Quality of care, patient safety & shared competencies : A dental perspective

(with a specific emphasis on collaborative practice, interprofessional education, oral health workforce planning)

Geneva 22.May.2016

- The **dramatic process of change** which has a clear impact on health-related issues

(e.g. changing disease, life-expectancy and life-style patterns, burden of NCDs, broader definition of health and quality of life, advances in science and technology, and disease and life, quality pressure, etc..)

- The **dramatic process of change** which has a clear impact on health-related issues

(e.g. changing disease, life-expectancy and life-style patterns, burden of NCDs, broader definition of health and quality of life, advances in science and technology, and disease and life, quality pressure, etc..)

- The **unsolved** health matters from the last millennium

(inequalities, problems of access to care, underserved areas and communities, shortage of qualified health professionals, cost-containment, etc..)

- The **dramatic process of change** which has a clear impact on health-related issues

(e.g. changing disease, life-expectancy and life-style patterns, burden of NCDs, broader definition of health and quality of life, advances in science and technology, and disease and life, quality pressure, etc..)

- The **unsolved** health matters from the last millennium

(inequalities, problems of access to care, underserved areas and communities, shortage of qualified health professionals, cost-containment, etc..)

bring out the **need** for exploring **new** and **effective models of provision of care**.

exploring **new** and **effective models of provision of care**.

Among the many other attempts

(allocating more budget for health, optimal workforce planning, curriculum changes for an education complying with the needs and demands, improving the working conditions of health professionals, etc..)

to overcome the existing matters

collaboration of various degrees and **between various health care providers**

is likely to serve as a **tool** to improve patient care and provision of care.

discussions *taking place in the wider health care system*

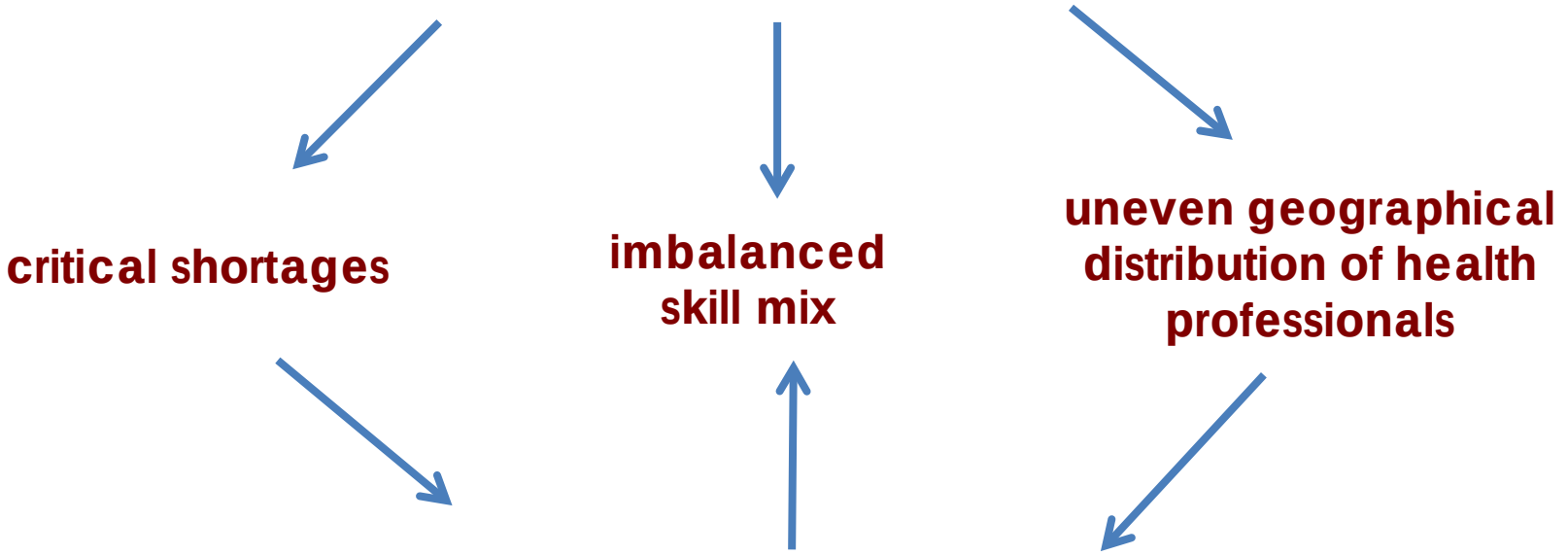
- Definitions
- Models
- Benefits
- Success factors
- Barriers
- Best practices
- Outcomes
- Others..

+

- Regulations

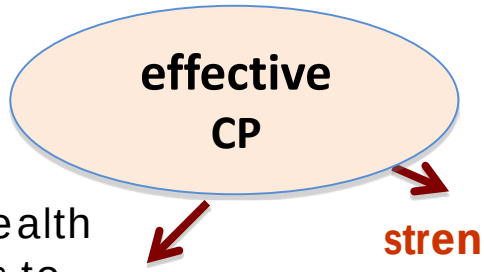
According to WHO;

'We are currently facing a **severe global health workforce crisis** with



***leaving millions without access to health services*.**

Transformative scale up of health professional education : An effort to increase the numbers of health professionals and to strengthen their impact on population health, World Health Organization WHO/HSS/HRH/HEP2011.01



allows health workers to engage any individual whose skills can help **achieve local health goals**.

strengthens health systems & **improves** health outcomes.

CP can improve:

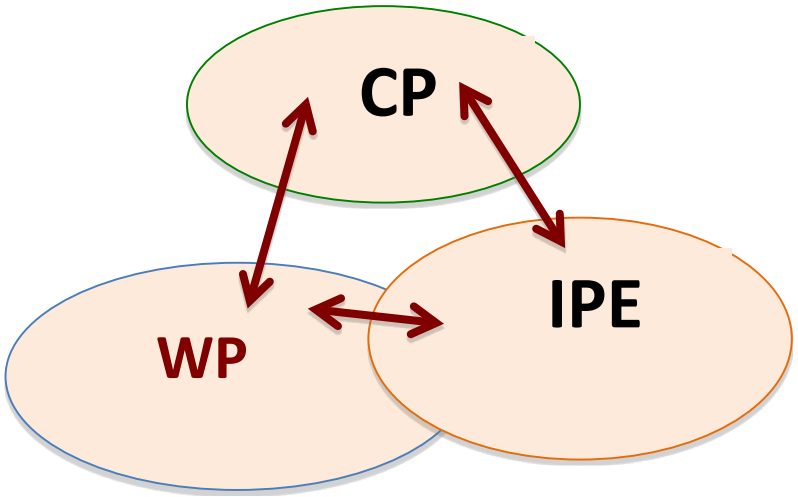
-access to and coordination of health-services
-appropriate use of specialist clinical resources
-health outcomes for people with chronic diseases
-patient care and safety

CP can decrease:

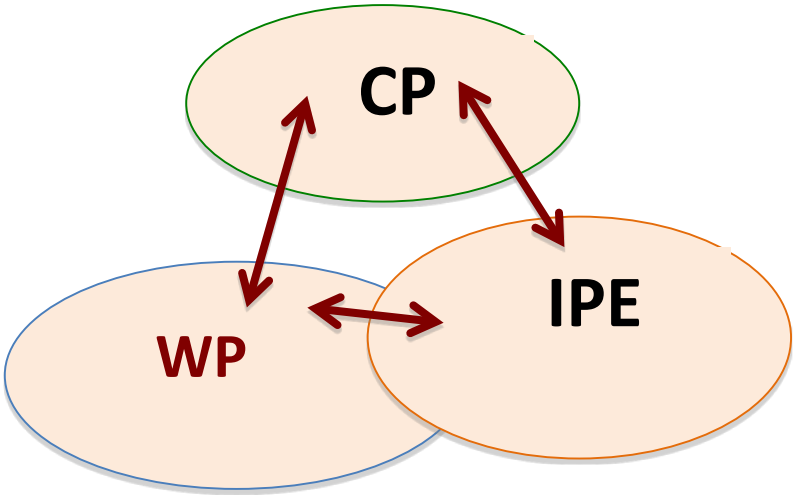
-total patient complications
-length of hospital stay
-tension and conflict among caregivers
-staff turnover
-hospital admissions
-clinical error rates
-mortality rates.

WHO Framework for Action on Interprofessional Education & Collaborative Practice

Health Professions Networks Nursing & Midwifery Human Resources for Health World Health Organization Department of Human Resources for Health www.who.int/hrh/nursing_midwifery/en/ WHO/HRH/HPN/10.3



health systems - **fragmented**



Collaborative practice-ready workforce
an **innovative strategy** that will play an important role in mitigating the **global health workforce crisis.**

Evidence shows that as these health workers move through the system, opportunities for them to gain i**nterprofessional experience** help them **learn the skills** needed to become part of the **collaborative practice-ready health workforce**.

WHO Framework for Action on Interprofessional Education & Collaborative Practice

Health Professions Networks Nursing & Midwifery Human Resources for Health World Health Organization
Department of Human Resources for Health www.who.int/hrh/nursing_midwifery/en/ WHO/HRH/HPN/10.3

Dentistry – No exception – Similar discussions

collaboration of various degrees and **between various health care providers**

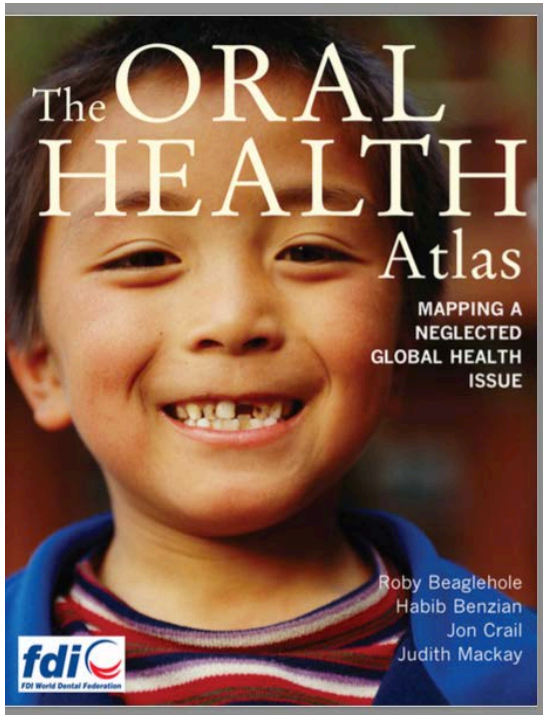
is likely to serve as a **tool** to improve patient care and provision of care.

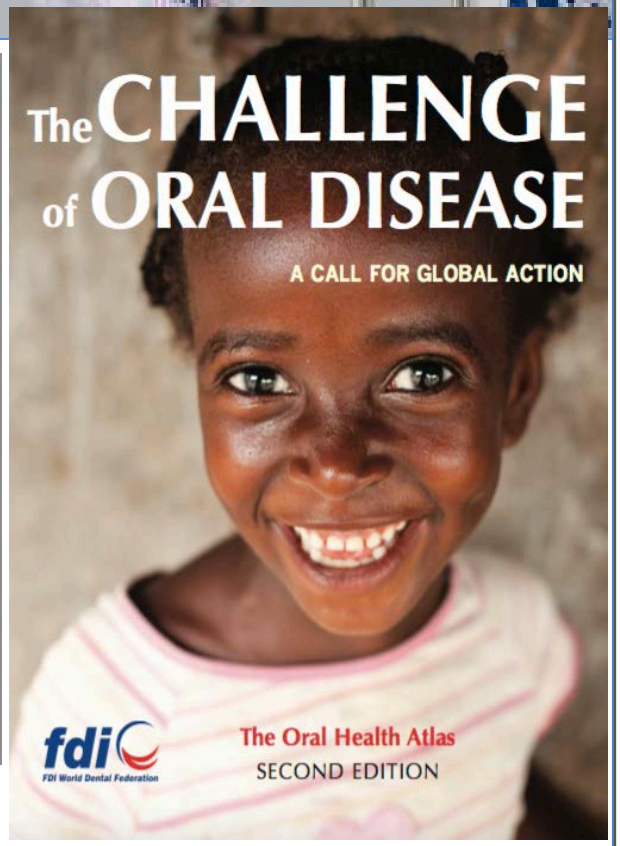
→

- Definitions
- Benefits
- Success factors
- Barriers
- Best practices
- Outcomes

\+ Regulations

Worldwide, authoritative & independent voice of dentistry





ORIGINAL ARTICLE

International Dental Journal 2013; 63: 296–305
doi: 10.1111/idj.12084

Oral health workforce planning Part 1*: data available in a sample of FDI member countries

Nermin Yamalik[1], Eduardo Ensaldo-Carrasco[2] and Denis Bourgeois[3]

[1]*Department of Periodontology, Faculty of Dentistry, University of Hacettepe, Ankara, Turkey;* [2]*Department of Microbiology, Faculty of Dentistry, National Autonomous University of Mexico, Mexico City, Mexico;* [3]*Department of Public Health, Dental Faculty, University of Lyon 1, Lyon, France.*

Background & aim: Workforce planning is a resource to measure and compare current versus future workforce. Organised dentistry needs to focus on the benefits and the determinants and various systems of workforce planning together with the challenges, new trends and threats. The aim of the study was to identify data sources from countries relating to a selection of oral health indicators in a sample of FDI member countries. The potential for differences between developed and developing countries was also examined. **Methods:** A cross-sectional survey study was carried out among FDI member countries classified in developed and developing countries between October 2011 and January/February 2012. A questionnaire was developed addressing the availability of 40 selected indicators distributed in four domains. Mann–Whitney *U*-tests to identify differences between developed and developing countries and chi-square tests for the degree of information regularly available were carried out. **Results:** There is an important lack of information about indicators relevant to oral health between FDI participating countries regardless of their level of economic development. Although not significant, the availability of indicators for developing countries showed higher variability and minimum values of zero for all domains. Surveys were the source of information more frequently reported. **Discussion:** Standardised and reliable methodologies are needed to gather information for successful workforce planning. It is of utmost importance to increase the awareness and understanding of the member National Dental Associations regarding the role, basic elements, benefits, challenges, models and critical elements of an ideal workforce planning system.

Key words: Oral health workforce, planning, indicators, oral health

INTRODUCTION

The latest and newest health technologies can have a positive impact on human health when proper systems exist to deliver them. However, health systems worldwide suffer from years of neglect[1]. This has been attributed to the lack of trained health workers and is considered one of the most important constraints to strengthening the delivery of primary and other health services[2], including oral health care[3–5]. As the epidemiology of oral diseases shifts over time owing to the variability of lifestyle and cultural factors, changes in oral health care and dental education are required[3]. Therefore, new approaches and processes to workforce planning are essential to meet the future needs and demands of the population[6].

Workforce planning is a procedure to measure and compare current (supplies) *versus* future workforce (demand or spaces) and provides an insight into the best policies and initiatives needed to improve the overall human resources system[7]. It also helps us to understand the internal and external environment and how these factors can affect our current and future workforce, by being aware of the skills, capabilities and aptitudes that are required to achieve business outcomes in our current and changing environment[7,8]. However, many countries lack the technical capacity to accurately monitor their own health workforce as data are often unreliable and out of date, and common definitions and proven analytical tools are

1

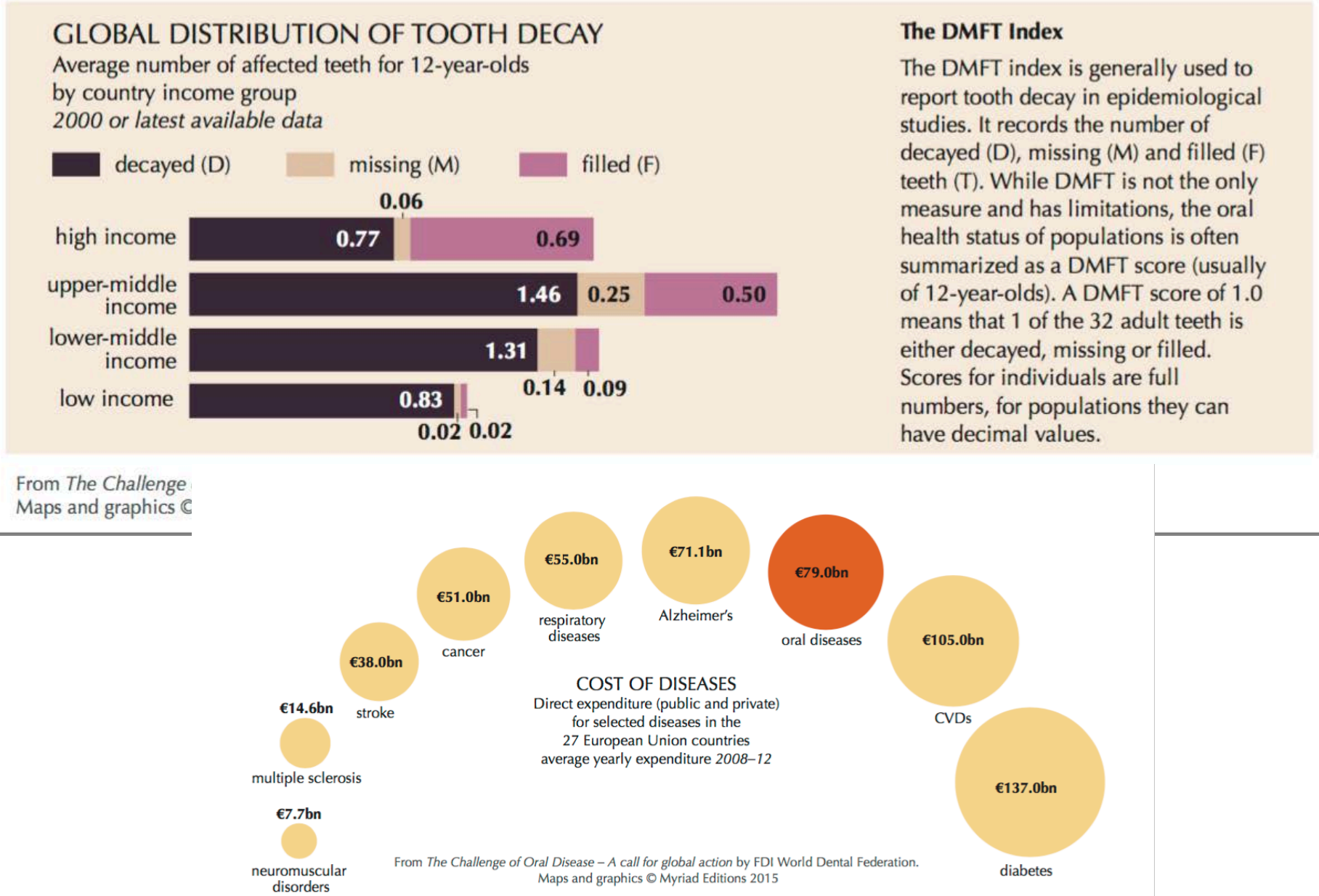
Workforce matters/issues

Dentistry – No exception

- *Shortage of oral health workforce (GDPs, specialist care,etc..)*
- *Uneven distribution of oral health workforce (E.g. rural areas, migration of oral health professionals, etc..)*
- *Lack of/limited access to primary oral health care (E.g. basic oral health coverage,)*
- *Limited resources devoted to oral health care*
- *Quality of care and standards and patient safety issues & matters (E.g. not adequately qualified personnel, illegal practice,..)*

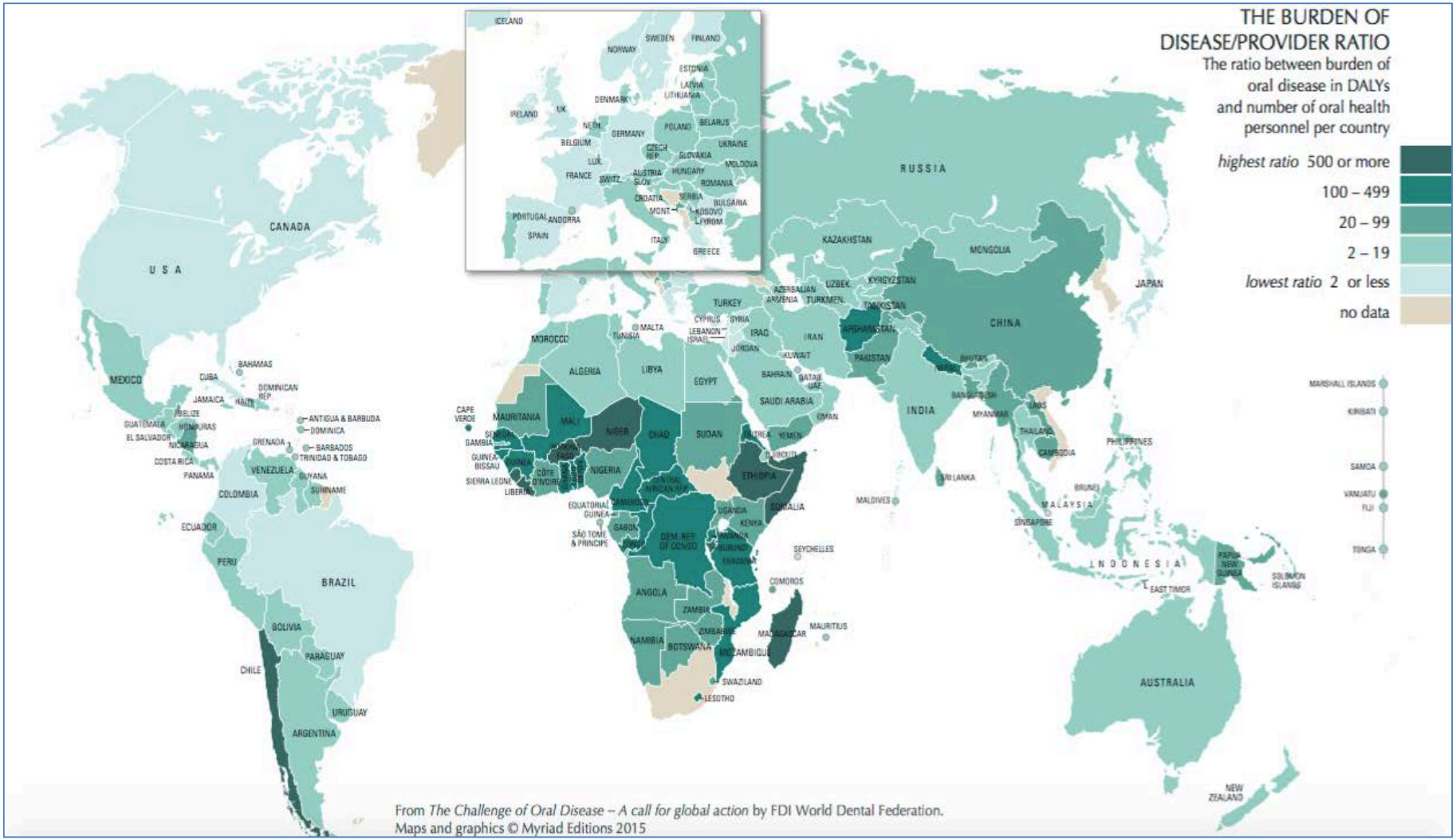
The burden of oral conditions

The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*



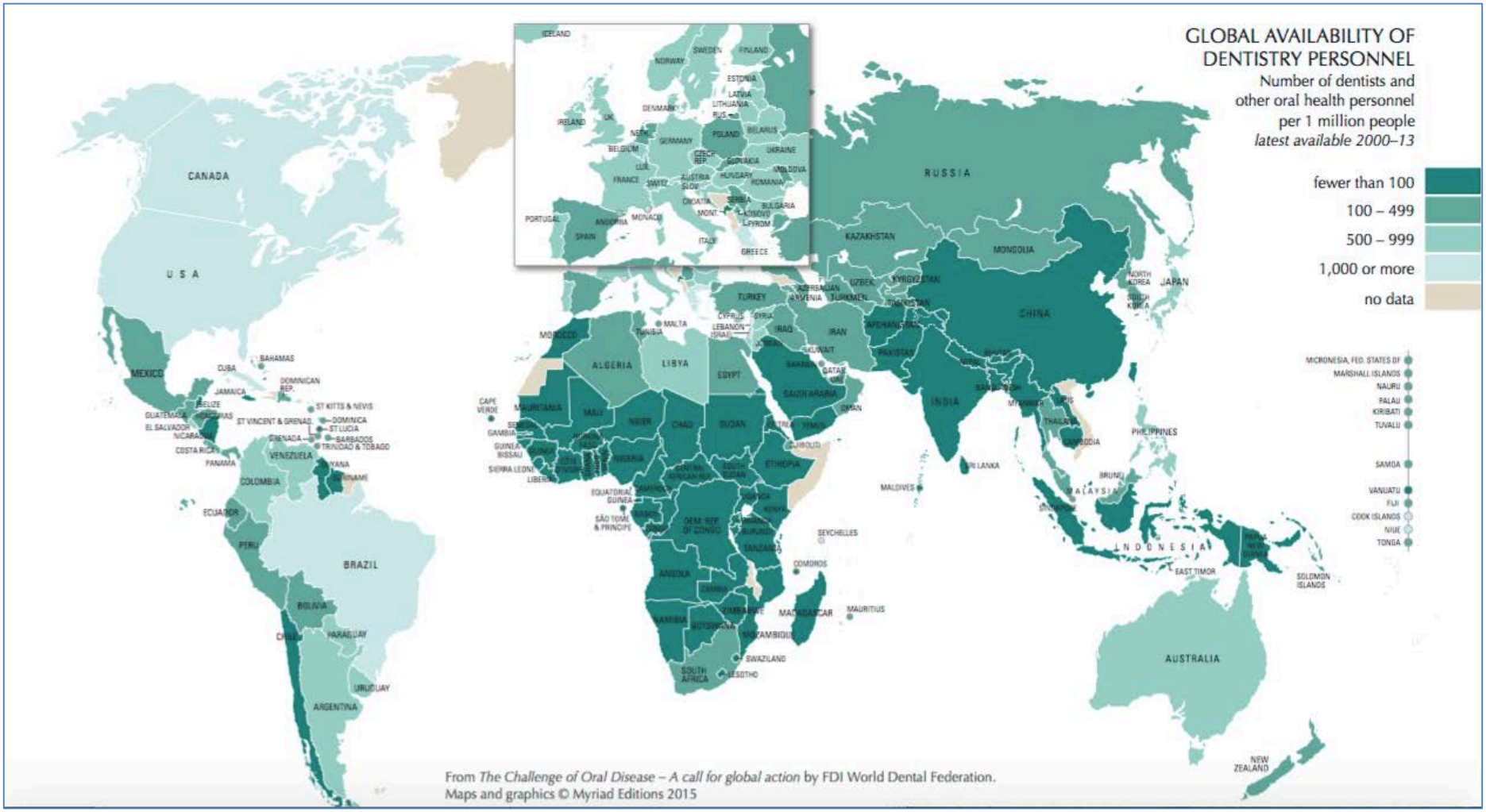
The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*

The burden of provider/disease ratio

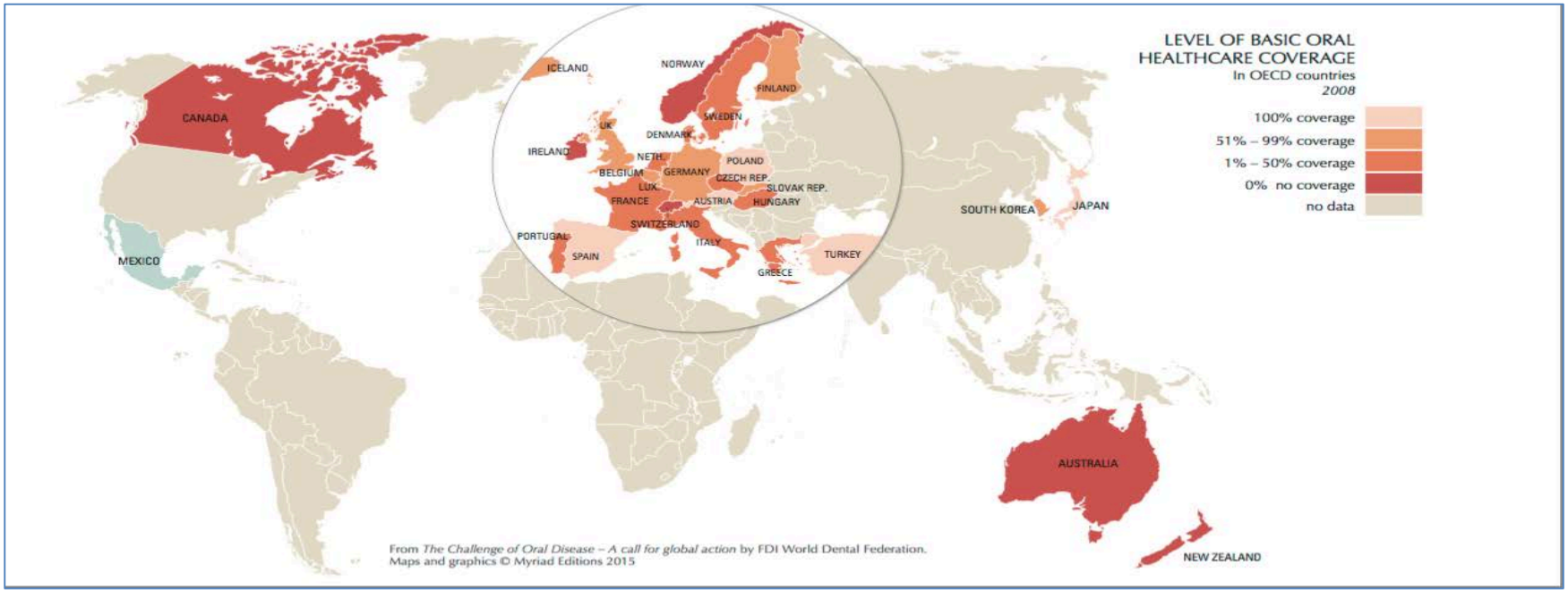


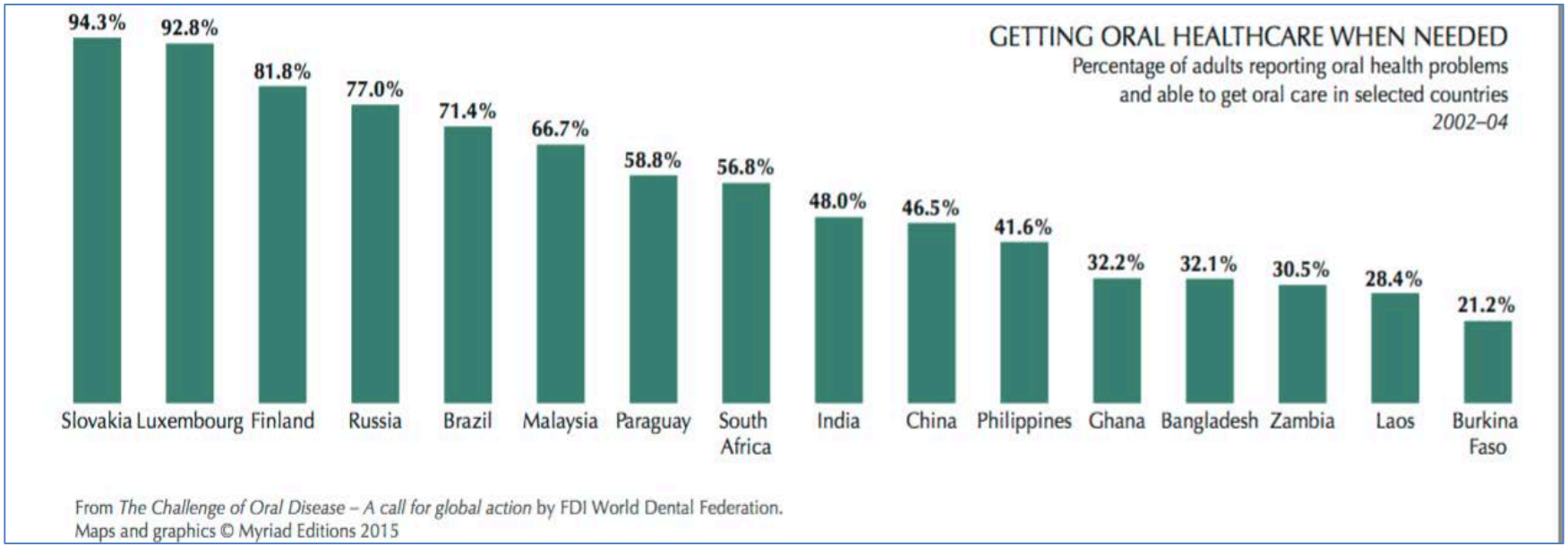
The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*

Global availability of dental personnel



The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*





The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*

ORIGINAL ARTICLE

International Dental Journal 2013; 63: 298–305

doi: 10.1111/idj.12084

Oral health workforce planning Part 1*: data available in a sample of FDI member countries

Nermin Yamalik[1], Eduardo Ensaldo-Carrasco[2] and Denis Bourgeois[3]

[1]Department of Periodontology, Faculty of Dentistry, University of Hacettepe, Ankara, Turkey; [2]Department of Microbiology, Faculty of Dentistry, National Autonomous University of Mexico, Mexico City, Mexico; [3]Department of Public Health, Dental Faculty, University of Lyon 1, Lyon, France.

Background & aim: Workforce planning is a resource to measure and compare current versus future workforce. Organised dentistry needs to focus on the benefits and the determinants and various systems of workforce planning together with the challenges, new trends and threats. The aim of the study was to identify data sources from countries relating to a selection of oral health indicators in a sample of FDI member countries. The potential for differences between developed and developing countries was also examined. **Methods:** A cross-sectional survey study was carried out among FDI member countries classified in developed and developing countries between October 2011 and January/February 2012. A questionnaire was developed addressing the availability of 40 selected indicators distributed in four domains. Mann–Whitney *U*-tests to identify differences between developed and developing countries and chi-square tests for the degree of infor… …f information about indicators relevant … …onomic development. Although not sig… …ability and minimum values of zero fo… …. **Discussion:** Standardised and reliable … …. It is of utmost importance to increas… … regarding the role, basic elements, … …stem.

Key wor…

Oral health workforce

Dental team

- Dentists
- Dental hygienists
- Dental therapists
- Dental technicians
- Dental nurses
- Dental assistants
- Community dental coordinators
- Others ..

INTRO… …tial to meet the future needs …ulation[6].

The lat… … a procedure to measure and positiv… …es) *versus* future workforce exist to… … provides an insight into the wide s… …ives needed to improve the attribut… … system[7]. It also helps us to conside… …nd external environment and strengt… …ffect our current and future service… …are of the skills, capabilities miolog… …required to achieve business variabi… …and changing environment[7,8]. oral he… …s lack the technical capacity There… …eir own health workforce as data are often unreliable and out of date, and common definitions and proven analytical tools are

alignment of the workforce with strategic objectives and performance measures, linkage of expenditures to an organisation's long-term goals and objectives, and ensuring replacement availability to fill critical vacancies, especially for those positions that might take a long developmental phase to be productive[7].

Incomplete and uneven information on workforce and lack of any state agency in charge of data collection is also problematic[16]. General dentists, dental specialists, dental therapists, dental hygienists as well as oral health therapists, oral prosthetists and expanded function dental assistants have been suggested as a complete oral health workforce[5]. The advanced dental hygiene practitioner, community dental health coordinator and dental health aide therapist are other workforce models that have also been proposed[4]. However, appropriate workforce models may depend on identifying the specific needs of the country or region they intend to address. Thus, workforce-planning research is fundamental to gather standardised and reliable evidence that can help to promote through strategies a shift of dentistry towards a profession delivering safe and high-quality health-care procedures. It also has to be kept in mind that workforce planning is about how one achieves that match of skills, knowledge and behaviours[7].

The growing complexity of oral disease epidemiology, prevention and treatment may need a variety of oral health professionals with a set of specific knowledge and skills in order to provide high-quality solutions to specific oral health issues. More research is needed to make informed decisions regarding workforce planning and determining future workforce requires taking into account population growth, demographic profiles, education and licensure, personnel requirements, employment status, training requirements, information on demand and supply, career planning and various elements of job satisfaction for

health workforce crisis[16]. The health and education systems are suggested to work together to coordinate health workforce strategies. If health workforce planning and policymaking are integrated, interprofessional education and collaborative practice can be fully supported.

Migrating to other (probably more developed) countries is a trend for developing countries. This trend is seen in all health-care professionals and the reasons for emigration may include the desire for postgraduate professional development, career growth, better-enumerated job opportunities, better working conditions and better living conditions[4]. In addition, shifts in people's health-care preferences, improvements in health-care delivery as well as demographic changes may contribute to this migration[3]. The present study revealed that dentists were not exceptions: we also have to consider dental care policies that can influence not only the education and movement of dentists, but health tourism[15].

Migration of health workers has a significant effect in developing countries because of the loss of workforce, inadequate funding, lack of infrastructure and low capacity to train personnel[1]. Thus, health-care systems without proper investment may lead to poor payment of the professionals as well as inappropriate working environments and an overall low job satisfaction[4].

Migrating to rural areas seems to be a new trend in developed countries. The reason may be the increased competition in big cities and/or the incentives provided for services in the rural areas[17]. However, the major trend both for the developing and the developed countries is still migrating to big cities and this is continuing to have a negative impact on the even distribution of oral health workforce throughout the country. These factors are among the priorities for research in low- and middle-income countries[18]. Another outcome may be increased competition among the oral health-care providers. Limiting work hours and preferring to have part-time work are also trends specifically related to the workforce in developed countries, which needs to be taken into account when compliance of the workforce with the needs and demands of individual patients and the public is concerned. One approach to reduce migration rates is to encourage health personnel to work within their own countries or regions for a period before they migrate no matter what their reasons[4,19].

One trend that seems to be similar for both the developing and the developed countries, is the preference for large dental clinics instead of solo practices. services in the recent years. Although this started as a trend in the developed countries, the present study demonstrates that it is also well accepted by dentists in developing counties. In contrast, specialisation training is gaining greater interest and more and more dentists appear to receive specialised training in all countries. This is likely to be more prominent for the developed countries at present but the same trend is also observed in developing countries.

At present, the oral health workforce, despite its scattered distribution among countries, still works mainly in private practice[20]. In addition, it is expected that higher densities of health personnel may be related with a better population health[3]. Recognition and reduction of oral health inequalities is a priority for dentists[15] and may require well-developed strategies in order to diminish them[21]. Economic disparities and government's failure to address the social determinants of health have been suggested as contributory factors[22]. Further, although mostly dental caries, periodontal disease (and sometimes oral cancers) are considered as major global oral health problems, it needs to be clearly understood that, depending on the local circumstances, various competing diseases/disorders also exist (e.g. noma, human immunodeficiency virus, etc.) and such diseases/disorders need to be taken into consideration in any planning or future projections. Furthermore, quality of care, professionally accepted standards of care and safety of individual patients and the public at large are also important elements of workforce planning[23].

Workforce planning ensures that 'the right people with the right skills are in the right place at the right time'. For the oral health workforce to prosper, it needs a source of income and/or funding along with appropriate government policies where dental services are integrated within primary care, in order to enable them to diminish inequalities by fostering oral health and providing treatment to the harm derived from oral and dental diseases[21,24,25].

Acknowledgements

The authors are grateful to all the NDAs that responded to this questionnaire, Isabelle Bourzeix for her kind assistance and members of OHWFTT members for their kind support.

REFERENCES

1. Clark PF, Stewart JB, Clark DA. Migration and recruitment of

etc.) and such diseases/disorders need to be taken into consideration in any planning or future projections. Furthermore, quality of care, professionally accepted standards of care and safety of individual patients and the public at large are also important elements of workforce planning[23].

Workforce planning ensures that 'the right people with the right skills are in the right place at the right time'. For the oral health workforce to prosper, it needs a source of income and/or funding along with appropriate government policies where dental services are integrated within primary care, in order to enable them to diminish inequalities by fostering oral health and providing treatment to the harm derived from oral and dental diseases[21,24,25].

Acknowledgements

The authors are grateful to all the NDAs that

18 questionnaires processed; 41.40% response rate.

Canada, Belgium, Bahamas, Austria, United States, Germany, France, Finland, Netherlands, Mozambique, Morocco, Cuba, Burundi, Costa Rica, Congo, Georgia, Benin.

Numbers of dentists and other oral health care providers

Regulations complying with workforce needs

Table 2 Comparison of the structure of dental workforce among participating countries

Number of...	Developed			Developing			*U*-statistic	*P*
	Median	Minimum	Maximum	Median	Minimum	Maximum		
Dentists	8,773	92	186,084	72	0	12,144	9.0	0.005
Specialists	600	0	39,027	10	1	8,423	30.0	0.353
Dental practices	6,000	60	127,022	55	0	2,500	5.0	0.002
Dental hygienists	550	0	181,800	0	0	0	13.5	0.005
Dental therapists	0	0	291	0	0	123	37	0.634
Dental nurses	2,500	0	21,100	5	0	2,000	26.0	0.187
Denturists	0	0	2,200	0	0	72	29.5	0.247
Dental technicians	620	0	4,050	0	0	1,100	13.0	0.013
Total dental faculties	5	0	62	3	0	17	27	0.232
Public dental faculties	4	0	38	2	0	17	25.5	0.182
Private dental faculties	0	0	24	0	0	10	38.5	0.846
Graduates per year	185	0	5,003	16	0	400	17	0.037

Table 3 Comparison between developed and developing participant countries

	Developed		Developin		
	Yes	No	Yes		
Regions that:					
Lack the number of dentists to meet demand	11.1	88.9	66.7	33.3	0.050
Have exceeded the number of dentists demanded	100	0	33.3	66.7	0.206
Lack the necessary specialist care	11.1	88.9	77.8	22.2	0.015
Have exceeded the number of specialists demanded	0	100	11.1	88.9	1
Lack the number of necessary dentists in rural areas	55.6	44.4	88.9	11.1	0.294
Have exceeded the number of dentists demanded in big cities?	44.4	55.6	66.7	33.3	0.637
Do you think...					
UGDE complies with the workforce needs?	85.7	14.3	37.5	62.5	0.119
UGDE needs reform to comply with the workforce needs?	42.9	57.1	50	50	1
SDE complies with the workforce needs?	66.7	33.3	66.7	33.3	1
SDE needs reform to comply with the workforce needs?	60	40	62.5	37.5	1
Regulations comply with oral health workforce needs?	71.4	28.6	12.5	87.5	0.041
Regulations need improvement to comply with the needs?	57.1	42.9	100	0	0.063
As NDA do you participate to the negotiations with the authorities regarding oral health workforce planning	57.1	42.9	50	50	0.614

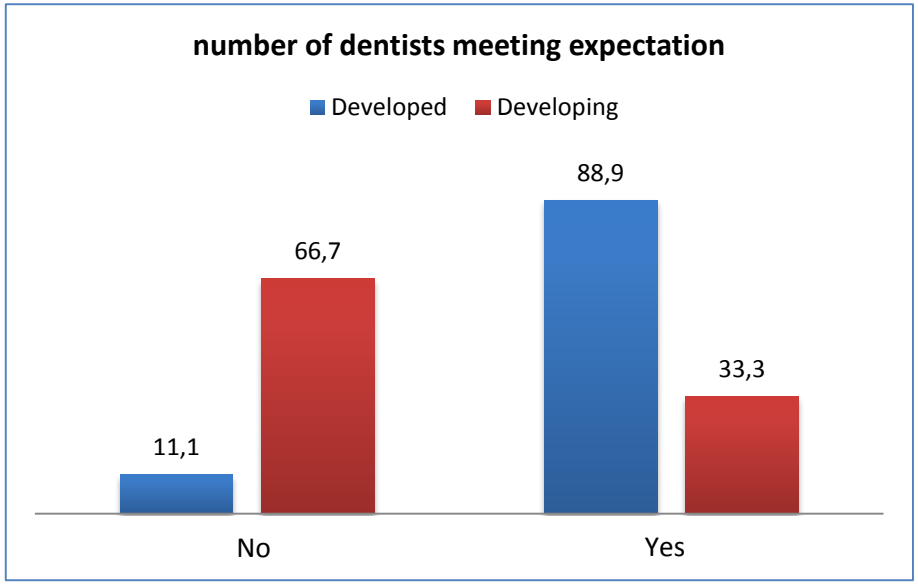
UGDE, undergraduate education; SDE, specialist dental education.

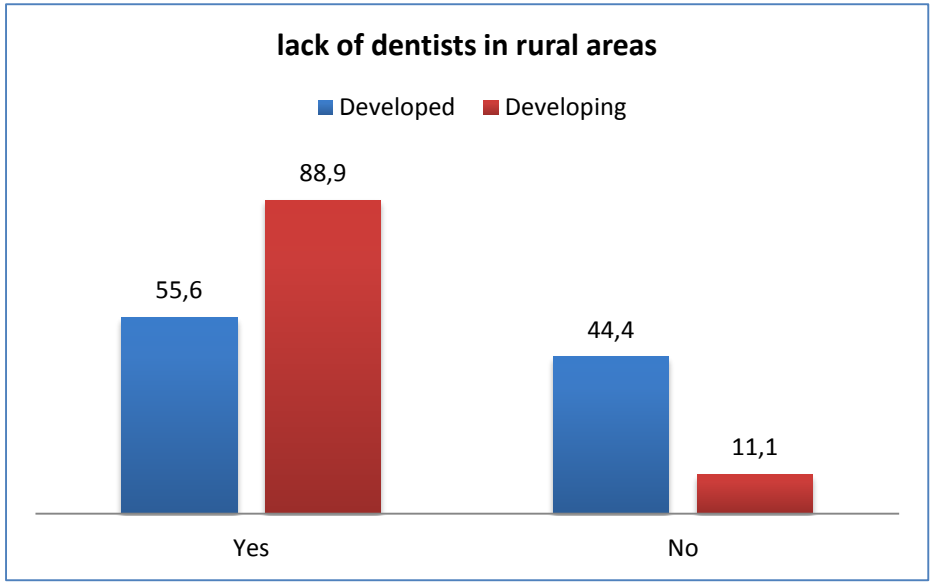
Dental team

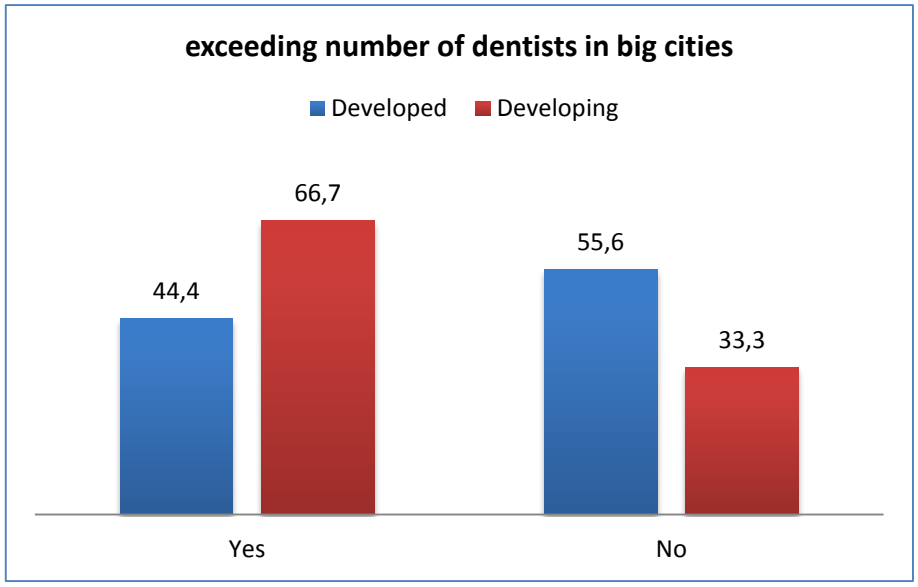
Developed vs. Developing countries

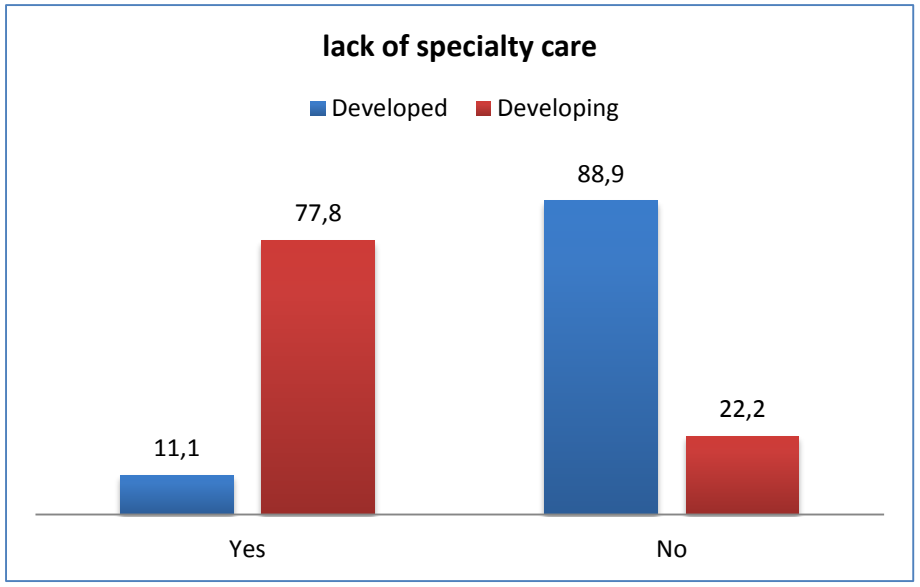
Number of...	Developed			Developing			u statistic	p
	Median	Min.	Max.	Median	Min.	Max.		
Dentists	7900	68	186084	72	0	12144	14.5	0.022
Specialists	600	0	39027	10	0	6043	22.5	0.111
Dental practices	3838	0	127022	51	0	2500	24	0.141
Dental hygienists	40	0	174100	0	0	0	18	0.012
Dental therapists	0	0	291	0	0	123	37	0.634
Dental nurses	0	0	11600	0	0	176	36.5	0.698
Denturists	0	0	2098	0	0	72	36	0.541
Dental technicians	65	0	4050	0	0	1100	25	0.152
Total dental faculties	5	0	62	3	0	17	27	0.232
Public dental faculties	4	0	38	2	0	17	25.5	0.182
Private dental faculties	0	0	24	0	0	10	38.5	0.846
Graduates per year	185	0	5003	16	0	400	17	0.037

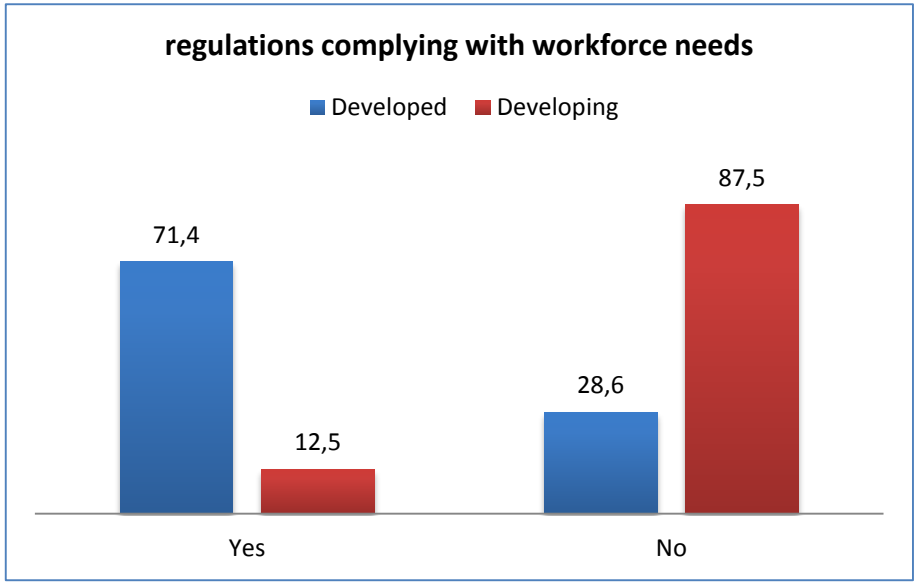
Table 2. Comparison of the structure of dental workforce among participating countries.

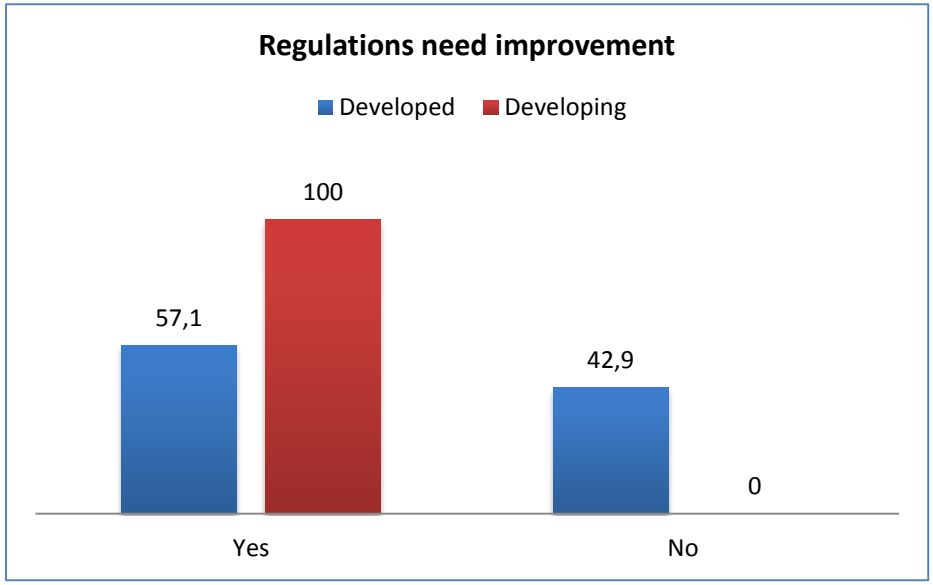

number of dentists meeting expectation
Developed
Developing
11,1
66,7
88,9
33,3
No
Yes

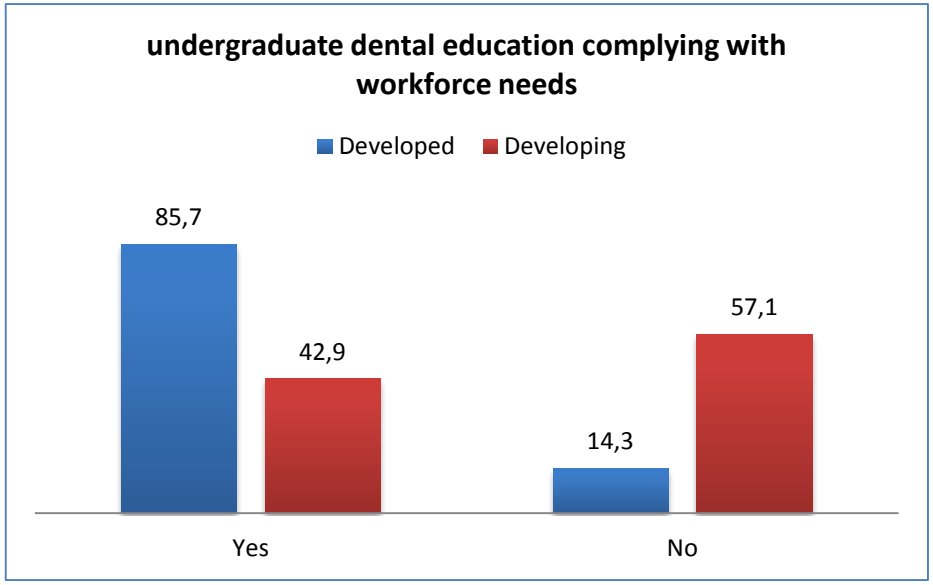

lack of dentists in rural areas
Developed
Developing
55,6
88,9
44,4
11,1
Yes
No

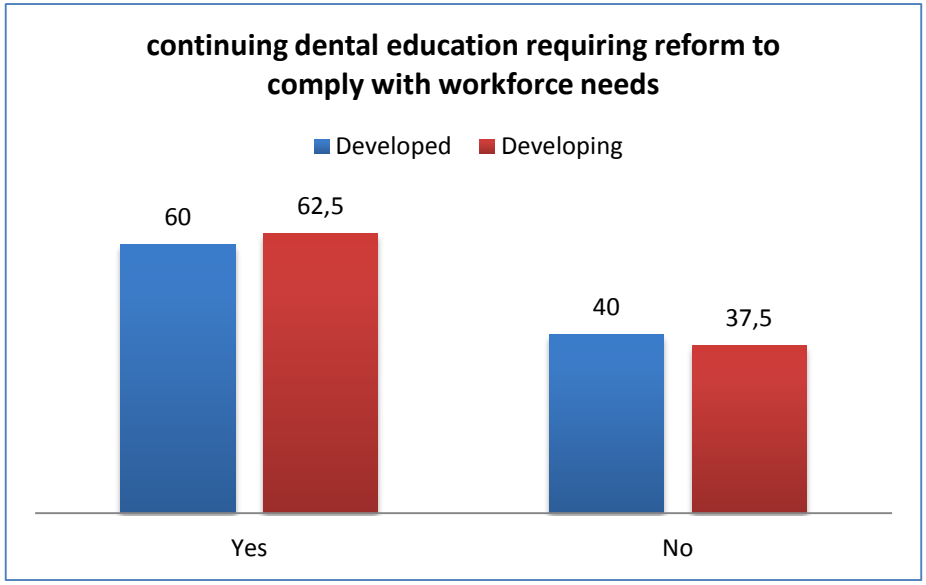

exceeding number of dentists in big cities
Developed
Developing
44,4
66,7
55,6
33,3
Yes
No


lack of specialty care
Developed
Developing
11,1
77,8
88,9
22,2
Yes
No


regulations complying with workforce needs
Developed
Developing
71,4
12,5
28,6
87,5
Yes
No


Regulations need improvement
Developed
Developing
57,1
100
42,9
0
Yes
No


undergraduate dental education complying with workforce needs
Developed
Developing
85,7
42,9
14,3
57,1
Yes
No


continuing dental education requiring reform to comply with workforce needs
Developed
Developing
60
62,5
40
37,5
Yes
No

2- FDI Vision 2020 & Optimal Oral Health Through Interprofessional Educaton and Collaboration

5 broad, transversal **themes** were identified:

Collaborative Practice

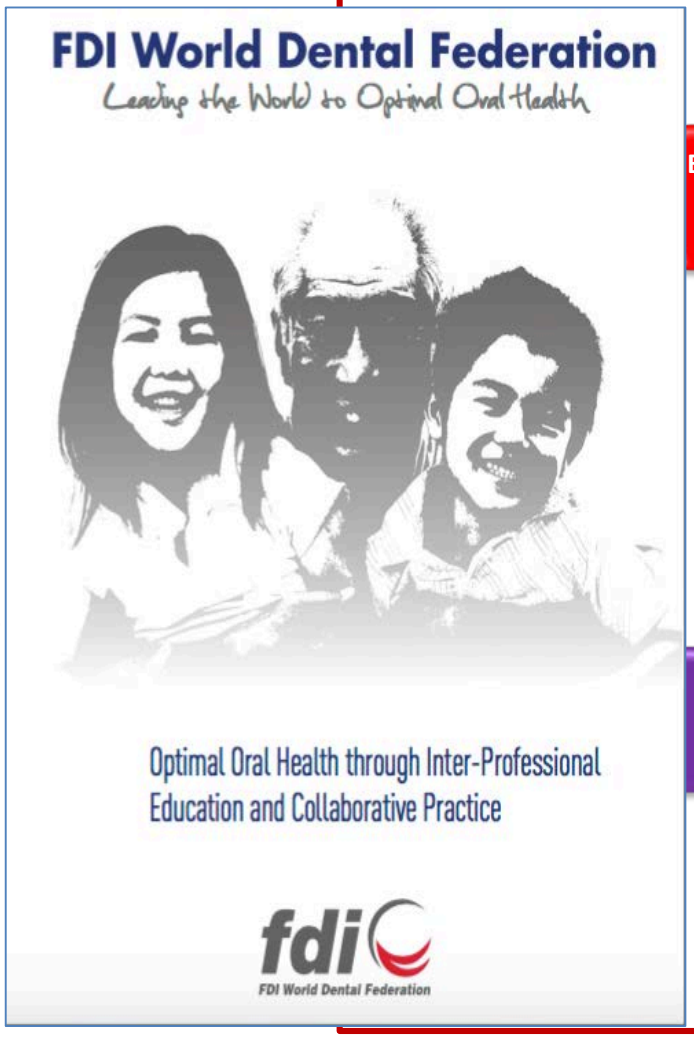
The dental profession needs to be familiar with the

- **broad context of collaborative practice (CP),**
- **the global trends, applications & even sometimes the *'pressure'* regarding CP**
- **the opportunities & threats**

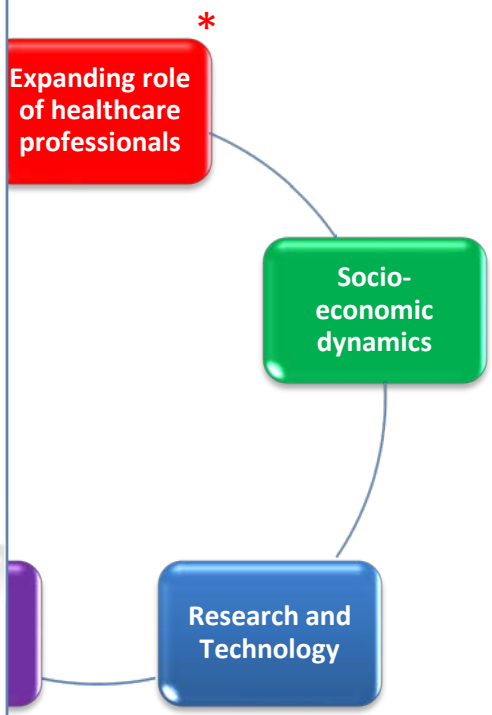
and become prepared for the future.

CP report

supportive document



FDI Vision 2020 Framework for Optimal Oral Health



http://www.fdiworldental.org/media/70740/collaborative-practice_digital.pdf

CP models, introduced within **a variety of contexts**, may have the primary objective of **improving different aspects of healthcare delivery**:

increasing access & quality

improving practice productivity & efficiency

improving patient clinical outcomes & satisfaction.

Good inter-professional CP models

may increase the contribution of the dentists to the general health and quality of life of patients and the public and subsequently **broaden** the role of dentists in the general health arena.

Good intra-professional CP models

may **improve access** to oral health care (especially in rural areas and for underserved communities) and **increase the efficiency** of provision of oral care.

http://www.fdiworldental.org/media/70740/collaborative-practice_digital.pdf

Intra-Professional Collaborative Practice

Dentist as a Leader of an Expanding Oral Health Team

Case 1: The Netherlands – Collaboration for Increased Oral Health Promotion and Disease Prevention

*This case describes the changing scene of oral health in the country, with a focus on prevention and the consequent **introduction of the professions of oral dental health hygienist**s and **prevention assistants** in the Netherlands.*

Case 2: USA - Community Dental Health Coordinators (CDHCs) & Minnesota case

*This case describes an instance **of intra-professional** as well as **multidisciplinary inter-professional collaboratio**n, where **dentists, dental hygienists, community dental health coordinators** and **dental assistant**s work side by side and collaborate with other professionals in healthcare, education and social services for the common goal to improve oral health of communities.*

Case 3: Thailand – Collaboration for Universal Oral Health Coverage

*This case is an example **of intra-professional education** between **dentists** and **dental health nurses**. The move towards Universal Health Coverage (UHC) has increased the demand for dental nurses in Thailand. Dental nurses provide preventive and basic dental services primarily to school children under a dentist's supervision. The **inter-professional education** of **dental** and **medical students** is also discussed.*

http://www.fdiworldental.org/media/70740/collaborative-practice_digital.pdf

Intra-Professional Collaborative Practice

Selected Countries - Collaboration to Improve Oral Health in Underserved Communities

Case 4: New Zealand – Improved Oral Health for Children

Case 5: Alaska, USA – Improved Oral Health for Tribal Communities

Case 6: Minnesota, USA – Improved Oral Health for Vulnerable Populations

*These examples give an overview of **different practice arrangements** involving **dental nurses, dental therapists**, all designed to enhance access to oral health services in disadvantaged communities.*

http://www.fdiworldental.org/media/70740/collaborative-practice_digital.pdf

Inter-Professional Collaborative Practice

Case 8: Lausanne, Switzerland – Dentist as a Guardian of General Health

*This case describes **intra-** and **inter-professional** collaboration at the **University Hospital of Lausanne**, where an **oral health team** composed of dentists, dental hygienists, assistants and technicians work with **physicians** to improve the **overall health** of patients.*

Case 9: Dentists as Expert Advisors in Wales – Improving Mouth Care for Patients in Hospitals

*This case of collaborative practice includes **intra-professional collaboration** within the dental profession as well as **inter-professional** teamwork with **nurses, physicians, pharmacists, dieticians, speech** and **language therapists** to improve the health of adult patients in **hospital ward settings**.*

http://www.fdiworldental.org/media/70740/collaborative-practice_digital.pdf

Table 4. Matrix to Compare Case Studies across Several Dimensions

	Minnesota	Lausanne	Netherlands	Thailand	Wales
Intra-Professional Collaboration	Yes	Yes	Yes	Yes	Yes
Inter-Professional Collaboration	No	Yes	No	Yes	Yes
Role of dentist	Leader of the dental team	Leader of the dental team	Leader of the dental team	Leader of the dental team	Expert Advisor
Drivers of change	• Impeded access to care • Need for prevention	Patient-centered care	• Changing demographic and epidemiology of disease • Focus on access to preventive care • Growing shortage of dentists	• Changing demographic and disease epidemiology • Focus on access to preventive care	• Fundamentals of Care (WG audit) • Patient-centered care
Barriers	• Low reimbursement • Initial opposition of dental profession	• Lack of funding for medical training of dentists and for vulnerable groups	N/A	N/A	• Strong nurse leadership • Funding & capacity of the dental team to provide training
Funding	Public	Public & private	Public & private	Public	Public
Provider satisfaction*	Acceptable	Good	Good	Acceptable	Good
Patient satisfaction**	Acceptable	Good	Good	Good	Good

http://www.fdiworldental.org/media/70740/collaborative-practice_digital.pdf

Interprofessional Collaboration
Dentistry & Medicine
Pediatricians – children's oral health

Abstract ▾ Send to: ▾

Pediatrics. 2016 Jan;137(1):1-8. doi: 10.1542/peds.2014-3532. Epub 2015 Dec 8.

Oral Health Prevention and Toddler Well-Child Care: Routine Integration in a Safety Net System.

Dooley D[1], Moultrie NM[2], Heckman B[3], Gansky SA[3], Potter MB[4], Walsh MM[3]

⊕ Author information

Abstract

BACKGROUND AND OBJECTIVE: Applying topical fluoride varn
early childhood caries (ECC). In 2008, the pediatricians at Contra
income pediatric patients had high rates of ECC and very limited
with the University of California San Francisco to implement routi
well-child exams for children aged 1 to 5 years.

METHODS: Over 3 years, the team developed clinical policies, e
primary care setting. A pilot study was performed in 2 health cent
and academic partners performed system-wide didactic and hand
Continued improvement strategies and provider feedback were p

RESULTS: In August 2012, 95% of all children aged 1 to 5 years
education during their primary care well visit. Repeat measureme
age group seen for well-child visits.

CONCLUSIONS: With institutional commitment and an academic
health interventions into well-child visits to reduce ECC.

PMID: 26647374 [PubMed - in process]

Abstract ▾ Send to: ▾

Pediatrics. 2002 May;109(5):E82-2.

Accuracy of pediatric primary care providers' screening and referral for early childhood caries.

Pierce KM[1], Rozier RG, Vann WF Jr.

⊕ Author information

Abstract

PURPOSE: Tooth decay is o
kindergarten. Primary care ph
population. Unlike dentists, th
on oral screenings and referra
to determine the accuracy of

METHODS: We sought to co
those of a pediatric dentist, c
group practice in North Caroli
pediatric primary care provide
months of age with erupted te
consisted of a review of the s
to the providers on how to rec
refer any child with 1 or more
study, calibration and a comp
Both a pediatric dentist and a
dental referral was needed. S
(pediatric dentist) in 3 categor

RESULTS: The final study sa
deviation [SD]: 9.13). One hu
Level Analysis: The pediatric
reported a mean of 0.25 (SD:
cavitated carious lesions, whe
include 41 false-negative teet
sensitivity of 0.49 (95% confi
were compared with the gold
teeth affected by cavitated les
achieved a sensitivity of 0.76
lesions. There were 6 false-n

Pediatrics. 2000 Dec;106(6):E84.

The role of the pediatrician in the oral health of children: A national survey.

Lewis CW[1], Grossman DC, Domoto PK, Deyo RA.

⊕ Author information

Abstract

OBJECTIVES: To assess pediatricians' knowledge, attitudes, and professional experience regarding oral health, and to determine willingness to incorporate fluoride varnish into their practices.

BACKGROUND: Poor and minority children suffer disproportionately from dental caries and have limited access to dental care. In a recent analysis of national survey data, the General Accounting Office reported that poor children had 5 times more untreated decay than did children from higher income families. Untreated decay can lead to problems with eating, speaking, and attending to learning. Children who are poor suffer 12 times the number of restricted activity days because of dental problems, compared with more affluent children. Despite higher rates of dental decay, poor children had one half the number of dental visits compared with higher income children in 1996. Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) program is intended to provide regular dental screenings and appropriate treatment but has apparently played a limited role in improving access to dental care for poor children. According to a report by the Office of the Inspector General of the Department of Health and Human Services, only 20% of children under 21 years of age, who were enrolled in Medicaid and eligible for EPSDT, actually received preventive dental services. By increasing their involvement in oral health prevention during well-child care visits, pediatricians may be able to play an important role in improving the dental health of their patients who have difficulty obtaining access to professional dental care. However, it is unclear to what degree pediatricians are knowledgeable about preventive oral health and the extent to which they may already be participating in prevention and assessment. Also, little is known about the incidence of dental problems in pediatric practice, and whether pediatricians perceive barriers to their patients' receiving professional dental care. Finally, it is important to know how pediatricians value the promotion of oral health and whether they would be willing to take on additional activities aimed at its improvement. We addressed these questions in a national survey of pediatricians.

DESIGN: We surveyed a national sample of 1600 pediatricians randomly selected from the American Medical Association Master File to assess their knowledge, current practice, and opinion on their role in the promotion of oral health; experience with dental decay among patients and in referring patients for professional dental care; and willingness to apply fluoride varnish.

RESULTS: Of 1386 eligible survey recipients, 862 returned surveys for a response rate of 62%. Respondents reported seeing dental problems regularly. Two thirds of respondents observed caries in their school-aged patients at least once a month. Of the respondents, 55% reported difficulty achieving successful dental referrals for their uninsured patients and 38% reported difficulty referring their Medicaid patients. More than 90% of the respondents agreed that they had an important role in identifying dental problems and counseling families on the prevention of caries. Moreover, respondents were interested in increasing their involvement: 74% expressed a willingness to apply fluoride varnish in their practices. One half of the respondents, however, reported no previous training in dental health issues during medical school or residency, and only 9% correctly answered all 4 knowledge questions.

CONCLUSION: Access to dental care and unmet dental health needs are serious, under addressed problems for poor and minority children in the United States. In promoting preventive oral health, pediatricians benefit all children and particularly the underserved. We know of 2 states, Washington and North Carolina, that have acknowledged, through the provision of reimbursement, that pediatricians have a unique opportunity at well-child care visits to provide caries prevention c

KEY MESSAGES

1.Collaborative Practice (CP) is more than just collaboration

According to World Health Organization (WHO) 'Collaborative practice (CP) happens when **multiple health workers** from different professional backgrounds **work together** with patients, families, carers and communities to deliver the highest quality care'.

2.CP increases efficiency and quality

In terms of service delivery, CP improves **access** and **quality.** Furthermore, it contains **costs**. Evidence also indicates that CP improves mutual trust and accountability among providers and results in **better coordinated care**.

3.Dentists should play a leadership role

Dentists are the front-line medical professionals in the prevention, early detection and treatment of oral and systemic diseases. They should therefore play a leadership role within the oral health profession and in relation to other health professions to improve **oral health** and thereby contribute to the improvement of **general health** and **quality of life** for all.

KEY MESSAGES

4.Collaboration needs to be broadened and efficiently applied in everyday practice

There has been **great progress** in the treatment of oral and dental diseases in recent years due to the special commitment of the dental profession and effective collaboration. This collaboration needs to be **expanded** and its **efficiency** increased in everyday practice.

5.Interprofessional Education (IPE) is an essential tool to prepare for CP

There is a need for the dental professional to **prepare** itself through **IPE**

6.There is no one-size-fits all approach to CP

FDI recognizes that there are **no one-size-fits-all approach** and delivery of health services will depend on **contextual factors** and **country needs**

- Mechanisms **are not the same** in all health systems.
- Health policy-makers should utilize the mechanisms that are **most applicable** and **appropriate** to their own local or regional context.

Regulations

Provision of oral health care
Dental profession

→

Highly regulated
Different bodies (local, regional, national context)
Continuing change & newly introduced regulations


Updating your details
Continuing professional development
Standards
Standards for the Dental Team
IMPORTANT
Standards for dental p
no longer in effect.
They were replaced
2013
LATEST POLICY
ALL >
CED STATEMENT ON COMMON TRAINING PRINCIPLES UNDER DIRECT
May 2015
EDUCATION | PQD
EN FR DE
CED STATEMENT ON WHITENING
May 2015
PATIENT SAFETY | TOO
EN FR DE
CED RESOLUTION ON THE DENT
May 2015
EDUCATION | HEALTH WORKFORC
EN FR DE
GENERAL DENTAL COUNCIL
STANDARDS GUIDANCE
PRINCIPLES OF DENTAL TEAM WORKING
General Dental Council
protecting patients, regulating the dental team
About us
Dental professionals
Patients
News & pu
Search this site...
Can we help?
You are here > Home
Standard
Standards for the Dental Team - Standards of conduct, performan
dental professionals
Find out more
Are you considering tooth whitening?
Read our information guide to find out
need to know before committing to tr
TDB
TÜRK DİŞHEKİMLERİ BİRLİĞİ
Turkish Dental Association
1946
KURUMSAL
DİŞHEKİMLERİ
ZİYARETÇİ
MEDYA
AĞIZ VE DİŞ SAĞLIĞI
MEVZUAT
T.C. Resmi Gazete
MEVZUAT
Kanunlar
Tüzükler
Genel Kurul Kararları
Yönetmelikler
Tebliğler
Yönergeler
Usul ve Esaslar
Protokoller
Genelgeler
Sağlık Alanı Sertifikalı Eğitim Standartları
Tabela Standartları
Diş Hekimlerinin Her Türlü İletişim Ortamında Yayın Yapmalarına İlişkin Kılavuz
Child protection and vulnerable adults (112KB, PDF)
Conducting clinical trials (128KB, PDF)
Raising and escalating concerns advice sheet (116KB, PDF)
Remote prescribing (158KB, PDF)
Direct Access (108KB, PDF)
Scope of practice (226KB, PDF)
Specialist Lists
Corporate dentistry
GDC | protecting patients, regulating the dental team
29 May 2015
CED-DOC-2015-003-FIN-E
CED
COUNCIL OF EUROPEAN DENTISTS
CED Resolution
THE DENTAL TEAM
RELATIONSHIP WITH PATIENTS
May 2015
0KB, PDF)

TÜRK DİŞHEKİMLERİ BİRLİĞİ
Turkish Dental Association
1986

KURUMSAL | DİŞHEKİMLERİ | ZİYARETÇİ | MEDYA | AĞIZ VE DİŞ SAĞLIĞI

Kanunlar

- ANAYASA
- AİLE HEKİMLİĞİ KANUNU
- ÇEVRE KANUNU
- DERNEKLER KANUNU
- ELEMAN TEMİNİNDE GÜÇLÜK ÇEKİLEN YERLERDE SÖZLEŞM… BAZI KANUN VE KANUN HÜKMÜNDEKİ KARARNAMELERDE …
- HUSUSİ HASTANELER KANUNU
- İSPENÇİYARI VE TIBBİ MÜSTAHZARLAR KANUNU
- İŞ KANUNU
- İŞ SAĞLIĞI VE GÜVENLİĞİ KANUNU
- ÖDEME GÜCÜ OLMAYAN VATANDAŞLARIN TEDAVİ GİDERLE… TARAFINDAN KARŞILANMASI HAKKINDA KANUN
- RADYOLOJİ, RADİYOM VE ELEKTRİKLE TEDAVİ VE DİĞER FİZ…
- 663 SAYILI SAĞLIK BAKANLIĞI VE BAĞLI KURULUŞLARININ … HÜKMÜNDE KARARNAME
- SAĞLIK HİZMETLERİ TEMEL KANUNU
- SAĞLIK HİZMETLERİNİN SOSYALLEŞTİRİLMESİ HAKKINDA K…
- SAĞLIK BAKANLIĞINA BAĞLI SAĞLIK KURUMLARI İLE ESENL… VERİLECEK DÖNER SERMAYE HAKKINDA KANUN
- SOSYAL GÜVENLİK KURUMU KANUNU
- SOSYAL SİGORTALAR VE GENEL SAĞLIK SİGORTASI KANUN…
- TARABET VE SUABATI SAN'ATLARININ TARZI İCRASINA DA…

KURUMSAL | DİŞHEKİMLERİ | ZİYARETÇİ | MEDYA | AĞIZ VE DİŞ SAĞLIĞI

Yönetmelikler

- AĞIZ VE DİŞ SAĞLIĞI HİZMETİ SUNULAN…
- AYAKTA TEŞHİS VE TEDAVİ YAPILAN ÖZ…
- BEŞERÎ TIBBİ ÜRÜNLERİN TANITIM FAA…
- DEVLET MEMURLARININ TEDAVİ YARDI…
- DİŞ PROTEZ LABORATUVARLARI YÖNET…
- GEÇİCİ KORUMA SAĞLANAN YABANCIL…
- GELENEKSEL VE TAMAMLAYICI TIP UYG…
- GENEL SAĞLIK SİGORTASI UYGULAMAL…
- HASTA HAKLARI YÖNETMELİĞİ
- İŞ GÜVENLİĞİ UZMANLARININ GÖREV, Y…
- İŞ SAĞLIĞI VE GÜVENLİĞİ HİZMETLERİ Y…
- İŞ SAĞLIĞI VE GÜVENLİĞİ HİZMETLERİN…
- İŞ SAĞLIĞI VE GÜVENLİĞİ KURULLARI H…
- İŞ SAĞLIĞI VE GÜVENLİĞİ RİSK DEĞERLİ…
- İŞYERİ HEKİMİ VE DİĞER SAĞLIK PERSO… YÖNETMELİK
- KAMU KURUM VE KURULUŞLARINA AÇI… VE ESASLARINA İLİŞKİN YÖNETMELİK
- KOZMETİK YÖNETMELİĞİ
- ÖZEL HASTANELER YÖNETMELİĞİ
- RADYASYON GÜVENLİĞİ YÖNETMELİĞİ
- REKLAM KURULU YÖNETMELİĞİ
- SAĞLIK BAKANLIĞI VE BAĞLI KURULUŞLARI ATAMA VE YER DEĞİŞTİRME YÖNETMELİĞİ

Ana Sayfa | İletişim | Site Haritası | Haber Arşivi | Dişhekimi Bul | English

TÜRK DİŞHEKİMLERİ BİRLİĞİ
Turkish Dental Association
1986

KURUMSAL | DİŞHEKİMLERİ | ZİYARETÇİ | MEDYA | AĞIZ VE DİŞ SAĞLIĞI

Tebliğler

- İŞ SAĞLIĞI VE GÜVE…
- İŞ SAĞLIĞI VE GÜVE…
- TIBBİ CİHAZLAR UYA…
- TIBBİ KÖTÜ UYGULA… İLİŞKİN USUL VE ESA…

Yönergeler

- AĞIZ VE DİŞ SAĞLIĞI BAKIM ÜRÜNLERİNİN UYGUNLUKLARINI ARAŞTIRMA YÖNTEMLERİ YÖNERGESİ
- AĞIZ VE DİŞ SAĞLIĞI BAKIM ÜRÜNLERİNİN UYGUNLUK ARAŞTIRMA VE ONAY LOGOSU KULLANMA KOŞULLARININ İŞLEYİŞ YÖNERGESİ
- SAĞLIK BAKANLIĞI'NA BAĞLI BİRİNCİ BASAMAK SAĞLIK KURULUŞLARINDA GÖREVLİ PERSONELE DÖNER SERMAYE GELİRLERİNDEN EK ÖDEME YAPILMASINA DAİR YÖNERGE
- TÜRK DİŞHEKİMLERİ BİRLİĞİ AKADEMİSİ YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ BİLİM, ARAŞTIRMA TEŞVİK VE HİZMET ÖDÜLLERİ YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ BİLİRKİŞİ ATAMA YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ VE DİŞHEKİMLERİ ODALARI DİŞHEKİMLİĞİ FAKÜLTESİ ÖĞRENCİLERİNE VERİLECEK BURS YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ KORUYUCU AĞIZ DİŞ SAĞLIĞI EĞİTMENİ DİŞHEKİMLERİ İLE TOPLUM AĞIZ DİŞ SAĞLIĞI EĞİTİM ÇALIŞMALARI YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ HAKEM ATAMA YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ HASAR TESPİT YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ KONGRE VE FUAR YÖNERGESİ
- TÜRK DİŞHEKİMLERİ BİRLİĞİ VE DİŞHEKİMLERİ ODALARI HİZMET ÖDÜLÜ YÖNERGESİ

MEVZUAT
- Kanunlar
- Tüzükler
- Genel Kurul Kararları
- Yönetmelikler
- Tebliğler
- Yönergeler
- Usul ve Esaslar
- Protokoller
- Genelgeler
- Sağlık Alanı Sertifikalı Eğitim Standartları
- Tabela Standartları
- Dişhekimlerinin Her Türlü İletişim Ortamında Yayın Yapmalarına İlişkin Kılavuz
- TDB Dişhekimliği Meslek Etiği Kuralları
- Hasta Hakları
- Tüketici Hakları

TDB Dişhekimliği Meslek Etiği Kuralları
Hasta Hakları

www.tdb.org.tr

Dental Practice Act

Division 1. Department of Consumer Affairs

Chapter 1.5 Unlicensed Activity Enforcement

Chapter 4. Article 5. Consumer Complaints

Chapter 7. Licensee

Division 1.2 Legislative Sunset Review Committee

Division 1.5. Denial, Suspension and revocation of Licenses

Chapter 1. General Provisions

Chapter 2. Denial of Licenses

Chapter 3. Suspension and Revocation of Licenses

Chapter 4. Public Reprovals

Chapter 5. Examination Security

Division 2. Healing Arts

Article 1. Records

Article 4. Frauds of Medical Records

Article 5. Illegal Advertising

Article 6. Unearned Rebates, Refunds and Discounts

Article 7.5. Health Care Practitioner

Article 9. Inactive License

Article 10. Federal Personnel

Article 10.5. Unprofessional Conduct

Article 11. Professional Reporting

Chapter 4. Dentistry

Article 1. Administration

Article 2. Admission and Practice

Article 2.4. Oral and Maxillofacial Surgery

Article 2.5. Special Permits

Article 2.6. Continuing Education

Article 2.7. Use of General Anesthesia

Article 2.8. Use of Conscious Sedation

Article 2.85. Use of Oral Conscious Sedation for Pediatric Patients

Article 2.86. Use of Oral Conscious Sedation for Adult Patients

Article 2.9. Dental Restorative Materials

Article 3. Registration

Article 3.5. Additional Offices

Article 4. Suspension and Revocation of Licenses

Article 4.7. Diversion Program

Article 5. Offenses Against This Chapter

Article 6. Fees

Article 7. Dental Assistants

Article 8. Dental Corporations

Article 9. Dental Hygienists

Article 9.5 California Dental Corps Loan Repayment Program

Dentists

The law regarding Dentists is ORS 679. Click here to link to these statutes.

Dental Hygienists

The law regarding Dental Hygiene in Oregon is found in ORS 680.010 to 680.205 and 680.990. Click here to link to these statutes.

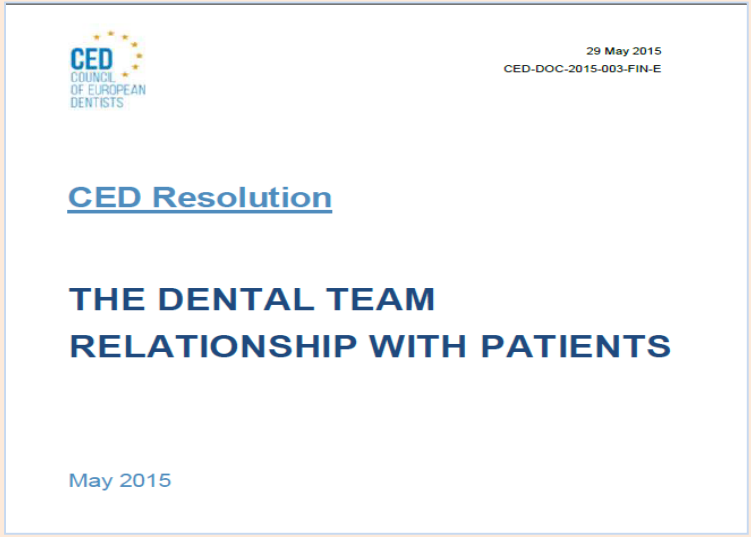
Administrative Rules

The administrative rules pertaining to dentistry, dental hygiene, dental assisting, and administration of anesthesia are found in OAR 818. Click here to link to the rules.

Dental Practice Act - Revised January 1, 2016

Directives regulating dentistry (EU)

- 25.07.1978. Council Directive 78/686/EEC - concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of practitioners of dentistry.
- 25.07.1978. Council Directive 78/687/EEC - concerning the coordination activities of dental practitioners.
- 25.07.1978 Council Decision 78/688/EEC - setting up an Advisory Committee on the Training of Dental Practitioners.
- 25.07.1978 Council Decision 78/689/EEC - setting up a Committee of Senior Officials on Public Health
- 07.09.2005 Directive 2005/36/EC - mutual recognition of professional qualifications comprehensively regulates mobility within the EU by setting minimum training requirements for health professionals, including dentists.



http://www.cedentists.eu

http://www.erodental.org

Developed vs. Developing countries

Do you think…	Developed		Developing		p
	Yes	No	Yes	No	
UGDE complies with the workforce needs?	85.7	14.3	37.5	62.5	0.119
UGDE needs a reform to comply with the workforce needs?	42.9	57.1	50	50	1
SDE complies with the workforce needs?	66.7	33.3	66.7	33.3	1
SDE needs a reform to comply with the workforce needs?	60	40	62.5	37.5	1
regulations comply with oral health workforce needs?	71.4	**28.6**	12.5	**87.5**	0.041
regulations need improvement to comply with the needs?	**57.1**	42.9	**100**	0	0.063
As NDA do you participate to the negotiations with the authorities regarding oral health workforce planning	57.1	42.9	50	50	0.614

Table 3. Comparison between develop and developing participant countries (UGDE= undergraduate education, SDE=specialist dental education)


General Dental Council
protecting patients, regulating the dental team
About us
Dental professionals
You are here > Home > Dental professionals > Standards > Standards
Dental professionals
Apply for registration
Updating your details
Continuing professional
Updating your details
Continuing professional development
Standards for dental professionals
IMPORTANT
GENERAL DENTAL COUNCIL
NDARDS GUIDANCE
CIPLES OF DENTAL TEAM WORKING
Department of Consumer Affairs
DENTAL BOARD OF CALIFORNIA
Home
About Us
Consumers
Licensees
Applicants
License Verification
Forms and Publications
Contact Us
Complaint Information
Frequently Asked Questions
Enforcement
Diversion
Board Meetings
A 'Genuine' Concern
Patient Safety & Quality of Care
Address Change Form (DDS)
Name Change Form (DDS)
Board Newsletters
Complaint Form
Education Providers
Military Information
Article 1. Records
Article 4. Frauds of Medical Records
Article 5. Illegal Advertising
Article 6. Unearned Rebates, Refunds and Discounts
Article 7.5. Health Care Practitioner
Article 9. Inactive License
Article 10. Federal Personnel
Article 10.5. Unprofessional Conduct
Standards for the Dental Team - Standards of conduct, performance and ethics for dental professionals
Find out more
For further search options, try advanced search
Are you considering tooth whitening?
Read our information guide to find out what you need to know before committing to treatment
About Us
Contact Us
Address, Name & Subscription Changes
Board, Committees & Staff
Board Meeting Information
Committee Meeting Information
Education/Continuing Education
FAQs for Consumers
Filing a Complaint
Forms & Brochures
Licenses & Permits
Dentists
Dental Hygienists
Dental Assistants
Licensee Lookup
Newsletters
Regulations
The Board
Dentists
Dental Hygienists
Administrative Rules
Dental Practice Act - Revised January 1, 2016
Direct Access (108KB, PDF)
Scope of practice (226KB, PDF)
Dental team working

protecting patients,
regulating the dental team

CED POSITION PAPERS

Education and Professional Qualifications

CED Resolution on the profile of the dentist of the future November 2007 , CED Resolution on the Bologna Process and dental training November 2005, Joint statement of the sectoral professions March 2005, DLC position paper on draft Directive June 2002
Joint statement of the sectoral professions June 2002

(b) "Direct supervision" means supervision of dental procedures based on instructions given by a licensed dentist, who must be physically present in the treatment facility during the performance of those procedures.

(c) "General supervision" means supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures.

'Co-operate with other members of the dental team and other healthcare colleagues in the interests of patients'

- Co-operate with other team members and colleagues, and
- and in line
- e and skills
- ssary in the
- members
- first priority.

Referrals

4.7 If you ask a colleague to provide treatment, a dental appliance or clinical advice for a patient, make sure that your request is clear and that you give your colleague all the appropriate information.

4.8 If a colleague asks you to provide treatment, a dental appliance or clinical advice for a patient, be sure that you are clear about what you are being asked to do.

nsed dentist:
the supervising licensed dentist, provided that these duties or procedures meet the definition of a basic supportive procedure specified in Section 1750.
(2) Operate dental radiography equipment for the purpose of oral radiography if the dental assistant has complied with the requirements of Section 1656.
(3) Perform intraoral and extraoral photography.
(b) A dental assistant may perform the following duties under the direct supervision of a supervising licensed dentist:
(1) Apply nonaerosol and noncaustic topical agents.
(2) Apply topical fluoride.
(3) Take intraoral impressions for all nonprosthodontic appliances.
(4) Take facebow transfers and bite registrations.
(5) Place and remove rubber dams or other isolation devices.
(6) Place, wedge, and remove matrices for restorative procedures.
(7) Remove postextraction dressings after inspection of the surgical site by the supervising licensed dentist.
(8) Perform measurements for the purposes of orthodontic treatment.

"We aim to protect patients

promote confidence in dental professionals

be at the forefront of healthcare regulation

We register qualified professionals

set standards of dental practice and conduct

assure the quality of dental education

ensure professionals keep up-to-date

http://www.gdc-uk.org/Pages/default.aspx

http://www.cedentists.eu

b) the composition of the dental team and the dentist's relationship with dental technicians; and,
c) the responsibilities and competences that dentists expect of their dental team members and their relationship with patients.

In the EU the composition of the dental team varies significantly and this document only intends to describe the professions that exist in the majority of EU countries.

The recommendations set out in this document reinforce the CED Resolution Delegation Yes - Substitution No adopted by the CED General Meeting in November 2009, and the CED-ADEE Joint Position on Competences adopted by the CED General Meeting in May 2013.

A - IMPORTANCE OF THE DENTIST'S LEADERSHIP IN THE DENTAL TEAM

The provision of oral healthcare requires sophisticated and extensive medical and scientific knowledge in order to undertake correct diagnosis and treatment planning. This is particularly true given demographic changes such as an increasingly ageing population with complex health issues.

In order to ensure the best oversight of treatment and continuing care at all times, there is a need for the dentist to have a leadership role. This is particularly relevant in light of the risks related to the complexity of individual patients' circumstances, including the need to consider drug interactions when treating those with multiple conditions.

The revised Directive on the Recognition of Professional Qualifications[2] introduced a new criterion for the minimum duration of training for dentists. Basic dental training now comprises a total of at least five years and 5000 hours of university education
practising independently.

B - COMPOSITION OF THE DENTAL
WITH DENTAL TECHNICIANS

Patient care will be optimised if dental teams
dentist. In the European Union the composition
country and as mentioned above this document only intends to describe the professions that exist in
the m

In so
mem
pract

Thes
defin
provi

Furth
have

Denta
usual
may
all pa

C - RESPONSIBILITIES AND COMPETENCES THAT DENTISTS EXPECT OF THEIR DENTAL TEAM MEMBERS AND THEIR RELATIONSHIP WITH PATIENTS

In order to safeguard adequate delivery of oral healthcare and appropriate relationship with patients, the members of the dental team must have the appropriate education, training and legal authorisation to provide specific oral care interventions as delegated by the dentist. They must follow a code of conduct or defined set of standards to ensure patient safety and good team work.

The core responsibilities and competences of dental team members are outlined below. They may vary from country to country. The level of regulation and registration is very varied across the European Union, which makes the leadership role of dentists, who are highly regulated in every country, extremely important.

Dental Chairside Assistants

Assisting the dentist during procedures, dental chairside assistants work under the supervision of the dentist and are responsible for preparing and providing instruments and materials needed for the treatment and follow-up with patients, along with any additional tasks related to laboratory and administrative work assigned to them by the dentist.

CED
COUNCIL OF EUROPEAN DENTISTS

29 May 2015
CED-DOC-2015-003-FIN-E

CED Resolution

THE DENTAL TEAM
RELATIONSHIP WITH PATIENTS

Patient Safety & Quality of Care

Dental hygienists only exist in some Member States and their education, training and field of competences differ greatly across the European Union.

Dental hygienists work under the supervision of the dentist, following prescribed procedures and protocols related to the promotion and maintenance of good dental hygiene. They perform dental prophylactics and scaling of teeth, apply prophylactic materials to the teeth, collect data, and educate patients on maintaining a good oral health regime.

Dental Technicians

Dental technicians as manufacturers cooperate with the dental team, work under dentists' prescriptions and specifications in order to manufacture dental custom-made devices such as bridges, crowns and dentures.[3] The dentist is the final user of dental custom-made devices[4] and bears the responsibility for the overall treatment.

http://www.cedentists.eu

Directive 2005/36/EC on the Recognition of professional qualifications

to provide more uniform framework for recognition of professional qualifications of the regulated professions

Seven sectoral directives for „sensitive“ professions: **dentists,** doctors, nurses, midwives, pharmacists, veterinarians and architects

Principle of free movement of people and services with minimal obstacles/barriers

But: Facilitation of services must be in context of respect for public health and **safety** and **consumer protection**

Implement the Directive faithfully, but in a way that safeguards **patient safety** and imposes minimum additional burdens on professional organisations / regulators

The Directive on the **application of patients' rights in cross-border healthcare** COM/2008/414/EC

states that in cases of **cross-border healthcare safety and quality standards** enforced in the country of treatment apply.
The Directive includes provisions on structures and procedures for informing cross-border patients about these standards (transparency) as well as provisions for **cooperation between member states** aimed at **increasing quality and safety.**

The quality and safety of healthcare services can best be ensured by having up-to-date minimum training requirements for health professionals; by promoting ethical codes developed by European health professionals' organisations in the context of cross-border care; through continuous professional development; and by a commitment to professional practice that is patient-safety-centred.

The CED believes that **professional and ethical standards can best be developed at national or regional level**.

ERO European Regional Organisation of the Federation Dentaire Internationale fdi

DENTAL TEAM, TASKS AND RESPONSIBILITIES:

Top quality for patient safety and oral health care

1. PREAMBLE

Dentistry is a complex medical
the prevention, diagnosis and rel
the hard and soft tissues of mout
the jaws, recognising oral sym
cancer, malformations and lesio
replacement of missing teeth

ERO EUROPEAN REGIONAL ORGANIZATION OF THE FEDERATION DENTAIRE INTERNATIONALE FDI

ERO resolution on the condition of possible delegation within the dental team

Dentistry is a complex medical science with high standards. A dental treatment calls for special knowledge, acquired with at least five years of fulltime University education, according to the European directives in force. It is the minimal level of education necessary to ensure patient's safety, which is attained only by the dentist and not by any other member of the dental team.

ged to provide dental care personally, however, in compliance with
may delegate to other dental team members certain performance of
hat form part of the overall dental care. In any case it is the dentist
patient for the overall treatment.

ERO European Regional Organisation of the Fédération dentaire internationale fdi

in provision of dental care

The ERO-FDI takes note of the recent actions of national and in
organizations associating dental technicians. These actions are carried on
forms and take place on various occasions, but they have a commo
ensuring an increased scope of professional tasks for dental technician
obtain the right of independent practice, including direct provision of c
patients without supervision by the dentist.

The ERO-FDI, in accordance with the FDI Policy Statement on Dental
Technician adopted in 1998 and revised in 2007, firmly opposes such a
draws attention of the authorities and the public to the fact that dentistry is

RESO
Dental Hyg

Pream

European Regional Organization of FDI, which r
wide, aims to promote high standards of oral heal
centred professional practice.

All members of the dental team should use only t
by the competent dental authority in their countries
of work, country of practice).

In those ERO Member States where dental hygien
education, training and field of competences are ve

The following professional profile, described, educ
the "Dental Chair side Assistant" and the "Denta
Hygienist's" Profile.

The European Regional Organization of the FDI wants to contribute to patient safety through the

opean Regional Organisation of
édération dentaire internationale fdi

Dental Chairside Assistant

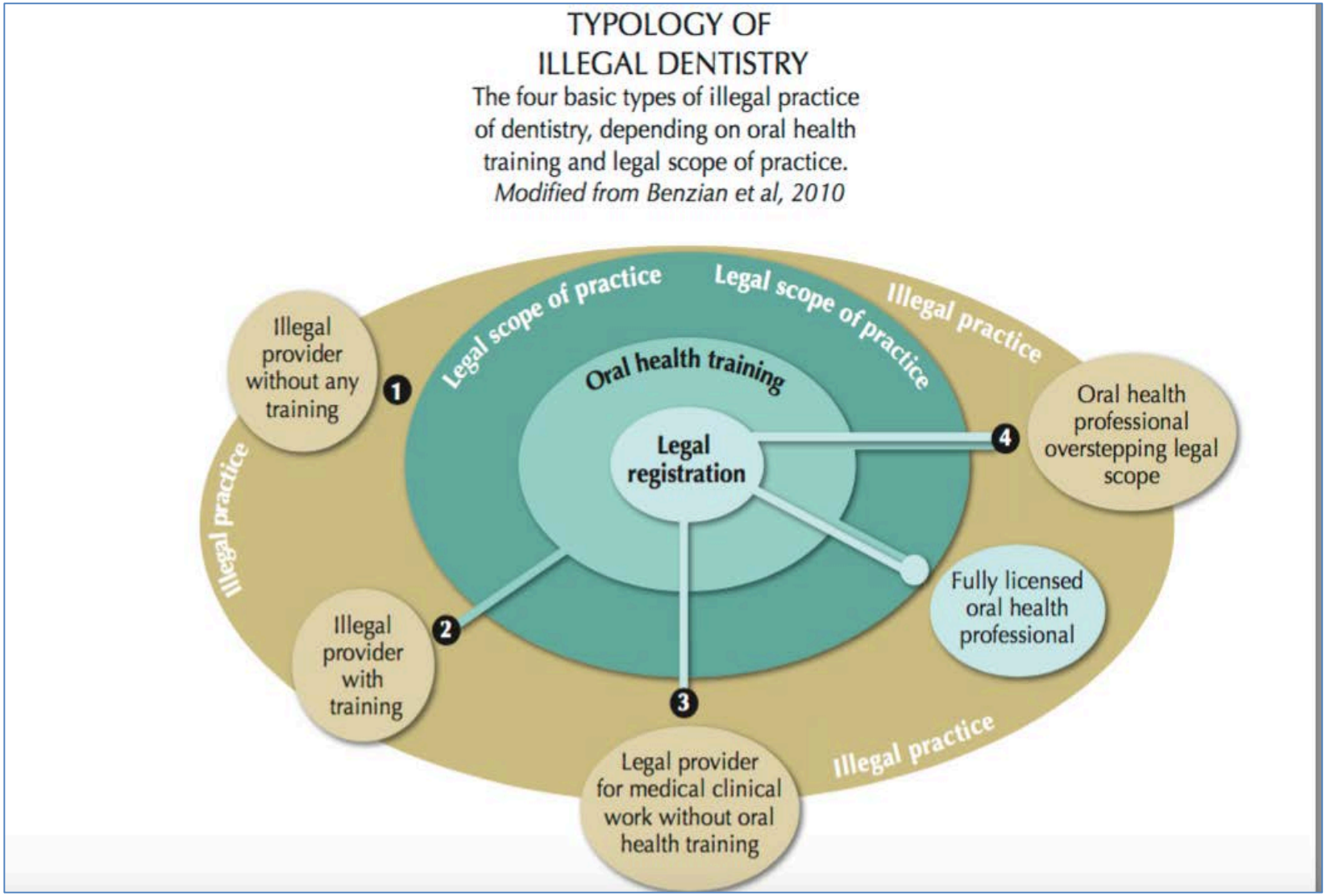
Preamble

The detailed definition of the DCA Profile should help to align the post of DCA to the European Qualification Framework (EQF) to be introduced in 2012. Each country has to make a proposal on how to develop this concept, which contains the minimum criteria for a qualified DCA.
The dental profession is absolutely against any kind of compulsory standardization.

The dental team, led by the dentist, is essential in the prevention of oral diseases and in ensuring the best possible quality of oral health care. All members of the dental team shall have the education and training appropriate to their areas of responsibility and be legally allowed to provide dental care always under the supervision and responsibility of a dentist. Roles and responsibilities of all team members should be specified and defined by national regulatory bodies and/or professional dental organizations.
All members of the dental team may only use those dental qualifications or titles which have been approved by the competent dental authority in that country (legislation in the awarding country, place of work, country where they practise).

Patient Safety & Quality of Care

http://www.erodental.org



The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*

FDI POLICY STATEMENT

Action Against Illegal Dental Practice

Adopted by the FDI General Assembly: 1 October 2002 – Vienna, Austria
Reconfirmed by the FDI Dental Practice Committee in September 2009 in
Singapore

The FDI recommends the competent authorities in each country :

· To develop and establish a legal framework for the entire area of the practice of dentistry
· To control the quality of the education and training for the practice of dentistry
· To control the practice of dentistry within the established legal framework
· To identify and suppress illegal dental practice

FDI POLICY STATEMENT

Supervision of Auxiliaries within the Dental Team

Reconfirmed by the FDI Dental Practice Committee in March 2007 in Ferney- Voltaire, France , Adopted by the FDI General Assembly: November 2000 – Paris, France

http://www.fdiworldental.org/publications/policy-statements/policy-statements-and-resolutions.aspx

Collaborative practice-ready workforce
an **innovative strategy** that will play an important role in mitigating the **global health workforce crisis.**

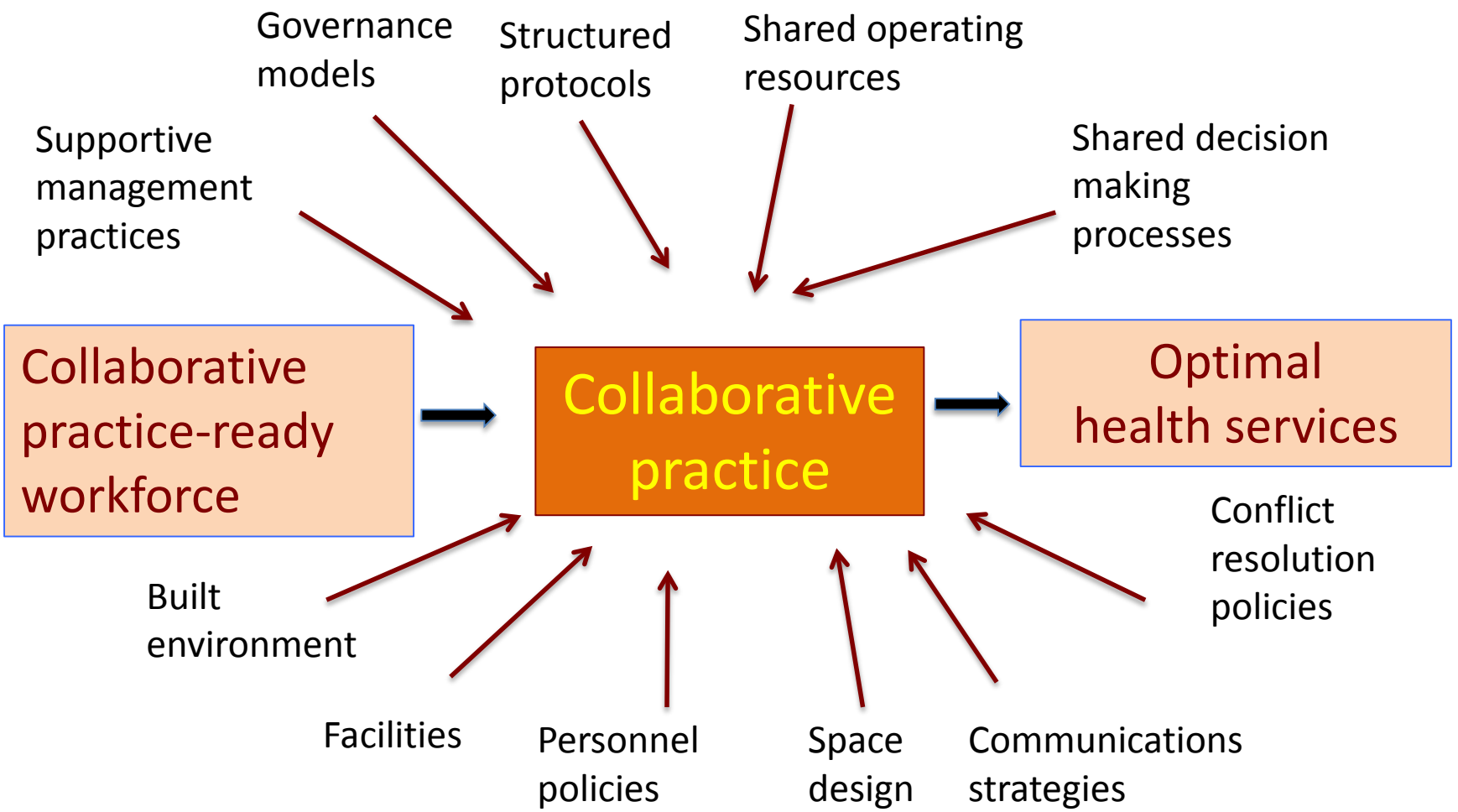
Optimal oral health is a function of a variety of factors - **in addition to intra- and inter-professional CP**

e.g.

- need & demand
- technological progress
- socio-economic dynamics
- satisfactory service delivery

They all need to be balanced according to the context.

Examples of mechanisms that shape collaboration at the practice level



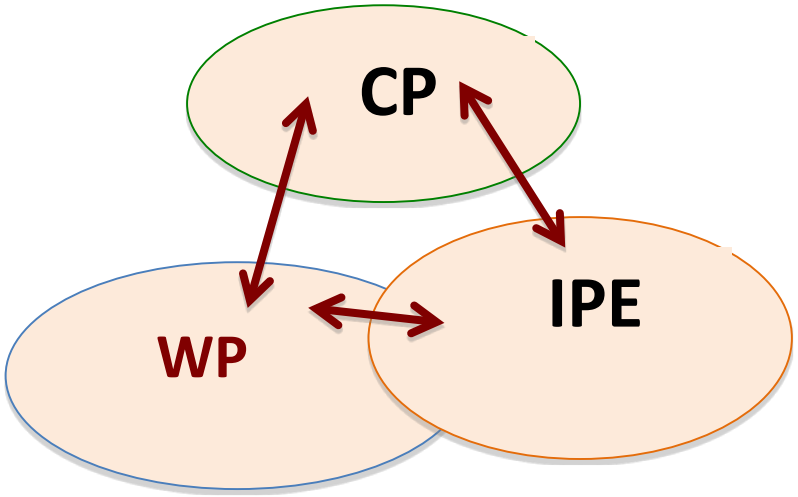
CP *(and IPE)* are **strategies** to improve access to care and achieve better quality of services efficiently

not end goals.

KEY MESSAGES

The dental profession should be recognized as a driving force behind CP

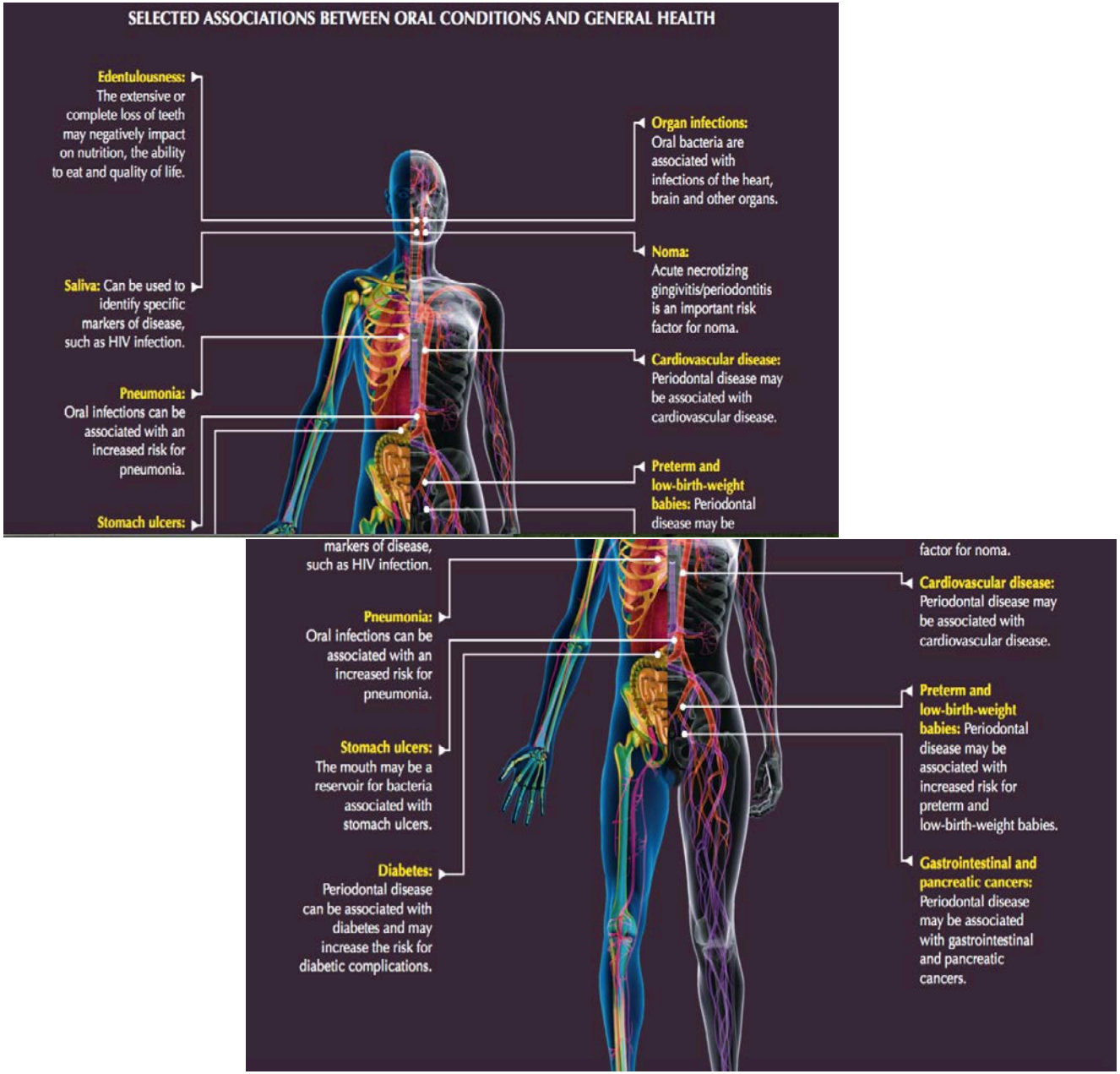
It is of utmost importance that the **dental profession** should be part of the political dialogue at national and global level and recognized as a **central driving force** behind the **development of competencies for CP** and the **implementation of any CP model**.



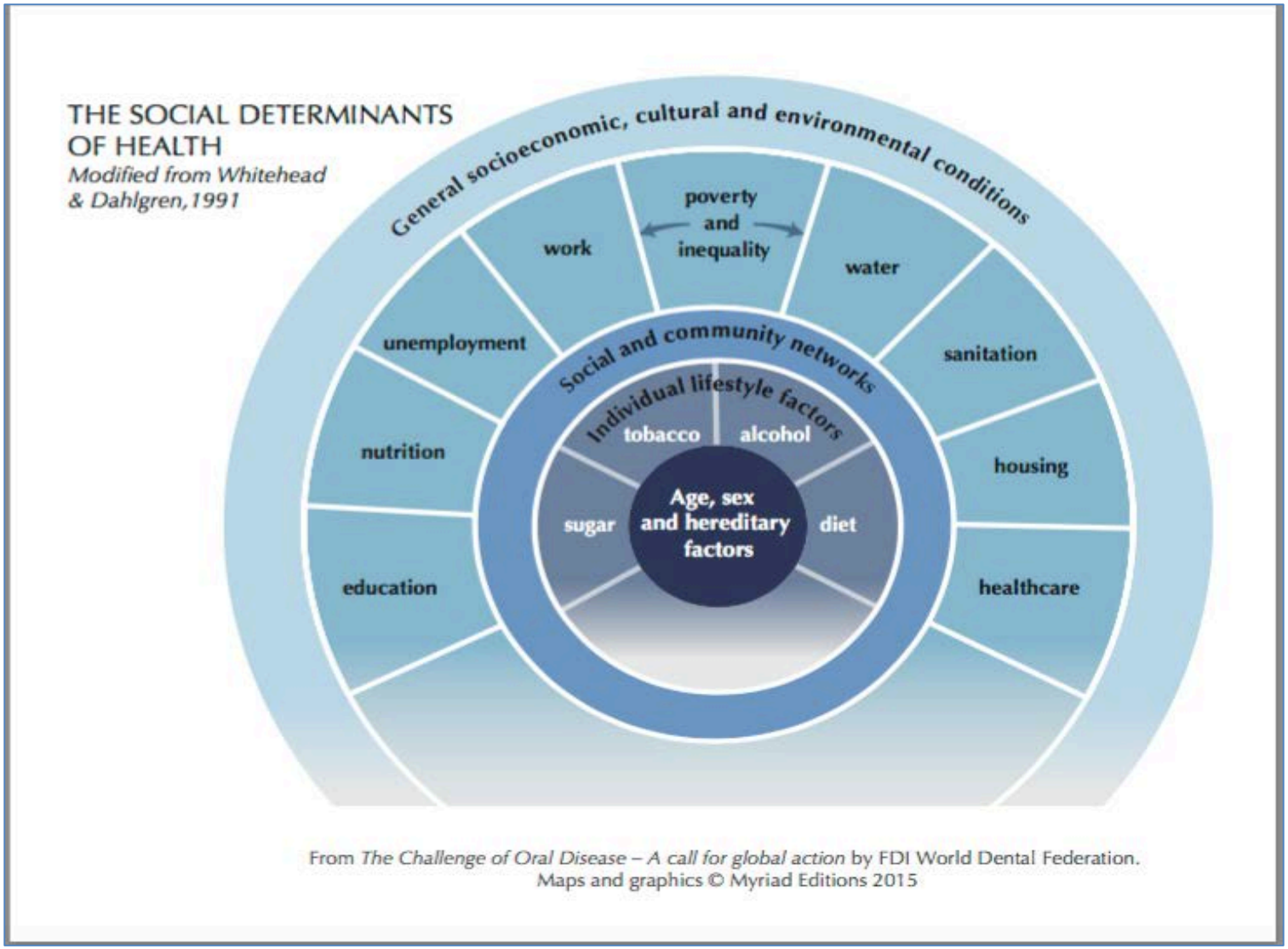
The **health** and **education** systems must **work together** to coordinate **health workforce strategies**.

Interprofessional health-care teams understand how to optimize the skills of their members, share case management and provide better health-services to patients and the community.

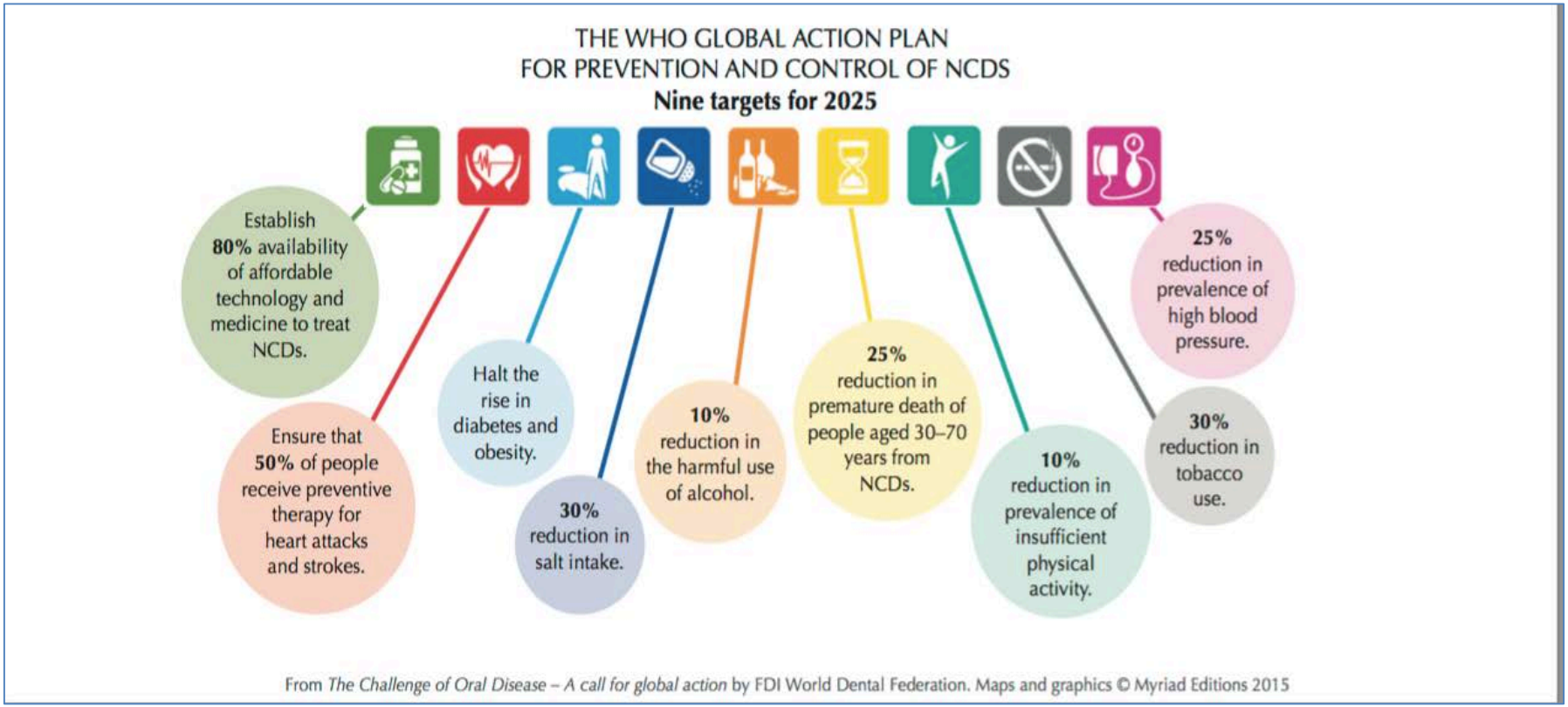
The resulting **strengthened health system** leads to **improved health outcomes**.



The Challenge of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*



The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*



The Challange of Oral Diseases . A call to action. The Oral Health Atlas. FDI World Dental federation. 2nd Ed. Myriad Editions, Brighton UK – *With permission from FDI*

Thank you..