

A photograph of a wooden table with a cup of coffee on a saucer and a small vase with greenery. The background is a window with a view of a snowy landscape. The text "Coach Cafe" is overlaid in white.

# Coach Cafe

For the Pop Health Learning Center - EPT

July 12, 2025

Lyndee Knox, PhD & Kevin Thomas, MD

By: LA NET

[www.lanetpbrn.net](http://www.lanetpbrn.net)

# What is a Coach Café?

A dedicated space for practice facilitators and staff & clinicians working to improve care processes to:

- Share solutions and ideas for addressing challenges
- Learn from one another's successes and gather “pearls”
- Create a supportive learning community
- Not a lecture or training & should repeat often (weekly in ideal world w/ Slack support in between)

PFs as  
“honeybees”  
spreading good  
ideas



# Agenda & Ground Rules

## Agenda

- 1) Quick review of pre-session input & flagging
- 2) Café chatter - idea sharing & brainstorming
- 3) Feedback
- 4) **Follow-up w/ colleagues** doing things that are helpful post-session

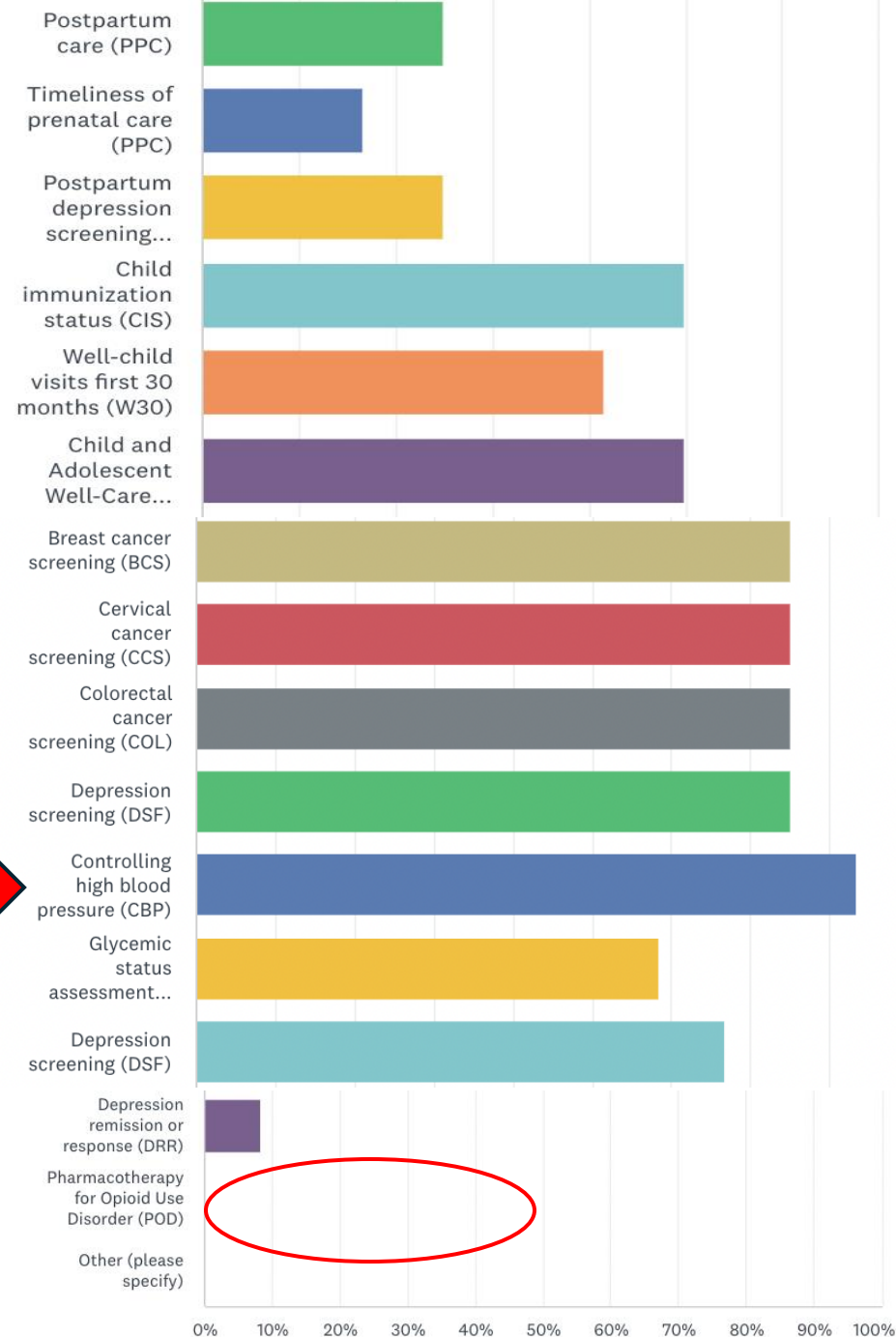
## Ground Rules

- **There are no bad ideas** – the more ideas the better! If you think it, share it!
- Be curious
- Share, Share, Share- It may not seem like that big of an idea to you, but it might be just what someone else is needing to hear.
- Raise hand, talk, use chat! –Share, share, share - the more the communication the better!
- VIDEO ON!

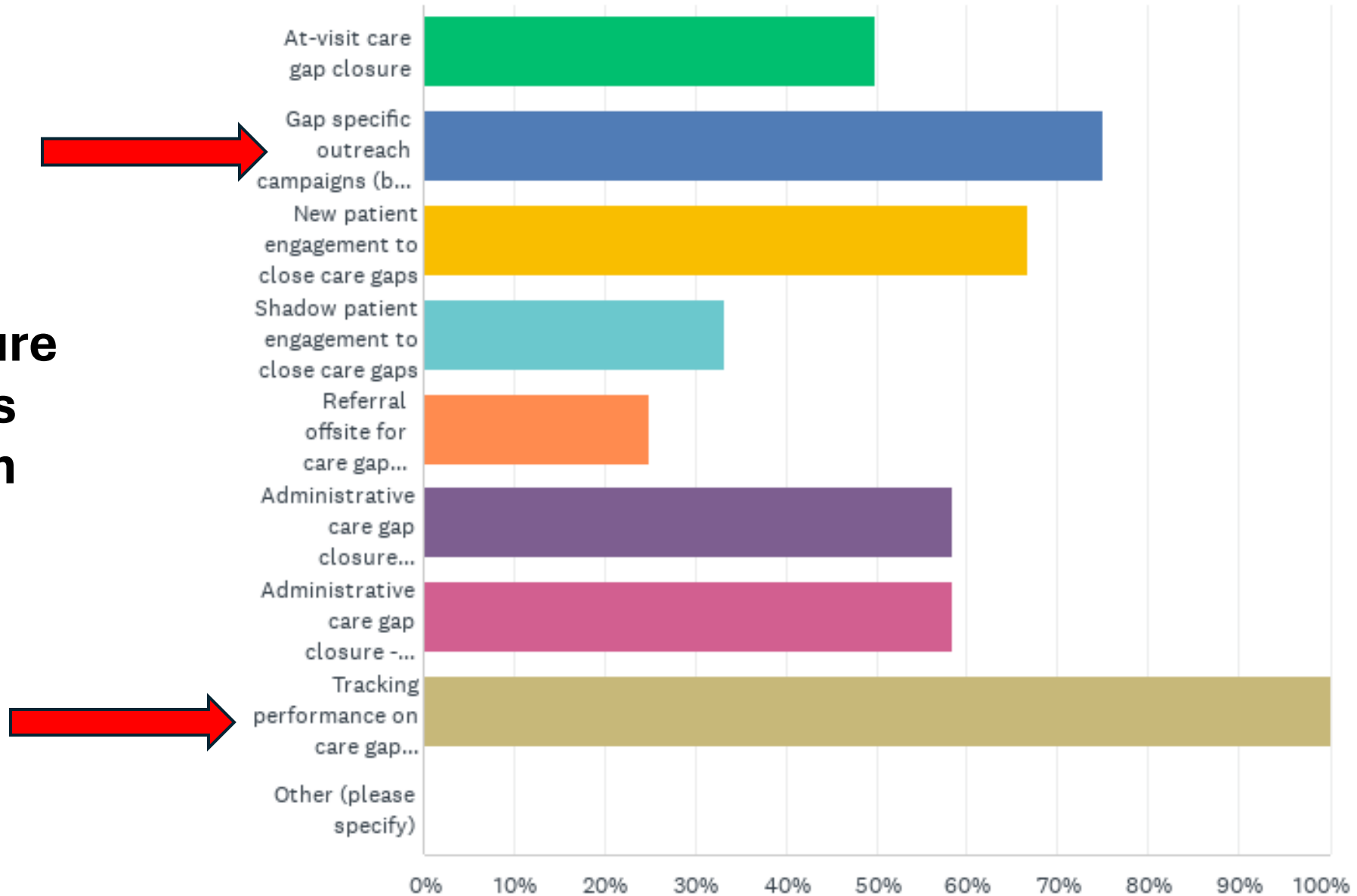
**What PFs and practices are  
working on per survey**

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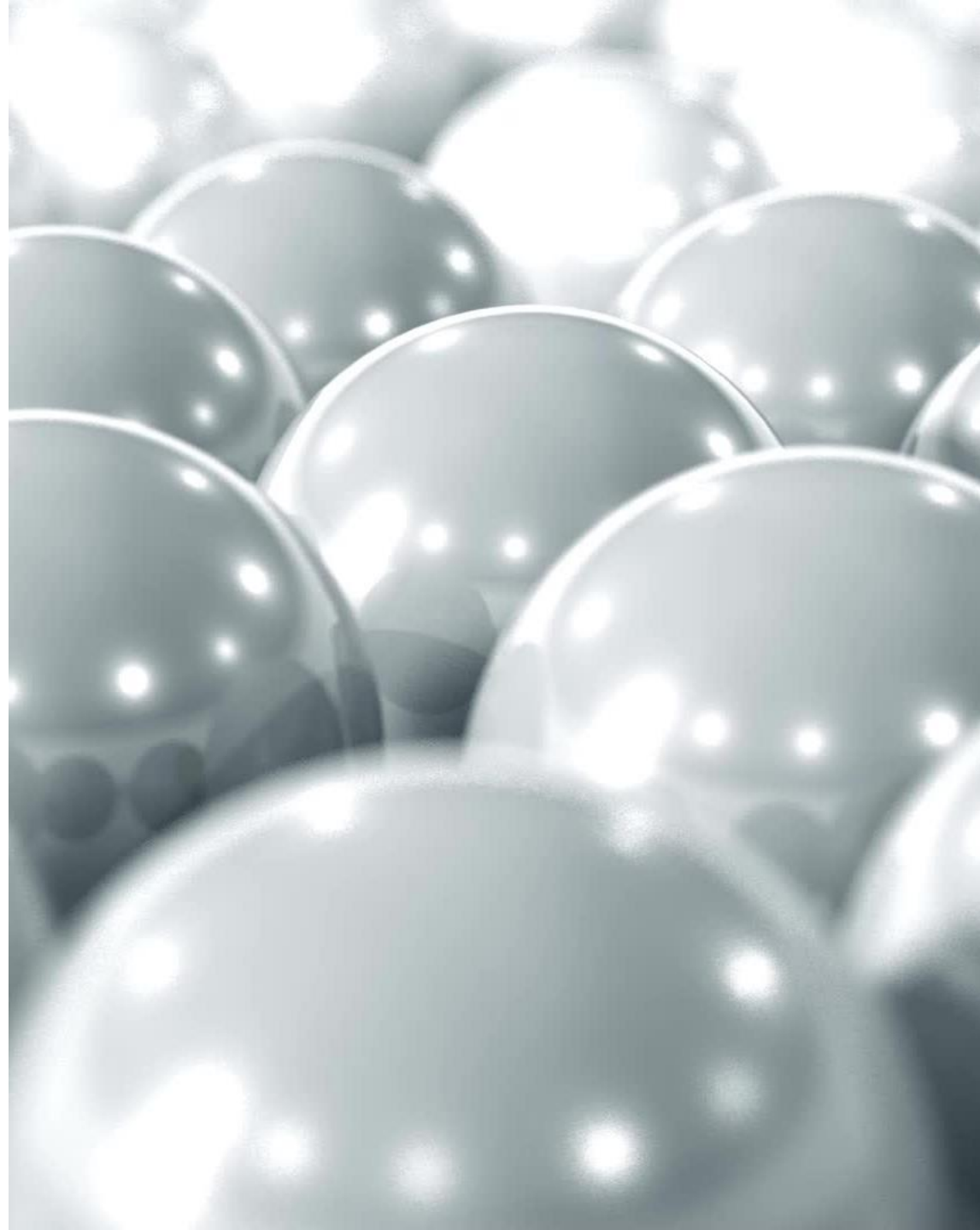
Care gap  
measures  
Café  
members  
worked on  
recently



**Gap closure  
processes  
worked on  
recently**



# PEARLS



**Kathryn Kane**

[kkane@doctorsonduty.com](mailto:kkane@doctorsonduty.com)

"Our MCP has contracted with a **mobile mammography clinic**. We are working with them to schedule onsite mammography events at our locations."

**Marie Wolf**

marie.wolf@montagemedicalgroup.org

**PEARL 1:**

"We've started to time AWC care gap closure around common school closures (i.e. the month before summer break starts).

**PEARL 2:**

For HTN - we are **encouraging second bp measurement processes** in the clinic (i.e. if first reading is high, getting that second read before they leave).

We've found that 35% of the time that we get a second reading, bp demonstrates adequate control (less than 140/90)."

**Stephanie Loomis**

[stephanie.loomis900@commonspirit.org](mailto:stephanie.loomis900@commonspirit.org)

"One success we've had in improving care gap closure is the implementation of **a shared Google Sheet** for our care teams and managers.

- provides real-time visibility into care gap reports,
- allows providers to track outreach efforts—such as appointment scheduling, orders, or referrals—related to their patients.
- managers use it to assign specific measures to staff and ensure follow-up is happening.

**Outcomes:**

Since adopting this approach, **we've seen measurable improvement in closing gaps for well child visits, breast cancer screenings, and other key measures.**"

**Edith Lopez**

[edithh@ftoc.us](mailto:edithh@ftoc.us)

"One success we've had in improving care gap closure is the **proactive use of Health Plan portals by our Care Coordinators**.

- pull non-compliant reports and begin chart scrubbing one week prior to appointments to identify care gap opportunities based on appointment type or chief complaint.
- the portal reports help us target the 'low-hanging fruit'

To support a collaborative approach, Care Coordinators also:

- train front desk staff to recognize and flag key opportunities.

This helps ensure that both front and back office teams work in sync

Linda Lopez

[llopez5@lacare.org](mailto:llopez5@lacare.org)

“Understanding their processes, mapping it and looking for areas that we can improve on. **One of them was their billing.**”

**Floribel Tabizon**

[floribelt@lakheir.org](mailto:floribelt@lakheir.org)

"Importance of monthly Supplemental data submissions."

**Elizabeth Martinez**

e.martinezmojica@gmail.com

**"Utilizing AWW appointments to close gaps."**

# Toi Holiday

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tholiday@lacare.org

One success I've had is coaching practices on care gap closures, which led to improved patient outcomes and higher performance in clinical quality measures—resulting in added incentive payments for the practices.

**Geraldine Sanchez**

[gsanchez@florencewestern.com](mailto:gsanchez@florencewestern.com)

"Improved tools for targeted patient outreach, such as scripts, spreadsheets for analysis."

**Nasser**

[NAlyami-LA@lacare.org](mailto:NAlyami-LA@lacare.org)

"How to conduct root cause analysis."

**Jessica Delgadillo**

[jgd@capitolfamilymed.com](mailto:jgd@capitolfamilymed.com)

"Monthly goals and annual scope and sequence."

**Jen Aiello**

[jaiello@lacare.org](mailto:jaiello@lacare.org)

"Outreach efforts."

**Joanna Garneau**

[joanna.garneau@ephc.org](mailto:joanna.garneau@ephc.org)

"Getting the whole team on board and discussing the issues has been a big success and pushes us in the right direction."

# Challenges

**Stephanie Loomis**

[stephanie.loomis900@commonspirit.org](mailto:stephanie.loomis900@commonspirit.org)

"One challenge we're facing is with the **Colorectal Cancer Screening metric**. While five of our providers are currently meeting the measure and four others are within 10% of the goal, our overall performance still isn't where we'd like it to be.

Our providers are consistently ordering Cologuard tests or referring patients for colonoscopies, but the main barrier seems to be patient follow-through—many are not completing the screenings.

We've partnered with our Exact Sciences representative to generate reports showing which tests have been shipped, which are pending insurance approval, and which have confirmed results. Exact Sciences has also been supporting outreach efforts by contacting patients directly to remind them to complete their tests. However, even with these efforts, completion rates remain lower than expected."

**Kathryn Kane**

[kkane@doctorsonduty.com](mailto:kkane@doctorsonduty.com)

"How to increase colon cancer screening rates."

**Toi Holliday**

[toi.holliday@lanetpbrn.net](mailto:toi.holliday@lanetpbrn.net)

tholliday@lacare.org

"Closing the care gap for **CIS Combo 10**, as it's largely driven by patient compliance, which can be difficult to control at the practice level."

**Joanna Garneau**

[joanna.garneau@ephc.org](mailto:joanna.garneau@ephc.org)

"Reporting is always a challenge. e.g. we identified that we are not able to map to our pap smears, **making it very challenging to track Cervical Cancer Screening.** Working to resolve, resolution anticipated January 2026."

**Edith Lopez**

[edithh@ftoc.us](mailto:edithh@ftoc.us)

"While our Care Coordinators and support staff are actively working to close care gaps, it's difficult to maintain momentum without strong clinical ownership. **Providers are balancing high patient volumes and competing priorities, which can make quality metrics feel secondary.**

We'd really value input on effective strategies to:

- 1. Encourage provider accountability in a way that feels supportive, not burdensome.**
- 2. Get provider leadership more actively involved in promoting and modeling engagement around quality metrics.**
- 3. Integrate care gap discussions into the clinical workflow without adding friction.  
Any best practices, incentive structures, or communication approaches that have worked for others would be helpful."**

**Elizabeth Martinez**

e.martinezmojica@gmail.com

**"Front office training, immigration status, staff shortages."**

**Marie Wolf**

marie.wolf@montagemedicalgroup.org

**"AWC is historically challenging due to the age demographic - specifically, the 18-21."**

Many simply do not want to come in or have moved out of the area for school/military."

**Jessica Delgadillo**

[jgd@capitolfamilymed.com](mailto:jgd@capitolfamilymed.com)

"Enough time to train staff, everything falling on provider, no schedule scrubbing and follow up after appts."

**Geraldine Sanchez**

[gsanchez@florencewestern.com](mailto:gsanchez@florencewestern.com)

"Challenges have been incorrect patient information which makes it difficult for outreach."

**Kathryn Kane**

[kkane@doctorsonduty.com](mailto:kkane@doctorsonduty.com)

"How to increase colon cancer screening rates."

**Floribel Tabizon**

[floribelt@lakheir.org](mailto:floribelt@lakheir.org)

"Blood Pressure control with telehealth compliance."

# Idea Sharing



# CHAT & CONVERSATION NOTES

**Notes from Coach Café July 11, 2025**

## **ACTION ITEMS**

1. **Connect Florabel and Adriana** on supplemental data and denominator exclusion challenges.
2. **Share front office training curricula** – Florabel offered to provide contacts and details.
3. **Share ECW wellness visit templates** – Mona and practice manager Gray to provide screenshots or contact info.
4. **Support provider engagement** – Follow up with Edith and others on non-burdensome ways to engage clinicians in care gap work.
5. **Continue using pre-surveys** Florabel requested that PHLC use pre-surveys like the one LA Net used today to shape agenda and deepen discussion in future Cafés.

## **PEARLS (What Worked Well in Practice Settings)**

### **Mobile Mammography Ideas**

- Practices partnered with mobile vendors and health plans to host onsite events, boosting access and compliance with screenings.

“We are contracted with Central California Alliance for Health... a mobile mammography unit. We can schedule... up to 40 patients a day... and the health plan is actually giving all patients that do complete their mammography a \$50 gift card.” – Catherine

- Hosting events on Saturdays and training front desk staff to manage logistics enhanced outreach and convenience.

“We even created special Saturday... events to be able to attract more folks.” – Florabel

“Maybe... smaller practices that are in close enough proximity... can partner together to host an event that’s big enough for the mobile mammography company to think it’s worth their while.” – Marie

Additional mobile options like the Pink Journey Foundation were shared to support outreach in underserved areas. (see copy of chat)

## **Training Front Office Staff**

- Front office staff were trained on population health tools and included in huddles, improving proactive identification and scheduling of patients with care gaps.

“We’ve also started transitioning into teaching [front office] how to use population health management tools to identify who has outstanding screenings.” – Florabel

- Training also addressed gaps in data capture, such as incorrect billing codes that blocked reporting of completed screenings.

“They were doing depression screenings, but it wasn’t showing, right? And it was a billing... issue with the way they were coding.” – Lynda Lopez

## **Monthly Supplemental Data Uploads**

- Shifting from annual or quarterly to monthly data submissions helped increase reported metrics and close gaps more effectively.

“We try to take opportunities to upload supplemental data now as a standard on a monthly basis... we’ve seen the percentages move in like the 4, 5, 6 percent.” – Florabel

## **Blind Data Dumps + Manual Chart Reviews**

- One group automated chart data pulls throughout the year and then followed with manual review at year-end to catch any gaps.

“We do what we call blind data dumps... then when we get toward the end of the year... we start doing those manual chart reviews.” – Marie

## **Cologuard automation**

- Automating test result submissions and building data interfaces between labs and EHRs (e.g., Epic + Exact Sciences) reduced delays and manual work.

“We know that getting patients screened is one thing, but then getting the information in the right place is another thing.” – Marie

## **In-person contact important**

For underserved or Spanish-speaking populations, in-person contact remained the most reliable outreach approach.

“Our patient population has been more receptive to phone calls or in person, you know, face to face.” – Elizabeth

### **AWE as a care gap closure entry point**

Embedding care gap tracking into the annual wellness workflow created a built-in opportunity to close multiple gaps at once.

“We have created... templates for annual wellness where our population health team actually proactively calls patients... and they populate in the template all the care gaps.”  
– Mona

### **CONTENTS OF THE CHAT**

**Absolutely — here is the same resource list, now showing all URLs in copy-paste format for easy access and sharing:**

## Mobile Mammography Resources

- Alinea  
Mobile vendor used for onsite events (note: minimum patient count required).  
Shared by: Floribel Tabizon
- Pro Life  
Alternative vendor shared by Floribel Tabizon.
- The Pink Journey Foundation (Rolling With Hope)  
Mobile mammography across Southern California  
Phone: 714-915-3101  
Shared by: Dominic Gonzalez
- Adventist Health – Bakersfield  
Mobile mammography services  
Phone: 661-637-8777  
Shared by: Dominic Gonzalez
- City of Hope Mobile Screening Program  
<https://www.cityofhope.org/locations/los-angeles/los-angeles-clinical-programs/mobile-screening>

## **EHR & Data Tools**

- eCW Annual Wellness Visit Templates  
Created by Mona Shah's team to pre-load care gaps before provider visits  
Request templates from:  
Grey: [GreyS@DrShahMD.org](mailto:GreyS@DrShahMD.org)  
PHLC: [info@pophealthlc.org](mailto:info@pophealthlc.org)
- Exact Sciences + Epic Integration  
Improves Cologuard result reporting  
Suggested by: Marie Wolf, Montage Medical Group

## **HEDIS Exclusions – Cervical Cancer Screening**

Exclusion Categories Include:

- Hysterectomy with no residual cervix
- Cervical agenesis or acquired absence
- Palliative care or hospice use
- Death during the measurement period

Example ICD-10 Codes:

- Z90.710, Z98.890, Q51.5, N87.9, Z51.5, G89.3

Note:

“This is an exclusion in the HEDIS measure specifications.” – Tammy Fisher / Prime Medical

## **Outreach & Access Strategies**

- Text Campaigns / MCP Incentives  
Consider aligning front office and outreach staff.  
Prompted by: Floribel Tabizon
- Coleman Associates Office Hours (Access TA)  
Shared by: Rachel Kochhar (especially helpful for staffing and outreach solutions)

## **PHLC Events & Support Resources**

- eClinicalWorks (eCW) EHR User Group  
<https://pophealthlearningcenter.org/event/ecw-ehr-user-group/>
- NextGen EHR User Group  
<https://pophealthlearningcenter.org/event/nextgen-ehr-user-group/>
- The Clinician's AI Toolbox  
<https://pophealthlearningcenter.org/event/the-clinicians-ai-toolbox/>
- PHLC Events Calendar (All TA Offerings)  
<https://pophealthlearningcenter.org/eventcalendar/>
- July 11 Coach Café Evaluation Form  
<https://form.jotform.com/251134873458159>

# CONTACT INFORMATION



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Rachel Kochhar	PHLC	<a href="mailto:info@pophealthlc.org">info@pophealthlc.org</a>
Elizabeth Martinez	Families Together of Orange County	<a href="https://www.linkedin.com/in/elizabeth-martinezmojica">https://www.linkedin.com/in/elizabeth-martinezmojica</a>



# A Reminder about the 101 Care Gap Blueprint Guide

## Where you can find it:

### A Practice Facilitation Blueprint Guide – Getting Started with Improving Care Gap Closure

Developed By:

Lyndee Knox, PhD & Kevin Thomas, MD

LA Net & Florence Western Medical Clinic

Contributors: Geraldine Sanchez, Demetrio Cardenas, DSc (ViaCare), Grace Floutsis, MD (White Memorial CHC), Heidi Winkler, MD (Community Pediatrics Center, Inc) , Dakota Letterman (Community Pediatrics Center, Inc), Susie Yagubyan (Central Medical Business Management), Ciara Murphy & Zeina Bahgat (LA Net)

For a downloadable PDF version of this guide click [here](#)



Old site

<https://a-practice-facilitation--guuasnt.gamma.site/>

Just published on PHLC!

<https://pophealthlearningcenter.org/improving-care-gap-closure/>

**Add to THIS! Share your tools & case examples for different EPT measures!!**

# What it includes (submit your PEARLS to keep adding to it!!!!):

Exemplar case examples

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

**Expert Contributor:** Demetrius Cardenas, PA  
**Contact information:** dcardenas@viacarela.org  
**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.

Virtual visits



“Key tasks” roadmap w/ worksheets – if you complete them you WILL get there!

## Key Tasks

[Pre-Work Task 1. Engage Leadership](#)

[Pre-Work Task 2. Form a Care Gap Closure Project Team](#)

[Pre-Work Task 3. Review the practice's current care gap closure processes](#)

[Task 1. Select a care gap or closure process to improve](#)

[Task 2. Use a last 10 patient chart audit to identify barriers to gap closure](#)

[Task 3. Identify root cause/s for missed opportunities in gap closure](#)

[Task 4. Select a care gap closure approach](#)

[Task 5. Inventory practice resources for care gap closure](#)

[Task 6. Design and map gap closure workflows](#)

[Task 7. Test and refine the workflows using Plan Do Study Act cycles](#)

**FOR MORE:**

Check the PHLC learning site for MORE virtual visits and case examples in the future!

<https://pophealthlearningcenter.org/improving-care-gap-closure/>

You can also find them on the LA Net Care Gap Closure site under Care Gap Closure Tab:

<https://www.lanetpbrn.net/>