ISSUE NUMBER 2 FALL 2012

# Mosaic

Canadian Association of Public Health Dentistry

## IN THIS ISSUE



## President Message

Dr. Gerry Uswak

Today, we know more about the oral health of Canadians than ever before. The Canadian Health Measures Survey, the Inuit Oral Health Survey Report and the Report on the Findings of the First Nations Oral Health Survey have provided us with important epidemiological data. While the oral health of Canadians has improved over time, certain segments of the Canadian population still face access to care barriers that negatively impact their oral health status.

The Canadian Association of Public Health Dentistry is the voice of Dental Public Health in Canada and its membership represents a cross-section of oral health professionals who are dedicated to improving the oral health of Canadians by effecting change at the community level and reducing access to care barriers so all Canadians can achieve oral health equity.

Oral health services in Canada are accessed through the private and public sectors. All oral health professionals in Canada, whether they work in academia, public or private practice, are dedicated to improving the oral health of Canadians and delivering high quality care to the patients they serve. We all do important work to assure the oral health of Canadians.

In the coming months, a new Canadian Oral Health Strategy will be released and will form the framework to guide our activities. If we are to be successful in our drive to improve the oral health of the nation, we have to work strategically and collaboratively to enhance the relationships between public and private practice, academia and between all oral health professions as no one sector of oral health care can be successful on its own.

CAPHD and its members across dental public health can enhance oral health care in Canada by providing evidence-based strategies to improve the effectiveness of preventive and clinical oral health care whether it is at the population level or at chairside. Our challenge is to maximize the effectiveness of existing oral health resources and knowledge we have across all sectors and identify new strategic investments for public and private funding. That is a tall order but I think we are up for the challenge.

The 2012 recipients of the Dr. James Leake Student Bursary were Dr. Singhal and Dr. Hayes. Congratulations!

For more information about the recipients and award criteria visit the CAPHD website.

## 2012 Conference

Assuring the Health of the Public through Life Long Access to Dental care

by Dr. Albert Adegbembo

The 2012 CAPHD Scientific Conference and Annual General Meeting was held in September 21-23, in Charlottetown, Prince Edward Island. The theme of the Conference was Assuring the Health of the Public through Life Long Access to Dental Care. The keynote speaker was Dr. W. Murray Thomson, Professor of Dental Epidemiology and Public Health, School of Dentistry, The University of Otago, Dunedin, New Zealand. The keynote presentation was entitled Oral Health and the Life Course. The Guest presenter was Dr. Belinda Nicolau, Associate Professor at the Faculty of Dentistry, McGill University, Montreal, Canada. Dr. Nicolau's presentation was entitled Insights from a Life Course of Oral Epidemiological Studies. Participants explored the theme of the conference after a short introductory presentation by Drs Thomson and Nicolau.

The Conference attracted participants from across Canada. Seventy practitioners registered for the conference. Researchers from across Canada also presented scientific papers on a range of topics. In all, there were 20 presentations, including the two presented by Drs Hayes (Time Loss Due to Dental Issues in the Canadian Population) and Singhal (Changes in Social Inequality in Smoking-Attributable Upper Aero-Digestive Tract Cancer Mortality in Canadian Males Between 1986 and 2001) winners of the 2012 James L. Leake Award.

It was not all work! Attendees participated in a variety of social events including the New Glasgow Lobster Supper, the dinner/boat cruise, and golf.


CAPHD members Maureen Connors, Janet Gray and Gerry Uswak enjoying a lobster dinner.

Dr. W. Murray Thomson, keynote speaker

**CAPHD members** have access to all **conference presentations**.

Visit the **members section** of the CAPHD website to view.


"A winning smile builds confidence and self-esteem that lasts a life time. Here's to improving the oral health of our communities"
*~John Albanese, Board of Health Chair, Northwestern Health Unit*

## Smile Mobile

by Dawn Sauvé, Manager Dental Health
Northwestern Health Unit

In October 2010, the Healthy Smiles Ontario (HSO) program, through the Ministry of Health and Long-Term Care (MOHLTC), was launched across Ontario. This program is part of the Government's poverty reduction strategy intended to provide service for children and youth who are unable to access regular dental care due to financial and access barriers.

The NWHU was very fortunate to receive capital funding to purchase a mobile dental van, support two community clinics and renovate three dental hygiene clinics. We negotiated a special pilot project status for the HSO program, so services could also be provided to individuals who receive benefits under Ontario Works (OW), Ontario Disability Support Program (ODSP), Children in Need of Treatment (CINOT) and the federal Non-Insured Health Benefits (NIHB) programs.

In the fall of 2011, our new Healthy Smiles Ontario Mobile Dental Office (MDO) arrived. This state-of-the-art, 33-foot-long "smile mobile" is a fully equipped dental facility.

For a year now, our MDO and community clinics have been providing preventive and treatment services to children and adults who have difficulty accessing dental service, including those who live in remote areas. Many have now benefited from a comprehensive range of dental treatments, which help to reduce the risk of serious dental health problems in the future.

Since September 2004, the NWHU has been in partnership with Health Canada to deliver the Children's Oral Health Initiative (COHI). We provide diversified oral health promotion and disease prevention activities such as education, oral health assessments, fluoride varnish, sealants, scaling and oral hygiene instruction to 15 First Nation communities.

In September, October and November 2012, using the provincial infrastructure of the MDO, COHI program and health unit staff, we were able to pilot and provide much needed preventive and dental treatment services to 4 of our First Nation communities in our area.

This pilot project has broken down the federal/provincial/First Nations jurisdictional barriers and ties in nicely with other tripartite initiatives across Canada. By using this approach and strategy, it enables us to provide desperately needed dental services to children and adults under federal jurisdiction.

Our Chief Medical Officer of Health for Ontario, Dr. Arlene King has stated in her "Oral Health – More Than Just Cavities – April 2012" that this type of "Best Practice Model" can be used to facilitate tripartite cooperation in treatment and prevention services. It is aligned with her report recommendation #4 – "Explore opportunities to improve access to oral health services as well as awareness of oral health services available to First Nations people in Ontario, with a focus on better integration and/or alignment of the variety of available dental programs."

Official floss cutting, May 2011

We anticipate the combination of initiatives such as the MDO, tripartite strategies, community clinics and preventive & health promotion activities delivered through private practice dentists and our own staff will help to remove the barriers to accessing dental care. Over time this will help to reduce the levels of dental disease among our children, youth and vulnerable adults.

Alberta Health Services

## Healthy Mouth - Healthy Seniors

by Sandra Jean Jensen & Brenda Pullar
Community Oral Health\Prevention, Calgary Zone,
Alberta Health Services

### Improving Oral Health and Increasing Quality of Life for Residents in Long Term Care

Residents in Long Term Care Centres often have oral health concerns, including: decayed, broken and missing teeth; abscesses; gingivitis and periodontal disease. Periodontal disease and plaque are linked to an increased risk of cardiovascular disease, stroke and aspiration pneumonia and may contribute to poor control of diabetes. Mouth pain, loose teeth, ill-fitting partial or complete dentures, and infection in the mouth may contribute to poor nutrition and compromise one's general health and quality of life.

Because of mobility issues, complicated medical histories or dementia, residents face challenges accessing dental care. Barriers, such as: cost of dental treatment for which they often require sedation or general anesthesia; cost of transportation to dental appointments; need for a staff member to accompany them to a dental appointment; and a limited number of specialized dental care providers, prevent ongoing dental care.

In 2007, the Calgary Zone of Alberta Health Services, Community Dental Hygienists began addressing these issues by providing an oral health education program to nursing staff at Long Term Care (LTC) Centres. The following programs contributed to the planning and development:

University of Manitoba - Centre for Community Oral Health, Ontario - Halton Region Health Department - Oral Health Outreach Program and Alberta - CareWest Supportive Pathways Program - Personalized Dementia Care in a Supportive Setting.

### Development of Oral Health Education Program

Historically, Community Dental Hygienists provided 30 minute didactic presentations which had limited results in changing behavior of staff in the daily provision of oral care for residents.

In 2007, a pilot project was initiated in two Calgary area LTC Centres, one urban and one rural. This 12 hour program provided didactic and hands-on training for only one Health Care Aide (HCA) and one Licensed Practice Nurse (LPN) per centre. These champions were to share knowledge and skills with colleagues to increase the capacity of all caregivers to provide improved oral care.

Beginning in 2008, the teaching program changed to better reflect the learning needs of staff for oral assessments and daily mouth care, LTC Centre philosophy of care, and adult learning principles. The program continues to offer a full day session for HCAs that focuses on daily mouth care and a 3 hour training program for RNs and LPNs which concentrates on oral assessments and referrals. The program is open to as many staff as the Centre chooses to train.

In 2010, the existing referral process was formalized in an effort to increase the recognition and referral of oral health concerns and completion of dental treatment. It includes a designated LTC staff member accountable for the follow up of dental treatment referrals. During that same year, the Alberta Dental Association & College and Alberta Seniors & Community Supports' Mobile Dental Van began providing treatment at some LTC Centres in Calgary and area.

### Successes:

Upon reviewing pilot projects' findings, pre and post test results and evaluation responses, there is some evidence of an increase in the following:

- ✦Awareness by staff regarding Healthy Mouth/Healthy Body concept
- ✦Capacity and confidence of staff to provide daily mouth care
- ✦Daily mouth care of residents
- ✦Oral assessments by staff for residents
- ✦Dental referrals
- ✦Number of residents receiving dental treatment
- ✦Number of residents on regular diets rather than pureed and minced diets
- ✦Amount of food purchased by LTC Centre for residents' meals
- ✦Quality of life

*continued on page 5...*

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## Tips for Success:

✦Provide Adult Education that is didactic and hands-on in order to change behavior.
✦During education, allow time for staff to provide daily mouth care or to perform oral assessments for resident using newly acquired skills, with guidance from Dental Hygienist.
✦Align with existing tools such as the Resident Assessment Instrument-RAI-MDS 2.0 which includes an oral health assessment.
✦Align with philosophy of care of the centre.
✦Formulate formal referral process.
✦Designate a LTC staff member to be responsible for follow up of dental referrals and treatment.
✦Gain support of LTC Managers to:

- Allow staff adequate time to perform oral screenings and arrange follow up with dental treatment referrals.
- Provide sufficient time for staff education.
- Ensure oral hygiene product availability.
- Agree to have ADA & C and Alberta Seniors & Community Supports' Mobile Dental Van provide on-site dental treatment for residents.

✦Train as many staff in LTC Centres as possible in order to increase the skill level and improve continuity of care.
✦Collaborate with and learn from Speech Language Pathologists, Dieticians, Registered Nurses, Licensed Practical Nurses, Health Care Aides and managers.
✦Understand how LTC Centres operate.
✦Keep up to date with Best Practices for care of the elderly by attending relevant Continuing Education.

## Challenges:

✦Continuing Education budget constraints of LTC Centres
✦Lack of adequate time to provide oral health education for LTC staff
✦LTC Staff turnover
✦Champion model not as effective in changing skill level; need to train all LTC staff

## Future Considerations:

✦Recognize the connection between oral health and general health when establishing policy, procedures and standards of care for LTC Centres
✦Implement a mandatory professional dental examination for residents prior to their admission to a LTC Centre
✦Increase training in daily mouth care and oral assessments for LTC caregivers
✦Increase dental coverage for seniors including general anesthesia and transportation
✦Increase the number of LTC Centres that access the provincial Mobile Dental Van
✦Include a dental clinic in future LTC Centres
✦Advocate for increased training regarding Healthy Mouth/ Healthy Body concept in post secondary Medical and Dental programs
✦Conduct a provincial dental survey of LTC residents

Currently in Alberta, the Oral Health Action Plan (OHAP) includes a province-wide initiative to pilot an oral health framework in Long Term Care Centres. The ideal outcome would be maintained or improved oral health of LTC residents, supported by a sustainable program with consistent messaging and skill-building for caregivers.

If you require further information about the AHS Calgary Zone LTC Education program please contact us at: OralHealthEducation@albertahealthservices.ca

### Biographies:

Brenda Pullar, RDH, Diploma in Dental Hygiene and Diploma in Nursing, is currently employed by Alberta Health Services-Calgary zone, Community Oral Health. Previously she worked as a dental hygienist in private practice in Calgary. Prior to that she practised as a Registered Nurse in both Canada and the United States in the areas of Oncology, Pediatrics and Emergency.

Sandy Jensen, RDH, Associate Degree in Oral Health, is also employed by Alberta Health Services- Calgary zone-Community Oral Health in urban and rural community and clinical settings. In her 35 year career she has been involved in general private practice, public health and as a post-secondary instructor.

As part of their roles, they have been involved in the development and delivery of caregiver training sessions in long term care centres; supported the oral health education for post-secondary health care providers; and collaborated with allied heath professionals in acute care. The focus of their work is to improve the oral health for the adult and senior population and to reduce barriers to accessing dental care.

## A Canadian Perspective at FDI 2012

by Dr. Peter Cooney, Chief Dental Officer of Canada

The 2012 Federation Dentaire Internationale (FDI) congress was held in Hong Kong. The Congress is a forum that allows for networking with dental colleagues from around the world and to learn about innovative technologies and interventions. I was invited to speak about the appropriate use of different oral health promotion/preventive interventions and materials from a Canadian perspective. A description of my presentation was also included in the Dental Tribune International, the official media partner for the FDI congress newspaper Worldental Daily. The entire article is presented below for your information.

### Global oral health in the context of preventive/treatment interventions and materials

In order to assess which preventive and promotion intervention to use, it is utterly important to evaluate the needs and current oral health status of the individual or population first, as well to conduct an assessment of the community. The oral health assessment would include the incidence of caries, periodontal disease, and oral cancer. The assessment of the community would include elements such as whether there is a community water system, whether the community is fluoridated and at what level, and the availability of dental and other health professionals.

Canada recently completed an oral health survey that established the current oral health status of Canadians and, in addition to describing the needs of the population, it established a baseline to which the effectiveness of any intervention can be compared. This assessment, along with an in-depth understanding of the dental public health community and the particularities of a community, lays the necessary groundwork for determining the intervention approach to take.

In addition to understanding the needs of an individual or a population, it is also important to compare the reach, effectiveness and costs of an intervention in order to determine which intervention will have the greatest impact. For example, a community with a high incidence of caries and a viable central water supply may benefit from introducing water fluoridation. At a cost per person of $0.77 to $4 and a potential 20 to 40% reduction in caries, water fluoridation is a cost-effective initiative for the appropriate community. A community without a viable central water infrastructure might benefit from a fluoride-varnish program, which has a cost per person of $24 to $51 and a potential 24 to 46% reduction in caries. Another potential intervention could be a sealant program, which has a cost per person of $20 to $36 and a potential 23 to 87% reduction in caries; however, this program relies heavily on the availability and participation of dental professionals. All of the above-listed interventions have been proven to be successful in individuals and in communities and can improve the oral health of a population; however, one invention (or a combination of a few interventions) may be more suitable after an assessment of the situation.

In terms of treatment options, an understanding of the individual or community is also vital when making clinical decisions involving different dental materials. For example, when deciding between composite or amalgam fillings for treatment of caries, establishing the ease of access to a dental professional and the size of the cavity are key. Amalgam is inexpensive, durable, and relatively fast and easy to place. Composites may cost more, may not be as strong or durable in locations where they are subject to forces produced by chewing, and are often more difficult to place. In some remote communities with limited access to a dental professional, amalgam fillings may be the material of choice.

In summary, it is essential when making an intervention or treatment decision to evaluate and consider the results of a thorough needs assessment, the pros, cons and effectiveness of the proposed intervention, as well as the associated costs. This detailed planning from the outset will translate into health improvements in a population.

The original article can be found here: http://www.dental-tribune.com/articles/content/id/9633/scope/news/region/asiapacific

**CAPHD thanks universities and colleges across the country who help improve access to dental care issues.**

**McGill University's** mobile dental unit reaches out to those who otherwise would not receive dental care.

**"Dental Care for All", a video about McGill's outreach program, can be viewed through iTunes U (video #51) or YouTube**

# Prince Edward Island's Children's Dental Care Program (CDCP)

by Dr. Albert Adegbembo

Prince Edward Island's Children's Dental Care Program (CDCP) began in 1971. The CDCP covers children aged 3 to 17 years. The program has two components, a preventative program that is provided in schools and two fixed public health clinics located in Charlottetown and Summerside. Dental public health staff provide annual screening, fluoride application, dental sealants, and scaling at these locations. About 14,000 receive preventative dental services at these locations annually.

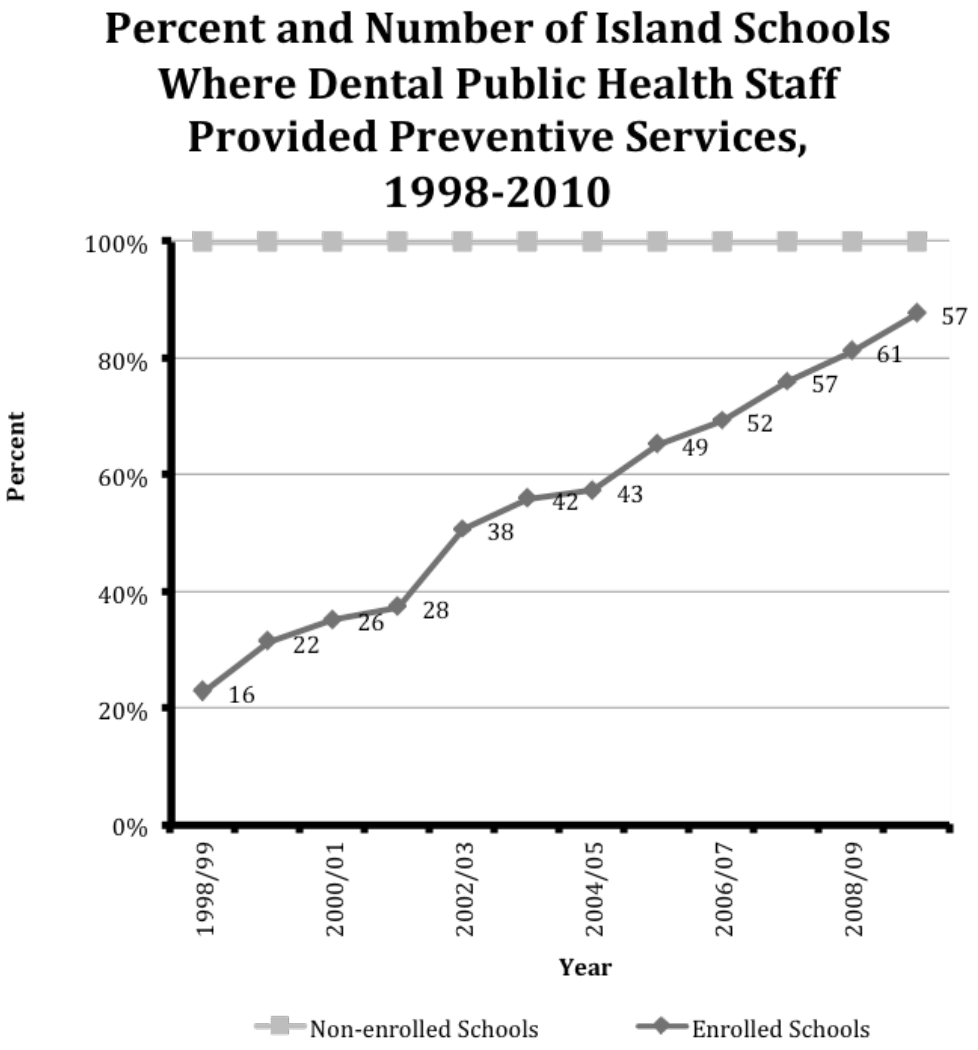
The second component – dental treatment services – are provided by dentists in private practice as well as salaried dentists who work at the two fixed clinics (and a fixed "mobile" trailer at Ellerslie). Government recently furnished a brand new 4-operatory dental clinic in Sherwood Business Centre (Charlottetown) to replace the old clinic that was located at the St. Jean School (Charlottetown).

Government has also approved capital funds to replace one of the dental units at Summerside. Both offices are equipped to provide minimal sedation. About 7,000 children receive dental treatment from both private offices and dental public health clinics annually.

Starting November 1, 2012, the CDCP will offer dental treatment services using a payer of last resort model, the treatment component of the CDCP will be limited to uninsured children.

Other dental public health programs provided by the Government of Prince Edward Island include the Cleft Palate Orthodontic Program, the Preventative Orthodontic Program, the Pediatric Dental Specialist Program, the Long-Term Care Facilities Dental Program, and the Dental Assistance Program for Social Assistance Clients.

For more information visit - http://www.healthpei.ca/dentalhealth



## CAPHD Members in Ontario Help Promote a Unified Public Oral Health Program in the Province

by Dr. Garry Aslanyan

In April 2012, at the Ontario Public Health Convention, members from Ontario set up a panel debate to consider policy options for a unified public oral health program in the province. This Convention is the largest meeting of public health professionals working in various parts of the public health system in Ontario. The debate, organized by the Ontario Association of Public Health Dentistry (OAPHD) and the University of Toronto, took advantage of the diversity of the Convention's audience and included panelists from the aforementioned groups, and from a Health Unit, the Ontario Dental Association and the Association of Ontario Health Centres (AOHC). The focus of the debate was the question of why, even with additional new funding available for oral health care in Ontario, inequalities in access to care still exist and access-limited populations continue to carry a higher burden of oral diseases. The panelists acknowledged that the current model of funding of oral health programs with various provincial ministries and local/regional governments is not optimal. The diversity of models of delivery for oral health care in the province is also not rational, leaving many behind. In addition, a lack of consistently collected information on the needs and services provided for oral health makes it difficult to track changes, evaluate and improve programs, and identify determinants of good oral health. This also makes evidence-based decision-making difficult and prevents containment of costs in publicly funded oral health care programs. The panel called on the provincial government to review and potentially replace the current patchwork with a unified oral health program in Ontario for all Ontarians. In October 2012 report entitled Staying Ahead of the Curve: A unified oral public health program for Ontario? has been launched and presented to the Ontario government and other stakeholders for action.

For more information please contact Dr. Garry Aslanyan at gaslanya@hotmail.com

In the photo from left to right:
Garry Aslanyan, Policy Manager, WHO; Carlos Quiñonez, Assistant Professor and Discipline Head, Dental Public Health, Faculty of Dentistry, University of Toronto; Andrea Feller, Associate Medical Officer of Health, Niagara Regional Public Health Department; Stephen Abrams, Chair, Dental Benefits Committee, Ontario Dental Association (ODA), Adrianna Tetley, Executive Director, Association of Ontario Health Centres (AOHC) and Member, Ontario Oral Health Coalition; Paul Sharma, President, Ontario Association of Public Heath Dentistry (OAPHD) and Manager, Oral Health,

## CAPHD MEMBERSHIP BENEFITS:

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

***Thanks to all who renewed your membership before March 31, 2012. You were entered into a draw for a FREE membership for 2013/2014.***

## THE WINNER:

### NATASHA BURIAN

Dental Hygienist, Alberta Health Services (Lethbridge)

**Congratulations!**

## COMMUNITY WATER FLUORIDATION

Dr. Luke Shwart

Caries is still a problem for a significant portion of the population. Some people may not have access to good, affordable dental care, routine fluoride toothpaste, and balanced diet. Is water fluoridation effective and is it the right thing to do?

In 2001 the US Centers for Disease Control gave water fluoridation a rating of grade II-1 (the second highest of five levels) for quality of evidence, and Grade A (highest) for strength of recommendation. The U.K. systematic review (York University 2000) found an evidence level of 'B' (moderate), and said water fluoridation was likely to have a beneficial effect, but at the expense of an increase in prevalence of dental fluorosis. The beneficial effects were: an increase in the number of children who are completely decay-free; and less decay in children with cavities (lower deft/DMFT). In 2007 the Australian National Health and Research Council updated and reconfirmed the U.K. systematic review by assessing and adding research from 1996 – 2006. These reviews consistently indicate that water fluoridation is effective.

In 2009 Health Canada released its 94-page risk assessment of fluoride in drinking water. It covered all identified human risks, taking into account new studies about cancer, brain, kidney, thyroid, bone, reproduction, etc. The comprehensive process involved recognized experts (toxicologist; dental fluorosis researcher; and a leading fluoride intake researcher), an external peer review, and provincial consultation. The review concluded that fluoride in water is safe, that the maximum level of natural fluoride in drinking water remain at 1.5 parts per million, and that the level of water fluoridation be set at 0.7 parts per million. In 2011 the European Commission's Scientific Committee on Health and Environmental Risks released their critical review of fluoride – it also found the weight of evidence pointed to no human health or environmental risks from levels used in water fluoridation; dental fluorosis was a risk but not a health concern.

Deciding if fluoridation is the right thing to do is another issue, because it affects the whole community: it is impossible to provide each resident with a choice of tap water. In 2011 Calgary's City Councillors convened a public input session on water fluoridation; some 50 people spoke – about 2/3 of them in opposition. They presented personal fluorosis stories, 'natural' products, Internet 'research', Europe's 'way', conspiracy theories, and other broad allegations. A poverty group representative said that poor people want dental treatment, not fluoride! Health professionals representing oral health, family physicians, dietitians, environmental health and members of the public also spoke about the benefits and safety of fluoridation, and how this effective preventive measure limits dental treatment costs.

Britain's Nuffield Council on Bioethics reports that "the most appropriate way of deciding whether to fluoridate the water supply is to rely on democratic decision-making procedures. These should be implemented at the local and regional level because the need for, and perception of, water fluoridation varies between areas." So taking the time to discuss the issue in public, and to hear views, is appropriate for the community. As dental health professionals, we should have some awareness of the state of the research (and the strategies of opponents) on this topic. Because there are so many published reports, we look to the systematic reviews by experts to summarize and give direction.

Why not just give toothpaste or fluoride treatments to at-risk people? There is no simple way to find and reach the people who are at most risk for tooth decay, but fluoridated water is available to everyone. It does not stigmatize citizens who might not have enough money to pay for their dental care or preventive services, or may not be able to brush daily.

Oral health is a key component of general health – you cannot separate the mouth from the body. Preventing cavities means fewer days missed from school, fewer instances of pain and swelling, better ability to chew healthy food, and improved quality of life. Preventing disease and promoting equity works best when the easy choice is the healthy choice: drinking tap water. By fluoridating, the community says it values oral and dental health of all its residents, and it respects the scientific research which supports water fluoridation as an important public health measure.

Alberta Health Services

**Fluoride Products for Oral Health**

http://www.albertahealthservices.ca/hp/if-hp-fluoride-product-guidelines-overview.pdf

Q&A

With Dr. Mario Brondi

# Proposed Graduate Program in Dental Public Health at University of British Columbia

*During the 2012 CAPHD Conference in Prince Edward Island, I coordinated a session to present a newly proposed graduate program in Dental Public Health, offered by the University of British Columbia (UBC) Faculty of Dentistry.This Q&A piece attempts to inform readers and those potentially interested in the program, but it is not meant to be exhaustive. For further information, please contact me at brondani@dentistry.ubc.ca*

| | |
|---|---|
| ***What is the program's structure?*** | The proposed program is a full-time 2.5-year combined Master of Public Health (MPH) with a Diploma in Dental Public Health (DPH) offered by the UBC Faculty of Dentistry in conjunction with the School of Population and Public Health, with more than 1,200 hours of instruction, course and field work. The diploma and the master are awarded conjointly and both must be completed. |
| ***Why is the program structured as such?*** | The proposed UBC's Dental Public Health program combines academic, services and research arenas from the UBC Faculty of Dentistry with the interdisciplinary academic environment offered by the UBC School of Population and Public Health. A Master of Public Health is the most widely recognized professional credential for leadership in population and public health, while a Diploma in Dental Public Health is a non-clinical dental degree that provides graduates with the necessary skills to work in government, academic, professional, and other organizations to ultimately be the leaders in dental public health. |
| ***What is the format of the combined program?*** | The combined program is course-based with 74 credits and a 420 hour practicum field-based research component. 36 credits taken at the School of Population and Public Health as per the MPH. Core courses on biostatistics, epidemiology, economics, program planning and evaluation, leadership, public policy analysis and elective courses on surveillance, environmental health, community-based participatory research, and so on. 38 credits taken at the Faculty of Dentistry as per the Diploma. 32 credits will be comprised of core courses on health promotion and education, evidence-based dentistry, ethics and economy, behavioural and management sciences and so on. 6 credits will be comprised of a field-based practicum research totalizing 420 hours. As a course-based program, there is no formal thesis defense. However, students will provide a field-based practicum proposal for approval and development, and a final paper for publication out of this experience. At least two other courses will require students to prepare a research paper each aimed at publication as well. |
| ***How will the courses be distributed?*** | The courses are based on weekly face-to-face instructor and student interaction, with classes physically on campus. However, most of the MPH courses can be taken using a 'Distant Leaning' format which entails once a month face-to-face instructor and student interaction supplemented by weekly online activities. |
| ***Where will the courses take place?*** | The MPH courses will take place at the SPPH while the Diploma courses will be hosted at the Faculty of Dentistry, both at the UBC campus. The field-based practicum will take place at different locations locally and outside the province. |
| ***Is there any partnership with out-of-the province organizations for the field-based practicum?*** | Yes. We are contacting out-of-the province health organizations, government agencies, and universities that might be interested in developing collaboratively practica placements as long as graduate students are supervised by certified specialist in dental public health. |
| ***Is this a full-time program & when will it start?*** | The combined program is based on a full-time schedule. Part-time prospective students might be considered under special circumstances. It will start either in September 2013 or 2014. |
| ***Who will the program enroll and what is the expected enrollment?*** | Nationally and internationally trained dentists and dental hygienists given proper credentials and registration. Upon successful completion of the program, dentists will be eligible to take the Canadian and American Board Certification exam for the Specialty of Public Health Dentistry. Dental Hygiene graduates will not be eligible for the same exam. A maximum of three students per year will be enrolled each year. |

National Collaborating Centre for Methods and Tools

Centre de collaboration nationale des méthodes et outils

## Evidence-Informed Public Health

by Jeannie Mackintosh, Communications Coordinator for NCCMT

### An Introduction from the National Collaborating Centre for Methods and Tools (NCCMT)

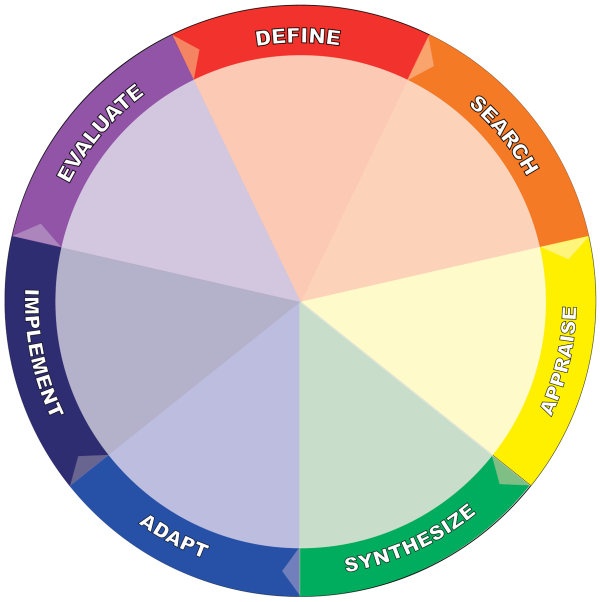
Public health decisions are made every day – decisions about practice, programs and policies. While they are all made with good intentions, not all of those decisions will achieve their objectives. Whether related to chronic disease prevention, oral health for populations, or water fluoridation, the use of the best available research evidence to inform public health decisions has the potential to produce better health outcomes for communities.

### What is evidence-informed public health?

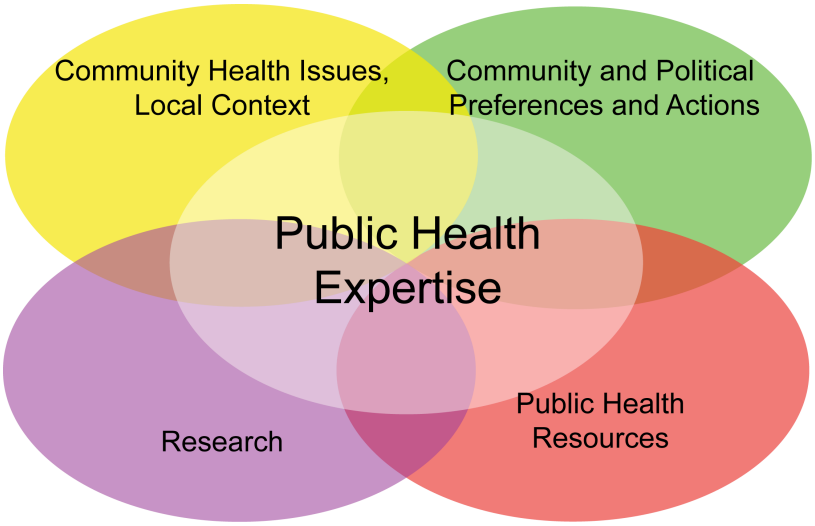
Evidence-informed public health (EIPH) is the process of distilling and disseminating the best available evidence, and using that evidence to inform and improve public health practice and policy. Put simply, it means finding and using evidence to inform policy and practice.

The National Collaborating Centre for Methods and Tools (NCCMT) has developed an approach to EIPH consisting of seven essential steps that can help decision makers consider the best available research evidence for the issue at hand. This step-by-step process provides a systematic way to incorporate research evidence into public health practice. (This article gives you an overview of the process. For more in-depth information and resources related to each step, and to see how the process can apply to decisions related to a realistic public health scenario, please see our online learning module Introduction to Evidence-Informed Decision Making in Public Health).

Step 1: **DEFINE** Clearly define the question or problem.
Step 2: **SEARCH** Efficiently search for research evidence.
Step 3: **APPRAISE** Critically and efficiently appraise the research evidence.
Step 4: **SYNTHESIZE** Interpret information and form recommendations for practice.
Step 5: **ADAPT** Adapt the information to the local context.
Step 6: **IMPLEMENT** Decide whether (and plan how) to implement the adapted evidence into practice or policy.
Step 7: **EVALUATE** Assess the effectiveness of implementation efforts. *continued on page 12...*




Steps of evidence informed public health




## A MODEL FOR MAKING EVIDENCE INFORMED DECISIONS

Most public health professionals recognize that the best decisions are not based on research findings alone. By considering evidence from a range of sources, you can increase the chances that your decisions will result in programs and actions that are both effective and appropriate for your communities and target populations.

*Image adapted from Dicenso, A., Ciliska, D.K., & Guyatt, G. (2005). Introduction to Evidence-Based Nursing: A Guide to Clinical Practice. (pp. 3-19). St. Louis, MO.: Elsevier/Mosby."*

*...continued from page 11*

### A model for making evidence-informed decisions:

Evidence-informed decision making involves integrating the best available research evidence into the decision-making process. Additional factors – community health issues and local context; community and political preferences and actions; and public health resources – create the environment in which that research evidence is interpreted and applied.

This model for evidence-informed decision making in public health is particularly relevant at the fifth step of evidence-informed public health: **Adapt** the information to a local context. Ultimately, decision makers must draw on their explicit and tacit public health knowledge and expertise to incorporate all the relevant factors into the final decision, conclusion or recommendation. (See the NCCMT fact sheet for more details on the model for evidence-informed decision making in public health.)

### Implementing a systematic process of EIPH ensures that you:

- ✦create programs and actions that are both effective and appropriate for your communities and target populations;
- ✦effectively transfer knowledge from both quantitative and qualitative research and other sources into practice and policy;
- ✦strengthen public health in Canada.

Of course, there are barriers to using research evidence in practice, including a shortage of time, a lack of access to research evidence, and inadequate skills necessary to critically appraise the research found. NCCMT provides resources and strategies that can help you overcome these challenges.

### How can NCCMT help you implement evidence-informed public health?

NCCMT has developed a series of innovative resources to support EIPH decisions, including:

- ✦traditional publications
- ✦workshops
- ✦dedicated website section
- ✦webcasts and
- ✦online learning modules

√ Visit the NCCMT website: www.nccmt.ca.

√ Sign up for the NCCMT newsletter to hear about upcoming events and new resources as they become available.

√ Watch for additional articles from NCCMT in future issues of Mosaic that will introduce resources that can support EIPH related to specific oral health topics.

### Resources:

Ciliska, D., Thomas, H., & Buffet, C. (2010). An Introduction to Evidence-Informed Public Health and A Compendium of Critical Appraisal Tools for Public Health Practice (Revised). Hamilton, ON: National Collaborating Centre for Methods and Tools. Retrieved from http://www.nccmt.ca/pubs/2008_07_IntroEIPH_compendiumENG.pdf.

National Collaborating Centre for Methods and Tools. (2012). A Model for Evidence-Informed Decision-Making in Public Health. [fact sheet]. Retrieved from http://www.nccmt.ca/pubs FactSheet_EIDM_EN_WEB.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.

## 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.

## 2013 CALENDAR:

**MARCH**
- Renew your CAPHD membership by March 31
- March 1- Deadline for Mosaic Submissions

**APRIL**
- Mosaic Newsletter Issue 3
- Dental Health Month

**OCTOBER**
- October 1- Deadline for Mosaic Submissions

**NOVEMBER**
- Mosaic Newsletter Issue 4

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**MOSAIC NEWSLETTER EDITORS:**

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