

Medicaid Innovation Accelerator Program (IAP) Children's Oral Health Initiative (OHI) Value-Based Payment (VBP) Technical Support National Dissemination Webinar:

Value-Based Payment (VBP) and Contracting Approaches for Caries Management: Implications for State Medicaid Programs

Webinar Date and Time: Wednesday, August 22nd, 2018 1:00 – 2:00 PM EST

Webinar Transcript

Welcome/Webinar Logistics

William Olesiuk (WO): Hello, and welcome to today's webinar, Value-Based Payment (VBP) and Contracting Approaches for Caries Management, Implications for State Medicaid Programs. I am a Senior Research Leader at IBM Watson Health. IBM Watson Health is the prime contractor for the Centers for Medicare & Medicaid Services' (CMS) Innovation Accelerator Program (IAP) contract for VBP in children's oral health and maternal and infant health. We work alongside our colleagues at the Children's Dental Health Project (CDHP), the National Academy for State Health Policy (NASHP), and the Actuarial Research Corporation (ARC) to provide targeted support to states.

(next slide) [reviews logistics for webinar]

Learning Objectives, Agenda, and Today's Presenters

Colin Reusch (CR), CDHP: I will give an overview of what we hope to accomplish and introduce our speakers. We hope you'll come away from today's webinar with an understanding of the general considerations for implementing VBP approaches and contracting approaches in dental caries management. We hope you will have an understanding of efforts to provide these approaches within state Medicaid programs on the ground, focusing on specific subpopulations. We hope you will come away with an understanding of how data and quality metrics can be leveraged to monitor and ensure that optimal oral health is being delivered in the context of VBP arrangements. Finally, we will reflect on some of the strategies and considerations that have been discussed during the webinar.

Our speakers will address:

- Overview of the Medicaid IAP within the context of the Children's Oral Health Initiative (OHI). You will get a sense of general considerations for VBP for caries management. New Hampshire will give their state perspective on how they're going about implementing VBP for caries management.
- Then, we'll get clinical insight into state strategies for VBP and considerations for the use of data and quality measurements.
- Then, we will provide you resources to take home.

I am Colin Reusch, the Director of Policy with the Children's Dental Health Project in Washington, D.C. Our speakers are:

- Burton Edelstein, a professor of dental medicine and health policy management at Columbia University, also the founder and current Senior Fellow in public policy at the Children’s Dental Health Project.
- Sarah Finne and Hope Saltmarsh from New Hampshire. Sarah Finne is the Dental Director with the Medicaid program of New Hampshire’s Department of Health and Human Services, and Hope Saltmarsh is the Oral Health Program Director with the Division of Public Health Services at New Hampshire’s Department of Health and Human Services.
- Paul Glassman, Professor of Dental Practice and Director of Community Oral Health at the University of the Pacific Center for Special Care.

Medicaid Innovation Accelerator Program (IAP) and Oral Health Initiative (OHI) Value-Based Payment (VBP) Technical Support

The program under which all this is happening is the CMS IAP. This is a commitment by CMS to build state capacity and support innovation efforts through targeted technical assistance to state Medicaid and CHIP (Children’s Health Insurance Program) programs. This is a program funded by CMS through the Center for Medicare and Medicaid Innovation (CMMI) and it is led by and lives in the Center for Medicaid and CHIP Services (CMCS).

This is support to states to advance delivery system reform efforts, the goal of which is to really increase the number of states that are moving forward with innovative delivery system approaches within their state Medicaid and CHIP programs. But, to be clear, this is not a grant program. It is really just a targeted technical assistance initiative.

This is the second in a series of public-facing webinars that have come out of this program. Last fall, you heard from the IAP OHI program, really getting a high-level view of VBP approaches within children’s oral health and considerations for those approaches. Today, we’ll be digging a little bit deeper into VBP and contract approaches for caries management and hearing some experience from states on the ground.

Then, we hope to be able to share with you later on more detailed information on the experiences of all the states engaging in this process. Currently, those states are Michigan, New Hampshire, and the District of Columbia. Michigan is focusing their efforts on reducing the proportion of Medicaid-enrolled children who are unnecessarily using the emergency department for dental purposes. New Hampshire is focusing on caries experience within the young child population 0-5 within WIC (Women, Infants, and Children) clinics. The District of Columbia is similarly focusing on decreasing caries experience and particularly looking to reduce the occurrence of operating room (OR) treatment for high-risk children in the Medicaid program who are age 0-6.

Poll Question 1

Before we hear from our first speaker, we will have a poll to gauge your understanding and familiarity with VBP approaches for pediatric caries management. Here are three options to gauge that:

1. You are well-versed in the approaches.
2. You are aware of these approaches but don't consider yourself an expert.
3. You're entirely new to the field of VBP within the context of pediatric caries management.

Select your answer. Not many folks consider themselves extremely well-versed in the realm of VBP for pediatric caries management (PCM), which isn't entirely surprising. I don't consider myself an expert

either. It looks evenly split between people aware of VBP in PCM and those entirely new to the field. Hopefully, many of you will come away with useful information today.

General Considerations for VBP in Caries Management

Dr. Burton Edelstein will talk about general considerations for VBP in PCM based on previous research and general expertise.

Burton Edelstein (BE): My task is to explain the opportunity to improve pediatric oral health by shifting gears from a repair-focused mentality to a true chronic disease management approach. I'll clarify what we mean by chronic disease management for childhood tooth decay and what that shift means in terms of VBP for Medicaid. I'll then explore four specific barriers you may confront as you implement VBP for childhood caries and offer potential solutions to each of those four barriers. Finally, we'll turn our attention to how you can contract for value-based PCM, as well as some things to try and not to try.

What is the opportunity? It all starts with a very straightforward premise. That premise is that the value in VBP comes from leveraging dental science. Specifically, as it says on this slide, current dental science suggests that the value in VBP comes from changing what you pay for in Medicaid as well as how you pay; specifically, what you reward. So, shifting gears from "pay for procedures" to "pay for disease management" is possible primarily because of the epidemiology.

Critical to the VBP approach is an understanding that most children in Medicaid have good to excellent oral health, but a small percentage, about 5%, truly suffer. In fact, we could consider all children in Medicaid to fall into one of three groups:

- Those with good to very good oral health, about 80%.
- Those with moderate to significant caries experience, about 15%.
- Those with truly devastating caries experience, about 5%.

It's that 5% where the dollars go. These are the young children treated under general anesthesia in the OR who have recurrent caries even after extensive repair and who are set up for a lifetime of dental woes unless their disease process is stopped. So, these three groups stratified by risk and caries experience into high, medium, and low gives us the opportunity to focus on the highest risk kids. The more you can do to suppress the caries process and stop that progression, even arresting existing caries so they're no longer active, the more you can improve health, lower cost, and enhance patient and population experience.

Current dental science stretches the very definition of dental treatment. We used to think only in terms of prevention versus repair. But, in between these two poles of prevention and repair is a third way, and that third way is the chronic disease management; that is, using behavioral interventions and pharmacological interventions to stop the caries process. The caries process, of course, is that process that leads ultimately to the cavity, to toothaches, to abscesses, and, finally, to trips to the dentist and the emergency room.

I'm not saying that dental repair is not necessary. What I am saying is that there's much we can do between prevention and repair and that we're spending too much time chasing the problem and not enough time addressing the underlying etiology. Imagine for a moment a child with a mouthful of existing cavities is successfully treated with chronic disease management, both behavioral and pharmacological. That child no longer has new cavities forming, no longer has existing cavities growing, and no longer has the risk of pain or infection. That child has had their disease process stopped in its tracks, frozen, if you will.

There are a number of additional benefits for that child, benefits that go beyond just stopping the disease process. That child no longer needs urgent dental repair. That child can wait. The care can be spread out over time. Or, the child may need less dental repair or less complicated dental repair.

So, what does this have to do with VBP? If you incentivize risk-based chronic disease management for that 5% with the greatest risk, you can see your costs go down as fewer children head to the OR and the ER (emergency room), and as the child feels better and is spared potentially traumatic dental intervention. But, let's be realistic about this. There are a number of potential barriers and we need to explore those, so let's take a look.

The first area is the most common; it is simply inertia. Change is hard, change is threatening, and change is difficult for everybody involved: for payers, for dentists, for parents. We have strong traditions in dentistry. We have trained the public to expect that when there's a cavity, it's immediately fixed. We rely on children coming to dental offices every six months and having the same preventive care regardless of their risk level. Dentists are paid for procedures with no consideration of paying for ultimate health outcomes. So, these traditions get in the way. But, they are giving way.

The two leading dental organizations concerned with children, the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD), have both issued guidelines that support disease management. In your various states, you can try a pilot program with interested practitioners targeting the youngest, most at-risk children. You can find the professional leaders who are anxious to do better for children. You can start small and scale up. And you can address inertia by offering incentives for outcomes, paying to get kids healthy and keep them healthy instead of focusing exclusively on dental repair.

The second barrier is boundaries. This turns out to be a pretty big one, bigger than it might seem at first. It's probably at least as big or bigger than inertia. Let's face it; oral health, like overall health, depends more on what we do day to day (our day-to-day health behaviors, our social conditions, our environment and our genes) than it has to do with our oral health or medical health, per se.

For pediatric caries, controlling tooth decay boils down to what a child eats and whether or not that child's teeth are brushed twice daily by a parent using fluoride toothpaste. While dentists and hygienists are very good at educating families about diet and hygiene, the literature is also crystal clear that this education does not translate into sustained changes in health behavior. Real change in health behavior can only happen when a family is counseled; when they're directed toward a specific goal; when they're engaged in specific, self-defined action planning; and when they're supported, not over a visit or over a day, but over weeks to months. This is clearly outside the boundary of current clinical dental practice.

But, it isn't outside the bounds for social workers, health educators, or nutritionists. It isn't out of bounds for community health workers (CHWs). It isn't out of bounds for those who are the professional thought leaders. For this reason, we need to re-envision interprofessional teams in dentistry to include the helping professions as well as CHWs. We need to rethink pediatric caries more the way we think about asthma management or diabetes management and bring in partners who can help families with their day-to-day experience.

The next one is network threat. It's really hard to know whether this is more perceived or real. This is the concern that any significant change in how you pay dentists is going to lead to dentists dropping off networks, that Medicaid dental participation is too fragile to tinker with. This, too, can be addressed if it's real. In addition to providing financial incentives and minimizing financial risk, you can also address it the way you address inertia: by starting small, by scaling up, by targeting only the youngest children and the most at-risk children first, and by partnering with leaders, particularly pediatric dentists who are most likely to see very young children.

The fourth and last barrier that I want to discuss is the barrier that arises because of the historical separation between medicine and dentistry, and, in particular, between medical vendors, medical managed care plans, and dental managed care plans. When a child goes to the OR for dental repair, it's the health plan that pays for the pediatrician, the hospital charge, the x-rays, and the lab, while the dental plan pays for the dentist. So, when caries management works and the child is kept out of the OR, much of the savings go to the health plan even though it's the dental side that did the work. This problem is structural and so is the solution. Medicaid authorities need to use their contracting negotiations to coordinate between medical and dental plans and set up relationships that make sure that everybody gets a fair shake.

The last note on this slide is a summary statement of importance. Please note that there is a supportive trend in the field of pediatric dentistry and medicine. That is that both professions are increasingly understanding caries as a chronic disease and are moving quickly away from just the awareness stage that something needs to change to the experimentation stage and maybe even into the implementation phase, as we'll hear from New Hampshire.

So, now is time to begin experimenting with both payment and contracting approaches as a first step and doing those small things.

Now, let's look at how payment might work. I want to address four potential arrangements for contracting. They are: bundled payment, nonpayment, pay-for-performance (P4P), and global payment. Bundled payment, the first on the slide, bundles services to appropriately trained dentists; it can define the content of caries management to include enhanced payment for specific services, increased periodicity for high-risk kids, and targeted services for high-risk kids.

Bundled payment means more than paying a single fee for multiple procedures. It means something totally different. It means bundling the services of multiple providers—dentists together with social workers, health educators, nutritionists, CHWs—and it means multiple different endeavors based both in the dental office and in home and community sites. It is a true bundling of a range of services. That is different than the way many people in dentistry are currently thinking of bundled payment (as simply charging one fee for multiple procedures).

Nonpayment sounds harsher than it is. It's simply the idea that if you do pay for disease management and you put the responsibility on the dental team to develop a comprehensive disease management protocol, you don't need to also pay for the full scope of dental repair if that intervention should fail. To put it more broadly, if you're paying the dentist for securing the child's oral health in the first place, you should not also be in a position to have to pay twice for the same outcome.

Two more. P4P or pay-for-quality. As with medical P4P, providers should be rewarded for exceeding network norms and for following professional guidelines. As I mentioned, AAPD has extensive guidelines on caries management. As with other P4P strategies, both upside rewards and downside penalties may be employed when incentivizing appropriate quality care.

Finally, the fourth option: Medicaid payers can move to the far end of the alternative payment spectrum by considering population-based global payment, as is being experimented in Oregon. This approach is best for broadening the treatment team and integrating dentistry within accountable care systems. It can be done at two levels or in two ways. It can be done with global payment only for oral health services or global payment for all pediatric health services, including oral health.

All four of these approaches—bundled payment, nonpayment, P4P, and global payment—are ripe: ripe for experimentation, for pilots, for implementation to promote chronic disease management. They can all complement essential traditional dental repair.

To sum up, let's review some key considerations. All of these depend on rethinking caries not as something that happens along and causes a hole in a tooth, but as a chronic disease, like asthma. Let's look at those key considerations:

- First, consider what you pay for because you will always get what you pay for. Use contracting and payment to incentivize best practices in early intervention in risk-specific, risk-tailored care and in holistic approaches to care.
- Second, consider how you pay for pediatric oral health outcomes. Supplement caries management to first complement and later ultimately displace much of traditional dental repair.
- Thirdly, leverage flexibility. Leverage flexibility that already exists within your vendor contracting and within Medicaid's allowances; Medicaid's in lieu of services provision, for example. Begin building upside and downside risk sharing into your contracts. Hold your vendors accountable to oral health outcomes, and take dentistry out of its silo by coordinating medical and dental plans so that both benefit from shared savings, and this will result in keeping young children out of the OR except in the most extreme cases.

We finish this portion with a summary statement. That is that early childhood caries management holds strong potential to both improve kids' oral health, lower costs, and produce a better experience. With these benefits possible, now is the time to give it a start.

Poll Question 2

CR: Before we move on, we've got another polling question to see what you think the challenges are to influencing VBP within your organization or state building off the barriers or challenges Dr. Edelstein just highlighted. Your choices are:

1. Inertia in general. For example, overreliance on semi-annual examination, cleaning, fluoride, varnish, etc. as kind of a one-size-fits-all effective model.
2. The boundaries discussed. For example, the difficulty in managing the social determinants of oral health.
3. Network threat. For example, the concern with losing dentists by changing the way we pay for delivered care.
4. The separate medical and dental systems; in particular, the vendors who administer and pay for services within Medicaid programs.
5. Lack of evidence or perceived lack of evidence when it comes to the effectiveness of improving oral health or achieving the intended results.
6. Uncertainty around risk. For example, whether there is effectiveness in implementing risk sharing and, again, achieving the intended results by doing so.
7. Leadership buy-in, so whether or not those who are responsible for administering benefits or benefit administrators themselves are bought into implementing VBP arrangements.
8. Legal and regulatory environment within your state that may present barriers to VBP arrangements.

9. Or anything else.

Select your answer. If you select *Other (9)*, add your specific response to the chat box.

Looks like it's distributed across quite a few of the responses, with quite a bit of weight on the separation between medical and dental vendors. Folks are giving us some useful answers in the chat box related to that.

VBP in Children's Oral Health – A State Perspective from New Hampshire

Now, we're going to hear from Dr. Sarah Finne and Hope Saltmarsh from New Hampshire, who will discuss their experience to date in pursuing a VBP arrangement within their Medicaid program and how that's going so far.

Sarah Finne (SF): I'd like to begin with describing our decision to implement this technical assistance project. New Hampshire Medicaid has a very traditional carved-out fee-for-service (FFS) dental benefit that is separate from a managed care medical benefit. These are what we refer to as wraparound benefits covered by our MCOs (managed care organizations) that include payment of facility charges and anesthesia charges when a child needs restorative treatment in the OR. Not unlike many other states, our FFS fee schedule has not been significantly changed (increased) in over a decade.

We were hoping to redesign our fee schedule and at the same time promote decreased caries experience, decreased need for costly OR visits, and also create a system where there is financial stability and sustainability for the WIC locations that are providing the dental services while also being a financially stable schedule of reimbursement for New Hampshire Medicaid.

What really led to us applying for the technical assistance was learning that we would be able to get the technical support we needed to model and test a change in payment methodology. Here in New Hampshire, we did not really have the manpower available to analyze data and model payment scenarios due to staffing constraints we have, which many states do.

(next slide) Our pilot program actually began in a prior IAP project. The New Hampshire team participated in the CMS OHI Learning Collaborative from 2013 to 2015, where we were working on a target goal from CMS to increase the proportion of children receiving a preventive dental service by 10 percentage points. The New Hampshire team looked at what location for services could lead to this type of improvement. We looked at why were we missing a significant portion of our 0-5-year-old population, and looking at that, we realized that it would make sense to provide oral health services where those clients were already going for other services. The original pilot was introduced in the spring of 2014 and has continued until today.

Hope Saltmarsh (HS): (next slide) Since 2014, our pay-for-prevention model has co-located preventive dental services with WIC services. In New Hampshire, certified public health dental hygienists provide interim therapeutic restorations in addition to other preventive services under public health supervision. Certified public health dental hygienists collaborate with WIC nutritionists to unify messaging with clients. In the pilot program, children from birth through their fifth birthday and pregnant women up to 21 years received these evidence-based services: anticipatory guidance, oral health instructions, toothbrush prophylaxis, fluoride varnish sealants, and interim therapeutic restorations. Clinical data is recorded on iPads with data stored offsite, and all children are referred to a dental home.

(next slide) Grant funding has been necessary to fill the gap between Medicaid reimbursement and program costs. During this VBP technical support opportunity, service bundles for children only will incorporate screenings, caries risk assessment, oral hygiene instruction, motivational interviewing with

parents and caregivers, toothbrush prophylaxis, silver diamine fluoride, fluoride varnish sealants, and interim therapeutic restorations.

(next slide) Data collection and monitoring is of key importance. The data collected since 2014 will be used to test the proposed payment model on the basis of client volume experience since the program's inception. The team will monitor financial and health outcomes data and we will incorporate key messages and identify unintended consequences using iterative testing.

(next slide) SF: That leads to some important lessons learned during the course of the prior pilot and our work this past year. One of the most critical issues is that it is incredibly important to have buy-in from leaders at each location where you would like to provide the oral health services. As a proposed solution to this, we have talked about the idea of creating a handbook that outlines the process and procedures involved in implementing such an offering at a WIC location so that staff on both sides, the WIC side and the oral health side, have a good understanding of what the needs will be to have a successful program.

The second one is something that we found out mid-program. While mothers are expected to come back to the WIC location on a quarterly basis to maintain their services, children do not have to accompany the parents on every visit. So, while we were hoping to see children at higher frequency, that wasn't always happening. One of the proposed solutions we are also discussing now is to possibly provide incentives to parents to induce them to bring their children in for each visit rather than just twice a year.

The last thing is a little bit different. It's the program's co-located services of nutritionists and oral health teams, and there is significant variability that can occur from site to site. Staff nutritionists and the other WIC staff need to be aware of their impact on the success of the project and improved outcomes for the WIC clients. It is their encouragement of client participation in the oral health offering that can have this significant impact. Encouraging clients to be seen in the oral health program can't be considered one more task I have to complete during a visit. It really needs to be an ingrained piece of what they do at each visit.

Then, additionally, the regular interaction between WIC staff and oral health staff can help support this and lead to increased participation.

(next slide) Future Implications:

- One will be the ability to assess whether or not the APM can be associated with lower costs and/or be financially stable. This is really the critical case for me here in New Hampshire was to do some modeling that we would not be able to do on our own.
- The second is to shift provider incentives from quantity to quality as has been discussed by Dr. Edelstein.
- Modeling of the APM for the two WIC sites likely will lead to an APM available for the entire Medicaid population. It is my hope that this will just be the first step for the state of New Hampshire and, ultimately, we will be able to offer a bundle for our 0-5 population at highest risk across the state.

[Update on the Virtual Dental Home: On the Road to Value in Oral Health Care](#)

CR: Now, we'll hear from Dr. Paul Glassman from the University of the Pacific, who will talk a bit about his efforts with teledentistry as well as share some insights into how quality measurement is an important component of any VBP arrangement.

Paul Glassman (PG): I'm going to be talking about something we developed in California and now in other states, which I'll get to in a little bit, called a Virtual Dental Home, and try to make the point that this *is* a delivery system, but it has important implications for VBP and, ultimately, value-based care. So, I've

entitled this bit of talk, “On the Road to Value-Based Care”, to make the point that we have a long way to go in the oral health industry to really develop and implement full value-based health and oral health systems, but there are a number of important developments already underway.

Of course, they're all really within the context of what has been articulated by some people as the national goal in the era of accountability of the Quadruple Aim, which is to produce better patient experiences, improve health outcomes, lower costs per capita, and the fourth one, added more recently, improve clinicians' experiences.

When we start to think about VBP systems, the point I want to make and reinforce is that it is much more than payment. What I've put on this slide, this overlapping Venn Diagram, is three of what I consider to be essential components if we're going to develop true, functioning, value-based care systems. One, of course, is payment, and before you have payment, you have to have a system for even defining what oral health is, collecting measures about oral health, and then have a way to pay people based on achieving the goals that we just articulated.

But, what sometimes gets let out of discussions like this is that a payment system by itself will not get us where we need to go. We really have to have a payment system that's combined with two other essential ingredients, one of them being a delivery system or systems that actually reach people who are not getting access to oral now and have most of the oral disease in our country, and the third one is—Dr. Edelstein already made this point—a strong foundation in prevention and behavior science.

Although we don't have a nationally adopted definition of what oral health means, there certainly are people working on measurement systems. There's the Dental Quality Alliance, there's multiple payers, both dental companies and public payers, and probably the health center system under HRSA's (Health Resources and Services Administration) guidance is probably the furthest along in the dental industry in terms of actually developing measures, and then multiple group practices are doing the same thing.

I want to spend a minute talking about a HRSA grant we have now at the University of the Pacific School of Dentistry, where we are taking the delivery system, the Virtual Dental Home, and, on top of that, adding some components of value-based data collection and value-based care. Specifically, the three components are those on this slide, which is we are defining a set of basic health outcome measures, which we have done. We are demonstrating through this pilot the ability to collect data about those measures because people have developed some pretty eloquent measures that it's pretty hard to collect data about. So, we want to show not only that we can come up with measures, but that we can actually collect the data. The third essential ingredient is if we have those measures and we apply the best prevention and behavior science that we know, we can actually demonstrate that people in the population get healthier based on those measures.

Again, it's certainly possible to come up with measures and collect lots of data and still not be able to show that there was actually improvement based on that data. So, those are three essential ingredients that will ultimately lead us to better directions in developing VBP systems.

The other point I want to make, and this is in brief going back to things Dr. Edelstein was saying, is that we are in a very, very different world now in terms of the practice and science of dentistry than we were when I was in dental school. The title of this slide says, “The Declining Role for the Dental Drill.” I think it's important to realize that we have had predominantly a disease repair system, not a healthcare system in oral health, and that might even apply to our general healthcare system. But we are in a very different era now where there are many things that can be done, including remineralization agents and buffering agents and caries-arresting medications and techniques for sealing caries. You already heard the interim therapeutic restoration mentioned. And also some significant improvements in understanding of behavior

support science, all these things that can keep a lot of people healthy without needing to be in the high-cost surgical suite, which is the dental office, and have reparative dentistry done by a dentist in that location.

Now, let me turn to the delivery system we are working on here in California and other places called the Virtual Dental Home. I'll make the point that this is a dental home. I hear people a lot and it's sort of a predominant paradigm in the dental profession that a dental home is a bricks and mortar dental office. People often say we're going to do this in the community and then will refer someone to a dental home. In our view we've created what we call geographically distributed, telehealth-connected teams, which actually form all the components you'd expect in a dental home.

So, this is a picture of a dental hygienist in an elementary school. This is the nurse's office where the nurse isn't there a number of days of week. She has set up some affordable equipment and is taking x-rays in this photograph, but it collects all the components of a fully populated dental record system with images and charting and health history and everything else you'd expect to see in a fully populated system. This fits very nicely into multiple kinds of community sites. This is a Head Start center. You can see it doesn't require a lot of equipment. We're not doing full-service dentistry here. It can be put in Head Start centers, elementary schools, residential facilities for people with disabilities, nursing homes across the age spectrum, and in many different kinds of community locations. It uses portable equipment so the equipment can be packed up. It can be in one Head Start center one day and a different Head Start center a different day.

This is a photograph of a dental hygienist placing one of those interim therapeutic restorations you've heard alluded to. On closer look, you can see this is a tooth that, in this young child, traditionally what would happen is nothing until that hole got to be a bigger and bigger hole and the child ended up with a toothache, possibly not learning in school, a bigger hole and more teeth with holes in them and end up maybe in the hospital in the emergency room or the hospital OR. But now, with the advent of the new science and materials and techniques we have, in just a few minutes with no drilling, no anesthetic, that tooth can be sealed, the caries can be sealed in place and put into a holding pattern for really a long period of time.

We did a 6-year demonstration of this concept across California. It took place in 13 different communities at about 50 different community sites. We were clearly able to demonstrate that we could make this idea of telehealth-connected teams work. Some of the outcomes from that demonstration were that we were able to show that we could increase access; basically, we could reach people not traditionally getting access to dental care or having dental care, which is the majority of the population. We could, in the community site, emphasize prevention and early intervention and lower costs.

Really of high significance is that the majority of people could be kept healthy and verified healthy onsite. In fact, about two-thirds of the children in this demonstration project were able to be kept healthy just by the services performed by the dental hygienist in the community site without needing to see a dentist in person. The dentist was involved in reviewing records in detail in the health system, but did not need to make a trip to a dental office.

Also of large significance is the fact that this was care taking place in the community location. We call it a continuous presence system, where the dental hygienist or community team, as we referred to it, were present in the community location throughout the year. They were not there five days a week. They might be in a particular Head Start location only one day every other week, but being there throughout the year had a huge impact on increasing people's awareness about dental health. They knew the team was coming back. When they were asked to do something, they would follow up on it. It gave the opportunity for the

dental professionals coming in periodically to help supervise, motivate, and support the professionals who were social service professionals or other kinds of professionals onsite at these locations and made a huge difference in terms of awareness and encouraging and supporting parents to adopt better, healthy lifestyles, and the children as well.

Currently, we are teaching and supporting 46 different provider entities in learning how to do this Virtual Dental Home system. We're doing that across multiple states, including California (primarily in California). The different colors here are different funders across California, and also teaching demonstrations going on in Hawaii and Oregon and Colorado.

So the takeaway, my conclusion after having been doing this for 15 years or so now, is that this is going to play a huge part in the dental industry in the future. This idea of dental practices incorporating geographically distributed telehealth and oral health teams is going to be everywhere. Twenty years from now, if you ask someone, "do you use telehealth connected teams in the way dental care is delivered?", people are going to say, "of course we do, why would we not do that?"

This system reinforces and leverages the opportunity to view dental disease as a chronic disease the way Dr. Edelstein has outlined it and to emphasize the use of chronic disease management techniques using biological, medical, behavioral, and social tools. It integrates oral health services with general health, education, and social service systems. And, as it begins to grow, we may have the opportunity to get the dental profession back to a system where we're interacting with a majority of the population, which we don't do now. I think there's going to be increasing interest and it will be imperative to take on these kinds of systems as we move further into the era of accountability.

I'll finish up with a couple slides that will be in the resource list for this webinar. It's a white paper that I wrote for the DentaQuest Foundation and the Kellogg Foundation on the use of teledentistry. I won't have time to go through all the components (you can read those), but I'll just emphasize two of them right now. These are really suggestions and ideas for if you want to adopt the system I'm describing, there are some things that need to be in place in terms of a regulatory environment for this to actually happen. One of them is the ability for allied personnel to be able to do certain things. That involves bill for practice laws, both their adoption, regulation, or interpretation. It would be important to have allied personnel be able to collect diagnostic records before a patient is seen by a dentist, to be able to have them perform procedures at locations that are separate from dentists, and understand that dentists can develop a diagnosis and treatment plan without an in-person visit with a dentist. I don't have time today to go into evidence why that's absolutely the case, but we certainly have a ways to go before there's a broad understanding of those three bullets. But many states have already—California adopted them after our demonstration—begun to change their regulatory environments to recognize those scope of practice parameters.

The second part is payment. That, if you're going to start to use telehealth-connected teams as part of a delivery system, there has to be a way to get paid for it. A principle I've been talking about and espouse is that it's important to think about this idea of telehealth or telehealth tools as communication tools. These are not actually services themselves. They allow people in different places to work together and to collaborate together and provide a full-service dental care system. But, it does require that the state pay for services delivered using telehealth-connected teams and telehealth technologies the same way they would if they were in person, and that it includes the idea of store-and-forward, which is not in a lot of laws that were written before store-and-forward was really a workable technology. Some suggested language if a state was going to incorporate this in a legal or regulatory environment would be to say something like face-to-face contact between a healthcare provider and a patient is not required for services performed using real-time or store-and-forward teledentistry.

I've tried now to present a little background about the actual system we're using, the Virtual Dental Home, but I think maybe more importantly in this context is to make the point that these kind of systems are an important ingredient of moving towards value-based care, but that the delivery system doesn't stand alone, the payment system doesn't stand alone, and the use of the latest prevention and behavior support science doesn't stand alone. It really takes those ingredients to come together to get to a place where we're going to be able to really achieve the goal of having value-based care systems.

I'll also add one note. Now that we have increasing evidence across multiple states that it's possible, some people brought up the idea of resistance from various sectors of the dental industry. It's possible actually to help people understand this is actually a win-win. It's a win-win for dentists, for other kinds of oral health professionals, for professionals who are not oral health professionals, for states, and for the people who desperately need this kind of care. I'll end there.

Questions or Comments?

CR: Before we wrap up I want to give folks an opportunity to ask questions. I've got a couple of questions that came in through the chat box. Perhaps Burton or Paul, this may best be fielded by you, but Dr. Finne or Hope, feel free to jump in. The question is, how might these approaches be relevant or applicable beyond Medicaid and beyond the child population? In other words, are the principles of chronic disease management in oral health and the VBP principles we've discussed here relevant for adult populations, both within Medicaid but perhaps within private insurance or employer-sponsored coverage?

PG: Based on the work we've been doing with the Virtual Dental Home system, we've been doing this across the age spectrum and not confined to just Medicaid populations. It certainly has an application to many groups of people who don't get dental care on a regular basis. Actually, children are the highest utilizers and the data for seniors and working age adults is much lower utilization, so there's plenty of opportunity to reach people outside of the traditional settings and to bring prevention and early intervention care to them. Again, it's more than just the delivery system reaching them. We have the opportunity to reach people and then apply different kinds of payment systems and the very best science that would allow us to have the same kind of benefit for adult populations as for children populations.

BE: I want to add to what Paul said that we can really look more to the medical side where much of the VBP and the chronic disease management has already been developed and expressed to see what might be applied to oral health services. Once we get past the silo problem, which so many people recognized, we can really have the opportunity to integrate care in a truly bundled way.

CR: Perhaps building off your response, Paul, there's a question whether or not you have a sense if the advent of teledentistry and other approaches that allow providers to reach beyond the four walls of the dental office is drawing more providers into the Medicaid program who previously may not have been interested and perhaps that data is not readily available? Are those new models attracting new providers into the program?

PG: I think the answer is clearly yes but it's not a large number yet. We have a long ways to go before these systems are widely available. What I can say is that our experience, and this is just anecdotal, is that there are many dental providers, specifically dentists, who are not serving Medicaid populations. They don't really want to "open their office up" and are sure when that happens there's a large no-show rate and you hear things like that, but have been very interested in being involved in a system where the primary care, the prevention, the early intervention is taking place in the community. When someone does get referred to their office, it's a very targeted referral where the parent, for example, knows they're coming just to get these couple fillings done. They're going to have their ongoing checkups and prevention and interventions back in the community site dentist. They're much more willing to participate in a system

like that than they are to, as I said, open their offices up to take people where they're providing all the services in their dental office. I think that idea is growing in interest from the dental professionals. We're hearing lots of conversation and calls and things about that and I think it's going to continue to grow.

CR: One concept you lifted, Paul, but all our presenters have touched on, is what Dr. Glassman calls "behavior support" or "behavioral support sciences." It seems that's key across any of these chronic disease management models for oral health. I don't know, Dr. Finne or Hope, if you have thoughts on how those behavioral supports are likely to be integral to your initiatives on the ground in New Hampshire, or Dr. Edelstein, if you have additional thoughts as to the emphasis that ought to be placed on that.

HS: We didn't think of the motivational interview training for the hygienists until they were practicing during our pilot period inside the WIC, and we got a lot of feedback from the people at WIC that we needed motivational interviewing skills because they are trained in them, and what conversations they heard or feedback they got from the clients led them to think we would do better if we had that training, and that did seem to solve the issues.

BE: Here in New York with our Medicaid innovation program, we've moved intervention from young children who already have early childhood caries directly into the community; just as New Hampshire has partnered with WIC, we've partnered with the local community health workers, provided them with some technology assistance to help keep the cariology science straight, and had them conduct over long periods of time, 6-12 months with each family, interventions in the home and in community sites where the real social determinants and behavioral determinants happen.

So, yes; I think to answer your question, if we partner with people who have a natural capacity to connect with high-risk populations and who can bring the messages directly into the homes and can do so over a sustained period of time, then we can see some real change in health behavior.

PG: I can add to what Hope and Burt just said. Just to give a very, very brief idea of some of my thoughts about what is that idea; a lot of us have been using the term "behavioral support science," but really what we're talking about here is what is it that's likely to get people to change their behavior. Changing behavior is extraordinarily difficult for all of us and no less so for a parent who's trying to think about how to raise their children with many, many concerns that they have. What we know is that people are much more likely to listen to somebody they consider a trusted member of their own community about behavior change than they are to a professional. They think professionals are very smart and they think that we don't understand their lives, so they often discount what we say.

People are much more likely to adopt what sometimes people call "tiny habits." Can you make one change? How about if you just try diluting the bottle with a little bit of water and let me talk to you tomorrow and see what happens? In order to be able to talk to the person tomorrow, you've got to be in a location where you're with them. So, the idea of this ongoing coaching and using proper language like motivational interviewing and mentoring, all that can take place really only in a community setting. The dental office really is a wrong place to try to do that. Most people who need this kind of support are not in dental offices at all or they're in there for an emergency or not very often. So, I see really the role of the dental profession is being coaches and mentors for the people who are on the ground: community health workers, family advocates, Head Start, other people like that, and being able to support them because they're the ones the parents are going to listen to. They're in contact with the parents on really a daily basis and that's where the change can happen.

Key Takeaways for Today's Webinar

CR: Unfortunately, we're out of time. We have other questions that came in. We'll find a way to answer those. Real quick, key takeaways from today's webinar:

- The shift away from the traditional model of dental care to a broader model that encompasses new payment initiatives and encourages a greater focus on chronic disease management is really the future we're looking at in terms of achieving improved outcomes and potentially making programs more efficient or responsive to patient needs.
- Medicaid agencies who are implementing or considering implementing these approaches should really consider how those delivery systems need to change in order to reach the intended population to better support evidence-based practices and behavior supports like all our presenters discussed. That may include supporting the right personnel through payment and training to engage those patients beyond the four walls of the dental clinic. We've seen that in New Hampshire with their efforts in the WIC clinic so far.
- Of course, those efforts are not without their challenges and many of you gave us some great insights into what those challenges are, whether it be the limitations of our health information technology systems and electronic health records to the training that providers currently receive. We will look to address some of those in our next webinars that are public-facing.

Medicaid IAP VBP Webinar Series and Other Resources Available

WO: Resources for this and other webinars in this series will be made available on the Medicaid IAP website. Those include the slides, the recordings, and resource lists and materials developed specifically for the IAP. The recording should be available in the next two weeks.

Thank You/Webinar Ends

Thank you for joining today's webinar. Please complete the evaluation survey.

[end of tape]