Clinical Quality Measures

A TOOL FOR CLOSING CARE GAPS

NATIONAL ASSOCIATION OF Community Health Centers®

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WHAT
are Care Gaps?

A **Care Gap** is the difference between recommended best practices and the care and services that are actually provided. These gaps can happen for many reasons but generally provide an opportunity for providers and care teams to strengthen and improve their processes.

In health care, care gaps are often discussed in relation to **Clinical Quality Measures (CQMs)**. CQMs are measures for assessing clinical quality and safety. They evaluate various aspects of patient care, including treatment, processes, patient experience, and outcomes. They are often collected and tracked using electronic health records (EHRs). CQMs assess 'the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in an optimal timeframe."[1] CQMs play an important role in health center quality improvement efforts.[2]

WHY
is Closing Gare Gaps Important?

Closing care gaps is important to healthcare quality and outcomes. It helps ensure patients receive recommended preventive care and treatment and that care is aligned with best practices. In this era of value-based care, closing care gaps can improve quality measures, leading to higher reimbursement. From the patient perspective, receiving the care they need, and improving patient outcomes, can lead to improved quality of life and improved patient experience.

HOW
to Close Care Gaps and Improve CQM Performance

This Resource Guide outlines a set of steps that health centers can take to close care gaps and improve CQM performance.

1. Choose a Measure of Focus
2. Define and Understand the Measure of Focus; Run a Report
3. Perform a Root Cause Analysis
4. Implement Small Tests of Change to Address Root Causes
5. Engage Patients

While the steps outlined in this Resource Guide may be used for any CQM, this document illustrates application of the steps using cervical cancer screening as an example.

STEP 1

Choose a Measure of Focus.

Health centers may have several quality improvement goals included in their QI/QA workplan. But with limited time, staffing, and resources, it's not realistic – or effective – to focus on improving everything at once. Instead, choose a small set of high-impact measures to actively work on, while continuing to monitor others in the background. For more guidance see the NACHC Improvement Strategy Action Guide.

Start with Measures that Serve Multiple Purposes

Focus your efforts on a CQM that supports multiple health center initiatives. This ensures your work has broad impact, aligns with key health center priorities, and gives you more bang for your buck. When selecting a CQM to focus on, consider measures that are:

- ✓ Included in Uniform Data Systems (UDS) reporting
- ✓ Required for Patient-Centered Medical Home (PCMH) recognition
- ✓ Incentivized in value-based payment (VBP) contracts
- ✓ Connected to legal risk (e.g., tied to FTCA-related concerns)
- ✓ Part of a grant funded initiative (e.g., cancer screening)

Be Aware of Measure Differences Across Programs

Different programs use different 'measure stewards', organizations that develop and maintain quality measures (e.g., CMS, HEDIS, etc.), leading to CQMs that do not align. This means the 'same' quality measure can have different definitions or denominators. For example, UDS includes patients who had at least one visit with the health center during a calendar year while a value-based payment (VBP) contract may include all patients attributed to a health center by a specific payer.

Despite these differences, improving your performance in one area often creates positive ripple effects in others. This Crosswalk of CQMs created by HITEQ may be used to assess differences across measure stewards.

Prioritize Measures Based on Stakeholder Goals

When deciding which measure to focus on, consider the goals and benchmarks that matter most to your stakeholders. These may include:

- ✓ UDS Table 6B and 7 measures
- ✓ National or state benchmarks
- ✓ VBP-related measures tied to financial outcomes
- ✓ Grant or program-specific goals

Not all benchmarks carry the same weight - *prioritize closing gaps for measures with the greatest impact on your organization's finances, compliance, or strategic direction*.

Look for the Biggest Opportunity for Impact

Target CQMs that represent the strongest opportunities for improvement, such as:

- ✓ Measures where your health center is close to reaching the benchmark ('low hanging fruit')
- ✓ Measures where your health center is significantly underperforming, and improvement would make a big difference

When making a decision as to which measure(s) to focus on, be sure you understand the specific measure definition and denominator. Use your dashboards or data systems to look at your current rate and the number of patients in the denominator (i.e., size of the opportunity).

Make Sure You Have the Tools to Succeed

Before diving into a specific CQM, be sure the health center has the necessary staff and resources to support process improvement efforts. Confirm the right people are in place to support the work and they are equipped to test and implement improvements. Also confirm the health center has the necessary HIT reporting systems and access to track and report progress.

Example:

Quality Health Center needed to narrow their quality improvement focus due to limited staff time and competing initiatives. Using the guidance from Step 1, they evaluated their options and selected a measure with broad strategic alignment and strong potential for improvement: cervical cancer screening rates.

Why Cervical Cancer Screening?

- **It serves multiple purposes:**
  - It is a required UDS measure reported annually to HRSA.
  - It is tied to their Value-Based Payment (VBP) contracts, impacting reimbursement.
  - It is part of a current grant-funded women's health initiative, aligning with existing investments.

By choosing this measure, they could meet the requirements of several programs at once, maximizing the return on their efforts.

- **It aligns with priority benchmarks:**
  - Their most recent UDS report showed a 50% screening rate, five percentage points below the national health center average of 55%.
  - The measure is included in UDS Tables 6B and 7, and is tracked by payers, funders, and internal leadership.
  - By improving this rate, the center could boost both their national standing and financial outcomes under their VBP model.
- **The opportunity for improvement is clear:**
  - The denominator for this measure includes women ages 24–64 who had a qualifying visit during the year.
  - Their UDS data showed 7,882 patients were eligible, making up about 35% of their entire patient population.
  - This means even a small improvement could benefit thousands of patients and meaningfully move their organizational metrics.
- **The timing and capacity are right:**
  - They recently hired a women's health nurse practitioner who is growing her panel, creating natural opportunities to increase screenings.
  - Most of their primary care providers are already trained to perform Pap smears, so they don't need to rely on referrals.
  - Their EHR can easily generate reports showing who meets the measure, who is due for screening, and who has documented exceptions or exclusions.
  - The QI team confirmed they have the staffing, leadership support, and reporting tools needed to focus on this measure effectively.

Bottom Line:
Quality Health Center didn't choose cervical cancer screening at random. They picked it because it was a high-impact, multi-purpose measure, had clear room for improvement, and the health center had the tools and team in place to tackle it effectively. This thoughtful approach sets them up for success and ensures their QI work aligns with organizational goals.

STEP 2

Define and Understand the Measure of Focus; Run a Report

Once you've chosen a CQM to focus on, take time to fully understand how the measure is defined and what criteria it includes. This step is crucial! As the definition of a measure varies across measure stewards, decide as a team which CQM definition will be utilized for quality improvement. This shared understanding will keep everyone on the same page.

Break Down the Measure

Be sure to understand each part of the CQM[2,3]:

- ✓ ***Denominator:*** Total number of patients who fit the detailed criteria described in the specific measure.
- ✓ ***Numerator:*** Total number of records (from the denominator) that meet the numerator criteria for the specified measure.
- ✓ ***Denominator Exclusions:*** Patients not to be considered for the measure and who are removed from the denominator before determining if numerator criteria are met.
- ✓ ***Denominator Exceptions:*** Patients who meet denominator criteria but do not meet numerator criteria because they meet any of the exceptions listed for the measure and, therefore, are removed from the denominator.

Tailor the Measure for Your QI Efforts

You can refine the denominator further to focus your quality improvement work, such as:

- ✓ All qualifying health center patients,
- ✓ Patients in a specific demographic group
- ✓ Patients attributed to your health center by a specific payor
- ✓ Patients seen at a specific health center site
- ✓ Patients who are part of specific provider's patient panel

Assess Reporting Capabilities

Check what your Electronic Health Record (EHR), registry, or population health management (PHM) system can support. Some systems have built-in reports for certain CQMs; others may require you to create or customize a report manually.

Run a Report

Once you've defined the measure and population you want to focus on, generate a report that includes:

- ✓ Patients who meet the measure
- ✓ Patients who do not meet the measure
- ✓ Patients who are excluded or fall under the exceptions

This report provides a starting point for analyzing current performance and identifying opportunities for improvement.

Example:

*After selecting **cervical cancer screening** as their focus measure in Step 1, Quality Health Center took the next crucial step: deeply understanding the measure definition to ensure clarity, alignment, and accurate reporting.*

They considered the following definitions for this measure:

- **CMS measure CMS124v12: Percentage of patients receiving a qualifying cervical cancer screening out of patients with a qualifying encounter during the reporting period with a few exceptions.**
- **From their Value-Based Payment (VBP) contract: Percentage of patients receiving a qualifying cervical cancer screening out of the attributed patients from Community Health Insurance.**
- **From their Cervical Cancer Grant: Percentage of patients receiving cervical cancer screening and appropriate follow-up care out of identified low-income patients who are at greater risk for undiagnosed disease.**

Quality Health Center decided to use the **CMS measure CMS124v12** for cervical cancer screening, which aligns with the UDS reporting requirement. This decision allowed them to stay consistent across internal teams and external reporting systems. This choice was strategic for two reasons:

- **It aligns with priority benchmarks:**
  1. The UDS definition is more inclusive, capturing a broader range of patients who have had at least one qualifying encounter.
  2. Their outreach team is already focused on engaging patients assigned to the clinic but not yet seen, so they can still influence the VBP performance while tracking quality improvement with a well-defined denominator.

Measure Details (CMS124v12): Cervical Cancer Screening:

- **Denominator:** Women ages 24–64 with at least one qualifying encounter during the measurement period.
- **Numerator:** Patients who had:
  - Cervical cytology (Pap smear) within the last 3 years, OR
  - HPV testing within the last 5 years (for women age 30–64)
- **Exclusions:**
  - Hysterectomy with no residual cervix or congenital absence of cervix
  - Hospice care or palliative care at any point during the measurement period

Tailoring the focus population:

They shared this detailed breakdown with their QI team, providers, and care coordinators to ensure that everyone understood exactly who was included and how performance would be measured. This avoided confusion between similar-sounding measures and ensured that improvement efforts were focused on the right patients.

To align with their grant funding goals and maximize their impact, Quality Health Center further narrowed their focus within the denominator to get started:

- They will prioritize low-income patients, since these individuals are disproportionately at risk for undiagnosed conditions.
- They will also identify patients with upcoming appointments who haven't yet had their screening, allowing the care team to proactively close gaps during those visits.

This approach balanced inclusiveness with practicality, enabling focused, actionable outreach while still aligning with strategic goals.

Assessing reporting capabilities:

Fortunately, their **population health management (PHM)** system already included this CMS measure, which meant they didn't need to build a custom report. Their QI analyst confirmed that the system could generate:

- A **full measure report**, showing patients in the denominator and those who met the numerator criteria.
- A **care gap report**, showing patients in the denominator without documented screening.
- **Filters** to sort patients by income level, upcoming appointment dates, and past visit history.

Running the report:

Using their PHM system, the QI team ran two key reports:

1. A summary report of current performance: showing overall screening rate, total number of eligible patients (denominator), and number of patients screened (numerator).
2. A care gap list: patients in the denominator who have not had a screening per the measure definition.

They then cross-referenced this care gap list with:

- Recent and upcoming appointments, so providers and support staff could prioritize in-visit screening.
- Outreach lists, to identify patients who could be contacted for scheduling or follow-up.

This level of detail allowed them to tailor their strategy and prioritize patients who were both eligible and reachable.

Summary: Why This Works

By thoroughly defining the measure, aligning stakeholders on the criteria, tailoring the focus population, and using their existing systems to track data, Quality Health Center set itself up for success. This clarity allows them to:

- Avoid confusion between UDS, VBP, and grant definitions
- Leverage their grant priorities
- Use data to drive targeted action
- Ensure the entire care team is working toward the same goal

STEP 3

Identify the Root Cause of the Gap

Before deciding how to improve a CQM, the team first needs to understand why a care gap exists and what is causing the low performance. This understanding begins by identifying the type of gap affecting the measure. Gaps usually fall into one of three categories:

1. **Data gaps** related to entering or mapping information in the Electronic Health Record (EHR) or Population Health Management (PHM) system.
2. **Service delivery gaps** related to care team workflows, knowledge, or roles.
3. **Service engagement gaps** related to patient engagement or ability to access services.

To help with this process, use NACHC's CQM Care Gaps: Root Cause Identifier Worksheet. It offers a structured way to investigate each type of gap, with guided questions and steps to confirm whether the gap is present.

Once the gap type is clear, use the Root Cause Analysis (RCA) section of the worksheet to explore it further. RCA is the process of identifying root causes of an event or process that resulted in an undesired outcome (care gap) and developing corrective actions.[4] The worksheet prompts your team to complete a RCA using the *Five Whys Tool*.

The *Five Whys Tool* is a simple way of getting to the true 'root' of an issue by asking 'why?' repeatedly. Sometimes one answer to a 'why?' question may yield two or more answers. Each of these 'branches' should be followed to its 'root'. Once a team feels it has reached the terminal end of the 'root' (or has asked 'why?' enough times), this can be considered a 'root cause'.

After the root cause is identified, the worksheet provides suggested interventions that health centers may implement to address the root cause of the gap. Completing this process allows a team to identify clear root cause(s) of the care gap for your chosen CQM and a targeted intervention to test and improve performance.

STEP 4

Implement Small Tests of Change to Address the Root Cause

Once you've identified the root cause of a gap, it's time to take action! Start by selecting a small change (intervention) to test. Use the ideas from the Root Cause Identifier Worksheet, but also involve other health center staff who understand the day-to-day process, including challenges and opportunities.

Assemble a Team

Put together a team to carry out the selected intervention(s). Include:

- A staff lead and a provider champion to help guide the effort
- Care team members who are directly involved in the process you're trying to improve

Set Clear, Acheivable Goals

Great SMART goals for your improvement plan. SMART goals are:

- **S**pecific (Who and What?): Concrete, detailed, and well-defined
- **M**easurable (By How Much?): Quantitative or qualitative means of measurement and comparison
- **A**chievable (How?): Feasible and agreed upon by key stakeholders
- **R**elevant (Why?): Importance to the organization
- **T**ime-Bound (When?): Time frame or target date

These goals help keep your improvement efforts focused and trackable. When setting SMART goals, consider the stakeholder goals deemed high priority by the health center.

Implement Small Tests of Change

Start with a small test of change using the Plan-Do-Study-Act (PDSA) method. This model is used to test a small change quickly over a short period of time.

- **P**lan: Choose a small change to test (e.g., try with one provider or test for one day)
- **D**o: Put your plan into action
- **S**tudy: Review the results. What happened?
- **A**ct: Decide what to do next:
  - » Adopt: it worked – keep doing it!
  - » Adapt: modify intervention; test again
  - » Abandon: it didn't work – try something else

Visit IHI to download a PDSA Worksheet.

Track Progress and Keep Everyone in the Loop

- Repeat the cycle as needed. Sometimes you'll need several PDSAs before expanding rollout.
- Assess the performance and effectiveness of improvement cycles through regular data analysis – and be sure to communicate progress and improvement with staff and providers.

Example:

***Quality Health Center* identified the root cause:**

Providers and staff are unaware that cervical cancer screenings received from outside providers (e.g., OB/GYNs) must be documented in structured EHR fields to count toward quality metrics.

They built a team that includes:

- Staff Lead: Maria (Medical Assistant Team Lead).
- Provider Champion: Dr. Patel (Family Medicine).
- Care Team Members: 2 MAs, 1 nurse, front desk staff member, 1 person from the quality team.

They set a SMART Goal:

- Specific: Ensure that external cervical cancer screening results are entered into structured EHR fields for all patients seen by Dr. Patel's team.
- Measurable: Increase structured documentation of external Pap/HPV results from 40% to 90%.
- Achievable: Start with one provider's panel and one MA team.
- Relevant: This aligns with our health center's UDS quality improvement goals.
- Time-bound: Achieve the goal within 30 days.

They used the PDSA Model to track small tests of change:

Plan:

- Change to test: Implement a new workflow for Dr. Patel's team: during chart prep, MAs will flag patients with scanned Pap/HPV results, and enter the screening information into the structured EHR field.
- Training: Provide a 15-minute huddle training on where and how to enter structured data for cervical cancer screenings.
- Data to collect: Number of external results entered into structured fields vs. scanned only.

Do:

- Run the test for one week with Dr. Patel's team.
- Quality team member checks the structured data entry daily and gives feedback.

Study:

- After one week:
- Structured documentation rate improved from 40% to 78%.
- MA staff said the new workflow took an extra 1–2 minutes per patient but felt manageable.
- One MA suggested a shortcut macro in the EHR to streamline data entry.

Act:

- Decision: Adapt
- Tweak the workflow by adding the EHR macro to save time and reduce clicks.
- Train a second care team and run the updated test for one more week.

They tracked and communicated progress:

- Weekly updates shared during team huddles and in the staff newsletter.
- Posted a simple data tracker on the huddle board to show progress toward the 90% goal.
- Celebrated success with shout-outs and a small prize for the first team to reach 100%.

STEP 5 Identify the Root Cause of the Gap

After root causes have been addressed and data and process issues remedied, engage or re-engage patients. Focus on patients who already have scheduled appointments as well as patients not yet scheduled for care, but who are due for services.

Use Risk Stratification to Focus Your Efforts

If your care gap report is too large a list to tackle all at once, you may need to stratify the list to focus on a specific high-risk population, condition, or other patient segment (e.g., patients with chronic conditions, patients with recent ER visits or hospitalizations, etc.). This will not only reduce the number of patients to a more manageable number, but can target interventions for patients most in need.

Check out:

- NACHC's Risk Stratification Action Guide for help segmenting patients by risk level.
- NACHC's Patient Engagement Action Guide for tips on how to support and engage patients in their care.

Example:

***Quality Health Center* started with patients who already have appointments:**

After training care teams to enter outside screening results into structured fields and streamlining in-visit workflows, the next step was engaging patients who were already coming in for care.

- During daily huddles, MAs reviewed patient charts to flag anyone due for a cervical cancer screening.
- MAs began conversations during intake: "I noticed you're due for your cervical cancer screening. Would you be open to completing that today?"
- If the patient had already completed a Pap test elsewhere, the MA requested the record and made sure it was entered in structured fields.
- The team tracked how often screenings were completed or documented during other types of visits.

Result: In 3 weeks, 64% of eligible patients with appointments had their screening completed or documented—without needing to schedule additional visits.

Next, *Quality Health Center* reached patients who are not scheduled

With workflows for in-visit care gaps running smoothly, the focus shifted to patients who were overdue but not scheduled. The list of overdue patients was long, so the team used risk stratification to focus first on:

- Women aged 50–65 with no documented screening in the last 5 years.
- Patients with multiple chronic conditions.
- Patients who had been hospitalized or visited the ER in the past 6 months.

The Quality Team ran a report to generate a prioritized list. Instead of offering only Women's Wellness Exams, outreach staff offered flexible options, including:

- Screening during a regular follow-up
- Drop-in Pap slots during certain clinic hours
- Community-based events with screening services

Result: Instead of long waitlists, patients were offered faster, more flexible screening opportunities. This helped build trust and increased screening rates among higher-risk patients.

Key Patient Engagement Strategies Used:

- Used plain language and scripts during outreach to explain why screening matters
- Included bilingual team members in calls to reduce language barriers
- Offered appointment times that worked around childcare, work, or transportation needs
- Celebrated progress visibly in the clinic (e.g., a "Care Gaps Closed" tracker on the wall)

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