Care Gap Closure Case Study: ViaCare's Integrated, Multi-Layered Approach to Care Gap Closure

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Organization: Via Care, Los Angeles
Date: February 2025
HIT: eCW 12**,** Cozeva**,** Azara
Link to virtual visit: https://vimeo.com/1082318010

Background

Via Care is a 10-year-old Federally Qualified Health Center (FQHC) that has grown rapidly from a startup serving ~400 patients to a full-service health system with over 25,000 patients and more than 400 employees. With this growth came the need for scalable care gap closure strategies grounded in EHR optimization, provider accountability, and layered workflows.

"As we grew, we had to change the way we do quality."

Overview of ViaCare's Multi-Layered Gap Closure Model

We start with the data and identify areas where we are weakest

Before setting benchmarks or launching campaigns, Via Care's strategy begins with a clear-eyed look at performance data. Leadership reviews EHR reports and gap rates to identify the weakest areas and uses this insight to drive improvement efforts, technology investments, and workflow redesign.

"First of all, I think, look through your data. You need to analyze… what are the weaknesses? For example, we realized diabetic retinopathy screening was one of our lowest performing measures — we were at 34-35% - so we used that data to make a decision and partnered with a group to bring AI retinal screening in-house. That's what I mean: start with the data, figure out what's broken, then build a solution from there."

Use a dynamic benchmarking process

This framework is reinforced by a unique organizational approach to goal-setting. Rather than rely on static benchmarks, Via Care uses a progressive strategy: starting from the national average, they raise expectations by 5 percentage points annually.

"We used the national average, first of all, so we wanted to get to that. Then, the next year, I increased it by 5%. Then the year after that, 5% more. And now we are way above the national average. That's how we've done it—by pushing a little more each year."

Via Care's model is built not only on structured workflows, but also on a strong culture of accountability and strategic goal setting. Each year, Via Care sets organizational targets for quality performance that begin at national benchmarks and increase by 5 percentage points annually. Providers receive monthly individual quality reports that help them monitor their progress and identify documentation gaps. This iterative approach has helped raise the overall quality rate well above national norms.

"*We had to meet regularly with providers, talk about the data, explain the value, and reinforce it over and over until it became second nature.*"

"*I send them a monthly report… so they know exactly what to do to reach the goal.*"

Use 4 care gap closure approaches
Via Care employs a structured care gap closure system that includes:
- **Opportunistic Gap Closure at the Point of Care**
- **HEDIS Measure-A-Month Calendar-Based Campaign Outreach**
- **Outreach to unseen patients**
- **Administrative Closure and Supplemental Uploads**

Each layer has its own workflows, tools, staffing model, and quality monitoring.

Staff Roles and Team-Based Model
Via Care's staffing structure includes five distinct layers of personnel who work in concert to close care gaps:

Role	Key Responsibilities	Quote
Medical Assistants (MAs)	Prepare charts, execute standing orders, support screenings	"Most of the quality is done by MAs. They're the ones screening, ordering, doing the work."
Primary Care Providers	Act on flagged gaps, receive monthly dashboards	"I send them a monthly report… so they know exactly what to do to reach the goal."
Lower-Volume, Providers from the college health centers	Conduct outreach from low-volume sites, place remote orders	"We fill their schedule gaps with quality. They call patients and get it ordered."
Retention Team	Reengage overdue or high-risk patients (diabetics, hypertensives, etc.)	"Their… focus is to re-engage patients and bring them back into care."
Senior Quality Team	Conducts chart audits, manages documentation and supplemental uploads, with a focus on closing gaps for seniors	"They are the ones that try to close the last little piece of the gap. For the senior population especially, they check the chart, clean up

	and ECM patients, and closing gaps with complex patients.	documentation, and make sure anything that was missed or not coded right gets fixed and submitted."

Level 1: Opportunistic Gap Closure at the Point of Care

Goal
Close gaps while the patient is physically present.

Process
- MAs and Clinical Quality Floaters scrub charts the day before or morning of visit using Azara and eCW.
- Clinical floaters specifically support Medi-Cal patients, reviewing the roster and pre-identifying any care gaps for each appointment.
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"This is how we do it: clinical quality floaters review the roster the same day. They go over the patient roster… make sure that if there are any gaps or opportunity to close the gap, we are already separately set up. So, when the patient comes in, the provider doesn't have to be looking into the chart. They already know exactly what the patient needs."

- Gaps are highlighted for the provider, including POC labs, screenings, and immunizations.
- MAs perform screeners and initiate standing orders; providers act on unresolved gaps.

"MAs use EHR prompts and standing orders to complete preventive screenings during rooming. They're trained to recognize what's due and act on it without waiting for the provider. If a patient needs a flu shot, a FIT test, or a depression screening, the MA can get it started right then, which makes the visit more efficient and improves closure rates."

- MAs perform screeners and initiate standing orders; providers act on unresolved gaps.

"The provider doesn't have to be looking into the chart. They already know what the patient needs."

Staff Involved
- Medical Assistants
- Clinical Quality Floaters
- Primary Care Providers

Tools Used
- Azara
- eCW

Level 2: Campaign-Based Outreach for Specific Measures

Goal
Target patients due for a single measure and engage them via a calendar-driven campaign.

Process
- Each month, one HEDIS measure is selected (e.g., mammograms, diabetic eye exams).
- Outreach lists are generated using Azara and validated by clinical staff.
- Staff call patients, place orders, or schedule visits.
- Clinics receive performance-based incentives (e.g., lunch, celebration).

"Every month we concentrate on one measure… and we compete. We pick a metric like diabetic eye exams or LDL, and everyone focuses on it. Staff make calls, we push reminders, and we track it day by day. We try to make it fun with prizes or lunches. It brings the whole team into the process."

Staff Involved
- Outreach Staff
- Lower-volume providers from the college-based health clinics
- Retention Team

Tools Used
- Azara
- eCW
- Health plan incentives

Level 3: Outreach to Unseen or Assigned Patients

Goal
Close care gaps for patients who have not yet visited the clinic but are assigned to Via Care through health plan rosters.

Process
- Review care gap reports received from health plans weekly, monthly, or annually.
- Identify overdue services and gaps for both inactive and first-time patients.
- Conduct outreach to engage these patients and schedule visits or remotely close gaps when possible.
- Prepare documentation or place standing orders ahead of the patient's first visit.

"Even if we haven't seen them yet… it's going to be first time… we already see what they're going to need and what they're not going to need."

"We are very on top of that. We call each patient, we see what's missing, what's not—even if we haven't seen them yet, they're just assigned to us."

"The retention team… calls every patient that hasn't had a physical exam in over a year… diabetic patients with A1c >9 and no visit in 4+ months… patients with uncontrolled hypertension. They bring them back to the clinic."
This proactive strategy helps Via Care prevent gaps from accumulating and ensures that every patient—regardless of visit history—is included in the quality framework.

Staff Involved
- Retention Team
- Lower-volume providers from the college-based health clinics
- Outreach Staff

Tools Used
- Azara
- eCW
- Health Plan Gap Reports

Level 4: Administrative Closure

Goal
Ensure all completed services are properly documented and submitted to health plans.

Process
- Gaps reported by Cozeva and other plan portals are reviewed.
- Senior Quality Team confirms whether services were completed.
- If yes, they upload labs, structured data, or images to close the loop.
- Focused documentation cleanup is done for seniors and ECM patients.

"Sometimes we do the measure, but it's just not documented well... that's the problem. Either it's not coded with the right CPT-II or the provider didn't click the right box in the EHR. So we don't get credit for it—even though the care was delivered. That's why we have a team to go back, clean it up, and make sure the plans see what we actually did."

Staff Involved
- Senior Quality Team
- Documentation Support Staff

Tools Used
- Cozeva
- eCW
- LumineticsCore (for AI-based retinal screening)

Key Infrastructure and Data Practices

Provider Efficiency with EHR in Clinical Care
- Providers are trained and encouraged to become fluent and efficient in EHR navigation.
- EHR fluency reduces time spent on documentation and increases focus on clinical care and quality metrics.

"The provider has to be pretty efficient at how to use the EHR. The better they are, the more they can do for the patient. If they're not optimized, they spend too much time in the chart and don't have time to focus on quality."

Monthly Performance Reporting
- Benchmarks are initially based on national averages, then raised annually by 5%.
- Dashboards are shared monthly with providers to track progress and identify gaps.

"These dashboards give providers a clear picture of which quality measures they're meeting, and which ones need attention. They also flag documentation issues, helping staff catch gaps that might otherwise be missed."

"I send them a monthly report… so they know exactly what to do to reach the goal."

Correct Data Mapping, Technical Assistance, and SQL Support
- eCW templates were remapped by internal teams for structured data entry.
- Reports were built using the EBO module and SQL programming.
- Support can be obtained from external TA partners such as CPCA, HCCN, or other CHC networks.

"Without the correct mapping and template, it's very difficult to track data. If the fields aren't mapped properly, the EHR doesn't pull the data you need, and providers don't get credit for the care they gave. Fixing this is foundational to everything else we do in quality."

Technology Used

Tool	Function
eClinicalWorks	Clinical charting, structured documentation
Azara	Reports, patient lists, care gap analytics
Cozeva	Supplemental uploads and plan-specific closure
LumineticsCore AI	In-house retinal screening (6-minute turnaround)
Innovacer	Population Health Management (PHM) tool (in rollout)

Preventive Service Strategies by Measure

Colorectal Cancer Screening

- Prefer Cologuard for 3-year compliance.
- Frees up colonoscopy access and reduces annual FIT burden.

Diabetic Eye Exams
- LumineticsCore AI used for onsite exams with immediate result and closure.

Well-Child Checks and Immunizations
- Scheduled proactively and integrated into campaign calendar.

Top Three Recommendations from Via Care

1. **Maximize the Visit**

"Get as many measures done as you can before the patient leaves. That's our rule. Don't let the patient walk out if you can take care of it right then—whether it's labs, screenings, or paperwork. Every time they're here, it's a chance to do something meaningful for their care and to hit a quality measure."

2. **Invest in Data Infrastructure**

"You need someone who knows SQL and can build your reports. A data analyst who understands how your EHR works can change everything. They help you see exactly where you're doing well and where you're missing the mark. Without those custom reports, it's hard to focus your efforts or see progress. It's one of the most critical hires you can make. If you don't have funding internally, apply for TA from CPCA or HCCNs. You can also write it into grants—that's how we started."

3. **Build a Culture of Quality**

"Quality is good medicine. It took months of education to build the mindset. We had to meet regularly with providers, talk about the data, explain the value, and reinforce it over and over until it became second nature. It's not something you can just announce—it has to be embedded."

TOOLS
- Patient pre-visit worksheet (UCSF)