Alaska Dental Health Aide Program - Evaluation Plan June 2005

Introduction: As a new paraprofessional program to improve access to primary health care in rural Alaska, the Alaska Dental Health Aide Program will have ongoing prospective evaluation of program impacts. This evaluation will include program impacts for all four categories of dental health aides. This site will provide routine updates on the status of this program evaluation.

An evaluation advisory committee will be assembled and will be comprised of Tribal and community representatives, CHAP administrators, dental practitioners and educators, and evaluation design experts. This committee will provide general guidance for the evaluation design, monitoring and for the assessment of outcomes.

Evaluation Strategy: The design of the evaluation will focus on the ability of the program to achieve its goals. Program goals include increased access to quality dental care for rural Alaska Natives; increased capacity of the dental workforce team in addressing oral health needs of rural Alaska Natives; and provision of care that is culturally sensitive, culturally acceptable and integrated into the overall health care delivery of care. Examples of proposed evaluation objectives for these program goals include:

Increased access to quality dental care:
- assess clinical impacts of the program
- assess clinical quality assurance program
- measure change in health status and preventive behaviors
- assess economic impacts of the program

Increased capacity of dental workforce team:
- measure clinical and administrative impacts of each dental health aide category and their interaction within the dental team
- assess the effectiveness of telehealth in general supervision of DHA

Provision of care that is culturally sensitive, etc.:
- measure acceptance of program by patients, the community, and providers

Current Status:
Under the auspices of the Alaska Native Tribal Health Consortium, the Institute of Social and Economic Research (ISER), University of Alaska-Anchorage (UAA) has primary responsibility for guiding data collection and analysis for select aspects of this program evaluation. The ISER also is developing a general framework for evaluation of primary health care paraprofessional programs. Clinical and quality assurance will be conducted by Tribal dentists and reviewed by an independent third party.

Ongoing quality assurance procedures are underway. Each provider in the Community Health Aide Program must meet the qualifications as outlined in the Federal Community Health Aide Program Standards and Procedures (a copy of these standards can be found on this web-site). A 12-member board administers the certification program. Each DHA

provider, in addition to meeting training requirements, must undergo a protracted preceptorship and each of their skills is evaluated by direct observation. This skill evaluation is completed every two years and, in addition to continuing education, is required for recertification. Every DHA in the program is assigned to and is under the supervision of a dentist. Each has a well-defined individualized scope of practice based on their proven competencies. This program has developed rigorous administrative controls, gleaned from 37 years of experience with the Community Health Aide Program, to ensure quality of care.

A detailed explanation of the quality assurance that takes place in Tribal programs can be found in the document entitled "Quality Assessment" and is located on this web site for review. DHAs must meet the same standard of care, for those procedures that they perform, as dentists or any other provider in our system. **There are not two standards of care**. Quality assessment reviews for DHAs will include both chart review and patient examination. During the first two years of their service this will occur on a quarterly basis.

In addition, baseline oral health status data is currently being collected using the Association of State and Territorial Dental Directors (ASTDD) model. Information from 37 villages including control villages will be gathered and compared in five years. This will enable us to compare villages with and without dental health aides and follow the effects of their activities through periodic assessments. UAA has begun development of both the clinical and economic impact designs and these will be completed by April 2006. In the next six months the DHA Evaluation Advisory Committee will be assembled. This committee will seek input on evaluation design from professional dental organizations such as the ADA and AAPHD, as well as from other interested organizations.