Health Plan Performance Improvement Project (PIP)

Health Plan: UnitedHealthcare LA (UnitedHealthcare Community Plan of 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, 2023–December 31, 2023

Project Phase: Proposal

Submission Dates:

	Report Year 2023
Version 1	03/01/2023
Version 2	

MCO Contact Information

1. Principal MCO Contact Person

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

First and last name: Heather Negrotto MSN, APRN, CPNP
Title: Population Health Strategic Consultant- EPSDT Coordinator – Louisiana C & S
Phone number: 1(225) 237-2014
Email: heather_negrotto@uhc.com

2. Additional Contact(s)

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

First and last name: Lauren Wetzlau, BSN, RN, CSSGB
Title: Associate Director of Quality Health/Population Health
Phone number: 1(952) 202-5981
Email: lauren_wetzlau@uhc.com

First and last name: Paula Morris, MSN, RN, CSSGB
Title: Director of Quality/Population Health
Phone number: 1(225) 237-2050
Email: paula_morris@uhc.com

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: UnitedHealthcare Community Plan of Louisiana (UHCCP LA)
Title of Project: Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 months through Age 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: _____
First and last name: Julie Morial, MD
Date:03/01/2023

CEO signature: _____
First and last name: Karl Lirette
Date: 03/01/2023

Quality Director signature: ___ _____
First and last name: Paula Mo
Date: 03/01/2023

IS Director signature: _____
First and last name: Kenny Landry
Date: 03/01/2023

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	February 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	**Developed Targeted ITM #4a** N: # contacts with either a well visit appointment made or the member was already scheduled with a provider that provides dental varnish **D**: # of outreaches to members due for a well visit and were linked to a provider that provides dental fluoride varnish (FV) application Discussion regarding the incorporation of FV application into routine EPSDT visits resulted in identifying the potential benefit to conjoin outreach of EPSDT members with members eligible for FV application in Q1 of 2022 to encourage both increase in EPSDT visits and FV application rates. Through direct provider and member feedback, along with EPSDT reports from the Centers for Medicare & Medicaid Services (CMS), it was noted that EPSDT rates/wellness visit rates remain lower than desired. The COVID-19 pandemic dramatically changed member healthcare habits and negatively affected providers mentally and physically while presenting significant challenges and changes to the delivery of care and office workflow. The COVID-19 pandemic and hesitancies or fears surrounding the pandemic presented a barrier to prioritizing EPSDT/wellness visits and the success of this PIP. The pandemic also contributed to our team's limited resources or

			staff to focus solely on member outreach. For this reason, the health plan conjoined EPSDT and FV outreach efforts and developed this ITM. With hesitancies and fears lessening in 2022, the health plan began seeing more staff going out into the field and attending available community events in July 2022. The community events allowed the health plan to enhance and broaden our member outreach efforts to support the goals of the PIP and more widely distribute FV educational materials and resources to both members and providers. Overall, increased presence in the field and community and the co-joined outreach of EPSDT and FV member outreach will serve the needs of two high-priority benefits offered to our members. The clinical reasoning is that with an increase in EPSDT rates, FV application rates will subsequently increase.
Change 2	February 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ ITM	To address ITM #3 related to provider education and information sharing, the FV team had meetings and discussions and set forth a plan to develop our provider outreach lists. UnitedHealthcare Community Plan of Louisiana (UHCCP LA) first identified PCPs with linked members eligible for fluoride varnish application to create a provider outreach list. The health plan began by providing targeted education to all appropriate PCPs in the identified facilities. Communication channels include fax blasts, emails, web-based conferencing, and in-person visits by our provider-facing staff (Population Health Consultants (PHCs). Clinical Transformation Consultants (CTCs), and Provider Advocates). PCPs are provided with LDH-approved educational

			materials on fluoride varnish application, required certification through Smiles for Life, appropriate CPT code 99188, and access to needed dental varnish supplies and educational materials resources from AAP and Well-Ahead LA. UHCCP LA created a resource tip sheet and faxed it to all PCPs who see children. Provider feedback is collected during provider encounters, Provider Advisory Committee meetings, and virtual web-based meetings with providers with high-linkage accounts held monthly. The provider-facing staff document feedback received from providers and submitted this information to the FV PIP team at the end of each month. The information is reviewed during a Team's meeting and utilized to modify or adapt interventions to limit identified barriers. To ensure uniform provider education, provider-facing teams use the Fluoride Varnish Application-Provider Education one-page document, the Fluoride Varnish Application toolkit, and/or the EPSDT toolkits for educational purposes. All educational materials are current and up to date. There will be continued efforts to educate providers by utilizing fax blasts, face-to-face education, and virtual educational meetings on the implementation of fluoride varnish application and utilization of appropriate billing and coding policies and procedures. Utilization of the provider portal, access to the fluoride varnish provider education, certification documents, and additional resources are available online via our Network Newsletter/Provider bulletin at UHCprovider.com. The health plan offers individualized support and guidance for

			providers who report challenges, have further questions, or need further assistance despite prior education on fluoride varnish application and follow-up to ensure their needs are met. Multiple staff members, including our PHCs, CTCs, Provider Advocates, and the PIP Lead/EPSDT coordinator, a Pediatric Nurse Practitioner, offer additional support and guidance. UHCCP LA will continue to outreach and educate providers to perform oral health screenings and fluoride varnish application as part of EPSDT guidelines. The health plan will continue to monitor the effectiveness of current educational outreach methods and increase efforts and focus as needed through our Population Health Team, PHCs, CTCs, and provider advocates to advance the goals of this PIP.
Change 3	March 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	**Developed Targeted ITM #5a** **N:** # of successfully contacted members from region 8 educated on fluoride varnish application and offered assistance with scheduling. **D:** # of attempted contacted members for Fluoride Varnish application in region 8 UHCCP LA increased our member outreach staff by hiring someone whose sole focus was member outreach for the FV PIP beginning in May 2022. The member outreach list was prioritized utilizing the Disproportionate Under-Representation to identify disparity subgroups to tailor this ITM. At that time, the area of highest disparity was OPH Region 8 (NE Louisiana). The health plan has created and submitted a telephone script for state approval for our internal outreach staff and an IVR script for ELIZA staff in Q1. Once the state approved the

			script, it began being used for member outreach in May 2022. Phase 1 of our external outreach through collaboration with Eliza IVR call started in July 2022. Our internal and external outreach efforts focused on educating guardians of FV-eligible members on LA's FV policy availability of receiving FV application by PCPs. Outreach encouraging guardians to discuss the FV application with the child's PCP during the child's wellness/EPSDT visit and the benefits of the FV application.
Change 4	March 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ ITM	The success of the PIP greatly relies on PCPs adapting fluoride varnish application practice in their offices. No or limited monetary incentives and reimbursement for the fluoride varnish application could decrease provider compliance and adoption or implementation of preventative oral health intervention into their practice. The health plan feels that offering a monetary incentive for closing GAPs in care will significantly increase provider compliance. Therefore, the plan developed a financial incentive available to providers for applying topical fluoride varnish to encourage increased participation in offering FV application services by PCPs. UHCCP LA began the process of developing this incentive in March of 2022. The incentive was completed, and the incentive payments began in June of 2022 and are available for back-billing with claims resubmission starting January 01, 2022. PCP adoption and implementation of preventative oral care, along with the fluoride varnish application to eligible members, is essential to achieving the goals of the FV PIP. The health plan began educating providers on the availability of the additional quality incentive of $10

			per gap closed twice a year for fluoride varnish application performed and billed with the 99188 CPT code regardless of fee-for-services reimbursement and FQHC/RHC status in March 2022 and reinforced education in conjunction with the distribution of the PCOR which became available in June 2022.
Change 5	April 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ ITM	To increase both fluoride varnish application rates and EPSDT rates in region 8, one of the Dental Health Professional Shortage Areas, UHCCP LA partnered with a local clinic that reported a high number of no-shows for EPSDT/well-child visits and agreed to provide fluoride varnish application in conjunction with EPSDT/well-child visits. The health plan began by conducting telephone outreach to 15 parents/guardians of UHCCP LA members who had a documented no-show visit in the previous month to identify the reason for the no-show for the scheduled EPSDT visit. The health plan then conducted telephone outreach to EPSDT and fluoride varnish application eligible members to notify the parent/guardian of the member's gaps in care and helped scheduling an appointment. This clinic offers transportation for all patients. If transportation was reported as a barrier to attending scheduled appointments, the parent/guardian was educated on this service provided by their PCPs facility (not the MCO benefit). The health plan also kept a list of those UHCCP LA members who attended appointments and were not linked to that PCP and followed up in one month to determine if PCP linkage had been updated. UHCCP LA educated the PCP, clinic manager, and EPSDT nurse on utilizing the provider portal/Gap report to identify

			those members with gaps in care. Upon follow-up after our collaboration, there has been an increase in the number of EPSDT visits kept and slight change in the number of no-show appointments. The nurse stated, "The fluoride varnish has been utilized here for several months now, and the parents are glad to have this option. I appreciate you reaching out. Have a nice day." when a phone follow-up was conducted at the end of June 2022. The health plan reviewed claims data and panel reports for this clinic at the beginning of this collaboration and then periodically throughout the remainder of 2022. Findings were discussed with the clinic staff at each claims review. The initial member linkage for members birth to 21 years of age in April 2022 for this clinic was 529 enrollees with 74 FV-eligible members. At follow up June 30, 2022, this clinic had completed 133 EPSDT visits and 2 FV applications for the 2022 year. As of August 01, 2022, this clinic had completed 201 EPSDT visits and 9 FV applications. As of December 01, 2022, this clinic had completed 350 EPSDT visits and 13 FV applications. Although EPSDT rates were steadily increasing due to low FV application rates, the EPSDT staff was re-educated 12/02/22 on LA's FV application policy, coding/billing/CPT codes, PCOR utilization for both EPSDT and FV application, and incentive available for FV application closures in gaps in care. UHCCP LA will continue to monitor claims data and follow up with this clinic quarterly throughout this PIP. The health plan also intends to find other clinics to collaborate with for 2023.

Change 6	April 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ ITM	Member informed barrier analysis obtained during internal telephonic outreach continues to indicate a knowledge deficit remains as many guardians report they are unaware of the FV application benefit available to the enrollee, the age at which FV application should begin, and the availability of FV application with the child's PCP. To expand our outreach efforts and strive to educate large groups of guardians, not just one guardian at a time, through telephonic outreach, the health plan collaborated with community organizations and participated in community events to disseminate information regarding the availability of FV application. Member outreach education was enhanced to include information that would increase guardian's awareness of the following: The importance/preventative benefits of fluoride varnish application Provide education that treatment is recommended as early as six months of age or with first tooth eruption Availability of FV application in the medical home, by PCPs, during EPSDT/wellness visits LA's FV application policy Some events attended include the 29th Annual Choctaw- Apache Tribe Powwow on April 29th and 30th, 2022, and The Louisiana provider Information Expo, on October 27, 2022, from 8 am - 4 pm, which will be held at the Marriott Lakeway Building. This enabled information sharing regarding the FV application and this initiative to be shared with large groups of people, increasing member awareness with a highly disparate population and providers who should be offering FV application services. UHCCP LA plans to continue to attend

			available community events and serve the needs of our members and providers and increase healthcare equity in Louisiana. The health plan will continue our member and provider outreach efforts to ensure receipt of care for the targeted FV application-eligible members.
Change 7	June 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	**Developed Targeted ITM #2a** **N:** # of contacted members on gap report educated on fluoride varnish application **D:** # of members on Fluoride Varnish Care Gap report ages 6 months through 5 years Due to the PCOR not becoming available until June 2022, this ITM was not reported until July 2022. Also, the PCOR was revised to include a monetary incentive available for FQHCs/RHCs and non- FQHC/RHC providers when they bill the 99188 CPT code. In the future, the health plan and providers will utilize the PCOR for each subsequent quarter to identify FV-eligible members with gaps in care for more consistent measurements and effective tracking for reporting purposes.
Change 8	June 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	Developed Targeted ITM #5b N: # of successfully contacted members from disparate groups (R1, NAI, Disability CM members) educated on fluoride varnish application and helped with scheduling. D: # of attempted contacted members for Fluoride Varnish application in disparity groups (R1, NAI, Disability CM members) Member outreach lists are developed and modified based on disparity groups to reach the most disparate first and then cascade to other areas. In May 2022, UHCCP LA enlisted additional employees to increase member outreach efforts; the health plan then

			expanded our outreach to other regions based upon disparity and extended outreach focus groups to include other disparate groups such as NAI and members with Disability members through CM. For member outreach ITMs, successful contact is the outreach team member contacting a guardian or leaving a voicemail notifying the guardian that the enrollee is eligible for fluoride varnish application with their PCP. In addition, UHCCP LA developed a comprehensive call outcome detail tab that is reviewed and utilized by our internal member outreach staff and FV team members to identify direct member feedback on barriers and modify interventions to improve the success of our interventions.
Change 9	September 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☒ ITM	Developed Targeted ITM #5c N: # of successfully contacted members from Foster Care disparate groups members educated on fluoride varnish application and offered assistance with scheduling. D: # of attempted contacted members for Fluoride Varnish application in Foster Care disparity groups. UHCCP LA developed tailored intervention #5c to enhance member outreach and focus efforts for our foster care group, identified as an area focus per the disparity index. The health plan continues to include our members with a disability in our outreach efforts monthly via our CM team. Our fluoride varnish PIP team is continuously reviewing claims data and utilizing direct provider and member feedback to identify barriers and modify and tailor interventions to minimize barriers and improve the overall progress of this PIP. UHCCP LA will continue to outreach to both members and

			providers, offering support, guidance, and educational information regarding fluoride varnish application. UHCCP LA discerns a positive impact on our ITMs and will continue to improve quality rates of success and minimize barriers. UHCCP LA provider-facing teams are distributing the fluoride varnish application educational materials in multiple electronic, virtual, and in-person methods to best accommodate our providers and meet their individual needs.
Change 10	October 2022	☐ Methodology ☒ Barrier Analysis ☒ Intervention ☐ ITM	Direct provider feedback, especially from more rural, smaller clinics with limited staff, new providers who are only beginning their careers in EPSDT services, and clinics with high volumes of visits and well-established workflow strategies, indicate concerns about logistical challenges of including fluoride varnish application into EPSDT/Well-child visits versus offering FV at Non-EPSDT/Well-child visits. These concerns are related to competing priorities, scheduling availability, workflow interruptions, staffing shortages, and the complexity and amount of time required to complete these visits adequately presents challenges. Providers report that EPSDT visits are already comprehensive and time-consuming, and they voice concerns that they do not want to overwhelm the guardians or patients with procedures, screenings, diagnostic tests, or the high content of anticipatory guidance and educational material needed to meet the EPSDT guidelines adequately. The health plan will continue to offer guidance and support to all providers and encourage incorporating FV application into well-child/EPSDT visits. To

			increase FV rates and EPSDT rates and provide support in identifying EPSDT and FV-eligible members using the PCOR (GAP Report). UHCCP LA emphasized the benefits of preventative health care for enrollees and the availability of a monetary incentive to close gaps in care for providers. The health plan anticipates this barrier will lessen as our provider-facing team continues to educate providers and assist providers as needs/concerns are identified.

Abstract

For Final Report submission only.

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:** Improving the rate of Fluoride Varnish Application to primary teeth by primary care providers (PCPs) for enrollees aged 6 months through 5 years is important to our members because good oral health is integral to general health and impacts quality of life. The mouth and oral mucosa reflect overall well-being and general health. Poor oral health in childhood is associated with development of multiple other chronic conditions later in life and can negatively impact physical, developmental, emotional, and social well-being. Dental caries, or tooth decay, is a preventable condition and is the most common chronic disease in children in the Unites States (American Academy of Pediatrics (AAP, 2020). Poor oral health shares common risk factors with the four leading chronic diseases: (1) cardiovascular diseases, (2) cancer, (3) chronic respiratory diseases, and (4) diabetes (Centers for Disease Control and Prevention, 2020). Failure to prevent dental caries and poor oral health have health, educational, and monetary consequences at both the individual and societal level. With early identification and treatment of dental caries, the process of decay can be halted or reversed by modifying the patient's individual risk and protective factors. Fluoride is a protective factor that helps to remineralize enamel, reduce enamel demineralization, and inhibit bacterial metabolism and acid production causing tooth decay (AAP, 2020).

- **Describe high-volume or high-risk conditions addressed:**
  Dental caries disproportionately affects poor, young, and minority populations. According to AAP (2020), dental caries is a "silent epidemic," and prevalence exists within specific populations in the United States, with 25% of children aged 2 to 5 years from low socioeconomic and minority groups experiencing 80% of total dental disease. Additionally, children with special health care needs, developmental delay, complex neurodevelopmental disabilities, or congenital heart disease are also affected disproportionately. The 2011-2016 National Health and Nutrition Examination Survey indicated; the prevalence of dental carries increased disturbingly in children under the age of 5 years. Approximately 23% of children aged 2 to 5 years reported to have dental caries in their primary teeth. Increased prevalence was reported in Mexican American children (33%) and non-Hispanic Black children (28%) than in non-Hispanic White children (18%) (United States Preventative Service Task Force [USPSTF], 2021). Reducing oral health disparities requires wide-ranging methodologies that target high risk populations and involves improving access to existing care, educational support, and use of preventative services. Since many risk factors for dental caries are thought to be influenced by parenting practices and health beliefs, access to care, and parents' attitudes and practices related to dietary and oral hygiene behaviors, studies show PCPs have a unique opportunity to participate in the primary prevention of dental caries and improve oral health rates in Louisiana by incorporating oral health education, anticipatory guidance, and application of fluoride varnish into well-child visits (AAP, 2020).

- **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)

  Oral health care is a component of Louisiana Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children birth to 21 years of age following guidelines and recommendations of AAP and Bright Futures © to promote preventive health care and emphasize the immense importance of continuity of care in comprehensive health supervision. Utilization of the tool known as the Periodicity schedule recommends an annual

anticipatory guidance screening for oral health in the newborn period and annually through the 21st year. Still, the Department of Health and Human Services (DHHS, 2020) reports that tooth decay or dental caries is more prevalent among low-income children, who are likely to be enrolled in Medicaid. Guideline recommendations set forth by the AAP and USPSTF recommend PCPs: (1) perform oral health risk assessments, oral health counseling, and anticipatory guidance for all children at every routine well-child visit beginning at 6 months of age, (2) inquire about fluoride in the child's drinking water, beginning at 6 months of age, and prescribe dietary fluoride supplement if deficient fluoride in primary drinking water, (3) provide fluoride varnish application to primary teeth of all children every 3-6 months, beginning with eruption of the first tooth through 5 years of age. All children should have an established dental home by 1 year of age. If PCPs follow these guidelines and recommendations, Louisiana's pediatric population will gain many health benefits in addition to improved oral health outcomes with potential to eliminate tooth decay or dental carries in childhood (USPSTF, 2021).

- **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.

Dental caries is the most prevalent, yet preventable, chronic condition that disproportionately affects poor, minority, and young children. Our data from 01/1/21 to 10/31/21 showed 412 claims with a dental caries diagnosis for EPSDT eligible children under 6 years of age. Claims data also showed 138 children of the same age receiving dental varnish. The percent of children that had dental varnish and did not have a claim for dental caries was 99% (137/138). Analysis of data from The National Survey of Children's Health (NSCH, 2021) [Survey years 2019-2020], reported Louisiana ranked 46th in the United States for 'Percentage of children ages 1-17 who had one or more preventive dental care visits during the past 12 months. Also, Louisiana Department of Health (LDH, 2018) reports 59 of Louisiana's 64 parishes (home to 86% of residents) as Health Professional Shortage Areas for dental care. According to the Community Preventative Services Task Force (CPSTF, 2017), studies showed that water fluoridation significantly decreases prevalence of dental caries; and of Louisiana's 64 parishes, 23 parishes do not have fluoridated water or 39% of Louisiana's population compared to 73% of the nationally. Johnson and French (2020), state "Prior systematic reviews have found that fluoride varnish may decrease caries in permanent dentition by up to 38% and can reduce decayed and filled tooth services by up to 37%" These statistics indicate that Louisiana remains below the national average in many oral health indicators and there are significant oral health disparities in Louisiana that need to be addressed. The application of fluoride varnish has been found to be safe and effective for dental caries prevention in children. For primary prevention to be effective, it is imperative that PCPs be knowledgeable about the process of dental caries, prevention of the disease, and available interventions, including application of fluoride varnish during well-child to help improve Louisiana's oral health outcomes.

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: 1/1/22–12/31/22	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 ages 6-18 months	N:1,526 D:11,292 R: 13.51%	N:647 D:16,029 R:4.04%	N: D: R:	R:18.51%	To surpass the aim of the Dental Varnish PIP by 5 percentage points
Indicator 2: Fluoride varnish application by PCP for children ages 19 months-2 years	N:1,049 D:16,514 R: 6.35%	N:1,306 D:22,170 R:5.89%	N: D: R:	R:11.35%	To surpass the aim of the Dental Varnish PIP by 5 percentage points
Indicator 3: Fluoride varnish application by PCP for children ages 3-5 years	N:1,238 D:35,271 R:3.51%	N:1,367 D:52,878 R:2.59%	N: D: R:	R:8.51%	To surpass the aim of the Dental Varnish PIP by 5 percentage points
Indicator 4: Fluoride varnish application by PCP for All Children Ages 6 months – 5 years	N: 3,611 D: 63,077 R: 5.73%	N:3,320 D:91,077 R:3.65%	N: D: R:	R:8.73%	Increase by 3 percentage points from CY 21 to CY 22 per PIP recommendation

[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 ages 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 ages 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 ages 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?

Yes, the entire eligible population, enrollees 6 months through five years of age, 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. No sampling was used for the study.

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:** Kenneth Landry, Associate Director of Louisiana Informatics along with UHC's Quality and Enterprise Analytics teams will be researching and pulling claims data with regards to: (a) CPT code 99188 Application of topical fluoride varnish by a PCP, (b) dental CDT codes D1206 professionally applied fluoride varnish or D1208 any topical application of fluoride including fluoride gels or foams, excluding varnish, (c) ICD-10 codes Caries- K02.52, K02.62, K02.7, K02.9 and Z29.3 Encounter for prophylactic fluoride.
- Data is collected for the "Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 months through 5 years by Primary Care Clinicians" performance measure by multiple systems within UHC. Member, provider, and medical claims data is collected within UHC's community and state platform "FACETS". Case Management data is collected by Case Managers and is stored in UHCs clinical documentation system "Community Care".
- Data from these systems along with pharmacy, state historical and vendor claim feeds e.g., dental, vision and lab are periodically extracted by enterprise analytics and stored in UHC's "SMART" data warehouse.
- Kenneth Landry, Associate Director of Louisiana Informatics along with UHC's Quality and Enterprise Analytics teams worked together to collect data utilizing structured query language (SQL) queries from UHC's SMART data warehouse in accordance with the PIP speciation's and code sets outlined in the "Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 months through 5 years by Primary Care Clinicians" template.
- Supplemental exclusion criteria data provided by MCNA and DentaQuest.

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:** The UnitedHealthcare Community & State of Louisiana Analytics Team validated data submitted for the "Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 months through 5 years by Primary Care Clinicians" Performance Improvement Project by verifying that the data from the SMART Analytics Data Warehouse coincided with data that had been entered in CSP Facets and Community Care; moreover, reviews and cross reference checks from the data extracts ensures validity of what has been entered in either system. CSP Facets is where UHCLA Member and Provider data is stored and where the claims data is extracted accordingly. ICUE and Community Care are Clinical Documentation interfaces where our Clinical/Non-Clinical Staff documents a Member's Utilization and Case Management information. As a result of the UHCLA Analytics Team data validation procedures, the UHCLA Analytics Team produced accurate and concise data for the "Fluoride Varnish Application to Primary Teeth of All Enrollees Aged 6 months through 5 years by Primary Care Clinicians" data extracts, adhered to Performance Indicators definition as well as continued to monitor the Intervention Tracking Measures.

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:** Methods to analyze data include a comparison of baseline results to state and national benchmarks. Rates are compared to the baseline data and will be compared with the collaborating MCO results. The results of the disproportionate under and over representation are reviewed to highlight differences between health outcomes among sub-populations.
- **Describe how plan will interpret improvement relative to goal:** Improvement will be interpreted in terms of the extent to which the target rates are met for each sub-measure, as indicated in the results table.
- **Describe how plan will monitor ITMs for ongoing QI:** Collaborations with the Quality, Clinical, and Analytics Team with regards to continuous monitoring of performance indicator benchmarks on a quarterly basis.
- **Describe how plan will analyze ITMs to trigger drill down barrier analysis in response to stagnating or declining ITMs:** Methods used to analyze the ITM data will include a review of all intervention tracking measures and drill down on any stagnating measures with the multi-disciplinary team to determine how interventions may need to be adjusted to increase efficacy.

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

Year 2 Intervention and First Re-Measurement Period:
Start date: 1/1/2023
End date: 12/31/2023

Submission of 1st quarterly status report for intervention period 1/1/23–3/31/23 is due on 4/30/2023.
Submission of 2nd quarterly status report for intervention period 4/1/23–6/30/23 is due on 7/31/2023.
Submission of 3rd quarterly status report for intervention period 7/1/23–9/30/23 is due on 10/31/2023.

Submission of Fluoride Varnish by PCPs Proposal/Baseline Report with calendar year (CY) 2022 data is due: 3/1/2023

Submission of Fluoride Varnish by PCPs Draft Final Report with CY 2023 data is due: 12/15/2023

Submission of Fluoride Varnish by PCPs Final Report with CY 2023 data is due: 12/31/2023

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	79,210	100%	3,274	100%	1
Age					
6-18 months	16,414	20.72%	767	23.43%	0.88454
19 months – 2 years	22,845	28.84%	1,378	42.09%	0.68524
3-5 years	39,951	50.44%	1,129	34.48%	1.46262
Race					
American Indian or Alaska Native	248	0.31%	9	0.27%	1.13896
Asian	645	0.81%	35	1.07%	0.76171
Black or African American	19,401	24.49%	1,246	38.06%	0.64358
Native Hawaiian or Pacific Islander	25	0.03%	1	0.03%	1.03333
White	20,435	25.80%	704	21.50%	1.19978
Other	93	0.12%	-	0.00%	#DIV/0!
Unknown	38,363	48.43%	1,279	39.07%	1.23977
Ethnicity					
Hispanic	384	0.48%	11	0.34%	1.44290
Non-Hispanic	40,732	51.42%	1,995	60.93%	0.84390
Unknown	38,094	48.09%	1,268	38.73%	1.24176
Enrollment category: Foster Care	54	0.07%	1	0.03%	2.23199
Enrollment category: Disabled	1,231	1.55%	57	1.74%	0.89265

LA MCO Region of Residence					
Region 1: Greater New Orleans	13,800	17.42%	230	7.03%	2.47999
Region 2: Capital Area	13,231	16.70%	630	19.24%	0.86806
Region 3: South Central LA	7,789	9.83%	402	12.28%	0.80086
Region 4: Acadiana	10,407	13.14%	918	28.04%	0.46858
Region 5: Southwest LA	2,992	3.78%	14	0.43%	8.83349
Region 6: Central LA	4,285	5.41%	127	3.88%	1.39459
Region 7: Northwest LA	10,051	12.69%	666	20.34%	0.62378
Region 8: Northeast LA	6,420	8.11%	55	1.68%	4.82471
Region 9: Northshore Area	7,875	9.94%	210	6.41%	1.54999

Barrier Analysis, Interventions, and Monitoring

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

Barrier(s) that Intervention 2 will address: **Method of barrier identification (MCO should identify barriers based upon member feedback):**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Intervention #2 to address barrier: Enhanced MCO CM member outreach + education with dental provider appointment scheduling **Planned Start Date: 2/01/22** **Actual Start Date**: N/A	**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[1]	N/A[1]	N/A[1]	N/A[1]	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Intervention #2a **Modified and Targeted ITM** **Planned Start Date: 2/01/22** **Actual Start Date**: **07/01/22**	**Intervention #2a tracking measure:** **N:** # of successfully contacted members on gap report educated on fluoride varnish application **D:** # of attempted contacts to members on Fluoride Varnish Care Gap report ages 6 months through 5 years	N/A	N/A	N: 5,592 D: 9,105 R:62.039%	N[2]: 956 D[2]: 1,752 R[2]:54.57%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Barrier(s) that intervention 3 will address: **Method of barrier identification: Lack of training (Sudhanthar et al., 2019). MCOs should identify additional barriers based upon provider feedback.**		**2022**				**2023**			
		Q1	**Q2**	**Q3**	**Q4**	**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: 2/1/22** **Actual Start Date**:**2/07/22**	**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:16,366 D:64,356 R:25.43%	N:25,998 D:64,356 R:40.40%	N:40,591 D:64,356 R:63.07%	N:64,356 D:64,356 R:100.00%	N: D: R:	N: D: R:	N: D: R:	N: D: R:

Barriers that intervention 4 will address: Method of barrier identification: Analysis of Disproportionate Under-Representation—MCOs should conduct a barrier analysis of the susceptible subpopulations identified:		2022				2023			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tailored and Targeted Intervention #4a to address susceptible subpopulation barrier(s): **Planned Start Date: 2/1/2022** **Actual Start Date:2/10/2022**	**Intervention #4a tracking measure:** **N:** # contacts with either a well visit appointment made or member was already scheduled with a provider that provides dental varnish **D:** # of outreaches to members due for a well visit and were linked to a provider that provides dental fluoride varnish application	N:216 D:1,834 R:11.78%	N:631 D:5,304 R:11.90%	N:282 D:1,752 R:16.09%	N:187 D:970 R:19.28%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored and Targeted Intervention 5a to address susceptible subpopulation barrier(s): **Planned Start Date: 2/1/2022** **Actual Start Date:5/9/2022**	**Intervention #5a tracking measure:** **N:** # of successfully contacted members from region 8 educated on fluoride varnish application and offered assistance with scheduling. **D:** # of attempted contacted members for Fluoride Varnish application in region 8.	N/A	N:532 D:2,655 R:20.04%	N:745 D:1,647 R:45.23%	N/A	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored and Targeted Intervention 5b to address susceptible subpopulation barrier(s): **Planned Start Date: 2/1/2022** **Actual Start Date:5/9/2022**	**Intervention #5b tracking measure:** **N:** # of successfully contacted members from disparate groups (R1, NAI, Disability CM members) educated on fluoride varnish application and offered assistance with scheduling. **D:** # of attempted contacted members for Fluoride Varnish application in disparity groups (R1, NAI, Disability CM members).	N/A	N:156 D:1,075 R:17.68%	N:57 D:132 R:43.18%	N:7 D:7 R:100.00%	N: D: R:	N: D: R:	N: D: R:	N: D: R:
Tailored and Targeted Intervention 5c to address susceptible subpopulation barrier(s): **Planned Start Date: 9/26/2022** **Actual Start Date:10/03/2022**	**Intervention #5c tracking measure:** **N:** # of successfully contacted members from Foster Care disparate groups members educated on fluoride varnish application and offered assistance with scheduling. **D:** # of attempted contacted members for Fluoride Varnish application in Foster Care disparity groups.	N/A	N/A	N: 7 D: 48 R:14.58%	N/A	N: D: R:	N: D: R:	N: D: R:	N: D: R:

[1] For ITM 2, No dental claims data is available.
[2] For ITM 2a, data collection for Q4 is reported on a monthly basis. The most recent data available for this ITM was 12/20/22.

[3]For All ITMs, successfully contacted members is defined by a guardian speaking to the outreach staff when telephonic outreach call is made or by a voicemail message notifying the guardian the enrollee is due for FV application and that the FV application service may be available through enrollees' PCP.

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 ages 6-18 months	N: 1, 526 D: 11,292 R: 13.51%	N:647 D:16,029 R:4.04%	N: D: R:	Rate: 18.51%
Indicator 2: Fluoride varnish application by PCP for children ages 19 months-2 years	N: 1,049 D: 16,514 R: 6.35%	N:1,306 D:22,170 R:5.89%	N: D: R:	Rate: 11.35%
Indicator 3: Fluoride varnish application by PCP for children ages 3-5 years	N: 1,238 D: 35,271 R: 3.51%	N:1,367 D:52,878 R:2.59%	N: D: R:	Rate: 8.51%
Indicator 4: Fluoride varnish application by PCP for all children ages 6 months – 5 years	N: 3,611 D: 63,077 R: 5.73%	N:3,320 D:91,077 R:3.65%	N: D: R:	Rate: 8.73%

[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.
[2]Data collection for Final Rate Measurement Period is reported on a monthly basis. The most recent data available for the indicator groups was 12/20/22.

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.

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

- **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.

- **PIP Highlights.**

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?**
  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.

- **Were there any threats to the external validity 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.

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
1.Conduct member outreach + education with dental provider appointment scheduling.	Lack of dental vendor data presents a barrier to achieving this ITM. Until the dental linkage is known, setting up appointments cannot occur. Until data feeds are acquired, gaps in care reports will not be accurate. Without dental claims data, the baseline and consecutive FV participation rate cannot be accurately determined and could cause confusion and abrasion to both providers and guardians of enrollees.	The lack of information regarding dental vendors was relayed to LDH. Solutioning to the access to vendor data and enrollee lists are pending. Although dental claims data is still not available from DentaQuest and MCNA, it continues to be a barrier for all MCOs and LDH is aware and working towards a solution. The Quality staff did reach out to the dental vendors to acquire needed information but were unsuccessful. Currently, there is no known process in place to find out which child is linked to which dental vendor, and which child has received dental varnish applications by dental vendors. Until the dental linkage is known, setting up appointments cannot occur. Until data feeds are acquired, gaps in care reports will not be accurate.	The health plan continues to review updates from LDH who is Working towards a Solution to the vendor data barrier. We will continue to encourage providers to communicate and collaborate with their local dental providers to improve access dental care and offer FV application per LA's Fluoride Varnish Policy; as well as AAPs and The United States Preventative Services Task Force (USPSTF) recommendations. We are reinforcing with providers the importance of establishing a dental home for all members by the age of 12 months and providing oral health anticipatory guidance per the Bright futures periodicity schedule. We are encouraging providers to include FV application into EPSDT visits and offer FV application in the Medical home.
2.Conduct provider education on LA's FV application policy, billing & coding guidelines.	1.Lack of a PCOR (gap report) and unknown prior FV application status resulted in provider hesitancy to immediately offer FV	1. The entire provider directory was sent via fax blast with the FV one-page information including LAs FV application policy, coding/billing/CPT, Smiles	We will continue to educate new staff and new providers on LAs FV application policy, coding & billing guidelines and review claims data and re-

	application services in the medical home. 2. Billing/Coding issues 99188 CPT code vs Z-codes/diagnosis codes resulted in inaccurate data counts. 3.Changing PCPs views towards offering FV application in the medical home during EPSDT along with referral to a dentist by 12 months of age proved an important barrier to overcome to increase provider participation in FV application by PCPs.	for life certification in March 2022. Information on LDH's recommendations per Dr. Dumas that the availability of the GAP report and/or Provider Portal should not affect the PCP's decision to apply fluoride varnish, nor should PCPs feel it is necessary to check the provider portal to do so, as some may feel it adds an unnecessary complication to their workflow. If the dentist did apply fluoride varnish, this does not preclude the PCP administering fluoride varnish so long as there are 3-6 months in between fluoride varnish applications was distributed beginning April 2022. 2. During Q2, our PHCs, CTCs, and Provider Advocates began to educated PCPs regarding LA's fluoride varnish policy and procedures for billing using the appropriate CPT code 99188 and educating on the difference between a diagnosis code (z-code) and CPT codes. We also began including education on the importance of appropriate member-provider linkage during provider education sessions. 3. In April 2022, to address this barrier, we our provider outreach staff began providing PCPs with additional resources on dental and FV statistical data including LA's Oral health report card and emphasized the benefits of preventative oral health screens and services for patients. To increase attention to the FV resources, we added FV	educate providers who are showing few or no claims for FV application services. our staff is available to assist and guide PCPs on how to streamline FV application into their workflow and practice. Going forward, we will consider barriers to provider portal use, and whether an ITM to measure who utilizes the provider portal would be more informative for performance improvement. We will continue to monitor claims data and collaborate with PCPs with low FV application claims volume and high-linkage member panels and identify barriers and seek solutions to Increase FV application rates on an individual basis. Provider facing staff monthly meetings will continue with FV agenda items addressed to improve the objectives of this PIP.

	4.PCP hesitancy to incorporate FV application into EPSDT visits due to perception of negative impact on patient flow efficiency and demand on staff prevents barriers to members seeking FV application by PCPs. PCPs who have competing priorities and responsibilities may choose to use their limited resources on other areas of healthcare.	provider education and certification documents to our Network Newsletter/Provider bulletin available at UHCprovider.com. Additionally, the provider facing staff would encourage providers to utilize the provider portal and UHCprovider.com resources routinely. 4. Some providers verbalized some apprehension regarding incorporating FV application into already comprehensive and time consuming EPSDT visits, we tailor our provider education and information sharing to our providers' individual needs and address barriers and provider concerns/hesitancy as needed providing needed support and follow up utilizing methods that accommodate the providers' schedule and form of interaction whether it be electronic, virtual, telephonic, or in-person. We are increasing provider outreach and collaboration efforts by having our EPSDT coordinator and fluoride varnish PIP lead outreach personally to PCPs to provide increased support and education on EPSDT requirements, LA's fluoride varnish policy, the importance of screening members at focused or sick-visits for well-child gaps in care, and offering strategies for performing EPSDT visits and fluoride varnish application in conjunction	

	5.Need for certification through Smiles for Life slowed the rate at which FV application services were offered to members. 6.Lack of electronic communication channels for PCPS slows down the rate in which providers are educated and subsequently certified and offering FV application services. 7.Despite receiving FV application education when the PIP first kicked off, some providers had few or no claims for FV application visits during Q4 data analysis which Suggests re-education and further assistance/ guidance is needed.	with sick-visits, when possible, to increase the rates of EPSDT visits and fluoride varnish application. Outreach is targeted, based upon high-volume provider linkage and our EPSDT coordinator, a Pediatric NP, is an additional resource for those PCPs who report apprehension, desire additional information/education, or need additional support. 5. Our FV PIP lead and EPSDT coordinator took the Smiles for Life Certification Course and Providers were reassured of the ease of access and that the course would only take about an hour of their time to complete and was a one-time certification, would not require recertification annually, and to keep a copy of the certificate in the employee record. 6. Providers who cannot be educated virtually or by email are being contacted by phone or in person at the PCPs convenience and the FV education materials have been sent via FAX to all PCPs with FV eligible members linked to them. Our FV PIP Lead made a focused effort to outreach to high-volume providers without electronic contact information available and updated the FV Provider outreach list for providers who have obtained electronic communication channels since the development of the list in Q1. 7. We are outreaching to	

		these providers, based on high-member linkage, and identifying the cause and helping providers overcome those barriers on an individual basis. As well as, educating all providers on the availability, and how to use the PCOR to identify gaps in care. Also, we are notifying PCPs of the incentive now available, twice a year, for FV application which we fill will motivate PCPs to more readily offer FV application services.	
3.Develop a FV application member gap report, PCOR and distribute to providers to identify FV eligible members and close gaps in care.	Clarified with LDH that FQHCs/RHCs can bill the 99188 CPT code but will not be reimbursed. Provider feedback indicated little interest in billing for no compensation.	UHC's Patient Care Opportunity Report (PCOR) now includes the FV application measure. When the FQHC/RHC bills the 99188 CPT code on a linked child, that gap will close on the PCOR. A $10 per gap closure, twice a year. The incentive became available for FQHC/RHCs as well as non-FQHC/RHC providers.	We will continue to distribute the PCOR (Gap Report) which includes FV application eligible members and encourage providers to utilize PCOR to close gaps in care. along with distribution of the PCOR, we also educate providers on how to access and utilize the PCOR to identify members with care gaps and encourage them to develop a process for outreaching to those members into their practice. We feel offering a monetary incentive for closing GAPs in care will increase provider compliance.
4.Conduct member outreach and education regarding FV application and availability with PCP during EPSDT/Wellness visits.	Parents/guardians of enrollees are difficult to reach with wrong numbers, disconnected numbers, no voice mail, and frequent changes of address. Also, low answer rates of member outreach calls with only about 30% who answer outreach calls.	In Q1, we began targeted member outreach to encourage receipt of FV application to eligible members-prioritized based upon disparity groups and linkage to providers who were participating in FV application at that time. In May 2022, we enlisted additional employees to increase member outreach	Our internal outreach team continues to make member education and outreach a priority. We will continue To outreach to FV eligible members and educate guardian's on FV application, benefits of FV application, timing of FV application, and availability of FV

		efforts, focusing on members in regions 8 and 5 (our most disparate regions per the disproportionate index). We have since expanded our outreach to other regions based upon disparity and extended outreach focus groups to include other disparate groups such as NAI and members with Disability members through CM. We also developed a comprehensive call outcome detail tab utilized by our internal member outreach staff to enhance direct member feedback on barriers. After approval of our telephone script by LDH, our internal member outreach team makes three telephone outreach attempts and leaves a detailed voicemail message, if able. We continue to update member contact information and explore alternative forms of communicating with members to distribute FV education materials. Our internal outreach staff have been educated on gentle persuasion techniques to encourage parents/guardians to schedule appointments to decrease gaps in care. The call log is provided to the Fluoride Varnish PIP team monthly, who then seeks solutions to improve appointment scheduling rates. Also, the external outreach collaboration efforts with ELIZA were finalized in June and IVR calls set to begin	application With PCPs. We will continue to update outreach lists and utilize the most recent contact information and will seek opportunities to attend community events that will allow us to reach and educate more people at a time. We will continue our enrollee outreach to promote wellness visits, and participation in FV application.

		July 12, 2022. During successful contact, guardians of FV eligible members are educated on the importance of FV application. Our team provides Information/ education on the importance and preventative benefits of FV application, as well as availability of services beginning as early as 6 months of age or with first tooth eruption. During the call, guardians are encouraged to discuss fluoride varnish application with the member's PCP during the wellness visits, along with offering scheduling assistance.	
5.Determine billing opportunities for FQHC/ RHC providers offering FV application and billing CPT code 99188. Consider offering additional incentive to promote billing of 99188 CPT code and offer FV application in medical home.	Clarified with LDH that FQHCs/RHCs can bill the 99188 CPT code but will not be reimbursed. Provider feedback indicated little interest in billing for no compensation	UHC's Patient Care Opportunity Report (PCOR) now includes the FV application measure. When the FQHC/RHC bills the 99188 CPT code on a linked child, that gap will close on the PCOR. A $10 per gap closure, twice a year. The incentive became available for FQHC/RHCs as well as non-FQHC/RHC providers.	The PCOR will continue to include the FV application measures for 2023.
6.Create and utilize Analysis of Disproportionate Under-representation index to determine areas of focus and plan which areas to outreach to based upon disparity.	We utilized the Analysis of Disproportionate Under-Representation to identify disparity subgroups to tailor interventions. .	In Q1 the regions of highest disparity are OPH Region 8 (N.E. Louisiana) and Region 5 (S.W. Louisiana). The subpopulations of highest disparity include American Indian or Alaska Native, Disabled, and 3–5-year-olds. Outreach was cascaded rom more disparate to less disparate subpopulations and regions. We also used claims data to focus member outreach to encourage receipt of FV application to eligible	We will continue our enrollee outreach to promote wellness visits, and participation in FV application. We will utilize the disparity index to focus outreach efforts to our most vulnerable populations. We will review claims data and call logs and develop a plan to outreach to our most disparate areas again once we have attempted to reach all enrollees. We will continue to prioritize

		members based on linkage to providers who were currently participating in FV application to attempt to minimize both member and provider confusion and abrasion. We determined one way to outreach to subpopulations, is to meet them where they are. For the American Indian subpopulation, educational materials were distributed at the 29th Annual Choctaw- Apache Tribe Powwow April 29th and 30th. For Q2, we identified that the areas of highest disparity were OPH Region 8 (N.E. Louisiana) and Region 1 (S. E. Louisiana), The Native American Indian population, and CM members who have approved PA for PDN, PDHC, PCS, and/or new UHCCP LA members who have been approved for Medicaid Eligibility through the Act 421 Program. These members have special needs and outreach to them were prioritized. Outreach efforts through collaboration with ELIZA, includes conducting IVR calls to eligible members of regions 8 & 5 with 3 attempts to contact per member began 07/12/22 after approval of the telephone outreach script by LDH. We continued to cascade our outreach efforts throughout Louisiana's other regions in the following order Regions 6, 9, 2, 3, 7, and 4 based upon more disparate	outreach based upon utilization of the Analysis of Disproportionate Under-Representation index and identify disparity subgroups to tailor the interventions for this PIP.

		to less disparate regions. We will also continue to use claims data to focus member outreach to encourage receipt of FV application to eligible members. In Q3, our member outreach efforts included members in Regions 8, 5, 6 and Foster Care and Disability eligible members.	

References

List any references that you cite.

American Dental Association. (2022). *Caries Risk Assessment and Management.* *https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/caries-risk-assessment-and-management#.Y4pTpVa_ngM.link*

Bright Futures. (2019). *Health Care (Periodicity Schedule) Bright Futures/American Academy of Pediatrics.* Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) (ucsf.edu)

Centers for Disease Control and Prevention. (2020). *Oral Health Conditions.* U.S. Department of Health and Human Services. https://www.cdc.gov/oralhealth/conditions/index.html

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.

Community Preventative Services Task Force. (2017). *Improving Oral Health: Community Water Fluoridation.* One Pager - Improving Oral Health: Community Water Fluoridation (thecommunityguide.org)

Department of Health & Human Services. (2020) *Centers for Medicare & Medicaid Services Informational Bulletin. https://www.medicaid.gov/federal-policy-guidance/downloads/cib062520.pdf*

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.

Louisiana Department of Health. (2018). *Closing the Gap on Dental HPSAs: Louisiana Oral Health Workforce Assessment.* https://ldh.la.gov/assets/oph/pcrh/OH_Assessment_Report_8_31_18_final_.pdf

National Center for Health Statistics (NCHS). National Health and Nutrition Examination Survey Data. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2013-16][https://health.gov/healthypeople/objectives-and-data/browse-objectives/oral-conditions

National Survey of Children's Health, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), (2021) [2019-2020]. https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/prev_dent_care/state/LA

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.

United States Preventative Services Task Force. (2021). 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

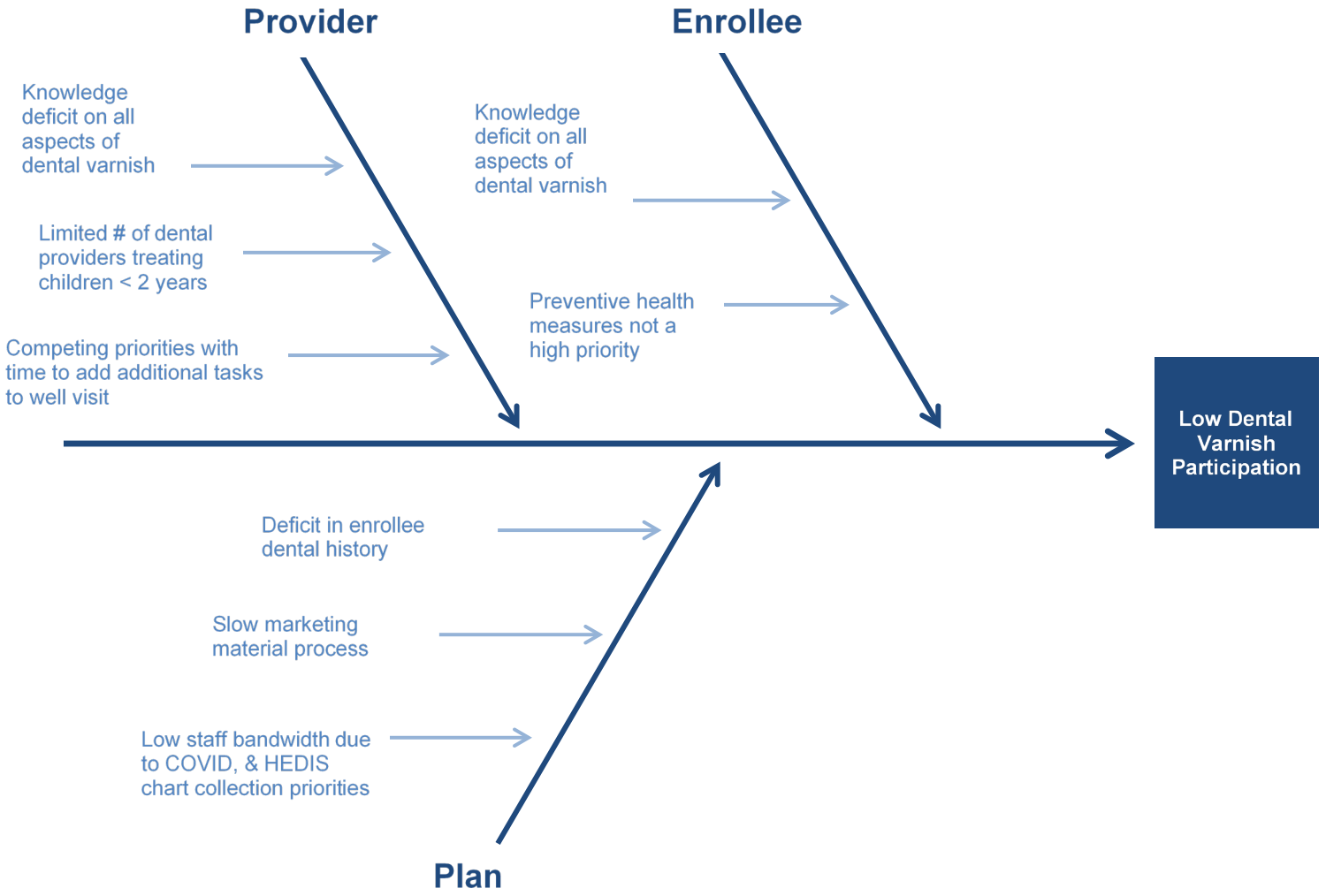
Glossary of PIP Terms

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 • Roadblock	To inform meaningful and specific intervention development addressing members, providers, and MCO staff.	Barriers are obstacles that need to be overcome 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

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address	1. Lack of PCP knowledge of the LA's Fluoride Varnish Policy and Louisiana Department of Health Informational Bulletin 16-7 and PCP not aware that Fluoride Varnish and oral health risk assessments is part of their responsibility. 2. Lack of PCP knowledge of coding/billing/reimbursement for CPT code 99188 (Application of topical fluoride varnish by a PCP). 3. Lack of PCP knowledge of required certification through smiles for life, and obtainment of dental varnish supplies. 4. Lack of access to all dental claims data needed for the creation of the dental varnish gap report. Indicating inaccurate varnish participation status could cause confusion and possible provider and/or member abrasion. 5. Lack of member knowledge of importance of dental varnish and its' role in prevention of tooth decay. Misinformation about fluoride supplementation, could lend to hesitancy to participate in dental varnish. 6. Insufficient knowledge among parents/guardians regarding importance of preventative care/EPSDT visits and application of fluoride varnish by PCPs. 7. Difficulty contacting parents/guardians of enrollees and when contact made often declined assistance in scheduling appointment.	1. Provider competing priorities, presence of time constraints to conduct additional oral health risk assessments and perform application of fluoride varnish during EPSDT appointments.

Less Feasible to Address	1. Lack of access to dental care, especially for children under 2 years of age, low-income families, and residents of rural areas. LDH reports 59 of LA's 64 parishes (home to 86% of residents) as Health Professional Shortage Areas for dental care. 2. Decreased access to care Covid-19 or other health issues take priority over preventative care and oral health visits. 3. Slow member communications as we obtained the needed approvals and data from vendors and dental claims.	1. Lack of dental providers not treating children< 2 years of age. Dental provider shortage. 2. Ability of enrollees/enrollee guardians to make and keep oral health appointments (such as availability of transportation, convenience of office hours, prioritization of oral health above other needs).

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

	Positives	Negatives
INTERNAL ***under your control***	***build on*** **STRENGTHS** ***Examples:*** PIP lead is certified for, and has experience with conducting dental varnish application on children < 6 years of age- can impart knowledge to staff and trouble shoot with providers Access to multidepartment resources to facilitate the dissemination of dental varnish information	***minimize*** **WEAKNESSES** ***Examples:*** Slow process for enrollee education communications approval Lack of staff and PCP knowledge of dental varnish procedures and billing options Lack of PCP knowledge regarding oral health assessments
EXTERNAL ***not under your control, but can impact your work***	***pursue*** **OPPORTUNITIES** ***Examples:*** Pursue relationships with DentaQuest and MCNA to create a strategy for enrollee education regarding dental varnish and the importance of pediatric dental health in general Collaborate with CM to educate enrollees on the value of dental varnish and where to acquire the services	***protect from*** **THREATS** ***Examples:*** Parent/guardian hesitancy to attend preventive care visits due to COVID Parent/guardian and PCP lack of knowledge on the value of dental varnish and what the dental varnish process entails.

Appendix D: Driver Diagram

Aim	Primary Drivers	Secondary Drivers	Change Concepts	MCO-identified Enhanced Interventions to test Change Concepts
Improve, by at least 10 % points from baseline to final measurement, the percentage of children ages 6 months through 5 years who received fluoride varnish application by their PCP	PCPs conduct fluoride varnish applications on children 6 months through 5 years	PCPs conduct oral health assessments to determine the need for fluoride varnish application	PCPs learn what dental varnish is and when it should be applied	Determine PCPs knowledge of dental varnish and educate those with knowledge deficit
			PCPs understand the certification and billing process for dental varnish application	Educate identified PCPs on certification and billing process
			Plan staff will determine subpopulations with highest disparity for dental varnish application	Prioritize PCP focus based on high disparity groups or areas
			Plan staff will learn tools for dental varnish education to disseminate to PCPs	Create dental fluoride varnish toolkit to use for staff & PCP education
	Parents/guardians bring enrollees in for dental varnish application	Enrollee parent/guardians seek dental varnish for their children	Enrollee parent/guardians will understand the importance of oral healthcare, and dental varnish specifically	Create tools to use for enrollee outreach and education on dental varnish
			Enrollee parent/guardians will know where to access dental varnish	Determine PCP readiness to conduct varnish application before outreaching to their patients

Appendix E: Plan-Do-Study-Act Worksheet

PDSA	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:Provider outreach			
Plan: Document the plan for conducting the intervention.	•Created a dental varnish staff and provider education toolkit and a single page, quick reference document for distribution via multiple communication channels.	•ITM 3**:** N # members whose PCP was outreached and educated / D # members on Fluoride Varnish Care Gap report ages 6 months through 5	•
Do: Document implementation of the intervention.	•Our key strategy is outreach and education.	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•The success of the PIP greatly relies on PCPs adapting fluoride varnish application practice in their	•	•

Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	• Based on our experiences with the developmental screening PIP, no or limited incentives and reimbursement for FQHC/RHC and their providers was essential in increasing provider compliance, and it is possible this could also be the case for the fluoride varnish PIP. We are working to develop an incentive for the fluoride varnish PIP and are confident that these processes will continue to improve, as these programs mature and continue to make enhancements, to increase fluoride varnish application by PCPs.	•	•
Intervention #2:Member outreach			
Plan: Document the plan for conducting the intervention.	•We are in the process of developing educational materials to increase patient awareness of oral health and how it affects overall wellbeing. Also, Develop dental varnish outreach scripting for members via IVR	•ITM 2a: N # contacted members from gap report educated on fluoride varnish / D # contacted members on Fluoride Varnish Care Gap report ages 6 months through 5 years of age.	•
Do: Document implementation of the intervention.	•Our key strategy is outreach and education.	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•Methods of direct member outreach proves to be a challenge.	•	•

Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	• There had been delayed due to the approval process and availability of dental claims data needed for creation of the dental varnish gap report. These have been resolved and we have begun collaboration with care management to begin implementation of our member outreach strategy. We will continue to modify and enhance outreach to meet the goals of the PIP.	•	•

Appendix F: 2022 Quarterly Performance Indicator Rates

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 ages 6-18 months	N:1,526 D:11,292 R: 13.51%	N:647 D:16,029 R:4.04%	N: D: R:	R:18.51%	To surpass the aim of the Dental Varnish PIP by 5 percentage points
Indicator 2: Fluoride varnish application by PCP for children ages 19 months-2 years	N:1,049 D:16,514 R: 6.35%	N:1,306 D:22,170 R:5.89%	N: D: R:	R:11.35%	To surpass the aim of the Dental Varnish PIP by 5 percentage points
Indicator 3: Fluoride varnish application by PCP for children ages 3-5 years	N:1,238 D:35,271 R:3.51%	N:1,367 D:52,878 R:2.59%	N: D: R:	R:8.51%	To surpass the aim of the Dental Varnish PIP by 5 percentage points
Indicator 4: Fluoride varnish application by PCP for All Children Ages 6 months – 5 years	N: 3,611 D: 63,077 R: 5.73%	N:3,320 D:91,077 R:3.65%	N: D: R:	R:8.73%	Increase by 3 percentage points from CY 21 to CY 22 per PIP recommendation

[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.
[2]Data collection for Final Rate Measurement Period is reported on a monthly basis. The most recent data available for the indicator groups was 12/20/22.