Improving Measure Outcomes:

Preventative Care for Children Ages 0 - 30 Months

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Overview of Clinical Guidelines for Pediatric Preventive Measures (0 - 30 months)

- Well-Baby Visits 0 - 30 Months
- Child Immunization Status
- Topical Fluoride for Children
- Lead Screening in Children

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Learning Objectives

Improving Measure Outcomes: Preventative Care for 0 - 30 Months

- **Define the clinical background, specifications, and performance threshold definitions of the 2025 Primary Care Provider Quality Improvement Program Specifications**: *Well-Child Visits for the First 30 Months of Life*, *Childhood Immunizations Status, Blood Lead Screening* and *Topical Fluoride in Children* 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 topical fluoride in children.

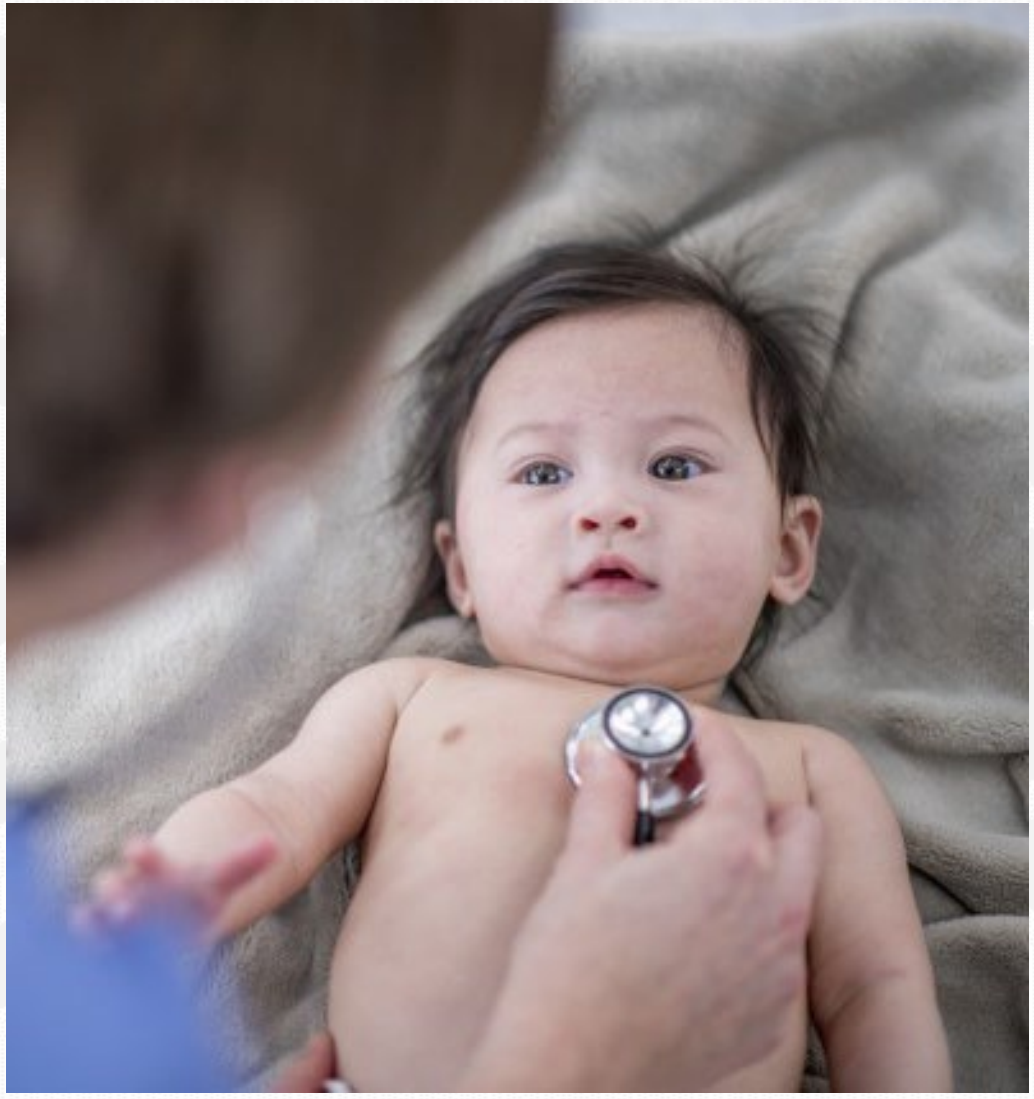
- **Understand best practices** to ensure delivery of blood lead screening in children and topical fluoride, including justification for its inclusion in preventative care for 0 - 30 months.

Learning Objectives - Continued

- **Recognize the minimum five components that are necessary for clinical standard practice** for the well-child visits for 0 - 30 months.

- **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 - 30 months.

Childhood Immunization Status



Why It Matters

- Childhood vaccines **protect children from several 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/?CDC_AAref_Val=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.

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.**

- **Consider administering the 2-dose series (Rotarix)** instead of the 3-dose series (Rotateq) to improve your series completion rates.

Well-Baby Visits

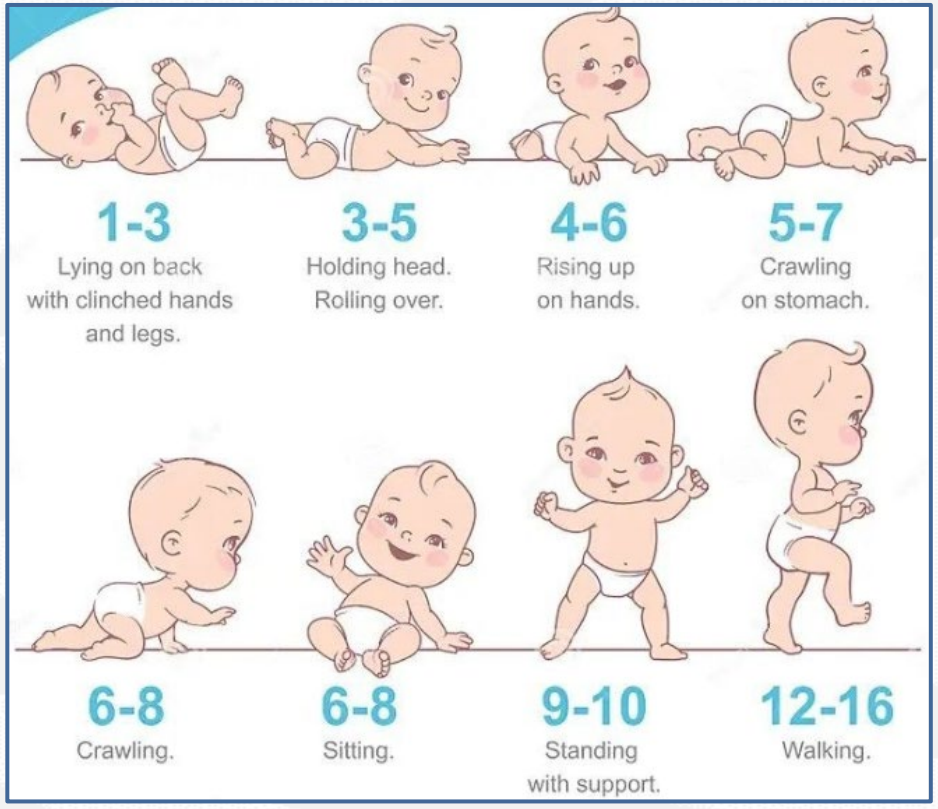
Why It Matters

- 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 - 30 Months Periodicity

When should newborns be scheduled for a visit with their PCP?

- Initial newborn visit
- 2 weeks
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months



Bright Futures Periodicity Guidelines - www.brightfutures.org

Components of a Well-Child Visit

1. **Health history:** allergies, medications, and immunizations documented on different dates of service as long as **all** are documented within the measurement year.
2. **Physical developmental history:** must mention specific development appropriate for age- scooting, creeping or crawling, may stand with support, etc.
3. **Mental developmental history:** must mention specific age-appropriate mental developmental milestones – finds hidden objects, looks at or points to a picture when you name it, bangs, throws, and shakes things to see what happens.
4. **Physical exam**.
5. **Health education/anticipatory guidance*:*** **information (with discussion)** is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face – tobacco exposure, auto safety.

Topical Fluoride Varnish

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

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.

Lead Screening (Testing) in Children

- Children 6 months to 6 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://tinyurl.com/CDCLeadPoisoningPrevention

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://tinyurl.com/BloodLeadScreening

Overview of QIP Specifications

- Well-Baby Visits 0 - 15
- Well-Baby Visits 15 - 30 months
- Childhood Immunizations Status
- Lead Screening in Children
- Topical Fluoride in Children

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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 (DOB between October 3, 2023, and October 2, 2024).

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.*

2025 PCP Measure Specification Manual

Well-Baby Visits 15 - 30 Months
Measure Specifications

New Measure in 2025

Description - The percentage of continuously enrolled Medi-Cal members who turned 15 months and one day - 30 months old during the measurement year and had two (2) or more well-child visits.

Denominator - The number of continuously enrolled assigned members who turn 30 months old during January 1 and December 31 of the measurement year (DOB between July 1, 2022, and July 30, 2023).

Numerator - The number of children in the eligible population with two (2) or more well-child visits on different dates of service between the child's 15-month birthday plus one (1) day and the 30-month birthday.

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.*

Pediatric Practice QIP Clinical Measure
Family Practice QIP Monitoring Measure only

2025 PCP Measure Specification Manual

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 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2023, and December 31, 2023).

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

Vaccines:

DTaP	MMR	HepB	PCV	RV
IPV	HiB	VZB	HepA	Flu

2025 PCP Measure Specification Manual

Lead Screening in Children Measure Specifications

Description - The percentage of continuously enrolled children 2 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 365 days, who turn 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2023, and December 31, 2023).

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

2025 PCP Measure Specification Manual

Monitoring Measures

The Monitoring Measurement Set is a separate and distinct measurement set that does not have any points assigned to each measure.

The intent of this set is to provide visibility to your performance and access to the member gap-in-care list throughout the measurement year.

Topical Fluoride in Children Measure Specifications

New Measure in 2025

Description - The percentage of members 1 to 4 years of age who received at least two fluoride varnish applications during the measurement year.

Denominator - The number of continuously enrolled Medi-Cal members 1 to 4 years of age as of December 31 of the measurement year (DOB between December 31, 2021, and December 31, 2024).

Numerator - The number of assigned children who had two or more fluoride varnish applications during the measurement year, on different dates of service.

Monitoring Measure only

2025 PCP Measure Specification Manual

Unit of Service Measures

Payment is independent of, and distinct from, the financial incentives a site receives from the core measurement set.

A PCP site receives payment according to the measure specifications if the requirements for at least one (1) unit of service measure is met.

Pediatric Unit of Services Measures

Early Admission of the Initial Flu Vaccine Series

Denominator - Assigned members who turn 7 months to 15 months of age during the current measurement year (DOB between October 2, 2024, and May 31, 2025).

Numerator - Assigned members who received their 1st Influenza dose and completed their 2nd dose within 60 calendar days of the 1st dose, between their 7 and 15 month birthday during the measurement year.

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

Pediatric Unit of Services Measures

Updated in 2025 - ***Pediatric Group Visits for Ages 0 - 30 Months***
Expanded current measure from 15 to 30 months.

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 times per year
- At least 16 Partnership total member visits per group

QIP Tools and Resources

- Landing Page
- Frequently Asked Questions
- QIP Dashboard

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 2025 PCP QIP

Equity Adjustment - PCP QIP Payment Methodology

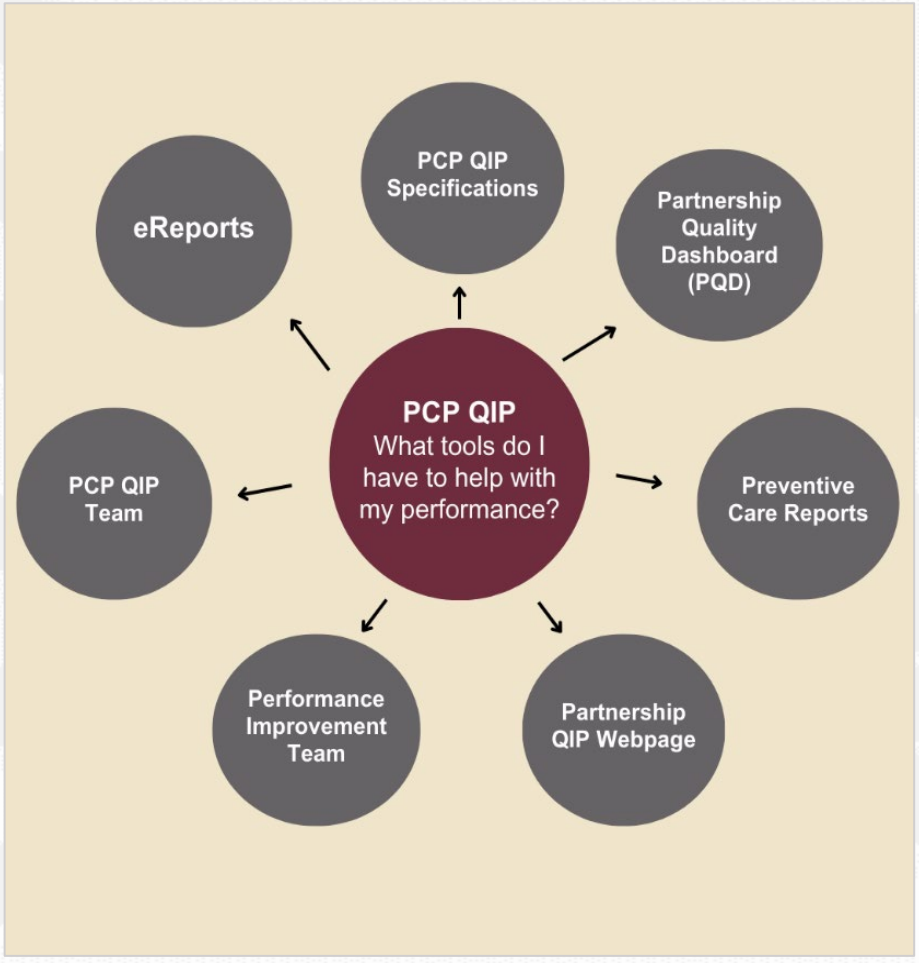
Webinars

PCP QIP webinars

Upcoming Webinars and Trainings

On Demand Courses

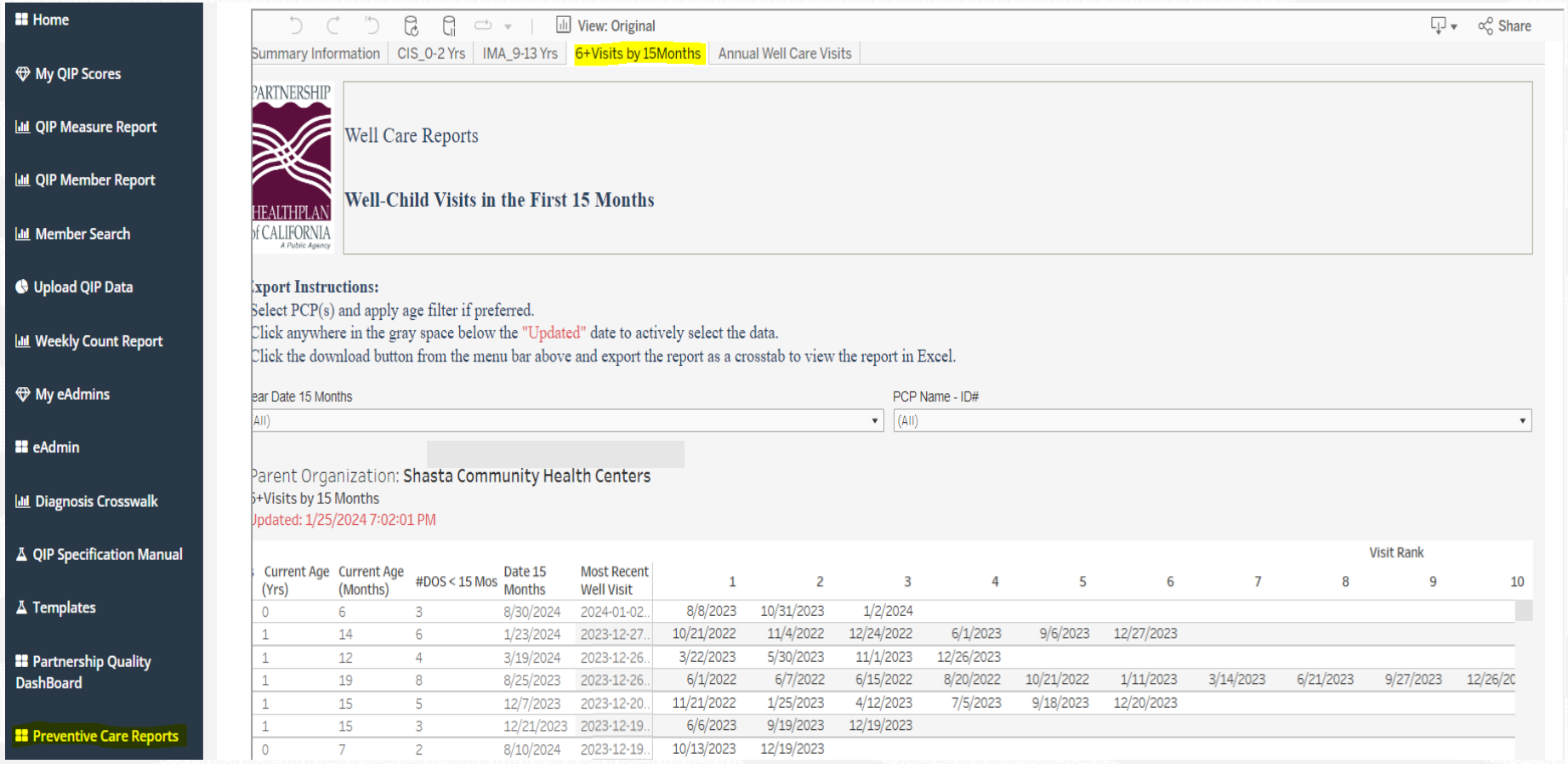
Quality Incentive Program (QIP) Tools



Tools and Resources

- 2025 PCP Measure Specification Manual
- PQD User Guide
- Preventive Care Reports User Guide
- PCP QIP Webpage
- eReports

eReports: Pediatric Preventive Care Dashboard



Use eReports to engage with members sooner to keep members on track with immunization schedules and well-baby visits.

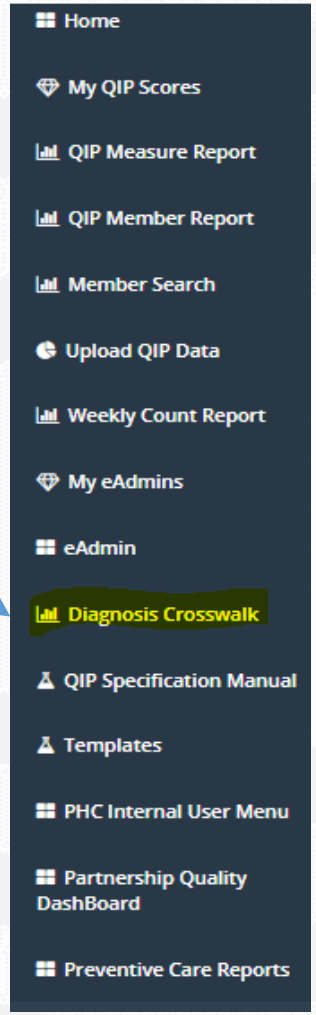
Childhood Immunization Status Combo 10
FAQ: Primary Care Provider Quality Improvement Program

1. **What billing codes are captured to meet the Childhood Immunization Status?**

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

2. **Can we exclude members who have missed early required vaccinations?**

   No, these members cannot be excluded.



Well-Baby Visits Frequently Asked Questions

1. **Are members assigned mid year to a Parent Organization included in their current measurement denominator?**

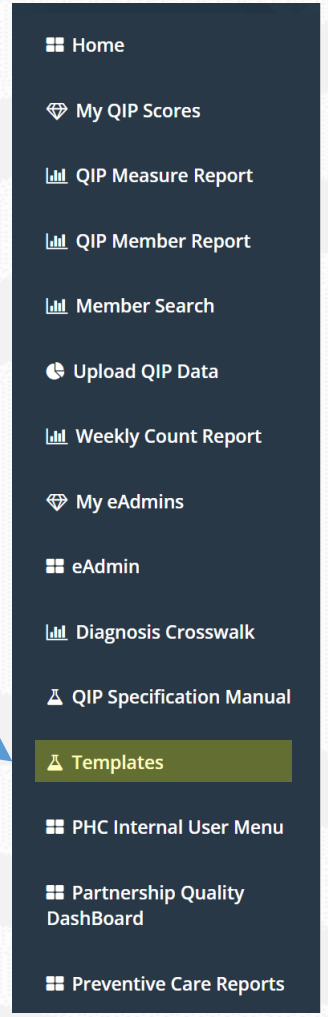
Yes, members may be assigned mid year and added to the current measurement denominator. The member will remain in the denominator until continuous enrollment is applied.

Continuous enrollment is defined as member assignment for nine out of the 12 months between January 1 and December 31 of the current measurement year.

Well-Baby Visits Frequently Asked Questions

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

A provider can upload visits from a previous provider for QIP credit using the Well-Child upload template found in eReports. The template will ask you to provide member CIN and Well-Child visit date.



Putting Quality Into Practice

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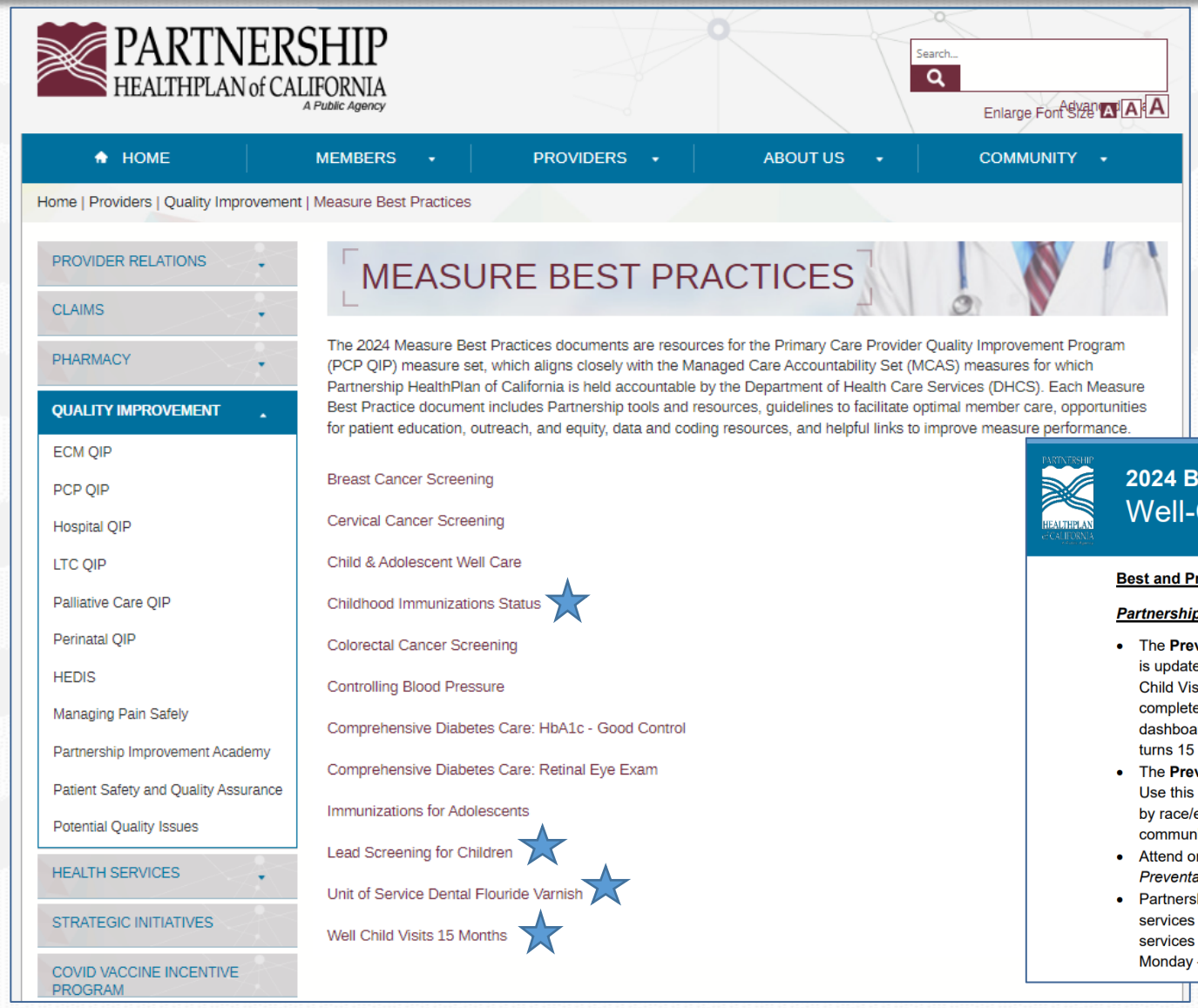
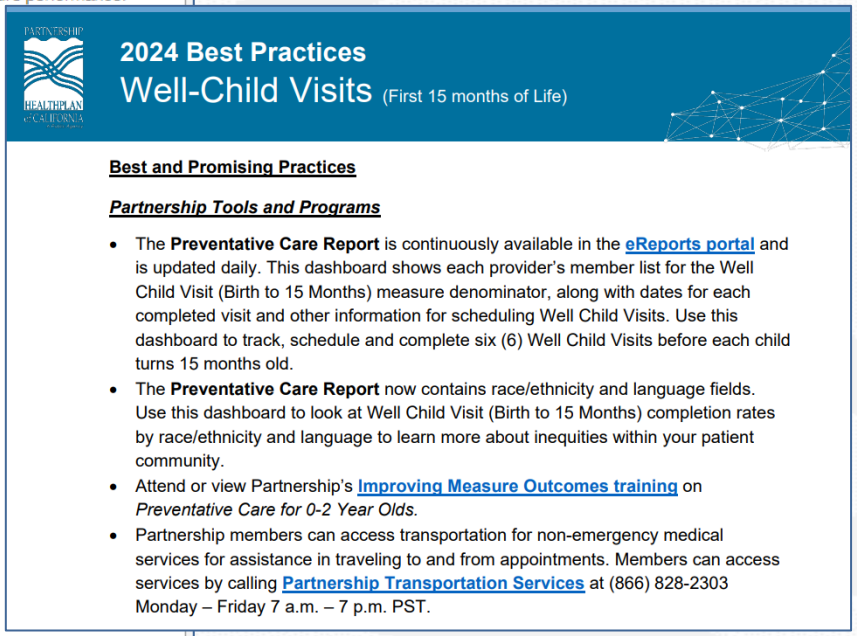
Measure Best Practices





2025 Measure Best Practices coming soon

Measure Best Practices: Short-Term Strategies

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

Measure Best Practices: Short-Term Strategies

- Utilize front office staff to check well-child visits and immunization status during all visits and when communicating by phone with members.
  (ePrompts is a great tool to help staff easily access Partnership members' clinical preventive screenings for which the member is due at the same time they are checking the members' eligibility.)

- 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.

- Consider converting from a three-part Rotavirus series to a two-part series, which streamlines completion of the Rotavirus series for providers and patients.

- Encourage patients to register for the Growing Together Program.

Growing Together Program

The Growing Together Program supports members during and after pregnancy, and children from birth up to age three. This program is offered to Partnership members at no cost.

- **The Prenatal Program – earn up to $50 in gift cards!**
  This program encourages early prenatal care. Members will receive a $25 gift card for getting their flu vaccine while pregnant, and another $25 gift card for getting their Tdap vaccine between 27 weeks and delivery. Call us to join as soon as you know you are pregnant.

- **The Postpartum Program – earn up to $100 in gift cards!**
  This program encourages postpartum and well-baby visits. Members will receive a $50 gift card for each of their 2 postpartum exams ($100 total) between 7 to 84 days after delivery.

Growing Together Program

- **The Healthy Baby Program – earn up to $200 dollars in gift cards!**

  This program encourages well-baby visits. Parents or caregivers will receive a $25 gift card each for taking their baby to the following visits: 2 well-child visits before 3 months
  - 2 well-child visits before 9 months
  - 2 well-child visits between 9 - 15 months
  - 2 well-child visits between 15 - 30 months

  Parents or caregivers can receive an extra $100 in gift cards if their baby receives all required vaccines, including 2 flu shots, by 24 months of age.

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

- 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: 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.

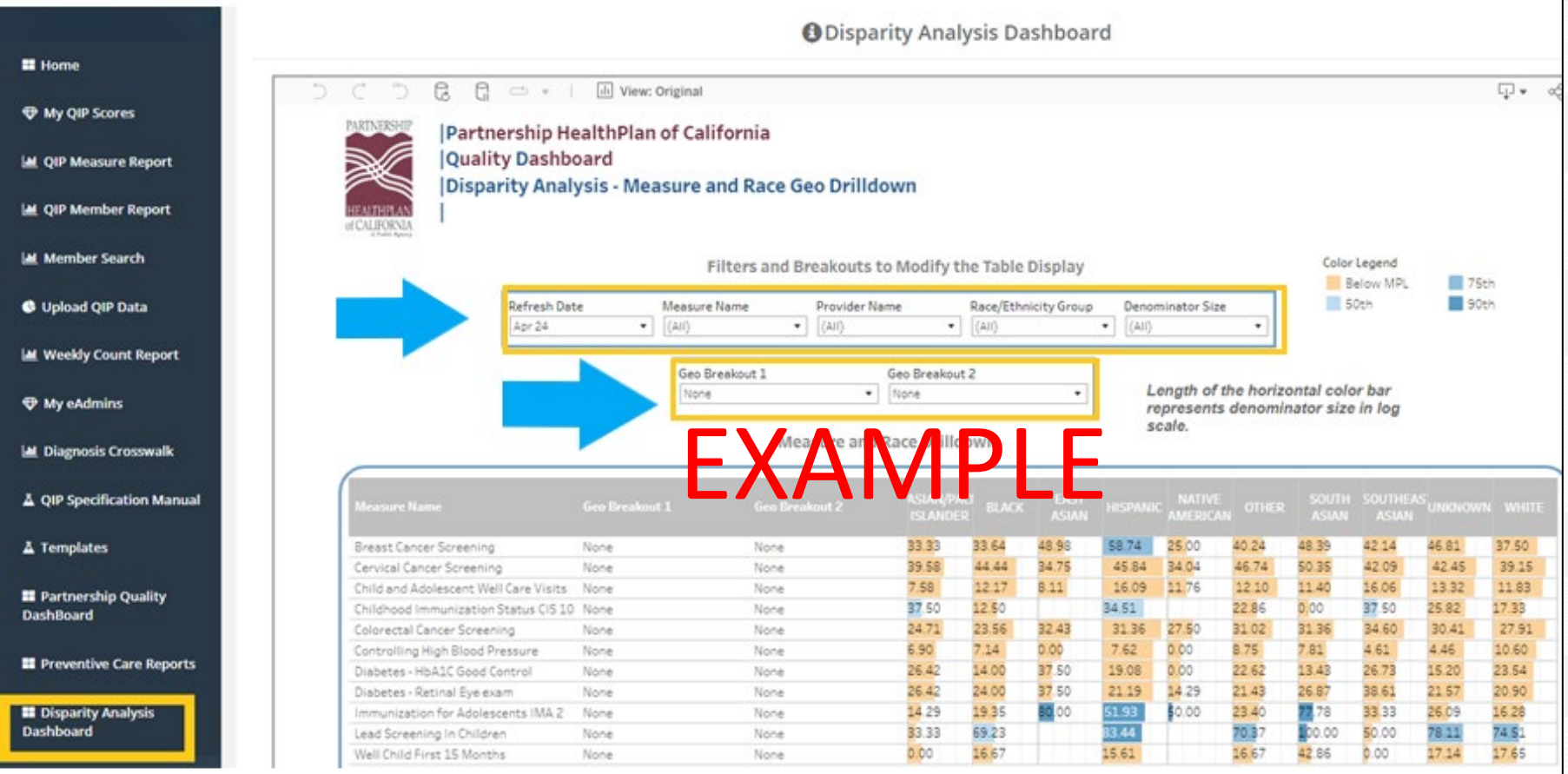
- Ensure information is consistent, welcoming, in plain, person-centered language, appropriate, and delivered in traditional and electronic applications (based on patient preference).

- 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: Health Equity Focus

- 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, childcare).
- Stratifying data (zip code, race, ethnicity, etc.).
- Utilize the Disparity Analysis Dashboard available in eReports.

Disparity Analysis Dashboard



Purpose: To promote the ease of identification of PCP QIP measure performance across Race/Ethnicity groups within various levels of geographic stratification. The dashboard also offers the ability to filter by denominator size for selected geographic and race/ethnicity group stratification.

Pediatric Care Management:

Using a Priority Score to Increase Pediatric Care Effectiveness and Efficiency

MARGIE POWERS, DIRECTOR OF QUALITY

LUCAS DRISDELL, DATA ANALYST

Background: QIP Challenges

For Pediatric Measures:

- Year-end outreach pushes miss patient cliffs in early part of year
- Workforce shortage and churn reduce outreach volume and efficacy
- Not all Medical Assistants trained to do complex pediatric scheduling

Setting Pediatric Goals

- Missed patient cliffs in early part of year → Outreach throughout the year, especially in flu season
- Workforce shortage and churn → Identify and cultivate outreach resources, expectations
- Not all MAs trained to do complex pediatric scheduling → Simplify or Remove decision making from outreach tasks

Pediatric Priority Score

SIMPLIFYING AND STREAMLINING OUTREACH DECISIONS

What Do Patients Need?
—Operationalizing Standards of Care

- Explicit care standards for pediatric patients from Newborn to 18
- Includes all required well visits, vaccines, screenings, dental visits

	0-36 mo									
	Newborn	3 wk	2 mo	4 mo	6mo	9mo	12mo	15mo	18mo	24mo
Well Visit	X	X	X	X	X	X	X	X	X	X
Immunization	Hep B-1		Dtap-1, IPV-1, HiB-1, PCV-1, Rota-1, HepB-2	Dtap-2, IPV-2, HiB-2, PCV-2, Rota-2	Dtap-3, IPV-3, HiB-3, PCV-3, HepB-3, Flu*, COVID*	Flu*, COVID*	MMR-1, VZV-1, HepA-1, Flu*, COVID*	Dtap-4, HiB-4, PCV-4, Flu*, COVID*	Hep A-2, Flu*, COVID*	Flu*, COVID*
Developmental Screening						ASQ		ASQ	M-CHAT	ASQ, M-CHAT
Lab Screening							Hgb, Lead (leave Hgb out of score)		higher prio if none by 16 mo, 19 mo	Hgb, Lead
ACEs Screening							X			X
Other Screening										
Dental Visits								First exam by 15mo; add priority score at 16 mo; maybe dental	q3mo	q3mo; higher priori if no exam in last 6 mo, no visit

Priority Score Building Blocks
—Points for Unmet Standards of Care

- List of care requirements by age
- Increased points:
  - Important items (clinician identified)
  - Approaching QI deadline
  - Generally increase up to deadline
- Customizable to emphasize areas of interest (equity, specific care standards)
- Identify patients with extreme lapses in care

7 or 8 mos with 0 or 1 WC	100
9 or 10 mos with 0 or 1 WC	100
13 or 14 mos with 5 WC	1
13 or 14 mos with 3 or 4 WC	0.8
2 mos with 0 WC	0.8
11 mos with 3 or 4 WC	0.5

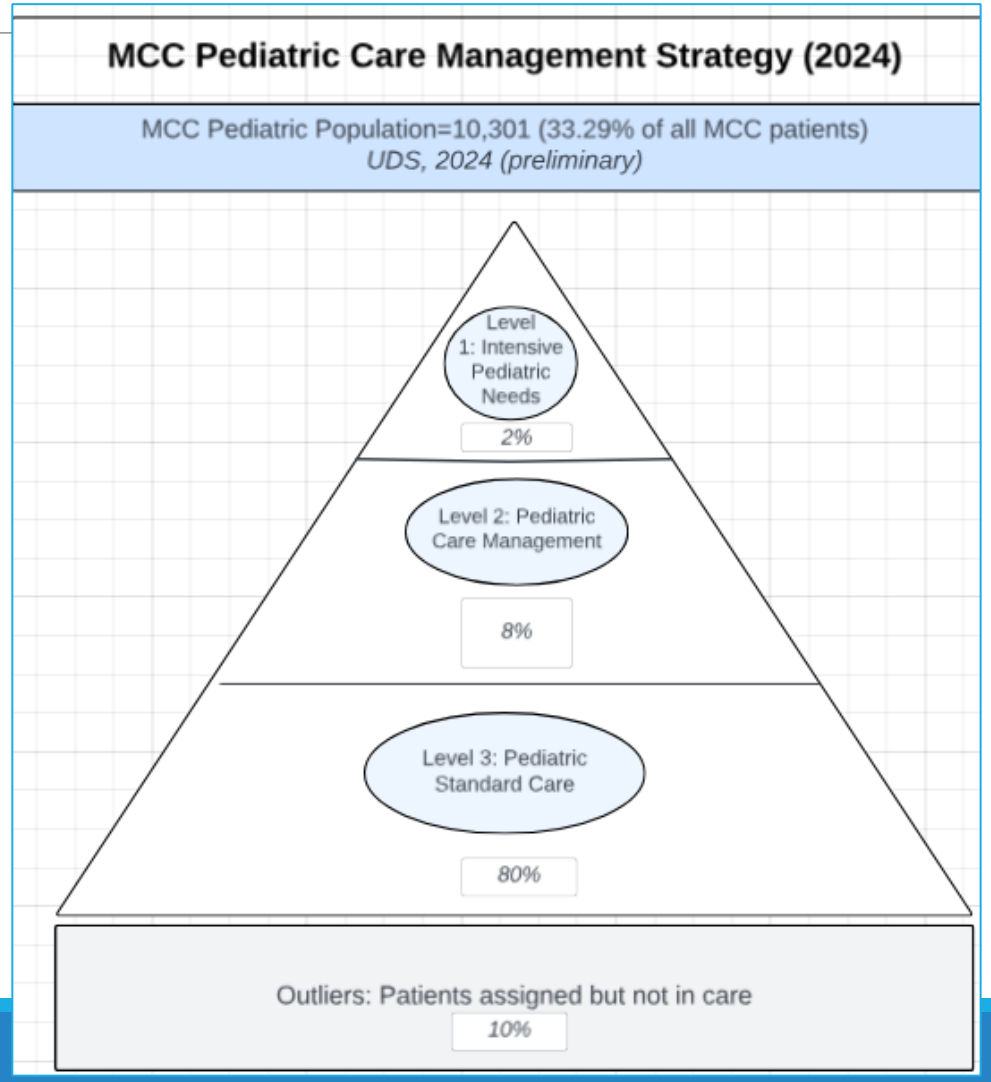
Pediatric Care Management Model
—Prioritizing Outreach Resources

Level 1: Often complex care or newcomers in need of team support

Level 2: Target for timely outreach

Level 3: Vast majority of patients mostly on track

Level 0: Outliers, out of care, moved, in care elsewhere



Implementation
— Sites and Medical Assistants

Easy lists, up to date

- **Outreach Lists of MCC Patients**
  - Separated by age category
  - Sorted by priority score
  - Site specific lists refreshed weekly

Outreach staff, outreach expectations

- **People**
  - Clinic managers brought on board
  - Site MA champions identified and trained
  - Engaged to improve the lists

Learnings
—Be consistent, efficient & targeted

- Dedicated resource for weekly outreach
- “Schedule Before” date
- Flu is seasonal and can be turned off/on for parts of the year
- Hot Sheets: precise targeting with access challenges
- “Outliers”—separate challenge

Need more than a score

- Strategize to increase provider access
- Be creative about dedicated / expert staffing
- Plan for missed appointments—Cancellations and no shows
- Implement patient education—Vaccine hesitancy requires extra and/or different types of patient conversation

Timeline: Year One

Timing	Task
Jan-Feb 2024	Design 0-3 Priority Score
Mar-Apr	Test 0-3 Priority Score Design 9-12 Priority Score
May-June	Test 9-12 Priority Score Identify resource at each pediatric site
July	Switch from full list to Hot Sheet format
July-present	Weekly outreach from new Hot Sheet lists
September	Add points for PHC members for QIP push
December	Start outreaching for babies turning 2 in 2025

Preliminary QIP Results —12/31/24

Refresh

Measure	QIP Score	50th(Target/Achieved)	90th Threshold %	90th(Target/Achieved)
Child and Adolescent Well Care 2024	67.42 %	3670/5147	61.15%	4669/5147
Childhood Immunization Status CIS 10 2024	32.41 %	168/176	45.26%	246/176
Immunization for Adolescents 2024	56.63 %	171/282	48.80%	244/282
Well Child First 15 Months 2024	84.46 %	267/386	68.09%	312/386

QIP Pediatric Measure Rates
—2023 vs 2024 by site

Measure	San Rafael 2023	San Rafael 2024	Campus 2023	Campus 2024	So. Novato 2023	So. Novato 2024
WCV 15 mos	65.02	85.94	79.61	77.60	67.50	90.36
WCV 3-17	66.19	66.70	65.60	68.27	66.60	68.67
CIS-10	32.56	29.69	30.83	37.86	48.11	32.73
Adolescent IZs	43.08	54.52	50.72	43.40	57.50	67.74

Plan for 2025
—Still lots to do

- Flu campaign to bring in babies before 24 months
- Priority scores for age bands 3-8 and 13-17
- Equity components / points
- Expand outreach capacity
- Follow-up for pediatric no-shows
- Evaluation of score effectiveness

Questions?

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ldrisdell@marinclinic.org

Upcoming Trainings:
Improving Measure Outcomes Webinar Series

Improving Measure Outcomes Webinar Series: February - April 2025

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.

Target Audience: Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.

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.

Planned sessions include:

- February 26, 2025 - Pediatric Preventative Care for Ages 3 - 17 years
- March 12, 2025 - Chronic Disease and Colorectal Cancer Screening
- March 26, 2025 - Perinatal Care and Chlamydia Screening
- April 9, 2025 - Breast and Cervical Cancer Screenings
- April 23, 2025 - Diabetes Control

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

http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx

Questions: improvementacademy@partnershiphp.org

Upcoming Trainings:
ABCs of QI In-Person Training – March 25, 2025

The ABCs of Quality Improvement is an in-person training designed to teach you the basic principles of quality improvement:

- Introduction to Quality Improvement and the Model for Improvement
- Learn how to create an Aim Statement (project goal)
- Learn how to use data to measure quality and drive improvement
- Tips for developing change ideas for improvement
- Testing changes via the Plan-Do-Study-Act cycle

Who Should Attend? *This 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.*

Date: Tuesday, March 25, 2025
Time: 8:30 a.m. – 4:30 p.m.
Location: The McConnell Foundation
800 Shasta View Dr, Redding
Registration and light breakfast from 8:30 – 9 a.m.
Lunch will be provided.

Registration is FREE

Scan me

*The AAFP has reviewed ABCs of Quality Improvement (QI) and deemed it acceptable for AAFP credit. Term of approval is from 11/07/2024 to 11/07/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session ABCs of Quality Improvement (QI) is approved for 5.50 Live AAFP Prescribed credits.
**Provider approved by the California Board of Registered Nursing, Provider Number CEP16728, for 5.50 contact hours.

Partnering for Pediatric Lead Prevention Program

Partnership invites your organization to participate in a program aimed at improving lead testing rates for age-appropriate pediatric patients in the primary care setting.

Partnership is awarding LeadCare II Point of Care testing devices to qualifying primary care sites within the Partnership network. Program materials and resources are available now on our Lead Poisoning and Prevention webpage.

Applications are now accepted year-round!

For more information, questions, or to submit an application, email: leadPOC@partnershiphp.org

The Growing Together Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA

The Growing Together Program

Our Growing Together Program supports members during and after pregnancy, and children from birth up to age 3. This program is offered to Partnership members at no cost. Learn how the Growing Together Program can help you.

The Growing Together Program features:

The Prenatal Program – earn up to $50 in gift cards!

This program encourages early prenatal care. Members will receive a $25 gift card for getting their flu vaccine while pregnant, and another $25 gift card for getting their Tdap vaccine between 27 weeks and delivery. Call us to join as soon as you know you are pregnant.

You will also get:

- A welcome call upon referral
- Up to 3 check-in phone calls throughout the program
- Information about doula benefits
- Support for prenatal visits
- Referrals to care coordination
- Health education

The Postpartum Program – earn up to $100 in gift cards!

This program encourages postpartum and well-baby visits. Members will receive a $50 gift card for each of their 2 postpartum exams ($100 total) between 7 to 84 days after delivery.

You will also get:

- A welcome call upon having your new baby
- Up to 2 check-in calls throughout the program
- Help to enroll your baby into Medi-Cal
- Support for postpartum and well-baby visits
- Referrals to care coordination
- Health education

The Healthy Baby Program – earn up to $200 dollars in gift cards!

This program encourages well-baby visits. Parents or caregivers will receive a $25 gift card each for taking their baby to the following visits:

- 2 well-child visits before 3 months
- 2 well-child visits before 9 months
- 2 well-child visits between 9-15 months
- 2 well-child visits between 15-30 months

Parents or caregivers can receive an extra $100 in gift cards if their baby receives all required vaccines, including 2 flu shots, by 24 months of age. A vaccine record must be submitted to Partnership's Population Health Department. Call us to enroll your baby as soon as they get Partnership.

You will also get:

- A welcome call
- Referrals to care coordination
- Check-in calls at 3, 7, 14, 22, 26, and 30 months
- Support for well-baby visits and the recommended screenings and vaccines

To learn more or sign up for the Growing Together Program, call us at **(855) 798-8764**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or **711**. You can also email us at PopHealthOutreach@partnershiphp.org.

This notice does not change your Partnership benefits or keep you from getting the care you need.

ACCREDITED NCQA HEALTH PLAN

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Evaluation

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

Contact Us

Regional Medical Director:

Jeff Ribordy, MD

jribordy@PartnershipHP.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.

Evaluation

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