

THREE YEARS.

Here's what we built.

Petaluma Health Center

Diabetes Care: Strategies to Improve A1c Measurement, Care, and Control

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



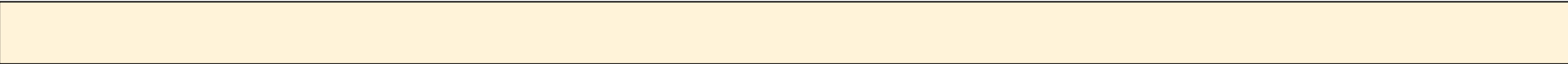
Petaluma Health Center



Who we are and who we serve



1	Practice type <i>Large FQHC serving two counties and a total of 4 main practice sites, as well as shelter- and school-based satellite sites and a mobile coach</i>
2	Patients served <i>36,485 patients (UDS 2026), and over 40,000 patients including non-UDS services 13,487 patients best served in a language other than English More than 40% living at or below the FPL</i>
3	Our EPT population of focus <i>Patients living with chronic conditions – including depression, hypertension, and diabetes</i>
4	What this storyboard is about <i>Pre-Visit Planning for Patients Living with Diabetes: To improve hemoglobin A1c assessment and control in our population.</i>



Three Years Ago

Who we were before EPT



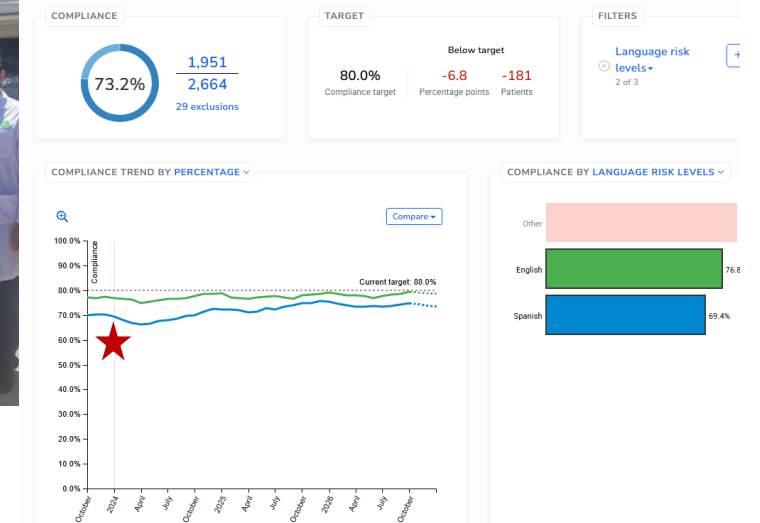
Where we were

In 2023, our practice team was in the midst of preparing for an EHR transition. Our population health management practices required that MA's and providers conducted pre-visit planning using two platforms, the EHR and an external population health management platform (Relevant). This incentivized asynchronous huddles and pre-visit planning that was not team-based.

Our team also identified disparities in diabetes control rates by primary language, where Spanish-speaking patients achieved a rate of A1c control that was 7.4% less than their English-speaking peers.



Diabetes: Glycemic Status Assessment Less Than or Equal to 9% inverted)



What Was Really Going On

What we learned

Staff expressed that they felt disconnected from their teammates. They planned care in virtual “vacuums” without having the chance to prepare together as part of team-based population health management time. They lacked easily accessible data on a single platform, and lacked high-quality clinical decision support resources.

Staff and patients also expressed a desire to have linguistically concordant care, and expressed that discordance increased the likelihood of poor quality communication and care engagement.

In their words

“ I feel like the EHR should be **working for me**, but instead I spend my time **working *through* the EHR**. It’s hard enough to do this work, but when I don’t have the tools I need, I spend more time and effort just to give the basics.”

— [a provider, of providing diabetes care in the new health record]

What We Built

The change

We resumed team-based population health management time.

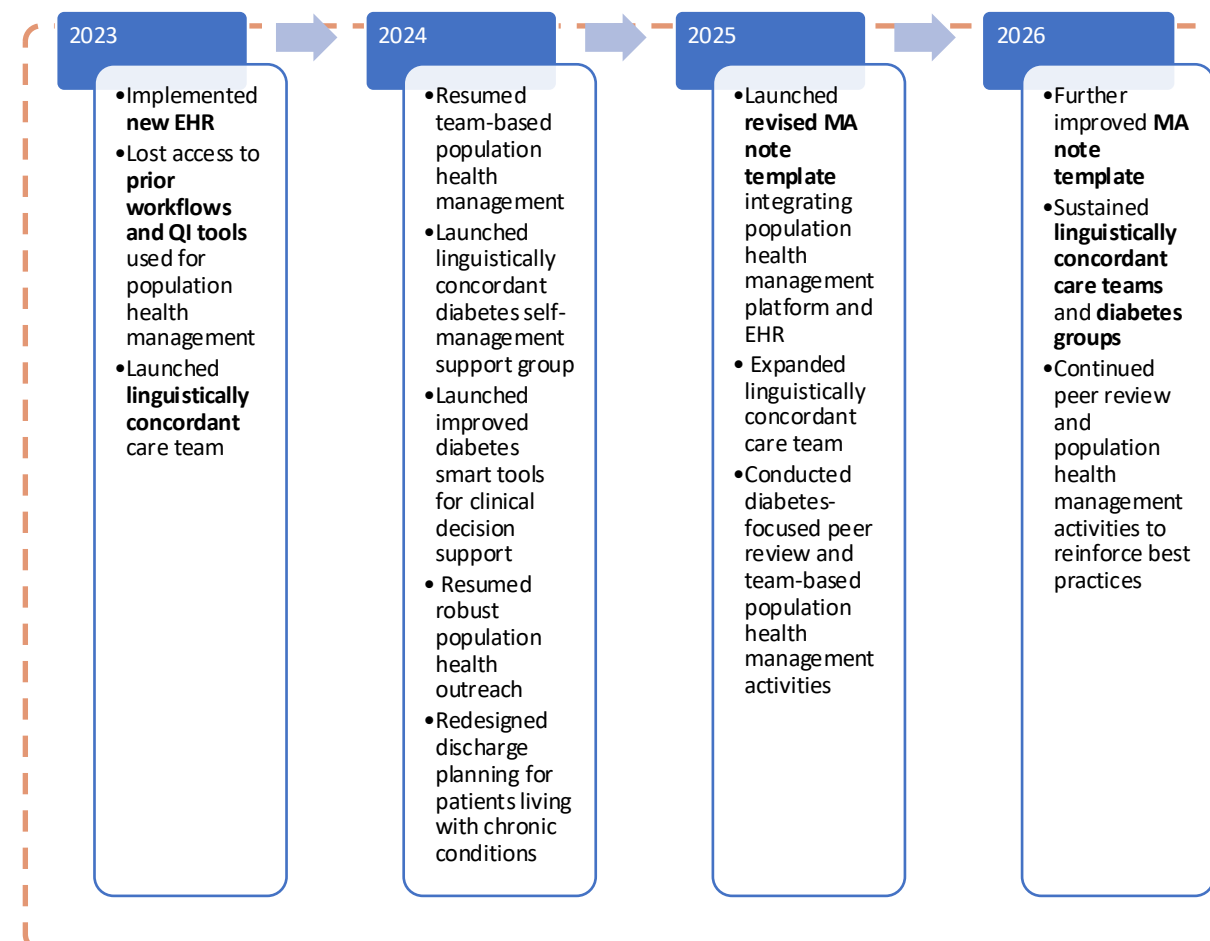
We integrated our PHM platform care guidelines into our EHR MA rooming template and built clinician smart sets that incorporated clinical decision support tools to improve evidence-based practice (including A1c screening rates)

We launched a linguistically concordant care team to serve Spanish-speaking patients, including those living with chronic conditions.

We redesigned discharge planning for patients living with chronic conditions to optimize post-discharge follow-up.

From the person who runs it

“ I can now find what I need to do in one place, and I feel like the EHR guides me!



What We Built

The tools

MA note now synthesizes data from EHR and PHM platform.

- Ensures huddles allow for optimal pre-visit planning
- Optimizes care team experience.

Appt Notes: Meet new / DM

Plan for today:

1. MA Screening and Counseling Today

[Anxiety Screen Today](#)

[PRAPARE Screening Today](#)

[ACES Screening Today](#)

[Flu Vaccine Screening Questions \(refresh note when complete\)](#)

NOTE: The patient has agreed to the flu vaccine and the medical provider has been made aware. If the patient is due for a second vaccine this season an appointment or plan was made:

General Vaccine Questionnaire

Is the person to be vaccinated sick today?: No

Has the person to be vaccinated ever had a serious reaction to any vaccines in the past?: No

Has the person to be vaccinated ever had Guillain-Barre syndrome?: No

Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?: No

Is the person to be vaccinated currently pregnant?: No

Has the person being vaccinated received any vaccinations in the past 4 weeks?: No

Is the person to be vaccinated ever felt dizzy or fainted during or after a shot?: No

Rx refills needed: no

Recent ER visit? no

2. Health Maintenance & Visit Planning

[Immunizations Due](#)

Most vaccines other than Flu for adults with insurance should be given at the pharmacy:

For Adults with Insurance [Please print pharmacy handout for patient](#)

Health Maintenance Due

Topic	Date Due
• Imm-COVID-19 (1 - Current season)	Never done
• Imm-Hepatitis B (1 of 3 - 19+ 3-dose series)	Never done
• Imm-DTaP/Tdap/Td (1 - Tdap)	Never done
• Imm-Pneumococcal 50+ (2 of 2 - PCV)	06/20/2023

Reviewed CAIR: yes

Last Immunization Review: Apr 17, 26 8:50 AM Hernandez, Gisselle

Last Immunization Registry Query: Sep 23, 26 4:53 PM

[Labs Due](#)

Health Maintenance Due

Topic	Date Due
• Lipid Screening/Monitoring	05/27/2026
• Serum Creatinine	05/27/2026
• Urine Albumin Creatinine Ratio Screening	08/20/2026

[Imaging Due](#)

There are no preventive care reminders to display for this patient.

SmartSets

Search for new SmartSet

+ Add

SmartSets

Associate

Edit Multiple

Patient Estimate

Providers

PHC Pharmacy - Petaluma, CA

707-559-7612

Remove

Pend

Sign

SA267 Diabetes

Manage User Versions

PHC SmartSet for the management of type 2 diabetes:

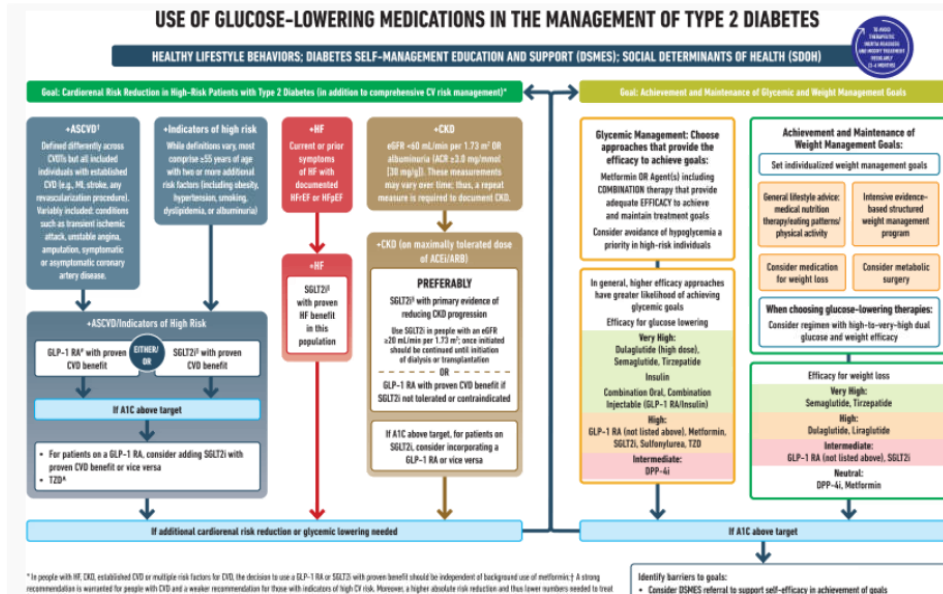
Based on [2023 ADA Guidelines](#) , [2018 NCEP Guidelines](#) & [MediCal Formulary](#)

Documentation Tools

Diabetes Documentation

- ☐ SA267 DIABETES MELLITUS TYPE 2
- ☐ SA267 DM HTN HYPERLIPIDEMIA
- ☐ DM FOOT EXAM (add to note)
- ☐ SM Goal (add to note)
- ☐ Blood Sugar Log - Attaches to after visit summary
- ☐ Diabetes Diet & Physical Activity - NIH - (ENGLISH)
- ☐ Diabetes Diet & Physical Activity - NIH - (SPANISH)
- ☐ Follow up in 3 Months (high risk or A1c not controlled)
- ☐ Follow up in 6 months (A1c controlled)
- ☐ OFFICE/OUTPATIENT ESTABLISHED [99214]
- ☐ OFFICE/OUTPATIENT ESTABLISHED LOW [99213]

Glucose Lowering Medications



- ▶ GLP1s
- ▶ Biguanides - Metformin
- ▶ SGLT-2 Inhibitors
- ▶ Insulins
- ▶ Sulfonylureas
- ▶ TZDs
- ▶ DPP-4 Inhibitors
- ▼ Other Medications

- Click for more
- Click for more
- Click for more
- Click for more
- Click for more
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If h/o ASCVD use high intensity statin (Atorvastatin 40-80mg or Rosuvastatin 20-40mg)
If no h/o ASCVD patients with Diabetes 40 - 75 yoa - Moderate intensity statin (Atorvastatin 10-20mg, Rosuvastatin 5-10mg)

All pts with DM and HTN should have a home monitor
ACE/ARB is recommended first-line treatment for HTN in patients with DM. Start with ACE/HCTZ combination unless contraindication. Address contraception if needed.

- <https://aliadoshealth.org/wp-content/uploads/2023/02/RHC-Cholesterol-Algorithm.pdf>

Other Medications

Click for more

Supplies

- ▶ Glucometers with Supplies
- ▶ Strips & Lancets
- ▶ Needles & Syringes

- Click for more
- Click for more
- Click for more

Labs

- ▶ Labs

Click for more

Referrals

- ▶ Diabetes Referrals

Click for more

Ad hoc Orders

What Happened



Our numbers, and what surprised us

73.6%

where you started

77.4%

where you ended

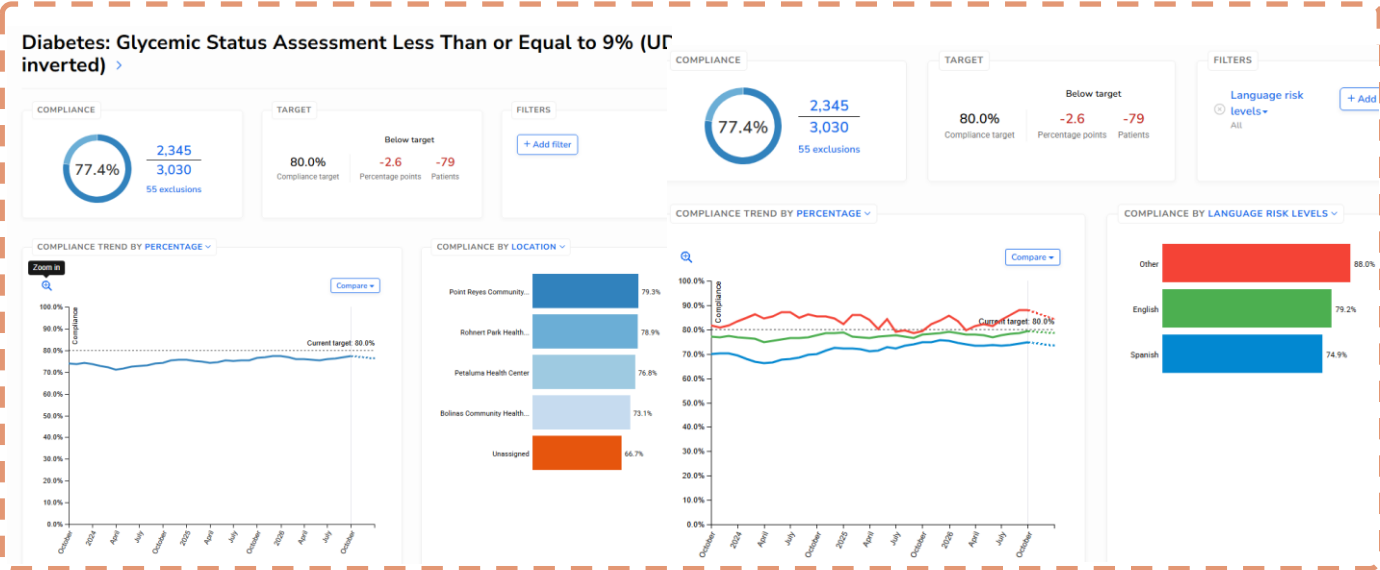
2,345

patients impacted

The numbers, in a sentence

An additional 3.8% of patients living with diabetes achieved A1c control during the grant period. This represents an **additional 114 patients with good control.**

The disparity in A1c control between Spanish- and English-speaking patients narrowed from 7.4% to 4.3%. This disparity **narrowed further** when comparing English-speakers to Spanish-speaking patients assigned to linguistically concordant care teams (2.4% disparity).

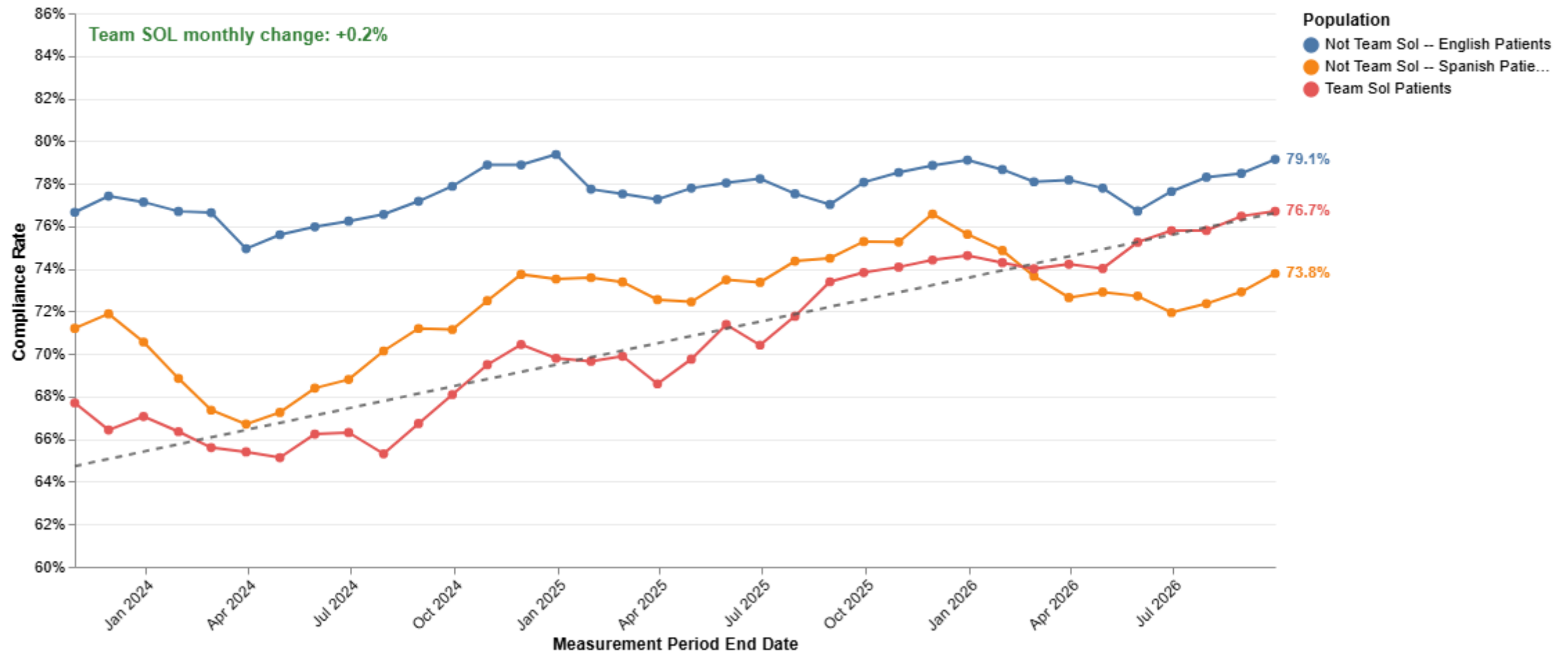


THE SURPRISE...

Tools aimed at improving pre-visit planning and care for patients living with diabetes correlated with improvements in rates of A1c measurement, clinician experience, A1c control rates, and reductions in disparities in A1c control by primary language.

Diabetes A1C Control Trend

Monthly compliance rate by patient population



What We Can Do Now

The capability we did not have before



We now have an **integrated tool** within the EHR enables us to **identify all gaps in care** for each patient living with diabetes with a visit today.

We have **clinical decision support** to enable providers to synthesize and respond to clinical data based on best practices.

We now have structures in place to **engage patients outside of office visits** to coordinate diabetes care (population health management time).

We have structures in place to ensure that patients who do present for **care experience reduced barriers** to communication and access.

What it feels like now

“ I feel like I can finally do my work in one ‘place’. And I feel like we’re practicing in a more standardized way as a practice.”



And who does it reach?

The patient who only presents for acute care, but is due for chronic disease management.

The patient who has been out of care for a prolonged period.

The patient who speaks a language other than English, and benefits from linguistically concordant care.

What It Took to Keep It Going

What it took, and what makes it sustainable



What it took

MA Huddle Note Design and Rollout: 15-20 hours of provider builder FTE, roughly 6 hours of EHR trainer FTE, and 2 hours of training per MA at least annually.

1 hour of clinical FTE per provider and MA biannually to perform panel-specific population health outreach.

What makes it sustainable

The MA rooming note is now used by all MA-provider dyads to plan care.

The clinic re-implemented scheduled population health management team time, ensuring that patients overdue for care are engaged at least biannually.

The clinic has an established workflows for matching patients to providers based upon their spoken languages to improve the quality of communication (and care).

The clinic regularly meets to revise EHR tools to meet evolving practice team needs.

What We'd Tell You

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

- Allow for time to engage staff in design and testing of huddle tools
- Engage patients to identify what, of the tasks associated with visits for diabetes care, requires the most support and coordination. Focus more effort in that area.

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

- *Restructure of the huddle: timing, content, and roles.*
- *Expand beyond the successes of the pre-visit plan and huddle, and address end-of visit/after-visit care and communication.*

3 Steal this from us.

- *Our MA note template.*
- *Our strategy to promote linguistically concordant care.*
- *Our population health activity templates for MA's and providers.*

THANK YOU

Questions?

Petaluma Health Center

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