2025 Best Practices
Well-Child Visits (0-30 months)

Partnership Tools, Programs, and Promising Practices:

- The **Preventive Care Report** is available on the **eReports portal** and is updated daily. This dashboard shows each provider's member list for the well-child visit (birth to 30 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 well-child visits before each child turns 30 months old.
- The **Preventive Care Report** now contains race/ethnicity and language fields. Use this dashboard to look at well-child visit (birth to 30 months) completion rates by race/ethnicity and language to learn more about inequities within your patient community.
- Partnership's **Growing Together Program** offers member incentives for completion of well-baby visits. Members can enroll directly by contacting the Population Health Department at (855) 798-8764 or emailing **PopHealthOutreach@partnershiphp.org.** Parents/ caregivers will receive a $25 gift card for taking their baby to the following visits:
  - Two well-child visits before 3 months
  - Two well-child visits before 9 months
  - Two well-child visits between 9-15 months
  - Two well-child visits between 15-30 months
- Members can enroll directly by contacting Population Health **PopHealthOutreach@partnershiphp.org** **(855) 798-8764.**
- Attend or view Partnership's **Improving Measure Outcomes training** on *Preventive Care for 0-30 month 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.

Patient Care:

- Well-child visits should be completed as in-person visits. Only in-person well-child visits will be counted towards the Primary Care Provider (PCP) Quality Improvement (QIP) in 2025.
- 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-carevisits and a different location for acute visits.
- Consider 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 preventive health care **periodicity schedule.**
- Utilize back-office staff and scribes to check and schedule well-child visits when patient is in the exam room. At minimum, schedule the next appointment 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 calls by staff member.
- Schedule the sixth well-child visit appointment prior to the child being 15 months.
- Use standardized templates in EMR/EHR 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 parents/caregivers 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.

Screening and Immunizations:

- Offer parents/caregivers one-page handout outlining well baby visit schedule, including immunization and screening milestones, in plain and appropriate languages.
- Promote and emphasize the 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 topical fluoride treatments as part of their well-child visit from 6 months.
- All children on Medi-Cal must complete a blood lead test. Include blood lead testing completion and coding steps in EMR/EHR templates for 12 months and 24 months 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 patient communities. By looking at well-child visits (birth to 30months) measure compliance rates by factors such 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 patient 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 parents/caregivers to confirm that health information and next steps covered in the visit are mutually understood, parents/caregivers agree with any plans made, and they were given the opportunity to ask questions.
- Identify and address barriers to care (transportation, hours of operation, childcare).
- Use approaches and partnerships that align with your practice's demographics (partner with local schools and 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:

2025 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
- Preventive Care Report