

# **Dental Quality Metrics Workgroup**

**Recommendations for the Metrics and Scoring Committee**

**December 2013**

## **Introduction**

In 2012, Oregon Senate Bill 1580, Section 21, established the nine-member Metrics and Scoring Committee, charged with identifying objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by coordinated care organizations.

### **Workgroup Charge**

The Dental Quality Metrics (DQM) Workgroup was convened in 2013 as a working group of the Metrics and Scoring Committee and charged with:

- Identifying objective outcome and quality measures and benchmarks for oral health care services provided by coordinated care organizations (CCOs); and
- Recommending no more than five measures and associated benchmarks for use in CCO monitoring, from which one or more will be considered for inclusion in the set of CCO incentive measures for the third measurement year (CY 2015).

These measures will be incorporated into Oregon Health Authority's overall measurement framework and recommended for inclusion in the set of CCO incentive measures for the third measurement year (CY 2015).

Oregon Health Authority (OHA) suggested that the Workgroup recommend measures and benchmarks for the adult and pediatric populations; and for the following domains: prevention; treatment; and access. These measures should be consistent with existing state and national quality measures and will be used by OHA to hold coordinated care organizations accountable for performance and customer satisfaction requirements.

### **Workgroup Membership**

Workgroup members were appointed by the Director of the OHA and include:

- Russ Montgomery – AllCare Health Plan
- Patrice Korjenek, PhD – Trillium Community Health Plan
- Janet Meyer – Health Share of Oregon
- Robert Finkelstein, DMD – Willamette Dental Group
- Deborah Loy – Capitol Dental Care
- Mike Shirtcliff, DMD – Advantage Dental
- Bill Ten Pas, DMD – ODS Dental Plan
- Daniel Pihlstrom, DDS – Permanente Dental Associates
- Eli Schwarz, DDS, MPH, PhD –School of Dentistry, OHSU

- Denise C.L. Stewart, DDS, MHSA – School of Dentistry, OHSU
- Michael Plunkett, DDS, MPH – School of Dentistry, OHSU

### **Workgroup Process**

The DQM Workgroup met monthly from July – November 2013 to review existing standardized measures and data sources, and consider their potential for use as performance measures in Oregon. The Workgroup also considered Oregon and national data, if available, as well as existing benchmarks or improvement goals established by national organizations to identify recommended benchmarks and improvement targets.

This document summarizes the Workgroup’s recommendation and rationale to the Metrics and Scoring Committee for CY 2015.

### **Recommended Measures and Rationale**

The DQM Workgroup is recommending two types of measures: measures for inclusion in the quality pool (i.e., new CCO incentive measures) and measures for ongoing monitoring and quality reporting (i.e., new state performance measures).

This section includes a summary of why each measure was selected, considerations the workgroup made, and any recommended modifications and deviations from existing specifications.

### **Measures Recommended for Inclusion in the Quality Pool**

#### **(1) Sealants on permanent molars for children.**

The Workgroup recommends using the Early Periodic Screening Diagnostic Testing (EPSDT) specifications for CY 2015, and consider adopting the equivalent Dental Quality Alliance (DQA) sealant measure in subsequent years when the new 2014 American Dental Association Current Dental Terminology (CDT) risk assessment codes are in widespread use in Oregon.

#### *Discussion*

The Workgroup noted that the Centers for Medicare and Medicaid Services (CMS) has an initiative to increase the number of sealants in the Medicaid population by 10 percentage points over five years. The performance measure recommended by the Workgroup aligns with this initiative.

The Workgroup also noted that state EPSDT data likely underreports sealants actually provided to children on Medicaid, due to some of the sealants being provided to covered children

statewide are done by the Office of Oral Health's school-based sealant program. Their program neither bills Medicaid and/or encounters any of the sealants they perform.

The Workgroup strongly recommends that OHA establish a sealant workgroup to address ways to integrate available data between the state sealant program operated by the public health division and what is available through Medicaid administrative (claims) data.

### **(2) Members receiving any dental services.**

The Workgroup recommends using the EPSDT measure specifications for CY 2015.

The Workgroup considered whether this measure should be (a) limited to services provided in a dental office setting, or (b) limited to services provided by a dental practitioner. The Workgroup agreed the measure should be a dental-focused measure, rather than a physical health measure, and should align with applicable national standards. The Workgroup thus concluded the measure should not be limited to a dental office setting but be limited to "dental services" as defined by CMS for EPSDT purposes, i.e. services provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (CDT codes D0100 - D9999). This definition includes dental services provided by an Expanded Practice Permit Dental Hygienist who has a collaborative practice agreement with a dentist.

The Workgroup further recommends that OHA explore options for reporting dental services as a subset of the timeliness of prenatal care incentive measure.

### **Measures Recommended for Monitoring**

All monitoring measures could be considered for future inclusion in the quality pool; the Workgroup recommends that OHA collect baseline data on these measures in 2014 and begin to monitor performance in 2015.

### **(3) Patient experience with access to dental care**

The Workgroup recommends using two questions from the Consumer Assessment of Health Care Providers (CAHPS) dental survey as patient experience measures, but also recommends that these questions be revisited after the first year for additional discussion about their utility.

- Question #4 – a regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?
- Question #14 – if you needed to see a dentist right away because of a dental emergency in the last 12 months, did you get to see a dentist as soon as you wanted?

Question #4 provides information on the awareness in the covered population of whether or not members have a regular dentist, and would provide information to CCOs on how well they are informing members and ensuring members have a dentist. Question #14 addresses whether or not members can actually receive care if they need it. Both questions are very useful for CCOs in changing their education, marketing profiles, or network contracts, and patient satisfaction is a key information component for moving towards better care.

The Workgroup recommends adopting the questions as written, without modification, so any data collected will be comparable to others using the CAHPS dental survey.

#### *Discussion*

The Workgroup notes that patient experience with dental care is another important component of care to be monitoring and that CAHPS questions can address whether or not members have a dentist and are able to see their dentist when needed: both responsibilities of the CCO.

The Workgroup notes that research in North Carolina indicated that patient experience measures were good for distinguishing between different dental plans, with distinct differences in outcomes.

The Workgroup notes that as with any patient experience measure, these two questions are highly subjective and may not accurately represent care provided. For example, OHA requires that members with emergency dental needs are seen within 24 hours, so organizations will get people in as soon as possible, but it may not be as soon as the member wanted, which is not reflected in the recommended survey question.

The Workgroup also notes that these questions are parallel to questions asked about access to physical health services.

#### **(4) Topical Fluoride Intensity**

The Workgroup recommends measuring the percentage of enrolled children who have received at least one dental service who received (1, 2, 3, >4) topical fluoride applications during the measurement year. This measure is adapted from the Dental Quality Alliance (DQA) measure “Topical Fluoride Intensity for Children at Elevated Caries Risk” and excludes the qualifier “children who are at elevated risk,” as the new 2014 American Dental Association Current Dental Terminology (CDT) risk assessments codes are not yet in widespread use in Oregon.

The Workgroup recommends monitoring the utilization of these new CDT risk assessment codes so the DQA measure specifications, inclusive of children who are at elevated risk, can be adopted if and when CDT code use in Oregon is adequate to support the DQA measure specifications.

## *Discussion*

The Workgroup noted that limiting a measure of fluoride to one particular treatment modality, such as varnish will underreport the actual use of fluoride in the member population. The Workgroup noted that there may be options for modifying the measure specifications to include other fluoride uses, such as fluoride supplementation with tablets, foams and gels, etc.

The Workgroup notes that caries risk assessment is an important measure and one that should be measured first, as those at low risk do not need the same preventive measures as those at moderate to severe risk. Risk assessments reduce the likelihood of children developing cavities and are a key component of every health history. Risk assessments represent an opportunity to integrate oral health into physical health and behavior health.

After considerable discussion, the Workgroup ultimately did not include caries risk assessment as a recommended measure at this time as there is (a) no national standard, and (b) further discussion on what should be included in a risk assessment, by which providers, and where should take place before implementation. However, the workgroup encourages OHA to continue to explore data collection and measurement options for risk assessments, as well as convene a workgroup group to determine community standards for risk assessments. The Workgroup notes that for future years, it will be key to measure risk assessments in a more meaningful way.

The Workgroup also discussed whether the recommended metrics are to be measurements of the dental delivery system, oral health services provided in the medical system, or both.

Some oral health services, such as fluoride varnish, may be provided by pediatricians in the context of well-child visits. However, potential barriers in the Medicaid reimbursement system may prevent the expanded use of this procedure during well-child visits. These barriers could potentially affect quality improvement efforts for CCOs striving to make improvements in this measure if expanded to include oral health services provided in the medical system. The Workgroup encourages OHA to address these provider barriers.

The DQA measure “Topical Fluoride Intensity for Children at Elevated Risk” includes three measurement groups:

- The percentage of children who **had at least one dental service** who received (1, 2, 3, 4+) fluoride applications **as a dental service**.
- The percentage of children who **had at least one oral health service** who received (1, 2, 3, 4+) fluoride applications **as an oral health service**.
- The percentage of children who **had at least one dental OR oral health service** who received (1,2,3,4+) fluoride applications **as a dental OR oral health service**.

The first option would not include fluoride provided in medical settings or by independent hygienists without collaboratives. The second option would not include fluoride provided by or under the supervision of dentists. The third option would include both.

At this time, the Workgroup feels more clarification on the intent of these recommended measures is necessary to determine whether the fluoride varnish measure should address the only the dental delivery system, or expand to include dental services provided in the medical system.

#### **(5) Comprehensive Exam Rate**

The Workgroup recommends stratifying this measure by children, by pregnant women, and by adults with disabilities.

#### *Discussion*

The Workgroup noted that this is a strong measure of access to dental care, although the measure as written does not take into account oral health services performed in other venues, such as virtual dental homes, or services performed by dental hygienists or team dentistry approaches. The Workgroup therefore recommends this measure for monitoring only, and recommends the “Any Dental Service” measure as the potential incentive measure instead.

### **Recommended Benchmarks and Improvement Targets**

This section includes a summary of why each benchmark and improvement target was chosen for the recommended CCO incentive measures, and provides the baseline data currently available for each measure.

The Workgroup considered available baseline data and existing benchmarks available from national sources, including the Centers for Disease Control and Prevention, the Centers for Medicaid and Medicare Services, and Healthy People 2020.

Measure	Baseline Data	Benchmark	Improvement Target
<b>Sealants on permanent molars for children.</b>	Medicaid children receiving a dental sealant in FFY 11: <ul style="list-style-type: none"> <li>• 6-9 year-olds: 15.4 percent</li> <li>• 10-14 year-olds: 12.7 percent</li> </ul>	Healthy People 2020 Goal: <ul style="list-style-type: none"> <li>• 3-5 year-olds: 1.5 percent</li> <li>• 6-9 year-olds: 28.1 percent</li> <li>• 13-15 year-olds: 21.9 percent</li> </ul>	Minnesota Method <sup>1</sup> with 3 percent floor.

The Workgroup recommends using the Healthy People 2020 benchmarks for CY 2015, with the potential to increase the benchmark for CY 2016, depending on CCO performance and regional variation. The Workgroup notes that Healthy People 2020 goals generally represent a gold standard in performance, but also recognizes that they represent a fairly low bar for Oregon performance in this instance and are more modest than what we would want to achieve as a state.

The Healthy People 2020 age groups are slightly different from the EPSDT measure specifications (ages 13-15 instead of 10-14), but the Workgroup agrees this is close enough to not cause problems.

The Workgroup recommends using the Minnesota Method for the improvement target, with a three percent floor, although the Workgroup notes that the three percent floor may be too low to incentivize 2015 performance.

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<sup>1</sup> The Workgroup agreed to recommend the same methodology the Metrics & Scoring Committee has used to set improvement targets for each measure. OHA has provided an overview of the methodology online here: <http://www.oregon.gov/oha/CCODData/Improvement%20Targets%20--%20Revised%20September%202013.pdf>

<b>Measure</b>	<b>Baseline Data</b>	<b>Benchmark</b>	<b>Improvement Target</b>
<b>Members receiving any dental service</b>	Any dental service ages 0-20 in FFY 11:  42.4 percent	Healthy People 2020 Goal:  49.0 percent	Minnesota Method <sup>2</sup> with 3 percent floor.

The Workgroup notes that the Healthy People 2020 benchmark is for all ages, and the baseline data is for ages 0 to 20.

The Workgroup recommends tying the quality pool payment to the rate for the total population for CY 2015, but also recommends that OHA begin reporting on the identified subpopulations: children, pregnant women, and adults with disabilities. The Workgroup suggests considering population-specific benchmarks in a future measurement year.

## Other Considerations

### Utilization and Cost

The Workgroup did not include additional utilization or cost measures in the recommendation as OHA had advised the Workgroup that its recommendation needed to be limited to just a few measures. As OHA will most likely be looking at cost and utilization data through the “2 percent test,”<sup>3</sup> and through ongoing quality reporting, the workgroup recommends that additional utilization or cost measures be considered in the future.

### Subpopulation Analysis

The Workgroup highlights the need to track performance on these metrics for a number of subpopulations, especially populations with severe and persistent mental illness (SPMI). OHA is already committed to reporting all adopted measures where possible by race, ethnicity, language, and disability status.

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<sup>2</sup> *ibid*

<sup>3</sup> Oregon has agreed in its waiver with CMS to reduce per capita medical trend by 2 percentage points by the end of the second year of the waiver. Additional details available online at: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>

## Next Steps

The Dental Quality Metrics Workgroup respectfully submits the draft recommendations in this report to the Metrics and Scoring Committee for review and feedback. If the Committee agrees with the substance of the recommendations, the Workgroup suggests the following as next steps:

- Reconvene the Dental Quality Metrics workgroup in the summer of 2014 to consider the use and viability of new CDT codes, particularly for risk assessments, consider potential future use of diagnostic codes, and the potential for adopting DQA measure specifications for future measurement years in Oregon.

This process will also inform any revisions to these initial recommendations for CY 2015 prior to the start of the measurement year, based on what can be learned from baseline measurement activities.

- Charge the Dental Quality Metrics Workgroup with recommending measures or modifications to existing measures, specifications, and benchmarks for CY 2016.