Centers for Medicare & Medicaid Services
ORAL HEALTH Initiative

Advancing Oral Health through Quality Improvement:

Performance Improvement Projects (PIPs) for States and Health Plans – Implementation Considerations

Wednesday, May 20th, 2015

Laurie Norris, JD
Roopa Mahadevan, MA
Janice Carson, MD
Shay Hawkins

The Role of PIPs in the CMS Oral Health Initiative

Wednesday, May 20, 2015

Laurie Norris, JD
Senior Policy Advisor
Centers for Medicare & Medicaid Services (CMS)

Welcome and Overview

CMS has published Oral Health PIP Manuals and Template on Medicaid.gov.

They can be found here!

Two webinars:

- May 6 – Click here to view!
- May 20

Today's Speakers

- **Laurie Norris, JD**, Senior Policy Advisor and Coordinator of the CMS Oral Health Initiative, CMS
- **Roopa Mahadevan, MA,** Program Officer, Center for Health Care Strategies (CHCS)
- **Janice Carson, MD,** Deputy Director, Performance, Quality and Outcomes, Georgia Department of Community Health
- **Shay Hawkins,** Quality Improvement Manager, Peach State Health Plan, Georgia

CMS Oral Health Initiative

- Increase by **10 percentage points** the proportion of Medicaid and CHIP children ages 1 to 20 (enrolled for at least 90 days) who receive a **preventive dental service**.
  - Baseline year is FFY 2011. National baseline is 42%.
  - Progress in FFY 2013. National rate is 44%.
  - Goal year is FFY 2015. National goal is 52%.
  - Every state has its own baseline and goal. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/OHIBaselineGoals.pdf

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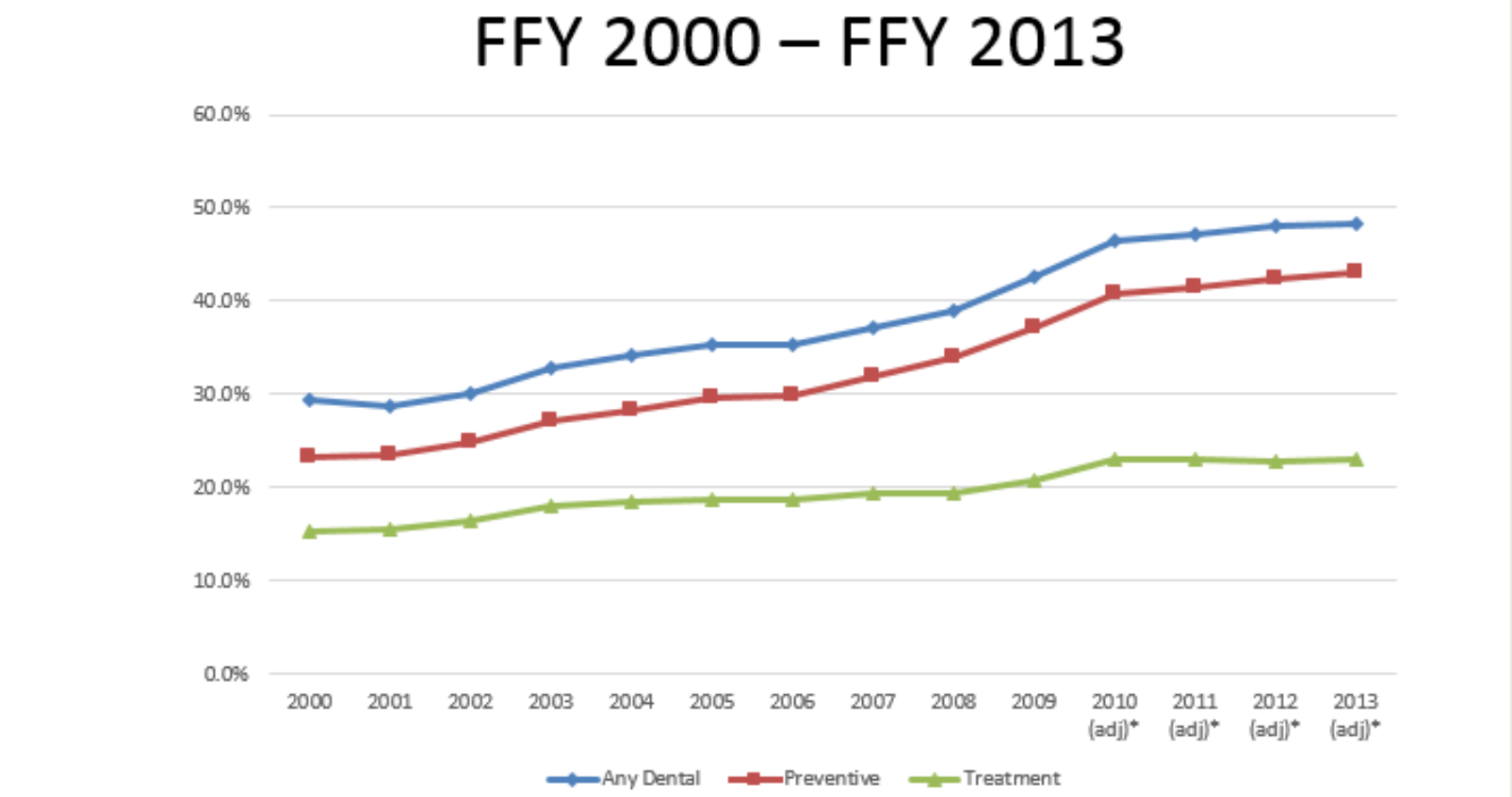
Progress on Children's Use of Dental Services



Source: FFY 2000-2013 CMS-416 reports, Lines 1, 1b, 12a, 12b, and 12c.
Note: *FFY 2012 data for Connecticut is not available and was substituted with FFY 2011 data. Data reflects updates as of 10/22/14.

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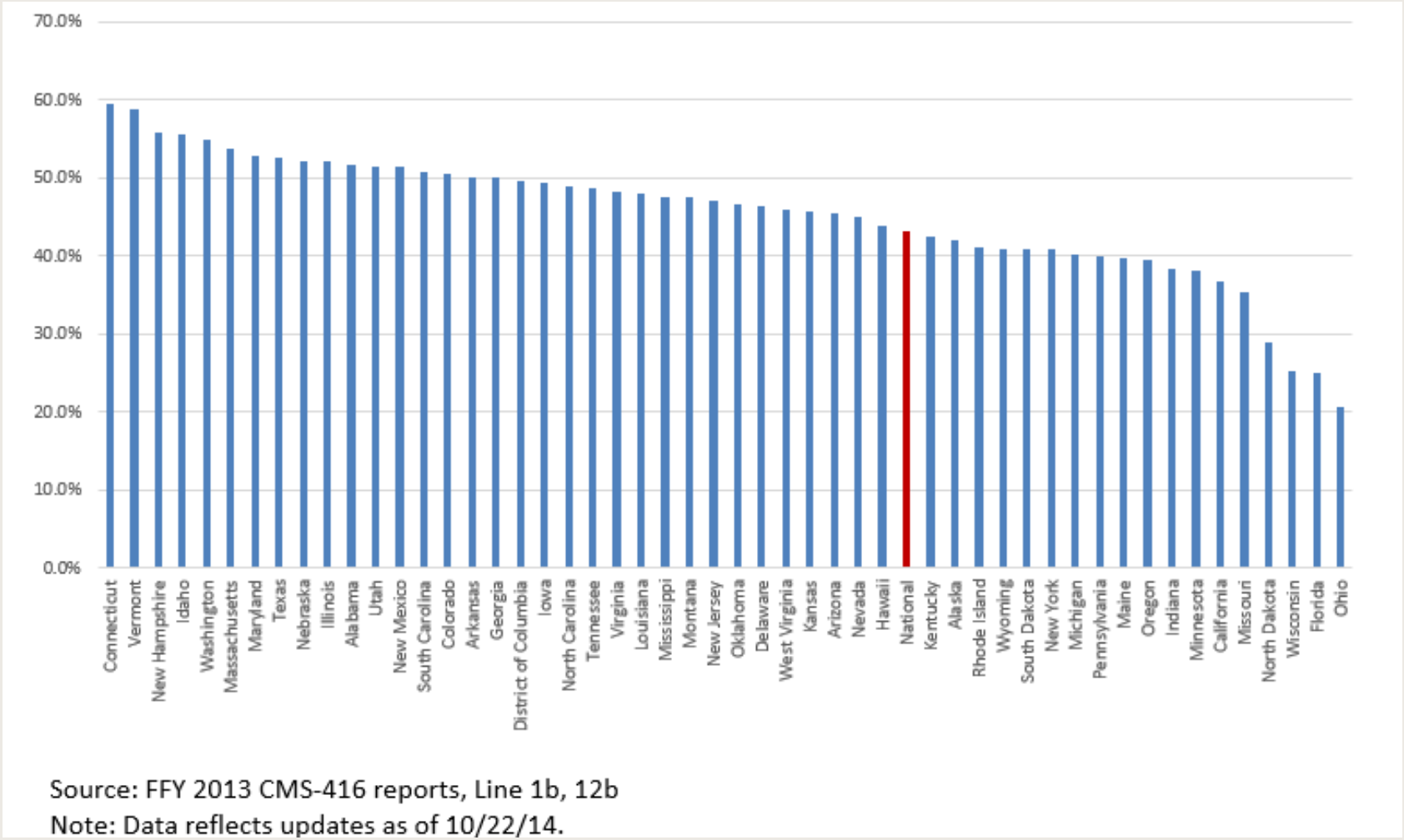
Percentage of Children, Age 1-20, Who Received Any Preventive Dental Service, FFY 2013



Source: FFY 2013 CMS-416 reports, Line 1b, 12b

Note: Data reflects updates as of 10/22/14.

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PIPs: Important Terms

- Performance Improvement Project (PIP)
  - A project designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
  - Are required for Medicaid MCOs and PIHPs, and are optional for PAHPs. They do not apply in FFS Medicaid.
- External Quality Review (EQR)
  - The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid recipients.
  - CMS protocols require annual validation of PIPs, performance measures, and every 3 years, a review of the compliance with state standards for access and quality. Other optional activities may be performed by the EQRO, including conducting a PIP.
- External Quality Review Organization(EQRO)
  - An organization that meets the competence and independence requirements set forth in § 438.354, and performs external quality review, other EQR-related activities as set forth in § 438.358, or both.
- Special Terms and Conditions (STC)
  - An agreement between CMS and the state that sets forth the parameters of an 1115 demonstration project; includes details related to the extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration.

Considerations Around PIPs

- Who conducts PIPs?
  - Health Plans
  - Providers
  - States
  - EQROs
- Why undertake a PIP?
  - To address a concern or problem;
  - It is required by contract;
  - It is required by STCs; and,
  - It is required by regulation
- Questions to ask yourself:
  - What is your market size and geography?
    - What is the composition of the market?
  - What are your current quality improvement initiatives?
    - And historic initiatives?
  - What has your past performance been?
    - Did we identify barriers previously?
  - What is your goal?
    - Make a goal that is both meaningful and obtainable.
  - What objectives will help you meet your goal(s)?
    - Objectives are typically more specific and measureable.

Review of May 6 Webinar: PIP Planning

- **May 6 webinar highlighted key strategies for developing an oral health PIP program:**
  - Understand variation in oral health care in your state
  - Involve oral health stakeholders
  - Define scope of the oral health PIP program
  - Determine the PIP aim
  - Maximize health plan participation
- **Today's webinar will highlight key strategies for effectively implementing a high-quality oral health PIP.**

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Q & A

Any questions?

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Key Considerations for Oral Health Performance Improvement Project (PIP) Implementation

Wednesday, May 20, 2015

Roopa Mahadevan, BS, MA
Center for Health Care Strategies (CHCS)

Phases of an Oral Health PIP

1. Select the PIP Topic
2. Identify the Population
3. Define the PIP Aim
4. Select the Performance Measures
5. Create a Data Collection Plan
6. Plan the Intervention
7. Implement the Intervention and Improvement Strategies
8. Analyze Data to Interpret Results
9. Plan for Sustained Improvement

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PIP Template

- To be filled out by health plans and submitted to the state over the course of the PIP
- Includes some information and guidance from the state on key aspects of the PIP (e.g., topic, performance measures)
- Guides health plans through key activities (e.g., aim identification; data collection; intervention planning; sustainability)
- Helps states track health plan effort and progress on the PIP
- Facilitates external validation (e.g., EQRO)
- Serves as project management resource or “diary” of strategies used and lessons learned

PIP Manual

- **Organized by phases of the PIP as laid out in the template**
- ***For States*:**
  - Helps customize the PIP template to their program and/or each health plan
  - Provides guidance on planning, oversight, and/or assistance to health plans for each phase
- ***For Health Plans*:**
  - Provides guidance on carrying out each phase
  - Provides key tools to assist with intervention planning and implementation

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Initial Phases of an Oral Health PIP

- **Each step is a combination of required elements and flexible elements, the balance of which is decided by the state.**
- **States are generally more prescriptive about the first four phases as these set the vision and parameters for the PIP.**
  1. Select the PIP Topic
  2. Identify the Population
  3. Define the PIP Aim
  4. Select the Performance Measures
- **Now, the health plan has an aim and can begin intervention planning and implementation.**
  - Example: "Improve by 10 percentage points the utilization of preventive dental services among 3 to 6 year olds"

Phase Five: Formation of QI Team and Data/Training Protocols

- **The PIP team should have a diverse set of skills:**
  - Executive leadership
  - Oral health/clinical expertise
  - Health information technology
  - Provider communication
  - Member and/or community engagement
- **Consider specific knowledge/training needed for the PIP, and use of external resources:**
  - Quality improvement methods
  - Data collection protocols - access to reliable data and use of effective staff workflows
  - Cultural competency
  - Stakeholder input – survey design, focus group moderation, meeting facilitation
  - *Helpful external resources:* EQRO, community partners, oral health coalitions, dental school students, neutral conveners, academic institutions

Phases Six and Seven of an Oral Health PIP

- **Plan and Implement an Oral Health Quality Improvement Intervention**
  - Identify root causes underlying the aim of the PIP
  - Identify interventions and consider feasibility
  - Use continuous quality improvement to track intervention implementation activities

Identify Root Causes Underlying the Aim of the PIP

- **Consider which root causes are driving the barriers experienced among your PIP population.**
  - Workforce availability, program administration, member/community factors
  - Use tools like *Fishbone (Cause and Effect) Diagram* and the *Five Whys*
- **Seek input to shed light on the barriers (e.g., appointment wait-times, travel distances, dentist reluctance to see young children, oral health literacy) impacting care.**
  - Members/caregivers, dental providers and front-line staff, safety net providers, community advisory board, oral health coalitions, community-based organizations, cultural associations
- **Prioritize root causes to address based on your organizational resources.**
  - Understand what is important to address vs. what is feasible

Identify Interventions and Consider Feasibility

Consider four types of interventions:

1. *Program administration*: targets policies, operations, and programmatic operations
2. *Provider-focused*: influences provider participation and encourages best practices in care delivery
3. *Member-focused*: at level of member or family, and encourages active participation in oral health care
4. *Collaborative*: leverages resources across multiple entities (e.g., state, providers, counties, public health, safety net, community organizations)

Select an intervention that is feasible given available, time, resources, and knowledge:

- Use tools such as a Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

Examples of Interventions: Addressing Member-Level Factors

Administrative	Provider-Focused	Enrollee-Focused	Collaborative
Update provider directories frequently. **Broaden provider network** to include school-based and -linked programs, safety net clinics, and **diverse provider types** (e.g., hygienists, dental therapists).	Create an **easy-to-use referral mechanism for primary care** medical providers to locate general **dentists willing to see very young children** and pediatric dentists accepting new patients.	Create **outreach programs on good oral hygiene practices** in the home. **Make them available** in Spanish, Chinese, Arabic, Tagalog, Korean, Urdu, or other **languages frequently-spoken** in the health plan's member network.	**Collaborate** with Title V, WIC, Head Start, Maternal/Infant/ Early Childhood Home Visiting Programs, and Title I schools to **help children find available Medicaid dentists** and book an appointment.

Use Continuous Quality Improvement to Track Intervention Implementation Activities

- **Create intervention tracking measures that measure <u>how you are implementing.</u>**
- **These are different from the measures that are tracking your PIP impact.**

Activity	Tracking Measure
Every three months, send "report cards" to practices comparing their dental practice's sealant application rate with others.	Percentage of practices who received a report card in the last three months.
Provide three trainings to health plan staff to implement a new Spanish-language help line.	• Number of trainings conducted. • Number of staff that attended each training. • Pre- and Post-tests of staff familiarity with the new phone system.

- **Use Plan-Do-Study-Act (PDSA) cycles to track "mini-improvements" as you go. Use the intervention tracking measures during the "Study" phase to course-correct as needed.**
  - **Pilot-testing a member oral health education tool**
  - **Sending a mailer to 20 providers, before sending to 100 providers**

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Steps Eight and Nine of an Oral Health PIP

- **Analyze data to measure impact**
  - Use frequent and multiple re-measurements
  - Track qualitative changes (pre-/post- focus groups, surveys)
  - Create a narrative: lessons learned, barriers faced, strategies used
  - Decide how often you will re-measure (e.g., every 3 months) to continue the PIP effort beyond the project timeline
- **Plan for sustained improvement**
  - Review the PIP effort and plan for beyond
  - Disseminate results

Plan for Sustained Improvement: Review the PIP effort

- **Identify components of the PIP that worked and those that can be improved:**
  - Timeline, staffing model, measure selection, leadership support, community engagement
- **Consider how the PIP can be modified or scaled up:** new populations, new measures, new interventions
- **Consider how you can build capacity for future PIP or broader QI efforts:**
  - *Internal*: staff training, financial resources, equipment, staff champions, data completeness
  - *External*: community partnerships, policy changes, provider relationships, financial assistance from the state
  - EQRO support, training, peer learning collaboratives

Plan for Sustained Improvement: Disseminate Results

- **Disseminate the results – including less successful aspects – of the PIP:**
  - Motivates productive conversations among staff
  - Generates buy-in from external supporters (e.g., philanthropies, community partners) to support future capitalization
  - Builds positive image of the organization
- **Customize the message based on the likely concern of each stakeholder:**
  - Leadership, providers, members, community partners
- **Consider the optimal vehicles for dissemination:**
  - State and health plan websites
  - Provider/consumer report cards, staff newsletters, waiting room posters
  - Member testimonials/story-telling
  - Oral health policy publications

Guiding Principles for Implementing Oral Health PIPs

In summary:

- **Consistently seek input** from those involved in the intervention, such as members/caregivers, providers, front-line staff.
- Consider **what is feasible** given timeline, resources, and staff commitment. The PIP needs protected staff time.
- Use a **continuous quality improvement approach** throughout. Create tracking measures to identify progress. If something is not working, stop and try something else.
- Think of the **PIP as part of a broader quality improvement effort**. It should support your organization's goals – not be a burdensome, one-time project.
- Build in QI processes – routine data review, stratification of performance data by demographics, staff training – that will last **beyond the PIP**.

Resources and Q&A

- **For more information and strategies on oral health PIPs, use the CMS resources below, that can be found on the Medicaid website (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html):**
  - *Medicaid Oral Health PIPs: A Template*
  - *Medicaid Oral Health PIPs: A How-to Manual for States*
  - *Medicaid Oral Health PIPs: A How-to Manual for Health Plans*

Q & A

Any questions?

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Oral Health Performance Improvement Projects: Georgia's Experience

Wednesday, May 20, 2015

Janice Carson, MD
Deputy Director, Performance, Quality and Outcomes
Georgia Department of Community Health

Georgia (GA) Medicaid Program

- 2006 – GA transitioned several eligibility categories to managed care including Right from the Start Medicaid (RSM) and PeachCare for Kids® (CHIP) children.
- 2014 – GA transitioned children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system to managed care.
- Small number of SSI, disabled, and adoption assistance children who opted out of managed care are in FFS Medicaid.
- As of January 1, 2015, there were 1,156,847 Medicaid and 154,590 CHIP children enrolled – for a total of 1,311,437.
  - 1,153,673 Medicaid and CHIP enrolled children in managed care
  - 157,764 Medicaid and CHIP enrolled children in FFS

GA Medicaid Program

- Dental Goal:
  - All Medicaid and PeachCare for Kids® eligible children will access their EPSDT preventive dental benefits.
    - Follow Bright Futures and AAPD periodicity schedules
    - Monitor access through:
      - HEDIS Annual Dental Visit measure
      - EPSDT 416 Report
        - » Preventive Dental Visits
        - » Sealant Use

GA: Annual Dental Visit PIP - 2010

- All three CMOs implemented a Dental PIP in 2010
- Original Study Indicator: Percentage of members who had at least one dental visit – HEDIS Annual Dental Visit measure
  - HEDIS measure required continuous enrollment for 11/12 months
- Study Populations: 2 to 3 years of age (lowest performance) and 2 to 21 years of age
- Sample CMO – Study Baseline for 2 to 21 years of age was 66.7 percent

GA: Annual Dental Visit PIP - 2010

- Barrier Analysis conducted → Interventions
  - Pay for performance for high volume practices
  - Posted missed opportunity reports
  - Provider report cards
  - Mobile vans to conduct screenings for noncompliant members
  - Partnered with provider to extend office hours
  - Reminder postcard
  - Missed appointment letters
- Many interventions didn't align with barrier analysis
- Progress measured annually

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GA: Annual Dental Visit PIP - 2010

- EQRO PIP Validation Protocol required the following for valid and reliable results:
  - ✓ All critical elements had to be “Met”
  - ✓ Any critical element that received a “Not Met” score resulted in an overall validation rating for the PIP of “Not Met”
  - ✓ “Partially Met” score if 60 - 79 % of all evaluation elements were “Met” or one or more critical elements were partially “Met”
  - ✓ Point of clarification provided when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements

GA: Annual Dental Visit PIP – 2010-2012

- Sample CMO's PIP Performance:
  - Baseline – 66.7 percent (CY 09)
  - Re-measurement 1 - 69.1 percent (CY 10)
  - Re-measurement 1 - 69.7 percent (CY 11)
  - Re-measurement 2 - 69.9 percent (CY 12)
    - PIP validation - statistically significant and sustained increase over baseline
    - HEDIS 90th percentile performance!
- State not satisfied with stalled performance improvement; CMO receiving 'Met' Validation Score; and static interventions

GA: Annual Dental Visit PIP - 2012

- CMS EQRO Protocols changed
- Georgia requested EQRO change scoring methodology
  - Step 8 (sufficient data analysis and interpretation) became a critical element. If study results not accurate, PIP didn't achieve overall "Met" status
  - Step 9 (real improvement achieved), statistically significant improvement for the study indicator outcome(s) between baseline and remeasurement period must be achieved
  - Step 10 (sustained improvement achieved) – assessed after statistically significant improvement achieved

GA: Annual Dental Visit PIP – 2012

Sample CMO PIP	Percentage Score of Evaluation Elements Met		Percentage Score of Critical Elements Met		Validation Status	
	Current Tool	New Tool	Current Tool	New Tool	Current Tool	New Tool
Annual Dental Visits	76%	76%	90%	73%	Partially Met	Partially Met

The new tool scored down the *Annual Dental Visits* PIP for omitting a study indicator and not reporting the omitted study indicator results.

Interventions evaluated - Sample CMO added mobile dental services to address GeoAccess issues and appointment time availability analyses; providers increased hours of availability for dental services. Interventions didn't address barriers identified.

GA: Annual Dental Visit PIP – 2013 Change

- CMOs' 416 Reports demonstrated Dental Performance not equal to the performance determined using the original study indicator.

GA: Annual Dental Visit PIP – 2013

Georgia changed the CMOs' Study Indicator to align with the CMS Oral Health Initiative. Sample CMO's Performance shown below. 416 dental rates lower than HEDIS dental rates:

Study Topic	Study Indicator Description
Annual Dental Visits	❑ The percentage of members 1–20 years of age who received any dental service during the measurement period (CMS 416 12A). ❑ The percentage of members 1–20 years of age who received preventive dental services during the measurement period (CMS 416 12B). ❑ The percentage of members 6–9 years of age who received a sealant on a permanent molar during the measurement period (CMS 416 12D).

Annual Dental Visits

Study Indicator	Baseline (10/1/2011–9/30/2012)	Re-measurement 1 (10/1/2012–9/30/2013)	Sustained Improvement
❑ The percentage of EPSDT eligible members ages 1–20 who received any dental services during the measurement period (CMS 416 12A).	54.2%	56.6%↑	NA
❑ The percentage of EPSDT eligible members ages 1–20 who received preventive dental services during the measurement period (CMS 416 12B).	51.1%	49.49%↓	NA
❑ The percentage of EPSDT eligible members ages 6–9 who received sealant on a permanent molar during the measurement period (CMS 416 12D).	22.4%	26.9%↑	NA

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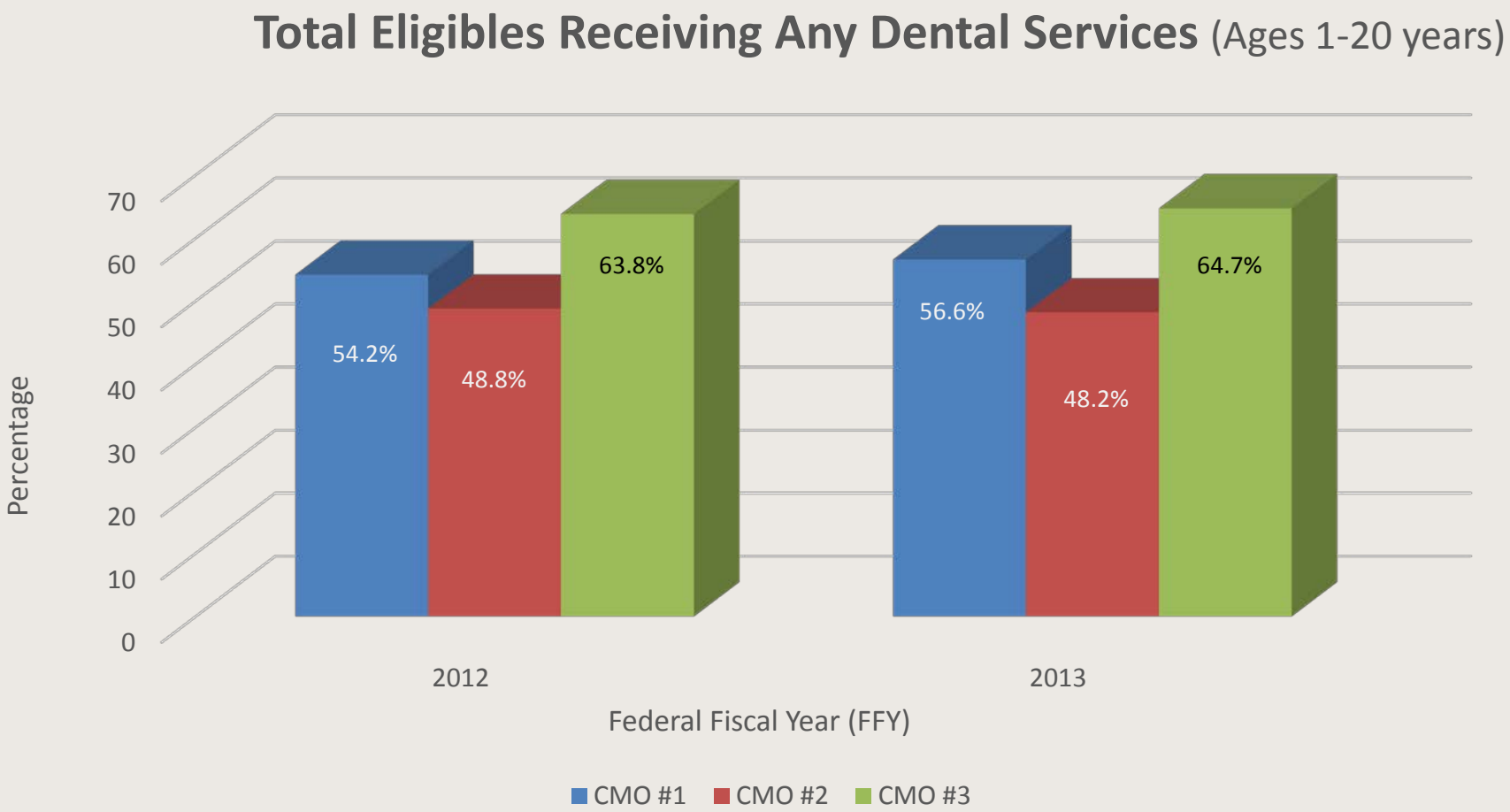
GA: Annual Dental Visit PIP – 2013 Validated in 2014

- EQRO validation of CMO's PIP showed:
  - Not all interventions linked to causal/barrier analysis or study indicators (robotic calls and text messaging didn't address barriers to making and keeping appointments).
  - No revisions made to improvement strategies to address decline at re-measurement 1 for one study indicator even though six months had passed between the completion of the first remeasurement and the submission of the PIP for validation.
  - Limited methods for evaluating effectiveness of interventions – evident across all three CMOs.

GA: Annual Dental Visit PIP – CMOs' 416 Dental Data



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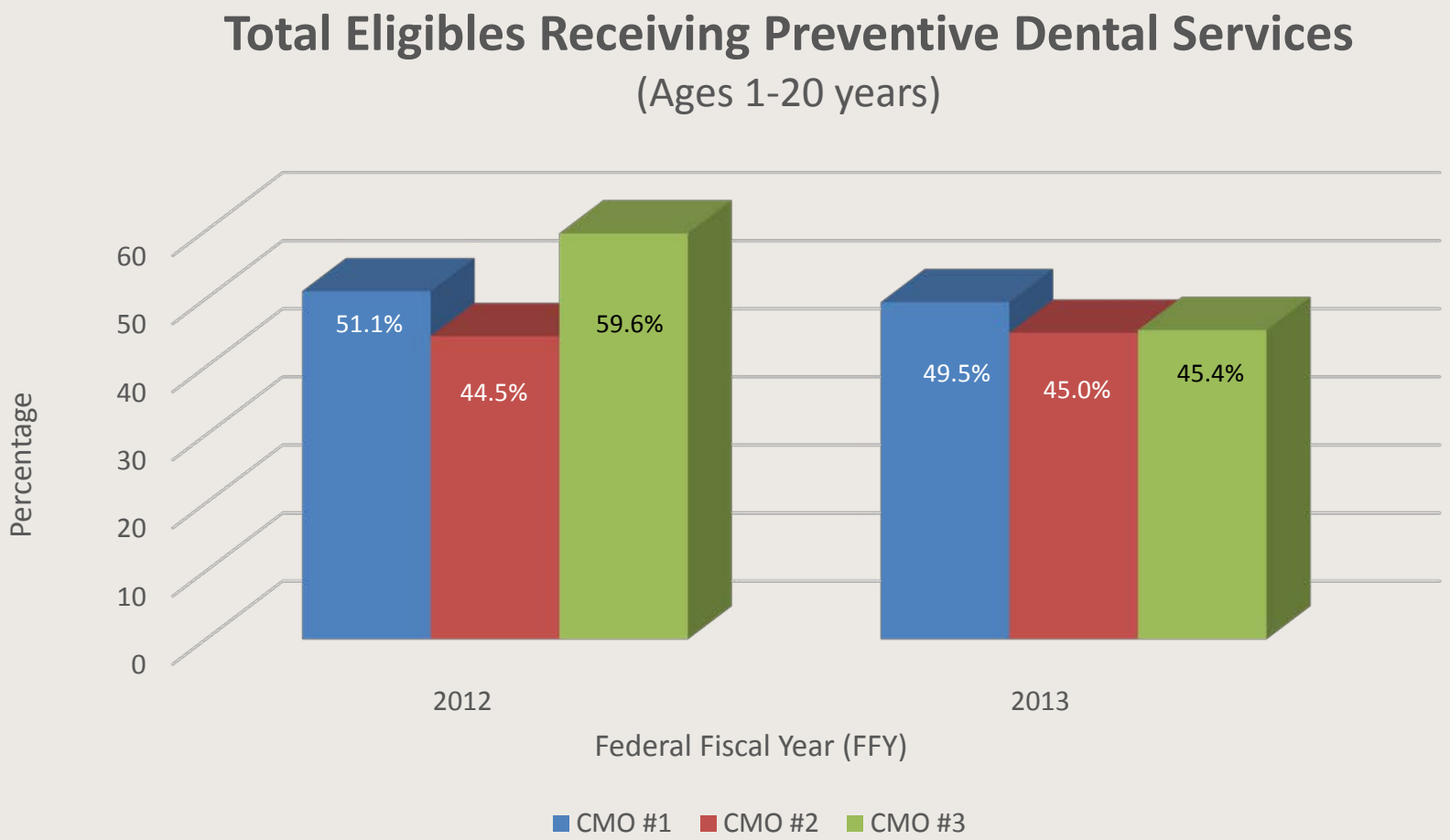
GA: Annual Dental Visit PIP – CMOs' 416 Dental Data



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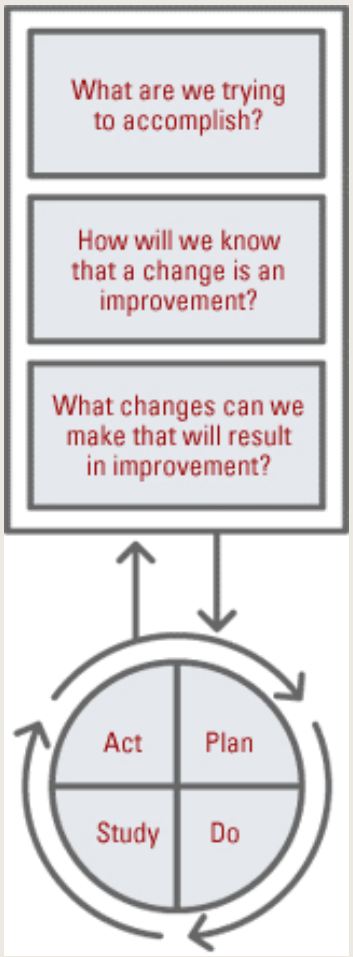
GA: Annual Dental Visit PIP - 2015

- Georgia transitioned to Rapid Cycle PIP process:
  - Based on IHI principles shared during CMS QI 101, 201, and 301 projects
  - Required new PIP implementation process:
    - EQRO training for CMOs began in December 2014 – February 2015
    - Transitioned to SMART Aim measures from PIP indicators with broad global aim to improve oral health for members
    - TA provided to CMOs for each Rapid Cycle PIP module
    - Small tests of change and data collection used to determine effectiveness of intervention and 'spread' ability

GA: Annual Dental Visit PIP – 2015 and Beyond



Module 1 – PIP Initiation. CMO must submit modules to EQRO for approval prior to moving to each subsequent step

Module 2 – SMART Aim Data Collection

Module 3 – Intervention Determination

Module 4 – Plan Do Study Act for each intervention

Module 5 – PIP Conclusions

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Q & A

Any questions?

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The Oral Health Performance Improvement Program

Wednesday, May 20th, 2015

Shay Hawkins
Peach State Health Plan, Georgia

Georgia Medicaid Oral Health Initiative Goals

Peach State Health Plan and DentaQuest are collaborating with the Georgia Medicaid Program on the Oral Health Initiative and are working to improve access to and utilization of oral health services for children enrolled in Peach State Health Plan.

- **The goals outlined in the Oral Health Initiative for Georgia are:[1]**
  - By September 30, 2015, increase to 58 percent the percentage of Georgia Medicaid children ages 1 to 20 enrolled for at least 90 continuous days who receive a preventive dental service during the FFY.[2]
  - By September 30, 2015, increase to 23.6 percent the percentage of Georgia Medicaid children ages 6 to 9 enrolled for at least 90 continuous days who received a sealant on a permanent molar.

1. Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs CMS ORAL HEALTH STRATEGY April 11, 2011
2. Percent of Children Ages 1-20 Enrolled in Medicaid for at Least 90 Continuous Days Receiving A Preventive Dental Service FFY 2011 Baselines, FFY 2012 Progress, and FFY 2015 Goals Revised April 10, 2014

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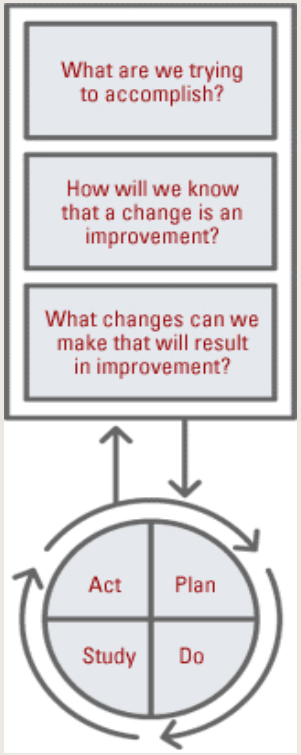
Peach State Health Plan and DentaQuest Oral Health Performance Improvement Project

- **Peach State Health Plan and Dentaquest collaborated to design, develop and implement a Performance Improvement Project (PIP) on the topic of Improving Oral Health.**



Use current knowledge, challenges of the population, national data and Plan specific data to drill down and determine improvement needs the plan will implement which will impact overall oral health outcomes for the state.

Develop a methodology and process to consistently and accurately collect data to determine if change has happened.

Take a step-by-step process to identify interventions to test using the Plan, Do, Study, Act (PDSA) methodology.

After identifying interventions, run the Plan-Do-Study-Act (PDSA) cycles to test a change or group of changes on a small scale to see if they result in improvement. If they do, expand the tests and gradually incorporate larger and larger samples until we are confident the changes should be adopted more widely. If not, modify or abandon the intervention and select another to test.

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Oral Health Multidisciplinary Workgroup

- Peach State Health Plan and DentaQuest developed an Oral Health Multidisciplinary Workgroup to include member and provider participants. This Workgroup assists with and oversees the Oral Health PIP efforts. Including the right people on an improvement team is critical to a successful improvement effort.

Team Members		
Name	Title	Project Role
Jason Grynbaum	Vice President, Finance	Executive Sponsor
Dr. James Thommes	DentaQuest VP Clinical Management	Clinical Lead
Christina Medina	Executive Director, DentaQuest	Day-to Day Leader
Rebecca Matthews	Regional Director, DentaQuest	Data Analyst
Shay Hawkins	Manager, Quality Improvement	QI Liaison
Latonya Sesberry	EPSDT Coordinator	Additional Team Member
Viane Bello	EPSDT Coordinator	Additional Team Member
Dr. Charlie Coulter	DentaQuest - Member of Dental Advisory Committee Georgia Dental Association	Advisor
Member Parent G.O.	Parent of two Peach State members	Advisor

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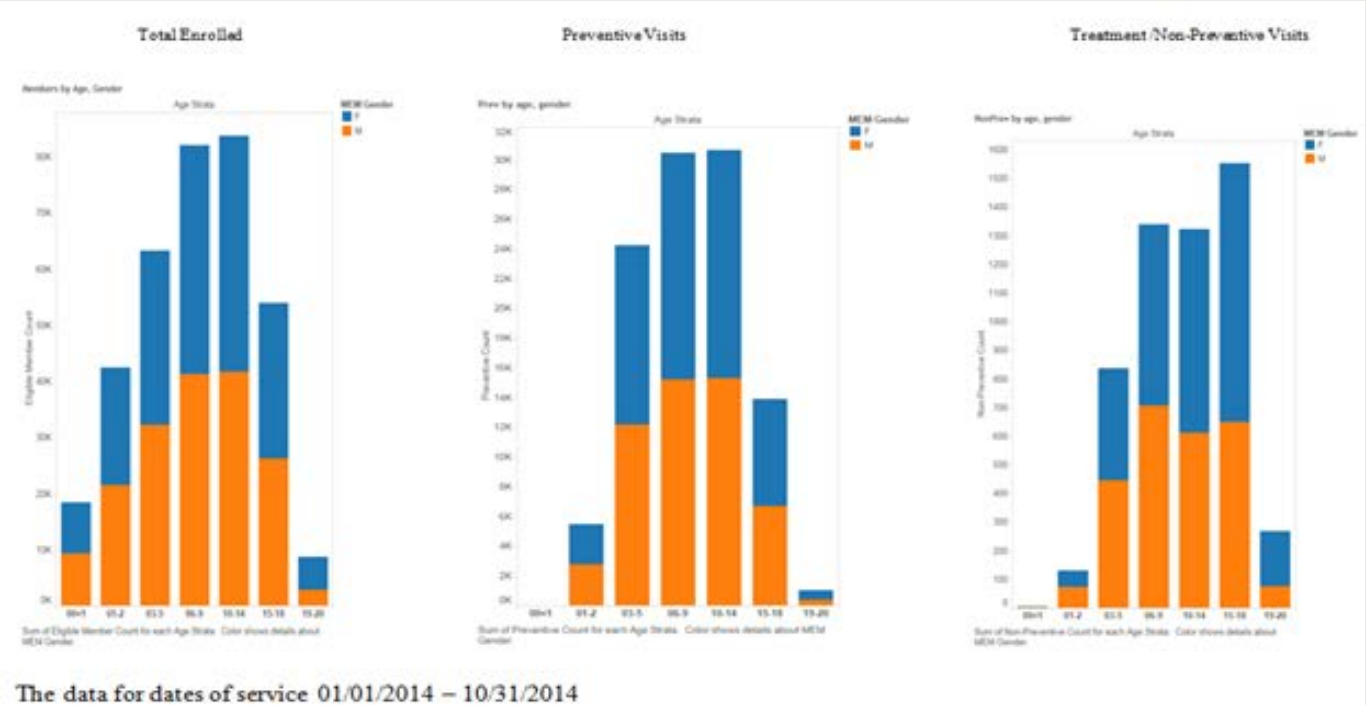
Peach State Health Plan and DentaQuest Determining the Oral Health SMART Aim

The Oral Health Multidisciplinary Workgroup used data to determine where improvements in access and utilization in oral health were most needed.

The Calendar Year (CY) 2011, 2012 and 2013 HEDIS Annual Dental Visits Rate results for Peach State Health Plan show a decrease in rates beginning after age 10 years old.

Measure	CY 2011	CY 2012	CY 2013
Annual Dental Visit - Ages 2-3 Years	43.9%	43.96%	44.28%
Annual Dental Visit - Ages 4-6 Years	75.6%	76.01%	75.09%
Annual Dental Visit - Ages 7-10 Years	78.6%	78.32%	78.08%
Annual Dental Visit - Ages 11-14 Years	70.5%	70.02%	70.66%
Annual Dental Visit - Ages 15-18 Years	58.9%	59.42%	59.81%
Annual Dental Visit - Ages 19-21 Years	39.2%	38.85%	35.77%
Annual Dental Visit - Total	67.5%	67.92%	68.13%

Determining the Oral Health SMART Aim (continued)



- There were more eligible 10-14 year old members than any other age band.
- There were no significant variations in the number of preventive dental visits.
- The 15-18 year old members have the highest volume of treatment and 4th lowest volume of preventive dental visits.

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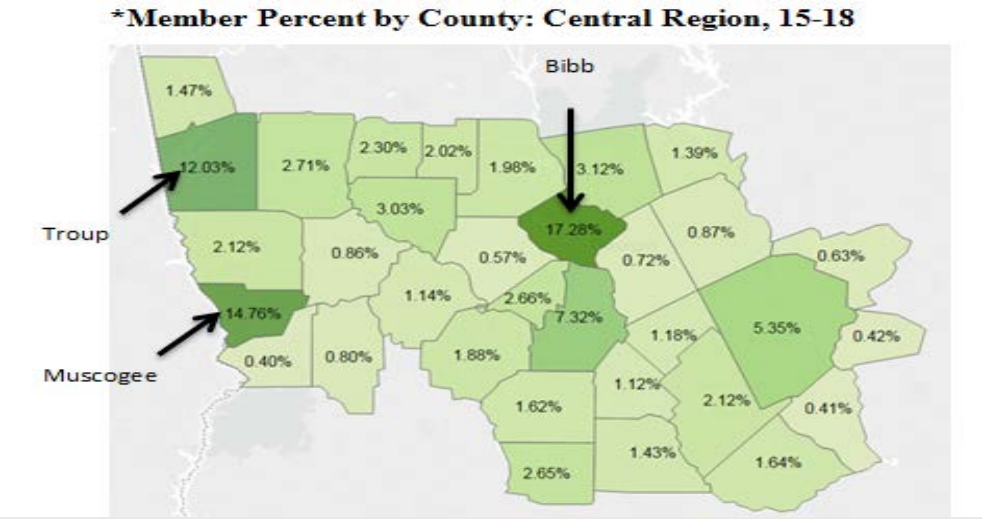
Peach State Health Plan and DentaQuest Oral Health SMART Aim

Based on data, the Oral Health Multidisciplinary Workgroup selected Muscogee County, targeting 15-18 year old members, for the Oral Health PIP.

Analysis of services received by Region for dates of services 01/01/2014 – 10/31/2014 indicates the need to ensure that children in the Central Region who receive a treatment service also receive a preventive dental service.

The counties in the Central Region with the membership enrollment percentage for children 15-18 years old.



The percentage of members 15-18 years old who received preventive dental services for the top three populated counties in the Central **Region.**

***Member Percentage of Compliant Services by County: Central Region, 15-18**

Counties	Percentage of Compliant Services
Bibb	71.55%
Muscogee	61.64%
Troup	63.83%

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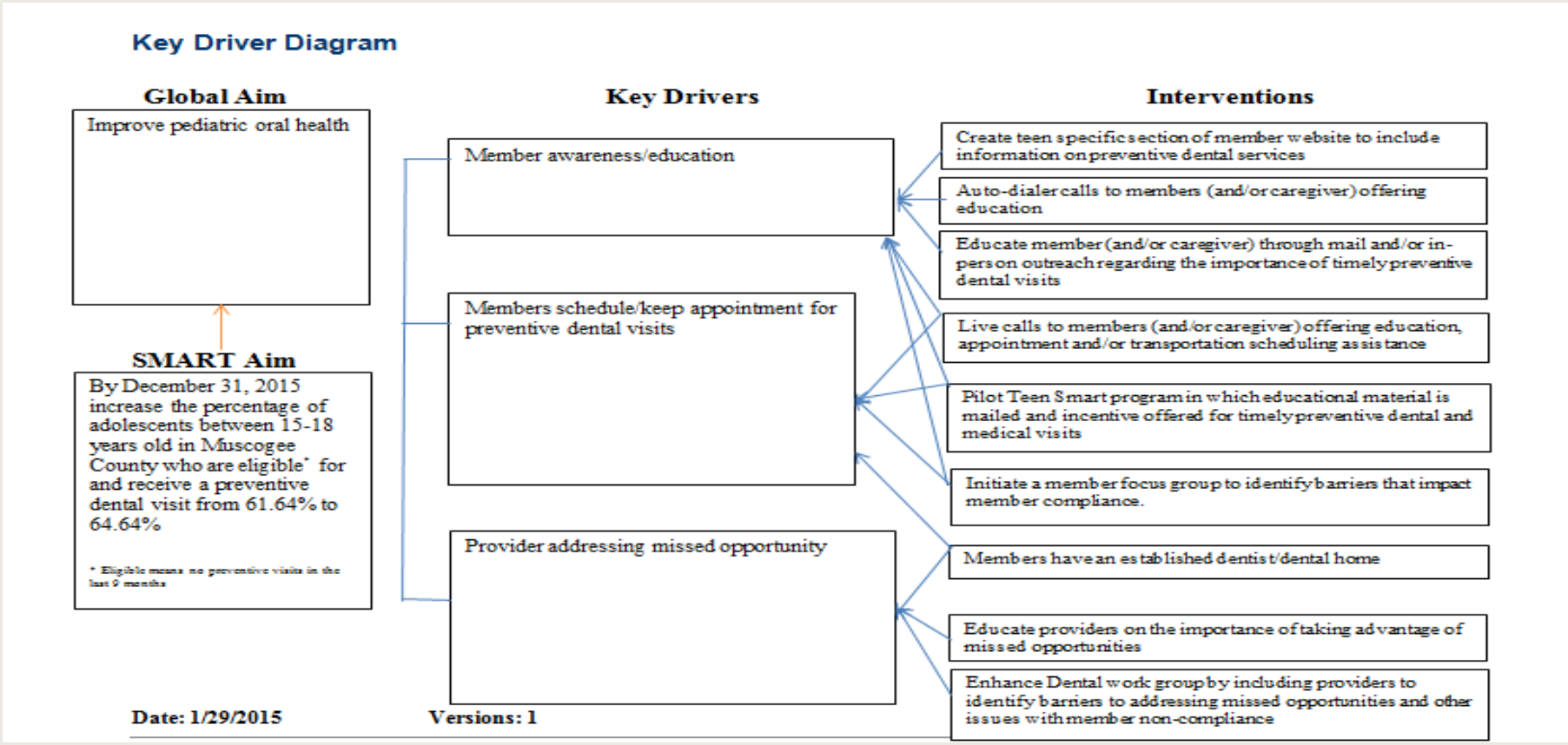
Key Driver Diagram

The Key Driver Diagram allowed the Oral Health Multidisciplinary Workgroup to identify key drivers (factors) influencing the ability to meet the SMART Aim.



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Failure Modes and Effects Analysis

A Failure Modes and Effects Analysis (FMEA) was used by the Oral Health Multidisciplinary Workgroup to pinpoint specific steps most likely to impact the overall aim. This allows for interventions that can impact the aim to be developed.

Failure Modes and Effects Analysis				
Sub-processes	**Failure Modes**	**Failure Causes**	**Failure Effects**	**Priority (High, Medium, Low)**
Provider outreaches to members due for preventive dental visit (PDV)	Provider does not contact members (parent/guardian) for visit	Limited staff to do outreach	No PDV education or appointment	Medium
	Provider has inaccurate demographic data for member (parent/guardian)	Member has not updated demographic data	No PDV education or appointment	Medium
	Provider does not have information on members they have not serviced	Members not assigned to Primary Care Dentist	No PDV education or appointment	High
Member schedules preventive dental appointment	Parent/guardian forgets about scheduled appointment	No reminder	No appointment	Low
	Parent/guardian receives information but does not understand the importance of preventive dental visits	Information is not member friendly	No PDV education or appointment	High
	Parent/guardian does not receive information about preventive dental visits	Inaccurate demographic information	No PDV education or appointment	High
	Member aware that dental visit not needed	Member changed health plans	No evidence of visit	Low
	Inconvenience of preventive visit appointment	Time of day/transportation	No appointment	Medium
The FMEA (selecting sub-processes, failure modes, failure causes, failure effects, and priority rankings) was based on nine years of Plan experience in providing dental preventive health services. Feedback from PSHP and DentaQuest staff and a parent of two PSHP members was used in completion of the FMEA.				

Intervention Determination

The Oral Health Multidisciplinary Workgroup decided on interventions to test based on research, experience, reliability and sustainability.

Intervention Determination		
Failures	**Potential Interventions**	**Consideration for Reliability**
Member does not receive information	Implement text and email notification/information	Educating guardians and families is essential to increasing the rate of adolescent preventive dental visits. According to recent surveys low-income populations have a high penetration rate of mobile phones.[1] Text messaging can serve as a useful vehicle to reach/communicate with enrollees about the important of preventive dental visits. PSHP will work to develop a process to provide electronic educational materials for adolescents that encourage the use of dental preventive services.
No information on members without visit history	Pilot primary care dental home assignment	Establishing a dentist/patient relationship early on in child's life can pay dividends. And the best way to establish this relationship is by implementing a dental home program. The American Academy of Pediatric Dentistry defines a dental home as "an ongoing relationship between a dentist and patient, inclusive of all aspects of oral health care delivery in a comprehensive, continuously accessible, coordinated and family-centered way." There are a number of ways to operationalize this concept and DentaQuest proposes implementing a process which encompasses education and member assignments.
The Team considered experience, research, reliability and sustainability when selecting potential interventions to make an impactful improvement on the SMART Aim.		

1. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Oral-Health-Quality-Improvement-Toolkit-for-States.pdf

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Q&A

Any questions?

Tools to Help States Improve

- Oral Health Performance Improvement Project (PIP) Manuals and Template for managed care
  - Webinar May 6, May 20
- Issue Briefs on Addressing Early Childhood Caries
  - Webinar May 27
- Web-based learning modules on how to report dental data on the Form CMS-416
  - Will be released in September
- Medicaid Dental Contracting Toolkit
  - Will be released in October

Upcoming CMS Oral Health Webinars

Wednesday, May 27, 1:00-2:30 pm EDT

Reducing Early Childhood Tooth Decay: Approaches in Medicaid

Register Here!

Speakers:

Dr. Burton Edelstein, Columbia University

Laurie Norris and Susan Ruiz, CMS

Dr. Mark Casey and Darlene Baker, North Carolina Medicaid

Centers for Medicare & Medicaid Services ORAL HEALTH Initiative

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