Smart Investments in Oral Health
State Policy Options for Improving Care and Reducing Costs
The Case of Early Childhood Oral Health

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“State Policy Options for Improving Care and Reducing Costs: Opportunities to Promote Access and Utilization”

Q’s:

1. What constitutes “Care” and what “Costs” count?
2. Exactly what services require “access” and “utilization”
3. Where is the best ROI for policymakers?
Goal Today: Answer these question from a public health perspective using early childhood as the example

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4. What policies can create the best ROI?
Why Early Childhood Oral Health?

* Early childhood oral health predicts lifelong oral health
* Early childhood provides best opportunity for ROI through prevention
* Early childhood provides best opportunity to leverage health system reform in Medicaid/CHIP policy (State Innovation Models, Delivery System Reform Incentive Payment Program, Medicaid Innovation Accelerator Program)
* Early Childhood Caries (“ECC”) is a chronic disease that is significantly preventable
Why a Public Health Perspective?

- Public health addresses your entire population
- Public health “goes upstream” to prevention
- Public health triages, prioritizes, and targets intervention to maximize the impact of limited recourses – best possible ROI
- Public health is the offspring of public policies that you influence
What two problems need solving?

1. Oral health disparities (not just dental care disparities)
2. Current dental Medicaid failures
   - Medicaid/CHIP pays for high-cost dental repair that doesn’t stop the underlying disease -- resulting in high rates of recurrence and retreatment
   - Medicaid/CHIP pays for high-cost ER care that provides only temporary relief
   - Medicaid/CHIP pays for high frequency/low cost “preventive” care that too often isn’t preventive and expends too much money
Problem 1:
Oral health disparities (not just dental care disparities)

Early Childhood Caries ("ECC") results from lack of daily health-promoting behaviors much more than from lack of dental care.

Lack of healthful behaviors result from disparities in education, knowledge, resources, & capacities
Problem 2:

Current dental Medicaid failures

High cost/low yield treatments reflect dentistry’s surgical legacy and traditional “volume-based” payment incentives

(Value-based purchasing in dentistry???)
Summary so far:
It is Time to Shift Gears in Pediatric Oral Health Policy

From a focus on dental care to a focus on oral health
From a focus on cavities to a focus on ‘caries’
Caries management fits the chronic care model better than the surgical model of healthcare.

The Surgical Model

High cost – Low long term outcomes

The Chronic Care Model

Low cost – High long term outcomes

Improved Outcomes

Caries management fits the chronic care model better than the surgical model of healthcare.
Surgical Management

Coverage

Access

Utilization

Content

Outcomes

Medical Management

Zero unfilled cavities

Zero unfilled cavities
Solutions to Problem 1:
Oral health disparities (not just dental care disparities)

1. Build early childhood oral health promotion into your MCH, Early Intervention, Home Visiting, WIC, & Early Head Start Programs
2. Periodically dispense oral hygiene supplies directly to high-risk families
3. Authorize pharmacists to dispense oral hygiene supplies to Medicaid beneficiary families
4. Support various fluoride interventions
5. Partner with public, academic, business, and CBO interests to promote healthful diets as children transition to solid foods (NAP, Food Rx Programs, GreenGrocer Programs)
6. Implement targeted public education campaigns through community resources used by high-risk groups
Solutions to Problem 2:
“Smart Policy Investments” to ‘fix’ dental Medicaid

1. Replace “one-size-fits-all” care with risk-based care in periodicity schedules
2. Leverage Medicaid Managed Care contracts to purchase disease management services and promote medical-dental integration
3. Pay licensed non-dental healing and helping professionals/health workers for protocol-driven early childhood oral care
4. Authorize Medicaid payment to un-licensed “peer counselors” through a “prevention delegation regulation” State Plan Amendment
5. Establish local ECC holistic management demonstrations (e.g., Targeted Case Management with disease management)
6. Establish local Value-Based-Purchasing demonstrations (e.g., pay for measurable outcomes in parent knowledge, disease arrest)
7. Require evidence of pharmaco-behavioral disease management before paying for dental rehabilitation in the operating room
8. Incorporate ECC in your Medicaid reforms
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Q & As:
1. What constitutes “Care” and what “Costs” count?
   Holistic family-centered community-level oral health promoting care that reduces treatment costs
2. Exactly what services require ‘access” and “utilization”
   Access and utilization of social, health, education, and nutrition services that reduce disease risk and experience
3. Where is the best ROI for policymakers?
   Risk-based disease prevention, management, and suppression
4. What policies can create the best ROI?
   Public health approaches that target highest risk, address disease determinants, engage multiple opportunities, & reward providers for value
For more....
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