**Blueprint CMP Implementation Guide for Practice Facilitators**

**Guideline-Based Clinical Reminders at Visit**

**Blueprint CMP Implementation Guide for Practice Facilitators**

**Guideline-Based Clinical Reminders for Preventive Services at Visit**

[Quick Start Guide 4](#_Toc185927745)

[Practice Facilitation Guide 4](#_Toc185927746)

[Purpose of This Guide 4](#_Toc185927747)

[How to Use This Guide 4](#_Toc185927748)

[CMP Description: Guideline-Based Clinical Reminders at Visit 4](#_Toc185927749)

[Rationale for Selecting CMP 6](#_Toc185927750)

[Benefits of This CMP 6](#_Toc185927751)

[What Good Looks Like for This CMP 6](#_Toc185927752)

[Key Tasks 7](#_Toc185927753)

[Start with practice leadership 7](#_Toc185927754)

[Task 1. Establish a governance committee for clinical reminders at visit 7](#_Toc185927755)

[Task 2. Assess the current status of clinical reminders at visit 8](#_Toc185927756)

[Task 3. Determine practice goals for clinical reminders at visit 9](#_Toc185927757)

[Task 4. Evaluate EHR and select approach for delivering clinical reminders at visit 9](#_Toc185927758)

[Task 5. Select which clinical reminders to implement 11](#_Toc185927759)

[Task 6. Confirm availability of structured data for generating clinical reminders 12](#_Toc185927760)

[Task 7. Define rules for the clinical reminders and their place in workflow 12](#_Toc185927761)

[Task 8. Test the clinical reminders and refine 13](#_Toc185927762)

[Task 9. Create job aids and implement 14](#_Toc185927763)

[Task 10. Monitor guidelines and update clinical reminders as needed 14](#_Toc185927764)

[Task 11. Incorporate into policies and procedures, onboarding training, and QI 15](#_Toc185927765)

[Quick Start Guide Diagram 16](#_Toc185927766)

[Worksheets 18](#_Toc185927767)

[Governance Charter Worksheet 19](#_Toc185927768)

[Current State Assessment: Guideline-Based Clinical Reminders at Visit 22](#_Toc185927769)

[Goal Sheet: Guideline-Based Clinical Reminders at Visit 23](#_Toc185927770)

[EHR Assessment: Guideline-Based Clinical Reminders at Visit 24](#_Toc185927771)

[Reminder Selection Worksheet: Guideline-Based Clinical Reminders at Visit 26](#_Toc185927772)

[Structured Data Worksheet: Guideline-Based clinical reminders at Visit 28](#_Toc185927773)

[Logic Map: Clinical Reminders at Visit 29](#_Toc185927774)

[Design Worksheet: Guideline-Based Clinical Reminders at Visit 30](#_Toc185927775)

[Last 10 Patients Chart Audit Form: Guideline-Based Clinical Reminders at Visit 31](#_Toc185927776)

[Job Aid Template: Guideline-Based Clinical Reminders at Visit 32](#_Toc185927777)

[Process for Updating Reminders: Guideline-Based Clinical Reminders at Visit 33](#_Toc185927778)

[Job Description Additions: Guideline-Based Clinical Reminders at Visit 34](#_Toc185927779)

[Additions to Job Evaluations: Guideline-Based Clinical Reminders at Visit 35](#_Toc185927780)

[Recommendations to QI Team for CMP Monitoring: Guideline-Based Clinical Reminders at Visit 36](#_Toc185927781)

[Additional Reading and Resources 37](#_Toc185927782)

**Blueprint CMP Implementation Guide for Practice Facilitators**

**Guideline-Based Clinical Reminders for Preventive Services at Visit**

# Quick Start Guide

The Quick Start Guide provides a list of the essential steps for setting-up clinical reminders at visit for diabetes care.

[Jump to the Quick Start Guide](#_Quick_Start_Guide_3)

# Practice Facilitation Guide

## Purpose of This Guide

This guide is designed to help practice facilitators (PFs) guide primary care practices in implementing an evidence-based diabetes care management process (CMP) for guideline-based clinical reminders of preventive services at the patient visit.

## How to Use This Guide

This guide provides a step-by-step blueprint for integrating guideline-based reminders into the practice workflow that a PF can use with a practice.

## CMP Description: Guideline-Based Clinical Reminders at Visit

Guideline-based clinical reminders at visit is a category of clinical decision support (CDS) that alerts clinicians to specific preventive or chronic care actions that a patient may need, such as vaccinations, screenings, labs or management steps for chronic conditions. They can help practices improve implementation of evidence-based clinical guidelines, improve quality of care and close care gaps. They are also required functionality by the Office of the National Coordinator (ONC) for certified electronic health records (EHRs).

The primary goal of clinical reminders is to improve patient outcomes by reducing missed opportunities for preventive and ongoing care.

Clinical reminders can be delivered in various formats including both active and passive formats including:

* pop-ups
* prompts
* best practice advisories
* required acknowledgement messages
* hard stop task completions
* smart sets
* flags
* health maintenance tabs
* summary lists
* dashboards

Clinical reminders are part of a broader suite of Clinical Decision Support (CDS) tools provided by EHRs that may also include:

* Drug-drug interaction alerts
* Order sets and protocols
* Condition-specific guidelines
* Data summaries and dashboards
* Diagnostic support
* Documentation templates
* Patient-specific recommendations
* Clinical calculators and risk scores
* Information buttons
* Public health reporting and safety alerts

The five rights framework is a useful tool for helping practices design new clinical reminders and evaluate existing ones. It lays out five criteria for assessing the design of clinical reminders:

1. The right information – providing accurate, evidence-based information.
2. To the right person – ensuring the reminder reaches the appropriate clinician or staff member.
3. In the right intervention format – delivering the reminder in a clear and actionable way.
4. Through the right channel – integrating the reminder seamlessly into the clinician’s system.
5. At the right time in the workflow – prompting the clinician at the point when the reminder can best inform the decision-making process.

This approach was detailed by Osheroff et al. (2012) in their guide on clinical decision support, highlights the importance of precision and timing in enhancing healthcare outcomes.

Read more about this important original work in clinical decision support and implementation design here:

Osheroff, J. A., Teich, J. M., Levick, D., Saldana, L., Velasco, F. T., Sittig, D. F., Rogers, K. M., & Jenders, R. A. (2012). Improving outcomes with clinical decision support: An implementer's guide (2nd ed.). Taylor & Francis.

For more information on clinical decision support in primary care review information at the ONC on clinical decision support [here](https://www.healthit.gov/sites/default/files/clinical-decision-support-0913.pdf).

If this is your first time helping a practice implement clinical reminders and you would like to see some examples in EHRs you can see examples in these videos below or do your own search online.

**Sample video 1: Configuration and end-user view (Elation health)**

<https://help.elationhealth.com/s/article/clinical-reminders-for-clinical-quality-measures>

**Sample video 2: Configuration (Dr. Chrono)**

<https://www.youtube.com/watch?v=Y9XuXZUE9NI>

## Rationale for Selecting CMP

*Guideline-based clinical reminders at visit* was identified in the UNITED study (Peterson et al., 2019) as one of the three care management processes (CMPs) out of 64 most strongly associated with improvements in care quality and health outcomes for patients with diabetes. Read the study here: <https://pubmed.ncbi.nlm.nih.gov/31882407/>

## Benefits of This CMP

The benefits of implementing guideline-based clinical reminders for preventive services during patient visits include:

* Improved clinician adherence to best practices for preventive services.
* Increased rates of preventive service delivery, such as vaccinations, screenings, and patient counseling.
* Increased rate of opportunistic care gap closure at visit and improved performance on national and local quality metrics and related performance-based funding.
* Better patient outcomes and a reduction in avoidable hospitalizations and emergency room visits.

## What Good Looks Like for This CMP

CASE EXAMPLES and PEARLS

As a practice facilitator (PF) or a primary care provider (PCP) implementing or enhancing CMPs in a practice, knowing what “good” looks like can help you implement CMPs more effectively and efficiently.

Case example and “pearls” (helpful tips and tricks) are contributed by PFs like you and practices that have developed exemplary processes and protocols for this CMP.

Click [here](https://www.lanetpbrn.net/clinical-reminders) to read or to submit case examples or PEARLS of your own for clinical reminders

## Key Tasks

### Start with practice leadership

As with any quality improvement work, it is essential to confirm that the proposed work aligns with the practice’s current goals and priorities, otherwise any work you undertake is likely to meet resistance. Before starting work on this and other CMPs, meet with practice leadership to confirm alignment with their goals and their buy-in

### Task 1. Establish a governance committee for clinical reminders at visit

Implementing clinical reminders at visit and other forms of clinical decision support (CDS) can be a contentious process for a practice. Well-designed reminders and other forms of CDS can increase clinician and staff efficiency and effectiveness, too many or poorly designed ones can increase workplace stress, harm quality and negatively impact patient flow.

Because of this, design of Clinical Reminder and other CDS requires careful planning and serious buy-in by clinicians and staff who will be impacted by them.

Find out if the practice already has a CDS governance process in place. If not, work with the CMP champion and practice leadership to create a project team for this CMP that can also serve as its first governance group.

The team should include representatives from all relevant roles in the practice, including:

* Front desk or scheduling staff: They will be involved in patient intake and verifying patient information, which can influence which reminders are triggered.
* Medical assistants (MAs): MAs may be responsible for educating patients about reminders and acting on them in preparation for the clinician's visit.
* Clinicians: Ultimately, clinicians will make the decision to act on the reminders, so their input is crucial.
* IT or EHR specialists: They will help configure the system and ensure the alerts are functioning as intended.

Some questions to ask the practice as they decide on the team are:

1. Who in our practice is interested in or passionate about CDS and/or improving diabetes care who could serve as the CMP champion and the lead of the Governance Group?
2. Who in our practice has experience with CDS and specifically clinical reminders?
3. Who has been involved in prior work or current work at this or another practice that can inform this effort?
4. Which disciplines and roles will be needed to help design and set-up the clinical reminders?
5. Which disciplines and roles will be impacted by the clinical reminders once they are live?

If the practice is establishing a CDS Governance for the first time, suggest they create an initial charter that they can use to guide their decision making around the clinical reminders they will be implementing (or improving).

[Governance Charter Worksheet](#_Sample_Agenda_for)

### Task 2. Assess the current status of clinical reminders at visit

Next, help practice conduct a brief assessment of the current state of its guideline based clinical reminders at visit.

Some questions you can ask:

* Which clinical reminders are currently active?
* How are they being generated and delivered?
* How well do they align with the “5 Rights?”
  1. *The right information*
  2. *To the right person*
  3. *In the right intervention format*
  4. *Through the right channel*
  5. *At the right time in the workflow*
* How satisfied are clinicians and staff with the reminders?
* How many clinical reminders does a clinician or staff person receive during a typical day?
* What percent are dismissed?
* Is alert or reminder fatigue a concern?
* How effective have the clinical reminders been for closing care gaps? Improving QI performance? Improving patient outcomes and safety?
* Are there reminders the practice would like to add/retire?

[Current State Assessment of clinical reminders](#_Current_State_Assessment)

### 

### Task 3. Determine practice goals for clinical reminders at visit

Work with the governance committee or CMP implementation team to define their goals for clinical reminders at visit based on results of the assessment or their aims for the practice.

Some questions to consider discussing with the practices

* Which preventive and health maintenance performance measures does the practice want to improve?
* What role do they see Clinical Reminder playing in these improvements?
* Why do they believe Clinical Reminder will be successful for this?
* What are their performance targets for these measures?

[Goal Sheet template](#_Task_2_-_1)

### Task 4. Evaluate EHR and select approach for delivering clinical reminders at visit

1. **Evaluate the EHR.** Begin your design and planning work with a practice for this CMP by reviewing the capacity of their EHR, and its Clinical Decision Support modules and resources.

Arrange for a meeting with the vendor and a demonstration of the EHR’s CDS and Clinical Reminder functions.

Some questions to consider asking the vendor:

* What clinical reminders for T2D diabetes care are available through the EHR?
* What guidelines or standards are the Reminders based on?
* Are guidelines or standards monitored and updated by the vendor? How often?
* Can the reminders by customized:
  + By patient cohort
  + Schedule
  + Satisfiers
  + Place presented in workflow?
  + Method of presentation to care team member?
* What does it cost to add this function to our agreement?
* What training is available to help us get started?
* What case examples does the vendor have of other similar practices’ use of clinical reminders that we can learn from?

1. **Consider other Health Information Technology (HIT) platforms.** If the EHR is does not provide the needed Clinical Reminder functionalities, work with the practice to explore other HIT resources and approaches:

**Population health management tools.** Many practices have access to population health management platforms (PHM) or health information exchanges (HIEs) that generate care gap reports that can be used to support clinical reminders at visit.

If the practice’s EHR does not provide sufficient support for clinical reminders at visit for T2D, explore how the practice’s PHM or HIE might be able to be used to provide this information.

* Could the PHM or HIE be used to generate gaps in care reports for patients scheduled to be seen the next day, that are then manually entered into the patient’s record as part of pre-visit preparation?
* Could these reports be printed out and provided to the clinician for use during the visit?
* Could these reports be used by other members of the team – the MA or clerk – for “in-reach” to assist patient to schedule needed labs, eye exams, etc.?

1. **Consider 3rd party platforms.** If the practice does not have access to HIT resources to use in lieu of reminder systems in their EHR, explore 3rd party vendors.

Platforms like DartNet’s In4medCare or Holon Ribbon can be integrated with a practice’s EHR system and generate clinical reminders through dashboard and EHR overlay functions that can be viewed side by side with the EHR record.

1. **Consider hybrid or manual processes that combine auto-generated reminders and manual processes.** If the practice’s HIT options for automating clinical reminders for T2D care are limited, explore whether a hybrid or manual process would be an effective step towards implementing this CMP.

**Care gap reports from Health Plans, ACOs and IPAs**. These reports can often be accessed through the entities’ provider portal, or are routinely provided to the practice as a digital list or report or even faxed list.

The practice can use these reports to create manual clinical reminders at Visit by adding this information to patient records as stickies or notes. For example, one practice uses a workflow where they add this information as a note to the patient’s name in the schedule for patients being seen the next day. The clinician and care team review these notes in their am and mid-day huddles, and address these issues during the visit, documenting this in the patient’s record.

**Manual chart reviews.** In smaller practices or settings with limited HIT infrastructure, the MA might be tasked with reviewing patient charts with a checklist before the visit and noting T2D care due. In one example of this, a small practice created a checklist of T2D care due based on the American Diabetes Association’s standards of care. The office manager reviews the patient visits scheduled for the next week and completes the T2D gaps in care checklist and conducts outreach calls to patients pre-visit to remind them to complete labs, schedule eye exam, etc. The office manger documents these calls in the patient record along with notes to the clinician that function as clinical reminders for the basic set services.

***A note about AI and machine learning***. **Machine learning can facilitate more automated and dynamic reminders.** Go to AHRQ, ONC, HIMSS and websites like AI in Healthcare to keep up to date on developments of AI in CDS systems.

[EHR Assessment for clinical reminders](#_EHR_Assessment:)

### Task 5. Select which clinical reminders to implement

Next, work with the practice to select which clinical reminders to implement.

From a best practices perspectivereminders should be based on:

* evidence-based guidelines
* national quality metrics or
* specific local needs.

**A. Guideline-based clinical reminders for Diabetes**

For diabetes related-clinical reminders, a suggested starter list from the American Diabetes Association is:

* Comprehensive annual eye exam
* A1C
* Lipids
* CKD screening w/ eGFR and UACR
* Foot exam
* Flu vaccine
* Covid vaccine

Use the American Diabetes Association’s Standards of Care in Diabetes as a reference for developing the Clinical Reminder rules: <https://professional.diabetes.org/standards-of-care>

Use the US Preventive Services Task Force Guidelines as an additional resource for Clinical Reminder selection and design: <https://www.uspreventiveservicestaskforce.org>

**B. Quality Metric Based Clinical Reminder**

The NCQA and the HEDIS (Healthcare Effectiveness Data and Information Set) is a good place to start: <https://www.ncqa.org/hedis/measures/>

**C. Local Needs-Based Clinical Reminder**

The unique context or needs of the practice or patients can be another reason for selecting specific Clinical Reminder to implement. Some questions for the practice to consider related to selection of Clinical Reminder based on local need include:

* Do we have specific patient groups that are unable to or fail to access specific preventive services as recommended?
* Are there preventive service metrics where our practice is performing particularly poorly or below local and national benchmarks?
* Are there specific patient groups who are experiencing **health** **equity issues** that clinical reminders could be a tool to help correct?

Alert fatigue is a special consideration when selecting clinical reminders to implement. While more may seem better, it is important to not overdo Clinical Reminder and other CDS reminders and alerts, as this can produce a phenomenon called “alert fatigue” in providers and staff where they begin to ignore clinical reminders and other CDS.

[Clinical reminders selection worksheet](#_Clinical_Reminders_at)

### Task 6. Confirm availability of structured data for generating clinical reminders

Structured data is required in order to generate automated clinical reminders at visit, as well as a consistent location for the documentation.

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 clinical reminders such as comprehensive annual eye exams and foot exams.

If any of these are captured in free text, or in inconsistent locations in the record, work with the practice to explore adding or changing to the use of structured data fields for these elements.

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

[Structured data worksheet](#_Structured_data_worksheet)

### Task 7. Define rules for the clinical reminders and their place in workflow

**A. Define rules.** For this task, work with the practice to determine the rules for each Clinical Reminder that align with the guidelines or relevant quality metrics.

For each reminder, the practice will need to decide:

1. The cohort of patients
2. Exclusion rules
3. The “finding” or event that will trigger the reminder
4. Type of Clinical Reminder notification used
5. Who on the care team or staff will receive the reminder
6. The specific actions that will satisfy the reminder (resolution logic that turns the reminder off)
7. How these actions are documented
8. What follow-up reminders are needed to confirm preventive services delivered outside of practice
9. Escalation protocols if the reminder is not resolved

Use a logic map that tracks exclusions, at visit satisfiers, post-visit satisfiers and the follow-up process.

**B. Decide best place to insert in workflow.** The practice will also need to decide here in the workflow the Clinical Reminder will be provided. Poor timing can undo any positive benefit from clinical reminders at visit.

If the Clinical Reminder occurs too late or too early in the care process, it will not be ineffective.

To do this, work with the practice to map out the entire patient visit for the , from check-in to check-out. Place the reminders at moments where they will be most useful and actionable, such as during patient intake, in consultation, or before completing orders.

Involve the care team member that will be receiving or acting on the Clinical Reminder in mapping their specific workflow and identifying the best timing for the reminder.

You may need to use swim lane maps to document the involvement of different members of the care team and staff in the reminder process.

[Logic map template](#_Clinical_Reminder_Logic)

[Clinical Reminder design worksheet](#_Design_Worksheet:_Guideline-Based)

### Task 8. Test the clinical reminders and refine

Before the practice goes live with a new Clinical Reminder, help them test the clinical reminders to evaluate their accuracy, impact on clinician and staff workflow, and patient flow.

**Background testing.** A first preferred option is to run them in the background and assess their accuracy, timing, and volume for a day or week. The technology the practice is using may or may not allow for background testing of reminders.

**Plan-Do-Study-Act Cycles.** If not, a second step for assessing reminders is to test them on a single day or week depending on eligible patient volume. You can use a last 10 or 20 patient audits to do an initial test of the effectiveness of the reminders.

Some areas to include in the testing include:

|  |  |
| --- | --- |
| Metric | Description |
| Accuracy of reminders | # of patients w reminder fired/# of patients seen that day that fit cohort and trigger (last 10 chart audit) |
| Dismissal rate | # of reminders dismissed/total # of reminders fired |
| Acceptance rate | # of reminders where user selected suggested action/total # of reminders fired |
| Volume of reminders | Total number of reminders fired |
| Volume of reminders by clinician/staff | Total number of reminders fired by clinician/staff |
| Accuracy of resolution of reminder | # of reminders resolved /# of reminders where receiver followed resolution protocol |
| End user satisfaction with reminders | Clinician/staff satisfaction with reminders: re usefulness, goodness of fit in workflow, impact on patient flow, impact on quality of care, impact on patient engagement/support/education (collected via survey/interview) |

[Last 10 Patient Chart Audit Form](#_Last_10_Patients)

Institute for Healthcare Improvement’s [PDSA Worksheet](https://www.ihi.org/sites/default/files/QIToolkit_PDSAWorksheet.pdf)

### Task 9. Create job aids and implement

Work with the practice to develop supportive materials for the staff who will be carrying out the new tasks including creating process maps and job aids to support training of current and future staff.

Click here for a [sample job](#_Sample_job_aid) aid for back-office staff for a manual Clinical Reminder generation process

[Sample job aid](#_Sample_job_aid_1)

### Task 10. Monitor guidelines and update clinical reminders as needed

Guidelines and quality metrics change over time. Once deployed, keeping Clinical Reminder content up to date is critical both for their adoption by clinicians and staff, and to their effectiveness to helping the practice attain the desired outcomes and improvement in patient care.

Work with the practice to determine how it will monitor changes in guidelines or metrics and update its Clinical Reminder to align with these changes.

Some questions to ask:

* How will the practice monitor for changes to key guidelines and quality metrics the clinical reminders are based on?
* Who will do this?
* How will modifications to clinical reminders decided upon ?
* Who will implement the changes?

[Process for Updating clinical reminders](#_Process_for_Updating)

### Task 11. Incorporate into policies and procedures, onboarding training, and QI

Work with the practice to ensure that the new processes are fully incorporated into the practice's policies and procedures manual, as well as into new staff training program.

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

These steps will help embed the clinical reminders into daily operations, support staff consistency, and drive measurable improvements in patient care outcomes.

Possible metrics to monitor

|  |  |
| --- | --- |
| **Measures** | **Description** |
| **Number of clinical reminders Generated per PCP/patient** | Average number of reminders generated per provider within a given period |
| **Reminder Dismissal Rate** | Percentage of reminders that are dismissed or ignored by providers |
| **Reminder Completion Rate at visit/post visit** | Percentage of clinical reminders that are addressed and completed by providers |
| **Care Gap Closure Rate for reminded services** | Percentage of identified care gaps that are closed within a specified timeframe |
| **Rate of missed opportunities for reminded preventive services** | Change in rate of missed opportunities to deliver preventive services at visit/post visit |
| **Provider satisfaction with clinical reminders & alignment of clinical reminders with 5 rights** | Interviews, satisfaction survey, feedback on clinical reminders |

## 

## Quick Start Guide Diagram

A diagram of a procedure

Description automatically generated with medium confidence

## 

## Worksheets

### 

### Governance Charter Worksheet

Practice name:

Date:

Attending:

**Section 1. Purpose and Objectives for the Clinical Reminder Governance Group**

1.1 What is the primary purpose of the Clinical Reminder Governance Group?

(Example: To review, approve, and monitor the use of clinical reminders in the EHR system, ensuring alignment with clinical practice guidelines and patient safety.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.2 What are the key objectives of the group?

(Examples: Prevent reminder fatigue, ensure clinical relevance, reduce unnecessary reminders, improve patient care.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2. Roles and Responsibilities**

2.1 Who will be part of the governance group? Identify roles below.

|  |  |  |
| --- | --- | --- |
| **Role** | **Name** | **Responsibilities** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

2.2 How often will the group meet?

* Weekly
* Biweekly
* Monthly
* Quarterly
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: Clinical Reminder Review and Approval Process**

3.1 What types of reminders will be reviewed by the governance group?

* New reminders for chronic disease management
* Medication safety reminders
* Preventive care reminders
* Reminders related to transitions of care
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.2 What criteria will be used to approve or reject clinical reminders?

* Alignment with evidence-based guidelines
* Relevance to the practice's patient population
* Reminder sensitivity and specificity
* Impact on workflow and efficiency
* Reduction of reminder fatigue
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Decision-making Framework**

4.1 What decision-making process will be used for approving or rejecting reminders?

* Consensus
* Majority vote
* PCP-led decision
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.2 Will there be a process for testing new reminders before implementation?

* Yes
* No
* If yes, describe the process for testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 5: Monitoring and Evaluation**

5.1. What metrics will be used to evaluate the success of the clinical reminder governance process?

* Reduction in reminder fatigue
* Improvement in care outcomes (e.g., chronic disease management)
* Time saved in workflow
* Reduction in unnecessary or duplicate reminders
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.2. How often will these metrics be reviewed?

* Monthly
* Quarterly
* Annually
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6: Continuous Improvement**

6.1. How will feedback from clinicians and staff be incorporated into the governance process?

* Surveys
* Focus groups
* Direct reporting during governance meetings
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.2. How will the governance group address issues with ineffective or unnecessary reminders?

* Regular review and removal of outdated reminders
* Revisions based on clinician feedback
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Summary and decisions:

To do:

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

### Current State Assessment: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

1. Does the practice currently use clinical reminders for preventive services at visit?

* Yes
* No

1. If yes, how are these reminders generated and delivered?

* Automated reminders through EHR
* Automated 3rd party platform. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Combination of automated and manual. Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Manual chart review and checklist

3. If yes, assess provider satisfaction and design of the existing diabetes-related preventive service reminders:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Preventive Service Reminder | In place/not in place | Right Information Y/N | Right Person/s Y/N | Right Format Y/N | Right Channel Y/N | Right Time Y/N |
| Comprehensive Annual Eye Exam |  |  |  |  |  |  |
| A1c |  |  |  |  |  |  |
| Lipids |  |  |  |  |  |  |
| CKD screening w/ eGFR and UACR |  |  |  |  |  |  |
| Foot exam |  |  |  |  |  |  |
| Annual Flu vaccine |  |  |  |  |  |  |
| Annual Covid vaccine |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |

Summary and decisions:

To do:

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

### Goal Sheet: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

Our goals for implementing/improving clinical reminders for our patients with diabetes are:

1.

2.

3.

New reminders we would like to implement are:

* Comprehensive annual eye exam
* A1C
* Lipids
* CKD screening w/ eGFR and UACR
* Food exam
* Flu vaccine
* Covid vaccine
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Improvements we would like to make to existing reminders are:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Improvements we would like to make to each reminder are :** | | | | |
| **Clinical Reminder** | **Right Information** | **Right Person/s** | **Right Format** | **Right Channel** | **Right Time** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Summary and decisions:

To do:

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

### EHR Assessment: Guideline-Based Clinical Reminders at Visit

Practice Name:

Date of Assessment: Assessor's Name and Role:

EHR/HIT Name:

1. **General Clinical Reminder Functionality**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Does the EHR/PHM provide clinical reminders during the visit? |  |  |  |  |
| Are the reminders based on clinical guidelines (e.g., USPSTF, CDC)? |  |  |  |  |
| Can reminders be customized to the practice's specific guidelines? |  |  |  |  |
| Does the system display reminders on the provider's main interface? |  |  |  |  |
| Are reminders visible without extensive navigation  or clicking? |  |  |  |  |
| Can the provider view the rationale behind each  reminder? |  |  |  |  |

1. **Types of clinical reminders**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Does the system support preventive care reminders (e.g., screenings, immunizations, etc.)? |  |  |  |  |
| Does it include chronic disease management reminders (e.g., diabetes, hypertension, etc.)? |  |  |  |  |
| Are there reminders for age-specific screenings (e.g., mammograms, colonoscopies, etc.)? |  |  |  |  |
| Can the reminders prompt for wellness visit actions (e.g., BMI, blood pressure check, etc.)? |  |  |  |  |
| Are there reminders for mental health screening (e.g., PHQ-9 for depression, etc.)? |  |  |  |  |

1. **Reminder Customization and Flexibility**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Can providers or administrators customize reminders? |  |  |  |  |
| Is there flexibility to modify reminder timing/frequency? |  |  |  |  |
| Can reminders be turned on/off based on specific conditions or comorbidities? |  |  |  |  |

1. **Reminder Integration and Workflow**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Do reminders integrate seamlessly into the provider's workflow? |  |  |  |  |
| Are reminders presented in a way that doesn't disrupt patient interaction? |  |  |  |  |
| Is there a way to acknowledge or defer reminders during the visit? |  |  |  |  |
| Can other team members (e.g., nurses, MAs) see reminders for pre-visit planning? |  |  |  |  |
| Is there a reminder tracking mechanism to follow up on deferred items? |  |  |  |  |

1. **Data Sources and Integration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Does the system pull data from multiple sources (EHR, PHM, lab, pharmacy)? |  |  |  |  |
| Are reminders updated in real-time based on new data (e.g., lab results)? |  |  |  |  |
| Can the system incorporate social determinants of health data in reminders? |  |  |  |  |

1. **Reporting and Analytics**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Is there feedback on which reminders are deferred or ignored by providers? |  |  |  |  |
| Can reports be segmented by provider or patient demographics? |  |  |  |  |

1. **Support and Training**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Does the practice receive vendor support for reminder configuration? |  |  |  |  |
| Is there training available on using and managing reminders? |  |  |  |  |
| Are there user-friendly guides or documentation for customizing reminders? |  |  |  |  |
| Does the system provide troubleshooting support for issues with reminders? |  |  |  |  |

1. **Other Considerations**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessment Item | Yes | No | DK | Notes/Comments |
| Are there additional costs to the practice to activate the clinical reminders? |  |  |  |  |

Summary and decisions

To do:

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

### Reminder Selection Worksheet: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Participating:

1. Review evidence-based guidelines from trusted organizations such as the American Diabetes Association (ADA) and the US Preventive Services Task Force (USPSTF). Select which to include in clinical reminders:

|  |  |  |
| --- | --- | --- |
| **Clinical Reminder (ADA Diabetes Standards)** | **Select (Y/N)** | **Notes/Justification for Selection** |
| Comprehensive annual eye exam |  |  |
| A1C test |  |  |
| Lipid profile |  |  |
| CKD screening with eGFR and UACR |  |  |
| Foot exam |  |  |
| Flu vaccine |  |  |
| COVID vaccine |  |  |

Reference Links:

* [ADA Standards of Care in Diabetes](https://professional.diabetes.org/standards-of-care)
* [USPSTF Guidelines](https://www.uspreventiveservicestaskforce.org)

1. Are there any quality metrics -based reminders you want to include related to T2D care?

Reference Links:

* [NCQA HEDIS Measures](https://www.ncqa.org/hedis/measures/)

1. Are there any reminders based on local needs or health equity concerns you want to include?

|  |  |
| --- | --- |
| **Questions** |  |
| Are there patient groups failing to access preventive services? |  |
| Are there areas where our practice performs below benchmarks? |  |
| Are specific patient groups experiencing health equity issues? |  |
| Other practice-specific concerns or needs? |  |

1. Prioritize your list of T2D clinical reminders

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Clinical reminder | Evidence based (Y/N) | Aligns with Quality Metrics (Y/N) | Local or Equity Need (Y/N) | Priority level (High/Med/Low) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Summary and decisions:

To do:

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

### Structured Data Worksheet: Guideline-Based clinical reminders at Visit

Practice name:

Date:

Attending:

|  |  |  |  |
| --- | --- | --- | --- |
| **Preventive care** | **Documentation Method: (S)tructured/(F)ree text** | **Location in record:** | **Additional locations in record?** |
| Annual comprehensive diabetes eye exam |  |  |  |
| CKD screening w/ eGFR and UACR |  |  |  |
| A1C |  |  |  |
| Lipids |  |  |  |
| Foot exam |  |  |  |
| Flu vaccine |  |  |  |
| Covid vaccine |  |  |  |

Summary and decisions:

To do:

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

### Logic Map: Clinical Reminders at Visit

Practice name:

Date:

Attending:

A diagram of a flowchart

Description automatically generated

Summary & decisions:

To do:

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

### Design Worksheet: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Preventive Service reminder** | **Patient cohort** | **Exclusions** | **Trigger event** | **Care team member receiving** | **Where in workflow** | **Resolutions** |
| Comprehensive eye exam |  |  |  |  |  |  |
| CKD screening w/ eGFR and UACR |  |  |  |  |  |  |
| A1c |  |  |  |  |  |  |
| Lipids |  |  |  |  |  |  |
| Foot exam |  |  |  |  |  |  |
| Flu vaccine |  |  |  |  |  |  |
| Covid vaccine |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |

Summary and Decisions:

To do:

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

### 

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

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 recommendations based on findings:

To do:

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

### Job Aid Template: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

Pro Tip: Write out the steps of the task and enter them into an AI generate such as Chat GPT to produce a quick, first draft Job Aid for this set of tasks.

**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. |  |  |

Pro tip: Enter the steps above into an AI engine like Chat GPT and give it the prompt,”Create a job aid based on these steps.”

Pro tip: Enter the steps above into a process mapping tool such as Lucid Charts using its AI generator, to auto-create a process map to include with the job aid and in onboarding training. LucidChart.com

### Process for Updating Reminders: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

Use this worksheet to track clinical reminders, their source guidelines or standards, how often they should be reviewed and updated, and who is responsible for making updates.

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical reminder** | **Guideline or Standard Used** | **Update Frequency** | **Responsible** |
| Comprehensive eye exam |  |  |  |
| A1C |  |  |  |
| Lipids |  |  |  |
| eGRF and UACR |  |  |  |
| Flu vaccination |  |  |  |
| Covid vaccination |  |  |  |
| Other |  |  |  |

Summary and decisions:

To do:

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

### Job Description Additions: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

**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:

To do:

|  |  |  |
| --- | --- | --- |
| **Responsible party name** | **Name:** | **Name:** |
| Task 1 |  |  |
| Task 2 |  |  |
| Task 3 |  |  |

### Additions to Job Evaluations: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

**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

To do:

|  |  |  |
| --- | --- | --- |
| **Responsible party name** | **Name:** | **Name:** |
| Task 1 |  |  |
| Task 2 |  |  |
| Task 3 |  |  |

### Recommendations to QI Team for CMP Monitoring: Guideline-Based Clinical Reminders at Visit

Practice name:

Date:

Attending:

|  |  |  |  |
| --- | --- | --- | --- |
| **Process** | **Measure 1** | **Measure 2** | **Measure 2** |
| 1: |  |  |  |
| 2: |  |  |  |
| 3: |  |  |  |
| 4: |  |  |  |
| 5: |  |  |  |

Summary and decisions

To do:

|  |  |  |
| --- | --- | --- |
| **Responsible party name** | **Name:** | **Name:** |
| Task 1 |  |  |
| Task 2 |  |  |
| Task 3 |  |  |

## Additional Reading and Resources

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*(00), 1–9. <https://doi.org/10.2337/dc22-2372>

Designing Effective EHR Alerts: The Smart Toolkit. Ohio State University. AHRQ funded project. Toolkit, PPTs and trainers guide for designing and implementing alerts in practices and hospitals https://smart.osu.edu/the-toolkit/ehr-alerts/

Indian Health Service Clinical Decision Support Guide. https://www.ihs.gov/ehr/ftpfiles/?p=ehr%5CTraining%5CManuals%5Clinical ReminderPMS+EHR+2014+for+MU+Meet+the+Measure%5CTab-04-CDSDrugChecks%5C04\_1\_CDS\_DrugChecks.pdf&flname=04\_1\_CDS\_DrugChecks.pdf&download=1

Osheroff, J. A., Teich, J. M., Levick, D., Saldana, L., Velasco, F. T., Sittig, D. F., Rogers, K. M., & Jenders, R. A. (2012). *Improving outcomes with clinical decision support: An implementer's guide* (2nd ed.). Taylor & Francis. Available at: <https://www.google.com/books/edition/Improving_Outcomes_with_Clinical_Decisio/KEswBQAAQBAJ?hl=en&gbpv=1&printsec=frontcover>

AHRQ CDS Connect: <https://cds.ahrq.gov/cdsconnect>

Health IT.gov on CDS: <https://www.healthit.gov/topic/safety/clinical-decision-support>

CDC Provider reminder planning guide. (Cancer) https://www.cdc.gov/cancer/php/ebiplanningguides/providerreminderplanningguide.html

CMS resource on CDS (2014) on Meaningful Use and CDS

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ClinicalDecisionSupport_Tipsheet-.pdf>

CDS case examples at HIMSS Davies Awards

<https://gkc.himss.org/resources/clinical-decision-support-tools-and-smart-tech-case-studies>

AI in healthcare AMA course

<https://edhub.ama-assn.org/course/318?utm_campaign=alwayson-google-paid_ad-ai&gclid=CjwKCAjw1NK4BhAwEiwAVUHPUF9Y3UJmXouk7k5J4QwC_X3daoPgl4ucobGfh3DxtYf1UwiWyQGLVRoCxQMQAvD_BwE>

National Academy of Medicine (2017). Optimizing Strategies for Clinical Decision Support

<https://www.healthit.gov/sites/default/files/page/2018-04/Optimizing_Strategies_508.pdf>