Improving Health Outcomes for Children (IHOC)

First STEPS Phase III Initiative: Improving Oral Health and Healthy Weight in Children

Final Evaluation Report

UNIVERSITY OF SOUTHERN MAINE
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About this Study

This report was written by Carolyn Gray and Kimberley Fox at the Cutler Institute of Health and Social Policy, Muskie School of Public Service at the University of Southern Maine. This is the final evaluation report of the First STEPS (Strengthening Together Early Preventive Services) Phase III Improving Oral Health and Healthy Weight in Children learning initiative. The evaluation assessed changes in rates of oral health and healthy weight preventive services and evidence-based office processes among practices that participated in the initiative, as well as related systems changes. This report presents key findings, summarizes lessons learned in implementing practice changes, and describes challenges in using CHIPRA, HEDIS and other oral health and healthy weight measures at the practice-level to inform quality improvement.

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The views expressed are those of the authors and do not necessarily represent the views of either the Department or the School. For further information regarding this report, or the broader evaluation of the local IHOC initiative, please contact Kim Fox at kfox@usm.maine.edu.

Table of Contents

Executive Summary 1

Introduction 7

Description of Phase III Initiative 8

Evaluation Methods 12

Findings 15

- Oral Health Practice-Level Improvement 15
- Healthy Weight Practice-Level Improvement 26
- Phase III Systems-Level Changes 38

Summary and Conclusions 40

Appendix A: Chart Review/EMR Measure Specification 41

Executive Summary

In February 2010, Maine and Vermont were awarded a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to improve the quality of health care for children insured by Medicaid and the Children's Health Insurance Program (CHIP).[1] Maine's Department of Health and Human Services' (DHHS) Office of MaineCare Services (OMS) received the Improving Health Outcomes for Children (IHOC) grant in partnership with the Maine Center for Disease Control, the Muskie School of Public Service at the University of Southern Maine (MSPS), Vermont's Medicaid Program, and the University of Vermont. In Maine, IHOC brings together public and private health stakeholders to standardize the delivery of preventive and follow-up care for children and to meet quality improvement goals of the Office of MaineCare Services.

As part of IHOC, Maine Quality Counts (QC) has been leading the First STEPS (Strengthening Together Early Prevention Services) Learning Initiative to support Maine's pediatric and family practices in improving preventive and screening processes. The purpose of First STEPS is to increase the rates of Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services for children receiving MaineCare benefits by providing tools and data monitoring, offering comprehensive educational support, and engaging primary care practices in multiple change interventions to build patient centered medical homes for children. The First STEPS initiative also helps inform and educate providers about policy changes made by the MaineCare program to support child health quality improvement. It is expected that improving rates of preventive services and proactively identifying children's unique needs will result in children and families accessing necessary medical and related services earlier, thereby reducing disease. As a result of these positive changes, it is anticipated that health outcomes for children and families in Maine will be improved.

To support system-level quality improvement, the Muskie School of Public Service is conducting an evaluation of the First STEPS initiative to assess how First STEPS helped improve the quality of child health in participating pediatric and family practices to help inform future child health quality improvement efforts. This report is the third in a series and summarizes evaluation findings from First STEPS Phase III, which focused on improving oral health and healthy weight screening, treatment, and referral for children in 19 participating pediatric and family practices serving an estimated 35,061 children with MaineCare coverage or 29% of all children enrolled.[2] Evaluation findings are based on pre/post analyses of chart review and electronic medical record (EMR) data reported by practices, MaineCare administrative claims data, self-reported office system surveys and interviews with participating practices and other key stakeholders and programs.

Key findings include:

1 CHIPRA quality demonstration grants are authorized by Section 401 (d) of the Child Health Insurance Program Reauthorization Act.

2 As of December 31, 2012 for children ages 18 and under.

Practice-Level Changes

During First STEPS Phase III, practices largely focused on integrating oral health into well-child visits (WCV) and reinforcing existing healthy weight documentation and prevention work; only one-third of practices focused on follow-up for overweight children.

- Very few practices had been doing oral health risk assessments during well-child visits for younger children prior to the learning session and nearly all participating practices chose to work on integrating this screening into the practice's WCV workflow.
- While half of the practices had been doing fluoride varnish (FV) prior to First STEPS, these practices worked to standardize FV application at well-child visits across all providers for all children under age 4 without a dental home.
- Seven practices focused on enhancing processes of follow-up and/or referral for children identified as being overweight.
- Many practices elected to focus more on oral health as they had already integrated the 5-2-1-0 Healthy Habits questionnaires[3] and body mass index (BMI) documentation in their practice as a result of their participation in *Let's Go!*

Compared to before Phase III, more practices document dental homes, make dental referrals, ask oral health risk assessment questions, and discuss oral health prevention during WCVs for younger children. However, there was no change observed in rates of fluoride varnish application at WCVs.

- Before Phase III only 39% of practices indicated they routinely asked if children under age 3 had a dental home. This increased to 83% of practices routinely asking parents of young children about dental homes by the end of Phase III, which was closer to rates for older children (72% pre, 94% post).
- The frequency of providers discussing all oral health prevention topics with parents of children under age four increased, with the largest improvements seen for the following topics: Baby bottle tooth decay (67% pre, 94% post); explaining the benefits of fluoride (33% pre, 72% post); and recommending the first dental visit by age one (33% pre, 61% post).
- Documentation of the oral health risk assessment and whether children had a dental home increased after Phase III, with some practices exceeding the initiative's targets (50% increase by the end of the initiative) in some areas. For example, OHRA documentation increased more than three-fold from 11% to 49% among practices reporting through their EMR. In addition, dental home documentation increased by 150% among practices reporting through chart review.
- There was minimal to no change in the rates of young children receiving fluoride varnish at WCVs as reported in chart review and EMR data—which remained constant at approximately one-third of children ages 6 months-4 years, and about half for children ages 2-4.
- Practices reported that Phase III helped identify dentists who accept young children for dental referrals, but also reported continued gaps in access to dental services for these children and in parent follow-up on referrals.

3 http://www.letsgo.org/toolkits/hc-toolkits/.

Integrating components of the new oral health risk assessment (OHRA) into EMRs is challenging but once implemented, providers found it very useful for integrating the assessments into well-child visits.

- Twelve practices attempted to modify their EMR to include components of an oral health risk assessment tool, including five practices in the MaineHealth system that were using the Clinical Improvement Registry (CIR) to report monthly data for First STEPS monitoring.
- Most practices indicated that the process of integrating the OHRA and/or entering and billing for fluoride varnish through the EMR was challenging and took longer than expected due to technological and administrative challenges.
- Monthly data from the EMR that was reported for the first time during Phase III helped highlight problems in how the EMR was capturing oral health data, reporting measures, and billing for services. This feedback loop triggered further investigations and ultimately resulted in changes to the EMR to support billing procedures and more accurate data collection for measure reporting.
- Despite the challenges, most practices reported that integrating the OHRA tool into the EMR was critical to successfully integrating the assessment into the well-child visit workflow for all providers.

Improvements in fluoride varnish and oral health evaluations for children under 4 years of age as documented in MaineCare claims data for participating practices exceeded initiative targets and increased at a greater rate than statewide; however, the increase in FV was concentrated in a few practices, and only one participating practice was billing for these oral health evaluations during First STEPS.

- First STEPS exceeded their target of increasing MaineCare claims for fluoride varnish application and oral health evaluations by more than 5 percentage points since the start of the initiative, but FV numbers remained constant from the prior year (potentially due to EMR issues that also affected claims submission).
- The overall increase in MaineCare FV claims during the initiative was due to increased billing in five practices, including one practice serving a high volume of children insured by MaineCare.
- The overall increases in oral health evaluation claims reflect a change in only one practice that submitted claims for administering the OHRA during the study period. Other practices were in the process of adding the new billing code to their processes, but were unable to implement changes until after the initiative ended due to the timing of final policy release and delays in integrating the codes and changes into the EMR.

For healthy weight promotion, most practices reinforced use of 5-2-1-0 Healthy Habits questionnaire, integrated healthy weight conversations in well-child visits, and documented healthy weight counseling in electronic health records.

- BMI documentation found that approximately one-third of young children in First STEPS practices are overweight.
- Providers reported increased use of—and confidence in using—the 5-2-1-0 Healthy Habits questionnaire and motivational interviewing, but also reported a slight decline in engaging families in conversations about weight.

More practices are tracking overweight children and most reported regularly discussing health behaviors and assessing for symptoms of other conditions during follow-up visits both before and after First STEPS, but only a few practices used the Next Steps guide for themed follow-up visits.

- More practices reported having a system in place to track children ages 2 to 18 with BMIs over the 85th percentile (50% pre, 61% post), primarily through the electronic medical record.
- Both before and after First STEPS, most practices reported regularly having discussions with overweight children on topics such as healthy eating, physical activity, screen time, and family health during follow-up visits (94% pre, 89% post) and assessing symptoms of other conditions such as diabetes, hypertension, and sleep apnea (83% pre, 78% post).
- While four practices reported some use of the Next Steps guide, most practices reported they had not yet used this curriculum in their practice as it was not fully available to practices until after the initiative ended.
- Among practices that did focus on follow-up, many reported continuing challenges of engaging families of overweight children in follow-up.

No increase in specialty clinic referrals for overweight children was observed; practices reported continuing challenges such as gaps in availability and coverage of additional support services, transportation/distance to services, and lack of parent commitment and patient readiness to change.

- Few practices reported changes in their referral rates, which was confirmed by specialty clinics interviewed who saw no notable increase in referrals.
- Some practices mentioned frustration with a lack of resources to help parents and their children who are overweight that do not meet the stricter eligibility requirements of specialty clinics (i.e., higher BMI), but who may be in need of less intensive treatment and ongoing support such as nutritional services.

All practices found First STEPS Phase III valuable in supporting quality improvement.

- Practices reported that First STEPS helped them stay on task, provided helpful deadlines, and provided ongoing learning throughout the process that helped them continue their work on healthy weight and oral health.
- Almost all practices reported that the learning sessions were the most helpful component of First STEPS, providing the chance to network with other practices, share ideas and get feedback from other practices, and learn from each other about successes and challenges.
- Practices noted the need to have all providers involved and that doing provider-specific chart audits or having the screens integrated into the EMR helps engage and motivate providers and staff to participate.

System-Level Changes

Phase III provided an opportunity to educate practices and get feedback on new MaineCare billing and reimbursement policy for oral health evaluations of children under three years of age, and on Maine's supporting Oral Health Risk Assessment tool.

- The First STEPS focus on oral health provided IHOC with a platform to support MaineCare in assessing and modifying its policies related to oral health for very young children. This work resulted in expanding reimbursement of oral health evaluations to the primary care setting as one approach for improving access to preventive oral health care and increasing referrals to dentists.
- First STEPS also began to test the oral health evaluation dental code identified for use in primary care practices and helped inform MaineCare's communication of the new policy to all providers.
- While still too early to detect changes in oral health evaluation billing practices and related increases in preventive dental services among young children, identifying the code and instituting policy on its expanded use by primary care practices has provided the State with more data and information about how primary care practices are addressing oral health for young children, which can ultimately inform future work in this area.
- IHOC's extensive planning and engagement of the dental community in the development of the oral health evaluation billing policy and supporting OHRA tool, and within the First STEPS Phase III learning sessions themselves, was helpful in allaying scope of practice concerns in the dental community and creating buy-in and building relationships across different provider groups.

Conclusion

While half of the practices had some experience with fluoride varnish prior to First STEPS, integrating oral health risk assessments into well-child visits for young children was new for most of the practices that participated in Phase III. The First STEPS learning initiative helped increase practices' awareness of the need for dental caries prevention, and also increased the rates of these interventions within well-child visits for children under 4. Unlike topics addressed in other First STEPS phases (e.g. immunizations and developmental screening), providers had some exposure to conducting systematic oral health risk assessments or applying fluoride varnish, but started at a much less experienced level than in other phases. Despite this fact, First STEPS practices were able to make inroads into building oral health processes into the workflow of well child visits. However, billing for fluoride varnish continues to be a challenge for many, and implementing a new service such as the oral health evaluation and developing the billing and workflow processes to support that service within the EMR and administrative systems requires time. As a result, the effects of practice-level improvements may need to be studied over a longer period of time to fully capture their impact.

Compared to oral health, there was less change in First STEPS Phase III healthy weight efforts in part because many practices had already been performing above metric targets. Practices reinforced work they had already been doing through the *Lets Go!* initiative to document BMI and use the 5-2-1-0 Healthy Habits questionnaire to initiate conversations about physical activity and nutrition. While they reported some improvement in process measures through chart review or EMR, and exceeded targeted goals from the outset in documenting BMI, they fell short of the targeted counseling goals set by the initiative. Also very few practices chose to focus on implementing the Next Steps themed visits for children identified as overweight, which was not fully available to practices until the end of the initiative.

First STEPS Phase III helped facilitate system-level changes. Phase III's approach to quality improvement, including the requirement of gathering data to track progress and use of plan-do-study-act (PDSA) cycles, was highly valued by participating practices and provided the impetus for several health systems and practices

to automate oral health screenings in electronic medical records, which practices indicated is essential for integration into well-child visit workflow and standardized use across providers. The quality improvement approach used by First STEPS has also helped inform the continued training provided through other statewide initiatives going forward.

Finally, for the MaineCare program, the learning collaborative offered an opportunity to get feedback from providers on MaineCare's new oral health evaluation policy and to educate providers about reimbursement for this new service to help improve access to necessary caries prevention for young children. However, since these changes were being implemented simultaneously to the learning sessions, many practices were not able to achieve full automation until after the initiative ended. Since the full effects of these changes cannot yet be seen in administrative data, we plan to re-evaluate the impact on oral health prevention and use of dental services by young children over a longer period of time for a future report.

Introduction

In February 2010, Maine and Vermont were awarded a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to improve the quality of health care for children insured by Medicaid and the Children's Health Insurance Program (CHIP). Maine's Department of Health and Human Services' (DHHS) Office of MaineCare Services (OMS) received the Improving Health Outcomes for Children (IHOC) grant in partnership with the Maine Center for Disease Control, the Muskie School of Public Service at the University of Southern Maine (MSPS), Vermont's Medicaid Program, and the University of Vermont. In Maine, IHOC brings together public and private health stakeholders to standardize the delivery of preventive and follow-up care for children and to meet quality improvement goals of the Office of MaineCare Services.

As part of IHOC, Maine Quality Counts is leading the First STEPS (Strengthening Together Early Prevention Services) Learning Initiative to support Maine's pediatric and family practices in improving preventive and screening processes and building medical homes for children. First STEPS provides wide-ranging and in-depth quality improvement, coaching, data monitoring of standardized quality measures and educational support to pediatric and family medicine practices as they continue to enhance health outcomes for children. The First STEPS initiative also has helped facilitate and educate providers about policy changes made by the MaineCare program to support child health quality improvement.

The purpose of the First STEPS Learning Initiative is to increase the rate of Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services for children receiving MaineCare benefits by providing tools and data monitoring, offering comprehensive educational support, and engaging primary care practices in multiple change interventions to build patient centered medical homes for children. It is expected that improving rates of preventive services and proactively identifying children's unique needs will result in children and families accessing necessary medical and developmental services earlier, thereby reducing disease. As a result of these positive changes, it is anticipated that health outcomes for children and families in Maine will be improved.

The First STEPS Learning Initiative is being implemented in phases, with each phase focusing on different substantive topics:

- Phase I (September 2011 - April 2012) focused on childhood immunizations,
- Phase II (May 2012-December 2012) focused on developmental, autism, and lead screening for children, and
- Phase III (April 2013 - November 2013) focused on oral health and healthy weight.
- First STEPS 2014 (March 2014-September 2014) focused on developmental and autism screening for children and spreading the work of Phase II.

Topics for each phase were selected in collaboration with Maine Child Health Improvement Partnership (MECHIP) and focused on targeted priority areas defined by the Centers for Medicare and Medicaid Services

for CHIPRA quality demonstration grants. Specific topics selected also focused on child health measures that were lower than the national average or that could build on or inform existing quality improvement efforts or policy changes in the state.

In order to assess the impact of the First STEPS initiative, the Muskie School of Public Service is conducting an evaluation of each phase of the First STEPS initiative. The evaluation is designed to support system-level learning by assessing how First STEPS has helped improve quality of health care for children in participating practices and to inform design of future statewide child health quality improvement efforts. Using multiple data sources, the evaluation assesses the degree to which the learning sessions and associated programmatic and policy changes have helped improve screening and treatment of children in general and specifically children on MaineCare in participating practices.

This report summarizes evaluation findings from Phase III and assesses change in oral health and healthy weight screening rates, referrals and related office system procedures in participating practices. The report also highlights challenges encountered and lessons learned in implementing changes to office systems, in responding to state policy changes, and in collecting and tracking oral health and healthy weight measures at the practice-level to inform quality improvement. The report includes:

- An overview of the Phase III initiative, including the number of practices participating, measures to be improved, and targeted improvement goals;
- An analysis of changes in oral health and healthy weight screening rates and related office procedures before and after participation in the First STEPS learning sessions based on chart review/EMR, MaineCare administrative claims data, and self-reported pre/post office surveys; and
- Findings from interviews with participating practices and key stakeholders about how the initiative has affected practice workflow, communications with parents, identification of at-risk children, coordination of treatment and referral to dental and healthy weight community resources, as well as barriers to, and best practices for, improving oral health and healthy weight screening rates, and how the initiative influenced or facilitated broader systems changes.

Description of Phase III Initiative

First STEPS Phase III began in April 2013 and ended in November 2013 and focused on improving oral health and healthy weight screenings in participating primary care practices. The decision to focus on oral health and healthy weight was based on the need for improvement in these areas, as well as the desire to expand and build on existing efforts and priorities in the state. Healthy weight and oral health are priority areas for CMS and MaineCare and are included among the CHIPRA and Meaningful Use child health measures that states and providers are being asked to report. In addition, there had been several initiatives in the state focused on improving healthy weight and oral health preventive screening in primary care practices including the *Maine*

Youth Overweight Collaborative (MYOC),[4] *Let's Go!*,[5] *From the First Tooth* (FTFT) program,[6] and the *Maine Kids Oral Health Partnership*.[7] To help support these local priorities and spread the work of these programs and QI approaches to more practices in the state, First STEPS partnered with FTFT and *Let's Go!* for Phase III.

Let's Go! is a Maine-based nationally recognized childhood obesity prevention program funded by MaineHealth and others[8] that seeks to increase physical activity and healthy eating for children from birth to 18 through policy and environmental change in six settings including healthcare. Prior to First STEPS in primary care settings, *Let's Go!* had focused on improving documentation of BMI and the 5-2-1-0 survey[9] to help talk with families about healthy weight and prevention. In planning for Phase III, Quality Counts staff and *Let's Go!* partners assumed that most Phase III participating practices were already documenting BMI and initiating healthy weight prevention conversations using the 5-2-1-0 survey as most First STEPS practices had previously participated in *Let's Go!* trainings. *Let's Go!* was also in the process of finalizing a new tool – the Next Steps guide[10] – to facilitate discussions with families whose children are identified as being overweight through themed follow-up visits, which was being pilot tested in 6 pediatric practices.[11] First STEPS Phase III offered an opportunity for participating practices to be trained on using this new tool. However, in analyzing Phase III practices' responses to the initial office systems survey, First STEPS Phase III planners discovered that, while most Phase III practices were familiar and using the 5-2-1-0 survey, it was not always incorporated into their office workflows or consistently used across providers. As a result, Phase III shifted its focus to reinforce information about healthy weight prevention in the first learning session including using the 5-2-1-0 *Let's Go!* survey with patients, BMI documentation, and exposing practices to tools to improve discussions about healthy lifestyles, such as ChooseMyPlate.gov. While First STEPS provided a preliminary overview of Next Steps at the first learning session and on coaching calls, the more comprehensive Next Steps training and toolkit were not introduced or given to the practices until the end of Phase III (November 2013) when the AAP released the tools at the National AAP meeting in late October 2013.

The *From the First Tooth* Program in Maine promotes oral health in babies and young children, from birth to three years old at well visits by providing training to primary care providers in oral health risk assessments, fluoride varnish application, and dental home referral. Providing fluoride varnish for young children is a particularly important in Maine given that only 40% of Maine's total population is estimated to have fluoridated drinking water from public water supplies.[12] The initiative, which is offered at no cost to healthcare providers, is supported by the Sadie and Harry Davis Foundation in partnership with MaineHealth, Eastern Maine Health

4 http://www.hsph.harvard.edu/prc/projects/clinical-interventions-to-prevent-childhood-overweight/.

5 http://www.letsgo.org/.

6 http://www.fromthefirsttooth.org/.

7 http://www.kohp.org/.

8 Harvard Pilgrim HealthCare Foundation, Maine Medical Center, New Balance, United Way, Anonymous Donor, Communities Transforming, Hannaford, Walmart, Aetna Foundation, Maine Center for Disease Control and Prevention, Anthem Blue Cross Blue Shield, Communities Transforming, Poland Spring, Visiting Board of the Children's Hospital, Marta M. Frank, and the Tides Foundation. http://www.letsgo.org/partners/sponsors/.

9 http://www.letsgo.org/toolkits/hc-toolkits/.

10 http://shop.aap.org/Next-Steps-A-Practitioners-Guide-For-Themed-Follow-up-Visits-For-Their-Patients-to-Achieve-a-Heal/.

11 https://aap.confex.com/aap/2011/webprogram/Paper15072.html.

12 http://www.maine.gov/dhhs/mecdc/population-health/odh/water-fluoridation.shtml.

System (EMHS), MaineGeneral Health, and Boston University Goldman School of Dental Medicine. As a member of the FTFT Advisory Board, MaineCare was an early adopter of fluoride varnish reimbursement to physicians and has covered it in medical practices since 2008.

Prior to First STEPS, *From the First Tooth* had conducted trainings with providers in more than 73 practices in the state since its inception and helped increase rates of fluoride varnish application in primary care settings, but there was still room for improvement. Even though one or two providers within a practice may have received *From the First Tooth* training, use of fluoride varnish was not always adopted across the whole practice. Also, due to staff turnover in practices, there is also a continuing need for re-training. The First STEPS initiative, which engages practice teams in quality improvement, represented an opportunity to build off and expand on the successes of *From the First Tooth* to re-train or expand the number of practices receiving trainings. In addition, working with IHOC staff and First STEPS, the MaineCare program was in the process of developing a new policy to reimburse primary care providers for conducting oral health risk assessments (OHRA) to children under age 3 that had no dental home (code D0145); Phase III was an opportunity to inform practices of these changes and to implement OHRAs in pediatric and family practice.[13]

IHOC staff worked with *From the First Tooth* and MaineCare to develop a one page fact sheet for practices about what is covered, and developed an OHRA template that practices could use to determine a child's level of risk for oral health caries which included the following topics:[14]

- Question about the existence of a current dental home/dental provider;
- Risk screening questions based on oral health history (may be performed by clinical support staff);
- Risk assessment of the mouth and teeth (must be performed by a licensed provider – MD, DO, NP, PA);
- Oral health plan, including parent/patient education about establishing a dental home and referral to a dentist (when possible).

As in prior phases, the First STEPS Phase III training offered through Maine Quality Counts provided Maintenance of Certification (MOC) credit for providers that participated and agreed to MOC requirements (e.g. data collection). The intervention included two all-day learning sessions with national and local experts that presented current evidence-based practices around oral health and healthy weight topics, monthly webinars and "all practice" calls, tools for practices to track their progress in improving defined healthy weight and oral health measures and report on change efforts such as the Plan-Do-Study-Act (PDSA) cycles. Through the partnership with *Let's Go!* and FTFT, First STEPS also helped facilitate additional one-on-one trainings or re-trainings on-site at practices as needed by these programs. First STEPS also helped promote FTFT's 'Dining with the Dentists' meetings to allow primary care providers and dentists to meet one another in person to help

13 As of August 1, 2013, MaineCare added to their provider contracts that primary care providers could be reimbursed for conducting an OHRA for children under the age of 3 who do not have a dental home (code D0145). The reimbursement rate for D0145 is $20, with a maximum of two assessments per child during the calendar year. Reimbursement for the fluoride varnish application (D1206) is separate from reimbursement for the OHRA (D0145). Reimbursement for D1206 is $12, with a maximum of two applications per calendar year. http://www.fromthefirsttooth.org/healthcare-providers/state-pages/maine/#reimbursement.

14 This link shows the one page fact sheet about MaineCare policy for reimbursement of the OHRA: http://www.mainequalitycounts.org/image_upload/MaineCare%20Pilot%20of%20D0145%20Summary2.pdf.

This link shows the OHRA template that was developed, which practices can use to conduct the OHRA: http://www.mainequalitycounts.org/image_upload/Maine%20draft%20OH%20Risk%20Assess-Ref%20Tool%2012062013%20v20SHADED%5B1%5D.pdf.

build referral relationships.

How many practices participated?

All practices that had participated in First STEPS Phase I or Phase II and serve a high volume of children insured by MaineCare (24 practices) were invited to participate in Phase III. In addition, four new practices that expressed an interest were invited to participate in Phase III. Practices that agreed to meet the necessary requirements could receive MOC credit. Of the 28 invited practices, 19 practices (15 pediatric and 4 family practices) that serve an estimated 35,061 children[15] with MaineCare coverage (29% of children enrolled) participated in Phase III.

What were the measures and targets for oral health and healthy weight quality improvement?

Phase III set several goals to improve oral health and healthy weight measures by implementing changes in office procedures advocated by the American Academy of Pediatrics' Bright Futures Recommendations for Pediatric Preventive Care. Office system goals included incorporating healthy weight assessment and discussion with parents/children over age 2 and tracking BMIs and follow-up visits; and implementing oral health screening and fluoride varnish application for young children (<4) in the office workflow, discussing oral health with parents/children, and making referrals to healthy weight and dental providers.

The initiative set the following improvement targets for participating practices to achieve by the end of the learning session (between April 2013 and November 2013):

- Based on EMR and chart review data, at least 80% of children over the age of 2 will have:
  - BMI percentile documented in their chart
  - Documented counseling for nutrition and physical activity (e.g. utilizing the 5-2-1-0 Healthy Habits Questionnaire),
- Increase by 50% the number of children ages 6 months to 4 years with the following:
  - A documented oral health risk assessment
  - A documented dental home
  - Fluoride varnish applied (for children with a moderate/high oral health risk assessment and without a dental home)
- Between April 2013 and April 2014, increase by 5 percentage points the number of fluoride varnish applications for children ages 6 months to 4 years as documented in MaineCare claims data for participating practices.

Practices seeking MOC credit — all 19 participating practices — were required to report specific measures (see Appendix A) on a monthly basis through chart review (n=13) or through their EMR (n=6). Reporting using the EMR was used for practices in one health system that could report through their Clinical Improvement Registry (CIR), who reported on all children that had a well-child visit in the age groups that had been programmed in the existing measure specifications in the CIR system (e.g. 2-<12, and 12-18 for BMI). In contrast, chart review data is based on 20 charts per practice for multiple providers pursuing MOC credit, and 10 charts for a single

15 As of December 31, 2012 for children ages 18 and under.

provider pursuing MOC credit in a practice for children ages 2-4 years with a well visit in the last month.[16] Chart reviews were conducted between March and October 2013; EMR data was reported between April-October 2013.[17] Due to the different populations, age groups, and time periods for chart review and EMR data collection, results from these different data sources are reported separately in this evaluation.

First STEPS uses a data-driven quality improvement approach that measures progress in meeting targets throughout the process to provide feedback to practices and inform further refinements to workflow as needed. As in other phases, Phase III monthly reports were shared with each of the practice sites using random, de-identified codes to allow them to compare their own rates with average rates for all participating practices and with each of the other practices reporting chart review/EMR data.

Evaluation Methods

We used a mixed methods approach to evaluate Phase III using both quantitative and qualitative data. To assess the degree to which screening and referral rates had improved, we analyzed chart review/EMR data from reporting practices, administrative data supplied by other programs before and after the Phase III (i.e. April/May 2013 to November 2013), as well as MaineCare claims data for the same period and compared to the same time period in 2012. To assess the impact of participation on practice workflow, we analyzed self-reported pre/post office surveys completed by 18 participating practices and supplemented this data with information provided in interviews with participating practices and other key stakeholders and programs. Due to differences in monthly report data collected from chart reviews and EMRs described in more detail below and in Appendix A, these data are reported separately in this report.

Chart Review/EMR Data

Rates of change were analyzed for oral health and healthy weight screenings and compared from the first month of the initiative to October 2013. Chart reviews were analyzed to compare March 2013 to October 2013; EMR data were analyzed to compare April 2013 to October 2013.[18] Practices in one health system that was connected to the CIR reported EMR data through the CIR. As indicated above, the measures slightly differ between chart review and EMR due to differences in specifications of measures already determined in the CIR system (see Appendix A). While the reported CIR and chart review data calculated BMI measure stratifications (i.e. underweight, overweight, etc.) by the percent of all children in the practice, for the purposes of the evaluation, we re-calculated BMI stratification rates to reflect the percent of children that received BMI assessments (not all children in the practice). Reported data was also cleaned to exclude any data that did not meet minimum validation criteria (e.g. the number of charts reported on a measure could not exceed the total number of charts reviewed). Average percentages were calculated for each measure during April and October 2013 for practices

16 If there were less than 10 children that met the WCV and age criteria, practices expanded chart review to children aged 2-18 years for healthy weight measures, and children age 6 months to 4 years for oral health measures.

17 EMR data was reported in April instead of March due to oral health metrics going live in April 2013.

18 EMR data was reported in April instead of March due to oral health metrics going live in April 2013.

that reported data in both months.[19] Reported averages are not weighted by the number of patients served per practice.

MaineCare Claims

To assess the effect of the First STEPS Phase III initiative on MaineCare billing rates for oral health evaluation and fluoride varnish, we analyzed MaineCare claims billed by First STEPS participating practices relative to claims billed statewide by other primary care practices during the same period. We analyzed monthly paid and denied claims for fluoride varnish (D0126) and oral health evaluations (D0145) performed in a medical setting[20] for all children 6 months to 48 months that had a well-child visit at a First STEPS Phase III practice from April through November 2013 compared with similar children that had a WCV at other practices in the state. We also analyzed monthly and aggregated rates for First STEPS and all other practices statewide during the same period in the prior year (April 2012 to November 2012).

First STEPS Phase III practices and associated MaineCare children served at those practices were identified in claims using the list of providers seeking MOC during Phase III and practice level claims.[21] If a MOC provider practiced at another location other than the First STEPS practice, we included their claims in this analysis. All MaineCare children receiving services from these providers were then assigned to that First STEPS practice. Members included in the Phase III practices could have one or more months of claims associated with the provider in the practice. The age of the child was calculated based on the time of the claim.

The evaluation team also investigated approaches for assessing the impact of First STEPS healthy weight quality improvement and increased referrals to healthy weight clinics using MaineCare claims. Because BMI documentation and healthy weight counseling are not consistently reported by primary care providers on claims, we were unable to assess changes in healthy weight measures using MaineCare claims. The evaluation team attempted to identify healthy weight clinics in MaineCare claims to assess whether referrals to these entities had increased during First STEPS Phase III. However, due to anomalies in how these clinics bill MaineCare, we were unable to assess referrals through claims data.

Other Administrative Data

In addition to chart review and claims data, we assessed changes in Phase III referral rates for children with healthy weight issues to other community resources using other administrative data supplied by these entities. We requested referral data from the list of agencies that Phase III practices had indicated in qualitative interviews they had made referrals to for further healthy weight counseling and treatment. We requested statewide and Phase III practices' monthly referral numbers for pre and post periods (April/May 2013 and November 2013). One clinic (Countdown for ME) was able to provide information on the number of children referred from First STEPS practices and other practices in the MaineHealth system who received services from Countdown for ME during Phase III, and in the prior year. Another clinic reviewed their internal data and provided impressions of general trends in referrals for First STEPS practices in an interview but they were unable to provide specific

19 One practice reporting data through the CIR reported data for both of their clinics. This data was averaged with the other practices' rates to calculate an overall average.

20 Dental providers and FQHC/RHCs were excluded from the analysis.

21 Due to how billing in claims is coded, we used claims by the MOC providers and did not include practice level claims at four practices, since billing at the site level reported claims from more than one site.

numbers of children referred for the specified time frames.

Surveys of Oral Health and Healthy Weight-related Office Procedures

Changes in oral health and healthy weight screening office procedures were assessed before and after First STEPS participation using the *Oral Health and Healthy Weight Office Systems Survey* (April 2013 and November 2013). The survey was developed by Maine Quality Counts, *Let's Go!* and *From the First Tooth* staff, and other stakeholders in collaboration with evaluators at the Muskie School of Public Service, drawing from existing surveys utilized in similar initiatives or identified in the literature.[22] The Phase III office systems survey assessed the frequency with which practices implemented certain office processes and procedures known to be effective in raising oral health and healthy weight screening rates and improving quality of care. Survey domains of specific office processes and procedures included:

- Healthy Weight
  - Assessment and documentation
  - Follow-up and referral
- Oral Health
  - Assessment of oral health issues
  - Treatment and referral

Eighteen of the 19 practices participating in Phase III completed both the pre and post survey; one practice answered only the pre survey. Our analyses of the office system surveys is limited to the eighteen practices that responded to both the pre and post surveys. For each question, responses were only analyzed for practices that responded to that question in both the pre and post survey. Detailed survey results are available upon request.

Interviews with Practices and Other Key Stakeholders

To assess providers' experience with First STEPS Phase III and its impact on practice change as well as perceptions of how the initiative contributed to broader system changes, we reviewed practice reports and conducted interviews with First STEPS Phase III practices and other key stakeholders. The interviews with practices and key stakeholders were semi-structured, lasted 30-60 minutes, and took place between January-March 2014 for practices, and between March-April 2014 for stakeholders.

All First STEPS Phase III practices were invited to participate in these interviews; fifteen of the nineteen practices agreed to participate. Interview questions focused on practice changes and improvements made by providers since participating in Phase III, perceived effectiveness of these changes, lessons learned in implementing improvements, recommendations for other practices that try to make similar changes, the perceived value and satisfaction with tracking oral health and healthy weight screening data, and reflections on participating in First STEPS generally. Given that many practices were using their EMR to gather practice-level data, we also asked specific questions of these practices and the larger health system about their experience in using the EMR to collect these child health quality measures at the practice-level. We analyzed monthly reports completed by practices and submitted to Quality Counts describing their PDSA activities and team assessment surveys. Results from interviews and monthly reports were analyzed for recurring concepts, themes, and patterns. We also interviewed practice coaches to get their perspective on the implementation of Phase III.

22 A copy of the full office systems survey is available on request.

Interviews with stakeholders were also conducted to assess the perceived impact of the First STEPS initiative on other programs or policymaking in the state. Stakeholders included those who presented at or participated in the Phase III learning sessions or planning process and those who were identified through interviews with the practices as being key community partners. Stakeholders interviewed included representatives from: *Let's Go!*, *From the First Tooth*, EPIC/CIR, Zing!, WOW, Quality Counts, Countdown for ME, MaineCare program and policy staff, presenters at First STEPS learning sessions, and IHOC staff involved with MaineCare on policy development. Semi-structured interviews focused on the perceived impact of First STEPS Phase III on referral rates to related providers, barriers encountered, and system-related changes resulting from the initiative.

Evaluation Limitations

The evaluation uses a pre/post design and had no control group to measure factors other than the First STEPS learning sessions that may have contributed to oral health and healthy weight screening rate improvements. We also relied on self-reported changes in office practices and procedures by the participating practices. The office system survey was administered by Maine Quality Counts as part of the initiative which may have biased responses towards demonstrating improvement. We did not analyze the statistical significance of changes due to the small number of practices reporting. In addition, oral health and healthy weight screening rates are based on random charts selected and reviewed by practices or based on EMRs.[23] Given differences in how these data were collected, results could not be combined. For chart review, given the small number of charts reviewed, changes in percentages are more likely to show large fluctuations. Lastly, there were other related initiatives and policy changes that occurred in Maine in the recent past that may have influenced screening rates that we could not control for in this evaluation.

Findings

Oral Health Practice-Level Improvement

Most practices focused on integrating oral health risk assessment and increasing fluoride varnish during well child visits for young children.

As in other phases of First STEPS, Phase III practices were allowed to choose which topic areas to focus on for their quality improvement work on within their practice. Based on interviews with the practices, many felt they had already worked on healthy weight and had integrated *Let's Go!* 5-2-1-0 surveys into their practice. Far fewer had been doing fluoride varnish or doing oral health risk assessments, and thus felt there was a greater need to focus on improving oral health screening.

Nearly all practices (14 out of 15 interviewed) worked to integrate an oral health risk assessment into well child visits for young children, which was new to the vast majority of practices. While some practices ask about whether older children have a dental home (>age 3), most had not had these conversations during WCV for

23 Twenty charts were reviewed per practice for multiple providers, and 10 charts for a single provider in a practice.

younger children. The few practices that had previously asked some oral health questions of parents of children under 3 expanded the list of questions asked to include the same or similar questions to those that had been developed by the MaineCare program that were shared at the Phase III learning sessions. Practices also worked to integrate OHRAs into the practice workflow with several building the form or questions into their EMR.

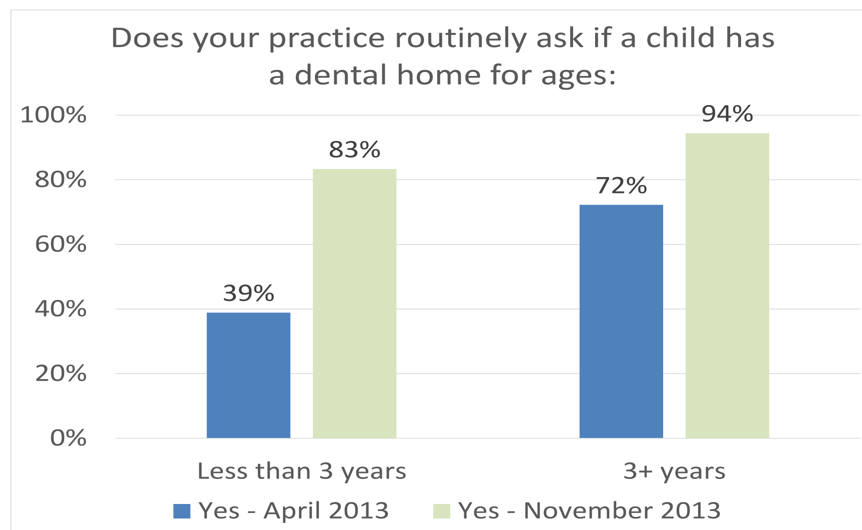
More than half of Phase III practices had been doing fluoride varnish prior to First STEPS and many had received prior trainings from FTFT. During Phase III, these practices worked to standardize FV use across providers or to occur at all well-child visits for children under age 3. FTFT also provided training or retraining to 13 practices during Phase III, with four of these practices having not received training previously. Most practices reported that they phased in new workflow changes with one or two providers, before spreading it to the rest of the practice.

Greater use and confidence reported by practices in discussing dental home and other oral health topics with parents of younger children.

Based on interviews with the practices, First STEPS Phase III increased providers' awareness and appreciation of the value of discussing oral health at well child visits for children age 3 and under, many of whom may not have access to dentists. After participating in Phase III, many practices reported talking more with parents of young children about oral health issues and increasingly recommending that children under age 4 see a dentist for oral healthcare.

Based on office system surveys, before Phase III only 39% of practices indicated they routinely asked if children under age 3 had a dental home. After Phase III, 83% of practices were routinely asking this for young children, which was much closer to rates for older children (Chart A).

CHART A

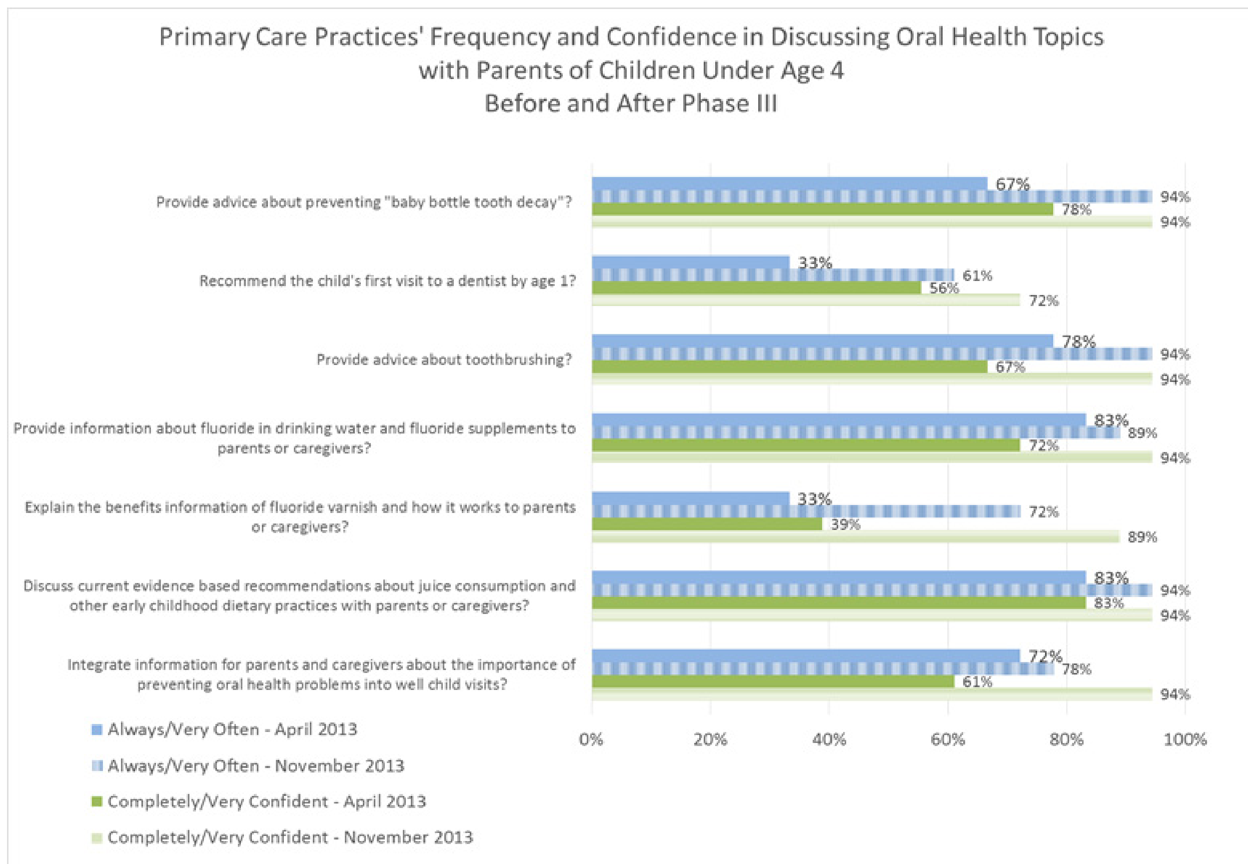


Data Source: First STEPS Phase III Office System Survey, n=18 practices reporting.

All practices completing surveys believed that primary care practices have a role in preventing dental disease

(94% pre, 100% post – data not shown). Practices also reported increased frequency of discussing oral health prevention topics with parents in all areas but particularly in discussing baby bottle tooth decay (67% pre vs. 94% post reporting very often or always), explaining the benefits of fluoride (33% pre, 72% post) and in recommending the first dental visit by age one (33% pre, 61% post). Providers also reported increased confidence in having these discussions, but particularly increased confidence in their ability to provide advice on toothbrushing (67% pre, 94% post reporting completely or very confident), discuss the benefits of fluoride varnish (39% pre, 89% post) and integrate oral health prevention discussions into well-child visits for young children (61% pre, 94% post). (Chart B)

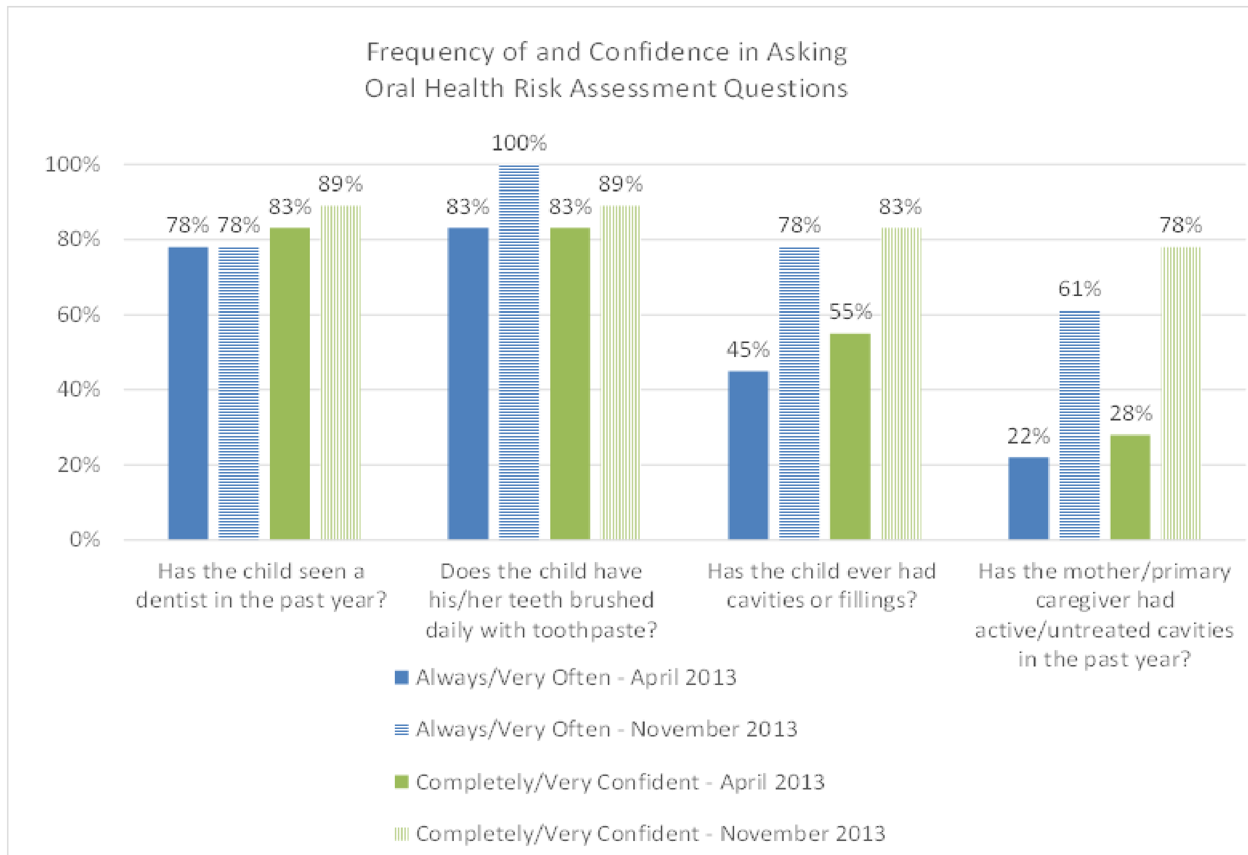
CHART B



Data Source: First STEPS Phase III Office System Survey, n=18 practices reporting.

For specific oral health risk assessment questions, most practices reported both before and after Phase III that they always/very often asked whether the child had seen a dentist in the past year (pre and post 78%) and asked about daily toothbrushing (83% pre to 100% post) and high levels of confidence in doing so. The largest increases after Phase III were in the frequency of practices asking and confidence in discussing if the child ever had cavities or fillings (e.g. 45% pre reporting they very often or always discuss vs. 78% post), or if the mother/primary caregiver had active/untreated cavities in the past year (28% pre reporting completely/very confident vs. 78% post) (Chart C).

CHART C



Data Source: First STEPS Phase III Office System Survey, n=18 practices reporting.

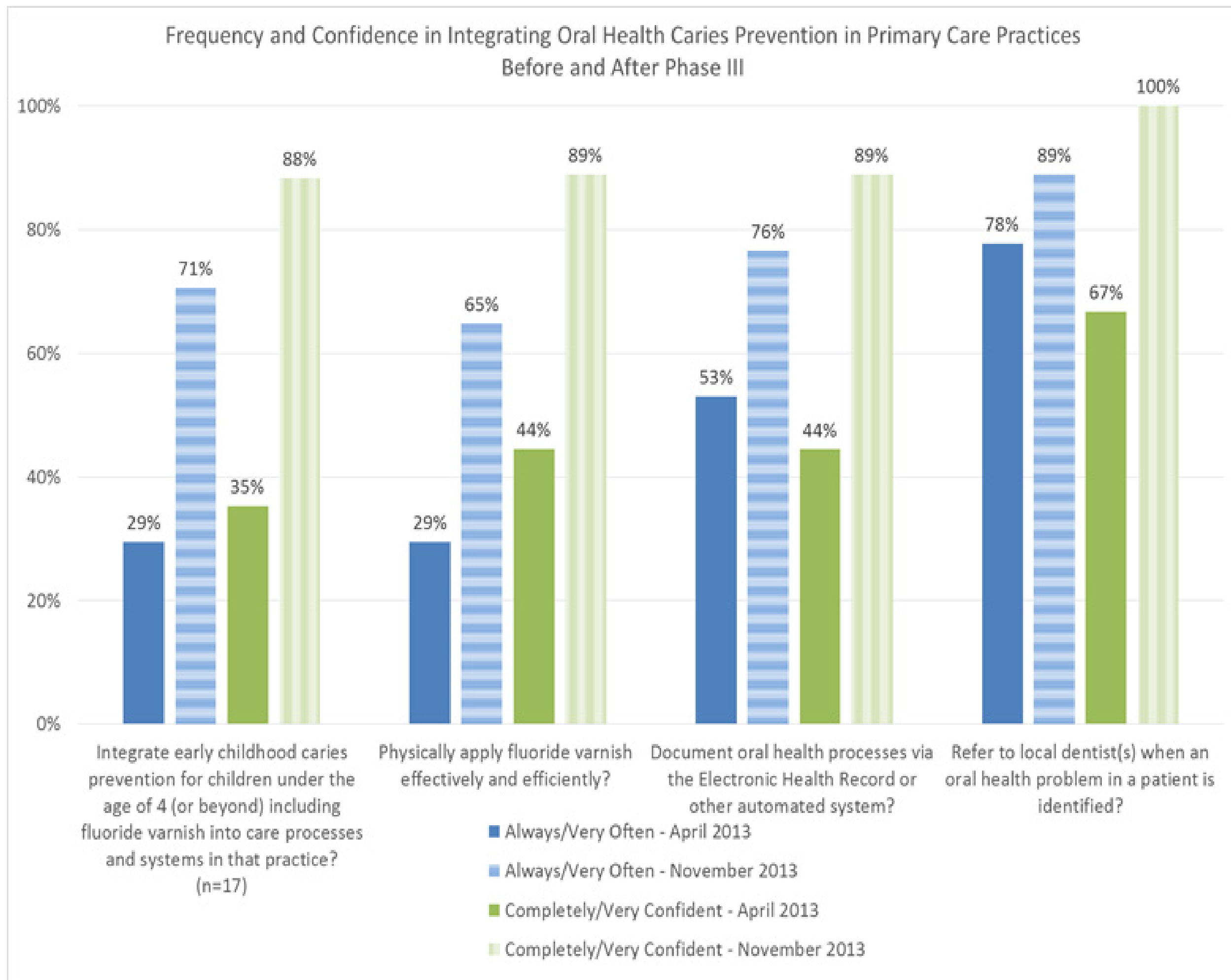
Increased integration of caries prevention, documentation of OHRA and dental homes, and dental referrals for children under age 4 while fluoride varnish remained constant.

Based on both office system surveys and EMR/chart review data, First Steps Phase III practices are increasingly implementing and documenting caries prevention during well-child visits for young children. As shown in Chart D, a much larger percentage of practices reported that they were always/very often integrating childhood caries prevention into WCVs for children under age four (from 29% to 71%) and were confident doing so after participation in Phase III (from 35% to 88%). Practices also showed moderate increases in their use and confidence in documenting oral health processes in the EMR or automated system, and in referring young children to a dentist when an oral health problem is identified (Chart D).

Monthly chart review and EMR data, confirmed that documentation of the oral health risk assessment and the percent of children with a dental home documented increased after Phase III, largely exceeding the Phase III target to increase these measures by 50%. (Chart E and F). For practices reporting through the EMR, documentation of OHRA increased three-fold (345% increase) from 11-49%, and documentation of dental homes increased from 22-29% (@32% increase). In contrast, practices doing chart review reported a greater

than 150% increase in dental home documentation (from 17-44%) and a 33% increase in documenting OHRA in charts (from 43-57%).

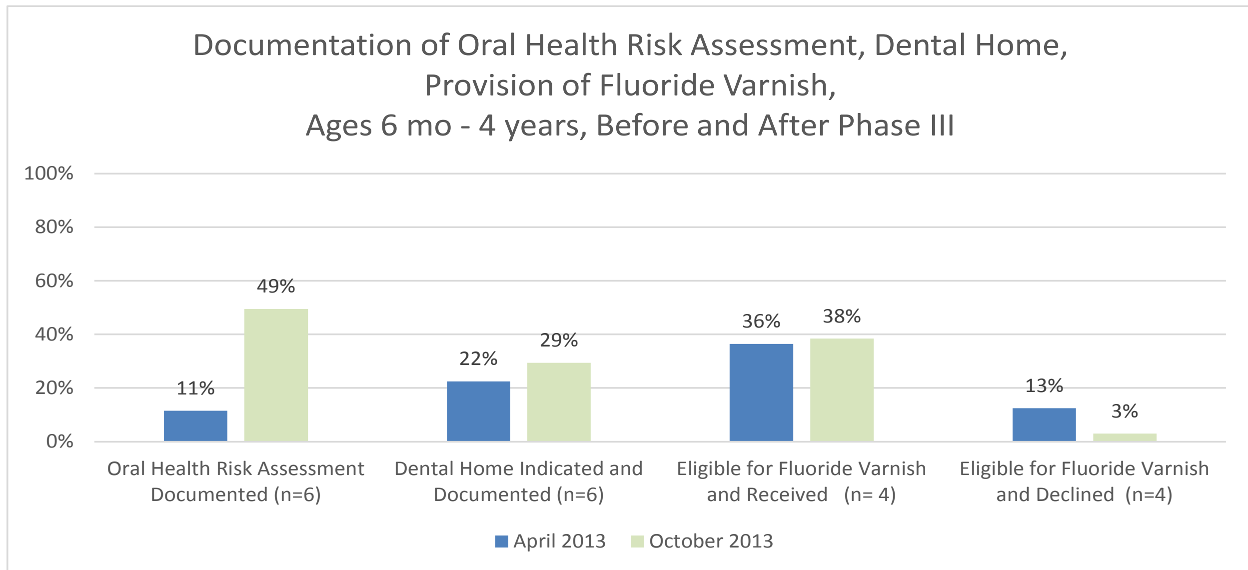
CHART D



Data Source: First STEPS Phase III Office System Survey, n=18 practices unless noted otherwise.

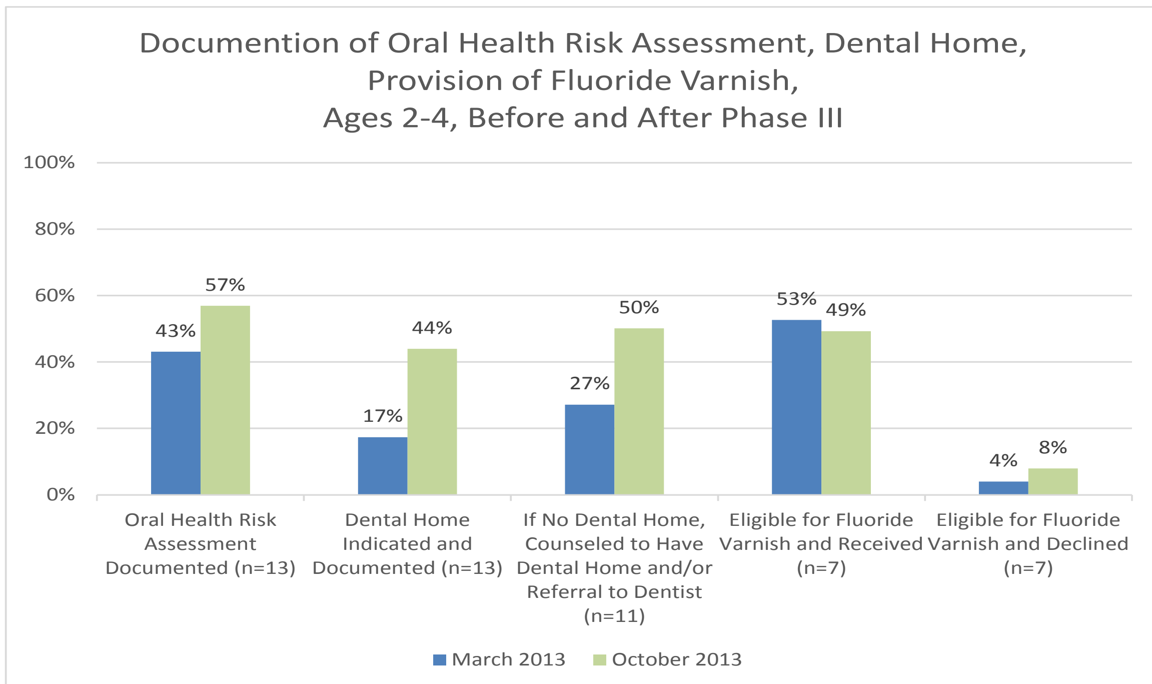
While practices indicated they were increasingly very often or always applying fluoride varnish effectively and efficiently (from 29% to 65%) as well as being very or completely confident in applying it (from 44% to 89%) in office system surveys, there was little change in the percent of eligible young children receiving fluoride varnish as reported in charts/EMR monthly data which remained at approximately one third of children for children ages 6 months-4 years and about half for children ages 2-4 (Charts E and F).

CHART E



Data Source: Monthly data for April 2013 and October 2013 reported from the CIR registry to First STEPS, n=number of practices reporting

CHART F



Data Source: Monthly chart review data for March 2013 and October 2013 collected by practices and reported to First STEPS, n= number of practices reporting

Integrating the new oral health risk assessment into EMR is challenging, but once implemented providers found it very useful for integrating into well-child visit.

Based on practice interviews, 12 practices tried to modify their EMR to include an oral health risk assessment, including five practices in the MaineHealth system that were using the CIR to report monthly data for First STEPS monitoring. Most of these practices indicated that the process of integrating the OHRA and/or entering and billing for fluoride varnish through the EMR was challenging and took longer than expected. However, despite the challenges, most reported that it was critical for successfully integrating the OHRA as part of the well-child visit workflow for all providers.

The MaineHealth system and related practices faced even greater challenges as the first system to attempt to integrate the OHRA because they were also simultaneously transitioning to a new EMR across the system. Thus the challenge of prioritizing OHRA integration in the queue of change requests was multiplied by transitional challenges that are common to introducing new EMRs. During the transition to a new EMR, some of the links to the existing CIR registry — which providers had been using to record fluoride varnish, other oral health questions and for tracking BMI — were temporarily broken. This problem, which was not immediately identified in the transition, resulted in EMR data showing much lower rates than practices were actually providing.

The change to a new EMR also resulted in the need for workflow changes in where the data needed to be entered for documentation and billing purposes, which were not fully communicated to practices. At the time of our interviews several months after the initiative had ended, many of these problems had been fixed and the process had improved. However, problems with the new EMR led to lack of confidence that the monthly data reported to First STEPS fully captured the changes practices were making until the end of Phase III. One practice indicated that, while data on oral health and healthy weight were technically available in the EMR in April 2013, they changed the location of where to document data in the EMR in September 2013, which could impact documentation data reported in later months. While practices expressed challenges with the data during the initiative, they acknowledged that the monthly data they got during First STEPS — which they had not received previously — helped highlight problems in how the EMR was capturing oral health data, reporting measures, and billing for services. In reviewing their monthly reports, many First STEPS practices did not believe that the CIR monthly reports accurately reflected the work they were doing. This feedback loop led to further investigations and ultimately resulted in changes to the EMR that led to more accurate data collection for measure reporting and billing.

Despite challenges, all the practices that successfully implemented the OHRA into the EMR said it was worth the effort. One practice had initially tried to implement a paper-based OHRA but was unable to get provider buy-in until they automated the screening questions into their EMR. Having the information in the EMR as part of the well-child visit template helps providers by integrating it into the existing practice workflow and documentation process, rather than requiring providers to fill out another form.

Billing MaineCare for fluoride varnish increased, but the number of children with a FV claim varied by practice; only one practice billing for OHRA due to delays in automating in EMRs.

An increasing percentage of practices reported that they had a specific workflow process in place to provide fluoride varnish during patient visits (56% pre, 94% post; data not shown) and there was an increase in practices reporting that they were billing MaineCare for fluoride varnish (Table A)

TABLE A

To what extent does your practice bill the following payers for fluoride varnish?	Always	Very Often	Some-times	Rarely	Never	Don't Know
MaineCare Pre	53%	6%	6%	0%	24%	12%
MaineCare Post	71%	12%	0%	18%	0%	0%
Commercial insurance or employers Pre	53%	6%	0%	0%	24%	18%
Commercial insurance or employers Post	47%	18%	6%	24%	0%	6%

Data Source: First STEPS Phase III Office System Survey, n=17 practices reporting.

MaineCare claims analyses confirmed that the number of practices billing for fluoride varnish increased from 8 in 2012 to 10 in 2013,[24] however it was less than the rates self-reported by practices. Between April through November 2013, the number of members with FV claims by practice across the time period ranged from 1 to 372, with six practices having fewer than 10 members with FV claims billed (data not shown).

As the final MaineCare reimbursement policy for the OHRA was not issued until August 1, 2013, many practices indicated in interviews that, while they were doing OHRAs, very few of them were able to incorporate this newly reimbursable service into their EMR and billing systems until the end of the initiative. Many practices indicated that they experienced problems in billing or did not begin billing until after Phase III ended. This was confirmed in our analysis of MaineCare claims, which revealed that only one First STEPS practice billed for OHRAs conducted for children age 4 and under that had a well-child visit during the study period (Table B).

Fluoride varnishes billed to MaineCare by First STEPS practices exceeded the targeted goal of 5 percentage point increase, but was largely concentrated in a few practices and comparable to 2012 rates.

During Phase III, First STEPS practices increased billing MaineCare for both fluoride varnish and OHRA. From April to November 2013, the percent of fluoride varnishes provided across all practices during well-child visit and billed to MaineCare increased from 13% to 21% — or 8 percentage points — which exceeded the First STEPS Phase III targeted billing increase of 5 percentage points. Billing rates for OHRAs also exceeded this target even though only one practice was able to bill during the study period due to it being a newly billable service.

When compared with same period (Apr-Nov) in 2012, MaineCare billing rates for OHRA in first STEPS practices similarly increased at a greater rate than statewide, which was expected because the new policy was not released statewide until August 2013. However, billing for fluoride varnish in First STEPS practices showed no change from the prior year, while statewide rates increased.

24 Data does not include the one FQHC practice participating in First STEPS Phase III.

TABLE B

MaineCare Total Claims for Fluoride Varnish (D1206) and Oral Health Evaluation (D0145) Provided to Children Age 6-48 months with a well-child visit in First STEPS Phase III practices compared to other primary care practices statewide

% /# of Members w/ WCV Receiving Fluoride Varnish and Oral Health Evaluation at Primary Care Provider (PCP)		Apr 2013	Nov 2013	% Point Change	Overall Apr-Nov 2012	Overall Apr-Nov 2013	Overall % Point Change
First STEPS Practices	Number of Members w/ WCV	562 n=18	462 n=18		3195 n=18	3040 n=18	
	% /# receiving Fluoride Varnish (D1206)	13% 71 n=5	21% 95 n=6	+8	23% 743 n=8	23% 714 n=10	0
	%/# receiving Oral Health Evaluation (D0145)	0% 0 n=0	10% 47 n=1	+10	0% 0 n=0	7% 203 n=1	+7
Statewide Other Primary Care	Number of Members w/ WCV	2053	1772		10534	10332	
	%/# receiving Fluoride Varnish (D1206)	8% 172	11% 195	+3	10% 1016	16% 1632	+6
	%/# receiving Oral Health Evaluation (D0145)	0% 0	0% 6	0	0% 1	0% 26	0

Source: Total MaineCare paid and denied claims data as of 3/20/15. First STEPS practices (n=number of practices with data). Data shown excludes multispecialty (e.g. FQHC/RHCs), including one Phase III First STEPS practice that is a FQHC. Statewide Other Primary Care excludes First STEPS practices, dental and multispecialty providers.

First STEPS practices may have shown no change from the prior year due to billing problems in one large health system that began in the Fall of 2012 and were not resolved until Aug/Sep 2013. Analyses of monthly MaineCare claims (data not shown) revealed a sharp decline in fluoride varnish billing in late 2012 which persisted through the beginning of 2013 until several months into Phase III. Based on further investigation with practices, these reductions in the number of billed fluoride varnishes during 2012 may be associated with billing problems as well as the loss of a dental hygienist in one practice that had the highest fluoride varnish rates. These issues preceded Phase III, but their effect persisted into the middle of 2013 therefore affecting billing rates relative to the prior year. Due to these data challenges, cross year comparisons should be interpreted with caution. These challenges also highlight the limitations of administrative claims in assessing practice-level improvements.

While the First STEPS initiative exceeded the targeted goal of a 5 percentage point increase in MaineCare FV billing, this increase was primarily concentrated in a few participating practices. Five practices increased their MaineCare billing for fluoride varnish by 3 to 27 percentage points, two of which had not previously billed MaineCare for this service. MaineCare FV billing declined slightly in 2 practices and eleven practices did not bill MaineCare for fluoride varnish in either period. Some of these variations may reflect differences in the

volume of young children receiving WCVs at participating practices in a month, which varied considerably by practice from 0 to 143, and/or differences in the number of children with a dental home that didn't receive FV in the primary care practice. In fact, one large practice was responsible for over half (65%) of all FV claims for children under age 4 in November 2013 (Table C).

TABLE C

MaineCare Total Claims for Fluoride Varnish (D1206) Provided to Children Age 6-48 months with a well-child visit in First STEPS Phase III practices by practice

%/# of Members with WCV Receiving Fluoride Varnish at PCP by Practice		**Apr 2013**	**Nov 2013**	**% Point Change**
Practice A	Number of Members w/ WCV	143	121	
	%/# receiving Fluoride Varnish (D1206)	24% 35	51% 62	+ 27
Practice B	Number of Members w/ WCV	9	4	
	%/# receiving Fluoride Varnish (D1206)	0% 0	25% 1	+ 25
Practice C	Number of Members w/ WCV	44	31	
	%/# receiving Fluoride Varnish (D1206)	0% 0	23% 7	+ 23
Practice D	Number of Members w/ WCV	91	51	
	%/# receiving Fluoride Varnish (D1206)	26% 24	31% 16	+5
Practice E	Number of Members w/ WCV	24	21	
	%/# receiving Fluoride Varnish (D1206)	21% 5	24% 5	+ 3
Practice F	Number of Members w/ WCV	86	69	
	%/# receiving Fluoride Varnish (D1206)	7% 6	6% 4	- 1
Practice G	Number of Members w/ WCV	46	57	
	%/# receiving Fluoride Varnish (D1206)	2% 1	0% 0	- 2
Practices H-R (11 Practices with No FV claims)	Number of Members w/ WCV	133	124	
	%/# receiving Fluoride Varnish (D1206)	0% 0	0% 0	0

Data Source: MaineCare paid and denied claims combined for fluoride varnish (D1206). Data shown excludes one Phase III First STEPS practice that is a FQHC. Note well-child visit totals differ slightly from those shown in Table B due to differences in how claims are billed for some providers at the practice level.

Some improvement in finding dentists that accept young children but continuing gaps in access and parents taking young children to dental referrals.

While practices worked on increasing referrals to dentists, they still encountered challenges finding dental practices that would accept MaineCare and would treat young children. The biggest challenge noted was that dentists in their area do not see kids under the age of 3 or don't accept MaineCare. Some practices (n=4) indicated that there was still resistance by some of their providers to referring that still did not agree that kids under age 3 need to see a dentist. In terms of follow-up and making appointments with dentists to whom they had referred, three practices mentioned that transportation/travel costs provided a challenge for some, especially if the only dental provider that accepted MaineCare was far away. A few practices mentioned the challenge of parents not wanting to pay for a dental visit for children under age 3, or the out-of-pocket costs to see a dentist if they do not have dental insurance or MaineCare.

First STEPS tried to address several of these challenges, by providing practices with several resources to support dental referrals including sharing information on dentists in different areas that accept MaineCare, which many practices found extremely helpful. Several practices used these lists, or developed their own list of dentists in their area that accept children under age 3 and those that accept MaineCare, and provided this list to patients as a resource. Three practices indicated that their increased knowledge and understanding about dental resources in their area helped increase their referrals to pediatric dentists. Another practice worked with the dental clinic associated with their practice to streamline the referral process and created a new electronic referral process between the primary care provider (PCP) office and the dental clinic. The dental clinic calls the parents after notification of a PCP referral to schedule an appointment to improve the likelihood of the parent following up and coming in for a dental visit. Even with these changes, parental follow-up remains a challenge as this practice did not see an increase in dental follow-up visits for young children. Other practices arranged to have a dental clinic that comes to their office to provide oral health services. One of these practices mentioned that they've been trying to get this in place a year ago, but First STEPS Phase III helped facilitate implementing it in their office.

First STEPS also coordinated with *From the First Tooth* to facilitate Dining with the Dentists. Dining with the Dentists provides a time for local dentists to meet with primary care practices to meet each other and discuss referrals and oral health for children. While several practices mentioned they had not done this yet but planned to, practices that had participated indicated it was very helpful. As one practice reported, "We now have someone we can refer our patients to." Another practice said these informal gatherings not only introduced the local dentist to the primary care team for the first time, but it also helped confirm that their current referral process was working well.

To evaluate whether increased discussion of oral health topics and dental referrals by primary care practices resulted in increased use of dental services by young children, we did a preliminary analysis of MaineCare dental claims but concluded that detecting an effect on dental service use requires a longer timeframe given the time lag between referrals and scheduled dental appointments. For a future report, we will assess how changes in First STEPS practices across phases have been sustained over time, which will include an updated analysis of fluoride varnish and OHRA rates in these practices and dental utilization by children receiving well-child visits at these practices over a longer timeframe (12 months after Phase III).

Healthy Weight Practice-Level Improvement

Practices reinforced existing healthy weight prevention conversations and documentation in electronic medical records, but smaller number of practices focus on follow-up for children identified as being overweight.

Based on PDSAs and interviews with practices, most practices focused on reinforcing existing healthy weight prevention and documentation that was already underway prior to Phase III; only 7 practices focused on enhancing processes of follow-up and/or referral for children identified as being overweight. Many practices indicated they had already integrated the 5-2-1-0 Healthy Habits questionnaires and BMI documentation in their practice as a result of their participation in *Let's Go!*

Despite the initial expectation that most First STEPS practices had previously worked with *Let's Go!* and had been using the 5-2-1-0 survey to initiate conversations with parents, the initial office systems survey revealed that one quarter of practices did not report using 5-2-1-0 very often or always at well-child visits and one third were not confident in using the survey. As indicated above, on seeing these survey results, Phase III planners decided to shift some of the substantive content of the healthy weight portion of Phase III learning sessions toward reinforcing preventive *Let's Go!* work before introducing Next Steps for children identified as overweight. This was reflected in what practices elected to focus on. During Phase III, most practices indicated they reinforced work they had already begun to raise awareness about healthy weight, emphasize the importance of documentation, improve the consistency in providing the survey to patients, and standardizing the use of surveys across all providers to prompt discussions with parents and children about healthy weight at well-child visits. Several practices also tried to integrate healthy weight screens and/or documentation into their EMR. Four practices that had not used the 5-2-1-0 survey prior to Phase III, began using or tested using it during well child visits.

In general, most Phase III practices have parents fill out the survey before their office visit or in the waiting room using paper forms but a few began scanning or entering the results in the chart for the doctor to access in the exam room to facilitate conversations with the parents. MaineHealth's EMR system had included a question to indicate if the 5-2-1-0 survey was administered, but it did not include all survey questions. Since Phase III, MaineHealth has begun testing having the questions in their patient portal (MyChart), and having parents fill out this information electronically prior to their visit. Two practices in Phase III mentioned that using the 5-2-1-0 helped providers start discussions with kids and families about a healthy lifestyle. As one practice reported, "[the 5-2-1-0 survey] has become part of the architecture of the well child visit."

"[the 5-2-1-0 survey] has become part of the architecture of the well child visit."

Most practices tracked BMIs prior to Phase III, but several practices did work during Phase III to improve this process and/or standardize it across providers. Some of the improvements included more consistency in identification and charting of BMIs over the 85th percentile, following up with patients that have a high BMI but no referral in the chart, adding a flag in the chart to talk with parents of children with high BMIs, querying patients with high BMIs to help identify patients for follow-up visits, and sharing BMI tracking with providers in the practice. In addition, one practice mentioned that BMI was recently added to their EMR.

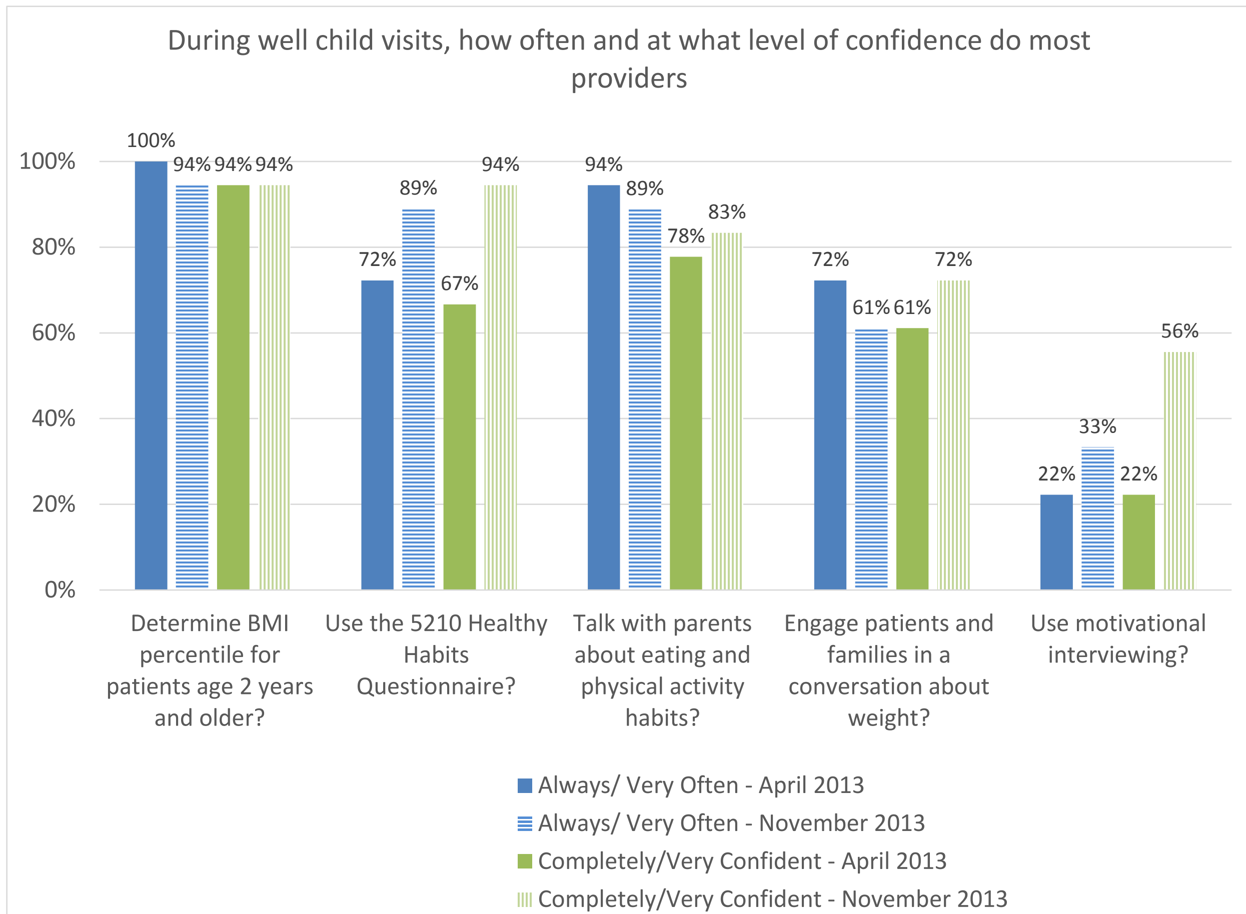
One practice mentioned that they have seen behavior changes in some of their patients, such as not playing video games all day long. As one provider stated, "The issue of overweight can feel so overwhelming... Phase III really energized me and got me thinking about high BMI, paying attention to healthy weight…[and] gave me the resources [and confidence] to have the conversations with patients and their parents, to make it feel more natural…[and] to come back and follow-through on trying to make changes." Other practice re-iterated some of these statements, mentioning that conversations with patients/parents have changed, and that tools presented at the Learning Sessions such as My Plate are being used to help discussions.

"The issue of overweight can feel so overwhelming... Phase III really energized me and got me thinking about high BMI, paying attention to healthy weight…[and] gave me the resources [and confidence] to have the conversations with patients and their parents, to make it feel more natural…[and] to come back and follow-through on trying to make changes."

Increased use of 5-2-1-0 surveys and motivational interviewing with parents, but slight declines in engaging families in conversations about weight

On pre/post office systems surveys, practices reported little change in their use or confidence in determining BMI for children ages two and older as rates were already high at 94% or above, and slight declines in engaging families in conversations about weight and eating/physical activity habits after Phase III, but greater use of the 5-2-1-0 Healthy Habits Questionnaire, and used motivational interviewing techniques (Chart G).

CHART G

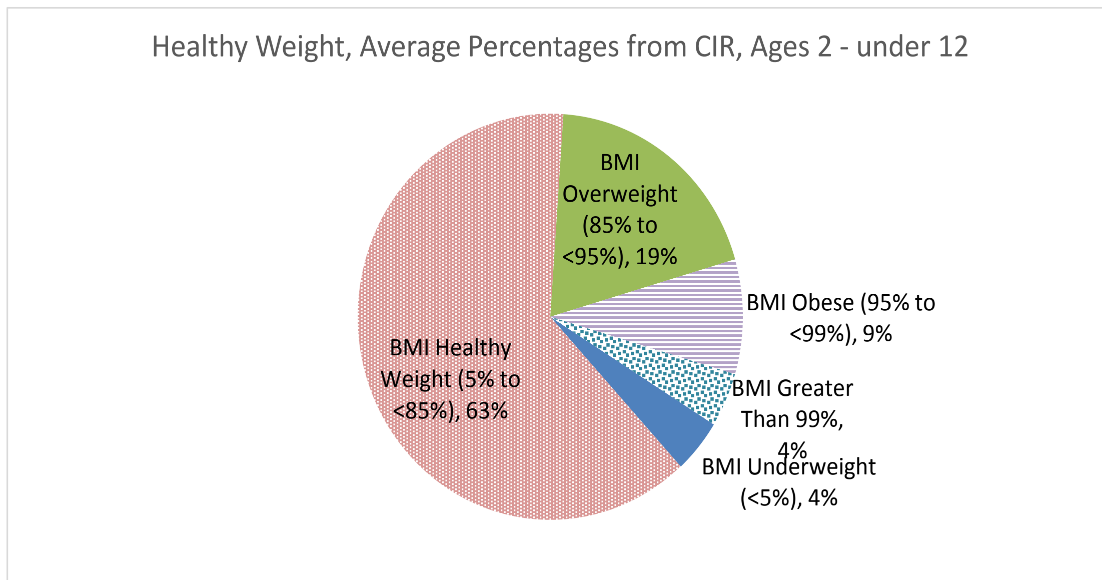


Data Source: First STEPS Phase III Office System Survey, n=18 practices reporting.

BMI documentation was high with approximately one third of children being overweight; some increases in documentation of 5-2-1-0 surveys for physical activity and nutrition counseling but below initiative target.

Nearly all patients (97-100%) in Phase III practices had their BMI assessed and documented, both before and after the initiative far exceeding the initiative targeted rate of BMI documentation for at least 80% of children. As shown in Chart H, based on CIR data in Oct, slightly less than two thirds of children age 2-12 had a healthy weight (63%), a small percent were underweight (4%) and one third were overweight or obese (BMI >85%) (32%). Chart review BMI levels for children age 2 to 4 revealed comparable rates (data not shown).

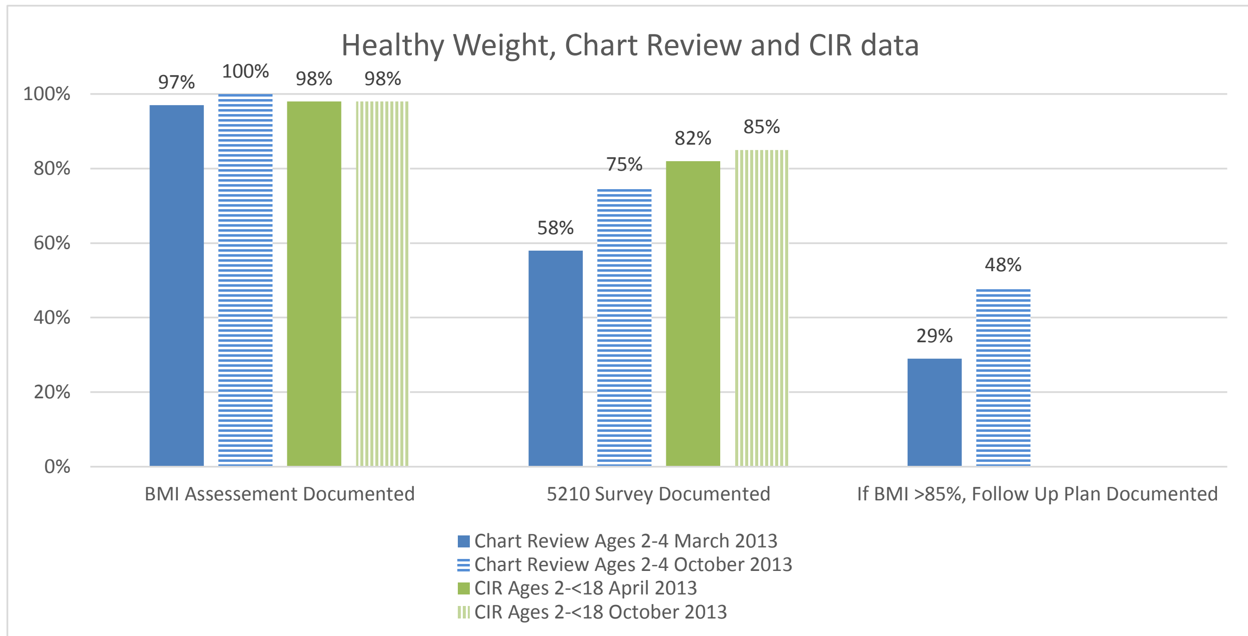
CHART H



Data Source: Monthly data reported from the CIR registry to First STEPS, October 2013, n=6 practices reporting.

Documented use of 5-2-1-0 surveys and resulting counseling on physical activity and nutrition in charts increased for practices doing chart reviews (58% to 75%) after Phase III, but did not reach the targeted Phase III goal of increasing counseling by 50%. Practices reporting data through the CIR also did not achieve the targeted increase of 50%, partially because they had very high rates of documenting 5-2-1-0 surveys from the outset of Phase III (increased from 82% to 85%) (Chart I).

CHART I



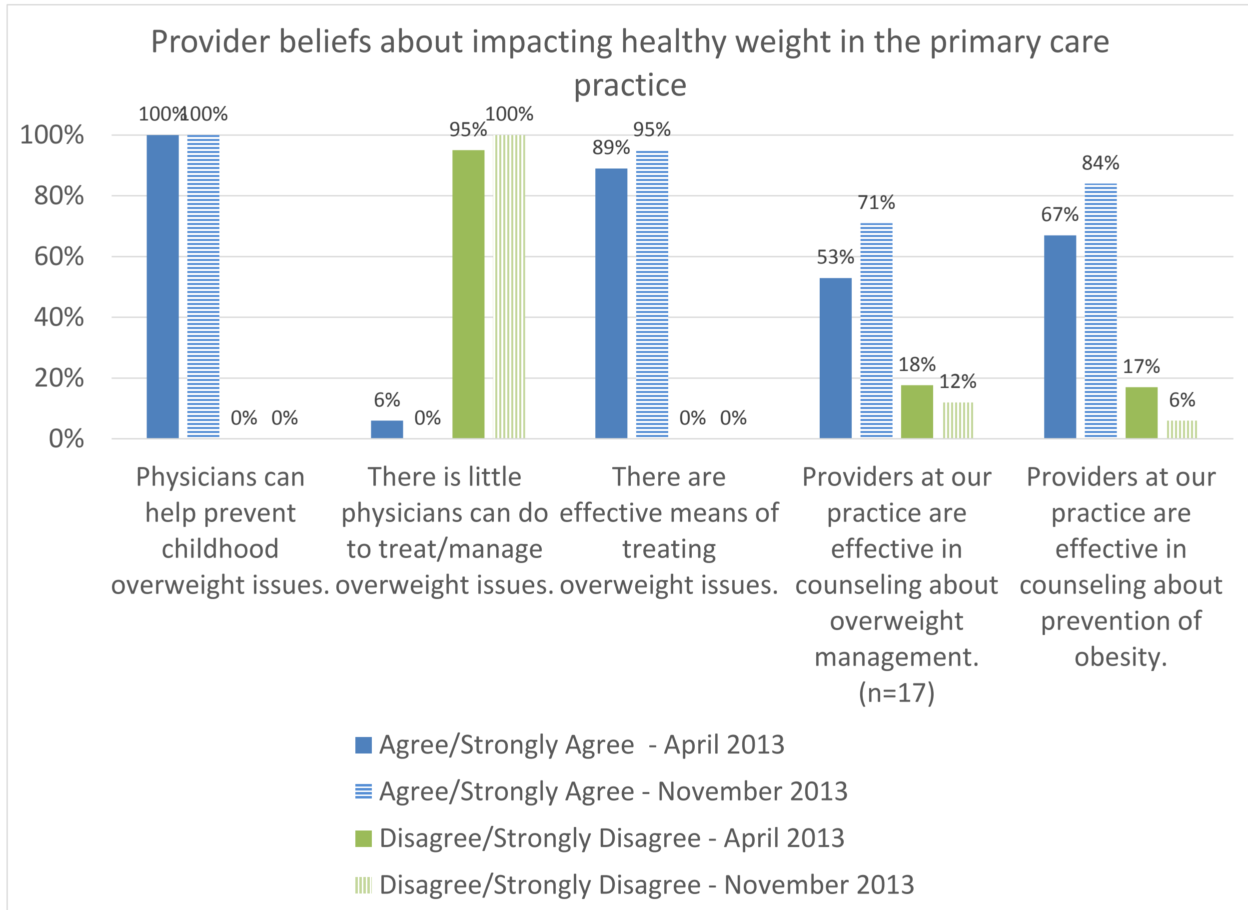
Data Source: Monthly data reported from the CIR registry (n=6 practices) and from chart review collected by practices and reported to First STEPS (n=13 practices reporting).

Greater provider confidence in counseling overweight children, but only a few practices used Next Steps themed follow-up visits.

Elements of Next Steps was introduced during the learning initiative, but the full guide was not available to practices until after the initiative had ended due to the AAP release of the tools at the National AAP meeting in late October 2013. While four practices reported some use of Next Steps, most practices reported they had not used this curriculum yet in their practice. This was supported in the office system survey, which showed no change (89% in pre and post) in practices reporting at least one physician in their practice was identified to address healthy weight related issues for children and adolescents with a BMI over the 85th percentile.

Both before and after Phase III, nearly all practices indicated that they believed that physicians can help prevent childhood overweight issues, and disagreed that there is little physicians can do to treat/manage overweight issues. After Phase III, more practices reported that they agreed that their providers are effective in counseling about prevention of obesity (67% to 84%) and overweight management (53% to 71%) (Chart J).

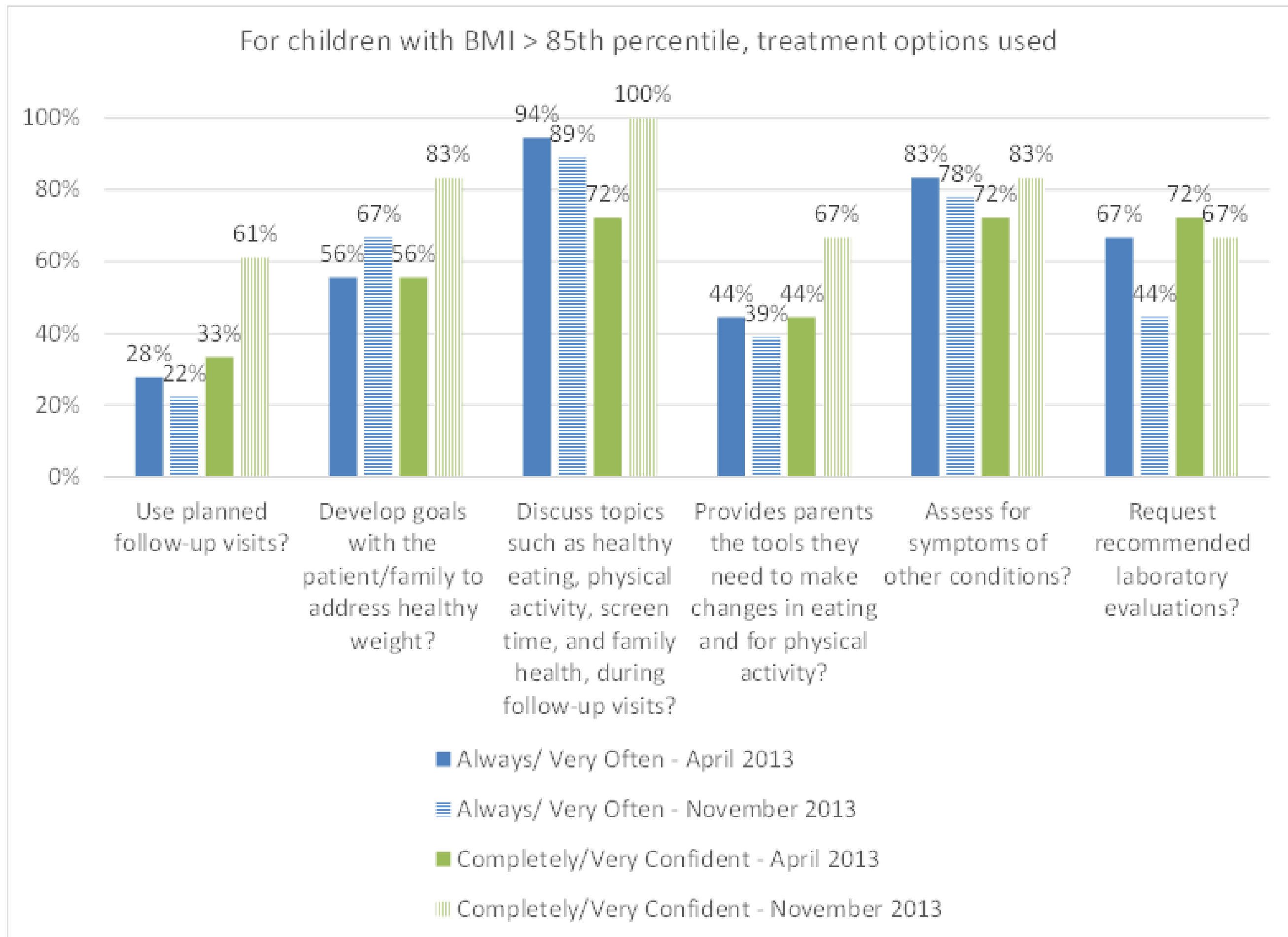
CHART J



Data Source: First STEPS Phase III Office System Survey, n=18 practices reporting unless noted otherwise.

While providers use of treatments for children with BMI over the 85th percentile remained relatively unchanged in most areas, providers confidence in these areas increased in most areas after Phase III. While most practices always or very often discuss topics such as healthy eating and physical activity (94% pre; 89% post), and all practices (100% post) reported being completely or very confident in addressing these topics during follow-up visits, only about a quarter of practices (22% post) reported always or very often conducting follow-up visits with children that have a BMI over the 85th percentile. Most assess for symptoms of other conditions (83% pre; 78% post), and more practice reported confidence in assessing for these conditions. While most assess for other conditions, fewer practices reported always or very often requesting recommended laboratory evaluations (67% pre; 44% post). Over half of practices (67% post) develop goals with the patient/family to address healthy weight, and about a third of practices (39% post) provide parents with the tools they need to make changes (Chart K).

CHART K



Data Source: First STEPS Phase III Office System Survey, n=18 practices reporting

There was only a slight change (50% to 61%) in practices reporting they have a system in place to track children ages 2 to 18 with BMIs over the 85th percentile. The primary tracking system noted was the electronic medical record. In addition, there was relatively no change in how practices provide follow-up with children with a BMI over the 85th percentile. All practices reported providers in their practice provide follow-up visits, most (78%) reported make referrals to a dietician, and about two-thirds of practices make a referral to a clinic specialized in child obesity treatment/management (67% pre, 61% post). About a third of practices (33%) do phone calls for follow-up, up from 6% at the beginning of the initiative. In addition, practices reported increased connections with community resources to support healthy eating and active living (Table D).

TABLE D

11. Is your practice connected to your community in any of the following ways to support healthy eating and active living? (check all that apply)	Pre	Post
We are connected with our local Healthy Maine Partnerships	53%	65%
We are involved with other *Let's Go* programs (e.g. schools…)	71%	88%
We participate in local, state, and/or national advocacy organizations (e.g. Let's Move…..)	12%	24%
We are connected with a Community Care Team.	35%	53%
Not yet, although we plan to connect with the community around healthy eating and active living.	0%	6%
No, we are not connected with the community and don't have plans to do so this year.	0%	0%

Data Source: First STEPS Phase III Office System Survey, n=17 practices reporting

While most practices will continue the changes they made during Phase III, one practice that piloted the 5-2-1-0 survey for the first time with two providers will not be continuing the use of the survey. The providers that used the survey felt the questions were already covered during patient visits, and that there was duplication with the Bright Futures form.

No increase in specialty clinic referrals.

To assess the degree to which First STEPS Phase III led to greater referrals for overweight children to specialty clinics (e.g. WOW, Zing!, and Countdown for ME), we interviewed these providers and asked about their knowledge of First STEPS and if they had noticed any increases in the number of referrals. Both of the clinics indicated there was no notable increase in referrals to their programs during Phase III. One of the clinics that was able to provide referral data from First STEPS practices during the learning initiative, did report an increase in referrals from two practices during or after Phase III.[25] This clinic also had recently expanded their program eligibility to include younger children (i.e. previously limited to children age 4 and up but changed to include children age 15 months and up). While the eligibility change was made at the end of Phase III and communication about the change in age criteria was still underway, few children under the age of 4 had been referred.

One specialty clinic indicated they had not expected their referrals to increase, given the First STEPS approach to encourage practices to schedule follow-up visits within the primary care practice and facilitate discussions with patients around different healthy lifestyle themes (i.e. Next Steps). Based on their analysis of EMR referral data, three First STEPS practices made referrals to Countdown ME ranging from 3 to 12 referrals for kids seen during Phase III. Several other practices in the health system had also made referrals during this time period, ranging from 1 to 19 referrals. Because the EMR was not fully implemented and utilized in 2012 by all practices, they could not determine if this represented an increase from the prior year.

The other specialty clinic reported seeing a positive change by First STEPS, but not through increased referrals.

25 Data on referral numbers by practice were not available, but described in aggregate by the program.

Positive change was seen through more providers using the 5-2-1-0 survey during well child visits.

The challenges faced by practices regarding providing follow-up visits for children and adolescents with BMIs over the 85th percentile remained constant throughout the initiative (Table E). Less than a quarter of practices identified reimbursement for services or knowledge about how to address healthy weight issues as a barriers to follow-up. The primary challenge identified was the slow process of patient's making change and time required to provide the service. Practices also indicated a variety of challenges related to parent/patient commitment (e.g. no shows/lack of follow-through on keeping appointments, lack of parent participation or patient compliance, limited financial resources of families) and limited access to needed support services (e.g. no access to nutritionist for patients with MaineCare).

TABLE E

12. What challenges does your practice encounter with providing planned follow-up visits with children and adolescents with a BMI greater than the 85th percentile? (check all that apply)	**Pre**	**Post**
Reimbursement for services	18%	12%
Time to provide services to patients	59%	65%
Knowledge about how to address healthy weight issues	24%	24%
Slow process in some patients making change	88%	82%
Other (please specify) (e.g. no shows/follow-through on keeping appointments, lack of parent participation; lack of patient compliance, financial resources of families, comfort with providing follow-up visits, and no access to nutritionist for patients with MaineCare)	24%	29%

Data Source: First STEPS Phase III Office System Survey, n=17 practices reporting

Many practices reported the continuing challenge of getting families of overweight children to engage in follow-up.

While there are some resources available to address healthy weight, practices that focused on follow-up with overweight children indicated that patient and family's readiness to change can be a challenge. While some families may be ready to make big changes in their lifestyle, others are in the contemplative stage. Successful follow-up treatment either provided within the practice or by specialty clinics to which patients are referred is directly related to the families' commitment to address the issue and readiness to change.

Other challenges mentioned were not as consistent across practices, but were still mentioned as challenges in addressing healthy weight. Some of these challenges included the time and commitment to travel to clinics for services, out of pocket costs for some services such as nutritionist services or other community resources to improve healthy weight. One pediatric practice identified the challenge that lifestyle change often requires the engagement and participation of the entire family unit which is difficult to achieve if your practice only treats the child (i.e. not a family practice). On the other hand, practices that serve both adults and children may only have a small population of kids that are struggling with healthy weight, so focusing on improving healthy weight in kids with high BMIs can be harder. As one practice stated, it's important to keep the conversation about

healthy weight going, both in the primary care practice and in the community at large; the reinforced discussion of healthy weight helps move patients from a pre-contemplative to action state.

"We were already doing this work before Phase III, but it helped [confirm] that we didn't have to refer out everyone [to a specialty clinic]; we can work on some of these issues with themed visits. If people want to make the commitment to big changes, [a specialty provider] is a good resource. If a patient is more just starting to think about it, the themed visits work pretty nice."

While practices did mention they make referrals to specialty clinics or other resources for kids with high BMIs, only five practices mentioned these referrals increased during Phase III. Most practices maintained the same referral resources they had used prior to Phase III. Several mentioned that most of these programs are targeted to kids with very high BMIs, and require a long term commitment by the child/parent that is not always present. As a result, practices' first course of action is typically to provide counseling within their office, and only make a referral when it's a significant issue. One provider stated, "We were already doing this work before Phase III, but it helped [confirm] that we didn't have to refer out everyone [to a specialty clinic]; we can work on some of these issues with themed visits. If people want to make the commitment to big changes, [a specialty provider] is a good resource. If a patient is more just starting to think about it, the themed visits work pretty nice." Some practices mentioned frustration with not having resources to help kids/parents that may need to address healthy weight who may not have a high BMI, but are in need of less intensive treatment and ongoing support such as nutritional services. As one provider mentioned, there are classes available for diabetics, but it's not as easy to find programs that help address healthy weight.

All practices found First STEPS Phase III valuable in supporting quality improvement, particularly the learning sessions.

Overall, practices had positive feedback about their participation in First STEPS Phase III. Practices reported that First STEPS helped them stay on task, provided helpful deadlines, and provided ongoing learning throughout the process that helped them continue their work on healthy weight and oral health. Several practices also reported that First STEPS was quick to respond to questions as they arose, and connected them with key people to address their questions. As one practice stated, "[First STEPS] hardwired practice improvement. People helped us and held us accountable. We wouldn't have been doing the oral health thing if it wasn't something we got help with." One pediatric practice also mentioned that they appreciated the focus on kids, as most initiatives primarily target adults and families. Only two practices mentioned potential improvements with First STEPS in terms of aligning with other initiatives, as practices are often involved in more than one project. Two practices mentioned that involvement in First STEPS has advanced their knowledge and understanding of improving

services, as they have found they are ahead of other practices in addressing issues now that their health system is emphasizing improvement in quality.

> "[First STEPS] hardwired practice improvement. People helped us and held us accountable. We wouldn't have been doing the oral health thing if it wasn't something we got help with."

Almost all practices reported that the learning sessions were the most helpful component of First STEPS in making changes around healthy weight and oral health. Key factors included the chance to network with other practices, sharing ideas and getting feedback from other practices, learning from each other about successes and challenges, and hands-on demonstrations. In particular, many practices noted that they found the demonstration of fluoride application on the young child whose parents had volunteered to participate by a pediatric dentist and a primary care doctor in-training to be very effective.

Several practices mentioned that the monthly calls and webinars were not as helpful as the learning sessions, as some felt the calls repeated material that was previously presented. Two practices mentioned the PDSA cycles were helpful. One practice stated, "PDSAs really make us think about how we're doing and what we need to do". One practice thought PDSAs were frustrating due to lack of progress or having too many PDSAs to do.

In terms of coaching, not many practices mentioned coaching as a resource. While one practice reported their coach had helped them with improving the fluoride varnish workflow, one practice reported they did not have a strong connection with their coach in this phase due to the coach changing halfway through Phase III, and another practices reported they did not know who their coach was. When the evaluation team tried to reach out to coaches for an interview, it was a challenge to reach coaches that were still in the same role as they were during Phase III. The coaches interviewed mentioned that the level of engagement with practices varied, as they were able to help some with process mapping, PDSAs, improving workflows, and developing aims statements, some practices were harder to engage. The challenge with engagement could be due to changes in coach assignments midway through the initiative due to staffing changes, or not having all staff on board with the initiative. Coaching also varied by practice, as some did not have coaches, others had coaches assigned, and some had existing coaches through their health system.

Practice factors that contributed to successful participation and implementation of changes

A number of practices stated the importance of having the whole practice staff engaged in the project and ideally having a physician champion. It's important to know the team's strengths and weaknesses. Having all providers involved is important, but can be challenging. One practice mentioned doing provider-specific chart audits to help engage and motivate providers to be involved. Having the EMR up and running with the elements you're working on, such as OHRA, also helps engage all staff. Another practice stated, "Providers are more in a business sense in terms of time and bottom line for reimbursement. They have less time with the patient and more with documenting and clicking. If you can spin it so they have more time with the patient then you have more buy in."

> "Providers are more in a business sense in terms of time and bottom line for reimbursement. They have less time with the patient and more with documenting and clicking. If you can spin it so they have more time with the patient then you have more buy in."

Another important element of improving care in primary care practices is to be realistic and start small with what you're trying to change. Small changes can be easier to focus on, and small successes can be built upon. A gradual roll out of the process can also help change fatigue, as many practices are often working on several projects at one time. Testing the process with one or two providers may be beneficial to work out initial issues before attempting to make changes across the whole practice. Practices reported that changes often took a few months to implement, but continued work is needed over a longer period to refine the process. Aligning change with other initiatives or with well-child visit workflow often helps facilitate provider buy-in and greater success. For example, changes in an EMR can often be challenging, but if aligned with other initiatives, there is greater support for changes to be made. As one practice stated, using the EMR to implement changes is best, but it's not always easy. Lastly, connecting with others that are doing what you want to do, and sharing successes and challenges, helps inform the process for practice transformation.

As there are multiple requirements for providers to address during well-child visits, practices were asked about ways to improve this process. Most practices agreed that getting all the necessary screenings into a fifteen to twenty minute well child visit is a challenge, with two practices mentioning there is not currently reimbursement for all the screenings and activities that occur during a well-child visit. Two practices mentioned that having an EMR helped the process, as it can queue the provider as to what needs to be covered in the visit. One family practice mentioned the use of checklists for pediatric visits was helpful to remind providers of what needs to be covered. As one practice mentioned, having items such as the OHRA in the EMR leads to less paper for parents to fill out, which helps the process. Two practices mentioned the importance of having all staff working to their capacity to help with coordination of the visits. One practice stated they use the well-child visit to address the overall needs, and then use follow-up visits to address the needs identified during the well-child visit. Other practices, highly recommended maximizing the use of other staff in preparing for the well-child visit, gathering information from parents and entering into the EMR if possible, so that the provider can focus on what issues to address.

Other challenges of implementing oral health in the primary care practice include having all providers address fluoride varnish at the same level of consistency, which was mentioned by four practices as a challenge. One practice mentioned that the implementation of fluoride varnish and the OHRA is very dependent upon medical assistants, as they are integral to making sure these assessments and applications are started for the provider. While some practices mentioned the medical assistant and providers do the OHRA during the visit, four practices mentioned that they start the process as soon as a parent is in the waiting room by having the OHRA questions attached to the forms that parents fill out prior to the office visit, such as the 5-2-1-0 survey.

Phase III Systems-Level Changes

Opportunity to educate practices and get feedback on new MaineCare oral health risk assessment reimbursement policy

Based on interviews with MaineCare officials, the benefit of First STEPS Phase III was that is provided the opportunity to get feedback from both primary care and dental providers to inform MaineCare policies and to test the new oral health risk assessment forms to be used for reimbursement in primary care settings. Prior to Phase III, MaineCare reimbursed fluoride varnish application twice a year for a child (billing code D1206) with no medical home, but MaineCare did not reimburse primary care offices to do an OHRA to assess if the child had a medical home. MaineCare children under age 3 were not accessing dental care, and MaineCare was interested in addressing this gap in services. During the planning process for Phase III, IHOC and First STEPS staff were learning about other states efforts to allow primary care offices to bill for OHRA, and worked with MaineCare to pursue this policy option for encouraging oral health in young children to meet EPSDT requirements.

IHOC's and First STEPS' focus on oral health helped provide the needed support to reassess the MaineCare policies for addressing oral health in young children, how they could be improved, and what options are available to improve dental access, initial dental assessments, and dental treatment when needed. First STEPS also helped in testing new OHRA dental codes for primary care practices to bill for reimbursement and helped inform MaineCare's communication of the new policy to all providers. While still too early to detect changes in OHRA billing and related increases in dental use by young children, having the new code for OHRA reimbursement has provided the state with more data and information about what primary care practices are doing to address oral health for young children, which can ultimately inform future work in this area. First STEPS work on improving fluoride varnish also helped shed more light on the need for continued improvement in this area to improve children's health.

IHOC's extensive planning and engagement of dental community in development of the OHRA and First STEPS Phase III Trainings were helpful in allaying concerns.

Based on interviews with dental providers and state policymakers, there was some concern in the dental community about primary care practices providing oral health risk assessments for young children. The need for standardized questions was addressed by First STEPS, IHOC staff, and *From the First Tooth* staff assessing existing templates in other states and professional groups such as North Carolina's version, and tailoring a standardized form that Maine primary care providers could use. Some stakeholders mentioned the resistance some dental providers have in treating younger children and having primary care providers provide fluoride varnish and OHRA. One way to address these concerns was emphasizing that the first question of the OHRA is if the child has a dental provider. If they do have a dental home, then further oral health services such as fluoride varnish would be addressed by the dental provider. The OHRA provides a way to open the communication with parents about oral health, assess if a referral to a dental provider is needed, and provide basic assessment and fluoride varnish services if dental provider services are not available. While First STEPS started doing work in this area and several dentists are on board with this new approach, it appears to still have some resistance by some dental providers.

The use of the D0145 code to bill for reimbursement of the OHRA was based on assessing other state's experiences

with how primary care practices were reimbursed. The code had been in existence previously for dental providers (few used it, as dental providers often provide more in-depth services at a higher reimbursement rate than the OHRA reimbursement rate), but was not available to primary care providers. An overview of this new process was presented by IHOC staff to the MaineCare dental advisory committee and the dental licensure board of medicine in Maine to be sure there were no scope of practice issues. Further work was then pursued with the coding committee about the rate of reimbursement, and having it included in the provider contracts so that First STEPS practices could use this new code.

First STEPS helped expand and improve ongoing oral health and healthy weight quality improvement (QI) efforts.

From the First Tooth had worked with practices before Phase III to train staff on fluoride varnish application. Partnering with First STEPS provided an opportunity to expand these trainings to new practices, and to integrate First STEPS quality improvement strategies (e.g. use of on-site coaches) into their training approach. During Phase III, FTFT trained all but one First STEPS practice on oral health prevention, with 13 practices receiving training on fluoride varnish application. Of these 13 practices, 4 had never received training before, and 9 of these practices received re-training. Using coaching with practices was new for FTFT, but they have found it has improved their training and they are hiring quality improvement staff in different systems to continue this coaching model going forward. They have also used Phase III's video-taped demonstration of fluoride varnish on a real child, which was recorded at one of the learning sessions, in their trainings.

FTFT also has shared the lessons learned during Phase III in integrating the OHRA into MaineHealth's EMR as part of their trainings with other health systems and practices interested in automating the OHRA. To generate monthly EMR data for Phase III, FTFT worked closely with the MaineHealth system and its practices to add the OHRA questions to their EMR for better tracking and billing. They have shared lessons learned and the OHRA screen shots in MaineHealth's EMR as part of their trainings of other practices interested in automating the OHRA. Since Phase III, FTFT has worked with both MaineGeneral and Eastern Maine Healthcare to incorporate the OHRA into their EMR since piloting it at MaineHealth for Phase III reporting. FTFT staff indicated that while it was a time consuming process, it simplified the process to have resources such as screen shots and sample workflows to be used by other systems. In addition, having the right people involved, such as the technical team and support from the organization, is also essential to making this implementation happen.

Program staff at FTFT indicated that integration of First STEPS quality improvement techniques into their model has made FTFT's process more systematic and beneficial for all. As participants in a national initiative, they indicated that this use of quality improvement and coaching techniques to improve oral health in primary care practices is unique to Maine and has not been widely done in other states. At the end of the initiative, First STEPS assembled a change packet for practices to use as a resource after completing Phase III and for maintaining work with *From the First Tooth* so practices can use the reference going forward.

Let's Go! mentioned that partnering with First STEPS incorporated both new and previous practices they had worked with previously. Practices were provided the Next Steps guide at the end of the initiative, and were provided references to online resources available from *Let's Go!*.

SUMMARY AND CONCLUSION

While half of the practices had some experience with fluoride varnish prior to First STEPS, integrating oral health risk assessments into well-child visits for young children was new for most of the practices that participated in Phase III. The First STEPS learning initiative helped increase practices' awareness of the need for dental caries prevention, and also increased the rates of these interventions within well-child visits for children under 4. Unlike topics addressed in other First STEPS phases (e.g. immunizations and developmental screening), providers had some exposure to conducting systematic oral health risk assessments or applying fluoride varnish, but started at a much less experienced level than in other phases. Despite this fact, First STEPS practices were able to make inroads into building oral health processes into the workflow of well child visits. However, billing for fluoride varnish continues to be a challenge for many, and implementing a new service such as the oral health evaluation and developing the billing and workflow processes to support that service within the EMR and administrative systems requires time. As a result, the effects of practice-level improvements may need to be studied over a longer period of time to fully capture their impact.

Compared to oral health, there was less change in First STEPS Phase III healthy weight efforts in part because many practices had already been performing above metric targets. Practices reinforced work they had already been doing to document BMI and use the 5-2-1-0 Healthy Habits questionnaire to initiate conversations about physical activity and nutrition. While they reported some improvement in process measures through chart review or EMR, and exceeded targeted goals from the outset in documenting BMI, they fell short of the targeted counseling goals set by the initiative. Also very few practices chose to focus on implementing the Next Steps themed visits for children identified as overweight, which was not fully available to practices until the end of the initiative.

First STEPS Phase III helped facilitate system-level changes. Phase III's approach to quality improvement, including the requirement of gathering data to track progress and use of PDSA cycles, was highly valued by participating practices and provided the impetus for several health systems and practices to automate oral health screenings in electronic medical records, which practices indicated is essential for integration into well-child visit workflow and standardized use across providers. The quality improvement approach used by First STEPS has also helped inform the continued training provided through other statewide initiatives going forward.

Finally, for the MaineCare program, the learning collaborative offered an opportunity to get feedback from providers on MaineCare's new oral health evaluation policy and to educate providers about reimbursement for this new service to help improve access to necessary caries prevention for young children. However, since these changes were being implemented simultaneously to the learning sessions, many practices were not able to achieve full automation until after the initiative ended. Since the full effects of these changes cannot yet be seen in administrative data, we plan to re-evaluate the impact on oral health prevention and use of dental services by young children over a longer period of time for a future report.

Appendix A. Chart Review/EMR Measure Specifications

TABLE 1

Specifications of Healthy Weight and Oral Health Measures by Data Source

Health Weight	Chart Review Mar-Oct 2013	EMR Apr – Oct 2013
Assessment and Stratification	NA	Ages 2-<18
BMI Assessment	Ages 2-4	Ages 2-<12 Ages 12-<18
BMI Underweight (<5%)[1]	Ages 2-4	Ages 2-<12 Ages 12-<18
BMI Healthy Weight (5-<85%)[1]	Ages 2-4	Ages 2-<12 Ages 12-<18
BMI Overweight (85-<95%)[1]	Ages 2-4	Ages 2-<12 Ages 12-<18
BMI Obese (95%-<99%)[1]	Ages 2-4	Ages 2-<12 Ages 12-<18
BMI 99%+[1]	Ages 2-4	Ages 2-<12 Ages 12-<18
If BMI >85%, follow-up plan documented?	Ages 2-4	NA
5-2-1-0 documented (all patients)	Ages 2-4	Ages 2-<18
OHRA documented	Ages 2-4	Ages 6 mo. – 4 yrs.
Dental home indicated and documented	Ages 2-4	Ages 6 mo. – 4 yrs.
If no dental home, family counseled about having dental home and/or referral made to dental provider	Ages 2-4	NA
Eligible for fluoride varnish	Ages 2-4	Ages 6 mo. – 4 yrs.
Eligible and received fluoride varnish	Ages 2-4 (mod/high OHRA and no dental home)	Ages 6 mo. – 4 yrs. (mod/high OHRA)
Eligible and declined fluoride varnish	Ages 2-4	Ages 6 mo. – 4 yrs.

1 Original data showed BMI stratification out of all patients, not just those with BMI assessment documented. The data in this report have been recalculated to show BMI stratification out of all patients with BMI assessments documented.