DENTAL QUALITY ALLIANCE®

Improving Oral Health Through Measurement

DENTAL QUALITY ALLIANCE: 2020 ANNUAL MEASURE REVIEW

REPORT FROM THE DQA MEASURE DEVELOPMENT AND MAINTENANCE COMMITTEE

JUNE 2020

Contents

INTRODUCTION AND PURPOSE

The purpose of this report is to summarize the outcomes of the 2020 annual review of the Dental Quality Alliance's (DQA's) quality measures for pediatric and adult populations. DQA measures address prevention and disease management of oral health diseases for both children and adults, including measures of utilization, access, cost, and quality of dental services for individuals enrolled in public (Medicaid, CHIP) and private (commercial) insurance programs.

The detailed specifications can be found on the DQA website at:

https://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-development-reports/dqa-dental-quality-measures

PROCESS

The DQA has established an annual measure review and maintenance process. This measure review process is overseen by the DQA's Measures Development and Maintenance Committee (MDMC), which is comprised of seven subject matter experts, a member of the DQA Executive Committee, and DQA Leadership. (Appendix A).

The DQA released a call for comments to its members and the broader oral health community in February 2020. Following a 30-day comment period, the MDMC carefully considered and addressed the comments.

The DQA's MDMC would like to thank all stakeholders who submitted comments to the DQA review processes to allow for thorough review of its measures. The DQA reviewed and reaffirmed its measures by approving this report at its meeting on June 5th 2020.

PUBLIC COMMENTS TO DQA ANNUAL MEASURE REVIEW

The following paragraphs summarize the review of the comments as addressed by the MDMC. The detailed public comments are contained in Appendix B.

MEASURE-SPECIFIC COMMENTS

Adults with Diabetes – Oral Evaluation

This measure assesses the percentage of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.

The commenter recommended incorporating stratification based on control (like HbA1c levels) to address that not all diabetics are alike and that some may be periodontally healthy adults. The MDMC appreciates the feedback to incorporate this stratification and will consider for future measure development purpose. However, the MDMC clarifies the intent of this measure is *not to evaluate the severity of diabetes* and its impact on oral health. Rather, the measure is intended to evaluate whether an individual with a diagnosiss of Diabetes (including both Type I and Type II), identified from medical and pharmacy claims data, had an oral evaluation. Oral evaluations represent an important entry point into the dental care system. Diagnosis and treatment planning for the prevention as well as the treatment of periodontal disease at these visits offer patients appropriate dental care with the potential to improve diabetes outcomes. The measure currently can be stratified by age, gender, race/ethnicity, and geographic location.

Follow-Up after Emergency Department Visits for Dental Caries in Children

This measure is a process of care measure that assesses any follow-up visit with a dental provider within 7 days or 30 days following an emergency department (ED) visit by a child for a dental caries related reason. The commenter expressed concern that the follow-up periods of 7 days and 30 days are unrealistic at a system level. The commenter rationalized that "a follow-up often requires social service intervention, cycling of re-care into a parental work schedule, transportation intervention, and other active steps that often, in themselves, take weeks even if they are directed and prioritized which, in an affected population may be unlikely." The commenter suggested that 60 days would be a more realistic follow-up period.

The MDMC appreciates the feedback on the follow-up period. During measure testing, several follow-up periods were examined, including 7 days, 30 days and 60 days.[1] Testing data indicated that approximately one-third of children have a follow-up visit with a dentist within 7 days of an ER visit and approximately one-half receive follow-up care within 30 days (Table 2). There were modest increases in follow-up when the follow-up time frame increased from 30 days to 60 days. Thus, it was determined that shorter follow-up periods are both appropriate and feasible. Because ER care generally focuses on symptom relief and not treatment, there was a general agreement among dental and emergency medicine experts that a 7-day follow-up period is ideal. However, there also was recognition of the difficulties encountered in seeking, scheduling and obtaining a visit within 7 days. Therefore, 30-day follow up was identified as a reasonable goal. A follow-up period of 60 days was viewed as too long for urgent health care needs addressed in emergency settings where care for dental-related conditions is generally focused on symptom relief and is not definitive.

Table 2: Percentage of ER Visits with Dental Provider Follow-Up by Follow-Up Period, CY 2011

	7-Day Follow-Up	30-Day Follow-Up	60-Day Follow-Up
Texas Medicaid	36%	50%	58%
Texas CHIP	38%	48%	53%
Florida CHIP	33%	52%	64%

The current MDMC reviewed the testing data and re-affirmed the determination to report 7-day and 30-day follow-up. The intent of this measure is to spur systems to improve. ED visits by children for dental caries related reasons indicate failure of the system to provide access to preventive services. This process of care measure is designed to encourage and assess efforts by programs to create mechanisms to link a child with a dental provider to receive much-needed definitive care following an ED visit. Programs, such as state Medicaid programs, need to have mechanisms in place to identify those beneficiaries who have accessed the ED for a dental problem and develop better care coordination, financing models for transportation coverage, etc. to help connect patients to a regular source of dental care.

The commenter also remarked that, "private practice had a better chance at follow-up than a larger system." MDMC identifies that a dental practice is certainly a critical component of that larger system in helping get a child into care but the practice cannot know if the child was seen in the ED, especially if the child was never connected to a practice in the first place. The "system" has to make that connection happen and only then can the practice follow-up with the family.

[1] Dental Quality Alliance. Testing Pediatric Oral Health Performance Measures: Emergency Room Use and General Anesthesia for Caries-Related Reasons. Chicago IL: Dental Quality Alliance; 2014.

Caries Risk Documentation

This measure assesses if a caries risk assessment was documented in the reporting year. One commenter specified, "that without a universally agreed upon definition, even if imperfect, it is hard to recommend a measure on CRA."

The MDMC thanks the commenter for this feedback. The recent findings of an American Dental Association – American Academy of Pediatric Dentistry Caries Risk Assessment Expert Panel, which reviewed the current state of science on caries risk assessment and developed guidance on risk categorization, found that current caries risk assessment tools share many common elements to assess risk and affirmed they have at least dichotomous predictive ability to identify "low risk" and "elevated "risk".[2] However, there is no evidence that supports one tool over another. As a result, different providers use different risk assessment tools, combined with clinical judgment, to arrive at a caries risk determination. Despite the limited evidence on the relative effectiveness of caries risk prediction using different assessment tools, professional clinical guidelines recommend that providers conduct caries risk assessment and use that information to develop individualized prevention and treatment care planning. This measure is designed for use in quality improvement applications to support quality improvement efforts around caries risk assessment and documentation. In addition, this measure is designed only to document that the enrollee received a risk assessment. This measure is not designed to be used to assess the health state of the population or to create population risk profiles.

Dental Services: Utilization of Services

The measure titled Utilization of Services is National Quality Forum (NQF) endorsed and assesses the percentage of enrolled children under age 21 years who received at least one dental service within the reporting year (NQF #2511).

One commenter stated that this measure "is essentially the old HEDIS measure and is so non-specific as to be useless and may in fact confuse the utilization landscape."

The MDMC would like to clarify that the DQA Utilization of Services and the NCQA HEDIS Annual Dental Visit measure are similar in that they both track any dental service use and do not provide any assessment of continuity of care beyond the visit captured. However, a significant difference between the two is the denominator – which identifies the children who are included in the measure. The HEDIS measure only includes children who are continuously enrolled for 11 out of 12 months. If a Medicaid program has significant churn, then a significant percentage of children enrolled in the program are dropped from the denominator. Testing data found that as many as 2/3 of children may be excluded when there is an 11-12 month enrollment requirement. The CMS-416 measure that examines any dental service receipt uses a 90 day enrollment which

[2] Dental Quality Alliance Guidance on Caries Risk Assessment in Children: A Report of the Expert Panel for Use by the Dental Quality Alliance: 2018. Available at: https://www.ada.org/~/media/ADA/DQA/CRA_Report.pdf?la=en. Accessed April 21, 2020.

takes the scenario to the other extreme in that any children enrolled only for 90 days will be included, which may provide insufficient time for families to schedule and obtain a visit. The DQA measures takes the middle road and includes children enrolled for 6 months holding the program/plan accountable for children in the system for ½ the year or more and affording families enough opportunity to get enrolled, get an appointment, and get to the dentist.

The measure of "any dental service" is a measure of access to dental care. Other DQA measures focused on evidence-based processes of care that can be used to assess the content of the visit.

GENERAL COMMENTS

Comments regarding separate specifications for dental services and oral health services

There were comments related to maintaining separate specifications for oral health services and dental/ oral health services for the following measures:

- Preventive Services for Children at Elevated Caries Risk
- Topical Fluoride for Children at Elevated Caries Risk
- Utilization of Services

The MDMC clarifies that some DQA measures have separate specifications to account for services rendered by providers who are not dentists. The purpose of these separate specifications is to track oral healthcare services rendered by dental and non-dental professionals. There are two related measures that focus on oral healthcare services provided by dentists and oral healthcare services provided by non-dental professionals, respectively. There is a third measure that looks collectively at the percentage of children who received oral healthcare services from either a dental or non-dental professional. These specifications collectively provide a more comprehensive picture of oral healthcare service provision by both dental and non-dental providers.

General comments on the pediatric measure set

One commenter provided general comments on the DQA pediatric measure set. The commenter highlighted the general improvements to the measures that DQA has made since their development, but also expressed concern that the existing measures are insufficient to fully measure dental program quality.

The MDMC appreciates the feedback from the commenter. The DQA strives to develop measures that are evidence-based, valid, reliable and feasible. Current DQA measures address several domains of quality as defined by the National Quality Measures Clearinghouse (NQMC), including access to care, use of services, and processes of care. The DQA has a systems-level outcome measure of caries-related ED use among children. The DQA recognizes the gap in

outcomes measurement and is actively engaged in identifying reliable and valid ways to measure health status and outcomes in the absence of routine structured capture of diagnostic codes in commonly used data sources. These efforts include exploring measures that are based on patient reported data.

General comments related to Medicaid data availability for external program measurement purposes

One commenter highlighted the challenges to securing access to Medicaid data by other state agencies interested in oral healthcare performance measurement.

The MDMC appreciates the comment and recognizes the systemic challenges in accessing data for measurement purposes. The success of any successful quality improvement endeavor hinges upon not just the involvement of key stakeholders internal to the program but also establishment and alignment of oral health priorities among the various entities involved with delivering services to the Medicaid population. Data sharing between different agencies within a state that serve Medicaid beneficiaries is a complex dynamic and requires sustainable interagency and interdepartmental agreements and relationships. The DQA is hopeful that the use of the DQA measures to assess programs that serve Medicaid beneficiaries may facilitate addressing some of the data sharing challenges.

GENERAL UPDATES TO MEASURE SPECIFICATIONS & USER GUIDE

In addition to the public comments submitted, the MDMC reviewed and approved several routine updates to the measure specifications. These include code updates, incorporation of an "optional" stratification, and some editorial updates.

CODE UPDATES

Review of the 2020 Code on Dental Procedures and Nomenclature (CDT) Manual and the Health Care Provider Taxonomy code set maintained by the National Uniform Code Committee (NUCC) identified two new codes relevant to measures. The MDMC reviewed and approved inclusion of these codes in the relevant measure specifications.

Measure	**Proposed Updae**
Applies to measures that include elevated risk code set: • Topical Fluoride measures (adults and children)	**CDT Code Update** Add the following code to the elevated risk code set: D2753: crown – porcelain fused to titanium and titanium alloys

• Preventive Services (Dental Services, Oral Health Services, Dental/ Oral Health Services)	Note: D2750-D2752 are currently included in the code set.
Applies to measure that contain the NUCC code set to identify "dental" or "oral health" services: • Caries Risk Documentation • Care Continuity • Oral Evaluation • Preventive Services (all variations) • Topical Fluoride (all variations) • Treatment Services • Usual Source of Care • Utilization of Services (all variations) • Follow-up after ED Visits for Dental Caries in Children • Follow-Up after ED Visits for NTDC in Adults • Per Member Per Month Cost of Clinical Services	**NUCC Code Update** Version 19.1 of the NUCC Health Care Provider Taxonomy Codes (http://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40): **1223X2210X** Dental Providers; Dentist - Orofacial pain A dentist who assesses, diagnoses, and treats patients with complex chronic orofacial pain and dysfunction disorders, oromotor and jaw behavior disorders, and chronic head/neck pain. The dentist has successfully completed an accredited postdoctoral orofacial pain residency training program for dentists of two or more years duration, in accord with the Commission on Dental Accreditation's Standards for Orofacial Pain Residency Programs, and/or meets the requirements for examination and board certification by the American Board of Orofacial Pain. Source: American Academy of Orofacial Pain, http://www.aaop.org Additional Resources: American Board of Orofacial Pain, http://www.abop.net

OPTIONAL STRATIFICATION

The MDMC reviewed and approved to include the Special Health Care Need (SHCN) stratification based on new CDT code (D9997) dental case management - patients with special health care needs:

CDT Code D9997 Descriptive: Special treatment considerations for patients/ individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations, which require that modifications be made to delivery of treatment to provide comprehensive oral health care services.

Identifying SHCN individuals from claims data is now possible through the introduction of the new CDT code. This would be an "optional" stratification variable to be added to DQA measures. During the 2019 cycle of annual measure review, the MDMC updated the 2020 User Guide with a new section on "Optional Stratifications." The "Optional Stratifications" guidance in the user guide allows programs flexibility to assess performance by beneficiary characteristics. The DQA recognizes the value of measure stratification to identify disparities and target outreach efforts.

EDITORIAL UPDATES

OH versions of measures Applicable measures: • Preventive Services • Topical Fluoride • Utilization of Services	Editorial – updates to footnote regarding identifying "oral health" services • AAP table in footnote updated to: https://www.aap.org/en-us/_layouts/15/WopiFrame.aspx?sourcedoc=/en-us/Documents/OralHealthReimbursementChart.xlsx&action=default . • Addition of the following resource to the same footnote: https://www.aap.org/en-us/Documents/coding_factsheet_oral_health.pdf
Sealant measures (first molars)	In the calculations defined in part 6. Starting on page 4, there are a number of calculations that call for the denominator "DEN" that has not been formally defined in the prior methodology. NUM1 and NUM2 are defined in parentheses in the methods steps 4 & 5, but there is no "DEN" defined in parentheses after step 3. It should read: YOU NOW HAVE DENOMINATOR (DEN) FOLLOWING EXCLUSIONS FOR TREATMENT: Enrollees who meet the age and enrollment criteria who have NOT had all permanent first molars previously treated (i.e., have at least one permanent first molar that is a candidate for a sealant

Appendix A: Measures Development and Maintenance Committee

Measures Development and Maintenance Committee:

Craig W. Amundson, DDS, General Dentist, HealthPartners. Dr. Amundson serves as chair for the Committee.

Frederick Eichmiller, DDS, Vice President & Science Officer, Delta Dental of Wisconsin

Chris Farrell, RDH, BSDH, MPA, Oral Health Program Director, Michigan Department of Health and Human Services

Gretchen Gibson DDS, MPH, Director, Oral Health Quality Group, VHACO Office of Dentistry, Veterans Health Care System of the Ozarks (VHSO)

Chris Okunseri, B.D.S., M.Sc., Director, Predoctoral Program, Dental Public Health, Marquette University

Bob Russell, DDS, MPH, MPA, CPM, FACD, FICD, State Public Health Dental Director

Chief, Bureau of Oral and Health Delivery Systems, Iowa

Tim Wright, DDS, MS, Distinguished Professor, University of North Carolina School of Dentistry

DQA Executive Committee Liaison to the MDMC:

Cary Limberakis, DMD, ADA/ Council on Dental Practice

DQA Leadership:

Mark Koday, DDS, Chair, Dental Quality Alliance

Tom Meyers, Chair-Elect, Dental Quality Alliance

The Committee was supported by:

Krishna Aravamudhan, BDS, MS, Director, Council on Dental Benefits Program, American Dental Association

Jill Boylston Herndon, PhD, Methodology Consultant to the DQA; Managing Member and Principal, Key Analytics and Consulting, LLC

Diptee Ojha, BDS, PhD, Director, Dental Quality Alliance & Clinical Data Registry, American Dental Association

Lauren Kirk, Coordinator, Office of Quality Assessment and Improvement, American Dental Association.

Marissa Sanders, Manager, Office of Quality Assessment and Improvement, American Dental Association.

Appendix B: Public Comments

MEASURE	COMMENT	SUBMITTED BY
Adults with Diabetes – Oral Evaluation **Description**: Percentage of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year. **Numerator**: Unduplicated number of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation. **Denominator**: Unduplicated number of adults with diabetes. **Rate**: NUM/DEN	The Texas Dental Association appreciates the opportunity to comment on the measures. DOE-A-A Adults with Diabetes – Oral Evaluation Percentage of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year N/A Administrative enrollment and claims Process Program, Plan **Adult Measures** Comment; Not all diabetics are alike. Some suffer from difficulty in diabetes control and present with compromised oral health while others often present with oral health similar to a non-diabetic. It is possible to have periodontally healthy adults who are diabetic. Is there a way to stratify based on control (like HA1C levels), etc?	Diane Rhodes Senior Policy Manager Texas Dental Association
GENERAL PEDIATRIC MEASURE COMMENT	**Pediatric Measures** The current 2020 DQA measures TDA reviewed, look to be only a slight improvement over what was previously on the books. The slight adjustments are surprisingly reflective of a few of the concerns TDA voiced early on in this whole Texas "buy-in" of the DQA measures. The acknowledgment that when counting teeth for sealants it should consider that some teeth are not candidates due to things that can be identified in the history, and the failure to consider disease development were verbatim from our discussions. The admission that, not having complete dental histories to base assessments and	

	predictions on, is a real problem is refreshing to see. That said, this whole thing is still a simplistic and inadequate methodology of measuring dental program quality. Measuring exams fluoride and sealants was inadequate. Now, adding subsequent carious experience and emergency encounters (because of caries) is improvement but still inadequate. Improving and maintaining good oral health is about more than who got one check-up and who got two check-ups. However, TDA was pleased that DQA acknowledged that children benefit from more than the standard one fluoride treatment every 6 months.	
GENERAL COMMENT	Good afternoon, I have expressed some of this feedback as one of the pilot states participating in the COHSII project on Oral Health Quality Indicators, but wanted to ensure it was offered as feedback on the general public comments process as well. A significant portion of the Quality Indicator measures data requires Medicaid data, not just the aggregate 416 Medicaid annual file, but more granular data. At least in Georgia obtaining this level of data can be cumbersome/pragmatically un feasible at best, and literally impossible at worst. Medicaid actually is housed in a totally separate state agency in Georgia and there are limitations and even some level of prohibition policies related to even basic communication with them. Even going through all the correct channels and approvals for data requests usually yields no response or extremely delayed responses (matter of months for basic data requests) and if data is actually	Adam Barefoot DMD, MPH Director of Oral Health Division of Health Promotion Georgia Department of Public Health

	obtained, it is usually of a quality level, that makes use of the information not feasible. This all to say, the portion of the quality indicators reliant on Medicaid data will likely be an ongoing struggle for states to report out on, especially if the goal is a uniform and standardized reporting approach.	

THE NEXT SET OF COMMENTS ARE FROM AAPD ON ALL DQA PEDIATRIC MEASURES

Thank you for the opportunity to comment on the 2020 Dental Quality Measures. Here is the response of the American Academy of Pediatric Dentistry.
Based upon a careful review of the measures by our leaders in clinical and scientific research, the 2020 Dental Quality Measures continue to provide metrics that help insure quality of care of children. The American Academy of Pediatric Dentistry supports the DQA process and encourages input to the measures through its membership on the DQA Executive Committee, and in concert with other DQA members in the course of discussions and measurement development and evaluation.
Please feel free to contact me with any questions or concerns.

Robin Wright, PhD, Director, Pediatric Oral Health Research and Policy Center, American Academy of Pediatric Dentistry

MEASURE	APPLICABLE AT SYSTEM LEVEL?	APPLICABLE AT PRACTICE LEVEL?	RECOMMEND SUPPORT?
2020 Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	yes	no	yes
2020 Follow-Up after Emergency Department Visits for Dental Caries in Children	No On the follow-up to emergency care: At a system level, the 30-day window is unrealistic. If it is a target to shoot for, then maybe ok, but in review our records at Nationwide Children's	yes	Yes with modification (one month not realistic).

	Hospital, where <u>every</u> child has the opportunity to be seen for follow up within the 30-day window (which is an ideal scenario not reality-based), the percentage falls way short of 50%. The measure does not account for the realities of social determinants of health that likely prompted the emergency in the first place. A follow-up often requires social service intervention, cycling of re-care into a parental work schedule, transportation intervention, and other active steps that often, in themselves, take weeks even if they are directed and prioritized which, in an affected population may be unlikely. In our experience, a system is not designed to address this occurrence in a 30-day window and may in fact, be the cause of the emergency visit because of its bureaucracy and inflexibility. A 60-day window likely is more realistic and even then, perhaps the best outcome one would hope for is "an appointment" and not resolution of the presenting emergency problem. I am not sure of how the		

	measure was "tested" but we felt it was unrealistic and might even create a false sense of accomplishment as we have experienced with missed follow-ups, and no real care seeking after the emergency, even with professional social intervention. Although not required, it was felt that a private practice had a better chance at follow-up than a larger system.		
2020 Dental Services: Care Continuity	yes	Yes, but in larger practices	yes
2020 Caries Risk Documentation	No The inability of the dental profession to land squarely on a CRA standard! Without a universally agreed upon definition, even if imperfect, it is hard to recommend a measure on CRA. I believe that if a CRA could be agreed upon, then this measure would be great! That is our main objection. Freelancing a CRA or several among different systems, seems to make little sense.	Yes	Yes
2020 Oral Evaluation	yes	yes	Yes, but reference basis cited is outdated and should be updated

2020 Per Member Per Month Cost of Clinical Services	yes	no	yes
2020 Dental Services: Preventive Services	yes		yes
2020 Oral Health Services: Preventive Services	yes	no	Yes, if for non-dentists
2020 Dental or Oral Health Services: Preventive Services	yes	no	Yes, if for non-dentists
2020 Dental Services: Topical Fluoride	yes	yes	Purpose: What percentage of children at elevated risk for dental caries receive at least 2 topical fluoride applications as oral health services (e.g., from a medical primary care provider) during the reporting period? Support – yes
2020 Oral Health Services: Topical Fluoride	yes	yes	Purpose: Among those enrolled, how many received preventive services as a dental or oral health service? 2. Over time, is the percentage of children who receive preventive services as a dental or oral

			health service stable, increasing, or decreasing? Support - yes
2020 Dental or Oral Health Services: Topical Fluoride	yes	yes	Purpose: What percentage of children at elevated risk for dental caries receive at least 2 topical fluoride applications as oral health services (e.g., from a medical primary care provider) during the reporting period? 2. Over time, is the percentage of children who receive at least 2 topical fluoride applications as oral health services stable, increasing, or decreasing? Support – Yes.
2020 Treatment Services	yes	no	yes
2020 Dental Services: Usual Sources of Care	yes	No – this measure does not make sense at the practice level	yes
2020 Dental Services: Utilization of Services	yes	Yes, but not useful	This measure is essentially the old HEDIS measure and is so non-specific as to be useless and may

			in fact confuse the utilization
2020 Oral Health Services: Utilization of Services	yes	No	If confined to non-dentists, it might be useful
2020 Dental or Oral Health Services: Utilization of Services	yes	Yes, but not useful	Repetitive
2020 Receipt of Sealants on First Permanent Molar	yes	yes	Yes
2020 Receipt of Sealants on Second Permanent Molar	yes	yes	yes