Medicaid Oral Health Performance Improvement Projects: A Template

June 2015

This template can be accessed online at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/ Dental-Care.html

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Inside back cover: Percentage of Medicaid children ages 1–20 receiving a preventive dental service, federal fiscal year 2013, 50 states and the District of Columbia

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ACKNOWLEDGMENTS:

The authors thank the team at Mathematica Policy Research for its project leadership, under the helm of **Dr. Len Finocchio**: **Abigail Phillip**, **Michaela Vine**, and **Rebecca Mongeau**. CHCS is also grateful for the input of the following Medicaid oral health care experts: **Meg Booth** and **Colin Reusch** of the Children's Dental Health Project; **Patrick Finnerty**, Virginia Dental Association Foundation; and **James Crall**, **DDS**, UCLA School of Dentistry. CHCS appreciates the generous time and knowledge of the following state, health plan, and External Quality Review Organization reviewers: **Dr. Janice Carson**, Georgia Department of Community Health; **Kim Elliott**, Arizona Health Care Cost Containment System; **Dr. Bonnie Stanley**, NJ Division of Medical Assistance and Health Services; **Kristin LaRoche**, DentaQuest; and **Gretchen Thompson**, Health Services Advisory Group. The guidance received from the CMS oral health team, specifically **Laurie Norris**, **Elizabeth Hill**, **TJ Shumard**, **Kristin Younger**, and **Susan Ruiz** was invaluable. And finally, CHCS recognizes Alexandra Maul, Kelly Church, Taylor Hendricks, Andrew Kolbenschlag, and Lorie Martin who contributed to the development of this manual.

PREFACE

Medicaid Oral Health Performance Improvement Projects: A Template and the two how-to manuals that accompany it (see below) are intended to **support state and health plan[1] implementation of an oral health performance improvement project (PIP) in Medicaid.** Performance improvement projects are not new to Medicaid managed care. States are required by federal regulation to include the requirement to conduct PIPs in their contracts with managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs).[2] States may extend the PIP requirement to other types of contracted plans, including dental maintenance organizations (DMOs), behavioral health organizations (BHOs), and prepaid ambulatory health plans (PAHPs) that provide carved-out (e.g., dental only) or otherwise limited (e.g., outpatient only) services.

PIPs are a valuable quality improvement strategy because they do the following:

1. Facilitate data driven, customized interventions at the point of oral health care delivery
2. Create significant and uniform change in a state's Medicaid delivery system
3. Maximize the strengths of each health plan and leverage local oral health priorities and resources
4. Ensure plan accountability through incorporation into health plan contract requirements
5. Leverage the expertise of external entities, such as external quality review organizations,[3] which already provide analytic support to state Medicaid managed care programs.

PIPs are most effective when they align with other quality improvement initiatives, link to meaningful health plan and/or provider incentives, engage stakeholders in the planning and implementation stages, and are supported by technical assistance and capacity-building resources.

States have the flexibility to decide how many, and in what clinical and nonclinical areas, PIPs are conducted. To date, however, few states have used PIPs to advance children's oral health. **Health plans may need states to take the lead** in promoting oral health quality improvement and leveraging the significant opportunity PIPs present to improve oral health care quality. On their own, plans participating in a comprehensive risk arrangement (e.g., MCOs) may not prioritize oral health above other quality improvement concerns, particularly if they are responsible for multiple health care areas such as medical and behavioral health. Also, plans in dental carve-out arrangements may not have the financial or broader capacity to pursue a resource-intensive quality improvement effort. A state-led oral health PIP, however, can provide the needed wherewithal – **a concrete aim, data-driven analyses, specialized resources, and capacity-building support** – to motivate and lead health plans to improve performance. As background, the chart on the inside of the rear cover shows state rates for children's preventive dental service use.

Three resources have been developed to support state Medicaid agencies and their contracted health plans to develop Medicaid oral health PIPs:

1. Medicaid Oral Health PIPs: A Template ("PIP template")
2. Medicaid Oral Health PIPs: A How-To Manual for States
3. Medicaid Oral Health PIPs: A How-To Manual for Health Plans

The PIP template can be customized by **state Medicaid agency staff with responsibilities in the areas of children's oral health, quality improvement, and/or managed care oversight**. Subsequently, the template can be used by health plan staff during the course of PIP implementation. The how-to manuals guide states and health plans on customization and use of the PIP template, respectively.

These resources have been **developed through the Oral Health Initiative**,[4] a federal effort through the Centers for Medicare & Medicaid Services (CMS) to advance improvements in children's oral health by providing performance data, tools, and technical assistance to states and their oral health stakeholders.

[1] The term *health plan* is used in this document to refer to managed care organizations, prepaid inpatient health plans, dental maintenance organizations and/or prepaid ambulatory health plans that administer oral health services and may perform oral health PIPs. Only MCOs and PIHPs are required by federal regulation to conduct PIPs.

[2] 42 Code of Federal Regulations §438.240(d).

[3] An EQRO is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review (EQR), other EQR-related activities as set forth in 42 CFR 438.358, or both. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors, furnish to Medicaid recipients.

[4] Information on the Oral Health Initiative is accessible at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-10-2014.pdf.

HOW TO USE THIS DOCUMENT

What is an oral health PIP?
Oral health PIPs are designed to improve oral health care utilization, quality, and/or timeliness among members enrolled in Medicaid-contracted health plans. State Medicaid agencies develop PIPs to achieve performance improvement goals in specific clinical or nonclinical areas, as well as to meet federal and state managed care requirements. Health plans fulfill the requirements of PIPs through the implementation of quality improvement interventions. Although only managed care organizations and prepaid inpatient health plans are required by federal managed care regulation to conduct PIPs, other health plans may do so because they are interested in oral health quality improvement or are otherwise mandated to conduct PIPs in a carve-out dental arrangement with the state or as a subcontractor to an MCO or PIHP.

What does the PIP template include?
This PIP template consists of 10 numbered sections that compose the planning, implementation, and evaluation phases of an oral health PIP. The PIP template seeks to ensure that the health plan's PIP is

- Aligned with federal regulations and subregulatory guidance for PIPs;[5]
- Consistent with CMS's protocols for PIP implementation and validation;[6]
- Focused on achieving tangible and sustainable improvements in oral health care utilization, quality, and/or timeliness;
- Based on continuous quality improvement principles;
- Supportive of the CMS's national oral health goals;[7] and
- Practical to adopt.

The template concludes with appendices of tools for health plans and a glossary of terms.

How should the PIP template be used?
Health plans will fill out the PIP template through the planning, implementation, and evaluation of their oral health PIPs. The accompanying tool, *Medicaid Oral Health PIPs: How-to Manual for Health Plans,* provides guidance on completing the template and pursuing activities in each of its phases. The recommended approach for developing and implementing the PIP is as follows:

1. State uses *Medicaid Oral Health PIPs: A How-To Manual for States* to customize the PIP template and subsequently provides it to each health plan.
2. State mandates regular submissions of the PIP template over the duration of the PIP program to assess health plan progress.
3. At the conclusion of the PIP, each health plan submits the final iteration of the PIP template as documentation of the PIP effort and impact.

States can use this PIP template in conjunction with other tools and resources that support PIPs, such as those provided by EQROs

[5] 42 Code of Federal Regulations §438.240(d).
[6] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQR-Protocols.zip.
[7] Increase by 10 percentage points the proportion of Medicaid and CHIP children ages 1 to 20 (enrolled for at least 90 days) who receive a preventive dental service; increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a sealant on a permanent molar tooth.

MEDICAID ORAL HEALTH PIPs: A TEMPLATE

State	[State to Fill]
Health Plan	[State to Fill]
Time Period for PIP Implementation	[State or Health Plan to Fill]

I. Background and Context
State Guidance: *[Optional for State to Fill]*
Describe your health plan's oral health priorities and quality improvement work to date, including the following: ▪ Covered oral health services ▪ Market size, geography, and scope ▪ Characteristics of provider network ▪ Performance on utilization, quality, and timeliness of oral health services ▪ Current/past quality improvement initiatives ▪ Leadership support for quality improvement activities
(type response here)

II. Select the PIP Topic
State Guidance: *[Optional for State to Fill]*
What is your PIP topic?
(type response here)
How did you select the PIP topic? Include rationale and key data.
(type response here)

III. Identify the Population
State Guidance: *[Optional for State to Fill]*
What population is your PIP targeting? Indicate if a representative sample will be used instead of the entire population. Include key stratifications (e.g., age, race/ethnicity) of the population.
(type response here)
Describe the data sources and protocols you will use to identify and stratify the PIP population.
(type response here)

IV. Define the PIP Aim
State Guidance: *[Optional for State to Fill]*
What is your PIP aim? The aim should include the desired change, the targeted degree of improvement, and the period of time over which this change is expected to take place.
(type response here)

V. Select the Performance Measures	
State Guidance: *[Optional for State to Fill]*	
List and define the primary and secondary measures that you will use to determine the impact of your PIP. For each measure, indicate the measure source, data specifications, measurement periods, benchmark, and goal. *Add sections for additional measures as needed (fields for two primary measures and two secondary measures have been provided).*	
Primary Measure #1	(type response here)
Measure Source (e.g., Dental Quality Alliance, Agency for Healthcare Research & Quality, health plan)	(type response here)
Numerator Specification	(type response here)
Denominator Specification	(type response here)

State Guidance: *[Optional for State to Fill]*	
List and define the primary and secondary measures that you will use to determine the impact of your PIP. For each measure, indicate the measure source, data specifications, measurement periods, benchmark, and goal. *Add sections for additional measures as needed (fields for two primary measures and two secondary measures have been provided).*	
Baseline Measurement Period Date	(type response here)
Remeasurement Period Dates (Add rows here as needed for repeated reporting)	(type response here)
Benchmark	(type response here)
Goal	(type response here)
Primary Measure #2	(type response here)
Measure Source	(type response here)
Numerator Specification	(type response here)
Denominator Specification	(type response here)
Baseline Measurement Period Date	(type response here)
Remeasurement Period Dates (Add rows here as needed for repeated reporting)	(type response here)
Benchmark	(type response here)
Goal	(type response here)
Secondary Measure #1	(type response here)
Measure Source	(type response here)
Numerator Specification	(type response here)
Denominator Specification	(type response here)
Baseline Measurement Period Date	(type response here)

State Guidance: *[Optional for State to Fill]*	
List and define the primary and secondary measures that you will use to determine the impact of your PIP. For each measure, indicate the measure source, data specifications, measurement periods, benchmark, and goal. *Add sections for additional measures as needed (fields for two primary measures and two secondary measures have been provided).*	
Remeasurement Period Dates (Add rows here as needed for repeated reporting)	(type response here)
Benchmark	(type response here)
Goal	(type response here)
Secondary Measure #2	(type response here)
Measure Source	(type response here)
Numerator Specification	(type response here)
Denominator Specification	(type response here)
Baseline Measurement Period Date	(type response here)
Remeasurement Period Dates (Add rows here as needed for repeated reporting)	(type response here)
Benchmark	(type response here)
Goal	(type response here)

VI. Establish the Data Collection Plan

State Guidance: *[Optional for State to Fill]*	
For each measure identified in Section V, describe the following aspects of your data collection. *Add sections for additional measures as needed (fields for two primary measures and two secondary measures have been provided).*	
Primary Measure #1	(type response here)
Organizational Data Source and Frequency of Collection (e.g., claims and quarterly)	(type response here)

State Guidance: *[Optional for State to Fill]*	
For each measure identified in Section V, describe the following aspects of your data collection. *Add sections for additional measures as needed (fields for two primary measures and two secondary measures have been provided).*	
Staff Responsible for Data Collection (include multiple staff or departments as appropriate)	(type response here)
Procedure for Data Analysis	(type response here)
Primary Measure #2	(type response here)
Organizational Data Source and Frequency of Collection	(type response here)
Staff Responsible for Data Collection	(type response here)
Procedure for Data Analysis	(type response here)
Secondary Measure #1	(type response here)
Organizational Data Source and Frequency of Collection	(type response here)
Staff Responsible for Data Collection	(type response here)
Procedure for Data Analysis	(type response here)
Secondary Measure #2	(type response here)
Organizational Data Source and Frequency of Collection	(type response here)
Staff Responsible for Data Collection	(type response here)
Procedure for Data Analysis	(type response here)

VII. Plan the Intervention
State Guidance: *[Optional for State to Fill]*
Provide the results of analyses you conducted to understand the drivers behind gaps in oral health utilization, quality, or timeliness related to your PIP aim. Indicate the methods you used to arrive at these conclusions (e.g., focus groups, surveys, fishbone/cause-and-effect diagrams). *Use the tools in Appendices A–C.*
(type response here)
Provide the rationale for choosing your PIP intervention(s). Include any analyses conducted that helped you arrive at your decision (e.g., Strengths, Weaknesses, Opportunities, and Threats).
(type response here)
Attach the driver diagram that guides your PIP strategy. Provide any related context below, as desired. *Use the worksheet in Appendix D to construct your driver diagram.*
(type response here)

Indicate below the measures you will use to assess progress of the intervention and correct course, as necessary. *Add rows for additional measures as needed*.

Intervention Tracking Measure	Data Source	Frequency of Collection	Staff Responsible	How This Will Inform Continuous Quality Improvement Strategy

VIII. Implement the Intervention and Improvement Strategies
State Guidance: *[Optional for State to Fill]*
Identify the staff who will be involved in the implementation of the intervention(s) and their respective roles. Include any relevant staff/leadership champions.
(type response here)

Indicate the timeline for implementation of the intervention. *Add rows for additional activities as needed.*

Implementation Activity	Time Period	Frequency of Recurrence

Report below on the results of the Intervention Tracking measures and how these results are helping to assess the progress of the intervention and correct course, as needed. *Use the PDSA worksheet in Appendix E to help complete this section.*

Intervention Tracking Measure	Measurement Period	Result	Results and How They Are Informing Course Correction

IX. Analyze Data to Interpret PIP Results						
State Guidance: *[Optional for State to Fill]*						
Report the results of the PIP measures.						
Primary Measure #1						
Measurement Period	***Measurement***	***Numerator***	***Denominator***	***Rate or Result***	***Benchmark***	***Goal***
	Baseline:					
	Remeasurement 1:					
	Remeasurement 2:					
Statistically Significant? (Yes/No)	**Test Used**	**p-value**	**Measurement Periods Compared**			

Interpret the rates for each measurement period. Discuss specific implementation barriers faced and strategies used during the time period that may have contributed to the observed results. Given these results, note how implementation may be improved during the next measurement period.

Measurement Period	***Measurement***	***Interpretation of Results***	***Barriers Faced and Strategies Used***	***Improvement Strategies for Next Measurement Period***
	Enter Rate at Baseline:			
	Enter Rate at Remeasurement 1:			
	Enter Rate at Remeasurement 2:			

Primary Measure #2						
Measurement Period	***Measurement***	***Numerator***	***Denominator***	***Rate or Result***	***Benchmark***	***Goal***
	Baseline:					
	Remeasurement 1:					
	Remeasurement 2:					
Statistically Significant? (Yes/No)	**Test Used**	**p-value**	**Measure Periods Compared**			

Interpret the rates for each measurement period. Discuss specific implementation barriers faced and strategies used during the time period that may have contributed to the observed results. Provide information on how implementation may be improved, based on the current results, for the next measurement period.

Measurement Period	***Measurement***	***Interpretation of Results***	***Barriers Faced and Strategies Used***	***Improvement Strategies for Next Measurement Period***
	Enter Rate at Baseline:			
	Enter Rate at Remeasurement 1:			
	Enter Rate at Remeasurement 2:			

Secondary Measure #1						
Measurement Period	***Measurement***	***Numerator***	***Denominator***	***Rate or Result***	***Benchmark***	***Goal***
	Baseline:					
	Remeasurement 1:					
	Remeasurement 2:					
Statistically Significant? (Yes/No)	**Test Used**	**p-value**	**Measure Period Compared**			

Interpret the rates for each measurement period. Discuss specific implementation barriers faced and strategies used during the time period that may have contributed to the observed results. Provide information on how implementation may be improved, based on the current results, for the next measurement period.

Measurement Period	***Measurement***	***Interpretation of Results***	***Barriers Faced and Strategies Used***	***Improvement Strategies for Next Measurement Period***
	Enter Rate at Baseline:			
	Enter Rate at Remeasurement 1:			
	Enter Rate at Remeasurement 2:			

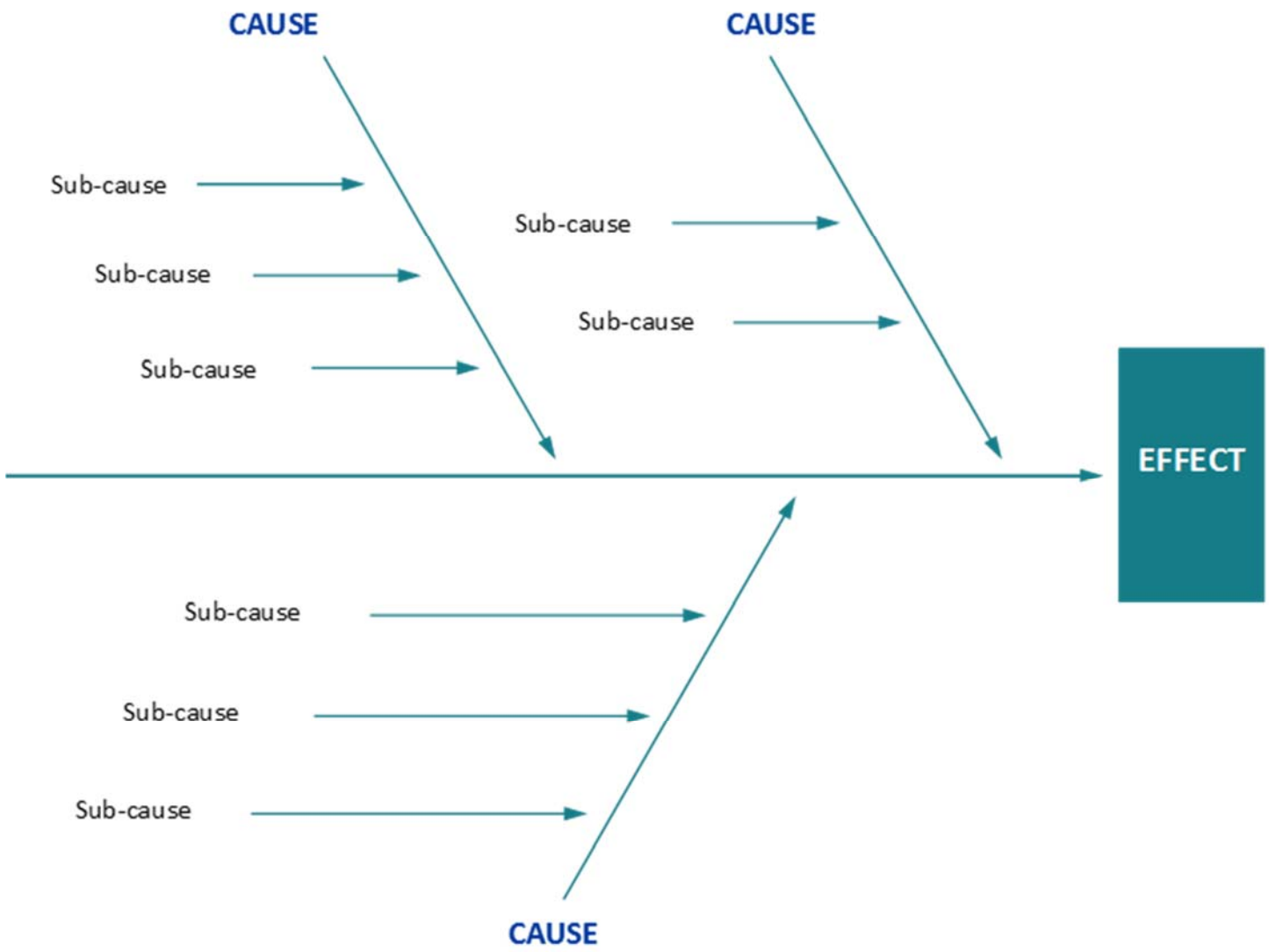
Secondary Measure #2						
Measurement Period	***Measurement***	***Numerator***	***Denominator***	***Rate or Result***	***Benchmark***	***Goal***
	Baseline:					
	Remeasurement 1:					
	Remeasurement 2:					
Statistically Significant? (Yes/No)	**Test Used**	**p-value**	**Measure Period Compared**			

Interpret the rates for each measurement period. Discuss specific implementation barriers faced and strategies used during the time period that may have contributed to the observed results. Provide information on how implementation may be improved, based on the current results, for the next measurement period.

Measurement Period	***Measurement***	***Interpretation of Results***	***Barriers Faced and Strategies Used***	***Improvement Strategies for Next Measurement Period***
	Enter Rate at Baseline:			
	Enter Rate at Remeasurement 1:			
	Enter Rate at Remeasurement 2:			
By the end of the project, which measures had a statistically significant improvement over baseline? Summarize the results in narrative form.				
(type response here)				

X. Plan for Sustained Improvement
State Guidance: *[Optional for State to Fill]*
How will you measure improvement beyond the duration of the PIP?
(type response here)
How will you sustain improvements observed through the PIP?
(type response here)
What aspects of this project would you replicate? What aspects would you replace or improve upon?
(type response here)
What aspects of the quality infrastructure established through this project will you build upon to advance oral health among your members?
(type response here)
What technical assistance or other support do you require to sustain the interventions of the PIP and/or to pursue broader oral health quality improvement?
(type response here)
How do you plan to disseminate the findings of the PIP?
(type response here)

Appendix A. Fishbone (Cause and Effect) Diagram



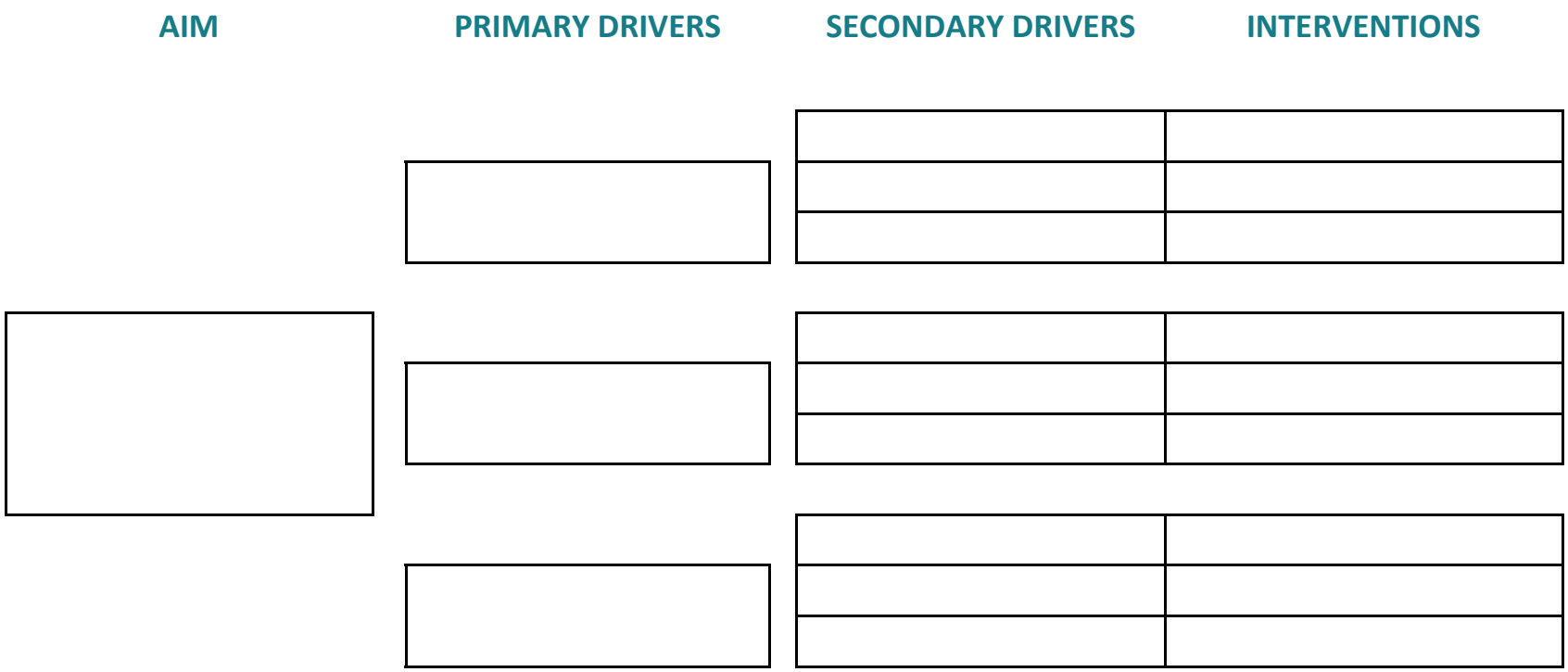
Appendix B. Priority Matrix

Which of the Root Causes Are . . .	Very Important	Less Important
Very Feasible to Address		
Less Feasible to Address		

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

	Positives	Negatives
INTERNAL *under your control*	***build on*** **STRENGTHS** *Examples:* ▪	***minimize*** **WEAKNESSES** *Examples:* ▪
EXTERNAL *not under your control, but can impact your work*	***pursue*** **OPPORTUNITIES** *Examples:* ▪	***protect from*** **THREATS** *Examples:* ▪

Appendix D. Driver Diagram



Appendix E. Plan-Do-Study-Act Worksheet

	Pilot Testing	Measurement #1	Measurement #2
Intervention #1:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•
Intervention #2:			
Plan: Document the plan for conducting the intervention.	•	•	•
Do: Document implementation of the intervention.	•	•	•
Study: Document what you learned from the study of your work to this point, including impact on secondary drivers.	•	•	•
Act: Document how you will improve the plan for the subsequent phase of your work based on the study and analysis of the intervention.	•	•	•

GLOSSARY

Aim statement: A written, measurable, and time-sensitive statement of the accomplishments a team expects to make from its improvement efforts.

Benchmark: The attribute or achievement that serves as a standard for other organizations to emulate.

Champion: An individual in the organization who strongly believes in quality improvement and is willing to work with others to test, implement, and spread changes. The champion should have a good working relationship with colleagues and leadership and be interested in driving change in the system.

Claims (Encounter) data: The electronic record of services provided to health plan enrollees. Encounter data provide the same type of information that is found on claim forms (e.g., UB-04 or CMS 1500), but not necessarily in the same format.

Continuous quality improvement: A cycle (structured trial) of a change during an improvement effort, to accelerate the adoption of proven and effective changes.

Denominator: Provides the general specifications of any clinical component that is the basis for inclusions and exclusions in the population to be considered in a measure; the number below the numerator, as in a fraction.

Disparity: A particular type of health difference that is closely linked with social or economic disadvantage.

Driver of change: The catalyst of a shift or transformation that can be leveraged in improvement efforts.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): A comprehensive and preventive child health benefit for Medicaid enrollees under age 21 that includes periodic screening, vision, dental, and hearing services.

Encounter data (see *Claims Data*)

External quality review (EQR): The analysis and evaluation of aggregated information on quality, timeliness, and access to health services provided to Medicaid/CHIP enrollees by MCOs or their contractors.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements (federal) set forth in 42 C.F.R. §438.354, to perform an EQR and/or other EQR-related activities.

Fee-for-service: Payment method whereby physicians and other health care providers receive a fee for each service delivered, such as an office visit, test, procedure, or other health care interaction.

Generalizability: The ability for findings and conclusions from a study sample to be applied beyond the population from which the sample was drawn.

Focus group: A group of individuals assembled to participate in a guided discussion.

Health literacy: Individuals' ability to find, process, and comprehend the basic health information necessary to act on medical instructions and make decisions about their health.

Implementation: Putting plans or concepts into action; taking a change and making it a permanent part of a system. A change may be tested first and then implemented throughout the organization.

Inclusion criteria: Characteristics that prospective subjects must have if they are to be included in a study or represented in the calculation of a measure rate.

Indicator: A measure of change. A focused, reportable unit that will help a team monitor its progress toward achieving its aim.

Intervention: An action or interference designed to improve the health of a patient or change the conditions (e.g., system, administrative, policies) that have a negative direct or indirect impact on the well-being of the patient.

Measure (*see Indicator*)

Numerator: In reference to the larger population of members, the number of members in a study meeting the specifications of a clinical component in a measure.

Pay-for-performance: A payment model in which health plans and/or providers are rewarded for the value, quality, and/or outcomes – rather than volume – of health care services.

PDSA: The Plan-Do-Study-Act (PDSA) cycle – a key component of continuous quality improvement - outlines steps to test a change on a small scale — by planning it, trying it, observing the results, and acting on what is learned.

Performance measure (or, performance data, quality measure, quality data): The specific representation of a process or outcome that is relevant to the assessment of performance; it is quantifiable and can be documented.

Pilot test: A small-scale trial of a new approach or process, designed to show if the change results in improvement.

Protocol: A systematic way of conducting an activity to ensure reproducibility, or abidance to a policy.

Quality: The degree to which a health care organization increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services. These services must be consistent with current professional knowledge in at least one of the six domains of quality, as specified by the Institute of Medicine – efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

Quality improvement: Systematic and continuous actions that lead to measurable improvement.

Registry: A list or database of records that contains individual patient information. Provides clinically useful and timely information, gives reminders and feedback to providers and patients, identifies relevant patient subgroups, and facilitates individual patient care planning.

Reliability: The degree to which a tool or system produces something reproducible.

Sampling: The process of measuring a sample (e.g., every sixth patient for one week; the next eight patients) to help understand how a system is performing.

Social determinants of health: Circumstances in which people are born, grow up, live, work, and age that can influence health, as well as the systems put in place to deal with illness.

Spread: The intentional and methodical expansion of particular components of health care delivery, such as a quality improvement intervention or system change.

Stakeholder (health care): Individuals/organizations who can influence, have a vested interest in, or can be affected by the health care system.

Statistical significance: Indication that a difference between rates or phenomena is likely due to elements of change in the system and not due to random chance.

Stratification: The process or result of separating a sample into subsamples according to specified criteria such as age or occupation.

Survey: A means (e.g., questionnaire, diary, interview script, group of items) to collect individuals' input.

Sustainability: The likelihood of an improvement persisting over time, and/or the capacity to support long-term improvement.

Sustained health care improvement: Changes in the fundamental processes of health care delivery demonstrated through repeated measurements over comparable time periods.

Target population: A group of individuals selected from the general population to be included in an improvement effort.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Validity: The degree to which a tool measures what it is intended to measure.

Variable: A characteristic or condition that changes or has different values depending on the context.

Definitions have been adapted from several sources, including the Institute for Healthcare Improvement, the Centers for Disease Control, Health Services and Research Administration, and the Agency for Healthcare Research Quality, among other organizations.

Percentage of children, age 1–20, enrolled for at least 90 continuous days, who received any preventive dental service, FFY 2013

Source: CMS-416 Reports, Line 1b, 12b. Data reflect updates as of 10/22/14.