Oral Health in Oregon's CCOs



A metrics report

March 2017

Oregon Health Authority

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Executive summary

A growing body of evidence shows that oral health is critical to overall health. Research suggests that gum disease and other oral health conditions are associated with heart disease, diabetes, low birth weight and certain types of cancers. Poor oral health also contributes to missed school and work days, and can have a negative impact on overall well-being. In short, the mouth is connected to the body.

In spite of this connection, historically oral health care has been delivered separately from medical care, and too often the two systems don't communicate well. One of the key goals of Oregon's coordinated care model is to integrate physical, oral and behavioral health care to treat the whole person.[*]

This report provides the first in-depth look at oral health care data in the context of Oregon's health system transformation, including the launch of the coordinated care organizations (CCOs) and expansion of its Medicaid program, Oregon Health Plan (OHP), through the Affordable Care Act. Individuals with low income are disproportionally likely to experience poor oral health, and people of color can face even worse health outcomes. Recognizing the importance of oral health across the lifespan, Oregon is one of only 13 states that offers comprehensive dental benefits to all adults with Medicaid, as well as children.[†]

In addition to being the first report of oral health services in OHP CCOs, much of the data in this report are being produced for the first time. Some data used preliminary specifications, courtesy of the national Dental Quality Alliance (DQA).[‡] Key trends in this report include:

- **Certain counties in Oregon have fewer dentists compared with the number of residents they serve,** and only about 2 of every 5 dentists report seeing Medicaid patients (41.5%). This could pose a challenge for members trying to access services.
- **Adult CCO members receive oral health services at lower rates than children**. Only about 1 in 3 adults receive dental services in a given year, compared with a little more than half of children. Adults are also less likely to report having a regular dentist (57% of adults compared to 79% of children).
- **Many members do not receive preventive dental services, like regular cleanings, fluoride treatments, and dental sealants.** Only 1 in 5 adults and just over half of children (50.1%) had a preventive service between July 2015 and June 2016. This is important, because dental diseases are largely preventable.
- **When stratified by race/ethnicity, the data show variation between groups.** Members who identify as Hawaiian/Pacific Islander consistently receive services at lower rates than other members. Members identifying as Asian American generally have higher rates of utilization and follow-up.

This report will be shared with key stakeholder groups to inform interpretation and use of the data. These include the Medicaid Advisory Committee, the CCO Quality and Health Outcomes Committee, and the Metrics and Scoring Committee. We hope these preliminary data will help CCOs and other stakeholders continue to integrate oral health and improve care for members.

[*] In 2014, CCOs began managing dental benefits for their members, mainly by contracting with existing dental plans called dental care organizations (DCOs). CCOs are working on improving oral health at the local level, and about half of CCOs have included oral health in their Transformation Plans.

[†] States are required to offer dental benefits to children on Medicaid, but adult dental benefits are optional.

[‡] The Dental Quality Alliance is an organization of major stakeholders in oral health care delivery, which develops performance measures for oral health care.

About this report

There are 13 measures in this report, including quality measures (e.g., percentage of children receiving topical fluoride varnish), provider distribution and patient experience with OHP. The measures in this report were included based on recommendations from three stakeholder groups: the Oral Health Workgroup of the Medicaid Advisory Committee, the Dental Metrics Workgroup of the Metrics & Scoring Committee, and the CCO Oregon Dental Workgroup (see Appendix A).

Data in this report are specific to members enrolled in CCOs, consistent with other CCO reporting such as the semiannual performance metrics reports. OHA is exploring options to report similar oral health data for the fee-for-service (FFS) population. OHA is also considering capacity to report additional oral health data, including more measures recommended by the Medicaid Advisory Committee, as new data become available. As recommended by stakeholders, measures are stratified, where possible, to assess potential disparities, including by race/ethnicity and age. OHA is exploring additional stratification by disability in future reports.

How to read this report

Measures in this report are reported in five domains based on oral health access priorities identified by the Medicaid Advisory Committee's Oral Health Workgroup:


Provider distribution


Utilization: Quality of services


Patient experience


Care coordination


Integration (of physical, oral and behavioral health)

Each section of this report starts with background on the domain and the measures included. Next, you will see data and charts for each measure. Data are reported at the state level, by race/ethnicity, by CCO and sometimes by age. Most measures include data reported for two time periods: 2015 (Jan. 1–Dec. 31, 2015) and mid-year 2016 (Jul. 1, 2015–Jun. 30, 2016). The service type indicates whether the measure includes services by dental providers, non-dental providers, or both (see sidebar).

For more information about technical measure specifications and data sources, see Appendix B: Technical Appendix (page 26).

Dental services vs. oral health services in measurement

Most oral health services are provided by or under the supervision of a dentist. However, independent dental hygienists, called expanded practice dental hygienists (EPDHs) in Oregon, can also provide many services without a dentist's supervision. EPDHs increasingly provide oral health services in community-based settings such as schools, WIC clinics, addiction centers and correctional institutions. And more and more medical providers are delivering some oral health services. Fluoride varnish and oral health assessments are two examples of services that can be delivered by a medical provider, such as a pediatrician during a well-child visit.

Some measures in this report include only services provided under the supervision of a dentist, and others include services provided by a non-dentist, such as in a medical setting. This report uses Dental Quality Alliance* definitions to distinguish between the two types of services:

Dental services means services provided under the supervision of a dentist.

Oral health services means services provided by a non-dentist (such as a primary care provider) and not under a dentist's supervision.

**Dental Quality Alliance User Guide for Measures Calculated Using Administrative Claims Data (Jan 2016) http://www.ada.org/en/~/media/ADA/Science%20and%20Research/Files/DQA_2016_User_Guide*

Provider distribution

Provider-to-population ratios can be a helpful starting point to see if there are enough providers in a given community to serve those needing services. The provider-to-population ratio by county can help show regional variation in potential provider availability.

Compared with other states, Oregon ranks eighth in terms of its dentist-to-population ratio (1:1,363, or a little more than 1 provider to every 1,500 people).[*] However, this statewide number can mask important variation at the regional level. Oregon has a greater mix of rural and frontier areas than many other states, and health providers tend to be more accessible in urban environments.

This report includes two maps to help shed light on the distribution of dental providers throughout the state and members using services by county.

Dentist to total population

The first map shows how dentists are distributed in each Oregon county compared with the number of people living in each county. This map shows all providers, whether or not they serve Medicaid members, and all county residents, whether or not they are part of the Medicaid program. More than half of providers (58.5%) report they do not see any Medicaid patients (see table on page 5). Of those providers who report seeing Medicaid patients, 46.1% have less than 25% Medicaid patients in their patient mix. The data for this map and the accompanying table comes from a licensing renewal survey and is self-report. Some dentists (11.5% of total dentist FTE) indicated they weren't sure if they saw Medicaid members, so the number of dentists who see Medicaid members could be higher or lower.

Percent of Medicaid members receiving dental services by county

The second map pulls information from Medicaid claims, and shows the percentage of members who received any dental service in 2015 by county.

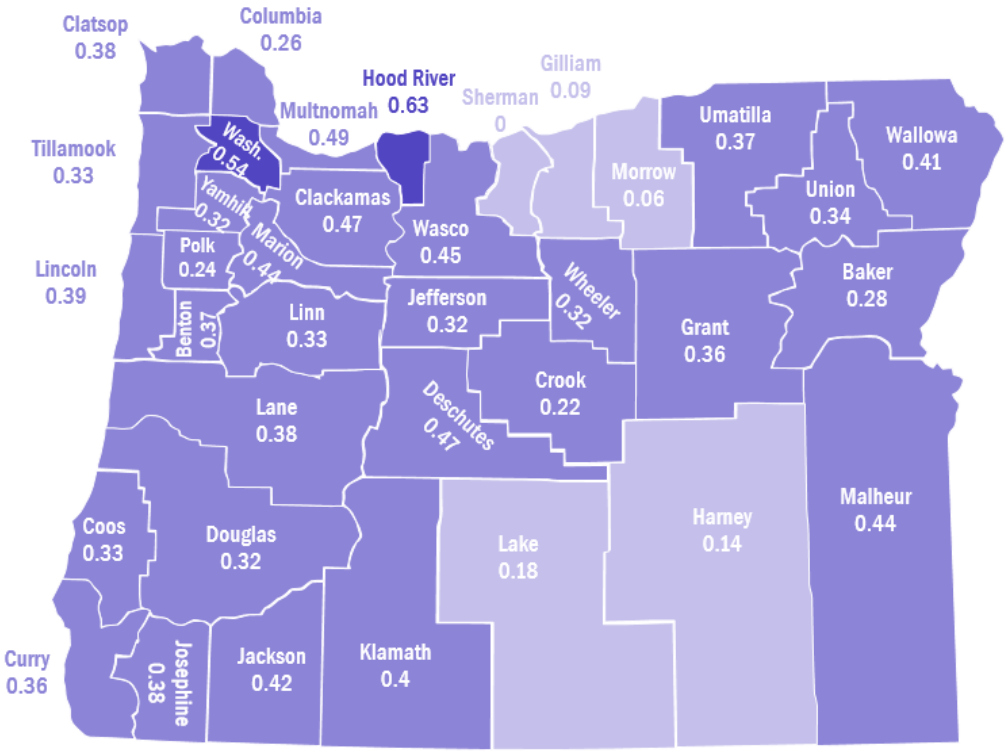
➤ Learn more about measure specifications in Appendix B: Technical Appendix (page 26).

[*] Smith, Jeanene et al. Oral Health Integration in Oregon: Environmental Scan and Recommendations. (2016). Health Management Associates

Provider distribution

All dentists: FTE dentists per 1,000 Oregonians

Source: Oregon Health Care Workforce Survey (2015/2016 renewal data)



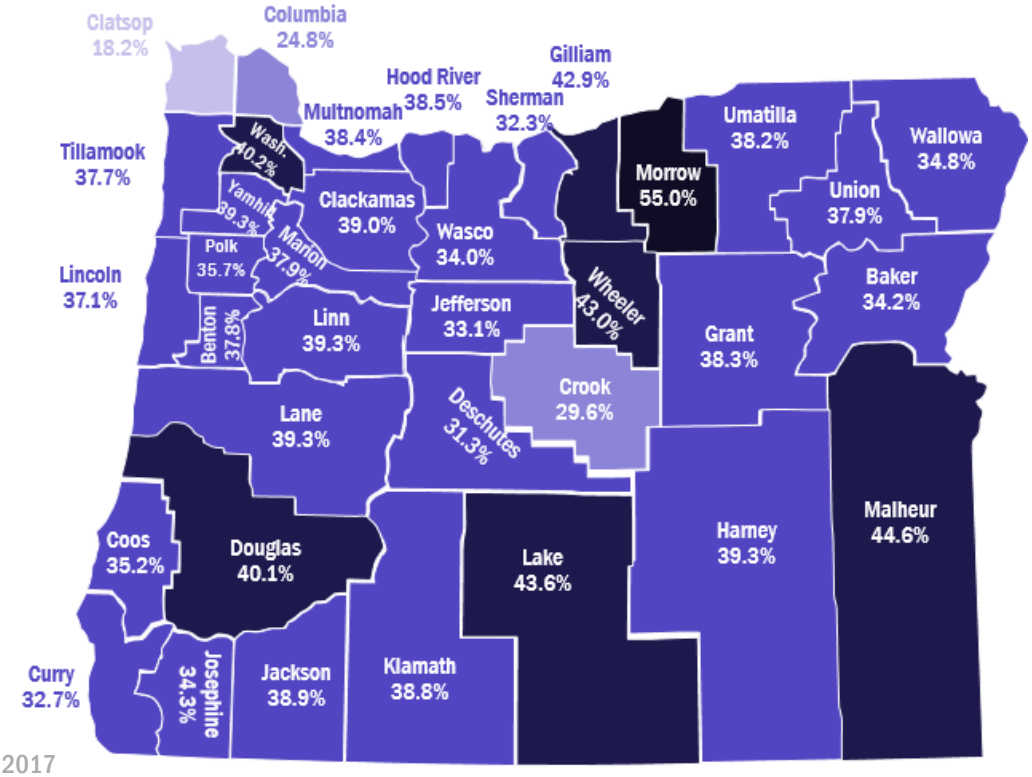
Percent of a dentist's caseload that are Medicaid patients. 2015/2016 renewal data (statewide)	
No Medicaid	58.5%
1-24% Medicaid	19.2%
25-49% Medicaid	7.5%
50-74% Medicaid	5.5%
75-100% Medicaid	9.4%

The percentages above reflect those with known Medicaid acceptance status. 11.5% of all providers report unknown Medicaid caseload.

Legend
0.0–0.20
0.21–0.50
0-51–0.75
>0.75

Percent OHP member receiving any dental service

Source: Administrative (billing) claims (2015)



Legend
11–20%
21–30%
31–40%
41–50%
51–60%

Utilization: Quality of services

A commonly used indicator of whether members have access to services is the proportion of members receiving services, also called utilization. Medicaid members typically receive services at lower rates than those with private or employer-based insurance. Just over half of Oregon's adult Medicaid population (51.7%) reported having a dental visit in 2014,[*] compared with 67% of the general adult population in Oregon.[†]

This report includes two measures of broad types of services received, preventive and dental services received during the year (both reported by adults and children). It also includes one measure of specific services received, topical fluoride applications for children. For recent data on dental sealants on permanent molars for children 6-14, see the CCO Metrics Performance Report: https://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx.

CCO members receiving preventive dental services

Preventive dental services include checkups, cleanings, fluoride and other services that help keep people healthy and catch early signs of disease. Regular preventive dental visits are important for both children and adults, as oral diseases are common and largely preventable. In fact, dental caries (tooth decay) is the most common chronic disease for children aged 6 through 11 years and 12 through 19 years in the United States.[‡]

CCO members receiving any dental services

The any dental service measure shows the proportion of members who saw a dentist during the year for any reason, whether a preventive service (such as cleanings), diagnostic service or treatment service (such as fillings, surgeries and other treatment).

Topical fluoride varnish for children

Professional topical fluoride treatments help prevent dental caries (tooth decay). The American Academy of Pediatric Dentistry recommends children at risk of tooth decay receive topical fluoride every three to six months,[§] and the U.S. Preventive Services Task Force recommends primary care clinicians apply fluoride varnish on children from primary tooth eruption to five years.[**] OHP reimburses topical fluoride varnish applications in dental and medical settings, up to age 19.

➤ Learn more about measure specifications in Appendix B: Technical Appendix (page 26).

[*] 2014 Medicaid Behavioral Risk Factor Surveillance System (MBRFF) Survey: Report of Results. Available at https://www.oregon.gov/oha/analytics/MBRFFS%20Docs/2014%20MBRFSS%20Report.pdf

[†] Oregon Oral Health Surveillance System 2002-2015. Available at: https://public.health.oregon.gov/PreventionWellness/oralhealth/Documents/OralHealthSurveillanceReport2016.pdf

[‡] https://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html

[§] http://www.aapd.org/media/policies_guidelines/g_periodicity.pdf

[**] https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening

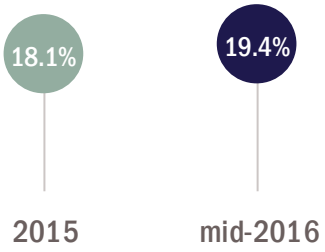
Any preventive service (adults)

Measure description

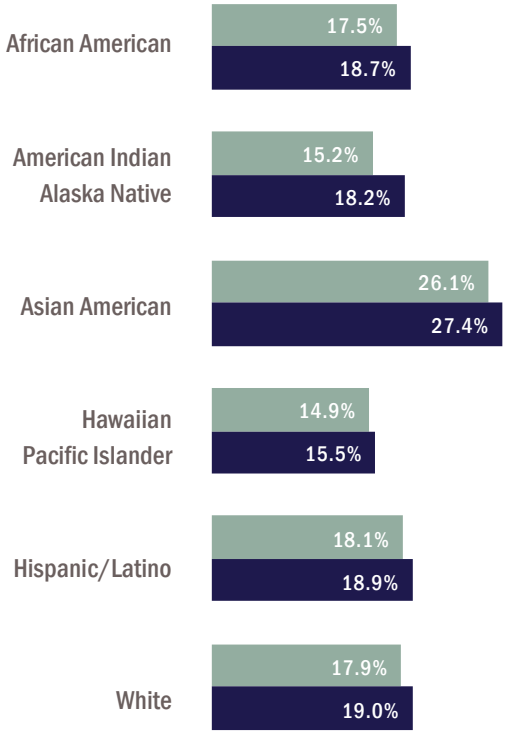
Percentage of enrolled adults (ages 19 and older) who received a preventive dental service during the measurement year.

Domain: Utilization (quality of services)
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, CCO Oregon Dental Workgroup
2015 n = 374,501 / mid-2016 n = 385,499

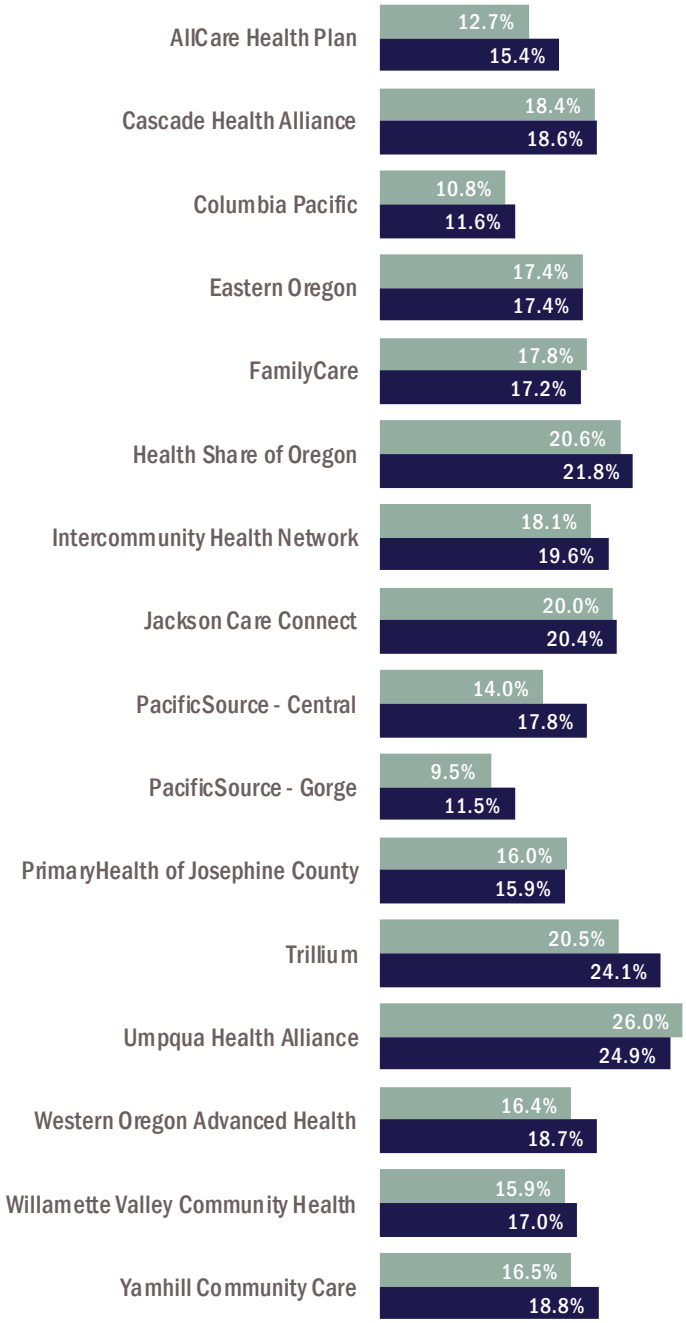
Statewide.
2015 and mid-2016



By race and ethnicity.
2015 and mid-2016



By CCO.
2015 and mid-2016



Any preventive service (children)

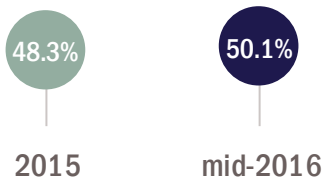
Measure description

Percentage of enrolled children (ages 0-18) who received a preventive dental service during the measurement year.

Domain: Utilization (quality of services)
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, CCO Oregon Dental Workgroup
2015 n = 259,708 / mid-2016 n = 253,058

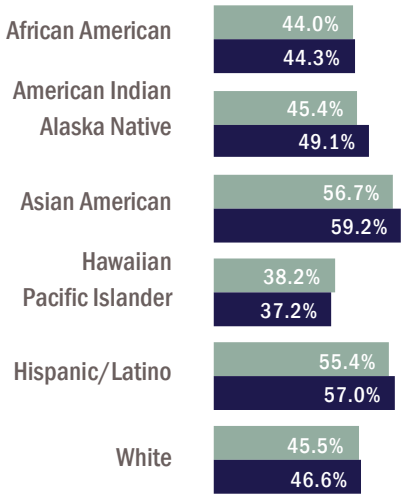
Statewide.

2015 and mid-2016



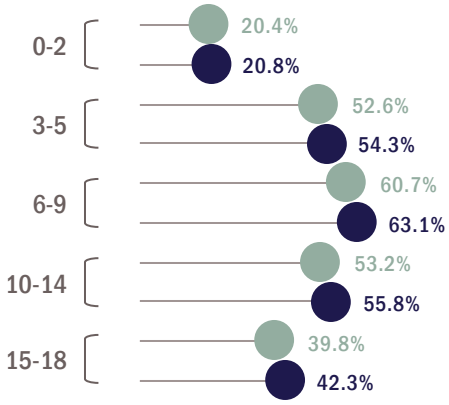
By race and ethnicity.

2015 and mid-2016



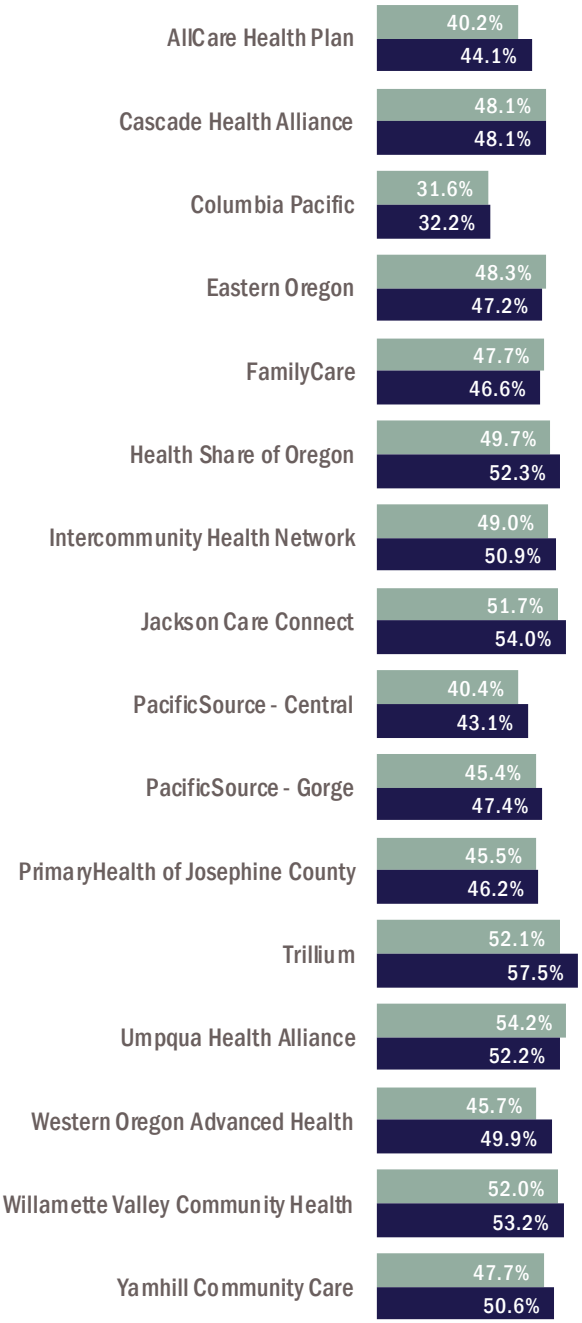
By age.

2015 and mid-2016



By CCO.

2015 and mid-2016



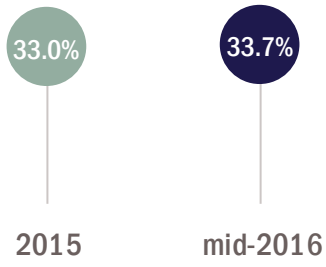
Any dental service (adults)

Measure description

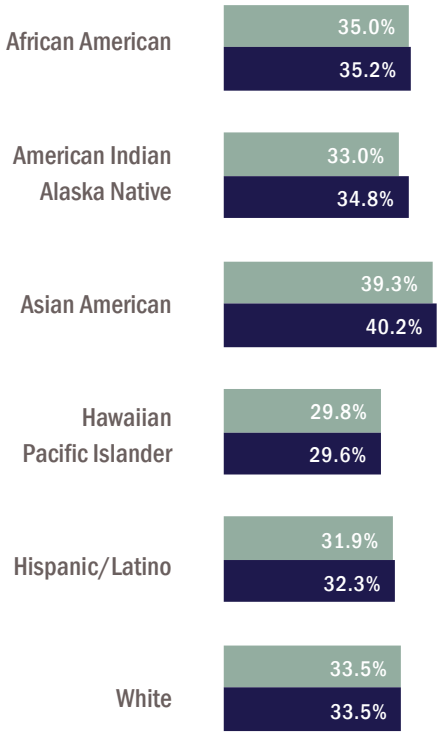
Percentage of adults (ages 19 and older) who received any dental service during the measurement year.

Domain: Utilization (quality of services)
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, Dental Quality Metrics Workgroup, CCO Oregon Dental Workgroup
2015 n = 374,501 / mid-2016 n = 385,499

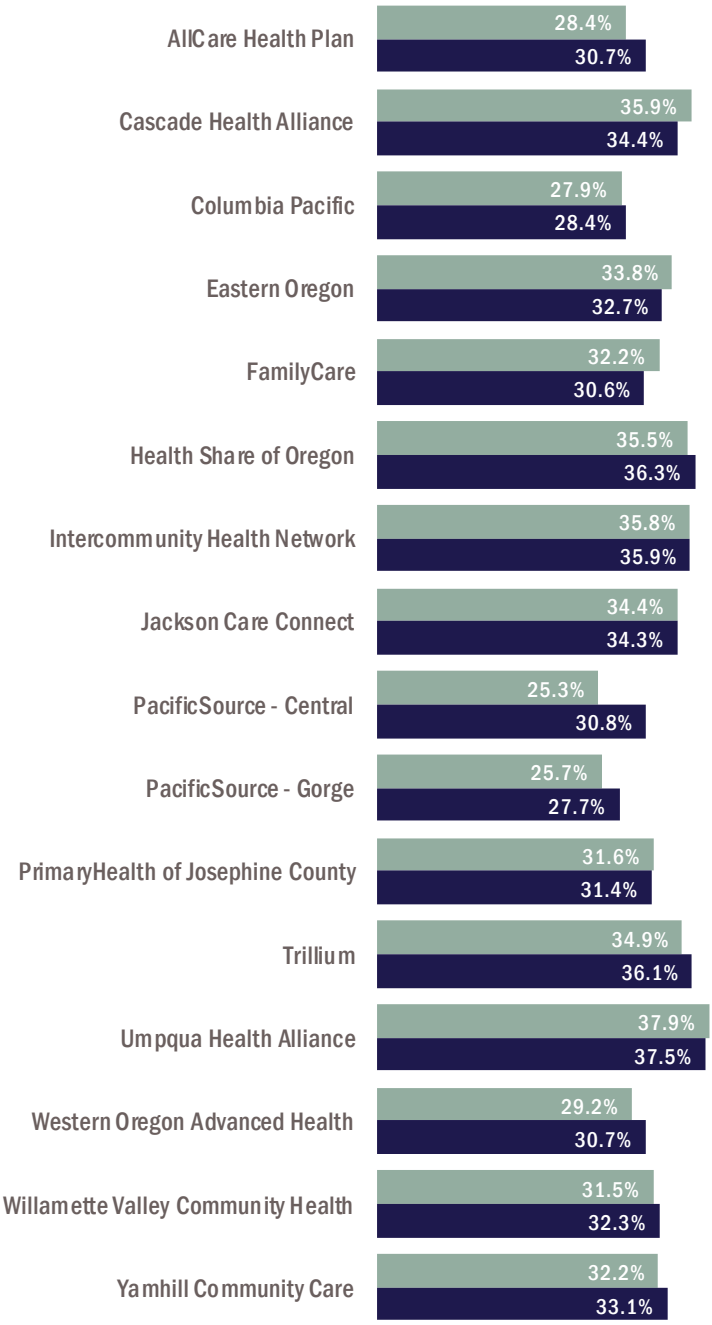
Statewide.
2015 and mid-2016



By race and ethnicity.
2015 and mid-2016



By CCO.
2015 and mid-2016

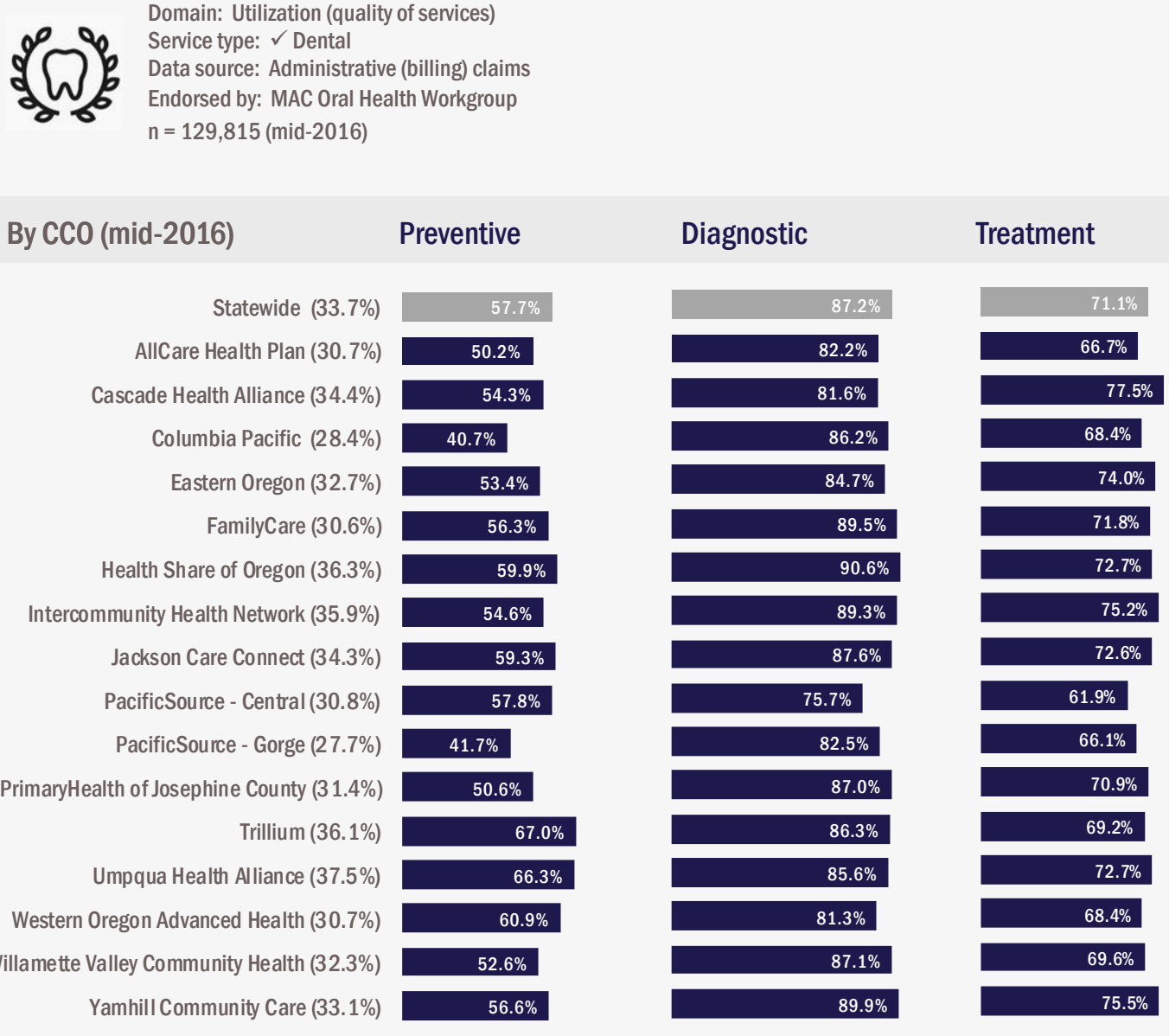


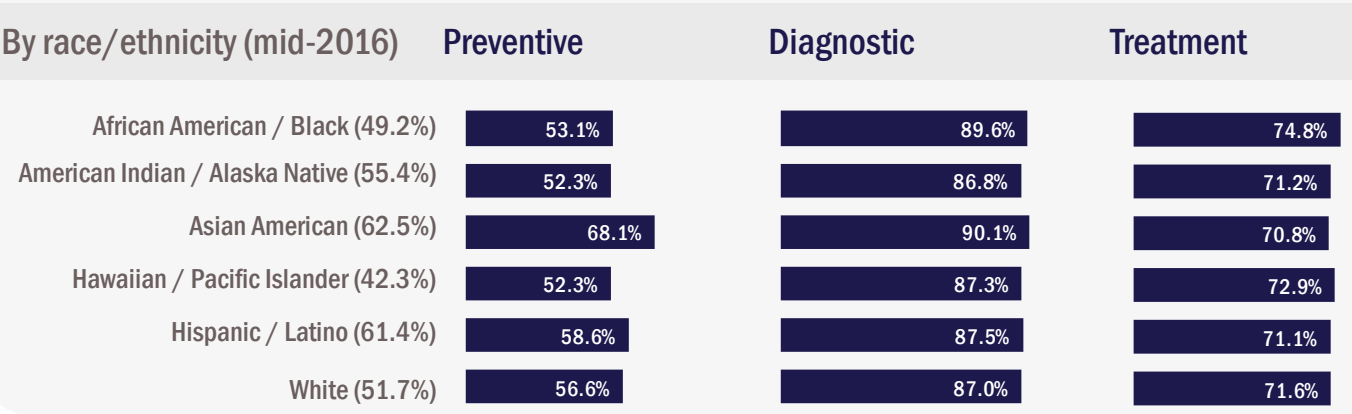
Any dental service by service type (adults)

Measure description

The charts below show the types of services received by adults who received any dental service (previous page) in mid-2016. The percentage of adults who received any dental service is shown in parentheses for reference. Percentages do not add to 100 because an individual can receive multiple types of service.

Domain: Utilization (quality of services)
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup
n = 129,815 (mid-2016)





Any dental service (children)

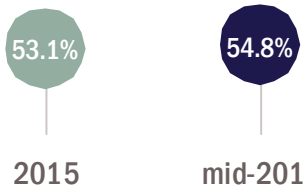
Measure description

Percentage of enrolled children (ages 0-18) who received any service during the measurement year.

Domain: Utilization (quality of services)
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, Dental Quality Metrics Workgroup, CCO Oregon Dental Workgroup
2015 n = 259,708 / mid-2016 n =253,058

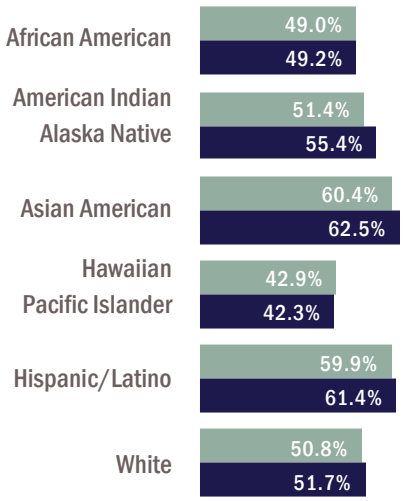
Statewide.

2015 and mid-2016



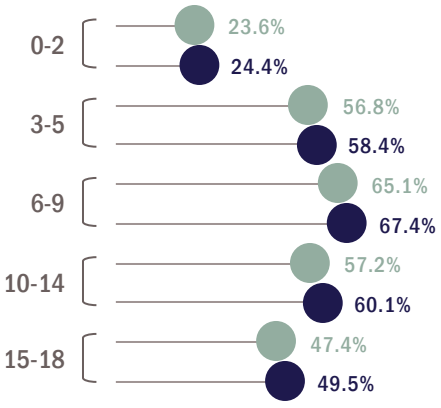
By race and ethnicity.

2015 and mid-2016



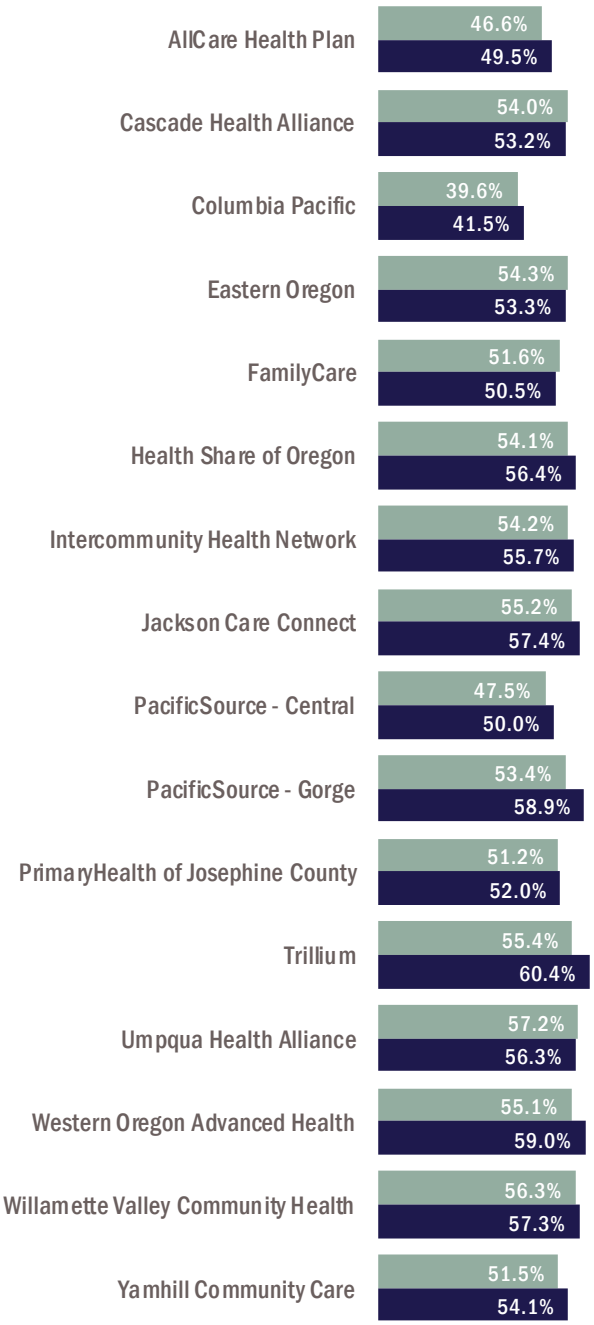
By age.

2015 and mid-2016



By CCO.

2015 and mid-2016

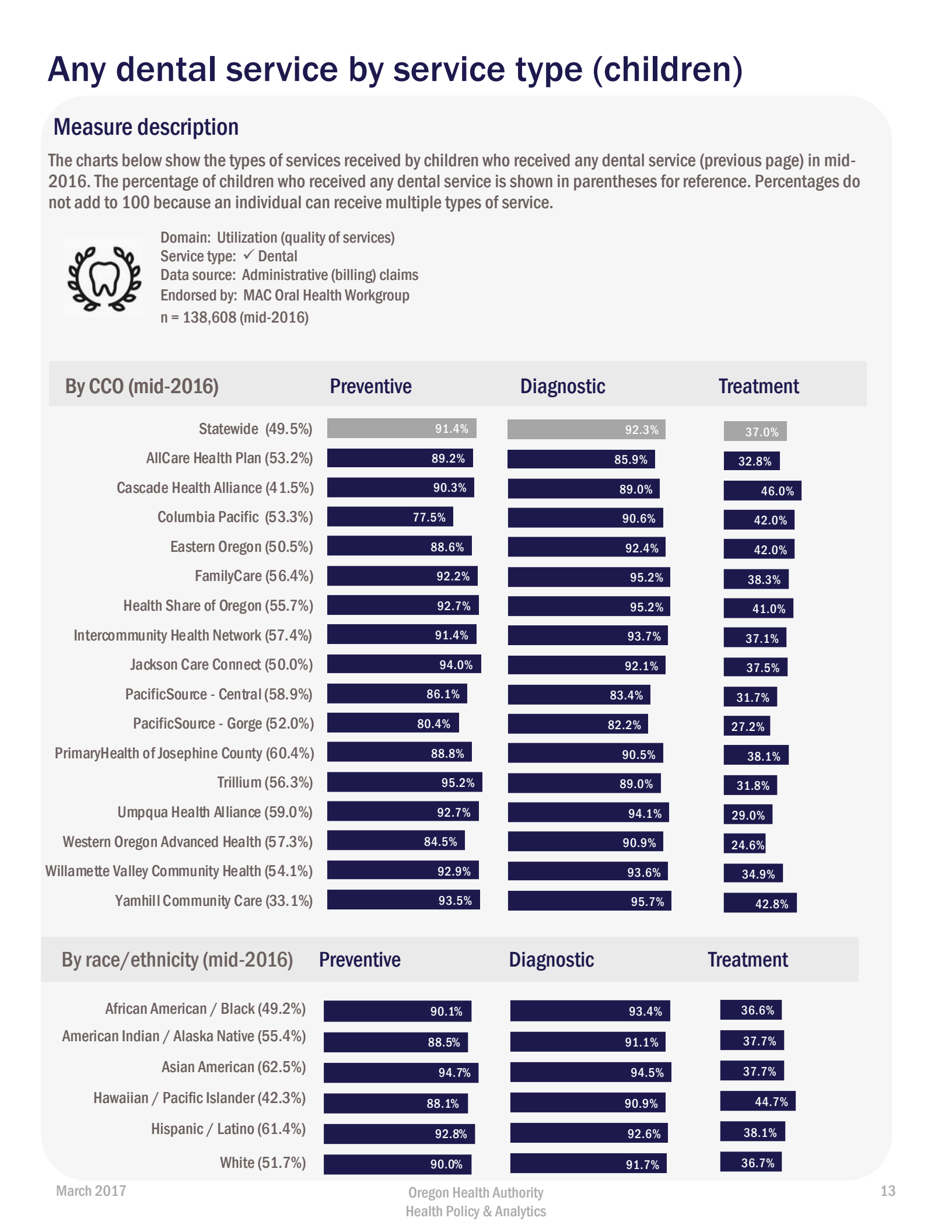


Any dental service by service type (children)

Measure description

The charts below show the types of services received by children who received any dental service (previous page) in mid-2016. The percentage of children who received any dental service is shown in parentheses for reference. Percentages do not add to 100 because an individual can receive multiple types of service.

Domain: Utilization (quality of services)
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup
n = 138,608 (mid-2016)



Topical fluoride varnish for children

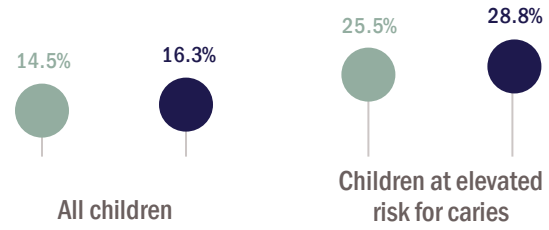
Measure description

Percentage of enrolled children (ages 1 to 21) who received at least two topical fluoride applications during the measurement year.

Domain: Utilization (quality of services)
Service type: ✓ Dental ✓ Medical
Data source: Administrative (billing) claims
Endorsed by: Dental Quality Metrics Workgroup, CCO Oregon Dental Workgroup
2015 n = 275,403 / mid-2016 n = 268, 009

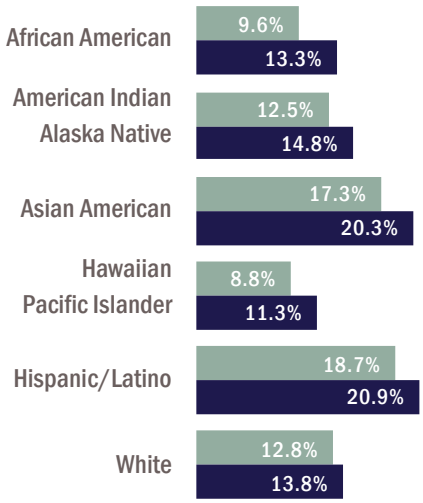
Statewide.

2015 and mid-2016



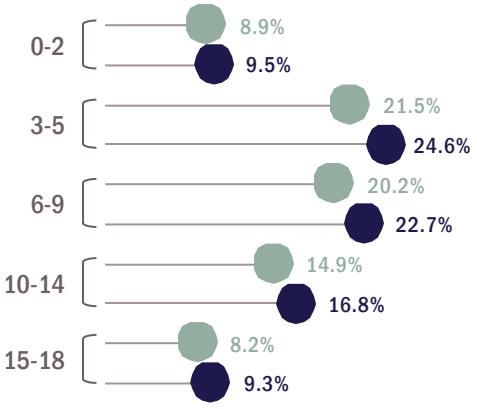
By race and ethnicity.

2015 and mid-2016



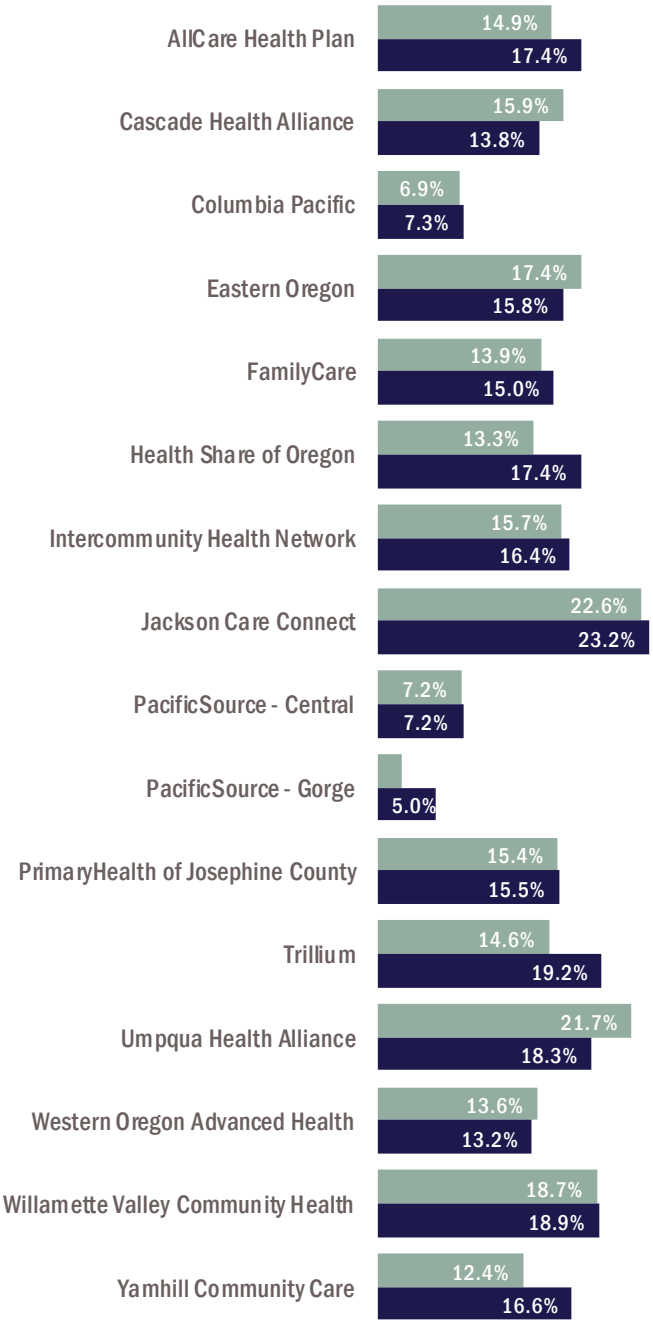
By age.

2015 and mid-2016



By CCO.

2015 and mid-2016



Patient experience

Patient experience measures, such as surveys, are an important way to understand barriers and challenges that may prevent members from receiving services. Oregon fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to ask members to report on and evaluate their experiences with health care.

In 2014, two oral health questions were added to the OHP CAHPS survey to assess: 1) percentage of CCO members who report having a regular dentist; and 2) percentage of CCO members who were able to see a dentist as soon as they wanted in the case of a dental emergency.

Regular dentist

Having a regular dentist may make members more likely to receive regular oral health services, particularly preventive care. The American Academy of Pediatric Dentistry, the American Dental Association, and the Academy of General Dentistry all recommend establishing a dental home for children by age 1. A dental home is the "ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health delivered in a comprehensive, continuously accessible, coordinated and family-centered way."*

Access to emergency dental care

Having access to a dental office for emergency dental care can help ensure appropriate treatment and follow-up care. Access to emergency dentistry also helps prevent unnecessary ED visits (see page 18). While the CAHPS survey does not provide a measure of how quickly patients are able to access emergency dental appointments, it gives important insight into whether patients feel their critical health needs are being addressed.

➤ Learn more about measure specifications in Appendix B: Technical Appendix (page 26).

* http://www.aapd.org/media/policies_guidelines/d_dentalhome.pdf

Had a regular dentist

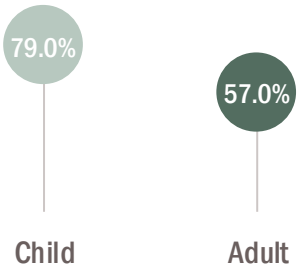
Measure description

Percentage of members who had a regular dentist 2015.

Domain: Patient experience
Data source: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which asks consumers and patients to report on and evaluate their experience with health care.
Endorsed by: Dental Quality Metrics Workgroup

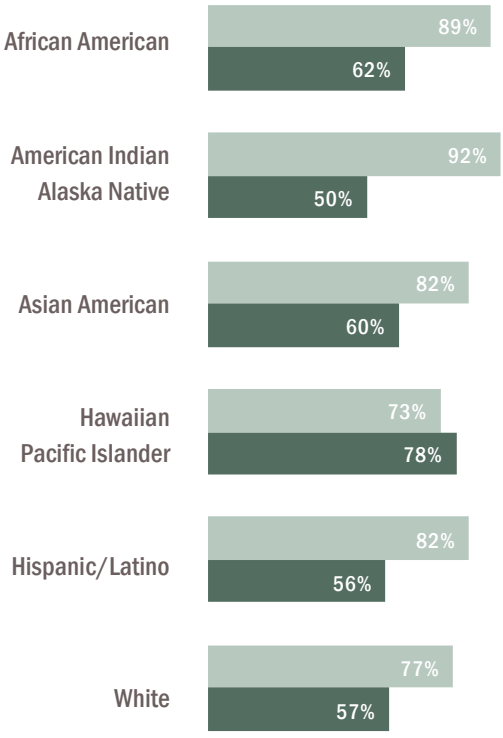
Statewide.

Children and adults



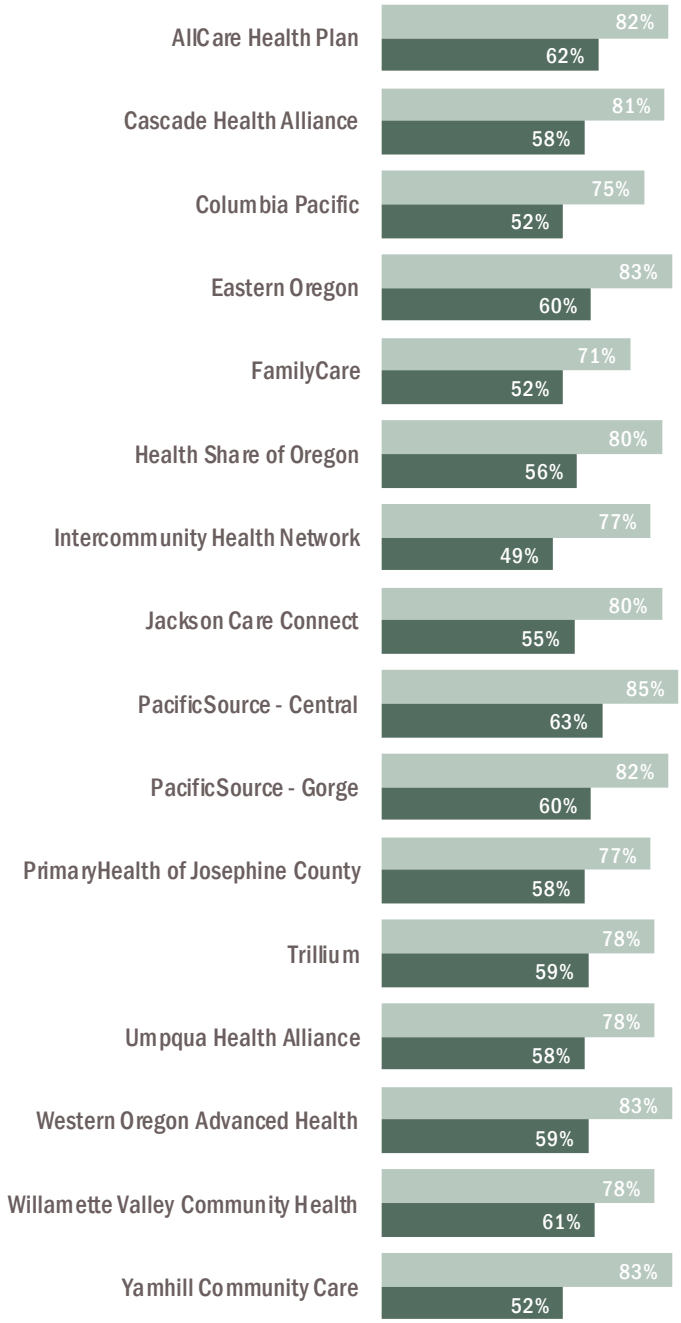
By race and ethnicity.

Children and adults



By CCO.

Children and adults



Access to emergency dental care

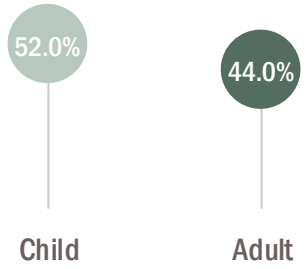
Measure description

Percentage of members who experienced a dental emergency and were 'always' or 'usually' able to see a dentist as soon as they needed.

Domain: Patient experience
Data source: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which ask consumers and patients to report on and evaluate their experience with health care.
Endorsed by: MAC Oral Health Workgroup, Dental Metrics Quality Workgroup, CCO Oregon Dental Workgroup

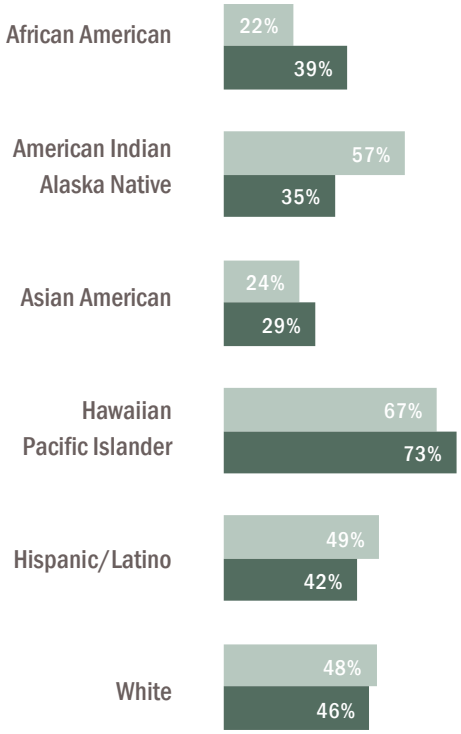
Statewide.

Children and adults



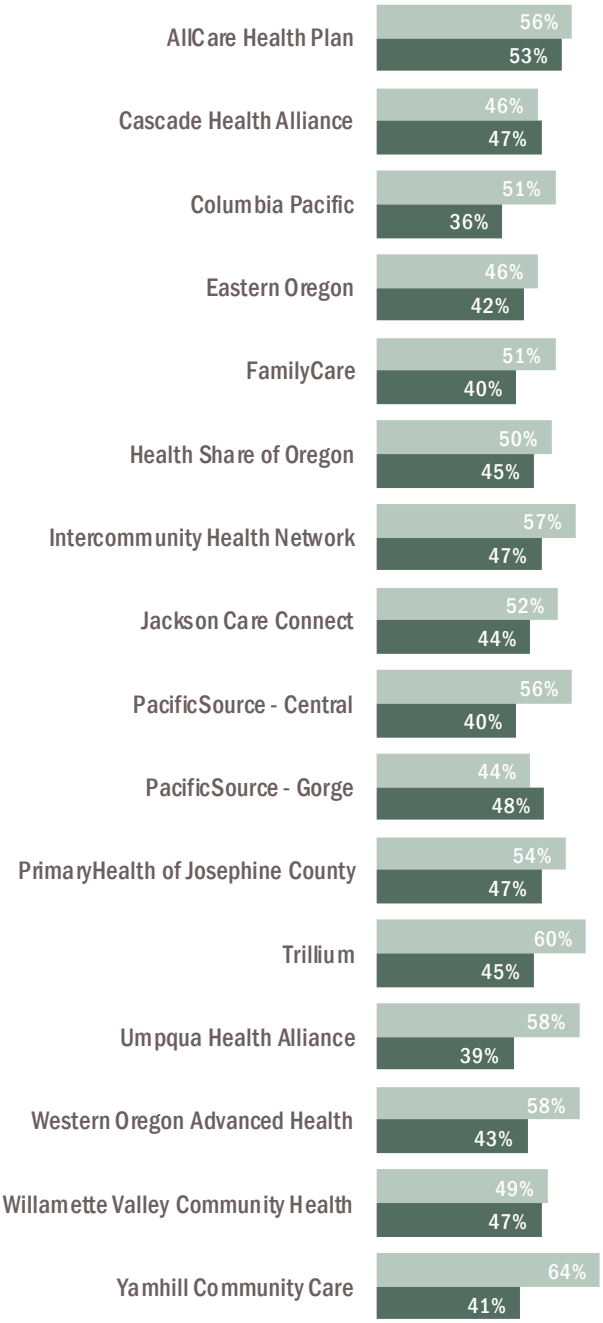
By race and ethnicity.

Children and adults



By CCO.

Children and adults



Care coordination

One aim of Oregon's health system transformation efforts is improved care coordination, with the goal of helping people better manage chronic conditions and prevent unnecessary emergency department visits. This section highlights two measures of care coordination recommended by the Medicaid Advisory Committee's Oral Health Workgroup.

Follow-up dental services for people seen in the emergency department for non-traumatic (caries-related) dental reasons

Non-traumatic dental reasons are conditions that could be treated in a regular dental office rather than the emergency department (ED) – in other words, avoidable ED use for dental care. A recent study found higher ED visits for dental-related visits in Oregon than nationally reported.[*] National research has shown that the majority of dental-related ED visits are caries-related, which are almost entirely preventable.[†] Connecting those seen in the ED with appropriate follow-up care can help ensure appropriate dental treatment and avoid future ED visits.

Follow-up care for patients with periodontal disease

Periodontal disease (gum disease) is one of the most common chronic health conditions for adults, affecting an estimated 47% of adults aged 30 years and older in the United States.[‡] Gum disease is also associated with a number of systemic health conditions, from diabetes, cancer and heart disease, to low birth weight.[§] Follow-up care can help reduce tooth loss and prevent recurrence of disease.

Case study: Reducing avoidable ED use for dental care

In 2015, hospitals in Oregon adopted the Emergency Department Information Exchange (EDIE), which alerts hospitals in real time when a patient visits the ED. PreManage is a complementary software that alerts care managers (CCOs, DCOs and other providers) when members are seen in the ED. The rollout of EDIE and PreManage may increase capacity for care coordination around ED use for non-traumatic dental. For example, CareOregon Dental is using PreManage to connect members with an ED dental visit with follow-up care, a dental home and resources to address barriers to care. As of February 2017, 13 out of 16 CCOs have or are in process of setting up subscriptions to use PreManage, which cover their dental care managers, and five DCOs have or are in process of setting up stand-alone subscriptions.

[*] Sun, B., Chi, D., et. al. Emergency Department Visits for Non-Traumatic Dental Problems: A Mixed-Methods Study (May 2015). Am J Public Health. 947-955. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386544/pdf/AJPH.2014.302398.pdf

[†] *See e.g.,* Seu K, Hall KK, Moy E. Emergency Department Visits for Dental-Related Conditions, 2009. Healthcare Cost and Utilization Project Statistical Brief #143. Rockville, MD: Agency for Healthcare Research and Quality; November 2012. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb143.pdf; Allareddy V, Nalliah RP, Haque M, Johnson BS, Rampa SB, Lee MK. Hospital-based emergency department visits with dental conditions among children in the United States: nationwide epidemiological data. Pediatr Dent 2014;37(5):393-9.

[‡] Eke PI, Dye BA, Wei L, Thornton-Evans GO, Genco RJ. Prevalence of periodontitis in adults in the United States: 2009 and 2010. J Dent Res. 2012:91(10):914-920.

[§] *See e.g.,* Borgnakke WS*,* Ylöstalo PV*,* Taylor GW*,* Genco RJ*.* Effect of periodontal disease on diabetes: systematic review of epidemiologic observational evidence. J Clin Periodontol 2013*;* 40 *(*suppl. 14*):* S135–S152*.;* Xiong, X., Buekens, P., Fraser, W., Beck, J. and Offenbacher, S. (2006), Periodontal disease and adverse pregnancy outcomes: a systematic review. BJOG: An International Journal of Obstetrics & Gynaecology, 113: 135–143.; Chaffee BW and Weston SJ (2010), Association between chronic periodontal disease and obesity: A systematic review. Journal of Periodontology, 81(12): 1708-1724; Humphrey, L.L., Fu, R., Buckley, D.I. et al. J GEN INTERN MED (2008) 23: 2079; Fitzpatrick SG and Katz J (2009), The association between periodontal disease and cancer: A review of the literature. Journal of Dentistry, 38(2): 83-95.

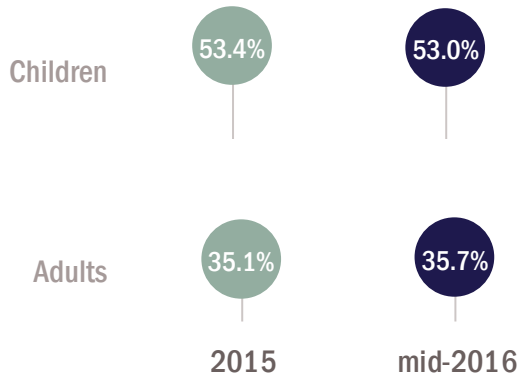
Follow-up after emergency department visits for caries

Measure description

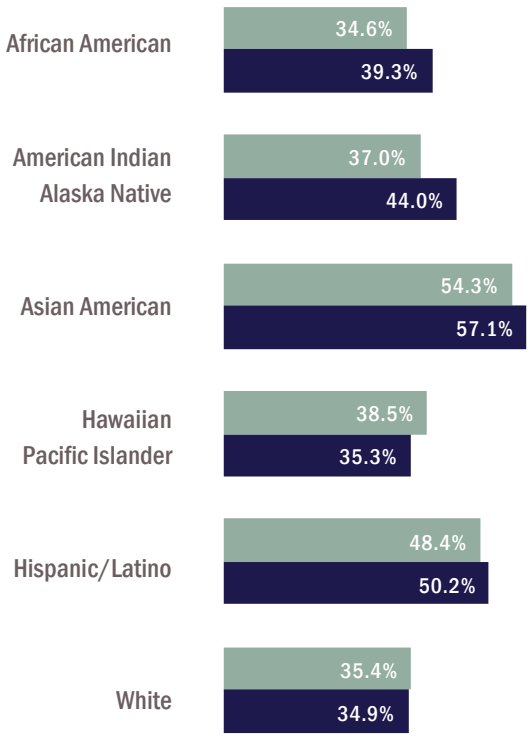
Percentage of CCO members (all ages) who were seen in the emergency department (ED) for non-traumatic (caries-related) dental reasons and visited a dentist within 30 days following the ED visit.

Domain: Care coordination
Service type: ✓ Dental
Data source: Administrative (billing) claims Endorsed by: MAC Oral Health Workgroup, CCO Oregon Dental Workgroup
2015 n = 6,915 / mid-2016 n = 6,960

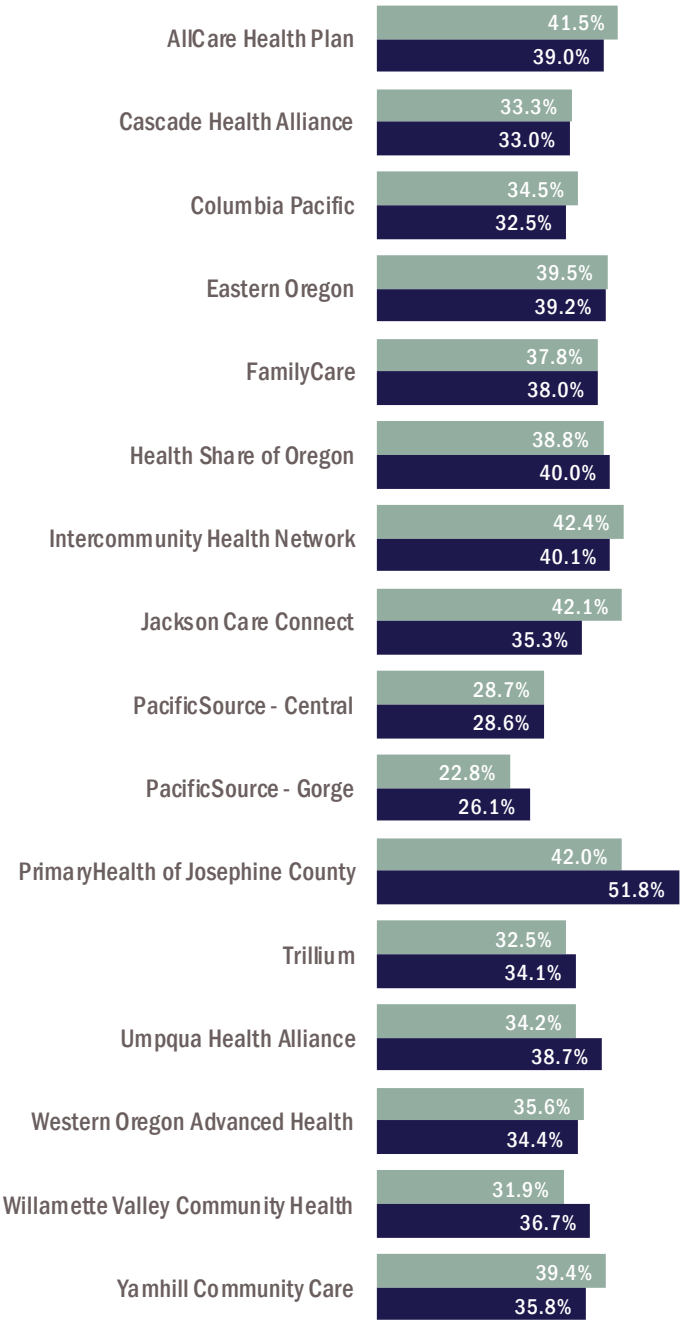
Statewide.
2015 and mid-2016



By race and ethnicity.
2015 and mid-2016



By CCO.
2015 and mid-2016



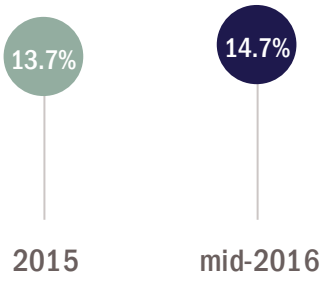
Oral health evaluation for patients with periodontitis

Measure description

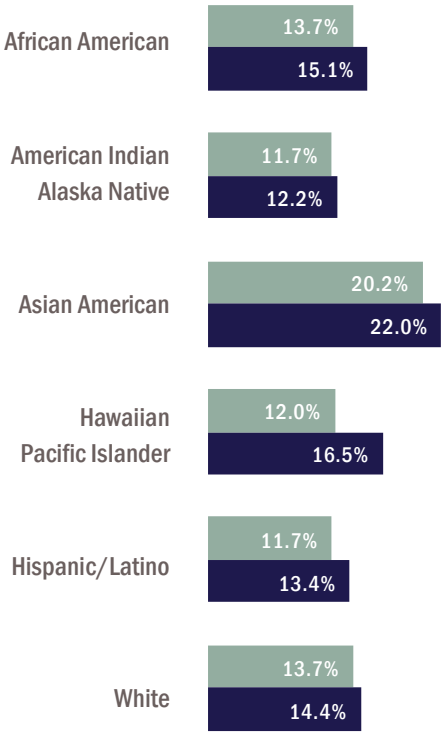
Percentage of CCO-enrolled adults (ages 18 and older) treated for periodontitis (serious gum infection) who received at least one comprehensive oral evaluation within the reporting year.

Domain: Care coordination
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, CCO Oregon Dental Workgroup
2015 n = 26,584 / mid-2016 n = 31,114

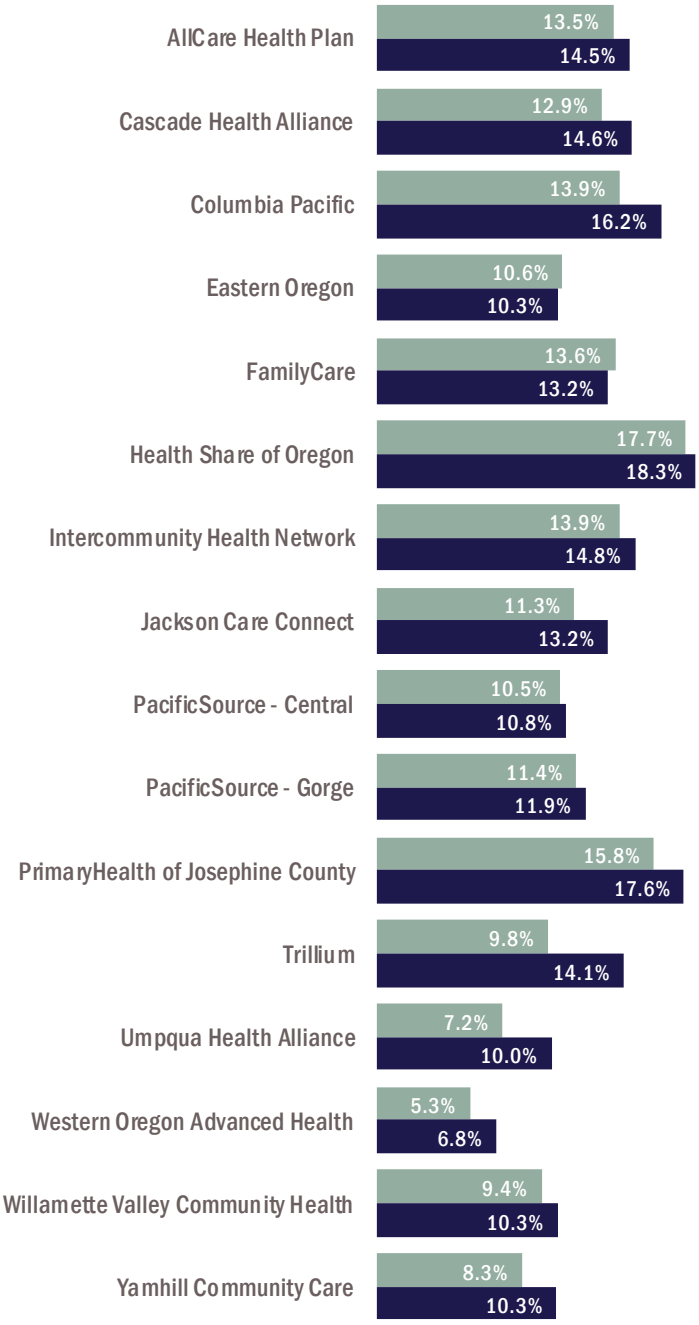
Statewide.
2015 and mid-2016



By race and ethnicity.
2015 and mid-2016



By CCO.
2015 and mid-2016



Oral health integration

One of the key goals of Oregon's coordinated care model is to integrate physical, oral and behavioral health care to treat the whole person. Poor oral health is linked to chronic diseases, such as diabetes and heart disease, and associated with other health risks such as stroke and low birth weight. More integrated health care delivery can improve health and control costs. Additionally, a greater connection between the physical, behavioral and oral health delivery systems can increase access to oral health services by enhancing care coordination and creating new opportunities to address oral health needs (e.g., providing fluoride varnish at well-child visits).

This section includes two measures of integration recommended by the Medicaid Advisory Committee's Oral Health Workgroup. For recent data on oral health assessments for children in DHS custody (foster care), see the CCO Metrics Performance Report: https://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx.

Dental care for adults with diabetes

Care coordination between the physical health and dental care delivery systems is particularly important for people with diabetes. People with diabetes are at greater risk of gum disease, and having gum disease can also make it difficult for people with diabetes to control their blood sugar.[*]

Oral health assessments for children younger than age 6

Oral health assessments are an important way for medical providers to integrate oral health into their work and increase care coordination with dental providers. The American Academy of Pediatrics recommends all children have an oral health assessment by a qualified pediatric health care professional starting at six months and periodically throughout early childhood. Oral health assessments include risk assessment for caries (tooth decay), anticipatory guidance and counseling on good oral hygiene practices and nutrition, and referral to a dentist to establish a dental home.

OHP reimburses providers for oral health assessments in medical settings for children under younger than age 6. To receive reimbursement, providers must have received recent training through Smiles for Life[†] or First Tooth[‡] (offered through the Oregon Oral Health Coalition). Some CCOs have voluntarily extended this coverage to all children aged 19 and younger.

➤ Learn more about measure specifications in Appendix B: Technical Appendix (page 26).

[*] B. Mealey. "Periodontal Disease and Diabetes: A Two-Way Street." *Journal of the American Dental Association 137*, 2006: 26S-31S.

[†] http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=555&pagekey=62948&cbreceipt=0

[‡] http://www.orohc.org/first-tooth/

Dental care for adults with diabetes

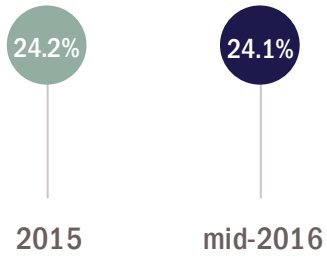
Measure description

Percentage of adult CCO members identified as having diabetes who received at least one comprehensive, periodic, or periodontal oral evaluation service within the reporting year.

Domain: Oral health integration
Service type: ✓ Dental
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, CCO Oregon Dental Workgroup
2015 n = 36,285 / mid-2016 n = 37,734 (mid-2016)

Statewide.

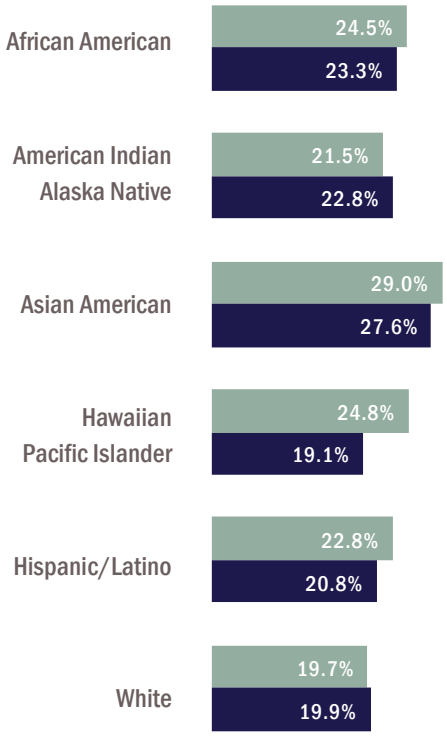
2015 and mid-2016



By race and ethnicity.

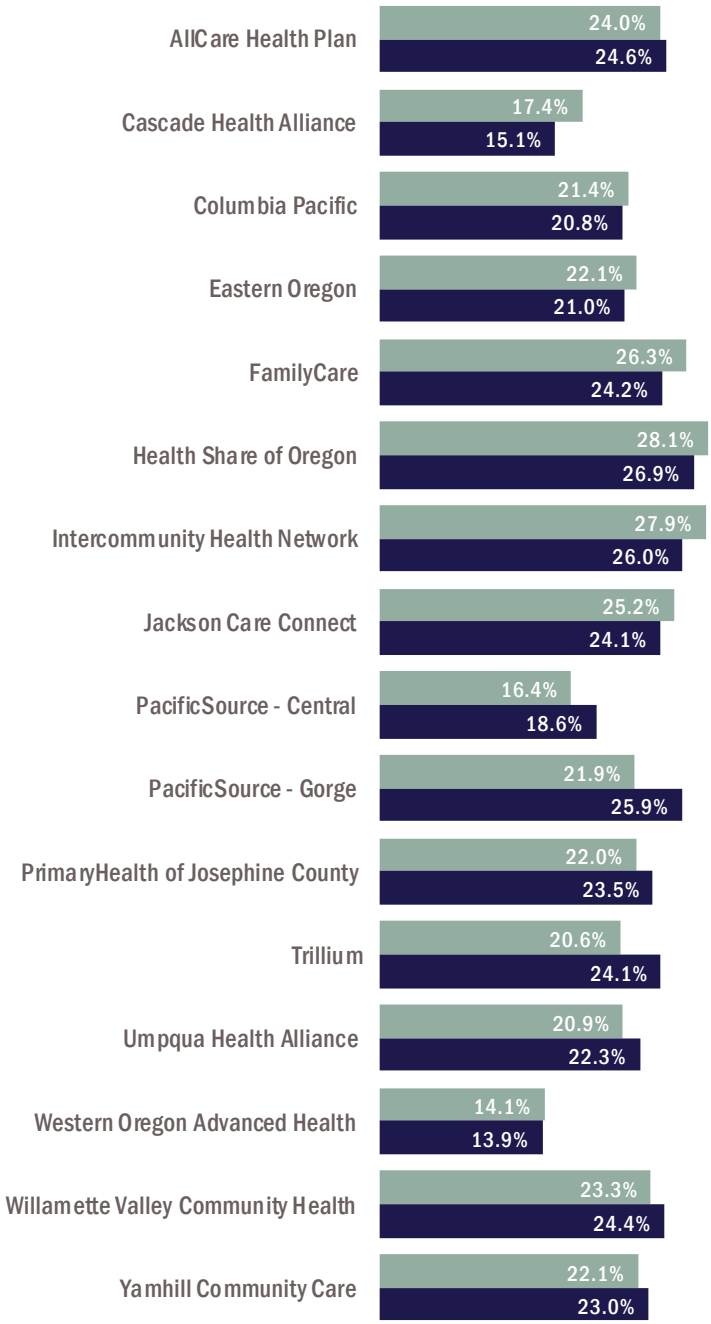
2015 and mid-2016

These data include Fee-for-Service



By CCO.

2015 and mid-2016



Oral health assessments in primary care

Measure description

Percentage of oral health assessments for children ages 0-6 that were provided by a medical practitioner.

Domain: Oral health integration
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup

Oral health assessments can be provided by both dental and medical practitioners. To further oral health integration, we looked at oral health assessments that were provided in a medical setting . The graphs on the next page show 1) the percentage of children 6 years and younger who had an oral assessment (by either a dentist or a medical provider) and 2) the percent of oral health assessments that were delivered by a medical provider (as opposed to a dentist).

In mid-2016, medical practioners in eight CCOs provided oral health assessments.

CCO	Number of children receiving an oral health assessment by a....		Total # of children receiving oral health assessment in primary care:
	...physician:	...advanced practice nurse or physician assistant:	
AllCare Health Plan	672	155	827
Eastern Oregon CCO		1	1
FamilyCare	1	4	5
Health Share of Oregon	1	14	15
Jackson Care Connect	170	3	173
PacificSource Gorge	1		1
Trillium	132	81	213
Yamhill Community Care	34	23	55

Case study: AllCare Health Plan

AllCare Oral Health Integration Manager Laura McKeane knows something about the importance of oral health in primary care. “Kids that are 0-3 will see their pediatrician 11 times during their first three years of life, but most won’t see a dentist at all,” she says. McKeane is one of a statewide network of trainers for First Tooth, a training-based program managed by the Oregon Oral Health Coalition (www.orohc.org/first-tooth) that helps medical organizations integrate oral health preventive services into current services. In 2015 and 2016 alone, McKeane trained more than 200 providers in Southern Oregon, including providers within and outside of her CCO's network and service area. In addition to the two-hour, interactive training, participants get a kit and resources to order more fluoride, and they also get continuing education credit, and even support through the implementation period. McKeane makes sure trainees are well fed, too. And McKeane says providers really see the need for these services in their clinics, especially in Josephine County where access to providers is difficult. She says that while many providers began the training wondering how they will fit oral health into already packed visits, by the end they’ve changed their minds. Seeing this transformation “makes it all worthwhile.”

Oral health assessments in primary care

Measure description

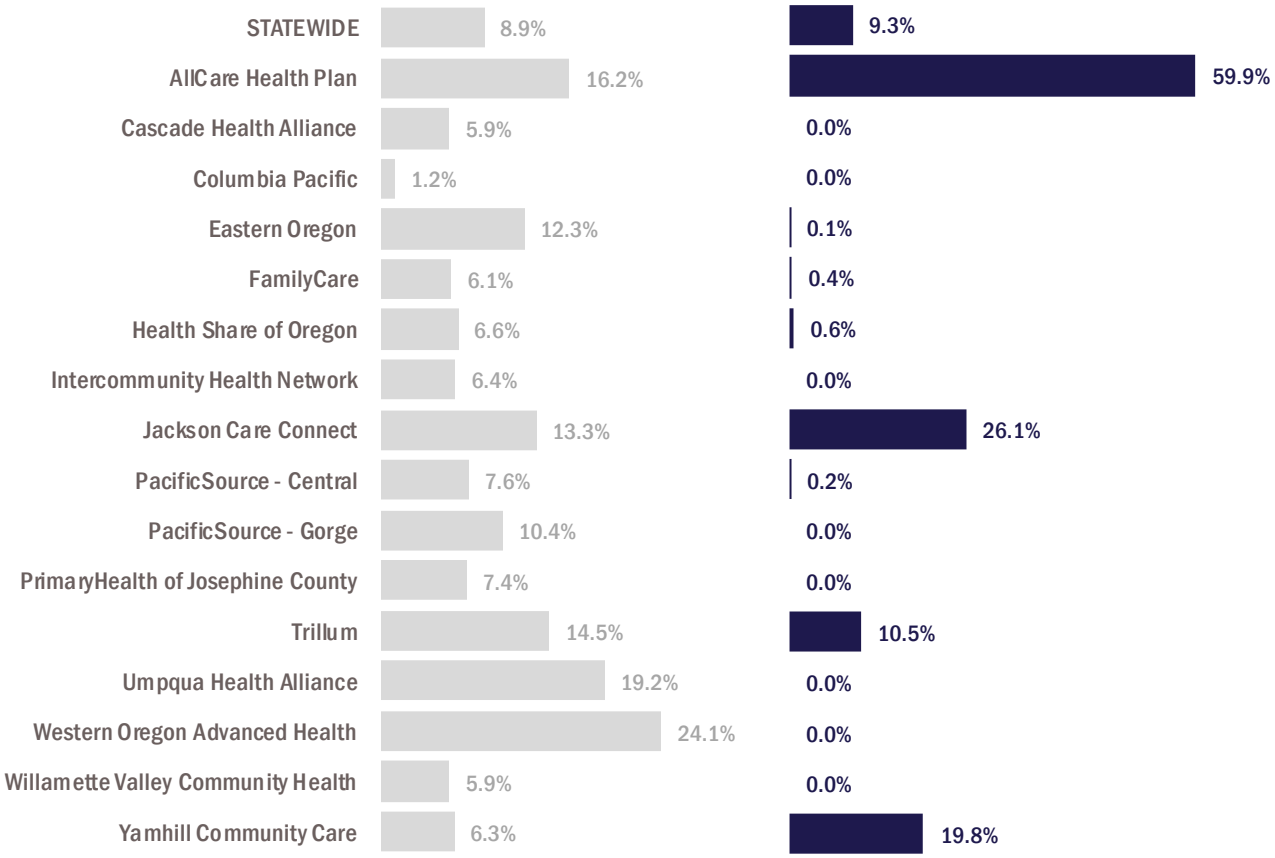
Percentage of oral health assessments for children ages 0-6 that were provided by a medical practitioner.

Domain: Oral health integration
Data source: Administrative (billing) claims
Endorsed by: MAC Oral Health Workgroup, Dental Metrics Quality Workgroup

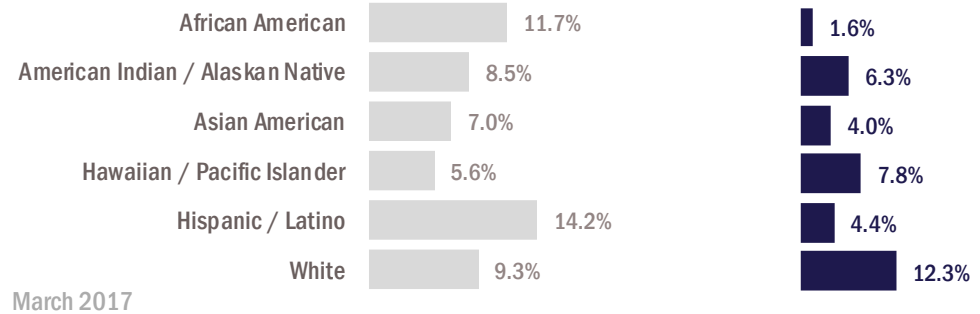
Percent of children (0-6) who had an oral health assessment in mid-2016.

Percent of oral health assessments provided by a medical practitioner (versus a dentist) in mid-2016.

By CCO.



By race and ethnicity.



Appendix A: Stakeholder groups

Stakeholder groups that informed the report

Oral Health Workgroup of the Medicaid Advisory Committee

The Medicaid Advisory Committee established the Oral Health Workgroup in 2016 to respond to an OHA request for a framework for assessing access to oral health services in OHP. The group included 16 community representatives from CCOs, dental care organizations (DCOs) contracting with CCOs and OHA, dental providers, consumer advocates and other community members from the oral health world. The final Framework for Oral Health Access in the Oregon Health Plan[1] included a recommended oral health monitoring dashboard with 15 measures (see Appendix B, MAC Oral Health Monitoring Measures Dashboard). Measures were pulled primarily from an environmental scan of recommendations from local workgroups, notably the Dental Quality Metrics Workgroup of the Metrics and Scoring Committee and CCO Oregon's Dental Workgroup, state oral health strategic plans, and national sources. Ten of the 15 recommended measures with available data sources and specifications were included in this report.

Dental Quality Metrics Workgroup

The Dental Quality Metrics Workgroup was convened as a working group of the Metrics and Scoring Committee. The workgroup was charged with recommending objective outcome and quality measures and benchmarks for oral health services provided by CCOs. The workgroup recommended[2] several incentive measures, and the Metrics and Scoring Committee ultimately adopted one quality measure and one measure modification starting with the 2015 incentive pool:

1. Mental, physical and dental* health assessments within 60 days for children in Department of Human Services (DHS) custody (e.g., foster care). (*measure amended in 2015 to include dental along with mental/physical health assessment)

2. Dental sealants on permanent molars for children (ages 6–14)

In addition, the workgroup recommended several measures for future exploration and monitoring, such as topical fluoride varnish applications, which are included in this report.

CCO Oregon Dental Workgroup

In 2015, CCO Oregon established a workgroup to develop a CCO-DCO quality metrics set[3] for recommended use by CCOs in subcontracts. The Medicaid Advisory Committee's Oral Health Workgroup included several CCO Oregon Dental Workgroup measures in its monitoring recommendations (see Appendix C).

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[1] http://www.oregon.gov/oha/OHPR/MAC/Documents/MAC-oralhealthframework-Oct2016.pdf

[2] http://www.oregon.gov/oha/analytics/DentalMetricsDocuments/Dental%20Metrics%20Recommendation.pdf

[3] http://www.ccooregon.org/media/uploads/CCODCOMetricSetFinal.pdf

Appendix B: Technical Appendix

Data sources

Administrative data

Claims data consider the billing and diagnostic codes physicians, pharmacies, hospitals and other health care providers submit to payers, in this case, Medicaid. Data follows a consistent format and uses a standard set of established codes to describe specific procedures, drugs and diagnoses. Claims data are primarily used for payment, while encounter data include all of the same information as a claim, but are provided for information or monitoring purposes.

Medicaid claims data are submitted to Oregon's Medicaid Management Information System (MMIS). We allow a lag of six months of all claims to be submitted.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The CAHPS survey asks Oregon Health Plan members to report on and evaluate their experiences with health care, focusing on aspects that members are best qualified to assess, such as ease of access to services. The U.S. Agency for Healthcare Research and Quality (AHRQ), funds and oversees the CAHPS program, which works closely with public and private research organizations to develop and maintain the surveys. Oregon has been administering the CAHPS Health Plan Survey for Medicaid since 1998.

Survey data used in this report come from the 2016 CAHPS survey, which reports on member experience in CY 2015. https://www.oregon.gov/oha/analytics/Pages/CAHPS.aspx

Health care workforce licensing

This data provides a snapshot of the state's dental workforce using data collected by the Oregon Health Authority in collaboration with Oregon Board of Dentistry. All data are self-reported at the time of license renewal (dentists and volunteer dentists: Jan. 1 through Apr. 30, 2015 and Jan. 1 through Apr. 30, 2016). The survey was completed by 89.7% of dentists with an active license as of October 2016. The majority of those that did not complete the survey are new licensees.

https://www.oregon.gov/oha/analytics/Pages/Health-Care-Workforce-Reporting.aspx

Measure specifications

Ratio of dental providers available by region and percent of FTE reporting seeing Medicaid

The map looks at the ratio of licensed dentists to Oregon's population. Results are presented by county.

The map displays the total FTE for licensees who:

1) Identified their employment status as "employed in the field," "self-employed in the field," "volunteer," or "other."
2) Reported a primary or secondary practice location in Oregon.
3) Reported practicing general dentistry (including pediatrics and public health, but excluding oral surgeons, etc.). (For dentists only)

FTE is based on time spent in direct patient care (capped at 40 hours) and, for dentists only, was weighted based on the number of auxiliaries (e.g., chairside assistants, hygienists, etc.) and age, according to HRSA Procedures for Shortage Designation.

Whether a dentist sees Medicaid patients is self-reported and may be unknown (11.5% of total FTE reported not knowing whether or not they saw Medicaid patients). Therefore the number of dentists that see Medicaid patients could be higher or lower than what can be reported here.

Data source: Health Care Workforce Licensing Database

Members receiving dental services by county

This measure looks at the percentage of OHP members receiving any dental service by county during 2015.

Denominator: Average number of member months during measurement year (by county)

Numerator: Number of clients who received any dental service under the supervision of a dentist (PT=17) or a dental hygienist (PT=18) as defined by CDT codes D0100–D9999 based on EPSDT specifications.

Data source: Administrative (billing) claims

Any dental service

This measure looks at the percentage of adults (aged 19 years and older) and children (aged 0–18) who received any dental service during the measurement year.

Denominator: Number of clients who have either 1. continuous enrollment for 12 months in a CCOA based on standard metric continuous enrollment table, or 2. are enrolled in OHP Open Card.

Numerator: Number of clients who received any dental service under the supervision of a dentist (PT=17) or a dental hygienist (PT=18) as defined by CDT codes D0100-D9999 based on EPSDT specifications.

Preventive Service is a subset of Any Dental Service and identified by CDT codes D1000–D1999.

Treatment Service is a subset of Any Dental Service and identified by CDT codes D2000–D9999.

Diagnostic Service is a subset of Any Dental Service and identified by CDT codes D0100–D0999.

Data source: Administrative (billing) claims

Measure source: Dental Quality Alliance, with modifications made to expand the age range to adults. http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2016_Utlization_of_Services.pdf?la=en

Preventive Dental Services

This measure looks at the percentage of adults (aged 19 years and older) and children (aged 0–18) who received preventive dental services during the measurement year.

CDT codes D1000–D1999

Denominator: Number of clients who have continuous enrollment for 12 months in a CCOA based on standard metric continuous enrollment table.

Numerator: Number of clients who received preventive dental services under the supervision of a dentist (PT=17) or a dental hygienist (PT=18) as defined by CDT codes D1000–D1999.

Data source: Administrative (billing) claims

Measure source: EPSDT specifications (CMS-416), with modifications made to expand the age range to adults and include full set of preventive dental services in ADA CDT codes, as well as to look at children and adults without elevated risk. https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf

Topical fluoride varnish for children

This measure looks at the percentage of children and adolescents (aged 1–21) who received at least two topical fluoride applications during the measurement year for children without elevated risk and children with elevated risk.

Numerator: Children and adolescents who received at least two fluoride applications on two separate dates during the measurement period. Numerator includes services provided by a dentist (D1206 or D1208) and by medical providers (CPT 99188).

Denominator 1: Children and adolescents aged 1–21 and continuously enrolled during the measurement period without elevated caries risk

Denominator 2: Children and adolescents ages 1–21 and continuously enrolled during the measurement period with elevated caries risk.

Continuous enrollment: 12 months with a gap of no more than 45 days

Data source: Administrative paid clean claims

Measure source: Dental Quality Alliance, with modifications made to look at fluoride varnish for children with and without elevated risk. http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2016_Topical_Fluoride.pdf?la=en

Have a regular dentist

This survey-based measure looks at the percentage of child and adult members who report they had a regular dentist. The question is, “A regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?”

Data source: CAHPS Health Plan Survey

Measure source: CAHPS Dental Survey – questions from the dental survey were added to Oregon's health plan survey. https://www.oregon.gov/oha/analytics/Pages/CAHPS.aspx

Access to emergency dental care

This survey-based measure looks at the percentage of child and adult members who report they have experienced a dental emergency and were "always" or "usually" able to see a dentist as soon as they needed. The question is, "In the last six months, if you needed to see a dentist right away because of a dental emergency, did you get to see a dentist as soon as you wanted?"

Data source: CAHPS Health Plan survey

Measure source: CAHPS Dental Survey – questions from the dental survey were added to Oregon's health plan survey. https://www.oregon.gov/oha/analytics/Pages/CAHPS.aspx

Follow-up after emergency department visit for dental reasons

This measure looks at the percentage of children (aged 0–18) and adults (aged 19 years and older) seen in the ED for a non-traumatic (caries-related) dental reason, and who visited a dentist within seven days and 30 days following the ED visit.

Numerator1: Among the visits identified in Numerator 2, any visit with a dentist for any dental service (D0100–D9999) within seven days of the ED visit.

Numerator 2: Any visit with a dentist for any dental service (D0100–D9999) within 30 days of the ED visit.

Denominator: Identify all emergency department visits for caries-related reasons occurring during eligible member months between January 1 and December 1 of the reporting year based on the standard metric ED visits table and using ICD9/10 diagnosis codes in Table 1 and Table 2 of the DQA specs. See link:

http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2016_Follow-up_After_ED_Visit_by_Children_for_Dental_Caries.pdf?la=en. Includes only paid clean claims and excludes inpatient claims.

Continuous enrollment: Member must be enrolled 12 months with a gap of no more than 45 days and must be in a CCO on the date of the ED visit and for 30 days following the ED visit.

Data source: Administrative (billing) claims

Measure source: based on preliminary specifications from the Dental Quality Alliance

Oral health evaluation for adults with periodontitis

This measure looks at the percentage of adults aged 30 years and older who have been treated for periodontitis (serious gum infection) who received a comprehensive oral evaluation at least once within the measurement period.

Numerator: Adults who received at least one periodontal evaluation (D0120 or D0150 or D0180).

Denominator: Adults aged 30 and older who have a history of periodontitis, defined by any instances of CDT code D4240, D4241, D4260, D4261, D4341, D4342 or D4910 in the measurement year or any of the three years before the measurement year.

Continuous enrollment: 12 months, with no more than one gap of up to 45 days

Data source: Administrative (billing) claims

Measure source: based on preliminary specifications from the Dental Quality Alliance

Oral evaluation for adults with diabetes

This measure looks at the percentage of adults aged 18–75 years who have diabetes, and received at least one comprehensive, periodic or periodontal oral evaluation service during the measurement period.

Numerator: Members who received a comprehensive, periodic or periodontal oral evaluation. CDT codes D0120 or D0150 or D0180.

Denominator: Members aged 18–75 years who have diabetes, as identified in claim and pharmacy data during the measurement year or the year before the measurement period, using any one of these criteria:

- At least two outpatient visits, observation visits or ED visits on different dates of service with a diagnosis of diabetes.
- At least one acute inpatient encounter with a diagnosis of diabetes.
- Dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis.

Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator; patients with a diagnosis of secondary diabetes due to another condition should not be included.

Continuous enrollment: 12 months, with no more than one gap of up to 45 days

Data source: Administrative data, paid and denied claims

Measure source: Numerator based on preliminary specifications from the Dental Quality Alliance. Denominator based on HEDIS Comprehensive Diabetes Care Measure http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx . Value set codes can be found at https://vsac.nlm.nih.gov/

Oral health assessments in primary care for children aged 0–6 years

This indicator looks at the percentage of oral health assessments provided to children in medical settings versus dental settings. The indicator is determined by looking at all claims for oral health assessments, CDT code D0191, and then whether that claim was submitted as a dental claim (services provided by dentists) or a medical claim (services provided in medical settings).

The indicator also looks at performing providers (physician, advance practice nurse or physician assistants) that had a medical claim for CDT code D0191 within medical settings.

Data source: Administrative (billing) claims

Measure source: OHA-developed, based on recommendation from the MAC Oral Health Workgroup

Appendix C: MAC Oral Health Access Monitoring Measures Dashboard

View the full report: A Framework for Oral Health Access in the Oregon Health Plan (http://www.oregon.gov/oha/OHPR/MAC/Documents/MAC-oralhealthframework-Oct2016.pdf).

ORAL HEALTH WORKGROUP: RECOMMENDED ORAL HEALTH ACCESS MONITORING MEASURES DASHBOARD					
ACCESS INDICATOR	**MEASURE NAME**	**DATA SOURCE**	**MEASURE STEWARD**	**ENDORSED (OREGON)**	**MEASURE TIER***
AVAILABILITY: CARE COORDINATION					
Coordination of emergency department visits and dental care	Percentage of all enrolled who were seen in the ER for non-traumatic dental reasons within the reporting year and visited a dentist following the ED visit	Medicaid Claims	DQA	CCO Oregon	Tier 1
Coordination for patients with chronic oral health disease	Percentage of all enrolled/enrolled adults treated for periodontitis who accessed dental services (received at least one dental service) who received comprehensive oral evaluation OR periodic oral evaluation OR comprehensive periodontal examination at least once within the reporting year	Medicaid claims	DQA (under consideration - no specifications)	CCO Oregon	Tier 2
AVAILABILITY: ORAL HEALTH INTEGRATION (COORDINATION WITH BEHAVIORAL AND PHYSICAL HEALTH CARE)					
Coordination of screenings for foster care kids	Mental, physical and dental health assessments within 60 days for children in DHS custody	CCO Performance Reports	OHA	CCO Incentive	Tier 1
Patients with chronic disease (e.g. diabetes) who accessed dental care	Percentage of all enrolled adults identified as people with diabetes who accessed dental care (received at least one service) within the reporting year	Medicaid claims	DQA (under consideration - no specifications)	CCO Oregon	Tier 2
Primary care providers offering oral health services	% or # primary care providers providing oral health assessment to patients, as seen through use of D0191 oral health assessment.	Medicaid Claims	None	Dental Metrics Quality Work Group (oral health services in medical settings)	Tier 2

AVAILABILITY: PROVIDER DISTRIBUTION					
Provider-to-population ratios	**Ratio of OHP licensed dental providers to OHP members, reported by region.** **Provider types to include the following:** • **Dentists** • **Dental Hygienists (reported by types of hygienist, including EPDH, non-EPDH)**	**OHA Licensing Database**	**OHA**	**NONE**	**Tier 2**
UTILIZATION: PATIENT-CENTERED CARE					
Linguistically and culturally appropriate care	**Number of OHP oral health care providers who completed cultural competency training as reported by the Oregon Board of Dentistry[1]**	**Data to be reported to OHA beginning Summer 2017**	**Oregon Oral Health Strategic Plan**	**Oregon Oral Health Strategic Plan**	**Tier 2**
Patient involvement in care	**How often did the dentists or dental staff explain what they were doing while treating you? (Q12 Dental CAHPS)**	**Under consideration for CAHPS 2017**	**Dental CAHPS**	**CCO Oregon**	**Tier 2**
	How often did your regular dentist explain things in a way that was easy to understand? (Q6 Dental CAHPS)	**Under consideration for CAHPS 2017**	**Dental CAHPS**	**CCO Oregon**	**Tier 2**
UTILIZATION: QUALITY OF SERVICES					
Proportion of population receiving services	**Number & percent of EVER/Number & percent of CONTINUOUSLY enrolled members receiving at least 1 preventive dental care service during the measurement year**	**Medicaid claims**	**OHA**	**OHA/DHS/DMAP Dental Access Measures Tool**	**Tier 1**
	Individuals with at least 90 continuous days of enrollment who received at least one diagnostic dental service by or under the supervision of a dentist	**Medicaid claims**	**OHA/EPSDT (measure built for children)**	**NONE**	**Tier 2**

[1] For example, HHS offers a free, online educational program in Cultural Competency accredited for oral health professionals: https://www.thinkculturalhealth.hhs.gov/education/oral-health-providers

	Percentage of all enrolled members who received a treatment service within the reporting year.	**Medicaid Claims**	**DQA/EPSDT (measure built for children)**	**NONE**	**Tier 2**
UTILIZATION: PATIENT EXPERIENCE					
Wait times for appointments	**If you needed to see a dentist right away because of a dental emergency in the last 12 months, did you get to see a dentist as soon as you wanted?**	**Oregon CAHPS Survey**	**Dental CAHPS**	**Dental Metrics Quality Work Group; Oregon FFS Access Monitoring Plan**	**Tier 1**
Customer services experience	**Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist?**	**Under consideration for CAHPS 2017**	**Dental CAHPS**	**CCO Oregon**	**Tier 2**
Distance to travel to provider	**Compliance with forthcoming Time & Distance standard: (e.g. minutes/miles standards for urban, rural communities) to pediatric dental providers*** *(Note that this measure is limited to pediatric dental providers per CMS network adequacy requirements, but monitoring could encompass other types of dental providers. If monitoring is limited to pediatric dental providers, the Work Group recommends "pediatric provider" be defined as all providers who serve children, rather than limiting the definition to pediatric specialists.)*	**NONE CURRENTLY - annual reports to begin 2018**	**CMS Network Adequacy**	**NONE**	**Tier 2**

*Tier 1 measures have the fewest challenges to adoption for monitoring. These measures have been endorsed by an Oregon group and have existing specifications for immediate use by OHA

*Tier 2 measures have more challenges to adoption for monitoring. These measures either have no current data source, are not endorsed by an Oregon group, do not have existing specifications for immediate use by OHA, or all of the above.

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