

Submission to the Australian Government Productivity Commission

Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform – Public dental services in Australia

I seriously challenge the Preliminary findings of the report as there is considerably more at stake than providing clinical services i.e. fillings & extractions.

The question that should be asked is do we want to promote oral health or disease management and at what cost?

As stated in the report, public dental services account for only 14% of expenditure on dental care in Australia and that figure is significantly inflated by recent Commonwealth Government programs. Until recently the states funded public dental and the Victorian budget for public dental services was ~ \$90M per annum.

Public oral health services have to be agile and innovative to manage the uncertainty and many changes in funding. In the past 7 years agencies have had to adapt to funding models i.e.:

1. State output funding
2. State course of care funding (Dental Unit Value - DuV)
3. State & Commonwealth activity funding (Dental Weighted Activity Unit – DWAU)
4. Medicare Chronic Conditions
5. Medicare Teen Dental
6. Medicare Child Dental Benefits
7. The National Partnership on Treating More Public Dental Patients – NPA1
8. The National Partnership on Treating More Public Dental Patients – NPA2
9. Voluntary Dental Graduate Year Program – infrastructure + subsidised graduate dentist salaries
10. Oral Health Therapist Graduate Year Program– infrastructure + subsidised graduate oral health therapist salaries

As of today, 26 October 2016, Victorian public oral health services have not been advised of State funding for 2016/17 and operate with the uncertainty as to future Commonwealth Government funding - will Medicare CDBS continue in 2017 or will there be a Child and Adult Public Dental Scheme?

How can this be considered to be acceptable practice or public policy? The public sector needs certainty of funding over the medium term (e.g. 4-5 years) to enable strategic planning, appropriate workforce recruitment, training and retention to support innovative, effective and targeted models of care and clinical service delivery.

The National Partnership on Treating More Public Dental Patients provided significant additional funding that resulted in a dramatic reduction in the number of adults waiting for general treatment. However, much of the funding was redirected to private practices to ensure targets were met. Vouchers issued for treatment in the private sector included Victorian Emergency Dental Service (VEDS), Victorian General Dental Service (VGDS) and Victorian Denture Scheme (VDS).

This strategy is inherently ineffective and costly compared with public sector treatment but with minimal lead in time and ultimately being short-lived, the opportunity to increase the capacity of community health oral health services was denied.

Table 1

2013/14	No. of patients	DWAU	Value per patient – DWAU	Value per patient – \$
Barwon Health	19,325	15,895.16	0.82	328.00
Private Practice	6,885	8,040.20	1.17	468.00

Minimal public performance reporting? Maybe the results aren't published by government but there is extensive data collected, measured and reported back to agencies enabling them to monitor and improve performance.

Audit results* are made available to our patients as posters displayed in the Community Health Centres.

Patients also can obtain information in the Quality Report published annually

Weekly

- Activity reports (DWAUs)

Monthly Scorecards

- Individuals treated inc. CDBS
- Individuals per operator
- Priority access clients
- Visits (adult & child)
- Visits per operator
- Dental Weighted Activity Units (DWAU)
- DWAU per operator FTE – dentist, Dental/Oral health therapist, Prosthetist, Student of State targets
- Attended appointments with no treatment
- Ratio Emerg: (General + Denture) COCS – KPI 40:60
- Access performance of targets
 - General Wait, Denture & Priority Denture Wait List additions, removals & waiting times
 - Children overdue for recall
 - Recall interval for children offered care
 - Triage compliance
 - Appointment failed to attend rate

Quarterly reports – benchmarked against Region & State When an unfavourable trend or outlier (> 1 standard deviation from the mean) is highlighted, investigation is required.

- Agency Quality Clinical Indicators Report*
 1. Restorative retreatment within 6 months – adult
 - 1a. Restorative retreatment within 6 months – Adult – emergency
 - 1b. Restorative retreatment within 6 months – Adult- non emergency
 2. Restorative retreatment within 6 months – Child
 - 2a. Restorative retreatment within 6 months - Child – emergency
 - 2b. Restorative retreatment within 6 months - Child – non-emergency
 3. Unplanned return within 7 days subsequent to routine extraction
 4. Unplanned return within 7 days subsequent to surgical extraction
 5. Extraction within 12 months of commencement of endodontic treatment

6. Denture remakes within 12 months
 7. Fissure sealant retreatment by multiple treatment modes within 2 years – child
 8. Pulpotomy/pulpectomy retreatment by extraction within 6 months - child
- Triage Compliance Report*
 - ✓ Agency's compliance is measured for each triage category 1-5, where a triage compliance result above the target percentage is considered favourable.
 - Dental Care Profile Report
 - ✓ Dental care profile is a measure of the number of services provided per 100 individuals treated. It provides a summary of the types of services and treatment needs of the client group being provided at an agency compared to the region and state.
 - ✓ To assess changes in service type provision and treatment needs over time.
 - ✓ To facilitate the quality of care in terms of assessing treatment planning/appropriateness of care. Areas of over or under servicing will be apparent when assessing the profile data.

Annual reports

- Dental Record Keeping Audit* - benchmarked against Region & State When an unfavourable trend or outlier is highlighted, investigation is required.
 1. Patient Charter & Privacy of Health Information Brochure Provided
 2. Patient Identification Confirmed
 3. Signed and Updated Medical History
 4. Drug Allergies Recorded
 5. Presenting Complaint
 6. Complete charting
 7. Diagnostic Tests / Investigations
 8. Diagnosis & Treatment Planning
 9. Evidence of Informed Consent
 10. Fees estimate
 11. Periodontal condition
 12. Time Out Procedure
 13. Treatment details
 14. Drugs prescribed – name, quantity, dose and instructions
 15. Drugs administered
 16. Legible, accurate and concise documentation (including corrections)
 17. Clinical Handover between visits & between clinicians
 18. Date and legible clinician's name and signature
 19. Standard abbreviations
 20. Chronological order
 21. Objective comments
 22. Referral documentation
 23. Instrument tracking
 24. Clinician working within defined scope of clinical practice
 25. Following best practice clinical guidelines

Provider Output Summary for Dentists, Dental/Oral health therapists, Prosthetists and Oral Health Educators – can be accessed at any time and formally provided to clinicians quarterly

- Service Output
 - ✓ No. individuals treated
 - ✓ No. courses of care
 - ✓ No. visits

- ✓ DWAU
- Appointments
 - ✓ No. appointments
 - ✓ No. FTA
 - ✓ % FTA
 - ✓ No. appointed hours
 - ✓ Appointed hours FTA
 - ✓ Attended appointment – no treatment

Barwon Health conducts audits & surveys independent of the DHSV mandatory requirements

- Pain Management* including triage compliance, clinical indicators & antimicrobial stewardship/medication management
- Storage of sterile stock
- Safe storage of Medication
- Hand Hygiene – 5 Moments*
- Patient feedback – “Let us know your experience with us” – routinely with a minimum requirement of 60 forms to be completed monthly

Medicare CDBS 2015-16

I am disappointed that Medicare only reports on the number of children treated and accountability for services provided should be a priority for government departments overseeing \$M’s in public funding.

Recently private sector dentists have been offering dental treatment in mobile dental clinics to children in local primary schools.

I am particularly concerned that they are over servicing the Medicare Child Dental Benefit Scheme as happened with the Medicare Chronic Conditions Dental Scheme.

The private mobile practice is providing primary school aged children “a Comprehensive check-up and clean, including any necessary x-rays, and, to finish off, a protective fluoride treatment”

Essentially, a child being treated by this private practice would incur a Medicare CDBS claim for examination (\$52.65), bitewing radiographs (\$30.45 x 2), removal of plaque (\$53.80) and topical application of fluoride (\$34.55), a total of \$201.90, before any consideration for other preventive services, restorations or extractions.

By comparison in 2015, Barwon Health treated 3,480 children aged 6 – 12 years in community health centre & mobile dental clinics and preventative services provided were:

- Removal of plaque and/or stain (Item # 88111) – 250 children (7.18%)
- Removal of calculus 1st visit (Item # 88114) – 332 children (9.54%)
- Topical appl. of remineralizing agent, 1 treatment (Item # 88121) - 52 children (1.49%)

However, our clinicians (predominantly Oral Health Therapists) applied concentrated remineralizing agent, application to single tooth (not eligible for CDBS funding) to 1,101 teeth. This is also our preferred treatment model for preschool children (Kinder Wide Smiles).

The above data demonstrates that cleaning teeth and protective fluoride treatments are unnecessary in the majority of child treatment plans but private practices do them as routine treatment adding considerable cost & exhausting funding for restorative work etc.

BH & CAH public clinics providing children with full a course of care for an average Medicare CDBS claim of \$228.58.

I also note that the evidence-based Dental Health Service Victoria (DHSV) Clinical Guideline “Use and Applications of topical remineralizing agents” states:

“Professionally applied topical fluoride gel is an effective way of preventing dental decay in patients at high-risk of developing caries. However, high concentration fluoride gels and foams (> 1.5mg/g F ion) are contra-indicated in children under 10 years of age due to the potential for ingestion. Furthermore, fluoride gels appear more efficacious on the permanent dentition.”

MIND THE DENTAL GAP – HERALD SUN 29 MAY 2013

“SMILES DISAPPEAR AS MEDICARE FAILS TO COVER COSTS”

THE PRESIDENT OF THE ADA SLAMMED THE \$620 MILLION-A-YEAR “GROWING UP SMILING” SCHEME ...WILL BE KNOWN AS THE GOVERNMENT THAT INTRODUCED “POOR DENTISTRY FOR POOR PEOPLE”....THE MEDICARE REBATES WERE LOWER THAN THE AVERAGE FEES...”LEAVE ABSOLUTELY NO ALTERNATIVE FOR DENTISTS BUT TO CHARGE COPAYMENTS FOR SERVICES”

Brokerage – vouchers

Agencies use external vouchers mainly to manage increased demand or to ensure additional funding can be used within prescribed timeframes.

In Victoria there are three categories – Victorian Emergency Dental Scheme (VEDS), Victorian General Dental Scheme (VGDS) & Victorian Denture Scheme (VDS) – but agencies incur a loss when using vouchers as they are paid out at face value but agencies are funded at the DWAU rate set by DHSV.

Agencies also incur costs associated with administrative staff processing the vouchers. The risks identified in recent years include:

- Private practices “maxing out” the vouchers with inappropriate item numbers and claims,
- Item # 213 Treatment of acute periodontal infection – per visit. In 2013, 16% of VEDS included this treatment compared with 1.5% of emergency patients treated in the public clinics
- Claiming Item # 213 (\$56.13) in addition to extraction of the same tooth and/or desensitization (165)
- Appointments – dentists charging for 4 x 30-minute appointments when the treatment was for 2 x 1-hour appointments and charging patients co-payments for 4 visits
- Radiographs – the fee schedule provides for intraoral radiographs, not OPG’s. Multiple radiographs taken for restorative Tx of a single tooth
- Extractions – claiming for surgical extractions when Tx was a simple extraction (311)

I can only reiterate that if agencies were guaranteed funding for 4-5 years instead of the current random funding models, they could plan effectively and use vouchers more efficiently and targeted to need e.g. General course of care patients screened and only issued a voucher (VGDS) if they have < 4 identified restorations/extractions

Refer to Table 1 – page 2

COMMUNITY ORAL HEALTH SERVICES – BARWON REGION - VICTORIA

I place the emphasis on “Community” as we offer more than public dental treatment and encourage community participation and strive to improve population health outcomes.

That includes recruiting young adults from disadvantaged backgrounds to participate in Dental Assistant traineeships, enhancing their skill sets, providing a career pathway and aspiring to elevate themselves from the poverty trap and generational dependency on welfare. They can then provide the inspiration to others to pursue a similar pathway.

The Barwon Health (BH) Oral Health Services in partnership with Colac Area Health (CAH), Wathaurong Aboriginal Health Service and Bellarine Community Health Inc. (BCH) has expanded to 31 chairs (including mobile dental clinics and 3 “virtual” chairs) in recent years.

The Service employs 107 staff in 74 EFT positions and actively participates in action research projects investigating innovative methods to improve oral health and advance healthcare for patients.

Barwon Health clinics are located at Newcomb, Corio, and Belmont Community Health Centres and at the Wathaurong Aboriginal Health Service (Bell Park) in Geelong.

To ensure staffing of clinics, dentists, oral health therapists and dental assistants are rostered on rotation to the 2-chair BCH and to the 5-chair CAH dental clinic.

Oro-Maxillo Facial Surgery (Oral Surgery Registrar) and Temporomandibular Joint Dysfunction (Physiotherapist) specialist clinics support dental and allied health staff and provide locally based services to patients.

Oral health services, taking a population health approach, should take the lead in asking and responding to:

Why is oral disease still a major local & global problem?

- ✓ Failure to implement prevention
- ✓ Failure to understand or choose not to tackle the social determinants of health
- ✓ Reliance on dental practitioners to provide care
- ✓ Reliance on behaviour change advice

There is evidence that:

- ✓ Restorations fail and tooth structure is lost forever in a destructive restoration cycle
- ✓ Tooth structure remineralizes including carious dentine under a well-sealed restoration
- ✓ Health outcomes in the vulnerable improve by early identification of risk and high quality prevention

What are we going to do to improve oral health?

- ✓ Target resources with intensity in proportion to need > closing the gap > reduced needs
- ✓ Develop disease prevention strategies based upon upstream prevention
- ✓ Acknowledge that the drill or scalpel will never succeed in eliminating disease or decay
- ✓ Implement a “Health Promoting Practice Model”

It is time to move towards a health promoting practice model which considers factors such as access, prevention, treatment options, referrals and workforce innovation.

Our intention is a partnership based approach which identifies clients of risk of future dental disease, improves client’s oral health literacy and focuses on prevention and minimal intervention dentistry

Strategic guidelines

Our mission is for our clients to avoid the consequences of poor oral health, maintain function and social confidence and therefore enjoy a better quality of life.

Our aim is to have a consistent approach to the detection of oral disease, prediction of future disease, disease management planning and setting of appropriate recalls.

Our goals are to:

- have our clients tooth brushing with fluoride toothpaste twice a day; and reduce the intake and frequency of fermentable sugars;
- implement workforce innovation; and
- develop and review policies and procedures that reflect best practice.

Methods and implementation

The Barwon South Western Region (BSWR) is a large diverse regional/rural area of Victoria containing the local government areas of Greater Geelong, Colac-Otway, the Surf-Coast, Colac-Otway and Corangamite shires. A range of socioeconomic status levels can be seen across the Barwon Statistical Division ranging from (Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD)) most disadvantaged to most advantaged (ABS, 2011).

Workforce is a key component of dental service continuity for patient care. Retention and recruitment of dental professionals is a challenge for dental services particularly in smaller clinics e.g. CAH & BCH. (Barwon-South Western Region Oral Health Plan, 2011).

Coupled with the challenge of recruiting dentists and oral health therapists within the region, there is considerable research suggesting that greater levels of oral disease are seen in rural dwellers (Rogers, 2011). Some areas covered by the BSWR are situated approximately 100 km or more from the nearest static public or private dental clinic (e.g. Apollo Bay).

Our aim is to provide a sustainable, financially viable model for the delivery of dental services to patients within the BSWR. The key theme involves the agencies working together to maximise access and improve coordination of the public dental workforce to advance patient healthcare.

Stakeholders in the process have included BH, Wathaurong Aboriginal Health Service, CAH, BCH, Department of Health Regional Office, Dental Health Services Victoria (DHSV), Otway Health & Community Services, Lorne Community Hospital and the Terang & Mortlake Health Service.

The process of implementing this initiative has included recruiting oral health clinicians and establishment of an outreach program to service disadvantaged communities. Many of these communities do not have private or public dental clinics.

The Oral Health Service has embraced the R3 principles – Right Time, Right Place, and Right Treatment – and has instituted outreach programs to support the local communities

- Wide Smiles – Oral Health Therapists and Dental Assistants (Certificate IV in Oral Health Promotion) visit kindergartens and primary schools (prep year) offering dental examinations, topical fluoride application to remineralize early carious lesions, education and parent engagement sessions.
- Mobile dental clinics
 - ✓ service communities without reasonable access to public or private dental services
 - ✓ infrastructure funding from VDGYP & OHTGYP for two mobile dental clinics
 - ✓ The itinerary includes kindergartens, Primary & P-12 schools in Moriac, Deans Marsh, Winchelsea, Forrest, Airey’s Inlet, Lavers Hill, Simpson, Lorne, Apollo Bay, Alvie, Beeac, Terang, Mortlake and Cobden.
 - ✓ Aged care facilities
 - ✓ Adult patients (public & private)
- Dental staff have been attending the Christ Church meals/health service and engaging with people who:
 - maybe at risk of homelessness (or actually homeless)
 - may not have the means, knowledge or confidence to access mainstream services
 - may be lonely, have substance abuse issues or mental health issues (or a combination of)

Minimal Intervention Dentistry brings an holistic approach to the treatment of dental caries. It is a cost-effective way to improve oral health, general health and quality of life. It includes early diagnosis, personalized risk assessment, early detection of mineral loss, non-surgical treatment and preservation of tooth structure. MID also recognizes the importance of the patient’s role in controlling their own dental caries.

- Diagnosis including identification of risk factors
- Remineralisation of early non cavitated lesions
- Individual prevention strategies
- If unavoidable – restoration with minimum cavity design
- Where possible – repair not replace restorations

Results and outcomes

In 2013, BH partnered with CAH in developing an outreach program for Kindergarten children using Minimal Intervention Dentistry (MID) principles.

Preliminary results include:

- Positive responses have been received from the parents and children regarding the effectiveness of the outreach project (92.53% of parents found the session helpful).
- 70% of parents consented to their child having an oral health screening. Of those parents, 95% consented to the topical application of fluoride to white spot lesions
- Efficiency - It takes only three to six minutes to examine and apply topical fluoride to a child in a kindergarten compared with the usual 30 minute appointment in dental clinics
- Reduced “dental anxiety” in these children.
- Only those children requiring treatment e.g. fillings, extractions are referred to clinics
- 2013 results:
 - Of the surfaces treated with topical fluoride at Visit 1:
 - ✓ 68% of surfaces with initial signs of decay remained stable or improved at Visit 2
 - ✓ 66% of surfaces remained stable at Visit 3

1,464 children whose parent/carer consented to the application of topical fluoride attended all 3 visits in 2013.

- ✓ 1,290 (82.1%) of surfaces that scored 01, 02 or 03 at visit 1 remained the same or improved at visit 2
- ✓ 1,157 (73.6%) of surfaces that scored 01, 02 or 03 at visit 1 remained the same or improved at visit 3
- From an initial 60 kindergarten settings the service now supports 138 settings including kindergartens, early learning centres and primary schools (Prep – year2)
- It has been demonstrated that primary school children who have been exposed to Smiles4Miles oral health promotion in kindergartens have significantly lower caries rates than those attending other pre-school settings
- A total of 6,501 (BH) & 997 (CAH) children have participated in the program from 2013 – 2015
- All children in the kindergartens receive a tooth brush & tooth paste at each visit irrespective of consent being given to participate in the program
- The screening provides us with the baseline data to inform which high needs settings should be included in the mobile dental clinic itineraries
- The program is funded by State activity, not Medicare CDBS
- The cost of delivering the program is ~ \$50.00 per child per year

Access to services

The Victorian average for the No. eligible individuals treated – 2 year period prior to end of July 2016 – is 30% for children and 30% for adults.

Table 2: Eligible population coverage for postcodes assigned to Barwon Health

	Estimated State eligible population	No. individuals treated – 2 year period prior to end of July 2016			
		No. treated within BH catchment by any agency	% State eligible	No. treated by BH within catchment	No. treated by BH outside catchment
Child (0-17 years)	44,439	16,535	37.2%	15,023	1,962
Adult (18 + years)	69,330	16,611	24.0%	15,271	1,251
Total	113,769	33,146	29.1%	30,294	3,213

Table 3: Eligible population coverage for postcodes assigned to Colac Area Health

	Estimated State eligible population	No. individuals treated – 2 year period prior to end of July 2016			
		No. treated within CAH catchment by any agency	% State eligible	No. treated by CAH within catchment	No. treated by CAH outside catchment
Child (0-17 years)	4,260	2,772	65.1%	2,121	193
Adult (18 + years)	7,120	2,501	35.1%	2,104	321
Total	11,380	5,273	46.3%	4,225	514

Research and Quality Improvement Projects

The Oral Health Service undertakes translational/action research independently, in partnership and in collaboration with Dental Health Services Victoria, LaTrobe University, Deakin University, University of Melbourne, Collier Charitable Trust, Western Alliance, Department of Education & Early Childhood Development, Catholic Education and the Alliance for a Cavity Free Future (ACFF), et al.

With minimal oral health prevention and research funding available, the Oral Health Service must be creative and link projects to “activity” to ensure the work we are doing is relevant, evaluated & the findings disseminated as widely as possible by publishing research.

Latest project - A novel approach for assessing diabetes in the general community – screening for diabetes in the dental setting (Pilot commenced 2016)

Aim:

- To determine the feasibility of screening for diabetes in the potentially high risk population at the community dental clinic at Colac
- To inspire a change in community and health service attitude towards diabetes testing in the community dental clinic setting
- Design and implement appropriate referral pathways for patients for further testing for diabetes
- Identifying diabetes at an early stage will improve outcomes and decrease the impact of complications associated with diabetes

Discussion:

2 in 3 patients presenting to the community dental clinic had either

- previously confirmed diabetes,
- were being tested by their GP for diabetes
- were in the high risk category according to the AUSDRISK assessment tool

In a USA study of 13 general dental practices, 30% of patients were in a high risk category for diabetes (Herman 2015). Our study reports 53% at high risk.

Recent report in the Medical Journal of Australia highlighted personalised intervention reduces distress and HbA1c in those with diabetes (Speight 2016)

Early intervention should decrease the impact of complications associated with diabetes

Next steps:

Refer adults identified as being at intermediate or high risk to nutritionists & fitness or life style coaches – Diabetes educators are focused on people who have been diagnosed as diabetic

Oral Health Educators provide regular sessions to monitor oral hygiene in collaboration with Dentists

and Dental Hygienists – overseas study has demonstrated that improved oral hygiene can reverse Type 2 Diabetes

Other projects and associated public manuscripts include:

1. Identifying the behaviours associated with dental care for adolescents in the Colac-Otway Region (Masters of Public Health project 2016)
2. Clinical guidelines pilot study
 - ✓ Final report presented to DHSV 'Measuring Adherence to Evidence-based Clinical Practice Guidelines'
3. Hall Technique stainless steel crowns – a novel child-friendly method for treating tooth decay
 - ✓ Tonmukayakul U, Martin R, Clark R, Brownbill J, Manton D, Hall M, Armfield J, Smith M, Shankumar R, Sivasithamparam K, Martin-Kerry J, Calache H (2015) 'Protocol for the Hall Technique study: A trial to measure clinical effectiveness and cost-effectiveness of stainless steel crowns for dental caries restoration in primary molars in young children.' *Contemporary clinical trials*. 44: 36-41. doi:10.1016/j.cct.2015.07.005.
 - ✓ 'Practical considerations for conducting dental clinical trials in primary care'. *British Dental Journal* (2015) 218:629-634.
 - ✓ 'The Hall Technique – Minimally invasive reducing method of managing dental caries in primary molars' *Australian and New Zealand Journal of Dental and Oral Health Therapy (ANZJDOHT)*. Editorial, Issue 2 December (2015).
 - ✓ 'No Needle No Drill. Reducing anxiety in the treatment of dental decay.' *The Health Advocate*, October (2015).
4. Centre Against Sexual Assault & Family Violence (CASA) - How do we improve pathways between BH & CAH Oral Health Services and Barwon CASA?
5. Outreach dental service – people at risk and homeless (Christ Church)
6. Refugee oral health project – using local capacity to address oral health challenges in the Geelong area – Buddy Project
7. Smoke free smiles pilot project
8. Kinder Wide Smiles
 - ✓ Mason A, Mayze L, Pawlak J, Henry MJ, Sharp S, Smith MC (2015) 'A preventative approach to oral health for children in a regional/rural community in South-West Victoria, Australia' *Dentistry* 5:313: doi: 10.4172/2161-1122.1000313.
 - ✓ The Prevalence of Caries Free Deciduous Teeth upon Visual Examination in Kindergarten Settings: A Preventative Approach to Oral Health for Children in a Regional/Rural Community in South-West Victoria. *Journal of Preventive Medicine* 1:2 2016
9. Audit of gross dental decay in young children under general anaesthetic – how can oral health services be improved pre and post-surgery?
 - ✓ Pawlak JA, Calache H, de Silva AM, Henry MJ, Smith M (2015) 'Audit of gross decay treatment in young children under general anaesthetic' *Dentistry*, 5:302. doi:10.4172/2161-1122.1000302.
10. Oral Health and Physiotherapy – TMJ Clinic
11. Barwon South Western Region Oral Health Plan – subregional model
12. Education and Implementation of Minimal Intervention Dentistry (MID) Technique
13. Medication Management & Antimicrobial Stewardship Project
14. Splash! Social and health inequalities related to changes in drinking water in rural Victoria
 - ✓ Splash! A prospective birth cohort study of the impact of environmental, social and family-level influences on child oral health and obesity related risk factors and outcomes.' *BMC Public Health* (2011) June 27;11: 505.
 - ✓ A qualitative study of the factors that influence mothers when choosing drinks for their young children Authors: Hoare Alexandria, Virgo-Milton Monica, Boak Rachel,

Gold Lisa, Waters Elizabeth, Gussy Mark, Calache Hanny, Smith Michael, de Silva M Andrea, Journal: BMC Research Notes MS: 5082056511364820

- ✓ Choosing foods for infants: a qualitative study of the factors that influence mothers' Child Care Health Dev. (2016) 42(3):359-369.

15. Romp & Chomp

- ✓ Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. Am J Clin Nutr doi:10.3945/ajcn.2009.28826
- ✓ Process and Impact Evaluation of the Romp & Chomp Obesity Prevention Intervention in Early Childhood Settings: Lessons Learned from Implementation in Preschools and Long Day Care Settings - Andrea M. de Silva-Sanigorski, B.Sc., M.H.N., Ph.D.,^{1,2} Andrew C. Bell, Ph.D.,³ Peter Kremer, Ph.D.,⁴ Janet Park, B.Ed.,⁵ Lisa Demajo, Adv Diploma Community Services,⁶ Michael Smith, BSc, L.D.S.,⁷ Sharon Sharp, D.A.,⁷ Melanie Nichols, Ph.D.,⁸ Lauren Carpenter, BAppSci, BAppSc, B.A.,¹ Rachel Boak, M.Sc.,¹ and Boyd Swinburn, MBChB, M.D., FRACP⁹ Childhood Obesity June 2012 | Volume 8, Number 3 © Mary Ann Liebert, Inc. DOI: 10.1089/chi.2011.0118
- ✓ Obesity prevention in the family day care setting: Impact of the Romp & Chomp intervention...

16. Smile4Miles

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