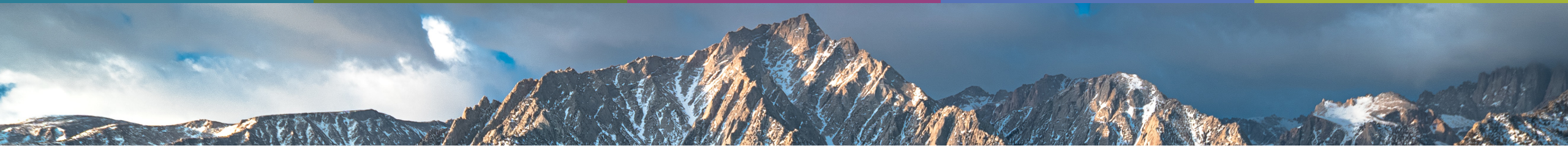
PHM INITIATIVE

EXECUTIVE SUMMARY:

Adults with Preventive Care Needs 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 with preventive care needs** with the goal of supporting substantive cultural, technological and process changes. In particular, it focuses on **increasing screening rates for colorectal cancer, breast cancer and cervical cancer.**

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)**.

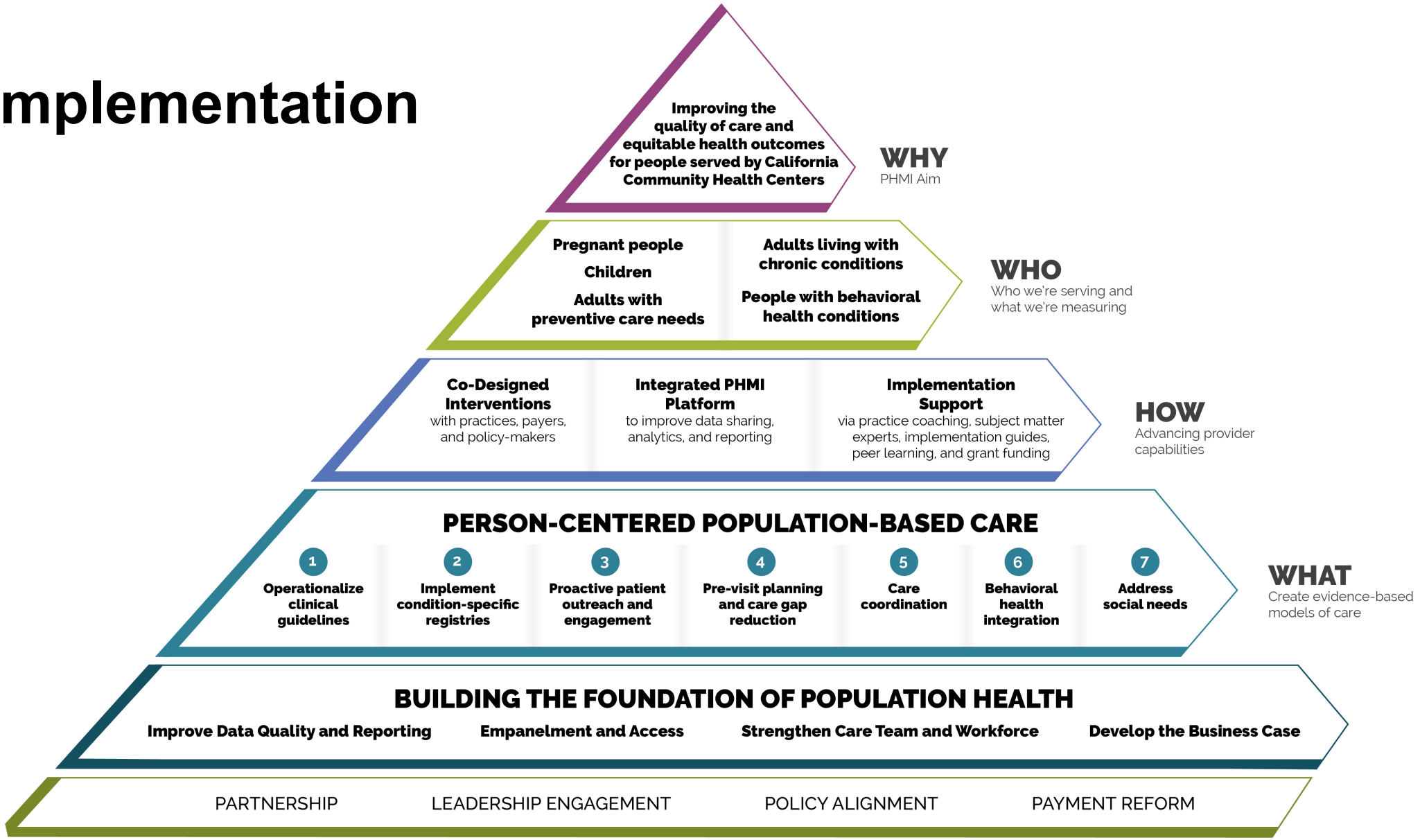
We're building on existing capacity of CHCs to employ **evidence-based models of care to improve quality of care and equitable health outcomes** for key populations of focus: children, pregnant people, adults with preventive care needs and adults living with chronic conditions, and people with behavioral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

According to the U.S. Center for Disease Control and Prevention (CDC), **in 2020, colorectal cancer, female breast cancer and cervical cancer resulted in over 98,000 deaths in the U.S.** and over 10,000 deaths in California.

One of our more powerful tools in the fight against these three cancers is **having all patients complete all the U.S. Preventive Services Task Force's (USPSTF) recommended screenings.** Despite the known benefits of screening, screening rates for these three cancers are suboptimal.

It is critically important to **develop, implement, and continually improve a multi-faceted and culturally relevant cancer screening protocol** that includes all patients, in order to help practices:

- Avoid missed or delayed diagnoses, which are devastating to patients and their families and other near ones.
- Address inequities in access and outcomes by tailoring outreach and education to the populations served by your practice.
- Adhere to the most current cancer screening guidelines.

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 disparities and improvement opportunities for colorectal, breast and cervical screening rates.
3. Use evidence-based clinical guidelines, identify when and where it is necessary to update, or develop new protocol(s) for colorectal, breast and cervical screening.
4. Create an outreach protocol to reach and engage all attributed patients.
5. Create a health-related social needs screening process that informs patients' treatment plans.
6. Assess current health information technology (HIT) capabilities and develop a plan for ongoing improvement in data utilization, care team workflows, and efficiency.

Who Should Use This Guide

Improving the health of a population impacts 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, such as a director of quality improvement, 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 Address Inequities within the Population of Focus
- Key Activity #10. Use Culturally Appropriate Educational Materials for Cancer Screening
- Key Activity #14. Use Social Needs Screening to Inform Patient Treatment Plans
- Key Activity #18. 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 Preventative Care Needs	
Core Measures	**Colorectal Cancer Screening** Percentage of 45- to 75-year-old people who were screened for colorectal cancer at the recommended interval.
Supplemental Measures	**Breast Cancer Screening** Percentage of people 50 to 74 years of age who had at least one mammogram to screen for breast cancer in the past two years. **Cervical Cancer Screening** Percentage of people who were screened for cervical cancer using any of the following criteria: • People 21 to 64 years of age who had cervical cytology performed within the last three years. • People 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. • People 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years.

Key Activity Summaries

Overview of Key Activities

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Foundational Activities

1. Convene a Multidisciplinary Implementation Team for Cancer Screening
2. Develop or Update the Practice's Cancer Screening Protocols
3. Use Care Gap Reports or Registries to Identify All Patients Due for Cancer Screening
4. Use a Systematic Approach to Decrease Inequities within the Population of Focus
5. Develop and Implement Standing Orders
6. Conduct Proactive Outreach to Patients Due for Screening
7. Create and Use Clinician Reminders
8. Refine and Implement a Pre-Visit Planning Process
9. Partner with Patients to Discuss Cancer Screening During Patient Visits
10. Use Culturally Appropriate Educational Materials for Cancer Screening
11. Provide or Arrange for Cancer Screening
12. Develop and Implement a Follow-Up System for Those Who Have Been Screened
13. Coordinate Care
14. Use Social Needs Screening to Inform Patient Treatment Plans

Going Deeper Activities

15. Strengthen Community Partnerships
16. Continue to Develop Referral Relationships and Pathways
17. Provide Care Management
18. Strengthen a Culture of Equity

On the Horizon Activities

19. Explore the Development of Self-Sampling Techniques for Human Papilloma Virus (HPV) Screening
20. Develop Customized, Culturally Appropriate Educational Materials

Foundational Activities

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1. **Convene a Multidisciplinary Implementation Team for Cancer Screening**
   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. **Develop or Update the Practice's Cancer Screening Protocols**
   Find guidance for developing or refining a cancer screening protocol that aligns to the PHMI clinical guidelines, establishes clinical and supportive processes that provide a framework for implementing the guidance safely, and leverages the capabilities of appropriate staff to carry out the protocols. It is the foundation of many of the remaining Key Activities in this Implementation Guide.

3. **Use Care Gap Reports or Registries to Identify All Patients Due for Cancer Screening**
   This activity provides detailed guidance on how to develop a regularly updated list of all patients eligible and due for colorectal cancer screening, breast cancer screening and/or cervical cancer screening.

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 inequitable cancer screening rates.

Foundational Activities

5. **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 meets 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.

6. **Conduct Proactive Outreach to Patients Due for Screening**
   By reaching out to patients in-between regular visits and creating and using tailored tools and techniques, your practice can help address the social needs of sub-populations who are in need of cancer screening.

7. **Create and Use Clinician Reminders**
   Develop, configure and use reminders in the Electronic Health Record (EHR) so that clinicians are aware of which patients are eligible for and due for their colorectal cancer, breast cancer and/or cervical cancer screening based on the clinical guidelines.

Foundational Activities

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8. **Refine and Implement a Pre-Visit Planning Process**
   Effectively and efficiently embed screening for colorectal cancer, breast cancer and/or cervical cancer into your practice's pre-visit planning Process (PVP), including huddles. Pre-visit planning works towards optimizing a team-based approach so patients receive comprehensive care in alignment with the latest clinical guidelines and their own needs and preferences.

9. **Partner with Patients to Discuss Cancer Screening During Patient Visits**
   Your practice care team can use patient visits (scheduled for other reasons) as an opportunity to discuss any needed colorectal, breast and/or cervical cancer screening and provide education (including choice of testing, where feasible) to patients.

10. **Use Culturally Appropriate Educational Materials for Cancer Screening**
    Practices can curate and use existing culturally appropriate educational materials to increase the rate of patients who complete recommended colorectal cancer, breast cancer and cervical cancer screening.

11. **Provide or Arrange for Cancer Screening**
    This activity provides guidance for setting up cancer screening for colorectal cancer, breast cancer and/or cervical cancer for any patient eligible and due for screening who agrees to complete the recommended screening. This includes patients who agree to get screened during a patient visit, in response to a screening reminder, or in response to an outreach activity.

Foundational Activities

12. **Develop and Implement a Follow-Up System for Those Who Have Been Screened**
    This activity provides guidance on communicating screening tests results to patients and initiating timely follow up on positive results.

13. **Coordinate Care**
    When care is coordinated well, the patient and 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.

14. **Use Social Needs Screening to Inform Patient Treatment Plans**
    Data from screening patients for health-related social needs can be used to inform patient treatment plans, including referrals to community-based services. Social needs are defined as individual material resources and psychosocial circumstances required for long-term physical and mental well-being, such as housing, food, water, air, sanitation and social support.

Going Deeper Activities

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15. **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.

16. **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

17. **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.

18. **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.

On the Horizon Activities

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19. **Explore the Development of Self-Sampling Techniques for Human Papilloma Virus (HPV) Screening**
    Self-sampling techniques that screen for the presence of human papillomavirus (HPV) offer an alternative to a clinician-obtained pap smear. Studies have demonstrated that self-sampling has the potential to increase participation of under-screened women.

20. **Develop Customized, Culturally Appropriate Educational Materials**
    This activity offers additional tips and considerations for developing customized educational and culturally appropriate materials, messages and messengers for patient subpopulations at your practice.

Thank you!