Milestone: Implement Pre-visit planning

Milestone Language: Implement pre-visit planning for scheduled patient care for population of focus to reduce disparities and improve receipt of evidence-based care using clinical guidelines. This should include development of workflows, including how patient-level health maintenance reports are reviewed and utilized, and identification and training of care team members to do the work.

1. Population of Focus (POF)

[Display Population of Focus]

2. Overview of Pre-Visit Planning (PVP) Workflow

Briefly describe the overall process of pre-visit planning for your selected population:

Prompt	Response
Which roles are responsible for conducting pre-visit planning?	(e.g., MA, RN, care coordinator)
When does pre-visit planning take place?	(e.g., day before visit, morning huddle, weekly batch review)
What is the format of pre-visit planning?	(e.g., individual chart review, team huddle, automated EHR tool)
What tools or data sources are used?	(e.g., EHR dashboard, HIE reports, MCP reports, care gap lists)
What steps are included in the PVP process?	(e.g., gap identification, order prep, team communication, patient outreach)
Which care gaps are addressed during PVP?	(e.g., preventive care screenings, chronic condition labs, immunizations)
What actions are taken as a result of PVP?	(e.g., standing orders placed, referral initiated, task assigned to care team)
How are outcomes of PVP tracked or monitored?	(e.g., order completion, visit follow-up, documented in EHR or spreadsheet)

3. Care Team Roles and Training

Complete the table below by listing the care team roles involved in pre-visit planning for your selected Population of Focus. For each role, describe the specific responsibilities they carry out as part of the PVP process (e.g., identifying care gaps, chart review, placing standing orders). Also include any trainings, scripts, or tools provided to support them in performing these responsibilities consistently and effectively.

Care Team Role	Responsibilities in Pre-Visit Planning	Describe any applicable trainings/scripts/tools provided

4. Use of Managed Care Plan (MCP) and Registry Reports

Complete the table below by listing the types of reports your practice uses to support pre-visit planning (e.g., gaps in care reports, assigned and unseen patient lists, immunization registries). For each report, describe how it is accessed and how it is used in your workflow.

Report Type (e.g., registry, gaps in care)	How Reports are Accessed	How Reports Are Used

5. Detailed Workflow Steps

Complete the table below by outlining the key steps in your pre-visit planning workflow. For each step, indicate who is responsible, what tools or systems are used, and when the step typically occurs relative to the visit.

Step in Workflow	Responsible Role(s)	Tools/Systems Used	Timing (e.g., 48 hours before visit)

6. Evidence of Implementation

To meet this milestone, your practice must implement at least two **new actions** (since the start of EPT) to strengthen pre-visit planning for your selected PoF. For each action, include the date it was launched (i.e., when it began being used with patients), the number of patients impacted, how success was measured, and any observed outcomes. Small-scale pilots or PDSA cycles are acceptable as evidence.

Please complete the table below for each implemented action:

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

Notes:

- Results may be **qualitative** (e.g., staff or patient feedback) or **quantitative** (e.g., care gap closure rates, number of care gaps identified through PVP).