



**Technical Report**  
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# **Patient-Centered Dental Home Development Project: Phase 1 Study Methodology**

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## Background

Recent changes in the health care system, including passage of the Affordable Care Act, have transformed the delivery of health care in the U.S. Changes include an emphasis on coordinated care that incentivizes value over volume. These incentives have led to the creation of health home models, including expanded use of the patient-centered medical home (PCMH), that connect primary care to other facets of health care such as primary mental health and secondary specialist care.

There is a need for similar care coordination within dental care delivery systems and for integration of dental health care within these new health home models. Within dentistry, there is no standardized definition of the dental home concept, which to date has focused primarily on access to care among children. Moreover, there are few examples of integration of the dental home into broader systems of care; existing efforts have largely focused on the provision of preventive dental care in primary medical care settings. However, there is a need to integrate *all* dental services, including both prevention and treatment, for both children and adults within health home models. This is supported by the mounting evidence on the association between oral and systemic health across the lifespan.

To facilitate improved coordination and integration, there is a need for oral health service models that emphasize patient-centered care and improved outcomes rather than the volume of services provided. To address these needs, the University of Iowa Public Policy Center convened a National Advisory Committee in 2015 to develop a measureable PCDH model that adopts the foundational elements of, and is positioned to integrate with, the PCMH. This new model aims to improve patient care and health outcomes and to facilitate the integration of dentistry with broader systems of care.

## National Advisory Committee Recruitment

Working in partnership with the Dental Quality Alliance (DQA), we solicited the input of a diverse group of national experts to form the National Advisory Committee (NAC) for this project. The NAC served as the participant group in a series of online surveys using a modified Delphi methodology.

NAC members qualified for selection based on either : 1) their individual expertise in predetermined area of need; and/or 2) as the representative of an organization with particular relevance to the topic of patient-centered care, quality measurement and the integration of oral health care.

The predetermined areas about which expertise was sought for this project included:

Individual Expertise	Organizational Representation
1. Clinical care for children, seniors and special needs populations	1. Medicaid/CHIP Professional Organizations
2. Quality measurement in oral health care	2. State Oral Health Programs
3. Oral health care delivery systems	3. Federal agencies with Oral Health Components
4. Oral health care policy	4. Payers
5. Dental home development and programs	5. Dental Delivery Systems
6. PCMH development, implementation and measurement	6. Accreditation/Certification Organizations
	7. Measurement Developers
	8. Safety Net Providers
	9. Oral Health Policy/Advocacy Groups

Members were identified through a purposive sampling process that included snowball sampling techniques. A heterogeneous sample was intended to include individuals with relevant expertise as well as those representing the range of stakeholders involved in implementing and using the PCDH model. Stakeholder and organizational representative recruitment involved identifying individuals and organizations within domains of needed expertise.

Email invitations that included a description of the study and expected time commitment were sent to all identified experts and organizations. Of those who did not respond, reminder emails were sent up to three times over the course of two months. In the case of organizational representatives, the initial contact person generally provided the name of another individual who would be representing the organization. Of 63 individuals/organizations contacted, four declined and four did not respond, for a final sample of 55 participants that formed the NAC for this project.

Delphi studies generally demonstrate a wide range of participant numbers; a larger size is more common when seeking a heterogeneous group.<sup>1</sup> Recruitment was not based on a specific sample size target, but rather to ensure that appropriate content expertise and stakeholder representation was achieved.

In order to gain input from the patient/community perspective and from non-NAC members, we will release sentinel deliverables for public comment throughout the project.

<sup>1</sup>Fitch et al. The RAND/UCLA Appropriateness Method User's Manual. 2001. Rand Corporation. Santa Monica, CA. <http://www.dtic.mil/cgi-bin/GetTRDoc?Location=U2&doc=GetTRDoc.pdf&AD=ADA393235>

# Study Plan

To develop a PCDH model that serves as a framework for quality measurement, we specified a 4-level framework outline to organize the model from broad concept to individual measures. Each level corresponds to a project phase.

- Phase 1: **PCDH Definition**, including essential **characteristics** of a PCDH (e.g., accessible)
- Phase 2: **Components** of each essential PCDH characteristic (e.g., timely)
- Phase 3: **Measure concepts** included in each component (e.g., population unable to obtain, or delay in obtaining, necessary dental care)
- Phase 4: **Specified Measures**

This document outlines the study protocol, analyses, and results from Phase 1, which identified the definition and essential characteristics of a PCDH.

## Phase 1: PCDH Definition, including essential characteristics of a PCDH

### Study Protocol and Analyses

A modified Delphi method was used to systematically obtain expert opinion through a structured group communication process. The Delphi method was originally developed by RAND in the 1950s and uses anonymous structured feedback, via several rounds of questionnaires, to arrive at group agreement.<sup>2</sup> This approach allows for in-depth and anonymous input by all NAC participants.

The purpose of Phase 1 was to identify the essential characteristics of a PCDH, which would be included in the PCDH definition.

### Phase 1, Round 1

#### Methods

We used the Agency for Healthcare Research and Quality (AHRQ) patient-centered medical home (PCMH) definition as a starting point to develop the PCDH definition. The AHRQ PCMH definition included the following characteristics: comprehensive, patient-centered, coordinated, accessible, and focused on quality and safety. We added family-centered and continuous based on the inclusion of these characteristics in existing dental home definitions. Appendix 1 provides descriptions of each characteristic for reference. These descriptions also are adapted from AHRQ.<sup>3</sup>

The NAC was asked, via a web-based survey, to rate how essential each of the eight characteristics was to the definition of a PCDH. Each characteristic was rated on a scale of 1 to 9, where 1 was “not essential” and 9 was “definitely essential”. Participants were also asked to identify any additional, conceptually distinct characteristics that they thought should be considered by the entire NAC for a final definition of a PCDH. Figure 1 shows the criteria and guidance provided in the Round 1 questionnaire for consideration in making these assessments.

<sup>2</sup> Helmer-Hirschberg O. Analysis of the Future: The Delphi Method. Santa Monica, CA: RAND Corporation, 1967. <http://www.rand.org/pubs/papers/P3558.html>.

<sup>3</sup> Agency for Healthcare Research and Quality. Defining the PCMH. <https://pcmh.ahrq.gov/page/defining-pcmh> Accessed 27 Jan 2016.

**Figure 1. Criteria and guidance for ratings of PCDH characteristics in Round 1 questionnaire**

FOR REFERENCE	
In determining how essential a characteristic is, please consider whether the characteristic:	
a. has a high potential for affecting the <b>quality</b> and <b>experience</b> of patient care, as well as <b>oral health outcomes</b>	
b. is applicable across <b>patient populations</b> (e.g., children, adults, individuals with special needs), and across <b>different types of settings</b> in which a PCDH may be implemented (e.g., private practices, community health centers, accountable care organizations)	
c. is <b>measurable</b> (Note: The details of how the characteristic would be measured will be a next step in the process. For now, focus on the potential for measurement.)	
d. is <b>potentially attainable</b> by health care delivery systems	
<hr/>	
Rating 7-9=Essential (include in definition)	
Rating 4-6=Uncertain (needs more discussion)	
Rating 1-3=Not essential (exclude from definition)	
<hr/>	
<b>Rate each characteristic on its own merits and NOT relative to the other characteristics</b>	

*A priori*, it was determined that characteristics with median ratings of 7-9 “without disagreement” would be included in the final PCDH definition. Agreement was determined using a measure of dispersion described in the RAND Appropriateness Method, which compares Interpercentile Range (IPR) with IPR Adjusted for Symmetry (IPRAS).<sup>4</sup> A rating is classified as “with disagreement” if IPR>IPRAS.

### Results

With 98% (n=54) participation, all eight characteristics had a median rating of 7 or higher without disagreement. Thus, there was agreement among NAC members that all were essential characteristics of a PCDH. In addition, a majority of respondents provided open-ended input regarding *additional* concepts to consider for the PCDH definition. Table 1 lists all additional concepts suggested by participants, as well as the number of participants that suggested each concept.

<sup>4</sup> Fitch et al. The RAND/UCLA Appropriateness Method User’s Manual. 2001. Rand Corporation. Santa Monica, CA. <http://www.dtic.mil/cgi-bin/GetTRDoc?Location=U2&doc=GetTRDoc.pdf&AD=ADA393235>

**Table 1. Additional concepts proposed by participants in Round 1 questionnaire**

<b>Concept</b>	<b>N</b>
Prevention-focused	6
Integrated	4
Affordable	3
Culturally competent	3
Health literacy-focused	3
Evidence-based	3
Community-connected	2
Patient Experience/Satisfaction-focused	2
Acceptable (to patients)	1
Adaptable	1
Cost-effective	1
Disease/Risk management-focused	1
Education-focused	1
Effective	1
Efficient	1
Equitable	1
Individualized	1
Learning health system culture/ Continuous quality improvement	1
Ongoing	1
Primary care-focused	1
Team-based	1
Timely	1

All additional concepts mentioned by three or more NAC members were included in a second survey. Six concepts met these criteria: prevention-focused, integrated, affordable, culturally-competent, health literacy-focused, and evidence-based.

Quantitative results and NAC members' open-ended comments from Round 1 are listed in Appendix 2.

## **Phase 1, Round 2**

### *Methods*

The purpose of the Round 2 survey was to evaluate the six *new* concepts identified in Round 1 as possible characteristics that could be included in the final PCDH definition. NAC members were sent a document describing the results from Round 1 as well as guidance for Round 2. Recognizing that the proposed additional concepts might be conceptually included within one of the agreed-upon eight characteristics, we specifically highlighted to the NAC the need to determine whether each proposed new concept was:

- 1) conceptually distinct from the eight essential characteristics agreed upon in Round 1 and, therefore, should be listed as a separate essential **characteristic** in the PCDH definition OR
- 2) might better be considered a possible **component** of one of the eight essential characteristics agreed upon in Round 1.

The Round 2 survey instrument used a similar rating method on a scale of 1-9, where 1 was "not essential" and 9 was "definitely essential".



## Results

With 96% participation (n=53), there was *not* agreement that any of the additional concepts should be included in the PCDH definition. Median ratings for all concepts were below 7 “with disagreement,” and the highest proportion of open-ended comments indicated that each should be included as a component of one of the original eight characteristics rather than as individual characteristics themselves. A third survey round was not conducted for the following two reasons: 1) the low probability that another survey would result in agreement that any of these additional concepts should be included in the definition and 2) to minimize the risk of respondent fatigue.

The PCDH definition was thus finalized as follows:

***The patient-centered dental home is a model of care that is accessible, comprehensive, continuous, coordinated, patient- and family-centered, and focused on quality and safety.***

Detailed quantitative results as well as NAC members’ open-ended comments from Round 2 are listed in Appendix 3.

## Next steps

The two next steps in the PCDH development process are:

- 1) Hold a public comment period to solicit input from patient/community members and other stakeholders about the PCDH definition and the identified characteristics
- 2) Begin Phase 2 to identify the components of each PCDH characteristic. This phase will answer the questions:
  - a. what does it mean to be accessible, comprehensive, etc. and
  - b. how can we translate these broad characteristics into measurable components?

We will use a similar modified Delphi process with the project’s NAC for Phase 2 of this project.



## Appendix 1

### Description of Each Potential Characteristic

**NOTE:** These are not final descriptions of how these characteristics will be defined if included in the final PCDH definition. These are derived from the AHRQ PCMH characteristic descriptions, and they are provided here as general guidance. Patient-centered and family-centered, and quality- and safety-focused are combined in order to mirror AHRQ descriptions.

ACCESSIBLE	The PCDH delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the dental care team, and alternative methods of communication such as e-mail and telephone care.
COMPREHENSIVE	The PCDH is accountable for meeting the large majority of each patient's dental care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive dental care requires a team of providers, which may include dentists, allied dental care providers such as dental hygienists and assistants, medical and mental health care providers, pharmacists, nutritionists, social workers, educators, and care coordinators. Some smaller PCDHs may build virtual teams linking to providers and services in their communities.
CONTINUOUS	The PCDH provides continuity of care by nurturing ongoing relationships between patients and the dental care team, and by serving patients throughout the life course, starting with age one. Regular, non-episodic care is emphasized in order to achieve and maintain optimal oral health.
COORDINATED	The PCDH coordinates care across all elements of the broader health care system, including specialty care, hospitals, and community services and supports. They also foster clear and open communication among patients and families, the PCDH, and members of the broader care team.
PATIENT/FAMILY-CENTERED	The PCDH provides primary dental care that is relationship-based with an orientation toward the whole person. This requires understanding and respecting each patient's unique needs, culture, values, and preferences. The PCDH actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, PCDHs ensure that they are fully informed partners in establishing dental care plans.
FOCUSED ON QUALITY AND SAFETY	The PCDH demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based dentistry and clinical decision-support tools to guide shared decision-making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population dental health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

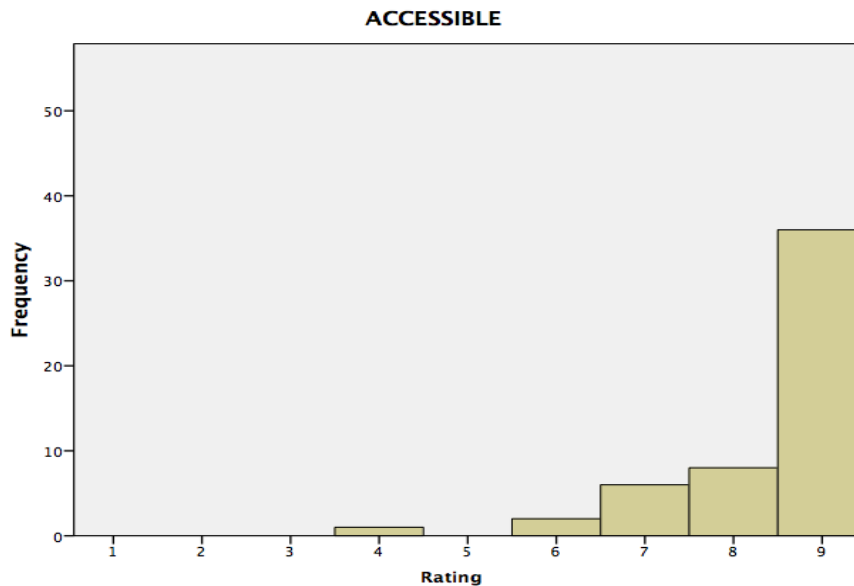
## Appendix 2

### Round 1 Survey Results

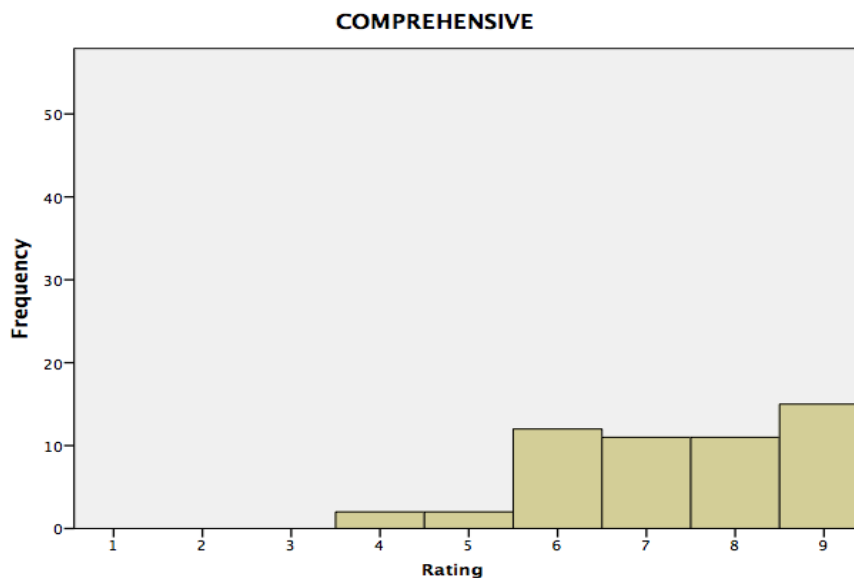
#### Quantitative Results

The figures below describe the quantitative results for respondents' ratings of each of the original characteristics, in alphabetic order. Participants were given the following guidance regarding rating criteria:

- Rating 7-9=Essential (include in definition)
- Rating 4-6=Uncertain (needs more discussion)
- Rating 1-3=Not essential (exclude from definition)

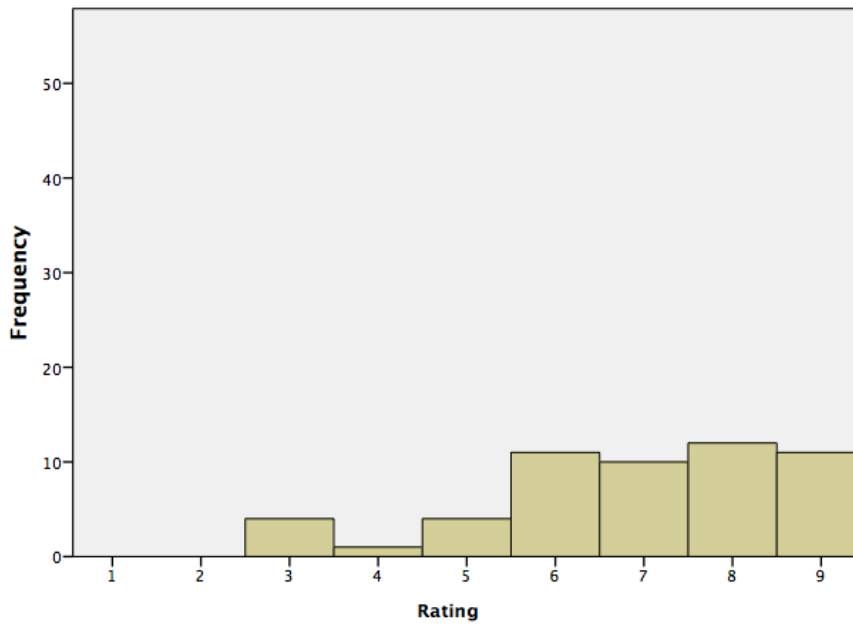


N = 53  
Median = 7  
Agreement? Yes



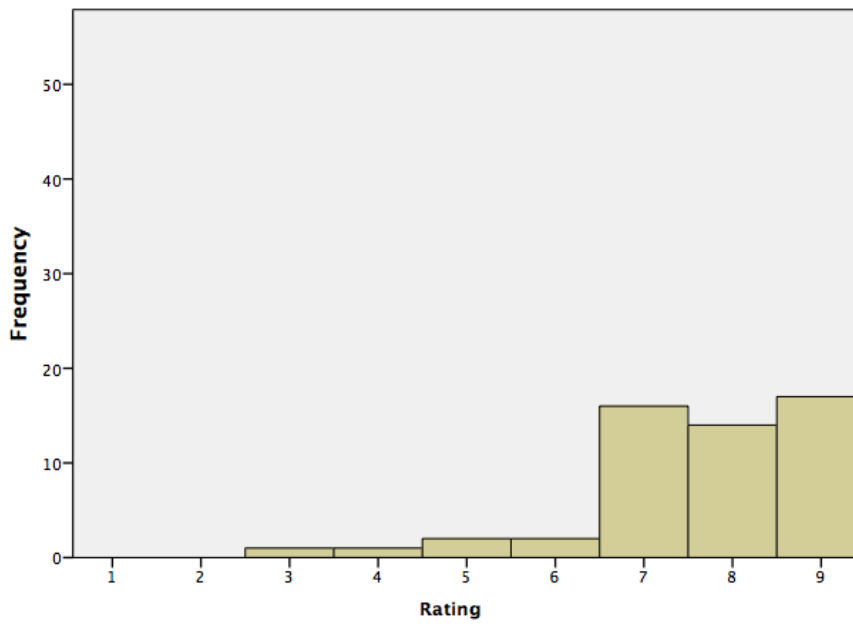
N = 53  
Median = 7  
Agreement? Yes

### CONTINUOUS



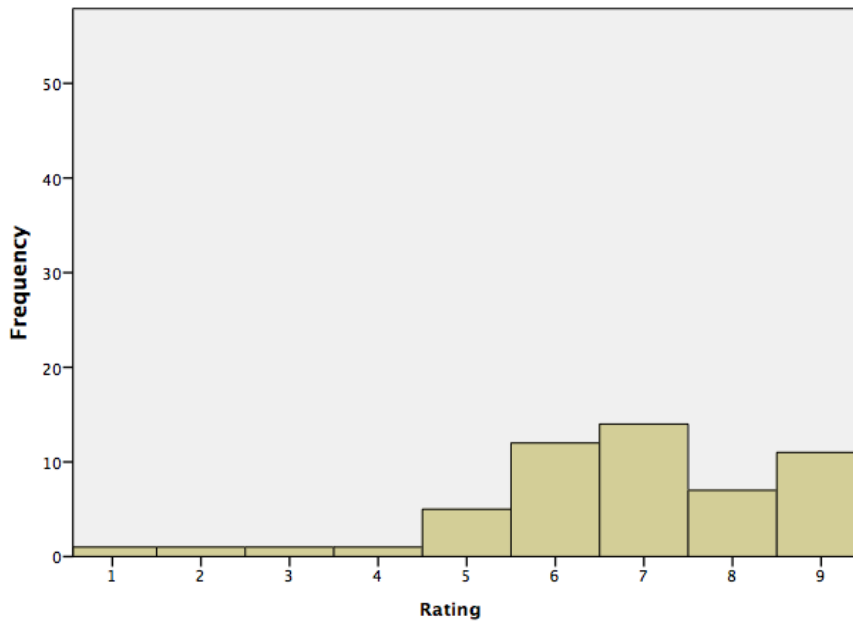
N = 53  
Median = 7  
Agreement? Yes

### COORDINATED



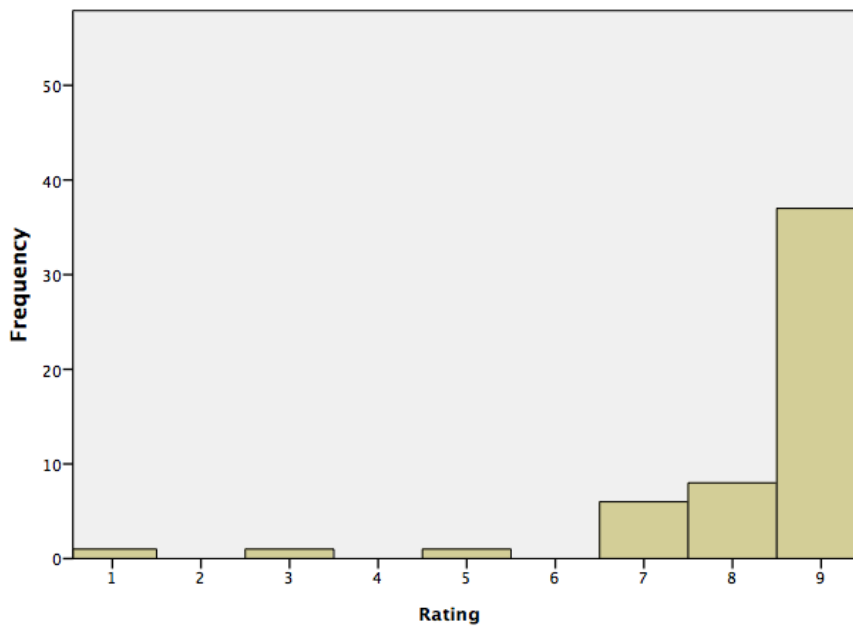
N = 53  
Median = 8  
Agreement? Yes

### FAMILY-CENTERED



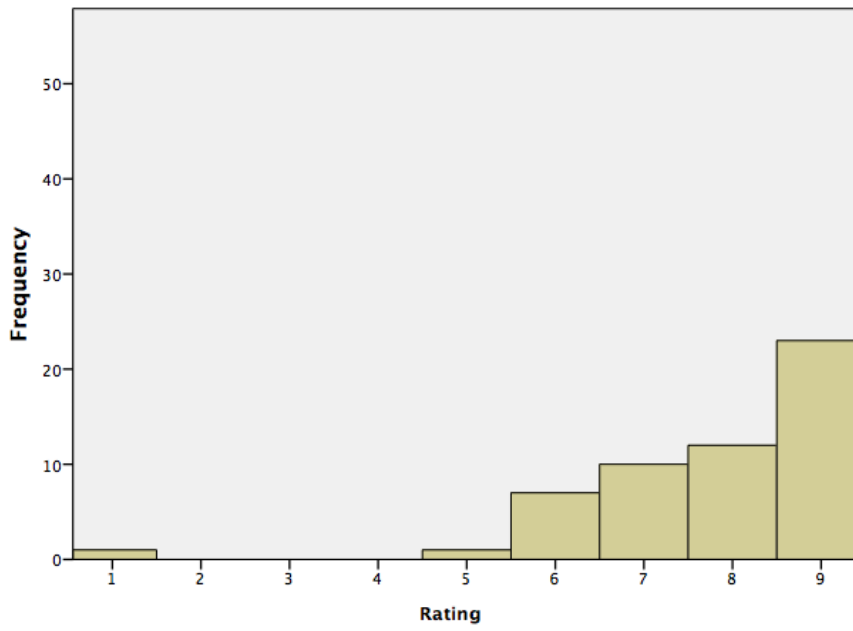
N = 53  
Median = 7  
Agreement? Yes

### PATIENT-CENTERED



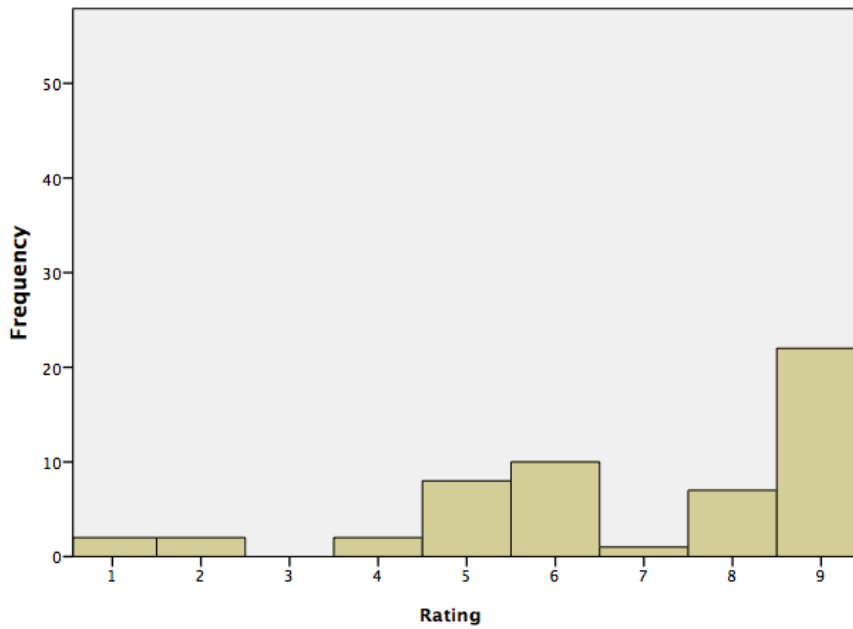
N = 54  
Median = 9  
Agreement? Yes

### QUALITY-FOCUSED



N = 54  
Median = 8  
Agreement? Yes

### SAFETY-FOCUSED



N = 54  
Median = 8  
Agreement? Yes

## Qualitative Results

After rating each characteristic, participants had the opportunity to provide their rationale or other feedback regarding their ratings. The tables below provide the open-ended comments related to each characteristic.

ACCESSIBLE	
1.	If it can't be accessed when needed, the relationship will be weak. Home implies comfort, support and safety.
2.	pillar to any outcome is access to services, what will need to be defined here is what constitutes access whether it be to any part of the system or to a fully comprehensive system. For example is access to primary care where [preventive] services can be [delivered] or to a comprehensive well integrated medical-dental model. Do you define access to care on a continuum?
3.	I find that much of this component is valuable, but that the around-the-clock access is a major barrier to attainability
4.	Uncertain of potential to improve oral health outcomes.
5.	An accessible patient-centered dental home is essential to the success of a model that seeks to improve oral health outcomes for all dental patients. I have some concerns about whether all aspects of access to care are measurable. For example, it may be [impossible] to get to the bottom of why a patient doesn't attend routine preventive dental care appointments at a PCDH practice if the cause of the failure to access care is not due to external barriers like, for example, lack of providers in an area. In [other] words, if the failure to access care has more to do with the individual choices of patients, it may be difficult to measure this using a survey tool or other data collection methodology.
6.	Accessible is important, but it is critical that that be defined. If it means people have to go somewhere, then is not really accessible. If it includes services being provided to the extent possible in the location where people live, work, play, and/or receive other services then that is important.
7.	The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being "applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations)," it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
8.	a definition of "accessible" would be helpful here. not sure if you mean "having access to care" ?
9.	This is the key thing - can a person obtain oral health care when needed? There's a reason that access is the de facto measure for "dental home-ness" in your background study -- because so many people don't have entry to, or can't afford, needed care.
10.	to be considered a health care home, patients need to be seen/served.
11.	We have several providers but who's willing to care for patients.
12.	A dental home must be accessible to be considered a "home" environment. Lacking access would not create the situation necessary for dental health care or monitoring dental health status when needed.
13.	If care is not accessible it has no value [for] either party---healthcare professionals or patients
14.	without access, only a concept
15.	I believe a critical aspect of the patient-centered model is accessibility. I prefer to conceptualize access to care in five dimensions conceived by Penchansky and Thomas - affordability, availability, accessibility, accommodation, and acceptability- [which] can be used to measure access. Although I rated accessibility as essential, I did not rate it higher because I believe it is influenced by many other contextual factors outside of the PCDH, such as dental coverage policies.
16.	PCHH cannot be achieved without a PCDH being materialized
17.	This is essential, fundamental to a patient centered dental home.(e.g.--patient emergencies)
18.	Absent accessibility there is no home. The question then becomes- what does it mean to be accessible

19. If the care is not accessible the entire concept falls apart.
20. Patient centric care demands accessibility. Patient comfort and confidence is built through access of the patient to their professional. In the safety net attaining equitable access can be significantly challenged by the diverse barriers and challenges [those] patients face starting with oral health literacy. Rural and socio demographic characteristics can also play a part. In short accessibility may be at different levels in differing populations but it should be defined and aspired to .
21. Gotta be there! Access means many things, so I guess it would depend to some degree on that definition.
22. If a patient cannot access care when they need it, assigning them to a dental home is of little use.
23. To me, this concept includes willingness to accept various insurance coverages. A major limitation I hear in dental care being accessible is the limited networks available for many insured parties.
24. Without accessibility, there is no possibility of “home.”
25. if you home is not accessible then you are homeless, somewhat defeating the purpose, no?
26. Accessible care, and all of its’ variations, is critically important to PCDH because without accessibility there can be no care.
27. Patient-centered dental homes must be accessible for everyone, and not only for a segment of the population, e.g. those who understand and have their needs met by the current health system.

<b>COMPREHENSIVE</b>
1. Comprehensive creates some concerns regarding attainability. In some settings the full range of important services will not be available so relationships outside the setting need to be put into place and communicate well.
2. Comprehensive may also include different types of dental providers
3. Will need to possibly define what comprehensive care is and who can provide that element of care. Also consider that [multiple] settings or providers may constitute the full world of comprehensive so that not just one provider or setting does it all. This ill allow for more [flexibility] of models. Would just need an underlying assumption of integration of services to reach comprehensive
4. The notion that most dental patients should be able to receive most of their care needs from their dental home (i.e., primary dental care provider) is a very important consideration. For most individuals, this also means being able to receive most of [their] care at one place (recognizing that some patients with advanced treatment needs may need to be referred for specialty services; however, these should not comprise the bulk of patients).
5. Advanced care not essential but disease control stability is essential
6. Comprehensive is not always what a dentist would view as important to ‘ideal dentistry’ but it should always include prevention, acute care, basic dental services, etc.
7. Comprehensive care for all people would be ideal. Including it in the definition would make the implementation of PCDHs difficult. For example, virtual dental homes that are primarily preventive in nature would not meet the definition unless they are [directly] connected to all types of restorative and specialty care. Programs experimenting with teledentistry may or may not meet the definition if they lack a “hands on” component. Barriers to access to comprehensive care - i.e. limits on insurance coverage, [paucity] of certain types of dental providers, lack of Medicaid providers, etc. would impact the practicality of a truly comprehensive definition.
8. comprehensive is subject to definition. Medically-necessary? What the patient desires? Restoration of full function? Having 28 teeth?
9. may be tricky as some treatments are highly specialized



10. Like having a PCDH that is accessible to all patients, it is of utmost importance that the model be a source for comprehensive dental care for all patients. I am all too familiar with models of care that seek to bring limited diagnostic/preventive care to disadvantaged Medicaid/CHIP beneficiaries. In my opinion, patients initially treated in a mobile practice that provides limited care are much less likely to receive an effective referral for care beyond the diagnostic/preventive level to another dental [provider] willing to accept a patient who has already had an oral evaluation, radiographs, prophylaxis, sealants and other preventive/diagnostic procedures rendered by another provider. Most providers who seek to become a PCDH would prefer to render [important] diagnostic and preventive care themselves rather than relying on work done by a referring mobile dental provider. This is true because of insurance plan limits on services and also because PCDH providers trust the quality of their own diagnostic and [preventive] services more than they do the diagnostic and preventive care rendered at a mobile dental practice.
11. Again, definitions matter. What is comprehensive? If it means the entire system has to include every specialized dental procedure known, then that is unreasonable. On the other hand screening and referral (i.e. good luck finding what you need) is not [enough]. There is a mid-point that makes sense for most people. A dental home confined to diagnostic, prevention and occasional very basic restorative and surgical services is what the vast majority of people need.
12. The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being “applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations),” it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
13. I’m in another workgroup that’s trying to come to a consensus about what “comprehensiveness” is, and that’s equally tricky. To me, stabilization, restoration of function, and ongoing preventive care are the key things. Depending on your point of view, [that] might be “comprehensive” care -- but then again, it may not be.
14. in dentistry, i’m not sure what comprehensive means. is it that everything a patient needs is done in one visit?
15. I think everyone should know what is expected as comprehensive to a dental home.
16. Should be comprehensive, depending on how this is defined - but essential services to monitor, restore or remove diseased oral tissues, and provide guidance that assures wellness.
17. We must make every effort to deliver the best dental healthcare possible to all patients
18. needs to address all needs
19. Comprehensive care is an essential component of the PCDH. Of course, comprehensive care can only be provided in the oral health context and not in the overall health. Thus, I think this concept needs to be rephrased to “comprehensive oral health care”. I [think] this is a key component to a patient’s experience and can be measured by the metrics such as dental services offered or referral process.
20. This depends on how one defines “ comprehensive” care. Cosmetics, implants, orthodontics, orthographic surgery..are they part of “ comprehensive care?”
21. There will be oral health services such as orthodontics, implants impacted third molars that may require a referral to a specialist.
22. Inasmuch as comprehensiveness is important the word requires further definition
23. In order to attain the objective of stable and long term oral health, the care must be comprehensive. Care that is less than comprehensive has the potential for causing additional demands on the system of care.
24. It is essential to be able to complete the circle of care comprehensively for the patient. There needs to be a way to fill all gaps to truly be comprehensive. If there is a gap there needs to be a strategy to bridge that gap and complete treatment fully [and] timely

25.	I am not a great fan of the Iranian or Cuban healthcare systems because they are the products of inadequate resources, but they rely on a pyramidal approach which means that at the entry level (bottom), comprehensiveness is not critical. It is more of an atrium than a home. If further assessment or therapy is needed, then the patient enters the next step which still may not be a comprehensive “home” but just a further more intensive stage, based on needs. So, theoretically, we could take care of some needs without entering the dental home. However, that approach assumes that somewhere down the street is a dental home.
26.	Unclear what “comprehensive” means, what “primary” dental care means. Is correcting malocclusion part of comprehensive dental care? Does the PCDH provide all specialty dental care such as endo, perio surgery, etc. because it is responsible for “comprehensive” care? Or does the PCDH provide “primary” dental care and is responsible for coordinating care with other specialties to achieve comprehensive care?
27.	Care should encompass the full range of services that a patient might need and should be coordinated across all domains of oral health and all relevant providers.
28.	Seems essential unless you drive toward a preventive care model. The best result, especially for the adult population would seem to be a care setting that is complete and can address all dental health needs.
29.	Not sure as comprehensiveness may mean addressing issues beyond oral health, however, “comprehensive” as it pertains or is limited to oral health may be essential, and PCDHs could be required to directly provide or facilitate access to specialty services
30.	What is meant by “comprehensive?” Is the Dental Home responsible for every possible contingency? That is, “comprehensive” should be defined and understood by stakeholders prior to Dental Home inclusion.
31.	depends on what you mean exactly by comprehensive
32.	Comprehensive care while valuable is more about the categories of care available and the levels within each category of care may vary greatly.

CONTINUOUS	
1.	I believe this is very important to attaining the goal of a patient-centered home but we have significant barriers such as changes in insurance coverage, etc. Is this an attainable goal in our present environment?
2.	Will need to define whether continuous means with the same provider or “setting” or does continuous mean access at all times and for all situations. Will need to define is continuous care for preventive, [restorative] and acute care?
3.	This may be a challenge for independent practitioners in small offices. They may be best able to focus on relationships for certain age groups.
4.	Continuous care helps support the building of positive relationships with a provider/team that is familiar with the patient and vice versa.
5.	Although ideally all people should have a PCDH. It would be great to include adult care in the concept, although the lack of a comprehensive adult dental benefit limits the attainability of including this element. If you are creating an ideal definition, this should be included. If this definition is to be used practically by providers and insurance (public and private) companies, requiring that all populations be included may not be realistic.
6.	may be tricky when it pertains to special populations, young children, elderly with chronic conditions
7.	Continuity of care “throughout the life course” (per the definition provided) may be very difficult to achieve, given the normal mobility of patients over years of life. Measurement may also be very challenging.
8.	Continuous oral health care is another important ingredient that results in better outcomes for patients. The ability to carefully monitor the incidence of new disease or other acute and/or chronic oral health conditions is highly dependent on patients [seeking] routine care at least every 6 months. Some patients who are at moderate to high risk for disease should probably be placed on a more frequent recall basis once they have had their initial treatment plans completed. Frequency of care is easily measure using administrative paid claims data.

9.	The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being “applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations),” it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
10.	not sure what continuous care means? do you mean across the lifespan? or all care provided by same team? terminology is a bit ambiguous.
11.	This is another tricky one for me - are we talking about continuity with respect to a dentist or other dental professional? What about low-risk individuals whose ongoing needs could be met by medical team members during routine wellness checks? Does that ass muster for “continuous-ness”?
12.	is this covered under accessible
13.	what does the evidence tell us about patient outcomes with continuous care? do we have to see the same care team to stay healthy, or just get care?
14.	This presupposes that all patients need regular contact with a dentist or dental team, which the evidence does not support. Continuity of care has many benefits, but is not a required element of high-quality specialty care.
15.	Continuous care provided by the dental home?
16.	Continuous as far as monitoring, preventive, and educational to maintain wellness - yes, but not continuous treatment which may indicate poor quality of care or lack of patient self- improvement.
17.	Continuous care ensures long term dental health and cost control and enhance the chance for a better livelihood for our patients
18.	Measuring continuous care is still unclear to me even though the term is commonly used. Is it when the patient seeks care they are able to be seen within a certain time period? If so, I would argue that “timely” is a more appropriate characteristic. Aside for care that is not “disrupted” I think this characteristic warrants further exploration and discussion.
19.	[continuity] of care is utmost important for healthy life status
20.	This element will require more discussion as there are arguments for second or multiple opinions, especially in the case(s) of misdiagnosis, inappropriate therapy etc..
21.	Disruptions to care to may lead to undesirable outcomes.
22.	Continuity brings integrity to the relationship between patients and professionals by tying the knot between professionals their care model and patients . It protects patients from episodic and fragmented systems of care
23.	Continuous means recurrent care to me and the opportunity for primary and secondary prevention. With children, we had that system until the Affordable Care Act intervened and made co-payment an issue. It wasn't perfect, but it wasn't the system at fault [but] rather the populous and its priorities. Now we have a huge economic gap for many children. For adults, it is somewhat different but still a problems.
24.	If we consider the use of electronic dental record system (once in broad use) then a patients data can be available continuously even if the patient changes “homes” or obtains care outside of their “home.”
25.	Continuous I assume applies the services “will continue” to be available. Continuous also implies that the patient will “continuously” use the services. I am not clear what meaning you are referring to here.
26.	By “continuous,” I assume we mean care that is available (accessible) over the patient’s lifespan from maternal health education [beginning] when the patient is in utero until death.
27.	Continuous care very important towards maintaining the care over the course of time for the patient.

COORDINATED
1. This doesn't happen currently but we have the potential to achieve this goal in the next 5 years with interoperability of electronic health records and health information exchanges that allow for meaningful sharing of information and communication between different providers.
2. Coordinating care with medical professionals is of importance, but may be challenging due to numerous models of medical/dental integration.
3. Coordinated is important but does it fall in as an element of comprehensive or efficient. How will coordinated be measured-from the provider level or the patient level. Could be two very different perspectives and priorities. Will need to consider the [financial] sustainability-business model to support this element. Finding metrics that show ROI or patient satisfaction and thus greater compliance with the coordination.
4. At certain age groups, such as teens and young adults, the dental office team may be the best site for broader care coordination. For older and younger patients, the dental home may take a secondary role in connection with the broader health home.
5. Coordination should mean more than just being a hub or 'entry point' from which referrals are made. Ideally care should be provided by individuals who are part of a true system of care and share a common value system.
6. I think this is the key characteristic of patient centered home model.
7. coordinated also needs definition. Coordinated within dentistry? Coordinated with medical services? etc.
8. The Dental (and health) system are often difficult to navigate, many patients need navigation and coordination. Health literacy is also a factor needed to be addressed.
9. Coordinated care is highly dependent on patient care needs and a patient's ability to navigate the oral health care system on their own. Some patients need considerable assistance with care coordination while others with a high dental IQ can easily manage their own care without prompting or assistance from trained care coordinators or health navigators. Better oral health outcomes for many high risk patients can be reduced if care coordination is employed. In other words, some people need no help, others [with] moderate needs require limited aid and there are still other high risk patients who need a lot of "handholding" to reach more optimal oral health status.
10. The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being "applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations)," it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
11. I feel like this is an important aspect of where we want oral health to be - well-connected to primary medical care - but measurement of coordination may be difficult. Use of a shared electronic medical/dental record could be an indicator that could be of use.
12. makes sense that all if my health care providers support my total health
13. Coordinated care means different thing to different people. This will need to be well defined.
14. Very important to coordinate care for the best outcome and not trap patients in a maze of disconnected systems and poor navigation methods. The care needed available when needed.
15. Coordinated care allows less confusion and duplication of services
16. must be coordinated with the rest of the health neighborhood
17. Referral in an integrated care model is important, so coordination of care is essential
18. In order to insure that the patient receives all needed care in the proper sequence, care must be coordinated with all providers needed to achieve and maintain [health].
19. Coordinated care leads to holistic whole patient approaches to the model of care and links inter professionalism and all that the coordinated care system brings to our patients. The days of siloed care are over.

20. The medical home was premised on what was needed for special needs children. The carryover to oral health for the general public for oral health care is a little sketchy, so I wouldn't make this a high priority. Since our oral health system is largely DDSGPs, I think that this may be a low priority.
21. Much of what impacts oral health can be addressed outside of the dental office, and, in some cases, outside of clinical settings altogether. It should, therefore, be the focus of a patient-centered model to coordinate care across dental and non-dental [providers] as well as any non-traditional or non-clinical providers that may be involved.
22. Need to connect to medical providers as well as other dental/oral health providers.
23. Define "coordinated." Does this solely involve dedicated referral to specialists (when appropriate) within the sphere of dentistry, or is it expanded to ... physicians, nutritionists, mental health, etc?
24. Coordination of care hugely important though fairly non-existent currently, which may be pre-biasing my score. Regardless, poorly coordinated Coordination of Care could turn into a huge obstacle, debacle or whatever best describes a system too mired in [non]-essential sequencing and bogs down.

<b>FAMILY-CENTERED</b>
1. This is essential and attainable. Shared decision making and tools to assist the process have come of age.
2. if care does not make sense to the end user, it doesn't matter how great of a model it will not be used to full potential. Need to be mindful of family centered metrics and how they can differ from health outcome metrics. Refer or seek guidance from PCORI
3. Family-centered care is likely to be more important for certain types of patients. Patient-centered should be the first priority.
4. this is more difficult to measure for all people, in my opinion.
5. would require additional training in dental school to work with patients and communities
6. Family-centeredness of care may not be relevant/achievable for all patients given complexity of family relationships, patient concerns about confidentiality, etc.
7. Again, this is one of those attributes that very much depends on the PCDH's mix of patients. For example, if the family has very young children, it may be prudent for them to seek care in two different arenas--at a pediatric dental office for the children and also at a general dental office for the adults in the family. As the children mature, it is always a good idea for the child to seek care at general dental office. Even though a parent is not receiving care from his and/or her child's dentist, it goes without saying that all dental offices including a pediatric practice and a geriatric practice should be family-friendly. Many patients are not legally competent to make important care decisions on their own. For this and many other reasons, a PCDH should seek to be a family-centered practice. Our colleagues in pediatric medicine and other medical specialties have for many years stressed the need to engage all of the individuals in a family who play a role in decision-making for the patient of record.
8. It is possible to do what is needed for most people without the family being the center of the interventions. In some cases it is essential, but not for every person and every circumstance
9. Family-centered PCDH models often do not adequately address the needs of pediatric patients who should be treated by a pediatric dentist when possible. This pediatric dentist relationship is very important and that level of dental home would not be [important] for older siblings or caregivers. The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being "applicable across different types of settings in which a PCH may be implemented (e.g., private practices, community health centers, accountable care organizations)," it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also not include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the [infrastructure] underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental [patients]. On a nationwide basis there are only 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should [continue] to be focused on the relationship between the dentist and the patient.
10. This is another one that's pretty important, but I'm uncertain of our ability to measure it. And I'm less certain of measures that could help us understand family-centeredness.



11. Family-centered and patient-centered overlap. "Person-centered care" may be a more inclusive and empowering term that also takes into account the role of caregivers (who may or may not be family members).
12. I would be interested to discuss the definition of family-centered care. I have never heard the before.
13. Outcomes will be determined by the patient's ability to navigate and engage the system. Also, patient engagement and understanding in a culturally competent fashion is essential for long term outcomes and self-management.
14. Family centered care creates a hierarchy of values which can transcend lifetimes creating a value system which can be passed on to future generations thereby reducing overall costs to society
15. to address the needs of all populations, the PCDH must be in the context of family and community
16. I believe this term is more so inclusive because it includes care delivered to children, the very old and those with special needs dependent on caregivers/parents. This characteristic is applicable across patient populations and attainable once supporting [relationships] are identified and engaged. Still, I think the measures on family-centered care need to more discussion.
17. Parents with good understanding and view of health care will have children with better care and health status because they believe in the value of good dental and overall health care
18. If family-centered care is to include the community then it is indeed an essential element.
19. Care that involves the entire family is likely to attain a more desirable result by incorporating education and obtaining buy in and understanding on the part of all family members.
20. Utilizing our approach to the patient as a portal to the family extends oral health and improved outcomes to all. The family centered Health Home is bidirectionally connected to the PCMH and the PCDH
21. Essential for children and potentially the elderly.
22. Some research suggests that this is a factor in compliance and care seeking.
23. Patient-centered care fits in all definitions but not sure about family-centered - whether it's applicable to all populations. It would seem this is an optional thing that the patient should have the choice on if the patient is an adult. Some patients may not want their families involved.
24. I think patient centered is more important. Family could be at the next concentric ring.
25. This seems less important to me except in the case of pediatric patients.
26. what is the difference between family-centered and patient-centered? are these different actual models of care?
27. For certain patients without doubt family centered is very important, though across the general populace the degree of importance here will be all over the board, and sometimes even non-existent.
28. Not everyone is part of a family, at least in a 'real world' sense. Agree that a patient-centered dental home would optimally be part of family-centered coordinated care, but feel that this item needs more discussion.

<b>PATIENT-CENTERED</b>
1. Patient centered can't be separated from family centered. One can't exist without the other.
2. Key element. May want to consider how to merge patient and family centered care. Essential in pediatrics and geriatrics is family centered. Patient centered more of an adult population term. Do the two represent similar elements and can few integrate the wo. May be a [benefit] to the end user as it may be a issue of definitions for the field that loses its significance or [relevance] to patients/families. Would assume if you asked families or patients what makes X-centered care they would over lap.
3. In my book, you can't have a patient-centered dental home without having patient-centered care.
4. As with family we need to treat primary care givers disease due to avoid transmission
5. can I give it a 10?

6.	I think a more holistic approach to oral health care is a strategy for change that can pay dividends. Many of us in dentistry have grown into the role of recognizing when an alternative approach to strict allopathic health care is effective. When a [patient] is treated like he has just had a visit with his or her “molar mechanic,” the patient will naturally be reluctant to return for care. Dentists who recognize that a patient is more than just an oral cavity with 32 teeth will reap the benefits of an [approach] to dentistry that seeks to educate patients about the important role that the tissues and anatomic structures of the head and neck play in achieving optimal systemic health. Focusing on a patient’s overall well-being rather than on if he or she is doing an adequate job brushing and flossing their teeth will result in more patient satisfaction and much higher patient retention rates.
7.	Of course, but this term means a lot of things to a lot of people. Again, the definition is important.
8.	The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being “applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations),” it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
9.	given the low value many families place in oral health, i’m not convinced this is a crucial component. unless we can make major breakthroughs in how the care team communicates and engages families, it may be hard to deliver evidence-based family centered care.
10.	Patient centered care is core to the concepts of a “patient-centered medical (or dental) home”.
11.	Person-centered care may be a more inclusive and empowering term that also takes into account the role of caregivers (who may or may not be family members).
12.	I don’t think this would be need for a dental home.
13.	Any treatment must be individualized to the specific patient if it is ever to be successful
14.	the essence of PCDH
15.	This is a fundamental characteristic however, it is not applicable across all patient populations since supporting relationships are not engaged in care.
16.	In order for care to be effective it must be designed around the needs of the individual patient. Subsequently, population health can be achieved when the needs of individuals are managed effectively.
17.	I believe we all believe highly related to patient centricity. However, we most often think of this in terms of the patients needs. What about in relation to the patients constraints, restraints and barriers? What I am getting at is that the needs of [patients] in the safety net are very similar and we address those most often. In relation to the PCDH, in order to reach and bring Oral Health Care to populations who have access problems due to public insurance, no insurance, restrictions on travel, [parent] or caretaker apathy..... it may be very difficult to extend ALL of the other characteristics of the PCDH to them. This may be a case where we need to think of the PCDH having to consider the characteristic of Adaptability. Where something is better [than] nothing, which I don’t think anyone is thinking of, or; whatever parts or characteristics of the PCDH that can be applied and adapted to the circumstances of the patient counts. Simply the consideration of Adaptability as a characteristic is what I am [suggesting].
18.	Is consistent with national quality goals, so essential here.
19.	is this a trick question? you have this in the title already....
20.	The absolute most important item in PCDH should always be the patient, and of course care should be Patient Centered.

#### QUALITY-FOCUSED

1. The challenge for dentistry is the lack of quality measures but they are being developed. I would like the group to consider both quality and outcomes when we talk about measurement.



2. Quality-focused care is of importance, taking into account one's perspective about patient experiences, satisfaction, expectation.
3. Since the models of care for oral health may be varied capturing what the standards for quality care are is the only way to ensure improved health outcomes and patient/family centered care
4. This is important, but challenged by the limitations to-date for measuring quality and documenting QI.
5. quality-focused care is part of effective care, so it's hard to imagine how a 'high quality' dental home could be patient-centered and not be focused on providing quality (effective) care. That said, I'm not sure this has to be a part of the definition of a PCDH (see comment for next question on 'safety-focused care'.
6. Measuring quality in dentistry is difficult, although very important. Working in alignment with others doing quality work (i.e. DQA) is critical.
7. I'm not really sure how to answer this one. We would hope that no receives less than quality care. Is "quality-focused" the same as quality care? By what measure will quality be determined? Is it measured at the patient level or by practice or plan [level]?
8. There is a huge gap in the area of dental quality measures development. It will be difficult to attain in the current state-of-the-science of dental quality measures
9. Although essential in this model, quality may be difficult to define in many aspects of dentistry and equally difficult to measure.
10. Quality also plays an important role in patient care. It is not enough to simply have a patient attend appointments. The care that is rendered must move the patient's oral health status in a positive direction. Compared to other health professions, [dentistry] has been woefully unprepared for the increasing focus on quality measures. It is not an exaggeration to say that our profession is sorely lacking in the ability to measure oral health outcomes. Process measures abound in dentistry. When dental [professionals] are asked to identify quality measures that are linked with better health outcomes, we become hard pressed to point to any measures that are consistently used across the broad spectrum of patient populations. In summary, I would say that while [quality]-focused care is crucial to the PCDH, there is a huge barrier to evaluating quality in dentistry--the lack of universally accepted quality measures. The DQA is working diligently on identifying, testing and developing true quality measures. Many dental [professionals] look forward to the day when we catch up to our medical colleagues in the use of well-conceived quality measures.
11. Again, the definition is important. If this means focused on the Triple Aim type of measures, then sure. If it means collects and reports on a lot of the measures coming out of the DQA, then it could result in unnecessary administrative burden of [questionable] value.
12. The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being "applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations)," it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
13. Very important, deeply challenging to measure, although we are in a better place with respect to the availability of DQA quality measures than we have been previously.
14. most assume quality should be high internal [priority]
15. it is absolutely critical that dental homes measure and improve quality as an integral practice.
16. While patient's sometimes don't recognize quality, it is essential to patient centered care. The challenges-standards of care in dentistry are not well established. Insurance does not always cover what dentists might consider as quality focused care.
17. The term "quality focused" sounds process oriented to me. Recommend clarifying that the goal of being "quality-focused" is to improve oral health and general health outcomes for patients. Alternatives could include: Data driven, outcomes-focused, etc.
18. A dental home needs to be built on quality.

19.	This is definitely an aim that should be sought- depending on how this is measured and outcomes desired. Today's level of outcomes monitoring in dentistry is highly primitive and lacking; mostly quantity measures rather than quality outcomes. More steps [in] developing valid quality measures needed first.
20.	Would be helpful to have a definition for this one. In answering I assume "quality focused" means appropriate attention to disease management and disease risk management rather than technical quality of [specific] services.
21.	All patients deserve the best possible care they can [receive] within the limits of program with which they are associated. Occasionally, we as dental professions may be required to go above and beyond
22.	need agreed-upon measures
23.	Quality is absolutely a concept that needs to be included, however, the measures of quality are difficult given the limited use of diagnostic codes. I believe the measures defined by the Dental Quality Alliance (DQA) are examples of how the PCDH can [measure] quality.
24.	Poor quality care does not result in good health outcomes, so quality care is important
25.	I am making the assumption "Patient Safety" is a part of the term "quality focused". The IOM study underpins the concept of patient safety. Something as simple as a checklist could be a significant patient safety element in a PCDM
26.	While quality is a [laudable] goal, it is elusive and to some extent defies definition. It is multifactorial in nature and because there are many elements the make up "quality" reaching consensus may be challenging.
27.	Pretty much a given! All care is provided under the umbrella of quality. Equitable care comes to mind and I will guess that we may have the opportunity to suggest that later. This is definitely essential. What we may need to consider is defining quality [focused] care in relation to the PCDH since there are so many different interpretations of Quality.
28.	Ditto with my former comment about the national quality agenda. I think this may be assumed these days, although QI in dental practice and education lags well behind its priority in general health care, due to lack of carrots and sticks.
29.	The term "quality" in dentistry means different things to different people. A provider may think it means just the technical quality of the procedure such as the margins, occlusion and contacts of a crown and not think of it in terms of the aims of [quality] care being care that is safe, effective, efficient, equitable, patient-centered and timely (IOM). While the concept of "quality" is definitely essential I'm not sure that the generic "quality-focused" care is a sufficient descriptor of the concept.
30.	Care should be appropriate and tailored to meet the needs of individual patients. It is therefore critical that appropriate quality measures be incorporated.
31.	Clearly this is an essential feature. I hear plenty of concerns from patients - how do I know this is a good dentist and that a particular service is truly necessary? Having clear measures of performance including overuse indicators will be important.
32.	What is meant by "quality-focused?" Should not every caring health professional have a core value dedicated to quality-focus? How would this be measured? (Other than statistical measurement -- such as assessing, for example, if sealants were placed on [permanent] first molars shortly after eruption).
33.	High quality - accountable, other ways to look at it.
34.	Quality of care is extremely important. Caution given though if volume of care is greatly reduced by pursuing ONLY quality, the overall demographic will be underserved.

SAFETY-FOCUSED	
1.	Research examining adverse events in dentistry is finally taking place. I am aware of two research projects related to this topic. In my mind it needs to be considered in concert with quality/outcomes. This is somewhat akin to talking about medications. We discuss both benefits and side effects with patients.
2.	Safety-focused seems as if it would fold into quality care. This can be captured by using best practices and having metrics on process to ensure safety focused approach is implemented. Not sure it needs its own element.
3.	I would not include safety in the definition. I think safety is a presumed requirement for all providers.

4.	See previous response regarding ‘quality-focused care’. These are different aspects of quality that have been identified by the IOM and others; and as such are all part of the quality of a PCDH -- I’m not sure they need to be enumerated in the definition of a dental home. To me, there are two parts of the definition of a patient-centered dental home -- one part deals with explaining what a dental home should be able to provide; the other deals with what it means to be patient-centered. Beyond that, the [quality] of a PCDH can be defined in terms of whatever framework or attributes are used to characterize and measure quality (which may be the IOM framework and characteristics .... or some other framework and characteristics).
5.	Safety of dental care is important, but is monitored by others - i.e. state dental boards. Focusing on quality and impact is probably more relevant to the PCDH concept.
6.	I subscribe to one of the messages that has often been attributed to the Hippocratic Oath: “First, do no harm.” I believe that since patient populations have for many years placed a lot of faith in our profession, we ought to reciprocate by adopting best [practices] that value patient safety above many other characteristics of our practice of dentistry. Nothing causes more consternation about dentistry in the general public than reports of patient morbidity or mortality in a dental office. If we cannot [render] safe care to our patients, then we have no business rendering any care to them.
7.	Again, sure, but the definition and what it implies is critical.
8.	The heart of the PCDH model is the relationship between the dentist and the patient. In terms of evaluating this item in under the characteristic of being “applicable across different types of settings in which a PCDH may be implemented (e.g., private [practices], community health centers, accountable care organizations),” it is important to state that I disagree with any model that is based on facility level relationships other than with a Federally Qualified Health Center. The dental home should also [not] include entities such as Accountable Care Organizations (ACOs). ACOs are designed to align provider incentives with provision of quality, coordinated care rather than volume based reimbursement, and to improve the infrastructure underlying care delivery. In practice capitation is the most common payment method attached to this type of approach. It simply does not work in dental. A capitated payment often results in less care rather than better care for dental patients. On a nationwide basis there are [only] 20 ACOs that include a dental component, and of those, only 14 ACOs have a Medicaid contract. Patients are always going to need to adhere to the appropriate periodicity schedule for care. The dental home should continue to be focused on the relationship between the dentist and the patient.
9.	how would this be measured? may require additional definition of term
10.	Quality and safety were bundled pretty closely together in the background materials, so I’m not sure how you’re thinking of distinguishing between the two here.
11.	see previous comment [Comment: quality-focused care is part of effective care, so it’s hard to imagine how a ‘high quality’ dental home could be patient-centered and not be focused on providing quality (effective) care. That said, I’m not sure this has to be a part of the definition of a PCDH (see comment for next question on ‘safety-focused care’]
12.	Above all, do no harm. Patient safety is essential
13.	Safety is also very important for a dental home.
14.	Absolutely, do no harm.
15.	Out patients must feel comfortable that their best interests are tantamount to their treatment
16.	Although nonmaleficence and “avoiding injury to patients from the care that is intended to help them” is a component of ethical standards of practice, I see this philosophy as having a limited relevance to the PCDH. Safety could be measured by adverse [drug] interactions, limited radiation exposure, and following OSHA standards (sterilization, appropriate disposal of amalgam), but in my opinion it is unclear how safety in a PCDH would differ from the safety expected in the traditional dental delivery setting I believe safety is a component of quality and not a unique characteristic of the PCDH.
17.	The IOM study greatly underscores this concept of safety-focused care. Checklists, [credentialing], training, and so on, are fundamental to patient safety.
18.	Patients expect a safe environment with all that makes up a safe environment and professionals are obligated to provide such an environment.
19.	Agreed. Safe for the patient, provider and staff. I would say that it would be supposed that the care be Safe, Efficient, Effective, Equitable , Timely and patient centric in line with the IOM report. To carve only safe out may not be needed? However, [care] sure needs to be Safe. It needs to be everything else mentioned in the IOM report also.

20. Safety as an aspect of dental care is barely out of the shell. Only recently, has safety entered the EBD arena. Think about mercury, BPA, nickel, nitrous oxide, radiation, latex, infection control issues, and a number of others that don't make the cut in [terms] of priorities in dental care! Has to be in the definition. Also, this safety concern touches on the inter-professional practice movement --- many believe that issues like child abuse, substance abuse, neglect are general safety issues that cross all f health care.
21. Need to better understand this attribute to form a good opinion. I assume patient safety is a core value of all dental/medical care and as such a baseline in the care of patients regardless of the setting.
22. Quality focused should encompass safety
23. This was hard to rate. I'm not clear on the safety issues that are critical in dental care so I think it warrants further discussion.
24. Regulatory compliance assures "safety."
25. or just "safe"
26. Safety will often be included with Physicians and Hospital definitions of quality but I think of it more as an essential part of care that should always be in place and not necessarily be required to be part of a definition. Safety is always part of the [baseline] of care.

Finally, participants were asked to comment on whether there are any additional essential characteristics of a PCDH that were missing from the original eight characteristics evaluated in Round 1, as well as their rationale for inclusion.

ADDITIONAL CHARACTERISTICS
1. Evidence-based care does not appear and should be considered. Delivering high-quality care requires having evidence-based standards of care. Also consider team-based care. Team-based care in the medical setting has been linked to improvements in [patient] health outcomes, patient engagement and activation, patient experience, and provider and staff satisfaction - all of which are relevant for the dental care setting. "Quality-focused care" and "safety-focused care" could be combined. See earlier [comment] on need to specify attention to and improvements in outcomes (not just processes). "Patient-centered" and "family-centered", while different, are also repetitive, and I wouldn't recommend including both. "Person-centered care" is a more inclusive term hat I believe adequately covers both domains.
2. 1. Literacy-focused. The challenge to optimal oral health begins with patient/parent/guardian comprehension of the importance of oral health and its relation to overall well-being. Oral health literacy under the aegis of the Dental Home is the foundation o a lifetime of wellness and is a shared responsibility across all sectors. 2. Individualized. The Dental Home utilizes evidence-based best practices, whereby the dentist renders appropriate preventive and therapeutic dental health programs based upon [individualized] caries-risk assessment, [periodontal] disease risk assessment, oral pathology risk assessment, anticipatory guidance of growth and development issues, and other age-specific oral health issues.
3. A learning health system culture that has in place continuous quality improvement. Without it a Patient-Centered Dental Home will not properly evolve.
4. A patient centered dental home gives patients access to ongoing and comprehensive care. Providing only emergency care or screening/exams/prophys without disease management or the ability to access ongoing care is not patient center.
5. ACCEPTABLE to patients (and families)
6. Adaptability to a mixed model of care. The field has made strides in developing diverse access points to care and diverse set of providers (health focused and oral health focused) that provide [preventive], restorative and acute care. Need to ensure that [integration] is an element of this process (look to oral health resource center levels of integration). Will integration be captured in the "comprehensive care" or "Continuous care" element or does it need its own element.
7. Advocacy has to be there. A growing body of literature suggests that healthy communities (another national priority, BTW) can really only be achieved with providers working from the dental home to exert influence in communities. It is a novel concept that probably needs some discussion.
8. All aspects were covered in the survey. Thanks.
9. Although this may be inherent in some of the other characteristics, I think it is important to include oral health in the PCMH - stress that dental homes aren't a separate entity, but are included as part of the overall care coordination for the best heath of the patient. Making sure that we are not creating a unique definition that will further silo dental care, but instead a universal concept that further integrates dental into current medical home concepts is key.



10. As is noted in the background materials, I'd just like to make sure that the definition of person-centeredness includes a strong emphasis on cultural competency.
11. Care that is preventive in nature Durable treatment modalities
12. Consider the term "integrated" as a proxy for: coordinated, continuous and comprehensive
13. Cultural competence
14. Culturally competent care .... Essential element of evidence based care ....patients values
15. Dentists have an obligation to disseminate educational information to patients about the etiology of dental disease, how to prevent oral health problems, the technical aspects of the treatment services we offer to restore function and esthetics, etc. [While] patient-centered care sort of touches on this obligation, I think that one of the essential characteristics of a patient-centered dental home should be that it seeks to be an information hub and/or repository for educational materials that are age and [educational] level appropriate, culturally competent and pertinent to the patient's need to know about everything from how to brush their teeth to the risks and complications associated with any invasive dental procedure. The need to educate our patients also touches on legal and ethical responsibilities like informed consent and maintaining standards of care. In my opinion, the essential characteristics of a patient-centered dental home ought to encompass that duty to educate our patients at a level of [understanding] that is acceptable to them.
16. equitable is an important concept. also should we be promoting oral health home as opposed to dental
17. Evidence-based - rationale is that application of best evidence is how all care should be provided timely - access is good but only if when you need it cost-effective - bring in good accountable resource management so patients know they are getting value affordable - so patients can actually purchase the care they need - number one barrier to care is affordability
18. evidence-based. while this is implicit in quality, it is severely lacking in the profession and needs to be highlighted as a critical component of a dental home.
19. I am a big fan of Efficiency of Care (within reason, not at the risk of quality). By providing more efficient care a clinician is able to see a higher volume of patients and serve a bigger demographic base. Efficiency of Care may also have dramatic [impacts] on related costs, thereby allowing the opportunity for more patients to be treated with time and/or treatments. A second item I would describe as the Patient Experience. This may be a subset of Patient Centered. It's all about their perception of [the] actual experience of care. Positive experiences increase the likelihood of patient returns, compliance and improvements.
20. I would hesitate to add to this list. The definition should be as simple as possible.
21. If patient satisfaction surveys are not woven into the "Quality" characteristic previously presented, I would establish this as a characteristic
22. in the context of community
23. Oral Health education on prevention should be included in the definition.
24. possibly preventively oriented. We will never get ahead of the need if we don't focus on prevention and enable patients and families to care for their health. This is implied in other characteristics, but perhaps should be explicit.
25. Prevention focused
26. Preventive-focused: current dentistry is highly procedural disease focused treatment with payments that reward invasive care. Invasive care does not lead to long-term health and has questionable quality when repeated after failures. Emphasis should be to [maintain] the health of the mouth and patient self-management as first priority. Diagnosis with causative factors should be part of patient evaluation with goal to reduce and eliminate causative factors.
27. Should we include something along the lines of "affordability" since we want this definition to cross all types of practices.
28. The essentials are the ability to reach people (maybe this is access??), emphasize diagnosis, prevention, and early intervention, case management, and improvement in health literacy, and finally get people to advanced surgical services on occasion when [these] services are needed. Characteristics that should NOT be included are: centered in bricks and mortar location, run by the system that delivers advanced surgical services; has an emphasis on advanced surgical services.
29. Timely is a characteristic that I would include. It is appropriate across all populations and settings and can be measured.
30. You covered the high-level characteristics. The real work will come in defining what it MEANS to be Accessible, Coordinated, etc. I can't think of any other over-arching characteristics to add.

31. I do not have an additional essential characteristic, but I would like to mention that the patient-centered characteristic (and/or another characteristic?) should also address elements of health/oral health literacy.
32. Affordable
33. Attributes related to care model or care philosophy may be helpful - or is a care model assumed - Access to urgently needed / emergency dental care - Disease management / risk management care - Reliance on or coordination with medical or public health [providers] in disease management efforts. - etc. (Perhaps this is beyond the scope).
34. A patient in the patient centered dental home must have “trust” in the healthcare professional and the proposed treatment. The patient must also believe in the integrity of the system
35. Well, I mentioned Adaptable in the block on Patient Centricity. I will copy that here: I believe we all believe highly related to patient centricity. However, we most often think of this in terms of the patients needs. What about in relation to the [patients] constraints, restraints and barriers? What I am getting at is that the needs of patients in the safety net are very similar and we address those most often. In relation to the PCDH, in order to reach and bring Oral Health Care to populations who have [access] problems due to public insurance, no insurance, restrictions on travel, parental or caretaker apathy..... it may be very difficult to extend ALL of the other characteristics of the PCDH to them. This may be a case where we need to think of the PCDH having to consider the characteristic of Adaptability. Where something is better than nothing, which I don't think anyone is thinking of, or; whatever parts or characteristics of the PCDH that can be applied and adapted to the circumstances of the patient [counts]. Simply the consideration of Adaptability as a characteristic is what I am suggesting.
36. If the characteristic “quality” includes the attributes of being effective, efficient, equitable and timely to go with the already identified characteristics of “patient-centered” and “safe” then I have no other essential characteristics to add. It seems his definition is elevating safe and patient-centered to be more important aims of quality care since they will be unique characteristics and the others may be “attributes” of the characteristic of “quality”.
37. The term ‘patient-centered’ is a very broad concept which may encompass or convey certain attributes to some (e.g., compassionate care, culturally effective care) and different attributes to others. Therefore it's rather hard to determine whether [additional] essential characteristics of a PCDH need to be listed or whether the focus should first be on defining what being ‘patient-centered’ means. For example, the IOM defines patient-centered care as: “Providing care that is respectful of and responsive to [individual] patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.” Those attributes are not explicitly considered in the survey questions, other than possibly being ‘assumed’ to be embodied in the term ‘[patient]-centered care’. A somewhat related open question that needs to be considered in this work is “what constitutes primary dental care and how does it relate to what it means to be a dental home?”. A lot of work has been done to define essential elements r hallmarks of primary care in medicine; but the translation or development of a corollary for dental care has received relatively little attention. “Patient-centered Dental Home” and “Primary Care Dental Home” were occasionally used interchangeably in [earlier] stages or discussions of the work that is the focus of this project. And while medicine (or at least some parts of medicine) has ‘merged’ the primary care and patient-centered concepts into the notion of a PCMH, medicine is at a very different [place] in terms of the evolution of defining these two concepts. One could argue that ‘patient-centered’ should broadly mean the same thing regardless of whether the focus is primary medical care or dental care (and I think I'm of this persuasion). However, [several] of the questions in this survey relate (at least historically) to the concept of primary care and/or conflate the concepts of patient-centered and primary care (and the concept of a medical/ dental home).
38. I will get back on this before 2nd phase

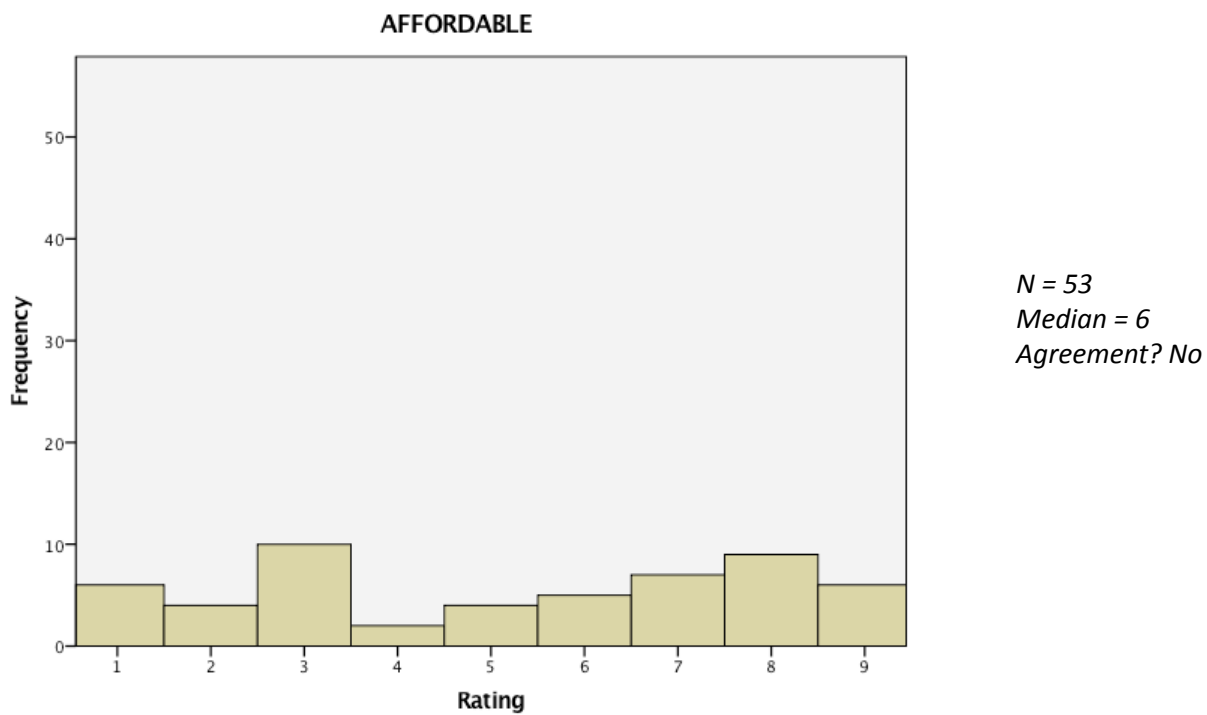
## Appendix 3

### Round 2 Survey Results

#### Quantitative Results

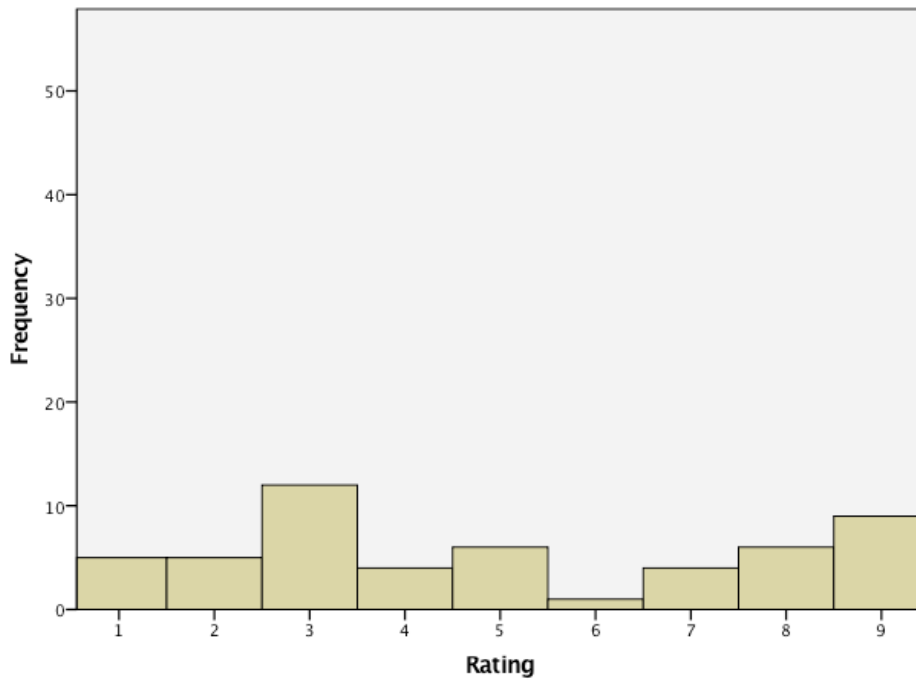
The figures below describe the quantitative results for respondents' ratings of each of the proposed additional concepts mentioned by at least three respondents in Round 1. Participants were given the following guidance regarding rating criteria:

- Rating 7-9=Essential (include in definition)
- Rating 4-6=Uncertain (needs more discussion)
- Rating 1-3=Not essential (exclude from definition)

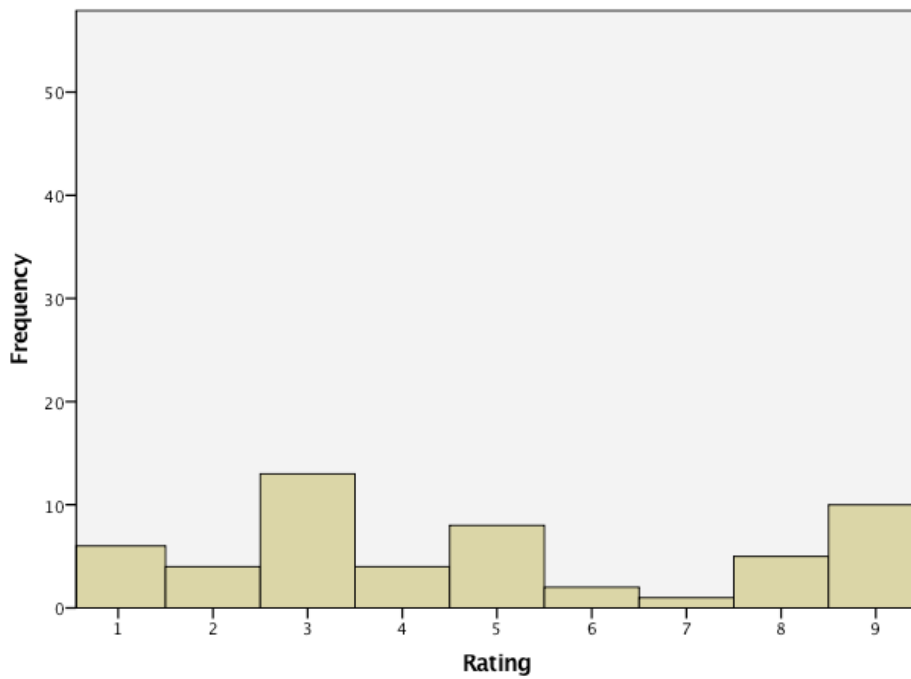




### PREVENTION-FOCUSED

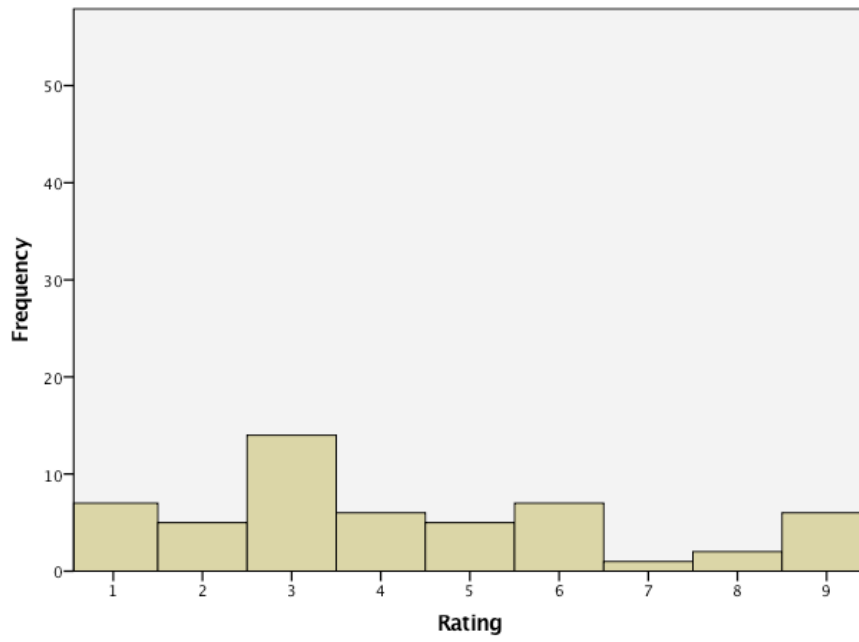


### INTEGRATED

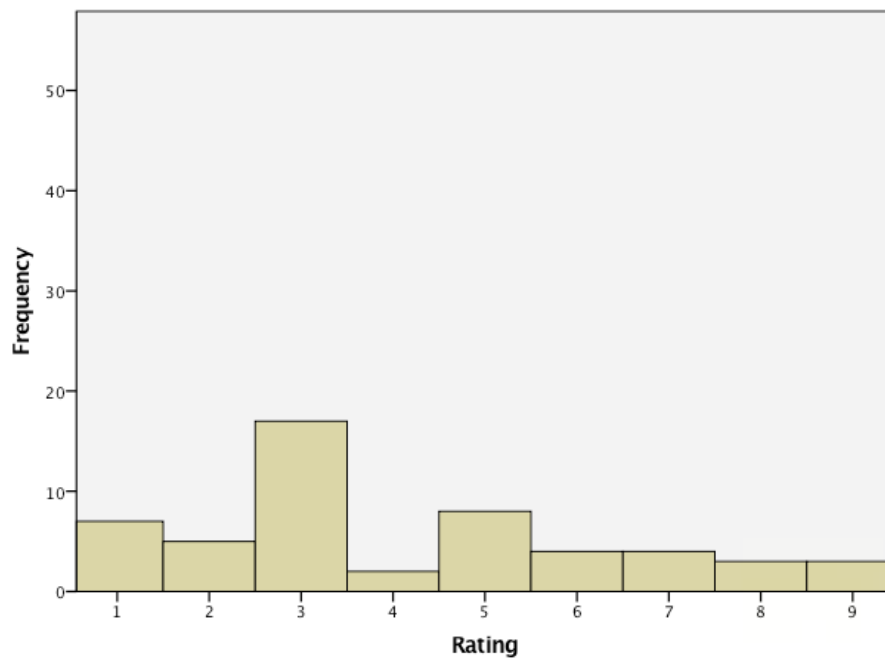


N = 53  
Median = 4  
Agreement? No

### CULTURALLY COMPETENT

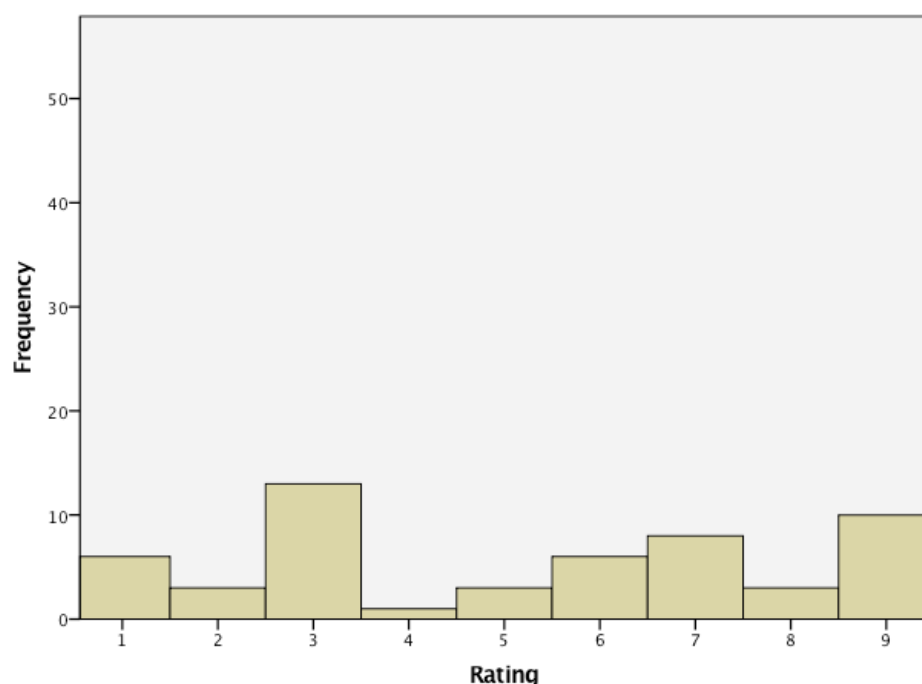


### HEALTH LITERACY-FOCUSED



N = 53  
Median = 3  
Agreement? No

## EVIDENCE-BASED



N = 53  
Median = 4  
Agreement? No

## Qualitative Results

After rating each characteristic, participants had the opportunity to provide their rationale or other feedback regarding their ratings. The tables below provide the open-ended comments related to each characteristic.

AFFORDABLE
1. While not in the description provided, affordable could be considered a component of accessible.
2. While affordability could be considered a subcomponent of accessibility I think it should stand alone so it is not missed.
3. This relates to accessibility. It is important that a [patient] centered dental home have a value, but this must not deter a [patient] from seeking care. For that reason the value(affordability) should be based on a sliding scale that allows for maximum participation [by] all involved parties. It must allow both the professional and the pt to feel they have given and received something (value) from the relationship. That value must be "accessible".
4. This may confuse the issue. Is a Medicaid practice more of a dental home than a private fee-for-service practice --- probably paradoxically the opposite in reality based on reimbursement rules/state rules? The affordability rests in the patient rather [that] the practice, I think --- coverage, [income], qualifying for different coverages, being an adult versus a child ---- all would affect as external factors, irrespective of the practice.
5. This could maybe be considered a component of the accessible characteristic, but given the current definition it does not really fit so should be separate.
6. this aspect should be rated high within the PCDH as access to the "home" is important and high costs present serious barriers; especially low income groups.
7. The issues with affordable are complex. Lack of insurance or limited benefit sets all impact affordability. How much can we make the dental home accountable? They can do things to lower costs but that isn't sufficient.
8. seems to be a component of accessible
9. part of accessible
10. may be a sub category to accessible, but is [likely] the largest factor
11. It should be a subset of accessible.
12. It is a component of accessible.
13. Include under the accessible characteristic

14. Include as a component of accessible.
15. In my opinion, this is essential because patients are unlikely to establish a dental home if the treatment is not affordable. They will continue to seek care episodic care for emergency treatment only if comprehensive care is not affordable.
16. If the PCDH is not affordable the population most in need of it will probably not be able to use it.
17. If health care is accessible, it is "affordable."
18. I would view this as being a potential component for Phase 2 (within accessible).
19. I think this is part of accessible
20. I think is a component of being "accessible"
21. I believe Affordable would be a component of the accessible characteristic.
22. I believe affordable is important though most likely subset of accessible - as in "access to care"
23. I believe affordable is a component of accessible, but not a stand alone essential characteristic.
24. For so many, the reason they are not accessing dental care is affordability. This could either be a characteristic or added to the accessible definition.
25. feel that this is a component of accessible. Difficult to define "affordable" from which perspective-patient, system delivery?
26. Due to the high level of dental un- and under-insurance, high out-of-pocket costs, and survey results citing cost as a barrier to dental care, I think this merits separate consideration in the patient-centered dental home.
27. does not fall under any other essential component
28. Care that is not affordable may cause the patient to avoid or forgo treatment.
29. Affordable is separate from accessible and doesn't fit with any of the other essential characteristics. If care is not affordable, it is deferred, and deferred care is neither accessible, comprehensive, continuous, coordinated, patient-centered, family-[centered] or quality and safety focused.
30. Affordable is an essential component of accessible.
31. affordable is a [characteristic] within accessible
32. affordable care is directly tied to access
33. affordable (if true) always important when describing any service or product
34. Affordability is part of accessibility
35. Affordability is a component of accessibility

<b>PREVENTION-FOCUSED</b>
1. While every aspect of care is important, it is critical to emphasize the necessity for prevention in the care continuum particularly when considering populations of patients.
2. This is more important than Comprehensive. Should include primary and secondary prevention
3. The falls under the characteristic of comprehensive
4. Since prevention is one of the nation's 6 priorities for quality health care, it would be tough to leave it out.
5. Since prevention and wellness are included in the comprehensive definition, believe this may be covered.
6. Primary care should be preventive
7. Prevention-focused is very important though I would place as component of either Comprehensive or potentially Patient-centered
8. Prevention-focused is a component of comprehensive care.
9. Prevention-focused is implicit in comprehensive, quality-focused
10. Prevention is included under comprehensive and continuous.
11. Prevention is already included in the description of the comprehensive characteristic.
12. Prevention is a key factor in any Dr/ Pt relationship and would seem to be an essential component of a PCDH. If there is no component for prevention a PCDH will inevitably fail, much as the current [Medicaid] program today flounders. This must be an integral part of all [patient] treatment. Can a strong enough argument be made that this is part of "comprehensive care" or does it stand alone?
13. Prevention focused is included in comprehensive and continuous care

14. Prevention could be considered part of Comprehensive, but having it as a separate characteristic adds greater emphasis to preventive services.
15. part of comprehensive
16. It is imbedded in comprehensive, continuous, and quality-focused.
17. It is certainly a gold- standard of our profession, and should be ( as probably is ) a main area in any dental curriculum, but is there a need to state the obvious? I think it is a component of “ comprehensive.”
18. Include under comprehensive characteristic
19. Include as a component of comprehensive
20. In my opinion, prevention-focused would be included in the definition under the term “quality-focused.” A quality-focused dental practice would include updated best practices for preventive oral health techniques.
21. I’d capture this under quality, comprehensiveness or access.
22. I would view this as being a potential component for Phase 2 (within comprehensive).
23. I think this is part of comprehensive
24. I feel this is essential, but could potentially be put as a component of quality and safety.
25. I feel more a component of comprehensive
26. I do think that this should be a component of the “comprehensive” and “quality-focused” characteristics.
27. I believe prevention-focused is a component of the quality (or maybe even safety) characteristic.
28. For patients at some stages in their care, prevention is not essential, unless you consider tertiary prevention. As care MUST be comprehensive, prevention first within the definition, as a component of Comprehensive care.
29. element of comprehensive
30. contained within comprehensive
31. Can be included in comprehensive
32. Absolutely important and essential to both maintain dental health and reduce future risks of dental disease expected in a “health home” definition.
33. A patient center health home is meaningless without PREVENTION!
34. A component of comprehensive and /or patient centered

<b>INTEGRATED</b>
1. Would be difficult to define “integrated” to be truly distinct from “coordinated”
2. While integration with medical care is a worthy goal, it is largely unworkable for most dental practices.
3. very similar to coordinated. Integrated into what?
4. To me integrated means something is an “integral part of” something. I don’t think that’s necessary as long as care is “coordinated” across all elements of the health care system.
5. This would seem to be part of any comprehensive program, therefore already defined. An integrated program means to me multi-level participation by a coordinated group of healthcare professionals. This should certainly be part of any PCDH but the parameter should further be discussed by the group.
6. This should be a component of the “coordinated” characteristic.
7. This is more of a component of coordinated or comprehensive.
8. This is analogous to coordinated but goes one step further by implying the patient-centered dental home is not a stand alone that works with other health components internally and externally but is an embedded part of the health care system.
9. There is overwhelming evidence that dental benefits administered by medical plans or physician groups as part of an “integrated program” are treated as ancillary services outside of their core competency. Dollars appropriated for dental care risk being [diverted] into medical cost categories, such as hospital care and pharmacy services. If medical plans or physician groups are permitted to manage the dental benefits of enrollees or serve as a dental home under an “integrated plan,” efforts to increase [the] effectiveness of any financial commitment to dental services will be diluted.

10. The PCDM needs to be integrated with the PCMH to maximize coordinated care. This might be included in the coordinated section of the definitions; however, there is no specific mention of primary care included in the “broader health care system”). [Perhaps] this is due to the fact the definitions were taken from AHRQ’s PCMH definition.
11. The level of “essential” that this characteristic represents is critically related to how you define Integrated. there are multiple layers and levels of integration and it is not clear here, what your definition is. I believe, based upon experience, and the Integrating Oral Health and Primary Care efforts that I’ve been engaged with that Integration with a Patient Center Health/Wellness Home is critical for achieving overall health.
12. system integration can be achieved in a lot of ways
13. Not sure what that means? Medical-dental, dental within comprehensive dental, dental within the dental health system????:
14. My sense is that the term “integrated” refers to the integration of dental services with other health care services. I think the term “integrated” is already included in the definition under the categories of “comprehensive” and “coordinated.” Thus, [including] “integrated” in the definition is not necessary.
15. might go under coordinated
16. may be sufficiently addressed under comprehensive and coordinated concepts
17. It isn’t really clear what you mean by Integrated. Integrated may be a component of continuous or coordinated. Thus, it isn’t clear what is intended by Integrated. Also, it lacks the imperativeness of the items in the current definition.
18. It is an nice ideal but not a distinct characteristic. It is already dealt with in comprehensive and coordinated characteristics.
19. Is already embedded in the following characteristics: Comprehensive Coordinated Continuous
20. integrated see as a component of coordinated
21. Integrated is part of Coordinated
22. integrated is part of continuous and coordinated
23. Integrated is included under the coordinated component. You may want to consider changing the term ‘coordinated’ to ‘integrated’.
24. Integrated is a stronger statement of overall health
25. Integrated could be included with comprehensive, which promotes the inclusion of oral health into a model that utilizes a team approach to care.
26. Integrated care is a distinct and valuable characteristic of an ideal PCDH.
27. Include as a component of coordinated.
28. If the dental home is comprehensive, continuous, and coordinated, it will be “integrated.”
29. I would view this as being a potential component for Phase 2 (within coordinated). Not all systems offer integrated care, but many may offer coordinated care.
30. I view integrated within comprehensive and not necessarily even a component but already within the broad definition of comprehensive
31. I think this is the most difficult characteristic to achieve in a PC setting ( I have tried twice and it is almost impossible with the current payment system and the current medical culture). Thus I think that for it to happen it needs to be mandated, [enforced], and paid- for. Also all team members need to be made aware of what it entails to really integrate it. It is a main characteristic to be considered for inclusion in the definition.
32. I think this is a key part of coordinated and should be explicit in the definition of coordinated
33. I think this is a component of Comprehensive care
34. Highly relevant as the dental profession alone cannot assure PCDH; particularly in health education and prevention. This must be wide and cross professions to reach as many individuals as possible and in differing environments.
35. covered by comprehensive
36. can be included in coordinated
37. A patient-centered dental home must not exist in a vacuum, but rather is integrated with all other health care families receive. I would argue to remove “coordinated” and use integrated instead.
38. a component of comprehensive or coordinated.

CULTURALLY-COMPETENT	
1.	While extremely important, this characteristic is listed as a component of patient/family-centered care.
2.	To appropriately address the health care needs of all segments of a community, cultural competency is a necessity. Which term should be used (cultural competency, cultural sensitivity, cultural awareness, or another) can certainly be debated. This could be specifically added to the patient/family centered definition.
3.	This should be a component in patient/family centered.
4.	This may be defined or incorporated in a variety of ways- until a method is established to assure consistency of intent, it should not be considered a primary characteristic
5.	This is part of accessible and patient centered and should be explicitly stated in the definition of patient centered
6.	This is imbedded in patient- and family-centered.
7.	This is an aspect of patient-centeredness.
8.	This is already dealt with in the patient/family centered characteristic.
9.	This feels like a component of the person- and family-centered characteristics.
10.	This could either be a component of patient centered or family oriented
11.	Patient and family centered inherently respects the individual and family heritage, and is therefore culturally competent.
12.	part of patient centered
13.	not important in my opinion
14.	Not feeling that culturally-competent is deserving of [recognition]
15.	may be a sub category though of high quality
16.	Lacking this would prohibit the PCDH from being effective.
17.	Included under accessible characteristic
18.	Include as a component of patient/family centered characteristic.
19.	I would view this as being a potential component for Phase 2.
20.	I would hope that is included in the other factors, but this bears discussing
21.	I would argue that culturally competent is included in patient/family centered. One other note.. it is redundant to say "patient-centered" in the definition of patient-centered dental home.
22.	I think this can be a component of patient and family centered care.
23.	I think it is an obvious component of accessible and patient- centered
24.	I believe this is part of patient centered.
25.	I believe this is a component of patient-centered or family-centered.
26.	I believe that this would fall under other existing characteristics. NOTE: in no way does it's placement within another characteristic diminish the importance of this element
27.	Culturally-competent is of great importance to health care. This characteristic should be incorporated under 'patient/family-centered'; however, it is clear that all providers do not take cultural-competency into consideration when providing care. It [should] be emphasized in the description.
28.	Culturally-competent is a component of patient- and family-centered care.
29.	Culturally competent oral health care is important. I believe that consideration of inclusion of the term in the definition warrants more discussion. It could be that some of the current essential characteristics already cover cultural competence.
30.	Culturally competent could be part of Patient-centered or Family-centered since it is the patient's or family's cultural considerations that presumably are relevant.
31.	cultural competency should be addressed under patient-focused
32.	Cultural competency is a component of Patient and family centered care.
33.	Could be part of patient-centered, as one's culture is encompassed in what one is.
34.	Component of Pt. Centered
35.	component of family-centered/patient centered
36.	close to patient and family centered



37. can be included in patient-centered
38. Also a national quality priority for health care; also has some core measures applicable based on legislation and federal rules that could be used to rate “the home”.
39. Again, there must be an awareness of cultural back grounds and possibly a training component to respect the cultural needs and mores of those being treated, but there needs to be further discussion to get it “right” for all involved. Do the terms “family centered”, or “patient-centered” already encompass this concept or is this important enough to stand alone? Suggest further discussion by the group.
40. a component of patient centered
41. “Understanding and respecting each patient’s culture” is clearly a component of Patient/Family Centered

<b>HEALTH LITERACY-FOCUSED</b>
1. would be an element of family and patient focused
2. While I agree with the principal - the patients have to understand how to manage their health, I don’t think health-literacy focus is the right way to get to that.
3. This should also be a component under patient/family centered rather than a characteristic.
4. This item is included under patient/family-centered. While very important, the focus is addressed in another characteristic within a context of patient-centered care.
5. The Patient/Family Centered definition (especially “understanding and respecting each patient’s unique needs”) implies that it encompasses Health Literacy
6. The patient (population) must be an equal partner in the PCDH and literacy is critical for this to occur.
7. Same as previous
8. Part of patient centered and accessible
9. part of accessible and patient-focused
10. part of a number of essential characteristics
11. Not sure whether “patient-centered” and “quality-focused” characteristics capture this idea fully. Think it merits further discussion.
12. Not sure I would include this as a separate element, as it is probably included or could be included in [culturally] competent characteristic.
13. not needed in the definition
14. It is imbedded in multiple existing terms.
15. Included under comprehensive, coordinated, continuous- patient centeredness
16. Include as a component in patient/family centered characteristic.
17. important though I may eventually place as component of comprehensive, though may deserve its’ own characteristic ranking. Will be curious to see the vote on this one.
18. If not implied, could be specifically added to the patient/family centered definition.
19. I’d include this as a component of “prevention focused” with the definition of prevention meaning that it is essential that people need to have support to understand how to care for themselves. - health literacy is a part of this.
20. I would view this as being a potential component for Phase 2.
21. I think this is a component of “comprehensive”
22. I suggest we expand the quality and safety description to include a reference to health literacy. Health literacy is important but we need a lot more science to support how best to achieve improved health literacy.
23. I guess the rationale for this would be the same as the preventive orientation and serves to highlight the need to focus on this element.
24. I believe that this would fall under other existing characteristics. NOTE: in no way does it’s placement within another characteristic diminish the importance of this element
25. Health literacy is THE KEY COMPONENT of ALL health care!!!! This is the most critical paradigm that needs to be addressed.
26. Health literacy is part of patient and family centered care.

27. Health literacy is essential to health care. May want to consider an essential element as ‘Cultural/Health Literacy Competent”
28. Health literacy is a part of Accessible and/or Patient-centered
29. Component of Pt centric
30. Component of patient- and family-centered.
31. can be included in patient -centered
32. Again, this warrants discussion because the characteristic of “health literacy-focused is important, but in my mind it may already be included in the definition under the “patient-centered” characteristic. It would seem that a patient-centered approach [would] take into account the health literacy level of an individual patient and/or caregiver of the patient.
33. Again, I think it is a component of accessible and patient-centered.
34. again part of patient-focused.
35. addressed under patient focused
36. a component of patient centered or comprehensive
37. Does this fall under “comprehensive”? Health [Literacy] must be a standard in any healthcare organization and it is of high probability that many of those being treated by a PCDH would have lower healthcare literacy. Therefore an educational component [becomes] a key element in the prevention of disease. If this concept is to be successful we must educate from the first encounter and continue to do so through out treatment and beyond, but is this not part of “comprehensive care”? Possible further discussion.

<b>EVIDENCE-BASED</b>
1. Today, all treatment must be evidence based. It has become an essential concept of all healthcare.
2. To some extent is part of quality and safety focused, but could be separate
3. This would be a strong consideration, but evidence-based applications are still relatively few in dentistry.
4. This is part of the Quality/Safety Focused characteristic.
5. This is one of those words/phrases that often creep into lists of characteristics along the lines of “appropriate” or other words meaning “do it correctly” Should be understood or called out in a preamble
6. This is already addressed in the quality/safety characteristic.
7. This is a component of quality-focused.
8. This is a component of quality
9. this could take the place of several of [the] existing descriptors such as comprehensive, continuous,
10. The current definition for “quality-focused” explicitly includes evidence-based practice.
11. so little in dentistry is evidence-based that including it in this definition may make nowhere a dental home
12. should be a component of “quality-focused”
13. Related to Quality
14. Quality-focused and safety-focused are components of an evidenced-base dental home.
15. not all services are or will be evidence based to limiting
16. needs more discussion
17. My view is similar to the Health Literacy-Focused, may deserve its’ own ranking as a characteristic but I am not convinced.
18. May be part of quality focused but could be separate
19. [Include] as a component of quality and safety characteristic.
20. Inherent in a patient centered definition of care
21. In my mind, the characteristic of “quality-focused” covers the characteristic of “evidence-based.” Quality care is founded on the principles of using evidence-based treatment.
22. Imbedded in quality-focused and safety-focused
23. If we are going to support dental homes, they must be evidence-based. Otherwise, why waste the patients’ time, and the health care system money to have people visit a dental office for care that is not steeped in science and evidence?

24. I think this is challenging since we have a long way to go before dental practice has evidence for all necessary interventions and therapies. but as an aspirational element, I think it is worthwhile. This may easily fall under Quality- focused.
25. I think this is a component of "Quality"
26. I think evidenced-based is really important, however, either quality-focused may encompass this, or evidenced-based might be the definitional title and quality-focused be a component of it. It is hard to get too many topics as the critical component [of] the definition.
27. I feel this is an essential piece, but it could potentially be put under quality and safety as a component.
28. fits under quality. I'm not clear on what components of dental care have strong evidence basis.
29. Evidence-based is a part of Quality-focused
30. Evidence-based care is an essential component of the PCMH Model of Care that should be applied to dental care. It is distinct from Quality and Safety.
31. Believe this is covered in "focused on quality and safety" definition.
32. As a stand alone, I would not include it as there is limited evidence for most of what we do, my specialty being the poster child with essentially nothing based on strong evidence! On the other hand, what really needs to be included is continuous quality [improvement] --- using systematic analysis of treatment and prevention to improve care. It is already a part of medical care and has been for two decades. We are way behind on the EBD-CQI continuum, so I'd like us to consider this as a characteristic.
33. Albeit it also is a gold standard for our profession, it is hard to achieve across all providers, and perhaps to emphasize and make it mandated and enforced, it needs to be within the main definition... Perhaps more discussion about this is needed!
34. a component of quality focused, safe or patient centered