**Detailed Case Study: Central Medical Business Management’s Three-Level Care Gap Closure Model for Replication**

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**Date:** April 2025

**Background**

Central Medical Business Management (CMBM) is a small physician-led practice located in Glendale, California. It supports two full-time primary care providers. The practice is known for its long-term leadership, disciplined workflows, and high standards of patient care. **CMBM has received 100% on Facility Site Reviews (FSRs) for several consecutive years,** with the exception of a 98% score in 2024 due to new staff onboarding. The CMBM team—led by Office Administrator Susie Yagubyan and supported by an Assistant Manager and staff—uses a three-level model for care gap closure, combining at-visit workflows, ongoing patient-specific outreach, and retrospective documentation.

**Overview of the Three-Level Gap Closure Model**

CMBM uses a structured three-level model for closing care gaps:

* Opportunistic Gap Closure at Visit
* Ongoing Outreach Based on Plan-Provided Gap Reports and Internal Alerting
* Administrative Closure

Each level includes specific workflows, staff roles, and tools, supported by team meetings and leadership oversight.

**Level 1: Opportunistic Gap Closure at Visit**

**Goal**

Close gaps while the patient is physically present in the clinic.

**Process**

* MAs conduct real-time chart review using Office Ally and a printed checklist created by Susie.
* Labs, assessments, and referrals (e.g., A1c, mammogram, PHQ-9) are addressed during the visit.
* Mental health assessments (PHQ-9, ACES) are completed via tablet during intake, or on paper when skipped.
* Patients are instructed to complete labs in advance; if labs are not completed, visits are rescheduled.

*“One of our MAs—when the day is done—they sit down and prep tomorrow’s charts… They already have everything ready.”*

**Staff Involved**

* Medical Assistants: Chart review, patient prep, screenings
* Front Desk: Ensures follow-up is scheduled at checkout
* Susie, , and Maria: Oversee chart audits and checklist implementation

**Tools Used**

* Office Ally: Clinical charting, alerts, documentation
* Paper Checklist: Manual visit preparation and care gap tracking
* Office Ally Tablet Intake System: Captures PHQ-9, ACES, Pearls, etc.

**Level 2: Ongoing Outreach Based on Plan-Provided Gap Reports and Internal Alerting**

**Goal**

Proactively address patient-specific care gaps identified through Preferred IPA reports.

**Process**

* Reports from Preferred IPA list patients with outstanding screenings (e.g., mammogram, Pap, colonoscopy)
* A part-time MA reviews reports, calls patients, enters alerts in Office Ally, and documents outreach
* The MA follows up on multiple types of care gaps, including HEDIS measures and imaging needs
* Visual alerts are added to charts to prompt follow-up during future visits

*“He’ll call the imaging place… and upload it either to Preferred IPA portal or securely email it to the health plan.”*

*“He follows up. He calls the imaging place, he uploads it, he emails it. If the patient says they didn’t get it done, then we mark that too.”*

*“One hour you have to do Cozeva, one hour you have to look at HEDIS... then whatever we cannot see in the Cozeva, we call... if they have done it or not, and get the documents.”*

**Deeper Dive: Internal Chart Alerting**

When a care gap cannot be formally closed—because documentation is still pending, the patient declined the service or has not responded—staff enter a visible chart alert in Office Ally.

These alerts serve as **internal flags**, ensuring that the gap remains visible to all team members and is not duplicated or overlooked.

*“He’ll write an alert into the patient’s chart... so anyone who goes into the patient’s chart sees that alert.”*

These chart alerts help the team:

* Prevent unnecessary repeat referrals or conversations
* Track progress on patient outreach or documentation retrieval
* Ensure gaps are addressed at the next visit
* Promote shared accountability across staff

**Staff Involved**

* Part-time MA (who also assists with other clinic operations): Primary point person for outreach and documentation
* Other MAs: Assist as needed
* Leadership: Assign follow-up and ensure reporting

**Tools Used**

* Preferred IPA Portal: Reporting and uploads
* Office Ally: Patient notes and chart alerts
* Internal Alert System: Color-coded notes for follow-up

**Level 3: Administrative Closure**

**Goal**

Ensure past services are properly documented and submitted to health plans for credit.

**Process**

* Staff manually upload lab results, imaging, and screening documentation to the Preferred IPA portal
* LOINC codes are entered, though manual uploads are often required because Cozeva doesn’t always auto-recognize them
* Staff verify that documentation appears correctly in the plan portal post-upload

*“Sometimes Cozeva doesn’t catch the LOINC… So we manually add it.”*

**Staff Involved**

* Part-time MA: Uploads documents, enters codes, and confirms closure
* and Susie: Monitor gaps and follow-up processes

**Tools Used**

* Preferred IPA Portal: Uploads and validation
* Office Ally: Primary clinical system
* Templates: Structured documentation for screenings and assessments

**Key Infrastructure and Data Practices**

**Chart Auditing**

Every chart is reviewed by at least three staff members before provider sign-off. Missing labs, screenings, or assessments are flagged immediately.

“Before we sign the chart, three people are reviewing the charts and whatever it’s missing—right away we give an appointment or call back.”

**Visit Preparation**

* Charts are prepped the day before or same-day
* Staff check previous visit notes and lab results and flag any unresolved care gaps

*“They go see what we ordered when they come… preparing blood work, mammogram results, everything.”*

**Team Communication**

* Weekly one-hour staff meetings every Tuesday
* Gaps, denials, and workflow challenges are discussed and resolved collaboratively

**Technology Used**

| **Tool** | **Function** |
| --- | --- |
| Office Ally | Clinical charting, patient alerts, checklist integration |
| Preferred IPA Portal | Reporting, uploads, care gap validation |
| Intake Tablet | Captures PHQ-9, ACES, and other screeners |
| Paper Checklist | Manual visit preparation, care gap tracking, and screening verification |

**Preventive Service Strategies by Measure**

**Diabetes**

* A1c, lipid panel, and CBC required before each visit
* Patients told labs must be done or the visit will be rescheduled

**Mental Health**

* PHQ-9 and ACES completed at intake on tablet every 6 months
* Paper backups used when digital version is skipped, following a protocol recommended by Maria

**Women’s Health**

* Referrals initiated same-day (mammogram, Pap, DEXA)
* Results tracked and uploaded post-visit
* Alerts entered in Office Ally to prevent duplication and ensure visibility

**Top Three Recommendations from CMBM**

1. **Assign a Dedicated MA to Gap Closure**
“He’s a medical assistant... One hour Cozeva, one hour HEDIS… That’s how it gets done.”
2. **Hold Weekly All-Staff Meetings on Care Gap Closure**
“Every Tuesday morning… we discuss what is missing.”
3. **Empower the Front Desk**
“Everything starts at the front. If the front desk isn’t trained right, it all falls apart.”

**Deeper Dive:** **Front Desk Training and Responsibilities at CMBM**

Front desk staff at Central Medical Business Management are trained to play an active and strategic role in care gap closure. Their responsibilities go beyond scheduling and are guided by structured training that emphasizes coordination, follow-up, and patient engagement:

1. **Schedule follow-up appointments before the patient leaves:**
	* Every **3 months** for patients with chronic conditions (e.g., diabetes, hypertension)
	* **Once a year** for patients in good health
	* Align appointment frequency with care gap and FSR/HEDIS requirements

*“We don’t let them go without an appointment… The front already knows. Three months if they’re diabetic or high risk. If they’re healthy, once a year.”* — Susie

*“They go into the chart and they’ll know… this patient is a diabetic. I’m gonna schedule them again in three months.”* —

1. **Recognize patient risk level and apply visit cadence based on diagnosis and prior documentation in Office Ally**

*“The front desk… they all know this patient. They read the chart and schedule accordingly.”* — Susie

1. **Communicate clearly with patients about visit expectations:**
	* Bring in lab results, medication bottles, or imaging reports before the next visit
	* Emphasize: “If you don’t bring it, don’t come.”

*“Make sure you bring your medication. When they give patient appointment, [they say] ‘don’t bring your medication, don’t come.’”* — Susie

*“They have to make sure to educate the patient… when they come back, they bring everything.”* — Susie

1. **Verify and update contact information (phone, address, insurance)** to support successful outreach and reduce claim errors

*“Make sure they correct all the correct information… it’s front desk, because everything starts there.”* — Susie

1. **Support documentation and alerts:**
	* Inform clinical staff if labs or screenings are incomplete
	* Monitor and relay gaps identified during pre-visit planning

*“They ask: ‘Did you go do your lab?’ If not, they go back and tell the MA or provider.”* — Susie

1. **Participate in weekly team meetings** to review gap performance, troubleshoot process breakdowns, and align on roles

*“We do our weekly meeting every Tuesday… discussing everything, how we gonna do it, how we can fix it.”* — Susie

*“Every Tuesday morning, nine to ten, it’s our corporate meeting with everyone.”* — Susie

**TOOLS**

* Patient visit checklist (HAVE)
* Patient visit workflow diagram (HAVE)
* Office Ally training resources and job aids
* Defined job descriptions for MAs, front desk, and outreach roles