Oral Health Quality Improvement for the Maternal and Child Health Population: Identifying a Set of Quality Indicators

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2018

Cite as

Center for Oral Health Systems Integration and Improvement Quality Indicator Advisory Team, National Maternal and Child Oral Health Resource Center, Dental Quality Alliance. 2018. *Oral Health Quality Improvement for the Maternal and Child Health Population: Identifying a Set of Quality Indicators.* Washington, DC: National Maternal and Child Oral Health Resource Center, and Chicago, IL: Dental Quality Alliance.

We would like to extend special thanks to the individuals who contributed to this report (see Appendix 1. Quality Indicator Advisory Team and Other Contributors).

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This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under award #U44MC30806 for the National Maternal and Child Center for Oral Health Systems Integration and Improvement in the amount of $4,000,000 over 4 years with no funding from nongovernmental sources. This information or content and conclusions are those of the authors and should not be construed as the official policy of HRSA, HHS, or the U.S. government, nor should any endorsements be inferred.

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Purpose

The Center for Oral Health Systems Integration and Improvement (COHSII) works with key stakeholders to improve systems of care[1] in support of a high-quality, person- and family-centered approach to address the oral health needs of the maternal and child health (MCH) population. COHSII is a consortium led by the National Maternal and Child Oral Health Resource Center (OHRC) at Georgetown University (GU) and is supported by a cooperative agreement (U44MC30806) from the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). The goal of this 4-year project (2017-2021) is to address three functions: (1) provide technical assistance and training to Title V recipients, (2) establish a set of MCH oral health quality indicators to monitor services delivered in public health programs and systems of care, and (3) develop and disseminate oral health educational resources for providers working in, or with, Title V agencies. OHRC partnered with the Dental Quality Alliance (DQA) and the Association of State and Territorial Dental Directors (ASTDD) in this consortium.

Specifically, DQA is assisting OHRC with goal 2 of the project (i.e., establish a set of MCH oral health quality indicators to monitor services delivered in public health programs and systems of care). Year 1 objectives for goal 2 included:

- Establish and support a Quality Indicators Advisory Team (QIAT) to guide and inform the identification and use of MCH oral health quality indicators.
- Conduct an environmental scan of existing oral health quality indicators and concepts.
- Develop recommendations for MCH oral health quality indicators that can potentially be used in public health programs and systems of care.

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[1] The "system of care" is a **constellation of programs and services** designed to improve the health of the population by increasing access to quality health services, strengthening the health workforce, building healthy communities, improving health equity, and strengthening program operations. Within this constellation lies the oral health care delivery system, a loosely organized network of private practices and the oral health safety net. The private practice community, primarily solo and small group practices, serves about two-thirds of the U.S. population, many of whom have commercial dental benefits or can pay out-of-pocket. The remaining one-third is served by the oral health safety net, which includes private practitioners participating in Medicaid and the Children's Health Insurance Program (CHIP), and private or government–supported health care programs (e.g., Indian Health Service, tribally operated clinics, community health centers (CHCs), health departments, school-based health centers, mobile dental programs, clinics in dental schools and dental hygiene programs).

The purpose of the project is to provide MCHB with a robust set of oral health quality indicators that can be used to establish baseline levels of performance and to monitor progress toward achieving various goals set forth in an MCH Oral Health National Action Plan. Work toward achieving goal 2 was guided by the QIAT. Members of the team are listed in Appendix 1 and include state and national experts representing pediatric oral health, dental, and medical provider organizations, state MCH programs, state oral health programs, CHCs, and managed care organizations.

This report provides the results from the QIAT's efforts and identifies a set of oral health quality indicators for MCH to monitor services delivered in public health programs and systems of care, including, but not restricted to, services supported through the Title V program. Indicators identified in this report are presented as indicator concepts at this juncture, with a detailed users guide including indicator specifications to be developed over the course of the project.

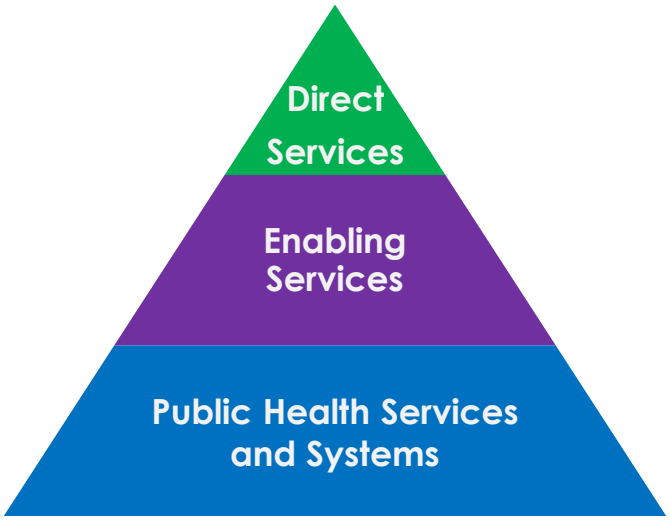
Identifying a Framework for Oral Health Quality Performance Measurement and Improvement

Development of a set of oral health indicators for the MCH population began with the identification of a framework for measurement to support an integrated multi-level approach to quality improvement. A framework for oral health quality performance measurement and improvement provides a model that specifies elements that can and should be measured and monitored to ensure a systematic process of improving quality of services. Clinical care is estimated to contribute as little as 10%-20% to health outcomes.[2] Consequently, a framework for improving the health of the MCH population must take into account the significant impact of non-clinical factors on health outcomes, including social, economic, and environmental factors and health behaviors.

[2] McGovern L, Miller G, Hughes-Cromwick P. 2014. *The Relative Contribution of Multiple Determinants to Health Outcomes.* Princeton, NJ: Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2014/08/the-relative-contribution-of-multiple-determinants-to-health-out.html

A framework can help align improvement efforts within Department of Health and Human Services (HHS) agencies that serve the MCH population. The framework also provides the structure for classifying and prioritizing quality indicators and for identifying measurement gaps. The QIAT developed a framework for goal 2 to encompass key elements of the MCH Pyramid of Services (Figure 1), which identifies three categories: direct services, enabling services, and public health services and systems.

Figure 1. MCH Pyramid of Services and Public Health Services for the MCH Population



MCHB defines these categories as follows:[3]

Direct Services – Direct services are preventive, primary, or specialty clinical services to pregnant women and children, including children with special health care needs (CSHCN).

Enabling Services – Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes. Enabling services include, but are not limited to, case management, care coordination, referrals, translation/interpretation services, transportation, eligibility assistance, health education for individuals or families, environmental health risk reduction, and outreach.

[3] Health Resources and Services Administration, Maternal and Child Health Bureau. N.d. *Glossary* [webpage]. Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. https://mchb.tvisdata.hrsa.gov/Home/Glossary

Public Health Services and Systems – Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation and evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns.

The framework for oral health quality performance measurement and improvement developed by the QIAT parallels the MCH Pyramid of Services and identifies:

- Three **categories of services**: "**Systems**" (programs or collections of elements or components organized for a common purpose), "**Community-Based Systems and Supports**," and "**Care**" (services provided directly to individuals, generally in clinical settings).
- Five **measurement domains** adapted from the Donabedian model for measuring quality: access, utilization, structure, process, and outcomes.[4]
- Multiple **quality/performance constructs or elements** within each category of service and measurement domain.

The framework for oral health quality performance measurement and improvement developed by the QIAT is depicted in Figure 2, with related definitions provided in Table 1.

[4] Donabedian A. 1966. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly* 44(3) (Suppl):166-206. Reprinted as Donabedian A. 2005. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly* 83(4):691-729.

Figure 2. Proposed Framework for Oral Health Quality Performance Measurement and Improvement

	SYSTEM	COMMUNITY-BASED SYSTEMS AND SUPPORTS	CARE
ACCESS	Eligibility Provider availability	Transportation	Provider availability Appointment availability Scope of services
UTILIZATION	Use of services Site of care	Use of services Site of care	Use of services Site of care
STRUCTURE	Leadership coordination Health information technology Case management Transitions to adulthood Provider training Scope of benefits Level of funding Policy linked with evidence Facilities and equipment	Facilitating service-delivery programs in community sites Health information technology Case management Supportive environment in a medical-dental neighborhood based on needs	Leadership coordination Service-delivery partnerships in community sites Health information technology Case management Provider training Coding
PROCESS	Enrollment Person-/family- centered care Population education	Enrollment (outreach) Person-/family- centered care Community needs assessment	Enrollment (assistance) Person-/family- centered care Culturally competent care Case management Evidence-based care Referral
OUTCOME	Health status (population) Patient-reported outcomes Health care system experience Health literacy	Health status (community) Patient-reported outcomes Health care system experience Health literacy	Health status (individual) Patient-reported outcomes Care experience Health literacy

Assuring health

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Table 1. Quality/Performance Indicator Constructs/Element Definitions

Provider – Oral health providers and other health providers (e.g., physicians, nurses, nurse midwives, nurse practitioners, physician assistants) providing oral health services.

MCH Population – Women of reproductive age, pregnant women, infants, children, and adolescents, including those with special health care needs.

Construct	Definition
Domain: ACCESS	
Eligibility	Clear policies and user-friendly tools to support eligibility verification and continuity of eligibility in private and public programs.[5]
Provider Availability	The availability of providers to ensure that benefits for beneficiaries are accessible without unreasonable travel or time delays.
Transportation	Accessible and affordable transportation services are available to connect patients to care sites.
Appointment Availability	Appointments are available during early morning, evening, and weekend hours in addition to typical business hours.
Scope of Services	Range of services provided to pregnant women and children of various ages.
Domain: UTILIZATION	
Use of Services (indicator)	Provision and utilization of services by a group of individuals identified by enrollment in a health plan or through use of clinical services.[6]
Site of Care (indicator)	Timely care provided in an appropriate setting.
Domain: STRUCTURE	
Leadership Coordination	Program leaders work across programs in the state to optimize resources, services, and supports.
Service-Delivery Partnerships in Community Sites	Services are provided in community-based clinical settings and/or in conjunction with other organizations or programs.
Health Information Technology	Interoperable health records and data aggregation technologies (including between private and public programs) (e.g., registries) across multiple levels of the health care system are in place to support care coordination, care continuity, referral systems, and data sharing along with the ability to report quality indicators at each level of the health care system (e.g., dental sealants provided to children enrolled in

[5] Definitions adapted from Association of Maternal and Child Health Programs. 2014. *Standards for Systems of Care for Children and Youth with Special Health Care Needs*. http://www.amchp.org/AboutTitleV/Resources/Documents/Standards%20Charts%20FINAL.pdf

[6] National Quality Measures Clearinghouse. http://www.qualitymeasures.ahrq.gov/about/domain-definitions.aspx

Construct	Definition
	Medicaid in school-based programs should be accounted for). Providers should be able to access data on quality or performance indicators (e.g., via practice and/or systems dashboards).
Case Management	A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet a person's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.[7]
Transitions to Adulthood	Children and adolescents receive services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence (e.g., care for CSHCN).[8]
Establishment of a Medical-Dental Neighborhood that Provides a Supportive Environment Based on Needs	The medical-dental neighborhood is a clinical-community partnership that provides the medical, dental, and social supports necessary to enhance health, with the patient-centered medical home coordinated with the patient-centered dental home, serving as the primary "hub" and coordinator of health care delivery.[9] The medical-dental neighborhood is composed of a patient-centered medical home (PCMH), coordinated with a patient-centered dental home (PCDH), and the constellation of other clinicians providing health care services to patients within it, along with community and social service organizations and state and local public health agencies. The PCMH, the PCDH, and the surrounding medical-dental neighborhood can focus on meeting the needs of patients but can also incorporate aspects of the health needs of the population and overall community in its objectives.[10]
Provider Training	Clinical providers and non-clinical team members receive training that incorporates evidence-based guidelines, integration of oral health care and primary health care, caring for diverse populations, and quality-improvement principles and methodologies.
Scope of Benefits	Coverage of services based on nationally recognized guidelines (e.g., Bright Futures, Early and Periodic Screening,

[7] Case Management Society of America. 2018. *What Is a Case Manager* [webpage]. http://www.cmsa.org/who-we-are/what-is-a-case-manager

[8] Adapted from Association of Maternal and Child Health Programs. 2014. *Standards for Systems of Care for Children and Youth with Special Health Care Needs*. Washington, DC: Association of Maternal and Child Health Program. http://www.amchp.org/AboutTitleV/Resources/Documents/Standards%20Charts%20FINAL.pdf

[9] Adapted from Patient-Centered Primary Care Collaborative. 2018. *Medical Neighborhood* [webpage]. https://www.pcpcc.org/content/medical-neighborhood

[10] Adapted from Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. 2011. *Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms—White Paper*. Rockville, MD: Agency for Healthcare Research and Quality. https://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms#tocChp2

Construct	Definition
	Diagnostic, and Treatment [EPSDT], U.S. Preventive Services Task Force) for screening, diagnosis, treatment of oral disease, and promotion of oral health.
Level of Funding	Adequate funding and appropriate reimbursement policies are established based upon actuarially sound methodologies.
Policy Linked with Evidence	Effective, evidence-based policies are in place that support the provision of oral health care services for improving oral health for pregnant women and children.
Facilities and Equipment	Availability of health care facilities (e.g., hospitals, emergency departments, clinics, CHCs, medical offices, dental offices) and equipment (e.g., dental operatory, tele-dentistry equipment and technology to support a virtual dental home) that meet federal and state standards, along with state systems to monitor and certify quality and safety.
Domain: PROCESS	
Enrollment	Mechanisms are established to support enrollment (including continuity of enrollment) of pregnant women and children into private dental insurance coverage and public programs that provide oral health care coverage.
Person-/Family-Centered Care	The provision of care that is respectful of, and responsive to, person and/or family contextual elements, preferences, needs, and values and that ensures that the person's and/or family's values guide all clinical decisions.
Community Needs Assessment	Community-level data are used to identify major oral health needs within the community.
Culturally Competent Care	Care is delivered in a manner that meets the social, cultural, and linguistic needs of people[11] in a manner the person understands.
Case Management	A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet a person's and family's comprehensive health needs through communication and available resources to promote high-quality, cost-effective outcomes.[5]
Evidence-Based Care	Oral health care is provided using the judicious integration of systematic assessments of clinically relevant scientific evidence (evidence-based guidelines), relating to the person's oral and medical condition and history, with the oral health care provider's clinical expertise and the person's treatment needs and preferences.
Referral	Pregnant women and children receive appropriate referrals for recommended care.
Domain: OUTCOME	

[11] Betancourt JR, Green AR, Carrillo JE. 2002. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. New York, NY: The Commonwealth Fund.

Construct	Definition
Health Status	The health state of a person or change in health state resulting from health care.
Patient-Reported Outcomes	Any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response.
Care Experience	Experience when a person seeks and receives care, including elements such as ease or difficulty in getting appointments, accessing information, and communicating with health providers.
Health Literacy	The degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[12]

Identifying Existing Indicators Applicable to the MCH Population: Environmental Scan

The framework developed by the QIAT was used to guide the environmental scan. Appendix 2 provides a summary of the methodology used for the scan. More than 2,000 indicators/concepts (before deduplication) and more than 200 articles were scanned (titles, abstracts, and full text, as appropriate). Identified indicators/concepts were deduplicated and entered into an Excel database with the following details included as available: title, description, denominator, numerator, population, age, indicator type (e.g., access, process, outcome), level (e.g., practice, plan, program), data source (e.g., claims, patient record, survey), availability of detailed specifications, current/prior use, source/steward, and framework domain. More than 400 indicators/concepts were included in the database.

Using the results of the environmental scan and the framework as guides, the QIAT identified a preliminary list of indicator concepts for:

- Women of child-bearing age and pregnant women
- Children, including infants, children, and adolescents from birth (or age when data are available) to age 21

[12] Office of Disease Prevention and Health Promotion. 2010. *Quick Guide for Health Literacy*. Rockville, MD: Office of Disease Prevention and Health Promotion. https://health.gov/communication/literacy/quickguide/Quickguide.pdf

Consideration was given to "ideal" **indicators that could drive meaningful improvements** in quality conceptually, in terms of the attributes of the indicators themselves (e.g., whether they were specified and tested for measurement reliability and validity), and as **implementation feasibility** in the short and long term. Appendix 3 provides the preliminary list of indicator concepts identified by the QIAT.

In an effort to further narrow the preliminary list of indicators to arrive at final recommendations for a set of indicators, state dental directors were engaged to provide input on the feasibility and importance of the concepts. Twenty state dental directors provided feedback on the preliminary list of indicators. Appendix 4 provides the questions, and Appendix 5 provides the state dental director's responses. The QIAT used the feedback results to finalize recommendations for the set of indicator concepts for near-term implementation.

Recommended Set of Indicators for Near-Term Implementation

The recommended initial set of quality indicators identified as conceptually important and feasible for near-term implementation are grouped below by MCH population and indicator domain. **Although the majority of these indicators can be computed using existing data sources, they have not been used consistently across the MCH population as part of an integrated and cohesive quality-measurement and -improvement strategy.**

Note that the indicators identified through the Pregnancy Risk Assessment Monitoring System (PRAMS) use data from the "standard" questions, which are the optional questions within PRAMS.[13] States that do not implement these questions will need to do so to report on the set of indicators. Similarly, some of the indicators computed using data from national surveys may not be readily accessible using currently available interactive tools. Thus, states may need to invest resources to enable computation of these indicators.

[13] Centers for Disease Control and Prevention. 2018. *PRAMS Questionnaires*. Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/prams/questionnaire.htm

To reduce disparities and promote equitable care across all constructs, the set of indicators should be stratified by race, ethnicity, and socioeconomic status where data are available.

Set of Indicators: Women of Child-Bearing Age and Pregnant Women

Summary:

Access
- Percentage of pregnant women reporting difficulty getting dental care
- Percentage of pregnant women who had insurance to cover dental care during pregnancy
- Percentage of pregnant women receiving oral health screening or information from medical PCPs

Utilization
- Percentage of women of child-bearing age (18-44 years) who report having a visit to a dentist or dental clinic in the past year

Outcome
- Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy
- Percentage of pregnant women who had a problem with their teeth or gums during pregnancy who received treatment for that problem

ACCESS	
Self-Reported Survey Indicators	
Indicator: Percentage of pregnant women reporting difficulty getting dental care **Denominator:** Number responding to question; exclude unknowns and refusals **Numerator:** Number indicating "yes" to any of the response options **Survey item:** Did any of the following things make it hard for you to go to a dentist or dental clinic about the problem you had during *your most recent* pregnancy? For each item, check No if it was not something that made it hard for you or Yes if it was. o I could not find a dentist or dental clinic that would take pregnant patients o I could not find a dentist or dental clinic that would take Medicaid patients o I did not think it was safe to go to the dentist during pregnancy o I could not afford to go to the dentist or dental clinic	Source: PRAMS Phase 8 – standard (optional) question Y6; Data: Survey of pregnant women. Survey Tab, Row 17
• **Indicator:** Percentage of pregnant women who had insurance to cover dental care during pregnancy **Denominator:** Number responding yes or no to question; exclude unknowns and refusals **Numerator:** Number indicating "yes" to question) **Survey item:** Do you have any insurance that pays for some or all of your dental care? Please include dental insurance, prepaid plans such as HMOs, or government plans such as Medicaid. o No o Yes	Source: PRAMS Phase 8 – standard (optional question) ME83; Data: Survey of pregnant women. Survey Row Tab, Row 20
• **Indicator:** Percentage of pregnant women receiving oral health screening or information from medical PCPs **Denominator:** Number responding to question; exclude unknowns and refusals **Numerator:** Number indicating "yes" to any of the response options **Survey item:** During your most recent pregnancy, did a doctor, nurse, or other health care worker do any of the things listed below? For each item, check No if it is not true or does not apply to you or Yes if it is true. o Ask me about my teeth and gums o Look at my teeth and gums o Talk with me about visiting a dentist or dental hygienist o Help me get dental care o Give me information about taking care or my teeth and gums o Give me information about taking care of my baby's teeth and gums	Source: PRAMS Phase 8 – standard (optional question) FL77; Data: Survey of pregnant women. Survey Tab, Row 21

UTILIZATION	
Self-Reported Survey Indicators	
• **Indicator:** Percentage of women of child-bearing age (18-44 years) who report having a visit to a dentist or dental clinic in the past year **Denominator:** Number of female respondents, aged 18-44 years; exclude unknowns and refusals **Numerator:** Number who report having been to the dentist or dental clinic within the past year **Survey item:** Including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists, how long has it been since you last visited a dentist or a dental clinic for any reason? [Response options only read if necessary.] o Within the past year (any time less than 12 months ago) o Within the past 2 years (1 year but less than 2 years ago) o Within the past 5 years (2 years but less than 5 years ago) o 5 or more years ago o Don't know/not sure o Never	Source: BRFSS 2018; Data: Survey stratified to women of child-bearing age. Survey Tab, Row 22
OUTCOMES	
Self-Reported Survey Indicators	
• **Indicator:** Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy **Denominator:** Number responding yes or no to question Y7, response option "I <u>needed</u> to see a dentist for a **problem**"; exclude unknowns and refusals **Numerator:** Number indicating "yes" to the response option: "I <u>needed</u> to see a dentist for a **problem**" **Survey item:** This question is about the care of your teeth <u>*during*</u> *your most recent pregnancy*. For each item, check No if it is not true or does not apply to you or Yes if it is true. o I knew it was important to care for my teeth and gums during my pregnancy o A dental or other health care worker talked with me about how to care for my teeth and gums o I had my teeth cleaned by a dentist or dental hygienist o I had insurance to cover dental care during my pregnancy o I <u>needed</u> to see a dentist for a **problem** o I <u>went</u> to a dentist or dental clinic about a **problem**	Source: PRAMS Phase 8 – standard (optional question) Y7; Data: Survey of pregnant women. Survey Tab, Row 18
• **Indicator:** Percentage of pregnant women who had a problem with their teeth or gums during pregnancy who received treatment for that problem **Denominator:** Number responding "yes" to **question Y7**, response option "I <u>needed</u> to see a dentist for a **problem**"; exclude unknowns and refusals **Numerator:** Number indicating "yes" to any of the 3 "yes" response options	Source: PRAMS Phase 8 – standard (optional) question Y8; Data: Survey of pregnant women. Survey Tab, Row 19

Survey item: Did you get treatment from a dentist or another doctor for the problem that you were having during your pregnancy? Check ONE answer. o No o Yes, I got treatment during my pregnancy o Yes, I got treatment after my pregnancy o Yes, I got treatment both during and after my pregnancy	

* Row number: match to the accompanying environmental scan Excel sheet.

Set of Indicators: Children

Summary:

Access
- Percentage of children eligible for Medicaid/CHIP who are enrolled in Medicaid/CHIP
- Percentage of children currently covered by health insurance or health coverage plan
- Percentage of children with consistent health insurance coverage during the past 12 months
- Access to dental care [CAHPS]

Utilization
- Percentage of children who had a dental visit in the last 12 months
- Percentage of children at elevated risk receiving preventive dental services

Process
- Percentage of children at elevated risk receiving at least 2 topical fluoride applications as a dental service
- Percentage of children at elevated risk receiving at least 2 topical fluoride applications as an oral health service
- Percentage of children aged 6–9 years at elevated risk who receive sealants in their permanent first molars
- Percentage of children aged 10–14 years at elevated risk who receive sealants in their permanent second molars

Outcomes
- Percentage of children with dental caries experience (treated or untreated tooth decay)
- Percentage of children with urgent dental treatment needs

ACCESS	
System-Level Administrative Databases	
• Percentage of population eligible for Medicaid/CHIP that is enrolled in Medicaid/CHIP **Note:** If not feasible to calculate, use: **KFF Medicaid/CHIP Participation Rates**	Data: Census data to estimate eligible & Enrollment/CMS 416 for enrolled
• Percentage of children currently covered by health insurance or health coverage plan • Percentage of children with consistent health insurance coverage during the past 12 months	Source: National Survey of Children's Health; Data: Surveys. Rows 75 and 76
• Access to dental care Individual Items **For each, report percentage responding "usually" or "always"** • How often were your [child's] dental appointments as soon as you wanted? (Row 59) • If you tried to get an appointment for your [child] with a dentist who specializes in a particular type of dental care (such as [extractions]) in the last 12 months, how often did you get an appointment as soon as you wanted? (Row 62) • How often did you have to spend more than 15 minutes in the waiting room before you saw someone for your [child's] appointment? (Row 434) • If you had to spend more than 15 minutes in the waiting room before you saw someone for your [child's] appointment, how often did someone tell you why there was a delay or how long the delay would be? (Row 435) **For the following, report the percentage responding "definitely yes" or "somewhat yes"** • If [your child] needed to see a dentist right away because of a dental emergency in the last 12 months, did [your child] get to see a dentist as soon as you wanted? (Row 60) Composite • A composite indicator can be calculated from the above items. See: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/dental/about/measures-dental-plan-709.pdf	Source: CAHPS; Data: Surveys (**Note:** modified for children)

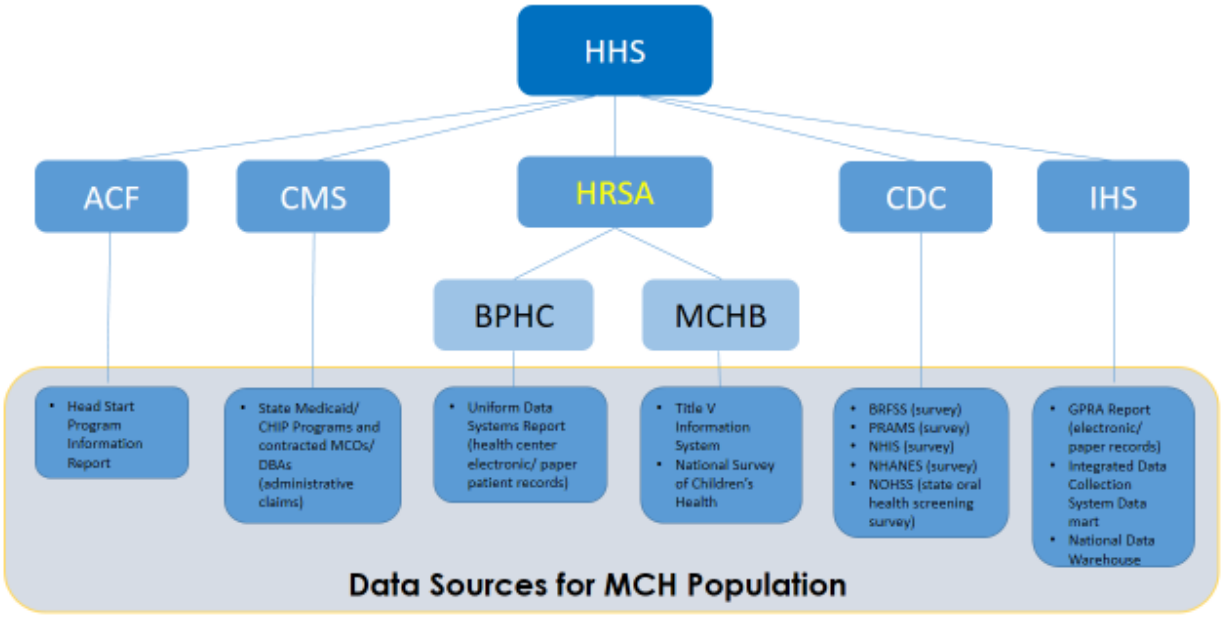
UTILIZATION	
System-Level Administrative Databases (enrollment and claims data)	
• Percentage of children who had a dental visit in the last 12 months	Source: DQA; Data: Claims. Row 2
• Percentage of children at elevated risk receiving preventive dental services	Source: DQA; Data: Claims. Row 221
If program administrative data not feasible then use summary EPSDT reporting to CMS:	
• Percentage of total eligibles receiving any dental services	Source: CMS 416; Data: Claims summary. Row 6
• Percentage of total eligibles* receiving preventive dental services/CHIPRA Core PDENT	Source: CMS 416; Data: Claims summary. Row 369
PROCESS	
System-Level Administrative Databases	
• Percentage of children at elevated risk receiving at least 2 topical fluoride applications as a dental service	Source: DQA; Data: Claims. Row 216
• Percentage of children at elevated risk receiving at least 2 topical fluoride applications as an oral health service	Source: DQA; Data: Claims. Row 218
• Percentage of children aged 6–9 years at elevated risk who receive sealants in their permanent first molars	Source: DQA; Data: Claims. Row 210
• Percentage of children aged 10–14 years at elevated risk who receive sealants in their permanent second molars	Source: DQA; Data: Claims. Row 213
If program administrative data not feasible then use summary EPSDT reporting to CMS:	
• Percentage of total eligibles receiving a sealant on a permanent molar tooth	Source: CMS 416; Data: Claims summary. Row 215
OUTCOME	
System-Level Administrative Databases	
• Percentage of children with dental caries experience (treated or untreated tooth decay)	Source: State Oral health Survey; Data: Survey. Row 256
• Percentage of children with urgent dental treatment need	Source: State Oral health Survey; Data: Survey. Row 258

* Row number: match to the accompanying environmental scan Excel sheet.

Limitations of Initial Set of Quality Indicators

Goal 2 of the COHSII project is to identify a comprehensive and implementable set of indicators to monitor oral health care delivery within existing systems of care. Figure 3 provides a graphic representation of the different agencies that address health and the associated measurement infrastructure.

Figure 3: Sources of Data for the MCH Population



The ability of a state program to implement quality indicators is dependent on the availability of reliable sources of data to support measurement. The following data sources are available to state programs for indicator reporting:

- PRAMS Core Questions
- PRAMS Standard Questions
- Behavioral Risk Factor Surveillance System (BRFSS)
- Basic Screening Survey
- National Survey of Children's Health (NSCH)
- Centers for Medicare & Medicaid Services (CMS) 416: Claims Summary from CMS Medicaid EPSDT Website
- Claims data from state Medicaid agency
- Dental Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Challenges in Obtaining Data in MCH Populations

Despite the existence of available data, MCH programs may face challenges obtaining data for the recommended indicators from existing data sources, including those listed below.

(1) State MCH programs are often reliant on other state agencies and organizations for measurement data. Consequently, building strong inter-agency/organization relationships should be a priority for MCH programs.

(2) A number of national and state oral health surveys have been established over time (e.g., NSCH, PRAMS, Behavior Risk Factor Surveillance System [BRFSS]). While these data are accessible and familiar to public health program officials, self-reported survey data are subject to recall bias, sample bias, the social desirability phenomenon, and inconsistent interpretation of questions, among other challenges. Further, well-validated national surveys often do not have sufficient sample sizes for reliable reporting at the state level, much less specifically for the MCH population within the state.

(3) Other important measurement gaps relate to:

   (a) Dental claims databases often lack the ability to identify pregnant women. Measurement for pregnant women relies heavily on PRAMS as the data source, which includes both a core question set and a standard (optional) question set. Core questions used by all states that administer PRAMS lack information to support measurement on many of the quality domains.

   (b) Similarly, stratification of indicators to identify disparities and measurement specific to CSHCN requires diagnostic data capture within dental claims or the ability to integrate medical claims data with dental claims data. Even with diagnostic data, complex methodologies are often required to identify CSHCN.

(4) Identifying outcome indicators based on available data sources remains an ongoing challenge. Ideally, measurement would focus on individual and population outcomes. However, our current data systems limit the ability to capture outcomes-related data. Dental data systems currently do not consistently capture diagnostic information in a structured format. Electronic patient record systems do not communicate with each other and, consequently, do not allow for aggregation from the clinic level to the plan, program, and population levels. Due to current limitations in reliably and validly measuring outcomes, measurement focuses largely on the other domains of access, utilization, structure and process. However, quality-improvement efforts in these domains should ultimately be aimed

toward improving individual and community outcomes and population health and well-being.

The Future: From "Data Silos" to a "Data System"

The MCH population is served through different health care financing and delivery systems within HHS, including Medicaid, the Indian Health Service (IHS), and CHCs. Each of these systems has its own measurement system (data silos), and **a cohesive and aligned measurement system for the MCH population has not been established**. Given the limitations of existing data sources to support measurement, **data infrastructure to support measurement for the MCH population must be improved to establish a future outcomes-oriented measurement system.**

A vision for improvements in data infrastructure for population health is similar to recent efforts launched by the National Institutes of Health (NIH) to establish a "biomedical data science ecosystem." NIH notes: "Accessible, well-organized, secure, and efficiently operated data resources are critical to modern scientific inquiry. By maximizing the value of data generated through NIH-funded efforts, the pace of biomedical discoveries and medical breakthroughs for better health outcomes can be substantially accelerated." Similarly, agencies responsible for achieving optimum population health must focus attention on the nation's data infrastructure to enable measurement to prove and improve quality and outcomes.

Recent enhancements indicate that their efforts are being made to improve data integration. Examples include:

(1) The IHS Oral Health Survey of American Indian/Alaska Native children uses the Basic Screening Survey protocol also used in state oral health surveys. Use of this protocol provides standardized data that can be reported as estimates for the National Oral Health Surveillance System child indicators. The Centers for Disease Control and Prevention (CDC) Oral Health Data website has been updated with IHS data. This feature allows comparison of IHS data with state oral health survey data.[14]

[14] Centers for Disease Control and Prevention. 2018. *Oral Health Data.* Atlanta, GA: Centers for Disease Control and Prevention. https://www.cdc.gov/oralhealthdata/index.html

(2) The California Department of Public Health (CDPH) is working with the California Department of Education (CDE) to develop a data sharing agreement that will allow CDPH to link oral health survey data with child-specific data collected by CDE. The CDPH oral health survey of children in third grade will include a child's unique state education identification number. The CDPH data file will be merged with the CDE data file; then all potential identifiers will be stripped, allowing CDPH to assess disparities based on race, ethnicity, socioeconomic status, English as a second language, **and special health care needs.**

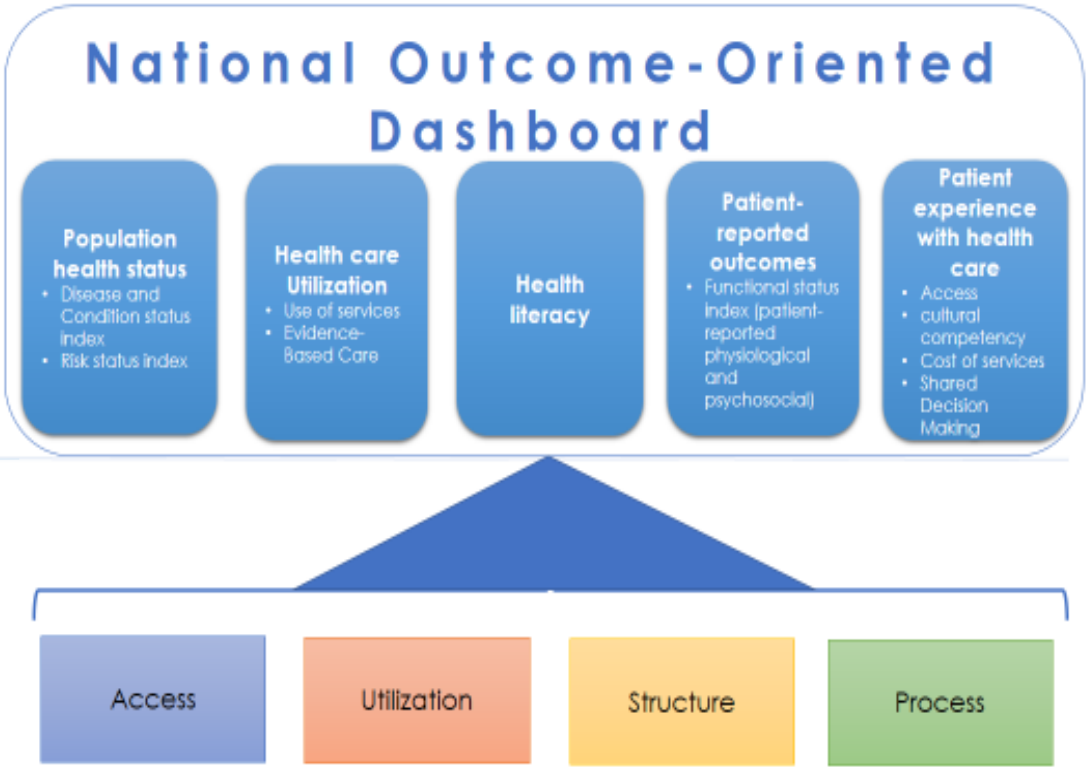
While these efforts represent a step in the right direction, a strategic approach to build an integrated data system through partnerships involving at a minimum HRSA, CDC, CMS, the Office of the National Coordinator for Health Information Technology, the Agency for Healthcare Research and Quality (AHRQ), and NIH is essential to realize this vision of a future state of measurement. When a robust set of outcomes can be reliably and validly measured, less emphasis will be needed on national measurement in the other domains. A future national outcomes-oriented measurement system is depicted in Figure 4. This system is based on the notion that outcomes measurement is national, while improvement is local. Thus, a set of indicators focused on outcomes are needed at the national level. States could then select indicators of structure, access, utilization, and process to help with their quality-improvement efforts toward improving performance on the national outcome indicators. This system envisions measuring oral health through five domains at the national level:

- Population health status
- Health care utilization
- Health literacy
- Patient reported outcomes
- Patient experience with health care

Figure 4. National Outcomes-Oriented Measurement

All states report all national performance measures to monitor improvement.

States conduct a needs-assessment to plan for improvement and address domains unique to each state to achieve national outcome goals.



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Improving Oral Health Through Measurement

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Some overarching recommendations to achieve this vision include the following:

(1) It is important for HHS agencies serving the MCH population to establish inter-agency agreements to share data and support standardized measurement. Likewise, it is important for state-level agencies serving the MCH population to collaborate, coordinate, and share data for robust measurement.

(2) Policymakers and agencies that fund data collection through various national- and state-level surveys should coordinate, streamline, and prioritize data collection so reliable, focused data are gathered to support an outcomes-oriented national measurement system. A patchwork of data gathered from multiple different state and national surveys cannot be the basis for measuring population health and quality of care.

(3) Instead of relying on a variety of disparate, disconnected data systems to measure population health, the future measurement landscape should be supported by a **data infrastructure that allows data capture and aggregation**. Data relating to population health status, health care utilization, health literacy, patient-reported outcomes, and experience of health care should be collected at each health care encounter. Infrastructure to aggregate these data at the local, state, and national levels should be developed. State programs can be part of the evolution of technology infrastructure to support such a vision.

To support development of streamlined **data capture systems**, policymakers should:

a. Encourage structured recording of diagnostic codes, medical and dental history to measure disease status, functional status, and risk status.

b. Establish standardized coding to identify people with special health care needs including those with intellectual disabilities.[15] For example, there are national efforts to develop a health-surveillance system for people with intellectual disabilities, which includes considerations for developing a clinically relevant operational definition.[16]

c. Encourage electronic health record (EHR) standards developers to include functional requirements to gather survey data at each patient encounter.

d. Facilitate development of a **single standardized population health survey** to assess

[15] The Developmental Disabilities Act of 2000[15] requires rights in medical and dental health in all settings for individuals with intellectual disabilities. Developmental Disabilities Assistance and Bill of Rights Act of 2000. Public Law 106-402, 106th Congress.

[16] Krahn G, Fox MH, Campbell VA, Ismaila R, Jesien G. 2010. Developing a health surveillance system for people with intellectual disabilities in the United States. *Journal of Policy and Practice in Intellectual Disabilities* 7(3):155-166. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1741-1130.2010.00260.x

i. health literacy
ii. patient-reported outcomes (physiological, psychosocial and functional oral health)
iii. patient experience with health care (access, cultural competency, cost, and shared decision-making)

Several independent efforts are underway to identify tools to assess the above domains. For example, NIH has funded the University of Minnesota and the University of California, Los Angeles, to identify patient-reported outcomes. Commercial entities such as Optum (SF Health Surveys)[17] and the International Consortium for Health Outcomes Measurement[18] are also engaged in building tools to identify patient-reported outcomes. There are several questionnaires for health literacy.[19] It is important that results of these efforts be used to create a standardized practical national tool, cognizant of implementation and reporting burden, to support measurement. Multiple distinct multi-item item surveys fielded by different public health agencies using different methodologies may not be the most efficient approach. A single national population health and quality of care survey developed to address these critical domains in a feasible, reliable, and valid manner is required.

To support development of infrastructure to **aggregate data**, policymakers should

a. Facilitate creation of **centralized oral health registries**. Efforts to develop integrated data from EHR systems and centralized registries are supported and incentivized through federal programs such as Meaningful Use (capturing and reporting EHR data that can be used for improving quality, engaging patients, and improving population health) and the Physician Quality Reporting System (quality reporting by health providers and group practices that participate in Medicare to CMS, including reporting data through qualified registries), which are now both components within the Merit-Based Incentive Payment System. However, the long-term vision should be for **a single national integrated data system through a clinical registry that supports**

[17] Optum. 2018. *SF Health Surveys.* Eden Prairie, MN: Optum. http://campaign.optum.com/optum-outcomes/what-we-do/health-surveys.html
[18] ICHOM. 2018. *The People Behind ICHOM* [webpage]. Cambridge, MA: ICHOM. http://www.ichom.org/who-we-are
[19] Agency for Healthcare Research and Quality. 2018. *CAHPS Health Literacy Item Sets* [webpage]. Rockville, MD: Agency for Healthcare Research and Quality. https://www.ahrq.gov/cahps/surveys-guidance/item-sets/literacy/index.html

meaningful measurement. While EHRs and associated health-information exchanges are the ultimate goal, clinical registries with the ability to automatically pull data from patient-management software can be a nearer-term achievable goal. Public and private entities, including professional societies, are embarking on this path and could support federal infrastructure-development efforts. For example, the American Academy of Pediatrics (AAP) is in the exploratory planning stages of creating a child health registry. The purpose of the registry is to enable pediatricians and others who care for children to improve child health and well-being through the use of data. The Michigan Department of Health and Human Services has partnered with Altarum to create a dental registry in Michigan (MiDR℠) that enables communication and referrals across medical and dental settings.[20] A similar registry is being developed in Los Angeles as part of the UCLA-led Dental Transformation Initiative, which is part of the California Medi-Cal 2020 Medicaid Waiver.

b. Encourage national standards development organizations that develop informatics standards to consider population health and quality reporting when establishing standards.

Next Steps: Year 2

Follow-up efforts in year 2 of the COHSII cooperative agreement will seek to identify user guidance and provide technical assistance to pilot programs' data-collection efforts and computation of the quality indicators identified in this report. Over the project period, recommendations for the future vision presented in this report will be explored further and refined to inform the development of a MCH Oral Health National Action Plan to achieve this future state.

[20] Dental Quality Alliance. 2017. *DQA Quality Innovators Spotlight: SmileConnect®, an Altarum Program.* Chicago, IL: Dental Quality Alliance. https://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2017_SmileConnectQIS.pdf?la=en

Appendix 1: Quality Indicators Advisory Team Members and Other Contributors

Quality Indicators Advisory Team

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Appendix 2: Summary of Environmental Scan Methodology

The initial framework and measurement constructs were used to guide the environmental scan to identify oral health quality indicators and indicator concepts. Indicators and concepts were identified through review of the following:

(1) Previous oral health indicator environmental scans:
- DQA, Pediatric Oral Health Quality and Performance Measures, 2012 (143 indicators)
- National Quality Forum (NQF), Oral Health Performance Measurement, 2012 (257 indicators)
- DQA, Practice Based Measures, 2015 (98 indicators)
- University of Iowa Public Policy Center, Patient-Centered Dental Home, 2018 (~400 indicators and standards)

(2) HRSA Child and Adolescent Health Measurement Initiative: Maternal and Child Health Measurement Portal
- 821 indicators total; 36 de-duplicated (within the 821), potentially relevant indicators

(3) Search on "dental" or "oral health" on NQF Quality Positioning System website
- 37 indicators total; 12 potentially relevant

(4) Search "dental" or "oral health" on National Quality Measures Clearinghouse website
- 85 indicators total; 37 potentially relevant

(5) Association of Maternal and Child Health Programs Life Course Indicators
- 107 indicators total; 5 potentially relevant

(6) AHRQ Pediatric Quality Measures Program Measures
- 95 indicators total; 6 potentially relevant

(7) Additional Resources and Measurement Sets
- ASTDD State Surveillance Data Resource Guide
- CDC Chronic Disease Indicators
- CMS Child and Adult Core Indicators
- CMS EPSDT Report
- Head Start Program Information Report
- HRSA HIV/AIDS Bureau HIV Performance Measures: Oral Health Services
- HRSA Uniform Data System Resources

- IHS Government Performance and Results Act (GPRA)/GPRA Modernization Act of 2010 (GPRAMA) Report
- NNOHA Dental Dashboard for community health centers
- Oregon Coordinated Care Organization Metrics

(8) PubMed Searches

- **Search 1:** (performance OR process OR outcome OR quality) AND measure AND (oral OR dental) AND (children OR child OR pediatric OR pediatric OR adolescent OR adolescents OR teenagers OR teens OR youth OR "pregnant women" OR "children with special health care needs" OR "youth with special health care needs" OR CSHCN OR CYSHCN) AND ("2012/01/01"[PDat]: "2018/03/19"[PDat]
  Results: 1,156 articles identified with poor specificity. Scan of titles revealed most were not relevant; more targeted search strategies identified (below).
- **Search 2:** ("quality measure" OR "quality indicator" OR "performance measure" OR "performance indicator") AND (oral OR dental) AND (children OR child OR pediatric OR pediatric OR adolescent OR adolescents OR teenagers OR teens OR youth OR "pregnant women" OR "children with special health care needs" OR "youth with special health care needs" OR CSHCN OR CYSHCN) AND ("2012/01/01"[PDat]: "2018/03/19"[PDat])
  Results: 13 articles identified; no new measures identified; noted that some known articles were not identified.
- **Search 3:** "Quality Indicators, health care"[Mesh] AND (dental OR oral) AND ("2012/01/01"[PDat]: "2018/03/19"[PDat])
  Results: 217 English-language articles identified; all titles scanned; no new measures identified; one article on clinically-focused outcome measures used in cleft care identified with extensive resources.
- **Search 4:** "Quality indicators"[All Fields] AND (("dental health services"[MeSH Terms] OR ("dental"[All Fields] AND "health"[All Fields] AND "services"[All Fields]) OR "dental health services"[All Fields] OR "dental"[All Fields]) OR "oral health"[All Fields]) AND ("2012/01/01"[PDAT]: "2018/03/19"[PDAT])
  Results: 42 articles identified; article on measures of systemic antibiotic use during dental treatment; systematic review of P4P in dentistry (abstract in English; article in German).

(9) Surveys and patient-reported outcome instruments

Extracted oral health-related indicators and questions from the following surveys:

- BFRSS
- NSCH
- PRAMS

Complete survey instruments identified:

- CAHPS, Dental Plan
- Early Childhood Oral Health Impact Scale
- Child Oral Health Impact Profile
- Oral Health Impact Profile
- National Health and Nutrition Examination Survey, Oral Health Questionnaire

(10) Review of National Academy for State Health Policy compilation of states that include quality measures for children and youth with special health care needs (CYSHCN) (nashp.org/wp-content/uploads/2017/09/NASHP-50-State-Medicaid-Managed-Care-and-CYSHCN-Scan-FINAL-09.2017.pdf).

- Review of several state contracts found that there are typically oral health measures (e.g., Children's Health Improvement Reauthorization Act [CHIPRA] core measures) and general measures related to CYSHCN, but not measures that link the two (e.g., oral health specified for CSHCN).

More than 2,000 unduplicated measures/concepts and more than 200 articles were scanned (titles, then abstracts, then full text as appropriate). Identified measures/concepts were de-duplicated and entered into an Excel database with the following details included as available: title, description, denominator, numerator, population, age, type (e.g., access, process, outcome), level (e.g., practice, plan, program), data source (e.g., claims, patient record, survey), concept versus specified, current/prior use, source/steward, and framework domain. More than 400 indicators/concepts were included in the database.

Appendix 3: Preliminary List of Indicator Concepts

Women of Child-Bearing Age and Pregnant Women

Summary:

Access
- Percentage of pregnant women reporting difficulty getting dental care
- Percentage of pregnant women who had insurance to cover dental care during pregnancy
- Percentage of pregnant women receiving oral health screening or information from medical PCPs (identified after the feasibility assessment was issued)

Utilization
- Percentage of women of child-bearing age (18-44 years) who report having a visit to a dentist or dental clinic in the past year
- Percentage of women who had their teeth cleaned **before** pregnancy
- Percentage of women who had their teeth cleaned **during** pregnancy

Structure
- Presence of interagency agreements between Title V programs and State Medicaid Office and other relevant program administrators to support program planning and quality improvement, including data sharing (standard)
- Percentage of oral health care providers who completed cultural competency training as reported by the Board of Dentistry
- Percentage of local health departments that have an oral health program
- Percentage of federally qualified health centers (FQHCs) that have an oral health program

Outcome
- Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy
- Percentage of pregnant women who had a problem with their teeth or gums during pregnancy who received treatment for that problem

ACCESS	
Self-Reported Survey Indicators	
• **Indicator:** Percentage of pregnant women reporting difficulty getting dental care **Denominator:** Number responding to question; exclude unknowns and refusals **Numerator:** Number indicating "yes" to any of the response options **Survey item:** Did any of the following things make it hard for you to go to a dentist or dental clinic about the problem you had during *your most recent* pregnancy? For each item, check No if it was not something that made it hard for you or Yes if it was. o I could not find a dentist or dental clinic that would take pregnant patients	Source: PRAMS Phase 8 – standard (optional) question Y6; Data: Survey of pregnant women. Survey Tab, Row 17 Notes: -Not an existing indicator. -**Proposed indicator created from survey item with proposed numerator and denominator).** -Does not appear to reportable from current

○ I could not find a dentist or dental clinic that would take Medicaid patients ○ I did not think it was safe to go to the dentist during pregnancy ○ I could not afford to go to the dentist or dental clinic	interactive tools; states would need to calculate (if they are collecting these data Standard/optional: 25 states
• **Indicator:** Percentage of pregnant women who had insurance to cover dental care during pregnancy **Denominator:** Number responding yes or no to question; exclude unknowns and refusals **Numerator:** Number indicating "yes" to question **Survey item:** Do you have any insurance that pays for some or all of your dental care? Please include dental insurance, prepaid plans such as HMOs, or government plans such as Medicaid. ○ No ○ Yes	Source: PRAMS Phase 8 – standard (optional question) ME83; Data: Survey of pregnant women. Survey Tab Row, 20 Notes: -Not an existing indicator. -**Proposed indicator created from survey item with proposed numerator and denominator).** -Does not appear to reportable from current interactive tools; states would need to calculate (if they are collecting these data). Standard/optional – state specific (Maine).
• **Indicator:** Percentage of pregnant women receiving oral health screening or information from medical PCPs **Denominator:** Number responding to question; exclude unknowns and refusals **Numerator:** Number indicating "yes" to any of the response options **Survey item:** During your most recent pregnancy, did a doctor, nurse, or other health care worker do any of the things listed below? For each item, check No if it is not true or does not apply to you or Yes if it is true. ○ Ask me about my teeth and gums ○ Look at my teeth and gums ○ Talk with me about visiting a dentist or dental hygienist ○ Help me get dental care ○ Give me information about taking care or my teeth and gums ○ Give me information about taking care of my baby's teeth and gums	Source: PRAMS Phase 8 – standard (optional question) FL77; Data: Survey of pregnant women. Survey Tab, Row 21 Notes: -Not an existing indicator. -**Proposed indicator created from survey item with proposed numerator and denominator).** -Does not appear to reportable from current interactive tools; states would need to calculate (if they are collecting these data). Standard/optional – state specific (Florida).

UTILIZATION	
Self-Reported Survey Indicators	
• **Indicator:** Percentage of women of child-bearing age (18-44 years) who report having a visit to a dentist or dental clinic in the past year **Denominator:** Number of female respondents, aged 18-44 years; exclude unknowns and refusals **Numerator:** Number who report having been to the dentist or dental clinic within the past year **Survey item:** Including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists, how long has it been since you last visited a dentist or a dental clinic for any reason? [Response options only read if necessary.] o Within the past year (anytime less than 12 months ago) o Within the past 2 years (1 year but less than 2 years ago) o Within the past 5 years (2 years but less than 5 years ago) o 5 or more years ago o Don't know/not sure o Never	Source: BRFSS 2018; Data: Survey stratified to women of child bearing age. Survey Tab, Row 22 Notes: -Not an existing indicator. -Proposed indicator created from survey item. -Does not appear to reportable from current interactive tools; states would need to calculate (if they are collecting these data).
• **Indicator:** Percentage of women who had their teeth cleaned **before** pregnancy **Survey item:** What type of health care visit did you have in the 12 months before you got pregnant with your new baby? Check ALL that apply o Regular checkup at my family doctor's office o Regular checkup at my OB/GYN's office o Visit for an illness or chronic condition o Visit for an injury o Visit for family planning or birth control o Visit for depression or anxiety o Visit to have my teeth cleaned by a dentist or dental hygienist o Other • Please tell us: _____	Source: PRAMS Phase 8 – core question; Data: Survey of pregnant women. Row 376 Note: Specified with numerator and denominator; can be reported from CDC PRAMS website; although missing for most states
• **Indicator:** Percentage of women who had their teeth cleaned **during** pregnancy **Survey item:** During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist? o No o Yes	**Title National Performance Indicator 13A.** Source: PRAMS Phase 8 – core question; Data: Survey on pregnant women. Rows: 11 and 377 Note: Specified with numerator and denominator; can be reported from CDC PRAMS website; although missing for most states on the website – only 8 states with data in 2011.

STRUCTURE	
Standards	
• Presence of interagency agreements between Title V programs and state Medicaid office and other relevant program administrators to support program planning and quality improvement including data sharing. [Not measured; Standard]	New concept
Other Data Sources: Indicators	
• Percentage of oral health care providers who completed cultural competency training as reported by the board of dentistry	Adapted from: OHA. Row: 100
• Percentage of local health departments that have an oral health program	Source: HP2020/ASTDD Synopses
• Percentage of FQHCs that have an oral health program	Source: HP2020/HRSA UDS
• Percentage of Level 1, 2, or 3 trauma-center hospitals that have a dentist on staff or on call	New concept
OUTCOMES	
Self-Reported Survey Indicators	
• **Indicator:** Percentage of pregnant women reporting that they needed to see a dentist for a problem during pregnancy **Denominator:** Number responding yes or no to question Y7, response option "I <u>needed</u> to see a dentist for a **problem**"; exclude unknowns and refusals **Numerator:** Number indicating "yes" to the response option: "I <u>needed</u> to see a dentist for a **problem**" **Survey item:** This question is about the care of your teeth <u>*during*</u> *your most recent pregnancy*. For each item, check No if it is not true or does not apply to you or Yes if it is true. o I knew it was important to care for my teeth and gums during my pregnancy o A dental or other health care worker talked with me about how to care for my teeth and gums o I had my teeth cleaned by a dentist or dental hygienist o I had insurance to cover dental care during my pregnancy o I <u>needed</u> to see a dentist for a **problem** o I <u>went</u> to a dentist or dental clinic about a **problem**	Source: PRAMS Phase 8 – standard (optional question) Y7; Data: Survey of pregnant women. Survey Tab, Row 18 Notes: -Not an existing indicator. -**Proposed indicator created from survey item with proposed numerator and denominator).** -Does not appear to reportable from current interactive tools; states would need to calculate (if they are collecting these data). Standard/optional – 36 states use
• **Indicator:** Percentage of pregnant women who had a problem with their teeth or gums during pregnancy who received treatment for that problem **Denominator:** Number responding "yes" to **question Y7**, response option "I <u>needed</u> to see a dentist for a **problem**"; exclude unknowns and refusals **Numerator:** Number indicating "yes" to any of the 3 "yes" response options **Survey item:** Did you get treatment from a dentist or another doctor for the problem that you were having during your pregnancy? Check ONE answer.	Source: PRAMS Phase 8 – standard (optional) question Y8; Data: Survey of pregnant women. Survey Tab, Row 19 Notes: -Not an existing indicator. -Proposed indicator created from survey item with proposed numerator and denominator). -Does not appear to reportable from current interactive tools; states

○ No ○ Yes, I got treatment during my pregnancy ○ Yes, I got treatment after my pregnancy ○ Yes, I got treatment both during and after my pregnancy	would need to calculate (if they are collecting these data). Standard/optional – 2 states use

Children

Summary:

Access

- Percentage of children eligible for Medicaid/CHIP who are enrolled in Medicaid/CHIP
- Percentage of children currently covered by health insurance or health coverage plan
- Percentage of children with consistent health insurance coverage during the past 12 months
- Percentage of dental providers who have provided X dental procedures to at least Y enrolled children

Utilization

- Percentage of children who had a dental visit in the last 12 months
- Percentage of children who had an oral health visit in the last 12 months
- Percentage of children with a usual source of dental services
- Percentage of children receiving dental treatment services
- Percentage of children at elevated risk receiving preventive dental services

Structure

- Presence of interagency agreements between Title V programs and state Medicaid office and other relevant program administrators to support program planning and quality improvement including data sharing (standard)
- Per member per month cost of dental clinical services
- Percentage of oral health care providers who completed cultural competency training as reported by the board of dentistry
- Percentage of local health departments that have an oral health program
- Percentage of FQHCs that have an oral health program
- Percentage of population receiving fluoridated water
- Percentage of school-based health centers with an oral health component: fillings and extractions
- Percentage of school-based health centers with an oral health component: dental sealants
- Percentage of school-based health centers with an oral health component: topical fluoride

Process

- Percentage of children at elevated risk receiving at least two topical fluoride applications as a dental service
- Percentage of children at elevated risk receiving at least two topical fluoride applications as an oral health service
- Percentage of children aged 6–9 years at elevated risk who receive sealants in their permanent first molars
- Percentage of children aged 10–14 years at elevated risk who receive sealants in their permanent second molars
- Percentage of caries-related emergency department visits among children for which the member visited a dentist within 7 and 30 days, respectively

- Percentage of children aged 1–5 years who received a follow-up oral evaluation within 3 months of a well-child visit
- Percentage of children receiving an oral evaluation
- Percentage of children with continuity of oral health care

Outcomes
- Caries at recall
- Percentage of children with dental caries experience (treated or untreated tooth decay)
- Percentage of children with urgent dental treatment need
- Percentage of children with an ambulatory care sensitive emergency department visit for dental caries
- Care experience composite

ACCESS	
System-Level Administrative Databases	
• Percentage of children eligible for Medicaid/CHIP who are enrolled in Medicaid/CHIP **Note:** If not feasible to calculate, use: **KFF Medicaid/CHIP Participation Rates**	Data: Census data to estimate eligible & enrollment/CMS 416 for enrolled
• Percentage of children currently covered by health insurance or health coverage plan • Percentage of children with consistent health insurance coverage during the past 12 months	Source: National Survey of Children's Health; Data: Surveys. Rows 75 and 76
• Percentage of dental providers who have provided X dental procedures to at least Y enrolled children	New indicator Data: Claims
If administrative data are not feasible then:	
Option: CAHPS Dental Plan Survey **Access to Dental Care** Individual Items **For each, report percentage responding "usually" or "always"** • How often were your [child's] dental appointments as soon as you wanted? (Row 59) • If you tried to get an appointment for your [child] with a dentist who specializes in a particular type of dental care (such as [extractions]) in the last 12 months, how often did you get an appointment as soon as you wanted? (Row 62) • How often did you have to spend more than 15 minutes in the waiting room before you saw someone for your [child's] appointment? (Row 434) • If you had to spend more than 15 minutes in the waiting room before you saw someone for your [child's] appointment, how often did someone tell you why there was a delay or how long the delay would be? (Row 435)	Source: CAHPS; Data: Surveys (**Note:** Modified for children)

For the following, report the percentage responding "definitely yes" or "somewhat yes" • If [your child] needed to see a dentist right away because of a dental emergency in the last 12 months, did [your child] get to see a dentist as soon as you wanted? (Row 60) Composite • A composite indicator can be calculated from the above items. See: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/dental/about/measures-dental-plan-709.pdf	
UTILIZATION	
System-Level Administrative Databases (enrollment and claims data)	
• Percentage of children who had a dental visit in the last 12 months	Source: DQA; Data: Claims. Row 2
• Percentage of children who had an oral health visit in the last 12 months	Source: DQA; Data: Claims. Row 3
• Percentage of children with a usual source of dental services	Source: DQA; Data: Claims. Row 13
• Percentage of children receiving dental treatment services: *Can be computed for those receiving a dental service	Source: DQA; Data: Claims. Row 399
• Percentage of children at elevated risk receiving preventive dental services: *Can be computed for those receiving a dental service	Source: DQA; Data: Claims. Row 221
If program administrative data not feasible then can use summary EPSDT reporting to CMS:	
• Percentage of total eligibles receiving any dental services	Source: CMS 416; Data: Claims summary. Row 6
• Percentage of total eligibles receiving oral health services provided by a non-dentist provider	Source: CMS 416; Data: Claims summary. Row 8
• Percentage of total eligibles* receiving preventive dental services/CHIPRA Core PDENT *can be computed for those receiving a dental service	Source: CMS 416; Data: Claims summary. Row 369
• Percentage of total eligibles* receiving dental treatment services *can be computed for those receiving a dental service	Source: CMS 416; Data: Claims summary. Row 400
STRUCTURE	
Standards	
• Presence of interagency agreements between Title V programs and state Medicaid office and other relevant program administrators to support program planning and quality improvement, including data sharing. [Not measured; standard]	New concept
System-Level Administrative Databases	

• Per member per month cost of dental clinical services	Source: DQA; Data: Claims. Row 101
Other Data Sources: Indicators	
• Percentage of oral health care providers who completed cultural competency training as reported by the board of dentistry	Adapted from: OHA. Row: 100
• Percentage of local health departments that have an oral health program	Source: HP2020/ASTDD Synopses
• Percentage of FQHCs that have an oral health program	Source: HP2020/HRSA UDS
• Percentage of population receiving fluoridated water	Source: CDC. Row: 115
• Percentage of school-based health centers with an oral health component: fillings and extractions • Percentage of school-based health centers with an oral health component: dental sealants • Percentage of school-based health centers with an oral health component: topical fluoride	(Source: HP2020/Census of School-Based Health Centers (CSBHC), School Based Health Alliance (SBHA). Rows 77-79)
• Percentage of Level 1, 2, or 3 trauma-center hospitals that have a dentist on staff or on call	New concept
PROCESS	
System-Level Administrative Databases	
• Percentage of children at elevated risk receiving at least two topical fluoride applications as a dental service	Source: DQA; Data: Claims. Row 216
• Percentage of children at elevated risk receiving at least two topical fluoride applications as an oral health service	Source: DQA; Data: Claims. Row 218
• Percentage of children aged 6–9 years at elevated risk who receive sealants in their permanent first molars	Source: DQA; Data: Claims. Row 210
• Percentage of children aged 10–14 years at elevated risk who receive sealants in their permanent second molars	Source: DQA; Data: Claims. Row 213
• Percentage of caries-related emergency department visits among children for which the member visited a dentist within 7 and 30 days, respectively	Source: DQA; Data: Claims. Row 156
• Percentage of children aged 1–5 years who received a follow-up oral evaluation within 3 months of a well-child visit	Source: DQA; Data: Claims. Row 190 (existing concept, new data source)
• Percentage of children receiving an oral evaluation	Source: DQA; Data: Claims. Row 207
• Percentage of children with continuity of oral health care	Source: DQA; Data: Claims. Row 222
If program administrative data not feasible then can use summary EPSDT reporting to CMS:	

• Percentage of total eligibles receiving a sealant on a permanent molar tooth	Source: CMS 416; Data: Claims summary. Row 215
• Percentage of total eligibles receiving diagnostic dental services	Source: CMS 416; Data: Claims summary. Row 121
OUTCOMES	
Patient Record Data (e.g., EHR/EDR)	
• Caries at recall	Source: DQA; Data: Patient records. Row 239
System-Level Administrative Databases	
• Percentage of children with an ambulatory care sensitive emergency department visits for dental caries	Source: DQA; Data: Claims. Row 253
• Percentage of children with dental caries experience (treated or untreated tooth decay)	Source: State Oral health survey; Data: Survey. Row 256
• Percentage of children with untreated tooth decay	Source: State oral health survey; Data: Survey. Row 257
• Percentage of children with urgent dental treatment need	Source: State oral health survey; Data: Survey. Row 258
Self-Reported Survey Indicators: Care Experience	
CAHPS Dental Plan Survey: **Care from Dentists and Staff** Composite o A composite indicator can be calculated from the individual items. See: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/dental/about/measures-dental-plan-709.pdf Individual Items **For each, report percentage responding "usually" or "always"** • How often did your [child's] regular dentist explain things in a way that was easy to understand? • How often did your [child's] regular dentist listen carefully to you? • How often did your [child's] regular dentist treat you with courtesy and respect? • How often did your [child's] regular dentist spend enough time with you? • How often did the dentists or dental staff do everything they could to help you feel as comfortable as possible during your [child's] dental work? • How often did the dentists or dental staff explain what they were doing while treating [your child]?	Source: CAHPS; Data: Surveys (Note: Modified for children)

Appendix 4: Feasibility and Importance Assessment Instrument

SCREEN 1: INTRODUCTION

The National Maternal and Child Oral Health Resource Center (OHRC) at Georgetown University has been awarded a cooperative agreement to administer the Center for Oral Health Systems Integration and Improvement (COHSII) supported by the Health Resources and Services Administration. The purpose of COSHII is to lead a consortium of partners, including the Association of State and Territorial Dental Directors (ASTDD) and the Dental Quality Alliance (DQA), to work with stakeholders to improve existing systems of care using a patient-centered approach that addresses the comprehensive oral health needs of the maternal and child health (MCH) population.

The DQA and OHRC are facilitating efforts to identify and develop MCH oral health quality indicators to monitor services delivered in public health programs and systems of care to improve access to and quality and outcomes of care for the MCH population. As part of this effort, a Quality Indicator Advisory Team (QIAT) has been convened to guide and inform the identification and use of MCH oral health quality indicators.

The QIAT would appreciate your feedback on the **feasibility** and **level of importance** of a preliminary list of indicator concepts.

SCREEN 2: FEASIBILITY ASSESSMENT

Several data sources that are available today to enable measurement are listed below. Please consider the **capacity of your state department of health/oral health program staff** to use each data source to compute indicators when responding to each item. While some data sources may have interactive tools available that make data capture relatively easy, some others may require staff resources to acquire raw data and compute indicators.

Do you have the **capacity (staff resources)** to report indicators using the following data sources?	**I can report now**	**I can try to report by 2020**	**I cannot report regardless of importance**
○ PRAMS Core Questions			
○ PRAMS Standard Questions [Note: If an indicator is based on a standard PRAMS			

Do you have the **capacity (staff resources)** to report indicators using the following data sources?	**I can report now**	**I can try to report by 2020**	**I cannot report regardless of importance**
question that is currently **not reported** by your state please consider whether you will be able to include a new item for data capture]			
o Behavioral Risk Factor Surveillance System [may vary based on whether the indicator can be reported from an interactive tool versus using raw data to compute]			
o Basic Screening Survey			
o National Survey of Children's Health			
o CMS 416: Claims Summary from CMS Medicaid EPSDT Website			
o Claims data from state Medicaid department			
o Dental CAHPS			

SCREEN 3: IMPORTANCE ASSESSMENT: Women of Child-Bearing Age and Pregnant Women

Please rate the importance of the indicator concept to your state oral health program. **Note that these are NOT specific indicators but merely concepts; these purposely lack specificity.** Details will be included in the final recommendations. At this time, we are seeking to understand the relative importance of each of these concepts.

	Concepts	**Rate the importance of this concept on a scale of 1 – 5** *(1 – high importance and 5 – low importance)*
1.	Needed to see a dentist for a problem during pregnancy	
2.	Difficulty getting dental care	
3.	Visit to a dentist or dental clinic in the past year	
4.	Teeth cleaned during pregnancy	
5.	Had a problem with teeth or gums during pregnancy	
6.	Had a problem with teeth or gums during pregnancy and received treatment for that problem	

Concepts		Rate the importance of this concept on a scale of 1 – 5 *(1 – high importance and 5 – low importance)*
7.	Presence of interagency agreements between Title V programs and state Medicaid office and other relevant program administrators to support program planning and quality improvement including data sharing	
8.	Oral health providers who completed cultural competency training	
9.	Local health departments that have an oral health program	
10.	Federally qualified health centers (FQHCs) that have an oral health program	

SCREEN 4: IMPORTANCE ASSESSMENT: Children

For importance please rate the importance of the indicator concept to your state oral health program. **Note that these are NOT specific indicators but merely concepts; these purposely lack specificity.** Details will be included in the final recommendations. At this time, we are seeking to understand the relative importance of each of these concepts.

Concepts		Rate the importance of this concept on a scale of 1 – 5 *(1 – high importance and 5 – low importance)*
1.	Children eligible for Medicaid/CHIP who are enrolled in Medicaid/CHIP	
2.	Oral health providers who meaningfully participate in Medicaid	
3.	Children covered by health insurance or health coverage plan	
4.	Children with consistent health insurance coverage during the past 12 months	
5.	Follow-up oral health visit after medical well-child visit	
6.	Dental visit in the last 12 months	

Concepts		Rate the importance of this concept on a scale of 1 – 5 *(1 – high importance and 5 – low importance)*
7.	Oral health visit in the last 12 months (e.g., visit to pediatricians)	
8.	Children receiving dental diagnostic services	
9.	Children at elevated caries risk receiving preventive dental services	
10.	Children receiving dental treatment services	
11.	Children at elevated caries risk receiving at least 2 topical fluoride applications	
12.	Children aged 6–9 years at elevated caries risk who receive sealants in their first molars	
13.	Children aged 10–14 years at elevated caries risk who receive sealants in their second molars	
14.	Ambulatory care sensitive emergency department visits for dental caries	
15.	Follow-up with dental provider after emergency department visit by children for dental caries	
16.	Usual source of dental services	
17.	Continuity of dental care	
18.	Per member per month cost of dental clinical services	
19.	Dental caries experience (treated or untreated tooth decay)	
20.	Children with urgent dental treatment needs	
21.	Child's regular dentist explained things in a way that was easy to understand in the last 12 months	
22.	Interagency agreements between Title V programs and state Medicaid office and other relevant program administrators to support program planning, quality improvement including data sharing	
23.	Oral health care providers who completed cultural competency training	
24.	Local health departments that have an oral health program	
25.	FQHCs that have an oral health program	
26.	Population receiving fluoridated water	
27.	School-based health centers with an oral health component	

SCREEN 5: Feasibility ASSESSMENT: Children with Special Health Care Needs

Does your state have any way to identify children with special health care needs and report on them? Please describe.

OPEN COMMENT BOX

Please provide any additional comments:

OPEN COMMENT BOX

Appendix 5: Results of Feasibility and Importance Assessment

There were a total of 20 responses to the assessment.

FEASIBILITY ASSESSMENT

Data Sources Do you have the **capacity (e.g., staff resources)** to report indicators using the following data sources?	**I can report now**	**I can try to report by 2020**	**I cannot report regardless of importance**
o Pregnancy Risk Assessment Monitoring System (PRAMS) core questions	17	2	1
o PRAMS standard questions [Note: If an indicator is based on a standard PRAMS question that is currently **not reported** by your state please consider whether you will be able to include a new item for data capture]	12	7	1
o Behavior Risk Factor Surveillance System (BRFSS) [may vary based on whether the indicator can be reported from an interactive tool versus using raw data to compute]	17	3	0
o Basic Screening Survey	17	3	0
o National Survey of Children's Health	9	10	1
o CMS 416: Claims summary from CMS Medicaid EPSDT website	15	4	1
o Claims data from state Medicaid office	11	8	1
o CAHPS dental plan survey	0	14	6

IMPORTANCE ASSESSMENT: WOMEN OF CHILD-BEARING AGE AND PREGNANT WOMEN

Indicator Concepts	**Rate the importance of this concept on a scale of 1 – 5** *(1 – high importance and 5 – low importance)*				
	Somewhat High - High Importance **(1 – 2)**	Neutral **(3)**	Somewhat Low - Low Importance **(4 – 5)**	N/A	**TOTAL**
Needed to see a dentist for a problem during pregnancy (Source: PRAMS)	10	1	6	3	20
Difficulty getting oral health care (Source: PRAMS)	9	1	5	5	20
Visit to a dentist or dental clinic in the past year (Source: BRFSS)	9	1	5	5	20
Teeth cleaned during pregnancy (Source: PRAMS)	7	4	5	4	20
Had a problem with teeth or gums during pregnancy (Source: PRAMS)	9	1	6	4	20
Had a problem with teeth or gums during pregnancy and received treatment for problem (Source: PRAMS)	9	0	7	4	20
Presence of interagency agreements between Title V MCH program and state Medicaid office and other relevant program administrators to support program planning and quality improvement including data sharing (Source: Not measured; standard)	3	5	7	5	20
Oral health providers who completed cultural competency training (Source: OHA)	3	5	6	6	20
Local health departments that have an oral health program (Source: HP2020/ASTDD)	5	3	7	5	20
Federally qualified health centers (FQHCs) that have an oral health program (Source: HP2020/ASTDD)	8	0	6	6	20

IMPORTANCE ASSESSMENT: CHILDREN (Aged 1–21 years)

Indicator Concepts	**Rate the importance of this concept on a scale of 1 – 5** *(1 – high importance and 5 – low importance)*				
	Somewhat High - High Importance **(1 – 2)**	Neutral **(3)**	Somewhat Low - Low Importance **(4 – 5)**	N/A	**TOTAL**
Children eligible for Medicaid or CHIP who are enrolled in Medicaid or CHIP (Source: Census data to estimate eligible and enrollment/CMS 416 for enrolled)	11	0	5	4	20
Oral health providers who meaningfully participate in Medicaid (Source: New)	8	2	6	4	20
Children covered by dental insurance or dental coverage plan (Source: NSCH)	10	2	4	4	20
Children with consistent dental insurance coverage during the past 12 months (Source: NSCH)	10	1	5	4	20
Follow-up oral health visit after medical well-child visit (Source: New)	8	2	6	4	20
Dental health visit in the last 12 months (Source: DQA)	10	0	6	4	20
Oral health visit in the last 12 months (e.g., visit to pediatricians) (Source: DQA)	9	0	7	4	20
Children receiving dental diagnostic services (Source: CMS 416)	8	3	5	4	20
Children at elevated caries risk receiving preventive dental services (Source: DQA)	10	0	6	4	20
Children receiving dental treatment services (Source: CMS 416)	8	2	6	4	20

Indicator Concepts	Rate the importance of this concept on a scale of 1 – 5 *(1 – high importance and 5 – low importance)*				
Children at elevated caries risk receiving at least two topical fluoride applications (Source: DQA)	10	0	6	4	20
Children aged 6–9 years at elevated caries risk who receive dental sealants in their first molars (Source: DQA)	10	0	6	4	20
Children aged 10–14 years at elevated caries risk who receive dental sealants in their second molars (Source: DQA)	10	0	6	4	20
Ambulatory care sensitive emergency department visits for dental caries (Source: DQA)	5	2	9	4	20
Follow-up with oral health provider after emergency department visit by children for dental caries (Source: DQA)	6	3	7	4	20
Usual source of dental services (Source: DQA)	7	4	5	4	20
Continuity of dental care (Source: DQA)	8	4	4	4	20
Per member per month cost of dental clinical services (Source: DQA)	6	4	6	4	20
Dental caries experience (treated or untreated tooth decay) (Source: State Oral Health Survey)	10	1	5	4	20
Children with urgent dental treatment needs (Source: State Oral Health Survey)	10	0	6	4	20
Child's regular dentist explained things in a way that was easy to understand in the last 12 months (Source: DCAHPS)	5	4	7	4	20
Interagency agreements between Title V MCH program and state Medicaid office and other relevant program administrators to	6	4	6	4	20

Indicator Concepts	Rate the importance of this concept on a scale of 1 – 5 *(1 – high importance and 5 – low importance)*				
support program planning and quality improvement including data sharing (Source: Not measured; standard)					
Oral health providers who completed cultural competency training (Source: OHA)	6	3	7	4	20
Local health departments that have an oral health program (Source: HP2020/ASTDD)	7	3	6	4	20
FQHCs that have an oral health program (Source: HP2020/ASTDD)	9	0	7	4	20
Population receiving community fluoridated water (Source: CDC)	9	2	5	4	20
School-based health centers with an oral health component (Source: HP2020/Census of School-Based Health Centers (CSBHC), School Based Health Alliance (SBHA))	9	1	6	4	20

FEASIBILITY ASSESSMENT: CHILDREN (Aged 1 – 21 years) WITH SPECIAL HEALTH CARE NEEDS

Does your state have a way to identify children with special health care needs and report on their oral health needs? Please describe.

- No. [4 responses]
- Yes, [state] has a special needs dental program.
- Yes.
- Yes, we have a shared database with Title V and Medicaid that tracks eligible children.
- We are working at the state department of health along with an intern on a special research project to help map and list resources for special health care needs individuals.
- Have a statewide protocol and standing order in local health district. Remote Desktop Session Host's (RSDH) report monthly.

- Our school-based dental sealant programs provide data on the children that they serve and we are able to pull out children with special health care needs from those data.
- Children with special health care needs are a specific subset of the population. For those children enrolled in the program due to their qualifying oral health condition, they are eligible for specialty services only such as orthodontics. Some qualifying conditions such as hemophilia, cystic fibrosis may qualify for general dental services. For those children who are eligible for Medicaid and children with special health care needs, they are coded as Medicaid eligible. Trying to determine this category for dental needs is very difficult since there are no diagnoses on the dental claim form to determine their enrollment type.

Please provide any additional comments:

- Need a standardized tool for capturing/identifying children with special health care needs.
- Pregnant women access and care monitoring should be a primary objective.
- A long term goal is to work on expanding Medicaid coverage from just comprehensive dental care for children to at least cover special needs individuals in the adult population.
- [State] has remote dental hygienist who provide preventive services in local health districts, and their communities.