



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.

Member Care

- Well Child Visits should be completed as in-person visits. Only in-person Well Child Visits will be counted towards the PCP QIP numerator in 2024.
- Every visit can be viewed as an opportunity to complete a well-child exam, including newborn weight check visits, or sick visits when appropriate. Newborn weight check visits can be converted into Well Child Visits when it has been more than 14 days since the last Well Child Visit.
- Use dedicated rooms for acute visits and well-care visits. Practices with multiple offices may consider using one location for well-visits and a different location for acute visits.
- Appoint a Pregnancy and Well Baby panel manager.
- Document and train clinical and front office teams on newborn intake workflows.
- Train front office staff on Pediatric Preventative Health Care [Periodicity Schedule](#).
- Utilize back office staff and scribes to check and schedule Well Child Visits when patient is in exam room. At minimum, schedule next appointment (if possible) before

the patient leaves the office. Have parent/caregiver address appointment reminder card in own handwriting.

- Confirm all appointments one day prior to the appointment, using text messages or phone calls. Actively pursue missed appointments within 48 hours with reminder call by staff member.
- Schedule the sixth well-child visit appointment prior to the child being 15 months of age.
- Use standardized templates in EMRs/EHRs to guide providers and staff through the visit to ensure all components were met and documented.
- Offer extended evening or weekend hours to accommodate work and school schedules.
- Have families complete “pre-work” forms in advance of visit via telephone or member portal.
- Age-appropriate anticipatory guidance handouts can be found on the [Bright Futures website](#).
- Physical and mental development history must include progress towards age-appropriate milestones; “development appropriate for age” is not sufficient documentation.
- Health history can be obtained by documenting review of allergies, medications, immunizations, chronic illnesses, standardize practice to review on each visit.

Screenings and Immunizations:

- Offer families one-page handout outlining well baby visit schedule, including immunization and screening milestones, in appropriate languages.
- Promote and emphasize importance of each well child visit’s milestones and importance, especially those visits that do not require immunizations.
- Train provider teams annually on the completion of the developmental screening tool used by your practice, and monitor completion rates. Developmental screening must be completed at every well child visit.
- Train provider teams to complete dental fluoride varnish treatments as part of their Well Child Visit from 6 months of age. The **Unit of Service Dental Fluoride Varnish Best Practices** document contains more information.
- All children on Medi-Cal must complete a blood lead test. Include blood lead testing completion and coding steps in EMR templates for 12-month and 24-month well child visits. The **Lead Screening for Children Best Practices** document contains more information on this required test for all children on Medi-Cal.

Equity Approaches:

- Consider using an equity approach to increase screening rates for targeted communities. By looking at Well Child Visit (Birth to 15 Months) measure compliance rates by such factors as race, ethnicity, location (i.e., zip code), and preferred

language, it is possible to identify barriers that affect specific communities, and plan interventions to address these barriers.

- Ensure member information is consistent, welcoming, plain and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Have a conversation with caregivers to confirm that health information and next steps covered in the visit are mutually understood, caregivers agree with any plans made, and the caregivers were given the opportunity to ask questions.
- Identify and address barriers to care (transportation, hours of operation, child care).
- Use approaches and partnerships that align with your practice's demographics (partner with local schools, faith-based organizations).

Data and Coding

- Ensure proper documentation of all components in the medical record for each visit where preventive services are addressed.
- Submit claims and encounter data within 90 days of service. We highly encourage submitting claims within 14-to-30 days of service toward the end of the measurement year period to avoid claims lag.
- Use complete and accurate codes to capture services completed for in-person visits.
- Establish or update EMR / EHR templates to accurately reflect coding for visit reason and diagnosis.

Helpful Links:

[2024 PCP QIP Technical Specifications](#)

- [Measure Description](#)
- [Exclusions](#)
- [PCP QIP Full Points, Partial Points, Relative Improvement Definitions](#)
- [Notes for eReports and PQD](#)

[QIP eReports Portal:](#)

- [Measure Reports](#)
- [Diagnosis Code Crosswalk Report](#)
- [QIP Member Report](#)
- [Preventative Care Report](#)