

## Report on a QI Project Eligible for MOC – ABMS Part IV and AAPA PI-CME

### Michigan Caries Prevention Program – Wave 21

#### Instructions

**Determine eligibility.** Before starting to complete this report, go to the UMHS MOC website [[ocpd.med.umich.edu](http://ocpd.med.umich.edu)], click on “Part IV Credit Designation,” and review sections 1 and 2. Complete and submit a “QI Project Preliminary Worksheet for Part IV Eligibility.” Staff from the UMHS Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

**Completing the report.** The report documents completion of each phase of the QI project. (See section 3 of the website.) Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (strongly recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-20.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font. Answers should be in regular font (generally immediately below or beside the questions). To check boxes, hover pointer over the box and click (usual “left” click).

For further information and to submit completed applications, contact either:

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#### Report Outline

Section	Items
<b>A. Introduction</b>	1-6. Current date, title, time frame, key individuals, participants, funding
<b>B. Plan</b>	7-10. Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies 11-13. Measures, baseline performance, specific aims 14-17. Baseline data review, underlying (root) causes, interventions, who will implement
<b>C. Do</b>	18. Intervention implementation date
<b>D. Check</b>	19-20. Post-intervention performance
<b>E. Adjust – Replan</b>	21-24. Post-intervention data review, underlying causes, adjustments, who will implement
<b>F. Redo</b>	25. Adjustment implementation date
<b>G. Recheck</b>	26-28. Post-adjustment performance, summary of individual performance
<b>H. Readjust plan</b>	29-32. Post-adjustment data review, underlying causes, further adjustments, who will implement
<b>I. Reflections &amp; plans</b>	33-37. Barriers, lessons, best practices, spread, sustain
<b>J. Participation for MOC</b>	38-40. Participation in key activities, other options, other requirements
<b>K. Sharing results</b>	41. Plans for report, presentation, publication
<b>L. Organization affiliation</b>	42. Part of UMHS, AAVA, other affiliation with UMHS

## QI Project Report for Part IV MOC Eligibility

### A. Introduction

1. **Date** (*this version of the report*): November 1, 2017
  
2. **Title of QI effort/project** (*also insert at top of front page*): Michigan Caries Prevention Program
  
3. **Time frame**
  - a. **MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project** (*e.g. date of general review of baseline data, item #14c*):  
See Appendix A for the overall project timeline. Twenty two “waves” of groups of medical practices will initiate their participation in the project monthly for 22 months. Wave 21 began in March 2017.
  
  - b. **MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project** (*e.g., date of general review of post-adjustment data, item #29c*):  
Each “wave” of groups of medical practices will perform two cycles of improvement effort over seven months. Wave 21 finished in September 2017.

### 4. Key individuals

- a. **QI project leader** [*also responsible for confirming individual's participation in the project*]  
**Name:** Carley Kirk, MS, RDH  
**Title:** Physician Engagement Lead  
**Organizational unit:** Altarum Institute  
**Phone number:** 734-302-4727  
**Email address:** carley.kirk@altarum.org  
**Mailing address:** 3520 Green Court, Suite 300, Ann Arbor, MI. 48105
  
- b. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/“sponsoring” the project within the specific clinical setting*]  
**Name:** Stephanie Goodson, MD, FAAP  
**Title:** Assistant Professor of Pediatrics  
**Organizational unit:** University of Michigan  
**Phone number:** 810-227-9510  
**Email address:** goodstep@med.umich.edu  
**Mailing address:** 8001 Challis Rd. Brighton, MI. 48116

### 5. Participants

- a. **Approximately how many health care providers (by training level for physicians) participated in this QI effort** (*whether or not for MOC*):

Profession	Number for Wave 21
Practicing Physicians	10
Residents/Fellows	0
Physicians’ Assistants	7
Nurses (APNP, NP, RN, LPN)	2

Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	0
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**b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?**

Profession	Specialty/Subspecialty (fill in)	Number for Wave 21
Practicing Physicians	Family Physicians	9
	Pediatricians	1
Fellows		0
Residents		0
Physicians’ Assistants	(Specialty not applicable)	7

**6. How was the QI effort funded? (Check all that apply.)**

- Internal institutional funds
- Grant/gift from pharmaceutical or medical device manufacturer
- Grant/gift from other source (e.g., government, insurance company): Center for Medicare and Medicaid Innovation Health Care Innovation Award
- Subscription payments by participants
- Other (describe):

*The Multi-Specialty Part IV MOC Program requires that QI efforts include at least two linked cycles of data-guided improvement. Some projects may have only two cycles while others may have additional cycles – particularly those involving rapid cycle improvement. The items below provide some flexibility in describing project methods and activities. If the items do not allow you to reasonably describe the steps of your specific project, please contact the UMHS Part IV MOC Program Office.*

**B. Plan**

**7. Patient population. What patient population does this project address (e.g., age, medical condition, where seen/treated):**

All children ages 0-3 years who receive preventive care in the participating primary care practices in Michigan.

**8. General goal**

**a. Problem/need. What is the problem (“gap”) in quality that resulted in the development of this project? Why is important to address this problem?**

Children at risk for early childhood caries often do not receive preventive oral health services during well-child visits. Preventive oral health services beginning at the 6 month well-child visit is supported by the American Academy of Pediatrics (AAP) Section on Oral Health policy and the Bright Futures periodicity schedule. These services include oral health screenings, fluoride varnish applications, and recommending seeing/facilitating referral to a dentist for the child to be seen at 12 months of age or at the time of first tooth emergence, whichever occurs first. However, primary care physicians are not prepared to provide oral health screenings and fluoride varnish applications and are not aware of the need to recommend seeing a dentist in this time frame. Primary care

physicians generally lack the education and training to provide these services. Most physicians are not aware they can bill most insurers for oral screening and varnish application. To bill Medicaid for providing these services a special “Smiles for Life” certification is required. As of May 2015, only 3.4% of primary care physicians in Michigan were Smiles for Life certified to provide preventive oral health services to patients ages 0-3 years. A very low percentage of children participating in Medicaid/MiChild receive these services or dental recommendations/referrals.

**b. Project goal. What general outcome regarding the problem should result from this project?**  
*(State general goal here. Specific aims/performance targets are addressed in #13.)*

Increase of oral health screenings, increase of fluoride varnish applications, and increase recommendations for/referrals to a dental home\*, resulting in an improvement in children’s oral health.

The Michigan Caries Prevention Program was created to transform the system of children’s oral health care in Michigan through providing the necessary education, technical assistance, and resources to primary care providers and clinical staff to increase the number of children receiving preventive oral health services during well-child visits and increase referrals made to a dental home.

\* The American Academy of Pediatrics and the American Academy of Pediatric Dentistry define a “dental home” as the “ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.”

**9. Which Institute of Medicine Quality Dimensions are addressed?** *[Check all that apply.]*  
<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> )

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Effectiveness | <input checked="" type="checkbox"/> Equity               | <input type="checkbox"/> Safety                |
| <input checked="" type="checkbox"/> Efficiency    | <input checked="" type="checkbox"/> Patient-Centeredness | <input checked="" type="checkbox"/> Timeliness |

**10. Which ACGME/ABMS core competencies are addressed?** *(Check all that apply.)*  
<http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/> )

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Patient Care and Procedural Skills      | <input checked="" type="checkbox"/> Medical Knowledge                      |
| <input checked="" type="checkbox"/> Practice-Based Learning and Improvement | <input checked="" type="checkbox"/> Interpersonal and Communication Skills |
| <input type="checkbox"/> Professionalism                                    | <input checked="" type="checkbox"/> Systems-Based Practice                 |

**11. Describe the measure(s) of performance:** *(QI efforts must have at least one measure that is tracked across the two cycles for the three measurement periods: baseline, post-intervention, and post-adjustment. If more than two measures are tracked, copy and paste the section for a measure and describe the additional measures.)*

Measure 1

**Name of measure:** Oral health screening – calculated separately for 9-month visits and 12-month visits.

- **Measure components** – for a rate, percent, or mean, describe the:
  - Denominator *(e.g., for percent, often the number of patients eligible for the measure):*  
 Number of patient charts pulled
  - Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation):*  
 Number of patients with oral health screening performed
- **The source of the measure is:**

- An external organization/agency, which is (*name the source*): Oral health screening-based on the DQA/NQF Measure: Oral Evaluation, Dental Services. This measure is specific to the dental setting, but because of the nature of our intervention, we have adopted it to apply to the medical setting as well.
- Internal to our organization and it was chosen because (*describe rationale*):
- **This is a measure of:**
  - Process – activities of delivering health care to patients
  - Outcome – health state of a patient resulting from health care

### Measure 2

**Name of measure:** Fluoride varnish – calculated separately for 9-month visits and 12-month visits

- **Measure components** – for a rate, percent, or mean, describe the:
  - Denominator (*e.g., for percent, often the number of patients eligible for the measure*):  
Excluding patients without teeth, the remaining number of patient charts pulled
  - Numerator (*e.g., for percent, often the number of those in the denominator who also meet the performance expectation*):  
Number of these patients with fluoride varnish applied
- **The source of the measure is:**
  - An external organization/agency, which is (*name the source*): Fluoride varnish- based on the Dental Quality Alliance (DQA) and National Quality Forum (NQF) measure: Topical Fluoride for Children at Elevated Caries Risk, Dental Services. This measure focuses on children with elevated risk; before the United States Preventive Services Task Force (USPSTF) released their new guidelines recommending fluoride varnish for all children regardless of risk. This measure also is specific to the dental setting, but because of the nature of our intervention, we have adopted it to apply to the medical setting as well.
  - Internal to our organization and it was chosen because (*describe rationale*):
- **This is a measure of:**
  - Process – activities of delivering health care to patients
  - Outcome – health state of a patient resulting from health care

### Measure 3

**Name of measure:** Recommendation for/referral to a dental home – calculated separately for 9-month visits and 12-month visits

- **Measure components** – for a rate, percent, or mean, describe the:
  - Denominator (*e.g., for percent, often the number of patients eligible for the measure*):  
Excluding patients known to have a dental home, the remaining number of charts pulled
  - Numerator (*e.g., for percent, often the number of those in the denominator who also meet the performance expectation*):  
Number of these patients with recommendation for/referred to a dental home
- **The source of the measure is:**
  - An external organization/agency, which is (*name the source*): Referral to a dental home- This is based on the American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry (AAPD) guidelines recommending the establishment of a dental home by the 1<sup>st</sup> birthday.
  - Internal to our organization and it was chosen because (*describe rationale*):
- **This is a measure of:**

- Process – activities of delivering health care to patients
- Outcome – health state of a patient resulting from health care

*(If more than two measures are tracked across the two cycles, copy and paste the section for a measure and describe the additional measures.)*

**12. Baseline performance**

**a. What were the beginning and end dates for the time period for baseline data on the measure(s)?**

Baseline data were collected retrospectively for the month prior to the beginning of a wave of participants. For Wave 21 it was for the month before March 1, 2017, February 1-28, 2017.

**b. What was (were) the performance level(s) at baseline?** *(E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)*

See Appendix B, first column of data, for the baseline percent of patients with service performed by Wave.

**13. Specific performance aim(s)/objective(s)**

**a. What is the specific aim of the QI effort?** *“The Aim Statement should include: (1) a specific and measurable improvement goal, (2) a specific target population, and (3) a specific target date/time period. For example: We will [improve, increase, decrease] the [number, amount percent of [the process/outcome] from [baseline measure] to [goal measure] by [date].”*

- 75% of patients receive oral health screenings
- 50% of eligible patients receive fluoride varnish applications
- 50% of eligible patients receive dental home recommendations/referrals.

**b. How were the performance targets determined, e.g., regional or national benchmarks?**

No national performance targets exist. Project leaders set goals based on likely practical performance rates given priorities for clinical prevention and time limitations during any one well-child visit and the possibility of providing the services at a subsequent well-child visit.

**14. Baseline data review and planning. Who was involved in reviewing the baseline data, identifying underlying (root) causes of problem(s) resulting in these data, and considering possible interventions (“countermeasures”) to address the causes?** *(Briefly describe the following.)*

**a. Who was involved?** *(e.g., by profession or role)*

Participating physicians, nurse practitioners, physician assistants, and clinical support staff.

**b. How?** *(e.g., in a meeting of clinic staff)*

During clinical staff meetings.

**c. When?** *(e.g., date(s) when baseline data were reviewed and discussed)*

Before the end of month 1 of the “Wave.” For Wave 21 it was before the end of month 1, March 2017.

**Use the following table to outline the plan that was developed: #15 the primary causes, #16 the intervention(s) that addressed each cause, and #17 who carried out each intervention.** *This is a simplified presentation of the logic diagram for structured problem solving explained at <http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation> in section 2a. As background, some summary examples of common causes and interventions to address them are:*

<b>Common Causes</b>	<b>Common Relevant Interventions</b>
<i>Individuals: Are not aware of, don’t understand.</i>	<i>Education about evidence and importance of goal.</i>

<i>Individuals: Believe performance is OK.</i>	<i>Feedback of performance data.</i>
<i>Individuals: Cannot remember.</i>	<i>Checklists, reminders.</i>
<i>Team: Individuals vary in how work is done.</i>	<i>Develop standard work processes.</i>
<i>Workload: Not enough time.</i>	<i>Reallocate roles and work, review work priorities.</i>
<i>Suppliers: Problems with provided information/materials.</i>	<i>Work with suppliers to address problems there.</i>

15. What were the primary underlying/root causes for the <b>problem(s) at baseline</b> that the project can address?	16. What intervention(s) addressed this cause?	17. Who was involved in carrying out each intervention? (List the professions/roles involved.)
<p><u>Clinical personnel</u></p> <p>Do not have the education and training to perform the procedures</p>	<p>Central program personnel train physicians, nurse clinicians, and physician assistants to:</p> <ul style="list-style-type: none"> <li>• Perform oral screening and apply fluoride varnish.</li> <li>• Utilize a clinical decision support tool to incorporate recommendation/referral to dental homes into routine care provision.</li> <li>• Understand AAP policy and the Bright Futures periodicity schedule related to providing preventive oral health services during well-child visits.</li> <li>• Make operational changes in the process of well-child care that facilitate the provision and documentation of appropriate care.</li> <li>• Collect and report individual practice data.</li> </ul>	<p>Central program personnel, local oral health champion and all clinic personnel (physicians, nurse clinicians, physician assistants, and office staff)</p>
<p><u>Problems with office set-up and workflow</u></p> <p>Resources needed to perform the procedures are not stocked</p> <p>No routine processes to coordinate office staff in delivering the care</p>	<p>Trained clinicians will work with their office staff to make operational changes in the local process of well-child care that facilitate the provision and documentation of appropriate care.</p>	<p>(Same as above.)</p>
<p><u>No financial incentive</u></p> <p>Without training and certification, the procedures cannot be billed</p>	<p>Physicians and nurse practitioners who have been trained and have set up appropriate office procedures can bill most insurers for preventive oral health services and will become certified to bill Medicaid for these services.</p>	<p>(Same as above.)</p>

Note: If additional causes were identified that are to be addressed, insert additional rows.

**C. Do**

**18. By what date was (were) the intervention(s) initiated?** *(If multiple interventions, date by when all were initiated.)*

Before the end of month 1 of the group's participation. For Wave 21, before the end of month 1, March 2017.

**D. Check**

**19. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see items 10 and 11)?**

Yes     No – If no, describe how the population or measures differ:

**20. Post-intervention performance**

**a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?**

From the beginning to the end of month 3 of the cycle. For Wave 21, during month 3, May 2017.

**b. What was (were) the overall performance level(s) post-intervention?** *(E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)*

See Appendix B, middle column of data, for the post-intervention percent of patients with service performed within and across the practices.

**c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?**

Yes, substantial improvement occurred across all measures. In aggregate, the participating practices exceeded all three performance targets.

**E. Adjust – Replan**

**21. Post-intervention data review and further planning. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions ("countermeasures") to address the causes?** *(Briefly describe the following.)*

**a. Who was involved?** *(e.g., by profession or role)*

Same as #14?     Different than #14 *(describe):*

**b. How?** *(e.g., in a meeting of clinic staff)*

Same as #14?     Different than #14 *(describe):*

**c. When?** *(e.g., date(s) when post-intervention data were reviewed and discussed)*

Before the end of month 4 of the group's participation. For Wave 21, during month 4, June 2017.

**Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments(s)/second intervention(s) that addressed each cause, and #24 who carried out each intervention.** *This is a simplified presentation of the logic diagram for structured problem solving explained at <http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation> in section 2a.*

*Note: Initial intervention(s) occasionally result in performance achieving the targeted specific aims and the review of post-intervention data identifies no further causes that are*

*feasible or cost/effective to address. If so, the plan for the second cycle should be to continue the interventions initiated in the first cycle and check that performance level(s) are stable and sustained through the next observation period.*

22. What were the primary underlying/root causes for the <u>problem(s) following the intervention(s)</u> that the project can address?	23. What adjustments/second intervention(s) addressed this cause?	24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)
<p><u>Clinic personnel.</u></p> <ul style="list-style-type: none"> <li>• Are less aware of the importance of dental recommendations/referrals at the 9-month visit than the 12-month visit. Children at 9 months with a tooth are to be recommended/referred for an initial dental visit. Even if the child does not have a tooth at 9 months, the recommendation/ referral at 9 months is important for parents to have advance time to schedule a recommended initial dental visit by the time the child is 12 months of age.</li> </ul>	<p>Central program personnel performed an on-site technical assistance meeting with the oral health champion to continue education and sharing of additional resources related to:</p> <ul style="list-style-type: none"> <li>• Importance of dental home recommendations/referrals during the 9-month visit.</li> <li>• Adjusting operational changes to better facilitate documentation of appropriate care, specifically recommendations/referrals to a dental home.</li> </ul>	<p>Central program personnel, local oral health champion and all clinic personnel (physicians, nurse clinicians, physician assistants, and office staff)</p>
<ul style="list-style-type: none"> <li>• Enthusiasm of some clinical staff reduces over time.</li> </ul>	<ul style="list-style-type: none"> <li>• Continuing clinical staff enthusiasm by emphasizing the ease of providing services.</li> </ul>	<p>(Same as above.)</p>
<ul style="list-style-type: none"> <li>• New staff hires brought on after the initial training lack education related to the appropriate services.</li> </ul>	<ul style="list-style-type: none"> <li>• Utilizing the follow-up conversations to ensure services continue to be provided, and clinical staff have access to onboarding resources for new staff.</li> </ul>	<p>(Same as above.)</p>
<ul style="list-style-type: none"> <li>• Staff were not prepared with sufficient talking points when faced with parents who decline the services.</li> </ul>	<ul style="list-style-type: none"> <li>• Talking points to support the provision of services when parents decline the services.</li> </ul>	<p>(Same as above.)</p>
<p><u>Office workflow.</u></p> <p>Documentation of new services is difficult, especially documentation of dental recommendations/ referrals.</p>	<p>The oral health champion will work with the trained providers to adjust operational changes to facilitate documentation of appropriate care.</p>	<p>(Same as above.)</p>
<p><u>Financial incentive.</u></p> <p>Adding new billing codes to certain EHR systems is time consuming.</p>	<p>The oral health champion will work with their clinic's billing support staff to ensure billing codes are inputted correctly and earlier in the process to avoid a delay in delivery of care.</p>	<p>Local champion and billing support staff.</p>

Note: If additional causes were identified that are to be addressed, insert additional rows.

**F. Redo**

**25. By what date was (were) the adjustment(s)/second intervention(s) initiated?** *(If multiple interventions, date by when all were initiated.)*

Before the end of month 4 of the group's participation. For Wave 21, before the end of month 4, June 2017.

**G. Recheck**

**26. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #21)?**

Yes       No – If no, describe how the population or measures differ:

**27. Post-adjustment performance**

**a. What were the beginning and end dates for the time period for post-adjustment data on the measure(s)?**

During months 5 and 6 of the group's participation. For Wave 21, months 5 – 6, July 2017 – August 2017.

**b. What was (were) the overall performance level(s) post-adjustment?** *(E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)*

See Appendix B, last column of data, for the post-adjustment percent of patients with services performed within and across practices.

**c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?**

Yes, goals were substantially surpassed for both age cohorts on all measures.

**28. Summary of individual performance**

**a. Were data collected at the level of individual providers so that an individual's performance on target measures could be calculated and reported?**

Yes       No

**H. Readjust**

**29. Post-adjustment data review and further planning. Who was involved in reviewing the post-adjustment data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions ("countermeasures") to address the causes?** *(Briefly describe the following.)*

**a. Who was involved?** *(e.g., by profession or role)*

Same as #21?       Different than #21 *(describe):*

**b. How?** *(e.g., in a meeting of clinic staff)*

Same as #21?       Different than #21 *(describe):*

- c. **When?** (e.g., date(s) when post-adjustment data were reviewed and discussed)  
 Before the end of month 7 of the group’s participation. For Wave 21, by the end of month 7, September 2017.

**Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments(s)/second intervention(s) that addressed each cause, and #32 who would carry out each intervention.** This is a simplified presentation of the logic diagram for structured problem solving explained at <http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation> in section 2a.

*Note: Adjustments(s) may result in performance achieving the targeted specific aims and the review of post-adjustment data identifies no further causes that are feasible or cost/effective to address. If so, the plan for a next cycle could be to continue the interventions/adjustments currently implemented and check that performance level(s) are stable and sustained through the next observation period.*

30. What were the primary underlying/root causes for the <u>problem(s) following the adjustment(s) that the project can address?</u>	31. What further adjustments/ intervention(s) might address this cause?	32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)
<p><u>Clinical personnel.</u></p> <ul style="list-style-type: none"> <li>• Feel less comfortable providing the fluoride varnish service to the 9 and 12 month olds due to the lack of patient cooperation, and fear of getting bit.</li> </ul>	<p>Central program personnel developed a best practices webinar that is available to participants that expands on:</p> <ol style="list-style-type: none"> <li>1) How to deal with uncooperative 9 and 12 month olds.</li> <li>2) How to provide fluoride varnish to an uncooperative child.</li> </ol>	<p>Central program personnel, local oral health champion and all clinic personnel (physicians, nurse clinicians, physician assistants, and office staff)</p>
<ul style="list-style-type: none"> <li>• Unsure of ability to provide fluoride varnish to an uncooperative child.</li> </ul>	<p>See above.</p>	<p>Same as above.</p>
<ul style="list-style-type: none"> <li>• Enthusiasm of some clinical staff reduces over time.</li> </ul>	<p>Continuing clinical staff enthusiasm by emphasizing the importance of the services to patients and the ease of providing services.</p>	<p>Same as above.</p>
<p><u>Office workflow.</u></p> <ul style="list-style-type: none"> <li>• Documentation of dental recommendations/referrals is difficult when the task is not specifically assigned to the correct clinical staff member.</li> </ul>	<p>Local staff are to assign to a specific clinical staff member the responsibility for documenting dental recommendations and referrals.</p>	<p>Same as above.</p>

*Note: If additional causes were identified that are to be addressed, insert additional rows.*

33. Are additional PDCA cycles to occur for this specific performance effort?

- No further cycles will occur.

No formal additional PDCA cycles are planned for this wave of participants. Project leaders will remain an available resource until the end of the grant period (August 2017).

- Further cycles will occur, but will not be documented for MOC. *If checked, summarize plans:*
- Further cycles will occur and are to be documented for MOC. *If checked, contact the UM Part IV MOC Program to determine how the project's additional cycles can be documented most practically.*

## I. Reflections and Future Actions

### 33. Describe any barriers to change that were encountered during this QI effort and how they were addressed.

The most significant barriers that were faced by participants include:

- Not being familiar with making customizable changes to their EHR system to accommodate the documentation and billing for preventive oral health services. Central program personnel were able to address these barriers by providing additional training to the technical assistance (TA) staff that included how to help guide participants in making direct changes to their EHR systems as well as how to effectively communicate with various EHR vendors to ensure sustainment of the customized changes.
- Low confidence when providing fluoride varnish applications to uncooperative children. Central program personnel worked with project partner, the University of Michigan School of Dentistry, to develop a webinar to increase the comfort level of participants when applying fluoride varnish to young and uncooperative children. This webinar is easily accessible online to past and current participants, and helps facilitate onboarding of new local clinical staff to ensure sustainability of the interventions.

### 34. Describe any key lessons that were learned as a result of the QI effort.

- Include clinical support staff. Including all clinical support staff in the training significantly helps with obtaining staff buy-in during the early stage of implementing preventive oral health services.
- Importance of oral health champion. The oral health champion plays an important role as they often are the ones who are able to assist in making local operational changes that are a best fit for their clinic, and are easily able to identify key clinical support staff to ensure that sustainment of the changes is achieved.
- Demonstrate safe fluoride varnish application. A hands-on demonstration of fluoride varnish application that includes safe provider hand positioning would help alleviate fears of biting.

### 35. Describe any best practices that came out of the QI effort.

Identified best practices include:

- Deploying in-person technical assistance (TA) for struggling clinics. Based on the post-intervention data findings submitted by the clinics, TA would either be by phone, email, or in-person. It was realized that for clinics that were either underperforming or delayed in implementing the interventions, that in-person TA resulted in significantly higher implementation rates for the post-adjustment period in comparison with other forms of TA provided.
- Facilitating a kick-off call pre-training between the TA staff member and the local Oral Health Champion. This discussion occurs a few weeks prior to the in-person training, and assists the TA staff member to better understand the clinic's current workflow and level of motivation to change. Key topics of the kick-off call include:
  - Documentation requirements for the activity
  - Ability to customize the current EHR if necessary
  - Comfort level of making referrals to the dental community
  - Current clinical workflow process for comparable interventions (e.g., developmental screening, immunizations)

**36. Describe any plans for spreading improvements, best practices, and key lessons.**

Project leaders have been able to identify consistent barrier trends to implementing preventive oral health services during the 9 and 12 month well-child visits among subsequent waves of participants. The local changes that were made by the first five waves of participants have been an integral part of rapid cycle process improvement to assist the central program personnel in their education, training, and technical assistance efforts for future waves of participants.

**37. Describe any plans for sustaining the changes that were made.**

Improvements that have now become part of the clinical workflow should remain self-sustaining over time. Peer-to-peer oral health champion networks are available as a resource, and a best practices webinar on the application of fluoride varnish for very young children has been developed. This webinar is available to all current and previous participants to increase their ability and their confidence in their ability to provide fluoride varnish to 9 and 12 month olds.

**J. Minimum Participation for MOC****38. Participating directly in providing patient care.****a. Did any individuals seeking MOC participate directly in providing care to the patient population?**

Yes     No    *If "No," go to item #39.*

**b. Did these individuals participate in the following five key activities over the two cycles of data-guided improvement?**

- Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #14.
- Implementing interventions described in item #16.
- Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #21.
- Implementing adjustments/second interventions described in item #23.
- Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #29.

Yes     No    *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.*

**39. Not participating directly in providing patient care.****a. Did any individuals seeking MOC not participate directly in providing care to the patient population?**

Yes     No    *If "No," go to item 40.*

**b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement? (E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)**

Yes     No    *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40. If "No," continue to #39c.*

**c. Did the individual(s) supervising residents or fellows throughout their performing the entire QI effort?**

Yes     No    *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.*

40. Did this specific QI effort have any additional participation requirement for MOC? (E.g., participants required to collect data regarding their patients.)

Yes     No    If "Yes," describe: Collect or oversee collection of data in the practice.

## K. Sharing Results

41. Are you planning to present this QI project and its results in a:

- Yes     No    Formal report to clinical leaders?  
 Yes     No    Presentation (verbal or poster) at a regional or national meeting?  
 Yes     No    Manuscript for publication?

## L. Project Organizational Role and Structure

42. UMHS QI/Part IV MOC oversight – indicate whether this project occurs within UMHS, AAVA, or an affiliated organization and provide the requested information.

University of Michigan Health System

- Overseen by what UMHS Unit/Group? (name):
- Is the activity part of a larger UMHS institutional or departmental initiative?  
 No     Yes – the initiative is (name or describe):

Veterans Administration Ann Arbor Healthcare System

- Overseen by what AAVA Unit/Group? (name):
- Is the activity part of a larger AAVA institutional or departmental initiative?  
 No     Yes – the initiative is:

An organization affiliated with UMHS to improve clinical care

- The organization is (name): Altarum Institute
- The type of affiliation with UMHS is:
  - Accountable Care Organization (specify which member institution):
  - BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative (specify which):
  - Other (specify): Project-specific agreement between UMHS and Altarum Institute for joint providership of activities of the Michigan Caries Prevention Program funded by a Center for Medicare and Medicaid Innovation Health Care Innovation Award

### Appendix A. Timeline for Waves of Groups of Participating Medical Practices

Twenty two “waves” of groups of participating medical practices are included in the project. Each “wave” starts a month after the previous “wave” starts. A “wave” participates in two cycles of data-guided improvement over seven months. The first “wave” starts July 1, 2015 and the last “wave” finishes October 31, 2017.

Michigan Caries Prevention Program									
Performance & Quality Improvement CME/Part IV MOC Cycles									
Training Months									
2015	Cycle	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Legend:
July	1	July	August	September	October	November	December	January	2015
August	2	August	September	October	November	December	January	February	2016
September	3	September	October	November	December	January	February	March	2017
October	4	October	November	December	January	February	March	April	
November	5	November	December	January	February	March	April	May	
December	6	December	January	February	March	April	May	June	
<b>2016</b>									
January	7	January	February	March	April	May	June	July	
February	8	February	March	April	May	June	July	August	
March	9	March	April	May	June	July	August	September	
April	10	April	May	June	July	August	September	October	
May	11	May	June	July	August	September	October	November	
June	12	June	July	August	September	October	November	December	
July	13	July	August	September	October	November	December	January	
August	14	August	September	October	November	December	January	February	
September	15	September	October	November	December	January	February	March	
October	16	October	November	December	January	February	March	April	
November	17	November	December	January	February	March	April	May	
December	18	December	January	February	March	April	May	June	
<b>2017</b>									
January	19	January	February	March	April	May	June	July	
February	20	February	March	April	May	June	July	August	
March	21	March	April	May	June	July	August	September	
April	22	April	May	June	July	August	September	October	

## Appendix B. Performance for Wave 21 of Practices for Percent of Patients with Service Performed

Service	Baseline Month -1	Post-Intervention Month 3	Post-Adjustment Months 5 & 6	Goal
<u>Clinic A</u>				
Oral health screening				
9-month visit	0%*	50% (n=6)	31% (n=13)	75%
12-month visit	0%*	29% (n=7)	45% (n=11)	75%
Fluoride varnish				
9-month visit	0%*	17% (n=6)	23% (n=13)	50%
12-month visit	0%*	43% (n=7)	27% (n=11)	50%
Recommend/refer to dental home				
9-month visit	0%*	33% (n=6)	31% (n=13)	50%
12-month visit	0%*	71% (n=7)	27% (n=11)	50%
<u>Clinic B</u>				
Oral health screening				
9-month visit	0%*	100% (n=8)	100% (n=15)	75%
12-month visit	0%*	100% (n=5)	100% (n=10)	75%
Fluoride varnish				
9-month visit	0%*	100% (n=8)	100% (n=15)	50%
12-month visit	0%*	100% (n=5)	100% (n=10)	50%
Recommend/refer to dental home				
9-month visit	0%*	100% (n=8)	100% (n=15)	50%
12-month visit	0%*	100% (n=5)	100% (n=10)	50%
<u>Clinic C</u>				
Oral health screening				
9-month visit	0%*	100% (n=4)	100% (n=14)	75%
12-month visit	0%*	100% (n=6)	100% (n=15)	75%
Fluoride varnish				
9-month visit	0%*	100% (n=4)	80% (n=10)	50%
12-month visit	0%*	33% (n=6)	67% (n=15)	50%
Recommend/refer to dental home				
9-month visit	0%*	100% (n=4)	100% (n=14)	50%
12-month visit	0%*	100% (n=6)	100% (n=15)	50%
<u>Wave 21 – Mean of 3 Practice Means</u>				
Oral health screening				
9-month visit	0%	83%	77%	75%
12-month visit	0%	76%	82%	75%
Fluoride varnish				
9-month visit	0%	72%	68%	50%
12-month visit	0%	59%	65%	50%
Recommend/refer to dental home				
9-month visit	0%	78%	77%	50%
12-month visit	0%	90%	76%	50%

% = percent of patients that received the service

n = number of eligible patient charts pulled

\* = the clinic did not previously provide the service, so no charts were pulled and the clinic mean at baseline is 0%

N/A = the clinic did not see any patients for that type of well-child visit