

**ORAL HEALTH WORK GROUP
OF THE MEDICAID ADVISORY COMMITTEE**

August 11, 2016
2:00-5:00pm
Oregon State Library, Room 103
250 Winter St., NE, Salem

Webinar registration: <https://attendee.gotowebinar.com/register/8488351087985818370>
Call– In number: 888.398.2342; code: 3732275

Time	Item	Presenter
2:00	Opening remarks <ul style="list-style-type: none"> • Agenda • Roll call 	Co-Chairs
2:10	Oral health care access framework model & definition <ul style="list-style-type: none"> • Present draft access framework model and definitions • Q&A and discussion • Finalize framework model and definition 	Matt Sinnott, Co-Chair; Alyssa Franzen, Care Oregon
2:40	Oral health measures – two perspectives <ul style="list-style-type: none"> • Dental Quality Metrics Work Group to the Metrics & Scoring Committee • CCO Oregon Dental Work Group • Q&A 	Eli Schwarz, OHSU (Dental Quality Metrics Work Group); Sara Love, CCO Oregon, and Matt Sinnott, Willamette Dental Group (CCO Oregon Dental Work Group Chair)
3:20	Break	
3:30	Measuring access to oral health care: framing the work	Amanda Peden, OHA
3:40	Indicators of oral health care access <ul style="list-style-type: none"> • Small group activity 	Co-Chairs
4:20	Priority factors of oral health care access <ul style="list-style-type: none"> • Prioritization activity to select key factors for purpose of oral health care access assessment 	Co-Chairs
4:45	Public Comment	
4:55	Closing comments	Co-Chairs

Next Meeting:

September 20th, 2016: 9-noon

Wilsonville Training Center, Room 111/112

29353 SW Town Center Loop

Wilsonville



**ORAL HEALTH WORK GROUP
of the Medicaid Advisory Committee**

July 7, 2016

9:00am-11:00am

Oregon Health Authority-Lincoln Building

421 SW Oak Street, Suite 775, Transformation Center Training Room

Portland, OR 97204

MEMBERS IN ATTENDANCE: Kelle Adamak-Little, (by phone) Laura Bird (by phone), Lisa Bozzetti, Jim Connelly, Christina Coutts, Bob Diprete (by phone), Alyssa Franzen, Tony Finch, Susan Filkins, Alison Lecatsas, Laura McKeane, Kuulei Payne, Dr Eli Schwarz, Dr Mike Shirtcliff, Heather Simmons, Matthew Sinnott, Jeffrey Sulitzer, James Tyack,

PRESENTERS: David Simnitt, Amanda Peden, Alyssa Franzen

STAFF IN ATTENDANCE: David Simnitt, Amanda Peden, Chris Norman, Margie Fernando

ALSO IN ATTENDANCE: Representative Alissa Keny-Guyer

TOPIC	<i>Key Discussion Points</i>
Opening remarks and introductions	<p>David Simnitt welcomed everyone to this first meeting of the Oral Health Workgroup and expressed his appreciation to everyone who agreed to be part of this workgroup. David gave a background of how this workgroup came about. This Workgroup was established at the request of the Medicaid Advisory Group in response to a request from the Oregon Health Authority to develop and recommend a framework on access to oral health for OHP members.</p> <p>David introduced the two co-chairs appointed for this workgroup, Matthew Sinnott and Dr. James Tyack. The group then introduced themselves and each member also kicked off the meeting by mentioning what they see as the biggest barrier they see to oral health access in the OHP.</p>
Oral Health Work Group guiding document	<p>The group then delved into an overview of this workgroup.</p> <ul style="list-style-type: none"> • David Simnitt explained the OHA Oral Health Initiative, its background, and how it fits into the big picture in OHA. The Presentation is included in the packet. • Dr. Alyssa Franzen, the designated MAC liaison to this Committee with Bob Diprete, gave an overview of what MAC expects from this committee in terms of its general guiding principles and the work plan.
Factors that influence oral health access: Structural Barriers,	<p>Matt Sinnott and Dr. Tyack led the group into the brainstorming session. The purpose of this was to get as full a picture as possible from the members on barriers or potential barriers as they see it. They</p>

TOPIC	<i>Key Discussion Points</i>
Financial Barriers, Personal Barriers <ul style="list-style-type: none"> • Small group activity (three groups, including one phone group) 	<p>were asked to come up with ideas/thoughts and identify root causes and put these ideas on the drawing board as a starting point. The group provided many ideas and a variety of barriers from their various perspectives.</p> <p>Amanda listed the ideas on a flip chart to carry forward to the next part of the session where the group broke into two groups to further analyze these.</p>
Model definitions and frameworks for oral health access <ul style="list-style-type: none"> • Presentation • Q&A 	<p>For this part of the meeting, Amanda provided a list of key model definitions and frameworks of national definitions and frameworks that can serve as a starting point to help the group develop Oregon’s own definition of oral health access specifically for OHP members. The goal is to create an overall framework for oral health access in Oregon.</p>
Oregon oral health access definition and framework <ul style="list-style-type: none"> • Small group activity • Report outs and discussion 	<p>The group continued the discussion by breaking into two groups to further detail their ideas using the brainstorm ideas listed on the flip charts earlier. Work group members categorized their ideas into “enrollee,” “availability,” “utilization,” and “other” factors. Other factors identified included population health factors and structural/systems of care factors. Staff will take these back to organize into a draft framework and definition, get feedback from the Medicaid Advisory Committee on July 27, 2016, and bring these back to the next meeting on August 11, 2016.</p>
Public Comment	<p>There was no public comment at this meeting.</p>
Closing Comments	<p>Matt Sinnott thanked everyone for their excellent contributions. The next two meetings will be extended to three hours so that they can more fully work on the final report due in September.</p>

Next Meeting
August 11, 2016 from 2:00-5:00pm
Oregon State Library Room 103
250 Winter St NE
Salem OR 97301



Guiding Document Oral Health Work Group of the Medicaid Advisory Committee

Authority
<p>On behalf of the Oregon Health Authority (OHA), the Medicaid Advisory Committee formed the Oral Health Work Group. The work group is tasked with developing a framework to assess oral health access in the Oregon Health Plan (OHP). The Work Group is directed to develop a framework by answering two key questions:</p> <ol style="list-style-type: none">1. What are the <u>key factors</u> that influence access to oral health care for OHP members (i.e. how should Oregon define access)?2. What <u>key data</u> should be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?
Timeline
July – September, 2016
Scope of Work
<p>The purpose of the Oral Health Work Group is to develop a <u>high-level framework</u>, including a shared definition of oral health access in OHP and recommended data OHA can use to assess access to oral health services for members.</p> <p>Criteria for Developing a Definition of Oral Health Access: The Work Group will draw on existing federal and state definitions and frameworks regarding access to oral health and other health services. The definition and framework adopted by the Work Group should be tailored to Oregon’s unique health care delivery system; demographic characteristics, health needs and disparities among populations served by OHP, provider composition, and other Oregon-specific considerations.</p> <p>Key Data to Assess Oral Health Access: The Work Group will review, select, and prioritize key measures on oral health access from existing local and federal sources, including local oral health advisory and work groups, existing oral health and oral-health-related strategic plans, and federal oral health access measures and metrics. Measures will be selected and prioritized for the purpose of OHA monitoring and evaluation of oral health access in OHP.</p> <p>The workgroup <u>is not tasked</u> with recommending incentive or accountability metrics for coordinated care organizations (CCOs). <u>The scope of work does not include developing recommendations related to oral health access improvement strategies or solutions.</u> While critically important, these discussions are outside of the current scope and timeline for the Oral Health Work Group of the Medicaid Advisory Committee.</p>
Deliverables
<p>The Oral Health Work Group will be responsible for developing a memo that recommends a framework for assessing oral health access in the Oregon Health Plan. The memo will be presented for review and discussion at the Medicaid Advisory Committee meeting on September 28, 2016. The Medicaid</p>

Advisory Committee will approve and submit the final Oral Health Access Framework to OHA.

Membership, Roles & Responsibilities

OHA Leadership Sponsors:

David Simnitt, Oregon Health Authority
Dr. Bruce Austin, Oregon Health Authority

OHA Staff:

Oliver Droppers, Health Policy and Analytics (staff to the MAC)
Amanda Peden, Health Policy and Analytics (staff to the MAC)
Margie Fernando, Health Policy and Analytics (staff to the MAC)

MAC Liaisons

Alyssa Franzen, Care Oregon
Bob Diprete, Retired health policy professional

Work Group Members:

By MAC designation, the Oral Health Work Group is comprised of representatives from Coordinated Care Organizations (CCOs), Dental Care Organizations (DCOs), providers, consumer/consumer advocates, tribal, and members of the general public

Kelle Adamek-Little, Coquille Indian Tribe
Laura Bird, Northwest Portland Area Indian Health Board
Dr. Lisa Bozzetti, Virginia Garcia Memorial Health Center
Jim Connelly, Trillium Community Health Plan
Christina Coutts, ShelterCare Homeless Medical Recuperation Program
Susan Filkins, Oregon Center for Children and Youth with Special Health Care Needs
Tony Finch, Oregon Oral Health Coalition
Allyson Lecatsas, NARA NW Clinic
Laura McKeane, AllCare Health
Kuulei Payne, Winding Waters Medical Clinic
Dr. Eli Schwarz, OHSU School of Dentistry, Department of Community Dentistry
Dr. Mike Shirtcliff, Advantage Dental
Heather Simmons, PacificSource Community Solutions
Matthew Sinnott, Willamette Dental Group (Co-Chair)
Dr. Jeffrey Sulitzer, InterDent/Capitol Dental
Dr. James Tyack, Tyack Dental (Co-Chair)

Meeting Schedule

Oral Health Work Group Meeting #1

Thursday, July 7, 9-11am
Lincoln Building, Suite 775, Transformation Center Training Room
421 SW Oak Street, Portland

Oral Health Work Group Meeting #2

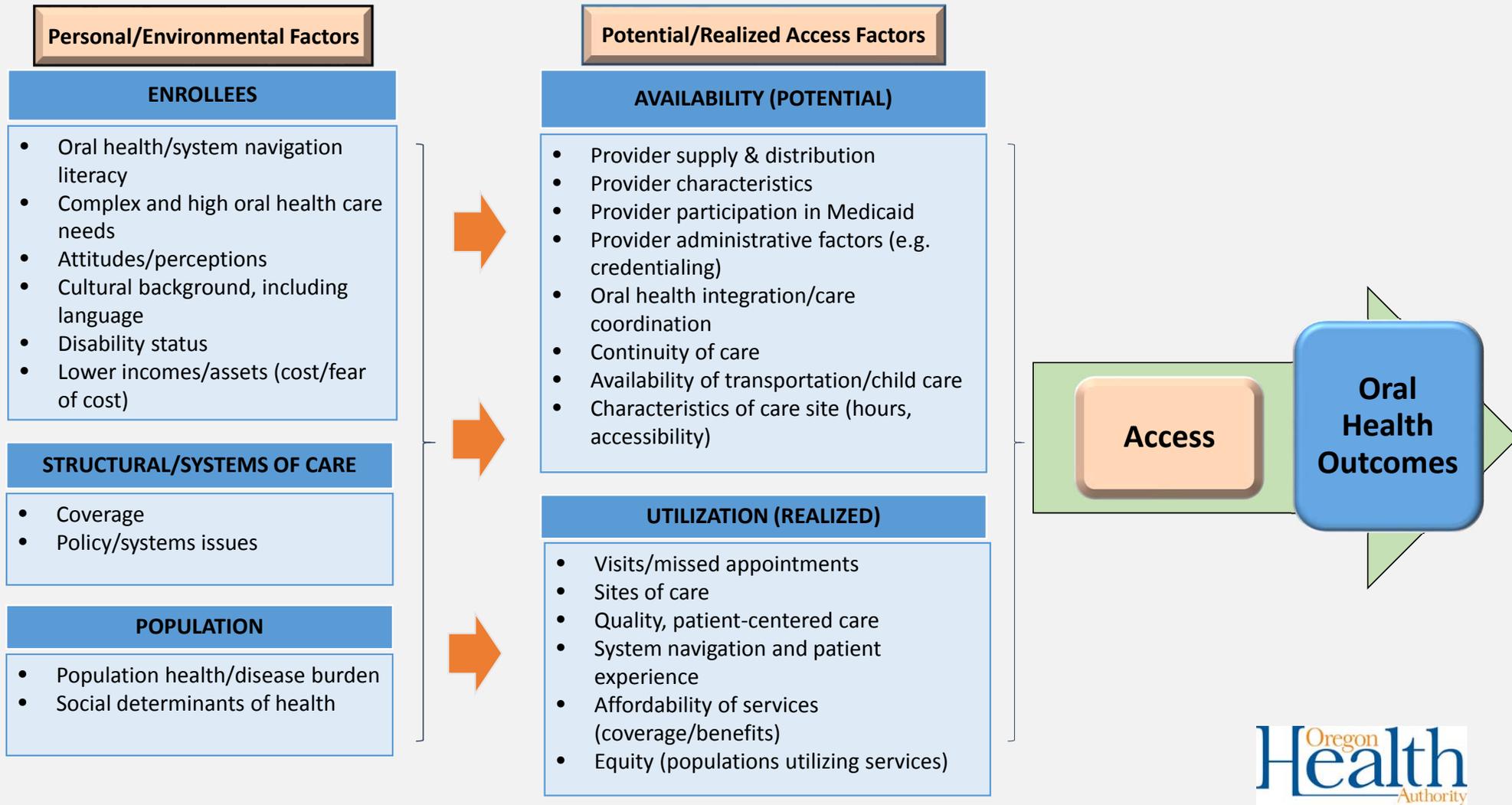
Thursday, August 11, 2-5pm

Oregon State Library, Room 103
250 Winter St., NE, Salem

Oral Health Work Group Meeting #3

Tuesday, September 20, 9-noon
Wilsonville Training Center, Room 111/112
29353 SW Town Center Loop
Wilsonville

ORAL HEALTH CARE ACCESS FRAMEWORK DRAFT



KEY :	X	1 small group identified category
	X X	Both small groups identified category (i.e. group agreement)
	Red	Factor added based on work group discussion, MAC and community feedback

Access Elements	Access Factors	Small Group Categorization Activity: July 7, 2016			
		Availability	Utilization	Enrollee	Other
Personal/Environmental Factors					
Enrollees	Oral health/system navigation literacy: oral health literacy; knowledge/knowledge of patient; knowledge of benefits/availability of coverage; system navigation literacy	X	X	X X	X
	Complex and high oral health care needs: high oral health care needs enrollees; complex, co-morbid conditions (e.g. diabetes and periodontitis)		X X	X X	X
	Attitudes/perceptions: Fear of dental services; dental history/perceptions of dental of parents/ caregivers ; perception of oral health importance			X X	
	Cultural background, including language: cultural background; race/ethnicity and structural racism; language spoken			X X	
	Disability status				
	Lower incomes/assets: Fear of cost; job flexibility		X	XX	
Structural/Systems of Care	Policy/system issues: e.g. discontinuous eligibility (churn), assignment of members, referral requirements (e.g. requirement to go through general dentist before pediatric dentist); acceptance of DCO/plan by provider groups (e.g. FQHC); incentive programs	X		X	X
	Coverage: e.g. adult Medicaid coverage, which is not federal requirement	X	X X		X
Population	Population health/disease burden: higher disease burden in Medicaid population; root causes of disease		X X		X
	Social determinants of health: social and environmental factors that contribute to health, such as income, housing, access to healthy food, social norms/attitudes (e.g. racism), language			X X	
Potential/Realized Access Factors					
Availability	Provider Supply & distribution: provider availability, provider turnover/churn, distribution of providers (rural vs. urban), supply of different types of providers (e.g. specialists)	X X			
	Provider characteristics: experience; philosophy of care; language spoken	X X			
	Provider participation in Medicaid: Provider acceptance of OHP (including managed care and FFS, types of providers); reimbursement rates/funding	X X			
	Oral health integration/care coordination: Coordination with mental and physical health, especially for chronic disease; oral health integration; Care coordination; Co-location	X X	X	X	
	Provider administrative factors: Provider credentialing; Capacity setting among DCOs; Access to data/reporting on access	X			
	Continuity of care				
	Availability of transportation/child care Characteristics of care site: hours, accessibility (for people with disabilities)	X	X	X	
Utilization	Visits/missed appointments: missed appointments; services used	X	X X	X X	
	Sites of care: ED utilization (ED); Expanded points of access (non-traditional care sites); programs for children	X	X	X X	
	Patient-centered care: "meet patients where they are"; quality of services, appropriateness of services	X	X		
	System navigation and patient experience: waiting times; delivery system differences; patient navigation challenges; patient experience	X	XX	X	
	Affordability of services (coverage/benefits): coverage of adult dental/loss of coverage impact on both adults and children Equity: relative utilization by vulnerable and underserved populations, including racial and ethnic minorities, people with intellectual and physical disabilities, pregnant women, children with special health care needs, and the aging	X	X		X
Access					

Dental Quality Metrics Workgroup

Recommendations for the Metrics and Scoring Committee

December 2013

Introduction

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

Workgroup Charge

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

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

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

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

Workgroup Membership

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

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

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

Workgroup Process

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

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

Recommended Measures and Rationale

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

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

Measures Recommended for Inclusion in the Quality Pool

(1) Sealants on permanent molars for children.

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

Discussion

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

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

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

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

(2) Members receiving any dental services.

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

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

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

Measures Recommended for Monitoring

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

(3) Patient experience with access to dental care

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

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

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

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

Discussion

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

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

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

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

(4) Topical Fluoride Intensity

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

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

Discussion

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

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

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

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

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

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

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

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

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

(5) Comprehensive Exam Rate

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

Discussion

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

Recommended Benchmarks and Improvement Targets

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

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

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

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

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

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

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

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

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

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

Other Considerations

Utilization and Cost

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

Subpopulation Analysis

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

² *ibid*

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

Next Steps

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

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

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

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



CCO Oregon: Policy Statement on Dental Quality Metrics in Service Level Agreements

This policy establishes the creation of quality metrics specific to oral health for CCOs to incorporate into their contractual relationships with DCOs while allowing flexibility of individual CCOs to choose suggested specific quality metrics from a menu.

In Oregon, there are 16 CCOs and 9 DCOs. As CCOs define their dental strategy, quality measures are becoming prevalent; both with regards to APMs for shared savings and/or SLAs to the CCO-DCO contracts. To date this has been an incremental evolution, on a CCO-by-CCO basis, resulting in DCOs having multiple APMs/SLAs with CCOs. This disjointed approach creates an administrative burden as DCOs must focus on a variety of metrics that may not be aligned across CCOs. This policy creates a bank of metrics developed by a workgroup including dental professionals, CCO administrators, and has the backing of CCO Oregon member organizations.

Definitions:

APM: Alternative Payment Methodologies

CCO: Coordinated Care Organization

DCO: Dental Care Organization

DQA: Dental Quality Alliance

SLA: Service Level Agreement

Quality metrics utilized in dental APMs/SLAs should be created thoughtfully with the Triple Aim in mind. Since CCOs may not have a dental professional on staff the bank of quality metrics is designed to ease the implementation and operational burdens while aligning APMs/SLAs for more robust and expansive health outcome analysis.

The four types of quality measures recognized by DQA are:

- Access
- Process
- Experience
- Outcome

CCOs would have the flexibility to create SLAs utilizing metrics from all four categories that are relevant to their membership. DCOs would be able to focus on quality metrics that are based in patient care and outcomes and aligned with other SLAs and reduce costs.



Participating Workgroup Members:

Chair: Matthew Sinnott, MHA, Director of Government Affairs and Contract Management, **Willamette Dental**

Gary Allen, DMD, Dental Director, **Advantage Dental**

Teri Barichello, DMD, Vice President & Chief Dental Officer, **ODS**

Christina Swartz Bodamer, Managing Director Public and Professional Affairs, **ODA**

Doreen Crail, Director, Dental Services, **Moda Health**

Tony Finch, Executive Director, **Oregon Oral Health Coalition**

Alyssa Franzen, DMD, Dental Director, **CareOregon**

Sean Jessup, Director of Medicaid Programs, **Moda Health/EOCCO**

Sharity Ludwig, EPDH, Director of Community Programs, **Advantage Dental**

Monica Martinez, JD, CCO Contract Administrator, **CareOregon (Columbia Pacific CCO and Jackson Care Connect CCO)**

Shanie Mason, MPH, CHES, **CareOregon**

Mike Shirtcliff, DMD, President/CEO, **Advantage Dental**

Heather Simmons, MPH, Dental Services Program Manager, Government Programs, **PacificSource**

Eryn Womack, Dental Program Coordinator, **InterCommunity Health Network CCO**

CCO-DCO Quality Measure Core Set

	Description	Numerator	Denominator
Utilization-Adults	<p>Percentage of all enrolled adults who received at least one dental service within the reporting year.</p> <p>Link to additional information on measure: http://www.ada.org/-/media/ADA/Science%20and%20Research/Files/Adult_Measures_under_consideration.aspx</p>	<p>Unduplicated number of adults who received at least one dental service.</p> <p>CDT codes included are D0100 – D9999</p> <p>Measure covers both dental services and oral health services</p>	<p>Unduplicated number of adults who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days).</p> <p>Adult age bands:</p> <ul style="list-style-type: none"> 21-34, 35-54, 55-64, 65-74, 75-84, 85+
Utilization-Children	<p>Percentage of all enrolled children under age 21 who received at least one dental service within the reporting year.</p> <p>DQA measure endorsed by NQF.</p> <p>Link to additional information on measure: http://www.ada.org/-/media/ADA/Science%20and%20Research/Files/NQF_Dental_DQA_Util_of_Services.aspx</p>	<p>Unduplicated number of children who received at least one dental service.</p> <p>CDT codes included are D0100 – D9999</p> <p>Measure covers both dental services and oral health services</p>	<p>Unduplicated number of children 0-21 who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days).</p> <p>Children age bands:</p> <ul style="list-style-type: none"> <1, 1-2*, 3-5, 6-9, 10-14, 15-18, 19-20 (*Includes 12-month visit)
Preventative Services-Children and Pregnant Women	<p>Percentage of children receiving at least one preventive dental service by or under the supervision of a dentist within a reporting year Link to additional information on measure: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Initial-Core-Set-Dental.pdf</p> <p>Percentage of pregnant women receiving at least one preventive dental service by or under the supervision of a dentist within a reporting year</p>	<p>Unduplicated number of children receiving at least one preventive dental service by a practitioner operating with the scope of their license.</p> <p>CDT codes included are D1000-D1999, measure covers both dental services and oral health services.</p> <p>Unduplicated number of pregnant women receiving at least one preventive dental service by a practitioner operating with the scope of their license.</p> <p>CDT codes included are D1000-D1999, measure covers both dental services and oral health services</p>	<p>The total unduplicated number of individuals age one through 20 who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days and determined to be eligible for Early Periodic Screening, Diagnostic, Testing (EPSDT) services.</p> <p>Children age bands:</p> <ul style="list-style-type: none"> <1, 1-2*, 3-5, 6-9, 10-14, 15-18, 19-20 (*Includes 12-month visit) <p>Pregnant Women</p>
CAHPS – Access to Care + Patient Experience	<p>Types of Measures The Dental Plan Survey generates three types of measures for reporting purposes:</p> <ul style="list-style-type: none"> Rating measures, which are based on items that use a scale of 0 to 10 to measure respondents' assessment of their provider. This measure is sometimes referred to as the "global rating" or "overall rating." Composite measures (also known as reporting composites), which combine results for closely-related items that have been grouped together. Composite measures are strongly recommended for both public and private reporting because they keep the reports comprehensive yet of reasonable length. Psychometric analyses also indicate that they are reliable and valid measures of patients' experiences. Individual items, which are survey questions that did not fit into the composite measures. These measures may be included in public reports, but they are especially useful in reports for providers and other internal audiences that use the data to identify specific strengths and weaknesses. <p>Measures Based on the Dental Plan Survey The Dental Plan Survey produces three Composite measures and four rating measures:</p> <ul style="list-style-type: none"> Care from dentists and staff (6 items) Access to dental care (5 items) Dental plan costs and services (6 items) Patients' ratings (4 items) 	<p>Care from Dentists and Staff Q6. How often did your regular dentist explain things in a way that was easy to understand? Q7. How often did your regular dentist listen carefully to you? Q8. How often did your regular dentist treat you with courtesy and respect? Q9. How often did your regular dentist spend enough time with you? Q11. How often did the dentists or dental staff do everything they could to help you feel as comfortable as possible during your dental work? Q12. How often did the dentists or dental staff explain what they were doing while treating you?</p> <p>Access to Dental Care Q13. How often were your dental appointments as soon as you wanted? Q15. If you tried to get an 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? Q16. How often did you have to spend more than 15 minutes in the waiting room before you saw someone for your appointment? Q17. 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? Q14. 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?</p>	<p>Patients' Ratings Q10. 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? Q18. 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? Q25. 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? Q29. 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?</p> <p>Dental Plan Costs and Services Q19. How often did your dental plan cover all of the services you thought were covered? Q22. How often did the 800 number, written materials, or website provide the information you wanted? Q27. How often did your dental plan's customer service give you the information or help you needed? Q28. How often did your dental plan's customer service staff treat you with courtesy and respect Q20. Did your dental plan cover what you and your family needed to get done? Q24. Did this information (from your dental plan) help you find a dentist you were happy with?</p> <p>Denominator: Unduplicated number of members who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment up to 45 days)</p>
Emergency Department	<p>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.</p> <p>Hybrid: blend of two DQA measures; 1 NQF endorsed.</p> <p>Link to Additional measure details: http://www.ada.org/-/media/ADA/Science%20and%20Research/Files/NQF2695_DQA_FollowUpAfterEDVisit_Specifications.aspx http://www.ada.org/-/media/ADA/Science%20and%20Research/Files/Pediatric_Measures_Under_Testing.aspx</p>	<p>Unduplicated number of children who were seen in the ED for caries-related reasons in the reporting year and visited a dentist within</p> <p>(a) 7 days (b) 30 days (c) 60 days (**added to NQF endorsed DQA measure based on another DQA ED measure**)</p> <p>following the ED visit.</p> <p>Caries related ED visit codes: See document hyperlinked in the description box of this ED measure.</p> <p>Follow-up visit CDT codes: D0100–D9999</p>	<p>DEN 1: Unduplicated number of children who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days).;</p> <p>DEN 2: Unduplicated number of children who are Continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days) seen in an ED for caries-related reasons</p> <p>Children age bands:</p> <ul style="list-style-type: none"> <1, 1-2*, 3-5, 6-9, 10-14, 15-18, 19-20 (*Includes 12-month visit) <p>Rates: NUM1/DEN1 and NUM2/DEN1 and NUM3/DEN1 NUM1/DEN2 and NUM2/DEN2 and NUM3/DEN2 DEM2/DEM1</p>
Emergency Department	<p>Percentage of all enrolled adults who were seen in the ED for non-traumatic dental related reasons within the reporting year and visited a dentist for treatment services within 60 days following the ED visit.</p> <p>Link to additional measure details: http://www.ada.org/-/media/ADA/Science%20and%20Research/Files/Adult_Measures_under_consideration.aspx</p>	<p>Unduplicated number of adults who were seen in the ED for non-traumatic dental related reasons in the reporting year and visited a dentist for treatment services within 60 days following the ED visit.</p> <p>Follow-up visit CDT codes: D0100–D9999</p>	<p>Unduplicated number of adults who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days) seen in an ED for non-traumatic dental related reasons.</p> <p>Adults age bands:</p> <ul style="list-style-type: none"> 21-34, 35-54, 55-64, 65-74, 75-84, 85+

CCO-DCO A La Carte Measures

	Description	Numerator	Denominator
Fluoride Varnish	<p>(1) Fluoride (Topical): Percentage of patients, assessed with moderate to high risk of developing dental caries, who received at least one topical fluoride treatment.</p> <p>(2) Fluoride Varnish Applications (Early Childhood Caries): Percentage of children 12 to 72 months of age defined as being at higher-risk of dental disease who receive 1 or more fluoride varnish applications.</p> <p>(3) Topical Fluoride Intensity for Children at Elevated Caries Risk: Percentage of a. all enrolled children b. enrolled children who received at least one dental service who are at "elevated" risk (i.e. "moderate" or "high") who received (1, 2, 3, >4) topical fluoride applications within the reporting year</p> <p>(4) Percentage of a. enrolled adults b. enrolled adults who accessed dental services (received at least one service) at elevated caries risk (i.e., "moderate" or "high" risk) receiving (1,2, 3, ≥4) topical fluoride application within the reporting year.</p>	<p>(1) Number of patients, assessed moderate to high risk of developing dental caries, with at least one topical fluoride treatment during the report period.</p> <p>(2) Number of patients in the denominator with a topical fluoride varnish (D1206 and D1208) documented (within the previous 12 months).</p> <p>(3) Unduplicated number of children at "elevated" risk (i.e. "moderate" or "high") who received (1, 2, 3, >4) topical fluoride applications as a dental service.</p> <p>(4) Unduplicated number of all enrolled adults at elevated caries risk who received (1, 2, 3, ≥4) topical fluoride application</p>	<p>(1) Number of patients, assessed moderate to high risk of developing dental caries, with a documented dental visit during the report period.</p> <p>(2) Number of children 1-6 years of age with a documented dental visit in the last 12 months.</p> <p>(3) DEN 1: Unduplicated number of all enrolled children at "elevated" risk (i.e. "moderate" or "high"); DEN 2: Unduplicated number of all enrolled children at "elevated" risk (i.e. "moderate" or "high") who received at least one dental service.</p> <p>Rates: NUM/DEN 1; NUM/DEN 2</p> <p>(4) DEN 1: Unduplicated number of all enrolled adults at elevated caries risk; DEN 2: Unduplicated number of all enrolled adults at elevated caries risk who received at least one dental service.</p> <p>Rates: NUM/DEN 1; NUM/DEN 2</p>
Smoking	<p>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</p> <p>Link to additional measure details: http://www.ada.org/-/media/ADA/Science%20and%20Research/Files/Adult_Measures_under_consideration.ashx</p>	<p>Unduplicated number of all enrolled adults identified as smokers who received a comprehensive or periodic oral evaluation.</p>	<p>DEN 1: Unduplicated number of adults who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days) identified as smokers; DEN 2: Unduplicated number of adults who are continuously enrolled in a CCO for the 12-month measurement year (with no more than one gap in continuous enrollment of up to 45 days) identified as smokers who received at least one dental service</p> <p>Adult age bands: • **Pediatric age band subject to Metrics and Scoring decision(s) • 21-34, 35-54, 55-64, 65-74, 75-84, 85+</p> <p>Rates: NUM/DEN1; NUM/DEN2</p>
Pregnant	<p>(1) Pregnant Women Who Received Prophy/Fluoride.</p> <p>(2) Percent of pregnant women with comprehensive dental exam completed while pregnant.</p>	<p>(1) Prophy/fluoride Codes - D1110, D1120, D1201, D1203, D1204, or D1205.</p> <p>(2) Pregnant women in the last 12 month with comprehensive exam while pregnant.</p>	<p>(1) Pregnant women were identified as having an expected due date within year and must have been enrolled in the DCO for at least 45 days for the baseline year and for the re-measure year.</p> <p>(2) Pregnant women in the last 12 months.</p>
Exams/Visits	<p>(1) The percentage of recipients 2-21 years of age who had at least one dental visit during the measurement year. The eligible population has to have continuous enrollment during the measurement year, with no more than one gap in enrollment of up to 45 days.</p> <p>(2) Use of Dental Services by Children - periodic or comprehensive examination.</p> <p>(3) Percentage of a. all enrolled adults b. enrolled adults who accessed dental care (received at least one service) who received a comprehensive or periodic oral evaluation within the reporting year</p> <p>(4) Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.</p> <p>(5) The percentage of enrolled members (age to be determined) who had at least one dental visit during the measurement year.</p>	<p>(1) Had at least one dental visit during the measurement year.</p> <p>(2) Number of enrollees who received comprehensive or periodic exam.</p> <p>(3) Unduplicated number of all enrolled adults who received a comprehensive or periodic oral evaluation.</p> <p>(4) Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service.</p> <p>(5) Medicaid members who had one or more dental visits with a dental practitioner during the measurement year.</p>	<p>(1) Members 2-21 years of age as of December 31 of the measurement year. Report six age stratifications and a total rate: 2-3 years, 4-6 years, 7-10 years, 11-14 years, 15-18 years, 19-21 years, and Total.</p> <p>(2) Number of children enrollees.</p> <p>(3) DEN 1: Unduplicated number of all enrolled adults; DEN 2: Unduplicated number of all enrolled adults who received at least one dental service.</p> <p>(4) Unduplicated number of all enrolled children under age 21.</p> <p>(5) Members 2- 21 years of age as of December 31 of the measurement year. Report six age stratifications and a total rate: 2-3 years, 4-6 years, 7-10 years, 11-14 years, 15-18 years, 19-21 years, and Total.</p>
Diabetes	<p>(1) Comprehensive Periodontal Oral Evaluation for those with a history of treated periodontitis: Percentage of a. all enrolled adults treated for periodontitis b. enrolled adults treated for periodontitis who accessed dental services (received at least one service) who received comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year.</p> <p>(2) Periodontal Maintenance Services for those with history of treated periodontitis: Percentage of a. all enrolled adults treated for periodontitis b. enrolled adults treated for periodontitis who accessed dental services (received at least one service) who received oral prophylaxis OR periodontal maintenance at least 1, 2, 3, ≥4 times within the reporting year.</p> <p>(3) People with Diabetes: Oral Evaluation: Percentage of a. all enrolled adults identified as people with diabetes b. enrolled adults identified as people with diabetes who accessed dental care (received at least one service) who received a comprehensive or periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year</p>	<p>(1) Unduplicated number of all enrolled adults treated for periodontitis who received comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination.</p> <p>(2) Unduplicated number of all enrolled adults treated for periodontitis who received oral prophylaxis OR periodontal maintenance at least 1, 2, 3, ≥4 times.</p> <p>(3) Unduplicated number of all enrolled adults identified as people with diabetes who received a comprehensive or periodic oral evaluation OR comprehensive periodontal examination at least once.</p>	<p>(1) DEN 1: Unduplicated number of all enrolled adults treated for periodontitis; DEN 2: Unduplicated number of all enrolled adults treated for periodontitis who received at least one dental service. "Treated for periodontitis" determined by prior claims history for specific periodontal treatment codes.</p> <p>Rates: NUM/DEN1; NUM/DEN2.</p> <p>(2) DEN 1: Unduplicated number of all enrolled adults treated for periodontitis; DEN 2: Unduplicated number of all enrolled adults treated for periodontitis who received at least one dental service. "Treated for periodontitis" determined by prior claims history for specific periodontal treatment codes</p> <p>Rates: NUM/DEN1; NUM/DEN2.</p> <p>(3) DEN 1: Unduplicated number of all enrolled adults identified as people with diabetes; DEN 2: Unduplicated number of all enrolled adults identified as people with diabetes who received at least one dental service.</p> <p>Rates: NUM/DEN1; NUM/DEN2.</p>
Additional E.D.	<p>(1) Ambulatory Care Sensitive ED Visits for Dental Caries in Children: Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children.</p> <p>(2) Follow-up after ED Visit by Children for Dental Caries: 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.</p> <p>(3) Follow-up after 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.</p> <p>(4) Use of ED for caries-related reasons: 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.</p> <p>(5) Use of ED for caries-related reasons: 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.</p>	<p>(1) Number of ED visits with caries-related diagnosis code among all enrolled children.</p> <p>(2) Number of caries-related ED visits in the reporting year for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit.</p> <p>(3) Unduplicated number of children who were seen in the ER for caries-related reasons in the reporting year and visited a dentist within 60 days following the ED visit.</p> <p>(4) Unduplicated number of all enrolled adults b. Unduplicated number of all enrolled adults seen in an ED at least once for any Reason.</p> <p>(5) Unduplicated number of children who were seen in an ED for 1, 2, 3 or more visits for caries-related reasons.</p>	<p>(1) All member months for enrollees 0-20 years during the reporting year.</p> <p>(2) Number of caries-related ED visits in the reporting year.</p> <p>Rates: NUM1/DEN; NUM2/DEN.</p> <p>(3) DEN 1: Unduplicated number of all enrolled children; DEN 2: Unduplicated number of all enrolled children seen in an ED for caries-related reasons.</p> <p>Rates: NUM/DEN1; NUM/DEN2.</p> <p>(4) DEN 1: Unduplicated number of all enrolled adults; DEN 2: Unduplicated number of all enrolled adults seen in an ED at least once for any reason.</p> <p>Rates: NUM/DEN1; NUM/DEN2.</p> <p>(5) DEN 1: Unduplicated number of all enrolled children; DEN 2: Unduplicated number of all enrolled children seen in an ED at least once for any reason.</p> <p>Rates: NUM/DEN1; NUM/DEN2.</p>

**Office for Oregon Health
Policy and Research**



Oral Health and the Oregon Health Plan

**Medicaid Advisory Committee
Staff Summary and Recommendations**

March 2009

March 31, 2009

Bruce Goldberg, MD
Director, Oregon Department of Human Services

Dear Dr. Goldberg:

At the request of several stakeholders, the Medicaid Advisory Committee (MAC) has reviewed key issues surrounding oral health services and the Oregon Health Plan. A brief introduction to the topic and a description of the MAC's deliberation process accompany the recommendations outlined in this report.

The MAC would like to take this opportunity to commend the State of Oregon for its commitment to providing quality health care to its citizens. Providing health care coverage to all children in Oregon has been at the forefront of the state's agenda and continues to be a top priority. Expanding coverage to low-income adults has also become a pertinent matter to the leadership within our state. One issue, however, that is continuously deferred is the importance of access to high-quality oral health care. We believe that health care services should not be segregated based on the part of the body they involve or the qualified health professionals who deliver them.

The prevalence of oral disease among Oregonians is rising. Left untreated, oral disease can lead to costly dental treatments and diminish the general health and well-being of those affected by this condition. Preventive dental care can stop oral disease establishment and progression, thereby reducing the likelihood that an individual will need costly treatments in the future. Access to dental services as well as a culture within state leadership dedicated to oral health education and promotion is critical to achieving and maintaining a population free of oral disease.

The federal government has demonstrated its support in providing access to dental services for children through the recently enacted Children's Health Insurance Program (CHIP) Reauthorization Act of 2009. Using federal matching funds as a means of financing, the Act allows states the option to provide dental-only supplemental coverage for children who otherwise qualify for a state's CHIP program, but have other health insurance without dental benefits. The Act also includes provisions related to the development and dissemination of dental education materials, as well as, data reporting on dental access and quality.

In the MAC's 2006 report to Governor Kulongoski regarding the Healthy Kids Plan design, the Committee recommended that all Oregon children be provided with access to comprehensive, affordable health insurance. The MAC continues to support plans to expand coverage, including dental benefits, to all uninsured populations. All Oregonians should have access to comprehensive, affordable oral health services.

While developing these recommendations has been a stimulating process, we realize that this is only the first step in achieving access to oral health services for all Oregonians. We look forward to working with the Department of Human Services on this and many other issues that are central to the delivery of high-quality health care within

the Oregon Health Plan. Please let us know if there are any pieces of these recommendations that require clarification or if we can be of further assistance.

Sincerely,



Carole Romm, RN, MPA
Co-Chair
Medicaid Advisory Committee



Jim Russell, MSW
Co-Chair
Medicaid Advisory Committee

Medicaid Advisory Committee Report

*Submitted to Bruce Goldberg, MD
Director, Oregon Department of Human Services*

March 31, 2009

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If you would like additional copies of this report, or if you need this material in an alternate format, please call Shawna Kennedy-Walters at (503) 373-1598.

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Medicaid Advisory Committee's Recommendations on Oral Health Care

Executive Summary

The following is a summary of the MAC recommendations on Oral Health Care in Oregon. The full recommendations follow this summary including rationale and supporting data for each.

1. All Oregonians should have access to comprehensive and affordable oral health care. This can be accomplished through policies that:
 - Expand access for all children;
 - Fully-fund Oregon's commitment to basic oral health for all Oregonians;
 - Create a dental benefit package to be included in the Oregon Health Plan Standard and Oregon Health Plan Plus; and
 - Increase dental capacity and infrastructure in community health centers, safety net clinics, and local public health departments.

2. Prevention should be prioritized in all oral health activities including:
 - Increasing alternative care delivery models such as community-based prevention strategies; and
 - Establishing school-based prophy-dental clinics staffed by Limited Access Permit Dental Hygienists and Expanded Function Dental Assistants to practice individualized needs-related preventive oral health services.

3. Oral, physical, and behavioral health services should be coordinated as much as possible. A strategy for achieving this goal could include:
 - Improving communication between medical, behavioral, and oral health providers on the importance of oral health for vulnerable populations and creating venues for collaboration to deal with oral access issues.

4. The state should provide leadership in oral health services statewide through coordination of a prioritized strategy including:
 - Establishing a cohesive, coordinated plan to decrease oral disease; and
 - Establishing a dental advisory committee for the Health Services Commission.

5. Oregon needs a long-range oral health workforce strategy to maximize availability and effectiveness of a limited workforce. This could be accomplished through:

- Advocating for policy changes that encourage and/or incentivize qualified oral health workforce providers to practice in Oregon, particularly rural Oregon; and
- Developing policies to foster the “Dental Team” concept.

6. The state should promote individual responsibility for maintaining and improving oral health by:

- Providing Oregonians the tools for good personal oral hygiene practices, appropriate health seeking behavior, good nutritional practices, and the importance of routine dental care in a culturally and linguistically sensitive manner.

7. To ensure that public resources are spent effectively and appropriately, the state should evaluate the provision of oral health services in the Oregon Health Plan. This could be accomplished by:

- Adopting policies that implement utilization of tools such as the “Dental Access Measures” to track oral health care.

Problem, Background, and Approach

The Problem – Access to Oral Health Services

In spite of safe and effective means of maintaining oral health that has benefited the majority of Americans over the past half century, many among us still experience needless pain and suffering compromising our oral and general health and diminishing our quality of life. The same can be said for Oregonians. Great disparities exist in oral disease prevalence. Poverty, race and ethnicity, education, geographic location, language, and insurance coverage play a role in disease rates. Above all, ACCESS to preventive and routine dental care has been shown to be a determinate of disease status.

–Gordon Empey, DMD State of Oregon Dental Health Consultant

Oral disease is affecting a growing number Oregonians and particularly members of the Oregon Health Plan. Recent state-wide trends indicate that since 2002 every major measure of oral health status for children has worsened while one in four children living in Oregon currently goes without dental insurance.¹ An increasing number of adolescents are reporting cavities,² and upon reaching retirement age (65-74), one in five Oregonians has lost all of their teeth, essentially making them dentally disabled.³ There is evidence, however, that improving access to oral health services through Medicaid programs reduces costs within the health system. For example, Medicaid enrolled children who have had an early preventive dental visit are more likely to use subsequent preventive services and experience lower dental-related costs.⁴ There is also evidence to suggest that early association with a dentist has the benefit of reduced cost of care, with the difference being attributed to an increased need for treatment services for those who delay the first dental visit.⁵ This epidemic is increasing costs to the health system, threatening the livelihood of Oregonians through decreased productivity and raising the risk for other diseases – yet it is also 100% preventable.

Involvement of the Medicaid Advisory Committee

Amid the state-wide oral disease epidemic there has been anecdotal evidence that members of the Oregon Health Plan have been experiencing difficulty accessing services in contracted managed care Dental Care Organizations (DCOs), yet there has been a dearth of empirical or qualitative data to substantiate such claims. In order to address this issue, the executive leadership of the Oregon Department of Human Services (DHS) began discussions with DCOs in 2007 to develop performance measures

¹ Oregon Smile Survey (2007) Oregon Department of Human Services, Division of Public Health.

² Oregon Healthy Teens Survey (2007) Oregon Department of Human Services, Division of Public Health.

³ The Burden of Oral Disease in Oregon (2006) Oregon Department of Human Services, Division of Public Health.

⁴ Savage MF, Lee JY, Kotch JB, Vann WF. (2004) Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs. *Pediatrics*; 114:4:e418-432.

⁵ Doykos JD III. (1997) Comparative cost and time analysis over a two year period for children whose initial dental experience occurred between ages 4 and 8 years. *Pediatric Dentistry*;19:61-2.

and access standards. Over the next year, a workgroup consisting of DCO representatives and DHS Division of Medical Assistance Programs (DMAP) representatives refined performance measures and created a “Dental Access Measures” tool which was released in January of 2009. Prior to its release, the Medicaid Advisory Committee (MAC) began discussing issues related to oral health and the Oregon Health Plan, which created a public forum for the performance measures and measurement tool developed by DMAP. Moreover, the MAC began to develop a plan for improving oral health throughout the state that would include, but was not limited to, performance measurement. The following is a description of the recommendation development process and action steps necessary to reduce the prevalence of oral health disease in the Medicaid population.

The MAC Process

Between June and November 2008, the MAC discussed oral health access issues and gathered input from 13 interested groups and stakeholders including: DMAP representatives, consumer advocates, dental insurance plans and DCOs, OHP Fully Capitated Health Plans (FCHP), DHS Public Health, Oregon Office of Rural Health, Oregon Child Development Coalition (Head Start focused), a rural practicing dentist, Oregon Dental Association, Oregon Dental Hygienists’ Association, and the Oregon Board of Dentistry. The committee was also given research on state level dental health status vital statistics, primary care dental capacity, and a national report on oral health access. Both feedback from these groups as well as current research helped to define recommendations the MAC could submit to the legislature.

Recommendations on Oral Health

The following recommendations were developed by the Medicaid Advisory Committee (MAC) under a set of policy objectives:

1. All Oregonians should have access to comprehensive and affordable oral health services.
2. Prioritize prevention in all oral health activities.
3. Oral, physical, and behavioral health need to be coordinated as much as possible. These disparate delivery systems need to work collaboratively.
4. Provide leadership in oral health services statewide through coordination of a prioritized strategy.
5. Oregon needs a long-range oral health workforce strategy so that there will be maximized efficiency of the available workforce.
6. Promote individual responsibility for maintaining and improving oral health.
7. Evaluate the provision of oral health services in the Oregon Health Plan to ensure that public resources are spent effectively and appropriately.

The Oregon Health Plan plays a critical role in improving oral health in Oregon; however, the epidemic of oral health disease also requires activities beyond the state's Medicaid program. It is anticipated that recommendations on oral health can further the goals of the Oregon Health Fund Board's Comprehensive Plan for Health Reform as well as the Governor's Healthy Kids Plan.

1. **Objective:** All Oregonians should have access to comprehensive and affordable oral health services.

Strategy: Establish policies that expand access for all children.

The proposed Healthy Kids program will maximize enrollment of the uninsured into private or public programs that will include oral health services as well as utilize safety net clinics and school-based health settings.

Strategy: Fully fund Oregon’s commitment to basic oral health for all Oregonians.

Dental benefits should be aligned and integrated with the Prioritized List of Health Services to secure funding for preventive oral health procedures and ensure that Oregonians have access to basic oral health care. Oral health treatments should be given equal parity with medical treatments when seeking cost-savings and considering benefit cutbacks.

Strategy: Through the Health Services Commission (HSC), create a dental benefit package to be included in both OHP Standard and OHP Plus.

A refined dental benefit package would free resources that could be distributed in an effective manner across both OHP Standard and OHP Plus. The new benefit package should be appropriate for the population it is meant to serve. An evidence-based benefit package should increase oral health by providing increased access to effective treatments.

Strategy: Increase dental capacity and infrastructure in community health centers, safety net clinics, and local public health departments as part of the proposed Community-Centered Health Initiatives Fund (CCHIF).

The Oregon DHS Division of Public Health has proposed, and the Oregon Health Fund Board has endorsed, creating an expanded revenue base for public health activities at the community level. These activities are based on the following:

- Require a minimum level of community investment to match state investment;
- Be based on community input;
- Be based on evidence and data, including population health measures reported and an evaluation component;
- Address behavior change at the individual, community and system levels;
- Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
- Work to reduce health care disparities; and

- Be contingent on effectiveness and require evaluation for effectiveness on an ongoing basis.

Action Steps:

- 1) Implement the proposed Healthy Kids Program that will expand oral health services to all children.
- 2) Integrate dental treatments with the Prioritized List of Health Services.
- 3) Redesign the OHP dental benefit package and implement in both OHP Standard and OHP Plus.
- 4) Implement financial incentive programs using CCHIF resources to encourage more dental providers to participate in the OHP.
- 5) Invest resources from the CCHIF in programs to address oral health access in community health centers, safety net clinics, and local public health departments.
- 6) Include culturally-specific approaches to disease prevention and treatment in oral health services as well as targeted outreach to members of racial, ethnic, language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness.

2. Objective: Prioritize prevention in all oral health activities.

Strategy: Enhance access by increasing alternative care delivery models such as community-based prevention strategies.

Creating and maintaining a bridge between population health, the oral health delivery system, and communities is an essential part of improving access. To maximize success, there must be involvement between public and private sector professionals in population evaluation and decision-making, particularly in strategizing how to effectively promote oral health and prevent disease. This includes conducting health impact assessments of projects in non-traditional health care delivery sectors such as education. DHS is currently proposing that investments be made in the current Oral Health Program run by the Division of Public Health as part of a policy option package (POP) for the 2009-11 budget. This program provides critical prevention strategies throughout the state.

Strategy: Establish school-based prophylactic dental clinics staffed by Limited Access Permit Dental Hygienists and Expanded Function Dental Assistants to practice individualized needs-related preventive oral health services.

A needs-related dental caries preventive program was introduced for all 0–19 year-olds in the county of Värmland, Sweden in 1979. This serves as an example of a community that has made great strides in overcoming prevalent oral health problems, even without fluoridating the water. This program integrates prophylactic dental clinics directly into elementary schools “enabling preventive dentistry assistants or dental hygienists to practice individualized needs-related preventive dentistry.” In placing these providers in the schools, cost-savings were realized with decreased utilization and a dramatic reduction in the treatment time by dentists.⁶

Action Steps:

- 1) Invest in the DHS Oral Health Program in order to create opportunities for local public health departments to invest in public health programs such as community water fluoridation, school-based fluoride and dental sealant initiatives, and other activities sought by communities to improve oral health.
- 2) Emphasize the delivery of preventive dental care services, particularly to pregnant women, children under age 3, and other vulnerable populations, by advocating for policy changes that provide incentives for OHP enrollees to access these services.
- 3) Improve collaborations to deal with access issues for special needs OHP enrollees, particularly in rural settings.
- 4) Build infrastructure for oral health prevention program data collection and evaluation.
- 5) Develop a pilot program of school-based, needs-related preventive prophylactic dental clinics targeted to schools with a large free-and-reduced-lunch program population that would possibly otherwise qualify for Medicaid.

These clinics will be administered by public health departments and funded through Medicaid. The clinics will be staffed by Limited Access Permit Dental Hygienists and Expanded Function Dental Assistants as well as a limited number of dentists.

3. **Objective: Coordinate oral, physical, and behavioral health services as much as possible. These disparate delivery systems need to work collaboratively.**

Strategy: Improve communication between medical, behavioral, and oral health providers on the importance of oral health for vulnerable populations and create venues for collaboration to deal with oral access issues.

⁶ Axelsson, P. (2006) The Effect of a Needs-Related Caries Preventive Program in Children and Young Adults – Results after 20 Years. BMC Oral Health, 6(Suppl 1):S7.

Integration of oral health with physical health care and within primary care is an essential goal of a reformed delivery system. A recent report from the Institute of Medicine's Quality Chasm series suggests that system transformation should progress from care collaboration to care coordination to care integration.⁷ Accomplishing this goal can and should occur in a progressive fashion over a reasonable period of time. Raising awareness of oral, physical, and behavioral health needs across provider disciplines through enhanced communication and referral strategies is fundamental to successful system transformation.

Action Steps:

- 1) The relevant divisions within DHS (DMAP, and Public Health's relevant offices), along with their constituent providers and consumer/advocate organizations, should collaborate to complete work that has evolved over the past five years to promote clinical integration. DHS and other relevant state agencies should develop policies, performance standards, and incentives that require contracted publicly-funded and commercial plans to develop effective care integration strategies.
 - 2) Develop a formal referral system and protocol that can be used by hospital emergency rooms, physicians, dental offices, DMAP, and others for referring patients who have oral health needs. This program should include:
 - a. Written instructions on who to call or how to access dental plans that patients may be enrolled in,
 - b. A common referral form for oral health care providers to track referrals,
 - c. A program to educate physicians, hospital staff, FCHPs, oral health care providers, DHS case managers, and others in the referral process.
 - d. Procedures for collaboration between dental plans to provide access for patients when plans are closed for enrollment or other emergent needs arise.
 - 3) Develop a Dental Access Council to include medical providers, dentists, FCHPs, DCO representatives, MHO representatives, etc. in order to address access difficulties and possibly a 1-800 referral "coach" program.
4. **Objective: Provide leadership in oral health services statewide through coordination of a prioritized strategy.**

Strategy: Through state government leadership, establish a cohesive, coordinated plan to decrease oral disease.

Part of the Oral Health Program DHS POP for the 2009-11 budget is to revise the 2005 State Plan for Oral Health. The State Plan for Oral Health is a roadmap for

⁷ Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions.

partners as they develop policies and implement programs, yet it can also serve as a needs assessment for oral health facilities in communities. A rural dentist that gave testimony to the MAC stated that in his community there is a “bricks and mortar mentality in the social system that is counter-productive to our goals.” In his opinion, the focus should be aimed at coordinating existing services, rather than building new ones.

There is also a DHS POP for the 2009-11 budget to create a State Dental Health Officer in DMAP which would serve 0.5 FTE as the State Dental Director. This individual would provide much needed guidance in assessing oral health status, implementing surveillance, developing plans and policies, mobilizing community partners, and conducting research and supporting demonstration projects. The individual would also provide vital clinical support, make dental policy recommendations, and act as an external, clinical, and professional liaison with staff, contractors, dental professionals, and dental organizations.

Strategy: Establish a dental advisory committee for the Health Services Commission.

It is imperative that qualified professionals are involved in the review process of treatments to be added or removed from the Prioritized List of Health Services. A dental advisory subcommittee composed of stakeholders from the oral health community should review evidence relating to the safety, effectiveness, and cost-effectiveness of dental technologies and procedures to ensure that dental treatments are properly prioritized according to the objectives of the Prioritized List.

Action Steps:

- 1) Expand dental expertise and infrastructure at the Oregon DHS to include a State Dental Director position which would develop and implement state initiatives related to oral health.
- 2) Bring all stakeholders together into a collaborative process to address the issues identified by the State Dental Director (in many cases this may be best done community by community)
- 3) Create an oral health advisory committee composed of stakeholders from the dental community to act as an advisory body to the HSC.

5. Objective: Oregon needs a long-range oral health workforce strategy to maximize availability and effectiveness of a limited workforce.

Strategy: Advocate for policy changes that encourage and/or incentivize qualified oral health workforce providers to practice in Oregon, particularly rural Oregon.

Oregon lacks a coherent strategy to assure an adequate and highly trained oral health care workforce to meet the needs of the 21st Century. Important work done by DHS to examine primary care dental capacity as well as work done by Oregon Health & Science University and other groups to provide information on all dental workforce practice patterns could be coordinated into the implementation of the Oregon Health Fund Board's proposed Health Care Workforce Strategy. This is critically important in rural areas where providers are less common and available.

Strategy: Develop policies to foster the “Dental Team”⁸ concept.

The Dental Team concept is akin to the “Medical Home” in that the underlying theme is that the whole is greater than the sum of the parts. Testimony given to the MAC by a DCO indicated that ideally the designation would include: one or more Limited Access Permit Dental Hygienists, Expanded Function Dental Assistants, Denturist, Dentist and others. The team described can effectively manage a larger patient panel size as well as work in multiple locations at the same time, while a solo dentist practitioner is usually limited to one venue.

Action Steps:

- 1) Integrate oral health into the state's Health Care Workforce Strategy.
- 2) Recruit practitioners to rural areas by providing loan payment, debt forgiveness, and/or tax incentives to support private practitioners taking a minimum level of OHP patients.
- 3) Explore ways to increase involvement and reimbursement of Limited Access Permit Hygienists.
- 4) Promote the “Dental Team” concept of providing care through DHS activities, including those of the State Dental Director.

6. Objective: Promote individual responsibility for maintaining and improving oral health.

Strategy: Provide Oregonians the tools for good personal oral hygiene practices, appropriate health seeking behavior, good nutritional practices, and the importance of routine dental care in a culturally and linguistically sensitive manner.

Throughout Oregon there are cultural and linguistic barriers to understanding the steps needed to maintain and improve oral health. Testimony to the MAC indicated

⁸ The Dental Team concept of care focuses on best meeting a patient's oral health needs by providing comprehensive, coordinated, team-based care. This is accomplished by expanding the function of dental hygienists, dental assistants, and others to provide the primary dental practitioner additional time for direct patient care.

that many enrollees and state caseworkers feel that the dental community does not accommodate these barriers as routinely as the physical health community. The Oregon Health Fund Board is proposing that the state should create a state-wide pool of qualified, certified interpreters and programs that can utilize and build on technologies being developed for telemedicine or telehealth.

Action Steps:

- 1) Raise awareness of OHP enrollees and their caregivers on how to access dental care and how to effectively raise issues of access and voice concerns through increased communication with case managers that is culturally and linguistically appropriate.
- 2) Coordinate the DHS Oral Health Program with the Oregon Department of Education's health education programs to ensure that they include comprehensive oral health education.
- 3) Strengthen ombudsman and other customer services for OHP clients, advocates, and providers by establishing a system to track and resolve problems with access to services including removal of barriers for both applicants and clients. The system needs to ensure communication between those lodging the complaints and/or concerns and those who can resolve them. This strategy was a component of DHS' 2009 - 2011 Policy Option Package.

7. Objective: Evaluate the provision of oral health services in the Oregon Health Plan to ensure that public resources are spent effectively and appropriately.

Strategy: Adopt policies such as the "Dental Access Measures" tool to track oral health care.

The Dental Access Measures tool represents a tremendous amount of work and consensus-building between DMAP and oral health care providers to create an evaluation tool that will identify areas for improvement and raise red flags where appropriate. It will also provide the ground work for relevant health planning agencies such as the Health Authority (proposed by the Oregon Health Fund Board) to identify oral health metrics in accountable care communities. In order to complement and improve these efforts, DMAP should also conduct a qualitative evaluation of oral health care and develop methods for tracking patient experience of care.

Action Steps:

- 1) Implement quantitative assessments of care such as the Dental Access Measures tool (*see definition below*) to evaluate oral health care provider performance.
- 2) Develop a qualitative evaluation of oral health care providers.
- 3) Develop an assessment to track patient experience of oral health care.

The Dental Access Measures tool was created in a collaborative effort by representatives from DHS, DMAP, and local DCOs to define a common set of dental access measures. The measures will be based upon EPSDT (Early Periodic Screening Diagnosis and Testing) and will include the following four basic measures:

- Percentage of clients receiving dental services in a year
- Per member per month utilization for dental services
- Preventive dental measures for both continuous and ever enrolled age groups
- Percentage breakdown of services provided, segregated by plan

Medicaid Advisory Committee Oral Health Access Stakeholder Summary Highlights

On September 24th and October 22nd of 2008 the Medicaid Advisory Committee (MAC) convened stakeholders regarding improving oral health access in the Oregon Health Plan. Below is a summary of public testimony presented to the MAC during these meetings.

MAC Meeting September 24, 2008

Dr. Gordon Empey, a dental consultant to the Public Health Division work in the Office of Family Health Oral Health Program:

- Emphasize the delivery of preventive dental care services, particularly to pregnant women and children under age 3 by advocating for policy changes that incentivizes access for these services to OHP enrollees.
- Bring all stakeholders together into a collaborative process to address the issues (In many cases this may be best done community by community).
- Get our fair share of the limited national workforce by advocating policy changes that make it easy for qualified dentists to settle in Oregon, particularly rural Oregon.
- Increase dental capacity and infrastructure in community health centers and safety net clinics and local health departments.
- Explore ways to increase involvement and capacity of Limited Access Permit Hygienists.
- Implement incentives to encourage more dental providers to participate in the OHP.
- Increase community based prevention strategies, including CWF; School- based fluoride and dental sealant programs.
- Advocate for dental infrastructure at DMAP, including dental leadership and expertise.
- Increase education of, and communication between, medical and dental providers on the importance of oral health for vulnerable populations and improve collaboration to deal with dental access issues.
- Improve collaborations to deal with issues of access for special needs OHP enrollees, particularly in rural settings.
- Raise awareness of OHP enrollees on how to access dental care and how to effectively raise issues of access and voice concerns.
- Establish a system to deal with and solve specific access complaints and concerns lodged by enrollees, advocates, and providers. The system needs to ensure communication between those lodging the complaints and/or concerns and those who can resolve them.

Donalda Dodson, Executive Director for Oregon Child Development Coalition, a private non-profit organization designated to do migrant Head Starts located in 12 counties:

- The Coalition sees about 3,500 children aged 6 weeks through kindergarten and 50-60% are in the infant and toddler population. At least 10% of the families seen must have a disabled child.
- The Coalition does education, health services, mental health, psycho-social and family services. They are required to see that children get services within 45 days of coming into the center.
- At least 92% of the families say they have a medical home of which 54% say it is the community clinic. About 84% are enrolled in Medicaid and 2% have private insurance. To qualify for Head Start individuals can't be over 100% of the poverty level. Three

Appendix A: Oral health stakeholder summary highlights

years ago \$40,000 was spent treating baby bottle mouth so education about that is being emphasized.

- About 73% needing treatment are getting it, but there is a need to increase that to at least 90%.
- The Coalition is active in the Varnish Program and all their centers are trained to do dental varnish, which has been well received by the families.
- Some families who have been identified as being able to get access to a provider may be given one in another county or city.
- Dental access in rural communities is the main goal the Coalition has identified and would like to see improved.

MAC Meeting October 22, 2008

Rural Oregon:

Scott Ekblad, Director Oregon Office of Rural Health:

- Data on oral health in rural Oregon is disconcerting.
- Since the first Smile survey in 2002, every major measure of oral health among Oregon school children has worsened.
- School children living outside the Portland metropolitan area experience more tooth decay and decay severe enough to require urgent treatment than their urban counterparts.
- Capacity is a major issue in rural areas. The number of dentists retiring is greater than the number being trained. There is 1 dentist for every 1,302 urban Oregon and 1 for 1,879 in rural areas. 38% of Oregon is considered rural.
- Economics is the major factor in recruiting dentists, making a living after incurring large school debts and practicing in a rural area where no insurance or Medicaid patients are higher. State loan repayment programs are underfunded and government reimbursement rates are often lower than the services cost.

J. Kyle House, DMD, Pediatric Rural Dentist and Oral Health Consultant for Region 10 Head Start:

- There is a need to focus on high risk, special needs patients that come into the clinics; patients on multiple medications for example.
- The OHP population can be higher maintenance in terms of social and language skills along with economic barriers.
- The answer lies in prevention first.
- Building more clinics will not necessarily create more access when already-established private practitioners and practices can be engaged in the process to create a partnership.
- Reimbursement should at least allow a provider to break even on care. Social services need to increase to get patients into clinics for needed preventative care.

Deborah Loy, Director of Professional Affairs Capitol Dental Group:

- Capitol is in rural and urban areas and is part of a partnership that expanded with 4 dental plans into a new coalition called Dental Outreach of Oregon.
- The coalition looks at how to do community partnering around the state to solve and identify each community's problems.
- An outreach program will be started in Coos County for expanding capacity and access for young children and potentially pregnant women, not just those eligible for OHP.
- Rather than competing for a single resource, the county or community-level conversations should address sharing resources.

Appendix A: Oral health stakeholder summary highlights

- Medicaid is highly relied upon in this system for funding everything whereas other states have grants and payment resource systems and are consistently committed to oral health.
- Oregon needs to decide that oral health is a priority that needs to be invested in.

Oral Health Workforce:

Beryl Fletcher, Director of Professional Affairs Oregon Dental Association:

- The dental workforce is on the decline but there are task forces dedicated to the issue of increasing this through expanded numbers of dental schools.
- The Safety Net Advisory Council (SNAC) presented recommendations including dentistry, such as increasing funds for the loan repayment program.
- The scope of where limited-access permit hygienists, dental hygienists, and dental assistants can practice has been expanded.
- The main issue is funding. Along with increasing the numbers of the dental workforce, there has to be adequate reimbursement and incentives to keep them in business.
- There needs to be a protocol for patients who go to the emergency room with a dental problem and a protocol and tracking system for referrals.
- There is a need for a dental access council that would address issues that come up.

Kelli Swanson-Jaeks, MA RDH, President Oregon Dental Hygienists' Association:

- Prevention is the key to lowering dental costs.
- The ADA came up with a plan for the ways to meet the need for more practitioners.
- The limited-access permit hygienists need to be allowed to work to the maximum level of licensure.
- One way to increase access is to utilize programs already in state where people are already gathered, such as Head Start, WIC, and school-based clinics.
- There are mobile-service centers, but are run by volunteers and cannot be expected to meet all the needs without adequate reimbursement.
- Money given to emergency rooms for dental emergencies could be given in part to preventative services, and studies could be done to see how much emergency rooms are receiving for treating dental emergencies.

Patrick Braatz, Director Oregon Board of Dentistry:

- With the national trend in the decrease in the dental workforce, Oregon is about the same that it was 2 years ago as far as the number of those licensed.
- There are 71 Limited Access Permit Dental Hygienists LAPs: 1/3 work in nursing homes and public and non-profit clinics, 13 do not practice and 29 work in private practice because there is no reimbursement for them to work elsewhere.
- Expansion of the dental workforce will not be the solution without reimbursement.
- Facilities also need to be available via public transportation and need to be opened at more expanded hours.
- Fluoride is the least expensive answer to preventative care.

Managed Care:

Janet Meyer, MHA, Director, Tuality Health Alliance, Tuality Healthcare:

- A health education district was opened on the Tuality campus in Hillsboro that includes dental programs. There is a 4-year college program in dental hygiene offered, and a dental clinic was opened that provides critical access.
- A federally-qualified health center was built on the Hillsboro campus and serves the Head Start programs in Washington and Yamhill counties. In the hospital there are 2 emergency rooms which often serve individuals with neglected dental issues. Diseases of

Appendix A: Oral health stakeholder summary highlights

the digestive systems are in the top 3 diagnoses, and in diseases of the digestive system, dental health is the #1 reason patients are in the ED.

- Tuality is also involved in the Salud program that raises money providing physical and dental health resources for migrant health workers.
- Measuring access is a task as families with children on OHP have separate appointments for each step of the dental process, requiring multiple trips to the dentist and possibly requiring language interpreters, the child's needs should be taken care of while the child is there.
- There is a need to define access and what is meaningful access.
- There is currently a system in place to educate enrollees along with a grievance system, which should be looked at before discussing building additional education systems.

Bill Ten Pas DMD, Senior Vice President, ODS:

- ODS pays the \$200,000/year for the dental hygiene school to provide free dental care due to the need for dentists in rural areas. It may be viewed as competition for the current rural dentists who barely make a living, yet the intent would be for the students to take the patients with no access or insurance.
- Due to the problem getting those who most need the access to travel to the dentist, they are creating ways to bring dental services to the patients using a traveling dental clinic where they care for patients in an area for a week.
- It costs about \$500,000/year to run this program without reimbursement.
- There needs to be an education in the truths and myths of fluoride as this is needed in preventative care.
- With the low reimbursement it is becoming harder to afford to stay in the dental workforce.
- There is a need to educate DHS on the dental model so better decisions can be made.

Gayle Pizzuto, Program Manager, MultiCare Dental:

- Emphasized the need for all delivery systems to cover dental. The different types of delivery systems: The open-panel model such as ODS and Advantage, combination plans such as Capitol Dental, and then the staff model plan such as Willamette and MultiCare Dental. In MultiCare's staff model, all dental staff is employed.
- MultiCare's DNA (did not arrive) rate is 25-30% so they keep a standby schedule. Their patients are 70% children.
- The outreach effort to pregnant women involves cultural issues. Some aren't getting on OHP until late in pregnancy.
- Community involvement is necessary as far as dental plans sitting down with stakeholders.
- Children need to be seen in settings outside of clinics. MultiCare has a project going into nursing homes and care facilities to identify patients who haven't seen a dental provider and sending staff to see those patients without reimbursement. Over 20% have been screened and ½ have dental issues.
- Community-based prevention strategies should encompass fluoride and dental sealant programs.
- According to performance measures, every dental plan has gone up in the number of prevention services being provided.
- With children ages 3-5, 64% of the ones on their program have had the prevention services program.

Appendix A: Oral health stakeholder summary highlights

- There needs to be an advocate/dental director for dental structure at DMAP. DMAP could look at utilization and prevention services and should put out reports to hold dental plans accountable.

Gary Allen DMD, Dental Consultant, Willamette Dental:

- There is a lack of a cohesive, coordinated definition of the problem and prioritized strategy to deal with it.
- DMAP could take on a dental advisory board to advise on prioritized strategies for the issues.
- School-based program for fluoride and sealants need to have a cohesive strategy and a model that works. In Sweden they developed a needs-based program on children aged 0-18 focusing on preventative strategies, focusing also on education for pregnant mothers, and delivering sealants on children. If there is a concentration of effort and resources and prevention it will be possible to achieve such a model.



November 17, 2008

To: Medicaid Advisory Committee (MAC)

From: Dental Stakeholders Workgroup

Re: Recommendations for Oregon oral health

The Dental Stakeholders Workgroup is responding to your request to review the recommendations made by many interested parties at the October 22, 2008 MAC meeting and prioritize the recommendations.

Introduction:

While many recommendations were offered from numerous interested parties, clear policy needs were conveyed. These policies included:

1. Oral health is an important part of overall health and should be a priority for statewide policy. The vision for dentistry is to be a part of the integrated health system.
2. Prevention is the number one cost containment factor in oral health and should be the foundation for oral health solutions.
3. Stabilized funding for oral health needs to be made a priority.
4. Dental infrastructure within DMAP is needed in order to effectively coordinate access strategies. This would include:
 - The addition of a Dental Director
 - Training and credentialing of DMAP Pre-Paid Health Plan Coordinators in dental practices
5. Implement more incentives to encourage dental providers to participate especially incentives for loan repayment, debt forgiveness and tax incentives for qualified dentists to settle in rural areas regardless of where they intend to practice (private practice or FQHC).
6. Development of meaningful utilization reports (review our data, utilization, reports category in the prioritized recommendations below).
7. Allow clients to access their Dental Care Organization (DCO) dental plans statewide rather than within a mileage radius.

The dental community including the Oregon Dental Association (ODA), private practitioners, DCO's, foundations, the Oregon Board of Dentistry and public and private sources have all contributed significantly toward developing Oregon's unique dental benefits and delivery

system. It is our desire to continue to work for the oral health of all Oregonians and be a part of the integrated health home. We must be cautious in the wave of economic conditions not to lose the dental system we have created but to stabilize it and work to further develop it.

Prioritized Recommendations

We have prioritized the recommendations into five specific categories with some recommendations bolded to represent key priorities. The categories include:

1. Access Development and Education
2. Funding
3. Data, Utilization and Reports
4. Services
5. Workforce

1. Access Development and Education

- a. **Develop a formal dental referral system protocol to be used across the state by hospital emergency rooms, physicians, medical plans, and others for referring patients who have dental needs. This referral protocol would include written instructions on who to contact both during and after business hours especially for those patients who may already be enrolled in a dental plan. This would include a referral form for DCOs to use to track referrals.**
- b. **Educate and collaborate with physicians, hospital staff, medical plans and DHS case managers in the referral process, the importance of oral health to increase the communication between medical and dental providers.**
- c. **Develop a Dental Access Council to include medical providers, dentists, FCHPs, DCO representatives, etc. in order to address access difficulties and possibly a 1-800 referral “coach” program.**
- d. **Set up a referral process between plans so that they may collaborate with each other for one time referral between plans to provide access for patients when plans are closed for enrollment or there are emergency needs.**
- e. Improve collaborations to deal with issues of access for special needs OHP (esp. in rural settings)
- f. Raise awareness of OHP enrollees on how to access dental care and how to effectively raise issues of access and voice concerns.

2. Funding

- a. **Reimbursement, for dental services in fees and on a per capita allocation, needs to be increased. Use dental provider taxes and the federal matching dollars from the dental provider tax for dental services.**

Funding recommendations continued

- b. Do not cut dental benefits or adult dental. It will not save money but will result in a cost shift to the emergency room, physician's office or other medical providers providing only short term palliative care.**
- c. Reimbursement is a barrier for out of network dentists and LAP hygienists.
- d. Provide same balanced reimbursement levels to practitioners that are seeing large number of DMAP clients regardless of whether in private office or FQHC.
- e. Establish a Community Oral Health Program Fund which will provide a pool of money where all DCOs and some small part of the hospital emergency room reimbursement dollars contribute to the fund. The fund would be for preventive services by Limited Access Permit Hygienists (LAPs).
- f. Provide and fund more direct case management of families.
- g. Restore ENCC (Exceptional Needs Care Coordination) funding to DCOs and improve collaborations to deal with access for special needs especially in rural OHP.

3. Data, Utilization and Reports

Develop meaningful utilization reports in the following specific areas using dental code categories from data provided to DMAP from the DCOs and fee for service client data:

- **Prevention services**
- **Emergency services including hospital ED visits**
- **Restorative care**
- **Failed appointments**
- **Monitor compliments as well as complaints**

Reports should be developed in the above areas not only by DCO and fee for service (FFS) clients but also by county reflecting client appointments, age categories, services provided etc. All these reports should be provided on a quarterly and annual basis in order to develop new access strategies based upon the data evidence.

We understand DMAP is working with the DCOs on developing a plan to initiate these types of reports.

4. Services

- a. Prevention is the number one cost containment factor through sealants, fluoride treatments, early intervention, intermediate restorative treatment and education. Change the paradigm to one of intense prevention with diminishing emphasis on repairing the damage.
- b. Emphasize the delivery of preventive dental services, particularly to pregnant women and children under age 3 by advocating policy changes that incentivizes access for these services to OHP enrollees.
- c. Increase community based prevention strategies, including Community Water Fluoridation; school-based fluoride and dental sealant programs.

Appendix B: Dental stakeholders workgroup recommendations

- d. Limit the covered services within the DMAP structure so that resources are going to where they will do the most good for the greatest number and that have long term scientifically proven outcomes.

5. Workforce

- a. Increase involvement of the Limited Access Permit Hygienist in community based health centers, WIC, Head Start and other locations.
- b. Develop a broader partnership and collaboration with private practitioners especially in rural areas to utilize efficiencies to improve access.
- c. Support the maintenance of the dental team concept of providing care. While we can support the expanded functions of auxiliaries, the full accompaniment of care will need to come from a team. Dilution of our workforce into smaller and less effective units will not address the needs of the OHP population.
- d. Encourage the use of Expanded Function Dental Assistants (EFDA).
- e. Use Mobile Dental Vans in rural and frontier areas.

There are many other data, utilization and program recommendations that were made but have not been specifically categorized in the above recommendations. We would be happy to share these in an addendum or continued conversations with the Medicaid Advisory Committee.

Thank you for the opportunity to provide recommendations.