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RESEARCH REPORT

PCDH PROJECT, PHASE 3: PRACTICE- AND SYSTEM-LEVEL MEASURE CONCEPTS SURVEY, RESULTS, AND MODIFICATIONS

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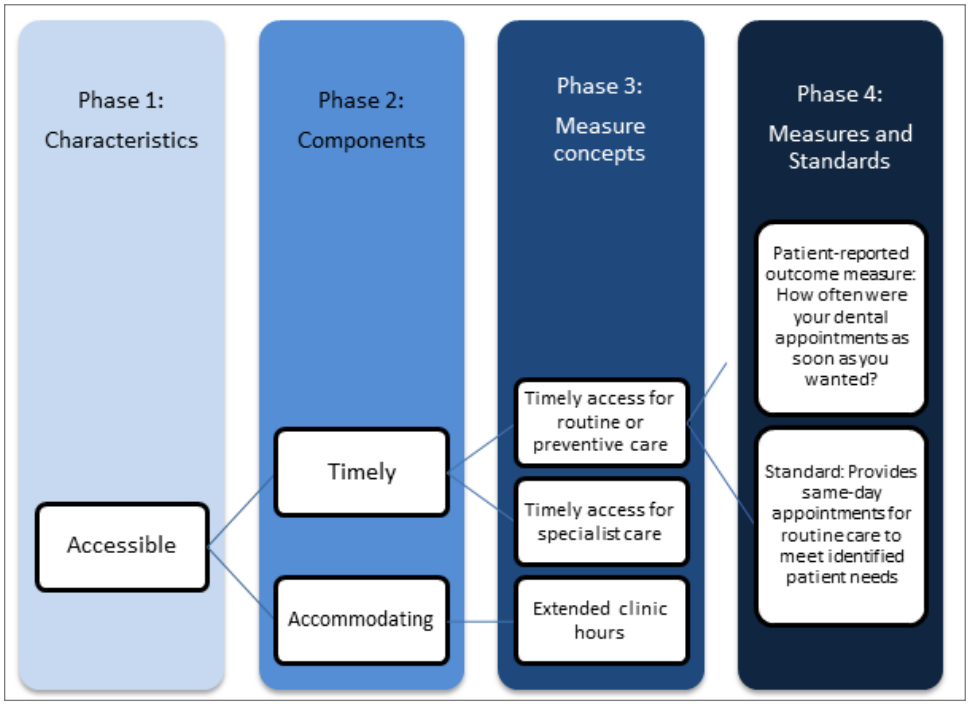
BACKGROUND

The goal of the Patient-Centered Dental Home (PCDH) project is to develop a standardized model of care that complements and integrates with the patient-centered medical home. The model is being developed in four phases, using a consensus-based process with a National Advisory Committee (NAC), that began with identifying the essential characteristics of a PCDH and will culminate in a measurement framework to assess and improve PCDH quality across different care settings. Figure 1 illustrates the framework.

Figure 1. PCDH 4-level framework with an example of the accessible characteristic



Phase 1 resulted in the following, consensus-built definition of a PCDH: *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 as an integrated part of a health home for people throughout the life span.*

In Phase 2, the NAC identified the components that fit within each PCDH characteristic.

In Phase 3, the NAC began by rating measure concepts that reflect potential measures to be nested under each component. During the Fall 2019, the NAC rated 62 measure concepts applicable at the *practice/clinic* level. A report describing the methods and results of these ratings is available here.

This report presents the results of ratings for 13 additional practice-level measure concepts that were identified through the prior Phase 3 round as well as 3 proposed system-level measure concepts.

SURVEY METHODS

To prepare for the Phase 3 survey with NAC members to identify measure concepts, the research team:

1. Compiled a list of over 500 measures and standards through an environmental scan of:
   - measures derived from the Dental Quality Alliance (DQA) and National Quality Forum (NQF) environmental scans and websites,
   - standards from major accrediting organizations (e.g., AAAHC and NCQA),
   - a review of literature published after 2012 (e.g., PubMed, online search of grey literature), and
   - an online search of measures used by organizations known to be involved in dental quality measurement (e.g., ACOs, Medicaid programs, practices, third-party payers).
2. Evaluated all identified measures and standards to identify a preliminary list for NAC review. Criteria used for the internal evaluation included: importance, feasibility, validity, reporting burden, duplication/overlap, and measures versus standards. Measures were given higher priority due to reporting consistency and ability to monitor improvement over time.

PHASE 3: DELPHI SURVEY ROUND 1

The first survey in Phase 3 asked the NAC to rate how important each of 62 proposed measure concepts were to the PCDH model on a scale of 1-9. *A priori*, it was determined that concepts with median ratings of 7-9 "without disagreement" would be included in the final PCDH model. 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).[1] A rating is classified as "with disagreement" if IPR>IPRAS. Additionally, participants were asked to provide open-ended comments related to the concepts, as well as suggest additional concepts for consideration. Comments generally (1) provided rationale for numerical rating, (2) identified a concern or suggested a change to the concept, or (3) suggested new concepts. **All 62 measure concepts met the quantitative criteria for inclusion in the PCDH model (Appendix 1).**

PHASE 3: DELPHI SURVEY ROUND 2

Based on a review of the comments provided on the first measure concept survey, 13 additional practice-level concepts were identified and included in a follow-up survey. In addition, the follow-up survey included 3 measure concepts identified as applicable only at the system level. The same methods used for the Round 1 survey were used to rate these 16 additional measure concepts. Each concept was rated on a scale of 1-9, and those with median ratings in the range of 7–9 without disagreement would be included in the PCDH model. **Table 1** includes all 78 measure concepts, with the 16 new concepts rated in Round 2 indicated in red font. Other changes made to the framework based on prior NAC feedback and additional evaluation by the research team are also noted.

1 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. PCDH Measure Concepts: New Concepts (n=16) for Round 2 Rating and Modifications Made BEFORE Round 2 Rating (indicated in red font)*

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
ACCESSIBLE	
Accommodating	
Extended clinic hours	No change
User-friendly system for patient requests (e.g., appointment making, prescription refills)	No change
Affordable	
Engages with patients regarding cost implications of treatment options	NEW FOR ROUND 2 RATING – Practice-level concept parallel to PCMH
Timely	
Timely access for emergency care	No change
Timely access for routine/preventive care	NEW FOR ROUND 2 RATING – replaced the concept of "appointment availability for routine care" to capture broader concept of timely access for routine/preventive care
Timely access for specialist care	NEW FOR ROUND 2 RATING – added to distinguish timely specialty care from routine/preventive care
Adequate provider network (SYSTEM-LEVEL ONLY)	
Dentist availability/workforce supply (e.g., dentist-to-population ratios, travel time and distance, ease of finding a dentist)	NEW FOR ROUND 2 RATING - System-level concept; includes geographic accessibility
COMPREHENSIVE	
Prevention and wellness focused	
Dental/medical history completeness	No change
~~HPV education and vaccination referral~~	REMOVED as a distinct concept. This concept was identified during the Phase 3, Round 1 Delphi survey as a potential measure concept. It is encompassed within another new concept: "Screening for comorbid conditions."
Oral health education provision	No change
Risk assessment/documentation	No change
Risk-based treatment planning	No change
Screening for comorbid conditions (e.g., hypertension, diabetes, HPV vaccination)	NEW FOR ROUND 2 RATING – collectively capture NAC members' recommendations for medical condition screenings
Sealant provision	No change
Tobacco use screening and cessation counseling provision	No change
Topical fluoride application	No change

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
~~Team-based~~	REMOVED team-based as a separate component. Based on a review of previous comments by the NAC as well as a lack of well-defined measures, this component was removed. In prior Delphi surveys, when commenting on team-based care, the NAC noted the importance of having coordination and communication between care team providers and also the importance of inter-professionalism. These concepts are encompassed in the coordinated component, which includes the concepts of effective communication between generalists and specialists and concepts of dental-medical coordination.
COORDINATED	
Appropriate referrals	
Effective communication between generalists and specialists	No change
Referral for comorbid medical conditions (e.g., hypertension, diabetes, obesity)	NEW FOR ROUND 2 RATING – collectively capture NAC members' recommendations for referrals to medical providers for comorbid conditions
Referral monitoring	No change
Use of clinical protocols for referral determination	No change
Community-connected	
~~Assessment of community resources necessary to support oral health care needs~~	Was identified during prior Delphi survey as a potential measure concept. Necessary precursor to "effective communication connecting patients with community supports" but does not require a distinct concept.
Effective communication connecting patients with community supports	No change
Dental-medical coordination	
Effective communication between dental and medical providers	No change
Coordinated dental-medical patient records **SYSTEM LEVEL**	NEW FOR ROUND 2 RATING – NAC members' recommendations. This is a system-level concept because it requires coordination at the broader system level.
Dental to medical referrals (e.g., referral for comorbid medical conditions)	NEW FOR ROUND 2 RATING – collectively capture NAC members' recommendations for referrals to medical providers for comorbid conditions
Medical to dental referrals (e.g., follow-up oral evaluation after medical visit for high-risk populations, follow-up care after ED visit or medical well child visit) **SYSTEM-LEVEL**	NEW FOR ROUND 2 RATING – Captures referrals from medical providers to dental providers. This is a system-level concept because this requires establishing referral relationships and processes with other system participants.
~~Follow-up oral evaluation after medical well-child visit~~	REMOVED as a distinct concept; instead captured in the broader concept of "Medical to dental referrals"
Population health oriented	
Identifies and addresses population-level health concerns based on the diversity of the practice and the community	No change
Proactively identifies populations of patients and educates them about needed care	No change
CONTINUOUS	
Follow up on needed care	
Treatment plan completion	No change

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
~~Follow-up care after ED dental visit~~	REMOVED as distinct concepts. Captured in the broader concept of "Medical to dental referrals" which clarifies the need for connection to a dental provider rather than suggesting that every medical visit be followed up by a dental visit.
~~Follow-up oral evaluation after medical visit for pregnant women~~	
~~Follow-up oral evaluation after medical visit for patients with diabetes~~	
~~Follow-up oral evaluation after medical visit for patients in long-term care~~	
Usual source of care	
Care continuity (e.g., recall exam completion in consecutive years)	No change
Care provided by dental practice or clinical entity of record	No change
PATIENT- AND FAMILY-CENTERED	
Cultural competence	
Accommodating of patient preferences (e.g., cultural, patient comfort)	No change
Assesses and addresses the language needs of patients	No change
Provider training in cultural competency	NEW FOR ROUND 2 RATING – NAC member recommendation
Effective communication with patients	
Provider communication about treatment	No change
Provider conveys respect for patients	No change
Provider listening	No change
Equitable care	
Assesses and addresses access and care disparities	No change
Individualized care	
Care recommendations based on patient level of risk for oral disease	No change
Patient self-management/self-care	NEW FOR ROUND 2 RATING – NAC members' recommendations; database review
Shared decision making	
Informed patient engagement in decision making	No change
Sensitive to health literacy	
Patient communications appropriate to patient population needs and understandability	No change
QUALITY- AND SAFETY-FOCUSED	
Evidence-based care	
~~Follow-up oral evaluation after medical well-child visit~~	REMOVED as a distinct concept. Captured in the broader concept of "Medical to dental referrals."
Guideline/risk-based radiograph use	No change
Ongoing care in adults with periodontitis	No change
Risk assessment/documentation	No change
Sealants for 6-9 year old children at elevated caries risk	No change
Sealants for 10-14 year old children at elevated caries risk	No change
Topical fluoride for adults at elevated caries risk	No change
Topical fluoride for children at elevated caries risk	No change
Clinical outcomes	

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
Caries experience	No change
Caries at recall	No change
Complications following extraction	No change
Periodontal disease status and improvement	NEW FOR ROUND 2 RATING – NAC members' recommendations
Risk status improvement	No change
Sealant retention	No change
Tooth loss/retention	No change
Treatment under general anesthesia	NEW FOR ROUND 2 RATING – NAC member recommendation and database review
Untreated caries	No change
Continuous quality improvement processes	
~~Quality improvement plan~~	REMOVED as a distinct concept. Encompassed within the concept "Performance assessment and improvement"
Performance assessment and improvement	NEW FOR ROUND 2 RATING – Replaces "Assessment of performance on quality improvement plan" with the broader concept of performance assessment and improvement.
Patient-reported outcomes and patient experience indicators	
Oral pain or discomfort	No change
Satisfaction with dental care	No change
Satisfaction with dental team	No change
Satisfaction with dentist	No change
Satisfaction with dentist communication	No change
Satisfaction with timeliness of needed dental care	No change
Recommendation to family and friends	No change
Satisfaction with aesthetics/appearance	NEW FOR ROUND 2 RATING – NAC member recommendation; aligned with increasing emphasis on patient-reported outcomes
Satisfaction with function	NEW FOR ROUND 2 RATING – NAC member recommendation; aligned with increasing emphasis on patient-reported outcomes
Satisfaction with psychosocial impacts of oral health (e.g., self-confidence, impact on work/social activities)	NEW FOR ROUND 2 RATING – Added to include the 4 major domains of the OHIP1
Minimizes adverse events	
Judicious opioid prescribing	No change
Post-operative infection following dental treatment	No change

Note: Modifications that are in addition to the new measure concepts being rated reflect changes from Table 1 in the Phase 3, Round 1 Delphi survey (available here) made during the process of developing the Phase 3, Round 2 Delphi survey.

1Naik A, John MT, Kohli N, Self K, Flynn P. Validation of the English-language version of 5-item Oral Health Impact Profile. J Prosthodont Res. 2016 Apr;60(2):85-91.

SURVEY RESULTS

A total of 41 out of 45 (91%) members participated,[2] with many providing open-ended comments. These comments were taken into consideration and resulted in modifications to the proposed measure concepts.

QUANTITATIVE RESULTS

15 of the 16 new measure concepts met the quantitative criteria for inclusion in the PCDH model (Appendix 1), bringing the total number of included measure concepts to 77. The one concept that did not meet the quantitative criteria was "treatment under general anesthesia," which had a median rating of 6. Written comments regarding this measure expressed concerns about: reliable measurement due to a range of measurement challenges, difficulties in interpretation, and which entities within the health care system should be accountable for performance and improvement. **Appendix 2** lists all of the rated measure concepts from the highest to lowest percentage of NAC members who rated the concepts as "very important."

QUALITATIVE RESULTS

The research team reviewed and discussed the NAC members' comments, which are contained in **Appendix 3**. Based on this feedback and subsequent reviews of the overall framework, the research team made modifications to the framework to improve clarity, address identified gaps, and reduce redundancy.

Table 2 summarizes additional changes in the measure concepts **after** the Round 2 Delphi survey. These changes were made based the NAC quantitative ratings, qualitative open-ended comments, and careful subsequent review by the research team.

Figure 2 provides the complete framework to date, reflecting the PCDH characteristics, components, and measure concepts.

2 Since the beginning of the PCDH framework development, there has been some attrition of NAC members.

NEXT STEPS

From the PCDH measurement framework, we will distill the hundreds of existing quality measures into smaller core measure sets, both at the practice and the system level. We will gather input from stakeholders regarding their current use of oral health measures and obtain feedback about how the PCDH could be helpful to their quality improvement efforts. We will then identify priority measures and measurement sets feasible for near-term implementation at the practice and system levels. Finally, we will collaborate with dental quality measurement stakeholders to develop a roadmap for PCDH implementation.

Table 2. PCDH Measure Concepts: Additional Refinements Made AFTER Phase 3 Round 2 Ratings (indicated in red font)*

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
ACCESSIBLE	
Accommodating	
Extended clinic hours	No change
User-friendly system for patient requests (e.g., appointment making, prescription refills)	No change
Affordable - SYSTEM level	
~~Engages with patients regarding cost implications of treatment options~~	REMOVED as a distinct concept. Although this concept met the quantitative criteria for inclusion, open-ended comments revealed that many NAC members felt this concept was a poor indicator of affordability. Affordability was also determined to fit better with the SYSTEM-level indicators. The AFFORDABLE component will be specifically reviewed with the NAC to identify concepts appropriate for inclusion in the PCDH framework.
Timely	
Timely access for emergency care	No change
Timely access for routine/preventive care	Retained based on Phase 3, Round 2 ratings
Timely access for specialist care - **SYSTEM LEVEL**	Retained based on Phase 3, Round 2 ratings; Re-classified as SYSTEM-LEVEL only concept – difficulty accessing specialty care often due to broader system issues
Adequate provider network (SYSTEM-LEVEL ONLY)	
Dentist availability/workforce supply (e.g., dentist-to-population ratios, travel time and distance, ease of finding a dentist)	Retained based on Phase 3, Round 2 ratings
COMPREHENSIVE	
Prevention and wellness focused	
Dental/medical history completeness	No change
Oral health education provision	No change
Risk assessment/documentation	No change
Risk-based treatment planning	No change
Screening for comorbid conditions (e.g., hypertension, diabetes)	Retained based on Phase 3, Round 2 ratings
Sealant ~~provision~~ for children	Edited to align with similar concept under evidence-based care
Tobacco use screening and cessation counseling provision	No change
Topical fluoride ~~application~~	Edited to align with similar concept under evidence-based care
COORDINATED	
Appropriate referrals	
Effective communication and monitoring regarding referrals between generalists and specialists	Edited to reflect referrals as part of effective communication rather than as separate concepts
Referral for comorbid medical conditions (e.g., hypertension, diabetes, obesity)	Retained based on Phase 3, Round 2 ratings

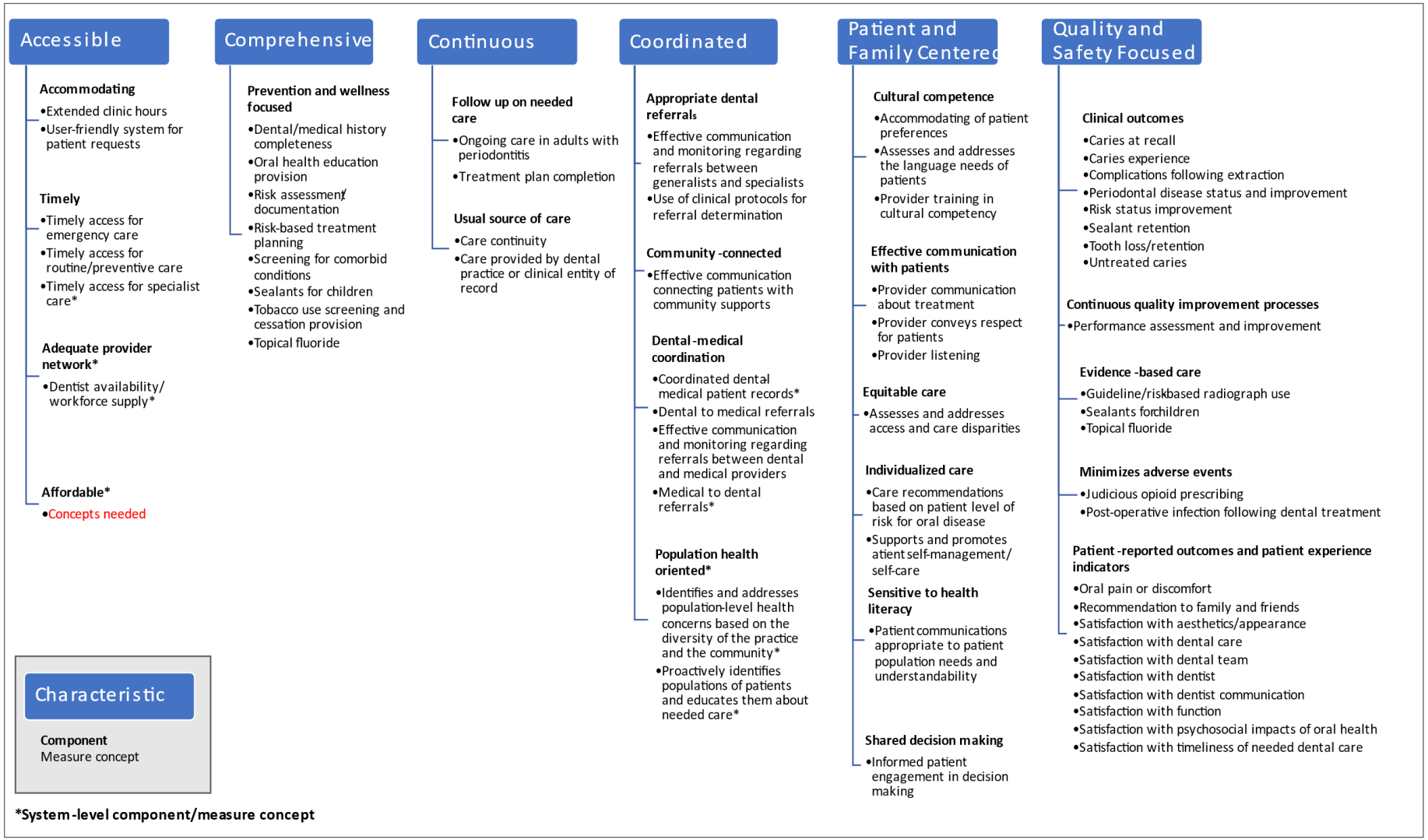
CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
~~Referral monitoring~~	REMOVED as a distinct concept. Integrated with "effective communication between generalists and specialists and "effective communication between dental and medical providers" to reflect referrals as part of effective communication.
Use of clinical protocols for referral determination	No change
Community-connected	
Effective communication connecting patients with community supports	No change
Dental-medical coordination	
Effective communication and monitoring regarding referrals between dental and medical providers	Edited to reflect referrals as part of effective communication rather than as separate concepts
Coordinated dental-medical patient records **SYSTEM LEVEL**	Retained based on Phase 3, Round 2 ratings
Dental to medical referrals (e.g., referral for comorbid medical conditions)	Retained based on Phase 3, Round 2 ratings
Medical to dental referrals (e.g., follow-up oral evaluation after medical visit for high-risk populations, follow-up care after ED visit or medical well child visit) **SYSTEM LEVEL**	Retained based on Phase 3, Round 2 ratings.
Population health oriented – SYSTEM LEVEL	Re-classified component and concepts as SYSTEM-LEVEL only - population health is broader than an individual practice
Identifies and addresses population-level health concerns based on the diversity of the practice and the community - **SYSTEM LEVEL**	Re-classified component and concepts as SYSTEM-LEVEL only - population health is broader than an individual practice
Proactively identifies populations of patients and educates them about needed care - **SYSTEM LEVEL**	Re-classified component and concepts as SYSTEM-LEVEL only - population health is broader than an individual practice
CONTINUOUS	
Follow up on needed care	
Ongoing care in adults with periodontitis	Moved from the component "evidence-based care" to the component "follow up on needed care"
Treatment plan completion	No change
Usual source of care	
Care continuity (e.g., recall exam completion in consecutive years)	No change
Care provided by dental practice or clinical entity of record	No change
PATIENT- AND FAMILY-CENTERED	
Cultural competence	
Accommodating of patient preferences (e.g., cultural, patient comfort)	No change
Assesses and addresses the language needs of patients	No change
Provider training in cultural competency	Retained based on Phase 3, Round 2 ratings
Effective communication with patients	
Provider communication about treatment	No change
Provider conveys respect for patients	No change
Provider listening	No change
Equitable care	
Assesses and addresses access and care disparities	No change

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
Individualized care	
Care recommendations based on patient level of risk for oral disease	No change
Supports and promotes patient self-management/self-care	Retained based on Phase 3, Round 2 ratings Added "supports and promotes" to more clearly reflect facilitating role of provider
Shared decision making	
Informed patient engagement in decision making	No change
Sensitive to health literacy	
Patient communications appropriate to patient population needs and understandability	No change
QUALITY- AND SAFETY-FOCUSED	
Evidence-based care	
Guideline/risk-based radiograph use	No change
Ongoing care in adults with periodontitis	No change
Risk assessment/documentation	No change
Sealants for children	REPLACES "Sealants for 6-9 year old children at elevated caries risk" and "Sealants for 10-14 year old children at elevated caries risk"; make measure concept broader with specificity contained within the measures
~~Sealants for 6-9 year old children at elevated caries risk~~	REMOVED as a distinct concept; replaced with Sealants for children
~~Sealants for 10-14 year old children at elevated caries risk~~	REMOVED as a distinct concept; replaced with Sealants for children
Topical fluoride	REPLACES "Topical fluoride for adults at elevated caries risk" and "Topical fluoride for children at elevated caries risk"; make measure concept broader with specificity contained within the measures
~~Topical fluoride for adults at elevated caries risk~~	REMOVED as a distinct concept; replaced with Topical Fluoride
~~Topical fluoride for children at elevated caries risk~~	REMOVED as a distinct concept; replaced with Topical Fluoride
Clinical outcomes	
Caries experience	No change
Caries at recall	No change
Complications following extraction	No change
Periodontal disease status and improvement	Retained based on Phase 3, Round 2 ratings
Risk status improvement	No change
Sealant retention	No change
Tooth loss/retention	No change
~~Treatment under general anesthesia~~	REMOVED as a distinct concept based on NAC Phase 3, Round 2 ratings.
Untreated caries	No change
Continuous quality improvement processes	
Performance assessment and improvement	Retained based on Phase 3, Round 2 ratings
Patient-reported outcomes and patient experience indicators	

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	NOTATIONS INDICATING NEW CONCEPTS AND MODIFICATIONS
Oral pain or discomfort	No change
Satisfaction with dental care	No change
Satisfaction with dental team	No change
Satisfaction with dentist	No change
Satisfaction with dentist communication	No change
Satisfaction with timeliness of needed dental care	No change
Recommendation to family and friends	No change
Satisfaction with aesthetics/appearance	Retained based on Phase 3, Round 2 ratings
Satisfaction with function	Retained based on Phase 3, Round 2 ratings
Satisfaction with psychosocial impacts of oral health (e.g., self-confidence, impact on work/social activities)	Retained based on Phase 3, Round 2 ratings
Minimizes adverse events	
Judicious opioid prescribing	No change
Post-operative infection following dental treatment	No change

[1]Naik A, John MT, Kohli N, Self K, Flynn P. Validation of the English-language version of 5-item Oral Health Impact Profile. J Prosthodont Res. 2016 Apr;60(2):85-91.

Figure 2. PCDH framework with characteristics, components, and measure concepts



APPENDIX 1 - QUANTITATIVE RESULTS

CHARACTERISTIC/COMPONENT/MEASURE CONCEPT	MEDIAN	AGREE-MENT	% RATING 7-9
ACCESSIBLE			
Timely			
Timely access for routine/preventive care	8.0	YES	85%
Timely access for specialist care	7.0	YES	78%
Affordable			
Engages with patients regarding cost implications of treatment options	8.0	YES	80%
Adequate provider network (SYSTEM)			
Dentist availability/workforce supply (e.g., dentist-to-population ratios, travel time and distance, ease of finding a dentist)	9.0	YES	90%
COMPREHENSIVE			
Prevention and wellness focused			
Screening for comorbid conditions (e.g., HTN, diabetes, HPV vaccination)	8.0	YES	73%
COORDINATED			
Dental-medical coordination			
Dental to medical referrals (e.g., referral for comorbid medical conditions)	8.0	YES	78%
Coordinated dental-medical patient records (SYSTEM)	8.0	YES	82%
Medical to dental referral (e.g., follow-up oral evaluation after medical visit for high risk populations, follow-up care after ED visit or medical well child visit) (SYSTEM)	8.0	YES	92%
PATIENT- AND FAMILY-CENTERED			
Cultural competence			
Provider training in cultural competency	7.0	YES	68%
Individualized care			
Patient self-management/self-care	8.0	YES	87%
QUALITY- AND SAFETY-FOCUSED			
Clinical outcomes			
Periodontal disease status and improvement	8.0	YES	88%
Treatment under general anesthesia	6.0	YES	35%
Continuous quality improvement processes			
Performance assessment and improvement	8.0	YES	80%
Patient-reported outcomes and patient experience indicators			
Satisfaction with function	8.00	YES	93%
Satisfaction with aesthetics/appearance	7.00	YES	73%
Psychosocial impacts of oral health (e.g., self-confidence, impact on work/social activities)	8.00	YES	70%

APPENDIX 2 - ALL RATED MEASURE CONCEPTS, SORTED BY PERCENTAGE (HIGHEST TO LOWEST) RESPONDENTS RATING CONCEPT IN THE RANGE OF 7-9

78 Concepts

*Shading Key:	
Green: 90-100% rated 7-9	18 concepts
Blue: 80-89% rated 7-9	33 concepts
Yellow 70-79% rated 7-9	16 concepts
Orange: 60-69% rated 7-9	8 concepts
Red: <50% rated 7-9	3 concepts

Measure Concept	Median	% rating 7-9
Sealants for 6-9 year old children at elevated caries risk	9.0	100.00%
Provider conveys respect for patients	9.0	97.83%
Topical fluoride for children at elevated caries risk	9.0	97.78%
Timely access for emergency care	9.0	97.78%
Provider communication about treatment	9.0	95.65%
Care recommendations based on patient level of risk for oral disease	9.0	95.65%
Reviews controlled substance database when prescribing relevant medications	9.0	95.65%
Sealants for 10-14 year old children at elevated caries risk	9.0	95.56%
Patient engagement in decision making	9.0	93.48%
Provider listening	9.0	93.48%
Ongoing care in adults with periodontitis	8.0	93.33%
Satisfaction with function	8.0	92.50%
SYSTEM: Medical to dental referral (e.g., follow-up oral evaluation after medical visit for high risk populations, follow-up care after ED visit or medical well child visit)	8.0	92.11%
Effective communication between dental and medical providers	8.0	91.30%
Patients with new caries at recall	8.0	91.11%
Risk status improvement	8.0	91.11%
Assessment of performance on quality improvement plan	8.0	91.11%
SYSTEM: Dentist availability/workforce supply (e.g., dentist-to-population ratios, travel time and distance, ease of finding a dentist)	9.0	90.24%
Sealant provision	8.0	89.13%
Topical fluoride for adults at elevated caries risk	8.0	88.89%
Tooth loss	8.0	88.89%
Untreated caries	9.0	88.89%
Appointment availability for routine care	8.0	88.89%
Care continuity (e.g., recall exam completion in consecutive years)	8.0	88.64%
Periodontal disease status and improvement	8.0	87.50%
Patient self-management/self-care	8.0	87.18%
Follow-up care after ED dental visit	8.0	86.96%
Patient satisfaction with timeliness of needed dental care	8.0	86.96%
Risk-based treatment planning	8.0	86.96%
Assesses and addresses the language needs of patients	9.0	86.67%
Caries risk assessment documentation	8.0	86.36%

Measure Concept	Median	% rating 7-9
Timely access for routine/preventive care	8.0	85.37%
Topical fluoride application	8.0	84.78%
Effective communication between generalists and specialists	8.0	84.78%
Referral monitoring	8.0	84.78%
Patient materials appropriate to patient population communication needs and understandability	8.0	84.78%
Patient satisfaction with dentist communication	8.0	84.78%
Caries experience	8.0	84.44%
Quality improvement plan	8.0	84.44%
Follow-up oral evaluation after medical visit for pregnant women	8.0	82.61%
Dental/medical history completeness	8.0	82.61%
Risk assessment completion	8.0	82.61%
Accommodating of patient preferences (e.g., cultural, patient comfort)	8.0	82.22%
SYSTEM: Coordinated dental-medical patient records	8.0	82.05%
Engages with patients regarding cost implications of treatment options	8.0	80.49%
Proactively identifies populations of patients and reminds them about needed care	8.0	80.43%
Follow-up oral evaluation after medical visit for patients with diabetes	8.0	80.43%
Assesses and addresses access and care disparities	8.0	80.43%
Patients with oral pain or discomfort	8.0	80.43%
Post-operative infection following dental treatment	8.0	80.43%
Performance assessment and improvement	8.0	80.00%
Timely access for specialist care	7.0	77.50%
Dental to medical referrals (e.g., referral for comorbid medical conditions)	8.0	77.50%
Treatment plan completion	8.0	76.09%
Follow-up oral evaluation after medical well-child visit	7.0	76.09%
Follow-up oral evaluation after medical visit for patients in long-term care	7.0	76.09%
Patient satisfaction with dental care	8.0	76.09%
User-friendly system for patient requests (e.g., appointment making, prescription refills)	7.0	76.09%
Use of clinical protocols for referral determination	8.0	76.09%
Patient satisfaction with dentist	7.0	73.91%
Patient satisfaction with dental team	8.0	73.91%
Frequency of dental radiograph use	8.0	73.33%
Screening for comorbid conditions (e.g., HTN, diabetes, HPV vaccination)	8.0	72.50%
Satisfaction with aesthetics/appearance	7.0	72.50%
Follow up after medical well-child visit	7.0	71.11%
Complications following extraction	8.0	71.11%
Psychosocial impacts of oral health (e.g., self-confidence, impact on work/social activities)	8.0	70.00%
Identifies and addresses population-level health concerns based on the diversity of the practice and the community	7.0	69.57%
Provider training in cultural competency	7.0	68.29%
Patient recommendation to family and friends	7.5	67.39%
Effective communication connecting patients with community supports	7.0	65.22%
Tobacco use screening and cessation provision	7.0	65.22%
Sealant retention	7.0	64.44%

Measure Concept	Median	% rating 7-9
Extended clinic hours	7.0	63.04%
Oral health education provision	7.0	63.04%
Care provided by dentist of record	7.0	58.70%
Use of diverse provider types for needed care and maintenance support	7.0	56.52%
~~Treatment under general anesthesia~~ (not included in framework due to not meeting quantitative criteria of median score of 7-9)	6.0	35.14%

APPENDIX 3 - NATIONAL ADVISORY COMMITTEE COMMENTS

ACCESSIBLE

Timely

- **Timely access for routine/preventive care**
- **Timely access for specialist care**

Affordable

- **Engages with patients regarding cost implications of treatment options**

- *While timely is important, affordability will present more of a barrier to all services if out of reach.*
- *This process involves patient in decision process that is very important in success of health outcomes. When patient is well informed of the necessity and value of treatment and transparent costs, the patient can make informed decision, get the buy-in, and benefit from getting the best outcome for their health*
- *It is important but its role in the overall population health goal lacks specificity and may be better considered at the person level. We will need latitude in defining this measure. There is also some concern about how actionable it may be.*
- *Cost implications of treatment options should be discussed; in addition, cost implications of no treatment should also be discussed.*
- *These new measures seems like more specific objectives to assess accessible.*
- *"Unclear about what terms mean. i.e. Is appointment availability of within 1 month timely? Or does it need to be within 1 week, 1 day, 1 hour? I see comments along same lines in summary of feedback in previous round. Same with ""engages"" - what does it mean? Apologies if there are definitions available that I don't have or know about."*
- *I suspect that there is variation in timeliness between publicly and privately-insured individuals at the system or state level; I'm not sure the extent to which such disparities might exist at the individual practice level.*
- *It's not clear to me if this is simply offering treatment alternatives, or if it is geared more toward financing or resources available to offset the cost of care. I would rate the latter as important and the former seems simply to be part of informed consent*
- *It is difficult to understand the connection between affordable and patient engagement related to cost implications. Understanding and engaging on cost implications does not make treatment affordable.*
- *To truly make the care affordable a different structure/financing is likely needed. This measures affordability at an individual level where the least control over cost is*
- *Affordable care is an important aspect of quality and patient-centered care. However the proposed measure concept is vague and doesn't address the core aspect of what makes care affordable.*
- *Timely and affordable care are likely to lead to favorable outcomes.*
- *In the post-COIVD world, we need to be clear about what access means. I don't think we need to develop more incentives to drive people into dental suites (which were designed for surgery & high cost) for preventive care. This can be done in a more patient-centered, cost-effective way. Not everyone needs to see a dentist every year, or every 6 months!*
- *Delays in accessing care and/or cost concerns about out-of-pocket costs of care can present barriers to patients seeking care or following up on recommended treatment.*
- *Timeliness for specialty care is rated more important that the rating for routine care under an assumption that a general dentist referral for care has been provided because of an urgent need.*
- *Not sure how criteria #2 fits or if we have data on it. Additionally, not sure criteria #3 fits or if there is data.*
- *SDoH have shown that providers need to consider factors related to accessibility and cost of care .*
- *Timely access for specialist depends on the urgency of the need for specialty care, I.e. presence of infection*
- *Be careful with timeliness. As I understand it, you are building measures that are meant to apply to all practices and providers, but for those few practices who focus on providing care to patients on public programs and uninsured, there is often a waiting list. Do not penalize those practices who are serving those that others turn away.*
- *Often alternative treatment options are not provided at all to patients.*
- *From a patient satisfaction perspective, these are probably the two most important measure concepts. A third might be the degree of discomfort that a patient experiences when receiving dental treatment. However, that is a concept that would be difficult to measure due to the variability in patient pain thresholds.*
- *I believe we're past the point, but I wonder if this concept doesn't directly address whether the patient (or parents) can afford the care or can find ways to enable affording the care, only that cost implications are communicated.*
- *Without timely affordable care pt needs are not being met. Needless pain and suffering are the outcome,along with anger and frustration on the patient's part which result in more costly emergency room costs and unnecessary legislation to mitigate the problem.*

COMPREHENSIVE
Prevention and wellness focused • **Screening for comorbid conditions (e.g., HTN, diabetes, HPV vaccination)**
• *Controlling costs of care and morbidity can best be accomplished if advanced disease is prevented and the causation of oral disease mitigated or reduced.* • *Essential with the movement to the team approach to health care and inclusive value based payment.* • *Integrated care model results in better health outcomes. Dental patients make more visits to dental practices on an average annually and can benefit from having their non-dental, underlying medical conditions screened, detected during their dental visits. They can get referrals to medical and other health disciplines in a more timely manner* • *Based on the primary purpose of dental home, this is less important, although nice to have.* • *If we want to have a greater impact on population health, we need to put a greater emphasis on managing co-morbid conditions and prevention strategies. Unfortunately, payment does not align with these priorities. This is a major disadvantage of dental plans and reimbursement.* • *Interprofessional practice is a key strategy to improved health of patients and communities.* • *Yes important and mostly required now but not relevant for majority of patients seeking treatment as we go forward* • *Screening I think is a clearer objective assessing prevention and wellness. You could expand to screenings for comorbid conditions and high risk behaviors to include tobacco use.* • *The measure(s) will need to address the appropriateness of the screening to prevent overuse and increased costs* • *We need to acknowledge and understand the implications of the documented findings that many patients tend to withhold health information from dental providers that is more likely shared with medical providers.* • *This needs to be more specific - which conditions and why?* • *Not sure what 'screening' implies ..... health questionnaire? A1C levels in the dental office? routine taking of blood pressure?* • *We need to decide... are dentists primary care providers? If yes, then they should screen for comorbidities. But if not, then let's protect oral health outside of the dental delivery system. and let primary care do these screenings.* • *Can help identify patients in need of follow-up, presents an opportunity to reinforce the need for them to address primary care issues and disease processes relate to dental care. Need to consider what type of screening can feasibly be done in a dental settting.* • *Screening is important, but there is limited scope for action in practice relationships that lack strong referral networks and/or enabling legislation to provide services (e.g., vaccine delivery).* • *Not sure there is any disparities data on this.* • *I think we should separate/clarify the concepts of: a) screening for medical conditions (i.e., HTN, diabetes, HIV positivity), b) risk assessment screening (i.e. tobacco, alcohol, oral HPV), and c) prevention provided in a dental setting (i.e. HPV vaccination)* • *Comprehensive screening not in scope fo practice in all states- nonetheless important topic* • *"Need to include social determinants of health - food insecurity, homelessness, addiction...* • *Without including this we are only skimming the surface of wellness."* • *Link between oral health and general health still vastly ignored* • *The dental profession has focused on informing the general public about how important oral health status is to an individual's systemic health. To not include this as an important measure concept would be hypocritical. The impact of oral health on systemic health almost begs for the creation of more dental outcome measures rather than process measures. Screening for comorbid conditions only goes so far toward true outcome quality measures. Of course, development of validated outcome measures is not easy. It will take a long time before outcome measures are implemented universally. Nevertheless, screening for comorbid medical conditions is very important.* • *Reasonable screening tests for comorbid medical conditions is a necessary component of any viable heath care system in today's society.*

COORDINATED
Dental-medical coordination • **Dental to medical referrals (e.g., referral for comorbid medical conditions)**
• *This is were potential patients can get lost attempting to navigate the oral health and health system. If complications, many will become discouraged and may fail to achieve health goals. A system should improve this in a coordinated fashion* • *Caring for the whole person -- team based care and the move to value based payment.* • *See comments above ["Integrated care model results in better health outcomes . . . ."]* • *Again, not primary reason but inextricable.* • *If we are ever going to achieve better health, a team approach will be critical. This will be the highway on which that work will be accomplished. Communication is critical and there is much room for improvement.* • *Very important measure concept. Wondering how it will be measured in practice. Let's say that a dentist thinks a patient has diabetes and should be referred for a medical consult. How can it be measured whether this is or is not done?* • *Dental Medical integration will be huge as we continue to expand across our mutually divided lines. Going back to prior question, would hate to think this is only triggered by C-19 but hopefully should be standard of care across all comorbid patients being seen.* • *This measure is the definition of dental-medical coordination...referrals. This measure is certainly specific and actionable.* • *A robust dental home will have tight linkage and interoperability between medical and dental clinical records.* • *The referral is measurable, but this seems to depend on the screening measure which is not defined well enough to be useful (any condition, which conditions?)* • *Referral should include follow-up efforts, but some/many dentists may believe that it's not their responsibility to do follow-up once they've advised the patient of their medical condition and taken steps to refer the patient to a medical provider.* • *Comorbid conditions maybe important as relates to dental care but referrals are only of importance where there is a demonstrated impact of the proposed care. Consultation rather than referral is more likely appropriate.* • *When the majority of underserved populations can't get into a dental office and outcomes are poor for low-income kids, shouldn't dental offices focus on oral health?* • *see prior response ["Can help identify patients in need of follow-up. . . ."]* • *Establishing effective referral networks would enhance the importance and impact of dental office screenings for medical co-morbities.* • *Not aware of any documented variation on this measure or any disparities data.* • *Just in case if this is not addressed in a later question, another important concept is medical to dental referrals. This may be less within the control of dentistry, but effective communication/coordination should facilitate dent to med and vice versa.* • *Sometimes there is a long delay to get a medical appointment. In the case of comorbid medical conditions or potential side-effects of prescribed medications, dental to medical referrals should be expedited* • *The integration of medicine and dentistry is an important measure concept for health care organizations that promote person-centered care. In public insurance plans that cover both dental and medical benefits like Medicaid, better health outcomes and cost savings can be realized with earlier detection and treatment of co-morbidities.* • *Liability is a fact of life. You cannot have one without the other*

PATIENT- AND FAMILY-CENTERED

Cultural competence

- **Provider training in cultural competency**

Individualized care

- **Patient self-management/self-care**

- *self management is equally if not more important than health system access to assure good health outcomes. If this is lacking little improvement will occur although more demand for services may occur.*
- *To reach those most in need, cultural humility is essential.*
- *Providers need to be more sensitive to various cultures and diversities of their community and more knowledgeable about social health determinants. at the same time, COVID19 has really caused a lot of stress in all of our lives so the providers need to make sure they know how to take care of their health, both physically, mentally and emotionally, so they can continue to take care of their patients and community*
- *The science has not caught up with this concept.*
- *Cultural competence is important but it is also about sensitivity to the needs of other cultures. What level of knowledge of many diverse cultures is needed to deliver effective health care is the question. Can we develop tools at assessment that can provide the information essential cultural competency needed for that patient? Individualized care tailored to that individual is critical at achieving good health outcomes at the individual level. Providers see patients one at a time and often don't think about population health. The population health should be a priority of the health system, ACO, etc.*
- *Both important and both easily measured.*
- *Yes basic awareness in cultural items are relevant but also hugely disparate depending on where the clinician is practicing, so important but specific to locations at the moment, may/will change over time. Patient self care, if was higher right now, huge impact! Perhaps bad for dentistry as a whole but good for all people.*
- *Training in cultural competency does not necessarily lend itself to created patient- and family-centered care. I think that there is more to be done beyond cultural competency trainings. Staff diversity, accessibility of offices, and open offices (meaning patients see practices that welcome them and their "differences") seem more concrete than a training. At this point in 2020, if providers have not received cultural competency training, we have bigger problems than we think. I encourage you to go deeper on this one; it reads too shallow.*
- *Cultural competency - could the measure look at impact of training, - actions, processes in place.*
- *It's probably implied, but the entire PCDH team should be trained*
- *Providing training is a nice idea. I believe the measurement should be to assure that the provider provides care and communicates in a culturally competent manner. Consider a measure that is a patient reported outcome related to cultural competence.*
- *The cultural competency training will be useless if the organizational design and structure do no support these efforts. It again seems to take a system/organizational issue and put the measurement on individuals vs climate/culture.*
- *Training in cultural competency is one of those necessary, but not sufficient things.*
- *Cultural sensitivity is of importance in that certain cultural beliefs or practices may affect the individuals likelihood of seeking and following through with care.*
- *the best way to prevent and manage disease is through healthy behaviors and tooth-friendly diet.*
- *Supports improved patient-provider relationship, builds trust, and communicates respect. An understanding of cultural differences will allow them to be considered when deciding on treatment strategies, and pt involvement in the development of self-management goals will improve patient compliance.*
- *Not aware of any data about the extent of the problem or if there are any known disparities with regard to this measure.*
- *not sure whether measuring whether Dr. counsels pt on self-mgmt or measuring Dr's comprehensiveness.*
- *I consider "Individualized care" as very different than "Patient self-management"- The former implies unique care based on the individual needs of each patient. The latter implies self-care as apposed to provider rendered care. Both are important. Not sure which you are actually asking about here.*
- *This is important, but doesn't consider that some patients are unable to manage self care.*
- *It's confusing here to be measuring "Patient self-management/self care," because to me the patients' ability to self-manage or self-care is more related to health literacy and ability to navigate the health care system rather THAN the providers' receiving training in cultural competency training. Yes being able to understand different cultural styles is important, and not all cultures may rely on one-self for self-maintenance, however isn't the ethics and professionalism of highly trained providers cover that already? I personally think (and I am Latino) that there is too much emphasis now-a-days on promoting "cultural competency training."*
- *Patient understanding of professional guidance regarding the treatment of oral disease is highly dependent on presenting recommendations in a manner that increases comprehension and motivates the patient to do his or her part in improving their*

oral health status. Cultural competency training gives dental providers more tools to communicate with patients from diverse backgrounds. Dental professionals realize early in their clinical careers that home care is just as if not more important than the treatment rendered in a clinical setting.

- *I'm not sure if the "patient self-management/self-care" concept is referring the the patient's capability or to instruction or means of instructing patients.*
- *We must always respect cultural needs and differences when possible. There can be no successful treatment without patient participation.*

QUALITY- AND SAFETY-FOCUSED

Clinical outcomes

- **Periodontal disease status and improvement**
- **Treatment under general anesthesia**

Continuous quality improvement process

- **Performance assessment and improvement**

Patient-reported outcomes and patient experience indicators

- **Satisfaction with function**
- **Satisfaction with aesthetics/appearance**
- **Psychosocial impacts of oral health (e.g., self-confidence, impact on work/social activities)**

- *Patient reported aesthetics while important isn't a great measure of health outcomes.*
- *Continuous quality improvement is a cornerstone of healthcare.*
- *Restoring function is much more important than aesthetics. While psychosocial impacts are important, the interpretation could vary vastly*
- *"Treatment under GA is critical; may be a referral rather than primary offering.*
- *Patient reported outcomes measures (at least in medicine) have tenuous association with health outcomes, so I think this may be down the road following more research."*
- *Anesthesia treatment needs to be safe. How that would be measured is critical. We need quality measures and related outcome data to inform how well we are doing. We need CQI processes if that data while be used for meaningful improvement.*
- *"I don't see treatment under general anesthesia as a clinical outcome, this is a process type of indicator. The clinical outcome would be that all conditions related to oral disease (dental caries, periodontal disease, oral cancer) were treated. Psychosocial impacts of oral health are hugely important; however, it is not clear how these would be measured."*
- *Perio is connected to the whole medical/dental integration piece due to the inflammatory condition along with the bacteria, etc. We should always be continuously improving our care provided to patients and measuring/tracking/monitoring it all the time. Without that we might still be doing gold foils and blade implants. Patient perception of treatment is critically important and currently mostly ignored, big failure on the part of our industry. Yes outcomes should be clinically acceptable, if not exceptional but if the patient does not realize that, less return visits, less focus on the own dental needs, more negative impacts on their quality of life as teeth affect more than most people realize*
- *All of the patient-reported outcomes and QI processes are definitely important. I am not sure that GA fits...but I may need more background information to see the value in this measure.*
- *"what does treatment under GA mean? need recognized, GA avoided by other means, referral made, services offered on site? - all very different things. Psychosocial - many factors. it would be difficult for any organization to track, measure, determine what factors influenced change, etc."*
- *I feel like I would need some additional information on the general anesthesia indicator to rate it fully - I assume that it's a "lower is better" measure, but I don't have a great sense for whether it would mainly be applicable to pediatric dentists and/or dentists who treat individuals with special health care needs. Is the pool of applicable patients big enough to be able to meaningfully move that measure? And for the patient-reported outcomes, do the three new indicators tell us anything more than what a broader indicator of "satisfaction with dental care" tells us?*
- *I'm not clear what aspect of outcomes the anesthesia concept is trying to capture. I would need more information to understand the importance*
- *some patients may find inquires of this nature to be intrusive*
- *The response to the measure concept related to general anesthesia is predicated on an assumption that the rationale for use of GA is tied to extent of disease and not due to "special needs" patients.*
- *the learning health care system concepts may have more specific measures than just assessment and improvement - like are there data dashboards and plans to operationalize improvement?*
- *I'm not sure what the general anesthesia item seeks to assess. QI is important, but likely difficult to measure in dentistry, where the majority of practitioners are not board certified or involved in credentialing that might serve as a stimulus for conducting QI.*

- *Certain aspects of care such as outcomes and perception of outcomes have a direct impact on the psychological impact of care which impacts satisfaction.*
- *I am conflicted by the general anesthesia questions, since I would prefer that the use of GA be substantially curtailed.*
- *Not aware of any data on the satisfaction and psychosocial impacts and disparities data.*
- *Tx under general anesthesia very important for some special population groups, I.e. early childhood for treatment of ECC; and persons with DD/ID. For the general population, I would propose that GA is not that critical.*
- *Outcomes in dentistry are largely effected by health disparities, more so than medicine.*
- *I am unsure how to rate General Anesthesia as a measure concept to obtain clinical outcomes, in children with severe dental disease perhaps it makes sense, but not for the general population as is a risky and expensive option. So unless there is a stated caveat to the use of general anesthesia, I abstain to vote on it.*
- *I'm not sure about the "treatment under general anesthesia" concept is. It shouldn't be a goal, but is the concept dealing with the importance of it being offered at a PCDH?*
- *Measuring performance allows necessary adjustments in procedures. Personal satisfaction can vary from person to person, while very important is not an absolute indicator of success. We must ask, what are/we're our goals and what can we hope to reasonably accomplish.*

System-level concepts

Accessible characteristic: adequate provider network component

- **Dentist availability/workforce supply (e.g., dentist-to-population ratios, travel time and distance, ease of finding a dentis**t)

Coordinated characteristic: dental-medical coordination component

- **Coordinated dental-medical patient records**
- **Medical to dental referral (e.g., follow-up oral evaluation after medical visit for high risk populations, follow-up care after ED visit or medical well-child visit)**

- *accessible and coordinated are very important aspects of a health home concept.*
- *Essential to the team approach to care and can use dentists and dental care team members for those functions they are uniquely trained to provide.*
- *Key concepts in patient-centered health home*
- *This is critical to success. We need to know the whole person and work with our medical colleagues to achieve overall health. Currently the oral health delivery system is generally not integrated and where it is integrated the level of truly effective integration likely leaves room for much improvement.*
- *If our door is not open, the don't walk in and/or they go somewhere else, both choices bad. Delay of treatment for the patient. Large scale electronic health records will be the standard for our industry as we progress. These will be "universal" charts for patients across all versions of health care provided for the patient.*
- *The rationale for adequate provider network and dental-medical coordination are definitely important. I wonder if the dental-medical coordination could be more specific. For example, would one follow-up on all medical well child visits or just those for children at high-risk for caries?*
- *Dentist:population assumes that the dentist delivers all care. Now old idea. Allied personnel and partnerships can make big difference - reduced need for dentists. Use of modern delivery systems and methods much more important than the number of dentists.*
- *I think these are all important, and many plans/states could use some help with standardized assessments of network adequacy.*
- *Coordinated dental-medical records is important, but the feasibility may be the issue depending on the structure of the system*
- *The "system" will have the significant information about patients, that is required to identify the need for referral or follow-up.*
- *I think affordability should be a system level measure.*
- *I presume you mean integrated medical-dental records ..... great goal ..... very limited implementation presently .... likely will be limited to large systems/networks for some time to come.*
- *The ability to track the patient and population is critical at the system level in providing population care. Monitoring at the system level helps insure beneficial outcomes in the population.*
- *Health plans, ACOs, etc. should be accountable for oral health outcomes - not how many people sat in a dentist's chair.*
- *Effective referral networks must be bi-directional. Dental care providers should be on equal standing with medical providers.*
- *As long as acceptance of certain insurance (Medicaid) is included in the ease of finding a dentist. Not sure "coordinated dental-medical patient records" is actionable because of limited availability of such compatible electronic records.*
- *"If we ever want to realize an integrated healthcare SYSTEM, then both of these two concepts are critical. Regarding provider network adequacy, beneficiary/provider ratios must be calculated at the Plan Level, NOT the State Level."*

- *--to add to my general anesthesia answer: Is it appropriate to have a general anesthesia measure WHEN evaluating "patient-centered care at the dental practice level." It is unlikely the general anesthesia would be applied at a regular dental practice (caveat: Hospital measure?).*
- *Coordinated care between the medical and dental homes is essential to person-centered health care.*
- *coordinated dental-medical patient records should and will likely have increasing importance, but as this isn't the current status, it shouldn't be an expectation for a PCDH yet.*
- *People tend to find health care providers no matter what the obstacles. Ideally providers should readily be available, but if they're not people will find them. Coordination of care is absolutely important in both directions.*

ADDITIONAL COMMENTS

- *Early access, preventive in focus, disease process intervention at earliest possible time, network assurance and collaborative management across disciplines.*
- *Great measure for considerations. Thanks*
- *I answered based on realistic expectations for the foreseeable future; some goals are ideal but in the context of resources and the system's limitations, may be only hopeful.*
- *I do think the group needs to start thinking about the barriers to achieving the goal and how they can be addressed.*
- *The ability to receive treatment under general anesthesia is important for young children with severe tooth decay (and is done in operating rooms in hospitals), but otherwise is not applicable for most dental procedures and the vase majority of dental practices. And although it is important for a subset of children, the ultimate goal is to prevent dental caries and eliminate the need for children to be treated under general anesthesia. Recommend eliminating this as a measurable concept.*
- *I know with good reason some questions are C-19 leaning but this is not the first nor will be the last virus to hit the human population. Hoping we can come to resolutions that improve and effect any and all various disease challenges we face collectively.*
- *Just to be be repetitive about what I have had said previously. There is still assumption in a number of the concepts that oral health care and good oral health happens with interactions with dentists in dental offices. No longer the reality in what is possible. Would like to see concepts reflect the importance of virtual interconnected homes more than they do.*
- *All of this fits very nicely in an effort to improve care for those who already have it. We get over 600 calls a week from patients with emergent (33%) or urgent dental needs in rural Northcentral Wisconsin. Many travel a great distance. Help me understand how this helps them. Our resources are not deployed equitably and many suffer needlessly as a result. Should a dental home be available to all in need? Or available only to those who fit evolving business models?*
- *The framework is getting rather large, which in itself may not be a problem. My greater concern is whether truly key aspects of care are being incorporated into a growing framework.*
- *None at this time other than the recognition that success at the individual level will lead to better resource and population management.*
- *While I think the PCDH model is framework is clear, I do think that perhaps more emphasis should be placed on coordination of behavioral health with the PCDH. The importance of behavioral health's impact on oral health and vice versa should not be underestimated. I am always surprised by the number of beneficiaries who receive behavioral health services in the State Medicaid agency where I work. I know that some of the measure concepts relate to behavioral health. For example, patient satisfaction with treatment may be directly impacted by a patient's mental health status. The patient's compliance with home care could be linked to the patient's behavioral health status. While I am not suggesting that the dental professional needs to be trained in psychological counseling, I do think that building rapport and a sense of trust between patient and dental professional can be facilitated if the dental professional has a better understanding of how a patient's behavioral health diagnosis (e.g., depression) may impact his or her OH status.*
- *These are all very thoughtful measures. It seems like too much in the current care delivery system. I suggest a narrow list, not more than 6-8 measures at a time. Maybe a menu that practices could choose from and work on over time.*
- *Excellent compilation of concepts*
- *Looks great - I'm excited to see this out there for providers to use after the final Phase!*
- *No, I think that the measure concept piece of the PCDH model was very thoroughly addressed in this first round of the Phase 3 Dental Home Delphi Survey.*
- *Lots of important concepts that could lead to even more actual measures. It will be important to balance 'measurement burden' with measure completeness in developing a measure set for PCDH.*