Gippsland Oral Health Plan

March 2009

Victoria
The Place To Be

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Contents

Foreword

The Gippsland Oral Health Plan provides a practical model for the application of the State government's *Improving Victoria's Oral Health* policy and its vision for high quality, affordable and timely access to oral health services across Victoria.

At the core of the recommendations in this paper is the establishment of a Gippsland Oral Health Consortium to lead and coordinate standardised practices and models of care including innovative approaches to workforce issues and outreach service models across the region. This will, over time, lead to more uniform, timely and responsive oral health services across Gippsland.

This Gippsland Oral Health Plan continues a series of integrated and collaborative planning activities in Gippsland aimed at enhancing access to quality, responsive, person-centred health services across the region. This is the detailed implementation component of action planning originally initiated during the *Gippsland Care In Your Community* Integrated Area Based Planning Trial conducted during 2006-07.

The approach being taken in Gippsland is truly exciting and unique and builds on the regional service development and integrated planning opportunities made possible by the Gippsland Health Services Partnership. The Gippsland Health Services Partnership is an alliance of over thirty Gippsland health service organisations and the Department of Human Services, which acts as a platform for a range of regional health planning and implementation projects.

Thanks must go to the Partnership, which has endorsed the plan, as well as the committed and active members of the Gippsland Dental Health Services Task Group which guided the development of this paper, and project consultants Jan Champlin and Amanda Singleton who put the paper together. Thanks are also extended to the Primary Health Branch of the Department of Human Services who's resourcing and support made the development of the paper possible.

We commend the Gippsland Oral Health Plan to you.

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1 Executive Summary

This Gippsland Oral Health Plan details a service configuration for oral health service provision in Gippsland. The proposed configuration in the plan has been discussed and agreed at the Oral Health Services Task Group. There has been considerable consultation with providers of oral health services across the Gippsland Region and with other leading oral health service providers from both metropolitan and rural Victoria. The resultant Oral Health Action Plan will be utilised by the Gippsland Oral Health Consortium to manage the regional direction for services into the future.

Key stakeholders in the provision of oral health services in Gippsland sat on the Task Group and played an important role in the development of the plan.

Gippsland Region participated in the Two Phase Integrated Area-Based Planning Trial of *Care in Your Community* (CinYC). During Phase 1 of the *Care in Your Community planning framework for integrated ambulatory health* care, a demographic and service profile was developed, and the areas of Renal Health, Mental Health, Diabetes, Oral Health and Health Promotion were identified and subsequently addressed in Phases 2 and 3 of the project. This project progresses this work through a commitment to a Dental Health Action Plan for Gippsland.

This project focuses on DHS Gippsland Region and this document relates specifically to the provision of oral health services in the area.

1.1 Policy context

Improving Victoria's Oral Health (DHS, 2007) recognises that oral health and Victoria's dental health services are a vital component of the Victorian health system. Oral health is fundamental to overall health, well-being and quality of life. The Victorian government has responsibility for the delivery of public oral health care but increasingly faces a gap between the oral health requirements of the state and the numbers of clinicians available. This is especially so in rural and regional Victoria.

Improving Victoria's Oral Health has the vision: "All Victorians will enjoy good oral health and will have access to high-quality health care delivered in an affordable and timely fashion when they require it". *Improving Victoria's oral health* shares the *Care in your community* principles of:

- The best place to treat
- Together we do better
- Technology to benefit people
- A better health care experience
- A better place to work

1.2 Public Oral Health Services

Dental Health Services Victoria (DHSV) is the leading public oral health agency with a role in:

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

Department of Human Services (DHS) has lead responsibility for:

- Capital and service planning -planning best distribution of these services;
- Funding and accountability; and
- Strategic policy development.

Community health services are responsible for:

- Delivery of integrated community-based care; and
- Local health promotion activity.

The School Dental Service (now known as the School Dental Program) was, until very recently, operated directly by DHSV as a separate service to the Community Dental program (CDP) although many clinics were collocated with the CDP clinics. Funding streams were separate; there was a separate administration and coordination of the programs (recall versus waitlist). The separate operation of the CDP and the SDS created confusion for clients and inefficiencies in the system with chair and workforce usage often not optimal. The benefit of integrating the two services was identified and the release of *Improving Victoria's Oral Health* (DHS, 2007) saw a clear vision for oral health in Victoria outlined.

1.3 Oral Health Promotion

Oral health promotion is seen as one of the major strategic priorities in the Improving *Victoria's Oral Health* policy document. In 2005 DHSV and the University of Melbourne reviewed the *Victorian Oral Health Strategy 2000-2004.* The review identified a number of themes for the future of oral health promotion;

- The important link/relationship between oral health and general health;
- The importance of fluoridation;
- Active development of partnerships by and with the oral health sector;
- Research, design and evaluation of interventions; and
- Access to timely and appropriate oral health care.

Gippsland understands the need to engage and partner with agencies / other service providers to ensure that oral health promotion is an integral part of the *Gippsland Action Plan.*

1.4 Gippsland Dental Chair Profile

Region	Planning Catchment	Total Population	Eligible Population	Number of Chairs	Ratio eligible population to chair
Gippsland	East Gippsland	41,046	18,484 (45%)	6	3,080
	Central West	108,870	44,090 (40%)	12	3,674
	South Coast	56,651	22,246 (39%)	4	5,561
	Wellington	41,591	21,318 (51%)	4	5,329
Total			**109,081**	**26**	**4,195**

Source: Improving Victoria's Oral Health, DHS 2007

1.5 Current service models

A model of care (MoC) is (in general terms):

"A description of how services are delivered. The objective of a MoC is to consistently and efficiently deliver patient-centred services at the right time, in the right manner, in the right setting, and at a high standard.

"Depending on the context, a MoC can emphasise different aspects of how services are delivered including the structure, processes, relationships, management and enabling technology".

The model of care for Gippsland will be principally based on Fixed State Funded Chair with integrated public oral health services provided for the eligible population

Development of an outreach model of care will be a priority to ensure equity of access for high needs and prioritised groups.

1.6 Eligible Population

The eligible population for public oral health services in Victoria is:

Services to Children:

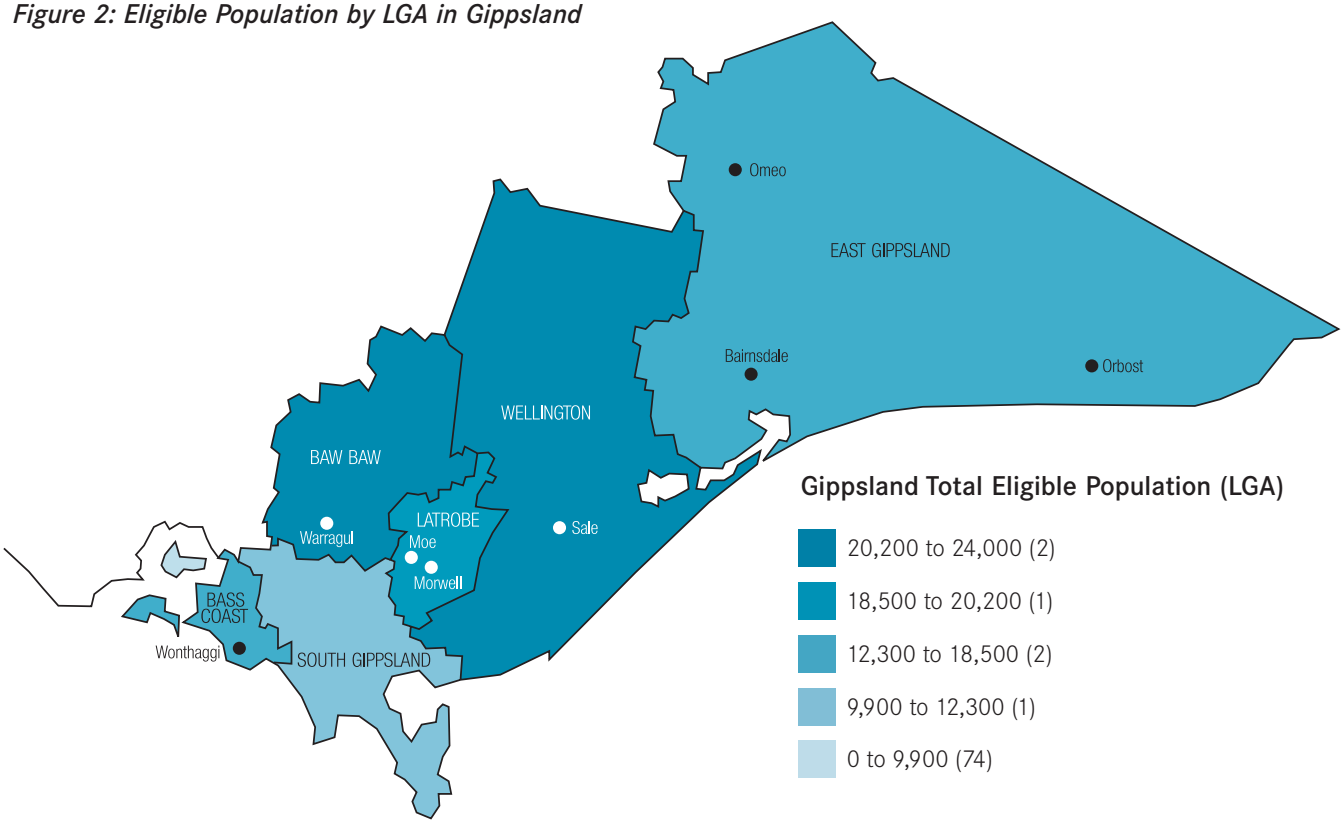
- Children up to the age of 12 years (priority access)
- Children 13-17 years who are dependents of health care or pensioner concession card holders
- The care for primary school aged children is free for dependents or holders of a health care or pensioner concession card (a service cost of $27 per course of care is imposed for other families)

Services for Adults:

- Health Care and pensioner concession card holders and their dependents over the age of 18 years
- Service cost of $22 per visit (up to maximum of $88 per course of care)

1.7 Eligible Population per LGA in Gippsland

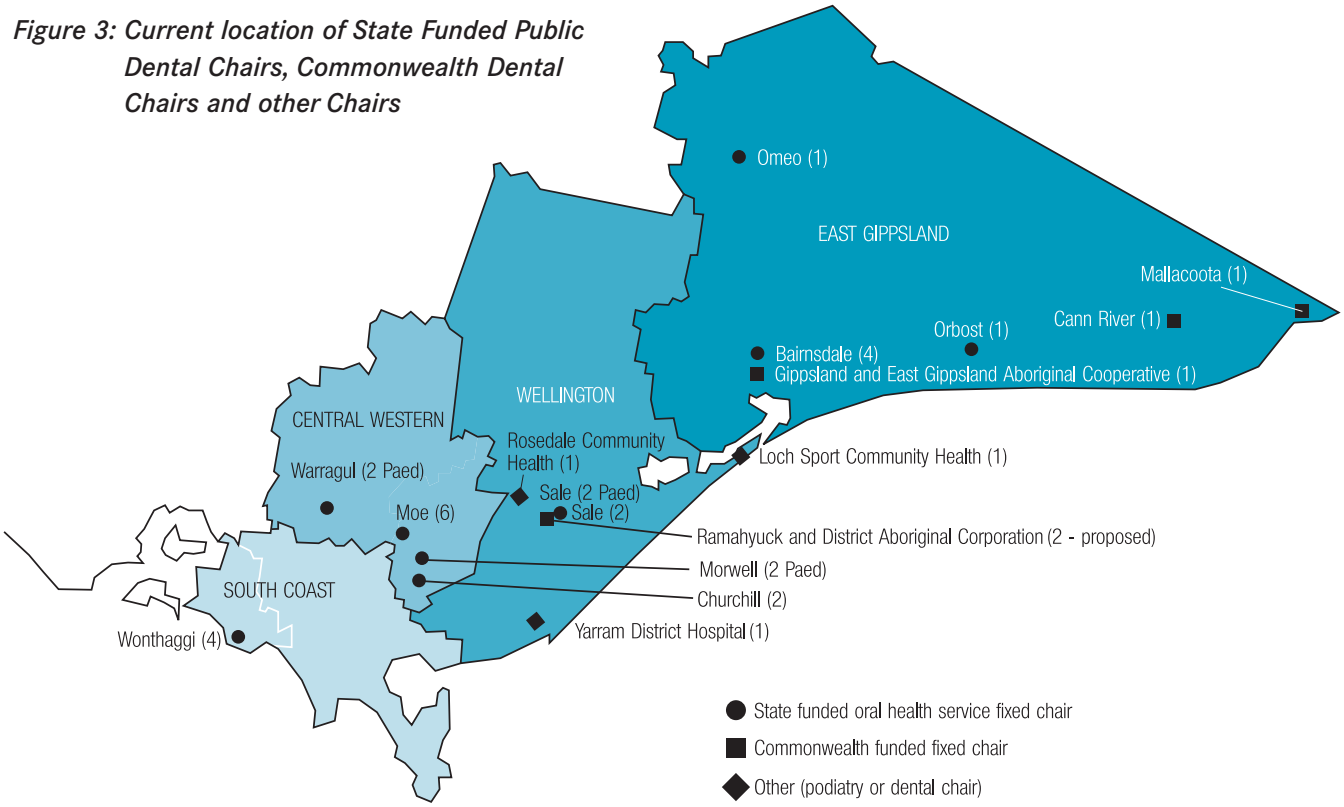
Figure 2: Eligible Population by LGA in Gippsland



Source: Dental Health Services Victoria

1.8 Location of oral health services in Gippsland Region

Figure 3: Current location of State Funded Public Dental Chairs, Commonwealth Dental Chairs and other Chairs



Source: Dental Health Services Victoria 2008

1.9 Wait List for Gippsland

Wait lists have been one of the indicators utilised in relation to access to services for the CDP. They depict the overall wait time of an adult once that adult approaches a public oral health service for a treatment.

Within the document wait list data is provided for each of the public oral health services across Gippsland within the CDP for 11 of the 12 months in the 2007/08 year. The overall number of persons waiting and the overall wait time in the entire region has reduced in both general (29% reduction in the number waiting and a 39% reduction in wait time) and prosthetic care (25% reduction in the number waiting and 60% reduction in wait time) in the last year.

1.10 Percentage of Eligible Population receiving Treatment per LGA

A measure of access to services is to identify the percentage of the population who have received dental treatments in the last 12 months rather than the number of the eligible population on the wait lists. Length of wait list should be proportional to the population receiving a treatment. If the wait list is short but the percentage of the population receiving service is not high, access to services remains an issue.

LGA Name	Eligible Population	Number receiving Service	%
Bass Coast (S)	12,308	2747	22.3
South Gippsland (S)	9,938	1705	17.2
Baw Baw (S)	23,923	4096	17.1
Latrobe (C)	20,167	5743	28.5
Wellington (S)	21,318	4162	19.5
East Gippsland (S)	18,484	4105	22.2

Percentage of eligible population (Adult and Children)
Data provided by DHSV and is based on 10 months July 2007 - April 2008

One of the key areas of improvement is to develop a process by which that percentage could be accurately monitored given the variables that would need to be considered.

1.11 Issues

Stakeholders raised a number of issues relating to the planning and provision of oral health services in Gippsland during the *Care in Your Community* consultations. Some issues have been separately considered by the Task Group but remain relevant to the development of the action plan. The issues are to be considered under the broader headings of Clinical Leadership and Governance, Access, Efficiency and Quality of Care, Health Promotion and Workforce.

Clinical Leadership and governance

This plan must ensure provision of coordination of services and clinical leadership for Gippsland public oral health services. Discussion regarding how a regional model would be configured to best suit the needs of Gippsland has been robust. The current arrangement is that individual service providers are responsible for all aspects in the delivery of oral health services, resulting in differences in governance, staffing mix, access and standards for clients across the region. There is considerable duplication of effort particularly for smaller providers.

Recommendations for Clinical leadership

1. Underpin the regional leadership model for Gippsland by a consortium approach (known as the Oral Health Consortium):
   - The Gippsland Oral Health Consortium will consist of representatives from all oral health providers in Gippsland, DHS, DHSV, university and private oral health providers;
   - The Gippsland Oral Health Consortium will operate under determined terms of reference (provided at Appendix 6);
   - A single agency will assume ultimate responsibility for the implementation of the Gippsland Oral Health Consortium decisions and directions. This shall be LCHS;
   - The Consortium shall be responsible to the GHSP;
2. Appoint a Project Worker/Manager to The Gippsland Oral Health Consortium to coordinate and facilitate the decisions of the consortium:
   - Develop and present a business case to DHSV on the benefits of supporting such a position
3. Ensure ongoing support to agencies to complete the transmission of business embedded in the principles of the integration process across Gippsland in partnership with DHSV;
4. Ensure that standardised clinical practice guidelines are developed and available across the region in partnership with DHSV; and
5. Develop a credentialing process within 12 months to be available for use across the region in partnership with DHSV and DHS.

Access

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

- Equitable access that considers remoteness and rurality;
- Chair utilisation;
- Length of the wait list deterring persons from seeking treatment
- Availability and capacity of workforce;
- Equitable access to special needs groups; and
- Equitable access to indigenous population.

Recommendations for Access

6. Reduce the wait time for access to public oral health services uniformly across the region to a maximum of 23 months for general and prosthetic care:
   - This target will be re-evaluated once that target has been achieved and a new target will be established by the Consortium;
   - Continue to explore the factors that affect the access to services;

7. Maximize the chair capacity across all planning areas by:
   - Ensuring infrastructure meets requirements of service delivery;
   - Workforce is developed to ensure that adults and children can be treated in any chair in the region;
8. Develop outreach models (See Models of Care Section 5.4) for Commonwealth chairs:
   - Model based on the need to manage wait lists or recall;
   - Public oral health service purchases entire service;
   - Public oral health service rents chair time and provides staff;
   - Service arrangement managed at a district level;
   - These models will be planned within 6 months;
9. Utilise other chair types for preventative and oral health activities.

Efficiency and Quality of Care

The length of time a person waits for a service and the responsiveness of the service providers in the provision of care are measures of efficiency and quality. In oral health care this can be reflected in wait list time and management. We need to interpret this cautiously as there are a variety of factors that influence the length of the wait list including clinician availability, chair utilisation and population.

Factors that potentially affect efficiency and quality of care are:

- Wait list management (availability of workforce and skill of workforce);
- Effective integration of SDP and CDP;
- Utilisation of private dentists in the management of public oral health services; and
- Increased utilisation of the oral health workforce - ensuring that the clinical workforce is supported to treat the full population. This will require supervision for clinicians as they treat parts of the population who have previously not attended their service.

Recommendations of Efficiency and Quality of Care

10. Reduce the wait time for access to public oral health services uniformly across the region to a maximum of 23 months for general and prosthetic care;
11. Ensure that the SDP recall system becomes part of the service system at a district and local level;
12. Ensure that the integrated service model is supported to allow access to both adults and children at any dental chair in Gippsland;
13. Develop common solutions to the management of day-to-day operational issues common to all oral health clinics:
    - Triage management;
    - Management of 'no-shows' including monitoring of the prevalence;
14. Engage the private dental practitioners in the plan for the management of the public oral health services:
    - Investigate the opportunity to employ a private dentist for a defined period of time in the provision of public oral health work in order to have immediate impact on the public wait list;
    - Contracted number of sessions;
    - Defined period of time and then evaluated; and
    - Provided at private oral health clinic.

Models of Care

Models of care should be developed and introduced in a planned and structured way. The purpose of the consideration of new and innovative models is to improve access and efficiency of service delivery. Models should be developed or expanded on the premise that the resources are available or can be developed to support them. It is also noted that oral health services are 'capped' with the provision of services needing to be balanced between resources available and the demand within any area. Resources should be able to be moved from an area of limited demand to an area of high demand (wait list, high eligible population and special needs groups) within the region.

Factors that potentially affect the development or sustainability of services (models of care) are:

- Current utilisation of the service;
- Lack of understanding about what the average utilisation of a chair is given a normal day. This information needs to be provided by a common source (DHSV);
- Service demand;
- Infrastructure to support the proposed models of care;
- Availability of a skilled trained oral health workforce; and
- Ability to develop and train an oral health workforce locally.

Recommendations for Models of Care

15. Ensure the continued support for a preferred model of care based on fixed chairs;
16. Develop a service structure that ensures capacity of each fixed chair is optimized according to the identified needs of each area;
17. Develop outreach service models to support access to services for children, indigenous and high needs groups;
18. Develop further processes that are able to ensure utilisation of chairs is in accordance with established identified needs; and
19. Ensure that integration results in efficiency of service, adequate management of wait lists and school dental recall.

Infrastructure

Infrastructure (building and equipment) is poor at some sites. The current integration of SDP and CDP has exposed a number of issues and deficiencies in arrangements. Whilst there are redevelopments underway that are addressing the need for collocation of services (Central Gippsland Health Service) there are a number of issues that need to be managed as a matter of urgency.

Recommendations for Infrastructure

20. Plan for the upgrade of the facility at Bass Coast Regional Health to allow for the full use of the four chairs:
    - Documented plan to be completed within 3 months;
    - Timeframe for completion of upgrade determined within that plan;
21. Plan for relocation of School Dental Program to the Community Health Service in Warragul:
    - Plan to be completed within 3 months;
    - Timeframe for completion of upgrade determined within that plan;
22. Completion of the upgrade and collocation of the services at Central Gippsland Health Service by early 2009;
23. Plan for the upgrade of the integrated facility at Morwell:
    - Plan to be completed within 3 months;
    - Timeframe for completion of upgrade determined within that plan;
24. Develop a prosthetic laboratory service at Morwell as part of the planned capital development;
25. Plan for the gradual upgrade of all state funded dental chairs to be determined within 12 months.

Oral Health Promotion

Oral health promotion is one of the strategic priority areas within *Improving Victoria's oral health* policy document. Oral disease is almost totally preventable therefore good health and reduced demand for oral health services are best approached through population health (strong focus on promoting health and the prevention and early identification of oral disease) and prevention strategies. The National Oral Health Plan called for an integrated and cross sectional approach that would achieve improvements to both general and oral health. Therefore it is anticipated that oral health promotion will form part of health promotion plans at local, state as well as national level.

Recommendations for Oral Health Promotion

26. Ensure oral health promotion is part of the core business of all health care services in Gippsland;
27. Implement alternate models of care in preventative care rather than restorative (dental hygienist);

28. Develop and submit a region wide oral health promotion program to be managed by the Gippsland Oral Health Consortium:
    - Requirement to collaborate with the Gippsland Health Services Partnership - Health Promotion task group;
29. Develop a business case for ongoing funding of oral health promotion staff located in Health promotion teams but linked to oral health programs;
30. Support the completion of fluoridation across Gippsland; and
31. Actively work with the acute health teams to further reduce the oral health and oral health related ACSC admissions to hospital.

Workforce

Availability of a skilled oral health workforce is a key element in the provision of public oral health care. The workforce includes specialist, dentists, therapist, hygienists, assistants, prosthetists and technicians (described in Table 2). Historically the public sector has been unable to recruit and retain enough clinicians to maintain the oral health workforce with demand clearly being outweighed by supply. Key issues identified in a 1999[4] report were:

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

Recommendations

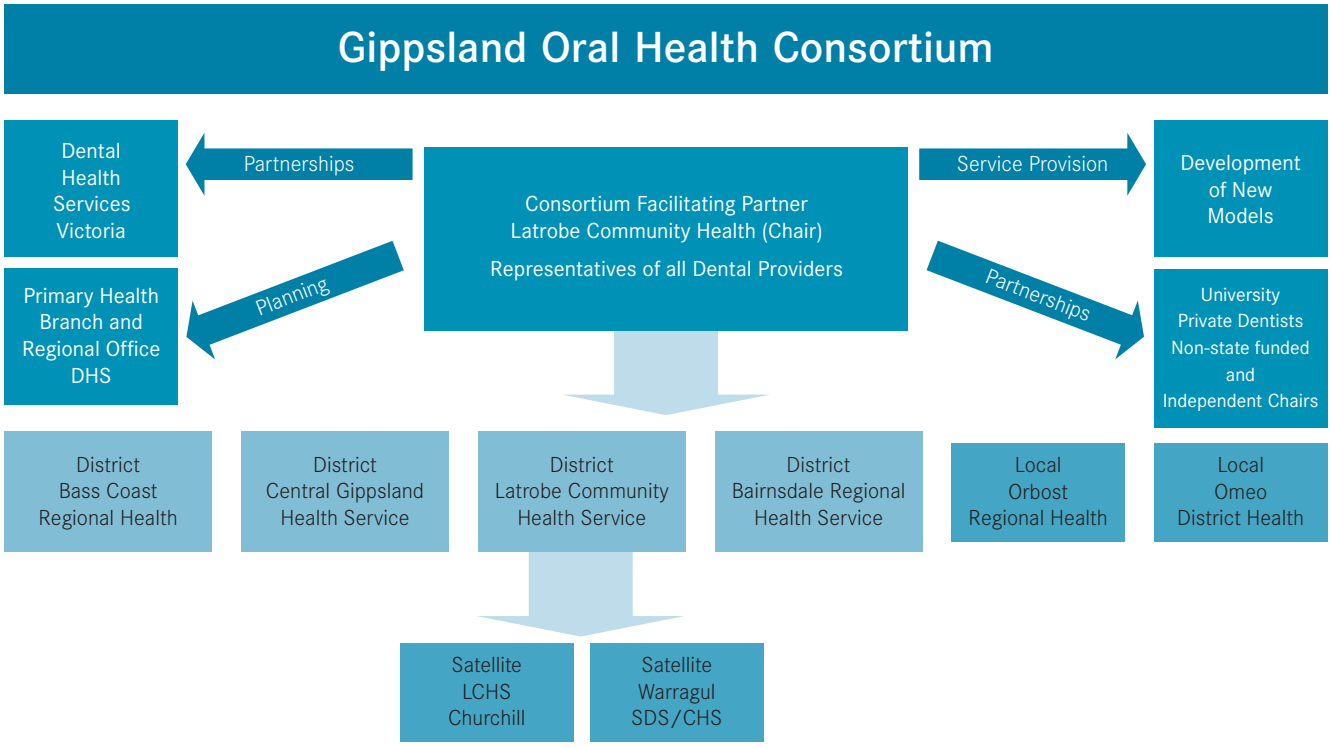
32. Develop a workforce plan aligned to the statewide oral health workforce development strategy from DHSV to identify the areas of greatest workforce needs in each planning catchment. The plan will:
    - Be developed within 6 months;
    - Identify gaps for specialist oral health services;
    - Prioritise the areas with the longest wait list in relation to recruitment;
33. Support the development of a clinical network for oral health clinicians in Gippsland (private and public clinicians);
34. Ensure that the oral health workforce is working to full potential by providing opportunities for supervision and mentoring of all oral health staff to provide oral health care across all ages;
35. Ensure a regional approach to the management and educational opportunities for Gippsland:
    - Training places to increase to equivalent of 5 chairs within twelve months;
36. Increase the recruitment potential of oral health clinicians by maximizing the opportunities created by the 'Filling the Gaps' submission; and
37. Support the development of an indigenous oral health workforce by providing opportunities for teaching and supervision.

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

1.12 Service Configuration and Roles

The Service Configuration considers an integrated service configuration model (lead agency model is proposed) and discussion on the priorities of service configuration and the responsibilities of each agency type.

Proposed Service Configuration



This model demonstrates the possible relationships between service providers. The main oral health service providers in Gippsland support this approach to ensure continued involvement of all agencies in the direction of oral health services across the region.

1.13 Gippsland Oral Health Action Plan

An action plan based on the recommendations has been developed. This action plan will form the basis for the work of the Gippsland Oral Health Consortium which will commence in August 2008.

2 Background

Gippsland Region participated in the Two Phase Integrated Area-Based Planning Trial of *Care in Your Community* (CinYC). During Phase 1 of the *Care in Your Community planning framework for integrated ambulatory health care,* a demographic and service profile was developed, and the areas of Renal Health, Mental Health, Diabetes, Oral Health and Health Promotion were identified and subsequently addressed in Phases 2 and 3 of the project. This project progresses this work through a commitment to a Dental Health Action Plan for Gippsland.

This project will focus on DHS Gippsland Region and this document relates specifically to the provision of oral health services in the area. The areas of interest are related to the Planning catchments in CinYC, Local Government Areas (LGAs) and Primary Care Partnership Catchments (PCPs):

Planning Catchment	LGAs	PCP
South Coast	Bass Coast Shire South Gippsland Shire	South Coast Health Services Consortium
Central West Gippsland	Baw Baw Shire Latrobe City	Central West Gippsland
Wellington	Wellington Shire	Wellington
East Gippsland	East Gippsland Shire	East Gippsland

Table 1: Planning Catchments vs. LGA vs. PCP

2.1 Methodology

This plan has been developed from two main sources: issues raised at the Phase 2 *Care in Your Community* (CinYC) workshop during 2007 and from comments and thoughts from the members of the Gippsland Oral Health Services Task Group. Participants at the Phase 2 CinYC workshop included key stakeholders in the provision of oral health services in Gippsland.

This paper provides the final action plan for Oral Health Services in Gippsland.

2.2 Policy context

Improving Victoria's Oral Health (DHS, 2007) recognises that oral health and Victoria's oral health services are a vital component of the Victorian health system. Oral health is fundamental to overall health, well-being and quality of life. The Victorian government has responsibility for the delivery of public oral health care but increasingly faces a gap between the oral health requirements of the state and the numbers of clinicians available. This is especially so in rural and regional Victoria.

Improving Victoria's Oral Health has the vision: "All Victorians will enjoy good oral health and will have access to high-quality health care delivered in an affordable and timely fashion when they require it". Improving Victoria's oral health shares the Care in your community principles of:

- The best place to treat
- Together we do better
- Technology to benefit people
- A better health care experience
- A better place to work

The realisation of the visions and principles identified in Improving Victoria's oral health will come through the implementation of 6 strategic priorities:

- Oral health service planning framework
- Integrated service model for adults and children
- Workforce strategy
- Oral health promotion
- Responding to high needs groups
- Oral health funding, accountability and evaluation

Public oral health services are seen to be an integral part of Victoria's Community Health Services. The policy envisages them working collaboratively through the planning framework and an integrated service model to provide health promotion, prevention, early intervention, treatment and self-management.

Improving Victoria's Oral Health identifies workforce shortages as a major issue which continues to affect the public oral health system particularly in rural areas. It notes that current initiatives endeavouring to address this issue include statewide professional development, mentor support, accommodation and travel assistance.

The National Advisory Committee on Oral Health released *Australia's National Oral Health Plan 2004 - 13* in July 2004. It notes the following:

- The States and Territories manage responsibility for the delivery of the major public programs for children and disadvantaged adults;
- Demand from concession care holders outstrips public oral health services' capacity to supply treatment;
- Waiting lists in some areas are five years and above despite significant increases in expenditure.

Four broad themes underpin the Plan:

- Recognition that oral health is an integral part of general health;
- A population health approach with a strong focus on promoting health and the prevention and early identification of oral disease;
- Access to appropriate and affordable services for all Australians; and
- Education to achieve a sufficient and appropriately skilled workforce and communities that effectively support and promote oral health.

Care in your community: a planning framework for integrated ambulatory health care (DHS 2005) is a planning framework for integrated and ambulatory health care. It is about investing in the best mix of inpatient and community-based integrated care services to better meet future needs and expectations of communities and individuals.

The vision for the health care system is of family and person-centred care provided in community-based settings. Health care will focus on individual need, rather than on service type, professional boundaries, organisational structure, program funding or reporting requirements. The policy seeks stronger focus on health promotion, prevention, early intervention and self-management.

The principles underpinning this policy framework are:

- Best place to treat - provision of health care in a community-based setting;
- Together we do better - recognition of the importance of health promotion and illness prevention;
- Technology to benefit people - technology to ensure a consistent, planned approach to care;
- A better health care experience - individual/family centered, responsive care; and
- A better place to work - workforce configured to provide integrated, flexible care.

Rural Directions for a Better State of Health provides a framework for rural health services to orientate themselves towards the changing needs of the community and make the best use of available resources. It identifies an integrated direction for service planning, mapping the shape and direction of Victoria's rural health system.

3 Public Oral Health Services

Private practitioners continue to provide the majority of oral health services in Victoria with the client taking responsibility for the cost. There is an estimated contribution of some $400M per annum from Commonwealth private health insurance rebates. The Victorian government, however, continues to take responsibility for the delivery of public oral health care for children and disadvantaged adults in the state. Availability of workforce creates issues with the delivery of both the private practitioner and public oral health models in Victoria. This is particularly felt in rural areas. Over the last decade, a focus on oral health and developments in the system has enabled increased resources for general treatment and dentures, capital development in oral health clinics and fluoridation of water supplies particularly in rural areas.

Oral health has a considerable impact on the number of hospital admissions for ambulatory care sensitive conditions (ACSCs). ACSCs are hospitalisations that are potentially avoidable for many patients through public health interventions, early disease management usually provided in ambulatory settings such as primary care, and community support. Oral health related conditions account for the highest rate of ACSCs for under-18-year-olds and the second highest rate of ACSCs for all ages in Victoria. In Gippsland during 2004-05, oral health conditions accounted for nearly almost 1,000 hospital admissions with an average length of stay of 1.07 days and a total number of bed days of 1060 (ACSC Update 2004-05 Gippsland Region). Most oral health hospital admissions are potentially avoidable given early access to appropriate services. Such avoidable admissions are substantially more common in rural areas, particularly among children[1].

Dental Health Services Victoria (DHSV) has been responsible for the delivery of oral health care directly through the Royal Dental Hospital of Melbourne as well as through a number of managed oral health services and the School Dental Program. They have purchased oral health services from Community Health Services under strict conditions. The Community Health Services provide community based public oral health care either in a fixed or mobile clinic or alternatively on an outreach basis. This is known as the Community Dental Program (CDP). Care is provided on a routine or emergency basis. Those requiring routine care are placed on a waiting list and those requiring urgent care are assessed and triaged and offered an appointment at which the urgent care is undertaken. It is noted that those patients requiring priority access (special needs groups) are given the next available appointment. The School Dental Service (now known as the School Dental Program) was, until very recently, operated directly by DHSV as a separate service to the CDP although many clinics were collocated with the CDP clinics. Funding streams were separate; there was a separate administration and coordination of the programs (recall versus waitlist). The separate operation of the CDP and the SDS created confusion for clients and inefficiencies in the system with chair and workforce usage often not optimal. The benefit of integrating the two services was identified and the release of *Improving Victoria's Oral Health* (DHS, 2007) saw a clear vision for oral health in Victoria outlined. It is the aim of DHSV to have the integration of the School Dental Service (SDS) into the Community Dental Program as the School Dental Program (SDP) complete across the state by September 1 2008.

The roles and responsibilities of the stakeholders have been articulated as:

Dental Health Services Victoria (DHSV) is the leading public oral health agency with a role in:

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

Department of Human Services (DHS) has lead responsibility for:

- Capital and service planning -planning best distribution of these services;
- Funding and accountability; and
- Strategic policy development.

Community health services are responsible for:

- Delivery of integrated community-based care; and
- Local health promotion activity.

The progress of the integration process for Gippsland will be discussed later in this document.

[1] *National Oral Health Plan, 2004*

3.1 Oral Health Promotion

Oral health promotion is seen as one of the major strategic priorities in the Improving Victorias oral health policy document. In 2005 DHSV and the University of Melbourne reviewed the *Victorian Oral Health Strategy 2000-2004.* The review identified a number of themes for the future of oral health promotion;

- The important link/relationship between oral health and general health;
- The importance of fluoridation;
- Active development of partnerships by and with the oral health sector;
- Research, design and evaluation of interventions; and
- Access to timely and appropriate oral health care.

Gippsland understands the need to engage and partner with agencies/other service providers to ensure that oral health promotion is an integral part of the Gippsland Action Plan.

3.2 Oral Health Workforce

One of the major issues facing oral health services is workforce shortage. Shortages are particularly noted in the rural areas. One of the benefits of the integration of CDP and the SDS is to ensure that resources are utilised to their capacity. There will be opportunities to ensure that the capacity of the oral health workforce is utilised (including maximisation of the practice of dental therapists who until now have been limited to the care of school aged children through the SDS) and potentially the hours of operation.

The following is a summary of the oral health workforce providing services across the range of interventions. It is not the intent to advocate for all types of oral health workforce to be available in Gippsland:

Professional Group	Description
Dentist	Health care professional who provides preventative and restorative treatments for problems that affect the mouth and teeth.
Dental Assistant	Prepares patient, sterilises and disinfects instruments, sets up instruments and assists the dentist during oral health procedures
Dental Hygienist	Works to prevent gum disease and tooth loss by educating patients and helping them to maintain oral hygiene. Performs examination of the mouth and builds a treatment program for the patient;, explains how to keep teeth clean and when required removes plaque
Dental Therapist	Examines and treats ailments of the teeth and gums, mainly among preschool and primary school aged children, under the supervision of dentists
Dental Laboratory Technician	Works to produce replacement parts for the dentist (crowns, bridges or complete dentures). They work in a dental laboratory.
Oral Pathologist	Studies nature, cause and development of diseases associated with the mouth
Periodontist	Diagnoses and treats inflammatory and destructive diseases of investing and supporting tissue of teeth. Performs surgical procedures to remove diseased tissue, using dental instruments
Prosthodontist	Measures jaw to determine size and shape of dentures required, makes impressions of patients' teeth, gums and jaws, constructs dentures, fits and modifies dentures and repairs dentures
Pedodontist	Provides oral health care for infants, children and adolescents
Endodontist	Examines, diagnoses and treats diseases of nerve, pulp, and other dental tissue affecting vitality of teeth

Table 2: Dental Workforce

Dentists usually work in teams to provide general oral health care but may specialise to provide specific oral and dental care.

3.3 Regional Dental Chair Profile in Victoria

The following table illustrates the location of current public dental chairs throughout rural Victoria. In addition it highlights the percentage of eligible population vs. total population. It is noted that Wellington is the area with the highest percentage of eligible population amongst the total population in the state. Apart from Barwon South West all regions have at least one area with a significantly disadvantaged planning catchment.

Region	Planning Catchment	Total Population	Eligible Population	Number of Chairs	Ratio eligible population to chair
Barwon-South West	Barwon	249,793	104,358 (42%)	27	3,865
	South West	63,886	26,027 (41%)	5	5,205
	Southern Grampians-Geelong	37,122	15,677 (42%)	6	2,613
Total			**146,062**	**38 (6 mobile)**	**3,844**
Gippsland	East Gippsland	41,046	18,484 (45%)	6	3,080
	Central West	108,870	44,090 (40%)	12	3,674
	South Coast	56,651	22,246 (39%)	4	5,561
	Wellington	41,591	21,318 (51%)	4	5,329
Total			**109,081**	**26**	**4,195**
Grampians	Grampians-Pyrenees	30,820	14,018 (45%)	3	4,673
	Central Highlands	144,433	60,959 (42%)	12	5,080
	Wimmera	38,063	16,163 (42%)	8	2,020
Total			**91,140**	**23 (6 mobile)**	**3,963**
Loddon-Mallee	Bendigo-Loddon PCP	103,021	46,094 (45%)	21	4,190
	Campapse PCP	37,193	16,395 (44%)	4	4,099
	Central Victorian Health Alliance	70,210	28,952 (41%)	6	4,825
	Southern Mallee	36,306	18,014 (49%)	4	4,504
	Northern Mallee	55,313	23,974 (43%)	11	2,179
Total			**133,429**	**43 (4 mobile)**	**3,103**
Hume	Upper Hume	56,126	21,894 (39%)	11	1,990
	Central Hume PCP	60,873	26,077 (49%)	6	4,346
	Goulburn Valley PCP	97,105	43,463 (45%)	14	3,105
	Lower Hume PCP	45,482	18,173 (40%)	3	6,068
Total			**109,607**	**34 (4 mobile)**	**3,224**

Table 3: Regional Chair Profile

*Data Source Improving Victoria's Oral Health (includes school dental numbers in this population data)

**The population numbers are based on the Estimated Resident Populations 2004 by LGA in all other regions. Gippsland eligible population data has been updated with current DHSV data on eligible adults and children (June 2008)

3.4 Current service models

A model of care (MoC) is (in general terms):

"*A description of how services are delivered. The objective of a MoC is to consistently and efficiently deliver patient-centred services at the right time, in the right manner, in the right setting, and at a high standard.*

"Depending on the context, a MoC can emphasise different aspects of how services are delivered including the structure, processes, relationships, management and enabling technology".

Model of Care and Description of Service		Infrastructure Requirement	Workforce Arrangements (per Chair)	Funding Source/ Arrangements	Comments
Fixed Chair Model	Fixed State Funded Chairs located at recognised integrated public oral health services	Public dental chair	1 clinician (dentist, therapist or prosthetist) I dental assistant Support staff	State	*This is the model that is utilised in Gippsland.* *Underutilised resource with capacity to increase throughput at sites given workforce availability.* *Not all sites will be truly 'integrated' from July 1 (issues relating to location of chairs and workforce will mean that access in some areas remains limited)* *Real opportunities for Gippsland to increase the scope of practice for dental therapists*
	Shared Public and Private Utilisation of fixed public chairs	Public dental chair - in areas where chairs are under-utilised possibility for private dentist to 'buy' capacity Public dentist may or may not provide additional private work from these chairs	1 clinician (dentist, therapist or prosthetist) I dental assistant Support staff or Private practitioner responsible to provide staff	State Private	*This model has been historically utilised in Omeo. Salaried dentist providing public oral health care in addition to providing private oral health care from the chairs which are rented from State during these treatments* *Potential for use but pressure on the capacity of private dentists in Gippsland limits its use*

Model of Care and Description of Service		Infrastructure Requirement	Workforce Arrangements (per Chair)	Funding Source/ Arrangements	Comments
Fixed Chair Model	Private Practitioners providing service from state funded chair	Public dental chair	Private practitioner responsible to provide staff	Private practitioner hires facility and generates private income	*Potential for use but pressure on the capacity of private dentists in Gippsland limits its use* *Private practitioners show no interest at present in this model*
	Sharing a chair with another discipline to ensure utilisation i.e. podiatry	Public dental chair	1 clinician (dentist, therapist or prosthetist) I dental assistant Support staff	State	*Public dental chair my be utilised by another discipline at times when it is not in use for dental services*
Outsourcing Model	Private Dentists undertaking public dental care	Private Dental Rooms	Private practitioner responsible to provide staff	Voucher system - service paid for by the state but provided by the private system (urgent or emergency use) Voucher system is full of different complexities including overall poor use of vouchers provided (approximately 1/3 unused)	*Voucher system has the potential to be misused - use should be restricted for emergency treatment.* *Potential for the client to attend private dentist before triage occurs* *Difficulty in the management of the quality of the care provided* *Once voucher is given to the client they are removed from the waiting list* *Commonwealth Teen Dental Program ($150 per person towards annual preventative check up for 12-17 year olds from families in Tax Benefit A or Teen Youth Allowance or Abstudy*

Model of Care and Description of Service		Infrastructure Requirement	Workforce Arrangements (per Chair)	Funding Source/ Arrangements	Comments
Outreach Model	Mobile Chair - can provide oral health care in remote locations or for persons who have difficulty accessing mainstream oral health services (aged/disabled)	Mobile chair can be transported in a car	Dental therapist or hygienist	State	*Not currently utilised in Gippsland.* *Known as the 'white' chair* *Issues with occupational health & safety* *Issues with infection control* *Not well utilised or liked in other oral health services where it has been tried* *Clients must still be referred for oral health appointment*
	State employed staff providing a service in a non state funded or privately operated chair	Infrastructure provided by the Commonwealth or private entity	1 clinician (dentist, therapist or prosthetist) I dental assistant Support staff	State provides the resources with infrastructure provided by the external entity	*Gippsland has potential to explore model with Commonwealth chairs located in East Gippsland and Wellington* *Commonwealth chairs been established prior to the development of a partnership with the state* *Potential difficulties to resource with 'state' employees in current workforce environment* *Need to identify potential eligible population for long term viability* *Further engagement of the parties is required*
	State employed staff providing a service in a chair in Public Hospital	State	1 clinician (dentist or prosthetist) I dental assistant Support staff	State Voucher or private payment to dentist	*Potential for use in Gippsland* *Chair identified at Yarram* *Currently used by private dentist in Yarram* *Real potential to use this chair to manage the wait list in Wellington* *Needs further exploration* *Similar models have worked to manage wait lists in other areas*

Model of Care and Description of Service		Infrastructure Requirement	Workforce Arrangements (per Chair)	Funding Source/ Arrangements	Comments
Outreach Model	Preventative Health Model/Virtual Chair	Available space in CH Building, Residential Aged Care	Hygienist	State	*Model not used in Gippsland but is used in other areas especially residential aged care, youth and homeless programs* *Requires the clinician to identify issue and make an appointment at a oral health clinic for the client* *Enables point of service oral health education & promotion* *Where has been successful, dovetails into other health promotion activities* *Positive is that it requires little capital infrastructure*
Mobile Dental	Mobile Van/Trailer	Fully equipped mobile oral health facility	1 clinician (dentist, therapist or prosthetist) I dental assistant Support staff	State	*Not used in Gippsland at present (identified as the only regional area where a mobile van is not utilised)* *Other regional areas have mixed thoughts on mobile vans* *Where vans are used they have often become stationary and are no longer 'mobile'* *Can be difficult to access for aged persons and the disabled* *Infection control difficulties*

Table 4: Oral Health Models of Care

4 Data Analysis

4.1 Gippsland Population Characteristics

Gippsland's population is unevenly spread between the six Local Government Areas (LGAs). The largest concentration of population is in Latrobe City, but strongest population growth is forecast in Bass Coast Shire and Baw Baw Shire. Table 5 shows five-year and ten-year projected growth outcomes for each of the six LGAs. By comparison, the Victorian population is expected to grow by 9.8 per cent over that period, while the Victorian rural population is expected to grow by 8.5 per cent.

LGA Name	2001	2006	2011	2016	% change 2006 to 2016
Bass Coast (S)	25,631	29,408	32,380	35,374	16.9
South Gippsland (S)	26,159	27,243	28,162	29,016	6.1
Baw Baw (S)	36,404	38,416	40,292	42,110	8.8
Latrobe (C)	70,643	70,454	70,537	70,468	0.0
Wellington (S)	41,462	41,361	41,519	41,511	0.4
East Gippsland (S)	39,439	41,046	42,487	43,790	6.3
Total	**239,738**	**247,929**	**255,377**	**262,270**	**6.4**

Table 5: Population Growth in Gippsland *Source: Victoria in Future, DSE, 2004*

Actual 2006 population data is available from census data but 2016 predictions are not available from this data source until late 2008. Actual 2006 data is identified below but has not been included in the % change.

LGA Name	Actual 2006
Bass Coast (S)	27,524
South Gippsland (S)	26,675
Baw Baw (S)	38,484
Latrobe (C)	72,075
Wellington (S)	41,591
East Gippsland (S)	41,361
Total	**247,710**

Table 6: Actual Population in Gippsland 2006

2006 Census Data

The population of the Region is forecast to change with decreases in infant population and increases in post-retirement population. Table 5 demonstrates the forecast change in population to 2011 and 2016 looking at the whole Region. The figure demonstrates likely continued emigration of the working age population (20 to 55 years) and a large increase in post-retirement population. Forecast growth in over-85 population is notable.

The most significant population growth in the overall population is seen in the South Coast Planning (17% in the Bass Coast Shire and 6% in South Gippsland), East Gippsland (6.3%) and parts of Central West (Baw Baw 8.8%). The most noted increases are in the South Coast. Although the data indicates a steep increase in the eligible population in the Bass Coast it cannot be assumed that all of this population will seek;

- Public oral health care;
- Care within the catchment (there is a sense that there may be a drift of persons from the Bass Coast to metropolitan fringes).

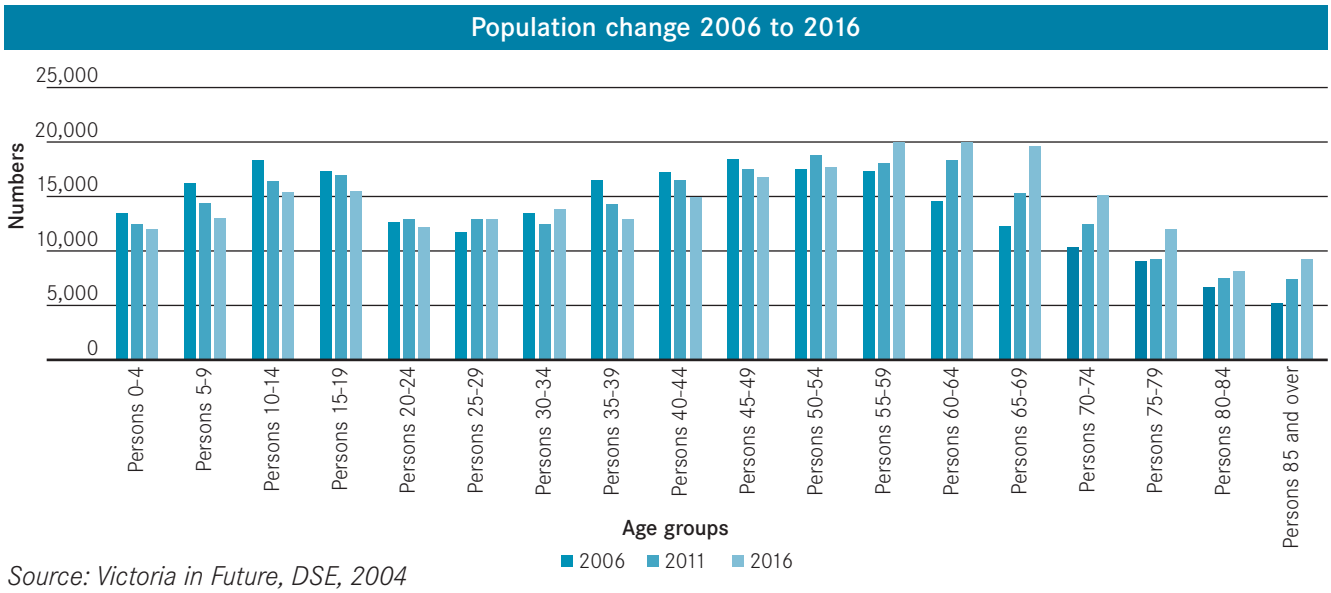
As a consequence real service demand can be difficult to identify.

In addition it is noted the percentage of eligible population and the number of persons on the wait list are not necessarily directly correlated. Reasons for this may be:

- Eligible persons not identifying with the need for public oral health care;
- Receiving care from another source (private or commonwealth provider)

There are examples of dispersed population in rural Victoria with large distances between the population centres. Like the Wimmera and Northern Mallee Catchments, East Gippsland covers an area in excess of 20,000km.

Figure 1: Forecast Gippsland demographic change 2006 to 2016



Source: Victoria in Future, DSE, 2004

4.2 Eligible Population

The eligible population for public oral health services in Victoria is:

Services to Children:

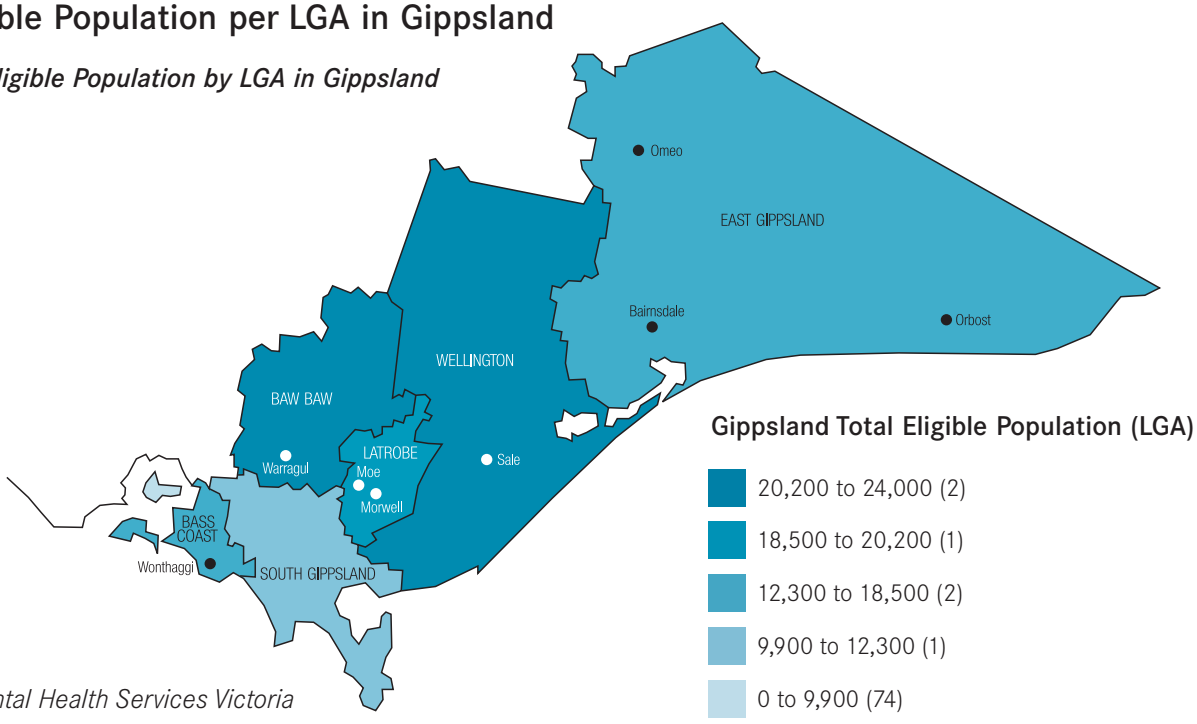
- Children up to the age of 12 years (priority access)
- Children 13-17 years who are dependents of health care or pensioner concession card holders
- The care for primary school aged children is free for dependents or holders of a health care or pensioner concession card (a service cost of $27 per course of care is imposed for other families)

Services for Adults:

- Health Care and pensioner concession card holders and their dependents over the age of 18 years
- Service cost of $22 per visit (up to maximum of $88 per course of care)

4.3 Eligible Population per LGA in Gippsland

Figure 2: Eligible Population by LGA in Gippsland



Source: Dental Health Services Victoria

The eligible population consists of children and adults meeting the eligibility criteria described in 4.2. This represents the following percentage of overall population in the Gippsland region by Planning Area.

Note when data is broken down into LGAs Wellington and Baw Baw are areas with significantly increased percentages of eligible population to total population residing in the LGA.

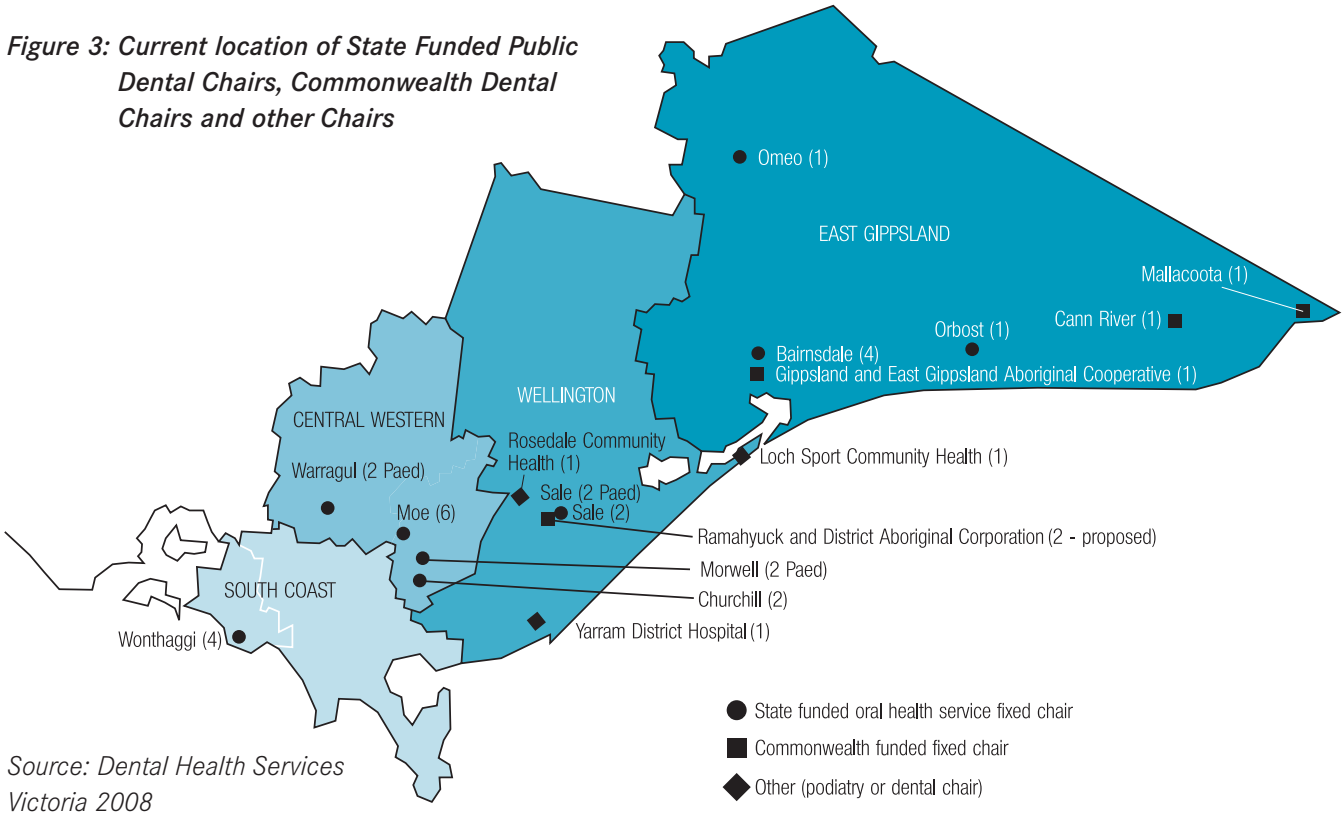
LGA Name	Total Population 2006	Eligible Population	%
Bass Coast (S)	29,408	12,308	42%
South Gippsland (S)	27,243	9,938	36%
Baw Baw (S)	38,416	23,923	62%
Latrobe (C)	70,454	20,167	28%
Wellington (S)	41,361	21,318	51%
East Gippsland (S)	41,046	18,484	45%
Total	**247,929**	**109,081**	**44%**

Table 7: Eligible Population per LGA

4.4 Current Public Oral health Services in Gippsland

4.4.1 Location of oral health services in Gippsland Region

Figure 3: Current location of State Funded Public Dental Chairs, Commonwealth Dental Chairs and other Chairs



Source: Dental Health Services Victoria 2008

This above map reflects the location of:

- All public dental chairs
- Commonwealth dental chairs
- Other Chairs (include podiatry and dental chairs). These chairs are located in health services or community health centres.

4.4.2 Configuration of State Funded Fixed Chairs in Gippsland

Criteria	Planning Catchment	Chair Location	Chair Type	Eligible Population	Eligible Population per Chair	General Waitlist (months)	Denture Waitlist (months)	Integration	Training Commitments
State Chairs	South Coast	Bass Coast 4	2 (CDP) 2 (SDS)	22,246	5,561	16	11	Complete April 2008	
	Central West	Warragul 2	2 (SDS)	44,090	3,674	27	24	Complete June 2008	
		Churchill 2	2 (CDP)						
		LCHS - Moe 6	2 (SDS) 4 (CDP)						Approved to take students
		Morwell 2	2 (SDS)						
	Wellington	Sale 4	SDS (2) Adult (2)	21,318	5,329	48	16	Complete May 2008	
	East Gippsland	Bairnsdale 4	3 (CDP) 1 (SDS) 1 podiatrist	18,484	3,080	7	5	Complete June 2008	Approved to take students
		Omeo DH 1	1 (CDP)			N/A	N/A	To be complete August 2008	
		Orbost RH 1	1 (CDP)			8	<0.5	To be complete August 2008	

Table 8: Public Chair Configuration

Note: Podiatry Chair located at Bairnsdale is not part of the State Funded Oral Health program (chair utilised by Dental Therapist)

The data in this table is sourced from improving Victoria Oral Health and is consistent with 2004 Data (DSE)

4.4.3 Configuration of Commonwealth Funded Fixed Chairs in Gippsland

Criteria	Planning Catchment	Chair Location	Chair Type	Eligible Population	Eligible Population per Chair	General Waitlist (months)	Denture Waitlist (months)
Commonwealth Chairs	Wellington	Ramahyuck	1 (June 08)	978 (SEIFA)	978	N/A	N/A
	East Gippsland	Cann River	1	112	112	N/A	N/A
	East Gippsland	Mallacoota	1	438	438	N/A	N/A
	East Gippsland	GEGAC	2	963 (SEIFA)	480	N/A	N/A

Table 9: Commonwealth Funded Chair Configuration

4.4.4 Configuration of other Fixed Dental or Podiatry Chairs in Gippsland

Criteria	Planning Catchment	Chair Location	Chair Type	Chair Number
Commonwealth Chairs	Wellington	Rosedale Community Health	Podiatry	1
	Wellington	Yarram & District Health Service	Dental	1
	Wellington	RAAF Base	Dental	n/a
	East Gippsland	Lochsport Community Health	Podiatry	1

Table 10: Other Chair Configuration

4.4.5 Wait List for Gippsland[2]

Wait lists have been one of the indicators utilised in relation to access to services for the CDP. They depict the overall wait time of an adult once that adult approaches a public oral health service for a treatment. They have historically not been reflective of the total numbers of the eligible population who might need a treatment. Wait lists only apply to adults seeking treatment in the CDP. Issues identified with wait lists include:

- Not able to reflect the entire target group (eligible population);
- Adults might be on multiple wait lists; and
- Eligible population may be seeking treatment elsewhere.

[2] *All Wait list data provided by Dental Health Services Victoria. Data provided to May 2008*

Until the integration of the SDS and the CDP, DHSV have managed the care of children. This has been done on a one-year recall basis (depending on assessment risk) for eligible children. As the management of the school dental program (SDP) will now pass to the local providers this will include the management of the recall system.

The following graphs depict the wait list time for public oral health services across Gippsland within the CDP for 11 of the 12 months in the 2007/08 year. It is noted that wait lists depict the persons waiting and the average wait time per facility. Wait lists have been divided into general care and prosthetic care. They are dependent on available staff, chair capacity and chair utilisation. Public oral health services in Omeo do not have a wait list for service provision in either general care or prosthetic care.

4.4.5.1 All Gippsland

The following is the combined wait list for the Gippsland region for General Care and Prosthetic Care for the CDP (adults). The overall number of persons waiting and the overall wait time has reduced in both general (29% reduction in the number waiting and a 39% reduction in wait time) and prosthetic care (25% reduction in the number waiting and 60% reduction in wait time) in the last year.

Figure 4: All of Gippsland 2007/08 General Care

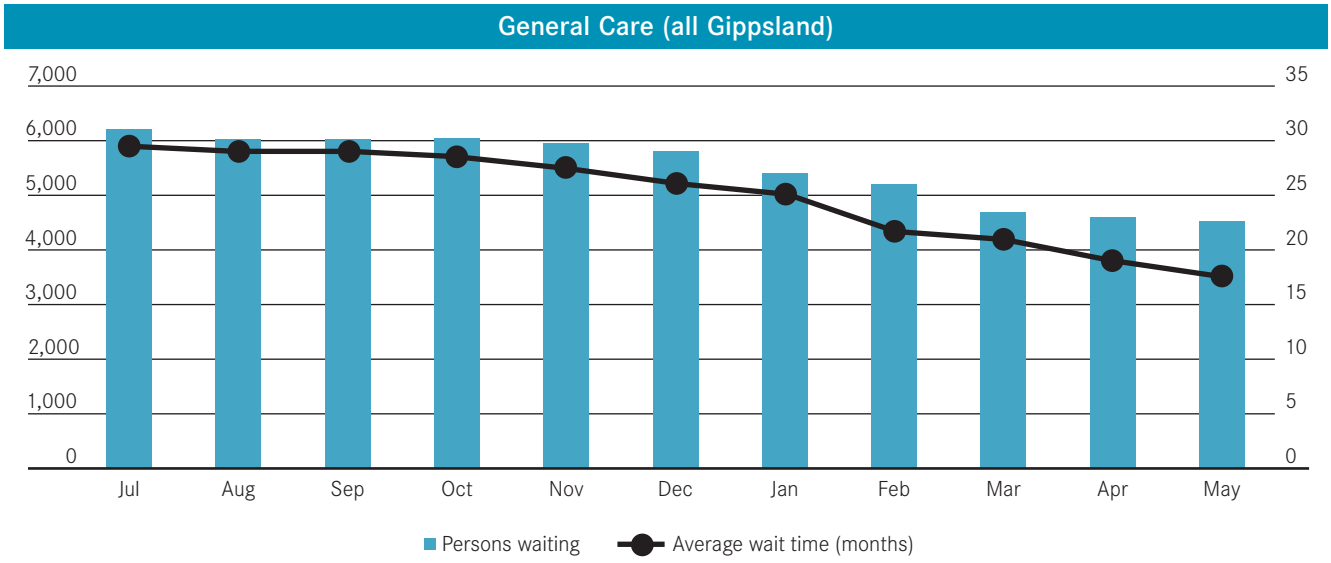
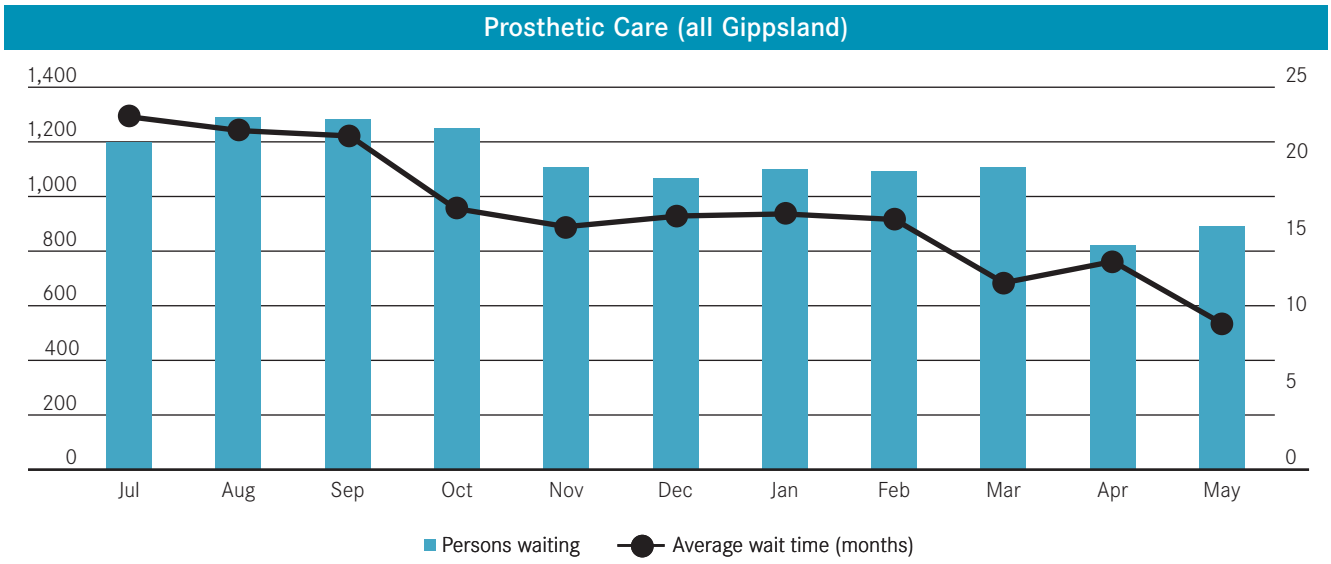


Figure 5: All of Gippsland 2007/08 Prosthetic Care



4.4.5.2 Bairnsdale Regional Health Service

The following are the wait lists for the CDP (general and prosthetic care) for Bairnsdale Regional Health Service.

Figure 6: Bairnsdale Regional Health Service 2007/08 General Care

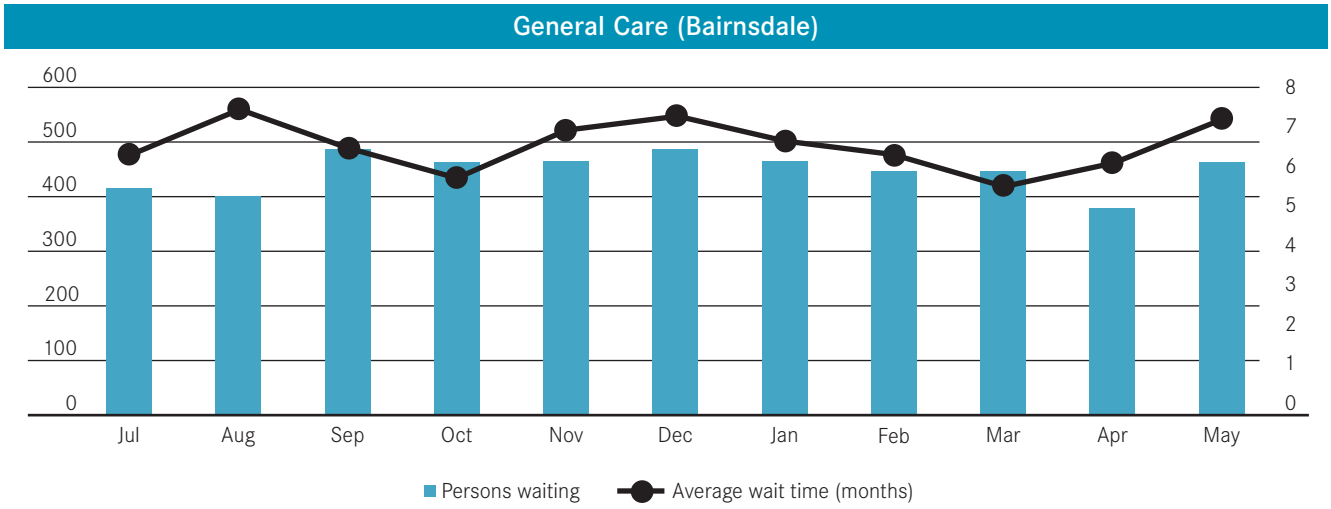
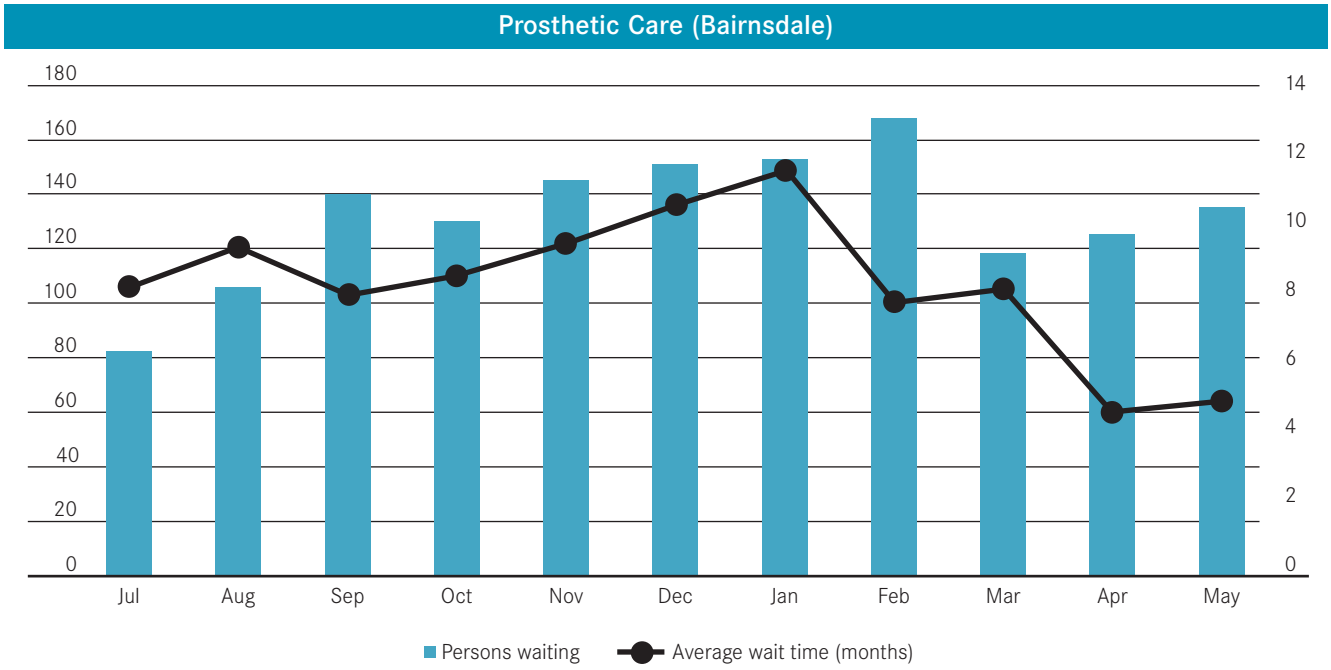


Figure 7: Bairnsdale Regional Health Service 2007/08 Prosthetic Care



BRHS has had reductions in the wait time for oral health services in previous years. This year the wait time for general care and the number waiting have remained steady. The number of people waiting for prosthetic care is actually higher than 12 months ago however the actual wait time is reduced.

4.4.5.3 Central Gippsland Health Service

The following are the wait lists for the CDP (general and prosthetic care) Central Gippsland Health Service.

Figure 8: Central Gippsland Health Service 2007/08 General Care

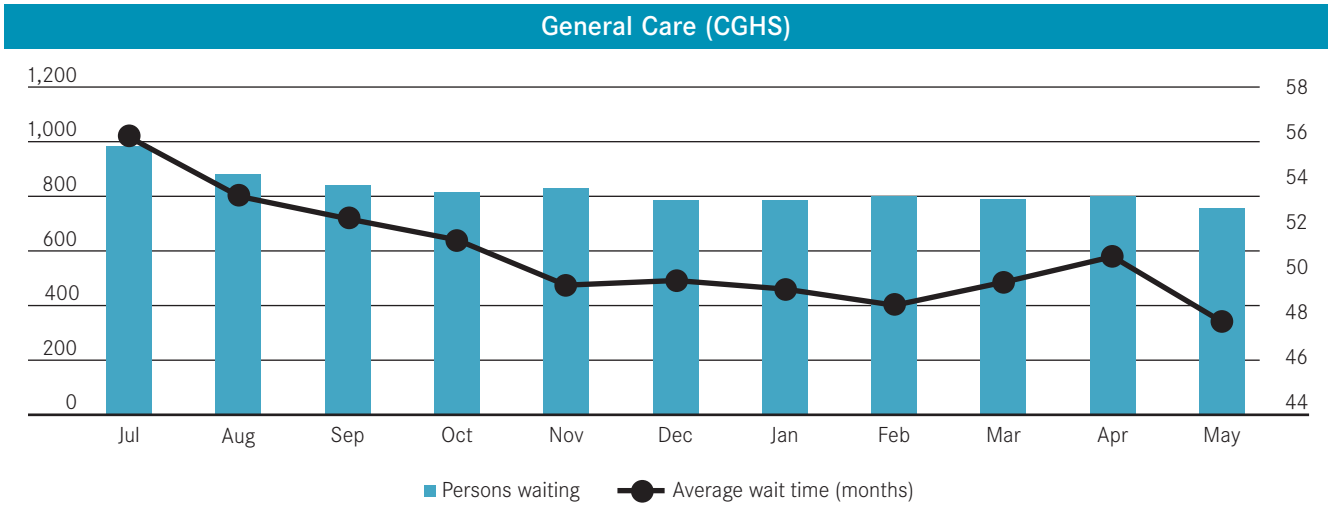
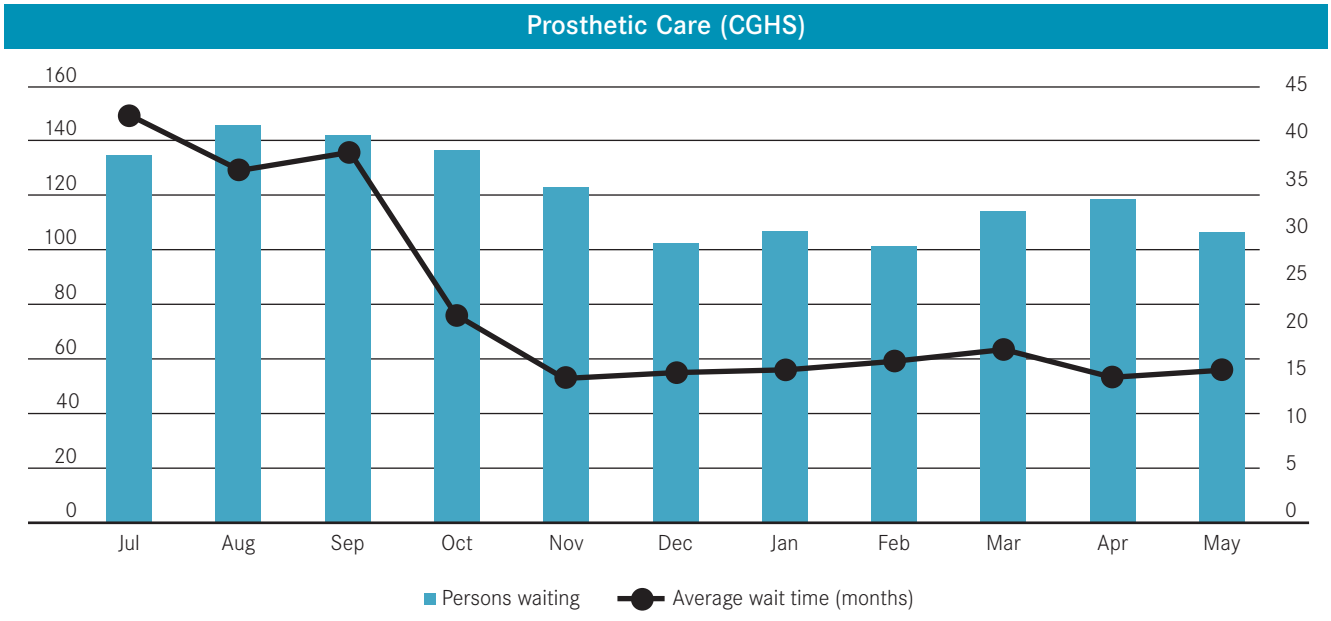


Figure 9: Central Gippsland Health Service 2007/08 Prosthetic Care



Although there has been a reduction in the number of people waiting and in the wait time for both general (21% reduction in people and 13% reduction in wait time) and prosthetic care (19% reduction in people and 62% reduction in wait time) the wait time for general care remains at 48 months (longest in the region).

4.4.5.4 Latrobe Community Health Service

The following are the wait lists for the CDP (general and prosthetic care) for Latrobe Community Health Service. This wait list is a combined CDP wait list for Moe and Churchill.

Figure 10: Latrobe Community Health Service 2007/08 General Care

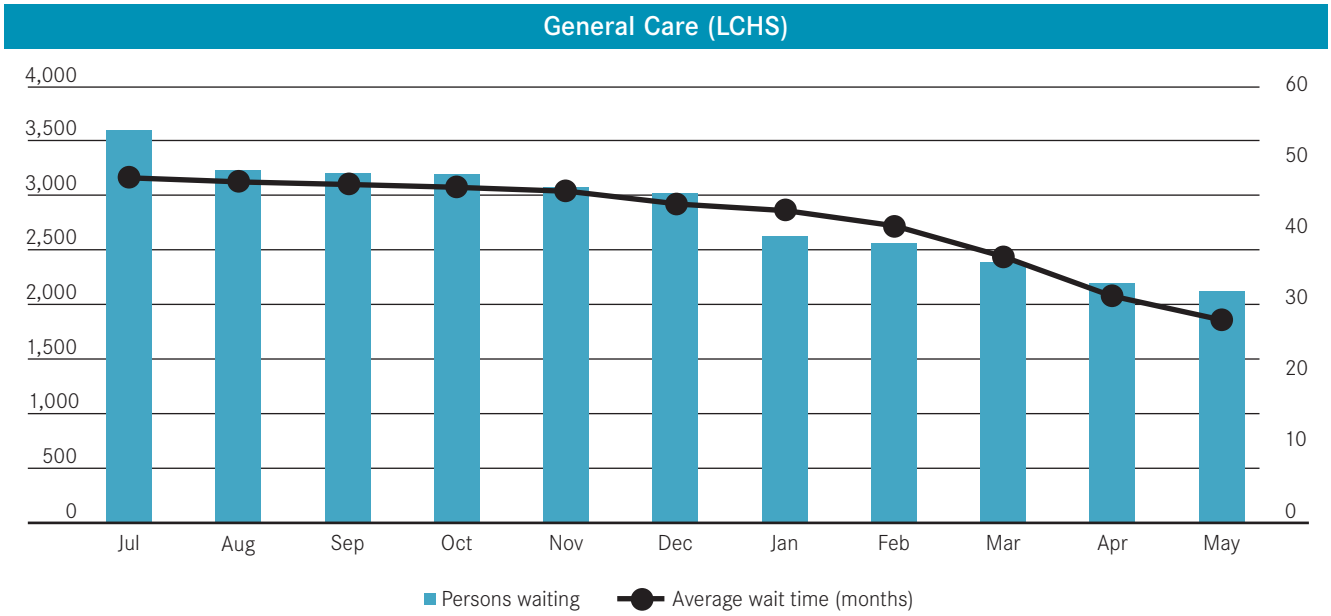
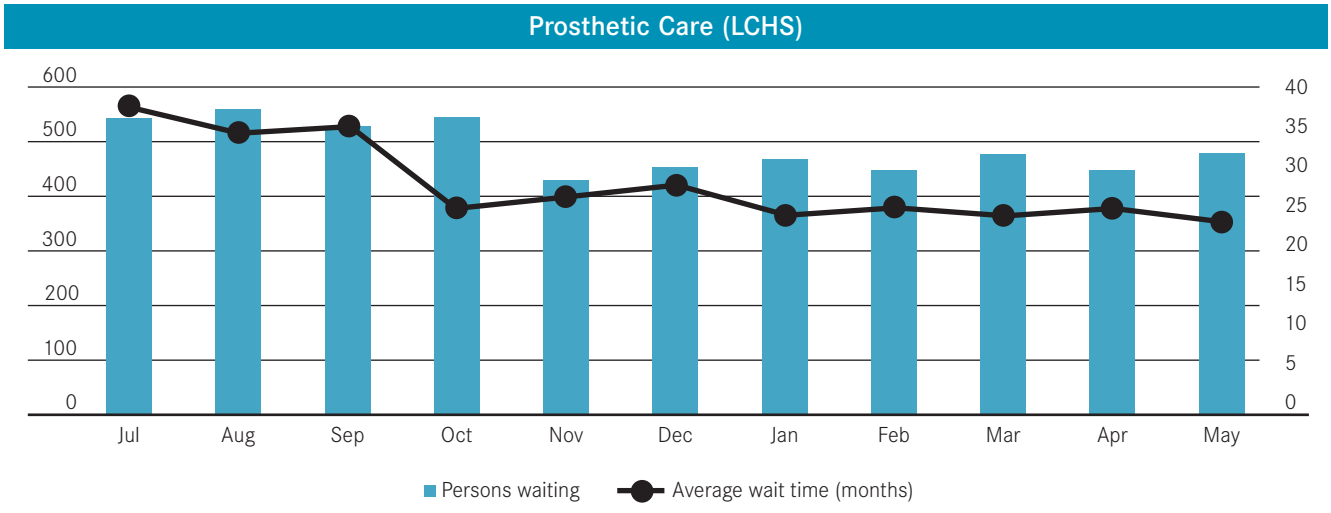


Figure 11: Latrobe Community Health Service 2007/08 Prosthetic Care



Although there has been a reduction in the number of people waiting and in the wait time for both general (41% reduction in people and 43% reduction in wait time) and prosthetic care (12% reduction in people and 36% reduction in wait time) there remains at least a two years wait for any oral health service in the Central West.

4.4.5.5 Orbost Regional Health

The following are the wait lists for the Community Dental Program (general and prosthetic care) for Orbost Regional Health. It is noted that there is no wait list at Omeo District Hospital

Figure 12: Orbost Regional Health 2007/08 General Care

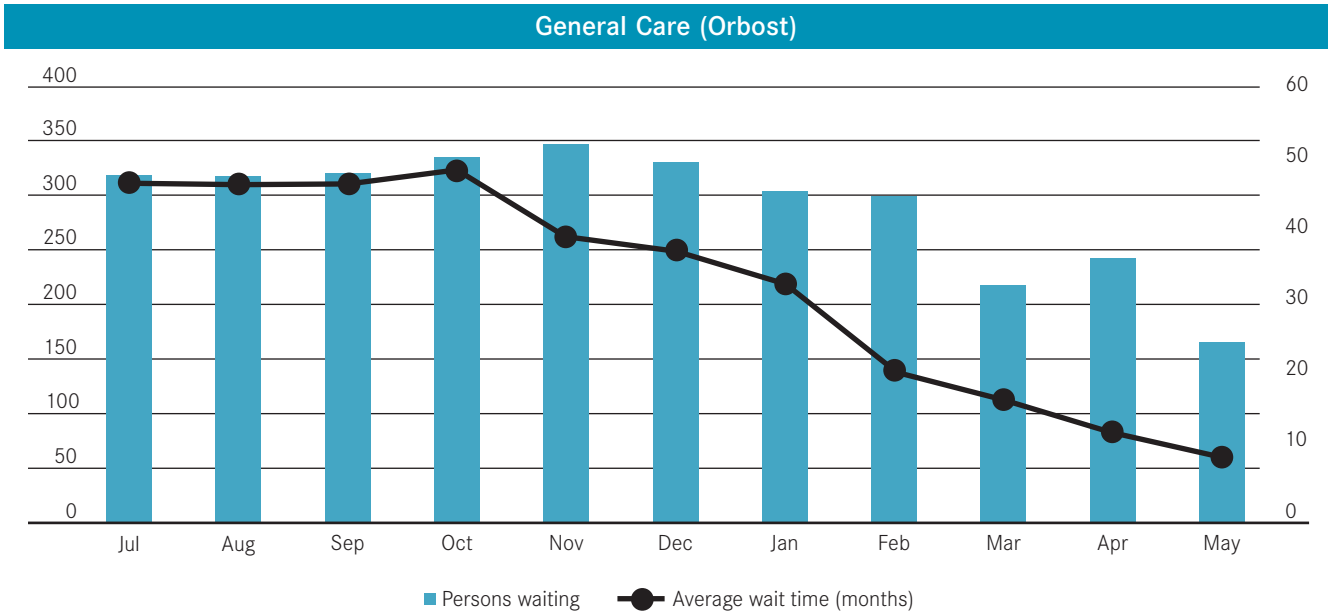
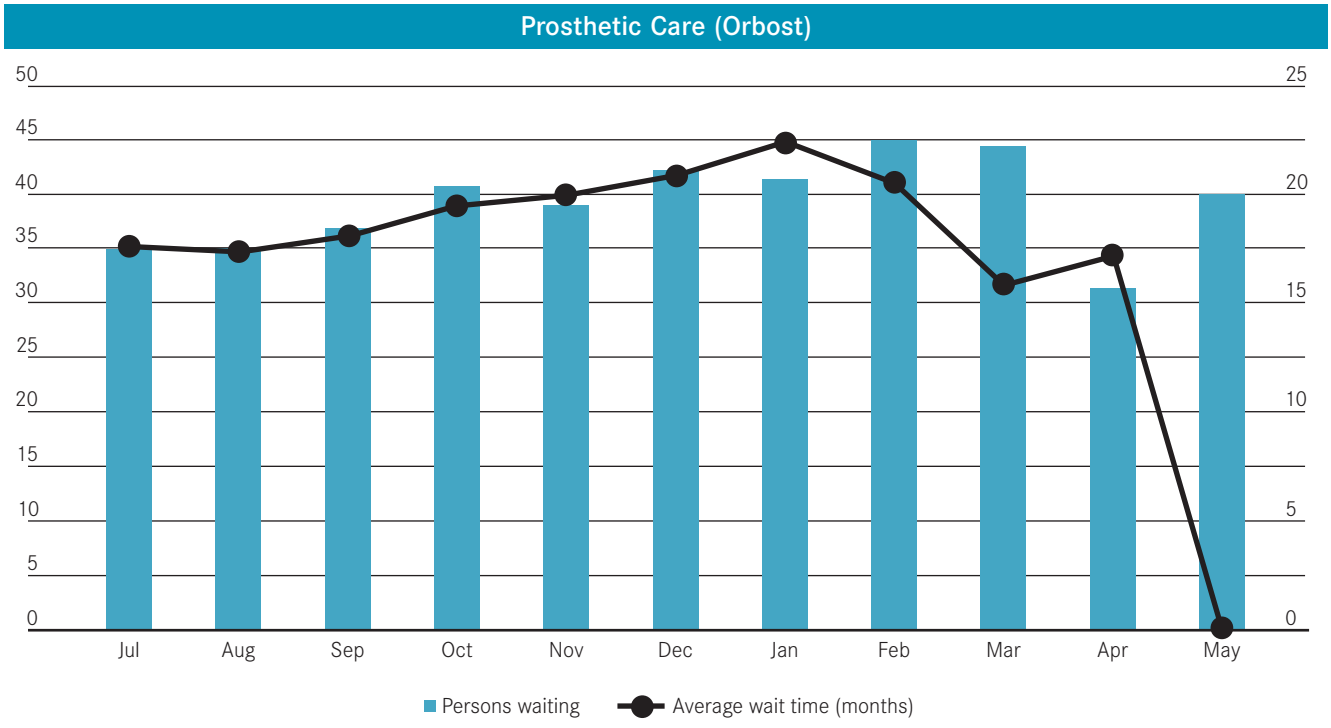


Figure 13: Orbost Regional Health 2007/08 Prosthetic Care



There has been significant reduction in both the number of people waiting (48%) and the wait time (82%) for general care at Orbost with the wait time at end May less than 10 months. There are actually more people waiting for prosthetic care but the wait time is less than one month.

4.4.5.6 Bass Coast Regional Health

The following are the wait lists for the Community Dental Program (general and prosthetic care) for Bass Coast Regional Health.

Figure 14: Bass Coast Regional Health 2007/08 General Care

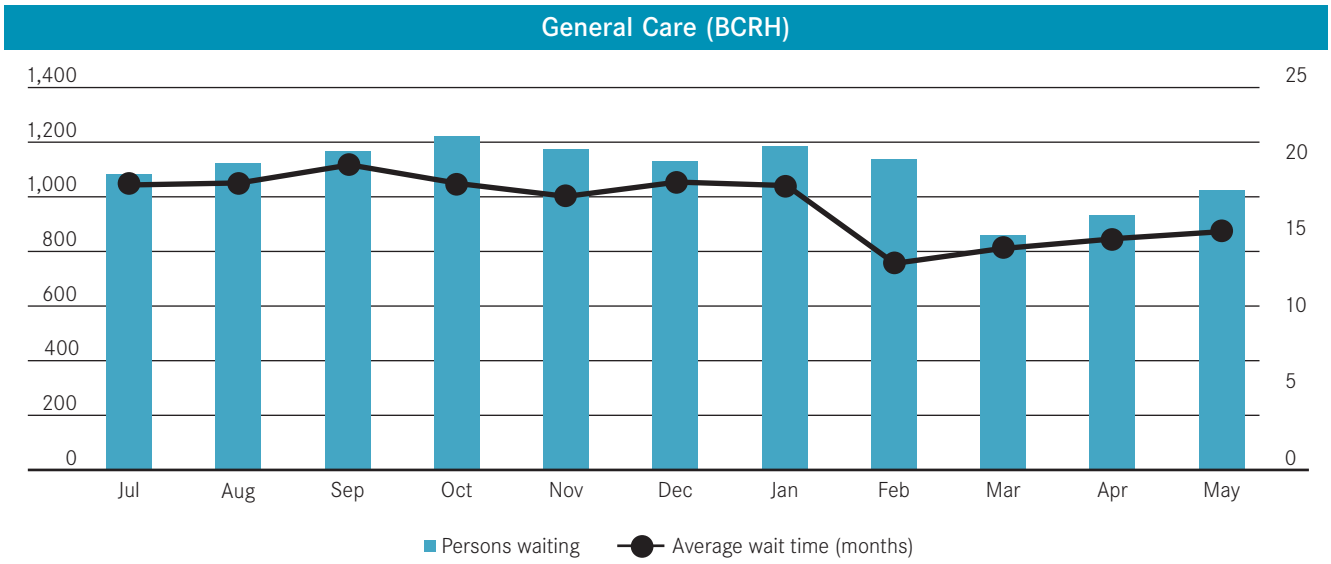
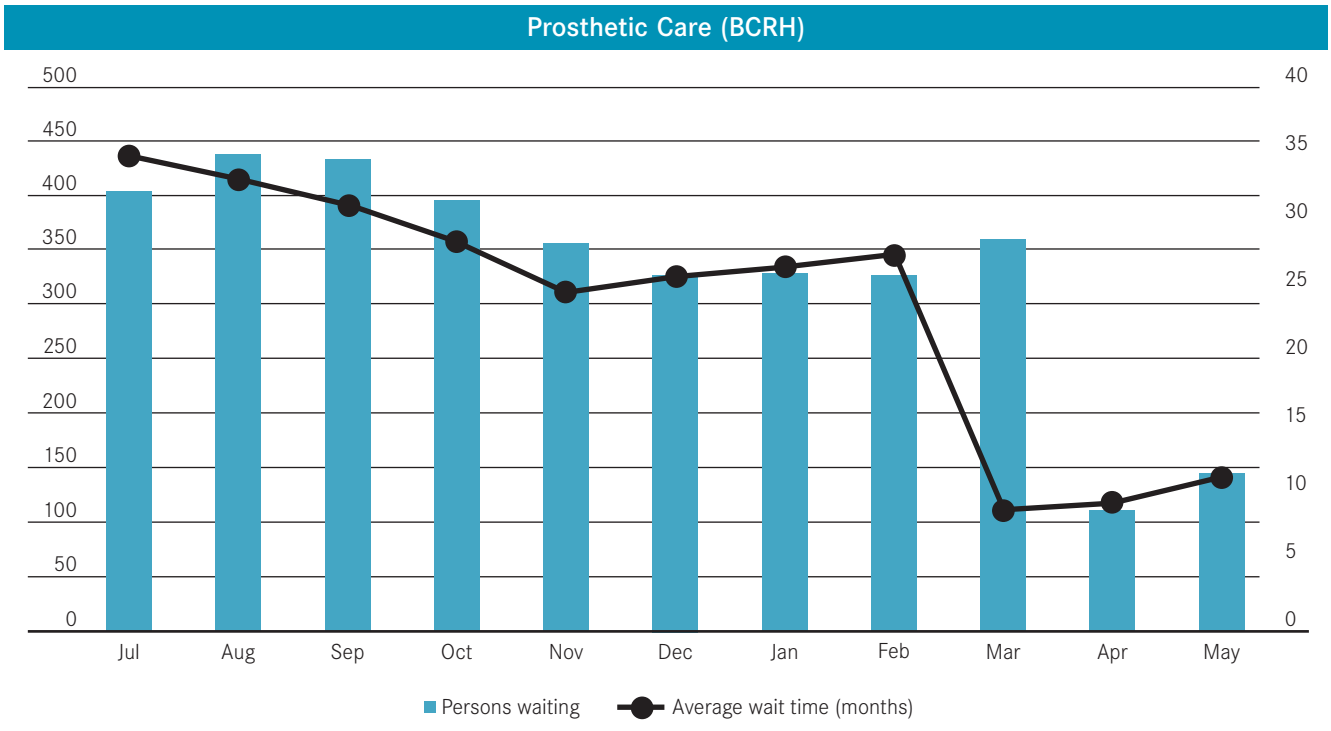


Figure 15: Bass Coast Regional Health 2007/08 Prosthetic Care



There has been a marginal reduction in the wait time for general oral health care (6% reduction in people waiting and 16% reduction in wait time) but a significant reduction in the wait time for prosthetic care (64% reduction in people waiting and 67% reduction in wait time).

The wait time for general care at BCRH is currently 16 months despite the number of chairs to eligible population being high with the wait for prosthetic care approximately 11 months.

4.4.6 Utilisation of Chairs

The utilisation rate is a measure of the propensity of the eligible population to receive treatment in a public dental chair.

Utilisation needs to be considered with caution, as it can be a crude measurement due to a number of issues:

- Availability of the general oral health workforce;
- Location of chairs in relation to the location of the eligible population;
- Availability of infrastructure when workforce is available;
- Availability of suitably trained workforce to manage the client group (dental therapist and the limitations of current scope of practice);
- Amount of private work being undertaken in a public chair; and
- Location of chairs.

Nevertheless, it is useful information as it identifies capacity and / or priority areas to increase throughput given optimal conditions.

The percentage of utilisation would be measured on the current hours of operation at each service compared to the available time (based on days available for each chair). A treatment would be routinely averaged at 40 mins for the purposes of this exercise.

Utilisation cannot be fully measured in areas where there is no demand for services and since infrastructure (chairs) cannot be divided and moved it can only be assumed that resources can ne diverted elsewhere to manage increased demand:

- Firstly within the planning catchment; and
- Secondly within the region.

4.4.7 Percentage of Eligible Population receiving Treatment per LGA

A better measure of access to services is to identify the percentage of the population who have received oral health treatments in the last 12 months rather than the number of the eligible population on the wait lists. Length of wait list should be proportional to the population receiving a treatment. If the wait list is short but the percentage of the population receiving service is not high, access to services remains an issue.

It is noted that this data is the best available and is based on the number of the eligible population who have accessed public oral health care in the 10 months (July 2007 - April 2008). Based on this data it is assumed that it is unlikely that 50% of the eligible population in 5 of the 6 LGAs would access public oral health services in a two-year period.

LGA Name	Eligible Population	Number receiving Service	%
Bass Coast (S)	12,308	2747	22.3
South Gippsland (S)	9,938	1705	17.2
Baw Baw (S)	23,923	4096	17.1
Latrobe (C)	20,167	5743	28.5
Wellington (S)	21,318	4162	19.5
East Gippsland (S)	18,484	4105	22.2

Table 11: Percentage of eligible population (Adult and Children)[3]

Data provided by DHSV and is based on 10 months July 2007 - April 2008

Variables that would affect this information would be:

- Those persons accessing private oral health care (currently unknown);
- Those persons accessing service outside region
- Those persons accessing oral health services in a Commonwealth or non-public funded chair

One of the key areas of improvement would be to develop a process by which that percentage could be accurately monitored given the variables that would need to be considered.

[3] *Dental Health Services Victoria*

4.5 Summary of Issues Per Planning Catchment

	South Coast	Wellington	Latrobe	East Gippsland
Overall Population Change	Increase in population in both LGAs (Bass Coast, South Gippsland)		Increase in population in Baw Baw Shire	
Eligible Population in relation to total population	39% 42% (Bass Coast) 36% (South Gippsland)	51%	45% 62% (Baw Baw) 28% (Latrobe)	44%
Chair Ratio	1:5561	1:5329	1:3674	1:3080
Infrastructure	One chair cannot be used	Poor facility	School Dental Program unable to be fully integrated at Warragul and Morwell	Integration of SchoolDental Program requires thought re service delivery
Wait list		Needs resources to reduce	Needs resources to reduce	

5. Issues

Stakeholders raised a number of issues relating to the planning and provision of oral health services in Gippsland during the *Care in Your Community* consultations. Some issues have been separately considered by the Task Group but remain relevant to the development of the action plan. The issues are to be considered under the broader headings of Clinical Leadership and Governance, Access, Efficiency and Quality of Care, Health Promotion and Workforce.

5.1 Clinical Leadership and governance

This plan must ensure provision of coordination of services and clinical leadership for Gippsland public oral health services. Discussion regarding how a regional model would be configured to best suit the needs of the Gippsland has been robust. The current arrangement is that individual service providers are responsible for all aspects in the delivery of oral health services, resulting in differences in governance, staffing mix, access and standards for clients across the region. There is considerable duplication of effort particularly for smaller providers

Issues identified in clinical leadership and governance for oral health services across Gippsland include:

- Differences in clinical leadership across the region with not all service providers having access to either senior and/or permanent dental officers;
- Service standards are not uniform across the region;
- Policy development is currently managed at a local service level;
- Credentialing of dental officers is managed poorly across the region. Limited accountability for the credentialing process at the local agency level. Credentialing of private dentists undertaking public oral health work is not enforced and it is unclear who holds responsibility for ensuring that this is undertaken. This is an opportunity for this issue to be discussed and addressed with a regional approach;
- No regional plan for the integration of the CDP and the SDP and hence it has been progressed differently across the region;
- Integration is not only about governance. The current plan to replace the paediatric infrastructure located at School Dental sites is limited by the footprint and location of current services; and
- There are no plans to maximize the potential of the oral health workforce (training requirements/refresher for all oral health clinicians to undertake oral health care across the age continuum with competence and confidence.

The planning for public oral health services in the future is underpinned by the principles in *Victoria - a better state of health* and *Care in your community.* The planning framework together with the integrated service model (merge of school and community dental) will result in community oral health clinics being a part of Victoria's network of Community Health Services. It is anticipated that the integration of oral health services with other primary health services will improve access to services and result in shared knowledge and resources, leading to better outcomes for patients.

The integrated service model described in Improving Victoria's oral health document describes three levels of agency (regional lead, district and local). This service model was not deemed to be acceptable to Gippsland oral health providers. Smaller agencies felt that there was potential for them to become disconnected and disengaged in the process.

5.1.1 Recommendations for Clinical leadership

1. Underpin the regional leadership model for Gippsland by a consortium approach (known as the Oral Health Consortium)
   - The Gippsland Oral Health Consortium will consist of representatives from all oral health providers in Gippsland, DHS, DHSV, university and private oral health providers;
   - The Gippsland Oral Health Consortium will operate under determined terms of reference (provided at Appendix 6);
   - A single agency will assume ultimate responsibility for the implementation of the Gippsland Oral Health Consortium decisions and directions. This shall be LCHS
   - The Consortium shall be responsible to the GHSP;
2. Appoint a Project Worker/Manager to The Gippsland Oral Health Consortium to coordinate and facilitate the decisions of the consortium;
   - Develop and present a business case to DHSV on the benefits of supporting such a position

3. Ensure ongoing support to agencies to complete the transmission of business embedded in the principles of the integration process across Gippsland in partnership with DHSV;
4. Ensure that standardised clinical practice guidelines are developed and available across the region in partnership with DHSV;
5. Develop a credentialing process within 12 months to be available for use across the region in partnership with DHSV and DHS.

5.2 Access

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

- Equitable access that considers remoteness and rurality;
- Chair utilisation;
- Length of the wait list deterring persons from seeking treatment
- Availability and capacity of oral health workforce;
- Equitable access to special needs groups; and
- Equitable access to indigenous population.

Access can be facilitated with the use of private oral health services and other providers (Commonwealth or independent) to assist in the management of wait lists and high needs groups.

The issues for Gippsland have been identified as:

- Inequitable access to oral health services across Gippsland. There are disproportional wait times in the CDP across the planning areas. Gippsland must aim to reduce the regional wait time to less than 23 months for both general care and prosthetic care;
- Management of wait list is a combination of access to workforce, chair availability, hours of operation and infrastructure and is not necessarily restricted by rurality. Omeo is the most remote location and there is no wait list;
- Small services are often dependent on sole practitioners; the loss of the practitioners exposes services to reduced service level. Succession planning is important in these location;
- Pockets of underutilised chair capacity in Gippsland. Maximisation of chair capacity can be restricted by availability of workforce, management of clinicians, hours of operation and after hours access, limitations of infrastructure and poor integration processes;
- Although there is a high level of commitment to provide oral health services to the indigenous population there has not been a coordinated response to provide services. Indigenous bodies have created infrastructure without a funding stream and now seek retrospective support for chairs. The approach must now be coordinated within policy direction. Funding of Commonwealth chairs can only be provided through an outreach arrangement from district or local providers to manage wait list, school recall or indigenous groups where access to services is accelerated;
- Continued debate about the use of Commonwealth Chairs in Mallacoota and Cann Valley. Whist the focus of public oral health care in the development of this plan should be on state funded oral health services the use of Commonwealth chairs to assist in the management of wait lists and access for high needs groups must be considered. Staffing of these services should remain the mandate of the service provider - payment for services provided to the eligible population needs further exploration. The location of the majority of the Commonwealth chairs is in East Gippsland where the overall wait list is the lowest in the region. This should not deflect from the use of the chairs to manage wait lists in areas with longer than acceptable wait times (dental chairs at RAAF Base Sale and Yarram and District Health Service, and podiatry chairs at Lochsport and Rosedale Community Health);
- Local agencies already support access for indigenous persons and special needs groups (Orbost provides a dedicated oral health session for the indigenous population and aged persons); and
- Ability to manage the load of a SDP in areas where there has been no increase in chair capacity (Orbost and Omeo).

The policy direction is underpinned by the fundamental principle of equitable access to oral health services within planning parameters of 1 chair to 5000 eligible population; with future planning of chairs based on growth of population (Gippsland has no expected growth in overall eligible population through to 2016 however, as Table 3 indicates, there is considerable growth expected in the LGA of Bass Coast and to a lesser extent in Baw Baw and South Gippsland).

The focus for Gippsland oral health services is to ensure the current chair capacity is fully optimised (correcting deficiencies in infrastructure that limits use of the full capacity of individual chairs, optimising the oral health workforce by ensuring that the workforce is competent and confident to utilise the full capacity of their skills and exploring opportunities to increase hours of operation).

As part of the response to the oral health needs of the high-risk groups, Aboriginal Community Controlled Health Organisations will enter into collaborative relationships with CDP to improve the responsiveness of public oral health agencies to the oral health needs of the indigenous population. This must however be done within the overall provision of oral health services in Gippsland.

5.2.1 Recommendations

6. Reduce the wait time for access to public oral health services uniformly across the region to a maximum of 23 months for general and prosthetic care;
   - This target will be re-evaluated once that target has been achieved and a new target will be established by the Consortium;
   - Continue to explore the factors that affect the access to services;
7. Maximize the chair capacity across all planning areas by:
   - Ensuring infrastructure meets requirements of service delivery;
   - Workforce is developed to ensure that adults and children can be treated in any chair in the region;
8. Develop outreach models (See Models of Care Section 5.4) for Commonwealth chairs;
   - Model based on the need to manage wait lists or recall;
   - Public oral health service purchases entire service;
   - Public oral health services rents chair time and provides the staff to operate the chair;
   - Service arrangement managed at a district level;
   - These models will be planned within 6 months;
9. Utilise other chair types for preventative and oral health activities.

5.3 Efficiency and Quality of Care

The length of time a person waits for a service and the responsiveness of the service providers in the provision of care are measures of efficiency and quality. In oral health care this can be reflected in wait list time and management. We need to interpret this cautiously as there are a variety of factors that influence the length of the wait list including clinician availability, chair utilisation and population.

Factors that potentially affect efficiency and quality of care are:

- Wait list management (availability of workforce and skill of workforce);
- Effective integration of SDP and CDP;
- Utilisation of private dentists in the management of public oral health services; and
- Increased utilisation of the oral health workforce - ensuring that the clinical workforce is supported to treat the full population. This will require supervision for clinicians as they treat parts of the population who have previously not attended their service.

The issues that affect quality efficiency in Gippsland are:

- No regional approach/plan for management of wait list. Significant differences in wait list times across the planning areas with East Gippsland having the shortest wait time across the region. A consolidated wait list is not deemed to be the solution to this issue by the oral health service providers in Gippsland;

- The effectiveness of the transition to the integration of SDP and CDP across the region. Whilst there have been working groups involved in the integration process, there has not been an overall planned approach to integration for the region. Integration is being phased in across the region with completion targeted for June 2008
  - Bass Coast Regional Health- April 2008 (Completed)
  - Central Gippsland Health Service- May 2008 (Completed)
  - Bairnsdale Regional Health Service- June 2008 (Completed)
  - Latrobe Community Health Service- July 2008 (Completed)
  - Orbost Regional Health - August 2008
  - Omeo District Health Service - August 2008
- Emphasis on the integration process appears to be around clinical governance rather than the detail of management (there has been limited consideration of the impact of managing the SDP recall system at a service level or the different policies and standards across SDP and CDP);
- Integration will result in the management of wait lists and school recall at a district and local level. Local service providers have always managed wait lists but DHSV has managed SDS recall. Recall will now be managed by district and local providers;
- There is no standardised approach to the management of day-to-day operational issues across oral health services. Issues that might benefit from regional discussion and common approaches are:
  - Triage management
  - Management of 'no shows' or 'fail to attend'
  - Treatment of emergency treatments
  - Use of vouchers or private dental clinicians;
  - Complaints and feedback
  - Management of workforce including acceptable times for set-up and meal breaks.
- There is no regional plan to ensure consistency in the support of the clinical workforce to treat the full population. Such a plan would require access to supervision and /or mentorship for clinicians as they treat parts of the population who have previously not attended their service;
- Limited use of private dentists as a vehicle for the management of waitlists. Although vouchers are used in Gippsland they are not widely supported. DHSV indicate that approximately one third of all vouchers issued across the state are not used. Gippsland focus must be on the development of mechanisms to engage private dentists in the provision of services to the public sector with a reduction on the reliance and use of the voucher system;
- Limited access to specialist services in Gippsland (endodontists, periodontists); and
- There has been some indication that Gippsland would be interested in developing and supporting a local dental laboratory.

Whilst there is no intent that Gippsland will have a centralised or consolidated wait list it is anticipated that wait list management will be coordinated to ensure that resources are directed to planning areas that have less than acceptable waiting times. Priorities for resources shall be directed to these areas - this would include the use of a private oral health model to manage lengthy wait list.

5.3.1 Recommendations

10. Reduce the wait time for access to public oral health services uniformly across the region to a maximum of 23 months for general and prosthetic care;
11. Ensure that the SDP recall system becomes part of the service system at a district and local level;
12. Ensure that the integrated service model is supported to allow access to both adults and children at any dental chair in Gippsland;
13. Develop common solutions to the management of day-to-day operational issues common to all oral health clinics;
    - Triage management;
    - Management of 'no-shows' including monitoring of the prevalence;

14. Engage private dental practitioners in the plan for the management of public oral health services;
    - Investigate the opportunity to employ a private dentist for a defined period of time in the provision of public oral health work in order to have immediate impact on the public wait list;
        - Contracted number of sessions;
        - Defined period of time and then evaluated; and
        - Provided at private oral health clinic.

5.4 Models of Care

Models of care should be developed and introduced in a planned and structured way. The purpose of the consideration of new and innovative models is to improve access and efficiency of service delivery. Models should be developed or expanded on the premise that the resources are available or can be developed to support them. It is also noted that oral health services are 'capped' with the provision of services needing to be balanced between resources available and the demand within any area. Resources should be able to be moved from an area of limited demand to an area of high demand (wait list, high eligible population and special needs groups) within the region

Factors that potentially affect the development or sustainability of services (models of care are):

- Current utilisation of the service;
- Lack of understanding about what the average utilisation of a chair is given a normal day. This information needs to be provided by a common source (DHSV);
- Service demand;
- Infrastructure to support the proposed models of care;
- Availability of a skilled trained oral health workforce; and
- Ability to develop and train an oral health workforce locally.

The issues for Gippsland in the development of Models of Care include:

- Currently fixed chair model exists across Gippsland (this is the model that is the prominent model in all public oral health services);
- It is anticipated that integration of school and community oral health programs will improve access to services and that collocation will increase efficiency of service. Day-to-day operational issues have yet to be addressed in the integration process;
- Development of an outreach model of care;
    - Plan for the Outreach model will be developed within 6 months of the commencement of the Gippsland Oral Health Consortium;
    - Outreach services shall be used to ensure priority access to manage access for children and high needs groups;
    - A single outreach model shall be developed within each planning catchment;
    - Sustainability should be the underpinning principle of the arrangement hence local and district providers should in the first instance develop a model based on renting chair time and providing staff to outreach site;
        - Use of Commonwealth chairs (indigenous);
        - Use other Commonwealth chairs (other health services);
    - All providers shall enter into collaborative discussions with outreach site;
    - A memorandum of understanding shall be developed between all health services involved;
    - Hours of service will be decided as a collaborative agreement;
    - Funding for outreach service will be directed to local or district provider;
- A drivable oral health van may be considered as a complementary resource that may be introduced in time. A service model for the introduction of such a resource is yet to be developed and would warrant further investigation and consideration by the Gippsland Oral Health Consortium.

5.4.1 Recommendations

15. Ensure the continued support for a preferred model of care based on fixed chairs;
16. Develop a service structure that ensures capacity of each fixed chair is optimized according to the identified needs of each area;
17. Develop outreach service models to support access to services for children, indigenous and high needs groups;

18. Develop further processes that are able to ensure utilisation of chairs is in accordance with established identified needs; and
19. Ensure that integration results in efficiency of service, adequate management of wait lists and school dental recall.

5.5 Infrastructure

Infrastructure (building and equipment) is poor at some sites. The current integration of SDP and CDP has exposed a number of issues and deficiencies in arrangements. Whilst there are redevelopments underway that are addressing the need for collocation of services (Central Gippsland Health Service) there are a number of issues that need to be managed as a matter of urgency.

Factors still to be considered in infrastructure are:

- The location of SDP on school sites. Such locations are unsuitable as venues for adult service delivery. It would be preferred to collocate the SDP at Warragul within West Gippsland Healthcare Group Community Health Service facilities. If this is not possible other options to be explored. Currently the SDP that are located on school sites continue to have paediatric chairs. Whilst these sites remain the infrastructure is unable to be changed hence once relocation occurs the paediatric chairs will be replaced as a matter of course;
- Any proposed development of the workforce (extended scope of practice) is not practical until after the facilities are moved away from a school location because it needs to be supported by the availability of both supervision and practice;
- Capital works at Bass Coast Regional Health to address the current limitations of the infrastructure (only three chairs can be currently used);
- The redevelopment of the Morwell facility to manage the integration of SDP and CPD and to increase the capacity of the site to support the 'teaching model' planned for Gippsland;
- The completion of the collocation at Central Gippsland Health Service for 2009. Currently CGHS has two poor facilities;
- The bariatric chair currently located at Moe should remain part of the LCHS service configuration; and
- Development of a regional model for the provision of prosthetic laboratory services in Gippsland. This would not only ensure that services were available locally but also create local workforce opportunities in workforce development. A centre of excellence should be located in Morwell as part of the planned capital redevelopment. There is currently a dental laboratory located in Sale - this could provide future opportunities to provide an outreach/satellite service. Development of this model should be on the basis of access to services from a regional perspective. It has been identified that the current plan for the redevelopment at Morwell does not include a dental laboratory and given that the funding for this development has been approved a dental laboratory may not be in scope and additional funding will then need to be sourced.

5.5.1 Recommendations

20. Plan for the upgrade of the facility at Bass Coast Regional Health to allow for the full use of the four chairs:
    - Documented plan to be completed within 3 months;
    - Timeframe for completion of upgrade determined within that plan;
21. Plan for relocation of School Dental Program to the Community Health Service in Warragul:
    - Plan to be completed within 3 months;
    - Timeframe for completion of upgrade determined within that plan;
22. Completion of the upgrade and collocation of the services at Central Gippsland Health Service by early 2009;
23. Plan for the upgrade of the integrated facility at Morwell:
    - Plan to be completed within 3 months;
    - Timeframe for completion of upgrade determined within that plan;
24. Develop a prosthetic laboratory service at Morwell as part of the planned capital development; and
25. Plan for the gradual upgrade of all state funded dental chairs to be determined within 12 months.

5.6 Oral health promotion

Oral health promotion is one of the strategic priority areas within *Improving Victoria's oral health* policy document. Oral disease is almost totally preventable therefore good health and reduced demand for oral health services are best approached through population health (strong focus on promoting health and the prevention and early identification of oral disease) and prevention strategies. The National Oral Health Plan called for an integrated and cross sectional approach that would achieve improvements to both general and oral health. Therefore it is anticipated that oral health promotion will form part of health promotion plans at local, state as well as national level.

Health promotion issues for Gippsland are:

- Oral Health service providers although cognisant of the importance of oral health promotion are currently caught in a treatment and restoration paradigm with limited resources to channel into health promotion;
- Oral health promotion needs to take both an all of population approach in a preventative approach and be imbedded in the day-to-day management of patients within the treatment and restoration dental model, with practitioners providing best practice and evidence based models for the provision of oral health education chair side and within the clinic environment;
- Currently there are two funded programs operating within Gippsland focusing on different aspects of health promotion. 'Smiles4Miles' focuses on policy development that incorporates the oral health messages of Drink Well, Eat Well, Clean Well and Stay Well within preschool and early childhood settings. A further aspect of this funding is the extension program that focuses on oral health promotion within the dental clinic (chair side oral health promotion, waiting room resources);
- Teeth and Tummy's is another education and screening strategy and needs to be supported with input from trained oral health practitioners. This form of health promotion focuses more on the health education and screening aspect and has the potential to compliment the Smiles4Miles strategy. This aspect of health promotion does not necessary fit well with the direction of the catchment based health promotion plans that are being considered by the agencies funded for the provision of health promotion (PCPs), however it presents an excellent opportunity for the Gippsland Oral Health Consortium to work with theses agencies in a complimentary way;
- The current funding for health promotion activities within the region could have the potential to provide on the ground oral health promotion workers for the region. Should oral health promotion funding be managed by the Gippsland Oral Health Consortium, there would be opportunities to embed health promotion resources within health promotion teams but have them integrally linked to oral health programs;
- The newly established Commonwealth Teen Dental Program for annual dental checkups will be supported in Gippsland and there is potential for the Consortium to look at this program across the region;
- There has been joint planning between the Primary Care Partnership (PCPs) who are responsible for the coordination of oral health promotion interventions and the Community Health Services/district agencies. There is a plan for the completion of a single health promotion plan for each catchment by June 2009. By working more closely with the PCP there is an opportunity to raise the profile of oral health on the back of existing effort. Collaborative effort between the PCP and Gippsland Oral Health Consortium will help imbed the oral health message within the catchment plans;
- There is a disconnect between the oral health and dental related ACSC admissions to hospitals with limited collaboration between the service providers. In Gippsland there are increasingly opportunities for improved collaboration between these service providers due to the integration of community health service and district health services. Opportunities to monitor the admission of patients with ACSC (dental related) with these improved relationships exist; and
- There are still unfluoridated areas within Gippsland; fluoridation of water is a priority (however it is not part of the Gippsland Oral Health Action Plan) - community water fluoridation is safe and cost-effective and should be introduced and maintained where acceptable and feasible.

5.6.1 Recommendations

26. Ensure oral health promotion is part of the core business of all health care services in Gippsland;
27. Implement alternate models of care in preventative care rather than restorative (dental hygienist);

28. Develop and submit a region wide oral health promotion program to be managed by the Gippsland Oral Health Consortium:
    - Requirement to collaborate with the Gippsland Health Services Partnership - Health Promotion task group;
29. Develop a business case for the ongoing funding of oral health promotion staff who will be located in Health promotion teams but linked to oral health programs;
30. Support the completion of fluoridation across Gippsland; and
31. Actively work with the acute health teams to further reduce the oral health and dental related ACSC admissions to hospital.

5.7 Workforce

Availability of a skilled oral health workforce is a key element in the provision of public oral health care. The workforce includes specialist, dentists, therapist, hygienists, assistants, prosthetists and technicians (described in Table 2). Historically the public sector has been unable to recruit and retain enough clinicians to maintain the oral health workforce with demand clearly being outweighed by supply. Key issues identified in a 1999[4] report were:

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

A workforce strategy was implemented with the aim of delivering an improved and consolidated workforce.

Workforce issues raised in Gippsland include;

- Significant inequity in availability of dental officers between planning areas:
  - Bairnsdale is reasonably well staffed;
  - Wellington and Latrobe have both benefited from the use of DHSV's travelling oral health team. This initiative has allowed continuing program delivery while recruitment of permanent staff occurred. CGHS has now successfully recruited an oral health team and the DHSVs travelling dentist will now be deployed elsewhere in the state; and
  - A traveling dentist continues to support Latrobe Community Health Service
- Availability of workforce directly impacts on the ability to manage the wait times of clients, utilisation of chairs at full capacity;
- Limited availability of private dentists within the region. Private dentists report extreme difficulty in attracting new dentists and oral health support staff;
- Identified gaps in the oral health workforce in Gippsland including:
  - Specialist services (endodontists, periodontists);
  - Dental Hygienist;
- In order to operate a fully integrated service model, dental therapists will need to have opportunities for the development of their practice ensuring they are able to practice up to their level that their training allows. Currently many of them have had limited exposure outside school age population;
- Alternately many of the Community oral health staff have had limited recent exposure to school aged children as these have been treated within the SCP;
- The commitment from Gippsland is to support local training opportunities to build their own workforce. This commitment includes provision of supervision and support at a local level. Student placements should be the responsibility of one service with other providers able to offer clinical placements. Discussion with the university partners (Melbourne University) have been occurring for 12 months; training places have now commenced;
- Retention of the oral health workforce has been problematic across the region. There are limited opportunities for professional support (mentoring, clinical supervision, shared professional development/education). There are currently no opportunities for the private and public sector to network or work together to improve access to public oral health care;

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

- Limited skills available locally to operate a dental laboratory;
- Retention of staff in areas where there is limited chair availability and the difficulty of recruiting into this environment; and
- Gippsland has been successful in its recent submission 'Filling the Gaps'. This will be an opportunity for the oral health partners in Gippsland to work together to increase recruitment of oral health clinicians in the region.

5.7.1 Recommendations

32. Develop a workforce plan aligned to the statewide oral health workforce development strategy from DHSV to identify the areas of greatest workforce needs in each planning catchment. The plan will
    - Be developed within 6 months;
    - Identify gaps for specialist oral health services;
    - Prioritise areas with the longest wait list in relation to recruitment;
33. Support the development of a clinical network for oral health clinicians in Gippsland (private and public clinicians);
34. Ensure that the oral health workforce is working to their full potential by providing opportunities for supervision and mentoring of all oral health staff to provide oral health care across all ages;
35. Ensure a regional approach to the management and educational opportunities for Gippsland;
    - Increase training places to equivalent of 5 chairs within 12 months;
36. Increase the recruitment potential of oral health clinicians by maximizing the opportunities created by the 'Filling the Gaps' submission; and
37. Support the development of an indigenous oral health workforce by providing opportunities for teaching and supervision.

6 Planning principles and criteria

This Section addresses the overarching principles that should guide the service configuration for oral health services in Gippsland Region. It will be considered firstly under the statewide principles and secondly under the agreed Gippsland principles.

6.1 State-wide service planning principles

Consistent with the approach of Care in your Community policy, oral health services will be planned so they

- Are based on a single set of area-based planning principles;
- Informed by a single set of planning principles;
- Supported by area-based planning networks;
- Focused on three high-level areas of need; and
- Conducted on the basis of defined modes, settings and levels of care.

Planning parameters for oral health services include:

- Planning will be based on the catchments described in *Care in your Community* with the view of achieving self-sufficiency for community oral health services within these attachments;
- Services are planned to a planning ratio of 1 dental chair: 5,000 eligible population (includes one clinician plus assistant and support staff);
- Services will be planned on a minimum of 4 chairs to enable cost efficiencies and facilitate recruitment of specialized staff (except in rural areas where smaller clinics may be required to maintain accessibility; this arrangement will be supported by a larger district or regional service);
- Greater proportion of resources will be directed to areas with larger eligible population numbers;
- Community dental chairs will be co-located with Community Health Services;
- Planning will identify the services that can be safely and effectively delivered in the community setting and which should be delivered in the more structured hospital setting;
- Services, where appropriate, will be provided close to where people live and access regularly;
- Planning will promote access to services with collocation occurring in locations that are easy to access for the eligible population; and
- Planning will deliver collaborative outcomes based on partnerships.

6.2 Gippsland service planning principles

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

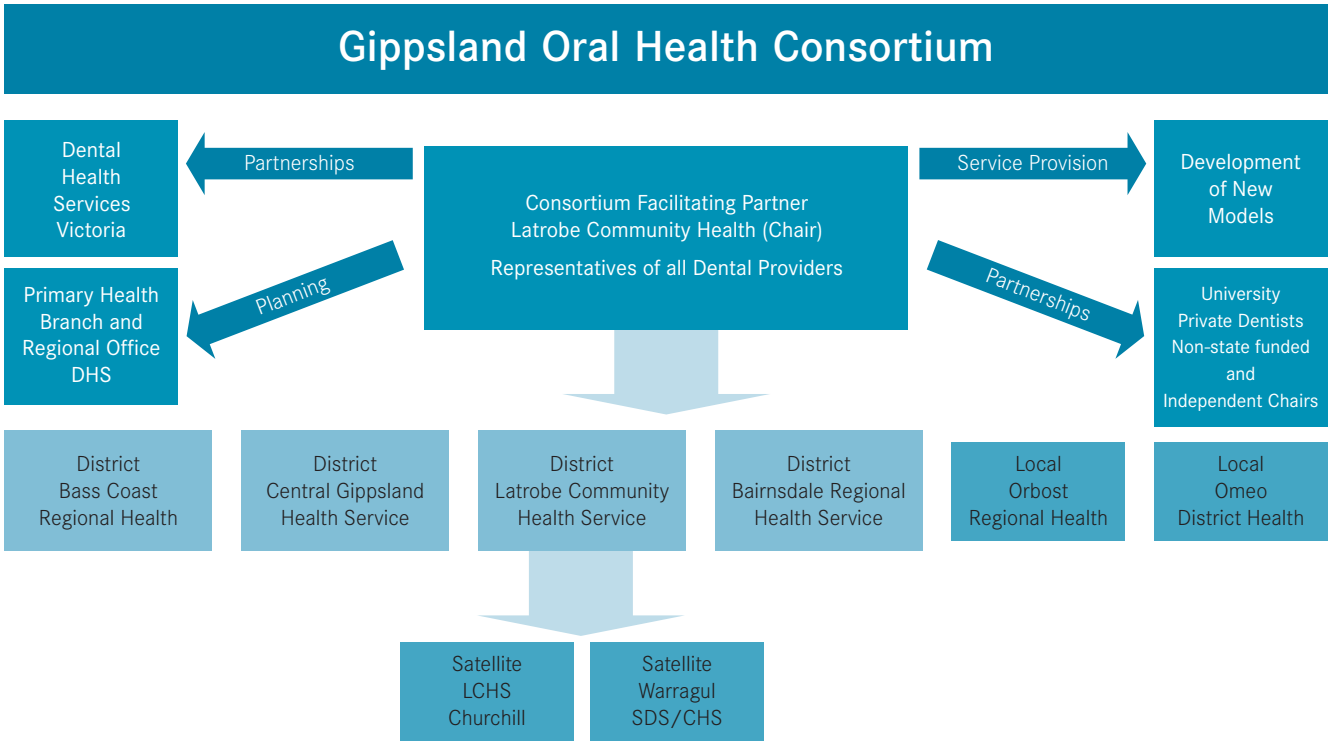
These statements are not listed in order of priority, as the service system should represent an effective balance between them:

- No diminution in overall service levels: while service configurations and service types may change, it is not intended to reduce the overall quality, capacity or resources of oral health services in the Gippsland region (reallocation of chairs between catchments will not be considered);
- Best models of care: options should be based on best models of care to achieve the goals of provision of oral health services – specialist assessment, care, treatment and prevention for the eligible population in the appropriate service setting for the individual consumer (mobile van, outreach, opportunities for interaction with private dental services, service models for indigenous chairs);
- Best access: consumers should have prompt access to appropriate services as close as practicable to their usual place of residence. Acceptable waiting time of less than 2 years for general oral health care;
- One philosophy of care throughout the Region: while the service system need not be standard across the Region, all service providers should adopt a single guiding philosophy of care to guide planning and priority decisions;
- No service faces sustainability risks: a new service model should improve the sustainability of individual services and the system as a whole;
- Fluoridation of water will be considered under a process separate from the service configuration process;
- Planning will develop partnerships and service configurations that improve workforce capacity in all catchments. This will include services for indigenous, disabled and aged persons;
- Planning will consider the already identified capital redevelopments at Morwell (Latrobe Community Health Services), Warragul and Sale; and
- There is no state policy position for the use of Commonwealth funded dental chairs by public dental services (Mallacoota and Cann Valley).

7 Service Configuration and Roles

The Service Configuration will consider an integrated service configuration model (lead agency model is proposed) and discussion on the priorities of service configuration ad the responsibilities of each agency type.

Figure 16: Proposed Service Configuration



This model demonstrates the possible relationships between service providers. The main oral health service providers in Gippsland support this approach to ensure continued involvement of all agencies in the direction of oral health services across the region.

The role of each agency type is well described in the Improving Victoria's oral health policy document.

Table 11: Roles and Responsibility of Agency Type

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

**Data Source Improving Victoria's Oral Health*

The Gippsland Region will work towards a Consortium model approach to the management of Oral Health Services within the region. The consortium will consist of senior agency representatives and clinicians who will lead the strategic planning for integrated oral health services in Gippsland.

The consortium will consist of clinical staff from each agency involved in public oral health care and appropriate oral health program management staff. There will be an opportunity for the consortium to determine the involvement of other oral health clinicians (private dentists) in the region. This will enable private / public relationships to be fostered.

Strength of this format is that it will enable all agencies to contribute to strategic planning. It will be collaborative and enable a regional approach to activities such as clinical practice, standards, credentialing and professional development. Within the model there will be a process to facilitate access to specialist oral health services based on the premise of regional support and equity of access.

8 Gippsland Oral Health Action Plan

Priority Action	Actions	Responsible Identity	Timeframe/ priority
Clinical Leadership and Governance 1. Underpin the regional leadership model for Gippsland by a consortium approach (known as the Oral Health Consortium)	Assume leadership and direction of dental health services in Gippsland Adopt Terms of Reference (to be confirmed by Consortium) Include a membership of representatives from all oral health providers in Gippsland, other associate memberships will be included as deemed appropriate (private dentist, University partners, commonwealth partners) Engage project worker /manager to implement decisions and coordinate network Meet at least b-monthly (may need to be monthly in initial establishment phase) Responsible for the prioritisation and implementation of the Gippsland Oral Health Action Plan Provide a chair from Latrobe Community Health Service for the Consortium at the outset Accountability for the implementation of the plan to be assumed by the chair The Consortium shall be responsible to the GHSP in a manner to be determined	Oral Health Task Group DHSV and Dental Health Branch	Imperative/ High priority First meeting July 2008
2. Appoint a Project Worker/Manager to The Gippsland Oral Health Consortium to coordinate and facilitate the decisions of the consortium	Appointment of this position to be undertaken by the Gippsland Oral Health Consortium within three months Responsible to the Oral Health Consortium Position description includes the coordination and implementation of decisions from the Oral Health Action Plan Provide a conduit for communication Develop and present a business case to DHSV on the benefits of supporting such a position Identify opportunities to redirect resources already available across dental services in the region to support the establishment of this position	Gippsland Oral Health Consortium	September 2008
3. Ensure ongoing support to agencies to complete the transmission of business embedded in the principles of the integration process across Gippsland in partnership with DHSV	Completion of the transmission of business required in the integration process is a high priority for the Consortium Prioritise actions that ensure integration of oral health operational processes (See Integration Action Plan for details)	Consortium DHSV Dental Health Branch	Imperative/ High priority July 2008

Priority Action	Actions	Responsible Identity	Timeframe/ priority
4. Ensure that standardised clinical practice guidelines are developed and available across the region in partnership with DHSV	Develop common practice guidelines to be available to agencies across the region Develop common guidelines for the newly integrated SDP and CPD (currently operating with different guidelines) Identify the guidelines required (New integrated guidelines and update of existing guidelines) Determine a schedule for the development and implementation of common clinical guidelines (within three months) Access expert advice to ensure that clinical practice guidelines are based on best practice principles	Consortium DHSV	Important/ Med Priority Complete within 12 months
5. Develop a credentialing process within 12 months to be available for use across the region in partnership with DHSV and DHS	Ensure that all dental officers and clinicians are credentialed to provide dental services Availability of a credentialing process within 12 months Consider the credentialing of private oral health providers utilised in public oral health services Develop a common approach to credentialing across Gippsland	Consortium DHSV Dental Health Branch	Important/ High Priority Complete within 12 months
Access 6. Reduce the wait time for access to public oral health services uniformly across the region to a maximum of 23 months for general and prosthetic care	Re-evaluation of the target by the Consortium once the target is achieved and establish a new target time Divert resources to areas of need to manage the wait list and ensure equity f access across the region Prioritise infrastructure redevelopment in the areas where wait lists are lengthy (Central Gippsland and Latrobe Community Health) Continue to explore the factors that affect the access to oral health services	Consortium	Important/ High Priority Complete within 12 months
7. Maximize the chair capacity across all planning areas	Support the full utilisation of current fixed model operating in Gippsland Ensure infrastructure meets requirements for service delivery Develop the workforce to ensure that adults and children are able to be treated in any chair in the region	Consortium	Important/ High Priority Complete within 12 months

Priority Action	Actions	Responsible Identity	Timeframe/ priority
8. Develop an outreach model to be implemented for Commonwealth and other chairs	Ensure that the model is based on the need to manage wait list and school recall Partnership between public dental provider and other entity based on the ability to provide a timely service, and to manage wait list and school recall Options are: - Public dental service purchases entire service - Public dental services rents chair time and provides the staff to operate the chair Develop a payment model for this service (local provider) Consider the following issues: - Ongoing capacity of the district or local public oral health service to provide staff to an outreach site if renting chair time - Coordination of service will require engagement of district and local providers particularly if more than one provider utilises a Commonwealth site	CGHS BRHS GEGAC Ramahyuck Yarram and other services	Important/ Med Priority Complete within 6 months
9. Utilise other chair types for preventative and oral health activities	Utilise the podiatry chairs within the region to increase the focus on oral health promotion Ensure the Consortium has a role in the development and promotion of this option (preventative and health promotion) Identify capacity to undertake preventative dental care in other chair types Develop the workforce to support this initiative (requirement for dental hygienist) Ensure that the Consortium becomes a aware of the location of podiatry or other chairs (currently available at Lochsport, Rosedale)	Consortium District Services	Requirement/ Low Priority
Efficiency and Quality of Care 10. Reduce the wait time for access to public oral health services uniformly across the region to a maximum of 23 months for general and prosthetic care	Maintain wait list management at the district and local level (facility) Reduce the wait time across the region to meet the acceptable time of two years Investigate innovative approaches to management of wait list, opportunity to increase hours of operation, student chair models, triage management, employment of private dental time	Consortium District Local	Imperative/ High Priority 12 months

Priority Action	Actions	Responsible Identity	Timeframe/ priority
11. Ensure that the SDP recall system becomes part of the service system at a district and local level	Ensure that the SDP recall is managed at the district and local level Identify outstanding additional requirements of the integrated dental service to provide this service	Local and District	Imperative/ High Priority 3 months
12. Ensure that the integrated service model is supported to allow access to both adults and children at any dental chair in Gippsland	Ensure that all staff are supported to manage oral health treatments and restoration across the population Investigate and develop teaching and or supervision opportunities for staff Actively discuss the issue of isolation of small satellite services (i.e. Warragul) currently providing school dental where collocation is not initially scheduled in relation to: - Support and supervision of staff	Consortium LCHS CGHS	Imperative/ High Priority 6 months
13. Develop common solutions to the management of day-to-day operational issues common to all oral health clinics	Identify opportunities to have common practices across the region - Triage management - Management of 'no shows' of 'fail to attend' - Treatment of emergency treatments - Use of vouchers or private dental clinicians; - Complaints and feedback - Management of workforce including acceptable times for set-up and meal breaks	Local and District	Imperative/ High Priority 6 months
14. Engage the private dental practitioners in the plan for the management of the public oral health services	Ensure Consortium takes a lead role in the identification of capacity in the private system to undertake public oral health work Provide the conduit (Consortium Manager) for discussions of potential options Investigate the opportunity to employ a private dentist for a defined period of time in the provision of public oral health work in order to have immediate impact on the public wait list; - Contracted number of sessions; - Defined period of time and then evaluated; and - Provided at private oral health clinic	Consortium	Important/ Med priority

Priority Action	Actions	Responsible Identity	Timeframe/ priority
Models of Care			
15. Ensure the continued support for a preferred model of care based on fixed chairs	Develop Models of care in correlation with development of workforce - First priority is the utilisation of the current capacity of the Fixed Chair Model Take a lead role in providing support to service providers in the development of strategies Establish the utilisation rate of chairs within each catchment (currently incomplete) Aim to increase workforce to maintain fulltime capacity of chair (where identified need) Implement strategies to increase utilisation and reduce wait list include: Increase the hours of operation of chairs (where workforce in available) Actively divert resources to areas that require additional hours to manage wait lists where chair capacity is only limited by lack of workforce Increase utilisation of chair by 'renting' out time to 'private' providers Support integrated workforce to ensure efficiency in oral health care (dental therapist to be supported in extended scope of practice initiatives which need to be planned, coordinated and supervised)	Consortium District and Local	Important/ Med priority 6 months
16. Develop a service structure that ensures capacity of each fixed chair is optimized according to the identified needs of each area	Identify where capacity is required (to manage wait lists and school recall) Identify the issues with achieving capacity (workforce, infrastructure) Prioritise the action required against the need to manage wait list (in some areas wait list is not lengthy and infrastructure is not operating at capacity)	District Consortium support	Imperative/ High Priority 3 months (plan)
17. Develop outreach service models to support access to services for children, indigenous and high needs groups	Ensure District and Local providers are involved in the development of the model with Consortium and DHSV support Plan for the Outreach model will be developed within 6 months of the commencement of the Gippsland Oral Health Consortium; - Output funding would need to be within the capped budget via the existing funding formula - Utilisation and productivity of the fixed chairs is not adversely affected Outreach services shall be used to ensure priority access to manage access for children and special needs groups	District and Local providers DHSV	Imperative/ High priority 6 months

Priority Action	Actions	Responsible Identity	Timeframe/ priority
	Develop a single outreach model within each planning catchment for: - Use of Commonwealth chairs (indigenous); - Use other Commonwealth chairs (other health services) Ensure all providers enter into collaborative discussions with outreach site; Ensure that a memorandum of understating is developed between all health services involved; Ensure sustainability is the underpinning principle of the arrangement hence local and district providers should in the first instance develop a model based on renting chair time and providing staff to outreach site; Decide hours of service will be decided as a collaborative agreement; Direct funding for outreach service to local or district provider		
18. Develop further processes that are able to ensure utilisation of chairs is in accordance with established identified needs	Identify areas based on need to manage wait list and provide services to high needs and prioritised groups Identify available resources that may be diverted from other planning catchments Identify timeframe for diversion Develop indicators for monitoring and measuring achievements	Consortium	Imperative/ High Priority 3 months (plan)
19. Ensure that integration results in efficiency of service, adequate management of wait lists and school dental recall	Identify the resources to manage both wait list and school recall Identify additional financial support required through a regional approach Document requirement and submit to DHSV once identified as a regional issue	District Consortium support	Imperative/ High Priority 3 months (plan)
Infrastructure 20. Plan for the upgrade of the facility at Bass Coast Regional Health to allow for the full use of the four chairs	Take a role with Bass Coast Regional Health in the planning for the upgrade of the Bass Coast Regional Health Dental facility to ensure availability of all four chairs Completion of plan within three month Ensure plan determines the timeframe for upgrade	Consortium BCRH	Imperative/ High Priority 3 months (plan)

Priority Action	Actions	Responsible Identity	Timeframe/ priority
21. Plan for relocation of School Dental Program to the Community Health Service in Warragul	Take a role with Latrobe Community Health Service in the planning for the relocation of the School Dental Program at Warragul to the Community Health Service. Work with west Gippsland Healthcare Group throughout the relocation planning process Completion of plan within three months Ensure the plan determines the timeframe for upgrade	Consortium LCHS WGHG	Imperative/ High Priority 3 months (plan)
22. Completion of the upgrade and collocation of the services at Central Gippsland Health Service by early 2009	Support CGHS n the completion of the upgrade of the integrated oral health facility at CGHS (integrated SDP and CDP facility)	CGHS Consortium (support)	Important Early 2009
23. Plan for the upgrade of the integrated facility at Morwell	Take a role with Latrobe Community Health Service in the planning for the upgrade of the dental facility at Morwell Completion of plan within three months Ensure the plan determines the timeframe for upgrade	LCHS	Imperative/ High Priority 3 months (plan)
24. Develop a prosthetic laboratory service at Morwell as part of the planned capital development	Development of dental laboratory (feasibility regarding establishment) Explore opportunity to increase capital development (and associated funding) at the Morwell site	Consortium LCH	Imperative/ High Priority
25. Plan for the gradual upgrade of all state funded dental chairs to be determined within 12 months	Complete an inventory list for upgrade of dental chairs across the region to ensure that capacity of chair is realised Develop plan within 12 months Source funding for required upgrade from DHSV	Consortium (Manager) District	Important/ Med Priority
Oral Health Promotion 26. Ensure oral health promotion is part of the core business of all health care services in Gippsland	Ensure oral health promotion becomes part of the care provided by restorative oral health teams during chair side treatment Ensure that oral health promotion becomes part of all health service health promotion activities (Consortium Manager to engage with acute health service health promotion teams) Adopt and further develop the Commonwealth Teen Dental program to ensure it is available across the region	District Local	Imperative/ High Priority

Priority Action	Actions	Responsible Identity	Timeframe/ priority
	Further develop the Smiles4Miles and Teeth and tummy health promotion initiatives to ensure that the clinical oral health staff are central to these activities		
27. Implement alternate models of care in preventative care rather than restorative (dental hygienist)	Investigate the benefits of dental hygienist in each planning area Develop appropriate resources in the workforce	Consortium	Important/ Med Priority
28. Develop and submit a region wide oral health promotion program to be managed by the Gippsland Oral Health Consortium	Work with local government to ensure all oral health promotion opportunities are maximised without duplication Ensure that the Consortium Manager is the vehicle for this engagement Link Gippsland Oral Health Consortium with PCPs and Community Health Encourage ongoing involvement in health promotion activities such as 'Smiles 4 Miles' and the 'Teeth and Tummy' projects	Consortium	Imperative/ High Priority
29. Develop a business case for the ongoing funding of oral health promotion staff who will be located in Health promotion teams but linked to oral health programs	Promote the engagement of dedicated oral health promotion workers embedded in the catchment Health Promotion team with dedicated links to the Oral Health program Seek ongoing funding for the health promotion roles from DHSV	DHSV DHS	Imperative/ High Priority
30. Support the completion of fluoridation across Gippsland	Support process for the completion of fluoridation across Gippsland	DHSV DHS	Imperative/ High Priority
31. Actively work with the acute health teams to further reduce the oral health and dental related ACSC admissions to hospital	Develop relationship with acute health services to further investigate the causes of hospital admissions for ACSC Identify target for further reduction Ensure Consortium Manager is involved in this priority action	Consortium	Imperative/ High Priority

Priority Action	Actions	Responsible Identity	Timeframe/ priority
Workforce			
32. Develop a workforce plan aligned to the statewide oral health workforce development strategy from DHSV to identify the areas of greatest workforce needs in each planning catchment.	Develop a workforce plan for the ongoing recruitment and retention of the oral health workforce in Gippsland. This plan should be based on the principles of: ***1. Providing appropriate dental health professionals for existing services*** ***2. Building self sufficiency within the region by developing own dental workforce (promotion of training)*** ***3. Prioritise the areas with the longest waitlists in relation to recruitment*** ***4. Consideration for a workforce that supports preventative oral health*** Determine the pool of resources currently available Determine the resources required in each catchment (according to resources per current chair) Identify the gaps in general workforce Determine the mix required in each catchment with a balance between preventative and restorative care for general chairs Identify the workforce required to support training chairs in each catchment Identify the workforce required to increase current service provision and create new models of care Identify the specialist workforce required within the region - location of specialist and mechanism required to share this resource across the region Identify opportunities to work constructively with private dentists to maximise opportunities to encourage new dental staff to the region Establish the need for dental hygienist model to be implemented within a preventative paradigm: - Establish model that is supported in each planning area - Provision of oral hygiene in residential aged care, to homeless and younger persons in community with referral pathway established to restorative dental care - Hygienists to utilise the podiatry chairs available within planning areas	Consortium (Manager)	Imperative/ High Priority 6 months
33. Support the development of a clinical network for oral health clinicians in Gippsland (private and public clinicians)	Develop a vehicle to engage with both private and public oral health practitioners across the region Develop professional development forums for all staff Engage with the Australia Dental association with a joint approach	Consortium	Important/ High Priority 12 months

Priority Action	Actions	Responsible Identity	Timeframe/ priority
34. Ensure that the oral health workforce is working to their full potential by providing opportunities for supervision and mentoring of all oral health staff to provide oral health care across all ages	Ensure that all oral health staff are supervised and mentored to enable the full capacity of the workforce to be realised Identify training and supervision requirements across the region for all level of staff	Consortium	Imperative/ High Priority
35. Ensure a regional approach to the management and educational opportunities for Gippsland	Collaborative partnerships with the University to be established to assist in the management of workforce issues Ensure training is managed and coordinated by LCHS Ensure dedicated training chairs are supported in two agencies within the region (LCHS and BRHS) Investigate the options for training opportunities at other district and local providers Commence dedicated training chairs at equivalent of two chairs (1 chair in East Gippsland and one chair in Central West) Increase dedicated training to equivalent of 5 chairs within 12 months	LCHS BRHS Melbourne University DHSV	Important/ High Priority 12 months
36. Increase the recruitment potential of oral health clinicians by maximizing the opportunities created by the 'Filling the Gaps' submission; and	Ensure that the Consortium utilised the opportunity of the Filling the Gaps subs=mission to develop a specialist oral health workforce in Gippsland	Consortium	Imperative/ High Priority
37. Support the development of an indigenous dental workforce by providing opportunities for teaching and supervision	Identify demand and interest Develop a program of supervision and support	Consortia BRHS GEGAC Ramahyuck	Requirement/ Low priority

Appendix 1 - Membership of Dental Health Services Task Group

Name	Position/Organisation
Ben Leigh (Chair)	CEO, Latrobe Community Health Service
Felix Pintado	Chief Executive, Dental Health Services Victoria
Trevor Adem	CEO, Omeo District Health
Ali Khan	CEO, Ramahyuck District Aboriginal Corporation
Brendan Coulton	Deputy CEO, Orbost Regional Health
Sajeev Koshy	Director of Dental Services, Bairnsdale Regional Health Service (Resigned May 2008)
Mandy Pusmucans	Director of Community Services, Central Gippsland Health Service
Ruth Churchill	Manager of Community Health, Central Gippsland Health Service
Kaye Beaton	Director of Community Services, Bass Coast Regional Health
Bill Davidson	Oral Health Services Manager, Eastern and Gippsland, Dental Health Services Victoria
Professor Mike Morgan	School of Dental Health - University of Melbourne
Glenn Becher	A/ Director of Allied and Community Health Services, Bairnsdale Regional Health Service
Greg Blakeley	Manager Health, Department of Human Services, Gippsland
Catherine James	Manager Dental Health, Department of Human Services
Keith Sutton	Team Leader Primary and Mental Health, Department of Human Services, Gippsland
Paul Butler	Manager Health, Disability and Aged Care, Department of Human Services, Gippsland
Lorraine Parsons	Director of Community Services, Bairnsdale Regional Health Service

Appendix 2 - Individuals consulted

Name	Position/Organisation
Trevor Adem	CEO, Omeo District Health
Ali Kahn	CEO, Ramahyuck District Aboriginal Corporation
Brendan Coulton	Deputy CEO, Orbost Regional Health
Terese Tierney	CEO, Orbost Regional Health
Private Dentists Sale	Sale
Sajeev Koshy	Director of Dental Services, Bairnsdale Regional Health Service
Judy Browning	Gippsland and East Gippsland Aboriginal Cooperative
Kaye Beaton	Director of Community Services, Bass Coast Regional Health
Lorraine Parsons	BRHS
Leigh Gibson	Director Primary Care, Goulburn Valley Health
David Whelan	Dental Officer, Goulburn Valley Health
Helen Matheson	Manager, Community Dental Services, Goulburn Valley Health
Mandy Pusmucans	Director of Community Services, Central Gippsland Health Service
Ruth Churchill	Manager of Community Health, Central Gippsland Health Service
Maureen Williams	Manager, Inner South Community Health Service
Tracie Andrews	General Manager Oral Health Services, DHSV
Bill Davidson	Manager, Oral Health Services, eastern and Gippsland, DHSV
Denise Harrison	Manager, Clinical & Service Quality, Knox Community Health

Appendix 3 - Workforce and EFT

LGA	Location	Workforce	EFT
South Coast	Bass Coast (CDP)	Dental Officer Dental Assistant Support Staff	1.6 3.25 1
	Bass Coast (SDS)	School Dental Therapist School Dental Nurse	1 1
Central West	Warragul (SDS)	Dental Therapist Dental Officer Dental Assistant	1.6 0.2 1.8
	Moe (SDS)	Dental Therapist Dental Officer Dental Assistant	1.2 0.15 1.47
	Morwell (SDS)	Dental Therapist Dental Assistant	1.2 1.07
	Moe/Churchill (CDP)	Dental Officer Dental Assistant Support Staff Prosthetist	3.6 4.8 2.8 1.0
Wellington	Central Gippsland (SDS)	Dental Therapist Dental Assistant	0.57 0.59
	Central Gippsland (CDP) As of 1st July 2008	Senior Dental Officer Dental Officer Dental Assistant Dental Therapist Support Staff Dental Technician	0.2 3 3.8 0.6 2 1
	Ramahyuck		
East Gippsland	Bairnsdale (CDP)	Dental Officer Dental Assistant Support Staff	3.5 5 2
	Bairnsdale (SDS)	School Dental Therapist Dental Officer Dental Assistant Dental Health Promotion Officer	0.71 0.1 0.85 1
	Omeo	Dental Officer Dental Assistant Support Staff	0.14 0.2 0.2
	Orbost	Dental Officer Dental Assistant	0.89 3
	Mallacoota		
	GEGAC	Dental Officer Dental Therapist	0.8 n/a

Appendix 4 - Hours of Operation of Clinics

LGA	Location	Hours of Operation	Total Hours Patient in Chair/day
South Coast	Bass Coast (CDP)	08:00 - 16:15 (Monday - Thursday) 08:00 14:00 (Friday)	6 hours 15 mins 4 hours
	Bass Coast (SDS)	08:00 - 16:21 (Monday - Thursday) 08:00 - 14:00 (Friday) Only 1 chair used for SDS	6 hours 15 mins 4 hours
Central West	Warragul (SDS)	08:00 - 16:21(Mon, Tues, Thurs, Fri) 08:15 - 16:36 (Wednesday)	6 hours 15 mins
	Moe (SDS)	08:15 - 16:36 (Monday - Thursday) Only 1 chair used	5 hour 30 mins
	Moe (CDP)	08:15 - 16:45 (Monday - Friday)	6 hrs 45 mins 4 chairs
	Morwell (SDS) Churchill (CDP)	08:15 - 16:36 (Monday - Thursday) Chairs not at capacity 08:15 - 16:45 (Monday - Friday)	5 hours 30 mins 6 hrs 2 chairs
Wellington	Sale (SDS)	08:30 - 16:45 (Tues, Thurs)	6 hours 30 mins
	Sale (CDP)	08:00 - 16:00 (Monday - Friday)	6 hours
East Gippsland	Bairnsdale (CDP)	Mon - Friday (9 hours)	6 hours 15 mins
	Bairnsdale (SDS)	08:15 - 16:36 (Mon, Wed, Thurs) 08:45 - 15:00 (Fri)	6 hours 15 mins 4 hours 30 mins
	Omeo	8 hours Monday and Friday every fortnight	6 hours 15 mins
	Orbost	07:30 -17:30 (Mon Week 1) 08:30 - 17:30 (Mon Week 2) 07:30 - 21:00 (Tues, Wed) 08:30 - 17;30 (Thurs Private and Public) 07:30 - 17-30 (Friday)	8 Hours 7 Hours 11.5 Hours 7 Hours 8 Hours

The hours of operation for the Commonwealth funded chairs are not included.

Appendix 5 - Infrastructure

LGA	Location	Building	Chairs
South Coast	Wonthaggi (CDP)	Collocated	Adec (adjustable)
	Wonthaggi (SDS)	Collocated	Adec (adjustable) one chair cannot be utilised
Central West	Warragul (SDS)	Located at School Plan for relocation to Community Health Centre	2 Belmont Paediatric Chairs Right Handed
	Moe (SDS)		2 Adec Chairs Right handed (unsure capacity to seat an adult)
	Moe (CPD)	Plan for redevelopment at LCHS	2 Adec Chairs Right handed (no Adjustment) 1 Adec Chair (Adjustable) 1 Midmark Chair (Adjustable) - suitable for heavy capacity
	Churchill (CDP)		2 Adec Chairs Right handed (no Adjustment)
	Morwell (SDS)	Plan for redevelopment at LCHS	2 Belmont Paediatric Chairs Right Handed
Wellington	Central Gippsland (SDS)	Plan for collocation currently poor facility Will be collocated at CGHS	2 Belmont Paediatric Chairs Right Handed
	Central Gippsland (CDP)	Plan for collocation currently poor facility Will be located at CGHS 4 new chairs (adult will be included in new facility) all adult, all adjustable	Adec Right Handed
East Gippsland	Bairnsdale (CDP)	Collocated with SDS at BRHS	Adec (adjustable with assistance)
	Bairnsdale (SDS)	Collocated with CDP at BRHS	Adec (adjustable with assistance)
	Omeo	Located at Omeo District Health Service	N/A
	Orbost	Located at Orbost Regional Health Service	Adec Right handed adjustable

The chair types for the Commonwealth funded chairs are not included.

Appendix 6 - Example Terms of Reference for Gippsland Oral Health Consortium

1. **Function of the Consortium:**
   - Work with agencies to drive the implementation of the Improving Victoria's oral health policy across the region;
   - Facilitate the integration of the School and community dental programs;
   - Ensure the services work together to optimise the community's access to quality dental services; and
   - Enable more efficient and cooperative use of resources whilst supporting an integrated approach to patient care.
2. **Role: The Gippsland Oral Health Consortium shall be the coordinating body of the GHSP for oral health within Gippsland.**
   - Regional planning;
   - Coordination of care across the region;
   - Prioritise the actions that will ensure the absolute integration of services in Gippsland;
   - Advise DHS and DHSV about priorities for future service development (this will include capital expenditure);
   - Communication and capacity building;
   - Governance and credentialing;
   - Development of common Standards of care; and
   - Alignment o the regional direction with DHS and DHSV policy.
3. **Responsibilities**
   - Nominate a health service to be the fund holder (LCHS);
   - Elect a consortium chair (LCHS);
   - Appoint and manage consortium manager;
   - Progress the regional action plan as agreed by consortium members;
   - Establish and manage consortium executive group;
   - Establish and manage clinical practitioners group;
   - Develop and implement clinical practice standards as required;
   - Facilitate effective communication processes between key stakeholders;
   - Link with specialist services and academic units on relevant issues;
   - Maintain a relationship with DHS and DHSV; and
   - Seek advice from clinical experts as required.
4. **Membership**
   - A minimum of one representative from each of the oral health service providers in the region;
   - Representative is either the CEO or has delegated authority granted by CEO for decision making;
   - At least one senior clinical oral health practitioner from an agency in the region;
   - One vote per funded agency;
   - A representative from the departmental regional office;
   - A representative from DHSV;
   - Any other service providers / stakeholders which the consortium nominates as having key relevance to the roles and responsibilities of the consortium;
   - Meet the minimum of 6 times per annum (expected to be more frequent during the establishment phase); and
   - The Consortium Manager will attend meetings to provide executive support and advice but will not hold a position as a voting member of the Consortium.
5. **Communication/Relationship with other Groups**
   - GHSP - it is the decision making arm for the GHSP on Oral Health in Gippsland;
   - Receive/supply bi monthly updates to DHS and DHSV;
   - Receive updates on statewide meetings via chair / consortium manager;
   - Link with Academic units and statewide services as required on particular issues; and
   - Consortium will consult with specialist services and academic units as appropriate.

The following Role Statements have been included for consideration:

A. Gippsland Oral Health Consortium Chair

Role

- Demonstrate a commitment to oral health services and champion oral health issues in the region;
- Chair consortium meetings effectively;
- Liaise directly with the DHS and DHSV on behalf of the consortium;
- Act in the best interest of all members of the consortium; and
- Liaise with consortium members.

Responsibilities

- Ensure that the implementation of the action plan is progressed in the region;
- Ensure that reports are provided to DHS on the progress of the action plan; and
- Represent the consortium at statewide meetings;

Structure

- Elected by the consortium - 2-year term.

Communication/Relationship with other Groups

- Receive and action strategic/policy level communication from DHS and DHSV;
- Monthly updates;
- Attend all statewide oral health meetings; and
- Communicate with Consortium manager regularly.

B. Gippsland Oral Health Consortium Manager (if position adopted)

Role

- Promote the change required in the region to achieve the implementation of the Oral Health Action Program;
- Take a lead role in undertaking strategic planning on behalf of the consortium;
- Knowledge management of the oral health consortium;
- Information management;
- Relationship building and management
- Build the relevance and effectiveness of the consortium for all members; and
- Act as a resource for the consortium.

Responsibilities

- Provide strategic advice re priorities for the consortium;
- Manage projects related to the implementation of the regional action plan;
- Coordinate the agenda for the consortium meetings;
- Manage the day to day operations of the consortium;
- Be a conduit for communications between the DHS and DHSV ad the consortium.
- Evaluate the implementation of initiatives undertaken by the consortium; and
- Keep abreast of oral health issues at a state and national level.

Structure

- Standard position description to be adopted for managers; and
- Position Description will identify the expected outcomes to be achieved by the consortium manager

Communication/Relationship with other Groups

- Day to day management communication from DHS and DHSV;
- Monthly updates;
- Attend all statewide oral health meetings;
- Attend statewide oral health meetings; and
- Communicate with Consortia members.

Appendix 7 - Glossary of Terms and Acronyms

Term	
ACCHO	Aboriginal Controlled Health Organisations
ACSCs	Ambulatory Care Sensitive Conditions
BCRH	Bass Coast Regional Health
BRHS	Bairnsdale Regional Health Service
CDP	Community Dental Program
CGHS	Central Gippsland Health Service
CinYC	Care in Your Community
CH	Community Health
DHS	Department of Human Services
DHSV	Dental Health Services Victoria
GEGAC	Gippsland and East Gippsland Aboriginal Cooperative
GHSP	Gippsland Health Services Partnership
LCHS	Latrobe Community Health Service
LGA	Local Government Area
MoC	Model of Care
ODH	Omeo District Hospital
ORH	Orbost Regional Health
PCP	Primary Care Partnerships
SDP	School Dental Program
SDS	School Dental Service
SEIFA	Socio-economic indexes for area

Appendix 8 - Policy frameworks

DHS, January 2006, *Care in your community: a planning framework for integrated ambulatory health care.*

DHS, Rural and Regional Health Services Branch, Rural and Regional Health and Aged Care Services, November 2005, *Rural directions for a better state of health.*

DHS, Primary and Community Health Branch 2007 *Improving Victoria's Oral Health.*

Dental Health Services Victoria (DHSV) 2005, *Oral Health Strategic Plan and Service Plan for Victoria 2005 - 2010,* Dental Health Services Victoria.

State Government Victoria
Department of Human Services