**Blueprint CMP Implementation Guide for Practice Facilitators:**

**After-Visit Follow Up by Non-Clinicians**

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**Blueprint CMP Implementation Guide for Practice Facilitators: After-Visit Follow Up by Non-Clinicians**

# 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 [Quick Start](#_Quick_Start)

# Practice Facilitation Guide

## Purpose of This Guide

This guide is designed to help quality improvement (QI) coaches support primary care practices in implementing and enhancing post-visit follow-up processes by non-clinicians. These follow-up processes are proven to improve patient engagement and health outcomes, particularly for those with chronic diseases like diabetes.

## How to Use This Guide

This guide provides a step-by-step approach for integrating after-visit follow up by non-clinicians into a practice’s workflow. Each section outlines specific tasks QI coaches can guide practices through, with practical worksheets to help with planning, decision making, and monitoring progress.

## CMP Description: After-Visit Follow Up by Non-Clinicians

Strong relationships with patients living with diabetes are associated with better outcomes. After-visit follow up by non-clinicians, the care management process (CMP) that is the focus of this guide, can be an important tool for building these relationships, help ensure patients adhere to care plans, and help patients receive support to maintain their health between visits.

After-visit follow up provides proactive, personalized outreach that can help patients feel cared for and supported between visits—reinforcing adherence to care plans and strengthening their connection and relationship with their primary care provider (PCP). After-visit follow up by non-clinicians can include checking whether medications were filled, if tests are due, if the recommended care (such as referrals or lab tests) was completed, and if barriers to care were addressed.

It can also help ensure patients are able to address any concerns they had during the visit and assess whether they were satisfied. Both of which support better patient experience, care, and outcomes and strengthen the provider-patient partnership.

Proactive follow-up goes beyond passive methods like sending portal messages or generic reminders. Follow-up should be active and tailored to each patient’s needs. Providing tailored support, education, or reminders, or offering assistance to address barriers, shows a commitment to patient care that automated-only systems alone cannot achieve.

Active, individualized follow-up reinforces the message that their care matters and improves adherence, patient retention, and ultimately, their health outcomes.

After-visit follow up by non-clinicians can be delivered by medical assistants (MAs), care coordinators, health coaches, social workers, community health workers, and administrative staff. The method and approach should align with the practice’s reasons for implementing the CMP.

Types of after-visit follow up include:

* Routine post-visit follow-up based on medical note. You may ask:
	+ Your PCP said you needed the following done, were you able to do this? Or do you need assistance doing this?
	+ Is there anything you were not able to ask your PCP you would like me to convey?
	+ Were you happy with the visit?
* Care plan check-ins
* Medication-related follow up
* Preventive care services and tests due follow up
* Health coaching and self-management follow up
* Behavioral and lifestyle follow up
* Social determinants of health follow up
* Care coordination referral follow up/navigation
* Referral services

## Rationale for the Selection of This CMP

After-visit follow up by non-clinicians was identified in the [UNITED study](https://diabetesjournals.org/care/article/46/10/1762/151458/Care-Management-Processes-Important-for-High) (Peterson et al., 2019) as one of three CMPs out of 64 that were associated with higher performance in the delivery of diabetes care and improved health outcomes.

## Benefits of This CMP

* **Improved continuity:** Helps patients remain engaged with their care team and care plans, necessary lab tests, follow-up appointments, and preventive services.
* **Stronger patient relationships:** Builds trusting relationships with patients to support greater adherence to care recommendations and proactive self-management.
**Addresses barriers to care:** Identifies and mitigates social and logistical barriers (e.g., transportation and medication costs) that may prevent patients from completing referrals, engaging in self-management activities, and following their care plans.
* **Supports full engagement of care team and staff:** Assigns follow-up tasks to non-clinicians, freeing clinician time for complex care tasks, increasing efficiency, and reducing clinician burnout.

## What Good Looks Like for This CMP

### CASE EXAMPLES

As a practice facilitator (PF) or PCP implementing or enhancing CMPs in a practice, knowing what “good” looks like can help you implement CMPs more effectively and efficiently. Case examples are contributed by PFs like you and practices that have developed exemplary processes and protocols for this CMP.

### PEARLS

PEARLS are contributed by PFs and their practices. This is a dynamic list of lessons learned can be used to enhance your CMP process, avoid common pitfalls, and refine your and your practice’s processes. Read or submit case examples or PEARLS for CRs.

## Key Tasks

### Start with Practice Leadership

Before you begin implementing this CMP, meet with practice leadership to confirm their buy-in and what they want to accomplish. Ask leadership to identify the practice champion for this CMP you will work with throughout the project.

### Form the CMP Project Team

Work with the CMP champion and practice leadership to create a project team for design and implementation. The team should include representatives from all relevant roles in the practice, including:

* **Front desk:** Clerks may be responsible for collecting updated contact information from patients and their communication preferences which will be important in the follow-up work.
* **MAs:** MAs may be responsible for carrying out follow-up processes.
* **Clinicians:** Clinicians will know which patients are most in need of follow-up and may prioritize these patients to receive after visit follow-up. They may also handle escalations.
* **Community health workers, health coaches, care coordinators, and managers:** They often play key roles in supporting patients between visits.
* **IT or electronic health record (EHR) specialists:** They will help the practice determine how they may want to automate different parts of follow-up processes using existing or new HIT resources and assist in configuring these actions and maintaining them.

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

1. Who in our practice is interested in or passionate about strengthening relationships with patients between visits?
2. Who could serve as the champion for this CMP if not already identified?
3. Who in our practice has experience with after-visit follow up and keeping patients engaged with care between visits?
4. Which disciplines and staff will be involved in the after-visit support activities and should be included on the team?
5. Who will help with the information systems and reports we will need to trigger and track between visit follow-up actions?

Use the project team worksheet to document who will be on the team.

[CMP Project Team Worksheet](#_CMP_Project_Team_1)

### **Task 1. Assess the current state of this CMP at the practice.**

Work with the practice to assess the current state of their processes for after-visit follow-up by a non-clinician. Use the informal assessment tool below to guide this assessment or you can design your own.

 [Current state assessment of after-visit follow-up by a non-clinician](#_Current_State_Assessment_1)

### **Task 2. Set goals for adding or enhancing this CMP.**

Work with the practice to identify set goals for adding or enhancing a new follow-up process using the current state assessment and their practice priorities.

Use the goal sheet below to help them identify which after-visit follow-up processes they want to implement or improve.

Help them define their reasons for implementing each chosen process, how they will measure their set goals for each process, and how they will determine they have attained them.

A practice may decide to implement more than one after visit follow-up processes. If so, have the practice one process to work on first, and work through the guide for this single process, repeating the cycle again for any additional ones. Have then identify the first process they work on during the goal setting process.

[Goal sheet for CMP](#_Goal_Sheet_for_1)

### **Task 3. Develop a high-level design for the selected after-visit follow-up process.**

Work with them to create a high-level process map of a first after-visit follow-up process. If the practice wants to implement multiple after-visit follow-up processes, help them decide which process they will start with. This might be the one they ranked as the highest priority on their goal sheet or the one that is the easiest for them to implement.

Starting with “easy” processes first can be a good way to help staff and clinicians in a practice build confidence in their ability to successfully design and implement changes—and a good way for them to attain a quick win.

Use a scenario-based design approach to help the practice identify the key elements of the process they want to implement. For scenario-based design, the practice creates an ideal scenario, or several scenarios, that illustrate how an ideal after-visit follow-up would look. This becomes the basis for creating an initial design for the process they want to implement.

**Instructions for Scenario-Based Process Design**

**Tips for facilitating the session:**

* Keep the discussion focused on patient-centered outcomes.
* Encourage participation from all team members to gain diverse perspectives.
* Emphasize that the scenario is a starting point and can evolve as the process is tested and refined.

**Step 1: Explain scenario-based design.**

Begin the session by introducing the concept of scenario-based design: A method where the team develops ideal scenarios of how a process should look. These scenarios act as a foundation for creating the process map and implementing improvements.

**Step 2: Brainstorm ideal follow-up scenarios.**

1. Ask the participants create a patient scenario that includes the ideal implementation of the follow-up process they want to implement (or improve).
2. Ask:
	* Who is the patient?
	* How old are they?
	* What triggers the follow-up?
	* Who conducts the follow-up?
	* Are others involved in the follow-up process? If so, who? How do they receive information from the process initiator?
	* What tools or resources are used for the process to run smoothly?
	* How does the larger team know the process has been initiated with a patient?
	* How does the larger team know where the patient is in the process?
	* How do we know we attained our goal for the process with the patient?
3. Capture detailed scenarios on a whiteboard or shared document as the practice crafts it.

**Example scenario:** *After her recent clinic visit, Ms. Garcia, a 64-year-old woman living with type 2 diabetes, received a follow-up call from the medical assistant (MA). The MA reviewed her medical note, which included scheduling an eye exam and refilling her medication. The MA asked whether she had any questions for her care team after the visit, if she was able to schedule her eye exam, and if she was able to get her prescription filled. During the call, Ms. Garcia shared she hadn’t scheduled the exam due to confusion about how to do it. The MA provided the contact details for a local optometrist who provides comprehensive diabetes eyes exams and offered to assist her with calling and scheduling. Additionally, Ms. Garcia mentioned mild dizziness after starting the medication her primary care provider (PCP) prescribed and indicated her husband told her to stop taking it. The MA documented this information and the follow-up support in Ms. Garcia’s record and escalated her concern about medication side effects via secure message to her PCP.*

**Step 3: Create a high-level process map based on the scenario.**Once the team has created an ideal scenario or story about the specific follow-up process, work with them to translate that scenario into a high-level process map.

**Step 4: Determine the timing of the follow-up.**

Consider the timing for the follow up and the rules the practice will use to determine this timing. Review the different approaches to timing follow-up and have the practice select the approach it will use.

[Approaches to timing after-visit follow-up](#_Timing_Models_for)

**Step 5: Have the team add roles, responsibilities, and resources needed at each step in the high-level map.**

1. Following the adage, “the person that owns the process holds the pen,” engage the non-clinician staff that will be conducting the follow-up in the next phases of the design process.
2. Add the roles, responsibilities, and resources needed at each step.
3. Refine the process map and expand to a swim-lane showing the roles of multiple team members, if indicated.

**Step 6: Identify any barriers to implementing the ideal scenario workflow and refine the process to accommodate/address them.**

Work with the team and staff who will be conducting the follow-up to identify potential barriers to implementation of the new process. Incorporate this information into the workflow design and resource checklist.

**Sample process map with barriers and resources identified**

****

By guiding the practice through this method, you help create a practical, patient-focused follow-up process tailored to the team’s goals and resources. Use the worksheet below or a workflow mapping tool like [Lucid Chart](http://lucidchart.com/) available online to help the practice document it’s ideal scenario and also document resources and barriers. Complete it as many times as needed depending on the number of distinct follow-up processes being implemented or enhanced.

Worksheet: [Ideal after-visit follow-up process workflow](#_Worksheet:_Ideal_Workflow)

### **Task 4. Identify HIT and other resources needed to implement the selected process.**

A primary goal of after-visit follow-up is relationship building between the PCP and the patient, and supporting the patients’ follow through and engagement with their care plan. Portions of after-visit follow-up can be automated to reduce burden on staff and any automated follow-up should be designed and/or evaluated for its ability to facilitate between visit relationship building and care plan implementation support.

HIT systems can be used to automate and reduce burden of tasks such as: follow-up list generation, follow-up communications via SMS, email, letter, e-calling and e-education/coaching as long as the use of these automated function support the strengthening of the relationship between the patient and the PCP and their engagement in their care plan.

**A. Work with the practice to evaluate the capacity of their Health Information Technology (HIT) systems to automate portions of this CMP.**

Some HIT functions that the practice may want to review for use in the after visit follow-up process they will be implementing.

* Automated reminders for a patient about follow-up actions, such as scheduling an eye exam or attending a diabetes management class.
* Customizable worklists that enable staff to track patients flagged for follow-up calls after visits, hospital discharges, or emergency room visits.

* Communication tools such as SMS, secure messaging, or a portal that clinical staff can use for after-visit follow up.
* Automated task creation based on provider notes that non-clinical staff can use to guide the content of the outreach.
* Trigger alerts for staff to contact patients if specific actions, such as labs or medication adjustments, remain incomplete.
* Integrated call scripts and call prompts or checklists to ensure all relevant topics are covered (e.g., "Did you fill your prescription?").
* Task assignment and tracking that can be used to assign follow-up tasks to specific staff members and track their completion.
* Structured note fields for documenting call outcomes, including what was discussed, actions taken, and patient feedback.
* Call tracking templates to document key follow-up call elements, such as whether the patient completed recommended actions or needed additional support.
* Call logs that maintain records of completed and scheduled follow-up calls, ensuring no patient is missed.
* Call outcome tracking to monitor call completion rates, patient satisfaction, and follow-up compliance.

**B. Work with the practice to identify additional resources they will need to implement the after visit follow-up process they are designing.**

In addition to HIT resources, the practice will need other resources to support the follow-up process. Have the practice review the process map they created earlier to identify other resource needs such as call lists, call scripts, educational materials, and response protocols for example.

Use the resource worksheet below to help them think through and develop a plan for obtaining these additional resources.

**Sample resource list based on the ideal after visit scenario for Ms. Garcia**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Step in process** | **Resources needed** | **Can we use our HIT to automate part of all of this step? How?** | **Do we have this? Y/N** | **Next step for creating this resource** |
| Call patient | Call list  | Yes, create report to generate call list | Y | Have Jenny create report for all patients seen in past week for comprehensive diabetes care visit  |
|  | Intro Script | No | N | Have Dr. Johnson and MAs develop a script to test during staff meeting |
| Ask patient about medication adherence | Access to notes and rx info in patient record & script | No | Y | Include this in job aid for MAs, create script w/ Dr. Johnson |
| Provide education re medication  | Script and e-educational materials | Yes | N | Review e-med adherence education in our EHR, develop script |
| Document outcome of follow-up | Access to patient record and place to document | No | Y | Have Dr. Johnson determine where MAs should document call, explore creation of template for follow-up |

[Worksheet: Resource list for after visit follow-up](#_Resources_Needed_for)

### **Task 5. Allocate staff time to support the new process.**

Work with the practice to identify which staff will support the after-visit follow-up process

and calculate the time needed to carry out the tasks.

* How many follow-up calls will they need to make weekly?
* What is the estimated average time needed for each call?
* How much time will it take for them to gather the information they need in order to make the calls and who will do this (e.g., create call lists)?
* How much time does it take for them to provide follow-up information to patients? Escalate to PCP?
* How will they document the calls and how much time will this require?
* How much time will it take for them to conduct second outreaches to patients who require it?
* What competing demands might interfere with their ability to complete this new process?
* What training needs will staff have?
* What additional resources beyond those on the checklist in Task 3 do staff believe they will need?
* Can technology, such as automated reminders or EHR features, be used to offset any human resource gaps or reduce time required by non-clinical staff to carry out these new tasks?
* Will more staff hours or new hires be necessary?

Here is an example of a table for calculating the amount of staff time that is required for a follow-up process.

**Sample Table for Estimating Process Time Requirements**

|  |  |
| --- | --- |
| **Table for Calculating Staff Time by After-Visit Follow-Up Tasks** |  |
| **Task** | **Estimated time per task** | **Frequency per patient** | **Calculation** | **Total time per patient (minutes)** |
| Generating call list | 2 minutes | 1 time per patient | 2 minutes × 1 | 2 |
| Making calls | 10 minutes per call | Up to 3 calls per patient | 10 minutes × 3 (if needed) | 30 (maximum) |
| Providing follow-up education/support | 5 minutes per call | 1 time per patient (on 1 successful call) | 5 minutes × 1 | 5 |
| Escalating to PCP | 5 minutes | 20% of patients (estimate) | 5 minutes × 0.2 | 1 |
| Documenting the call | 3 minutes | 1 time per patient | 3 minutes × 1 | 3 |
| **Total estimated time** |  |  | Sum of all time allocations | Up to 41 minutes per patient |

Use the worksheet below to help a practice estimate the amount of time the new process may require and make adjustments to ensure they have sufficient resources.

[Worksheet: Staff time estimator](#_Staff_Time_Needed_1)

### **Task 6. Create protocols and job aids for the follow-up process.**

Work with the practice to develop protocols for the staff conducting outreach to follow based on common tasks expected as part of the follow-up process.

Depending on the goals and scope of the after-visit follow-up support, these might include protocols that provide guidance to non-clinical staff on:

* Care plan adherence
* Medication adherence
* Self-management support and education
* Scheduling preventive services
* Coordinating lab testing
* Addressing behavioral and social health needs
* Navigating and completing referrals
* Identifying and escalating urgent issues
* Communicating patient information with the PCP
* Communicating patient concerns/praise regarding visits with the care team

Once developed, the protocols can be included in job aids and used to train and support staff carrying out the follow-up.

**Sample protocol**

**Follow-Up Call Steps**

**1. Consult the call list provided by the office manager**

**2. Review patient information**

* Access the patient’s electronic health records (EHRs).
* Confirm the following details:
	+ Reason for the follow up (e.g., medication adjustment, test results, appointment scheduling).
	+ Primary care professional’s (PCP’s) notes and instructions.
	+ Any previous documentation related to the visit.

**3. Initial contact**

* Attempt to contact the patient by phone or preferred communication method.
* **If the patient answers:**
	+ Introduce yourself and the purpose of the call (“Hi this is \_\_\_\_\_ from Wellness Practice. Dr. Johnson asked me to call and see how things have been going since your recent visit. Is now a good time for a quick visit?”
	+ Verify the patient’s identity (e.g., full name, date of birth). (“Could you confirm your name and date of birth for me?”
	+ Conduct follow-up: (“Dr. Johnson asked me to follow-up and see if you were able to get your medications? Have you been able to get them filled? Etc.”
* **If unable to reach the patient:**
	+ Leave a HIPAA-compliant message (do not disclose personal health information) voicemail that includes your name, the practice’s name, and a callback number. “This is Sally from Wellness Practice. I’m calling to check-in and see how you are doing. Please give me a call at (number).”

**4. Actions based on patient’s follow-up needs**

 *(Fill in as appropriate for specific scenarios)*

| **Circumstance** | **Steps to take** | **Notes/resources** |
| --- | --- | --- |
| **Medication refill assistance** | - Verify medications prescribed by the PCP. | Use the EHR to confirm pharmacy details. |
|  | - Ask if the patient has filled the prescription or encountered issues. | Provide pharmacy contact info or escalate issues as needed. |
|  | - Document the outcome in the EHR. |  |
| **Lab/test results** | - Confirm whether results were communicated by the lab or provider. | Check the EHR for lab status updates. |
|  | - Review PCP’s instructions for sharing results with the patient. | Ensure results requiring explanation are escalated to the PCP. |
|  | - Schedule follow-up appointments if needed. |  |
| **Appointment scheduling** | - Identify the needed appointment type (e.g., eye exam, specialty referral). | Use scheduling systems or provide patients with contact information for external specialists. |
|  | - Offer assistance if the patient expresses difficulty in scheduling. |  |
| **Patient concern/feedback** | - Listen to the patient’s concern or feedback during the call. | Document details in the EHR. Escalate to PCP if the issue is clinical or beyond the MA’s scope. See escalation protocol below. |
| **Symptom management** | - Ask about new or worsening symptoms since the last visit. | Use scripted questions to gather relevant information. |
|  | - Document findings and escalate to PCP if the symptoms are concerning. |  |

 **Escalation Protocol Table**

| **When to escalate** | **How to escalate** |
| --- | --- |
| Clinical issues requiring decision-making. Examples: concerning symptoms, medication adjustments | Notify the PCP or appropriate team member via secure messaging or task assignment.  |
| Unresolved patient concerns | Notify the PCP via secure message or tasking and provide background information for follow-up.  |

**5. Conclude the call**

* Summarize the steps taken during the call.
* Ask if the patient has additional questions or concerns.
* Remind the patient of the next steps (e.g., appointments, actions they need to take).
* Thank the patient for their time.

**6. Document the call in the Patient Record under “health maintenance” tab**

* Record the following in the EHR under the “Name” tab:
	+ Date and time of the call.
	+ Reason for follow-up and actions taken.
	+ Patient’s response and any concerns raised.
	+ Escalations to PCP or other team members.

**Notes:**

* Ensure HIPAA compliance during all communications.

Use the worksheet below to help the practice create a job aid for the follow-up process they will be implementing or enhancing. If the practice is implementing multiple processes with different workflows, create one for each new workflow or process.

[Worksheet: Protocol and Job Aid Template](#_Protocol_and_Job)

### **Task 7. Test the after-visit follow-up process and refine.**

Before the practice goes live with the after-visit follow-up process, work with them to test and refine it before implementing.

Use a QI process like Plan-Do-Study-Act (PSDA) cycles to structure the testing process. Have the non-clinical staff conduct calls to three to four patients and provide feedback to the team on the content of the calls, their response, and the effectiveness of the workflow.

Work with the non-clinical staff to make refinements to the process and then test it again until it is ready to implement.

Areas for testing include:

|  |
| --- |
| Metric |
|  # of patients to receive after-visit follow up during (day/week) |
| # of patients eligible for after-visit follow up  |
| Outcome of the follow-up events |
| Documentation of the follow-up action |
| # of patient responses requiring escalation to the PCP |
| Outcome of these escalations |
| Follow-up staff’s satisfaction with the process and recommendations for enhancements |
| Care team satisfaction with the process and recommendations |

Use the on-line worksheet below to help the practice plan and document the outcomes of each PDSA cycle or use your own form.

[Worksheet: Plan-Do-Study-Act Worksheet](https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/pdsa-form.pdf)

### **Task 8. Train staff and implement the process.**

Work with the practice to refine the workflows and job aids based on the lessons learned during the PDSA testing. Help them schedule and deliver training to staff on the process using group trainings and one one one trainings. You can review the Agency for Healthcare Research and Quality (AHRQ) module on [helping practices scale improvements](https://www.ahrq.gov/downloads/ncepcr/pf-modules/scale-improvements/story.html) for a quick reminder on elbow support coaching sessions.

Use the worksheet below to create a staff training plan for the new process.

[Worksheet: Staff training plan](#_Staff_Training_Plan)

Once training is completed, work with the practice to implement the new after-visit follow-up process/

One key to implementation is the ability to monitor performance during the first few weeks and provide elbow-support training to key staff who are having difficulty implementing or sustaining the process.

During elbow-support sessions, you can review the job aid with the non-clinician, and conduct an informal audit and then feedback to the staff person of their implementation of the new process. Specifically, you can review staff person’s follow-up list, the number of follow-up attempts made, barriers and facilitators to these, the outcomes of each and their satisfaction and recommendations for continually improving the process. You can also use the time to celebrate “wins” as staff succeed in implementing the workflows.

 Use the worksheet below to help them create a weekly performance report on after-visit follow-up work to support maintenance of the new process during the early stages.

[Worksheet: Performance monitoring form for CMP Implementation](#_Performance_Monitoring_During)

### **Task 9. Add the CMP to job descriptions, evaluations, and QI program.**

**A. Revise Job Descriptions and Staff Evaluation Protocols to Include CMP**

Revise job descriptions for positions with significant responsibilities for the after-visit follow-up workflows to include the addition of these tasks and responsibilities, as well as how their performance will be evaluated.

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.

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

These revisions not only clarify expectations, they ensure accountability, helping the practice build a cohesive approach to follow-up. Incorporate training on after-visit follow up into onboarding training for new hires for the positions that will be responsible for the process.

Use the worksheets to create additions to add to job descriptions and to draft additions to staff performance evaluation standards.

[Worksheet: Additions to job descriptions for CMP](#_Job_Description_Additions:)

[Worksheet: Addition staff performance evaluations for CMP](#_Additions_to_Job)

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

Work with the practice to ensure the new processes are fully incorporated into their policies and procedures (P & P) manual, as well as the new staff training program.

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

**C. Select and add metrics for monitoring 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

[Worksheet: Recommendations to QI team on metrics for After-Visit Follow-up by Non-Clinician](#_Recommendations_to_QI)

## Quick Start



## Worksheets

### CMP Project Team Worksheet: After Visit Follow-Up

**Practice name:**

**Date:**

**Participating:**

Name of Team:

|  |  |  |
| --- | --- | --- |
| **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

Task list:

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

### Current State Assessment of After-Visit Follow Up by Non-Clinicians

**Practice name:**

**Date:**

**Participating:**

**Which processes for after-visit follow-up by non-clinicians are currently in place at the practice?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **After-visit follow-up process** | **In use? Y/N** | **Current goal of the process** | **How effective is the current process?** (1 not at all effective–10 very effective) | **What would it take to make it a 10** (if it isn’t)? |
| After visit reminders of tests due (e.g., appointments, tests) |  |  |  |  |
| After visit referral reminders and support  |  |  |  |  |
| After visit health coaching and patient education |  |  |  |  |
| After visit support for social determinants of health (SDOH)  |  |  |  |  |
| After visit support with medication adherence  |  |  |  |  |
| After visit behavioral health support |  |  |  |  |
| After visit care plan review and goal setting |  |  |  |  |
| Other: |  |  |  |  |

Summary and decisions

Task list:

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

### Goal Sheet for After-Visit Follow Up by Non-Clinicians

Practice name:

Date:

Participating:

|  |  |  |  |
| --- | --- | --- | --- |
| **After-visit follow-up process** | **Implement? Y/N** | **Our reasons for implementing this process are:** | **High-level brainstorming of process/enhancement we would like to put in place** |
| After-visit reminders of tests due (e.g., appointments, tests) |  |  |  |
| Post-visit care referral reminders and support  |  |  |  |
| Post-visit health coaching and patient education |  |  |  |
| Post-visit support for social determinants of health (SDOH)  |  |  |  |
| Post-visit support with medication adherence  |  |  |  |
| Post-visit behavioral health support |  |  |  |
| Group-based education or support |  |  |  |
| Post-visit follow-up on gaps in care |  |  |  |
| Post-visit care plan review and goal setting |  |  |  |
| Post-visit escalation/crisis follow-up |  |  |  |
| Other: |  |  |  |

**Which of the processes selected will we focus on implementing first?\_\_\_\_\_\_\_**

Summary and decisions:

Task list:

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

###

### Approaches to Timing After-Visit Follow-up

Following are different approaches and models for determining timing of after-visit follow-up. Review these with the practice to help them determine the best approach for their process/es.

**Option 1. Align Timing with the Purpose of Follow-Up (sample timelines)**

* Building Relationships and Trust: Early follow-up (within 1-3 days) to check on understanding, address questions, and reinforce care instructions.
* Medication Access and Adherence: Follow up within 3-7 days after prescribing a new medication to confirm it has been filled, check for side effects, and ensure correct usage.
* Symptom Monitoring: Determine frequency based on symptom severity:
* Acute symptoms: Daily or every few days.
* Chronic, stable symptoms: Weekly or biweekly.
* Preventive and Routine Care: Schedule reminders 1-2 weeks before the next scheduled service (e.g., lab work, screenings).

**Option 2. Tailor Timing Based on Patient Risk and Complexity**

* High-Risk Patients: Follow up sooner and more frequently (e.g., daily or weekly check-ins) for patients with severe symptoms, uncontrolled chronic conditions, or recent hospitalizations.
* Low-Risk Patients: Extend follow-up intervals (e.g., biweekly or monthly) for patients with stable conditions and good self-management practices.

**Option 3. Consider Patient Preferences**

* Engage patients during the visit to determine their preferred frequency of follow-up and communication methods.
* For patients who prefer more frequent interactions, adjust timing accordingly to provide reassurance and support.
* Ensure flexibility to meet the needs of patients with unpredictable schedules or preferences for less frequent contact.

**Option 4. Factor in Practice Resources**

* Staffing Levels: Ensure follow-up timing aligns with the practice’s capacity to manage outreach efforts (e.g., phone calls, portal messages, or texts).
* Technology: Leverage remote monitoring tools for real-time data and automated alerts to reduce manual follow-up efforts.Use automated reminders for routine check-ins or preventive care needs to ease the burden on staff.
* Care Team Coordination: For more complex follow-ups (e.g., addressing Social Determinants of Health or medication adjustments), allocate follow-up timing based on the availability of care managers, social workers, or pharmacists.

 **Option 5. Leverage Predictive or Patient-Specific Data**

* Remote Monitoring Alerts: Trigger follow-up based on real-time patient data (e.g., elevated blood glucose, abnormal blood pressure).
* Clinical Guidelines: Use condition-specific guidelines (e.g., weekly glucose monitoring for diabetes) to determine follow-up timing.
* Behavioral and Social Factors: Adjust timing for patients with known barriers to care (e.g., transportation, health literacy) to ensure adequate support.

**Option 6. Synchronize with Care Plan Goals**

* Align follow-up timing with short-term and long-term care plan goals:
	+ Short-Term: Immediate actions like medication adherence or acute symptom management require quicker follow-up (e.g., within 1-7 days).
	+ Long-Term: Goals like improving blood sugar control or lifestyle changes may require ongoing monthly check-ins or educational sessions.

 **Option 7. Address Quality Measure and/or Regulatory Requirements**

* Ensure follow-up meets documentation and care coordination requirements for chronic care management (CCM) or transitional care management (TCM) billing codes, which often specify contact within 2-7 days post-visit or discharge.

 **Option 8. Build in Flexibility for Escalation**

* Establish a process for adjusting timing based on patient feedback or worsening conditions. Example: Move a follow-up earlier if a patient reports new or worsening symptoms.

 **Sample Timing Rules a practice might select**

* 1-3 Days: To build relationships, reinforce trust, and address immediate post-visit concerns.
* 3-7 Days: For medication adherence, follow-up on referrals, or monitoring for early side effects.
* Weekly or Biweekly: For stable chronic conditions, reviewing action plans, and checking in on symptoms or self-management tasks.
* Monthly or As Needed: For long-term goals, such as preventive care, lifestyle coaching, or health education.

Summary and decisions:

Task list:

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

### Ideal Workflow for After-Visit Follow-up by Non-Clinician

Practice name:

Date:

Participating:

*Name of Process:*

Start

End

Notes:

Summary and decisions:

Task list:

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

### Resources Needed for the CMP: After-Visit Follow-up by a Non-Clinician

Practice name:

Date:

Participating:

Use the process map developed during task (x) to define the steps, and then brainstorm the resources needed

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Step in process** | **Resource needed** | **Can we use our HIT to automate this? Y/N** | **Do we have this? Y/N** | **Next step for obtaining resource** |
| *Ex: Make outreach call* | *Call list* | *Y* | *Yes/Not Yet* | *Have Tom create report for patients seen during week for comprehensive diabetes care visit*  |
| *Ex:Make outreach call* | *Intro script*  | N | N | *Have Dr. Johnson and MAs create at next staff meeting* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Summary and decisions:

Task list:

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

### Staff Time Needed for of After-Visit Follow-Up Process

Practice name:

Date:

Participating:

**Process name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Task** | **Staff person**  | **Estimated time per task (minutes)** | **Frequency per patient** | **Calculation** | **Total time per week/patient (minutes)** |
| **Ex: Generate call list** | Office manager | 5 minutes using EHR | 1 time per week | 5 x 1 | 5 minutes |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Summary and decisions:

Task list:

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

### Protocol and Job Aid Template for After-Visit Follow-up by Non-Clinician

Practice name:

Date:

Participating:

**Job Aid for (ROLE/STAFF PERSON):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Follow-up process this job aid is for:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A. List steps in the workflow/process here:

B. List out the steps/protocols for responding to different patient needs/issues:

*(Fill in as appropriate for specific scenarios)*

| Circumstance | Steps to take | Notes/resources |
| --- | --- | --- |
| Medication fill assistance |  |  |
| Lab/test results |  |  |
| Appointment scheduling |  |  |
| Referral completion |  |  |
| Patient concern/feedback |  |  |
| Social determinants of health (SDOH) need identification and resolution |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_\_ |  |  |

When to escalate:

| When the non-clinician should escalate an issue | Who to escalate to | How to notify this team member | How to confirm receipt by team member |
| --- | --- | --- | --- |
| 1.  |  |  |  |
| 2. |  |  |  |

C. Create the job aid:

* Option 1. Create by hand
* Option 2. Enter the list above into Chat GPT or a generative AI platform using the prompt: “Create a job aid using these steps.” Edit until accurate.
* Option 3. Log onto a process map generator online like Lucid Chart and copy the list above into is AI process map generator to create a process map. Edit until accurate.

Summary and decisions:

Task list:

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

### Staff Training Plan for After-Visit Follow-up by Non-Clinician

Practice name:

Date:

Participating:

Name of Follow-up Process: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learners/Groups needing training:

1.

2.

3.

4.

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

### Performance Monitoring During CMP Implementation

Practice name:

Date:

Data collector:

A. Implementation of follow-up process by staff:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Target # of patients  | # of patients receiving follow-up | % of target reached | #Successfully completed | # Not reached | % successfully completed | Notes: reasons for fall-out/non-completion |
| Staff 1: (Name) |  |  |  |  |  |  |  |
| Staff 2: (Name) |  |  |  |  |  |  |  |
| Staff 3: (Name) |  |  |  |  |  |  |  |

B. Staff satisfaction with workflow: \_\_\_\_\_\_ (1=very dissatisfied, 5= neutral, 10=very satisfied)

Recommendations for workflow improvement:

C. Impact on patients and patient outcomes based on staff and PCP observations:

* Very negative
* Somewhat negative
* Neutral impact.
* Somewhat positive
* Very positive

Describe reasons for rating:

Summary and decisions:

Task list:

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

### Job Description Additions: After-Visit Follow-up by Non-Clinician

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 |  |  |

### Additions to Job Evaluations: After-Visit Follow-up by Non-Clinician

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: After-Visit Follow-up by Non-Clinician

Practice name:

Date:

Participating:

To the Quality Improvement (QI) Team: 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% |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |

Summary and decisions:

Task list:

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