask other PFs and PCPs in the area what third-party vendors they use and their opinion of them. You can also search online or use an AI search tool to help you identify third- party services for them to consider.

Worksheet for Evaluating 3rd Party Platforms for Automating Patient Reminders

Step 3. Explore hybrid or manual processes if EHR and 3rd party options not feasible

If existing EHR/HIT systems are not adequate and purchasing 3rd party vendor services is not feasible, work with the practice to develop a hybrid or manual reminder process

If the practice's current IT systems are not useful for automating patient reminders, and leadership is not ready to consider supplementing functionality with a 3rd party service, work with the practice to design a hybrid reminder approach – that leverages the digital automated processes they do have available to them and combines it with manual workflows.

Two online resources that you can use to get ideas for manual or hybrid patient reminder workflow are:

- Client (Patient) Reminder Planning Guide
- Tracking and Reminder Systems

Use the worksheet below to help the practice brainstorm hybrid and manual reminder workflows.

Brainstorming Sheet for Hybrid and Manual Reminder Workflows

Task 4. Select and design patient reminders of tests due

Step 1. Help the practice determine the criteria or set of standards it will use to select reminders.

Help the practice decide the approach it will use for selecting patient reminders of tests due to send. **The American Diabetes Association** recommends the following base set of patient reminders for improving outcomes for patients living with T2D.

A1c
Lipid test
Kidney function tests (eGFR, UACR)
Annual comprehensive diabetes eye exam
Self-management resource referrals
Flu vaccination
Covid vaccination

Ask the practice if they would like to start with this set of reminders or use another set of criteria. If they would like to review other criteria, walk through the options below with the practice.

- **Option 1. Tests that align with existing practice resources (for example the capabilities of the reminder system within its EHR).**

The practice might decide to select a "starter set" of reminders based on the functionality available from its EHR or HIT systems or reports it can generate from Population Health Management (PHM) platforms or reports provided by health plans or Independent Physician Associations (IPAs).

This can be a good option for a practice interested in implementing patient reminders but that does not have a lot of band width or resources to develop custom reminders.

- **Option 2. Evidence-based standards of care**.

The practice may opt to select tests due recommended by authoritative bodies like the American Diabetes Association or the U.S. Preventative Services Taskforce Guidelines, or another service.

The ADA's *Standards of Care* is an excellent resource for this. It outlines essential tests such as A1C, lipid profiles, and eye exams that a practice should review for inclusion. Go here to view the Standards: https://professional.diabetes.org/standards-of-care

Another resource to consider using is the U.S. Preventive Services Taskforce Guidelines. Go there to learn more: https://www.uspreventiveservicestaskforce.org/uspstf/

- **Option 3. Required quality metrics**.

Another approach is to align reminders directly with standardized quality metrics the practice reports on and is evaluated on. These may be the Healthcare Effectiveness Data or another related set of measures.

The practice may opt to focus on those metrics where they are performing the lowest, using the reminders as one approach to help them improve their performance.

Consult the Nation Committee for Quality Assurance (NCQA), health plans for the practice or the practice's state health department websites for lists of these measures to review prior to your meeting with the practice.

The practice will likely know which measures are the most relevant to them and which they are underperforming on.

Examples of measures to consider as basis for patient reminders

HEDIS Quality Metrics for Type 2 Diabetes (T2D) Management

1. **HBD:** Hemoglobin A1c Control for Patients with Diabetes
2. **EED:** Eye Exam for Patients with Diabetes
3. **BPD:** Blood Pressure Control for Patients with Diabetes
4. **NPH:** Medical Attention for Nephropathy
5. **SPD:** Statin Therapy for Patients with Diabetes
6. **CDF:** Screening for Depression and Follow-up Plan
7. **CDC:** Comprehensive Diabetes Care

The NCQA website is: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

And here is an example of a state health department website with information on metrics relevant to practices in California that care for patients with MediCal -California's Managed Care Accountability Set (MCAS): https://www.dhcs.ca.gov/dataandstats/reports/Documents/Managed-Care-Accountability-Set-Reporting-Year-2025.pdf

- **Option 4. Performance on quality measures stratified by Race Ethnicity and Language (REaL) or other equity measures.**

Even if the practice is performing well on relevant HEDIS or related quality metrics, the practice might decide to base its selection of reminders on performance metrics stratified by REaL if they identify disparities in performance.

Use the worksheet below to document the criteria the practice will use to select patient reminders of tests due.

Criteria and Reminder Selection Worksheet

Step 2. Select the specific tests that will generate reminders and design them

Once the practice has selected the criteria it will use, work with them to use this to identify the tests for which it will send patient reminders.

They will also need to:

- define which patients will receive these reminders,

- what factors will exclude patients in these cohorts from receiving a reminder, and
- what action/s will satisfy the reminder
- timing for these reminders
- how often they will be repeated until satisfied.

Use the Design Worksheet below to help the practice define these elements of their patient reminders.

Criteria and Reminder Selection Worksheet

Task 5. Assure structured data is available to generate reminders

Structured data is required in order to generate automated clinical reminders at visit and is also important to manual workflows if the practice is not using its EHR for reminders.

As a next step, work with the practice to evaluate how and where the practice documents the services that will be used to trigger the patient reminders such as comprehensive annual eye exams and foot exams.

If any of these data are captured in free text or recorded in different locations by different providers and staff, these must be revised in order to support patient reminder generation.

Work with the practice to evaluate the type and location of the data that it will use to generate the reminders and develop a plan for ensuring key data are available in structured format and in a consistent single location in the patient record.

For example, if the practice is documenting eye exams in encounter notes, work with them to add eye exam to the template they use for diabetes care, or to their health maintenance section in a manner that it can be recorded in a structured yes/no and date format that can then be incorporated into the EHR reminder algorithm or used to run reports and create patient lists.

You may need to engage the vendor during this process if the practice does not currently have structured data fields to capture data points needed for the reminders.

The completeness and consistency in documentation of key variables used to generate patient reminders is key to their accuracy and ultimate usefulness.

One side note, as AI becomes more available in health IT products, the ability of these systems to automatically capture and translate free text into structured data will increase. Check to see

if these capabilities exist for the HIT systems used by the practice – and confirm their accuracy. This AI based functionality eventually may be a resource for you and the practice at this step.

Worksheet on Availability of Structured Data

Task 6. Modify intake forms to collect patient preferences & SMS consent

Next work with the practice to help them assess their current intake and patient information collection and identify any gaps in information collection that need to be addressed before going live with the reminder system.

Have the practice review the intake information for patients to assure it includes:

Patient opt-in to specific reminder types (appointment, preventive care reminders, tests due)
Patient communication preference(s) (SMS, email, portal, letter, call, other)
Contact information that supports the use of patient-preferred method(s) for reminders
Information about their option to withdraw consent at any time

These data will need to be available in the EHR or third-party platform for use in generating automated reminders that send messages based on patient communication preference.

Be sure to take equity issues into account when thinking through collection of these data and their accuracy.

Patients experiencing social health barriers, such as financial distress or housing insecurity, may have frequent address and phone number changes and intermittent phone service which can affect their ability to receive reminders and impact health equity. The practice will need to pay special attention to any groups experiencing these social health factors.

Use the worksheet below to help the practice assess their current intake forms and process, and identify any additions needed.

Updates to Intake Form: Patient Communication Preference

Task 7. Decide on format and content of messages

Whether the practice is using an automated reminder system from their EHR or related vendor, or implementing a manual reminder system, they will need to decide which modes of communication they want to use for the reminders.

Step 1. Select method/s of delivering the reminders

Help the practice review the options available to them to use, either through their IT system or manually, and determine which are likely to:

- Be most effective with their patient population in terms of ability to reach, motivate, and support the patient to complete their tests
- Align with patient preference and existing practice human and IT resources
- Address inclusion and equity barriers

Reminder methods available to practices include a range of traditional and technology-driven strategies, such as:

- **Phone calls (live):** These are labor intensive but can be one of the most effective reminder methods

- **Auto-dial calls:** Automated calls can reach many patients quickly but are less engaging

- **SMS/text messages:** These are easily accessible by many patients but cellular service providers have restrictions on delivery that will need to navigated
- **Email:** An efficient way to send reminders but some if not many patients may not monitor their email frequently, or may not have access to email

- **Patient portals:** Messages posted on the patient's portal. These can be efficient and easier to track especially if integrated with the practice EHR but adoption of patient portals is low among many patient populations

- **Postcards and letters:** Letters or postcards with reminders. These are useful for patients who prefer more traditional communication methods or lack access to SMS/text messaging or email or have not adopted the use of the patient portal

- **Appointment-driven reminders:** The practice schedules follow-up visits with the patient at check-ups that coincide with when tests are due. Reminder calls to the patient about the upcoming visit are also used to provide patients with reminders of their test due

Other methods of communication include:

- **Mobile health (mHealth) apps**: These may be integrated with EHR systems to send push notifications when tests are due, helping patients stay actively involved in their care

- **Wearable devices:** These include fitness trackers and can remind patients to schedule regular diabetes tests or monitor key health metrics like blood glucose

- **Interactive voice response (IVR) systems:** These enable patients to interact with automated calls, allowing them to confirm or reschedule tests without needing to speak with staff

- **Gamified apps and behavioral nudges:** These can keep patients motivated by rewarding them for completing necessary tests or emphasizing the importance of timely screenings

Use the worksheet below to help the practice select and document the format the practice will use for sending the reminder messages.

Message format and content worksheet

Step 2. *Draft the content of the reminder messages*

If the platform the practice is using allows for customized messages, work with the practice to craft reminder messages. If not, review the available templated message options and confirm they are acceptable to the practice for use. Also, assess the languages and reading levels of the messages and their goodness of fit with the practice's patient population. If there is not a fit, consider Some best practices in content for test reminders are:

- Ensure content includes only essential details and education to encourage patient action
- Must be HIPAA compliant and offer an opt-out option
- Present a call to action, such as a link to schedule an appointment or to add a reminder to their calendar
- Send multiple times if follow-up action is not completed

Some examples of test reminder messages are:

SMS: *You are overdue for your eye exam. Please tap here [online scheduling hyperlink] or call Clinica Medicina Familiar at 222-222-2222 to set up an appointment. Text STOP to OPT OUT of future messaging.*

Email: *Janice, your eye health is important to us. You are overdue for your annual eye exam. Please select the link below for more information and to request an appointment.*

SCHEDULE AN APPOINTMENT [online scheduling hyperlink]

Clinica Medicina Familiar
222-222-2222

Use the worksheet below to help the practice think through each of these elements and create an initial design for their patient reminders.

Message format and content worksheet

Task 8. Assure the new process aligns with HIPAA

Work with the practice to ensure the reminders are HIPAA compliant. In addition to confirming the EHR system or third-party vendor use appropriate encryption and privacy protection processes, the practice will need to ensure their own processes and messages are HIPAA compliant.

1. Inform the patient about test reminders and their option to opt out. The practice should include general information about test reminders and the option to decline or change opt-in status in the:
   - Waiting room
   - Practice's website
   - Intake paperwork when patients first register with the practice

2. Inform the patient of PHI disclosure risk of from e-reminders. Because there is always a risk that someone might see the patient's personal information texted to a patient's phone or email, the practice should warn patients in writing about these risks. A good way to do this is to include this information in the practice's intake forms or opt-in text message to the patient.

3. Obtain patient consent to receive test reminders (particularly via SMS) via opt in. The practice should obtain patient consent to receive reminder messages from the practice. The practice can obtain this at intake, at check in, or through a follow-up or opt-in message campaign.

4. Have the patient verify their identity before displaying message content that includes PHI. Vague reminder messages that do not include PHI do not require identify verification. However, reminders that include more details and incorporate PHI should include a step for the patient to verify their identify before displaying the portion of the message that includes PHI. Examples:

A vague reminder message that may not require patient verification:

Hi there! You have a test due. Visit your patient portal to view it.

A more detailed reminder message that includes PHI. This message type should include patient identity verification before disclosure of PHI-related content:

Message one: *Hi, this is a reminder from (Organization) that you have a test due. To see details, please verify your identity by entering your name and date of birth.*

Message two (once their identity has been verified): *Hi, Tom. This is Dr. Johnson's office reminding you about your annual comprehensive diabetes eye exam that is due by January 10th. Tap here to schedule your eye appointment, request help from our office, or confirm that you have completed your eye exam.*

Use the checklist below to help the practice assess the alignment of its new process with HIPAA requirements.

HIPAA alignment checklist

Task 9. Design workflow for patient reminders

Next, work with the practice to define the workflow(s) for generating, monitoring and responding to the reminders.

Begin by creating a high-level map of the entire process.

Then create detailed process maps for each distinct element of the patient reminder process. Common workflows associated with reminders include:

1. Configuring EHR to deliver reminder (IT staff)
2. Periodic validation of accuracy of reminders (IT or QI staff)
3. Monitoring of receipt/response to reminders (MA, clerk, other)
4. Response to patients requiring escalation (MA, care manager, RN, CHW, other)

Tip: You can use an online process map generator and their AI functions to efficiently create process maps. An example of this is Lucid Charts available at lucidcharts.com – click the AI generator button and enter steps in the workflow and the system will generate a process map that you can then modify, saving you and the practice time.

Another tip: To train a practice on process or workflow mapping you can use this module from the U.S. Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/downloads/ncepcr/pf-modules/process-mapping/story.html

Use the Patient Reminders Roles and Workflows Worksheet to help the practice identify key roles and workflows for the new reminders.

Patient Reminders Roles and Workflows Worksheet

Task 10. Conduct small tests of the reminder processes and refine

Work with the practice to design a "small" test of the changes.

Use the model for improvement and plan-do-study-act cycles (PDSA), or a similar process, to guide the tests.

Use the lessons learned from each test to refine and perfect the process and workflows.

You can use this PDSA worksheet to help the practice design and document a small test of their patient reminder process.

If you would like to provide training to the practice on PDSAs you can use this resource at U.S. AHRQ: https://www.ahrq.gov/downloads/ncepcr/pf-modules/model-pdsa/story.html

You can also conduct a last 10 patients chart audit using this form below

Last 10 patient chart audit form

Or a basic implementation feedback survey

Implementation feedback survey form

Task 11. Create job aids, train staff and implement the new reminder processes

Step 1. Create job aids for key workflows

Work with the practice to refine the workflows they created earlier in the guide based on the lessons learned from the PDSA cycles in the previous task.

Use these to create job aids based on the workflows they created earlier in this Guide.

Use the worksheet below to help them design their job aids.

Job aid creation worksheet

If you want to train the practice to create job aids on their own, you can use the following module from U.S. AHRQ
https://www.ahrq.gov/downloads/ncepcr/pf-modules/scale-improvements/story.html

Step 2. Design and deliver staff and clinician training

Work with the practice to design and deliver training to the staff and clinicians on the new process via group training or using one-to-one elbow support training and launch the reminder process.

Align the training with the job aids and provide staff and clinicians with copies of the job aids.

Training plan worksheet

Step 3. Implement and monitor the new reminder processes.

Work with the practice to implement the patient reminders as well as monitor its implementation as it is implemented.

Work with the office manager or QI team to design an implementation performance and feedback report that the practice can use to monitor adoption of the new workflows by staff and clinicians and gather feedback to continually improve the processes.

Help the practice monitor implementation of the new processes using Last 10 Patient Chart audits or a similar method, and use the results to identify need for additional training, one-on-one elbow support, or modifications to the process to assure eventual full implementation.

Track the "outcomes" of the last 10 patients at the practice who should have received a patient reminder of tests due, or use a random sample. Work with the practice to conduct a root cause analysis of any missed reminder opportunities and use this to improve the implementation.

You can use the Last 10 Patient Audit Data Sheet to gather and analyze these data

Last 10 Patient Audit Data Sheet

To teach a practice to complete a last 10 patient chart audit you can use this training module: https://www.ahrq.gov/downloads/ncepcr/pf-modules/chart-audit/story.html

Implementation monitoring worksheet

Task 12. Design and launch patient education about patient reminders

Educating patients about the purpose of patient reminders is crucial for the success of a reminder system and for patients to have a positive experience with the reminder process. Before the practice implements the reminders, work with the practice to develop scripts, posters, flyers, and other methods of educating patients on the reminder process. Include information about:

- How reminders can improve their experience at the practice and their health
- How the reminders are delivered
- Its privacy features
- The patient's role in responding to the reminders

This education promotes patient engagement and increases their comfort level with the technology, leading to higher acceptance and usage rates. Use the worksheet below to help the practice design a patient education campaign on the reminders.

Work with the practice to develop its patient education program. Use the worksheet below to guide them through this process.

Patient education design worksheet

Task 13. Add the CMP to job descriptions, evaluations, and QI program

Next work with the practice to incorporate the new Patient Reminder workflows and materials into their job descriptions, evaluations, onboarding training, QI program and policies and procedures.

Taking these extra steps helps to "bake" the new process into the practice's operating procedures and contributes to long-term sustainability and also continuous quality improvement.

The practice may want to stop but encourage them to take these few extra steps.

Step 1. Revise job descriptions, staff evaluation protocols and new hire on-boarding training to Include this new or enhanced CMP

A. **Revise job descriptions** for positions with significant responsibilities for the after-visit follow-up workflows to include the addition of these tasks and responsibilities.

Examples of role updates on job descriptions:

- MAs: Conduct phone outreach to patients living with diabetes with A1C over 9 to check on medication adherence and SDOH.

- Care coordinators: Conduct follow-up with higher-risk people living with diabetes and with A1Cs equal to or greater than 9 to check on completion of referrals and tests due.

B. **Add performance criteria and metrics to quarterly and end-of-year evaluation protocols** for roles involved in patient reminder processes.

Examples of updates to staff evaluations:

- MA: Completed target 10 follow-up calls per week
- Care Coordinator: Completed follow-up outreach for referral navigation with at least 80% of patients requiring follow-up

C. **Incorporate the job aids and staff training on the CMPs into new staff onboarding** for roles that will be involved in the process.

These revisions not only clarify expectations and help institutionalize the new process at the practice, they ensure accountability, helping the practice build a cohesive approach to follow-up.

Use the worksheets below to help the practice made additions to their job descritions, evaluation protocols and onboarding process.

Job description additions worksheet
Staff evaluation protocol additions worksheet
New hire training additions worksheet

Step 2. Incorporate metrics to monitor and improve the CMP to the practice's QI program

As with any improvement you are working with a practice to implement (or enhance), select a few key metrics that align with their QI objectives that can be tracked as part of their routine QI activities before you complete your work on after visit follow-up.

These steps will help embed the follow-up activities into daily operations, support staff consistency, and drive measurable improvements in patient care outcomes.

Metrics to consider monitoring might include:

- # of patients eligible for after-visit follow up process
- # of attempts per patient for follow up process
- # status of follow-up effort (received, declined, unable to reach, etc)
- Type of support provided
- # of patients requiring escalation
- Average number of minutes spent per follow-up cycle
- Impact on patient satisfaction
- Impact on patient care gap closure

Use the worksheet to prepare recommendations to the practice QI team to identify and track performance metrics associated with after-visit follow-up

Recommendations for the practice QI plan worksheet

Step 3. Add description of CMP (using these worksheets) to the practice policies and procedures manual

As a final step, the practice should update its policies and procedures manual or file to include this new CMP.

The practice can use the worksheets they completed as part of this Blueprint Guide as an informal P & P document or rewrite them into a formal P & P to include in their Standard Operating Procedures manual.

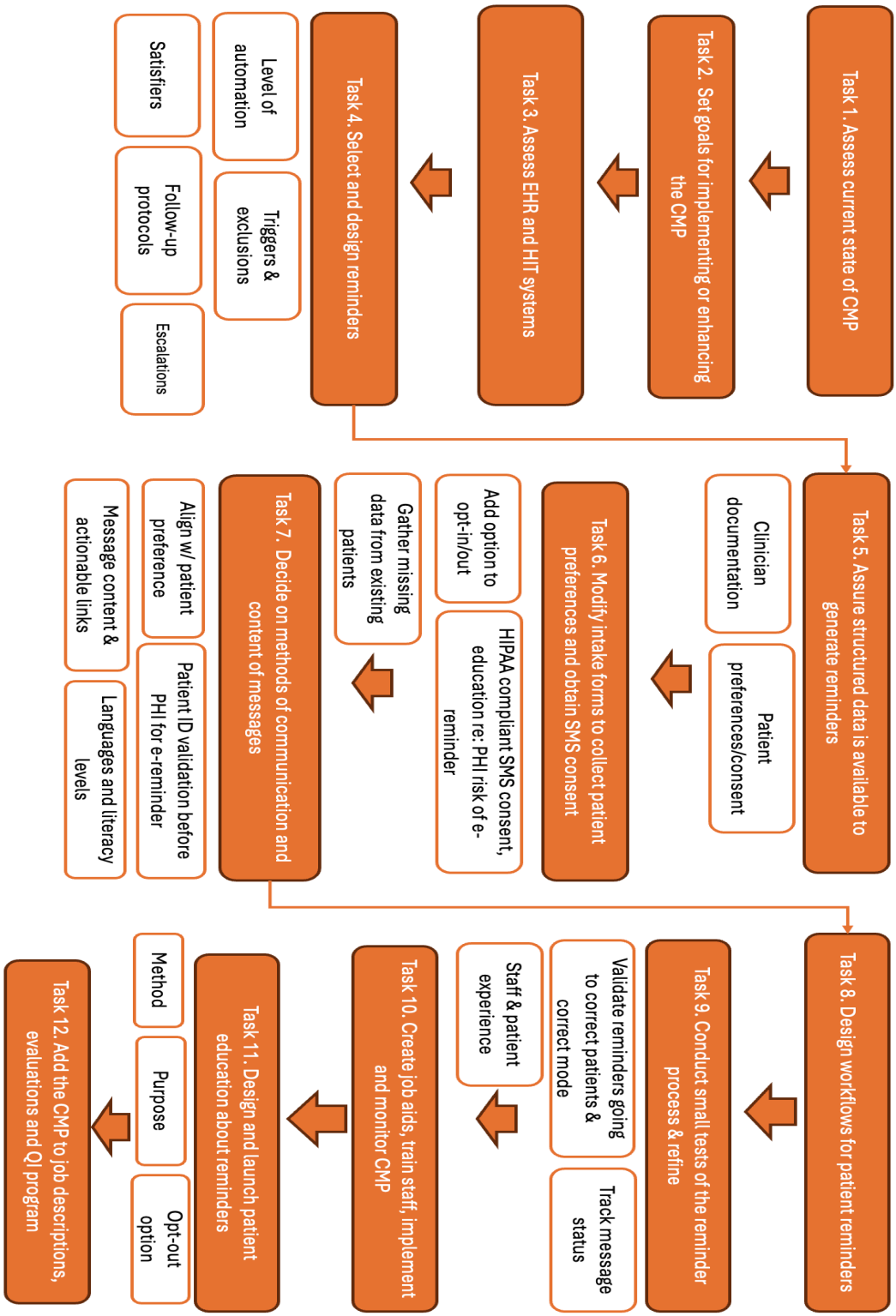
A formal P & P document might include:

- Goals

- Purpose
- Target populations
- Reminder types, methods, and timing
- Methods of delivery
- Workflows
- Performance metrics
- Alignment with HIPAA and any relevant billing regulations

Quick Start

(return)



Worksheets

Project Team Formation Worksheet

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Practice:
Date:
Participating:

Name	Role in Practice	Contact Information
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

1. Is there someone with experience in this area at the practice who should be included on this team?

2. Whose workflow will be impacted by patient reminders? Do we have a representative from each position/role that will be involved in this process on the team?

3. Do we know any PCPs that have excellent or "exemplary" patient reminder processes in place that we can learn from?

Summary and Decisions

To dos:

Task	Date due	Responsible
1.		
2.		
3.		

(go to next task)

Current State Assessment of the CMP Patient Reminders of Tests Due

(return)

Practice:
Date:
Participating:

Question	Response
1. Does the practice currently provide test due reminders to patients?	☐ Yes ☐ No ☐ Don't Know
If you answered YES to question 1, complete questions 2-10. If you answered NO skip to question 11 2. If yes, what methods does the practice use to do this?	☐ Pre-visit prep with reminder delivered: ☐ Before visit by:_____ ☐ At visit by:_____ ☐ Automated reminders sent outside of visit by:_____ ☐ Manual reminders sent outside of visit by:_____
3. How satisfied are clinicians and staff with the patient reminder of tests due process? (1=not at all satisfied) to 10 (very satisfied)	1 2 3 4 5 6 7 8 9 10
3A. What would it take for them to rate it a 10?	(Describe potential changes or improvements)
3B. How satisfied are patients with the reminders for tests due they receive outside of the visit? (1=not at all satisfied) to 10 (very satisfied)	1 2 3 4 5 6 7 8 9 10
4. Which patients living with diabetes are eligible to receive reminders for tests due?	Describe: _____ Any Exclusion criteria ?(Describe)_____ (E.g., all patients with diabetes, high-risk patients only)
5. What method do you use to provide patients with reminders of tests due at point of care?	☐ EHR. Name:_____ ☐ Third-party service. Name:_____ ☐ Hybrid process (part manual part electronic) ☐ Manual process ☐ Other: ☐ We don't do this

6. What system do you use to send patients' reminders of tests due outside of the visit?	☐ EHR. Name:_____ ☐ Third-party service. Name:_____ ☐ Manual process ☐ Other ☐ We don't do this
7. What methods of communication are used for reminder/s outside of visit? (Check all that apply.)	☐ Phone calls ☐ Text messages ☐ Emails ☐ Patient portal notifications ☐ Postal letters or cards ☐ Test-linked visit scheduling ☐ Other (specify):_____
8. Which tests does the practice generate patient reminders for? (Check all that apply)	☐ A1C testing ☐ Lipid screening ☐ Kidney function testing ☐ Diabetes-related eye exams ☐ Flu vaccination ☐ Covid vaccination ☐ Other (specify):_____
9. What is the content of the messages? (check all that apply)	☐ Customized ☐ System template ☐ Multiple languages:_____ ☐ Actionable link ☐ Multi-gated validation process before PHI
Is there a dashboard available for monitoring the status of outside of visit patient reminders?	☐ Yes. Describe:_____ ☐ No
Who oversees the reminder process?	At visit: _____ Outside of visit: _____
Is the status of reminders sent outside of visit recorded in the patient's record?	☐ Yes. Describe:_____ ☐ No
Are patients instructed about "tests-due" reminders and their purpose.	☐ Yes. Describe:_____ ☐ No
Is patient consent to receive tests-due reminders outside the visit obtained?	☐ Yes. Describe:_____ ☐ No (e.g., during registration, through patient portal)
Are patient preferences for reminder communication methods (SMS, email, phone, letter, other) collected and recorded?	☐ Yes. Describe:_____ ☐ No (e.g., patient forms at intake, EHR settings)

Summary and Decisions

To dos:

Task	Date due	Responsible
1.		
2.		
3.		

(Go to next task)

Goal Sheet: Patient Reminders of Tests Due

(return)

Practice:
Date:
Participating:

1. Why do we want to implement Patient Reminders for Tests Due at our practice?

2. What are our specific objectives for implementing this CMP? Ex: Implement basic set of patient reminders recommended by ADA for all adult patients living with T2D in two languages

Objective 1.
Objective 2.
Objective 3.

3. What specific measurable outcomes do we want to achieve with each/all reminders and how will we know when we've achieved these outcomes?

Specific Tests Due Reminder	Desired short-term outcome	Desired long-term outcome	Ways we will measure and know we've accomplished this
1.			
2.			
3.			
4.			
5.			
6.			

4. How does implementing patient reminders align with or compete with our top three practice priorities right now?

Overall practice priorities right now	How does implementing patient reminders align with this priority?	How does implementing practice reminders compete with this priority?
1.		
2.		
3.		

If there are areas of competition, how will we address/resolve these?

5. What timeline is our timeline for implementing Patient Reminders of Tests Due?

Summary and Decisions

To dos:

Task	Date due	Responsible
1.		
2.		
3.		

(go to next task)

Informal EHR/IT System Assessment for Patient Reminders

(return)

Practice:
Date:
Participating:

1A. Does our EHR have functionalities we can use to automate/support Patient Reminders of Tests Due

Name of EHR:_____

- ☐ Yes
- ☐ No
- ☐ Don't know

1B. Check the functionalities the EHR has

- ☐ Automated patient reminders of tests due for basic diabetes related items (A1C, lipids, kidney health, eye exam, flu vaccine, covid vaccine, self-management services)
- ☐ Automated reminders for scheduled appointments (to possibly leverage if needed)
- ☐ Message formats
  - ☐ Email
  - ☐ SMS
  - ☐ Postal Letter
  - ☐ Automated call
  - ☐ Call list for live call
  - ☐ Portal message
  - ☐ Phone app reminder
  - ☐ Other:_____
- ☐ Ability to send messages in multiple languages
- ☐ Customizable message templates
- ☐ Ability to put actionable links in messages
- ☐ Recipient validation before displaying PHI
- ☐ Ability to create customized cohorts to receive the reminders
- ☐ Ability to customize satisfiers for reminders
- ☐ Ability to customize timing and number of reminders sent
- ☐ Report/dashboard for reviewing the status of reminders sent
- ☐ Automatic documentation in patient record of status of reminders

1C. Is this functionality included in our current subscription/license agreement with the EHR?

- ☐ Yes
- ☐ No
- ☐ Don't know

If no, what is cost?:_____

2A. Do other HIT systems in the practice have these functionalities?

Name/type of system:_____

- ☐ Yes
- ☐ No
- ☐ Don't know

2B. What functions does _____ system have?

- ☐ Automated patient reminders of tests due for basic diabetes related items (A1C, lipids, kidney health, eye exam, flu vaccine, covid vaccine, self-management services)
- ☐ Automated reminders for scheduled appointments (to possibly leverage if needed)
- ☐ Message formats
  - ☐ Email
  - ☐ SMS
  - ☐ Postal Letter
  - ☐ Automated call
  - ☐ Call list for live call
  - ☐ Portal message
  - ☐ Phone app reminder
  - ☐ Other:_____
- ☐ Customizable message templates
- ☐ Ability to send messages in multiple languages
- ☐ Ability to put actionable links in messages
- ☐ Recipient validation before displaying PHI
- ☐ Ability to create customized cohorts to receive the reminders
- ☐ Ability to customize satisfiers for reminders
- ☐ Ability to customize timing and number of reminders sent
- ☐ Report/dashboard for reviewing the status of reminders sent
- ☐ Automatic documentation in patient record of status of reminders

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(go to next task)

Worksheet for Evaluating 3rd Party Platforms for Automating Patient Reminders

(return)

Practice:
Date:
Participating:

Platform name	Description of "tests due" reminder	Description of other capabilities	Costs	Additional comments	Vendor contact
1.					
2.					
3.					
4.					

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(return to next step)

Brainstorming Sheet for Hybrid and Manual Reminder Workflows

(return)

Practice:
Date:
Participating:

1. What events is the practice currently sending patient reminders to patients for?

- ☐ Appointments:_____
- ☐ Other:_____
- ☐ None (skip to #5)

2. What process do we use to send these reminders?

- ☐ Automated through the EHR another HIT system
- ☐ Hybrid (combines automated actions and manual)
- ☐ Manual (entirely manual)

Describe process:

3. Can we add patient reminders for tests due to these workflows?

- ☐ Yes
- ☐ No (skip to #5)
- ☐ Don't know

4. If yes, describe how we can re-design or leverage these existing workflows to send patient reminders for tests due:

5. What is a possible workflow for hybrid or manual patient reminders for tests due?

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(return to next step)

Criteria and Reminder Selection Worksheet

(return)

Practice:
Date:
Participating:

1. Criteria we will use to select patient reminders of tests due

Select	Criteria
☐	ADA's starter set of recommended reminders for primary care
☐	Tests that are already available in our EHR/HIT system or 3rd party service we are contracting with
☐	Evidence-based standards of care (e.g., ADA Standards of Care, U.S. Preventive Services Taskforce Guidelines)
☐	Required quality metrics (e.g., HEDIS measures for Type 2 Diabetes management, MCAS metrics)
☐	Performance on quality measures stratified by Race, Ethnicity, and Language (REaL) or other equity measures
☐	Other:_____

(return)

2. Design

Test/Preventive Service	Patient eligibility	Exclusions	Trigger	Timing	Repeat schedule	Resolution	Escalation criteria
Example: A1C testing	*All patients living with T2D*	*A1c testing in record within past 4 weeks*	*Patient living with diabetes + no A1c lab in record in last 3 months*	*2 weeks before due*	*Every 1 week until satisfied*	*Receipt of lab result in EHR*	*No closure after 4 sends triggers outreach call*
A1c							
Lipids							
Kidney functioning							
Comprehensive diabetes eye exam							

Flu vaccination							
Covid vaccination							
Other:_____							

Things to consider in the design process:

Selecting patients to receive reminders:

Demographics: Identify which patients should receive reminders based on age, gender, and other demographic factors.

Medical history: Consider the patient's medical history, including any chronic conditions (e.g., diabetes, hypertension) that require regular monitoring or testing.

Risk factors: Take into account specific risk factors such as smoking status, family history of certain diseases, or other lifestyle factors that may necessitate more frequent testing.

Exclusion criteria

Exclusion: Recent test completion: Implement criteria to exclude patients from receiving reminders if they have already completed the test within the recommended timeframe.

Exclusions: Exceptions: Define any exceptions for patients who should not receive reminders, such as those with terminal illnesses or those who have opted out of reminders.

Triggers

Guideline-based intervals from the last test/order: Determine the appropriate intervals for testing based on evidence-based guidelines, such as those from the U.S. Preventive Services Task Force (USPSTF) or the American Diabetes Association®. For instance, A1C tests might be scheduled every three to six months for patients with diabetes.

Custom intervals: Adjust testing intervals based on individual patient needs, such as more frequent monitoring for patients with poorly managed conditions or less frequent reminders for patients with stable conditions.

Timing of Reminders

Lead time: Establish how far in advance a reminder should be sent before the test is due. This might range from a few weeks to a month, allowing patients enough time to schedule and complete the test.

Recurrence: Decide if and when follow-up reminders should be sent if the patient does not respond to the initial reminder. This could involve a second reminder sent a week before the test is due or a follow-up after a missed appointment.

Escalation

Escalation: Determine what factors will trigger an escalation of response. For example, additional messages or an outreach call by staff may be necessary. This could involve a patient's risk level, prior history of test completion, or exposure to barriers that affect equity in access.

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(go to next step)

Availability of Structured Data to Generate Patient Reminders of Tests Due

(return)

Practice:
Date:
Participating:

Test/Service Due	Included in our patient reminder of tests due plan? Y/N	Where documented in the patient record in EHR/HIT system	How documented: (st)ructured field/s or free text/€ncounter note	Changes needed to support patient reminder
A1c				
Lipids				
eGFR and UACR				
Annual comprehensive diabetes eye exam				
Flu vaccine				
Covid vaccine				
Other:_____				
Other:_____				

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(return to next step)

Updates to Intake Form: Information from patients needed for reminders

(return)

Practice:
Date:
Participating:

Use this checklist to assess your current intake forms to determine if any modifications are needed.

Category	Item	Yes	No	Plan for "No's"
Patient Contact Information and Consent	Patient phone number	☐	☐	
	Patient cell phone number	☐	☐	
	Cell receives SMS/text messages (Y/N)	☐	☐	
	Opt-in/consent to receive SMS/text messages for:	☐	☐	
	— Appointment reminders	☐	☐	
	— Tests due reminders	☐	☐	
	— Other: _____	☐	☐	
	Plan to update these data for existing patients	☐	☐	
Preferred Communication Method	Patient communication preference recorded	☐	☐	
	Phone call	☐	☐	
	SMS/text message	☐	☐	
	Email	☐	☐	
	Letter	☐	☐	
	Other: _____	☐	☐	
	Opt-in/consent to receive SMS/text messages for:	☐	☐	
	— Appointment reminders	☐	☐	
	— Tests due reminders	☐	☐	
	— Other: _____	☐	☐	
Education on reminders	Education on option to withdraw consent (HIPAA)	☐	☐	

Category	Item	Yes	No	Plan for "No's"
	Education on risk of PHI exposure with reminders (HIPAA)	☐	☐	
	Patient signature acknowledging consent and education (HIPAA)	☐	☐	
Demographics and Language Preferences	Race	☐	☐	
	Ethnicity	☐	☐	
	Preferred language for receiving messages	☐	☐	
	Special needs or accommodations (e.g., vision, hearing, lack of digital access)	☐	☐	
	Other: _____	☐	☐	
Plan to update these data for existing patients				

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(return to next step)

Message Format and Content Worksheet

(return)

Practice:
Date:
Participating:

A. Methods of communication we will use for our patient reminders:

Communication Method	Yes	No	Available in EHR/HIT System? (check if Yes)
Phone calls (live)			
Auto-dial calls			
SMS/text messages			
Email			
Patient portals			
Postcards and letters			
Appointment-driven reminders			
Mobile health (mHealth) apps			
Wearable devices			
Interactive voice response (IVR) systems			
Gamified apps and behavioral nudges			
Other: _____			

(return to next step)

B. Message content

Test/Preventive Service	Method of communication	Message 1 Or Use system text (S)	Include HIPAA ID validation step? Yes/N0	Message 2 Or Use system text (S)	Actionable link Y/N?
Example: A1C testing	*Patient preference from intake*	*Your doctor wants to remind you that you have tests due. Click here for details.*	*Y*	*Your quarterly A1C testing is due. Click here to schedule at our lab: xxxxx*	*Y*
A1c					

Lipids			☐		☐
Kidney functioning			☐		☐
Annual diabetes eye exam			☐		☐
Flu vaccination			☐		☐
Covid vaccination			☐		☐
Other:_____			☐		☐

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(return to next step)

HIPAA Alignment Checklist for Patient Reminders of Tests Due

(return)

Practice:
Date:
Participating:

Use this checklist to assess the patient reminder process' alignment with HIPAA

Item	Yes	No	If NO, our plan is
Obtain and document explicit patient consent for SMS communications	☐	☐	
Limit the information in SMS messages to the minimum necessary	☐	☐	
Provide clear instructions for patients on how to opt-out of receiving SMS messages	☐	☐	
Implement policies and procedures for securely handling and sending SMS reminders	☐	☐	
Consider using HIPAA-compliant messaging platforms that offer encryption and secure delivery options	☐	☐	
Provide patient education on patient reminders that includes discussion of risk of PHI exposure in e-reminders, and instructions on how to "opt-out" of SMS-reminders	☐	☐	
Include 2-step patient identify verification before displaying PHI related information in message: e.g. patient enters first and last name as recorded at practice and DOB before message listing name of test due or education about the test due is displayed	☐	☐	

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(go to next step)

Roles and Workflows Worksheet for Patient Reminders

(return)

Practice:
Date:
Participating:

A. Roles in Patient Reminders

Clinician/staff	Role/s
HIT staff:	
Front Office Clerk:	
MAs:	
RNs:	
CHW:	
Office manager:	
Care Manager:	
Clinicians:	
Patients:	
Other:	
Other:	

B. Workflows to Map for Patient Reminders

Select	Workflow	Role/Name
☐	1.	
☐	2.	
☐	3.	
☐	4.	
☐	5.	
Other potential workflows to consider:		
☐	Identify patients due for tests using EHR reports or Population Health Management (PHM) tools.	
☐	Generate reminder lists based on upcoming or overdue tests.	
☐	Configure automated reminders (email, SMS, phone calls) for scheduled intervals.	
☐	Send manual reminders for patients who do not receive automated messages.	
☐	Coordinate follow-up reminders for patients who have not scheduled tests.	

Select	Workflow	Role/Name
☐	Track patient responses to reminders (e.g., acknowledgment, appointment scheduled).	
☐	Escalate follow-ups for patients who do not respond after multiple reminders.	
☐	Document all patient reminder interactions in the EHR for tracking and compliance.	
☐	Review reminder effectiveness and adjust workflows based on completion rates.	
☐	Address patient questions about the reminders and assist with scheduling.	
☐	Reconcile test results with patient records and close any open care gaps.	
☐	Educate patients on patient reminders and opt out option	
☐	Manage appointment scheduling for tests, screenings, and follow-ups.	
☐	Troubleshoot any technical issues with reminder systems or integration.	
☐	Oversee the entire reminder process to ensure it aligns with clinical guidelines and practice protocols.	
☐	Generate reports for practice performance on reminders and completion rates.	
☐	Review analytics and reports to identify workflow improvements.	
☐	Run reports to assess the completion rates of tests due after reminders were sent.	

C. Draft of key workflows

1) <u>High-level workflow</u> for the patient reminder process/es
Patient Reminder name:
Workflow name: High level

Step 1.
Step 2.
Step 3.
Step 4.
Step 5.

Tip: Copy this into LucidCharts or a similar process map application with an AI generator to create a draft process map.

2) Draft detailed steps for process/workflows

Tip: Copy these into LucidCharts or a similar process map application with an AI generator to create a draft process map.

Process/workflow name:
Patient Reminder name:
Role/Name of owner:
Step 1.
Step 2.
Step 3.
Step 4.
Step 5.

Process/workflow name:
Patient Reminder name:
Role/Name of owner:
Step 1.
Step 2.
Step 3.
Step 4.
Step 5.

Process/workflow name:
Patient Reminder name:
Role/Name of owner:
Step 1.
Step 2.
Step 3.
Step 4.
Step 5.

Summary and Decisions:

To do:

Tasks	Describe	Responsible
1.		
2.		
3.		

(go to next step)

Job Aid Worksheet

(return)

Practice name:
Date:
Attending:

Job Aid for (ROLE/STAFF PERSON):_____

Clinical Reminder at Visit. This job aid is for:_____

Steps for Clinical Reminder at Visit (name of the follow-up process):_____

Step 1.

Step 2.

Step 3.

Step 4.

Step 5.

Step 6.

Step 7.

Summary and decisions:

To do:

Task	Name	Due
1.		
2.		
3.		

Tip: Enter the steps outlined above (or in your workflow maps from earlier) into an AI resource like Chat GPT and ask it to draft a job aid based on the list of steps. Use this as a first draft and modify to create a final job aid for that workflow or task to use for training and also to put in the practice's onboarding and policies and procedures manual.

(go to next step)

Training Plan Worksheet

(return)

Practice name:
Date:
Participating:
Name of Process: _____

Learners/Groups needing training:
1.
2.
3.

Training Schedule

Completed Y/N	Date/Time/ Meeting	Location/ duration	Trainer Name	Learner/Staff Being Trained	Training Format	Resources required
	Ex: Dec 5, 2024 2pm Staff huddle time	*Virtual 15 minutes*	*Gwendolyn*	*MAs on Green Team*	*Group*	*Slide deck*

Summary and decisions:

Task list:

Task	Name	Due
Task 1		
Task 2		
Task 3		

(Go to next step)

Last 10 Patients Chart Audit Form: Guideline-Based Clinical Reminders at Visit

(return)

Practice name:
Date:
Completed by:

Clinical reminder being studied:_____

Pt who should have generated at-visit clinical reminder	Reminder provided at visit (Y/N)	Clinician/staff receiving: (role)	Clinician/staff viewed reminder (Y/N)	Clinician/staff took action (Y/N)	Care gap closed	
					via service at visit (Y/N)	via referral (Y/N)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total Y/N						

Summary and decisions:

To do:

Task	**Name**	**Due**
1.		
2.		
3.		

(return)

Implementation Monitoring Worksheet

(return)

Practice name:
Date:
Data collector:
Role:
Key Workflow Name:

A.Task/process: Time period assessed: _____

	Target # of patients/reminder tasks to complete. Name of task:	#/% completed	Reasons for fall-out/failure to complete
Staff 1: (Name)			

B. Staff satisfaction with workflow: _____

- ☐ Very dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Neutral
- ☐ Somewhat satisfied
- ☐ Very satisfied

Describe reasons for rating and recommendations to be "very satisfied":

C. Perception of impact on patients:

- ☐ Very negative
- ☐ Somewhat negative
- ☐ Neutral impact.
- ☐ Somewhat positive
- ☐ Very positive

Describe reasons for rating and recommendations to be "very positive":

Summary and decisions:

Task list:

Task	**Date Due**	**Responsible**
Task 1		
Task 2		
Task 3		

(return)

Worksheet: Patient Education About Reminders

(return)

Practice name:
Date:
Completed by:

Persons in charge of patient education on patient reminders:

1.
2.
3.

Method/s we will use to educate our patients about patient reminders

- ☐ Poster in waiting or exam room
- ☐ Flyer at check in
- ☐ Portal message
- ☐ SMS message
- ☐ Email message
- ☐ Letter
- ☐ Notification with intake forms
- ☐ Verbal by staff
- ☐ Other:_____

Educational message we will deliver:

Summary and decisions:

Task list:

Task	**Date Due**	**Responsible**
Task 1		
Task 2		
Task 3		

(go to next step)

Sample Language for Educational Letter to Patient about Reminders

Patient Test Reminders: Keeping All of Us on Track

Why You'll Receive Reminders

We use reminders to help you stay on track with important tests and screenings. These reminders ensure you complete essential tests like bloodwork, cancer screenings, or diabetes check-ups—keeping your health on track.

Types of Reminders

You can receive reminders in the way that works best for you:

- Text messages
- Emails
- Phone calls
- Patient portal notifications
- Mail (postcards or letters)

Tests You Will Be Reminded About

You'll get reminders for key tests, including:

- Diabetes tests (like A1c)
- Cholesterol or blood pressure
- Routine bloodwork
- Vaccinations (like flu shots)

How to Choose Your Reminder Preferences

You can select your preferred way of receiving reminders. Just let us know your choice during your next visit or by calling our office.

What to Do When You Get a Reminder

1. Review the reminder to see what test is due.
2. Schedule your test or appointment via our patient portal or by calling us or clicking through the message to schedule.
3. Reach out with any questions—we're here to help!

Why It Matters

Regular tests help catch potential issues early, allowing us to provide the best care possible. Staying informed through reminders keeps your health on track.

Need Help?

For any questions or help with scheduling, please contact us!
Phone: [Practice Phone Number]
Email: [Practice Email Address]
Patient portal: [Link to Portal]
If you do not wish to receive reminders, you can opt out anytime. Let our staff know when you check in for a visit or call our office.

Summary and decisions:

Task list:

Task	Date Due	Responsible
Task 1		
Task 2		
Task 3		

Job Description Additions for Patient Reminders of Tests Due

(return)

Practice name:
Date:
Participating:

Job Title:_____
Additions related to this CMP:
1.

2.

3.

Job Title:_____
Additions related to this CMP:
1.

2.

3.

Job Title:_____
Additions related to this CMP:
1.

2.

3.

Summary and decisions:

Task list:

Task	Date due	Responsible
Task 1		
Task 2		
Task 3		

(go to next step)

Additions to New Hire On-Boarding Training

(return)

Practice name:
Date:
Participating:

All hands new hire on boarding training:_____
Additions to onboarding training about this CMP
1.

2.

3.

Role specific onboarding: Role/Job Title:_____
Additions to onboarding training about this CMP
1.

2.

3.

Role specific onboarding: Role/Job Title:_____
Additions to onboarding training about this CMP
1.

2.

3.

Summary and decisions:

Task list:

Task	Date due	Responsible
Task 1		
Task 2		
Task 3		

(go to next step)

Additions to Job Evaluations: Patient Reminders of Tests Due

(return)
Practice name:
Date:
Participating:

Job Title:_____
Additions to evaluation of job performance related to this CMP
1.

2.

3.

Job Title:_____
Additions to evaluation of job performance related to this CMP
1.

2.

3.

Job Title:_____
Additions to evaluation of job performance related to this CMP
1.

2.

3.

Summary and decisions:

Task list:

Task	**Date due**	**Responsible**
Task 1		
Task 2		
Task 3		

Recommendations to QI Team: Patient Reminders of Tests Due

(Return)

Practice name:
Date:
Participating:

To the Quality Improvement (QI) Team/Lead: We are recommending the following metrics be added to the practice's QI program and dashboard for monthly monitoring and continuous improvement.

CMP Details

Name of CMP: _____
Start Date of CMP: _____
CMP Champion: _____

Suggested measures

Will use	Metric Name	Description	Data Source	Target
☐	Ex: Follow-Up Completion Rate	% of follow-up calls completed within 48 hours.	Call logs, EHR data	90%
☐				
☐				
☐				
☐				
☐				
☐				

Summary and decisions:

Task list:

Task	**Date due**	**Responsible**
Task 1		
Task 2		
Task 3		

(go to next step)