PATIENT-CENTERED DENTAL HOME PROJECT: DENTAL QUALITY MEASUREMENT USE AMONG STAKEHOLDERS
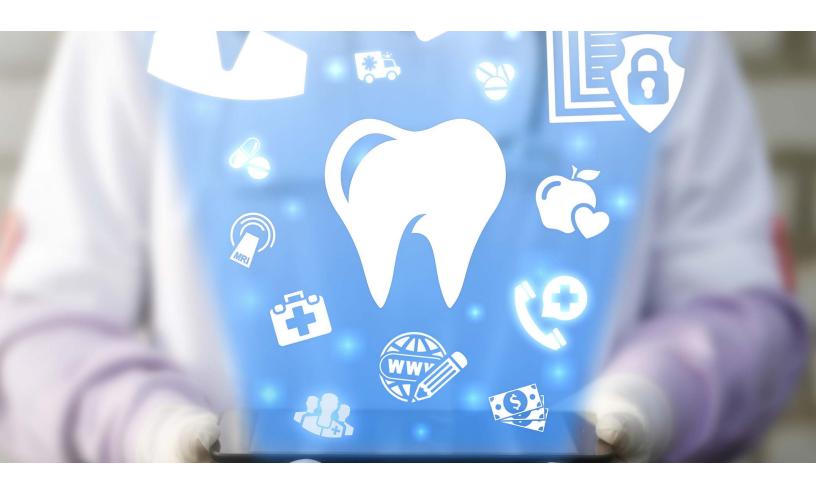
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BACKGROUND

The goal of the Patient-Centered Dental Home (PCDH) project is to develop a PCDH model 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 broad-based 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.

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.*[1] In **Phase 2,** the NAC identified the conceptual components that fit within each PCDH characteristic. For example, within the characteristic of *accessibility*, components included timeliness and provider network adequacy. In **Phase 3**, the NAC identified measure concepts that reflect potential measures to be nested under each component. This phase explored how we can begin to measure the components identified in Phase 2. **Phase 4** focuses on linking existing dental quality indicators to the PCDH framework, developing measure sets, and identifying measurement gaps. To help inform measure set development, we conducted a small pilot survey among a diverse group of members within the National Advisory Committee and several other organizations to explore the ways in which dental quality measurement is currently being utilized or may be utilized in the future. This report describes the methods and results of this pilot survey.

More information about the PCDH Project can be found on the project website.

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1   Damiano PC, Reynolds J, Herndon JB, McKernan S, Kuthy R. The patient-centered dental home: A standardized definition for quality assessment, improvement, and integration. Health Services Research. 2019;54(2):446-454.

METHODS

The research team first identified the types of organizations that are currently using quality measurement at both the system and practice levels. These included the following organizational types:

- Public and private payers
- Large group practices
- FQHCs
- Accreditation organizations
- Other health systems (e.g., integrated medical–dental systems)

Survey items were developed to explore current and future dental quality measure use, accreditation experiences, experiences collecting patient-reported outcomes, and the potential role of a PCDH model within their organizations. The specific survey questions varied depending on the organization type. Survey items are listed in Table 1, as well as which types of organizations received the item.

Table 1. Survey questions and types of organizations that received the questions

Question number	Question	Organizations receiving questions
1	How is dental care quality measurement currently being used by your organization? Below are some examples of potential uses. For each use, please provide a description of the application and list the dental quality measures that are used including the steward/source of the measures (e.g., Dental Quality Alliance, CAHPS, etc.). Please describe in as much detail as possible. • Pay for performance • Performance reporting (to whom?) without ties to payment • Quality improvement • Provider dashboards • Accreditation • Others	• Private and public payers • Large group practices • FQHCs • Other health systems
2[2]	Has your practice, or the dental practices within your organization, received AAAHC accreditation as a Dental Home? If no, please describe whether you have considered pursuing accreditation and, if considered, the reason for not pursuing. If yes, please address the items below: • What is the motive for seeking accreditation? • How has accreditation impacted the organization? Has it been effective at improving quality? • What are the pitfalls or most difficult aspects of the accreditation process?	• Large group practices • FQHCs • Other health systems
3	What is the current status of your organization's interest in accrediting dental programs as dental homes? • What would it take to increase interest? What are barriers to developing dental accreditation, if any? • What is the process for developing accreditation standards?	Accreditation organizations
4	How could a PCDH model and associated quality indicators be helpful for your organization? What concerns do you have, if any, regarding adopting a PCDH model?	All respondents
5	Would you be interested in having your network providers/practices have some sort of dental home accreditation?	Private and public payers
6	Does your organization collect CAHPS or other patient-reported outcome measurement for application at the practice level? If so, please describe your sampling process and fielding approach. Do you conduct it yourself or have a contractor conduct it?	• Private and public payers • Large group practices • FQHCs • Other health systems
7	How do you anticipate that quality measurement in dentistry will impact your practice or organization in the future?	All respondents

Members of the National Advisory Committee were selected to receive the survey based on their involvement in one of the organization types listed previously (e.g., payers, delivery systems, practices, and accreditation organizations). Surveys were fielded by email in October 2020 to a total of 18 individuals, and respondents were given the option to respond by email or via videoconference call.

Among the 18 individuals contacted, 16 provided a response; 11 responses were by email and five by videoconference call. Themes and example quotations are provided below. Responses were provided on condition of anonymity, so no identifiable information is provided.

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2   Question 2 focuses specifically on AAAHC dental home accreditation because this is the only known accreditation program that includes standards specifically for dental homes at the time of the survey.

SURVEY RESULTS

Below we present themes on five overarching topics: dental quality measure use, accreditation experiences, use of patient-reported outcomes, the role of a PCDH, and perspectives on the future of dental quality measurement.

DENTAL QUALITY MEASURE USE

This topic includes which types of dental quality measures are currently being used by the organization, and how they are used.

Types of Dental Quality Measures Used

Across all organization types, there was considerable variation in the types of dental quality measures used. Third party payer or affiliated organizations were the most likely to use Dental Quality Alliance (DQA) or DQA-adapted measures, whereas large group practices more often used measures that were internally developed or a combination of internally developed and DQA-adapted measures. Organizations using internally developed measures indicated that they wanted to develop and use measures that were consistent with their organizational priorities.

Within large and small practices, example categories of dental quality measures included, but were not limited to, the following:

- Clinically-assessed outcomes/disease-based measures (e.g., caries at recall)
- Prevention-based process measures (e.g., caries and periodontal risk assessment, fluoride and/or sealant placement)
- Treatment plan completion
- Clinical technical quality measures (e.g., remake percentage)
- Indicators of efficiency (e.g., production, appointment length)
- Indicators of timeliness (e.g., new patient appointments within 7 days, on-time recalls)
- Indirect indicators of patient satisfaction (e.g., patient retention)
- Patient-reported outcomes (e.g., satisfaction, provider communication)

How Dental Quality Measures are Used

Dental quality measure uses also varied by organization type. Among **payers**, quality measures were used for:

- internal quality improvement or evaluation
- external reporting
- to populate dental provider dashboards/scorecards with or without pay for performance

One payer organization noted that even with significant financial incentives for providers to just log in to the dental dashboard, there has been very limited use among providers. Another organization reported that it uses enhanced payments in addition to fee for service reimbursement with no downside risk. One respondent noted "*There seems to be little utility to [provider scorecards] without any tie to provider compensation or provider recognition.*"

One organization reported using dental quality measures for internal performance evaluation, including examining potential disparities. The respondent noted that "*stratification by county and race/ethnicity has helped us identify gaps in performance that need to be addressed.*"

Large group practices also commonly used provider dashboards, with or without ties to pay for performance. For some organizations, up to 10-15% of provider compensation was tied to performance on quality metrics, whereas for others, provider dashboards were solely for providers' reference with no ties to performance. One organization that does not tie performance to measurement noted that there is variation in the value of the scorecard to providers; some providers look at it and improve their performance, and others don't.

There was variation in the timeliness of dashboards/scorecards; some organizations had dashboards that showed provider metrics in real time, and other organizations shared scorecards with providers quarterly or twice a year. Some dashboards provided benchmark comparisons to indicate performance goals, for comparison with other providers or clinics, or to show changes over time.

Large group practices also commonly used quality measures for internal quality improvement projects, and some used them for external performance reporting. One innovative example of large group practice external reporting is the Wisconsin Collaborative for Healthcare Quality, which is composed of a cohort of large group practices in the Midwest

that have published organization-level quality measures on a public-facing dashboard, the first of its kind.[3]

Key quality measure uses among **FQHCs** included internal quality improvement, external reporting to HRSA, and quality dashboards. Once center reported that they set target goals for each metric in the dashboard, and then undergo the following internal improvement process: "*we look for 'Best Practices' – the clinics that consistently get the best scores. We then do a workflow analysis to see why they have been successful. As we identify those ideal workflows we then spread them out to the other clinics. We also look for changes needed in our EDR to make it easier for our providers to record what we ask of them.*" This center also indicated that while current provider incentives are based solely on productivity, the development of a dashboard is the first step in a process toward rewarding providers for improvement on quality measures.

ACCREDITATION EXPERIENCES

Among **dental delivery systems**, several organizations had experiences with accreditation, and some did not. Among organizations that were accredited, some received accreditation from The Joint Commission, particularly if they were in an organization that also provided medical care. In this case, the decision about whether and which organization to use for accreditation was usually made among high-level organizational leadership and which may or may not include dental clinic leadership. Some organizations were accredited through AAAHC, and among those some included the sub-chapter on dental home and some did not. Among those with AAAHC accreditation, motivations for seeking accreditation included helping the organization standardize their policies and procedures across sites, the requirement to undergo quality improvement projects, and the ability to market their accreditation status.

The value of being required to do quality improvement as part of accreditation was an important theme among several organizations. One organization noted that undergoing accreditation has "*forced us into a paradigm of quality thinking that we might not have achieved on our own. We can't just operate from a check off list. Accreditation for us involved a total change in how we look at, track, and improve patient care.*"

Among those with AAAHC dental home accreditation, most felt like they were already doing the activities that were required for dental home accreditation so that component didn't necessarily result in practice transformation toward a dental home. None of the accredited organizations received financial incentives for being accredited. Some organizations were accredited as a single enterprise, whereas others received accreditation separately for each clinic.

Accreditation organizations were asked about the standards development process, as well as their interest in accrediting dental programs, or dental home programs, if they were not already doing so. Development of accreditation standards included consensus-driven processes, receiving input from advisory committees, testing, and putting standards out for public comment. According to multiple accreditation organizations, the main factor that would drive interest in developing dental or dental home standards would be demonstration of market demand.

PATIENT-REPORTED OUTCOME USE

There was considerable variation in the use of patient-reported outcomes among organizations. Most organizations use a contracting agency to conduct patient surveys, whereas one organization conducts patient surveys internally due to increased flexibility. Survey contractors include, but are not limited to, Press Ganey and CrossRoads. Some use Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions, and many use other non-CAHPS items. Fielding methods for patient surveys included text, telephone, mail, email, iPads in the clinic waiting room, or a combination of methods. One organization noted that it uses a random sample of patients, but is not able to achieve a high enough response rate to attribute results at the practice level at this time.

One organization noted the importance of an item on overall patient satisfaction; however, it also noted that the provider satisfaction metric can be problematic because internally it tended to skew negatively for female providers, younger providers, and providers with English as a second language.

PERSPECTIVES ON A PCDH MODEL

Potential value of a PCDH model

Multiple payer organizations noted the potential value of a PCDH model for publicly insured populations where managed care plans and providers can be held to standards and required or incentivized to adopt the model. Many respondents felt that a PCDH model could facilitate value-based care and alternative reimbursement models, as well as facilitate standardized quality measurement to enable comparisons across entities (e.g., benefit plans, practices, providers).

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3   Wisconsin Collaborative for Healthcare Quality. Reports. Accessed March 10, 2021. https://reports.wchq.org/

<u>Concerns about a PCDH model</u>

Organizations also had concerns about implementation of a PCDH model, including the following:

- Lack of viability in the commercial market without regulations or financial incentives
- If overly complicated, there will be low feasibility of adoption
- Need a parsimonious set of measures, not a bunch of measure sets
- Needs to be as easy and automated as possible
- Concern that metrics will penalize safety net clinics due to the populations they serve
- Cost/resources to achieve and sustain PCDH designation, lack of incentives to do so

The themes of feasibility/ease of use and the need to avoid the proliferation of measures seen in medicine were common across organizations. One organization that was already involved in many quality measurement and improvement and dental home-type activities noted that "*PCDH designation would only be an advantage if it were tied to increased funding like the PCMH.*"

FUTURE OF DENTAL QUALITY MEASUREMENT

Common themes across organizations about the future uses of dental quality measurement included:

- Value-based payment/pay for performance
- External quality reporting to help patients select a practice and provider
- Monitoring managed care plan performance, tie performance to payment
- Expand quality improvement opportunities
- Expanded use of patient-reported outcomes

One respondent noted that "*until and unless there is a concerted effort on the part of 'organized' dentistry to encourage the implementation of quality measures or insurance/payors require such measures, I believe the adoption will be slow in coming.*"

CONCLUSIONS AND NEXT STEPS

This survey aimed to explore existing quality measurement activities within a variety of organization types and to inform the next steps of the PCDH development process. Key themes identified in these surveys include:

- There was significant variation in the types and uses of dental quality measures, though communicating dental quality measure results to providers through dashboards and/or scorecards was very common among this group

- Organizations that were accredited found significant value in accreditation from a quality improvement perspective, despite not being financially rewarded for it

- Accreditation organizations' interest in developing a PCDH-type accreditation tool would be dependent upon sufficient market demand

- There was significant variation in the content and administration of patient surveys, but several organizations used patient satisfaction data as part of a measure set used for provider pay-for-performance

- Organizations both saw value in adoption of a PCDH model as well as had concerns about its use

As a next step, we will continue to work with the project National Advisory Committee to develop parsimonious measure sets that fit within the PCDH quality measurement framework. Using measures and standards collected through a previous environmental scan, we have created a PCDH Quality Indicators Clearinghouse, which can be found here. Quality indictors listed in this clearinghouse will be culled down to smaller draft sets to field to the National Advisory Committee to be rated on feasibility, validity/reliability, burden, and the degree to which they are actionable.