**Case Study: How Via Care Excels at Care Gap Closure**

**Background**

Via Care, a primary care provider in East and Southeast Los Angeles, faced challenges in closing care gaps for a diverse, high-need population. Patients often missed essential screenings, and providers struggled to track outstanding quality measures.

**Challenges**

* High no-show rates led to gaps in preventive screenings.
* Limited provider time resulted in missed opportunities to close gaps.
* Reliance on multiple health plans made tracking and reporting cumbersome.

**Solution**

Via Care implemented a **five-layered system** to systematically close care gaps:

**1. Five-Layered Workforce Approach**

1. **Medical Assistants (MAs)** – The frontline workers responsible for addressing care gaps during patient visits by completing necessary screenings and documentation.
2. **Primary Care Providers (PCPs) at the Visit** – During patient encounters, PCPs review outstanding quality measures and close as many gaps as possible using EMR prompts and patient visit plans.
3. **Quality Providers** – Underutilized providers at student health centers who are reassigned to care gap closure tasks, calling patients and addressing pending screenings (e.g., mammograms, colon cancer screenings).
4. **Retention Team** – Dedicated administrative staff who focus on:
	* Scheduling physicals for patients who haven’t had one in over a year.
	* Contacting diabetic patients with an HbA1c >9 who haven’t visited in four months.
	* Reaching out to patients with uncontrolled hypertension to schedule follow-ups.
5. **Senior Quality Team** – A specialized administrative team focused on high-priority populations, such as seniors, ensuring all outstanding quality gaps are closed before the end of the measurement period.

**2. Data-Driven Population Health Management**

* Via Care initially used **Azara** as a population health management (PHM) tool but is transitioning to **Innovacer**, a more advanced platform that includes case management.
* They also leverage **Cozeva** for **supplemental data uploads**, ensuring accurate documentation of closed gaps.
* For clinics **without** PHM tools, a **manual patient visit panel report** is used to identify and track patient needs.

**3.** Via Care also launched **daily clinical huddles** and **pre-visit planning**, ensuring that providers and MAs addressed all possible care gaps before the patient left the clinic.

* **Daily Clinical Huddles** – A 5-10 minute morning or pre-shift meeting to review patient lists and identify pending screenings.

**In addition, they also implemented**:

* **Standing Orders & Pre-Visit Planning** – Ensuring key health maintenance measures are completed during visits.
* **Clinic-Wide Incentives** – Bonuses are awarded at the **clinic level** for meeting care gap closure benchmarks, rather than for individual providers.
* **Whole-Person Care Approach** – PCPs and MAs aim to address **multiple care gaps** in each patient visit rather than focusing on one at a time.

**4. Current performance**

* **Hypertension Control**: Over **70%** of hypertension patients are well-managed.
* **Diabetes Management**: Less than **40%** of diabetic patients are uncontrolled, a significant improvement over previous years.
* **Improved Preventive Screenings**: Annual physicals, mammograms, and colon cancer screenings increased due to proactive outreach and scheduling.

**5. Key Takeaways for Small Practices**

* **Maximize Staff Roles** – Use all available staff, including MAs, PCPs, and administrative personnel, to assist in care gap closure.
* **Use PHM Tools If Available** – Leverage platforms like Asara or Innovator to track care gaps.
* **Pre-Visit Planning Works** – Implement clinical huddles to anticipate and close gaps efficiently.
* **Whole-Person Approach** – Address multiple gaps in a single visit rather than focusing on one at a time.
* **Build a Culture of Quality** – Engage providers and staff in quality improvement, offering incentives for clinic-wide performance.

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