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Hello, everyone, and thank you for attending today's webinar, Advancing Oral Health Through Quality Improvement, Performance Improvements Projects for States and Health Plans Planning Considerations.

Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets you can use. You can expand each widget, as well as your slide area, by clicking on the maximize icon at the top right of the widget panel or by dragging the bottom right corner of the panel or slide area.

A copy of today's slide deck is available in the resource list widget, indicated by the green folder icon at the bottom of your screen. If you have any technical difficulties, please click on the help widget. It has a question mark icon and covers common technical issues. However, you can also submit technical questions through the Q & A widget.

If you have any questions for presenters during the webcast, you can click on the Q & A widget at the bottom of the console and submit your question there. We will address as many questions as possible during the session. An on-demand version of the webcast will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

Finally, CMS requests that you submit your feedback on this webinar using the survey widget. It has a checklist in the icon and the survey will automatically pop up at the end of this webcast. If you need to leave the webcast early, please click on the widget to submit feedback there. If you are unable to provide your feedback today, you can view the on-demand recording of the event and access the survey there. Again, the on-demand recording will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

Additionally, this webinar will be posted on the CMS website in approximately three weeks.

Now I'd like to introduce Laurie Norris, Senior Policy Advisor at CMS. Laurie, you now have the floor.

Thank you, Brice, and good morning and good afternoon to all of you.

I want to welcome you to today's webinar. This is the second of two that CMS is hosting this month, focusing on PIPs as a way to improve delivery of dental and oral health services to children enrolled in Medicaid and CHIP.

We are thrilled to have more than 500 people registered for today's webinar from across the nation. We thank you for your interest and for all that you do to support improvements in children's oral health.

Our primary purpose today is to pick up the discussion where we left off on May 6th. We hope that most of you on today's call were able to join us for that webinar, but if you weren't, we encourage you to go back and view that webinar at the link provided on this slide.

On May 6th we focused in particular on the process for planning an oral health performance improvement project. Today we will continue this discussion with a focus on PIP implementation consideration. We will be discussing new tools soon to be released by CMS: A how-to manual for states, a how-to manual for health plans, and a template for use by both states and health plans. These manuals have step-by-step instructions in them and the template is customizable for each state.

We had hoped to release these tools before today's presentation, but you know how that goes. Our new intention is to get them out within two weeks of today. They will be posted on the dental page of medicaid.gov and everyone who registered for the May 6 webinar or today's webinar will receive an e-mail with a link to these tools once they have been posted.

I also want to mention that CMS hopes to offer an opportunity soon for a few states and their health plan partners who are interested in using these tools. We hope to launch a learning collaborative probably in

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late summer or early fall in which participating states and health plans would be supported by experts and their peers in other states to develop and then implement impactful oral health tips.

So while you are listening today, be thinking about that opportunity and whether you and your state would be interested in participating.

During today's webinar you will hear from four speakers.

I will begin by framing today's topic within the context of the CMS children's oral health initiative and by defining some terms and giving a brief introduction to PIPs. Then Roopa Mahadevan from the Center for Healthcare Strategies will introduce you to the manuals and outline the implementation considerations for oral health PIPs.

Roopa is a Program Officer at the Center for Healthcare Strategies. She contributes to programs focused on improving quality, reducing disparities in care, and enhancing cost effectiveness for Medicaid and CHIP beneficiaries. Roopa specifically provides technical assistance in the areas of quality improvement, equity, measurement, and financing.

She also leads the organization's racial and ethnic disparities and health literacy work.

Next we'll hear from Dr. Janice Carson of Georgia Medicaid about her state's experience in using PIPS to boost the use of dental services by children enrolled in Medicaid. Since 2009 Dr. Carson has served as Deputy Director for Performance Quality and Outcomes with the Medicaid Division of the Georgia Department of Community Health. In this role she has many responsibilities, including oversight of quality and improvement initiatives for both Fee for Service and Managed Care, required Managed Care reporting, including performance improvement projects and performance measures, and the EPSGT benefits.

Prior to her transition to Medicaid in 2009, Dr. Carson was a Public Health Director for eight years with service at both the local and state levels.

And finally we will hear from Shay Hawkins with the Peach State Health Plan in Georgia. Peach State is one of Georgia's Medicaid Managed Care contracted health plans.

Shay will share with us her plan's experience with the oral health PIP in Georgia.

Shay is a quality improvement manager for Peach State, where she is responsible for overseeing EPSGT, the EPSGT team, and EPSGT-related performance measures and performance improvement projects. She previously worked as a program specialist with the Department of Community Health Performance Quality and Outcomes Unit, where her responsibilities included oversight of care management organizations, contractually required activities, and quality and medical management. She has more than ten years of experience in Medicaid Managed Care, with a strong background in quality assessment and performance improvement.

So we're really thrilled to have these speakers with us today. I wanted to mention that we will be taking questions after each speaker, so please go ahead and type your questions into the Q & A box when and as they come to mind.

Now before we launch into the PIP-specific content, let me give you a very brief orientation to the Children's Health Work at CMS. So I hope all of you are aware that CMS has underway a children's oral health initiative. We are striving, with the help of states, to increase by 10 percentage points between 2011 and 2015, so we're coming to the end of our improvement period, the percentage of Medicaid-enrolled children who receive a preventive dental services. We are focusing on children ages 1 to 20 who have been enrolled in Medicaid for at least 90 continuous days. We set a national baseline and a national goal. The baseline is 42% and the goal is 52%. As of 2013, our national rate had improved to

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44%, and we also set baselines and goals for each individual state. If you're curious about the baseline and goal for any particular state, you can click on the link on this slide and get the whole list.

This chart reflects our progress for 2000 to 2013, with preventive dental services reflected in the red line in the middle. So as you can see, we have been and continue to make progress, but so much more needs to be done. Fewer than half of all enrolled children are receiving a preventive dental service, or any dental service, for that matter. That is the blue line at the top of the chart.

Here you can see the 2013 performance levels of each individual state. If you look at the left-hand side of the graph, you will see that 16 states have broken the 50% mark on providing preventive dental services to enrolled children. Our highest performing state is Connecticut, which served 59.5% of enrolled children in 2013.

But if you look at the right-hand side of the graph, you will see that ten states are still serving fewer than 40% of enrolled children, including four states that have not yet reached the 30% mark.

So now we'll segue into the world of performance improvement projects, or PIPs, as they are fondly known.

A PIP is a project designed to achieve significant improvement sustained over time in a clinical or nonclinical area. Ongoing measurement is certainly involved. The overarching intent is to have a favorable effect on beneficiary health outcomes and/or their satisfaction with their healthcare experience.

In Medicaid, MCOs, and PIHPs, which stands for prepaid inpatient health plans, are required to undertake PIPs. For PAHPs, or prepaid ambulatory health plans, a performance improvement project is optional and performance improvement projects do not apply in the fee-for-service realm.

PIPs can vary considerably in their scope and design. They can also be formal to fulfill the intent of regulations or informal, such as a changing a business practice in a provider's office. The ultimate goal is to increase quality outcomes and also possibly to bend the cost curve.

An external quality review organization, or EQRO, or EQRO, is an organization that meets the competence and independence requirements set forth in federal regulations, and performs the external quality review related activities as also set forth in federal regulations.

On the May 6th webinar, for those of you who were able to attend that, we heard Gretchen Thompson from the Health Services Advisory Group, which is an EQRO serving several states.

So here are some of the things to think about when you design a PIP. You should consider your market size and geography. You should also consider where you can utilize other efforts already underway in your health plan. For example, is your target patient population included in another PIP that's already underway on a different topic? You should also strive to leverage lessons learned from other providers where applicable.

It's important to consider not only the future, but also the past. Consider your past successes and failures. Often we learn more from our failures than our successes.

And there is certainly no need to completely reinvent the wheel. If your health plan has done other PIPs in the past, some of those designs, perhaps, can be adapted for oral health.

Make sure your goal is meaningful and obtainable. We spoke on the May 6 webinar a bit about how to create your PIP aim, so I won't go into detail about that now. But if you have questions about it, please review the May 6 webinar.

So, again, these are the topics we covered on the May 6 webinar where we talked about planning. We discussed understanding variations in oral healthcare in your state. We discussed the importance of

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involving oral health stakeholders, how to define the scope of the PIP program, how to determine the PIP aim, and how to maximize health plan consideration.

So, again, today we'll be focusing on the implementation phase of the PIP.

So that's all I had for the introduction and I am ready to pass the mic over to Roopa, unless anybody had some questions. All right, I don't see anything coming in to the Q & A box at the moment, so, Roopa, go ahead.

Great, thank you, Laurie.

Hello, everyone. Our last webinar focused, as Laurie mentioned, on considerations for states and health plans in planning their oral health PIPs.

Today we will explore implementation issues. We're going to focus mainly on activities the health plan will perform as they conduct quality improvement interventions to meet the aims of the PIP, but also on state considerations in providing the appropriate support and technical assistance to health plans -- as health plans implement the appropriate -- the relevant quality improvement interventions.

So listed here are the nine phases of an oral health performance improvement project. For those of you who have conducted a PIP before or are familiar with CMS validation protocols, these probably look pretty familiar. The remaining slides in my presentation, however, will highlight a few important aspects of each of these components for oral health PIPs, with suggestions for health plans who are conducting quality improvement interventions to further the PIP aim, as well as suggestions for states on how they can support health plans through specific guidance tools and resources.

And what I'll share are just snippets, sort of a highly condensed version of the material that Laurie mentioned earlier, the PIP template, the PIP manual for states, and the PIP manual for health plans. All of these were developed to promote and support states and health plans in developing and implementing oral health performance improvement projects.

So the PIP template is a form that health plans can use to report on each phase of the PIP and submit to the state over the course of the PIP. It is customizable, meaning states can edit the questions and provide guidance or instructions to health plans as needed before they start using the template.

There are four main purposes of the PIP template. One is to guide health plans through key activities of planning and implementation and we'll discuss these in more detail later on. The second is for states to be able to track how health plans are doing in their PIP projects and what assistance they may need specifically. The third is for states, as well as external entities that they've appointed to perform validation to be able to assess the impact of the PIP. These external parties include EQROs. And, fourth, the purpose is to be used internally by health plans as sort of a project management tool or diary, for health plans to keep track of their key strategies and lessons learned as they move through the various phases of the PIP process.

There are two PIP manuals that have been created. One is for states and another is for health plans.

The state manual guides states on options for customizing the template to suit the needs of their particular oral health PIP program. It also provides guidance corresponding to each of the nine phases of the PIP on how prescriptive to be and the types of support and technical assistance that can be offered to the health plan for each of the nine phases.

The health plan manual guides health plans in completing the PIP template and conducting each phase of the PIP. The manual also includes specific tools that health plans can use throughout their activities and I'll discuss some of these tools a little bit later.

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So the nine phases of a PIP are a combination of required and flexible elements. The level of flexibility, though, is generally decided by the state. States are prescriptive about the first four phases: select the PIP topic, identify the population, define the PIP aim, and select the performance measures.

These phases were discussed in more detail in the last webinar, so please do check out the slides in the recording. But essentially they are a direct reflection of the state's vision. They describe where oral healthcare needs to advance, by how much, and by when. By the end of the fourth phase, an AIM statement has been created to guide health plans in implementation of a quality intervention. For example, the PIP aim might be to improve by 10 percentage points the utilization of preventive dental services among three to six year olds.

So the PIP topic here is preventive dental services; the population is children ages three to six; the aim is to improve utilization by 10 percentage points; and the performance measure is likely the child core set preventive measure, or the variety of preventive measures submitted by states on the Form CMS-416.

Like I said, while these components are generally prescribed by the state, the state might also incorporate some flexibility for the health plans. For example, the state might prescribe the PIP topic, but allow health plans to choose the particular population focus. Or the health plan might be prescribed one particular performance measure, but be encouraged to choose other measures, maybe homegrown measures that health plans have or other qualitative measures that can support what they're trying to achieve through the PIP.

So safe size is around implementing a data collection protocol. I've expanded that a bit to also discuss the formation of the QI team which happened early on in the PIP process. You need to be able to identify who is involved in your PIP work and what types of resources and training they may need. Your QI or quality improvement team may change slightly once you identify the intervention for the PIP.

For example, you may realize you need more staff from member engagement departments or community development, but essentially you want to make sure you have the following bases covered: Executive leadership, folks with oral health or clinical expertise, the health information technology department, staff who are involved in provider communication, and staff with expertise in member and community engagement.

Executive leadership has a bird's eye view of policy that's impacting oral healthcare. They have control over overall operations and can influence culture change, as well as staff time and resources. Staff with clinical or oral health expertise are important to be able to weigh in on the feasibility of the PIP aim from a clinical standpoint, as well as the expected timeline for improvement.

Health information technology staff are very important for ensuring that staff have access to the needed data and that this data is reliable. Provider communication staff are also key in communicating new changes to care delivery that providers will have to implement and getting their buy-in on the PIP project.

And finally member and community engagement staff are important in order to make sure that communications with patients, as well as new community partnerships grow smoothly to further the aims of the PIP.

In addition, staff may need specific training and guidelines during the course of the PIP. A key activity that I'd like to highlight is the collection analysis of data which is really central to the PIP effort. It's highly encouraged that health plans create a data collection protocol with very specific procedures that ensure data security and consistency in how data is collected. The procedures should also elucidate staff responsibilities and timelines, as well as protocol for sharing data externally. For example, with frontline providers, community partners, or community health workers who would need to be able to actively use the data throughout the project.

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Another important aspect of data and training is around data that may not be routinely collected, such as provider interviews or data that's collected manually, for example, dental chart reviews. You may need to create additional procedures or training to ensure that staff have the knowledge and consistency to do this effectively throughout your PIP project.

As we proceed with the PIP process, consider other types of training that will be important, for example, quality improvement methodology, cultural competency, or stakeholder engagement. For example, designing surveys, moderating focus groups or facilitating meetings may be competencies your staff will have to develop in order to pursue the PIP effectively.

In thinking through all these aspects, also consider what external resources might be helpful. The state here can be a great partner. EQROs also, as well as a number of community partners, academic partners, oral health coalitions, dental school students, and mutual conveners who can play a key role as you implement your quality intervention.

The next two phases deal with planning and implementing the quality improvement intervention. There are three important components here that will be discussed in upcoming slides.

The first is identification of root causes underlying the aim of the PIP; in other words, what needs to be addressed or needs to be changing to improve oral healthcare and meet the PIP aim. The second is the identification of intervention. How exactly do we address the barriers to care? And the third is using continuous quality improvement. How can we ensure that we are being efficient in our improvement approach, and giving the time frame of the PIP? How can we ensure that our resources are being put to the best use and we are creating meaningful intervention that will bring about the desired results?

So to elaborate a little bit more on that first component I discussed, identifying root causes underlying the aim of the PIP, there's sort of three main activities here that you'll want to pursue.

The first is about working backwards from the PIP aim to identify the causes and effects that are at play in oral health care delivery. Think about all of the factors that might be creating barriers. Consider specific buckets like workforce availability. For example, there may not be enough dental providers in a given area for your members. Think about program administration, how effectively a language line is being implemented or member and community factors. Perhaps members don't know how early a child needs to go in to see the dentist or there may be misconceptions about the cost of services. You can use tools like a fishbone diagram or the five whys to help you through these considerations. I'll note as well that those tools are included in the PIP template and manuals as well, and that states should think about how they might be able to share these tools with health plans.

The second activity is to reach out directly to those involved in care delivery to get their input on what is happening and why. As a health plan you may have a limited view that can be strengthened by providers and frontline staff who are delivering care, by members who are receiving that care in the clinic and also living outside in their neighborhoods and work places where they have to maintain healthy oral health behaviors, and also by public health and community partners who can give you a population level view of what might be effective care and healthcare -- and health, sorry.

For example, there may be halted bus lines, there may be a lack of fluoridation in the community water supply, oral health education curriculum might have been recently cut by schools; these are all things that you may not know within the confines of the health plan or provider world, but reaching out to community partners can help shed light on those barriers.

Also consider culturally specific resources, such as your Hispanic oral health coalition, local church partners, as well as assets close to you, such as your community advisory board.

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There are many interventions out there that might be able to address some of the barriers discussed in the previous slide, and it can be overwhelming to think through all of them. Consider these four categorizations and you'll see some examples in the following slide that go into more detail.

As you consider each of these types of interventions, program administration, provider-focused, member-focused, or collaborative, consider using tools such as a SWAT analysis to identify what's most feasible to implement within your setting. Things like protected staff time, resources, as well as staff know-how and provider know-how will probably play a big role in some of those decisions.

Here's an example of interventions that meet the four categories I listed previously. The first is administrative. So this category of intervention has to do with reimbursement structures, with member enrollment and retainment, with claims reporting and so forth. An intervention here might be that ensuring the provider directories are updated frequently so members have access to correct information. Another intervention might be broadening the provider network to include school based and linked programs, safety net clinics, and diverse provider types to increase access for members.

Provider-focused interventions focus on access to providers, the willingness of providers to see children, as well as their knowledge to provide high-quality care. So one intervention here might be creating 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.

The third type is enrollee-focused interventions. These interventions deal with the factors that impact how members receive care, how they're able to communicate with providers, but also how they are able to maintain healthy oral health practices outside the clinic setting. An intervention here might be creating outreach programs on good oral hygiene practices, but also importantly, making them available in the multiple languages spoken by your member network.

The last type is collaborative. This has to do with leveraging resources across multiple entities or sectors of the healthcare system and beyond to ensure that the infrastructure is in place to advance oral healthcare. An example here of an intervention is to collaborate with Title V, WIC, Head Start, and home visiting programs to ensure that children who are dependent on public systems for care are able to find available Medicaid dentists and book an appointment.

One thing I wanted to add is that the selection of interventions is a particularly complicated process for health plans and the states have a role here in providing guidance, so, for example, a state, based on its own priorities and aspects of healthcare it's trying to promote, may provide specific best practices for health plans in this area, or even a database of suggested interventions for health plans to pursue.

Okay. It's important that once you decide on the intervention that you create measures that help you decide how much fidelity you have to the intervention. If the PIP fails, you don't want it to be because you didn't implement the intervention the right way. Including intervention tracking measures can help with this. These are different from the impact measures that are going to decide whether or not your PIP met the aim, rather these help you course correct as you go, to ensure that you're, in fact, moving towards your aim in the way that you expect. Intervention tracking measures are quite simple in nature, but it's important to make sure that staff responsibilities and data elements are in place to actually be able to track them. For example, an activity might be to send report cards to practices every three months, comparing their dental practice's sealant application rate with other practices. A measure here could be the percentage of practices who receive this report card. It might be that the mailer never went out; it might be that the practice received the mailer but never opened it. It could also be that the practice received the mailer but wasn't actually able to interpret the report card, so creating measures along the way to ascertain these various aspects is very important.

Another activity could be providing free trainings to health plan staff to implement a new Spanish language help line. You'll want to be tracking the number of trainings that were conducted, the number of staff that attended each training, as well as the level of staff familiarity with the new phone system after

the training. You'll want to look at how many staff members actually attended these, whether there was attrition after the first meeting, and the level of knowledge that staff were actually able to gain and make tweaks accordingly in your approach.

Related to intervention tracking measures is the concept of the PDSA cycle. PDSA cycles are a crucial aspect of continuous quality improvement and all health plans are strongly suggested to incorporate this into their approach. PDSA cycles allow health plans to track mini improvements. The intervention tracking measures get incorporated into the study phase of these cycles. Essentially the way it works is that you're pilot testing or testing on a small scale your intervention to see what changes need to be made as you go. An example could be having a focus group to report on the features of oral health education tools before deploying the oral health education tool to all your members.

Another example is sending a mailer to only 20 providers and seeing if you're seeing the expected results from that before sending them to 100 providers.

The signs of PDSA cycles and more information on how to incorporate them into your PIP process are featured in the health manual, so -- sorry, the PIP manual, so I encourage you to look at those as well.

The final phases are analyzing your data to measure impact and planning for sustained improvement. Analyzing data is something that's typical of all PIPs, so I won't go into too much detail there. What I would highlight though is in addition to monitoring the quantitative changes in your measured data, you'll also want to look at sort of the narrative or the story of how change occurred. Use your PDSA cycles to create somewhat of a diary that explains the lessons learned along the way, the barriers that you faced, and strategies that you used to ensure that measures were actually changing in the direction that you wanted them to.

As important as implementing a successful PIP, is actually sustaining the successful PIP. To ensure that the PIP does not become a resource-heavy, one-time project, your team will have to study the PIP and understand what worked, how it can be supported further, and how other projects to advance oral healthcare might benefit from the infrastructure that you developed.

Think about factors such as timing. Did you have enough time to see movement in the measure? Were particular staff members missing from the team or could more training have helped? Were the right measures chosen? Did you have leadership buy-in? And, was there enough protected staff time?

Also consider how the PIP effort could be modified or scaled for the future. For example, can strategies that were used on six to nine year old members also work on older populations? Can an intervention on preventative services also work on treatment services? And might the success of a school partnership also transfer to a different type of community partnership?

Also consider how external resources can be leveraged towards your PIP effort. For example, are there particular community partnerships that you'll want to bake in or streamline into regular care? Are there particular policy changes around reimbursement or use of workforce types that you may want to see happen in order to be able to deliver better care?

And are there certain types of technical assistance, for example, peer opportunities to share across health plans or more EQRO support around data analytics, for example, that could really help you maximize the effort spent.

An important component of sustainability is communication. Disseminating results of the PIP, even though they don't go as planned or are considered failures can motivate discussion about learnings, generate buy-ins from external parties to support future resources capacity and build an image of the health plan as being committed to its members and striving to improve.

When disseminating, consider tailoring your message to the likely concern of each stakeholder. For example, what leadership may be interested in could be very different from what frontline staff are

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interested in hearing. And also consider the vehicles by which the message is delivered. States can consider various options, perhaps requiring that each health plan post its results on websites. The state could also publically report all health plan projects and results and health plans should also think creatively about the best way to disseminate: report cards, monthly newsletters, waiting room posters. Personal stories from members can also be very powerful. And states and health plans can work together in this process to decide what might be the next and best option for dissemination once the PIP has ended.

In summary, there are a number of different activities, as you heard about, and a number of different considerations, but I would say there are around five that are the most important. The first is throughout your PIP process, from planning through implementation, consistently seek input from those involved in the intervention: Members, caregivers, providers, frontline staff, and key community partners, such as public health, oral health coalitions, and so on.

Consider what is feasible, given your timeline resources and staff commitments. Without feasibility, even the most planned projects will likely fail. Use a continuous quality improvement approach throughout. Create tracking measures to identify progress, pilot test your interventions, and if something isn't working right, stop, and try something else.

Think of the PIP as part of a broad quality improvement effort. You're going to be investing a lot of resources into data, staff training, member engagement, community partnerships and so on, so to the extent that this can support broader capacity building or future projects, the better.

And finally, be creative and specific about how you're going to build QI processes into everyday care delivery. For example, you might have stratified data by race ethnicity for your PIP project. Think about how you can stratify all of your measure data, regardless of what you use for the PIP routinely.

Also consider how you might incorporate staff training into job descriptions, as well as continue to make the case for oral health within your organization beyond the PIP project timeline.

As mentioned earlier, we have three resources that detail a lot of the information you heard today and hopefully will be helpful to states and health plans in developing and implementing these oral health PIPs. The materials are the template, the manual for states, as well as the manual for health plans.

Please do check out the link above in the next couple of weeks to be able to download these materials. And thank you again for your time.

Thank you, Roopa. So just a reminder for anyone who joined a little bit late, these materials have not yet been posted to our website. As Roopa said, they will be posted in the next couple of weeks. You can check back at that link in a couple of weeks, or just watch your e-mail inbox. Everyone who was registered for this webinar or the May 6 webinar, will receive the link by e-mail.

So once again, we have a moment for questions. If anything has occurred to you about the material that Roopa just presented, please open the Q & A tab and click on the little orange plus sign that says add question and then type your question into the question box.

I'm not seeing any questions at this time. This is a very quiet audience compared to our May 6th audience. All of our noisy people from May 6 decided not to come back today.

All right. So I'm going to go ahead then and turn the mic over to Dr. Carson. We're about ready to move from the hypothetical to the actual now and here how things went in Georgia, Dr. Carson.

Well, thanks, Laurie, and let me just begin by stating that Georgia is on a journey. You know, our mission statement says that we are dedicated to a healthy Georgia and our goal is to achieve the best health status for our citizens. So for our Medicaid and our CHIP populations, we use performance improvement

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projects and data to guide us and inform our course corrections so that we can arrive at our ultimate destination.

So in 2006 the state transitioned the majority of our Medicaid and our CHIP children to managed care after our data showed that the path that we were on was unsustainable. Then in 2014 we transitioned our children in foster care, adoption assistance, and certain of our children in the juvenile justice system to managed care. Few children remain now in our fee-for-service program and you can see on the slide our enrollment as of January 1st of this year.

Now in keeping with our mission, our dental goal is that all of our Medicaid and Peach Care for Kids -- that's the name of our CHIP program, all of those eligible children will access their EPSDT preventive dental benefits per the bright futures and the American Academy of Pediatric Dentistry schedules. We monitor their utilization of these benefits through the HEDIS annual dental visit measure and the EPSDT 416 measures for preventive dental visits and sealant use.

So because our children are enrolled in Medicaid managed care plans and because these plans must conduct performance improvement projects as previously referenced, we required our CMOs to implement a dental performance improvement project in 2010.

The results of this and other PIPs are validated by our EQRO for their study design, their implementation process and their outcomes. A component of the study design is the selection of the study indicator and for the dental PIP, our original study indicator was the HEDIS annual dental visit measure. HEDIS requires continuous enrollment for 11 of 12 months of the measurement period. The study design also included the study population and we asked the CMOs to particularly focus on their two to three year olds because that population was the lowest performing based on our data.

Ultimately though, we wanted all of our children, as we've said with our mission, to access these services, so we monitored the two to 12 year old age group as well.

One of our CMOs had a baseline access rate for the 2 to 21 year old age group of 66.7 percent, which was above the HEDIS 2011 90th percentile for Medicaid-managed care, and that had been the target overall, so all three CMOs had the same performance target.

Now the CMOs dental intervention were to be informed by the barrier analysis that they conducted. And you've heard Roopa talk about that.

Interventions were aimed at the dental providers and the members and included pay-for-performance for the providers and reminder postcards for the members, as well as mobile vans to conduct screenings for noncompliant members. Unfortunately, many of the interventions that were implemented by the CMOs did not align with their barrier analysis. The effectiveness of the individual interventions was not measured and the performance improvement was only measured annually.

This annual performance monitoring, aligned with the PIP protocols that our EQRO followed so they validated the PIPs on the annual basis and, as a result, it took three years to identify whether or not there was improvement. The first year was baseline, the second year was the first re-measurement, and the third year was the determination whether the improvement was sustained over time.

So this slide describes the requirements for the CMOs to achieve a met validation score by the EQRO for their dental and for all of the other PIPs. They had to meet the critical elements that were identified in the EQRO scoring tool. Most of the validation process, though, focused on a documentation that the CMOs provided for the PIP activities. So based on the validation conducted in 2013 for the dental PIP, the CMO achieved statistically significant and sustained improvement over baseline and their results were still at the 90th percentile for HEDIS.

Not all of the CMOs performed at this level, and as a state we were concerned about the static interventions that were in play for the PIP and the fact that the improvement seemed to have stopped. So

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you can see that from baseline between measurement one, there was a slip, slightly more than a 2 percent improvement, but then between calendar year '10 and calendar year '12, we saw only a 0.8 percentage point improvement and that was of concern.

So Georgia asked its EQROs to modify the scoring methodology as a result of those concerns and they did, indeed, change the methodology for us, and that's outlined on the slide with the changing in step eight, step nine, and step ten.

Now at the same time that Georgia was asking our EQRO for changes, CMS was modifying its EQRO protocols, including its protocols for PIP validation in late 2012. So as you can see from this slide, and it's very tiny, so I apologize for that, you can see at the very top with the annual dental visits that the tool that the EQRO had been using in the column that says percentage score of critical elements met, where the current tool was showing 90%, with a new tool they were only achieving 73% net score.

The validation process, again, identified that the interventions were not addressing the barriers that had been identified by the CMOs as the causes for the lack of continued improvement. So concurrent to our review of the CMO's dental PIP performance was our review of the CMO's individual dental performance based on the Form CMS-416 report that doesn't require the 11 out of 12 months of continuous enrollment.

So looking at this slide and the metrics that we utilized -- and that's small, too, at the top, you see that the study indicated descriptions now align with the measured descriptions and the 416 report. So we decided that the dental metrics in the 416 report would be better metrics to monitor the effectiveness of the CMO's dental PIPs.

As you can see in this slide, there was actually a decline in performance relative to the preventative dental visits that was detected using the 416 metric as a study indicator, and you can also see that these rates are a bit lower than the rates that we saw with the HEDIS dental measure.

So when the dental PIP was validated in 2014 using the CMS-416 metrics as the study indicators, the EQRO identified again that measurement was only occurring annually, that interventions were not linked to causal barrier analysis or the study indicators and that revisions were not being made to the interventions despite the decline in performance.

So this slide demonstrates the disparities in performance between the three CMOs, and I might add that because we have three separate managed care plans, we allow each one of them to do their own causal and barrier analysis and establish their own interventions. So you can see in this slide that while two plans showed some slight improvement in performance in receiving any dental services, one plan's performance worsened for the members receiving any dental services.

This slide shows that two CMOs performance relative to preventable dental services actually declined from federal fiscal year '12 to federal fiscal year '13 and we also noted that our sealant performance was extremely low across all three of the CMOs.

So Georgia realized that our journey needed a significant course correction, so we engaged our EQRO to assist us in transitioning our CMO's PIPs from annual measurements to rapid-cycle process improvement and small tests of change.

Georgia participated in the CMS QI101, 201, and 301 projects, and received technical assistance from Jane Taylor regarding rapid cycle improvement, so that by the fall of 2014 the state felt that we needed to move in this direction. This course change required significant formal training for the CMOs that began in December of 2014 and continued through February of this year. The CMOs were required to create a smart aim and measures for the dental PIP, have a dedicated PIP team, and utilize PDSA cycles to test interventions for their effectiveness and spreadability.

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The training was divided into five modules, as you see here on the screen. Throughout the course correction, DCH and Georgia and the CMOs have moved forward as partners on this journey with our EQRO providing guidance throughout the process whenever it appeared that we were veering off course. All three CMOs are in the module four phase of intervention implementation and we at the state level are excited about the forthcoming results of these tests of change.

So, in essence, we started down one path and recognized that that was not working for us regarding our PIP implementation and we have since changed course and we are hoping for better results going forward.

Any questions?

Thank you very much, Dr. Carson, and we do have a couple of questions.

The first question is that you noted -- that the EQRO noted that the interventions in that first round of PIPs were not that effective and they weren't being integrated into the overall operation of the plan. So what actions did you take or did you direct the EQRO to take or the plans to take to improve the processes for updating the interventions?

So at that point in time, because the PIPs were starting anew every year, the plans were to go back to the drawing board, they were to repeat their causal and barrier analysis, identify what was going wrong in a process, and then revise their interventions in order to address the issues. But despite doing that work, it appeared that those changes were not made.

So we have another question, and this is asking you to take a step back into the bigger picture. Why did Georgia decide to transition from fee-for-service to managed care?

Well, back in 2004 and 2005, we recognized that the state was on a financial trajectory that just was not going to be sustainable for our Medicaid program and that we needed to do a much better job, not only at managing the cost of the program, but managing care over all. There had not been -- because it was in a fee-for-service environment, there had not been any real measurement of performance other than reporting of the 416 measures to CMS. So we began after the transition to Medicaid managed care actually measuring performance of population, both fee-for-service and managed care, even though there was no requirement to track and report fee-for-service performance.

Thank you. I have another question here, and this one may be for you, Dr. Carson, or maybe for Roopa. Is each health plan -- so let's start with Georgia. Is each health plan required to have its own oral health PIP or are they just required to have interventions that comply with the state PIP program?

So Georgia requires that each of our managed-care plans have certain performance improvement projects that they're working on. We actually identify the projects that we need them to work on and then we allow them to go through the process of conducting the analysis for their population, because each one of the plans -- initially they were not all statewide, only one was, and we have transitioned over time. So they would have different nuances to their population, their demographics, and that kind of thing. So we allowed them the opportunity to go through the analysis for their population, identify what was going on, and then create interventions and implement those to address the needs in their population.

Thank you. We have a question which may be partially answered by Shay's presentation, but I'll put it out there and, Dr. Carson, maybe you'll know whether we should just move ahead to Shay or whether there's a separate answer.

Do you know what the CMO that increased its dental utilization from FY12 to '13, the successful plan, do you know what their interventions were? And, in contrast, do you know what the CMO that had decreased dental utilization, what were they trying?

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Well, I think part of our dilemma, in answer to the question, is that the CMOs were implementing lots of interventions at the same time. So because they had so many interventions, it was difficult to determine which were the interventions that were effective and which ones were not. And that was a repeated comment from our EQRO when they were conducting the validation activities. And despite that, we continue to get the same kind of PIP submission on an annual basis, and that was part of our reasoning for saying we needed to do something different going forward, hence the new process.

All right, thank you. So I think there are more questions pending, but let's hold those to the end and let's transition now to Shay and hear specifically from one of the CMOs and their participation in implementing planning and implementing their PIP. Shay?

Thank you, Laurie. Again, I'm Shay Hawkins and I'm one of the QI managers here at Peach State Health Plan, which, as Dr. Carson said, is one of the care management organizations or MCOs in Georgia.

I'll be sharing information on our current methodology and status on our oral health PIP. This is one of eight PIPs that we submit, and fortunately the state's EQRO vendor is providing assistance as we navigate through this new process.

The PIP framework is a modified version of the Institute for Healthcare's QI model form improvement. Thank you.

In line with the oral health initiative and in collaboration with the Georgia Medicaid program, Peach State and our contracted vendor, DentaQuest, has goals to increase the percentage of one to 20 year olds who receive a preventive service to 58% and increase the percent of sealants placed on a permanent molar of a six to nine year old to 23.6%.

Peach State and DentaQuest worked together to design and implement a PIP in the area of improving oral health. The QI model for improvement has two parts. The first part of this model is the three core questions. The first question is what are we trying to accomplish? And Peach State used research, knowledge, analysis and data to determine what in the area of oral health needed to be improved.

The second question is how will we know the changes in improvement? We developed a methodology to collect data to help us determine if and when a change has occurred.

And the last question is what changes we can make that will result in improvement. We used process mapping, failure modes and effects analysis, and prioritizing to determine interventions to test.

The second part of the QI model for improvement is the actual PDSA cycle. This is where we currently are. We are in this and, as Dr. Carson said, it's module four. We are developing and testing interventions on a small scale to see if there is an improvement. We'll evaluate the intervention and make changes, if needed, and will continue the cycle until an intervention that works is identified and we're able to roll it out on a larger scale successfully.

In 2014, Peach State convened a multidisciplinary work group that included members from -- staff of a member area EPSDT, a different quality staff and provider area. This work group transitioned to service as the oral health PIP team, and following the IHI guidance and guidance from the state's EQRO, we enhanced this team by adding member representation and a member from our senior leadership team and a member from the Georgia dental association. And what we found is having these additions significantly improved our brainstorming efforts and offered a kind of a fresh, real feet on the street approach to gathering information.

The oral health PIP team reviewed multiple data points to identify what needed to be improved. We initially reviewed CMS-416 data -- that's not shown on the slide. We also looked at our HEDIS data, both of which data points show children, as they get older, they receive less preventive visits.

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The team then reviewed dental data for the most recent nine month period. And I apologize about this slide, I realize it's difficult to read, so let me tell you the data on the -- the data labels on the bottom of each of those graphs is a stratification of eligible members using the CMS-416 age categories. That's the 1, 1 to 2, 3 to 5, 6 to 9, 10 to 14, 15 to 18, and 19 to 20 year olds.

Females are represented by blue and males by orange. So the first bar graph shows total eligibility of members by age and gender. It showed about equal parts male and female and we had more 6 to 9 and 10 to 14 year olds in our overall population, with less 19 to 20 year olds.

The second bar graph shows the number of preventive visits by age span, and children age 10 to 14 and 6 to 9 had the highest number of preventive visits, where 15 to 18 year olds had the fourth lowest.

And the third bar graph shows the number of preventive or restorative or treatment visits and the 15 to 18 year old population had the highest number of treatment visits.

So further drill down showed that in -- the area in Georgia with the highest treatment visits was the central area. The oral health team noted the percentage of 15 to 18 year olds was highest in three particular regions in the central area and they were Troop, Muskogee, and Bibb.

The team then looked at the three counties to determine which had the lowest preventive dental compliance rate and noted it was Muskogee County. The oral health team decided that the overall goal or global aim is to improve oral health of members and we decided the SMART aim and SMART means specific, measurable, attainable, relevant, and time bound, is, by December 31st, 2015, to increase from 61.64% to 64.64% the percentage of 15 to 18 year olds in Muskogee county who are eligible for (inaudible) and receive preventive dental visits.

The team identified the key drivers or factors that directly impact the ability to achieve the SMART aim as member education, member scheduling and keeping appointments, and providers addressing missed opportunity.

And some of the interventions identified to address these barriers and positively impact the key drivers included phone calls, (inaudible), auto and live mailings, website enhancements, and incentives.

The oral health team mapped out the process from the time the member joins the plan to the member receiving a preventive dental visit. Each step or sub-process was reviewed to determine the impact, if the step did not occur and if this did happen, what process was in place to address it? This allowed the team to identify sub-processes that will more likely impact the SMART aim and allow for development of impactful interventions.

For example, one of the sub-processes identified below that could have great impact if it did occur was that providers outreach to members due for a dental visit. The failure mode, or what could have went wrong to make this process fail, is the provider did not contact the member. The failure cause, or why this happened, is the provider has limited staff to do outreach. The failure effect, or consequence, is the member does not receive education on the need to have the visit or schedule an appointment. And the priority for developing an intervention for this failure mode is medium.

So there's several failure modes. There's two sub-processes and some failure modes and causes listed on the slide. For each failure mode, a potential intervention was identified and the team analyzed a priority list, did research, and took into account experience and knowledge of team members.

When interventions were implemented we took into consideration that they had to be -- data had to be reliable and the intervention had to be sustainable. In the first example shown below, the sub-process is the member did not receive information about preventive dental visits. The intervention is to implement text and e-mail information and notifications for members or their caregivers and the reason or consideration is that research and experience has shown that members are more technologically savvy and many have mobile devices.

Any questions?

So thank you, Shay. We do have a few questions at this stage. One person has asked that we redefine MCOs and PIHPs. So I'll just say, very quickly, that an MCO is a managed care organization. In Georgia you call it a CMO. What does that stand for, Shay?

It's a care management organization.

Care management organization, okay. And then a PIHP is a prepaid inpatient health plan. And what those are -- prepaid means the plan is at risk, so it's a type of managed care. And inpatient means it's hospital based. So it's not the type of thing that would intersect with children's oral health. The other type of entity that I mentioned at the beginning was the PAHP, which is the prepaid ambulatory health plan. Some states have those that provide dental services to children. And, again, it's a prepaid risk-based managed care approach, but it's -- it can be carved out of the managed care organization rubric or responsibility.

There's another question that is related to this. It's probably a question for Dr. Carson. Can you just explain how the Georgia contracting works? Is the -- are the dental services carved into the CMO responsibility and contract or is it carved out? And if it is carved in, do the CMOs subcontract with other dental entities to manage the networks, et cetera.

So, yes, in Georgia all three of the CMOs are full-service managed care plans. They provide all services available and all three of them then have subcontractors with dental -- subcontracts with dental vendors.

Thank you. So here's a question probably for both Dr. Carson and Shay. When you were -- I think you mentioned that you sort of started with the HEDIS annual dental visit measure and then you also added the 416 measure to your analysis. And the HEDIS dental measure has a different continuous eligibility specification. The HEDIS measure is 11 months; the 416 measure is 90 days of continuous eligibility. And our questioner is wondering whether you encountered any barriers related to that shorter 90-day eligibility requirement under the 416 as opposed to the HEDIS measure.

Well, I think probably the HEDIS measure was more of an issue. When I first came to Georgia, we had six month Medicaid eligibility span such that members would have to go through an eligibility redetermination every six months. So you can imagine then that when we were looking at our HEDIS data that required the 11 months of continuous eligibility, that there are several members who would fall out of, you know, the running to be counted because they would sometimes have those lapse in their coverage. So we felt it would be better for us to look at those who had at least 90 days of continuous eligibility and begin able to track whether or not the managed care plan was able to ensure that the members that they would have for that six months would at least have access and utilize dental services for that time span.

As of January of 2014, I think it is, we migrated to 12 months of continuous eligibility for our Medicaid program, so we are hopeful that we will see improvements across the board in all of our performance as a result of that.

Thank you. I have one more question here from the participants and then I'm going to turn it back over to you, Roopa, for the discussion part.

So we have a questioner who is asking about the reimbursement rates for dental services in Georgia and whether there is -- first of all, you know, how -- how do those rates compare to the usual and customary for either providers in your state? Do they vary across the CMOs or does the state dictate what the rate schedule needs to be? And has anyone done an analysis to see what impact those rates are having on your use of discipline services by children?

So I can tell you that at the state level, we have actuarially found capitation rates for our three managed care plans, and then the state does not get involved in the contracting that the managed care plans do with their provider network. So they establish the arrangements whether or not they reimburse on a

capitated basis to their subcontractors or their vendors or if they do fee-for-service rates, that's up to the managed care plan to arrange.

And then you asked a question about whether or not those rates might impact access to services. The state holds the managed care plans accountable for ensuring that all of the members in their member network have access to the services that should be available to them, especially making sure that they have access to the EPSDT-related services, since that's a federal benefit that they are required to provide the services for, and dental services is one of those.

Thank you. Shay, do you have anything to add to that answer?

Yes. We actually, Peach State, worked with our dental vendor to -- that's one of the interventions that we are going to implement. Again, we have to do it on a smaller scale so that it can be measured and we can determine if that intervention actually had some impact on us meeting our SMART aim, as Dr. Carson mentioned earlier, there have been times in -- before now we have been doing multiple interventions, so even when we did employ some reimbursement incentives, if you will, there were -- it was difficult to tell exactly what intervention made the impact. So we will be doing that and gladly share that information as we get it.

Thank you, Shay. So, Roopa, did you have some questions for Dr. Carson and Shay?

Sure. So my first question is to Shay. Shay, as a health plan or CMO as they're called in Georgia, what recommendations do you have to other health plans in developing the appropriate QI capacity to take on an effort like a PIP? What were the most crucial aspects of the process? You detailed a lot of the activities that were conducted, like the construction of a driver diagram, the failure modes analysis and so forth. I'm wondering sort of what on the ground kind of capacity was needed in terms of staffing, sort of the makeup of the team, particular staff skills, measurement, data recording protocols, things like that?

Okay, so on our dental work routine we have someone from senior leadership, it's always good to have -- what we've read is it's always good to have someone who, if you will, holds the purse as we implement interventions or need PIPs or additional staffing, we have to someone who can be readily accessed and available to approve these things to make sure that the process flows.

We have EPSDT coordinators and our dental vendor because those staff touch the provider, dental providers, and the members. I will say some -- one thing that I would like to mention is the -- it is resource intensive. It's people's resource and money, along with time, so I would really advise everyone taking on oral health PIP or a PIP in general to have -- make sure that they have the correct people from their plan. Previous to this it was really equality. We didn't have a lot of member and provider relations along with our contracting and other staff involved, so we really worked to have a good multidisciplinary group, so that we can make better impacts.

Great, that's really helpful. And is there anything in particular about the oral health PIP as opposed to other PIPs that were conducted in other healthcare areas that you think stands out in terms of your experience in lessons learned, particularly around engaging oral healthcare providers the types of issues that you faced?

I will say Peach State does have a contracted dental vendor, so we had to really firm up our collaboration, so that we could make sure we have -- we weren't duplicating efforts and that we were outreaching to all providers that we needed. Also involving our dental vendor meant that we had the expertise at the table. I think that a big difference with the oral health PIP also is, unfortunately when we look at our population, we concentrate more on the medical, not realizing how important oral health care is to the overall health outcomes of our members. So I think that making sure that we -- the biggest thing for us was understanding that the collaboration needed to happen internally with Peach State with our vendor and with the provider society, so we got Georgia Dental Association on board, because they could help us push out messages, information, and the urgency of improving oral health to the providers.

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The next question is for Dr. Carson as well as Shay. It looks like in Georgia you kind of arrived at a really nice collaborative relationship in terms of how the state works closely with the CMOs in order to not only develop the vision but also help implement the PIP. Do you have sort of best practices that you can share with audience members around kind of the ideal type and frequency of communication between the two entities, sort of what level of oversight in (inaudible) is sort of ideal, and what types of technical assistance sort of might be best suited for this kind of effort. I know you also partnered with the EQRO, so feel free to talk about that as well.

I think for me and for Georgia, we have come to recognize that our managed care plans and the state, we must work together as a team. And because of that then we work to try to understand, you know, the issues from their perspective and figure out how, as a state, we can help facilitate the resolution of some of those issues. We also work very closely with our EQRO for all of our performance improvement projects, and because of the way that we contract for those services, we've included in that their capacity to provide assistance with the -- now with the new version of the PIP process that we have in place. And then we also have meetings with our managed care plans. In fact, it was through some of our regularly scheduled meetings that we had the webinars that provided the training on the new process. So we have in-person meetings with our managed care plans once a month, and we have a teleconference with them also once a month, so we meet the second and the fourth Wednesdays. And we give them opportunities during those in-person meetings to share what kinds of activities they are engaged in. While we realize that they are all competitors, the fact that they're able to talk about some of the things that they're doing, there's like learning that's occurring across the three plans and across DCH, and I know that I find those meetings very valuable as well.

Thank you Roopa and Dr. Carson and Shay. I think we're out of time for more questions. If we could go to the next slide, just to share with everyone a little bit of information about additional tools available from CMS to help improve our delivery of dental services to children in Medicaid and CHIP. In addition to the tools we've been talking about today, we will be publishing a set of issue briefs on addressing tooth decay in young children and we have a webinar, another webinar next Wednesday to debut those issue briefs.

We hope you've been on the list to get the invitation to that webinar. We're also soon going to be releasing web-based training modules to help states more completely and accurately report their dental data on the Form CMS-416. And we are working on a Medicaid dental contracting tool kit. We recognize that contracting is a very powerful way to get performance in our Medicaid programs and we're pulling together some really strong contracting provisions from states and we want to make sure that all states have access to that.

So this is the information about next Wednesday's webinar, Reducing Early Childhood Tooth Decay, Approaches in Medicaid. We're very pleased that we'll have Dr. Burton Edelstein from Columbia University as well as some folks from North Carolina Medicaid to share with us, and we hope you'll join us on that webinar.

So in closing, please join me in saying a big thank you to all of our guest speakers. We thank you very much for the terrific information you shared with us today and thanks also go to all of you for participating in the webinar. We truly appreciate your interest and we look forward to continuing to partner with you to improve children's access to oral health services as well as improving their oral health status.

Now I'll turn the mic back to Brice to close out the webinar.

This concludes the webcast for today. Please submit feedback to the presentation team using the survey in your browser window when the event concludes. If you are unable to provide your feedback at this time, you can review the on-demand recording of the event and access the survey widget there. The on-demand will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration.

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Any future topics or discussion points can also be shared with the team using the MACQualityTA@cms.hhs.gov mailbox. Thank you.