PHM INITIATIVE

Workflow Examples for the PHMI Populations of Focus

Updated July 2024

Example Workflows for Children

Recommended Clinical Guidelines for Children

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

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.

Child and Adolescent Well-Care Visits

Conduct annual well-child visits for persons three to 21 years of age.

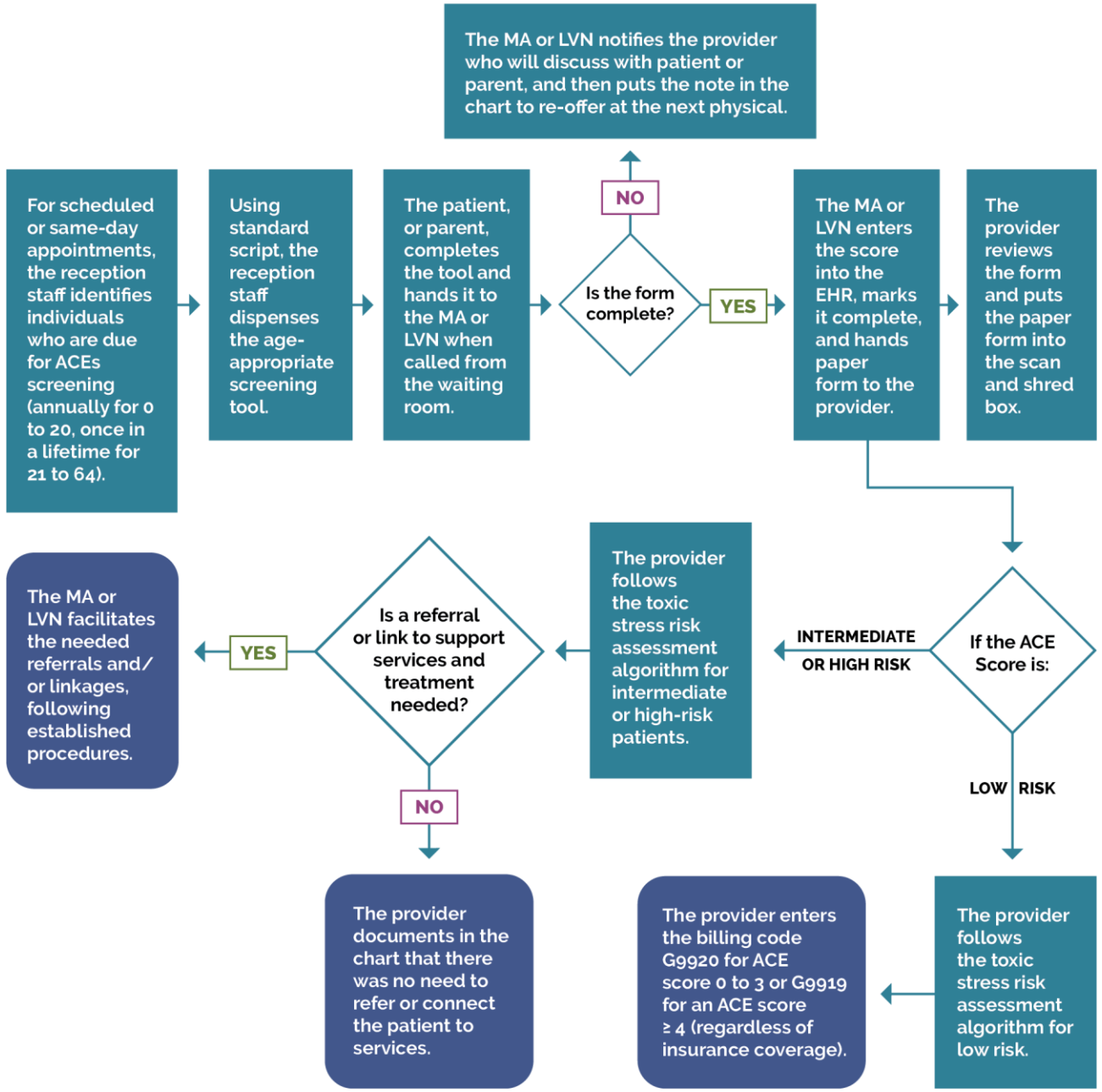
For more information, please see the full Clinical Practice Guidelines.

Workflow Examples

- Marin Community Clinics workflow for Well-Child Visits in the First 15 Months of Life
- La Clinica ACE's screening and coordination with Help Me Grow (HMG)
- West County Health Center's Well Child Visit Recall Workflow
- Sonoma Valley Community Health Center Childhood Immunizations Procedure
- Petaluma Health Center Childhood Immunization Workflow
- AAP Use of Standing Orders for Vaccination Among Pediatrics
- Immunize.org Clinical Resources: Standing Orders Templates

Example Workflow for Screening for Adverse Childhood Experiences.

Source: Figure 13 in the [PHMI Children Implementation Guide](#).



PHM INITIATIVE

Example Workflows for Pregnant People

Recommended Clinical Guidelines for Pregnant People

Prenatal and Postpartum Care (Timeliness of Prenatal Care)

Ensure a prenatal care visit occurs 280 to 176 days prior to delivery (or estimated delivery date (EDD)) for pregnant persons.

Prenatal and Postpartum Care (Postpartum Care)

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.

For more information, please see the full Clinical Practice Guidelines

Workflow Examples

- Preconception Health Toolkit
- Women's Health Practice Bulletin
  - *(contains decision trees and recommendations for appropriate next steps and follow-ups)*
- Client-Centered Reproductive Goals & Counseling Flow Chart
- Preconception Counseling Checklist
- Primary Care Checklist Suggestions for Assessment Referral Process

Summary of OB Psychosocial Screening Process

Screening

- **Method:** A single screening questionnaire that includes:
  - ***Depression and Anxiety:*** Edinburgh Screening Questionnaire
  - ***Substance Use:*** Substance Use Screening Questionnaire
  - ***Intimate Partner Violence:*** 1. Domestic Violence Screening Questionnaire +2. Danger Assessment -5 (DA-5) for patients who screen positive to #1

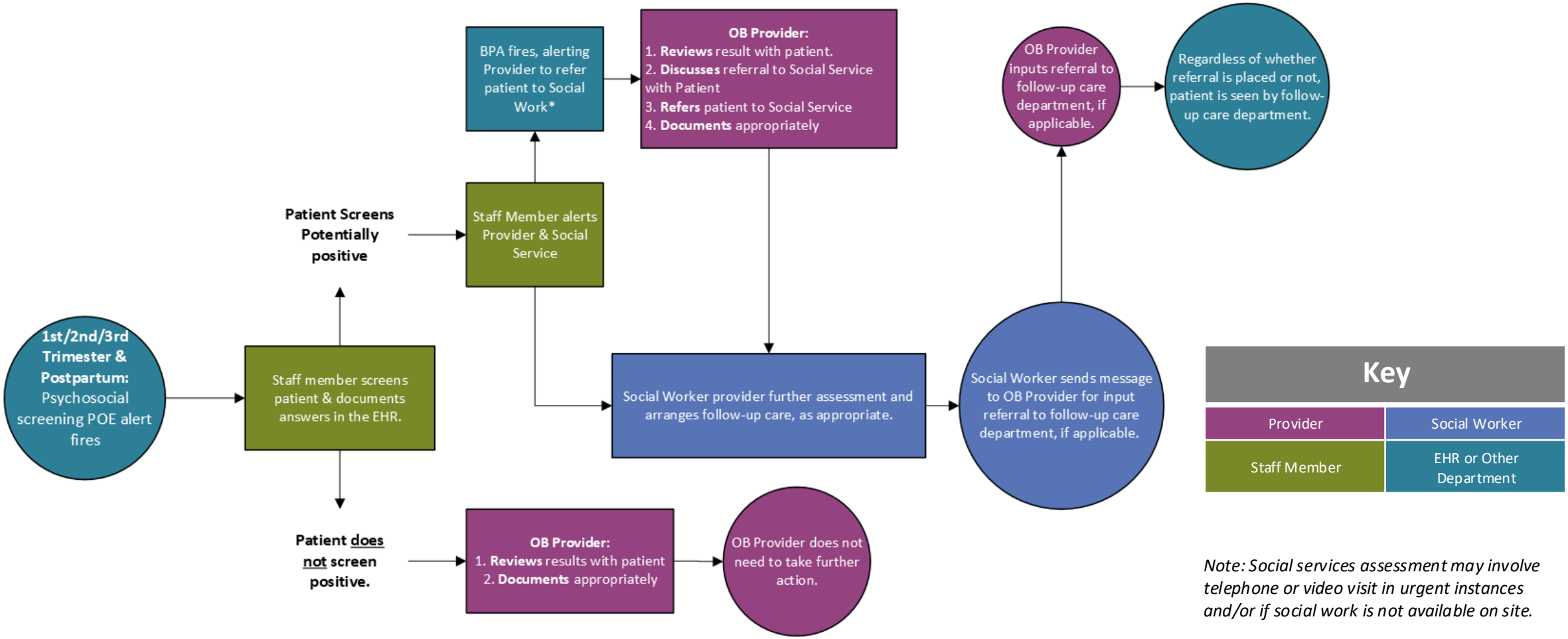
- **Frequency:** Once a trimester and postpartum (with POE alert for staff):
  - ***1st Trimester:*** Prenatal intake/6-10 week appt
  - ***2nd Trimester:*** 24-28 week appt
  - ***3rd Trimester:*** 34 week appt—end of pregnancy
  - ***Postpartum*** appt

Follow-up Care

- OB Physician/Provider refers patients who screen positive to social work for further assessment
- Upon further assessment, Social Work assists with arranging appropriate follow-up care for patients
  - Depending on score and further assessment, follow up care may include: Depression Care Management, Psychiatry, Addiction Medicine, and/or appropriate follow up for Intimate Partner Violence

- **This process is in alignment with key recommendations:**
  - New California maternal mental health screening law (AB 2193)
  - New NCQA/HEDIS measures for prenatal & postpartum screening and follow-up
  - Current research and clinical principles

OB Psychosocial Follow-up Care Workflow



Note: Social services assessment may involve telephone or video visit in urgent instances and/or if social work is not available on site.

***Psychosocial BPAs**

1. Urgent Psychological Assessment BPA: BPA fires if positive answer to Edinburgh question #10 (suicidal ideation) AND/OR positive answer to any IPV danger assessment question.
2. Non-Urgent Psychosocial Assessment BPA: BPA fires if positive screen for depression, substance use, or intimate partner violence. If urgent BPA fires, non-urgent BPA will also fire.

PHM INITIATIVE

Example Workflows for Adults with Preventive Care Needs

Recommended Clinical Guidelines for Adults with Preventive Care Needs

Colorectal Cancer Screening

Conduct a colorectal cancer screening for persons aged 45 to 75 years using any of the following screening modalities and intervals:

- 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.

For more information, please see the full Clinical Practice Guidelines

Workflow Examples

- Sample Mammogram Protocol for Care Coordinators
- Colorectal Cancer Screening Decision Tree
- Maximizing Mammography Participation
- Redbook Health Community Coalition-Colorectal Cancer Screening Promising Practices
- West County Health Centers: Increasing Cervical Cancer Screenings through Data Clean-up & PDSA Cycles
- Alexander Valley: Cervical Cancer Screening Promising Practice
- Breast Cancer: Screening Policies, Procedures, and Practices

PHM INITIATIVE

Example Workflows for Adults Living with Chronic Conditions

Recommended Clinical Guidelines for Adults Living with Chronic Conditions

Controlling High Blood Pressure

Follow recommended guidelines respectively for each element of blood pressure control:

- Blood pressure screening.
- Hypertension definition.
- Treatment initiation.
- Treatment target.
- Initial pharmacotherapy.
- Follow-up.

Comprehensive Diabetes Care

Follow recommended guidelines respectively for each element of diabetes control:

- Screening (USPSTF).
- Diagnosis (ADA).
- Glycemic control and treatment target (Kaiser Permanente National Guideline Program).
- Self-monitoring: blood glucose (ADA).
- Self-monitoring: continuous glucose monitoring (ADA).
- Initial pharmacotherapy (ADA).

For more information, please see the full Clinical Practice Guidelines

Workflow Examples: Blood Pressure

- Centers for Disease Control and Prevention/Million Hearts' Hypertension Control Change Package
  - Including BP check, HTN management, and medication adherence
- Aliados Health Promising Practice: Hypertension Control
- Redwood Health Community Coalition Standard Nursing Procedure for Blood Pressure Management
- Golden Valley Health Center—Blood pressure care workflows
- National Association of Community Health Centers' Hiding in Plain Sight Change Package
  - Including a workflow from Golden Valley Health Centers
- Chapa-De Indian Health: registered nurse case manager workflow
- Los Angeles Medical Center (LAMC) Sample Protocol for Hypertension Management (on cohort portal)

Workflow Examples: Diabetes

- North Coast Clinics Network: Controlling Diabetes
- Ocean Park Health Center—Diabetes Standing Order Checklist
- Alexander Valley Healthcare—Workflows and Promising Practices for Diabetes Retinal Screening
- Chapa-De Indian Health: registered nurse case manager workflow
- Kaiser Permanente Standardized Procedure for Diabetes Mellitus Type 2 Management (on cohort portal)

PHM INITIATIVE

Example Workflows for People with Behavioral Health Conditions

Recommended Clinical Guidelines for People with Behavioral Health Conditions

Depression Screening and Follow-Up for Adolescents and Adults

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.

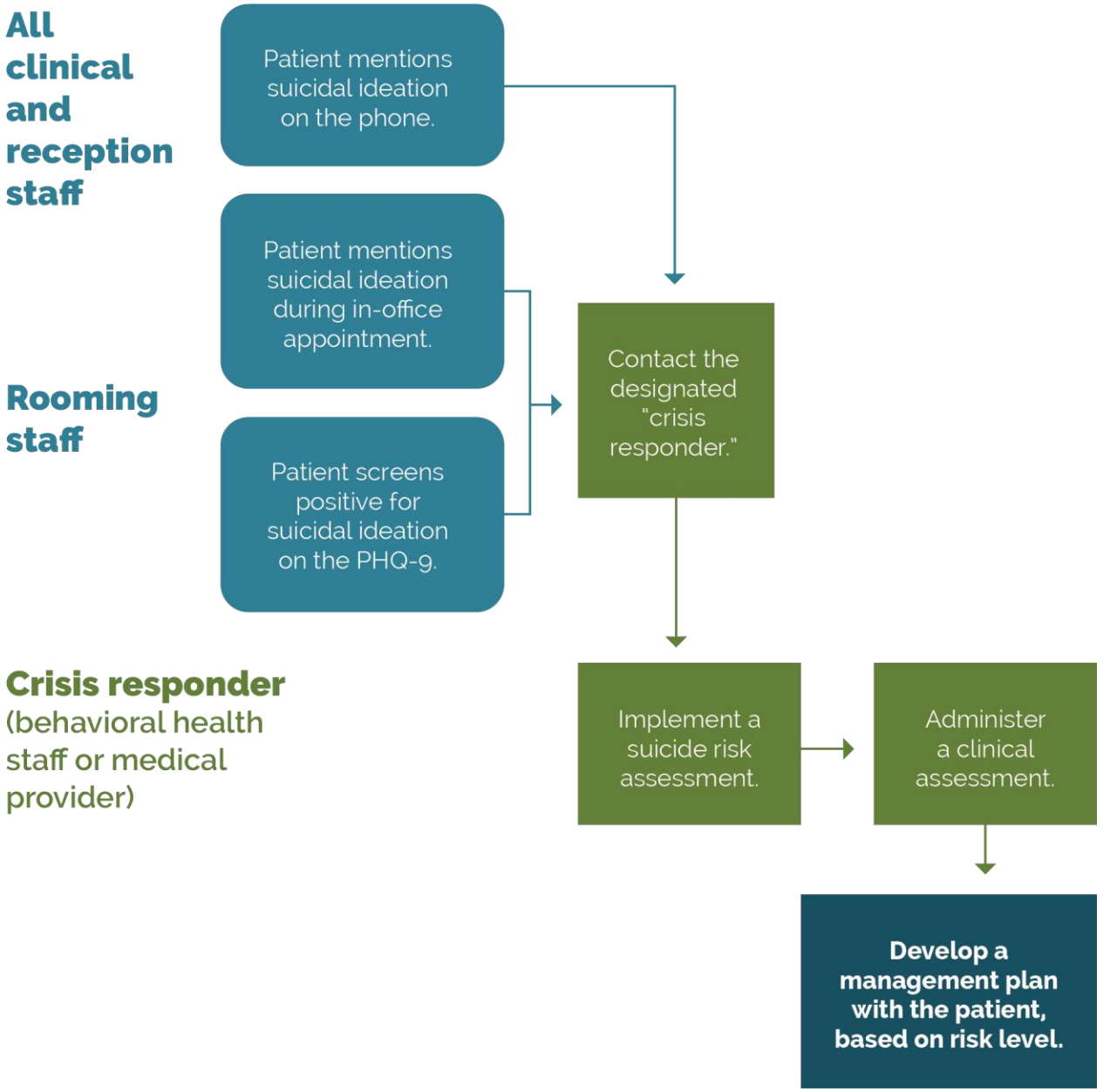
For more information, please see the full Clinical Practice Guidelines

Workflow Examples

- Suicide Assessment Five-Step Evaluation and Triage for Clinicians (SAFE-T).
- Childrens Hospital of Philadelphia Outpatient Behavioral Health Care Clinical Pathway for Assessment and Care Planning for Children and Adolescents at Risk for Suicide
- SAMHSA Treatment Improvement Protocol (TIP) 63
- Maryland Primary Care Program: Behavioral Health Integration Establishing a Workflow
- AAFP Opioid-Associated Emergency of Health Care Workers Algorithm
- Aliados Health BH Care Coordinator workflow
- OLE Health Integrated Healthcare

Example Workflow for Responding to Suicidal Ideation.

Source: Figure 8 in the [PHMI Behavioral Health Implementation Guide](#).



PHM INITIATIVE

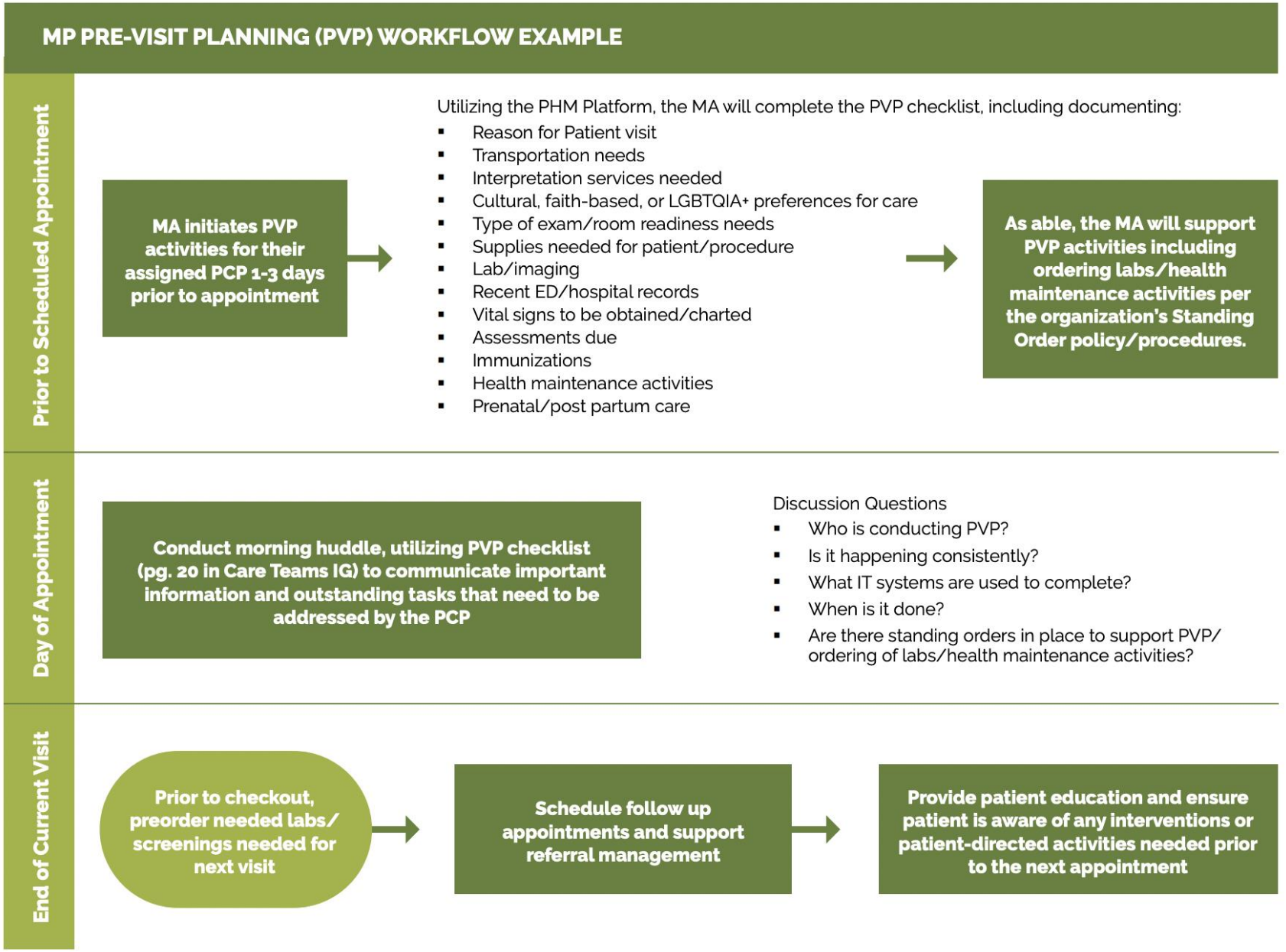
Example Daily Huddles and PVP Workflows

Workflow Examples

- AMA Pre-Visit Planning: Save Time, Improve Care, and Strengthen Care Team Satisfaction
- Centers for Care Innovation Daily Huddle Checklist
- CP3 Population Health Toolkit (section on Standing Orders)

Pre-Visit Planning Workflow Example.

Source: Figure 6.1 in the [PHMI Care Teams Implementation Guide](#).



Pre-Visit Planning: Leveraging the Team to Identify and Address Gaps in Care.

Source: PHMI Resource.

COMMON PREVENTIVE AND HEALTH MAINTENANCE SERVICES

Updated January 1, 2024

Services Due	Population	Recommendation Owner	Examples of Possible Actions (These Are NOT Recommendations)
Adverse childhood experiences screening	Children and adolescents ages zero to 19; adults	Encouraged by the California Department of Health Care Services	MA/nurse: administer screening tool to caregiver (if patient is zero to 12 years of age) or to patient (if 13 years of age or over); advise clinician of positive screens
Anxiety and anxiety disorders screening	Adults 64 and under (including pregnant and postpartum persons); children and adolescents ages eight to 18 years	U.S. Preventive Services Task Force (USPSTF) • Adult Guidelines • Children Guidelines	MA/nurse: administer screening tool; advise clinician of any positive screens
Breast cancer screening	Women ages 50 to 74: every two years *This guideline from 2016 is currently under review.*	USPSTF	MA/nurse: pend an order (or order and schedule if standing order) if due and patient agrees; notify clinician if patient declines Clinician: document informed consent if patient declines
Cervical cancer screening	Women ages 21 to 65 years: every three years (or, for women ages 30 to 65, every five years with cytology [Pap]	USPSTF	MA/nurse: schedule patient for Pap if due

And many more...

Example Chart: Scrub Process for Open Orders.

Source: Figure 12 in the [PHMI Children Implementation Guide](#).