Victorian Medicare Locals
Dental Briefing Pack 2

Dental Policy Issues relevant to Medicare Locals

PURPOSE

To provide Medicare Locals in Victoria with information on current dental policy issues relevant to Medicare Locals.

As the peak body of dentists in Victoria, the ADAVB has primary responsibility for engaging with health reform processes and helping our members to understand the potential impact of these reforms on their services and relationships with patients. The ADAVB also takes an advocacy role in promoting oral health in the community.

The ADAVB has been involved in a number of reform and advocacy processes, however those that are seen as most relevant to Medicare, and included in this briefing pack are:

Paper 2.1: After hours care
Paper 2.2: E-Health
Paper 2.3: Oral health checks for 4 year olds
Paper 2.4: Aged Care
Paper 2.5: Coordinated care for chronically ill patients

The ADAVB has chosen to bring these issues to the attention of Medicare Locals across Victoria as we can appreciate the potential benefits of linking across health sectors in these areas.

ENQUIRIES

Garry Pearson
CEO, ADAVB
Ph. (03) 8825 4600
Email: garry.pearson@adavb.org

Kate Jameson
Policy and Research Officer, ADAVB, (Mon-Wed)
Ph. (03) 8825 4611
Email: kate.jameson@adavb.org

Victorian Medicare Locals
Dental Briefing Pack 2
Dental Policy Issues relevant to Medicare Locals

Paper 2.1: After hours dental care

Dentistry is not medicine. The after-hours dental service model is quite different from medical emergency services.

The Dental Practice Survey conducted by ADA Inc in 2010 found that:

- most (90%) practices offered any patient an emergency appointment on the same day or the next day.
- Some practices only offered emergency treatment for their own patients.
- Some practices did not offer emergency treatment on weekends.
- Responses indicated that 65% of practices had emergency oxygen equipment.
- Availability was more likely with GPs than specialists; country than metropolitan; and in ACT.
- Availability was also higher with government and other organisations.
- Availability for some private practices was with shared or adjacent medical facilities.

Access to after-hours dental care is not seen as a private sector issue as most after-hours dental services are weekend trauma related (mainly road accidents and sports injuries), requiring hospitalisation. The rest can be considered as elective.

In Victoria, the public has access to after-hours dental services through the Royal Melbourne Dental Hospital and other public hospitals. It would be uneconomic for private dental practices to be open 24 hours per day and seven days per week, or even for extended periods outside ordinary hours as defined in the relevant industrial awards.

Medicare Locals have been charged with addressing after hours care in their respective regions and generally this will mean liaising with public dental clinics and hospitals about their opening hours and services.

The ADAVB is aware that after hours dental care may be identified as a service gap by a number of Medicare Locals. We are also aware however, that the reason dental services may be identified as an area of high need, is that public dental services are inadequately funded, waiting lists are therefore long, and patients with deteriorating dental health will ultimately present for emergency relief of pain if they do not receive timely dental care.

Other factors in After Hours Primary Care models that would be well regarded, but are not essential, include:

- Having multiple funding sources;
- Building on current infrastructure;
- Ensure appropriate servicing of outer suburbs
- Bulk billing and/or keeping patient costs minimal;
- Taking into consideration needs of vulnerable groups (i.e. mental health, substance misuse, culturally and linguistically diverse [CALD], Aboriginal and Torres Strait Islanders [ATSI], refugee/asylum seekers, those affected by homelessness, etc);
- Taking into consideration needs of groups identified as requiring more and /or flexible AH PC options (i.e. residents of aged care facilities, house-bound aged, palliative care patients and carers, residents of disabled care facilities, disabled patients and carers, chronically ill patients and carers, carers of young children, etc);
- Use an interdisciplinary approach (i.e. general practice, pharmacy and dental working together, welfare and health, etc);
- Close to public transport or have mobile service options; and,
- For fixed sites, utilise a model that allows for 'walk-ins' rather than an appointment only.

One Medicare Local document sighted by ADAVB advised that the groups they would like to see get more flexible after-hours care as being:

- Residents of aged care facilities;
- The house-bound aged;
- Palliative care patients and carers;
- Residents of disabled care facilities;
- Disabled patients and carers;
- Chronically ill patients and carers; and
- Carers of children.

ADAVB notes these groups rarely need after hours dental services, however they all require move timely access to basic dental care. The ADA Inc. (federal body) has proposed a targeted Commonwealth Dental Program called Dental Access in order to improve access to dental care for eligible patients. See http://www.betterdentalaccess.com.au/ for more information.

Victorian Medicare Locals
Dental Briefing Pack 2
Dental Policy Issues relevant to Medicare Locals

Paper 2.2: e-Health issues

The ADA Inc policy statement on eHealth and dentistry seeks to ensure that:

- E-Health measures adopted by dental practices are for the benefit of their patients and Practitioners.
- Health practitioners continue to own their records, regardless of the record format employed.
- Professional indemnity implications are considered in implementation of any e-Health services.
- E-Health information should only be available to patients and their treating practitioners.
- E-Health should not add any administrative burden and should be integrated seamlessly into to a dental practice.

The dental profession has considerable interest in accessing medication summaries for patient history taking. Dental practices are not generally conversant with secure messaging requirements and yet they frequently need to exchange confidential patient information with their medical colleagues and other health practitioners.

The ADAVB is concerned that practitioners from different disciplines have not been provided with opportunities to develop insight into each other's information requirements, and patients do not understand what information various health professions need to be able to provide them with optimal care. We recognise the potential of e-Health to contribute to more efficient and effective communication between health professionals.

The ADAVB considers that there are limited resources to ensure that non-medical health professionals are able to adopt the same methods as those addressed by doctors. Dental practice software developers have not yet incorporated e-Health functionality in dental software. This is an obstacle to rolling-out e-Health to the dental profession.

The 2010 Dental Practice survey conducted by ADA Inc showed that:

- 55% of respondents would support use of electronic prescription writing.
- 49% of respondents would support the use of e-Health records.

The Survey results showed no real change in the percentage of ADA members that use computers for patient accounts from the last survey, conducted in 2007 (86% compared to 87% per cent).

However, the results of the latest survey showed that computers are now used for: charting by 62% (52% in 2007); photography by 55% (50%); radiographs by 64% (47%); and digital models by 14%.

The ADAVB appreciates that NEHTA has significant challenges ahead in establishing eHealth systems initially available to General Practitioners, hospitals and pharmacies. The ADAVB is committed to working with relevant organisations to implement similar systems in dental practices in due course.

In February 2011 the Department of Health and Ageing engaged international management consultant McKinsey Pacific Rim Inc to gauge the eHealth readiness of Australia's allied healthcare practitioners and medical specialists. Representatives from each sector participated in a national survey. The main findings were that:

- Respondents want to receive information and education from their associations
- Most want collaboration and continuity of care benefits

Below is an extract from the report in relation to dentists:

> *"Dentists are generally technologically competent and comfortable with IT due to the nature of their work. A few older sole practitioners are very attached to card file systems but these tend to be the exception. The trouble is that technical support in the private sector tends to be poor and does not meet their needs, leading to problems with the security and backup of most systems. This could be a problem if minimum standards are set for privacy and data integrity, which require upgrades to current facilities.*
>
> *For busy practices, the clinical interface needs to be really simple and easy to use, with minimal technical explanation required. Ideally a product would be created which would provide clinicians with the building blocks of the ideal eHealth system at the practice level as well as the system level.*
>
> *In terms of dentists' engagement with eHealth reforms, the ADA takes the view that what is missing is a road map of the 'need to know' requirements of each allied health profession, which would accurately chart what needs to be done to establish and use eHealth facilities. Dentists are concerned they will be excluded from a shared medical record, despite the fact that oral health is inextricably linked to the health of the whole body. So too, many systemic conditions affect the mouth.*
>
> *In terms of the new health identifiers, it is critical that this information is integrated with dental records for forensic purposes. This is a key issue for the ADA. Forensic identification through dental records identified 60% of all victims of the 'Black Saturday' bushfires as DNA had been destroyed."*
>
> Source: http://www.health.gov.au/internet/publications/publishing.nsf/Content/ehealth-readiness-allied-toc

The ADAVB has advised its members that eHealth provides significant opportunities for healthcare organisations to improve efficiency and effectiveness through eHealth. We have advocated that members recognise the immediate need to get 'eHealth ready', especially around the personally controlled electronic health record (PCEHR). Specifically, the ADAVB is looking to advise members to:

- Look at practices within their organisations – e. g. data quality practices, security protocol guidelines
- Gain an understanding of the intent and scope of the PCEHR
- Talk to the software vendors of their patient administration systems
- Start considering what it will mean for their organisation and patient care
- Discuss implications of eHealth with their colleagues

Victorian Medicare Locals
Dental Briefing Pack 2
Dental Policy Issues relevant to Medicare Locals

Paper 2.3: Oral health checks for 4 year olds

The ADAVB is aware of the benefits for the shared patient when health professionals work together to achieve positive health outcomes. There are a number of initiatives emerging in which oral health is recognised as a part of general health and in which health professionals can promote overall health to certain population groups. An example of this is the Healthy Kids Check.

The Healthy Kids Check is an assessment of a child's physical health, general well-being and development, with the purpose of initiating medical interventions as appropriate. It promotes early detection of lifestyle risk factors, delayed development and illness, and provides the opportunity to introduce guidance for healthy lifestyles and early intervention strategies. The ADAVB is aware that the Healthy Kids Check must include an oral health check and supports the use of a tool, such as the 'lift the lip' guide, by medical professionals when assessing oral health under the Healthy Kids Check (see http://www.sadental.sa.gov.au/DesktopDefault.aspx?tabid=195).

A healthy kids check must include:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- making an overall assessment of the child;
- recommending appropriate interventions;
- providing advice and information to the child's parent(s) or carer;
- keeping a record of the health assessment, and offering the child's parent(s) or carer a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- updating any relevant records, such as a parent-held child health record.

Examinations and assessments must include:

- height and weight (plot and interpret growth curve and calculate BMI);
- eyesight;
- hearing;
- **oral health (teeth and gums);**
- toileting; and
- allergies.

The Healthy Kids Check may be completed by a medical professional under MBS Items 701 (brief), 703 (standard), 705 (long) or 707 (prolonged), depending on the length of the consultation. If a practice nurse or registered Aboriginal health worker undertakes the Healthy Kids Check on behalf of a medical practitioner, MBS item 10986 may be claimed.

Victorian Medicare Locals
Dental Briefing Pack 2
Dental Policy Issues relevant to Medicare Locals

Paper 2.4: Aged care dental services

The ADAVB has long been advocating for improved dental care for the aged. There are about 45,000 elderly residents living in about 850 residential aged care facilities in Victoria. Improvements in oral health over the past 50 years have seen a substantial increase in the proportion of dentate people in this sub-population, resulting in more than 50% of residents having their natural teeth (on average 14 teeth present).

Co-morbidity, polypharmacy, physical and cognitive impairment inherent in this group substantially increases their risk of dental disease. There are also known links between oral and systemic diseases, including atherosclerosis, stroke and aspiration pneumonia.

What is known is that:

- A pain free, healthy dentition (natural or prosthetic) is essential for adequate nutrition and quality of life;
- Improved oral health may result in up to a 40% reduction in admissions to hospitals for aspiration pneumonia;
- Caring staff can be instructed about the specific oral hygiene requirements of residents;
- That improved oral hygiene programs should be implemented to assist older people to live independently in the community.

There are multiple opportunities for oral health professionals to work with other health professionals to improve oral health outcomes for the aged. There are also a number of processes that could be put in place in aged care facilities to improve the oral health of residents. An oral health check upon entry and the development of a comprehensive treatment plan for each resident is necessary for optimal oral health outcomes within aged care facilities.

In relation to aged care, ADAVB advocates:

- That the standards for new residential aged care facilities be amended to include provision for a multi-purpose treatment centre which could be used for medical, dental, podiatry and other health services
- That portable dental units be provided for use in a multi-purpose treatment room for ambulatory or semi-ambulatory residents or at the bedside for those who are bed-ridden
- Unwanted dental chairs from public dental clinics being reconditioned and installed in the multi-purpose treatment rooms of an appropriate residential aged care homes
- That sufficient funding be provided to ensure that oral health is taken into account when developing a care plan for people in residential accommodation

- That affordable transport (travel vouchers) be provided to enable older people to attend dental appointments in dental clinics
- That consideration be given to three ways to improving access to oral health for nursing home residents via:
    - Dental teams visiting nursing homes
    - Enhancing the existing public Domiciliary Unit
    - Engaging private dental care providers.

Provision of appropriate basic treatment facilities in residential aged care facilities will encourage more dental practitioners to offer services to the residents.

Victorian Medicare Locals
Dental Briefing Pack 2
Dental Policy Issues relevant to Medicare Locals

Paper 2.5: Dental care for the chronically ill

The Medicare Chronic Disease Dental Scheme (CDDS), introduced by the Australian Government in 2007, was designed to provide dental care to people who have a chronic medical condition and complex care needs and whose oral health is also impacting on, or likely to impact on, their general health.

The Government has made a number of attempts to close the CDDS. An audit process has been undertaken and the ADAVB continues to voice concerns in relation to the operation of the scheme itself as well as the audit process.

The Australian Dental Association (ADA) opposes the CDDS because:

- Government dental schemes should target the disadvantaged
- Patients must be referred by medical general practitioners to be eligible for benefits
- It is complex, requiring dentists to be enmeshed in paperwork
- Doctors and dentists were not educated about the scheme's requirements. There was confusion about referral arrangements.

The ADA, along with the support of its branches, has proposed a dental scheme to be implemented by the Australian Government in place of the CDDS. This alternative scheme – *DentalAccess* – features:

- A targeted, affordable and equitable program that will address the needs of the 30% of Australians who say they cannot access appropriate dental care, largely due to chronic underfunding of public dental services.
- A targeted scheme which will direct more funds to treat the extensive needs of disadvantaged Australians rather than rationing resources thinly over the entire population.
- Personal funding caps will be used rather than narrow schedules of services, with a bias towards preventive and restorative dental care.
- Extra provision will be made for other needy groups such as chronically ill and special needs patients.
- Improved funding and direction for community oral health promotion based on individual responsibility, as most oral diseases are almost entirely preventable.

The ADA does not support the introduction of a universal dental health scheme because it:

- Will not deliver targeted quality dental care to those most in need
- Would limit dental treatment to a restricted range of treatments, which is not an effective solution as disadvantaged people tend to have more complex dental health conditions
- Would create a complex two-tier system of delivery/funding of limited dental treatments, either through health funds or via an under-resourced public dental sector, which is an inappropriate way to utilise government funding
- Would be very costly – ADA estimates that it would cost between $11-13 billion a year.

See http://www.betterdentalaccess.com.au/ for more information.