ISSUE NUMBER 3 APRIL 2013

Mosaic

Canadian Association of Public Health Dentistry

IN THIS ISSUE

President Message

Dr. Gerry Uswak

On a daily basis, we in dental public health are challenged with improving the oral health of those we serve. Part of this challenge focuses on population-based endeavours such as community water fluoridation and health promotion. At the same time, we have patients with immediate treatment needs who face access barriers that prevent them from receiving timely care. This tug of war between upstream and downstream programming characterizes dental public health in Canada.

Recently, the city of Windsor, ON decided to cease community water fluoridation (CWF). To us, such decisions seem counter-intuitive based on what we know about the effectiveness of CWF. But the voting of decision-makers in these matters is tempered by emotions, politics and in some cases, naivety with respect to science and research. Success in CWF debates owes more to networking, social marketing, and political spin than evidence-based dental public health research. That said, Red Deer, AB and Prince Albert, SK city councils have decided to continue CWF. What is clear to me is that if CWF is to be seen as relevant and important by communities and their decision-makers then we need to completely re-think our approach of engaging their support.

The Ontario Public Health Association has committed to assessing the size and adequacy of Ontario's public health workforce including dental public health. This effort is commendable because Canada lacks human resources for oral health workforce planning strategies. This process highlights our need to figure out how to balance our upstream and downstream activities and establish the correct number and mix of providers for our workforce. Ideally, the mix of dental public health specialists, dentists, dental hygienists, dental therapists, dental assistants and other oral health professionals would be defined based on our need to balance population-based endeavours with an increasing demand for clinical care for those facing access barriers.

Our dental public health programs are challenged to be everything for everyone all within a razor thin funding envelope which often leave us spread too thin. This balance is best established based on an understanding of the context, timing, available resources, mandate or evidence associated with a particular set of interventions. OPHA's workforce planning assessment may represent a model for the rest of the country in terms of determining how best to deploy our dental public health workforce. Understanding and re-inventing how we advocate for CWF in light of recent decisions will make us more effective.

It is a delicate balance between upstream and downstream and we have to pick our battles wisely otherwise all we are doing is treading water.

Preliminary Highlights

INTERNATIONAL GUEST SPEAKER:

Dr. Myron Allukian Jr. DDS, MPH

The Neglected Epidemic and Social Injustice: What Can Be Done for Better Oral Health?

This presentation will discuss the neglected epidemic of oral diseases, the social injustices of : promoting disease by the food and tobacco industries, and how organized dentistry has limited access to care for the public. It will also include the importance of community water fluoridation, population-based prevention and access initiatives for cost effective delivery systems using expanded duties and dental therapists.

PANEL DISCUSSION ON ACCESS TO DENTAL CARE WITH:

- Dr. Peter Doig, President (in April), Canadian Dental Association (CDA)
- Ms. Sandra Lawlor, President, Canadian Dental Hygienist Association (CDHA)
- Dr. Peter Cooney, Chief Dental Officer, Public Health Agency of Canada (PHAC)
- Dr. Peter Trainor, President, Canadian Dental Regulatory Authorities Federation (CDRAF)

WORKSHOPS FOR FRONT-LINE DENTAL PROFESSIONALS:

OAPHD Calibration Session for Public Health Dental Hygienists, *Heather Murray, RDH BA - Supervisor, Oral Health, Simcoe Muskoka District Health Unit*

Developing Infection Prevention & Control Policies and Procedures for Dental Public Health: Experience from Prince Edward Island
Dr. Shannon Fitzpatrick, BSc (Honours), DDS), clinical dentist with Dental Public Health in Prince Edward Island

SCIENTIFIC SESSIONS:

- Scientific sessions to be announced in the coming months.

CONNECT & GET INSPIRED!

- Connect & network with dental public health professionals all weekend!
- Registration includes a cocktail reception on Friday evening!

2013 CAPHD Scientific Conference and Annual General Meeting

The Paradox of Oral Health Care in Canada: Bridging the Gap Between Abundance and Scarcity

September 27-28th, 2013
Toronto, Ontario

PRELIMINARY SCHEDULE:

Will be available in April!

REGISTRATION:

Early Registration will open in April!

VENUE:

Toronto Reference Library

ACCOMMODATION:

Room blocks have been reserved for conference delegates at the Delta Chelsea. Rates guaranteed until August 27, 2013.

Held in partnership with the Ontario Association of Public Health Dentistry (OAPHD) & the University of Toronto.

NOW ACCEPTING APPLICATIONS FOR THE DR. JAMES LEAKE STUDENT BURSARY

UNTIL JUNE 15, 2013

CAPHD Continues to Value Student Members

CAPHD is now accepting applications for the Dr. James Leake Student Bursary. This valued award was established in 2010 to recognize the significant contributions of Dr. James Leake to the education of Dental Public Health professionals in Canada and abroad.

Award Criteria:

The Canadian Association of Public Health Dentistry (CAPHD) supports up to and including two student conference bursaries each year. These awards will be given to up to two students (undergraduate or graduate) each year who are CAPHD student members and apply to attend the annual CAPHD Conference, Scientific Session and Annual General Meeting. This award will include the following:

1. The value of the award will be variable (cover travel expenses- flight/bus/train, hotel, ground transportation up to a maximum of $500 for each student). Recipients will be required to pay for travel and submit original receipts to the CAPHD Secretary/Treasurer following the conference for reimbursement according to CAPHD travel policy and procedures.

2. The award recipient will have CAPHD conference registration costs waived.

3. Preference will be given to students in Canadian programs of study related to community oral health who are authors or co-authors of a submitted or selected abstract for the CAPHD Scientific Sessions. Award recipients will not be restricted to these criteria however.

APPLY TODAY AT WWW.CAPHD.CA

Call for Abstracts

Canadian Association of Public Health Dentistry
2013 Scientific Conference and Annual General Meeting

September 27th and 28th, 2013
Toronto, Ontario, Canada

Deadline for submission:
June 15, 2013

Conference Theme:
The Paradox of Oral Health Care in Canada: Bridging the Gap Between Abundance and Scarcity

Instructions:
The abstract presentations will be held on Saturday, September 28th, with each presentation limited to a maximum of 15 minutes duration, plus 5 minutes for questions. Abstract presentations are intended to summarize the methods and results of current or in-progress research projects or innovative programs.

Please provide an abstract of less than 300 words. To achieve a consistent style, the words: "Objectives:", "Methods:", "Results:", and "Conclusion:", each immediately followed by a colon as shown, must appear in the body of your abstract. Submissions that are not in this format will be returned. More than one abstract can be submitted, and each must include a title, author(s), and institutional affiliation(s). Please demarcate the presenting author with an asterisk.

Abstracts will be evaluated and selected according to the following criteria: significance, timeliness, originality of the subject; quality of writing; study/program design; and quality of supporting data.

CAPHD welcomes submissions from dentists, dental hygienists, dental therapists, dental assistants, students, and other professionals from all areas of the country on topics related to the general conference theme.

Please e-mail your submission by June 15th, 2013 to:

Dr. Carlos Quiñonez
Scientific Program Chair
carlos.quinonez@utoronto.ca

CAPHD and OAPHD are honoured to include
The Murray Hunt and James Leake Lecture
during the 2013 Conference and Annual General Meeting!

The Murray Hunt & James Leake Lecture

Compiled by Lewis DW, Leake JL and adapted by Dr. Patricia Main

When AM (Murray) Hunt retired a few years ago, dentists in practice and educators in universities across Canada joined together to establish this lectureship to honour the lifetime contributions of this kind and gentle man. His work in basic science and dental epidemiologic research, his support for so many students, young researchers and academics and his contributions to the University Board of Governors, Metropolitan Toronto Social Planning Council and the Medical Research Council influenced us all.

Murray's original field of research was nutrition and health. In the mid to late 1960s, he was engaged in research to measure and plot radiation fallout from prior international atomic bomb tests. He would measure the radiation emitted by the exfoliated teeth of children who had resided in various geographic areas when fallout was at its peak to see (a) the extent of radioactive uptake in the teeth of these children, and (b) the geographic distribution of this fallout, e.g., whether it paralleled the prevailing wind patterns. The collection of the children's teeth was facilitated by the cooperation of a large women's group. Periodically, Dr. Hunt would be required to pay his dues to the executive of this group by taking them to lunch. We always knew when these special days occurred because the troupe of women, each wearing an enormous hat - no doubt the fashion of the day - would be waiting in the foyer for Dr. Hunt's, I suspect, less-than-eager appearance to take them to lunch. The amusing part to some of us was that we were aware that Dr. Hunt was also collecting for similar examination teeth from the jaws of slaughtered livestock that had foraged on grass in various Ontario locations. I suspect that Dr. Hunt avoided the topic of having seen luncheon meat earlier that week at Canada Packers.

Perhaps Murray's greatest contribution to academic dentistry in Canada was his successful recruitment to our Faculty, fully supported by Dean Ellis, in the late 1960s and early 1970s of a rather large number of prominent academics from the United Kingdom. These people became the academic backbone of our Faculty and have given it an international reputation in scholarship and research. For example, in recent years, three of these people have been elected presidents of the International Association of Dental Research. Two of them are currently dental Deans in Canada, and another is a graduate school Dean. A third dental Dean (there are only 10 dental schools in the country) - although not among this group of imports - would, I know, agree that it was through Murray's help and encouragement that he went on to pursue his PhD and eventual role in academia. Those whom he recruited included; A.H. (Tony) Melcher, who formed the MRC Periodontal Physiology Group here at U of T; A.R. Ten Cate, later our Dean and Vice Provost of Health Sciences at U of T and President of IADR; George Beagrie, later Dean of UBC; Tony Hargreaves, researcher in Pedodontics.

If we didn't now that Murray's given first name was Arthur, we would assume that it was Altruism since "unselfish devotion to the welfare of others" (Webster) characterizes his activities over the years so well. Although each staff member would have his own bits of evidence over the years to support this, his altruism was brought most sharply into focus to Don Lewis during some discussions he had with Murray about those times. Don records that '... concerns about his own salary relative to the newcomers and his own future administrative status were not even considered; improvement of the intellectual fibre of the Faculty was all that counted...'.

There are those in the audience who will remember Murray as gentle, i.e., not tough. Well, if there's a worthwhile principle to defend, such as shabby treatment of a graduate student of the equitable provision of dental care, Murray is as tough and as stubborn as they come. He stated clearly, and then stood up for, his beliefs, and was attacked by others for them., especially his support of the use in Canada of the "New Zealand" operating dental auxiliaries. However, Murray has the unique capacity (which some may falsely interpret as softness) of making even those who held opposing views opponents like him. Again in Don Lewis' words '... its called respect, not softness...'.

Murray is well thought of by all. He was always most courteous and humble towards the graduate and specialty students when teaching or working through their problems. He went to war for students who were exploited by their supervisors. He was present at a critical time in Dental Education in Canada. Along with his colleagues, J.B. Macdonald - later president of UBC; Jack Paynter - later Dean of Saskatchewan and, I believe, president of the MRC, and with the support of Roy Ellis our Dean, influenced the training and development of dental schools and curricula beyond Toronto and to a large degree across Canada.

History of the Lectureship

Topics of the lectures are consistent with Dr. Hunt's research interests: oral health (especially the epidemiology and prevention of dental disease) and the organization and delivery of dental services. In the spirit of Murray's concern for the oral health of all Canadians the lectures alternate between the University and other parts of Canada. Lectures have included the following:

John R. Evans. "Frontiers in Health: An International Perspective". October 17, 1984. Faculty of Medicine, University of Toronto

Harry M. Bohannan DMD, MSD. "Results and implications for public health of the National Preventive Dentistry Demonstration Project". September 1985. Ottawa Ontario (In conjunction with the annual meeting of the Canadian Society of Public Health Dentistry).

Phillip J. Holloway BDS, LDS, RCS (Eng), MSc, PhD. "Capitation - the British Study". May 11, 1988. Faculty of Dentistry, University of Toronto.

Martin Downer DDS, LDS, DDPH, PhD. "How Canadians' Dental Health can Benefit from Community Dental Research". August 27, 1990. Ottawa, Ontario (In conjunction with the annual meeting of the Canadian Society of Public Health Dentistry).

John Stamm DDS, DDPH, MSc. "Risk Assessment in Dentistry from the Perspective of Dental Public Health". May 21, 1992. Faculty of Dentistry, University of Toronto

Alexia Antczak-Bouckoms BA, DMD, MPH, MS, DSc. "Assessment of Health Care Technologies and the Cochrane Collaboration". October 2, 1994. Vancouver, BC (In conjunction with the annual meeting of the Canadian Society of Public Health Dentistry and the meeting of the Chief Dental Officers attending the Federation Dentaire International).

James D. Bader PhD. "Some evidence for evidence-based dentistry." May 2, 1997. Faculty of Dentistry, University of Toronto

Aubrey Sheiham BDS, PhD, DHC. "Dental Public Health: Meeting the challenges in a Changing Europe". August 7, 1999. Halifax, Nova Scotia (In conjunction with the annual meeting of the Canadian Association of Public Health Dentistry).

Following this Presentation at the 2009 Symposium to honour Prof Emeritus James Leake at the time of his retirement, we added to the lectureship some $25,000 in recognition of Jim's contribution to Dental Public Health and with the consent of the original proposers for the A Murray Hunt Lecture, this was renamed the Murray Hunt and James Leake Lecture.

This year 2013 will mark the first lecture honouring Dr. Leake. He has promised to attend and he suggested our lecturer for 2013: Dr. Myron Allukian Jr. The Neglected Epidemic and Social Injustice: What Can Be Done for Better Oral Health?

Oral Health Results of the Canadian Health Measures Survey for Adults Aged 60-79

by Amanda Williams, MPH, Policy Advisor, Office of the Canadian Oral Health Advisor

This was presented at the 40th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology which took place in Ottawa in 2011. The Canadian Association on Gerontology (CAG) is a national, multidisciplinary scientific and educational association established to provide leadership in matters related to the aging population.

Introduction:

Everyone is affected by their oral health. Good oral health is a key component to a healthy life because it affects how we eat, speak and how we relate to each other with confidence in our healthy smiles.

Older adults who enjoy strong, healthy natural teeth or well-fitting, comfortable dentures can eat a wide variety of good-tasting and nutritious foods. At the opposite, poorly fitted dentures, illness and poor oral hygiene can lead to pain and gum disease, which in turn may contribute to poor nutrition. In some extreme cases, oral diseases can cause severe disability or even death, as is the potential with oral cancer.

While oral conditions are important in and of themselves, there is an increasing awareness regarding their contribution to the incidence and severity of other diseases. Conditions that may be affected by poor oral health include diabetes, respiratory diseases and cardiovascular health.

For all of these reasons, it is important that Canadians, and Canadian public, private and professional policy makers become informed as to the extent and severity of oral health conditions in Canada, so that appropriate efforts can be taken to reduce the burden of illness for the benefit of all Canadians.

Objectives:

This poster is an overview of the oral health results from the Canadian Health Measures Survey (CHMS) with a focus on Canadian aged 60-79.

Methodology:

The CHMS was led by Statistics Canada in partnership with Health Canada and the Public Health Agency of Canada. The data collection occurred in 2007-2009 on approximately 6,000 people representing 97% of the population aged 6-79. Data was collected from a team who travelled to the 15 collection sites across Canada in mobile clinics.

To conduct the oral health component of the CHMS, Health Canada partnered with the Department of National Defence to obtain the dentists who conducted the clinical examinations. Health Canada implemented the training of the dentists and calibrated them to World Health Organization standards to ensure each dentist recorded conditions in the same manner.

The data were analyzed by Statistics Canada in collaboration with Health Canada.

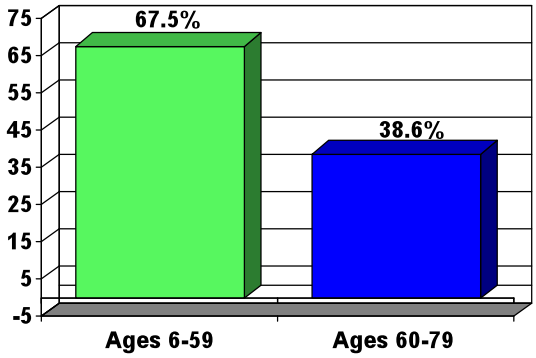
Results:

Private Dental Insurance

Having dental insurance coverage is one of the main factors that determine whether Canadians go to see a dental professional for dental care. The CHMS asked all respondents whether they had insurance or a government program that covered all or part of their dental expenses. The results indicate that:

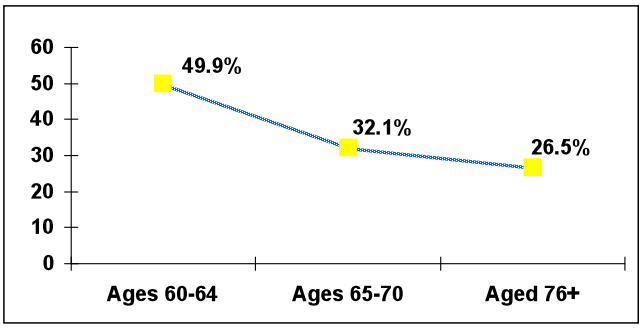
- 62% of Canadians have private dental insurance
- 6% have public insurance; and
- 32% have no dental insurance.

These overall results were further broken down to compare the older age group to the rest of the sample:



Percentage of people with private dental insurance

The results within the age group 60-79 years of age were further teased out in order to note any changes that occur as people continue to age. When these results are plotted along a line, the percentage of people with private dental insurance continuously declines. In the oldest group of adults only 26.5% of them had private dental insurance.



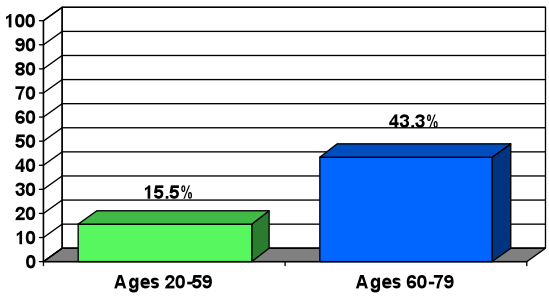
Percentage of people with private dental insurance

Cavities

A cavity is a disease that damages the structure of a tooth. The decay starts by attacking the enamel, and causes a hole to develop. If the cavity is left untreated, it can get bigger and, in addition to causing pain, it could also lead to the loss of the tooth.

A root cavity is found along the root (or the part of the tooth that is usually hidden by the gums) of a tooth. A root cavity is difficult to find and can be difficult to treat.

The percentage of adults with root caries aged 60-79 years of age was compared to the remaining adults from the sample. The results indicate an almost three fold increase in root caries among older adults compared to those aged 20-59 years of age.



Percentage of people with root caries

Gum Disease

Loss of Attachment (LOA) is the distance from where the enamel of the tooth meets the root to the bottom of the pocket between the gum tissue and the tooth.

• A LOA of 3 mm or less is considered to be healthy.

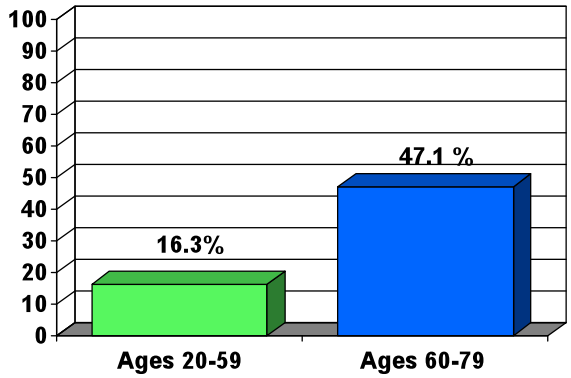
• A LOA of 4–5 mm is considered to have moderate disease.

• A person's ability to chew can be affected at a LOA of 5mm or greater.

• A LOA of 6 mm or more is considered to have severe disease.

• A person is at risk of losing the tooth if the LOA is 6 mm or greater.

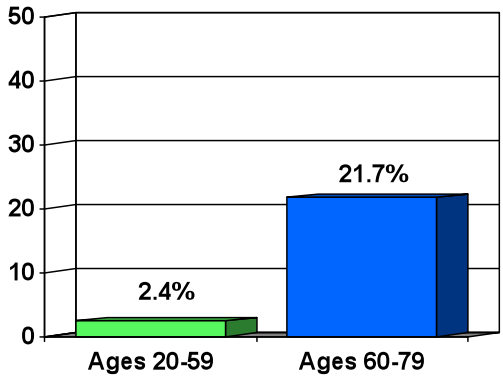
While it is expected that there will be an increase in the LOA as one ages, it is important to note that LOA is not reversible. LOA is considered the true measure of the effects of disease on the periodontal structures.



Percentage of People with Loss of Attachment (4+mm)

Complete Loss of Natural Teeth (Edentulism)

The edentulous rate of people in Canada refers to the percentage of people who do not have any of their natural teeth. People who are edentulous have usually lost their teeth due to extensive cavities or as a result of severe conditions with their gums. Not having any natural teeth can cause eating problems which can affect how many nutrients a person gets in their body and also affects the way a person talks.



Percentage of people who are edentulous

Conclusions:

Upon comparing the results between the majority of the respondents to those respondents aged 60-79 years of age, there appears to be a trend toward an increasing level of need among the older population which is coupled with a decrease in the percentage of older adults with private dental insurance. In fact, the percentage of those with private insurance begins with one person out of every two having private dental insurance between the ages of 60-64 dropping to about one in every three people in the 65-70 age group and by the time they are 76 years of age and older only one person out of every four has private dental insurance.

These results support the need for continued discussions at a national level on oral health disparities and on issues related access to care. The information can also be used to guide the development of oral health public policies and promotion programs designed to improve the oral health, and thus the overall health, of older Canadians.

Bibliography:

Health Canada. (2010). Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey.

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The original poster presentation can be found on the CAPHD website under "Resources for Professionals"

Acknowledgements:

The Office of the Chief Dental Officer would like to acknowledge the unique and productive partnership between Statistics Canada, the Department of National Defence and Health Canada as the reason behind the success of the oral health component of the CHMS. These findings and the numerous studies that have since been conducted with the results are the outcome of this partnership.

The Office would also like to acknowledge all those who participated in focus group testing, calibration sessions and the 6000 Canadians, who by participating in the survey, made these results possible.

About the Author:

Amanda Williams is a Policy Advisor in the Office of the Canadian Oral Health Advisor, Public Health Agency of Canada. Amanda has a Masters of Public Health degree from the University of Waterloo and a BSc in Health Education from Dalhousie University.

CAPHD MEMBERSHIP BENEFITS:

- Networking
- Conference fee discounts
- E-mail news bulletins
- Student bursaries
- Subscription to Mosaic
- Discussion group (listserv)

Thanks to all who renewed your membership before March 31, 2013. You were entered into a draw for a FREE membership for 2014/2015.

THE WINNER:

DR. ANDRE LAVALLIERE
Sherbrooke, Quebec

Congratulations!

Q&A Discipline Competencies for Dental Public Health in Canada

http://www.caphd.ca/professional-development

What are dental public health discipline competencies?	Discipline competencies are the essential knowledge, skills and attitudes necessary for the practice of dental public health. They provide the building blocks for effective dental public health practice, and the use of an overall public health approach. They provide a baseline for what is required to fulfill dental public health system functions that include population health assessment, surveillance, disease and injury prevention, health promotion and health protection. http://www.caphd.ca/professional-development
Why do we need discipline competencies?	They encourage service delivery that is evidence-based, population-focused, ethical, equitable, standardized and client-centred. They help to create a more unified workforce by providing a shared understanding of key concepts and practices. They help to explain the nature of dental public health and dental public health goals.
Who are they for?	The Discipline Competencies were intended to be inclusive; they were developed to identify the abilities needed by various dental health workers (such as dental assistants, dental hygienists, dental therapists, dentists, public health dentists) in the public health sector. To support this, the competencies have been stratified into four layers, with each layer building on the previous one.
How do they benefit people who work in dental public health?	They provide guidelines for the basic knowledge, skills and attitudes required by individual workers in dental public health: • support the recruitment, development and retention of dental public health workers • provide a rational basis for developing curricula, training and professional development tools • improve consistency in job descriptions and performance assessment • help professionals identify learning needs
How can they benefit dental public health organizations & departments?	They identify the knowledge, skills and attitudes required to fulfill dental public health functions: • help identify the appropriate numbers and mix of dental and other public health workers in a given setting; • identify staff development and training needs; • provide a rationale for securing funds to support workforce development; • develop job descriptions, interview questions, and frameworks for evaluation and quality assurance; and • facilitate collaboration, shared goals and interdisciplinary work. In summary, discipline competencies are designed to strengthen practice, support standards of practice and recognize specialized knowledge and skills.
What are the discipline competencies?	The discipline competencies are based on the essential functions of dental public health: population health assessment, health surveillance, disease and injury prevention, health promotion and health protection. They are organized under eight categories: 1. oral public health sciences 2. oral health assessment and analysis 3. oral health program planning, implementation and evaluation 4. oral health policy planning, implementation and evaluation 5. partnerships, collaboration and advocacy 6. diversity and inclusiveness 7. communication 8. leadership
Where can I find more information?	Public Health Agency of Canada- Core Competencies for Public Health Canadian Association of Public Health Dentistry- Discipline competencies for dental public health CHNET archived presentation #247 Public Health Workforce Development Projects

Has your organization used the discipline competencies for dental public health?
We want to hear from you if you did! Email us at: info@caphd.ca

National Collaborating Centre for Methods and Tools

Centre de collaboration nationale des méthodes et outils

Critical Appraisal of Research

by Jeannie Mackintosh, Communications Coordinator for NCCMT

(A previous article in the November Issue of the Mosaic Newsletter introduced the process of evidence-informed public health. This article focuses on critical appraisal, and specifically the Critical Appraisal of Intervention Studies online module.)

Some resources from the National Collaborating Centre for Methods and Tools (NCCMT):

Many public health practitioners are looking to research evidence to guide their decisions about programs and interventions. But in the process of examining the research evidence, it's important to determine whether the research we are relying on is of good quality. That's where critical appraisal comes in. If we want to improve our decisions by using research, we will need to be selective about which research we use.

What is critical appraisal?

Critical appraisal is the process of judging the quality of a research study's methods. In other words, we want to answer the question: Were the methods used in this study good enough that I can be confident in the findings?

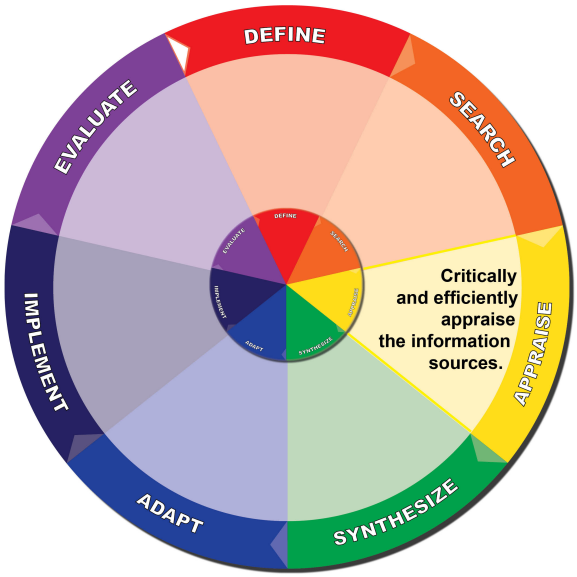
Sometimes we can find 'pre-appraised' sources, such as in a synopsis, which means that someone has already done the appraisal for us. But if we are reviewing a study with no other information about the quality of the research, we need to bring our own critical eye to the article.

We frequently see problems associated with a lack of critical appraisal. It seems that people can find research to bolster any conclusion they want to support. Debates about water fluoridation, for example, are often fueled by reliance on poor quality research evidence (or sometimes, no research evidence at all!). Critical appraisal is a step in evidence-informed decision making that moves us away from bias, preference, or opinion, and into the realm of reliable, high quality evidence.

Appraisal is the third step in the NCCMT's approach to evidence-informed public health (see What is Evidence-Informed Public Health?). Appraisal is an important step, but one that is often problematic because people don't have time to thoroughly review research evidence, or because they lack the skills to appraise research with confidence. NCCMT has several resources that can build critical appraisal skills. Although building these skills can take some time up front, the investment pays off when critical appraisal becomes familiar. NCCMT tools can improve the efficiency of your appraisal process by introducing a system and structure you can use for critical appraisal. By critically appraising research, you ensure that you are:

- Basing your decisions on high quality research evidence
- Helping to create an environment in which good quality research is valued.

The seven steps of evidence-informed public health



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How can NCCMT help you efficiently appraise research articles?

The Critical Appraisal of Intervention Studies online learning module is one comprehensive skill-building resource available through NCCMT. The module provides in-depth guidance about the process of critical appraisal and builds on a scenario that illustrates how critical appraisal works in practice (see Critical Appraisal of Intervention Studies). You can find the module on the NCCMT website: www.nccmt.ca.

Another NCCMT online learning module provides guidance on determining whether the research design is the most appropriate design for answering the question being asked. (See Quantitative Research Designs 101: Addressing Practice-Based Issues in Public Health). Additional modules are in development now: Critical appraisal of qualitative research and Critical appraisal of systematic reviews. All modules can be found in the Learning Centre on the NCCMT website.

The NCCMT site also provides resources such as a guide to available tools for critical appraisal, and other publications relevant to this step in the EIPH process. For example, see A Compendium of Critical Appraisal Tools for Public Health Practice.

Also on the NCCMT site, you will find links to sources of pre-appraised evidence. Health-evidence is a site that provides easy access to current review-level research evidence through a searchable online registry. On that site you can find material related to evidence of the effectiveness of community water fluoridation. Public Health + provides easy access to pre-appraised sources, where someone has already done the critical appraisal for you, so you can be confident that the public health research available there is of good quality. Although evidence on Public Health + will be of good quality it is important to note that not all evidence shared is at the review-level; this resource also includes evidence from primary studies.

Want to know more?

Contact the National Collaborating Centre for Methods and Tools to find out about more about critical appraisal. Sign up for the NCCMT Weekly Roundup to be sure that you hear about upcoming events and new resources as they become available.

Resources:

Ciliska, D. (2011) Critical Appraisal of Intervention Studies. Hamilton, ON: National Collaborating Centre for Methods and Tools. Retrieved from http://www.nccmt.ca/en/modules/cais/index.php

Ciliska, D., Thomas, H., & Buffet, C. (2012). A Compendium of Critical Appraisal Tools for Public Health Practice (Revised). [tool]. Hamilton, ON: National Collaborating Centre for Methods and Tools. Retrieved from http://www.nccmt.ca/pubs/CompendiumToolENG.pdf

National Collaborating Centres for Public Health (2011). What is Evidence-Informed Public Health? [fact sheet]. Retrieved from http://www.nccph.ca/docs/EIPH_Factsheet_EN.pdf.

DID YOU MISS A RECENT DISCUSSION ON THE LISTSERV?

CAPHD led discussion topics and responses are now archived on the members-section of the CAPHD website.

Just login to view.
Easy to access!

Get dental public health information when you need it!

CAPHD Mosaic Newsletter Submission Guidelines

The goal of the Mosaic newsletter is to provide twice yearly useful and current information to members about what's happening across Canada in community and population oral health, and to educate the members on dental public health topics.

Topic:
We welcome any news or information that you would like to share, including research studies, outreach projects, new initiatives, event information, or advertisements for employment within the public health field. Please include a title (if applicable) in your submission.

Due Dates:
Please submit by March 1st for the April newsletter and October 1st for the November newsletter.

Length:
There is no minimum length, but a maximum length of 800-1000 words is recommended.

Format:
Submissions should be in DOC or DOCX format.

Images:
Images should be submitted as separate JPG or GIF files, in high quality (at least 300 dpi for pictures and 600 dpi for graphics). Please include descriptive captions as required, and ensure that you reference any images that do not belong to you. Copyright rules require written permission from the owner to publish any image. Simply referencing is not sufficient. Consent must be acquired from all people/clients in photos and the CAPHD photo consent must be completed.

Author Information:
Please include your name and credentials, along with a short biography (approximately 25 words) and an optional photo of yourself. Also let us know if you would like your contact information such as email address or website included in the newsletter.

References:
Please include an organized list of references, if applicable.

Please email submissions or questions to the Communication Committee at info@caphd.ca for consideration. To view the newsletter, please visit the CAPHD website at www.caphd.ca/mosaic.

Also, keep in mind that these are guidelines only, and exceptions may be made at the discretion of the Communication Committee.

The CAPHD reserves the right to edit/alter articles for length or clarity. Authors will be notified of any such changes prior to publishing the newsletter. Opinions contained in this newsletter are of the authors and may not reflect the opinions of the Canadian Association of Public Health Dentistry.

CALENDAR *of events*

APRIL
•Mosaic Newsletter Issue 3
•Dental Health Month

JUNE
•15th- deadline for Dr. James Leake Bursary applications & abstract submissions for 2013 CAPHD Scientific Session

SEPTEMBER
•27-29- CAPHD Scientific Conference & AGM

OCTOBER
•October 1- Deadline for Mosaic Submissions

NOVEMBER
•Mosaic Newsletter Issue 4

www.caphd.ca

info@caphd.ca

MOSAIC NEWSLETTER EDITORS:

Andrea Richard (Executive Director & Communication Committee Chair), Lisette Dufour, Mary Bertone, Dr. Michelle Budd (Communication Committee Members)