



DENTAL QUALITY ALLIANCE: 2016 ANNUAL MEASURES REVIEW

FINAL REPORT FROM THE DQA MEASURES
DEVELOPMENT AND MAINTENANCE
COMMITTEE

JUNE 2016

Contents

Introduction and Purpose	3
Process	3
Call for Public Comments.....	3
Utilization of Services Measure	4
Breadth of Measure.	4
Enrollment Continuity Requirement.	4
Preventive Services Measures: Elevated Risk Criteria	5
Sealant Measures.....	5
Measure Score Interpretation.....	5
CDT Code D1354.	5
Care Continuity Measure.....	6
Usual Source of Services Measure	6
Measures of Caries-Related Emergency Department Visits	7
Naming Consistency.....	7
Ambulatory Care Sensitive Terminology.	7
Stratification by ED Disposition (Ambulatory Care Visits for Dental Caries)	7
Per Member Per Month Cost of Clinical Services	8
User Groups	8
Code Updates	8
Streamlining the Starter Set Measures	9
Appendix A: MDMC	10
Appendix B: Public Comments.....	11
Appendix C: List of DQA Measure Versions Maintained.....	15
References	16

Introduction and Purpose

The purpose of this report is to summarize the outcomes of the 2016 annual review of the Dental Quality Alliance's (DQA's) Pediatric Measures Set. The measure set targets the goal of addressing Prevention and Disease Management for Dental Caries in Children and addresses utilization/access, cost, and quality of dental services for children enrolled in public (Medicaid, CHIP) and private (commercial) insurance programs. Seven of these measures are endorsed by the National Quality Forum (NQF).

The detailed specifications can be found on the DQA website at:

<http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/access-to-pediatric-starter-set>.

Process

In order to ensure transparency, establish proper protocols for timely assessment of the evidence and measure properties, and to comply with the NQF's endorsement agreement, the DQA has established an annual measure review and maintenance process. This measure review process is overseen by the DQA's Measures Development and Maintenance Committee (MDMC) which is comprised of six subject matter experts ([Appendix A](#)). This annual review process includes: (1) call for public comments, (2) evaluation of the comments, (3) user group feedback, and (4) code set reviews.

Call for Public Comments

The DQA released a call for comments to the dental community as well as to its stakeholders at large in February 2016. Following a 30-day comment period, the MDMC conducted review of the comments received during March-April 2016 through conference calls.

The DQA's MDMC would like to thank all the stakeholders who submitted comments to the measures. The following paragraphs summarize the review of the comments as addressed by the MDMC. The detailed public comments are contained in [Appendix B](#). The goal of this final report is to inform the stakeholders at large of the MDMC evaluations and recommendations. The DQA reviewed and reaffirmed its measures by approving all changes outlined in this report at its meeting on Friday, June 10th, 2016.

Utilization of Services Measure

Breadth of Measure. One commenter questioned the lack of specificity associated with an overall dental service use measure.ⁱ The MDMC noted that although each measure can stand alone, no single measure is intended to be a stand-alone indicator of overall program quality. This measure was designed as a broad access to care measure given the overall low utilization of dental services by children within some delivery systems. It also provides important contextual information for interpretation of other measures, including other quality measures and utilization measures.

Enrollment Continuity Requirement. Another commenter expressed concern that there was only a 180-day enrollment requirement, and no longer a 90-day enrollment option for calculating the measure.^{xv} The 90-day enrollment option was viewed as beneficial for comparability to the Centers for Medicare and Medicaid Services (CMS) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reporting. During measure testing, the following enrollment intervals were evaluated: a) ≥ 30 days; b) ≥ 90 days; c) ≥ 180 days; d) 365 days, allowing a single 1-month gap; and e) person-time equivalent (weighting members in the denominator by enrollment length).^{1,2} Through evaluation of the data on the measure denominator and overall measure score and using a face validity consensus process, the MDMC elected to use the 180-day continuous enrollment requirement in order to balance sufficient enrollment duration to allow children adequate time to access care with the number of children who are excluded from the denominator due to stricter enrollment requirements. The final measure specifications originally included a 90-day continuous enrollment requirement for three measures (Utilization of Services, Oral Evaluation, and Treatment Services) to allow for historical comparisons to the CMS EPSDT data. The 90-Day enrollment option was eliminated from the NQF-endorsed Utilization of Services measure because the NQF does not permit multiple denominators within a single measure in order to ensure standardization and consistency in quality measure reporting. CMS and other stakeholders (e.g., state Medicaid programs and state Marketplaces) have adopted NQF-endorsed DQA measures. The 180-day enrollment interval has not been cited as a barrier to implementation although it has been recognized as a distinction from the CMS EPSDT data reporting requirements. The DQA has and will continue to work with the oral health care stakeholder community to promote the development and adoption of validated quality measures and alignment in oral health care performance measurement across stakeholder groups.

Preventive Services Measures: Elevated Risk Criteria

One commenter questioned whether the elevated risk criteria (for inclusion in the preventive services measures' denominators) are necessary for measures of sealant and fluoride applications. ^{ii,iii} The MDMC notes that the DQA has focused on children at elevated risk for prevention measures to focus measurement on priority populations where evidence of effectiveness is greatest and there is the least uncertainty about the appropriateness of the intervention.^{3,4} Testing data found that significant performance gaps existed within the elevated risk populations. The measures should not be construed as a policy statements or recommendation for benefit design.

Sealant Measures

Measure Score Interpretation. One commenter questioned whether successful sealant programs would result in a decline in measure scores in subsequent years ⁱⁱⁱ – e.g., if a program seals a child's first permanent molars at ages 6 or 7 and the child remains in the measure denominator when she is 8 and 9 years old.

The MDMC noted that this issue was addressed through data analysis during the initial testing of the measures. To evaluate the implications of this for performance measurement, testing was conducted by identifying a sample of children who were enrolled throughout the ages of 6-9 years or 10-14 years to analyze (1) the percentage who received sealants in any of those years; and (2) among those receiving sealants, (a) the frequency distribution by age (i.e., the percentage who received sealants at 10 years, 11 years, etc.) and (b) the percentage who received sealants in only one of the years, 2 of the years, and so forth while they were within the specified age range. Testing results affirmed the age ranges of 6-9 years for permanent first molars and 10-14 years for permanent second molars and found that sealant placement rates were not concentrated in the lower ages within each of these age ranges.⁵

However, a more detailed review of the measure score by age may be helpful to plan and program administrators to assist with measure score interpretation within the context of their own systems of care. Consequently, during the 2015 Annual Measure Review cycle, the DQA added reporting guidance within the measure specifications that defines the approach for examining sealant placement by age to enable programs to monitor trends in sealant placement by age over time.

CDT Code D1354. One commenter asked whether the new CDT code D1354 – Interim Caries Arresting Medicament Application - would be included in the numerator for the two sealant measures. ^x CDT code D1354 is defined as “conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.” The

MDMC has determined that this code will not be added as a qualifying code for the numerator for the two sealant measures. Evidence-based clinical guidelines recommend that sealants should be placed on pits and fissures of children's primary and permanent teeth when it is determined that the tooth, or the patient, is at risk for experiencing caries.³ Code D1354 references placement of topical application of a caries arresting medicament in the presence of an *active carious lesion*. This procedure does not anticipate preventing future carious lesions. However, as described in the Code Updates section below, this code will be added to the code set used to identify elevated caries risk.

Care Continuity Measure

The Care Continuity measure examines whether a child received a comprehensive or periodic oral evaluation in each of two consecutive years. One commenter questioned how this measure may be affected by Medicaid eligibility churn and by the impact of the Affordable Care Act on preventive care seeking.^{iv} The MDMC notes that this measure requires children to be enrolled at least 180 days within each of the two consecutive years; children not meeting this enrollment requirement would not be included in the measure's denominator. Care Continuity, combined with DQA utilization measures, should allow states to monitor trends over time.

Usual Source of Services Measure

Usual Source of Services examines whether a child visited the same practice or clinical entity in each of two consecutive years. One commenter questioned whether the "source" could be an emergency department (ED), reflecting emergency care seeking, which could be inconsistent with the intent of this measure.^v The MDMC notes that this measure is restricted to procedures identified using CDT codes rendered by "dental" providers. Although there was not an explicit exclusion of EDs as a place of service, measure testing did not find EDs to be among the dental service provider types. ED visits are more likely to be billed through medical claims.

Another commenter questioned the evidence for including this as a quality of care indicator.^{viii} Evidence in support of the Usual Source of Services measure identified during testing included: (1) a study finding that a usual source of dental care is a strong and consistent predictor of dental visits;⁶ (2) a study finding that having a usual source of care promotes preventive health counseling;⁷ and (3) an Institute of Medicine report that identified having an "ongoing relationship with clinicians who know their patients and their patients' health histories" as a core element of primary care.⁸

Measures of Caries-Related Emergency Department Visits

Naming Consistency. One commenter noted inconsistencies in the measure names for the two emergency department (ED) related measures ^{xiv} and recommended aligning the two measure names:

1. Ambulatory Care Sensitive Emergency Department Visits **for Dental Caries in Children**
2. Follow-Up after Emergency Department Visit **by Children for Dental Caries**

The MDMC proposes to change the second measure name to: Follow-Up after Emergency Department Visits for Dental Caries in Children.

“Ambulatory Care Sensitive” Terminology. One commenter felt that the connection between the “ambulatory care sensitive” terminology and the measure specifications was unclear and recommended adding language to the Rationale section for the measure. ^{xii} **The MDMC recommends adding the following language to the Rationale section for each of the two measures:** “Because dental caries can be reduced and managed through outpatient care processes, caries-related ED visits represent “ambulatory care sensitive” visits - visits that are potentially avoidable through timely and effective use of the ambulatory health care system.”

Stratification by ED Disposition (Ambulatory Care Sensitive ED Visits for Dental Caries).

One commenter suggested changing the measure name or description to reflect that the measure results are stratified by ED disposition. ^{xiii} The MDMC elected not to highlight the stratification in the measure name or description because it is not a focal point of the measure. Rather, it is provided to allow programs to have additional information for measure score interpretation and to inform their quality improvement efforts. This is similar to the age stratifications included in all of the DQA measures, which also are not highlighted in the measure name or description.

Same Day ED Visit and Dental Outpatient Visit (Follow-Up after ED Visit).

One commenter questioned whether there was an assumption in the measure that ED visits did not follow a visit to a dentist. ^{vi} The MDMC notes that the specific issue evaluated during testing was how to handle the 5% of ED visits that had an outpatient visit to a dentist on the same day as the ED visit given that administrative claims data do not allow for the identification of the relative timing of these visits. It was recognized that some outpatient visits may occur before the ED visit instead of after the ED visit. Based on expert opinion, there was a consensus that a majority (not all) of these visits would involve the ED visit preceding the outpatient visit. A significant factor in the determination to include same-day outpatient visits was the concern that *excluding these visits would potentially create a disincentive for same-day follow-up*, which would be in direct contrast to the intent of the measure (i.e., measure scores are higher when

there are fewer same-day follow-up visits when those visits are excluded). Thus, the MDMC elected to err on the side of potential modest inflation of the measure rate rather than potentially dis-incentivizing the very behavior the measure was designed to encourage.

Per Member Per Month Cost of Clinical Services

One commenter inquired whether this measure had been fully specified. ^{vii} The MDMC affirms that it has been fully specified and tested. The specifications are available from DQA staff.

User Groups

The DQA pediatric measures are specified for program-level and plan-level reporting. In 2016, the DQA expanded its scope of review of its measures by convening conference calls for two user groups – one comprised of representatives from 6 state Medicaid programs (Alabama, Florida, Kentucky, Oregon, Nevada, and Pennsylvania) and the other comprised of representatives from 8 dental plans. Participants shared their experiences implementing DQA measures in their respective programs, including any challenges related to the DQA measures specifications and use of these measures in their quality improvement programs. Participants did not have any significant issues related to the clarity or feasibility of implementing the measure specifications.

The DQA would like to thank all the participants from these two user groups for their time and active participation in the conference calls.

Code Updates

The MDMC has elected to include the *Code on Dental Procedures and Nomenclature* (CDT) code D1354, a new code included in the 2016 CDT, in the code set that is used to identify children at elevated caries risk for inclusion in the denominators of the prevention measures.

D1354: Interim caries arresting medicament application

Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.

This addition will be made to the code set used to identify elevated caries risk for the following measures:

1. Topical Fluoride
2. Sealants 6 – 9 years
3. Sealants 10 – 14 years

4. Preventive Services

Both the 2016 CDT Manual and National Uniform Code Committee Health Care Provider Taxonomy code updates were reviewed. No additional codes were identified as being relevant to the pediatric measures.

Streamlining the Starter Set Measures

To provide users with flexibility in examining measures within the context of their own programs, the Starter Set of measures included reporting options within the measure specifications. These options included reporting the measure scores for: (1) the subset of enrollees who “accessed a dental service” during the reporting period, (2) “oral health” services in addition to “dental” services, and (3) 90-day enrollment intervals for comparisons to CMS EPSDT reporting. However, due to the reported lack of use of these separate reporting options and added resource requirements for measure maintenance, the MDMC, through careful review and discussions, made the determination to not maintain separate specifications for each of these versions/ reporting options. Consequently, the Starter Set core measures have been streamlined, and guidance is provided in the User Guide for those who would like to take a “deeper dive” into the data for quality improvement or other purposes. To view the complete list of the DQA measures and multiple reporting options/versions please access [Appendix C](#).

Appendix A: MDMC

Measures Development and Maintenance Committee:

Craig W. Amundson, DDS, General Dentist, HealthPartners, National Association of Dental Plans. Dr. Amundson serves as chair for the Committee.

Mark Casey, DDS, MPH, Dental Director, North Carolina Department of Health and Human Services Division of Medical Assistance

James J. Crall, DDS, ScD, American Academy of Pediatric Dentistry; Professor & Chair, Division of Public Health & Community Dentistry and Director, National Oral Health Policy Center at UCLA

Frederick Eichmiller, DDS, Vice President & Science Officer, Delta Dental of Wisconsin

Chris Farrell, RDH, BSDH, MPA, Oral Health Program Director, Michigan Dept. of Health and Human Services

Todd Marshall, DDS, MBA, General Dentist, Park Dental Brookpark, ADA/ Council on Dental Practice

DQA Executive Committee Liaison to the MDMC:

Mathew Vaillant, DDS, General Dentist, Vaillant Family Dental, ADA/ Council on Dental Benefit Program

DQA Leadership:

Michael Breault, DDS, Periodontist, Chair, Dental Quality Alliance

Marie Schweinebraten, DMD, Periodontist, Chair-Elect, Dental Quality Alliance

The Committee was supported by:

Krishna Aravamudhan, BDS, MS, Director, Council on Dental Benefits Program, American Dental Association

Jill Boylston Herndon, PhD, Methodology Consultant to the DQA; Managing Member and Principal, Key Analytics and Consulting, LLC

Diptee Ojha, BDS, PhD, Senior Manager, Office of Quality Assessment and Improvement, American Dental Association

Appendix B: Public Comments

Dr. Paul Casamassimo

- i. 2511 UTL-CH-A: Any service Philosophically, I am concerned that this will become a rallying point for failed Medicaid systems. The lack of specificity concerns me (eg, an emergency service gets credit but is really a statement on a failed system). It also begs the question of "what next if anything" if a kid has an exam visit but then nothing else. Maybe we have determined how this measure and PRV-CH-A and TRT-CH-A all fit together?
- ii. PRV-CH-A Preventive service I was apprised last week that the most recent USPHSPTF report recommends fluoride varnish for all kids under 5 years of age. I don't know that was available when this measure was made, but asks the question of whether a risk factor appraisal is needed or if a measure needs to be added. I was unaware of that recommendation (it really pertained to primary care providers, but certainly would apply to DDSs seeing young kids)
- iii. 2509 SL2-CH-A Sealants/Year We looked at this measure in OH recently and the irony is that the declining number of kids receiving a sealant in a year may actually mean the state is being successful. I also wonder if elevated risk is needed as sealants remain, to my knowledge, a universally recommended preventive service. And does this include non-Medicaid kids and if so, how will that figure into a measure of success?
- iv. CCH-CH-A Percentage in 2 year period – Care Continuity Do we know how many kids come in and out over that period of time in Medicaid? If this relates to all kids, the DQA should be apprised that the ACA is having an effect on seeking of preventive services for children. The extent is unknown at this point, but early indications are that some families are deferring care due to sky-high deductibles.
- v. USS-CH-A – Same Practice Could this be an ED? I think some data may be a statement of emergency care seeking rather than a dental home
- vi. 2695 EDF-CH-A Follow-up When I reviewed this a while back, the assumption was made that ED visits did not follow a visit to a DDS before for the same problem. We are conducting an emergency CQI and about 40 percent tried

to see a DDS for management of the caries-related problem prior to seeking ED care.

- vii. CCS-CH-A – PMPM I guess I am wondering about this one's details. No PDF cited... seems it would be difficult to measure at a coarse level...

Fred Eichmiller Vice President & Science Officer, Delta Dental of Wisconsin.

- viii. I fail to see the core value of maintaining the continuity of care measure. It is currently unused and difficult to put into the context of interpretation as a quality measure of access. Those of us that operate urban school-based programs understand the high mobility of children within these urban settings. The quality of the delivery system is being able to provide access in spite of this mobility, and not penalize a system because of it. It is totally unrealistic to have an expectation that visiting the same delivery site two years in a row indicates a better quality of care than having that same child visit two different delivery sites. We have no evidence to support this measure and it should be dropped from this set.

American Academy of Pediatric Dentistry

- ix. The American Academy of Pediatric Dentistry (AAPD), and its 9,500 member dentists, reaffirms its endorsement of the *DQA Pediatric Measures Set*. The AAPD recognizes that the promotion of optimal oral health for America's children requires the prevention of dental caries, the most common chronic disease in children in the United States¹. A comprehensive plan that evaluates, on a program level, utilization and quality of care is essential for measure validation and ultimately development of policies that target resources to improve care. Accurately measured data leads to policies that support appropriate use of timely evidence-based preventive services. Validated measures produce data that leads to higher utilization and maintenance or even lowering per capita costs. Our member dentists treat the pain and suffering that result from tooth decay and counsel on caries prevention every day on an individual, patient by patient basis. Achieving a high-level of community-wide oral health in children requires comprehensive performance measurements to improve oral health, patient care, and safety. Most importantly the pediatric measures set is actionable, in accordance with the AHRQ Child Quality Measures Subcommittee criteria; States, Medicaid, CHIP managed care plans, and healthcare organizations now

¹ Vargas CM, Crall JJ, Schneider Da. *Sociodemographic distribution of pediatric dental caries: Nhanes iii*, 1988–1994. *J Am Dent Assoc.* 1998;129:1229–38

have the ability to measure the quality of the oral health care they provide. With measurement comes awareness and ultimately change leading to better oral health for children.

Dr. Mary Lee Conicella, CDO, Aetna.

- x. In the current measures related to sealants, the documents refer to CDT code D1351. With the introduction of new code D1354 in CDT 2016, will the preventive "sealant" measures be expanded to include placement of caries arresting medicaments as an alternate to sealants?

Dr. Mark Antman, Health Care Quality Consultant.

- xi. In response to your call for comments on the DQA measure set, I am submitting the following suggestions/comments related to the two new (and newly NQF-endorsed) caries-related measures: EDV-CH-A and EDF-CH-A. Regarding the two measures added to the pediatric measure set and NQF-endorsed in 2015 -- ED Visits for Dental Caries (EDV-CH-A, NQF #2689) and Follow-up After ED Visits (EDF-CH-A, NQF #2695):
- xii. "Ambulatory care" descriptor -- "Ambulatory care sensitive" appears in the measure name or description for these two measures but does not appear to be related to specifications or instructions for any data elements. The phrase has already been removed from the measure description in the EDF measure specification sheet ("caries-related emergency department visits") so, for consistency, you may wish to also remove it from the EDV measure name. If the intent of the phrase was to emphasize that caries-related ED visits reflect inadequate utilization of dental services available in the ambulatory (primary care) setting, perhaps that point can be made with language added to the rationale section for each measure.
- xiii. Stratification by inpatient admissions -- The spec sheet and logic diagram for the EDV measure clarify that the measure results are to be stratified by ED disposition (discharge or inpatient admission), although that intent is not reflected in the measure name or description. Consider adding "... that (a) resulted in inpatient admission and (b) did not result in inpatient admission" to the end of the EDV measure description -- comparable to the separate 7-day and 30-day numerators described for the EDF measure. It may also be useful to add a question to the measure purpose section pertaining to the relationship between caries-related ED visits and admissions.
- xiv. Consistency in naming -- Lastly, the name for the EDF measure currently ends with "... by Children for Dental Caries," which differs slightly from the name for the EDV measure, "... for Dental Caries in Children." The difference in syntax is unnecessary -- data elements for the two measures are clearly related -- and

may be misleading to some users. Consider renaming the EDF measure to be more consistent with the EDV measure.

Thanks for the opportunity to comment on the DQA pediatric measures.

ASTDD.

- xv. The Association of State and Territorial Dental Directors (ASTDD) supports the Dental Quality Alliance's (DQA) ongoing efforts to develop and maintain a set of standardized and validated measures that can be applied in both the public and private sectors. The Pediatric Starter Set, initially released in 2013, has been reviewed by a multitude of stakeholders and the 2016 revisions address most of the issues raised during previous review cycles. While ASTDD commends DQA for the development of the Pediatric Starter Set, we would like to voice concern regarding the technical specifications for the measures and how these may impact the usefulness of the measures to state oral health programs. It is the responsibility of state oral health programs to monitor oral health at the state, and in some cases, the local level. This requires access to data that is both comparable across groups and consistent over time. For example, states need dental utilization data that is comparable between Medicaid and private insurance enrollees and is collected in a similar manner across years. As of January, the DQA measure for utilization of dental services revised the denominator to include only those children "continuously enrolled for at least 180 days." The previous denominator included those children continuously enrolled for at least 90 days, which is the denominator used for reporting utilization among Medicaid eligible children. These differences, although relatively minor, make it difficult for states to compare groups and monitor trends. ASTDD would like to encourage DQA to continue working with stakeholders at the federal and state level to assure that the pediatric measures endorsed by DQA are comparable to measures used by federal and state agencies. Please note that we are not suggesting that DQA change their technical specifications, only that they consider the impact of the specifications on the usefulness of the data to state oral health programs. ASTDD is a national non-profit organization representing the directors and staff of state public health agency programs for oral health. ASTDD provides leadership to promote a governmental oral health presence in each state and territory, to formulate and promote sound oral health policy, to increase awareness of oral health issues and to assist in the development of initiatives for prevention and control of oral diseases. ASTDD appreciates this opportunity to respond to the call for the Annual Measure Review.

Appendix C: List of DQA Measure Versions Maintained²

Reporting Options	Utilization of Services	Preventive Services	Treatment Services	Oral Evaluation	Fluoride Intensity (1,2,3 or 4 applications)	Topical Fluoride (at least 2 services)	Sealants 6-9	Sealants 10-14	Care Continuity	Usual Source of Care	PMPM	Caries-Related ED Visits	Follow Up After ED Visit
DEN 1: all members meeting age and enrollment criteria	NQF Endorsed;			NQF Endorsed;	Guidance provided in User Guide	NQF Endorsed;	NQF Endorsed;	NQF Endorsed;				NQF Endorsed	NQF Endorsed
DEN 2: all members meeting age and enrollment criteria who have used a "Dental Service".		Guidance provided in User Guide		Guidance provided in User Guide									
Oral health Services DEN 1													
Oral health Services DEN 2													
Dental OR Oral Health DEN 1													
Dental OR Oral Health DEN 2													
90 days enrollment versions	Guidance provided in User Guide		Guidance provided in User Guide	Guidance provided in User Guide									

² **Key for the table:**

Green Tab: Measure Versions Maintained

Red Tab: Separate measure specifications no longer maintained; guidance on implementing select reporting options is provided in the User Guide

References

1. Herndon JB. Testing Pediatric Oral Health Performance Measures in the Florida and Texas Medicaid and CHIP Programs: Final Report. Prepared for the Dental Quality Alliance. 2013.
2. Herndon JB, Crall JJ, Aravamudhan K, et al. Developing and testing pediatric oral healthcare quality measures. *J Public Health Dent* 2015; 75(3):191-201.
3. Beauchamp J, Caufield PW, Crall JJ, et al. Evidence-based clinical recommendations for the use of pit-and-fissure sealants: a report of the American Dental Association Council on Scientific Affairs. *J Am Dent Assoc* 2008;139(3):257-68.
4. Weyant RJ, Tracy SL, Anselmo TT, et al. Topical fluoride for caries prevention: Executive summary of the updated clinical recommendations and supporting systematic review. *J Am Dent Assoc* 2013;144(11):1279-91.
5. Herndon JB, Tomar SL, Catalanotto FA, Rudner N, Huang I, Aravamudhan K, Shenkman E, Crall JJ. Measuring quality of dental care: Caries prevention services for children. *J Am Dent Assoc* 2015;146(8):581-91.
6. Davidson PL, Cunningham WE, Nakazono TT, Andersen RM. Evaluating the effect of usual source of dental care on access to dental services: comparisons among diverse populations. *Med Care Res Rev* 1999;56(1):74-93.
7. DeVoe JE, Tillotson CJ, Wallace LS, Lesko SE, Pandhi N. Is health insurance enough? A usual source of care may be more important to ensure a child receives preventive health counseling. *Matern Child Health J* 2012;16(2):306-15.
8. Institute of Medicine (U.S.). Division of Health Care Services. Committee on the Future of Primary Care, Donaldson MS. *Primary care : America's health in a new era*. Washington, D.C.: National Academy Press; 1996.