Social Rick Factors Associated with Hospital Emergency Department Visits for Dental Pain

D. Von Kaenel, D. Vitangeli, P.S. Casamassimo, S. Wilson, J. Preisch

Disproportionate caries rates and access difficulties affect the poor and minorities, often leading to acute dental problems in children and inappropriate care seeking patterns. Little confirming data validates anecdotal observations about children who seek care in emergency departments (ED) of hospitals for acute dental pain. The purpose of this retrospective study was to describe and relate social and demographic risk factors in children who seek ED treatment and follow-up. This study used chart review of 984 after-hour ED patients seeking relief of caries-related tooth pain in a large Midwest urban children's hospital in 1998. Calibrated reviewers used established criteria to record age, parental insurance and martial status, residence, gender, race, treatment rendered, 36-month prior care and follow-up within 12 months. The 300 children meeting selection criteria were disproportionately black (134/44.9%), covered by government programs or uninsured (174/58%), and from single parent families (199/66.3%). Over a third (109/33.6%) were under six years old. Only 20% (60) received definitive treatment of extraction or filling. Teeth associated with baby bottle tooth decay were least commonly affected while lower primary and permanent molars were most affected. Follow-up was not affected by social risk factors of race, parental marital status, or payment method. Children under 5 years old and out of county were most likely to attend follow-up visits. This study concludes that children who seek caries-related emergency care at a hospital ED are most likely minority, poor, and from a single parent family. These same three factors do not influence follow-up.

Children's Dental Care in A Medicaid Managed Care-A District of Columbia Experience

Chang-fu Chien

Background: Medicaid managed care is widely viewed as a fundamental building block for state health care reform, both with respect to controlling costs and enhancing access to consistent primary care services. Medicaid EPSDT program covers children age up to 21 for their medical needs. The Health Plan Employer Data and Information Set (HEDIS) is the most widely used tool for assessing the quality of health care provided by health maintenance organizations (HMOs). Using HEDIS data, public health agencies routinely have access to outcome and prevention oriented clinical information on the more than 60 million Americans enrolled in HMOs.

Method: Annual Dental Visit is a measure of Access/Availability of Care of a Managed care (HEDIS 3.0/1998). The Medicaid claims data obtained from District of Columbia, Department of Human Services, Office of Medical Assistance Administration contains the encounter data from October 1, 1994 through September 30, 1997. As in 1994 to 1997, the HMO penetration rates in the District of Columbia are 22.4%, 34.4%, 33.7%, and 39.6%. In addition to it, a 4-year recipient enrollment file included demographic information such as race, gender, age, and living address is also available. Because the information indicated any single specific health plan Medicaid recipients participate is not available on the claims file, we sum up the this Medicaid population as a single group.

Results & Discussions: The rates of annual dental visits will be obtained from DC Medicaid encounter data. Medicaid population's socio-demographic characteristics and their fluctuating enrollment status make them different from the general population of commercial HMO. Medicaid recipients drop in and out of plans by their eligibility, especially for AFDC group. So the requirements for generating HEDIS indices need to be examined, and recommendations need to be made at state level for documenting Medicaid claims in order to increase the reliability of encounter data.

Risk Factors Associated with the Prevalence of Oral Health Problems in Central Harlem

Georgina Zabos, Joyce Moon Howard, Chau Trinh and Mary Basset

Healthy People 2000 acknowledge that poor and minority populations require special attention with regards to needs assessment. To characterize the prevalence of oral health problems and their risk factors, we examined a population-based survey of adults (18-65) in a representative sample of Central Harlem and a longitudinal study of a probability sample of adolescents aged 12-17 from the same area. The cross-sectional study revealed that among a range of 50 common health complaints, the most common noted was “problems with teeth or gums”. Nearly 1/3 admitted to such problems in the past 12 months. Of these, 2/3 reported to having seeing a dentist for that complaint. Prevalence of oral health complaints did not vary by age and complaints were common in young adults 18-24 (34.2%) Medical insurance status was as follows: 20% uninsured, 46% Medicaid, 5% Medicare/Medicaid, 29% private insurance. The frequency of dental complaints varied by insurance status. Among the uninsured, fewer than half (47.6%) had seen a dentist. In the first “round” of the longitudinal study, data was collected on utilization of dental health services, oral hygiene behaviors and a dental examination of the oral cavity. At baseline, nearly 9 out of 10 youths examined required referral. In subsequent years, dental problems continued to be the most commonly self-reported health problem. Using these two data sets, we further examined high risk groups by socioeconomic variables and dental complaints by health services utilization and presence of chronic disease to identify missed opportunities for dental referral.

Results of the 1999 Iowa Head Start Dental Survey

M. Kanellis, D. Gustmann, A. Requa, M. Manter, D. Hade

Purpose: The purpose of this study was to document and qualify problems Iowa Head Start Preschool programs have obtaining access to oral health care for children they serve.

Methods: In April, 1999, Health Coordinators for each of Iowa's Head Start Programs were asked to complete a mailed survey for each county they served.

Results: Responses were received for all 99 counties (100%). Forty-six programs (46.0%) indicated their ability to obtain dental services had gotten worse or much worse during the past five years. The average number of miles children must travel to obtain dental services was 21 miles one-way (range 1-210 miles). Fifty-two counties (59.8%) indicated their children needed to travel out-of-county for dental services. The mean wait time for a dental appointment was 4.38 weeks, with a range of less than a week to 6 months. Twenty-seven (28.4%) Head Start Programs responded they are not able to obtain dental examinations for the Head Start Children in their programs within 90 days (a Head Start Performance Standard).

Conclusion: Access to dental health services is a continuing challenge for Iowa Head Start children.

The Need for Dental Case Management for Children of the Poor and Working Poor in Kentucky.

M.R. Mullins* J.C. Cecil, J. White and L.N. Lawless (University of Kentucky College of Dentistry, Lexington KY USA).

An estimated 40% of Kentucky=s school children live in poverty or near poverty (185% federal level). The University of Kentucky administers school-based mobile dental programs. In 1998-99, dental screenings at 26 elementary schools (4109 children) found over 50% of children with visible untreated decay. A school with 88.4% of children on reduced or free lunch was identified with an ongoing dental sealant program, but no dental treatment program. A prospective study was designed to document: (1) dental treatment needs and (2) numbers of children receiving needed services. Initial findings documented 43% of children (172/392) had sealed permanent teeth compared with a 10% average at eleven similar schools without sealant programs. However, 51% of children (200) still had significant treatment needs (2.9 visits each) including 5 children with abscesses. The county has 25 private dentists including 2 pediatric dentists. However, 59% of parents (230) responded their children did not have a local dentist. Parents received screening results and encouragement to seek follow-up treatment. In February 2000, a second screening will be conducted to document children who did and did not receive needed services. Results will be available in April. Initial findings suggest dental case management is needed to monitor and improve access to dental services for children of the poor and working poor in Kentucky.

THE INVERSE CARE LAW IN ORAL HEALTH CARE AMONG CHILDREN. UNITED STATES, 1988-94

Clemencia M. Vargas, DDS, MPH, PhD, Department of Pediatric Dentistry, University of Maryland, Baltimore, MD and CDC, National Center for Health Statistics; Cynthia R. Ronzio, PhD, CDC, National Center for Health Statistics, Hyattsville, MD.*

Julian Hart's Inverse Care Law (ICL) states that those who need the most health care get the least. Data from NHANES III are used to analyze the ICL in dental care among U.S. children aged 2-5 (n=4,411) and 6-18 (n=5,311) years. Dental care need was measured as perceived (self-reported treatment needs) and normative (untreated caries determined by dentist). Dental care utilization was measured as self-reported past year visits and frequency of visits.

Results compare children with and without needs and control for sociodemographic factors. Younger children with perceived and normative needs are more likely to be episodic users (aOR [adjusted odds ratios] 1.60 and 1.52 respectively). Children with normative needs are less likely to be regular users (at least one visit every year) (aOR 0.56) and more likely to have never seen a dentist (aOR 1.49). However, younger children with perceived needs are more likely to be regular users (aOR 1.59) and less likely to have never seen a dentist (aOR 0.46). Older children with perceived and normative needs are more likely to be episodic users (aOR 1.68 and 1.81) and less likely to be regular users (aOR 0.68 and 0.49). Low income and ethnic minority children were more likely to be episodic users or to have never seen a dentist while their counterparts were more likely to be regular users.

For young children, their normative needs predict utilization consistently with the ICL, whereas their perceived needs do not. Dental health care among older children follows the ICL.

STRONG TEETH FOR A MILLENNIUM – A SCHOOL-BASED DENTAL SCREENING AND PREVENTION PROGRAM

L. M. Lawrence

Mott Children's Health Center in collaboration with the Genesee Intermediate School District and Hurley Mcdical Center established an oral health initiative in Genesee County, Michigan. A School-based Dental Screening and Prevention Program was established to increase dental awareness and decrease access to care barriers for children at high risk for dental caries and tooth infection. In the first year of operation, nearly 6,700 kindergarten through fifth grade children were screened in 375 classrooms in 10 School Districts.

This multifaceted program includes dental screenings, classroom instruction, and a parent oral health education piece as well as the assessment for the potential benefit from timely placement of dental sealants. Partnerships with local dentists have been established to link children with dental needs to providers. The data collected is used to assess the potential benefit of this intensive prevention program on the community.

Preliminary results from the data collected suggest that a significant number of children in Genesee County have significant unmet dental needs. A comparison of data from the 1997 Bendle School District pilot study to the 1998 Screening are encouraging. Significant reductions in untreated permanent and primary tooth decay, 35% and 24% respectively, and a 26% reduction in the incidence of permanent tooth decay.

This program is a contributing factor to the positive trends seen in these results. By highlighting the importance of dental care for children, identifying children with unmet needs and facilitating access to care, more children will receive services. The programs focus on education, while facilitating access, targets the two most important reasons children do not gee a dentist.

Oral Health Disparities Among Asians & Pacific Islanders in Hawaii

M.H.K. Greer, R. Louie

Data from comprehensive oral health surveys in 1989 and 1999 among elementary school children in Hawaii has demonstrated statistically significant variance among ethnic groups. At an estimated 61.8 percent of the total resident population, Hawaii is the only state in which Asians & Pacific Islanders are the ethnic majority. The group, categorized by federal designation, is very broad, representing wide ranging geographic origins and significant ethnic, cultural and social diversity.

Oral health indicators among young children in Hawaii demonstrate significant disparities, with Asians & Pacific Islanders, as a group, having far poorer oral health than non-Asians or Pacific Islanders (caucasians, blacks and hispanics). 1999 survey data shows dft rates among 5 through 9 year olds of 4.288 vs. 2.329 ($p < 0.001$) and DMFT rates among 8 year olds of 0.611 vs. 0.261 ($p < 0.001$). In addition, sub-populations of the Asian & Pacific Islander class exhibit wide variance. By contrast with children in Hawaii of Japanese and Chinese ancestry, consistently Native Hawaiian, Filipino, Southeast Asian and children of Pacific Islanders other than Native Hawaiians (Samoans, Micronesian, Tongan, Marshallese, etc.) have among the poorest oral health indicators in the nation. For instance, the dft rate among 5 through 9 year old Japanese children is 2.748 vs. 5.479 among Filipino children. Also noted in this study were significantly earlier secondary tooth eruption patterns among Native Hawaiians, Samoans and Tongans by contrast with children of European, African, Hispanic or Asian origins. Both high early childhood caries and secondary tooth development and eruption rates among populations of Pacific origin need consideration within the development of effective disease prevention and clinical management strategies.

Oral Health Status of Children Living in Low Income Areas.

K.M. YODER, J.M. OLDHAM, M.E. MALLATT*, C.O. HAZELRIGG, E. BRIZENDINE. (Indiana State Department of Health, Indiana University School of Dentistry, Indiana University School of Medicine)

An oral screening to assess the dental needs of a sample of school children from Title I schools in the Fort Wayne Community School (FWCS) district was conducted during the 1998 – 1999 school year. Title I schools have a high percentage of children enrolled who belong to families with low income. A total of 1240 children ages (6-9) and (14-16) from ten schools participated. A visual inspection by four dentist/recording teams using mirrors, tongue blades, portable equipment, and artificial light was performed on-site at the individual schools. The criteria employed were simple, mainly noting 1) severe dental disease requiring immediate attention, 2) obvious dental decay and 3) absence of dental disease. Data were also obtained to the presence of sealants, history of any past dental decay (restorations) and the presence of fluorosis. Demographic data were also obtained relative to frequency of dental visits, dental hygiene products used, dental insurance and eligibility for Medicaid. More children had untreated dental decay than the national norm in both age categories. An indicator of access to dental care is the percentage of children who have never seen a dentist. Because parents may be reluctant to admit that their child has never been to a dentist, the percentages may actually be higher than reported. From these data it can be inferred that despite current preventive modalities available, increased access to care is necessary in order to improve the oral health of the children in FWCS Title I schools.

Children's Oral Health Care Programmes in Kuwait Since 1986: A Successful Public/Private Sector Partnership

Authors: Robert E. Morris
George M. Gillespie

In 1983, Kuwait initiated a pilot protect to examine whether a targeted private sector managed children's oral health programme would improve the oral health of children compared with a traditional on demand polyclinic service. The project was successful, and in the mid-1980s Kuwait initiated both a school-based and a clinic-based WHO Type 3 children's oral health programme in two of the country's five health regions. These programmes were destroyed by the war of 1990-91. Post war, the government expanded the programmes to all five regions, specifically in the face of rising oral disease rates. For this study, programme data, surveys and reports were reviewed, analyzed and compared to determine cost, effects, and benefits of the programmes. Three programmes have reported significant improvements in health, while two programmes have not reported health improvements. These three programmes have stabilized and reduced the rising disease trends over both the mid and long term; caries prevalence and intensity have been reduced. The reparative care reaching the population has increased over baseline. The d(e)ft index has decreased significantly in a programme with a daily fluoride supplement. Sealant coverage has dramatically increased and appears to have further reduced caries prevalence. The costs per child are below target, and below the mainstream Ministry of Health costs per child. The programme which uses multi-dentist teams and -moveable equipment has demonstrated greater resource utilization as measured in procedures per chair or per operator per year. Kuwait through the development of these programmes has become the leader in Southwest Asia in highly sophisticated oral health programmes for children.

5 September 1999

MONITORING AND ASSESSMENT OF OUTCOMES RELATED TO CRANIOFACIAL HEALTHCARE

S Lieff, PhD, MPH, MSW, BJ Philips, EdD, DW Warren, DDS, PhD, BL Ramsey, University of North Carolina at Chapel Hill, Chapel Hill, NC

Objectives: The Craniofacial Outcomes Registry (COR) has been created to stimulate positive change in clinical outcomes of treatment related to craniofacial healthcare and to provide a focus for educational and research efforts in this area.

Methods: This will be accomplished through (1) establishment of a multidisciplinary advisory council to assist in design and validation of outcome measures; (2) development of a secure, web based data entry system for recording demographic, diagnostic and outcome data from participating cleft/craniofacial teams; and (3) analysis and reporting of aggregate data to teams for comparison with individual site data.

Results: Registry staff and expert advisors have developed 42 outcome measures related to cleft/craniofacial care. The COR website is active. To date, 1,715 patients have been registered by 19 teams. Demographic analyses indicate broad diversity among registered patients with regard to gender, race and age. Fifty-nine percent of the population are male, 1 0% are African American, 11% Hispanic, 70% are White and 8% are of other racial origins. There are 915 patients with cleft lip/palate related diagnoses, 78 with craniosynostosis, 19 with facial clefts and 43 with positional skull deformity. Approximately 27% (n=455) of the registered patients have known or suspected syndromes - over 30 individual syndromes have been identified thus far. Data analyses and reporting of aggregate and individual team data occur at six month intervals.

Conclusions: These preliminary data demonstrate interest and cooperation in the study of craniofacial healthcare outcomes. The Craniofacial Outcomes Registry model provides a unique opportunity to evaluate treatment outcomes and to plan for their enhancement.

Supported by NIDCR#DE12514

K.D. Jowers

The Children's Dental Program of Mission+St. Joseph's Hospital in Asheville, North Carolina was developed to improve the oral health of Western North Carolina's children. From the inception of the program to the present, data collection has been key in determining what care would be provided and to what children. Analyzing information and patient encounter data helps us define program expansion and redirect efforts to better-serve our region.

WNC has a lack of: fluoridation municipal water, education and awareness regarding oral health, and access to oral health care providers. This combination results in high caries rates in WNC children. Our program takes advantage of this opportunity to study contributory and preventive factors of caries in children. Such information is valuable when illustrating the great needs of WNC's children, and is also useful when examining etiology of disease, preventive and contributory factors, and effectiveness of treatment and education.

We will review the matrix used to define our geographical region of service, the one-on-one interviews initially undertaken with the health care community, and data collection instruments that reveal information such as race, economic status, fluorosis, dmft, plaque scores, and history of signs/symptoms. We will then describe the programs that were developed as a result of information analysis, including: comprehensive school-based care, full-mouth restoration under general anesthesia, and education efforts involving health care providers, hospital staff, caregivers and children.

T.P.G. Barham, Jr.

Purpose: The aim of this study was to determine the dental caries rates in children from Western North Carolina who receive comprehensive dental care from a non profit, hospital run, mobile dental treatment program. In addition the study sought to examine the relationship between caries experience and racial and economic factors in this population.

Methods: This retrospective study abstracted data from 400 patient records including demographic information and caries experience. This reflects the patient population of approximately 150,000 from a ten county area in Western North Carolina.

Results: The composite demographic portrait of this population shows that less than 10% are non-white (Black, Native American, or Hispanic) and over 90% are Caucasian. The children are from families that qualify for Medicaid, Child Health Insurance Program, or whose family's income is 250% below the poverty level. The caries experience is the same throughout the patient population and reflects trends shown in the NHANES III Study.

Conclusions: Despite a homogenous demographic group, caries rates were similar to those reported by other studies. The demographic make-up of this study points out how racial profiles only relate to a particular population in the geographic area studied. The study confirms that caries experience and income level are inversely related. Thus a key factor for identifying at risk children is the income level of the family.

Improving Access to Dental Care Services for Low-Income Children in Illinois

GR Byck, JA Cooksey, H Russinof

Background: Dental and oral health care services are a vital component of comprehensive primary care services. National studies have identified inequities in access to dental care and a higher disease burden among low-income children. Illinois has had one of the lowest reported rates of state Medicaid spending for children's dental care services and lowest rates of dental care needs of low-income.

Purpose: To assess the capacity if Illinois dentists to meet the dental care needs of low-income children of Illinois, specifically those covered by Medicaid and those eligible for the State CHIP program, KidCare.

Methods/Objectives: (1) Describe the current supply of dentists who participate in the Medicaid program in Illinois, by specialty and county. This analysis will identify the practice setting of participating dentists to assess the relative contribution of dentists in private practice and those in organized care settings, such as public health clinics, community and migrant health centers, dental school clinics, and other safety net settings. (2) Estimate the capacity of those dentists currently providing Medicaid services to increase their services to children with Medicaid (or Chip-based) coverage, using different scenarios. (3) Examine the experience of other state Medicaid/CHIP dental programs. (4) Identify options for safety net providers of medical care to low-income communities, such as the community health centers in Illinois, to increase their provision of dental services.

Results: Descriptive results and a discussion of policy implications will be presented.

The Prevalence of Dental Caries in Minority Children in Northern Manhattan

Dennis A. Mitchell-Lewis, David A. Albert, Georgina P. Zabos, Sally E. Findley, Chau B. Trinh, Kavita P. Ahluwalia, Carol Kunzel, Stephen E. Marshall, James E. McIntosh, Allan J. Formicola.

This study reports the prevalence of dental caries in public school children in the Central Harlem(CH) and Washington Heights/Inwood (WH/I) communities of Northern Manhattan collected by the Community DentCare Network(CDCN). The CDCN is a comprehensive community-based oral health program formally established in 1994 by the Columbia University School of Dental and Oral Surgery, the Harlem Hospital Dental Service and several community-based organizations to address the oral health needs of the communities of Northern Manhattan. The CDCN has established school-based dental prevention centers at seven public schools throughout Northern Manhattan. Oral examinations using calibrated examiners and NIDCR criteria for the NHANES III examination were administered to a representative sample of children in five of the school-based dental clinics during the academic school year 1997-98. A total of 566 children ages 12 to 17 years were examined (males=240, females=313), 68.5% were Hispanic(WH/1) and 31.5% were African American(CH), all children are classified as low socioeconomic status. The mean DMFT for CH was 3.66(DT=1.47, MT=.30, FT=1.89) and for WH/I. 3.22 (DT=.90, MT=.99, FT=1.33) compared to U.S. children of the same age collected in NHANES III: all children 2.60(DT=.43, MT=.06, FT=2.1 1); white 2.53(DT=.32, MT=.05, FT=2.16); black 2.36(DT=.73, MT=.11, FT=1.52); and hispanic 2.74(DT=.75, MT=.06, FT=1.93). These preliminary data suggest that the prevalence of dental caries among the children of Northern Manhattan is significantly higher than previously reported national figures for comparable aged children.

Dental Caries in 2-5 year olds in Northern Manhattan

Albert D*, Mc Manus J**, Mitchell-Lewis D*, Findley S*, Dincer E**,
Park K***. Columbia University School of Dental and Oral Surgery*
Children:s Aid Society** Harvard University School of Dental
Medicine" ***(Senior Dental Student)

The Children:s Aid Society operates a dental van within the Northern Manhattan communities of Washington Heights/ In wood and Harlem. The van is staffed by a dentist, dental assistant, and an administrative assistant/driver. The van travels to 26 Head Start and Day Care centers to provide examination and treatment. This study was carried out to provide additional data concerning the dental health of this age group in a particularly disadvantaged community of New York City. A retrospective chart study of examinations was completed in 1998. A total of 1778 charts were reviewed. All exams-reviewed were completed by one staff dentist. The data was tabulated using SPSS software. We calculated mean dfs, ds, fs, %d/dfs, %f/dfs, mean dft, mean dt, mean ft, %f1dft, mean dfs occlusal, mean dfs B-L, mean dfs M-D, dfs by tooth, and %d/dfs by tooth. According to the National Health and nutrition Examination Survey (NHANES III 1988-1994), on average, America:s youngest and poorest children (ages 2-5 living below the poverty level) have almost five times as-much tooth decay as children of higher income families(>300% poverty). 50.1 % of the children were male and 49.9% were female. 47. 1 % were African American, 50.1% were Latino and .02% for other groups. Mean dft was 1.1, with 1.3 for African-Americans, and 0.8 for Latinos. The level of untreated decay, %d/dft for all children in our study was 91.7%. There was no difference for African-American,'or Latino children. %d/dft in NHANES III was recorded as 66.7% for all children, 51.7% for children above 200% FPL and 76.2% for children at or below 200% FPL. The high level of untreated decay found in this particularly disadvantaged community suggests that enhanced dental services targeting the very young are needed in our poorest communities.

REGULAR DENTAL ATTENDANCE OF LOWER INCOME CHILDREN INCREASES WITH DENTAL INSURANCE AND A USUAL SOURCE OF DENTAL CARE

JEM Steffensen *, BS, MPH, CHES, JP Brown, BDS, PhD, W Anderson, BS,
MX Baez, RDH, MPH, NB Porteous, BDS, MPH, D McMahon, MS, DL Carlson, DDS, MA,
MA de la Torre, RDH, BS, Department Community Dentistry, University of Texas Health Science Center at San Antonio

CONTEXT: Access to oral health care is important to children, their families, and society because oral health influences children=s physical and emotional health, growth and development as well as their capacity to reach their full potential. When children fail to receive necessary oral health care their health, well-being, and educational attainment can be affected for many years. OBJECTIVE: The aim was to evaluate the influence of a usual source of dental care and dental insurance coverage (public and private) on regular dental attendance. METHODS: A statewide survey of lower income schoolchildren (90% <$30,000 / year) in Grade 2 and Grade 8 was conducted in 1998. Participants were from 16 elementary schools and 16 middle schools randomly selected (with >60% of students in the free lunch program) in all 8 Texas public health regions. This assessment is based on 1124 children in Grade 2 and 802 in Grade 8 with questionnaires completed by parents and protocol-based clinical examinations made by one dentist. FINDINGS: Grade 2 children with dental insurance were twice as likely to have had a dental visit in the past year (i.e., regular dental attenders) than children without dental insurance (33% vs. 15%, OR: 4.1). nose children with a usual source of dental care were seven times as likely to have had a dental visit in the past year (42% vs. 6%, OR: 12.8). Grade 8 results were similar. It is apparent that both conditions, having insurance and having a usual source of care, increase these children's dental attendance. CONCLUSIONS: To eliminate disparities in access to oral health care for children, innovative strategies are essential to both expand dental insurance and increase the availability of a regular source of dental care. It is important for children to have a Adental home@ in order to reach the Healthy People 2010 Oral Health Objective to increase use of the oral health care system by children each year. IMPLICATIONS: As Medicaid and CHIP-funded state plans continue to be developed and monitored, indicators of access to health care for children should be adapted and incorporated into quality assurance systems. This is important to gauge program effectiveness, improve program operations, assess dental health services, and evaluate access to oral health care. Measures of oral health access and utilization such as dental insurance coverage, usual source of dental care, number and types of dental visits, unmet dental needs, and delayed dental care should be under surveillance. These measures should be included in health services research initiatives that are supported by agencies and organizations from the public, private, and nonprofit sectors. (Support: TX Dept. Health)

MEASUREMENT OF HEALTHCARE OUTCOMES

MJ Buckley, DMD[0], BJ Philips, EdD[5], S Lieff, PhD[5], BL Ramsey[5] [0]University of Pittsburgh, [5]University of North Carolina at Chapel Hill

Improvement in healthcare can be promoted by monitoring outcomes of assessment and treatment. Objectives in development of outcome measures of assessment and treatment procedures are to provide measures that (1) are easy to obtain and record, (2) employ routine clinical procedures, (3) are quantifiable, and (4) are reliable. Procedures to develop a measure (1) select objectives, of a healthcare procedure, for measurement, (2) identify patients for whom the outcome is to be measured, (3) specify a time-frame for measuring, (4) describe procedures for measurement, (5) identify person(s) to do the measuring, (6) provide provision of information for stratifying data, (7) plan for assessment of reliability, and (8) plan for recording data. Measures of outcomes of alveolar bonegraft surgery will illustrate the procedures. Oral health, one factor influencing alveolar bonegraft results, is measured to provide one piece of information for stratification of the outcome data. To promote and assess reliability, clinicians trained in the measurement procedures, conduct independent evaluations. The measures were developed by staff of the Craniofacial Outcomes Registry assisted by consultants from the Council on Craniofacial Outcomes Research. Results: Nineteen teams are using these measures in a study of the outcomes of alveolar bonegraft treatment for patients who have clefts involving the primary palate. Longitudinal study of the data with comparison of individual team data provides a stimulus for and measure of changes in outcomes. This model has applications for all aspects of oral healthcare.

(NIDCR#DE12514)

Barriers to Accountability In Missouri (MO) Medicaid Dental Managed Care

DV Hubener, DDS, MS, MAEd
Washington University School of Medicine, St. Louis, MO USA

While researchers have documented the issues relating to access to dental care, information regarding obstacles in accountability and access to information is lacking. The objective of the present retrospective study is to determine current barriers to accountability and to encounter information in the Missouri (MO) Medicaid Dental managed Care Program. Such information will enable better system planning, access to care providers, financial considerations, and outcome measurements for recipients in the state program. The methods consisted of data from the previously published (March 1999) document, "Evaluation of the Missouri Medicaid Program", and the current proceedings of the Missouri Medicaid Quality Assurance and Improvement (QA&I) Dental Subcommittee which were analyzed to evaluate (1) initial recording issues; (2) data transmission; (3) system administration; (4) retrieval information; and (5) outcome data. Specific attention was directed to those frequently occurring issues. A three part grading system was employed in the evaluation process indicating the level of issue reoccurrence. The results indicate two major areas of focus: (1) providers encounter data (incorrect fields, missing data, complicated forms and (2) internal system data management (computer form rejection, data re-entry, system coding). Both separate data events (origination and system integration) contributed to the majority of the barriers to access encounter information and subsequent accountability. The conclusions are (1) barriers to accountability and access data have been identified in the MO Medicaid Dental Program: (2) shared knowledge of these barrier factors has assisted the state in improving data collection, reporting, and information retrieval: and (3) adjustment in system management and program improvement at the state level have been anticipated positive outcomes in this study.