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Well-Child Visits in the First 30 Months of Life Playbook

Purpose: This document's purpose is to assist health centers with well-child visits in the first 30 months of life as it aligns with the HEDIS and Azara versions of the measures. It is not a comprehensive playbook of all best practices but rather serves as a summary of selected quality improvement best practices based on experience from the High Impact Performance Program's limited time focusing on this quality measure.

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INTRODUCTION

Background: Well-child visits during the first 30 months of a child's life are crucial for ensuring optimal growth, development, and overall health. These routine check-ups provide a structured opportunity for healthcare professionals to monitor a child's physical and developmental milestones, assess nutritional needs, and detect any early signs of health issues [Cited]. They also offer an essential platform for parents to receive guidance on child-rearing aspects, such as sleep habits, immunizations, safety, and behavioral concerns. The American Academy of Pediatrics recommends 12 well-child visits in the first 30 months of life [Cited]. By fostering an ongoing relationship between families and healthcare providers, these visits help build a foundation for

preventive care, promote healthy habits, and support the early identification of any conditions that may require timely intervention, contributing to better long-term health outcomes.

Note: Throughout this playbook, we abbreviate well-child visits as 'WCVs.' There is a different HEDIS measure with WCV as the abbreviation. For the purpose of this playbook, WCV is referring to 'well-child visits' and not the HEDIS measure.

HEDIS MEASURE DEFINITIONS

The HEDIS measure 'Well-Child Visits in the First 30 Months of Life' is defined as the percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported in two different age groups and sub-measures:

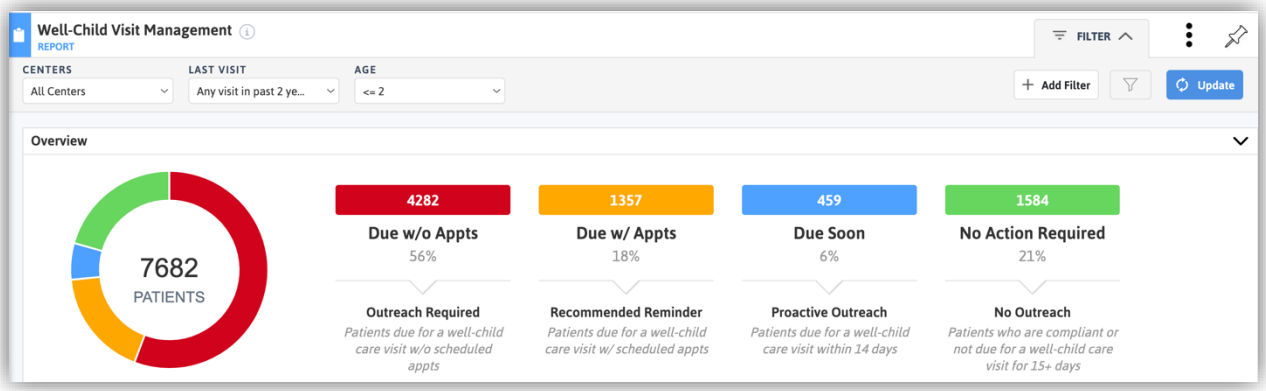
1) Well-Child Visits in the First 15 Months: Children who turned 15 months old during the measurement year: ***Six or more well-child visits*** on different dates of service on or before the 15-month birthday.
2) Well-Child Visits for Age 15-30 Months: Children who turned 30 months old during the measurement year: ***Two or more well-child visits*** on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.

POPULATION HEALTH MANAGEMENT

Obtaining Patient Lists: As a health center member of MCHN, Azara has many resources for managing the pediatric population. There are various measures available to monitor performance in Azara. Four of the main measures include the HEDIS and Azara versions of the measures, and are screenshotted below for your reference:

This quality measure is unique compared to other measures of focus, as the patient lists for outreach and population health management are ***not*** best generated from the actual HEDIS or Azara measures. Based on the measure definition, only children turning 15 or 30 months, respectively, during the measurement year will be in the detail list for the Azara and HEDIS measures. This means generating an inclusive list of patients in this 0–30-month age range who need their WCVs will not be fully represented in the quality measure patient lists/gap lists. We

recommend using the Well-Child Visit Management report for any outreach and population health management. The report is shown below:



The patient lists are categorized by action needed for WCVs, and color-coded in red, orange, blue, and green as seen above. You can add filters to this report, including for providers or sites/locations within your organization to be more manageable for care teams and staff to use these lists for outreach.

The patient list in this report is very detailed and includes what WCV they are due for, age in months, count of completed WCVs, if they have an upcoming appointment scheduled, their most recent encounter, as well as a detailed list of the recommended WCV appointment schedule and which appointments they have completed and the date. This is helpful to staff managing this population, as it can lend itself to see if a patient may have transferred care based on the last time seen at your health center for a WCV, an example is included below:

DATES WELL-CHILD CARE (0-30 MOS)

7D	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
11/5/2021		1/3/2022	3/3/2022	5/5/2022	8/2/2022	12/15/2022		4/6/2023	12/15/2023	
11/8/2021	12/1/2021	1/3/2022	3/7/2022	6/29/2022	8/22/2022	11/9/2022			1/18/2024	
11/9/2021	11/12/2021	1/6/2022	3/14/2022	6/28/2022	9/7/2022		1/16/2023		12/11/2023	
11/8/2021	11/15/2021	1/7/2022	3/7/2022	5/25/2022	8/29/2022	11/22/2022		4/4/2023		
	11/16/2021	12/28/2021		5/31/2022	8/4/2022			4/4/2023		
11/9/2021		2/1/2022	4/1/2022		7/25/2022	12/19/2022			3/14/2024	
11/9/2021		1/4/2022		4/27/2022	9/6/2022			6/19/2023		
11/12/2021	11/19/2021	1/6/2022	3/10/2022		7/19/2022	10/25/2022		4/20/2023	3/4/2024	
		1/7/2022	4/1/2022			11/21/2022				
11/10/2021		12/22/2021						5/17/2023	12/11/2023	
	11/24/2021	1/5/2022		5/23/2022	9/21/2022	11/22/2022	2/22/2023			
11/16/2021			3/16/2022	5/20/2022	8/23/2022					

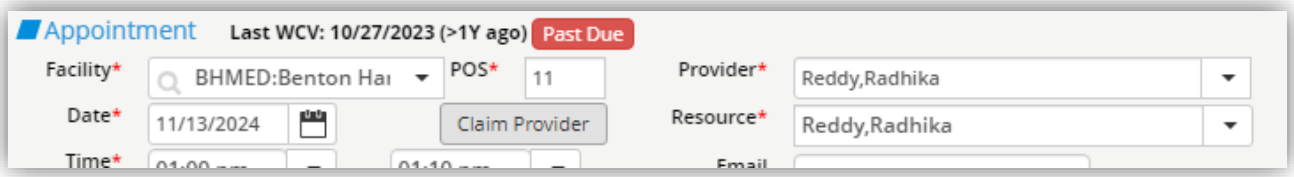
Transitions of Care: In order to reach patients who are newborns and may not show up on outreach lists, some health centers monitor transitions of care discharge lists for deliveries. Ideally, an employee at the health center is working these TOC lists daily or weekly and reaching out to patients who need follow-up appointments. In this workflow, they may be able to identify patients who have given birth and request that they come in for both a postpartum visit for the birthing parents and a well-child visit for the newborn. This should not be relied on as the sole workflow for identifying newborn patients but can serve as another safety net identification and outreach process.

In addition to MIHIN data feeds for transitions of care, some health centers have partnerships with local hospitals. Through these partnerships, the hospital can alert the health center of any of its patients who have been admitted for a delivery. Some health centers even have CHWs or other care coordinator staff who work at the hospital location to schedule these patients at the health center before discharge and begin the warm handoff process.

HEALTH CENTER BEST PRACTICES

Clinical Workflows: Due to the frequency at which patients need to attend appointments to meet the requirement for this measure, relying solely on outreach will not lead to success in this clinical measure or achieving optimal patient care. Often, by the time a patient is overdue for a well-child visit and shows up on a quality department outreach list, they may have already missed an opportunity to be a numerator hit for this measure. Because of this, below are workflow recommendations to ensure patients come to their appointments as needed:

- **POC Scheduling** - The most impactful workflow is to ensure patients are scheduled for their next appointment before leaving the current appointment. Scheduling upon checkout should be required for all pediatric patients under 30 months. Health centers with this workflow perform better on this HEDIS measure.
- **Appointment Reminders** – Patients should receive reminders for their upcoming appointment both one week and one day prior to the scheduled time. Appointment reminders utilizing various modalities can successfully decrease no-show rates. Modalities include phone, text, and patient portal.
- **Utilize Technology**—To reduce employee burden and time, utilizing technology to automate outreach and reminders for well-child visits has been shown to increase performance in these measures. Some EMRs have timers that can be sent to automatically reach patients when they are due and encourage them to make appointments if they don't already have one.
- **CDSS Alerts** – A clinical decision support system (CDSS) informs or generates medical recommendations for healthcare practitioners. An alert is the most common way for a CDSS to interact with practitioners [Cited]. While pre-visit planning and during the appointment, staff can review CDSS alerts to prompt them to address various care gaps. While W30A&B are access measures, and the patient being at the appointment itself helps to satisfy the measure (no additional service to render), there is still a role CDSS can play. Some EMRs may have an alert or flag on the scheduling pop-up box to alert staff that the patient is overdue for their WCV. This can be especially helpful if parents are calling to schedule a sick or other acute care visit, notifying the staff that they should schedule the WCV in place of or in addition to the sick visit. If MAs pre-visit plan the day before or the morning of appointments, they may also catch this type of alert and can review the schedule and determine if there is time to convert the visit, or at a minimum make sure they schedule the WCV before the patient leaves. Training for call centers, registration/front-desk staff, and MAs to enable and review these alerts is key. Below is an example from eCW, where you can see the 'Past Due' WCV alert in the scheduling window:



- **Set Expectations** – Parents may not be aware of expected pediatric appointment frequency before baby is born. Best practices include educating parents toward the end of the gestation period to set the stage for the number of well-child visits in the first year of life. Some health centers have created educational handouts on this to ensure consistent messaging and endeavor to turn these handouts into magnets so that parents have easy access to this information. An example can be found under Appendix Item 1.
- **Warm Handoffs**—For health centers that have both OBGYNs and Pediatricians/Family Physicians, a warm handoff between these two provider groups can help parents feel comfortable with the next steps for well-child visits after the baby is born. A warm handoff is a transition conducted in person between two members of the health care team in front of the patient (and family if they are present). The warm handoff engages the patient as a team member and partner in their care.

Outreach: As mentioned above, point-of-care clinical workflows are most critical for providing patients with the number of visits they require in the first 15 months of life. If a part of this workflow breaks down, outreach will be necessary to bring patients into care. Some health centers have had successful outreach campaigns using unique methods such as sending video/voice messages from providers. These campaigns have helped patients feel that their provider cares about them and their health and may lead to greater acceptance of appointments at the health center.

Additionally, assigning a staff member as the owner of this population can help patients avoid being lost to follow-up and decrease no-show rates. Often, this employee may also be the "screening champion" at your health center, in charge of ensuring developmental screenings occur for this population.

Many health centers may have standard or automated outreach to patients if they miss their appointments. Some health centers may also have punitive scheduling policies that are included in these outreaches (i.e., 'three strikes and you're out' resulting in an inability to advance schedule future appointments after three no-shows). It is never recommended to create punitive scheduling policies, which have *not* been shown to help improve access to care. One health center had standard messaging/letters that were mailed after all no-showed appointments. After reviewing them in the context of this population, parents could easily be 'offended' or minimize the urgency and importance of rescheduling promptly. Creating a tailored message for WCV no-shows to differentiate from other appointment no-shows can help foster rapport and engagement with families, an example is included in the Appendix under Item 2.

Incentives - In addition to outreach phone calls, health centers may have success with text message campaigns. One intervention for another measure of focus showed that combining text campaigns with health plan member gift card incentives produced a greater number of completed services. Known health plan incentives for 2024 are shown below. These often change year to year so it is recommended to contact your health plan representative for up-to-date information on patient incentives.

Meridian

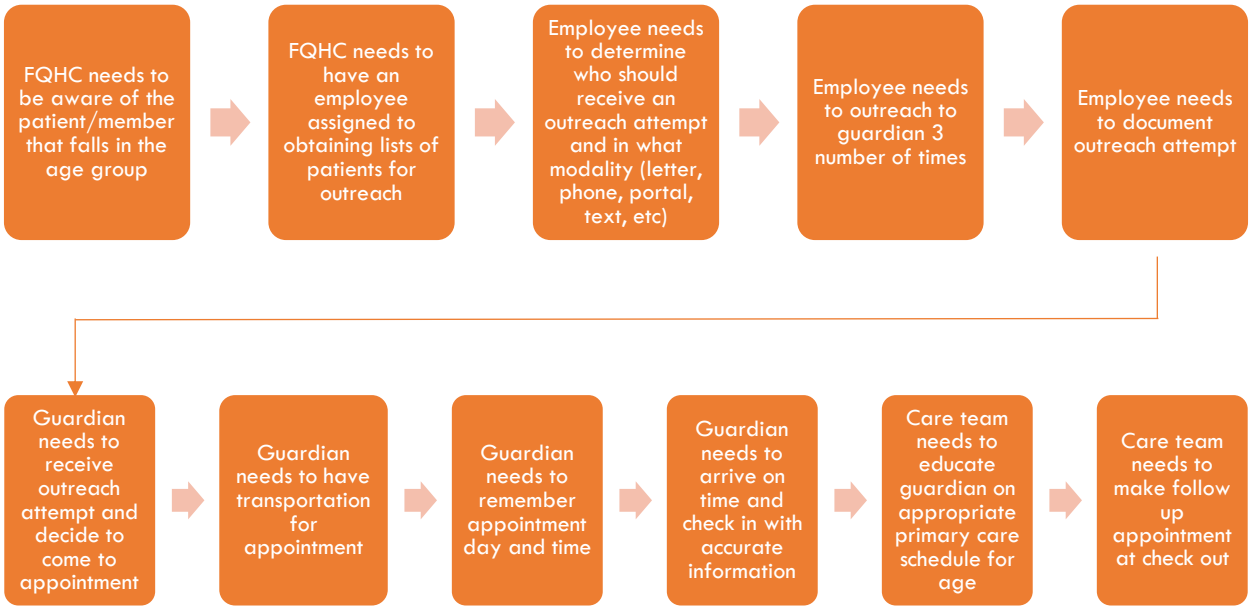
HEDIS Measure	Rewards Card Value	Meridian Eligibility
Child Lead Screening	**$15**	Ages 0-24 months. One time reward
Child Immunizations	**$40**	Ages 0-24 months. One time reward requires the following: 4 DTap, 3 IPV, 1 MMR, 3 HiB, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV
Well Child Visits	**$25**	Ages 0-15 months. Requires 6 visits for reward

Molina

HEDIS Measure	Gift Card Value	Molina Eligibility
Lead Screening in Children (LSC)	**$25**	Ages ≤12 months and ≤24 months. Members must complete a blood lead screening prior to member's 1st and/or 2nd birthdays
Childhood Immunization Status (CIS_CO3)	**$100**	Ages ≤24 months. Members must complete the Combo 3 immunizations prior to/by the members 2nd birthday
Well Child Visit (W30)	**$100**	Members ≤15 months. Complete 6 well-child visits before turning 15 months of age.

WORKFLOWS

Workflow: This process has many steps that need to occur for patients to achieve six well-child visits before the age of 15 months or an additional two visits before the age of 30 months. Below is an outline of what needs to go right, which represents areas a health center may target for quality improvement.



DOCUMENTATION AND CODING

Coding: There are some CPT and HCPCS codes most frequently used and recommended by a health plan outlined below. Of note, codes are often updated yearly and are always subject to change. Please refer to the Value Set list for each measurement year for this HEDIS measure.

Well Care Visit Code Type	Corresponding Codes
CPT	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461
HCPCS	G0438, G0439, S0302, S0610, S0612, S0613

Converting Sick Visits: Often, this population is more likely to come into a health center for a "sick" visit, as opposed to a preventive well-child visit. If specific criteria are met and the provider deems it clinically appropriate, a sick visit can be converted to a well-child visit with appropriate coding and documentation. Providers must evaluate if the patient is presenting with mild to no symptoms. If the patient shows symptoms that require workup and decision-making, then the visit should remain a sick visit. If this is the case, the health center should schedule the well-care visit with the parent/guardian before the patient leaves the clinic. The components that must be included for the well-child visit are:

- Health History
- Physical Development History
- Mental Development History
- Physical Exam
- Health education/anticipatory guidance

Converting Sick Visits Coding: Health centers should bill a well-care visit CPT code and well-care ICD-10 diagnosis code as the primary diagnosis. When billing a sick visit with a well-care visit, sufficient evidence must be documented in the medical record to support a stand-alone visit for both services. Providers must include ***modifier 25*** with the evaluation and management (E/M) CPT code for the sick visit.

Example:

CPT Codes	ICD-10-CM Codes
99393	Z00.129
99213-25	R05.1 Acute Cough

OTHER RESOURCES AND BEST PRACTICES

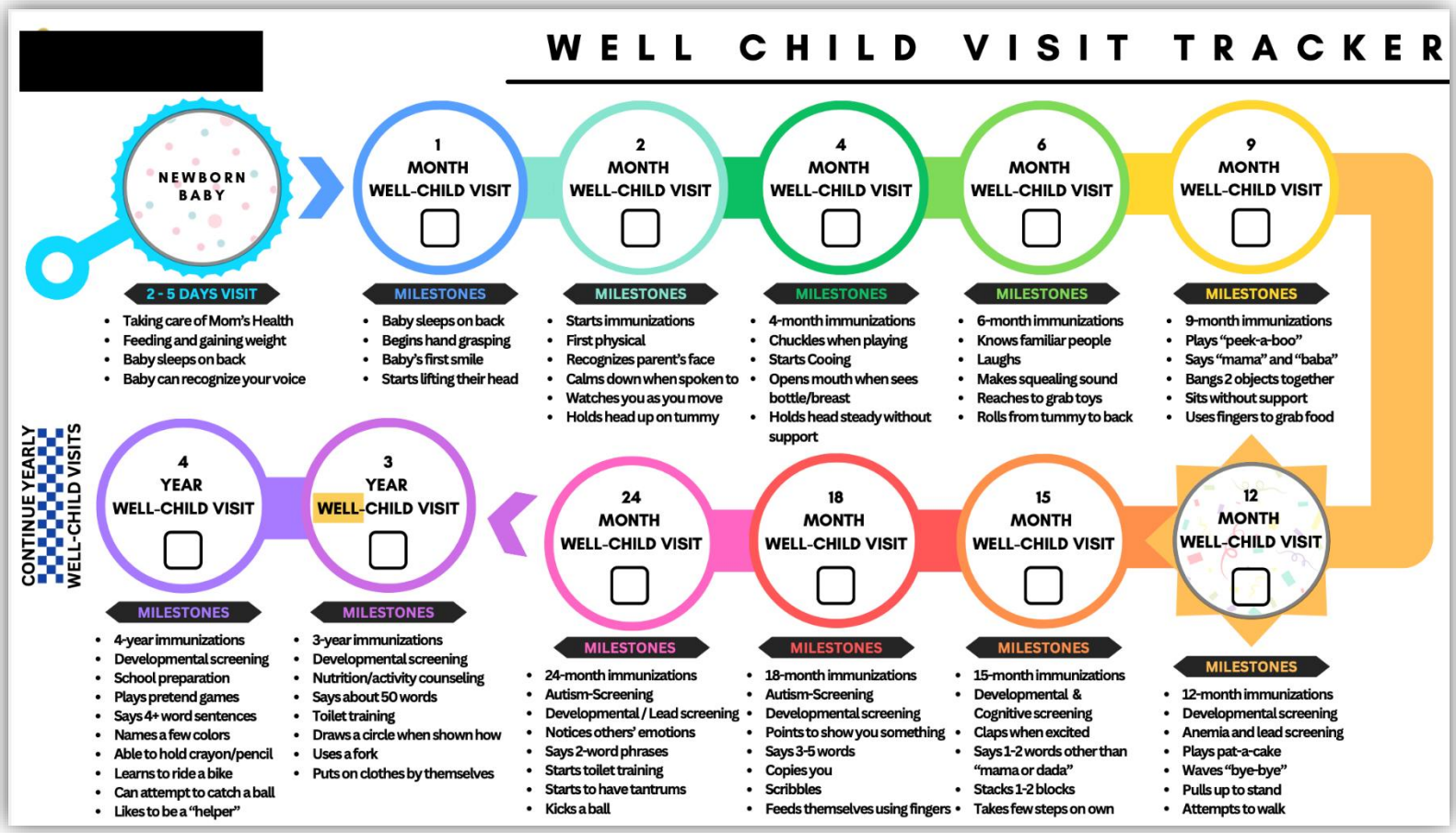
Overview: Below are websites with pediatric resources that health centers may find particularly helpful for best practices during well-child visits.

- AAP Bright Futures - Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
- Ages and Stages Questionnaires—This screener tool unlocks critical knowledge about young children's development and helps give all children the best start in life.
- Survey of Well-being of Young Children (SWYC) - This tool can be used for general developmental surveillance and screening of young children in the pediatric primary care context.

APPENDIX

Note that most appendix items can be sent as a separate document resource.

Item 1: Example WCV Schedule Education Materials



Item 2: Updated No-Show/Canceled Appointment Letter for Well-Child Visits

June 24, 2024

To the Parent/Guardian of:
Little Guy
432 One St
Star, MI 48000

Dear Parent/Guardian,

We understand you were unable to make it to [Little Guy]'s recent medical appointment. Please call our office today to reschedule that missed appointment, 231-xxx-xxxx.

Will you need a ride to and from the rescheduled appointment? If so, our Community Health Worker can help you with that. At least a week before the appointment, call 231-xxx-xxxx and ask to speak with the Community Health Worker to schedule medical transportation.

When you are unable to keep a scheduled appointment with us, please call us at least 24 hours before your appointment to cancel it so the provider can see another child at that time.

Thank you for partnering with us so we may provide the best care for [Little Guy]! We look forward to seeing you and [Little Guy] soon!

[Provider Name]