# Oregon Health Authority Dental Quality Metrics Workgroup

## AGENDA

**January 15, 2014**
**1:00 – 3:00 p.m.**

**Call In: 1-888-398-2342, Participant Code: 5731389**

**Human Services Building, Room 456**
**500 Summer Street, NE**
**Salem, OR 97301**

**Lincoln Building, Mary Room**
**421 SW Oak Street, Suite 850**
**Portland, OR 97204**

| # | Time | Item | Presenter |
|---|---|---|---|
| 1 | 1:00 | Welcome and introductions | Lori Coyner |
| 2 | 1:10 | Consent agenda: Nov minutes | Lori Coyner |
| 3 | 1:15 | December Metrics & Scoring Committee debrief | All |
| 4 | 2:00 | Metrics alignment discussion<br><br>*Opportunities for dental metrics to align with current CCO measures, populations of interest, and other quality improvement efforts.* | All |
| 5 | 2:45 | Next steps / February meeting | |

**<u>Next Meeting: February 5, 2014</u> from 2:00 – 4:00 p.m.**

Salem – HSB Room 354
Portland – Lincoln, Mary Room

Call In: 1-888-398-2342
Participant Code: 5731389

DRAFT

**Oregon Dental Quality Metrics Workgroup**
**November 6, 2013 Minutes**
**10:00a.m.-12:00p.m.**
**Human Services Building**
**500 Summer St, NE**
**Salem, OR 97301**

| ITEM |
| --- |
| **Welcome**<br>Attending: Deborah Loy, Mike Plunkett, Dan Pihlstrom, Denise Stewart, Eli Schwartz, Michael Bailit, Mike Shirtcliff, Robert Finkelstein, Linda Mann, Bill Ten Pas, Patrice Korjenek, Russ Montgomery, Janet Meyer<br><br>OHA: Rhonda Busek, Stefanie Murray, Shanie Mason, Dee Weston, Susan Arbor, Carole Romm, Geralyn Brennan<br><br>Non-OHA: Larry Burnett |
| **Consent Agenda**<br>The workgroup approved the October 2nd meeting minutes. |
| **Review Decisions**<br>Michael Bailitt: Review decisions from October meeting. Confirmation of measures recommended for quality pool and measures recommended for monitoring:<br><br>Measures recommended for quality pool:<br>• Sealants on permanent molars for children (EPSDT measure specifications for CY 2015, consider DQA measure specifications in subsequent years).<br>• Members receiving any dental services (EPSDT measure specifications for CY 2015, explore other ways to measure this involveing providers and services not currently picked up in EPSDT specs).<br><br>Measures recommended for monitoring:<br>• Two questions from the CAHPS dental survey: questions #4 and #14.<br>• Fluoride varnish application rate.<br>• Comprehensive exam rate.<br><br>The workgroup endorsed using HealthyPeople 2020 as benchmarks. Michael Bailit described the Minnesota Method for setting improvement targets, and the Measures and Scoring Committee's modification to the Minnesota Method (i.e. setting a floor). CCOs are using the Minnesota Method already.<br><br>*Sealants on permanent molars*<br>• Workgroup confirmed endorsing sealant measure for the incentive pool for 2015 but reiterated desire to establish a subgroup to clear up discrepancy between |

DRAFT

Medicaid data on children who have received sealants and data from the state sealant program. There was discussion on whether the HealthyPeople 2020 was too low of a target. Workgroup decided to use the Minnesota method with tentative 3% floor, with the desire to further discuss whether 3% is correct and potentially recommend something higher in the future.

- Deborah Loy stated she would like to send data and recommendations on CMS's sealant goal for states to Sarah Bartelmann or Stefanie Murray to inform discussion about setting the floor for the improvement target.

- The workgroup discussed challenges in ensuring that all children who have been given sealants were represented in CCO reports.

*Members receiving any dental services*

- Michael Bailit reviewed the measure and highlighted that the HealthyPeople2020 goal is 49% and that the rate varies by CCO, with some above the benchmark and some below. Workgroup discussed that this measure targets organization and structure. There was considerable discussion on whether group wanted to go with "dental services" or "oral services"; the difference between the two lies in the provider of the services. Workgroup decided to accept the measure as any "dental services". Workgroup accepted a 3% floor.

*Other workgroup recommendations*

- Workgroup accepted other recommendations:
  - OHA should establish a workgroup to obtain / reconcile data on sealants across programs or explore building a sealant registry in order to have a clear picture of which Medicaid children received sealants.
  - OHA should assemble a workgroup in the summer of 2014 to:
    - Revisit measurement activities to date;
    - Assess use of CDT codes in Oregon; and
    - Revisit the DQA measure specifications.

*Draft recommendations document*

Workgroup accepted the draft document with the exception of the following revisions:

- Page 2: Russ Montgomery's name should be added
- Page 5: In the 3rd paragraph, change sentence to say, "For example, OHA requires that members with emergent dental needs…"

DRAFT

- Page 5: Workgroup wanted to strengthen the Fluoride Varnish section to indicate that the group believes strongly in the use of risk assessments in reducing the likelihood of children for developing cavities, and would like there to be a reduction in provider barriers to bill and provide those services. The workgroup would like to strongly affirm they would like to move in the direction of measuring risk assessments in a way that is more meaningful than using a proxy that is essentially measuring widgets.
- Page 8: In first bullet, add "consider adding potential future use of diagnostic codes" before "the potential for adopting DQA measures…"
- There was comment on calling out the need to track performance of populations with severe and persistent mental illness. OHA (Rhonda Busek and Carole Romm) stated they would look into populations that may need to be called out specifically.
- Workgroup agreed to continue to edit the Draft Recommendations and would send comments to Sarah Bartelmann and Stefanie Murray by November 22nd. The final draft will be sent out by December 6th. There will be no Dental Quality Metrics Meeting in December; the Metrics and Scoring Committee Meeting is on December 13th.

*Presentation to Metrics and Scoring Committee*

- Workgroup nominated Eli Schwartz to present the workgroup recommendations at the Metrics and Scoring Committee meeting, along with Patrice Korjenek.
- In terms of presentation of recommendations, workgroup discussed emphasizing that they recommend pursuing a coordinated care system, especially when discussing the fluoride varnish measure.
- Deadline for submitting comments on presentation is November 22nd.

*Reconvening*

Workgroup recommended reconstituting the group to work on metrics going forward. Discussed including information from the dental care contractor meetings about fluoride in the Dental Quality Metrics Workgroup's work. It was recommended that the group reconvene before the Metrics and Scoring Committee September 2014 meeting in which all the measures and measure changes will be finalized. Group decided to reconvene in February to discuss codes. A future conversation would be to decide on a risk assessment tool and what the codes mean. Metrics and Scoring Committee have until April 2014 to give feedback to the DQM workgroup on their recommendations.

**DQA Measure Discussion**

Geralyn Brennan discussed calculating the DQA measure with 2011 data for all age

DRAFT

groups. She discussed the drawbacks for using 2011 data as a baseline, which included the difference in plans between 2011 and 2014, as CCOs and DCOs did not exist in 2011. In addition, the DQA measure did not look at risk or the results of the assessment. There is also a difficulty in reporting the information quarterly, as some CCOs would have very low denominators (that is, women who are pregnant, who had a live birth covered by OHP who have been enrolled for 90 days). Alternative approach would be to focus on females of reproductive age.

Workgroup discussed why this was important for women who were pregnant, specifically because many women lose coverage after they give birth, and it is important to try to give women as many services while they are pregnant as possible. It is also possible to pass infection from mother to child.

Workgroup discussed the challenges of effectively tracking from child back to the mother, to see how many mothers had utilized a dental service.

One recommendation was to report annually for all CCOs, and not quarterly. There was also interest in stratifying information by DCO.
Geralyn recommended that a workgroup should spend time discussing the issues around DQA, as there will be new eligibility codes coming out and reporting will continue to be an issue. In addition, there needs to be discussion around what a comparable baseline is, as 2011 and 2014 are not comparable without many caveats.

**Public testimony**:
My name is Larry Burnett; I am a retired dentist, and I'm here to listen and comment on the information you are discussing. I posed a question last week—what is the most important development in dentistry in last 100 years? The ability see and reverse early decay. Nothing approaches significance of that. We haven't put that to work, and we can virtually wipe out decay in Medicaid children. We can wipe out and reverse early decay if we get access to 1 yr olds. CCOs have boosted the number of kids who have been seen for treatments at early age, but leaves 90% of 0-2 year olds to go and see a dentist. However, all of the modern preventive techniques that can wipe out decay can be presented to care giver through pediatric medical visits and public health officials such as Eli have recognized this and teach pediatric physicians to deliver this service. The problem is that it cannot be incentivized and thus will not be put this into place. They are already doing this in NC where pediatric physicians are trained in Camber techniques, and this is now the standard of care for treating young children. They saw a 40% reduction in carrier rates in well-baby visits. It could be much stronger. This is a lot more than just fluoride varnish; sealants are a small part. The process is simple and

DRAFT

based on risk assessment. Every process is to reverse early decay—often times you can see it. You can teach parents how to apply fluoride on tooth and then the tooth will never need to be drilled. Filling is a long term risk factor in itself, as it is prone to be re-decayed. Single filling costs $2-3000 over the life span of a person. One reason to do this is to reduce cost over lifetime. The ADA has accepted it as standard of care. We look at this lesion in the mouth—drill or re-mineralize? There are not enough dentists who understand the process and we end up with massive amount of over treatment. DO145 is dental code for 0-3 year old children who receive this treatment. It encompasses everything that needs to be done to wipe out caries in kids. Pediatric assistants are how we're going to wipe out caries. The solution lies in the beginning of the spectrum—bacterial infection.

DRAFT

**Summary of Dental Metrics Workgroup Presentation to the Metrics & Scoring Committee**
12/18/13

On December 13, 2013, Patrice Korjenek and Eli Schwarz presented the Dental Quality Metrics Workgroup recommended measures and benchmarks to the Metrics & Scoring Committee. They provided an overview of workgroup membership, charge, and process used to develop the recommendation.

They highlighted some of the discussions the workgroup had, including:

- The lack of national, standardized dental measures;
- Developmental work on dental measures by the Dental Quality Alliance;
- Sealants provided through DCOs and through the state school-based sealant program;
- Risk assessments;
- Additional population analysis (e.g., adults with disabilities, SPMI).

The Committee asked a number of questions, including:

- Whether or not the recommended measures were HEDIS;
- How the measures were coded (and which provider types were included);
- How the school-based sealant program and Medicaid services and data are related or overlap;
- What the evidence-base behind some of the recommended measures is (sealants and fluoride varnish).

The Committee discussed the lack of standardized measures for dental outcomes. The Committee was particularly interested in measures such as "improved oral health", "school absenteeism due to dental pain", "retaining teeth as long as possible" or "not having new cavities from one visit to the next."

The Committee also briefly touched on whether dental measures should be pediatric or adult (or both), and whether dental metrics should be determined based on dental as a line of CCO business, or based on how oral health affects members' lives and health outcomes.

The Committee was very interested in whether or not the recommended dental metrics aligned with other metrics, with priority populations, and with the quality improvement focus areas for CCOs. The Committee highlighted the importance of measures that would "force" cooperation between dental and medical, to further integration and drive performance improvement.

<u>The Committee did not make a decision about the recommended dental metrics</u> in their December meeting, and have requested additional information for consideration at their next meeting, including:

DRAFT

- Exact methodology and specifications (including list of codes) for each of the recommended measures.
- Baseline data at the DCO level for the recommended measures.
- Opportunities for dental metrics to align with current CCO measures, populations of interest, and other quality improvement efforts.

OHA will compile the measure specifications and baseline data, and proposes bringing the Dental Quality Metrics Workgroup back together in January and early February for further discussion / regrouping on metrics alignment.

The Dental Quality Metrics Workgroup is invited to attend the February Metrics & Scoring Committee meeting (February 21, 2014 from 1:00 – 4:00 pm) to continue the discussion.

DRAFT