Population Health: Patient Care Reminders Step-By-Step

Setting up a process to remind patients of care gaps is an important component of a population health management program. Both mailed and telephone reminders to at-risk patients have been shown to be effective at increasing screening and immunization rates across a wide variety of patient populations and healthcare settings.[1] This step-by step guide will assist you in planning, implementing, and evaluating your process for providing this proactive enhancement to the care of your patients.

How to use this tool

First, review the "Steps For Big Picture Planning" in Table 1 to understand the road map for this work beginning to end. The steps listed here are high-level activities that align with the domains identified in the Agency for Healthcare Research and Quality's (AHRQ) Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care publication 10-00092-EF, July 2010. Then use the columns provided to note the current status of each step in your organization, who is responsible for that step, and when you plan to implement it. There is also a column available to note any comments or issues related to the domains.

Table 2 provides a comprehensive list of specific considerations. These are very detailed, practical, hands-on activities to consider as you develop or enhance your Patient Care Reminder process. Review these and use the columns provided in the same manner as you did when reviewing the Steps For Big Picture Planning. Once you have reviewed the entire tool, make your plans and set your priorities for moving forward.

1 Schmittdiel J, McMenamin SB, Halpin HA, et al. The use of patient and provider reminders for preventive services: results from a national study of physician organizations. *Preventive Medicine.* 2004; 39(5):1000-1006.

Table 1: Steps for Big Picture Planning

AHRQ*	Steps For Big Picture Planning	Status	Who/When	Comments / Issues
Domain 1	1. **Decide on population(s) and service(s) to address:** • *Choose a focus: preventive services, chronic or important conditions, high risk patients* • *Align with existing projects, programs, measures, new processes, QI initiatives, PDSAs* • *Create a vision for a comprehensive population health management program with short and long term goals and priorities that align with your QI plan and other strategic initiatives*			
Domains 1 - 3	2. **Generate lists and provide outreach to patients in need of services: (Table 2, pages 3-6)** • *Identify specific tasks involved* • *Identify technology needs (registry, reports from EHR or practice management system, mail merge function, automated calls)* • *Identify who can perform each task and when* • *Provide training including cross training so tasks are not dependent on one person* • *Determine frequency, scale, and duration (try monthly or quarterly on an ongoing basis so volume is manageable once established)*			
Domains 4 - 5	3. **Include evaluation and measurement: (Table 2 pages 3-7)** • *Begin with initial small scale testing and modification (PDSA)* • *Continue with ongoing measurement and refinement*			

**Adapted by Qualis Health from: Crossmaps to Domains identified in Association of Healthcare Research and Quality's Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care publication 10-00092-EF, July 2010.*

Table 2: Specific Considerations

Items with this icon represent activities or consideration that give your process a special patient-focused design.

Specific Considerations	Status	Who/When	Comments / Issues
Lists of Patients Needing Services			
1. **Capture accurate data in structured fields for reporting:** a. *Include demographics, risk factors, and clinical information including medication and problem lists* b. *Consider standard workflows and processes for initial and ongoing capture* c. *Identify missing data at time of visit (huddle) – ask patient or look up results* d. *Capture and document data between visits (faxes, mail, transferred records, consult notes, online information from facilities including admissions/HIE, historical data not in designated structured field)* e. *Leverage patient portal or in-office kiosk (establish process to ensure accuracy)* f. *Use automated interfaces / preloading whenever possible (establish process to ensure accuracy)* g. *Identify deceased, inactive, and test patients and ensure they will not be included in your lists or reports* h. *Standardize the process, put it in writing, and train staff*			
2. **Design and set up of reports or lists:** a. *Outline and document report specification decisions (Who decides how to address conflicting guidelines / opinions? Do these align with other measures / evidence-based guidelines in use in the clinic?)* b. *Share the report specifications with key staff to understand potential barriers* c. *Inform everyone of the process, be inclusive and transparent* d. *Ensure patient exclusions are set up* e. *Identify the process for patients who have refused the service in the past*			

Specific Considerations	Status	Who/When	Comments / Issues
3. **Generate reports or lists** a. *Identify who runs the report, how often, on what day (staff need to know this to be up to date on any pending data entry)* b. *Consider using a list or report from an external entity such as the state immunization registry*			
4. **Validate the report or list** a. *Sort the patients' names by PCP / team and distribute (export into Excel – can a printable report be provided?)* b. *Provide time and process for teams to validate:* • *PCP / provider attribution* • *Patients meet eligibility criteria* • *Service is really missing* c. *Look in narrative notes, consult notes, etc. for missing information to ensure it is not just missing from the data field. Instruct staff to add it to the appropriate field as needed. This helps the team see the difference between not offering the service, not entering data in the right field, patient refusal, or patients with a pattern of not completing the service. Patients in need of care management can be identified as part of this process.*			
5. **Modify and re-run the report or list if necessary based on feedback and corrections from the team**			

Specific Considerations	Status	Who/When	Comments / Issues
Outreach to Patients In Need of Services			
6. **Use the validated report or list for outreach:** a. *Identify method for contacting patient and check if EHR has a method to document patient preference as structured data (phone call, text, letter, email)* b. *Identify if patient speaks languages other than English and establish if contact can be sent in patient's preferred language* c. *Format and word the letter or telephone script to ensure maximum patient understanding and response (keep positive tone; don't have it look like a bill; educate and engage patients in the PCMH)* d. *Leverage the technology and this contact with the patient to provide services to improve care, enhance clinic operations, and help patients overcome barriers to getting the service they need when and how they need it* e. *Include: multiple missing services in the same letter or call; referral or test requisition, clear instructions on how to obtain the service (PCP office, specialist, facility); names of two staff as the contact for follow up and their direct phone numbers (prevent overuse of main phone line and expedite reaching the correct person)* f. *Consider the time of year / time of day (flu season, back-to-school, October as breast cancer awareness month, patient birthdays)* g. *Establish how many attempts and by what method you will use to contact the person (usually 2 attempts using one method and the third using another – for example, 2 phone calls then a letter. Consider whether you will send final certified letter)* h. *Decide how much time / effort to invest to correct issueswith incorrect phone numbers or addresses* i. *Create a "Do Not Call" list based on patient or clinician request*			

Specific Considerations	Status	Who/When	Comments / Issues
7. **Operational considerations** a. *Assess capacity to handle additional phone calls and appointment requests* b. *Consider when and how patients may obtain a service without an office visit* c. *Ensure supplies / vaccines are adequate to meet demand* d. *Identify impact on other initiatives* e. *Communicate with other facilities and specialists of effort so they can be prepared* f. *Communicate with key staff for input, then inform all staff (even vendors when appropriate) so they can assist in patient communication* g. *Provide script for staff to respond to patient calls (including special situations such as deceased patient's family member, patients not eligible or who are up-to-date)* h. *Implement standing orders, workflow standardization, documentation shortcuts (macros, templates, etc.) to accommodate a possible surge of patients* i. *Develop a process to ensure the service (and other services due) are addressed when the patient comes in for the appointment (inbox reminders or alerts)* j. *Use standard documentation in the patient record for outreach and follow-up*			

Specific Considerations	Status	Who/When	Comments / Issues
Evaluation and Measurement			
8. **Evaluate your work** a. *Test on a small scale first (one measure, one team, small number of patients – plan for how to measure success)* b. *Roll out same measure to all teams first then move on to next measure* c. *Run metrics to show the impact of the work and share with staff and patients; establish internal and external benchmarks and goals; use dashboards* d. *Run metrics by clinicians / teams to identify best practices and engage in healthy competition* e. *Consider staff rewards or link to evaluations or compensation* f. *Solicit and communicate feedback from patients to make improvements on the fly* g. *Formalize feedback from patients (follow up calls, focus groups, survey questions)* h. *Consider whether patient incentives are possible* i. *Congratulate and celebrate*			
Budget and Business Case			
9. **Establish a budget and business case** a. *Identify any required new or upgraded technology, materials and postage for mailings* b. *Include staff time or additional staffing, vendors or consultant time* c. *Return on investment (improved quality of care and patient experience, shared savings, increase in fee-for-service charges, improved employee engagement and retention)*			

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S.

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