Better Care at Lower Cost: The Sweet Spot
Implications of the term “Sweet Spot”?  

- Sweet spot = a place where a combination of factors results in a maximum response for a given amount of effort  \((Source: Wikipedia)\)  
  → focus on efficiency or optimizing impact

- Sweet spot = the point at which an indicator or policy provides the optimal balance of costs and benefits  \((Source: Investopedia)\)  
  → focus on value
Better Care / Lower Costs: The Quest for Value

Jim Crall, DDS, ScD
Chair, DQA Measures Research & Development Committee / UCLA Public Health & Community Dentistry
Definitions of Value (within the context of health care)

• Value = benefits / cost

• Value = quality (performance) / cost

• Value = patient outcomes achieved / $ spent
## Elements of Quality Care & Quality Problems

**Opportunities to lower cost??**

<table>
<thead>
<tr>
<th>Elements of quality care</th>
<th>Type of quality problem</th>
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</thead>
<tbody>
<tr>
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*Source: Institute of Medicine, 2001.*
Elements of Quality Care & Quality Problems

Important considerations, but what about uncircled problems?

Source: Institute of Medicine, 2001.

Elements of quality care

- People get the care they need
- People need the care they get
- Provided safely
- Timely
- Patient centered
- Delivered equitably
- Delivered efficiently

Type of quality problem

- Effectiveness
  - Underuse
  - Overuse
- Error
- Delays
- Unresponsive
- Disparities
- Waste
Historical Paradigms:

The Iron Triangle of Health Care Policy
Cost—Quality—Access Tensions / Trade-offs

From WILLIAM L. KISSICK, MEDICINE’S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES 1994
Cost, Quality and Access: Iron Triangle Trade-offs

• Health policy analysts commonly refer to an “iron triangle” of health care. The three vertices of the triangle are the cost, quality and accessibility of care.

• The “iron triangle” means that, in equilibrium, increasing the performance of the health care system along any one of these dimensions can compromise one or both of the other dimensions.

• Such tradeoffs are not always required.
  – For example, tying payments to health care providers to the quality of services provided could improve providers’ incentives to contain costs and improve quality.
  – Better quality also could be achieved at less cost by reducing unnecessary services and managing consumers with chronic conditions more cost-effectively.
IHI Triple Aim

Better Care, Better Health, Lower Costs

Population Health

Experience Of Care

Per Capita Cost

June 29, 2013

J. Crall: 2013 DQA Conference
Questions about the Triple Aim Model: Concerns about Determinants ‘Beyond the Reach of Health Care’
Who is accountable for addressing those factors? Clinicians?

David A. Kindig, MD, PhD, Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health
Efforts to quantify impact of multiple determinants: Influence of Multiple Social Risks on Children's Health
Kandyce Larson, Shirley A. Russ, James J. Crall, Neal Halfon *Pediatrics* 2008;121;337-344
Social Risk Factors: Clinician Responsibility?

- No education more than high school
- Family income <200% FPL
- Not a 2-parent household
- Black/Hispanic
- Uninsured
- Family conflict
- Low maternal mental health
- Unsafe neighborhood
Better care at lower costs: a laudable, but elusive or perhaps implausible goal... depending on point of reference or starting point
U.S. Dental Care Financing Trends: Total and Public Funding

Medicaid vs Total Dental Expenditures: 1965-2020
(2010-2020 = projected)

Year

Dental Expenditures (Billions)
$- 20 40 60 80 100 120 140 160 180

- Medicaid Enacted
- OBRA '89 No regs.
- HRSA-NGA GAO Report SGROH
- CHIPRA ACA

Total Dental Expenditures
Total Medicaid Expenditures
Real-world example: What do you think are the prospects for better care (or access) at lower cost?

- Medicaid payments = *70% discount* to dentists’ average charges
  - i.e., payments = 30% of average charges
- State is planning to further reduce rates by 10%
  - i.e., proposed payments = 27% of average charges
- CHIP program being discontinued and children being ‘transitioned’ to Medicaid
  - Over 500,000 additional children enrolled in Medicaid
- ACA → estimated 700,000 additional children enrolled in Medicaid
Percentage of Children Receiving Preventive Dental Services, 2000 to 2010

Percentage of Children Age 1-20 Eligible for EPSDT who Received Preventive Dental Services, 2000-2010

Source: FY 2000 – 2010 CMS-416 Reports, Line 1, Line 1b, 12b as adjusted by GWU
Variation Among States in Medicaid Utilization of Any Dental Service (2009)

- 13 states over 45%
- 9 states under 35%

Source: CMS-416 2009 state reports.
Focus on value measurement within the context of the DQA

• Goal of DQA efforts:
  – Develop and encourage the use of reliable measures of quality and/or performance that serve as indicators of important aspects of care
  – Develop and encourage the use of reliable measures of resources devoted to financing benefits and paying for services provided to ‘target populations’ (e.g., plan/program enrollees)
DQA Pediatric Measures Development

- **Use of services:**
  - Any service
  - Oral evaluations
  - Preventive services
  - Treatment services

- **Usual source of care**

- **Continuity of care**

- **Experience with care**

- **Financial resources measures**
  - Funding level for benefits / Funds spent on services

* - under consideration
Wide Variation Among States in Rate of Improvement: “Any Dental Service”

Percent Change, Any Dental Services, 2000-2009, Line 12a
Basic Use of Service Measures Can Be Helpful in Assessing Program Performance: CT Example

- State-wide Medicaid program data revealed:
  - 40% of children received dental services
  - 30% received preventive services
  - 17% received treatment (beyond diagnostic & preventive) services

- Utilization varied widely by county of residence
  - Preventive services ranged from 20%-47%

- Utilization also varied considerably by plan
  - Plan A: 48% of enrolled children received preventive services
  - Plans B,C,D,E: use of preventive services ranged from 1%-14%

- Subsequently moved to single-vendor arrangement
Additional Proposed Pediatric Measures

- GA use
- ER use
- Follow-up care following ER use
- Treatment following sealant placement
- Loss of permanent molars before age 10
Better care at lower costs: a pipe dream?

• Pipe dream = an unrealistic hope or fantasy

• The early references to the phrase all originate from in or around Chicago. The earliest is from *The Chicago Daily Tribune*, December 1890:

"It [aerial navigation] has been regarded as a pipe-dream for a good many years."

- “The age at the first preventive dental visit had a significant positive effect on dentally related expenditures.”

- 1st dental visit / Total cost:
  - Before age 1: $262
  - Age 1-2: $339
  - Age 2-3: $449
  - Age 3-4: $492
  - Age 4-5: $546
Longitudinal Studies: Dunedin, NZ
Analyses of Dental Caries Trajectories

Better Care at Lower Costs: Other strategies

- Disease management strategies
- Reduce/eliminate use of ineffective services
  - Unnecessary services (over-utilization)
  - Inappropriate services
- Reduce need for re-treatment (technical quality)
- Incentives for providers (and patients) to maintain health
- Risk-based, targeted approaches to care delivery
UCLA-First 5 LA DHP & CDCP Objectives

• Identify and address barriers that limit clinics’ ability to serve as dental homes for infants’ & young children at highest risk of disease

• Increase the number of children 0-5 who receive preventive oral health measures, including fluoride varnish applications if necessary

• Increase providers’ awareness of the importance of early establishment of dental homes, risk-based care, cultural competency and disease management for children ages 0-5

• Increase the number of general dentists that treat children aged 0-5

• Establish systems that promote oral health education and access to care within community clinics’ pediatric and OB/GYN services

• Increase parents’ and caretakers’ awareness of the importance of oral health for young children
Strategies for Improving Performance and Quality

• Provider-Oriented Quality Improvement

• Patient-Oriented Interventions

• Systems-Oriented Interventions

All will require and benefit from the development and use of valid and reliable measures of performance and quality.