10/23/2026

Making Every A1C Count: Embedding Diabetes Care Into Daily Workflows

Sonoma Valley Community Health Center (SVCHC)
Promising Practice

PROMISING PRACTICE OVERVIEW

Sonoma Valley Community Health Center (SVCHC) has sustained performance of approximately 79% - 81% in their Diabetes glycemic status assessment measure over the past two years through the integration of diabetes management into routine clinical operations. SVCHC uses a coordinated, team-based approach that combines targeted patient outreach, standing clinical protocols, daily care-gap management, and data-driven patient identification. These established practices are supported by monthly follow-up for patients with elevated A1C, in-house A1C testing, and multidisciplinary care coordination. More recently, SVCHC has expanded its approach through behavioral health integration and diabetes self-management education to further support patient engagement and continuity of care. Integrated daily workflows supports sustainability, while an added population-of-focus layer, like patients with high A1C and PHQ-9, helps identify patients who need more intensive support.

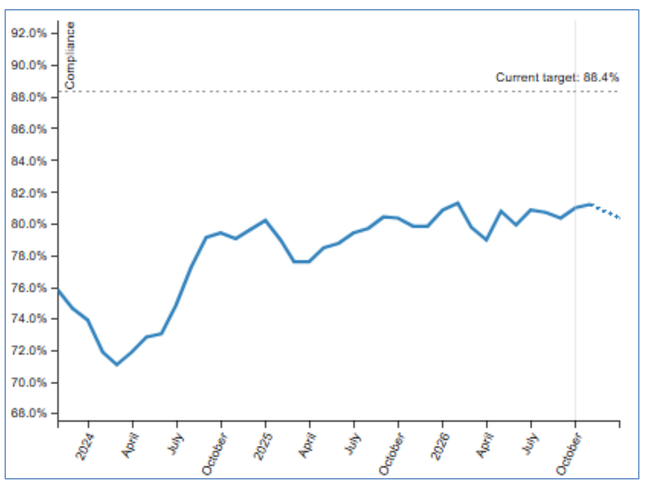
AIM

To improve diabetes outcomes by ensuring patients receive timely monitoring, follow-up care, and support services through a coordinated, team-based approach focused on proactive patient engagement.

MEASURE

Diabetes: Glycemic Status Assessment Less Than or Equal to 9% (UDS 2026 Table 7, inverted)

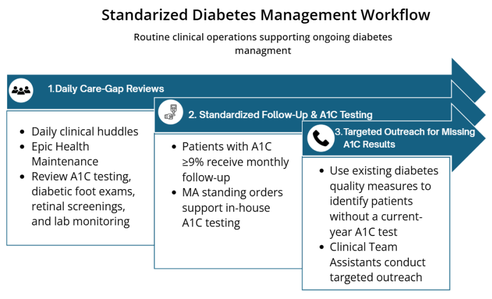
RESULTS TO DATE



Diabetes: Glycemic Status Assessment Less Than or Equal to 9% (UDS 2026 Table 7, inverted)



WORKFLOW



Please see Appendix 1 for full size version.

LESSONS LEARNED / HIGH VALUE TAKEAWAYS

- Coordinated workflows, rather than a single intervention, contributed to sustained diabetes outcomes.
- Care coordinators strengthen patient engagement and often uncover barriers or concerns that patients may not share with their provider.
- Data-driven outreach helps identify high-risk patients and prioritize care-gap closure efforts.
- Standing orders, in-house A1C testing, and monthly follow-up visits reduce barriers and support timely diabetes management.

ACTIONS TAKEN

Core Diabetes Management Workflows

Integrated Daily Care-Gap Reviews into Clinical Workflows

- Conducted daily clinical huddles to review patient care gaps before scheduled visits.
- Utilized Epic Health Maintenance to identify outstanding diabetes-related gaps, including:
  - HbA1c testing
  - Diabetic exams
  - Retinal screenings
  - Microalbumin testing
  - Creatinine monitoring
- Incorporated diabetes management into routine care-gap discussions rather than creating separate diabetes-specific meetings.

Standardized Monthly Follow-Up and HbA1c Monitoring

- Established a clinic-wide expectation that patients with HbA1c levels % receive monthly follow-up appointments rather than quarterly visits.
- Shared monthly follow-up expectations across providers, medical assistants (MAs), and front desk staff.
- Utilized MA standing orders to perform in-house HbA1c testing during patient visits without waiting for individual provider orders, reducing the need for outside laboratory visits.

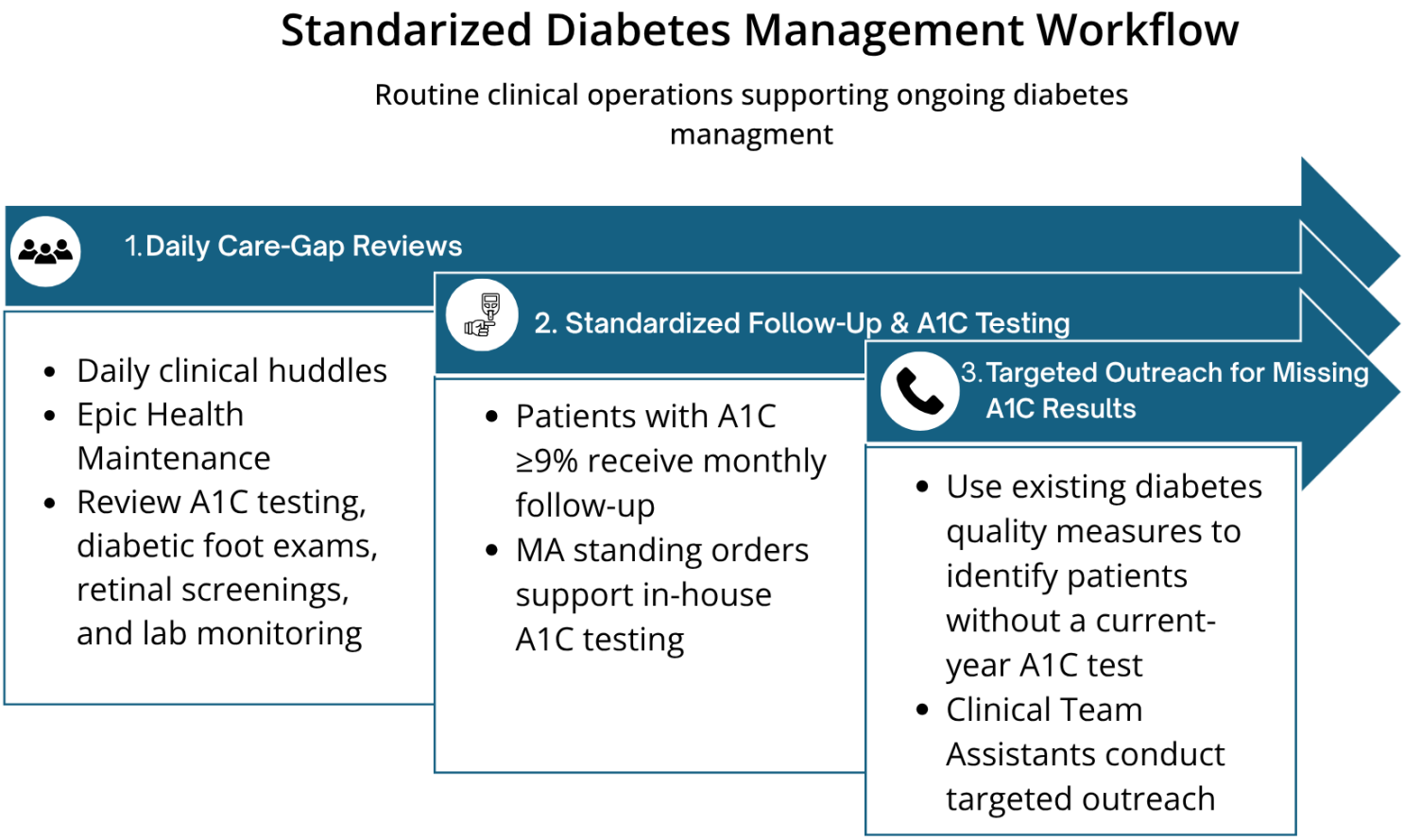
Conducted Targeted Outreach to Patients Missing Current-Year HbA1c Values

- Used existing diabetes quality measure reports to identify 57 patients without a documented A1C result during the current measurement year.
- Redistributed quality-measure outreach responsibilities previously managed by the quality coordinator to Clinical Team Assistants (CTAs), assigning staff specific measures for targeted patient outreach. This approach helped expand SVCHC's outreach capacity.
- Conducted targeted outreach to patients missing current-year A1C results, including those who previously demonstrated controlled diabetes, to support completion of overdue testing.

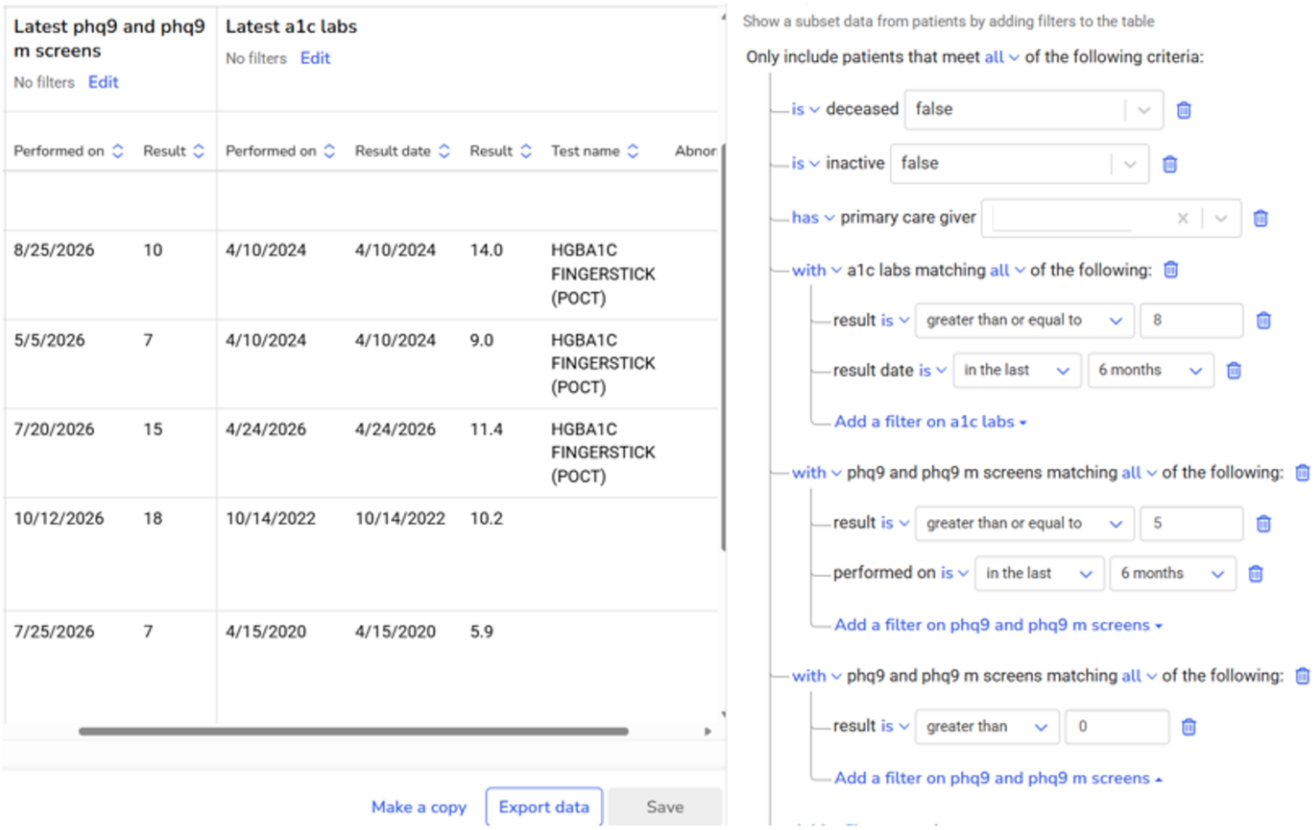
Supplemental Population-of-Focus Interventions

- **Created a Customized Data Explorer Report:** SVCHC's Population Health Manager developed a customized Data Explorer report to identify patients needing additional diabetes support. Report criteria included factors such as HbA1c levels, PHQ-9 scores, behavioral health indicators, and visit history. Supplemented existing diabetes quality measure reports to create targeted outreach lists and prioritize outreach efforts and guide population health management activities. (See Appendix 2 for Data Explorer Report Criteria)
- **Piloting a Wellness Care Program:** Piloted an integrated care-team approach involving primary care, behavioral health, and care coordination. Expanded eligibility criteria to include more patients with elevated A1C and behavioral health needs. Expanded the program from one provider panel to all provider panels. Used customized Data Explorer report data to identify patients requiring additional support and guide population-of-focus outreach efforts.
  - Utilized four care coordinators to provide additional patient outreach and follow-up through phone calls, text messages, and in-person communication.
  - Leveraged Epic MyChart for individualized communication and CareMessage for broader outreach. Care coordinators provided support with appointment scheduling, rescheduling, and access to resources, with monthly contact serving as the general outreach goal.
- **Diabetes Group Visits:** Offered a six-week bilingual education program with weekday and Saturday sessions covering diabetes self-management. The Population Management Program Manager led the initiative, supported by rotating staff. Food boxes given at the sessions, and a grocery gift card raffle was done at the end of the six sessions. (see attached flyers)

Appendix 1:


Standarized Diabetes Management Workflow
Routine clinical operations supporting ongoing diabetes managment
1. Daily Care-Gap Reviews
Daily clinical huddles
Epic Health Maintenance
Review A1C testing, diabetic foot exams, retinal screenings, and lab monitoring
2. Standardized Follow-Up & A1C Testing
Patients with A1C ≥9% receive monthly follow-up
MA standing orders support in-house A1C testing
3. Targeted Outreach for Missing A1C Results
Use existing diabetes quality measures to identify patients without a current-year A1C test
Clinical Team Assistants conduct targeted outreach

Appendix 2:



Latest phq9 and phq9 m screens

No filters Edit

Performed on	Result
8/25/2026	10
5/5/2026	7
7/20/2026	15
10/12/2026	18
7/25/2026	7

Latest a1c labs

No filters Edit

Performed on	Result date	Result	Test name	Abnor
4/10/2024	4/10/2024	14.0	HGBA1C FINGERSTICK (POCT)	
4/10/2024	4/10/2024	9.0	HGBA1C FINGERSTICK (POCT)	
4/24/2026	4/24/2026	11.4	HGBA1C FINGERSTICK (POCT)	
10/14/2022	10/14/2022	10.2		
4/15/2020	4/15/2020	5.9		

Make a copy | Export data | Save

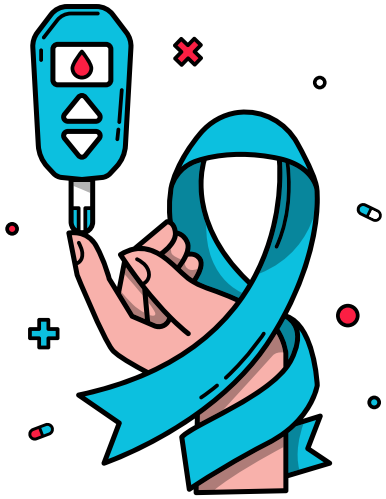
Show a subset data from patients by adding filters to the table

Only include patients that meet all of the following criteria:

- is deceased false
- is inactive false
- has primary care giver
- with a1c labs matching all of the following:
  - result is greater than or equal to 8
  - result date is in the last 6 months
  - Add a filter on a1c labs
- with phq9 and phq9 m screens matching all of the following:
  - result is greater than or equal to 5
  - performed on is in the last 6 months
  - Add a filter on phq9 and phq9 m screens
- with phq9 and phq9 m screens matching all of the following:
  - result is greater than 0
  - Add a filter on phq9 and phq9 m screens

SVCHC

Wellness Alliance - Diabetes Support Group (DM)



About us

Living with diabetes is more than doctor visits—it's about daily habits, support, and confidence. The Wellness Alliance - Diabetes Support Group is a 6-week, peer-led program designed to help you better manage your Diabetes in a supportive group setting.

What to expect

- **Weekly 60-minute group sessions**
- **Practical, easy-to-use tools for managing diabetes**
- **Support from peers facing similar challenges**
- **Guidance on medications, nutrition, movement, and stress**
- **Help with follow-up care with labs, eye exams, and refills**

Details

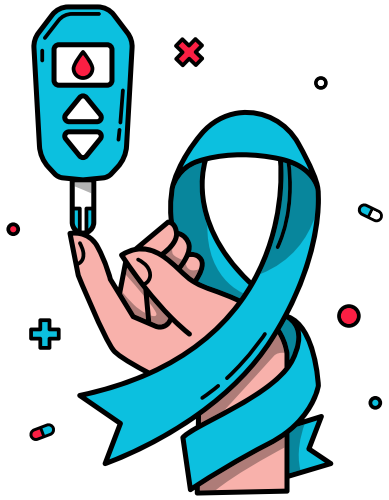
- **Two session times each week (choose what works for you):**
- **Wednesdays | 5:30–6:30 PM**
- **Saturdays | 9:30–10:30 AM**
- **Available in English and Spanish**



Interested?

Talk to your care coordinator to enroll.

Alianza por el Bienestar: Grupo de apoyo para la Diabetes



Sobre nosotros

Vivir con diabetes es más que visitar al médico: se trata de hábitos diarios, apoyo y confianza. Alianza por el Bienestar es un programa de 6 semanas diseñado para ayudarte a manejar mejor tu diabetes en un entorno grupal de apoyo.

Qué esperar

- **Sesiones grupales semanales de 60 minutos**
- **Herramientas prácticas y fáciles de usar para manejar la diabetes**
- **Apoyo de compañeros que enfrentan desafíos similares**
- **Orientación sobre medicamentos, nutrición, movimiento y estrés**
- **Ayuda con el seguimiento de cuidados con análisis de laboratorio, exámenes de los ojos y renovaciones de medicamentos**

Detalles

- **Dos sesiones cada semana (elige lo que te funcione):**
- **Miércoles | 5:30–6:30 PM**
- **Sábados | 9:30–10:30 AM**
- **Disponible en inglés y español**



¿Interesado?

Hable con su coordinador de salud para inscribirse.