Improving Measure Outcomes: Preventive Care for Children Ages 0 - 30 Months

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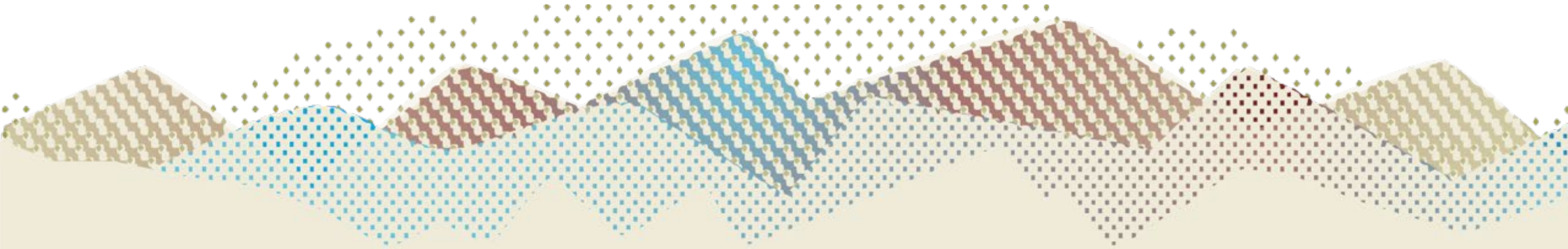

Learning Objectives

- Understand the clinical background, specifications, and 2026 performance thresholds for key pediatric measures in the Provider Quality Incentive Program, including:
  - Well-child visits in the first 30 months of life
  - Childhood immunization status
  - Blood lead screening
  - Topical fluoride in children

- Apply quality measure specifications to enhance adherence and performance across well-care visits, immunizations, lead screening, and topical fluoride application for children ages 0 – 30 months.

- Identify best practices for implementing blood lead screening and topical fluoride applications, including clinical rationale for their inclusion in early childhood preventive care.

Learning Objectives

- Identify the five essential components of standard clinical practice for well-child visits through 30 months.

- Identify promising strategies to:
  - Strengthen clinical workflows and care coordination
  - Improve caregiver communication and education
  - Address barriers to access and equity
  - Enhance outreach for historically, economically, or socially marginalized families

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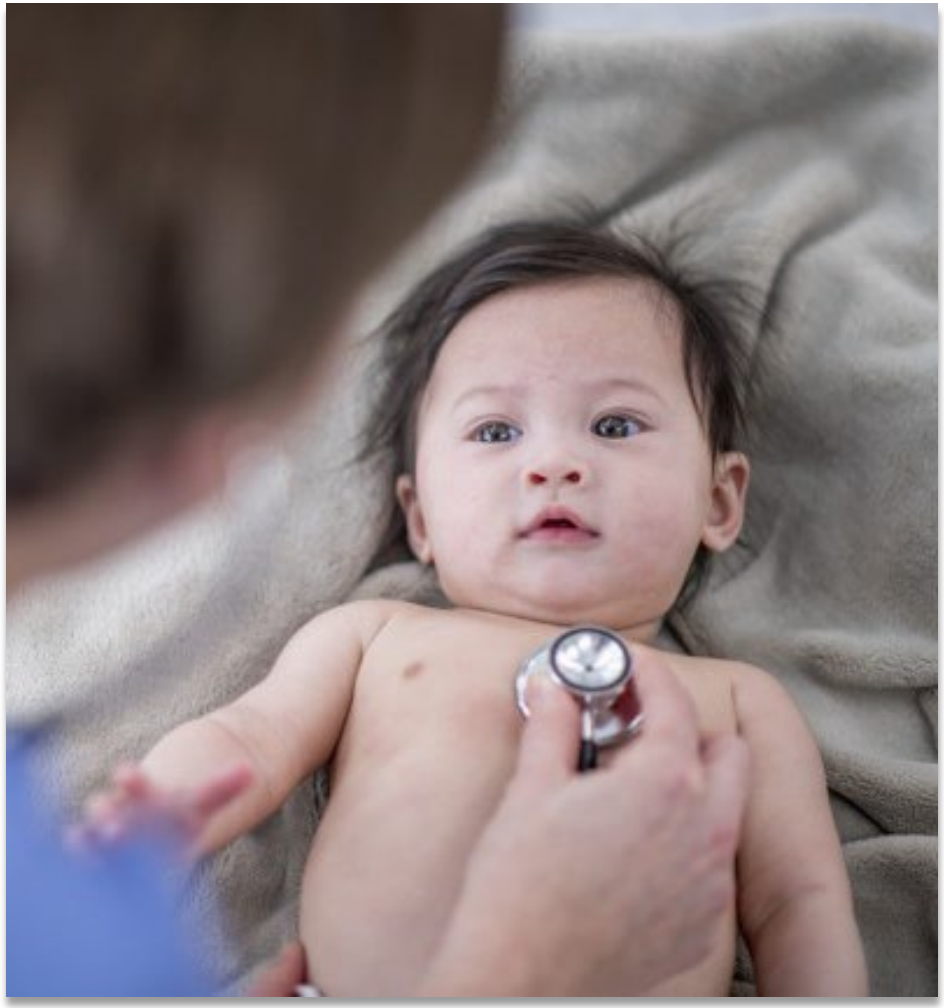
Overview of Clinical Guidelines

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

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.**

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Childhood Immunization Status: Combo 10

Dosage	Abbreviation	Description
Between 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

See CDPH and AAP for full recommended vaccine schedule.
RSV and COVID are also recommended within this age group.

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Childhood Immunization Status Medical Record Documentation

- Immunizations with dates of administration are required to document that the patient is up to date with all immunizations for HEDIS and the Quality Incentive Program reporting.
- Retroactive entries are unacceptable if documented after the second birthday.
- Vaccination administered prior to 42 days after birth (before six weeks of age) are not compliant for DTaP, IPV, Hib, RV, and PCV.
- Document parental refusal to vaccinate (Z28 code).

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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 second 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.**
- **Consider administering the two-dose series (Rotarix)** instead of the three-dose series (Rotateq) to improve your series completion rates.

Well-Baby Visits

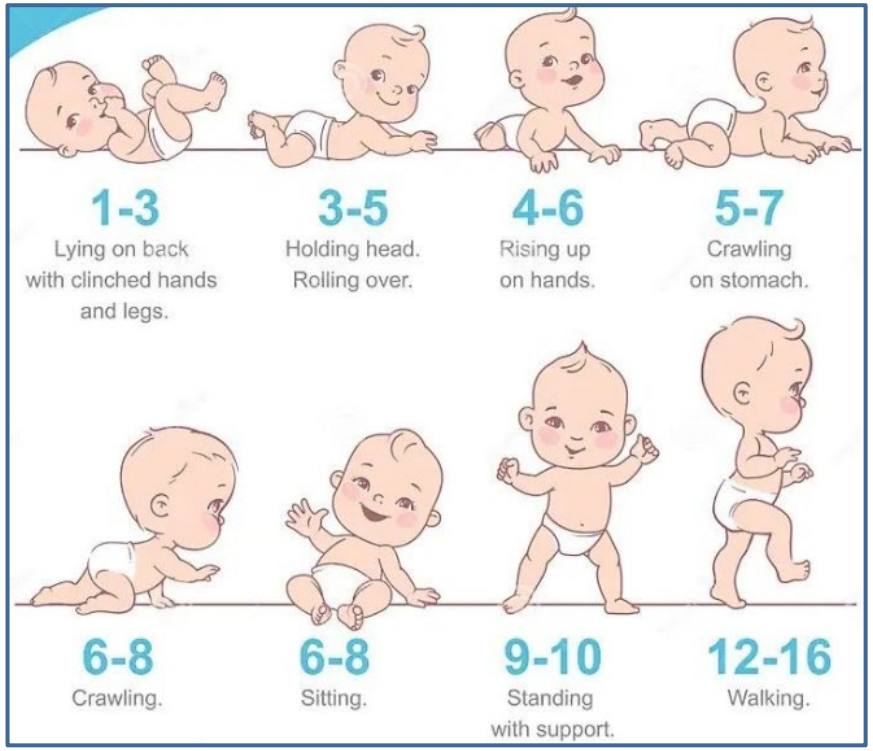
Why It Matters

- Tracking growth and development
- Opportunity for caregivers / parents to raise concerns
- Team approach with regular visits
- Helps caregivers / parents 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
- 30 months



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. **Motor 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, etc.

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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.

Resources:

American Academy of Pediatrics

American Dental Association Guidelines

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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).

Standard of Care on Screening for Childhood Lead Poisoning from CDPH

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 well-child checkup 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 Resources:

Partnership Lead Poisoning and Prevention

Developmental Screening

- Developmental screening is **the use of a standardized set of questions** to see if a child's motor, language, cognitive, social, and emotional development are on track for their age.

- National guidelines recommend **developmental screening for all children at 9 months, 18 months, and 30 months** of age and as medically necessary when risk is identified on developmental surveillance (done at every well-child check).

- **All Medi-Cal enrolled children are entitled to developmental screening** as it is a required service for children under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

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Developmental Screening Tools

A standardized screening tool that meets the criteria set by the American Academy of Pediatrics (AAP) and the Centers for Medicare and Medicaid Services (CMS) will be used. The following tools currently meet these criteria:

- Ages and Stages Questionnaire – Third Edition (ASQ-3) - 1 month to 5.5 years (or ASQ prior version)*
- Survey of Well-Being of Young Children (SWYC) – 1 month to 65 months *
- Parents' Evaluation of Developmental Status (PEDS) – Birth to age 8 *
- Parents' Evaluation of Developmental Status – Developmental Milestones (PEDS-DM) *
- Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) – 3 months to age 2
- Brigance Screens-II – Birth to 90 months
- Child Development Inventory (CDI) – 18 months to age 6
- Infant Development Inventory (IDI) – Birth to 18 months

* Screening tools currently listed on AAP website

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Billing Guidelines

Ages 0 to <20 years only

- **CPT Code:** 96110 or 96110 with modifier KX
  - Each payable, per year of age without a treatment authorization request (TAR)
- **Service limitation:** Twice per year.
  - 96110 billed with KX modifier will not count towards the service limitation
- **Modifier KX:** 96110 with a KX modifier may be used for screening that does not include one of the listed nine screening tools.
  - For example, the MCHAT screening for autism.
- **Paid fee for service:** Not part of PCP capitation

Important Note: Effective January 1, 2020

- 96110 may only be used with a validated screening tool that tests for all four developmental domains (motor, language, cognitive and social/emotional) and meets the Centers for Medicare & Medicaid Services (CMS) Child Core Set developmental screening criteria.

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Incentive Payment

- Developmental screenings are recommended at three specific times in early childhood:
  - 9 months, 18 months, 30 months
- State-Funded incentive payments will be given ***in addition** to* the base fee for service payment of 96110:
  - Without a modifier
  - Once per year from age 0 to age 3
    - Once between age 0 to 1
    - Once between age 1 to 2
    - Once between age 2 to 3
- Incentive Payment Rate: $59.90 per eligible screening

All PCPs, including Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Service MOU clinics, are eligible for this incentive payment.

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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

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 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, 2024, and October 2, 2025).

Numerator - The number of children in the eligible population with at least six 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 December 1, the next date of service would have to be December 15 (first date of service plus 14 days) or later.*

2026 Measure Specification Manual

Well-Baby Visits
15 - 30 Months Measure Specifications

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

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 5, 2023, and July 4, 2024).

Numerator - The number of children in the eligible population with two or more well-child visits on different dates of service between the child's 15-month birthday plus one 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 December 1, the next date of service would have to be December 15 (first date of service plus 14 days) or later.*

Pediatric Practice QIP Clinical Measure

Family Practice QIP Monitoring Measure only

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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, 2024, and December 31, 2025).

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

2026 Measure Specification Manual

Lead Screening in Children Measure Specifications

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 365 days, who turn two years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2024, and December 31, 2024).

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

2026 Measure Specification Manual

Monitoring Measures

The monitoring measurement set is a separate and distinct measurement set that does not have a financial incentive 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

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

Denominator - The number of continuously enrolled Medi-Cal members one to four years of age as of December 31 of the measurement year (DOB between January 1, 2022, and December 31, 2025).

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

Denti-Cal Claims Code: Z29.3

Monitoring Measure only

2026 Measure Specification Manual

Fluoride Varnish Billing Change

Partnership urgently needs your help in updating Dental Center billing practices!

- **Dental Centers** in FQHC, Rural Health Centers, and Tribal Health Centers must use **ICD code Z29.3** (Encounter for prophylactic fluoride administration) to bill fluoride varnish services
- Include diagnosis code Z29.3 on the UB-04 claim form
  - The code should be listed as the secondary diagnosis (not the principal diagnosis)
  - Enter it in Box 67A of the UB-04 form as Z293 (do not include a decimal point)
- Pair Z29.3 with the appropriate dental code
  - Code 03 is for fee-for-service members or Medi-Cal Managed Care members not enrolled in a Dental Managed Care Plan (DMC plan)
  - Code 0521-T1015 SE is for MCP members enrolled in a DMC plan
- Measure requires minimum of 2 fluoride varnish applications per year.
- For Topical Fluoride applied in in a **primary care medical setting**, continue to use CPT code 99188 when billing for the fluoride varnish application. ICD code Z29.3 is recommended but not required.
- Questions? Contact: DentalSupport@partnershiphp.org

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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 unit of service measure is met.

Pediatric Unit of Services Measures

Pediatric Group Visits for Ages 0 - 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

2026 Measure Specification Manual

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Quality Incentive Program (QIP) Tools and Resources

- Landing Page
- QIP Dashboard

Primary Care Provider (PCP) Quality Incentive Program

PCP QUALITY INCENTIVE PROGRAM

The Primary Care Provider Quality Incentive 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 members so that significant improvements can be made in the following areas:

- Preventive Screening
- Pediatric Access
- Hospital Utilization
- Primary Care Utilization
- Chronic Disease Management
- Patient Eperience

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 2026 PCP QIP

Equity Adjustment - PCP QIP Payment Methodology

Webinars

PCP QIP Webinars

Upcoming Webinars and Trainings

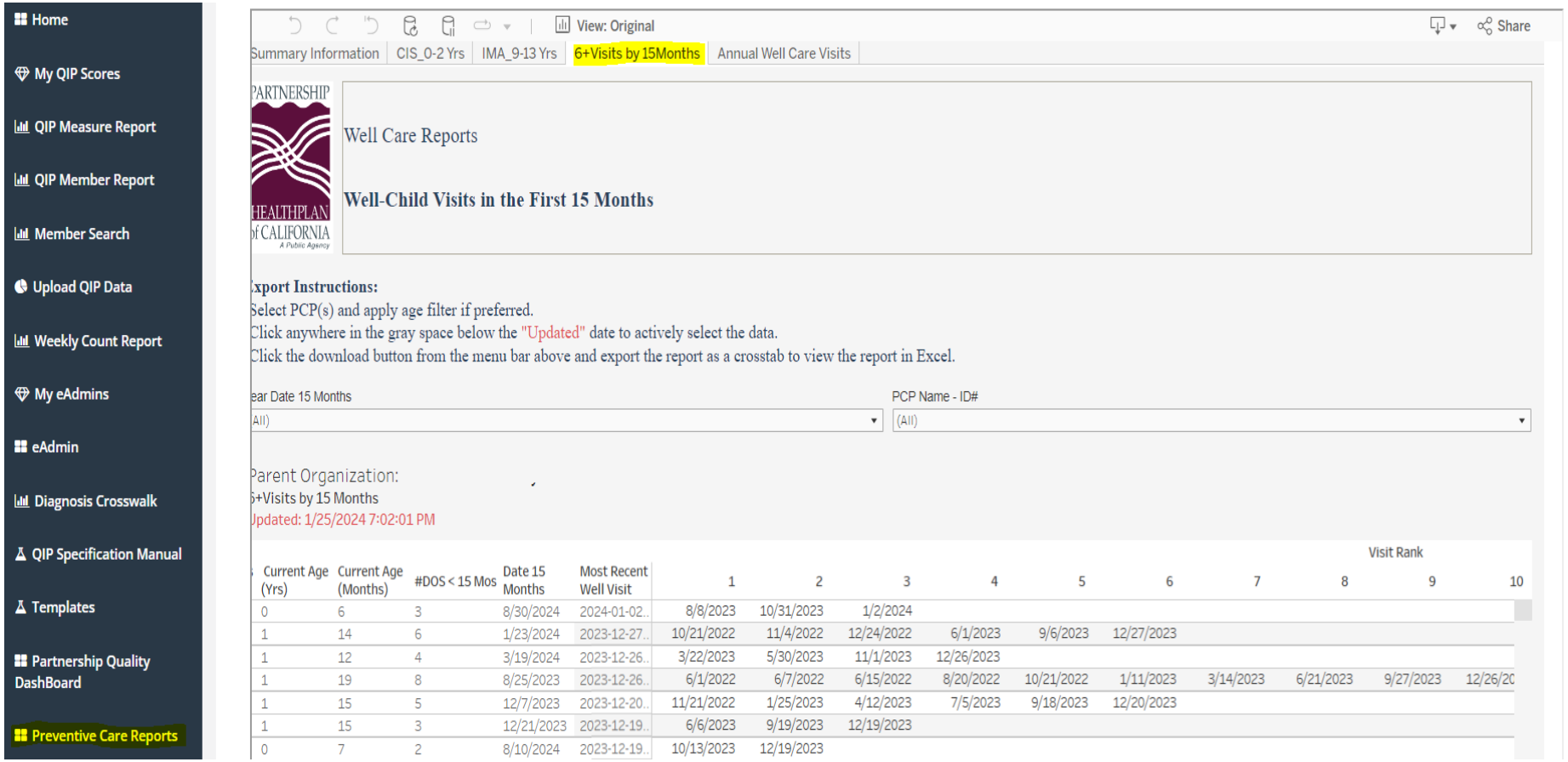
On Demand Courses

PCP QIP Tools

Tools and Resources

- 2026 PCP Measure Specification Manual
- PQD 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.

Microlearning: Preventive Care Reports

Microlearning: Preventive Care Reports

VIDEO TUTORIAL

This short, focused training module delivers key concepts in easily digestible formats – perfect for busy schedules and quick access when needed.

This microlearning is designed to empower staff in closing preventive care gaps for your patients.

Scan the QR code or click here to view our 8-minute training!

Preventive Care Reports is a tool in eReports that tracks patients who are due or will be due for pediatric immunizations and well-child visits. The report helps staff ensure timely care and improves patient engagement by keeping children up to date on their well-care.

This report also helps identify patterns and trends in immunization and well-visit rates for staff to utilize in driving performance strategies and targeted interventions.

Reports include:

Well-Visit Reports	Immunization Dose Reports
Six well-baby visits in first 15 months	Child immunization status
Annual well-child visits 3-17 years of age	Immunizations for adolescents
Two visits between 15 and 30 months	–

For questions, email pit@partnershiphp.org.

PartnershipHP.org (800) 863-4155

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Putting Quality Into Practice

Measure Best Practices

MEASURE BEST PRACTICES

The 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 is updated annually and 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 ★

Chlamydia Screening

Colorectal Cancer Screening

Controlling Blood Pressure

Comprehensive Diabetes Care: HbA1c - Good Control

Comprehensive Diabetes Care: Retinal Eye Exam

Dental Flouride Varnish ★

Immunizations for Adolescents

Lead Screening for Children ★

Well Child Visits 0-30 Months ★

Performance Improvement

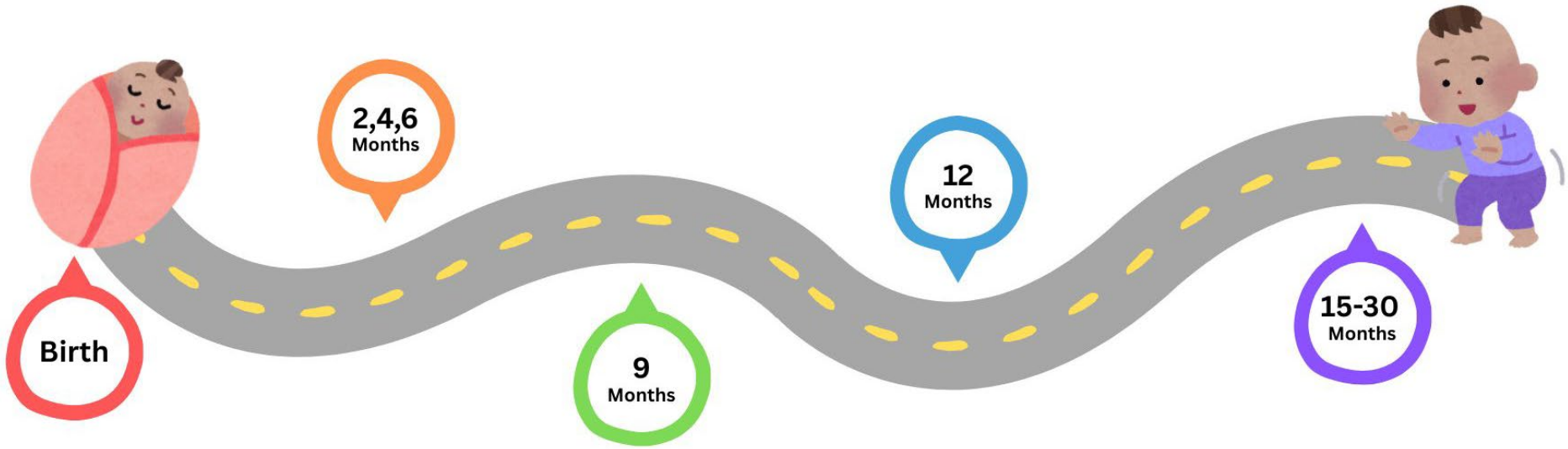
2026 Best Practices

Childhood Immunization Status 0-2 Years

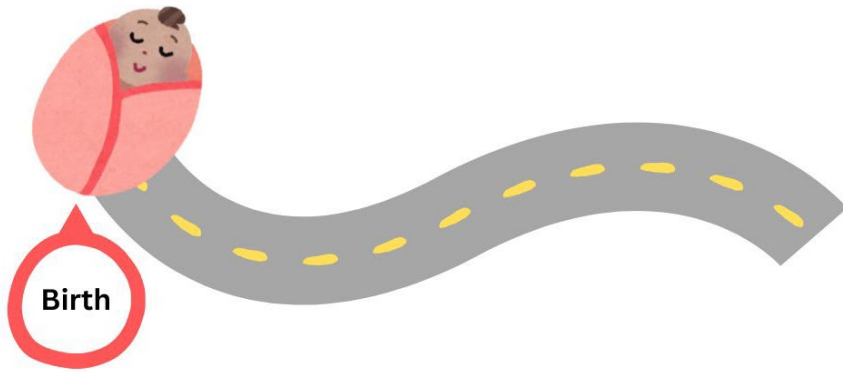
Partnership Tools, Programs, and Promising Practices:

- The **Preventive Care Report** is available in the **e-Reports portal** and is updated daily. This tool shows each provider's member list for the childhood immunization series measure denominator, along with completion dates for each immunization in the series. Use this tool to track, schedule, and complete all immunizations in the series before each child turns two years old.
- The **Preventive Care Report** now contains race / ethnicity and language fields. Use this dashboard to look at childhood immunization series 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 the childhood immunization series. A $100 gift card is offered to members who complete the recommended immunization series. Members can enroll directly by contacting the Population Health Department at **(855) 798-8764** or PopHealthOutreach@partnershiphp.org.
- Partnership has published **VaxFacts websites** in collaboration with local providers in some of our counties. Refer your patients and parents / caregivers to these websites to learn more about the importance of childhood vaccinations.
  - Del Norte VaxFacts: http://www.delnortevaxfacts.com
  - Humboldt VaxFacts: https://humboldtvaxfacts.com/
  - Lake VaxFacts: https://www.lakevaxfacts.com/
  - Mendocino VaxFacts: http://www.mendocinovaxfacts.com
  - Nevada VaxFacts: https://nevadacountyvaxfacts.com/
  - Shasta VaxFacts: http://www.shastavaxfacts.com
  - Solano VaxFacts: https://solanovaxfacts.com/
- Attend or view Partnership's **Improving Measure Outcomes training** on *Preventative 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.

Birth - 30 Month Journey



Birth



- **Scheduling:** Pre-schedule the first three visit series at discharge.
- **Handouts:** Give families a tangible roadmap for their baby's first 30 months of life.
- **Vaccine Schedule**: Review early CIS-10 schedule.
- **Growing Together Program:** Encourage patients to register for Partnership's incentive program where families can earn up to $200 for completing their well-child visits and immunizations.

2, 4, 6 Months

- **At these ages, success relies on predictable workflows:**
  - **Automated Reminders:** Communicate with families when immunizations are due or late via portal, texts, and/or calls.
  - **MA Prep Checklists:** Create checklists that MAs can use to prep the room for the visit.
    - Check baby's age and what vaccines are due
    - Prep supplies and screening tools
    - Confirms standing orders
    - Review family reminder preferences
  - **Standing Orders:** Set standing orders for CIS-10 vaccines.
  - **Missed Opportunities:** View every visit as an opportunity to complete a well-child exam or offer immunizations.

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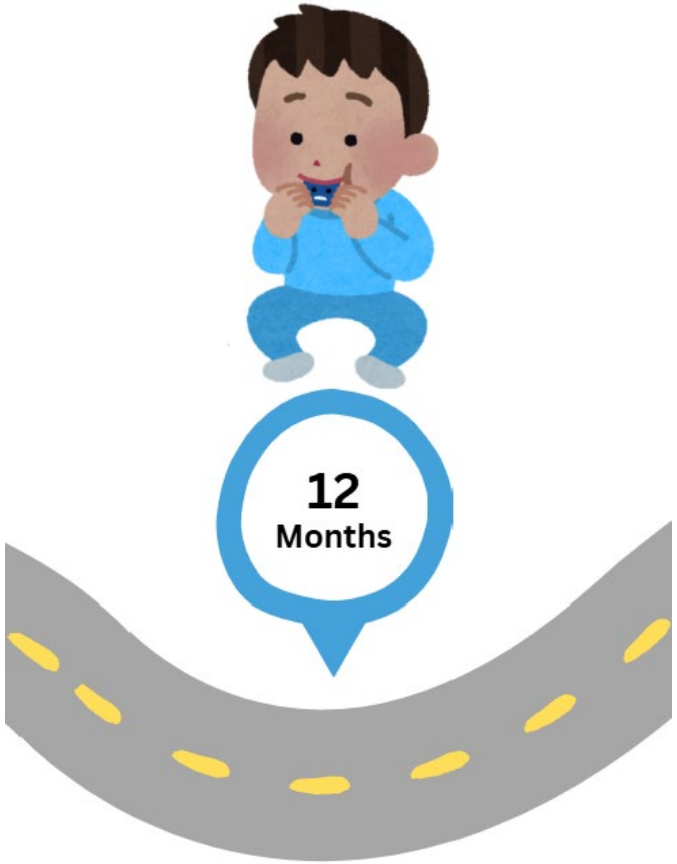
9 Months

This period is a **major risk point** in the journey. Families often start to miss visits and fall through the cracks.

- **Pre-Gap Outreach Strategy:** Proactive communication with families **before** a child becomes late for a well visit, vaccine, or screening.
- **Catch Up Opportunity:** Even though fewer vaccines are due at 9 months, this visit is a major catch-up opportunity.

12 Months



- Continue to use standing orders for CIS-10 visits.
- **Prepare Lead Screening Kit:** Have the lead test kit ready in the exam room to draw the sample during the visit rather than sending families to an outside lab.
- **Script:** Schedule the 15- and 18-month visits before checkout using a standard script that emphasizes convenience and helps prevent future missed visits.
- Consider this another catch up opportunity for any missed vaccines.

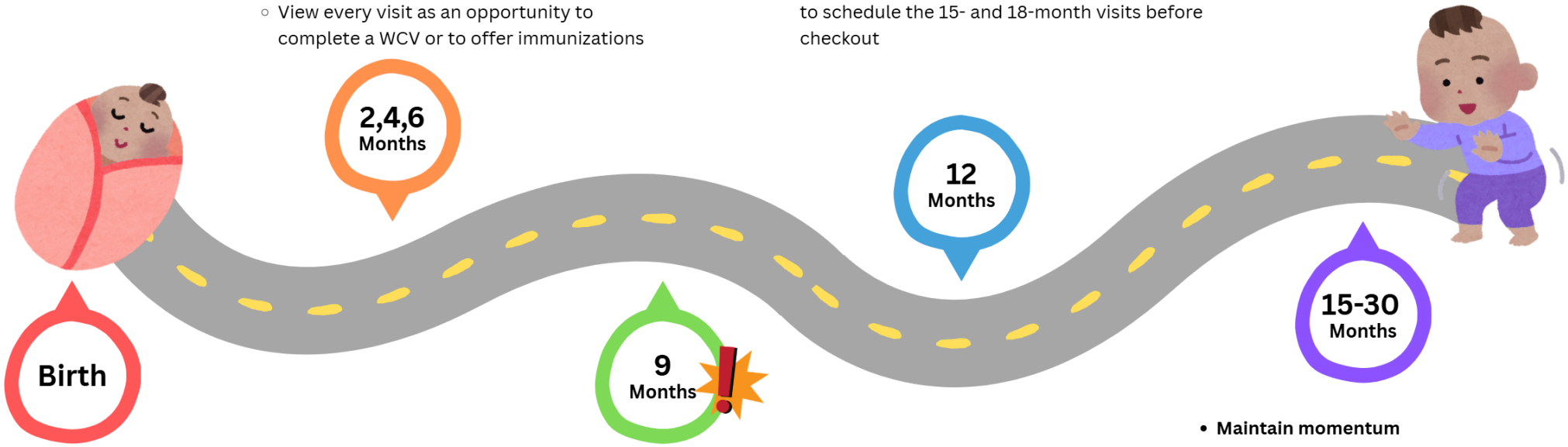
15 - 30 Months

- At this stage, it's all about maintaining momentum.
- **Scheduling**: Pre-schedule visits in advance at 15, 18, 24, and 30 months.
- **Reminder and Recall Systems**: Continue using automated reminders and outreach calls to keep families engaged.
- **Nurse-Only Visits**: Use nurse-only visits or short catch-up visits for any missed vaccines or screenings.

Birth - 30 Month Journey Workflow

- **Create predictable workflows**
  - Automated reminders
  - MA prep checklists
  - Standing orders for CIS-10 vaccines
  - View every visit as an opportunity to complete a WCV or to offer immunizations

- Standing orders for CIS-10 visits
- Prepare leads screening kit in advance and leave it in the exam room
- Use a standard script that emphasizes convenience to schedule the 15- and 18-month visits before checkout



- Preschedule as many visits as possible at discharge or at their first visit
- Give families a tangible roadmap for their baby's first 30 months of life
- Review early vaccine schedule
- Encourage Growing Together Program registration

- Complete pre-gap outreach
- Use appointment as a catch up opportunity

- **Maintain momentum**
  - Pre-scheduling future visits
  - Use automated reminder and recall systems
  - Use nurse-only visits to close gaps quickly

Integrating Best Practices into Your Existing Workflow

1. What can we fix *this week?*
   (workflow fixes)

2. What can we optimize *this quarter?*
   (system optimizations)

3. What becomes part of our clinic's culture *long-term?*
   (cultural / process shifts)

Immediate Workflow Fixes

- **Well-Baby and Well-Child Visits**
  - Pre-schedule the next visit before the family leaves
  - Use simple scripts like: “We always schedule the next visit at checkout, so you don’t have to remember to call us later”

- **CIS-10**
  - Standing orders so nurses can give vaccines during *any* visit
  - Use sick visits as opportunities to vaccinate

- **Lead Screening**
  - Draw lead in the **12-month visit**, not at an external lab
  - Prep the lead kit before rooming

System Optimization (1 - 3 Months)

- **Automated Reminders**
  - Texts for upcoming 2-, 4-, 6-, 9-, and 12-month visits
  - “Your child is due for vaccines this visit” messaging for CIS-10 catch-up
- **Pre-Scheduling Processes**
  - Create a script and workflow for pre-scheduling as many visits as you can through 30 months
    - Especially effective for 15-, 18-, 24-, 30-month visits
- **Monthly Outreach Lists**
  - Identify 9-month-olds at risk of missing 12-month visit
  - Identify 13-month-olds who haven’t had lead screening
- **Morning Huddle System**
  - Daily list: Who is due for what today?
    - Helps staff catch CIS-10 and lead opportunities early
- **Nurse-Only Visit Blocks**
  - For quick vaccination or lead draw catch-ups

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Cultural and Process Shifts

- **CIS-10 Culture Shift**
  - Everyone adopts the mindset: “If the child is here, it’s a vaccination opportunity”
- **Proactive Care Philosophy**
  - Shift from gap-filling → gap prevention
  - Clinic looks ahead at the 9- and 13-month milestones every month
- **New Hire Training Built Around these Norms**
  - Ensure new MAs, nurses, and front desk staff learn the workflows from day one
- **Celebrating Data Wins**
  - Monthly shoutouts when coverage rates improve
  - Reinforces that the work matters

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A Public Agency

Health Equity

Health Equity Focus

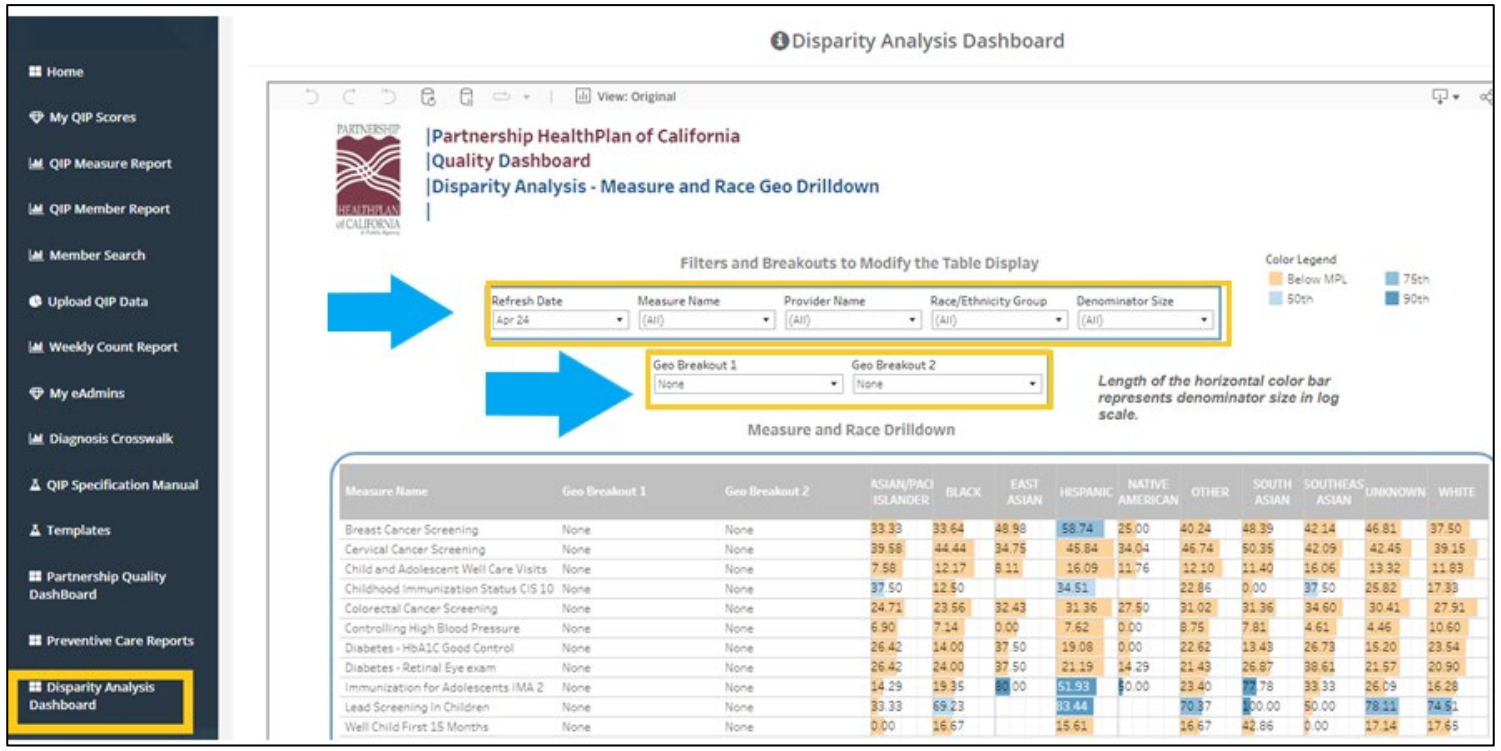
View vaccination rates and well-baby visits by race, ethnicity, location, and preferred language, it is possible to identify barriers that affect specific communities and plan interventions to address these barriers.

Health Equity Focus

- 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.
- 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).
- Utilize the Disparity Analysis Dashboard available in eReports.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

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.

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Voices of the Field

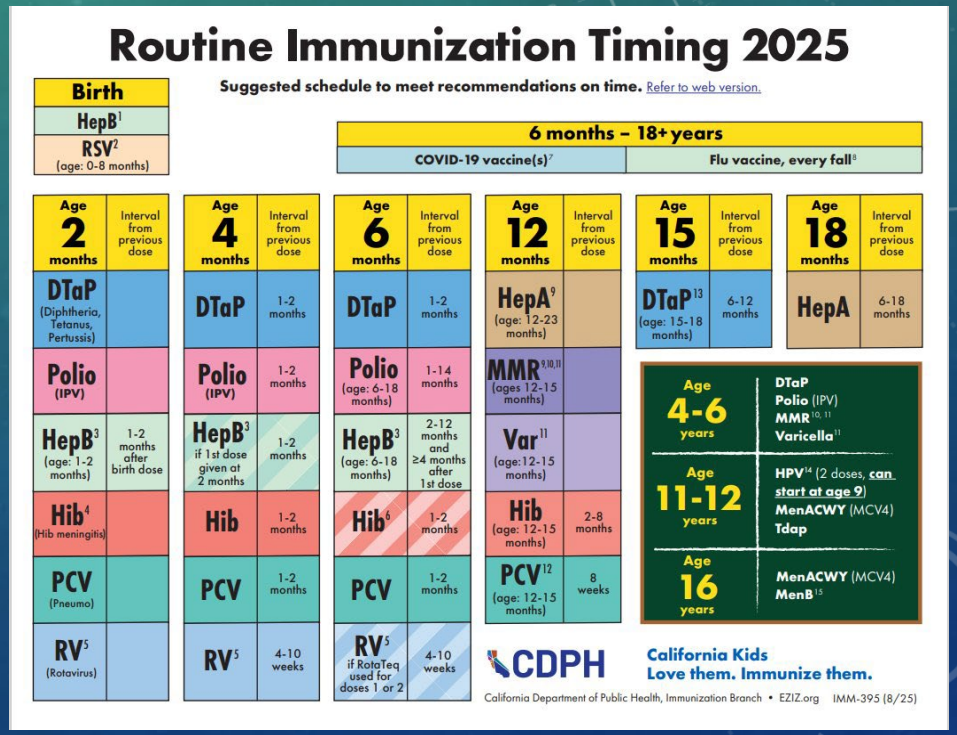
Amy Windrem BA, RN, Alliance Medical Center

THE KEY TO VACCINE UPTAKE

MAKE IT EASY MAKE IT FAST

VACCINE SYSTEMS

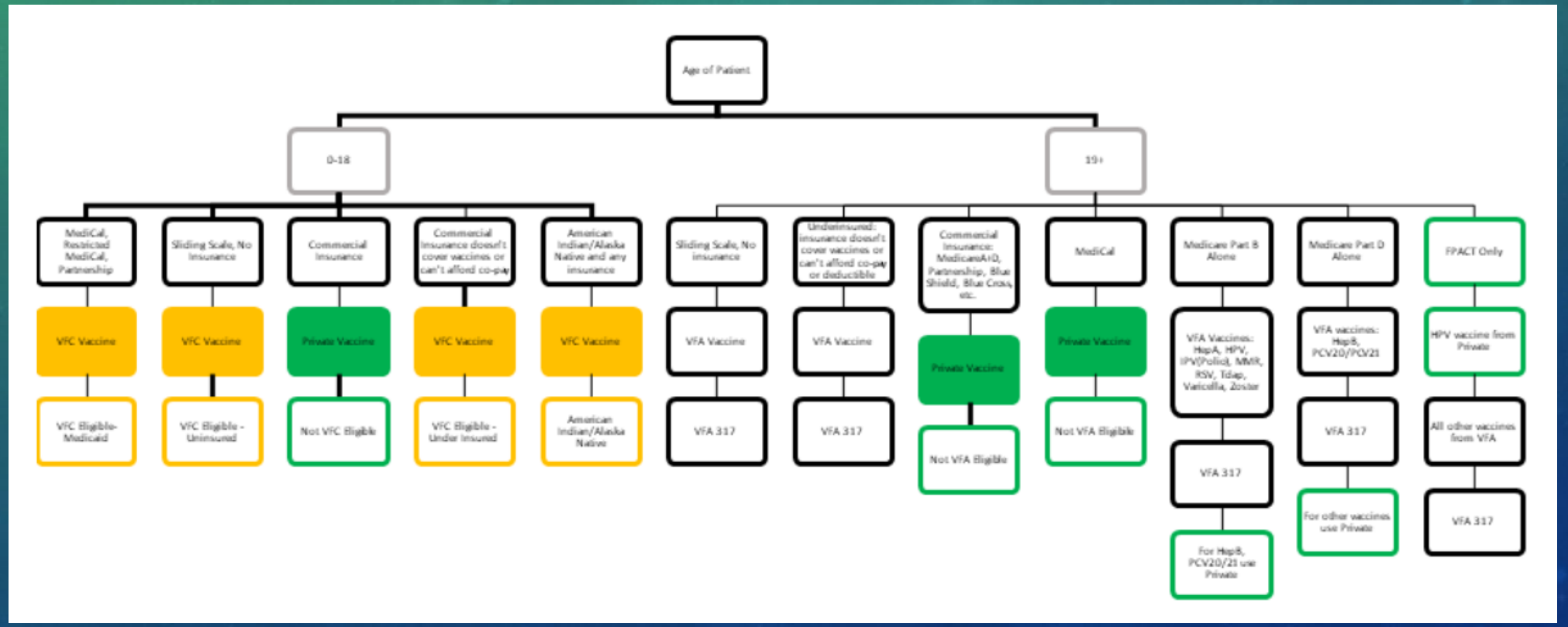
- Goal: Make a system where vaccines easy and fast
  - Address routine vaccine hesitancy – no one likes shots!
    - Efficient visits
    - After work access
- Impact
  - Vaccine rates go up
  - Safety goes up



VACCINE SYSTEMS

Decision Trees – make it easy to decide

Color code labels – make it easy to find

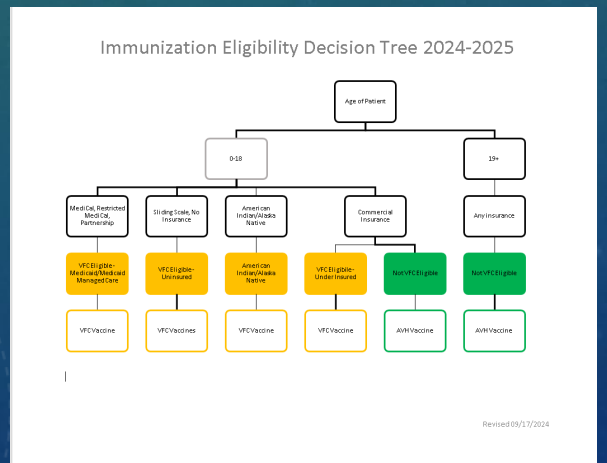


*Excludes flu and covid vaccine

VACCINE SYSTEMS

BEST PRACTICE: Labeled vaccine inventory has standard format and matches decision tree and EMR

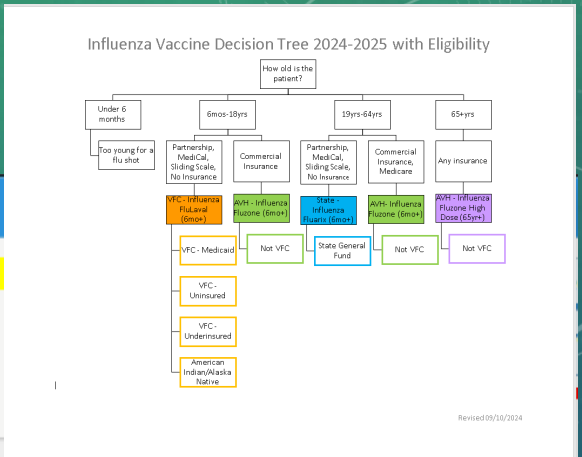
IMPACT: Faster and easier, reduces errors



Basket label

Box sticker

EMR ORDER MATCHES FRIDGE MATCHES TREE



Immunization Details [redacted]

Active

state

STATE - Influenza Fluarix (6mo+)

Note: There is no drug/allergy interaction check for immunizations

STATE - Influenza Fluarix (6mo+)

Vaccination given in the p

Biological/Medication Wasted

Visit Date 2023-12-21 EstPt

Dose 0.5 milliliters

Dose Number 0

Lot Number ... VFC

Route

Location

Exp. Date

VIS Given Date 12/06/2023

Status Pending

Reason ... Clr

By ... Me Clr

Given Time 12/21/2023 10:38 AM

Manufact

VFC State General Fund

Date on VIS

Allergies

Comments

Decrement the dose

Billable Counseling

New

Save and New OK Cancel

Fridge

STATE – Influenza Fluarix (6mo+)

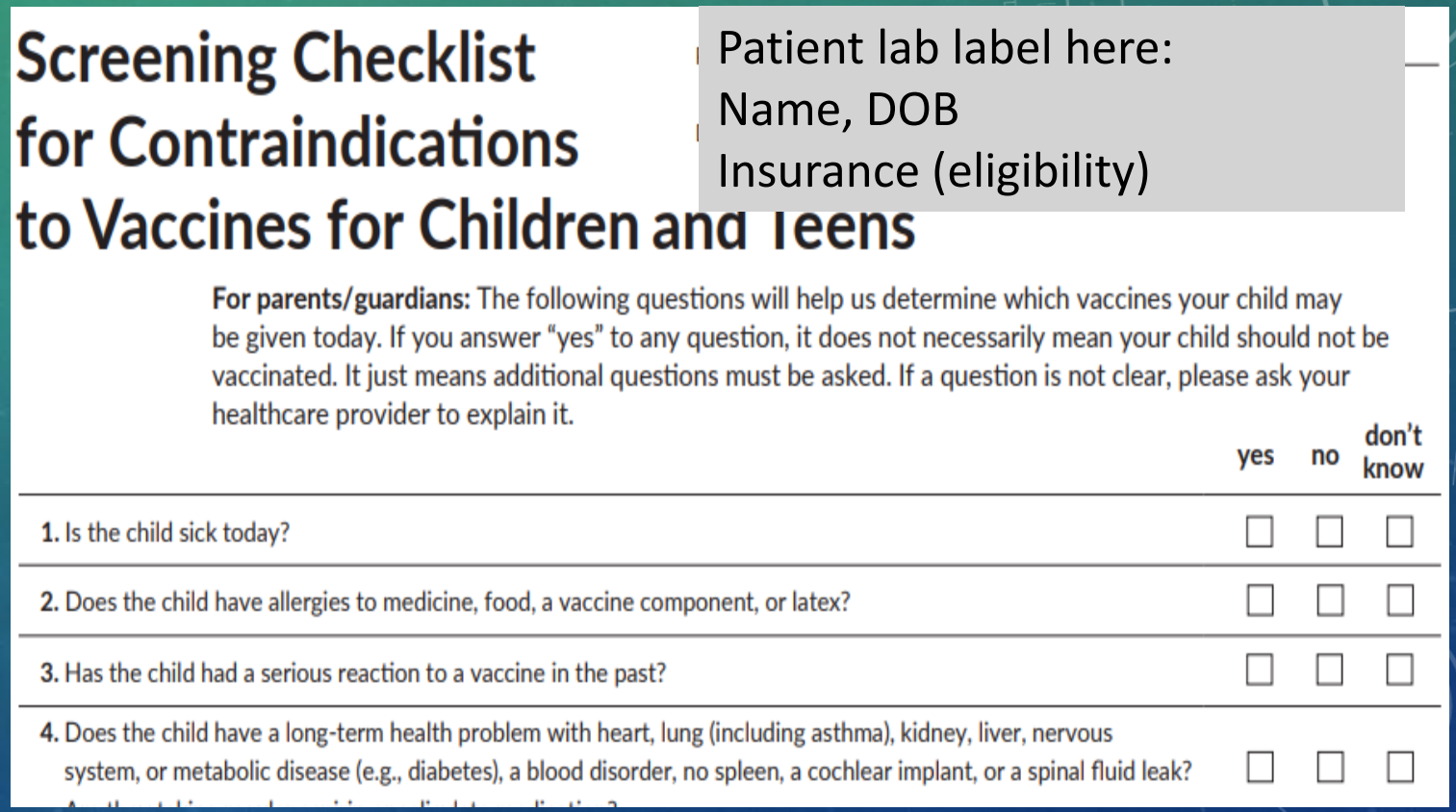
VACCINE SYSTEMS

Give this in the lobby to save time and ensure safety

Assume Opt In.

Best Practice: Print the label with the insurance – funding

Impact: faster and easier, safer, builds trust



Screening Checklist for Contraindications to Vaccines for Children and Teens

Patient lab label here:
Name, DOB
Insurance (eligibility)

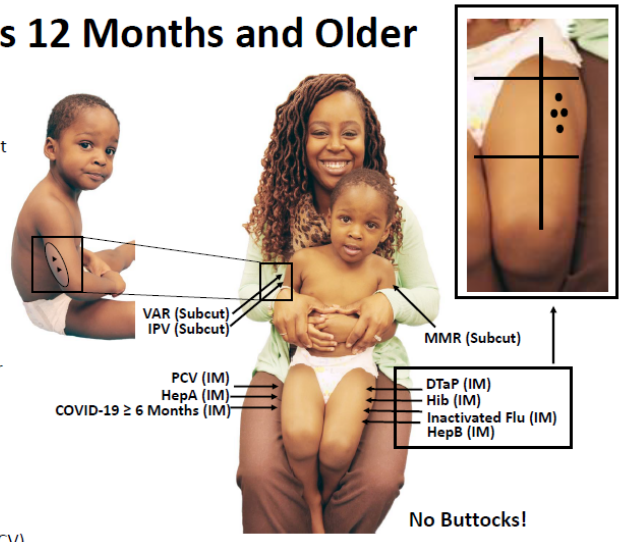
For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?	☐	☐	☐

VACCINE SYSTEMS - ADMINISTRATION

Giving All the Doses 12 Months and Older

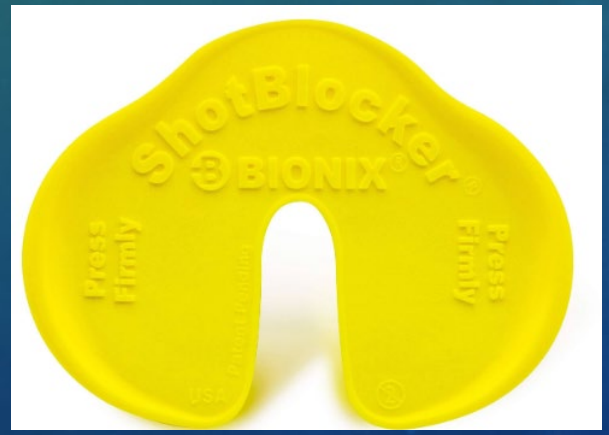
- **Intramuscular (IM)** injections are given at a 90° angle in the anterolateral thigh (preferred site for 12 mos.-2 yrs.) using a 1" needle (see ● to the right for placement)
  - Separate IM injection sites by a minimum of 1"
  - Deltoid is preferred IM site for 3 yrs. and older
    - Anterolateral thigh is an alternative site if deltoid cannot be used
- **Subcutaneous (Subcut)** injections are given at a 45° angle in the upper outer triceps area or thigh using 5/8" needle (see ▲ to the right for placement in triceps area)
- Using combination vaccines decreases the number of injections
  - IPV must be given IM when given as a combination vaccine (e.g., DTaP-IPV/Hib, DTaP-IPV-HepB, DTaP-IPV, DTaP-IPV-Hib-HepB)
- Give vaccines likely to cause greater local reaction into separate limbs (e.g., DTaP, PCV)
- Give the most painful injections last (e.g., MMR, PCV)



Additional vaccines may be needed. This handout only displays routine vaccines. For additional vaccine administration information see: "Administering Vaccines: Dose, Route, Site, and Needle Size" at www.immunize.org/catg.d/p3085.pdf

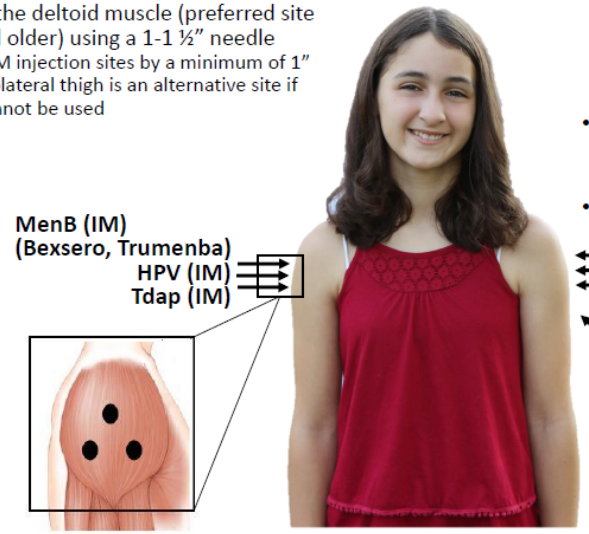
AIM ALLIANCE FOR IMMUNIZATION IN MICHIGAN

Revised: January 12, 2024



Giving All the Doses: Adolescents

- **Intramuscular (IM)** injections are given at a 90° angle in the deltoid muscle (preferred site for 3 yrs. and older) using a 1-1 ½" needle
  - Separate IM injection sites by a minimum of 1"
  - The anterolateral thigh is an alternative site if deltoid cannot be used
- **Subcutaneous (Subcut)** injections are given in the upper outer triceps area at a 45° angle using a 5/8" needle
  - The thigh is an alternative site if outer triceps area cannot be used
- Give vaccines likely to cause greater local reaction (e.g., Tdap, MenACWY) in separate limbs
- Give the most painful injections last (i.e., HPV)



Give other vaccines as needed (to bring up-to-date, high-risk): MMR (Subcut), HepA (IM), HepB (IM), IPV (Subcut), Mpox (Subcut), RSV (IM), and Pneumococcal (IM)

For additional vaccine administration information see: "Administering Vaccines: Dose, Route, Site, and Needle Size" at www.immunize.org/catg.d/p3085.pdf

AIM ALLIANCE FOR IMMUNIZATION IN MICHIGAN

Revised: January 12, 2024

MAXIMIZE ACCESS TO VACCINES

- **Goal:** Expand vaccine access for the patient
- **Impact:** Faster and easier to come to appointments, vaccine rates go up
- Under 19 yrs with Medical cannot go to a pharmacy

TRACKING VACCINE DATA, OPPORTUNITES FOR OUTREACH

GET THE DATA:

Pull report monthly; Work on it at least weekly

Sort by **Partnership** Y/N → **sort by days until 2 years of age**

OUTREACH IN VACCINE WINDOW:

Rotavirus window closes first

Target outreach to patients who are still eligible or short window

Call parents a few days before their appointment

Catch no shows to reschedule

CONFIRM NEED FOR VACCINES:

Check CAIR before each scheduled visit

If new patient with no history, get records to check vaccine history

MRN	Insurance (orig)	Partnership	Age today in months	BIRTH DATE (Patient-3)	Days until 2 yrs	Notes	3 RV	4 Dtap	3 IPV	1 MMR	3/4 Hib	3 Hep B	1 VZV	4 PCV	1 Hep A	2 Flu
					-5		0	0	0	0	0	0	0	0	0	0
					-5		0	3	3	1	3	3	1	4	1	0
					-3		3	4	3	1	3	3	1	4	1	0
					3		2	3	3	1	1	3	0	1	0	0
					8	meets	3	4	3	1	3	3	1	4	1	2
					11		3	4	3	1	3	3	1	4	1	0
					12		3	4	3	1	2, out	3	1	4	1	0
					14	needs 2 flu	3	4	3	1	3	3	1	4	1	0
					16		2	4	3	1	3	3	1	3	1	1
					23	meets	3	4	3	1	3	3	1	4	1	2
					24	needs 2 flu	3	4	3	1	3	3	1	4	1	0
					25	MA 9/29, will not me	3	4	3	1	3	3	1	3	1	0

Thank you!

Questions?

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707-385-2329

Upcoming Trainings

Improving Measure Outcomes Webinar Series

The Improving Measure Outcomes learning series is designed to help quality improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes.

2026 Webinar Schedule

All webinars are held from noon to 1 p.m.

February 25, 2026 - Preventive Care for Children and Adolescents Ages 3 – 17 Years
March 11, 2026 - Preventive Cancer Screenings: Improving Outcomes through Early Detection
March 25, 2026 - Managing Chronic Disease: Strategies for Blood Pressure and Diabetes Control
April 8, 2026 - Sexual and Reproductive Health
April 22, 2026 - Improving Perinatal Outcomes

**Continuing education credits available.*

For details and registration, visit Improvement Academy's event page
Questions? Email improvementacademy@partnershiphp.org

ABCs of Quality Improvement

An in-person training designed to introduce participants to key Quality Improvement (QI) methodologies, with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings

Thursday, March 19, 2026
8:30 a.m. – 4:30 p.m.
Redding

REGISTER HERE

Course topics include:

- Basic Principles of Quality Improvement
- Introduction to the Model for Improvement
- Creating an Aim Statement
- Using Data to Measure and Drive Improvement
- Developing Change Ideas
- Testing Changes with the Plan-Do-Study-Act Cycle

**CME/CEs available.*

Email questions to improvementacademy@partnershiphp.org

Vaccine Hesitancy in the Current Climate Webinar

This webinar is designed to equip providers to address vaccine misinformation and navigate recent immunization changes. Learn directly from a panel of pediatric organizations as they share their strategic blueprints for achieving benchmark-setting vaccination rates and overcoming vaccine hesitancy.

REGISTER HERE

Tuesday, March 3, 2026
Noon - 1 p.m.

**Continuing education credits available.*

Questions? Email improvementacademy@partnershiphp.org

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. The program features:

- The Prenatal Program
- The Postpartum Program
- The Healthy Baby Program

To learn more, email PopHealthOutreach@partnershiphp.org.

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

PartnershipHP.org (800) 863-4155 HealthEd175_102324

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

Evaluation

Contact Us

Teresa Frankovich, MD MPH FAAP
Associate Medical Director

tfrankovich@partnershiphp.org

pit@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