

THREE YEARS.

Here's what we built.

Indian Health Center of Santa Clara Valley

Care Team Assessment & Implementation

Daniela Arcienega-Director of Population Health

EPT Final Learning Community · Part 1 · September 29, 2026



Indian Health Center of Santa Clara Valley

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Population Health



Who we are and who we serve



1	Practice type <i>Non-profit FQHC Urban Indian health center in Santa Clara County</i>
2	Patients served <i>21,135 active patients, 17,678 Medi-cal, 2,017 Medicare 55.6% Hispanic/Latino, 44.4% Non-Hispanic/Latino</i>
3	Our EPT population of focus <i>Adults with chronic conditions-DM and HTN prevalence</i>
4	What this storyboard is about <i>Care Team Assessment and Implementation</i>

Three Years Ago

Who we were before EPT

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Where we were

In 2023, our uncontrolled A1c rate was 27% and our CBP rate was 54%.

In our old model, we didn't have standing orders and expanded scopes of practice for MAs and RNs. We used printed GIC lists and handed them to clinic managers for the MAs to work on them during their "downtime". The Health Maintenance tests were performed at the end of the visit after the provider placed the order and sometimes not completed. We had a rudimentary pre-visit planning tool, but it wasn't standardized and used inconsistently.



What Was Really Going On

What we found when we looked closer

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What we learned

Patient Engagement

- Low health literacy led to patients not understanding how to take their medications
- Patients are reluctant to take their meds
- Culture(bad eating habits and missing preventative follow-up appointments)
- Lifestyle(competing priorities such as multiple jobs, family, etc., limited time for exercise and eating healthy)
- Lack of more Spanish-speaking providers

Patient Access

- Transportation barriers
- Long wait times to get specialty care(i.e. ophthalmology)

System Workflow

- Absence of standing orders(caused delays in workflows due to MAs not being able to pend orders and all DM overdue tests needed to be done after the provider placed the order at the end of the visit), oftentimes patients left without completing the test
- MA's never had "downtime" to work on their outreach lists. Even though a clinic support pool was created, the TE's remained untouched due to time limitations from the MAs that worked with the providers, leading to an ineffective clinic support pool created.
- MA's that worked with full-time providers didn't have time for pre-charting
- Missed opportunities to close diabetes care gaps during PCP appointments(clinical teams had a pre-visit planning tool in relevant but its use was not standardized and consistent)

In their words

“ Patients often are rushed to leave and unwilling to wait for additional in-house testing after they have completed their appointment with their provider.

— an MA lead

What We Built

The change we made, and who runs it

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The change

Patient Engagement

- Started monthly educational campaign series on various DM topics
- Implemented care plan use with patient input on self-goals

Patient Access

- Allocated funds for Uber Health rides
- Implemented daily case management schedules in MR and SC clinics to close care gaps

System Workflow

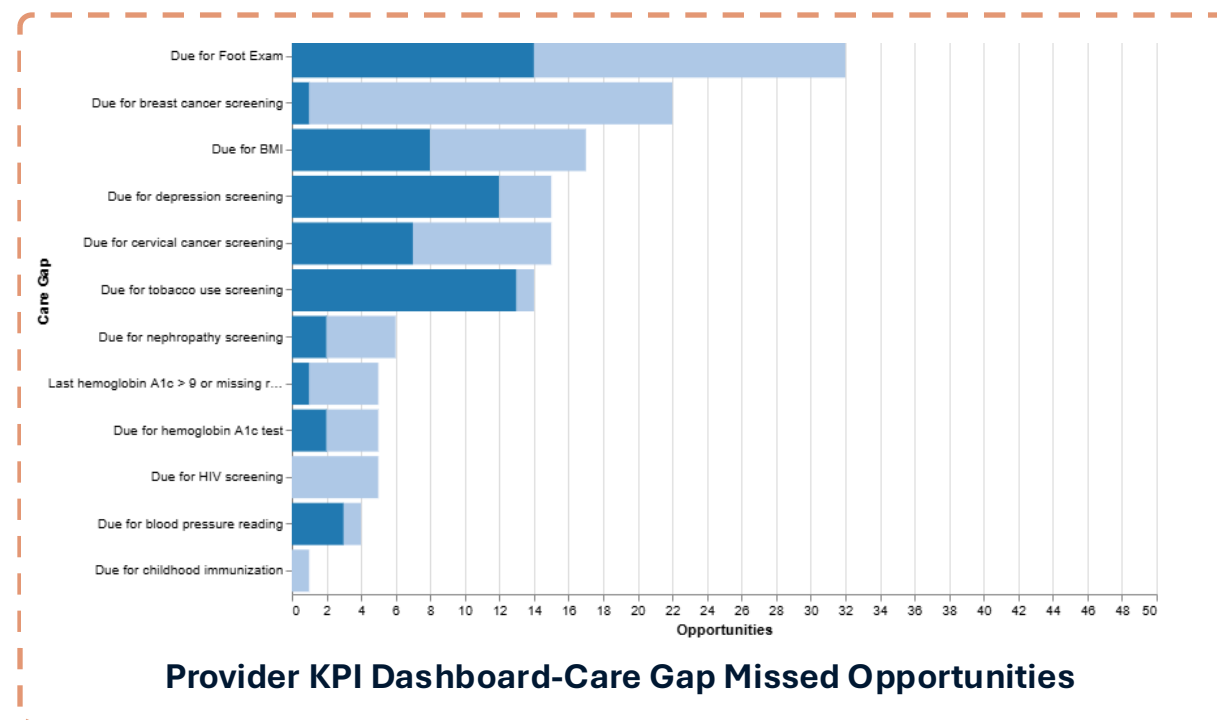
- Implemented the use of standing orders
- Expanded the scope of practice for RNs and MAs
- More training for clinical staff to prevent missed opportunities to close care gaps during office visits
- The clinic support pool is now managed by other roles such as pt navigators that conduct outreach

From the person who runs it

“

Being able to do pre-visit planning by reviewing care gaps and pending orders through standing orders beforehand has helped with time efficiency/organization for a smoother shift

— an MA lead



Provider KPI Dashboard-Care Gap Missed Opportunities

What Happened

Our numbers, and what surprised us

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27.42%

where you started

21.13%

where you ended

1,658

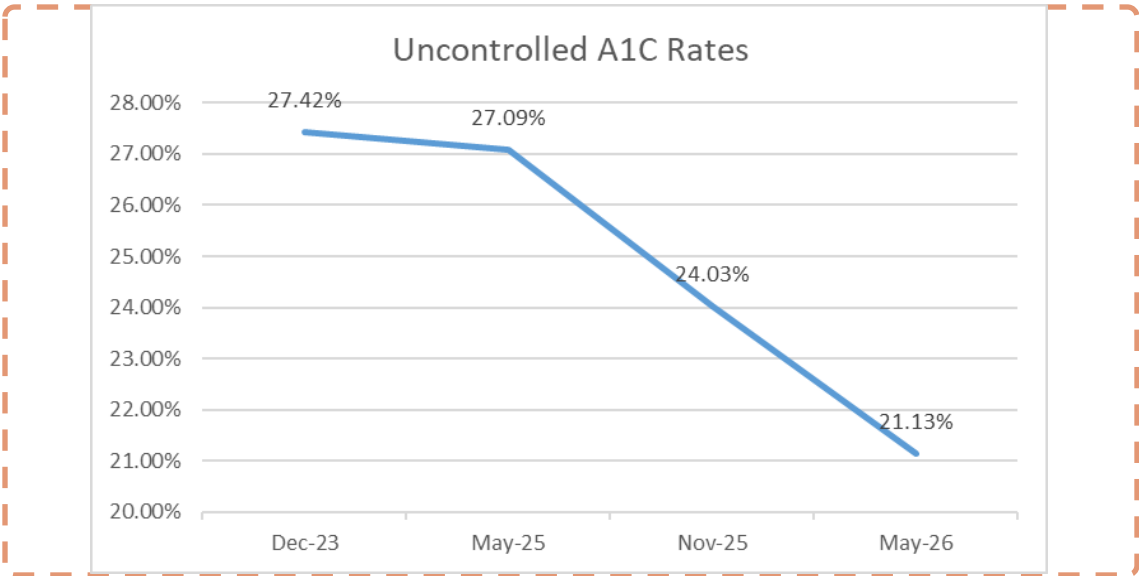
patients impacted

The numbers, in a sentence

Uncontrolled A1c is the percentage of diabetic members (18-75) who had HbA1c testing with a result of above 9% or a missing result. Our A1c rate trended downwards, starting at 27.42% in Dec 2023 and ending at 21.13% in May 2026.

What did not go as planned — and what surprised you

- Length of time and reiteration needed to standardize workflows across all providers in IHC
- Provider buy in in adopting new workflows
- Significant no-show rate in our case management schedules
- High staff turnover for MAs
- Provider staffing shortages
- Inconsistent Provider/MA huddles for some teams



What Happened

Our numbers, and what surprised us

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10.54%

where you started

30.76%

where you ended

637

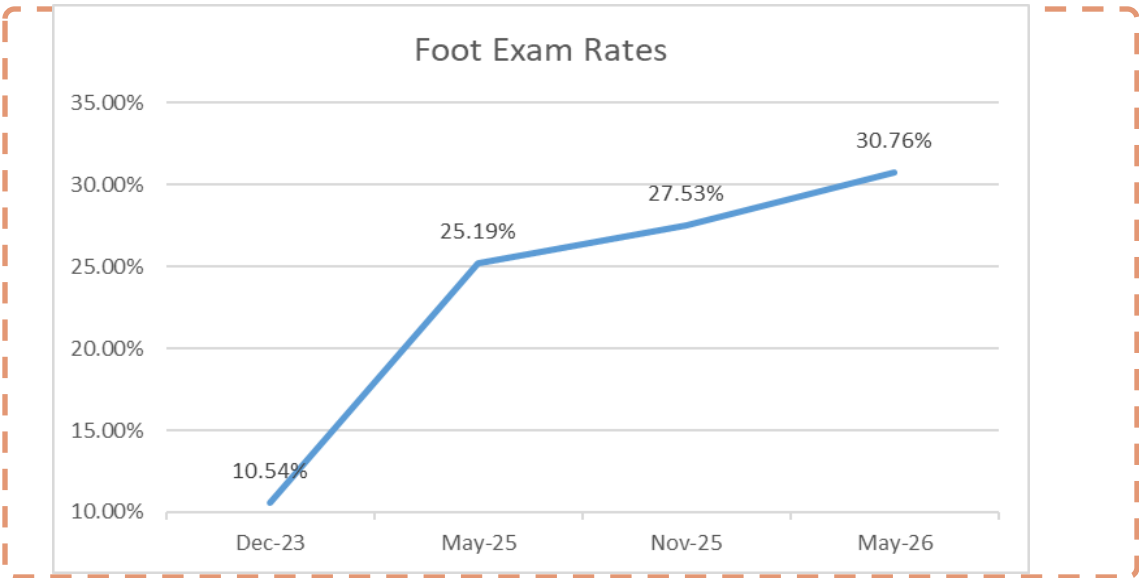
patients impacted

The numbers, in a sentence

Our foot exam rates have steadily improved in the past 3 years.

What did not go as planned — and what surprised you

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What Happened

Our numbers, and what surprised us

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21.46%

where you started

44.37%

where you ended

978

patients impacted

3,273

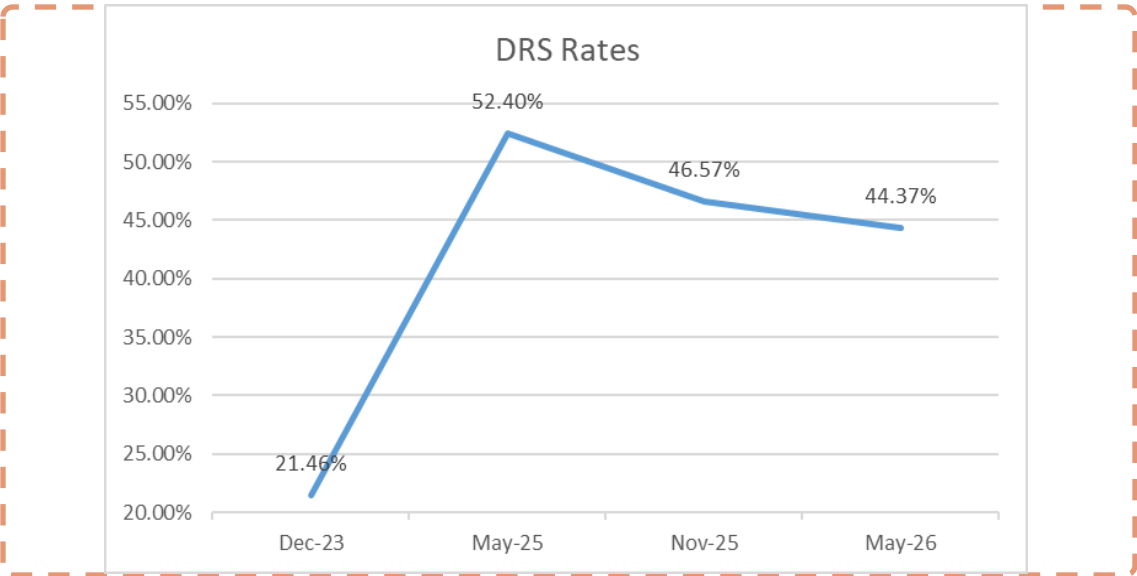
Total # diabetic
patients impacted

The numbers, in a sentence

Our eye exam rates for our diabetic patients have improved over the past 3 years. However, staffing turnover due to the high cost of living in the Bay Area has made it challenging to sustain this improvement.

What did not go as planned — and what surprised you

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What Happened

Our numbers, and what surprised us

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53.89%

where you started

67.51%

where you ended

2,305

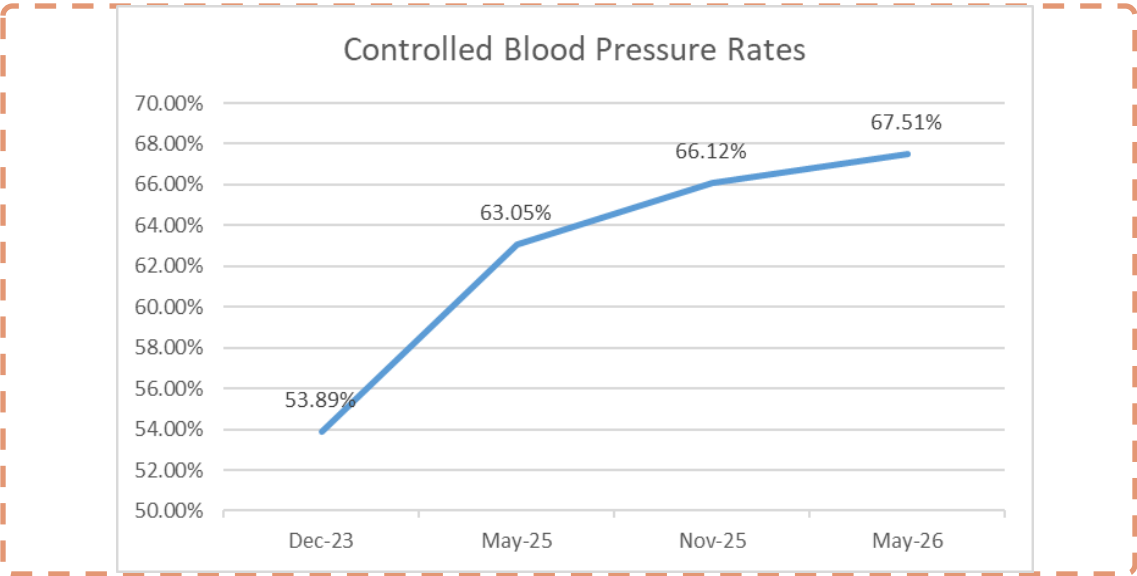
patients impacted

The numbers, in a sentence

CBP is the percentage of members 18-85 diagnosed with HTN whose BP was adequately controlled (<140/90 mm Hg). Our CBP rate trended upwards, starting at 53.89% in Dec 2023 and ending at 67.51% in May 2026.

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The Patient Behind the Number

One story behind the numbers

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“

Patients are more appreciative of a more smoother and efficient visit because of the standing orders. MA staff are more content during their shift with this new workflow that allows them to be more efficient. Clinical teams also find that chart reviews done by patient navigators prior to the visit are helpful to identify missed opportunities to close care gaps.

— Patients and clinical staff

And the story around it

Prior to making workflow adjustments, we were missing many opportunities to close care gaps. Being more efficient during visits has allowed patients to come less often and be more timely with their Health Maintenance testing and take less time off work.



What We Can Do Now

The capability we did not have before

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- We can now be more efficient with our pre-planning process due to having standing orders and expanded MA and RN roles
- We have patient navigator support for patient outreach and in-reach chart review prior to the visit
- We analyze individual provider performance progress through KPI Dashboards for MAs and providers
- We have daily case management schedules assigned for care gap closure under standing orders
- We can now monitor BP and glucose values through RPM Programs

What it feels like now

“

Motivated to make sustainable changes to our workflows to continue to provide quality care for our patients while keeping in mind our staff wellbeing



And who does it reach?

All adult patients with chronic disease such as DM and HTN, and patients in general who need preventative screenings and tests

Care Gap Opportunities >

Showing results from the last time this report was run at 9/22/2026 2:30 PM. If the queried data has changed since then, results may be out of date.

Report

Use this Report to:

Identify which Care Gaps were addressed and missed at visits, and track trends by visit type, provider, location, and other visit dimensions.

Description:

This report was developed for the Care Gap Opportunities Dashboard. Each row represents an opportunity to resolve a particular open Care Gap at a UDS Medical visit. A Care Gap opportunity is considered addressed if the Care Gap is closed within the required time window (see "Parameters" below) from the visit date.

Please note that a Care Gap may appear "addressed" for reasons other than an intervention being performed at the visit. Examples of these include:

- A patient aged out of the Care Gap
- The Care Gap's definition was changed and the patient is no longer eligible
- The required intervention was performed at another visit roughly within the same time window.

What It Took to Keep It Going

What it took, and what makes it sustainable

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What it took

- Ongoing discussions with each clinic leadership during internal QI meetings
- Reiteration of this topic during trainings in clinic huddles and in RN and provider meetings
- Building reports that allow us to track progress
- Adding more support roles into the care teams with patient navigators-we added 1.8 FTE with a FTE support grant from our MCO for patient navigator work

What makes it sustainable

- *Buy in from each clinic leadership*
- *Adjusted workflows to continue using case management schedules managed by RNs and MAs*
- *Ongoing monitoring of performance through reports that we built*
- *Continued grant funding for FTE support for patient navigators to help with chart review and outreach*

Say it in one sentence

We are thrilled to celebrate an incredible milestone-our 2025 Provider Performance Program (PPP) HEDIS score reached 67.9%, the highest score in our Medical Department's history!

What We'd Tell You

What we'd tell another practice

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1

If you were doing this over, what is one thing you would do differently?

- Training MA with pre-charting workflows early in their onboarding
- Emphasizing not missing care gap closure opportunities in the New Provider onboarding-tied to Quality and incentive programs
- Having clinic huddles have more focus on HEDIS measures and care gap closure sooner

2

Where would you like to build on this, or grow next?

- *Expand our RPM Program for DM and HTN*
- *Reinstating consistent daily provider/MA huddles*
- *Utilizing Cheers Campaigns for automating outreach*

3

Highlights to share

Get buy in from clinic leadership
Incorporating patient navigators into care teams if possible
Training MA with pre-charting workflows early in their onboarding
Expanding clinical support roles as best as possible

THANK YOU

Questions?

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