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

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> **Tip for using during virtual facilitation/coaching:**
> Click on a Table of Contents line to go directly to that section.

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Quick Start Guide

See the Quick Start Guide for a summary of the essential steps for working with a practice to enhance their care gap closure processes. Click here.

Practice Facilitator Guide

Purpose of This Guide

This guide is for Practice Facilitators, Primary Care Providers (PCPs), office managers, medical assistants (MAs), and quality improvement (QI) teams.

It's a **step-by-step blueprint** designed to help you improve how your practice identifies and closes care gaps — whether in preventive care, chronic disease management, or behavioral health.

You'll find:
- A quick start guide if you only have a few minutes at a time to work on this
- list of essential tasks for improving care gap closure processes in a PCP
- Worksheets for each task you can use to help practices reflect on and plan improvements
- Real-world case examples from "exemplars" in care gap closure
- "PEARLS" — pro tips from the field
- A reusable structure you can use to address different care gap closure processes or HEDIS-like metrics

Contents of This Guide

The Care Gap Closure (CGC) improvement process begins with three essential prework steps:
- engaging practice leadership,
- forming a dedicated CGC project team, and
- conducting a brief current state assessment of the clinic's current gap closure processes

Following this prework, the practice team completes a structured sequence of 12 tasks that guide them through the full cycle of quality improvement—from selecting a care gap and mapping workflows, to testing changes, training staff, evaluating results, and fully integrating the new process into the clinic's quality infrastructure.

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Together, these 15 activities provide a practical roadmap for a PF, office manager or PCP QI team for building sustainable, team-owned workflows that close care gaps efficiently and equitably.

Ways to Use this Guide

This guide is designed to be practical and flexible—whether you're a **Practice Facilitator** supporting multiple clinics or a **clinic leader** (such as an office manager or lead clinician) guiding your own team.

Ways to Use This Guide:
- **Facilitator-Led:** Use the guide as a roadmap to structure your coaching sessions with a practice, focusing on one task at a time.
- **Practice-Led (No PF On-Site):** Clinic leaders can walk their team through the guide, using it to lead short, focused improvement huddles or meetings.
- **Peer Coaching:** Share the guide with a trusted peer or colleague at another clinic and work through tasks together.
- **Support from Health Plan or IPA:** Ask your health plan or IPA if they can provide a facilitator or quality coach to help you implement the guide.

"[The Guide] should be self-explanatory enough that Geraldine could train office managers. Walk through each task, complete each worksheet, and by the end, you've improved something or built something new." Kevin Thomas, MD

Defining Care Gap Closure

Care gap closure refers to identifying and addressing missing clinical services — such as screenings, immunizations, or follow-up care — that patients are due for based on clinical guidelines and quality measures.

Care gaps commonly include:
- Missed preventive services (e.g., mammograms, colonoscopies)
- Missed chronic disease care (e.g., A1C or blood pressure checks)
- Missing or inaccurate documentation (e.g., uncoded services, missing LOINC codes for PHQ-9s)

Addressing care gaps directly impacts your practice's performance on **HEDIS-like metrics** and improves patient outcomes.

Practices use a variety of strategies to close care gaps. These include:
- **Opportunistic/At-Visit Closure:** Embedding real-time alerts and workflows to address care gaps during patient encounters.
- **Between-Visit Outreach:** Using automated and manual reminders (SMS, calls, letters) to engage patients between visits.

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- **Problem-Specific Campaigns:** Running targeted outreach efforts for a particular care gap with automated follow-up and manual engagement.
- **Unseen patient outreach:** Focused outreach on patients who have not been seen in a specified period of time 12-24 months, or who have been assigned to the practice but have not established care.
- **Remote Monitoring:** Utilizing devices and data tracking for chronic conditions (e.g., BP monitors, glucometers).
- **Administrative Closure:** Ensuring proper reporting and documentation of closed care gaps through EHR coding, supplemental data uploads, and accurate billing.

"You have to do it all — patient-level closure, population reports, and validating plan data like in Cozeva."— Grace Floutsis, MD, CEO/CMO at White Memorial CHC

Equity Practice Transformation (EPT) HEDIS-Like metrics

The **EPT Initiative** is focused on closing the following high-impact care gaps for each population of focus (POF):

Population	HEDIS-like Measures
Pregnant People	Postpartum care (PPC) Timeliness of prenatal care (PPC) Postpartum depression screening (PDS-E)
Children/Youth	Child immunization status (CIS) Well-child visits first 30 months (W30) Child and Adolescent Well-Care Visits (WCV) Depression screening (DSF)
Adult Preventive	Breast cancer screening (BCS) Cervical cancer screening (CCS) Colorectal cancer screening (COL) Depression screening (DSF)
Adult Chronic Care	Controlling high blood pressure (CBP) Glycemic status assessment (GSB) Depression screening (DSF)
Behavioral Health	Depression screening (DSF) Depression remission or response (DRR) Pharmacotherapy for Opioid Use Disorder (POD)

Benefits of Closing Care Gaps

Benefits of improved processes for care gap closure include:
- Better **health outcomes** for patients
- Fewer **hospitalizations and ER visits**
- Improved **patient engagement and trust**

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- Higher **performance on quality metrics**
- Increased practice revenue from incentives and value-based payment
- Enhanced **teamwork**

Determining What "Good" Looks Like

"If you don't know where you are going, any road will take you there."

When working to improve care gap closure, knowing what "good" looks like helps the PCP gather ideas and jump-start their own design and implementation work in these areas.

Find examples of what "good" looks like by:
- reviewing resources and literature online
- attending trainings
- identifying and then learning from "exemplars"

A special word on exemplars
An exemplar is a clinic, team, staff person or clinician that is performing at a high level on specific metrics (e.g., HEDIS-like measures) or demonstrating success with a particular care gap closure process that your practice is working to improve.

Identify exemplars through:
- peer nominations,
- practice facilitators working with other practices on care gap closure, and
- reviewing performance data for high-performers on a specific metric - both internal (an exemplar may be from your own practice) and external

Exemplars do not need to be good at everything. They may be an exemplar in one specific process, and not in another. Engage them for that one process.

Arrange **virtual visit** to the exemplar – a video conference where the exemplar shares their process, workflows, and "top three recommendations" and you get to ask questions to inform your own care gap closure design process.

(Optional) Worksheet
(Optional) Virtual Visit Planning Worksheet

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Case Examples of Exemplars

Here are some case examples from your peers that have been nominated by their peers, plan or practice facilitator as an "exemplar" in care gap closure for one or more metrics.

Table 1. Partial list of case Examples. Click here: https://www.lanetpbrn.net/caregapclosure

Name	Practice type	Size	EHR	PHM/Gap data
Case example: ViaCare	FQHC	Medium	eCW 12	Azara, Innovacer, Cozeva
Case example: White Memorial	FQHC	Medium	eCW	Azara, Cozeva
Case example: CPC, Inc	Independent, 1 FTE	Very small	Reli-Med	Cozeva, manual
Case Example: Central Business Medical Management	Independent, 2 FTE	Small	Office Ally	Cozeva, manual

Recorded Virtual Visits with Exemplars

Table 2. Partial list of virtual visits. Click here: https://www.lanetpbrn.net/caregapclosure

➢ Demetrio Cardenas, DSc, CMIO – Via Care
➢ Geraldine Sanchez, Operations Manager – Florence Western Medical Clinic

Share your own ideas and case examples

Please contribute your own case examples here by using this case study generator link: https://www.surveymonkey.com/r/TXB7MZG

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Key Tasks

Pre-Work Task 1. Engage Leadership

As a first step in care gap closure improvement, meet with practice leadership to discuss their interest in this improvement work, their goals for their care gap closure processes, and the area they would like to focus on first and why. Also identify who will be the "champion" for the CMP at the practice. This individual should have sufficient authority to ensure the implementation of the processes at the practice and a personal interest or passion for the CMP or the practice's goals for implementing it.

Worksheet
Leadership Goals Worksheet

Pre-Work Task 2. Form a Care Gap Closure Project Team

For the next step, identify the team that will lead care gap closure improvement efforts. This may be an existing QI team, or a new group brought together for this purpose. Also remember, the most critical voices are not always the most obvious. Successful care gap closure depends on engaging the right people from across the workflow—those who play a hands-on role in identifying, addressing, and documenting gaps in care—make sure these roles are present on the team.

Worksheet
Project Team Worksheet

> *"Include people who know the work... the ones touching the process every day." — Chey Douglas, Practice Facilitator*

Pre-Work Task 3. Review the practice's current care gap closure processes

Work with the project team to review their current care gap closure processes and identify areas of strength and areas where they are experiencing challenges.   Use the assessment worksheet below to get started.

Worksheet
Informal Assessment of Gap Closure Processes

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Task 1. Select a care gap or closure process to improve

Work with the project team to set their first care gap closure process improvement goal. Use the Worksheet below to help the practice select which care gap they will focus on first. Use the worksheet below to guide the practice through this selection process.

"We'll look at Cozeva and say, 'We're at 87th percentile, if we just fix 100 more, we'll hit the 95th.' So, we do it for the care and the dollars." -Practice owner

Worksheet
Care gap selection worksheet

Task 2. Use a last 10 patient chart audit to identify barriers to gap closure

Next work with the practice to conduct a small n chart audit to identify reasons the selected care gap is not being closed. Use a "last 10 patient" chart audit to review the records of the last 10 patients this week (or day) that should have received the indicated preventive care service and the most common reason/s they did not.

A "Last 10" Patient Chart Audit is a simple, hands-on way for practices to understand how their current workflow is (or isn't) closing the selected care gap. It looks at what actually happened with recent patients, rather than relying only on reports or assumptions. This gives the team insight into where things are working and where they break down that they can use to design changes to their processes.

Steps to complete a Last 10 Audit on the care gap or gap closure process:

1. **Pull the records for the last 10 patients** seen in the practice who were eligible for that service/care process.
2. **Review each record** to see whether the gap was: identified, addressed, closed.
3. **Document where and why** the service was not delivered (e.g., no flag, patient declined, staff didn't act).
4. **Calculate your "missed opportunity" rate:** the % of patients who did not receive the indicated service or associated action (e.g. referral, visit scheduled)
5. **Look for patterns in the reasons for missed opportunities:** were multiple patient records missing alerts? was the gap closure missed on particular types? Or with a particular care team?

Use the audit sheet below to collect and organize the data and calculate your "missed opportunity" rate. As you do improvement work, the missed opportunity rate should decline.

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If you need a resource to train practice staff on how to conduct a "last 10" audit you can use this module: https://www.ahrq.gov/downloads/ncepcr/pf-modules/chart-audit/story.html

Worksheet
Last 10 patient chart audit worksheet

Task 3. Identify root cause/s for missed opportunities in gap closure

Next examine the results of the Last 10 Audit for patterns and root causes. The practice can then use the findings to design improvements to their current processes.

Steps to complete a simple Root Cause Analysis:
1. **Pick a few missed opportunities** from the Last 10 Audit.
2. **Look for patterns** across patients that did not receive the care.
3. **Use the 5 Whys technique** to dig deeper into why the patients did not receive the indicated care.
4. **Use the findings** to inform the new workflow design and future tests.

The **5 Whys** is a simple but powerful tool for identifying the root cause of a problem. It works by asking "Why?" five times—or as many times as needed—to dig beneath the surface of a missed opportunity and uncover the underlying reasons it occurred.

For a brief training on the "5 whys" and other tools for conducting root cause analysis, view this module: https://www.ahrq.gov/downloads/ncepcr/pf-modules/5-whys/story.html

It's especially effective when used as a team activity and should be applied to both problems and successes to identify what's working well and where improvements are needed.

Worksheet
5 Whys worksheet

PEARL: Last 10 Chart Audits and 5 Whys are not just for identifying what's broken. ALSO use them to identify what is working well! The things that facilitate gap closure that you can scale and spread.

Task 4. Select a care gap closure approach

Using insights from the Last 10 Chart Audit and Root Cause Analysis, identify the care gap closure approach the practice would like to focus on first. Each approach involves different workflows, staff roles, and technology supports. While most practices eventually use a

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combination of strategies to fully address care gaps, starting with one can help your team test changes, build confidence, and learn what works best.

Common Care Gap Closure Approaches:
- Opportunistic (at-visit) care gap closure
- Between-visit outreach
- Gap-specific campaigns
- Outreach to patients not recently seen or who have not yet established care
- Administrative closure

Choose the approach that best fits the barriers identified in earlier tasks and the resources currently available in your practice. Think about where your efforts can have the most immediate impact while staying feasible for your team.

For example:
- If your Last 10 audit revealed that most missed opportunities were due to documentation gaps or incorrect coding, starting with administrative closure processes could be most effective.
- If the primary issue was care team members not being aware of open gaps during visits, your team might focus on improving at-visit gap closure workflows.

Over time, your practice may decide to layer in additional approaches—either to focus on a high-priority gap (e.g., colorectal cancer screening) or to adopt a more comprehensive "whole-person" approach that addresses all open gaps whenever possible.

Worksheet
Care gap closure approach worksheet

Task 5. Inventory practice resources for care gap closure

Work with the practice to inventory the health IT, human and point of care resources that can be used to enhance its care gap closure workflows; and to identify technology gaps that the practice may want to add.

Use the worksheet below to inventory resources the practice has in these areas as well as the practice's level of expertise and current use of these tools:
- health IT tools (such as EHR alerts, patient reminder systems, and pop health management platforms)
- manual tools (like paper logs or outreach lists),
- technologies (like patient portals, remote blood pressure monitoring tools, digital eye screening devices), and
- human resources (including available staff, dedicated time for outreach, etc.)

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Also, use the worksheet to create a "wish list" of technologies and tools the practice would like to add in the future to enhance its work in care gap closure.

Worksheet
Resource Inventory Worksheet

Task 6. Design and map gap closure workflows

Work with the practice to map the current care gap closure process, begin by identifying the starting and ending points, and creating a high-level process map. Then create a detailed swimlane maps that show the workflow for each member of the staff and care team related to the care or administrative process.

Map current processes as they are
Begin with the process as it currently is, not how the practice would like it to be. Process mapping works best as a group activity, with the individual who conducts the actions, completing the mapping of their part of the process -based on actual actions – not memory.

Any steps involving HIT—such as generating care gap reports, sending automated patient reminders, updating the EHR, or triggering clinical decision support—should be labeled with the name of the tool or system used (e.g., EHR, registry, patient portal, HIE). Use specific symbols or annotations (e.g., icons, shaded boxes, or color codes) to distinguish HIT-supported steps from manual tasks.

Re-design existing workflows or create new ones
Once the practice has mapped the current process, work with them to improve the process using information they learned from the last-10 chart audit and the root cause analysis, and also from reviewing approaches used by any exemplars they have identified.

If the practice does not have a current process for closing the care gap it is working to improve, they can use the results of the Last 10 audit and root cause analysis and review of exemplars to guide design of a new process.

For a brief review of process mapping to share with a practice go here:
https://www.ahrq.gov/downloads/ncepcr/pf-modules/process-mapping/story.html

Worksheets
High-level process mapping worksheet
Detailed workflow mapping cheat sheet

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Task 7. Test and refine the workflows using Plan Do Study Act cycles

Use Plan-Do-Study-Act (PDSA) cycles to test the new or enhanced workflows. PDSAs are "small tests" of the new or redesigned process. It is an iterative process where you test your new workflows with one patient, or with one care team, or for one day, study what worked and didn't work, refine the process based on that information, test again, until the process is ready to fully implement.

Use PCP and staff and patient feedback and modified Last 10 chart audits to study the workflows. Do as many small tests as you need to do until you are ready to scale and spread to the entire practice.

You can use this module to provide a quick training to the practice on PDSA cycles: https://www.ahrq.gov/downloads/ncepcr/pf-modules/model-pdsa/story.html

Worksheet
PDSA worksheet (Option 1)
PDSA worksheet (Option 2) : https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/pdsa-worksheet.pdf

Task 8. Create job aids and train staff

Once the PDSA testing is complete and the team feels confident in the new workflow, it's time to prepare to implement.

- Create simple job aids for staff and PCPs to train staff and clinicians on the new processes.

- Schedule trainings. In an ideal world, have the PCPs and staff who participated in the PDSAs and are already familiar with the new workflows deliver this training.

For a brief training on how to create a job aid, use the module at U.S. AHRQ here: https://www.ahrq.gov/downloads/ncepcr/pf-modules/scale-improvements/story.html

Worksheets
Job Aid Template
Training plan worksheet

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PEARL: To save time, drop the process map (or list of steps) the practice made earlier in this Guide into an AI engine like Chatgpt with the prompt: "create a simple job aid" and it will generate a first draft that then you can edit and refine.

Task 9. Create staff & clinician buy-in to care gap closure

Making care gap closure part of your practice's culture requires consistent reinforcement in daily conversations, visible tracking of progress, recognition of contributions, and meaningful rewards that make the work feel worthwhile.

Start by integrating care gap closure into the rhythm of practice operations. Talk about it often and tie it to your team's identity. Reinforce that this is a shared goal, not just another task handed down from leadership. Motivate your team by helping them feel their progress and success.

Saying "We closed 20 gaps today" builds energy and pride—and helps replace a culture of doing the minimum with one that values excellence.

Specific strategies to operationalize this culture include:
- **Use slogans** like "Every visit is an opportunity to close care gaps" to keep the goal visible and memorable.
- **Include care gap metrics** in regular staff and clinician meetings to keep performance on the radar.
- **Produce monthly dashboards** that highlight care team and site-level performance to stimulate friendly competition.
- **Offer incentives** such as paid time off for meeting group care gap closure targets (e.g., "Close 100 gaps and everyone earns 8 hours of PTO." Kevin Thomas, MD)

These approaches help create momentum and signal to staff that care gap closure is a priority—one that brings real rewards and shared wins.

"It took months and months of doing provider meetings to continue hammering the idea of quality, the idea of quality, of quality, because quality is good medicine. ... You need to change the culture of providers, medical assistants. They tend to only do the job they have right in front of them." Demetrio Cardenas, DSc, Via Care

Worksheet
Care Gap Buy-In Worksheet

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Task 10. Implement and monitor

Once new workflows are launched, monitor how well they are being adopted by both staff and clinicians and gather feedback from them and patients to continue to refine the new workflows.

Use the following strategies:

- **Use Last 10 Chart Audits** to monitor adoption of the new workflows, and to track the "missed opportunity" (MO) rate for the care gap the practice is working to close. This rate should steadily decline from the baseline MO rate calculated in Task 2.
- **Identify patterns and root causes** for deviation from new or redesigned workflows, and for missed opportunities and use these to refine steps, training and job aids.
- **Conduct Audit & Feedback Sessions** where you meet with individual staff/clinicians and conduct individual "Last 10" audits, gather feedback to improve processes, and celebrate improvements.
- **Deliver Elbow Support**, one-to-one individualized coaching to staff and clinicians with high MO or low adoption rates, to support adherence to the new workflows, and gather feedback to continually improve them. This peer-level coaching can be especially effective when delivered at the point of care.

For a brief training on audit and feedback and "elbow-support" to support new workflow adoption view this module: *https://www.ahrq.gov/downloads/ncepcr/pf-modules/scale-improvements/story.html*

Worksheets
Implementation monitoring worksheet
New workflow effectiveness audit sheet

Task 11. Add gap closure metrics to QI plan and administration

Work with the practice to include the new care gap closure process into their QI plan and dashboard. Use the worksheet below to help the practice draft recommendations to their QI team/director or office manager on possible metrics to add to the practice's overall QI program.

Use the worksheet below to generate a guidance letter to the practice's QI team/director/data governance team.

Worksheet
Recommendations to QI team letter generator

Also add a description of the new process/es to the practice's:
- Standard Operating Procedures (SOPs) manual,

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- job descriptions,
- job evaluations and
- onboarding training as appropriate.

Use the worksheets below to document additions to administrative documents.

Worksheets
Additions to job description
Additions to job evaluation
Additions to onboarding training
Sample on-boarding training outline

Task 12. Share what you've learned and use this guide again

Your insights—whether a simple workflow tweak, a training guide, or a practical workaround—can be invaluable to others trying to implement similar improvements.

Click here to share your tools and what you've learned:
https://www.surveymonkey.com/r/TXB7MZG

Or email them to: rkochhar@pophealthlc.org

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Worksheets

Leadership Goals & Priorities Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

What are the top 3 priorities for our practice right now?

1. _____
2. _____
3. _____

Which care gaps (or HEDIS-like metrics) matter most to our practice right now?

Gap	Reason it is a priority

What is our level of interest in improving our care gap closure processes at the practice?

Circle one: Low   Medium   High

Who will serve "Champion" for the care gap closure improvement work we will be undertaking:

Name: _____

Project Team Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:
_____

Name	Role in Practice	Role/expertise in care gap closure
1.		
2.		
3.		
4.		
5.		

Do we have everyone we need?

- ➢ Do we have representatives for each role in care gap closure on our team?
  - Front desk clerk
  - MA
  - Health IT
  - Referral staff
  - PCPs
  - Office manager
  - Other:
- ➢ Is there anyone at our practice with expertise in improving performance in care gap closure that should be included?
- ➢ Are any of our care teams or staff "exemplars" in closing care gaps and should be included?
- ➢ Do we know any local exemplars in care gap closure – practice facilitators with this knowledge? Other PCPs or practices that we can learn from? How will we include them?

Informal Review of Care Gap Closure Processes

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:
_____

Use this worksheet to guide an informal assessment of the practice's current care gap closure processes.

1. High-Level Review of Gap Closure Processes

Check each process currently in use and describe how it's implemented.

Process	Description / Comments
At Visit	
Between Visits	
Unseen Patients	
Gap Closure Campaigns	
Administrative Closure	

2. Practice's population of focus (POF):_____

Performance on Population of Focus HEDIS-Like Metrics.

HEDIS-like Metric	Most recent performance (%)	Our practice benchmark (%)	% to reach benchmark	Needs improvement
1.				
2.				
3.				
4.				

➢ Which metric is our strength/bright spot?   _____
➢ Where are farthest from our benchmark/goal?   _____

3. Supportive Processes for Care Gap Closure
Check which strategies are currently in place and describe their use.

Process	Description / Comments
Regular performance dashboards by provider/team	
Repeated PCP/staff training on importance of care gap closure and performance on quality metrics	
Culture where every visit is an opportunity to close care gaps, and every staff/clinician is involved	
Incentives/bonuses for care gap closure	
Awareness of ROI for gap closure	

1. Facilitative Technologies to Close Care Gaps
Check tools currently in use and describe implementation.

Tool	Description / Comments
Cologuard (non-invasive colorectal screening)	
Onsite retinal eye scan	
Point-of-care lab testing	
Proactive visit scheduling (e.g., well-child, diabetes)	
Remote blood pressure monitoring	
Other: _____	

Care Gap Selection Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Use this worksheet to help decide which care gap the practice will focus on first.

1. Which care gaps or care gap closure processes do we want to improve?
(*Think about high volume, low performance, payer alignment, and patient impact.*)

Care Gap / HEDIS-like measure	Reason for Consideration (e.g., performance data, patient impact, payer priority, practice priority)

2. What is the ROI to the practice for closing specific care gaps?

Incentives from health plans for closing specific care gaps

POF HEDIS-like metric	Plan 1: _____ PCP incentive payment/other ROI	Plan 2: _____ PCP incentive payment/other ROI	Plan 3: _____ PCP incentive payment/other ROI	Plan 4: _____ PCP incentive payment/other ROI	Potential ROI
1.					
2.					
3.					
4.					

3. Our care gap closure improvement goal is to:

SMARTIE Element	Description	Practice's Goal Statement
S – Specific	We will improve (what we will improve)	
M – Measurable	By this much (numeric measurement)	
A – Achievable	We know this goal is achievable because:	

SMARTIE Element	Description	Practice's Goal Statement
R – Relevant	This goal aligns with our practice priorities in the following ways:	
T – Time-bound	We will achieve this goal by:	
I – Inclusive	This improvement supports inclusiveness by:	
E – Equitable	This improvement supports equity by:	

Last 10 Patient Chart Audit Template

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Enter the data from your chart audit onto this form. Change the column headers to align with the part of process or outcome you are assessing.

Patient name/ID	Date of visit	Care gap closed (Y/N)	Date of closure	PCP/Team	Factors contributing to missed opportunity or facilitating closure
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Our Missed opportunity % is:_____

Missed opportunity % = (# of Ys/10)*100

The 5 Whys

Cheat Sheet

The 5 Whys is a simple method of finding the root cause of a quality issue you are trying to improve.

Rules for the 5 Whys method:
- Be as specific and factual as possible with your answer to the first "Why?"
- Know when to stop. Keep asking "Why?" until the responses aren't useful.
- If there is more than one reason for the problem, complete a separate 5 Whys for each reason.
- The root cause cannot be a person or unchangeable event. It must be a processor something that can be changed.
- Don't stop at the fifth "Why?" if you haven't found the root cause. Ask "Why?" as many times as you need to arrive at the root cause.

To do a 5 Whys analysis:
- Write down the problem you are trying to solve.
- Write down one reason you think this problem is happening. If there are
- multiple reasons, pick the one you think is the most important to start.
- Ask "Why?" until you find the root cause.

Use the diagram on the following page to complete a 5 Whys analysis.

The 5 Whys Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

What is the problem/barrier (or success)?

1. Why is this happening?

2. And why is this happening?

3. And why is this happening?

4. And why is this happening?

5. And why is this happening?

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Review each care gap closure strategy with your team and strengths, challenges, and key considerations. Identify the strategies that have the best fit for the practice.

1. Care Gap of Focus
What care gap is the practice aiming to improve (e.g., colorectal cancer screening)?

2. Summary of Findings from Last 10 Chart Audit
What were the common reasons the care gap was not closed?

3. Summary of Root Cause Analysis (5 Whys)
What underlying causes did the team identify as contributing to the missed opportunities?

4. Current Strengths & Resources to Build On
What staff, workflows, technologies, or partnerships can support improvement?

5. Current Barriers or Constraints
Are there limitations related to staffing, time, systems, or training?

6. Based on the Above, Which Closure Approach is a Good Starting Point?
Select one approach the practice will start with:
☐ Opportunistic (at-visit) care gap closure
☐ Between-visit outreach
☐ Gap-specific campaigns
☐ Outreach to unseen patients
☐ Administrative closure
    Other:

Why does this approach make sense as a starting point?

Resource Inventory Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:
_____

Review practice resources available to support care gap closure processes.

Resource Inventory 1: Health information technologies for supporting care gap closure

Resource	Practice has (Y/N)	Practice acquiring (Y/N)	Product name & sponsor/s	Current level of use in care gap closure 0=None, 1=Some, 2=Frequent
1. Electronic Health Record (EHR) Features				
- Care gap alerts and reminders (e.g., overdue screenings, immunizations)				
- Clinical decision support (CDS) prompts for evidence-based care				
- Health maintenance modules to track preventive services				
- Patient outreach and bulk messaging tools				
- Referral tracking systems				
- Embedded care gap reports and dashboards				
- Documentation templates and smart forms				
2. Population Health Management Platforms				
- Gap reports				
- Bulk patient list generation for outreach campaigns				
- Automated patient reminder letters/other				
- Integration with external data sources (e.g., claims data, HIEs)				
- Quality measure tracking (e.g., HEDIS, UDS)				

- Pre-claim attestation				
- Supplemental data upload				
- Integration w/ EHR				
- Plug-in/visual overlay with EHR				
3. Patient Engagement Technologies				
- Patient portals with messaging, education, and appointment scheduling				
- Automated appointment reminders (text, voice, email)				
- Secure two-way messaging for outreach and follow-up				
- Self-scheduling tools for recommended visits or screenings				
5. Analytics and Reporting Tools				
- Quality improvement dashboards (custom or vendor-supplied)				
- Reports on open care gaps by provider, location, or patient panel				
- Integration with payer data for supplemental reporting				
- Exportable data for practice-level QI projects				
6. Health Information Exchange (HIE) Tools				
- Access to external clinical data for care received outside the practice				
- Closing gaps with historical or payer-submitted data				
- Notifications of hospital/ED visits or other external events				
7. Revenue Cycle Management platforms				
- Care & coding opportunities dashboards				
- Code editing tools				
- Denial management system				
- Eligibility and benefits verification				

- Supplemental data upload				
8. Third-Party Platforms				
- Name:				
- Name:				
9. Other:				
-				
-				

Resource Inventory 2: Human resources inventory for supporting care gap closure

Staff name	Job title	% time available for care gap closure focused work	Potential role in care gap closure processes
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Resource inventory 3. Clinical health technologies for supporting care gap closure

Technology / Tool	Purpose / Use Case	Practice has? (Y/N)	Practice acquiring? (Y/N)
Self-monitored blood pressure tools	Remote BP readings for chronic care and hypertension		
Point-of-care lab testing	Enable in-visit labs for diabetes, cholesterol, etc.		
Digital retinal screening	In-clinic eye exams for diabetic retinopathy		
Home-based colorectal screening kits	FIT or Cologuard mailed to patient		
Remote patient monitoring (e.g., glucose, BP)	Ongoing tracking of chronic conditions from home		
Digital e-screeners (e.g., PHQ-9, SDOH)	Pre-visit screening via portal, tablet, or text		
Other:			

High-Level Process Map Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Use this worksheet to identify high-level steps for the improved care gap closure process.

Note: If the practice will use multiple strategies for closing this care gap, complete a separate sheet for each strategy the practice plans to use.

Step 1. Care gap closure strategy (select one)
      At visit identification and closure/referral
      Between visit patient reminder/outreach, navigation support
      Gap specific campaign
      Unseen patient outreach
      Administrative closure enhancement
      Other:_____

Step 2: Identify the <u>current high-level steps</u> for closing the care gap of focus using the strategy selected in Step 1.

Step	Action	Who is responsible?	Where/how is it Documented? (EHR, PHM, Other)
1. Identify the gap How is the care gap identified (e.g., EHR alert, PHM report, payer list)?			
2. Engage staff How is staff be notified of the gap (e.g., alert, huddle discussion)?			
3. Take action What action is taken to close the gap (e.g., order test, schedule referral, administer vaccine)?			
4. Follow-up & tracking How is gap closure tracked and followed up if not completed?			
5. Validate & report How is closure confirmed and reported (e.g., structured EHR entry, claims submission)?			

Step 3: Identify the <u>desired high-level steps</u> for closing the care gap of focus using the strategy selected in Step 1.

Step	Action	Who is responsible?	Where/how is it Documented? (EHR, PHM, Other)
1. Identify the gap How will the care gap be identified (e.g., EHR alert, PHM report, payer list)?			
2. Engage staff How will staff be notified of the gap (e.g., dashboard, huddle discussion)?			
3. Take action What action is needed to close the gap (e.g., order test, schedule referral, administer vaccine)?			
4. Follow-up & tracking How will gap closure be tracked and followed up if not completed?			
5. Validate & report How will closure be confirmed and reported (e.g., structured EHR entry, claims submission)?			

Detailed Workflow Map Cheat Sheet

Create detailed process maps of the new or enhanced care gap closure processes
Use the information from the High-Level process map worksheet as a guide to now developing detailed process maps for separate parts of the care gap closure process.

You can then use these maps to test and refine the new workflows using PDSAs and as the basis for job aids.

Use a tool like: Use a process mapping tool like Lucid Charts. Link to LucidChart:
https://www.lucidchart.com/pages

PEARL: Many online process mapping tools now include AI engines. You can list out the steps, drop them in and the platform will auto-generate a process map the practice can then edit. This can sometimes save time.

Types of maps

➢ **A simple process map** shows how a process works in a few steps and is useful for providing a simple overview of a process.

➢ **A detailed process map** shows detailed steps for each task in the map.

➢ **A swimlane diagram** or process map shows the roles and specific actions of different individuals (or departments) in the process and the places where handoffs occur.
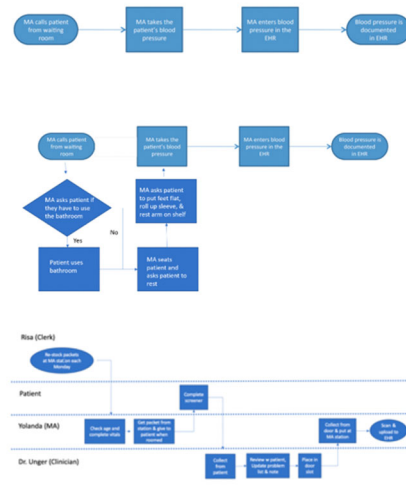
Steps for mapping processes (map "what is" first)
1. Gather your materials, including sticky notes and pens.
2. Identify start and end points of the process. There may be more than one end point.
3. Follow the flow through decision points to completion before mapping alternate paths
4. Write each step of the process on a sticky note/whiteboard/e-platform using the correct symbol.
5. Move steps into the correct order, and into swimlanes, vertically stacking actions that are done at same time, and add arrows.
6. Validate with individuals involved with the process.
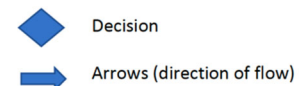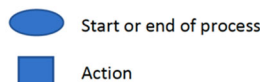
Steps for re-designing
1. Review the map
2. Identify problem areas that need to be redesigned

3. Brainstorm changes with participants and using data from the Last 10 and 5 Whys
4. Modify the map to address problems, or create a new process map using the steps above
5. Test and refine with PDSA cycles (see next task)

Techniques for facilitating a mapping processes session
1. It's ok to be low-tech. A packet of post notes is a great way to start.
2. Have the person who owns the step "hold the pen."
3. Take a photo of the finished map on your phone to save it.

PDSA Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Complete this worksheet to plan and conduct a small test of the new process.

When will the test be conducted? _____Who will oversee the test? _____
PDSA Cycle #: _____

Step 1: Plan

What specific part of the process is being tested? _____

Who will be involved in the test? _____

What is the expected outcome? _____

Step 2: Do

When will the test be conducted? _____

What small sample size or setting will be used? (e.g., 1 PCP, 1 week, 10 patients) _____

What challenges or issues arose during implementation? _____

Step 3: Study

What worked well? _____

What didn't work as expected? _____

Were the expected outcomes achieved? Why or why not? _____

Step 4: Act

What adjustments need to be made before expanding the process? _____

Should this test be repeated with modifications? If so, what changes will be made? _____

When will the next test cycle take place? _

Job Aid Template

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____
Use this worksheet to create job aids for each distinct workflow in the enhanced care gap closure process.

Job Aid for (ROLE/STAFF PERSON):_____

This job aid is for (care gap process name:)_____

Steps:

Step 1.

Step 2.

Step 3.

Step 4.

Step 5.

Step 6.

Step 7.

PEARL: Enter copy information above into an AI engine like Chat GPT and give it the prompt, "Create a job aid based on these steps." Use this as a first draft to jump start creation of each job aid.

Training Plan Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

Use this worksheet to create a plan for training the practice on the workflows you tested and finalized with the PDSA cycles.

Learners/Groups that need training:

Learner/Group	Workflow/process
1.	
2.	
3.	
4.	

Training Schedule

Completed Y/N	Date/Time/ Location	Trainer Name (participated in PDSA ?) (Y/N)	Learner/Staff Being Trained	Training Format (Group, indiv, virtual, etc.)	Resources required
	Ex: Dec 5, 2024, 2pm Staff huddle time	*Gwendolyn (Y)*	*MAs on Green Team*	*Group*	*Job aid for gap report generation from Cozeva* *Sample gap report* *Overview deck on care gap closure as at "team sport"*

Care Gap Closure Buy-In Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

Use this worksheet to choose specific strategies for building team buy-in. For each item, check the action(s) you plan to implement and assign a responsible party. Add any custom strategies in the blank rows provided.

Reinforce Care Gap Closure in Daily Culture

✔	Strategy	Responsible
☐	Use a team slogan (e.g., "Every visit is an opportunity to close care gaps")	
☐	Include care gap closure reminders in huddles or shift changes	
☐	Recognize care gap wins during staff meetings	
☐	Use visual cues (posters, whiteboards) to keep focus visible	
☐	Celebrate milestones in newsletters or on bulletin boards	
☐	Other: _____	

Integrate Metrics into Practice Operations

✔	Strategy	Responsible
☐	Add care gap metrics to staff or clinician meetings	
☐	Create a visual dashboard (breakroom, EHR homepage, etc.)	
☐	Track and post daily/weekly "gaps closed"	
☐	Use care gap data in 1:1s or evaluations	
☐	Share rankings across sites or teams	
☐	Other: _____	

Recognize and Reward Contributions

✔	Strategy	Responsible Party
☐	Group incentive for hitting shared goals (e.g., PTO for 100+ gaps)	
☐	Monthly lunch for top-performing team or site	
☐	Public shout-outs during meetings	
☐	Raffle entry per gap closed	
☐	Badge/sticker system for participation	
☐	Other: _____	

Plan:

Implementation Monitoring Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:
_____

Use this sheet to track implementation of new workflow of modifications of existing workflows during the first week.

Process Name	Staff	Process	Metric	Change to process or elbow support needed Y/N	Next step & person responsible
Example: Generate gap reports from Cozeva day before visit	*Dean*	*Review appointments for (day) and cross check presence of gap report from Cozeva in front clerk's MS Teams inbox.*	*Metric: Number of gap reports in MS Teams inbox (20) / No. scheduled patients (25) x 100 = 80 % completion* *Target 90%* *Reasons for fall-out: 5 patients straight MediCal and not available through data source (Cozeva)*	*Y -change to process (need to add data source for straight MediCal)*	

New Workflow Effectiveness Audit Sheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Use this worksheet to conduct a Last 10 Patient chart audit during the first 2 weeks of new/modified workflow implementation to monitor staff/clinician adoption and effectiveness.

Method of
1. Service provided at visit
2. Follow-up visit scheduled
3. Referral made
4. Documented service provided elsewhere
5. Exclusion documented
6. Other:

Patient name/ID	PCP/ Team	Date of visit/ mode (in person (IP), virtual (T)	Care gap closed at visit (Y/N)	Method of closure (see legend above)	Documented in EHR (Y/N)	Billed & accepted by plan (Y/N/pending)	Possible reasons for fall-out
Example: LK2025	Dr. Green	IP	Y	1	N	P	e-screener not populating in record
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

9.							
10.							

Recommendations to the QI Team for Metric/s

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Use worksheet this to generate a letter to the QI team about new metrics to add.

To the Quality Improvement (QI) Team: We are recommending the following metrics be added to the practice's QI program and dashboard for monthly monitoring and continuous improvement.

Care gap of focus: _____

Associated HEDIS-like metric: _____

Strategies in use:

      At visit closure

      Between visit outreach

      Gap specific campaign

      Unseen patient outreach

      Administrative closure enhancement

      Other:_____

New/enhanced processes start date: _____

Practice champion for this care gap: _____

Suggested measures

QI team will add (check)	Metric Name (formal or informal)	Method	Description or process to be used & data source	Performance Target	Responsible
	Example: Missed opportunity %	Quarterly Last 10 audit spot check	Last 10 patients eligible for ___ but not received, was gap identified and closed at most recent visit?	<20% missed opportunity percent	Office manager

Job Description Additions

<div align="center">Process Name:_____</div>

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____
Use this worksheet to draft changes to job descriptions for the practice administrator to incorporate.

Person at practice who will make these additions:_____ by date:_____

Job Title:_____
Additions related to this enhanced process:

1.

2.

3.

Job Title:_____
Additions related to this enhanced process:

1.

2.

3.

Job Title:_____
Additions related to this enhanced process:

1.

2.

3.

Job Evaluation Additions

Process Name:_____

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

_____

Use this worksheet to draft changes to job descriptions for the practice administrator to incorporate.

Person at practice who will make these additions:_____ by date:_____

Job Title:_____
Additions to evaluation of job performance related to this CMP

1.

2.

3.

Job Title:_____
Additions to evaluation of job performance related to this CMP

1.

2.

3.

Job Title:_____
Additions to evaluation of job performance related to this CMP

1.

2.

3.

Sample Training Outline on Care Gap Closure (8 Slides)

Practice:

Date:

PF/Coach:

Participating:

Care gap of focus:

Modify this sample **8-slide training** outline to orient new clinicians and staff to care gap closure at your practice.

Slide 1: Welcome & Introduction to Care Gap Closure
- Overview of **why care gap closure matters**
- **Practice goals** for improving care gap closure
- How **staff roles contribute** to closing care gaps

Slide 2: The Care Gap Closure Improvement Team
- Care gap closure as a team sport
- Who is on the team?
- Responsibilities of different team members
- Identifying **peer-nominated exemplars**

Slide 3: Care Gap Priorities at Our Practice
- Every visit is an opportunity to close care gaps
- **Which care gaps are we focusing on?** (Preventive, chronic disease, behavioral health, etc.)
- **Whole-person vs. issue-specific approach**
- How priorities align with **practice quality measures**

Slide 4: Identifying & Tracking Gaps – Data & Tools
- **What IT and data resources do we use?** (EHR, PHM, payer reports)
- **Limitations and solutions** (claims lag, missing data, documentation challenges)
- **How staff access and use data to close gaps**

Slide 5: Care Gap Closure Workflows
- The big picture: Overview of **our workflow for closing gaps**
- **Process mapping example** (opportunistic at-visit, outreach, referral follow-ups)
- How to **document and track progress** in the EHR

Slide 6: Running Small Tests & Continuous Improvement
- **Using PDSA cycles** to test small changes
- **Example of a recent process test** and lessons learned
- How staff can provide **feedback to refine workflows**

Slide 7: Job Aids, Training Tools & Staff Support
- Overview of **job aids** available for care gap closure
- How to access **training guides, scripts, and workflow checklists**
- **Who to ask for help?** (Process champion, supervisor, practice facilitator)

Slide 8: Next Steps & Ongoing QI Integration
- How care gap closure fits into the **practice's QI plan**
- Staff roles in **monthly monitoring and reporting**
- **Opportunities to improve and share learnings** with other practices

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Links to Exemplar Case Studies & Tools

A. Exemplar Case Studies. Click here: https://www.lanetpbrn.net/caregapclosure

B. Virtual Visits to Exemplar Practices. Click here: https://www.lanetpbrn.net/caregapclosure

C. Tools shared by EPT Community. Click here: https://www.lanetpbrn.net/caregapclosure

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Optional Worksheets

Arranging a Virtual Peer Learning Visit: A Guide for Practice Facilitators & Office Managers

Virtual peer visits are a powerful way for practices to learn from high-performing peers by observing real-world workflows and gathering improvement ideas. To set up a successful virtual visit, practice facilitators begin by identifying an exemplar clinic through peer recommendations or performance data (e.g., HEDIS metrics). Once identified, reach out to ask if the practice is willing to host a video-based visit. Clearly explain the purpose of the visit: for the other practice to observe, ask questions, and take away actionable ideas to improve their own process. Share a specific agenda—such as reviewing their daily huddle, their approach to closing care gaps during visits, or their visit workflow from start to finish—and request any required consents. Once the practice agrees, schedule the visit (lunchtime often works best), send a calendar invite and video link, and prepare the visiting team by helping them define their goals and what they hope to learn. On the day of the visit, serve as emcee to keep the session focused and flowing—ensuring the exemplar has time to explain their process in detail, and the visiting clinicians have time for Q&A. Afterward, follow up with a thank you, request any tools or templates the exemplar offered to share, and stay in touch to support continued learning or a follow-up session if needed.

Step-by-Step Checklist for Virtual Peer Visits

1. Identify the Exemplar
   - Ask fellow PCPs, practice facilitators, and QI teams for recommendations
   - Review quality data (e.g., HEDIS or internal metrics) to find top-performing peers
   - Choose a clinic that has strength in a specific area your practice is trying to improve
2. Reach Out and Request the Visit
   - Contact the exemplar and explain the purpose of a virtual peer visit
   - Describe what it involves: a video session where they walk through their workflow, share tips, and answer questions
   - Be specific about what you'd like them to cover (e.g., "walk us through your huddle and gap closure process at point of care")
   - State the goal: to help another PCP team learn and gather ideas
   - Confirm their willingness and obtain any necessary consents
3. Schedule the Visit
   - Agree on a date and time (lunchtime often works best)
   - Send a calendar invite with the virtual meeting link and a reminder
4. Prepare the Visiting PCPs
   - Help them define what they hope to learn from the visit
   - Encourage them to come with questions and specific goals
   - Provide background on the exemplar site and agenda
5. Hold the Virtual Visit
   - Facilitate the session as emcee

- Keep the conversation focused and on time
- Ensure the exemplar explains their process in detail
- Allow ample time for Q&A

6. Follow Up
- Send a thank-you note to the exemplar team
- Collect and share any tools, templates, or resources they offered

7. Sustain the Connection
- Stay in touch with both practices
- Schedule a follow-up or reconnect session if helpful

Let me know if you'd like this turned into a formatted one-pager or included in a practice facilitation toolkit!

(Optional) Virtual Visit Worksheet

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

Use this worksheet to plan a virtual visit to an exemplar practice/provider. Remember that your "exemplar" might also be in-house.

1. Focus of Virtual Visit
What specific workflow, process, or area of care is the focus of the visit?

2. Exemplar Practice Information

Exemplar Practice Name: _____
How was this exemplar identified?
(e.g., peer recommendation, HEDIS performance, facilitator network)

2.5. Primary Contact who has the information we would like to learn from the Exemplar Site

Name: _____

Role/Title: _____

Email/Phone: _____

3. Date and Time of Virtual Visit

Scheduled Date: _____

Scheduled Time: _____

Meeting Link: _____

4. Goals for the Visiting PCP(s)
What does the visiting team hope to walk away with?
List 2–3 key questions they want answered, or insights they aim to gain:

What we want to learn:

1.

2.

3.

Questions to cover during the visit:

1.

2.

3.

5. Summary Notes & Action Items from Visit
Key Takeaways:

1.

2.

3.

Action Steps for Our Practice:

- _____

- _____

- _____

6. Tools & Resources Shared by Exemplar Practice
List any forms, templates, workflows, or reference materials provided:

(Optional) Time of Year & Care Gap Closure

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

Use this worksheet to think through seasonal opportunities and variations into the practice's care gap closure processes.

Q1 (January–March): Launch & Align

	Task	Implications for Our Gap Closure Processes
☐	Launch outreach campaigns for annual wellness visits, screenings, and immunizations	
☐	Train staff on priority measures and care gap workflows	
☐	Send "New Year" health reminders to boost patient engagement	
☐	Other:	

Q2 (April–June): Track & Adjust

	Task	Implications for Our Gap Closure Processes
☐	Run mid-Q2 reports on care gap closure rates	
☐	Engage patients overdue for care	
☐	Identify underperforming measures or populations and adjust outreach	
☐	Prepare for mid-year payer feedback and quality data sweeps	
☐	Other:	

Q3 (July–September): Accelerate & Expand

	Task	Implications for Our Gap Closure Workflow
☐	Prioritize outreach to patients with persistent gaps	
☐	Coordinate back-to-school visits with vaccinations and wellness checks	
☐	Begin outreach for flu and other seasonal vaccinations	
☐	Review payer-specific incentive deadlines and thresholds	
☐	Other:	

Q4 (October–December): Close & Document

	Task	Implications for Our Gap Closure Workflow
☐	Consider "Year-End Gap Closure Blitz"	
☐	Audit and reconcile documentation for key measures	
☐	Submit final quality data to payers, if required	
☐	Develop goals and engagement strategies for the next year	
☐	Other:	

(Optional) Patient Considerations & Care Gap Closure

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:
_____

Use this worksheet to think through patient considerations and care gap closure processes.

Address in workflows	Patient preference/need	Implications for gap closure workflow/s
☐	**SDOH Needs:** Screen for and address health related social needs/social determinants of health (e.g., transportation, food insecurity, housing, internet access) to reduce barriers to services & gap closure	
☐	**Patient Communication Methods:** Consider patient communication preferences for outreach and automated reminders.	
☐	**Insurance-Related Behavior:** Consider effects of patient's insurance type on willingness to seek care and close care gaps	
☐	**Patient Knowledge about Deductibles:** Educate patients about no-cost preventive services & deductibles	
☐	**Chronic Care Visit Schedule:** Leverage chronic care visit schedules to close care gaps	
☐	**Synchronized sibling scheduling:** Consider leveraging scheduled well child visits to complete visits with siblings as well.	
☐	**Early-Year Engagement:** Consider patient psychology in completing annual wellness exams. Leverage new year fresh start thinking.	
☐	**Visit Mode Preference:** Consider patient preferences for in-person vs. tele-visits and incorporate into care gap closure workflow.	
☐	**Identify In-Person Thresholds:** Care gaps that require face-to-face care.	

The Quick Start Guide

Practice:
Date:
PF/Coach:
Participating:
Care gap of focus:

Use this "Quick Start Guide" as an alternative to the full Guide.

Task Number	Task Description	Associated Worksheets (Page #)
Pre-Work Task 1	Engage Leadership	Leadership Goals & Priorities Worksheet (p. 19)
Pre-Work Task 2	Form a Care Gap Closure Project Team	Project Team Worksheet (p. 20)
Pre-Work Task 3	Review the practice's current care gap closure processes	Informal Review of Care Gap Closure Processes (p. 21)
Task 1	Select a care gap or closure process to improve	Care Gap Selection Worksheet (p. 23)
Task 2	Use a Last 10 patient chart audit to identify barriers to gap closure	Last 10 Patient Chart Audit Template (p. 24)
Task 3	Identify root cause(s) for missed opportunities in gap closure	The 5 Whys (p. 25)
Task 4	Select a care gap closure approach	Care Gap Closure Approach Selection Worksheet (p. 27)
Task 5	Inventory practice resources for care gap closure	Resource Inventory (p. 28)
Task 6	Design and map gap closure workflows	High-Level Process Map Worksheet (p. 31), Detailed Workflow Map Cheat Sheet (p. 33)
Task 7	Test and refine the workflows using Plan-Do-Study-Act cycles	PDSA Worksheet (p. 35)
Task 8	Create job aids and train staff	Job Aid Template (p. 36), Training Plan Worksheet (p. 37)
Task 9	Create staff & clinician buy-in to care gap closure	Care Gap Buy-In Worksheet (p. 38)
Task 10	Implement and monitor adoption and effectiveness	Implementation Monitoring Worksheet (p. 39), New workflow effectiveness audit sheet (p.40)
Task 11	Add gap closure metrics to practice QI plan and administration	Recommendations to the QI Team (p. 41), Job description additions (p.42), Job evaluation additions (p.43) Sample Training Outline (8 Slides) (p. 44)
Task 12	Share what you've learned with other PCPs and use this guide again	

Links to Exemplar Case Studies and Virtual Visits: https://www.lanetpbrn.net/

Link to case example generator: https://www.surveymonkey.com/r/TXB7MZG