

# PHM INITIATIVE

## CLINICAL PRACTICE GUIDELINES FOR KEY MEDI-CAL POPULATIONS OF FOCUS



Population Health Management Initiative (PHMI), a California partnership of the Department of Health Care Services, Kaiser Permanente, and community health centers.

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# PHMI CLINICAL GUIDELINES

## PHMI BACKGROUND

The Population Health Management Initiative (PHMI) is a California partnership of the Department of Health Care Services (DHCS), Kaiser Permanente and community health centers (CHCs).

Currently, PHMI serves a geography-based cohort of 32 CHCs to implement a robust portfolio of population health management and practice transformation solutions to augment clinical outcomes for 1.1 million patients cared for across eight regions: Humboldt, Kern, Los Angeles, Mendocino, Merced, San Joaquin, Sonoma and Stanislaus counties.

Within these regions, PHMI's goals are to improve quality metrics and address disparities, improve patient engagement and experience of care, and increase access to primary care services through team-based care in CHCs. PHMI offers co-designed evidence-based models of care where each CHC focuses on shared priority measures and populations, including children, pregnant people, people with behavioral health conditions, and adults living with chronic conditions and preventive care needs.

## CLINICAL GUIDELINES ADVISORY GROUP BACKGROUND

California community health centers vary greatly in their approach to utilizing clinical guidelines (CGs), and many do not have a formal process to review, adopt and follow CGs consistently in clinical practice. For those CHCs that do embark on developing and adopting CGs, most do so independently of other CHCs and other healthcare institutions, creating a significant body of work to execute and maintain over time. This often becomes burdensome to support with already stretched CHC clinical staff, resulting in limited ability to consistently utilize CGs over time.

In 2022, PHMI conducted a clinical guidelines survey at PHMI CHCs and found:

- 56% of CHCs do not follow a formal process to review, adopt and promote a set of CGs.
- 64% of CHCs do not monitor the use of CGs in assuring that services are provided.
- 65% of CHCs do not incorporate specific CG recommendations into their practice through an electronic medical record or public health management platform.
- 63% of CHC providers individually reference CGs on their own using platforms, such as UpToDate.

These findings suggest there is an opportunity to improve the way that CGs are developed and adopted at CHCs, and to design an efficient process to develop and update CGs that involves CHCs working together as opposed to individually. The PHMI Clinical Guidelines Advisory Group (CGAG) was established to create a standardized approach to review, adopt and promote established CGs in the PHMI cohort. The CGAG's approach includes a clinical review and presentation of a selection of current and widely used CGs, including their similarities and key differences, to CHC clinical representatives for discussion and selection. This approach gives CHCs the opportunity to share thoughts and challenges across CHCs and ultimately build consensus for guideline selection. Additionally, Southern California Permanente Medical Group participated in the guideline development process and shared its best practices as an institution that has effectively standardized, adopted and maintained CGs for provider use over many years.

## **PHMI CPG Implications:**

PHMI plans to support CHCs in using selected CGs to guide care. This may include operationalizing key workflows, standardized protocols and standing orders; embedding links to CGs in the EHR; incorporating recommendations as notifications or alerts in the EHR; and building the capacity to evaluate their effectiveness.

## **CGAG Focus Areas**

The set of clinical guideline recommendations selected by the CGAG are guided by PHMI's populations of focus and core measures. Seven core HEDIS measures, and an additional 10 supplemental HEDIS measures, were selected to be the focus of PHMI and are identified as Alternative Payment Methodology (APM) pilot metrics for CHCs in California. The CGAG has focused on recommending established CGs for six of these core measures, and two supplemental measures.



From the core measures:

- Children: Well Child Visits in the First 30 Months of Life (First 15 Months)
- People with Behavioral Health Conditions: Depression Screening and Follow-Up for Adolescents and Adults
- Pregnant People: Prenatal and Postpartum Care (Postpartum)
- Adults with Preventive Care Needs: Colorectal Cancer Screening
- Adults Living with Chronic Conditions: Controlling Blood Pressure
- Adults Living with Chronic Conditions: Comprehensive Diabetes Care (HbA1c Poor Control (> 9%))

From the supplemental measures:

- Children: Child and Adolescent Well Visits
- Pregnant People: Prenatal and Postpartum Care (Timeliness of Prenatal Care)

## CGAG Composition and Process

The CGAG is composed of clinical leadership representation from each of the 32 CHCs participating in PHMI. Eight CHC clinical representatives were selected to serve in a primary reviewer role. All other CHCs in the cohort identified a clinician representative to serve as a secondary reviewer. Primary reviewers were responsible for reaching consensus to recommend a set of CG recommendations by participating in monthly meetings and interim work. This process included identifying current established CGs, including national guidelines from United States Preventive Services Task Force (USPSTF), medical specialties (American College of Obstetrics and Gynecology, American Diabetes Association and American Academy of Pediatrics/Bright Futures), and Kaiser Permanente National Guideline Program.\* The CGAG considered the range of guidelines for each population and condition and engaged in discussion to recommend final CG recommendations for adoption.

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\* The Kaiser Permanente National Guideline Program clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of the more common problems of patients. They are not intended to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. It is understood that some patients will not fit the clinical conditions delineated within these guidelines, and that a clinical practice guideline will rarely establish the only appropriate approach to a problem. Deviations from guidelines are appropriate in specific cases, yet exceptions to the guidelines should be infrequent when there is strong direct medical evidence closely linked to health outcomes. In more controversial clinical subjects with weaker or indirect evidence, occasional exceptions are appropriate and anticipated.

Clinical guideline recommendations are not intended to be used as standards for utilization management or performance. Providers are responsible for applying recommendations to the specific clinical characteristics of each patient. In all clinical situations, providers have authority and autonomy in planning and directing the care of patients.

For each clinical guideline, the primary reviewers discussed the various guideline elements and prioritized which elements to focus on during this first round of CG selection. For example, for controlling blood pressure, guideline statements for blood pressure screening and definition were reviewed and selected, but guidelines for uncontrolled blood pressure despite guideline-concordant care were not reviewed.

Through this process CHCs determined that, in addition to reaching consensus on specific guideline recommendations, individual CHCs could provide a more rigorous standard of care. For example, a CHC could choose to provide more frequent prenatal visits beyond the requirements of the prenatal and postpartum care clinical guidelines.

After reaching consensus amongst the primary reviewers, CG recommendations were shared with the secondary reviewers. Secondary reviewers voted to endorse or not endorse the selected guideline recommendations with the goal of reaching a majority decision. For specific concerns raised amongst primary or secondary reviewers, webinars and individual conversations were used to gain insight and reach the final endorsement status.

All recommended CG recommendations represented in this document were supported by a consensus among primary reviewers and a majority across secondary reviewers and are intended to present a consensus standard for adoption by the PHMI cohort. Guidelines are designed to serve as an evidence-based guide for clinical evaluation and treatment of patients; they are not intended to replace a clinician's judgment for an individual patient. Clinical judgment and shared decision-making with the patient may merit deviation from a guideline recommendation with respect to individual patient care.



# RECOMMENDED CLINICAL GUIDELINES SUMMARY

PHMI Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
Children	<b>Well Child Visits in the First 30 Months of Life (First 15 Months)</b>	Conduct well child visits as a newborn, at three to five days old, by one month, and then at two, four, six, nine, 12 and 15 months.  <a href="#">See Full Recommendation</a>	<a href="#">American Academy of Pediatrics (AAP)/ Bright Futures</a>
	<b>Child and Adolescent Well Visits</b>	Conduct annual well child visits for persons three to 21 years of age.  <a href="#">See Full Recommendation</a>	<a href="#">American Academy of Pediatrics (AAP)/ Bright Futures</a>
People with Behavioral Health Conditions	<b>Depression Screening and Follow-Up for Adolescents and Adults</b>	Complete a depression screening annually for persons 12 years of age and older (a specific screening questionnaire is not endorsed). Although USPSTF does not specify frequency, the group endorsed the recommendation to screen annually.  <a href="#">See Full Recommendation</a>	<a href="#">United States Preventive Services Task Force (USPSTF)</a>
Pregnant People	<b>Prenatal and Postpartum Care (Timeliness of Prenatal Care)</b>	Ensure a prenatal care visit occurs 280 to 176 days prior to delivery (or estimated delivery date (EDD)) for pregnant persons.  <a href="#">See Full Recommendation</a>	National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)
	<b>Prenatal and Postpartum Care (Postpartum)</b>	For persons who have delivered a live birth in any setting, conduct a postpartum visit with a maternal care provider within 21 days of delivery . After the initial visit, provide ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.  <a href="#">See Full Recommendation</a>	<a href="#">American College of Obstetrics and Gynecology (ACOG)</a>

PHMI Population	Related HEDIS Measure	CGAG Supported Recommendations	Source
Adults with Preventive Care Needs	Colorectal Cancer Screening	<p>Conduct a colorectal cancer screening for persons aged 45 to 75 using any of the following screening modalities and intervals:</p> <ul style="list-style-type: none"> <li>High-sensitivity guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) every year.</li> <li>Stool DNA test with FIT (sDNA-FIT) every one to three years.</li> <li>Computed tomography (CT) colonography every five years.</li> <li>Flexible sigmoidoscopy every five years.</li> <li>Flexible sigmoidoscopy every 10 years and FIT every year.</li> <li>Colonoscopy every 10 years.</li> </ul> <p><a href="#">See Full Recommendation</a></p>	<a href="#">United States Preventive Services Task Force (USPSTF)</a>
Adults Living with Chronic Conditions	Controlling High Blood Pressure	<p>Follow recommended guidelines respectively for each element of blood pressure control:</p> <ul style="list-style-type: none"> <li>Blood pressure screening.</li> <li>Hypertension definition.</li> <li>Treatment initiation.</li> <li>Treatment target.</li> <li>Initial pharmacotherapy.</li> <li>Follow-up.</li> </ul> <p><a href="#">See Full Recommendation</a></p>	Kaiser Permanente National Guideline Program (February 2021)
	Comprehensive Diabetes Care (HbA1c Poor Control >9%)	<p>Follow recommended guidelines respectively for each element of diabetes control:</p> <ul style="list-style-type: none"> <li>Screening (USPSTF).</li> <li>Diagnosis (ADA).</li> <li>Glycemic control and treatment target (Kaiser Permanente National Guideline Program).</li> <li>Self-monitoring: blood glucose (ADA).</li> <li>Self-monitoring: continuous glucose monitoring (ADA).</li> <li>Initial pharmacotherapy (ADA).</li> </ul> <p><a href="#">See Full Recommendation</a></p>	USPSTF, <a href="#">American Diabetes Association (ADA)</a> and Kaiser Permanente National Guideline Program (April 2022)

# PHMI POPULATION: CHILDREN

## Well Child Visits in the First 30 Months of Life (First 15 Months)

**Guideline Source:** American Academy of Pediatrics (AAP)/Bright Futures

**PHMI Measure:** Well Child Visits in the First 30 Months of Life (WC15)

**Definition:** **Well Child Visit:** The well child visit must occur with a primary care provider (PCP), but that PCP does not have to be the clinician assigned to the child.

Documentation includes all five of the following components:

- 1) Health history.
- 2) Physical developmental history.
- 3) Mental development history.
- 4) Complete physical exam.
- 5) Health education and anticipatory guidance.

**Guideline Language:** Conduct well child visits as a newborn, at three to five days old, by one month, and then at two, four, six, nine, 12 and 15 months.

If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

## Child and Adolescent Well Care Visits

**Guideline Source:** American Academy of Pediatrics (AAP)/ Bright Futures

**PHMI Measure:** Child and Adolescent Well Care Visits

**Definition:** **Wellness Visit:** The well child visit must occur with a PCP or an OB/GYN practitioner, but the clinician does not have to be assigned to the individual.

Documentation includes all five of the following components:

- 6) Health history.
- 7) Physical developmental history.
- 8) Mental development history.

- 9) Complete physical exam.
- 10) Health education and anticipatory guidance.

**Guideline Language:** Conduct annual well child visits for persons three to 21 years of age.

## PHMI POPULATION: PEOPLE WITH BEHAVIORAL HEALTH CONDITIONS

### Depression Screening and Follow-Up for Adolescents and Adults

**Guideline Source:** United States Preventive Services Task Force (USPSTF)

**PHMI Measure:** Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

**Definitions:** **Depression Screening:** A patient screened for clinical depression using a standardized assessment instrument that has been normalized and validated for the appropriate patient population (e.g., adolescents aged under 17 years or adults aged 18 years or older).

**Depression Follow-Up:** Patient screened for clinical depression with a positive result using a standard assessment instrument as above and who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen:

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication.

OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument (e.g., brief screens include PHQ-2, BDI-FS, GDS Short Form). For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.

**Guideline Language:** Complete a depression screening annually for persons 12 years of age or older (a specific screening questionnaire is not endorsed). Although USPSTF does not specify frequency, the group endorsed the recommendation to screen annually.

## PHMI POPULATION: PREGNANT PEOPLE

### Prenatal and Postpartum Care (Timeliness of Prenatal Care)

**Source:** National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)

**PHMI Measure:** Prenatal and Postpartum Care (Timeliness of Prenatal Care)

**Definitions:** **First Trimester:** 280 to 176 days prior to delivery (or estimated delivery date (EDD)).

**Prenatal Care:** Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP:

- A bundled service where the organization can identify the date when prenatal care was initiated. Because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated.
- A visit for prenatal care.
- A prenatal visit (prenatal visits value set; telephone visits value set; online assessments value set) with a pregnancy-related diagnosis code (pregnancy diagnosis value set).

**Recommendation Language:** Ensure a prenatal care visit occurs during the first trimester for pregnant persons.

## Prenatal and Postpartum Care (Postpartum Care)

**Guideline Source:** American College of Obstetrics and Gynecology (ACOG)

**PHMI Measure:** Prenatal and Postpartum Care (Postpartum Care)

**Definition:** **Postpartum Care:** Documentation of a postpartum visit to an OB/GYN practitioner, midwife, family practitioner or other PCP. Must include a note indicating the date when a postpartum visit occurred and one of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts, and abdomen:
  - » Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
  - » Notation of "abdominal wound healing" is acceptable for abdominal assessment.
- Notation of postpartum (PP) care including but not limited to:
  - » Postpartum care, postpartum check, six-week check.
  - » Preprinted "Postpartum Care" form in which information was documented during the visit.
  - » Perineal or cesarean incision wound check.
  - » Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.
  - » Glucose screening for patients with diabetes.
  - » Documentation of any of the following topics:
    - Infant care or breastfeeding.
    - Resumption of intercourse, birth spacing or family planning.
    - Sleep and fatigue.
    - Resumption of physical activity and attainment of healthy weight.

**Guideline Language:** Conduct a postpartum visit in the first three weeks after delivery with a maternal care provider for persons who have delivered a live birth in any setting. After the initial assessment, provide ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.

# PHMI POPULATION: ADULTS WITH PREVENTIVE CARE NEEDS

## Colorectal Cancer Screening

**Guideline Source:** United States Preventive Services Task Force (USPSTF)

**PHMI Measure:** Colorectal Cancer Screening (COL)

**Guideline Language:** Conduct a colorectal cancer screening for persons 45 to 75 years of age using any of the following screening modalities and timing:

- High-sensitivity guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) every year.
- Stool DNA test with FIT (sDNA-FIT) every one to three years.
- Computed tomography (CT) colonography every five years.
- Flexible sigmoidoscopy every five years.
- Flexible sigmoidoscopy every 10 years and FIT every year.
- Colonoscopy every 10 years.

# PHMI POPULATION: ADULTS LIVING WITH CHRONIC CONDITIONS

## Controlling High Blood Pressure

**Guideline Source:** Kaiser Permanente National Guideline Program (October 2021)

**PHMI Measure:** Controlling High Blood Pressure (CBP)

**Guideline Language:** **Blood Pressure (BP) Screening:** Screen adults 18 years and older for high blood pressure.

- In adults aged 18 to 39 years with blood pressure <130/85 mm Hg without other risk factors, screen every three to five years.
- In adults 40 years and older and those at increased risk of high blood pressure, screen annually.



- Adults at increased risk include those who have blood pressure  $\geq 130/85$  mm Hg or are overweight, obese or Black/African American.

**Hypertension Definition:**

- Obtain measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
- Blood pressure readings equal to or higher than those in the first row of Figure 1 below confirms the diagnosis of hypertension. Use clinical judgment if obtaining blood pressure outside the clinical setting is not possible. Automated office blood pressure (AOBP) measurements at more than two visits may be used.
- Diagnose hypertension for blood pressure  $\geq 180/110$  mm Hg at a single office reading or  $\geq 150/100$  mm Hg with clinical evidence of target organ damage (left ventricular hypertrophy, hypertensive retinopathy or hypertensive nephropathy).

**FIGURE 1: CORRESPONDING SBP/DBP VALUES**

	<b>Confirms Dx of HTN</b>	<b>Office BP</b>	<b>AOBP</b>	<b>Home BPM</b>	<b>Day ABPM</b>	<b>Night ABPM</b>	<b>24-Hour ABPM</b>
<b>Row 1</b>	<b>General population</b>	140/90	135/85	135/85	135/85	120/70	130/80
<b>Row 2</b>	<b>High risk population*</b>	130/90	130/85	130/85	130/85	110/70	125/80
<p><b>Office BP:</b> Taken in the clinic setting using oscillometric (preferred) or aneroid device but not including automated office BP.</p> <p><b>AOBP:</b> Taken in the clinic setting using a commercially available device that allows for measurements to be taken with the patient unobserved.</p> <p><b>Home BP monitoring (Home BPM):</b> Taken by the patient at home.</p> <p><b>Ambulatory BP monitoring (ABPM):</b> Taken at regular intervals by a device worn by the patient, usually for 24 hours.</p> <p>*In adults with atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), aged 75 years or older, or 10-year ASCVD risk greater than or equal to 10%.</p>							

**Treatment Initiation:**

- In adults with confirmed hypertension, initiate pharmacologic treatment to lower blood pressure at systolic blood pressure (SBP)  $\geq 140$  mm Hg OR diastolic blood pressure (DBP)  $\geq 90$  mm Hg.
- In adults with atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), aged 75 years or older, or 10-year ASCVD risk greater than or equal to 10%, consider pharmacologic treatment at SBP  $\geq 130$  mm Hg and treat to a goal of SBP  $< 130$  mm Hg.

**Treatment Target:**

- Treat to a goal of SBP  $< 140$  mm Hg AND DBP  $< 90$  mm Hg.
- Lower targets are reasonable based on clinical risk factors, clinical judgement and patients' preferences.
- DM alone does not qualify for goal SBP  $< 130$  mm Hg.

**Initial Pharmacotherapy:**

- Initial single pill combination therapy with lisinopril-hydrochlorothiazide is preferred.

(Clinical Guidelines Advisory Group reached consensus on adaption of Kaiser Permanente National Guideline Program Adult Blood Pressure clinical practice guideline for initial pharmacotherapy language to say: Initial single pill combination therapy is preferred.)

- If blood pressure goal is not achieved within one month of treatment, consider increasing the dose of the initial drug OR add a second drug from one of the thiazide-type diuretic, angiotensin-converting-enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or calcium channel blocker (CCB).

**Follow-Up:** Within one month after initiation or change in therapy.

## Comprehensive Diabetes Care

**Guideline Source:** [USPSTF, American Diabetes Association \(ADA\)](#) and Kaiser Permanente National Guideline Program (July 2023)

**PHMI Measure:** Hemoglobin A1c Control for Patients with Diabetes (Poor Control  $> 9\%$ ) (HBD)

**Guideline Language:** **Screening (USPSTF):** Asymptomatic adults aged 35 to 70 years who have overweight or obesity.

**Diagnosis (ADA):**

- Fasting plasma glucose  $\geq 126$  mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least eight hours.

OR

- Two-hour postprandial glucose  $\geq 200$  mg/dL (11.1 mmol/L) during oral glucose tolerance test. The test should be performed as described by World Health Organization using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.

OR

- A1C  $\geq 6.5\%$  (48 mmol/mol). The test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program-certified and standardized to the Diabetes Control and Complications Trial assay.

OR

- In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq 200$  mg/dL (11.1 mmol/L).

*For the full ADA guidelines, see [Diabetes Care 2. Classification of Diabetes: Standards of Care in Diabetes - 2023](#).*

**Glycemic Control and Treatment Targets (Kaiser Permanente National Guideline Program):**

- For adults with known diabetes, consider an overall treatment goal of HbA1c  $< 7\%$ . Initiate an individualized HbA1c goal using shared decision-making:
  - » For patients aged over 65 years or with significant comorbidities, initiate a less stringent treatment goal.
  - » Conversely, in individual patients, consider a more stringent goal. The desired goal is the lowest achievable A1c with a low risk of hypoglycemia.
- Patients Aged 18 to 64 Years: Target A1c  $< 7\%$ 
  - » A1c  $< 8\%$  is acceptable if there is a history of dementia, blindness, lower extremity amputation, chronic kidney disease 4/5, end-stage renal disease, cardiomyopathy or heart failure, or ASCVD (acute coronary syndrome; history of myocardial infarction; stable or unstable angina; coronary or other revascularization; ischemic stroke; transient ischemic attack; or symptomatic peripheral artery disease, all of atherosclerotic origin).

- Patients Aged 65 to 75 Years: Target A1c <8%
  - » The ACCORD trial demonstrated that those with longstanding (median 10 years) diabetes and established cardiovascular disease (CVD) (or 2 or more CVD risk factors) with an A1c of <6.5% are at higher risk for mortality than similar patients with an A1c of 7.5%. This does not apply to diet-controlled diabetes or diabetes controlled only with medications with a low risk of causing hypoglycemia (e.g., metformin, sodium-glucose cotransporter-2 (SGLT-2) inhibitors, glucagon-like peptide-1 (GLP-1) agonists).
  - » A1c 6.5% to 6.9% is acceptable in the absence of multiple comorbidities and/or history of severe hypoglycemia and/or medications that may cause hypoglycemia.
  - » A1c 7% to 7.4% for older adults with few chronic conditions and intact cognitive functional state (longer life expectancy).
  - » A1c 7.5% to 7.9% for older adults with multiple chronic conditions, minor cognitive deficits, or two or more deficits in instrumental activities of daily living (life expectancy less than 10 years).
- Patients Aged 76 Years or Older: Target A1c <9%
  - » A1c 6.5% to 6.9% is acceptable in the absence of multiple comorbidities and/or history of severe hypoglycemia and/or medications that may cause severe hypoglycemia.
  - » A1c 7% to 7.4% for older adults with few chronic conditions and intact cognitive and functional status (longer life expectancy).
  - » A1c 7.5% to 7.9% for older adults with multiple chronic conditions, minor cognitive deficits, or two or more deficits in instrumental activity of daily living (life expectancy less than 10 years).
  - » A1c 8% to 9% for older adults with multiple chronic conditions, significant cognitive deficits, or two or more deficits in basic activities of daily living (short life expectancy and/or significant geriatric syndromes leading to a decreased quality of life).

### **Self-Monitoring - Blood Glucose (ADA):**

In people with type 2 diabetes not taking insulin, routine glucose monitoring may be of limited additional clinical benefit. By itself, even when combined with education, it has shown limited improvement in outcomes. However, for some individuals, glucose monitoring can provide insight into the impact of nutrition, physical activity and medication management on glucose levels. Glucose monitoring may also be useful in assessing hypoglycemia, glucose levels during intercurrent illness or discrepancies between measured A1c and glucose levels when there is concern that an A1c result may not be reliable in specific

individuals. It may be useful when coupled with a treatment adjustment program.

*For the full ADA guidelines, see [Diabetes Care, Standards of Care: 7. Diabetes Technology: Standards of Care in Diabetes – 2023](#).*

### **Self-Monitoring - Continuous Glucose Monitoring (ADA):**

The use of continuous glucose monitoring (CGM) devices should be considered from the outset of the diagnosis of diabetes that requires insulin management. This allows for close tracking of glucose levels with adjustments of insulin dosing and lifestyle modifications and removes the burden of frequent blood glucose monitoring.

*For the full ADA guidelines, see [Diabetes Care, Standards of Care: 7. Diabetes Technology: Standards of Care in Diabetes – 2023](#).*

### **Initial Pharmacotherapy (ADA):**

- Healthy lifestyle behaviors, diabetes self-management education and support, avoidance of clinical inertia, and social determinants of health should be considered in the glucose-lowering management of type 2 diabetes. Pharmacologic therapy should be guided by person-centered treatment factors, including comorbidities and treatment goals.
- In adults with type 2 diabetes and established high risk of atherosclerotic cardiovascular disease, heart failure and/or chronic kidney disease, the treatment regimen should include agents that reduce cardiorenal risk.
- Weight management is an impactful component of glucose lowering management in type 2 diabetes. The glucose lowering treatment regimen should consider approaches that support weight management goals.
- Early combination therapy can be considered in some individuals at treatment initiation to extend the time to treatment failure.
- A person-centered approach should guide the choice of pharmacologic agents. Consider the effects on cardiovascular and renal comorbidities; efficacy; hypoglycemia risk; impact on weight, cost and access; risk for side effects; and individual preferences.
- Recommendation for treatment intensification for individuals not meeting treatment goals should not be delayed.

*For the full ADA guidelines, see [Diabetes Care, Standards of Care: 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes – 2023](#).*

*[View the ADA pharmacotherapy algorithm here.](#)*