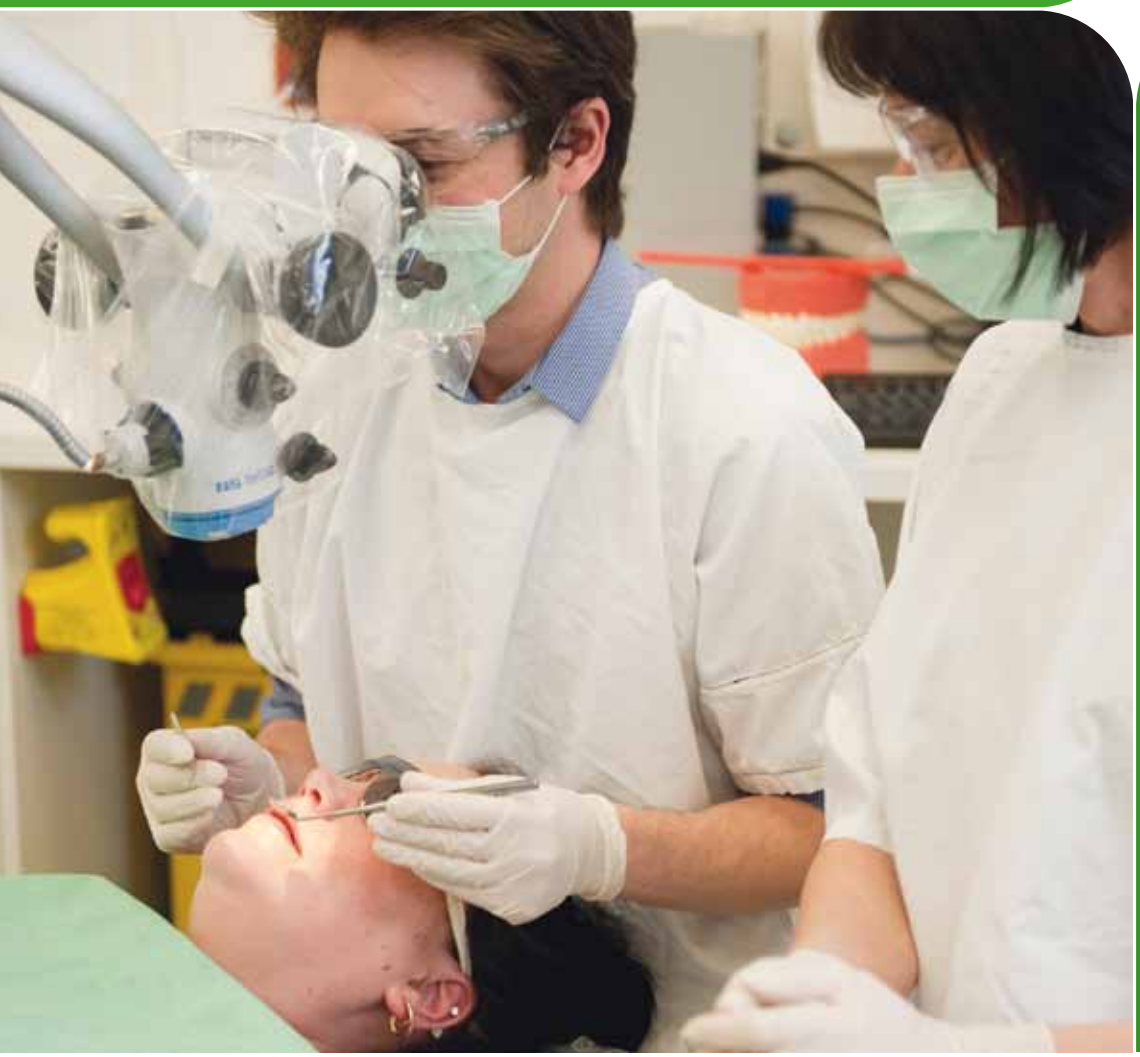
Department of Health

health

Hume Region integrated oral health plan 2010–2013



A Victorian Government initiative

Hume Region integrated oral health plan 2010–2013

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Foreword

As outlined in *Improving Victoria's oral health* (Department of Health 2007), community oral health services are a key component of the community-based health service system. Over 2009 and 2010, the Hume Oral Health Partnership worked collaboratively to implement key aspects of policy and practice directions in the development of this integrated area-based oral health plan for the Hume Region. This plan will inform future investment of human and capital resources, strengthen systems integration and increase preventative efforts to enhance oral health in communities across the region.

The *Hume Region integrated oral health plan* aligns with area-based service planning and broader developments driven by the Hume Health Services Partnership.

The Hume Oral Health Partnership wishes to acknowledge the contribution and assistance provided by member agencies, in particular the support of Goulburn Valley Health as project lead. Thanks are also extended to the Hume Region Department of Health and Dental Health Services Victoria, who provided resourcing, information and ongoing support in the development of this plan.

The project consultants, LIME Management Group, also wish to acknowledge and thank the many individuals and organisations who generously gave of their time and provided valuable contributions along the way. Those involved were required to reflect on their practice, consider key issues and identify strengths and areas for improvement. This resulted in the key priorities and actions reflected in the plan which aim to create a more integrated and responsive community oral health service system. Thanks also go to Hume Oral Health Partnership members who provided guidance and helpful feedback at important stages of the project.

The Hume Oral Health Partnership is committed to building on the work to date and implementing the recommended priorities and actions.

We are pleased to commend the *Hume Region integrated oral health plan 2010–2013*.

Leigh Rhode
Chair
Hume Integrated
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Felix Pintado
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Victoria

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Hume Region

Contents

Executive summary

Guided by members of the Hume Oral Health Partnership ('the partnership'), the project consultants developed the *Hume Region integrated oral health plan*. This plan includes:

- an overview of needs, priorities and factors influencing oral health service delivery (including workforce)
- a proposed service mix based on current need and population projections
- a responsive remote/rural service model that includes the promotion of access for disadvantaged population groups and service coordination practice
- an integrated approach to prevention and oral health promotion.

Oral health services in the Hume Region are working through the partnership to create an integrated approach to oral health service delivery and greater accessibility for service users. This approach is bolstered by existing good practice and strengths, including the following:

- Goulburn Valley Health (GVH) providing sessional public oral health services in Cobram.
- A GVH outreach approach via a 'virtual chair,' an innovation that provides oral health services via a dentist and a mobile cart to people living in aged care facilities.
- Despite difficulties experienced in recruiting oral health staff in regional areas, a high level of commitment from oral health staff working in the system.
- A high quality oral health student placement program and effective relationships with Melbourne and La Trobe universities. This has led to some students, when qualified, seeking employment in community oral health services in Hume.
- Oral health promotion work undertaken through Smiles 4 Miles.
- Relocation and growth of the oral health service in Wodonga.

Community oral health services – issues and priorities

Information about current issues and priorities for community oral health services in Hume Region was gathered through consultation with service providers and other key stakeholders (refer Appendix 1 for list); analysis of current and future demand; and ongoing discussion with the partnership group. The issues and priorities are described in detail in section 3 of this report and summarised below:

1. No adult community oral health services are provided in **Lower Hume** and more than one-third of the population is eligible. The partnership wishes to undertake a planned approach to meeting current and future demand for oral health services in this area considering access issues and infrastructure requirements.
2. The condition of the community oral health facility in **Wangaratta** (refer page 31) is of concern to the partnership. A process to consider options to address this issue is planned.
3. The eligible population in some areas of Hume has limited access to services due to distance from services and lack of transport options. A priority for the partnership is to investigate and develop **outreach models and service options** (for general and denture services) in areas of limited access, including consideration of public/private service mixes. Of particular import are areas in Lower Hume and Upper Hume (particularly Tallangatta and Corryong).
4. Partnership members wish to be cognisant of current and projected community oral health service demand – that is, who is on the waiting lists? From which postcodes and areas? How many people are on more than one waiting list? An opportunity exists for the partnership to work with Dental Health Services Victoria (DHSV) to **better understand demand**.
5. Promoting equitable and timely access for **priority groups** (Indigenous people, refugees and children) is a priority for the partnership with several required actions identified. These include improving the cultural competence of service providers and building relationships with organisations that work with Indigenous people and refugees.

6. Similar to other health sectors in regional and rural areas, oral health services (public and private) grapple with the issue of finding and recruiting staff. The partnership is working on a shared model for credentialing and clinical governance. There is an opportunity to build on this work and develop shared approaches to **recruitment and workforce retention**.
7. The partnership recognises the positives to be gained from supporting the placement of oral health students in Hume; both as a broader responsibility to develop the oral health workforce and as a key mechanism in encouraging graduates to return and work in the Hume Region. Working with the universities, partnership members see value in developing the experience for oral health students via a **coordinated and planned approach to student placement**.
8. Access of eligible people to specialist oral health services is an issue. The development of a **regional specialist service mode**l is supported.
9. Policy directions promote the take up of **service coordination** by oral health services to improve access, share knowledge and resources, and to support early identification of client needs using the Service Coordination Tool Templates (SCTT). Oral health services in Hume do not currently use the SCTT for initial needs identification or referral. Partnership members agreed to develop service coordination practice through education and practice development.
10. Stakeholders recognise the value of oral health promotion; particularly given that risk factors for poor oral health are often risk factors for other health issues. Partnership members agreed to priorities regarding developing Smiles 4 Miles; identifying a regional leader for **oral health promotion** (as per DHSV strategic plan); and working with primary care partnerships (PCPs) to include oral health promotion in broader health promotion activities.

Future oral health service configuration

Mechanisms to create greater community oral health service integration and collaboration are essential to support future oral health development. With GVH as the lead regional agency and a well developed communication and reporting process to the overarching Hume Health Partnership, the Department of Health and DHSV, the Hume Oral Health Partnership agreed to implement an integrated service configuration and two sub-regional network structures, namely:

- **Goulburn Valley/Lower Hume Network** – comprises GVH, Rumbalara and Seymour and District Hospital
- **Upper and Central Hume Network** – consists of Albury Wodonga Regional Health, Northeast Health and Benalla Health.

Within the overarching partnership, the two networks provide central mechanisms to plan and support:

- clinical leadership processes
- workforce development strategies
- oral health student placements
- access to specialist services (working with the Royal Dental Hospital Melbourne)
- development of outposted or satellite services
- a range of other recommended actions as described in the plan.

Recommended priorities – action plan

The priorities outlined below are devised following extensive consultation with oral health service providers and other stakeholders; analysis of relevant data and reports; and ongoing discussion with partnership members. The priorities and associated actions are detailed in section 6.2. These are underpinned by a series of principles (section 6.1). The initial role of the newly configured Hume Oral Health Partnership is to implement priorities and actions as described.

Priorities	
Development and leadership	As per the proposed service configuration (6.1), develop sub-regional oral health networks
	Develop clinical leadership model for oral health services
	Inform future oral health service planning and development
	Identify best practice model/s of oral health care for children
Access	Build community oral health services in Lower Hume
	Build community oral health services in Upper Hume – Corryong, Tallangatta
	Build awareness of, and links with, private practices and support public/ private partnerships
	Further develop outreach oral health models
	Undertake activities that promote access to community oral health services including denture services
	Explore options for a specialist oral health service model
	Strengthen community awareness and uptake of oral health services
Priority groups	Promote use of priority tools
	Promote uptake of oral health services by Indigenous communities, refugee communities and eligible children
	Build on work to date to link residents of aged care facilities to oral health services
Workforce	Undertake community oral health workforce analysis
	Undertake community oral health workforce development
Oral health students	Support and develop oral health student experiences via a coordinated and planned approach to student placements
Service coordination	Develop (oral health) service coordination practice and approach
Oral health promotion	Promote fluoridation across Hume
	Develop oral health promotion planning and practice including specific activities for children
Infrastructure	Redevelop Northeast Health Wangaratta community oral health facility
	Develop oral health services in Lower Hume

1. Introduction and context

1.1 Introduction

Aligning with key policy directions relating to integrated area-based service planning and development, oral health services in the Hume Region have taken steps towards creating more integrated and accessible dental services. These steps include integrating School Dental Services (SDS) with community dental services and promoting access through models of support and mentorship to smaller dental clinics, for example, Goulburn Valley Health (GVH) and Rumbalara.

Building on this work, the Hume Oral Health Partnership worked in collaboration to:

- develop an integrated area based **oral health plan** for the Hume Region that will inform future investment of human and capital resources, strengthen systems integration and increase preventative efforts to enhance oral health in communities across the region.

1.1.1 Aims

The key aims of this plan are to:

- develop an integrated community-based oral health service system, including a picture of needs, priorities, capacities and factors influencing supply and demand
- propose a service mix based on current need and population projections
- develop a responsive remote/rural service model that includes the promotion of access for disadvantaged population groups and service coordination practice
- consider the role of health promotion and primary care partnerships (PCPs) in relation to oral health and develop an integrated approach to prevention and oral health promotion across the region
- identify priorities for integrated oral health promotion activity (including fluoridation) in partnership with Dental Health Services Victoria (DHSV)
- identify workforce issues and priorities to support the plan.

1.1.2 Project methodology

The resulting action plan (section 5) is developed in consideration of the following:

- Consultation with key stakeholders (refer Appendix 1), including:
  - community oral health services
  - other community services, including services for Indigenous communities
  - Department of Health
  - DHSV
  - universities
  - PCPs
  - private dentists/practices.
- Various data streams:
  - demographic data
  - dental health program service provision data
  - dental Ambulatory Care Sensitive Conditions (ACSC) data
  - dental weighted inlier equivalent separations (WEIS).
- Other factors impacting on the development of the plan, for example, rural, sector, workforce.
- Information pertaining to key policy and directions.

The development of the *Hume Region integrated oral health plan* was guided by members of the **Hume Oral Health Partnership** (refer Appendix 2).

1.2 Project context

1.2.1 Policy context

National context

The significance of oral health is demonstrated by the range of policies at national and state levels. The key national policy is the *National oral health plan, healthy mouths healthy lives: Australia's national oral health plan 2004–2013*.

Four broad themes underpin the national plan and recognise that oral health is an integral part of general health. These themes are:

- a population health approach, with a strong focus on promoting health and the prevention and early identification of oral disease
- access to appropriate and affordable services – health promotion, prevention, early intervention and treatment – for all Australians
- education to achieve a sufficient and appropriately skilled workforce
- communities that effectively support and promote oral health.

The plan identifies six population groups that have poor access to dental care and whose oral health status is well below the rest of the community, including Aboriginal and Torres Strait Islanders, people in low socioeconomic groups, and people with special needs relating to disabilities, health conditions or ageing.

In 2008, the Commonwealth Government announced a $290 million Commonwealth Dental Health Program with $72.65 million allocated to Victoria over three years to deliver an extra 258,000 dental services. At the time of writing this plan, this initiative had not passed through the Senate.

Denticare

More recently, as part of the 2009 National Health and Hospitals Reform Commission (NHHRC) report, the Denticare initiative proposes dental cover for all, either via a private health insurance plan or through community oral health services. The commission acknowledges that providing universal access to dental services will require significant growth in the community oral health workforce. This will require an investment in facilities, equipment and supervision. The NHHRC also supports the adoption of a nationally consistent approach to the best use of all oral health professionals (for example dental therapists and oral hygienists). Recent reports (May 2010) indicate that Denticare would not be funded in the 2010 Federal Budget.

Medicare

The Medicare Chronic Disease Scheme (previously known as the Enhanced Primary Care item) is available for people who have chronic medical conditions and complex care needs whose oral health is impacting on their general health. These clients receive care from a multidisciplinary team including a general practitioner (GP) and have a GP Management Plan and Team Care Arrangement. For residents of aged care facilities, the GP contributes to a multidisciplinary care plan prepared for the resident by the facility. Medicare items cover services such as dental assessments, preventive services, extractions, fillings, restorative work and dentures to an amount up to $4,250 for eligible dental services over two consecutive years.

The Medicare Teen Dental Plan is designed to promote the oral health of teenagers aged 12–17 years whose families are in receipt of government support or the Family Tax Benefit Part A. A voucher entitles the young person to claim up to $157.00 per year for a preventative dental check.

Victoria

Care in your community: a planning framework for integrated ambulatory health care (Department of Health 2006) outlines a comprehensive framework for area-based planning. It seeks to progress the health service system towards improving the health outcomes of Victorians through person and family centred care in community-based settings with an associated reduction in the need for inpatient care. Planning for the delivery of integrated, community-based health care will be:

- based on a single set of area-based planning catchments
- informed by a single set of planning principles
- supported by area-based planning networks

- focused on three high level areas of need
- conducted on the basis of defined modes, settings and levels of care.

Improving Victoria's oral health 2007 is Victoria's major oral health policy presenting a vision to guide oral health care for the next four years. The policy highlights six strategic priorities:

- an oral health service planning framework
- an integrated service model for adults and children
- a workforce strategy
- oral health promotion
- responding to high-needs groups
- oral health funding, accountability and evaluation.

The planning framework and the integrated service model aim to ensure that community oral health services are an integrated part of Victoria's network of community health services and will work collaboratively to provide health promotion, prevention, early intervention, treatment and self-management. The workforce strategy is intended to consolidate a diverse, robust community dental workforce to equip the oral health care system to meet the future needs and expectations of communities and users. The Victorian Government, DHSV, universities, dental health professional organisations and community health services will all work together to achieve these aims.

Funding model

A key task noted in *Improving Victoria's oral health* was the review of the existing funding model for community oral health services and the roll out of a new funding model. The new funding model will be output-based. It will provide a transparent means of determining prices, set universal prices for the same outputs and provide known targets and three-year funding certainty. Regional sessions to provide information about model refinement and implementation will be conducted during 2009–10. The new funding model will be implemented in 2010.

More recently, *Primary health care in Victoria: a discussion paper* (Department of Health 2009) proposes that the future primary health care system in Victoria focus on wellness and person-centred care, address inequalities in primary health care access, and enable people with chronic and complex conditions to have well-planned, integrated care. This should be available for people regardless of where they live, their socioeconomic status, cultural and social background, Indigenous status or the complexity of their health needs. The paper outlines the directions for primary health care for the next three years.

The *DHSV strategic plan 2007–2010* proposes a series of outcomes significant to this plan, including:

- equitable access to appropriate services, including treatment, prevention and health promotion for those with the greatest oral health need
- entrenching the link between oral health and general health in the minds of the community
- successfully delivering programs underpinned by the social model of health
- ensuring a sufficient, skilled and sustainable workforce with capacity to meet the community oral health goals
- continuously innovating to maximise oral health gains from the use of available resources.

1.2.2 Local sector developments

Various health and service sector developments and future plans required consideration in the development of the *Hume Region integrated oral health plan*. These are outlined below.

Wallan

Discussions were held regarding the development of a health service that would include dental chairs in Wallan (Lower Hume). Lead agencies, Mitchell Community Health Service and Mitchell Shire, decided against progressing with this option as funding was insufficient and, more recently, both organisations are focused on community needs generated by the bushfires.

A private dentist based in Wallan has put forward a proposal to the Department of Health to deliver community oral health services in a recently developed five chair clinic in Wallan. The clinic employs oral hygienists who have community oral health service experience. The Department of Health response noted that the proposal be considered as part of the *Hume Region integrated oral health plan*.

General Practice (GP) super clinics

Wallan and Wodonga (in August 2009) were chosen to house federally funded GP super clinics. As no one model is proposed, the mix of services, and potentially the target populations, is determined by local community need and

priorities to complement existing health services. Private dental services may be included.

Kyabram Better Oral Health Trial

The Better Oral Health trials are federally funded projects focusing on oral health assessment and treatment in aged care facilities. Through a train the trainer model, nursing staff undertake an oral health assessment and provide follow up general oral hygiene. GVH is involved in a trial of this program at a Kyabram nursing home. An evaluation of the trial has been completed and recommendations1[1] include:

- that private and public dental providers have access to portable dental equipment to facilitate treatment in aged care facilities
- that mechanisms be put in place to provide extra support for the implementation of the model for Indigenous residents.

Alpine Health

A review of oral health service availability in the Alpine local government area (LGA) in 2007 recommended:

- an exploration of options with local and public providers for rotational oral health sessions within private clinics in Alpine
- an exploration of options to enable resident access to travel assistance for people in remote areas of the LGA
- working with Northeast Health to develop a planned approach to oral health promotion.

Cobram Plan

Cobram Dental Clinic, a privately funded business of Cobram District Health, is developing a five chair clinic from 2010. Cobram will continue to provide limited community oral health services as an outreach service from GVH for public clients.

Cross region and border clients

The Victorian Department of Health and NSW Health have an agreement that clients may be treated 'across the border' when appropriate (for example, NSW Health pays for eligible Berrigan residents to use the Cobram service).

There is no restriction on which service people may access and, as such, Hume residents are accessing services in the North West and Eastern Region and people from Loddon Mallee access services in Hume.

1.2.3 Rural considerations

Environmental

Residents of the Hume Region have faced the dual environmental challenges of prolonged drought and, more recently, serious bushfires. In the areas already reported as highly disadvantaged (see table 3), it can be anticipated that the effect of the drought will add to the socioeconomic disadvantage in pockets of the Hume Region. Anecdotally, community oral health services in Hume report an increasing number of people presenting to their services who are more recent health care card holders.

Research has shown a consistent correlation between low socioeconomic status and poor oral health. Almost one-third (31.2 per cent) of all Australian adults avoided or delayed visiting the dentist due to cost.[2]

The impact of the bushfires on residents in the Mitchell and Murrindindi shires is significant with many people losing their homes and livelihoods. In response, organisations such as Mitchell Community Health Service (which services both these shires) have directed resources to provide additional counselling and support services.

Note: Following the bushfires, Plenty Valley Community Health Service increased the level of services provided through an initial one chair service (van) located in Whittlesea to cater for people from the Kinglake area.

1 Fricker, A & Lewis, A. 2009 *Better oral health in residential care final report. Central Northern Adelaide Health Service: Adelaide*

2 J Spencer and J Harford 2008, *Improving oral health and dental care for Australians*, Discussion paper commissioned by the National Health and Hospitals Reform Commission.

Fluoride

The proposed timeframe for the introduction of a fluoridated water supply across Hume is:

- Yarrawonga, Benalla, Barnawartha, Seymour 2009
- Cobram 2010

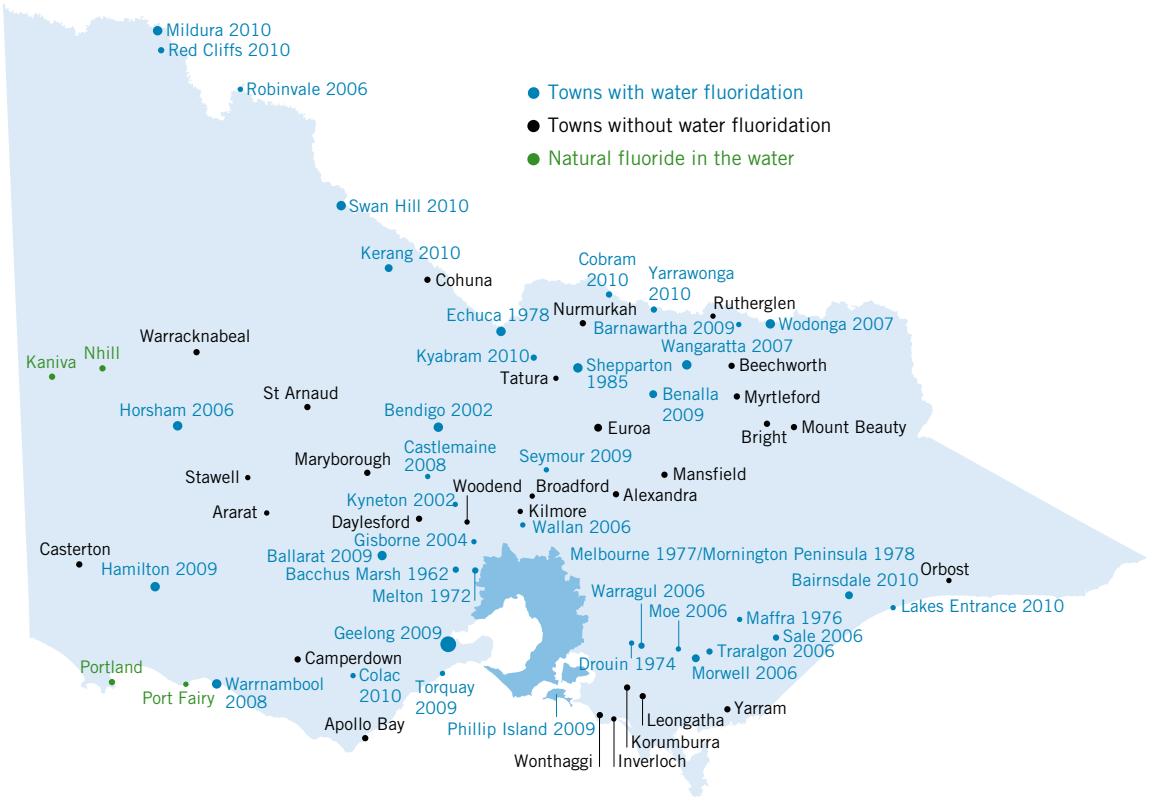


Figure 1: Victorian fluoridation map

This leaves areas in Lower Hume (Broadford, Kilmore and Alexandra), Central Hume (Mansfield, Bright, Mt Beauty and Myrtleford) and Upper Hume (Beechworth, Corryong, Tallangatta and Rutherglen) without a fluoridated water supply. Note: it is also unknown how many people are using tank water and thus are not linked into fluoridated water supplies.

This is significant in planning for oral health service delivery as the impact of fluoridation is well understood. For example:

> ...six-year-olds living in fluoridated areas of Victoria experience 45 per cent less tooth decay in their baby teeth than those in non-fluoridated areas, with 12-year-olds experiencing 38 per cent less decay in their adult teeth[3]

3 Department of Human Services, 2007, *Improving Victoria's Oral Health 2007*, Victorian Government, Melbourne

Refugees

Between 2005 and 2009, 2,152 people took up residence in Hume via humanitarian and non-humanitarian settlement programs. This is greater than neighbouring regions: Loddon Mallee (1,723) and Gippsland (1,515)[4].

Greater Shepparton has significant numbers of these refugees (more than any other rural LGA[5]), with most arriving from Iraq, Afghanistan, the Congo and Sudan. GPs, the hospital emergency department and a refugee health nurse based at the local community health service refer refugees to the Goulburn Valley oral health service. In addition, the refugee population in Albury/Wodonga will increase as the area has recently been designated a refugee resettlement area for refugees with an agricultural background.

Research in 2005[6] found the dental health of refugees, particularly untreated decay, compared poorly to that of Indigenous Australians and other special needs populations in Australia (who have known worse oral health than the general population). The report noted an urgent need to include refugees in targeted dental services, including on-arrival dental assessment and treatment and community-based oral health programs.

Other factors

Other significant factors or impacts for the Hume Region include the following:

- Challenges presented by distance, particularly for people living in outlying areas such as Corryong. Transport is limited and costly and public transport can take a lot of time (for example, travel from Corryong to Wodonga can take one and a half to three hours).
- Reductions in community infrastructure (like transport services) in smaller towns.
- The complex issue of service access is exacerbated by the closure of private dental services in smaller townships for example, Tallangatta and Corryong.
- The needs of other marginalised communities combined with the above infrastructure issues, for example, Indigenous people, people who are ageing, people with mental health problems.

4 DIMIA website – Settlement reports www.settlement.immi.gov.au

5 Department of Human Services 2008 *Refugee health and wellbeing action plan 2008–2010*, Department of Human Services, Melbourne

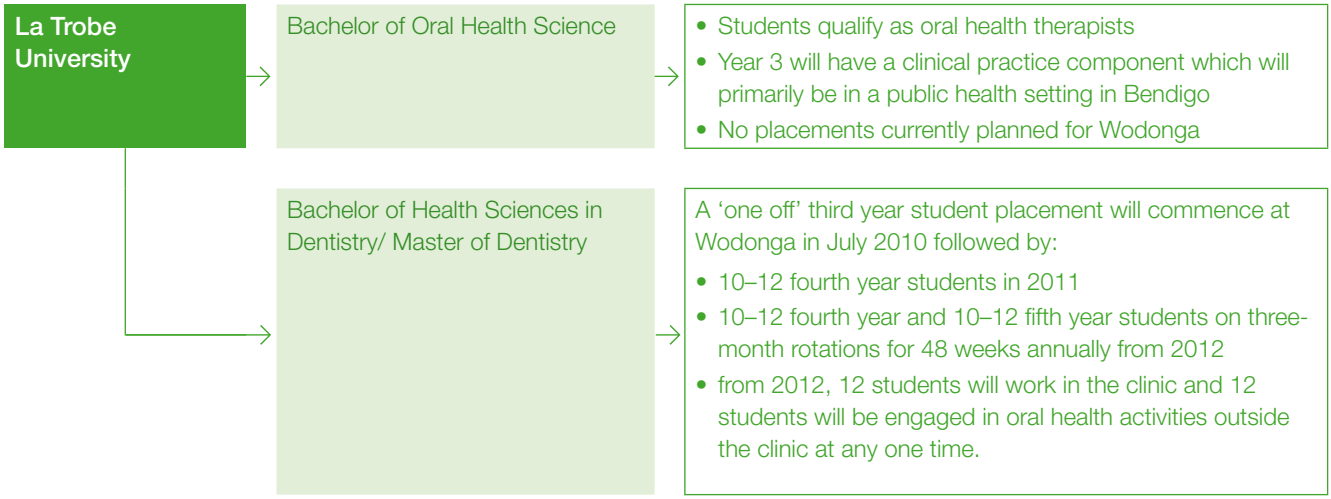
6 Davidson, N, et al: Holes a plenty: oral health status a major issue for newly arrived refugees in Australia, *Australian Dental Journal* 2006;51:(4):306–311

1.2.4 Oral health students

Various developments and other factors relating to the often complex issues surrounding the oral health workforce are relevant to this plan and future actions.

Denticare proposes that graduate students (of which there are 600–700 across Australia) have an intern year. If implemented, this will impact on student placement opportunities and will require a major investment in additional infrastructure and facilities to support these placements.

Oral health student placements



The experience of La Trobe University students may include the following outreach components:

- screening/treatment programs in remote townships
- oral health promotion
- working with Indigenous and refugee communities
- working with other clients of Gateway CHS via a service integration approach
- service provision to other groups including young children and people in care facilities.

Note: In an outreach approach, appropriate infrastructure is required to support effective clinical practice.

Charles Sturt University	Bachelor of Oral Health	This course commenced in 2009 with 20 student places. Students will qualify to register as dental hygienists and dental therapists.
	Bachelor of Dental Science	This course commenced in 2009 with 40 student places. A Dental Education Clinic will be established in Albury by end 2010.

Charles Sturt University will rotate students through clinics in Albury, Bathurst, Dubbo, Orange, and Wagga Wagga. The rotations occur for both oral health and dentistry placements. There will be 10 dental chairs available for use with student placements so any combination of third year oral health students or fifth year dental students (up to ten) could be accommodated either individually or in pairs. Students will spend up to 20 per cent of their final year on rotation in Albury.

In addition:

- Under the leadership of a dental academic, it is anticipated that students will become familiar with a multidisciplinary approach to patient care, as they would experience in practice.
- There are future curriculum plans to incorporate outreach dental visits using travel kits.
- The dental education clinics will provide services to a mix of both public and private patients.

Melbourne University Melbourne Dental School (MDS)	Bachelor of Oral Health	• Third year students have a four-week placement at GVH. Ten rotations occur annually. • The course has places for 30 students per year
	Bachelor of Dental Science	• Fifth year students have a four-week placement at GVH which includes time at Rumbalara • From 2011, Cobram Dental Clinic will have two fifth year students • Currently 70 students per year

A mix of 8–10 dentistry and oral health students complete a mandatory rotation at GVH of four weeks. Students:

- participate in tutorials at the School of Rural Health, Shepparton, and in oral health education within integrated health programs
- are assigned a topic related to rural oral health to research and present on their final day
- are mainly based at the GVH but are rostered to Rumbalara for one week clinical practice
- visit private practices for observation and for interaction with the dental staff
- are involved in oral health promotion.

From 2010, due to increased student numbers, the University of Melbourne is seeking to increase the number of students to 11–15 with seven rotations of five to six weeks.

1.3 Community oral health services

In Victoria, most dental care is provided by private practitioners with public dental care (general and emergency) available to children and disadvantaged adults through the Dental Health Program.

DHSV has key responsibility for purchasing dental services from community health services and rural hospitals on behalf of the Department of Health[7]. DHSV also has a role in recruiting and retaining the oral health workforce, including establishing partnerships with universities in the education, training and continuing professional development of clinicians; and developing and providing re-entry and mentoring programs for the oral health workforce.[8]DHSV is also a key provider of services at Royal Dental Hospital of Melbourne (RDHM).

To provide a forum for senior community oral health clinicians to discuss issues affecting clinical performance at DHSV, the Clinical Leadership Council (CLC) was established in 2005. Its key focus areas are:

- advising on DHSV strategy
- providing advice on clinical issues with a population health perspective
- supporting clinicians in leadership roles
- advising on clinical governance structures.

The DHSV Annual Report (2009) provides an overview of the DHSV role and a summary of services provided to eligible Victorians.

Emergency care

Emergency dental care is available to health care and pensioner concession cardholders at RDHM and community dental clinics. Emergency care is also available to the general public at RDHM on weekends and after hours.

General care

General dental care, including fillings, dentures and preventative care, is available to current health care and pensioner concession cardholders through RDHM and community dental clinics.

Specialist care

Patients may be referred to RDHM for specialist dental care including orthodontics, oral and maxillofacial surgery, endodontics, periodontics, prosthodontics, paediatric dentistry and oral medicine.

Oral health promotion

Integrated health promotion programs deliver benefits for the community by promoting wellbeing, strengthening community capacity and minimising the burden of disease. DHSV's statewide health promotion program supports key policy objectives, including prevention of oral disease, delivery of services to those in highest need and building capacity to improve oral health outcomes.

Education

RDHM's teaching clinics support the University of Melbourne's education of dentists, specialists, dental therapists and hygienists and RMIT University's education programs for dental assistants and technicians. RDHM also provides bridging programs for overseas-trained clinicians seeking registration. DHSV also works with La Trobe University to support its rural oral health teaching program.

Purchased services

DHSV purchases oral health services from 58 community health services and hospitals. DHSV ensures there is a fair and equitable distribution of public money utilised in the most effective and efficient way to improve community oral health. DHSV has developed policies and procedures to ensure that defined levels of agency support are provided.

Continuous improvement

The Continuous Improvement Team supports statewide planning and the monitoring and reviewing of continuous improvement functions arising from the Oral Health Quality Framework.

Information communication technology

The DHSV ICT Team is responsible for maintaining patient management system solutions and associated centralised infrastructure to support the clinical and administrative activities to 85 sites across Victoria.

7 Department of Health 2009 *Victorian health services policy and funding guidelines 2009–10* – Primary and dental health

8 Department of Health website www.health.vic.gov.au/communityhealth/service_provider/phw.htm

2. Hume Region: data and oral health services

2.1 Hume Region demographic data

Table 1: Total population and eligible population by LGA & IAP/PCP

IAP	LGA	Total pop	Eligible adults	Child 3–13 yr	Total eligible	Child per cent of total eligible	Per cent Total pop eligible
Central Hume	Alpine	12,626	3,213	1,939	5,152	38	41
	Benalla	13,986	4,110	2,138	6,248	34	45
	Mansfield	7,455	1,771	970	2,741	35	37
	Wangaratta	27,431	7,145	3,820	10,965	35	40
Total		**61,498**	**16,239**	**8,868**	**25,106**	**35**	**41**
Goulburn Valley	Gt Shepparton	59,280	17,105	9,856	26,961	37	45
	Moira	27,983	8,006	3,120	11,126	28	40
	Strathbogie	9,628	2,652	1,133	3,785	34	39
Total		**96,891**	**27,764**	**14,109**	**41,873**	**34**	**43**
Lower Hume	Mitchell	32,082	4,880	4,349	9,229	47	29
	Murrindindi	14,198	5,263	3,028	8,291	37	58
Total		**46,280**	**10,142**	**7,377**	**17,519**	**42**	**38**
Upper Hume	Indigo	15,430	2,950	2,244	5,194	43	34
	Towong	6,273	1,390	1,092	2,482	44	40
	Wodonga	34,646	7,698	5,097	12,795	40	37
Total		**56,349**	**12,038**	**8,433**	**20,470**	**41**	**36**
HUME		**261,018**	**66,183**	**38,787**	**104,968**	**37**	**40**

Source: Total Population ABS 2006 Census, Eligible Adults Centrelink, Children ABS Census 2006

LGA – Local Government Area/IAP – Integrated Area Plan/PCP – Primary Care Partnership

Of note in table 1 is the high percentage of the total population eligible for the community oral health service, particularly in Murrindindi, Greater Shepparton and Benalla, and the high percentage of eligible children in Mitchell and the whole Upper Hume area. Greater Shepparton also has a significant number of eligible children.

Note: These population figures do not include eligible youth.

Table 2: Hume Region projected population growth 2006–2021

IAP	LGA	2006	2011	2016	2021	Table change	Per cent change 2006–21
Central Hume	Alpine	12,626	13,048	13,405	13,771	1,145	9
	Benalla	13,986	14,419	14,750	15,121	1,135	8
	Mansfield	7,455	8,257	9,080	9,968	2,513	34
	Wangaratta	27,431	28,199	28,912	29,657	2,226	8
Goulburn Valley	Gt Shepparton	59,280	63,101	66,243	68,995	9,715	16
	Moira	27,983	29,477	30,686	31,814	3,831	14
	Strathbogie	9,628	9,844	10,069	10,299	671	7
Lower Hume	Mitchell	32,082	37,065	42,523	48,640	16,558	52
	Murrindindi	14,198	14,318	14,670	15,249	1,051	7
Upper Hume	Indigo	15,430	16,214	16,768	17,265	1,835	12
	Towong	6,273	6,270	6,193	6,102	-171	-3
	Wodonga	34,646	37,352	39,713	42,101	7,455	22
HUME		**261,018**	**277,565**	**293,011**	**308,982**	**47,964**	**18**

Source: Department of Planning and Community Development

LGA – Local Government Area/IAP – Integrated Area Plan

Table 2 indicates that the most significant population growth will occur in the Mitchell LGA, which includes Seymour, Wallan, Kilmore and Broadford. Mansfield and Wodonga will experience population growth of over 20 per cent in the same time period.

As recently reported[1], and an example of projected growth in the Mitchell Shire, an additional 5,000 people are expected to live in the Wallara Waters Estate within 15 years.

1 *The Age* Saturday 29 August 2009

Table 3: Index of Relative Socioeconomic Disadvantage 2006 Census by LGA

IAP	LGA	Towns with areas in first decile of disadvantage	Towns with areas in second decile of disadvantage
Central Hume	Alpine	Myrtleford	Myrtleford, Mt Beauty
	Benalla	Benalla	Benalla
	Mansfield		Mansfield
	Wangaratta	Wangaratta	Wangaratta, Moyhu, Springhurst
Goulburn Valley	Gt Shepparton	Shepparton	Shepparton, Mooroopna
	Moira	Barmah, Cobram, Numurkah, Tungamah, Yarrawonga	
	Strathbogie	Euroa	Violet Town, Nagambie
Lower Hume	Mitchell	Seymour, Broadford	
	Murrindindi		Parts of Yea, Alexandra, Eildon
Upper Hume	Indigo		Chilten
	Towong		Corryong
Wodonga	Wodonga		Wodonga

Source: DPCD SEIFA Index of Relative Socioeconomic Disadvantage 2006 Census

LGA – Local Government Area/IAP – Integrated Area Plan

The SEIFA Index of Relative Socioeconomic Disadvantage is based on census variables related to disadvantage, such as low income, unemployment and level of education. As demonstrated in table 3, the Hume Region includes many towns that have areas within the first decile of disadvantage (that is, the most disadvantaged as compared to other regions across Victoria). Particularly:

- Central Hume: Myrtleford, Benalla and Wangaratta
- Goulburn Valley: Shepparton, Barmah, Cobram, Numurkah, Tungamah, Yarrawonga, Euroa
- Lower Hume: Seymour and Broadford
- Upper Hume: Wodonga

Table 4: Percentage of overseas born and NESB per Hume LGA and IAP

IAP Catchment /LGA		Cultural Diversity		
		Per cent born overseas	Per cent CALD	Top 5 languages
Central Hume	Alpine	14.8	13.4	Italian, German, Dutch, Arabic, Croatian
	Benalla	7.6	5.8	German, Italian, Polish, Dutch, Hindi
	Mansfield	11.0	8.4	German, Italian, Spanish, French, Dutch
	Wangaratta	8.1	7.9	Italian, German, Greek, Dutch, Filipino
Upper Hume	Indigo	7.8	6.5	German, Italian, Dutch, Croatian, French
	Towong	7.8	5.1	German, Dutch, Italian, Croatian, Yugoslavian/ Serbo-Croatian (as described)
	Wodonga	9.2	6.9	German, Croatian, Italian, Serbian, Mandarin
Lower Hume	Mitchell	10.6	9.6	Italian, Mandarin, Macedonian, Greek, Maltese
	Murrindindi	11.2	9.2	German, Italian, Greek, Dutch, Arabic
Goulburn Valley	Gr Shepparton	10.9	14.7	Italian, Arabic, Turkish, Albanian, Greek
	Moira	8.2	8.3	Italian, Arabic, Dutch, German, Cantonese
	Strathbogie	8.0	6.6	Italian, German, Greek, Hakka, Tagalog

Source: DHSV: Hume Region Oral Health Needs Profile May 2009

CALD – Culturally And Linguistically Diverse/LGA – Local Government Area/IAP – Integrated Area Plan

As noted in table 4 (based on 2006 Census), more people born overseas and those categorised as being from a non-English speaking background (NESB) reside in Goulburn Valley and Central Hume than in Lower and Upper Hume.

Table 5: Indigenous population by LGA and IAP

IAP	LGA	No. Indigenous people	Per cent of population
Central Hume	Alpine	61	0.5
	Benalla	133	1.0
	Mansfield	37	0.5
	Wangaratta	208	0.8
Total :		**439**	**0.7**
Goulburn Valley	Gt Shepparton	1,819	3.2
	Moira	308	1.1
	Strathbogie	77	0.8
Total:		**2,204**	**2.3**
Lower Hume	Mitchell	344	1.1
	Murrindindi	102	0.7
Total:		**446**	**1.0**
Upper Hume	Indigo	94	0.6
	Towong	45	0.7
	Wodonga	455	1.4
Total:		**594**	**1.1**
HUME Total:		**3,683**	**1.4**

Source: ABS Census 2006

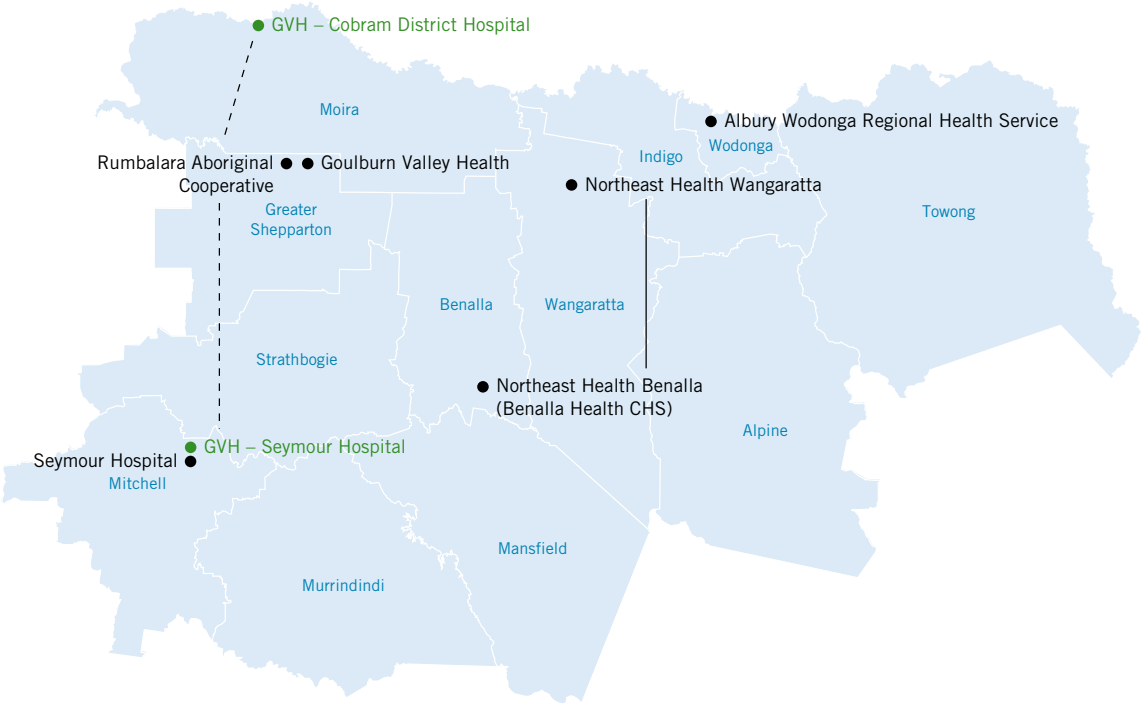
LGA – Local Government Area/IAP – Integrated Area Plan

The largest groupings of Indigenous people reside in the Greater Shepparton, Wodonga and Mitchell LGAs. Significantly, **46.3** per cent (or nearly half) of the Indigenous population in Hume are aged under 17 years.

It is important to note that the number of Indigenous people may be under-reported in the latest census (2006). Stakeholders from Mungabareena Aboriginal Cooperative estimate the Indigenous population in Albury Wodonga to be as high as 3,500, which is higher than census reports.

2.2 Hume oral health services

Figure 2: Location of Hume oral health services



2.3 Hume oral health service profile and data

Sub-region	Service	Chairs	Out-posting	Workforce	Denture work	Students	Oral health promotion	Other
Goulburn Valley	Goulburn Valley Health (GVH)	12 fixed	Cobram District and Seymour Hospitals – both 1 day per f/n	GVH: clinical director 1.0, practice manager 1.0. lab manager 1.0, dentists 3.9, therapists 2.4, technician 2.0, apprentice technician 1.0, instrument technician 1.0, dental assistants 11.2, reception 1.0. senior dentist 0.3 student supervision	Internal GVH lab	Ten groups of 8-10 Melbourne Uni students (4 week blocks) per year, plus private practice rotation. Will include Cobram rotation	GVH Integrated HP Plan inc OHP. Smiles for Miles (S4M)	Kyabram nursing homes outreach. Outreach/virtual chair using mobile cart.
	Rumbalara Aboriginal Cooperative	3 fixed	No	One dentist 7 days per f/n. Locum dentist from Bendigo (La Trobe Uni) provides 1 day per f/n	Private dental technician in Shepparton	Fifth year dental students (Melbourne Uni) from GVH	Some talks in schools. Dental dreaming (in past)	
Lower Hume	Seymour Hospital	1 fixed (children)	Sessional supervision from GVH	0.6 dental therapist 0.6 dental assistant	N/A	No	Links with Mitchell CHS (provider of S4M). Seymour special school	Option for additional oral surgery
Central Hume	Northeast Health Wangaratta	2 fixed 2 relocatable	No	Current – 0.8 practice manager, 3.4 dentists, 0.86 dental therapists, 0.2 prosthetist plus administration. Plan for – 4.8 dentists, 4.8 dental assistants and 1.6 dental therapists	Via private labs in Albury & Wangaratta	Discussions with Melbourne Uni – no capacity to take students at present	Limited S4M	Proposal re issue of split chairs and poor facilities
	Northeast Health Benalla	2 fixed (Benalla CHS)	No		2 private prosthetists fit in clinic, dentures in private lab		No S4M	
Upper Hume	Albury Wodonga Regional Health	4–2 fixed, 2 relocatable (10 fixed in 2010)	No	2.89 dentists 0.84 dental therapists	Private lab currently. Public lab planned in new development	La Trobe university dental students commence 2010	S4M via local government, CHS	Relocation of service to CHS site

The following table shows the number of patients, treatments, service visits and courses of care provided through community oral health services in the Hume Region across 2008–2009.

Table 6: Oral health service provision by Hume COHS July 2008–June 2009

Service	No of visits	No of treatments	No of patients	No of courses of care	Courses of care per patient
Northeast Health	7,289	23,115	3,892	4,481	1.15
Goulburn Valley Health	17,650	60,477	8,803	11,688	1.33
Rumbalara	1,518	5,657	637	858	1.35
Seymour District Hospital	3,896	6,876	686	925	1.35
Albury Wodonga Regional Health	5,455	16,673	2,689	3,300	1.23
Total	**35,808**	**112,798**	**16,707**	**21,252**	**Av - 1.28**

Source: Hume Dental Care Profile Report

COHS – Community Oral Health Services

It is important to consider these figures in light of information contained in table 7 below, which demonstrates that a significant number (1,812) of the eligible population in Lower Hume accessed services outside of the Hume Region. Specifically:

- 1,222 attended Plenty Valley CHS in Epping
- 482 went to Ranges CHS in Lilydale
- 60 accessed Nillumbik CHS in Eltham
- 48 received services from Dianella CHS in Broadmeadows.

GVH also provided services to 411 people from Seymour, Kilmore and Broadford, while 144 people from the Goulburn Valley area accessed services in Echuca.

The final column in table 7 shows the percentage of eligible Hume residents who accessed services in this period. Should this level of service provision continue, the eligible population of Upper and Lower Hume will only have access approximately every six to seven years, which is well over the standard of every two years for children and every three years for adults.

Table 7: Patient numbers by Hume COHS, vouchers & non-Hume COHS July 2008–June 2009

IAP	Hume patients COHS & vouchers	Hume patients – non-Hume COHS	Total patients	Eligible pop	Per cent eligible pop treated
Central Hume	5,487		5,487	25,106	22
Goulburn Valley	10,173	144	10,317	41,873	25
Rumbalara	635		635		
Lower Hume	677	1,812	2,489	17,519	14
Upper Hume	3,055		3,055	20,470	15
Total	**20,027**	**1,956**	**21,983**	**104,968**	**21**

Source: Hume profile and COHS service provision by Postcode

COHS – Community Oral Health Services

Table 8: Voucher issue by service July 2008–June 2009

Service	Victorian Emergency Dental Scheme (VEDS	Victorian General Dental Scheme (VGDS)	Victorian Denture Scheme (VDS)
Northeast Health	2,613	296	500
Goulburn Valley Health	1,074	15	85
Rumbalara	0	0	0
Seymour District Hospital	3	0	0
Albury Wodonga Regional Health	607	247	134
Total	**4,297**	**558**	**719**

Source: DHSV

Table 9: Hume Region adult waiting list at 30 June 2009

	General all Target <23 months		Denture all Target <22 months	
Service	No.	Months	No.	Months
Northeast Health	2,742	38	597	41
Goulburn Valley Health	3,608	19	630	33
Albury Wodonga Regional Health	1,321	21	278	14
Total/Ave.	**7,671**	**26**	**1,495**	**29.3**

Source: DHSV

RDHM presentations

Eight hundred and eighty-two people from the Hume Region were treated at the Royal Dental Hospital Melbourne (RDHM) in 2008–09. The services most frequently used were oral/maxillo-facial surgery and theatre followed by primary and emergency care, orthodontics and oral medicine. More than 440 of these people live in Lower Hume with primary (69) and emergency care (67) being the main services accessed at RDHM (possibly reflecting the absence of adult services in Lower Hume and the closer proximity to Melbourne than other parts of Hume).

Hospital presentations

- For Seymour Hospital, the largest diagnostic related group (DRG) for 2007–08 was dental extractions and restorations at 146, compared with 114 in 2008–09. In addition, 60 people presented to the emergency department for dental issues; of these, 35 had toothache and 16 had a dental abscess.
- Stakeholders from Upper Murray Health and Community Services estimated they had 50 emergency presentations for oral health issues in 2008–09.
- Dental weighted inlier equivalent separations (WIES) for 2008–09 for Hume Region hospitals are shown in the table below. Northeast Health Wangaratta, GVH, Seymour Hospital and Benalla Hospital all have similar dental WIES; the exception being Albury Wodonga Health Wodonga campus (which may be due to the proximity of Albury Hospital).

Table 10: Dental WIES Hume Region public hospitals 2008–09

Hospital	Separations	WIES
Northeast Health Wangaratta	137	64.71
Goulburn Valley Health	136	62.67
Seymour District Memorial	121	58.15
Benalla & District Memorial	120	58.41
Albury Wodonga Regional Health	30	9.79
Yarrawonga District Health	4	2.04
Yea & District Memorial	3	1.53
Alexandra District Hospital	2	1.02
Cobram District Hospital	2	1.02
Kilmore & District Hospital	2	0.37
Mansfield District Hospital	2	1.02
Beechworth Health Service	1	0.51
Nathalia District Hospital	1	0.66
Numurkah & District Health	1	0.51
Tallangatta Health Service	1	4.25

Source: Department of Health

WIES – Weighted Inlier Equivalent Separations

Dental Ambulatory Care Sensitive Conditions

Overall, the Hume Region is below the state average of admissions for dental Ambulatory Care Sensitive Conditions (ACSC). However, both Central and Lower Hume dental ACSC are ranked third, which is the same as the state average for admissions per 1,000 persons, while Upper Hume is significantly below the state average.

Table 11: Hume Region and Victoria dental ACSC all ages 2007–08

IAP	Rank	No. of admissions	Rate per 1,000 persons	Av bed days	Total bed days
Central Hume	3rd	208	3.47	1.24	257
Lower Hume	3rd	163	3.45	1.13	184
Goulburn Valley	8th	233	2.36	1.21	282
Upper Hume	11th	45	0.81	1.40	63
Hume Region	**5th**	**649**	**2.46**	**1.21**	**786**
Victoria	3rd	15697	3.02	1.14	17954

Source: Department of Health Victorian Health Information Surveillance System

As presented in table 12, the Hume Region is close to the state average for dental ACSC for those aged between 0–14 years. It is worthwhile to note that over 46 per cent of the admissions for dental ACSC in Hume are for this age group (300 from an overall 649) with Goulburn Valley and Central Hume each having more than 100 admissions in this period. This compares with 36 per cent of total admissions for Victoria for this age group.

Table 12: Hume Region and Victoria dental ACSC 0–14 years 2007–08

Age cohort	Rank	No. of admissions	Rate per 1,000 persons	Av bed days	Total bed days
0–4yr	3rd	119	7.26	1.03	123
5–9yr	1st	151	8.42	1.01	158
10–14yr	2nd	30	1.52	1.13	34
Hume Region 0–14 yrs	**1st**	**300**	**5.66**	**1.03**	**310**
Victoria 0–14yrs	1st	5,265	5.37	1.03	5,415

Source: Department of Health Victorian Health Information Surveillance System

Across 2007–08, Central Hume had a rate per 1,000 persons of 13.78 for 0–4 year olds and 15.02 for 5–9 year olds, far exceeding the state rate of 5.21 and 8.53 respectively for these age cohorts. High levels of dental ACSC for these age cohorts may relate to the perceived need to use general anaesthetics on younger children to enable complex dental treatments.

It is also worthwhile to note the marked differences in dental ACSC admission rates across Victoria in areas where water is fluoridated compared to not fluoridated (higher dental ACSC) and those of high SEIFA compared to low (higher dental ACSC).

Table 13: Decayed, missing and filled teeth (DMFT) 2004–06

IAP	Aged 6 yrs DMFT	Aged 12 yrs DMFT
Central Hume	3.46	1.26
Lower Hume	3.81	1.17
Goulburn Valley	3.49	1.18
Upper Hume	2.74	0.97
Victoria	**2.79**	**1.22**

Source Department of Health VISDED data 2004–2006

Table 13 demonstrates that in all areas, except Upper Hume, the level of decayed, missing and filled teeth (DMFT) for children aged six years is well above the state average. The DMFT for children at 12 years was below the state average in all areas except Central Hume.

Table 14: Hume Region decayed, missing and filled teeth (DMFT) and decay experience 2008

Region	Aged 6 yrs DMFT	Per cent with no decay	Per cent with active decay	Aged 12 yrs DMFT	Per cent with no decay	Per cent with active decay
Hume	3.38	34.40	45.80	1.32	48.40	32.40
Victoria*	**2.80**	**40.60**	**48.60**	**1.50**	**46.40**	**37.70**

* Source DHSV n=3232 6 year old children and 2442 12 year old children

Table 14 shows that for children aged six years, Hume Region is above the state average for DMFT and is below the state average for children who have no decay experience. In comparison, for children aged 12 years Hume Region is below the state average for DMFT and above the state average for children with no decay experience.

Table 15: Children recall interval (June 2009)

Service	No. for recall per annum	Low risk – month	High risk – month	Change in low risk over last 1/4	Change in high risk over last 1/4
Northeast Health	1,867	25.0	13.0	-1.0	-1.0
Goulburn Valley Health	2,936	23.0	11.0	0.0	0.0
Seymour District Hospital	925	26.0	14.0	3.0	3.0
Albury Wodonga Regional Health	2,004	39.0	27.0	1.0	1.0
Hume Total/Average	**7,732**	**28.0**	**16.0**	**0.3**	**0.3**
State Total/Average	**78,674**	**32.9**	**19.9**	**1.2**	**1.1**

Source DHSV

With regards to the recall intervals for children in June 2009:

- GVH was the only service in Hume to achieve recall targets for both high and low risk children.
- Northeast Health focused on service provision to children and reduced the recall time for both high and low risk children by one month.
- It is thought that issues with data entry may be a factor in the high recall intervals recorded for Wodonga.
- Overall, 90 per cent of children due for recall were offered an appointment but only 46 per cent accepted (or 41.8 per cent of those due for recall).
- The majority (4,221) of children on the recall system are aged 5–12 years, although this is only 10.9 per cent of the total 5–12 year population.

Further information from DHSV identifies the percentage of children from preschool, primary school and secondary school age groups who were treated during 2008–09:

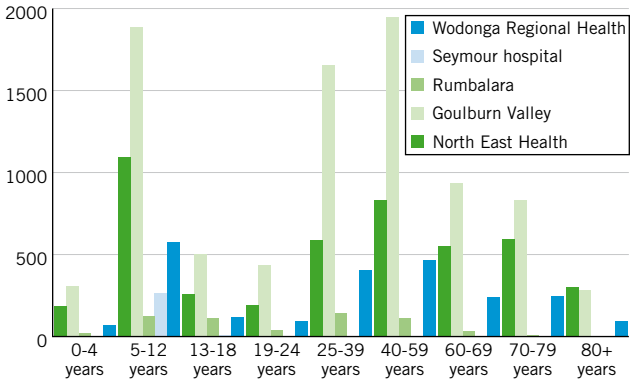
- Approximately 4.8 per cent of the estimated preschool population was treated, which equates to generally very poor access.
- Around 15 per cent of the estimated 5–12 year population was treated, which is higher than a number of other regions.
- Overall, 9.5 per cent of the estimated secondary school age population was treated, which due to eligibility restrictions is not unexpected.

(Note: No benchmarks re percentage of child population treated are in place)

Age and language spoken

Data relating to age and language spoken was available for 80 per cent of all Hume oral health clients (not all statistics were collected). This data indicates that 28 per cent of clients treated in Hume are aged between 0–12 years and 37 per cent are aged between 25–59 years. Nineteen per cent of clients serviced by Rumbalara were aged 13–18 years, which is a higher proportion than for other services.

Figure 3: Number of occasions of service by age by site 2008–09



Source – DHSV

Four per cent of Hume clients (672 in total) were recorded as speaking a language other than English, with Arabic, Dari, Turkish, Italian and Albanian being the most common languages spoken. Of the 672 clients, 580 were treated at GVH. Forty-six people treated at Northeast Health recorded their primary language as Italian, while Albury Wodonga Regional Health saw 15 people who spoke Nepali.

3. Service strengths, issues and priorities

This section outlines the strengths of the existing services and the identified issues and gaps that impact on service capacity, supply and demand in relation to:

1. oral health services
2. oral health workforce and students
3. service coordination
4. priority groups
5. oral health promotion
6. facilities (capital requirements)

These are derived from consultation with key stakeholders (see Appendix 1 for full list); reference to the findings of previous sections; and analysis undertaken by the project consultants. Stakeholder suggestions regarding future service development were considered by partnership members. Agreement was reached regarding those of high priority, forming the basis of the service configuration and action plan as outlined later in this document.

3.1 Oral health services

Current strengths

Satellite services supporting areas of limited access

Various initiatives have been implemented in an effort to build service capacity and meet needs across Hume, particularly in areas of limited access. For example, GVH provides sessional supervision to Seymour and sessional public services in Cobram. GVH also developed an outreach approach via what is commonly referred to as a 'virtual chair,' an innovation which provides a basic oral health service via a dental therapist and a mobile 'cart' to people residing in aged care facilities. GVH was also the first oral health service in Victoria to integrate the School Dental Service with the adult dental service.

Virtual chair

GVH first to integrate SDS

Rumbalara capacity building

Support is provided by GVH to Rumbalara through mentoring of dentists and student placements. While increasing service capacity at Rumbalara, this practice also provides students with knowledge and experience in working with Indigenous communities.

Children

Taking over from DHSV in 2008, the Seymour District Hospital provides a quality and viable children's service. The integration of the oral health service within the Community Services program demonstrates an overall organisational commitment to oral health.

Cobram growing

Effective public/private mix

Providing a successful, but limited, public/private oral health service, Cobram District Health is extending its four chairs to five to increase the level of oral health services available to public and private patients. This is a unique approach with Cobram supported by GVH (one day per week for public service) in a hub and spoke model. Sharing the facility with a medical clinic should support the referral of eligible public patients via the Medicare Chronic Disease Scheme for people with chronic conditions.

Committed staff

Despite the current situation of facilities in Wangaratta (see section 3.6), Northeast Health is committed to community oral health and will be at a full complement of staff late this year.

The newer facilities located in Benalla are a more positive work environment for staff; however, keeping the clinic staffed is an issue (see section 3.2).

New Wodonga locale and chairs

The relocation of the Albury Wodonga Regional Health oral health service to the Gateway Community Health Service site in the main street of Wodonga (2010) and the addition of more chairs provided through the university increases the capacity to host student placements.

Positive outcomes from student placements

Student placement at GVH is viewed positively by the University of Melbourne Dental School which, working with GVH, has developed a sustainable student placement program. The return rate of graduates to work in the Hume Region bears out the value of this approach. Opportunities exist for a similar outcome from the La Trobe University oral health student placements at Wodonga.

Issues and gaps

Lower Hume is the only area in the Hume Region that does not have a sustainable community oral health service (other than one chair dedicated to children's services). A high proportion of the eligible adult population are not accessing services at all. For example, only four per cent of eligible clients accessed community oral health services in Lower Hume in 2008–09 with a total of 14 per cent accessing services when Lower Hume residents accessing service at Plenty Valley and Ranges CHS are taken into account. In the same period, 440 Lower Hume residents accessed RDHM for treatment with primary (69) and emergency care (67) being the main services provided (again reflecting the absence of adult services in Lower Hume).

Lower Hume – no chairs

To meet some of the demand for adult services, discussions are in train regarding the option of providing a two chair relocatable dental clinic to be housed on the hospital site in 2010. Stakeholders commented, however, that placing the relocatable clinic in a different area of Seymour Hospital to the current single children service's chair (due to space constraints) has the potential to create similar issues to those experienced in Wangaratta (see section 3.6), for example relating to client access and service delivery in proximity to the reception area.

Other areas of need: Corryong Oven's Valley

Stakeholders noted two other locales – Corryong and surrounds and the Oven's Valley – as areas where access to community oral health services is very limited due to distance and minimal transport options. There are also very few private services available and cost is a prohibitive factor for many. Having had access to a limited community oral health service at Corryong until recently, Upper Murray Health and Community Services has suggested that it could financially and logistically support initiatives to re-establish oral health services in that area.

Chair ratio

Stakeholders commented that the current 'chair ratio' (one dental chair per 5,000 eligible population) does not take into account student placements and the resulting reductions in chair productivity. It is estimated that student placements can reduce output by half. Where oral health clinics have a large complement of students (for example, GVH and in future Albury Wodonga Regional Health) stakeholders recommend an acknowledgement of these 'productivity losses' in the ratio of chairs to eligible population.

Waiting lists

As described in table 9, waiting lists average 26 months for general services and 28 months for denture services across Hume, with both figures higher than the statewide average.

Meeting increasing demand

The drought is a significant issue for the region and is expected to add to the socioeconomic disadvantage of the community. This will translate to (an already seen) increase in the number of health care card holders, more people eligible for community oral health services and more pressure on services and waiting lists. Rumbalara is also experiencing an influx of clients from more outlying areas such as Deniliquin, which impacts on their capacity and waiting list.

The issue of meeting demand is compounded by a limited number of private dentists to undertake voucher work in some areas. Long waiting lists are evident for most private dentists. In the past, additional payments to help meet waiting list demand in Wangaratta resulted in private practices employing more staff to meet the increased demand. When the additional voucher payments ceased, demand on these practices reduced and they were faced with the issue of having more staff than required.

Denture services

Access to denture services and denture waiting lists is another area of concern for stakeholders. For example, in Wangaratta there is currently an eight week wait for non-priority denture repairs. People are required to wait for dentures for close to three years at GVH, which leads to an expectation from clients that new dentures are required.

'If they didn't need to wait for so long the client may be happy to hear that they didn't need new dentures and come back in one year. But because they wait for three years they demand that they get new dentures even if they don't really need them'. (Dental Officer)

Children

Several stakeholders cited issues and gaps in relation to children's services. The integration of children's services in Wangaratta has meant oral health staff are required to see more children, resulting in an increase to the adult waiting list (table 9). However, changing the children's service to a centre-based rather than school-based service has increased the number of children not responding to recall, particularly in parts of Benalla. Access to transport and the move to more 'family friendly' hours were suggested by some stakeholders as options to promote access for children (for example, Plenty Valley CHS provides services on Saturday mornings).

Specialist services

Some specialist service types are available publicly in Hume (for example, GVH has some capacity for endodontics due to their endoscopic microscope). For others, people are required to pay privately (with costs too prohibitive for some) or travel to RDHM (also a difficulty for some families). In 2008–09, 882 people from the Hume Region were treated at RDHM. Specialist services used by these people included oral/maxillo-facial surgery, orthodontics, theatre and oral medicine).

Stakeholders cited a need for more locally-based specialist options that include procedures requiring a general anaesthetic, other oral surgery and orthodontics for adults and children. Of note is the limited access to theatre for dental treatment requiring general anaesthetic in Wodonga. The specialist service gap is further discussed in section 3.2 as it relates strongly to workforce issues. The development of a regional specialist service model is outlined as a partnership priority.

Partnership priorities for oral health services

Partnership members agreed to the following three key priorities (recommended strategies and actions to progress these priorities are provided in section 6: Action Plan).

1: Promote access to community oral health services

Build access to community oral health services

Continuously seek out and develop strategies that promote access and reduce waiting times to community oral health services for eligible people who live in Hume. In particular:

1a): Lower Hume

Lower Hume

Undertake a planned approach to meeting current and future demand for oral health services (across Mitchell and Murrindindi) that takes into account the transport and access issues in Lower Hume and the natural movement of people.

1b): Outreach/access models

Investigate/further develop outreach models in areas of limited access, including:

Virtual chair
Mobile services

- expansion of outreach/virtual chair approach (see Action Plan for examples)
- mobile service options (for example, DHSV has a domiciliary treatment van under development which is planned for use in rural Victoria)

Replicate GVH approach

- replicate GVH approach of outposting services in areas of need
- explore public/private options (see 1c).

1c): Public/private options

Map private services
Private public mix

Map private dental services to understand the level, type and locale of private services and to identify further options for public/private mix.

Link with health services

Consider the option presented by the private dentist in Wallan (see page 3). Note: strong links with a health service would need to be part of any public/private service (for example similar to those between GVH and Cobram District Hospital).

1d): Denture services

Create greater access to public denture services. Consider:

Lab facilities

- understanding options for laboratory facilities in service developments or redevelopments

Central portfolio role

- centralising laboratory services (also an option to be a 'portfolio role' for one organisation)

Re-screen denture clients

- exploring possibilities to 're-screen' clients on denture waiting lists (being cognisant of the level of actual need).

2: Sub-regional oral health networks

Sub-regional networks

Develop two sub-regional clinical oral health networks based on a natural alignment of organisations as follows:

Sub-region 1:

- Goulburn Valley Health
- Cobram District Hospital
- Seymour Hospital
- Rumbalara

Sub-region 2:

- Albury Wodonga Health
- Northeast Health
- Benalla Health

Built on shared agreements (potentially Memorandum of Understanding based), the (non-operational) role of the sub-regional networks will be to implement priorities outlined in the *Hume Region integrated oral health plan*, for example sharing staff training and development opportunities, shared waiting list management.

3.2 Oral health workforce and students

Current strengths

While the recruitment and retention of oral health staff is a continuing issue, stakeholders commented on several key strengths of the oral health workforce in the Hume Region:

Northeast Health – full staff

- Northeast Health is pleased to achieve a full staff complement later this year after concerted recruitment efforts.

GVH – positive environment

- GVH is able to offer a wide breadth of experience for staff and also focuses on maintaining a close team and a friendly and relaxed environment.
- The GVH Internship Model has supported full dental staffing. Extending this program to a second year of internship provides the flexibility to develop and expand the virtual chair/outreach approach.
- Of the 100 students who had placements at GVH in 2008, 10 have returned on graduation to work in Hume Region in the public or private sector.

University/ student developments

- Positive relationships with universities are recognised as a key opportunity to build oral health service range and availability through student placements (refer 1.2.4 Student Placement Developments). La Trobe University is planning to create a specialist teaching school at Bendigo which could potentially meet (with appropriate supervision arrangements) some of the specialist service gaps in Hume Region.
- The Cobram redevelopment will provide student (registrar) placements and options for additional theatre and oral surgery specialities.

Public/private options

Cobram Hospital facilitates a successful public/private oral health service which addresses a workforce and service gap in that area. Options to develop approaches of this type were suggested by several stakeholders.

Issues and gaps

Staff recruitment a key issue for rural services

Similar to other health sectors in regional and rural areas, oral health services, both public and private, grapple with the issue of finding and recruiting appropriate staff. All those consulted (including private dentists) cited this as a key, significant and ongoing issue that impacts on their capacity to maintain fully functional services. Table 16 compares average FTE over 2008–09 to available public chairs, demonstrating this issue.

Table 16: Community oral health chairs and workforce (June 2009)

Community oral health Agency	Chairs	Av FTE	Workforce			
		Jul 08–Jun 09	DO	DT	DP	UGT
Northeast Health	6	4.45	3.41	0.86	0.20	-
Goulburn Valley Health	12	10.79	4.96	2.48	0.75	2.61
Rumbalara	3*	1.10	0.60	0.50	-	variable
Seymour District Hospital	1	0.94	0.07	0.60	-	-
Albury Wodonga Regional Health	4	2.40	1.39	1.01	-	-

Under staffing = underutilised chairs

* Rumbalara has 2 full service chairs and 1 limited service (examination and dentures only)

DO – Dental Officers/DT – Dental Therapist/DP – Dental Prosthetists/UGT – Under Graduate Trainee

Staff retention

The retention of oral health staff is also an issue cited by stakeholders. In particular, retaining staff who often have to work in challenging conditions, and the perception that the work is not very rewarding.

> We are always responding to emergencies and doing things like quick extractions – it feels like very 'in and out' type work (dental officer)

Other issues include:

Salaries

- The rural salary loading available to some oral health staff is not available to dental technicians, which impacts on recruitment and retention of these staff.
- Salaries are lower than those available to NSW community oral health staff.

Sick leave, annual leave cover

Staffing

- While Northeast Health is pleased to be achieving full staffing later this year, cover for sick leave and other staff absences is always an issue. Identifying options to address staff cover for sick leave and annual leave (for example, on-call, rotating staff) was suggested by several stakeholders.

Seymour

- Some stakeholders are concerned that it will be difficult to find dentists to staff the proposed additional chairs in Seymour.

OHP experience

- It is difficult to recruit staff with oral health promotion experience in some areas.

Lack of private dentists and long waiting lists for private services in some areas

As is an issue for many rural regions, there is limited access to private dentists in many areas of Hume. The Dental Practice Board register of dental care providers shows the following towns have no dentists:

- Upper Hume: Beechworth, Chiltern, Corryong, Mitta Mitta, Rutherglen, Tallangatta, Yackandandah
- Lower Hume: Broadford, Flowerdale and Yea.

The National Dental Labour Force Survey (2007) indicated that across PCP catchments in Hume there were only nine dentists working in Lower Hume (0.19 per 1,000 people), 23 in Central Hume (0.37 per 1,000 people), 23 in Upper Hume (0.41 per 1,000 people) and 45 in Goulburn Valley (0.46 per 1,000 people) compared to a rural average of 0.44 per 1,000 people. As a result, many dentists have long waiting lists (up to six months in Benalla and three months in Wodonga) which is an issue for the sector as it can be difficult to then find private dentists willing to undertake public 'voucher' work. Some private dentists have also had difficulty finding buyers for their practices if wanting to sell.

Many of the private dental services in the Hume Region are operated by the Alliance Dental Group, which run clinics in Yarrawonga (five days week one, three days week 2), Bright (two days each week), Myrtleford (five days week one, three days week two), Benalla (two days each week), Cobram (two days every second week) and across the border at Corowa (four days per week). Some of these dentists live locally while others travel from Melbourne. An option exists to explore the current use of these chairs to see if they are fully utilised.

Lack of local specialists

As identified in section 3.1, many eligible people travel to RDHM to access specialist services, while some are provided locally. In Hume over 2008–09, oral surgery was the most often accessed speciality, followed by endodontics, orthodontics and periodontics[9] (across all services).

Mapping to underpin developments

Stakeholders cited a preference to build the Hume oral health workforce and provide some specialities locally. A more detailed mapping of what is currently delivered and available is required, in addition to identifying options and capacity requirements for local delivery.

Analysis of student placement implications

With proposed increases to the number of oral health students, some stakeholders believe an analysis of student placement demands is warranted and could be undertaken statewide. For example, there is a need to provide amenities, accommodation and staff support to the student pool – what are the costs involved? Future service and capital development should also be cognisant of the requirements to support student placements.

9 DHSV data

Partnership priorities for oral health workforce and students

Specialist service model

Partnership members agreed to the following three key priorities (recommended strategies and actions to progress these priorities are provided in section 6: Action plan).

1: Regional specialist service model

Develop a regional specialist service model based on a clear understanding of demand and need; current specialist service options in Hume including private; options for graduate and postgraduate students in more specialist roles; and resource requirements. Consider opportunities presented by postgraduate students, for example outreach student experiences in different locations.

2: Shared workforce development

Shared workforce development

The partnership is working together on a shared model for credentialing and clinical governance. The opportunity exists to build on this work and develop the following:

2a): Shared recruitment approach

A centralised recruitment approach – potentially a portfolio or role of one organisation. While stakeholders recognised the benefits of a more integrated oral health service, and the potential for a centralised recruitment approach, some cited concerns that this may create an expectation of staff moving around to fill gaps which is not seen as a preferred option for most staff. Minimising this perception will be important.

2b): Shared approach to workforce retention

A centralised approach to workforce retention. For example, expanding/sharing learnings from the GVH model, continuing education, career path development.

Linking to 'dentaljobs' and 'dentalgaps' (see below) are also suggested.

'Dentaljobs' is a website linked to DHSV that advertises job vacancies including graduate and trainee positions (www.dentaljobs.org.au).

'Dentalgaps' is a Victorian Government funded website being implemented by the Gippsland Oral Health Consortium and led by Latrobe Community Health Service to improve access to dental services in the Gippsland region, particularly for public patients. It aims to strengthen partnerships between public and private sector dental service providers and assists with the recruitment and coordination of vacant dental positions within Gippsland.

3: Rural dental student placements – demand analysis

Take part in a statewide analysis of student placement demands and requirements (with DHSV).

Other considerations:

Dental Therapist Expanded Scope of Practice: A pilot bridging program facilitated by DHSV (November–March 2010) targeting dental and oral health

therapists working at RDHM and oral health services. The aim is to translate the current scope of practice from under 25 years only to include older adults and broaden the range of places a dental therapist may work.

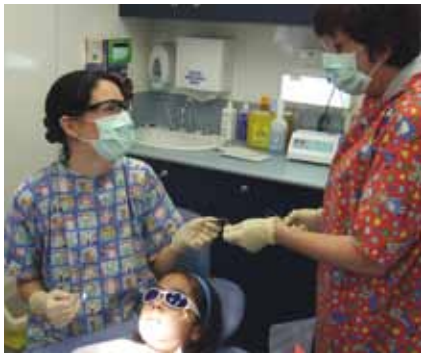
'Region of Choice': A recruitment and support service for health professionals in regional Victoria (as yet dental professionals are not included but may be so in future).

3.3 Oral health service coordination

Expectation that oral health services adopt service coordination and use the SCTT

Improving Victoria's oral health[10] promoted the take-up of service coordination by oral health services to improve access, share knowledge and resources and to support early identification of client needs using the Service Coordination Tool Templates (SCTT). Despite service coordination and use of the SCTT being mandated in the Dental Health Program in 2003[11] there has been limited use of the SCTT by oral health services.

The SCTT supports service coordination through:



- collecting and sharing common consumer information when making referrals
- aligning information from different processes (for example, initial needs identification and consent to share information)
- reducing the need for consumers to provide the same information to each new service provider.

Many organisations across Victoria have adopted the SCTT as their core information and referral tool. The recently released SCTT 2009 introduced oral health questions on the Health Behaviours and Health Conditions optional profiles:

- Are you currently experiencing any problems with your gums, teeth or mouth?
- Have you had a dental check up in the last three years?

These questions support a whole-of-health approach to ensure that other primary health workers consider their clients' oral health and that needs are identified early. The letter template files in Titanium were updated in the new version of SCTT in July 2009. Oral health services in Hume do not use the SCTT for initial needs identification and referral.

Chronic health conditions

The links between poor oral health and other chronic health conditions are well recognised, for example, those between periodontal disease and cardiovascular conditions and those connecting diabetes and development of dental cavities.[12] Service coordination also offers an opportunity to link oral health clients with chronic health conditions to appropriate services and approaches, such as the Early Intervention in Chronic Disease in Community Health (EliCD) initiative which focuses on community-based early intervention services for people with chronic diseases.

10 DHS: *Improving Victoria's Oral Health 2007*

11 Primary Care Partnerships and Public Dental Services Service Coordination

12 Australian Dental Association Media Release August 2004

Current strengths

Service coordination at the developmental stage

- Integration of oral health services with general health services (for example, integration of oral health into community services at Seymour) across Hume provides opportunities for service coordination over a wide range of programs.
- GVH has worked in a developmental way with services such as Aged Care Assessment Services (ACAS) in assisting them to identify clients' oral health concerns. Service coordination work to support the identification of oral health issues has also occurred with the emergency department, paediatric speech pathology and diabetes service.
- The Goulburn Valley Primary Care Partnership (GV PCP) is working with services to build capacity in service coordination practice (for example, best practice in assessment).
- The Northeast Health oral health service has met with Wangaratta Hospital regarding the implementation of a single point of entry. Consideration is being given to adopting a dental screening practice for people being admitted to the aged care facility.
- Central intake is to commence at Benalla Community Health Service. Currently there is little cross referral from allied health services to oral health, excepting the dietician.
- Relocation of the Albury Wodonga service to Gateway CHS building provides greater opportunity for the development of cross-program links
- The Rumbalara oral health service works alongside the onsite medical clinic. The GPs refer clients via the Medicare Chronic Disease Scheme.

Partnership priorities for service coordination

Partnership members agreed to the following three key priorities (recommended strategies and actions to progress these priorities are provided in section 6: Action plan).

1: Service coordination: education and practice development

Two aspects of service coordination are relevant:

'We need to get all sectors to think above the neck line and ask about oral health'

- **Linkage in** to the oral health service and how the client's oral health issue is identified in other parts of the service system, for example by GPs and emergency departments. Work needs to be done on mainstreaming the screening for oral health issues (see continuum in point two). Other options are the development of oral health champions, similar to the work done by GVH in promoting the screening of oral health issues.

Educating oral health staff

- **Linkage out** – How does the oral health service identify other health issues and link the client to appropriate services? This will involve education on service coordination principles and practice. Service coordination provides an effective basis to work with people with chronic conditions and complex needs by assisting them to access other health and support services. Key to this is oral health staff familiarity with service coordination principles and understanding of the range of other services provided.

Flag high needs clients

GP education

Other considerations suggested by stakeholders in developing service coordination include:

- developing a system that may 'flag' potentially high needs clients; for example, people with chronic diabetes may be sent a letter asking about oral health needs
- working with the GP Divisions and School of Rural Health (which has a GP teaching clinic) in developing GP oral health screening practice.

2: Service coordination approach

The partnership works to develop an integrated service coordination approach for people who are at risk of or have oral health concerns, recognising that the development of service coordination practice is at different stages for organisations across Hume. For example, some community health services have fully adopted the SCTT in practice while other services, including oral health, are still developing service coordination practice.

Organisations agree to adopt practice along continuum

As such, the opportunity exists to develop a continuum of practice to support the development of service coordination. Organisations, agreeing to promote oral health service coordination in their own agency, will identify at which point of the continuum their organisation will develop associated practice. For example, some may promote the use of the SCTT Health Behaviours profile (which asks questions about oral health) at intake. Relevant members of the oral health team could be trained to undertake initial contact and initial needs identification with oral health clients who have chronic health conditions.

3: Analysis of demand

The partnership would like to clearly understand current service demand – that is, who is on the waiting lists? From which postcodes and areas? How many people are on more than one waiting list? Analysis of service demand is a priority. Note: this work is soon to commence statewide (Department of Health).

The issue of a single point of entry, pathway and central waiting list for community oral health services in Hume was put to the partnership, which concluded that the above priorities be addressed before this is considered.

3.4 Priority groups

Current strengths

Services provided to Indigenous and special needs groups, pregnant women and teenagers and people with chronic conditions

Community oral health services in the Hume Region are inclusive of the following high needs groups as identified in *Improving Victoria's oral health*[13]:

- Indigenous people – a large number of Indigenous people live in Hume. Rumbalara provided oral health services to 637 people in 2008–09 (the 2006 census indicates there were 3,683[14] Indigenous people residing in Hume). GVH supports Rumbalara with mentoring and student placements.

13 *Improving Victoria's oral health 2007*

14 Note: Mungabareena staff believe this figure may be under reported.

- People with special needs (for example those with physical and intellectual disabilities, medical or mental health issues) – the GVH virtual chair/outreach approach provides services for some of these client groups.
- Pregnant women – anecdotally, GVH is seeing an increase in pregnant teenagers.
- People with chronic and complex conditions (via Medicare Chronic Disease Scheme) – one stakeholder noted that private practices have not seen as many clients referred via this item as they would have anticipated, which is perhaps an issue of GP unfamiliarity with this item as an option for their clients with chronic conditions.
- GVH service provision to refugees and CALD communities (including S4M) is supported by links with settlement services and other agencies.

Issues and gaps

Refugees – resources to promote literacy

Stakeholders discussed the needs of Hume residents from marginalised groups. For example, working with the current and increasing refugee population requires more time and resources, particularly around issues of communication and gaining informed consent from people who have had no experience of oral health care and poor health literacy.

People in care

People with special needs in care facilities. like supported residential services (SRS) and nursing homes, are another high needs group reported by stakeholders. Additional time and resources are required to service these groups. (Note: A census[15] of SRS in 2008 noted that 62 per cent of residents of pension level SRS had a psychiatric disability.)

Children with special needs

The special needs theme also extends to children with disabilities who require oral health services. Providing outreach oral health services to special development schools was suggested as an unmet need.

Drought and bushfire affected

As mentioned, people affected by drought and bushfires are another group of growing need. Anecdotally, stakeholders have noticed that some of these people are putting off visiting oral health services and when they eventually do present, the oral health issue may be significantly worse.

Closing the Gap[16] highlights the Australian Government's priorities for improving the health, wellbeing and life expectancy of Indigenous people. The government has committed funds 'to improve chronic disease management and expand the capacity of the health workforce to tackle chronic disease in the Indigenous population'. This strategy includes extra health professionals in Indigenous services.

15 Department of Human Services 2008, Supported Residential Services Census March 2009

16 Australian Government, Closing the Gap on Indigenous Disadvantage: The Challenge for Australia 2009

Within this broader context, the Victorian Government has endorsed Department of Health regional implementation plans[17] which detail actions within five priority areas: tackling smoking; primary health care services that can deliver; fixing the gaps and improving the patient journey; health transition to adulthood; and making Indigenous health everyone's business.

Developing approaches for Indigenous communities

Research[18] has also identified that Indigenous children have higher rates of dental caries than their non-Indigenous counterparts.

Most agreed that continuing to build oral health service delivery to Indigenous people, particularly children and other high needs groups (for example, people with chronic diseases), is a priority and requires consideration of different models and options, including improving the cultural literacy and practices of oral health services in their dealings with Indigenous people.

The virtual chair/outreach approach with Indigenous people experiencing alcohol and drug issues was valued but difficult to maintain due to high resource requirements.

People with issues of drug use

The poor oral health of some groups of drug users is also becoming recognised as a key issue. For example, people who frequently use methamphetamines experience severe and significant tooth decay. Some stakeholders suggested that people affected by longer term drug use be included as a group of high need.

Painting by Dennis Baksh

Partnership priorities for priority groups

Partnership members agreed to the following three key priorities (recommended strategies and actions to progress these priorities are provided in section 6: Action plan).

1: Indigenous communities

Promote greater access of Indigenous people to oral health services through:

- building links and working relationships with services for Indigenous people; for example, the relocation of the Albury Wodonga service is seen by Mungabareena Aboriginal Cooperative as an opportunity to build links and access to the local service rather than transporting clients to Rumbalara
- building the cultural literacy and practice of oral health services in working with Indigenous people (this may include accessing resources such as Mungabareena Cultural Awareness Kits)
- promoting the participation of oral health services in *Closing the Gap* activities. For example, the government is funding Indigenous Health Project Officer positions to be located in Divisions of General Practice. Opportunities exist to work with these officers in oral health service development and promoting access.

17 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Hume Regional Implementation Plan (Draft)

18 Parker EJ, Oral health comparisons between children attending an Aboriginal health service and a Government school dental service in a regional location. Rural remote Health Apr-Jun 2007

Department of Health is also undertaking a project to identify models to improve access for Indigenous clients across all health services.

2: Refugee communities

Continue to promote access of refugees to community oral health services through understanding the numbers of newly arrived refugees and their communities of origin, the level of oral health need and appropriate service responses that promote oral health literacy within refugee communities.

3: Outreach/access models (for priority groups)

In section 3.1, the partnership identified a priority of developing outreach models for eligible people in areas of limited access. This priority is also identified for special needs groups with similar options to be considered:

- Expansion of virtual chair/outreach approach. For example, screening/basic work with children in special schools, Indigenous services, alcohol and drug services, other care facilities.
- Investigate mobile service options (for example, accessing the two DHSV 'special services' vans for children in special developmental schools. Currently they mainly operate in Melbourne but do at times visit rural locations).
- Replicate GVH approach of outposting services in areas of need.

3.5 Oral health promotion

DHSV 10-point oral health promotion plan

The current DHSV oral health promotion strategy[19] sets out actions to 'improve the oral health of Victorians, particularly the disadvantaged and those most in need'.

The strategy includes a 10-point oral health promotion plan:

1. Develop and disseminate best practice approaches, tools and resources
2. Evaluate existing and pursue new, evidence-based health promoting approaches
3. Enhance oral health awareness and literacy in the community
4. Improve the capacity of individuals and populations to manage their oral health
5. Develop regional leaders and oral health champions to drive local health promotion
6. Target interventions at high risk groups
7. Develop multi-sectoral partnerships to address risk factors of oral disease
8. Adopt a population health approach to underpin multiple integrated strategies
9. Develop systems to monitor population oral health status
10. Consider other settings, environments and approaches to address the underlying determinants of oral health.

19 Dental Health Services Victoria, *Statewide oral health promotion strategic plan 2008–2010*, DHSV, Melbourne

Smiles 4 Miles (S4M)

S4M aims to provide community oral health services and prevention programs for Victorian preschool-aged children through integrated health promotion programs focusing on building capacity and supportive environments in the early childhood sector and targeted treatment services focusing on children at highest risk of oral disease. An overall evaluation of S4M is in progress and will consider outcomes and the future of S4M.

Current strengths

S4M in 31 per cent of Hume facilities

Where present in Hume, the S4M program is seen as a strength; however, it is only run in 31 per cent of the early childhood services in the region. There are 152 early childhood services (86 kindergartens and 66 long day care services) and S4M is conducted in 47 of these venues (42 kindergartens and five long day care services). In 2009, S4M reached approximately 1,570 children attending kindergartens and around 200 children who attend long day care.

S4M promoted organisation links in Greater Shepparton

GVH is a facilitator for S4M in Greater Shepparton. A key positive of S4M for GVH is the development of stronger links between GVH Health Promotion, Greater Shepparton Family Services, Goulburn Region Preschool Association and local kindergartens.[20]

Dental dreaming valuable

Targeting Indigenous children and working in partnership with Hume Hygiene, Rumbalara developed 'dental dreaming,' an oral health promotion strategy. The strategy integrates Aboriginal dreamtime culture and art with contemporary dental health messages. The aim is to nurture leadership and build the capacity of local oral health professionals to deliver culturally appropriate oral health education resources. Seen as a successful approach, Rumbalara has been unable to maintain this program due to staff changes and issues of resources.

Limited OHP by dental assistants in schools

Resources

Dental assistants in some of the oral health services have responded to requests from local, predominantly special schools for student oral health education. This is limited due to resource constraints.

Issues and gaps

Confusion re responsibility for OHP

Stakeholders agreed that oral health promotion is valuable, particularly given that the risk factors for poor oral health are often risk factors for other health issues. The key issues, given the emphasis on direct service delivery and throughput, are the perceived lower priority of oral health promotion in the broader health promotion arena, the limited direct resources available in this area and the lack of clarity regarding the DHSV/Department of Health resourcing/activity monitoring role.

Incorporate 'whole of health'

All commented that, given more resources, they would like to further incorporate oral health promotion as part of their service suite in addition to seeing it aligned to a 'whole of health' approach, with oral health as 'part of the core business in work with all clients across all health services'. Furthering this aim could be

20 Goulburn Valley Health, *Shepparton Smiles for Miles Final report 2008–2009*

assisted via better relationships with PCP to 'further the recognition of oral health as an area which could benefit from health promotion strategies'.

Coverage of S4M – DHSV open to discuss needs

With regards to health promotion more broadly, PCPs have more recently assumed the role of facilitating local area health promotion plans in consultation with their member agencies. Discussions with PCP representatives noted that, while not a separately identified activity (in most instances), oral health promotion could be linked with other strategies around nutrition and chronic disease.

There is limited coverage of S4M across Hume Region, particularly in Central Hume – Benalla, Mansfield and Wangaratta and Lower Hume, with no S4M programs operating in the Murrindindi Shire. DHSV is open to discuss with stakeholders the needs and issues in areas where S4M is currently not available.

Partnership priorities for oral health promotion

OHP responsibility

Partnership members agreed to the following three key priorities (recommended strategies and actions to progress these priorities are provided in section 6: Action plan).

1: Oral health promotion in Hume

Regional leader

- Stakeholders agreed with the concept of an identified regional leader for oral health promotion (as per DHSV strategic plan) and saw it as an organisational role or portfolio that would require additional resources.
- Work in partnership with DHSV to ensure available resources are used effectively in the Hume Region.
- Work with PCPs, where possible, to promote the inclusion of oral health promotion in broader health promotion activities.

2: S4M priorities

Build S4M

Partnership members are cognisant of S4M evaluation findings (when Department of Health evaluation completed). This awareness will underpin S4M developments, for example, improved links with local governments that have projects to support oral health promotion for children, working with DHSV (see above) to address S4M gaps across the Hume Region.

3: Fluoride

Fluoride

Promote whole of Hume Region access to a fluoridated water supply.

3.6 Facilities (capital requirements)

Current strengths

Purpose built GVH clinic
On site with CHS

Community oral health services are delivered in a range of settings across Hume. The GVH clinic is purpose built and housed in the same building as the CHS and staff enjoy working in the facility which provides adequate space for clinical treatment, student teaching and lab work.

Also housed in a CHS, the two chair clinic at Benalla provides adequate space and a positive working environment.

Benalla clinic

Oral health service growth

The relocation and growth of the oral health service in Wodonga next year is a major plus for Upper Hume as is the planned increase from three to five public/private chairs at Cobram for people who live in the upper regions of the Goulburn Valley.

Innovations to meet need

As noted in previous sections of this report, oral health services in Hume have implemented several innovative approaches (staff outposting, virtual chair/ outreach approach) in an attempt to meet needs across the region, recognising that not all eligible people are able to access community oral health centre-based clinics.

Issues and gaps

Wangaratta facilities

Of key concern for Northeast Health staff is the current state of their Wangaratta facilities. These are cramped, not located together (two chairs are in a different area), are difficult for clients to access and provide little opportunity for private consultation with clients. Discussions with the Department of Health and DHSV are taking place to consider options to address this issue. Planning should incorporate capacity to accommodate growth in student numbers.

Wangaratta towable van

Lower Hume

As noted in section 3.1, Lower Hume currently has no adult community oral health facilities.

Partnership priorities regarding facilities (capital requirements)

1: Wangaratta facility

Confirm and progress the best option to address Wangaratta facility issues.

2: Lower Hume

- Upgrade facilities in the Lower Hume area through placement of the two chair clinic from Wodonga in the short term.
- Undertake a planned approach to meeting current and future demand for oral health services (across both Mitchell and Murrindindi) to underpin future capital bids.

4. Summary per sub-region

The following sections compile the key issues and factors related to community oral health services for each of the four sub-regions in Hume. The issues arise from analysis of data and consultation with key stakeholders.

Note: Given there are no **adult community oral health services in Lower Hume** and that the relocation of the two chair clinic is only a short term measure, partnership members agreed to the need for a planned approach to meeting current and future demand based on available information on current and proposed need. Further information to understand demand in Lower Hume is provided in Appendix 3.

4.1 Lower Hume

The Lower Hume sub-region comprises:

- Mitchell
- Murrindindi
  (see Map pg 13)

No adult community oral health services are provided in Lower Hume.

Parts of Seymour and Broadford are in the first decile (most) of disadvantage on SEIFA scale.

38 per cent of Lower Hume residents are eligible for community dental services.

Children make up 47 per cent of the eligible population in Mitchell with the total population projected to grow by 52 per cent by 2021.

58 per cent of the population of Murrindindi is eligible for community dental services. Natural travel routes and minimal public transport from Murrindindi to Mitchell results in limited access to the Seymour service from Murrindindi

Fluoridated water supply is not available in Broadford, Kilmore, Alexandra.

In addition:

- Only four per cent of the Lower Hume eligible population was treated at Seymour, with just 14 per cent of the eligible population receiving community oral services in 2008–09. Of those treated, 72 per cent were treated outside of Hume Region (impacting on waiting lists at Plenty Valley and Ranges CHS).
- **No private dental providers** are available in Broadford, Flowerdale and Yea.
- Dental ACSC rated 3rd and above state in admissions per 1,000 people.
- Sixty people presented to Seymour Hospital emergency department for dental issues in 2008–09 and 440 people sought treatment at RDHM.
- There were 114 dental DRG at Seymour Hospital in 2008–09 and 146 in 2007–08.
- DMFT rate above state average for six year olds. Recall rate for children not achieved.
- There is **no S4M program in the Murrindindi Shire**.

4.2 Goulburn Valley

The Goulburn Valley sub-region comprises:

- Greater Shepparton
- Moira
- Strathbogie
  (see Map pg 13)

Parts of Greater Shepparton, Barmah, Cobram, Numurkah, Tungamah, Yarrawonga, Euroa are first decile (most) disadvantage on SEIFA scale.

34 per cent of GV residents is eligible for community dental services.

45 per cent of the total population of Greater Shepparton is eligible with 25 per cent of the eligible population treated by GVH in 2008–09.

Four per cent of GVH clients were from Lower Hume.

In addition:

- Waiting list (GVH): General 19 months and 33 months for non-priority dentures.
- Dental ACSC rated 8th and just below state in admissions per 1,000 people.
- Significant number of eligible children; with DMFT rate **above state average for six year olds**. GVH has achieved target in child recall rates.
- 5.7 per cent of GVH clients spoke a language other than English.
- Goulburn Valley is home to the largest number of **Indigenous people** in Hume.
- Significant **refugee** population.

4.3 Central Hume

The Central Hume sub-region comprises:

- Alpine
- Benalla
- Mansfield
- Wangaratta
  (see Map pg 13)

Parts of Benalla, Wangaratta and Myrtleford are in the first decile (most) of disadvantage on SEIFA scale.

35 per cent of the total population of Central Hume is eligible for community dental services with 22 per cent of the eligible population treated by Northeast Health in 2008–09.

The population of Mansfield is projected to grow by **34 per cent** by 2021.

Fluoridated water supply is not available in Bright, Mansfield, Mt Beauty and Myrtleford.

In addition:

- Waiting list: general **38** months, non-priority dentures **33** months (staffing issue related).
- Dental ACSC rated 3rd and above state in admissions per 1,000 people. Dental ACSC for **0–4 and 5–9 year olds vastly higher than state**. DMFT rate above state average for **six and 12 year olds**. Recall rate for children not achieved.
- Limited coverage of S4M, particularly in Benalla, Mansfield and Wangaratta.
- High number of vouchers issued (3,409).
- 20 per cent oral health clients are aged 70+.
- Benalla unable to accept students at present.

4.4 Upper Hume

The Upper Hume sub-region comprises:

- Indigo
- Towong
- Wodonga
  (see Map pg 13)

42 per cent of Upper Hume residents are eligible for community dental services. Fifteen per cent of the eligible population was treated in 2008–09.

Children comprise over **40 per cent** of the eligible population in Towong, Indigo and Wodonga.

The population of Wodonga is projected to grow by 22 per cent by 2021.It is currently in the first decile (most) of disadvantage on SEIFA scale

Fluoridated water supply is not available in Beechworth, Tallangatta, Rutherglen and Corryong.

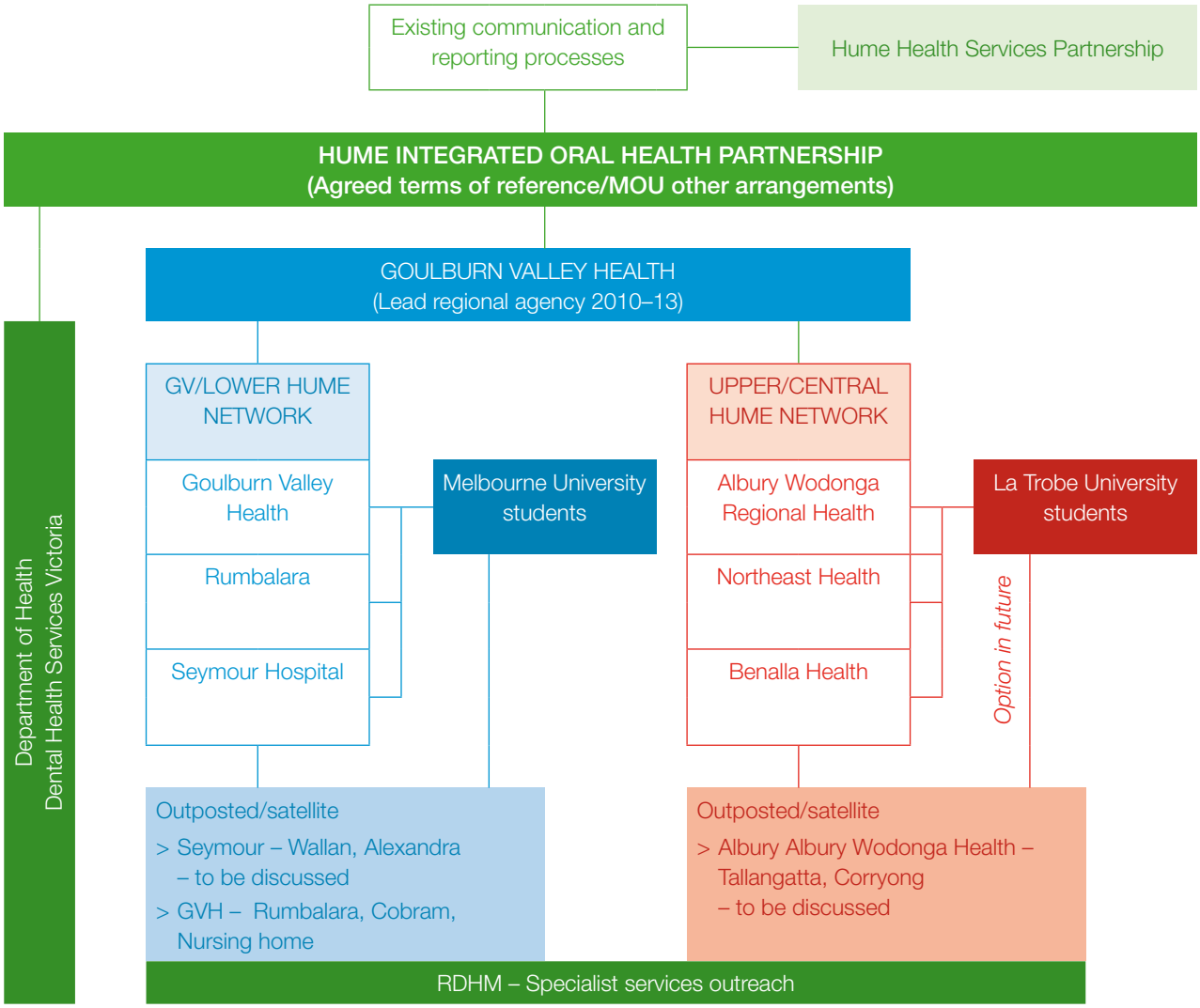
In addition:

- Waiting list: general 21 months, non-priority dentures 14 months.
- Dental ACSC rated 11th and well below state in admissions per 1,000 people.
- 50 people presented to Upper Murray H&CS emergency department for dental issues.
- A higher percentage of the Wodonga eligible population (12 per cent) was treated than those in Corryong (6 per cent) over 2008–09.
- Recall rate for children not achieved.
- Albury Wodonga is designated as resettlement area for **refugees**.
- **No private dental providers** are available in Chiltern, Beechworth, Yackandandah, Mitta Mitta, Corryong, Tallangatta and Rutherglen.
- The community oral health service that was available at Corryong and Tallangatta has ceased.
- Minimal public transport available across Upper Murray area, thus limited options for people in outlying areas to access community oral health services.

5. Service configuration

The following diagram outlines the recommended integrated service configuration of the Hume Region community oral health services. *Improving Victoria's oral health* (2007) describes the roles and responsibilities of each service type. These are included in Appendix 4.

Figure 5: Hume region oral health service configuration



6. Hume oral health action plan

6.1 Principles

Improving Victoria's oral health (Department of Health 2007) provides five key principles to promote oral health for disadvantaged Victorians. These are documented in Appendix 5.

Within this broader context, the following principles are recommended to underpin the development of the Hume Region integrated area-based oral health plan and the oral health service system in Hume.

- **Partnership commitment:** Hume Oral Health Partnership member organisations commit to the integration of oral health services and the best use of available resources to achieve sustainable models of community oral health service delivery and the best outcomes for consumers.
- **Planning:** Community oral health service configurations and levels are based on the statewide planning principles and shared and sound (partnership) planning process.
- **Integrated models of care:** Community oral health service delivery is promoted via appropriate and sustainable models of care including:
  - community oral health facility based
  - public/private mix
  - other outreach, such as virtual chair and service outposting.
- **Oral health promotion:** Appropriately prioritised and adequately resourced oral health promotion forms part of the overall model of oral health care in Hume.
- **Access:** Consumers are able to access community oral health services within the sub-region of their residence and efforts are directed to promote the access of eligible people who live in more remote areas and identified priority groups, such as Indigenous people, refugees and children.
- **Workforce:** The Hume Oral Health Partnership and sub-regional networks drive priorities that ensure required community oral health workforce levels are achieved and maintained, and that staff benefit from shared workforce development strategies.
- **Facilities:** Future oral health facility developments are prioritised as per the Hume Oral Health Plan and:
  - promote equitable and safe access for consumers
  - ensure a safe working environment for oral health staff.
- **Service coordination:** Service coordination practice improves consumer access, shares knowledge and resources and supports a 'whole of health' approach via the appropriate and timely identification of consumer health needs, using the Service Coordination Tool Templates (SCTT).

6.2 Action plan

6.2.1 Development and leadership

Priorities	Recommended actions	Responsibility	Timing – years 1.2 or 3
As per the proposed service configuration (6.1), develop sub-regional oral health networks	1. Sub-regional networks: That two sub-regional oral health networks be further developed based on the existing alignment of organisations as follows: Sub-region 1: • Goulburn Valley Health • Seymour Hospital • Rumbalara Sub-region 2: • Albury Wodonga Health • Northeast Health • Benalla Health	Partnership	Year 2
Develop clinical leadership model for oral health services	2. Develop a clinical leadership model (linked to DHSV Clinical Leadership Council refer page 8) and aligned to the two sub-regional networks.	Partnership, DHSV	Year 2
	3. Support implementation of the DHSV Clinical Practice Guidelines.	Partnership, DHSV	Year 1
	4. Coordinate professional development opportunities across the region.	Partnership, DHSV	ongoing
	5. Continue work undertaken by the partnership in the development of credentialing and scope of practice.	Partnership, DHSV	Year 1
Inform future oral health service planning and development	6. Undertake analysis of current community oral health waiting lists across Hume (understand demand, identify duplicate clients).	DHSV	Year 1
	7. Inform future planning and oral health service development through cognisance of the Hume Oral Health Report Card, which outlines Hume oral health status and service delivery patterns.	Partnership	Year 1
	8. Undertake a study of current dental chair utilisation rates and the factors that influence chair usage.	DHSV, Partnership	Year 1
Identify best practice model/s of oral health care for children	9. Apply for a DHSV Research and Innovation Grant to identify optimal models of oral health care for children in rural areas (consider inviting Murdoch institute involvement).	Partnership	Year 1

6.2.2 Access

Priorities	Recommended actions	Responsibility	Timing
Build community oral health services in Lower Hume	10. Move the two chair relocatable clinic from Albury Wodonga Health to Seymour Hospital in 2010 as a short-term measure to deliver (existing) children's and limited (new) adult services via an arrangement with a local private dentist.	Seymour Hospital, Albury Wodonga Health, DHSV	Year 1
	11. Via a planned approach, implement a decision-making process that considers available data on current and projected need in Lower Hume to underpin future resource/budget bids for community oral health funding (link to Action 56).	Sub Regional Networks, DHSV, DH	Year 1
Build community oral health services in Upper Hume – Corryong, Tallangatta	12. Explore service outposting options (similar to GVH at Cobram) that provide greater access to eligible clients in the Tallangatta and Corryong (areas) and work with the existing health services (build on expressed good will and offers of support, for example Upper Murray Health and Community Services).	Albury Wodonga Health, Sub Regional Network, DHSV, DH	Year 2
Build awareness of, and links with, private practices and support public/private partnerships	13. Linked to work undertaken as part of Action 10, map private dental services (locale, type, capacity, including denture), establish communication channels and identify those that may potentially provide community oral health services via private/public mix agreements.	Sub Regional Networks, DHSV, DH	Year 3
	14. Build links and communication channels to the Australian Dentists Association (ADA) Northeast Branch as required.	Partnership	Year 1 and ongoing
Further develop outreach oral health models	15. Trial and investigate outreach model options (potentially via a DHSV Research and Innovation Grant) including: • 'virtual' outreach chair and mobile cart • outposting public services at private clinics • delivery of oral health promotion and screening.	Partnership	Year 2
	16. Develop sub-regional outreach service plans (via sub-regional networks) to promote access of eligible clients across Hume.	Sub Regional Networks	Year 3
Undertake activities that promote access to community oral health services including denture services	17. Linked to workforce development, encourage and support dental therapists to complete bridging training to expand the client age range to the '25+' group. Consider options where each service has access to this training.	Partnership	Ongoing
	18. Consider learnings from Action 8 and identify options to maximise chair capacity, for example, after hours service delivery, 'back up' staff, joint work across services to minimise 'fail to attends'.	Partnership, DHSV	Year 2

Priorities	Recommended actions	Responsibility	Timing
	19. Investigate options for using podiatry chairs for oral health screening, assessment and basic intervention.	Partnership	Year 1
	20. Review existing model/s of public denture services across Hume including screening practices, wait list practices, volume of public denture work.	Partnership, DHSV	Year 1 investigation Year 2/3 model development
	21. Explore and test options/feasibility for future public denture services across Hume, for example: • private provider contracted services • centralised public denture services from one or two (lab) locations • feasibility of outreach prosthetist services (dependant on chair availability).		Year 2–3
	22. Consider the feasibility of developing a denture laboratory as part of Northeast Health oral health service developments in Wangaratta.	Northeast Health	Year 1
Explore options for a specialist oral health service model	23. Share findings of the analysis undertaken by GVH (in preparation for Melbourne University postgraduate students) regarding specialist referral types and referral rates to RDHM for services such as paedodontics, oral surgery and orthodontics.	GVH, DHSV	Year 1
	24. Linked to Action 12, undertake mapping of private specialist services across and surrounding Hume.	DHSV, ADA	Year 2
	25. Work with Melbourne University to clarify/ develop the role of postgraduate students in the delivery of some specialist service types.	GVH, DHSV, Melbourne University	Year 3
	26. As part of DHSV service provision reports, receive regular updates re specialist service delivery and uptake at RDHM for Hume residents.	DHSV	Ongoing
	27. Explore options for visiting specialists to provide local sessions as an outreach service from RDHM.	DHSV	Year 3
Strengthen community awareness and uptake of oral health services	28. Working with primary care partnerships, develop a shared community oral health service promotion strategy targeted to eligible adults and children.	Partnership, PCP	Year 2
	29. Working with primary care partnerships, develop navigation and service promotion strategies that support the access of refugee and migrant communities to community oral health services.	Partnership, PCP	Year 2

6.2.3 Priority groups

Priorities	Recommended actions	Responsibility	Timing
Promote use of priority tools	30. Promote use (for example, via planned education sessions) of the Dental Priority Tool as outlined in Community Health Priority Tools (Deparment of Health October 2009). An overview is provided in Appendix 6.	Partnership	Ongoing
Promote uptake of oral health services by Indigenous communities	31. Use *Closing the Gap* cultural competence framework and strategies to build cultural literacy regarding Indigenous communities.	Partnership	Year 2
	32. Build and further develop relationships with Indigenous services, for example Rumbalara, Mungabareena Aboriginal Cooperative, Albury Wodonga Aboriginal Health Service and Indigenous Health Officers located within Divisions of General Practice.	Partnership	Year 1 and ongoing
	33. Advocate for the inclusion of 'oral health' in the MBS Aboriginal Health Checks.	Partnership, DHSV	Linked to Action 31
	34. Work with universities to build the experience of oral health students in working with Indigenous communities.	GVH, Albury Wodonga Health, Rumbalara, DHSV, Universities	Linked to Action 31
Promote uptake of oral health services by refugee communities	35. Implement strategies to build the cultural competence of the oral health workforce in the delivery of services to refugees and migrant communities.	Partnership, DHSV, DH	Year 2
	36. Build links to local and regional refugee settlement groups, inform about the Refugee Health and Wellbeing Plan.	Partnership	Year 1
	37. Linked to Action 36, advocate for the inclusion of 'oral health' in the on-arrival health assessment undertaken with refugees.	Partnership, DHSV	Year 2
Promote uptake of oral health services eligible children	38. Develop service responses and new strategies to ensure that health care card holder dependent children access community oral health services (link to Action 28).	Partnership	Year 1
Build on work to date to link residents of aged care facilities to oral health services	39. Continue to work with and support Better Oral Health approaches and related best practice development in Hume. Consider recommendations from the Better Oral Health in Residential Care Final Report (November 2009)	Partnership	Ongoing

6.2.4 Workforce

Priorities	Recommended actions	Responsibility	Timing
Undertake community oral health workforce analysis	40. Confirm workforce capacity/requirements based on: • proposed service configuration (refer page 34) and service mix • expanded scope of practice • partnership opportunities.	Partnership, DHSV	Year 1
Undertake community oral health workforce development	41. Invite Hume Region representation to the DHSV Workforce Advisory Group	DHSV	Year 1
	42. With reference/linkage to work being undertaken centrally by DHSV*, consider shared workforce developments/strategies/models that: • promote workforce attraction, recruitment and retention across Hume • create effective supervision and mentoring structures (linked to Clinical Leadership model Section 5.2.1).	Partnership, DHSV	Year 2
	43. Investigate the applicability of options such as 'dentaljobs' and 'dentalgaps' to support workforce recruitment (see page 24).	Partnership, DHSV	Year 2
	44. Evaluate and build on existing GVH Internship model as a potential approach to be adopted across the two sub-regions (and linked to statewide considerations).	Partnership, DHSV	Year 2

* DHSV Oral Health Workforce Action Plan (2008–10) and related strategies to be outlined in DHSV Strategic Plan 2010–2013

6.2.5 Oral health students

Priorities	Recommended actions	Responsibility	Timing
Support and develop oral health student experiences via a coordinated and planned approach to student placements	45. Secure representation from La Trobe University and Melbourne University to the Hume Oral Health Partnership.	Partnership, Universities	Year 2
	46. Maintain/further develop student placement sub-committees via the two networks with planning/development roles for placements across the two sub-regions: • Goulburn Valley Health and Melbourne University, DHSV, Department of Health • Albury Wodonga Regional Health and La Trobe University, DHSV, Department of Health.	Sub-Regional Networks, DHSV, Department of Health, universities	Year 2
	47. Contribute to a statewide analysis of student placement costs and infrastructure requirements.	Partnership, DHSV	As required

6.2.6 Service coordination

Priorities	Recommended actions	Responsibility	Timing
Develop (oral health) service coordination practice	48. Define options to build the oral health literacy and practice of the health workforce in the Hume Region via primary care partnerships (confirm PCP responsibilities).	Partnership, PCP	Year 1
	49. Develop/access training programs for oral health staff regarding service coordination principles and practice.	Partnership, PCP	Year 2
	50. Further develop practices, via Divisions of General Practice, that promote uptake of the Enhanced Primary Care (EPC) MBS dental items.	Division of GP, Partnership, PCP	Year 1
Develop (oral health) service coordination approach	51. Member organisations to each define oral health service coordination practice within their own organisations, including: • screening/assessment of oral health needs as part of Initial Needs Identification or practitioner assessment • use of the Service Coordination Tool Templates and the oral health questions on the Health Behaviours/Conditions forms • encourage oral health screening/assessment practice development across the sector (for example GVH encouraging the development of Aged Care Assessment Service practice).	Partnership, PCP	Year 1

6.2.7 Oral health promotion

Priorities	Recommended actions	Responsibility	Timing
Promote fluoridation across Hume	52. Promote fluoridation across Hume and inclusion of fluoridation as a priority in local government municipal health plans where relevant.	Partnership	Ongoing
Develop oral health promotion planning and practice including specific activities for children	53. Identify a regional leader for oral health promotion (as per DHSV strategic plan) and define the resource requirements of this role.	GVH, DHSV	Year 1
	54. Linked to service coordination (5.2.6), develop the oral health literacy of practitioners planning health promotion programs.	Partnership, PCP	Year 1
	55. Understand findings from the statewide evaluation of Smiles for Miles and work in collaboration with DHSV to address Smiles for Miles gaps in Central Hume and Lower Hume	Partnership, DHSV	Year 1
	56. Review the oral health profile of children in Hume and work with other services to promote oral health promotion activities targeted to children (for example, working with maternal and child health services).	Partnership, DHSV	Year 1 scoping Years 2–3 development

6.2.8 Infrastructure

Priorities	Recommended actions	Responsibility	Timing
Redevelop Northeast Health Wangaratta community oral health facility	57. Confirm and progress agreed options (via a planning process commencing mid 2010) to develop the Wangaratta community oral health facility (via an integrated health care precinct and considering options for laboratory facilities).	Northeast Health, Sub-Regional Network, DHSV, Department of Health	Year 1
Develop oral health services in Lower Hume	58. Implement a decision-making process that considers available data on current and projected need in Lower Hume to underpin future resource/budget bids for community oral health funding (link to Action 10).	Sub-Regional Network, DHSV, Department of Health	Year 1

Appendix 1: Stakeholder consultation list

Lower Hume	Louise Sharkey	Director Community Services, Seymour District Hospital
	Andrea Boland	Dental Therapist Seymour District Hospital
	Chris McDonnell	CEO Mitchell CHS
	Rowena Excell	Health Promotion Officer Mitchell CHS
	Elizabeth Jenkins	Lower Hume PCP
	Carmel Aliano	Plenty Valley CHS Oral Health
Central Hume	Janine Holland	Director Community & Aged Care Services, Northeast Health
	Tricia Voss	Dental Practice Manager Northeast Health
	Diana Chomley	A/CEO Delatite CHS
	Dan Weeks	CEO Benalla Hospital
	Jan Lang	Manager Operations Ovens and King CHS
	Rachael Duncombe	Health Promotion Officer Central Hume PCP & Delatite CHS
	Dr Stuart Jones	NE Vic ADA contact
Goulburn Valley	Leigh Rhode	Director Community and Integrated Care Goulburn Valley Health
	Helen Mathieson	Dental Practice Manager Goulburn Valley Health
	David Todd	Dental Lab Manager Goulburn Valley Health
	Sam Campi	Goulburn Valley PCP
	Tracey Hearn	Dental Practice Manager, Rumbalara Aboriginal Coop Ltd
	Nick Bush	CEO Cobram Health Service
	Melissa Mathieson	Dental Practice Manager Cobram Health Service

Upper Hume	Greg Pearl	Director of Business Services, Albury Wodonga Health Service
	Sam Zahedi	Senior Dentist, Wodonga
	Kerryn Beer	Practice Manager Wodonga
	Leonard Peady	CEO Gateway CHS
	Kylie Weir	Health Promotion Gateway CHS
	Darren McDonald	CEO Mungabareena Aboriginal Corporation
	Natalie Clark	Family Support Coordinator, Mungabareena Aboriginal Co-op
	Tyler Keoth	Pre School Teacher, Mungabareena Aboriginal Co-op
	Kerry Brown	Maternity Enhancement Worker, Mungabareena Aboriginal Co-op
	Maxine Brockfield	CEO Upper Hume Health and Community Services
	Will Mollison	EO Upper Hume PCP
	David Noonan	CEO Albury Wodonga Aboriginal Health Service
	Wendy Cisar	Tallangatta Health Service
	Mark Ashcroft	Alpine Health Service
	Trevor Marshall	
	Neville Heer	Albury Community Health Service
	David Dart	NE Vic Div GP
DHSV	Colin Riley	Agency Relationship Manager
	Mark Sullivan	Chief Operating Officer
	Valda Groves	Strategic Planning
	Edward Howarth	Strategic Planning
	Sue Kearney	Health Promotion
DH	Janet Chapman	Manager Population Health & Service Planning Hume Region
	Catherine James	Manager Primary Health Programs, Integrated Care Branch, Wellbeing, Integrated Care and Aged
Universities	Dr. Ben Keith	La Trobe University
	Dr. Mark Gussy	
	Mike Morgan	Melbourne University
	Menaka Arundathi Abuzar	
	Sabrina Manickam	Charles Sturt University

Appendix 2:
Hume oral health partnership

- Albury Wodonga Regional Health Service
- Benalla Health
- Cobram and District Hospital
- Dental Health Services Victoria
- Department of Health
- Goulburn Valley Health
- Northeast Health Wangaratta
- Rumbalara Aboriginal Health Service
- Seymour District Memorial Hospital

Appendix 3: Lower Hume – additional data

Population

Table 17: Lower Hume population projections 2006–21 and eligible population

Murrindindi	Total population	Estimate of eligible adults	Estimate of eligible children	Total eligible population
2006	14,198	5,263	3,028	8,291
2011	14,318	5,441	2,838	8,279
2016	14,670	5,679	2,727	8,406
2021	15,249	6,018	2,634	8,652

Mitchell	Total population	Estimate of eligible adults	Estimate of eligible children	Total eligible population
2006	32,082	4,880	4,349	9,229
2011	37,065	5,625	4,847	10,472
2016	42,523	6,601	5,277	11,878
2021	48,640	7,676	5,795	13,471

Lower Hume	Total eligible population in Lower Hume
2006	17,520
2011	18,751
2016	20,284
2021	22,123

Source: DPCD Victoria in Future 2008 second release

No. Eligible adults 2006 from DHSV data from Centrelink, No Eligible children 2006 DHSV

Table 17 outlines the Department of Planning and Community Development (DPCD) population projections across the Murrindindi and Mitchell shires from 2006–21. The percentage of population eligible for community oral health services as calculated by DHSV (2006 Census) is used to estimate the eligible population numbers in Mitchell and Murrindindi for the years 2011, 2016 and 2021.

Of note is the 52 per cent increase in the Mitchell Shire total population over 2006–21 across all age cohorts, while the projected growth in Murrindindi is in the adult population with the child and youth population projected to fall.

Chair ratio

- The current eligible population in Lower Hume is **17,520**.
- This equates to a need for **3.5 chairs** in Lower Hume (according to the ratio of one dental chair to every 5,000 eligible population).
- There is currently only one dental chair in Lower Hume that provides dental care for children at Seymour and District Hospital.

If the population projections are correct (and the percentage of eligible people remains the same), by 2021 the Lower Hume area will have **22,123** people eligible for community oral health services. This would equate to a need for **4.4 chairs**.[21]

21 While applying the current percentage of eligible people for community oral health services to the population projections for the Mitchell and Murrindindi shires gives an indication of the future demand for oral health services, it is important to note that this can only be regarded as indicative of likely future demand.

SEIFA Index of Relative Socio-economic Disadvantage

SEIFA is based on census variables related to disadvantage, such as low income, unemployment and level of education. As shown in table 18, Lower Hume has areas within the first decile of disadvantage (that is, the most disadvantaged as compared to other regions across Victoria) and also the second decile of disadvantage.

Table 18: SEFA rates for Lower Hume

	Areas in first decile of disadvantage	Areas in second decile of disadvantage
Mitchell	Seymour, Broadford	
Murrindindi		Parts of Yea, Alexandra, Eildon

Source: DPCD SEIFA Index of Relative Socio Economic Disadvantage 2006 Census

Community wellbeing indicators

Consideration of community wellbeing indicators[22] is relevant in oral health service planning as these factors can provide an indicator of the level of socioeconomic disadvantage, the potential level of people needing health care cards, and the need for low or no cost health services. Of note in Lower Hume are the:

- low median equivalised household incomes in both Murrindindi and Mitchell
- higher percentage than state average of people indicating food insecurity
- lower than state and region average of self-reported health status
- transport limitations particularly for Murrindindi respondents.

Table 19: Median equivalised household income: Lower Hume, Hume and Victoria

		Comment
Mitchell	$563	Median equivalised household income is the adjustment of the total income of the household according to the number of persons and household type. Both Murrindindi and Mitchell are below the Victorian average.
Murrindindi	$517	
Hume Region	$521	
Victoria	$600	

Source: ABS 2006 Census

22 Community Wellbeing Reports

Table 20: Food security per cent of residents: Lower Hume, Hume and Victoria

		Comment
Mitchell	8.7 per cent	Survey respondents were asked if there were any times in the previous 12 months when they had run out of food and could not afford to buy any. Both Murrindindi (11.5 per cent of residents) and Mitchell (8.7 per cent of residents) are well above the Hume and Victorian average. Note: The survey was undertaken in 2007 and thus full effect of the drought and bushfires is not yet reflected.
Murrindindi	11.5 per cent	
Hume Region	7.3 per cent	
Victoria	6.0 per cent	

Source: 2007 Community Indicators Victoria Survey

Table 21: Self-reported health per cent of residents: Lower Hume, Hume and Victoria

		Comment
Mitchell	51.2 per cent	The respondents were asked to rate their health as excellent, very good, fair or poor. 51.2 per cent of Mitchell residents and 48.9 per cent of Murrindindi residents rated their health as excellent or very good which is lower than the percentage of 54.3 per cent across the whole of Hume and Victoria.
Murrindindi	48.9 per cent	
Hume Region	54.3 per cent	
Victoria	54.3 per cent	

Source: 2007 Community Indicators Victoria Survey

Table 22: Transport limitations per cent of residents: Lower Hume, Hume and Victoria

		Comment
Mitchell	27.3 per cent	Survey respondents were asked if their day-to-day travel had been limited or restricted in the previous 12 months. More Mitchell and Murrindindi residents had experienced travel limitations than across the Hume Region and Victoria as a whole.
Murrindindi	34.3 per cent	
Hume Region	20.2 per cent	
Victoria	20.3 per cent	

Source: 2007 Community Indicators Victoria Survey

Appendix 4: Improving Victoria's oral health organisation roles

Department of Human Services, 2007, *Improving Victoria's oral health* 2007, Victorian Government, Melbourne

1. Lead regional agency

One lead agency will be identified for each region that will provide coordination and clinical leadership for community dental services in that region, provide preventative, primary and specialist dental care and provide training for dental clinicians.

2. District agencies

One or more district agencies (which may be a lead agency) will be identified in each catchment that will provide preventative, primary and specialist dental care and provide training for dental clinicians.

3. Local agencies

One or more local agencies (likely to have only one or two chairs) will be identified in each catchment that will provide preventative and primary dental care and provide clinical placements for dental clinicians.

Tasks/roles	Regional Lead	District	Local
Lead catchment planning	✓		
Manage consolidate waiting list	✓		
Manage recall and reminder service for children	✓		
Preventative dental care	✓	✓	✓
Primary dental care	✓	✓	✓
Specialist dental care	✓	✓	
Lead outreach services	✓	✓	
Dental laboratory services	✓	✓	
Lead oral health promotion planning		✓	✓
Participate in oral health promotion	✓	✓	✓
Develop (with DHSV) recruitment and retention strategies	✓		
Coordinate clinical placements		✓	
Provide clinical placements	✓	✓	✓
Coordinate professional development	✓		
Provide support services to local clinics	✓	✓	
Provide links to other sectors (eg. Children's services, aged care services)	✓	✓	

Appendix 5: Improving Victoria's oral health principles

Department of Human Services, 2007, *Improving Victoria's oral health* 2007, Victorian Government, Melbourne

Principle one: The best place to treat

Dental care will be provided in community-based settings, whenever it is safe and cost effective to do so. Dental services will be brought together with other ambulatory care services and integrated to improve accessibility, availability and quality of care. Dental services will build safety and continuous care quality improvement into their systems. Dental clinicians will be regulated to ensure professional conduct and fitness to practice.

Principle two: Together we do better

Planning for good oral health will incorporate a population health approach that recognizes the social determinants of health and priorities health promotion and illness prevention. The provision of dental care will be based on partnerships among levels of government and public and private health care services. Individuals, families and carers, will be encouraged to take more responsibility for their health care and will receive support for self-management

Principle three: Technology to benefit people

There will be consistent, planned approach to developing the infrastructure for the delivery of integrated health care, including dental care, which includes information and communications technology (ICT), standard tools and protocols, facilities and equipment. ICT will be used to better inform people about their dental health and about how to better manage their health.

Principle four: A better health experience

Care will be 'person and family centered', focusing on the needs of the whole person as these change over time. People will have equitable, timely and appropriate access to dental care regardless of where they live. The delivery of dental care will be based on the best evidence available and will be support the provision of the right care, at the right time, and in the right place.

Information about people and the services they receive will be consistently managed and coordinated across health care services to protect privacy and support integrated service delivery and continuity of care. Funding and accountability arrangements for the delivery of quality dental care will support the provision of the right care, at the right time, and in the right place.

Principle five: A better place to work

The dental workforce will be configured to deliver integrated health care. The future workforce will be flexible and multi-skilled to deliver care in a variety of settings. The full range of dental providers will be available to work together and provide an appropriate and multidisciplinary range of professional expertise. Consolidation of service delivery in community-based settings will support improved working conditions, more efficient use of the workforce, and better quality systems.

Appendix 6: Dental priority tool

Department of Health, 2009. Community Health Priority Tools DH October 2009. Victorian Government, Melbourne

Dental priority tool

Introduction

Public dental services provide routine and urgent dental care by teams consisting of dentist, dental therapists, dental hygienists, dental prosthetists and dental assistants. They are responsible for delivering integrated community-based dental care and oral health promotion.

Eligibility

Dental services provided through CHSs target children and disadvantaged adults, and have strict eligibility criteria.

Please refer to the Dentistry in Victoria website for current eligibility information at <http//www.health.vic.gov.au/dentistry/clients/dental_system.htm>.

Instructions for use

This priority tool is designed to determine the need for dental services and the level of priority for service. Intake workers without a background in dentistry should consult with a dental practitioner if unable to determine the level of priority for service.

People seeking urgent dental care are triaged, assessed and managed using the Emergency Care Demand management System (ECDMS). The ECDMS triage tool is designed so that clients essentially self-assess their priority for emergency care. A series of questions guiders the collection of information required to determine the ECDMS priority category. The tool identifies five categories and indicates the maximum timeframe for the client to be clinically assessed for emergency care.

- category 1 – emergency care within 24 hours
- category 2 – emergency care within one week
- category 3 – emergency care with two weeks
- category 4 – emergency care within four weeks
- category 5 – no emergency care.

ECDMS urgent emergency (category 1) clients include people:

- with a swollen face, neck or mouth
- with bleeding following recent extraction
- unable to open their mouth
- with tooth/gum pain that resulted in waking overnight
- aged under 14 who have had an accident leading to problems with teeth or gums
- with swelling or difficulty opening their mouth due to their wisdom teeth
- with intellectual disability
- with immunosuppression
- aged over 80

People who require routine care should be asked the questions in the generic priority tool. If they do not meet the criteria for high priority, the questions in the remaining item in the dental priority tool should be asked to determine priority for routine care.

High priority dental clients for routine care include:

- children up to 12 years of age, and 13–17 year olds who are, or are dependants of, health care or pensioner concession card holders
- children and young people up to 18 years of age in residential care provided by the Children Youth and Families division (Department of Human Services)
- eligible pregnant women
- others determined to be high priority according to the generic priority tool, except those with complex care needs (see note below*).

These clients hold be offered the next available appointment and should not be placed on the waiting list.

*Clients with complex care needs seeking dental services will be eligible for Commonwealth government NBS services. Due to the high demand for state-funded dental services, agencies should seek to ensure that such clients have access to services through this stream.

Further information about the MBS for dental services is available at <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B1597A1010C947C3CA257599000203FB/$File/200905-Dental.pdf.>

Reference

Dental Health Services Victoria 2009 Emergency Care Demand Management System user instructions. Available at <http://extranet.dhsv.org.au/IgnitionSuite/uploads/docs/ECDMSpercent20Userpercent20Instructions.pdf>

Dental priority tool