VALUE-BASED CARE

In the July JADA editorial entitled "Achieving Oral Health for All: Accepting the Challenge" (Johnsen DC, Wright JT. *JADA*. 155[7]:553-555), the authors highlighted the significant prevalence of oral disease, disproportionate burden of oral disease among low-income and racial and ethnic minority groups, and the need to develop and support integrated care models that "move people toward a health trajectory." I believe value-based oral health care to be an important pillar in the development of a coherent agenda to address these challenges.

As noted in the editorial, there is widespread acceptance of the importance of oral health to total health. Indeed, the World Health Organization now recognizes oral health as a primary and integral component of health.[1] There is also an increase in public health care professionals advocating key principles of sustainable oral health, including greater investment in preventive oral health care, payer models that promote oral health care, and integration of oral health care into primary care.[1]

It is estimated that 90% of medical diseases have dental manifestations.[2] Poor oral health care is associated with worsening chronic disease, lost productivity, and higher risk of emergency department visits. Every year, an estimated 2 million hospital visits are due to dental issues.[3] Infections of the gingivae (eg, gingivitis and periodontitis) can be a gateway to other health issues, from infections of the heart and lungs to progression of Alzheimer disease and even cancer.[4,5]

When oral health deteriorates, it is not just a patient's smile or ability to chew that is affected; their whole body suffers, and there is a cascade of negative social and economic effects. The reverse is also true. When oral health is optimized, patients not only feel better, but they also save money on health care and have a better opportunity to support their families or pursue their passions. The old adage ". . . an Ounce of Prevention is worth a Pound of Cure . . ."[6] is probably truer in dentistry than in any other health care field.

In multiple high-quality studies, researchers have found that oral health care reduced medical costs. Researchers at the Mayo Clinic found that people with coronary artery disease who visited their dentists saved, on average, $549 per year.[7] Cigna found that routine oral health care reduced total medical costs by 4.4% per year in the general population, but for those with certain medical conditions, such as diabetes, the savings could be as high as 12.3%.[8] For patients who are socially disadvantaged, the savings from routine oral health care are even higher, at 37%.[8]

In a letter to the US Department of Health and Human Services, 28 senators called on the government to improve coverage for seniors, citing, among other reasons, a $63.5 billion net savings for the traditional Medicare program over 10 years.[9] It seems that at least the insurance world responded. Patient enrollment in Medicare Advantage plans with mandatory dental benefits increased from 60% in 2018 to 86% in 2021.[10]

Yet, the movement for value-based oral health care is just getting started. Most dental provider payments are still fee-for-service and devoid of quality performance measures. To date, value-based oral health care has been limited primarily to unstandardized networks and third-party administrators. However, we are now starting to see dental models and partnerships that focus on proactive population management and payment for outcomes rather than services.

Researchers have found that population health can be optimized by means of

- offering programs that have low-cost (or no-cost) preventive dental services
- ensuring that patients with chronic disease undergo thorough examinations and receive customized treatment plans
- integrating oral health care into medical care delivery
- making (at least part of the) payment for dental services contingent on achieving quality metrics.

Oral health care may be the most overlooked service in value-based care. Yet, by means of following these simple steps, there is unprecedented opportunity for dental groups, health systems, and payers to improve quality of life pronouncedly, while reducing costs for everyone. ■

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AUTHORS' RESPONSE

We thank Dr. Hernandez for her response to our July JADA editorial entitled "Achieving Oral Health for All: Accepting the Challenge." Her letter expands on the topic of value-based care and offers components of a system to improve health. We

see this as an opportunity to comment on the well-researched and well-referenced points in her letter and extend the discussion on issues related to treatment and achieving health.

Dr. Hernandez makes the following compelling points that add valuable perspectives to the dialogue on value-based care and care systems

- ". . . value-based oral health care [is] an important pillar in . . . a coherent agenda . . ."
- Oral health as part of total health: ". . . 90% of medical diseases have dental manifestations."
- ". . . oral health care reduced medical costs."
- ". . . population health can be optimized by means of
  - offering programs that have low-cost (or no-cost) preventive dental services
  - ensuring that patients with chronic disease undergo thorough examinations and receive customized treatment plans
  - integrating oral health care into medical care delivery
  - making (at least part of the) payment for dental services contingent on achieving quality metrics."

The letter is a well-contemplated piece in a dynamic story.

To extend the dialogue beyond the editorial and the letter, our focus turns to the characteristics of the people and groups that deserve attention and will challenge further progress. Dr. Hernandez offers strong points on value-based oral health care. We agree with the concept of value-based care. The following comments are more about limitations of the system (any system) described than the concepts.

One extension of the discussion on value of care is that it means sustained health, and if sustained health is not practicable, then at least providing temporary health. A challenge is that for groups of high-risk people with recurring disease, we do not have evidence-based interventions proven to be successful for bringing sustained health. Can we call on practitioners to bring health with any metric without proven interventions known to bring sustained health? It is not that successful intervention is being withheld but that there is a lack of successful interventions. The ethical alternative is to offer care that will bring health, if only temporarily. Such a compelling case is made particularly with people with special health care needs.

The focus of Dr. Hernandez's letter is on systems. She agrees that systems are needed as part of sustained health, with the question raised on US effectiveness brought into question in the figure in the editorial. Leading into any system are people. For higher-risk people with recurring disease, 2 perspectives are offered for continued discussion that will be a challenge for any system. One perspective is regular attention paid to the person's capacity to subscribe to professional recommendations. With unrestricted sweets, smoking, obesity, unmanaged diabetes, and so forth, dental disease will continue. Yes, a more inclusive, preventive-oriented system can offer interventions found to improve health, but it will not eliminate disease with escalating and switching interventions for higher-risk people over time. People with less capacity will be less able to participate in a recommendation.

A second perspective is the domestic stability or instability for a person, whether private or institutional. Higher-risk people with unresolved social (domestic) barriers to care will continue to have disease at some level. In her letter, Dr. Hernandez recommends that ". . . patients with chronic disease undergo thorough examinations and receive customized treatment plans." To follow the people theme, the matter of systematic risk assessment along with prognosis and longer-term projection for status of health and disease articulated to the person makes a partnership for the person and caregiver, sometimes with unwelcome news. A point raised in our editorial was a call for the development of interventions to bring sustained health to higher-risk people with recurring disease, and this raises the question of whether treatment brings health for these people.

We thank Dr. Hernandez for raising several key perspectives on value-based care and system recommendations. The issues raised in her letter add to the depth of the dialogue. This general issue is not going away any time soon. A continuing challenge will be to frame these highly complex issues succinctly in a coherent package for further dialogue with explicit actions leading to improved health. ■

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