## Well Child Documentation Tips

Be sure your documentation meets all EPSDT well child requirements. Thorough EPSDT well child documentation may help improve your P4P and HEDIS scores.

### Health History
*Should be documented at every EPSDT and well child visit.

**EXAMPLES:**
- “Medical history, surgical history, allergy list, medical list was reviewed and updated. No illnesses since last visit.”
- “39.4 weeks gestation, vaginal delivery, mom GBS +ve, Hep B Immun at birth, birth weight 7.6oz.”
- “Here for 6yo well visit. Historian: foster mother. Pt’s problem list, medical history, surgical history, and medication list were reviewed. Sleeping >8 hours. No enuresis. Saw allergist yesterday, awaiting lab results.”

### Psychosocial/Family History
*Should be documented at every EPSDT and well child visit

**EXAMPLES:**
- “PSH/PFM reviewed and updated.”
- “Parent adjustment to child: adjusting well; sibling adjustment to child: adjusting well; childcare: in-home daycare 3xweek; living at home with mom, dad, sisters (x2), and 2 cats. Smoking: dad smokes outside only.”
- “Family history reviewed– unremarkable; interacts well with peers; involved in school activities; parents involved with homework and know child’s social circle. No signs of domestic violence or child maltreatment.”

### Structured Developmental Screening
*Development screening at 9 mos., 18 mos., and 30 mos. Autism screening at 18 mos. and 24 mos. Name of screening tool used AND result should be documented at each EPSDT visit (as indicated by age).

**EXAMPLES:**
- “PSC completed. WNL.”
- “Development normal for age– see Ages and Stages Questionnaire in chart.”
- “M-CHAT completed– results reviewed with pt’s grandmother. First Steps referral.”

### Ongoing Developmental Surveillance
*Developmental milestones should be documented at each EPSDT and well child visit. A complete listing of developmental milestones or a statement similar to, “all areas of development normal for age,” meet both mental and physical developmental surveillance.

**EXAMPLES:**
<table>
<thead>
<tr>
<th>Mental</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Alert. Turns and calms to parent’s voice.”</td>
<td>“Strong root reflex. Follows face to midline.”</td>
</tr>
</tbody>
</table>

### Depression Screening/ Risk Assessment
*All children ages 11-21 years. Depression screening using the PHQ-2, PHQ-9 or other tool. Risk assessment using CRAFFT, HEEADSSS or a similar screening tool should be document at each EPSDT visit (as indicated by age).

**EXAMPLES:**
- “CRAFFT screening completed– negative. PHQ-9 completed-positive. Refer to behavioral health.”
- “HEEADSSS completed. PHQ-2 negative. No behavioral concerns identified. No suicidal ideation or depression symptoms identified.”
- “SBIRT completed– no concerns identified. PHQ-9 negative. Will re-screen in 3 months.”
Nutritional and Physical Activity Assessment
*Nutritional assessments should be documented at all EPSDT and well child visits, and a physical assessment beginning at age 3 years and older.

EXAMPLES:
- "Nutrition hx reviewed. Exercise includes softball and volleyball. Positive body image."
- "Reviewed nutritional habits, no concerns. 60 mins outdoor play time: yes. Outdoor activities as a family: yes."
- "Enjoy physical activity and a variety of fruits and vegetables every day."

Physical Examination
*A head to toe exam should be documented at all EPSDT and well child visits. “PE: WNL” is NOT sufficient. EPSDT requires an external eye exam and an oral inspection at each EPSDT visit.

EXAMPLES:
Documentation examples of external eye inspection:
- “PEERL, lids NL, conjunctivae/sclera clear.”
- "EOMI, pupils equal and round, no eye redness or drainage noted."

Documentation examples of oral inspection:
- "Mouth/gums: palate intact, no thrush, no dental ridges, no bleeding or inflammation of gums."
- "Oral cavity: MMM, tongue/frenulum: NL, gums NL, dentition NL, no staining, no lesions."

Vision and Hearing Screenings
*Screenings should be implemented and documented according to the Bright Futures periodicity schedule for all EPSDT visits (as indicated by age).

EXAMPLES:
- “Vision acuity: 20/40 OU. Pt has appt with ophtho next month. Hearing screening done at school earlier this year, was normal per mother.”
- "Vision acuity tested, 20/15 OU. Referred to audiologist for hearing screening."
- "Unable to perform vision acuity or hearing testing d/t child unable to cooperate. Will retest in 6 months."

Dental Screening
*Dental referrals should be made and documented beginning at age 2 years and older at all EPSDT visits.

EXAMPLES:
- "Reviewed importance of dental hygiene. Has never been to a dentist. Referral given for dental clinic."
- "Dental home: yes. Dental visit within past 6 months: yes. Recent dental emergencies: no."
- "Brushes teeth 2x day, flosses, annual dental visits. Discussed importance of routine dental care."

Anticipatory Guidance/ Health Education
*Should be documented at every EPSDT and well child exam

EXAMPLES:
- "Bright Futures handout given."
- "AG discussed."
- "Preventive health reviewed: nutrition, exercise, safety, dental, development, & behavior."

Immunizations
*Should be documented at all EPSDT and well child visits

EXAMPLES:
- "IMMS UTD. See IMM record."
- "Checked CHIRP. Due for Dtap and Hep A. Referred to Health Dept. Health Dept. to fax UTD IMM record."
- "Needs HPV #1. To RTC in 1 mos. for HPV #2."