Department of Health

health

Eastern Metropolitan Region integrated oral health plan 2011–14

State Government Victoria

Eastern Metropolitan Region integrated oral health plan 2011–14

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Foreword

We are pleased to present the *Eastern Metropolitan Region integrated oral health plan 2011–14* (the plan).

This plan is a collaboration between regional public dental services delivered though community health services, Dental Health Services Victoria (DHSV), the Department of Health and other key stakeholders.

Oral health is integral to health and wellbeing. Despite the fact that poor oral health is largely preventable, a range of social, economic and other factors can impede this. The awareness of the consequences of poor oral health is increasingly becoming recognised both overseas and in Australia. There is, for example, significant correlation between oral health and other chronic diseases like cardiovascular disease and diabetes. Nationally, the Australian Health and Welfare Institute's *Oral health and dental care in Australia: key facts and figures 2011* highlights some alarming statistics about the state of Australia's oral health (AIHW 2011).

This plan was developed during a time of change for public dental services in Victoria as new funding and accountability arrangements were implemented. We would like to thank LIME Consulting who were engaged to develop the plan in collaboration with a broad-based steering group. Thanks must also go to the various organisations, including regional Primary Care Partnerships (PCPs) Medicare Local, Divisions of General Practice, consumers and other stakeholders who contributed their time, consideration and expertise to the plan's development.

The plan is a clear commitment on the part of the Department of Health, DHSV, public dental services and other stakeholders to work together to maximise available resources to improve the oral health of the region.

The *Eastern Metropolitan Region integrated oral health plan 2011–14* provides a framework for improving the oral health of the region's residents now and into the future, and we commend it to you.

Mr Chris Potter
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Executive summary

This three-year, whole-of-region plan builds on existing collaborations and relationships between community health services (CHSs) and other stakeholders providing public oral health services in the Eastern Metropolitan Region (EMR).

Development of the plan included:

- scoping oral health needs and service activity in the region
- identifying opportunities for further collaboration, partnerships and service integration, and agreeing to processes and arrangements to support regional collaboration
- advising the Department of Health and DHSV of future oral health needs and priorities to inform planning and resource allocation.

The development of an EMR plan with an emphasis on sector collaboration is particularly important given the region does not currently meet the Victorian public dental chair to eligible population defined ratio of 1:5,000.

The plan involved extensive consultation with project stakeholders (including CHS oral health services, consumers, other community and health services, Department of Health and DHSV), an examination of demographic and oral health service provision data, and a review of other related factors and sector developments.

Analysis of key policy directions was also undertaken. Of particular relevance, the *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* provides a framework and priorities for the Victorian health system (Department of Health 2011a, p. 11) and its companion document, the *Victorian Public Health and Wellbeing Plan 2011–15*, notes the significance of good oral health to the overall health and wellbeing of individuals and lists a series of opportunities to strengthen the oral health prevention system and support priority settings for action (Department of Health 2011b, p. 26). Other relevant policies are described in Appendix 3.

The consultation and analysis process involved gathering information and summarising key findings and issues for consideration. Development of the plan was guided by members of the EMR Oral Health Partnership Steering Group and overarching Governance Group (see Appendix 1 for membership). The group included members from all EMR CHS with dental health services – EACH Social and Community Health, Inner East Community Health Service (IECHS), Knox Community Health Service (KCHS), MonashLink Community Health Service (MonashLink), Ranges Community Health (RCH) and Whitehorse Community Health Service (WCHS) – and representatives from Eastern Health, the Outer and Inner East Primary Care Partnerships, Department of Health and DHSV. Two consumer representatives also provided advice and support to the project.

EMR Oral Health Network

Representatives from the partnership discussed options for a preferred governance and planning structure to underpin EMR community oral health service integration and collaboration and to support future oral health service development and targeting of resources to meet demand across the region. They agreed to form the EMR Oral Health Network, which includes connections to the Department of Health, DHSV and peak bodies, universities and oral health students, and the private sector. The network also supports cross-region relationships between oral health services in, for example, the Southern Metropolitan Region (SMR).

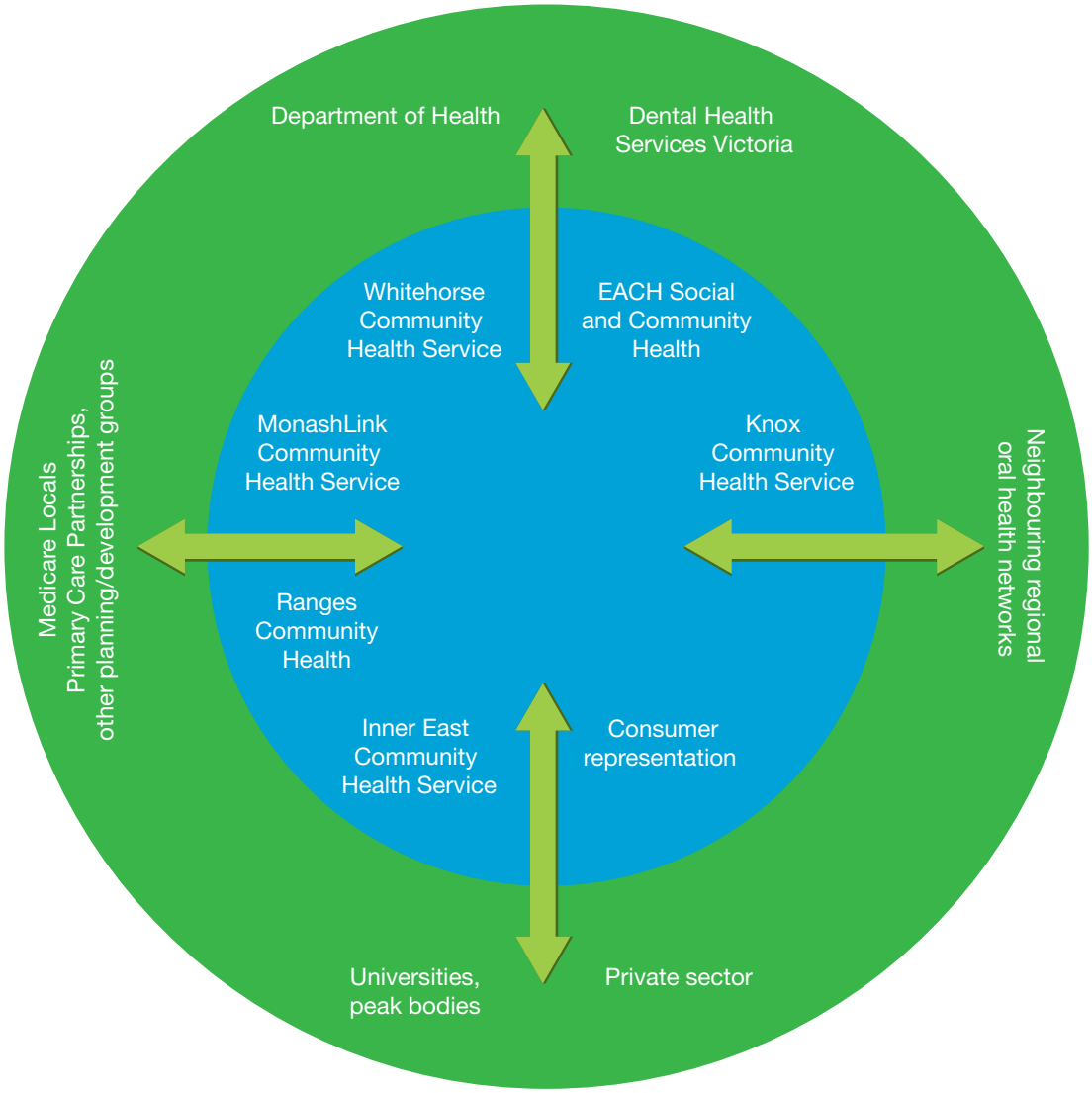
The network is responsible for:

i) the implementation of the *EMR integrated oral health plan 2011–14* and the related actions listed in the action plan and

ii) provide a strategic forum and leadership to develop public oral health services in the EMR.

The network's governance responsibilities include oversight and management of resources, project workers, portfolio holders and working groups. Chairing network meetings is the responsibility of the nominated lead organisation.

Figure 1: EMR Oral Health Network



Opportunities for collaboration, partnerships and integration

In addition to the opportunities for partnerships and governance (and the resulting EMR Oral Health Network) the plan lists seven additional key objectives for collaboration, partnership and integration. All actions are listed in detail in the action plan.

Objective	Actions
Promoting access Promote the access of eligible and high-need groups to community oral health services including specialist services.	Biannual forums inform shared planning and development for community oral health services. Develop shared and common practices for the priority access of high-needs groups.
Demand management Develop shared practices that promote efficiency and respond to existing and new service demand.	Implement consistent and shared child-recall protocol and practice across all EMR oral health services. Review existing models of community denture services in the EMR and develop a denture service delivery model.
Private sector Build private sector collaboration and (internal) private practice development.	Build private practice involvement in community oral health services. Develop community oral health services' capacity to deliver private services as part of their model.
Early intervention and service coordination Build practice in early intervention and service coordination.	Identify CHS (planned) training and development activity for early intervention and service coordination. Promote access to planned training for community oral health staff.
Oral health promotion Build opportunities for oral health promotion (OHP) via an integrated approach and collaboration with planning networks and others.	Work with Department of Health and DHSV to identify resources and options for local implementation of children's OHP across the EMR. Link to broader planning across subregions, for example lobby Primary Care Partnerships to raise the profile of OHP and identify options for OHP with specific groups linked to broader health promotion activities.
Consumer participation and information Ensure consumers are informed about oral health services and participate in service development and evaluation.	All EMR Oral Health Network members share information about their own CHS community participation practices. Network members develop or build on CHS systems to obtain systematic feedback from oral health clients with processes to analyse findings.
Workforce development Develop and maintain the community oral health workforce.	The EMR OH Network participates in the DHSV workforce development strategy – provides input and feedback and develops local activities and actions as an outcome.

Introduction

Background and aims

Good oral health is becoming increasingly recognised as fundamental to good overall health and wellbeing. The Department of Health funds the delivery of public oral health services through organisations operating within the Oral Health Program. In the EMR the following services provide general, conservative, prosthetic (denture) and emergency oral healthcare:

- EACH: Social and Community Health (EACH)
- Inner East Community Health Service (IECHS)
- Knox Community Health Service (KCHS)
- MonashLink Community Health Service (MonashLink)
- Ranges Community Health (RCH)
- Whitehorse Community Health Service (WCHS).

The services across the EMR worked together in the development of the whole-of-region *EMR integrated oral health plan 2011–14* (the plan). The plan aims to further develop oral health services in the EMR and it builds on existing subregional collaborations and relationships, region-wide population health data and planning and stakeholder input from across the region.

The key objectives of the planning process were to:

- identify and scope existing oral health needs in the region and the work and activity of oral health services in addressing need
- work with services to identify opportunities for collaboration, partnerships and service integration
- develop a framework and processes that build and support regional collaboration and enable joint activity and accountability
- devise agreed governance arrangements that support ongoing collaboration and service development
- advise Department of Health and DHSV of future oral health needs and priorities to inform planning and resource allocation.

Project overview

The development of the plan was guided by members of the EMR Oral Health Partnership Steering Group and overarching Governance Group (refer to Appendix 1 for membership). The group included representation from all EMR Community Health Services (CHS) that deliver oral health services, Eastern Health, the Outer and Inner East Primary Care Partnerships, Department of Health, DHSV and two consumer representatives.

The steering group met between March and November 2011 to discuss project findings and to work together in the development of the actions outlined in the action plan. Information considered by the group was contained in an interim findings presentation and an EMR oral health plan briefing paper. Information provided in the briefing paper underpinned the agreed priorities for the plan and was based on analysis of the following information sources.

Consultation with key stakeholders (see Appendix 2) included:

- consumers
- community oral health services
- Department of Health
- DHSV
- Primary Care Partnerships
- local government
- Divisions of General Practice.

Analysis of relevant data included:

- demographic data
- oral health service provision data
- dental Ambulatory Care Sensitive Conditions (ACSC) data
- other health and wellbeing data.

The steering group also reviewed other factors and sector developments relevant to the plan, as well as key policy and directions (see Appendix 3).

Contextual factors

This section provides an overview of the key contextual factors and considerations in the development of this integrated oral health plan. This includes an overview of the population and health and wellbeing of the EMR and other significant developments such as the development and implementation of the new Commonwealth-funded Medicare Locals. Policy directions were also considered and these are detailed in Appendix 3.

The EMR

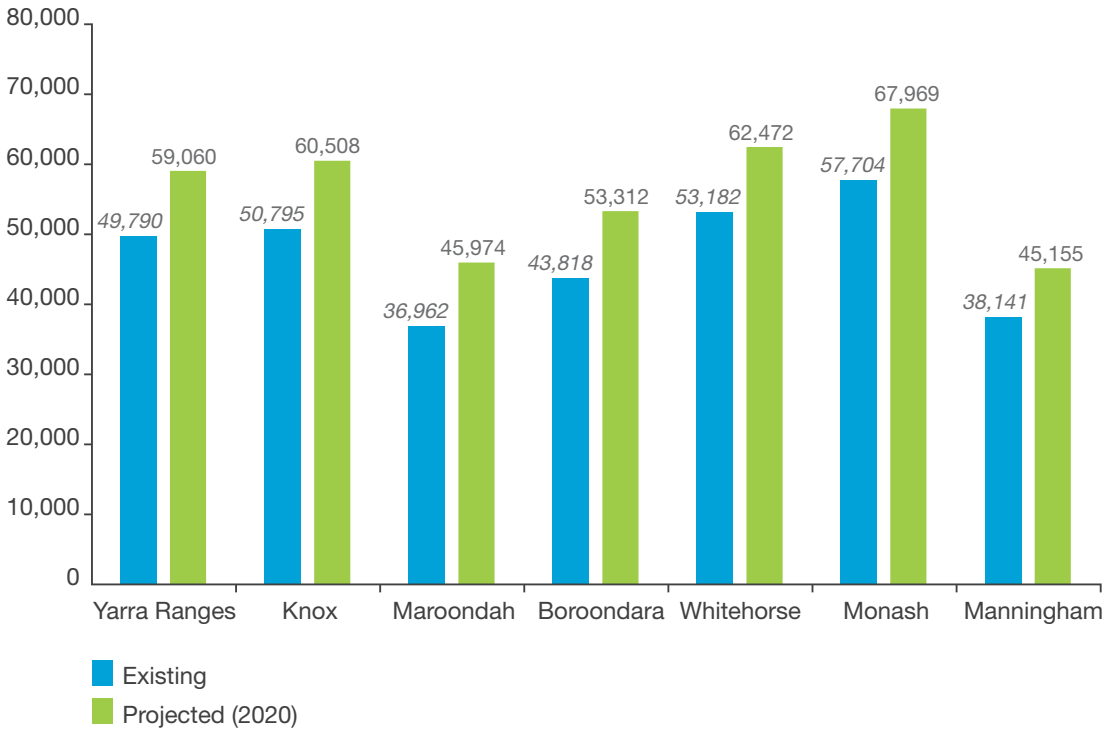
The EMR is comprised of seven Local Government Areas (LGAs). It is a large region that includes highly urbanised areas closer to the city of Melbourne, and stretches to rural areas in Yarra Ranges Shire Council to the east (which makes up 83 per cent of the entire EMR territory). The rural location means that people who live in Yarra Ranges need to travel greater distances to access community oral health services, which in turn reduces service accessibility for people with limited transport options. Analysis of service uptake data from DHSV indicates that just over 1,000 people travelled from Yarra Ranges for treatment at Royal Dental Hospital Melbourne (RDHM) in 2009–10.

Population

In 2010, the population of the total catchment was 1,037,347, equating to 18.7 per cent of the Victorian population (Australian Bureau of Statistics 2011). The EMR has a slightly older population than Victoria as a whole, and the outer eastern catchment is expected to experience a higher growth in older persons than the inner EMR catchment, metropolitan Melbourne and Victoria.

Population eligible for community oral health services

Figure 2: EMR eligible population current and projected to 2021



Source: Department of Health 2011, EMR oral health plan project brief

Based on the 2006 census and Centrelink data, Figure 2 shows the current and projected eligible population for each EMR LGA. The eligible population is the sum of the total of children aged three to 13 and Health Care Card (HCC) holders and pensioners, and their dependents to age 18. Note: projected figures are estimates only.

In percentage terms, the largest increase in EMR is expected to be in Maroondah LGA with a projected increase of 9.6 per cent from 2009 to 2021. The population aged over 65 is projected to increase by 75.5 per cent in Knox LGA and 67 per cent in Yarra Ranges LGA over 2009–21. The growth in those aged 65 and over could result in an increase in demand for community oral health services as people retire and become eligible for a HCC.

Culturally and linguistically diverse (CALD) people and refugees

The inner east has a high percentage of people born overseas and of non-English speaking background, with the City of Monash having almost 40 per cent of residents born overseas. Languages other than English spoken in the inner east include Mandarin, Cantonese, Vietnamese, Sinhalese, Greek and Italian.

Maroondah is now home to the largest Burmese community in Melbourne's east; between 2002 and 2007, 277 refugees of Burmese origin settled in Maroondah and it is anticipated that Maroondah will continue to receive high numbers of refugees from Burma (Maroondah City Council undated).

Aboriginal people

The EMR houses 2,814 Aboriginal people in total. Most Aboriginal people reside in the outer eastern LGAs of Maroondah, Knox and Yarra Ranges. Census data between 1999 and 2006 indicates a 37.6 per cent increase in the number of Aboriginal people residing in Knox.

Aboriginal people, in particular those with a HCC, are a priority group for community health services. An issue is that not all Aboriginal people are eligible as some do not have a HCC.

Affordable housing projects

The Nation Building – Economic Stimulus Plan will build 700 new buildings in EMR. The largest developments are in Knox (173 units) and Maroondah (161 units). In addition to 110 units in Monash, 282 units are being built in the Gateway project at Chadstone. This may result in an increased number of people eligible for community oral health services living in the EMR.

Health and wellbeing

Health

- Monash and Whitehorse have the highest percentage of total population with a disability in the EMR. Whitehorse has the highest level of people with profound disabilities.
- Yarra Ranges has the highest incidence of all causes of ill health in the EMR and the lowest perceived health status, plus the highest rate for diabetes.
- Participation in childhood health assessments and immunisation were lowest in Maroondah and Yarra Ranges.

- In 2009–10 Yarra Rages had 9.1 mental health clients per 1,000, Maroondah 8.7, Knox 8.3 and Whitehorse 7.9. These exceeded the regional average but fall under the state figure of 11 people per 1,000.
- Four people per 1,000 in the EMR sough treatment for alcohol and other drug issues in 2009–10. Yarra Ranges had 6.0 per 1,000, Knox 5,8 and Maroondah 5.1 which exceeds the regional average and is close to the state average of 5.3 people per 1,000.

Wellbeing

Taken as a whole, the EMR has relatively low levels of disadvantage. However, localised areas do show the disadvantage characteristics. The 2006 Census reveals 53 collection districts with disadvantage scores in the bottom 20 per cent of the State. These lower scores reflect issues such as relatively low income, low educational achievement, high unemployment and jobs in relatively unskilled occupations, the suburbs listed below all contain pockets of disadvantage.

Inner East

- Ashburton/Ashwood/Chadstone (estimated population 22,645)

Outer East

- Bayswater (estimated population 11,364)
- Boronia/Ferntree Gully (estimate population 48,827)
- Croydon/Mooroolbark (estimated population 45,134)
- Healesville (estimated population 10,844)
- Millgrove/Warburton (est. population 4,288)
- Ringwood (est. population 16,386)

Maroondah also has the highest rate of one-parent families of all EMR LGAs. The outer east unemployment rate is slightly higher than the inner east, while the inner east has a higher proportion of aged and disability pensions and carer payments. In addition people in the outer east are more likely to experience food insecurity than those in the inner east.

Other developments

Dental health program funding and accountability reform

Community dental services are funded under the Dental Health Funding Model. The Dental Health Program Data Set will be used to monitor performance. A new funding and accountability model was implemented across 2011 and a two-year (1 July 2011 to 30 June 2013) transition phase will build-in time to consider and validate the new funding model and reporting arrangements. The EMR participates in the Dental Health Funding Model Validation Project Stakeholder Reference Group to review implementation of the new funding formula. Titanium, the DHSV oral health IT application, has been updated to include links to funding and accountability reform, and regional staff have been trained in this version.

Medicare Locals

Medicare Locals are being established across Australia to promote a greater focus on primary health. The Inner East Melbourne Medicare Local (covering the inner east LGAs), formerly Melbourne East GP Network, was among the first group of Medicare Locals to be established and will focus on:

- growing collaboration with local hospital networks and lead clinician groups to deliver coordinated, integrated, responsive and flexible health services
- supporting the development of e-health and health information systems
- supporting the ongoing development of healthcare infrastructure
- increasing and enhancing the primary healthcare workforce to meet local community needs
- promoting initiatives to improve disease prevention and management and improve access to services
- coordinating primary healthcare services
- consolidating local healthcare planning
- driving more efficient use of health resources.

Eastern Ranges GP Association will become Eastern Melbourne Medicare Local on 1 July 2012.

Enhanced Primary Care Medicare items

Clients eligible for Enhanced Primary Care Medicare dental items are those with chronic 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 generally have a GP Management Plan.

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.

Summary of key contextual implications

Demographic and population

- Large increases in the population aged 65 years and over, especially in Knox and Yarra Ranges may increase demand for community oral health services and, in particular, denture services.
- Maroondah is home to an increasing refugee (particularly Burmese) community. A significant number of the Burmese refugees are accessing EACH oral health services.
- Most Aboriginal people reside in the outer east (Maroondah, Knox and Yarra Ranges). Aboriginal people have higher rates of poor oral health.
- More affordable housing developments may translate to more clients seeking community oral health services.
- Yarra Ranges, Knox and Maroondah LGAs had significant numbers of people who sought treatment for alcohol and other drug issues in 2009–10. People with these issues are more likely than the general population to experience poor oral health.
- Significant numbers of people with disabilities (including profound disabilities) reside in Monash and Whitehorse LGAs.
- Generally, people who reside in the outer east and some areas of Monash are more disadvantaged than those in the inner east (more pensions, higher food insecurity, lower Socio-Economic Index for Areas (SEIFA), more unemployment).

Policy and developments

- New community oral health service funding and accountability arrangements have been implemented. A two-year transition phase will build-in time to consider and validate the new funding model and reporting arrangements.
- Relevant policies (see Appendix 3) advocate:
  - developing service systems that are responsive to need and increase access
  - identifying groups who are vulnerable to poor health and chronic conditions
  - the importance of prevention and meeting needs of disadvantaged groups
  - investigating opportunities for private sector collaboration in service model development
  - the need for culturally appropriate assessment and care and, more recently, promoting the oral health of people across a variety of settings and program developments.
- The role of the new Medicare Locals should be addressed.

EMR oral health services profile

Each of the community oral health services in the EMR is described in the section below. The latter section summarises key points derived from an analysis of service delivery and data.

EMR oral health services

Inner East Community Health Service (IECHS)

IECHS is located in the LGAs of Boroondara and Yarra and operates four centres in Ashburton, Hawthorn and Richmond (two sites). The IECHS dental clinic is based at Ashburton.

Oral Health Program staffing	• Dental Officers: 2.72 • Dental Therapists: 1.12 • Dental Prosthetist: 0.2 • Dental Assistants: 3.3 • Reception: 1.75
Leadership structure	Dental Therapist acts as the Program Manager with an administration and clinical role. A senior dentist has the clinical oversight and clinical governance roles.
Students	No capacity at present.
Dental chairs	Four located onsite in Ashburton at Craig Family Centre. Good links with children's services means large number of children seen.
Service uptake 2009–10	3,328 individuals 8,517 visits 24,455 treatments 4,350 courses of care Use of interpreters – 417 occasions
Denture services	0.2 Prosthetist does full dentures including complex cases. Other denture work is outsourced to a commercial prosthetics laboratory.
Other	Deliver Smiles 4 Miles (S4M). Provide information about services to every school in area annually. Reserve appointments for Youth Substance Abuse Service (YSAS), Salvation Army, East Care clients.

MonashLink Community Health Service

MonashLink is located in the LGA of Monash and delivers services from four sites (Glen Waverley, Ashwood, Hughesdale and Clayton) and various outreach locations. Their dental clinic is based at Clayton.

Oral Health Program staffing	• Dental Officers: 4.45 • Dental Therapists: 3.0 • Dental Hygienist: 0.8	• Dental Prosthetist: 0 • Dental Assistants: 7.0 • Reception: 3.0
Leadership structure	The Senior Dentist supervises the Oral Health Service Manager and also has a clinical load.	
Students	Dental students use two chairs, DHSV graduate program has four interns.	
Dental chairs	Ten located onsite at MonashLink CHS in Clayton.	
Service uptake 2009–10	6,542 individuals 20,035 visits 69,687 treatments	8,985 courses of care Use of interpreters – 476 occasions
Denture services	Outsource fitting and denture work to three different laboratories.	
Other	Keeping Kids Smiling program. Venue for Enhance 2 Clinical dentistry program. Part of Supported Residential Service (SRS) initiative. Plan to develop private services and develop internal prosthetics lab. Eastern Drug and Alcohol Service (EDAS), a consortium with IECHS and EACH, brings clients to appointments.	

Whitehorse Community Health Service (WCHS)

WHCS is located in Box Hill, in the LGA of Whitehorse.

Oral Health Program staffing	• Dental Officers: 3.7 • Dental Therapists: 2.8 • Dental Prosthetist : 0.55	• Dental Assistants: 8.8 • Reception: 8.4 (includes CHS)
Leadership structure	The WCHS Quality and Risk Manager manages the Oral Health Service. Structure includes Clinic Coordinators, Dentist and Therapist Team Leaders, Senior Nurse and Senior Clinicians. All have administration and clinical responsibilities.	
Students	Fifth-year dental students use two chairs	
Dental chairs	Ten located on site at WCHS in Box Hill	
Service uptake 2009–10	7,005 individuals 18,285 visits	9,281 courses of care Use of interpreters – 632 occasions
Denture services	Outsource all denture work.	
Other	Deliver S4M and ‘I love my teeth days’ for preschoolers. Commenced private service one day per week. Special needs outreach program; SRS initiative. Integrated Care Oral health for people with chronic and complex needs. Standby lists at reception.	

EACH Social and Community Health

EACH has 17 sites across the LGA of Maroondah. Their dental clinic is located in Ringwood East. They operate a dental van in the outer catchment of EMR.

Oral Health Program staffing	• Dental Officers: 3.35 (including 1.0 mobile van), • Dental Therapists: 0.225 • Oral Health Therapist: 0 • Dental Prosthetist: 0.3 • Dental Assistants: 4.2 (including 1.0 mobile van) • Reception: 3.5 (including 0.5 mobile van)
Leadership structure	Chief Executive Officer (CEO) General Manager Primary Health Care Clinical Services Manager (0.25 EFT dental program) Dental Clinic Coordinator (1.0 EFT plus liaison with Senior Dentist 0.8 Clinical as needed)
Students	No capacity at present.
Dental chairs	Three located at a stand-alone site in Ringwood. Also manage mobile van (one chair) for outer east.
Service uptake 2009–10	2,782 individuals 6,981 visits 3,824 courses of care Use of interpreters – 417 occasions
Denture services	Salaried prosthetists (0.33 EFT) provide onsite appointments with all lab work completed off site in the laboratories of these practitioners.
Other	No S4M, work with EACH to deliver OHP session for refugees. Part of SRS initiative. Afterhours Wednesday and Thursday pm. Reminder calls to reduce Failure To Attend (FTA) rate.

Knox Community Health Service (KCHS)

KCHS is located in the LGA of Knox with two sites – one in Ferntree Gully and the other in Wantirna. Their dental clinic is based at Ferntree Gully.

Oral Health Program staffing	Dental Officers: 5.4 Dental Therapists: 1.6 Oral Health Therapist: 1.8	Dental Prosthetist: 1.0 Dental Assistants: 10.0 Reception: 4.3
Leadership structure	General Manager with Oral Health Program Management has responsibility for reporting, monitoring of activity and recruitment. Two Team Coordinators have responsibility for the general day-to-day program management tasks. One position is a 0.6 EFT (one day admin, one day supervision of students, one day clinical load). The other is 1.0 EFT two days admin, three days Dental Assistant. Senior Dentist (0.7) has clinical leadership role with responsibility for the oversight of clinical activity – quality, output, development. Two days clinical, one day supervision of students, 0.5 day admin.	
Students	Two chairs: fifth-year BDSc. and third-year BOH.	
Dental chairs	Ten located onsite at KCHS in Ferntree Gully.	
Service uptake 2009–10:	8,288 individuals 20,263 visits 10,899 courses of care Use of interpreters – 152 occasions	
Denture services	Three salaried prosthetists Commercial laboratory work outsourced	
Other	Deliver S4M. GP does oral surgery sessions. Cultural training for staff and General Practitioners. Part of SRS initiative.	

Ranges Community Health (RCH)

RCH is located in the LGA of Yarra Ranges. Services are delivered from two sites in Lilydale and Belgrave. Their dental clinic is located at Lilydale.

Oral Health Program staffing	• Dental Officers: 4.2 • Dental Therapists: 0.8 • Oral Health Therapist:1.0 • Dental Prosthetist: 0.2 • Dental Assistants: 6 • Reception: 6 (includes CHS)
Leadership structure	Senior Dentist acts as Program Manager (also has a clinical load). Dental officers, therapist and assistants report to Program Manger who reports to RCH CEO.
Students	No capacity at present.
Dental chairs	Six located on site in Lilydale.
Service uptake 2009–10:	6,176 individuals 15,956 visits 51,542 treatments 7,490 courses of care
Denture services	0.2 prosthetist does denture work in own private laboratory.
Other	Info session for Oral Health team with CHS diabetes program. Oral health screening of Aboriginal students at school plus block appointments for Aboriginal people. Part of SRS Initiative. Senior Dentist on Clinical Leadership Council and Department of Health-funded Healthy Mothers, Healthy Babies program steering group. Investigating private sessions to support retention of dentists. High FTA rate amongst children.

EMR oral health service delivery summary

Over 2009–10, in the EMR:

- 35,345 people accessed a community oral health service (in any location across Victoria) or 10.7 per cent of the eligible population. This includes people from Manningham (where there are no fixed chairs). Manningham had a greater percentage of eligible people who accessed services than Whitehorse and Boroondara.
- 34,121 people accessed an EMR community oral health service.[1]
- Based on recorded postcodes[2] 4,078 eligible people accessed community oral health services external to the EMR (excluding RDHM). This is mostly people living near LGA borders.
- 3,374 eligible people (who live outside the EMR) accessed community oral health services in the EMR.
- 7,481 eligible people accessed RDHM for emergency and specialist services, with most of these coming from Monash. 286 people from the Yarra Ranges attended RDHM for emergency treatment – a significant distance for some people to travel.

1 In 2010–11, 35,533 people accessed a community oral health service located in EMR.

2 Some postcodes cover more than one municipality so figures are estimates.

- The rate of dental Ambulatory Care Sensitive Conditions (ACSC) is significant in Whitehorse and Manningham for children aged 0–14.
- Children comprise a significant proportion of all general clients. The response rate of children who are recalled is generally good for low-risk children in most services. However, not all children are on a recall list and this is of concern especially where children are in the high-risk category. This is an area stakeholders agree could be improved.
- All waiting lists are close to or under the performance indicator with the exception of WCHS (29.9 months) and Ranges CH (30.98 months) for (all) dentures (2011).
- In comparison to other areas, the inner east has a reasonable supply of private dentists. Currently the EMR has a rate of 31 dentists per 1,000 people in the inner east and 14 dentists per 1,000 people in the outer east. Stakeholders report few private dentist services in the Yarra Ranges. However, the region does not currently meet the Victorian public dental chair to eligible population defined ratio of 1:5,000.

Appendix 5 provides maps of inter-regional service usage during 2009–10.

Opportunities for collaboration, partnerships and integration

Improving Victoria's oral health (Department of Health 2007) sets out five key principles to achieve improved oral health for disadvantaged Victorians. These are reflected in areas of current practice and planned developments and collaborations to be undertaken across the EMR and the community oral health service system (see Appendix 3).

More recently, and of key relevance to this plan, the *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* establishes a framework for the planning and development of priorities for health services across the Victorian healthcare system by the year 2022. The framework articulates seven planning and development priorities for metropolitan and statewide health services:

- develop a system that is responsive to people's needs, including:
  - planning tools and approaches such as area-based planning
  - defining the role and scope of services across the care continuum
  - analysis of up-to-date and correct population statistics to inform planning
  - evaluation of existing and new care settings
  - development of opportunities for private sector collaboration
  - joint planning with Commonwealth – particularly Medicare Locals
- improve every Victorian's health status and experiences, including:
  - identifying groups who are vulnerable to poor health and developing interventions that address their health needs
  - developing a strategy for improving people's health knowledge and supporting patient choices.

Victoria's Health and Wellbeing Plan 2011–2015 lists key settings and opportunities for the promotion of oral health (Department of Health 2011b, p. 26)

- expand service, workforce and system capacity, including:
  - the evaluation and development of existing efficient and effective service models and settings
- implement continuous improvements and innovation, including:
  - promoting clinical leadership of service improvements and innovation
  - development of more effective and centralised data acquisition and management system
- increase the system's financial sustainability and productivity, including:
  - consideration of new funding models such as packages of care for targeted patient groups, such as those with chronic and complex care needs
- increase accountability and transparency (using a health outcomes framework)
- utilise e-health and communications technology.

Partnerships, planning and governance

Strengths: commitment to a shared plan and service developments

An effective governance and planning structure is imperative to underpin EMR community oral health service integration and collaboration and to support future oral health service development and targeting of resources to meet demand across the whole EMR. In coming together to develop this plan, services in the EMR have demonstrated a commitment to working together to build service capacity and meet identified oral health need.

The development of the plan was guided by the steering group and an overarching governance group. WCHS was the fund holder and lead agency for the plan.
In 2007 KCHS was nominated as the the lead dental organisation for the outer east, while in early 2008 WCHS was nominated the lead role for the inner east.

Members of the governance and steering groups considered options for a future governance and partnership structure best suited to driving and supporting the implementation of the plan and broader strategic direction. The relationship of the preferred option to other regional planning and sector structures was discussed. It was decided to undertake an Expression of Interest process in early 2012. KCHS was unanimously nominated to undertake this role for the whole of EMR.

Opportunities: formalising relationships with Medicare Locals and PCP

Stakeholders agreed to the need for a framework and shared process to support future oral health service planning and development. They also support raising the profile of oral health services and oral health need in the service system, particularly in the context of developing relationships with the Inner East Melbourne and Eastern Melbourne Medicare Locals and improving connections to the existing Inner and Outer East Primary Care Partnerships.

The EMR Oral Health Network configuration is described in Figure 1. It includes connections to universities (via oral health student placement activity) and the private sector. The network supports ongoing working relationships with the Department of Health, DHSV and peak bodies, as well as building cross-region relationships across oral health services (for example with Southern Metropolitan Region (SMR) services regarding waiting list management activities and opportunities for shared training).

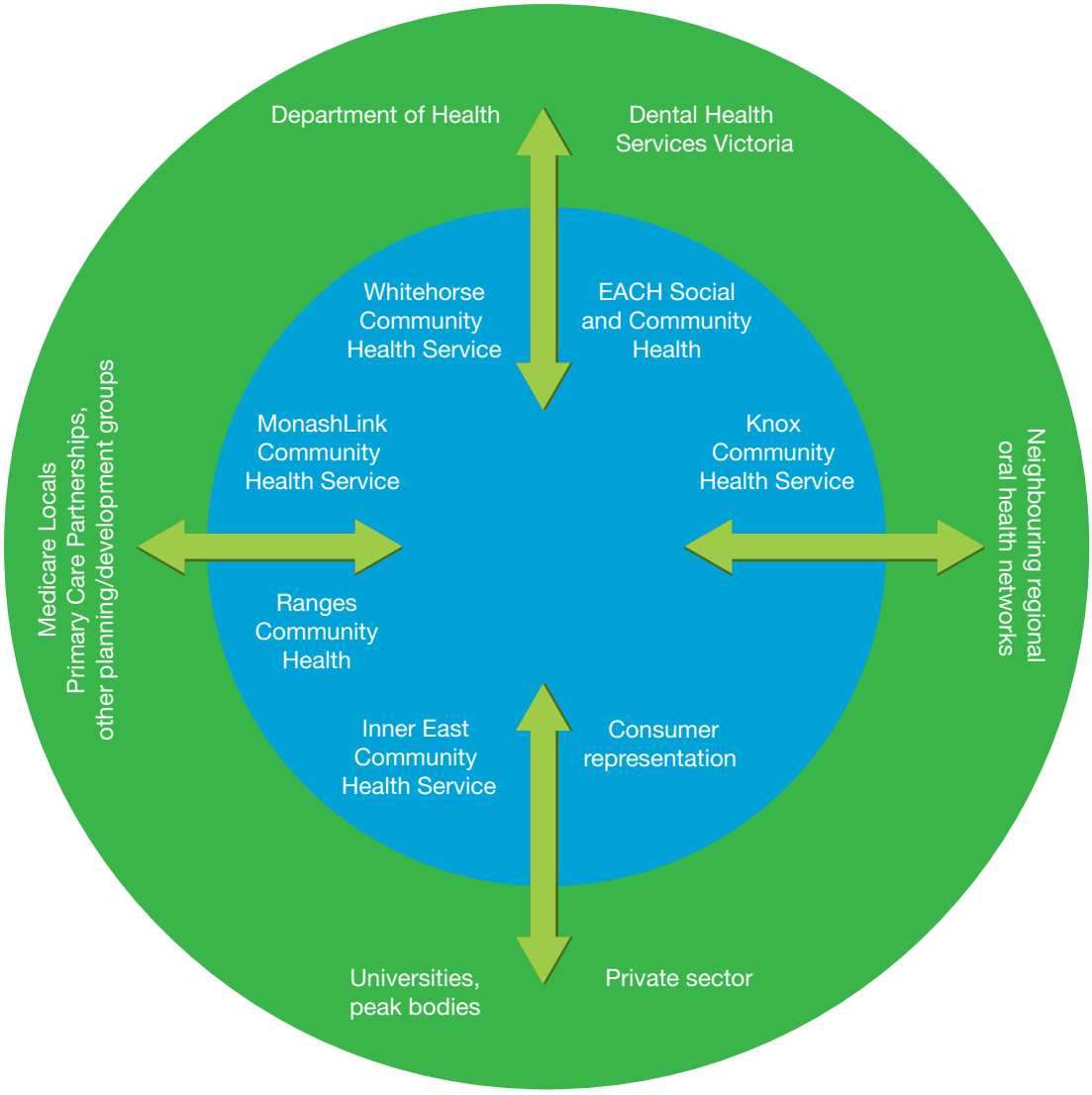
EMR network and auspice organisation

The network is responsible for the implementation of the *EMR integrated oral health plan 2011–14* and the related actions listed in the action plan. Responsibilities include the oversight and management of resources, project workers, portfolio holders and working groups. The chairing of network meetings is the responsibility KCHS as the nominated lead organisation.

Action plan evaluation

An evaluation framework template is included in Appendix 4. An initial task of network members, the lead organisation and the selected project worker will be to set agreed indicators to measure process and impact outcomes delivered through implementation of the actions contained in the action plan. Example indicators are provided for action 3 regarding promoting the access of SRS residents to community oral health services.

Figure 1: EMR Oral Health Network



Promoting access

Eligible population projections

Projected increases in the eligible population indicate that an increased level of community oral health services will be required in coming years. Stakeholders concur that services will need to work collaboratively to address and meet current and projected demand.

It is important to note that the wait list only reflects the number of people who have sought access to community oral health services, not the actual eligible population. There is a (significant) gap between the number of people who are eligible and the number of people who have sought treatment or are on waiting lists. While service capacity is relevant (in that it would be impossible to provide timely direct treatment to the total eligible population), it is especially pertinent to early intervention and oral health promotion strategy development.

Strengths: working with high-needs groups

Refugees

Organisations in the EMR are effective in delivering a range of oral health services to eligible high-needs groups. Refugees currently make up a significant number of the eligible population receiving oral health services through EACH, especially the Burmese community. External services that work with these groups appreciate the relationships they have and the work done by the community oral health services in reaching out to refugees and CALD groups through health information sessions and information in other languages. Stakeholders noted the need to:

- monitor refugee arrivals in the EMR and plan for service responses
- ensure access to sufficient funding for interpreters (via the allocated budget for interpreter services through the Department of Health language services program). It is noted the Dental Health Program recently made a funding allocation to language services. This funding will increase the budget available for language services
- provide links to broader health services.

Aboriginal people

Community oral health services are often the key entry point for Aboriginal people to access community-based health services. Various initiatives support and encourage access, for example those at EACH, KCHS and RCH which include cultural training for staff, access-promotion projects and health-check days.

People with alcohol, drug and mental health issues

Stakeholders noted the high oral health needs of people with mental health, alcohol and drug issues. IECHS reserves weekly appointments for YSAS clients. The KCHS amphetamine-type stimulants and oral health initiative promotes access to oral health information and services for people who use amphetamines.

An EACH project aims to develop and implement strategies to improve access to primary healthcare services, improve health literacy (across clients and staff) and to minimise the impact of physical health issues for people with a serious mental health illness. EACH was funded for a demonstration project to develop links between the local adult mental health service Psychiatric Disability Rehabilitation and Support Services (PDRSS) and CHS. These links include oral health. The project is now ongoing with recurrent funding provided from the Department of Health's Integrated Chronic Disease Management program.

Children

Only 12 per cent of eligible children in EMR are on a recall list, with the percentage varying across each LGA. The development of this plan presents an opportunity to consider ways (including shared practice development and consideration of effective strategies) to improve the access and recall of children – particularly those in the high-risk category.

Tracking high-needs groups

The opportunity to further collaborate and build on existing good practice and explore ways of providing services to these identified groups was confirmed. Being able to effectively identify and track high-needs or priority groups in the new data system (as is possible for Aboriginal people and refugees) is noted as a future requirement and one which DHSV will be undertaking statewide.

Opportunities: options for greater access to specialist services

Stakeholders made several suggestions regarding the provision of oral health services for high-need groups in future:

- continued collaboration on the SRS oral health project (see case study below) with the aim of maintaining referral pathways and appointments for SRS residents
- developing connections with the Department of Human Services EMR Disability Accommodation Services and other providers to identify feasible options for health promotion/education of staff/clients
- sharing of practices developed by KCHS for people with alcohol and drug issues (information and priority access to oral health services). Option to also provide information about access to oral health services at Needle and Syringe Program exchange sites
- consider ways to improve the access and recall of children (including shared practice development and consideration of effective strategies).

Exploring additional options for delivery of direct care and health promotion to people in remote or isolated areas.

Specialist services

Consultation identified support for a collaborative EMR approach to create more locally based specialist options and in particular, promoting access to specialist services for eligible people in outer LGAs. While community organisations are only funded for general activity, the opportunity exists to work with DHSV in the planning and development of pathways that promote client access to specialist services.

Case study: SRS Oral Health Project

The EMR Pension-Level SRS Oral Health Initiative Pilot Project commenced in 2008. KCHS received funding to provide an outreach hygienist to undertake oral health assessments of residents at the eight pension-level SRS across the EMR participating in the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI).

The model involved dental hygienists and assistants providing resident oral health assessments and oral health education and health promotion to pension-level SRS residents and staff. The participating residents were subsequently referred to their local CHS Oral Health Program for clinical treatment services with ongoing support and collaboration with the KCHS project team.

In 2010, the pilot was extended to the WCHS catchment beyond the initial KCHS, MonashLink, EACH and Ranges catchments and has provided a foundation for the regional model of DHSV funded SRS oral health treatment initiatives.

Models of care

Strengths: effective and good quality services

Community oral health services are delivered from six sites in the EMR. Most are delivered from well-equipped, purpose built, integrated CHS sites like KCHS, MonashLink CHS, RCH and WCHS. The IECHS oral health service is located within the Craig Family Centre which also houses maternal and child health, play groups, preschool and paediatric allied health (and as a result has a high number of younger clients). Most report that community oral health services in the EMR have well-functioning models of service delivery supported by qualified staff and managers with high levels of experience in the sector.

Opportunities: developing services

The key objectives in considering future, potentially reconfigured, models of care are:

- improve the access of eligible population particularly identified high need groups
- offer services at accessible locations and where there are existing service gaps
- support workforce development activities (for example meeting the workforce requirements of particular areas)
- aim to reduce waiting times and FTA rates
- meet increasing demand.

Centre-based fixed chairs

With regards to fixed chair services *Improving Victoria's oral health* (Department of Health 2007) notes that community oral health services should encompass a minimum of four chairs for greater efficiency and be in accessible locations ideally co-located with a CHS. A greater proportion of resources should also be directed to areas with greater eligible population numbers with higher levels of need using SEIFA and available population data.

Linked to the overall planning framework, stakeholders concurred that EMR needs to consider service demand, and to be open to exploring different models and approaches (links to private practice, outreach services; fixed chairs in identified locations) which address ongoing need and gaps across the region.

Stakeholders also advocated:

- maximising utilisation of existing chairs and ensuring all chairs are available for all client groups. This requires analysis of chair utilisation at each site (with DHSV)
- maximising clinical hours of operation and staff mix. For example: exploring options for services to open afterhours and on weekends; increasing the scope of practice for some staff.

Outreach services

EACH has operated a one-chair mobile outreach dental clinic on behalf of Outer East Oral Health Services since November 2010. A dentist and dental assistant currently provide clinical services rotating between two sites: Glen Park Community Centre in Bayswater North, and Yarra Valley CHS in Yarra Junction. A Healesville location continues to be explored along with further discussions with Swinburne TAFE to increase the access of priority population groups. EACH, DHSV and the Department of Health also continue to monitor the outreach service in relation to the new DHSV funding model.

Stakeholders recognised several valuable and effective outreach activities. For example screening children from housing estates by IECHS and the SRS Oral Health Initiative has proved effective in addressing oral health issues for SRS residents and as an effective vehicle for service collaboration between the oral health services across the EMR. At a minimum, these effective strategies should be maintained. Opportunities to build on and create additional outreach activities should also be considered.

Private services

This plan explored private services in two areas:

- working with the private sector to build access and better meet demand. The new Metropolitan Health Plan (Department of Health 2011a) advocates options for private sector collaboration. Stakeholders agreed that it could be useful to map private services in the EMR with a view to future collaboration and noted that various collaborations have worked well in other areas
- developing (internal CHS) private practice models like the one at WCHS and those being considered at other sites. These offer the potential to generate income and improve the scope of practice for on-staff dentists. Services could also work together and develop similar fee structures, shared learnings and approaches.

Demand management

Strengths: working on ways to meet demand

In June 2008 the Department of Health Dental Waiting Times Grants Program[3] endorsed four proposals including a shared waiting list for the outer east. This project evolved into promoting access to the mobile van for people on the outer east waiting list. Examples of other initiatives developed by EMR services to manage demand and increase efficiency include:

- appointment reminder telephone calls to reduce FTA rates at EACH
- standby lists at WCHS
- afterhours services (which were offered at some sites in the past).

Stakeholders agreed that this plan provides an opportunity to identify and develop shared ways of working and new practices that promote efficiency and effectiveness of services and potentially better-manages existing and projected service demand. The need to gain consumer input to development of strategies and impacts is supported.

Opportunities: future demand-management strategies

Suggested areas to explore include:

- creating a 'helicopter view' across all EMR agency waiting lists and child recall lists, exploring waiting list reduction strategies and considering options and approaches to support services being offered across sites where lists are shorter
- reviewing the learnings and potential application of demand management projects and activities developed in other areas, and looking at ways to collaborate with services in the SMR.

Denture services

Denture service models and practices vary considerably across the EMR with services most often tailored to locally available staff and laboratories. The differences in waiting times for denture services vary widely, from MonashLink CHS at 7.5 months for dentures to WCHS and RCH at close to 30 months (2011). Stakeholders agree there is an opportunity to consider denture service models and the cost-effectiveness of various approaches to promote greater equity of access. Given the ageing population there could be significant demand and need for denture services in the near future.

3 See http://www.health.vic.gov.au/dentistry/service_provider/waiting_times.htm

Early intervention, service coordination and health promotion

Strengths: good practice examples

Improving Victoria's oral health (Department of Health 2007) promotes 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. The links between poor oral health and other chronic health conditions are well recognised, such as the relationships between periodontal disease and cardiovascular conditions, and diabetes and dental cavities (Australian Dental Association 2004).

Early intervention and service coordination creates an opportunity to refer oral health clients with chronic health conditions to appropriate services and to create improved access to oral health care for high-needs groups. Oral health early intervention and service coordination practice is at different stages for organisations across the EMR.

The following examples demonstrate effective and developing practice in the EMR.

- An integration project at KCHS developed pathways for oral health clients to other CHS services and CHS clients to oral health services. Strategies and key learnings from the KCHS approach could be considered across other services.
- EACH is facilitating the EMR component of a demonstration project which aims to promote the access of people with serious mental illness to models of care that identify client needs through effective screening and identification practices.
- The WCHS, KCHS and RCH Integrated Diabetes Education and Assessment Service (IDEAS) program facilitates an integrated care team approach to the management of diabetes. It aims to provide community-based, integrated care (including oral health) for people with diabetes.
- Other EMR oral health services have also established connections with diabetes services and there is willingness to build service coordination practice for people with diabetes and other chronic conditions.

Stakeholders discussed the value of building practice around the early identification of chronic health needs of oral health clients and the oral health issues of people with complex needs (for example mental health) and appropriate referral practices and pathways.

Opportunities: oral health promotion

Oral health promotion (OHP) programs are a key mechanism to prevent the development of oral disease in the eligible population, especially early in life. Stakeholders note the importance of effective oral health promotion, particularly given the high rates of dental ACSC in the EMR and the understanding that the risk factors for poor oral health are similar to the risk factors for other health conditions.

Oral health service providers welcomed the opportunity presented by this plan and their collaboration (via an integrated population health focus) to consider options for OHP developments. The recent *Victorian Public Health and Wellbeing Plan 2011–2015* and the *Evidence-based oral health promotion resource* (Department of Health 2011b, p. 27) provide an ideal platform to develop strategies. The health promotion resource also outlines a series of activities undertaken by services in other areas.

In aiming to make the S4M program more sustainable, DHSV will directly support early childhood services in some areas, while other areas will retain a local coordinator (DHSV 2011). Early childhood

centres that have been involved with S4M through their CHS can be supported to continue after the extension funding has ceased.

Options to promote OHP include:

- assessing the gaps left by changes in S4M – identifying what is needed in response
- building on and expanding successful programs like MonashLink's Keeping Kids Smiling
- linking to broader planning across subregions, lobbying Primary Care Partnerships and Medicare Locals to raise the profile of oral health promotion, and identifying opportunities for OHP with specific groups, for example people with disabilities, refugees (building on existing good work) and SRS staff.

Consumer participation and information

Strengths: consumer representation

The DHSV *Community participation plan 2010–2014* (DHSV 2010) seeks to promote community participation throughout the services and programs of DHSV. Each organisation is required to implement quality of care, consumer engagement standards (Department of Health 2010 – see Appendix 7 for current agency consumer engagement activities). In this context, the opportunity exists to build good quality, effective and measurable consumer participation in oral health service development and delivery.

Opportunities: agreement to build consumer participation

Community representatives on the project steering group welcomed the opportunity to suggest options for ongoing consumer involvement in the implementation of recommendations and actions outlined in this plan. Partner organisations appreciated the feedback from the community representatives and agreed that future active community participation be sought, starting with the inclusion of a community representative in the EMR Oral Health Network.

The representatives noted that effective community participation can be assisted by:

- referencing the DHSV *Community participation plan* (and its actions)
- ensuring feedback systems are bottom up (from consumers), not top down
- obtaining systematic feedback from consumers (satisfaction, access, new initiatives) and including consumers in devising feedback processes and tools
- identifying accountable staff for these steps and processes
- writing community participation indicators in all position descriptions
- being proactive in offering feedback forms or other mechanisms that may not be in written form.

All CHS involved in the development of the plan have internal community participation plans, policies and practices, either existing or in development. Rather than developing additional consumer participation strategies specific to oral health, participants suggested building on their existing practice, ensuring strategies and activities are inclusive of oral health services. Broader CHSs community participation activities are described in Appendix 8. An opportunity exists for partners to come together and share information about their own practices, identify the community involvement essential to the development of oral health services in the EMR and how this can be achieved and effectiveness measured.

The action plan lists several action areas relating to consumer involvement in current and future planning and service developments and the evaluation framework will identify related process and outcome indicators.

Consumer information

Consumer consultation and feedback identified the need for information and better promotion of community oral health services. This included:

- clearer information about appointment systems and the process for emergencies
- addressing consumer fear of oral health services through timely information and promotion
- better promotion of community oral health service through local papers, Centrelink, community centres, CALD communities
- using the term 'dental' rather than oral health as it is more meaningful to consumers
- providing lists of local dentists and prosthetists who do voucher work.

Stakeholders discussed strategies and ideas for improved information provision and service promotion. These included:

- developing key contact people in local government and potentially in other services who can act as conduits for information
- providing information about dentists and prosthetists , including private dentists and prosthetists, via existing communication tools such as the Human Services Directory.

Workforce development

Strengths: committed and skilled workforce

Each EMR oral health service enjoys the benefit of a highly committed and skilled workforce which includes multilingual staff at some sites. Staff have been supportive and willingly engaged in several new initiatives like the SRS project, mobile van and others. Training options like Enhance offered at MonashLink CHS are well regarded and could potentially be shared.

Recruitment of appropriately skilled oral health staff is an issue at times, with some positions attracting few applicants. Another area of concern is that some staff do not want to work afterhours at some of the services which provide afterhours access.

DHSV have a statewide mandate in the training, recruiting and retaining the oral health workforce, including the establishment of partnerships with universities in the education, training and continuing professional development of clinicians, and the development and provision of re-entry and mentoring programs for the oral health workforce. As well, all EMR oral health service stakeholders considered the area of workforce development a key area for collaboration across the EMR with a shared strategy considering:

- workforce attraction, recruitment and retention (including shared positions)
- effective supervision and mentoring structures
- credentialing and scope of practice
- professional development activities. Some noted that this could later be expanded to include broader areas like the SMR services.

In some instances the workforce configurations are based on available staff rather than derived from service demand and the needs of priority groups. This can result in under utilisation of some staff, for example where dental therapists can only work with children, opportunities to book adults into cancelled appointments are reduced. Some organisations aim to continuously configure the staff profile to service need where possible, for example a vacant dentist position may be partially filled by a dental therapist if the need for paediatric services is high.

A shared workforce development approach offers an opportunity to consider this issue and confirm workforce configurations based on service need across the EMR. Consideration of student placements should also be factored as a whole-of-region activity.

Action plan

Objective	No.	Actions	Responsibility	Priority/ Timing
Promote access Promote the access of eligible and high-need groups to community oral health services including specialist services.	1	Shared community oral health service planning and development is informed by: • biannual forums (DHSV or network sponsored) • ongoing opportunities to share learning and practices (e.g. 'virtual' networks).	DHSV Auspice/project worker Network members	Years 2–3
	2	Develop shared and common practice for the priority access of high-needs groups (consider KCHS tools to support practice development).	Network members Project worker	Year 2
	3	Discuss the future access of SRS residents to community oral health services with a view to establishing shared protocols and practice across EMR.	Network members Project worker	Year 2
	4	Improve access of people with disabilities to community oral health services – DHSV/Network to engage with the Department of Human Services in development of service pathways.	DHSV Network members	Year 2
Demand management Develop shared practices that promote efficiency and respond to existing and new service demand.	5	Implement consistent and shared child-recall protocol and practice across all EMR oral health services to achieve recall interval benchmarks.	Network members	Year 1
	6	Review existing models of community denture services across the EMR including screening practices, wait list practices and denture waiting list criteria. Develop a denture service delivery model that provides a more equitable access to denture services across the EMR and targets denture service provision to areas with high waiting lists.	Network members Project worker	Year 2
Private sector Build private sector collaboration and (internal) private practice development.	7	Build private practice involvement in community oral health services by: • exploring options to include (external) private dentists in service delivery models • developing a service model where community oral health services develop private practice capacity to deliver private services as part of their model.	Network members Project worker DHSV	Year 1
Early intervention and service coordination Build practice in early intervention and service coordination.	8	Identify CHS (planned) training and development activity regarding early intervention and service coordination. Promote access to planned training for community oral health staff.	Project worker	Years 1–3

Objective	No.	Actions	Responsibility	Priority/ Timing
Oral health promotion Build opportunities for oral health promotion (OHP) via an integrated approach and collaboration with planning networks and others.	9	Work with Department of Health and DHSV to identify resources and options for local implementation of children's OHP across the EMR.	Project worker	Year 1
	10	Link to broader planning across subregions; lobby Primary Care Partnerships, Medicare Locals, CHS to raise profile of OHP and identify opportunities for OHP with specific groups linked to broader health promotion activities.	Network members	Year 1
Consumer participation and information Ensure consumers are informed about oral health services and participate in service development and evaluation.	11	All EMR oral health network members: • share information about their own CHS community participation practices • develop/build on (CHS) systems to obtain systematic feedback from oral health clients with processes to analyse findings (use opportunity to gather information on service access and information, for example asking 'How did you find out about our services?') • link with CHS staff accountable for consumer participation activities and measurement • ensure community participation indicators are in all oral health staff position descriptions • include consumer participation and feedback as a standard agenda item on program meeting agendas.	Network members	Years 1–2
	12	Investigate options for a website-based information directory of dentists and prosthetists in EMR (consider role of existing databases for example Human Services Directory, InfoXchange Service Seeker).	DHSV DH	Year 2
Workforce development Develop and maintain the community oral health workforce.	13	The EMR network actively participates in the DHSV workforce development strategy – provides input and feedback and develops local activities and actions as an outcome.	DHSV Network members	Year 1

References

Australian Bureau of Statistics 2011, *Population by age and sex, regions of Australia*, cat. no. 3235.0, viewed 7 March 2012, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3235.0>.

Australian Dental Association 2004, *Looking beyond teeth: the link between overall health and oral health,* viewed 4 March 2012, http://www.ada.org.au/App_CmsLib/Media/Lib/0610/M19252_v1_2004%20DAM%20General%20media%20release.pdf>.

Australian Institute of Health and Welfare 2011, *Oral health and dental care in Australia: key facts and figures 2011*, cat. no. DEN 214, AIHW, Canberra, viewed 4 January 2012 <http://www.aihw.gov.au/publication-detail/?id=10737420710>.

Maroondah City Council undated, *Refugee settlement in Maroondah fact sheet*, viewed 1 March 2012, <http://www.maroondah.vic.gov.au/common/files/CommunityHealthServices/Factsheets.pdf>.

Dental Health Service Victoria 2010, *Community participation plan 2010–24,* State Government of Victoria, Melbourne.

—— 2011, *S4M award program: information for early childhood services*, State Government of Victoria, Melbourne.

Department of Families, Housing, Community Services and Indigenous Affairs 2009, *Closing the gap on Indigenous disadvantage: the challenge for Australia,* Australian Government, Canberra.

Department of Health 2007, *Improving Victoria's oral health*, State Government of Victoria, Melbourne, viewed 4 March 2012, <http://www.health.vic.gov.au/dentistry/downloads/vic_oral_health.pdf>.

—— 2009a, *Primary healthcare in Victoria: a discussion paper,* State Government of Victoria, Melbourne.

—— 2009b, *Doing it with us not for us: strategic direction 2010–2013*, State Government of Victoria, Melbourne.

—— 2011a, *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*, State Government of Victoria, Melbourne.

—— 2011b, *Victoria's Health and Wellbeing Plan 2011–2015*, State Government of Victoria, Melbourne.

—— 2011c, *Evidence-based oral health promotion*, State Government of Victoria, Melbourne, viewed 4 March 2012, <http://docs.health.vic.gov.au/docs/doc/Evidence-based-oral-health-promotion-resource-(2011)>.

Department of Human Services 2008, *Refugee health and wellbeing action plan 2008–10*, State Government of Victoria, Melbourne.

National Advisory Committee on Oral Health 2004, *Healthy mouths healthy lives: Australia's national oral health plan 2004–13*, Australian Government, Canberra.

Williams S, Jamieson L, MacRae A and Gray C 2011, 'Review of Indigenous oral health', *Australian Indigenous Health Bulletin*, vol. 11, no. 2.

Appendix 1: Steering and governance groups

EMR Integrated Oral Health Plan 2011–14 Steering Group	
Ms Sophy Athan	Consumer representative
Ms Sandra Pearce	Consumer representative
Mr Jonathon Brown, Senior Project Officer, Primary Health, EMR	Department of Health
Mr Colin Riley, Manager Oral Health Agencies – Western	DHSV
Ms Amy Patterson, Manager Oral Health Agencies – Eastern	DHSV
Ms Heather McMinn, Clinical Services Manager	EACH
Ms Jackie Kelly, Service Manager	EACH
Ms Jane Judd, Associate Program Director, Ambulatory and Community Services	Eastern Health
Ms Niki Hantzis, Oral Health Manager	IECHS
Dr Ruth Heredia, Senior Dentist	IECHS
Mr Gregg Nicholls, CEO, MonashLink CHS and Chair	IEPCP
Mr Chris Potter, CEO, Knox CHS	Interim Chair
Ms Denise Harisiou, General Manager, Clinical and Service Quality	KCHS
Ms Esther Murray, CEO	MCHS
Ms Sharon Strutt, Acting CEO	MCHS
Dr Felicia Valianatos, Oral Health Services Manager	MonashLink
Mr Peter Ruzyla, CEO, EACH and Chair	OEPCP
Ms Jacky Close, Manager	OEPCP
Ms Karyn McPeake, CEO	RCH
Dr Andrea Nazareth, Senior Dentist	RCH
Mr Stuart Margison, General Manager Oral Health and Quality	WCHS
Ms Gillian Leach, CEO	WCHS
EMR Oral Health Governance Group	
Mr Jonathon Brown, Senior Project Officer, Primary Health, EMR	Department of Health
Mr Colin Riley, Manager Oral Health Agencies – Western	DHSV
Ms Amy Patterson, Manager Oral Health Agencies – Eastern	DHSV
Ms Heather McMinn, Clinical Services Manager	EACH
Ms Niki Hantzis, Oral Health Manager	IECHS
Dr Harry Majewski, CEO	IECHS
Mr Gregg Nicholls, CEO, MonashLink CHS and Chair	IEPCP
Mr Chris Potter, CEO, KCHS	Interim Chair
Ms Denise Harisiou, General Manager, Clinical and Service Quality	KCHS
Dr Felicia Valianatos, Oral Health Services Manager	MonashLink
Mr Peter Ruzyla, CEO, EACH and Chair	OEPCP
Dr Andrea Nazareth, Senior Dentist	RCH
Ms Karen McPeake, CEO	RCH
Mr Stuart Margison, General Manager Oral Health and Quality	WCHS
Ms Gillian Leach, CEO	WCHS

Appendix 2: Other stakeholders consulted

Ms Janet Shortal, Maternal and Child Health Coordinator	City of Boroondara
Mr Mark Stracey, Director, Health and Aged Care, EMR	Department of Health
Ms Annette Worthing, Team Manager, HACC and Aged Care, EMR	Department of Health
Ms Trudy Parker, Senior Project Officer, HACC and Aged Care, EMR	Department of Health
Mr Robert Stephens, Project Manager, Closing the Health Gap, EMR	Department of Health
Ms Catherine James, Manager, Dental Health Program, Integrated Care	Department of Health
Ms Amanda Watts, Disability Services, EMR	Department of Human Services
Prof Mike Morgan, Executive Director, Oral Health Leadership	DHSV
Ms Lisa Arton, Clinic Coordinator	EACH
Ms Penny Wagstaff, Indigenous Health Facilitator, AHPACC	EACH
Mr Geoff Rowe, Finance Manager	Eastern Health
Ms Michele Goding, Associate Program Director	Eastern Health
Ms Kristen Michaels, CEO	Eastern Ranges GP Association
Ms Wendy Thomas, Chronic Disease Management Team Leader	Greater Monash GP Network
Ms Jill Kelly, Primary Health Integration Manager	Inner East Melbourne Medicare Local
Ms Debra Harper, Team Coordinator, Clinical Program	KCHS
Ms Eva Saris, Team Coordinator, Reception	KCHS
Ms Fiona Tobias, Team Coordinator, Clinical Program	KCHS
Ms Véronique Roussy, Project Officer, Service Coordination	KCHS
Ms Penny Christie, Aboriginal Liaison Project Officer	KCHS
Ms Fleur Cousins, Coordinator – Health Services	Knox City Council
Ms Keri Kennealy, Manager, Aged and Disability Support Services	Manningham City Council
Ms Barbara George, Coordinator, Care Planning and Aged	Maroondah City Council
Ms Robyn Kilpatrick, Settlement Worker	Migrant Information Centre — Eastern
Ms Jennifer Sebire, Coordinator Children's Services	Monash City Council
Ms Sarah Baldock, Health Promotion Project Officer	Monash City Council
Ms Kaye Farnsworth, Senior Dental Nurse	RCH
Ms Stephanie Grabb, Health Promotion Officer	RCH
Ms Maureen Joel, Dental Program	WCHS
Ms Janine Scott, Manager, Primary Health Care	WCHS
Ms Carina Martin, Strategic Projects Manager	WCHS
Ms Kellie Handicott, Reception Team Leader	WCHS
Dr Summy Fung, Senior Dentist	WCHS
Ms Cherie Borwick, Senior Dental Therapist	WCHS
Community Advisory Group	WCHS
Mr Travis Heeney, Manager, Home and Community Care	Whitehorse City Council
Ms Cheryl McInnes, Manager, Aged and Disability Services	Yarra Ranges Shire Council

Appendix 3: Key policy documents

National

Healthy mouths healthy lives: Australia's national oral health plan 2004–13 (the national plan)

The national plan acknowledges that oral health is an integral part of general health and that a strong focus on promoting health and the prevention and early identification of oral disease is required, along with access to appropriate and affordable services. The national plan identifies population groups who have poor access to dental care and whose oral health status is well below the rest of the community: Aboriginal and Torres Strait Islander people; people in low socioeconomic groups; and people with special needs relating to disabilities, health conditions and ageing.

Victoria

Department of Health

Health Priorities Framework 2012—2022: Metropolitan Health Plan

The *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* articulates the long-term planning and development priorities for Victoria's health services throughout the next decade. It sets out seven priority areas for metropolitan, rural and regional and health capital planning into the future:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and experiences
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communications technology.

The plan provides health services and their governing boards with directions to set out their planning and service delivery strategies.

Under each of the seven priorities of the framework, *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* details proposed actions within a metropolitan health service context.

Victorian Public Health and Wellbeing Plan 2011–2015

As a companion document to the Victorian Health Priorities Framework, the *Victorian Public Health and Wellbeing Plan 2011–2015* (the wellbeing plan) aims to improve the health and wellbeing of Victorians by engaging communities in prevention activities across a number of settings, and by strengthening systems for health protection, health promotion and preventative healthcare across all sectors and levels of government. It describes a series of opportunities to:

- strengthen the prevention system through governance and leadership, information systems, financing and resource allocation, partnerships and workforce development
- support priority settings for action and development through with a focus on local communities, workplaces, early childhood and education settings and health services
- continue to protect the health of Victorians (health protection) – including environmental health and communicable disease control

- keep people well (health promotion and primary prevention) – focusing on lifestyle-related risk factors such as smoking, diet and physical activity
- strengthen preventive healthcare – including cancer screening, newborn screening, and early detection and intervention.

In Section 5.3 (public health and wellbeing in early childhood and education settings) the wellbeing plan discusses a series of opportunities where the oral health needs of children could be considered. These include establishing local prevention teams in selected communities, and healthy children positions that will provide support to early childhood and education settings to participate in health promotion in partnership with their local community. The wellbeing plan also describes the key role of health services in preventative healthcare.

In Section 7.4 (keeping people well), the wellbeing plan notes the significance of good oral health to the overall health and welling of individuals and lists the following opportunities for progress in 2011–2015:

- include oral health promotion approaches in an update of Victoria's oral health plan and in health promotion plans at local, state and national levels, for example, S4M
- increase oral health literacy through integrating oral health information with other health information and including oral health in school curricula, supported by the research, development and consistent use of evidence-based oral health approaches
- introduce oral health policies and practices in key settings (including healthy food and drink policies and daily oral healthcare where required such as in residential care)
- target high-risk populations with prevention programs
- maximise the benefits of water fluoridation to all Victorian communities
- strengthen early detection of oral disease and early intervention
- utilise health and welfare workers such as Maternal and Child Health Nurses and Family and Children's Services Workers as oral health promoters (including integrating oral health into well persons' visits). This includes implementing the early intervention oral health program Healthy Families, Healthy Smiles to build the capacity of health workers working directly with young families.

Evidence-based oral health promotion

This resource is published by the Department of Health. It describes oral diseases and their determinants, and indicates the most effective health promotion strategies for prevention. The guide was developed to assist health promotion practitioners and policy makers to further promote oral health. By drawing together the evidence and considering implications for practice, the resource is a practical summary for policy development and program implementation. It presents a framework for OHP that brings together determinants of oral health, key population groups, action areas, settings for actions, outcomes and long-term benefits.

Improving Victoria's oral health

Improving Victoria's oral health sets out five key principles to achieve improved oral health for disadvantaged Victorians. These are reflected in some of the current and proposed practice developments for EMR oral health services:

- **the best place to treat** – most EMR community oral health clinics are located within CHS, which creates more opportunities for linkages to a broader range of services; a mobile van is being trailed in the outer east
- **together we do better** – existing partnerships and collaborations have resulted in the effective SRS initiative, and EMR services have demonstrated a commitment to working together in the implementation of this policy framework
- **technology to benefit people** – organisations are working with technology to improve infrastructure for the delivery of more integrated health care
- **a better health experience** – services are working to achieve improved spread and timely access to community oral health care for eligible people; active consumer participation is sought consistent with *Improving Victoria's oral health* and measurable consumer outcomes
- **a better place to work** – a strong theme across all consultation was the opportunity presented in *Improving Victoria's oral health* for a shared workforce development strategy.

Primary health care in Victoria: a discussion paper 2009

This discussion paper proposes that the primary health care system in Victoria should 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. These things should be available for people regardless of where they live, their socioeconomic status, cultural and social background, Aboriginality or the complexity of their health needs.

The discussion paper advocates service delivery models that promote afterhours primary health care and team-based care arrangements using a range of appropriately skilled providers and early detection and health promotion activities as well as treatment services. The discussion paper also suggests that future actions must focus on improving the system's capacity to intervene early, provide proactive and high quality chronic disease care and ensure that client care is effectively coordinated across a mix of program areas.

Doing it with us not for us: strategic direction 2010–13

Consumers, carers and community members work with health services and the Department of Health to improve health policy and planning, care and treatment, and the wellbeing of all Victorians. The document lists five standards for consumer, carer and community participation in Victorian public health services. These are listed in Appendix 6 and include standards for the inclusion of consumers, information, decision making and capacity building.

Dental Health Services Victoria

Strategic plan 2010–13

The DHSV *Strategic plan 2011–13* proposes a series of goals significant to this plan:

- embed oral health initiatives within other health issues
- lead the change in emphasis from treatment interventions towards prevention of oral disease
- continue to develop and implement universal access models for at-risk populations
- build capacity to undertake population health studies and gather information on at-risk populations
- identify and implement new, innovative, best-practice clinical models and low-cost, high quality, readily accessible provider models.

Community participation plan 2010–13

The *Community participation plan 2010–13* seeks to organise community participation activities throughout services and programs of DHSV, particularly at the RDHM and incorporating statewide programs where relevant. It is structured into five goals:

- integrate community participation into DHSV business
- develop effective communication with Victorian communities
- strengthen RDHM community consultation processes
- strengthen RDHM responsiveness to consumer needs
- ensure RDHM consumers are informed of issues relevant to their needs.

High-needs groups

Closing the gap

Closing the gap (Department of Families, Housing, Community Services and Indigenous Affairs 2009) highlights the Federal Government's priority for improving the health and life expectancy of Aboriginal 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 Aboriginal population.' EMR's *Closing the health gap plan 2009–13* lists a series of health service system and partnership priorities, some highly relevant to this plan:

- reduce barriers for Aboriginal people to access EMR health services
- improve health pathways, reduce the impact of chronic conditions and increase healthy behaviours
- partner across government to reduce negative impacts of social determinants of health.

Review of Indigenous oral health

A review of Aboriginal oral health in 2011 (Williams et al. 2011) noted that Aboriginal Australians have poorer oral health than other Australians; suffer from more caries, periodontal diseases, and tooth loss than non-Aboriginal people and that tooth decay among the Aboriginal population more commonly goes untreated leading to more extractions. The report identifies several actions to meet the oral health needs of Aboriginal people. These include the provision of oral health services that are culturally appropriate and increasing oral health care promotion for Aboriginal people.

Refugee health and wellbeing action plan 2008–10

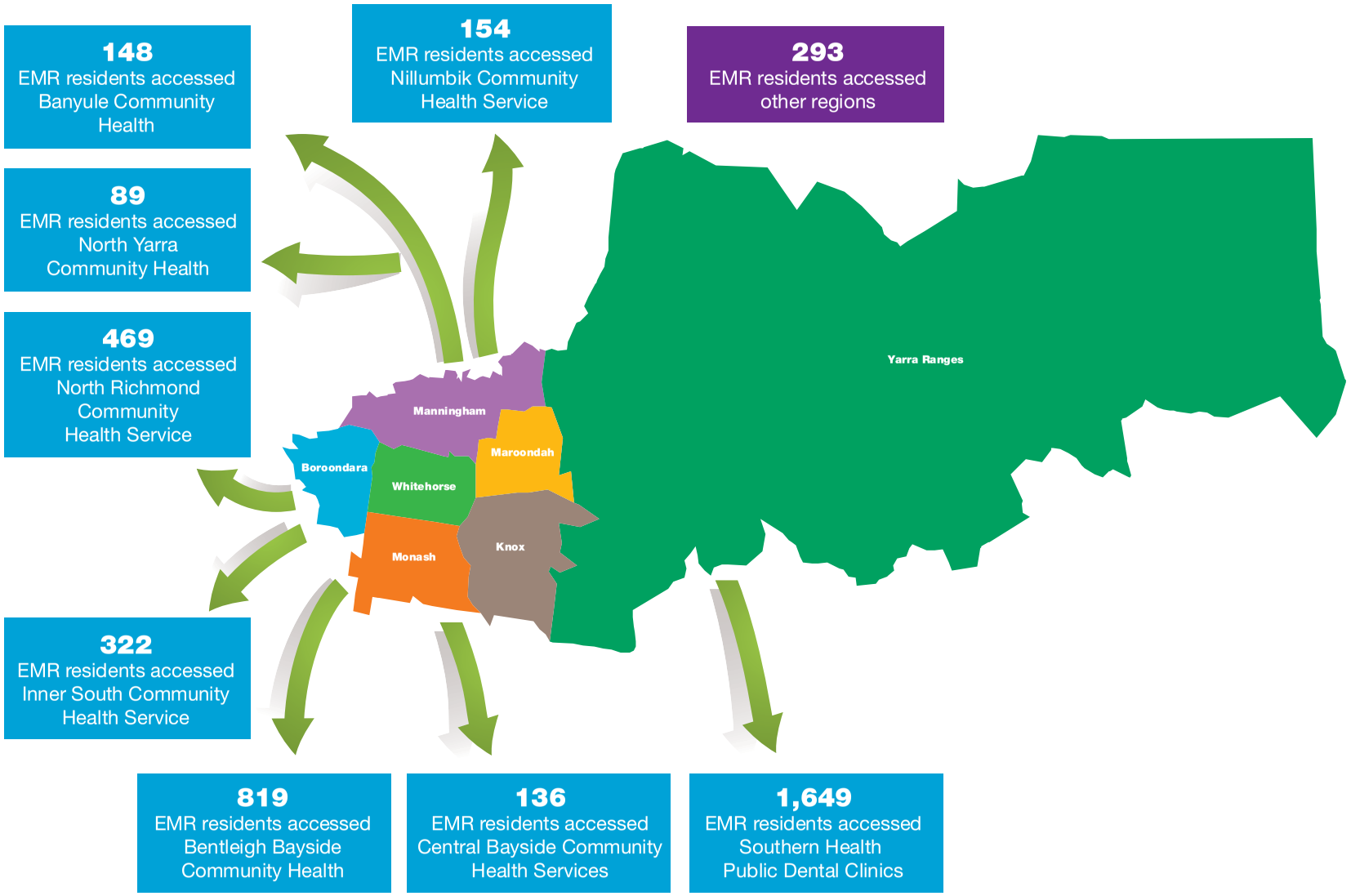
Many refugees have higher rates of long-term medical and psychological conditions than other migrants, with most health problems due largely to physical and psychological trauma, deprivation and prolonged poverty, and poor access to health care prior to arrival. Refugees are also less likely than other migrants to have family and community support in Australia on arrival. The action plan articulates the need for family-centred flexible service approaches and culturally appropriate assessment and care and notes that it is vital that professional interpreters or bilingual workers are used as part of culturally sensitive assessment and care.

Appendix 4: Evaluation framework template

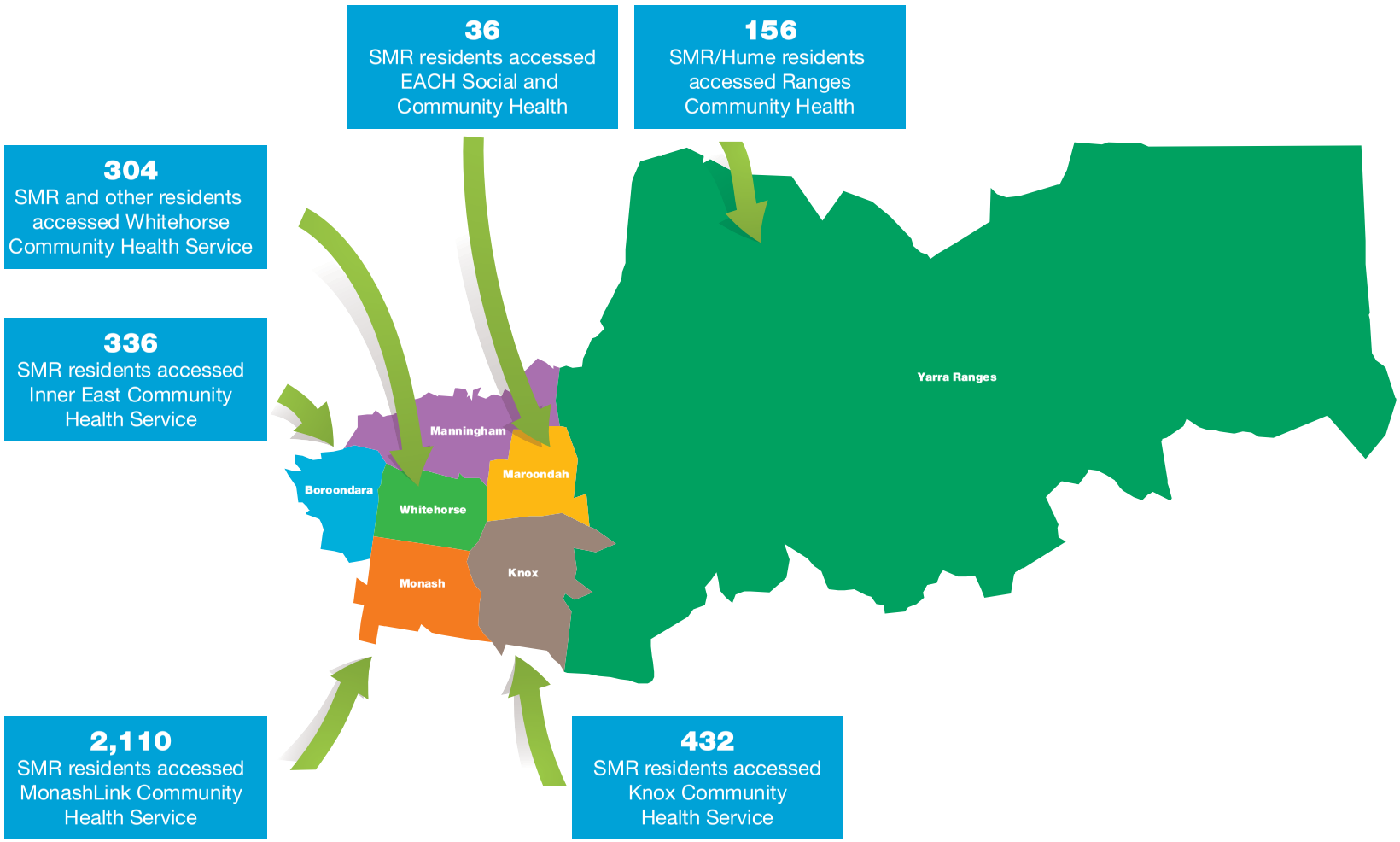
EMR integrated oral health plan evaluation framework			
Objective	**Actions**	**Process evaluation** *Shows progress made towards an objective being delivered as intended, in accordance with best-practice strategies/activities*	**Impact evaluation** *Shows progress made towards the program achieving what it set out to achieve*
Promote access Promote the access of eligible and high-need groups to community oral health services including specialist services.	Shared community oral health service planning and development is informed by: • biannual forums (DHSV or EMR Network sponsored) • ongoing opportunities to share learning and practices (e.g. 'virtual' networks). Develop shared and common practice for priority access of high needs groups (consider KCHS tools to support practice development). Discuss the future access of SRS residents to community oral health services with a view to establishing shared protocols and practice across EMR. Improve access of people with disabilities to community oral health services – DHSV/EMR network to engage with the Department of Human Services in development of service pathways.	Indicators: For example: discussions re SRS residents held at xx meetings with xx member organisations present.	Indicators: For example: shared protocols for SRS residents access established. For example: xx residents from xx SRS accessed services 2012–13.
Demand management Develop shared practices which promote efficiency and respond to existing and new service demand.	Implement consistent and shared child-recall protocol and practice across all EMR oral health services which maintains recall-interval benchmarks. Review existing models of community denture services across the EMR including screening practices, wait list practices and denture waiting list criteria. Develop a shared denture service delivery model that provides a more equitable access to denture services across the EMR and targets denture service provision to areas with high waiting lists.	Indicators:	Indicators:
Private sector Build private sector collaboration and (internal) private practice development.	Build private practice involvement in community oral health services by: • exploring options to include (external) private dentists in service delivery models • developing an internal workforce able to deliver both public and private services.	Indicators:	Indicators:

EMR integrated oral health plan evaluation framework			
Objective	**Actions**	**Process evaluation** *Shows progress made towards an objective being delivered as intended, in accordance with best-practice strategies/activities*	**Impact evaluation** *Shows progress made towards the program achieving what it set out to achieve*
Early identification and service coordination Build practice in early identification and service coordination.	Map CHS (planned) training and development activity in service coordination and staff development. Promote access to planned training for community oral health staff.	Indicators:	Indicators:
Oral health promotion Build opportunities for oral health promotion (OHP) via an integrated approach and collaboration with planning networks/ others.	Working with Department of Health/DHSV to identify resources and options for local implementation of children's oral health promotion across the EMR Link to broader planning across subregions; lobby Primary Care Partnerships, Medicare Locals, CHS to raise profile of OHP and identify opportunities for OHP with specific groups linked to broader health promotion activities.	Indicators:	Indicators:
Consumer participation and information Ensure consumers are informed about oral health services and participate in service development and evaluation.	All EMR Oral Health Network members: • share information about their own CHS community participation practices • develop/build on (CHS) systems to obtain systematic feedback from oral health clients with processes to analyse findings (use opportunity to gather information on service access and information, for example asking, 'How did you find out about our services?' • link with CHS staff accountable for consumer participation activities and measurement • ensure community participation indicators are in all Oral health staff position descriptions • include consumer participation and feedback as a standard agenda item on program meeting agendas. Investigate options for a website-based information directory of dentists and prosthetists in EMR (consider role of existing databases, for example Human Services Directory).	Indicators:	Indicators:
Workforce development Develop and maintain the community oral health workforce.	The EMR network actively participates in the DHSV workforce development strategy – provides input and feedback and develops local activities and actions as an outcome.	Indicators:	Indicators:

Appendix 5: Inter-regional service usage maps 2009–10



This map shows the number of people residing outside of EMR who received services from oral health services located in EMR in 2009–10.



Summary information

EMR eligible population accessing community oral health services external to EMR in 2009–10: 4,079.
External (to EMR) eligible population accessing community oral health services in the EMR in 2009–10: 3,374.

Appendix 6: Community engagement standards

Standards for consumer, carer and community participation in Victorian public health services:

- The organisation demonstrates a commitment to consumer, carer and community participation appropriate to diverse communities.
- Consumers, and, where appropriate, carers are involved in informed decision-making about their treatment care and wellbeing at all stages and with appropriate support.
- Consumers, and, where appropriate, carers are provided with evidence-based, accessible information to support key decision-making along the continuum of care.
- Consumers, carers and community members are active participants in the planning, improvement and evaluation of services and programs on an on-going basis.
- The organisation actively contributes to building the capacity of consumers, carers and community members to participate fully and effectively.

Appendix 7: CHS community participation activities

MonashLink Community Health Service: • Consumer and Community Participation and Engagement Policy • community participation in all position descriptions and performance plans • allocated staff role – Community Engagement Coordinator • team leaders regularly report on community participation strategies and activities • MonashLINKED newsletter reports on community participation activities • consumer register provides details of consumer interest in required feedback areas • Quality Improvement Committee in process of recruiting consumer representatives.	Knox Community Health Service: • Consumer and Community Participation Policy • Consumer Participation Procedure • annual formal community consultation process • range of specific short-term consumer advisory groups for specific areas of service delivery • measures of consumer and community involvement includes complaints/compliments, consumer opinion surveys, program evaluations, specific service delivery feedback, quality of care reports and partnership surveys • exploring innovative ways to enhance community participation • involving community reps in development of Cultural Diversity Plan • audit publications in line with the *Doing it with us not for us* framework
Whitehorse Community Health Service: • Community Participation Policy • Community Participation implementation guidelines and plan • WCHS community participation model evaluation • development of Community Participation Action Plan • Community Participation Advisory Group • identify and meet training needs of Community Participation Advisory Group members • 'Voices for access' forums with diverse community members – plan to review outcomes • WCHS new volunteer framework	Ranges Community Health: • Quality and Business Plan lists goals and activities re consumer participation • activity to encourage client feedback, service sensitive to client needs. A KPI is to increase compliments to complaints ratio • activity to inform oral health clients of other CHS services. A related KPI an increase in referrals from dental to other services
EACH: EACH Consumer/Carer/Community Engagement Manual provides guidance and direction on: • consumer and public relations • feedback and complaints processes (use interpreters when meeting with refugees) • volunteer – recruitment and management • reference groups (or advisory committees) established to provide specific advice and/or stakeholder/community perspective in designated areas of EACH activity. This includes focus groups for specific input.	Inner East Community Health Service: IECHS does not have a current Community Participation Policy. They are currently in the process of developing a Cultural Diversity Plan which will include strategies and activities related to consumer participation.