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Dental and Oral Health Therapists' perceptions of continuity of patient care

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Abstract

Background and objectives: Continuity of patient care is important in healthcare as it can enhance service provision and improve patient outcomes. However, there is little research into continuity of patient care in the oral health professions. This study investigated dental and oral health therapists' perceptions of continuity of patient care and the importance they placed on it.

Methods: Fourteen therapists from the Otago/Southland region of New Zealand participated in one of three audio-recorded focus groups. Data were transcribed verbatim, then analysed using a general inductive approach.

Results: Four major themes emerged from the data: autonomy, time management, patient and parent rapport, and job satisfaction. Therapists working in the public sector, compared with those working in the private sector, experienced a lack of continuity of patient care, and this impacted on the level of autonomy they experienced. Loss of autonomy was a major issue for therapists as it led to job dissatisfaction. The lack of continuity of patient care also impacted negatively on therapists' time management and clinical learning. Participants stated that patient rapport, trust, and compliance improved with consistent continuity of patient care, and this affected the likelihood of successful treatment outcomes for patients.

Conclusion: The findings of this study highlight the need to address the lack of continuity of patient care and autonomy experienced by the public sector therapists in the Otago/Southland region of New Zealand. Alternative models that promote continuity of patient care should be considered; these may have the potential to improve patient experience, as well as improve job satisfaction for dental and oral health therapists.

Introduction

Continuity of patient care (COPC), defined as care over time between a health practitioner and a patient (Institute of Medicine (US), 1996), has been found to improve patient outcomes, particularly for patients with chronic conditions. COPC can result in decreased hospitalisation, improved acceptance of preventative services, and improved patient satisfaction (Cabana and Jee, 2004). Patients were more likely to feel satisfied and follow recommended advice from practitioners when they returned to the same practitioner (Albrecht and Hoogstraten, 1998). Additionally, increased COPC has been linked to fewer ambulatory hospitalisations and improved acceptance of preventative measures (Enlow et al., 2017). Therefore, it seems intuitive that COPC is also important to dental and oral health therapists (hereafter referred to as "therapists") but there is little evidence for this view in the research literature. Most of the research on COPC is centred on medicine, nursing, and midwifery, with very little in dentistry or oral health. Specifically, there has been no substantial research on New Zealand (NZ) therapists' views on COPC. Consequently, the questions, how do NZ therapists define and enact COPC? and what value do NZ therapists place on COPC? remain unanswered.

The need for COPC has been formalised by several health professional bodies. The American Academy of Paediatrics (1992) established comprehensive guidelines to create a patient-centred "medical home" where a patient is assigned a physician who leads a team of clinical care providers to take collective responsibility for delivering continuous, comprehensive, coordinated care. Evaluation found a "medical home" encouraged COPC for patients, resulting in improved acceptance of preventative services and increased patient satisfaction (Cabana and Jee, 2004). Subsequently, in 2001, the American Academy of Paediatrics (2016) formally adopted a policy endorsing the term "dental home", based around the idea of the "medical home". The dental home features a personal dentist who leads a multidisciplinary team to deliver comprehensive, prevention-based dental care that is accessible, family-centred, compassionate and culturally competent (American Academy of Paediatrics, 2016), and where continuity of oral health care can be established (Girish Babu and Doddamani, 2012). There is a strong link between having a dental home and patient trust with dental professionals (Girish Babu and Doddamani, 2012). Establishing a trusting relationship to gain a child's cooperation is important in order to provide for a child's oral health care needs (Nash, 2006). Furthermore, when patients received COPC, compliance and behavioural problems improved, as did patient satisfaction (Dietrich and Marton, 1982 cited in Cabana and Jee, 2004).

COPC is also an important aspect of health professional training. Interactions with patients form the foundations of clinical learning, but one study found that when students experienced a lack of COPC, there was an impact on their clinical learning. Specifically, students found it difficult to build ongoing patient relationships (Asgarova et al., 2017). Lack of COPC also resulted in students being unable to see, and therefore reflect on, the results of their clinical decisions or diagnostic and management outcomes. This negatively impacts developing professional

competence because reflective ability is fundamental to deeper learning (Mann et al., 2009).

Despite the evidence that COPC has advantages for both patients and practitioners, there can be unanticipated negative consequences of what is referred to as long-term or persistent COPC (Adeoye et al., 2014). Although what is meant by long-term or persistent COPC and how it differs from COPC is not clearly defined in the literature, documented negative consequences include issues for practitioners such as burnout and compassion fatigue, informal and ill-defined professional boundaries, and diagnostic and intellectual curiosity fatigue (Adeoye et al., 2014). In addition, the familiarity that can result from a long-term patient/physician relationship can lead to encounters becoming more routine and less clinically productive (Adeoye et al., 2014; Cabana and Jee, 2004). However, Adeoyde et al. (2014) found that the shortcomings of persistent COPC did not necessarily mean that practitioners failed to deliver a positive service; rather, they inferred that the concept is better understood now than it was at its inception, and practitioners must ensure solutions are found to emerging problems at a pace consistent with problem identification.

Patients' health care needs are rarely met by a single professional (Gulliford et al., 2006). However, there is little evidence in health service research that COPC is advocated as an essential element of general medical practice. In addition, the traditional view of the importance of COPC is documented as difficult to sustain. Consequently, primary health care provision needs to develop more diversified multidimensional models of continuity (Gulliford et al., 2006). Doing so would achieve the traditional patient ideal of a continuous caring relationship whilst meeting the provider's ideal of an integrating service that includes the sharing of information by teams of health care professionals.

In NZ, therapists in the Southern District Health Board (DHB) region viewed the reduction in COPC, following the reorientation of the School Dental Service (SDS) to the Community Oral Health Service (COHS) from 2006, as a negative outcome of the change to the service (Ahmadi, 2016). However, overall, there is little research exploring oral health professionals' perceptions of COPC. The current study provides in-depth insight into the views that therapists have of COPC and how COPC is implemented into NZ therapists' practices, alongside any possible consequences for both the public and private sector.

Methods

Ethical approval to undertake this phenomenological research was obtained from the University of Otago Human Ethics Committee (D18/062) and consultation undertaken with Ngāi Tahu. Dental and oral health therapists from the Otago/Southland region were invited to participate in focus group discussions via an advertisement and information sheet distributed during an Otago New Zealand Dental and Oral Health Therapists Association (NZDOHTA) branch meeting. An advertisement was also distributed during a Southern District Health Board Continuing Professional Development (CPD) in-service meeting, and at an Otago/Southland NZDOHTA CPD roadshow. Participants were sought from Otago/Southland for convenience of being able to take part in a face-to-face focus group. Participants were assured of confidentiality, and no incentive was offered for participation. A total of 14 therapists took up the invitation and subsequently participated in one of three focus group. Seven therapists attended the first focus group, four attended the second group, and three attended the final group.

The focus group discussions were informal face-to face conversations between the participants, facilitated by KC. The facilitator only provided input to guide the direction of the conversation when required (Edmunds and Brown, 2012). Each focus group covered a consistent set of topics through a semi-structured series of open-ended questions to initiate discussion, encouraging participants to explore the issues of importance to them, in their own vocabulary. Participants were also encouraged to generate their own questions and pursue their own priorities (Kitzinger, 1995). The precise questions that were asked during the focus groups were not entirely determined beforehand; they depended on the way in which the focus group discussion developed. Conversations were audio-recorded and transcribed verbatim by KC. Transcripts were anonymised and each participant was given a unique identifier (for example, "P1") for reporting purposes.

A general inductive approach (Thomas, 2006) was used to analyse the transcripts. The primary purpose of this approach was to allow research findings to emerge from the frequent, dominant, or significant themes inherent in the raw data (Thomas, 2006). Through a constructionist lens, the researchers used an iterative process of analysis, where the transcripts were read, coded, then re-read and coding refined several times (Braun and Clarke, 2006). Analysis and data collection were synchronous, and all three focus groups raised the same points of discussion, suggesting that further focus groups would not yield any further information. Consistent with a constructionist approach, the researchers had no pre-formed hypotheses. KC, who facilitated the interviews and led the analysis, is a dental therapist and hygienist with experience in the public and private sectors. These experiences necessarily informed the inquiry and analysis. Consequently, KC took a reflexive approach to data collection and analysis (Pillow, 2003) through recording fieldnotes, and discussing assumptions with the other researchers. The other two researchers (SM, a dental therapist and academic, and LA a dental education academic) independently analysed the transcripts, and the three analyses were compared for consistency and trustworthiness, to ensure a "logical generalisation" of the data (Patton, 2002, p. 243). From this process, four broad themes emerged. These themes were autonomy, time management, patient and parent rapport, and job satisfaction.

Results

Before discussing the four themes, it is first necessary to establish what the participants understood COPC meant. All participants defined COPC in similar terms, and this quote best encapsulates the shared perspective:

> A patient seeing the same practitioner from beginning of treatment to the end, and ideally including any future preventative reviews [seeing a patient for a specific reason before their annual recall] put in place by that practitioner (P1).

Autonomy

The most dominant theme that emerged from the focus groups was autonomy. Therapists classified professional independence, initiative and being able to treat patients according to their best judgement as an important factor contributing to their job satisfaction. Conversations that were coded to this theme included discussions about not being able to schedule bookings or carry out treatments in the way that they preferred, leading to a feeling of lack of responsibility towards their patients.

A view that arose strongly from public sector therapists was the loss of autonomy that followed the reorientation of the SDS to the COHS. Participants regularly compared the "old model of care" (SDS) to the "new model of care" (COHS). The therapists who had worked under both schemes reported experiencing greater COPC within the SDS system. For example, P3 explained, "And that was actually something, you know when we worked in schools, you worked very closely with parents and the people who assisted those children and staff too…It's very rewarding and you felt responsible for the child."

Public sector urban therapists reported that they often experienced a lack of control over their day-to-day patient bookings, the clinic they worked from, and the patient group they might be responsible for. Appointments were made for the therapist by other staff prior to the therapist arriving at the clinic. Often the appointments were made without considering COPC. P10 explained, "Yeah, the roster comes out, we've gotta fill the book up in a week or two and they just plough through and book anyone anywhere."

The lack of control they experienced resulted in the therapists feeling a lack of responsibility towards their patient group. For example, P1 stated:

> … like some people have kinda given up, I know this is a fact and I'm probably a culprit myself … taking responsibility for booking things in – it's like, why should I? You know that sounds like a really awful thing to say, but because, you know, when you had your own patient group you took such pride in keeping it up-to-date and doing everything right, now everything is so ad hoc, it's like pfft it's not my problem.

Some urban public sector therapists reported that moving between clinics regularly resulted in them routinely taking over other therapists' treatment plans, which further reduced their autonomy. Many described situations where the therapist who examined a patient and created a treatment plan was not necessarily the clinician who carried out the treatment. This experience was described by P16: "I've worked in DHBs where someone else would do the exam and then the treatment would come to me, and you might not necessarily agree with that treatment plan." Therapists also attributed their loss of autonomy and COPC to heightened stress levels. This was most strongly noted by part-time therapists. P12 commented: "Being a part-timer – I get stressed because I'm getting other people's treatment plans all the time – so I find that really stressful." P12 went on to say that this often led to treating patients who were difficult to manage, and who other therapists did not want to treat.

Consequently, the change in therapist often resulted in changes to the treatment plan due to differences in diagnosis, as well as changes to consent and clarification (related to the clinical reasoning for the changes) for the patients and parents. Parents and patients accepted, without complaint, changes made to previous therapists' clinical reasoning and treatment planning. However, there were numerous reports where a lack of COPC resulted in parents expressing annoyance at seeing different therapists throughout a treatment plan, particularly if they were not given notice of the change in clinician. P12's explanation encapsulated this view:

> The one thing that I find they get disgruntled at, like I have had a couple recently, disgruntled at having a different practitioner. "Can we just have the same person please; can I please stay with you for the next appointment!" and I think that's becoming more prevalent.

Therapists who were working in rural regions of the public sector indicated they had more control and autonomy over their booking system and patient group than their urban counterparts. P10, a rural therapist, reported that she had been encouraged by management to inform staff in the clinic of the way she would like the appointment book to be managed to suit her needs, including the amount of time she required for patients:

> I said I was really struggling, and I was running behind often because I was new… I got told it's my appointment book, you book the patients the way you want, you tell the staff this is what I want, this is how it has to be booked, make your own choice … Now I'm back in the city, I have no control over it, no control at all.

Rural therapists also indicated that they experienced more COPC than their urban colleagues; this was because they had a set placement they visited in rotation and were more likely to return to the same clinics.

Private sector therapists' focus group conversations also revealed greater instances of COPC. These therapists reported that patients saw the same practitioner from beginning of treatment to the end, which improved their autonomy. They stated that under the COPC model, reviews and annual recalls were managed on time (thus eliminating arrears), allowing for monitoring of early signs of decay and appropriate preventive measures to be carried out. P15 explained, "In private practice, I have very good continuity of care, very much so … watches [on teeth], monitoring and stuff … you just put them on a recall, and they'll be bought back in on time, yep very lucky, no arrears."

Time management

The theme of time management was evident across all of the focus groups and was linked with the theme of autonomy. Therapists described the extra effort that the loss of autonomy entailed, such as adjusting treatment plans, differences in diagnosis and communicating clarification for the patients and parents, as frustrating and unsatisfying. Additionally, the therapists shared the view that not having COPC impacted on their time management. Participants across all of the focus groups expressed frustration over being required to introduce themselves to a new patient and parent, and the time it took to do this, as well as the time it took to rationalise alterations to treatment plans. Participants collectively agreed this impacted heavily on their time and overall management of the patient and their care.

Some participants, said that in order to save time, they would follow other colleagues' treatment plans even if they did not agree with them.

> … so sometimes even when I think things are really unnecessary, I've just gone and done them cause it's in the treatment plan and the person before me has said let's do it and I've sort of felt I don't like to change it (P4).

The participants' conversations often centred on the importance of informative and accurate records on file, particularly when there was a lack of COPC. A detailed record of the proposed treatment and materials discussed, what consents had been obtained, and family preferences and history were deemed essential for good care and to meet legal requirements. Many participants discussed the extra time it took to make clear and detailed notes for every case, with the knowledge that the notes and treatment may need to be followed by another therapist. This view was evidenced by P12's comment:

> And you have to make sure, again the notes, has the filling material been discussed? If it hasn't been documented you might be like, ok so today, we were going to do this, are you aware that's what we were doing? The last therapist… you know, I always do a brief sort of almost like an overview before I even begin.

The importance of accurate record-keeping was similarly stressed by P14 who explained, "So, records are quite important … to record all the information that we can, because we know that we're not going to get them back … " The therapists were all aware that detailed record-keeping, although time-consuming, was a necessary aid to time-management when COPC was unlikely.

Patient and parent rapport

Throughout the focus groups, all participants agreed that when they experienced a lack of COPC, this resulted in a negative impact on the therapist-patient relationship. Participants spoke of the importance of building rapport with their patients and parents. They described how both therapists' and patients' experiences were enhanced when they were able to develop a trusting relationship over time, resulting in better treatment outcomes for the patient.

Participants frequently spoke of the benefits of repeated contact with the same patient and how this aided patient management and compliance:

> For complex treatment plans, continuity of care absolutely plays a huge part … when children have a lot of work to do and you want to do it successfully, so you need to have that [COPC], they need to have that trust in you (P4).

Many of the therapists treating children in the public sector thought COPC reduced the need for patient referrals to manage behaviour. P2 spoke about this in terms of trust:

> … you know that whole continuity of care makes such a difference to that trust thing, like, we're referring out so many children [for treatment under sedation], if people had more continuity of care, there may not be so many referrals due to limited patient compliance.

Once a trusting relationship had been developed, some therapists within the public sector reported that parents would follow them to whichever clinic they were working from to ensure COPC. However, the therapists acknowledged clinician changes could happen at short notice and there was no guarantee a patient would see the therapist they expected to on the day.

Job satisfaction

The theme of job satisfaction was related to ongoing learning and reflecting on job performance, including COPC. The themes of autonomy, time management, and patient rapport were intertwined with job satisfaction. All the participants talked about job satisfaction that resulted from reviewing patients they had treated previously. Public sector participants also reported that their job satisfaction improved if they knew they would be placed in a particular clinic for periods longer than eight weeks.

Participants who had worked in both the SDS and the COHS felt strongly that the loss of COPC was connected to their job satisfaction. P2 stated, "In the change from SDS to COHS came less continuity of care, and the change in job satisfaction was huge, HUGE!"

Participants also identified clinical learning as an important factor of their job satisfaction. With better COPC, participants were able to evaluate and reflect on their clinical practice and this resulted in improved clinical learning and development. P1 explained, "Lack of continuity of care is a whole lost learning opportunity, that's the biggest learning you can do; getting your own patients back." For new graduate participants, not having COPC, meant that they frequently felt uncertain about their clinical skills and judgement:

> Well, I found; I was really worried with things 'cause you don't see your work back so … I'm being in 2nd year out now … 'cause I was like I think that'll be alright … but you don't have that assurance of seeing it back (P14).

These views reflected the importance of COPC for ongoing learning and professional development for both new graduates and therapists who had been in the workforce for some time.

Discussion

This research investigated the questions, what are NZ therapists' perceptions of COPC? and what value do they place on COPC? All participants in this study defined COPC as a practitioner seeing the same patient from the beginning of treatment until completion and, ideally, including future preventive review appointments put in place by the same practitioner. The views of the participants in this study align with existing literature. COPC has been described as "care over time, by an individual or team of health care professionals, incorporating effective and timely communication of patient health information" (The American Institute of Medicine, 1996, p.69), and as encompassing enough patient knowledge and information to best apply professional competence, and having confidence that care inputs would be recognised and pursued by other clinicians (Haggerty et al., 2003).

The principal findings of the current study reveal that autonomy, time management, and patient rapport were intertwined with job satisfaction and, consequently, participants' conversations about COPC drew on all these themes. Participants perceived autonomy as the most important aspect of COPC and they described the loss of autonomy within the public sector as a major issue. Many participants experienced a lack of autonomy and control over their patient group, their appointment book and clinic, as well as experiencing a lack of COPC, leading to self-expressed job dissatisfaction. Participants working in urban areas of the public sector felt this more strongly than those in rural areas of the public sector, or those in the private sector. The loss of autonomy that urban participants described is consistent with Ahmadi (2016) who concluded that, following the reorientation of the SDS to the COHS in the Southern region, public sector rural therapists experienced less loss of autonomy when compared with public sector urban therapists.

Participants in the current study, who were employed in private practice, spoke of having more autonomy and control over their patient group which, in turn, led to greater job satisfaction. Other research has also found that autonomy is one of the most important elements contributing to health professionals' job satisfaction (Luzzi and Spencer, 2010; Stamps and Piedmonte, 1986 cited in Finn, 2001). Furthermore, the public sector participants in the current study noted that, on the occasions where they were placed in clinics for longer periods, or were able to return to the same clinic, as in the case of rural therapists, COPC and job satisfaction improved. Implementing a model in the public sector that promoted COPC and autonomy, particularly in urban areas, would likely result in the same benefits. The private practice COPC model may not be appropriate for the public sector; private sector practitioners tend to be responsible for smaller patient group numbers, and staff shortages are an issue within the public sector, often requiring frequent movement of staff. It is now rare for a patient's health care needs to be met by only one provider and multidimensional models of continuity are often necessary. In multidimensional models, services are provided by integration, coordination and the sharing of information between different providers (Gulliford et al., 2006).

Participants working in urban areas of the public sector revealed the frequent moving between clinics and changes in patient groups resulted in many of them feeling less responsibility towards their patients and reduced workplace effort. This aligns with other research showing that clinicians who experienced more COPC with their patients also experienced a greater responsibility towards their patients (Hjortdahl, 1992). Increasing COPC in the public sector would most likely lead to a greater sense of patient responsibility and improved workplace effort, and address the issue of any negative changes to healthcare provision that may have developed from reduced workplace effort.

The participants attributed the lack of COPC they experienced to heightened stress levels. This was most strongly noted by part-time therapists, who experienced less COPC than full-time therapists. Participants attributed the stress to taking over other therapists' treatment plans, and the likelihood of reduced patient compliance and behaviour due to inadequate COPC. On nursing shifts when structures were changed to incorporate high levels of COPC, patient satisfaction improved and staff stress levels were shown to decrease (Kalisch et al., 2008). Adeoye et al. (2014) acknowledged that there were also negative issues associated with long-term or persistent COPC, such as burnout and compassion fatigue, informal and ill-defined professional boundaries, and diagnostic and intellectual curiosity fatigue on the part of the health care provider. Although these consequences were not expressed by participants in the current research, it is entirely feasible that dental and oral health therapists who manage the same difficult patient groups for some years, for example, groups with high disease experience, may suffer burnout or fatigue, and may prefer a regular change of patient group.

In NZ, therapists are able to work in both public and private practice, but anecdotal evidence shows they are likely to earn considerably more in the private sector. Furthermore, those therapists employed in private practice are more likely to have greater opportunity to practise their full scope of practice than those employed in the public sector (Moffat and Coates, 2011; Moffat et al., 2017). The findings of the current study suggest that therapists employed in private practice appear to experience greater COPC, job satisfaction, autonomy and less stress compared with those employed within the public sector; this may impact on recruitment and retention in the public sector. The COHS throughout NZ is experiencing workforce shortages (McLean et al., 2017), and other studies have found that a lack of autonomy impacts on job satisfaction and increases the likelihood of leaving employment (Luzzi et al., 2005; Bolin and Shulman, 2005). Encouraging COPC and allowing greater autonomy for therapists in the public sector may go some way to improving retention within

the COHS workforce.

Greater COPC would also most likely improve time management with therapists having to spend less time getting to know patients and managing patient records. Time management pressures were particularly evident in instances where therapists would follow their colleagues' treatment plans in order to save time, even if they did not agree with the plan. This raises an issue of professional responsibilities; the standards outlined in the NZ Dental Council Standards Framework state a practitioner must put the patient's interests first, and that the practitioner's primary concern is the health needs and safe care of their patient (Dental Council of New Zealand, date unknown). The current findings suggest that lack of COPC creates a tension within these responsibilities.

The participants in the current study described clinical experiences as being enhanced for both the patient and the therapist, and treatment outcomes as being more successful, when COPC is in place, and a trusting relationship has been established. This finding is supported by the research of Nash (2006) who revealed the importance of establishing a trusting relationship and effective communication to gain a child's cooperation in order to provide oral health care. Likewise, when a patient receives COPC, compliance and behavioural problems improve (Dietrich and Marton, 1982 cited in Cabana and Jee, 2004). This indicates strategies and policies to increase patient and clinician trust would be beneficial, and increasing COPC is a probable solution. It is also likely that with COPC in place, fewer referrals to manage patient behaviour would be necessary.

To maintain a trusting patient-clinician relationship, some parents would take their children to where a particular therapist was working. This right to choose a provider, and have a preference met, is supported by NZ's Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner, 2022). Last-minute changes on the day of an appointment mean that seeing the preferred therapist may still not be guaranteed; however, any new provider is always able to access a patient's dental records, and will follow set protocols to offer the same standard of care. There are, in fact, three types of continuity in terms of patient care documented in the literature; informational continuity (use of past information for appropriate care), management continuity (a consistent and coherent approach based on the patient's needs), and relational continuity (an ongoing relationship between a patient and one or more providers) (Haggerty et al., 2003).

Participants identified clinical learning as important to job satisfaction and noted that being able to evaluate and reflect on their clinical practice resulted in improved learning opportunities and professional development. Reflective ability is an essential characteristic for professional competence; it is linked to deeper learning and is an integral part of learning for continuing medical education (Mann et al., 2009). COPC was viewed by all participants to be of the greatest importance for new graduates; however, all new graduates who participated in the focus groups discussions spoke of practising with a lack of COPC. Consequently, they expressed that they regularly felt uncertainty about their clinical skills and professional judgement and were frustrated by the inability to reflect on their clinical practice. Not having the opportunity to see the long-term outcomes of their treatments, and effectively reflect on their practice, most likely hinders ongoing learning for new graduates. In April 2020, the Dental Council of New Zealand introduced a new recertification model for all practitioners (Dental Council of New Zealand, 2019). The policy incorporates clinical reflection into practitioners' ongoing professional development activities, and the Council also plans to implement a two-year mandatory mentoring programme for new graduates (Dental Council of New Zealand, 2019). Long-term mentoring for new graduates, that incorporates more COPC and reflective practice, may alleviate much of the uncertainty expressed by participants about their clinical practice.

The findings from this research indicate a tension is evident between the participants' desire to undertake COPC and organisational systems and processes that prevent this. One way this could be resolved would be to roster the same group of therapists to a set clinic over a longer period of time. This would effectively enhance COPC and therapists' job satisfaction, and could be a way forward. Provider continuity is key to high-quality paediatric primary care but continuity with a small group of health care providers can be as effective as continuity with a single health care provider (Enlow et al., 2017).

The small number of participants and geographical restriction to the Otago/Southland region are limitations of the present study. An investigation on a wider scale that incorporates and compares other regions of NZ would give a more representative sample of opinions among therapists in NZ. It is possible that therapists in different regions of NZ will have had different experiences; data that reflect the views and perceptions of a wider geographical spread of NZ therapists would add to our understanding of the implications COPC can have on autonomy, job satisfaction, trust and professional learning, and help inform ongoing improvements to NZ dental and oral health therapy practices and outcomes.

Conclusion

The present research has highlighted the need to address the lack of COPC and autonomy experienced by public sector therapists in the Otago/Southland region of NZ. Private sector practitioners experienced greater control and autonomy over their patient group, and a level of COPC that enabled them to see the same patient from the beginning of treatment to the end, leading to greater job satisfaction. Applying a similar model in the public sector would likely result in similar benefits, and have the potential to improve workforce recruitment and retention. However, patient groups and working conditions differ between the private and public sectors; more multidimensional models of care provision are needed to support autonomy, COPC, time management, and job satisfaction. Further research is required to understand which models of care currently work in the New Zealand context, and what changes could be made, to promote better job satisfaction for practitioners and improve patient outcomes and experiences.

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