Detailed Case Study: White Memorial CHC's Three-Level Care Gap Closure System for Replication

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Background

White Memorial Community Health Center (WMCHC) is a Federally Qualified Health Center (FQHC) serving a large, diverse, predominantly Medi-Cal population. To meet preventive care benchmarks and value-based payment targets, WMCHC has implemented a **three-level care gap closure model** that integrates clinical workflows, technology tools, and dedicated staffing.

Overview of the Three-Tiered Gap Closure Model

WMCHC employs a **three-level system** for gap closure:

1. **Opportunistic Gap Closure at the Point of Care**
2. **Proactive Campaign-Based Outreach**
3. **Retrospective Documentation Closure (Supplemental Data Upload)**

Each level has its own workflows, staffing, tools, and role requirements.

Level 1: Opportunistic Gap Closure at the Point of Care

Goal

Close gaps while the patient is physically present.

Process

- Use **Azara** to generate a **daily pre-visit planning report** listing each patient's open care gaps.
- Assign a **care coordinator** to a pod of 4–5 providers to print and distributes these reports daily to MAs.
- MAs review the list during rooming, confirm missing services (e.g., mammograms, FIT test), and flag for the provider.
- Providers either:
    - Perform the service (e.g., Pap smear),
    - Place an order (e.g., FOBT), or
    - Schedule a follow-up.

"The goal is that every group of 4 or 5 providers ideally has a care coordinator, when staffing allows, who prints the report out every day and hands it to the MAs and says, 'Here's what your patients need."

"The MA can say to the provider, 'Do you want to do the Pap today, or should we schedule it?'"

Staff Involved

- **Medical Assistants (MAs)**: Room patients, review reports, and communicate with providers.
- **Care Coordinators**: Generate and distribute reports.
- **LVNs or Experienced MAs**: Validate whether the gaps are accurate (i.e., whether the service was already done but not recorded).

"Anyone can print that out and say, 'Oh, the patient needs these things,' because it's right there. But the person who actually validates a report—that's usually a well-trained MA or an LVN."

Challenges: "…you have a position open, we fund it, but even then, you can't always find the right people for the job, or someone leaves, or you're short-staffed, and you have to pull people to do something else."

Level 2: Campaign-Based Outreach for Specific Measures

Goal

Target patients due for specific services and bring them into care.

Process

- Care coordinators run **Azara reports** on patients who are overdue for a measure (e.g., mammograms, colon cancer screening).
- Staff **validate the list** by checking charts to confirm whether the screening was done but not recorded.
- Based on results, they:
    - Call patients to schedule visits,
    - Text reminders via **Luma** or ECW automated tools,
    - Offer to order the test, or
    - Ask the patient to see a provider for multiple services.

"We have a report of people who haven't had a mammogram yet—or we don't have a mammogram in the system. So we go through that report."

"We are using Luma so that it's well automated. Some are automated in ECW. If you just say, 'Mammogram screening is very important,' that's one thing. If you say, 'You are due for a mammogram,' that's another—it may be a HIPAA issue."

Staff Involved

- **Care Coordinators**: Run and validate lists, schedule patients.
- **LVNs/MAs**: Help validate gaps.
- **Clinical Director / RN**: May help coordinate outreach priorities.

Tools Used

- **Azara**: Reports by measure.

- **Luma**: SMS campaigns and reminders.
- **eCW**: Appointment scheduling and messaging.

Level 3: Retrospective Documentation Closure (Supplemental Data Upload)

Goal

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

Process

- WMCHC receives **Cozeva** reports from health plans, showing open gaps.
- Staff validate whether gaps are real by checking the patient's EHR.
    - If service was completed, staff upload documents or structured data to **Cozeva**.
    - If not, staff follow up as appropriate.

"We get a report from Cozeva, then go into the patient's chart and say, 'Did they really not get their mammogram or Pap smear?' because the data's not always up to date."

"That's my least favorite kind of gap closure—it's time-consuming, and it's not helping the patient. The patient got it. It's just helping the health plan and us get credit."

Staff Involved

- **RN, Clinical Director, or trained staff** with knowledge of how to upload to Cozeva and validate measures.
- Staff must understand how **measures are mapped** (e.g., HL7 lab results, CPT codes, structured fields).

Key Infrastructure and Data Practices

Mapping Measures to Reports

WMCHC ensures that **all labs, screenings, and services are properly structured and mapped** into Azara or EHR reports.

"We spend a lot of time mapping the data… all results have to be HL7, CPT codes, or labs, or else they won't show up in Azara."

"If it's not mapped correctly, it won't appear on the report—even if the patient had it done."

Technology Used

Tool	Function
Azara	Pre-visit planning, population reports
eCW (ECW)	Clinical charting, EHR
Cozeva	Health plan gap closure and supplemental uploads

Tool	Function
Luma	Patient engagement via SMS

Preventive Service Strategies by Measure

Mammograms

- Verified via chart audits.
- Ordered during visit or telehealth if needed.
- Text campaigns sent in batches.

Colon Cancer Screening

- Recommend both **FOBT** and **colonoscopy**.
- Prefer **FOBT** due to long colonoscopy wait times.
- Staff fast-tracks diagnostic referrals if FOBT is positive.

"Colonoscopy takes forever… we tell providers to order both FOBT and colonoscopy. If the FOBT is positive, then it's not screening—it's diagnostic."

Well-Child Visits

- Reminder messages and proactive scheduling at visit check-out.
- WMCHC has achieved 95th percentile on this measure.

"If you aren't scheduling those when they leave, and if you aren't reminding them… you have to actually call and schedule them."

Top Three Recommendations from WMCHC

1. **Invest in a Data System with Pre-Visit Planning Tools**
    - *"Azara takes our schedule and spits out a report for the day with everything that the patient needs… you can just, in a second, look and see what that patient needs."*
2. **Dedicate Staff to Gap Closure Tasks**
    - *"It's very staffing-dependent… Even if we have funding, we can't always find the right people for the job."*
3. **Use Campaigns and Multiple Modalities**
    - *"Calling patients is low-yield compared to when they're here… but if they're not coming, you've got to engage them some other way."*

TOOLS (PENDING)

1. **Sample scripts** for phone calls, mammogram outreach, or campaign texts (internal drafts exist, but format and availability for sharing are still being evaluated).
2. **Screenshots or templates** of Azara pre-visit planning reports.
3. **Supplemental data upload checklist for Cozeva** (currently used internally, with ongoing refinements).

4. **CPT II code mapping sheet** for depression screening, hypertension, and A1c currently under development