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NEO QI Hub
NORTHEAST OHIO QUALITY IMPROVEMENT HUB

Resource B3.1: Example High-Level Process Map for Outreach

Standard Outreach

Outreach report generated automatically from EHR data at routine intervals*

*Outreach report might consist of any of the following: 1) patients with diabetes who did not keep their appointment; 2) patients with A1C ≥ 9% with no scheduled follow-up; or 3) diabetes care gap report. Routine intervals may be set up for monthly, every 3 months, every 6 months, or annually, depending on the capacity of the clinic.

Care team initiates outreach
- Attempt to schedule appointment using the patient's preferred communication method (e.g., text, portal message, phone call)
- Address barriers to care and connect patients with available resources (e.g., transportation, financial concerns, scheduling, social needs)

RN/MA schedules timely 30-day follow-up appointment with:
- Pharmacist, diabetes educator, nurse, dietitian, community health worker, provider, or another team member as appropriate

Real-Time Outreach

RN/MA contacts patient after no-show on the same day of missed appointment

RN/MA schedules appropriate follow-up
- Convert to same-day telehealth visit
- Reschedule for same-day in-person visit
- Reschedule within 30 days
- Offer walk in-hours
- Address barriers to care and connect patients with available resources (e.g., transportation, financial concerns, scheduling, social needs)

Patient rescheduled?

No

Initiate outreach
- Attempt to reschedule using the patient's preferred communication method (e.g., text, portal message, phone call)

Yes

Continue diabetes management and ongoing follow-up according to practice policy