Milestone: Implement Enhanced Outreach and Engagement

Milestone Language: Develop and implement outreach strategy for Population of Focus (PoF) to ensure access to evidence-based care using clinical guidelines and to address disparities. This should include review of reports of patients assigned but not seen and patients with care gaps, development of workflows, and identification and training of care team members to do the work.

1. Population of Focus
[Population of Focus Automatically Displayed]

2. Outreach Strategy

Describe how your practice conducts outreach and engagement for your selected PoF. Use the table below to detail your current outreach approach, including how patients are identified, who conducts outreach, and how you track and tailor your efforts to support equity and access. (You may reference plans described in your EPT data implementation plan.)

Prompt	Response
How do you identify patients who need outreach?	(e.g., panel reports, care gap reports, MCP lists)
What is your outreach target?	(e.g., monthly outreach to 50 patients, reach 80% of assigned and unseen patients by Q4)
How often is outreach conducted?	(e.g., weekly, biweekly, monthly)
How do you protect staff time for outreach activities?	(e.g., dedicated staff, blocked scheduling time, shared roles)
Who is responsible for conducting outreach?	(e.g., care coordinator, MA, CHW, outreach team)
What outreach methods are used?	(e.g., phone calls, text messages, mailed letters, home visits)
What is being offered or communicated during outreach?	(e.g., PCP visit, screening appointment, reminder to complete lab work, support with barriers to care)

How is outreach documented and tracked?	(e.g., EHR encounter note, outreach log, care management platform)
How many outreach attempts are made? What happens if the patient is not reached?	(e.g., 3 attempts before mailing a letter; CHW follow-up for hard-to-reach patients)
How is outreach tailored to address equity and access challenges?	(e.g., offering transportation, scheduling support, providing culturally and linguistically appropriate communication, flexible appointment hours)

3. Care Team Roles and Training

Please describe which care team members are responsible for outreach, what activities they perform, and any training, scripts, or tools provided to support them.

Care Team Role	Outreach Responsibilities	Describe any applicable trainings/scripts/tools provided (e.g., call scripts, training on cultural humility, EHR documentation training)

4. Evidence of Implementation

List at least two actions your practice has implemented to strengthen outreach and engagement for your selected PoF. For each, include the date the action was first implemented (i.e., when it launched or began being used with patients), how many patients were impacted, how success was measured, and any observed outcomes. Small-scale pilots and PDSA cycles are acceptable. To meet this milestone requirement, practices must implement **at least two NEW actions** (since the start of EPT) by **November 2025**.

For each implemented action, please complete the table below:

Implemented Action	Date of Implementation Start	# of Patients Impacted	Metrics Used to Evaluate if Action was Successful	Results Observed

Notes:

- Results may be qualitative (e.g., staff or patient feedback) or quantitative (e.g., care gap closure rates). Use specific data where possible.