Department of Health

health

Southern Metropolitan Region oral health plan 2012–2016

State Government Victoria

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Acknowledgments

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Contents

Executive summary

The *Southern Metropolitan Region oral health plan* provides a four-year framework for developing community dental services in the region. Building on a history of collaboration, the services will work together to implement a series of actions (described in section 10) with the aims of: improving access for people with complex health needs; improving coordination between services; strengthening the workforce; and increasing preventative efforts to improve oral health across the region.

Under the direction of a project steering group, the plan is a culmination of work undertaken over the past year and the result of the input of many stakeholders. The project methodology included: extensive consultation with the five community dental services, Dental Health Services Victoria (DHSV), the Department of Health, consumers and external stakeholders; a review of relevant policy and key directions; analysis of relevant demographic and service uptake data; and ongoing input from the project steering group. Section 2 of the plan provides an overview of the five Southern Metropolitan Region (SMR) community dental services and key points of note regarding their local areas and communities. Section 3 summarises the findings from consultations with all stakeholders.

Southern Metropolitan Region Oral Health Network

A key objective of the planning process was to consider and clarify options for governance, leadership and organisational roles to maximise resources and strengthen linkages and supports between oral health services. Discussion with the project steering group identified considerable commitment to a continued network and ongoing collaboration, building service capacity and working together to meet identified oral health needs. Establishing the Southern Metropolitan Region Oral Health Network (SMROHN) to drive this process is action 1.1. The SMROHN will also be active in influencing and advising broader oral health planning across a range of other health planning processes including the new Medicare Locals.

Key themes and actions

The project identified several key themes, which were considered when developing the agreed actions.

Dental service access and demand

Demand for dental services and resulting waiting lists are higher in the Mornington Peninsula area and the South East than the inner subregions. ‘Load sharing’ approaches have been adopted where services with shorter waiting lists provide access to general appointments to people on longer waiting lists at Southern Health and Peninsula Health Community Health (PHCH). SMROHN members agreed that an opportunity exists to broaden and formalise this approach across the SMR.

The services are also dealing with significant numbers of failures to attend (FTAs) despite developing strategies to minimise their occurrence. Southern Health completed several pilot projects in 2010, with the aim of better managing demand and reducing FTAs. SMROHN members agreed it would be valuable to consider learnings from the work undertaken by Southern Health and apply these more broadly.

SMROHN members also commented on the opportunity provided by the plan to build a shared regional process for access to community dental services. Oral health consumers would then be presented with the same eligibility criteria, information and service referral processes, regardless of where they initially present. The viability of a central intake number was also discussed.

Service coordination and integration

The coordination and integration of dental services is at different stages for each of the SMR services, from very well integrated (established referral practices and pathways in both directions, particularly for people with chronic health issues) to very little integration and minimal understanding of primary health services by oral health staff and vice versa.

A range of pilot projects and other service coordination/integration strategies have been developed by some SMROHN member agencies. Actions 3.1 and 3.2 state that SMROHN member agencies will review outcomes from all projects, with a view to implementing shared practices to build service coordination and integration capacity across the region.

Priority and special needs groups

The access of priority and special needs groups to dental services is well developed in some areas, for example, with Aboriginal people and supported residential services residents at Inner South Community Health Service, people with mental health issues at PHCH and refugees at Southern Health. Several actions contained in section 7 are concerned with reviewing existing, effective practices and developing standardised region-wide approaches and practice to promote equitable access among priority and special needs group.

Oral health promotion

Recent policy highlights an increasing emphasis on establishing settings and developing approaches for health prevention and promotion including oral health promotion (OHP). SMROHN members are keen to work on shared OHP activities and in particular a region-wide OHP activity targeting children because the numbers of children are increasing and large numbers of children with dental ambulatory care sensitive conditions reside in the outer regions of the SMR. SMROHN members also recognise that they have a responsibility and role in advancing oral health knowledge, expertise and practices in other sectors and as part of their role in influencing other broader planning processes.

Oral health workforce

A central issue noted by all SMR community dental services is attracting and retaining (predominately dental assistants) staff. Dental assistants also have the highest absentee rates. Opportunities exist, as an outcome of the planning process, to strengthen and support the oral health workforce and develop and participate in shared subregional, regional and statewide workforce action plans for recruitment, retention and training and development. This includes accessing continuing professional development programs (including those offered by DHSV and Southern Health) and the participation of SMR community dental services in the federal and state programs to engage with new graduates and provide them with experience in the community dental service system.

1. Introduction

1.1 Overview and aim

Providing timely and effective oral health services is a significant contributor in promoting the health, wellbeing and independence of oral health service consumers. Oral health service development, including integrated oral health service models, is a key focus of various government directions in recent times.

> 'Oral health is fundamental to overall health, well-being and quality of life.'[1]

Five organisations provide dental services in the Southern Metropolitan Region (SMR):

- Bentleigh Bayside Community Health (BBCH)
- Central Bayside Community Health Services (CBCHS)
- Inner South Community Health Service (ISCHS)
- Peninsula Health Community Heath (PHCH)
- Southern Health.

These services have taken some preliminary steps towards creating more integrated and accessible services through: aligning with statewide directions and integrating the School Dental Services with community dental services; promoting access through involvement in the Supported Residential Services (SRS) Oral Health Initiative; and intra-regional waiting list sharing.

Using a population-based health planning approach, the five organisations received funding through the Department of Health to work in collaboration and develop this four-year oral health plan. The aim of the planning process and resulting plan was to improve oral health service delivery to existing and potential consumers of community dental services.

The objectives of the plan are to:

- improve coordination and integration across and between services
- create better access to services, particularly for priority target groups
- strengthen and support the workforce
- develop a more integrated and planned approach regarding oral health promotion and regional oral health planning.

1.2 Methodology

The project was guided by a steering group comprising representatives of each SMR community dental service, the Department of Health, Dental Health Services Victoria (DHSV) and consumer representatives (see Appendix 1). The project methodology comprised the following steps.

Key policy and directions

A summary of key policy and directions and other factors of relevance to the plan are included in Appendix 2.

1 Department of Human Services 2007, *Improving Victoria's oral health*, State Government of Victoria, Melbourne.

Current oral health service models

Section 2 of the plan provides an overview of each SMR community dental service and lists key points and demographic factors of note regarding that service and catchment area.

Extensive consultation

- Consultation with community dental services (listed in Appendix 3)
- Consultation with a range of external stakeholders including community health programs; local government; divisions of general practice; services that work with culturally and linguistically diverse (CALD) and refugee communities; services that work with Aboriginal people; youth services; the Department of Health; DHSV; and the Department of Human Services (listed in Appendix 4)
- Consultation with consumers and SRS staff.

Section 3 provides a summary of the key findings from the consultation phase of the project.

Data analysis – demographic and oral health service delivery

A demographic overview of the SMR data (as it relates to the development of the plan) is provided in Appendix 5.

An overview and discussion of relevant oral health service provision data and other related data is included in Appendix 6.

Development of the action plan

The steering group met regularly over the term of the project to discuss project findings and in later stages develop actions that will: improve oral health service delivery to existing and potential consumers (including priority groups); improve SMR oral health service coordination and integration; drive and support the oral health workforce; and continue the collegiate and collaborative approach to oral health service planning and development in the SMR. This is covered in sections 4–9, with the resulting actions formalised in section 10: Action plan.

2. SMR community dental services

This section provides an overview of the five SMR community dental services and key points of note regarding their local areas and communities. The SMR is home to significant populations of eligible and priority consumer groups with complex needs. This is discussed further in section 7.

Access to services and length of wait times is variable across the SMR, with the inner region services, BBCH, CBCHS and ISCHS having current waiting lists well below benchmarks. Publicly available waiting list data shows that outer region services, PHCH and Southern Health, have much longer waiting lists, particularly for denture services.[2] Representatives from these two services report that this is an ongoing issue.

It is important to note, however, that the waiting list only reflects the number of people who have sought access to community dental services, not the actual eligible population. There is a gap between the number of people who are eligible and the number of people who have sought treatment or are on waiting lists. Not all eligible people will seek treatment and realistically it is beyond the capacity of the services to provide direct treatment to the total eligible population. It is relevant, however, when considering early intervention and oral health promotion aspects, which are discussed in other parts of this report.

2 Victorian health service performance data website, June 2011

2.1 SMR dental services overview

	BBCH	CBCHS	ISCHS	PHCH	SH
Chairs	7 (all in one location)	8 (all in one location)	8 (4 in South Melbourne, 4 in Prahran)	18 (4 in Hastings, 4 in Rosebud, 10 in Frankston)	24 (4 in Dandenong Thomas St, 2 in David St, 5 in Springvale, 8 in Cranbourne, 2 in Pakenham, 2 in Berwick, 1 in Kingston Centre)
Staffing	Dental officers Dental therapists Dental hygienist Dental prosthetist Dental assistants Receptionist	Dental officers Dental therapists Dental technician Dental assistants Receptionist	Dental officers Dental therapists Dental hygienist Dental prosthetist Dental assistants Receptionist	Dental officers Dental therapists Dental prosthetist Dental assistants Dental technician Receptionist	Dental officers Dental therapists Dental hygienist Dental assistants Receptionist
Students	No	No	Undergraduate clinic in past; postgraduate special needs clinic ongoing	Dental prosthetist	Limited student observation experience offered
2010–11 individuals treated	7,323	6,662	6,222	17,810	26,007
2010–11 visits	19,065	17,238	17,544	37,825	62,002
2010–11 courses of care	11,176	8,714	8,649	23,770	35,552

2.2 SMR dental services profile

Bentleigh Bayside Community Health

BBCH is located in East Bentleigh and provides services in the City of Bayside and the lower half of the City of Glen Eira.

BBCH provides services to people who reside in Glen Eira and Bayside. While these areas do not have the projected growth in population of the outer areas of SMR, they have higher percentages of people aged over 65 than SMR and Victoria. There are also some pockets of disadvantage in both local government authorities (LGAs); particularly in relation to the Office of Housing estates located in these areas.

BBCH is in the enviable position of having a small waiting list for oral health services. It is currently offering appointments (load sharing) to people on the PHCH and Southern Health waiting lists (this is described in more detail in section 5). The BBCH recall rate for high-risk children is one of the highest in the state. It has also developed a range of outreach services to children in schools.

Central Bayside Community Health Services

Based in the City of Kingston, this community dental service operates from one site located in Parkdale.

Similarly to Bayside and Glen Eira, Kingston does not have the projected growth in population of the outer areas of SMR, but has a higher percentage of people aged 65 and over than SMR and Victoria.

A key issue for CBCHS is that the clinic, built in 1999, is in need of repairs and new equipment in some areas. CBCHS has access to a part-time on-site oral surgeon who will see clients from across the SMR. Staff also report well-established links with schools, which provides annual information about the oral health service.

Inner South Community Health Service

ISCHS delivers community dental services in the cities of Port Philip, Stonnington and Glen Eira (plus some services are statewide). The oral health program operates across two sites in Prahran and South Melbourne.

In Port Phillip, 14.2 people per 1,000 registered as mental health clients in 2009–10, which is well above the state figure of 11.2 per 1,000 people.[3] ISCHS is well known for its outreach service approaches for people with alcohol and/or drug and mental health issues, people with HIV and people who are homeless. This includes outreach work in SRS and rooming houses.

ISCHS have strong connections with services for Aboriginal people and well-developed links with local preschools and schools for oral health screening and referring children to on-site services.

Peninsula Health Community Health

PHCH operates out of three sites (Frankston, Hastings and Rosebud) in the City of Frankston and Mornington Peninsula Shire.

The PHCH catchment contains identified locales of disadvantage, particularly Frankston, Rosebud and Hastings. PHCH covers a large geographical area and service access issues (such as limited transport options) exist for some of the eligible population.

In Frankston, 25 per cent of children aged under 16 years live in welfare-dependent or low-income families and 7.4 people per 1,000 sought treatment for alcohol and/or drug issues exceeding the state figure of 5.3. In addition, 13.1 people per 1,000 registered as mental health clients in 2009–10, which is above the state figure of 11.2 per 1,000 people.[4]

3 2009 Local Government Area Statistical Profiles. Modelling, GIS and Planning Products Unit. Department of Health.

4 2009 Local Government Area Statistical Profiles. Modelling, GIS and Planning Products Unit and Public Health Information Development Unit (PHIDU) Social Atlas, Department of Health

PHCH is one of the few services to provide the Smiles 4 Miles (S4M) program and works with a number of preschools providing health promotion and screening. Staff report well-developed links and effective client pathways with alcohol and drug services and innovative approaches to helping teenagers access oral health services.

Southern Health

The Southern Health dental services sit within the Ambulatory and Community Care Services division of Southern Health. They provide services in the City of Greater Dandenong, Shire of Cardinia and City of Casey, and also support a single-chair dental clinic based at Kingston Centre.

Southern Health's dental services are the largest service in the SMR (by number of chairs) and, not surprisingly, has the most clients and longest waiting lists. Population growth in the South East (Greater Dandenong, Casey and Cardinia) is projected to be 38.7 per cent (to 2022), an increase from 453,598 to 628,930 people. Currently the population in the City of Casey increases by nearly 120 people per week. These are also areas of noted disadvantage. More than 111,600 people who reside in the three LGAs are Health Care Card or Pensioner Concession Card recipients.[5]

Greater Dandenong, with over 61.5 per cent of the population from a non-English speaking country, is the most culturally diverse local government area in Victoria. In addition, significant numbers of refugees from Afghanistan, Sri Lanka, Sudan and Burma have settled in Greater Dandenong, with some now relocating to Casey.[6] Southern Health has large numbers of clients who are refugees and from CALD communities; costs for interpreter services are significant as a result.

In Greater Dandenong, a significant number (33 per cent) of children aged under 16 years live in welfare-dependant or low-income families. In Casey it is 19.4 per cent of children and, in Cardinia, 17 per cent. In addition, children comprise approximately 50 per cent of the eligible population in Casey and Cardinia.[7]

5 PHIDU Social Atlas
6 DIAC Settlement Database July 2008
7 PHIDU Social Atlas

3. Summary of consultation findings

SMR community dental services

The SMR community dental services were active partners in developing this plan. Dental health service staff were extensively consulted and representatives held key roles on the project steering group. Findings from consultations underpinned the development of the themes discussed in the following sections of this plan.

The following list summarises the main findings from consultation with SMR oral health services:

Waiting list demands

FTA rates high

Supporting access of priority groups

Limited access by teens

Increasing numbers of children

Children's OHP a need, S4M limited

Access to specialist and general anaesthetics

Service integration and coordination

Workforce issues

- Waiting list pressures are significant for PHCH and Southern Health, less so for BBCH, CBCHS and ISCHS.
- Most services are dealing with significant numbers of failures to attend (FTAs) and all have developed a range of practices with the aim of reducing and/or filling FTA appointments.
- The access of priority or special needs groups to community dental services is well developed in some areas such as SRS residents at ISCHS, people with mental health issues at Peninsula Health and refugees at Southern Health. This requires staff who are well trained to work with these groups, additional time for treatment, access to transport for some groups, and interpreters, all of which require resources.
- Community dental services are underutilised by teenagers. Strategies to promote their access are considered a priority.
- Most services currently have reasonable recall response rates of both high- and low-risk children for oral health treatment; however, the number of eligible children is projected to increase.
- Providing oral health promotion to families and children is often constrained due to resource issues; the availability of S4M is limited (see Appendix 6).
- Access to locally based general anaesthetic services is an issue cited by some, particularly in outer parts of the SMR where travel to The Royal Dental Hospital of Melbourne (RDHM) is an issue for some clients. Some of the other specialist services are offered more locally, for example, an oral surgeon at CBCHS. Maintaining local access to these services when specialists retire or take other roles will be important.
- The coordination and integration of dental services is at different stages for each of the SMR services, from very well integrated (established referral practices and pathways in both directions, particularly for people with chronic health issues) to very little integration and minimal understanding of primary health services by oral health staff and vice versa.
- A central issue for SMR agencies is attracting and retaining dental assistants who also have the highest absentee rates.
- Opportunities exist, as an outcome of the planning process, to strengthen and support: the oral health workforce; shared subregional or region-wide workforce development practices for recruitment; retention; training and development addressing absenteeism; and staff recognition programs.

Consumers

Consumer consultation was an essential part of the planning process. The project consultants attended consumer advisory group meetings at ISCHS, Southern Health and PHCH, and spoke with SRS proprietors at two Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) meetings. Generally speaking, consumers who had experienced the public oral health service system in the SMR were positive about their contact with the service. Treatments were completed and staff viewed as professional.

Consumers felt that services could be promoted to encourage the access of eligible people in need, plus opportunities to educate about oral health more broadly explored. They also commented on the need to promote access for people with special needs:

- *Supported transport is a must for vulnerable people, plus services need to acknowledge these groups need longer appointment times.*
- *Consider the bulk purchase of items like toothbrushes to sell for reduced cost, more affordable.*
- *Young at risk people and other people with complex needs (such as SRS residents) have high levels of fear which needs to be addressed. Staff need to have the right skills including good communication.*
- *Dental services for people with complex needs can have great benefits (such as building self-esteem, increasing the client's capacity to work).*

Similar themes from consumers and external stakeholders:

Supporting access for marginalised groups

Oral health staff experienced in working with special needs groups

Importance of oral health promotion across all sectors

Opportunities for early intervention for people with chronic conditions

External stakeholders

External stakeholders were asked to contribute their views on the factors that should be considered when developing the SMR oral health plan. The following comments summarise central themes from their feedback.

- *'There is a stronger emphasis in recent policy on the importance of oral health promotion; however, there needs to be funding attached to develop shared and cross program approaches.'*
- *'There needs to be greater recognition of oral health as an essential part of being physically healthy – opportunities exist for mainstream health promotion and other programs to provide these messages.'*
- *'Marginalised people need to have their access to dental services facilitated. This includes appropriately trained oral health staff and transport.'*

External community health and other stakeholders consider there are important early intervention opportunities to screen/discuss other health issues (particularly people with chronic conditions) with the large numbers of people who present for oral health services.

> 'Many people access oral health so it would be great to build more of a pathway to other [community health] services. It would also be useful to have more information about the oral health program – who to contact if we have an issue with a client.'

Regional-level approaches and roles in oral health service delivery are timely and realistic, given there will be resourcing available to support and encourage regional work and integration. It is also critical to consider and develop subregional roles, given the implementation of Medicare Locals.

4. SMR Oral Health Network and planning

4.1 Southern Metropolitan Region Oral Health Network

Improving Victoria's oral health proposed that the publicly funded community-based service system could be seen as having three levels of organisational development: a lead regional agency, district agencies and local agencies. The policy also suggests that, in metropolitan areas, agency identification can occur at the service catchment level.

A primary objective of the SMR oral health planning process was to consider and clarify options for governance, leadership and organisational roles to maximise utilisation of resources and strengthen linkages and supports between community dental services in the SMR. In terms of publicly funded dental services both the South East and Mornington Peninsula have one organisation providing services and in the Bayside catchment three organisations provide oral health services.

Consultation with stakeholders has identified little support for a formal 'lead agency' regional (whole SMR) or subregional (Bayside) concept. There is, however, considerable commitment to a continued network and ongoing collaboration, building of service capacity and working together to meet identified oral health needs.

Action:
1.1 A network of SMR community dental services, inclusive of relevant stakeholders, will be formed to comprise the Southern Metropolitan Region Oral Health Network (SMROHN).

It will be important that the SMROHN continues to participate in, and influence, subregional planning and service coordination processes within each member organisation's own catchments. Developing this plan has created an awareness of the potential benefits of a regional focus, particularly in the context of working with other oral health providers and the benefits this can bring to oral health practice and to clients through improved coordination and access to services.

Action:
1.2 The SMROHN will meet on a regular basis and actively collaborate in achieving agreed joint activities detailed in the action plan and act on other emerging issues.

The specific interests, skills and innovative practices developed by agencies in response to the needs of their diverse catchments underpin many of the proposed activities. As work progresses in implementing the action plan, leadership in specific aspects of service delivery will become more obvious and acknowledged and accepted by regional network members.

4.2 Oral health planning and service sector engagement

Primary Care Partnerships

The SMR has had four Primary Care Partnership catchments since 2000. In future, three key subregional service catchments will become increasingly relevant to providing health- and community-based services. These correspond to the three Medicare Local catchments of Bayside, South Eastern Melbourne and Frankston-Mornington Peninsula.

In terms of providing community-based services these catchments are also consistent with the metropolitan health services catchments for Alfred Health, Southern Health and Peninsula Health. Note these are notional catchments for planning purposes, rather than constraining service delivery.

In order to factor oral health and oral health promotion in the broader health continuum it will be essential to create a platform for oral health in these broader regional and subregional planning structures.

SMROHN members discussed options and strategies to influence both internal organisational and other planning processes; an important initial strategy is about building an oral health 'evidence base' to contribute to these planning processes ('the what') and devising an approach where this information is provided to these planning forums.

Medicare Locals

Across Australia, Medicare Locals have been formed to bring together doctors, nurses and allied health professionals to work with consumers to identify gaps and develop frontline primary health services in their communities. There will also be a key focus on people with chronic conditions, chronic disease prevention and mental health initiatives. Within SMR, Bayside Medicare Local, Frankston-Mornington Peninsula Medicare Local and the South Eastern Melbourne Medicare Local have been established.

Each LGA develops plans for the health and wellbeing of people in their LGA. The next series of plans are due to be developed within 12 months of council elections due in October 2012. Plans are developed in consultation with local health and community services and there is an opportunity to work with local government to promote oral health information and action on oral health.

Both the City of Greater Dandenong and Shire of Cardinia have projects as part of the *National partnership agreement on preventative health*, which aims to reduce the incidence of chronic disease by embedding healthy behaviours in the settings of preschools, schools, workplaces and community, and support behavioural change through public education. These projects promote healthy eating, physical activity and smoking cessation, which are all factors known to have an effect on oral health. It also provides SMR dental services with an opportunity to work alongside local government in supporting oral health promotion.

Action:

1.3 The SMROHN will coordinate, influence and advise on oral health planning by building an oral health evidence base and developing mechanisms for input to catchment-based population health planning processes. These include municipal health plans, Primary Care Partnerships, Medicare Locals, the Department of Health and DHSV.

4.3 Review and evaluation

The SMROHN will review and evaluate progress on the action plan after 12 months. The network is keen to progress work on multiple fronts, which explains the number of actions outlines in the action plan (section 10) that have a year 1 start date. The plan is ambitious in year 1, but inevitably some actions will need a longer term focus. The review will provide the opportunity to assess achievements but also develop a more informed staging of the work over the remaining three years.

5. Oral health service access and demand

Community dental services in the SMR are working to manage and meet demand. Current approaches include load sharing and strategies to reduce FTA rates.

Load sharing

As noted previously, Southern Health and PHCH have significant numbers of people on their waiting lists. 'Load sharing' approaches have been adopted by BBCH and ISCHS where these services assist Southern Health and PHCH clients (currently on the waiting list) by providing access to general appointments at their sites, with some success. This load sharing approach is regarded as valuable support for Southern Health. SMROHN members agreed there is an opportunity to broaden and formalise this approach across the SMR.

Action:

2.1 The SMROHN will review current load sharing arrangements and improve current models in order to increase the number of people who can access a service.

Reducing FTA rates

All services have developed a range of practices with the aim of reducing and/or filling FTA appointments, for example, 'sit and wait' emergency clients filling unattended appointments and telephone 'reminder calls' made to clients on the day prior to an appointment. Southern Health completed several pilot projects in 2010 with the aim of better managing demand and reducing FTAs, including a trial of reminder calls. SMROHN members agreed it would be valuable to undertake further 'root cause' analysis to gain a better understanding of FTAs and consider learning points from this and the work undertaken by Southern Health.

Option to develop a practice working group to oversee implementation of these strategies, including strategies to reduce FTAs and load sharing practice

Action:

2.2 The SMROHN will undertake further analysis and develop shared strategies to reduce failure to attend rates.

SMROHN members also commented on the opportunity provided by the plan to build a shared regional process for access to community dental services. Consumers can then be presented with the same criteria, information and service referral, regardless of which service they initially present to. The viability of a central intake number was also discussed.

Action:

2.3 The SMROHN will develop a common, shared approach to service access so clients are provided with the same information and criteria for service, regardless of where they present in the SMR.

Medicare EPC item/teen dental

SMROHN members also recognise the opportunity to improve access to community dental services for people with chronic medical conditions by maximising uptake of Medicare dental items (that cover services provided by dentists, dental specialists and dental prosthetists) via building practice relationships with Medicare Locals and, by extension, general practitioners (GPs). Eligible clients are those people with chronic health conditions who are managed by their GP under a GP management plan.

Since July 2008 the Commonwealth Government, through Medicare, has funded dental care for 12–17-year-old Australians through the *Teen dental plan*. As at 1 January 2012, the *Medicare Teen dental plan* provides dental benefits of up to $163.05 per eligible teenager, per calendar year, to help with the cost of a 'preventative dental check'. The preventative dental check can be provided by or on behalf of a representative public dentist working in a community dental agency. Improving the uptake of the Medicare teen dental item, linked to work suggested in section 7, could also improve the teenagers' access to community dental services.

SMROHN members considering strategies to utilise these Commonwealth Government initiatives should be aware of two important tax determinations from the Australian Taxation Office: 'Private practice dentists in [community health services] participating in the Commonwealth Medicare Chronic Disease Dental Scheme' and 'Public dentists employed by [community health services] to provide public dental services under the Medicare Teen Dental Plan'. Advice on these issues is available from DHSV.

Private practice projects have to date been developed by Southern Health and PHCH, with the intention of recruiting and retaining experienced dentists to provide private services (as part of their broader role) to people eligible for the Medicare dental items including the *Teen dental plan*.

It is worth conducting further exploratory work on improving the take-up of these initiatives. This would be most feasible initially at a subregional/individual service level, with a view to extending the work to other areas/services. Merri Community Health Services has recently been funded by the Department of Health for a pilot project in relation to Medicare EPC items and any initiative in SMR should liaise with Merri Community Health Services to minimise duplication and share learnings and experience.

Actions:
2.4 The SMROHN will sponsor a subregional project to learn from other work and test ways of improving access to Medicare EPC items via improved relationships with Medicare Locals and GPs.
2.5 The SMROHN will develop strategies that will increase the uptake of the Medicare teen dental item and improve teenagers' access to community dental services.

Access to specialists

Generally speaking SMR community dental services have reasonable access to some specialist service types, and referral across sites to these services tends to work effectively. For example, the oral surgeon at CBCHS accepts referrals from across the region. Current arrangements with specialists across sites are largely dependent on the goodwill and commitment of the staff involved. Maintaining access to the same level of specialist services if current specialists leave is an area of concern noted by services.

PHCH has access to procedures requiring general anaesthesia facilities at Frankston, which works well, and is exploring alternatives for this at Rosebud. Southern Health would like to explore options for accessing general anaesthesia at Southern Health, and BBCH would prefer more local access to general anaesthesia. While not addressed specifically in the action plan, access to specialist services and general anaesthesia is noted as an area for future consideration on page 30.

6. Service integration and coordination

Improving Victoria's oral health promotes dental services taking up service coordination practice to improve access, share knowledge and resources, and support early identification of client needs. All SMR community dental services currently have a separate service access system for oral health clients from the main community health intake system and service coordination tool templates are not used by community dental services.

Promoting service integration and coordination for people with chronic health issues is recognised as valuable given the range of chronic health conditions associated with oral disease. People with diabetes or stroke are twice as likely to require urgent dental treatment. Gum disease is associated with rheumatoid arthritis, adverse pregnancy outcomes and coronary heart disease. People with rheumatoid arthritis, emphysema or liver conditions are between three and five times as likely to have urgent dental treatment needs compared with others without these conditions.[8]

Significant steps undertaken to build practice and capacity in this area by SMR community dental services include:

- An ISCHS intake and referral pilot is underway where all oral health clients (unconnected to other services) are contacted to ask if they would like to receive information about other ISCHS services; similarly, all community health clients are screened for oral health services.
- A PHCH broader needs assessment template (tool) is being piloted, which includes a comprehensive list of questions about oral health needs. These questions support a 'whole of health' approach to ensure clinical staff consider their clients' oral health and that needs are identified early and access to dental services promoted.
- Southern Health is looking at ways to develop central intake for oral health clients across its seven sites. It is also aiming to build an integrated intake with its broader community health services.

Actions:
3.1 SMROHN members will review the outcomes from all pilot projects undertaken to build service integration and coordination practice.
3.2 SMROHN members will identify and implement shared and key strategies that promote better service integration and coordination.

8 Department of Health 2010, *Evidence-based oral health promotion resource*, State Government of Victoria, Melbourne.

7. Priority and special needs groups

The following groups have priority access for public oral health services:[9] Aboriginal and Torres Strait Islanders; children and young people; pregnant women; homeless people and people at risk of homelessness, which includes people who reside in SRS; refugees and asylum seekers; and registered clients of mental health and disability services.

On contact with community dental services these clients must be offered the next available appointment for general care. A number of the SMROHN services have developed comprehensive and well-regarded service approaches with these groups. For example, ISCHS has developed special needs clinics that target people who are homeless, who have mental health issues and pregnant women.

Aboriginal and Torres Strait Islanders

More than 4,800 Aboriginal people live in SMR, with most residing in the South East and Peninsula areas.[10] A recent review of Aboriginal oral health[11] noted that Aboriginal Australians have poorer oral health, suffering from more caries, periodontal issues and tooth loss than non-Aboriginal people. The report recommends several strategies to meet the oral health needs of Aboriginal people including providing culturally appropriate and well-promoted dental services for Aboriginal people.

Oral health service responsiveness to Aboriginal people is generally positive across the SMR, with all services providing priority appointments. The ISCHS targeted outreach and on-site models are highly regarded by external providers. Southern Health Oral Health has established links with the local Aboriginal co-operative and provides set weekly appointments for Aboriginal people. PHCH provides priority bookings once a week at its Frankston site and Koori support workers bring clients to appointments.

All stakeholders noted access for Aboriginal people who do not have a Health Care Card as a significant challenge, both in the SMR and statewide.

People with mental health issues

An increased risk of oral health issues can occur for people with special needs when their ability for self-care is reduced. People presenting with mental health and/or alcohol and drug issues are known to have increased and complex oral health needs due to their condition and medical treatment.

SMR community dental services have developed successful service models and approaches to working with people who have mental health and/or alcohol and drug issues. In particular Dental as Anything (developed by ISCHS) involves a dentist and a mental health worker meeting clients in their own environments (such as a park or rooming house) to establish connections, undertake initial screening and link to onsite services.

PHCH has worked effectively with its mobile intensive team to help people with mental health issues access oral health services. External stakeholders note an opportunity to explore how these types of approaches could be developed and implemented more broadly to other high-needs groups and in other areas of the SMR. This would require staff skilled to undertake assertive outreach and effective cross-program partnerships.

9 Department of Health 2010, *Eligibility and priority access for public dental services policy*, State Government of Victoria, Melbourne.

10 PHIDU Experimental Estimated Resident Population based on the 2006 Census

11 Williams S, Jamieson L, MacRae A, Gray C 2011, *Review of Indigenous oral health.* Online at <www.healthinfonet.ecu.edu.au/oral_review>.

Supported residential services residents

ISCHS also works with people living in an SRS and participated in the statewide SRS Oral Health Initiative, which conducted oral health education, assessment, and referral to oral health services. SRS proprietors commented on the excellent dental services their residents continue to receive following the pilots. For example, the dentist from ISCHS assisted SRS clients to access BBCH and CBCHS, particularly for essential denture services. Transport is provided for most residents by ISCHS volunteers.

Southern Health has also worked with South East Access and Advocacy Service to increase the access of SRS residents to its services and PHCH has allocated appointment times for SRS residents. Another positive outcome at PHCH has been linking some SRS residents to smoking cessation programs.

People with disabilities

External stakeholders noted the limited access to oral health services for people with intellectual and physical disabilities. People with disabilities experience substantially more oral health problems that can impact on their overall health than people without disabilities. For people with disabilities living in supported residential care, access to appropriate oral healthcare is limited, even though they are at greater risk of developing oral disease.[12]

Children and youth

In 2012 there are 24,109 children on recall lists in the SMR. Community dental services are largely on track with the recall of both high- and low-risk children on these lists. However, there are currently 46,085 children living in welfare-dependent or low-income families[13] (who are all eligible for services) plus the number of children in the South East is forecast to grow. In addition, only seven per cent of SMR preschools participate in the S4M program. This requires consideration both in terms of direct service delivery and oral health promotion activities.

A range of approaches are used to engage eligible children to SMR community dental services, depending on the level of resourcing available and individual service staffing profiles. ISCHS is resourced via local government and an experienced oral health therapist is actively engaged in screening and health promotion with early childhood centres and schools. PHCH is one of the few services to provide S4M and works with a number of preschools providing health promotion and screening. BBCH and CBCHS send oral health service information to local schools and Southern Health provides a Saturday clinic at the David Street site to treat more children on its recall list.

All SMROHN members commented that access to community dental services among teenagers could be improved. In 2010–11, PHCH has worked with youth services and the local Victorian Certificate of Applied Learning (VCAL) program to encourage access to oral health services among secondary school students. It has also developed a package of care developed for unaccompanied refugee minors.

12 DHSV 2008, *Oral health information for people with an intellectual disability,* Melbourne.

13 Public Health Information Development Unit (PHIDU)

Refugee and CALD communities

The community of SMR is very culturally diverse, particularly the areas of Greater Dandenong and Casey where Southern Health provides oral health services.

In considering approaches to providing services to refugees and asylum seekers, services should be aware of resources and a model of care developed by Foundation House, The Victorian Foundation for Survivors of Torture (see Attachment 8).

Southern Health reports that large numbers of CALD clients require interpreter services, which are costly. Southern Health's work with CALD and refugee clients is well regarded and stakeholders from AMES commented favourably on the communication networks and referral pathways they have with Southern Health oral health services.

In dealing with the high demand from refugees, Southern Health is planning to develop an evidence-based minimal intervention approach (such as risk assessment and application of fluoride) at a refugee clinic in Doveton. A Southern Health oral health staff member, in partnership with the community health promotion team, also undertakes screening and provides oral health information to refugee families at a school in Doveton.

Actions:
4.1 The SMROHN with relevant stakeholders will develop a standardised region-wide approach and practice to promote equitable access to community dental services among Aboriginal people.
4.2 The ISCHS will review its practice and approaches with all people who have special needs and share the practice learnings with other SMROHN members. The SMROHN will apply these learnings to improve access to community dental services in SMR among special needs groups.
4.3 The PHCH will review and provide learnings to SMROHN from its work with teens, that is, its package of care for unaccompanied refugee minors and its work with VCAL in promoting teenagers' access to oral health services.
4.4 The SMROHN will develop a shared oral health promotion strategy targeted to children.
4.5 Southern Health will review and provide learnings to SMROHN from its minimal intervention approach with refugees at the Doveton Refugee Clinic. The SMROHN will apply a minimal intervention approach with identified refugee and CALD groups more broadly.
4.6 When providing services to refugees and asylum seekers SMROHN members will work within the framework developed by Foundation House.

8. Oral health promotion

Recent policy highlights an increasing emphasis on establishing settings and approaches for health prevention and promotion including oral health. Internal stakeholders recognise the value of oral health promotion (OHP) and some key practice developments have taken place. Examples include:

- the Southern Health 'oral health champions' at each Southern Health service site who have completed a health promotion course at Monash University (champions have developed an OHP kit that includes references and support materials for other Southern Health staff groups to use and stakeholders consider this is an approach that could be applied more broadly)
- the linkages between the oral health program and community health promotion at most sites
- the inclusion of health promotion activities in work with preschools (PHCH S4M) and schools (such as PHCH and VCAL) and with priority groups (such as Aboriginal people in the Inner South).

The key issue is time and resources available for OHP activities, given the emphasis on direct service delivery and meeting targets. Stakeholders note this is of particular concern in relation to children (noted in section 7) and given the increasing rates of caries. More opportunity for engagement and program development with preschools, day centres and schools would be optimal.

SMROHN members recognise that they also have a responsibility and role in advancing oral health knowledge, expertise and practices in other planning processes (such as with Medicare Locals) and plans (such as local government). The *National partnership agreement on preventative health* contributes another platform to promote oral health (see Appendix 6).

DHSV is currently in the process of developing the statewide *Oral health promotion plan* due for completion in late 2012. SMROHN members have provided input into consultation forums that took place when developing the plan. It will be important for SMROHN to be cognisant of strategies identified in the plan and to seek out opportunities to work with DHSV in promoting oral health.

The Department of Health has also developed an oral health promotion resource *Evidence-based oral health, 2011* to assist health promotion practitioners to further promote oral health. It describes oral diseases and their determinants, as well as the most effective health promotion strategies for their prevention.

Actions:
5.1 Linked to the priority and special needs groups action 4.4, the SMROHN will identify ways to build capacity and support existing practice in relation to oral health promotion (OHP) targeting children such as maternal and child health centres and preschools.
5.2 The SMROHN will pursue strategies that formally link oral health clinicians and health promotion teams and/or activities (in line with the DHSV OHP).

9. Oral health workforce

With the exception of dental assistants, SMR community dental services report little difficulty in recruiting and retaining staff. Each service is well supported by a highly engaged and committed workforce and morale is reported to be high. In the consultations, staff themselves reported a number of incentives of working in the public dental system including: a positive workplace culture; access to a good range and supply of training, development and mentoring; the broader range of clients with complex conditions in the public sector; and working with disadvantaged groups.

SMR community dental services aim to configure a workforce best suited to local service demand and the needs of eligible groups. The changing nature and scope of oral health staff, in particular oral health therapists and hygienists, provides an opportunity to review roles and responsibilities and promote full utilisation of some staff, for example, dental therapists being able to provide services to adults.

Developments in on-site private practice rights for some dentists at Southern Health and PHCH has been mutually beneficial, with dentists more willing to remain working at these sites and some clients being referred to the private service via Medicare items or vouchers. The other sites would like to explore options for on-site private practice development; however, finding dentists willing to take on this role is an issue as many already work part time in external private practices. This is listed in future considerations on page 30.

Federal and state developments

In the latest budget the Commonwealth Government announced it will provide $158.6 million over four years to increase the capacity of the dental workforce. Under this measure, the government will:

- introduce an oral health therapists graduate year program
- expand the Voluntary Dental Graduate Year Program by up to 50 additional places by 2016
- fund infrastructure and relocation grants for dentists who relocate their practice to regional, rural or remote areas.

DHSV has been developing a three-year workforce strategy in 2012 (refer to Appendix 7 for an overview of its main components). SMROHN members, SMR and DHSV met to discuss areas of synergy and overlap between the DHSV strategy and workforce issues and areas of priority identified by SMR organisations. DHSV is keen to support the SMR with workforce issues and is seeking the sector's involvement into workforce strategy initiatives.

9.1 Dental assistant workforce

A central issue for SMR agencies is attracting and retaining nursing staff. Dental assistants also have the highest absentee rates. Some SMR clinics offer traineeships via TAFE but are finding that some nurses leave once the traineeship ends. SMR stakeholders suggested the reasons underpinning this issue include:

- The profession has a history of little movement in pay and conditions for dental assistants combined with limited access to wider work experiences and broader training.
- The dental assistant role has changed and this is not reflected in salary increases.
- There is no access to a professional or industrial body to support the dental assistant case for better conditions.

SMROHN members see a need to promote a greater focus on developing and supporting the dental assistant workforce. One regional proposal is that the SMROHN develops and implements an SMR dental assistant survey to identify 'satisfaction factors' and training needs. Based on survey findings then create opportunities for nurses to share practices (via clinical reflections and other processes) and attend relevant training.

Actions:
6.1 The SMROHN will further consider ways to raise awareness of the importance of promoting a greater focus on developing and supporting the dental assistant workforce, both locally within the region but also with state and federal stakeholders.
6.2 The SMROHN members will share strategies to address workforce issues such as a shared pool of dental assistants across SMR or parts of SMR.

9.2 Dental Practitioners Graduate Program

The Dental Practitioners Graduate Program is a four-year program that aims to place a range of professionals, including dental officers, oral health therapists and prosthetists, in areas with high workforce need. A funding amount of $10,000 is provided per year for program development. Mentors and supervisors provide support and training to graduates.

SMR stakeholders concurred that being involved in the program, and participating in developing skills and engaging new graduates, has potential to add value to the public oral health service system. This could lead to better retention of staff and provide self-sufficiency for dental graduates in both clinical and non-clinical areas. Working in collaboration to develop the model in partnership with DHSV also builds relationships and communication across the SMROHN.

ISCHS, PHCH and Southern Health agreed to work with DHSV to develop a preferred model for graduate placement in the SMR. PHCH will aim for a graduate placement as part of the 2012 intake and Southern Health and ISCHS have flagged their interest to be involved at a later date. The federally funded Voluntary Dental Graduate Year Program, which is broader in scope, is to start in 2013 and is likely to have an impact over time on the state DHSV-led graduate program that the SCONH should take into account.

Action:
6.3 The SMROHN will work with DHSV to develop an SMR model/approach for participating in the Dental Graduate Year Program.

9.3 Continuing professional development

The DHSV continuing professional development (CPD) program is offered to clinicians who work in the SMR. This was previously funded by the participating agencies but is now free. A high demand has meant there are insufficient placements available in 2012. CPD programs are developed in response to sector needs and evaluations indicate that participants see it as quality training.

SMROHN members agree the DHSV CPD program is a valuable initiative and provided feedback to DHSV. At present it is a very open process; many clinicians apply individually and sometimes without their agency's knowledge. The SMROHN also recommends that DHSV CPD guidelines be developed and the CPD calendar be aligned with identified needs raised by the sector and underpinned by a clear process that supports fair access to training.

Southern Health has developed its own well-regarded professional development program, which is open to other SMR services. Other SMROHN members were positive about the program and indicated that more could be done to identify training needs and encourage participation in professional development within the region.

Actions:
6.4 The SMROHN will undertake a collective SMR training needs analysis and provide findings to key stakeholders and providers (including the Australian Dental Association).
6.5 The SMROHN members will actively participate in available continuing professional development (CPD) programs and identify options to support and engage with the Southern Health CPD program.

9.4 Dental students

- The Melbourne Dental School offers a Bachelor of Dental Science (fifth year) and a Bachelor of Oral Health (third year).
- Latrobe University (Bendigo) – Bachelor of Health Sciences in Dentistry, a Master of Dentistry and a Bachelor of Oral Health Science (to enable oral health therapists to treat consumers over 25 years of age).
- RMIT offers a Certificate 111 in Dental Assisting.

SMR community dental services currently offer limited or no access for dental student placements. An opportunity exists to hold discussions with universities and other education providers to identify how the SMR services could participate in developing the oral health workforce by participating in student placements. SMR community dental services have a wide variety of experiences to offer students including: a diverse community that includes SRS residents, mental health clients, refugees and CALD communities.

In the past two years 11 Clinical Placement Networks (CPNs) have been established across Victoria with funding through Workforce Australia. Two CPNs are located in SMR: the Southern and Peninsula CPNs. CPNs aim to increase opportunities for placements across all health-related disciplines, as well as improving coordination between the education and service delivery sectors. CPNs facilitate locally driven, stakeholder-led clinical placement initiatives and partnerships, and the Victorian Clinical Placements Council, gives statewide leadership and advice on clinical placement issues.

Action:
6.6 The SMROHN will map current opportunities for students in SMR dental services, identify other good practice service models and develop and implement strategies to improve opportunities for students in SMR.

10. Action plan

Key area of development	Action(s)	Responsibility	
1. SMR Oral Health Network and planning	1.1 A network of SMR community dental services, inclusive of relevant stakeholders and consumers, will be formed to comprise the Southern Community Oral Health Network (SMROHN).	SMROHN members	Year 1
	1.2 The SMROHN will meet on a regular basis and actively collaborate in achieving agreed joint activities detailed in the action plan and act on other emerging issues.	SMROHN members	Year 1 and ongoing
	1.3 The SMROHN will coordinate, influence and advise on oral health planning by building an oral health evidence base and developing mechanisms for input to catchment-based population health planning processes. These include municipal health plans, Primary Care Partnerships, Medicare Locals, the Department of Health and DHSV.	SMROHN members	Year 1 and ongoing
2. Oral health service access and demand	2.1 The SMROHN will review current load sharing arrangements and improve current models in order to increase the number of people who can access a service.	SMROHN members, practice working group	Year 1
	2.2 The SMROHN will undertake further analysis and develop shared strategies to reduce failure to attend rates.		
	2.3 The SMROHN will develop a common, shared approach to service access so clients are provided with the same information and criteria for service, regardless of where they present for service in the SMR.		
	2.4 The SMROHN will sponsor a subregional project to learn from other work and test ways of improving access to Medicare EPC items via improved relationships with Medicare Locals and GPs.	SMROHN members	Year 1
	2.5 The SMROHN will develop strategies that will increase the uptake of the Medicare teen dental item and improve teenagers' access to community dental services.	SMROHN members	Year 2

Key area of development	Action(s)	Responsibility	
3. Service integration and coordination	3.1 SMROHN members will review the outcomes from all pilot projects undertaken to build service integration and coordination practice.	SMROHN members	Year 1
	3.2 SMROHN members will identify and implement shared and key strategies that promote better service integration and coordination.	SMROHN members	Year 2
4. Priority and special needs groups	4.1 The SMROHN, working with relevant stakeholders, will develop a standardised region-wide approach and practice to promote equitable access to community dental services among Aboriginal people.	SMROHN members, DHSV	Year 1 and ongoing
	4.2 The ISCHS will review its practice and approaches with all people who have special needs and share the key practice learnings with other SMROHN members. The SMROHN will apply these learnings to improve access to dental services in SMR among special needs groups.	ISCHS SMROHN	Year 1 Year 2
	4.3 PHCH will review and provide learnings to SMROHN from its work with teens, that is, its package of care for unaccompanied refugee minors and its work with VCAL in promoting teenagers' access to oral health services.	PHCH	Year 1
	4.4 The SMROHN will develop a shared oral health promotion strategy targeted to children.	SMROHN	Year 2
	4.5 Southern Health will review and provide learnings to SMROHN from its minimal intervention approach with refugees at the Doveton Refugee Clinic. The SMROHN will apply a minimal intervention approach with identified refugee and CALD groups more broadly.	Southern Health SMROHN	Year 1 Year 2
	4.6 When providing services to refugees and asylum seekers SMROHN members will work within the framework developed by Foundation House.	SMROHN members	ongoing

Key area of development	Action(s)	Responsibility	
5. Oral health promotion	5.1 Linked to the priority and special needs groups action 4.4, the SMROHN will identify ways to build capacity and support existing practice in relation to oral health promotion (OHP) targeting children such as maternal and child health centres and preschools.	SMROHN	Year 1
	5.2 The SMROHN will pursue strategies that formally link oral health clinicians and health promotion teams and/or activities (in line with the DHSV OHP).	SMROHN	Year 2
6. Oral health workforce	6.1 The SMROHN will further consider ways to raise awareness of the importance of promoting a greater focus on developing and supporting the dental assistant workforce, both locally within the region but also with key state and federal stakeholders.	SMROHN	Year 1
	6.2 The SMROHN members will share strategies to address workforce issues such as a shared pool of dental assistants across SMR or parts of SMR.	SMROHN	Year 2
	6.3 The SMROHN will work with DHSV to develop an SMR model/approach for participating in the Dental Graduate Year Program.	DHSV, ISCHS, PHCH, Southern Health	Year 1
	6.4 The SMROHN will undertake a collective SMR training needs analysis and provide findings to key stakeholders and providers (including the Australian Dental Association).	CBCHS	Year 1
	6.5 The SMROHN members will actively participate in available continuing professional development (CPD) programs and identify options to support and engage with the Southern Health CPD program.	SMROHN	Year 1
	6.6 The SMROHN will map current opportunities for students in SMR dental services, identify other good practice service models and develop and implement strategies to improve opportunities for students in SMR.	SMROHN	Years 2 and 3

Future considerations

SMROHN members identified a number of other areas as requiring further consideration and discussion in future, with actions potentially developed and formally included in the action plan.

In summary these were:

- how to maintain the current level of access to specialist services currently enjoyed by dental services in the SMR
- to consider options to promote access to general anaesthetic services and have services more readily available in subregions, particularly those areas further away from RDHM
- to consider developing the oral health champion role at each SMROHN site
- remaining cognisant of strategies identified in the DHSV Oral health promotion plan plus seeking opportunities to work with DHSV in promoting oral health
- exploring options for on-site private practice development at CBCHS, ISCHS and BBCH.

Appendix 1: Project steering group

Name	Organisation	Role
Amanda Hart	Department of Health	Project Officer, Aged and Integrated Care
Amy Patterson	Dental Health Services Victoria	Manager, Oral Health Agencies – Eastern
Attilio Biondio	Southern Health	Senior Dentist
Christine Burrows	Peninsula Health Community Health	Director, Child and Family Services
Donald Park	Community member	Community representative
George Robinson	Central Bayside Community Health Services	General Manager, Primary Health
Greg Nott	Department of Health	Manager, Aged and Integrated Care, SMR
John Turner	Bentleigh Bayside Community Health	CEO
Leigh Hebbard	Community member	Community representative
Maureen Williams	Inner South Community Health Service	Manager, Oral Health
Patricia Pickett	Central Bayside Community Health Services	Practice Administrator, Oral Health Services
Ramini Shankaumar	Southern Health	Director, Southern Health Oral Health Services
Sue McKinlay	Peninsula Health Community Health	Program Manager, Community Dental
Sue White	Inner South Community Health Service	General Manager

Appendix 2: Policy and key directions

In addition to broad consultation with a range of stakeholders, development of the SMR oral health plan was also informed by a number of government health policies and other relevant programs.

The *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*[14] provides a framework and priorities for the Victorian health system. Priorities to note in this plan include:

- **responsiveness to need:** developing new settings for the delivery of care including collaboration with the private sector; using area-based planning approaches
- **improving health status:** developing responses for groups that are vulnerable to poor health; improving people's health knowledge and supporting choice
- **increase system financial sustainability and productivity:** consider new funding models such as packages of care for people with chronic and complex care needs.

As a companion document to the *Victorian Health Priorities Framework* the *Victorian Public Health and Wellbeing Plan 2011–2015*[15] describes a series of opportunities to improve health and wellbeing by strengthening systems and settings for health protection, health promotion and preventative healthcare. In section 7.4 (*Keeping people well*), the plan notes the significance of good oral health to the overall health and wellbeing of individuals and lists the following opportunities for progress by 2015:

- include oral health promotion in the update of Victoria's oral health plan
- increase oral health literacy through integrating oral health information with other health information
- introduce oral health policies and practices in key settings (including healthy food and drink policies and daily oral healthcare instruction)
- target high-risk populations with prevention programs
- strengthen early detection of oral disease and early intervention
- utilise health and welfare workers such as maternal and child health (MCH) nurses and family and children's service staff as oral health promoters.

Improving Victoria's oral health[16] is the driver behind the development of dental services in Victoria. This Department of Human Services strategic directions paper promoted the integration of dental services with other primary health services to improve access to services and share knowledge and resources, in turn leading to better outcomes for consumers. The document described a future oral health vision, principles and minimum standards though implementing six 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.

14 Department of Health 2011, *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan and Metropolitan Health Plan Technical Paper,* State Government of Victoria, Melbourne.

15 Department of Health 2011, *Victorian Public Health and Wellbeing Plan 2011–2015,* State Government of Victoria, Melbourne.

16 Department of Human Services 2007, ***Improving Victoria's oral health***, State Government of Victoria, Melbourne.

New funding and accountability arrangements for the Dental Health Program have been implemented from 1 July 2011. Its major components include a new funding model and dataset. A two-year (1 July 2011 to 30 June 2013) transition period is included to allow for review and validation of the new funding model and reporting arrangements. The SMR is represented on the Dental Health Program Funding Model Validation Project Stakeholder Reference Group.

Key principles of the new funding model are:

- activity/output-based funding
- agreed activity targets (dental units of value – DUV)
- three-year funding certainty for agencies
- a universal base price paid for the same activity/output (course of care)
- a universal base price applicable to public dental services delivered and/or purchased by DHSV from both public and private providers
- transparent loadings to the base price in accordance with agency classification, for example, designated specialist and special needs clinics and small agency sustainability; small agency sustainability eligibility is determined according to chair numbers and throughput (fewer than four chairs and less than 1,000 courses of care per chair per annum)
- allowances for treating Indigenous clients and refugee and asylum-seeker clients
- block-funded grants for language services,* clinical placements and after hours (RDHM only).

A new dataset complements the funding model and will provide robust, unit record level data to support the funding model, meet reporting requirements and support policy development and decision making.

* Note that initial information suggested that funding for language services would be allocated through the department's language services program; however, funding has since been provided as block grants directly to agencies (via DHSV).

Care in your community

In 2006 *Care in your community* provided a vision for an integrated and person-centred health system and a framework for conducting area-based planning, including providing locally available and accessible services and how to improve integration with and between other community-based health services. This vision was reflected in Improving Victoria's oral health.

Healthy Mouths Healthy Lives: Australia's national oral health plan 2004–2013

The plan describes oral health as an integral part of general health that requires a strong focus on oral health promotion and the prevention and early identification of oral disease plus access to appropriate and affordable services. It identifies various population groups that have poor access to dental care and whose oral health status is well below the rest of the community, in particular Aboriginal and Torres Strait Islanders, people in low socioeconomic groups, and people with special needs relating to disabilities, health conditions or ageing.

Primary health care in Victoria – discussion paper 2009

This paper recommends that the primary healthcare system in Victoria focus on wellness and person-centred care, address inequalities in primary healthcare access, and enable people with chronic and complex conditions to have well-planned, integrated care.

It also recommends that service delivery models aim to promote after-hours primary healthcare and team-based care arrangements using a range of appropriately skilled providers and early detection and health promotion activities. Future actions must focus on early intervention, proactive and high-quality chronic disease care, and ensure care is effectively coordinated across a mix of program areas.

DHSV strategic plan 2012–2015

The DHSV strategic plan proposes a series of goals significant to this plan:

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

Refugee health and wellbeing plan 2008–2010

Refugees are known to have higher rates of long-term medical and psychological conditions than other migrants, with most health problems due to past histories of physical and psychological trauma, poverty and poor access to healthcare prior to arrival in Australia. The plan describes the need for flexible service approaches and culturally appropriate assessment and care. The use of professional interpreters or bilingual workers as part of culturally sensitive assessment and care is recommended.

Closing the gap

Closing the gap is a strategy that aims to reduce Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational achievement and employment outcomes. Endorsed by the Australian Government in March 2008, *Closing the gap* is a formal commitment developed in response to the aim of achieving health equality for Indigenous people. The SMR closing the gap plan[17] lists several objectives including: guiding the development of a regional plan (which includes local Aboriginal population and health status, current health services and community development activities, identifying what works well, what could be improved and key gaps and strategies); identifying projects for implementation; raising the profile of health services in meeting the health needs of Aboriginal communities and; promoting collaborative approaches to regional, subregional and local area service delivery.

Note that *Closing the gap* in SMR has no specific oral health related initiatives and funding for the strategy is due to end at 30 June 2013.

Focusing on the oral health needs of children, *Smiles 4 Miles* (S4M) was developed by DHSV working in partnership with local organisations to improve the oral health of children. In the SMR S4M was delivered the City of Casey. This has ceased, but the council provides the S4M kit for loan. More recently PHCH has taken over the program from local government.

17 Department of Health 2011, *SMR Closing the health gap plan 2009–13,* State Government of Victoria, Dandenong.

Koolin Balit – Victorian Government strategic directions for Aboriginal health 2012–2022

Koolin Balit outlines the Victorian Government's strategic directions for Aboriginal health over the next 10 years. It sets out what the Department of Health, together with Aboriginal communities, other parts of government and service providers, will do to achieve the government's commitment to improve Aboriginal health.

Broader, whole-of-government strategies are outlined in the *Victorian Indigenous affairs framework.* Koolin balit means 'healthy people'. The department will work with Victorian Aboriginal communities to achieve this, and to meet the government's commitment to improve outcomes for Aboriginal people in Victoria.

The government's objectives are to:

- close the gap in life expectancy for Aboriginal people living in Victoria
- reduce the differences in infant mortality rates, morbidity and low birthweights between the general population and Aboriginal people
- improve access to services and outcomes for Aboriginal people.

Poor oral health is identified in the policy as one of the factors contributing to both lower birthweight and perinatal mortality in the Aboriginal population.

Healthy Families Healthy Smiles is a four-year program that commence in 2011 for disadvantaged families with children aged 0–3 years. It works with health and childcare workers such as maternal and child health nurses, midwives, Aboriginal health workers, GPs and pharmacists to increase the capacity of staff to be oral health promoters and to build local referral pathways to community dental services. DHSV is responsible for rolling out the program.

Appendix 3: SMR community dental services stakeholders

Organisation	Name	Role
Bentleigh Bayside Community Health	Alicia Clark	Senior Dental Assistant
	Amanda Whitford	Dental Assistant
	Ari Barr	Dentist
	Deepti Sharma	Dentist
	Donna Bourke	Dental Therapist
	Hafize Coskun	Oral Health Therapist
	John Turner	CEO
	Judy Wu	Dentist
	Nikki Liew	Dentist
	Marie Bencraft	Reception Coordinator
	Marko Torres	Dental Prosthetist
	Sum Soo	General Manager, Dental Services
Central Bayside Community Health Services	George Robinson	General Manager, Primary Health
	Patricia Pickett	Practice Administrator, Oral Health Services
	Priya Gopalakrishnan	Clinical Coordinator
	Sue Marshall	Senior Dental Assistant
Inner South Community Health Service	Aleem Usif	SRS Dentist
	Ali Sefidroodi	Dentist
	Amena Hasanzada	Dental Assistant
	Andrew Neil	Dentist – Dental As Anything
	Clare English	Dental Therapist
	Dianne Frigo	Coordinator – Nurses
	Mary Stephens	Senior Dentist/Coordinator
	Maureen Williams	Manager, Oral Health
Peninsula Health Community Health	Bev Frey	Dental Private Practice Manager
	Christine Burrows	Director, Child and Family Services
	Colin Carey	Dental Technician
	Fayed Azouz	Dentist and Clinical Head
	Jacqui Isaacs	Senior Dental Therapist
	Kim McKinney	Dental Assistant
	Lily Milczarek	Senior Dentist
	Lindy McCaan	Senior Dental Assistant

Peninsula Health Community Health	Liz Coxen	Senior Dental Assistant
	Mandy Halsall	Senior Dental Assistant
	Margaret Kruk	Senior Dentist
	Pam Deal	Dental Assistant
	Pam Ryder	Dental Team Leader
	Sarah Johnson	Dental Therapist
	Shelley Warrington	Dental Receptionist
	Sue McKinlay	Program Manager, Community Dental
	Ronald Tan	Oral Health Therapist
	Vin Mugunthan	Senior Dentist
Southern Health	Ronald Tan	Oral Health Therapist
	Vin Mugunthan	Senior Dentist
	Attilio Biondio	Senior Dentist
	Beth Irvin	Dental Therapist
	Carmel Holcroft	Senior Dental Assistant
	Deb Bisley	Senior Dental Assistant
	Hasina Rashidzada	Dental Therapist
	Jennifer Smith	Practice Manager
	Kara Press	Team Coordinator
	Kim Tran	Dental Therapist
	Mehran Garoosy	Senior Dentist
	Melanie Kuhn	Dental Assistant
	Naseem Rather	Senior Dentist
	Nicole Steendamn	Dental Assistant
	Ramini Shankaumar	Director, Southern Health Oral Health Services
	Sharon Aliu	Receptionist/Dental Assistant
	Youen Lee	Dentist

Appendix 4: External stakeholders

Name	Organisation/role
Ben Dewar	Central Bayside Community Health Service
Bobbie Nugent	ISCHS, community representative (consumer consultation)
Brian Oates	Southern Health Community Advisory Group
Buzz Johnson	ISCHS, Intake and Referral
Campbell Rule	PHCH, Project Manager, Care in Your Community
Catherine Rampant	Southern Health Community Advisory Group (observer)
Craig Wallace	ISCHS, Peer Support Worker, PHaMs
Christine Pompei	Southern Health, Greater Dandenong Community Health, Health Promotion
Dot Henning	Frontyard Youth Worker
Danice Kuzmic	BBCH, General Manager Health
Deb McIntosh	ISCHS, Community Connections Worker
Deb Smith	ISCHS, Mental Health Program
Donald Park	ISCHS, Community representative (consumer consultation)
Erica Lane	Peninsula Health Youth Services
Emma Harris	PHCH, Team Leader Health Promotion
Gamini Wijesinghe	Southern Health Community Advisory Group
Greg Nott	Department of Health, Manager, Aged and Integrated Care SMR
Helen Furniss	Department of Health, Authorised Officer (SRS Program) SMR
Helen Ireland	ISCHS/Southern Health, Community Midwife
Iain Edwards	PHCH, Director, Chronic Disease and Aged Care
Janine Woodman	PHCH, A/Team Leader, MI Health
Sharon Konig	Brotherhood of St Laurence
Jo Moss	ISCHS, Program Manager, Primary Health
Jo Simsa	ISCHS, community representative
John Rogers	Principal Dental Advisor, Manager Nutrition, Physical Activity and Oral Health Promotion Section Department of Health
Julie White	PHCH, Integrated Chronic Disease Management Coordinator
Kath Ferry	CEO, Peninsula GP Network
Karen Anderson	PHCH, Program Manager, Children's and Family Services
Kathleen Mitakakis	ISCHS, Community Participation Officer
Kim Evitt-Gooding	Department of Human Services, Active Support Coordinator, Inner SMR
Lee Robson	City of Greater Dandenong, Manager Community Engagement
Lisa Finnamora	PHCH, Occupational Therapist, Early Intervention in Chronic Disease
Leeisa Felton	Southern Health, Site Coordinator, Thomas St
Mark Hammersley	Galliamble

Name	Organisation/role
Mary Saunders	Dandenong Casey GP Association
Megan Boland	Department of Health, Manager, Drugs, Health Protection and Mental Health, SMR
Mey Ady	RDNS Homeless Youth
Melissa Yong	Department of Health, Regional Public Health Officer (Health Promotion), SMR
Michael Brayne	PHCH, Care Coordinator, HARP
Naomi Kubina	CBCHS, Service Integration Project
Natasha Saddington	ERMHA, Supporting Connections program
Nicole Molina	Kingston Council Community Wellbeing Officer
Norma Seip	Southern Health Community Advisory Group
Pamela Sloss	Southern Health Community Advisory Group
Peter Jarrett	AMES
Peter Spyker	CBCHS, Manager, Aged and Disability
Sarah Ott	PHCH, Team Leader, Northern Children's Services
Sue Gebert	Department of Human Services, Nutrition and Dietetics Adviser, Inner SMR
Rebecca Pang	PHCH Pharmacist HARP
Reg Shelley	Southern Health Community Advisory Group
Sally Elizabeth	Department of Health, Project Officer, SAVVI SMR
Sonali Wijesinghe	Southern Health Community Advisory Group
Sue Viney	Southern Health Community Advisory Group
Sue Casey	Foundation House, Refugee Oral Health Sector Capacity Building Project
Sue Moulton	CBCHS, Program Manager, Primary Health
Sue White	ISCHS, General Manager
Sue Willey	Southern Health, Refugee Health Nurse
Shyvonne Foggitt	PHCH, Outreach Worker Koori Services
Tracee-Anne Graham	ISCHS, Community representative
Violet Trutoiu	Southern Health, South East Access and Advocacy Service
Wendy Mason	SEHCP, Executive Officer
Inner South SAVVI Meeting	8 proprietors
Outer South SAVVI Meeting	11 proprietors
Peninsula Community Advisory Group	

Appendix 5: SMR data

Population

The SMR is made up of 10 LGAs. It is a large area that includes urbanised areas close to the city of Melbourne stretching to a quickly developing urban fringe in the City of Casey, and shires of Cardinia and Mornington Peninsula.

The population of the SMR is 1,305,685, which is 32 per cent of the metropolitan Melbourne population. The following points are of note:

- South East (Greater Dandenong, Casey and Cardinia) population growth to 2022 is projected to be 38.7 per cent – an increase from 453,598 to 628,930 people. The population in the City of Casey increases by nearly 120 people per week. The South East is also noted for high unemployment and large migrant populations, with Greater Dandenong having the highest number of new arrivals.
- Peninsula (Frankston and Mornington Peninsula) houses a high proportion of older people. Frankston also has the highest percentage of one-parent families in Victoria.
- The Inner South East (Bayside, Kingston, Port Phillip, Stonnington and Glen Eira) does not have the projected growth in population of the other areas within SMR. With the exception of Port Phillip, all LGAs have higher percentages of people aged 65 and over than SMR and Victoria.

Population eligible for community dental services

Table A1: Population eligible for community dental services

IAP	LGA	Adults	Children	Total	Children as % of total
Frankston and Peninsula	Frankston	31,387	17,663	49,050	0.36
	M Peninsula	36,321	18,881	55,202	0.34
Total		**67,708**	**36,544**	**104,252**	
Inner South	Glen Eira	25,661	15,734	41,395	0.38
	Port Phillip	13,856	5,034	18,890	0.27
	Stonnington	12,092	8,080	20,172	0.40
Total		**51,609**	**28,848**	**80,457**	
Kingston Bayside	Kingston	33,234	17,848	51,082	0.35
	Bayside	15,713	12,725	28,438	0.45
Total		**48,947**	**30,573**	**79,520**	
South East	Cardinia	10,049	10,316	20,365	0.51
	Casey	44,555	39,420	83,975	0.47
	Gt Dandenong	41,635	16,718	58,353	0.29
Total		**96,239**	**66,454**	**162,693**	
SMR total		**264,503**	**162,416**	**426,919**	**0.38**
State total		**1,196,621**	**691,556**	**1,888,177**	**0.37**

Source: SMR Profile DHSV 2006 census

The following cohort groups are eligible for community dental services

- all children aged 0–12 years – Table A1 lists all eligible children aged 0–12 years (it is to be expected that some families will use private dental services)
- young people aged 13–17 years who are Health Care or Pensioner Concession Card holders or dependents thereof
- people aged 18 years and over who are Health Care or Pensioner Concession Card holders or dependents of concession card holders
- all refugees and asylum seekers
- Aboriginal people.

Dental ambulatory care sensitive conditions

Dental ambulatory care sensitive conditions (ASCS) are those for which hospitalisation is avoidable through preventive care and early intervention. A range of dental conditions are defined as ambulatory care sensitive, including dental caries and periodontal diseases. As indicated in Table A2, Frankston, Mornington Peninsula, Port Phillip and Stonnington are all above the SMR rate per 1,000 people for dental ambulatory care sensitive conditions, with Cardinia and Casey above the SMR rate per 1,000 children aged 0–14 years.

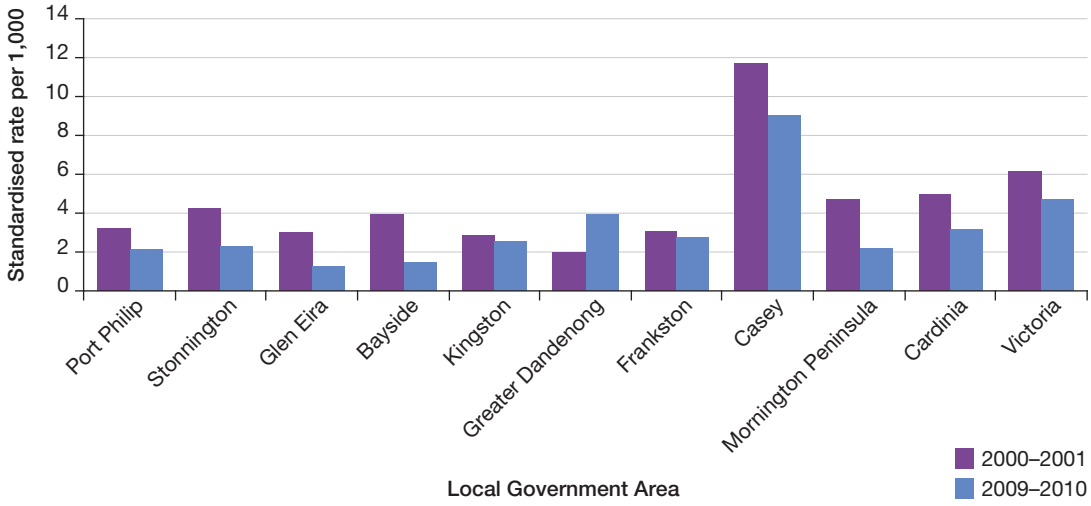
Table A2: Dental ACSC all ages and 0–14 years, 2009–10

LGA	Dental all ages	Dental 0–14 years	Rate per 1,000 people all ages	Rate per 1,000 0–14 years
Frankston	4th	3rd	2.71	3.65
Mornington Peninsula	2nd	3rd	3.25	3.42
Glen Eira	3rd	2nd	2.14	2.75
Port Phillip	5th	2nd	2.66	4.20
Stonnington	2nd	3rd	3.26	3.37
Bayside	5th	3rd	2.11	2.29
Kingston	4th	2nd	2.10	2.63
Cardinia	4th	2nd	2.36	4.00
Casey	8th	3rd	1.96	3.39
Greater Dandenong	8th	2nd	1.75	3.13
SMR	4th	2nd	2.39	3.22
Metro regions	2nd	2nd	2.72	4.39
Victoria	2nd	2nd	3.03	5.46

Source: Victorian Health Information Surveillance System (VHISS)

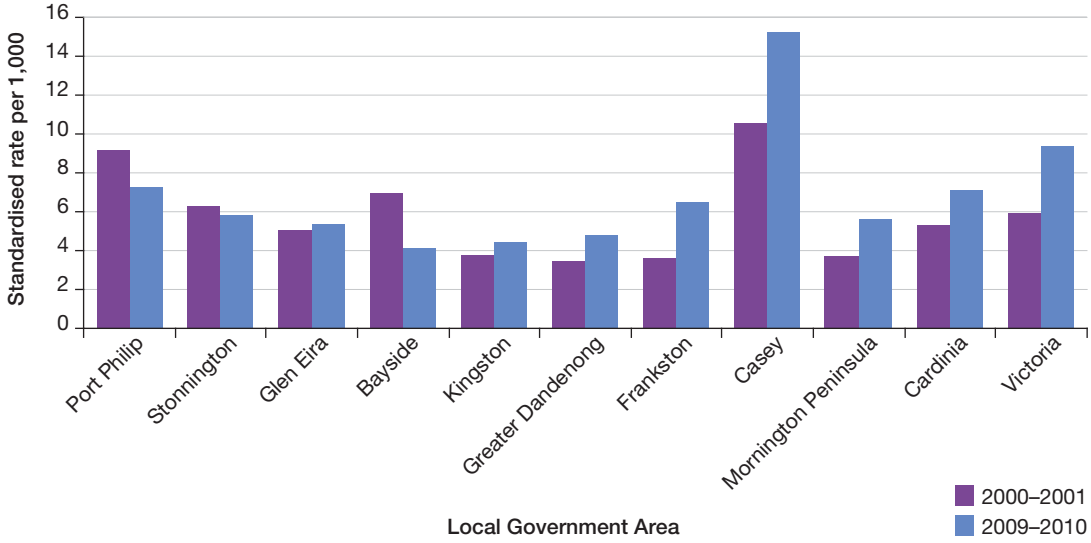
The following tables (A3, A4 and A5) compare dental ACSC rates for 0–4 year olds, 5–9 year olds and 10–14 year olds in 2000–01 and 2009–10 in each SMR LGA. The overall rate for Victoria is included as further comparison. The data shows that the rate for 0–4 year olds is very high in the Casey LGA and notable in Greater Dandenong. For 5–9 year olds, Casey again rates highly followed by Cardinia, Frankston and Port Phillip. In the 10–14 age cohort, Casey remains highest followed by Port Philip and Mornington Peninsula.

Table A3: Dental ACSC 0-4 years 2000–01 to 2009–10



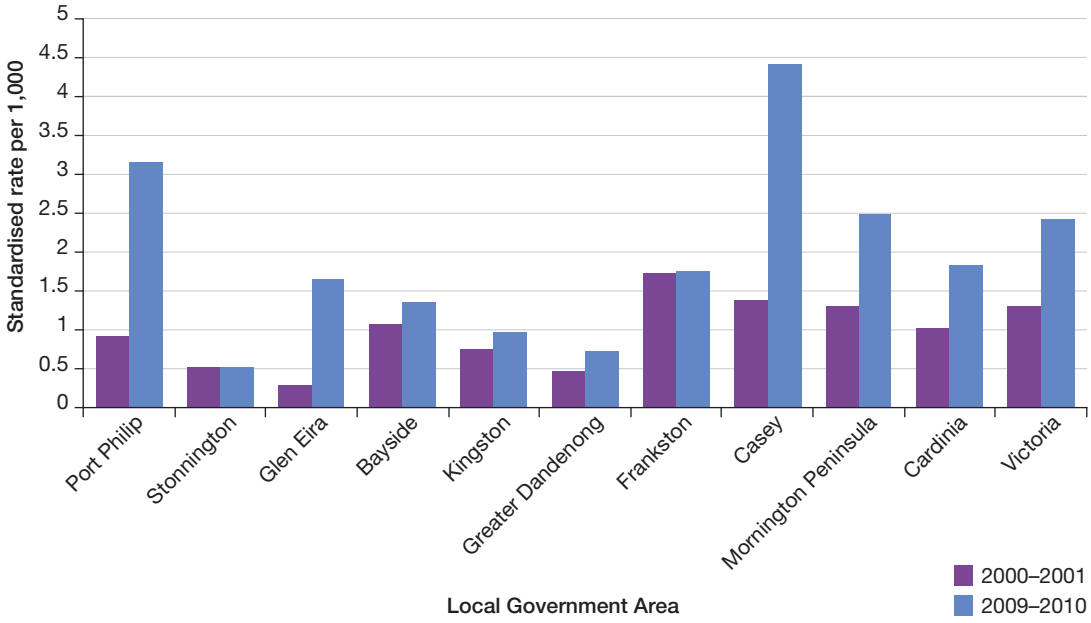
Source: Victorian Health Information Surveillance System (VHISS), February 2012

Table A4: Dental ACSC 5–9 years 2000–01 to 2009–10



Source: Victorian Health Information Surveillance System (VHISS), February 2012

Table A5: Dental ACSC 10–14 years 2000–01 to 2009–10



Source: Victorian Health Information Surveillance System (VHISS), February 2012

People with chronic/complex health issues

A range of health conditions are associated with oral disease. Chronic infection of gums has an adverse effect on diabetes. People with diabetes or who have had a stroke are twice as likely to have urgent dental treatment needs as those without these conditions. Poor oral health is associated with poor diet, pneumonia and endocarditis. Gum disease is associated with rheumatoid arthritis, adverse pregnancy outcomes and coronary heart disease. Sufferers of rheumatoid arthritis, emphysema or liver conditions are between three and five times as likely to have urgent dental treatment needs compared with non-sufferers.[18] Of note in the SMR:

- Greater Dandenong is ranked in the top 10 LGAs for type 2 diabetes.
- Frankston is in the top 10 of LGAs for poor self-reported health and percentage of smokers, and fifth for people with type 2 diabetes.
- Mornington Peninsula ranks 10th in Victoria for smoking.

People with mental health, alcohol and drug issues

An increased risk of dental problems can occur among people with special needs when their ability to care for themselves is reduced. Psychiatric disabilities and the treatment of these conditions may lead to impacts on oral health and people with these conditions and/or alcohol and drug issues are known to have increased oral health needs that are often more complex. Of note:

- 9.1 people per 1,000 are registered as mental health clients in 2009–10 in the SMR. Port Phillip had 14.2 per 1,000, Frankston 13.1 per 1,000, Greater Dandenong 9.8 per 1,000 and Mornington Peninsula 9.4 per 1,000. These exceed the regional (SMR) figure, with some above and some under the state figure of 11.2 people per 1,000.

18 Department of Health 2010 *Evidence-based oral health promotion resource*, State Government of Victoria, Melbourne.

- 4.4 people per 1,000 in the SMR sought treatment for alcohol and other drug issues in 2009–10. Frankston had 7.4 per 1,000, Port Phillip 6.8 per 1,000 and Greater Dandenong 5.7 per 1,000. These exceed the regional (SMR) figure and are above the state figure of 5.3 people per 1,000.
- Mornington Peninsula also ranks sixth in the state for risky alcohol consumption.[19]

People with disabilities

People with disabilities experience substantially more oral health problems that impact on their overall health than people without disabilities; they receive reduced oral health care that is often of a lower quality. For people with disabilities living in supported residential services, access to appropriate oral healthcare is limited even though they are at greater risk of developing oral disease in the future.[20] DHSV has developed a toolkit[21] designed specifically for the promotion of oral health care practices in government-funded Disability Accommodation Services (DAS). In the SMR, Mornington Peninsula, Greater Dandenong and Kingston have the highest percentage of total population with a disability.

Income

Table A6: Health Card and Pensioner Concession card holders, June 2009

IAP	LGA	HC number	PC card	Total
Frankston and Peninsula	Frankston	11,223	22,718	33,941
	Morn Peninsula	9,990	28,864	38,854
Total		**21,213**	**51,582**	**72,795**
Inner South	Glen Eira	6,782	17,185	23,967
	Port Phillip	4,608	10,143	14,751
	Stonnington	3,919	8,898	12,817
Total		**15,309**	**36,226**	**51,535**
Kingston Bayside	Kingston	9,203	22,956	32,159
	Bayside	3,524	10,492	14,016
Total		**12,727**	**33,448**	**46,175**
South East	Cardinia	5,182	8,688	13,870
	Casey	21,761	30,771	52,532
	Greater Dandenong	16,667	28,549	45,216
Total		**43,610**	**68,008**	**111,618**
SMR		**92,859**	**189,264**	**282,123**

Source: Public Health Information Development Unit (PHIDU)

19 2009 Local Government Area Statistical Profiles. Modelling, GIS and Planning Products Unit. Department of Health.

20 DHSV 2008, *Oral health information for people with an intellectual disability,* Melbourne.

21 DHSV 2010, *Promoting oral health for people living in Disability Accommodation Services toolkit,* Melbourne.

Table A6 provides a summary of the number of Health Care and Pensioner Concession Card holders in the SMR; the largest numbers are located in the South East. These groups are eligible, along with their dependents, to use community dental services.

Concentrations of significant socioeconomic advantage and disadvantage exist across the SMR. According to Socio-economic Indexes for Areas data, Greater Dandenong (at 894) and Frankston (997) are the most disadvantaged in the SMR. Greater Dandenong is noted as one of the most socially and economically disadvantaged communities in Victoria, while the cities of Bayside and Stonnington are among the most affluent.

Table A7 identifies the number of children aged under 16 years living in welfare-dependant or low-income families in SMR. Most of these families are living in the South East. This data could potentially serve as an indicator of the number of children who could be targeted for community dental services in future. Currently there are 24,109 children on recall lists in the SMR, although 46,085 children live in welfare-dependent or low-income families.

Table A7: Children in welfare-dependent and other low-income families, June 2009

IAP	LGA	Number	% of children aged under 16 years
Frankston and Peninsula	Frankston	6,738	25.1
	Mornington Peninsula	5,628	19.5
Total		**12,366**	
Inner South	Glen Eira	2,200	8.7
	Port Phillip	1,519	15.0
	Stonnington	876	6.5
Total		**4,595**	
Kingston Bayside	Kingston	3,881	14.3
	Bayside	1,342	6.8
Total		**5,223**	
South East	Cardinia	2,958	17.0
	Casey	11,837	19.4
	Greater Dandenong	9,106	33.0
Total		**23,901**	
SMR		**46,085**	

Source: Public Health Information Development Unit (PHIDU)

Aboriginal people

More than 4,800 Aboriginal people live in SMR. As shown in Table A8, most Aboriginal people live in the South East and Peninsula areas. Aboriginal people are a priority group for community dental services.

Table A8: SMR Aboriginal population

IAP	LGA	No. Aboriginal people
Frankston and Peninsula	Frankston	834
	Mornington Peninsula	721
Inner South	Glen Eira	192
	Port Phillip	297
	Stonnington	202
Kingston-Bayside	Bayside	155
	Kingston	318
South East	Cardinia	257
	Casey	1,290
	Greater Dandenong	560
SMR		**4,826**

Source: PHIDU Experimental Estimated Resident Population based on the 2006 Census

People from culturally and linguistically diverse backgrounds

The community of SMR is very culturally diverse. Greater Dandenong, with over 61.5 per cent of the population from a non-English speaking country, is the most culturally diverse local government area in Victoria. All LGAs in the Inner South and the cities of Kingston and Casey have over 27 per cent of their population from non-English speaking countries.

Table A9: SMR cultural diversity

IAP catchment/LGA	Cultural diversity		
	% born overseas	% CALD	Top 5 languages
Frankston and Peninsula			
Frankston	20.8	14.0	Greek, Italian, German, Spanish, Arabic
Mornington Peninsula	17.1	11.0	Italian, Greek, German, Dutch, Croatian
Inner South			
Glen Eira	31.9	32.4	Greek, Russian, Mandarin, Hebrew, Italian
Port Phillip	27.1	30.1	Greek, Russian, Italian, Mandarin, Cantonese
Stonnington	27.1	28.0	Greek, Mandarin, Cantonese, Italian, Russian
Kingston-Bayside			
Bayside	22.4	16.7	Greek, Italian, Russian, German, Mandarin
Kingston	28.3	27.8	Greek, Italian, Cantonese, Mandarin, Vietnamese

IAP catchment/LGA	Cultural diversity		
	% born overseas	% CALD	Top 5 languages
South East			
Cardinia	14.2	9.0	Italian, Dutch, German, Croatian, Greek
Casey	30.3	28.4	Sinhalese, Spanish, Italian, Arabic, Serbian
Greater Dandenong	51.5	61.5	Vietnamese, Khmer, Cantonese, Greek, Italian

Source: DHSV SMR profile, 2006 Census

Refugees

Table A10 identifies Greater Dandenong as first and Casey as fifth for refugee settlement in the period 2005–08.

Significant numbers of refugees from Afghanistan, Sri Lanka, Sudan and Burma have settled in Greater Dandenong, with some now relocating to Casey.

Table A10: Refugee settlement 2005–2008

Metropolitan LGA	Total
Greater Dandenong	2132
Brimbank	1060
Wyndham	1046
Hume	978
Casey	605
Maroondah	527
Maribyrnong	515
Hobsons Bay	378
Whittlesea	274
Yarra	198
Other	1288
Total metropolitan	**9001**

Source: DIAC Settlement Database, July 2008

Appendix 6: SMR oral health service delivery

Eligible population and uptake per chair

Table A11: SMR eligible population and service uptake per chair, 2010–11

	Total eligible pop.	Total no. of chairs	Eligible pop. per chair	Eligible pop. treated 2010–11	Eligible pop. treated 2010–11 per chair	Percentage of eligible pop. treated 2010–11
Frankston/ Mornington Peninsula	104,252	18	5,792	17,810	990	17%
Inner South East Bayside, Glen Eira, Kingston, Stonnington, Port Phillip	159,977	23	6,955	20,207	878	13%
South East Greater Dandenong, Cardinia, Casey	162,693	24	6,790	26,007	1,084	16%
SMR total	**426,922**	**65**		**64,024**	**984**	**15%**

Source: (Individual Service) Balanced Scorecards, 30 June 2011

Table A11 shows the uptake of community dental services by the eligible population in 2010–11. BBCH, CBCHS and ISCHS all provide services in the Inner South East area. In considering this data it is worthwhile to note:

- The Inner South East is a generally more affluent area (despite some pockets of disadvantage) and some of the eligible population may be accessing private oral health services. The same could be said for parts of Mornington Peninsula.
- ISCHS predominantly services people with complex needs who will require longer courses of care prior to treatment being completed.
- Southern Health achieved the greatest throughput per chair despite treating a significant number of people from CALD/refugee backgrounds (who may require longer appointment times).

Total individuals treated per service

The number of individuals treated by age cohort during 2010–11 is described in Table A12. Across the SMR, 42 per cent of those treated are aged under 17 years. This ranges from 52 per cent at Central Bayside (a high proportion) down to 24 per cent at Inner South where the number of eligible children is low (it is expected that some families will be accessing private dentists in this area).

Table A12: Total eligible individuals treated in all SMR services, 2010–11

	0–5	6–12	13–17	0–17 total	Adult	Total	Children as % of those treated
BBCH	237	1,937	255	2,429	4,894	7,323	33%
CBCHS	211	2,837	409	3,457	3,205	6,662	52%
ISCHS	339	976	177	1,492	4,730	6,222	24%
PHCH	1,643	5,099	994	7,736	10,074	17,810	43%
SH	1,490	9,011	1,543	12,044	13,963	26,007	46%
SMR	**3,920**	**19,860**	**3,378**	**27,158**	**36,866**	**64,024**	**42%**

Source: (Individual Service) Balanced Scorecards, 30 June 2011

General and emergency care – individuals treated per service

As shown in Tables A13 and A14, children aged 0–17 years comprised 58 per cent of the total individuals in SMR who had general care and only 20 per cent of those who required emergency care (possibly an indicator of effective recall where children are being seen for regular check-ups, potentially reducing the need for emergency treatment).

Table A13: Total eligible individuals treated (general) in all SMR services, 2010–11

	0–5	6–12	13–17	0–17 total	18–24	25–44	45–64	65+	Total
BBCH	230	1,310	381	1,921	191	505	767	1,479	4,863
CBCHS	276	2,227	550	3,053	172	406	476	734	4,841
ISCHS	326	777	185	1,288	143	757	865	679	3,732
PHCH	1,394	3,845	1,189	6,428	463	763	833	1,797	10,284
SH	1,422	6,319	2,184	9,925	578	1,275	1,398	2,012	15,188
SMR	**3,648**	**14,478**	**4,489**	**22,615**	**1,547**	**3,706**	**4,339**	**6,701**	**38,908**

Source: DHSV Data Unit, not published

Table A14: Total eligible individuals treated (emergency) in all SMR services, 2010–11

	0–5	6–12	13–17	0–17 total	18–24	25–44	45–64	65+	Total
BBCH	22	166	49	237	105	352	582	1,267	2,543
CBCHS	46	402	93	541	114	357	436	670	2118
ISCHS	2	33	5	40	96	540	648	749	2,073
PHCH	170	928	323	1,421	535	1,943	1,626	2,321	7,846
SH	380	2,085	511	2,976	945	3,580	2,744	2,176	12,421
SMR	**552**	**3,046**	**839**	**4,437**	**1,576**	**6,063**	**5,018**	**5,246**	**22,340**

Source: DHSV Data Unit, not published

Denture care – individuals treated per service

As would be expected most denture services were provided to people aged over 65. Most denture services were delivered by Southern Health.

Table A15: Total eligible individuals treated (denture) in all SMR services, 2010–11

	13–17	18–24	25–44	45–64	65+	Total
BBCH		1	44	195	557	797
CBCHS	1	1	34	150	530	717
ISCHS			28	119	305	452
PHCH	2	5	137	353	858	1,355
SH		6	156	490	1,054	1,706
SMR	**2**	**11**	**321**	**962**	**2,217**	**3,513**

Source: DHSV Data Unit, not published

Children

Table A16: Children on recall to 31 October 2013

	Children on recall	Eligible children	% of eligible children on recall
BBCH	1,754	22,096*	0.08
CBCHS	2,702	24,210*	0.11
ISCHS	1,540	13,114*	0.12
PHCH	6,783	36,544	0.19
SH	11,330	66,454	0.17
SMR	**24,109**	**162,418**	**0.15**

* Eligible children for BBCH include Glen Eira and 50 per cent of Bayside, CBCHS includes Kingston and 50 per cent of Bayside, ISCHS includes Port Phillip and Stonnington. Source: individual agency records, not published

Table A16 shows the number of children on SMR recall lists (to October 2013); the number of children eligible for community dental services and the percentage of eligible children on recall ranging from eight per cent at BBCH to 19 per cent at PCHC. It is again worth noting that some of the eligible families will be accessing private dentists.

As noted in Table A17, data from 2009 shows there are 46,085 children aged under 16 years living in welfare-dependent or low-income families who would be eligible for community dental services. A total of 24,109 children are due for recall over the next two years, which translates to 52 per cent of those in welfare-dependent or low-income families.

Table A17: Children – SMR recall response rate, 2010–11

	Low risk	High risk
BBCH	62.1%	71.8%
CBCHS	51.8%	64.7%
ISCHS	48.2%	54%
PHCH	46.3%	61.4%
SH	28%	36.3%

Source: (Individual Service) Balanced Scorecards, 30 June 2011

Children deemed at low risk are recalled every two years and those at high risk recalled every 12 months. Most services have a good recall response rate. The recall rate of Southern Health is lower than the other sites.

Interpreters

Table A18: Use of interpreters

	No. of individuals	Cost
BBCH	110	$8,591
CBCHS	24	$1,900
ISCHS	397*	$33,695
PHCH	137	**
SH	1,699*	$137,520

*Including Auslan interpreters
**Interpreter costs at PHCH are absorbed by the Social Work department.
Source: SMR dental services data

Table A18 provides an overview of the costs associated with providing interpreters for community dental service clients. Unsurprisingly, the area with the highest promotion of non-English speaking people (Greater Dandenong) has the largest expenditure on interpreters. Greater Dandenong also has the highest number of chairs and largest number of clients.

Service uptake per client

Table A19 provides a summary overview of 2010–11 service data. It lists:

- the total eligible clients treated per service
- the total number of visits and the average number of visits per client
- the total number of treatments, the average number of treatments per client
- the total courses of care (COC) and the average number of COC per client.

Of note:

- BBCH and CBCHS provided the highest number of treatments per client and above the SMR rate.
- BBCH and, to a lesser degree, ISCHS provided more COC per client than other sites and above the SMR rate.

- This information should be viewed along with the information in Table A20 indicating the ratio of emergency to general care, which shows Peninsula and Southern Health have a higher ratio of emergency visits and COC than the other agencies.

Table A19: Total eligible clients treated, visits and COC, 2010–11

	No. of clients (total)	No. of visits (total)	No. of visits per client	No. of treatments (total)	No. of treatments per client	No. of COC (total)	No. of COC per client
BBCH	7,236	18,517	2.6	72,736	10.1	10,630	1.5
CBCHS	6,569	17,041	2.6	63,406	9.7	8,557	1.3
ISCHS	6,204	17,423	2.8	58,370	9.4	8,529	1.4
PHCH	15,057	32,471	2.2	103,310	6.9	18,464	1.2
SH	21,959	54,132	2.5	177,670	8.1	28,389	1.3
SMR	**57,025**	**139,584**	**2.4**	**475,492**	**8.3**	**74,569**	**1.3**

Source: DHSV Dental care profile report. Note: There is a difference between the total no. of clients listed in Table 12 and the client total figures in the first column. The Dental care profile report data above lists INT COC only (work provided by the clinic's operators) while the Agency Balanced Scorecard covers all COC (INT and EXT).

Table A20: Ratio of emergency to general care, 2010–11

	Visits		CoC	
	Emergency	Gen	Emergency	Gen
BBCH	25	75	36	64
CBCHS	22	78	31	69
ISCHS	23	77	37	63
PHCH	33	67	44	56
SH	31	69	46	54

Source: Agency Balanced Scorecards

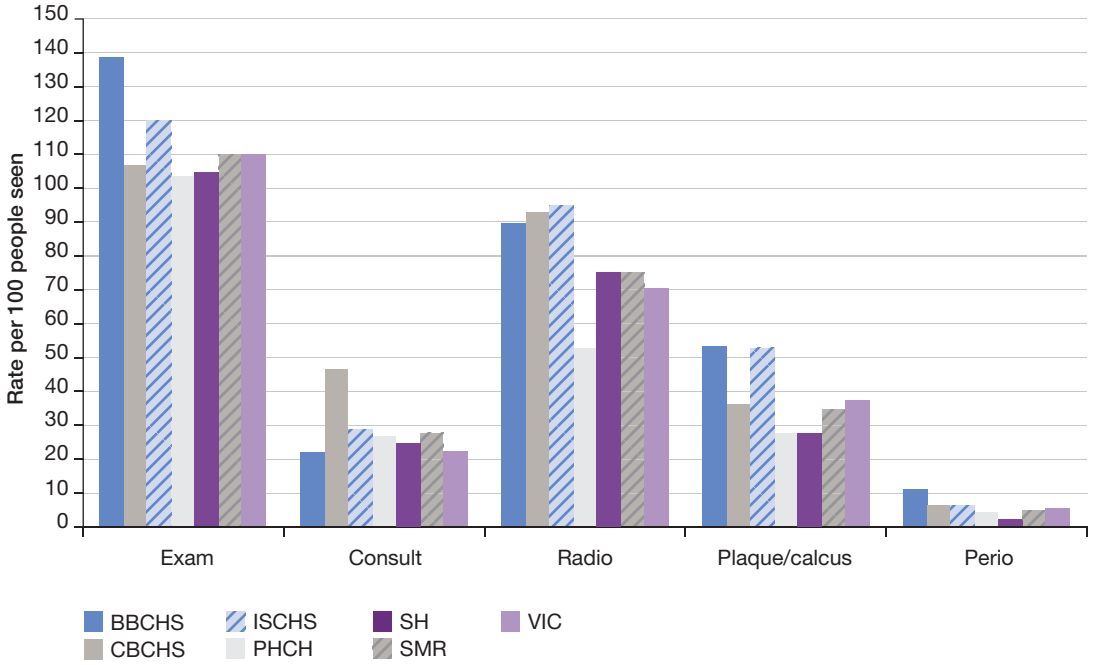
Table A20 shows the ratio of emergency to general care visits and COC are similar for Bentleigh Bayside, Central Bayside and Inner South. Peninsula and Southern Health also have similar ratios for emergency and general care, although considerably higher ratio for emergency care than the other agencies, which could reflect the client groups with whom they work and the wait for treatment.

Dental care profile

Figure A1 compares the treatment rates for service types: examination; consultation; radiography; plaque and calculus removal; and periodontal treatment (excluding surgery) over 2010–11.

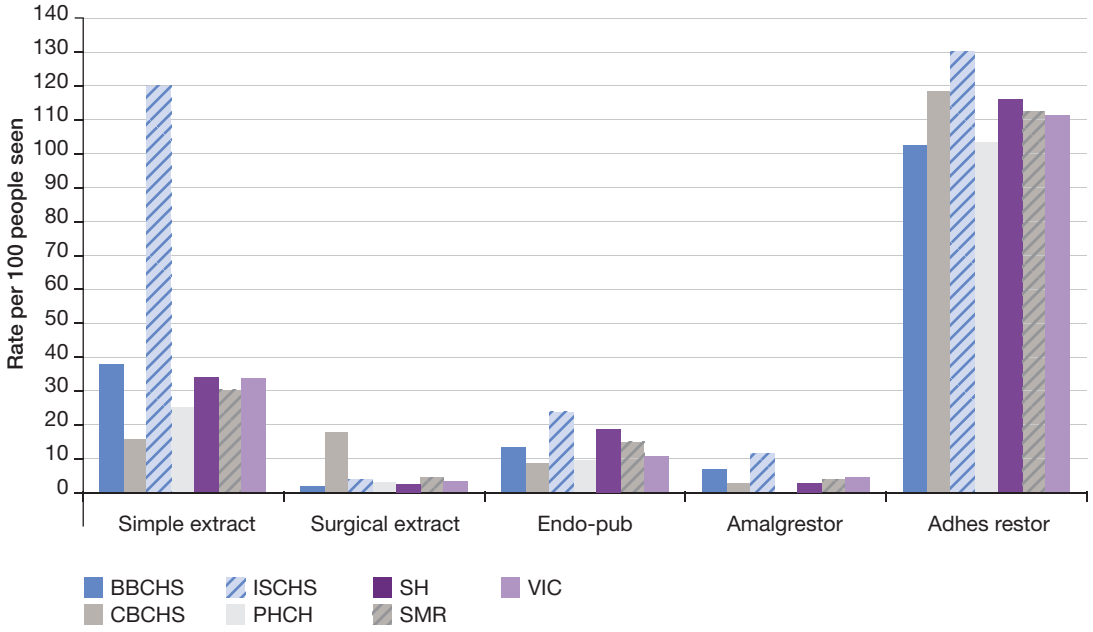
BBCH, CBCHS and ISCHS had higher rates (than the SMR and Victoria) per 100 people treated for most service types.

Figure A1: Treatment items and rates per 100 people treated 2010–11, no. 1



Source: DHSV

Figure A2: Treatment items and rates per 100 people treated 2010–11, no. 2



Source: DHSV

Figure A2 compares the treatment rates for service types: simple and surgical extractions pulp treatment, amalgam and adhesive restoration over 2010–11. CBCHS had a higher rate of surgical extractions, which is understandable given they have access to an on-site oral surgeon.

Figure A3: Treatment items group 3 and rates per 100 people treated 2010–11, no. 3

Source: DHSV

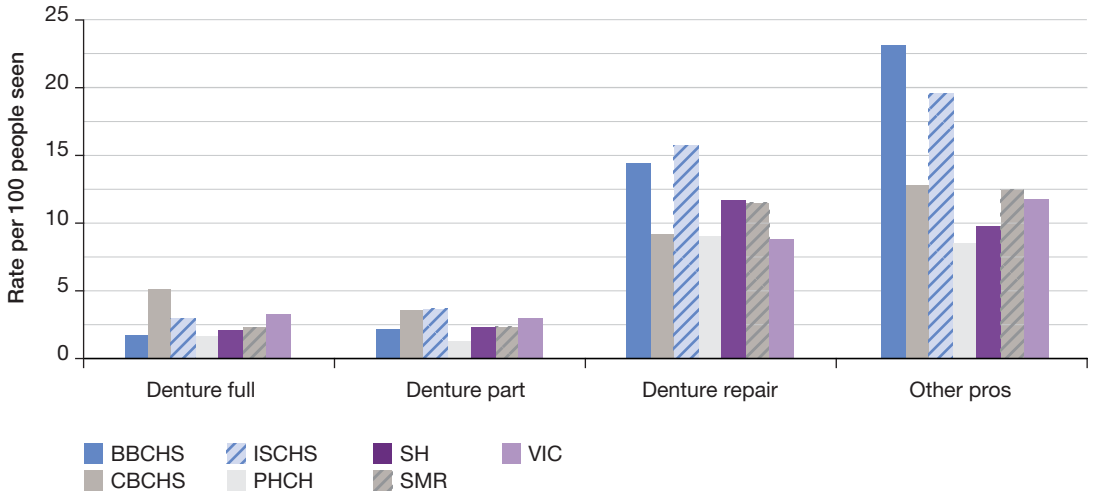


Figure A3 compares the treatment rates for service types: full dentures, partial dentures, repairs and other prosthodontics over 2010–11. BBCH had a lower rate of full dentures than other services and SMR and Victoria. However, BBCH (and ISCHS) had higher rates of partial dentures, denture repairs and other prosthodontics.

Failure to attend

Table A21 lists the 2010–11 FTA rates as a percentage of all appointments for each service.

Table A21: FTA as percentage of total appointments by agency, 2010–11

	Total appointments	Total fail to attend	% of total appointments	% receiving reminder call or text who FTA
BBCH	19,065	927	4.9%	84%*
CBCHS	17,145	1,156	6.7%	0%
ISCHS	19,844	2,667	13.4%	0%
PHCH	36,942	4,823	13.1%	2%
SH	71,162	9,764	13.7%	5%

Source DHSV: Day Sheet Exports from Reporting Titanium

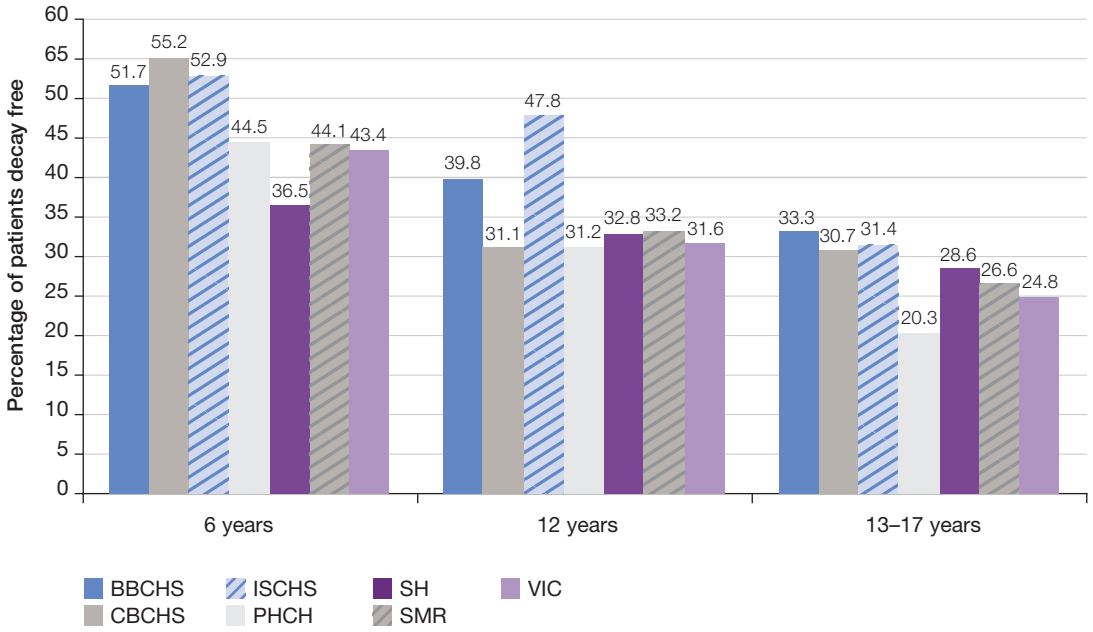
*Possibly a reporting anomaly.

Decayed, missing and filled teeth

Decayed, missing and filled teeth (DMFT) data assesses the level of decayed (caries), missing and filled teeth of clients accessing public oral health services. Figure A4 details the percentage of clients aged six years, 12 years and 13–17 years receiving care at SMR public oral health services who are decay free or have no decay experience. Southern Health had the least percentage of decay-free six year olds at 36.5 per cent (and less than SMR and Victoria rates).

CBCHS, PCHC and Southern Health had similar rates to each other and SMR and Victoria. CBCHS had the least percentage of decay-free 13–17 year olds at 20.3 per cent.

Figure A4: DMFT six years, 12 years and 13–17 years, 2010–11



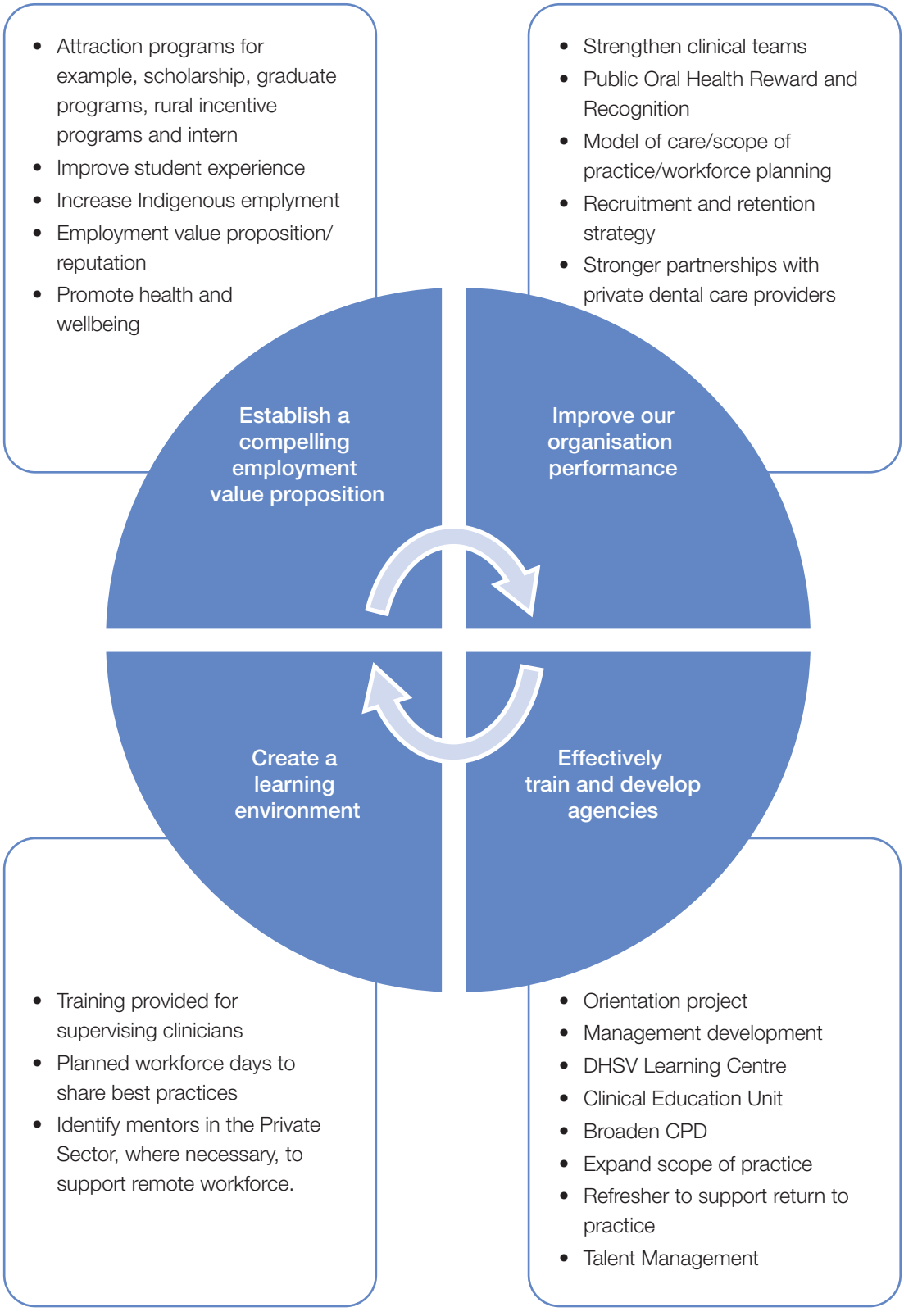
RDHM specialist clinics

Table A22 collates the number of SMR clients who accessed RDHM specialist services and the COC provided to these clients over 2010–11. Oral surgery and orthodontics were the most utilised specialist services followed by oral medicine.

Table A22: RDHM specialist services provided for SMR patients, 2010–11

Clinic	Service type	No. of COC	No. of clients
ENDO	Endodontics	274	273
IC	Implant clinic	56	56
OM	Oral medicine	545	532
ORTHO	Orthodontics	1,015	878
OS	Oral surgery	983	972
PAEDO	Paediatrics	236	236
PERI	Periodontics	316	310
PROF	Prosthodontics fixed	379	324
PROR	Prosthodontics removable	71	71
THTR	Theatre (day surgery)	691	653
RDHM – SPEC (all spec total):		**4,566**	**3,618**

Appendix 7: DHSV workforce strategy components



Appendix 8: Model of care – refugees and asylum seekers

A model of care for oral health providers and two fact sheets can be obtained from the link below:
http://refugeehealthnetwork.org.au/publications/

Abbreviations

ACSC	ambulatory care sensitive conditions
BBCH	Bentleigh Bayside Community Health
CALD	culturally and linguistically diverse
CBCHS	Central Bayside Community Health Services
CDS	Community Dental Services
COC	courses of care
CPD	continuing professional development
CPN	Clinical Placement Network
DHSV	Dental Health Services Victoria
FTA	failure to attend
ISCHS	Inner South Community Health Service
LGA	local government area
OHP	oral health promotion
PHCH	Peninsula Health Community Health
RDHM	Royal Dental Hospital Melbourne
SAVVI	Supporting Accommodation for Vulnerable Victorians
SMROHN	Southern Community Oral Health Network
S4M	Smiles for Miles
SMR	Southern Metropolitan Region
SRS	supported residential services