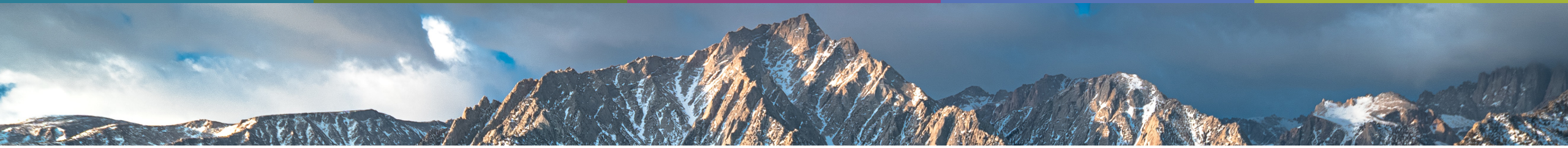
PHM INITIATIVE

## EXECUTIVE SUMMARY:

# Adults Living with Chronic Conditions Guide

Population Health Management Initiative (PHMI), a California collaboration of the Department of Health Care Services, Kaiser Permanente, and Community Health Centers.



# Populations of Focus Guide Series

This guide is part of a series focused on improving quality of care and equitable outcomes for five high-priority populations:

- Children
- Pregnant People
- Adults with Preventive Care Needs
- Adults Living with Chronic Conditions
- People with Behavioral Health Conditions

This guide provides step-by-step guidance for improving population-based care for **adults living with chronic conditions** with the goal of supporting substantive cultural, technological and process changes. In particular, it focuses on **increasing controlling high blood pressure and comprehensive diabetes care.**

# Population Health Management Initiative (PHMI) Overview

These guides were produced by PHMI, a **California collaboration of the Department of Health Care Services (DHCS), Kaiser Permanente and Community Health Centers (CHCs)**.

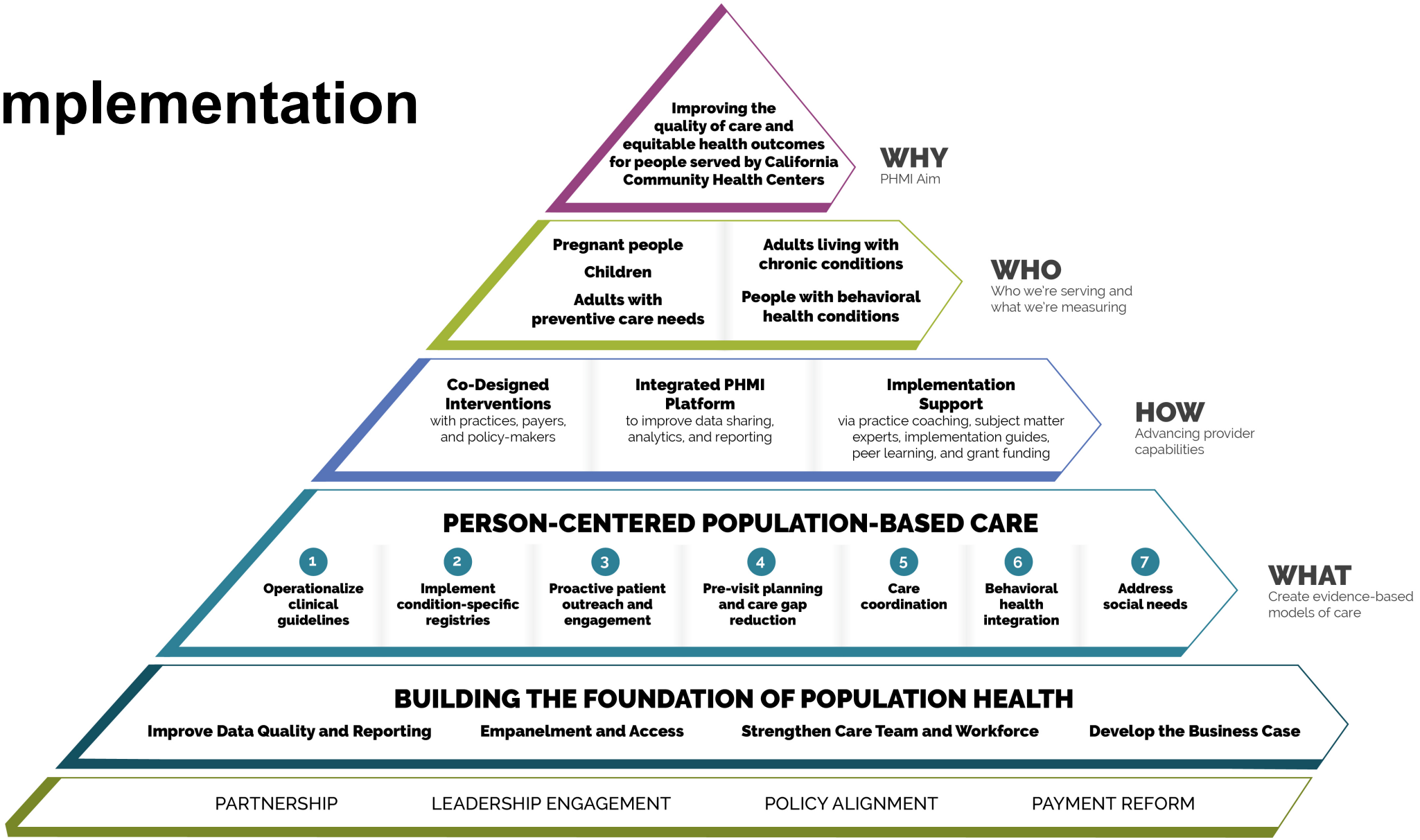
We're building on existing capacity of CHCs to employ **evidence-based models of care to improve quality of care and equitable health outcomes** for key populations of focus: children, pregnant people, adults with preventive care needs and adults living with chronic conditions, and people with behavioral health conditions.

Together, we are **empowering CHCs to successfully transition to the structural transformation** brought about by California Advancing and Innovating Medi-Cal (CalAIM) and new payment models through Alternative Payment Methodology (APM) 2.0.

As part of the capacity-building process, **CHCs can assess their existing population health management capacity** with the Population Health Management Capabilities Assessment Tool (PhmCAT). This self-administered tool can help organizations identify strengths and opportunities for improvement.

For more information about PHMI, visit www.phminitiative.com.

# PHMI Implementation Model



# Why This is Important

Chronic diseases are the leading cause of death and disability in the United States.

- An estimated 60% of adults are living with a chronic disease.
- The impact of chronic conditions and rates of complications are higher among historically marginalized populations.

Systematic, person-centered care for managing chronic conditions improves equity in care and patient outcomes by:

- Improving health and well-being among all patient populations.
- Recognizing and reducing potential barriers to care.
- Reducing burnout among clinicians and staff.

Adopting standard procedures to identify and manage chronic conditions allow practices to:

- Provide high quality, person-centered, culturally competent care.
- Foster efficiency.
- Reduce clinician and staff burden.

**A systematic, team-based care approach to wellness visits to screen for chronic diseases is of the most effective ways to manage chronic diseases and reduce health inequities.**

# How This Guide Is Organized

The guide uses existing evidence and bright spot examples from the field to offer practical guidance on improving care.

The key activities are organized into three categories, and we recommend that practices consider planning and attempting to implement the activities in the same order:

1. **Foundational activities:** Activities that all practices should implement.
2. **Going deeper activities:** More advanced activities that build off the foundational activities and help ensure your practice can achieve equitable improvement.
3. **On the horizon activities:** Additional activities, including “ideas worthy of testing” that include the latest ideas and thinking.

For each activity, we provide:

- **Guidance** on how to plan, test and implement the activity.
- **Links** to other resources, technology considerations and examples.
- **Tips** for periodically reviewing and making improvements to key workflows.

This guide also includes sections on measurement, equity, social health and behavioral health integration.

# How To Use This Guide

The guide is designed to be part of an organized quality improvement strategy, with the goal of supporting substantive cultural, technological and process changes.

- **Sequencing activities:** We recommend implementing the activities in the sequence provided in this guide, but recognize that different practices may prioritize differently.
- **Testing and implementing:** Consider testing different versions of the action steps and roles on a small scale before scaling throughout your practice.
- **Maintaining the progress:** Ongoing review and continual improvement is important for your practice to maintain your progress and adapt to changes in patient demographics, clinical best practices, payment policies and workforce.

# Foundational Competencies

If you implement the activities in this guide, you should be able to perform these foundational competencies:

1. Engage patients served by your practice to validate any of your proposed process improvements and to propose alternative methods to improve quality in your focus area.
2. Analyze core quality measures to identify inequities and opportunities for improving A1c control and BP among attributed patients.
3. Implement chronic care management activities.
4. Create an outreach protocol to reach and engage all attributed patients due for care.
5. Integrate behavioral health follow-up services as needed (e.g., for positive depression screens).
6. Create a health-related social needs (HRSN) screening process that informs patients' treatment plans.
7. Assess current capabilities and develop a plan for ongoing improvement in data utilization, care team workflows and efficiency that includes sustainable health information technology (HIT) strategies and continuous staff training on technology.

# Who Should Use This Guide

Working to improve the health of a population leverages everyone in a practice. Critical roles needed to engage in the work outlined in this guide and support practice change include:

- Quality improvement (QI) leadership, like a QI director, or additional team leads (i.e., clinical, front office, etc.) to support cultural changes.
- Coaches or practice facilitators who are partnered with teams to help identify areas for improvement and support change through change management strategies.

# Advancing Equity and Social Health

**Many key activities in this guide include considerations for:**

- Using the intervention to improve equitable health outcomes and reduce the effects of racism, bias and discrimination.
- Social needs at the individual or population level, such as expanding referral networks.

**The following activities dive into these more deeply:**

- Key Activity #4. Use a Systematic Approach to Decrease Inequities within the Population of Focus
- Key Activity #17. Use Social Needs Screening to Inform Patient Treatment Plans
- Key Activity #23. Strengthen a Culture of Equity

**For a more in-depth understanding of these topics, please see:**

- PHMI Equity Framework & Approach
- PHMI Social Health Framework & Approach

# Supported Quality Measures

This guide provides detailed guidance to improve your practice's results on the following HEDIS quality measures. These measures were chosen by PHMI to help CHCs improve their population health management capabilities and prepare for APM and CalAIM.

| Adults Living with Chronic Conditions HEDIS Measures for PHMI | |
|---|---|
| **Core Measures** | **Controlling High Blood Pressure**<br>Percentage of 18-85 year old people with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg).<br><br>**Comprehensive Diabetes Care (HbA1c Poor Control >9%)**<br>Percentage of 18 to 75 year old people with diabetes whose hemoglobin A1c was not under control (>9%). |
| **Supplemental Measures** | **Adults' Access to Preventive and Ambulatory Health Services**<br>Percentage of members 20 years and older who had an ambulatory or preventive care visit. |

# Key Activity Summaries

# Overview of Key Activities

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## Foundational Activities

1. Convene a Multidisciplinary Implementation Team for Chronic Care Management
2. Update or Implement Clinical Practice Guidelines
3. Use Care Gap Reports or Registries to Identify All Patients Eligible and Due for Care
4. Use a Systematic Approach to Decrease Inequities within the Population of Focus
5. Expand Clinic Hours Outside of a Typical Work Day
6. Incorporate Chronic Disease Management into Sick Visits
7. Create and Use Clinician Reminders
8. Proactively Reach Out to Patients Due to Care
9. Develop and Implement Standing Orders
10. Develop or Refine and Implement a Pre-Visit Planning Process
11. Screen for Chronic Conditions
12. Manage Medication Therapies
13. Manage Treatment of Comorbid Hypertension and Diabetes
14. Foster Patients' Ability to Self-Monitor Their Blood Pressure and/or A1c at Home
15. Implement Behavioral Health Screening
16. Support Patient Self Care
17. Use Social Needs Screening to Inform Patient Treatment Plans
18. Coordinate Care

## Going Deeper Activities

19. Provide Group Visits for Chronic Care Management
20. Strengthen Community Partnerships
21. Provide Care Management
22. Continue to Develop Referral Relationships and Pathways
23. Strengthen a Culture of Equity

## On the Horizon Activities

24. Develop System to Provide Remote Patient Monitoring

# Foundational Activities



1. **Convene a Multidisciplinary Implementation Team for Chronic Care Management**
   Develop, launch, and sustain a multidisciplinary team or task force within your practice that will be responsible for the planning and implementation of all of the foundational key activities in this guide and overseeing related quality improvement and equity efforts.

2. **Update or Implement Clinical Practice Guidelines**
   By establishing clinical practice guidelines, practices work to ensure a standard of care for patients that is equitable and promotes high quality care.

3. **Use Care Gap Reports or Registries to Identify All Patients Eligible and Due for Care**
   This activity provides detailed guidance on how to develop and utilize a standardized list or registry to ensure that gaps in standard screenings or interventions (i.e. updated A1c screening, current labs) are identified and closed. This helps to ensure that patients are up to date on their chronic disease management needs in a reliable and efficient manner.

4. **Use a Systematic Approach to Decrease Inequities within the Population of Focus**
   Find guidance for a systematic, evidence-based approach for identifying and then reducing inequities for adults with chronic conditions.

# Foundational Activities

5. **Expand Clinic Hours Outside of a Typical Work Day**
   This activity discusses methods and considerations for determining which expanded clinical hours best fit the needs of your practice and your patients.

6. **Incorporate Chronic Disease Management into Sick Visits**
   Incorporating appropriate interventions for chronic disease management expands patients' access to care during a sick visit.

7. **Create and Use Clinician Reminders**
   By developing, configuring, and using reminders in the electronic health record (EHR), your practice can raise clinician awareness of which patients are eligible and due for regarding their management of chronic diseases.

8. **Proactively Reach Out to Patients Due to Care**
   Find methods and workflows for developing outreach approaches that are sub-population specific. These outreach approaches focus on reaching patients who may benefit from additional outreach or more personalized interactions that encourage them to engage in care.

# Foundational Activities

9. **Develop and Implement Standing Orders**
   This activity outlines the actions required to create a standing order, or a pre-approved provider order to perform a specific intervention during standard workflows for any patients who meet the criteria. Standing orders, in concert with other key activities, allow care team members to work to the full scope of their license and provide scaffolding to support care team members as they work to greater autonomy.

10. **Develop or Refine and Implement a Pre-Visit Planning Process**
    Effectively and efficiently implement a pre-visit planning process (PVP) for better team-based coordination of care. Pre-visit planning facilitates optimization of practice workflows, so that patients receive comprehensive care in alignment with the latest clinical guidelines and their own needs and preferences.

11. **Screen for Chronic Conditions**
    By having standard screening protocols, practices can identify patients who are pre-diabetic or have elevated blood pressures while also reducing barriers to care.

# Foundational Activities

12. **Manage Medication Therapies**
    Medication therapies require a comprehensive approach to care and provide guidance on different interventions and techniques that can be utilized to effectively manage medication therapies for diabetes and hypertension.

13. **Manage Treatment of Comorbid Hypertension and Diabetes**
    This activity outlines interventions for streamlining treatment between chronic conditions and options that can be offered that address lifestyle factors along with clinical interventions.

14. **Foster Patients' Ability to Self-Monitor Their Blood Pressure and/or A1c at Home**
    Self-monitoring is an important aspect of patients' self-efficacy, which allows for them to see how lifestyle choices have a corollary impact on overall health.

15. **Implement Behavioral Health Screening**
    Depression plays a significant role in a patient's ability to manage chronic conditions, especially for patients who are diagnosed with diabetes. Behavioral health needs should be addressed in concordance with physical health in order to ensure a holistic approach to care.

16. **Support Patient Self Care**
    This activity provides guidance on supporting patient self-care. The term “self-care” refers to patients’ engagement in the activities and decisions that improve their health and well-being. Supporting self-care involves activities that enhance the capacity of individuals to engage in their care.

17. **Use Social Needs Screening to Inform Patient Treatment Plans**
    This activity provides guidance on screening patients for health-related social needs and how the information can begin to be used to inform patient treatment plans, which includes referrals to community-based services. Social needs are individual material resources and psychosocial circumstances required for long-term physical and mental health well-being, such as housing, food, water, air, sanitation, and social support.

18. **Coordinate Care**
    When care is coordinated well, the patient as well as their core and extended care team members know who is responsible for different parts of the patient’s care and everyone has the information they need. Care coordination is central to population health management and works to achieve safer processes and more effective outcomes.

# Going Deeper Activities

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19. **Provide Group Visits for Chronic Care Management**
    This activity outlines steps necessary to begin providing group visits for chronic care management. Group visits typically involved a healthcare team facilitating an interactive process of care delivery.

20. **Strengthen Community Partnerships**
    Establishing partnerships in the community can help address the most pressing social needs and leverage essential resources that support or assist patients. Deep engagement in this work can require significant resources from your practice.

21. **Provide Care Management**
    Led by a care manager (a licensed clinician or a non-licensed trained individual), care management is an intervention intended to support the highest-need individuals within your practice.

# Going Deeper Activities

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**22. Continue to Develop Referral Relationships and Pathways**

Your practice can take steps to optimize both the referral pathways to providers and receipt of a referral outcome, regardless of referral source. This activity builds on an inventory of existing referral services outside the clinic and identifies steps to support the systematic management of the referral process

**23. Strengthen a Culture of Equity**

Find strategies and resources to create a culture of equity in your practice. That means a transformational shift at the organizational level that is necessary for long term and sustainable improvement to health and racial equity.

**24. Develop System to Provide Remote Patient Monitoring**

Remote patient monitoring (RPM) programs serve as a way for practices to monitor the health and well-being of patients outside of a traditional clinic setting.

# Thank you!