Oral Health-Dentistry 101

A Basic Course for Program Administrators and Policy Makers

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Mary E. Foley, RDH, MPH

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Acknowledgements

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Sarah Kolo
National Maternal and Child Oral Health Resource Center

Health Resources and Services Administration
Maternal and Child Health Bureau

American Academy of Pediatric Dentistry
Session Objectives

• Describe the role of Medicaid/CHIP dental program managers

• Increase knowledge and understanding of:
  - Oral health
  - Oral diseases that affect health
  - Risk factors that contribute to oral diseases and conditions
  - Preventive factors that contribute to oral health
  - Effective evidence-based preventive services
  - Other dental care services
The Role of the Medicaid Dental Program Manager
Program Effectiveness

• Access to dental care for enrollees
• Dental benefits administration
  - Dental practice standards and guidelines
  - Dental procedure codes
  - Coverage limitations
• Cost effectiveness
  - Budget initiatives
  - Fiscal notes
Program Effectiveness

• Contracting - fiscal agents and managed care organizations
  - Oversight & monitoring of delivery system(s)
  - Rate renewal
  - Contract amendments
  - Contract procurement and re-procurement
Quality Assurance
Quality Improvement Activities

- Adequate dental provider network(s)
  - Demographic mix
  - Geography
- Customer service measures
  - Call center statistics
  - Member satisfaction surveys
  - Member handbooks and ID cards
- Utilization measures
  - Monitoring trends
Program Integrity Review

• Audit and recovery (fraud and abuse)
• Clinical audits-dental record reviews
• Beneficiary grievance and appeals
• Retrospective provider audits
  – Captures trends and outliers
  – Captures elements that system claims miss
Enrollee Assistance

• Outreach and education
  - State run
  - Fiscal agents
  - Dental managed care organizations

• Collaboration
  - Parent information networks
  - Case management contractors
  - Head Start Programs
Community Liaison

- Oral health commissions and coalitions
- Dental associations
- Other state agencies
- Community groups and schools
- Advocates
- Federal partners-
  - Center for Medicare and Medicaid (CMS)
  - Health Resources and Services Administration (HRSA)
Development and Review of Dental Policies

• Establishing provider reimbursement
  – Consider budget restraints
  – Political drivers
  – Assist in promulgation of rules and rule amendments

• Authorization

• Other billing policies
  – Evidenced-based
  – Outcome-based using clinical and utilization data
  – Disease management
National Rationale

• Centers for Medicaid and Medicare Services
  – Oral Health Goals for State Medicaid Programs

• Centers for Disease Control and Prevention
  – Healthy People 2020 National Oral Health Objectives

• Health Resources and Services Administration
  – Maternal and Child Health Bureau Title V Performance Standards

• Administration for Children and Families
  – Office of Head Start Program Performance Standards
Oral Health and Dentistry
The Mouth

- **Hard palate:** The front of the roof of the mouth
- **Soft palate:** The back of the roof of the mouth
- **Uvula:** Soft tissue that hangs from the soft palate
- **Tonsil:** Ball of tissue on the side of the throat (there is one on each side)
- **Retromolar trigone:** Tissue that joins the upper and lower jaws
- **Inside of the cheek:**
- **Tongue:**
- **Gum:**
- **Lower lip:**
- **Underside of the tongue:**
- **Floor of the mouth:** Soft tissue under the tongue
Tooth Structure

Crown
- Enamel
- Dentin
- Gum
- Pulp chamber
- Pulp
- Cementum
- Periodontal ligament

Root
- Root canal
- Vein
- Artery
- Nerve

Cusp
Teeth

Primary Dentition
“Baby Teeth”

Permanent Dentition
Primary Teeth

Tooth Identification
Labeled with Letters
A-T

Incisors: 4 upper; 4 lower
Canines: 2 upper; 2 lower
Molars: 4 upper; 4 lower
Permanent Teeth

Tooth Identification
Numbered 1-32

- Incisors: 4 upper; 4 lower
- Canines: 2 upper; 2 lower
- Pre-molars: 4 upper; 4 lower
- Molars: 6 upper; 6 lower
Tooth Surfaces and Quadrants

Surfaces

- Facial
- Lingual
- Mesial
- Distal
- Occlusal or Incisal

Quadrants
Dental Disease

Dental Caries
Tooth Decay
Cavities
Dental Caries

Dental caries is a serious chronic disease that causes pain and disability in children.
### Dental Caries Prevalence

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Primary Teeth</th>
<th>Permanent Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>37.92%</td>
<td>39.88%</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>43.25%</td>
<td>38.78%</td>
</tr>
<tr>
<td>Mexican American</td>
<td>54.90%</td>
<td>48.81%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poverty Status</th>
<th>Primary Teeth</th>
<th>Permanent Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100% FPL</td>
<td>55.28%</td>
<td>48.29%</td>
</tr>
<tr>
<td>100-199% FPL</td>
<td>45.15%</td>
<td>46.70%</td>
</tr>
<tr>
<td>&gt;200% FPL</td>
<td>30.60%</td>
<td>36.13%</td>
</tr>
</tbody>
</table>

Dental Caries is...

- a *chronic* disease
- similar in nature to asthma, diabetes and heart disease
- infectious
- acquired most often from mothers
- has multiple risk factors
Dental Caries is...

- caused by an oral bacteria (Mutans Streptococci)
- diet dependent
- progressive
- destructive
- late stage = cavities result
- Dental caries is minimally affected by dental repair (fillings) alone
Dental Caries is...

- Inequitably distributed
- Consequential to lives of children and families
- Highly prevalent among children ages 2-5
- When present in the primary dentition- significant marker for disease in permanent teeth
Dental Caries is...

- Fluoride-mediated
- Preventable
- Reversible
- Manageable
What does dental caries look like?

Early Stage: Non-cavitated

Late Stage

Advanced: Cavitated

Rampant
What causes dental caries?

Dental caries is a multi-factorial disease.
Major Risk Factors

• Presence of oral bacteria (Mutans Streptococci)
• Frequent ingestion of fermentable carbohydrates
• Sub-normal salivary flow
Major **Protective** Factors

- Fluoride exposure
- Dental sealants
- Daily oral hygiene to reduce bacterial count
- Carbohydrate regulated diet
- Normal salivary function
- First preventive visit by age 1
Key = Find the Caries Balance
Pathogenic & Protective Factors

The Caries Balance

Pathological Factors
- Acidogenic bacteria
  [mutans streptococci (S. mutans and S. sobrinus), lactobacilli]
- Reduced salivary function
- Frequency of fermentable carbohydrate ingestion

Protective Factors
- Saliva flow and components
- Proteins, calcium phosphate, fluoride, immunoglobulins
- Antibacterials
  - in saliva and extrinsic – chlorhexidine, iodine?, New?

Caries

No Caries

Featherstone
Protective Factors
and
Preventive Dental Services
Daily Oral Hygiene

- Drink fluoridated water if readily accessible
- Brushing twice daily with fluoride toothpaste
- Antimicrobial therapy
- Fluoride supplements when indicated
Diet Control

• Limit *frequency* and total *intake* of fermentable carbohydrates
Dental Home by Age One

- Recommended by AAPD\textsuperscript{1}, ADA\textsuperscript{2} and AAP\textsuperscript{3}
- Goal is to reduce risk of preventable disease
- Provides EPSDT\textsuperscript{4} oral health services
- Provides anticipatory guidance; emergency plan; access to comprehensive dental care, including any necessary referrals

\textsuperscript{1} American Academy of Pediatric Dentistry
\textsuperscript{2} American Dental Association
\textsuperscript{3} American Academy of Pediatrics
\textsuperscript{4} Early Periodic Screening, Diagnosis and Treatment
Fluoride

• Preventive agent
• Inhibits the growth of oral bacteria
• Inhibits the breakdown of enamel
• Builds a stronger enamel
• Prevents and manages dental caries
Sources of Fluoride

Drinking Water

Fluoride Toothpaste

Fluoride Varnish
# Fluoride Concentrations

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoride (F) adjusted water supplies</td>
<td>.07 ppm</td>
</tr>
<tr>
<td>Daily F mouthrinses</td>
<td>200 ppm</td>
</tr>
<tr>
<td>F Toothpaste</td>
<td>800-1,200 ppm</td>
</tr>
<tr>
<td>Weekly school-base F mouthrinses</td>
<td>800 ppm</td>
</tr>
<tr>
<td>Behind counter F toothpastes</td>
<td>5000 ppm</td>
</tr>
<tr>
<td>Fluoride gel</td>
<td>12,000 ppm</td>
</tr>
<tr>
<td>Fluoride varnish</td>
<td>22,600 ppm</td>
</tr>
</tbody>
</table>
Fluoride Varnish
Arresting Dental Caries

1. Non-cavitated dental caries
2. Application of fluoride varnish
3. Arrested disease
American Academy Pediatric Dentistry
Clinical Guideline on Fluoride

“Children at moderate caries risk should receive a professional fluoride treatment at least every 6 months; those with high caries risk should receive greater frequency of professional fluoride applications (i.e. every 3-6 months).”

AAPD Guideline on Fluoride Therapy, 2008
### Professionally Applied Topical Fluoride: Evidence-based Clinical Recommendations

<table>
<thead>
<tr>
<th>Assess Caries Risk (see back for risk factors)</th>
<th>Risk Group/Age</th>
<th>Advise</th>
<th>18+ years</th>
<th>Decide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate &amp; Patient Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Under 6 years</td>
<td>Patient may not receive any additional benefit*</td>
<td>Patient may not receive any additional benefit*</td>
<td>whether to apply fluoride</td>
</tr>
<tr>
<td>Moderate</td>
<td>Varnish every 6 months</td>
<td>Varnish or Fluoride gel every 6 months</td>
<td>Varnish or Fluoride gel every 6 months</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Varnish every 6 or 3 months</td>
<td>Varnish every 6 or 3 months or Fluoride gel every 6 or 3 months</td>
<td>Varnish or Fluoride gel every 6 or 3 months</td>
<td></td>
</tr>
</tbody>
</table>

* Fluoridated water and fluoride toothpastes may provide adequate caries prevention in this risk category.
- Application time for fluoride gel and foam should be 4 minutes.
- Due to limited evidence these recommendations have not been extrapolated to foams.
- There is limited evidence differentiating NaFand AFl gels.

### Levels of evidence and strength of recommendations:
Each recommendation is based on the best available evidence. The level of evidence available to support each recommendation may differ. Lower levels of evidence do not mean the recommendation should not be applied for patient treatment.
# Professionally Applied Topical Fluoride: Evidence-based Clinical Recommendations

**Determination of Caries Risk**

There are many systems to determine caries risk. One such system is offered below that can be used for caries risk assessment.

**Individual risk factors increasing risk for developing caries may also include, but are not limited to:**

- High titers of cariogenic bacteria
- Poor oral hygiene
- Prolonged nursing (bottle or breast)
- Poor family dental health
- Developmental or acquired enamel defects
- Genetic abnormality of teeth
- Cariogenic diet
- Active orthodontic treatment
- Presence of exposed root surfaces
- Restoration overhangs and open margins
- Physical or mental disability with inability or unavailability of performing proper oral health care

<table>
<thead>
<tr>
<th>Risk group</th>
<th>Age</th>
<th>Primary or Secondary Carious Lesions in the past three years</th>
<th>Risk factors listed above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Any age groups</td>
<td>None</td>
<td>and</td>
</tr>
<tr>
<td>Moderate</td>
<td>&lt; 6 years</td>
<td>None</td>
<td>and</td>
</tr>
<tr>
<td></td>
<td>&gt; 6 years</td>
<td>One or two</td>
<td>or</td>
</tr>
<tr>
<td>High</td>
<td>&lt; 6 years</td>
<td>Any</td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>&gt; 6 years</td>
<td>Three or more</td>
<td>or</td>
</tr>
</tbody>
</table>

* Medication, radiation or disease induced xerostomia.

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1. ADA Council on Scientific Affairs. Professionally applied topical fluoride: Evidence-based clinical recommendations. JADA 2006;137(8):1151–59. Copyright ©2006 American Dental Association. All rights reserved. Adapted 2008 with permission. To see the full text of this article, please go to [http://jada.ada.org/cgi/reprint/137/8/1151](http://jada.ada.org/cgi/reprint/137/8/1151).
Dental Sealants

• Plastic material that is professionally applied to “seal” the pits and grooves generally found on the chewing surfaces of back teeth.

• Sealants provide a physical barrier from oral bacteria and food debris that may become lodged in the pits and fissures of molars and premolars.

• Prevents and manages dental caries.
Preventive Dental Sealants

Virgin Tooth  |  Sealant Placement  |  Non-sealed & Sealed
Scientific Evidence on Dental Sealants

- Proven effective as a preventive approach
- CDC, HRSA and CMS national goals regarding dental sealants
- 90% of dental caries occurs on occlusal surfaces
- Sealants are applied most often on occlusal surfaces
- Reduce dental caries by 60% in 2-5 years after placement
- Reduce the percentage of non-cavitated lesions that progress by 71%
- Effective in school-based settings- 90% retention rate
- Utilization falls below national goals:
  - 30.5% prevalence ages 6-11

NHANES III 1999-2002
JADA, Vol. 139 http://jada.ada.org
March 2008 Association Center for Evidence-based Dentistry and Prevention
JADA, Vol. 140 http://jada.ada.org November 2009
Scientific Evidence
Efficacy of Dental Sealants

“Placement of pit-and-fissure sealants significantly reduces the percentage of non-cavitated carious lesions that progress in children, adolescents and young adults for as long as five years after sealant placement, compared with unsealed teeth.”

ADA Recommendation: Sealants on Permanent Teeth

Sealants should be placed on pits and fissures of children’s and adolescents’ permanent teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries.


Scientific Evidence
Effectiveness of Dental Sealants

Decrease in *occlusal* caries incidence in permanent first molars:

76.3% at 4 years when reapplied as needed

65% at 9 years with no reapplication during the last five years

JADA, Vol. 139 http://jada.ada.org
March 2008 Association Center for Evidence-based Dentistry and Prevention
## Cost-Effectiveness of Dental Sealants

### Cost of Re-Restoring Teeth (50th Percentile)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-8 yrs</td>
<td>$160</td>
</tr>
<tr>
<td>4-5 yrs</td>
<td>$195</td>
</tr>
<tr>
<td>10 yrs</td>
<td>$134</td>
</tr>
<tr>
<td>13 yrs</td>
<td>$106</td>
</tr>
<tr>
<td>8.5 - 20 yrs</td>
<td>$1090</td>
</tr>
<tr>
<td>2007 Compton Adapted from Simonsen, 1991</td>
<td></td>
</tr>
</tbody>
</table>

*Image of diagrams showing the stages of tooth decay and sealant application.*
Primary Teeth

• “They’re *just* baby teeth.” NOT!

• Scientific evidence is in.

• Disease status of primary teeth is one of the *strongest indicators* of disease status in permanent teeth.

• Target strategy-> primary prevention of primary teeth
Retention on Primary Molars

Pit-and-fissure sealants are retained on primary molars at a rate of:

74.0 - 96.3 % at 1 year

70.6 - 76.5 % at 2.8 years
ADA Recommendation: Sealants on Primary Teeth

“Sealants should be placed on pits and fissures of children’s primary teeth when it is determined that the tooth, or the patient, is at risk of experiencing caries.”


## Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

<table>
<thead>
<tr>
<th>Activity</th>
<th>6 TO 12 MONTHS</th>
<th>12 TO 24 MONTHS</th>
<th>2 TO 6 YEARS</th>
<th>6 TO 12 YEARS</th>
<th>12 YEARS AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral examination</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assess oral growth and development</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Caries-risk assessment</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Radiographic assessment</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Fluoride supplementation</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Oral hygiene counseling</td>
<td>Parent</td>
<td>Parent</td>
<td>Patient/parent</td>
<td>Patient/parent</td>
<td>Patient</td>
</tr>
<tr>
<td>Dietary counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Injury prevention counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for intraoral/perioral piercing</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2 By clinical examination.
3 Must be repeated regularly and frequently to maximize effectiveness.
4 Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
5 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
6 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.
7 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the pacifiers at a more advanced stage; finally discuss their eventual removal in most cases.
8 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the pacifiers at a more advanced stage; finally discuss their eventual removal in most cases.
9 Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
Periodontal Diseases
Periodontal Diseases

• Gingivitis
  – Inflammation of the gingiva
  – Red, swollen or bleeding gingiva

• Periodontitis
  – Inflammation of supporting bone
  – Bone loss around roots of teeth
Healthy Gingiva
Gingivitis
Periodontitis

Moderate

Severe
# Factors Related to Periodontal Diseases

**Risk Factors**
- Bacterial plaque
- Tobacco use
- Tooth loss
- Malocclusion

**Protective Factors**
- Tooth brushing
- Dental flossing
- Antimicrobial rinses
- Routine professional care

**Note**
- Association with diabetes and pre-term, low-birth weight.
Relevance of Periodontal Disease to Dental Programs

- Some states include periodontal benefits only with pediatric benefit
- Some states have special perinatal benefits which include periodontal care
- Some states include periodontal benefits with adult services
Diagnosis and Radiographs (X-Rays)
Dental Examinations

• Performed by dentist
• Comprehensive examination: D0150
  – Extra-oral: Head and neck
  – Intra-oral: Teeth, gingiva and bone
• Periodic dental examination: D0120
• Radiographic (x-ray) assessment
• Diagnosis and treatment plan
Dental Screening - Oral Assessment

• Not the same as a *dental examination*
• Screening for abnormalities in teeth and supporting gingiva and bone
• Performed by dentist, hygienist, physician, PA, RN, NP, school nurse
• Dental codes: **Differ by state practice acts**
Periapical X-Ray
Full Mouth X-Rays
Bitewing X-rays
Panoramic X-Ray
Occlusal X-Ray
Amalgam Fillings

MODL: 4 Surfaces
MOD: 3 Surfaces
DO: 2 Surfaces
O: 1 Surface
Composite Fillings
Endodontic - Root Canal Treatment
Crows

1. Decayed Tooth

2. Prepared Tooth

3. Crown Adjustment

4. Crown Inserted
Fixed Bridge
Partial Denture
Denture

Edentulous

Upper Denture
Dental Implants
Orthodontics
“...(clinical and policy decisions) ...should be based on the best available evidence about the effectiveness of the intervention; and on knowledge of the epidemiology of dental caries (risk factors and patterns of disease).”
Question and Answers

1. Using your mouse, place your curser in the “message box” on the lower right portion of your screen and left click

2. Specify to whom you wish to address your question
   - Presenter 1: Martha Dellapenna
   - Presenter 2 or Host: Mary Foley

3. Type your question into the “message box”

4. Questions will be taken in the order received
Participant Poll
Post-Event Survey

See what you’ve learned and compare your current selection to your pre-event responses.
Congratulations!
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Oral Health and Dentistry 101
Thank you~
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June 27th-28th, 2011
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Martha Dellapenna is the Project Manager for the Rhode Island Oral Health Access Project. She joined the RI Department of Human Services in the Center for Child and Family Health in 2003 through its project management contractor, ACS State Healthcare Solutions (a Xerox Co.). Ms. Dellapenna’s primary role at that time was to manage the development of RIte Smiles, the state’s first managed care dental program for young children. Ms. Dellapenna now performs oversight and monitoring for the RIte Smiles Program, in addition to various project management functions for the Department.

A registered dental hygienist with clinical practice and clinical instruction background Ms. Dellapenna also has extensive experience in the managed care arena. In addition, she has worked with numerous national organizations that specialize in healthcare industry compliance and risk management, program development and practice management.
Ms. Mary E. Foley is the Executive Director of the Medicaid/SCHIP Dental Association (MSDA). Prior to her appointment, she was the Dean of the Forsyth School of Dental Hygiene at the Massachusetts College of Pharmacy and Health Sciences (MCPHS). Ms. Foley is a licensed dental hygienist in Massachusetts and holds a Masters Degree in Public Health with a concentration in Epidemiology and Biostatistics from the University of Massachusetts School of Public Health and Health Policy.

Earlier in her career, Ms. Foley served as the Director of the Massachusetts Department of Public Health, Office of Oral Health, as well as the Region I Head Start Oral Health Consultant. In 2005, she was named a Fellow by the Bureau of Health Professions, Primary Health Care Policy Fellowship.