



EPT MILESTONE — PRE-VISIT PLANNING

Implement Pre-Visit Planning

Family Health Matters Community Health Center

FQHC | Anaheim, CA

Population of Focus: Diabetic Patients | A1c >9 Priority Subgroup

Our Foundation: Mission & History

Dr. Minal Borsada, Chief Medical Officer



Our History

Family Health Matters has served North Orange County for over 20 years — providing compassionate, comprehensive, culturally sensitive care regardless of ability to pay.

**The Women's Center
Founded**

**2008
Community Clinic**

**2012
FQHC Designation**

**20+ Years Serving N.
Orange County**

Vision

To help the communities we serve stay healthy, get well, and live better.

Mission

- Comprehensive integrated care
- Services regardless of ability to pay
- Promoting prevention and chronic disease management

Core Values

- Integrity
- Quality
- Collaboration
- Compassion
- Diversity

What We Accomplished

Rapid Growth without Performance Decline



50%

More Patients Treated
Since Baseline

1,000+

More Unique Patients
Served in 2025

4

HRSA CHQR Awards
in 2026

Service Expansion

- 4/10 provider schedule
- Expanded telehealth capacity
- Naturopathy, Psychiatry & Dental
- Medical mobile & vision mobile programs

2025 HRSA Recognition

- 3 HRSA CHQR Awards
- Preventive Care
- Cancer Screening Performance
- Health Care Access

2026 HRSA Recognition



2026 Awardee

4 HRSA CHQR Awards including
Health Center
Quality Leader Gold
Medal National
Quality Leader in
Heart Health

EPT Milestone at a Glance

FHM-CHC | 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."

4

New Actions
Since EPT Start

1,682

Patients Impacted
Across All Actions

6

Quality Measures
Improved

5

Care Team Roles
Trained

Population of Focus

All diabetic patients, with A1c >9 identified as the priority subgroup for intensified outreach and standing-order activation.

Organization

FHM-CHC — an FQHC serving North Orange County / Anaheim, CA. Full-scope primary care including behavioral health integration.

Milestone Status

4 new PVP actions implemented since EPT start — meeting the 2-action minimum. Evidence documented in EHR with measurable outcome data.

Care Delivery Transformation

MA Population Health Tools & Provider Engagement



MA Population Health Tools

Pre-Visit Gap ID

Identify care gaps before the patient arrives

Preventive Screening

Review preventive screening status for each visit

Chronic Disease Tracking

Monitor chronic disease metrics across the panel

Standing Orders

Execute standing orders to close care gaps efficiently

Provider Engagement

- Trust population health data generated outside the exam room
- Work within structured teamlets to distribute care responsibilities
- Incorporate pre-visit gap reports into routine clinical workflow
- Accept empanelment accountability for their patient panels
- Rely on standing orders executed by trained Medical Assistants

Pre-visit planning enabled providers to focus on complex clinical decision-making rather than preventive care reminders.

Pre-Visit Planning Workflow Overview

Roles responsible and when PVP takes place



ROLES RESPONSIBLE

Medical Assistants (MAs)

Conduct initial chart reviews and flag care gaps for overdue labs, screenings, and preventive services before every scheduled visit.

Referral Coordinators

Ensure needed specialist appointments are scheduled ahead of patient visits, and that consultation notes are available for providers to review prior to or during the visit.

WHEN PVP TAKES PLACE

1–2 Days Before

MAs and Referral Coordinators complete chart reviews and outreach. Allows time to prepare orders and schedule appointments before the patient arrives.

Morning Huddles

Held day-of to review patient needs, finalize care plans, and assign tasks. Multi-disciplinary team (MA, RN, Provider, RC) participates.

Weekly Batch Reviews

Performed for high-risk populations across upcoming patient panels. Used to proactively identify and address care gaps at the population level.

Roles and timing work together: MAs and Referral Coordinators drive chart-review and scheduling 1–2 days before the visit, while morning huddles and weekly batch reviews give the care team two additional checkpoints before the patient walks in.

PVP Format & Tools

Formats used and the tools/data sources that support them



FORMAT OF PRE-VISIT PLANNING

Individual Chart Review

MAAs and providers perform detailed chart reviews to identify care gaps, overdue labs, and needed referrals prior to each visit.

Team Huddles

Daily/weekly multidisciplinary huddles discuss high-risk patients and coordinate care strategies across the care team.

Care Gap Tool Review

EHR-integrated care gap tool covers preventive care and chronic condition management gaps — used to prioritize outreach.

TOOLS & DATA SOURCES USED

EHR (eClinicalWorks)

Primary source for patient data, lab results, medication lists, and clinical documentation.

Relevant (PHM Platform)

Generates patient registries, care gap reports, and dashboards for proactive population management.

Clinical Decision Support

EHR-integrated alerts, reminders, and order sets to guide evidence-based care.

PVP Reports

Automated and manual reports highlighting overdue tests, screenings, and chronic disease needs.

Referral Tracking System

Monitors specialist appointments and ensures follow-up consult notes are available for providers.

Steps Included in the PVP Process

Five sequential steps carried out ahead of every scheduled visit



The workflow turns population-health data into defined action
— before and during the encounter — rather than leaving care-gap review to chance.

Actions Taken & Outcome Tracking

What PVP triggers, and how results are monitored



ACTIONS TAKEN AS A RESULT OF PVP

Standing Orders

Activated for labs, screenings, immunizations due — HbA1c, microalbumin, foot exams — through pre-visit chart review.

Referral Initiation

Proactive referrals for diabetic eye exams, podiatry, and behavioral health placed ahead of the patient visit.

Task Assignment

RNs conduct outreach, MAs prepare labs, coordinators schedule appointments — all assigned through EHR task workflow.

Patient Outreach & Education

Patients informed of needed tests/appointments ahead of visit; barriers such as transportation, language addressed proactively.

HOW OUTCOMES ARE TRACKED



Order completion tracking in the EHR



Visit follow-up via care coordination workflows



Full EHR documentation of all PVP activity



Spreadsheets/dashboards aggregating PVP outcomes



Regular review by clinical leads and QI teams at monthly meetings

Care Team Roles & Training

Responsibilities and supporting trainings/scripts/tools by role



Care Team Role	Responsibilities in PVP	Trainings / Scripts / Tools Provided
Medical Assistant (MA)	Conduct individual chart reviews; prepare orders under standing orders; flag patients for overdue labs and screenings.	EHR care gap report and standing orders training; patient outreach call scripts; lab/screening prep checklists.
Registered Nurse (RN)	Review complex patient cases; coordinate care plans; assist with patient education and outreach.	Clinical guidelines training (diabetes, hypertension); motivational interviewing scripts; patient education materials.
Referral Coordinator	Schedule specialist appointments ahead of visits; ensure consult notes are available for providers.	Referral tracking system training; patient communication scripts; workflow protocols for closing referral loops.
Clinical Pharmacist	Review medication regimens during PVP; prepare medication adjustment recommendations; coordinate with providers.	Medication management guidelines training; medication review documentation templates; provider collaboration protocols.
Provider (Physician/NP/PA)	Review pre-visit summaries and prepared orders; make final clinical decisions; discuss care gaps and plans with patient.	Guideline summaries within EHR; decision support tools/alerts; shared decision-making communication training.

Detailed Workflow Steps & Timing

Who is responsible, what tools are used, and when each step occurs



Step in Workflow	Responsible Role(s)	Tools / Systems Used	Timing
Identify care gaps	Medical Assistant, RN	EHR care gap reports, PHM platform (Relevant)	48–72 hours before visit
Prepare orders and referrals	Medical Assistant, Referral Coordinator	EHR order sets, standing orders protocols	48 hours before visit
Conduct team huddle	Care Team (MA, RN, Provider, RC)	EHR messaging, team communication tools	Morning of visit or day before
Patient outreach	Care Coordinator, RN	Phone, patient portal, outreach scripts	Months to 48–72 hrs before visit
Document plan in EHR	Medical Assistant, RN	EHR documentation templates	Before patient encounter
Provider review & final prep	Provider (Physician, NP, PA)	EHR summary reports, clinical decision support tools	Day of visit

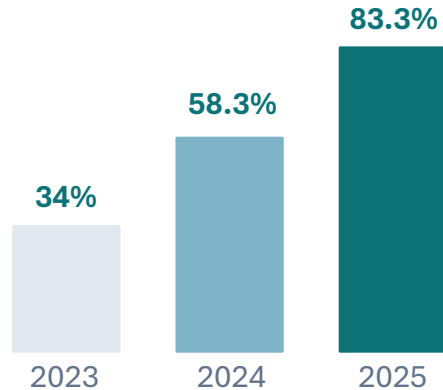
Quality Improvement Over Time

Year-end rolling 12-month results — sustained progress across three priority measures



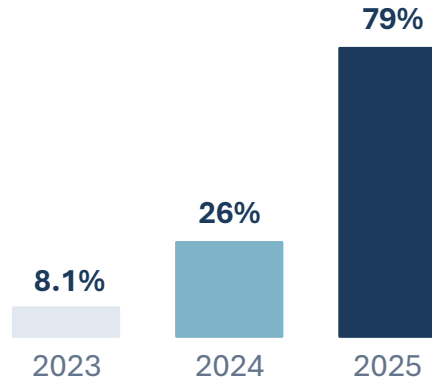
Rolling 12-month UDS/quality data — 2023 → 2024 → 2025.
The largest gains occurred in HIV screening and diabetes foot-exam completion.

HIV SCREENING



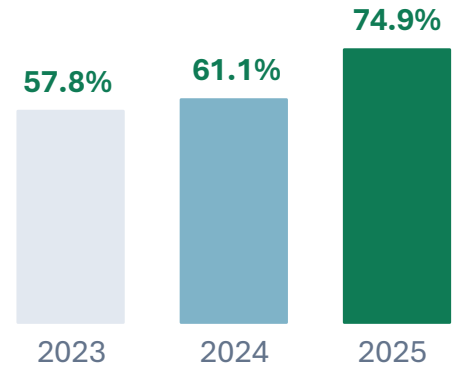
3-Year Gain: +49.3 pts

DIABETES FOOT EXAM



3-Year Gain: +70.9 pts

NEPHROPATHY SCREENING



3-Year Gain: +17.1 pts

Evidence of Implementation

4 new actions implemented since EPT start — meeting the 2-action minimum



4

New Actions

1,682

Patients Impacted

≥2

Action Min. Met

Implemented Action	Start	Patients	Metrics Used	Results Observed
Pilot CGM program with pre/post surveys for diabetes patients	Jul 2025	20	HbA1c before/after 3 months; patient-reported experience surveys	HbA1c reduction at 3-month follow-up; positive feedback on CGM ease-of-use and engagement
Standing orders for annual microalbumin and foot exams	Jan 2025	690	EHR completion rates; monitored at monthly QI meetings	Microalbumin screening 55% → 76.5%; foot exam documentation improved 30%
Pre-visit immunization review and standing orders	Jan 2025	848	Vaccine completion rates (Tdap, HepB); EHR care gap closure tracking	Tdap +27%, Hep B +92% vs. prior year; more timely administration
Standardized diabetes care plan with RN and clinical pharmacy	Jan 2025	124	EHR care plan documentation; referrals completed; A1c tracking	DM care plan documented for 54.6% of A1c >9 patients; 12.2% all DM patients; improved coordination

Milestone Summary

Pre-visit planning is not a report or a huddle — it is a system built around the population of focus



WORKFLOW BUILT

Roles, timing, format, and tools are defined for identifying and closing care gaps before every visit.



REPORTS IN USE

MCP roster and Relevant care-gap reports drive population-level prioritization and individual chart review.



TEAM TRAINED

Five care team roles (MA, RN, Referral Coordinator, Clinical Pharmacist, Provider) have defined responsibilities and training.



EVIDENCE DOCUMENTED

4 new actions since EPT start, 1,682 patients impacted, with measurable improvement across 6 quality measures.

Next Steps: Continue monthly QI review of the 4 implemented actions; expand the CGM pilot beyond its initial 20 patients; and sustain standing-order and pre-visit immunization workflows as standard practice for the diabetic population of focus.