



POLICY BRIEF

**ORAL HEALTH
QUALITY IMPROVEMENT
IN THE ERA OF
ACCOUNTABILITY**

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A Report Prepared by:

Paul Glassman DDS, MA, MBA

Professor of Dental Practice,
Director of Community Oral Health,
and Director of the Pacific Center for
Special Care at University of the Pacific
Arthur A. Dugoni School of Dentistry

Prepared for



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THE ERA OF ACCOUNTABILITY

The U.S. healthcare system is undergoing profound changes and has now entered the “Era of Accountability.” This is evident in the decade-long journey from “pay-for-performance” experiments to “Accountable Care Organizations” established in the Affordable Care Act (ACA), and the current call for “Value-Based Care.” A 2010 Urban Institute report on *Moving Payment from Volume to Value* highlighted the need to align payment incentives with health care outcomes and value for patients, a persistent theme in health reform. Donald Berwick, former Administrator of the Centers for Medicare & Medicaid Services (CMS) and former President and Chief Executive Officer of the Institute for Healthcare Improvement has referred to the goals of this journey as the “Triple Aim.” The three aims are improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The drivers of this journey include:

- The skyrocketing cost of health care unrelated to improvement in health outcomes. The U.S. health care system spends significantly more money per capita as a percent of our gross domestic product (GDP) than other developed nations. In fact, the U.S. share of GDP was over 17% in 2009, while the rest of the developed world spent single digit percentages of their GDP on health. However, in spite of this level of spending, U.S. consumers rate their care worst among these nations and the U.S. trails most of the rest of the developed world on many health indicators. It has been argued that the way to transform health care is to realign competition with value for patients where value is the health outcome per dollar cost expended based on health conditions over the full cycle of care.
- Increasing understanding of the harm and unwarranted variability our fragmented health care system produces. It has long been recognized that there are significant variations in costs of health care in the U.S. unrelated to the complexity of the population served or the quality of health outcomes achieved. There are many areas in the country where fragmentation of the health care system has led to competition for profits among components of the system to the exclusion of improved quality and lower costs for the system as a whole.
- Evidence of the profound health disparities that still exist in the population in spite of scientific advances in care. The IOM, in the 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, clearly demonstrated that racial and ethnic minorities tend to receive lower quality health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled. In addition to complex historic and contemporary societal and administrative inequities there was evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment.

QUALITY IMPROVEMENT AND ORAL HEALTH

The drivers of quality improvement in oral health are the same as those in general health systems. These are:

- **the increasing cost of oral health care,**
- **increasing understanding of the unwarranted variability produced by the oral health care system,**
- **evidence of the profound health disparities that still exist in the population in spite of scientific advances in care, and**
- **increasing awareness of these problems in the age of consumer empowerment.**

The Centers for Medicare and Medicaid Services (CMS) projects that the total national expenditures for dental care will almost triple between 2000 and 2020, going from \$62.0 billion in 2000 to \$167.9 billion in 2020, a 271% increase. This increase in expenditures is significantly higher than the increase in the Consumer Price Index, the best measure of inflation as experienced by consumers in their day-to-day living expenses. In the decade between 2000 and 2010, the CPI rose to 127% of the 2000 level, while oral health spending rose to 165% of the 2000 level. One component of the CPI is the CPI for Dental Services (CPI-DS). During the same time period, 2000-2010, the CPI-DS rose to 154% of the 2000 level, double the rise in

the CPI for all items and higher than the 149% rise in the CPI for all Medical Care.

Also, dental expenses are among the highest out-of-pocket health expenditures for consumers. In 2008 dental expenditures accounted for \$30.7 billion or 22.2% of total out-of-pocket health expenditures, second only to prescription medications. The cost of oral health care, coupled with the large portion paid out-of-pocket compared to other health services are reflected in the fact that affordability of dental care is the number one reported barrier to access to dental care. Affordability concerns are most common among uninsured people, but also a concern for people with privately and public insurance.

There is limited evidence for most procedures performed in oral health care. As a result, there are widespread unexplained variations in clinical decisions among dentists. Even when differences in patients are accounted for, variations in dentists' clinical decisions are still widespread.

The 2000 Report of the Surgeon General, *Oral Health in America*, stated that “Despite improvements in oral health status, profound disparities remain in some population groups as classified by sex, income, age, and race/ethnicity. For some diseases and conditions, the magnitude of the differences in oral health status among population groups is striking.”

These factors will drive the oral health system in the same direction that general health is being driven — toward increased measurement of the outcomes of oral health activities, using data to improve quality and lower costs, and moving incentives from *Volume to Value*.

QUALITY IMPROVEMENT ACTIVITIES IN ORAL HEALTH

There are many groups and individuals engaged in developing or using oral health measures and in oral health quality improvement activities. They can be categorized by sectors of the oral health industry including:

- Federal or National Agencies and Programs
- The Oral Health Safety-Net
- Large Group Dental Practices

- The Dental Benefits Industry
- Professional Dental Associations
- Hospital-based Dental Practices
- Dental Practice-based Research Networks

There are many oral health measures, guidelines, and other sources of data being developed and used across multiple sectors of the oral health care industry. However, in spite of these efforts oral health systems lag behind those in general health because of a limited systematic and organized quality improvement agenda in place to improve quality in dentistry. The reasons include an emphasis on assessment of the technical excellence of restorations which is not associated with long term treatment outcomes. It has been said that too often the dental profession has regarded quality assessment as an evaluation of clinician, rather than of the effects of clinicians' efforts on patients' health.

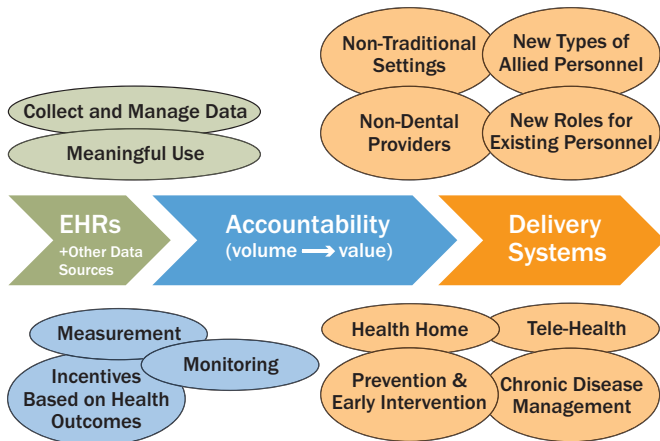
A related reason for the lack of dental quality improvement systems is that federal and state governments only pay for about 6 percent of dental care nationally. About 50 percent of the population has private insurance, but it is divided up among a large number of private insurers. Thus, in general, neither dental practices nor dental patients are integrated into large provider or payer organizations that have the capacity, funds, and political will to establish meaningful quality improvement programs.

FUTURE TRENDS AND POLICY CONSIDERATION IN ORAL HEALTH QUALITY MEASUREMENT AND IMPROVEMENT

The U.S. health care system has entered the “era of accountability.” The drivers of change include concern about the rapidly increasing costs of care, concern about unwarranted variability in costs and outcomes, and recognition of the profound health disparities that exist among racial and ethnic minorities, low-income populations, people with disabilities and other vulnerable populations. These drivers of change apply not only to general healthcare, but oral healthcare as well. Although efforts to institute quality improvement systems in oral health care lag behind those in general health care, they do exist and are increasing. Figure 1 illustrates a pathway to move oral health care from the current emphasis

on volume to an emphasis on value. Each of the steps on this path will need policy support at many levels.

Moving Oral Health Care from Volume to Value**



**Value = health outcomes achieved per dollar spent over the lifecycle of a condition

Figure 1: Moving Oral Health Care from Volume to Value

The pathway involves increased use of EHRs and other data sources, the establishment of accountability in the move from volume to value, and ultimately the evolution of delivery systems. Some trends to watch and ideas to pursue on this path are:

- Pressures to control costs and provide care to currently underserved populations, including racial and ethnic minorities, low-income and rural populations and people with complex health conditions, will drive development and use of measures of oral health outcomes.
- Efforts to develop and use measures of oral health outcomes will drive development and use of diagnostic coding systems and other means of collecting data on oral health outcomes of populations.
- The spread of electronic dental records (EDRs) and integrated electronic health records (EHRs) will make collection and analysis of data easier, especially across providers, and incentives for meaningful use will drive and facilitate analysis of these data.
- As the use of oral health quality measurement and quality improvement systems develop, more attention will be drawn to the IOM-defined quality domains (i.e. creating an oral health care system which is safe; effective; patient centered; timely; efficient; and equitable).

- Pressures to control costs and improve oral health of vulnerable and underserved populations will drive accountability through innovation in payment mechanisms in a move from “paying for volume” to “paying for value.” This will mean developing and deploying payment, monitoring, and incentive mechanisms tied to the oral health of the population being served.
- Pressures to improve oral health of vulnerable and underserved populations and the advent of accountable systems will drive innovation in oral health delivery models including an emphasis on using chronic disease management strategies, integrated health homes, and prevention and early intervention activities. These developments will be facilitated by changes called for by the IOM report, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* (e.g. delivering oral health care in nontraditional settings, engaging non-dental professionals in delivering oral health services, developing new types of allied dental personnel or expanded roles for current allied dental personnel, and connecting geographically distributed providers of health serves through the use of telehealth technologies).

Don Berwick, in *The Triple Aim: Care, Health, and Cost*, indicated that the barriers to achieving the triple aim in the U.S. health care system “are not technical, they are political.” While there may still be technical barriers in moving oral health care toward achieving the triple aim, many of the barriers are also political. The developments envisioned here will take concerted efforts by many individuals and groups to become reality. These include government at the federal, state and local levels; organized health professions; individual health care providers; the dental and general health benefits industry; private philanthropy; and consumer groups. The 2000 Report of the Surgeon General, *Oral Health in America*, elevated the visibility of oral health disparities in America. Now, the pressures and opportunities arising in the “Era of Accountability” will be the road to address these issues.