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June 3rd- 4th, 2013 Washington DC

Session 7: Quality of Care and Delivery Systems
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Robert Compton, DDS
Man Wai Ng, DDS, MPH
Session Objectives

• Know the tools necessary to improve quality
  – Risk Assessment
  – Disease Management
  – Systems that can measure results
  – Formal Quality Improvement Process

• Present real example of Quality Improvement

• Understanding of how Policy and Finance Systems need to align to support quality care in Delivery System
Disease Management

• No single definition of DM’s interventions
• Improve care through strategies such as:
  – Adherence to evidence-based prevention and treatment guidelines
  – Patient education aimed at improving self-care and communication with health care providers
  – Supports such as coordinating or providing transportation, medication, or social supports
Disease Management’s Appeal

• Improving health care quality
• Reducing costs
• Widely used by insurers and employers, with revenues approaching $2 billion a year

(Mattke, Seid, and Ma, 2007)
Disease Management
Cost Implications

Although disease management seems to improve quality of care, its effect on cost is uncertain.
The Value of Supporting Evidence

Payers and policy makers should be vigilant when considering disease management interventions that include supporting evidence based on transparent and scientifically sound methods.

(Mattke, Seid, and Ma, 2007)
Quality Improvement and Data for Measurement

Robert Compton, DDS
Executive Director
DentaQuest Institute
Quality of Care

• The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

• This prescript contains just two concepts: measurement and knowledge.

Medicare: A Strategy for Quality Assurance. IOM, 1990, p.21
Quality Improvement

• The combined and unceasing efforts of everyone to make changes that will lead to better patient outcomes (health).

• The systematic, data-guided activities designed to bring about immediate improvements in health care delivery in particular settings.

Batalden PB, Davidoff F. What is “quality improvement” and how can it transform healthcare? Qual Saf Health Care. 2007 Feb
Opportunity for Improvement

**Actual**
*What we do*

**Desired**
*What we know*

- Applying evidence
- Aligning payment
- Preparing workforce
- Educating parents
- Changing processes
- Using information technology
Opportunities for Improvement

What we know

The Gap

What we do

- Focused prevention
- Change biochemistry
- Assess and manage risk
- Repair defects
- Support behavior change

- 6-month recall visits
- Restore teeth
- Prevention essentially the same for everyone
- Little focus on self management
Early Childhood Caries Cost in Medicaid/CHIP

ECC Collaborative

P = Permanent or adult teeth
D = Deciduous or baby teeth

- D 2nd Molar
- D 1st Molar
- D Canine
- D Lateral Incisor
- D Central Incisor
- P 3rd Molars
- P 2nd Molars
- P 1st Molars
- P 2nd Premolars
- P 1st Premolars
- P Canines
- P Lateral Incisors
- P Central Incisors

Age of Beneficiaries

Millions of Dollars
| MEASURE                                                        | NUMERATOR                                                                 | DENOMINATOR                                                                 |
|                                                               |                                                                           |                                                                           |
| M10: Percent of patients with risk assessed                    | N10: Count of “Active” patients with risk assessment document at most recent visit | D10: Count of “Active” patients with visits during the measurement period |
| M1: Percent of patients with improved risk status              | N1: Count of ECC patients whose most recently documented risk status is lower than that on their initial visit | D1: Count of ECC patients with risk assessed as “high” or “medium” at initial visit |
| M6: Percent of ECC patients with DM treatment plans           | N6: Count of “high-risk or medium risk” ECC patients with DM visits treatment planned | D4: Count of “high-risk or medium risk” ECC patients                        |
| M7: Percent of ECC patients with on-time DM visits            | N7: Count of ECC patients whose most recent disease management visit meets interval criteria |                                                                       |
| M9: Percent of ECC patients with SM goals reviewed            | N9: Count of ECC patients with SM goals reviewed at most recent DM visit    | D7: Count of ECC patients                                                  |
| M3: Percent of ECC patients with pain due to untreated decay  | N3: Count of ECC patients who presented with pain after the first visit, where the pain was attributable to untreated decay | D3: Count of ECC patients                                                  |
| M2: Percent of ECC patients with new cavitation               | N2: Count of ECC patients with new clinical cavitation, demineralization or new radiographic caries after their second visit | D2: Count of ECC patients                                                  |
| M4: Percent of ECC patients with “unplanned” referrals to OR  | N4: Count of ECC patients with “unplanned referrals to OR” for caries management after their second visit | D4: Count of ECC patients                                                  |

Count of children between 6 months of age at the time of “enrollment” in the practice and who had a visit within 12 months

Count of “Active patients” with caries or hx of caries within the past 18 months or classified as “high risk”
<table>
<thead>
<tr>
<th>Report (sheet)</th>
<th>Type</th>
<th>Criteria</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>RVU</td>
<td>ADA Code = 'D0120' or 'D0150' Procedure date ≥ &lt;past 24 mo&gt;</td>
<td>All active patients in the practice (with ≥1 exam in past 2 years)</td>
</tr>
<tr>
<td>D2a</td>
<td>LETTERS</td>
<td>Last Visit Date = &lt;meas month&gt;</td>
<td>Patients with visits in the measurement month</td>
</tr>
<tr>
<td>D3</td>
<td>RVU</td>
<td>ADA CODE = 'D0120' OR 'D0150' Procedure date = &lt;meas month&gt;</td>
<td>Patients with exam in the measurement month</td>
</tr>
<tr>
<td>D4</td>
<td>RVU</td>
<td>ADA CODE = 'D0120' OR 'D0150' Procedure date = &lt;start month&gt;</td>
<td>Patients with exam in the start month (1 year prior to measurement month)</td>
</tr>
<tr>
<td>D5a</td>
<td>RVU</td>
<td>dummy code = &lt;Tx plan complete&gt; Procedure date ≥ &lt;past 24 mo&gt;</td>
<td>All active patients with complete treatment plans</td>
</tr>
<tr>
<td>N1</td>
<td>RVU</td>
<td>ADA CODE = 'D0120' OR 'D0150' Procedure date ≥ &lt;past 12 mo&gt;</td>
<td>Patients with exam in the past 12 months</td>
</tr>
<tr>
<td>N2</td>
<td>RVU</td>
<td>dummy code = &lt;Tx plan complete&gt; Procedure date = &lt;beginning of start month thru end of meas month&gt;</td>
<td>Patients with treatment plan completed within 1 year of start month</td>
</tr>
<tr>
<td>N3</td>
<td>RVU</td>
<td>dummy code = &lt;risk assessed&gt; Procedure date = &lt;meas month&gt;</td>
<td>Patients with risk assessed in the measurement month</td>
</tr>
<tr>
<td>N4a</td>
<td>RVU</td>
<td>dummy code = &lt;med risk or high risk&gt; Procedure date = &lt;meas month&gt;</td>
<td>Patients assessed in the measurement month with high or medium risk</td>
</tr>
<tr>
<td>N4b</td>
<td>RVU</td>
<td>dummy code = &lt;self mgmt goal reviewed&gt; Procedure date = &lt;meas month&gt;</td>
<td>Patients with self management goals reviewed in the measurement month</td>
</tr>
<tr>
<td>N4c</td>
<td>RVU</td>
<td>dummy code = &lt;low risk&gt; Procedure date = &lt;meas month&gt;</td>
<td>Patients assessed in the measurement month with low risk</td>
</tr>
<tr>
<td>N5</td>
<td>RVU</td>
<td>dummy CODE = &lt;new cavitation&gt; AND &lt;Tx plan complete&gt; Procedure date = &lt;measurement month&gt;</td>
<td>Patients with completed treatment plans who had new cavitation at a visit in the measurement month</td>
</tr>
</tbody>
</table>
Early Childhood Caries Protocols

Man Wai Ng, DDS, MPH
Dentist-in-Chief
Boston Children’s Hospital
Disclosure: The ECC Collaborative projects were funded by the DentaQuest Institute and DentaQuest Foundation.

Acknowledgements

– DentaQuest Institute
– DentaQuest Foundation
– Saint Joseph Hospital
– ECC Phase I and Phase 2 participants and faculty
– Children’s Hospital Boston’s Program for Patient Safety and Quality
What is the BCH Dental Clinic?
We’re a safety net provider for Massachusetts

- 26,000 annual outpatient visits
- 750 operating room procedures
- 24/7 coverage of ED, inpatients
- Provides consultations for oncology, cardiology, craniofacial team
- Patients
  - 55% healthy
  - 45% special health care needs
  - Age 0-21 and beyond
  - 70% public insurance and no insurance coverage
Problem Statement

- Hospital-based dental clinics in the US care for a disproportionate number of children with ECC.
- Many of these children are treated surgically.
- Months-long backlogs for operating room care.
- High rate of decay after treatment.
- High cost of operating room treatment.
- Caries is a highly preventable disease.
Example of an ECC Patient

7/07 – Age 3
12/08 – Age 3.5
11/07 – Age 3
3/13 – Age 9
ECC Management Demonstration Project*

Aim Statement

Over an 18 month period, caries will be managed and caries progression will be reduced in all children under 60 months of age who present with high risk for ECC.

Goals

• Reduce the percent of patients with new cavitation
• Reduce the percent of patients who are referred to the OR
• Reduce the percent of patients with pain

*At Boston Children’s Hospital and St. Joseph’s Hospital in RI
Funded by DentaQuest Institute
Disease Management Clinical Protocol

Initial or recall visit
- Review medical history and dental history
- Perform caries risk assessment
- Perform clinical/radiographic exam and charting
- Assess cooperation

Inclusion Criteria
- At least one tooth with caries (including white spots) or history of caries

Exclusion Criteria
- Not interested
- Allergic to fluoride

Self-management goals
- Diet
- Oral hygiene
- Gelkam

Indicated clinical care
- Fluoride varnish

Disease Management Follow-up Visits**
- Perform caries risk assessment
- Perform clinical exam and charting
- Perform radiographic exam if indicated and if possible
- Re-define or re-emphasize self-management goals
- Assess cooperation

Restorative/ Interim therapeutic restoration Visit (s)
- Provide restorative treatment as indicated or desired
- Provide ITR as indicated
- Schedule GA/OR or sedation as indicated

**For Children at High Risk
Next DM visit in 1-2 months

**For Children at Medium Risk
Next DM visit in 3-4 months

**For Children at Low Risk
Next DM visit in 6-12 months

ECC = early childhood caries     ITR = interim therapeutic restoration     GA/OR = general anesthesia/operating room    DM = disease management
# Caries Risk Assessment/ECC Encounter

**Patient’s First Name** 

**Last Name** 

**Today's Date**

**Clinician’s ID:**

**Child's DOB:**

### Today’s Visit: 

- [ ] Is Patient ECC? (No/Yes)
- [ ] If yes, check:
  - Initial (Study Enrollment)
  - Medical Management (F/U)
- [ ] Every Patient:
  - New Patient Visit
  - Recall Visit
  - Medical Management
  - Urgent/Emergency
  - OR

### Step mutans culture this visit?

- [ ] Yes
- [ ] No

### SM Levels:

- [ ] Zero
- [ ] Low
- [ ] Medium
- [ ] High
- [ ] V High
- [ ] N/A

### History:

- [ ] SHCN
- [ ] Pre-natal hx/pre-term
- [ ] On Meds
- [ ] Breast/Bottle
- [ ] Other

### Caries Risk Status:

- [ ] High
- [ ] Medium
- [ ] Low

### Caries History:

- [ ] Child
- [ ] Mother
- [ ] Siblings

### Caries Risk Status:

- [ ] High
- [ ] Medium
- [ ] Low

### Clinical Evaluation:

- [ ] Visible plaque
- [ ] Gingivitis
- [ ] Existing Cavitated lesion
- [ ] NEW cavitated lesions
- [ ] Existing Demin enamel
- [ ] NEW Demineralized enamel
- [ ] Enamel defects
- [ ] Deep pits / fissures
- [ ] Other

### Existing Remin. surfaces:

- [ ] Yes, complete
- [ ] Yes, SW

### Fluoride / Home care:

- [ ] F-toothpaste
- [ ] Fluoride in drinking H2O
- [ ] Suppl F (Gelkam, Prevident, ACT)

#### Daily Use:

- [ ] 1x
- [ ] 2x
- [ ] 3x

### Flossing:

- [ ] No
- [ ] Yes

### Caries Risk Status:

- [ ] High
- [ ] Medium
- [ ] Low

### (Required for ECC Patients)

- [ ] GelKam Staining?
  - [ ] No
  - [ ] Yes
  - [ ] N/A

### Compliance w/ Tx Plan?

- [ ] No
  - [ ] Yes
  - [ ] N/A
  - [ ] SW

### Comments:

- [ ] Frankl: 0
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4

### Supplemental Assessment:

- [ ] Pain
- [ ] Sensitivity
- [ ] Radiographic caries
- [ ] New radiographic caries

### Overall Risk (before SM test):

- [ ] Very Low
- [ ] Low
- [ ] Medium
- [ ] High

### Overall Risk (after SM test):

- [ ] Very Low
- [ ] Low
- [ ] Medium
- [ ] High

### Care Provided Today:

- [ ] SM Test
- [ ] Self-mgmt edu given
- [ ] OH Literacy
- [ ] F-Varnish

### Recommended Gelkam:

- [ ] 1x
- [ ] 2x

### ART:

- [ ] Conventional Restorative
- [ ] OR

### Tx Plan:

- [ ] Fluoride:
  - [ ] One month
  - [ ] Three months
  - [ ] Six months

- [ ] Restorative:
  - [ ] None -> monitor
  - [ ] Conventional restoration

### Next Visit:

- [ ] One month
- [ ] Three months
- [ ] Six months

**Draft**
Goals for Healthy Teeth (Age 5 and younger)

Patient Name: __________________________
Date of Visit: _________________________
Dentist: _______________________________
Hygienist: _____________________________

Your child has been assessed to have the following for caries (cavities):

- High
- Medium
- Low

Between today and your next visit, please work on the Goals checked (*) below:

- Next fluoride visit in ____ months
- Healthy snacks such as fruit, carrot sticks, yogurt, low fat cheese, pretzels, whole grain crackers
- No soda/energy drinks
- No juice
- Juice only with meals
- Less or no candy & junk food
- Chew sugar-free gum (e.g., Tridec, Extra)
- No sippy cup/bottle
- Only plain milk or water in cup or bottle if bottle to bed, use only water
- Drink fluoridated water, tap water
- Daily flossing with floss string or pick
- Fluoride varnish was applied in clinic today.
  * Wait until tomorrow to brush/floss. Avoid hard, crunchy, and sticky foods.

IMPORTANT:
The last thing that touches your child’s teeth before bedtime is the toothbrush with fluoride toothpaste.

Brush morning and before bed with fluoride toothpaste:
- Thin smear (~2 years old)
- Pea-size amount (~2-5 years old)

- Use Gel-Kam ___ a day
  - Apply thin smear to bed teeth
  - Wait 30 minutes before eating, drinking or rinsing after

On a scale of 1-5, how likely do you think you can help your child meet these goals?

1  2  3  4  5
Not very likely  Not sure  Very likely

Clinician’s Comments:

Next visit Date: __________
- Preventative
- 1 month follow-up
- 3 month follow-up
- Restorative
- 6 month checkup
## Results After 30 Months*

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>CHB</th>
<th>SJH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (N=129)</td>
<td>ECC (N=403)</td>
</tr>
<tr>
<td>New cavitation</td>
<td>75%</td>
<td>26%</td>
</tr>
<tr>
<td>Pain</td>
<td>22%</td>
<td>13%</td>
</tr>
<tr>
<td>Referral to OR</td>
<td>21%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Boston Children’s Hospital

• Time period: 3/2008-9/2009 (subject enrollment)
• Number of Patients with at least 2 visits (N=403)
  – Mean number of visits: 5.3
  – Mean follow-up time: 377.4 days
  – Mean visits/year: 9.2
  – New Remineralization: 39.8% (N=160)
  – Risk Improved*: 40.4% (N=135/335)

* From High Risk at first visit to Medium/Low Risk at last visit
BCH: Overall Risk Level by Visit Number

The proportion of high risk patients decline with consecutive visits
Utilization ECC vs. Baseline

ECC Disease Management patients had more visits, more preventive visits, and fewer restorative and OR visits than historical control patients.

Mean number of diagnostic and preventative visits by lengths of follow-up for ECC compared to baseline patients.

<table>
<thead>
<tr>
<th>Months</th>
<th>Mean number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
</tr>
<tr>
<td>0 to 3</td>
<td>1.2 visits</td>
</tr>
<tr>
<td>0 to 6</td>
<td>1.4 visits</td>
</tr>
<tr>
<td>0 to 9</td>
<td>1.7 visits</td>
</tr>
<tr>
<td>0 to 12</td>
<td>2.0 visits</td>
</tr>
<tr>
<td>0 to 24</td>
<td>3.4 visits</td>
</tr>
</tbody>
</table>

Visit type utilization for ECC compared to baseline patients

<table>
<thead>
<tr>
<th>Type of dental care</th>
<th>Parameter Estimate</th>
<th>St Error</th>
<th>P-value</th>
<th>Hazard Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic or preventive²</td>
<td>0.55</td>
<td>0.11</td>
<td>&lt;.0001</td>
<td>1.734</td>
</tr>
<tr>
<td>Restorative/ART</td>
<td>1.32</td>
<td>0.42</td>
<td>.0016</td>
<td>3.728</td>
</tr>
<tr>
<td>OR</td>
<td>-0.59</td>
<td>0.20</td>
<td>.0028</td>
<td>0.552</td>
</tr>
<tr>
<td>Restorative/surgical</td>
<td>-0.61</td>
<td>0.12</td>
<td>&lt;.0001</td>
<td>0.545</td>
</tr>
</tbody>
</table>

¹ Using Proportional hazards models adjusting for patient age, gender, race, ethnicity, type of dental insurance, and spoken language
² Including disease management among ECC patients
OR=operating room
Costs: ECC vs. Baseline

Mean patient costs for all dental care including 1st month

<table>
<thead>
<tr>
<th>Length of evaluation</th>
<th>COSTS (2011 dollars)</th>
<th>Net savings</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months</td>
<td>Baseline</td>
<td>ECC</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$699</td>
<td>$669</td>
<td>$30</td>
</tr>
<tr>
<td>6</td>
<td>$1,092</td>
<td>$880</td>
<td>$212</td>
</tr>
<tr>
<td>9</td>
<td>$1,660</td>
<td>$1,097</td>
<td>$563</td>
</tr>
<tr>
<td>12</td>
<td>$2,025</td>
<td>$1,262</td>
<td>$762</td>
</tr>
<tr>
<td>24</td>
<td>$2,678</td>
<td>$1,834</td>
<td>$844</td>
</tr>
</tbody>
</table>

Mean costs of care were estimated using generalized linear models, adjusting for patient age, gender, race, ethnicity, type of dental insurance, and spoken language.

Return on Investment

<table>
<thead>
<tr>
<th>Length of evaluation</th>
<th>Added cost of diagnostic and preventative care</th>
<th>Net savings</th>
<th>Return on investment (ROI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>$30.9*</td>
<td>$30</td>
<td>0.99</td>
</tr>
<tr>
<td>6</td>
<td>$47.3*</td>
<td>$212</td>
<td>4.48</td>
</tr>
<tr>
<td>9</td>
<td>$60.9*</td>
<td>$563*</td>
<td>9.23</td>
</tr>
<tr>
<td>12</td>
<td>$70.4*</td>
<td>$762*</td>
<td>10.83</td>
</tr>
<tr>
<td>24</td>
<td>$114.3*</td>
<td>$844*</td>
<td>7.38</td>
</tr>
</tbody>
</table>

*Statistically significant at p<0.05

Net savings = reduced cost of restorative and operative care net of the added cost of diagnostic and preventative care;
ROI = Net savings / cost of investment
ECC Phase 2 Collaborative*

- 18 month project launched in 2011
- Participating sites
  - Hospital dental clinics
    - Children’s Hospital Boston (Boston, MA)
    - Nationwide Children’s Hospital (Columbus, OH)
    - University Pediatric Dentistry (Buffalo, NY)
    - Saint Joseph Health Services of Rhode Island (Providence, RI)
  - Community health centers
    - Holyoke Health Center (Holyoke, MA)
    - Neighborcare Health (Seattle, WA)
    - Native American Health Center (San Francisco, CA)

*Funded by DentaQuest Institute
## Early Childhood Caries Collaborative Phase II Results (7 sites)

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Baseline</th>
<th>Result Achieved</th>
<th>Percentage Improvement</th>
<th>Improvement Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Cavitation</td>
<td>46%</td>
<td>33%</td>
<td>▼28%</td>
<td>▲14% - ▼71%</td>
</tr>
<tr>
<td>Pain</td>
<td>11%</td>
<td>8%</td>
<td>▼27%</td>
<td>▲80% - ▼100%</td>
</tr>
<tr>
<td>Referral to the Operating Room</td>
<td>22%</td>
<td>14%</td>
<td>▼36%</td>
<td>0% - ▼81%</td>
</tr>
</tbody>
</table>

Results include seven (7) clinical locations: Boston Children’s Hospital (MA); Holyoke Health Center (MA); Native American Health Center (CA); Nationwide Children’s Hospital (OH), Neighborcare (WA); St. Joseph’s Hospital for Specialty Care (RI); University Pediatric Dentistry (NY)

Results reflect random sample of 438 children/families drawn from a total ECC Collaborative population of 3,030.
### Boston Children’s Hospital

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>ECC Phase I Baseline</th>
<th>ECC Phase I ECC</th>
<th>ECC Phase II Baseline</th>
<th>ECC Phase II ECC</th>
</tr>
</thead>
<tbody>
<tr>
<td>New cavitation</td>
<td>75%</td>
<td>26%</td>
<td>46%</td>
<td>26%</td>
</tr>
<tr>
<td>Pain</td>
<td>22%</td>
<td>13%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Referral to OR</td>
<td>21%</td>
<td>11%</td>
<td>24%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Sustainability and Dissemination

Why?

- Can be implemented into clinical practice
- Has potential to improve care delivery, patient outcomes and reduce costs

How?

- ECC Collaborative Phase III
- Funding mechanism(s) needed to target highest-risk children
  - Caries risk assessment
  - Preventive counseling/self-management goals
  - More frequent visits based on caries risk assessment
  - Fluoride varnish
Where Do We Go from Here?

Marty Dellapenna, RDH, MEd
Director, Center for Medicaid/CHIP Oral Health Program Quality, Policy & Financing
Medicaid-CHIP State Dental Association
Disease Management’s Spread

• Programs are being considered/adopted by public payers

• DM Challenges:
  – Growing disease burden
  – Emphasis on lifestyle related conditions
  – Escalating health care costs
Disease Management in Medicaid Dental Service Delivery

- Traditional service delivery structures for payment of dental care use Current Dental Terminology (CDT) Codes.
- As of January 1, 2014, three new caries risk assessment CDT codes will be available for use
Disease Management in Medicaid Dental Service Delivery

The new codes are essentially non-specific to age or risk assessment method.

• caries risk assessment and documentation, with a finding of low risk

• caries risk assessment and documentation, with a finding of moderate risk

• caries risk assessment and documentation, with a finding of high risk
IT Systems & Measurement

- DQA is developing eMeasures for dentistry
- Work is being done on “meaningful use” measures
- Discussions are happening with Practice Management Software (PMS) vendors
- DentaQuest Institute is developing software to interface with PMS to perform measurements
What’s Next?

• Test a benefit structure that is based on the ECC project, whose protocols have demonstrated success.

• Population data analysis will help guide State decision-making

• Align with the administrative models.

• Test findings for cost-effectiveness in Medicaid dental programs.
Questions
Contact Information

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Marty Dellapenna, RDH MEd

Martha Dellapenna is currently the Director of MSDA’s Center for Medicaid and CHIP Oral Health Program Quality, Policy and Financing. Prior to this role, Marty was the Oral Health Program Manager for the Rhode Island Executive Office of Health and Human Services (EOHHS) for 8½ years.

At Rhode Island Medicaid, Marty was charged with managing the development and implementation of RIte Smiles, the state's first Medicaid managed care dental program. Marty directed all oversight and monitoring activities for RIte Smiles, which has garnered national attention as a best practice.

Marty also has extensive background in healthcare risk management and compliance, in the commercial dental managed care arena, in dental practice management and in clinical dental hygiene. Marty has continued involvement in both national and statewide oral health committees.

Marty is a graduate of Old Dominion University in Norfolk, VA with a Bachelor of Science in Dental Hygiene and also received her Master in Education degree in Health Education from Rhode Island College in Providence, RI.
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Dr. Compton is the Executive Director of the DentaQuest Institute, a national non-profit organization helping dental professionals improve oral health care. He recently was Vice President of Quality Management at DentaQuest where he was responsible for developing and implementing programs designed to improve the quality of clinical care as well as developing methods for rewarding providers who achieve measurable improvement in clinical performance. Dr. Compton has over 17 years experience in dental benefits administration and has served on numerous committees for America’s Health Insurance Plans (AHIP), the National Association of Dental Plans (NADP) and the Delta Dental Plan Association (DDPA), as well as others. He is one of 5 individuals initially chosen by the Dental Quality Alliance to develop quality performance measures for the Medicaid dental program. He is also on the faculty of the Harvard School of Dental Medicine.
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Dr. Man Wai Ng is Chief of the Department of Dentistry at the Boston Children’s Hospital and Assistant Professor of Developmental Biology (Pediatric Dentistry) at the Harvard School of Dental Medicine. Dr. Ng received her DDS degree from Stony Brook University in NY and her MPH degree from the Harvard School of Public Health. She completed residency training in Pediatric Dentistry at Boston Children’s Hospital. She has been collaborating with the DentaQuest Institute in designing, testing, implementing and disseminating evidence-based approaches into practice by using quality improvement methods. Her interest is to improve care delivery, clinical outcomes and cost of care.