Engaging in Oral Health Policy at the State Level and Beyond

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In 1997, the **Children's Dental Health Project** was founded by Dr. Burton Edelstein, a pediatric dentist.

CDHP was created to advance innovative policy solutions so that no child suffers from tooth decay. We are driven by the vision that all children will achieve optimal oral health in order to reach their full potential.

Policy is more than legislation

Governor/ executive decision

Stakeholder engagement/ planning initiatives

Budgetary policy/ financial transfers

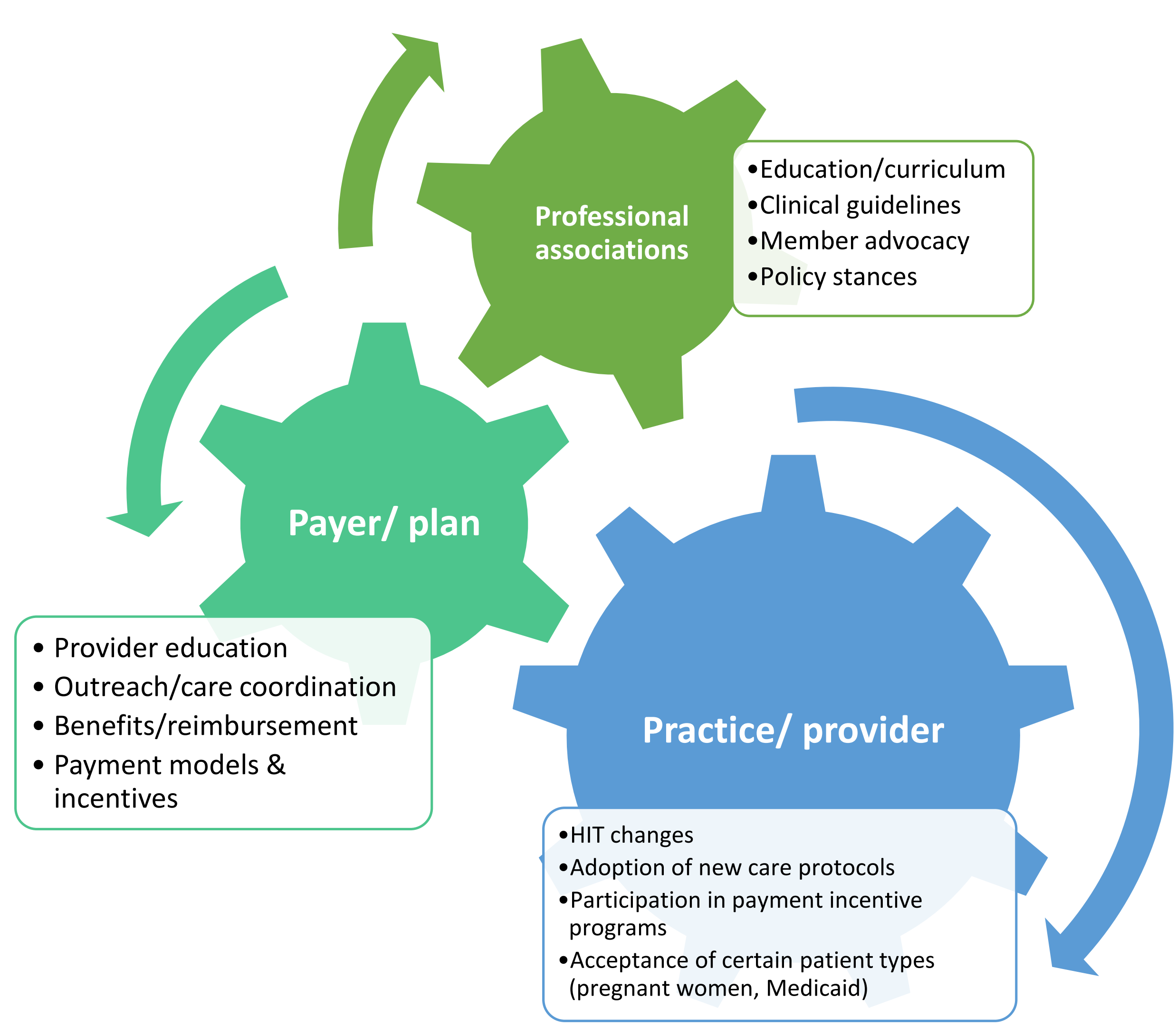
Legislative changes

Inter-agency agreements

State agency/ regulation

Administrative rulemaking

Policy is more than government



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What is Oral Health "Policy?"

Dental	Tooth
Oral	Mouth
Personal	Individual
Behavioral	Family
Environmental	Community
Policy	Society

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Kingdon's Theory of Policy Change*

- Agenda setting: what is considered strongly influences what is done – need to "prime the pump"
- 'Trashcan Model': **not** typically linear (or as logical as we'd like)
- Policy change is most likely to occur when policy windows open and the "streams" have been addressed
  - Problem Stream: policy issues that need attention, evidence helps to frame the issue
  - Policy Stream: solutions evolve and often are developed in anticipation of a problem
  - Political Stream: receptive to a solution when there is opportunity

*Kingdon, J. W. *Agendas, Alternatives and Public Policies* 2nd ed. (New York: Longman, 2003).

Agenda Setting: Kingdon's Theory of Policy Change*

Problem Stream:
Defining the Problem

Policy Stream:
Developing a Solution

Political Stream:
Working the Politics

Policy Window Opens

*Kingdon, J. W. *Agendas, Alternatives and Public Policies* 2nd ed. (New York: Longman, 2003).

Political and policy climate shape what can be

Current policy climate indicators

State Budgets
- Look beyond health agencies

Gubernatorial elections
- Will there be an appetite for change?

State agency institutional memory
- Can be good or bad

History of healthcare policy
- e.g., ACA implementation

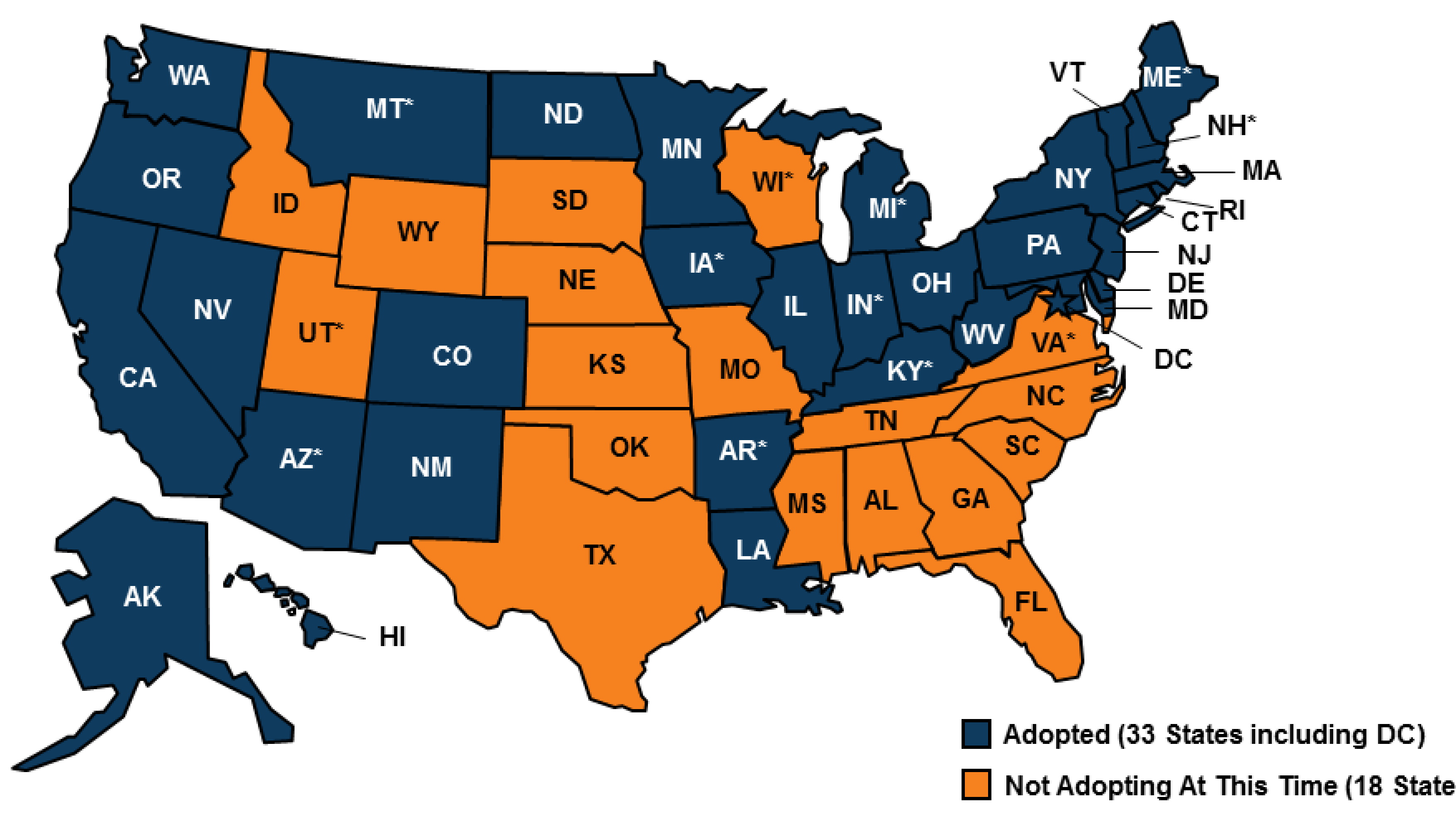
Attitudes of citizenry
- What do voters, parents, patients want?

Federal Budget
- Tax cuts & deficits
- Scrutiny of public programs
- Increases to many HHS agencies

National trends
- Medicaid waivers & work requirements
- De-regulation of private coverage
- Elimination of benefit requirements & oversight
- Ant-immigrant sentiments

Working Americans Fed Up
- More affordable coverage
- Better access
- Family supports
- Jobs & economic stability

Policies tend to diffuse across states



Source: Current status for each state is based on KFF tracking and analysis of state executive activity. Also see the related State Health Facts page "Status of State Action on the Medicaid Expansion Decision" for additional details.

Resources for state-level policy

- Children's Dental Health Project
- Families USA
- Community Catalyst
- Georgetown Center for Children and Families
- National Academy for State Health Policy (NASHP)
- Kaiser Family Foundation (KFF)
- Center for Health Care Strategies (CHCS)
- National Maternal and Child Oral Health Resource Center
- ADA Health Policy Institute
- Association of State and Territorial Dental Directors (ASTDD)
- Medicaid/Medicare/CHIP Services Dental Association (MSDA)
- CMS Innovation Center
- National Council of State Legislatures (NCSL)
- National Governors' Association (NGA)
- Council of State Governments (CSG)

What it means to be an Advocate

"…to speak up, to plead, or to champion for a cause while applying professional expertise and leadership to support efforts on individual (patient or family), community, and legislative/policy levels, which result in the improved quality of life for individuals, families, or communities."

Source: *Wright C.J., Katcher M.L., Blatt S.D., Keller D.M., Mundt M.P., Botash A.S. and Gjerde C.L. Toward the development of advocacy training curricula for pediatric residents: a national Delphi study. Ambulatory Pediatrics. 2005, 5:3, 165-71, https://www.ncbi.nlm.nih.gov/pubmed/15913410.*

Opportunities for Policy Advocacy

Thinking outside the tooth

"…the current dental care delivery and financing model will not drive significant, sustained improvements in oral health going forward like it did in the past, particularly for key segments of the population. We are stuck. And the changes needed to get unstuck are not tweaks, but major reforms."

Sources: *Marko Vujicic, American Dental Association Health Policy Institute:*
Our dental care system is stuck. The Journal of the American Dental Association , Volume 149 , Issue 3 , 167 – 169.

What ought the oral health system look like?

Adequate **AND** Affordable Coverage	Benefit structure, cost-sharing, etc.	Payment and periodicity policies	Flexibility and provider supports
Access to **AND** Accessibility of Care	Outreach & care coordination	Medical/Dental/ Other provider Integration	Alternative care settings
Appropriate, Efficient, Patient Centered Care	Risk assessment & individualized protocols	Emphasis on low-cost, high-impact interventions	Non-clinical interventions & family supports
System Accountability & Improved Quality of Life	Quality & outcomes measures	Value-based incentive structures	Sufficient HIT systems

Why is this difficult to accomplish?

Fear of change

Separation of Dental Care

Separation of Dental Financing

Upside-down incentives

Oral health not seen as priority health care issue

Requires testing new approaches

Examples of System Changes

Care Delivery System Experimentation	Program Level Tweaks	Plan/practice level changes	Innovation beyond the dental clinic
1115 Waivers for local pilot projects	State Plan Amendments to delegate services to new providers	Provider payments to achieve or avoid certain outcomes	Inclusion of oral health into home visiting programs
CMMI funding to test new care delivery models	Alignment of periodicity schedules & payment policies	Value-add benefits for non-covered populations	Oral health interventions for moms via WIC
Establishment of Accountable Care Organizations	Performance metrics for MCOs	Tracking patient disease & outcomes in HER	Oral health guidelines for OBGYNs

Examples of innovation in the field

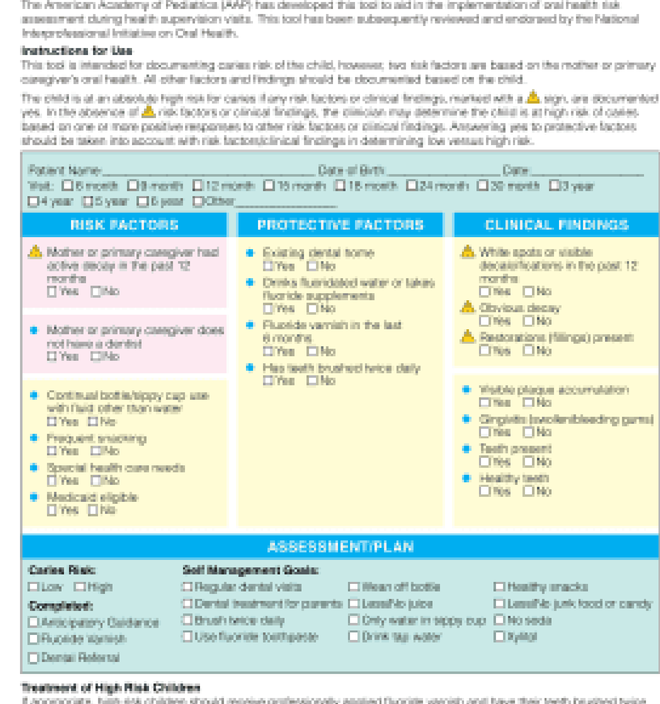
Oral health/ Caries risk assessment: driving accountability

- Well-established in clinical guidelines but not widely implemented
- CDT billing/diagnostic codes available
- Can be performed by medical & dental professionals and shows promise beyond clinicians

- **Uses include:**
  - Serving as basic screening tool
  - Tracking patient health over time
  - Targeting intensive care to highest risk patients
  - Tailoring interventions for specific risk factors
  - Raising awareness among providers AND patients
  - Improving care coordination & referral
  - Driving payment incentives

Oral health/ Caries risk assessment: driving accountability

- Major component of California Dental Transformation Initiative
- Used for adults as part of Iowa's Dental Wellness Program
- Requirement of Texas First Dental Home initiative
- Delaware tying payment for other oral health services to risk assessment, especially for pediatricians



Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a ⚠ sign, are documented yes. In the absence of ⚠ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

Patient Name: ______________ Date of Birth: ______________ Date: ______________

Visit: ☐ 6 month ☐ 9 month ☐ 12 month ☐ 15 month ☐ 18 month ☐ 24 month ☐ 30 month ☐ 3 year ☐ 4 year ☐ 5 year ☐ 6 year ☐ Other ______________

RISK FACTORS	PROTECTIVE FACTORS	CLINICAL FINDINGS
⚠ Mother or primary caregiver had active decay in the past 12 months ☐ Yes ☐ No	• Existing dental home ☐ Yes ☐ No	⚠ White spots or visible decalcifications in the past 12 months ☐ Yes ☐ No
• Mother or primary caregiver does not have a dentist ☐ Yes ☐ No	• Drinks fluoridated water or takes fluoride supplements ☐ Yes ☐ No	⚠ Obvious decay ☐ Yes ☐ No
• Continual bottle/sippy cup use with fluid other than water ☐ Yes ☐ No	• Fluoride varnish in the last 6 months ☐ Yes ☐ No	⚠ Restorations (fillings) present ☐ Yes ☐ No
• Frequent snacking ☐ Yes ☐ No	• Has teeth brushed twice daily ☐ Yes ☐ No	• Visible plaque accumulation ☐ Yes ☐ No
• Special health care needs ☐ Yes ☐ No		• Gingivitis (swollen/bleeding gums) ☐ Yes ☐ No
• Medicaid eligible ☐ Yes ☐ No		• Teeth present ☐ Yes ☐ No
		• Healthy teeth ☐ Yes ☐ No

ASSESSMENT/PLAN

Caries Risk: ☐ Low ☐ High

Completed: ☐ Anticipatory Guidance ☐ Fluoride Varnish ☐ Dental Referral

Self Management Goals: ☐ Regular dental visits ☐ Dental treatment for parents ☐ Brush twice daily ☐ Use fluoride toothpaste ☐ Wean off bottle ☐ Less/No juice ☐ Only water in sippy cup ☐ Drink tap water ☐ Healthy snacks ☐ Less/No junk food or candy ☐ No soda ☐ Xylitol

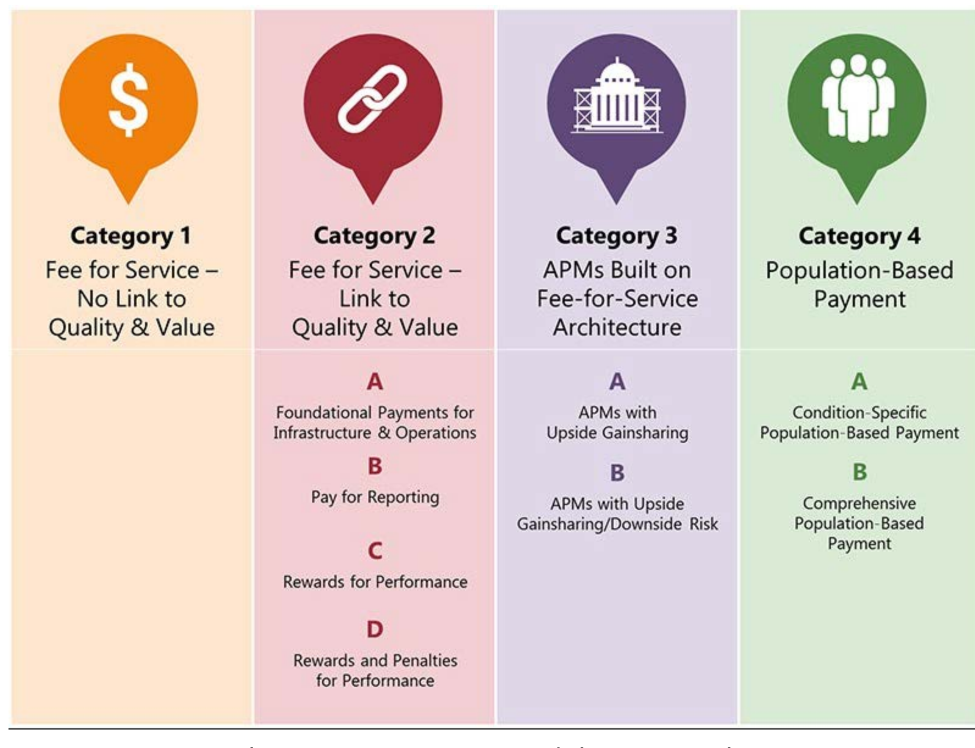
Treatment of High Risk Children

If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

Payment incentives to drive access and/or specific interventions

- Can be used at either plan or provider level
- Often tied to performance metrics of some sort
- Most often involve upside gains (e.g., bonus payments, shared savings)
- May include downside risk (e.g., relinquishment of savings or % of up-front payment)
- **May be operationalized through:**
  - Medicaid waivers (e.g., California, Oregon)
  - MCO contracting arrangements (e.g., Pennsylvania)
  - Inherent flexibility of managed care arrangements
  - Restructuring of fees/reimbursement structure (may require plan amendment)

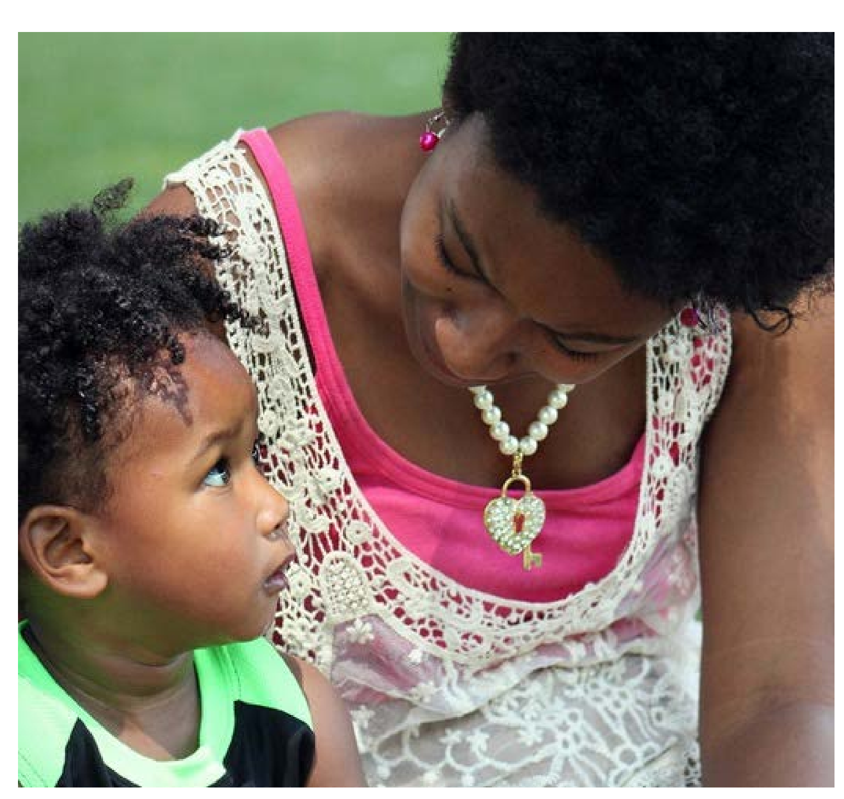
Payment incentives to drive access and/or specific interventions



Alternative Payment Model Framework –
Health Care Payment Learning & Action Network

- **Georgia:** Medicaid dental provider bonus payments for application of silver diamine fluoride AND avoidance of operating room care
- **Texas:** Dental pay for quality program, including at-risk capitation based on Dental Quality Alliance measures
- **Pennsylvania:** Setting targets for MCOs to engage in value-based purchasing & pay for quality, including dental
- **CMS:** Supporting 3 states (DC, NH, MI) to support innovative care delivery models with alternative payment.

Experimenting with bringing oral health to children and families



- Capitalizing on existing touchpoints & inherent connection between children & parent/caregiver's oral health
- Utilizing allied health professionals, lay health workers, and other non-clinicians to:
  - Address oral health in context of social determinants
  - Connect families to care
  - Promote & support healthy behaviors

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Experimenting with bringing oral health to children and families

- **Columbia/NYU:** CMMI-funded project using community health workers & iPad app (MySmileBuddy) for risk assessment, motivational interviewing, self-management goals, family supports in NYC
- **Kentucky:** Use of care coordinators for "Screening + Brief Intervention + Referral to Treatment (SBIRT)" for Medicaid eligible individuals
- **New Hampshire:** WIC clinics as touchpoint for children & pregnant women - assessment, parent education, sealants, SDF, and interim therapeutic restorations by advance practice hygienists

Thank You!

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