



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

### Brief Measure Information

**NQF #:** 1419

**Corresponding Measures:**

**De.2. Measure Title:** Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers

**Co.1.1. Measure Steward:** University of Minnesota

**De.3. Brief Description of Measure:** The measure will a) track the extent to which the PCMP or clinic (determined by the provider number used for billing) applies FV as part of the EPSDT examination and b) track the degree to which each billing entity's use of the EPSDT with FV codes increases from year to year (more children varnished and more children receiving FV four times a year according to ADA recommendations for high-risk children).

**1b.1. Developer Rationale:** Caries (the process of which the end result is the cavity) is the most common chronic disease of childhood (five times more common than asthma and seven times more common than hay fever). Dental care is the most common health need of high-risk children; yet, according to the GAO, only about one third of the 20 million children covered by Medicaid/CHIP received any dental care in 2007. Children are 2.6 times more likely to have medical coverage than dental coverage. Only 20-30% of Medicaid-eligible children receive preventive healthcare. Based on 2005 enrollment, the GAO estimated that 6.5 million Medicaid-eligible children 2-18 years of age had untreated tooth decay and more than five percent had urgent conditions. 1.1 million children 2-18 years of age had conditions that warranted seeing a dentist within two weeks. The sad reality is that 50% of tooth decay in low-income children goes untreated. One in eight children never sees a dentist, while more than half of children with private insurance received dental care in the preceding year. The GAO has estimated that in 2005, 724,000 children 2-18 years of age could not get needed dental care. Starting several decades ago, the Scandinavian countries began to use topically applied FV as a way of preventing caries. Wentraub recently showed that one application of FV will cut the caries rate by 50% and a second application will cut it by another 50%. 43 state Medicaid programs are currently reimbursing PCMP for offering caries prevention intervention (CPI) as part of well/ill child care. Reimbursement rates range from \$9.00 to close to \$62.00. The procedure takes little time – less than five minutes for a child with a full set of primary teeth, and is noninvasive. FV reverses demineralization and enhances remineralization of the enamel of the tooth. Both actions will lead to the reduction of caries.

**S.4. Numerator Statement:** The number of EPSDT examinations done with FV.

**S.7. Denominator Statement:** All high-risk children (Medicaid/CHIP-eligible) who receive an EPSDT examination from a provider (PCMP or clinic).

**S.10. Denominator Exclusions:** None

**De.1. Measure Type:** Process

**S.23. Data Source:** Claims

**S.26. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Other

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 15, 2011 **Most Recent Endorsement Date:** Aug 15, 2011

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?**

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

### 1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 1419\_Evidence\_MSF5.0\_Data.doc

#### 1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

**1b.1. Briefly explain the rationale for this measure** (e.g., the benefits or improvements in quality envisioned by use of this measure) Caries (the process of which the end result is the cavity) is the most common chronic disease of childhood (five times more common than asthma and seven times more common than hay fever). Dental care is the most common health need of high-risk children; yet, according to the GAO, only about one third of the 20 million children covered by Medicaid/CHIP received any dental care in 2007. Children are 2.6 times more likely to have medical coverage than dental coverage. Only 20-30% of Medicaid-eligible children receive preventive healthcare. Based on 2005 enrollment, the GAO estimated that 6.5 million Medicaid-eligible children 2-18 years of age had untreated tooth decay and more than five percent had urgent conditions. 1.1 million children 2-18 years of age had conditions that warranted seeing a dentist within two weeks. The sad reality is that 50% of tooth decay in low-income children goes untreated. One in eight children never sees a dentist, while more than half of children with private insurance received dental care in the preceding year. The GAO has estimated that in 2005, 724,000 children 2-18 years of age could not get needed dental care. Starting several decades ago, the Scandinavian countries began to use topically applied FV as a way of preventing caries. Wentraub recently showed that one application of FV will cut the caries rate by 50% and a second application will cut it by another 50%. 43 state Medicaid programs are currently reimbursing PCMP for offering caries prevention intervention (CPI) as part of well/ill child care. Reimbursement rates range from \$9.00 to close to \$62.00. The procedure takes little time – less than five minutes for a child with a full set of primary teeth, and is noninvasive. FV reverses demineralization and enhances remineralization of the enamel of the tooth. Both actions will lead to the reduction of caries.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Minnesota's DHS can create a report that shows by PCMP the number of EPSDT examinations done on unduplicated and duplicated patients, with or without FV. Following are data from 2009 and 2010:

2009: EPSDT service recipients, all ages – 235,493; EPSDT visits, all ages – 350,430; FV recipients, all ages – 9,104; FV service visits; all ages – 11,006

2010 (first 6 months)\*: EPSDT service recipients, all ages – 172,852; EPSDT visits, all ages – 234,188; FV recipients, all ages – 9,238; FV service visits, all ages – 10,258

\*DHS does not consider the data set complete until 12 months after last date of service

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

JA. Wentraub, F. Ramos-Gomez, B. Jue, S. Shain, Cl. Hoover, JDB. Featherstone, and SA. Gansky. Fluoride Varnish Efficacy in Prevention ECC. J Dent Res 85(2): 172-176, 2006.

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity,**

**gender, age, insurance status, socioeconomic status, and/or disability.** (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

**1c. High Priority** (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

**1c.1. Demonstrated high priority aspect of healthcare**

Affects large numbers, A leading cause of morbidity/mortality

**1c.2. If Other:**

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.**

The literature reflects that fluoride varnish when applied to the teeth of high-risk children, reduces, in conjunction with anticipatory guidance provided to the caregiver, the risk of the child developing caries.

**1c.4. Citations for data demonstrating high priority provided in 1a.3**

See reference page.

**1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)**

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Dental

**De.6. Non-Condition Specific** (check all the areas that apply):

Primary Prevention

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

**This is not an eMeasure Attachment:**

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

**No data dictionary Attachment:**

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)  
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

**The number of EPSDT examinations done with FV.**

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

**Yearly**

**S.6. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Application of FV is identified by a discrete code. The measurement will be based on clinic data (the ICD-9 code for the EPSDT examination (99381, 99382, 99391, 99392) and D-1206, the code for FV); both are billed on the same CMS-1500 medical billing form. From these data it will be possible to know, by billing entity, the percent of EPSDT examinations that included FV and, by including the patient's discrete participant number, the number of FV applications (and the dates of those applications) provided to the high-risk child annually. If proven to be useful, the process will be promoted to the Medicaid programs of the 43 states that, as of 12/1/10, are reimbursing PCMP for applying FV to the teeth of high-risk (Medicaid/CHIP-enrolled) children as part of the EPSDT examination. Each of the 43 state Medicaid programs which are currently reimbursing PCMP for CPI has identified a specific code to reflect FV application. The code can be used as part of either an EPSDT examination or an episodic visit. All but three states (FL, TX, UT) use the dental CDT code, D-1206, or its predecessor, D-1203. The three use a recognized and approved medical CPT code (FL: 99499 with SC modifier, TX: 99429 with U5 modifier and ICD-9 EPSDT code, UT: EP modifier added to appropriate ICD-9 EPSDT code).

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

**All high-risk children (Medicaid/CHIP-eligible) who receive an EPSDT examination from a provider (PCMP or clinic).**

**S.8. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

**Children**

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

All but three states use the dental CDT code for FV application (2a.3 above). Payors have adjusted their computers to recognize the CDT dental code when billed on the CMS-1500 medical billing form. In Minnesota, DHS for the first time generated a report in 2008 which shows by provider (PCMP or clinic) (whichever holds the billing provider number) the number of duplicated and unduplicated EPSDT examinations done, and the number of FV applications performed (unduplicated and duplicated) as part of the EPSDT examination. The data are broken down by age group (0-5 years, 6-12 years, 13-20 years). Aggregate data for 2009 and the first six

months of 2010 are shown above 1b.2.

**S.10. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

None

**S.11. Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

NA

**S.12. Stratification Details/Variables** (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

The data are broken down by age group (0-5 years; 6-12 years; 13-20 years)

**S.13. Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

**S.14. Identify the statistical risk model method and variables** (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

NA

**S.15. Detailed risk model specifications** (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** (if not provided in excel or csv file at S.2b)

**S.16. Type of score:**

If other:

**S.17. Interpretation of Score** (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

**S.18. Calculation Algorithm/Measure Logic** (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

NA

**S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment** (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

**S.20. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

NA

<p><b>S.21. Survey/Patient-reported data</b> <i>(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)</i>          IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.</p> <p><b>S.22. Missing data</b> (specify how missing data are handled, e.g., imputation, delete case.)          Required for Composites and PRO-PMs.</p>
<p><b>S.23. Data Source</b> <i>(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</i>          If other, please describe in S.24.  <a href="#">Claims</a></p> <p><b>S.24. Data Source or Collection Instrument</b> <i>(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)</i>          IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.          In every state, claims data reflecting the EPSDT examination and FV application are reported by provider to payor and from payor to each state's Department of Human Services. Payors have adjusted their computers to recognize the CDT dental code when billed on the CMS-1500 medical billing form. Minnesota's use of the claims data are described above as is the use to which those data will be used for this project.</p> <p><b>S.25. Data Source or Collection Instrument</b> <i>(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i></p> <p><b>S.26. Level of Analysis</b> <i>(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</i>  <a href="#">Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Other</a></p> <p><b>S.27. Care Setting</b> <i>(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</i>  <a href="#">Outpatient Services</a>          If other:</p> <p><b>S.28. COMPOSITE Performance Measure</b> - Additional Specifications <i>(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</i></p>
<p><b>2a. Reliability</b> – See attached Measure Testing Submission Form</p> <p><b>2b. Validity</b> – See attached Measure Testing Submission Form</p> <p><a href="#">MeasureTesting.doc</a></p>

<p><b>3. Feasibility</b></p> <p>Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.</p> <p><b>3a. Byproduct of Care Processes</b>          For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p> <p><b>3a.1. Data Elements Generated as Byproduct of Care Processes.</b>          generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)          If other:</p> <p><b>3b. Electronic Sources</b></p>
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The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

Yes

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

Attachment:

### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** (*e.g., value/code set, risk model, programming code, algorithm*).

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

**4a.1. For each CURRENT use, checked above, provide:**



- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

**4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons?** (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

**4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement.** (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

#### **4b. Improvement**

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)**

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

**4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

#### **4c. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

Claims data are only as accurate as 1) the PCMP is in recording on the billing form the services provided to the patient; 2) the data entry person is in entering the billing form information into the electronic process that creates the bill to the payor; 3) the payor is in bundling patient-specific information in an electronic report to DHS and; 4) the DHS staff person is in compiling the DHS report from payor reports. Because clinics today are highly focused on maximizing revenue, most have staff whose sole responsibility it is to capture on the bill all the services provided and to make sure that what is recorded on the billing form accurately reflects the services provided as noted in the medical record.

### **5. Comparison to Related or Competing Measures**

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

#### **5. Relation to Other NQF-endorsed Measures**



Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

**5a. Harmonization**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications completely harmonized?**

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

**Appendix**

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment:**

**Contact Information**

**Co.1 Measure Steward (Intellectual Property Owner):** [University of Minnesota](#)

**Co.2 Point of Contact:** [Amos , Deinard, deina001@umn.edu, 612-377-1020-](#)

**Co.3 Measure Developer if different from Measure Steward:** [University of Minnesota](#)

**Co.4 Point of Contact:** [Amos , Deinard, deina001@umn.edu, 612-377-1020-](#)

**Additional Information**

**Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

#1419 Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers, Last Updated: Mar 02, 2015

NA
<b>Measure Developer/Steward Updates and Ongoing Maintenance</b> <b>Ad.2</b> Year the measure was first released: <b>Ad.3</b> Month and Year of most recent revision: <b>Ad.4</b> What is your frequency for review/update of this measure? <b>Ad.5</b> When is the next scheduled review/update for this measure?
<b>Ad.6</b> Copyright statement: <b>Ad.7</b> Disclaimers:
<b>Ad.8</b> Additional Information/Comments: