Advancing Quality and Program Effectiveness through Performance Measurement: DQA Starter Set

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Vision

All Medicaid and CHIP beneficiaries receive quality and cost appropriate oral health care services.

Mission

Promote evidence based policies and “Best Practice” models that improve Medicaid and CHIP oral health program quality, processes and services.
Learning Objectives

To gain knowledge:

• About newly developed evidence-based oral health care performance measures and measurement resources.

• On how to advance Medicaid and CHIP Dental Program effectiveness through performance measurement and improvement and

• On how to foster and support professional accountability, transparency, and value in oral health care through program evaluation and performance measurement.
What is Quality in Healthcare?

• The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge

• This prescript contains just two concepts: measurement and knowledge.

What is Performance Measurement?

Performance measurement allows us to assess care against evidence-based clinical guidelines and nationally recognized standards.

A quality measure is a mechanism that enables the user to quantify the quality of a selected aspect of care by comparing it to a criterion.
Quality measures are used for three general purposes:

- Quality improvement
- Accountability
- Research

Other potential uses:

- Policy
- Reimbursement
Business Intelligence

Data → Information → Knowledge → Business Intelligence

Slide courtesy of Dr. Rob Compton
Observations

• There are no experts in dentistry in this area
• It’s knowing what questions to ask of the data
• It’s knowing that the first generation of questions are rarely the important ones
• Data drives more important questions and subsequent decisions
• DQA is leading the way with expertise and representatives from across the disciplines and professions

Slide courtesy of Dr. Rob Compton
Krishna Aravamudhan, BDS, MS

Jill Boylston Herndon, PhD
2008
- DQA Proposed by CMS

2009
- Formation of Steering Committee

2010
- 1st DQA Meeting

2013
- 1st Measure Set approved
DQA Mission

Advance the field of performance measurement to improve oral health, patient care, and safety through a consensus building process.

Objectives:

• To identify and develop evidence-based oral health care performance measures and measurement resources.
• To advance the effectiveness and scientific basis of clinical performance measurement and improvement.
• To foster and support professional accountability, transparency, and value in oral health care through the development, implementation and evaluation of performance measurement.
Counting What Counts

MEASURING PROGRESS TOWARD BETTER HEALTH AT LOWER COST

What matters most for improving the health of Americans and the affordability of our health care? Because what gets measured gets done, progress in health and health care depends on the measures used to guide our efforts, and our focus can be blurred without a sense of what’s most important among the thousands of measures in use across the nation. Our challenge is to identify a small, practical set of key indicators of our progress—how we are doing in achieving better health, better care, lower costs, and in involving people more in their own health and care. We need core metrics for continuously learning health and health care in America.

TODAY’S CHALLENGES

- Too many measures
- Uneven relevance
- Little sense of priority
- Uncoordinated efforts
- Limited multi-level comparability

A PATH TO IMPROVEMENT

- Specify a core set of measures
- Align measures to focus on the most important priorities
- Assess progress across the system, from the organizational, community, regional, state to national levels

INFRASTRUCTURE FOR MEASURES

- Build data systems that capture and exchange key data elements
- Integrate measures into processes for reporting, regulation, and payment
- Develop approach to continuously update measures and adapt to new technologies

ANTICIPATED BENEFITS

- Reduce the measurement burden on clinicians and organizations
- Allow for comparisons and identification of best practices
- Promote collaborations and coalitions
- Ensure data systems capture the most important information

BUILDING ON CURRENT INITIATIVES

- Leading Health Indicators for Healthy People
- AHRQ’s National Healthcare Quality Report
- CMS’s ACO Measures
- Consumer Reports health rating metrics
- ONC’s Meaningful Use
- NOF’s Buying Value and MAP
- NCQA’s Quality Measurement Programs

This graphic summarizes themes that emerged from a workshop. For more information, please visit www.iom.edu/countingwhatcounts.

NOTES: ACO = accountable care organization; AHRQ = Agency for Healthcare Research and Quality; CMS = Centers for Medicare & Medicaid Services; MAP = Measure Applications Partnership; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; ONC = Office of the National Coordinator for Health Information Technology.
Measures

- Important
- Valid and reliable
- Usable
- Feasible

Measure Development Process

- Collaborative
- Transparent
- Objective
- Meaningful
Dental Caries: Prevention and Disease Management

• Environmental Scan

• Starter Set of Concepts

• Fully Specified Measures (based on administrative enrollment and claims data)
## Overview

http://www.ada.org/8472.aspx

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<th>Purpose</th>
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<td>Evaluating Quality of Care (Evidence-Based with link to outcomes)</td>
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<td>Sealant use in 6 – 9 years</td>
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<td>Care Continuity</td>
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<td>Usual Source of Services</td>
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<td>Evaluating Cost</td>
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<td>Cost</td>
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## Using a Measure Set

<table>
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<th>Measure Set</th>
<th>Indicators</th>
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<td>Linked to Care</td>
<td>• Utilization of Services, Oral Evaluation: Access</td>
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<td>Retained in care</td>
<td>• Care Continuity, Usual Source of Services</td>
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<td>Prevented</td>
<td>• Fluoride, Sealants, Preventive Services</td>
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<tr>
<td>Pt. Engaged</td>
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<td>Healthy</td>
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</tbody>
</table>
Measure

DEN 1 (Access)
“among all enrollees”

DEN 2 (Process)
“among all users”

Dental Service
Oral Health Service
Dental OR Oral Health Service
Dental OR Oral Health Service
Dental Service
Oral Health Service
Dental OR Oral Health Service

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Valid and Reliable scores can only be obtained if specifications are followed.
Measures in More Detail

Following slides illustrate measures for:

- **“Dental” Services**
  - Measures can also be run for “oral health” services or combined dental/oral health

- **Denominator 1** - all enrollees meeting age/enrollment/risk criteria
  - DEN 2 focuses on subset of Den1 enrollees who had at least one service

**Note:** Detailed specifications should be consulted prior to implementation.
**Utilization of Services**

**What:** Percentage of children who receive at least one dental service during reporting year

**Denominator:** Children <21 years and continuously enrolled ≥ 6 months

**Numerator:** Subset of DEN who received at least one dental service

**Purpose:** Overall use of services measure; provides context for other measures

**Note:** 90-day enrollment option for comparison to current CMS 416

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**Oral Evaluation**

**What:** Percentage who receive at least one periodic or comprehensive oral evaluation during the reporting year

**Denominator:** Children <21 years and continuously enrolled ≥ 6 months

**Numerator:** Subset of DEN who received at least one oral evaluation

**Purpose:** Access and process measure

**Note:** 90-day enrollment option
**Preventive Services**

**What:** Percentage who receive fluoride or sealants during the reporting year

**Denominator:** Children <21 years, continuously enrolled ≥ 6 months, and at elevated risk for caries

**Numerator:** Subset who received a topical fluoride application and/or sealants

**Purpose:** Captures overall receipt of at least one primary prevention service for those at elevated risk

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**Treatment Services**

**What:** Percentage who receive at least one treatment service during the reporting year

**Denominator:** Children <21 years and continuously enrolled ≥ 6 months

**Numerator:** Subset who received at least one treatment service

**Purpose:** Use of services; used in conjunction with other measures (e.g., evaluate prevention and treatment trends over time)

**Note:** 90-day enrollment option for comparison to current CMS 416 Preventive Services and Treatment Services
**Care Continuity**

**What:** Percentage who had an oral evaluation in each of two years

**Denominator:** Children <21 years, continuously enrolled ≥ 6 months in reporting year and continuously enrolled ≥ 6 months in prior year

**Numerator:** Subset who received a comprehensive or periodic oral evaluation in the reporting year and in the prior year

**Purpose:** Designed to capture continuity of access to/use of care over time

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**Usual Source of Services**

**What:** Percentage who visited the same practice or clinical entity in each of two years

**Denominator:** Children <21 years, continuously enrolled ≥ 6 months in reporting year and continuously enrolled ≥ 6 months in prior year

**Numerator:** Subset who received a dental service from the same practice/clinical entity in the reporting year and in prior year

**Purpose:** Designed to measure whether the child has a usual source of dental care
Fluoride Intensity

What: Percentage who receive 0, 1, 2, 3, >4 fluoride treatments during the reporting year

Denominator: Children <21 years, continuously enrolled ≥11 months, and at elevated risk for caries

Numerator: Subset who received 1, 2, 3, >4 topical fluoride applications

Purpose: Addresses both receipt and intensity

Sealants

What: Percentage who received a sealant
- Measure 1 - 6-9 years on 1st permanent molar
- Measure 2 - 10-14 years on 2nd permanent molar

Denominator: Children (Measure 1: 6-9 years)
(Measure 2:10-14 years); continuously enrolled ≥6 months; elevated risk for caries

Numerator: Subset who received a sealant on
Measure 1 – 1st permanent molar
Measure 2 – 2nd permanent molar

Purpose: Addresses age-specific prevention
**PMPM Cost**

**Enrollment:** ≥ 1 month

**Measure:** Per member per month cost for dental/oral health services receive during year

**Denominator:** Total dental member months for children <21 months, enrolled at least one month in dental coverage

**Numerator:** Total amount paid for dental services

**Purpose:** Cost of care; resource use

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**Stratifications**

**What:** Measure rates can be stratified by sub-populations of interest.

**Examples:**
- Age
- Race
- Ethnicity
- Geographic Location

**Purpose:** Identify and monitor disparities in use, access, quality

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Topical Fluoride, Elevated Risk, Dental

Enrolled 12 months, allowing a one-month gap

68% had at least one TF
61% had at least one TF
78% had at least one TF
62% had at least one TF

Sealants for 6-9 Years Elevated Risk, Dental

Enrolled 6 months continuously

Sealants for 10-14 Years Elevated Risk, Dental

Enrolled 6 months continuously
Stratification by Age – Oral Evaluation Dental Services

Program 1

- Total: 26.3%
- <1 year: 0.3%
- 1-2 years: 5.8%
- 3-5 years: 28.0%
- 6-7 years: 37.3%
- 8-9 years: 40.1%
- 10-11 years: 36.7%
- 12-14 years: 32.3%
- 15-18 years: 27.1%
- 19-20 years: 15.7%

Program 2

- Total: 66.6%
- <1 year: 18.7%
- 1-2 years: 58.8%
- 3-5 years: 73.6%
- 6-7 years: 76.3%
- 8-9 years: 76.2%
- 10-11 years: 75.1%
- 12-14 years: 71.5%
- 15-18 years: 62.0%
- 19-20 years: 36.7%
Measure Implementation: Importance

- What are your program’s overall goals for oral health?
- How do existing measures map to those goals?
- Consider how specific measures and measure sets will allow your program to
  - Identify baseline performance
  - Develop performance improvement initiatives
  - Monitor and track progress over time
  - Identify disparities in performance by enrollee and program characteristics
Measure Implementation: Feasibility

- Assess whether critical data elements for each measures are currently captured in administrative data.
- What measures can you calculate now?
- What measures are missing critical data elements?
  - Assess the steps, relevant stakeholder involvement, and resources required to capture missing data for future measurement.

Data fields critical to calculating the measure must be consistently available for capture in administrative databases.
Reliability is the degree to which the measure allows for meaningful comparisons across reporting entities (states, programs, plans, providers).

- Reliability is promoted by clear measure specifications and consistent implementation of those specifications
  - Review specifications carefully (http://www.ada.org/8472.aspx)
  - Implement measures according to specifications
  - Seek clarification if unsure about how to implement measures
    - Refer to Measure User Guide (http://www.ada.org/8472.aspx)
    - Submit questions to DQA
  - Note any deviations from specifications or data limitations in reporting
Measure Implementation: Reliability

Reliability is promoted by use of standardized data elements and requires complete and accurate data

- Assess missing and invalid rates of critical data elements
  - Identify where data collection and quality can be improved
- Are standardized codes being used where available?
- What policies, practices are in place to evaluate data quality?
Measure Implementation: Validity

Validity refers to the extent to which a measure truly measures what it is intended to measure.

- Measure validity is promoted by data element validity
  - Is administrative data quality regularly assessed to ensure the validity of the data elements used to calculate the measures?
    - CMS External Quality Review Encounter Data Validation Protocol

- How do measure rates for newly implemented measures compare to rates reported for similar measures for the same plans/programs?
“The only way to know whether the quality of care is improving is to measure performance.”

Future Measures

- ED Use
- Follow-up after ED
- GA Use
- Treatment in sealed tooth
- Early tooth extraction
- Adult measures
- eCQM’s
W. Ken Rich, DDS
Kentucky Medicaid Dental Program Director
Relevance to State Programs

• More accountability required
• Federal and state mandates
  – Quality of care is a priority
  – Costs must be controlled
Quality Measurement is New for Medicaid Programs

- Some states are ahead of others
  - They have developed *their own* quality measures
- Others contract with vendors
Need for Uniformity

• Need for uniformity across federal and state programs, and plans
• Must measure apples to apples
• Must define the parameters or inclusion criteria
  – If using claims data- must define which CDT codes will be used in numerators and denominators
  – Need to understand why each has been selected as inclusion criteria and why some have not
Need for Broader Measures

• CMS-416 data provides limited program information
  – Only measures “access” or “use of services”
• AHRQ domains identify other important areas for measurement within a program
• All must ultimately be measured
• This starter set addresses some of the other domains
• Also teaches us how to better use our claims data to improve our programs
Challenges with Implementation

• Variability in state program administrative models exists

• DQA measures will need to be part of all administrative model types
  – FFS programs may implement simply through data processing services
  – MCO programs must include contractual arrangements with detailed measurement specificity
  – Dashboards via other external vendor- need also to include these measures
In Kentucky

• We are exploring the use of the DQA Starter Set of Measures

• Why?
  – Because we believe that performance measurement will lead to improved quality in our program.

• Who?
  – Director; Managed Care; IT, Dental Program Staff

• What?

• When?
  – 2014
Resources

• Information on DQA: http://www.ada.org/5105.aspx
• DQA Measure Set: http://www.ada.org/8472.aspx
• Future DQA measures/activities: http://www.ada.org/7503.aspx
• DQA Educational Resources: http://www.ada.org/7504.aspx
ANNUAL SYMPOSIUM

State Contracting: Improving Medicaid Program Quality and Value

Washington Marriott Wardman Park,
Washington DC
June 8th, 9th and 10th, 2014
Krishna Aravamudhan, BDS, MS
Dental Quality Alliance

**Dr. Krishna Aravamudhan** serves as the Sr. Manager in the Office of Quality Assessment and Improvement at the American Dental Association. Previously, Dr. Aravamudhan has served as the Associate Director of the ADA’s Center for Evidence Based Dentistry (EBD) where she led the development of clinical guidelines and managed the EBD Website and critical summaries. Krishna currently serves as the lead staff for the Dental Quality Alliance and the ADA’s Peer-Review program. Krishna staffs the DQA’s efforts in developing performance measures using claims data as well as eMeasures.
Jill Boylston Herndon, PhD
University of Florida

Dr. Herndon is an Associate Professor in the Department of Health Outcomes and Policy at the University of Florida. Dr. Herndon is a health economist and health services researcher with expertise in analyzing access to and quality of care in Medicaid and CHIP programs. Dr. Herndon led the feasibility, reliability and validity testing of the Dental Quality Alliance’s starter set of pediatric oral health performance measures. Jill’s research has been published in a broad range of journals in the medical and social sciences.
W. Ken Rich, DMD
Kentucky Medicaid Dental Director

William (Ken) Rich, DMD is currently the Kentucky Dental Medicaid Director. In June 2013 Dr. Rich was also elected as the MSDA President for a two year term. In addition, Dr. Rich is the Dental Quality Alliance (DQA) CHAIR elect. Dr. Rich is a former ADA Trustee. Dr. Rich has spent 38 years as a practicing private practice dentist in Dry Ridge, Kentucky.
Martha M. Dellapenna, RDH, MEd
Center Director

Martha Dellapenna is the MSDA Center Director. In this role, Ms. Dellapenna provides oversight to the projects and activities of each division within the Center. She is the former Project Manager for the Rhode Island Oral Health Access Project. Ms. Dellapenna joined the RI Department of Human Services in the Center for Child and Family Health in 2003 through its project management contractor, Xerox. Ms. Dellapenna’s primary role at that time was to manage the development of RIte Smiles, the state’s first managed care dental program for young children. Ms. Dellapenna is also the current Chair of the Center for Medicare and Medicaid Services (CMS) Oral Health Technical Advisory Group.
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