AHIP

America's Health Insurance Plans

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Guiding Principles for the Development of Quality Affordable Dental Coverage Based on Evidence

Task Force on Evidence-based Dental Coverage

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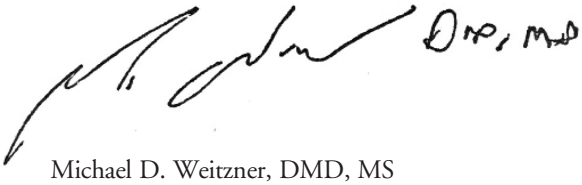
LETTER FROM THE CHAIR

Since the publication in 1996 of Dr. David Sackett's landmark paper, "Evidence Based Medicine: What It Is and What It Isn't," the trend toward understanding and incorporating evidence-based methods has moved from clinical medicine alone into most other clinical fields and into a diverse array of related disciplines, such as public health, health policy, health promotion, research, quality assurance, clinical education and even clinical licensure. Dentistry, led by its academic institutions, specialty societies, and the American Dental Association (ADA), has also worked to adopt evidence-based approaches, and we have begun to see the impact these changes are having on dental practice.

In 2006, America's Health Insurance Plans (AHIP), in partnership with its member dental carriers, formed the Task Force on Evidence-based Dental Coverage (the task force). The task force's purpose was to define "Evidence Based Dental Coverage" and develop core principles and recommendations for consideration by dental insurance companies on an individual basis. In fulfilling this purpose, the task force was to develop a meaningful framework for use in this process.

The task force hopes that each dental insurance company will carefully consider the principles offered as it decides upon its own approach to evidence-based dental coverage and policies. The task force also hopes that those of you outside the dental insurance industry, but with an interest in our work, find this informative.

Warmest regards,



Michael D. Weitzner, DMD, MS

Chair, AHIP Task Force on Evidence-Based Dental Coverage

INTRODUCTION

Oral health is an important component of the overall health care system. But studies continue to demonstrate wide practice variations, inconsistent quality outcomes, and safety issues. Necessary change will only occur if we engage all stakeholders and seek solutions that support care that is safe, effective, patient-centered, timely, efficient, and equitable.[1] To achieve these goals, the dental profession and the dental benefits industry should strive to incorporate evidence into health care and health care coverage decisions.

The primary objective of this paper is to provide guidance that can be used by dental benefit plans as each decides how to move toward a more evidence-based approach to designing coverage and policies. Additionally, we would expect to see overall improvement in oral health as the oral health profession continues to implement evidence-base clinical guidelines.

"Evidence-based decision-making" is a process that is being used with increasing frequency in the health care sector to improve the quality of care. To date, however, there has been limited consensus on principles for applying this approach to oral health care decisions or to oral health care coverage and policy decisions, or how evidence-based decision-making could more efficiently and effectively impact oral health.

To address this need, the Dental Committee of America's Health Insurance Plans (AHIP) chartered a task force to conduct research and publish a position paper with its recommendations to further advance evidence-based decision making in oral health. Specifically, the task force was asked to:

- Provide guidance to dental benefit companies on how to identify which dental services are based on the highest level of available evidence; where gaps in evidence exist; and how the evidence or gaps impact those services and related oral health coverage and policies.
- Provide examples of nationally-recognized standards for evaluating evidence.
- Develop guiding principles to aid individual companies in translating evidence into oral health coverage and policies.
- Create partnerships with the appropriate stakeholders to encourage adoption of clinical practice guidelines that are based on the highest level of evidence.
- Suggest strategies that advance evidence-based decision-making.

The task force believes that consumers should receive clinically-appropriate and cost-effective care that is based, to the greatest extent possible, on the highest level of evidence. To achieve that goal the task force offers the following:

- Examples of nationally-recognized standards of evidence;
- Guiding principles to aid individual companies in developing criteria to translate scientific evidence into dental coverage and policies; and
- Recommendations for individual companies to consider when adopting policies in support of an evidence-based approach.

It is the hope of the task force that dental benefits administrators and dental practitioners will use this information to help make dental care and dental coverage decisions more evidence-based. It is believed that doing so will lead to improved patient health outcomes and more affordable oral health care.

[1] IOM, *Crossing the Quality Chasm*, 2001, National Academy of Science, Pgs. 39-40.

DEFINITIONS

The Task Force believes that using clearly understood terms is critical to achieving a better understanding of how evidence can be used to lead to better coverage and policy decisions and better patient care and satisfaction. In working towards such an understanding, the task force recognized that oral health care is part of a broader oral health system (see Appendix A – Oral Health System) in which there are many stakeholders that have a significant impact on oral health.

It is important to distinguish between a *clinical practice guideline*, which addresses health care decisions, and a *coverage guideline*, which addresses coverage decisions. Both of these decision areas are important and will present opportunities for evidence-based dentistry and evidence-based dental coverage to interface.

In choosing definitions to highlight, the task force looked to key nationally recognized work pertaining to evidence-based care, levels of evidence, and practice guidelines created by others in the health care sector, such as, the American Dental Association (ADA) definition of evidence-based dentistry and a definition of evidence-based medicine put forth by Dr. David Eddy[2] that is gaining acceptance in the medical community.

The Task Force acknowledges the American Dental Association's work in defining evidence-based dentistry, and includes this definition, because of the significant interaction and interdependence of an evidence-based approach between the design of oral health coverage and policies and patient treatment. Additionally, the Task Force modified Dr. Eddy's definition for use as the Evidence-based Dental Coverage definition. It is important to develop such a common understanding of evidence-based terms by the various stakeholders (payers, providers, researchers, etc.) to maintain a consensus throughout medicine, dentistry and oral health.

Finally, the task force recognizes that each stakeholder (referenced in Appendix A) within the "oral health system" makes a unique contribution to oral health and that input from, and consensus among, these stakeholders is needed to advance a common understanding of "evidence-based dentistry." To begin the conversation, the task force recommends focusing on the following definitions:

Evidence-based Dental Coverage[3]

[Evidence based dental coverage determinations are based on] a set of principles and methods intended to ensure that to the greatest extent possible, medical [and dental] decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit. [4]

Evidence-based Dentistry (EBD)[5]

"An approach to oral health that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's needs and preference."

Clinical Practice Guideline[6]

Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

Evidence-based Coverage Guideline

Evidence-based coverage guidelines are systematically developed statements that are based on the best available evidence and intended to assist dental benefit plans and purchasers in choosing appropriate coverage to meet the clinical needs of the members while providing an affordable benefit package.

All stakeholders, in both the dental insurance industry and the oral health profession, have an interest in identifying high-quality, strong scientific evidence that supports effective treatments for oral disease and in seeking evidence that a particular treatment is effective in preventing or treating disease prior to considering any other factor when designing a benefit plan or the treatment plan.

[2] David Eddy MD Ph.D. is the founder and medical director of Archimedes Inc. in Aspen, Colorado, Archimedes was founded to improve the quality and efficiency of health care by using advanced mathematics and computing methods to build realistic simulation models of physiology, diseases, and health care systems. Eddy has made seminal contributions to evidence-based medicine, coining the term "evidence based" and applying it to guidelines, coverage policies, and performance measures.

[3] Definition is modified from: DM Eddy, Evidence-Based Medicine: A Unified Approach. Health Affairs. Vol. 24 No 1. Jan/Feb 2005.

[4] According to Eddy the term "policies" includes such things as benefit coverage, disease management, performance measures, quality improvement, medical necessity, regulations, public policy, etc.: A Unified Approach. Health Affairs. Vol. 24 No 1. Jan/Feb 2005.

[5] Source: The American Dental Association.

[6] Institute of Medicine. (1990). Clinical Practice Guidelines: Directions for a New Program, M.J. Field and K.N. Lohr (eds.) Washington, DC: National Academy Press. page 38.

STANDARDS OF EVIDENCE

Not all evidence is equal. The scientific community has developed methods to help distinguish high-quality, sound evidence that has undergone rigorous validation processes (Appendix B) from lower-quality, weaker evidence.

Recognizing these differences, the task force recommends that when determining the level of evidence with respect to the quality and strength of research findings, an unbiased rating system should be used that is:

- Developed by a recognized, credible professional organization or institution (such as Shekelle's, the US Preventive Services Task Force, or the Oxford Centre for Evidence-based Medicine, The Cochrane Collaboration – see Appendix C for an example of a classification scheme and links for additional information).
- Transparent and publicly available so that all interested parties may review and understand the criteria and rating system used.

In addition, where a rating score has been assigned to research studies or peer reviewed literature it should be publicly available so that all interested parties can easily access the material. The system should be clear enough to be understood by employers, as well as dental consumers.

GUIDING PRINCIPLES

The task force recommends the use of the following principles to aid in developing criteria to translate scientific evidence into dental coverage and policies.

Effectiveness: the degree to which action(s) achieves the intended health result under normal or usual circumstances.[7] The Institute of Medicine defines ***effective*** care as "providing services based on scientific knowledge to those who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)".[8]

Efficacy: the ability to provide a clinically measurable effect, preferably beneficial.[9] Scientific evidence should demonstrate a beneficial efficacy. From an epidemiological perspective, the difference is that effectiveness refers to the impact under normal or usual circumstances in the real world while efficacy refers to the impact of an intervention in a controlled clinical trial environment, which may or may not translate to the real world.

Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy.[10] Efficiency is assessed by considering resource use and those services that yield limited dental benefit and/or needlessly waste consumer dollars.

Cost-benefit: Cost-benefit analysis measures the costs and benefits of a proposed course of action in terms of the same units, usually monetary units.[11] For example, a cost-benefit analysis of periodontal treatment would determine the number of dollars spent toward saving teeth through periodontal treatment. It would then determine the number of dollars saved because the patient would not need extractions, or other dental treatment related to the loss of the teeth. Another important measurement unit is quality of life, which should also be considered.

Cost-effective: the minimal expenditure of dollars, time, and other elements necessary to achieve the health care result deemed necessary and appropriate.[12] For example, a cost-effectiveness analysis could compare the costs (in units such as dollars or quality of life) of replacing missing teeth with removable prosthetics versus fixed prosthetics or dental implants.

Each dental benefit plan should consider ways to design coverage and policies to make the best use of the highest level of available evidence for coverage determinations. In addition, individual dental benefit plans should consider, consistent with the plan's procedures and policies, ways to best provide practitioners with an explanation of, and opportunity to appeal, a denial of coverage or payment, when such denial is based on the plans understanding of highest level of evidence currently available.

[7] Mosby's Dental Dictionary. Mosby, Inc., St. Louis. 2004
[8] Crossing the Quality Chasm, Institute of Medicine, 2001
[9] Mosby's Dental Dictionary. Mosby, Inc., St. Louis. 2004
[10] Ibid
[11] Jekel JF, Elmore JG, and Katz DL. Epidemiology, Biostatistics and Preventive Medicine. WB Saunders Company. 1996 p. 187
[12] Mosby's Dental Dictionary. Mosby, Inc., St. Louis. 2004

RELATIONSHIP BETWEEN DENTAL COVERAGE, POLICES AND DENTAL PRACTICE

Both the dental benefits sector and the dental care delivery system are striving to become more evidence-based, to advance services that result in the best patient outcomes and maintain affordability. It is important that patients receive care based on sound scientific evidence that supports both its clinical and cost effectiveness, and that dental benefits are aligned to support such care. In achieving this goal, clinical guidelines are a logical focal point for dental benefits providers and the dental delivery system. This focus on guidelines promotes interaction and cooperation in aligning treatment and financial incentives to achieve the best health and financial outcomes for dental plan members and patients.

The National Guideline Clearinghouse (NGC) serves both as an example of how key stakeholders can interface and work cooperatively on evidence-based initiatives and as a resource for clinical guidelines that can be used to advance evidence-based dental care coverage and treatment decisions. NGC was created as a joint effort of the American Medical Association, the American Association of Health Plans (now America's Health Insurance Plans [AHIP]) and the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services. In existence since 1998, the NGC is a Web-based database of evidence-based clinical practice guidelines, including several related to oral health, and related documents, maintained as a public resource by AHRQ. NGC's mission is to provide physicians, nurses, and other health professionals, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to promote the dissemination, implementation, and use of the clinical guidelines.

AHIP encourages qualified organizations to continue to use scientific evidence to create clinical guidelines related to dental treatment and post them at this Web site. It also encourages dental benefit plans to review and consider these guidelines when modifying their existing dental benefits or creating new plan designs.

RECOMMENDATIONS

To help drive the benefit determinations and the practice of dental care towards being more evidence-based, a process must be created to both identify high-quality evidence and translate that evidence into useful and relevant guidelines. The task force recommends the following process to further advance the movement toward the highest level of evidence-based decisions in dental coverage and policies and dental practice:

1. IDENTIFYING EVIDENCE

To transition to an evidence-based dental benefit structure, entities such as dental benefit plans, dental associations, and employer groups, should have a process in place to identify and assess the research with respect to quality and cost effectiveness or contract with entities that have that capacity.

2. ACCESS TO EVIDENCE

The task force recommends that the National Guideline Clearinghouse be considered as the place for evidence to be accessed, and coordinate with other interested parties to make sure that the data bases remain easily accessible, reliable, and widely available.

CLINICAL PRACTICE GUIDELINES

Consideration should be given for the development of clinical practice guidelines wherever the scientific evidence indicates that treatment variability can be reduced and lead to improved health outcomes and cost-effectiveness. The task force is currently discussing with the NGC ways to increase the availability of dental evidence-based guidelines.

4. RESEARCH ASSESSMENTS AND GUIDELINE DEVELOPMENT

Once evidence has been identified, evaluated for quality and strength, and used to create a clinical guideline, the National Guideline Clearinghouse process should be followed to determine whether the guideline merits public posting. In this process, dental benefit plans should actively participate as part of a multi-stakeholder workgroup that would apply specific, predefined, transparent criteria to evaluate the guideline evidence in the areas of clinical effectiveness, cost-benefit analysis, and cost-effectiveness. Approved guidelines will be publicly available on the National Guideline Clearinghouse database.

5. ALIGNING EVIDENCE-BASED DENTAL TREATMENT AND REIMBURSEMENT

Dental benefit plans may consider further aligning their reimbursement methodology and other financial incentives to promote the most clinically and cost-effective treatment based on the best available scientific evidence and consistent with their own product designs, client needs and demands, market and regulatory environments and other company-specific factors.

6. INTERNAL STRUCTURES AND PROCESSES

Dental benefit plans that adopt an evidence-based approach should examine their internal structures and processes to determine if they have the necessary capabilities to gather and evaluate scientific evidence to use in designing dental benefits, policies, and reimbursement and incentive methodologies. An example of such structures and processes is provided in Appendix D.

APPENDICES

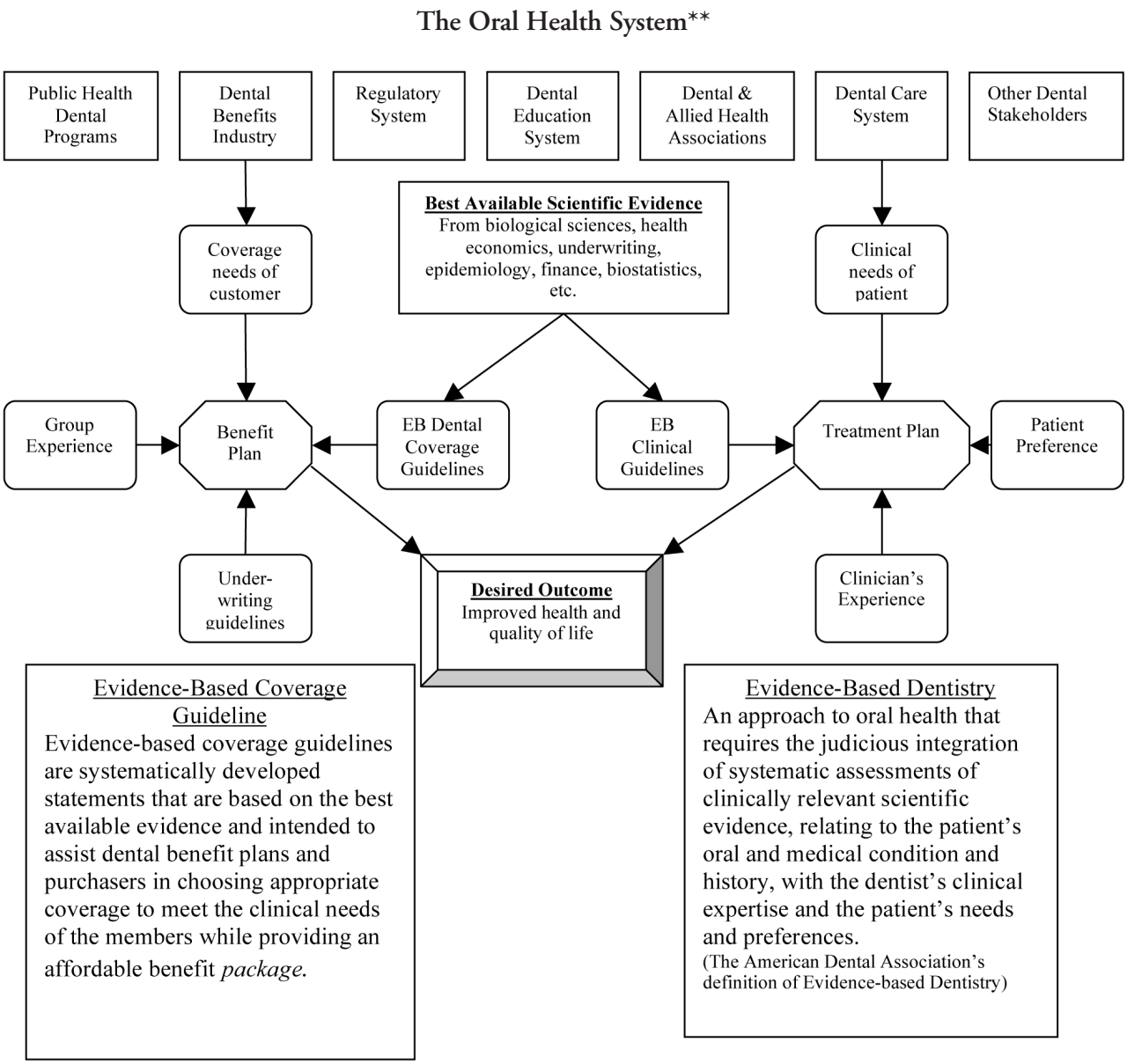
A. Oral Health System

B. Clinical Practice Guideline Development and Inclusion Criteria

C. Categorizing Evidence

D. Sample Model for Internal Structures and Processes to Facilitate Evidence-Based Dental Coverage and Policy Development

APPENDIX A: ORAL HEALTH SYSTEM



*(**The above AHIP graphic is not meant to be an exhaustive list of all the stakeholders within the oral health system)*

APPENDIX B. CLINICAL PRACTICE GUIDELINE DEVELOPMENT AND INCLUSION CRITERIA

NATIONAL GUIDELINE CLEARINGHOUSE
This information was obtained from the following Web site: http://www.guideline.gov/resources/glossary.aspx

METHOD OF GUIDELINE VALIDATION

- *Clinical validation-pilot testing/clinical validation-trial implementation period*

  These methods "test drive" the recommendations in an actual clinical setting. The information obtained during the pilot testing or initial implementation period is incorporated back into the guidelines in an attempt to improve their utility in actual practice.

- *Comparison with guidelines for other groups*

  The process whereby the guideline developer compares their recommendations to those issued by different groups as a way of gauging the validity of their guideline. The authors may explain conflict or agreement with guidelines for the same health problem from other organizations.

- *External peer review*

  The process whereby the guideline is evaluated by reviewers that do not belong to the same organization that developed the guideline.

- *Internal peer review*

  The process whereby the guideline is evaluated by reviewers that belong to the same organization that developed the guideline.

- *Peer review*

  The process to evaluate or audit the relevance, appropriateness, validity, or utility of the final guideline recommendations.

METHODS USED TO ANALYZE THE EVIDENCE

- *Decision analysis*

  A quantitative method for representing and comparing the expected outcomes of management alternatives.

- *Meta-analysis*

  A quantitative method of combining and synthesizing the results of multiple independent studies (usually drawn from the published literature) to arrive at conclusions about a body of research.

- *Meta-analysis of individual patient data*

  A meta-analysis that combines and synthesizes data collected from individual patient data (versus summary statistics).

- *Meta-analysis of observational trials*

  A meta-analysis that combines and synthesizes data collected from observational studies (e.g., a cross-sectional study, a case series, a case-control study, or a cohort study), versus a randomized controlled trial.

- *Meta-analysis of randomized controlled trials*

  A meta-analysis that combines and synthesizes data collected from randomized controlled trials (i.e., clinical trials that involve at least one test treatment and one control treatment, concurrent enrollment and follow-up of the test- and control-treated groups, and in which the treatments to be administered are selected by a random process, such as the use of a random-numbers table).

- *Meta-analysis of summarized patient data*

  A meta-analysis that combines and synthesizes data collected from summarized patient data (versus individual patient data or summary statistics).

- *Review*

  A summary of published material on a subject. It may be comprehensive to various degrees and the time range of material scrutinized may be broad or narrow. The conclusions of a review are often combined qualitatively with little, if any, quantitative manipulation of the published information.

- *Review of published meta-analyses*

  A summary of published meta-analyses on a subject.

- *Systematic review*

  A review of a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant research, and to collect and analyze data from studies that are included with the review.

- *Systematic review with evidence tables*

  A systematic review that utilizes a tabular compilation of the data from individual studies.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

- *Expert consensus*
  A formal method used to generate expert collective decisions. The steps in the process are made explicit and could be replicated.

- *Expert consensus (committee)*
  A formal method involving a dedicated committee to generate expert collective decisions. The steps in the process are made explicit and could be replicated.

- *Expert consensus (Delphi method)*
  A formal method used to generate expert collective decisions. The steps in the process are made explicit and could be replicated. In the Delphi method, participants receive questionnaires and record their views. The responses are aggregated by the organizers and sent back to participants in summary form, indicating the group judgment and the individual's initial judgment. The participants are given the opportunity to revise their judgments, and the process may be repeated. In this method, the participants never meet face-to-face or interact directly.

- *Subjective review*
  A process of review relying on the use of an individual's or group's experience or knowledge, as conditioned by personal mental characteristics or states. This method uses a descriptive (qualitative) approach rather than a quantitative and/or numerical method to evaluate the quality and strength of evidence.

- *Weighting according to a rating scheme*
  This method consists of using a system that assigns a weighted value (e.g., levels or grades) to distinguish high from low quality research studies and/or strong from weak bodies of evidence. Systems have been developed for studies/evidence pertaining to therapy, prevention, diagnosis, prognosis and harm.

METHODS USED TO COLLECT/SELECT THE EVIDENCE

- *Hand searches of published literature (primary sources)*
  Methods based on a manual review (i.e., page-by-page) of literature sources that report original research (e.g., peer-reviewed journal articles).

- *Hand searches of published literature (secondary sources)*
  Methods based on a manual review (i.e., page-by-page) of literature sources that synthesize and summarize the theories and results of research (e.g., textbooks, monographs, review articles).

- *Searches of electronic databases*
  Methods that employ the use of free-text keywords/phrases and/or controlled vocabularies to identify information contained within computer-based repositories of information (e.g., bibliographic, full-text).

- *Searches of patient registry data*
  Methods that employ the use of repositories of patient-specific data maintained by sources such as medical specialty societies, disease-specific associations, government agencies, and manufacturers are accessed.

- *Searches of unpublished data*
  Methods that employ the use of data that has not been published (e.g., proprietary data, unpublished manuscripts, data from ongoing research).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

- *Balance sheets*
  A tool used in clinical decision-making capturing the benefits, harms and costs of different interventions. Information to complete the sheet is obtained from data in medical literature, local organizational data or best estimates when data is of low quality or unknown.

- *Expert consensus*
  A parent term identifying recommendations formulated by one of several formal consensus development methods.

- *Expert consensus (Consensus development conference)*
  A selected group of around ten people is brought together to reach consensus about an issue in an open meeting. Evidence is presented by various groups/experts that are not part of the decision-making group and the selected group retreats to consider the issue and evidence.

- *Expert consensus (Delphi method)*
  Participants receive questionnaires and record their views. The responses are aggregated by the organizers and sent back to participants in summary form, indicating the group judgment and the individual's initial judgment. The participants are given the opportunity to revise their judgments, and the process may be repeated. In this method, the participants never meet face-to-face or interact directly.

- *Expert consensus (Nominal group technique)*
  With a purpose of structuring interaction within a group, after participants record views independently and privately, the facilitator will collect one view from each individual and create a list. All views are collected and listed, and discussion ensues about each view. Individuals then privately record their judgments or vote for options. Further discussion and voting may take place. The individual judgments are aggregated statistically to derive group judgment.

- *Informal expert consensus*
  An approach to consensus development that lacks structure. Participants publicly express their views, the aggregate of which may be summarized by the group's leader and considered the final decision.

CRITERIA FOR CLINICAL PRACTICE GUIDELINE TO BE POSTED TO NGC

All of the criteria below must be met for a clinical practice guideline to be included in NGC.

1. The clinical practice guideline contains systematically developed statements that include recommendations, strategies, or information that assists physicians and/or other health care practitioners and patients to make decisions about appropriate health care for specific clinical circumstances.
2. The clinical practice guideline was produced under the auspices of medical specialty associations; relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level; or health care organizations or plans. A clinical practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations does not meet the inclusion criteria for NGC.
3. Corroborating documentation can be produced and verified that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development. A guideline is not excluded from NGC if corroborating documentation can be produced and verified detailing specific gaps in scientific evidence for some of the guideline's recommendations.
4, The full text guideline is available upon request in print or electronic format (for free or for a fee), in the English language. The guideline is current and the most recent version produced. Documented evidence can be produced or verified that the guideline was developed, reviewed, or revised within the last five years.

APPENDIX C. CATEGORIZING EVIDENCE

Systems have been developed to categorize evidence based on its methods of avoiding various biases that are possible in research and the strength of the evidence. An example of a system of categorizing evidence is the following developed by Shekelle, et al[13]:

Category of evidence (susceptibility to bias):

I.a. Evidence from meta-analysis of randomized controlled trials

I.b. Evidence from at least one randomized controlled trial

II.a. Evidence from at least one controlled study without randomization

II.b. Evidence from at least one other type of quasi-experimental study

III. Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies

IV. Evidence from expert committee reports or opinions or clinical experience of respected authorities, or both

Strength of recommendation:

A. Directly based on category I evidence

B. Directly based on category II evidence or extrapolated recommendation from category I evidence

C. Directly based on category III evidence or extrapolated recommendation from category I or II evidence

D. Directly based on category IV evidence or extrapolated recommendation from category I, II or III evidence

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Links to other credible systems for evaluating evidence:

- Oxford Center for Evidence-based Medicine (http://www.cebm.net/index.aspx?o=1025).
- U.S. Preventive Service Task Force (http://www.ahrq.gov/clinic/uspstfix.htm
- The Cochrane Collaboration (http://www.cochrane.org/index.htm)

[13] Shekelle PG, Woolf SH, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. BMJ 1999;318 (7183) :593-6.

APPENDIX D. SAMPLE MODEL FOR INTERNAL STRUCTURES AND PROCESSES TO FACILITATE EVIDENCE-BASED DENTAL COVERAGE AND POLICY DEVELOPMENT

Developing evidence-based dental coverage and policies is more than just re-labeling products. It can require significant resources and changes to internal structures and processes. Those dental benefit companies who embark on such a change may want to examine their own internal structures and processes to determine if they have the necessary capabilities. The following sample model may prove helpful as each company makes its company-specific decisions related to ensuring that it has the necessary structures and processes to develop evidence-based dental coverage and policies.

Structures

1. Staff
   a. A dedicated employee or consultant with clinical expertise (e.g., a dentist or hygienist) could be designated to advise management on evidence-based dental coverage and policies
   b. Creation of a cross-functional workgroup that serves to ensure that the plan benefits are and remain evidence-based. The workgroup could include:
      i. Clinically knowledgeable person (chair)
      ii. An actuary
      iii. Marketing/sales/competitive intelligence individual(s)
      iv. Information Technology(IT) and Operations individual(s)
2. Information technology systems could include:
   a. Access to databases; and
   b. Analytic capabilities
3. Access to library materials and search engines such as PubMed and EviDents to do literature reviews.
4. Financial support in budget for items such as subscriptions to periodicals, attendance at professional meetings, etc.

Processes

1. The workgroup may establish a process to identify opportunities to make benefits more evidence-based and to periodically review new evidence to update existing dental coverage and policies.
2. A reporting process may connect the workgroup with the decision makers at the highest level, including the Board, to give forward looking trend information regarding benefits.
3. A reporting process may update senior management at regular intervals on such topics as:
   a. Modification of existing dental plans
   b. Financial impact of new therapies
   c. Need to change utilization review criteria
   d. Need for system upgrades
   e. Need to design new dental plans
   f. Need for additions or deletions to the CDT procedure code set working through the American Dental Association (ADA) Code Revision Committee
   g. Need for implementation of diagnostic codes (ties back to IT/Ops)
4. A Marketing mechanism may be developed to communicate evidence-based information to purchasers and members so that they can make informed decisions. Marketing is the link to members and groups.
5. A timely process to update adjudication guidelines and utilization review processes may be considered.
6. A timely process to ensure that all quality initiatives and processes, including credentialing of networks take into account evidence-based care may be considered.
7. Companies, while making its individual decisions about all reimbursement-related policies, may consider how best to align financial incentives for providers to encourage adoption of the most efficacious and cost-effective care.