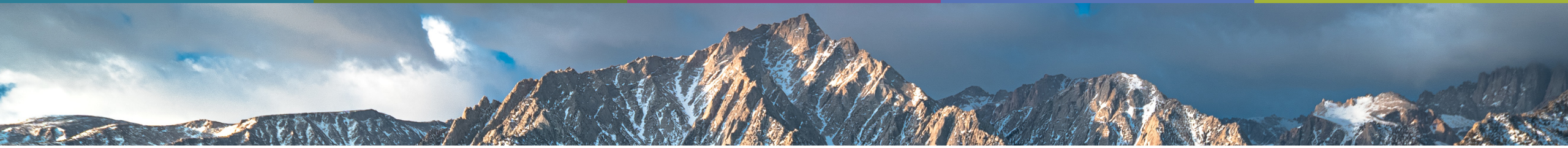
PHM INITIATIVE

EXECUTIVE SUMMARY:

Children Guide



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 **children** with the goal of supporting substantive cultural, technological and process changes. In particular, it focuses on **child immunization status, well child visits in first 30 months of life, child and adolescent well care visits, and immunization for adolescents.**

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)**.

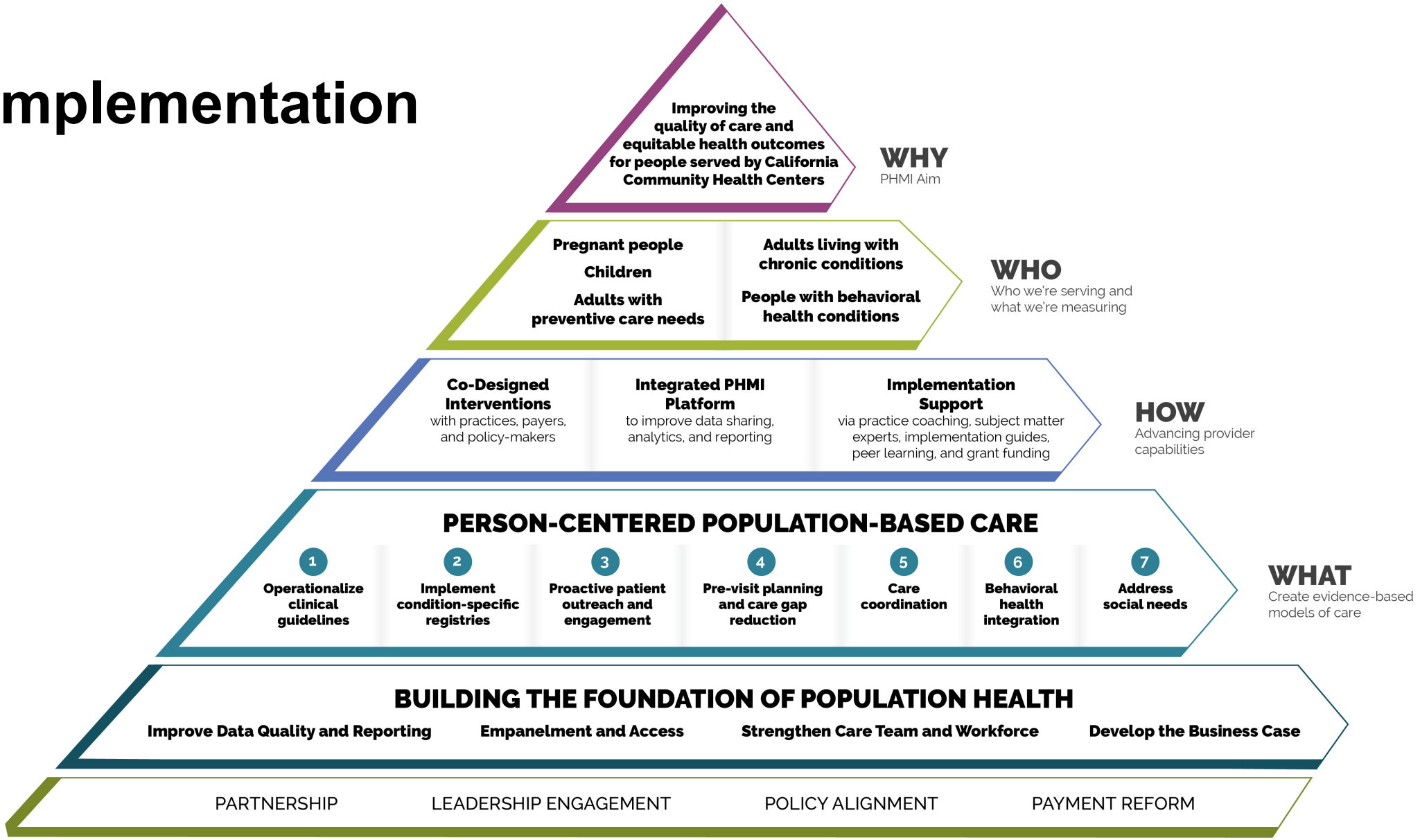
We're building on existing capacity of CHCs to employ **evidence-based models of care to improve quality of care and equitable health outcomes** for key populations of focus: children, pregnant people, adults with preventive care needs and adults living with chronic conditions, and people with behavioral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

- Children need regular well-child visits to track their development and find health problems early, when they're usually easier to treat.
- Services like screenings and vaccinations are key to keeping people of all ages healthy.
- Many families in the United States do not utilize suggested preventive healthcare services.

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 two 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 that help ensure your practice can achieve equitable improvement.

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 proposed process improvements and to learn alternative methods to improve quality in your focus area.
2. Analyze core quality measures to identify disparities and improvement opportunities for adherence to American Academy of Pediatrics (AAP) preventive care guidelines year over year among attributed patients.
3. Incorporate AAP preventive care guidelines into well-child visit protocols for infancy and early childhood (up to 30 months).
4. Create an outreach protocol to reach and engage all attributed patients due for care.
5. Prepare for integrating behavioral health follow-up services as needed.
6. Create a health-related social needs 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

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 leadership, like a director of quality improvement (QI) or additional team leads (e.g., 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
- Key Activity #11. Coordinate Care
- Key Activity #15. Strengthen Community Partnerships
- Key Activity #20. 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.

Children HEDIS Measures for PHMI	
Core Measures	**Child Immunization Status** Percentage of two-year-old children who have received the 10 recommended vaccines (CIS 10) **Well Child Visits in First 30 Months of Life** Percentage of children who have had six or more well child visits in their first 15 months of life
Supplemental Measures	**Well Child Visits in First 30 Months of Life (15 to 30 months)** Percentage of children who turned 30 months old during the measurement year, and had at least two well child visits with a primary care physician in the last 15 months. **Child and Adolescent Well Care Visits** Percentage of children three to 21 years of age who received one or more well care visits with a primary care practitioner or an OB/GYN practitioner during the measurement year. **Immunization for Adolescents (Combo 2)** Percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus (HPV) series by their thirteenth birthday.

Key Activity Summaries

Overview of Key Activities

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Foundational Activities

1. Convene A Multidisciplinary Implementation Team Focused on Pediatrics
2. Assess and Improve Reliability in Meeting Well-Child Care Visit (WCV) Recommendations
3. Use Care Gap Reports or Registries to Identify All Patients Eligible and Due for Care
4. Use a Systematic Approach to Decrease Inequities
5. Develop or Refine and Implement a Pre-Visit Planning Process
6. Develop and Implement Standing Orders
7. Attend to Social and Emotional Development in WCVs
    a. Develop a Screening Process for Social Needs and Adverse Childhood Experiences (ACEs) that Informs Patient Treatment Plans
8. Provide Dyadic Care: Screen for Postpartum Depression
9. Proactively Reach Out to Patients Due for Care
    a. Provide Caregiver Support to Overcome Vaccine Hesitancy
10. Implement Trauma-Informed Care Approach Across the Patient Journey
11. Coordinate Care
12. Expand Family-Friendly Access to Care
    a. Provide Clinic Hours Beyond The Typical Work Day
    b. Incorporate Prevention Activities Within Sick Visit Appointments

Going Deeper Activities

13. Coordinate Care with Home/Community Visiting Services
14. Provide Tailored Outreach, Screening and Managing of Treatment for Adolescent Behavioral Health
    a. Provide Proactive Inreach and Outreach to Help Adolescents Engage in Behavioral Health Care
    b. Screen Adolescent Patients for a Range of Behavioral Health Needs
    c. Manage Treatment of Adolescents' Behavioral Health Needs in Integrated, Person-Centered Ways
15. Strengthen Community Partnerships
16. Offer Non-Practice Based Access to Immunizations
17. Expand Dyadic Care to Provide More Comprehensive Social and Behavioral Health Services
18. Continue to Develop Referral relationships and Pathways
19. Provide Care Management
20. Strengthen a Culture of Equity

Foundational Activities

1. **Convene a Multidisciplinary Implementation Team Focused on Pediatrics**
   Find guidance for developing, launching and sustaining 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. **Assess and Improve Reliability in Meeting Well-Child Care Visit (WCV) Recommendations**
   This foundational activity deals with assessing and then improving your practice's reliability in implementing the guidelines in the Bright Future/AAP periodicity schedule.

3. **Use Care Gap Reports or Registries to Identify All Patients Eligible and Due for Care**
   Find detailed guidance on how to reliably and efficiently develop and use a regularly updated list of all patients eligible for recommended or standard screenings or interventions (i.e., childhood immunizations and standard well-child care visits) through a care gap report or registry.

4. **Use a Systematic Approach to Decrease Inequities**
   This activity provides guidance for a systematic, evidence-based approach for identifying and then reducing inequities for children.

5. **Develop or Refine and Implement a Pre-Visit Planning Process**
   The care team can achieve better team-based coordination of care by effectively and efficiently implementing a pre-visit planning process (PVP). 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.

6. **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.

7. **Attend to Social And Emotional Development in WCVs**
   This activity outlines how practices can support social-emotional development of their patient population, as well as screen for and respond to children with social-emotional development needs.

   a. **Develop a Screening Process for Social Needs and Adverse Childhood Experiences (ACEs) that Informs Patient Treatment Plans**
      Screening for health-related social needs and Adverse Childhood Experiences (ACEs) can inform patient treatment plans, including referral to community-based services.

Foundational Activities

8. **Provide Dyadic Care: Screen for Postpartum Depression**
   Currently, the American Academy of Pediatrics (AAP) recommends that pediatricians screen birthing people for postpartum depression at the infant's 1, 2, 4, and 6-month well child visits (WCVs).

9. **Proactively Reach Out To Patients Due For Care**
   Proactive outreach focuses on identifying sub-populations among patients that may benefit from additional outreach and implementing more personalized reminders and “touches” for them to engage in care.

    a. **Provide Caregiver Support to Overcome Vaccine Hesitancy**
       While the minority of parents who decline all vaccines may be fixed in their beliefs, most vaccine-hesitant parents are responsive to vaccine information, will consider vaccinating their children and are not opposed to all vaccines.

10. **Implement Trauma-Informed Care Approach Across the Patient Journey**
    This activity provides guidance on concrete actions practices can take to embed trauma-informed care into their practices.

11. **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.

12. **Expand Family-Friendly Access To Care**
    This set of foundational activities provides two key ways that clinics can improve access to care for families:

    a. **Provide Clinic Hours Beyond The Typical Work Day**
       This key activity describes strategies for clinics to expand access to timely appointments through shifting clinic hours

    b. **Incorporate Prevention Activities Within Sick Visit Appointments**
       By incorporating prevention activities, including immunizations and other well-care visits, into sick visit appointments, you can meet patients and/or family where they are and maximize the value of their time in the clinic.

Going Deeper Activities

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13. **Coordinate Care with Home/Community Visiting Services**
    Find tips and considerations for expanding access to home visiting services which may be available to patients as a managed care plan benefit or through other public services.

14. **Provide Tailored Outreach, Screening And Managing Of Treatment For Adolescent Behavioral Health**
    These three activities provide considerations for supporting the behavioral health needs of your adolescent patients (ages 12-18 years).

    a. **Provide Proactive Inreach and Outreach to Help Adolescents Engage in Behavioral Health Care**
       Outreach consists of identifying the behavioral health (BH) care needs of adolescents in the community, while inreach involves identifying the same among your practice's adolescent patients.

    b. **Screen Adolescent Patients for a Range of Behavioral Health Needs**
       Find recommendations on screening for behavioral health needs for adolescents, starting with depression screening.

    c. **Manage Treatment of Adolescents' Behavioral Health Needs in Integrated, Person-Centered Ways**
       Confidentiality considerations are outlined, with tips and resources specific to adolescent treatment.

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. **Offer Non-Practice Based Access to Immunizations**
    Promoting vaccinations at community-based pharmacies and developing mobile vaccination centers are potential strategies to provide access to recommended immunization for children and youth.

17. **Expand Dyadic Care To Provide More Comprehensive Social And Behavioral Health Services**
    This activity provides resources and considerations for expanding dyadic care, which supports child development and mental health by treating children and caregivers together.

18. **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 that can be taken to support the systematic management of the referral process.

Going Deeper Activities

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19. **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.

20. **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.

Thank you!