Milestone: Adopt Clinical Guidelines

**Milestone Language:** Adopt evidenced-based clinical guideline(s) related to KPI metrics for selected PoF. Monitor adherence to guideline(s) for providers to ensure standardization in practice. This includes communication of guidelines to providers and staff, adapting workflows based on clinical guidelines for patients seen and not seen in clinic, integration of guidelines into the EHR, and tracking provider/care team adherence to guidelines.

**Instructions:**
For the selected Population of Focus (PoF), please identify one evidence-based clinical guideline your practice is using to improve care. Your responses in the sections below should focus on how this specific guideline has been adopted, communicated, integrated into workflows and EHR systems, and monitored for adherence.

**[automatically display PoF and corresponding HEDIS-like measures]**

## 1. Clinical Guideline Adoption for Selected Population of Focus

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| **Prompt** |  **Response** |
| Please see the appendix for a list of suggested guidelines [auto-populate]. Do you use these guidelines? | [] Yes[] Yes but with some changes (please describe)[] No, we use different guidelines (please describe) |
| Who selects, reviews, and tailors clinical guidelines into clinic policy at your practice(s)? (Please list the title or role of the person(s) responsible—for example, “Chief Medical Officer” or “Clinical Lead.”) |  |
| How often are guidelines reviewed? |  |
| How are clinical guideline-related policies updated, and approved at your practice? *(Please describe the process and note who is responsible for updating and approving policies—for example, Clinical Committee, Medical Director, or QI Lead. If you have a written policy or procedure that outlines this process, please note that as well.)* |  |

## 2. Communication and Staff/Clinician Engagement

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| **Prompt** | **Response** |
| How are staff involved in clinical guideline review? |  |
| How are providers and staff trained or oriented around guidelines and related clinic policies? |  |
| How are updates to guidelines and related policies communicated to staff and clinicians? |  |

#### 3. Workflow Adaptation

**Note:** The following questions ask about how your practice has adapted workflows to support implementation of the evidence-based clinical guideline selected for your PoF. Please describe any protocols, workflows, or tools used to support consistent care delivery based on this guideline.

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| **Prompt** | **Response** |
| The relevant workflows our practice uses are... [e.g., care coordinator outreach workflow for colorectal cancer screening] |  |
| The standing orders and/or standardized protocols we use are... |  |
| Are pre-visit planning or flagging tools used? | ☐ Yes ☐ No (If yes, describe) |

#### 4. EHR/Data Integration

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| **Prompt** | **Response** |
| Are clinical guidelines incorporated into the EHR (or EHR-linked PHM platform)? | ☐ Yes ☐ Partially ☐ No |
| If yes/partially, describe how: | ☐ Order sets ☐ Alerts/reminders ☐ Templates ☐ Dashboard ☐ Registry flags[list examples for each checked tool of what’s being used, ex. EHR Alert when out of date for A1c monitoring] |
| How is the EHR and/or PHM system used to identify care gaps for this clinical guideline? |  |

#### 5. Monitoring Provider/Care Team Adherence

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| **Prompt** | **Response** |
| What indicators and data are used to track adherence to the clinical guideline? |  |
| Who reviews adherence data? | ☐ Clinical Lead ☐ QI Team ☐ Medical Director ☐ BH Director ☐ Others |
| How often is adherence reviewed? | ☐ Weekly ☐ Monthly ☐ Quarterly |
| Describe challenges and/or barriers to adhering to the clinical guideline |  |
| What actions has your practice taken to address gaps in adherence |  |

**Appendix: Clinical Guidelines Advisory Group (CGAG) Overview**
 To support greater consistency and collaboration in the use of clinical guidelines (CGs) across community health centers (CHCs), the PHMI Clinical Guidelines Advisory Group (CGAG) was established in 2022. This effort was prompted by findings that many CHCs lacked formal processes for adopting and monitoring CGs, often resulting in inconsistent application across sites. The CGAG brought together clinical leaders from 32 CHCs to review, compare, and reach consensus on a core set of CGs aligned with PHMI's population and quality measure priorities. These guidelines focus on preventive care, chronic conditions, behavioral health, and maternal-child health and are informed by national and specialty-specific recommendations. Through a structured, multi-phase review and endorsement process, the CGAG established evidence-based CGs to serve as a shared foundation across PHMI CHCs, while allowing flexibility for clinical judgment. Recommendations are intended to guide care delivery, support EHR integration, and inform quality improvement efforts.

As part of the Equity and Practice Transformation (EPT) program, a list of CGAG-endorsed clinical guidelines is being shared as a starting point for practices that do not currently follow an established set of guidelines, helping to reduce the burden of identifying guidelines independently and to accelerate standardization and implementation. Practices can read more and access the full recommended guidelines list on the PHMI website: <https://phminitiative.com/resource/clinical-guidelines/#recommended-clinical-guidelines-summary>.

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| **Population** | **Related HEDIS Measure** | **CGAG Supported Recommendations** | **Source** |
| **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. | [American Academy of Pediatrics (AAP) / Bright Futures (2024)](https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.215623191.1803532441.1662651728-379008272.1662651728) |
| Child and Adolescent Well Visits | Conduct annual well child visits for persons three to 21 years of age. | [American Academy of Pediatrics (AAP) / Bright Futures (2024)](https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.215623191.1803532441.1662651728-379008272.1662651728) |
| Immunizations for Adolescents | * Tetanus, diphtheria, and pertussis (Tdap) vaccination.
* Human papillomavirus vaccination (HPV).
* Meningococcal serogroup A,C,W,Y vaccination.

[See Full Recommendation](https://phminitiative.com/resource/clinical-guidelines/) | [Centers for Disease Control and Prevention/Advisory Committee on Immunization Practices (2024)](https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html) |
| **Population** | **Related HEDIS Measure** | **CGAG Supported Recommendations** | **Source** |
| **Pregnant People** | Prenatal and Postpartum Care (Prenatal) | Ensure a prenatal care visit occurs 280 to 176 days prior to delivery (or estimated delivery date (EDD)) for pregnant persons. | National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) (2019) |
| Prenatal and Postpartum Care (Postpartum) | 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. | [American College of Obstetricians and Gynecologists (ACOG) (2018)](https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care) |
| Perinatal Depression Screening and Follow-Up | * Prenatal depression screening is recommended in the first 12 weeks (Kaiser Permanente Southern California).
* Postpartum depression screening is recommended once during the postpartum period (ACOG).
 | Kaiser Permanente Southern California (November 2021)  [American College of Obstetricians and Gynecologists (ACOG) (2018)](https://www.acog.org/programs/perinatal-mental-health/implementing-perinatal-mental-health-screening) |
| **Population** | **Related HEDIS Measure** | **CGAG Supported Recommendations** | **Source** |
| **Adults with Preventive Care Needs** | Breast Cancer Screening | * Biennial mammography screening is recommended for women aged 40 to 74 years (USPSTF).
* Transmasculine individuals are recommended to follow the guidelines for cisgender women (USPSTF).
* Risk assessment by age 25 is recommended to determine if screening earlier than age 40 is needed (American College of Radiology/Society of Breast Imaging).
 | [United States Preventive Services Task Force (USPSTF) (2024)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening) [American College of Radiology/Society of Breast Imaging (2023)](https://www.jacr.org/article/S1546-1440%2817%2931524-7/fulltext)  |
| Cervical Cancer Screening | * Screen women aged 21 to 65.
* Recommends against screening in women younger than 21 years and for women who meet specific criteria.
 | [United States Preventive Services Task Force (USPSTF)(2018 - update in progress)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening) |
| Colorectal Cancer Screening | Conduct a colorectal cancer screening for persons aged 45 to 75 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.
 | [United States Preventive Services Task Force (USPSTF)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening) |
| **Population** | **Related HEDIS Measure** | **CGAG Supported Recommendations** | **Source** |
| **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.
 | Kaiser Permanente National Guideline Program (February 2021) |
| Hemoglobin A1c Control for Patients with Diabetes (Poor Control >9%) (HBD) | 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).
 | [USPSTF (2021)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes)[American Diabetes Association (ADA) (2023)](https://diabetesjournals.org/care/issue/46/Supplement_1)Kaiser Permanente National Guideline Program (April 2022) |
| **Population** | **Related HEDIS Measure** | **CGAG Supported Recommendations** | **Source** |
| **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 and older (a specific screening questionnaire is not endorsed). Although USPSTF does not specify frequency, the group endorsed the recommendation to screen annually.   | [United States Preventive Services Task Force (USPSTF)(2016)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening) |
| Depression Remission or Response for Adolescents and Adults | Measurement-Based Care    * In adults with Major Depressive Disorder (MDD), use the Patient Health Questionnaire-9 (PHQ-9) or other validated tool to quantitatively measure depression severity in initial treatment planning.
* In adults with MDD, use the PHQ-9 to monitor treatment response at four to six weeks, after each change in treatment, and until full remission (i.e., sustained PHQ-9 at zero to four weeks for a minimum of two months) is achieved.
* At a minimum, assessments should include a measure of symptoms, as well as adherence to treatment, emergence of adverse effects, and the therapeutic alliance.
 | Kaiser Permanente National Guideline Program (September 2023) |