MODELS OF CARE WITHIN PUBLIC DENTAL SERVICES

The Obligation for Change

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Overview

• The Need
• Evidence
• Challenges/hurdles
• The adaption of Models of Care (MOC)
Key Questions

- What services?
- Why we provide these services and in a specific way (currently & future options)?
- Who to?
The Need

- Primary health care team approach
- Patient (not tooth/teeth) focused → a population outcome
- Cannot continue to “deliver more of the same”
- Workforce population ratios
The Need ...cont`d

- Outcome support derived from Preventive Maintenance Programs (PMP).
- The increasingly pressured health dollar.
- Management of the oral environment.
- A need to reduce the overall burden of disease.
The Need ....cont`d

- A requirement to capitalise on resource intensive oral disease end stage treatments.

- Efficient and effective workforce utilisation (including education, clinical and non-clinical)

- Demand increase
The Evidence

• The common “Oral environment” diseases now considered “Chronic”

• Chronic disease management requires a combination of individual, community and population approaches.

• Dental caries and periodontal disease activity depends on disease process activity.
The Evidence…cont`d

- Social, dental and medical co-morbidity effect and impact on the disease process influencing care planning and priorities.

- Oral health improvements occur synergistically with improvements in the social determinants of health and management of common risk factors.
The Evidence – cont`d.

- PMP significantly improve “definitive interventions” outcomes.

  1. Intensive
  2. Moderate
  3. Review/reinforcement

- Primary care team

- Coaching, motivational interviewing, health message reinforcement
The Evidence –cont`d

• Minimum Intervention Dentistry (MID) Care phases.

• Oral “Chronic disease” MOC.

• PMP directed at “Home care”.
The Evidence-cont`d.

• Health literacy required to exceed social scale 3 (41% nationally), to maximise MOC.

• If less than social scale 3- Step down interventions can be utilised as a transitional or maybe even as final management.
The Challenges.

• Culture – internal and external-Dentistry isolated from mainstream health.

• Under Graduate Education.

• Marketing – information access- accuracy.

• Mandatory vs. elective concept within dentistry.

• Dentistry as a “Business” vs. Healthcare.
The Challenges…cont`d

• Funding models – Commonwealth and Jurisdictions.

• Item number driven-Health funds

• Focus on W/L reduction / activity .
The Challenges – cont`d.

• Absence of consistent oral health/dental advice at a National level.

• Fragmented programs and views – an issue managing chronic diseases.

• “New” Workforce working effectively

• The “Second rate” dentistry view.

• Focus on “Duty of Care”

• An understanding of the accountabilities of a public system
Adapting MOC principles to service delivery.

Overarching aim – the adaption of Principles into all service delivery areas

✓ Effectively and efficiently reducing the negative impact of the oral environment and its diseases on the overall Quality of Life – (medical, social)
✓ Utilising interventional, preventive, stabilisation or self-managed/guided approaches delivered by the complete team.
Adapting MOC Principles, cont`d

• At all patient service Entry points - team approach to Model of Care pathways.
• Dentists, Oral Health Therapists, dental hygienists, dental assistants, students
  
  i. Emergency/urgent care - ROP, disease endpoint management,
  
  ii. General Care - off W/List
  
  iii. General anaesthetic - W/List and post op.
  
  iv. Preventive Maintenance Program – aggressive monitoring/coaching
Adaption of MOC Principles, cont`d

• Consideration /awareness of all levels of society when adapting a MOC:
  i. Individual/family unit level
  ii. Community level
  iii. Population level
Adapting MOC to Service delivery: Clinical Scenario

- Triage – “Urgent” - Category 2?
- Pain -26 with additional generalised carious lesions
- Primary Care Team management
  - medical/social/dental History – OHT
  - Radiographs etc – DA (Cert IV)/OHT
  - Proposed plan - clinical pathway/s – “Team”
  - LA- OHT
Adapting MOC to Service delivery: Clinical Scenario cont`d

• 26 – Palatal canal Pulp extirpation or extraction
  Dentist/student

• Seal closure or obtain haemostasis OHT
  Dentist/student
Adapting MOC to Service delivery: Clinical Scenario cont`d

- General stabilisation-refer care plan
  - OHT/Student-OHT/Dentist

Clinical Scenario – cont`d

- **DA** Fluoride Varnish

  - Initial Home care – **DA /OHT** – TB/interdental cleaning, TP, diet, Xylitol gum.
  - Referral MGP- community programs.
  - Relevant clinical pathway to appropriate W/List Specialist referral.
  - Re-appoint “stabilisation”-managed W/L
  - PMP – “Aggressive” review /in house/phone
Scenarios – cont’d

• Paediatric GA - re admission sibling admissions- consent - Dentist
• “Family unit” W/Listed - consult home care - re-enforcement /review (can move between PMP levels) DA/OHT
• All contact modes utilised as considered necessary.
Scenarios – cont’d

• Appropriate pharmacological products mailed-selected cases

• key messages motivational interviewing DA/OHT

• Post-op – Initially “Aggressive” PMP 1. – high risk re-presentation, siblings similarly high risk.
The way forward

• Planning/development phase
• Areas /units/facilities for possible trialling concept
• Introducing a pilot – Research project?
• Evaluating
The way forward cont’d

• Review

• Modifications to /piloting of the way we deliver care – “one size doesn't fit all”.

• ...The “Philosophy” and principles need to ...