MEDICAID ADVISORY COMMITTEE
October 26, 2016
9:00am-12pm
Oregon State Library, Room 103
250 Winter St. NE, Salem OR 97301

Webinar registration: https://attendee.gotowebinar.com/register/3556399319701831682
Conference number: 888.398.2342; Public listen-in only: 3732275

Time	Item	Presenter
9:00	Opening remarks • Committee transitions	Co-chairs
9:15	CCO Listening Tour: Part two • Presentation • Discussion of committee recommendations	OHA staff
10:15	**Break**	
10:30	Transformation Center and Patient-Centered Primary Care Home Program: Updates from OHA	Alissa Robbins & Chris Carrera, OHA
11:00	Oregon Ombuds Advisory Council	Ellen Pinney, OHA
11:20	MAC Retreat Discussion	Committee staff
11:50	Public Comment	
11:55	Closing comments	Co-Chairs

Materials:

1. Agenda
2. Draft minutes September 2016 *(*committee only)*
3. Oral Health Access Framework – Final report
4. CCO Listening Tour Presentation
5. Transformation Center Presentation
6. OHA Ombuds report

Next Meeting:
Wednesday, December 7, 2016 9:00 a.m. – 12:00 p.m.
Oregon State Library bldg. -Room #103
250 Winter St. NE, Salem, OR 97301

Oregon
Medicaid Advisory Committee:
Oral Health Work Group

A Framework for Oral Health Access in the Oregon Health Plan

Report and Recommendations

October 2016

Oregon Health Authority

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Oregon Medicaid Advisory Committee

Kate Brown, Governor

Oregon Health Authority

MEMORANDUM

DATE: October 17, 2016
TO: Lori Coyner, Medicaid Director and Dr. Bruce Austin, Dental Director
Oregon Health Authority
FROM: Medicaid Advisory Committee
RE: A Framework for Oral Health Access in the Oregon Health Plan: Report and Recommendations

Dear Ms. Coyner and Dr. Austin,

The Medicaid Advisory Committee (MAC) is committed to ensuring equitable access to health services for all populations served by the Oregon Health Plan (OHP). Despite a growing body of evidence connecting oral health to overall health and wellbeing, many OHP members face significant barriers to accessing oral health care. Improving access to and integration of oral health is critical to ensuring Oregon can meet its Triple Aim for better health, better care, and lower costs to the approximately 1.1 million Oregonians served by OHP.

In May 2016, OHA asked the MAC to recommend a framework for defining and tracking access to oral health for OHP members. In response, we created an Oral Health Work Group comprised of 16 members with representation from coordinated care organizations (CCOs), dental care organizations (DCO), dental providers, consumer advocates, and other community members. To incorporate consumer perspectives, committee staff engaged OHP consumers directly through in-person discussions at several CCO Community Advisory Committee (CAC) and other consumer group meetings in rural and urban communities, as well as a small survey. The impressive interest in work group membership among the community and the level of engagement in all three summer meetings are testaments to the importance of this work.

The MAC is pleased to submit the Oral Health Access Framework for OHP, as recommended by the Work Group, including the full report and recommendations to OHA to adopt:

- **Standard Definition of Oral Health Access** that provides a common language and understanding of oral health access in OHP for OHA and the broader stakeholder community. **(pg. 7)**
- **Oral Health Access Framework Model (pg. 10)** that lays out the key factors and influencers that help or hinder oral health access in OHP.
- **Oral Health Access Monitoring Measures Dashboard** that provides recommended priority measures to monitor key factors of access for OHP members. **(Table 1, Page 12; Appendix B).** <u>It is critical that monitored measures be stratified and reported wherever possible to highlight inequities for vulnerable populations, such as racial and ethnic minorities, pregnant women, people with disabilities, and others.</u>

The Work Group and Committee strongly concurred that the Oral Health Access Framework will only be of value if implemented by OHA. To that end, the MAC recommends OHA

develop and share a comprehensive implementation strategy as recommended in the following report, including:

- Designated responsibility for implementation and plans for engagement across divisions and leadership.

- An agency communications plan for the Oral Health Access Framework that targets relevant boards and committees, such as the Oregon Health Policy Board, as well as the broader community, such as Regional Health Equity Coalitions, CACs, CCOs, and providers.

- A mechanism to review and update the framework and plan, given the changing environment. For example, the report recommends revisiting the oral health measures within two years to incorporate newly developed measures such as those around the social determinants of health. The Work Group recommendations for future potential measures (Table 2, pg. 13) can be a useful resource in this process.

We urge the OHA to continue its transparent approach to this work by engaging the MAC in an ongoing monitoring and advisory role. Consumer voices should continue to inform monitoring, as well as program improvement and policy development efforts. The set of recommendations will help OHA and stakeholders move from an anecdotal understanding of oral health access to a data-driven approach to identifying barriers and inequities and targeting incentives to improve access. We hope this approach will lead to concrete improvements in services for members, and we look forward to continuing to support OHA in this work.

Sincerely,

Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee

Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

cc: Lynne Saxton, Director, OHA
Leslie Clement, Health Policy and Analytics Director, OHA
David Simnitt, Health Policy Director, OHA

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Laura Etherton – policy director, Oregon Primary Care Association
Alyssa Franzen, DMD – dental provider; Dental Director, Care Oregon
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Marcia Hille – Executive Director, Sequoia Mental Health Services
Ross Ryan – OHP member, consumer advocate
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If you would like additional copies of this report, or if you need this material in an alternate format, please email: Mac.Info@state.or.us.

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A Framework for Oral Health Access in the Oregon Health Plan

Executive Summary

There is a growing body of evidence that connects oral health to overall health and wellbeing. Yet, low-income Oregonians, many of whom are OHP members, experience worse oral health outcomes than their higher income counterparts. Improving oral health is critical to ensuring that Oregon can meet its Triple Aim for better health, better care, and lower costs.

In May of 2016, the Oregon Health Authority (OHA) asked the Medicaid Advisory Committee (MAC) to develop a framework for assessing access to oral health services in the Oregon Health Plan (OHP), including both managed care and fee-for-service populations. The committee was asked to address two foundational questions:

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
2. What key data or information could be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

In order to carry out its task, the MAC designated a limited duration Oral Health Work Group, made up of oral health experts and representatives of key groups. The Work Group included two MAC liaisons and 16 community representatives from the following perspectives: Coordinated Care Organizations (CCO), Dental Care Organizations (DCO) contracting with CCOs and OHA, dental providers, consumer advocates, and other community members from the oral health world. The Oral Health Work Group met three times from July to September to:

- discuss barriers to oral health access in Oregon and OHP;
- identify key factors that contribute to oral health access; and
- identify priority monitoring measures to assess the degree to which OHP members are accessing oral health services and the degree to which OHP's oral health delivery system supports access.

Because no OHP consumers applied to be Work Group members, MAC/Work Group staff were charged with engaging OHP members regarding their experiences with oral health access, and reporting the results of these efforts to inform the overall oral health access framework. Results of these efforts were shared with the Work Group at its September 20 meeting (see Appendix A: Oral Health Access Member Engagement: Summary Report).

After much discussion, the Oral Health Work Group agreed on three components of its Oral Health Access Framework:

1. Standard Definition of Oral Health Access: A shared vision of oral health access to unite stakeholders around a common understanding of oral health access in OHP, and to guide OHA in its access monitoring efforts. (pg. 7)
2. Oral Health Access Framework Model: A model laying out the key factors and influencers that help or hinder oral health access in OHP. (pg. 10)

3. Oral Health Access Monitoring Measures Dashboard: A list of priority measures for OHA to use to monitor six key factors of access for OHP members: care coordination; integration of oral, physical and behavioral health; provider distribution; patient-centered care; quality of services; and patient experience. (Appendix B)

The Oral Health Work Group recommends the Oral Health Access Framework to provide a shared understanding of oral health access factors within OHP, and to facilitate OHA and other stakeholders' access monitoring efforts for the purpose of program improvement and policy development efforts. As the work moves toward implementation, the Work Group recommends OHA take the following steps:

- *Develop a comprehensive strategy to implement the Oral Health Access Framework in order to monitor access for OHP members, including designating responsibility for implementation and ensuring communication and engagement across OHA leadership and divisions.*

- *Develop strategies to maintain the oral health access monitoring measures dashboard, starting with revisiting the dashboard within two years of implementation. Reconvene the MAC and the Oral Health Work Group as needed to inform the work.*

- *Develop and share a communications plan and resources regarding the Oral Health Access Framework and implementation plans, including engaging relevant boards and committees, such as the Oregon Health Policy Board.*

- *Continue and expand consumer engagement with regard to their access to oral health services in OHP, in order to inform monitoring, as well as program improvement and policy development efforts.*

Introduction

Oregon's Medicaid Advisory Committee (MAC) has had a long interest in oral health. In 2009, the MAC submitted comprehensive recommendations on oral health in the Oregon Health Plan (OHP), including recommendations to increase benefits, enhance the dental provider workforce, and to better integrate oral health and physical health care. Since 2009, the oral health care landscape has changed dramatically, with the development of Oregon's coordinated care model and the subsequent integration of dental care within the Coordinated Care Organizations (CCO); expanded Medicaid eligibility; and the restoration of comprehensive adult dental benefits for OHP members.

During a strategic planning session in late 2015, the MAC once again identified oral health as a priority, this time focusing on access to oral health services in OHP. Several months later, in May 2016, the Oregon Health Authority (OHA) asked the Medicaid Advisory Committee (MAC) to develop and recommend a framework for defining and assessing oral health access for members of the Oregon Health Plan (OHP), including both managed care and fee-for-service populations. The committee was asked to address two foundational questions:

3. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
4. What key data or information could be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

Background

Access to oral health services is an important issue for Medicaid programs. Low-income individuals are disproportionally likely to experience poor oral health which can lead to poor overall health and lost income and productivity. Populations of color, who are disproportionately represented on Medicaid, face even worse health outcomes. A recent study found that 1 in 12 (8%) low-income Oregon adults reported missed work days due to the condition of their mouth and teeth.[1] In the same study, four times as many low-income adults reported reducing participation in social activities due to the condition of their mouths compared with middle and high-income adults.

Many Oregonians with Medicaid coverage struggle with poor oral health and yet access dental services at lower rates than their commercially insured counterparts. Just over half of Oregon's adult Medicaid population (51.7%) reported having a dental visit in 2014,[2] compared with 67% of the general adult population in Oregon.[3] Claims data suggests an even larger gap. In 2015, only about 1 in 4 adults OHP members (27%) had a dental visit in the past year, and less than half (44%) of OHP children had a dental visit.[4] Private claims data from 2013 reveals that more

[1] American Dental Association. Oral Health and Well-Being in Oregon. Available at http://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/Oregon-facts
[2] 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFF) Survey: Report of Results. Available at https://www.oregon.gov/oha/analytics/MBRFFS%20Docs/2014%20MBRFSS%20Report.pdf
[3] Oregon Oral Health Surveillance System 2002-2015. Available at: https://public.health.oregon.gov/PreventionWellness/oralhealth/Documents/OralHealthSurveillanceReport2016.pdf
[4] *Ibid.*

than two in three (69.1%) of Oregonian adults and similar numbers of children (71%) with private dental benefits had a dental visit in the past year.[5] Oral diseases are preventable, so it is critical to ensure that individuals have access to oral health services, in addition to conducting prevention efforts at the community level. Beyond the impacts on health and wellbeing, lack of access to regular oral health preventive care and treatment services can be costly for individuals and taxpayers. In a recent study, OHP members were four times more likely than commercially-insured Oregonians to visit the emergency department for non-traumatic dental problems.[6]

While access to oral health care is not an issue unique to Medicaid, Medicaid members may experience unique and significant barriers to accessing oral health care. Commonly cited challenges from a national perspective include: [7]

- inadequate dental coverage (dental benefits are federally required for children, but adult coverage is optional for states);
- lack of providers accepting Medicaid;
- individual barriers (such as lack of transportation or child care, and time off work); and
- lack of integration between oral, physical, and mental health providers.

Despite general agreement about potential barriers to oral health access, there is no agreed upon definition or set of measures to monitor access either in Oregon or at the federal level. However, various Oregon and national groups have sought to identify and implement oral health measures, including measures related to oral health access. Local work groups and committees, including the Dental Metrics Quality Work Group and the CCO Oregon Dental Work Group have recommended priority oral health measures as accountability metrics for Oregon CCOs and DCOs. Other local collaboratives, led by Oregon Oral Health Coalition, OHA, and Oral Health Funders Collaborative of Oregon and Southwest Washington, have identified key metrics to guide Oregon's strategic work to improve oral health services and outcomes.[8] Nationally, the Dental Quality Alliance, an organization of major stakeholders in oral health care delivery, develops performance measures for oral health care. And, the Centers for Medicare and Medicaid Services (CMS) has included oral health measures in its Child core set measures and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) reporting requirements. However, CMS efforts have focused on measures related to children's access to dental care, as dental benefits are required for children in Medicaid but are offered to adults at state option. (See Appendix C, Environmental Scan). These local and national efforts can be built upon to identify a strong set of access measures for OHA monitoring purposes.

Oregon's unique delivery system and oral health landscape calls for a focused effort on defining and measuring access for OHP members. Oregon's adult dental package is more generous than

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[5] Vujicic, Marko & Kamyar Nasseh. (December 2015 (Revised)). Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrows, Remains Large for Adults. ADA Health Policy Institute. Available at: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0915_1.pdf?la=en

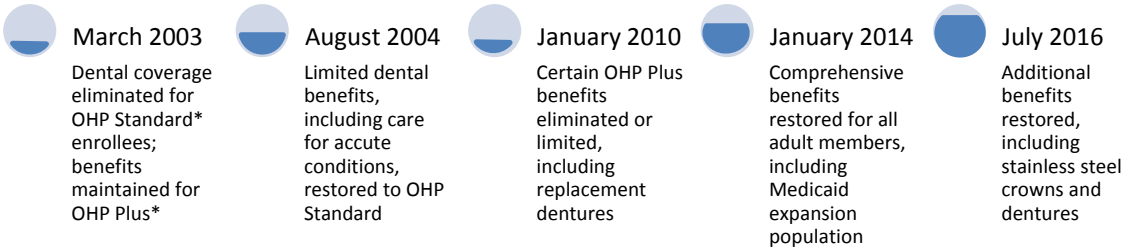
[6] Sun, B., Chi, D., et. al. Emergency Department Visits for Non-Traumatic Dental Problems: A Mixed-Methods Study (May 2015). Am J Public Health. 947-955. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386544/pdf/AJPH.2014.302398.pdf

[7] Center for Health Care Strategies. Medicaid Adult Dental Benefits: An Overview. http://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/

[8] Strategic Plan for Oral Health in Oregon: 2014-2020. Available at: http://static1.squarespace.com/static/554bd5a0e4b06ed592559a39/t/55a7f5aae4b01d3d0f766de4/1447361848914/Strategic+Plan+for+Oral+Health+in+Oregon.pdf

most states, as one of only 13 states currently offering comprehensive adult dental benefits to both its traditional Medicaid and Medicaid expansion populations. However, the nature and level of these benefits has changed over time, with benefits reduced at various points due to budgetary considerations and restored at other points to reach the comprehensive package OHP adults have today (see Figure 1 below). These changes are important to consider in light of how member and provider awareness of OHP benefits can contribute to oral health access. Additionally, Oregon's integration of dental services into its Coordinated Care Model as of July 2014 offers a new context for discussions of improved access (See Appendix D, Dental Care Delivery for Oregon's Medicaid Population). Looking more broadly at the context for oral health, Oregon ranked 48th out of 50 states in optimally fluoridated community water systems, an evidence-based, safe, and low-cost community-level strategy for preventing tooth decay.[9]

Figure 1. Oregon adult benefits timeline (2003-2016)



*OHP Plus: Individuals categorically eligible for Medicaid, prior to federal Medicaid Expansion (e.g. pregnant women and children)
*OHP Standard: Adults not eligible for Medicaid pre-Medicaid Expansion (e.g. single adults)

Work Group Process

The MAC established the Oral Health Work Group to carry out the development of the oral health access framework. The MAC and OHA staff recruited members with expertise in oral health from the following areas: Coordinated Care Organizations (CCOs), Dental Care Organizations (DCOs), dental providers, consumer/consumer advocates, tribal members, and members of the general public. Matt Sinnott, Government Affairs Director for Willamette Dental Group and James Tyack, dentist and owner of Tyack Dental, co-chaired the work group. Alyssa Franzen, Dental Director for Care Oregon, and Bob Diprete, retired health policy professional, participated as liaisons from the MAC. (See Appendix E, Roster). Below is a brief summary of work group representation:

- CCO members = 3
- DCO members = 3
- Providers = 3 (including two dentists, and one hygienist)
- Consumer advocates = 2
- Tribal representatives = 3
- General public = 2

[9] one of 14 community-level initiatives included in the CDC's "Health Impact in 5 Years initiative that have evidence for 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier http://www.cdc.gov/policy/hst/hi5/

Work Group member demographic information:
Gender: 69% Female; 31% Male
Race: 16 identify as Caucasian, 1 identifies as Native American
Ethnicity: 16 members identify as non-Hispanic
Geography: 8 Portland area, 2 Willamette Valley, 1 Oregon Coast, 1 Central Oregon, 3 Eastern Oregon, 1 Southern Oregon
Disability: 0 members identify as disabled

MAC committee members and staff from the Oregon Health Authority were unsuccessful in their efforts to recruit OHP consumers for the Oral Health Work Group. As a result, staff engaged in a separate effort to engage OHP consumers in the oral health access framework discussions. The process and results of the consumer engagement effort are described in Appendix A. A summary of consumer feedback was presented at the September 20 meeting of the Oral Health Work Group and informed its final recommendations to the MAC.

The Oral Health Work Group met three times during the summer of 2016: July 7, August 11, and September 20. During these meetings, the work group held robust discussions to address the two foundational questions originally posed to the MAC.

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should Oregon define access)?
2. What key data or information could be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

The Work Group adopted a standard definition of oral health access (pg. 7) and an oral health care access framework model (pg. 10) that lays out four key components of access:

- OHP member/population factors;
- structural/systems of care factors (e.g. State policy);
- availability factors; and
- utilization factors

Next, the Work Group selected six priority factors from the "availability" and "utilization" sectors of its oral health access framework model to recommend for OHA monitoring purposes. Availability and utilization factors were used as the most readily measurable for the purposes of monitoring access. These priority factors were tied to 15 recommended measures in the Work Group's final Oral Health Access Monitoring Measures Dashboard (see Appendix B). The MAC reviewed and provided feedback to the Work Group's efforts on July 27 and reviewed final recommendations on September 28.

Guiding assumptions

Over the course of the Work Group's discussions, several themes were raised frequently as basic assumptions and principles underlying the Work Group's recommendations:

1. Access to oral health care is an essential component of improving oral health and overall health[10]
2. The state Medicaid program and its contractors are responsible for ensuring timely access to health services for Medicaid members[11]
3. All components of oral health access are important to consider when identifying and addressing oral health access issues, including factors at the individual level (e.g. fear of the dentist), factors at the population level (e.g. Social Determinants of Health), factors of availability (e.g. provider distribution) and factors of utilization (e.g. patient experience). Some components of oral health access lend themselves more readily to monitoring efforts, including availability and utilization factors (e.g. monitoring provider distribution, or use of services). However, future initiatives to address access should consider opportunities at all points of oral health access. Changes at the personal, population health, and systems/policy level can facilitate improvements in availability and utilization, ultimately improving access to services and oral health outcomes.

The first two of these themes support the importance of the Work Group's task in developing the Oral Health Access Framework. The last theme calls attention to the importance of a holistic approach to resolving access issues as OHA moves forward in its efforts to enhance and improve access for members.

Recommendations

The Oral Health Work Group developed the Oral Health Access Framework in order to guide OHA's efforts to monitor oral health access in the Oregon Health Plan. The Framework is meant to provide a shared definition of oral health access for OHA as well as for Oregon stakeholders; to identify the key factors that influence access and provide a model an access system for OHP; and to identify priority measures that OHA could use to monitor access in OHP. To that end, the Work Group recommends the following three key elements of the Oral Health Access Framework, which are described in more detail in the following pages:

1. Standard Definition of Oral Health Access: A shared vision of oral health access to unite stakeholders around a common understanding of oral health access in OHP, and to guide OHA in its access monitoring efforts.
2. Oral Health Access Framework Model: A model laying out the key factors and influencers that help or hinder oral health access in OHP.
3. Oral Health Access Monitoring Measures Dashboard: A list of priority measures for OHA to use to monitor key factors of access for OHP members.

Standard Definition of Oral Health Access

To ensure a common understanding of the key components of oral health care access, the Work Group developed a definition of oral health care access in the Oregon Health Plan. The group considered the work of national stakeholders and experts, including the Medicaid and CHIP

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[10] See *e.g.* Committee on Oral Health Access to Services; Institute of Medicine and National Research Council, (2011), Improving Access to Oral Health Care for Vulnerable and Underserved Populations.
Research Council. (2011). Improving Access to Oral Health Care for Vulnerable and Underserved Populations. http://www.nationalacademies.org/hmd/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations.aspx; U.S. Surgeon General. (2000). Oral Health in America. http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf
[11] For example, 42 CFR 422.112 Access to Services requirements for Medicaid Managed Care

Payment and Access Commission and the Institute of Medicine and National Research Council (see Appendix F: Oral Health Work Group Presentation Slides, July 7). Key concepts from national work were incorporated into the committee's definition, such as the importance of timely care, appropriate sites of care, patient-centered care, and equitable access. The work group adopted the following definition:

Standard Definition: Oral health access in the Oregon Health Plan

Oral health care access is achieved when people* are able to seek out and receive the right care, from the right provider, in the right place, at the right time.

Oregon Health Plan members have better oral health care access when:

- Members, their caregivers, providers and plans understand the importance of oral health and are aware of dental benefits
- Members have the resources – such as transportation, child care, and accessible care sites – to seek regular oral health preventive services and appropriate treatment as needed
- Policies and systems are built to facilitate access, by funding oral health benefits, addressing administrative barriers, and incentivizing provider participation
- Health care providers of all types work together to coordinate oral health care and integrate care into a plan for overall health

**Regardless of race, ethnicity, language spoken, culture, gender, age, disability status, income, education, or health.*

Oral Health Care Access Framework Model

The Work Group developed the Oral Health Care Access Framework Model to provide an overview of the key factors of access and visual representation of how factors interact to produce or hinder access. The Work Group used three strategies to develop its oral health access framework model:

- Review of national research and models of oral health access and health care access for Medicaid populations (see Appendix F);
- Group brainstorm of barriers to oral health access for OHP members; and
- Group activity to translate barriers to oral health access into four categories of oral health care access factors (see below). A full list of factors brainstormed, including MAC member input, is attached as Appendix G.

The Oral Health Access Framework Model (Figure 2) has four main components:

- **OHP Member/Population Factors:** Member awareness and understanding of their benefits, as well as the resources members have to access care (e.g. transportation), are important factors in access. Access to resources such as plain language materials, interpretation services, and other tools to improve health literacy and to facilitate access for Limited English Proficient members are key to improving member awareness and understanding. Additionally, population-level factors play a role in member access, including poor oral health outcomes and underlying social determinants of health, such as lack of housing, that disproportionately impact lower income populations.
- **Structural/systems of care:** Policy and systems issues provide context and may help or hinder availability and utilization factors. Maintaining comprehensive dental benefits for

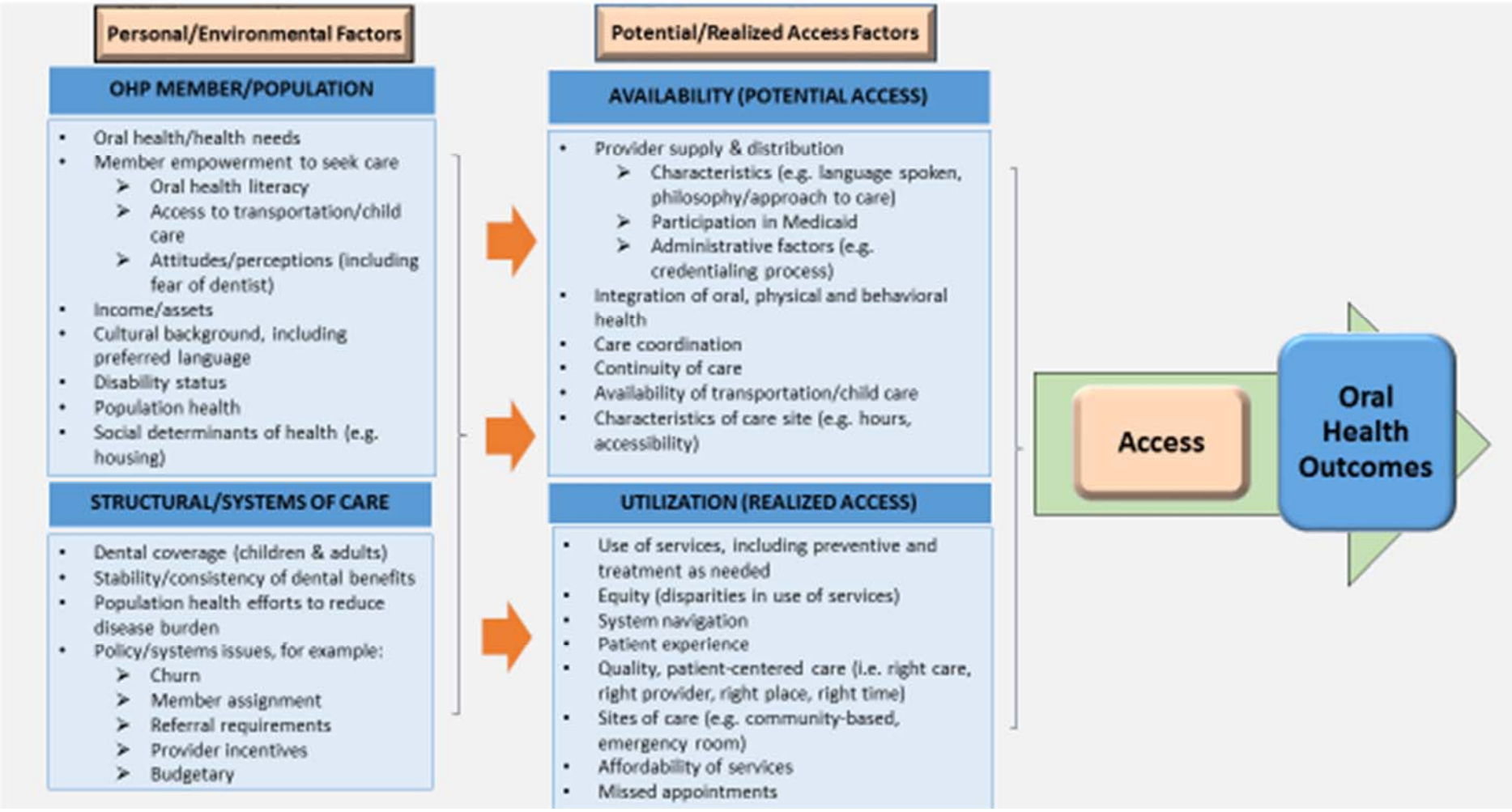
the adult population is one policy that helps ensure adults can afford dental services, which also impacts children's dental access, as children are more likely to get care when their parents have coverage. Additionally, the relative consistency of these benefits over time may impact overall awareness and understanding of benefits on the part of both patients and their providers. Other systems issues, such as disruption in coverage (i.e. churn), may hinder member utilization and access. Population health efforts to reduce disease burden, such as community water fluoridation, can improve oral health and thereby reduce the need for treatment.

- **Availability:** Availability, also known as "potential access" includes the factors of oral health services that enable members to access the services they need, from the right provider, in the right place, at the right time. The availability of providers throughout the state, as well as the characteristics of providers (e.g. language spoken) and care sites, are important availability factors. Availability also entails continuity of care, care coordination for dental services, and integration of oral health care into a larger plan for overall health via coordination with physical and behavioral health providers.

- **Utilization:** Utilization encompasses factors related to the actual use of services, otherwise known as "realized access." Important here are concepts of who is getting services (equity), whether members are getting the right services (preventive care and treatment), and whether they are getting services from the right provider (whether dental or other health care provider), in the right place (office and community-based sites, and emergency departments only when truly needed), and in a timely manner.

These components combine to determine whether or not OHP members have access to oral health access, which in turn impacts oral health outcomes.

Figure 2. Oregon Health Plan Oral Health Care Access Framework Model



Oral Health Access Monitoring Measures Dashboard

The Work Group recommends OHA implement a measures dashboard to provide a picture of oral health access in the Oregon Health Plan. The dashboard should include priority measures from the availability and utilization components of the Oral Health Care Access Framework Model. The dashboard can be used to monitor access to oral health care, identify barriers to access and/or areas of insufficient access, and inform action such as policy development, informing Medicaid program priorities, or allocating resources. Measures were selected for monitoring purposes, rather than as CCO or DCO accountability measures. The Work Group recommends that OHA review the dashboard on an annual basis (see page 14, recommendations for implementation of framework).

The MAC directed the Oral Health Work Group to select a mix of priority factors for monitoring that:

(1) Support the Triple Aim: importance of care coordination and patient experience as a critical components of oral health care access in Medicaid; and
(2) Promote health equity and access for vulnerable and underserved populations within OHP (including people with intellectual and physical disabilities, racial and ethnic minorities, pregnant women, children with special health care needs, and the aging)

The six priority factors selected for inclusion in the measures dashboard therefore focus strongly on measures related to care coordination and integration of oral and physical health, as well as quality of care and patient experience of care. In order to address equity, the Work Group recommends the dashboard measures be stratified when reported in order to assess possible disparities, with stratification minimally including race, ethnicity, people with disabilities, and children with special health care needs whenever possible. OHA's Health System Transformation Reports currently stratify and report performance metrics by OHP members with disabilities. The Work Group recommends similar efforts be taken where possible, and that as capabilities evolve to identify and define members with disabilities and children with special health care needs in reporting, that new capabilities be used to enhance access monitoring for these vulnerable populations. Finally, the Work Group would like to note that while many existing measures traditionally focus on children, partly due to limited nationwide coverage for adults, the recommended dashboard emphasizes population-wide measures due to Oregon's coverage system and concern about low utilization of services in the adult population.

The final selected measures were drawn primarily from an environmental scan of existing measures reviewed and endorsed by local work groups, existing oral health strategic plans, and national sources (e.g. Dental Quality Metrics Work Group). See the full environmental scan in Appendix C. Table 1 below provides a summary of the monitoring measures recommended by the committee. The full recommended measures dashboard can be found in Appendix B.

Table 1. Summary of Recommended Measures of Access

Priority Factors	Measures
Care coordination	Percentage of all enrolled who were seen in the ER for non-traumatic dental reasons within the reporting year and visited a dentist following the ED visit
	Percentage of all enrolled/enrolled adults treated for periodontitis who accessed dental services (received at least one dental service) who received comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year
Integration of oral, physical and behavioral health	Mental, physical and dental health assessments within 60 days for children in DHS custody
	Percentage of all enrolled adults identified as people with diabetes who accessed dental care (received at least one service) within the reporting year
	% or # primary care providers providing oral health assessment to patients, as seen through use of D0191 oral health assessment.
Provider Distribution	Ratio of OHP licensed dental providers to OHP members, reported by region. Provider types to include the following: • Dentists • Dental Hygienists (reported by types of hygienist, including EPDH, non-EPDH)
Patient Centered Care	Number of OHP oral health care providers who completed cultural competency training as reported by the Oregon Board of Dentistry
	How often did the dentists or dental staff explain what they were doing while treating you? (Q12 Dental CAHPS) /
	How often did your regular dentist explain things in a way that was easy to understand? (Q6 Dental CAHPS)
Quality of Services	Number & percent of EVER/Number & percent of CONTINUOUSLY enrolled members receiving at least 1 preventive dental care service during the measurement year
	Individuals with at least 90 continuous days of enrollment who received at least one diagnostic dental service by or under the supervision of a dentist
	Percentage of all enrolled members who received a treatment service within the reporting year.
Patient Experience	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? (CAHPS)
	Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist?
	Compliance with forthcoming Time & Distance standard: (e.g. minutes/miles standards for urban, rural communities) to pediatric dental providers (per CMS Network Adequacy Requirements)

Future measures for exploration and development

The work group recommends additional indicators for exploration by OHA and other stakeholders in future monitoring efforts. These measures, while not as readily usable as those in the recommended dashboard, may be useful for future consideration by groups considering

oral health access measures, including the Metrics & Scoring Committee, CCO Oregon, and other groups. Table 2 provides a list of additional indicators the Work Group recommends for future consideration.

In particular, the Work Group would like to call out the importance of identifying and monitoring measures that address additional aspects of patient experience and resources, and measures that could speak to whether access improvements are leading to improvements in oral health outcomes. Additional patient experience/resource questions could include questions around transportation challenges and resources (including awareness and availability of non-emergency medical transportation), whether patients are receiving the care they expect or feel they need, and whether members understand "where to go" to find information and support about their benefits. Monitoring of broader oral health outcomes might include measures of disease burden among children (e.g. kindergarten-age children who are disease free) and assessments of oral health improvements in the general population.

Table 2. Recommended indicators of access for future consideration

To measure…	Indicators
Care coordination	Dental referrals in community-based settings, such as schools
	FTE dedicated to case management/care coordination
	Utilization of PreManage/EDIE by dental providers
Integration	Other dental services (e.g. fluoride) provided in a primary care setting
	# referrals by primary care to dental/dental to primary care
	# people receiving physical health care and what % received dental
	Pharmacy spend by chronic disease/condition (e.g. diabetes)
Quality of services	Repeat visits
	Ratio of emergent/urgent services to preventative services
	Dental service utilization outside of normal business hours
	Dental service success (e.g. need for follow-up, re-do)
Patient Experience	Transportation challenges/resources (including non-emergency medical transportation)
	Patient awareness of resources/support to understand their benefits
	Patient perception of whether receiving care they need
	Appeals/grievances related to oral health access
	Rate of member change in provider/plan
Patient Centered Care	Accessible care/care accommodation for people with disabilities
	Integrated systems for member clinical records
	Monitoring of social determinants of health in care population
Oral health outcomes	Kindergarten-age children who are disease free
	Oral health improvements in the OHP population

Implementation of the Oral Health Access Framework: Recommendations

The recommended Oral Health Access Framework is meant to shape and guide oral health access monitoring efforts of OHA. As OHA moves toward implementation of the Oral Health Access Framework, the Work Group recommends the following:

OHA develop a comprehensive strategy to implement the Oral Health Access Framework in order to monitor access for OHP members, including designating responsibility for implementation and ensuring communication and engagement across OHA leadership

The Work Group recommends OHA's Statewide Dental Director lead the implementation of the Framework, including regular monitoring of recommended access measures on an annual basis, beginning with year one as a baseline. Additionally, the implementation of the Oral Health Access Framework should involve and engage leadership across OHA's divisions, including Health Systems Division, Health Policy and Analytics, and other relevant divisions in order to ensure integration of this effort into broader health system transformation.

OHA develop strategies to maintain the oral health access monitoring measures dashboard

The Oral Health Work Group has recommended the Oral Health Access Monitoring Measures Dashboard based on current conditions in OHP and available measures at the time of this report. Future changes to policy and the delivery system, as well as new measures becoming available, may warrant revisiting of OHA's monitoring strategy and dashboard. The Oral Health Work Group recommends OHA develop a process for maintaining the Framework and its measures dashboard, including returning to the MAC and reconvening the Oral Health Work Group as needed to inform updates to the work. A reasonable timeline for the first update of this work could be within the first two years after it is first implemented.

OHA develop and share a communications plan and resources regarding the Oral Health Access Framework and implementation plans

The Oral Health Access Framework is meant to inform OHA and also may be useful and of interest to various stakeholders, including CCOs, DCOs, providers, consumers and advocates, and others. The Work Group requests that OHA develop and implement a communications plan for the Framework to allow Work Group members and the broader public to digest and share this work. As part of this plan, OHA might consider holding a meeting or conference with stakeholders to share the work. Additionally, the Work Group recommends the Oral Health Access Framework be shared with relevant OHA boards and committees, including the Oregon Health Policy Board.

OHA continue and expand consumer engagement with regard to their access to oral health services in OHP

The consumer engagement effort (Appendix A), while limited in scope and sample due to timeline, was critical to the work of the Oral Health Work Group and the Oral Health Access Framework. The Oral Health Work Group recommends that OHA build additional consumer engagement efforts into its implementation of the Oral Health Access Framework. For example, OHA could expand its effort to engage members throughout the State, especially in the Eastern and Southern communities that were not touched in the initial effort. This could allow OHA to get a more comprehensive look at the issues consumers face, as well as the magnitude of access challenges or barriers in rural vs. urban communities. Additionally, this could provide the opportunity to ask additional questions related to patient experience (see pg. 13).

Conclusion

Equitable access to oral health services is critical to ensure effectiveness of the Oregon Health Plan and also to help the State meet its goals for better health, better care, and lower costs. Oral health access is complicated by a number of factors related to individual OHP member, state policies and administrative systems, provider availability and characteristics, and the nature of utilization of oral health services. The Oral Health Work Group developed the Oral Health Access Framework to be included in recommendations from its parent group, the Medicaid Advisory Committee, on how OHA should define and assess access to oral health services for members of OHP. OHA and other government and community stakeholders should use the Oral Health Access Framework to provide a shared understanding of oral health access factors, and to monitor access for the purpose of program improvement and policy development efforts.

Introduction and Process

Despite outreach efforts to recruit consumers to join the Oral Health Work Group, no individual members of the Oregon Health Plan (OHP) applied for Work Group membership. The Medicaid Advisory Committee and the Oral Health Work Group each expressed the need to engage members directly in a conversation about oral health access, to ensure that member perspectives informed the development of the Oral Health Access Framework.

To address this need, OHA staff crafted a set of questions to engage consumers during in-person meetings or a written survey. The goal of these tools was to gather on-the-ground, qualitative feedback from consumers about what oral health means to them, how they access dental care, and how their experiences with the OHP dental system could be improved. The results represent a snapshot of member experiences, and should not be viewed as either representative of the entire OHP population, all Coordinated Care Organizations (CCOs) and Dental Care Organizations (DCOs), or dental providers broadly.

The timeline for the consumer engagement effort was from August 1 to September 15. In order to engage as many consumers as possible, OHA staff reached out to CCO Community Advisory Councils (CACs) and other groups connected to OHP consumers that were scheduled to hold meetings during the time period for consumer input. OHA staff attended six community-focused meetings and events to hear directly from consumers and advocates in 5 Oregon communities: Hood River/Wasco, Columbia, Yamhill, and Lane Counties; as well as the tri-county Portland metro area. while the focus of these meetings was expressly to hear directly from OHP members, staff also heard perspectives from consumer advocates and other community members who participate as members of the CACs and other visited groups. Additionally, one meeting (Allies for a Healthier Oregon) was made up entirely of advocates. Due to the condensed timeline for consumer input, some CACs distributed an electronic version of a questionnaire designed for OHP members. The survey was available in both English and Spanish, and one in-person event focused on Spanish speaking consumers.

Meetings attended:

- Hood River/Wasco County – PacificSource CCO CAC meeting, Hood River August 22 & Next Door's Latinos en Acción September 8;
- Lane County – Trillium CCO CAC's Rural Advisory Council meeting in Florence September 9;
- Columbia County – Columbia Pacific CCO CAC meeting in St. Helens September 12;
- Portland Metro – Allies for a Healthier Oregon meeting in Portland September 13;
- Yamhill County – Virginia Garcia Medical Center Patient Advisory Council in McMinnville September 14.

Summary of Feedback

Consumers expressed appreciation for efforts to solicit their perspective on oral health and access to dental benefits, and spoke extensively on their feelings and experiences with the dental health care system. For the purposes of this summary, consumer comments are summarized in four broad categories.

Importance of Dental Coverage

Consumers generally understood the importance of dental care and in many cases expressed great appreciation for the enhanced dental benefits recently made available under OHP for adults. Specifically, several consumers reported financial barriers to accessing dental care without coverage, and as a result felt especially pleased to have dental benefits through OHP.

In many cases, however, consumers did not fully understand what dental benefits they might be eligible for, how much services might cost, and how they might find more information about their benefits. Some consumers also were unaware that they were eligible for non-emergency medical transportation to dental appointments. Many patients suggested that additional, and more user-friendly, resources would be helpful for them to understand their dental benefits and how to access them. It was suggested as well that consumers who are comfortable with mobile technology may appreciate app-based resources, while hard-copy and additional in-person resources may help other consumers.

In their words:
"less stress & worry over how to pay for proper dental care"
"first teeth cleaning ever!"
"oral health affects the rest of my health"
"every dollar in my family counts"

Access to Care and Barriers

Many consumers raised issues related to their choice of dental network and the availability of providers in their community. This concern was raised most prominently by consumers living in smaller and rural communities, while members in larger cities expressed greater satisfaction with the choice of providers and DCOs.

Many consumers expressed frustration with limited appointment availability, noting that appointments were often only available several months into the future. Similarly, some consumers lamented that "urgent" or drop-in care was extremely hard to come by. Limited appointment availability was compounded by the challenge of getting time off work to visit dental providers, who often only have appointments during regular working hours.

Many consumers also brought up transportation barriers that are both related to their individual situations as well as the availability of providers in their community. Some consumers in Columbia County noted that they had 45 minute or more commute each way to a dentist, which essentially meant that it took close to a half-a-day to get care. Consumers in the Eugene-Springfield area noted that the non-emergency transportation options there were effective; however, residents of rural Lane County felt that this was not necessarily the case in

their community. In some cases, consumers were not aware that they were eligible for transportation services or did not feel comfortable with the services available.

Many Spanish speaking consumers also noted language barriers to their access to care, while English and Spanish speaking patients alike expressed that more understandable "plain language" information about their plan and benefits would be helpful.

In their words:
"I need… more availability when trying to make an appointment…"
"[more] mobile dental care"
"I want information in plain language…"
"how would you find out if you were eligible?"
"distance is a huge barrier"

Patient Experience

Many consumers expressed concerns with their treatment when accessing care as OHP members. Consumers noted explicitly that not feeling welcome or comfortable with their provider makes them less likely to seek care, which includes being less likely to seek routine and preventive care. One consumer noted that compared to her experiences with non-OHP coverage, as an OHP member her dental providers did not explain procedures or describe options for care, and she was concerned that treatments were overly quick and rushed. Another consumer wondered why their cleaning had been staggered over multiple visits without explanation, which led the consumer to feel as though it was related to their OHP status.

Consumers also raised concerns about DCO and/or clinic policies related to no-shows that they viewed as overly harsh. One OHP member explained that their provider would cancel an entire family's appointments if any member of the family missed an appointment. Others explained that even one missed appointment made it much more difficult to get additional appointments. Given transportation issues faced by many OHP members (such as the 45 min trip each way for some), some expressed a desire for more understanding when appointments are missed.

In their words:
"OHP always gets the 8am appointment… it's like they want you to miss that appointment"

Care Coordination / Integration

Consumer views on the coordination and integration of their care were mixed. In particular, some consumers spoke highly of the connection between their physical and dental health by providers while they were pregnant. Some consumers suggested that their dental and physical health providers often missed opportunities to educate patients on the value of good oral health and the connection between physical and oral health. One reason for this disconnect, raised by consumers, is that there is simply not enough time built into their appointments to adequately connect these issues.

Some consumers expressed specific concern with the lack of information sharing between dental and physical health providers as it related to prescription medications. Consumers and

community members noted that this lack of coordination could be especially problematic in light of prescription drug abuse issues in many parts of the state and raised questions about whether dental providers have access to the same prescription drug monitoring resources that their primary care providers use.

Some members noted that referral requirements can make it difficult to get appointments with a pediatric specialist for their children. For example, one woman noted that there is a pediatric dentist in her community that takes OHP, but she is required to get a referral to take her child there. The referral process is confusing, and she is concerned she will need to get an appointment with a general dentist first in order to see the pediatric dentist.

In their words:
“oral health affects the rest of my health”
“[there’s] not enough time to talk to my doctor about this”

Overall Observations

On the whole, consumers understood the importance of dental benefits and that the scope of benefits had recently been increased. Still, there was confusion about what services are now covered and about why OHP members who are also covered by Medicare do not have dental benefits. Consumers in smaller or rural communities in particular noted greater access challenges related to their distance to providers, while many in rural and non-rural communities noted the importance of patients feeling comfortable with their providers. Language barriers also prevent individuals not only from accessing care, but also from fully understanding their dental and transportation benefits.

Consumers were pleased to give their input and expressed great interest in learning more about the next steps in the process and how they can continue to help improve dental health systems in OHP, improve consumer access to care, and eventually improve their overall oral health.

Appendix B: Oral Health Access Monitoring Measures Dashboard

ACCESS INDICATOR	MEASURE NAME	DATA SOURCE	MEASURE STEWARD	ENDORSED (OREGON)	MEASURE TIER*
AVAILABILITY: CARE COORDINATION					
Coordination of emergency department visits and dental care	Percentage of all enrolled who were seen in the ER for non-traumatic dental reasons within the reporting year and visited a dentist following the ED visit	Medicaid Claims	DQA	CCO Oregon	Tier 1
Coordination for patients with chronic oral health disease	Percentage of all enrolled/enrolled adults treated for periodontitis who accessed dental services (received at least one dental service) who received comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year	Medicaid claims	DQA (under consideration - no specifications)	CCO Oregon	Tier 2
AVAILABILITY: ORAL HEALTH INTEGRATION (COORDINATION WITH BEHAVIORAL AND PHYSICAL HEALTH CARE)					
Coordination of screenings for foster care kids	Mental, physical and dental health assessments within 60 days for children in DHS custody	CCO Performance Reports	OHA	CCO Incentive	Tier 1
Patients with chronic disease (e.g. diabetes) who accessed dental care	Percentage of all enrolled adults identified as people with diabetes who accessed dental care (received at least one service) within the reporting year	Medicaid claims	DQA (under consideration - no specifications)	CCO Oregon	Tier 2
Primary care providers offering oral health services	% or # primary care providers providing oral health assessment to patients, as seen through use of D0191 oral health assessment.	Medicaid Claims	None	Dental Metrics Quality Work Group (oral health services in medical settings)	Tier 2

ACCESS INDICATOR	MEASURE NAME	DATA SOURCE	MEASURE STEWARD	ENDORSED (OREGON)	MEASURE TIER*
AVAILABILITY: PROVIDER DISTRIBUTION					
Provider-to-population ratios	Ratio of OHP licensed dental providers to OHP members, reported by region. Provider types to include the following: • Dentists • Dental Hygienists (reported by types of hygienist, including EPDH, non-EPDH)	OHA Licensing Database	OHA	NONE	Tier 2
UTILIZATION: PATIENT-CENTERED CARE					
Linguistically and culturally appropriate care	Number of OHP oral health care providers who completed cultural competency training as reported by the Oregon Board of Dentistry[12]	Data to be reported to OHA beginning Summer 2017	Oregon Oral Health Strategic Plan	Oregon Oral Health Strategic Plan	Tier 2
Patient involvement in care	How often did the dentists or dental staff explain what they were doing while treating you? (Q12 Dental CAHPS)	Under consideration for CAHPS 2017	Dental CAHPS	CCO Oregon	Tier 2
	How often did your regular dentist explain things in a way that was easy to understand? (Q6 Dental CAHPS)	Under consideration for CAHPS 2017	Dental CAHPS	CCO Oregon	Tier 2
UTILIZATION: QUALITY OF SERVICES					
Proportion of population receiving services	Number & percent of EVER/Number & percent of CONTINUOUSLY enrolled members receiving at least 1 preventive dental care service during the measurement year	Medicaid claims	OHA	OHA/DHS/DMAP Dental Access Measures Tool	Tier 1

[12] For example, HHS offers a free, online educational program in Cultural Competency accredited for oral health professionals: https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers

ACCESS INDICATOR	MEASURE NAME	DATA SOURCE	MEASURE STEWARD	ENDORSED (OREGON)	MEASURE TIER*
	Individuals with at least 90 continuous days of enrollment who received at least one diagnostic dental service by or under the supervision of a dentist	**Medicaid claims**	**OHA/EPSDT (measure built for children)**	**NONE**	**Tier 2**
	Percentage of all enrolled members who received a treatment service within the reporting year.	**Medicaid Claims**	**DQA/EPSDT (measure built for children)**	**NONE**	**Tier 2**
UTILIZATION: PATIENT EXPERIENCE					
Wait times for appointments	**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?**	**Oregon CAHPS Survey**	**Dental CAHPS**	**Dental Metrics Quality Work Group; Oregon FFS Access Monitoring Plan**	**Tier 1**
Customer services experience	**Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist?**	**Under consideration for CAHPS 2017**	**Dental CAHPS**	**CCO Oregon**	**Tier 2**
Distance to travel to provider	**Compliance with forthcoming Time & Distance standard: (e.g. minutes/miles standards for urban, rural communities) to pediatric dental providers*** *(Note that this measure is limited to pediatric dental providers per CMS network adequacy requirements, but monitoring could encompass other types of dental providers. If monitoring is limited to pediatric dental providers, the Work Group recommends "pediatric provider" be defined as all providers who serve children, rather than limiting the definition to pediatric specialists.)*	**NONE CURRENTLY - annual reports to begin 2018**	**CMS Network Adequacy**	**NONE**	**Tier 2**

*Tier 1 measures have the fewest challenges to adoption for monitoring. These measures have been endorsed by an Oregon group and have existing specifications for immediate use by OHA
*Tier 2 measures have more challenges to adoption for monitoring. These measures either have no current data source, are not endorsed by an Oregon group, do not have existing specifications for immediate use by OHA, or all of the above.

Appendix C: Environmental Scan

ORAL HEALTH ACCESS MEASURES ENVIRONMENTAL SCAN

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	OREGON FFS ACCESS MONITORING PLAN (DRAFT)	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	EPSDT	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
AVAILABILITY																									
Provider supply & distribution	**Percentage of eligible schools with dental sealant programs:** --Percentage of eligible schools served with dental sealant program (40% FRL or greater) (target grades 1 and 2 or 2 and 3) --Percentage of eligible schools served with dental sealant program (40% FRL or greater) (target grades 6 and 7 or 7 and 8)	OHA Oral Health Unit; Oregon Smile Survey	x																						1
	Oral health service - local health departments/FQHCs: Proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health program	Uniform Data System (UDS); HRSA/BPHC																				x			1
	Oral health services - School-based Health Centers: Number of SBHCs that provide routine access to a dental provider on site	OHA Public Health Division; School-Based Health Center Program	x																			X			2
	Number of providers - EPDH: Number of expanded practice dental hygienists practicing in Oregon communities	Oregon Board of Dentistry	x	x																					2
	Providers in rural areas: Number of dental and dental hygiene students completing a 30-day rural rotation	OHSU		x																					1
	Network adequacy - provider distribution: --Geographic location of network providers and medicaid enrollees, considering distance, travel time, The means of transportation ordinarily used by medicaid enrollees --Time & Distance standard (e.g. 30 minutes/30 miles) to pediatric dental providers	Future reports to CMS																	x						1
	Provider to covered person ratios: --Population to full-time-equivalent dentist ratio of at least 5,000:1 (Dental health provider shortage area (HPSA)) --Population to full-time equivalent dentist ratio of less than 5,000:1 but greater than 4,000:1 and unusually high needs for dental services (Dental HPSA) --Ratio of the number of persons in the population group to the number of dentists practicing in the area and serving the population group of at least 4,000 (Dental HPSA)	HPSA Maps, additional analysis												x						x					2

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
Provider characteristics	**Providers - race/ethnicity:** Proportion of underrepresented minority students admitted to dental and dental hygiene programs	Oregon School Admissions		**x**																					1
	Providers - culturally competant care: Number of oral health care providers who completed cultural competency training as reported by the Oregon Board of Dentistry	Oregon Board of Dentistry		**x**																					1
	Network adequacy - provider characteristics: --Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted medicaid services --Ability of network providers to communicate with limited English proficient enrollees in their preferred language --Ability of network providers to ensure physical access, reasonable accommodations, culturally compentent communications, and accessible equipment for medicaid enrollees with physical or mental disabilities	??																	**x**						1
	Treatment plan completion rate: --Percent of dental patients with a Phase I treatment plan completed within a 12 month period --Percentage of patients that have treatment plan completed within 6 months	Unknown									X													X	2
Provider participation in Medicaid	**Network adequacy - number of Medicaid providers:** Number of network providers who are not accepting new medicaid patients	Provider database																	**x**						1
Provider administrative factors	None found																								0

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
Care coordination	**Caries-related ED visit follow-up - children:** --The percentage of caries-related ED visits among children 0 through 20 years in the reporting year for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit --Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children 0–20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit --Percentage of all enrolled children who were seen in the ED for caries-related reasons within the reporting year and visited a dentist within 60 days following the ED visit --Percentage of all enrolled children who were seen in the ER for caries-related reasons within the reporting year and visited a dentist following the ED visit	Medicaid claims							**x**				**x**												2
Care coordination/Oral Health Integration	**Care coordination - chronic disease:** --Percentage of all enrolled adults identified as people with diabetes/enrolled adults identified as people with diabetes who accessed dental care (received at least one service) who received a comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year --Percentage of all enrolled/enrolled adults treated for periodontitis who accessed dental services (received at least one dental service) who received comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year --Percentage of all enrolled adults/enrolled adults treated for periodontitis who accessed dental care (received at least one dental service) who received oral prophylaxis OR periodontal maintenance at least 1, 2, 3, >=4 times within the reporting year --Percentage of a. all enrolled identified as smokers b. enrolled adults who accessed dental care (received at least one service) identified as smokers who received a comprehensive or periodic oral evaluation within the reporting year	Medicaid claims							**x**				X												2

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	OREGON FFS ACCESS MONITORING PLAN (DRAFT)	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	EPSDT	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
Care coordination	**Care coordination - foster kids** --Mental, physical and dental health assessments within 60 days for children in DHS custody	Metrics reports			x																				1
Oral Health Integration	**Oral health integration** --Percent of adults have received information from the dentist or dental hygienist focusing on reducing tobacco use or on smoking cessation in the past year in 2011–12 (age adjusted to the year 2000 standard population) --Percent of adults have received an oral and pharyngeal cancer screening from a dentist or dental hygienist in the past year in 2011–12 (age adjusted to the year 2000 standard population)	Medicaid claims																			x			1
Care continuity	**Patients with a usual source of care:** --Members with a regular dentist (Do you have a regular dentist?) --Percentage of all children enrolled in two consecutive years who visited the same practice or clinical entity in both years	CAHPS; Unknown				x	x						x											3
	Alternative payment methodologies - dental plans: --Number of public health plans that receive an incentive or shared savings payment for improved oral health outcomes --Number of public health plans that incorporate oral health in alternative payment methodologies for contracted providers	OHA Metrics & Scoring; CCO Transformation Plans	x																					1
Availability of transportation/child care	None found																							0
UTILIZATION																								0
	Children with dental sealants: --Children aged 6-9 years with dental sealants on one or more permanent molars --Children ages 6-9 and 10-14 who received a sealant on permanent molar tooth, regardless of whether the sealant was provided by a dentist or a non-dentist --Percentage of enrolled children in the age categories of 6-9 and 10-4 years at "elevated" risk (e.g. "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year	Oregon Smile Survey; Medicaid claims	x	x	x		x				X		x			x						x			8

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
	Any dental visit in the previous year - children: --Children aged 0 to 5 with a dental visit in the previous year --11th graders with a dental visit in the previous year --Total members ages 0-21 receiving at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (CDT codes D0100-D9999) --individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one dental service by or under the supervision of a dentist --Percentage of all enrolled children under 21 who received any dental service within the measurement year/reporting year --percentage of Medicaid members 2-21 years of age with dental benefits, who had at least one dental visit during the measurement year --individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received either a "dental service" by or under the supervision of a dentist or an "oral health service" by a qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim	PRAMS2; Medicaid claims	**x**	**x**			**x**	**x**	**x**				**x**			**x**	X								8
	Any dental visit in the previous year - adults: --Adults with a dental visit in the previous 12 months --Adults 18 and older with a dental visit in the previous year --Percentage of all enrolled adults who received at least one dental service within the reporting year	Medicaid claims	**x**	**x**					**x**				**x**												4
	Any dental visit in the previous year - all populations: --Percent of persons aged 2 years and older had a dental visit in the past year --Percentage of enrolled members (age to be determined) who had at least one dental visit during the measurement year --Saw a dental professional (past 12 months) --Percentage of clients receiving dental services in a year	Medicaid claims							**x**	**x**								**x**				**x**			4
	Per member per month utilization: Per member per month utilization for dental services	Medicaid claims								**x**															1

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	OREGON FFS ACCESS MONITORING PLAN (DRAFT)	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	EPSDT	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
Use of Services, including preventive and treatment as needed	**Service breakdown by plan:** Percentage of breakdown of services provided, segregated by plan	Unknown								X															1
	Preventive dental visits - Children: --Percentage of children receiving at least one preventive dental service by or under the supervision of a dentist within a reporting year --Percentage of children who received a preventive dental visit during their first year [of life] --Number of children less than 7 years old who receive oral health risk assessment and intervention during the well-child visit --Percent of children and adolescents aged 2 to 18 years at or below 200 percent of the Federal poverty level received a preventive dental service during the past year	Medicaid claims	X					X	X			X				X		X				X			7
	Preventive dental visits - all enrollees: --Number & percent of EVER enrolled members receiving at least 1 preventive dental care service --Number & percent of "CONTINUOUSLY" enrolled members receiving at least 1 preventive dental care service	Medicaid claims								X															1
	Preventive dental visits - pregnant women: --Pregnant women who had their teeth cleaned in the previous year --Percentage of pregnant women receiving at least one preventive dental service by or under the supervision of a dentist within the reporting year	Medicaid claims; PRAMS	X					X	X																3
	Fluoride treatment - all populations: --% of patients who receive topical fluoride application	Medicaid claims									X														1
	Fluoride applications - Pregnant women: --Pregnant women who received prophyl/flouride	Medicaid claims							X																1

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
	Fluoride applications - Children: --Percentage of children who have received at least one dental service in the year who received (1,2,3,>4) topical fluoride applications during the year --Percentage of children ages 1-6, assessed with moderate to high risk of developing dental caries, who received at least one topical fluoride treatment. --Percentage of all enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application within the reporting year --The percentage of children ages 1-5 with receipt of fluoride varnish in any setting (dental, primary care, schools) at least annually --The percentage of children ages 12-72 months defined as being at higher-risk of dental disease who receive 1 or more fluoride varnish applications --Percentage of all enrolled children who received at least one dental	Medicaid claims					x	x	x				x												4
	Comprehensive dental exam - children: --Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year --Percentage of all children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years	Medicaid claims											x												1
	Comprehensive dental exam - pregnant women: --Percent of pregnant women with comprehensive dental exam completed while pregnant	Medicaid claims							x																1
	Comprehensive dental exam - all populations: **--**Comprehensive exam rate (stratified by children, pregnant women, and people with disabilities)	Medicaid claims					x																		1
	Periodic or comprehensive exam - children: --Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year	Medicaid claims							x																1
	Periodic or comprehensive dental exam - adults: --Percentage of enrolled adults/enrolled adults who accessed dental care (received at least one service) who received a comprehensive or periodic oral evaluation within the reporting year	Medicaid claims							x																1

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
	Risk assessment: --% of patients that have oral health risk assessment performed	Medicaid claims									X														1
	Any dental treatment service - children: --individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one dental treatment service by or under the supervision of a dentist --Percentage of all enrolled children who received a treatment service within the reporting year.	Medicaid claims											**x**			**x**									2
	Any dental diagnostic service - children: --individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one diagnostic dental service by or under the supervision of a dentist	Medicaid claims														X									1
Site of care	**Emergency Department Utilization - Children:** --Number of emergency department visits for caries-related reasons per 100,000 member months for all enrolled children --Percentage of all enrolled children who were seen for caries-related reasons in an ED for 1, 2, 3 or more visits within the reporting year	Medicaid claims							**x**				**x**												2
	Emergency Department Utilization - Adults: --Percentage of all enrolled adults who were seen for non-traumatic dental reasons in an ED for 1, 2, 3 or more visits within the reporting year	Medicaid claims							**x**				**x**												2
	Emergency Department Utilization - all populations: --Number of emergency department visits for nontraumatic dental problems --ED utilizations for nontraumatic dental problems	Medicaid claims	**x**	**x**																					2
	FQHC Utilization - all populations: Proportion of patients who receive oral health services at Federally Qualified Health Centers (FQHCs) each year	Unknown																			**x**				1
Quality of Services	***See*** **Patients with a usual source of care (i.e. repeat visits)**																								

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
Patient-centered care	**Patient involvement in care** How often did your regular dentist explain things in a way that was easy to understand? How often did your regular dentist listen carefully to you? How often did the dentists or dental staff explain what they were doing while treating you?	**CAHPS Dental Survey (*not currently part of Oregon CAHPS)**																							0
	Care from dentists and staff: How often did your regular dentist treat you with courtesy and respect? How often did your regular dentist spend enough time with you? How often did the dentists or dental staff do everything they could to help you feel as comfortable as possible during your dental work?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																1
	Customer service How often did the 800 number, written materials, or website provide the information you wanted? How often did your dental plans customer service give you the information or help you needed? How often did your dental plans customer service staff treat you with courtesy and respect? Did this information(from your dental plan) help you find a dentist you were happy with?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																
Patient experience	**Patient ratings** Using any number from 0 to 10, where 0 is the worst regular dentist possible and 10 is the best regular dentist possible, what number would you use to rate your regular dentist? Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all of the dental care you personally received in the last 12 months? Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist? Using any number from 0 to 10, where 0 is the worst dental plan possible and 10 is the best dental plan possible, what number would you use to rate your dental plan?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																1

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
	Waiting time for an emergency appointment: If you needed to see a dentist right away in the last month because of a dental emergency in the last 12 months, did you get to see a dentist as soon as you wanted?	CAHPS				x	x		x																3
	Waiting time for a specialist appointment: If you tried to get a dental appointment for yourself with a dentist who specializes in a particular type of dental care (such as root canals or gum disease) in the last 12 months, how often did you get an appointment as soon as you wanted?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																1
	Waiting time - general: How often were your dental appointments as soon as you wanted?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																1
	Waiting time - waiting room: --How often did you spend more than 15 minutes in the waiting room before you saw someone for your appointment --If you had to spend more than 15 minutes in the waiting room before you saw someone for your appointment, how often did someone tell you why there was a delay or how long the delay would be?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																1
	Dental care - unmet need: --The proportion of persons who are unable to obtain or delay in obtaining necessary dental care --Any time when needed dental health care was delayed or not received (past 12 months)	MEPS, AHRQ, National Survey of Children's Health																x				x			2
	Perception of benefits --Did your dental plan cover what you and your family needed to get done?	CAHPS Dental Survey (*not currently part of Oregon CAHPS)							x																
Affordability	**Unmet need - due to cost:** Unmet need for dental care due to cost	National Health Interview Survey																x							1
ORAL HEALTH OUTCOMES																									
	Children with untreated decay: --The proportion of children and adolescents with untreated dental decay	Unknown	x																			x			2

Factors	MEASURES	POTENTIAL DATA SOURCE	STATE/OREGON								STATE/WASHINGTON		NATIONAL/FEDERAL												Total X
			SHIP	STRATEGIC PLAN FOR ORAL HEALTH IN OREGON	OHA CCO INCENTIVE METRICS	**OREGON FFS ACCESS MONITORING PLAN (DRAFT)**	DENTAL QUALITY METRICS WORK GROUP	OHA 2016 METRICS STAKEHOLDER SURVEY	CCO OREGON DENTAL WORK GROUP	**2009 OHA/DHS/ DMAP DENTAL ACCESS MEASURES TOOL**	Washington Dental Metrics Dashboard	Washington State Common Measures for Health Care Quality & Cost	DQA	HPSA	CMS ADULT/CHILD CORE SET	**EPSDT**	NCQA HEDIS	MACPAC MACStats	CMS NETWORK ADEQUACY RULES 2016	NETWORK ADEQUACY MODEL ACT	CMS CQMs (clinical quality measures) 2014	HEALTHY PEOPLE 2020	PQRS 2015	HRSA sample clinical measures	
Oral health outcomes	**Adults with untreated decay:** The proportion of adults with untreated dental decay	National Health & Nutrition Examination Survey (NHANES); CDC/NCHS																				**x**			1
	Children with decay experience: --% children ages 0-20, who have had tooth decay or cavities during the measurement period --The proportion of children and adolescents who have dental caries experience in their primary or permanent teeth --Third graders with decay experience	Unknown		**x**											**x**						**x**	**x**			5
	Adults with tooth extraction - ever: Proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease	National Health & Nutrition Examination Survey (NHANES); CDC/NCHS																				**x**			1
	Adults with periodontitis: Proportion of adults aged 45 to 74 years with moderate or severe periodontitis	National Health & Nutrition Examination Survey (NHANES); CDC/NCHS																				**x**			1
	Oral/Pharyngeal cancer: Proportion of oral and pharyngeal cancers detected at the earliest stage	National Health & Nutrition Examination Survey (NHANES); CDC/NCHS																				**x**			1

Dental Care Delivery for Oregon's Medicaid Population

Oregon's Coordinated Care Model

Coordinated Care Organizations (CCOs)

A CCO is a network of all types of health care providers (physical health care, addictions and mental health care, and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

- 16 CCOs serve approximately 90% of Oregon Health Plan members.
- Mental, physical, dental care held to one per capita budget.
- Responsible for health outcomes and receive monetary incentives for quality care.
- Required to develop Transformation Plans with strategies to improve health outcomes, increase member satisfaction, and reduce overall costs.

Dental Care Integration

Prior to Oregon's health system transformation, Dental Care Organizations (DCOs) served the majority of the Medicaid population.

As of July 1, 2014, CCOs began managing the dental benefit, primarily by contracting directly with DCOs.

- Nine DCOs work with 16 CCOs and community partners to improve oral health for adults and children.
- CCOs contract with all DCOs available in their region (in some cases, all nine).
- CCOs connect members with DCOs.

Eight CCOs have specific oral health strategies in their 2015-2017 Transformation Plans, including:

- Eliminate/minimize barriers to dental care for all members
- Primary care integration, including implementing First Tooth early childhood prevention training, referral mechanisms, dental screenings for co-morbid severe and persistence mental illness (SPMI)/diabetes populations
- Value-based payments for dental
- Dental/medical integration

A small percentage of Oregon Health Plan members receive dental care outside of a CCO dental care arrangement, either in dental-only managed care or through the fee-for-service delivery system.

Developing Dental Quality Metrics

In 2013, OHA convened the Dental Quality Metrics Workgroup, including dental and CCO stakeholders.

Workgroup purpose: Recommend to the Metrics and Scoring Committee objective outcome and quality measures and benchmarks for oral health services provided by the CCOs.

Parameters: Metrics should align with national measures, be measurable, and focus on outcomes where possible.

Outcome: Metrics and Scoring Committee adopted two incentive pool quality metrics as of 2015.

1. Mental, physical and dental* health assessments within 60 days for children in Department of Human Services (DHS) custody (e.g. foster care). *(*measure amended in 2015 to include dental along with mental/physical health assessment*)

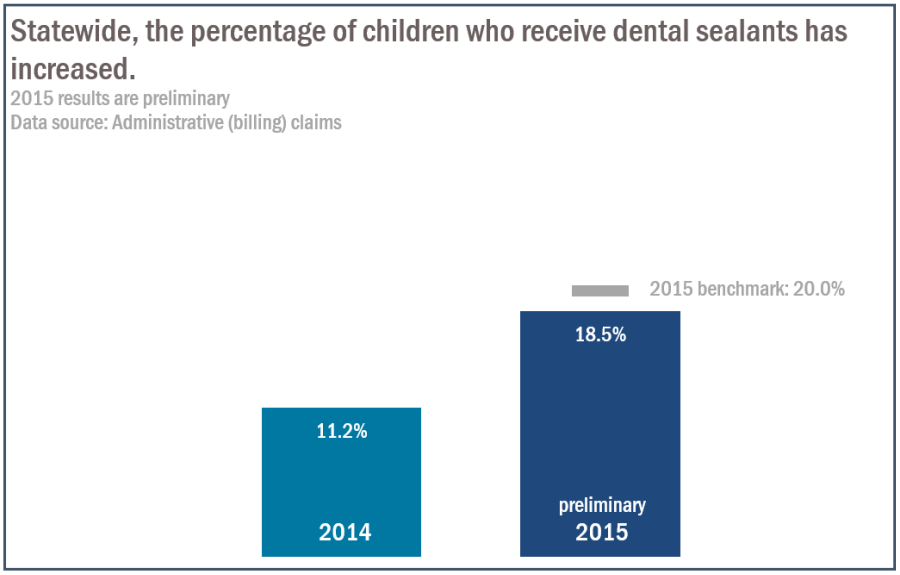
2. Dental sealants on permanent molars for children (ages 6-14)

Quality Metric: Dental Sealants on Permanent Molars for Children

Dental sealants are a widely recognized, evidence-based tool used to prevent tooth decay. Childhood tooth decay causes needless pain and infection, and can affect a child's nutrition and academic performance.

Description: Percentage of children ages 6-14 who received a dental sealant during the measurement year.

- Preliminary 2015 data indicates improvement by all 16 CCOs
- Statewide change since 2014: +65%
- All racial and ethnic groups experienced improvement



Appendix E: Oral Health Work Group Roster

Medicaid Advisory Committee: Oral Health Work Group						
Member Name	**Title**	**Organizational Affiliation**	**City**	**Race/ Ethnicity**	**Gender**	**Category**
Christina Couts	Community Health Worker	ShelterCare Homeless Medical Recuperation Program	Junction City	C	F	Consumer/ Advocate
Susan Filkins	Nutrition Consultant	Oregon Center for Children and Youth with Special Health Care Needs	Portland	C	F	Consumer/ Advocate
James Tyack	Dentist	Tyack Dental	Clatskanie	C	M	Provider
Kuulei Payne	Dental Hygienist	Winding Waters Medical Clinic	Wallowa	C	F	Provider
Lisa Bozzetti	Dentist/ Dental Director	Virginia Garcia Memorial Health Center	Gresham	C	F	Provider
Heather Simmons	Medicaid Dental Services Director	PacificSource Community Solutions	Bend	C	F	CCO
Laura McKeane	Oral Health Integration Coordinator	AllCare Health	Grants Pass	C	F	CCO
Jim Connolly	VP of Network Development and Contracting	Trillium Community Health Plan	Eugene	C	M	CCO
Laura Platero (formerly Bird)	Director of Government Affairs/Policy Analyst	Northwest Portland Area Indian Health Board	Portland	NA	F	Tribal
Allyson Lecatsas	Health Director	NARA Northwest Clinic	Portland	C	F	Tribal
Kelle Adamek-Little	Health Administrator	Coquille Indian Tribe	Coos Bay	C	F	Tribal
Mike Shirtcliff	President	Advantage Dental	Redmond	C	M	DCO
Matthew Sinnott	Director of Government Affairs and Contracts	Willamette Dental Group	Hillsboro	C	M	DCO
Jeffrey Sulitzer	Chief Clinical Officer/Dental Director	InterDent/Capitol Dental	Happy Valley		M	DCO
Eli Schwarz	Dentist, Professor & Chair	OHSU School of Dentistry, Department of Community Dentistry	Portland	C	M	General Public
Tony Finch	Executive Director	Oregon Oral Health Coalition	Happy Valley	C	M	General Public
Alyssa Franzen	Dental Director	Care Oregon	Portland	C	F	MAC Liaison
Bob Diprete	Retired health policy expert	Retired	Amity	C	M	MAC Liaison

Medicaid Advisory Committee
Oral Health Work Group

July 7, 2016

Portland, OR

Oregon Health Authority

Time	Item	Presenter
9:00	Opening remarks and introductions	David Simnitt, OHA Co-Chairs
9:10	Oral Health Work Group overview	David Simnitt, OHA; Alyssa Franzen, Care Oregon; Bob Diprete, Retired health policy professional (MAC Liaisons)
9:25	Barriers to oral health access in the Oregon Health Plan • Brainstorm	Co-Chairs
9:45	Defining access to oral health – model definitions and frameworks • Presentation • Q&A	Amanda Peden, OHA
10:00	OHP oral health access framework and definition • Small group activity • Report-outs and discussion	Co-Chairs
10:45	Public Comment	
10:55	Closing comments	Co-chairs

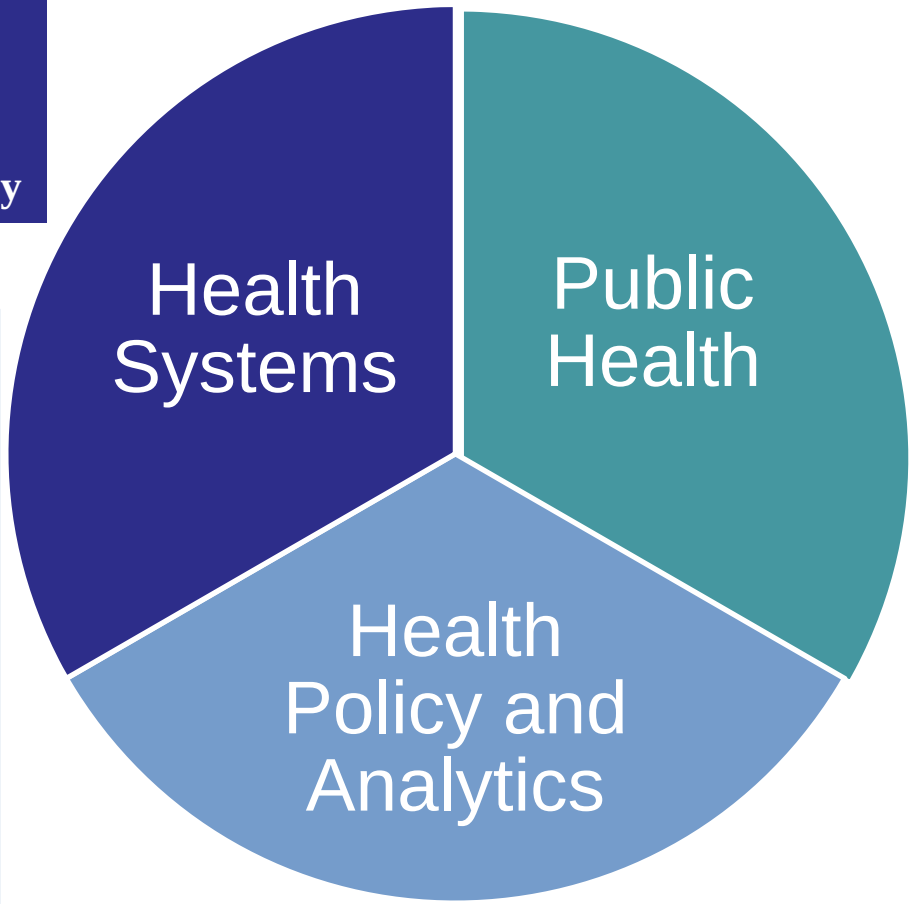
OHA Oral Health Initiatives

David Simnitt, Director of Health Policy
Oregon Health Authority
Office of Health Policy and Analytics

Oregon Health Authority

Oral Health in OHA

- Medicaid policy analysis, rules and policy implementation
- OHP oral health benefits and delivery



- Oral health surveillance
- School-based programs (e.g. dental sealant and fluoride) and dental sealant certification
- Dental pilot projects
- HRSA Oral Health Workforce Grant
- Public health interventions local & statewide (e.g. Title V)
- Health education (e.g. tooth brushing, benefits of fluoridation)

- State Dental Director (works across agency)
- Dental data hub and dental metrics
- Oral health policy development/health system transformation policy
- Strategic planning/ coordination of oral health team
- Transformation Center TA, QA, support

Oral health in a changing landscape

2013

Medicaid expansion

Affordable Care Act Insurance Marketplaces launch

- Pediatric dental of one 10 Essential Health Benefits

2015

State Health Improvement Plan (2015-2019)

- OHA Public Health Division created plan for statewide use
- Oral health one of 7 priorities

OHA Dental Director hired

Dental sealant metric adopted as of 2016

2014

Strategic Plan for Oral Health in Oregon (2014-2020)

- Statewide multi-stakeholder plan for oral health improvement

Dental integrated into CCO model (July)

2016

Oral Health in Oregon: OHA Dental Director report to the legislature (March)

Restored certain dental benefits

Develop OHA Oral Health alignment and coordination strategic plan and road map

The case for considering oral health access in Oregon

- Historically, OHP members show lower utilization rates than the general population
  - In 2014, 23% of OHP adults had dental visit in 2014[1]; while 67% of all adults reported having a dental visit[2]
- Recent developments call for agency exploration of oral health access
  1. **Influx of new enrollees**: over 440,000 Oregonians newly enrolled in OHP since Medicaid expansion
  2. **Oral health integration:** Integration of oral health into CCO model occurred in July 2014.
  3. **State responsibility re: network adequacy**: Recent CMS rules require network adequacy standards for pediatric dental providers

1. OHA administrative data
2. 2014 Behavioral Risk Factor Surveillance System (BRFSS) data from the Oregon Oral Health Surveillance System https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/surveillance.aspx

Oregon Health Authority

MAC Oral Health Work Group Ask and Guiding Principles

Alyssa Franzen, Care Oregon
Bob Diprete, Retired health policy professional
Medicaid Advisory Committee Liaisons

Oregon Health Authority

MAC Ask to Oral Health Work Group: Oral Health Access Framework

Develop a framework for defining and assessing access to oral health for OHP members.

- Deliverable: Memo recommending framework to be presented to Medicaid Advisory Committee, September 29, 2016

Oregon Health Authority

Guiding Questions

1. What are the key factors that influence access to oral health care for OHP members (i.e. how should we define access)?
2. What key data and information could OHA use to assess access to oral health services for OHP members (i.e. how should we monitor and identify access problems)?

Oregon Health Authority

Scope of Work

- **Define oral health access:**
  - Draw on existing federal and state definitions and frameworks regarding access to oral health and other health services
  - Tailor to Oregon's unique health care delivery system; demographic characteristics; health needs and disparities among populations served by OHP; provider composition; other Oregon-specific considerations.
- **Recommend key data to assess access (i.e. access measures):**
  - Identify, select, and prioritize key access measures from existing local/federal sources
  - Purpose is for OHA monitoring/assessing access; not recommending incentive or accountability metrics for coordinated care organizations (CCOs).

*The scope of work does not include developing recommendations related to oral health access improvement strategies or solutions.

Oregon Health Authority

Oral Health Access Framework – Work Plan

Date (2016)	Task Description
May 25 (MAC Mtg.)	*MAC* commits to developing a framework for oral health access and directs OHA to form the Oral Health Work Group to develop recommendations and a proposed framework.
June 2016	Oral Health Work Group recruitment and appointment (see Oral Health Work Group Roster)
June 22 (MAC Mtg.)	*MAC* approves Oral Health Work Group roster and revised work plan.
July 7 (OHWG Mtg #1)	• Introduction to the Work Group purpose and objectives • Presentation on national model access definitions and frameworks • *Work Group* identify barriers to oral health care access in the Oregon Health Plan and develop shared definition of oral health access
July 27 (MAC Mtg.)	*Work Group* present list of key factors influencing access for OHP members and working definition of access.
August 11 (OHWG Mtg #2)	• Presentation and review of model metrics/measures of access from dental work groups, strategic plans, national sources • *Work Group* develop and prioritize list of key data to assess access for OHP members
August/September	*Staff* draft memo on framework for oral health access in OHP per Work Group and MAC discussions
September 20 (OHWG Mtg #3)	*Work Group* review and discuss draft memo on framework for oral health access in OHP. Recommend revisions for memo to present to MAC.
September 28 (MAC Mtg.)	*MAC* review and finalize draft committee memo on framework for oral health access in OHP for OHA

Barriers to Oral Health Access in the Oregon Health Plan Brainstorm

Question: What barriers do you know or imagine that may prevent Oregon Health Plan (OHP) members from accessing oral health services in OHP? Consider barriers from perspectives such as: consumer/family perspective, provider, and health care organization/delivery

Oregon Health Authority

Defining Access to Oral Health: Model Definitions and Frameworks

Amanda Peden, Policy Analyst
Oregon Health Authority
Office of Health Policy and Analytics

Oregon Health Authority

Potential Barriers to Health Care Access[1]

1. Structural barriers related to the supply of care (e.g. providers, organization and delivery of care, and transport to care;
2. Financial barriers related to insurance coverage and continuity, provider payments, and benefits/cost sharing;
3. Personal barriers related to patient characteristics such as culture, language, attitudes, education, and income, which may influence acceptability of care.

Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services; Millman M, editor. Access to Health Care in America. Washington (DC): National Academies Press (US); 1993. 2, A Model for Monitoring Access. Available from: http://www.ncbi.nlm.nih.gov/books/NBK235891/

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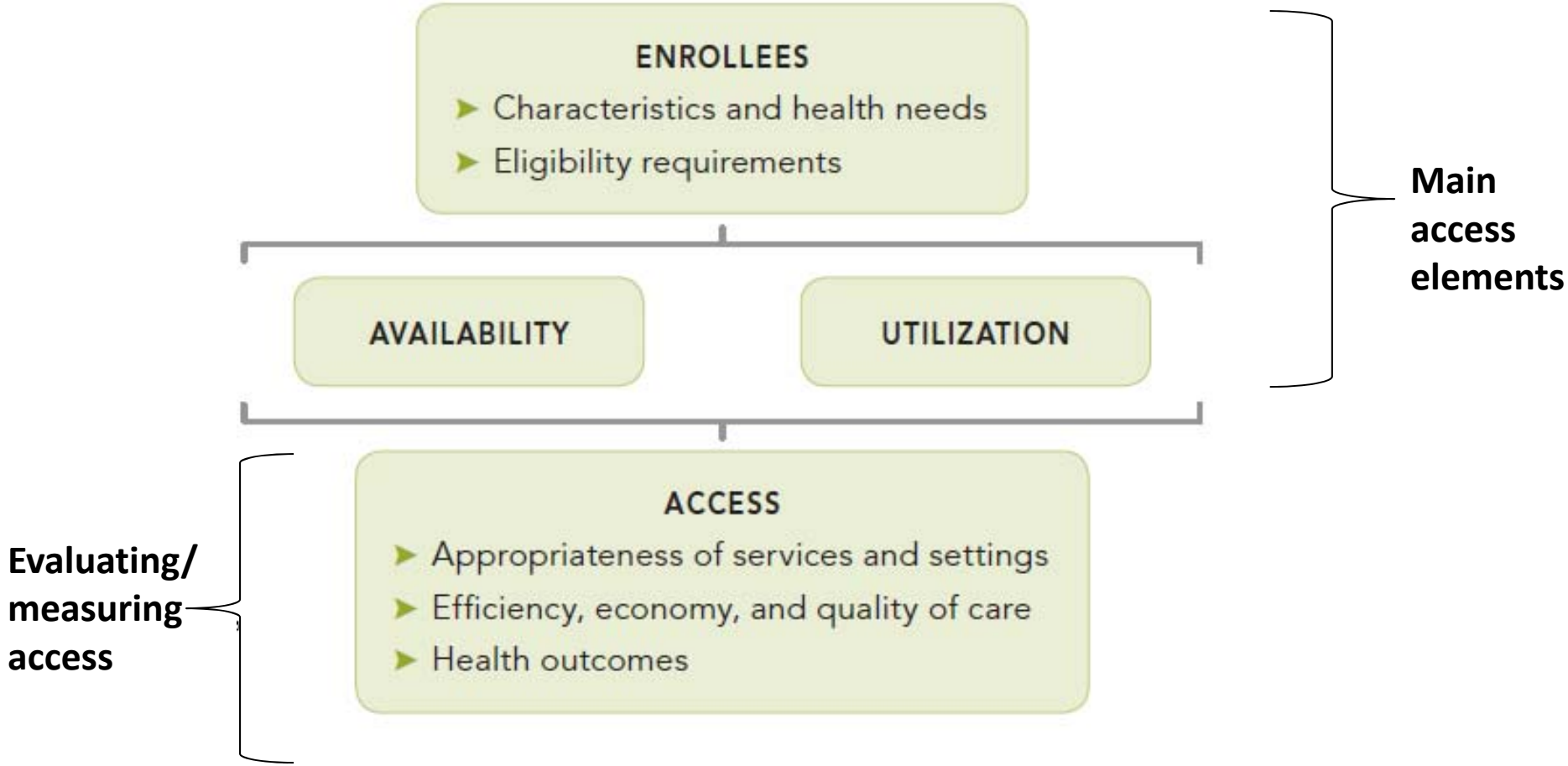
MACPAC Access Framework



Medicaid and CHIP Payment and Access Commission (MACPAC). (2011). Report to the Congress on Medicaid and CHIP, Chapter 4: Examining Access to Care in Medicaid and CHIP. Available at: https://www.macpac.gov/wp-content/uploads/2015/01/Examining_Access_to_Care_in_Medicaid_and_CHIP.pdf

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Enrollees

Medicaid and CHIP enrollees differ from the general population in terms of their demographic characteristics, health needs, and how they qualify for coverage.

- lower incomes and assets;
- discontinuous eligibility;
- geographic location;
- complex health care needs;
- cultural diversity;
- level of health literacy; and
- state variation in composition of enrollees.

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Availability

Availability of providers represents "potential access." Provider availability includes the characteristics of local health care markets, and state policies and provider responses to those policies (e.g. payment rates, participation rates, willingness to accept Medicaid, scope of practice).

- Provider supply (including provider characteristics, e.g. languages spoken)
- Provider participation
- Influenced by:
  - Health care delivery system
  - Distribution of providers
  - State policies and provider response (e.g. provider payment, participation rates, willingness to accept Medicaid, workforce issues [e.g. scope of practice])

Utilization/Use of Health Care Services

Utilization is "realized access," or how services are actually used by individuals, and reflects availability, affordability, and acceptability of services:

- What services are used
- Affordability to enrollee
- How easily enrollees can navigate the health system (e.g. wait times, transportation)
- Enrollee experience/satisfaction with care
- Whether care is considered necessary/appropriate

Oregon Health Authority

IOM-NRC Committee on Oral Health Access to Services

- The National Research Council (NRC) and the Institute of Medicine (IOM) formed the Committee on Oral Health Access to Services to assess the current oral health care system with a focus on the delivery of oral health care to vulnerable and underserved populations (2009)
- Guiding Principles:
  1. Oral health is an integral part of overall health and, therefore, oral health care is an essential component of comprehensive health care.
  2. Oral health promotion and disease prevention are essential to any strategies aimed at improving access to care.

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IOM-NRC Vision for Oral Health Care in the US

Everyone has access to quality oral health care across the life cycle.

To be successful with underserved and vulnerable populations, an evidence-based oral health system will

1. Eliminate barriers that contribute to oral health disparities;
2. Prioritize disease prevention and health promotion;
3. Provide oral health services in a variety of settings;
4. Rely on a diverse and expanded array of providers competent, compensated, and authorized to provide evidence-based care;
5. Include collaborative and multidisciplinary teams working across the health care system; and
6. Foster continuous improvement and innovation.

Oregon Health Authority

IOM-NRC endorsed broad definition of oral health access for vulnerable and underserved[1]

- Timely use of personal health services to achieve the best possible health outcomes (earlier NRC-IOM committee definition) [2]
- Incorporate health care disparities:
  - Individual's ability to gain entry into the health care system (e.g. cost barriers) & appropriate sites of care to receive needed services.[3]
  - Providers who meet the needs of individual patients
- Additional considerations:
  - Access to oral health preventive services at regular intervals and treatment services when needed
  - Access to *quality* care – care that is safe, effective, timely, efficient, equitable, patient-centered

1. http://www.nationalacademies.org/hmd/Reports/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations.aspx
2. Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993.
3. AHRQ 2011 www.ahrq.gov/research/findings/nhqrdr/nhqr11/chap9.html

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Proposed definition of oral health access based on IOM-NRC considerations

Oral health access is the availability, affordability and timely use of quality oral health services at appropriate sites of care and from providers who meet the needs of individual patients, including oral disease preventive services at regular intervals and treatment services when needed, to achieve the best possible health outcomes.

Oregon Health Authority

Oregon Oral Health Access Framework and Definition

Small Group/Large Group Discussions

Oregon Health Authority

Public Comment

Oregon Health Authority

	Access Factors	Access Barriers	
Environmental/Personal Factors	Enrollees	**Oral health/system navigation literacy:** oral health literacy; knowledge/knowledge of patient; knowledge of benefits/availability of coverage; system navigation literacy	Oral Health Outcomes/Health Equity
		Complex and high oral health care needs: high burden of disease.	
		Attitudes/perception: Dental history of parents/caretakers (barriers for children); fear among patients.	
		Cultural background/equity: cultural background; health equity issues/race ethnicity	
		Lower incomes/assets: Culture of poverty/understanding cultural language of poverty and fear of costs	
	Structural/Systems of Care	**Policy/system issues:** discontinuous eligibility (churn), assignment of members, FQHCs may not be able to accept certain plans, requirement to go through general dentist before pediatric	
		Adult Medicaid coverage	
	Population	**Population health/disease burden:** disease in population trying to serve; root causes	
		Social determinants of health	
Potential/Realized Access Factors	Availability	**Supply & distribution:** provider availability/access, turnover/churn, mal-distribution of providers (rural vs. urban)	
		Characteristics: experience; different philosophies of care between DCOs	
		Participation in Medicaid: Reimbursement rates/funding, lack of providers accepting OHP; Availability - lack of open card provider/Low volume of FFS providers; incentive programs don't provide continuity; lack of incentives to work in rural communities	
		Oral health integration/care coordination: Need for coordination with mental and physical health, especially for chronic disease; oral health integration; need better care coordination and co-location	
		Administrative: Provider credentialing slow; Capacity setting structural (by DCO), reporting on access	
		Availability of transportation/child care	
	Utilization	**Visits/missed appointments:** missed/failed appointments; Accountability/responsibility	
		Sites of care: history of using emergency departments (ED); need to expand points of access; need more programs for children (preschool children)	
		Patient-centered care: need to meet patients where they are	
		Affordability of services (coverage/benefits): coverage for adults (loss potential barrier); coverage of adult dental - impact to children	

Appendix H: Oral Health Access Member Survey

The State Medicaid Advisory Committee (the "MAC") makes recommendations to the Oregon Health Authority about how to make the Oregon Health Plan work better. The MAC and the Oregon Health Authority want to hear from you about your experiences with oral health and dental services in the Oregon Health Plan.

Why are we reaching out to you?
The MAC formed an Oral Health Work Group to:

1) suggest how to define access to oral health care, and
2) suggest how to check if OHP members are getting the services they need.

The work group has people from dental and health care organizations, and advocates, but it doesn't have OHP members. That is why we want to hear from you!

What do we want to know?
We have questions about your experience with oral health services in the Oregon Health Plan. Your answers will help us understand what helps OHP members get access to dental services and what makes it harder to get dental services. We will share your feedback with the Oral Health Work Group to help them make better recommendations to OHA. Your responses to this survey will be anonymous, so your name or identity will not be shared.

---

1) Are you a member of the Oregon Health Plan?

   ☐ YES ☐ NO

2) What County do you live in?

3) Are you aware that you have dental benefits as a member of the Oregon Health Plan?

   ☐ YES ☐ NO

4) When was the last time you visited the dentist?

   ☐ Within the last 6 months

   ☐ Between 6 months and 1 year ago

   ☐ Between 1-2 years ago

   ☐ More than 2 years ago

   ☐ Do not remember

5) What was the reason for the visit

☐ Regular check-up or cleaning,

☐ A Filling or other restorative work (not emergency)

☐ Dental emergency

☐ Other (please specify) _____

6) What does having dental benefits mean to you and/or your family?

7) Think about the times when you or your family want or need dental services. What affects your ability to get the dental care you need or want? (These could be things in your personal life like transportation, or work hours; things related to your dental office or dental providers like no appointments in the afternoon, or nobody that speaks your language; things related to your benefits like you wanted a treatment they told you is not covered, or other things you can think of.)

8) What other services or information – either from your CCO, dentist, or from another place – would make it easier or more likely for you to get regular dental checkups or treatment when you need it?

9) When you visit your dental provider, do they talk to you about the health of the rest of your body?

☐ YES ☐ NO

☐ NOT SURE

10) When you visit your regular doctor, do they talk to you about the health of your mouth?

☐ YES ☐ NO

☐ NOT SURE

11) Do your dentist and your primary care doctor ever talk to each other about your care or ways they could work together to help improve your overall health?

☐ YES ☐ NO

☐ NOT SURE

Oregon Health Policy Board CCO Listening Sessions

Medicaid Advisory Committee Discussion

Steph Jarem

September 28, 2016

Oregon Health Authority

Coordinated Care Organizations: The Model

- Locally governed by a partnership between health care providers, community partners, consumers, and those taking financial risk.
- Consumer advisory council requirement
- Behavioral health, physical, dental care held to one budget.
- Responsible for health outcomes and receive incentives
  for quality

Oregon Health Authority

Listening Sessions: The Future of Coordinated Care

- The Oregon Health Policy Board is gathering input from key stakeholders, including consumers, advocates, and providers about coordinated care in Oregon.
- Input to help shape recommendations for a report to the legislature and OHA about the future of Oregon's coordinated care organizations.
- Report release: January 2017

Oregon Health Authority

CCO Listening Sessions around Oregon

Data	Time	Region	Location
9/1/2016	11-1:30	Bend	Deschutes National Forest Supervisor's Office Aspen Ponderosa Conference Room 63095 Deschutes Market Road
9/9/2016	4:00-6:30	Tillamook	Port of Tillamook Bay Officers' Mess Hall 6825 Officers Row
9/21/2016	5:30-8:00	Rogue Valley (Medford)	Inn at Commons Crater Lake and Rogue River Rooms 200 North Riverside Avenue
9/26/2016	12:00-2:30	Eugene	Unitarian Universalist Church 1685 West 13th Avenue
10/7/2016	12:00-2:30	Pendleton – Hermiston	Eastern Oregon Trade and Event Center 1705 East Airport Road
10/18/2016	4:30-7:00	Portland	Ambridge Event Center Ballroom 1333 NE MLK Boulevard

Please RSVP to HealthPolicyBoard.Info@state.or.us

Coordinated Care: What's next

- 5 years since implementation of CCOs
  - How are we doing?
  - Where should the next 5 years take us?

We need YOUR input to drive Health Transformation 2.0

Oregon Health Authority

Social Determinants of Health/ Flexible Services

How can CCOs can strengthen their efforts to address the social determinants of health (e.g. housing) for members?

For example:

Are there ways CCOs can change/improve use of flexible services?

Do you have innovative ideas for how CCOs can connect with community-based organizations and resources?

Integration

One of the goals of health care transformation is to integrate physical, oral and behavioral health.

What evidence are you seeing that health care is more integrated since the launch of the CCOs?

How can the CCO model change to encourage greater integration?

Oregon Health Authority

Cultural Competency

What changes or improvements are needed to strengthen CCO cultural competency and increase availability of culturally appropriate services for members?

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Governance

- What changes or improvements are needed to ensure the “right” people are at the table to make decisions at CCOs?
- Should all CCO decision-makers be locally-based and part of the CCO regional community?
- Are there opportunities to enhance the governance relationship between CCOs and Consumer Advisory Councils (CACs)?

Next Steps

Take the full survey:
https://www.oregon.gov/oha/OHPB/Pages/cc-future.aspx

To learn more….

www.health.oregon.gov

Oregon Health Authority

EXTERNAL RELATIONS DIVISION
Kate Brown, Governor

Oregon Health Authority

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Salem, OR 97301
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September 12, 2016

The Honorable Kate Brown
Office of the Governor
160 State Capitol
900 Court Street
Salem, OR 97301

Zeke Smith, Chair
Oregon Health Policy Board
500 Summer Street NE
Salem, Oregon 97301

RE: Oregon Health Authority April to June 2016 Quarterly Ombudsperson Report

Dear Governor Brown and Chair Smith:

Pursuant to Oregon Revised Statutes (ORS) 414.712, the Oregon Health Authority (OHA) provides ombudsperson services to individuals who receive medical assistance. The ombudsperson is directed to serve as the medical assistance recipient's ("Member") advocate on issues concerning access to and quality of care received by Members.

The OHA Ombudsperson position is a formal, internal voice for process and system improvements responsive to identified trends impacting services for the over 1 million people served by the Oregon Health Plan / Medicaid.

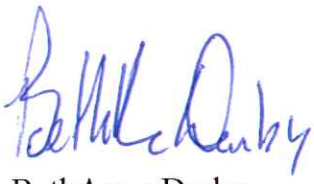
Per ORS 182.500, the OHA ombudsperson provides a quarterly report to both the Governor and the Oregon Health Policy Board (OHPB). The report is required to include:

1. A summary of the services that the ombudsperson provided during the quarter; and
2. Recommendations for improving access to or quality of care provided to Oregon Health Plan (OHP) eligible persons by health care providers and coordinated care organizations (CCOs) as well as improvement to Ombudsperson's services.

Please find the Oregon Health Authority's Ombudsperson report for the second quarter of 2016 attached. We look forward to continuing service to our members and welcome any feedback, comments or questions you may have.

Sincerely,

Ellen Pinney
Ombudsperson



BethAnne Darby
Director, External Relations

CC: Lynne Saxton, Director, Oregon Health Authority
Jeremy Vandehey, Health Care Policy Advisor, Governor's Office
Dr. Varsha Chauhan, Chief Health Systems Officer, Oregon Health Authority

EXTERNAL RELATIONS DIVISION

Kate Brown, Governor

Oregon Health Authority

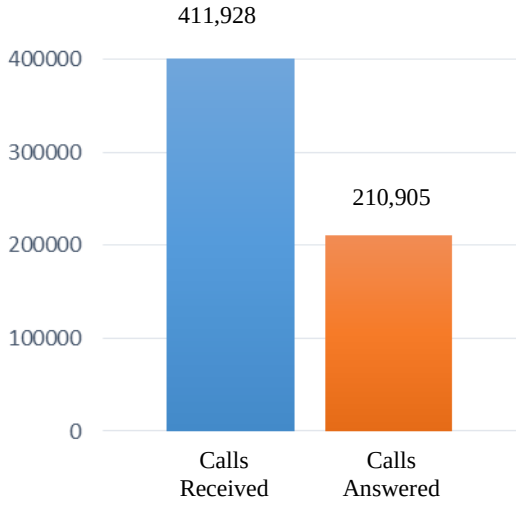
Summary of Direct Client Services Provided by OHA Ombudsperson

Issues	April, 2016	May, 2016	June, 2016
Enrollment/Renewal	15	33	30
Health Services	8	18	17
Dental	3	1	10
Pain Management	5	6	9
Non-Emergency Medical Transportation (NEMT)	3	2	3
Behavioral Health	4	4	3
Request for Open Card.	1	3	4
Medicaid – Medicare transition challenges	4	2	3
Billing	1	0	0
OHP Related Call Total	44	68	79
Other Calls	12	18	26

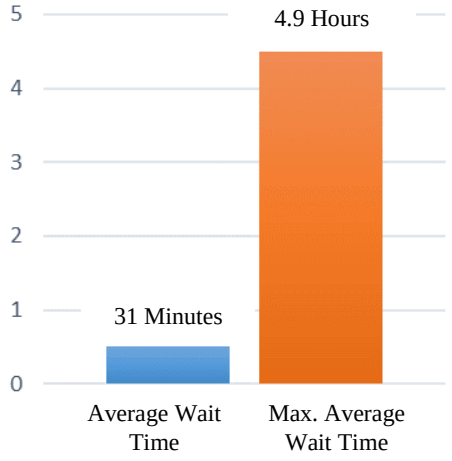
April to June 2016 Summary of OHP Member Access and Quality Concerns.
Oregon Health Plan (OHP) client calls to the Ombudsperson reflect enrollment and renewal problems as the biggest challenge. When renewals are not completed on-time, OHP members experience breaks in coverage, breaks in ongoing treatment and breaks in established provider-patient relationships. OHP enrollment and renewals information is reported to stakeholders during monthly webinars and is posted on the agency's website. Quarterly information on major themes is included in the charts below.

The biggest areas of OHP member concern that are non-application related are Non-Emergency Medical Transportation (NEMT) and Access to services.

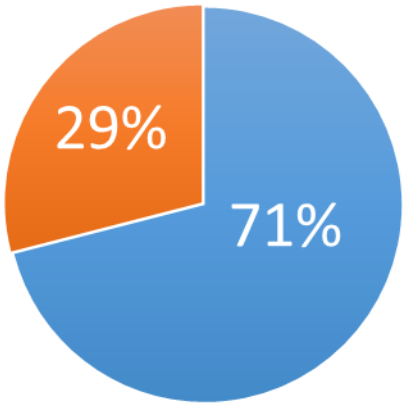
1 **51%** of the calls to the OHP Call Center were answered.



2 Average reported wait time was **31 minutes** with a reported maximum of **4.9 hours**.

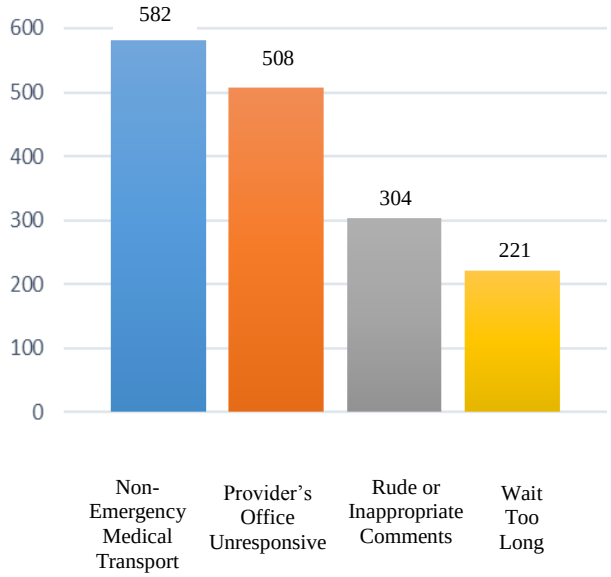


3 **71%** of client calls answered related to OHP application and renewal process.



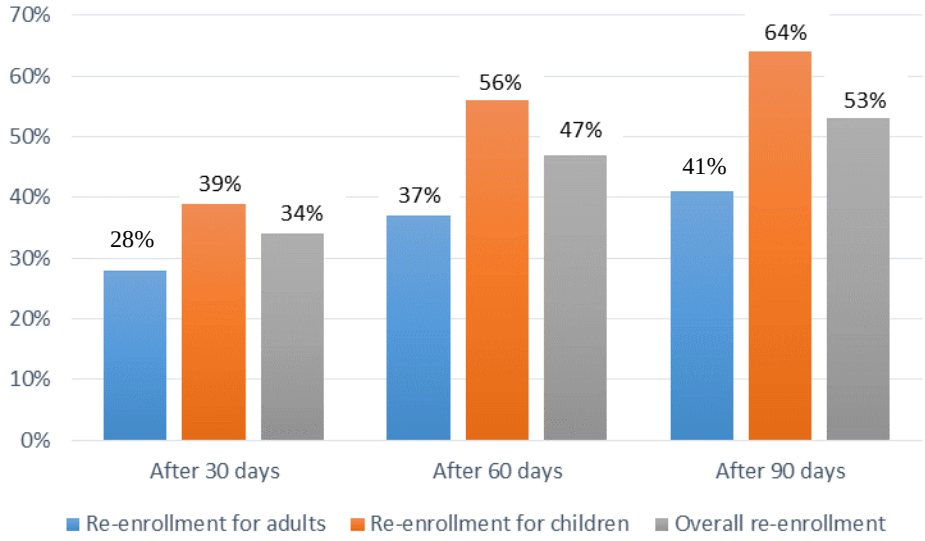
Non-application related calls include: plan change, adding or removing private insurance, billing, and requests for general information.

4 CCOS reported **582** Non-Emergency Medical Transportation related complaints from January-March, the single biggest reason for CCO reported complaints.



CCO reported complaint data for March through June will be compiled and reported to CMS in September.

5 **75,229** OHP enrollees experienced a break in OHP coverage during January, February, and March. Within 90 days **14,069** adults and **21,895** children had renewed coverage.



OHP members lose coverage for a variety of reasons, including: moving out of state, qualifying for private market coverage, failing to send in their application or additional requested information on-time, as well as delayed processing of applications and other information. This data reflects how many individuals experienced a break in coverage during the second quarter of 2016 for any reason and how many of them were reinstated within 30, 60, and 90 days.

Quarterly Highlights

- Changes in OHA's ability to monitor and utilize a consistent, data-driven agency-wide complaint system effectively are underway.
- OHA leadership is working on an agency-wide complaint escalation system which includes a cross agency IT solution.
- The OHA Health Systems Division is working to improve CCO and internal agency implementation of complaint and grievance system requirements and expectations.[1]

OHA Ombudsperson Recommendations

- Establish a formal internal team to analyze and provide recommendations for resolving identified trends in OHP provider and client complaints.
- Clarify the confidentiality of information provided to the OHA Ombudsperson, consistent with similarly situated roles in other agencies. Complaints made to an Ombudsperson should not be subject to FOIA unless the action or inaction of the Ombudsperson is in question.
- Formally clarify the relationship between the OHA ombudsperson, Governor's Advocacy Office (GAO) and other state agency ombuds staff;
- Enhance information technology (IT) ability and capacity to allow for improved communication of Member complaints and grievances received throughout the systems that support Oregon's administration of medical assistance.
- Expand access to full time, certified application assistance to support quality, accuracy and consistency. Opportunities include improved collaboration between DHS and OHA and exploring options for allowing CCOs to offer application assistance to their members.
- Clarify complaint process and systems:
    - Members
        - When and how to communicate regarding a complaint with CCOs, OHA's Client Services Unit; and OHA Ombudsperson
        - Availability of intensive care case managers to help high needs clients navigate care.
        - Significance and understanding of Notices of Action.
    - CCOs
        - Distinction between 'member call' and 'complaint'.
        - Uniform reporting of member 'expressions of dissatisfaction'.

[1] CMS considers complaints, denials and hearing process part of the 'grievance' system.