Quality Resource Guide

Value Considerations in Oral Health Care

Author Acknowledgements

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Educational Objectives

Following this unit of instruction, the reader should be able to:

1. Define value as it relates to health care.
2. Identify factors underlying the growing emphasis on value in health care.
3. Identify major domains of quality outlined by the Institute of Medicine/ National Academy of Medicine.
4. Identify initiatives/strategies aimed at improving value in health care.
5. Identify examples of value-based care involving oral health care.

MetLife designates this activity for **1.0 continuing education credits** for the review of this Quality Resource Guide and successful completion of the post test.

The following commentary highlights fundamental and commonly accepted practices on the subject matter. The information is intended as a general overview and is for educational purposes only. This information does not constitute legal advice, which can only be provided by an attorney.

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The content of this Guide is subject to change as new scientific information becomes available.

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Introduction

Value considerations are taking on growing importance in efforts to reform and improve the U.S. health care system, including oral health care. As a result, there is increasing interest in understanding the concept of value as it relates to oral health care and its application to clinical practice and third-party benefits. Factors underlying the emphasis on value include: continuing cost increases and cost shifting to consumers; variations in care and costs without demonstrated differences in outcomes; consolidation of purchasing power intent on reducing costs; increasing attention to chronic diseases and associated disease management strategies; and growing emphasis on improving population health via more effective and efficient clinical care, combined with non-clinical approaches for promoting health across diverse communities. This updated Quality Resource Guide has been developed to equip readers interested in the concept of "health care value" with a foundation and overview of current major initiatives being pursued to advance increased value in health care, including oral health care.

The U.S. Health Care Environment

Dynamic and profound changes are occurring throughout the U.S. health care system. Concerns about cost, affordability and accountability are major drivers of efforts to reform the way that health care in the U.S. is organized, delivered, financed and reimbursed.

At a macro level, health care spending comprises nearly 18% of the U.S. gross domestic product, nearly 50% more than the next-highest country and double the average for other developed nations.[1] U.S. health care spending grew 4.1 percent in 2022, reaching $4.5 trillion or $13,493 per person.[2] Sources of payment for U.S. health expenditures in 2022 included: private insurance – $1.29 trillion; Medicare – $944 billion; Medicaid – $806 billion; other insurance – $172 billion; and out-of-pocket – $471 billion.[2]

Spending on dental services totaled $165.3 billion or $500 per person in 2022, an increase of over $25 billion since 2020.[2] Given that an estimated 43 percent of the U.S. population used dental services in 2021,[3] spending on dental care equated to an average of approximately $1,160 per person who used dental services. Sources of payment for U.S. dental expenditures in 2022 included: private insurance – $68 billion; government programs – $28 billion; other programs – $2 billion; and out-of-pocket – $67 billion.[4] In 2021, 53 percent of children (0-18) were covered by private dental plans, 38 percent by public programs (*e.g.,* Medicaid, CHIP), and 9 percent had no coverage. For adults (19-64), 61 percent were covered by private plans, 16 percent by public programs, and 23 percent had no dental coverage.[3] With limited exceptions, dental benefits are not provided to seniors (65+) enrolled in original Medicare, but are included in many Medicare Advantage plans.

Compared to other types of health care services, cost barriers are most severe for dental care services – with 13 percent of the population reporting cost barriers to dental care, compared to 4-5 percent for other health care services.[3] In addition to concerns about absolute and relative levels of U.S. health care costs, including dental care, there is growing concern that these higher expenditures do not consistently result in higher quality care or better health outcomes. For example, the U.S. has the highest death rates for avoidable or treatable conditions among 13 high-income countries.[1] A male child born in the U.S. in 2021 had an estimated life expectancy of 73.5 years, ranking the U.S. in 44th place among all countries. On average, U.S. women are expected to live to 79.3. By comparison, within the European Union, average life expectancies for males and females are 77.7 and 83.3 years respectively.[5]

Cost is the foremost, but not the only reason for forgoing the use of dental services.[6] Other top reasons noted in recent surveys include respondents reporting having a healthy mouth (no perceived need for dental care) and not having time to get to a dentist. The top reason why privately insured and high-income adults report not planning to visit the dentist in the next 12 months is due to perceived lack of need.[7] Collectively, these findings highlight the issue of value – outcomes obtained relative to costs, or the relative worth or importance that consumers and purchasers assign to dental care.[8,9]

Defining Value

Value in the context of health care has been defined as the ratio of the level of quality, performance or outcomes achieved for a given level of cost.[10] Put more simply, value is the relationship between the benefits of health care and the cost of providing or obtaining that care.[8,9] Accordingly, to understand value as it relates to health care, one must understand current concepts of quality, performance and outcomes.

A universally accepted definition of ***quality*** as it relates to health care has been elusive, but the following examples are often cited and used to convey the important tenets of health care quality:

- The Agency for Healthcare Research and Quality (AHRQ), the federal government's leading agency charged with improving the quality, safety, efficiency and effectiveness of health care for all Americans, defines quality health care as: "doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."[11]
- The Institute of Medicine (IOM), which became the National Academy of Medicine (NAM) in 2015, defines quality health care as: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[12]
- The Health Resources and Services Administration (HRSA) defines quality health care as: "The provision of appropriate services to individuals and populations that are consistent with current professional knowledge, in a technically competent manner with good communication, shared decision-making and cultural sensitivity."[13]

The broad concept of quality generally is further divided into the following six major domains or aims for health care systems initially put forth by the IOM:[14]

- **Safe:** Avoiding harm to patients from the care that is intended to help them;
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively);
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care;
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas and energy;
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, country of origin, geographic location and socioeconomic status.

Performance generally refers to the degree to which a health program, plan, organization or providers meet established process or outcome goals, or provide services according to evidence-based guidelines. Narrow definitions of ***outcomes*** are limited to clinical outcomes or changes in health status, while broader definitions include assessments of patients' experiences with care and health-related behaviors. Outcomes, the numerator of the value equation, are inherently condition-specific and multidimensional.[10]

Determining the level of quality, performance or outcomes depends on having scientifically sound measures of the attributes of interest. Despite strong emphasis and preference for the development and use of outcome measures in assessing quality, performance and value, numerous data collection challenges initially led to reliance of process measures. However, increasing access to electronic clinical data systems and validation of Patient Reported Outcome Measures (PROMs) hold promise for greater use of outcome measures going foward.

Consumer Perspectives on Health Care and Value

An important part of the IOM's framework looks at consumer perspectives of health care needs, which reflect Foundation for Accountability (FACCT) research showing that consumers think about health care according to the following categories:

- ***Staying Healthy*** – Getting help to avoid illness and remain well;
- ***Getting Better*** – Getting help to recover from an illness or injury;
- ***Living with Illness or Disability*** – Getting help with managing an ongoing, chronic condition or dealing with a disability that affects function;
- ***Coping with the End of Life*** – Getting help to deal with a terminal illness.

Recent surveys indicate that customer service and convenience also are key components of the health care value equation for consumers. In focus groups, consumers defined "quality care" as providers that take their time during an appointment, are easily accessible and convenient, exhibit good 'bedside manner' and demonstrate knowledge and technical proficiency.[15]

The other component of the value equation, cost or price, is slowly becoming more transparent and available for consumers, providers and payers; however barriers to understanding the cost of care are numerous and often perplexing. The message that "more isn't always better" has not yet fully resonated with consumers, despite research that shows higher health care costs do not necessarily lead to higher quality health care.[16]

Growing consumer demands for value in health care are seen as key drivers for changes in the way that health care is financed and delivered, including:

- Emergence of choice-oriented coverage;
- Employer risk-sharing and enhancements to support consumer choice;
- Improved consumer accessibility to quality ratings and price information.[15]

Current Efforts to Increase Value in Health Care

A number of initiatives focused on increasing value in health care have been promulgated recently by federal and state agencies, and by private organizations. Prominent among them are: (1) efforts to implement the Institute for Healthcare Improvement (IHI) Triple Aim concept put forth by Dr. Don Berwick and colleagues, and its adaptation as the National Quality Strategy; (2) strategies focused on "value-based care" or "value-based purchasing" and increased accountability; and (3) efforts to restructure care delivery systems.

The Triple Aim contends that improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.[17] Promising innovations being applied in health care include: implementation of patient-centered medical home strategies; non-traditional sources of care such as small, walk-in preventive and primary care facilities; new telecommunications (telehealth) modalities; and lean production methods. The IHI has developed and is using a balanced set of system-wide measures closely related to the Triple Aim, and has developed a more complete set of system metrics to track the experience of care in ambulatory settings – including measures of patient engagement, continuity and clinical preventive practices. The Triple Aim concept relies heavily on implementation of quality improvement (QI) methods and runs counter to previous frameworks such as The Iron Triangle

of Health Care, which viewed cost cutting as an inherent threat to access and/or quality.[8] Numerous successful applications of QI and the Triple Aim focused on integrated care systems and system redesign have been documented (https://www.ihi.org/), and subsequently led to the adoption of this approach as the basis for the federal government's National Quality Strategy (http://www.ahrq.gov/workingforquality/). The concept of the Triple Aim has been expanded to the Quadruple Aim –adding a goal of improving the work life of health care providers, including clinicians and staff, to improve retention and morale within the health care workforce.[18]

Value-Based Care (VBC) care ties the amount that health care providers earn for their services to the results they deliver for their patients, such as the quality, equity and cost of care. Through financial incentives and other methods, value-based care programs aim to hold providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.[19]

A related strategy, ***Value-Based Purchasing (VBP)***, seeks to measure, report and reward excellence in health care delivery. Value-based purchasing involves the actions of coalitions, employer purchasers, public sector purchasers, health plans and individual consumers to make decisions, taking into consideration access, price, quality, efficiency and alignment of incentives across stakeholders. Effective health care services and high-performing health care providers are rewarded with improved reputations through public reporting, enhanced payments through differential reimbursements, reduced administrative requirements and increased market share through purchaser, payer and/or consumer selections. The premise underlying VBP is summarized as follows: "*Purchasers buying on quality, service and cost, rather than cost alone, will catalyze the re-engineering of health care toward a system of population health improvement and management and a value-driven system in which ever-increasing quality of care is achieved at the lowest possible cost.*"[20]

Tenets of VBP emphasize:

- Standardized performance measurement conducted on multiple levels, including health plans, hospitals, clinician groups and individual health care practitioners;
- Transparency and public reporting on performance;
- Payment innovation geared toward payment for bundles of services or complete episodes of care; and
- Informed consumer choices, including lifestyle choices, patient preferences for treatment and selection of providers.

In addition to public reporting sites such as the federally run Hospital Compare (https://hospitalcompare.io/), several organizations – such as Healthgrades.com and Consumer Reports – have developed websites and apps that collate quality and safety data and make information accessible to consumers in a user-friendly way. The Medicare Advantage program also has a five-star quality rating system, which was developed to make ratings of health plan service and quality more transparent. The Medicare Star Ratings System measures the performance of health plans in more than 50 areas, which are then grouped into five categories: (1) Screenings, tests, and vaccines; (2) Managing chronic conditions; (3) Plan responsiveness and care; (4) Members complaints, problems getting services, and choosing to leave the plan; and (5) Customer service.[15]

VBP efforts initially were focused on hospital care, but have since been expanded to other health care sectors. In recent years, VBP models have become more common across the U.S. health system, increasing from 30 percent to 40 percent of payments between 2016 and 2021.[21]

Restructuring health care delivery systems includes the development of Accountable Care Organizations, Coordinated Care Organizations and other inter-organizational arrangements, including Dental Support Organizations and Dental Group Practices.

An Accountable Care Organization (ACO) is a group of providers – which can include both clinicians and hospitals – that accepts joint responsibility for health care spending and quality for a defined population of patients. The ACO concept can be considered an extension of the staff model health maintenance organization (HMO) and shares features with the patient-centered medical home (PCMH) model in its focus on a robust primary care nexus that serves to coordinate patients' care. According to the ADA Health Policy Institute,[22] most ACOs in place as of 2015 were not responsible for dental care as part of their contracts. The top reason ACOs report for excluding dental care is a lack of integrated health information technology. The perceived potential for cost savings associated with dental care is the top motivation among ACOs that include or plan to include dental care.

Coordinated Care Organizations (CCOs) are regional networks in Oregon, consisting of all types of health care providers—including dental care providers—who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention, chronic disease management and early intervention, while working to reduce waste and inefficiencies in the health care system. CCOs are required to meet quality standards that show how well they are improving key areas such as access to care, prevention and health screening, mental health care, and other areas. Reports are published regularly on the performance of CCOs.

Dentistry has been called the last cottage industry in health care because the dominant mode of care delivery has been one- or two-provider practices privately owned by dentists and with relatively small numbers of employees. However, new models of dental practice are emerging and expanding, notably Dental Service Organizations (DSOs) and Dental Group Practices. In 1990, almost 93 percent of dentists chose to care for their patients in small private practices, according to ADA survey data. By 2009, that number had dropped to 86 percent, and the percentage of

employed dentists had more than doubled.[23] Recent data from the ADA Health Policy Institute,[24] indicate that in 2021 the percent of dentists who were in solo practice had declined to 46 percent, and that early career dentists are far more likely to practice in larger groups and far more likely to be affiliated with a DSO. Overall, the percentage of U.S. dentists affiliated with a DSO increased from 8.8 percent in 2017 to 13 percent in 2022.

Value Considerations for Dental Practice

A report commissioned by the ADA Health Policy Institute[25] concluded that with increased demand for value in dental care spending, practices will need to become more efficient. The trend towards larger, multi-site practices will likely continue, driven by dental plan pressures for smaller provider networks with demonstrated levels of performance, trends in dental school graduates' employment choices, and increased competition for patients. Moreover, continuing health care reform and public program expansions – with an increasing emphasis on outcomes and cost-effectiveness – will encourage growth of alternative models of dental care delivery, benefits, financing and value-based payments. Ultimately, the authors of the ADA-commissioned report envision that the impact will be felt more broadly, as there will be pressure to increase value and reduce costs from all payers – governments, employers and individuals.

Continuing pressure to reduce costs and improve health outcomes will drive innovation, including exploring alternative care delivery models. The Affordable Care Act (ACA) seeks to promote increased coordination of care, providing an opportunity to bridge historical gaps between oral and general health care and to re-examine the role of oral care providers within the health care system. Immediate opportunities initially appeared within programs for pediatric and Medicaid populations. However there is growing evidence of benefits arising from medical-dental integration for adults and seniors involving large Dental Group Practice organizations such as Permanente Dental Associates (in collaboration with Kaiser Permanente Northwest) and Health Partners.[26,27]

Value Considerations for Medical and Dental Health Benefits

The ACA increased health care costs for many employers; and the majority believe that, absent changes in plan designs and financing, escalating cost pressures will continue. The ACA also has created additional choices for consumers and purchasers, highlighting the importance of understanding how consumers think about and value health care and health benefits. A report from the ADA Health Policy Institute revealed key value-related differences in consumer attitudes about medical plans and dental plans.[28] Specifically, the report found that when asked about preferences for medical and dental plans, the majority of adults indicated they prefer a dental plan that costs less and has limited provider choice, even if this means they might no longer be able to visit their usual dentist. In contrast, for medical plans, the majority of adults indicated they prefer a plan that costs more and has a broader choice of providers. Young adults and low-income adults have the strongest preference for less costly dental plans that have a more limited choice of providers. Only adults with incomes above 400 percent of the Federal Poverty Level prefer higher-cost dental plans with broader choice of providers.

Rather than merely being expected to reduce or contain costs, medical plans and dental plans increasingly are being called upon to use the data they collect to demonstrate value in terms of improved health outcomes and consumer satisfaction. Outcome measurement in dentistry has been limited by a host of organizational, behavioral and technological challenges – *e.g.,* limited requirements or incentives for submitting diagnostic codes to provide information about why dental services are being provided, and limited ability to access clinical oral health status data contained in electronic health/dental records.

Recent developments concerning data collection on patients' oral health status include validation and use of a five-item Oral Health Impact Profile (OHIP-5). The OHIP-5 is a widely used oral health-related quality of life instrument, which captures data on the extent of adults' difficulties with oral function, orofacial pain, ability to taste food, orofacial appearance and psychosocial impact.[29,30] The Dental Quality Alliance recently issued a Request for Proposals to conduct feasibility, reliability and validity testing of OHIP-5-derived patient-reported outcome performance measures for use in assessment of systems, programs or plans.[31] The Centers for Medicare and Medicaid Services (CMS) also has shown interest in using the OHIP-5 as part of the Medicare Current Beneficiary Survey.[32]

Despite research suggesting that integration of medical and dental care may benefit patients,[26] financing and delivery of dental care remains largely disconnected from other health services, even among health insurance plans and ACOs working to improve overall population health. Continued medical-dental care integration may provide opportunities for improved accountability for total health; yet to date, there appears to be little in the way of broad-based incentives for health plans to facilitate access to integrated services.

A number of models and pilot studies involving value-based payments for dental services continue to be highlighted in industry publications, while simultaneously acknowledging challenges that limit more wide-spread adoption.[33] A framework outlining steps that could be taken to transition payment from the current predominant fee-for-service system to various alternative payment models have been highlighted in recent reports and publications.[9,34] Alternative approaches for increasing value for dental practices involve reducing dentists' administrative or other costs based on practice service delivery profiles, providing expanded benefits and recognizing dentists for customized evidence-based preventive services based on individual risk assessments.[35,36]

Value Considerations for Patients and Consumers

Dental patients expect to have their oral health care needs (diagnosis, treatment and disease prevention or management) met. They also expect to get timely appointments, have easy access to information, have informative communication with and feel known by their oral health care providers, and have good interactions with office staff – *i.e.,* they expect good care experiences.[37] They also expect support to help maintain their oral health. Despite the obvious importance of understanding patients' and consumers' values and experiences, there is little published quantitative research that has examined patient experiences with oral health care.[37] Financial considerations – *i.e.,* cost of care, insurance coverage, out-of-pocket expenses – are important factors in patients' selection of dentists and decisions about whether to switch to other providers. Patients and consumers increasingly expect to be able to obtain information about health care providers, including dentists. Therefore, improving value for patients and consumers depends on greater availability of credible information on expected costs of care, patient experiences and oral health care outcomes.

Summary

This Quality Resource Guide was developed to provide readers interested in the topic of value, as it relates to dental care and dental benefits, with a conceptual foundation and an updated overview of current major initiatives that are being pursued to advance increased value in health care. Forces underlying the growing emphasis on value are expected to persist and grow. As is often the case, changes in response to these forces initially occur in the larger medical care sectors (hospitals, physicians, Medicare). Nevertheless, evidence of similar types of changes occurring within dental care delivery and dental benefits has begun to emerge. Being informed about the underlying forces and expected changes can help dental practitioners, dental benefit providers and other key stakeholders succeed in the emerging environment. Strategies for demonstrating and increasing the value of dental care include: adopting evidence-based care processes (derived from evidence-based guidelines); developing methods for measuring and reporting value-related aspects of care; adapting care delivery to improve performance consistent with the Triple or Quadruple Aim; creating new care delivery arrangements that can demonstrate and improve value; and enhancing stakeholders' understanding of health care trends, quality improvement, population health and risk-based care.

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POST-TEST

Internet Users: This page is intended to assist you in fast and accurate testing when completing the "Online Exam." We suggest reviewing the questions and then circling your answers on this page prior to completing the online exam.

(1.0 CE Credit Contact Hour) Please circle the correct answer. 70% equals passing grade.

1. **Which of the following is NOT commonly used to define value as it relates to health care?**
   a. Cost
   b. Coverage
   c. Outcomes
   d. Performance
   e. Quality

2. **Factors underlying the growing emphasis on value in health care include all of the following EXCEPT:**
   a. Cost shifting to consumers
   b. Inconsistencies in care
   c. Increases in chronic diseases
   d. Demonstrated improvements in U.S. life expectancy
   e. Rising health care premiums

3. **According to the Institute of Medicine, quality health care should be:**
   a. Accessible
   b. Effective
   c. Efficient
   d. Timely
   e. All of the above

4. **Major initiatives aimed at improving the value of health care in the U.S. include all of the following EXCEPT:**
   a. Iron Triangle of Health Care (access, cost, quality)
   b. Triple Aim
   c. Restructuring health care delivery
   d. Alternate payment methods
   e. Public reporting on performance

5. **Compared to other countries, U.S. total health care spending ranks:**
   a. 1st (highest)
   b. 2nd-highest
   c. 3rd-highest
   d. 4th-highest
   e. None of the above

6. **Compared to other countries, U.S. life expectancy for males ranks:?**
   a. 1st (highest)
   b. 7th-highest
   c. 27th-highest
   d. 44th-highest
   e. None of the above

7. **Examples of entities involved in restructuring health care delivery in the U.S. include which of the following?**
   a. ACOs – Accountable Care Organizations
   b. CCOs – Coordinated Care Organizations
   c. DSOs – Dental Support Organizations
   d. LGDPs – Large Group Dental Practices
   e. All of the above

8. **Which of the following statements is TRUE?**
   a. The percentage of U.S. gross domestic product devoted to health care is approximately 50% higher than the next-highest country.
   b. The percentage of U.S. gross domestic product devoted to health care is approximately 25% higher than the next-highest country.
   c. The percentage of U.S. gross domestic product devoted to health care is approximately 25% lower than the next-highest country.
   d. The percentage of U.S. gross domestic product devoted to health care is approximately 50% lower than the next-highest country.
   e. None of the above

9. **Consumer-driven changes aimed at increasing value include which of the following:**
   a. More choice-oriented benefits coverage
   b. Employer risk-sharing and changes to support consumer choice
   c. Consumer accessibility to quality ratings and price information
   d. All of the above
   e. None of the above

10. **According to results of a recent study commissioned by the ADA Health Policy Institute, which of the following is TRUE?**
    a. Adults place more value on being able to choose a dental care provider than a medical care provider.
    b. Adults place more value on being able to choose a medical care provider than a dental care provider.
    c. Narrow networks are expected to be used less often by commercial dental plans in the future.
    d. Consumers are more concerned about being able to choose their dentist than the cost of their dental plans.
    e. None of the above

Registration/Certification Information (Necessary for proper certification)

Name (Last, First, Middle Initial): _____

PLEASE PRINT CLEARLY

Street Address: _____ Suite/Apt. Number _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Date of Birth: _____ Email: _____

State(s) of Licensure: _____ License Number(s): _____

Preferred Dentist Program ID Number: _____ ☐ Check Box If Not A PDP Member

AGD Mastership: ☐ Yes ☐ No

AGD Fellowship: ☐ Yes ☐ No Date: _____

Please Check One: ☐ General Practitioner ☐ Specialist ☐ Dental Hygienist ☐ Other

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Evaluation - Value Considerations in Oral Health Care 2nd Edition

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Please respond to the statements below by checking the appropriate box, using the scale on the right.

	1 = POOR 1	2	3	4	5 = Excellent 5	
1. How well did this course meet its stated educational objectives?	☐	☐	☐	☐	☐	
2. How would you rate the quality of the content?	☐	☐	☐	☐	☐	
3. Please rate the effectiveness of the author.	☐	☐	☐	☐	☐	
4. Please rate the written materials and visual aids used.	☐	☐	☐	☐	☐	
5. The use of evidence-based dentistry on the topic when applicable.	☐	☐	☐	☐	☐	☐ N/A
6. How relevant was the course material to your practice?	☐	☐	☐	☐	☐	
7. The extent to which the course enhanced your current knowledge or skill?	☐	☐	☐	☐	☐	
8. The level to which your personal objectives were satisfied.	☐	☐	☐	☐	☐	
9. Please rate the administrative arrangements for this course.	☐	☐	☐	☐	☐	

10. How likely are you to recommend MetLife's CE program to a friend or colleague? *(please circle one number below:)*

10 **9** **8** **7** **6** **5** **4** **3** **2** **1** **0**

extremely likely — neutral — not likely at all

What is the primary reason for your 0-10 recommendation rating above?

11. Please identify future topics that you would like to see:

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