NATIONAL QUALITY FORUM

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ORAL HEALTH EXPERT PANEL

IN-PERSON MEETING

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FRIDAY
MARCH 30, 2012

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The Panel met at the National Quality Forum, 1030 15th Street N.W., Suite 800, Washington, D.C., at 8:30 a.m., Paul Glassman and David Krol, Co-Chairs, presiding.

PRESENT:

PAUL GLASSMAN, DDS, MA, MBA, Co-Chair, University of the Pacific School of Dentistry
DAVID KROL, MD, MPH, FAAP, Co-Chair, The Robert Wood Johnson Foundation
AMIT ACHARYA, BDS, MS, PhD, Marshfield Clinic
TERRENCE BATLINER, DDS, MBA, Center for Native Oral Health Research
JIM CRALL, DDS, ScD, University of California / Center for Healthier Children, Families & Communities
DAVID GESKO, DDS, HealthPartners
RICHARD HASTREITER, DDS, MPH, WellPoint
MICHAEL HELGESON, DDS, Apple Tree Dental
AMY HESSEL, MD, FACS, University of Texas MD Anderson Medical Center
ELSBETH KALENDERIAN, DDS, MPH, Harvard Dental Center
MARY ALICE LEE, PhD, MSN, Connecticut Voices for Children

PRESENT(Cont'd):

DIANE LIMBO, BS, MSN, RN, CPNP, Healthy Smiles for Kids of Orange County
BOB RUSSELL, DDS, MPH, Iowa Department of Public Health
CHRISTOPHER SMILEY, DDS, Smiley Family Dentistry, PC
ANDREW SNYDER, National Academy for State Health Policy

NQF STAFF:

HEIDI BOSSLEY, MSN, MBA
KRISTIN CHANDLER, MPH
DONNA DUGAN, PhD, MS
ANN HAMMERSMITH, JD, General Counsel

ALSO PRESENT:

KRISHNA ARAVAMUDHAN, BDS, MS Dental Quality Alliance
RALPH FUCCILLO, MA, DentaQuest Foundation
RENEE JOSKOW, DDS, MPH, FAGD, HRSA

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

8:33 a.m.

DR. DUGAN: It's 8:30 so we're going to go ahead and get started. Anthony? One more time. Anthony? Our phone operator let us know before that they had to evacuate their building and so they were out for awhile but he said they were back. Maybe not. Well, if there's anyone on the phone please feel free to announce yourself. Okay.

Well, I'm Donna Dugan. I hope I have introduced myself to all of you individually. If not I'll see you throughout the day. Thank you so much for coming and being part of our Oral Health Expert Panel. I'm going to turn it over to Heidi Bossley to introduce herself and welcome you from NQF and we'll go ahead and get started.

MS. BOSSLEY: Great. I don't want to say much other than thank you so much for flying to D.C. if you have or driving here, however you did come. We appreciate having

you. We're excited to have you provide some input on this. It was not a small amount of work I know we asked you to do with those Excel spreadsheets so we do appreciate it. And hopefully we'll walk out today with some recommendations.

CO-CHAIR KROL: Just to say hello and welcome. Some familiar faces, some folks I haven't met. I hope to meet you all during this process. But again, just to repeat the thanks for all the work that you've put into looking at these.

I know there were times when I was going through it and my eyes would glaze over and think I saw something and rated it one way and then another time thought I rated it a different way. And so I appreciate that challenge and the time you took.

CO-CHAIR GLASSMAN: And I'm Paul Glassman. I also was asked by the staff to be co-chair of this group which really means that we've had a couple of phone calls with the

staff that you all haven't had. It doesn't mean much more than that. So we're going to be here with you participating in this as we go through the day today.

MS. BOSSLEY: So, what we would like to do is introductions but along with that also disclosures. So I'm going to turn it over to Ann Hammersmith, our general counsel, to walk you through that.

MS. HAMMERSMITH: Good morning, everyone. As Heidi said I'm going to go through the disclosures of interest with you. I'm just going to make a few remarks and then we'll go around the table.

If you recall several months ago you received a disclosure of interest form from us which you filled out where we asked very detailed questions. What we like to do at the first meeting of a committee is to go through the disclosures orally in the spirit of transparency so everyone knows where everyone else is coming from.

Just a few remarks and reminders about the oral disclosure. You don't need to be exhaustive. You do not need to recount your CV. We know you're all extremely qualified and smart so there's no need to go through your entire resume. We are particularly interested in consulting, speaking, grants or research that you have engaged in that is relevant to what's before this committee.

I also want to remind you that you sit on the committee as an individual. Occasionally at these meetings I'll hear a committee member say, "I am John Doe and I'm here representing the interests of the American Society of" fill in the blank. And you only represent yourselves. You sit as an individual. You're here because you are experts in the field. You don't represent the interests of anyone else including your employer or anyone who may have nominated you to serve on this panel.

The other thing that I want to remind you of is that I often hear people say "I have no financial disclosures" or "I have no financial conflict of interest." Because of the nature of the work whether you are paid or not doesn't tell the tale. You can have a real or apparent conflict of interest even if no money changed hands.

For example, if you served on a committee where measures were discussed that are relevant to what's before this panel. Usually those people don't wind up on the panel because we see it on their DOI form and they are excluded. But I just want to stress it's not strictly an exercise in financial conflict of interest.

So what I'm going to ask is that we start with the chairs. If you can tell us who you are, who you're with and if you have anything you'd like to disclose.

CO-CHAIR KROL: I'm David Krol. I'm with the Robert Wood Johnson Foundation

and I have no significant disclosures.

CO-CHAIR GLASSMAN: I'm Paul Glassman. I work at the University of the Pacific School of Dentistry in San Francisco.

A couple. I'm a member of the board of directors of the DentaQuest Institute which has sponsored some work around quality and is going to be doing some major initiative over the next several years related to quality activities. I'm also a member of the CHIPRA -- get the name right -- CHIPRA Pediatric Quality Measures Program Dental Expert Panel. It's a long name.

And finally, I just authored a report which was released by the Kellogg Foundation and the DentaQuest Institute on Oral Health Quality Improvement in the Era of Accountability.

MEMBER BATLINER: Hi, I'm Terry Batliner. I'm a faculty member at the Colorado School of Public Health. I'm also a consultant to the Kellogg Foundation on

Midlevel Providers. I'm a PI for an early childhood caries clinical trial on a Northern Plains as we say Indian reservation. We don't disclose what reservations we work on without tribal permission. I think those are my -- I'm a private practice owner also.

MEMBER GESKO: Good morning, David Gesko from Health Partners in Minneapolis. And I speak with Institute of Oral Health. Otherwise really no significant disclosures.

MEMBER HELGESON: Hello, I'm Michael Helgeson with Apple Tree Dental, a non-profit organization based in Minnesota. And I'm not aware of any conflicts of interest.

MEMBER HESSEL: I'm Amy Hessel. I work at the MD Anderson Cancer Center in the Department of Head and Neck Surgery and I have no disclosures.

MEMBER HASTREITER: I'm Dick Hastreiter. I am the dental director of 15 Blue Cross and Blue Shield states and the

dental consultant for three Delta Dental states. I've been involved in developing proxy quality measures for 15 years but I have no disclosures to make.

MEMBER SNYDER: I'm Andy Snyder with the National Academy for State Health Policy. And before coming back to NASHP I worked for the Pew Charitable Trust's Children's Dental Campaign which included lobbying to state legislatures on issues related to kids' access to dental care. Part of that work included doing a report card that had measures related to state performance. Not exactly the same thing as quality.

My other significant disclosure is that I've been fighting a head cold all week so if I don't shake your hand it's not just because I'm not a nice person.

(Laughter)

MEMBER LIMBO: Good morning. I'm Diane Limbo. I'm a pediatric nurse practitioner. I work for Healthy Smiles for

Kids of Orange County. The only disclosure I might make is I have two grants from HRSA currently that are to ingrate oral health into practices, including a school-based health program.

MEMBER RUSSELL: Good morning, I'm Bob Russell. I represent the Association of State and Territorial Dental Directors. I'm also a consultant for DentaQuest Corporation under disease elimination progress. And I'm also on the board of directors for the National Network of Oral Health Access representing federally qualified health centers.

The other disclosure I could say, I'm also a member of the federally appointed Advisory Committee on Training in Primary Care and Dentistry. And we do look at quality measures, but none of the ones we are currently looking at overlap what we're doing here.

MEMBER ACHARYA: Good morning,

everybody. My name is Amit Acharya. I'm a dental informatics scientist at the Marshfield Clinic in Wisconsin.

The conflict of interest, I have a grant from AHRQ that I'm a co-investigator on working with the Kaiser Permanente group on developing diabetes registry. Then I also have a grant with NIDCR and a grant from Delta Dental of Wisconsin especially working on integrating medicine and dentistry.

I'm also the chair of the Dental Informatics Section within the American Medical Informatics Association and also the chair-elect at the Dental Informatics Section at the American Dental Education Association.

MEMBER KALENDERIAN: Good morning, I'm Elsbeth Kalenderian. I'm the chair of Oral Health Policy Department at Harvard and the chief of quality at the Harvard Dental Center which is all the clinics.

I don't know all of my conflicts. I'll just tell them what I think are the

conflicts. I am the co-chair of the quality group that we put together for 24 dental schools. I have an NIDCR grant that deals with electronic health records. I have -- I'm a co-investigator on a G08 grant regarding data repository. We submitted an R01 grant around patient safety. I work closely with Lucian Leape on a lot of patient safety stuff. Just got a paper accepted around patient safety. I think that those are the main quality stuff thing that I do.

MEMBER SMILEY: Good morning, I'm Chris Smiley. I'm a general dentist practicing in Grand Rapids, Michigan.

I'm so conflicted. Let's see. I serve as chair of the Dental Quality Alliance which is a multi-stakeholder organization that many of you also participate in. I am also a consultant for the code subcommittee for the ADA Council on Dental Benefit Programs. Other than that I know of nothing else.

MEMBER LEE: My name's Mary Alice

Lee. I work for a non-profit research and advocacy group in New Haven, Connecticut. My work is in conducting independent performance monitoring in our Medicaid and CHIP programs, the Husky program in Connecticut. My work is almost entirely state-funded by the state of Connecticut. I do have some additional grant funding that supports some fee-for-service work. I also teach at the Yale School of Public Health.

MEMBER CRALL: Hi, I'm Jim Crall. I'm chair of Public Health and Community Dentistry at UCLA School of Dentistry. Let's see, I am the child advocate for the American Academy of Pediatric Dentistry which means I'm a non-voting ex officio member of the board of trustees. I'm on the Dental Quality Alliance representing the academy and the executive committee, and I chair the major research and development committee for the DQA.

I am a member of the MetLife Dental Advisory Council, I have been for some

time and they have quality initiatives on the commercial side. I'm a member of the DentaQuest registry advisory group. I'm currently involved in a CHIPRA TA contract with Mathematica and I'm involved in a couple of HRSA training grants as well.

MS. HAMMERSMITH: All right, thank you everyone for making those disclosures. Do you have anything that you would like to discuss with each other or any questions for me based on the disclosures this morning?

(No response)

MS. HAMMERSMITH: Okay. Just one last little reminder that you sit as individuals. And thanks for coming today and have a good meeting.

MS. BOSSLEY: Thanks, Ann. Can I ask the guests in the back to introduce yourselves?

MR. FUCCILLO: I'm Ralph Fuccillo with the DentaQuest Foundation and DentaQuest Institute.

DR. JOSKOW: Good morning, Renee Joskow, the new senior advisor for oral health at HRSA, a.k.a., chief dental officer.

DR. ARAVAMUDHAN: Krishna Aravamudhan, American Dental Association and Dental Quality Alliance.

DR. DUGAN: And we missed one important person. Kristin, who you all probably have heard from.

MS. CHANDLER: Hi there. I'm Kristin Chandler, I'm a project analyst on this project. Welcome.

DR. DUGAN: Can I make sure just to remind everyone to use your microphones when speaking. We're recording the meeting for a transcript for notes. So just make sure you hit the "Speak" button when you are speaking. Can I ask Anthony on the line if anyone has dialed in?

OPERATOR: We have no participants dialed in at this time.

DR. DUGAN: Okay, thank you. In

terms of restrooms, actually just go right back out straight through the door, past the elevators and they're on the right-hand side there. There is breakfast in the back if anyone missed that. And then hard copies of materials are right here on the shelf. I'm not sure if anyone missed those but we can get those to you.

Are there any questions or comments before we go ahead and get started on the agenda?

(No response)

DR. DUGAN: All right. So we'll just go ahead and move right onto the project overview, meeting goals and review of the agenda. You should have a copy of the slides. They were over there on the side and we'll just work our way through those.

I just wanted to review with you to start off the tasks for this project. We're to do an environmental scan of oral health measures, measure developers. That

includes measures that are concepts, measures in use and then various characteristics of those measures which we have completed, a catalog of oral health priority areas from HHS, HRSA and Health People 2020 which we've also completed, and then a mapping of those measures to those priority areas.

We were to convene an expert panel, which we have, and then use the expert panel to help us with the following: prioritize measure concepts within the priority areas, identify any remaining gaps within those priority areas, identify any additional concepts to help fill those gaps if available, and then we'll prepare a report based on your recommendations and post that report for public comment.

In terms of a time line, so a few of these we've already completed, as I mentioned: the scan, the expert panel, the catalog of priorities. Today we'll be working on prioritizing measures, identifying gaps and

making recommendations. We will work on producing a report in the month of April based on your recommendations and we may be in contact with you to review some of the recommendations or the report prior to it going to public comment which will happen in May.

Most likely any review we have you do would be offline, it would be a review of the report and then for you to provide any comments to us. So, we may reach out to you for that in the month of April.

Then the report will go up for public comment on the NQF website for a month. We'll receive comments about the report and then we'll contact you about helping us reconcile some of those comments to edit the report if we need to do so, and then the report will be released in July. So it's a pretty quick project, 6-month turnaround. We're feeling that and I'm sure you are too with our requests for your activities. Moving

along. But again, we very much appreciate your active participation.

So we were asked some questions about, you know, what's the project's purpose and the value-add. As you know, there are many things going on in terms of quality measurement for oral health.

So what are we trying to do here? Well, we know there's lots of measures and you know that very well from your own work, but also in the environmental scan you saw over 250 measures. So there are lots and lots of oral health measures which I think surprised a lot of people.

When we started off on this project we weren't expecting to find so many. And a lot of them are redundant or variations on a theme, but there are a lot of measures. But the issue is they're not standardized and I think that's the biggest issue is we don't have standardized oral health measures across the board.

And I know HHS is looking for standardized measures to be used for providers, programs, plans and populations. So, we want to build on existing work. We're not starting from scratch. We know there have been previous projects and we're trying to work from those projects moving forward. There are also parallel projects going on as we speak.

But right now there are only four NQF-endorsed oral health measures and if -- at the back of the slide set, just for your reminder there are the four listed there. Just so you know which four oral health measures have already been NQF-endorsed. So they meet all of the NQF criteria. They were also in your environmental scan as well. That's for your reference.

So, given there are so many measures and they're not necessarily standardized we want to figure out what the environment, the total environmental oral

health measurement looks like in terms of quality and quantity of measures. And that's what we're doing in this project.

And then in terms of all of those measures, since there are over 250, which ones are important? Which ones are the most important concepts to measure? So, if we want to go somewhere first, where should we be going? Which measures are important in terms of evidence, in terms of a quality gap, in terms of feasibility?

And then once we start with those, are we missing anything? Are there major gaps? To improve quality of care we want to obviously fill those gaps, so we need your help in determining if there are any gaps that we can currently fill.

So, what's next? Well, I talked about the actual next steps in this project being the report going out for public comment, but the goal and the hope with this project is this may be first of a few projects for NQF in

oral health. But we really want to move the field towards additional development, testing, endorsement of important, feasible, standardized measures.

So what will we be doing today? The goals for today are to help prioritize measure concepts within priority areas. And let me clarify, the work that you did offline in terms of prioritization was more at the measure level. And we heard feedback from quite a few people to take your ratings with a grain of salt, and I understand that given the breadth of measures, how many measures there were across how many priority areas and they were repeating. And you'll see, as evidenced by that when you look at the ratings summaries that the numbers really range from maybe 1.5 to about 3 and there's not a lot of difference. So we understood that and we took a look at that, and Paul emphasized that with us. And that's why he created the concept table and we'll talk about that a little bit

later.

So, the ratings in that spreadsheet are not going to be the major focus today. That'll be one piece of the larger picture. But we needed you to do that for us to understand really where we were and where we wanted to go, so we appreciate that.

So we want to not only prioritize concepts, major concepts within the priority areas, but then identify remaining gaps and any additional concepts to fill those gaps. So those are the goals for today. And as we walk through the agenda we'll be more specific about tasks for the committee and what we really want you to discuss.

So let's review the agenda at a high level right now and then when we get to each item at the appropriate time we'll talk to you again about how -- what we would like the committee to specifically discuss.

So the next item after this overview will be the state of oral health

performance measurement discussion of environmental scan results. This item is really to get you -- the conversation started about your impressions of the state of oral health performance measurement as informed by what you saw in the scan but also from your own experience. What does it look like out there? We just talked about it not being standardized, but what are you really seeing? Is it mostly process measures, is it mostly child measures, that type of discussion.

Then we'll move onto the meat of the day and each of the next agenda items are really about using the priority areas from the scan and talking about the measure concepts within each priority area. And we'll work our way through all priority areas A through J throughout the day, receiving your recommendations on priority concepts.

And then once we've worked our way through those we'll try to do a summary of recommendations. We'll be taking realtime

notes here and we'll open it up a few times during the day for member and public comment if anyone's on the phone or any of our guests would like to comment. And we'll review next steps one more time and then adjourn.

So, any comments or questions from the group before we go ahead and get started on our first discussion item?

MEMBER CRALL: Just one thing. One of the sort of challenges I thought in terms of jumping in and rating the measures was really trying to get a grasp of the intended users or the focus for this. I mean, when you say safety net providers, Medicaid, Medicare, others, I mean you really start covering some waterfront.

And in terms of the short time frame for the project I really sort of think it's useful to try to understand if there's going to be an effort to try to segment, you know, the thinking or the recommendations around some of those kinds of categories, or

you know, whether we just sort of still try to deal with this in some big global sort of piece of work.

DR. DUGAN: Yes. I can try to address that. Maybe Heidi or Renee could actually also respond from HRSA. I think initially -- and when talking with our HHS representatives, you know, they're really looking for measures across the board for Medicaid, for Medicare, for HRSA's special populations. There are a number of HHS agencies really looking for standardized measures.

So, I think, you know, the first goal is to talk about the universe, you know, what's out there and what's important. And our project's a pretty short time frame. I mean, those discussions can be very lengthy in terms of taking a concept and then changing the concept or the specific measure and creating it for a specific population. That takes a long time. Those are measure

development activities.

I think right now we're looking for what are the important concepts that you could use possibly across the different types of programs and then as the measures get developed or tested later on they would then be framed for those special populations or that special program. So I think right now we're at a higher level and we're talking about what's important in general.

MEMBER CRALL: Yes, and I think you know, at the concept level I think --

DR. DUGAN: Yes, we can do that.

MEMBER CRALL: -- sort of reasonable. Where it gets to be important though is when you start getting into sort of the nitty-gritty of some of the measures and what are the mechanisms for data collection which could vary considerably across, you know, those different sort of categories.

DR. DUGAN: That's right. And I think when we start talking about the concepts

and we'll ask you, you know, we'll be talking about important concepts, but then there will be time when any panel member, knowing the measures that were in the scan, given there's limited information about data elements or denominators, anything from the scan. But if there are concepts or measures you saw in the scan that you think would be appropriate for a specific type of population or -- it would be okay to mention that.

You know, like when we're talking about a concept, this is an important concept and I saw this measure in the scan. Maybe you know about it more personally. Maybe you've used the measure. You might say this is an important measure. I would recommend this measure be used because. But we may not be able to say that at all because of the limited information in the scan.

So I think we're starting at the high level. If we have anymore detailed information and you'd like to contribute that

please do so. Please do so.

Any other comments or questions?

(No response)

DR. DUGAN: No? Okay. So, if we want to go ahead and get started on the 9:15 agenda item here, State of Oral Health Performance Measurement. Just to tee this up, again, we're looking here for sort of descriptive characteristics. So what is your impression in general of the state of performance measurement for oral health care based on what you saw in the scan or based on your own knowledge in terms of quantity and quality of measures, most measures being for pediatrics? How -- are they mostly at the concept level or are they specified? So I'm just giving you examples of what types of discussion items we're looking for here. Go ahead.

CO-CHAIR GLASSMAN: Maybe I'll jump in and just give my two cents' worth on that question which is I did have the

opportunity to sort of dig into this question extensively over the last year because of this report that I did for the Kellogg Foundation and the DentaQuest Institute. Some of you I think may have seen it.

And my impression after spending quite a bit of time reviewing literature, talking to a lot of people including many who are in the room is, number one, there's a lot of measures out there which I think we've just been through an exercise. Everyone fully recognizes that now having waded through that extensive spreadsheet. There's a lot of measures out there. There -- many of them are redundant as you saw and overlapping, but still, even without that there's still a lot of measures that are out there.

The problem with I think the current state of measurement of quality in oral health is that the measures are often not well-defined, that they tend to be performance measures that tend towards sort of the lower

level. If you had sort of a pyramid of measuring procedures, those are the most rigorously used and defined measures. If you look up at population health, those are much less widely in use.

Measures tend not to be tied to performance. So, most of the measures, particularly the higher level ones looking at population health tend to be used for informational purposes. So somebody, government agency or other people, collect measures and they produce reports and say this is what we found, that this, you know, 3- to 5-year-olds with brown hair have this much caries by our definition, whatever it is. I mean, to put it out there hoping someone will do something about it. But it's not -- there are very few examples of measures actually being tied to performance, particularly financial performance, particularly incentives that would have somebody do something different which I think is the goal ultimately

of having performance measures is you want people to use them in quality improvement programs where people -- where they would be used to drive performance in a direction. So, there's very little of that.

And then I also agree with I think the point that you were making, Jim, which is that many measures don't really specify who the target is for the measure. And I think that it's important to do that. I think anyone who's doing measures needs to have that as a part of it because if the target is to look at the performance of a Medicaid program in a state I think that's pretty different than looking at the performance of a provider or looking at the health of low-income kids in a school district. So, I think that that's typically left off of measurement concepts and I believe it should be -- that's my sense of where we are with the state of measurement.

DR. DUGAN: Can I just respond to your last point in terms of when the measures

come in for NQF endorsement there is -- part of the submission form does ask for that as a piece of information which is who was the measure created for, what population is it appropriate for. And then the testing information should represent that it was tested in that type of population or for that specific population. So we need to get there, but we aren't right now.

MEMBER ACHARYA: Yes, just one other brief comment was I agree with what Paul mentioned. A general pattern was there's not much diagnostic information being embedded in any of these. For a very well known problem in dentistry that we do not have a standardized diagnostic exam. I mean, there are several organizations -- what I was trying to make the point was we need to have it standardized where we could talk about, you know, whether is it ICD-9's or is it SNODENT or Elsbeth's EZcode. So there's a lot of diagnostic codes out there, maybe kind of

trying to develop these measures including some of those concepts, diagnostic concepts would be really, really necessary. Because right now we might be saying measuring -- based on a procedure versus, you know, what was the actual diagnostic problem that existed. So that's a big, big gap right now I think.

MEMBER HASTREITER: I think there's a real point to that. And I've had an opportunity to work at the Marshfield Medical Foundation on Medical Research and I had seven nurses who worked for me who actually abstracted medical records. And the reason they abstracted the medical records was because they didn't believe the physician's diagnostic coding. So, I think diagnostic coding brought to dentistry would be great but it isn't the gold standard.

MEMBER CRALL: Yes, I would say, you know, using Donna's example is that most of the things that people consider to be

measures that are used in a pretty broad sense are focused on children and around what I'd call use of services. And the one other example that I sort of think we ought to have on the table is at least in the adult side, you know, the Department of Defense did invest in developing a CAHPS survey for dental care. And I personally worked with some folks at RAND on the development of a pediatric module that's based on the CAHPS sort of framework. And it's been used by the Healthy Families, the CHIP program in California for a number of years.

And I know that, you know, in the measures that we were asked to rate there were sort of individual items. But I think that those consumer assessment surveys are an important element that do need to be considered and at least on the adult side there has been some investment in doing that as well.

MEMBER BATLINER: You know, I work

in kind of two different worlds. In native populations clearly I see issues with access. And there were some access measures for the underserved, you know, primarily groups that I saw.

But then as a private practice person, you know, the issue of over-treatment is something that you see all the time with people who flow through. So if you do a great crown on a tooth that didn't need a crown, is that good quality? I don't think so. So, how -- I mean, I think this is one of our big challenges and I think it goes to the issue of lack of diagnostic codes. How can we examine appropriate treatment based on the actual need of the person?

MEMBER KALENDERIAN: And that actually leads to the next thing is there were no measures on patient safety which is one of my big pet peeves which I think is really important. Medicine has really done I think a good job in measuring outpatient safety and I

think it's really, really important for us to add that in that. And I agree, these measures were very static and look-back, and we really need to make them quality improvement measures.

CO-CHAIR GLASSMAN: Michael, why don't you go first. You were in the queue before me. Go ahead.

MEMBER HELGESON: Yes, I just -- I think it's interesting, you know, that these are framed in terms of measures that are of use to government agencies. And I'm not opposed to that, obviously that's what we're trying to improve. But I think the issue of quality in oral health is one that's a population issue.

And I think if we -- I like the Institute of Medicine framework around quality: safety is first, effectiveness is second. Does whatever it is work. Patient-centered. To what degree does the health intervention respect and collaborate with the

patient. And they're an active player in evaluating whether they were happy with it or not. So patient-centered.

Timely, that gets at some of the access measures. Do people get the care at the right time in the right frequency, that sort of thing.

Efficiency is something that I think we overrate to be honest with you. A lot of the measures that are in here, my opinion is most of them relate to what I would call efficiency. And efficiency is how rapidly are you delivering the things that you've been delivering for the last 20 or 30 years. But you may be rapidly delivering the wrong stuff, you know. You might be getting too many things to the wrong people and not enough, you know, whatever.

So I think if you have measures of efficiency and you lack diagnostic information and you lack effectiveness measures you're really not measuring anything that's

meaningful in my opinion in terms of actual health improvement which is really what the whole endeavor is all about.

And then equity is the final IOM category. You know, are these health services being available on an equitable basis to various population groups and categories and so on.

So I guess my sense is I like those six IOM categories. To me they frame quite nicely -- just as both a provider and a consumer of health care, you know, those are sort of the six things I would be looking for.

So I would hope that we would, you know, not get totally trapped into just looking at existing measures which I think for the reasons that have been cited by everyone else really are not very good. I'm not impressed.

You know, nobody can tell me, for example, what the right utilization rate is. There is no answer to that and the reason

there's no answer is because you would need to know the diagnoses and you would need to know the effectiveness of the interventions and how frequently they needed to be applied in order to say what the correct utilization rate is. So, utilization rate in today's environment doesn't really tell you anything about quality other than that activity is happening. You know, it tells you that activity is happening and how much, but it doesn't tell you whether the activity is improving health.

MEMBER SMILEY: And I respect also, you know, something that Paul touched upon as far as measurement as a economic tool, as a cost containment tool. However, I think when we identify gaps and we take a look at evolving recommendations for future measurement I think it's important that we look at those measures that advance the health of the population that's being served, the oral health of the population that's being served. And we're handicapped in a lot of

ways because there is such a dearth of evidence-based clinical guidelines or recommendations. But I think that we have to take a look at what those guidelines are that are out there and base hopefully recommendations towards that with the goal towards improving overall oral health for the population.

MEMBER HASTREITER: I think you raised a very good point. Measures should never be used for cost containment. And as you know, I am heavily into both the commercial and the government program side of measurements. And if insurance companies or Medicaid programs or SCHIP programs are using measurement for that purpose it's totally inappropriate and could definitely lead to the detriment of the oral health of the people being served.

MEMBER GESKO: Dick, how do you square what you said with the Triple Aim where you're simultaneously advancing the health,

the experience and the affordability of a population? Am I missing something there? Because I would come at it differently and say that measures can absolutely use to measure affordability and efficiency in the delivery of care.

MEMBER HASTREITER: Oh, I agree with that. But what I'm talking about is that there are some especially commercially insured insurance products that use measurements not to determine efficiency or appropriateness of care based on current research and scientific evidence and the epidemiology of the population being served. They use it merely to keep the costs down so that the loss ratio in the program is quite opportune for the company as opposed to the patients and the providers.

MEMBER CRALL: I was just going to say. I think the efficiency sort of label from maybe an economic standpoint is fairly commonly used, but I think a lot more people

now are talking about value which relates the cost to the outcome of the care. And I think that's a way to use sort of the economic side of things but also get to the issue about is it really making a difference.

MEMBER HELGESON: I think Jim's right. That's exactly what we're using measurements for.

CO-CHAIR GLASSMAN: So just one more comment on that point. I think what we're coming around to is the idea that it's appropriate to use measures related to cost but if you're just trying to save money and you're not concerned about the health of the population that might not be appropriate. But I think it is clearly in the interest and one of the primary goals behind doing measurement at all is to make sure we're spending our scarce resources wisely. So that does involve measuring things and looking at what's being done and the outcomes of it. So I think there's a direct relationship between

measurement and cost, but in an appropriate manner.

And just one other comment about something that got said earlier. I think we're struggling with -- I think you just said it, Chris -- the fact that we don't have very many evidence-based standards of care in the dental world. And so the question about did you do that crown, was that the right thing to do, it's often very hard to answer that question because you want to answer that based on some sort of evidence-based standards of care and in many cases we don't have anything that you could actually point to and say yes, you should have done that crown or you shouldn't have.

And then if you don't have that to start with it's hard to -- not that we don't have any of those, they are there, but there's many things that are done in the dental world that we don't really have a way of saying this was the right thing to do or it wasn't the

right thing to do.

MEMBER HELGESON: I just wanted to echo the -- some of the comments related to pitfalls related to doing financial analysis related to health care. And maybe just emphasize the point that the efficiency in terms of providing a unit of service for a lower cost is usually the way it's measured today. Whether it's on a fee-for-service model where, you know, if you can deliver more fill-in-the-blank crowns at a lower cost then that's -- economically the traditional analysis says well, that's a better value. Or on the health plan side if you can deliver a package of services at a lower per-member per-month cost then that's -- but those things aren't really measuring a meaningful health outcome at all.

And that gets at this value that Paul described in his paper I thought quite well, that we need to move to determining what value actually is. And once we figure out

what that actually is then set up some measures that relate to it.

And I think what we're trapped in right now is that the tools and the measures we have are not actually measuring value. We don't have benchmarks. And so if we codify them, my concern is that we will do what Dr. Hastreiter suggested would be wrong which is we will end up squeezing out what good quality there is in the interest of driving down cost. And you know, throwing out the baby with the bath water basically.

MEMBER KALENDERIAN: I would disagree a little bit. I think Michael Potter and Tom Lee have very well defined how to define value and it's the elimination of disease and morbidity and ultimately mortality. And actually I took their model and created a dental model for that. So I think there's the beginning of that and I think we can take that and learn from that. So, I think there's something out there.

There's a lot for us to do but I do agree with you, it's not about on the treatment end, it's about elimination of disease and the diagnostic end, I totally agree.

MS. BOSSLEY: I just wanted to add a few things from the NQF perspective. And I've listened to all this so a couple of things kind of listed together. But, I wanted to emphasize that today even though this is HHS-funded work NQF always looks for measures that are as broad as possible. So I think as you look at what you have here and you come up with the concepts that you would prioritize, if there are things that you think may be unique to a given population let's definitely capture it. But ideally we're looking for measures that go broad across the populations, across providers, across settings. So, the more we can do that the more actually other individuals can take those measures and use them as well. So we really would love you to do that. If you think there's something we

need to target though, please. We'll want to capture that.

The other thing is we have work on efficiency that I think we haven't provided to any of you looking at the cost component as well as the quality component. And we've started endorsing measures that are looking at relative resource use and cost.

Oral health is obviously not one of the areas that we've seen anything come in yet, but we've emphasized that that's a building block, that you want those cost measures paired with the quality. One without the other doesn't set the context that you really want when you're looking at efficiency.

So I think as you discuss it it's probably worthwhile to talk about are there resource use or cost measures that perhaps could be built in the future, what would those look like. And then, you know, as that gets built out we'll start looking at in the future how would you then gear that and merge that

together with the quality measures.

Then I had one other thing and now I've forgotten it. Oh, evidence, yes. I knew Donna would remember. So the other thing is we actually -- not only do we want to capture what gaps there are in measures, but if there's gaps in evidence I think that's equally important to capture in your discussion today. Because part of what we will do is try to show where you think you can head with measurement now, where you think that the evidence doesn't yet exist but you want to encourage others to perhaps support and focus on, and I think that's an important thing for us to do. HHS has asked us to do that in a lot of our projects. I think this is a good one to focus that on as well.

MEMBER ACHARYA: Just one other thought I had was as I was looking through, you know, some of the referral measures, you know, obviously all of us know here that oral health is so intricately connected with our

systemic health. I just saw probably one measure talking about pregnant women coming in during the pregnancy for some kind of a dental procedure, but there's nothing about diabetics or cardiovascular disease patients where there is a necessary oral screening or some kind of periodontal screening, at least for diabetic patients. There are guidelines out there, especially if we look at the American Diabetes Association guidelines on a diabetic patient needs to have at least a 6-month dental visit, some kind of oral screening if they're edentulists, or in a 12-month if they are edentulists. So those are some of the things, you know, there is a strong gap right now. We need to be also looking at some of the systemic health side of things and how that relates to the oral health.

CO-CHAIR KROL: So keep that in mind as we get into these different -- we'll come back to that. Hopefully we'll bring that back up when we get into the concepts and

things like that, the gaps that we have.

CO-CHAIR GLASSMAN: I also want to comment about that point as well because we're going to get into this as we move through the rest of the day. I think one of the things we're going to wrestle with today is the issue of sort of concepts versus stratification. So, if you want to measure some kind of frequency of visits, you know, is the best and most useful way to do that to come up with how do you measure visits. What does that mean? Or you want to measure caries, what does that mean? Versus stratification. Do you want to measure caries, you know, in 2 and a half year olds with brown hair and then you can have 47 different measures of where you use the concept of caries to measure it in different populations.

So for instance, visits. You could measure that in people with diabetes, you could measure it in pregnant women. You could measure it in a lot of different -- you

could stratify the data in a lot of different ways. You might want to have a sort of standardized measure of what a visit is or what a service is or service utilization. And so I think we're going to wrestle with that as we go through the day is the idea of what's the big concept, what's the stratification of how you might use it in different populations or different ways.

CO-CHAIR KROL: So I have Richard, Amy and David.

MEMBER HASTREITER: There are methods of synthesizing the epidemiology of oral disease in a population and using measurements to come to some conclusion about what is going on in that population relative to their oral disease, and then using proxy variables to translate that information into cost-effectiveness in terms of the oral disease condition of individual patients and populations of patients. I mean, it can be done. It's not as clean as we'd like but

there are ways to do this. And I have never seen it done. We've been working on it for 15 years and it's not perfect but it's pretty good because our in-office audits and surveys are consistent with the results we get with statistical and mathematical analysis.

MEMBER HESSEL: One of the things that's been very helpful in identifying metrics for cancer patients in general is to create guidelines on the treatment of those patient populations and then looking at the stepwise process through a treatment and deciding which level in the algorithm that has a decision-making point that then affects prognosis or care.

And so, of course I don't really know the dental process but perhaps if there's guidelines on these different patient populations on appropriate -- access to care and then the appropriate work-up and the appropriate, you know, offering of treatment or whatever. I don't know but if we can go

back to an algorithm and say yes, this is how this patient population should be treated and then at that point you look at at what level can you find a branch point that affects, you know, prognosis, good care, whatever, and then you can say is there a metric that identifies that.

It's just easier to step back to the algorithm to find the metrics than to just randomly say well, if you survived cancer then you had good care. You know, I mean that doesn't make any sense.

But again, I don't -- because when we were looking at this very large Excel spreadsheet I just felt, I got overwhelmed by the multitude of similar metrics coming through for very small populations. And it seemed like that there probably has to be some generalized algorithm of care for that whole population that then we could then stratify down to a very nice broad metric that would fit for this process. But again, I don't

know, so.

MEMBER GESKO: My comments I think build very nicely on what Amy said and speak to those kind of processes.

In the group that I come from the way we define evidence-based care is the fact, and it's not an exclusive definition, is that we have guidelines that we create. And we have those guidelines that are available in the public domain at guideline.gov for caries, periodontal treatment, et cetera.

And then what we measure in our practice is that those guidelines have with them risk assessment tools for caries, for periodontal disease, for oral cancer. And then the measurement that we do is are you first of all doing a risk assessment on all patients and then are you doing interventions that are proven to mitigate those risks. And if you are we use that presently as a surrogate measure of quality.

And you know, we could debate

that, whether that's valid or not, but there were measures in the analysis that we did that were similar that talked about things that you do relative to a risk assessment. And so I guess I'm speaking in favor of looking at those measures as ones that pull a lot of these things together.

And then because some of us have talked about the specific populations, diabetics, cardiovascular disease, et cetera. Those things are a part of a risk assessment. When you do a risk assessment in my opinion those things are touched upon and then that contributes to a patient's risk and then that contributes to a treatment plan based on that evidence.

And so in some ways we're a long ways away from having things and in other ways I think we're pretty close. I mean, we've got some good building blocks.

MEMBER LEE: I just wanted to say that with respect to looking at people with

other medical conditions for whom oral health is a really key component of their treatment, pregnant women and those with diabetes and cardiovascular disease, I think that speaks to being able to link claims data sets across oral health care systems and medical systems. And most of the measures that we looked at were based solely on oral health -- on dental claims, those that were claims-based. I think that we won't get a total picture of the quality of care of some of these people with other diseases unless we do that.

And then the one other area I would mention with respect to that is injuries. We don't -- I didn't see any measures in here that had anything to do with dental injuries. And where you can use emergency department records, and there is a diagnosis and there's a secondary diagnosis with nature of the external cause of injury. I think there's a wealth of information about how to improve oral health in general and to

what extent the treatment is being given in non-dental sites like the emergency room.

MEMBER CRALL: I actually wanted to follow up on Dick's comment but it set the same theme I think that Mary Alice had.

You know, I don't know the details, but the folks at CDC at least are starting to work on linking epidemiologic data coming out of NHANES with utilization data. And I think that, you know, that's what Dick's saying. It's not going to be a perfect world but -- and of course there's always limitations about sample size and sensitivity about how far you can generalize with some of those survey type of data.

But at least at a concept level for articulating that I think that -- and identifying processes by which that can be done. You know, that at least would allow if it can't be done at a national level or maybe it can be done at a national level but then you can't extrapolate, that you know, maybe

states will want to sort of pick up on that approach.

The other thing that comes into play though when I think -- when you start looking at some of those kind of things is the issue about the variability and differences you see depending on the source of the data. You know, data that comes out of MEPS or places like that that actually have some verification process vis-a-vis telephone surveys historically have yielded some pretty different results.

And I think that, you know, so that mechanism though I think is important and it goes back to that value piece that we were talking about earlier. But the data source and understanding the validity and reliability of those data sources I think is going to be important going forward.

CO-CHAIR GLASSMAN: And just one -- a bit further about what you just said, Jim. I think that the data sources actually are

important to consider when you're talking about the measure. Because if, for example if you're talking about a measurement of trying to come up with some kind of standard measurement of dental caries you might have a pretty different measurement if you're talking about doing that based on some kind of a screening examination versus a full examination in a dental office with X-rays. So the source of the data actually does impact the measure as well.

DR. DUGAN: Okay. Thank you very much for your feedback on this first item. I think we're going to go ahead and move to our next agenda item and start talking about your recommendations for the priority areas.

So, for these next agenda items you'll need three different documents. First, we'll be using this slide as a guide for the discussion. It's in your slide set but it will also be here up on the screen. That's the "Concepts, Prioritization and Gap

Analysis" will be used to guide the discussion.

You'll also want to have in front of you the "Oral Health Concept Areas" document. This is the document that Paul Glassman helped us put together. And then you'll want the infamous measure workbook in front of you as well.

So again, the measure workbook is what you're very familiar with. The only difference is it now has an average rating column which was calculated as an average of all 16 panel members' ratings for each measure. Again, you'll see that the ratings are pretty much from about 1.5 to 3. There's not a ton of variation and we know it was a difficult exercise. Again, we heard, "Take our ratings with a grain of salt."

So, given that I think it's still important to have that piece of information here in front of you, and also to have the measures that we did go through, have that in

front of you as well. So we'll be using that workbook, we'll be using Paul's concept sheet and this slide for the discussion.

So I will turn it over first to Paul for him to review with you how he came up with this concept sheet and then I'll discuss exactly the discussion points we'll want the committee to consider as we go through each priority area.

CO-CHAIR GLASSMAN: Well, I would say that I came up with this really out of just frustration at the task. So I'm sure you all experienced some version of that, that it became very clear early on that it was going to be impossible. Although I did it, and thank all of you for doing it as well.

But you know, I had first of all attention deficit very early on which meant it was just hard to concentrate on the 47th measure of caries, you know, in 3-year-olds with brown hair and blue eyes. So, that was one thing.

And second of all, it began to be apparent to me that we were talking about -- something I mentioned a few minutes ago. We were talking about two different things, maybe more, but at least two different main concepts.

One was what the actual concept is that's being measured. So dental caries as opposed to dental caries in 3-year-olds, and dental caries in 5-year-olds, and people with caries, and people without caries. Really the issue, the overriding concept was is there a standardized measure that could be used for dental caries, and if there is then for various purposes people could use that measure in various ways.

So I just really started at the beginning just for my own sanity to try and keep track of what I thought the big picture measures were and turned to the spreadsheet. And we had some conversations with the staff over the phone and decided to try and use that

for the work today because it just seemed very difficult to do what came out in the measurement analysis.

I also just did a little -- this is my obsessive-compulsive disorder coming out here, but I looked at the standard deviation on our ratings and the standard deviation is about as high as the variability.

(Laughter)

CO-CHAIR GLASSMAN: So it showed that we were all over the place. Not only was it hard to do but we were all over the place. We weren't well calibrated. So, I think that we're really -- the numbers themselves are really clearly not going to be that useful.

So with that in mind I tried to look at what I thought were the bigger picture concepts. I came up with something. It had about 30 items in it but it's now been expanded up to 101. Probably because the staff took some of them and they're now repeated so that they fit within the Healthy

People priority areas. So, some of them you'll see come out multiple times although I didn't originally have it that way.

So, what we discussed in a phone call prior to today is that we would work off of this sheet with the one that Donna just referred to and we would talk about the -- within the Healthy People priority areas we would look at sort of the bigger picture concepts. And as the example, the first one there under priority area --

CO-CHAIR KROL: Just so you're oriented, make sure you have the right one, it says "Oral Health Concept Areas" in the upper lefthand corner, small print. You'll see priority area A on there. So it's not the -- there's two that you might be confused with. But up in the upper lefthand corner it should say "Oral Health Concept Areas." No, it's not part of the giant metallic clip section.

DR. DUGAN: Though you'll want to have the clip handy because it has the

measure, the detailed measures in it as well which we will want to refer to.

CO-CHAIR GLASSMAN: So, for example -- we'll both use an example of a suggestion how we're going to move forward and also as the first item to talk about is this first priority area under Healthy People which is Oral Health of Children and Adults and OH1 is "Reduce proportion of children and adults with dental caries experienced in their primary permanent teeth."

Again, my idea was that the concept here is dental caries, what's the measure of dental caries. And in looking through all the various measures there it seemed that there was really two different ways that dental caries was being addressed in all the other measures that mentioned caries. One was caries based on a screening examination and caries based on a full examination with radiographs. And so I listed those as the two concepts that came out of OH1

is measure dental caries based on screening examinations or surveillance and then measure caries based on full dental examination with radiographs.

I also tried to do -- this is just my own guess -- there's nothing set in stone about it -- is to list potential sources for that kind of data and potential targets for that data. So, as you can see I thought if you were looking at based on surveillance you have a chance then of getting at the whole population. You can measure population caries, you can measure a particular program like a Medicaid program in a state. You can also look at issues related to provider performance and you could also look at patient characteristics.

Whereas if you're looking at measures of caries based on a full examination of radiographs then you're probably now looking more at something that would be based on a review of dental records which again

limits the population of people who have actually gone into a dental office and had a full examination with radiographs. And that also limits the potential target. You're looking then probably at providers and patients because it's not going to be a whole population kind of measure if that's the way you're measuring it.

So I think maybe we should just stop there and look at that particular one, OH1, and see what people's thoughts and comments are about, in looking at it that way.

MEMBER CRALL: Paul, actually just a question. So, in your use of the terms "surveillance" would that include a telephone survey?

CO-CHAIR GLASSMAN: Well, I think that the idea that I had here was that these things need some definition. I wasn't trying to do that work at this stage.

MEMBER CRALL: Yes, no, but I'm just trying to figure out do we need another

category or is that part of the same category.

CO-CHAIR GLASSMAN: Because yes, you know, it's a good point. Because could you, you know, what would you ask people on a telephone survey. Do you have, you know, are you aware of any holes in your teeth? Well, I guess you could do that. Obviously you'd get different kind of answers than if a dental professional was looking in the mouth with a flashlight and tongue blade.

So, that would be the kind of I think maybe the next work that we would propose to NQF or back to the HHS is that there ought to be some secondary process, not today, to define what these things might be or how you would gather the data.

But the thing I was trying to get away from, or get to, was the idea of come up with some standard definition of what do you mean by caries in whatever circumstance, surveillance, survey, from dental office and sort of get away from the, you know, 3 and a

half year olds with brown hair. If you had a standard definition then people could use it in a lot of different ways.

MEMBER CRALL: Right, well but that's why I'm raising the question about do you need a third category. Because obviously my take of sort of what comes out of NHANES data versus National Survey of Children's Health are two different.

CO-CHAIR GLASSMAN: That's a good point. So you're suggesting maybe a third category here would be useful.

MEMBER CRALL: Yes.

CO-CHAIR GLASSMAN: Okay, good.

MEMBER HESSEL: I was going to say if you're just doing surveillance that may be coming from school nurse and pediatrician as opposed to the dental people. So I agree, maybe you have to define at what level are you going to be doing surveillance.

MEMBER HASTREITER: One of the most difficult problems that we have in

working with dentists, or the expanded duty individuals who are licensed in Minnesota, is the whole concept of caries measurement.

Now, some of these people measure caries as it would have been back in the 1940s and '50s and it runs all the way up to the most recent dental school classification of how to measure caries. So the problem is that we bring dentists in and talk to them about the services they are providing and I purposely ask them how they're measuring caries. And they say, "Well, I use a very sharp explorer and every little pit or fissure that sticks even a little bit I put a restoration in there."

And then it goes all the way up to dentists who understand the current incidence, distribution, etiology of dental caries. So they don't get excited about that at all.

So, it's really difficult to assume that a definitive clinical caries measurement among dentists or auxiliaries that

have not been calibrated is going to make any sense. And some of the research that's going on now in the actual dental offices concerns me for that reason. If these dentists are not highly calibrated in how to measure dental caries you're getting results all over the place.

MEMBER CRALL: Well (a) we're never going to calibrate all the dentists. And that's the difference in dealing in sort of health services type of an arena.

But I do think again it comes back to a basic point which is none of these measures or even a set of measures is going to be used to necessarily establish judgment about care. I mean, it can give you an indication. But you know, go back to Jack Winberg. At least in those situations you'd start seeing variation and then you're going to have to sort of, you know, follow through after that to find out how close that is to what are recommended approaches that are

contemporary and whatever. But that's where I think -- where we have to go.

MEMBER HASTREITER: Yes, I agree with Jim. I wasn't trying to imply that we were going to calibrate all the dentists in the United States.

MEMBER CRALL: Minnesota --

MEMBER HASTREITER: We're working on it.

CO-CHAIR GLASSMAN: But I guess the question that I would pose to the group to think about is --

MEMBER HASTREITER: Could I just finish?

CO-CHAIR GLASSMAN: Oh, I'm sorry. I thought you were.

MEMBER HASTREITER: I do think though that there are ways of measuring caries in populations who are receiving either commercial or government programs dental care that can provide the distribution that Jim was talking about, and that can be transformed

into proxy quality measurements and also integrated into cost value measurements.

CO-CHAIR GLASSMAN: So, I guess the question that I would pose to the group I think based on this bit of discussion is would there be value in suggesting to NQF and HHS that there be -- that some work be done, again not today, some work be done on a standardizing definitions of caries.

So for example, the ASTDD has a basic screening survey for kids and now one for adults or for older adults that has a pretty nicely put together definition of caries with calibration, with videos and slides to calibrate people.

And I'm not suggesting that that's necessarily the right answer, but I'm thinking if something like that were to be adopted or something else were to be adopted that had those kind of tools with it one could say okay, this is the sort of gold standard we're going to adopt as a country for what

measurements of caries would be. Now, if someone doesn't do that and they use some other measurement they're not using the gold standard.

So the question I'm posing to the group, should we suggest that that kind of work be done to try and come up with a sort of standard definition that people would shoot for and then realizing everyone's not going to do it?

MEMBER KALENDERIAN: Although I do not disagree because it's a good thing as Martha Stewart would say, in the end it's like I remember when I did my heart failure work. And the patients were very worried that they had, you know, I don't have a correct scale. It wasn't about the correct scale, it was about are you gaining weight.

And so it's all about the movement of the measure. So even if we are not all perfectly calibrated, it's about is the average measure getting better.

So yes, it would be very good if we had a standardized measure and everybody's calibrated, but in the end it's about are we making progress over 1 year or 5 years, 10 years, and are we seeing less caries. So I think yes, of course we should be calibrating and of course we should have a better measure, but that's not I think the end point that we need to shoot for.

DR. DUGAN: Just to respond. I think to that point, I mean I think in the end we're looking for measures that would eventually come to NQF to be endorsed, to be used on a very wide scale. So the more standardized they are the better because the committees who will ultimately have the discussions about which measures should be endorsed and which ones shouldn't will all be about the evidence surrounding that measure, how well it tested and how well it can be applied across populations. So, that's I think where we want to go in the end but I

completely understand your point.

So I think the discussion now is, you know, if we were going to recommend to measure developers what the best caries measure should look like that would come in and possibly get endorsed, what would it look like. And is it anything that you saw here already, you know, possibly? Any of the measures that you saw. Is it any one of those?

I know Richard, you talked about proxy measures that could work. Well, would any of those be sufficient enough to come in and get endorsed? Would they sort of meet the criteria to get endorsed? Could they be used across populations? Those are really the questions we should be thinking about when we're recommending, you know, which way we move forward on these types of measures.

CO-CHAIR GLASSMAN: Just one caveat though.

DR. DUGAN: Sure.

CO-CHAIR GLASSMAN: I think that the measures, the 275 measures, the 85 that had to do with caries in there, they really talk more about how they're used for the population or a sort of stratification. What was listed on the sheet didn't actually define what the measure of caries was. So I don't think we're going to be able to look at that and say did -- was there something on the list that was the right measure of caries because that really wasn't on the list.

MEMBER HELGESON: I just wanted to support what Paul was saying which is I do think that we should define how we're going to measure the basic thing, you know, which is caries. You've got these two diseases, well, three if you count oral cancer, but we've got caries, periodontal disease and we've got a few others. But those are the big three.

I think it's just super important to do what Paul said which is establish just some baseline, this is the guidance for

whoever is claiming to have more or less of caries or whatever, this is how it needs to be. These are the essential elements. You need to look in the mouth, you know, et cetera. So there needs to be some guidelines. And that gets away from the gaps between sort of self-reported and survey stuff which is all over the map and doesn't really correlate with either in-the-mouth or claim data.

So I just wanted to second Paul's thing, that I feel strongly that we should make a recommendation about that. Because if we don't have that then the data is really not worth a lot.

MEMBER LIMBO: I just want to say I was at HHS last week presenting on oral health and actually met people there that are working to develop competencies that are going to be used by non-dental personnel for doing oral assessments and for doing all of the other components to it. So they will be establishing competencies that will be

generic, and I think that's where you will have -- while we can't necessarily do an inter-reliability of testers or surveyors, there will at least be some competency base that it will be used as a tool. So I feel comfortable saying that there will be a standard that we can use.

MEMBER HASTREITER: Based on the research that we've done I think there could be a different approach taken to this issue. And it's an approach that would be used in SCHIP, Medicaid and commercial populations where knowing the epidemiology of caries in a specific population you can measure one dentist against another in terms of the way they practice that can be used as a proxy variable for their perception of how caries should be measured. However, an important thing should be noted that claims data cannot be used to measure caries.

MEMBER CRALL: Well, I was actually going to seek some clarification. I

mean, because a couple of people have said a standard and you talked about a way of measuring. I think the way of measuring needs to be also specified within the categories. Because, for example, back to the point about others are going to be doing assessments. I mean, you know, the earlier work that I'm familiar with out of North Carolina, pediatricians, family physicians, you know, at the level of the mouth, the accuracy is pretty good, at the level of the tooth it's not. So, I think, you know, and maybe even survey data if it were asked better or had a better question could get us closer to what objective so measures seem to be. So I think, you know, it's sort of pointing to best ways of measuring within data sources.

DR. DUGAN: Can I make just a point of clarification too? Sort of thinking about this I see two different levels of measurement here. One measure is about how the dentists are diagnosing caries in the

patient, and that's what Richard was talking about. But the other level of measurement is from a performance measurement perspective which is how do you collect the data to understand whether -- what the proportion of caries is. So, I think that's two different things. So there's a standard related to how you diagnose caries. But then how do you collect the information to report the performance measure?

CO-CHAIR GLASSMAN: Well, so I think what I had proposed on the sheet was a call for development of two different definitions, one based on screening, examination, surveillance and one based on examination with radiographs. And I think I agree with Jim, he suggested a third based on phone surveys.

And that as I'm hearing the discussion still makes sense to me that what we would call for out of this meeting is say that there needs to be definitions developed

for those three different ways of collecting data.

I think we talked about this on the phone call the other day. I don't think this process is about deciding who's going to use those measures or what they're going to do with them or what conclusions they're going to make once they gather the data. It's just about how -- what kind of measures should be developed.

DR. DUGAN: Yes.

MEMBER KALENDERIAN: I just want to echo that you cannot measure caries based on claims data, or maybe therefore based on interviews because somebody might have a -- might perceive that they have caries because they had a filling or a crown, but maybe they didn't have. Maybe they had that for a different diagnosis. So I think we want to be very careful that we don't mix diagnosis and treatment which, you know, the public certainly does at times.

CO-CHAIR GLASSMAN: Okay. Although I think I just heard Jim suggest that based on phone surveys you could get some information with an appropriately structured set of questions that would -- that might be useful.

MEMBER CRALL: It's something that could be tested.

CO-CHAIR GLASSMAN: Yes. It's certainly something that someone who's proposing a measure and could bring data that says here's what we did, here's the way we measured it, here's the results, here's our reliability data. So, but I think he's pointed out correctly that that would be a different set of considerations than one that was based on a surveillance where someone actually looked in the mouth versus radiographs would be a third category.

MEMBER KALENDERIAN: Right and caries might be the hard one. There might be other measures that are very well measurable

with interviews.

CO-CHAIR GLASSMAN: Yes, and it might be that if we call for the development of measures in those three categories that there wouldn't be one that would rise up to meet the NQF standards based on phone interviews. Maybe it's just not doable.

MEMBER ACHARYA: I just want to throw out another thought. Within those three categories there are a lot of teledentistry where, you know, you do the screening using internal cameras from a remote site. Where would that kind of fit in? Would it be kind of a real examination or would it be kind of similar to a telephone but still there's more information? Because of the picture being broadcasted live.

So I wanted the group to also think about -- because there's a lot of technology being used it has to be moved forward. So we also want to make sure that all of those areas gets covered as well within

the measures where we specifically say, you know, was it onsite or kind of remotely and some of those aspects.

CO-CHAIR GLASSMAN: That's an interesting question, and the question is is that different than characterizing by screening examination versus full examination. And I could argue it both ways.

We just actually completed a study at my institution looking at dentists' ability to make decisions based on a tele-health exam where they were reviewing tele-health records only versus tele-health records plus an in-person exam, and found that they made the same decisions based on both methods. So, from that perspective you could say that depending on how much data was gathered in the tele-health examination it could either be a screening or it could be a full examination.

Are there any other thoughts about this particular area we're talking about, just basically measurements of caries? I think the

conversations are coalescing around that we suggest that measures be developed in three different categories based on the sources of the data.

(No response)

CO-CHAIR GLASSMAN: Okay. Wow, I wasn't sure a few minutes ago if we were actually going to come to closure on this but we did. Congratulations.

(Laughter)

CO-CHAIR GLASSMAN: Okay. Let's see. So, that was -- what else have we not talked about on there, Donna?

DR. DUGAN: I'm trying to just make sure we've covered all of our bases here.

CO-CHAIR GLASSMAN: Well, the third sub-bullet I think we -- at least in my opinion that's going to be very hard to do. I don't see us being able to go back to the -- because there was actually no definitions of what caries -- yes.

DR. DUGAN: Yes. So the last

bullet about across the priority area was really about, you know, if you looked at the measures that were existing, as Paul is saying. But it's hard to tell from what was listed there. But is there anything else we're not talking about as related to the priority area?

So in speaking about the concepts that Paul was talking about is there anything else we're missing in terms of trying to measure reducing the proportion of children who have caries? Or do we have it covered?

MEMBER GESKO: I'm wondering, at the risk of being a broken record, about the risk assessment. I'm not seeing anything there that might call on that. Knowing that even in the CDT book now we see risk assessment there and we see codes now having developed that rely on a risk having been done on a patient.

And so oddly enough maybe and not to be critical, there's no code for a risk

assessment which sort of is like, you know, which came first, the chicken or the egg. I'll take either as long as both follow. And so, again, I think very broadly, you know, a direction that this group could go would be to promote the use of risk assessment as a surrogate of quality. And it's building on a lot of things. I just want to note that I don't --

CO-CHAIR GLASSMAN: I think what you're suggesting is that we add that as another item, that we call for development of measures of risk for dental caries. I agree with you.

MEMBER KALENDERIAN: And I don't see any patient safety measure. I only want to point out the Deamonte case, that there's no patient safety. And I think in any of these buckets there should be a patient safety measure. And we can debate at length what that should be, but there's all kinds of patient safety measures we can think about.

CO-CHAIR GLASSMAN: Could you just say something about what you mean by that? Not to define it, but as an example. What would a patient safety measure related to caries be?

MEMBER KALENDERIAN: So, the Deamonte case is very simple. Caries that was not diagnosed, not treated and ended up in a fatality. So that would be extensive untreated, undiagnosed disease.

CO-CHAIR GLASSMAN: So a little further down there's an item that talks about signs of infection, pain, swelling, draining fistulas. Is that the kind of thing you're talking about or is it something different than that?

MEMBER KALENDERIAN: I think along those lines. But there's also safety issues of -- But also, during treatment patient safety issues. We just had a simple case where a patient was being treated and had an extensive burn from the drill. You know, so

that is patient safety during treatment. So there's patient safety because of missed diagnosis, non-diagnosis, patient safety during treatment or other kind of patient safety issues.

CO-CHAIR GLASSMAN: So, maybe the one about safety during treatment we can hold because there are some other categories we get more into measurement of processes that take place during dental office visits. So we can hold -- let's not forget that one. And then the one about the caries leading to further kinds of complications we'll come to in a few minutes so let's hold that one too.

MEMBER CRALL: Yes, I was just going to suggest also that the, you know, patient safety, it's important that it sort of be a category even of its own.

And you know, I'd also broaden the realm to think of things like, you know, sedation, use of sedation. Because I mean, you know, we don't see nearly the number of

instances where that occurs. There's no really good reporting mechanism for that but you know, there are both deaths and morbidity as a result of kids being sedated to treat caries. But I think that falls in the safety of the treatment realm, not in the caries realm.

CO-CHAIR GLASSMAN: And there is a category of sedation and general anesthesia stuff that's coming up in awhile too.

MEMBER KALENDERIAN: Although I would really echo Jim's suggestion of a separate patient safety bucket. But then I'm very biased by Lucian Leape. That is my earlier conflict of interest.

CO-CHAIR GLASSMAN: Make sure we don't lose that by the end of the day if we haven't come to it naturally in the course of moving forward. Let's make sure we get back to that.

MEMBER LIMBO: I also wanted to add in terms of that definition, in terms of

defining caries the population I work with are predominantly zero to 5 and so the absence of their teeth because they no longer have decays because of all the extractions. So somehow making sure we capture that.

And again, also I want to get back to the sedation. You said we'll cover it later. Because I know there's a proposal at some point in 2016 to be looking at that as a recommendation from the Organized Dentistry Coalition to be including addressing the issue of the use of sedation, not only for children but also for adults.

MEMBER RUSSELL: Yes, I have one concern. I don't know whether or not this is appropriate, but when we talk about caries as a definition should we consider life for example the level of decay? In other words, the amount of structure that's actually involved when caries is detected because that ultimately determines the procedure that leads to the outcome. So I'm wondering do we need

to drill down a little further.

(Laughter)

MEMBER GESKO: I mean that's -- the use of diagnostic codes or the lack of use of diagnostic codes gets to that point because diagnostic codes can differentiate caries to outer enamel, middle enamel, et cetera. Or root caries, exactly. And so just defining caries maybe doesn't go far enough because there's a lot of research that would show that enamel caries can in fact be re-mineralized and should not in fact be drilled upon which is the same point made earlier about if you do a beautiful crown on a tooth that doesn't need one is that high-quality.

The same point, if you're drilling on an enamel lesion that we were all taught was the perfect board lesion, should you in fact have flunked that board because you failed treatment planning. So, higher level.

The Dental Practice-based Research Network did a lot of studies on recognition

and when to intervene on caries, and I think that work might be something that could be drawn upon.

CO-CHAIR GLASSMAN: So, I think that that's a good point. I think we should add that as we're talking about calling for people to develop measures of caries in the three circumstances that we have now listed, to put a footnote that also it would be valuable if they could include measures of the extent of caries, not just yes or no.

MEMBER BATLINER: Can I just say one thing? I think we can train people to look at cavitated lesions and try to get, you know, sort of figure out that they can look at those the same. But I can tell you from my experience you can't train dentists to look at non-cavitated lesions and do it comparably in any way, shape, or form. So to think that we can never look at pure enamel decalcifications and include them I think is dreaming because you just can't do that.

CO-CHAIR GLASSMAN: Of course, fortunately that's a part of the NQF process is when someone submits a measure they have to have data that they've used it, it's reliable, people can come up with the same answer in the same circumstance. So that would be something that would fall out if it's not doable.

MEMBER HASTREITER: I thought the comments about measurements in terms of trying to determine quality, again, it depends upon the definition of quality. I think that technical quality is something that is very, very difficult to measure on a population of dentists.

However, I think the quality of the decision-making process, in other words, diagnosis and treatment planning can definitely be measured through various measurements that we've developed and others that other people have developed. And I think the quality of the diagnosis and treatment-making process is key. In fact, it's at least

as important as the quality of technical acumen.

CO-CHAIR GLASSMAN: Good. And again, I just would suggest hold that thought because right now we're at a level of talking about the existence of disease in the population and there is some stuff later on that talks about what dentists do. So I think that would be appropriate to bring back up at that stage.

MEMBER ACHARYA: Just another, maybe if you want to call it an attribute within these three different categories. For example, there was like different age groups within, you know, the different caries categories itself.

Maybe kind of proposing kind of core attributes for each of these categories that have been recommended would be good. Like, for example, age, gender, whatever that we need to measure, and maybe also kind of talking about what are the different

populations that these measures might be viewed into.

CO-CHAIR GLASSMAN: I think that's something we could do. Let me just give you my thought about that which is I think that would be hard because if we come up with a definition of caries based on the stratification and the considerations you just came up with that would be one bit of work.

Once you have that definition to say, here's sort of the gold standard of measuring caries based on a screening examination where you're looking in the mouth. You could apply that across, you might come up with 50 or 60 or 100 different kinds of slices of the population stratification based on age, stratification based on gender, socioeconomic status, some things that get at disparities which we're going to talk about later on. So, we could at some stage try to define what population should use that. I don't know if it makes sense to try to do it

at this stage.

DR. DUGAN: To that point, I would just say that you're right, there were some priority areas which actually called out specific age ranges.

We're not going to talk about those in detail here but I would say if, for example, there is an age cohort for which a concept we're talking about is very important because it's a certain stage of a person's growth where you want to focus there at that age I'd say let's call it out. So, if sealants are appropriate at age X and that's a lot more important than age Y, please note it. But in general I think most measures should be across the population, unless there's a specific reason to talk about a specific age.

CO-CHAIR GLASSMAN: Or if there's something different. If caries in diabetics is markedly different than caries in people with heart disease we should talk about that. I don't know if that's a good example, but if

there is something like that then we should note that.

DR. DUGAN: Yes.

MEMBER SNYDER: And this is what I've -- one of these things in the three categories that we've come up with, telephone surveys. I think an important distinction is are you answering for yourself, are you answering for somebody else.

MEMBER HASTREITER: What we try to do in doing comparative measurements of populations is we always adjust for SES, gender and age. And when we do we get very different results than when we don't.

MEMBER CRALL: I would add based upon some work we did on NHANES data awhile back, race and ethnicity within age and SES even will give you variability. So, and I think that's, as Paul was saying, that's the important part is that, you know, people realize that, you know, get as close to apples and apples comparisons as you can. Because

there is some value in having knowledge about the broad population, but certainly when you get into programs or whatever they're dealing with.

DR. DUGAN: We will talk about disparities and stratification in a separate bucket entirely. But I would question when you're talking about these measures, when the measure comes to NQF, you know, it needs to have a defined population. So, is it all kids? Is it all adults? Is it the whole population? Do you cap the age? So, we just need to know right now in terms of caries would you say the measure would be appropriate if it came in for all patients in general. Okay, so that's just good to know. Thank you.

CO-CHAIR GLASSMAN: Okay. So now we're going to -- we've gotten through the first of 600 things we need to talk about today.

(Laughter)

CO-CHAIR GLASSMAN: All right, so

maybe it'll speed up. Now, the second item on the same first page there is OH2 which is Proportion of Children and Adults with Untreated Dental Decay. And what's not repeated, obviously the measure on caries applies there as well but we won't talk about that again. But there's a couple of other things we haven't talked about yet although they came up just peripherally we should talk about. So, there's some measures that don't measure decay as a single entity but measure it as a component of DMF or DMFT, so decayed missing and filled teeth, or -- and then there's another, a separate one that was called out and came out in many different places which is various signs of infection which can be -- using the ASTDD definition they refer to the signs of urgency. This sort of translates the problem into a reaction to it, but it really is -- they were all signs of infection which is pain, swelling or draining fistulas. So, again, the idea here would be

to call for measure development in these two areas and further definition. So let's have some discussion about those two areas or anything else that would be different about adolescents -- or children or adolescents.

MEMBER CRALL: Paul, I think, you know, under the one that's sign of infection, pain, swelling, fistula, et cetera, I think a point was made earlier. The importance of capturing data from emergency departments and other areas other than just sort of in the dental care delivery system I think is really an important one for looking at systems and for connectiveness across dental services and medical services, et cetera.

MEMBER HASTREITER: I don't believe, and we talked about this before, that you can use claims data as a surrogate measurement for DMF and DMFT. It just is unreliable, completely.

MEMBER KALENDERIAN: Well, it's not only unreliable, you're using a treatment

to relate to a diagnosis. It's not even apples and pears, it's apples and vegetables.

MEMBER HASTREITER: I agree.

MEMBER LIMBO: I'd just also like to point out one of the signs of long-range disease and acute consequence. One of the things that I include in my presentations is having medical providers look at failure to thrive in children because there's often indications that are there, the child's not eating. And I tell the provider look and see what the child's state of their mouth is and they're not eating because the severity of their disease is significant, but they're under the age of 3 and they're not able to communicate that they're having pain. But what they're doing is not eating and not sleeping and not growing as evidenced by their growth percentiles being tracked. So, is there some indication there that might just as an added note.

CO-CHAIR GLASSMAN: I'm just

trying to think about is that a data source or is that a different concept to measure. In other words, if they had failure to thrive you said look at their mouth, what would they be looking for? They'd be looking for signs of pain, infection or swelling I think. So maybe it's the same concept but a different -- adding a different data source you're suggesting.

MEMBER LIMBO: Exactly.

MEMBER HESSEL: I just was wondering is this a measure that's actually measuring the performance of the dental providers or is this measuring the state of our dental access? Because DMF may not have anything to do with the dental people seeing these kids because the kids never actually make it to the office. So I think we have to define who we're measuring there because I don't think that necessarily reflects poor performance by the providers.

CO-CHAIR GLASSMAN: So, I think

this sheet is talking about the characteristics of the people, not the service delivery system, or who they're seeing, or if they're seeing anybody. It's really the people themselves, their conditions.

MEMBER CRALL: Well, I guess I want to have you elaborate on that then because my answer was going to be it could be both. I mean, you could have -- once a provider assumes some responsibility for care if patients, you know, large numbers of patients keep having infections and you know, and can't really get in I think that's an indicator of the performance of the provider. But at a system level you could have the same thing going on and kids spilling over into emergency rooms simply because they can't even get access to even start the care. So, it could be a system issue, it could be a provider issue.

CO-CHAIR GLASSMAN: I totally agree with that and I'm sorry if what I said

might have suggested otherwise. The only thing I was suggesting was that the actual concepts on this sheet are concepts related to the patient, conditions in the patient.

Now, you could use that measurement to decide are they under good care, are they seeing the right people, are the right things being done for them, but the concept is actually related to the patient.

MEMBER HELGESON: Yes, I just wanted to sort of pick up. I know when you were kind of organizing this initially it was by either surveillance or in a dental office's diagnosis of caries. But I think what we're hearing is that we should probably have another category which is in medical settings, you know, broadly where other things are triggering it. As you described, you know, the failure to thrive.

But it does seem like that's another, it's another potential source of information about the -- certainly when the

subjective complaints arise, you know, the child's not sleeping and whatever, and they're in a medical setting, not a dental setting. So I'm just suggesting maybe we should call that out as another kind of an event. We've got phone surveys, we've got in-the-mouth screenings by dental professionals presumably, we've got in the dental office assessment and then we've got other medical settings I guess is what I'm -- I'm hearing maybe that's a discrete setting where maybe a different set of protocols might be used.

CO-CHAIR GLASSMAN: Well, I guess that's the question I would ask you or anyone else who wants to weigh in on it would be we're talking about a source of data and we're talking about the definition. So if you have a definition.

If the call was for people to develop definitions of measurements of pain, infection and swelling, or signs of infection which would be pain, swelling or draining

fistulas, and that might not even be what the actual measure is that someone proposed, but some kind of signs of dental infection. And then collecting that data in a medical setting versus in a dental setting, would the definition be different or would it just be applying that definition in a different location?

MEMBER CRALL: I'm not sure how to answer your last question but I'll give you an example.

(Laughter)

CO-CHAIR GLASSMAN: I'm just trying to understand --

MEMBER CRALL: You can fit into your terminology. I mean, I think there are issues about if they come through an emergency room specifying or, you know, testing at least what's the best way to determine that. Because, I mean Pew put out a report fairly recently and my read of that was, I think they looked at primary and secondary diagnosis.

But I know other people that have looked deeper, you know, an additional number of diagnoses turn up dental cases. So I think that, you know, from the standpoint of whether you call that just a different data source, you know, making the point that work needs to be done and NQF process I assume would sort of handle that, that different mechanisms or you know, recommendations for the best way to measure that within those particular strata would be an important part of the work going forward.

CO-CHAIR GLASSMAN: Okay.

MEMBER LEE: I just would say that -- please pardon my voice today. Bronchitis I think starting yesterday. I think the medical record might be useful for identifying people with a particular condition for which you think that dental care might be indicated and then you would look at the claims record in the dental system to determine whether or not the care was there. But it seems to me

unlikely that a pediatrician who puts down a primary diagnosis of failure to thrive is going to actually record a secondary diagnosis of dental caries, or something that, you know, so that the medical record alone is not going to be useful I guess is my point. Linking the claims records across medical and dental is what's most useful I think.

MEMBER BATLINER: I just wanted to say I think it's important -- this signs of infection I think is very important and I think it's important to develop a definition that works across, you know, different treatment areas and also different locations.

I can tell you if you go to the Navajo reservation and you look at kids, the people who serve those folks are kind of jaded by how many infections they see. And they don't consider a draining fistula a big deal. They only consider facial swelling a big deal. And I think we need a standard definition that respects the pain and

suffering people are going through everywhere, not just in certain locations.

CO-CHAIR GLASSMAN: I think one thing I'm hearing, just to summarize here, is that in putting out a call for a definition in this area we might want to at least note that the definition might be different based on the data source. I'm not sure if it is, but at least make that as a note.

MEMBER KALENDERIAN: The last comment is that the signs of infections are sitting in the bucket of untreated dental decay, but it could also be a periodontal reason or another reason. So, I'm not sure if it needs to be sitting in every bucket, or that it needs to be sitting in its own bucket. It's just that it's linked -- it doesn't have to be only linked to this bucket. That's the only issue that I have with it.

CO-CHAIR GLASSMAN: And Donna, I think you have repeated that one. It comes up in several places here because of that. Maybe

it needs to come up in a few more places too. So as we go through let's watch for the sort of places it needs to be repeated.

MEMBER KALENDERIAN: Yes, or just lift it out and be separate, something like that.

CO-CHAIR GLASSMAN: Well, this is organized by the Healthy People priorities so that's the kind of categories we're using.

Okay. Any other comments on that one? So, I didn't hear any comments about the DMF or DMFT. I think there are definitions out there but I don't know that they're NQF-endorsed definitions so maybe that's a call for someone to do that.

MEMBER HELGESON: I just want to highlight that seems like a really logical thing. Because DMFT is -- it's a good measure of history of dental experience. You know, how many teeth have active decay, how many teeth are missing as a result of dental disease, how many teeth have been filled is

how much treatment activity has occurred. So I think that measure is a good measure of the history. So I think that ought to be something we ought to highlight I guess.

MEMBER KALENDERIAN: It's a history of treatment. It's not a history of diagnosis. I want to be really, really careful. Because teeth could be missing for a whole bunch of reasons, it doesn't have to be caries. So we just have to be very careful about that.

MEMBER HELGESON: Right. It would span all of our disease categories.

MEMBER KALENDERIAN: So again, it doesn't probably belong in this bucket. Yes, injury, you know, congenital reasons, you know, just impacted wisdom teeth. Lots of reasons why teeth are missing. So I want to just be careful that we don't think it only belongs in this bucket.

CO-CHAIR GLASSMAN: So this is another one that is repeated in multiple

places, and maybe again we'll watch for -- it may need to be repeated. It's a little awkward trying to fit these things into the Healthy People categories because we're talking about some things that don't need to be fit into a Healthy People category.

Okay, so I think we're ready to move to the one on adults.

CO-CHAIR KROL: Can I just add one more thing? And maybe this is a question that I should have asked earlier for NQF. Specifically, the limitation of -- limiting to only the OH1 and OH2. The one thing that came up in some conversation around oral health of children and adolescents was trauma since that's such a significant issue for children especially, injury and trauma. If there is something that needed -- if that's a concept that needs to be part of the oral health of children and adolescents is some measurement around that.

DR. DUGAN: Let me just sort of

speak more to our process, which was taking -- working from the priorities and then working down. So we fit whatever measures we found into the priority areas, OH1, OH2. But if you think that there's a concept that would fall under a higher level priority area that's completely missing feel free to throw that out there. Again, we were just working with whatever priority areas there were listed, so OH1 was caries, OH2 was decay, and that's where we stopped.

CO-CHAIR GLASSMAN: But I think it's worth noting we've heard two now that may end up as we're done at the end of the day come back to make sure that they don't get lost, and maybe need their own category which is patient safety and trauma might need to be.

DR. DUGAN: Okay.

MEMBER KALENDERIAN: I would say if trauma is not in there and it's not trauma only but sports, trauma around injuries, trauma around domestic violence which is a

huge issue. I think if trauma is not in here it better get in here.

DR. DUGAN: Okay. So we can include trauma and patient safety as a stand-alone buckets later on --

CO-CHAIR GLASSMAN: Maybe we should --

DR. DUGAN: Or you want to talk about them.

CO-CHAIR GLASSMAN: If they haven't been covered as we go through the various things we'll come back to them. I think that's the way to do it.

DR. DUGAN: Okay. And I also want to just remind you, so we were talking about the two concepts under OH1 and the two concepts under OH2. Just to remind you, those are concepts that relate to the measures we found, meaning they were somewhere in the scan. But there could be other measures out there that are important related to that priority area, and that's the question about

is there a gap still.

So, there's just DMF and sign of infection that we found measures for related to this priority area. But are there any other concepts that relate to this priority area that are not listed here? And we definitely want to talk about that. If there are, please throw them out.

CO-CHAIR GLASSMAN: Jim and then Michael.

MEMBER CRALL: That actually just triggered a thought because, I mean, things like DMFT typically are assessed clinically, but there's another measure that's reported often which is unmet treatment needs which may have different criteria. And I don't know whether that belongs here or not.

MEMBER HELGESON: Yes, I don't know if -- were you asking Paul for an answer? Or anyone?

MEMBER CRALL: Yes, I mean in terms of the, you know, sort of part of the

scheme here.

MEMBER HELGESON: I think the concept is that there is an access category, isn't there, coming up?

CO-CHAIR GLASSMAN: Yes, there is.

MEMBER HELGESON: That it might fit better under that.

CO-CHAIR GLASSMAN: Priority area C which I think has to do with access. So let's not lose that, make sure that that does get included when we get into that area.

MEMBER HELGESON: I had another sort of reaction. It was keying off of the whole safety and the reference to abuse and the whole issue around vulnerable people. I'm sort of an elder care person here. We'll get to elder neglect concepts, you know, probably later. But child neglect and sort of the whole issue of when you have a vulnerable person for whom -- who is dependent on another person to make their health decisions. So a child would obviously fall into that category.

There's that whole issue around neglect which is an aspect of safety, you know.

Are you in an environment where you're safe and you could be either not safe because your persons don't get you any kind of health care at all or don't care if you're crying or have infections or whatever, or you could be not safe because they're actually, you know, abusing you or whatever. But so anyway, I just wanted to raise the whole neglect and the whole caregiver aspect as an aspect of quality that the health system needs to identify where there are breakdowns in that.

CO-CHAIR GLASSMAN: I'm keeping a list of things we're bringing up that may or may not get covered later. We'll definitely want to come back to all of them, make sure that they get included. So far I've got unmet treatment needs, neglect, patient safety, trauma injuries. I've got unmet needs twice.

MEMBER HASTREITER: You know, when

you look at OH2 it's somewhat concerning that we only have two measurements and as far as I'm concerned I have very little confidence now in DMF and DMFT no matter if it's measured in an epi survey or in an office or whatever because I think in general it over-measures the incidence and/or prevalence of dental caries in the population.

CO-CHAIR GLASSMAN: You know, I just want to clarify that -- what you're talking about is really an artifact of the way the spreadsheet got put together. It wasn't to suggest that when you're measuring in OH1 which is children with dental experience in their primary permanent teeth and OH2 is children and adolescents with untreated decay, that the first two only belong to the first category and the second two only belong -- that wasn't the idea.

Obviously, measures of decay belong in the second category as well. And maybe when you're done with this process,

Donna, you can lengthen this document even further by repeating those things in the places where they need to be repeated.

MEMBER CRALL: And then, you know, maybe to try to interpret what I think Dick's saying is, I mean, if you just looked at DMFT or DMFS that -- as an indication of caries, you know, the fact that the T's are already done and you don't know why the T's were done. But, I mean, we're not getting down to the level of specification now that just basically says DMFT. I mean, there are sort of ratios, you know, decayed over DMFT, percent decayed or number decayed, those kind of things, that are derivative sort of of that general approach to measurement, right? And that's detail to be dealt with later.

CO-CHAIR GLASSMAN: And I would say that when I first just pulled out these concepts I didn't have them organized by these Healthy People priorities. So, because that was the charge to the NQF the staff did put

them back in that, but my idea was let's look at the concepts. Because clearly DMFT doesn't belong only in this little bucket here and caries doesn't only belong in the bucket above that. So, I think maybe our work today, we want to try to help staff meet their goal which is to respond to HHS about the priorities, but also realize we're talking about concepts that cross many, many lines here.

MEMBER ACHARYA: Just another area looking at the signs of infection, pain, swelling. I mean, what about, you know, drug-seeking behavior at the medical center because of some of these dire oral pain? Maybe they are -- that needs to be reported in some way or fashion. So, I don't know whether it would fit in here or maybe in some other area we might want to address that as well.

CO-CHAIR GLASSMAN: I think that's good to note that as a potential data source.

MEMBER HASTREITER: You know, I

would say one's confidence in DMF or DMFT and its derivatives must be consistent with the confidence that you have in the individual measurements themselves and in the collective measurements, and that's where I have problems.

CO-CHAIR GLASSMAN: Well, again, I think what we'd be doing here is calling for people to develop measures that they would submit to NQF potentially or other places. And because of the nature of how those measures get proposed and submitted and analyzed that if someone can come up with something that does make sense and has the right definitions and has reliability then it might be adopted, or if they can't then they won't.

DR. DUGAN: But I would say in your discussions if you're coming up with concepts that you think, you know, would be feasible for most people to do, meaning it could come reliably from claims, then it's

probably preferential over something that you have to get from a medical record obviously for the burden issue. Or for a survey. You know, so if there's something here that lends itself very well to a claims-based measure please call that out, or something that lends itself very well to -- or is connected very well to an evidence base we would like you to please call that out because those are priority areas.

You know, priority is doing measures at a population level that are easier to do, meaning instead of going into the medical record and collecting information you can get it from claims, or there's a great evidence base. Those are definitely priorities.

Eventually, you know, I think we want to get to the best information and maybe EHR is the way, but not everyone has one of those as we know.

MEMBER LIMBO: Can I ask for

clarification? You say claims. Are we only looking at dental claims? Because I thought we would include medical because here again that integration is critical. Because here I would state that the medical provider who does find a failure to thrive would in fact put a diagnostic code as to the possible cause which could be multiple, but if there is in fact evidence of the decay I think that's an important factor.

And again, because of the fact that the majority of people have greater access to medical care and they're having to fill in claims, particularly for government programs that this would be a reliable source of data.

DR. DUGAN: Sure, and if you think that's a data source that represents the concept well I would definitely suggest to call that out as an option to explore for a measure developer for sure.

MEMBER HESSEL: Well, and signs of

infection and trauma are both going to usually be evaluated probably by a pediatrician before maybe even making it to the dental. So medical claims in those particular issues are probably going to pick up those things a little bit faster, may be a little more complete.

CO-CHAIR KROL: Okay. Anything else on this one?

So let's pause now. We've sort of gotten through that first one and got our heads wrapped around the process at least. Let's take a little bit of a break.

Thank you for your patience with me and sort of being the traffic cop. I know sometimes I skipped some of you or passed over you and I appreciate your patience with that. But I think that's how we're going to divide things up. I'm going to be the traffic cop and timekeeper and Paul is going to be sort of helping us along as much as we can in the process.

So let's take a 15-minute break. Fifteen-minute break. Bio break, Outlook, Blackberry, all that stuff. Thanks, everyone.

(Whereupon, the foregoing matter went off the record at 10:31 a.m. and resumed at 10:57 a.m.)

DR. DUGAN: I think we're going to go ahead and get started. We are on priority area B.

Let me remind everyone, too. If you see some concepts in here that aren't really all that important related to the priority area please don't feel like you can't say that. Because we'll get to the prevention suite and the access suite where there's 40 concepts or 30 different measures and you know, again, back to the burden issue. We can't measure everything, so if there's 20 concepts under prevention we need to focus on the ones that are higher priority, meaning they're more important, there's evidence base, they're less burdensome. Let's concentrate on

those. So again, if you see something in here that may or may not be a great measure concept please feel free to mention that as well.

CO-CHAIR KROL: Why don't we get started with -- maybe what I'll do is I'll continue to be the traffic cop and the timekeeper, and maybe we'll sort of split across starting these conversations.

CO-CHAIR GLASSMAN: Okay. All right, in area B, I think, again, just to the point that got raised towards the end of the last discussion. Although the staff has repeated some things, they haven't repeated everything and many of these things could be repeated in every section here. So priority B starts with oral health of adults and I think everything we've already talked about, all those measures we already talked about, those concepts, could be -- so we're not going to go through them again for adults unless you see something specific about adults that wasn't addressed previously.

But otherwise I just added a couple of things that struck me as different that had been talked about which was these two concepts for adults, ill-fitting dentures and the ability to chew or discomfort in chewing were two of the measures that sort of came out as different for adults. So let's just have some conversation about those concepts.

MEMBER HELGESON: I just -- my only thing is just to call out root caries. You know, with the typical caries assessment is related to coronal caries and caries experience among children and so forth, whereas older adults experience root caries when they have had a history of periodontal disease. And diagnosing it and tracking it hasn't been done very well to date. So I just, it's an example of caries. We did talk about whether or not we wanted to actually diagnose it with some specificity, and certainly caries on the root surface would fall under that.

But I didn't want us to lose root caries because that's a very significant disease, especially in the old.

CO-CHAIR GLASSMAN: Okay. I think that does seem different than what we were talking about previously. Good.

MEMBER HESSEL: Well, I don't know where this is going to fit. I'm trying to look through, but you know, non-healing ulcers and leukoplakia need to go somewhere in this. And I don't know if it's in this oral health or if it's somewhere else, and I can search through and see.

But one of the measures that we have in head and neck cancer is early diagnosis and staging drastically affects prognosis. And so, this is -- screening for oral cavity cancer, try to fit somewhere in here. And maybe it's in oral health, and maybe it's somewhere else, but I think it has to be a measure. Is it coming up somewhere else?

DR. DUGAN: We'll get there. Yes. OH6, yes.

MEMBER HESSEL: OH6, okay, then I'll be quiet now. Sorry.

CO-CHAIR GLASSMAN: Coming up pretty soon.

DR. DUGAN: Yes.

CO-CHAIR GLASSMAN: Okay, anything else about the two concepts that were listed here, ill-fitting dentures or ability to chew, discomfort chewing?

(No response)

CO-CHAIR GLASSMAN: Okay. So again, the call is going to be a call for people to develop more specific measures related to those concepts.

DR. DUGAN: Or is it? That's another question. I mean, are those important enough areas that there should be a call for measures in those areas, that's the question. Just because they were found in the scan doesn't mean necessarily that they should be

submitted. So that's a question back to the group. Is this -- are these areas very important, or are there more important areas that you would focus on if you had a choice?

MEMBER HELGESON: I can chime in. As the geriatric dentist, I guess I didn't point that out but my background is as a geriatric dentist.

Certainly among the old old which are people 85-plus where the prevalence of partial and complete edentulism is very high if you ask people, you know, about their oral function, their oral health, whether or not they can smile, chew, you know, and do that with comfort versus with pain and so forth is really critical to them. So I think these are important, particularly for that age cohort. Yes.

MEMBER LEE: I just wondered when I saw the one on ability to chew how you would assess that on a population-wide basis.

DR. DUGAN: I'm not sure if it's a

survey-based measure or if it's -- are those the nursing home measures?

MEMBER HELGESON: Yes, I can comment on that. They're part of the MDS 3.0, the federally mandated set of assessments for people in nursing homes. And they are -- no, that's the way they're currently collected is it's part of an assessment typically done by an assessment team usually involving nurses. We have oral health professionals in our model that do those oral parts of the assessment. That's where it's currently being collected.

MEMBER GESKO: There's a work that's called "Oral Health Quality of Life" that I'm sure many of you are aware of. Mike John out of the University of Minnesota has been part of that work. And we recently validated a five-question piece of that work that goes to some of these questions. And it really asks patients in their terms whether they're happy with their quality of life.

I find it very interesting because

many times as dentists we'll walk into a treatment room and look at a patient that's missing every other tooth and thinking, you know, oh my gosh, you know, you're just in terrible shape, and they say they're doing fine and they're very happy with their function and things. And you know, that's really where we should be focusing many times.

And so I think it might be interesting to note that because there's a lot of research around that oral health quality of life study. I think it's been done extensively in Europe.

CO-CHAIR GLASSMAN: And there are well validated tools for that.

MEMBER GESKO: Correct.

CO-CHAIR GLASSMAN: Yes. Okay. So that might be a data source for that kind of concept.

MEMBER GESKO: Anything coming out of Minnesota is of course --

(Laughter)

MEMBER GESKO: As Garrison Keillor says, you know, above average.

(Laughter)

MEMBER GESKO: So you can note that as well.

CO-CHAIR GLASSMAN: You know, I think maybe -- I just want to note, rather than take the next one at a time because they're kind of overlapping a little bit, let's just note that the next concepts at the bottom of this page and the top of the next page, broken teeth, missing teeth, extractions, edentulism, bleeding gums, loose teeth and oral lesions were the other sort of health concepts that appeared in one or more places in the general list of measures. So we can talk about them maybe one at a time, but keep in mind that was the things that I at least pulled out of the general set of measures.

So, comments about any of those really.

MEMBER RUSSELL: One thing I did want to mention that seems to be begging in everything we're kind of looking at is I think we're going to have to at least put on the table that there will have to be a movement toward diagnostic coding of some type that differentiates the various degrees of disease that these individual measures are looking at. We're going to have to somehow come to a point where we have an agreement so that it's easily translatable between professions like medicine and dentistry. Because otherwise we're just looking at state of being.

This is -- you don't have a tooth, you've got a decay. These are just, to me just nebulous. It doesn't really get down to what we really need to do is a set of diagnoses with a set of outcome goals and a plan how to address those issues. That's where we need to go. Where we are is not adequate. And I think -- and I know that we have to deal with the realism of where we are,

I understand that, but I think also for this panel we need to recommend that as a country we've got to move in another direction.

CO-CHAIR GLASSMAN: So I think we had identified that earlier on with caries was the idea if you're going to develop a measure of caries you might want to suggest or encourage people to develop not only a yes or no, but a differentiation. You're suggesting that as a more general principle for all these measures, not just a yes or no, but more a stratification of how severe the problem is.

MEMBER HASTREITER: Chris, being a member of the code committee, do you know what the latest stance is of the ADA on the development of diagnostic codes?

CO-CHAIR GLASSMAN: Through the chair.

MEMBER SMILEY: Yes. You know, it's -- there are issues related to the development of diagnostic code sets, modifiers and the like that are not because of

intransience but because frankly we're up against some barriers that perhaps the NQF can identify. When we take a look at diagnostic code sets, be it Elsbeth's or the ADA's, you know, these code sets exist, they're basically input code sets and we need output code sets so we've mapped them all to ICD.

The problem that we have is that ICD currently is not as granular as we would like it. It doesn't include enough concepts to really be rich enough for what you're all calling for around this table. Yet there's a moratorium right now on any sort of changes or additions to ICD.

You've got ICD-10 also on the horizon or is it? There's now potentially delay on whether or not we'll even go to ICD-10. So as Elsbeth and I were talking about earlier, the earliest avenue we have right now for even hoping of inclusion of diagnostic code sets is ICD-11.

We also had an interesting

conversation just recently regarding modifiers and the incorporation of modifiers into the code set because the ADA is interested in bringing forward modifiers as part of it.

And it's surprising because in code development for many years the payers have often said we want modifiers and it has gone nowhere. And now that the ADA has come to the table and said yes, we're ready to go with modifiers, the payers have said whoa, wait a minute, the cost to implement that, the barriers that we're coming up with as far as all the health care reform and things that payers are looking at, they don't want to look at modifiers for another 3 to 5 years.

So, there's a lot of institutional issues, there's a lot of regulatory issues. The code sets exist right now, both these code sets being mapped to ICD and getting ICD to be a little more granular to accept the dental concepts for output. Not just the input at the coding in the patient record site, but

also the output into the claims system is where the big problem is. And I think that we can identify that and say we've got to find at least on the oral health side the ability to make ICD more granular to accept these dental concepts.

MEMBER HASTREITER: Just a response. I would suggest that you have the wrong payer representatives on the committee.

MEMBER KALENDERIAN: I'm not sure how to interpret that, but just to add to the comment. Being the very practical Dutch person that I am, waiting is not part of my vocabulary. So I simply developed a dental diagnostic terminology that is very practical that is now being implemented by 15 schools, Children's Hospital, a very, very large dental practice group, and we have now 1.6 million patient visits per year that are actually using this dental diagnostic terminology. It's been validated, evaluated through a very rigorous R01 research project.

So, although indeed it's not part of ICD-10 yet or ICD-9, it's actually out there. It's being used. So I would argue that there's something out there that's validated that's being used that works.

So, we could say that there's nothing. We can also say there's something that potentially we can look at, and that's better than ICD.

CO-CHAIR GLASSMAN: So I just want to ask Donna a question for you to respond to in terms of -- this has come up before and probably will come up many times today. The idea a lot of the things we're going to talk about point to, well, if we had diagnostic codes or if we had universally accepted diagnostic codes the world would be better in some way.

I'm not sure what the relation is between that discussion and what we're doing today, and I don't know if we ought to just sort of say, okay, we've recognized that we

need diagnostic codes, now we probably shouldn't keep coming back to that because it's not actually part of today's work. Or maybe I'm incorrect about that, so I'm trying to get your read on that.

DR. DUGAN: No, I mean I think primarily, you know, the conversation should be about what is most important and feasible right now because those measures are going to be developed and submitted, or hopefully eventually be submitted as standardized measures.

But probably the best measures that get at the most important issues are measures that we don't currently have data sources for and that's where we need to go. So, I think it's definitely two different conversations. I don't want to say don't have that conversation because it's very important and those are the measures we ultimately need.

So I think, you know, the general conversation about diagnosis codes and how

we're going to get there I think we can have right now. When you're talking about a specific area let's focus on what we can do, what's most feasible, and then also if you think there are other measures that we ultimately need to get to we can mention them and say, you know, the committee noted it would also be great to measure X, Y, Z because this is where the evidence is, this is where we need to go and make a note of it. Because I don't want to leave that out. I think it's very important. We just need to note that this is what we can do, this is what we would like to do.

CO-CHAIR GLASSMAN: So in some sense we're talking today about the concepts that need to be measured. Diagnostic codes would be one data source or one way of getting at that, but to the extent we have it or don't have it the concept might not change.

DR. DUGAN: Yes.

MEMBER GESKO: Just a quick

comment. Just, I like the idea of this group potentially showing leadership and to express that desire for a movement towards diagnostic codes. That may be the only thing that we can do and then not just beat it over the head every time that we have the open mic.

MEMBER ACHARYA: All right. Just kind of moving along here. BOH5. I mean, I look at bleeding gums and loose teeth, but maybe the concept is, you know, periodontitis there. I mean, that's -- clearly mention it there.

There is a definition from the CDC and American Academy of Periodontology which looks at a couple of these, you know, I think probing depth and clinical attachment loss. So maybe trying to look at the moderate and severe periodontitis based on some of those guidelines might be good.

However, that is based for surveillance on a population base rather than the clinical definition of periodontitis. And

when we come to the clinical definition of periodontitis everybody here knows how complicated it is. There's different sets of definitions out there. But I just wanted to point out that there is a definition from CDC and American Academy of Periodontology for assessing moderate and severe periodontitis based on different sites and also based on the two variables that they look into.

CO-CHAIR GLASSMAN: So, just to point out that periodontitis did come up as a concept in the -- it's actually on page 4 for no particular reason. So it could be here as well. But I think you're adding something different because what was actually pulled out of what was in the large measure set was periodontal screening and you're -- and so periodontal screening could be one thing. Your periodontitis definition could be something else, so maybe we need to think about periodontitis, multiple measures including things like bleeding gums and loose

teeth, and then actual clinical definitions of periodontitis based on either screening or full examinations.

MEMBER LIMBO: That was a question actually I was going to ask because if you look at the Healthy People again it was BOH5 and it says adults aged 45 to 74. It excludes all pregnant women who we know have gingivitis which is bleeding gums. It also excludes the consideration that some of the studies are finding that we're seeing periodontal disease evidence in 11- and 12-year-olds as pre-indicators to Type 2 diabetes. It's a comorbidity but it's not addressed anywhere.

And a generic category that someone brought up in a conversation I had was we really don't see any discussion about soft tissue as an evaluation. And whether or not this is something we should be looking at as a standard or something that we should be evaluating as a quality.

MEMBER HELGESON: Yes, I don't

know if there's -- people want to respond to that. I thought that was interesting. So I had a different -- something different to say. If people have comments about that.

CO-CHAIR GLASSMAN: Can I just say, I want to make sure we don't lose that idea about the soft tissue. There is a category here that says oral lesions, and so when we talk about that let's talk about whether that's way too broad, if we need to differentiate further.

MEMBER LIMBO: Okay, because oral lesions, I'm starting to think about the evidence of -- you mentioned oral cancer detection. And we previously thought of it in people 40 and older, but research is showing younger ages not related to high-risk behavior such as smoking or tobacco use, but rather as a result of sexually transmitted diseases, specifically HPV. And where are we including some discussion or awareness of that?

CO-CHAIR GLASSMAN: All right, so

let's come back to that. Actually it'll be the next thing we talk about once we come to these ideas of missing/broken teeth and then periodontitis, and then we'll come to lesions.

MEMBER HELGESON: I just wanted to speak about extractions and in particular the rate of loss of teeth. There have been a number of international studies looking at the rate of loss of teeth as a proxy for the cumulative experience of mouth infection, both caries and periodontal disease. So the rate of loss of teeth, it's a good indicator of the rate of impact of these mouth infections in damaging the mouth. And anyway, I just wanted to raise that as an issue.

You know, I think if we could develop -- and that's probably something we can measure with claims data and other data that's out there is how rapidly and during what periods of the life span. So you could have rapid -- you know, in the 1900s you had rapid loss of teeth in childhood with people

being edentulists from the time they were in their twenties or thirties till they died.

And now we have this compression of morbidity where people are healthier and healthier in their childhood and then they have this compression of disease at the end when they get dry mouth and all these other conditions.

Anyway, I just wanted to raise the notion of the rate of loss of teeth. I know it's been studied in connection with a number of different diseases including just even life span. There's a correlation between the rate of loss of teeth and a shorter life span, for example. I just wanted to bring that up.

CO-CHAIR GLASSMAN: Okay, so we can have that in addition to the other ones which are pretty static measures. This is a measure over time.

MEMBER HELGESON: Right. Yes.

CO-CHAIR GLASSMAN: Okay.

MEMBER LEE: I'd just like to make

a comment about the rate. And I am looking at my more detailed BOH, right? BOH. And an extraction rate. There are -- one of the example measures that you pulled out requires a 2-year continuous eligibility requirement to even show up in the denominator.

I just wanted to raise this because I think that it applies -- it's a problem not only for extraction rate but for any of these measures. You need somehow or another this group, NQF needs to identify a lookback period that's reasonable and won't result in exclusion of most of the population. And this is even assuming that people are insured and we're getting claims data for them.

MEMBER CRALL: Well, two points. I mean, one is I assume that issue is going to be dealt with sort of through the harmonization aspect of things. Because I mean, that's a general point that goes well beyond just extractions.

I mean, you know, looking -- differences between CMS criteria of eligibility versus NCQA versus any sort of adjusted piece, you know, that's going to apply across everywhere. And at least my understanding of the current framework is that harmonization is where that comes up so that it may not dictate which measure somebody uses, but at least sort of points out where the apples and the pears or whatever they are, you know, for comparison.

The other point I was going to make though specifically related to extractions, based upon some work we did many years ago when I was at Connecticut looking at a population in both Connecticut and North Carolina. You know, not to in any way detract from Mike's point about sort of rates and relationship to diseases or whatever, but I mean, socioeconomic status and options available were clearly major determinants of decisions for extraction.

And so that's another sort of element that has to be captured somewhere because you know, we had buckets of extracted teeth and measured clinical conditions and some of them were still in people's -- some of them are no longer in somebody's mouth but would have been the clinical condition and certainly the treatment options were extensive. But you know, depending on whether they had coverage and whether they had financial resources they were in a bucket as opposed to in somebody's mouth.

CO-CHAIR GLASSMAN: Good. I just wanted to make a comment about the denominator issue which is that I think that -- Lisa's suggestion and see if the group agrees or disagrees with it, but is that we probably don't get too deeply into that today because I think if we're talking about -- it applies to every measure here. Who's the population you're studying and how you define it. So I think it would be one of the things that would

fall under the category of stratification.

So if we have a measure for caries, it would come up under caries measures 3 or 4 depending on the data source, then you can use that measure whether you're talking about 3-year-olds who have been continuously enrolled in X program for this amount of time. So the denominator, many different cuts on the denominator, but I think the point we try to emphasize is that we need a standard definition that can be applied in all these settings.

MEMBER HELGESON: Actually, sorry. I don't know if we want to go on about extractions anymore. I was going to bring up xerostomia.

CO-CHAIR KROL: Do you have a comment specifically on the extractions?

MEMBER HELGESON: So, I wanted to bring up the topic of xerostomia which isn't listed in here, but dry mouth. This is a very serious condition for adults and actually

pushing into younger adults as more younger adults are taking chronic medications earlier to prevent or delay chronic diseases. So, dry mouth is a really important symptom and risk factor for dental problems.

MEMBER ACHARYA: Just kind of more on the lines of kind of disease or conditions. I look at missing teeth and edentulism kind of being part of -- because of dental caries or periodontal disease. But that could also be because of congenitally missing teeth. And there are oligodontia or anodontia.

Does it need a separate bucket on its own in terms of, you know, how are we going to do that? Would it be part of -- and I know this might even be crossing both priority areas A and B because depending upon when that is measured.

CO-CHAIR GLASSMAN: You're suggesting a separate measure for congenitally missing teeth which would be different than the current measure. Missing teeth could be

from many causes, or edentulism could be from many causes.

MEMBER KALENDERIAN: But they're so hard to measure.

CO-CHAIR GLASSMAN: It might be difficult. Again, and that would be the challenge if you call for measures in that area. Someone is going to have to propose that, how they're going to do it and how they're going to gather the data. It might fall out because it's hard to do, but we can at least list it as a potential.

So, we've talked about some of the measures of teeth that are gone or partially gone. Broken teeth, missing teeth, extractions, edentulism, rate of tooth loss. Mike suggested a new category which I don't think fits into any of those under xerostomia and sort of a modification of the missing teeth which is congenitally missing teeth. And then we've talked a little bit about periodontal disease, bleeding gums, loose

teeth and then actual measures of periodontal disease itself, whether a clinical examination or screening examination.

Anything else that goes -- before we get to oral lesions in the next topic, anything else that goes into other oral health conditions of -- so I guess tooth-related oral health conditions of adults?

MEMBER GESKO: I'm really not trying to irritate you by bringing up risk assessment, but --

(Laughter)

MEMBER GESKO: Risk assessment really, it embodies so many of these things. Okay, so like xerostomia. An excellent question or element of a risk assessment is the medical history of the patient and whether or not they're taking xerostomic medications that drives caries.

And so it to me, you know, maybe I'd describe myself as just super practical rather -- person that just says why do we want

to have measures around xerostomia or some of these other things that we're touching on if it were not the means to the end on how we can evaluate that patient better and develop a treatment plan that's appropriate for them.

CO-CHAIR GLASSMAN: So you're suggesting that tied to periodontal disease, risk assessment?

MEMBER GESKO: Yes, absolutely. And caries.

CO-CHAIR GLASSMAN: Well, we've got it for caries, but you're suggesting adding here. My question for you, David, is in Minnesota is everybody at above average risk?

(Laughter)

MEMBER GESKO: No, we're below.

MEMBER HASTREITER: I can answer that too. Actually --

MEMBER HELGESON: I thought he was going to say the thing that characterized Minnesota was that we were cold. Or losers as

evidenced by the Gophers last night. Not a good showing.

MEMBER HASTREITER: Actually, in Minnesota the commercially insured population is at very low risk and other than the safety net clinic patients the government programs patients are relatively low risk too. But that's Minnesota.

MEMBER HESSEL: Along the lines of risk assessment though, and I don't know, but when you go to do your billing for various levels of care I assume part of that is your inclusion of a review of systems, right? That's what we do in medicine. And the more complete the review of systems the higher level of care you can bill. So, risk assessment can fall under review of systems and then it's a searchable data in an electronic medical record.

So, I would assume if that became a measure then the electronic medical records could then follow through with, you know,

making that a data point that is assessed.

CO-CHAIR GLASSMAN: But, that's not currently the system in dentistry though actually.

MEMBER HESSEL: They aren't? Because I fill out a review of systems for my dentist when I go to see him.

CO-CHAIR GLASSMAN: It's not part of the claims system.

MEMBER HESSEL: It's not. Interesting.

CO-CHAIR GLASSMAN: Doesn't get into the claims system, right. Yes.

MEMBER GESKO: It's a great point that goes to a future state. Because I think that's what this group is all about is not to say well, we don't have that now, and I'm not being critical, but is that well, that's where we want to get. That's where we want to get and learn from our medical colleagues and learn things that are in place that have worked well for a long time and incorporate

those things.

I look at you, Amit, just in terms of medical records and dental records and the future state of that very exciting area of being able to push that frontier.

CO-CHAIR GLASSMAN: So, any other concepts under the issue of either missing teeth or periodontal disease?

MEMBER ACHARYA: Just kind of touching upon the risk assessment itself. We spoke about caries, we spoke about periodontal disease and also oral cancers or lesion. You know, root fractures, it's another big area where, you know, we might also want to kind of include that concept within the risk assessment side of things.

CO-CHAIR GLASSMAN: I'm sorry, say the last? Root fractures? Different than broken teeth? Do you want to differentiate that somehow? Is it the same thing or different?

MEMBER ACHARYA: Yes, the broken

teeth could be from an anatomical side of the, you know, view. It could be any of the crown but especially the root fractures.

CO-CHAIR GLASSMAN: Okay.

MEMBER RUSSELL: I don't know if this is applicable, but we should consider the iatrogenic potential causes of some of these issues such as broken teeth, such as fractured roots and other things due to the placements of removable or other type of prosthesis. I mean, we do have breakdown and failure that's due to an intervention that was done. So I think we should somehow capture that.

MEMBER ACHARYA: Yes, kind of more along the lines of what Bob was talking about. When we do the risk assessment it's these are all the variables that come in when you assess a particular condition. So I totally agree with Bob.

CO-CHAIR GLASSMAN: Which may be a second level. So, one idea would be that you would want to have measures of missing teeth

and then a level down for that would be, to the extent that it's doable, measures of the reason a tooth is missing which is congenitally missing teeth, trauma of iatrogenic. Okay.

MEMBER HASTREITER: You know, as far as perio is concerned, I wouldn't totally throw away the concept of CPITN. I think in terms of a dental public health program in a health department, say a state health department, the use of CPITN can predict the needs of treatment, both in terms of access and extent of treatment that's needed with regards to perio. It's not an epidemiologic tool obviously but it is one that can be helpful for state dental directors and other program managers related to dental.

CO-CHAIR GLASSMAN: I'm not sure everyone knows what CPITN is.

CO-CHAIR KROL: Could you explain what that is for folks?

MEMBER HASTREITER: It's Community

Periodontal Index of Treatment Needs. It was developed in Europe.

CO-CHAIR GLASSMAN: It's a screening tool for periodontal disease.

MEMBER HASTREITER: No, it's not a screening tool, it's a tool to determine what service needs are needed.

CO-CHAIR GLASSMAN: Oh, okay. All right. Anything else in these categories?

So let's move to the next one which is oral lesions. And we've had a number -- this has come up a number of times and maybe this needs to be broken down in some way, that oral lesions is too broad. So let's have some discussion about that category. What do we want to do with that in terms of calling for measures?

MEMBER HESSEL: Well, I think that it probably needs to be broken down into screening. You know, doing an exam and screening for these things. And then I think that there needs to be a measure that is for

rate of referral or timing of referral. Because it's really one thing to identify it and then watch it for 6 months as opposed to identify it, follow up and then make the appropriate referral.

And then I think in risk assessment I think it has to come back to, you know, what is the reasoning for that. Because HPV is becoming more and more prominent, though not so much in the oral cavity as it is in the oral pharynx. But these patients are under the age of 45 so not your standard person that you're going to see. They don't have tobacco history. Most of them are upper socioeconomic status and they are not going to be real happy if they sit on an oral cavity lesion for a long time. So, I think that this is a broader thing than just one, you know, is there a mass or not a mass.

MEMBER CRALL: Do we have -- this is a little outside this, but I think it's analogous. Do we have measures that relate to

conditions around patients with cleft lip and cleft palate? That used to be a Healthy People area of focus. Or are we considering that a subset? It's a potential subset within any of the ones we've discussed so far, but are there particular issues that warrant some focus around that as another category?

CO-CHAIR GLASSMAN: It is a category. Not in -- I don't think I pulled it out into this spreadsheet.

DR. DUGAN: It's a priority under F but the priority area is about monitoring and surveillance, so it's more about whether states have monitoring systems, not about the measures per se. So we weren't actually going to tackle F but if you think the content of cleft lip should be a separate content area then we should talk about it. If it belongs here --

MEMBER CRALL: You know, I don't want to infuse that on top of this particular area of discussion, but.

DR. DUGAN: Do you want to call that out separately?

MEMBER CRALL: Yes.

DR. DUGAN: We can do that.

MEMBER CRALL: Yes.

MEMBER ACHARYA: Just kind of more on Jim's thought here. Maybe having a concept or a group or a bucket where we would want to tackle congenital anomalies. That would be one way of looking at some of the areas where we could be developing some measures.

MEMBER HASTREITER: Just an observation about lesions related to papilloma viruses. The way dentists examine patients now for all cancer is insufficient in terms of the type of cancers that develop from papilloma viruses.

I was talking to the oral medicine director at the University of Minnesota and I said, you know, dentists are going to miss a lot of these new types of cancerous lesions. I said what they really need are the long

mirrors that otolaryngologists use because you can't see into the pharynx without them. The only reason I mention it is because I think a lot of dentists think they're doing a great job and you know, they're missing probably about one-third of the tissue that could be cancerous.

MEMBER HESSEL: Right. I'm not totally sure though that at least in the head and neck surgery community we would hold dental evaluation responsible for oral pharynx cancer. So anything soft palate and back I would probably say is probably more on the primary care physician, and the neck mass in an adult is cancer until proven otherwise. But that's not for this discussion.

But I think picking up those pre-malignancies in the oral cavity and lesions along the teeth that aren't healing, and loose teeth that really don't need a root canal. Those are the things that probably just -- it's more education but we just need to make

it a metric so that people start looking for those things.

MEMBER HASTREITER: I'm sorry but I have to disagree with you. I don't think that's just the field of otolaryngologists at all.

MEMBER HESSEL: No, I'm not saying it is but I don't think -- I agree with you if we could train our dentists as they come out of dental school to do an oropharyngeal exam that would be great. But I don't think the expectation is there right now. It would be great.

MEMBER KALENDERIAN: I'm with you.

MEMBER HASTREITER: I mean, that's my expectation.

MEMBER KALENDERIAN: Absolutely. I disagree and I think if we want our pediatricians to do sealants we should definitely have our dentists do an oropharyngeal exam.

It's about a partnership. I think

all of these metrics are about measuring how we can move forward so that really as inter-professionally we can move the health of the population forward. And so it's about doing better on the provider side and then measuring on the patient side. So yes, absolutely, we all need to do better.

CO-CHAIR GLASSMAN: So, we're trying to come up with sort of concepts that call for people to develop specific measures in these areas. So, I want to see if we can come back to that discussion.

So we talked about within the area of oral lesions having specific measures based on screening results. Rate of referral was a separate item suggested, risk assessment again. There's some things about tobacco use later on, but there's other risk factors that maybe haven't been called out so that people could develop measures based on the risk factors. And we had a suggestion about developmental anomalies including cleft palate

which may not exactly fit under oral lesions. Any other thoughts about other things that could be cause for people to develop measures in this area?

DR. DUGAN: I want to ask Amy a question. This is your specialty. So, a couple of important things we want to get out of this are, you know, where is there a good evidence base and are there guidelines. And so to you in these areas are there both?

And then we didn't find any, in our general scan find any specific measures being utilized, but do you know of any that we missed that we could include?

MEMBER HESSEL: Right. So the evidence is one step beyond this which is after identification then what do you do with it. So appropriate staging documented on the chart, multidisciplinary work-up, whatever. But I envision that this group is looking for the step right before that.

I found a Cochrane Review I'll

send to you that I thought might be reasonable to at least start with. But you're right, there is no good evidence because nobody's really writing papers about this. Clearly there's good evidence about the rate of progression from a white lesion to cancer, but again, not really the evidence you probably want for this.

DR. DUGAN: But are there guidelines for the specialty groups for this?

MEMBER HESSEL: For appropriate screening for oral cavity.

DR. DUGAN: Yes.

MEMBER HESSEL: Yes. But I don't know where they are. I can get them to you though.

MEMBER CRALL: Well, and I was just going to raise the question. And I don't know the literature well, but there definitely are papers in the literature about screening mechanisms, brush biopsies, different sort of things like that. So that would be the

performance piece that I think, you know, that would be the question is is there some sort of a standard that people should be held to, you know, that's generally accepted and has some evidence.

MEMBER HESSEL: Right. So I think that's the problem is the level of evidence is sort of I won't say case series but certainly small series and individual patient populations. So nobody's going to say that it's Level 1 randomized controlled series which is what we try to hold ourselves to.

And then also the techniques involved with brush biopsies and then the fluorescence and whatever is very technology-heavy and you either have that in your office or you don't. So whether it works enough to say that every provider should be investing in this, it's just the evidence isn't really out there. But there are some nice papers out there, so we might want to look into something like that.

CO-CHAIR KROL: Bob. And then before you comment I just want to let you know to keep us on track we've got about 5 minutes left in this.

MEMBER RUSSELL: One of the things we should consider on the oral lesion too is as we look at risk factors we need to consider self-mutilation or any things that the individual might be doing that might be inducing some of the problems that they're seeing. Some of the lesions might actually be instrumental or other, chewing-related or other categories. It could also fit into socioeconomic status and certain cultural characteristics or habits that certain individuals or subgroups of individuals tend to have. So I just want to make sure we broaden this enough to include some of those other areas that are not so distinctly just pathological.

CO-CHAIR GLASSMAN: Great. Anything else in oral lesions? All right.

Ahead of the 5 minutes. Four extra minutes in the bank for something else. So, should we just move right into priority C?

So, C. So, we've been talking about oral health up till now, sort of characteristics of the patient, what's going on in their mouth. Now we're talking about oral health care, so that shifts it. So the first bucket at the bottom of page 2 was a whole bunch of things that had to do with patient satisfaction. So I listed I think, I'm not sure I got every one but I listed most of the patient satisfaction measures that were there.

And just before we talk about the first one at the bottom of page 2, also notice the one on the bottom of -- top of page 3. So, on page 2 are measures of patient satisfaction with the care they're receiving. Page 3 I tried to break it out of their satisfaction with their health plan. So they're different concepts, actually.

I think what we'd be seeing here is, again, the framework is a call for people to develop measures related to patient satisfaction that could be submitted to NQF or others, and a whole list of possible sub-topics for that, and then related to their satisfaction with their health plan. So, any discussions about these concepts?

CO-CHAIR KROL: Mary Alice?

MEMBER LEE: I think there's a big omission here in terms of any measurement of dental health insurance coverage. Access to care that is afforded by health insurance is one aspect of quality that needs to be measured, and I didn't see anything in this entire pack.

CO-CHAIR GLASSMAN: So, I want to say a little bit more about that. On page 2 it does at least reference the idea of developing measures about people's satisfaction with sources of care. Is that different than what you're seeing?

MEMBER LEE: Yes. You don't have a source of care if you can't pay for it.

CO-CHAIR GLASSMAN: Okay, so you're talking about --

MEMBER LEE: If you don't have a provider that's willing to see you because you're uninsured or because you're on Medicaid. Or if you have Medicare and no coverage.

MEMBER CRALL: Yes, Paul, if I could just chime in there. I think that, I mean just the term "patient satisfaction," I know, you know, the folks that did the CAHPS development definitely wanted to get sort of beyond that notion. Because, I mean, the fact that you're not getting measured or the notion that you wouldn't be measured until you become a patient is a limiting issue.

And so, you know, but it is possible to certainly identify and survey members of plans or members that have coverage. So that's sort of one additional

category that gets you beyond the users of care. And then I guess the broader question Mary Alice is raising is a way also to examine individuals who don't even have coverage currently which for the United States is half the population.

MEMBER LEE: Right. The one other point I'd like to make with that is that lapses in care are significant. I don't know how we can measure those. One aspect of the Deamonte Driver story is that his Medicaid coverage lapsed.

MEMBER CRALL: Lapses in coverage, not care necessarily.

MEMBER LEE: Lapses in coverage, right. And this is very, very common in Medicaid and SCHIP. That's why you can't have a 2-year lookback.

And then under-insurance with respect to dental coverage is also a huge problem for people. So that even those who have dental care can't afford to go in with

the amount of cost-sharing that they have. So, to begin with, just measuring satisfaction with the care that people are getting who have access to care to me misses a big part of what state and federal government entities would want to know.

MEMBER HELGESON: Yes, I just wanted to comment that large groups of the population aren't able to self-report their satisfaction, namely vulnerable either children or adults who are not able to make those assessments on themselves. So, whether they access care at all is actually driven by a parent or responsible party or guardian, that sort of thing.

And I think it gets into the question of we usually call it access because we have sort of a dentist office-centric look at oral health. We think that oral health happens in a dental office and so, you know, if you access the dental office you're getting oral health. But a lot of people don't get to

the dental office and they would actually need either a proactive dental delivery system that would get to them, or would need their representatives to be able to be proactive on their part.

So I think that's a big part of the access issue is people who either are vulnerable in the sense that they literally don't have the mental or physical capacity to proactively go and get into a dental system, or they're in a situation where the people that are acting on their behalf aren't doing that. So I don't know how to measure that but I think it's important.

CO-CHAIR GLASSMAN: Maybe what we're talking about here is that in pulling from what was in there they were mostly measures of patient satisfaction, either with the care they're receiving or with their dental plan.

But what I think we're talking about here is calling for development of

measures of barriers to -- health barriers to care. I'm not sure what the last half of that sentence is, but calling for measures about barriers would sort of get at this issue. We're not just talking about patients who are getting care and we're not necessarily talking about whether it's -- different data sources could be the patient, it could be caregivers, it could be other things, all would contribute to barriers.

MEMBER CRALL: Right. And I think the distinction you made between looking at the experience or the level of satisfaction with sort of the clinical aspects of care, or the care that occurs within some sort of provider context as opposed to looking at plan issues, or you know that could be program issues or whatever. Certainly the CAHPS, you know, approach definitely picked up on that a long time ago. And so I think that is a useful way of gathering some information about the fact that yes, you have coverage, but it

really isn't sort of addressing your barriers.

MEMBER LEE: Responses to a question on unmet need, for example, are going to be hugely different if a person is insured or not. If the person's in Medicaid or not. And then you can also get down to the questions about transportation, or lack of willing providers, or my mother didn't take me, or you know, whatever else it is that resulted in this unmet need. But I think measuring uninsurance and under-insurance is really important.

MEMBER KALENDERIAN: I think it comes down to two things. It's not insurance, it's a benefit. Because it's like medical insurance, but you're really insured for catastrophes, dental insurance is a misnomer.

And then second, I think with the whole access issue, maybe thinking about measuring the number of dentists per population might get to if there is really good coverage. Because it's really out in

those very rural areas where there simply is -- there are not enough dentists for the populations. Plus there might be just really access issues from a standpoint of distance as well as issues of do you have a car, as well as do you have people to drive you. So those might be different kind of epidemiological measures to get at it versus the satisfaction measures.

MEMBER HESSEL: Well, and then the other thing is the insured versus the uninsured, the time of treatment is going to be very different too. Because the uninsured are going to need to seek out a very small population of dental providers that have a huge waiting list. And while they're going to get much lower cost for care, they may have to wait a year to get it, whereas someone who can pay or has insurance won't be in there and out of there in 30 days. So, you have to caution yourself when you look at the insured versus the uninsured for that reason as well.

CO-CHAIR GLASSMAN: So, I think what we're saying is that some of these things could be combined together. So unmet needs, availability of sources of care could be combined with measures of have insurance, don't have insurance, where you live, urban, rural. A lot of things could be combined to get measures, but the bigger concepts would be whether you -- do you have barriers, do you have unmet need, is care available, and then you could look at a lot of ways of combining those things.

MEMBER LIMBO: Also, in all our discussions we're talking, seemingly talking about individuals who have no physical challenges, mental challenges, or chronic illnesses in terms of individuals with special health care needs. Because one of the things that I had is a situation where I had a mother with a child who had significant cerebral palsy and was home-cared, fortunately for the child, but had tried for 11 years to try and

access oral health care and wasn't able to do so. And it was a combination of a physical barrier and it was also, again, a resource. Who was going to take the insurance this child had. And it bounced between two.

MEMBER HELGESON: Yes, and I don't know exactly how to broach the subject, but I think most people know that adults in most states do not have much Medicaid coverage whatsoever. And then in states that do they have, like in Minnesota we now have a limited adult benefits set which doesn't include any benefits related to periodontal disease, for example, at all.

And so what about the quality implications of having a vulnerable adult say with special needs or elderly vulnerable adult whose only health benefit doesn't include coverage for major conditions in the mouth? And I don't know where you go with that, but it seems to me that's a huge barrier to both access and quality. Because if you get in and

you have a very limited benefit set the odds are you're going to get what's in your benefit set and not what isn't in it. So, your rate of extraction of teeth for example may go way up, et cetera.

So I don't know how we broach that. It's a sensitive subject because it's a public-private issue and there's, you know, it's very complicated.

MEMBER KALENDERIAN: That's why I think that trying to measure if somebody has benefits or not is I don't think a very good measure because you don't know what's in the benefits.

MEMBER HELGESON: Correct.

MEMBER KALENDERIAN: So, even with the better benefits plan it might still not be the same for different people and different populations. So I think it's much better to really try to measure if people get the right care for the right condition, and if they have unmet needs or not.

MEMBER LEE: The U.S. Census Bureau conducts two major nationwide surveys a year measuring whether people have medical insurance or not. And they don't assess what the benefit package is in there. But we don't even have the answer to the question of who has dental insurance as well. So, I think asking the question, you know, whether or not it's a comprehensive plan, you know, that's for another day. But even asking the basic question I think is really important.

MEMBER LIMBO: And again I ask for clarification because I thought one of the charges we had with this group was to make a recommendation as to what we said minimum standards should be. And so I come from a start which has no adult dental. They've eliminated it. And so the charge should be to be able to go back and say if the recommendation is you have this then there's some grounds for arguing to the fact you don't have the right to eliminate this because we

have set a standard of quality that this needs to be provided. And I know that's a little bit of a political issue as well, but that's what I thought we were trying to do. And if we're saying the minimum requirements are that you have this and this, it's prevention, to include some minimal for restorative. And you're right, it's not going to cover everything, we know that. But that's what I felt --

CO-CHAIR GLASSMAN: So let's see if we can get some clarification on that because I don't think that that's the charge of this group is to develop standards. I think we're talking about potential things that could be measured at the concept level which is different than what the answer should be once you measure it.

MEMBER CRALL: I think it's, you know, well beyond. Having decent measures could help to make the case for that, but that's going to be dealt with through some

combination of the Surgeon General and the Institute of Medicine and Congress.

CO-CHAIR GLASSMAN: I have to say I totally agree with the sentiment. I'd love to be able to have this group bang the gavel and say every state has to have dental benefits.

(Laughter)

MEMBER HASTREITER: You know, the difficulty with that entire issue is when you try to measure whatever you want to measure in populations that have various benefit structures you're going to get different answers. And the epidemiology people might be the same.

For example, in Minnesota there has been a downgrading of the adult dental benefit but EPSDT kids still get everything, pregnant women get scaling and root planning, some outpatient centers can have covered people get scaling and root planning. And even within the government programs there's a

lot of variations.

And that really affects, as you know, the dentists will tell you when you call them well, you didn't pay for such and such so you know, the patient just can't get it. And then you tell them well, are you treating the patient or are you treating the insurance company?

And so there's a feeling among the dentists that -- for practical reasons the only things patients will get are those that are paid for either under commercial product or government programs product. And so, I guess the point is that studying these things given the different benefit structures will definitely give you different answers.

MEMBER LEE: Having the information about who has health insurance or not at the national level, at the state level, at the community level now from the ACS is a very powerful advocacy tool. And we don't even have that basic information about dental

care, never mind the variation in the packages. And so I think just having the data available, adding a question to the CPS or to the ACS would be worthwhile.

CO-CHAIR GLASSMAN: So, I'm trying to just summarize these things as people are talking. Let me just throw out what I'm hearing here. Hopefully I haven't missed something important.

But I think what I'm hearing is four big concepts related to this area. One is satisfaction with care that people actually received. One is satisfaction with the health plan. The third one is barriers to care, and the fourth one is unmet need. And then all of these things being potentially stratified by whether you're insured or not, the level of coverage, lapses in coverage, of health conditions that you have, disabilities, other kind of things that might affect your either actual use of services or your feelings about them would all be sort of ways of stratifying

those four basic concepts.

MEMBER CRALL: And I think it's obvious, but you know, even with -- and then getting down to actual plan level as well. Because you know, certainly within a state Medicaid program for kids you can see considerable variation by plan. You know, and I think some states over time have acted upon that and gotten rid of some plans. But I mean, yes exactly. But I mean, it's, you know, it starts with measurement.

MEMBER RUSSELL: On the state level though I believe, like in my own state we do a family and household survey which is done by the police center, Dr. Damiano. And actually many of the questions that we talked about, level of coverage, ratio between medical and health, satisfaction rates and so forth and timeliness of care are answered. At least for the population, we're talking about really Title 5 and children population under that but it's a pretty broad survey. It's a

phone survey. So I think other states probably are doing similar things. No?

CO-CHAIR KROL: I think there's significant variation.

MEMBER RUSSELL: Okay.

CO-CHAIR KROL: Yes, you're one end of the spectrum probably. Dick?

MEMBER HASTREITER: I certainly think that Mary Alice is right in saying on a large population basis, for example a national population study or even multi-state study or regional study that there's no doubt that the fact that people who have dental insurance seek treatment and get much more treatment than others.

But the only reason I brought that up is because it's much more complex than that. I mean, and some of you have mentioned it. The complexity of this issue is much more difficult to assess and utilize than just a broad-based look at that situation.

CO-CHAIR GLASSMAN: Agreed. And I

think we're about to move into another area which gets even more complex which is -- if that wasn't difficult enough. Because you've been talking about sort of satisfaction measures, but the next grouping of things, they are sort of loosely related together. We're on page 3 so we've talked about, the top one was about dental plans and we've made some modifications of that.

But then we get into a whole bunch of things related to oral health services provided by a non-dental provider, by a non-dentist provider. I used those -- those are my terms. What I meant by that is a non-dental provider is someone who's not an oral health care professional. A non-dentist provider could be, like a dental hygienist or a dental assistant could be a non-dentist but maybe could be an oral health care provider. There's things about referrals and visits with dentists, there was stuff about daily mouth care by caregivers, provider availability,

continuous sources of care, so a whole bunch of things that are sort of loosely -- it was hard to actually lump them together because they're all related but different enough I had trouble lumping them together. So maybe we just think about are there some big concepts here that, again, could be called for measurement areas or do we just need to talk about each one individually. I'm not sure, so.

CO-CHAIR KROL: Mary Alice and then Bob.

MEMBER LEE: I just wondered, when I saw the measures that specified non-dental provider or non-dentist provider that I thought to myself why wouldn't you measure it for everybody and then ask a second question who provided the care? Because you also want to know what subset of all the services being given or the people being served are being served by dentists versus allied dental professionals versus non-dental providers.

CO-CHAIR GLASSMAN: So you're suggesting those things could actually be just part of the stratification of answers to other questions.

MEMBER RUSSELL: One thing you are missing here is the availability of care coordination. And I think, you know, some states are implementing various care coordination models that link health and primary care with dental so that it facilitates patients finding resources for care. That's been very successful in some states.

And so I think we should at least have a category where we captured the availability or lack thereof, because that may have a big variation on how many are getting, for example, the Medicaid population and one state may be getting a greater level of care even though they have similar programs because there's another variable that's kind of accelerating that access. So I think we need

to consider that too.

MEMBER HASTREITER: Bob, I think that's a very good point. In fact, Delta Dental in Minnesota has a care coordination plan for the SCHIP and the Medicaid and other programs and it works very well, at least in terms of getting non-institutionalized people care.

The other thing I wanted to mention was that the issue of people other than dentists but who are dentally trained is very important. In Minnesota, we have two different -- I'll just, for practical purposes I'll call them dental nurses. We have a dental nurse light program and a dental service heavy program. And it's obvious that the dental service light program is almost useless and that dental service heavy program will really help in decreasing -- increasing access to care.

MEMBER CRALL: Paul, you know, just I happen to see, you know, you've got

daily mouth care by caregiver in here. And I think, you know, from a performance measurement standpoint I think that is probably only going to apply where there's a requirement that that actually be done. I mean, I don't know how we're going to get into figuring out whether parents are monitoring --

CO-CHAIR GLASSMAN: That actually came from the nursing home section, so.

MEMBER CRALL: Right.

CO-CHAIR KROL: Michael, you might want to comment on that.

MEMBER HELGESON: Yes, I can comment on that a little bit. In both long-term care and group home settings where you have people who are presumably permanently disabled and presumably lifelong Medicaid and as they get older Medicare recipients there are requirements around that. And it's really, in terms of who's going to be stable orally and who isn't, this is it.

CO-CHAIR KROL: Mary Alice.

MEMBER LEE: Just one other thing I thought of with respect to the oral health screenings provided by non-dental providers. In Connecticut for example our Medicaid program reimburses for that service when it's provided by pediatricians, but only for children under 3. So, the measure is going to need to be stratified by some other factors too.

CO-CHAIR KROL: That varies by state. There's --

MEMBER LEE: Yes, it varies by state.

MEMBER BATLINER: But see, I want to get back to your point. I think we focus on what, you know, what's important to provide, what's important to receive as a patient and much less on who's providing it. Because we're in the midst of a huge change, a huge change in what and who's going to provide care to dental care and who is also going to be involved in oral health care, physicians,

et cetera. So, I think your first point I agree completely with, focus on what needs to be provided and then, you know, not make assumptions about quality based on who's providing it, but maybe just track who's providing it.

CO-CHAIR GLASSMAN: So I wonder how that discussion relates to the measure here about the receipt of referrals and visits with the dentist. There's a lot of measures about utilization of services.

I mean, the one that's the most crosscutting across any measurement system is dental visits. That would seem to be different than, you know, did they get what was needed. Dental visit may or may not be a measure of that.

So I wonder how do you all feel about the measures? It comes up in a couple of places about referrals and visits with dentists. Is that something we need to call for more development?

MEMBER CRALL: I would say yes. Well, I mean, again, I couldn't get into the details but you know, I certainly heard Alan Finkelstein when he was with United Healthcare talk about a program they implemented in New Jersey where they not only looked at, you know, whether kids were getting services in primary care offices or whether they were getting assessments in things that they paid for, but they actually looked at the connection in whether those kids ended up in dental plans and set up dental providers --

CO-CHAIR KROL: Actually financially incentivizing pediatricians to do that.

MEMBER CRALL: Right. So, I think you know, more of those things. And again, it ought to be benchmarked against whatever guidelines, you know, periodicity schedules, whatever say is the appropriate sort of approach to care. But I think, you know, actually tracking some of those things.

Because I agree. I mean, I think we ought to track where the services occur and evidence over time will tell us whether that's efficient and effective or not, or whether or not that's just duplication and one's better than the other.

CO-CHAIR KROL: Elsbeth, you were about to comment?

MEMBER KALENDERIAN: Yes. Having actually spent the early part of my career in geriatric care, the measure that I didn't see in here is -- reminds me of you thought about in the failure to thrive in the pediatric population.

It's a simple measure of can the elderly population eat. Do they have dentures? Do they have dentures that fit? Do they have teeth that they can chew with? Are they losing weight? You know, very practical measures that when I worked in the nursing home industry a lot of elderly people just didn't do well because they didn't have teeth,

or they didn't have teeth that worked.

MEMBER CRALL: So that's an activities of daily living kind of corollary?

MEMBER KALENDERIAN: Yes, more along those things. And yes, it's important that they do get twice a day oral care if they cannot do it themselves, but if they only get it for their upper denture because they don't have a lower denture and they're still gumming, you know, a little bit of their mashed potatoes that's not getting the nutrition that they need. And that was kind of --

CO-CHAIR GLASSMAN: So we did a little while ago did talk about specifically the measure we pulled out of the longer list which is ability to chew or discomfort chewing. We have gotten -- I think we've agreed to include that one already. So does that get at what you're talking about?

MEMBER KALENDERIAN: I think so, yes.

CO-CHAIR GLASSMAN: Okay.

CO-CHAIR KROL: Mary Alice, you wanted to say something?

MEMBER LEE: I come from using claims data to try and track services. And so measures like advising about tooth decay, receipt of referral and dental counseling in the medical setting are -- those are aspects of the quality of care that don't typically generate a claim. And so, tracking the information on a population basis is really, really difficult and resource-intensive.

CO-CHAIR KROL: The first, the assessing, at least for those states that -- for most of the states that pay non-dentists to do that, there is some requirement of documentation that the service be provided. So in that case there would be. Now, the referral doesn't necessarily generate a claim because there's no payment for the actual referral, but in the case of the assessment in order to get the payment from the Medicaid

managed care system or from the -- well, from Medicaid one has to document that in there.

MEMBER LEE: Submit a claim for reimbursement.

CO-CHAIR KROL: Yes, that's correct.

MEMBER LEE: I've seen -- and in the patient education measures. So, just things that will be found in a chart review but not found in claims data. So feasibility was on my mind when I was looking at those.

MEMBER CRALL: But then to your point, I mean, the claim in different states, the requirement for submitting a code may include all those things or it may not.

CO-CHAIR KROL: That's right.

MEMBER CRALL: And that's where it has to get down to the level.

MEMBER HESSEL: Well, and we're running into that with survivorships. A big push at the Institute of Medicine right now, making sure that people who survive their

cancer get into routine follow-up which includes appropriate screening. And we've found that if you just look at the people that go to the survivorship appointments that you're missing a large portion of the population because you can advise someone to do it but whether they do it or not is not really there. And the measure you actually want to measure is whether or not you're advising them. It's not how many people actually follow your advice which in cancer is huge.

So, we've started looking at putting into the medical record a data point, a checkbox, you know, because we're electronic, a checkbox that can then be searched that says that you did advise the patient about survivorship. And it's in like the assessment and plan of the medical record. And maybe that's what you're looking for here is in the dental record having a data point, a checkbox that says we did discuss oral

prevention, or you know, whatever they are, caries prevention and whatever, and then that can be -- yes, you have to search the medical record, but if it's a checkbox then it's a data point as opposed to reading the assessment and plan of whatever, a busy dentist and provider.

MEMBER BATLINER: I'm going to be a little controversial here in saying that. I mean, I'm not so sure it's all that important to track, you know, education efforts with patients because frankly most research indicates they don't work. You know, most of what we do when we talk to patients doesn't result in any change in behavior and any positive result in their oral health.

So I mean, I think if we're going to waste, you know, spend effort tracking things we should track things that have some hope, some evidence of showing they're going to improve somebody's oral health and right now the way we do patient education, the way

we were all taught and are still taught in dental schools doesn't work.

MEMBER ACHARYA: Just to kind of add to that. Medical provider provides a certain amount of education that has a much more impact on the patient and especially the medical providers talking about the oral health related. Maybe there is a point to kind of track that and make sure whether -- did the referral go through.

So there are like two aspects. One, the oral -- the education component, the patient education component itself coming from a medical provider. And maybe even stratifying it based on the specialty of the medical provider and also looking at the referrals being made. I mean, obviously there are challenges when we look at the different states, you know, how much of that information is actually going into the medical record. Is that available? You know, how much of it could come through claims? Those are some of

the current issues. But you know, as a group when we sit here maybe those are a couple of things that we might want to kind of start developing or at least recommending.

MEMBER SNYDER: So, I just have one pertinent thing to say about referrals. I'm working on a project right now where there's a couple of different organizations looking at how EPSDT information is captured in the CMS-416 form. One of the things that's in there is a measure on referrals and the latest word from the group that's working on that is the quality of information that's available to Medicaid right now is approaching useless.

CO-CHAIR GLASSMAN: So, we've had some sentiment that measuring provider education at least in the dental world might not be a good thing to do because there's no evidence that it actually produces any improvement in health. What about referral? I'm hearing different things about referral.

The data is terrible but it still might be important to track whether it was done. Is that the sentiment of the group, that that -- probably you should still call for measures about referral, or does that also fall in the category of education and why it might bother you to do more important things?

MEMBER KALENDERIAN: Well, I think you get to the heart of the issue of how does it get documented in order for us to measure it. And that's probably not the scope of this group. I know that the way we document referrals is in data points so that you can actually measure them all in dropdown boxes that were all first validated and it was a long process that gave my hairdresser lots of work to do on my gray hairs. And now we have great data that we share among different organizations and a great data repository. So, you know, I think it's possible but if you don't do it like that then you have 0.00 results. So I think referrals is where it

needs to go. I think that is really, really important information. But it's like with caries, how do you calibrate all the providers and all the people who refer.

CO-CHAIR GLASSMAN: But if you're saying it's important then there still could be a call for people to develop measures and maybe they'll come up with them or not.

MEMBER KALENDERIAN: Absolutely. I would say so. Yes, there's hope.

CO-CHAIR KROL: Michael?

MEMBER HELGESON: I was just going to comment. I know in Minnesota there's something called Minnesota Community Measurement that looked at care for diabetics, for example. And I know a big part of that is you've got standard recommendations regarding referrals for eye exams, dental, different pieces, and tracking, you know, not only whether the referral was made but whether the person actually followed up.

So I agree, my sense is that if we

want to integrate over time the practice of medicine with dentistry that we've got to start setting up and tracking, you know, especially for diabetics. Maybe we could agree, you know, hey let's, for diabetics, it's pretty obvious that we ought to be doing this. Maybe there's a couple other categories that we want to -- pregnant women. But anyway, I think it's important.

CO-CHAIR GLASSMAN: All right. So then we would say -- we're talking about the same kind of thing. We're talking about calling for people to develop measures of referrals. What does it actually mean when you say there was a referral or not, and then you might want to stratify whatever day you get by the various kind of examples like you just gave.

MEMBER KALENDERIAN: So maybe here we might want to think looking at the meaningful use measures because there are measures around referral and how that's being

measured. I know that we are going with the meaningful use measures, implementing those. So that might be, you know, one area to look at.

CO-CHAIR GLASSMAN: So that might be a data source for people who are already doing meaningful use work then.

So, this next one kind of in the middle of the page I think we've already addressed unless people have things to say more about it, which is provider availability and contribution which has to do with -- it just was many different kinds of measures about whether there's availability in the safety net, or adequacy of the network, or who were the dentists that are available, or where are they. Retention rates among dentists. Those I think all sort of come under the category of availability of providers. Any discussion about that, calling for measures to track availability of providers?

CO-CHAIR KROL: Mary Alice touched

on that a little bit before I know.

CO-CHAIR GLASSMAN: Okay. It's line 36.

CO-CHAIR KROL: Thirty-six on page three. Got it?

CO-CHAIR GLASSMAN: So, if not, the next grouping has to do with kind of loosely the use of various kinds of services, specific services.

So, it was actually more detailed in the long version. There was everything from endodontic services and ratios of endodontic treatment to extractions and crowns versus fillings and all kinds of use-of-service measures.

Actually just an anomaly of the organization here, preventive services are broken out in a different section so this kind of grouping doesn't include them because they come up really next, in the next page.

But so, I guess the call if we agree that this is important would be to call

for people to call for people to develop various measures of services received by people. Thoughts about that?

MEMBER CRALL: Well, I think in general people think that it's useful but, you know, grossly inadequate. I mean, it's just the beginning. But it is useful as a means of comparison for looking at, you know, individuals covered by certain types of program, Medicaid versus a CHIP program versus commercial plan versus uninsured if you can get that kind of information.

Within those categories again you can look at specific contractors who are responsible and see variation. You can see regional differences. You could see differences by age, et cetera. So I mean, it's just a very coarse and crude way of starting to look at whether or not -- at utilization of services. And you know, then let the debates begin as to whether it's because of providers or whether it's because

of people who don't seek care and whatever. But you measure and then you go from there.

CO-CHAIR KROL: Okay. You're voting for leaving it in. Andrew?

MEMBER SNYDER: So, when I worked for the Wisconsin Medicaid program one of the things I always wanted but could never get was completion of treatment plan. And I think that that would be something that really is worth emphasizing so that it's not just okay, I saw Johnny, Johnny had a claim for a two-service filling in a front tooth. Is Johnny set now? You know, do I know enough about, you know, whether he's gotten to a place where maybe you can do disease management and getting to a lower risk status. And so if there were some better way to track that off claims that would be extremely helpful to public insurance management.

CO-CHAIR GLASSMAN: So, let me just ask a question about that to the group which as you're suggesting that is important.

The question I want to ask, is it feasible based on do people know what completion of treatment plan means.

MEMBER CRALL: Yes, I mean some dentists will tell you a treatment plan is never complete. I mean, you know, they sort of -- hey.

(Laughter)

MEMBER CRALL: I'm telling you, okay? So but in fact we've recently sort of, you know, toyed with this through some of the work we're doing through the Dental Quality Alliance as well. And Krishna can remind me what we've come up with. I guess it's treatment that's planned but not completed?

DR. ARAVAMUDHAN: No, actually towards the end we decided we couldn't really define the word "completion."

MEMBER CRALL: Right. But again, I mean exactly to Andy's point. An individual enters a care system, they get an examination. Along with that they get a plan for at least

an episode of care. I think that's what we've sort of moved the language and the frame to, to defining episodes of care.

And you know, so in an ideal world, in a pediatric dentist's mind set it's, you know, you come in, you get the examination, you get your list of things and you'll be done. You've worked through the restorative and all that, and then you go into a maintenance phase of care, et cetera. But a way to mark those, you know. So I think that's an important piece which is very much astride to what you see in terms of measurement in other aspects of care, episodes of care.

CO-CHAIR KROL: David?

MEMBER GESKO: Not intended to be kind of a quip, but the measurement of a completion of a treatment plan is one thing. But in many cases these populations that we're talking about, it's the measurement of the creation of a treatment plan. So many just

seek care for episodal acute need and we're challenged to even get them to a point where they have a comprehensive examination and the creation of a treatment plan. So again, just couldn't help but make that comment.

CO-CHAIR KROL: Dick?

MEMBER HASTREITER: I couldn't agree with you more. Every time I hear the --

MEMBER GESKO: Stop there.

(Laughter)

MEMBER HASTREITER: No, I'm just going to back you up a little bit more. Every time I hear the discussion about quality of care I kind of get the shakes because it has so many different definitions. But there are ways using the data that's available not the measures of the technical quality of care but the quality of the decision-making process of the dentists, both in terms of the services that are planned and the treatment plan, and the execution of that plan. And Dave, you're actually right, that's definitely the case,

especially with large populations.

MEMBER CRALL: Yes, and just -- so as a point. I mean, one of the measures that the DQA is looking at and including in a starter set is that does a patient receive a comprehensive examination or a periodic examination. And you know, that looks like a narrow little slice of what you're trying to look at but as a marker in a process of care I think it's an important marker. So I think that, you know, in these utilization of services measures no one of them is going to tell you anything, but you can start to construct profiles and sort of, as you said, assessments of proxies of what's going on in care by having some of these markers. And the issue about defining when an episode of treatment has been completed, whatever, however you use it, that N marker is a longstanding void in the data capture systems.

CO-CHAIR KROL: So, what I'm -- oh, go ahead Bob.

MEMBER RUSSELL: I can say that for the federally qualified health centers there is an effort afoot and DentaQuest is also working with us to develop a treatment completion monitoring tool as an indicator of quality.

Now, it's very important when you consider the FQHCs because they're paid, unlike general practice in fee-for-service they're on a cost-based reimbursement type of system that actually rewards visits rather than procedures done per visit. So for that reason it's important for them because we want to make sure that within a given time, in this case a year is what we're looking at, that a proportion of those treatments are completed because it would be easy to milk that patient by having them come back per service and just simply put a filling in and just stretch out each of the encounters in order to generate more revenue. So this is a way to say that the churning effect isn't happening because we

can document to some extent the treatment that was planned, or as we say the episode of treatment was completed within a calendar year.

So there are -- I mention this because there are efforts afoot to do this. Granted it hasn't been a part of the past, not at least to a degree that it would be useful, but it is becoming a part of the trend. So, in one sense it would not hurt us to be at least aware of that trend and actually maybe capture that. If this activity is occurring there will be data down the road. We should be ready in order to capture that data.

CO-CHAIR GLASSMAN: And you're talking about that's based on what are called phases of care, like phase I completion is the --

MEMBER RUSSELL: Right. Well, I mean -- for the sake of this argument I would say it doesn't have to necessarily be phase I, it can actually be whatever the episode that -

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CO-CHAIR GLASSMAN: That's --

MEMBER RUSSELL: -- for example, you load the system with what you're going to do over a period of time and then you measure the cutoff point. I've completed that entire system of episode. And then there's a benchmark. You can put a dummy code. There's a number of ways of doing it where you can flag that is now in a maintenance state.

CO-CHAIR GLASSMAN: So, what I'm getting here out of -- this is a huge effort in reductionism here, but out of what's probably 100 measures in the big pile that had to do with services received, and again we're cutting out preventive services, that's coming for the next category, but forgetting preventive for a moment which is measures -- we're calling for measures of oral health, examination or assessment, comprehensive dental examination, creation of treatment plan, completion of treatment plan based on

episodes or phases of care, whether any service was received, and then a whole list of specific treatment services that might have been received. Did we miss anything in that, in that reductionist exercise? Okay, good.

Well, then we're into, the last couple in this section have to do with use of the emergency room and the use of the operating room. And maybe sedation needs to be in there a little more explicitly than it is.

MEMBER LEE: I just was thinking with respect to use of the emergency department, why limit it to just account of after hours visits?

CO-CHAIR KROL: Oh no, I think that's in addition to an emergency department, an after hours setting. Not after hours in the emergency department, but an urgent care center or something like that. So that's a separate location from an emergency department.

CO-CHAIR GLASSMAN: There's a slash between those two so they're two concepts just scrunched into one sentence. It's two concepts.

MEMBER CRALL: Paul, in this context and I had a little bit of discussion with folks at the American Academy of Pediatrics who are actually working on a project for AHRQ to look to try to see if there's some way to enhance the current treatment measure which is not this per se.

But I think one of the ideas that came up which I think is an interesting one is not just looking isolated to see, you know, how many individuals present in an emergency room for some dentally related condition, but looking to see, you know, even beyond that then do they get hooked up with a dental provider to address what's the fundamental problem that got them to the emergency room in the first place.

So I mean, again, it's part of

this sort of looking at sort of the pathways of care, or patterns of care that are important. Looking at, you know, not just did they show up. I mean, I think that's important in itself to get an extent, an indicator of whether your upstream system is working, but to look, you know, at sort of was there any care, you know, in the dental arena at any period prior to that and was it episodic or was it something that was, you know, something that's a little bit more continuous. And then following the emergency visit is there a system in place, care coordination or whatever, that gets that person to somewhere where they can get the problem definitively --

CO-CHAIR KROL: It touches on the referral as well.

MEMBER CRALL: Yes.

CO-CHAIR KROL: Andrew?

MEMBER SNYDER: I just want to make sure, one key stratification that I don't

want to lose out of the emergency room data is between ambulatory care sensitive I think is what the California Healthcare Foundation study called it which I think is a good term. So preventable conditions that are dentally related and those that aren't, sort of fights, falls and accidents. Right. And then related to the OR indicator which we may not be ready to move to yet.

One of the things I thought was interesting I think Burt Edelstein's worked on in past years is repeat trips to the OR for sedation dentistry which I think is something worth keeping track of which may be a little separate than just straight visits to the OR.

CO-CHAIR KROL: Diane?

MEMBER LIMBO: When you said that ambulatory care, would that capture -- and again, because I deal in pediatrics the kids that show up at a medical provider with a fever who during the exam when the provider sees that in fact the fever is related to the

fact that the child doesn't have the swelling but in fact has an abscess and is seen in the medical setting for the dental emergency. They then put them on antibiotics and make the referral to the dental. Will it capture that? Because we hear a lot of that happening.

MEMBER CRALL: I think if we make that point and indicate that it should. I mean to me, I would want to know the difference or at least the stratification by whether or not they are seen in sort of a typical primary care outpatient setting vis-a-vis an emergency room.

MEMBER LIMBO: Right, because one of the things we're promoting is the fact that the utilization of urgent care in pediatrics versus, again, the more costly higher level which is going to the emergency room. So that'll also be impacted whether or not there's availability of an access. Because if the only thing you have is an emergency room then you're going to use it versus having

access to an urgent care.

CO-CHAIR GLASSMAN: Okay. So, we had talked about some things related to emergency room use. It seems that everybody agrees that's important and we got some various parameters that could be added to that. And is after hours services any different or are we just -- the same kind of parameters about subsequent referrals and all that kind of stuff would apply to after hours care as well. Mike, did you want to?

MEMBER HELGESON: I just had an added concept too that some emergency department visits result in just, you know, antibiotics and narcotics and so on. I know in one study that was done a few years ago in Minnesota 40 percent of those people were repeat visitors. So they were doing that at least twice in a calendar year, 40 percent. Most were adults, not children.

But the most costly scenario are the ones that get admitted. So I'm wondering

if we could track, you know, people that go in and they're at such a state that they need to be admitted to the hospital as a result of their untreated dental problems.

CO-CHAIR GLASSMAN: Okay, subsequent admissions would be another --

MEMBER HELGESON: Yes, I think we should capture that.

CO-CHAIR KROL: You could argue that any disease process like dental caries that results in an OR is essentially an ambulatory sensitive admissions.

MEMBER KALENDERIAN: You just -- Paul, you made a quick comment about after hours. I think we want to be very careful how we define that because there's many clinics who are open, you know, until 8 which would not be considered after hours because that's their regular hours. So it needs to be after closing hours.

MEMBER BATLINER: Could I -- with respect to OR I want to make sure we don't

miss this repeated OR issue. And I also think we need to track, we need to make some statement about what's done in the OR.

I worked on a Medicaid project over the past year and because of some rules that were put in in Colorado for Medicaid that restricted what you could do outside of the OR lots more things happened in the OR. And repeated hospitalizations, repeated OR visits happened which were, you know, it's not good to keep putting a kid under general anesthesia for relatively minor stuff. So I think sometimes we need to track what's going on with Medicaid plans and health plans. Because it can have perverse incentives that lead to things that aren't good for kids.

MEMBER HESSEL: Well, and then the other thing in regards to what Michael was saying was that if a patient shows up in the emergency room and gets admitted that's a medical admission. Even though the CPT codes may say dental abscess it's usually admitted

by a physician so that's on the insurance. Whereas if they showed up in the dental office and had it treated appropriately and they didn't have dental coverage that's not on the insurance. So you're incentivizing adult population to be using emergency room because it's covered by their insurance. We see it all the time in general ENT.

CO-CHAIR GLASSMAN: So would you say that medical admissions for dental problems is a separate area of measure?

MEMBER HESSEL: Well, I just think that you might want to stratify admission status, whether or not they truly get admitted. And then the other thing you might want to stratify is insured versus uninsured because that might show.

CO-CHAIR GLASSMAN: Right. But I was also trying to differentiate may or may not follow an emergency room visit. You could have a medical admission that came from somewhere else.

MEMBER ACHARYA: And just kind of related to that. Urgent care, sort of ambulatory setup, ambulatory setup. In a study that I was conducting last year there were a lot of evidence from our urgent care physicians telling that they would see patients repeatedly coming in and kind of talking about pain and asking for narcotics. So there is also real need versus kind of a drug-abusing scenario that comes in. Maybe we want to capture or ask the people who develop some of the measures to kind of distinguish between that. I mean, I don't know how we would do it but that's an area which a lot of the physicians kind of point out, medical providers, which is a big concern.

CO-CHAIR KROL: Jim?

MEMBER CRALL: This -- I think I'm probably at the risk of sort of restating, but I mean, the whole business about repeat operating room episodes, et cetera. I mean, I think I'd broaden that a bit. Again, all the

things said about, you know, people seen in the emergency room, you know, the question is yes, fine, you know, they've gone in and gotten a mouth full of fillings and crowns and things of that nature. But the real thing that ought to be measured is then do they -- are they identified as high risk, do they get channeled into regular, you know, basic care and preventive services. And then what's the downstream sort of consequences of that. So, it's that same concept about if they -- just because they show up in an emergency room. I mean, the same thing applies within the dental world that if the kid gets to the operating room, I mean, way too often, I mean the literature is pretty replete. They don't show up for follow-up visits, you know, there's no sort of special program put in place other than, you know, the same message, come back in 6 months for your checkup kind of thing. So, I mean, that really I think does need to be a part of medicine -- or I mean the measurement

to really start to look at sort of that process of care around that issue.

CO-CHAIR GLASSMAN: So that applies to both emergency room and operating room. You're right.

And so I also wonder, to come back. Earlier we had talked about patient safety and maybe it comes in here. We're talking about sedation. Now we're moving into sedation anesthesia. We want to call for some measures based on outcomes or adverse outcomes based on complications of sedation anesthesia. I mean, there's complications for anything you do potentially, but these seem like in a different category so I wonder how the group feels about that.

MEMBER LIMBO: Yes, Paul. I just want to pick up too that more and more I know as a community setting we do general sedation in our clinic. And so you might not capture that because we're trying to keep the kids out of the hospital because of a negative impact

in terms of an association of going to the hospital plus the cost containment. So we do general anesthesia in our community setting as do a lot of the private dentists in the area, particularly for the Medi-Cal kids because they get a decent reimbursement for the service.

CO-CHAIR KROL: You mean sedation, not general anesthesia.

MEMBER LIMBO: Anesthesia, yes.

CO-CHAIR KROL: General anesthesia?

MEMBER LIMBO: Yes.

CO-CHAIR GLASSMAN: The anesthesiologists come to the office.

MEMBER LIMBO: Yes, yes. If you use a medical anesthesiologist you get a very high reimbursement. If you use a dental anesthesiologist then it's a lower reimbursement but it's a much easier access to be able to do that because of the fact that the hoops and jumps that have to go into doing

either a pre-hospitalization H&P and also the preauthorization. So yes, we do general anesthesia. Plus, oral sedation and nitrous. Those are other levels.

CO-CHAIR KROL: Jim and then Dick.

MEMBER CRALL: And I think, you know, (a) I think it's important to be trying to capture that, but (b) the measurement issues around it are the data sources. You know, I mean if that adverse event happens in a hospital setting or whatever it's going to get reported more than likely, you know, because there's an adverse, you know, an incident reporting system in place. But that doesn't really sort of exist I don't think in the general population.

And then, you know, you get into malpractice and then everything gets locked up and sealed. So I mean, that's why there's I think tremendous under-reporting about the extent to which this is happening.

MEMBER HASTREITER: We're seeing a

lot more GA and IV sedation than we did before, especially in California. And it looks like just on the face of it that it's being overutilized. And I think that there has to be an analysis of the risk associated with doing that versus not.

And it seems that a lot of dentists are starting to do this just for their own ease of treating the patient as opposed to a child really needs it or something of that nature. So that's a concern to us because there could be, obviously there could be untoward health outcomes associated with this. But the dentists, as I say especially out West do not seem to recognize that, or don't want to.

CO-CHAIR GLASSMAN: So I think we've identified that this area is something that's potentially important but potentially hard to get data.

MEMBER CRALL: But again from a concept and a development standpoint I think

that ought to be on our list of things somebody ought to be trying to work on.

CO-CHAIR GLASSMAN: Right. I think we're kind of over our time so we probably should --

MEMBER KALENDERIAN: So again, I think hard to get data. Maybe not if the dentists have electronic health records. I think if the dentists are on paper it is much, much harder. If they are not on paper then it might be easier to get data.

CO-CHAIR GLASSMAN: So I think we're running a little bit over our time. The last area within this group actually I think we've already talked about which is the annual dental utilization, you know, the one sort of measure everyone has is visits per year. So I think we've already talked about that.

So, any other missing concepts in this area that we didn't talk about?

MEMBER CRALL: There's one we really didn't discuss, and you know, we've

again sort of tossed it around a little bit at the DQA level which is, you know, some sort of measures of continuity of care, dental home. I think that's an area that, you know, there's a lot of work going on on the medical side now about --

CO-CHAIR KROL: The usual source of care is what's often used in the medical literature.

MEMBER CRALL: And there's patient-centered medical homes and, you know, there's quite a bit of work being done in that area. And again, it's all -- it's a general sort of, you know, looking at sort of patterns of care or whatever. But I think, you know, way beyond just did somebody get a service in a year, looking at sort of that profile of what kind of care they're getting.

MEMBER HASTREITER: We've done a number of studies on large population bases where we've looked at frequent attenders versus non-frequent attenders. And there's no

doubt that over a period, a prospective study over a period of say 6 to 7 years, those that are frequent attenders have much better oral health based upon surrogate measurements than those who are not frequent attenders. But we've also found out that the cost at the end of 6 or 7 years between the frequent and unfrequent is the same.

CO-CHAIR GLASSMAN: Anything else that's missing? Big concepts missing other than prevention which we'll get at next from this idea of care? Everybody ready for --

CO-CHAIR KROL: All right. So before we break for lunch I just want to make sure, is there anybody on the phone that wants to make any comments, add to the conversation? Please do.

(No response)

CO-CHAIR KROL: So any of our visitors with us that want to make a comment at all to the group? No?

(No response)

CO-CHAIR KROL: Okay, great. I think we're going to take a half hour break for lunch, so a little longer than we had planned because you're doing so well. That's your reward. And we're not going to work through lunch so just talk to each other, enjoy yourself, do whatever you need to do. We will come back though, I'm going to be very sticky on this, 10 after 1 we're going to start up again. Thanks, everyone.

(Whereupon, the foregoing matter went off the record at 12:42 p.m. and resumed at 1:14 p.m.)

CO-CHAIR KROL: All right, so we're going to get back into the swing of things. I think we're on priority area D if I'm not mistaken. So we'll get started there.

So again, thank you all for your attention. I know sometimes it's hard to get motivated after lunch. We'll try to keep you awake and away from the food coma. Paul?

CO-CHAIR GLASSMAN: I think it was

something you said. You might have mentioned the word "dessert" because half the table got up and walked away.

(Laughter)

CO-CHAIR KROL: They're getting coffee so they can last the afternoon.

CO-CHAIR GLASSMAN: Okay. So this next area is about oral health promotion, disease prevention, although many of the items under here really relate to the stuff we were just previously talking about. They just pulled them out of the way they were originally listed on the spreadsheet so forgive the sort of non-logic in terms of the way this all rolls out.

So, there's just a number of -- really they're just more utilization of services, only these are services for the most part related to preventive services. So there are things like sealants, fluoride varnishes, oral health education which we've talked about, prophylaxis. Those are sort of the

major prevention procedures that are listed here.

And so let me just ask the group about -- I think again we're going to call for people to develop measures around these concepts. Are there some specific things we want to say about them, some things that are missing in terms of the preventive services? We'll get back to in a few minutes the intra-oral films taken and restorations. I think those belong in the previous discussion. So for the moment let's focus on the preventive things that are here.

So other than calling for people to develop measures around these preventive concepts, any other thoughts about them?

MEMBER LEE: From a non-dentist, can you tell me why it would make sense to count numbers of sealants applied as opposed to children who receive sealants?

CO-CHAIR GLASSMAN: I can say something about it. Jim, do you want to?

MEMBER CRALL: I was just going to say I was going to sort of leave all of that, but maybe it shouldn't be assuming as to what it says, definitions and various parameters. I figured that a lot of those stripes were going to get tossed in, you know, whether or not simple counts or percentages or numbers around particular teeth or whatever. I would have assumed all that was sort of going to fall in there.

Yes I mean, I agree. From my standpoint just counting numbers of things that were done without having anything to relate it to to me was, you know, not the most meaningful of measures.

CO-CHAIR GLASSMAN: And I think these are -- people have done this in various ways. We saw in the big pile of stuff that there's a lot of different measures of sealants. Some people are measuring children who have sealants, you know, at the child level. Some people are measuring it at the

tooth level how many teeth had sealants, tooth per child, sort of various age groups.

So I guess what we'd be calling for in terms of a high-level concept is what do you mean by when you're measuring sealant, what's the thing you're measuring and how do you measure it, and then leave it up to people to use that to stratify it by various child teeth, age groups, ethnicity, all the other ways you could stratify the results of that.

MEMBER HASTREITER: One thing I just wanted to mention about sealants is that Delta Dental in Michigan and Delta Dental of Minnesota have done a number of studies on sealants. And we've used a number of different methodologies and we've done prospective studies that have probably gone on for 8-10 years. And we've looked at individual teeth and split mouth models and number of children and so on and so forth. And we look at sealants versus non-sealants in the population.

And what we found out in the end in terms of numbers of restorations in sealants versus non-sealant individuals or teeth is that it ends up that there's no difference. And the reason there's no difference is not because sealants don't work from a research and clinical standpoint, but it gets back -- and I hate to bring this up. What's happening is dentists and public health clinics are not doing risk assessment. So they're sealing a lot of teeth that do not need to be sealed. So the return on investment is very poor.

I got up and discussed this about 2 years at the National Oral Health conference and I was tarred and feathered and carried away. But you have to be very careful --

MEMBER HELGESON: I'm surprised you brought it up again actually after the roasting.

MEMBER HASTREITER: Do you remember that? Yes. You know, the feds said

well, we have all the studies and we know exactly what's going on. But you know, what could I say to them? I mean, we're looking at millions of people and they're probably looking at I don't know how many but not very many. So, sealants are really a problem because there's not risk assessment. And that happens both in private practice offices and in public health settings.

CO-CHAIR GLASSMAN: So, again, you're playing David and suggesting that we add risk assessment to this preventive category as something that people should develop measures.

MEMBER HASTREITER: Every one of them needs risk assessment.

MEMBER KALENDERIAN: A different comment not related to that. What I don't see in this is the ART. I'm not sure if it should be in there. And the other thing that I don't see in there at all is anything about nutrition, nutritional counseling, nutritional

habits which is a different focus on prevention.

CO-CHAIR GLASSMAN: Okay. Those are good to add. You have a puzzled look on your face, Andrew. Were you about to say something?

MEMBER SNYDER: I do. Maybe it will help to get the group sense on this. But there's not a whole lot of evidence to support that prophylaxis does much of anything, right?

CO-CHAIR GLASSMAN: I was about to say that.

MEMBER SNYDER: So maybe we should de-emphasize that.

CO-CHAIR GLASSMAN: Actually, what I was going to ask is do you want to -- because I think one of the things that we're maybe not doing as much as we've been asked to do is as we're talking about these various things to say which are the really important ones and which are the not so important ones. And I know within this area you talk about

sealants, fluoride varnishes, other kinds of fluoride treatments, prophylaxis. There's probably a degree of which we think are evidence-based. So do you want to try to stratify for NQF and HHS what are the important ones there?

MEMBER CRALL: I mean, I would say on Andy's comment certainly when you're talking about children, you know, both in terms of fluoride uptake and caries, you know, the prophylaxis piece. But you know, I mean. So I think the emphasis needs to be much more on the fluoride in that case. In fact, any measure that looked at just prophylaxis I wouldn't invest a whole lot of time in.

Sorry, I should say but adults could be a totally different sort of situation in terms of, you know, early periodontal disease and things of that nature. I'm just speaking particularly of the kids.

MEMBER HASTREITER: I certainly agree with Jim. And as with sealants, both

Delta Dental of Michigan under Steve Ecklund and we have done a number of studies looking at fluoride applications, prospective studies, probably about 8 or 9 years.

And we found that after a period of 8 or 9 years and you look at children who get fluoride and those who don't, that there's no difference in restorations over time. And you know why, I won't even tell you why.

MEMBER SMILEY: To that point. It's interesting, and I'll get you to that. At the recent evidence-based dentistry conference where I am one of the moderators I was talking about a program that I am involved with, the First Steps program where we train physicians on placing fluoride varnish in the zero to 3 population. And all the grand successes that we're having with that because it falls into the accepted evidence-based guidelines that are out there and all the grand successes that we're having.

And whereupon I was taken to task

by one of the presenters. Many of you know Philippe Hujoel who went off on the fact that he doesn't believe that the evolving evidence shows that zero to 3 fluoride is something that is taken up in the children's teeth and has any effect whatsoever.

I think when we take a look at measurement -- besides the fact that I left that conversation quite deflated on all my wonderful things that I've been doing in the world.

(Laughter)

MEMBER SMILEY: When we take a look at measurement, I think we have to take a look at at least what is considered to be accepted evidence-based guidelines that are out there. Agreed there's a lot of questions that you can have on your claims analysis about the efficacy of sealants and you know, it's the Wizard of Oz. You know, it's the man behind the curtain, I get it, but we have the evidence-based guidelines.

And if we're taking a look at measurement, and this is the best we have to hang our hat on today, then that's our measurement. As evidence evolves these measures are maintained and they will evolve.

MEMBER CRALL: You know, the same themes are just going around. It's the risk assessment and risk-based approach to that that is sort of the key to it. So I think in terms of measures development going forward, those two things go sort of hand in hand. I mean, when you're really looking at where do you want to concentrate your resources and get out of a one size fits all approach, I mean that's basically where they come together.

MEMBER HASTREITER: And I think there's another issue too, and that's research and publications that have been done in sealants and published in JADA and other dental peer-reviewed journals, and the real world experience. There's definite differences between those. And we would

expect that to occur. A controlled environment where sealants or fluorides are used is going to perhaps, and we found, lead to a different conclusion than real world experience.

CO-CHAIR GLASSMAN: So I think he question in that though is is it something that we want to recommend that there be measure development in this area. I'm getting the sense that the answer is yes even though in certain circumstances obviously putting a sealant on someone who doesn't need one is not going to reduce their caries level later on. But still, it seems like we ought to be calling for measure development in these areas. What I'm hearing is that probably the most important of the things in the preventive list is sealants in fluoride varnish which have the highest level of evidence followed by fluoride treatments and prophylaxis being the least important for kids maybe have some importance for adults. Is that -- and all of

that being based on risk assessment and risk-based procedures. Does that seem to capture what we've been saying? Okay.

So the rest of this little grouping here has some things we've already talked about. Restorations were just -- we already talked about list of procedures previously. The intraoral OPG films taken -- I don't remember what OPG stands for. Anybody know what that is? No, nobody knows. That's all right, we won't worry about it.

(Laughter)

CO-CHAIR GLASSMAN: Oh, that's right. Yes. That just I think goes under -- putting that in the list of procedures we've talked about previously.

And the only other thing I think here that's not been talked about is -- actually, recording of assessment of risk is here. The only thing we haven't talked about is this one I think came from the nursing home group, Mike, which is on the daily care needs

assessed. That's I think tied to the daily mouth care of --

MEMBER HELGESON: Whether or not a person is able to self -- brush their own teeth or -- physical or mental disabilities so that -- the caregiver can actually do that.

CO-CHAIR GLASSMAN: So do you think that needs to be called out separately from risk assessment and risk-based procedures? Or is that sort of subsumed within that?

MEMBER HELGESON: I'm not really sure. It is something that nurses are expected to do as part of their standard of care around oral health and oral infection control is to make this assessment. It's part of one of the activities of daily living, et cetera. And so for this subgroup, you know, people generally 85 and older who are dependent, to me this is really -- it's the most important prevention thing is whether or not this was assessed and whether or not

they're getting appropriate help on a daily basis.

MEMBER CRALL: Well, I was just going to add sort of the second piece, that you know, that the assessment might be important, are they even being assessed, but then I think that that's the issue I had. With the way that measure was originally worded, you know, that we got it, I thought well, you know, how do you relate that to actual process of care or expectation in terms of care. But I think, you know, with what Mike said, you know, I mean if there are requirements to do it and then if you capture the findings that differentiate those that need follow-up or not it would be important also to make sure they got the follow-up care.

MEMBER HELGESON: At the risk of saying in Minnesota again, our state nursing home regulations which implement really vague federal nursing home regulations, but in Minnesota the formulation of a daily oral care

plan, the assessment of the resident's ability and then a regimen, a written daily oral care plan must be part of the resident's care plan. So in Minnesota it's actually required that they carry it out. Whether they do or not, you know.

MEMBER CRALL: That's what I was going to -- what's the experience with what -- getting that done?

MEMBER HELGESON: It's not good, although I think it's improved over our 25 years. Twenty-five years ago this law didn't exist. This came into effect after the -- over '87. So in '92, '93 it went into effect.

Prior to that the nursing home surveyors didn't look at this at all and there were zero violation tags related to oral health problems among surveyors. So nursing homes really didn't care. They care now because they have been getting tagged and they get fined if they're, you know, if they don't comply. So it's not perfect by any stretch,

but at least it's a step in the right direction.

CO-CHAIR KROL: Diane and then Dick.

MEMBER LIMBO: I'd just like to expand the description in terms of limiting it to assessment of caries risks to say maybe this is where we expand it to assessment of oral disease risks. Because again, it would be much more comprehensive, it would address the issues we talked about in reviewing systems if you have someone whose behaviors are risky to subject them to a higher risk. They may not have a caries risk but they have other disease risks and to identify it as that and make it much more comprehensive. Risks that would impact their oral health. Pregnancy, substance abuse, history of domestic violence, trauma, smoking, tobacco use.

CO-CHAIR GLASSMAN: I'm not sure what category that goes in but we won't worry

about that. Get that on the list of something just to add as a concept which is a general risk for oral disease which might include some subsets for caries and periodontal disease, but with other risk factors that are not tied to a specific disease.

DR. DUGAN: Can I ask a question related to that since risk assessment keeps coming up? Is there a standardized risk assessment tool, questions, anything that we could refer people to? No? Okay. Part of the issue.

CO-CHAIR GLASSMAN: Yes.

DR. DUGAN: Okay.

CO-CHAIR GLASSMAN: Right. There are risk assessment tools in use. Previous groups have developed them. Some are further along in their development. There isn't a standard.

MEMBER HELGESON: Earlier the point was made though that the ADA has included some examples of risk assessment

tools in the CDT book which I think is meaningful.

CO-CHAIR GLASSMAN: So again, I think that falls in the category of some have been developed and some are being distributed, but there isn't the standard yet of this is the risk assessment tool for any disease including caries which is probably the most developed.

Okay, so the other thing that's left in this grouping here comes up on this page on oral health education received and on the next page, two additional items that haven't been talked about which is adding -- advising about tooth decay and diet counseling in the medical setting. Those were all education things which I think we talked about earlier and felt that in general we don't have much evidence that that does any good so it wouldn't be a top priority. We wouldn't be recommending that as a top priority. Anything more we want to say about educational

interventions?

MEMBER ACHARYA: Paul, just kind of talking about patient education and especially coming from the medical providers, I believe there are some literature out there. I don't have the actual paper in my mind, but I've kind of read through an increased behavioral changes and kind of in 4-year-old and 6-year-old kids when their pediatrician actually told them why is it important for them to go to a dentist. So there was an increased, you know, number of kids going and seeking dental care.

So, obviously it would go back on the level of evidence in terms of what's out there and that might be something that we might want to look at or the people who are developing. So, I would leave it up to the group in terms of, you know, looking at that.

CO-CHAIR GLASSMAN: Okay. Any other comments about this area?

MEMBER KALENDERIAN: To open a

Pandora's box which is about the intraoral films taken. Terry, you made a comment about overuse or underuse, overutilization, underutilization. I think that's an area definitely to try to measure that. Because I think there's certainly times that are underutilization, significant underutilization, and I would suspect that there's times that are significant overutilization. There are definitely guidelines out there. So I think that would be worthwhile trying to see how we can measure that.

CO-CHAIR GLASSMAN: So we had previously a list of services. You know, there was a whole list of different kinds of services. Are you suggesting adding that to the list?

MEMBER KALENDERIAN: Yes.

CO-CHAIR GLASSMAN: Right. Although I would just comment, I think that the guidelines out there are pretty vague.

MEMBER KALENDERIAN: I would agree and I think that's why there's potential. But even if you make them vague and you have a gray area, I think there's still a lot of patients who they should have gotten X-rays, they didn't and therefore there's caries and periodontal disease that is not being treated, and then there are some aggressive revenue enhancement.

CO-CHAIR GLASSMAN: We just did a study at our school where we took a set of cases, basically just slides of people described their health condition, showed pictures of their mouth and asked the group of our faculty and students what X-rays would you take. And their agreement was worse than our agreement on these measures that we try to do, so.

(Laughter)

MEMBER HASTREITER: I was just going to mention that we've looked at these radiography and dentistry for a long time

looking at millions of people. And although I believe in some cases there is an underutilization of radiographs, the overutilization of radiographs in dentistry is shocking. It's -- I don't know why people don't glow in the dark from dental radiographs quite frankly. I mean, there's no doubt in my mind that in many cases either dentists graduated from dental school and were told to take radiographs every 6 months come hell or high water, or they use it as a revenue enhancement vehicle.

And whatever is occurring -- my daughter's a radiologist. And I mean, she just can't believe these radiography in dentistry. I mean, she just thinks it's abuse and an overuse.

CO-CHAIR GLASSMAN: So, yes. So I think what I'm hearing is agreement this is an important issue. The question is whether it's feasible in terms of can you actually come up with -- if you measure, what are you measuring

against. Are there really criteria that could be developed. So.

MEMBER KALENDERIAN: Right. Like I said, it was a Pandora's box.

CO-CHAIR GLASSMAN: Yes.

MEMBER KALENDERIAN: I'll close it again.

CO-CHAIR GLASSMAN: Right. I think that's the end of area D unless there's anybody else who wants to add anything to area D.

We'll move right into area E then which really only has one new thing in it which is -- oh, it's got a couple on the next page. So, on page 5 the only new thing there is the fluoridation of the water supply. Or either the water supply or use of fluoridated water. So, I don't know if there's any comments about that as developing measures around that. Right now there are lots of people who are measuring that, it's assessed in a lot of different ways and we get all

kinds of charts, but there really aren't standardized measures, at least not at the NQF endorsement level, so.

CO-CHAIR KROL: Although the use of fluoridated water is an issue. You know, so as a pediatrician I can say is your water fluoridated but I can't necessarily -- I don't necessarily get into the detail. Okay, where do you get -- for this child, where do they drink most of their water. Are they spending their days at their grandmother's house that doesn't have fluoridated water? Is the water at school fluoridated? You know, where are they getting their intake of water. So, that's -- I think that's a different question is -- other than is your water fluoridated which is what a lot of the information is.

MEMBER CRALL: Well, I was just going to say, I mean, CDC tracks this and I basically look at this as a public health sort of measure in terms of the extent of water fluoridation. I don't see it falling all that

much into performance measurement within the context that I understood. I thought it was just maybe a little bit of field.

MEMBER KALENDERIAN: The way I understand the question is not is your water fluoridated, are you drinking it. That there's a lot of kids and a lot of adults who are drinking bottled water and are not getting that at all.

MEMBER CRALL: Yes, well if that's the case then I go back to David's point. How are you going to measure that?

CO-CHAIR GLASSMAN: Right.

MEMBER KALENDERIAN: Right.

CO-CHAIR GLASSMAN: Which would be, again, it would be the use of fluoridated water, not whether it's in the water.

MEMBER KALENDERIAN: Correct.

CO-CHAIR GLASSMAN: What's the use of it, but then you're raising the question is that actually feasible to measure.

MEMBER KALENDERIAN: Right, it's

much more difficult.

MEMBER SNYDER: I guess I do have one thing on my mind. I didn't really raise my hand. But -- I must have had a puzzled look on my face again.

The one place that I think you might use it for kind of either performance measurement or sort of program management would be studies like the one that Texas did that tried to correlate Medicaid spending with whether or not the counties of the kids' residence were fluoridated or non-fluoridated. But again, that's a little distal from where we are today.

CO-CHAIR KROL: Mary Alice.

MEMBER LEE: I just was thinking as a quality measure for dental practice you would want to know whether the provider has assessed whether the water's fluoridated or not and that that's what the child's drinking. Not whether the town is fluoridated or --

CO-CHAIR KROL: Assessed whether

the water is fluoridated or whether the water that the child's drinking is fluoridated, is that what you're saying?

MEMBER LEE: Right. And so for me it's like the same as advising about tooth decay. If you're going to do a chart review and find out whether somebody conducted a risk assessment part of it is asking about fluoridated water. Not whether the water is fluoridated or not, but asking about whether --

CO-CHAIR KROL: And all sources of fluoride, I suppose.

MEMBER SMILEY: Now, recognize I do have a bias and that I come from Grand Rapids, Michigan which is the birthplace of water fluoridation, so.

(Laughter)

MEMBER SMILEY: One of the thoughts here too is that the very notion of measuring is to cause motivation. And we do see -- I mean, the effects of community water

fluoridation from an oral health standpoint is considered one of the greatest public health measures that we've done. And by measuring it I see in this political time where we're seeing communities recede from community water fluoridation I think us measuring this makes a statement that we feel that it is important to stay the course on this, especially if we're looking at having our return on investment here, the return on investment for that compared to the adverse outcomes is great, at least the evidence makes us think it is. So I think we should continue to navigate for measurement.

MEMBER CRALL: Well, I'd just say -- I mean, I'm from apple pie too, but I mean from my standpoint where it comes down, it's the original comment I made about, you know, are we talking about safety net context, the Medicaid context, the public health? Are we going to, you know, is part of this project to identify what are really public health

measures? Because I don't know, I mean who, other than CDC determining what communities have water fluoridation that -- I don't think they're going to quit that. So, how does that fit within this measurement context?

And I totally agree with everything that's been said about the positive effects of water fluoridation. I just didn't think it was a very good fit for what this task was as I understood it.

CO-CHAIR GLASSMAN: What I'm hearing is that if you take it down to the level of --

MEMBER CRALL: Risk assessment.

CO-CHAIR GLASSMAN: -- of the use of fluoridated water, the use of fluoridated water could fit into what we're doing so that it could be considered important. But I'm also hearing and thinking myself it's unfeasible because I don't know where the data would come from. I don't think we have data sources now that you could look at.

CO-CHAIR KROL: Dick?

MEMBER HASTREITER: Who could be against water fluoridation? Nobody.

(Laughter)

CO-CHAIR GLASSMAN: Right.

MEMBER HASTREITER: Anybody that has a reasonable mind.

But there's another side of this issue that doesn't have necessarily to do with public water fluoridation. It's naturally occurring fluoride. And there are parts of this country that have very high levels of naturally occurring fluoride.

When I was a state dental director in Minnesota we had some children referred to us that were in the Duluth area on private well water. There just happened to be an old public health service dentist at the University of Minnesota. Nobody could figure out what was wrong with these kids. Their teeth were brown and black and so on and so forth.

And so we did an epidemiologic investigation of that whole subdivision and found that the water, the naturally occurring fluoride in the water was about 4 parts per million. In addition, although the health department had been promulgating the need to test the water supply these dentists were giving these children dietary fluoride supplements on top of it. Because it was well water.

And I had a little bit of difficulty convincing the Minnesota Dental Association that they needed to test the drinking water, but after this happened I never heard a word again. So you know, there's places like little towns in Minnesota that even the well water supplies are naturally fluoridated. Elm Grove is one of those places.

So, all I have to say is I think there's an importance to testing the water supply of wells. The importance is greater in

some areas of the country than in others, but I personally didn't think it would be necessary in Minnesota but it definitely is.

CO-CHAIR GLASSMAN: Okay. Any other thoughts about this area? The only other thing that's left in this group -- we've talked about abnormal mouth tissues -- is the one about tobacco use, screening education.

So we have talked about that before, we talked about it in the context of soft tissue lesions and we talked about it in the context of overall risk assessments, looking at various factors that could lead to various kinds of dental disease.

MEMBER HESSEL: Paul, there is a tremendous amount of evidence that says that the potential to quit smoking is 60 percent higher if a health care provider mentions that they think they should quit. So even if they aren't going to do, you know, offer tobacco cessation therapy, just asking the question "Do you smoke?" and if they say yes, "Are you

interested in quitting? How can I help you?" Just, you know, "It would be good for your health." Just asking will improve -- it should be a measure.

CO-CHAIR GLASSMAN: Okay. So you're advocating for that one as listing it, right?

MEMBER HESSEL: The more people that say it the better.

CO-CHAIR GLASSMAN: Okay, good.

MEMBER HASTREITER: I really think that's important. A few years ago Bob Mecklenburg and I did a study with dentists, dental hygienists and dental assistants in Minnesota to see who they were counseling about tobacco, what they were saying, what they were doing and so forth. And we found out that hardly any dental professionals were doing anything in that regard. And as you know, smoking is one of the primary etiological causes of periodontal disease.

Once I was going to buy a house

and I went to the bank. And there was a woman sitting across from me. She says, "I see you're a dentist." She said, "Well, you know, I've had two periodontal surgeries, major periodontal surgeries," and you could see it.

And I said to her, "How many packs of cigarettes do you smoke a day?" She said, "Oh, two or three." And I said, "You're never going to be successful. Hasn't any periodontist or any dentist ever told you about the relationship between cigarette smoking and periodontal disease?" She says, "No, I didn't know this at all." So I mean, that's the level of knowledge that's existing in the community because dentists are not providing the message that staying away from tobacco is just as important as staying away from refined carbohydrates.

MEMBER RUSSELL: I'd like to consider another aspect that maybe has not been listed here and that's blood pressure monitoring and dentistry. I know many

community health centers do routine blood pressure monitoring before administering any kind of local anesthetic or procedure on a patient. It's not necessarily wide scale at this point but it's definitely being done. But we found in our own state efforts to educate dentist, even giving them free blood pressure cuffs and automatic systems that they are reluctant to use them.

In addition to the fact that they don't talk much about cessation of tobacco even though we have a quit line program and all sorts of resources available to them. So I think in one sense we're going to have to probably emphasize the importance of the connection between blood pressures and adverse safety outcomes from treatment that can actually be heightened if that person's blood pressure is out of control.

I might even want to mention one other step that has not been considered and certainly is not in practice today. It's that

dentists should be a part of assessing diabetes or the potential of diabetes among patients who come into their practices that are adults. And there are multiple reasons why. Because it's a fact they have abnormal periodontal tissue response, they can exacerbate other conditions of the mouth. Having knowledge of that person's A1c or other level might be very effective in helping that dentist formulate a treatment regimen that is multidisciplinary that may be able to bring that patient into compliance. So, I think there are pieces here that we're not looking at.

MEMBER ACHARYA: Just to kind of touch base on what Bob was mentioning, that a lot of these criteria are measures within the meaningful use side of things. Although they don't mention for dentistry, but if you look at eligible providers, dentists are also one of those. But there are several other challenges which I'm not going to get into

because of the Medicaid and the Medicare not taking dental patients. But if you look at some of the measures there are I believe some NQF measures as well that rate high tobacco usage within that.

And all these -- there are also more granularity in terms of collecting the data in a structured way within the EHR. So that might be a good place for us to kind of take a look at.

MEMBER KALENDERIAN: And just to follow up on that. There's now -- there's one commercial vendor, dental vendor, EHR vendor who is fully certified. I know your EHR is fully certified. So there's at least two EHRs who have six meaningful use quality measures implemented. So, I think we probably want to look at those because my gut feeling is they are the same. I know for sure the blood pressure is one of them. Pneumococcal vaccine for patients over 65 is another one. So we probably want to piggyback on those so that

we're really in synch with those which I think are really important measures.

MEMBER ACHARYA: Just to add to that, Elsbeth. At Marshfield Clinic we have an integrated medical/dental record and you know, we went for the certification in meaningful use. Your system has to be certified and the way we kind of handled it was making dental module as a part of the medical EHR and then certifying it as a module.

So, a lot of these measures are kind of across whether you're a dentist or a physician. You know, reporting the rate, and you know, tobacco usage and a bunch of other things that are there, it -- we are covering it for the dentists as well. So that might be a good area to look at.

CO-CHAIR GLASSMAN: I'm just wondering about how to categorize this. So we have a couple of things we've just been talking about that would be under the general

listing of risk for oral diseases. So tobacco is clearly one although it has impacts beyond oral diseases, but it does have a risk for oral diseases. And you listed I think some others, pregnancy, a whole list of other things that would be risk assessment for oral diseases.

I think the things we're now talking about in the last couple of minutes have been risk assessment or screening for general health conditions. In other words, to what extent are dentists doing risk assessment or screening for conditions like high blood pressure or measuring blood glucose. I could come up with a whole list of potential things that people could measure to what extent dentists are doing them. Some of them there would be no point in it because we know no dentists are doing them, but some things, I think for instance blood pressure monitoring has been promulgated for a long time. Dentists have been told in dental school that

they should be doing that. It's a reasonable measure to see what people are doing.

MEMBER KALENDERIAN: Yes, so I call that where the role as the dentist is the public health ambassador. And I think where -- it's really where the dentist and the medical doctor work together and really are in this collaboration and cooperative relationship. Which again I think that's part of what we're trying to do here. So I think it's to say well, the dentists are never going to do that, I think we need to say the dentist is going to do that and this is one, you know, way hopefully that we can nudge towards that.

MEMBER RUSSELL: Also -- I'm sorry. I was just thinking that the fact that dentists don't do it doesn't mean we shouldn't measure it. At the same time, how do we get them to start doing it if we don't have a benchmark in order to compare if there's an improvement?

But the other issue is I disagree

with the fact that this has no direct effect on oral health. I think the fact that diabetes has a direct effect on oral health. The fact is that blood pressure monitoring has a direct effect on quality outcomes in dentistry. In other words, doing procedures in a situation that's unsafe for that patient puts them at risk. So I tend to disagree that this is not overlapping.

MEMBER HESSEL: I was just going to say this is probably one of the few areas where you might actually be able to find some really good evidence because wound healing is impaired by all of those diseases. I mean, the plastic surgeons won't operate on you if your BMI is greater than whatever. And so it would make sense that if you were offering an elective restorative dental procedure that you would have to do -- notify those patients of their wound healing problems that might occur if they're still smoking or if their blood pressure is out of control. So I mean, I

totally agree with you, Bob. I think this is one of the areas that you will be supported by CMS because these are already measurements that they're measuring at the medical level.

CO-CHAIR GLASSMAN: So maybe we just change the characterization. The bucket would be maybe risk. These are all things that would affect risk for oral disease or impact oral disease treatment.

MEMBER ACHARYA: I just wanted to reiterate what Amy just mentioned. Hypertension, there are literature out there that kind of connects it to periodontal disease. And that we should definitely look at them.

CO-CHAIR GLASSMAN: Okay. So, anything else in the last category we're talking about? I mean, the title of it is "Oral Health Interventions," but some of the things more or less fall into that general description.

So, the next one which -- and

Donna, I don't know if you want to say a little bit about this. The one, number H which is disparities. We've been asked to think about --

CO-CHAIR KROL: No, G. Priority area G.

DR. DUGAN: G which is --

CO-CHAIR GLASSMAN: Well, I skipped it because there's -- everything in there is a repeat from some other area.

DR. DUGAN: Well, we should just ask the question whether or not there's anything we haven't talked about that should -- that belongs here.

CO-CHAIR GLASSMAN: Okay.

DR. DUGAN: So.

CO-CHAIR KROL: Amit?

MEMBER ACHARYA: Just one thing that I wanted to highlight there was kind of continuation from our topic about what are the things that we want to measure. One thing dentists have not done before and I don't know

whether they would really do it or not, but we see a lot of kids walk into our dental clinics and you know, we use -- most of our physicians have access to a system called RECIN which is an immunization registry where all of our medical centers and now we are also trying to target the dental centers where it's an added opportunity to kind of see whether the kids are immunized or not. Have they kind of you know -- are they meeting with some of the immunization or not. Maybe it's not even kids.

They are kind of people who are making the first point of contact to any health care centers coming into a dental center. And you know, maybe just trying to kind of ask that question as to are you immunized and some way of figuring that out. That has to come from that interdisciplinary team and I strongly feel dentists are part of it.

CO-CHAIR GLASSMAN: Okay, we can

add that.

MEMBER HASTREITER: This is for Bob Russell's sake. I think it's extremely important for the public health infrastructure in the state to include some type of a dental health organization with a dental director who can serve as the coordinating focus, especially for disadvantaged adults and children to work with the health commissioner and the legislature and the bureaucrats to really focus whatever resources are available on treating individuals in need. Now, in states that have that there's much more success than there is in states that do not have a dental health program. So in terms of oral health infrastructure or public health infrastructure I think that's a very definite need. Do you agree, Bob? Okay.

MEMBER RUSSELL: Yes.

MEMBER SNYDER: Mine was just really housekeeping. Just I know that F, priority area F doesn't show up in the high-

level thing but I just wanted to make sure that we had talked about -- that's cleft lip and palate. And we had kind of talked about that earlier in the day and said we might get back to it. So I just wanted to make sure we didn't drop it if there was something, if there was anything else anybody had to say about it.

DR. DUGAN: We'll get to that in a second. I'm not sure G, we fully finished with G. But yes, we will touch on the F piece.

MEMBER LEE: I just had a question about provider network. Again, that presumes that people are covered by a particular plan or insurance company the way it's phrased, "Provider network." I wonder if what we are talking about really is measuring licensed dentists in the state and then the subset of those that are taking new patients or have appointment slots available or that kind of thing. And whether that ought to be fleshed

out a bit.

CO-CHAIR GLASSMAN: So, do you want to -- because, you know, the -- I guess it's line 85 sort of lumps stuff together talking about the provider availability contribution of the safety net, is there an adequacy of the network. The number of dentists, characteristics, training. A lot of sub-points could come under there. Do you want to call out any specific ones?

MEMBER LEE: Do I want to call out?

CO-CHAIR GLASSMAN: Do you want -- in other words, I'm asking the group do we want to add, other than listing it as a summary like that do we want to identify some specific measures of the adequacy, provider availability, adequacy of the workforce. Do we want to list some specific measures for development, specific areas?

MEMBER LEE: A couple of things came to my mind. One I was looking at, the

safety net should be not just FQHCs but also community clinics and school-based dental centers, dental clinics. So I think you can get much more specific. And then provider network to me implies an insurance plan or a managed care program or something like that that really doesn't get at the number of providers that are available to serve the population and whether they're willing to serve the population.

MEMBER CRALL: But Paul, I think you're saying that the STEM up there, provider availability, includes things like number of dentists and location of dentists.

CO-CHAIR GLASSMAN: Right.

MEMBER CRALL: Ratio to the population.

CO-CHAIR GLASSMAN: What I'm saying is we could say we're calling for measures of provider availability or adequacy of the workforce to address the needs. That would be sort of one way to say it. The other

way to say it is we want that -- what that means and we can list some things under that. So I'm asking do we want to list --

MEMBER CRALL: Somewhere I think that, you know, needs, you know, in some draft we'll look and see what level of detail sort of that gets to be, you know, whether it's numbers of individuals, whether they're accepting new patients. I mean, all of those kind of things could be laid out.

CO-CHAIR GLASSMAN: So what I listed here were some examples that were in the big thing. There were some measures of contribution to the safety net, or some measures of adequacy of the network that use the word "network."

MEMBER LEE: I think maybe my problem is with the word "network."

CO-CHAIR GLASSMAN: Yes. I just pulled that phrase in from the figure.

CO-CHAIR KROL: Dick and then Michael.

MEMBER HASTREITER: Well, miracle of miracles. In the states that I'm licensed there are surveys that go along with the renewal of your dental licensure that ask those very questions. Now, I don't think that all states do it but there are a lot of states that do survey dentists in terms of issues like access and so on and so forth. So I think that you could actually survey boards of dentistry to see how many do this and see if there are differences by region, by state and so forth. Now, I really don't know how many states do this but I know the data does exist.

CO-CHAIR KROL: Michael?

MEMBER HELGESON: Yes, I just wanted to emphasize the availability of the dentist is really critical. Because you can -- it can be very misleading if you just look at the ratio of dentists to population.

And also, if you don't consider sub-populations. For example, geriatric or special need patients. You may have, for

example, Medicaid providers that are seeing children but they may not be accepting adults or persons with disabilities. So, I don't know if there's a way to capture that it's really the availability of a real appointment that's an issue, not some sort of magic ratio of dentists to population or something like that.

CO-CHAIR KROL: Bob. Did you have a comment, Bob? And then Jim and then Diane. Oh, Diane first on this point.

MEMBER LIMBO: I was going to ask the question. You actually addressed it also, Mike. It's not only a question of knowing how many dentists there are but who they are serving in terms of the populations. If they're only serving within a network of an insurance group you may have -- and the biggest challenge we have is how many endodontists are available. There's lots of them but they're all in networks. They're not available to uninsured individuals in our

county, very, very few even within the community clinics because they're specialists. So that's a limited resource that I think need so be addressed.

And then how many, again, specialists. I don't even know how many periodontists we have versus endodontists versus pediatric dentists. So those subspecialties and what are the needs for them. And again, not within, as was mentioned, a network, but again for people that are not connected to.

MEMBER CRALL: Well, I was going to say -- I mean, the feds have tried or at least started to try to get at this through Insure Kids Now. And you know, that's got its own set of issues. So, but I think you know, that building upon that and trying to refine that process might be one mechanism at least for the pediatric population. And you know, it's just a question of how broadly do you want to expand that.

And to the point about the different kinds of providers, most of the time in the reports I've seen pediatric dentists aren't listed as a provider type. So, I think, you know, in terms of in the Medicaid world where that's the bulk of the current covered population at least getting people to sort of break that out would be useful. And you know, whether it makes a difference or not, the results will tell.

MEMBER RUSSELL: One framework we could start with, and I know this is still under remodeling, is the health profession shortage designation criteria that HRSA uses. It does get at a lot more detail as far as the populations that are -- and the ratios of providers available to the population. It also breaks down the actual FTE availability of that provider depending on the number of assistants, allied professionals, so forth. And it looks at the populations from the perspective of the insurance level or

insurability and those are not. And it really changes the entire ratio effect of some counties can be population-based, some can be Medicaid shortages or low-income.

It's a framework that certainly needs to be further fleshed out, I understand that, but it certainly is a lot better than a simple count of the number of dentists in a given state and the number of people in a given state.

MEMBER BATLINER: Yes, I was just kind of going along with what Bob said. I think we ought to just encourage people to take as broad and all-encompassing approach to looking at the number of dentists and accessibility to those dentists as possible. Because clearly in places I work, you know, the dentists may be accessible in the summer but they're not accessible in the winter, and you may have to drive an hour to get to them in the summer. So, weather is a factor, distance is a factor, all those things need to

be considered when looking at this. And when you talk about subspecialists, I mean a lot of places I work you're just hoping for somebody who can hold a drill and fill a tooth.

MEMBER HASTREITER: Just a couple of things. Just because a dentist or a specialist is in an insurance network does not mean that they cannot provide specialty services to Medicaid, SCHIP and so forth. They just won't do it.

What Minnesota Delta Dental has done is develop a case management system so that if say a person needs an endodontist and none of them want to indicate that they're in the Medicaid network they can find endodontists for that individual. So, one way of getting around all this trouble is having a good case management system.

CO-CHAIR GLASSMAN: So, I'm sort of trying to organize this into what I'm hearing is the whole issue about provider availability or adequacy of the workforce, I

heard three sort of concepts. One is what providers exist and where are they and how they're organized. That's sort of a numbers game, and are they in safety nets and networks. The second one is how accessible are they by various ways of looking at that. Only in the summer or geographically, or other things.

And the third one is who are they serving which would have to do with special populations and both in terms of medical conditions, disabilities, insurance coverage, not insurance coverage. So, who they are, how accessible they are and who are they serving would be the three main concepts.

All right, anything else on that area? And then I also heard a call for a separate measure which was about the public health infrastructure, so measurement about the dental director and other kinds of public health infrastructures in the state.

Okay, so now are we ready for the

disparities discussion?

DR. DUGAN: Actually, one before that. So F we did take out and it was monitoring and surveillance systems, because it was about increasing states who did X, Y and Z. So we didn't think it was appropriate for the discussion. But one piece of that is the cleft lips and cleft palates content area. So maybe this is just a good time to just touch on that if you think that's generally an important area to measure. If anyone has any comments about measurement of cleft lips and cleft palates.

MEMBER HESSEL: I don't treat this disease, but I think the key thing is the multidisciplinary care. And I don't know how to make that into a measurement, but if you can measure that everybody has the multidisciplinary group ENT, you know, dental and plastic surgery, if they have that then probably you're going to be hitting all the measures because you've got the whole team

involved.

MEMBER CRALL: I mean, Renee or somebody may know, but there used to be I think a Healthy People measure that looked at that and if not I'm pretty sure that Wendy Mouradian and some other folks were -- might have been conducting some study. So I think you could find somebody that could lay a little definition and specification to that. That is definitely one sort of quality I think or performance sort of criteria that would be measurable.

CO-CHAIR KROL: Yes, definitely referral too although more often than not the pediatrician is going to see those kids right when they're in the newborn nursery and send them off to whatever team is available. But it's possible that they'll --

MEMBER CRALL: Probably so, but I remember back from Connecticut days there was, despite a very sincere effort in a small state to identify every birth and to get somebody

from a cranial-facial team there to do it there were still fair numbers of kids who just happened to get hooked up with some surgeon and they weren't getting the multidisciplinary piece at all.

CO-CHAIR GLASSMAN: So we did have a recommendation earlier on in the day about having some kind of category related to developmental anomalies, and maybe what we're saying here, we can bring that back together with this which is for developmental anomalies -- cleft lip being an example of that -- call for measures based on both the assessment and also the treatment services available. That's pretty general but that would be the kind of thing we'd ask for people to develop measures around.

MEMBER CRALL: Well, I think, you know, I generally agree with that but by the same token I think the cleft one and the team approach to that is I mean, very much sort of a systemized, you know, sort of process of

care that is much more than, you know, congenitally missing teeth or things of that nature. I think it's definitely its own.

MEMBER HESSEL: And I think there's probably pretty good documentation that says that the kids that get, you know, a whole team involved do better. And that's ultimately what you want to do is show that by doing this it's better. So you know, what they have done is very variable so you don't want to measure the individual components of that, but as long as the team is together they probably --

CO-CHAIR KROL: That's actually probably one of the few places where there's actually really good evidence on interprofessional teams and the value of them. That's the example that often comes up.

CO-CHAIR GLASSMAN: Okay. Now we're ready for H. Okay.

DR. DUGAN: So, a little bit of background here. So this is the priority area

for eliminating oral health disparities and improving equity. Initially we didn't find necessarily any specific measures for reducing disparities per se, so what we had done and as you saw in the workbook was we included all of the measures that were currently in use for special populations, such as geriatrics, HIV in use in Medicaid or CHIPRA and that's what we put in that category.

But thinking about this a little further and talking with folks from HHS, that's not necessarily what they wanted to see. We really want to talk about are there any measures -- thinking out of the box are there any measures here that target specifically the elimination of health disparities and improving health equity. One way to look at this is something we've talked about throughout the day which is stratification of the measures you've already talked about by specific factors like race, SES, gender. So we can talk a little bit more

about that to make sure we've caught all the factors or risk stratifications.

One other thing that came up was measures of acculturation. So the research shows that maybe it's not one or two factors, but multiple factors that may be involved related to disparities for oral health care. So that's one other thought.

And then the second piece is related to how we categorized all the measures for special populations the question is related to vulnerable populations such as patients in nursing homes, those with developmental disabilities, HIV, wounded veterans, underinsured, underserved and high-risk are there any specific measures we've talked about today that would be most appropriate for those vulnerable populations other than others? You know, so if we're trying to reduce disparities are there things we should focus on for some of those special populations that may not be as important as

others? So, just a few pieces of information to throw out there.

CO-CHAIR GLASSMAN: So, maybe we could start with the question of when you're trying to get at the issue of disparities are there specific measures of disparities that are different than measuring all the things we've talked about and then just stratifying them by how do those measures come out in populations at different ages, different socioeconomic classes, different ethnicities. That's stratification of the existing measures, but is there something else that could be a more direct measure of disparities.

MEMBER HELGESON: I don't know if this is an answer to the question that you just posed, Paul, but especially for vulnerable populations that are in care-giving systems. There are regulatory environments around group homes, around assisted living, around skilled nursing, et cetera. And there's wide variation from state to state in

terms of the degree to which things like we talked about earlier, having oral health assessments at admission, having care planning around oral health issues and having accountable systems for triaging and care coordinating dental events when dental problems arise.

So I'm not exactly sure where this goes but the regulatory environment around the places where vulnerable people receive their other health and social services to put in place practices and policies that enable them to access the system. Because these are not people who get up and say hey, you know, I feel like getting a checkup and I've got the money and I've got the keys and I'm going to go get a checkup because I think it's important.

You know, these are people that are living in settings where unless the caregivers and the guardians and so on in those settings have practical systems to get

oral health care, whether it's daily help with daily care or whether it's professional care they're not going to get it. So I'm not sure if there's a way to talk about the regulatory environment.

CO-CHAIR GLASSMAN: Well, maybe what you're suggesting is just that we call for measures within care-giving systems to measure whether there are accountable systems to recognize and address oral health issues.

MEMBER HELGESON: There you go. Thank you, Paul.

CO-CHAIR GLASSMAN: Anything else anybody can think of?

MEMBER RUSSELL: This is a complicated area. As I think about it, what we're talking about is whether or not we have a system that's distributed in such a way that people across these determinants have access to care. And that brings up a huge boatload of well, shall we say, even the current new innovative programs of expanding dental

workforce and educating other workforce or trying to get them into areas like rural niches, and areas where they traditionally don't exist and where people don't necessarily travel to get care elsewhere. That's one thing.

Then there's the economic piece. That is, how do we get care such that it's less expensive to people who can pay less. So, I think this really dovetails out of an entire new area where right now the states are wrestling with it, there's no doubt. We have a variety of state approaches to how this can be addressed, Minnesota being one of the stars in this area.

(Laughter)

MEMBER RUSSELL: And if for no other reason, maybe it's just a matter of monitoring those new innovative systems that try to address these issues. I mean, we don't have a cookbook how to do it. We certainly don't have a method yet that's happening

that's necessarily proven. But we have new measures and new things out there that are subject to be shall we say determined to be effective. So maybe that's a category under here we might want to include. If nothing else, a monitoring system to say what are the new innovative programs, how effective are they over a longitudinal period.

MEMBER CRALL: Well, I -- I mean, I sort of think about that in a general sense, that that's what the rest of what we're trying to come up with is supposed to be used for. Because you have proponents of X, Y and Z, and the question is what's the evidence that it makes a difference. And so if you're talking about disparities, I mean I guess it's sort of figuring out what's the unit of action or the unit of analysis and then I mean, is it enough to just say, you know, does state X have a plan to reduce oral health disparities, or does county X, or does plan X, or does whatever.

You know, but again to me what we've been doing up to now is to try to figure out sort of if you had things that you could measure to figure out whether X, Y or Z made a difference, that that's sort of the role of measurement. The rest of it's complexity -- either chaos theory or complexity theory, I'm not sure which one. But you know, but I think we're about the measurement piece and I was sort of thinking, you know, what is there. You know, we have the sort of classical or typical things we've talked about that have been dissected out from a health status standpoint, from a utilization of service standpoint.

You know, if we relate all those things back to the cost of services and all that, we have sort of that general framework. So, my initial reaction was make sure we identify sort of the important stratification factors, that strategy that you pointed out, and look at the special groups including

things like kids in foster care or whatever to, you know, where you have a system that's supposedly in place.

Going beyond that into the big Pandora's box, I don't know if that's within the realm of this project or not.

CO-CHAIR GLASSMAN: Well, so we're kind of generally talking about assessment of systems so I think I saw some, you know, good nodding which could have been people falling asleep, but nodding when we talked about --

(Laughter)

CO-CHAIR GLASSMAN: -- about systems related to care-giving systems or care-giving facilities. There seemed to be agreement that would be something you could measure. Now what you're asking is can you actually measure it at a level above that which is what Bob's suggesting or are we really just talking about a roll-up of a lot of the other individual measures to see how the systems are working. I don't know the

answer to that.

MEMBER CRALL: Yes, because you know, Dick's talked about a case management approach and Bob's got a, you know, an infrastructure approach that they're using in Iowa and whatever. And I would hope that everything that we've talked about up to now would sort of help identify things that people could get their hands on in terms of data and actually look to see, you know, to what extent those were working and what extent it improved disparities over time. But the measurement of whether that happened or not would be taking the general set of measures we talked about and then identifying what you thought were the important groups where the disparities existed in looking to see if the intervention made any difference. I mean, that's the way I think about it.

MEMBER RUSSELL: Generally I agree. I mean, I'm not framing this in any specific way but I think I agree with Jim that

we really just want to know of those innovations that are coming out whether or not over time they are effective. And I think we should be monitoring that type of activity on an ongoing basis. Doesn't mean that we're a proponent of anything, it just simply means that we are very much interested in what works. And we know that this area here is a vacuum and it has to be filled at some point. And then we can be on top of it.

CO-CHAIR GLASSMAN: I know one of the things that on this other quality panel I'm serving on for AHRQ with the CHIPRA measures, one of the things that has been suggested there is that when they're developing measures for that process that any measures developed that the data collection include the -- getting enough data about the populations that are being measured so you could be able to make determinations about age and socioeconomic status and ethnicity. So you don't just measure caries and say gee, we

don't know what the ethnic makeup was of the group we just measured, you make sure you do that every time you do a measure so you can get at some of those answers.

MEMBER HASTREITER: Just a little word of caution. Disparities aren't always what they seem to be. Back before protease inhibitors were really being used we did a study in Minnesota looking at the utilization of services among HIV-infected persons versus the Medicaid population and SCHIP and the commercially insured population. Now we adjusted for everything so I'm not going to go through that.

But what we found out was that the HIV-infected persons who were income-eligible for Ryan White Healthcare Act money had utilization of services that was very similar to the commercially insured population. However, the Medicaid population utilization of services was much different and much lower. So, just because somebody's HIV-infected

doesn't necessarily mean they're in some disparity group. That's all I have to say.

MEMBER HELGESON: Yes, I wanted to talk about the concept of equity and just highlight that in oral health, and of course I'm the geriatric guy so maybe what I'm about to say is expected. But the biggest inequity is the age discrimination in dental benefits and coverage, public and private. It's an enormous age discrimination and it's been there for a long time for a lot of reasons. But it's so huge that, you know, it's measurable 100 ways already.

But I don't know if that's something we want to talk about in terms of quality, the notion that we want equity across the life span as well as across ethnicities and urban/rural, and you know, things like that. For me it's kind of a big deal that that's, to me that's like the most glaring problem in our oral health care system right now. So I don't know where that goes but I

just wanted to say it.

CO-CHAIR GLASSMAN: It does sound like another example of using the -- maybe it's not a different measure, but it's a matter of making sure you collect data about whatever measure it is, how it relates to people at different age groups and different care settings, and et cetera.

CO-CHAIR KROL: Dick and then Elsbeth.

MEMBER HASTREITER: Yes, that age situation is very interesting. Some of you may remember that Larry Meskin published a study about the use of dental services based upon age in the Journal of Gerodontics which no longer exists.

And what that study showed was that people with means and elderly came in for dental services like crazy. And it was the people without means, the elderly people did not get the services they need. So it's not just a function of age, it's a function of the

means to be able to afford dental care.

CO-CHAIR KROL: Elsbeth?

MEMBER KALENDERIAN: At least with respect to equity I think it is -- you want to define that a little bit because it's -- I think about England with when do you get a kidney transplant. Is it at 65 or 75? You know, what kind of care do you get when you're 95? Should you get an implant or not?

I remember one of my students who came to me with this fantastic treatment plan, very well done which, you know, got definitely points for that. Nine implants, patient was 94. Very good argument. The patient says, you know, I'm in very good health, I might live another 4 or 5 years and I want to be able to chew and eat and look good. You know. So I think we want to define that a little bit.

CO-CHAIR KROL: Dick?

MEMBER HASTREITER: That's really not funny because there's some --

(Laughter)

MEMBER HASTREITER: There are some dental plans that would cover that completely. And it's part of the certificate and they're required by law to cover it.

CO-CHAIR KROL: Christopher?

MEMBER SMILEY: But truthfully, age is a determinant in that so many health plans that are -- so many dental plans that are out there are part of a dental benefit package that a retired employee loses when they go into Medicare eligibility. And then when they have their health care benefits switched over to that they do lose their dental benefits. And we see that in a lot of the industrialized states. So I think that there is an age determinant that we need to pay attention to.

CO-CHAIR KROL: Dick?

MEMBER HASTREITER: You know, that's true, but the dental benefits industry has been trying to close that gap. And many

dental benefit corporations are actually selling individual plans to individuals without any underwriting. And that's really taking care of those people as you mentioned.

The reason they're doing it is not because they're good guys, but because there is actually a profit to be made there. And I'm sure the underwriters looked at it every which way but loose. And so I think the solution to that is going to be greater and greater. Now, that's not based on altruism but on the ability to make a profit on those plans.

CO-CHAIR GLASSMAN: So, I think we're not trying to design a dental benefits program here but we are looking for measures. What I'm still hearing out of this conversation is that most of the things we're talking about is using the measures already talked about and making sure we're collecting data across various groupings, age, ethnicity, socioeconomic status, et cetera, so that we

can make disparity calculations based on the data.

The only thing that I've heard so far which is a new measure sort of unrelated to that is the one that Mike said about accountable care systems within care-giving institutions or systems.

The one though that Donna raised earlier was measures of acculturation. I'm actually not sure what that means. I'd ask Donna what you mean by that. Sorry to interrupt you guys.

I'm guessing that has to do with health literacy, is that what that means? To the extent the people have developed an understanding of the importance of disease? Is that what that was getting at?

DR. JOSKOW: The acculturation?

CO-CHAIR GLASSMAN: Yes, what does that mean?

DR. JOSKOW: So, the concept of -- there's a number of -- there's quite a bit in

the literature on acculturation factors. And some of those theories roll up the particular measures that you've already discussed. Things like economics, level of education, where you were born and where the parent was born, language spoken in the home. But they're looked at as a measure in and of itself.

So it is -- in some cases it's derived from other measures that you've already talked about today, but in other cases some people have proposed that there are other aspects to acculturation that we in the research community who deal with for example NHANES have not yet been able to account for. So, there's aspects to acculturation that don't account for all of the disparity. When you consider -- sorry, I'm a little dry today. When you consider things like SES, as I said, education, et cetera. Does that help answer that?

CO-CHAIR GLASSMAN: No. And the

reason not is I'm just -- so I think I'm following what you're saying, these are all factors that would I think again fall under the general heading of people's understanding about the importance of disease, or their care-seeking behavior, or their personal caring behavior. I'm wondering though what is the measure that we would be trying to propose and would it be different than the things we've already described as measures.

DR. JOSKOW: Well, I think the acculturation measure or a measure of acculturation takes into account those factors as they influence one another together as one factor. It's kind of like, you know, the sum is -- the whole is greater than the sum of its parts.

And then there's some piece there that is not accounted for that you can't relate to just by looking at SES and whether that's an influence of someone's culture or belief system, we don't know. And it may be

one of those areas that we just -- one of those areas we just don't have the information of yet. But there are great thinkers who have really discussed and thought about this, that maybe what we're talking about is an acculturation measure which includes all the things that we do know plus something else.

And maybe it's just a matter that that allows you a different way of talking about it, but perhaps, you know, we may find what those other, that last little sliver that we can't figure out what that is that contributes to disparities that we haven't already measured.

CO-CHAIR GLASSMAN: So it would be really a call to develop measures of acculturation that would be different than anything else we've talked about it sounds like.

DR. JOSKOW: Yes.

CO-CHAIR KROL: Jim and then Bob.

MEMBER CRALL: Yes. So I was

going to say, you know, listening to that it's sort of that it's going to be up to the research community to sort of identify what that is and how it could be measured. And then sort of in a performance context one way we could get at that are through things like the CAHPS instruments or whatever that basically ask individuals whether they thought they were treated with respect and whether or not they were able to communicate. I mean, I'm just sort of -- that's where I think those, you know, might be headed. But there's a lot of development it sounds like work to be done on many fronts.

CO-CHAIR GLASSMAN: It didn't sound like you were saying that there are some existing tools out there already. You talked about people are beginning to theorize about this and beginning to develop tools.

DR. JOSKOW: Well, I think there are -- there is information in the public literature in the, excuse me, published

literature that has discussed and used acculturation as means of explaining disparities in oral health.

CO-CHAIR GLASSMAN: But are there tools that could be --

DR. JOSKOW: But the actual --

CO-CHAIR GLASSMAN: An actual tool. So I'm going to go measure acculturation of this population.

DR. JOSKOW: Right.

CO-CHAIR GLASSMAN: I'm going to go grab this tool. You're saying that does not exist.

DR. JOSKOW: I don't believe it is. Can I? In listening to you on this particular topic I thought of something for you to respond to. And that is when you talk about the vulnerable populations or the vulnerable groups or categories, many of which have been mentioned here, is there value in measuring or looking at the shrinkage or expansion of the either number of groups that

then fall into what we consider vulnerable, or -- from a population perspective. Or the number of people in those groups collectively?

So what I was thinking of, you know, you can look at disparity at the person level. Say this person's low SES or in a particular race/ethnicity. Or you can -- and you can stratify that based upon the criteria or measures you've mentioned. Versus if you're looking at a population basis then maybe there's a decrease in the number of groups. Then maybe nursing home residents, as we improve nursing home residents are no longer considered vulnerable because we fixed that problem.

So is there a measure in looking at this from a population, vulnerable populations as a group in terms of who those component systems are or what those component systems are that make up the vulnerable population we're talking about that there is a disparity that we could maybe show improvement

or -- hopefully, improvement. That we're not getting worse. Because now this other new group or new system now 10-20 years from now become part of that vulnerable population because we're doing worse than we were today. So that was something in listening to you that I just thought I would put out to the group.

CO-CHAIR KROL: Bob, you had a comment prior to that?

MEMBER RUSSELL: As I was listening I started thinking about one of the things in the disease elimination project we're working with DentaQuest that kind of came up was the idea of literacy. Dental health literacy. IQ. The ability for the patient to self-manage and self-determine outcomes as far as the intervention. So, I think that's -- I have to say 50 percent of the conversations should include some measure of how to measure the individual entering into the system, their literacy, and then to that

term acculturation.

Because sometimes what they know, their literacy, is affected by their environment. In other words, the culture, the beliefs, the community and its identification. I mean, we have many different -- like Indian Health Services. They master in this kind of thing because they work with populations that have very unique specific belief systems where they have to adapt their interventions to fit within that culture's beliefs. Okay?

And that's one of the things we've not thought about in America because as America diversifies and more people are coming from many, many countries that are becoming Americans, the reality is we've got to tailor our intervention in order to meet the needs of these populations where they come from, not what we ultimately believe is the right way to behave when you become an American.

So I think that is getting at the substance here, but the question is how do we

measure it. I mean, we can measure it -- to a degree we might be able to measure entrance literacy when it comes to do you know about how to appropriately take care of your mouth. There are probably questions we can design, surveys, things of that nature that might be able to get at some of those pieces. Certainly if we ever get to full use of electronic health records and a true health history that looks at behavioral as well as those things we would be able to capture that kind of data. It's a futuristic thing. But that's what I think I'm hearing and I think that's where we need to be moving toward at some point. Otherwise, everything we've talked about here is going to be pretty -- we're not going to really get at outcomes, we really are not, if we don't get this piece.

CO-CHAIR GLASSMAN: So, this could end up in a call for people to develop measures related to health literacy or belief systems, and then the question is the

feasibility of that. Are there tools that could now be used, or is this a, you know, back to the basic research community that is going to have to develop those things. I don't know personally how much that's developed for people to use them in terms of population measures at this point. But that's something we could put out calls for people to develop those and they may come forward with them or not.

CO-CHAIR KROL: Michael?

MEMBER HELGESON: Yes, I just wanted to comment. This is circling back a little to under those IOM six goals for a health system. Patient-centered, you know, is a key one and that really gets at sort of the discrepancy between the patient's desires and beliefs and the health care provider's parameters and beliefs. And you get into the whole issue of sort of the word "compliance." You know, we use that word, are the patients compliant.

I think that's kind of a disrespectful from a patient-centered point of view, you know, to think of it that way. I was at a conference on patient-centered care where it was mentioned and I forget the year but there was more money spent, it was on the order of $30 or $40 billion on various alternative health modalities than there was on all of the hospital-based health care combined. And that that tends to be actually the direction that more and more people are actually making their own decisions and deciding what they do with what is being recommended by their doc or their dentist as one data point, but not a determining data point.

So, that's a long way of saying, you know, I think this is an interesting area and the question has to do with patient-centeredness. And how do you resolve, you know, the old way of looking at medicine is how do we force all our patients to take drug

X, Y and Z if the 30-year-old data that we're basing it on makes it look like that's scientifically valid when the patients don't necessarily want to do that.

And so I don't know how we measure this. But I think it's an important part of the health care world today that there be some kind of a fit. And the degree to which the health provider community gets off track with what individual patients or groups of patients that have certain religious or other beliefs, when those get misaligned I think you have a dysfunctional health system where people aren't getting what they want. So, I don't know, but I think it's a great topic that you brought up and I don't know if there -- if we frame it as patient-centered what are some things that we could measure about the degree to which the oral health system is patient-centered. Maybe we can -- I don't know what the answer is.

CO-CHAIR GLASSMAN: Well, so it

sounds like we're talking about an area that there's some general recognition that it's important but it may not be feasible based on the fact that none of us seem to say yes, there are measures out there that can do that. So we just need to start using them or develop them further. We're maybe at an earlier developmental stage in this area than we are in some of the others.

So, I think we can put it on our list but maybe if we're reporting back in terms of the ranking these things at some point the feasibility of this one may not be as high as some of the others. High importance but not so feasible.

CO-CHAIR KROL: Diane?

MEMBER LIMBO: I'd just like to comment. Perhaps that could go back to the access to care where the patient's survey satisfaction and include something that would address it because I think that's a good point. As a provider we're trained to -- we

have an agenda and we know the patient has an agenda and hopefully at the end of a visit we've met both agendas.

But that may be it in terms of how the survey is framed in terms of its presentation to the customer's satisfaction. It's one thing to say were they courteous, were you comfortable, did you have a, quote, "good experience" versus were you given advice you were able to follow through with.

I mean, it's one thing to tell a family to do oral hygiene for your kids twice a day, but if they're living in a car what's the probability of them being able to comply? And yet are they then considered non-compliant?

MEMBER CRALL: I was just going to say, I mean I think the folks that have worked on CAHPS would -- that's probably the closest thing we have to a vehicle for doing that. The extent to which it adequately addresses cultural competency is probably still fairly

general but I think it's an area that's probably going to receive some additional attention for development within that framework as well.

So, I mean I think that's as close as we have to sort of, you know, current or short-term, near-term possibilities. It's only one point. You know, it's the recipient or the beneficiary or the whatever's point of view, but at least it's a measure.

CO-CHAIR GLASSMAN: Okay. So, we could frame this as something that could be incorporated into patient survey data, satisfaction data. It's a slightly different -- put in patient satisfaction it's a slightly different concept than assessing belief systems directly or -- but it's still something that might be more feasible to do that given the current state of the world.

All right. Yes, so then we're ready for that one?

CO-CHAIR KROL: So, priority area

I is -- so most of this stuff we've touched upon. Are there things that are missing here that we need to speak about?

DR. DUGAN: Let me give you a little bit more information about the priority area. It's linking people to services and support from other sectors. So, which contribute to good health and well-being. And health IT can be used to link providers to each other through the use of EHR systems. Facilitating -- so the mean idea is to facilitate communication between patients, between types of providers and services through each. So I think the goal is really trying to get at communication between providers about patients and then from patients back to their providers. So that's what we're looking for measures related to.

CO-CHAIR GLASSMAN: So, there really isn't anything listed here that directly addresses what you said. The question is could there be, should be.

DR. DUGAN: Right. Well, I think the one piece about communication between types of providers could be related to the service. You know, the referrals or the health care being provided by different types of providers if there's communication between them. But yes, nothing direct.

MEMBER RUSSELL: Certainly the care coordination model is important. But I look at states like Kansas where they've got the spoke and hub concept where they actually get extenders out into their rural actually frontier regions that connect to hubs through tele-health type connections. And they actually can provide services in those areas and facilitate getting those patients into those hubs where they can get definitive care.

I think in this situation it's "linkage" which is the key term. How do we link the various systems together to create a net that people can find, an access point to get the care they need? And I think that's

really what this is fundamentally talking about. You know, certainly our previous recommendations about care coordination, integrated care, working as a team and extending is definitely part of this system solutions and how did we monitor that probably would be important.

CO-CHAIR GLASSMAN: So again, this is one that's not quite so easy to see exactly how it would be done. But I think the concept you just said, Bob, makes sense to me at least which is to call for measures about communications or linkages among providers, and examples of that being the use of care coordination, the use of tele-health systems, the use of other kinds of methods that would allow different providers to be communicating. Shared electronic records, obviously.

MEMBER ACHARYA: Just another topic to add there is kind of use of patient portals. I mean, if you look at, again, meaningful use, there are certain measures

that they kind of go in different stages. The number of people who are registered who are using patient portals, maybe that's one way of linking, especially looking at dentistry, linking the patients to they're dental provider. That's something we might want to look at as well.

CO-CHAIR KROL: Michael?

MEMBER HELGESON: Yes, I just wanted to just emphasize the whole interoperable health records and ability to -- the degree to which dentists and pharmacists and physicians and plans are able to exchange information and avoid sort of duplication of, you know, entering the same stuff over and over again and things like that. It seems like that would be a systemwide quality improvement if, you know, to the degree to which -- and again, I don't know how to measure it, but emphasizing that.

CO-CHAIR KROL: Amy and then Dick.

MEMBER HESSEL: I think that's one

of this administration's ultimate goals with medicine in 2014 or whatever is to try to get a better electronic medical record linkage. Because, I mean, it's not just a problem between dental and whatever, it's a big problem even from doctor to doctor they're redoing tests. And the amount of waste is extreme. So I think, I don't know if this group needs to really identify it as a measure because I think in the whole health care unit we're going to see that happen in the next year or two.

CO-CHAIR KROL: Dick?

MEMBER HASTREITER: Amit, is Marshfield doing this already?

MEMBER ACHARYA: Yes.

MEMBER HASTREITER: Good. And have you done any research on any of the data analysis of connecting medical to dental?

MEMBER ACHARYA: So we are current -- from 2010 April we went live with an integrated system. So there is a lot of

research being planned and some being done. It is a challenge when you talk about bringing dental data in a medical record, but you know, then you're talking about like a lot of different specialties talking about, okay, endocrinologists, they like it, but maybe there are other groups who are going to say no, we already are dealing with a lot of -- or load issues in terms of information. So, there's some amount that we've started off but it's just the tip of the iceberg I would say. And there's so much more.

MEMBER HASTREITER: So, there is some resistance among certain groups of physicians?

MEMBER ACHARYA: It's not, I wouldn't call it resistance, it's just that they are in the mind set of, okay, we already are having a tough time trying to see through the important information. Now you add some more from the dental side, we don't want that. But then there are certain groups who say

yes, you know, it's very unique for my patient and I do need, you know, some level of dental information being sent to us.

MEMBER HASTREITER: It will be interesting to see how that develops.

CO-CHAIR GLASSMAN: This could be another example of something we talked about earlier whereas if we were to have a measure of communication or linkages among providers, including care coordination, shared interoperable records, tele-health, we could all predict the results right now which was nobody would do very well on those measures because there's very little of that going on. So the question for us, is it still worth developing measures as a way of saying let's get the measures out there as a way of encouraging people to do this and that was the conclusion we made in the last similar discussion. But I think we all know there's not much of this, any of these things going on right now.

CO-CHAIR KROL: Mary Alice?

MEMBER LEE: I really thought from the title of this, "Build Healthy Communities," that this was more about integrating oral health education and public awareness into the community. You know, changing what's sold in the corner bodegas near the schools, making sure that there's an oral health education component in school, promoting oral health in the community, not just the linkage between patients and their providers. And the other providers to whom they'd be referred. But I could be reading this totally wrong.

CO-CHAIR GLASSMAN: No, you could be reading it totally right. So that -- I think that's a good suggestion for something to add which would be to try and call for measures of integrating how well oral health is integrated into other community systems. It brings up the feasibility question how do you do that but still, I think the general

topic as what you said makes sense.

CO-CHAIR KROL: Or educational systems. You know, in a health curriculum if oral health is part of it and things like that. Michael?

MEMBER HELGESON: I was just going to mention the whole topic of social marketing. You know, we've got all these messages about the American smile, you know, the white perfect teeth and that's most of the general public thinks of it as elective cosmetic area. We don't have good social marketing around mouth disease and the impact of mouth disease on heart disease and other, you know, chronic illnesses and things like that. So maybe part of this is having good social marketing around essential oral health as opposed to elective oral health. I don't know. So maybe it's something about that that we need to develop measures about the communications that the public is getting. It kind of relates to your, you know, soda pop in

the public schools, and you know, a variety of different initiatives that could be done.

CO-CHAIR KROL: Dick?

MEMBER HASTREITER: A number of years ago the Minnesota Dental Association spent hundreds of thousands of dollars to attempt to increase the awareness of periodontal disease in the population. They did everything, TV ads, radio ads, things on the sides of buses, handouts, everything that you can imagine. And after the study was finished they found out that the campaign they had going increased dental knowledge, but it had no effect on dental health-seeking behavior.

CO-CHAIR KROL: Mary Alice?

MEMBER LEE: I just was thinking of one other example, a community that promotes breastfeeding has public spaces, has laws protecting nursing and things like that, where oral health problems in infants oftentimes -- the problem arises in infants

and their nutritional patterns. That could be another example of how a community supports oral health. And I was just thinking of this much more broadly in that way.

MEMBER RUSSELL: I have to agree with that because in community-based interventions we do find a great deal of improvement. We study WIC populations, Head Start and others where we've done very small money, I mean we didn't put a lot of money in it but we chose pilot communities, develop a -- not more or less a care coordination but kind of like a champion in that community that basically did outreach to their churches, their local public places. There was someone they knew in that community and they organized around others and began to build a community-based awareness campaign. And it drove a lot of people in our particular case to care. And we saw some significant increases in Medicaid utilization in those communities. And that's one of the reasons that we were able to build

our statewide model, now -- model based upon those pilots.

So I have to say that, you know, I can say from a top-down level it doesn't work well, but if you focus the resources into the community among the culture, among the individuals that you target and then let them promote the awareness it has a much greater effect.

CO-CHAIR GLASSMAN: So, I guess that would be some kind of call for measures about community awareness, either measures of process, what kind of activities are taking place, or measures of outcomes, to what degree are people in this community aware of oral health, how to prevent it, what resources are available. A lot of things you can measure about people's awareness around oral health.

MEMBER HELGESON: Having things that work is key. Obviously marketing works, right, in general, but not all marketing works. You've got to have the right strategy

for the right thing you want to change. So yes, some measures around that I think would be really great.

CO-CHAIR GLASSMAN: Okay. So, we're a little bit ahead of time and I wanted to just give people the option of taking a 5-minute bio break or whatever you want to do. Or we can just plow right through. Is there any preference? Five minutes? Let's take 5 minutes. So that's like a one bio break and then back, or whatever you need to do.

(Whereupon, the foregoing matter went off the record at 2:54 p.m. and resumed at 3:03 p.m.)

CO-CHAIR GLASSMAN: So we really are into the home stretch here, really down to the last area which is item J.

And I just actually picked out really just one concept here which was the expenditures on various aspects of oral health care. There was a number of items that had to do with how much money is being spent on

various things.

And then the other one, there were just too many of them and too all over the place so I didn't even try. But if we want to pull out the longer spreadsheet on number J which is I think the bottom one in the pile that we all got, the big pile, the big heavily clipped pile.

If you want to pull out the bottom one and really just scan through it to see if there's anything else that jumps out other than expenditures on various aspects of oral health care that seem like they're important that we should be talking about. Maybe we'd just take a minute to do that. And also that seem different than stuff we've already talked about.

MEMBER HELGESON: I'm not sure I'm finding it.

CO-CHAIR GLASSMAN: It says priority area J. It's the last bundle. It's not the last page but if you look at the last

thing in the pile, unclip the clip and look at the bottom one, bottom thing in it. It says priority area J. It may be the second to the last one.

DR. DUGAN: Yes, the last one was the list of priority areas. So it's the second to last one. It says priority area J. These were all measures when we did our scan that we didn't think fit under any of the other buckets. You may argue that some of the ones we put in the other buckets didn't fit either but these were sort of our leftover measures. So I think the conversation, what Paul just mentioned, is there anything in here worthwhile talking about as important as feasible we might suggest?

CO-CHAIR GLASSMAN: Many of these seem like sort of stratifications on the things we've talked about. For example, ECC patients with documented caries risk. So we've talked about measures of caries, we've talked about measures of caries risk so I'm

not sure there's anything new in that. So, David.

MEMBER GESKO: One thing that comes to mind is some work that's been done on determinants of health. As caregivers I think we're always surprised that health care per se is only worth about 20 percent of one's health outcomes, and this social determinants and Healthy Communities is significant.

One thing that I was thinking of that might be considered here is placing in school systems, you know, encouraging better snacks and beverage choices than currently exists. I'm struck by the fact that you go into a lot of schools, you see just Coke and you know, high carb snacks and things like that versus water, other choices that would be encouraging better oral health.

So, I'm going to try to see if I can re-frame that in terms of a measure. Maybe proposing some kind of measure of the -- something related to school-based food or

drink choices to the extent that they're being available, being used, I guess multiple kinds of measures related to that concept.

DR. DUGAN: And does that fit under the Healthy Communities?

MEMBER GESKO: That's where I was putting it but do you see not? Okay, okay. Healthy communities.

MEMBER ACHARYA: There is another concept of complications that's been mentioned here under some of the Australian Council on Healthcare standards. I don't believe we addressed kind of the bucket that we're going to kind of measure any of the complications after -- I mean, there are a couple of routine extractions, surgical extractions here.

I'm sure there could be other complications associated with dental procedures, so maybe creating a bucket for measuring some of the complications after a pretty clear type of treatment.

CO-CHAIR GLASSMAN: Okay. Yes, we

did talk about complications after sedation, but there's a lot of other --

MEMBER CRALL: Did we sort of capture the re-treatment sort of piece which a lot of those Australian ones are sort of directed at. Need for additional treatment beyond sort of -- and linkage of procedures within some time period. We didn't really, I don't recall that we really sort of got into that piece of the realm.

CO-CHAIR GLASSMAN: No, we didn't, so let's put that down as a concept for development which is complications and need for re-treatment.

DR. DUGAN: Does the complications go under patient safety bucket or is it separate?

CO-CHAIR GLASSMAN: Well, I had patient safety as something to come back to, so we've --

DR. DUGAN: Separate.

CO-CHAIR GLASSMAN: -- again

identified it slightly when we were talking about anesthesia. But maybe it's this whole issue of complications which includes complication sedation, includes need for re-treatment. These are all things didn't go well, as well as you wanted them to, some measures of that.

MEMBER CRALL: Yes, which I think are going to, you know, may reflect on whether the appropriate diagnosis and selection of treatment was made, or it may reflect on the sort of technical ability, technical competency around carrying out the procedure. But that's a whole realm that sort of, I don't recall we discussed to a great degree. Yes, that's right, part of it is that from a patient standpoint and then part of it, yes, is more sort of adherence to guidelines and sort of clinical competency.

CO-CHAIR GLASSMAN: Anybody see anything else? Mary Alice?

MEMBER LEE: I had a comment about

expenditures on various aspects of oral health care. There's -- I wondered what the purpose was of measuring this as a quality measure. Do we have a standard for how much should be spent per person, or should there be a distribution of expenditures for different types of services like orthodontia versus restorative care, or preventive services, that kind of thing?

And if so, how are we going to get at that with the difference between amounts paid and amounts allowed, amounts billed and amounts paid, capitated systems, FQHC reimbursement which is lump sum.

CO-CHAIR GLASSMAN: You're not forgetting that we're in Washington, D.C., are you?

(Laughter)

MEMBER CRALL: Yes, I think the first answer to that, that in and of itself it's a way to get the value. So I think it's sort of used in conjunction with a lot of

other measures. The allusion that we are in Washington, D.C., certainly there's parallels in the Affordable Care Act as it stands, you know, for looking at things like that. And I think there is interest in determining whether adequate resources are going into certain kinds of programs. And you could do comparisons with actuarial analysis, you know, actuarial projections or estimates. So there's, you know, but in and of itself, just knowing that X number of dollars were spent I don't think necessarily tells you. It's using that in conjunction with other things.

CO-CHAIR GLASSMAN: So that came from, it's really the very last things on the last page of that other section which says -- there's really two measures there. One is Medicaid from CMS, Medicaid expenditures on pediatric dental care, and the other is from Delta Dental value of services. But both of them, the actual measure if you look under the description column talks about the percentage

of the dollar or the percentage of the expenditure that actually goes to care I assume other than administrative, although it doesn't say that.

But it says it's really a measure of percentage of money being spent that goes to actual care. That's just one sort of, one slice of expenditures. There's a lot of other things you could think about with expenditures.

MEMBER HELGESON: I just wanted to pick up on that whole volume to value, efficiency, you know, looking at that. So measures, measures that look at value beyond the normal dental expenditures. So for example, a lot of work on the value of regular dental care and cleanings for diabetics in terms of reducing non-dental costs, for example. So, looking at value to the total health of the person outside of the dental budget.

One of the problems we've had in

Minnesota is you can come up with arguments why dental interventions based on the science are likely to drive down non-dental budgetary costs and yet the way the accounting systems work they don't care. So, if we could have measures that cause more rational spending where we don't just look in one bucket, we look at all the buckets and say, well hey, we might have to spend a little bit more money in this bucket, but if we do that the diagnosis will be more accurate, the number of unnecessary procedures will be reduced and people will save twice as much money on other health consequences because they were healthier, for example. So, measures that look at the total value of oral health interventions, the total -- inside and outside of the dental budget I guess.

MEMBER HESSEL: This is not related -- but sort of following up on number 22. The metric that's there, or the measure that's there on radiation oncology.

Referrals, that's probably not appropriate for this, but what is probably appropriate is that all patients being referred for radiation therapy to their oral cavity needed dental evaluation prior to starting radiation for caries management, fluoride and management of disease beforehand.

MEMBER HASTREITER: Most dental plan corporations have actuaries that are beating their pencils to death or their computers to determine the distribution of services provided and the various costs associated with those services by group and subgroup. But the key to that is linking that information to the quality of the clinical decision-making process and that can be done. And when that's done it probably shows the effect that the dentist has on the oral health care that the person is getting. I mean, some of the treatment plans are just, they're wall-to-wall crowns and so on and so forth. Others are preventive and very conservative treatment

plans.

And by looking at that and looking at the populations that are being -- providing the care, you can really look and see which dentists are providing care that's most consistent with the epidemiology of the group or subgroup, and also most consistent with the most recent scientific evidence and scientifically based clinical knowledge.

Now, as Bob has pointed out it is also interesting after you see the quality of the decision-making process in diagnosis and treatment to see if that care is completed, and look then over time at the oral health status of that individual using proxy variables.

CO-CHAIR GLASSMAN: So, one thing in what you said is that there's some value in just collecting the data on exactly how much money was spent on different kinds of things. So that might even just be your, you know, we spent so much money on a whole list of

procedure codes. This is how the distribution was. Not that that is an end in itself, but you could use that data to look at -- in plans or areas or people or groups that spend more money on X, Y and Z, how does it impact their overall outcome. So, there is some value in collecting just the data, the raw expenditure data itself.

What else about expenditures then? Anything else that falls in? Again, I'm sort of mindful of what David was referring to earlier about the whole issue of the Triple Aim. So, the idea is just not to cut the cost of dental care, but it's to do that at the same time you're improving patient experiences and improving the health care outcomes. So, in what other ways could we use measurement to drive that Triple Aim equation.

MEMBER CRALL: Paul, I mean one thing, I don't know if this is on point or not. Certainly when it comes to some historical performance of some Medicaid

program, I mean that business -- it depends on how you interpret that Triple Aim piece, right? Because I will contend for a number of Medicaid programs in fairly recent times cost savings was not a very reasonable objective. Because if you got utilization that's abysmal you know it's going to cost you more in the aggregate.

But if you apply that to the individual, down to the level of individual, is it costing you less over time, you know, with certain patterns of care. So I think, you know, tracking expenditures per individual and then measuring that against either direct measurements of health status, or change in health status, or some sort of proxy measure if you can get it, that's where the dollar expenditure, you know, really comes in.

And likewise, you know, if you look at a profile of services being provided in a Medicaid population and 80 percent of your procedures and dollars are going into the

diagnosis and prevention, and nothing's coming through beyond that when you know an epidemiologic, you know, condition of your population is much higher.

Again, that may allow you to either question whether or not the program is being effective overall or whether one particular plan might be doing a better job of providing a more comprehensive care. And the expenditures are only sort of a start of answering the question.

CO-CHAIR GLASSMAN: Yes, yes. I don't think anybody would think that a state that cuts its adult program because of budget shortfalls is moving towards the Triple Aim. They're just trying to save money, keep from going broke. David and then Dick.

MEMBER GESKO: You know, our medical colleagues are very firmly entrenched in total cost of care, and that's an area that might belong here is to be able to evaluate measures that could get at that in dentistry

as well.

Jim, you just mentioned it. You know, there's the cost per widget, and then there's the utilization of the widget. And so often dental benefits plans and so on just focus on the cost of the widget. You know, how much discount are you going to give me, dentist, for being in my network versus well, I'm not going to give you any discount, but I'll be a better value for you because I use care guidelines to employ the utilization of the services that I offer. They don't tend to get that. Yes, I think I can say that.

CO-CHAIR GLASSMAN: Dick?

MEMBER HASTREITER: I think what Jim and I were talking about was a way to objectively get at economic value. You can actually measure the types of services provided in relationship to cost, total patient care cost over time, and determine which dentists or which group of dentists are providing care that is most consistent with

individual or population-based needs, and get from that the return on investment and the quality of the clinical decision-making process that allows you to determine which dentists are the most cost-effective and efficient for the population being served.

CO-CHAIR GLASSMAN: Okay. Other thoughts? So we were focusing on economics a little bit, the last bit of discussion, and then anything else from the other category that jumps out?

So, if not, we've reached the end of the list. So Donna, what do we do in terms of summarizing?

DR. DUGAN: Are there any other concepts that we talked about earlier in the day that we sort of moved to the end or did we give those all due time? I remember patient safety was one that kept coming up. Do we want to spend any time on patient safety or do you think we've already talked about it enough?

MEMBER KALENDERIAN: The development of measures of patient safety for us or for another -- the development of the measures of the patient safety.

DR. DUGAN: Well, you had mentioned before that you think that patient safety -- that patient safety was missing from some of the other buckets.

MEMBER KALENDERIAN: Right.

DR. DUGAN: And I just wanted to know if there was anything more you wanted to say about patient safety in terms of standardizing definitions or any types of measures to focus on specifically? I'm not asking you to start developing the details, but anymore guidance.

MEMBER KALENDERIAN: The only type of measure that I would really think of and that would need further development is doing the same that has been done in the outpatient medical world as well as in the inpatient medical world is thinking along the lines of a

trigger tool which is essentially a script that you run against an electronic health record.

So this would only be for those offices that have an electronic health record. You run it against the electronic health record and it gives you back records that have a significant chance that they have adverse events. And then you do a process and you look at those adverse events. That is a real good measure to find harm.

CO-CHAIR GLASSMAN: So, the potential is we could call for measures that would look at identifying and analyzing critical or adverse events.

MEMBER KALENDERIAN: Correct.

CO-CHAIR GLASSMAN: Yes.

MEMBER KALENDERIAN: Yes.

CO-CHAIR GLASSMAN: Okay.

MEMBER KALENDERIAN: I'm just mentioning it because I developed three of those trigger tools and I know that they work.

CO-CHAIR GLASSMAN: Okay. You're going to have lots of applications to NQF for things.

MEMBER BATLINER: Can I just ask, can you give me an example of one of your trigger tools?

MEMBER KALENDERIAN: Yes. One is filled implants. And you run that against a script that has endodiagnosis and the CDT, sort of diagnosis of filled implant and the CDT of removal of implant. One is I&D, incision and drainage, together with diagnosis of an abscess or an infection. And then you can, potentially if you want to you can link the EHR with giving of antibiotics. So it's kind of a complex script that you write.

And the third one is a very interesting script that you write for -- we call that very simply multiple visits, but it's multiple visits in a short time frame with like dentists. So, not a dentist and a specialist, but two general dentists or two

prosthodontists. So, it's like a handoff and it was often an indication of unhappiness of the patient. And then when you dug into it, it's because something had happened.

And then the fourth trigger tool that we haven't fully run yet but we know we'll be working is actually, letters of complaints. We scan our letters of complaints in and we know that on the medical side too when you start running scripts against letters of complaints, very often adverse events will come back.

CO-CHAIR GLASSMAN: Okay.

DR. DUGAN: There was only one other thing I had written which was trauma.

CO-CHAIR GLASSMAN: Actually, I have two more. So go ahead.

DR. DUGAN: Okay, trauma was one that came up earlier. So if there's anything anyone wants to add to the trauma discussion.

CO-CHAIR GLASSMAN: Trauma or injuries was, you know, as a general category.

I don't think we really got too much of that as we went through. So are there some specific things we want to say about that in terms of measures?

MEMBER GESKO: Would there be a fit there possibly with that health community section? I don't know, thinking out loud, but. I mean, trauma can be just slipping at home, you know, around the bathtub or something like that when you're a little kid, but it can also have to do with the livability of communities and the safety of that as well.

CO-CHAIR GLASSMAN: Yes, I don't know. Well, no one's jumping out with specific ideas so I think we could just list it as one of the items to call for a development of measures around. Recognizing, identifying and trying to understand the causes of trauma, and then maybe even what was responses.

The one other one I had we didn't talk, I don't think really came up was, really

was the issue of neglect. Mike, I think you raised it. So I don't think we really addressed it as we went through. Anything that you think of -- or anybody thinks reflecting back on that in terms of what kind of measures would you propose? What kind of categorization of measures would you propose?

MEMBER HELGESON: Yes, I'm not really sure. I know that, you know, for both children and vulnerable adults dentists are mandatory reporters of suspected neglect. And you know, I know in the elder care environment it's very challenging, you know, because you have, especially in long-term care where you have people who don't have appropriate dental coverage under Medicaid, for example, no care for periodontal disease. And they're suffering from periodontal disease at high rates. And you're recommending various things which then their family member or somebody third party to them would have to come up with funds to be able to do that.

And you can have people with abscessed teeth, you can have, you know, candidiasis on dentures and inflammation, you know, lesions, et cetera, where you don't have coverage. And then you're dealing with a family member who may have limited resources. And so you're sort of -- at what point is it neglect? It's very difficult. And I think that the gross inequity and disparities in funding put both the dental provider in an ethical dilemma and the family member, the decision-maker for the person in an ethical dilemma.

And it just raises a lot of issues about at what point do you say, you know, this vulnerable person is suffering unnecessarily day to day. And who ultimately is responsible. It's actually a very tough area. I know there was a paper written about it and Paul and I were not happy with the paper because everybody is responsible. Medicaid is responsible, everybody is responsible for that

scenario.

But it's real and we have people -- if you were to take that environment and put it on children in today's environment, boy, there would be huge outcry because children are mandatory to be covered and there are procedures and standards in place for children that would say it's neglect to allow a child to suffer with painful infections, for example.

CO-CHAIR GLASSMAN: So, maybe the issue is -- I mean, you can go back to the fact that dental professionals are mandatory reporters. So you could, maybe you could get data about how often neglect or abuse is reported. Whether you could get data about how often it should be reported, that seems almost impossible to me, but maybe you could get at least data on how much it is reported and maybe that would be useful in some kind of comparison. Because you know it's -- even though you can't measure it, you know it's a

lot more than is being reported. Reporting data might be useful in that context.

MEMBER HELGESON: Yes.

MEMBER LIMBO: I'd like to go back, just a second for the patient safety. I'm thinking is there any way, or is it solely self-reporting, that dentists indicate errors that they've made? I know we've had an instance where we had a situation where X-rays were reversed in our system and we didn't realize until after we had re-treated a tooth. I mean, we acknowledged it to the family, we told them what the error was. I mean, we took note of it in our own quality review, but that's something to me that you know, what if you pulled out the wrong tooth? And it was a permanent one. How is that reported, how is that tracked?

And it makes me think again about that conspiracy of secrecy that used to be in a hospital operating room. I know, I've been trying to propose, you know, stop, let's look

at the record, make sure. And everybody knows it's the right patient but do we have the right treatment plan up? Do we have the right X-rays up? And that's sort of like oh yes, it's Diane, but you know, slowly but surely we're doing it in the clinical. I'm saying this is an operating room, no different. But I'm wondering is there a place to report that, or at least monitor it.

MEMBER KALENDERIAN: Self-reporting doesn't happen among dentists, I can tell you that. We have put in a timeout. I'm not very much liked I can tell you. I'm working on checklists. I'm probably less liked after that. Running trigger tools against EHR, not a hit. But on the other hand, at the quality improvement committee that we have people are very enthusiastic. It's like anything else. Everybody loves measures, nobody wants to be measured.

And so it's just moving the ship very slowly that we need to go there. I

started actually with shifting the culture and doing a survey that, you know, we need to really go there. We are where medicine was 20 years ago. It's a very long road to go. I just presented it to IHI that dentistry is at measuring culture, changing culture, that we need to do this.

We have a very long road ahead of us. This is why I'm just hammering on this patient safety that if we don't get it in now then we have another 10 years that we need to wait. And then Lucian is very unhappy with me. So we'll have to do this.

CO-CHAIR GLASSMAN: I think the answer to that question was that it is not very well reported, and to the extent that it is in more organized systems like a dental school or a larger practice that tends to be reported in a way that is protected from disclosure because of the issues about malpractice. So, you know, it tends to be reported in secret vaults that are locked at

night and all that kind of stuff.

MEMBER BATLINER: I think you bring up a good point. I really do think we need to change the culture because there are a lot of things that happen that don't get reported and nobody talks about. You know, drilling on the wrong tooth, taking out the wrong teeth, doing the wrong thing on the wrong tooth and on the wrong, you know, that stuff happens all the time.

And I think that our medical colleagues have led the way. If we just start having timeouts, empower everybody in the room to say they think it's wrong if something's wrong. Just do some of those basic things that other people have been doing for years and make that part of our culture. I think it could make a big difference. So I think it's important to put something in.

MEMBER KALENDERIAN: We actually started a root cause analysis. We took -- I come out of the hospital world. So I

literally took the root cause analysis form and we had three major incidents. And once nobody got fired, no resident got put in the corner and shamed, I now have people knocking on my door, "Can I have that RCA form?" And it's exciting that people now actually want to talk about it and put a group together. But it took a little bit to get there.

MEMBER BATLINER: You bring up a really important point. I used to work for Ken Kaiser in the VA who started this organization and the one thing he did is develop amnesty for people who report their mistakes. And then a lot of mistakes came out. Then politicians came in in subsequent administrations who said we want accountability and everything went subterranean and nobody knew what the hell was going on again. So I think that's an excellent point.

MEMBER HESSEL: And let me tell you, it's a very long road. Even in an area

that's been doing it for years and years, I mean we still in our huge and humongous institution have doctors who don't want a timeout. And it's crazy.

MEMBER KALENDERIAN: That gives us a job and a cause.

(Laughter)

MEMBER HESSEL: Yes. And we're reported by the government. I mean, if we don't timeout it's a JCAHO hit. So, I mean it's not just us trying to protect ourselves.

CO-CHAIR GLASSMAN: Okay. So it sounds like we could, again, call for measurement development in that area, how much the data is available is a question of feasibility.

MEMBER KALENDERIAN: I think if there is an EHR there's data. If there's no EHR then we just have to wait. And I think as meaningful use is in place and people get very excited about the money. So, if you just think about the FQHCs, the dental schools, all

the clinics and the hospital, there's lots of areas where we can start. We might not be able to start with the individual practitioner, but that does not mean that we cannot start somewhere.

CO-CHAIR GLASSMAN: Okay.

MEMBER HELGESON: I just wanted to comment. I don't know how widespread it is. I know in Minnesota there are mandatory reporting forms for adverse events related to anesthesia, either IV sedation or other anesthesia. So there might be some readily available reporting on at least that from several states. I'm not aware of other categories like that.

CO-CHAIR GLASSMAN: Anything else that we've missed? I think we've picked up the other things we put aside during the day. We've come back and picked those up. We've been through the other list. Ready for the?

DR. DUGAN: Yes. Before we wrap up and do next steps I just want to see if

there's anyone either on the phone or any of our guests here that wanted to comment or ask questions or anything of the group?

MR. FUCCILLO: I don't want to take a lot of time but I want to thank you for having a public -- thank you. I was saying it's great to be here today and I want to thank you for that. But I was particularly sensitive to the discussion, maybe this is expected from someone in philanthropy, on the disparities in the Healthy Communities sections.

And I was talking to Mary Alice about the fact that Healthy Communities really is not about services which makes it difficult I think to put it in this measurement piece. However, I do think that there is some way in which the provider, the dentist have a sense of understanding the prevalence of dental disease in the communities in which they're serving. I don't know how to get at that. So there's a way in which I as a patient or the

patient is able to understand where -- someone mentioned why something is being recommended, but really, where do I fit? What's going on? And also the potential identification of some things in the community that might be apparent.

The other piece is on the disparities. And you know, several of the discussions have started to take away from the clinical experience into the capabilities and perhaps the frequency in which a dental provider could be able to conduct a social history. And in terms of some experiences around trauma, issues of foster care, fear of dental experiences and probably the one that might be most difficult but was -- could be brought up in the context of either HPV -- HIV/AIDS is how to do a sexual history for patients. So, I think that those are some of the things that are difficult to deal with but ought to continue to be -- we ought to challenge ourselves to figure out how to get

at that. Because in many cases it's the most vulnerable populations that we're trying to reach with improvement in quality. And some of these things are still not solved. So I just thought I'd add to the challenges.

CO-CHAIR GLASSMAN: Thanks, Ralph.

DR. DUGAN: Any other comments or questions from our guests? Okay. I think Paul has done a really nice job throughout the day of summarizing each piece, so unless you feel compelled to summarize the whole day right now.

CO-CHAIR GLASSMAN: I don't feel compelled.

(Laughter)

DR. DUGAN: Then I think we're in a really good place.

CO-CHAIR GLASSMAN: I can summarize it in one word, or two words: quality measures.

DR. DUGAN: There you go. So, just for next steps. We'll take all of the

information we talked about today and summarize that into a report. And we'll likely send out an email to you for your review, either some specific sections, your recommendations, or the report in general. But the goal is for us to get that report out for public comment in May. So we're working on this report in April.

In May it will be up on the NQF website for 30 days for comment and then we will convene you by conference call likely in June to help us respond to any of the comments that came up from public comment so we can finalize the report and get it out in July. So those are our next steps.

So then thank you so much for being here today and your feedback and your comments. Safe travels home.

CO-CHAIR GLASSMAN: I just want to also add that at the beginning of this process, you know, a couple of weeks ago I thought this was going to be absolutely

impossible. I couldn't imagine us actually producing anything useful. So it's been a pleasure to be with you all today and I think we actually did some good work here. So give yourselves a hand.

(Applause)

(Whereupon, the foregoing matter went off the record at 3:39 p.m.)