Role of the Oral Health Workforce in the Health Care Value Equation

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Wisconsin Oral Health Coalition
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Marshfield, WI
Learning Objectives

1. Review the basic components of the value equation in health care
2. Review key historical elements of the dental-medical divide and the challenge of externalities
3. Describe organizational design approaches to reorient workers and workflow to the value approach
4. Workforce implications of health care redesign efforts
5. Explore changing dental workforce models and their impact on the health care value equation
Definitions & Context

Learning Objective 1: Review the basic components of the value equation in health care
Value Based Care (VBC)

- A health care delivery model in which providers are rewarded for **quality health outcomes** rather than the quantity of care delivered, with the triple aim of better care for individuals and improved population health at lower cost.

- Following the Affordable Care Act (ACA), VBC was driven primarily by the Centers for Medicare & Medicaid Services (CMS) goals to prioritize value through Medicare contracting.

- In dental care, efforts are primarily in the children's’ Medicaid payment space.
Triple Aim: Better Care, Better Health, Lower Costs

- Better Care
- Better Health
- Lower Costs

Improve quality while reducing costs
Improve population health and equity
Improve the patient care experience

Quadruple Aim: Better Care, Better Health, Lower Costs, Engaged Workforce

- Per Capita Cost
- Clinician Well-Being
- Population Health
- Experience of Care

Improve the work life of those who deliver care

More engaged and satisfied workforce

The US dental workforce challenges

• Access to care problematic for 30% of US population

• Increasing dentist supply, but at great cost (avg debt is $250K+) and 8+ yrs of college+ education

• Geographic maldistribution of providers, highly segmented public/private markets

• High variations in capacity use (eg. low level of busyness reported in many private practices, high level of impacted public practices)

• Most providers not working to top of scope, high level of variation in scope by states
Value Equation in Health Care**

\[ V = \frac{Q + S}{\$} \]

- Health outcome achieved per dollar spent*

**Hypothesis:** If value improves, then patients, payers, providers, and suppliers can all benefit while the economic sustainability of the health care system increases.


**https://uofuhealth.utah.edu/value/value-equation.php**
**Value Equation in Health Care**

Health outcome achieved per dollar spent*

Equation principles:
- Defined around the customer
- Depends on results, not inputs. Process is tactical toward these ends
- Shifts focus from volume to value
- Outcomes are condition specific and multidimensional
  - In equation above outcomes are represented by Quality of Care and Patient Experience
  - Re: Porter - quality usually means adherence to evidence-based guidelines, and quality measurement focuses overwhelmingly on care processes.
- Costs refer to full cycle of care, not individual service.
  - Value for the patient is created by providers' combined efforts over the full cycle of care.

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**https://uofuhealth.utah.edu/value/value-equation.php
Value of/in Dentistry

Learning Objective 2: Review key historical elements of the dental-medical divide and the challenge of externalities
Historical separation across all sectors

- Workforce and education
- Delivery system
- Insurance design and coverage
- Federal and state policy
- Scientific discovery and research
- Technology and infrastructure

Externalities =

Reward for reform

Cost of doing nothing
Value in Integration vs. Value in Separation?

**Integration**: promises to improve patient experience and outcomes through better screening, referral and coordination of care while reducing overall costs through better prevention and early treatment

- Few good models in direct health service delivery, better success in public health

**Separation**: adopt policy approaches from medical or behavioral health and transport them to the dental field to drive value

Oral Health Parity?

[Diagram showing balance between Oral, Medical, and Behavioral]
System-level reorganization of work

Learning Objective 3. Describe organizational design approaches to reorient workers and workflow to the value approach
Organizations! The missing link

Policy/Payment

Organizations

Workforce
Chronic care model

Source: http://www.ihi.org/resources/Pages/Changes/ChangestoImproveChronicCare.aspx
Chronic Oral Disease Management

Social Determinants of Health including minority status, immigration status, age, family structure, socio-economic status, income, literacy etc.

Parent Outcome
Expectations
Physical: no new cavities, avoid general anesthesia etc.
Social: peer recognition for positive parenting
Self-evaluative: feel good about self

Parent Outcome

Facilitators
Knowledge and skills regarding ECC CDM

Executive Function

Action to manage ECC through diet & tooth brushing with fluoride toothpastes

Implementation

Intention

Barriers
Environmental, socio-structural, logistic, & temporal barriers

Behavioral Intention
To manage ECC

Self-Efficacy to manage diet & tooth brushing with fluoride

Normative beliefs about oral health, caries, diet, fluoride

Cues to Action

Healthforce Center at UCSF

Edelstein BL, Ng MW. Chronic Disease Management Strategies of Early Childhood Caries: Support from the Medical and Dental Literature. Pediatric dentistry. 2015;37(3):281-287.
The medical home encompasses five functions and attributes: comprehensive care, patient-centered, coordinated care, accessible services, quality and safety.

Source: AHRQ. https://pcmh.ahrq.gov/page/defining-pcmh
Patient-Centered Dental Home

Definition based on characteristics

- Accessible
- Available

Components

- Timely

Measure concepts

- Short wait-times for routine and specialist care
- Available same-day appointments for routine care
- Extended clinic hours

Measures

- Population who received care as soon as needed

Four-level framework used for PCDH model development [Colour figure can be viewed at wileyonlinelibrary.com]

Accountable Care Organizations

Accountable Care Organization (ACO)

- Post-Acute Alignment
- Disease Management Programs
- Population Health Analytics
- Specialists
- Payer Partners
- Primary Care Physicians
- Hospital
- Patient Activation

Source: CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/
Dental and ACOs

- Rationale is strong to include from patient, cost and overall health perspective

- Biggest limitation is lack of integrated health information technology

- As of 2016, only 14% of ACO’s surveyed had any responsibility for dental
  - Those that did also tended to have vision, hearing & speech – so were more comprehensive in nature

- Oregon’s health transformation has large ACO dental component

Dental Delivery System Trends

Key trends shaping the dental market (as predicted by ADA HPI)

• Value agenda
• Increased consumerism
• Shifting dental care use patterns
• Increased collaboration
• Practice consolidation

OF U.S. DENTISTS were affiliated with dental service organizations (DSOs) in 2016. In 2015, it was 7.4%.

How Big are Dental Service Organizations?

https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIwebinar05222018.pdf?la=en
Health workforce approaches and implications

Learning Objective 4: Workforce implications of health care redesign efforts
Examples of strategies include:

- Strategic management
- Patient Navigation/Care Coordination
- Team reorientation: comprehensive, coordinated, collaborative, care models.
- IT /Measurement Integration/e-Health
- Working top of license/scope
- Home & community based services

Risks:

- Upfront costs
- Burnout
- Confusion on roles
- Data - Garbage in-Garbage out’
- Changing generational values regarding work and life balance
Dental workforce implications of adapting to value-based payment models

Learning Objective 5: Explore changing dental workforce models and their impact on the health care value equation
<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE FOR SERVICE – NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE – LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION – BASED PAYMENT</td>
</tr>
<tr>
<td><strong>A</strong> Foundational Payments for Infrastructure &amp; Operations</td>
<td><strong>A</strong> APMs with Shared Savings</td>
<td><strong>A</strong> Condition-Specific Population-Based Payment</td>
<td></td>
</tr>
<tr>
<td>(e.g., care coordination fees and payments for HIT investments)</td>
<td>(e.g., shared savings with upside risk only)</td>
<td>(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
<td></td>
</tr>
<tr>
<td><strong>B</strong> Pay for Reporting</td>
<td><strong>B</strong> APMs with Shared Savings and Downside Risk</td>
<td><strong>B</strong> Comprehensive Population-Based Payment</td>
<td></td>
</tr>
<tr>
<td>(e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>(e.g., global budgets or full/percent of premium payments)</td>
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<tr>
<td><strong>C</strong> Pay-for-Performance</td>
<td><strong>C</strong> Integrated Finance &amp; Delivery System</td>
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</table>

3N Risk Based Payments NOT Linked to Quality

4N Capitated Payments NOT Linked to Quality

## Workforce redesign to support VBC

What skills can be retooled from existing staff models, and what is new?

<table>
<thead>
<tr>
<th>Dental-only workforce implications</th>
<th>Level 1: FFS</th>
<th>Level 2: FFS+Value(A,B,C)</th>
<th>Level 3: APM + FFS(A,B)</th>
<th>Level 4: Global Payment (A,B,C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current system</td>
<td>Central administration for overall control (A)</td>
<td>L2 + IT for data analytics, contract lawyers, clinical care coordination (A)</td>
<td>L3+ clinical decision support to meet population health goals (A)</td>
<td></td>
</tr>
<tr>
<td>IT for data capture &amp; reporting (B),</td>
<td>Strategic risk management (B)</td>
<td></td>
<td>Research capacity (B)</td>
<td></td>
</tr>
<tr>
<td>Clinical management for QI (C)</td>
<td></td>
<td></td>
<td>Management structure to incentivize team performance (C)</td>
<td></td>
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<tbody>
<tr>
<td>Dental-Medical</td>
<td>Referral</td>
<td>Capturing and reporting</td>
<td>L2+ Shared risk</td>
<td>L3+ shared system/team accountability for health and dental outcomes</td>
</tr>
<tr>
<td>integration</td>
<td>Only</td>
<td>dental outcomes in broader health context (measure enhancement)</td>
<td>management &amp; care coordination</td>
<td></td>
</tr>
<tr>
<td>implications</td>
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<tr>
<td>Social-health</td>
<td>Referral</td>
<td>Capturing social</td>
<td>L2+ Redesigning risk</td>
<td>L3+ whole person population health management</td>
</tr>
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<td>integration</td>
<td>Only</td>
<td>determinant data</td>
<td>management &amp; coordination</td>
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Workforce transitions in **dental care redesign**

- **Operation Scale**
  - Solo/single specialty → Workforce Model → Multi-specialty
- **Clinical Coordination**
  - FFS Only → FFS + Value → APM + FFS
- **Global Payment**
- **Strategic Management**
  - Small/Independent → Care Delivery Model → Large/Integrated
Value: Leveling Up

<table>
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<tr>
<th>System</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public / Social Health System</td>
<td>Value added practices?</td>
</tr>
<tr>
<td>Health System</td>
<td>Value added practices?</td>
</tr>
<tr>
<td>Dental System</td>
<td>Value added practices?</td>
</tr>
</tbody>
</table>

Do value added practices at one level also contribute at the next?
New and Emerging Dental Care Providers

• Dental Therapist
  – Alaskan Dental Health Aide (DHAT)
  – Dental Therapist / Advanced Dental Therapists (DT / ADT)
  – Advanced Dental Hygiene Practitioner (ADHP) = ADT + RDH

• Dental Hygienists in Alternative (RDHAP), Public Health, or Direct Access Practice
  – Also can have expanded function (restorative, e.g., Oregon)

• Extended Function Dental Assistant (EFDA)
  – CA: Dental Sedation Assistant and Orthodontic Assistant Permit Holders

• Community Dental Health Coordinator (CDHC)
  – Primary roles are to connect patients to dentists and provide community-based preventive education
  – Alternative variations are community health workers or social workers who add dental to case load
  – In Tribal system have Primary Dental Health Aide (PDHA)

• Primary Care (MD, NP, PA etc) & Public Health Practice (PHNs, )
Workforce transitions in oral health care redesign

Dental Only → Workforce Model → Interprofessional

Clinical Care → Care Delivery Model → Public Health

Healthforce Center at UCSF

FFS Only

FFS+Value

APM + FFS

Global Payment

Dentist/Specialist

Care Coordination

Physician/Nurses

Community Health Workers

Public Health Hygienist

Dental Therapist/EFDA

IT, Management & Leadership
Cycle of Dental Isolation

Field Isolation

Professional dominance over policy

Preservation of status quo

Ideology that professional dental training is only indicator of quality

Resistance to systems of accountability

Limited adoption of policy innovations
Taking stock...

• Lots of waste and excess in system along with great need
• Conceptual framework of VBP is well defined
• Pilot projects abound
• Stakeholders are engaged in looking for new/better ways to solve intractable problems
• Workforce innovations continue to spread and adapt to local circumstances
• Quality & payment linked accountability can provide the bridge to traditional workforce disputes
Key Challenges

- Finding consensus across stakeholders for shared goals
- Quality measurement using Dx & IT/EHRs
- Evidence based practice & clinic decision support
- Professional resistance to change
- Lack of incentive intersections between dental, medical and public health to produce value
  - Pipeline of interprofessional practice
- Strategic Leadership
  - Public Health has much to offer in this space
- Public policy for oral health equity
Thanks!

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Resources