

Health Plan Performance Improvement Project (PIP)

Health Plan: Fluoride Varnish Application

**PIP Title: Fluoride Varnish Application to Primary Teeth
of All Enrollees Aged 6 months through 5 years by
Primary Care Clinicians**

**PIP Implementation Period: January 1, 2022–December
31, 2022**

Project Phase: Proposal

Submission Dates:

	Report Year 2022
Version 1	12/09/2022
Version 2	12/30/2022

MCO Contact Information

1. Principal MCO Contact Person

[Person responsible for completing this report and who can be contacted for questions]

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2. Additional Contact(s)

[Person(s) responsible in the event that the principal contact person is unavailable]

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3. External Collaborators: MCNA and DentaQuest, and Well-Ahead Louisiana; PCP practices with Electronic Health Records {e.g., for incorporation of automated reminders per Carmen and French (2020)}.

Attestation

Plan Name: **Fluoride Varnish Application**

Title of Project: **Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 months through 5 years by Primary Care Clinicians**

The undersigned approve this performance improvement project (PIP) and assure involvement in the PIP throughout the project.

Medical Director signature: Madelyn M. Meyn, MD
First and last name: Dr. Madelyn M. Meyn
Date: December 30, 2022

CEO signature: Richard C. Born
First and last name: Richard C. Born
Date: December 30, 2022

Quality Director signature: Arlene Pagan-Loots
First and last name: Arlene Pagan-Loots
Date: December 30, 2022

Updates to the PIP

For Interim and Final Reports Only: Report all changes in methodology and/or data collection from initial proposal submission in the table below.

[Examples include added new interventions, added a new survey, change in indicator definition or data collection, deviated from HEDIS® specifications, reduced sample size(s)]

Table 1a: Updates to PIP

Change	Date of Change	Area of Change	Brief Description of Change
Change 1 Dental data availability for age group identified in the PIP.	End of Quarter 1	<input type="checkbox"/> Methodology <input checked="" type="checkbox"/> Barrier Analysis <input type="checkbox"/> Intervention <input type="checkbox"/> ITM	LDH reported data for 21+ year old members and not children 6 months-5 years of age.
Change 2 Gap in Care (GIC) reporting development	Quarter 2	<input checked="" type="checkbox"/> Methodology <input type="checkbox"/> Barrier Analysis <input type="checkbox"/> Intervention <input type="checkbox"/> ITM	The custom measure that initially was supposed to be completed by Innovolan was not completed on time. ABHLA decided to utilize Availability as a method get the GIC reports to providers.
Change 3: Dental data availability for age group identified in the PIP	Quarter 3	<input type="checkbox"/> Methodology <input checked="" type="checkbox"/> Barrier Analysis <input type="checkbox"/> Intervention <input type="checkbox"/> ITM	Although regions 4 and 7 were identified initially when reviewing the Disproportional grid. As the plan continues to make strides to get enrollees fluoride varnish in the PCP office additional targeted areas were identified. Regions 5 and 8 were targeted due to ongoing barriers for African American (Non- Hispanic) population.
Change 4		<input type="checkbox"/> Methodology <input type="checkbox"/> Barrier Analysis <input type="checkbox"/> Intervention <input type="checkbox"/> ITM	

Abstract

For Final Report submission only. Do not exceed 1 page.

Provide a high-level summary of the PIP, including the project topic and rationale (include baseline and benchmark data), objectives, description of the methodology and interventions, results and major conclusions of the project, and next steps.

Objectives:

The overall objective for this PIP was to work with pediatricians who are servicing enrollees for 6 months to five years to receive fluoride varnish in their primary care office visits. In addition, we wanted to ensure that we educated providers on billing CPT code 99188 and the need to obtain the smiles for life certification to ensure that they were eligible to provide this service, which would intern help to reduce/prevent various dental caries being seen in this population.

Description of the Methodology and Interventions:

ABHLA utilized the data to help to determine the areas and enrollee populations who were underserved and focused on getting education and resources available in those areas. In addition, it was a push to provide education on the appropriate CPT code and building of community partnerships such as the American Association of Pediatrics (AAP), Open Health, and one of our Tribal provider representative Chief Warhorse. In addition, the plan reached out to Smiles for Life to build a relationship that would allow providers to take the appropriate course via a link after attending an educational course/presentation presented by LA- AAP ABHLA. The plan hosted multiple community events in the various regions based on population disparities. Those community partnerships included SWLA Center for Health, Enrollee Activity committees, Provider Advisory Committee, and others. Several articles for provider newsletters were developed that encouraged PCPs to apply Fluoride Varnish to children 6 months- 5 years of age to prevent dental diseases. ABHLA analysis data systems information to monitor progress of each intervention and meets weekly with workgroups to determine if the identified interventions were yielding the progress to reach the target score for this PIP.

Results and Major Conclusions:

Based on the data we are seeing continued utilization of the CPT code 99188 and continuous increases in the various ITM's that have been developed. In reviewing data, we saw an increase of 32.68% in educational efforts from Q2 to Q3, and a 1% increase in the utilization of the code over the same time period. In addition, the plan also saw an approximately 2% increase in the number of enrollees receiving the fluoride varnish in the PCP office. As we are moving to the end of 2022 the plan is looking to see a significant increase in the 4 indicators monitored. One of the major conclusions identified in this PIP was that the plan was not able to determine if members were receiving the fluoride varnish in the dentist office due to the inability to capture this data through claims, as we move into 2023 it will be important to capture this information to truly understand the percentage of enrollees who are not receiving treatment at all.

Next Steps:

Interventions that are currently in place will be continued in 2023. ABHLA will continue focus on regions 5 (SWLA) and 8(NELA) two regions that were identified as underserved for the fluoride varnish application by PCPs. There is a plan to partner with Chief Warhorse and her tribe and to

spread education to our Native American enrollees. The goal is to develop community events to connect with the enrollees of those regions, to develop materials that meet their needs, provide resources and to build stronger relationships/partnerships with providers and enrollees.

Project Topic

To be completed upon Proposal submission. Do not exceed 2 pages.

Describe Project Topic and Rationale for Topic Selection

- **Describe how PIP Topic addresses your member needs and why it is important to your members:**

Our population assessment showed a membership of 131,715 individuals within the TANF, ABD, CHIP, and SSI. There are 88,885 (67.48%) adult members (greater than 18) and 42,830 (32.52%) members under the age of 19. Children 6 months to 5 years of age are approximately 34.61% of our population of members under the age of 19.

ABHLA identifies the opportunities to improve health outcomes to our members due to the low percentage rates seen in the 2021 data for those members receiving fluoride varnish by their PCP's. The data shows that we are less than 9% in all 4 indicators identified by the Louisiana department of health. In reviewing information from the American Association of Pediatrics (AAP) it identified that oral health for the pediatric population has been unchanged since 2014 and understanding that tooth decay is a bacterium of the surface, which is an infectious disease. ABHLA is committed to improving monitoring and treatment to improve members' health outcomes and lessen their barriers to receiving the treatment and services they need.

As ABHLA continues to review the analysis of the disproportionate under representation of fluoride varnish receipt for the plan population, it has been identified that there are a range when looking at regions, race/ethnicity, and age. Based on the data found in the graph, although Region 1 has the highest population, it is Regions 4 and 7, which have been identified with disparities. In addition, to that information we are aware that age ranges 19 months to 2 years hold the greatest risk based on the age categories and the plans African American (non-Hispanic) population shows the highest based on race and ethnicity.

- **Describe Project Topic and Rationale for Topic Selection**

ABHLA identified above the high-risk population based on the disproportionate analysis completed. As a result of this analysis, ABHLA will focus on key areas to ensure education and resource availability for its members, especially in the regions defined. The graph below depicts the appropriate population based on regions. As discussed earlier, Region 1 has the highest population, but Regions 4 and 7 were identified as underserved based on the analysis. The additional graph allows for the breakdowns based on gender and rate codes.

Regions	Eligible Member
Region 1 - Greater New Orleans Area	4485
Region 2 - Capital Area	2002
Region 3 - South Central Louisiana	1079
Region 4 - Acadiana	2164
Region 5 - Southwest Louisiana	349
Region 6 - Central Louisiana	894
Region 7 - Northwest Louisiana	2445
Region 8 - Northeast Louisiana	909
Region 9 - Northshore Area	1954
Grand Total	16281

Regions	Eligible Member
F	7928
M	8353
Grand Total	16281

- **Describe current research support for topic (e.g., clinical guidelines/standards):** Include discussion of the following:

- Prevention of Dental Caries in Children from Birth Through Age 5 Years: US Preventive Services Task Force Recommendation Statement (update in progress as of May 4, 2021). <https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1>
- American Academy of Pediatrics Clinical Guidance Report on Fluoride Use in Caries Prevention in the Primary Care Setting (Clark et al., 2020)

Regions	Eligible Member
ACA	1
BH	8
CHIP	54
FC	17
SSI	355
TANF	15846
Grand Total	16281
Appropriate membership based on rate code	

Based on research, this is a silent epidemic, and it is important that ABHLA helps their members improve their health outcomes. “An updated AAP clinical report from the Section on Oral Health aims to assist pediatricians in maximizing the use of fluoride for caries prevention while minimizing the risk of enamel fluorosis. It also clarifies the advice pediatricians should give regarding fluoride use in the home (graph right in document).”

In reviewing the Journal of The American Dental Association, and the clinical practice guidelines, it was identified that 2.26 percent of the physicians agreed that fluoride varnish for children younger than 6 years at least every three to six months is beneficial, stating that “the benefit of receiving the treatment outweighs the potential harm”. (JADA, 2013)

Data reviewed in the Centers for Disease Control and Prevention it was identified that there is no published evidence that indicates that professionally applied fluoride varnish is a risk factor for dental fluorosis, even among children under the 6 years of age. The actual recommendation based on CDC data is as follows:

Fluoride modalities for low- and high-risk patients

Fluoride modality	Low caries risk	High caries risk
Toothpaste	Starting at tooth emergence (smear of paste until age 3, then pea-sized)	Starting at tooth emergence (smear of paste until age 3, then pea-sized)
Fluoride varnish	Every 3-6 months starting at tooth emergence	Every 3 months starting at tooth emergence
OTC mouth rinse	Do not use	Starting at age 6 years if the child can reliably swish and spit
Community water fluoridation	Yes	Yes
Dietary fluoride supplements	Yes, if drinking water supply is not fluoridated	Yes, if drinking water supply is not fluoridated

Source: AAP clinical report *Fluoride Use in Caries Prevention in the Primary Care Setting*, <https://doi.org/10.1542/peds.2020-034637>

“Advice for Parents

For children aged 6 years and younger, some simple recommendations are advised to reduce the risk of dental fluorosis.

- Supervise brushing to discourage swallowing toothpaste
- Place only a small pea-size amount of fluoride toothpaste on your child’s toothbrush
- For children younger than 2, consult first with your doctor or dentist regarding the use of fluoride toothpaste.” (CDC, 2019)

- **Explain why there is opportunity for MCO improvement in this area, by addressing the following:**

- Current MCO data on caries prevalence and fluoride varnish receipt rates ABHLA baseline data for all 4 indicators defined by the Louisiana Department of Health were less than 9%, which identifies that there is a disparity surrounding the process of members 6 months to 5 years receiving fluoride varnish in the PCP office. In addition, when looking at the number of claims received from providers it is ABHLAs assumption it may be an under reported or lack of knowledge concerning the utilization of CPT code 99188.

In addition, based on information on social determinants of oral health it further advances the prevalence of ABHLAs stance that there is an opportunity for ensuring that fluoride varnish in children becomes a focus. In reviewing documentation, it was identified that tooth decay affects more than 1 in 4 U.S. children ages 2 to 5. The ability to access oral health care is associated with gender, age, education level, income, race and ethnicity, access to medical insurance, and geographic location. The utilization of data surrounding ABHLA members to address these social determinants is key in reducing disparities and improving the health of members. Efforts are needed to overcome barriers to access to oral health care caused by geographic isolation, poverty, insufficient education, and lack of communication skills.

- Consider PDSA findings about barriers and drivers in the scientific literature, for example:
 - Johnson SC and French GM. A quality improvement project to optimize fluoride varnish use in a pediatric outpatient clinic with multiple resident providers. *Hawaii Journal of Health & Social Welfare*, May 2020, VOL 79, NO 5, Supplement 1.
 - Sudhanthar S, Lapinski J, Turner J, Gold J, Yakov S, Thakur K, et al. Improving oral health through dental fluoride varnish application in primary care pediatric practice. *BMJ Open Quality* 2019; 8: e000589.doi:10.1136/bmj-oq-2018-000589.

Aims, Objectives and Goals

Healthy Louisiana PIP Aim: The overall aim is to improve, by at least 10 percentage points from baseline to final measurement, the percentage of children ages 6 months through 5 years who received fluoride varnish application by their PCP, by implementing new or enhanced interventions to achieve the following **objectives**:

1. Create a Member Fluoride Varnish Care Gap Report, with a version organized by PCP, that identifies all enrollees ages 6 months through 5 years who have not received any fluoride varnish application by their PCP (CPT code 99188) or dentist (CDT code D1206 or D1208) during the baseline year. The gap report would also identify missed opportunities by reporting the number of PCP visits for each child on the list.
2. Conduct member outreach to (a) educate parents of each child on the Member Fluoride Varnish Care Gap report about oral hygiene, caries risk and the importance of fluoride (e.g., toothpaste, varnish), (b) to link with a PCP if they do not already have one, and (c) to schedule a dental provider appointment. Collaborate with MCNA and DentaQuest for dental provider referrals. Use AAP resources available at: <https://www.healthychildren.org/English/healthy-living/oral-health/Pages/Brushing-Up-on-Oral-Health-Never-Too-Early-to-Start.aspx>
3. Conduct provider educational outreach to each PCP with patients on the Member Fluoride Varnish Care Gap Report and support by distributing the following educational materials:
 - (a) Fluoride Varnish Age-Stratified Member Care Gap Reports to each PCP (using the PCP-specific member listing),
 - (b) American Academy of Pediatrics Clinical Guidance Report on Fluoride Use in Caries Prevention in the Primary Care Setting (Clark et al., 2020), and
 - (c) LDH Informational Bulletin 16-7, Revised June 27, 2017: Professional Services Fluoride Varnish Program Policy. Educate PCPs about how physicians, nurse practitioners and physician assistants can qualify for reimbursement for fluoride varnish services by reviewing the “Smiles for Life Caries Risk Assessment, Fluoride Varnish, and Counseling Module” and successfully passing the post assessment, at the link provided:

www.smilesforlifeoralhealth.org, Course No. 6: Caries Risk assessment, Fluoride Varnish & Counseling.

(d) Well-Ahead Louisiana resources on preventive oral health:

<https://wellaheadla.com/prevention/oral-health/>

(e) Well-Ahead resources for fluoride varnish applications by PCPs:

<https://wellaheadla.com/prevention/oral-health/>

4. Develop and implement tailored and targeted interventions informed by your Analysis of Disproportionate Under-Representation.

Table 2: Goals

Indicators	Baseline Rate ¹ Measurement Period: 1/1/21–12/31/21	Final Rate Measurement Period: 1/1/22– 12/31/22	Subsequent Rate Measurement Period: 1/1/23– 12/31/23	CY 2022 Target Rate ²	Rationale for Target Rate ³
Indicator 1: Fluoride varnish application by PCP for children aged 6-18 months	N: 130 D: 2794 R: 4.65%	N: 152 D:3300 R:4.60%	N: D: R:	R: 7.65%	Increase by 3 percentage points from CY 22 to CY 23
Indicator 2: Fluoride varnish application by PCP for children aged 19 months-2 years	N: 122 D: 1381 R: 8.83%	N: 291 D:4 060 R: 7.16%	N: D: R:	R:11.83%	Increase by 3 percentage points from CY 22 to CY 23
Indicator 3: Fluoride varnish application by PCP for children aged 3-5 years	N: 433 D: 11990 R: 3.61%	N:280 D:6680 R:4.19%	N: D: R:	R: 6.61%	Increase by 3 percentage points from CY 22 to CY 23
Indicator 4: Fluoride varnish application by PCP for All Children Ages 6 months – 5 years	N: 685 D: 16165 R: 4.24%	N:723 D:14,040 R:5.14%	N: D: R:	R: 7.24%	Increase by 3 percentage points from CY 22 to CY 23

¹ Baseline rate: the MCO-specific rate that reflects the year prior to when PIP interventions are initiated.

² Upon subsequent evaluation of performance indicator rates, consideration should be given to improving the target rate, if it has been met/exceeded at that time.

³ Indicate the source of the final goal (e.g., NCQA Quality Compass) and/or the method used to establish the target rate (e.g., 95% confidence interval).

Methodology

To be completed upon Proposal submission.

Performance Indicators

Table 3: Performance Indicators

Indicator ¹	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator 1: Fluoride varnish application by PCP for children age 6-18 months	Percentage of enrollees who received one or more fluoride varnish applications to a primary tooth by a PCP while age 6 months through 18 months during the measurement year	Administrative	Enrollees who were between and including 6 months of age and 18 months of age during the measurement year	Children who received fluoride varnish application ONLY by a dentist during the measurement year (CDT codes D1206 {professionally applied fluoride varnish} or D1208 {any topical application of fluoride including fluoride gels or fluoride foams, excl, varnish}. If unable to obtain exclusion data administratively, include a footnote to explain, and coordinate with parent, PCP and dental provider to identify children who have already received fluoride varnish from their dental provider, and exclude from ITM 1.	Fluoride Varnish Applied during the measurement year: CPT code: 99188 Application of topical fluoride varnish by a PCP (a physician or other qualified health care professional) on the same day of service as an office visit or preventive screening visit	Eligible population less exclusions

Indicator ¹	Description	Data Source	Eligible Population Specification	Exclusion Criteria	Numerator Specification	Denominator Specification
Indicator 2: Fluoride varnish application by PCP for children age 19 months-2 years	Percentage of enrollees who received one or more fluoride varnish applications to a primary tooth by a PCP while age 19 months through 2 years during the measurement year	Same as above	Enrollees who were between 19 months of age and 2 years of age during the measurement year	Same as above	Same as above	Same as above
Indicator 3: Fluoride varnish application by PCP for children age 3-5 years	Percentage of enrollees who received one or more fluoride varnish applications to a primary tooth by a PCP while age 3-5 years during the measurement year	Same as above	Enrollees who were between 3 through 5 years of age during the measurement year	Same as above	Same as above	Same as above
Indicator 4: Fluoride varnish application by PCP for All Children Ages 6 months – 5 years	Percentage of enrollees who received one or more fluoride varnish applications to a primary tooth by a PCP while age 6 months-5 years during the measurement year	Same as above	Enrollees who were between 6 months of and 5 years of age during the measurement year	Same as above	Same as above	Same as above

¹ HEDIS Indicators: If using a HEDIS measure, specify the HEDIS reporting year used and reference the HEDIS Volume 2 Technical Specifications (e.g., measure name(s)). It is not necessary to provide the entire specification. A summary of the indicator statement, and criteria for the eligible population, denominator, numerator, and any exclusions are sufficient. Describe any modifications being made to the HEDIS specification, e.g., change in age range.

Data Collection and Analysis Procedures

Is the entire eligible population being targeted by PIP interventions? If not, why?

All enrollee meeting the criteria are being targeted by PIP interventions.

Sampling Procedures

If sampling was employed (for targeting interventions, medical record review, or survey distribution, for instance), the sampling methodology should consider the required sample size, specify the true (or estimated) frequency of the event, the confidence level to be used, and the margin of error that will be acceptable.

- **Describe sampling methodology:**

ABHLA did not complete sampling for this PIP

Data Collection

Describe who will collect the performance indicator and intervention tracking measure data (using staff titles and qualifications), when they will perform collection, and data collection tools used (abstraction tools, software, surveys, etc.). If a survey is used, indicate survey method (on-line, phone, mail, face-to-face), the number of surveys distributed and completed, and the follow-up attempts to increase response rate.

- **Describe data collection:**

Data collection will be performed by Analyst and IT department members. Data collection will be setup weekly utilizing the below software tools and methodologies:

- **TOAD Data Point:** Software will be utilized to generate automated custom reporting specifically around this PIP by combining multiple data sources listed below.
- **Annual Population Assessment:** Annual report generated integrating member enrollment demographic data, Elli data software linked to State claims received with diagnoses codes, ABHLA QNXT claims database.
- **CM Utilization rates:** Report generated utilizing CM Dynamo data platform monthly, quarterly, and final annual rate of enrollment patterns.
- **Utilization Management Rates:** QNXT database system generated quarterly and annual report of member utilization patterns for telemedicine, tele-therapy, outpatient services, and treatment centers.
- **Member Surveys:** Use of data received from Interactive Telephone Calls to the members with PIP age-appropriate children, who have been identified as non-compliant.
- **Vendor Reports:** Received monthly, quarterly, and final annual rates of text messages and IVR calls to members.
- **QNET Reporting:** Development or reporting surrounding the utilization of CPT code 99188

Validity and Reliability

Describe efforts used to ensure performance indicator and intervention tracking measure (ITM) data validity and reliability. For medical record abstraction, describe abstractor training, inter-rater reliability (IRR) testing, quality monitoring, and edits in the data entry tool. For surveys, indicate if the survey instrument has been validated. For administrative data, describe validation, methods to address missing data and audits conducted.

- **Describe validity and reliability:**

- **Annual Population Assessment:** Member demographic and claims information validated by Aetna IT informatics and Health Care Equities Director. We utilize Elli data software program, which is linked to State claims received, ABHLA QNXT claims received, and member enrollment data to produce reliable data over time.
- **HEDIS: Currently** working with vendor to develop custom catalog to manage the data collection and reporting regarding the Fluoride Varnish PIP. By doing so, we will ensure standardization of reporting and in accordance with NCQA's protocols, validity audits are conducted by Advent Advisory Group, an NCQA-licensed organization, and led by a Certified HEDIS Compliance Auditor (CHCA). The IT team assists with data collection and rate calculations, and the quality management team reviews the data for validity and reliability. Audits are conducted in accordance with NCQA *HEDIS Compliance Audit: Standards, Policies and Procedures*. NCQA's Information Systems

(IS) and HEDIS Measure Determination (HD) standards were the foundation on which auditors assessed the organization's ability to report HEDIS data accurately.

- **Member Survey:** Vendor data file validated by QI Director, Developmental Screening Project Manager and/or designee. Discrepancies discussed with vendor during monthly meetings. Utilizing interactive phone surveys with State approved scripts. Same method utilized for each survey conducted.
- **Pharmacy Rates:** Data file validation by CVS pharmacy and Aetna Pharmacy Director
- **Vendor Reports:** Vendor data file reports of text messages, mailers, and IVR calls generated validated by QI Director, Project Manager and/or designee. Aetna IT generation of member lists utilizing same logic. Discrepancies discussed with vendor during monthly meetings.
- **CM Utilization Rates:** Validated by Project Manager and CM project manager for variances in data and/or technical reporting issues within the Dynamo data platform. Aetna IT informatics review of final rates and of discrepancies found and using the same database system and logic for reliable results.
- **Utilization Management Rates:** Validated by UM Manager and Medical Management Director for validity and accuracy of data with Aetna IT informatics review of final rates, and of discrepancies found for member utilization of treatment services.
- **Chart Review:** Identify methods to ensure validity and reliability, including IRR methods, as well as alternative methods for chart selection and how to ensure sample representative of eligible members:
 - Data Analytics has developed a macro that will allow for random sampling of the population. These samples will be provided quarterly for chart retrieval.
 - To address the chart return being unknown, if the return on sample is low, we will default to utilizing EMR's that we have access to
 - We will be utilizing the standard AETNA IRR process

Data Analysis

*Explain the data analysis procedures and, if statistical testing is conducted, specify the procedures used (note that hypothesis testing should only be used to test significant differences between **independent** samples; for instance, differences between health outcomes among subpopulations within the baseline period is appropriate). Describe the methods that will be used to analyze data, whether measurements will be compared to prior results or similar studies, and if results will be compared among regions, provider sites, or other subsets or benchmarks. Indicate when data analysis will be performed (monthly, quarterly, etc.).*

Describe how a plan will interpret improvement relative to a goal.

Describe how the plan will monitor ITMs for ongoing quality improvement (QI; e.g., stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions).

• Describe data analysis procedures:

- Our data collection for identifying, measuring, and reporting for needs related to Global Developmental Screenings is generated from claims and chart reviews. In addition, the plan integrates QSI HEDIS performance metrics, Care Management dynamo platform of enrollment patterns and care coordination for screening and treatment, enrollee participation, and intervention tracking measures, as well as any additional process metrics. An analysis of related utilization management services, provider/enrollee claims audits to ensure provider and/or member adherence to screening and linkage to treatment and/or evidence- based guidelines is conducted. Data is stratified by at risk populations identified for Global Developmental Screenings including key clinical factors. Data is further stratified by some of the following categories: age, gender, ethnicity, city, zip code, parish, region, urban/rural. Stratification of the data supports the analysis and identification of variables for consideration in intervention design and implementation. We analyze results in workgroups with key leaders and PIP Global Developmental Screenings committee members, comparing prior years and target goals by conducting five whys, barrier analysis, root-cause analysis, and PDSAs to find opportunities for improvement and/or barriers that impact intervention success. In addition, ABH-LA may use QI process data generated from the following tools: fishbone diagram, priority matrix, and the SWOT diagram. ABH-LA regularly conducts evaluation using both quantitative and qualitative (when applicable) methods. Both key performance indicators and

intervention tracking measures are continuously monitored to evaluate the plan's path to attaining the target rates of the Global Developmental Screenings PIP and its corresponding goals.

- **Describe how plan will interpret improvement relative to goal:**
 - In identifying reasons for variations in provision of care and evaluating practice variation, we assess the effectiveness of care rendered, adherence to evidence-based guidelines, treatment options chosen, and frequency of use of clinical activities as it relates to the capacity of our healthcare system, such as services rendered, emergency and hospital admissions. Inappropriate variation occurs when non-evidence-based care is provided, or the care lacks wide acceptance, and the high level of variation cannot be supported on a quality or outcomes basis which can lead to disparate outcomes for enrollees, higher utilization, costs, and waste. We analyze data reports, provider patterns of over-and-under utilization of services, regional, member, and provider demographic variations, to identify variation in access and health care services. We also examine any social determinants or disparity prevalence and cost-ratios, incorporating outreach activities and care management strategies to further engage enrollees to initiative and/or continue to engage in screening and active treatment.
- **Describe how plan will monitor ITMs for ongoing QI:**
 - The plan will create custom reoccurring reports around this PIP and will host reoccurring meetings to monitor the progress. If positive progress is observed through these reports, we will continue to scale the efforts to increase improvements. If little to no impact is being observed, then our efforts will be revisited and optimized further to create a greater impact.

PIP Timeline

Report the measurement data collections periods below.

Baseline Measurement Period:

Start date: 1/1/2021

End date: 12/31/2021

Year 1 Intervention and First Re-Measurement Period:

Start date: 1/1/2022

End date: 12/31/2022

Submission of 1st quarterly status report for intervention period 1/1/22–3/31/22 is due on 4/30/2022.

Submission of 2nd quarterly status report for intervention period 4/1/22–6/30/22 is due on 7/31/2022.

Submission of 3rd quarterly status report for intervention period 7/1/22–9/30/22 is due on 10/31/2022

Submission of 1st quarterly status report for intervention period 1/1/21–3/31/21 is due on 4/30/2022.

Submission of 2nd quarterly status report for intervention period 4/1/21–6/30/21 is due on 7/31/2022.

Submission of 3rd quarterly status report for intervention period 7/1/21–9/30/21 is due on 10/31/2022.

Submission of Fluoride Varnish by PCPs Proposal/Baseline Report with calendar year (CY) 2021 data is due: 3/1/2022

Submission of Fluoride Varnish by PCPs Draft Final Report with CY 2022 data is due: 12/9/2022

Submission of Fluoride Varnish by PCPs Final Report with CY 2022 data is due: 12/30/2022

Table 4a: Analysis of Disproportionate Under-Representation of Fluoride Varnish Receipt

Subpopulation	Members from 6 months through age 5 years		Members who Received Fluoride Varnish applied by PCP		Disproportionate Index of Fluoride Varnish Under-Representation
	# of Enrollees in the Denominator	% of MCO TOTAL Denominator	# of Enrollees in the Numerator	% of MCO TOTAL Numerator	$\frac{\% \text{ of MCO TOTAL Denominator}}{\% \text{ of MCO TOTAL Numerator}}$
MCO TOTAL	16165	100.00%	685	100.00%	
Age					
6-18 months	2794	17.28%	130	18.98%	0.91
19 months – 2 years	1381	8.54%	122	17.81%	0.48
3-5 years	11990	74.17%	433	63.21%	1.17
Race					
American Indian or Alaska Native	70	0.43%	2	0.29%	1.48
Asian	3579	22.14%	135	19.71%	1.12
Black or African American	5914	36.59%	278	40.58%	0.90
Native Hawaiian or Pacific Islander	23	0.16%	0	0.00%	-
White	4776	29.55%	203	29.64%	1.00
Other	43	0.27%	0	0.00%	-
Unknown	1757	10.87%	67	9.78%	1.11
Ethnicity					
Hispanic	58	0.36%	0	0.00%	-
Non-Hispanic	10568	65.38%	477	69.64%	0.94
Unknown	5539	34.27%	208	30.36%	1.13
Enrollment category: Foster Care	17	0.11%	0	0.00%	-
Enrollment category: Disabled	355	2.20%	7	1.02%	2.15
LA MCO Region of Residence					
Region 1: Greater New Orleans	4479	27.71%	55	8.03%	3.45
Region 2: Capital Area	1995	12.34%	73	10.66%	1.16
Region 3: South Central LA	1073	6.64%	23	3.36%	1.98
Region 4: Acadiana	2091	12.94%	315	45.99%	0.28
Region 5: Southwest LA	349	2.16%	4	0.58%	3.70
Region 6: Central LA	891	5.51%	32	4.67%	1.18
Region 7: Northwest LA	2430	15.03%	149	21.75%	0.69
Region 8: Northeast LA	909	5.62%	1	0.15%	38.52
Region 9: Northshore Area	1948	12%	33	4.82%	2.5

Barrier Analysis, Interventions, and Monitoring

Table 4b: Alignment of Barriers, Interventions and Tracking Measures

Barrier(s) that Intervention 2 will address:		2022				2023					
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Method of barrier identification (MCO should identify barriers based upon member feedback): Intervention #2 to address barrier: Enhanced MCO CM member outreach + education with dental provider appointment scheduling Planned Start Date: Quarter 2 Actual Start Date: June 18,2022		Intervention #2 tracking measure: N: # members for whom dental provider appointment made D: # members on Fluoride Varnish Care Gap report ages 6 months through 5 years		N/A N: D: R:	N: 64 D:12958 R: 0.49%	N: 448 D: 13523 R: 3.31%	N: 723 D: 14,040 R: 5.15%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier(s) that intervention 3 will address:		2022				2023					
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Method of barrier identification: Lack of training (Sudhanthar et al., 2019). MCOs should identify additional barriers based upon provider feedback. Intervention #3 to address barrier: Provider outreach and education using care gap report, AAP guideline on Fluoride Use in Caries Prevention, and LDH bulletin re reimbursement and course requirements/link, and Well-Ahead Louisiana resources Planned Start Date: Quarter 2		Intervention #3 tracking measure: N: # members whose PCP was outreached and educated D: # members on Fluoride Varnish Care Gap report ages 6 months through 5 years		N/A N: D: R:	N:12000 D:12958 R:92.61%	N: 12000 D: 13523 R: 88.7%	N: 14,040 D: 14,040 R: 100% December 19, 2022, educational sessions through LA-AAP were conducted (educational flier provided)	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Actual Start Date: April 22, 2022									
Barriers that intervention 4 will address:		2022				2023			
Method of barrier identification: Analysis of Disproportionate Under-Representation—MCOs should conduct a barrier analysis of the susceptible subpopulations identified:		Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Tailored and Targeted Intervention #4a to address susceptible subpopulation barrier(s): Planned Start Date: Quarter 2 Actual Start Date: April 1, 2022	Intervention #4a tracking measure: N: # members American Indian or Alaska Native who receive Fluoride Varnish D: # members in the appropriate age group identified as American Indian or Alaska Native	N/A N: D: R:	N:0 D:30 R:0.00%	N: 1 D: 14 R: 7.14%	N: 0 D: 7 R: 0%	N: D: R:	N: D: R:	N: D: R:	
Tailored and Targeted Intervention 4b to address susceptible subpopulation barrier(s): Planned Start Date: Quarter 2 Actual Start Date: April 1, 2022	Intervention #4b tracking measure: N: # members in regions 5 and 8 who receive Fluoride Varnish D: # members within the appropriate age group in regions 5 and 8	N/A N: D: R:	N: 0 D: 1441 R: 0.00%	N: 4 D: 3054 R: 0.13%	N: 12 D: 9,480 R: 0.13%	N: D: R:	N: D: R:	N: D: R:	
Barriers that intervention 5 will address:		2022				2023			
Method of barrier identification: Barrier Analysis completed to identify educational concerns for guardians of enrollee on the necessity and process of getting Fluoride Varnish treatment in the PCP office:		Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Utilization of technologies to ensure education of guardians on receiving Fluoride Varnish treatment in the	Intervention #5a tracking measure: N: Number of guardians who have received education on Fluoride Varnish for enrollees identified	N:0 D:15127 R:0.0%	N: 2068 D: 15127 R:13.15%	N: 3283 D:13,736 R:23.90%	N: 605 D:17,638 R: 3.43%	N: D: R:	N: D: R:	N: D: R:	

<p>PCP office for appropriate ages:</p> <p>Planned Start Date: Quarter 2</p> <p>Actual Start Date: April 1, 2022</p>	<p>D: Enrollees 6 months to 5 years of age</p>								
<p>Working with guardians to get enrollees into the PCP office to receive treatment:</p> <p>Planned Start Date: Quarter 2</p> <p>Actual Start Date: April 1, 2022</p>	<p>Intervention #5b tracking measure:</p> <p>N: Number of enrollees receiving treatment in the PCP office</p> <p>D: Number of enrollee guardians who have received education on Fluoride Varnish</p>	<p>N/A-Denominator based on 5a</p> <p>N: D: R:</p>	<p>N: 36 D: 2068 R: 1.74%</p>	<p>N: 114 D: 3283 R: 3.47%</p>	<p>N: 192 D: 1943 R: 9.88%</p>	<p>N: D: R:</p>	<p>N: D: R:</p>	<p>N: D: R:</p>	<p>N: D: R:</p>
<p>Barriers that intervention 6 will address:</p> <p>Method of barrier identification: The Fluoride Varnish PIP was presented at the PAC meeting and information discussed allowed for identifying educational opportunities for both members and providers. In addition, we have developed a multidisciplinary team and performed preliminary research to assist in understanding this disparity.” <i>Untreated dental caries occurs among 25 percent of children living in poverty compared with 10.5 percent of children living above poverty (Dye, Li, and Thorton-Evans 2012).</i></p>		<p>2022</p>				<p>2023</p>			
<p>Educate Primary Care Providers on the practice of applying Fluoride Varnish in the office setting and appropriate utilization of CPT code 99188:</p> <p>Planned Start Date: Quarter 2</p>		<p>Intervention #6a tracking measure:</p> <p>N: Provider who have received education</p> <p>D: Providers with enrollees 6 months to 5 years of age on their panels</p> <p>*Education mechanism used virtual meetings, in person provider visits, provider newsletters, fax blast, and PAC</p>	<p>N:0 D:1908 R:0.0%</p>	<p>N: 1122 D: 1935 R:58.00%</p>	<p>N: 1762 D: 1943 R:90.68%</p> <p>Of those 103 received virtual training by plan Practice Transformation Specialist</p>	<p>N: 2057 D: 2057 R: 100%</p> <p>Of those 406 received virtual training by plan Practice Transformation Specialist</p>	<p>N: D: R:</p>	<p>N: D: R:</p>	<p>N: D: R:</p>
		<p>Q1</p>	<p>Q2</p>	<p>Q3</p>	<p>Q4</p>	<p>Q1</p>	<p>Q2</p>	<p>Q3</p>	<p>Q4</p>

Actual Start Date: April 1, 2022									
Working with providers to ensure that Fluoride varnish treatments are occurring in the office: Planned Start Date: Quarter 1 Actual Start Date: March 1, 2022	Intervention #6b tracking measure: N: Providers who are billing CPT code 99188 D: Providers with enrollees 6 months to 5 years of age on their panels	N:106 D:1908 R:5.56%	N: 133 D: 1935 R: 6.87%	N: 149 D:1943 R: 7.67%	N: 192 D: 2,057 R: 9.33%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Results

To be completed upon Proposal with Preliminary Baseline Measure, Baseline Report with Updated Baseline Measure, Interim and Final Report submissions.

The results section should present project findings related to performance indicators. **Do not** interpret the results in this section.

Table 5: Results

Indicator	Baseline Measure Period 1/1/21–12/31/21	Final Measure Period 1/1/22–12/31/22	Subsequent Measure Period 1/1/23–12/31/23	CY 2022 Target Rate ¹
Indicator 1: Fluoride varnish application by PCP for children age 6-18 months	N: 130 D: 2794 R: 4.65%	N: 152 D: 3300 R: 4.60%	N: D: R:	Rate: 7.65%
Indicator 2: Fluoride varnish application by PCP for children age 19 months-2 years	N: 122 D: 1381 R: 8.83%	N: 291 D: 4060 R: 7.16%	N: D: R:	Rate: 11.83%
Indicator 3: Fluoride varnish application by PCP for children age 3-5 years	N: 433 D: 11990 R: 3.61%	N: 280 D: 6680 R: 4.19%	N: D: R:	Rate: 6.61%
Indicator 4: Fluoride varnish application by PCP for all children ages 6 months – 5 years	N: 685 D: 16165 R: 4.24%	N: 723 D: 14,040 R: 5.14%	N: D: R:	Rate: 7.24%

¹ Upon subsequent evaluation of quarterly rates, consideration should be given to improving the target rate, if it has been met or exceeded at that time.

OPTIONAL: Additional tables, graphs, and bar charts can be an effective means of displaying data that are unique to your PIP in a concise way for the reader. If you choose to present additional data, include only data that you used to inform barrier analysis, development, and refinement of interventions, and/or analysis of PIP performance.

In the results section, the narrative to accompany each table and/or chart should be descriptive in nature. Describe the most important results, simplify the results, and highlight patterns or relationships that are meaningful from a population health perspective. **Do not** interpret the results in terms of performance improvement in this section.

Discussion

To be completed upon Interim/Final Report submission. The discussion section is for explanation and interpretation of the results.

PIP Highlights:

Discussion of Results

- **Interpret the performance indicator rates for each measurement period**, i.e., describe whether rates improved or declined between baseline and interim, between interim and final and between baseline and final measurement periods.

In reviewing the data on table 2 in the document, ABHLA is continuing to make significant improvements from the baseline report to the final report. ABHLA are continuing to implement interventions for our members children ages 6 months to 5 years for the applications of fluoride varnish by their respective PCP's. For each quarter during CY 2021, the data reflected increases in percentage by ___ points. With continuing the current interventions, along with the planned next steps for CY 2023, ABHLA will continue to work towards meeting the target rate for Indicator 1: 7.65%; Indicator 2: 11.83%; Indicator 3: 6.61%, and Indicator 4: 7.24%.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations.

Several of the goals and objectives that were identified during the initial phases of the FV PIP have shown significant improvements. In reviewing ITM 3, the metrics from Q2 and Q3 we can see that our staff made significant progress through outreach and providing educational providers such as the GIC reports, along with significant information regarding the importance of applying fluoride varnish to children ages 6 months-5 years.

- **What factors were associated with success or failure?** For example, in response to stagnating or declining ITM rates, describe any findings from the barrier analysis triggered by lack of intervention progress, and how those findings were used to inform modifications to interventions.

The success of the improving numbers for the Fluoride Varnish PIP. is contributed to the many partnerships with Smiles for Life Oral Care, American Association of Pediatrics, MCNA, DentaQuest, and ABHLA Tribal liaisons. The many systems that were put in place to provide education and communication between the providers and ABHLA was a positive factor. Utilizing the gap in care report (GIC) and providing the necessary data to providers through ABHLA system called Availity. Also, the Floride Varnish campaign, which was our SMS and IVR messaging systems, that was used to communicate and provide education to our members about the importance of the Fluoride Varnish applications being completed by their children's PCP/pediatricians.

Limitations

As in any population health study, there are study design limitations for a PIP. Address the limitations of your project design, i.e., challenges identified when conducting the PIP (e.g., accuracy of administrative measures that are specified using diagnosis or procedure codes are limited to the extent that providers and coders enter the correct codes; accuracy of hybrid measures specified using chart review findings are limited to the extent that documentation addresses all services provided).

- **Were there any factors that may pose a threat to the internal validity of the findings?**

Definition and examples: internal validity means that the data are measuring what they were intended to measure. For instance, if the PIP data source was meant to capture all children 5-11 years of age with an asthma diagnosis, but instead the PIP data source omitted some children due to inaccurate ICD-10 coding, there is an internal validity problem.

No, there were not factors that would pose a threat to the internal validity of the findings.

- **Were there any threats to the external validity of the findings?**

No, there were no threats to the external validity of the findings.

Definition and examples: external validity describes the extent that findings can be applied or generalized to the larger/entire member population, e.g., a sample that was not randomly selected from the eligible population or that includes too many/too few members from a certain subpopulation (e.g., under-representation from a certain region).

- **Describe any data collection challenges.**

Definition and examples: data collection challenges include low survey response rates, low medical record retrieval rates, difficulty in retrieving claims data, or difficulty tracking case management interventions.

The only data challenge identified was the ability to identify those enrollees who may have received fluoride varnish at the dentist's office. Currently, the data being received by the plan encompasses enrollees 21+ and this information has been shared with the Louisiana Department of Health.

Next Steps

This section is completed for the Final Report. For each intervention, summarize lessons learned, system-level changes made and/or planned, and outline next steps for ongoing improvement beyond the PIP timeframe.

Table 6: Next Steps

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
Provider Education Distribution	Needing to research identify upcoming seminars for pediatricians or dentists to provide Fluoride Varnish educational materials to be distributed, included in trainings, or posted to their websites.	Partnerships	<ul style="list-style-type: none"> Research upcoming seminars and training for pediatricians and dentists. Give incentives to providers who complete the Smiles for Life Certification.
Member Material Development and Approval Process	Utilizing various communication platforms to provide education to the members.	ABHLA distributed communication to members at community events and outreach activities, uploaded communication into the member portal.	<ul style="list-style-type: none"> ABHLA will include member material/education to the Enrollee Activity Committee (EAC).
Work with various departments and committees to implement mechanisms to ensure AETNA utilizes feedback from both members and providers to identify barriers and drive outcomes	PCP's that are in smaller settings are not willing to purchase the needed supplies in bulk.	Utilize technology vendor Who can develop and monitor data regarding feedback from members and providers.	<ul style="list-style-type: none"> Identify vendors that will allow PCPs to buy supplies as needed as opposed to buying in bulk. Continue utilizing PAC and EAC to obtain feedback from members and providers. Partner with Open Health as system to provide education and receive feedback from providers and members.
Developing member materials for implementation of web-portal, utilization in community events and outreach activities.	Certain regions are understaffed or don't host community events and are unable to facilitate events.	Vendors, partnership relationships	<ul style="list-style-type: none"> Attend community day Care facilities and elementary school-based clinics to provide educational material to parents regarding fluoride varnish applications and encourage them to schedule an appointment with their respective pediatricians.

References

List any references that you cite.

Clark M, Keels MA, Slayton RL. American Academy of Pediatrics Clinical Guidance Report on Fluoride Use in Caries Prevention in the Primary Care Setting. Pediatrics Volume 146, number 6, December 2020: e20200034637.

Johnson SC and French GM. A quality improvement project to optimize fluoride varnish use in a pediatric outpatient clinic with multiple resident providers. Hawaii Journal of Health & Social Welfare, May 2020, VOL 79, NO 5, Supplement 1.

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Weyant R. J, Tracy S. L, JADA Topical Fluoride for caries prevention VOLUME 144, ISSUE 11, P1279-1291, NOVEMBER 01, 2013
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CDC Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion: March 8, 2019
<https://www.cdc.gov/fluoridation/basics/fluoride-products.html#>

Glossary of PIP Terms

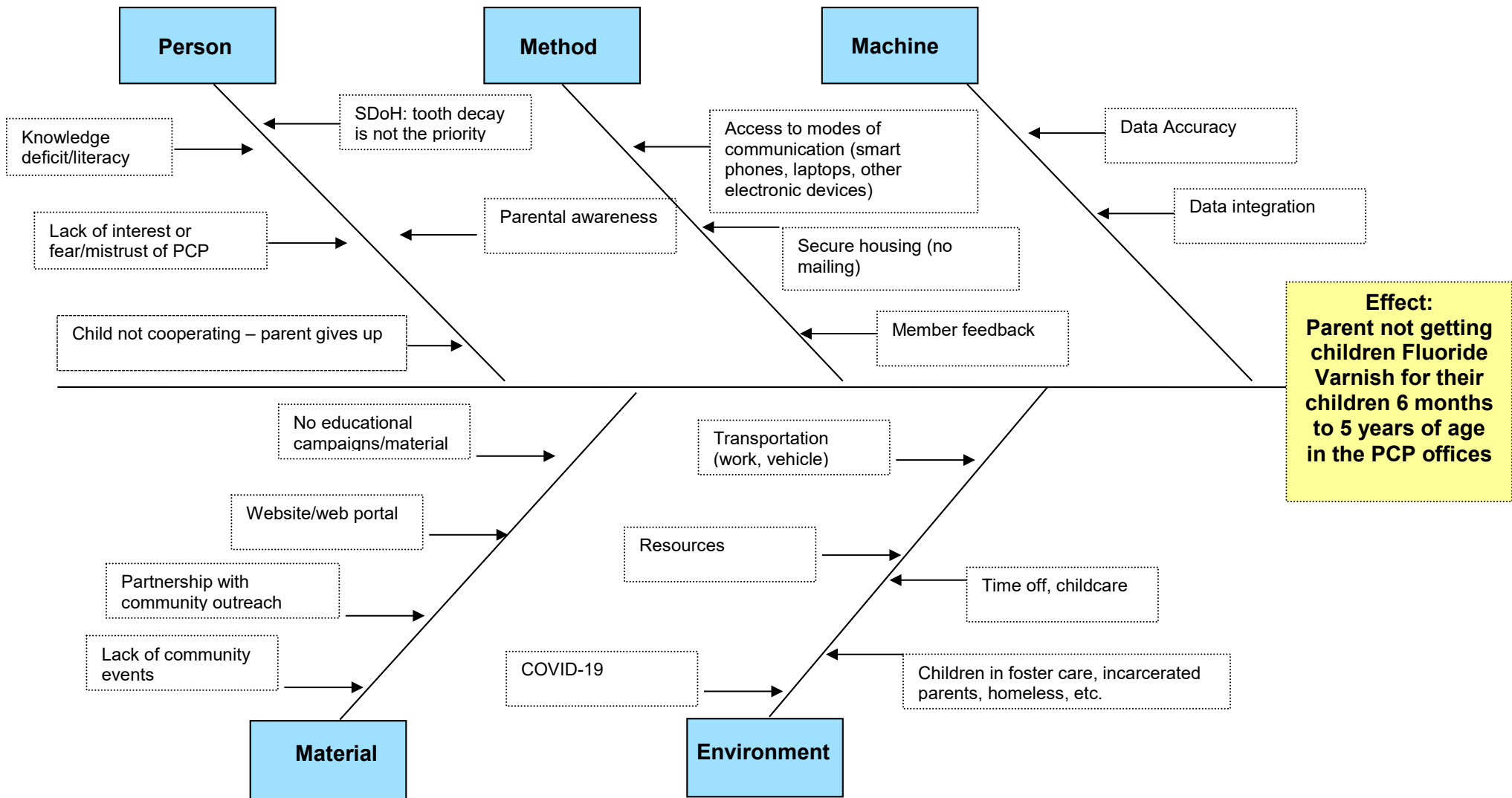
Table 7: PIP Terms

PIP Term	Also Known as...	Purpose	Definition
Aim	<ul style="list-style-type: none"> • Purpose 	To state what the MCO is trying to accomplish by implementing their PIP.	An aim clearly articulates the goal or objective of the work being performed for the PIP. It describes the desired outcome. The Aim answers the questions “How much improvement, to what, for whom, and by when?”
Barrier	<ul style="list-style-type: none"> • Obstacle • Hurdle • Roadblock 	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome in order for the MCO to be successful in reaching the PIP Aim or target goals. The root cause (s) of barriers should be identified so that interventions can be developed to overcome these barriers and produce improvement for members/providers/MCOs. A barrier analysis should include analyses of both quantitative (e.g., MCO claims data) and qualitative (such as surveys, access and availability data or focus groups and interviews) data as well as a review of published literature where appropriate to root out the issues preventing implementation of interventions.
Baseline rate	<ul style="list-style-type: none"> • Starting point 	To evaluate the MCO’s performance in the year prior to implementation of the PIP.	The baseline rate refers to the rate of performance of a given indicator in the year prior to PIP implementation. The baseline rate must be measured for the period before PIP interventions begin.
Benchmark rate	<ul style="list-style-type: none"> • Standard • Gauge 	To establish a comparison standard against which the MCO can evaluate its own performance.	The benchmark rate refers to a standard that the MCO aims to meet or exceed during the PIP period. For example, this rate can be obtained from the statewide average, or Quality Compass.
Goal	<ul style="list-style-type: none"> • Target • Aspiration 	To establish a desired level of performance.	A goal is a measurable target that is realistic relative to baseline performance, yet ambitious, and that is directly tied to the PIP aim and objectives.

PIP Term	Also Known as...	Purpose	Definition
Intervention tracking measure	<ul style="list-style-type: none"> • Process Measure 	To gauge the effectiveness of interventions (on a quarterly or monthly basis).	Intervention tracking measures are monthly or quarterly measures of the success of, or barriers to, each intervention, and are used to show where changes in PIP interventions might be necessary to improve success rates on an ongoing basis.
Limitation	<ul style="list-style-type: none"> • Challenges • Constraints • Problems 	To reveal challenges faced by the MCO, and the MCO's ability to conduct a valid PIP.	Limitations are challenges encountered by the MCO when conducting the PIP that might impact the validity of results. Examples include difficulty collecting/analyzing data, or lack of resources / insufficient nurses for chart abstraction.
Performance indicator	<ul style="list-style-type: none"> • Indicator • Performance Measure (terminology used in HEDIS) • Outcome measure 	To measure or gauge health care performance improvement (on a yearly basis).	Performance indicators evaluate the success of a PIP annually. They are a valid and measurable gauge, for example, of improvement in health care status, delivery processes, or access.
Objective	<ul style="list-style-type: none"> • Intention 	To state how the MCO intends to accomplish their aim.	Objectives describe the intervention approaches the MCO plans to implement in order to reach its goal(s).

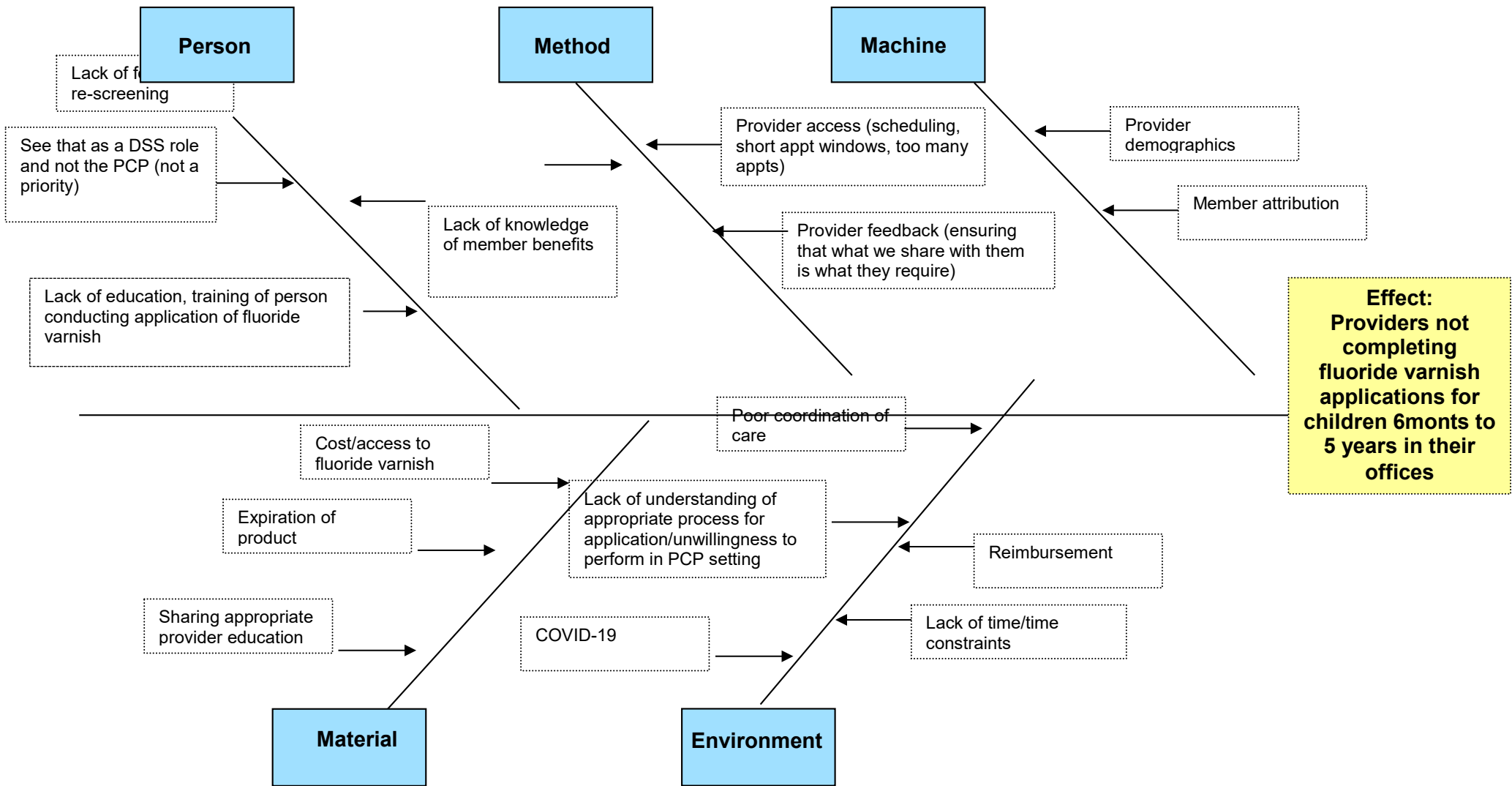
Appendix A: Fishbone (Cause and Effect) Diagram

Member Focused



Appendix A: Fishbone (Cause and Effect) Diagram

Provider Focused



Appendix B: Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	<ul style="list-style-type: none"> • Educate Providers on the reimbursement opportunities with CPT Code 99188 • Develop Member educational materials about the importance of receiving fluoride varnish (What to expect) • Work w/community Outreach team to develop partnerships • Develop Provider Gap Reports for 99188 • Develop unified/collaborative MCO's provider communications concerns with access to care/treatment 	
Less Feasible to Address	<ul style="list-style-type: none"> • Working with DDS to assist providers with education 	

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Diagram

	Positives	Negatives
INTERNAL <i>under your control</i>	<p style="text-align: center;"><i>build on</i> STRENGTHS</p> <ul style="list-style-type: none"> • Ability to identify enrollee who have claims for Fluoride Varnish • The development of educational materials • Working with our internal partners to share information w/providers and members through various mechanisms. 	<p style="text-align: center;"><i>minimize</i> WEAKNESSES</p> <ul style="list-style-type: none"> • Time to get materials through the marketing process • Time to get approval through the various checkpoints developed by the plan and LDH
EXTERNAL <i>not under your control, but can impact your work</i>	<p style="text-align: center;"><i>pursue</i> OPPORTUNITIES</p> <ul style="list-style-type: none"> • Policies and procedures for the development of campaigns 	<p style="text-align: center;"><i>protect from</i> THREATS</p> <ul style="list-style-type: none"> • In ability to identify those members who are receiving fluoride varnish in the dentist office.

Appendix D: Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts

Appendix E: Plan-Do-Study-Act Worksheet

PDSA	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
Intervention #2:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•