



Evaluation of Minnesota's Community Collaborative Practice Model A Strong Start & Guide for the Future



Our goal today...

To share the results of an initial evaluation of
Minnesota's Community Collaborative Head Start Oral
Health Model.

Evaluation Purpose

To evaluate the first year impact of implementation of the Community Collaborative Practice Head Start Oral Health Model on Head Start grantees, dentists and dental hygienists.

Evaluation Methods

- Email, telephone and online survey of dental hygienists involved with Head Start programs
- Online Survey of Health Coordinators
- Site Visits to 3 Head Start grantees identified by MHSAs as successfully implementing the model

Key Findings

- 12 of Minnesota's 34 Head Start grantees have established collaborative practice models

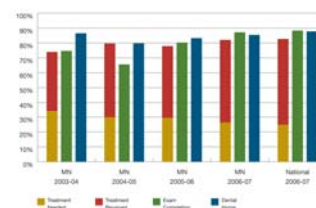
Key Findings

- 1,527 Head Start children were served by collaborative practice dental hygienists from September 2007 through March 2008.

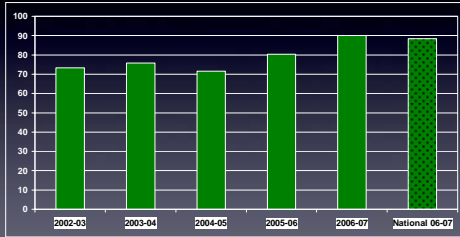
Key Findings

- Collaborative practices in Head Start vary according to local needs and resources while sharing an emphasis on early oral health education, prevention and timely referrals.

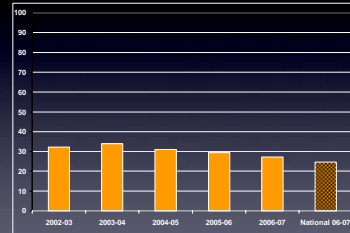
Minnesota's PIR Data



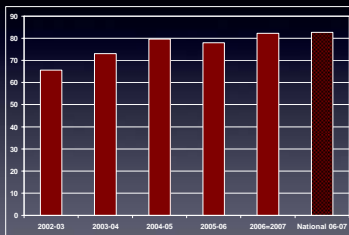
Minnesota Exam Completion Rates
73 - 90%



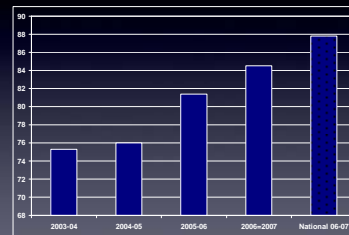
Minnesota Treatment Need Rates
32% - 27%



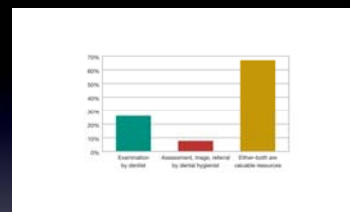
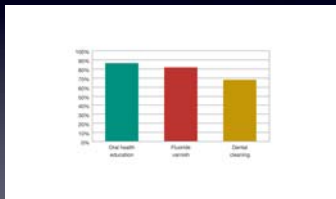
Minnesota Treatment Received Rates
66% - 82%



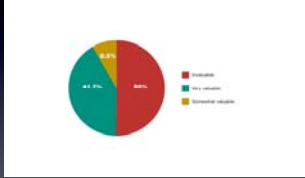
Minnesota Dental Home Rates
75 - 85%



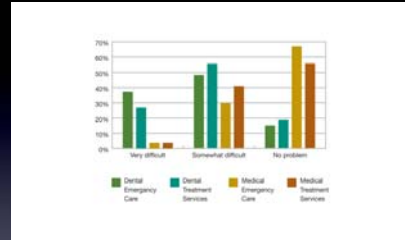
**"This is a wonderful opportunity for Head Start children and the dental community. Many of these children only need preventive care, and what a cost effective model of providing these services."
(Collaborative Practice Dental Hygienist)**



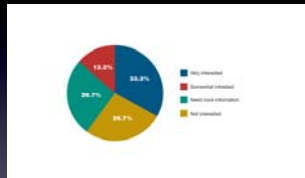
A majority of health coordinators consider the services of both dentists and collaborative practice dental hygienists to be valuable.



The Collaborative Practice model is the “biggest change for families to access services that I’ve seen in Head Start – ever”.
(Head Start Program Director)



In finding medical care and dental care for their children, health coordinators overwhelmingly responded that it was more difficult to find dental care.



Additional programs expressed interest in the collaborative practice model.

Programs without access to care problems are not interested in the model.

Conclusions

- The Community Collaborative Practice Model has been adapted to local needs and resources
- Location of services
- Referral Process
- Billing and Compensation

Conclusions

- Collaborative Practice Dental Hygienists:
 - expressed satisfaction in working with Head Start and the benefits to children of receiving center-based services.
 - desire opportunities for mentorship and resources for quality improvement.

Conclusions

- Dentists in Collaborative Practice:
 - Treated children in their private practices, safety-net clinics, and non-profit dental organizations as volunteers, practice owners and employees.
 - Agree that the system is working but have concerns about liability.

Recommendation

- The creation of an online accessible data and surveillance center for statewide and local initiatives was important to nearly all interviewed dentists, dental hygienists, and health coordinators.
- A state registry of local initiatives is strongly recommended to assure public health and monitor long term progress.

Recommendation: further study needed

- Analysis of year-end BSS data
- Rates of referral and treatment completion as a result of the model
- Oral health knowledge of Head Start staff and parents
- Sibling oral health status

In Summary

- This initial evaluation shows:
 - Evidence of successful implementation of the Community Collaborative Practice model in Minnesota Head Start.
 - Strong demand for infrastructure to support this practice model.
 - The need for further research on the effect on oral health of Head Start children and their families.