



Appendix: Supplemental Materials

Measure: Follow-up after

Emergency Department Visit by Children for Dental Caries

NQF Measure Number 2695

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DQA Measure Specification Sheet: Follow-up after Emergency Department Visit by Children for Dental Caries

Description: The percentage of caries-related emergency department visits among children 0 through 20 years in the reporting year for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.

Numerators: Number of caries-related ED visits in the reporting year for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit.

Denominator: Number of caries-related ED visits in the reporting year

Rates: NUM1/DEN and NUM2/DEN

Rationale: Rationale: There are approximately 1 million ED visits per year for non-traumatic dental conditions in the United States and more than 200,000 visits are made by children. (1, 2, 3) Untreated dental caries (tooth decay) and its sequelae (e.g., dental infections) account for almost 80% of these visits. (2, 3) Dental caries is preventable, and use of the ED for dental caries related conditions results in substantial costs. (1, 3) Moreover, ED care for dental caries-related conditions is generally not definitive compared to that provided in primary care dental settings and often results in referral to primary care dental sites. (4, 5, 6) This process of care measure can be used to assess if the patient had timely follow-up with a dentist for more definitive care.

1. Allareddy V, Rampa S, Lee MK, Allareddy V, Nalliah RP. Hospital-based emergency department visits involving dental conditions: profile and predictors of poor outcomes and resource utilization. J Am Dent Assoc. 2014;145(4):331-7.

2. Seu K, Hall KK, Moy E. Emergency Department Visits for Dental-Related Conditions, 2009. Healthcare Cost and Utilization Project Statistical Brief #143. Rockville, MD: Agency for Healthcare Research and Quality; November 2012. URL: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb143.pdf> [accessed on January 15, 2015].

3. Allareddy V, Nalliah RP, Haque M, Johnson BS, Rampa SB, Lee MK. Hospital-based emergency department visits with dental conditions among children in the United States: nationwide epidemiological data. Pediatr Dent 2014;37(5):393-9.

4. Cohen LA, Bonito AJ, Eicheldinger C, Manski RJ, Macek MD, Edwards RR, Khanna N. Comparison of patient visits to emergency departments, physician offices, and dental offices for dental problems and injuries. J Public Health Dent. 2011;71(1):13-22.

5. Hocker MB, Villani JJ, Borawski JB, Evans CS, Nelson SM, Gerardo CJ, Limkaken AT. Dental visits to a North Carolina emergency department: a painful problem. N C Med J. 2012; 73(5):346-51.

6. Lewis C, Lynch H, Johnston B. Dental complaints in emergency departments: a national perspective. Ann Emerg Med. 2003; 42(1):93-9.

National Quality Forum Domain: PROCESS¹

Institute of Medicine Aims: Equity, Safety, Timeliness

National Quality Strategy Priority: Health and Wellbeing

Level of Aggregation: Program *(NOTE: This measure only applies to programs such as Medicaid that provide both medical insurance and dental benefit. Use of this measure as a requirement for stand-alone dental benefit plans will result in feasibility issues due to lack of access to appropriate data. Use by health plans that provide both medical insurance and dental benefit to a population may be considered after assessment of data element feasibility within the plans databases)*

Improvement Noted As: Higher the better

Data Required: Single year (Medical and Dental)

Measure Purpose: Examples of questions that can be answered through this measure at each level of aggregation:

1. What is the percentage of ED visits for caries-related reasons for which children see a dentist for follow-up within 7 days and 30 days, respectively?
2. Does the percentage caries-related ED visits that are followed up by visit with a dentist within 7 days and 30 days, respectively, stay stable, increase or decrease over time?

Primary Stratification Variables

1. Age: <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

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¹ **Process:** A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus. Accessed from "NQF Glossary" at

http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx. Accessed December 2014.

Follow-up after Emergency Department Visit for Dental Caries Calculation:

1. Run records for one reporting year for paid claims²
2. Identify all emergency department visits for caries-related reasons occurring during eligible member months between January 1 and December 1 of the reporting year:
 - a. Identify a health care encounter as an ED visit if any of the following are met:
 - CPT codes 99281-99285 (ED visit for patient evaluation/management); **OR**
 - Revenue code 0450-0459 (Emergency Room) or 0981 (professional fees for ER services); **OR**
 - CMS place of service code for professional claims - 23 (Emergency Room)
 - b. Exclude visits that result in inpatient admissions where inpatient admissions are identified as:
 - (i) the patient has an inpatient admission defined by UB Type of Bill = 11x OR 12x OR 41x
AND
 - (ii) that admission occurred within 48 hours:

[inpatient admit date] – [ED admit date] >= 0 days AND <= 2 days.
 - c. Count only one visit per member per day
 - d. Member must be <21 years on date of visit
Reporting note: Age stratifications will be based on subject's age on date of ED visit.
 - e. Identify an ED visit as being caries related if:
 - i. any of the ICD-9-CM diagnosis codes in Table 1 is listed as a FIRST-LISTED diagnosis code associated with the visit

OR
 - ii. (a) any of the ICD-9-CM diagnosis codes in Table 2 is listed as a FIRST-LISTED diagnosis **AND** (b) any of the ICD-9-CM diagnosis codes in Table 1 is listed as an ADDITIONAL LISTED diagnosis. (Codes from Table 2 must be accompanied by a code from Table 1 to qualify.)
 - f. Member must be enrolled on date of ED visit and through 30 days following the visit.
 - g. Sum the number of ED visits for caries-related reasons.

YOU NOW HAVE THE DENOMINATOR: Number of ED visits for caries-related reasons

² Medicaid/CHIP programs should exclude those individuals who do not qualify for EPSDT benefits.

Table 1. Caries-Related ICD-9-CM Diagnosis Codes

ICD-9 CODE	DESCRIPTION	ICD-10 CODE	DESCRIPTION
521.00	Unspecified dental caries	K02.9	Dental caries, unspecified
521.01	Dental caries limited to enamel	K02.61	Dental caries on smooth surface limited to enamel
521.02	Dental caries extending into dentine	K02.62	Dental caries on smooth surface penetrating into dentin
521.03	Dental caries extending into pulp	K02.63	Dental caries on smooth surface penetrating into pulp
521.04	Arrested dental caries	K02.3	Arrested dental caries
521.05	Odontoclasia	K03.89	Other specified diseases of hard tissues of teeth
521.06	Dental caries pit and fissure	K02.51	Dental caries on pit and fissure surface limited to enamel
521.07	Dental caries of smooth surface	K02.61	Dental caries on smooth surface limited to enamel
		K02.62	Dental caries on smooth surface penetrating into dentin
		K02.63	Dental caries on smooth surface penetrating into pulp
521.08	Dental caries of root surface	K02.7	Dental root caries
521.09	Other dental caries	K02.9	Dental caries, unspecified
522.0	Pulpitis	K04.0	Pulpitis
522.1	Necrosis of the pulp	K04.1	Necrosis of pulp
522.2	Pulp degeneration	K04.2	Pulp degeneration
522.3	Abnormal hard tissue formation in pulp	K04.3	Abnormal hard tissue formation in pulp
522.4	Acute apical periodontitis of pulpal origin	K04.4	Acute apical periodontitis of pulpal origin
522.5	Periapical abscess without sinus	K04.7	Periapical abscess without sinus
522.6	Chronic apical periodontitis	K04.5	Chronic apical periodontitis
522.7	Periapical abscess with sinus	K04.6	Periapical abscess with sinus
522.8	Radicular cyst	K04.8	Radicular cyst
522.9	Other and unspecified diseases of pulp and periapical tissues	K04.90	Unspecified diseases of pulp and periapical tissues
		K04.99	Other diseases of pulp and periapical tissues
525.3	Retained dental root	K08.3	Retained dental root
525.60	Unspecified unsatisfactory restoration of tooth	K08.50	Unsatisfactory restoration of tooth, unspecified
525.61	Open restoration margins	K08.51	Open restoration margins of tooth

525.63	Fractured dental restorative material without loss of material	KØ8.53Ø	Fractured dental restorative material without loss of material
525.64	Fractured dental restorative material with loss of material	KØ8.531	Fractured dental restorative material with loss of material
525.8	Other specified disorders of the teeth and supporting structures	KØ8.8	Other specified disorders of teeth and supporting structures
		M26.79	Other specified alveolar anomalies
525.9	Unspecified disorder of the teeth and supporting structures	KØ8.9	Disorder of teeth and supporting structures, unspecified
526.4	Inflammatory conditions of jaw	M27.2	Inflammatory conditions of jaws
526.5	Alveolitis of jaw	M27.3	Alveolitis of jaws
526.61	Perforation of root canal space	M27.51	Perforation of root canal space due to endodontic treatment
526.62	Endodontic overfill	M27.52	Endodontic overfill
526.63	Endodontic underfill	M27.53	Endodontic underfill
526.69	Other periradicular pathology associated with previous endodontic treatment	M27.59	Other periradicular pathology associated with previous endodontic treatment
528.3	Cellulitis and abscess of oral soft tissues	K12.2	Cellulitis and abscess of mouth
Codes translated with the AAPC (formerly American Academy of Professional Coders) ICD-10 Code Translator tool at https://www.aapc.com/icd-10/codes/			

Table 2. Additional First-Listed ICD-9-CM Diagnosis Codes to Identify Caries-Related Visits when Paired with an Additional Listed Diagnosis Code from the ICD-9-CM Codes in Table 1

ICD-9 CODE	DESCRIPTION	ICD-10 CODE	DESCRIPTION
682	Cellulitis and abscess of face	K12.2	Cellulitis and abscess of mouth
	· must be paired with additional diagnosis code from Table 1	L03.211	Cellulitis of face
		L03.212	Acute lymphangitis of face
682.1	Cellulitis and abscess of neck	L03.221	Cellulitis of neck
	· must be paired with additional diagnosis code from Table 1	L03.222	Acute lymphangitis of neck
682.9	Cellulitis and abscess of unspecified sites	L03.90	Cellulitis, unspecified
	· must be paired with additional diagnosis code from Table 1	L03.91	Acute lymphangitis, unspecified
782.3	Edema	R60.0	Localized edema
	· must be paired with additional diagnosis code from Table 1	R60.1	Generalized edema
		R60.9	Edema, unspecified
784.2	Swelling mass or lump in head and neck	R22.0	Localized swelling, mass and lump, head
	· must be paired with additional diagnosis code from Table 1	R22.1	Localized swelling, mass and lump, neck

3. Check if subject had a visit with a dentist (dental service) within 30 days of the ED visit:

- a. If CDT [SERVICE-CODE] = D0100 – D9999 (any dental service), AND;
- b. [DATE OF ED VISIT]-[DATE OF DENTAL VISIT] <=30 days;

Note: If two or more caries-related ED visits occur for same child within 30 days of one another, then use the first ED visit as the index date for follow-up. Both ED visits will count in the denominator. A follow-up dental visit within 30 days of the first ED visit will be counted once in the numerator.

AND;

- c. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 3 below³, then proceed to next step (#4).

- d. If a **AND** b **AND** c are not met, then the service was not a “follow-up dental service” STOP processing. This ED visit is already included in the denominator but will not be included in the subsequent counts.

Note: In this step, all **claims** with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 3 should be excluded.

YOU NOW HAVE NUMERATOR 2 (NUM2): ED visits for caries-related reasons for which the child had a visit with a dentist within 30 days

4. Among the ED visits identified in Step 3, check if the subject had a visit with a dentist (dental service) within 7 days of the ED visit: [DATE OF ED VISIT]-[DATE OF DENTAL VISIT] <=7 days

YOU NOW HAVE NUMERATOR 1 (NUM1): ED visits for caries-related reasons for which the child had a visit with a dentist within 7 days

5. Report
- Unduplicated count of caries-related ED visits with 30-day dentist visit follow-up in numerator
 - Unduplicated count of caries-related ED visits with 7-day dentist visit follow-up in numerator
 - Unduplicated count of caries-related ED visits in denominator
 - Rates: (NUM1/DEN), (NUM2/DEN)

Table 3: NUCC maintained Provider Taxonomy Codes classified as dentist*

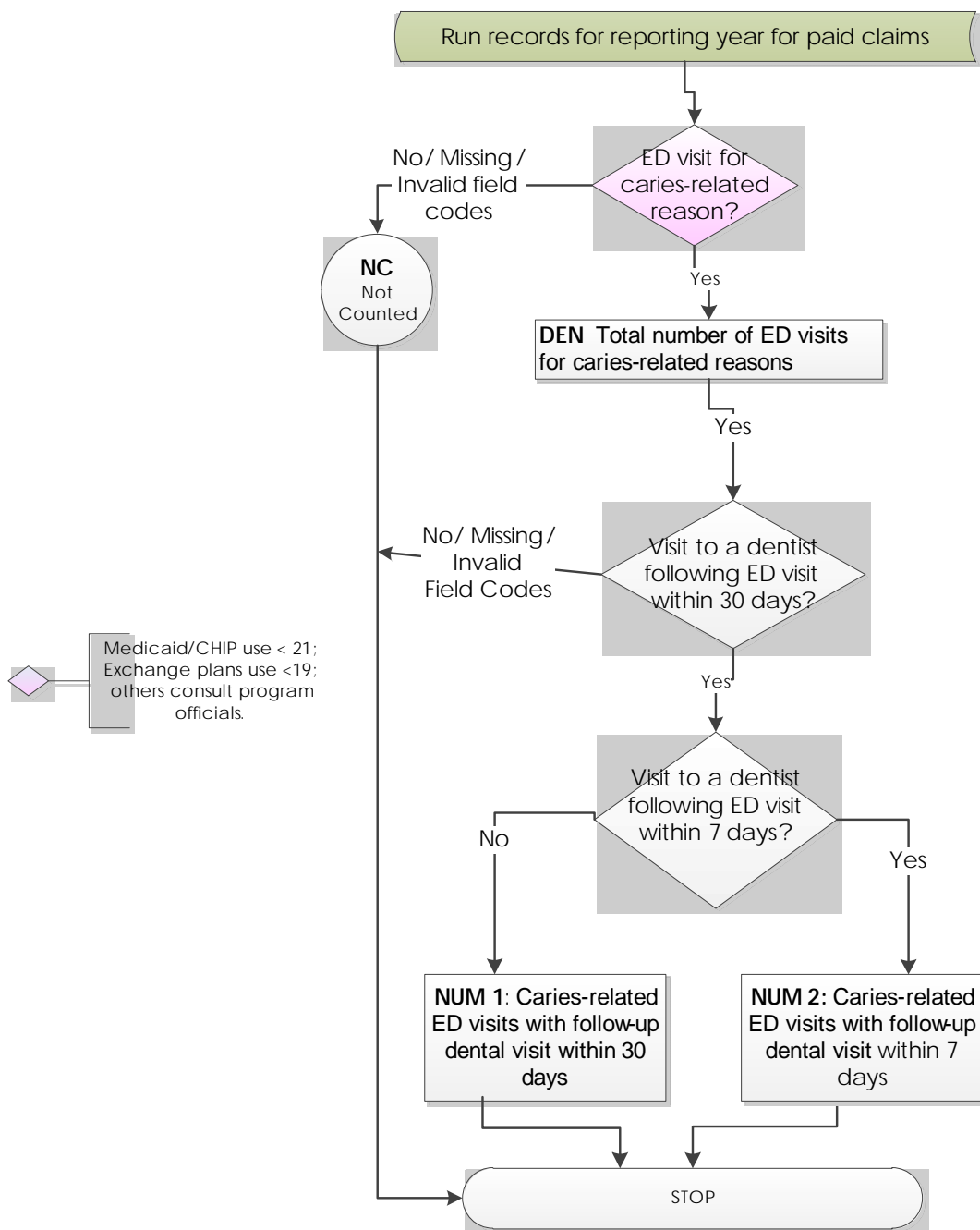
122300000X	1223P0106X	1223X0008X	261QF0400X
1223D0001X	1223P0221X	1223X0400X	261QR1300X
1223D0004X	1223P0300X	124Q00000X+	
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

*Services provided by County Health Department dental clinics may also be included as “dental” services.

+Only dental hygienists who provide services under the supervision of a dentist should be classified as “dental” services.

*** Note: Reliability of the measure score depends on quality of the data that is used to calculate the measures. Flow rates (% of missing or invalid data) for these data elements must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, records with missing or invalid SERVICE-CODE will be counted in the “all enrollees” but not in “all enrollees who received service”. These records are assumed to not have had a visit. In this case, a low quality data set will result in a low utilization score and will not be reliable.***

Measure Logic Diagram



Ballot: Measure Evaluation Using NQF Criteria and Overall Measure Approval

Please complete the survey as appropriate for the measures that have been developed and tested by the DQA. The survey questions are based on the measure evaluation criteria set forth by the National Quality Forum (NQF). The measures that are to be evaluated are as follows:

Measure A: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries,

Measure B: Follow-up after Emergency Department Visits

Rating Definition

- **High** Based on the information submitted, there is high confidence (or certainty) that the criterion is met
- **Moderate** Based on the information submitted, there is moderate confidence (or certainty) that the criterion is met
- **Low** Based on the information submitted, there is low confidence (or certainty) that the criterion is met
- **Insufficient** There is insufficient information submitted to evaluate whether the criterion is met (e.g., blank, incomplete, or not relevant, responsive, or specific to the particular question)

NQF Endorsement	Criteria for Evaluation of Measure	Measure A ED Use	Measure B ED Follow-up
Importance to Measure and Report 1. High Priority/Impact	a. Measure addresses specific national health goal or priority; OR data demonstrate a high priority aspect of health care in terms of the numbers of individuals affected, resource use, or severity in consequences of poor quality care.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
2. Evidence to Support Measure Focus	a. Process measures: The proposed measure is substantiated in terms of the quantity, quality, and consistency of the body of evidence to support that the measured process leads to a desired health outcome in the target population. b. Health outcome measures: Rationale supports the relationship of the health outcome to processes or structures of care.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
3. Performance Gap	a. Demonstration of the opportunity for improvement: data demonstrate considerable variation across providers OR overall less than optimal performance across providers OR disparities across population groups.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient

Scientific Acceptability of Measure Properties 1. Reliability	a. The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allow for comparability.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	b. Reliability testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. NOTE: Data element reliability can be established through <u>validation</u> of the critical data elements.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
2. Validity	a. The measure specifications are consistent with the evidence presented to support the focus of measurement.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	b. The measure is specified to capture the most inclusive target population indicated by the evidence, and exclusions are supported by the evidence (supported by clinical evidence or by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion).	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	c. Validity testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	d. Analysis of the computed measure scores demonstrate that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance OR there is evidence of overall less-than-optimal performance.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	e. Outcome measures: Evidence-based risk adjustment strategy is specified based on patient factors that influence the measured outcome (but not factors related to disparities in care or the quality of care) and are present at start of care; and has demonstrated adequate discrimination and calibration	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient

	OR rationale/data support no risk adjustment/stratification.		
Feasibility Extent to which the required data are readily available or could be captured without undue burden and can be implemented for performance measurement.	a. For clinical measures, the required data elements are routinely generated and used during care delivery.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	b. 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.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	c. Demonstration that the data collection strategy (e.g., source, timing, frequency etc.) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use).	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
Usability and Use Extent to which intended audiences (e.g., consumers, purchasers, providers, policymakers) can understand the results of the measure and find them useful for decision making.	a. 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 there is a credible plan for implementation within the specified timeframes.		
	b. 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.	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
	c. Benefits of the 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).	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> Insufficient
OVERALL RECOMMENDATION	Approval of the measure as currently specified	<input type="checkbox"/> Yes, approve <input type="checkbox"/> No, disapprove	<input type="checkbox"/> Yes, approve <input type="checkbox"/> No, disapprove

Dental Quality Alliance Membership Representatives

Organization: American Association of Endodontists Name: Dr. Brian Bergeon Degrees: D.D.S.	Organization: American Academy of Periodontology Name: Marie Schweinebraten Degrees: D.M.D Title/Position: Periodontist Practitioner
Organization: American Academy of Oral & Maxillofacial Pathology Name: Maria Fornatora Degrees: D.M.D Title/Position: Assistant Dean for Academic Affairs, Temple University Komberg School of Dentistry	Organization: American Academy of Pediatric Dentistry Name: James Crall Degrees: D.D.S, ScD Title/Position: Professor and Chair, Section of Pediatric Dentistry Director, National Oral Health Policy Center at UCLA
Organization: American Association of Orthodontists Name: Allen H. Moffitt Degrees: D.D.S. Title/Position: Orthodontists Practitioner	Organization: American Association of Public Health Dentistry Name: Robert Isman Degrees: D.D.S, M.P.H. Title/Position: Dental Program Consultant
Organization: American Association of Oral & Maxillofacial Surgeons Name: Robert Clark Degrees: DMD Title/Position: Oral and maxillofacial surgeon	Organization: American College of Prosthodontists Name: Rand Harlow Degrees: D.D.S Title/Position: Director of Predoctoral Implant Education, UIC College of Dentistry
Organization: American Dental Hygienists' Association Name: Lynn Ramer Degrees: L.D.H. Title/Position: Immediate Past President	Organization: Academy of General Dentistry Name: Ralph Cooley Degrees: D.D.S. Title/Position: General Dentistry
Organization: American Dental Education Association Name: Ronald Hunt Degrees: D.D.S. Title/Position: Associate Dean for Academic Affairs Midwestern University/College of Dental Medicine	Organization: American's Health Insurance Plans Name: Tom Meyers Degrees: N/A Title/Position: Vice President, Product Policy Department
Organization: American Medical Association Name: Mark Antman Degrees: D.D.S. , M.B.A. Title/Position: Director, Measure Development Operations Performance Improvement	Organization: American Dental Association, Council on Dental Practice Name: Miranda M. Childs Degrees: D.D.S. Title/Position: General Dentist

Organization: DentaQuest Name: John Luther Degrees: D.D.S. Title/Position: Chief Dental Officer and Senior Vice President of Dental Management	Organization: Delta Dental Plan Association Name: Jed Jacobson Degrees: D.D.S, M.S., M.P.H. Title/Position: Chief Science Officer and Sr. Vice President
Organization: National Network for Oral Health Access Name: Huong N. Le Degrees: D.D.S Title/Position: Dental Director, Asian Health Services	Organization: Public Member Name: Degrees: Title/Position: Address: Email: Phone:
Organization: The Joint Commission Name: Sharon Sprenger Degrees: Title/Position: Director, Measurement Coordination and Outreach Division of Healthcare Quality Evaluation	Organization: National Association of Dental Plans Name: Craig Amundson Title/Position: General Dentistry with HealthPartners Medical and Dental Group
Organization: American Dental Association's Board of Trustees Name: Joseph Crowley	Organization: Medicaid and SCHIP Dental Directors Association Name: Ken Rich Degrees: D.M.D Title/Position: President
Organization: American Dental Association, Council on Dental Benefit Programs Name: Robert Mazzola Degrees: D.D.S. Title/Position: General Dentist	Organization: American Dental Association, Council on Access, Prevention, and Interprofessional Relationships Name: David Schirmer Degrees: D.D.S. Title/Position: General Dentist
Organization: American Dental Association, Council on Government Affairs Name: Michael R Breault Degrees: D.D.S. Title/Position: Periodontist	Organization: American Association of Oral & Maxillofacial Radiology Name: Bob Cederberg Degrees: D.D.S. Title/Position: Associate Dean for Patient Care
Organization: American Board of Pediatric Dentistry Name: JC Shirley Degrees: DMD	Organization: Managed Care of North America (MCNA) Dental Name: Phil Hunke Degrees: D.D.S. Title/Position: Executive Director
Organization: American Association for Dental Research Name: Paul Casamassimo Title/Position: Chief of Dentistry/Professor & Chair	

Associate Members

Organization: Adirondack Oral & Maxillofacial Surgery Name: Gary Wadhwa Degrees: Title/Position: CEO	
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Department of Health and Human Services Technical Advisors/Liaisons

Organization: Health Resources and Services Administration Name: Renee Joskow Degrees: D.D.S., M.P.H., F.A.G.D. Title/Position: Senior Dental Advisor	Organization: Centers for Disease Control and Prevention Name: Laurie Barker Degrees: M.S.P.H. Title/Position: Mathematical Statistician Surveillance, Investigation and Research Team, Division of Oral Health
Organization: Centers for Medicare and Medicaid Services Name: Lynn Douglas Mouden Degrees: D.D.S., M.P.H. Title/Position: Chief Dental Officer	Organization: Agency for Healthcare Research and Quality Name: Richard Manski Degrees: D.D.S, M.B.A, Ph.D.



James Crall, DMD
Chair, Dental Quality Alliance
c/c American Dental Association
211 E. Chicago Ave.
Chiacgo, Illinois 60611

Dear Dr. Crall:

On behalf of the Medicaid CHIP State Dental Association, I am writing this letter in support of the two Dental Quality Alliance (DQA) measures:

- Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
- Follow-up after Emergency Department Visit for Dental Caries in Children

A recent study of the National Emergency Department Sample reported that in 2008, children 21 years and younger accounted for a total of 215,073 ED visits for dental related conditions¹; amongst which Medicaid-enrolled children accounted for the largest share (43%)¹, consistent with earlier research indicating that Medicaid is the primary payer for dental-related ED visits among children². In its recent policy document the Partnership for Medicaid noted that “The Medicaid program must be efficient and effective, and must provide value to its beneficiaries and to those who fund it. Without a comprehensive measurement and reporting system, we cannot know whether this is the case, nor determine where improvements may be needed.” Strong support and implementation of quality measures identified by the DQA has helped pave the way for improvement in the oral and overall health of the population our members serve. The proposed system level measures represent an avoidable deterioration in oral health and overall health due to untreated dental caries, the outcome of which can be positively impacted by evidenced-based processes of care delivered in outpatient dental settings.

The Medicaid-CHIP State Dental Association (MSDA) has been serving on the Executive Committee of the DQA since the DQA Steering Committee was formed in 2009, and our current President, Dr. W. Ken Rich serves as the Chair of the DQA.

¹ Allareddy V, Nalliah RP, Haque M, Johnson BS, Rampa SB, Lee MK. Hospital-based emergency department visits with dental conditions among children in the United States: nationwide epidemiological data. *Pediatr Dent* 2014;37(5):393-9.

² Nalliah RP, Allareddy V, Elangovan S, Karimbux N. Hospital based emergency department visits attributed to dental caries in the United States in 2006. *The journal of evidence-based dental practice*. 2010;10(4):212-22. Epub 2010/11/26.

In the short time frame since the DQA was established, it has successfully achieved a number of significant milestones; including endorsement of its five measures by the National Quality Forum (NQF). The NQF endorsement definitely paved the way for the CMS to consider the inclusion of the DQA measure into the 2015 updates to the Child Core Health Care Quality Measurement set; Sealants for 6-9 Year-Old Children at Elevated Caries Risk.

We are pleased to support your application and request serious consideration of the DQA measures by the NQF.

Sincerely,

A handwritten signature in black ink, reading "Mary E. Foley". The signature is written in a cursive, flowing style.

Mary E. Foley, MPH
Executive Director