Overview of Clinical Guidelines for Pediatric Preventative Measures (0 - 2)

- Well Baby Visits 0-2 Years
- Child Immunization Status
- Lead Screening in Children

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Learning Objectives

Improving Measure Outcomes: Preventative Care for 0 - 2 Year Olds

- Define the clinical background, specifications, and performance threshold definitions of the 2024 Primary Care Provider Quality Improvement Program Specifications: *Well-Child Visits for the First 15 Months of Life*, *Childhood Immunizations Status, Blood Lead Screening* and *Dental Fluoride Varnish* measures.
- Apply measure specification requirements to maximize measure performance adherence in the delivery of infant well-care visits, screenings, immunizations, blood lead screening in children and application of dental varnish.

Learning Objectives

Improving Measure Outcomes: Preventative Care for 0 - 2 Year Olds (Continued)

- Understand best practices to ensure delivery of blood lead screening in children and dental varnish, including justification for its inclusion in preventative care for 0 - 2 year olds.
- Recognize the minimum five components that are necessary for clinical standard practice for the well-child visits for 0 - 2 year olds.
- Identify best and promising practices that can be used to address clinical processes, improve interpersonal communication and education, eliminate barriers to access, improve outreach for groups that have been historically, economically, or socially marginalized, and improve technical barriers to improve well-child, immunizations, and related services for children ages 0 - 2.

Childhood Immunization Status

Why It Matters

- Childhood vaccines protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough at a time in their lives when they are most vulnerable to disease.
- Approximately 300 children in the United States die each year from vaccine preventable diseases.
- Vaccines are essential for disease prevention.

Childhood Immunization Status: Combo 10

Dosage	Abbreviation	Description
At birth and second birthday		
3	(HepB)	Hepatitis B
Between 42 days old and second birthday		
2 or 3	(RV)	Rotavirus (dosage dependent on manufacturer)
4	(DTaP)	Diphtheria, Tetanus and acellular Pertussis
At Least 3	(Hib)	Haemophilus Influenza type B
3	(IPV)	Polio
4	(PCV)	Pneumococcal conjugate vaccine
On or between the first and second birthday		
1	(MMR)	Measles, Mumps, and Rubella
1	(Varicella)	Chickenpox
1	(HepA)	Hepatitis A
Annual – Between 180 days old and second birthday		
2	(IIV)	Influenza

CDC Recommended Schedule Link: https://www.cdc.gov/vaccines/schedules/index.html

Childhood Immunization Status
Medical Record Documentation

- A note that the “patient is up to date” with all immunizations. Without the dates of all immunizations, the names of the immunizations **is not** enough evidence of immunization for HEDIS or the Quality Incentive Program reporting.
- Retroactive entries are unacceptable if documented after the second birthday.
- Vaccination administered prior to 42 days after birth (between birth and 41 days old) are not compliant for DTaP, IPV, Hib, RV, and PCV.
- Document parental refusal to vaccinate (Z28 code).

Childhood Immunization Status Challenges to Note

Influenza (Flu)

- **Proactive scheduling** of the Flu vaccine is critical!

The Advisory Committee on Immunization Practices (ACIP) recommends two influenza vaccines before age two, starting at six months. In 2022, 57% of Partnership's members turning age two, did not complete the two dose series. **If 2nd dose is given after age two, the child will not be in the numerator.**

Rotavirus (RV)

- **Proactive scheduling** of the RV vaccine is critical!

Rotavirus cannot be given as part of a "catch-up" schedule. RV cannot be initiated in children if they are older than 15 weeks.

If the infant has not completed the full schedule by eight months, no further vaccines are given, and the child will not be in the numerator.

Well-Baby Visits

Why It Matters

- Tracking Growth and Development
- Opportunity for caregivers/parents to raise concerns
- Team Approach with regular visits
- Address population health issues early
- Helps parents/caregivers stay on top of immunization schedules

Well-Baby Visit 0-15 Months Periodicity

Birth

1 months

2 months

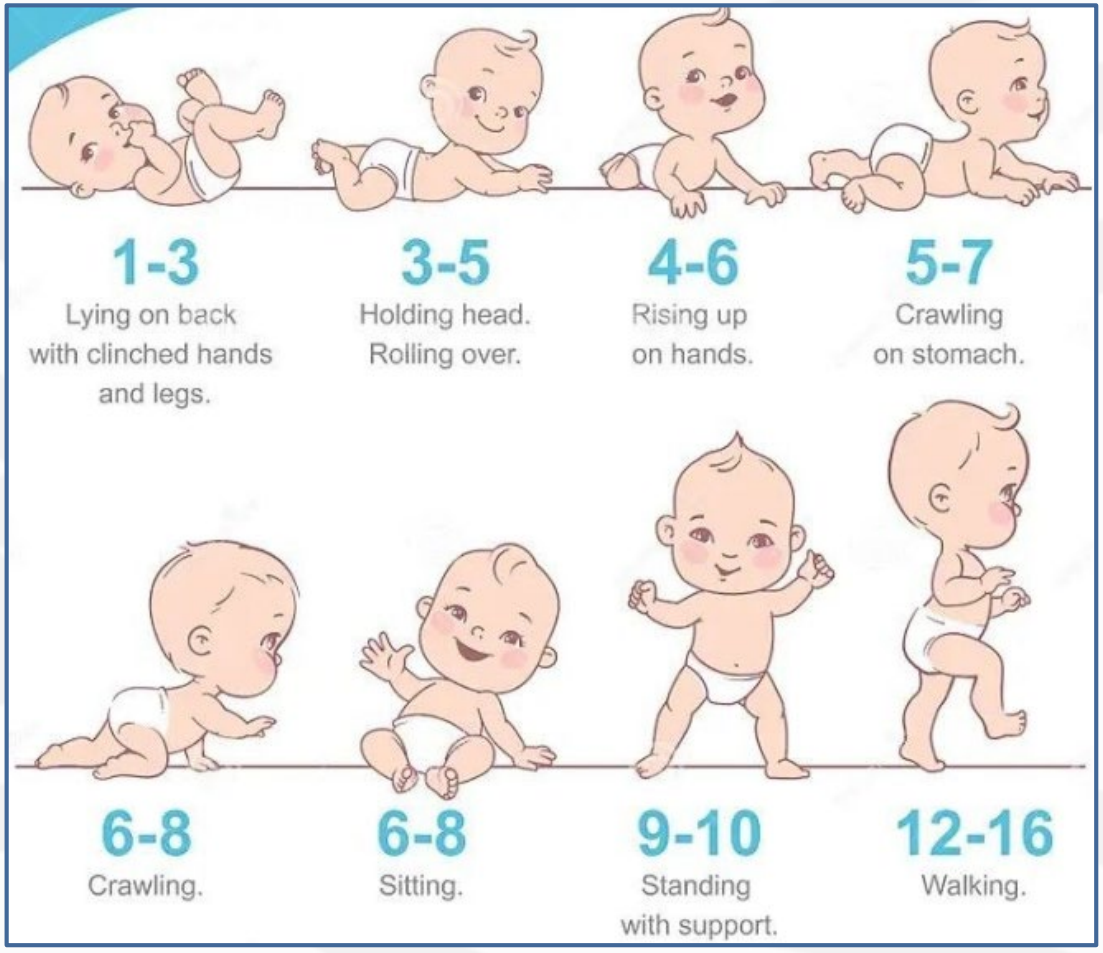
4 months

6 months

9 months

12 months

15 months



Bright Futures Periodicity Guidelines - www.brightfutures.org

Components of a Well-Child Visit

1. Health history: Examples - allergies, medications, and immunizations documented on different dates of service as long as **all** are documented within the measurement year.
2. Physical developmental history: Examples include **"development appropriate for age,"** must mention specific development - scooting, creeping or crawling, may stand with support, etc.
3. Mental developmental history**:** Examples include **"development appropriate for age,"** must mention specific development.
4. Physical exam.
5. Health education/anticipatory guidance*:* ***Information given with discussion*** is provided on issues – document that there was a review of information/handouts.

Components of a Well-Child Visit (Continued)

Well-Child Screenings:

- Percentage of eligible Partnership members who received preventive dental services
- Developmental screening in the first three (3) years of life

Lead Screening (Testing) in Children

- Children six months to six years of age are most at risk for lead poisoning.
- There is no known “safe” level of lead exposure.
- The only way to identify lead poisoning is by testing a capillary or venous blood sample. Most children who have lead poisoning have no early signs or symptoms.
- According to the CDC, approximately 500,000 children between the ages of one and five in the United States have blood lead levels greater than 3.5 micrograms per deciliter (µg/dL)

Blood Lead CDC Reference: https://www.cdc.gov/nceh/lead/default.htm

Lead Screening (Testing) in Children

- California regulations require lead testing at ages 12 months and 24 months for Medi-Cal enrolled children. Catch-up testing must be done up to 72 months of age (if not tested at 24 months or if previous test results are not documented).

- Capillary testing results of 3.5mcg/dL or higher require a confirmatory venous test.

- Lead prevention education must be documented at every WCC from six months to six years.

- Parental refusal of lead testing (and the reason) must be obtained in writing, signed by the parent and placed in the medical record. If a parent refuses to sign, the provider must sign noting that parents have declined and why, if known.

- Additional training offered:
  https://www.partnershiphp.org/Providers/Medi-Cal/Documents/OnDemandTrainingWebinars/On-Demand%20Webinar%20Content/Blood%20Lead%20Screening%202021_COM%20updated.pdf#search=blood%20lead

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Health Disparities and Inequities

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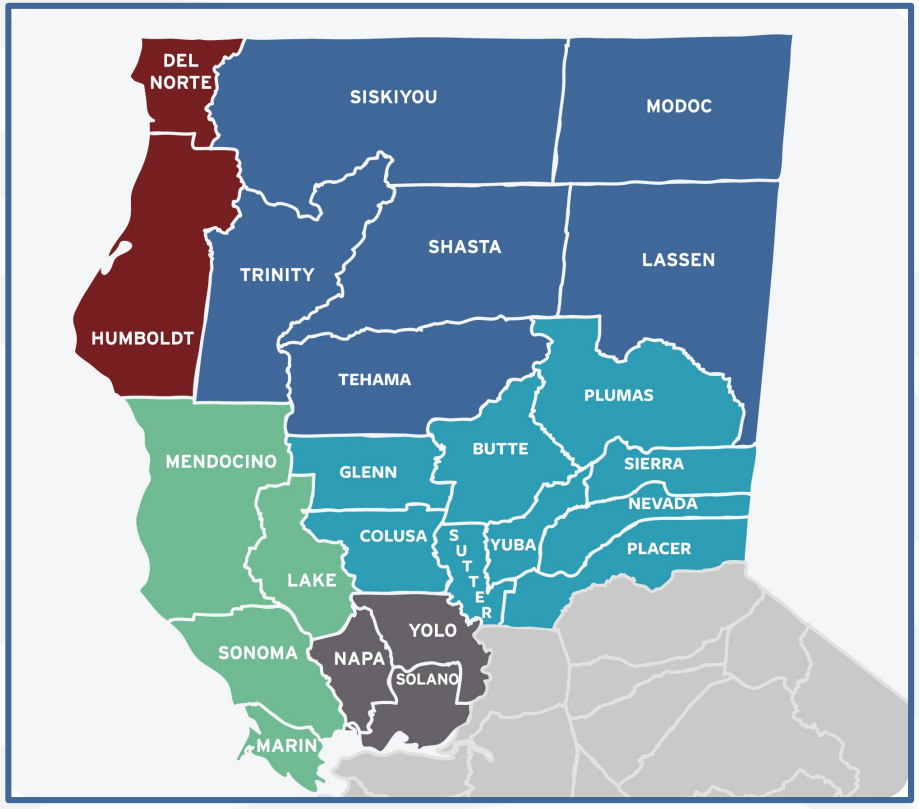
Health Disparities and Potential Drivers

Children are generally referred to as a vulnerable population with respect to their health because of their relative inability to advocate for their own interests and to protect themselves from harm.

Barriers to well-baby visits and immunization appointments include:

- Lack of transportation
- Difficulty for parents/caregivers taking time off work
  - Financial stressors (transportation associated costs, reduction in pay)
- Competing priorities, including caring for other children, school schedules, and caregiver's own medical needs
- Caregiver concerns with language and immigration status
- Poverty, unequal access to healthcare
- Lack of education
- Vaccine hesitancy due to mistrust in healthcare system

Partnership HealthPlan of California Regions



Southeast: Solano, Yolo, Napa

Southwest: Sonoma, Marin, Mendocino, Lake

Northeast: Lassen, Modoc, Siskiyou, Trinity, Shasta, Tehama

Northwest: Humboldt, Del Norte

East: Glenn, Butte, Plumas, Colusa, Sutter, Yuba, Nevada, Sierra, Placer

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Well-Baby Visits 0-15 Months
Health Equity Data from Partnership

NE	NW	SE	SW
51.18	49.21	53.50	68.90

NW

Hispanic	56.24
Unknown	51.05
White	47.76

NE

Hispanic	58.07
Unknown	50.34
White	52.10

75th%	61.19
50th%	55.72
25th%	49.88
below 25th%	

SW

Hispanic	72.44
Other	69.57
Unknown	64.52
White	63.56

SE

Black	56.52
Hispanic	54.66
Other	69.77
Unknown	48.97
White	49.15

The Partnership Northwest (NW) region overall has the lowest rates for the Well-Baby Visits. Northeast (NE) region all populations are under the 50th percentile with Hispanics at the 50th.

White population is below the 25th percentile in both the NW and Southeast (SE) regions.

Childhood Immunization Status Health Equity Data from Partnership

NE	NW	SE	SW
6.63	18.54	35.79	32.94

NW

Hispanic	18.63
Native American	10.53
Unknown	20.25
White	16.60

NE

Hispanic	11.11
Other	12.12
Unknown	6.02
White	6.50

75th%	42.09
50th%	34.79
25th%	28.95
below 25th%	

SW

Hispanic	38.23
Other	40.80
Unknown	28.05
White	18.11

SE

Asian Indian	45.16
Black	24.87
Filipino	51.61
Hispanic	39.16
Other	29.66
Unknown	37.92
White	21.05

The Partnership Northern Region overall has the lowest rates noting Native America and White populations being the lowest for each sub region.

White and Black population are below the 25th in the Southern Region.

Health Equity Data* from Partnership for Lead Screening in Children (Testing Only)

NE	NW	SE	SW
45.92	62.35	55.64	49.99

NW

American Indian an	62.22
Hispanic	69.31
Other/Unknown	65.13
White	52.52

NE

Hispanic	52.85
Other/Unknown	46.91
White	43.69

75th%	70.07
50th%	62.79
25th%	49.61
below 25th%	

SW

American Indian an	20.51
Asian/Pacific Island	53.66
Black	38.71
Hispanic	64.02
Other/Unknown	44.75
White	31.79

SE

Asian/Pacific Island	56.29
Black	39.09
Hispanic	63.73
Other/Unknown	54.20
White	46.56

**2023 Partnership Claims and Encounter Data Only (not QIP data).*
Reflects only members turning 2 years of age in 2023 *who have had at least 1 lead test completed by their 2nd birthday.*

Health Equity Efforts

County-specific or regional initiatives for addressing health inequities:

- Quality Project in Solano County to focus on improving frequency of well baby visits 0-15 months for Black/African American members.
- Two year pilot in Humboldt County with 18 Tribal Health Centers to improve birthing outcomes and newborn care.

Why Collect Language/Race/Ethnicity Data?

Capturing language/race/ethnicity data at the organization/clinic level may assist with:

- Identifying race/ethnicity related disparities
- Enhancing availability of interpreters and translated, health-education member-facing materials
- Adaptation of existing services to better meet the cultural and health needs of members
- Improved community relations
- Improve member-clinician communication
- Improve member satisfaction

Overview of Measures: QIP Specifications/ Tools and Resources

- Well Baby Visits 0-15
- Childhood Immunizations Status
- Lead Screening in Children

Well-Baby Visits First 15 months Measure Specifications

Description - The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life.

Denominator - The number of continuously enrolled Medi-Cal members who turn 15 months old between January 1 and December 31 of the measurement year (October 3, 2022 and October 2, 2023).

Numerator - The number of children in the eligible population with a least six (6) well-child visits with a PCP by the date of age 15 months.

14-Day Rule: ***There must be at least 14 days between each date of service for this measure.*** *For example, if the first date of service was competed on 12/1, the next date of service would have to be 12/15 (first date of service plus 14 days) or later.*

2024 PCP Measure Specifications link

https://www.partnershiphp.org/Providers/Quality/Documents/Perinatal%20QIP%202023-2024/2024%20PCP%20QIP%20Measure%20Specifications_Website%20Version_Final.pdf

Childhood Immunization Status Measure Specifications

Description - The percentage of children continuously enrolled, two years of age who had completed all vaccines according to the CDC recommended Child immunization schedule by their second birthday.

Denominator - The number of continuously enrolled Medi-Cal members who turn two years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2022 and December 31, 2022).

Numerator - The number of assigned children who have had all of the vaccines by their second birthday.

2024 PCP Measure Specifications link:

https://www.partnershiphp.org/Providers/Quality/Documents/Perinatal%20QIP%202023-2024/2024%20PCP%20QIP%20Measure%20Specifications_Website%20Version_Final.pdf

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Lead Screening in Children Measure Specifications

New in 2024 *(previously Unit of Service Measure)*

Description - The percentage of continuously enrolled children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

Denominator - The number of continuously enrolled Medi-Cal members within last 12 months, who turn two years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2022 and December 31, 2022).

Numerator - The number of assigned children who had at least one lead capillary or venous blood test on or before their second birthday.

2024 PCP Measure Specifications link

https://www.partnershiphp.org/Providers/Quality/Documents/Perinatal%20QIP%202023-2024/2024%20PCP%20QIP%20Measure%20Specifications_Website%20Version_Final.pdf

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Pediatric Unit of Services Measures

New in 2024 - *Early Admission of the Initial Flu Vaccine Series*

Denominator - Assigned members who turn one year of age during the prior and current measurement year (DOB between January 1, 2023 and December 31, 2024).

Numerator - Assigned members who received their 1st Influenza dose and completed their 2nd dose within 60 calendar days of the 1st dose, by their second birthday during the measurement year.

Thresholds - Incentive payment: $50 per early administration with completion of initial flu vaccine series.

- Assigned members two years of age who received their 1st initial Influenza dose and completed their 2nd dose within 60 calendar days of the 1st dose, by their second birthday during the measurement year.

2024 PCP Measure Specifications link

https://www.partnershiphp.org/Providers/Quality/Documents/Perinatal%20QIP%202023-2024/2024%20PCP%20QIP%20Measure%20Specifications_Website%20Version_Final.pdf

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Pediatric Unit of Services Measures

New in 2024 - Pediatric Group Visits for Ages 0-15 Months

Expanded current Peer Led measure to include Pediatric Group Visits.

Importance - Promote formation and implementation of cohorts by age that are devoted to a group timely completion of pediatric well visits.

Thresholds - The parent organization is eligible to earn $1,000 per group, maximum 15 groups.

- 50 minimum assigned members
- Groups meet minimum of four (4) times per year
- At least 16 Partnership total member visits per group

2024 PCP Measure Specifications link

https://www.partnershiphp.org/Providers/Quality/Documents/Perinatal%20QIP%202023-2024/2024%20PCP%20QIP%20Measure%20Specifications_Website%20Version_Final.pdf

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Pediatric Unit of Services Measures

*Continuing Measure - **Dental Fluoride Varnish Use***

Importance: Dental caries remains the most common chronic disease of childhood in the United States. Studies show that low-income children are often at higher risk for dental decay. Early detection of dental disease and opportunities for varnish application during annual check-ups are more likely to occur in the PCP office.

The American Academy of Pediatrics recommends children receive fluoride varnish treatments between two to four times a year until the age of five.

Numerator: Percentage of members 6 months to 5 years of age within the PCP, Family or Pediatric practice having at least one or more dental varnish applications during the Measurement Year.

Denominator: Assigned members aged 6 months to 5 years during the measurement year. (DOB between January 1, 2019 and July 1, 2024).

- Thresholds:
    1. Parent organization submission of proposed plan to implement fluoride varnish application in the medical office - $1,000 per parent organization.
    2. Minimum 2% of the sites assigned members must receive fluoride varnish. The incentive amount for reaching this threshold is $5 per application.

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Primary Care Provider (PCP) Quality Improvement Program

PCP QUALITY IMPROVEMENT PROGRAM

The Primary Care Provider Quality Improvement Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience

Contact Us

Email: QIP@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

PCP QIP Overview

To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

Learn More about the 2024 PCP QIP

New 2023 Equity Adjustment

Webinars

PCP QIP webinars

Upcoming Webinars and Trainings

On Demand Courses

Childhood Immunization Status Combo 10
FAQ: Primary Care Provider Quality Improvement Program (PCP QIP)

Question: What billing codes are captured to meet the Childhood Immunization Status?

Answer:
These billing codes can be found in eReports via the Diagnosis Crosswalk.

Question: Can we exclude members who have missed early required vaccinations?

Answer:
No, these members cannot be excluded.

Well-Baby Visits: FAQ - PCP QIP

Question: Are members assigned mid year to a Parent Organization included in their current measurement denominator?

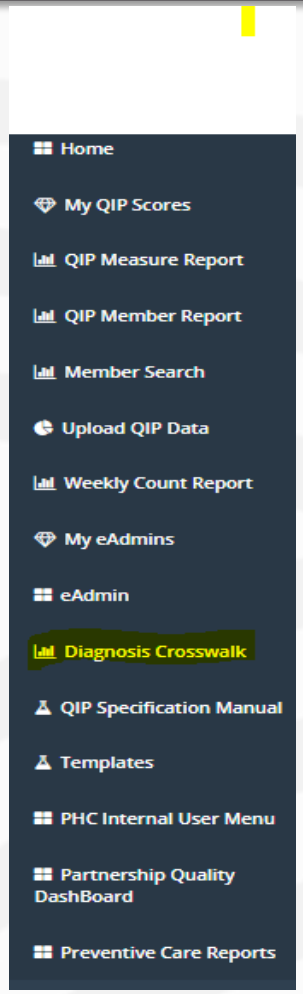
Answer: The member will remain in the denominator until continuous enrollment is applied. For members to remain in the denominator, they must be continuously enrolled within a Primary Care Provider parent organization, with continuous enrollment defined as member assignment for 9 out of the 12 months between January 1 and December 31 of the current measurement year.

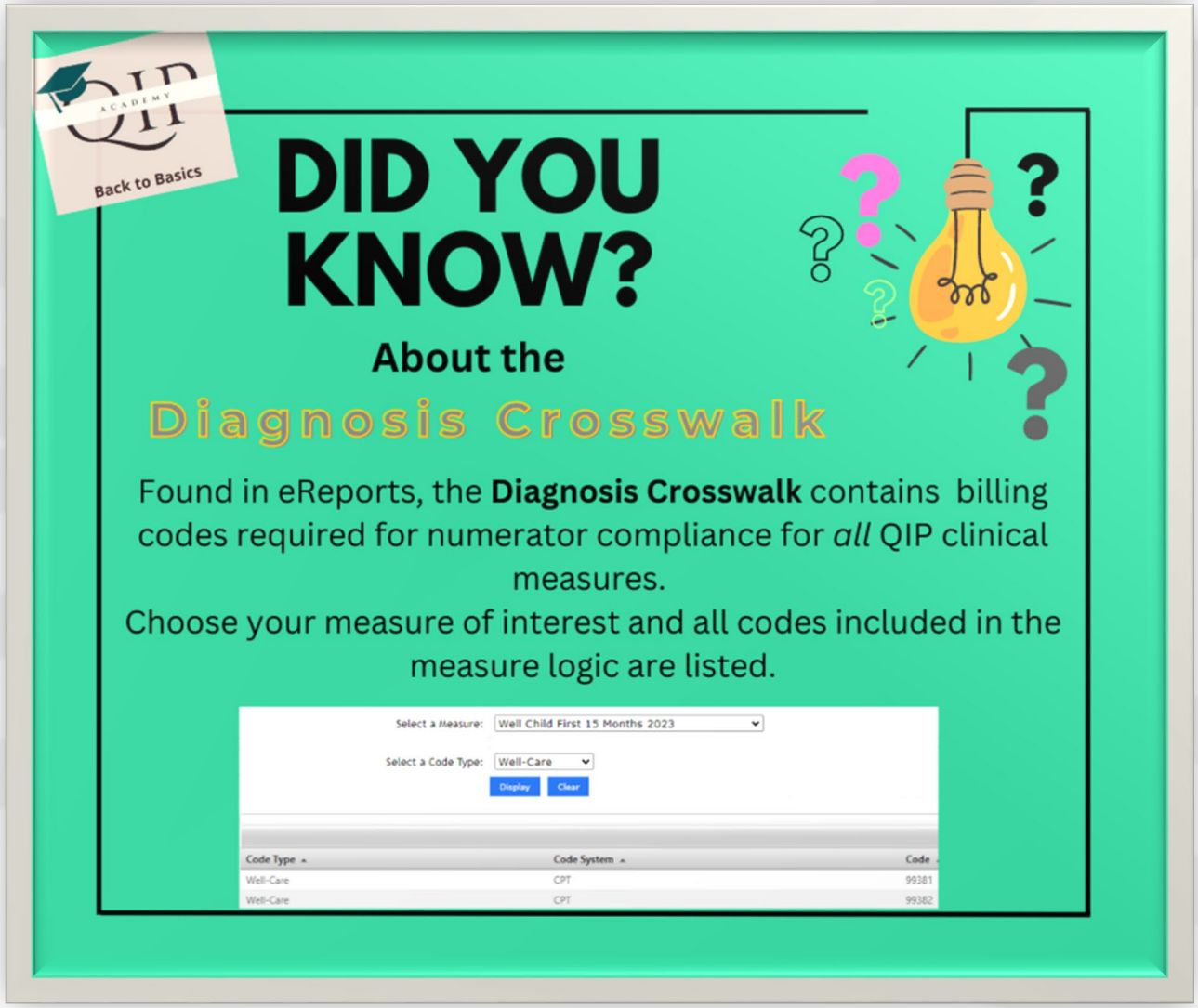
Question: How does a provider upload prior visits for a member that is newly assigned to them?

Answer: A provider is able to upload visits from a previous provider for QIP credit using the W15 upload template providing member CIN and WC visit date. Uploads would be completed in eReports.

Quality Incentive Program (QIP) Tools

eReports - Coding Questions





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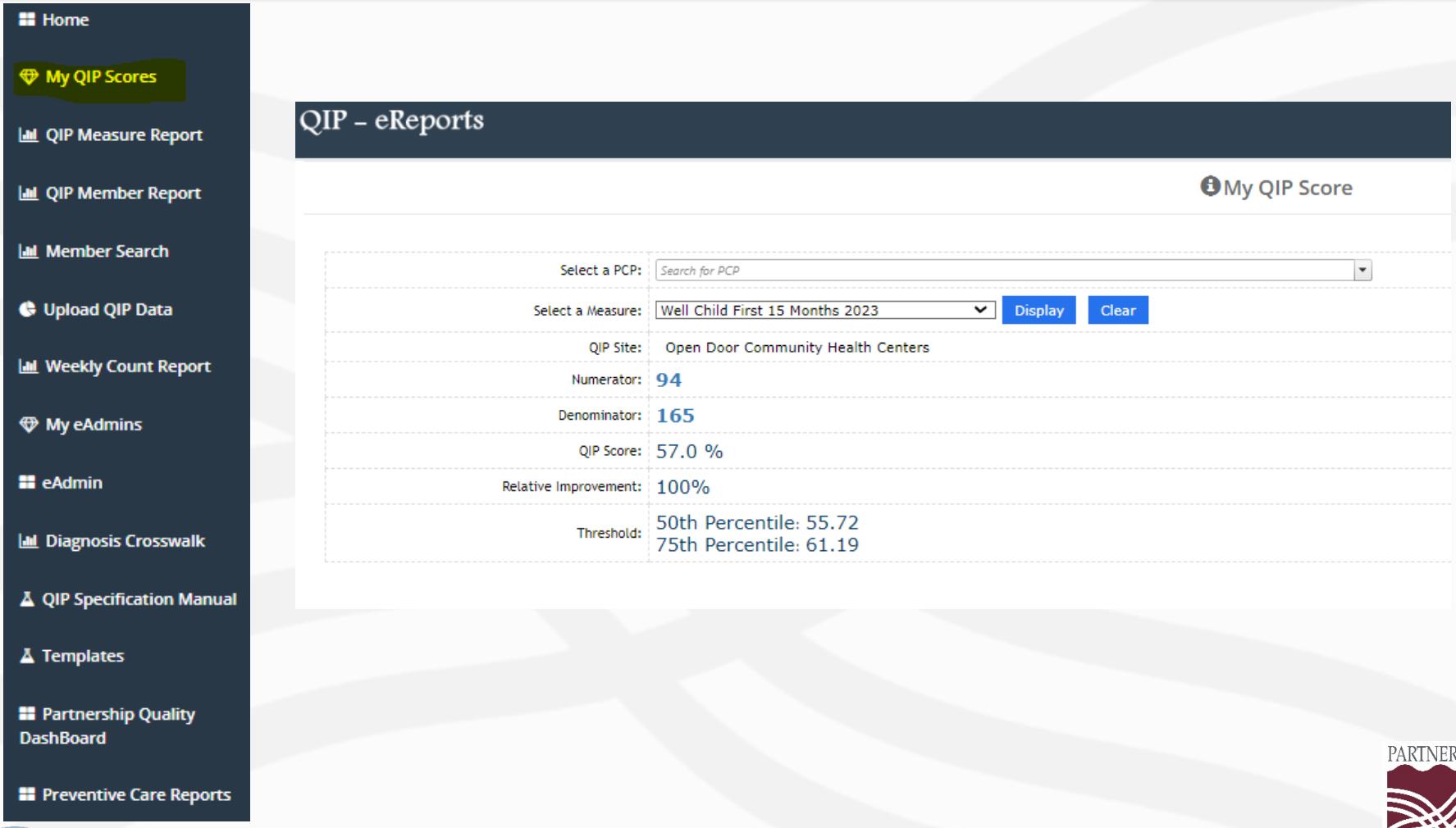
eReports - QIP Scores



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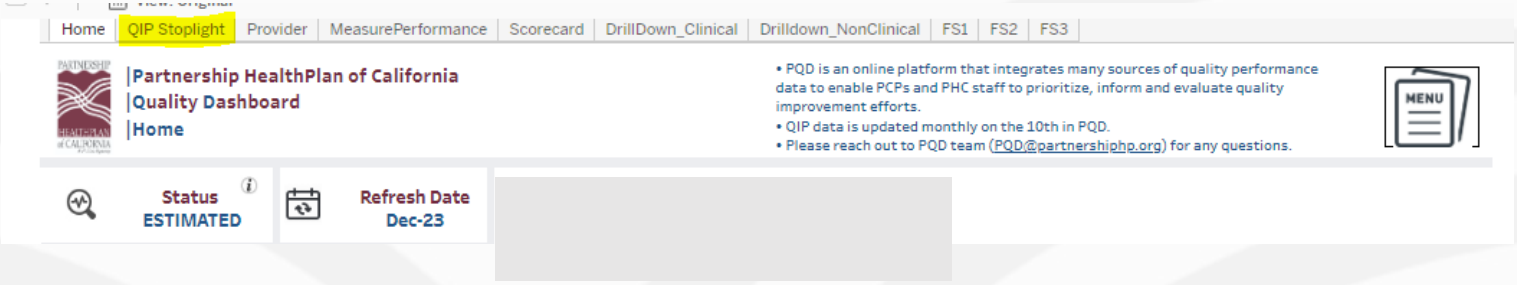
eReports: Partnership Quality Dashboard - QIP Stoplight Report

- Home
- My QIP Scores
- QIP Measure Report
- QIP Member Report
- Member Search
- Upload QIP Data
- Weekly Count Report
- My eAdmins
- Diagnosis Crosswalk
- QIP Specification Manual
- Templates
- Partnership Quality DashBoard
- Preventive Care Reports



QIP Stoplight

Refresh Date: December 2023

Target/Benchmark Filter: PCP QIP Full Points target

Gap Size & Dollars Remaining

< 10 From Target | < 30 From Target | > 30 From Target | Target Met

Measure	Total Org Gap	Total Org Num	Total Org Denom	Anderson Family Health Center (17323)	Enterprise Family Health Center (67777)	Shasta Community Health Center (27942)	Shasta Lake Family Health Center (27935)
Asthma Medication Ratio	3	248	356	2 $9,949	1 $4,764	0 $0	0 $0
Breast Cancer Screening	57	694	1,311	4 $4,975	0 $0	48 $160,209	5 $5,056
Cervical Cancer Screening	297	3,129	5,783	4 $29,847	0 $0	210 $160,209	83 $30,338
Child and Adolescent Well Care Visits	989	4,824	10,346	41 $9,949	0 $0	824 $240,314	124 $45,507

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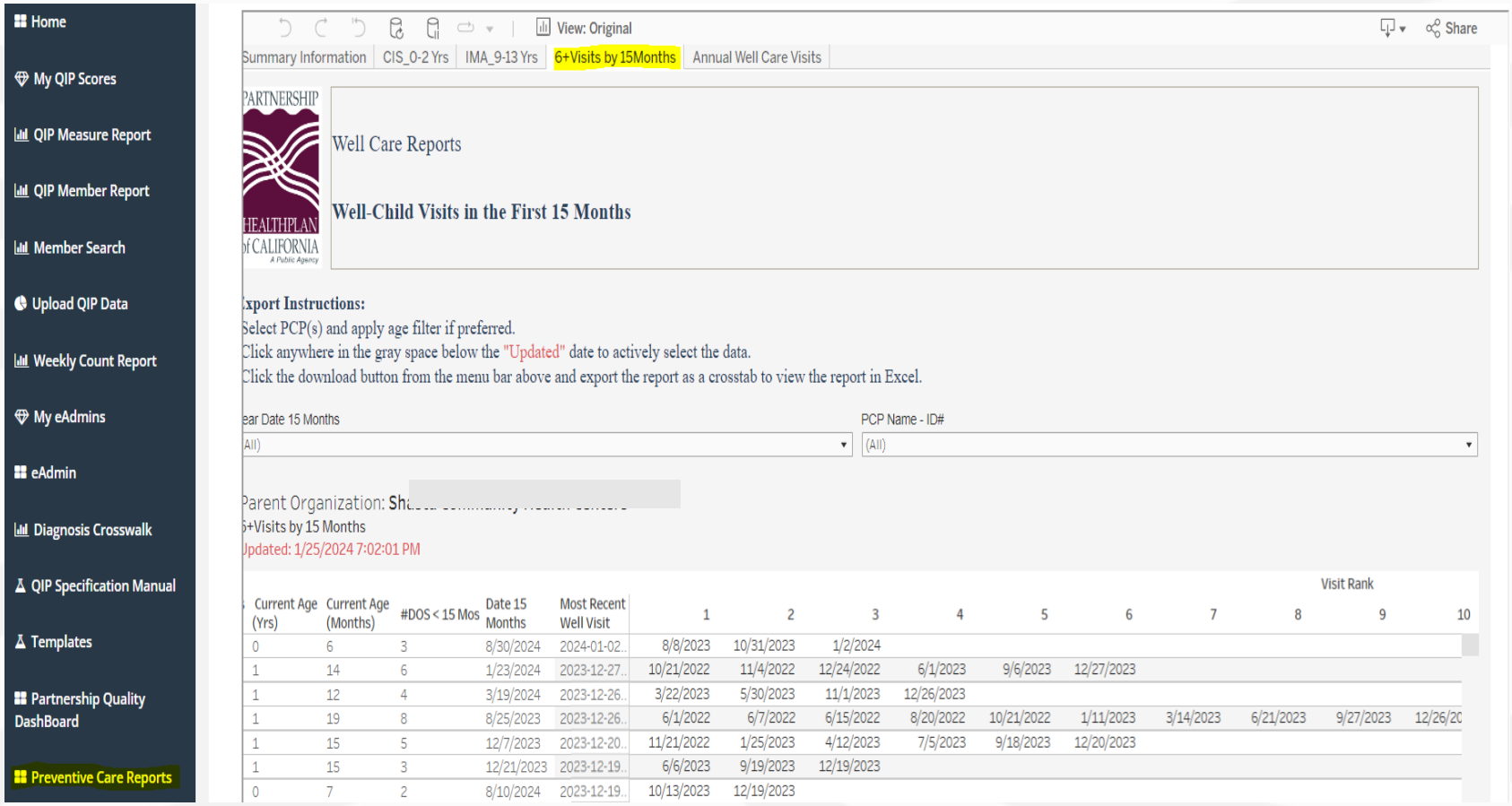
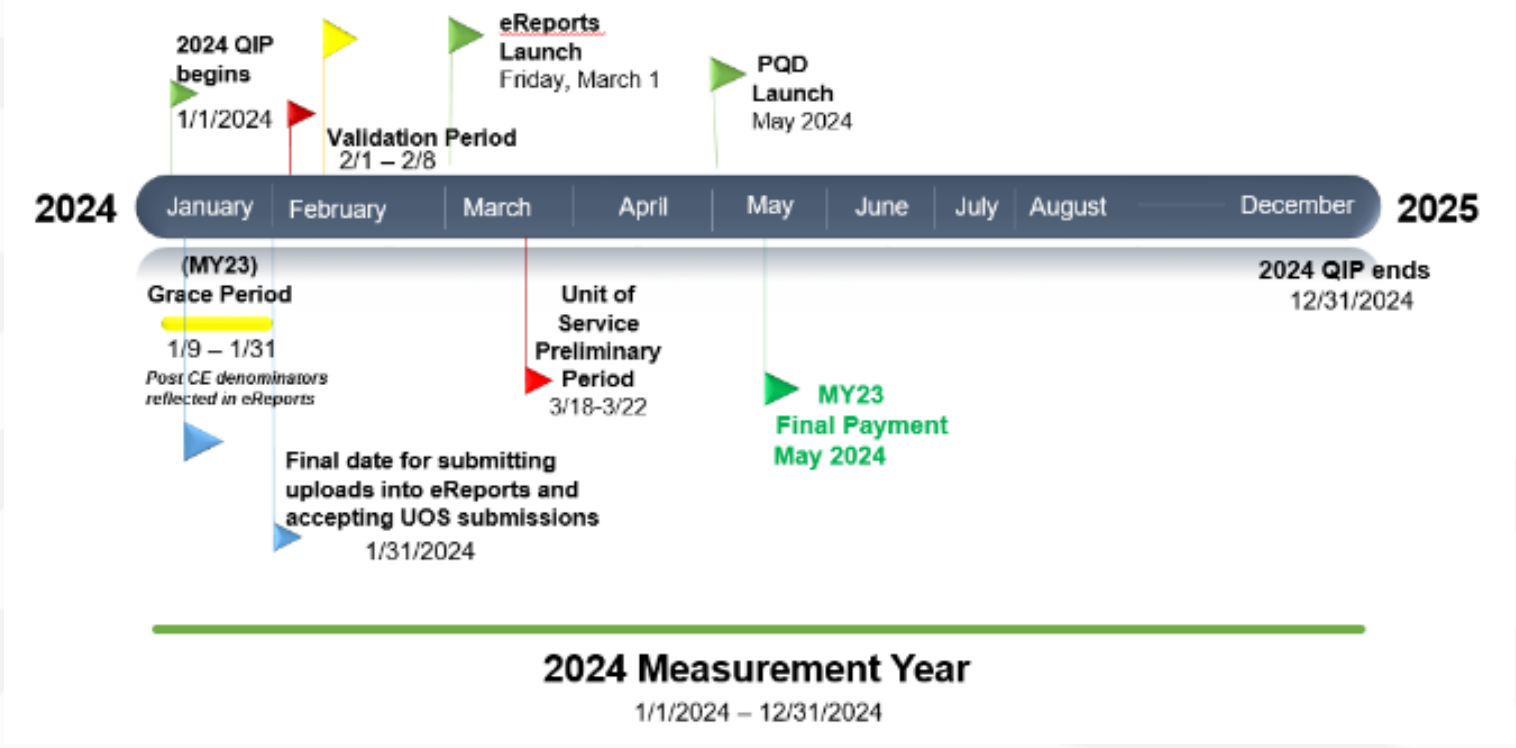
eReports: Pediatric Preventative Care Dashboard



- Use Reports to engage with members sooner, keep members on track with Immunization schedules and well baby visits.

Accessing Information

- eReports
- Partnership Quality Dashboard (PQD) User Guide
- 2024 PCP QIP Specifications



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Putting Quality Into Practice

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Measure Best Practices

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MEASURE BEST PRACTICES

The 2024 Measure Best Practices documents are resources for the Primary Care Provider Quality Improvement Program (PCP QIP) measure set, which aligns closely with the Managed Care Accountability Set (MCAS) measures for which Partnership HealthPlan of California is held accountable by the Department of Health Care Services (DHCS). Each Measure Best Practice document includes Partnership tools and resources, guidelines to facilitate optimal member care, opportunities for patient education, outreach, and equity, data and coding resources, and helpful links to improve measure performance.

- Breast Cancer Screening
- Cervical Cancer Screening
- Child & Adolescent Well Care
- Childhood Immunizations Status ★
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Comprehensive Diabetes Care: HbA1c - Good Control
- Comprehensive Diabetes Care: Retinal Eye Exam
- Immunizations for Adolescents
- Lead Screening for Children ★
- Unit of Service Dental Flouride Varnish ★
- Well Child Visits 15 Months ★

2024 Best Practices
Well-Child Visits (First 15 months of Life)

Best and Promising Practices

Partnership Tools and Programs

- The **Preventative Care Report** is continuously available in the eReports portal and is updated daily. This dashboard shows each provider's member list for the Well Child Visit (Birth to 15 Months) measure denominator, along with dates for each completed visit and other information for scheduling Well Child Visits. Use this dashboard to track, schedule and complete six (6) Well Child Visits before each child turns 15 months old.
- The **Preventative Care Report** now contains race/ethnicity and language fields. Use this dashboard to look at Well Child Visit (Birth to 15 Months) completion rates by race/ethnicity and language to learn more about inequities within your patient community.
- Attend or view Partnership's Improving Measure Outcomes training on *Preventative Care for 0-2 Year Olds.*
- Partnership members can access transportation for non-emergency medical services for assistance in traveling to and from appointments. Members can access services by calling Partnership Transportation Services at (866) 828-2303 Monday – Friday 7 a.m. – 7 p.m. PST.

Measure Best Practices

Short-term Strategies/Easy Wins

- Missed opportunities - View every visit as an opportunity to complete a well-child exam or offer immunizations.
- Utilize back office and/or scribes to check and schedule well-child visits.
- Actively pursue missed appointments within 48 hours with a reminder call by staff member.
- Communicate with families when immunizations are due (reminders) or late (recall) via portal, texts, and/or calls.

Measure Best Practices

Short-term Strategies/Easy Wins (Continued)

- Utilize front office staff to check well-child visits and immunization status during all visits and when communicating by phone with members.
- Schedule the 6th well-child visit appointment prior to the child turning 15 months of age. eReports Preventative Care dashboard is a great tool to track visits.
- Schedule next appointment before the member/patient leaves the office or while “waiting” to be seen by the provider (e.g., in the exam room).
- Consider converting from a three-part Rotavirus series to a two-part series, which streamlines completion of the Rotavirus series for providers and patients.

Measure Best Practices

Long-term Strategies

- Appoint a well-baby visit/immunization panel and outreach manager.
- Offer extended evening hours or weekend hours to accommodate work and school schedules.
- Use dedicated rooms for acute visits and well-care visits.
- Train front office staff on well-child visits and immunization periodicity.
- Offer immunization-only visits or walk-in services to reduce need to make an appointment

Measure Best Practices

Long-term Strategies (Continued)

- Offer Vaccines For Children (VFC) coverage to allow services to be given to any child.
- Establish a formal practice commitment to well-child visits and immunizations.
- Promote staff consistency with offering immunizations. It may take several conversations with families before they agree to complete vaccinations.
- Use California Immunization Registry (CAIR), ideally with a bi-directional interface between CAIR and the practice's EHR. Resources for practices can be found at http://cairweb.org/how-cair-helps-your-practice/

Measure Best Practices

Strategies with a Health Equity Focus

- View vaccination rates and well-baby visits by race, ethnicity, location, and preferred language, it is possible to identify barriers that affect specific communities, and plan interventions to address these barriers.
- Ensure information is consistent, welcoming, in plain, person-centered language, appropriate, and delivered in traditional and electronic applications (based on patient preference).
- Have a conversation with caregivers to confirm that vaccination and well-baby information and next steps covered in the visit are mutually understood and caregivers were given the opportunity to ask questions.

Measure Best Practices

Strategies with a Health Equity Focus (Continued)

- Use approaches and partnerships that align with your practice's demographics (partner with local schools, faith-based organizations).
- Identify and address barriers to care (transportation, hours of operation, child care).
- Stratifying data (zip code, race, ethnicity, etc.)

Voices from the Field

Valerie Padilla, Director of Quality

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PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

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Improving Pediatric Care

Ages 0-2

Valerie Padilla | Director of Quality
February 14, 2024| Voices from the Field

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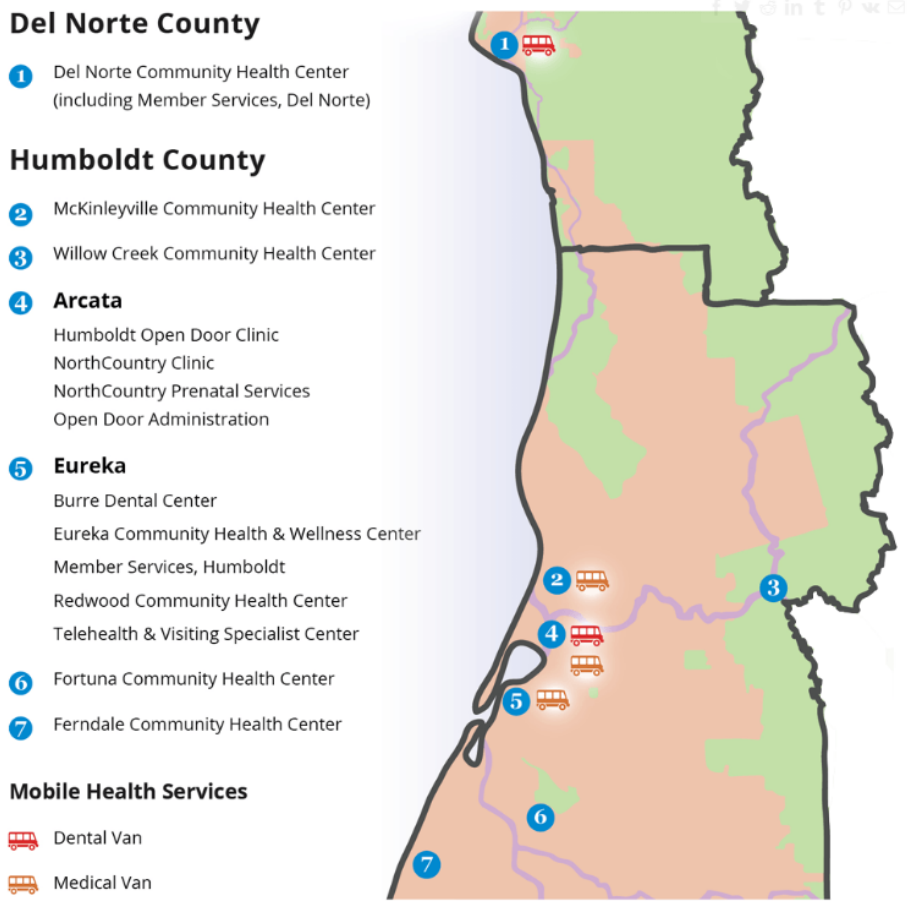
Community Health Centers

Background

- Founded in 1971
- Staff: 800
- Patient Population: 62,000 in 2 counties
- Service area: size of Connecticut
- EMR: OCHIN EPIC
- 12 health care delivery locations
- Services
  - Medical
  - Dental & Dental Residency
  - Behavioral Health
  - Gynecology & Pregnancy
  - Mobile Medical & Dental
  - Residencies: Dental, Family Medicine, and Advanced Practice Clinician (APC)
  - Specialty Services



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Pediatric Well Care (0-2 years)

- Infant Well Care
- Childhood Immunization
- **New!** Blood Lead Screening in Children

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Infant Well Care

Best Practices

- Patient lists to care teams EARLY
- Assign patient lists to a specific staff person/team
- Leverage EHR reminder list functions to manage next appointments
- Schedule appointment during robust confirmation calls or before leaving
- Train providers to code hospital follow up as a Well Visit
- Improve transition of care workflows between pregnancy services & primary care
- After hours or weekend well exam clinics

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Infant Well Care

Challenges

- Consistent working lists
- Training Care Teams to EHR reminder workflow
- No shows
- Provider and Care Team burnout
- 1st and 2nd well visits billed through Mom & not captured in claims via eReports
- Developing accurate upload reports with internal BI team

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Immunizations

Best Practices

- Patient lists to care teams EARLY
- Assign patient lists to a specific staff person/team
- Leverage EHR reminder list functions to manage next appointments
- Assess immunization only appointment access often
- Schedule flu #2 before leaving health center
- Offer vaccines at EVERY opportunity

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Immunizations

Challenges

- Vaccine hesitant population
- Flu declined by many
- Flu #2 not administered
- Vaccines given after 2nd birthday
- Developing accurate upload reports w/ internal BI team

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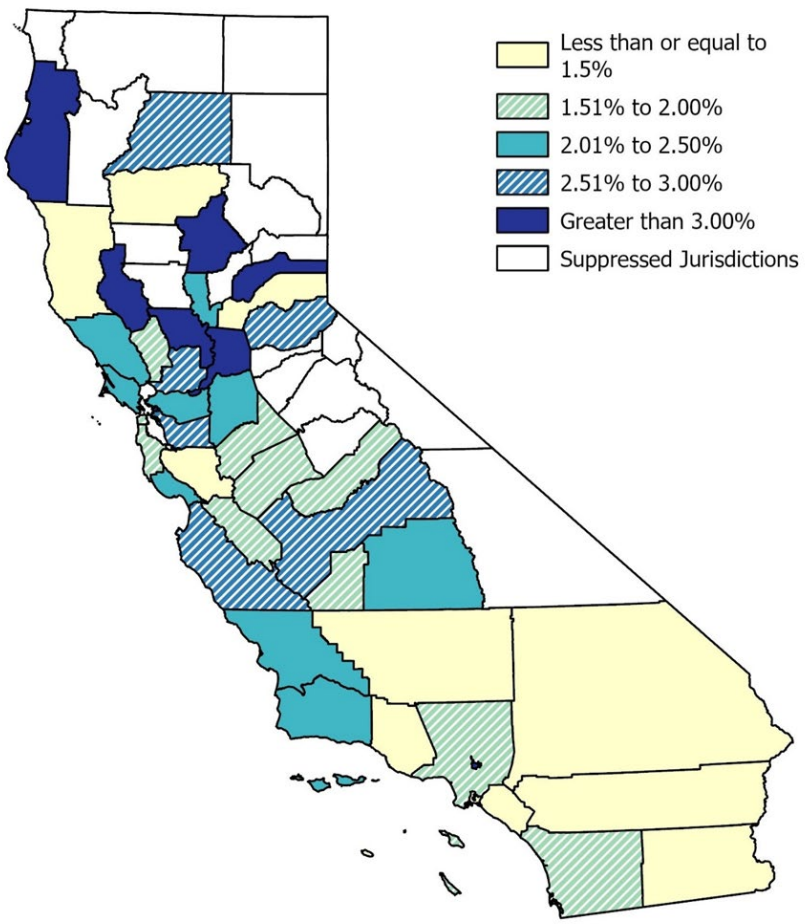
Blood Lead Screening

Best Practices

- Screen at 9 months (no vaccines typically)
- Use capillary testing
- Partner with Public Health Department



% of Children Under 6 years old with a blood lead level of 3.5 micrograms per deciliter (µg/dL) or greater, by California Local Health Jurisdiction, 2021, CDPH

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Blood Lead Screening

Challenges

- Capillary testing recalls & supply shortages
- Inconsistent workflows across health centers

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What's Next?

Well Care & Immunizations

- Improve next visit scheduling
- Systemize workflow for flu #2 reminders
- Testing direct education/communication with a provider

What's Next?

Blood Lead Screenings

- Implement Point of Care (POC) testing at Del Norte health center
- Consistent data review

All measures

- Missed opportunity report

Questions?

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Upcoming Trainings:
Improving Measure Outcomes Webinar Series

Improving Measure Outcomes Webinar Series: February - April 2024

Target Audience: Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.
The ***Improving Measure Outcomes Webinar Series*** allows Quality Improvement teams to make knowledge actionable, improving quality service and clinical outcomes around specific measures of care.

These learning sessions will cover Partnership's Primary Care Provider Quality Incentive Program measures. Content will focus on direct application on best practices including eliminating health disparities with examples from quality improvement teams who are doing the work.
CME/CEs are available.

Sessions will be offered during the lunch hour and will be approximately 60 minutes in length. CME/CEs will be offered for live attendance.

Planned 2024 sessions include:
- February 28, 2024 - Preventative Care for 3 - 17 Year Olds
- March 13, 2024 - Chronic Disease
- March 27, 2024 - Diabetes Management
- April 10, 2024 - Women's Cancer Screenings
- April 24, 2024 - Women's Sexual and Reproductive Health

Registration: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: improvementacademy@partnershiphp.org

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Upcoming Trainings:
ABCs of QI In-Person Training - May 1

ABCs of Quality Improvement

Wednesday, March 20 - 8:30 a.m. to 4:30 p.m. - **IN PERSON**
McConnell Foundation
800 Shasta View Drive - Redding
Breakfast and lunch included for attendees

Wednesday, May 1 - 8:30 a.m. to 4:30 p.m. - **IN PERSON**
Enloe Health
1531 Esplanade - Chico
Breakfast and lunch included for attendees

The ABCs of Quality Improvement (QI) is a one day in person training designed to teach you the basic principles of quality improvement.

The course is designed for clinicians, practice managers, quality improvement team members, and staff who are responsible for participating and leading quality improvement efforts within their organization. Excellent refresher course for repeat attendees or skill-builder for new quality professionals.

CME/CEs available.
Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: improvementacademy@partnershiphp.org

Evaluation

Please complete your evaluation. Your feedback is important to us!

Contact Us

Regional Medical Director:

Jeff Ribordy, MD

jribordy@partnershhp.org

QI/Performance Team:
ImprovementAcademy@partnershiphp.org

Reference Materials

- Bright Future Guidelines (American Academy of Pediatrics)
  www.brightfutures.org
- Center for Disease Control
  www.cdc.gov
- American Academy of Pediatrics
  www.aap.org
- California Immunization Registry
  https://www.cdph.ca.gov/Programs/CID/DCDC/CAIR/pages/cair-updates.aspx

Reference Materials

Partnership Offerings and Materials

- Lunch and learn sessions for measure specific questions
- Well-Child Visit member facing information on our website
  - Includes “what is a well-child visit”, schedules and assessments, immunization information, developmental milestones, transportation resources, and more.