

## CLINICAL QUALITY MEASURES – CLOSING CARE GAPS

### *A Preliminary Document*

#### CLINICAL QUALITY MEASURES

The Value Transformation Framework addresses how an improvement strategy encompasses the systematic, continuous process of quality *planning, improvement, control, and assurance*. This document is a companion to the [Improvement Strategy Action Guide](#) and details the *improvement* phase (Improvement Strategy Action Guide Step 6) in more detail, offering specific guidance on closing care gaps for clinical quality measures.

#### WHY are clinical quality measures essential to health center performance?

Providing high quality clinical care to patients has always been a priority of health centers, and collecting and reporting on clinical data has also been a longstanding effort. In 1996, Uniform Data Systems (UDS) was introduced as a standardized reporting system used by all HRSA-funded health centers (and by all look-alikes since 2011). Health centers are required to report each year on a core set of information, so that BPHC can ensure compliance with program requirements and assess the impact of the program. The UDS has grown significantly over time, particularly in clinical quality. BPHC started collecting data on quality of care and health outcomes for the first time in the 2008 reporting cycle. It became possible for health centers to provide aggregated data on all their patients—not just samples—once electronic health records were in use almost everywhere, and over time many more clinical quality measures have been added.

(<https://bphc.hrsa.gov/sites/default/files/bphc/about/health-center-program-history-full-report.pdf>) Currently, the UDS Modernization Initiative aims to reduce the reporting burden, improve data quality, and better measure program services and outcomes. This effort includes the UDS Patient-Level Submission (“UDS+”) initiative to move from aggregate reporting of UDS patient demographics and clinical quality measures to the reporting of de-identified patient-level data (<https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance/uniform-data-system-uds-modernization-initiative>).

Clinical quality measures are also incorporated in other health center programmatic and care transformation efforts, including Patient-Centered Medical Home (PCMH) initiatives. PCMH recognition evaluates health centers against national standards for primary care that emphasize care coordination and on-going quality improvement. (<https://bphc.hrsa.gov/focus-areas/health-center-performance-impact/hrsa-accreditation-patient-centered-medical-home-recognition-initiative>) For example, the National Committee for Quality Assurance (NCQA) PCMH standards require the practice to establish a culture of data-driven performance improvement on clinical

quality, and to monitor, set goals, and act to improve upon clinical quality measures across the categories of immunization measures, preventive care measures, chronic or acute care clinical measures, and behavioral health measures. (<https://store.ncqa.org/pcmh-standards-and-guidelines.html>)

In addition, with healthcare payment shifting from fee-for-service to value-based, healthcare providers are financially incentivized to deliver care designed to meet the goals of the Quintuple Aim: improved patient experience, improved health outcomes, reduced cost, improved staff experience, and health equity (<https://www.ihl.org/resources/publications/quintuple-aim-health-care-improvement-new-imperative-advance-health-equity>). With this increasing emphasis, there is a greater level of importance being placed on CQM reporting and outcomes.

### **WHAT are clinical quality measures and care gaps?**

Clinical Quality Measures (CQMs) are a mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care. They assess *the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in an optimal timeframe* (<https://www.healthit.gov/faq/what-are-clinical-quality-measures>).

CQMs provide a standardized means of measuring and comparing delivery of care. The use of CQMs allows care services to be measured in a clinically meaningful way and may facilitate improvements in care that can be easily communicated to care team members and stakeholders (e.g., health care providers, payors, and the public). ([https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/guidetocqms\\_remediated\\_2011.pdf](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/guidetocqms_remediated_2011.pdf))

Within UDS, the quality of care measures reported on Table 6B are *process measures*. This means they document services that have been shown to be correlated with and serve as a proxy for positive long-term health outcomes. Individuals who receive routine preventive care and timely chronic care are more likely to have positive outcomes (<https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf>).

The health outcome and disparity measures reported on UDS Table 7 are *clinical process and outcome measures*, which document measurable outcomes of clinical intervention as a surrogate for good long-term health outcomes. Increasing the proportion of health center patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future. (<https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf>)

For each CQM, a health center may have a list of qualifying patients who have been provided with the care service as indicated, thereby meeting the measure, and a list of qualifying patients who have not been provided with the care service indicated. The later list represents patient care gaps.

Care gaps are the discrepancy between a current outcome and the desired outcome ( <https://health.ucdavis.edu/media-resources/cme/documents/pdfs/GapsNeeds.pdf>). Health centers have a responsibility to the patients and communities they serve to provide high-quality care, and addressing care gaps is an important component of these services.

The reasons for care gaps can vary, though in general, a care gap presents an opportunity for providers and care teams to improve upon their current processes. ( <https://health.ucdavis.edu/media-resources/cme/documents/pdfs/GapsNeeds.pdf>). This Action Guide will later describe three categories of care gaps that may be impacting CQM performance – *data gaps*, *service delivery gaps*, and *service engagement gaps* – as well as how to identify the root cause of the care gap and implement rapid cycle improvement to test an intervention.

## **HOW do health centers address care gaps?**

Monitoring CQMs and improving upon CQM performance (i.e., address care gaps) is an essential component of a health center's HRSA required [QI/QA Program](#) and Workplan. NACHC's [Improvement Strategy Action Guide](#) offers detailed guidance on how a health center can develop and implement an effective organizational improvement strategy that meets HRSA health center program requirements and serves as the foundation to a health center value-based care transformation. This CQM Action Guide is a companion to the Improvement Strategy Action Guide and details the *improvement* phase (Improvement Strategy Action Guide Step 6) in more detail, offering specific guidance on closing care gaps for clinical quality measures:

### **Quality Improvement (QI) Action Steps:**

1. Choose a measure of focus
2. Define and understand the measure of focus
3. Perform a Root Cause Analysis
4. Execute Rapid Cycle Improvement Initiatives for Root Causes
5. Engage Patients

These QI Action Steps are designed for improving any clinical quality measure. This Action Guide will incorporate the example of the Controlling High Blood Pressure to help illustrate the application of each QI Action Step.

## **STEP 1: Choose a measure of focus**

Health centers may have several quality improvement priorities included in their QI/QA workplan (See Step 5 of the [NACHC Improvement Strategy Action Guide](#)). Since health center resources, including staffing and time, are often limited, only a limited number of measures should be selected to focus on for active improvement. This enables the health center to expedite

improvement progress, while a larger number of measures may still be the subject of regular monitoring (see Step 6 of the [NACHC Improvement Strategy Action Guide](#)).

When determining a measure of focus for active improvement, there are a few key considerations:

1. **Weigh the priority of benchmarks/goals set by stakeholders.** The CQMs that a health center has selected to regularly monitor are likely to include UDS tables 6B and 7 measures. A health center may determine it is high priority to work toward exceeding state or national UDS benchmarks. A health center may also be regularly monitoring CQMs that are part of value-based payment arrangements, for which performance is tied to financial implications. In this case, a health center may determine it to be high priority to exceed CQM goals set by payors. While all stakeholder benchmarks/goals are important, it is essential to determine which stakeholder benchmarks/goals the health center is prioritizing. Consider financial implications and grant obligations amongst any other relevant criteria.

2. **Assess the impact of CQMs included in multiple health center programs/initiatives.** Focusing on a CQM that is included in more than one health center initiative can increase the impact of improvement (i.e., ‘more bang for your buck’). For example, CQMs that are:

- Included in Uniform Data Systems (UDS) reporting
- Required for Patient-Centered Medical Home (PCMH) recognition
- Incentivized in value-based payment (VBP) arrangements
- Have legal claim risk (or past related FTCA claims)
- Related to a grant funded project (e.g., expanding mental health services)

It is important to note that programs may utilize differing measure stewards (e.g., CMS, HEDIS, etc.) leading to CQMs that do not align exactly across programs. Denominator criteria may also differ across programs (e.g., UDS considers qualifying health center patients, while a VBP arrangement may consider all patients attributed by a specific payor). However, there is still a high likelihood of performance improvement having a positive impact across programs/initiatives regardless of these differences. This [Crosswalk of CQMs](#) created by HITEQ may be used to assess differences across measure stewards.

3. **Consider CQMs that offer the greatest opportunity for improvement** relative to the stakeholder benchmarks/goals deemed high priority by the health center. CQMs with high opportunity for improvement may include CQMs for which the health center is close to meeting a stakeholder benchmark/goal (i.e., ‘low hanging fruit’), as well as CQMs for which the health center is far from a stakeholder benchmark/goal. When comparing the health center’s current performance to stakeholder benchmarks/goals, the specific CQM (i.e., measure steward) and the denominator criteria must align. Consult CQM dashboards, if available, to view

performance information. In addition to the current health center rate, also note the size of the measure denominator for insight into the number of care gaps.

4. **Confirm health center resources and capabilities.** For the CQM selected for focus, ensure the health center has the necessary staff available to support process improvement efforts. Also confirm the health center has the necessary HIT reporting systems and access to the data needed.

**Example:**

*Quality Health Center* decided to focus on a measure for improving hypertension management. In addition to being a UDS measure, hypertension management is included in *Quality Health Center's* value-based payment arrangements and is the subject of the Million Hearts project in which they participate. *Quality Health Center* reported 60% hypertension control on their last UDS report, which is 5% below the health center national average of 65%. *Quality Health Center* has confirmed they have the necessary staff support and data/reporting systems needed to improve this measure.

**STEP 2: Define and understand the measure of focus**

After selecting a CQM on which to focus improvement efforts, it is essential to understand the measure and its criteria in detail, and further define as needed. As mentioned previously, CQMs may not always align across programs due to utilizing different measure stewards (e.g., CMS, HEDIS, etc.), and/or differing denominator criteria. For the measure of focus, the health center must determine which CQM definition will be utilized for quality improvement to eliminate confusion among staff and providers.

Explore the detailed definition of the measure of focus and the criteria that makes up the measure:

- **Denominator:** Patients who fit the detailed criteria described in the specific measure are to be included and evaluated. (<https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf> page 91)
- **Numerator:** Records (from the denominator) that meet the criteria for the specified measure. (<https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf> page 91)
- **Denominator Exclusions:** Patients not to be considered for the measure and who are removed from the denominator before determining if numerator criteria are met.

(<https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf>  
page 91)

- **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.  
(<https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf>  
page 91)

Additionally, for the purposes of quality improvement, the health center can further define the measure denominator to include only a specific population of focus. For example:

1. All (qualifying) health center patients,
2. Patients attributed to the health center by a specific payor,
3. A specific health center pilot site, or
4. A specific provider's patient panel.

It is important to evaluate each requirement in terms of EHR, registry, or population health management system reporting capabilities. Some systems have certain CQMs built into the reporting system. Depending on the CQM chosen and system limitations, health centers may be required to manually build or customize reports to align with reporting needs.

Once there is a clear understanding of the measure definition and criteria, health centers should use a standardized process for recording the measure elements. NACHC has developed a [CQM Documentation Tool](#) to methodically record metric data. As measure definitions and reporting capabilities change, this document helps provide continuity and consistency over time, recording the historical details around each CQM quality improvement effort.

#### Example:

*Quality Health Center* has determined that they will use the CMS measure for Controlling High Blood Pressure to align with UDS reporting ([CMS165v11](#) in the [2024 HRSA UDS Manual](#)).

Measure Description: "Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period." (See full measure details for numerator, denominator, and exclusion/exception criteria.)

*Quality Health Center* has confirmed that this CMS measure is built into their population health management system.

### STEP 3: Perform a root cause analysis

To determine the intervention most likely to result in closing care gaps and improving CQM performance, health centers must first determine the type of care gap impacting the CQM, and the root cause of the gap.

There are three categories of gaps that may be impacting CQM performance:

1. **Data gaps** related to EHR documentation and mapping to reports,
2. **Service delivery gaps** related to care team knowledge and workflows, and
3. **Service engagement gaps** related to patient engagement and ability to access services.

NACHC's CQM Care Gaps: Root Cause Identifier Worksheet can be used to jumpstart a health center's CQM improvement through a systematic approach to identifying the root cause of care gaps by providing questions to assess each gap and investigation steps for ways to confirm whether the gap is occurring.

Once the type of the gap is identified, the worksheet prompts the health center to complete a Root Cause Analysis (RCA) using the *Five Whys Tool*. An RCA is defined by CMS as “a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions. The RCA process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events. The purpose of an RCA is to find out what happened, why it happened, and determine what changes need to be made.” (<https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf>) 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 offers possible interventions that health centers may implement to address the root cause of the gap. The result of completing this worksheet will be an identified root cause of the care gaps for the selected CQM and the intervention that your health center will test.

### Example:

When completing the *NACHC CQM Care Gaps Root Cause Identifier* worksheet for their selected measure, Controlling High Blood Pressure, *Quality Health Center* began with the first question and confirmed through reviewing their EHR setup that there is a structured data field available to capture blood pressure measurements. They moved onto the second question and confirmed that the data from these fields is pulling into their reports. For the third question, *Quality Health Center* spot checked a sample of patient charts and noted that several had blood pressure readings in the controlled range, but the numbers were documented in the wrong field and so, not pulled into the report.

*Quality Health Center* then used the *Five Whys Tool* and asked, “**Why** are some of the blood pressure readings being documented in the wrong place?” The team discusses this and notes that the readings were entered by the three newest Medical Assistants (MAs). They then asked, “**Why** are these three newest MAs entering this data incorrectly?” The team again discusses this and discovers that the Nurse who was responsible for training the MAs was out on maternity leave at the time the three newest MAs were hired. They then asked, “**Why** was the onboarding process not handed off to another nurse?” After further discussion, the team concluded that there is no process in Human Resources for ensuring all components of the required training are completed before newly hired MAs provide patient care.

*Quality Health Center* has identified this root cause to be a **data gap** and identified an appropriate intervention to be developing a formal onboarding process.

## STEP 4: Execute rapid cycle improvement initiatives for root causes

Once a root cause is identified, the health center can now begin improvement activities:

**Determine which intervention to test.** Consider those suggested in the CQM Care Gaps: Root Cause Identifier Worksheet and be sure to involve care team members in the determination process.

**Assemble a team** based on the needs of the chosen intervention. Assign staff leads and provider champions to organize and drive performance improvement efforts and involve care team members who are directly involved in delivering the service and therefore are stakeholders in the process.

**Set “SMART” objectives** for performance improvement goals. SMART objectives are:

- **Specific** (Who and What?): Concrete, detailed, and well-defined
- **Measurable** (By How Much?): Quantitative or qualitative means of measurement and comparison
- **Achievable** (How?): Feasible and agreed upon by key stakeholders
- **Relevant** (Why?): Importance to the organization
- **Time-Bound** (When?): Time frame or target date

For more information on setting SMART objectives, visit resources from the [IHI](#). When setting SMART objectives, consider the stakeholder benchmarks/goals deemed high priority by the health center.

**Initiate rapid cycle improvement** for your targeted intervention. One common rapid cycle improvement model is called a [PDSA](#) or the Plan-Do-Study-Act method. This model is used to test a small change quickly over a short period of time. It begins by planning a small change using a small sample size and for a short duration (this could be as limited as one hour or one week as an example). The team then executes the plan (“Do”) and then evaluates (“Studies”) the outcome of the small test of change. Based on the outcome, the team will decide whether to “Adopt” (continue the intervention), “Adapt” (modify the intervention slightly and continue), or “Abandon” the intervention all-together.

(Graphic from <https://www.ihi.org/resources/tools/plan-do-study-act-pdsa-worksheet#downloads>)



**Plan:** Plan the test, including a plan for collecting data.

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect.



**Do:** Run the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyze the data.



**Study:** Analyze the results and compare them to your predictions.

- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.



**Act:** Based on what you learned from the test, make a plan for your next step.

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

Health centers may leverage resources and learning opportunities offered through NACHC's [Elevate](#) program to support improvement initiatives. Elevate is a national community of health centers and partners coming together to transform systems and enhance value. Elevate offers a guided approach to health center systems change through resources, including step-by-step action guides, self-guided online learning modules, tools, and learning forums.

Assess the performance and effectiveness of improvement initiatives through regular data analysis. Once a rapid cycle improvement initiative has been completed, communicate improvement progress with staff and providers on a routine basis.

**Example:**

After *Quality Health Center* identified that there is no process in Human Resources for ensuring all components of the required training are completed before newly hired MAs provide patient care, the team decided to use the PDSA method for small tests of change in their hiring process.

**PLAN:** Develop a simple skills checklist for the newly hired MA who began patient care the week prior. One of the skills included in this checklist is to connect with a nurse or MA and be “signed-off” on documenting vital signs properly in the EHR.

**DO:** The Quality Manager developed the new-hire skills checklist and oriented the newly hired MA to the EHR documentation process for patient vital signs.

**STUDY:** The Quality Manager spot-checked the newly hired MA’s documentation of vital signs on the first three patients she roomed the day immediately following her orientation using the new checklist and discovered 100% of the three patients she roomed had the vital signs documented in the correct location.

**ACT:** The Quality Manager saw that this intervention was successful and resulted in improvement in the documentation. The team decided to “Adopt” this process for all new hires moving forward.

**STEP 5: Engage Patients.**

After root causes have been addressed and data and process issues have been remedied, engage or re-engage patients in care. In addition to closing care gaps for patients who already have scheduled appointments, it may be helpful to perform outreach to patients who are not yet scheduled for care, but who are due for services. When care gap reports are run, the numbers yielded may be too large to outreach all at once. Health center teams may consider risk-stratifying the list to focus on a specific high-risk population. This will not only reduce the number of patients to a more manageable number, but it will target interventions for patients most in need. Refer to [NACHC’s Risk Stratification Action Guide](#) as well as [NACHC's Patient Engagement Action Guide](#) for more information.

**Example:**

*Quality Health Center* pulled a new report for all patients who have not been seen for a visit in the last 6 months and whose last blood pressure was greater than 140/90 mmHg. The Quality Manager sees that the list contains 1,000 patients. She determines that this number is too large to work on with limited staff availability and so she lengthens the time to include only patients who have not been seen for a visit in the last 12 months and risk stratified the report to patients whose last blood pressure was greater than 150/100 mmHg. This narrowed the list to 25 patients. The Quality Manager felt this was a reasonable number to start with and gave the list of 25 patients to a Medical Assistant who was directed to call each of the 25 patients on the list and work to schedule them for a focused “hypertension follow-up” appointment with their assigned primary care provider in the next month.

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