ORAL HEALTH CARE DELIVERY WITHIN THE ACCOUNTABLE CARE ORGANIZATION

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Editor's Note

This article describes value-based healthcare in action using the example of an interdisciplinary team approach that includes a dental hygienist/dental therapist and an oral health focus. Accountable care organizations will be well-positioned to collect metrics to document viability of these ideas.

ABSTRACT

The accountable care organization (ACO) provides an opportunity to strategically design a comprehensive health system in which oral health works *within* primary care. A dental hygienist/therapist within the ACO represents value-based health care in action.

Background

Inspired by health care reform efforts in Minnesota, a vision of an accountable care organization that integrates oral health into primary health care was developed. Dental hygienists and dental therapists can help accelerate the integration of oral health into primary care, particularly in light of the compelling evidence confirming the cost-effectiveness of care delivered by an allied workforce.

Methods

A dental insurance Chief Operating Officer and a dental hygiene educator used their unique perspectives and experience to describe the potential of an interdisciplinary team-based approach to individual and population health, including oral health, via an accountable care community.

Conclusions

The principles of the patient-centered medical home and the vision for accountable care communities present a paradigm shift from a curative system of care to a prevention-based system that encompasses the behavioral, social, nutritional, economic, and environmental factors that impact health and well-being. Oral health measures embedded in the spectrum of general health care have the potential to ensure a truly comprehensive healthcare system.

INTRODUCTION

Picture a health system where people have greater well-being than in their past; the quality of care continually improves, and the cost of care is affordable for all Americans. This vision describes an accountable care organization which can be defined as a group of healthcare providers who take responsibility and accountability for the health of a population of patients. The arrival of accountable care organizations (ACOs) has ushered in a new paradigm for health care delivery focused on

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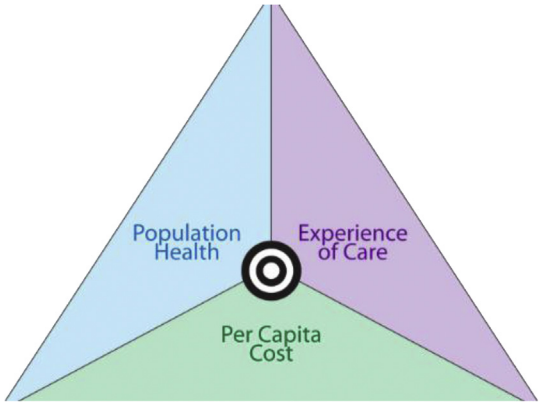
Figure 1. The Triple Aim of Health Care System Reform from the Institute for Health Care Improvement. The 3 components of Triple Aim are interconnected—a change in 1 component can affect the other 2.



prevention, efficiency via team-based care, and community engagement. This new paradigm, conceived by the Institute for Healthcare Improvement, is called the Triple Aim.[1] Simply put, health systems should be organized in a way that optimizes their ability to perform in 3 dimensions: (1) the 'experience' of the individual; (2) the 'health' of a defined population; and (3) per capita 'cost' for the population (see Figure 1).

The Centers for Medicare and Medicaid Services has embraced the Triple Aim approach in their funding for innovations in the delivery of care.[2] In 2013, Centers for Medicare and Medicaid Services funded 6 states to test a variety of approaches to forming an ACO that would improve delivery systems and expand access to care; Minnesota was 1 of the 6 states. Health systems and communities across Minnesota are redesigning their services. The focus has been on offering a seamless, comprehensive, and coordinated approach to patient care. The ACO is becoming a microsystem within the larger health system, facilitating an interdisciplinary population-based approach to health care.

Currently, ACOs in Minnesota and across the nation are focused on Medicare-covered populations, yet Medicare does not have significant coverage for dental services. Thus, ACOs are missing the key component of oral health. Attention to the oral health of the adult population is further hampered because the essential benefit package of the Affordable Care Act (ACA) includes dental benefits for children only.[3] A small number of states provide adult dental benefits via Medicaid; however, most dentists in the United States do not accept patients on public insurance[4]. Combined, these system-level factors result in the current dental delivery and payment model, leaving vulnerable population groups such as seniors, minorities, people with special needs, and those in lower socioeconomic groups unable to access affordable dental care.

Impact of the ACA

The ACA provides incentives to move toward ACOs, and a new marketplace for the purchase of health insurance called health exchanges. With health exchanges, an employer or individual will no longer negotiate with local health insurance companies for affordable insurance. Health insurance exchanges also facilitate the use of federal premium subsidies for families and tax credits for small employers. The federal health insurance exchange, known as healthcare.gov, and the Minnesota state health insurance exchange, known as MNsure, have been creating these marketplaces since 2013. An unintended consequence has emerged from employers and individuals purchasing their health insurance through the health exchanges rather than directly with an insurance company. According to the Health Policy Institute of the American Dental Association, a decreasing number of Americans have private dental insurance.[5] The purchase of health insurance on exchanges does not easily facilitate the purchase of adult private dental insurance. Because the main purpose of the health insurance exchange is medical insurance and there is no mandated adult dental coverage, lower rates of dental coverage are likely to occur. Health insurance companies are realizing that treating periodontal disease correlates with lower medical costs (see Figure 2). Nothing in the ACA prevents an ACO from filling the gap in access to dental care. ACOs can strategically redesign the way oral health care is delivered. By integrating oral health within primary care, improved access to oral health services is created, rounding out the ACO as a patient-centered health home. General health is impacted by oral health; consequently, the oral health needs of a population are critical to an ACO's goal of improving health outcomes while lowering the cost of health care.

Evolution of the Concept of Inclusion of Oral Health Care Within the ACO

Our personal stories inspired our vision for oral health care delivery within the ACO. In the spring of 2009, a bill approving the creation of a new oral health care team member, the dental therapist, was signed into law in Minnesota. That fall, the first dental therapy students arrived on the campuses of the University of Minnesota and Metropolitan State University. This was a milestone event, as the development of a dental therapist had been surrounded by controversy and uncertainty (see Brickle et al., in this issue).

During 2007-2008, coauthor C.B. was part of a team that traveled around the world to study global dental therapy models. Appointed to serve on the governor's legislative workgroup for the state of Minnesota charged with making recommendations on dental therapy scope of practice and supervision level, she was concurrently co-creating the dental therapy curriculum in preparation for the arrival of the first dental therapy students in the School of Dentistry. Curriculum