Declaration of Interests

Dental Health Services Victoria is funded by the State and Federal Governments to provide public oral health services to eligible population across Victoria.

This presentation represents the original work carried out by DHSV to improve public oral health care and service delivery for the Victorian community.

There is no conflict of interest to declare.

In the spirit of reconciliation, DHSV acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respect to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Value-based health care Principles

Care is designed with and around person

The right care is provided, to the right person, at the right time, in the right location, by the right provider

Value is used to measure effective and efficient resource utilization and outcomes that matter most to the patient

Continuous measurement is utilized to improve care and remove unwarranted variation

Prevention and early intervention are prioritised at an individual and population level

Care is integrated coordinated and based on risk

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Oral health in Australia

- Oral disorders are the 6th biggest source of the non-fatal burden of disease

- Tooth decay is five times more common than asthma in Australian children.

- An estimated 67,000 potentially preventable hospital admissions are due to dental conditions, representing 21.5 per cent of all potentially preventable admissions for acute conditions.

- More than 2 million Australians report that they avoided or delayed going to the dentist because of the cost

- Oral diseases can contribute to other health problems, including diabetes and heart disease

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This ad from a dental company. 😆

WHY IS DENTISTRY IMPORTANT?
Because even though *he's missing an eyebrow,* the first thing you notice is his **smile!**

the why
drivers for change

Population growth and ageing

Increasing costs

Uneven quality and significant variation in care and health outcomes

Despite what we do waitlists continue to grow and oral health does not improve

People return for the same issue or to repair work previously done

We want to take an active role in decision making about our health

We need to know how to prevent poor oral health

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Where to

We believe our new world can look different?

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Current State

Future State

- Working in silos – in our '_professional patches_'

- Disease focused

- Clinicians in control

- Fee for service

- Think productivity

- Demand management

- Variable service delivery

build an enabling information technology platform

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The How

We know we
needed to
change.
So where did
we start?

We looked at the 'Harvard model' developed by Porter and Lee.

1 Organize into integrated practice units (IPUs)

2 Measure outcomes and costs for every patient

3 Move to bundled payments for care cycles

4 Integrate care delivery across separate facilities

5 Expand excellent services across geography

6 Build an enabling information technology platform

Porter, M.E & Lee, T.H 2013, "The Strategy That Will Fix Health Care", Harvard Business Review, October 2013.

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Significance of the 'war' room?

Dedicated space for our move towards value-based healthcare

People are visual beings – helps to 'see' current and future states

Staff and consumers invited to actively contribute

A space to research, debate, hypothesise, plan, dream, challenge and evaluate

Helped identify that there were multiple patient experiences and flaws with the current system.

We then started work on the **implementation** of each of the components of the model

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Embedding a culture of co-design
to support transformation and continuous improvement

New model

PATIENT RINGS OR IS REFERRED

EMERGENCY → TREATMENT → DISCHARGED

GENERAL CARE → RISK AND NEED ASSESSMENT → INTRO SESSION EAT WELL DRINK WELL CLEAN WELL

CHECK UP ← CHECK IN ← TREATED BASED ON RISK AND NEED ← COACHING

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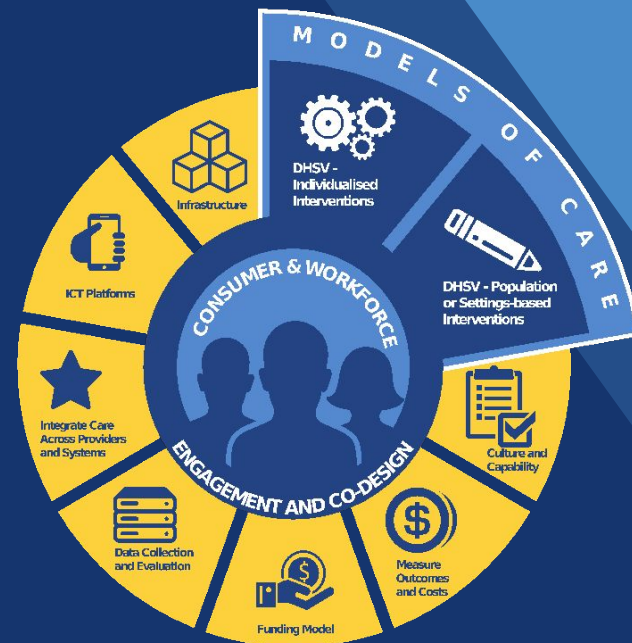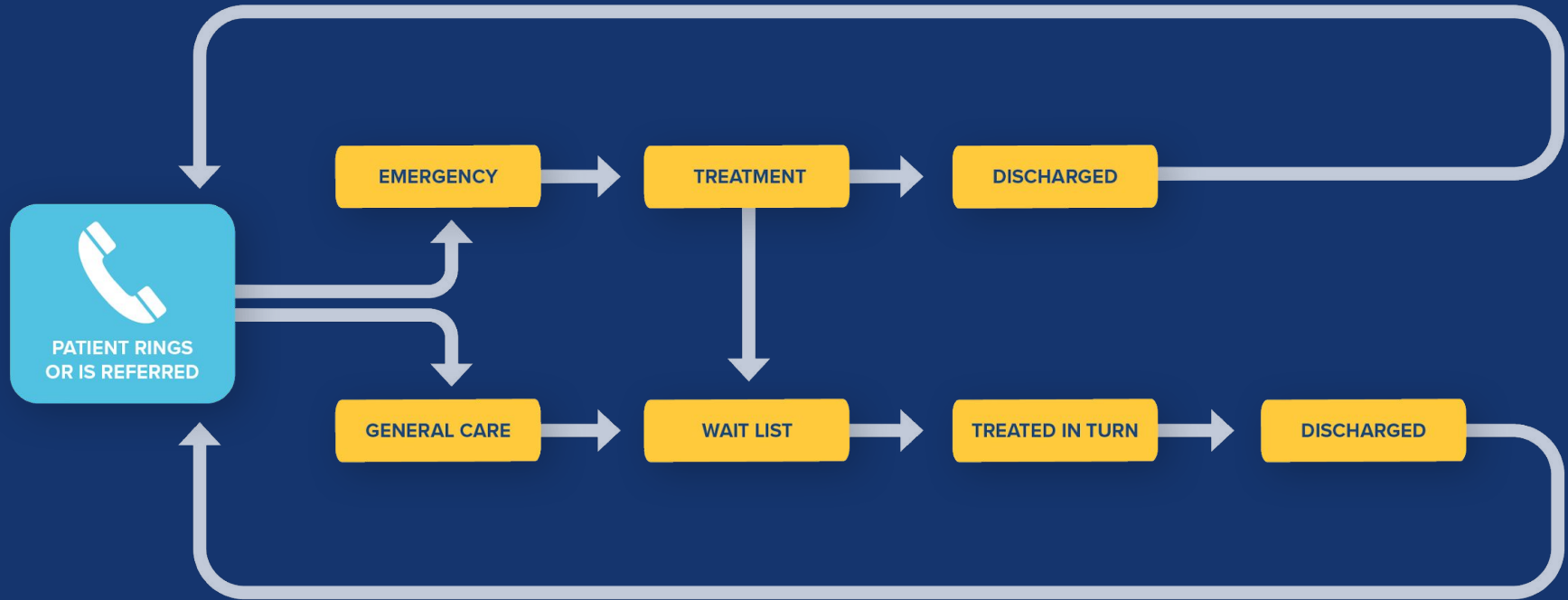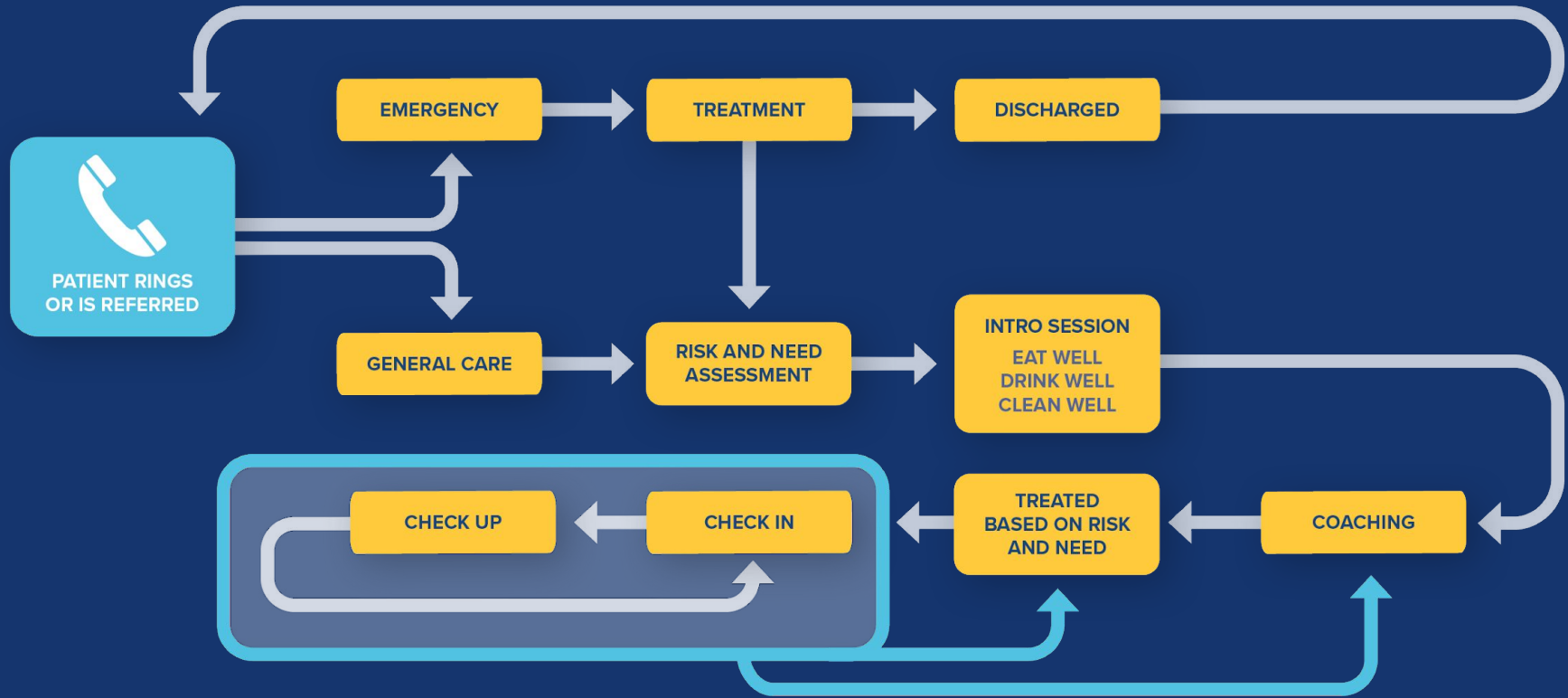
working to creating an inclusive workplace **culture** and improving workforce **capability**

MODELS OF CARE

CONSUMER & WORKFORCE

ENGAGEMENT AND CO-DESIGN

Infrastructure

DHSV - Individualised Interventions

DHSV - Population or Settings-based Interventions

Culture and Capability

ICT Platforms

Measure Outcomes and Costs

Integrate Care Across Providers and Systems

Funding Model

Data Collection and Evaluation
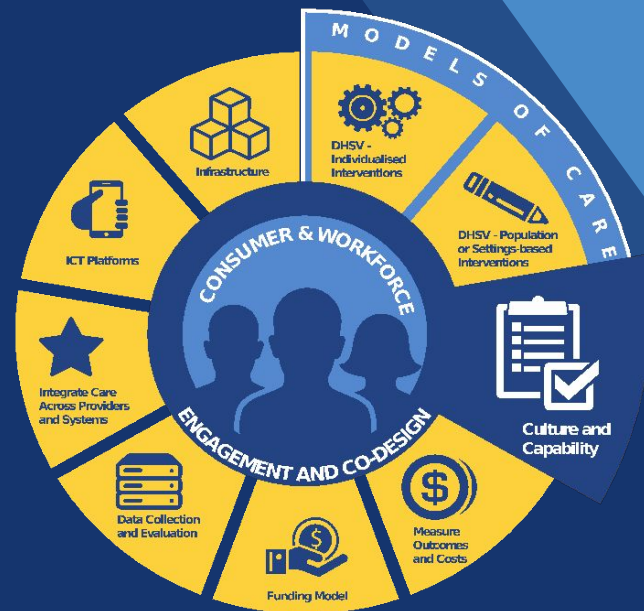
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Creating a workplace culture that embraces change

to support transformation and continuous improvement
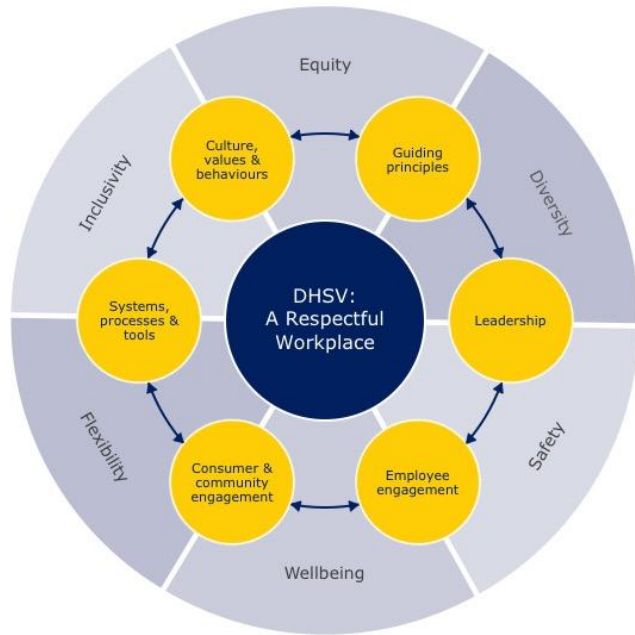
ICHOM organizes Working Groups to define minimum outcomes sets that we recommend all care providers track

DHSV and two consumer representatives worked with ICHOM to develop a standard set of oral health outcome measures for adults

ICHOM facilitates a process with international **clinical and registry leaders and patient representatives** to develop a global Standard Set of outcomes that really matter to patients, along with corresponding case-mix factors

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Measuring Outcomes – ICHOM data set

23 PROM questions – How often do you?

- find it hard to eat because of problems with your teeth, gums or dentures?
- find it hard to speak clearly because of problems with your teeth, gums or dentures?
- have trouble sleeping because of problems with your teeth, gums or dentures?
- clean your teeth?
- have sugary food and/or drinks?

Demographic Questions
age, educational level, financial burden

Complications
Unexpected return visits or harm

General Health Review
Cardiovascular disease, diabetes, facial abnormalities

Clinical Oral Health Review
Caries staging, basic periodontal examination

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Costing Model

- Use time based activity allocation methodology to measure costs at client level

- Establish a model to test scenarios to ensure the value equations is maintained

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