Ngā Ara Tika

Integrated Practice Guidelines
for Māori Oral Health Providers
in the Primary Care Setting

2013 (updated 2016)
National Māori Oral Health
Coordination Service

ACKNOWLEDGEMENTS

We wish to thank the Quality Improvement Group for Māori oral health providers for their expertise and leadership throughout the development and review of these guidelines.

We also acknowledge the contribution of the Māori oral health providers and their primary care staff that attended workshops, and provided vital service and clinical input into the guidelines.

We also wish to thank Dennis Thorburn (Specialist in Oral Medicine) for peer reviewing these guidelines.

Author: Charrissa Makowharemahihi (Strategic Advisor, National Māori Oral Health Coordination Service).

CONTENTS

GLOSSARY

This section provides definitions for the Māori terms, general terms, and acronyms used in this report. The definitions are limited to the context in which they are used in this report.

MĀORI TERMS		**ACRONYMS**	
Hauora	Health	*ARF*	Acute Rheumatic Fever
Hui	Meeting, gathering	*BSMC*	Better, Sooner, More Convenient
Iwi	Tribe	*FS*	Family Start – a home visiting programme that focuses on child health and well being
Kaupapa	Issue / Subject	*GAS*	Group A beta-haemolytic streptococcal pharyngitis
Māori	Indigenous people of New Zealand	*GP*	General Practitioner
Ngā Ara Tika	Best practice pathways	*IT*	Information Technology
Oranga niho	Oral health	*MOHP*	Māori Oral Health Provider
Pēpi	Baby	*NIR*	National Immunisation Register – A computerised information system
Rangatahi	Youth	*NMOHCS*	National Māori Oral Health Coordination Service
Tamariki	Children	*NZ*	New Zealand
Whānau	Family	*NZGG*	New Zealand Guidelines Group
GENERAL TERMS		*PHOs*	Primary Health Organisations
Oral health practitioner	Dentist, Dental Therapist	*PMIS*	Patient Management Information System
Primary care practitioner	General Practitioner, Nurse Practitioner, Primary Care nurse	*QIG*	Quality Improvement Group for Māori Oral Health Providers
Primary health care practitioner	General Practitioner, Nurse Practitioner, Primary Care nurse, smoking cessation advisor, health promotion coordinator, Tamariki Ora Well Child nurses, and other community based health workers	*WCTO*	Well Child Tamariki Ora – a nationwide publicly funded child health programme

INTRODUCTION

Oral health and primary care practitioners have very specialised training and their work is often restricted to a specific scope within their area of expertise. Integrating oral and primary care practices can maximise opportunities to improve clinical decision making and patient care pathways beyond these individual areas of expertise and, ultimately, improve patient health outcomes.

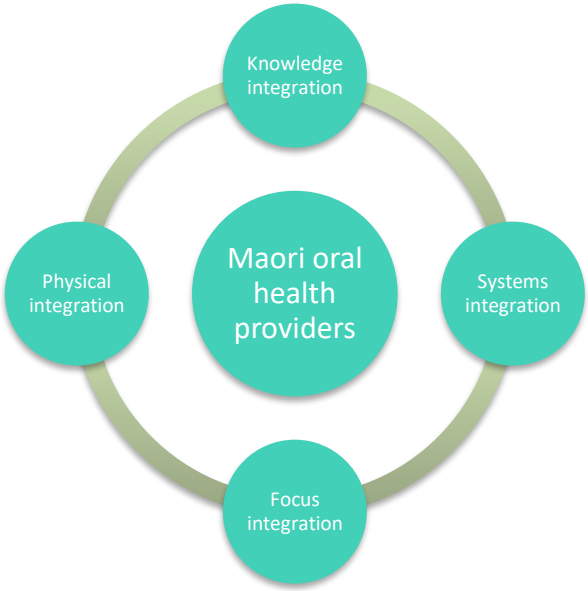
AIM

Integrated Practice Guidelines will assist Māori oral health providers and primary health care professionals to maximise opportunities for patients to get the right information and the right care, at the right time; resulting in improved access to oral and primary health care services, clinical decision making, and better patient experience.

ABOUT THE GUIDELINES

In June 2012, a literature review was completed on oral and general health integrated practices in the primary care setting (NMOHCS, 2012). The review identified four main areas where integrated practices could happen. These areas are:

- **Knowledge integration**: the management and sharing of information between oral and primary care health practitioners to inform patient decision making
- **Physical integration**: the co-location of primary care and oral health facilities to improve clinical care pathways and patient accessibility
- **System integration**: processes that facilitate integration and appropriate care pathways
- **Focus integration**: the shift that needs to occur within the organisation to facilitate change toward integrated service delivery



The development of these Guidelines has been informed by the literature review, government reports, policy and strategic documents, published literature, relevant clinical guidelines, and on-going input from the Quality Improvement Group for Māori oral health providers (appendix 1). The process has also included feedback from the Ministry of Health, workshops with Māori oral health providers including a range of oral and general health professionals, and external peer review.

The priority areas identified in these Guidelines were agreed by the Quality Improvement Group for Māori oral health providers (QIG) with the support of the Ministry of Health. To keep current with emerging and growing health concerns new priority health areas are added as appropriate. The priority areas are:

- Helping people who smoke to stop
- Rheumatic Fever, and
- Hauora Tamariki
- Oral health and diabetes

Under each of the identified priorities, the Guidelines set out key points and recommended integrated practices. Note that the integrated area 'physical integration' has not been included as all MOHP have co-located dental clinics.

TARGET AUDIENCE

These guidelines are intended primarily for Māori oral health providers co-located with primary care services. However, they are relevant and applicable to the wider health sector providing services and programmes for Māori patients and their whānau, especially those with young tamariki, or those at greater risk of oral health problems because of a chronic health condition.

Building a local picture of health and need

These Guidelines can be best utilised when the MOHP has a working knowledge of the demographic and health status of their local communities and population groups. MOHP should obtain and assess, on a regular basis, local information about:

- smoking prevalence and quit statistics;
- people with chronic conditions; and
- Well Child Tamariki enrolment status.

Gathering information about local services and programmes (smoking cessation, family violence, rheumatic fever, child health programmes and services) will also increase provider awareness and support processes to initiate integrated practices.

GRADING OF RECOMMENDED PRACTICES

Each of the priority areas contains recommended practices under the three integrated areas: knowledge, systems, and focus. The main sources for recommended practices are: published guidelines, handbooks, protocols, and systematic reviews. Each recommended practice has been assigned a grade (A and/or B) based on the evidence reviewed or the support of the QIG.

Grade	Recommendation
A	The recommendation is supported by GOOD (strong) evidence
B	The integrated best practice is supported by the Quality Improvement Group for Māori oral health providers

NGĀ ARA TIKA: INTEGRATED PRACTICES FOR HELPING PEOPLE WHO SMOKE TO STOP

AIM:

To take full advantage of every opportunity to provide smoking cessation advice and assistance to people who smoke

RATIONALE

In New Zealand smoking is responsible for nearly 5000 deaths per year including deaths due to second hand smoke (Ministry of Health, 2006). At least 50 percent of all regular cigarette smokers will eventually die from smoking, and on average will lose 14 years of quality life (ASH, 2009). Smoking substantially increases the risk of developing diseases of the respiratory and circulatory systems including cancers of the lung, as well as other non-fatal diseases such as periodontal disease (WHO, 2012; Ministry of Health, 2005).

Smoking disproportionately affects Māori. Māori adults are more than twice as likely to smoke than other adults, with two in five Māori adults (41%) smoking (Ministry of Health, 2013). In 2000-2004, respiratory diseases were one of the five leading causes of death and hospitalisation for Māori (Crengle et al, 2007). Lung cancer is one of the most common causes of cancer among Māori, contributing to over 31% of Māori cancer deaths, compared to 17% of non-Māori cancer deaths (Robson and Harris, 2007).

On average, current smokers have a three-fold increased risk of oral cancer (Gandini et al, 2008). For oral cancers overall, Māori and non-Māori were diagnosed at similar rates, but Māori males were more likely to die from their cancer than non-Māori males (Robson et al, 2005). Tobacco usage combined with alcohol consumption is also major risk factors for oral and pharyngeal cancer (Rodriguez et al, 2004; Blot et al, 1988; La Vecchia et al, 1997).

Evidence shows that tobacco use prevention and cessation, where even basic smoking cessation is offered, can have a measured beneficial effect on the prevalence of smoking (Hendricson and Cohen, 2001; Lamster & Eaves, 2011). The World Health Organisation (2012) states that, '*dentists are as effective as other clinicians in helping tobacco users quit, and results are improved when more than one discipline assists individuals during the quitting process*.'

The co-location of MOHP services with primary care, maternity and Well Child Tamariki Ora providers enables collaboration across services for tamariki and whānau at risk of smoking related illnesses. Smoking around children significantly increases the risk of respiratory illnesses such as croup, bronchitis, and glue ear (Ministry of Health, 2013b). The impact of smoking on tamariki continues on into adulthood as children of a parent who smokes are seven times more likely to become smokers (Ministry of Health, 2013b). Smoking can also have a harmful effect on pregnancy and infant health outcomes (Ministry of Health, 2005). Lead Maternity Carers, including general practitioners have a role to offer smoke free/cessation advice to pregnant women at the time of confirming their pregnancy (Ministry of Health, 2013).

These guidelines support the New Zealand Cessation Guidelines (Ministry of Health, 2007) ABC approach to ***Ask*** about smoking, give ***Brief*** advice to quit, and to offer ***Cessation support*** to those who want to quit.

INTEGRATED PRACTICES

KEY POINTS

- Smoking affects good oral health, and dental treatment outcomes
- Smoking is a health epidemic disproportionately affecting Māori
- Attention should be paid to pregnant women, and whānau of tamariki who smoke
- All health workers, regardless of their location, speciality or seniority, have a responsibility to motivate people who smoke to quit and to assist them in doing so
- Dentists and primary health care professionals have an important role to play in screening for tobacco use, making an offer of treatment and, referring people who want help quitting to cessation services or providing this assistance themselves
- Most people who smoke want to quit and will be grateful for your advice
- There are a range of effective options available to people who want help in quitting

RECOMMENDATIONS

KNOWLEDGE

- Patient information is available at every point of care to ensure clinicians (Dentist, Dental Therapist, appropriate primary health care practitioner) are informed about patient health status (B)
- Attend or instigate inter-service meetings (Primary health care, Cessation Services/Aukati Kaipaipa, Well Child/Tamariki Ora, Lead Maternity Carers) to ensure quality and continuity of care. These hui may discuss how respective services can facilitate access to smoking cessation support, development and implementation of formal (two-way) referral processes (B)

SYSTEMS

- MOHP and Primary Care Practices have information systems that enable the exchange of, and access to, patient information to inform patient care decisions and pathways (B)

Oral health practitioners must:

- Ask patients their smoking status at regular intervals (A) with an increased focus on young people, pregnant women, smokers, and recent ex-smokers (A)
- Record smoking status in the patient information system (B)
- Provide brief advice to all those patients that smoke. Promote the benefits of quitting and the effects of tobacco on the mouth, and make an offer of treatment. Document that advice was given (A). Provide brief advice to whānau and caregivers of young children who smoke (B)
- Patients and/or whānau and caregivers who want help quitting should be referred to an appropriate smoking cessation service/programme. Document that you have done so (A)
- Patients who want to quit, but are not ready to be referred, should be given an appropriate smoking cessation medicine, advice on how to use it, and some basic advice on quitting in the dental setting (A). Practitioners may also promote other quit services.
- Give particular attention to pregnant women, new mothers, and whānau/caregivers of children and provide advice about quitting and promote importance of smoke free areas for children and infants (A) (B)
- Establish referral pathways that enable the exchange of information between MOHP and Primary Care Practices to manage smoking cessation support of patients (B)

Primary care practitioners should:

- Identify people who smoke, who would benefit from oral health care. For example, pregnant women and people with a chronic health condition (i.e. diabetes) will have greater oral health needs and will benefit most from quitting (A) (B). Refer them to the MOHP or their preferred dental provider and document that you have done so (B)
- Provide brief advice to stop smoking and document that advice has been given (B)
- Seek advice and support from the MOHP service to support good oral health practices among pregnant women and people with chronic health conditions who smoke (B)

FOCUS

- All oral health practitioners must undertake the Ministry of Health's online ABC smoking cessation and treatment training to understand the complex nature of tobacco use, its impact on health, and to become proficient in ABC (A) (B)
- Hold an MOHP oral health team meeting to clarify roles and responsibilities of the team in smoking cessation, identify barriers that may prevent involvement, and ways to facilitate greater involvement (A) (B)
- Māori oral health services and primary care services (appropriate primary health care practitioner, Lead Maternity Carers) must meet to establish and maintain effective integration and coordination practices for dealing with patients who smoke and have been identified as at risk of oral health problems (B).
- All MOHP staff must participate in a hui with local cessation providers to review referral pathways and processes for effective exchange of information
- Oral health practitioners may consider education relevant to the component of care they are providing (B). For example, MOHP staff may consider education in:
  - motivational interviewing techniques
  - ABC for pregnant women and/or young people
- Increase awareness of other programmes and support services being accessed by, and available to whānau (B). This will ensure oral health practitioners have confidence in the range of programmes, and that they are appropriate for whānau
- MOHP should be informed of local activities (B) and consider the role they can play in the advocacy of wider tobacco control policies to actively contribute to the reduction of smoking related illnesses in their community (A)

Key to Grades of Recommendations
A: The recommendation is supported by GOOD (strong) evidence.
B: The integrated best practice is supported by the Māori oral health provider Quality Improvement Group.

OTHER KEY GUIDELINES AND DOCUMENTS

Beaglehole. R, Watt, RG. (2004). *Help smokers stop: A guide for the dental team*. London: Health Development Agency.

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NGĀ ARA TIKA: INTEGRATED PRACTICES FOR RHEUMATIC FEVER

AIM

To contribute to the early identification, treatment, and management of Group A beta-haemolytic streptococcal pharyngitis throat infection, and the prevention of Acute Rheumatic Fever among children aged 4 – 19 years, and Māori and Pacific children

RATIONALE

Acute Rheumatic Fever (ARF) is a serious disease that disproportionately affects tamariki Māori, Pacific children, and those living in certain locations in the North Island. ARF can occur after a 'strep throat' – a throat infection caused by Group A Streptococcus (GAS) bacteria. Most strep throats get better and do not lead to ARF. However, in a small number of people, an untreated strep throat causes an 'autoimmune reaction' where the body attacks itself. This autoimmune reaction causes rheumatic fever and the heart, joints, brain and skin become inflamed and swollen.

While the symptoms of rheumatic fever may disappear on their own, the inflammation can cause rheumatic heart disease, where there is scarring of the heart valves. People with rheumatic heart disease may need heart valve replacement surgery, and it can cause premature death. The health burden for a child with ARF and the impact on whānau can be significant. ARF requires long term medical care, particularly if it results in rheumatic heart disease, which can result in disruption to learning, social development, whānau relationships, as well as a financial cost to whānau and the health system.

ARF can be prevented through the early identification and treatment of a strep throat. All sore throats should be checked by a health professional and if a strep throat is suspected, antibiotics should be prescribed.

MOHPs can contribute to goals to reduce ARF through integrating practices. 'Primary Prevention' is one of four intervention points identified to reduce ARF. This involves the early detection and treatment of GAS throat infections with antibiotics, and an increased awareness and education about rheumatic fever (NZGG, 2011).

MOHPs are well positioned to engage in primary prevention activities because of their co-location with primary health services (NMOHCS, 2012). MOHPs are in a position to identify and refer, or manage any sore throats among high risk populations. Integrated practices will ensure appropriate clinical and patient pathways to identify tamariki and rangatahi at risk of ARF, and those that have rheumatic fever.

INTEGRATED PRACTICES

KEY POINTS

- Rheumatic fever is almost exclusively a disease affecting Māori and Pacific people
- Children aged 4–19 years are most at risk
- It is important to identify and treat strep throats in order to prevent ARF
- The Rheumatic Fever Prevention Programme is located in Porirua, Northland, Hawke's Bay, Bay of Plenty, Lakes District, Tairawhiti, Waikato and the Auckland area, and may be a useful source of information for oral health practitioners and whānau
- Take responsibility for helping the child, not just treating the complaint in your particular field of expertise
- General and oral health practitioners need to be able to identify and meet the needs of vulnerable children

RECOMMENDATIONS

KNOWLEDGE

- Patient information is available at every point of care to ensure clinicians (Dentist, Dental Therapists, appropriate primary health care practitioner) are informed about patient health status (B)
- All Māori oral health provider staff should undertake health and education training to recognise and respond appropriately to the signs, symptoms, treatment, and prevention of GAS throat infections and ARF (A)
- MOHP can raise awareness of rheumatic fever and of the importance of getting sore throats checked through posters and DVDs

SYSTEMS

- MOHP and Primary Care Practices have information systems that enable the exchange of, and access to, patient information to inform patient care decisions and pathways (B)

Oral health practitioners must:

- Ensure appropriate systems are in place (which is in line with local practices) to manage sore throats presenting to MOHP for the prevention of ARF (B)
- Ask the patient or caregiver/parent about current sore throats (A)
- Quickly assess and manage all patients aged 4–19 years with a sore throat as outlined in the Sore Throat Management Guidelines (A) by either the oral health practitioner or appropriate primary health care practitioner (B)
- Provide rapid access to antibiotics for strep throat (A). Taking into consideration the individual needs and circumstances of the patient/whānau the dentist should either prescribe and dispense antibiotics, refer the patient to their GP, or a primary care nurse with standing orders (B)
- Record in patient notes that the swab has been taken and/or antibiotics have been given (B) and notify the patients primary care practitioner for follow-up (B)
- Ask about the overall health and well being of a patient with ARF and, where appropriate, exchange information with their primary care practitioner to establish an appropriate oral and health care plan (B)

Primary care practitioners must:

- Advise the oral health practitioner of swab results and confirm treatment provided (B)
- Refer patients with rheumatic heart disease to the MOHP or their preferred dental provider for regular dental care and document in patient notes that you have done so (B)

FOCUS

- Māori oral health services and umbrella primary care services must meet to establish and maintain effective integration and coordination practices for dealing with patients with rheumatic fever or at risk of rheumatic fever (B)
- Attend or instigate inter-service (oral health care practitioners, primary health care practitioner/s, Community nurse, Public Health nurses) meetings as appropriate to ensure quality and continuity of care. These hui might discuss how respective services can facilitate access to care, or the development of formal (two-way) referral processes, which includes documenting outcome of referral (B)
- Increase awareness of other programmes and support services being accessed by, and available to whānau (B). This will ensure oral health practitioners can have confidence in the range of programmes, and that they are appropriate for whānau
- Oral health practitioners may consider education relevant to the component of care they are providing (B). For example, MOHP staff may consider education in:
  - components of the B4 school programme
  - benefits of immunisation
  - Family Start (FS)

  MOHP should participate in a hui with local Rheumatic Fever Prevention Programme providers and consider the role they can play in the advocacy of wider rheumatic fever prevention policies and activities i.e. poverty and housing (B)

Key to Grades of Recommendations
A: The recommendation is supported by GOOD (strong) evidence.
B: The integrated best practice is supported by the Quality Improvement Group for Māori oral health providers.

OTHER KEY GUIDELINES AND DOCUMENTS

New Zealand Guidelines Group. (2011). *Management of Group A Streptococcal Sore Throat*. Wellington: New Zealand Guidelines Group.

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The Heart Foundation. (2006). *New Zealand Guidelines for Rheumatic Fever – 1. Diagnosis, management and secondary prevention*. Auckland: The Heart Foundation.

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NGĀ ARA TIKA: HAUORA TAMARIKI

AIM:
To check, connect, and organise care for tamariki with unmet health needs

RATIONALE

There is good reason for MOHP to focus on integrated practices for tamariki Māori. Māori children are almost twice as likely to be hospitalised as non-Māori children for avoidable illness such as respiratory disease and skin infections, and are more likely to experience poorer health outcomes than other children (Ministry of Health, 2012a). But, despite this higher level of health need, a significant amount of need for health care among tamariki Māori remains unmet.

The NZ Health Survey reported that 28% of tamariki Māori had unmet need for primary health care in the previous 12 months (Ministry of Health, 2012a). There are also significant levels of unmet oral health need among tamariki Māori, with 27.8% having untreated decay in baby teeth compared to 13.5% of non-Māori children (Ministry of Health, 2012a). In children aged between 1 to 4 years, only 52% had visited a dental health care worker in the past year. The government is also shining a light on children at risk of harm, neglect and abuse. Tamariki Māori are at greater risk of harm, neglect, and abuse (MSD, 2012). Through the White Paper, the government is investing in a range of mechanisms to protect vulnerable children. Part of the approach is a greater responsibility on people and organisations working with children to identify and respond to the needs of vulnerable children early (MSD, 2012).

There are opportunities and obligations for both primary care and oral health providers to contribute toward efforts to intervene and reverse these disparities. MOHPs will connect with primary health care services and Well Child Tamariki Ora services to work in a collaborative and coordinated way to ensure whānau have the right information to make informed decisions about health care for their child. Both professions, dental and primary care, have the opportunity to ***check***, ***connect***, and ***organise care*** for tamariki with unmet needs.

The burden of avoidable disease and ill-health on a child and its whānau can impact on the child's learning, school attendance, parental work obligations, financial pressures, as well as the stress of caring for a child that is unwell. Particular emphasis is placed on those tamariki eligible for B4 School checks to minimise the impact of poor health on learning outcomes. Interventions and new ways of doing things are needed to address and improve oral health for tamariki Māori, and vulnerable tamariki.

Integrated practices between MOHP and primary care will maximise opportunities to ensure tamariki and their whānau are connected to health services, and address and prevent oral health disease and other avoidable child health illnesses. This *ara tika* (pathway) acknowledges the importance of healthy tamariki in the context of healthy whānau. Pregnancy and the first years of life are critical stages in the life cycle, so opportunities to inform and connect pregnant women and new mothers to child health services are a priority.

Working in an integrated way to respond to the oral health and general health needs of tamariki will go a long way to achieve good health outcomes over the long term, and contribute to healthier and happier tamariki.

INTEGRATED PRACTICES

KEY POINTS

- 0 – 2 year olds are a priority, particularly tamariki Māori and vulnerable children
- Every whānau contact with primary care and oral health services is an opportunity to connect those whānau to other needed health services
- It is better to keep people from falling ill than to treat them once they are ill (WHO)
- Take responsibility for helping the child, not just treating the complaint in your area of expertise
- General and oral health practitioners need to be able to identify and meet the needs of vulnerable tamariki
- Factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community (MSD, 2012)
- Oral health practitioners can contribute to ensuring tamariki in their community are fully immunised

RECOMMENDATIONS

KNOWLEDGE

- Patient information is available at every point of care to ensure clinicians (Dentist, Dental Therapists, primary health care practitioner) are informed about patient health status (B)
- Dental team must complete training with Tamariki Ora provider about the purpose of the Well Child programme to better inform parents/whānau (A) (B)

SYSTEMS

- MOHP and Primary Care Practices have an information system that enables them to exchange and access patient information as appropriate, to inform patient care decisions and pathways (B)

Oral health practitioners must:

- Ask the parent/primary caregiver if the child is enrolled with a Tamariki Ora/Well Child Provider (A, B)
- Where appropriate, facilitate access to care by referring the child and their whānau to the primary care nurse or WCTO provider for follow up and document that you have done so (B)
- Where a child is enrolled with a WCTO provider, use appropriate referral pathways to fill any gaps in scheduled health checks (B)
- Where the child is not enrolled with the WCTO programme, get appropriate consent from whānau, and refer them to their preferred WCTO provider. Document that you have done so (B)
- Ask the parent/whānau if the child is enrolled with the MOHP or community dental service provider. If not, obtain consent to enrol the child or use referral pathway to refer the child to the community dental service (A) (B)
- Promote understanding of the community oral health service and importance of good nutrition and healthy teeth (B)
- Inform pregnant women or new mothers about WCTO and Community Oral Health services for pēpi/tamariki (B). Use this opportunity to promote good nutrition during pregnancy, benefits of breastfeeding, and good oral health practices for mother and baby. Give information as necessary
- As appropriate, determine any additional health, educational, or social needs of the child and/or whānau and use appropriate referral pathways to services and programmes who can further

assess child/whānau needs

Primary care nurses & WCTO providers must:

- Encourage whānau to enrol their pēpi/tamariki with the MOHP or the community dental health service. Provide information about the service and encourage regular dental visits even if there are no dental problems (B)
- As appropriate, refer children to their MOHP or community dental health service earlier than recommended particularly where the child was premature, low birth weight, or with developmental disabilities and disorders (B)
- At the B4school visit carry out an 'oral health check' at core contacts (B). The oral health check assessment should determine:
  - enrolment status with the community oral health service or MOHP
  - any previous dental visits
  - lift the lip for signs of untreated dental decay
  - check for barriers to access, and
  - where appropriate, referral to an oral health service provider for follow up (A,B)

  Particular attention should be paid to children completing the B4 school check to identify untreated decay.
- Review enrolment/dental visits at subsequent core visits and where there are gaps, facilitate access to a community dental services (A) or MOHP and document you have done so (B)
- Promote whānau understanding of oral health care and importance of healthy teeth, good nutrition, and how to avoid dental caries (A,B)

FOCUS

- Attend or instigate inter-service (oral health care, primary health care practitioner/s, WCTO staff, lead maternity carers) meetings as appropriate to ensure quality and continuity of care. These hui may discuss how respective services can facilitate access to and completion of core health checks such as B4 school and immunisation or the development of formal (two-way) referral processes, which includes documenting outcome of referral (B)
- Participate in a cross organisation hui to increase awareness of other services being accessed by and available to whānau (B). This will ensure oral health practitioners can have confidence in the range of programmes, and that they are appropriate for whānau
- Oral health practitioners may consider education relevant to the component of care they are providing (B). For example, MOHP staff may consider education or training in:
  - components of the B4 school programme
  - benefits of immunisation
  - recognising family violence, and local agencies and initiatives
  - Family Start (FS)
  - assessment skills – to identify health need and to take into account everything happening around that child (A)
- MOHP should consider their role in advocating for improving child health (B)

Key to Grades of Recommendations
A: The recommendation is supported by GOOD (strong) evidence.
B: The integrated best practice is supported by the Māori oral health provider Quality Improvement Group

OTHER KEY GUIDELINES AND DOCUMENTS

Ministry of Health, (2002). *Well Child National Schedule Handbook*. Wellington: Ministry of Health.

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NGĀ ARA TIKA: INTEGRATED PRACTICES FOR ORAL HEALTH AND DIABETES

AIM:

To be an effective part of comprehensive care for people who are at risk of, or have diabetes.

RATIONALE

Diabetes is a major health problem, and is a leading cause of morbidity and mortality in Aotearoa New Zealand (MoH, 2009). It is also an area where significant disparities exist in both prevalence and outcomes. For example:

- Diabetes is almost three times more common in Māori than non-Māori
- The mortality rate for Māori with type 2 diabetes is seven times higher than non-Māori
- Māori aged between 45-64 years have a death rate due to diabetes nine times higher than for non-Māori of the same age
- Māori women more likely to die from type 2 diabetes at 13 times the rate of non-Māori women, and Māori men at 10 times the rate of non-Māori men (Robson & Harris, 2007).

Diabetic complications are disproportionately higher for Māori than non-Māori (Robson et al, 2009); these complications include renal failure, lower limb amputation, eye problems, and heart disease (Robson et al, 2009). Diabetes accelerates atherosclerosis and the relationship between diabetes and cardiovascular disease (CVD) is well known; people with type 2 diabetes are two to four times more likely to have CVD, and CVD is the leading cause of death in people with diabetes (MoH, 2011). It is essential that oral health practitioners working with at-risk population groups have a thorough knowledge of diabetes, its prevention, symptoms, treatment, and management.

Progress to develop better integrated oral and general health practices has been slow, despite good evidence that supports the pivotal role of oral health care and dentistry in the early detection, prevention, and management of care for people with diabetes (Ding et al, 2011). There is an established link between good oral health and good general health. Acute or chronic dental problems can be compounding factors in medical problems such as poorly controlled diabetes, smoking related illnesses, and people requiring a dental exam or dental certification prior to surgery (Robson et al, 2011).

The Ministry of Health's policy for oral health 'Good Oral Health for All, For Life' states, '*primary care practitioners are suitably placed to identify individuals at high risk of developing poor oral health, or to refer an individual with pain or signs of oral disease on to a dental professional* (MoH, 2006). Growing international evidence also identifies the need for greater coordination and collaboration between medical and dental providers for patients with diabetes by developing an integrated model of care that is more tailored around the needs and risks of the patient (Hummel & Gandara, 2011).

Māori oral health providers are committed to efforts to reduce health inequalities and improve access to care for people with diabetes, by being part of a comprehensive package of care necessary for maintaining good oral health, and overall good health and well-being.

INTEGRATED PRACTICES

KEY POINTS

- Periodontal disease is more common in people with diabetes; about one-third of diabetics have severe periodontal disease
- Ensuring equity of access to quality oral health care will help reduce the risk of developing complications for those with diabetes
- Informing diabetic patients about the relationship between diabetes and periodontal disease as an important part of maintaining good oral and general health
- The closer alignment of oral health with general health creates a significant opportunity for dental health professionals to help reduce the incidence and adverse impact of chronic conditions on the quality life of their patients
- Effective diabetes management and oral health are impossible to attain without self-management skills

RECOMMENDATIONS

KNOWLEDGE

- Patient information is available at every point of care to ensure oral health and primary care practitioners, treating the same patient, have all the information they need, organised correctly at the point of care, to make the right clinical decisions (A) (B)
- Attend or instigate inter-service meetings (Primary health care, Diabetes Services, Diabetes practitioners), to ensure quality and continuity of care. These meetings may discuss how respective services can facilitate access to comprehensive diabetes care, as well as the development and implementation of formal (two-way) referral processes (B)

SYSTEMS

- Māori oral health providers and primary care practices have information systems that enable the exchange of, and access to, patient information to inform patient care decisions and pathways (A) (B)

Oral health practitioners must:

- Ask patients if they are diabetic, with a focus on risk factors such as established cardiovascular disease, or those who are over-weight
- Ask patients about their family history of diabetes and determine if there are any classic signs and symptoms of diabetes mellitus in the patient such as: polyuria (excessive urination), polydipsia (excessive thirst), polyphagia (excessive sense of hunger), and recent onset of blurred visions or recent weight loss (A). If family history is positive for diabetes mellitus and such signs or symptoms are present, the oral health practitioner must inform the patient's GP (A)
- Refer the patient to their GP when the dentist suspects that patients may have undiagnosed diabetes mellitus, diabetes that is poorly controlled, or have an established CVD condition and have not had regular care (A)
- Practitioners should be mindful of other oral health conditions which can be diabetes related, whether diabetes has been diagnosed or not. These conditions include:
  - Salivary and taste abnormalities
  - Fungal infection e.g. candidiasis in various presentations
  - Bacterial infections e.g. space infection
  - Poor wound healing
  - Neurosensory changes i.e. burning mouth syndrome

- Evaluate and treat a diabetic patient with acute periodontal disease. If there are concerns that poor glycaemic control may contribute to the severity of the patient's periodontal disease, refer the patient to their GP outlining concerns and request that the GP review the patients glycaemic control to determine whether the treatment for diabetes should be adjusted (A)
- Vice versa, acute and chronic infection is a factor in poor glycaemic control. Untreated dental and periodontal infection can be a cause of brittle, or poorly controlled diabetes. If there are concerns that the patients dental and/or periodontal disease may contribute to poor glycaemic control refer the patient to their GP outlining concerns and request that the GP review the patients glycaemic control to determine whether the treatment for diabetes should be adjusted (B)
- Evaluate referred diabetic patients for periodontal disease and treat as necessary (A). Ensure the patient is scheduled for follow up with the referring primary care practitioner after being seen by the dentist (A). Send dental findings and treatment to the referring primary GP. Schedule the patient for a dental follow up appointment for on-going care (A)
- Provide patients with information about the relationship between diabetes and oral health, advise and reinforce to patients that adequate day-to-day oral care is a normal patient responsibility in diabetes self-management for maintaining good oral health, and the need for regular check-ups (A) (B)
- Establish referral pathways that enable the exchange of information between MOHP and primary care practices to manage care for patients with diabetes (B)
- Record patient status and document all actions in the patient information system (A) (B)

P**rimary care practitioners must:**

- Identify people at risk of diabetes, who would benefit from oral health care (A) (B) and refer them to the MOHP or their preferred dental provider to evaluate the patient for periodontal disease and other oral health conditions associated with diabetes, and document that you have done so (A) (B)
- Refer patients with diabetes to the MOHP or their preferred dental provider for a complete evaluation of their oral health (A) if they answer 'no' or 'unsure' to the following questions about oral health:
    - Do you visit your dental provider at least once a year for a full-mouth exam?
    - Do you know how diabetes can affect your teeth and gums?
    - Do you know the best way to brush your teeth and use dental floss?
    - Do you know the early signs of tooth, mouth, and gum problems?
    - Do you have any problems in your mouth, such as loose teeth, red or swollen gums, burning, difficulty chewing, or poorly fitting dentures (A)
- When receiving a referral from the dentist gather additional information from the patient and from laboratory tests, and with the patient develop a treatment plan to improve the patient's glycaemic control. Recommend regular oral health checks as part of the patient's treatment plan. Send relevant patient information to the referring dentist advising that the patient has been seen, addressing any specific issues raised by the dentist in the consultation, and that a follow up appointment with the dentist has been recommended (A)
- Provide the results of laboratory tests such as HbA1c to dentists on request (A)
- Be aware of the effects of oral infection and periodontal inflammation have on achieving ideal glycaemic control (A)
- Practitioners should be mindful of other oral health conditions which can be diabetes related, whether diabetes has been diagnosed or not. These conditions include:
    - Salivary and taste abnormalities
    - Fungal infection e.g. candidiasis in various presentations

- Bacterial infections e.g. space infection
- Poor wound healing
- Neurosensory changes i.e. burning mouth syndrome

- Provide patients with information about the relationship between diabetes and oral health, advise and reinforce to patients that adequate day-to-day oral care is a normal patient responsibility in diabetes self-management and for maintaining good oral health, and the need for regular check-ups (A) (B)
- Establish referral pathways that enable the exchange of information between MOHP and primary care practices to manage care for patients with diabetes (B)
- Record patient status and document all actions in the patient information system (A) (B)

FOCUS

- Hold an MOHP oral health team meeting to clarify roles and responsibilities of the team in diabetes care, identify barriers that may prevent involvement, and ways to facilitate greater involvement (A) (B)
- Māori oral health services and primary care services (appropriate primary health care practitioner, diabetes services) must meet to establish and maintain effective integration and coordination practices for working with patients with diabetes, who have been identified as at risk of, or who have existing oral health problems (B)
- Oral health practitioners should complete appropriate training so they can become experienced in delivering nutrition promotion messages to support patients to actively participate in programmes aimed at weight reduction (A)
- All MOHP staff must participate in a hui with their diabetes services to review referral pathways and processes for effective exchange of information
- Increase awareness of other programmes and support services being accessed by, and available to people with diabetes (B). This will ensure oral health practitioners have confidence in the range of programmes, and that they are appropriate for whanau/families.
- MOHP should be informed of local diabetes services and initiatives (B) and consider the role they can play in the advocacy of wider diabetes activities to actively contribute to the impact of diabetes in their community (A)

Key to Grades of Recommendations
A: The recommendation is supported by GOOD (strong) evidence.
B: The integrated best practice is supported by the Māori oral health provider Quality Improvement Group.

OTHER KEY GUIDELINES AND DOCUMENTS

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APPENDIX 1: QUALITY IMPROVEMENT GROUP FOR MĀORI ORAL HEALTH PROVIDERS

The Quality Improvement Group for Māori oral health providers comprises representation from the Māori oral health provider sector. QIG members are appointed by the Executive Leadership Team of the Ministry of Health's Māori Health Business Unit.

QIG MEMBERSHIP

QIG MEMBERSHIP	PROVIDER
Justin Wall (Chair*)	Te Runanga o Toa Rangatira Inc, Porirua
Cheryl Britton	Te Hauora o te Hiku o Te Ika, Kaitaia
Greg Keay	Ngāti Hine Health Trust, Kawakawa
Ana Randall	Raukura Hauora o Tainui, Hamilton
Minnie McGibbon	Te Manu Toroa, Tauranga
Pera Ngerengere (2014) Wiremu Reihana (2016)	Ngāti Porou Hauora, Te Puia Springs
Raewyn Bourne	Tipu Ora, Rotorua
Patrick LeGeyt (2014) Tina Godbert (2016)	Te Taiwhenua o Heretaunga, Hastings

*Current Chair as at 4 April 2016