health

Grampians Region oral health strategy and action plan

State Government Victoria

Department of Health

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Grampians oral health strategy and action plan

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Table 1: Glossary of terms

Abbreviation	Full Title
ABS	Australian Bureau of Statistics
ACSC	Ambulatory care sensitive conditions
BADAC	Ballarat and District Aboriginal Co-operative
BHS	Ballarat Health Services
BSHS	Beaufort & Skipton Health Service
CDP	Community Dental Program
CEO	Chief executive officer
DALY	Disability adjusted life years
DEECD	Department of Education and Early Childhood Development
DH	Department of Health
DHS	Department of Human Services
DHSV	Dental Health Services Victoria
DT	Dental therapist
EDMH	Edenhope & Districts Memorial Hospital
EFT	Effective full time
EGHS	East Grampians Health Service
EWHS	East Wimmera Health Service
HHS	Hepburn Health Services
IAP	Integrated area of planning
KPI	Key performance indicator
LGA	Local government authority
MoC	Model of care
OHN	Oral health network
OOS	Occasions of service
PCP	Primary care partnership
RDHM	Royal Dental Hospital Melbourne
SDS	School Dental Service
SRHS	Small rural health service
WHCG	Wimmera Health Care Group
WWHS	West Wimmera Health Service

Executive Summary

Oral health care is fundamental to overall health, well-being and quality of life. Responsibility for public oral health services in Victoria essentially lies with Dental Health Services Victoria and the Department of Health (the department), with services purchased through community based programs.

Improving Victoria's oral health [1] is the key policy document underpinning this plan. In addition to an integrated planning approach to service delivery, the key elements of the policy direction include the fundamental principle of equitable access to oral health services within the planning parameters of one chair[2] to 5000 eligible population, with future planning of chairs based on growth of the eligible population and integration of the Community Dental Program and School Dental Service.

The Grampians Region is taking an integrated, area based planning approach to oral health in order to plan and commit necessary resources across the region. This document is an oral health strategy encompassing both a strategic plan and an action plan for the implementation of the strategy. The strategy was developed through an inclusive and transparent review which took place over a 12 month period and included document reviews, the development of a discussion paper, extensive consultations and workshop processes.

The reviews and consultations identified a number of key messages of which the Grampians Region needed to be aware in the development of oral health services. These include:

- Priority areas for service development in oral health to be driven by population growth and by the age cohorts affected.
- Areas of identified poor health status need to be prioritised.
- The importance of public health strategies and health promotion, including fluoridation, cannot be overemphasised.
- Wait list management continues to be a key priority for the region.
- Increases in the productive hours of current service delivery have the direct effect of increasing throughput.

The following key areas for future focus have been developed using the information gathered by the aforementioned processes:

- strategic leadership
- access
- efficiency and effectiveness
- models of care
- workforce and health promotion.

Using these key focus areas, recommendations and required actions are provided in the action plan. In summary, the recommendations are:

- Develop an oral health network.
- Focus on equity of access.
- Increase productivity and create capacity.
- Develop a model of care that addresses areas of need.
- Develop a regional approach to workforce planning.
- Adopt a regional population health approach to oral health promotion and disease prevention.

[1] Improving Victoria's oral health, Department of Human Services, Victoria 2007
[2] A 'chair' is defined as infrastructure in which care is provided by a dentist, dental therapist or prosthetist per the planning parameters of 1:5000 population.

Good oral health is not just about increasing the number of dental chairs. In order to meet growing demand and ensure appropriate access, the service system will need to become more integrated, workforce capacity increased and efforts to prevent oral health problems strengthened.

This means improving the integration of dental chairs into a system that includes enhanced health promotion and prevention, and enabling more tailored responses to meet the range of community needs, particularly the needs of people who are isolated and vulnerable such as people who are elderly, people with mental health problems and people from Aboriginal communities. The key to high quality, responsive oral health care is making it everyone's business, including doctors, community health providers, families, and education providers.

2 Background and approach

Oral health care is fundamental to overall health, well-being and quality of life. While private practitioners provide most oral health services in Victoria, the state government has responsibility for public oral health care delivery for children and disadvantaged adults.

Workforce availability creates issues for both private and public oral health delivery in rural Victoria. Oral health ambulatory care sensitive conditions are more common in rural areas, particularly among children, and are potentially avoidable with early access to appropriate services.

Dental Health Services Victoria is the leading public oral health agency with a role in oral health workforce management, oral health promotion, quality assurance and the purchase of integrated community oral health services. The School Dental Service and Community Dental Program have recently been integrated to increase efficiency and ease of access.

The Department of Health (the department) has lead responsibility for capital and service planning, funding, accountability and strategic policy development.

Community health services have primary responsibility for the delivery of integrated community-based oral health and for local health promotion activity.

The Grampians Region is taking an integrated, area based planning approach to oral health in order to plan and commit necessary resources across the Grampians Region. This has resulted in the development of the oral health strategy encompassing both a strategic plan, including service models, and an action plan for the implementation of the strategy over the next seven years.

The aims of the plans are to:

- improve the oral health of the population in the Grampians Region
- reduce inequalities in oral health outcomes
- provide equitable access to public dental services.

2.1 Approach

Development of the oral health strategy commenced in July 2009, and to ensure inclusive and transparent review processes the project was extended into 2010. Analysis of the current service model was undertaken through detailed reviews of existing documentation pertaining to oral health services, service mapping, plans, demographic and workforce information. Following the distribution of a discussion document based on the aforementioned review, an extensive consultation process was undertaken which ensured that all appropriate stakeholders were contacted and their views provided through either individual consultation or workshop processes. All oral health care providers in the region were also visited.

A list of all the stakeholders that were consulted is provided in Appendix 2.

The first part of this report provides the environmental, demographic and data analysis. This information supports the issues that emerged from the consultation process to become the foundation of the way forward for oral health care in the Grampians Region.

3 Context

3.1 Policy context

Planning for oral health services in the Grampians Region has been undertaken in line with *Australia's national oral health plan*[3], *Care in your community*[4], and more specifically *Improving Victoria's oral health*[5]. It has been informed by background work undertaken by the Grampians Region in *Oral Health in the Grampians Region*[6].

Within this policy context the broad themes underpinning oral health are:

- Recognition that oral health is an integral part of general health.
- A population health approach with a strong focus on prevention and early identification of oral disease through health promotion is important.
- Access to appropriate, affordable and local services.
- Availability of sufficient and appropriately skilled workforce.

Improving Victoria's oral health describes the current oral health system and recent achievements, and outlines the consequences of poor oral health. It summarises the broader policy context for public oral health and shares key principles with the *Care in your community* policy, these being the best place to treat, together we do it better, technology to benefit people, a better health care experience and a better place to work. *Care in your community* encourages person centred rather than agency centred health care and focussing on delivery within the community rather than in organisational settings. This policy direction underpins an integrated planning approach to service delivery, which is an important aspect of this oral health plan.

Additional key elements of *Improving Victoria's oral health* include the fundamental principle of equitable access to oral health services within the planning parameters of one chair[7] to 5000 eligible population, with future planning of chairs based on growth of the eligible population and integration of the Community Dental Program and School Dental Service.

The eligible population for public oral health services in Victoria is defined in Australia's National Oral Health Plan 2004-2013[8] and summarised below.

Services for children

- All children aged 0-12 years.
- Young people aged 13-17 years who are health care or pensioner concession card holders or dependents of concession card holders.
- Care for preschool and primary school aged children is free for dependents or holders of a health care or pensioner concession cards.

Services for adults

- Health care and pensioner concession card holders over the age of 18 years.

3 Australia's National Oral Health Plan 2004-2013, National Advisory Committee on Oral Health, South Australian Department of Health, July 2004

4 Care in your community, Department of Human Services, Victoria 2007

5 Improving Victoria's oral health, Department of Human Services, July 2007

6 Oral Health in the Grampians Region, Health and Aged Care Department of Human Services Grampians Region 2009

7 A chair is defined as infrastructure in which care is provided by a dentist, dental therapist and / or prosthetist per the planning parameters of 1:5000 population

7 Australia's National Oral Health Plan 2004-2013, National Advisory Committee on Oral Health, South Australian Department of Health, July 2004

Priority access to treatment

Priority access to oral health services is afforded to the following groups within the community who have poor access to dental care and whose oral health is well below the rest of the community:

- pregnant women
- Aboriginal and Torres Strait Islanders
- children and young people
- homeless people and people at risk of homelessness
- refugees and Asylum Seekers
- registered clients of mental health and disability services, supported by a letter of recommendation from their case manager or staff of special developmental schools.

The aim of integration is to improve access to oral health services for the eligible population by improving capacity, utilisation and the availability of an appropriate workforce. While the aim is for all public oral health services to provide an integrated service, some agencies in the Grampians Region have indicated that they are not currently in a position to comply with this policy direction. Hepburn Health Services have indicated that the expectation of increased numbers through integration would be problematic for the service and Edenhope and District Memorial Hospital have indicated that staffing issues do not allow integration to be considered.

Until recently the School Dental Service, now known as the Child Oral Health Program, was operated directly by Dental Health Services Victoria as a separate service to the Community Dental Program, although many clinics were co-located with community dental agencies. Funding streams were separate and there was separate administration and coordination of programs based on recall versus waitlist.

The separate operation of the Community Dental Program and the School Dental Service created confusion for clients and inefficiencies in the system, with chair and workforce usage often suboptimal. The benefit of integrating the two services was identified, and the release *of Improving Victoria's oral health* clearly articulated the improved vision for oral health in Victoria.

3.2 Governance and funding for public oral health services in Victoria

Responsibility for public oral health services in Victoria essentially lies with two entities, Dental Health Services Victoria and the department. *Improving Victoria's oral health* clearly outlines the roles and responsibilities of both in the provision of oral health services. Despite this direction the lines of responsibility remain unclear. The development of this plan has enabled both Dental Health Services Victoria and the department time for discussion about the expectations of both in the future provision of oral health services in the Grampians Region.

As defined in *Improving Victoria's oral health*, Dental Health Services Victoria is the leading public oral health agency and it plays the primary role in:

- training, recruiting and retaining the oral health workforce
- oral health promotion
- quality assurance, including clinical leadership and ensuring compliance with relevant standards
- purchasing integrated community oral health services, planning the best distribution of purchased services and providing specialist and generalist services through Royal Dental Hospital Melbourne.

The Department of Health has lead responsibility for:

- capital and service planning, and planning the best distribution of services
- funding and accountability
- strategic policy development.

3.3 New funding model

Recently the department has undertaken work in the area of funding and accountability that will underpin the strategy for improved planning and service integration in dental services. The funding review aims to achieve improved alignment between funding, service delivery, policy objectives and value for money. The review will essentially recommend:

1. Streamlining current funding arrangements to support service integration, workforce strategies, demand management and oral health promotion.
2. Improving the effectiveness and efficiency of budget allocation, payment processes and performance measures.
3. Detailing how funding will be commensurate with department policy and industry best practice.

At the time that this report was released the revised funding formula had not been implemented, and to date agencies are not aware of how the funding formula will impact on them. There were concerns raised during the consultation for the development of this action plan that it was being developed without consideration of the implications of the new funding model.

3.4 Models of care

This section describes the models of care that are available within restorative dental care across Victoria. It is important to understand the available models of care and to appreciate that not all models are, or can be, available at each site. Availability of different models can affect access to oral health services for some sections of the population.

A working definition for a model of care could be a description of how services are delivered. The objective of a model of care is to consistently and efficiently deliver patient-centered services at the right time, in the right manner, in a suitable setting, at a high standard within a risk management framework. Depending on the context, a model of care can emphasize different aspects of how services are delivered including the structure, processes, relationships, management and enabling technology.

Models of care vary according to the setting, the spread of the eligible population, access to infrastructure and the availability of appropriate staff. Oral health services are no longer only provided in a fixed chair within a dental surgery. Services need to be designed around the system-wide issues that affect the delivery of all health care. These issues consist of workforce, including an increasingly part-time workforce and shortages of care providers particularly in rural and remote areas, providing appropriate care as close to home as possible to reduce the impacts of travel on access to treatment, understanding and balancing the available resources between preventative and restorative dental care and meeting the challenges of providing services within a designated fiscal environment.

When service providers look at potential future design of a service framework they need to:

- Be guided by best available evidence.
- Ensure that consumers' needs are met.
- Ensure any change considers effectiveness, efficiency and cost benefit.
- Ensure there is an appropriate balance in the allocation of resources between preventative and restorative dental care, in consideration of the importance of health promotion and early intervention.
- Address priorities of care through collaboration, availability of workforce and infrastructure.
- Address the need to provide care in a variety of settings as close as possible to people's homes.
- Be mindful of the need to have a skilled oral health workforce to provide care.

This process requires service providers to actively incorporate and consider consumer needs, professional responsibility and preference into the matrix of services that they develop.

While it is recognised that this will not be an easy task, it is an important shift if oral health services are to be appropriate, safe and fiscally responsible. The challenge for the Grampians Region is how to achieve incremental change within the current system.

Table 1 below outlines the models of care available for restorative oral health services in Victoria.

Table 1: Models of care for restorative oral health services

Model of care/service description		Infrastructure requirement	Workforce requirements (per chair)	Comments in relation to Grampians region
Fixed chair model	Fixed state funded chairs located at recognised, integrated, public oral health services	Public dental chair	Single clinician (dentist, therapist or prosthetist) Single dental assistant Support staff	• Principal model in Grampians Region • Limiting factor can be availability of workforce to maintain or increase throughput and realise capacity of chair • Real opportunities for Grampians Region to utilise capacity of chair by development of a mixed workforce, that is, enhanced scope of practice for dental therapists • Opportunity for public dental chair to be utilised by another discipline, often podiatry, when chair not used for principal purpose
	Private practitioners providing private service from state funded chair (hires chair and generates private income)	Public dental chair	Private practitioner responsible to provide staff	• Potential for use to increase access to restorative services in areas where chairs are not being used full time, but pressure on the capacity of private dentists in Grampians Region is limiting factor • Private practitioners show limited interest in this model at present
	Private practitioners undertaking public oral health services. This may or may not be in conjunction with the provision of private dental work	Public dental chair	Single clinician (dentist, therapist or prosthetist) Single dental assistant Support staff or Private practitioner responsible to provide staff	• Dentist providing public oral health care with potential to provide private oral health care. The chairs are 'rented' from State during these treatments • Potential for use but pressure on the capacity of private dentists in Grampians Region is a limiting factor
Outsourcing model	Private dentists undertaking public dental care in private dental rooms Voucher system – service paid for by the state but provided by private system	Private dental rooms	Private practitioner responsible for the provision of all staff	There are inherent complexities in the voucher system including: • Poor use of vouchers provided (approximately 1/3 of the vouchers are unused) • Potential for overuse. Strict monitoring and auditing of this process needs to be maintained. There are instances in Grampians (East Wimmera Health Service) where access to services is totally reliant on the voucher system • Potential for the client to attend private dentist prior to triage through the public system

Model of care/service description		Infrastructure requirement	Workforce requirements (per chair)	Comments in relation to Grampians region
	Historically the voucher system has been used to manage urgent or emergency dental care			• Difficulty in the management of the quality and consistency of the care provided. Dentists normally nominate availability to undertake public dental work but there is no credentialing system in place for practitioners • The Commonwealth Teen Dental Program provides $157 per person towards annual preventative check up for 12-17 year olds from families in Tax Benefit A or Teen Youth Allowance or Austudy. This care is available from private practitioners or public providers
Outreach model	Mobile chair – can provide oral health care in remote locations or for persons who have difficulty accessing mainstream oral health services (aged / disabled)	Mobile chair can be transported in a car	Dental therapist or hygienist	• Not currently utilised in Grampians Region • Known as the 'white' chair • Misgivings about the use of the chair in dental health services where it has been trialled because of issues with occupational health & safety and infection control • Clients must still be referred for oral health appointment
	Roving public health team Regionally employed staff providing a service in state funded chair	Public dental chair	Single clinician (dentist, therapist or prosthetist) Single dental assistant Support staff	• Potential for development of this model in Grampians Region. • Potential to develop a mobile team that provides outreach services in underutilised public chairs. This model may have potential to manage wait lists in high demand areas. • The model would require significant exploration and investigation to determine the availability of an appropriate workforce
	Roving public health team State employed staff providing a service in a non state funded or privately operated chair	Infrastructure provided by the Commonwealth or private entity	Single clinician (dentist, therapist or prosthetist) Single dental assistant Support staff	• Grampians Region has the potential to explore this model with Commonwealth chairs, particularly chairs located in the Wimmera • Remuneration for this model would need to benefit parties • Location of chairs may not necessarily be in high needs areas as Commonwealth chairs have been established independent of any needs analysis of potential eligible population • Potentially difficult to resource with state employees in current workforce environment • Further engagement of the parties is required
Mobile dental service	Mobile v or trailer	Fully equipped mobile oral health facility	Single clinician (dentist, therapist or prosthetist) Single dental assistant Support staff	• Historically there were three dental vans within the complement of public dental services in the Grampians Region. The one allocated to the Grampians Pyrenees through integrated area planning was retired from service in January 2010 leaving two vans in the region. In general there is a lack of engagement within the entire region in relation to utilising the mobile van concept, consequently the other two are not mobile across the sub-region and remain fixed in their current location

Model of care/service description		Infrastructure requirement	Workforce requirements (per chair)	Comments in relation to Grampians region
				There are mixed thoughts on the use of the mobile van in both the state and the Grampians Region with some of the barriers to utilisation identified as: • Staff preferences to working in fixed environment. There is a perception that the mobile van will by definition be constantly moving. Schedules could be established where the van remains in one location for a reasonably defined period • Perception that this model will result in a loss of time due to travelling. Again scheduling would reduce this problem • Mobile vans require certain utilities for set up (access to water and electricity). Remote sites often do not have these available. Consultation with remote sites during this review indicates that this issue is eminently solvable. In addition Dental Health Services Victoria is considering a solution to make the vans self-contained • Allocated set up locations are often isolated and away from the immediate health precinct leading to concerns regarding security of staff. Again consultation with remote sites indicates that this issue can be overcome • Security of staff once in the van, even at a well maintained site as there is only one exit point • The vans can be difficult to access for aged persons and people with disabilities • Maintenance of infection control principles in this environment Given that there are currently two 'functioning' dental vans in the region, both being less than one year old, it is important that exploration of this model is not limited by fixed ideas from clinicians and that access to services is prioritised over staff preferences.

3.4.1 Care types

Within these models of care for oral health services, different care types are provided to the eligible population. These care types can be summarised under the following headings.

General care – adults

For general dental care, patients are placed on a wait list at the local public oral health service. Wait lists are managed according to the date that the referral was received. Self-referral to service generally occurs with occasional referral from general practitioners or allied health professionals. The length of the wait list is variable at each oral health service provider within the Grampians Region; the reasons for this variation will be explored later in this document. Patients who change residence are able to transfer their waiting times as they transfer from one wait list to another.

For general dental care wait lists do not apply to eligible pregnant women, primary school age children and some groups listed under priority access to treatment.

There are limitations on access to treatment, with patients who receive general care not being eligible to return to the wait list until a period of 12 months has elapsed after the completion of their course of general care. Exceptions to this occur when clients who are deemed to be at risk are recalled earlier at the treating clinician's discretion.

In certain situations vouchers enabling public patients to access the services of a private clinician may be issued. General vouchers are valid for six months from the date of issue. Not all private practices accept vouchers and consequently patients may have to travel further afield to receive care.

General care – children

Children up to the age of 12 have priority access to public dental care. Until recently this service was provided through the School Dental Service but this has now amalgamated with the Community Dental Program. Primary school aged children are offered services on a recall basis that depends on their oral health needs. After any requisite work is completed children are assessed as 'high risk' or 'low risk' and placed on a recall list for checkups at an appropriate time.

Emergency Care

There is no wait list for emergency care but there may be a wait time depending on the severity of the emergency. Emergency presentations are triaged under the triage tool provided by Dental Health Services Victoria and approved by the department, and patients are offered treatment according to the timeline identified by the triage tool. If the agency cannot provide emergency care within the timeline required, then an emergency voucher is issued for presentation to a private dentist. Only the problem specified as requiring emergency care will be managed through this voucher. If other ongoing care is required then the patient will be directed to their local oral health clinic to be placed on the waiting list for treatment. It should be noted that not all private practices accept vouchers and consequently public patients may have to travel to another area for treatment. Emergency vouchers are valid for 28 days from the date they are issued.

Denture care

Patients with no natural teeth who require care for existing dentures will be added to the denture wait list. In the event that a person with natural teeth may require dentures they will usually have had an initial general care appointment (accessed through the general wait list). Once general care is completed the patient will take a place on the denture wait list. In order that the patient is not disadvantaged they are placed on the denture wait list according to the date that they were originally placed on the general care wait list.

Some community dental clinics are not able to provide a full range of denture services. In this situation a voucher may be offered so that the patient can receive denture services from a private dentist or prosthetist. Denture vouchers are valid for six months from the date of issue.

Specialist Care

The Royal Dental Hospital Melbourne provides a number of specialist dental services for eligible patients. The public oral health service can refer patients to specialist services at the Royal Dental Hospital Melbourne for treatment. Specialist dental services can also be provided by limited on-site general practitioners with advanced skills or by private practitioners.

4 Analysis

The first part of this section addresses the current population together with population projections, and the second part looks at current service provision. The analysis presented in this report is based on the three integrated area planning catchments in the Grampians Region. The catchments are defined at a sub regional level and are built from local government areas (LGAs). These catchments align with the three primary care partnerships (PCPs) within the region and are therefore already in use in a number of programs within the department. This has been done to acknowledge and capture the specific issues within each integrated area of planning (IAP) for the planning of service configuration in the future.

4.1 Population and population projections

The population of the Grampians Region is unevenly spread between the three IAP catchments. The largest concentration of population is in the Central Highlands. This area, together with parts of the Grampians Pyrenees, is expected to have the strongest population growth over the next 15 years. Of particular note is the expected growth in the LGAs of Ballarat and Moorabool. Table 2 shows the projected growth for each of the three planning catchments. By comparison, the total Victorian population is expected to grow by 9.8 per cent over that period, while the total Victorian rural population is expected to grow by 8.5 per cent.

Table 2: Population projections in Grampians

LGA	2006 Population	2026	Variation Change	% Change	Implication
Central Highlands					
Ballarat	88,437	118,752	30,315	34.3%	Significant population growth in all LGAs
Golden Plains	17,077	24,378	7,301	42.8%	
Hepburn	14,235	17,159	2,924	20.5%	
Moorabool	26,445	34,710	8,265	31.3%	
Grampians Pyrenees					
Ararat	11,653	12,178	525	4.5%	Marginal or negative population growth in Ararat and Northern Grampians
Northern Grampians	12,330	10,980	(1,350)	-11.0%	
Pyrenees	6,772	7,982	1,210	17.9%	
Wimmera					
Hindmarsh	6,235	5,124	(1,111)	-17.8%	Negative growth with the exception of Horsham
Horsham	19,098	20,829	1,731	9.8%	
West Wimmera	4,614	3,474	(1,140)	-24.7%	
Yarriambiack	7,742	6,310	(1,432)	-18.5%	

2026 Projections prepared by Department of Sustainability & Environment

4.2 Forecast population change in Grampians by integrated area of planning

Figure 1: Grampians Region population forecast

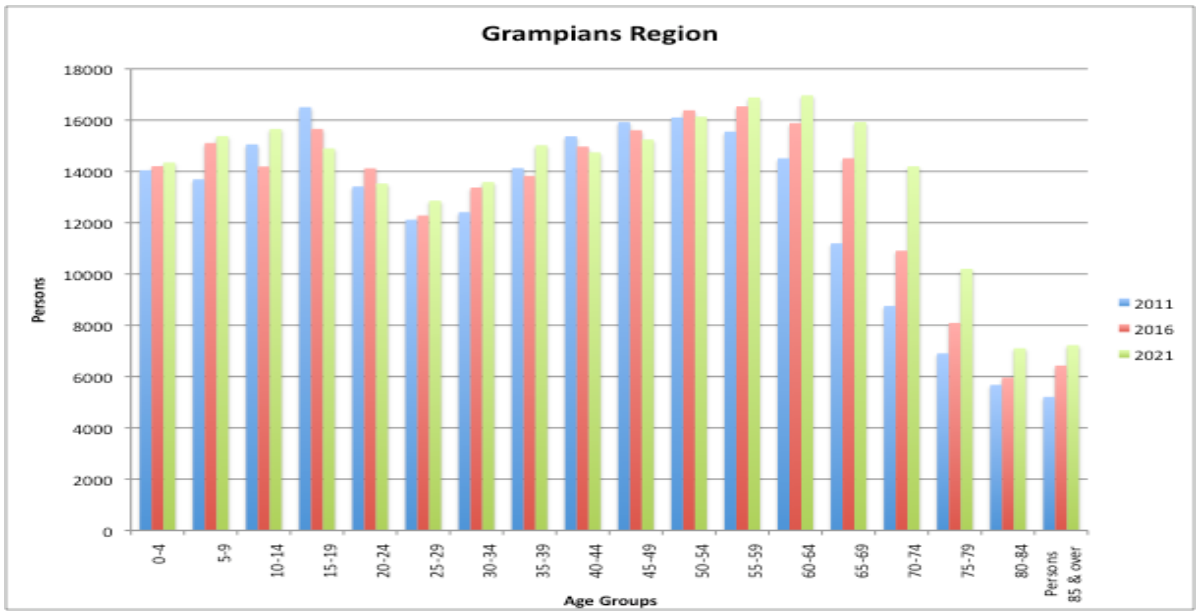
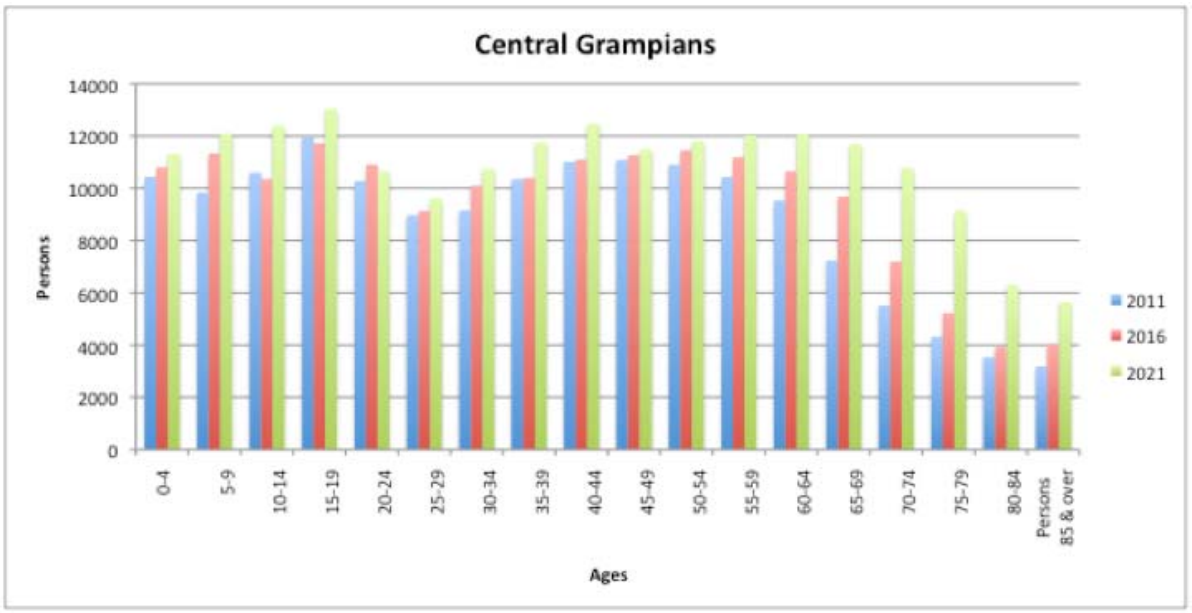


Figure 1 indicates that population growth in the Grampians Region is likely to occur in all ages with the exception of 15-19 years, 20-24 years and then 40-44 years, 45-49 years and 50-54 years. From a planning perspective it is important to look at each integrated area of planning.

Figure 2: Central Grampians population forecast



In Figure 2 we note that population growth for Central Grampians is spread across all ages groups through to 2021, with significant growth in teenage and aged profiles.

Figure 3: Wimmera population forecast

In Figure 3 it is noted that there is population growth expected in the Wimmera in all age brackets 60-64 years and above. In addition there is a predicted decline in population in all other age groups.

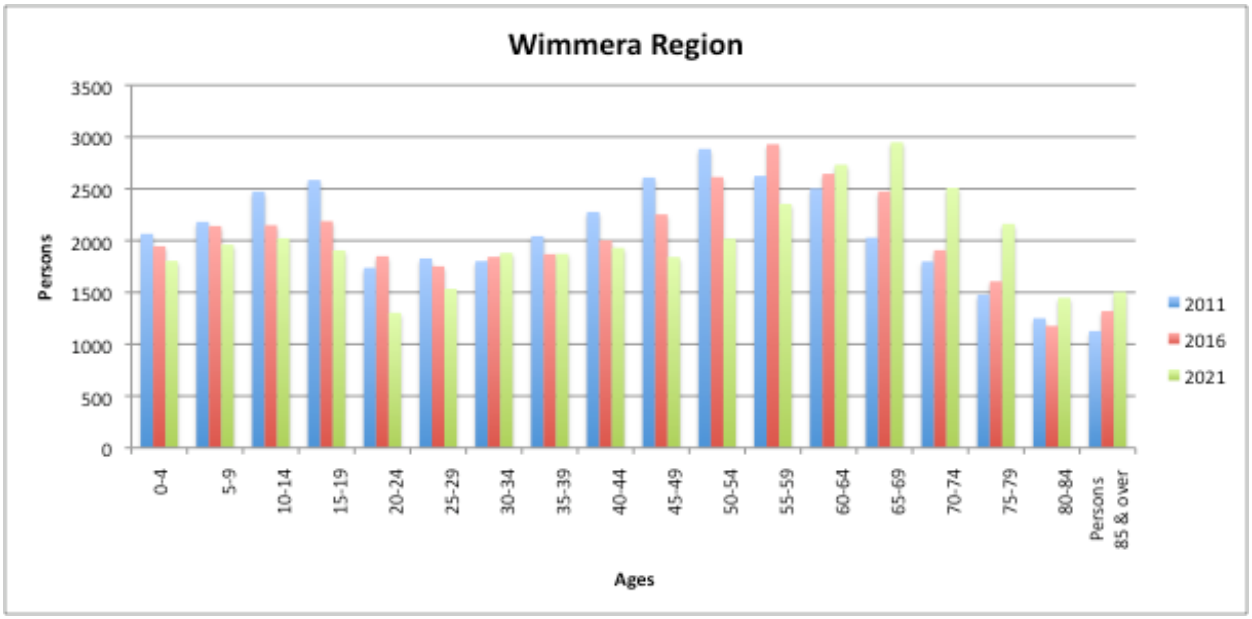
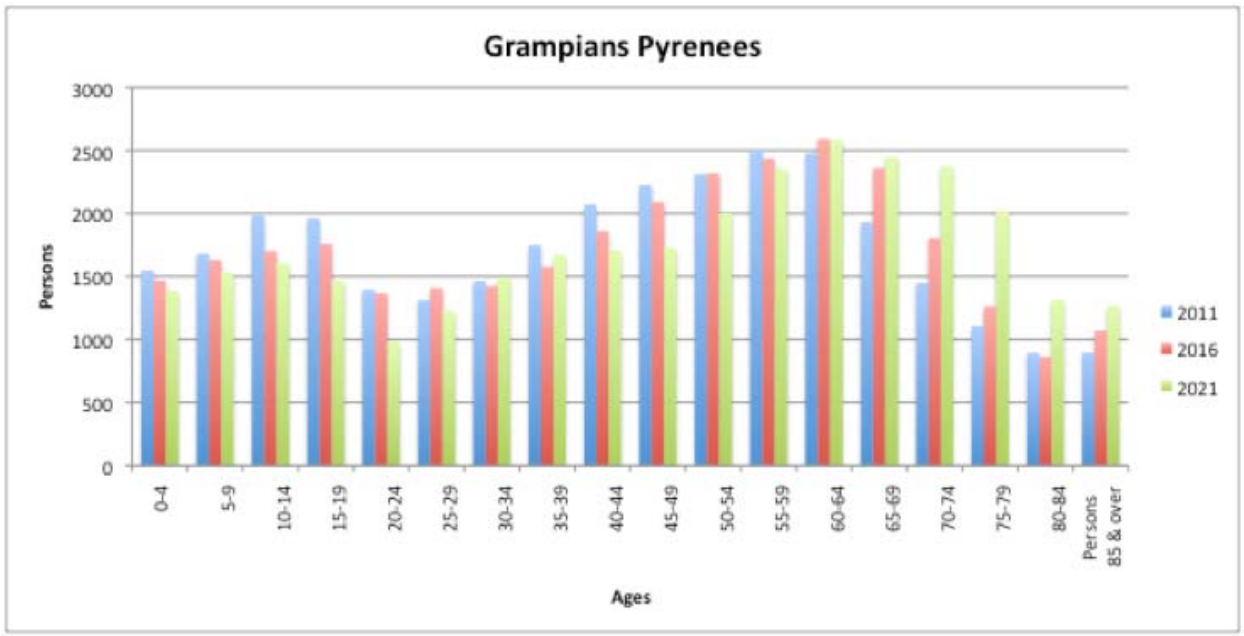


Figure 4: Grampians Pyrenees population forecast

Figure 4 shows that in Grampians Pyrenees there is significant population growth expected in the ageing population across all age brackets 60-64 years and above. As in the Wimmera, the forecasts suggest that in all other age groups including children and adults there is likely to be minimal population growth.



Key Messages

Predicted population growth is not consistent across the region. Population growth is expected in all age groups in the Central Highlands and in aged populations in Grampians Pyrenees and Wimmera. Population growth will drive service development priorities for oral health services.

4.3 Health indices

The Burden of Disease analysis for Victoria is undertaken periodically by the Department of Health. This provides an indicator of the types of ill health across major disease types and allows identification of areas where there may be higher rates of disease and injury compared with state averages.

The information can provide a guide to health care priorities and investment of effort to reduce the incidence of disease.

While the data for individual LGAs are considered too small to be of statistical significance, the analysis of this data provides an indicative health status of the catchment population when compared with the region as a whole and with the state average.

The measure used is the Disability Adjusted Life Years (DALY) per 1,000 population by gender for 2001[9]. The report was released in 2006. While the base data is ageing, it is nonetheless the most accurate available indicator of underlying community health conditions.

A high DALY rate indicates poor health status of the population. A low DALY rate reflects better health status. Comparisons can be made for all causes or specific diseases. Findings are important to support resource allocation decisions that aim to redress health inequalities. A significant part of the Grampians Region is relatively disadvantaged with respect to health indicators. Areas with high DALY rates for chronic disease include Grampians Pyrenees and Central Highlands as well as the LGA of Hindmarsh.

Key message

As oral disease shares common risk factors with a number of chronic health conditions, areas of identified poor health status should be prioritised in any service planning project.

4.4 Ambulatory care sensitive conditions

Ambulatory care sensitive conditions (ACSC) are hospitalisations that are potentially avoidable for many patients through public health interventions, primary care or community support. These include conditions such as hypertension, bronchitis & asthma, diabetes complications, chronic obstructive pulmonary disease, angina, dehydration and gastroenteritis, cellulitis, dental conditions and ear, nose and throat infections amongst others.

According to the data relating to ACSC, dental conditions are ranked as the second most common cause of hospital admissions for every IAP in the Grampians Region. Preschool aged children were the predominant group affected. The region's admission rate is significantly higher than the state average (see Table 3 below).

There is a significant difference in ACSC admission rates between regions in Victoria. In relation to admissions for dental conditions, access to fluoridated water and the proportion of households living in poverty are significant predictors of the difference. In Grampians Region the dental ACSC admissions were significantly higher in those catchments with lower access to fluoridated water supply and where the proportion of households living in poverty was higher.

This analysis demonstrates the value of providing fluoridated water in reducing dental disease and subsequent need for treatment, especially treatment in hospitals. The analysis also demonstrates the importance of providing access to dental services for families and individuals on low incomes.

9 http://health.webcentral.com.au/bodw/HomProcess.asp

Table 3: Admission rate for ambulatory care sensitive conditions

Standard ambulatory care sensitive conditions admission rates: trend for Victoria and the Grampians			
Year	**Standardised admission rate in Victoria per 1000 population**	**Standardised admission rate in Grampians per 1000 population**	**Ranking of dental in overall ACSC admissions for the Grampians Region**
2004-05	2.86	4.98	2nd
2005-06	2.89	4.87	2nd
2006-07	2.72	4.54	2nd
2007-08	3.02	4.62	2nd
2008-09	3.05	4.35	2nd

Although declining over the last five years, the standardised admission rate for ACSC in the Grampians Region is still consistently higher than the state average. In all years dental related admissions ranked second in admissions.

Key Messages

ACSC are considered avoidable admissions. Consequently the importance of public health strategies and health promotion which minimises the impact of preventable oral health disease cannot be overemphasised. This includes the necessity of ensuring that region wide fluoridation remains high on the priority list.

4.5 Current service capacity and expected demand

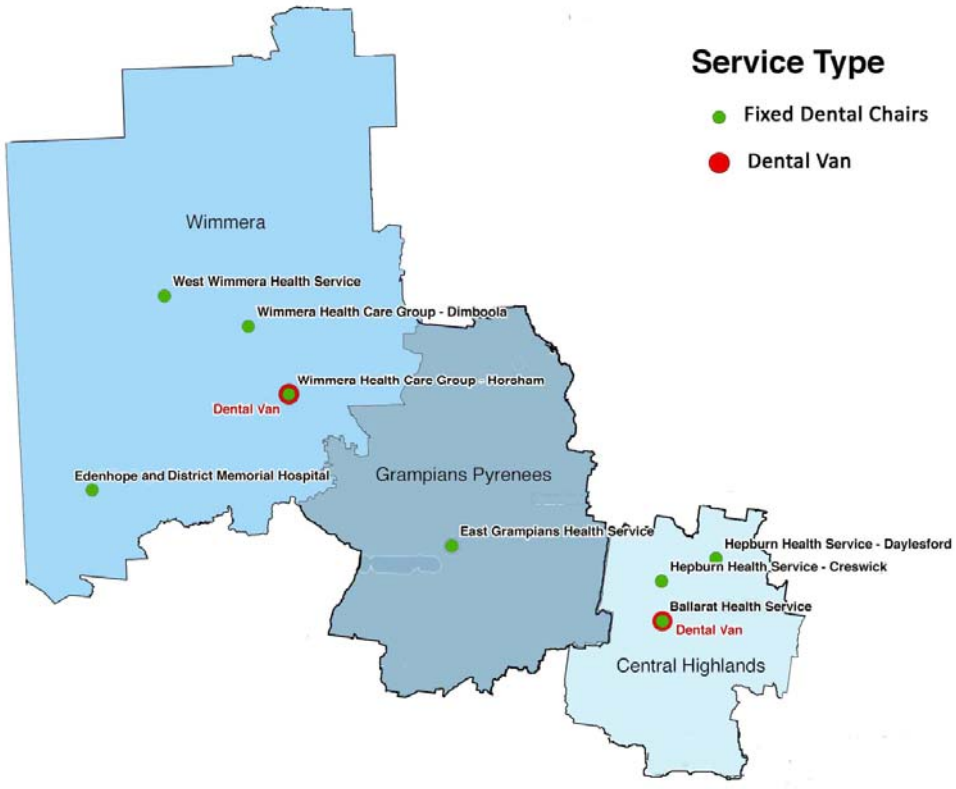
This section analyses the current service capacity, utilisation and expected demand for oral health services in the Grampians Region. This has been analysed on a sub regional basis.

4.5.1 Service capacity and access

The history of the allocation of public dental chairs is unclear, however, going forward the allocation of community dental services will be based on the planning parameters defined in *Improving Victoria's oral health* and expected population growth.

The location of public dental services in the Grampians Region is depicted in Figure 5 below.

Figure 5: Public chair locations per planning catchment



Eligible population per chair

The tables below demonstrate the current infrastructure and eligible population[10] in Grampians Region. The geographic units of analysis are the three IAPs in the sub region.

In relation to eligible populations there are variations in the data sets used (Department of Health, Dental Health Services Victoria, Centrelink and ABS Census).

For the purposes of more detailed analysis at LGA level, the postcode data provided by the Department of Health Grampians Regional office will be used. This project acknowledges that no data sets for eligible population include the number of eligible youth.

In the population data there are approximately 31,000 persons in the Grampians Region in the age groups 10-14 and 15 – 19 years.

Table 4: Eligible population per chair Central Highlands IAP

LGA	2006 Population	Chairs	Eligible population	Eligible population % of total population	Eligible population per chair
Ballarat	88,437	11[11]	36,591	41%	3,326
Golden Plains	17,077		5730	33%	N/A
Hepburn	14,235	2	6521	46%	3260
Moorabool	26,445		8552	32%	N/A
Total		**13**	**57,394***		**4415**

* Note that *Improving Victoria's oral health* indicates an eligible population for the Central Highlands IAP of 60,959.

While Ballarat Health Services (BHS) currently has ten fixed chairs, two are operating as a satellite service at Yuille Park Community College. The remaining eight chairs are co-located at the main health precinct of BHS in Drummond Street, Ballarat. Due to infrastructure difficulties two of the chairs are restricted for use with children only and one chair is used for prosthetics only. A one-chair mobile van allocated to BHS is operational intermittently. Both chairs within the Hepburn LGA are single site chairs sites managed by Hepburn Health Service (HHS).

Table 5: Eligible population per chair Wimmera IAP

LGA	2006 Population	Chairs	Eligible population	Eligible population % of total population	Eligible population per chair
Hindmarsh	6,235	1	2,591	41%	2,591
Horsham	19,098	4	7,577	40%	1,894
West Wimmera	4,614	3	1,751	38%	583
Yarriambiack	7,742		2,920	38%	N/A
Total			**14,846***		**2120**

10 Eligible population includes adults and children – there is a gap in the number of eligible teenagers where data is not available.

11 Includes the dental van

* Note that *Improving Victoria's oral health* indicates an eligible population for the Wimmera IAP of 16,163

Wimmera Health Care Group (WHCG) is responsible for a total of five chairs. There is a three-chair clinic in the main health precinct (Horsham LGA), a new dental van with a single chair and a single chair at Dimboola (Hindmarsh LGA).

West Wimmera Health Service (WWHS) has a two-chair clinic at Nhill (West Wimmera LGA). In addition they have two Commonwealth funded chairs – one in Kaniva and one in Rainbow. There is funding for an additional Commonwealth chair at Goroke that has yet to be built.

Edenhope & District Memorial Hospital (EDMH) has a single chair (West Wimmera LGA).

Table 6: Eligible population per chair Grampians Pyrenees IAP

LGA	2006 Population	Chairs	Eligible population	Eligible population % of total population	Eligible population per chair
Ararat	11,653	4	5,576	49%	1,394
Northern Grampians	12,330		5,871	47%	N/A
Pyrenees	6,772		5,117	75%	N/A
Total			**16,564**		**16,564**

* Note that *Improving Victoria's oral health* indicates an eligible population for the Grampians Pyrenees IAP of 14,018.

East Grampians Health Service (EGHS) has a four-chair clinic (Ararat LGA) which opened in August 2010. There are no chairs in the Northern Grampians LGA and restorative dental services are provided to this population through a brokered voucher system. The population of the Northern Grampians and Pyrenees LGAs is unable to access dental services locally and even with vouchers must travel to other locations which may include Maryborough, Ararat or Ballarat.

Forecast eligible population

The forecast eligible population is based on the eligible population. There are no planning benchmarks for dental services that consider factors such as percentage of eligible population who choose to use private services or flow out of region, hence forecasting of the eligible population is based on the current percentage of eligible population within total population.

Table 7:Forecast eligible population

LGA	2006 Population	Chairs	Eligible population	Eligible population % of total population	Eligible population per chair
Central Highlands					
Ballarat	118,752	10	41%	48,688	5576
Golden Plains	24,378		33%	8,045	N/A
Hepburn	17,159	2	46%	7,893	3,947
Moorabool	34,710		32%	11,107	N/A
Total	**194,999**	**12**[12]		**75,733**	**6.311**
Wimmera					
Hindmarsh	5,124	1	41%	2,100	2,100
Horsham	20,829	4	40%	8332	2083
West Wimmera	3,474	3	38%	1320	440
Yarriambiack	6,310		38%	2,398	N/A
Total	**35,737**	**8**		**14,150**	**1,769**
Grampians Pyrenees					
Ararat	12,178	4[13]	49%	5,967	1,492
Northern Grampians	10,980		47%	5,160	N/A
Pyrenees	7,982		75%	5,986	N/A
Total	**31,140**	**4**		**17,113**	**4,278**

Key messages

The available eligible population data does not include specific data for eligible youth as this is unavailable. Planning should therefore consider that the numbers forecast may be short of the true eligible population figures. It is apparent that this will have more impact in the Central Grampians as this is where there will be overall population growth in all age groups.

Waitlists management for adults

Wait lists have been one of the indicators used in relation to access to public dental services for adults. Wait lists consist of two main elements, the wait time and the number of people waiting. Wait lists are divided between general dental care and denture care. Historically the direct service providers of public dental services have managed wait lists individually, therefore wait lists do not represent how many persons in any LGA are waiting for a service but rather how many persons are waiting at an individual agency for treatment cycle.

12 Based on planned developments

13 Based on introduction of a four chair clinic

The following tables represent snapshots of wait list data from June 2009 – April 2010[14].

Table 8: Consolidated wait list data

Agency	General dental wait list June 2009		General dental wait list April 2010		Denture wait list June 2009		Denture wait list June 2010	
	No.	Time (mths)	No.	Time (mths)	No.	Time (mths)	No.	Time (mths)
Central Highlands								
BHS	3258	52	3432	32	463	20.9	330	20
HHS Creswick	199	23	92	11	84	39.8	40	23
HHS Daylesford	492	34.8	339	20	93	36.3	17	6
Wimmera								
WHCG Horsham and Dimboola	1049	26	1252	30	220	18.8	184	16
WWHS	285	30	308	28	2	1.3	2	0
EDMH	43	2.1	7	2	4	10.3	5	9
Grampians Pyrenees								
EGHS	816	20	846	25	92	17.5	90	14
EWHS St Arnaud[15]	49	12	48	15	58	11.3	43	16

As in other regions of Victoria there are extreme variations in wait time for a public oral health service in the Grampians Region. Despite significant work being undertaken in the 12 months through to June 2010, access to restorative oral health services in the Grampians Region still has an unacceptable wait time. There are variations in the waiting time for people living in the same IAP, for example, within the Central Highlands IAP the waiting time in Ballarat is 32 months and in Creswick 11 months.

Key messages

Wait list management across the region will continue to remain one of the key priority areas for the region. Priority IAPs for increases in resources and management of wait lists are Grampians Pyrenees and Central Highlands.

Recall for eligible children

Until the integration of the School Dental Program and the Community Dental Program, Dental Health Services Victoria was responsible for the child dental program, with school dental services often located separately to the local public oral health service provider. The recall program was undertaken on an annual basis based on the assessment of eligible children. As responsibility for management of the School Dental Program has passed to local providers, it is now incumbent on these entities to provide this service locally.

Integration has been largely successful across the Grampians Region with three exceptions. Hepburn Health Services has chosen to relinquish this role to Ballarat Health Service due to concerns over the impact of increased numbers on their waiting list. Neither Edenhope & District Memorial Hospital nor East Wimmera Health Service provides this service as they work through private dentists or vouchers.

14 Wait list data is routinely reported to DHSV – data provided for this analysis by DHSV

15 Note that East Wimmera does not have any dental chairs and operates through voucher service

Demand for service versus eligible population

The wait list only indicates the number of people who want to access public oral health services. There is a significant gap between the eligible population and the wait list numbers. As in all health streams the inability to 'manage' current demand means that people who do not present for service are often forgotten.

Table 9: Demand for services versus eligible population

Agency	Eligible Adults	Eligible Children	Number on Wait List
Central Grampians	36,917	20,478	3,949
Wimmera	9,419	5,426	865
Grampians Pyrenees	11,099	5464	1,377

However the strong links between good oral health and good general health, in addition to ambulatory care sensitive hospital admissions and oral health prevention and early intervention, mean that access to services is a priority. Such services may not necessarily be restorative in nature but involve early intervention and prevention principles.

4.5.2 Self sufficiency and utilisation

Analysis of self-sufficiency levels for dental services is summarised in Table 10.

Table 10: Self-sufficiency for adult restorative care within IAP in Grampians Region.

People's place of residence	Location of health service				Self-sufficiency within IAP	Self sufficiency within region
	Within IAP	Within Grampians	Outside Grampians	Total	%	%
Central Highlands						
Ballarat	6034	30	62	6126	98%	99%
Golden Plains	76	1	405	482	16%	16%
Hepburn	1227	0	53	1280	96%	96%
Moorabool	617	1	350	967	64%	64%
Wimmera						
Horsham	1474	17	8	1499	98%	99%
Hindmarsh	551	4	6	561	98%	99%
West Wimmera	273	3	59	335	81%	82%
Yarriambiack	398	11	106	515	77%	79%
Grampians Pyrenees						
Ararat	750	94	5	849	88%	99%
Northern Grampians	389	108	5	502	79%	99%
Pyrenees	106	231	1317	1654	6%	20%

Analysis of utilisation patterns

This section describes dental service utilisation by adults in the Grampians Region.

The utilisation rate of chairs is defined as the propensity of the eligible population to receive treatment in a public dental chair. The utilisation of dental services is best measured using the current hours of operation at each service compared to the available time (based on actual operational days and hours of operation for each chair) and working on an average time for a treatment. Utilisation may be considered a crude measure by some due to limiting factors such as:

- Location of chairs in relation to the eligible population.
- Ability to operate the chair full time is often limited by the availability of the oral health workforce.
- Availability of diverse oral health workforce that enables effective productivity of the chair.
- Amount of private work being undertaken in a public chair; private clinicians can put unnecessary restrictions on the productivity of the chair.

It is nevertheless, useful information, as it identifies capacity and priority areas to increase throughput given optimal conditions.

Current utilisation

Table 11 looks at the utilisation by sub region in the Grampians Region. Key assumptions for this data set include: 1) a dental visit will assume two visits per treatment cycle and 2) an average length of visit will be 40 minutes.

Table 11: Agency utilisation based on actual hours of current operation[16]

Agency	No. of people treated	Visits	Avail - able chairs	Visits per chair	Total minutes required per chair	Total hours required per chair	Days required for service	Available days	No. of operational days	Utilisation %
Central Highlands										
BHS	7363	14,726	8	1841	73,630	1,227	189	246	5	77%
HHS Creswick	436	872	1	872	34,880	581	89	246	5	36%
HHS Daylesford	774	1548	1	1548	61,920	1032	159	246	5	65%
Wimmera										
WHCG Horsham & Dimboola	2424	4848	4	1212	48480	808	115	246	5	47%
WWHS	519	1038	2	519	20,760	346	63	197	4	32%
EDMH	109	218	1	218	8720	145	22	50	1	45%
Grampians Pyrenees										
EGHS	1216	2432	1	2432	97,280	1621	232	246	5	94%
EWHS*	122	244	0	N/A						

* EWHS manages its eligible population via voucher system.

With the exception of EGHS, current utilisation at each site is less than 77%. These utilisation rates identify potential in the system for increasing throughput without changes to current infrastructure and workforce. Variability in productivity was an issue identified during the consultations.

16 Hours of operation are 6.5 hours per day with the exception of WHCG (7 hrs), WWHS (5.5Hrs), EGHS (7 hours), EDMH not defined at consultation assumed at 6.5 in utilisation

Utilisation modelling

Marginal changes in the assumptions for utilisation, that is, increases in days of operation or increased hours of operation, will change the percentage of opportunities for utilisation. Where sensitivity affects available days or utilisation this is marked in red in Tables 12 and 13.

Table 12: Potential utilisation based on 5 – 5.5 days a week operation[17]

Agency	No. of people treated	Visits	Avail - able chairs	Visits per chair	Total minutes required per chair r	Total hours required per chair	Days required for service	Available days	Utilisation %
Central Highlands									
BHS	7363	14,726	8	1841	73,630	1,227	189	267	71%
HHS Creswick	436	872	1	872	34,880	581	89	246	36%
HHS Daylesford	774	1548	1	1548	61,920	1032	159	246	65%
Wimmera									
WHCG Horsham & Dimboola	2424	4848	4	1212	48480	808	124	267	43%
WWHS	519	1038	2	519	20,760	346	53	246	26%
EDMH	109	218	1	218	8720	145	22	246	9%
Grampians Pyrenees									
EGHS	1216	2432	1	2432	97,280	1621	232	246	94%
EWHS*	122	244	0	N/A	N/A	N/A	N/A	N/A	N/A

* EWHS manages it eligible population via voucher system – all persons travel out of town for service.

Even where services do not operate each day 'the capacity' has been determined for potential utilisation.

17 Assumption for utilisation – visits assumed to be 2 per treatment cycle, actual hours of operation, assuming chair operational 5 or 5.5 days per week days per week (BHS and WHCG are assumed operate 5.5 days per week)

Table 13: Potential utilisation based on 5–5.5 days a week operation in addition to increased hours[18]

Agency	No. of people treated	Visits	Avail - able chairs	Visits per chair	Total minutes required per chair	Total hours required per chair	Days required for service	Available days	Utilisation %
Central Highlands									
BHS	7363	14,726	8	1841	73,630	1,227	164	267	61%
HHS– Creswick	436	872	1	872	34,880	581	78	246	32%
HHS Daylesford	774	1548	1	1548	61,920	1032	159	246	56%
Wimmera									
WHCG Horsham & Dimboola	2424	4848	4	1212	48480	808	108	267	40%
WWHS	519	1038	2	519	20,760	346	46	246	19%
EDMH	109	218	1	218	8720	145	19	246	8%
Grampians Pyrenees									
EGHS	1216	2432	1	2432	97,280	1621	216	246	88%
EWHS*	122	244	0	N/A					

* EWHS manages it eligible population via voucher system – all persons travel out of time for service

Key messages

Utilisation rates are extremely sensitive to change. Even a small increase in the productive hours will have the direct effect of creating capacity and throughput. Potential utilisation identifies the capacity of the current system to undertake additional work should flexible workforce arrangements be created.

18 Assumption for Utilisation – OOS assumed to be 2 per treatment cycle, assuming chair operational 5 or 5.5 days per week days per week (BHS and WHCG are assumed operate 5.5 days per week), all health services increase to 7.5 hours per day

4.6 Summary of data analysis

Table 14: Summary of data analysis

Issue	Central Grampians	Grampians Pyrenees	Wimmera	Implications
Population distribution (age) / forecast	Population increased in all age groups forecast	Population increase forecast for aged persons only	Population increase forecast for aged persons only	• Priority to develop model of care for aged persons in all IAPs • Develop model of care for children and adults in Central Highlands
Self sufficiency	Highly self sufficient	Highly self sufficient	Moderate self sufficiency	
Service capacity and demand (access)	High ratio of eligible population to chair across IAP	High ratio of eligible population to chair across IAP	Acceptable planning ratios per chair	• Priority for growth in chair numbers for Grampian Pyrenees and Central Highlands
Utilisation	Average utilisation <70%	High utilisation	Utilisation across the IAP < 50%	• Potential capacity in the system to increase productivity and reduce the wait list
Wait list	Average 25 months in IAP Remains higher at BHS	Remains two years for general dental	Areas of population density (Horsham) still has lengthy wait time	• Wait list management is a priority

5 Planning principles for oral health

Planning parameters for oral health services include:

- Planning will be based on the planning catchments described in *Care in your community* with a view to achieving self-sufficiency for community oral health services within these catchments.
- Services are planned with a planning ratio of one dental chair: 5,000 eligible population (includes one clinician plus assistant and support staff).
- Future services will be planned on a minimum of four chairs to enable cost efficiencies and facilitate recruitment of specialised staff. This arrangement will be supported by a larger district or regional service except in some rural areas where smaller clinics may be required to maintain accessibility.
- A greater proportion of resources will be directed to areas with larger eligible population numbers.
- Community dental chairs will be co-located with community health services; it is noted that these may be in local health services in rural areas.
- Planning will identify the services that can be safely and effectively delivered in the community setting and those which should be delivered in the more structured hospital setting.
- Where appropriate, services will be provided close to where people live or where they access services.
- Planning will promote access to services with co-location occurring in areas that are easy to access for the eligible population.
- Planning will deliver collaborative outcomes based on partnerships[19].

The following principles are proposed to guide the development of a service system for oral health services in the Grampians Region. They are based on known policy and funding guidelines, and service provision in other rural regions in Victoria.

These statements are not listed in order of priority as the service system should represent an effective balance of all.

- *No diminution in overall service levels*: while service configurations and service types may change, it is not intended to reduce the overall quality, capacity or resources of oral health services in the Grampians Region (reallocation of chairs between catchments will not be considered).
- *Best models of care*: options should be based on best models of care to achieve the goals of provision of oral health services, specialist assessment, care, treatment and prevention for the eligible population. This should occur in the most appropriate service setting for the individual consumer (mobile van, outreach, opportunities for interaction with private dental services, service models for Aboriginal chairs).
- *Best access*: consumers should have prompt access to appropriate services as close as practicable to their usual place of residence. The aim is to have one acceptable waiting time across the whole of the region for general oral health care regardless of where the client resides.
- *One philosophy of care throughout the region*: while the service system need not be standard across the region, all service providers should adopt a single guiding philosophy of care to guide planning and priority decisions.
- *Planning* will develop partnerships and service configurations that improve workforce capacity in all catchments. This will include services for Aboriginal, disabled and aged people and other groups with special interests.
- *No service will experience sustainability risks*: a new service model should improve the sustainability of individual services and the system as a whole.
- Planning will consider the already identified capital redevelopments at Ararat and Djerriwarrh.
- The use of Commonwealth funded infrastructure will be considered to manage wait lists and emergency oral health services where applicable.

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19 Improving Victoria's Oral Health, Department of Human Services, July 2007

6 Issues

This section identifies and examines the key issues that have arisen from the data analysis and the stakeholder consultations. Table 14 at the conclusion of section 4 summarised the key issues from the data analysis. In addition to this, the consultations and service mapping that occurred at each site (Appendix 4 provides an overview of each site) has enabled service gaps to be identified at an IAP level. This service gap analysis is the basis for the future development of oral health services in the Grampians Region.

6.1 Strategic leadership

One of the fundamental concerns for oral health services in the Grampians Region is that service planning has, to date, been ad hoc and based on the needs of individual agencies rather than taking a whole of region or sub regional planning approach. Under the current arrangement, individual service providers are responsible for all aspects of the delivery of oral health services. This arrangement has led to a mosaic of operational structures across health services in relation to access to services, workforce arrangements and governance. Adding to this complexity is how integration of the Community Dental Program and the School Dental Service has been managed at each site.

There is no clinical leadership, service coordination or planning across the whole of the region. Health services in the Wimmera have either undertaken, or are in the process of undertaking, planning for oral health services in isolation of a regional approach. Given planning parameters of 1:5000 it will be important for a whole of region approach to service planning and development.

The issue of strategic leadership was discussed during a workshop involving key stakeholders in the region. The participants identified merit in planning and working together rather than working independently, however no single agency emerged from the consultation process as a potential ‘lead’ for the region, and the general consensus was that the way forward would be best identified through the formation of a network to act in this stead. This suggestion is not totally in accord with the service system identified in *Improving Victoria’s oral health*, which looks to the development of three levels of agency – lead, district and local – to manage oral health in the region.

A number of models have been canvassed during this project. Table 15 is a summary of the suggested options that have been discussed with key oral health stakeholders. Each option is rated according to its acceptability by oral health stakeholders in addition to its potential to meet the requirements of strategic leadership for oral health services.

Table 15: Strategic Options for the Grampians region

Option	Description	Possible Consequences	Acceptability
Option 1 Status quo	No change to the current scenario is proposed. All services remain as currently available.	• Opportunities to establish new or improved oral health services for the Grampians Region may be lost • There would be little opportunity to attract more oral health staff to the region	√
Option 2 Principal agency model	One regional agency is selected to manage the future development of the Grampians Region Oral Health Strategy. The role of this agency would include provision of supporting services to agencies across the region	• Smaller agencies believe that they may be excluded from the decision making process • At this point in time no major agency is prepared to undertake this role • Training possibilities may be improved through establishment of a centre of excellence	√√
Option 3 Sub regional model	Two agencies are selected, geographically placed to cover the entire Grampians Region. Ideally these agencies would be large enough to provide support to all smaller agencies in the region	• These agencies may not have the necessary systems to support smaller agencies • Resources may not be available to ensure adequate spread across the region • Opportunity lost for regional planning and service coordination	√√
Option 4 Network model	All Grampians Region oral health providers participate in a network that provides an ongoing vehicle for development of services to the region. The network comprises senior agency representatives and clinicians who will lead strategic planning for integrated oral health services in the region. In the first phases of this process, DHSV would take a particular role involving responsibility for employment and management of a network coordinator. DHSV would provide support, supervision and leadership for this role until the network was well established and able to adopt responsibility	• All oral health providers in the Grampians Region would be represented (particularly important that all IAPs are represented) • The employment of a network coordinator would ensure ongoing sustainability of the network • The burden on any one agency would not be too onerous • Consensus agreement on all future activities could be gained through the consortium process • The strength of this format is that all agencies will contribute to strategic planning. The network will be collaborative and enable a regional approach to activities such as clinical practice, standards, credentialing and professional development. Within the model there will be a process to facilitate access to specialist oral health services based on the premise of regional support and equity of access.	√√√

Based on option 4 a model similar to the current Palliative Care Consortium in Grampians Region would be a possible blueprint. This would enable the participation of the private sector. It is proposed that the composition of a network body would include relevant government and education bodies in addition to service providers and practitioners.

Key areas where the network would take a coordinated approach to the management of oral health services in the region are:

- Development of uniform service standards and policies. Small health providers such as EDMH, WWHS and HHS would particularly benefit.
- Access to clinical leadership for clinicians; at present not all service providers have access to senior or permanent dental officers.
- Credentialing of dental officers; this is of particular concern where private dentists undertake public oral health work. EDMH and the clinic at WWHS are both serviced by private dentists undertaking public work. The terms and conditions of employment are different at each site.
- Progress of integration across all health services. Integration has led to a myriad of issues for service providers resulting in some services not being integrated as at June 2010.
- Planning new models of care and infrastructure development.
- Consolidated approach to management of wait times across the region or sub region.
- Take a lead role in the coordinating the efforts of the service providers involved in the provision of oral health care in the region, including education, communities, PCPs and health service providers. This would be undertaken in close accord with both DHSV and the Department of Health.

The network will require coordination and facilitation, and to that end this resource will be provided at the outset by DHSV in the form of a project manager.

Recommendation 1

Establish an oral health network in the Grampians Region to ensure a single entity is responsible for strategic leadership, service planning, service development and coordination.

6.2 Access

Access is the availability and use of current public oral health services by the eligible population. In general, factors that potentially inhibit the access to services are:

- Eligible persons do not live near a public oral health provider and are not able to travel.
- Limited awareness in the eligible population of the need to access oral health services and the links between oral health and general well being.
- Length of the wait list deterring persons from seeking treatment.
- Ability to offer care across the eligible population in a form that is able to be accessed by priority groups.

Implications for the Grampians Region

The policy direction is underpinned by the fundamental principle of equitable access to oral health services within planning parameters of one chair to 5000 eligible population with future planning of chairs based on growth of population.

Firstly we note that there is a significant gap between the number of eligible adults in the region and the numbers of persons on wait lists for treatment, even accounting for the fact that once a person has received a cycle of treatment it is twelve months until they are entitled to be placed on the wait list again. Table 9 indicates that at any given time 90% of the population are not ‘in’ the system. While we may not fully appreciate how this issue can be appropriately addressed it must be considered in terms of improvements in prevention and early intervention initiatives across the region. The link between poor oral health and poor general health is not contested.

Secondly, there are extreme variations across the IAPs in eligible population versus chair numbers. Planning parameters are set at 1:5000, however the rural and remote access issues must temper this measure across the three IAPs in the Grampians Region.

Current eligible population versus chair numbers is approximately 1:2100 in the Wimmera IAP and forecasted to drop to about 1:1800 by 2026. With additional chairs in the new clinic in Grampians

Pyrenees the ratio is 1:4141. Eligible population projections for the Grampians Pyrenees indicate only a slight growth through to 2026.

Central Highlands IAP has an overall eligible population per chair ratio of 1: 4783. Population projections indicate that this figure will reduce to 1: 6311 by 2026 if there are no additional resources for the IAP.

Given the overall picture of access to chairs in the region, and given population projections through to 2026, the priority area to be addressed (should any capital funding be available after development of the four chair clinic at Ararat in the Grampians Pyrenees IAP) would be Central Grampians IAP.

The data analysis indicates that although there is a high level of self-sufficiency in some LGAs (Ballarat, Hepburn, Horsham, Hindmarsh, Ararat and Northern Grampians), the self-sufficiency directly relates to local chair access. In the LGAs of Pyrenees and Golden Plains there is patient flow out of the region to Maryborough and Barwon Health. In addition, residents of the Moorabool LGA seek services in Loddon Mallee, Sunbury and outer metropolitan Melbourne.

Another access issue for the region is centred on wait list and wait list management. While there has been significant reduction in waiting times for the region in the last two years (see Table 8) there are still significant differences in both the general and denture wait times between planning catchments.

While there is no intention that Grampians will have a regional wait list, it is anticipated that uniform wait list management will maximise efficiencies and increase productivity within the system. Grampians must aim for a regional wait time of no more than 24 months for general dental and prosthetic care. Sites should not be disadvantaged if they achieve wait times better than this, however any available additional resources should be directed to the agencies who have wait times in excess of this as a priority in order to uniformly improve access across all IAPs. Apart from improved operational initiatives, additional resources may include limited access to private oral health providers as a short-term initiative to reduce wait lists and increased access to a public oral health workforce through increased hours of operation or use of a mobile oral health team.

Access to services by priority groups has not been a priority in the region to date. Although there is a high level of commitment to provide oral health services to the Aboriginal population there has not been a coordinated response to provide services. The approach must now be coordinated within policy direction to ensure priority access to services is facilitated.

Recommendation 2

Focus on equity of access across the three IAPs in the Grampians Region, and within two years achieve an acceptable regional wait time of no more than 24 months for both general and prosthetic care.

6.3 Efficiency and effectiveness

The length of time a person waits for a service and the responsiveness of the service providers in the provision of care are measures of efficiency and quality. In oral health care this is not only reflected by the wait list but by the daily management of services to ensure maximum productivity and utilisation.

There are a variety of factors that influence efficiency of a service:

- Ability to maximise utilisation of chairs. Single chair sites with a part-time workforce often have the capacity to increase productivity but limited resources to do so.
- Variability in the productivity level of clinicians. Not all clinicians want, or are able to operate at a the same level. In areas where private dentists operate from public chairs the health service would rather maintain a service than risk losing the service, so expectations of service delivery parameters may never be discussed.
- There is no standardised approach to the management of day-to-day operational issues across oral health services. Issues that might benefit from regional discussion and common approaches are:

  – Emergency care and triage (not all services are able to provide an emergency dental service).

  - Management of ‘no shows’ or ‘fail to attend’. The keeping of detailed records allows services to monitor the number of clients who routinely fail to attend for a planned appointment. Proactive planning can result in this capacity being utilised on a regular basis.
  - Management of workforce including acceptable times for set-up and meal breaks.
  - Use of vouchers or private dental clinicians.
- The effectiveness of the transition to an integrated service model.

Implications for the Grampians Region

The priority for Grampians Region is firstly to maximise the utilisation of the current chairs and secondly to increase productivity. Not all strategies will require increased resources (workforce and funding) as even slight increases in productivity will create capacity and impact directly on the ability to better manage wait lists.

Increasing capacity within current resource allocation includes:

- Better understanding how chair utilisation is affected by the productivity of individual clinicians. Across the region, managers indicated that there is extreme variability in the productive hours of individual clinicians. Inexperienced junior clinicians, salaried staff with no motive to increase throughput, the influence of work ethics and difficulties in managing private clinicians can impact on chair utilisation. While it may not be possible to control private clinicians, the provision of support and mentoring for inexperienced clinicians will be beneficial.
- Maximising clinical hours of operation. There are no standards for set up times or breaks during the day. Clinical hours of operation (hours when a patient is actually being treated) across the region vary for example WWHS operates 5.5 hours per day while EGHS operates at seven hours a day. There is enormous potential in the region to increase throughput by standardising and reducing non-productive hours.
- Improved day to day management of the clinic, ‘no shows’ and emergency cases. Not all sites have a strategy that effectively manages ‘no shows’; initiatives such as a limited wait list of people who would be available at short notice would be an effective strategy. Not all sites (for example, EDMH) have the ability to manage emergency cases in a timely way as the private clinician does not work each day at Edenhope.

Increasing capacity requiring additional resources includes:

- Correcting deficiencies in infrastructure that limits the use of individual chairs, for example BHS has a two-chair surgery that is unable to be used for adults. While not an immediate priority it would enable flexible use of the infrastructure.
- Increasing hours of operation to include evening or weekend clinics or slightly extending daily hours of operation (must be able to manage one additional appointment). HHS already operate an evening session at Daylesford and BHS has identified the potential to operate a weekend service.
- Where sites do not operate over five days there is an opportunity for preventative oral health to be undertaken, particularly with the use of dental therapists.

There has been a positive response to the process of integration in the Grampians Region, with the majority of agencies having successfully transitioned through the process. HHS have indicated that as a small provider with single chair sites they are concerned about the increased demand on their service if they adopt the integrated model, and at this stage have chosen not to integrate. This has occurred at EGHS where, with a single chair operating at near capacity, they are having difficulties managing the additional throughput that the integrated service model has produced. At present EMDH does not provide an integrated service model. The involvement of a private dentist in this model who is not inclined to provide care for children is problematic, and at present all children travel from Horsham to either Nhill or Edenhope to obtain a service.

Recommendation 3

Create an efficient and effective oral health service across all IAPs firstly by creating capacity and secondly by increasing productivity.

6.4 Models of care

While there is a vision for oral health service delivery through DHSV and the Department of Health, this has not translated into a strategy for how different models will interface and how they will work together to provide equitable access to public oral health services for the eligible population.

Models of care should be developed and introduced in a planned and structured way with consideration given to the different types of care to be provided – general, emergency, denture and specialist. They also need to address the priority access groups identified by policy and the special needs groups who have been identified in this report.

The main objectives for the introduction of new and innovative models must be to improve access to the eligible population, be available locally where possible, effectively utilise the available workforce, improve capacity at each site and reduce wait times across the entire region while not reducing services within any planning catchment. Models should be developed or expanded within existing resources or where resources can be developed to support them. The model of care should be identified and the workforce built around the model. It should be possible to move resources from an area of limited demand to an area of high demand (wait list, high eligible population and special needs groups) within firstly the planning catchment and then the region.

The consultation process was an opportunity for the stakeholders to discuss the limitations of the current service models within the region. While there may not have been consensus on all models there was some mutual acknowledgement of the limitations and benefits of some of the models.

A more detailed description of models of care is available in section 3.4.

Implications for the Grampians Region

6.4.1 Fixed chair model

The fixed chair model is the only model currently working in each IAP in the region. As discussed in section 6.3, the issues for this model relate to productivity at individual sites. The positive aspect of this model is the potential for consolidation of services at one location, particularly where there is a critical mass of chairs, enabling the development of an interdisciplinary workforce for dental services. Critical mass enables mentoring and supervision of junior staff as evidenced at BHS. Single chair sites often have limitations in being able to sustain the workforce and difficulties in providing clinical supervision and support from peers. Where fixed chairs are underutilised, because of resource or demand issues, the physical resource cannot be relocated to areas of greater demand. EDMH only operates its chair one day a week and indicates that additional time is not required. On a positive note it was also identified that single chair services have the benefit of being able to integrate well with other services such as maternal and child health and podiatry.

6.4.2 Mobile model

There are differing perceptions of what constitutes a mobile dental service, with most of the workforce in the region reluctant to support the mobile van model. The concept of an outreach team travelling to a site or transporting people to an available chair was not at the forefront when mobile services were discussed. The poor perception of the current mobile service will mean that introduction of this model into the region will require further consultation and negotiation with the current workforce in the region. Two of the three IAPs have a mobile van, but they are either not in use or have no schedule for outreach visiting.

Limitations for this model include:

- The site requirements of the mobile van place limitations on the placement of the vehicle when it goes on the road. These difficulties have never been articulated to service providers and Beaufort & Skipton Health Service have indicated that they would be happy to ensure that these facilities were available if the dental van was scheduled for visits to Beaufort and Skipton.
- Travel and set up time increases the non-productive time of the workforce. Having a schedule that included a limited number of moves over the year would address some of these concerns.
- Security of the dental workforce when on the road. Providing a site close to current health facilities, whether a hospital or community health centre, could ensure this concern is easily overcome.

Universally the concept of having a roving dental team providing services either in Commonwealth chairs or in underutilised public chairs is an option that would require significant further consultation. Again issues around non-productive time and the availability of a willing workforce were raised as potential limitations during consultations.

6.4.3 Brokerage systems

Brokerage systems using vouchers from the Victorian Dental Scheme authorities are working well for some services in the region. Vouchers may take the form of general, denture or emergency vouchers and be provided when the local public oral health service is unable to provide care. Dental care is provided by private clinicians, who identify that they are willing to participate in the scheme, with vouchers lasting 28 days (emergency care) and six months (general and denture care). St Arnaud has not had dental infrastructure for some time and utilises a general voucher system.

Conversely some agencies report there can be difficulties securing the services of private dentists willing to be part of this system. Other issues identified with this model include a lack of quality control over the services being provided, credentialing of participating dentists and the monitoring of vouchers, with reports that up to 30% of vouchers may not be used.

In the Grampians Region EDMH and WWHS operate totally on a voucher system from their own public chair with visiting private dentists providing the service at these sites.

6.4.4 Models of care for high needs groups

The *National oral health plan* identified a number of groups within the community who have poor access to dental care and whose health status is below the rest of the community, thus increasing their propensity for oral health disease. The public dental service in Victoria is highly targeted towards these groups and the development of any models of care must consider these marginalised groups. In general the Grampians Region does not target care for marginalised groups.

6.4.4.1 Aboriginal groups

On average Aboriginal Australians have twice the rate of dental decay and a greater proportion of dental caries in children, more missing teeth in adults and generally poorer periodontal health[20]. A 2004 review of access to oral health services for Koori people concluded that dental services for Aboriginal people in Victoria are inadequate. It was concluded that there should be more partnering arrangements and priority access to community dental clinics for the Aboriginal population.

Although there is a high level of commitment to provide oral health services to the Aboriginal population in the Grampians Region, to date there has not been a coordinated response to provide services. Most agencies note that there are few Aboriginal clients seen.

A business plan has been developed to establish a dental chair at Ballarat & District Aboriginal Co-operative (BADAC) to target the aboriginal population; this approach must be coordinated within policy direction and work in collaboration with other oral health initiatives. A planned workforce approach to the

20 Improving Victoria's oral health, Department of Human Services, July 2007

funding and staffing of this chair must also be considered within the wider context of oral health care in the region.

Despite having a Koori liaison officer at WHCG there is a considerable 'no show' rate at this service for the Aboriginal population. This should be a priority area for the Grampians Region.

6.4.4.2 Care for the ageing population and residential aged care

Elderly patients within residential aged care facilities are an at-risk group in terms of oral health. More residents still have their existing teeth and so greater emphasis needs to be placed on providing adequate oral health support, particularly by carers within the sector. This is recognised as an area that needs improvement even though it is one of the mandatory residential care standards.

There have been a number of initiatives based on the development of an Oral Health Assessment Tool implemented across the state, which are reported to have had a significant impact in terms of identification and treatment of residents with oral health problems. Some agencies have gone on to develop close working relationships with public dental services and have brokered the services of a dental team to visit the residential aged care facility to perform restorative care.

For the elderly there is a clear link between poor oral health (ill-fitting dentures, tooth ache) and the ability of the residents to eat and therefore maintain good overall health. Although two agencies in the Grampians report they have conducted successful programs for residential care residents in which staff undertook basic assessments and made referrals as required, there is no formal program or formal assessment tool.

The implementation of such a tool in aged care facilities in the Grampians Region, as well as other oral health-related capacity building activities for carers, could potentially provide significant benefit to oral health amongst the elderly, and particularly so given the ever increasing numbers of the population moving into the older aged group demographic. An alternative to this type of program is a visiting domiciliary dental care program to undertake dental checks and restorative care. Such a program is currently run by DHSV for eligible metropolitan clients but is not available outside Melbourne.

As each of the IAPs has a forecast increase in the ageing population there must be capacity for an aged care model to be developed in each IAP.

6.4.4.3 People with special needs

The *National oral health plan* defines special needs in relation to oral health care as meaning persons who have intellectual or physical disabilities, medical or psychiatric conditions, which increase their risk of having oral health problems. It is anticipated that for these groups an outreach approach to care will be the most likely to be effective[21]. Such a service will need to be coordinated and integrated within the landscape of oral health services. Dental hygienists may be the best placed in the dental workforce to provide this service.

6.4.4.4 Culturally and linguistically diverse (CALD) people

CALD people are among the most disadvantaged groups in terms of being able to access public health services. Ballarat has been a key site for a recent Humanitarian Settlement Pilot with 12 Togolese families moving to the area over the past two years. It is thought that many of this group arrived in Ballarat with almost no dental issues, but the lack of understanding of a rapid change to their diet, access to fast foods and drinks with high amounts of sugar will ensure that this situation does not last. Future efforts and resources directed towards this group in terms of oral health promotion would be highly effective in terms of raising levels of oral health. In the event that families move to other regions, this will become an important part of oral health promotion in these regions.

21 Improving Victoria's oral health, Department of Human Services, July 2007

6.4.5 Distribution by age

There is no uniform distribution of the eligible population across age brackets in the Grampians Region. All three IAPs are forecast to have increases in the ageing population with only Central Highlands forecast to have growth in children and adults age groups through to 2026. Models of care for aged persons must be a priority for each IAP, with models of care for adults and children being priorities for Central Grampians.

Recommendation 4

Models of care to be developed to address identified areas of need across the IAPs

6.5 Workforce

The availability of a skilled oral health workforce is a key element in the provision of public oral health care. The workforce includes specialist dentists, dental therapists, dental hygienists, dental assistants, prosthetists and technicians. Historically the public sector has been unable to recruit and retain enough clinicians to maintain the oral health workforce with demand for services clearly greater than the availability of resources. In rural areas availability and access to a specialist workforce can often be limited. Key issues identified in a 1999[4] report were:

- Remuneration, with most public sector salaries lower than the private sector.
- Issues of re-entry and re-training.
- Inflexible work hours and arrangements.
- Poor access to continuing professional development.
- Poor career pathways.

Implications for the Grampians Region

Workforce recruitment and retention is an issue for all oral health agencies in the Grampians Region. There is currently no collaborative regional approach to recruitment and retention, continuing professional development or oral health workforce planning. This is an area of real opportunity in the region. Workforce discrepancies in the region include:

- Availability of dental clinicians across the region. Smaller health services are dependent on private dentists to provide the public service while larger providers employ public dentists. Private dentists provide the service in Wimmera at EDMH and WWHS.
- Dental therapists are not necessarily available at all sites. While all IAPs have access to some dental therapist time there are opportunities to increase utilisation by increasing the number of dental therapists in the region. EDMH has capacity but currently sends children to Nhill and Horsham for treatment. HHS has limited dental therapist time and currently is not an integrated service model. If utilisation could be improved there may be increased opportunities for a dental therapist. Additionally, WWHS has a non-operational fixed chair and access to other infrastructure, but the recruitment of dental clinicians has been problematic for the health service. A well supported dental therapist could provide a solution.
- Single site chairs often do not have a full-time workforce. The dentist at EDMH only operates from this site one day per week and while this is sufficient for local needs it means that infrastructure critical to service delivery is not fully utilised.
- There is not a coordinated approach to continuing professional development. Most sites report that their workforce must travel to either Ballarat or to Melbourne to receive training. This is not conducive to attracting or retaining staff in more remote areas.

[4] Victorian oral health services labour force planning report 1999

- There is virtually no access to specialist oral health services (endodontic, periodontal) in the Grampians Region, with data provided by DHSV indicating that the population either travels to the RDHM for services or does not access specialist dental services; the further from Melbourne a person resides the less likely they are to access specialist services at RDHM. *Improving Victoria's oral health* policy emphasises the need to provide access to specialist oral health services at a regional and sub regional level.

The development of outreach models using mobile vans, underutilised chairs or Commonwealth chairs, has not been favoured in Grampians Region.

While outreach models may address issues for areas that do not have immediate access to fixed chairs or to people with high needs, they are often considered problematic due to the amount of non-productive time used in travel and preparation. One solution to this would be to develop an outreach team who could;

- Provide care from one of the mobile vans in the region which would move on a designated timetable throughput the region. This could be particularly useful in Yarriambiack, Golden Plains and Pyrenees which have limited access to fixed chairs.
- Maximise the potential of current fixed chairs in the region.
- Provide the resources to provide a service in a Commonwealth chair.

There is potential for an increase in the levels of service provided by oral health workers other than dental clinicians. Oral health workforce shortages can be addressed to a considerable extent by a shift in the scope of work undertaken by practitioners such as dental therapists, as described above. Their scope of practice has been reviewed and extended to include adult practice, performing assessments for referral purposes, taking impressions and providing oral health promotion information. This shift in approach enables more effective utilisation of skills and expertise, thereby freeing clinicians to focus on more complex dental treatments. The provision of more autonomy and more interesting work is also an important factor in attracting and retaining an oral health workforce. The transition of a dental therapist to enable this advanced scope to be utilised requires support and mentoring. This can be difficult in isolated areas but provides opportunities.

The Grampians Region is committed to supporting local training opportunities to build its workforce. Opportunities for training and clinical placement within the Grampians Region are currently limited. Supervision arrangements required during clinical placement means that single chairs surgeries cannot be used for training by universities, however two chair facilities have a possible role in a mentoring model. The development of a 12-chair clinic at Melton, to be used by La Trobe University as a teaching facility, and the potential for teaching at the four-chair clinic proposed at Ararat, will greatly assist the Grampians to be more involved in training oral health staff closer to home.

Student chairs can affect the productivity of clinics. This is an area that requires ongoing discussion and engagement to ensure that the expectation of productivity is managed when chairs are used for teaching purposes. Latrobe University indicate that they are willing to work with the region to develop a robust dental workforce.

The challenges for ongoing professional development in rural practice are associated primarily with issues of access, including the time and cost of accessing appropriate programs, professional isolation, and the limited opportunities for undergraduates to gain experience. These issues are of considerable concern for clinicians at single chair sites who cannot be replaced, and for those who work in isolated areas where distance to relevant professional development is prohibitive.

It was recognised that there is also a need to encourage the involvement of other health professionals, particularly with regard to early intervention and prevention programs. There are already a number of initiatives aimed at building the capacity of health workers to provide incidental and opportunistic oral health education and referrals. Examples include the involvement of Maternal and Child Health Nurses in the provision of information to new mothers, La Trobe University's provision of oral health education resources for undergraduate nurses and interdisciplinary health professionals working with people who have mental health problems.

Such involvement needs to be encouraged through interaction with government, universities and service providers at the leadership level. Currently there appears to be a lack of awareness of such initiatives in both the oral and general health sectors, which diminishes up-take, effectiveness and impact.

Recommendation 5

The Oral Health Network establishes a collaborative regional approach to recruitment, retention and oral health workforce planning.

6.6 Health prevention and early intervention

6.6.1 Health promotion

Oral health promotion is one of the strategic priorities within *Improving Victoria's oral health* policy document. Oral disease is almost totally preventable and has been closely linked to general health, sharing common risk factors with chronic conditions such as heart disease and diabetes. Despite this, there is limited awareness in the general community of the importance of preventing oral disease. It is for these reasons that good health and reduced demand for oral health services are best addressed through a population health approach with a strong focus on early identification of oral disease and prevention strategies. The *National oral health plan* called for an integrated and cross sectional approach that would achieve improvements in both general and oral health.

It is anticipated that oral health promotion will form part of broader health promotion plans at agency, local, state and national levels. Providers of public dental services have a role and responsibility to be involved in the delivery of oral health promotion activities in their local catchments. Confusion exists as to the level of health promotion services expected to be provided by each agency; it is not necessarily the role of restorative agencies to provide the bulk of health promotion, but rather that each agency is one of a number of providers of oral health promotion services.

Implications for the Grampians Region

There are a number of providers of health promotion activities in the region but current oral health promotion efforts are seen as fragmented and uncoordinated. In addition, strong competition from other significant health areas such as mental health and chronic disease management has prevented oral health from maintaining its presence as a priority area for PCPs and other health promoting agencies.

Oral health promotion would benefit from a region wide approach engaging all stakeholders including PCPs, Department of Education and Early Childhood Development (DEECD), Dental Health Services Victoria, the Department of Health, providers of public dental services and local councils, in the development of common strategies, if not a common plan, that address oral health promotion in the region.

It was apparent during the consultation process that many of those involved in oral health promotion were operating in isolation.

DEECD has a role in health promotion in over 140 primary schools in the region, but has had limited contact from providers of public dental services in relation to oral health promotion, a role in which they are well placed to assist. Oral health promotion must have an integrated approach across all ages, addressing the wider impacts on oral disease of good nutrition, health living and healthy eating as part of the priority of preventing oral disease.

The limited acknowledgement of the achievements of oral health promotion activities such as Smiles4Miles is an issue. There is also considerable concern that funding for these programs may not be ongoing.

There are opportunities for technology to be utilised in oral health promotion. To date emphasis has been on the limited time the workforce has to provide these activities. The sector must look to learn from other industries, including those outside health, that have utilised technology to successfully disseminate information. In addition the wider community is changing and its use and reliance on technology is increasing as is its acceptability of this means of communication.

Common issues in oral health promotion in the Grampians are:

- Oral health service providers, although cognisant of the importance of oral health promotion, are currently caught in a treatment and restoration paradigm.
- Oral health promotion needs to be embedded in the day-to-day management of patients within the treatment and restoration dental model, with practitioners providing best practice oral health education chair side. While clinicians would believe it is difficult to channel already limited resources into health promotion, technology within waiting rooms could provide an avenue.
- The spread of current funding for health promotion activities across the region means that it is dispersed and has the propensity to provide multiple small resources rather than dedicated oral health promotion workers for the region.
- Dental related ACSC admissions remain high in this region. Strong health promotion activities will potentially impact on these admissions. Opportunities to monitor the admission of patients with dental related ACSC should be further explored.

6.6.2 Fluoridation

Water fluoridation helps protect teeth against decay and is the most effective way to allow universal access to the benefits of fluoride. Even though there is widespread use of fluoridated toothpaste, scientific studies have shown that water fluoridation is the safest and most effective way to reduce tooth decay. In Australia children living in optimally fluoridated areas experience considerably less tooth decay than those in areas without optimal fluoridation[22]. There are still unfluoridated areas within the Grampians Region. Fluoridation of water is a priority; community water fluoridation is safe and cost-effective and should be introduced and maintained where acceptable and feasible.

Discussions with Grampians Wimmera Mallee Water and Central Highlands Water Boards in late 2009 indicated that only Horsham in the Wimmera sub region, and Ballarat in the Central Highlands, are fluoridated. Ararat, which accounts for a significant proportion of the population in the Grampians Pyrenees sub region, remains un-fluoridated. Many of the water supply systems in the region have some low levels of natural fluoride, but this needs to be one part per million to be effective. Both water boards indicated that the drivers for further fluoridation in the region would come through Department of Health directives.

Recommendation 6

The Oral Health Network will adopt a regional, population health approach to the provision of oral health services, with strong focus on promoting oral health and on prevention and early identification of oral disease.

[22] Improving Victoria's oral health, Department of Health 2009

6.7 Summary of recommendations

Recommendations	Goals
1. Establish an oral health network in the Grampians Region to ensure a single entity is responsible for strategic leadership, service planning, development and coordination.	1.1. Diverse range of input into oral health services in Grampians Region 1.2. Single point of coordination through the Oral Health Network 1.3. Uniform processes across the region 1.4. Expectation that oral health clinicians meet recognised professional standards
2. Focus on equity of access across the three IAPs in the Grampians Region, and on achieving an acceptable regional wait time of 24 months for both general and prosthetic care within two years.	2.1. Acceptable regional wait time (24 months) 2.2. Reduce wait times uniformly within two years 2.3. Improve wait list management 2.4. Equitable access to infrastructure across the region 2.5. Increase capacity in Grampians Pyrenees 2.6. Improve access to prosthetic services across the region
3. Create an efficient and effective oral health service across all IAPs firstly by creating capacity and secondly by increasing productivity.	3.1. Maximise chair utilisation 3.2. Effective local management of clinics 3.3. Effective local management of clinicians
4. Models of care to be developed to address identified areas of need across the IAPs	4.1. The fixed chair model will remain the predominant model for restorative dental health services in the Grampians Region 4.2. Equitable access to services for aged persons in the region 4.3. Enhance capacity in locations that do not have fixed chairs 4.4. Recognise the importance of prevention and early intervention is in oral health care
5. The Oral Health Network to establish a collaborative regional approach to recruitment and retention and oral health workforce planning.	5.1. Access to an appropriate trained and skilled workforce (including specialist workforce) 5.2. Local peer support for clinical staff 5.3. Local mentoring and supervision for junior and inexperienced staff 5.4. Regional educational opportunities
6. The Oral Health Network will adopt a regional, population health approach to the provision of oral health services with strong focus on promoting oral health and on prevention and early identification of oral disease.	6.1. Oral health promotion is part of the core business of all health care services in Grampians Region 6.2. Integrated oral health promotion in the Grampians Region 6.3. Regional fluoridation 6.4. Reduced dental admission to acute care

7. Action plan

The action plan that follows addresses each of the priority recommendations with goals and actions.

Each of the goals is rated in terms of the following criteria:

- Importance or urgency
- Strategic versus operational focus
- Capability to implement
- Stakeholder support.

In addition, responsible parties are identified and timelines for action indicated.

A legend for the action plan symbols is provided below.

Importance/ urgency	Current capability to implement	
High Priority	√√	Fully capable
Medium Priority	√	Some capability
Low Priority	X	No or limited capacity at present / need considerable resource
	N/A	Not applicable

7.1 Grampians oral health action plan

Area of focus	1. Strategic leadership Recommendation 1. Establish an oral health network (OHN) in the Grampians Region to ensure a single entity is responsible for strategic leadership, service planning, development and coordination								
Goals	**Strategies / actions**	**Importance/ urgency**	**Strategic/ operational**	**Current capability to implement**			**Stakeholder support**	**Responsibility**	
				Workforce	**$**	**Infrastructure**			
1.1 Provide diverse range of input into oral health services in Grampians Region	• Develop an oral health network (OHN) that includes representatives from all public oral health providers • Encourage representation for other key stakeholders including private dentists, university partners, commonwealth partners and potentially SRHS	High priority	Strategic	√√	√	N/A	√√	All parties coordinated through DHSV with assistance from the Department of Health	
1.2 Single point of coordination for Network	• OHN to be responsible for the appointment of an OHN manager • DHSV to provide support and leadership for this role until the OHN is well established	High priority	Strategic	√√	√ √	√	√√	All parties coordinated through DHSV with assistance from the Department of Health	
1.3 Uniform processes across the region	• Identify clinical practice guidelines and job descriptions required across the region • Determine the process for the development, approval and implementation of uniform processes across the region. • Determine ratification and implementation process	Medium priority	Strategic	√	√	√	√√	OHN	
1.4 Expectation that oral health clinicians meet recognised professional standard	• Develop standardised credentialing for all providers of public oral health services in the Grampians Region	Medium priority	Strategic	√	√	√	√√	OHN	
In accordance with Victoria's *Improving oral health* the OHN will assume leadership and direction of oral health services in Grampians Region, and coordinate the implementation of the *Oral health action plan.* The OHN manager will be responsible for the implementation of the OHN priorities. This position will provide a conduit for communication for the OHN. DHSV will be a leading contributor to the OHN and will be responsible for funding the OHN manager role for at least the first year.									

Area of Focus	2. Access **Recommendation 2. Focus on equity of access across the three IAPs in the Grampians and on achieving an acceptable regional wait time of 24 months for both general and prosthetic care within two years.**								
Goal	Strategies / actions	Importance/ urgency	Strategic/ operational	Current capability to implement			Stakeholder support	Responsibility	
				Workforce	$	Infrastructure			
2.1 Acceptable regional wait time (two years)	• Confirm acceptable time by identifying against state-wide target • Develop annual plan prioritising areas with lengthy wait times • Re-evaluate target on an annual basis • Continue to explore factors that affect access to oral health services	High priority	Strategic	√	√	√	√√	OHN	
2.2 Reduce wait times uniformly within two years to an average of two years	• Temporary utilisation of private providers • Purchase resources from other sites where clinicians/ infrastructure are underutilised • Potential diversion of clients to other sites where clinicians/ infrastructure are underutilised • Diversion of public resources to areas of need • Extension of oral health delivery hours to increase utilisation • Develop a roving oral health team that can provide a public service in non-state funded chairs that are either not utilised or underutilised	High priority	Strategic	√	√	√	√√	OHN DHSV DH	
2.3. Improved wait list management	• Coordination of wait lists at sub regional or regional level • Day to day wait list management to be maintained at the district and local facility level and fed into regional planning processes	High priority	Operational	√	√	√	√√	OHN Oral health providers	
2.4. Equitable access to infrastructure across the	• Prioritise infrastructure redevelopment to meet planning	Medium	Strategic	X	X	N/A	√√	OHN	

region	parameters • Support Central Highlands as a priority area for development if growth funding is allocated • Plan for the gradual upgrade of all state funded oral health chairs to be determined within 12 months • Develop full inventory of chairs • Develop plan for future upgrades	priority						DHSV & DH	
2.5. Increase capacity in Grampians Pyrenees	• Install and commission the four-chair clinic as a priority • Ensure that the capacity of these chairs firstly manages demand in IAPs and then in Grampians Region	High priority	Strategic	√√	√√	√√	√√	EGHS OHN DHSV DH.	
2.6. Access to prosthetic services across the region	• Explore feasibility of increasing laboratory services at Ballarat Health Services • Identify the capital development required • Explore the possibilities of utilisation of West Wimmera Health Services' laboratory • Investigate possibilities for attracting staff • Determine if outreach possibilities from Melton would be more cost effective	High priority	Strategic	X	X	√	√√	Relevant agencies OHN DHSV.	

The goal of DHSV and DH is to ensure equitable access to services across the region. The goals for Grampians Region identified above are in accordance with this direction.

This plan tries to consider the issues of isolation and travel and with this in mind access has been approached from an IAP perspective.

There are already initiatives in place that support service provision across the region these are:

- A business plan to upgrade the oral health facility at Ararat has been negotiated with DHSV (the plan indicates support for the installation and commissioning of the clinic)
- Laboratory prosthetic facilities will be provided through the development of the facility at Melton, however facilities also exist at Ballarat and West Wimmera Health Service. West Wimmera's laboratory is currently non-operational due to staffing shortages. If the issue of resources were to be solved there would be benefits to have access at both ends of the region. Access to prosthetic services is a component of the waiting list for non-urgent oral health services.

Area of Focus	3. Efficiency and effectiveness Recommendation 3. Create an efficient and effective oral health service across all IAPs firstly by creating capacity and secondly by increasing productivity								
Goal	Strategies / actions	Importance/ urgency	Strategic/ operational	Current capability to implement			Stakeholder support	Responsibility	
				Workforce	$	Infrastructure			
3.1. Maximise chair utilisation	• Standardise productive operating times at fixed chair sites • Provide support and mentoring for inexperienced dental clinicians • Discuss potential for increased use of dental therapists with providers and universities, particularly at sites that are not operating full time • Identify potential capacity for additional work at public service providers (resources to realise capacity need to be identified) • This would include agreement on after hour service provision	High priority	Strategic	√	√	√	√√	OHN	
3.2. Effective local management of clinics	• Develop common practices across the region with respect to: o Triage management o Management of 'no shows' o Emergency treatment o Use of vouchers o Use of private oral health clinicians	High priority	Strategic	√	√	√	√√	Oral health service providers OHN DHSV	
3.3 Provision of an integrated Oral Health Service	• Identify changes required to support an integrated service delivery model • Provide mentoring and supervision for staff to enable a dental therapist to manage oral health treatments and restoration within their scope of practice • Investigate and develop teaching and/or supervision opportunities for all oral health staff • Explore opportunities for all health services to provide an integrated service model (HHS and ED&MH) and	High priority	Strategic	√	√	√	√√	Oral health service providers OHN Education & training providers	

	look at model that will enable children to receive some services locally								

Area of Focus	4. Models of Care Recommendation 4. Models of care to be developed to address identified areas of need across the IAPs								
Goal	Strategies / actions	Importance/ urgency	Strategic/ operational	Current capability to implement			Stakeholder support	Responsibility	Timeline
				Workforce	$	Infrastructure			
4.1. The fixed chair model will remain the predominant model for restorative dental health services in the Grampians Region	• Confirm and ensure continued regional provider acceptance of the current fixed chair model	Medium priority	Strategic	N/A	N/A	N/A	√√	OHN	
4.2. Equitable access to services for aged persons in the region	• Develop and implement a model whereby oral health services can be provided for residential aged care facilities and for people ageing in private homes • Establish a team approach to the management of this model involving o Dentists o Nurses o GPs o Other oral health workers • Develop and implement a sustainable education program based on work already undertaken in the area (Oral Health Assessment Toolkit)	Medium priority	Operational	X	√	N/A	√√	OHN	
4.3. Enhance capacity in locations that do not have fixed chairs	• Establish an outreach service in each planning catchment (this may be a mobile van or a roving team) • Ensure memorandums of understanding are developed between relevant parties • Ensure sustainability of current service provision is underpinning principle of any arrangement	Medium - high priority	Strategic	√	√	√	√√	OHN DHSV Private providers	

	• Hours of service will be agreed on collaboratively • Direct funding for outreach service will be provided to local or district providers • Develop a payment model for this service (common principles could apply across the region) • Ensure district and local providers are involved in the development of the model with the OHN • Target use of mobile van model to LGAs that have no access to fixed chairs • Consider use of dental therapist workforce in outreach model								
	• Continue to support brokerage models using this plan as a base • Identify all current brokerage models across the Grampians Region • Develop a standard brokerage model which address identified issues such as quality control and monitoring of utilisation • Establish standard methods of utilisation of vouchers by oral health providers across region • Develop a standard set of rules for voucher utilisation to which all parties agree	Medium priority	Operational	√	√	√	√√	OHN DHSV Private providers	

	• Engage private oral health practitioners in management of public oral health services • Discuss potential options through the conduit of OHN • Employ private dentists for defined periods of time to provide public oral health work with immediate impact on the public wait list • Contract sessions from private dentists for a defined period of time and then evaluate	Medium priority	Operational	√	√	N/A	√√	OHN DHSV	
4.4. Recognise the importance of prevention and early intervention is in oral health care	• Establish a preventative model of care (oral health hygienist) • Develop appropriate workforce resources • Negotiate the possible use of other chair types (e.g. podiatry chairs) with relevant agencies	Medium priority	Strategic	X	X	N/A	√√	OHN DHSV DH Relevant professional bodies.	
All models of care will be developed with access in mind. The development of an aged care model in each IAP will ensure that residential aged care facilities are compliant with Aged Care Standard 2.15, which states that oral health checks will be provided as part of the routine care of residents. Such a model will be based on the provision of oral hygiene checks within residential aged care facilities. While it might seem ambitious to aim for the introduction of the model in all facilities, the enormity of the task should not be a deterrent. An outreach service model will facilitate management of access and equity issues particularly in areas that do not have immediate access to a fixed chair. The rationale for the model would be to provide a timely service without adverse effect on utilisation and productivity of existing chairs. There are several models of outreach services: • Public oral health service rents chair and purchases staff time • Public oral health service rents chair time and provides staff to operate chair • Public oral health team provides service from a mobile van. In order to pursue outreach models of care involving mobile vans, permanent sites need to be appropriately configured (3 phase power, safety for staff) and a visiting schedule needs to be developed.								

Area of Focus	5. Workforce Recommendation 5. The Oral Health Network establishes a collaborative regional approach to recruitment and retention and oral health workforce planning.								
Goal	Strategies / Actions	Importance / urgency	Strategic/ operational	Current capability to implement			Stakeholder support	Responsibility	Timeline
				Workforce	$	Infrastructure			
5.1. Access to an appropriate trained and skilled workforce, including specialist workforce	• Develop and implement a workforce plan aligned to the statewide oral health workforce development strategy from DHSV • Determine resources required in each catchment (according to current chair capacity/utilisation) • Determine pool of resources currently available • Identify gaps in general oral health workforce • Determine mix required in each catchment with a balance between preventative and restorative care for general chairs • Identify workforce required to support training chairs in each catchment • Identify the workforce required to increase current service provision and create new models of care • Identify the specialist workforce required within the region (i.e. endodontist) including location and mechanism required to share this resource across the region. There should be specialist oral health provision at least regionally if not at a sub regional level • Identify opportunities to work constructively with private dentists to maximise opportunities to encourage new oral health staff to the region	High priority	Strategic	√	√	√√	√√	OHN Manager DHSV Relevant professional and educational bodies.	

5.2. Local peer support for clinical staff	• Develop a clinical network for oral health clinicians in Grampians Region (private and public clinicians) • Develop and implement a strategy to engage with both private and public oral health practitioners across the region • Develop professional development forums for all oral health staff • Engage with Australia Oral Health to develop a joint partnership approach	Medium priority	Strategic	√	√	N/A	√√	OHN DHSV DH Relevant professional bodies.	
5.3. Local mentoring and supervision for junior and inexperienced staff	• Adequate and appropriate supervision and mentoring should be available to ensure ongoing excellence of care and training for oral health staff • Identify and tailor training and supervision requirements for oral health staff	High priority	Strategic	√	√	N/A	√√	OHN DHSV DH Relevant professional and educational bodies	
5.4. Regional educational opportunities	• Collaborative partnerships with the La Trobe University to be further developed to address workforce issues • Clarify the potential to have dedicated training chairs supported in at least three agencies within the region o Djerriwarrh Health Service straddles Grampians and North West Metropolitan region o Ballarat Health Service o Potentially in the Wimmera • Investigate training opportunities at other district and local providers	Medium priority	Strategic	√	√	X	√√	OHN DHSV DH Relevant professional and educational bodies	

	• Collaborative partnerships have been undertaken with La Trobe University; regional education would benefit from further interaction.								
5.5. Culturally sensitive workforce in the region	• Support the development of an Aboriginal oral health workforce by providing opportunities for teaching and supervision • Identify demand and interest • Develop and implement a program of supervision, training and support	Low priority	Strategic	X	X	N/A	√	OHN DHSV DH Relevant professional and educational bodies.	

The workforce plan needs to be developed within the aims and priorities of DHSV's *Workforce capacity and development strategy* and consider the newly introduced *Statewide Aboriginal oral health plan* (DHSV) and needs to be based on the principles of:

1. Providing appropriate oral health professionals for existing services
2. Building self sufficiency within the region through development of the oral health workforce
3. Prioritising the areas with the longest waitlists with regard to recruitment
4. Consideration for a workforce that supports preventative oral health

The workforce plan will address gaps and issues as identified in this with regard to the following:

1. Establish models supported in each planning area.
2. Provide oral hygiene in residential aged care, homeless and younger persons in community with referral pathways established to restorative oral health care.
3. Hygienists to utilise dental and podiatry chairs available within planning catchments.
4. The mix of oral health staff should ensure both restorative and preventative oral health care can be delivered at each site and appropriate supervision and mentoring opportunities are available for staff.
5. It will be necessary to utilise the resources of both public and private oral health service providers in order to meet the current needs of the eligible population.

Area of Focus	6. Health Promotion Recommendation 6. The Oral Health Network will adopt a regional, population health approach to the provision of oral health services with strong focus on promoting oral health and on prevention and early identification of oral disease								
Goal	Strategies / actions	Importance/ urgency	Strategic/ operational	Current capability to implement			Stakeholder support	Responsibility	
				Workforce	$	Infrastructure			
6.1 Oral health promotion is part of the core business of all health care services in Grampians Region	• Actively increase the profile for Oral Health Promotion • Ensure oral health promotion is provided by restorative oral health teams during chair side treatments • Ensure oral health promotion becomes part of all acute health services' health promotion activities (OHN manager to engage with acute health services) • Work with PCPs and community health agencies to ensure oral health promotion forms an integral part of overall health promotion activities • Adopt the Commonwealth Teen Oral Health program to ensure it is available across the region • Encourage further provision of Smiles4Miles and Teeth and Tummy health promotion programs for children	High priority	Strategic	√	√	N/A	√√	OHN DHSV DH DEECD PCPs LGAs Relevant agencies	
6.2 Integrated oral health promotion in the Grampians Region	• Development of plan to be the responsibility of the OHN • Plan to link Grampians OHN with PCPs and community health • Work with local government to ensure all oral health promotion opportunities are maximised without duplication	High priority	Strategic	√	√	N/A	√√	OHN Manager	

	• Seek ongoing funding for health promotion roles from DHSV • Develop a business case for the ongoing funding of oral health promotion staff who will be located in generic health promotion teams but linked to oral health programs								
6.3 Regional fluoridation	• Support process for the completion of fluoridation across the Grampians Region.	High priority	Strategic	N/A	X	N/A	√	OHN DHSV DH	
6.4 Dental admission to acute care reduced	• Actively work with acute health teams to further reduce oral health related ACSC admissions to hospital • Develop relationship with acute health services to further investigate the causes of hospital admissions for ACSC • Incorporate this information into oral health promotion planning	High priority	Strategic	√	X	N/A	√√	OHN Manager	
Grampians Region has the highest rate of admission for dental decay in Victoria. Main cities such as Ballarat, Hamilton and Horsham are fluoridated but more work is required. Oral health promotion forms a part of most agency and PCP plans across the region through the inclusion 'appropriate nutrition' as an priority within agency integrated health promotion work. Many service providers see current oral health promotion efforts as fragmented and uncoordinated. Oral health promotion would benefit from a region wide approach which engages stakeholders from across the region. Oral health related admissions are one of the highest ACSC in the Grampians Region.									

8 Appendices

8.1 Appendix 1: Consultative Committee Membership

Name	Position
Mr Trevor Adem	Chief Executive Officer Beaufort & Skipton Health Service
Ms Melanie Albrecht	Operations Manager West Wimmera Health Service
Dr Jennifer Barke	Representative Australian Dental Association
Mr Robert Bulmer	Chief Executive Officer East Grampians Health Service
Mr Peter Daffy	Prosthetist Wimmera Health Care Group
Ms Sue Daly	Manager Service & Workforce Development Department of Health Grampians Region
Ms Maureen Gleeson	Manager Community Services Hepburn Health Services
Dr Meral Layik	Chief Dental Officer Wimmera Health Care Group
Mr Mike Morgan	Dental School University of Melbourne
Ms Judy Perkins	Program and Service Adviser Department of Health Grampians Region
Ms Judith Perrin	Manager Primary Health Department of Health Grampians Region
Dr Colin Riley	Manager Agency Relationships Dental Health Services Victoria
Mr Glenn Rowbotham	Chief Executive Officer Ballan & District Hospital
Ms Mandi Stewart	Executive Officer Wimmera Primary Care Partnership
Mr Mark Sullivan	Chief Operating Officer Dental Health Services Victoria
Ms Katrina Toomey	Health Promotion Stawell Regional Health
Ms Helen Wade	Executive Officer Central Highlands Primary Care Partnership
Ms Helen Watt	Clinical Services Director East Grampians Health Service
Ms Tracey Wilson	Manager Dental Health Services Ballarat Health Services

8.2 Appendix 2: Individual consultations

Name	Position
Mr Trevor Adem	Chief Executive Officer Beaufort & Skipton Health Service
Ms Melanie Albrecht	Operations Manager West Wimmera Health Service
Dr Jennifer Barke	Australian Dental Association
Mr Don Connelly	Primary Health Manager East Wimmera Health Service (telephone)
Ms Sheree Cooper	Dental Administration Edenhope & District Memorial Hospital
Dr Colin Crook	Adviser, Ballarat Division of General Practice (telephone)
Ms Sue Daly	Manager Service & Workforce Development Department of Health Grampians Region
Ms Maureen Gleeson	Manager Community Services Hepburn Health Services
Mr David Grace	Melton Community Health Centre Djerriwarrh Health Service
Ms Wendy Gray	Primary Health Care Manager Ballan District Health & Care (telephone)
Ms Valda Groves	Planning and Development Dental Health Services Victoria
Ms Katrina Hishon	Ballarat & District Aboriginal Cooperative
Ms Cathy Ivett	Dental Program Manager Wimmera Health Care Group
Ms Catherine James	Manager Dental health Program Department of Health
Mr Sue Kearney	Manager Health Promotion & Communication Dental Health Services Victoria
Dr Meral Layik	Dental Officer Wimmera Health Care Group
Dr Simon Estifo	Dentist Wimmera Health Care Group
Mr David Lenehan	Chief Executive Officer Hepburn health Service
Ms Kim Ludbrock	Manager School Nursing Program Department Early Education Childhood
Ms Jill Miller	Chief Executive Officer Grampians Community Health Service
Professor Mike Morgan	Head of School of Dentistry and Oral Health University of Melbourne
Ms Sharon Morrison	Dental Therapist West Wimmera Health Service
Mr Anthony Ohlsen	Coordinator of Operations & Planning Central Highlands Water (telephone)
Ms Judy Perkins	Program and Service Adviser Department of Health Grampians Region
Ms Robyn Reeves	Chief Executive Officer Ballarat Community Health (written submission)
Dr Colin Riley	Manager Agency Relationships Dental Health Services Victoria
Mr Glenn Rowbotham	Chief Executive Officer Ballan & District Hospital (telephone)
Mr Alistair Sandison	Project Officer Department of Health
Ms Claire Sandford	Manager Health Service Operations Department of Health Grampians
Mr Chris Scott	Chief Executive Officer Wimmera Health Care Group
Mr Tom Niederle	Director Health & Aged Care Grampians Regional Office
Ms Helen Wade	Executive Officer Central Highlands Primary Care Partnership
Ms Nicole Wall	Administration Manager East Grampians Health Service
Ms Helen Watt	Clinical Services Director East Grampians Health Service
Ms Karen Werner	Refugee Nurse Grampians Region
Mr Greg Whorlow	Coordinator of Water Quality Grampians Wimmera Mallee Water (telephone)
Professor Peter Wilson	Head of School of Dentistry and Oral Health Latrobe University Bendigo
Ms Tracey Wilson	Manager Dental Health Services Ballarat Health Services

8.3 Appendix 3: Oral Health Workshop Attendees

Name	Position
Mr Trevor Adem	Chief Executive Officer Beaufort & Skipton Health Service
Ms Melanie Albrecht	Operations Manager West Wimmera Health Service
Dr Jennifer Barke	Representative Australian Dental Association
Mr Robert Bulmer	Chief Executive Officer East Grampians Health Service
Ms Elizabeth Casey	Grampians Pyrenees Primary Care Partnership
Mr Don Connelly	Primary Health Manager East Wimmera Health Service
Mr Peter Daffy	Prosthetist Wimmera Health Care Group
Ms Sue Daly	Manager Service & Workforce Development Department of Health Grampians Region
Ms Maureen Gleeson	Manager Community Services Hepburn Health Services
Dr Ben Keith	Dental Course Co-ordinator La Trobe University
Dr Meral Layik	Dental Officer Wimmera Health Care Group
Ms Deidre McKechnie	Chief Learning Officer Dental Health Services Victoria
Ms Judy Perkins	Program and Service Adviser Department of Health Grampians Region
Ms Judith Perrin	Manager Primary Health Department of Health Grampians Region
Ms Robyn Reeves	Chief Executive Officer Ballarat Community Health
Dr Colin Riley	Manager Agency Relationships Dental Health Services Victoria
Mr Alex Serrurier	Manager Environmental Services Golden Plains Shire
Ms Mandi Stewart	Executive Officer Wimmera Primary Care Partnership
Mr Mark Sullivan	Chief Operating Officer Dental Health Services Victoria
Ms Cindy Sutton	Manager Dental Services, Djerriwarrh Health Services
Dr Rachel Tham	Office of Research Monash University
Ms Katrina Toomey	Health Promotion Stawell Regional Health
Ms Helen Wade	Executive Office Central Highlands Primary Care Partnership
Ms Helen Watt	Clinical Services Director East Grampians Health Service
Ms Tracey Wilson	Manager Dental Health Services Ballarat Health Services

8.4 Appendix 4: Agency service mapping by IAP

Agency	Current Service Provision	Workforce	Integration	Fluoridation	Health Promotion	Comments
Central Highlands						
Ballarat Health Services 2 sites 1. Drummond Street Clinic 2. 2.Yuille Park	• Integrated service provision at both sites • Limitations of infrastructure at Ballarat Dental Clinic – two chairs located in shared room have very limited use for children • Dental van allocated for this catchment is only intermittently operational	Full range of workforce Variability of the standards and the productivity	√	√	Provides no specific health promotion activities for oral health	• Capacity of the current infrastructure • Length of wait list • Consider underutilised resources at other sites – Ballan & HHS • Variability in productivity across the dental team
Hepburn Health Service	• HHS provides oral health services through clinics at the Community Health Service at Daylesford (one chair) and Creswick (one chair) • Service five days a week at both sites. In addition, Daylesford operates a weekly evening session in summer (fortnightly in winter)	Limited availability of dental technician and dental therapist A private dentist also visits Creswick 1-2 days per week	X	X	Smiles4Miles program is conducted at preschools across the Central Highlands (funded through the PCP)	• Emergency services are currently provided through the emergency voucher system • HHS has not proceeded with integration - concerns over their ability to manage additional numbers • All routine school dental work is managed through BHS • HHS concerned about viability of the current service. Would be prepared to consider alternative methods of service provision such as a dental van from another agency or a public/private arrangement • Part of the project “Strengthening the Bite – Improving Oral Health for Older People” which involved examinations in residential care facilities

Wimmera						
Wimmera Health Care Group – Horsham & Dimboola Provides public oral health services	• The Horsham clinic comprises two dental chairs and one prosthetic chair • Services are provided five days per week • Dimboola has a single chair clinic which is open one day per week and is managed from Horsham – potential for Dimboola to increase to two days • Recent delivery of a new dental van with 1 adult chair. No plan for how this service will be used and it is expected that it will remain on site at Horsham	There is a full range of workforce available – the services of the dental therapist are shared with WWHS Staffing for the Dimboola clinic is supplied from Horsham Recruitment is an issue but not retention	√	√ Only immediate City of Horsham.	WHCG works with the PCP to provide Smiles4Miles.	• WHCG indicate that there are a disproportionate number of emergency clients • Almost all clients require extensive work and this adds to the waiting list issue • There are a large number of referrals for paediatric oral health surgery including referrals from Ararat and Nhill • Failure to attend is an issue – particularly for Koori community • Provision of oral health care for mental health patients – extended visit times • WHCG has developed a new plan for provision of dental service independent of other stakeholders. The status of this plan is unknown • Children are seen for checkups and then placed on a two-year recall system • Commonwealth funded Teen Dental program, which sees health care cardholders
West Wimmera Health Service	• Provides public oral health services through a two chair clinic at Nhill (refurbished 2007) • Dental services in Nhill are provided four days per week. Fifth day reception only • There is a functional dental laboratory at Nhill – non operational at present • Model is a public/private mix under which the dentist pays rental and WWHS provides the staffing. Under this arrangement, the dental officer undertakes 1.5 days per week of public dental work and the remainder is private.	Private dental officer from Melbourne provides public service three days per week. No dental technician or prosthetist. Insufficient staff to operate second chair	√	X	Provides no specific health promotion activities.	• Currently only one surgery utilized (concerns with infection control standard in the second surgery). • Commonwealth funded single chairs and equipment at Rainbow and Kaniva (2009). • Neither chair is operational (non recurrent funding for capital). • Capital funding to establish a third chair in Goroke not progressed at this stage. • Emergency services are triaged using the DHSV triage system (majority managed at Horsham). • WWHS has had discussions with DHSV and DH regarding opportunities for two dentists (and associated staffing). Any opportunity to reconfigure staffing and hours would take into account all four clinics (Nhill, Kaniva, Rainbow and Goroke). • WWHS believes that there is sufficient work for utilisation of the dental laboratory one day per week.

	• All public patients are voucher patients. • An oral surgeon from Melbourne provides a public/private service one afternoon (pre surgery) and one morning per week (theatre list).					
Edenhope & District Memorial Hospital	• Service provided by visiting dentist from Casterton one day per week • Dentist manages the appointment schedule – both public and private dental patients are seen • All public patients are managed through general voucher system	Serviced by private dentist who brings his own staff. Edenhope & District Memorial Hospital provides administration of the service but no other staff	X School aged children are seen at Nhill or Horsham	X	Provides no specific health promotion activities.	• The hospital, DHSV and the dentist jointly own the dental chair and equipment at Edenhope. • Maintenance is managed by the hospital. • Unable to meet emergency requirements for dental services. In some cases emergency patients have to travel to Nhill or Horsham • No wait list – dentist provides hospital with a list of who is to be seen. • There are no plans for alterations to this service, which has been in place for some ten years. Edenhope reports that it would not have a requirement for a service more than one day per week.
Grampians Pyrenees						
East Grampians Health Service – Ararat. Service provided at Community Centre	• Four chair clinic	There is a full range of workforce available with the exception of a prosthetist	√	X	PCP manages Smiles4Miles project. EGHS provides some health promotion activities	• Emergency vouchers not provided at Ararat (no private dentist accepts vouchers in Ararat). • Integrated yet concerned not meeting child recall targets • Identified need for improved oral health care in residential services
East Wimmera Health Service – St Arnaud	• There is no public dental available in St Arnaud (ceased four years ago) • General dental vouchers provided for care through dentists registered with the health service. Appointments are made via community health reception.	A small grant is provided by DHSV to cover oral health reception costs at EWHS.	N/A	X	Provides no specific health promotion activities for Dental	• A limited private dental service is provided from Stawell to Donald • Funding for school aged children in the St Arnaud area is provided to the East Grampians Community Dental Service

Other						
Ballan District Health Care	• One Commonwealth chair (provision for a second)					
Djerriwarrh Health Services (Melton)	• Plans for a 12 chair dental unit together with a dental laboratory (two technicians).					Although this service is on the metropolitan fringe, for planning purposes it is to be considered part of the Grampians Region. The new dental clinic will be a teaching facility in a model yet to be officially defined by La Trobe University (Bendigo). The net effect of a teaching model is that the clinic will operate as an estimated 4.5 – 5 chair clinic.