Health Plan Performance Improvement Project (PIP)

Health Plan: AmeriHealth Caritas Louisiana

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

Submission Dates:

	Report Year 2022
Version 1	12/09/22
Version 2	12/30/22

MCO Contact Information

1. Principal MCO Contact Person

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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: AmeriHealth Caritas Louisiana
Title of Project: Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 Months to 5 years by Primary Care Clinicians

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

Medical Director signature: Rodney Wise, MD
First and last name: Rodney Wise, MD
Date: 12/28/22

CEO signature: ______________________
First and last name: Kyle Viator
Date: 12/28/22

Quality Director signature: Rhonda Baird
First and last name: Rhonda Baird
Date: 12/28/22

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	July 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	To supplement lack of response from live outreach, an auto-dialer system was implemented to reach more members with the same message.
Change 2	December 2022	☐ Methodology ☐ Barrier Analysis ☒ Intervention ☐ ITM	A fluoride application varnish text messaging script has been approved by LDH and the campaign is planned to start in Q1 2023.
Change 3		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	
Change 4		☐ Methodology ☐ Barrier Analysis ☐ Intervention ☐ ITM	

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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.

Project Topic and Rationale

The Fluoride Varnish Application by PCPs Performance Improvement Project (PIP) was implemented to increase the number of children receiving oral health protection through fluoride varnish treatments. AmeriHealth Caritas Louisiana (ACLA) developed a multi-disciplinary workgroup to develop, design, test, implement, and refine interventions to address the objectives listed below:

1. Member Fluoride Varnish Care Gap Report to increase continuity of care between PCPs and Dentists
2. Member outreach
3. Provider educational outreach
4. Targeted interventions to identified disparity populations

Only 39% of Louisiana residents receive fluoridated drinking water. Early examination, intervention, guidance, and referral can prevent future costly and painful dental diseases, including dental caries (cavities). It is important to identify barriers to fluoride varnish application such as Dental Health Professional Shortage Areas (HPSAs) or lack of continuity of care.

Objectives, Methodology, and Interventions

The overall objective was to design and implement innovative initiatives and strategies to improve rates for the 4 Performance Indicators listed in Table 2- Goals. The Performance Indicator methodology used to determine the baseline, quarterly, and final rates is provided in Table 3-Methodolgy. It is important to note that this methodology excludes members that have received a fluoride varnish application by a dental provider only which is 18% of the eligible population.

Provider education included: instructions for access to online trainings and certifications, informational bulletins, Care Gap Report/Provider Portal utilization training and the creation of a toolkit.

Member education and outreach was enhanced to target disparity subpopulations, this included: Automated and live telephonic outreach, website updates and newsletters, community events, and social media campaigns. Members were also educated about benefits available such as transportation/mileage reimbursement and incentives for closing specified care gaps.

Results and Major Conclusions of the Project

Using Table 2-Goals, comparing the baseline rates to interim final rates (claims through October 2022), Indicators 2, 3, and 4 show a year over year decrease. Conversely, the interim final rates for Indicator 1 have increased from 2021 to 2022. Target rates established in the PIP proposal (at least 3 percentage point increase from 2021 to 2022) were not met for any of the indicators.

Next Steps

Although the Plan did not meet target goals for the Performance Indicators, meaningful interventions were implemented and enhanced throughout the year. The Plan acknowledges barriers such as Dental HPSAs, unable to contact populations, and competing priorities continue to directly impact outreach, interventions, and utilization of services. The Plan will utilize the ITMs to revise and add additional interventions to increase the number of members who receive a fluoride varnish application by a PCP.

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:**

  Dental caries, or tooth decay, is the most common and preventable chronic disease of childhood in the United States and can make children more susceptible to infections in other parts of their body (Clark et al., 2020). Fluoride varnish application by primary care providers (PCPs) and dentists can help to prevent or slow the progression of tooth decay and its negative impacts on overall pediatric health.

  As a managed care organization in Louisiana, the focus of AmeriHealth Caritas Louisiana (ACLA) is to improve the quality of life for our pediatric members by encouraging their parents/caregivers to seek preventive care, based guidelines published by the American Academy of Pediatrics (AAP) and the American Dental Association (ADA). The Plan estimates that there are about 20,000 members ages 6 months to 5 years who did not receive at least one fluoride varnish application by a PCP or dental provider in 2021.It is important to develop and monitor interventions to enhance member/provider education in order to decrease avoidable hospitalizations, costly repair, educational consequences, and treatment among the pediatric population due to tooth decay.

  The aim of the Fluoride Vanish Application PIP aligns with ACLA's mission, to help our members 'get well, stay well, and build healthy communities.'

- **Describe high-volume or high-risk conditions addressed:**

  The Fluoride Varnish Application PIP will address the following high-volume and high-risk conditions:

  1. Members serviced by community water systems with low fluoridated water.

     Methodology and Data: Currently, 44% of Louisiana residents are served by community water systems with optimally fluoridated water, which is far below the national average of 72.4% from 2008 and the Healthy People 2020 target of 79.6% (CDC, 2017). The United States Preventative Services Task Force (USPSTF) recommends oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.

  2. Members who live in Louisiana parishes designated as Dental Health Professional Shortage Areas (HPSAs).

     Methodology and Data: 84% of Louisiana parishes are Dental HPSAs (Casamassimo et al., 2020), mostly rural areas.

  3. Members 3-5 years of age.

     Methodology and Data: The Analysis of Disproportionate Under-Representation of Fluoride Varnish Receipt for 2021 data shows that members ages 3-5 years old make up about 50% of the total population and also have the largest disparity for the age group subpopulation.

- **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)

  Dental-related illness affect children and their parents, attributing to a loss of work hours and school hours (Clark et al., 2020). The solution to preventable dental caries, also known as the "silent epidemic", is fluoride varnish application. Fluoride has proven effectiveness in preventing dental caries, the recommendation is to apply fluoride varnish at least once every 6 months (Clark et al., 2020),The United States Preventative Services Task Force (USPSTF) recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

  In 2018, 40.9% of Louisiana children ages 1-5 had the highest prevalence of not having a dental visit in the past year. In addition, the American Academy of Pediatric Dentistry reported that children in the Medicaid program have a higher rate of oral disease (Casamassimo et al., 2020). Minorities, such as the Hispanic population, experience disproportionate percentages of dental disease (Clark et al., 2020). This aligns with ACLA's Analysis of Disproportionate Under-Representation of Fluoride Varnish Receipt for 2021 data, the Hispanic population has a disproportionate index of 150.26%.

- **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
    - 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 a primary care paediatric practice. BMJ Open Quality 2019; 8:e000589.doi:10.1136/bmjoq-2018-000589.

ACLA's baseline rates for claims through 2021 show that less than 8% of the eligible population received at least one fluoride varnish application in the measurement year. This data shows there is an opportunity for improvement in this area to proactively reduce preventable dental caries in children. Many children don't receive dental care at young ages (Clark et al., 2020), 59% of children ages 12-19 are predicted to have at least one documented cavity (Sudhanthar et al., 2019). The Fluoride Varnish Application PIP will assist in increasing preventative oral health for children staring at 6 months.

In Louisiana, members under 21 years of age are eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program. This Program includes a biannual preventative dental visit. While this program is available, members may have difficulty establishing a dental home before 3 years of age (Sudhanthat et al., 2019).

ACLA recognizes that members may have limited access to dental providers in their area. As stated previously, 84% of Louisiana parishes are HPSAs. However, despite dental shortages, members can also receive oral fluoride supplementation by their PCP. The American Academy of Pediatrics (AAP) has added fluoride varnish application as a guideline for well-child visits for primary care physicians (Sudhanthar et al., 2019) which aligns with the USPSTF's recommendation. Additional provider education may be an opportunity to increase compliance (Johnson SC and French GM). To address this barrier, ACLA will use the PDSA cycle to educate PCPs about how physicians, nurse practitioners and physician assistants can qualify for reimbursement for fluoride varnish services and skills training on how to apply the varnish. This PIP will be used to measure, monitor, and modify interventions as needed.

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 quality 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: 1/1/22–10/31/22	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 age 6-18 months	N: 310 D: 5,004 R: 6.20%	N: 326 D: 4,939 R: 6.60%	N: D: R:	R: 9.20%	Increase by 3 percentage points from CY 21 to CY 22
Indicator 2: Fluoride varnish application by PCP for children age 19 months-2 years	N: 654 D: 6,126 R: 10.68%	N: 486 D: 5,758 R: 8.44%	N: D: R:	R: 13.68%	Increase by 3 percentage points from CY 21 to CY 22
Indicator 3: Fluoride varnish application by PCP for children age 3-5 years	N: 611 D: 10,852 R: 5.63%	N: 434 D: 10,334 R: 4.20%	N: D: R:	R: 8.63%	Increase by 3 percentage points from CY 21 to CY 22
Indicator 4: Fluoride varnish application by PCP for All Children Ages 6 months – 5 years	N: 1,575 D: 21,982 R: 7.16%	N: 1,246 D: 21,031 R: 5.92%	N: D: R:	R: 10.16%	Increase by 3 percentage points from CY 21 to CY 22

[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?

The entire population is 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:** N/A

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:**

  AmeriHealth Caritas Louisiana's Enterprise Analytics (Informatics) Department collects data from claims/ encounter files of all eligible members. Data sources may include: claims/encounter data (administrative data). Administrative data will be collected as needed, monthly, quarterly, and annually. For Intervention Tracking Measures (ITM), data will be collected monthly utilizing claims/encounter data, clinical documentation software, and departmental tracking tools.

  ACLA's EPSDT team will conduct manual telephonic outreach and the Community Health Education team will host community events to obtain direct member feedback on barriers. In addition, focused provider outreach by multidisciplinary teams will be used to obtain feedback on drivers and barriers to members' access to care and fluoride varnish treatment.

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 that has occurred, methods to address missing data and audits that have been conducted.

- **Describe validity and reliability:**

  Administrative data is collected by the Enterprise Analytics (Informatics) Department. The process for verifying ITM data validity and reliability will be conducted by quality associates within each department. Through the PDSA cycle, analysis will be conducted to determine process improvements, strengths and opportunities.

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 plan will interpret improvement relative to 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:**

  Analysis will address the comparability of baseline and re-measurement data, including factors that impact validity. Results will present numerical data that is accurate, clear, and easily understood. Interpretation

will involve looking at all possible explanations for results and factors that may have affected them. Historical circumstances will be considered. Visual displays of data will facilitate analysis and communicate results.

- **Describe how plan will interpret improvement relative to goal:**

  Data analysis will guide how well interventions are influencing performance indicator rates and outcomes. This data will be assessed against established goals and will drive decisions on effectiveness of change.

- **Describe how plan will monitor ITMs for ongoing QI:**

  ITMs will be validated and monitored weekly and monthly as appropriate through trending, PDSA cycles, run charts, and other QI tools to analyze impact and effectiveness. The process for verifying ITM data validity and reliability will be conducted by quality associates with each department.

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:

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

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	% of MCO TOTAL Denominator ÷ % of MCO TOTAL Numerator
MCO TOTAL	**21982**	100%	**1575**	100%	
Age					
6-18 months	5004	22.76%	310	19.68%	**115.66%**
19 months – 2 years	6126	27.87%	654	41.52%	**67.11%**
3-5 years	10852	49.37%	611	38.79%	**127.26%**
Race					
American Indian or Alaska Native	66	0.30%	3	0.19%	**157.63%**
Asian	184	0.84%	11	0.70%	**119.85%**
Black or African American	8978	40.84%	793	50.35%	**81.12%**
Native Hawaiian or Pacific Islander	0	0.00%	0	0.00%	**0.00%**
White	5660	25.75%	357	22.67%	**113.60%**
Other	20	0.09%	3	0.19%	**47.77%**
Unknown	7074	32.18%	408	25.90%	**124.23%**
Ethnicity					
Hispanic	985	4.48%	47	2.98%	**150.16%**
Non-Hispanic	5816	26.46%	477	30.29%	**87.36%**
Unknown	15181	69.06%	1051	66.73%	**103.49%**
Enrollment category: Foster Care	5	0.02%	1	0.06%	**35.82%**
Enrollment category: Disabled	498	2.27%	34	2.16%	**104.95%**
LA MCO Region of Residence					
Region 1: Greater New Orleans	4548	20.69%	72	4.57%	**452.59%**
Region 2: Capital Area	3452	15.70%	262	16.63%	**94.40%**
Region 3: South Central LA	1501	6.83%	69	4.38%	**155.86%**
Region 4: Acadiana	2743	12.48%	519	32.95%	**37.87%**
Region 5: Southwest LA	741	3.37%	47	2.98%	**112.96%**
Region 6: Central LA	1849	8.41%	82	5.21%	**161.56%**
Region 7: Northwest LA	3405	15.49%	428	27.17%	**57.00%**
Region 8: Northeast LA	1592	7.24%	21	1.33%	**543.17%**
Region 9: Northshore Area	2151	9.79%	75	4.76%	**205.49%**

Barrier Analysis, Interventions, and Monitoring

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

Barrier(s) that Intervention 2 will address: Members that have not established a dental home due to lack of access to dentists. **Method of barrier identification (MCO should identify barriers based upon member feedback): Over 84% of Louisiana is designated Dental Health Professional Shortage Areas.**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4 *October Only**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #2a to address barrier: Enhanced member outreach + education **Planned Start Date**: August 2022 **Actual Start Date**:	**Intervention #2a tracking measure:** **N:** # members who received a fluoride varnish text message **D:** # members on Fluoride Varnish Care Gap report ages 6 months through 5 years	N/A	N/A	N/A	N/A	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Note: The FVA text message is in progress with a planned implementation Q1 2023. The text message script was submitted to LDH for approval.									
Intervention #2b to address barrier: Designated PCP **Planned Start Date**: Jan 2022 **Actual Start Date**: Jan 2022	**Intervention #2b tracking measure:** **N:** # members with an assigned PCP **D:** # members on Fluoride Varnish Care Gap report ages 6 months through 5 years (cumulative)	N: 22,696 D: 22,696 R: 100.00%	N: 21,604 D: 21,604 R: 100.00%	N: 20,732 D: 20,732 R: 100.00%	N: 21,031 D: 21,031 R: 100.00%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Intervention #2c to address barrier: Enhanced MCO CM member outreach + education with dental provider appointment scheduling **Planned Start Date**: May 2022 **Actual Start Date**: May 2022	**Intervention #2c tracking measure:** **N:** # members for whom dental provider appointment made (non-cumulative) **D:** # members on Fluoride Varnish Care Gap report ages 6 months through 5 years (cumulative)	N/A	N: 30 D: 21,604 R: 0.14%	N: 44 D: 20,732 R: 0.21%	N: 4 D: 21,031 R: 0.02%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Intervention #2cii tracking measure: Member Educational Outreach, Dental Appointment Scheduling	**Intervention #2cii tracking measure:** **N:** # members for whom dental provider appointment made (non-cumulative)	N/A	N: 30 D: 104 R: 28.85%	N: 44 D: 245 R: 17.96%	N: 4 D: 217 R: 1.84%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Planned Start Date: May 2022 **Actual Start Date**: May 2022	**D:** # members on Fluoride Varnish Care Gap report ages 6 months through 5 years who were successfully contacted to provide fluoride varnish treatment education and care coordination (non-cumulative)								
Intervention #2ciii tracking measure: Member Educational Outreach, Dental Appointment Scheduling **Planned Start Date**: May 2022 **Actual Start Date**: May 2022	**Intervention #2ciii tracking measure:** **N:** # members who received a fluoride varnish application by a dentist (cumulative) **D:** # members on Fluoride Varnish Care Gap report ages 6 months through 5 years (cumulative)	N/A	N: 2,493 D: 24,120 R: 10.34%	N: 4,410 D: 25,142 R: 17.54%	N: 4,546 D: 25,577 R: 17.77%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier(s) that intervention 3 will address: Providers unaware that fluoride varnish applications can be done in PCP office; not aware of what members are eligible/overdue; not sure where to purchase fluoride varnish **Method of barrier identification (MCO should identify barriers based upon provider feedback): Focused outreach to providers with the highest number of noncompliant members on the Fluoride Varnish Care Gap Report**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4 *October Only**	**Q1**	**Q2**	**Q3**	**Q4**
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:** March 2022 **Actual Start Date**: Feb 2022	**Intervention #3 tracking measure:** **N:** # members whose PCP was outreached and educated (non-cumulative) **D:** # members on Fluoride Varnish Care Gap report ages 6 months through 5 years (cumulative)	N: 1,440 D: 22,696 R: 6.34%	N: 3,895 D: 21,604 R: 18.03%	N: 2,010 D: 20,732 R: 9.70%	N: 1,122 D: 21,031 R: 5.33%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barriers that intervention 4 will address: Susceptible subpopulations identified using MY2021 data. **Method of barrier identification: Analysis of Disproportionate Under-Representation—barrier analysis of the susceptible subpopulations identified Region 8 exhibited the highest regional disparity; identified a significant disparity in children ages 3 years to 5 years and members that identify as Hispanic/Asian/American Indian**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4 *October Only**	**Q1**	**Q2**	**Q3**	**Q4**

Tailored and Targeted Intervention #4a to address susceptible subpopulation barrier(s): EPSDT member outreach + education to establish a dental home and dental provider appointment scheduling **Planned Start Date:** April 2022 **Actual Start Date**: May 2022	**Intervention #4a tracking measure:** **N:** # members successfully contacted to provide fluoride varnish treatment education and care coordination (non-cumulative) **D:** # members on Fluoride Varnish Care Gap report ages 3 years through 5 years (cumulative)	N/A	N: 70 D: 10,030 R: 0.70%	N: 204 D: 10,420 R: 1.96%	N: 39 D: 10,034 R: 0.39%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored and Targeted Intervention #4aii to address susceptible subpopulation barrier(s): EPSDT member outreach + education to establish a dental home and dental provider appointment scheduling **Planned Start Date:** April 2022 **Actual Start Date**: May 2022	**Intervention #4aii tracking measure:** **N:** # members successfully contacted to provide fluoride varnish treatment education and care coordination **D:** # members on Fluoride Varnish Care Gap report ages 3 years through 5 years attempted to contact to provide fluoride varnish treatment education and care coordination	N/A	N: 70 D: 333 R: 21.02%	N: 204 D: 695 R: 29.35%	N: 50 D: 91 R: 54.95%				
Tailored and Targeted Intervention 4b to address susceptible subpopulation barrier(s): Focus on rural areas whose water supply is most likely deficient in fluoride. **Planned Start Date:** May 2022 **Actual Start Date**: May 2022	**Intervention #4b tracking measure:** **N:** # members successfully contacted to provide fluoride varnish treatment education and care coordination **D:** # members on Fluoride Varnish Care Gap report in Region 8 who were attempted to contact to provide fluoride varnish treatment education and care coordination	N/A	N: 66 D: 317 R: 20.82%	N: 3 D: 12 R: 25.00%	N: 15 D: 52 R: 28.85%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Note: This subpopulation was added to an automated call campaign MY22Q2 which included fluoride varnish treatment education and care coordination. Denominator only reflects members who were attempted by LIVE telephonic outreach.										
Tailored and Targeted Intervention 4c to address susceptible subpopulation barrier(s): EPSDT member outreach + education to establish a dental home and dental provider appointment scheduling with	**Intervention #4c tracking measure:** **N:** # members who identify as Hispanic/Asian/American Indian who received at least one Fluoride Varnish Application	N/A	N: 17 D: 81 R: 20.99%	N: 2 D: 8 R: 25.00%	N: 2 D: 6 R: 33.33%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

members who identify as Hispanic/Asian/American Indian **Planned Start Date:** June 2022 **Actual Start Date**: May 2022	**D:** # members on Fluoride Varnish Care Gap report who identify as Hispanic/Asian/American Indian who were successfully outreached by EPSDT team								
Note: This subpopulation was added to an automated call campaign MY22Q2 which included fluoride varnish treatment education and care coordination. Denominator only reflects members who were attempted by LIVE telephonic outreach.									

Results

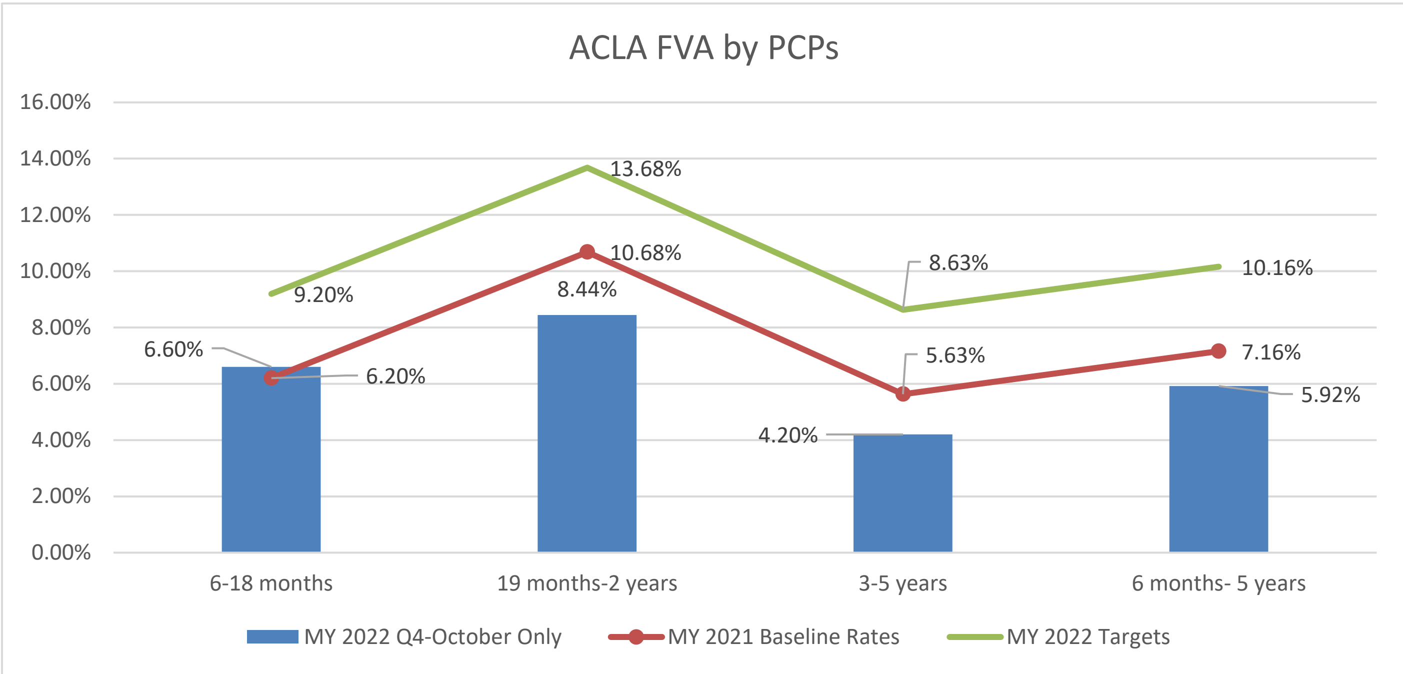
To be completed upon Proposal with Preliminary Baseline Measure, Baseline Report with Updated Baseline Measure, Interim and Final Report submissions.
The results section should present project findings related to performance indicators. ***Do not*** interpret the results in this section.

Table 5: Results

Indicator	Baseline Measure Period 1/1/21–12/31/21	Final Measure Period 1/1/22–10/31/22	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: 310 D: 5,004 R: 6.20%	N: 326 D: 4,939 R: 6.60%	N: D: R:	Rate: 9.20%
Indicator 2: Fluoride varnish application by PCP for children age 19 months-2 years	N: 654 D: 6,126 R: 10.68%	N: 486 D: 5,758 R: 8.44%	N: D: R:	Rate: 13.68%
Indicator 3: Fluoride varnish application by PCP for children age 3-5 years	N: 611 D: 10,852 R: 5.63%	N: 434 D: 10,334 R: 4.20%	N: D: R:	Rate: 8.63%
Indicator 4: Fluoride varnish application by PCP for all children ages 6 months – 5 years	N: 1,575 D: 21,982 R: 7.16%	N: 1,246 D: 21,031 R: 5.92%	N: D: R:	Rate: 10.16%

[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.

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.

- **Performance Indicator #1 (6 months-18 months):** Displayed an increase of 0.41 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (6.20% to 6.60%) as of claims data received through October 2022. The target goal of 9.20% was not achieved for the 2022 interim rate measurement period.

- **Performance Indicator #2 (19 months-2 years):** Displayed a decrease of 2.24 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (10.68% to 8.44%) as of claims data received through October 2022. The target goal of 13.68% was not achieved for the 2022 interim rate measurement period.

- **Performance Indicator #3 (3 years-5 years):** Displayed a decrease of 1.43 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (5.63% to 4.20%) as of claims data received through October 2022. The target goal of 8.63% was not achieved for the 2022 interim rate measurement period.

- **Performance Indicator #3 (6 months -5 years):** Displayed a decrease of 1.24 percentage points from 2021 baseline measurement period to the 2022 interim measurement period, (7.16% to 5.92%) as of claims data received through October 2022. The target goal of 10.16% was not achieved for the 2022 interim rate measurement period.

- **Explain and interpret the results by reviewing the degree to which objectives and goals were achieved.** Use your ITM data to support your interpretations**.**
  - Although target goals were not met for the 4 Performance Indicators, meaningful interventions were developed and implemented throughout the PIP such as:
    - The Member FVA Care Gap Report which is published to the provider portal.
      - Providers who are not registered in Provider Portal or unfamiliar with the portal are offered scheduled and adhoc trainings (ITM 3). Because of limited training staff, the team was not able to reach all providers with linked members. There may be an opportunity to work with other MCOs to create a standardized provider education training.
      - This report also verifies that all members are linked to a PCP (ITM 2b). Members are all assigned a PCP when joining the Plan. The quarterly Member Reassignment Policy ensures that members are linked to the PCP that they receive the most care with/have established a relationship with.
    - Appointment Scheduling.
      - The Plan noted that there were issues with the call tracking process, some successful calls/appointments scheduled may not have been captured due to the way that they were documented. A call tracking standard operating procedure was developed.
      - ITM 2c- Less than 1% of eligible members were scheduled for dental appointments, however ITM 2ciii shows that 17.54% of the eligible population received an application by a dental provider. Our staff noted that members did not want/need assistance scheduling dental provider visits. The ITM may need to be revised to capture members who requested assistance (denominator).
    - Susceptible Subgroups
      - More than 70% of the members attempted were unsuccessful contacts (ITM 4aii). Due competing resources, members in suspectable subgroups were put on an autodialer for outreach (ITM 4b/4c).

- **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 Plan received member feedback that providers did not have the fluoride treatment available during their well visit. Provider feedback aligned as providers were unaware that the treatment should be done during well visits, how often, and by whom. Only 6% of the eligible population received a treatment by a PCP type provider as compared to 18% by a dental provider (ITM 2c).

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 the findings?**
  <u>Definition and examples</u>: 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.

    - Threats to the internal validity of the findings include member outreach data accuracy due to the limitations of documentation and data abstractions from the plan’s integrated care management software.

- **Were there any threats to the external validity the findings?**
  <u>Definition and examples:</u> 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).

    - The retrieval of data was affected by several factors. The Wellness Team experienced several Unable to Contact parent/guardians. Further, the COVID-19 Pandemic impacted overall outreach for the year as outreach to encourage member vaccination was prioritized.

- **Describe any data collection challenges.**
  <u>Definition and examples</u>: 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 Plan faced data collection challenges for numerous ITMs with accurately tracking member outreach interventions. Limitations relative to the documentation and data abstraction from the plan’s integrated care management software resulted in under-represented member interactions.

- **PIP Highlights.**

    - Our most effective member intervention was for the number of members whose PCP was outreached and educated. These members were identified using the Fluoride Varnish Care Gap report. PCPs were outreached for thousands of members in 2022.

    - Our most effective provider intervention was for PCPs registered on the Provider Portal with access to the Fluoride Varnish Care Gap report. These were identified as PCPs with noncompliant members on the Fluoride Varnish Care Gap report. 1,858 PCPs were registered as of October 2022.

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
ITM 2a- Text Message, Parent/Guardian Education	Anticipate approval delays with member educational materials (internal and external)		Distribute text messages to members when fully approved by LDH.
ITM 2b- Linked PCP	35% of members who have not received an FVA application have had a least one PCP visit in the calendar year.		Utilize the Care Gap Report to identify members who have not had a ‘missed opportunity’ with their linked PCP. Conduct a barrier analysis to determine why the member has not had a well visit in the calendar year. Outreach and educate linked providers who did not complete any fluoride varnish treatments in 2022.
ITM 2c, 2cii, 2ciii- Dental Appointment Scheduling	Different teams performing outreach and there is not a standardized process for documentation. This affected the ITM data collected for member outreach. Parent/Guardian unavailable due to: • Wrong number • Does not answer unknown numbers • Request call after work hours	Develop a standardized workflow across MCO for FVA documentation.	After the standardized workflow is developed, train all member facing associates. Conduct a randomized analysis to ensure that the workflow is being used appropriately for documentation. Retrain associates as needed. Member Education via other avenues: • Texting Campaign, • Automated Calls, • Mailers, • Newsletters, • Website Updates, • Social Media Community Events including mobile dental units Work with PCPs/Pharmacy to obtain correct phone numbers

Description of Intervention	Lessons Learned	System-Level Changes Made and/or Planned	Next Steps
ITM 3- PCP Educational/Outreach	Many PCPs/staff is not trained to apply fluoride varnish applications. PCPs unaware of which members have received treatment.		Distribute the Fluoride Varnish Treatment Toolkit when approved. Host SmilesforLife trainings with a PCP/Dental profession to increase PCPs certified. Educate PCPs on Provider Portal and Utilization of the Fluoride Care Gap Report.
ITM 4a- Susceptible Population, Ages 3-5 **ITM 4b- Susceptible Population, Region 8** **ITM 4c- Susceptible Population, Hispanic/Asian/American Indian Populations**	Susceptible populations may require tailored interventions. Competing outreach priorities. Members live in a Dental HPSA/ rural area		Combine COVID vaccine outreach calls with FVA outreach MCO Spanish speaking staff are outreaching Spanish speaking members Website updates/Flyers are printed in multiple languages Identify specific barriers for each subgroup to address Text Message/Automated Calls in multiple languages After Hours Incentive for providers Community Events including mobile dental units Parent/Guardian education of what to expect at well-visit

References

List any references that you cite.

Casamassimo PS, Chin JR, Conte CE, et al. Treating Tooth Decay: How to Make the Best Restorative Choices for Children's Health. Chicago, IL: Pediatric Oral Health Research and Policy Center, American Academy of Pediatric Dentistry; 2020

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.

Sudhanthar S, Lapinski J, Turner J, Gold J, Yakov S, Thakur K, et al. Improving oral health through dental fluoride varnish application in a primary care paediatric practice. BMJ Open Quality 2019; 8:e000589.doi:10.1136/bmjoq-2018-000589.

USPSTF. 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

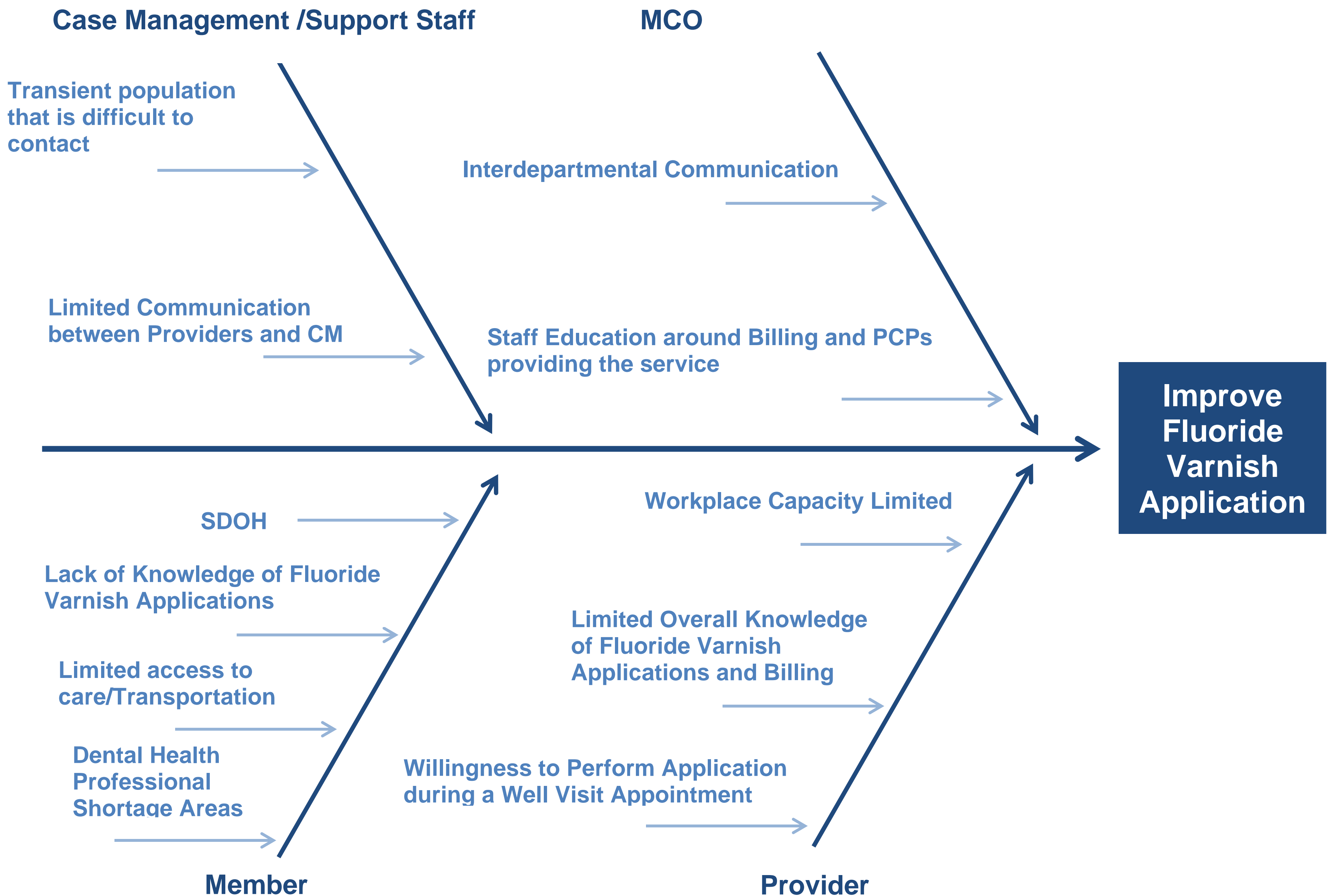
Glossary of PIP Terms

Table 7: PIP Terms

PIP Term	Also Known as…	Purpose	Definition
Aim	• 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	• Obstacle • Hurdle • Road block	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	• 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	• 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	• 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.
Intervention tracking measure	• 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.

PIP Term	Also Known as…	Purpose	Definition
Limitation	• 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	• 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	• 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



Appendix B: Priority Matrix

<table>
<tr><th>Which of the Root Causes Are . . .</th><th>Very Important</th><th>Less Important</th></tr>
<tr><td>Very Feasible to Address</td><td>Internal Staff Education
Provider Education: Alerts, Newsletters, Website Updates that address billing and provides links to trainings
Provider Portal: Fluoride Varnish Application Care Gap Report
Member Education: Texting Campaign, Automated Calls, Mailers, Newsletters, Website Updates, social media</td><td>Face to Face Provider Trainings</td></tr>
<tr><td>Less Feasible to Address</td><td>Members Unable to Contact
Providers unwilling to apply Fluoride Varnish Application during Routine Well Visits
Reimbursement for FQHC/RHC type providers who bill CPT code 99188
Dental Health Professional Shortage Areas (HPSAs)</td><td>Locating Transient Members</td></tr>
</table>

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

	Positives	Negatives
INTERNAL *under your control*	***build on*** **STRENGTHS** ***Examples:*** • Provider Education: Alerts, Newsletters, Website Updates • Enterprise Analytics Reports including the Fluoride Varnish Care Gap Report on the Provider Portal • Ability to outreach and educate disproportionate populations with care gaps via Care Management/Support Staff	***minimize*** **WEAKNESSES** ***Examples:*** • Approval Process of ACLA Provider/Member Outreach Materials
EXTERNAL *not under your control, but can impact your work*	***pursue*** **OPPORTUNITIES** ***Examples:*** • Member outreach opportunities via Community Events including mobile dental units • COVID-19 • Provider Education received via fax/email only • Dental Health Professional Shortage Areas (HPSAs)	***protect from*** **THREATS** ***Examples:*** • Provider participation • Limited Workforce Capacity • Transient Population that is difficult to contact/educate

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.	•	•	•