



BRIGHT FUTURES and MANAGED CARE

Action Brief

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Improving Quality of Care for Children

Quality of health care is a primary concern for everyone in today's health care arena. It is particularly topical for children because the National Committee for Quality Assurance (NCQA) expanded its HEDIS performance measures for children's health for 1999. Also, the Health Care Financing Administration (HCFA) has proposed new regulations for Medicaid managed care that include new requirements for managed care organizations' quality assessment and performance improvement programs.

To share ideas and insights about "Improving Quality of Care for Children," NIHCM convened a forum of health plan quality improvement managers and other quality improvement and child health experts on December 4, 1998. The forum was the third in a series entitled, "Bright Futures and Managed Care," which NIHCM is conducting under a cooperative agreement with the Maternal and Child Health Bureau of the U.S. Health Resources and Services Administration (HRSA). This *Action Brief* summarizes the key issues and discussion from the December forum.

Keynote Presentations

Keynote Speakers

Lisa A. Simpson, M.B., B.Ch., M.P.H.,
Deputy Administrator, Agency for Health
Care Policy and Research

Wendy J. Wolf, M.D., M.P.H., Senior Policy
Fellow, Health Resources and Services
Administration and Agency for Health Care
Policy and Research

Current State of Quality for Children

Dr. Lisa Simpson opened the forum by emphasizing the overarching importance of quality measurement and improvement and highlighting a number of critical issues for both the public and private sectors.

Quality Defined. The Institute of Medicine defines quality of care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current

professional knowledge. AHCPR also uses a simple definition that quality of care is doing the right thing for the right person at the right time. Whatever the definition, the focus should be appropriate care for both individuals and populations.

Partnerships are Essential. To accomplish the goals of quality health care for children, said **Dr. Simpson**, the public and private sectors must coordinate their efforts on quality. This is particularly true for children, because many of them are covered by public insurance programs but have their care delivered by private delivery systems.

Currently, national interest focuses on developing measures of quality. As health services research increases, the ability to measure quality improves. "The reality is you actually can measure it increasingly in a reliable and systematic and reproducible way," said **Dr. Simpson**.

Quality measures presently are used for two purposes—to inform choice for consumers and purchasers and to improve quality of care. The effect on improving quality, however, is dependent on what data is collected and how it is used.

Managed Care Can Improve Quality. Performance measures primarily have been used in managed care settings due to the existence of a defined denominator population. As managed care becomes the dominant form of health services delivery for children, there is greater emphasis on assuring appropriate quality care. **Dr. Simpson** noted that managed care provides an opportunity to emphasize prevention, which is critical for children because they have a disproportionate need for preventive health services in their early years. The challenge for managed care, Dr. Simpson noted, is caring for chronically ill children.

"As we think about quality in children, we can't just assume that the approaches we use for adults are going to work for children. They are not just little adults. We have to specifically address and understand what children need in quality."

—Lisa Simpson

Defining Quality for Children

As health care coverage becomes more available for children, noted **Dr. Wendy Wolf**, the focus must shift to defining quality of care for children.

Characteristics of Quality Care. **Dr. Wolf** presented HRSA's nine characteristics of high quality care for children. Care must be:

- accessible to families;
- continuous throughout childhood;
- comprehensive, beyond preventive or acute care;
- coordinated;
- clinically effective, including evidence-based;
- child centered;
- community oriented;
- culturally competent;
- accountable to the families' needs.

Numerous resources are available, particularly from the Federal Government, to those interested in promoting quality in children's health. They include sources of data such as *America's Children: Key National Indicators of Well-Being* from HRSA, the Title V Performance Measures from the Maternal Child Health Bureau, the Medical Expenditure Panel Survey from AHCPR, and the Youth Risk Behavior Surveillance System from the Centers for Disease Control. Publications that outline quality health care services include the *Bright Futures Child Health Supervision Guidelines* and AHCPR's *Improving Quality Care for Children: An Agenda for Research*.

CHIP Requires Goals and Performance Measures. The new State Children's Health Insurance Program requires states to assure quality and appropriateness of care and describe how performance will be measured through objective, independently verifiable means and comparison with performance goals.

Based on a review of the state plans for CHIP, **Dr. Wolf** found that a majority of states are using selected HEDIS measures. She foresees problems in assessing quality, however, primarily due to a lack of baseline data about the health status of the children. Other issues that states will have to address include inadequate data information systems, variability in measures used, inadequate mechanisms for risk adjustment, and changing insurance status among low-income children.

As we continue to focus on providing quality health care for children, **Dr. Wolf** emphasized that the efforts should include all children, both insured and uninsured. Because some children receiving coverage through publicly-funded programs may change their status often, all children need to be assessed when defining a quality system.

Measuring Quality

Presenters

Joseph W. Thompson, M.D., M.P.H., Center for Applied Research and Evaluation, University of Arkansas

Ann E. K. Page, R.N., M.P.H., Technical Director, Division of Quality Systems Management, Center for Medicaid and State Operations, HCFA

Performance Measures

Performance measures that specifically address children's health will help purchasers and health plans to evaluate their efforts to deliver quality health care for children.

Dr. Joe Thompson reviewed performance measures now in use and discussed current efforts to develop better measures that focus on children. As of December 1998, there were fifteen out of fifty-six HEDIS measures related to children's health (including prenatal care) for clinical care, access and utilization. These measures show a wide variation in performance among managed care plans but do not provide any specific information on disease conditions.

During 1999, NCQA is requiring (as part of HEDIS) that managed care plans conduct a Children's Quality Survey which is adapted from the Consumer Assessment of Health Plans Survey (CAHPS). Parents are questioned about their children's experiences with both plans and providers. The survey applies to both commercial and Medicaid populations for children birth to 12 years old. Components under development would apply to adolescents and children with chronic illnesses. The survey will provide comparative data on the pediatric delivery system for parents, purchasers, providers and health plans, and may help in development of new measures for children's health care.

A New Framework for Accountability. Better performance measures for children's care are needed to help families, purchasers, providers, health plans, and policy makers make better health care decisions and improve the quality of children's care. To meet this need, the Foundation for Accountability (FACct) and NCQA jointly established the "Child and Adolescent Health Measurement Initiative." The project will help develop and test new performance measures specific to children.

Developing measures specific for children is crucial because, as **Dr. Simpson** also emphasized, children are different from adults. Children do not have the common pathways of illness found with adult disease. They do not have as many common conditions as adults; children

are dependent on adults for care; and health care for children goes beyond the medical system such as when a coordinated diagnosis of attention deficit hyperactivity disorder is made jointly by the health care system and the school system.

Specific challenges face those developing quality measures for children's care, noted **Dr. Thompson**. For any given group of children, the needs and expected outcomes may be different. The small sample size for many clinical conditions limits statistical evaluation efforts. There is also a lack of scientific evidence about standards of care and desired outcomes for children.

Three criteria for measure development are being followed: Is the topic a priority that is relevant to consumers, purchasers and delivery systems? Does the measure fit within a measurement set to provide comprehensive, balanced and affordable measures? And, are the measurement concepts and methods sound? To work effectively, measures need to have valid and reliable tools and methods, be sensitive to quality variations, discriminate among providers, be feasible, and not induce a perverse incentive.

The Measurement Initiative has four task forces looking at various aspects of children's health. The Staying Healthy task force focuses on early childhood development and adolescent preventive care. The Getting Better task force looks at acute illness and follow-up with a primary care provider. The Living with Illness and Changing Needs task force uses a survey to address children with chronic illness and then will focus on specific disease processes in chronic illnesses.

The fourth task force, Health Plan Assessment, refines proposed measures for submission to NCQA for potential inclusion in HEDIS. The task force has already recommended implementation of the pediatric CAHPS and is reviewing measures under development by the other task forces.

The Initiative will give recommendations and measurement proposals to NCQA and will suggest focus group protocols for consumers and parents. In addition, the project will develop public education materials and generate recommendations for parents, physicians, health care systems and purchasers on improving quality in children's care.

Federal Standards

Ann Page described the quality assessment and performance measurement strategy now mandated by the Balanced Budget Act of 1997 (BBA) for state Medicaid managed care programs.

HCFA's proposed regulation implementing the BBA would require states: to have standards for plan design

and access to care for all contracts with managed care plans; to have standards for how plans will measure and work to improve quality of care, including a process of monitoring compliance with the standards; and to assure that each contract with a managed care organization undergoes an annual, independent review by an external quality review organization (EQRO) to evaluate the plan's compliance.

Access standards include availability of services, continuity of care, and authorization for covered services. **Plan design and operations standards**, or structure of care, address provider credentials, enrollee information, confidentiality and grievance procedures. "It is not just the processes of care, it is also the structure of care, how organizations are designed and how the design influences how they operate," said **Ms. Page**.

Quality measurement and improvement standards require three processes: using clinical guidelines; having a quality assessment and improvement program; and having a health information system that allows a plan to assess its capabilities in measuring quality.

The quality assessment and improvement program consists of two parts: performance measurement and performance improvement projects. **Performance measures** are specified by the state and must be reported by health plans that hold contracts with the state for Medicaid services. HCFA's regulation requires at least two measures but does not define them, so a state has flexibility to use HEDIS or any other measures.

Under the proposed regulation, the **performance improvement projects** require health plans to measure performance in both clinical and non-clinical areas. Health plans are required to achieve "significant and sustained improvement," but the level of improvement is left for the state to determine. Guidance can be found in HCFA's "Quality Improvement Strategy for Medicaid Managed Care" (QISMC).

Many of the strategies for quality assessment and improvement in the proposed regulation also are found in QISMC. QISMC was in effect before the BBA mandates and is not binding on states. Whereas the proposed regulation specifies standards for states, QISMC provides guidelines to managed care organizations.

Another BBA requirement is that states conduct an annual evaluation of the level of quality provided by each managed care plan with which the state has Medicaid contracts. Many states presently use external quality review organizations for performance evaluation and audits of performance measures. To implement this BBA requirement, HCFA will be issuing a proposed rule which will allow states flexibility to continue their successful efforts.

Health Plan Initiatives in Quality

Health Plan Representatives

Shelly Smith, R.N., M.N., Manager of Clinical Quality and Health Improvement, Premera Blue Cross

Vickie Evans, R.N., C.P.H.Q., Consultant Clinical Quality Improvement Department, Wellmark Blue Cross and Blue Shield

Mark Clanton, M.D., M.P.H., Vice President, Managed Care and Medical Quality, Blue Cross and Blue Shield of Texas

Consistent with their overall mission, managed care organizations are continuing their efforts to measure and improve quality of care. Many of these efforts focus on children.

Shelly Smith discussed clinically-focused child health initiatives at **Premera Blue Cross**, such as immunizations, well-child examinations, and middle ear disease, which Premera has found to be the number one reason for emergency room visits in the Medicaid population.

Understanding the barriers to care and the needs of the families, noted **Ms. Smith**, are crucial first steps in increasing immunization rates. Premera identified barriers in four key areas: member-related, provider-related, the timing of vaccination and data collection challenges.

Member-related issues involve families not knowing the importance of immunization or what immunizations a child has received. The health plan may not have access to a child's full record, so they often do not have a good immunization history. Additionally, access remains a key problem, particularly for the Medicaid population.

Many **providers** are not following national recommendations on immunizations, in particular for newer vaccines. Hepatitis B and Varicella have poor rates, especially for adolescents. And better office procedures are needed to improve tracking of immunizations.

Timing Issues. Precisely when a child receives an immunization also impacts measured immunization rates. Being even a few days off from the national recommendation on the timing of an immunization can lead to a dramatic rate change. **Ms. Smith** provided the example of Hepatitis B: the third shot should be given after six months of age, but 35 percent were given within seven days before the child reached six months old. Even

though the vaccine was delivered, it is not reflected in the immunization rate and therefore the quality indicator.

Data collection from other sources is a challenge for health plans. As the Medicaid population moves to managed care, care received in the traditional delivery system is difficult to track. Health plans find that contracting with the public health district helps in collecting some data. Washington state now has a state-wide childhood immunization registry, the "Child Profile", which receives data from the state, health districts, and physicians. Once the data is gathered, children's immunizations will be easier to follow.

Based on their barrier analysis, **Premera Blue Cross** is developing new quality strategies following the "best practices" of successful clinics which routinely check for immunizations at every visit and accommodate families for scheduling. They are working to strengthen providers' recall systems, because people pay most attention to their physicians. Premera continues their mail and telephone reminders that provide a simply message about the immunization schedule.

Through state-mandated reviews for compliance with EPSDT standards for managed care members, **Premera** found that very few infants were receiving the recommended well-child exams. But in all age groups, the use of a structured tool was associated with much higher compliance. Use of a tool not only improved documentation, but also provided guidance about the appropriate content of the visit.

"[C]are is better if you have a structured tool because you are reminded of things that need to happen."

–Shelly Smith

Premera Blue Cross participates in two other broad-based quality initiatives. Premera is working with other health plans and health districts on a statewide quality improvement task force focused on improving specific areas of care within each age group. An association of health plans in Washington also is collaborating to promote a single well-child screening tool. Presently, plans and the state are using different tools, if they are using anything at all; and the plans would like to promote one tool to providers in the state. The group is considering the Bright Futures materials.

Wellmark Blue Cross and Blue Shield's quality improvement initiatives for children start with their maternity program, Better Beginnings, which is a preconception and prenatal education program. **Vickie Evans** noted that the voluntary program attempts to reduce premature births by guiding at-risk mothers

through the pregnancy. Eighty-one percent of Better Beginnings members who were determined to be at-risk for premature births carried their babies to term.

Like Premera, **Wellmark** uses immunization reminder programs. To remove potential financial concerns, immunization schedules sent to parents point out that immunizations are a fully-covered benefit. Another program entails sending a birthday card to each child at one year of age with a recommended schedule for well-child visits and immunizations.

Wellmark has been using clinical practice guidelines for several years and now has developed preventive health maintenance guidelines. Plan providers developed the guidelines as a tool for themselves and for families. The guidelines will be reviewed annually, and Wellmark is looking at Bright Futures to modify the guidelines based on feedback from participating providers.

Last year, **Wellmark** spearheaded the Iowa Clinical Guideline Collaborative, a statewide effort of several health plan medical directors, hospital groups, and state medical societies working to adopt one guideline to reflect the best practice in treating a disease.

Other **Wellmark** initiatives include the "Health Wise Handbook," a self care guide that contains immunization and preventative care schedules. All participating primary care physicians have them in their examination rooms. A "Well Being" magazine is sent to the HMO members, and every issue has an article on parenting. Wellmark also has a 24-hour call-in nurse line via a toll-free number.

The "**Wellmark Report**" is a highly regarded annual publication that provides comparative data across Iowa about 14 key indicators of health (disease prevalence and use of health care services). Wellmark presents the data to local communities and helps form, and provides technical assistance to, local community task forces which seek to undertake health improvement initiatives. Based on the Wellmark Report finding that Iowa children have more upper respiratory infections and otitis media than the national average, **Ms. Evans** noted, the Iowa Medical Society is looking into better ways to educate parents and providers to the dangers of inappropriate antibiotic use.

Dr. Mark Clanton outlined a new, five-year collaborative quality improvement research project that Blue Cross and Blue Shield of Texas is working on with the Henry Ford Health System, Harvard School of Public Health, the Children's Hospital of Boston and the American Academy of Pediatrics (AAP). The "Making Advances against Jaundice in Infant Care" (MAJIC) project, funded by AHCPR and the David and Lucile Packard Foundation, focuses on the type of care that newborns with jaundice receive.

The project is unique in that it focuses on one condition, jaundice, and it measures both clinical performance as well as patient satisfaction. To measure satisfaction, the health plans are using a form of CAHPS to question parents about the care that their infants received for jaundice.

Neonatal jaundice affects about half of all newborn babies and, with the emergence of short hospital stays and a shortage of pediatricians, the incidence is increasing. Using existing data bases, researchers on the MAJIC project will evaluate whether physicians are treating infants for jaundice according to the AAP guidelines. Based on the analysis, the health plans will work with the physicians to improve care. The MAJIC project will be able to produce comparative data on clinical care and patient satisfaction between two health systems and, as a sub-component, between types of products, to evaluate and improve the overall quality of care for jaundice.

Bright Futures and Quality Improvement

Moderator

Charles LaVallee, Executive Director and Vice President, Western Pennsylvania Caring Foundation

Presentation

Sharon Muret-Wagstaff, Ph.D., M.P.A., Research Associate, Boston Children's Hospital, and Instructor in Pediatrics, Harvard Medical School

The *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* are a powerful tool that can help to improve the quality of health care children receive. **Charlie LaVallee** opened the discussion on this topic by emphasizing that physicians and parents both are responsible for assuring that children receive the care that they need in a timely manner.

Commenting on the usefulness of Bright Futures in quality improvement, **Dr. Muret-Wagstaff** noted that Bright Futures works not only for children, but also for managed care organizations. Bright Futures addresses the needs of the key customers of managed care organizations: children, parents, providers, and purchasers. It engages parents as partners and supports pediatric providers. "It doesn't say to the provider, 'Do more.' It says to the provider, 'Here's a tool to help you do the kind of job that you want to do,'" said Dr. Muret-Wagstaff.

Bright Futures offers evidence-based preventive practices, provides pediatric expert consensus on key approaches to child health supervision, and emphasizes links to the community.

Dr. Muret-Wagstaff outlined ten ways that Bright

Futures can improve health care quality for children not only at the clinical level, but also at the organization level. Her analysis is based on the Core Values and Concepts of the Malcolm Baldrige National Quality Award Health Care Criteria for Performance Excellence. The table below outlines the concepts.

Quality Principles*	“Bright Futures” Opportunity	Pay-Off
1. Design Quality and Prevention: Provide work aids. 2. Continuous Improvement and Learning 3. Management by Fact 4. Fast Response	Encounter Forms for Health Professionals Pocket Guides Anticipatory Guidelines Flip Charts	Increase % of quality care delivery Improve data-tracking capacity Improve performance on HEDIS® measures Meet Medicaid contract requirements Improve provider network satisfaction Streamline care for single largest medical cost item for young children Improve outcomes for which clinical counseling works Note: Provider satisfaction influences member satisfaction
5. Patient-Focused Quality and Value	Encounter Forms for Families Developmental Context for Health Care and MCO Communication Spanish Versions Culturally Sensitive Materials for Providers and Families	Informed consumers Consumer-driven visits Patient satisfaction Improved communication is highly associated with quality of care ratings by parents Parents consistently expect developmental information integrated with health care Note: Young children are at the leading edge of the changing faces of diversity in the US
6. Long-Range View of the Future	Nutrition and Exercise Volumes Age-Specific Injury Prevention	Attenuate leading causes of adult mortality and morbidity (heart disease, cancer, stroke) Reduce leading cause of morbidity and mortality for children and adolescents after the first year of life Elucidate a critical quality and cost area that may be masked by conventional ICD-9 coding
7. Valuing Staff	<i>Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents</i> - a reference for non-clinical departments in MCOs	Inform and create synergy among MCO departments, e.g., sales, marketing, prevention and wellness, contracting, credentialing and office review, provider network communications, public affairs, community benefits, foundations
8. Results Focus	Age-Specific Health Supervision Outcomes	Reduce inadvertent errors Focus for quality improvement efforts, individual and collaborative, internal to the MCO and external
9. Public Responsibility and Community Health 10. Partnership Development	Age-Specific Community Links (e.g., child care, WIC, Head Start)	Informed consumer Opportunities for low-cost group approaches (e.g., workplace, day care) Shared responsibility and accountability Demonstrate community benefits with respect to non-profit tax status

*Core Values and Concepts, 1998 Health Care Criteria for Performance Excellence, Malcolm Baldrige National Quality Award

Bright Futures Discussants

Kelly Kelleher, M.D., M.P.H., Staunton Professor of Pediatrics, Psychiatry and Health Services Administration, University of Pittsburgh

Mary Kay Holleran, R.N., Quality Improvement Department, Highmark Blue Cross Blue Shield

Shelly Smith, R.N., M.N., Manager of Clinical Quality and Health Improvement, Premera Blue Cross

Sally Fogerty, B.S.N., M.Ed., Deputy Director, Bureau of Family and Community Health, Massachusetts Department of Public Health

Ann Drum, D.M.D., M.P.H., Acting Director, Division of Science, Education and Analysis, Maternal and Child Health Bureau, HRSA

“The ultimate goal [in using encounter forms] ... is to educate providers to make sure that they are aware of all of the [child’s] needs.”

–Mary Kay Holleran

Shelly Smith noted that there has been improvement in the tools that are available, but no one group has the capacity to develop and maintain multiple tools. Ms. Smith believes that the effort to promote structured tools and improve well child care needs to be a much larger, state-wide effort. The greatest success occurs when health plans join with the public health system and providers collaboratively to develop a single tool.

Sally Fogerty found that one of the keys to Massachusetts’ success in promoting preventive health care for children was the working relationship among the various state agencies that address children’s issues. The Commonwealth of Massachusetts recognized the need for one state-wide program that meets the needs of all of the children in the state, not just children in public programs, and adopted the Bright Futures approach of comprehensive preventive care.

Looking at Bright Futures from the perspective of business, **Dr. Kelly Kelleher** suggested innovative ways that Bright Futures can be used beyond providing accountability guidelines. Bright Futures can provide guidelines for “environmental assessments” of provider’s offices, such as how to make an office more child friendly or developmentally appropriate. Plans can learn about providers and their attitudes on care. In order to have an impact on children’s care, though, health plans, providers and families need to work together.

Dr. Kelleher described one example of how technology and Bright Futures’ materials could be adapted for use as innovative screening tools in physicians’ offices. Families would use a touch-screen computer to complete a questionnaire based on the age of the child. Not only would families get instant feedback and information to discuss with the provider, but the provider would get a complete print-out before seeing the child. This would greatly increase the chance that important issues would be addressed during the visit.

Bright Futures also helps to improve managed care plans’ HEDIS measures. **Mary Kay Holleran** noted that health plans truly are committed to improving the quality of care and they, as well as providers, are searching for a simple tool to help them in their efforts.

Compared to the challenges that using numerous tools brings, **Ms. Holleran** favors Bright Futures because it presents a uniform checklist for providers. Bright Futures materials are available electronically and are scannable, which decreases the time spent on medical record review.

Through a public-private partnership, Massachusetts encourages state agencies, providers, purchasers and families to work toward the same goal of prevention. One of the products of the initiative is a “child health diary,” based on Bright Futures materials, to help families monitor a child’s care. The diary provides information on preventive care and what to expect during visits, along with an immunization record. It is written at the fifth-grade reading level and is available in Spanish.

Dr. Ann Drum pointed out that, although Bright Futures began from the need for one set of comprehensive prevention guidelines in Medicaid, it has grown into a program for all children with an impact on both the public and private health care systems.

Dr. Drum encouraged managed care organizations and private practitioners interested in promoting effective child health supervision to contact the federal agencies for assistance. Bright Futures is a joint effort between HRSA and HCFA that is managed by the National Center for Education in Maternal and Child Health (NCEMCH) of Georgetown University. Both agencies and the Center are prepared to provide technical assistance on how to implement prevention programs.

During discussion among conference participants on the value of having one set of standards and one tool to help improve quality of care, **Dr. Rochelle Mayer, Executive Director of NCEMCH**, pointed out that the Bright Futures encounter forms not only provide tremendous information for parents and providers, but they “set the

stage for a partnership” between them. With the limited time physicians have to spend with each child, the encounter forms help to focus the care more effectively.

Mary Kay Holleran believes the benefit of the Bright Futures encounter forms is their versatility to various practices. **Highmark Blue Cross Blue Shield** is developing a partnership with their contracting physicians to use the encounter forms and modify them to suit their needs.

Bright Futures and Oral Health

Bright Futures Update

James J. Crall, D.D.S., Sc.D., Chief,
Department of Pediatric Dentistry, and
Associate Dean, Program Evaluation and
Planning, University of Connecticut
School of Dental Medicine

As **Dr. Drum** pointed out, Bright Futures is a multidisciplinary effort with guidelines for general health, oral health, mental health and others. Dental care is an important component of comprehensive preventive care for children. Dental services account for approximately 4.5% of all U.S. health care expenditures and 20% of pediatric health care expenditures. To address the significance of oral health in the overall health of children, **Dr. James Crall** provided an overview of children’s oral health status and Bright Futures’ role in integrating oral health services into general health services.

Dr. Crall explained that oral health services face the same issues as general health services in terms of promoting preventive care: a need to reach families early, particularly low-income families, and a need to form partnerships with other organizations involved in children’s health.

Twenty-five percent of U.S. children experience 80 percent of all childhood tooth decay. Lower-income children are more likely to experience tooth decay and more likely to have untreated dental problems. Dental disease is progressive; therefore dental problems which are not treated in young children tend to become more severe with age, often with significant effects on children’s functions and usual activities. “It is through public programs and through ... the type of activities that Bright Futures is trying to foster that we will impart the benefits that have been extended to three-fourths of the [children] in this country to the other 25 percent,” said **Dr. Crall**.

Dental care expenditures are not meeting the need for care. Dental benefits are required for children enrolled in Medicaid, but Medicaid historically has invested only

2.3 percent of pediatric health care expenditures on dental care (compared to 20 percent of all children).

Even with dental coverage, children may not receive the care they need. A 1996 DHHS Inspector General’s investigation found that only one in five Medicaid-eligible children had received at least one diagnostic or preventive dental service in the preceding year (an EPSDT requirement).

Performance measures have not been widely applied for dental care. For Medicaid, HCFA has generally monitored whether a child has had a “preventive dental visit” within a 12-month period. HCFA and HRSA are now working to develop improved EPSDT dental performance measures that provide profiles of services for children enrolled in Medicaid.

HEDIS has only one measure at present on dental care (an annual dental visit), although NCQA has organized a Pediatric Oral Health Expert Panel that has made recommendations for additional measures for the near-term and beyond. AHCPR has supported the development of new clinical measures and is considering a CAHPS dental supplement.

Dental providers also are working on defining the content of pediatric dental care. The American Academy of Pediatric Dentistry has developed quality assurance criteria as well as other oral health policies that are published annually in the [Journal of] *Pediatric Dentistry*. They also can be found on the Academy’s web site at www.aapd.org.

Oral Health Supervision Guidelines can be found in **Bright Futures in Practice: Oral Health**, available from NCEMCH. The Bright Futures guide defines all of the essentials of good oral health for children and families and specifically addresses preventive oral health issues. It goes beyond the currently followed practices and promotes very early interventions, prenatal prevention efforts by the parents and the first child dental visit at age one.

The National Maternal and Child Oral Health Resource Center has a broad range of current information and materials on oral health services which can be accessed at www.ncemch.org.

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