

RapidID Case Study Follow-Up Email Sequence

A six-email nurture sequence for EMS and hospital stakeholders

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Speculative Portfolio Sample



Sample Context

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Audience	EMS leaders, hospital stakeholders, MedTech marketers
Asset Type	Email nurture sequence
Objective	Show how follow-up email copy supports case-study engagement and a protocol-review offer.
Scenario	Speculative sequence tied to the RapidID prehospital sepsis identification case study.
What This Demonstrates	Campaign sequencing, operational fluency, sales enablement logic, and MedTech follow-up strategy.

Campaign Objective

Use the case study as the anchor asset, then guide the reader through timing, protocol, financial, adoption, and close themes before pointing toward a prehospital protocol review.

Email Sequence Overview

Email	Focus	Role in Sequence
Email 0 Delivery	Case study delivery	Delivers the case study and frames the upstream identification issue.
Email 1 Timing	Timing gap	Reframes delay as a prehospital timing problem rather than only an ED issue.
Email 2 Protocol	Protocol limitations	Shows why protocols alone do not remove field variability.
Email 3 Financial	Financial impact	Connects delayed recognition to downstream operational and financial cost.
Email 4 Adoption	Adoption barriers	Explains why field fit determines whether a solution is usable.
Email 5 Close	Protocol review close	Moves the reader toward a structured prehospital protocol review.

Email 0 — Delivery Case study delivery	
Subject line	Case study: 34% more sepsis cases identified prehospital as requested
Preview text	See where the identification gap started before ED arrival.
Body copy Hi [First Name], Tri-County EMS had a problem -- they had a sepsis mortality rate 14% higher than any other county in their area. "How One Regional EMS System Identified 34% More Sepsis Cases — Before the Patients Reached the ED" tells the story of how their Medical Director identified and fixed the problem. You can access it here: [Insert Link] As you review it, pay attention to where identification actually begins. In this system, the gap wasn't protocol compliance. It was where identification actually started. If you don't have time to go through it now, I'll highlight a few of the key findings in follow-up notes. Best, [Your Name]	
CTA	Purpose
Download your case study here.	Delivers the case study and frames the upstream identification issue.

EMAIL 1 — TIMING

Email 1 — Timing Timing gap	
Subject line	Where delays actually begin
Preview text	The field assessment may be where the clock really starts.
Body copy Hi [First Name], If you haven't had a chance to review the case study yet, it's worth a quick look: [Insert Link] When sepsis outcomes fall outside benchmark, most reviews start in the ED. Are antibiotics delayed? Is SEP-1 compliance slipping? In many systems, those aren't the issue. In the Tri-County EMS system, the delay started earlier—in the field. Field identification rates were as low as 12%. By the time the patient reached the hospital, the clock had already been running—without a clear trigger to start treatment. Standard vitals don't always show early decline. So the system responds on time... to a signal that arrived late. That's why two systems with similar protocols can see very different outcomes. It's not always about treatment. It's about when identification actually begins. Best, [Your Name]	
CTA	Purpose
<i>In case you misplaced it, download your case study here</i>	Reframes delay as a prehospital timing problem rather than only an ED issue.

Email 2 — Protocol Protocol limitations	
Subject line	Why protocols don't eliminate the gap
Preview text	SIRS and qSOFA still rely on judgment and incomplete information.
Body copy Hi [First Name], When Dr. McGrew dug into the numbers, he found something unexpected. Like most EMS systems in the US, Tri-County had sepsis protocols in place. But protocol adherence wasn't the issue. In the field, tools like SIRS and qSOFA still rely on: Judgment under pressure Incomplete information Variation across EMS crews Two paramedics can assess the same patient and reach different conclusions—both defensible. And that variability showed up clearly once the run data was pulled. But without an objective trigger, protocols don't remove uncertainty. They just organize it. If you're seeing variation in how cases are identified, that usually becomes clear when prehospital data is reviewed side by side. Best, [Your Name]	
CTA	Purpose
No separate CTA; educational follow-up email.	Shows why protocols alone do not remove field variability.

Email 3 — Financial Financial impact	
Subject line	What those delays actually cost
Preview text	The cost shows up in ICU days, staffing, equipment, and compliance.
Body copy Hi [First Name], When the numbers were broken down, the clinical gap was only part of the picture. Each missed early identification carried a downstream cost. In Dr. McGrew's system, earlier identification moved care forward by an average of 18 minutes. And when a case turned into septic shock, the impact was clear: Additional ICU days—roughly four per case—about \$14,000. Higher use of staff and equipment Increased compliance exposure The financial impact didn't start in the ICU. It started before the patient ever reached the ED. That's where the delay was. And where the cost actually started. If you're looking at outcomes or budget impact, it's worth revisiting how those cases were identified in the field: [Insert Link] Best, [Your Name]	
CTA	Purpose
Schedule a review of your numbers here	Connects delayed recognition to downstream operational and financial cost.

Email 4 — Adoption Adoption barriers	
Subject line	Why some options never make it into the field
Preview text	Accuracy mattered, but field fit decided adoption.
Body copy Hi [First Name], Before moving forward, several options were reviewed. Most looked solid on paper. They still didn't move forward. Not because of accuracy—but because they didn't fit how crews work: - Couldn't hold up under field conditions - Added extra steps - Introduced delay or risk in handoff That's where many evaluations break down. A tool can work in testing and still fail in the field. In the pilot, results were in the ED before arrival in 94% of transports. That's what allowed the protocol to execute consistently. The system ultimately moved forward with a point-of-care lactate device that matched the realities of the field—simple to use, reliable, and able to transmit results before arrival. If you're evaluating options, this is the section most teams go back to before making a decision: [Insert Link] Best, [Your Name]	
CTA	Purpose
Click here to schedule a discussion of your options	Explains why field fit determines whether a solution is usable.

EMAIL 5 — CLOSE

Email 5 — Close Protocol review close	
Subject line	Ready to see where your system is losing time?
Preview text	No sales discussion. Just your data, in context.
Body copy Hi [First Name], If you've reviewed the case study, you've seen how a single upstream gap drove both clinical and financial impact. In the Tri-County EMS pilot, the turning point wasn't a protocol change. It was identifying where time was being lost before arrival. And making that visible. Once that gap was clear, the system was able to act earlier, more consistently, and with measurable impact on outcomes and cost. Most systems have this blind spot. Some just don't see it yet. If you're responsible for outcomes or system results, this is the next step. A structured prehospital review will show where time may be slipping—before it shows up in outcomes. We analyze your run data, compare how cases are identified, and highlight where delays are occurring upstream. No device evaluation. No sales discussion. Just your data, in context. [Insert Link] Or reply with a time that works, and we'll walk through it together. Best, [Your Name]	
CTA	Purpose
<i>You can schedule the review here.</i>	Moves the reader toward a structured prehospital protocol review.

Strategy Note

This sequence demonstrates how a case-study asset can be extended through follow-up emails. The sequence progresses from delivery, to timing, to protocol limitations, to financial impact, to field adoption, and finally to a protocol-review CTA.

The copy remains anchored in the same operational logic as the RapidID case study: the problem is not only treatment delay, but where identification begins.

Why This Sample Works

Why This Sample Works	
Sequence logic	Shows the progression from proof delivery to problem reframing to next-step conversion.
Sales enablement use	Gives sales or marketing teams follow-up language tied to the case study.
Operational fluency	Keeps the sequence grounded in EMS workflow, ED handoff, and adoption realities.
Portfolio value	Demonstrates campaign thinking without separating the work from the core MedTech sample system.

Disclaimer

This is a speculative portfolio sample created to demonstrate copywriting, messaging, and sales-enablement capabilities in realistic MedTech and prehospital scenarios. It was not produced for, approved by, or published by a real client unless otherwise stated. The email sequence is presented as a formatted portfolio sample and does not represent an active commercial campaign.