

THREE YEARS.

Here's what we built.

Tuolumne Me-Wuk Indian Health Center

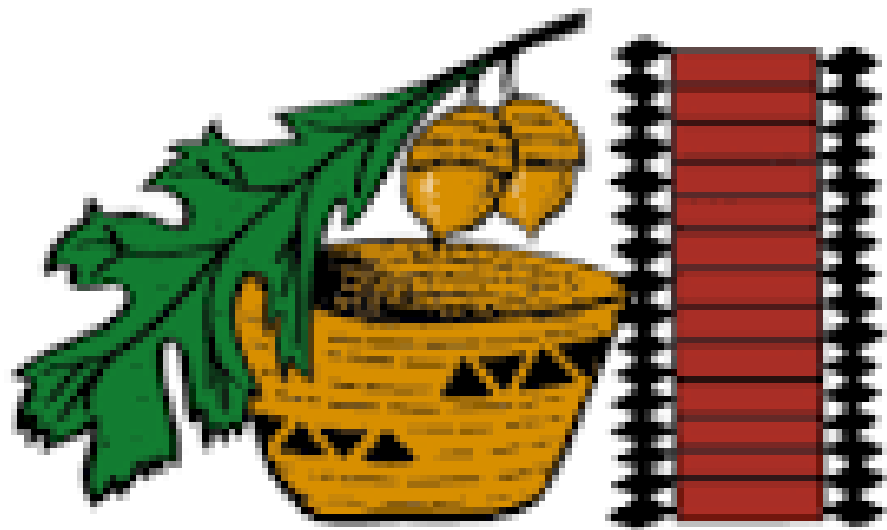
Pre-Visit Planning & Disparity Reduction in Depression Screening

Dee Baldwin · Director of Tribal Health Outreach & Danielle Doane · Grant Administrator

EPT Final Learning Community · Part 1 · [Sept 29, 2026]

Tuolumne Me-Wuk Indian Health Center

Who we are and who we serve



Tuolumne Me-Wuk
Indian Health Center

WHO SPEAKS HERE

[Dee Baldwin, Director of Tribal Health Outreach]



1

Practice type

Tribally owned Rural Health Center serving the Tuolumne Band of Me-Wuk Indians, other American Indian/ Alaskan Natives, and Tuolumne County residents.

2

Patients served

6,700 patients seen annually across 2 primary care clinics, 2,000 Medi-Cal, 1,600 Medicare, 2,600 Commercial, and 200 IHS Beneficiaries, and 300 cash pay patients.

3

Our EPT population of focus

Adult Chronic Care — chosen because it is a key area of focus within our Primary Care clinics and presents the greatest opportunity for impact. We aim to address existing gaps, improve patient engagement, and advance health equity within this group.

4

What this storyboard is about

Disparity Reduction plan for depression-screening in patients ages 18-44 and the Pre-visit planning deliverable.

Three Years Ago

Who we were before EPT

WHO SPEAKS HERE
[Danielle Doane, Grant Administrator]



What could you not do in 2023 that this work was going to require?

Where we were

In 2023, care gap reports existed, but outreach and patient visits were not connected. Providers and staff lacked a standardized pre-visit planning process to identify and act on care gaps before appointments. EPT helped us to create dedicated workflows that link population health data to individual patient visits, supporting more proactive whole-person care.



What Was Really Going On

What we found when we looked closer

WHO SPEAKS HERE
[Danielle Doane, Grant Administrator]



Why was the gap there? And how did you find out — did you ask patients, ask staff, dig into the data?

What we learned

We talked with 7 staff members in person and surveyed 6 community members by email. Staff pointed to patients only coming in when something is wrong, work schedules, and transportation and childcare barriers. Community members told us it was hard to reach anyone by phone to schedule, cited travel cost, distance to the clinic, turnover among the providers they saw, and calls that went unreturned.

In their words

“*The doctors I see keep leaving after a few months.*”

— a patient, patient/community survey

What We Built

The change we made, and who runs it

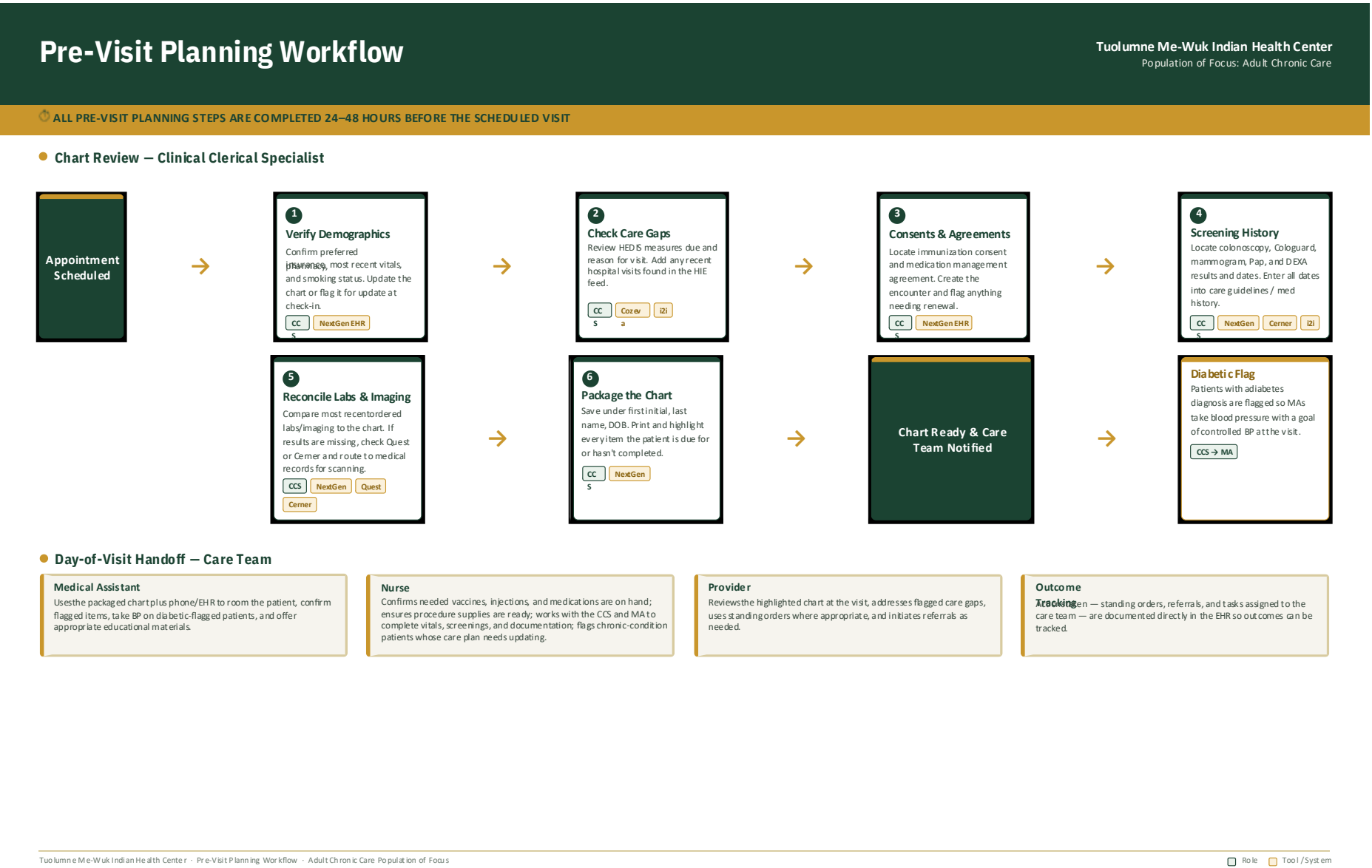
The change

A dedicated Clinical Clerical Specialist now does pre-visit chart review 24–48 hours out, using our EHR dashboard and MCP/Cozeva/i2i data to flag care gaps. For depression screening, we shifted from email/letter outreach to live phone calls that schedule the visit on the spot.

From the person who runs it

“ For every patient, my goal is to identify every care gap, so nothing is missed before the visit.

WHO SPEAKS HERE
[Dee Baldwin, Director of Tribal Health Outreach]



What Happened

Our numbers, and what surprised us

WHO SPEAKS HERE
[Danielle Doane, Grant Administrator]



0 dedicated staff

where you started

2 dedicated staff

where you ended

198+

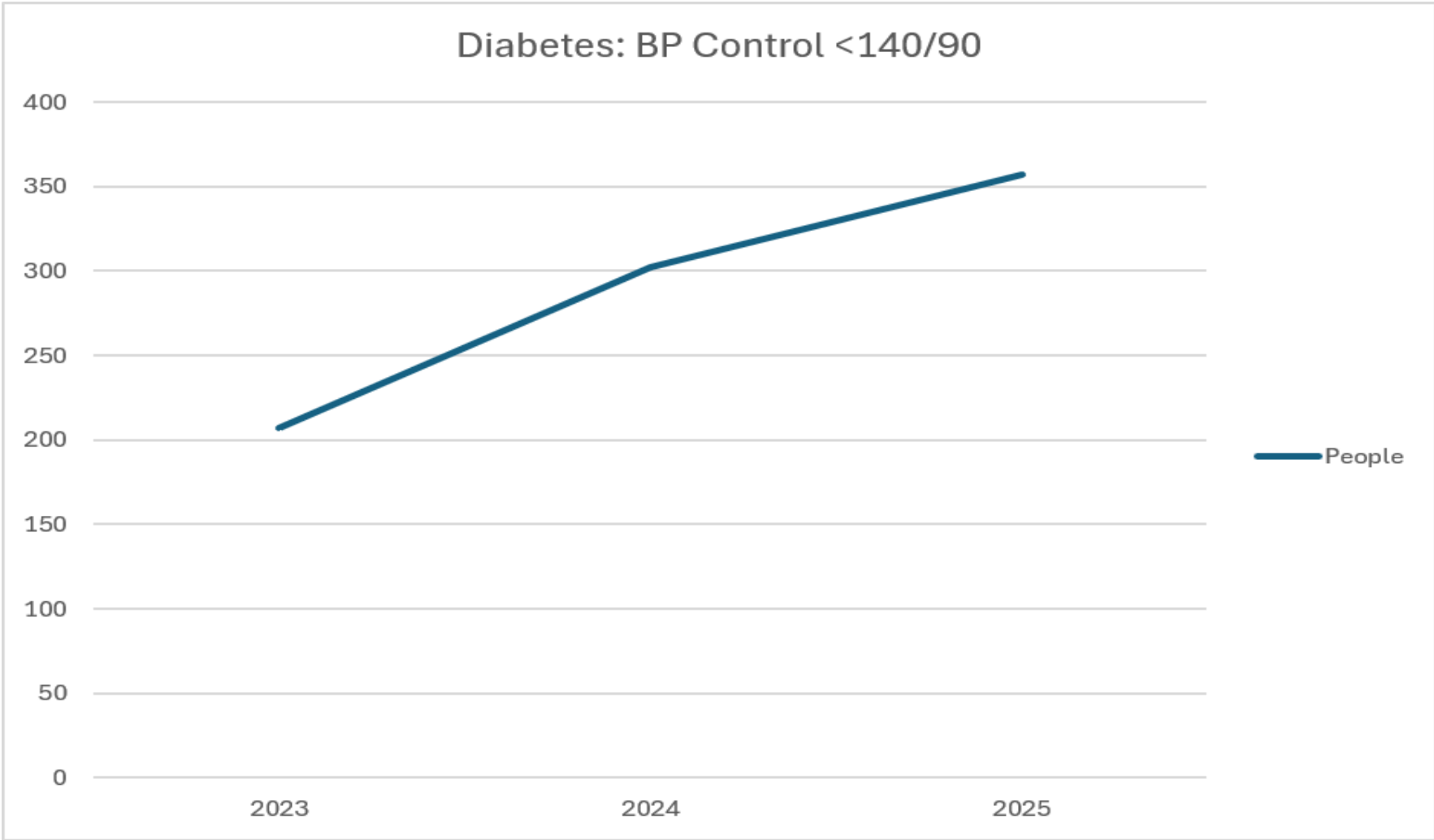
patients impacted

The numbers, in a sentence

Since 3/1/2025: +143 A1C tests, +55 controlled BP, +100 patients with 2+ BP checks (2024 vs. 2025).

What surprised us

Our first try at closing the depression-screening gap (ages 18–44: 82% vs. 88–89% for older groups) used email and letters — we got zero calls. We switched to live phone outreach with same-call scheduling, which improved appointment scheduling rates by 8%.



The Patient Behind the Number

One story behind the numbers

WHO SPEAKS HERE
[Dee Baldwin, Director of Tribal Health Outreach]



“*"I kept meaning to come in, but life gets in the way — work, my kids, all of it. When they called and said I was overdue, I almost said I'd call back later. But she asked me right then if I wanted to just get it on the books, so I did. At the visit, they asked me some questions about how I'd been feeling — I hadn't really said it out loud to anyone before. It felt strange, but also kind of a relief that someone finally asked."*

— [a male patient in their mid 40's]

And the story around it

He hadn't been in for a wellness visit in several years, though he'd been to our clinic a few times in between for unrelated issues. When our pre-visit outreach flagged him as overdue, he was scheduled for a same-call appointment, and the depression screening was completed during the visit.

What We Can Do Now

The capability we did not have before

WHO SPEAKS HERE
[Danielle Doane, Grant Administrator]



Finish this sentence: “We can now...”

We can now flag every Adult Chronic Care patient's outstanding labs, screenings, and immunizations 24–48 hours before their visit — and for patients with a depression-screening gap, our team can reach them by phone and get them scheduled on that same call.

What it feels like now

“*The work feels more meaningful when I can call the patient, connect with them, and get them scheduled at the same time.*”

★ And who does it reach?

Diabetic patients whose A1C/BP gaps went unnoticed until their visit, and patients ages 18–44 — our lowest-screened age group for depression — who weren't responding to mail and email.

What It Took to Keep It Going

What it took, and what makes it sustainable

WHO SPEAKS HERE
[Dee Baldwin, Director of Tribal Health Outreach]



What did it take to build and run, and what will keep it going? Dollars, FTEs, or hours all count, and estimates are fine.

What it took

Two staff dedicated full-time to pre-visit planning (Clinical Clerical Specialists), plus nurse and MA time built into the existing pre-visit workflow. Training covered NextGen EHR, Cozeva, i2i, and the immunization registry — all existing tools, no new licensing cost.

What makes it sustainable

Pre-visit planning is now a standing position, with outcomes tracked directly in NextGen. For the depression-screening intervention, the Director of Outreach and Grant Administrator review process and outcome measures, and live phone outreach is part of the outreach team’s regular workflow.

2

to build, one time

2

to keep it running

Care

What it gives back

Two staff and existing EHR/registry tools closed 143 A1C-testing gaps and 55 controlled-BP outcomes — now a standing part of daily workflow, not a grant-dependent pilot.

What We'd Tell You

What we'd tell another practice

WHO SPEAKS HERE
[Danielle Doane, Grant Administrator]



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

Don't give up on a good goal because the first solution doesn't work. We learned that improvement comes from testing, learning, and adapting. When email and letters produced 0 appointments, we switched to live phone outreach and kept moving forward.

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

Our next step is to make pre-visit planning more efficient through greater automation and better EHR integration. By reducing manual chart review and making care gap information easier for providers to find, we can identify more patient needs and support more effective whole-person care.

3 Steal this from us.

The two-person dedicated pre-visit planning model, and the shift from passive outreach (email/letter) to live phone outreach with same-call scheduling for closing care gaps. Reach us at Daniell.Baldwin@tmwihc.org or Danielle.doane@tmwihc.org.

THANK YOU

Questions?

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