Using Data to Drive Policy Change

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Children’s Health Alliance of Wisconsin
Children’s Health Alliance of Wisconsin

- Wisconsin Asthma Coalition
- Emergency Medical Services for Children Wisconsin
- Infant Death Center
- Keeping Kids Alive in Wisconsin
- Wisconsin Medical Home
- Oral Health
- Reach Out & Read Wisconsin
Desired outcomes

• Understand how data can be used to identify a need for policy change

• Understand how data can be used to build broad coalition support

• Understand how data can be used to change policy
The problem

• Dental disease is the most common chronic disease of childhood – 5x more prevalent than asthma.

• Dental disease impacts things far beyond the mouth.

• Low income children are 12x more likely to miss school due to dental problems.

• Children with tooth pain are 4x more likely to have below average GPA
What success looks like
Supporting Organizations

- CHW
- CHAW
- WOHC
- WDA
- WDHA
- WHA
- WPHCA
- WI-AAP
- WPHA

- Delta Dental of WI
- Assoc. of Health Insurers
- Disability Rights Orgs.
- Several Health Systems

and many more...

- More than 75 legislators signed on as co-sponsors
Opponents
Background

Settings

Supervision

Scope
This change only addresses

Settings

Supervision

Scope
Initial practice settings

1. In a dental office.
2. For a school board, a governing body of a private school, as defined in s. 115.001 (3d), or a governing body of a tribal school, as defined in s. 115.001 (15m).
3. For a school for the education of dentists or dental hygienists.
4. For a facility, as defined in s. 50.01 (1m), a hospital, as defined in s. 50.33 (2), a state or federal prison, county jail or other federal, state, county or municipal correctional or detention facility, or a facility established to provide care for terminally ill patients.
5. For a local health department, as defined in s. 250.01 (4).
6. For a charitable institution open to the general public or to members of a religious sect or order.
7. For a nonprofit home health care agency.
8. For a nonprofit dental care program serving primarily indigent, economically disadvantaged or migrant worker populations.
RDH can practice unsupervised

1. In a dental office.

2. **For a school board, a governing body of a private school, as defined in s. [115.001 (3d)],[1] or a governing body of a tribal school, as defined in s. [115.001 (15m)].**

3. **For a school for the education of dentists or dental hygienists.**

4. For a facility, as defined in s. [50.01 (1m)], a hospital, as defined in s. [50.33 (2)], a state or federal prison, county jail or other federal, state, county or municipal correctional or detention facility, or a facility established to provide care for terminally ill patients.

5. **For a local health department, as defined in s. [250.01 (4)].**

6. For a charitable institution open to the general public or to members of a religious sect or order.

7. For a nonprofit home health care agency.

8. For a nonprofit dental care program serving primarily indigent, economically disadvantaged or migrant worker populations.
Proposed changes

1. In a dental office.

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3. For a school for the education of dentists or dental hygienists.

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5. For a local health department, as defined in s. 250.01 (4).

6. For a charitable institution open to the general public or to members of a religious sect or order.

7. For a nonprofit home health care agency.

8. For a nonprofit dental care program serving primarily indigent, economically disadvantaged or migrant worker populations.

9. At a facility, as defined in s. 50.01 (1m), a hospital, as defined in s. 50.33 (2), or a facility that is primarily operated to provide outpatient medical services.
9. Outpatient medical facility
What we can agree on

- Dental MA rates are some of the worst in the country.
- Access to dental services for MA patients is poor.
- Dental disease continues to be an issue for young children, adults and the elderly with limited access to dental care.
- Improvements could be made to improve provider efficiency using existing models.
Show me the data

• Helps to support a generalized claim

• Puts into perspective where you are and what you have/can accomplish

• Highlights best practices
MA enrolled providers

WI – PCPs

- Enrolled: 85%
- Not enrolled: 15%

WI – PAs

- Enrolled: 91%
- Not enrolled: 9%

WI - DDS

- Enrolled: 63%
- Not enrolled: 37%

Source: Wisconsin Medicaid Data -2014
Level of participation

Source: Wisconsin Medicaid Data - 2014
Figure 3: Percentage of Head Start Children with Treated Decay, Untreated Decay, Caries Experience, and Early Childhood Caries by Age, 2013-14

Source: Wisconsin Dept of Health Services - 2017
Figure 7: Percent of Dentate Older Adults with Periodontal Indicators by Setting

Source: Wisconsin Dept of Health Services - 2013
Figure 5: Percent of Dentate Older Adults with Untreated Decay and Root Fragments by Setting

Source: Wisconsin Dept of Health Services - 2013
PROBLEM

Solution 1

Solution 2

Solution 3
National Governors Association

As states face more demand for oral health, they should examine the role dental hygienists can play in increasing access to care by allowing them to practice to the full extent of their education and training.
Statewide Outcomes – Wisconsin 3rd Graders

Total needing care
- 2001-02: 31%
- 2007-08: 20%
- 2012-13: 17%

Dental sealants
- 2001-02: 47%
- 2007-08: 51%
- 2012-13: 61%

Source: Wisconsin Dept of Health Services - 2013
Number of Children Screened and Receiving Dental Sealants

- 205,344 total children screened
- 130,100 total children sealed

- 2000-01: $60K
- 2001-02: $120K
- 2002-03: $200K
- 2003-04: $200K
- 2004-05: $600K
- 2005-06: $600K
- 2006-07: $600K
- 2007-08: $700K
- 2008-09: $700K
- 2009-10: $700K
- 2010-11: $700K
- 2011-12: $700K
- 2012-13: $700K
- 2013-14: $700K

Children’s Health Alliance of Wisconsin

www.chawisconsin.org
Enhances existing systems

- WDA Dental Home Initiative
- Increased referrals to establish a dental home
- Potential to reduce ECC
- Increased medical/dental collaboration
- Improves efficiency
MDs ability to provide FVT

• NC study showed 17% decrease in referrals with caries when children 6-36 mo receive 4+ FVT

However

• Wisconsin data shows fewer than 5% of MA children 12-24 mo received FVT by non-dental provider
Integration effect

• Denver Health co-located RDH in pediatric medical office, more than 80% of children 6-36mo received FVT

• Other potential integration points exist and improve efficiency.
Current business model

• DDS provides exams at a physicians office which allows an RDH to see the patient at the next visit
  – Cost to provide exams = $750/day (labor and supplies)
  – MA revenue generated = $320
  – Lost production from the DDS = $3,700
  – Total loss of $4,000+ daily using this model or $1.05M annually
Financial viability

• RDH integration would generate two billing codes
  – D0191 (assessment) and D1206 (FVT)
  – Estimated MA payment = $23/pt
  – RDH could see 4 pediatric patients/hr = $92
  – Average cost of consumables = $8/pt

• Average cost of labor = $35/hour

• ROI = $52K annually
Other potential examples

- RDH practicing in pediatric/family physician/OBYGN offices
- Nursing home hub and spoke model
- RDH practicing in a daycare facility
- RDH practicing in other medical settings
- RDH practicing in home health care settings
Questions and thank you

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