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Methodological considerations to conduct a community fluoridation cessation study

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The prevalence of dental caries has declined remarkably in industrialized countries in the last few decades; this has been attributed to community water fluoridation (CWF), widespread usage of fluoridated tooth paste, improved oral hygiene, diet, oral health education and dental care. Specifically, CWF is considered an equitable, population based approach to improve the oral health of a society. However, the oral health implications of discontinuing CWF at the population level are difficult to assess, because of exposure to fluoride through various sources, and socio-demographic differences.

With these considerations in mind, Public Health Ontario collaborated with the Faculty of Dentistry, University of Toronto to assess the methodological and operational feasibility of conducting a CWF cessation study in Ontario. A meeting took place in the fall of 2014 and included experts in the field and relevant stakeholders, to discuss the feasibility of conducting such a study in Ontario municipalities. Invitees included academics, researchers, clinicians, epidemiologists, environmentalists, medical officers of health, public health professionals, and representatives from government. Academics and researchers from the United States and Canada, who have significant expertise in the field, were invited as key speakers.

During this meeting, methodological and operational limitations were recognized as important feasibility challenges in conducting a CWF cessation study in Ontario. Nevertheless, a number of useful considerations were raised during the meeting that may enhance a successful assessment of CWF cessation in the province. For example, Dr. Jayanth Kumar, one of the speakers from the New York State Department of Health, discussed important methodological aspects that can enhance the validity of results in an epidemiological study conducted to assess the effect of CWF cessation. They were as follows: calibrate examiners, with each examiner examining equal proportions of participants in test and control communities, and in cases of inter-examiner differences, the distribution of these differences should be presumed to be the same across all examination sites; record personal level, as well as, tooth level caries scores; water fluoride

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levels in community water supplies should be recorded on a monthly basis; and extensive recording of covariate data are required (e.g., income, dental insurance, careful documentation of exposure to other fluoride sources, etc.), as they can dramatically confound results.

In terms of sampling, Dr. Lindsay McLaren from the University of Calgary emphasized that appropriate sample size calculations are important; and it is desirable to produce sampling weights to account for complex sampling and imbalances in socio-economic status. She also noted that biomarkers are valid estimates of fluoride intake and therefore are important to include in such studies. She suggested including fingernail clippings, as they can be collected non-invasively. In the current environment, when there are multiple fluoride exposures, assessment of total fluoride intake becomes important. Finally, Dr. McLaren mentioned the need to include assessments of the socio-economic patterning of outcomes to identify the potential equity impacts of CWF cessation.

Dr. Steven Levy, from the University of Iowa, reflected that professional interventions act as an important confounder in estimating the true effect of water fluoridation cessation. Realizing that the community no longer has a fluoridated water supply, a lower treatment threshold to fill cavities can be expected. Dentists may restore incipient caries lesions more readily assuming that the progression of the lesion will be quicker to advance and the chances of caries arrest will be lower. Adding to this, he mentioned that if conducting a study with large sample sizes is not feasible, a meta-analysis could be conducted utilizing the information from existing studies that have been done in countries with similar socio-demography.

Dr. Dick Ito, from the University of Toronto, focused on aspects in the Ontario context that might act as limitations when planning a CWF cessation study. For example, there are a number of municipalities in Ontario where CWF has ceased, yet including them in a single study is difficult, as the dates of cessation vary. Most of the municipalities that stopped fluoridation do not have large populations. In such a scenario, if children of only particular ages are selected as the study sample, then attaining optimal sample size might not be possible. Past studies suggest response rate of 20% - 25% for oral health surveys undertaken in Ontario, which make optimal sample sizes difficult to achieve.

Attendees also had some Ontario specific concerns which were mainly surrounding target population, data collection, and health equity. Considering the increasing proportion of elderly population, who have significantly lower dental insurance, more barriers in access to dental care and have a higher burden of dental diseases, a CWF cessation study having elderly as target population was suggested. Regarding data collection, oral health assessment data are collected and inputted into the Oral Health Information Support System (OHISS). As examiners differ across municipalities, and there is no consistent calibration of examiners, it is difficult to use pre-cessation records of a municipality as a control. On the same note, an opportunity to improve screening and surveillance systems in Ontario with enhanced standardization of examiners was recognized in the current discussions regarding the integration of existing public dental care programs for children in the province. This integration will also lead to a single claims data repository, which can be used for the economic evaluation of CWF cessation. Also, in Ontario, there is a disproportionate distribution of the burden of dental disease among people of different social strata. Therefore, using a health equity lens, observing the effects of water fluoride cessation in terms of differences among social groups may provide another important perspective on the effects of water fluoridation cessation.

Ultimately, the meeting provided some important considerations for researchers and stakeholders when planning any CWF cessation study:

- Meta-analyses of existing studies could be conducted to assess an aggregate effect of CWF cessation on dental caries.
- Elderly populations can be targeted in future; such a study might require a smaller sample size.
- Specifically, in Ontario, after current publicly funded dental programs for children are integrated into one program, cost-effectiveness analysis for treating dental caries can be performed among communities with and without fluoridation.

Utilizing this information, a proposal could be prepared and submitted to the Canadian Institute of Health Research for acquiring an operating grant to conduct such a study in future.

President's Message

Message du Président

Alyssa Hayes, BDent (Hons), MSc, FRCD(C)

I am honoured to be the current CAPHD president and am looking forward to the upcoming year, which promises to be a busy one. The past year saw a governance review be undertaken; CAPHD'S participation in the Canadian Oral Health Roundtable (COHR); the policy advocacy committee (PAC) highlighting the importance of oral health, oral health inequalities and dental public competencies to the federal parties during the election, the provincial ministries and federal representatives, respectively. The year wrapped up with a successful Annual Conference, held in collaboration with the Ontario Association of Public Dentistry (OAPHD).

Looking forward to 2016, my goals are similar to those of my predecessor, to continue with the governance review, increase membership to ensure our web presence reflects who we are and what we do. Additionally, I would like to capitalize on the board scope of experience and what our board members and our general membership bring to the organization to improve our collaborative efforts within oral and primary health care.

As members, I encourage you all to continue to be advocates for dental public health in Canada and welcome your suggestions or feedback on what you think would help move our organization forward.

Je suis honorée d'être la Présidente de l'ACSDP et je suis enthousiaste à l'année à venir, qui promet être une année bien remplie. Au cours de la dernière année, l'Association s'est impliquée à la revue de la gouvernance et a participé à la table ronde canadienne sur la santé buccodentaire. Le comité de la défense des politiques de l'Association a également contribué à souligner l'importance de la santé buccodentaire, des présentes inégalités et des compétences en santé dentaire publique aux partis fédéraux lors de l'élection ainsi que les représentants des ministères provinciaux et fédéraux. L'année s'est terminée avec le franc succès de la conférence annuelle, organisée en collaboration avec l'Association en santé dentaire publique de l'Ontario.

Mes objectifs pour l'année 2016 sont comparables à celles de mon prédécesseur, soit de poursuivre la revue de la gouvernance, d'accroître le nombre d'adhésions et d'assurer que notre présence sur le Web reflète qui nous sommes et ce que nous nous faisons. De plus, j'aimerais capitaliser sur la portée de l'expérience du conseil d'administration et de nos membres pour agrandir notre collaboration au sein des soins de santé buccodentaire et des soins primaires.

En tant que membres, je vous encourage à continuer à être les défenseurs de la santé dentaire publique au Canada et j'apprécie vos suggestions ou commentaires afin de faire avancer notre organisation.

Call for Submissions

Now accepting submissions for the
Summer 2016 Issue of the Mosaic Newsletter.
Deadline: April 31, 2016.

Guidelines can be found on page 15 or
http://www.caphd.ca/programs-and-resource/the-mosaic-newsletter

Message from the Acting Chief Dental Officer

Mot du Dentiste en Chef Intérimaire

Martin Chartier, DMD, MPH

I am very pleased to present to the CAPHD members the new and dynamic team at the Office of the Chief Dental Officer (OCDO) at the Public Health Agency of Canada. In continuity with our discussions during the CAPHD Annual Scientific Conference in September, this is a very exciting time to work in raising awareness and working in integrating oral health. Indeed, integrated policies to prevent oral and non-communicable diseases (NCDs), based on a common risk factor approach are well needed. There is also a need for innovative practices and multi-professional collaboration to maintain good oral health throughout life, which will contribute to protect from NCDs and improve quality of life. We look forward to collaborating with stakeholders, within and above the oral health community toward this endeavor of reducing oral diseases and existing health inequalities nationwide!

Lisette Dufour, RDH
Senior Oral Health Advisor

Lisette is a registered dental hygienist who graduated in 1985 from Cambrian College in Ontario. Lisette has been employed by Health Canada for the last 10 years. After three years of absence, she just returned to OCDO from the Non Insured Health Benefits Program (NIHB), where she was given the mandate to implement the National Dental Predetermination Centre at the Non Insured Health Benefits Program (NIHB). Amongst her duties within Health Canada, she has also taken a leading role in the management of the First Nations and Inuit Oral Health Surveys 2008-2010 as well as the Children's Oral Health Initiative (COHI). Prior to being employed at the Federal Government, Lisette also worked for five years with an Insurance company as a Dental Claims Specialist. She also worked in the private practice setting for 17 years in northern Ontario and in the national capital region and was a part-time

Je suis très heureux de présenter aux membres de l'ACSDP la nouvelle équipe dynamique du Bureau du dentiste en chef (BDC) de l'Agence de la santé publique du Canada. Comme il a été souligné lors de la conférence scientifique annuelle de l'ACSDP en septembre, la période actuelle est particulièrement propice au travail de sensibilisation à la santé buccodentaire et à l'intégration de cette dernière. En effet, il nous faut adopter des politiques intégrées pour la prévention des maladies buccodentaires et des maladies non transmissibles basées sur une approche des facteurs de risque communs. Nous devons aussi encourager l'innovation et la collaboration entre les professionnels afin de favoriser la bonne santé buccodentaire tout au long de la vie, ce qui contribuera à la protection contre les maladies non transmissibles et à l'amélioration de la qualité de vie. Nous sommes impatients de travailler avec tous les intervenants, qu'ils fassent partie ou non du milieu de la santé buccodentaire, dans le cadre de cet effort visant à réduire la prévalence des maladies buccodentaires et les inégalités de santé à l'échelle du pays!

Lisette Dufour, H.D.A.
Conseillère principale en santé buccodentaire

Lisette, qui a obtenu son diplôme d'hygiéniste dentaire autorisée du Cambrian College (Ontario) en 1985, a travaillé à Santé Canada pendant les dix dernières années. Elle est récemment revenue au BDC après un mandat de trois ans au sein du programme des Services de santé non assurés (SSNA), dans le cadre duquel elle s'occupait de la mise en œuvre du Centre national de prédétermination des soins dentaires. La gestion des enquêtes sur la santé buccodentaire des Premières Nations et des Inuits (2008-2010) et de l'Initiative en santé buccodentaire pour les enfants (ISBE) comptent aussi parmi les fonctions qu'elle a assumées à Santé Canada. Avant son arrivée au gouvernement fédéral, Lisette a travaillé pendant cinq ans pour une compagnie d'assurance à titre

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clinician/clinical coordinator at a community college in the Dental Hygiene Program. When time permits, Lisette continues to play an active role with the Commission of Dental Accreditation of Canada and with the National Dental Hygiene Certification Examination Board. Proud mother of two children, Lisette enjoys being a trainer and coach for her kids' hockey and softball teams.

Annie Bronsard, Ph.D.
Policy Analyst

Annie has joined the Office of the Chief Dental Officer's team (OCDO) in October 2015. She holds a PhD in medical anthropology from Université Laval, QC, and brings to the OCDO her expertise in qualitative and applied research. Annie has been a policy analyst with the Science Policy Directorate, Strategic Policy Branch at Health Canada for the past six years where she worked on numerous internal and interdepartmental files. She also worked with the Social Determinants and Science Integration Directorate, Health Promotion and Chronic Disease Prevention Branch at the Public Health Agency of Canada before joining the OCDO. Prior to being employed by the Federal Government, Annie worked in academia on several health research projects related to marginalized and vulnerable populations, health care system, primary health care services delivery, access barriers and eye care in developing countries (and more specifically on childhood blindness in East Africa). She lived in Guinea, Ivory Coast and Tanzania for a few years. Annie is the proud mother of two daughters, and the whole family loves to travel. It is with great enthusiasm that she is joining the OCDO and she is looking forward to contribute and support its work, in collaboration with the different partners and stakeholders in oral health.

Ana Mayorga
Liaison and Coordination Officer

In 1998, Ana Mayorga graduated from Algonquin College after completing a diploma in Office Administration - Executive. Since then, she has held numerous administrative positions in various federal Departments including Aboriginal

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de spécialiste du remboursement des frais pour soins dentaires. Elle a également travaillé pendant 17 ans dans des cliniques privées du nord de l'Ontario et dans la région de la capitale nationale, et elle a été coordonnatrice clinicienne à temps partiel pour un collège communautaire offrant le programme d'hygiène dentaire. Lorsque son horaire n'est pas trop chargé, Lisette continue de jouer un rôle dynamique au sein de la Commission de l'agrément dentaire du Canada et du Bureau national de la certification en hygiène dentaire. Fière mère de deux enfants, Lisette aime agir comme entraîneuse des équipes de hockey et de balle-molle de ses enfants.

Annie Bronsard, Ph. D.
Analyste des politiques

Annie s'est jointe à l'équipe du BDC en octobre 2015. Elle détient un doctorat en anthropologie médicale de l'Université Laval (Québec) et apporte au BDC son expertise en recherche qualitative et appliquée. Annie a occupé les fonctions d'analyste de politiques à la Direction des politiques scientifiques de la Direction générale de la politique stratégique de Santé Canada au cours des six dernières années où elle a travaillé sur de nombreux dossiers internes et interministériels. Elle a aussi travaillé à la Direction des déterminants sociaux et de l'intégration scientifique de la Direction générale de la promotion de la santé et de la prévention des maladies chroniques de l'Agence de la santé publique du Canada avant de rejoindre le BDC. Avant son arrivée au gouvernement fédéral, Annie a travaillé dans le milieu universitaire sur divers projets de recherche en santé concernant les groupes marginalisés et vulnérables, le système de santé, la prestation des soins primaires, les barrières d'accès aux soins en santé visuelle dans des pays en développement (particulièrement la cécité infantile en Afrique de l'Est). Elle a habité en Guinée, en Côte d'Ivoire et en Tanzanie pendant quelques années. Annie est la fière maman de deux filles et toute sa famille adore voyager. C'est avec beaucoup d'enthousiasme qu'elle se joint au BDC et elle est impatiente d'apporter sa contribution et son soutien en collaboration avec les différents partenaires et intervenants du domaine de la santé buccodentaire.

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Affairs, Northern Development, National Defence, Natural Resources, Correctional Services, and Public Work and Government Services. From November 2000 to March 2008, Ana worked at Health Canada in the First Nations and Inuit Health Branch and with the Health Products and Food Branch. In 2008, she joined the Public Health Agency of Canada and more recently, this past June, Ana joined the OCDO. Ana attends a Toastmaster club and enjoys reading and the outdoors.

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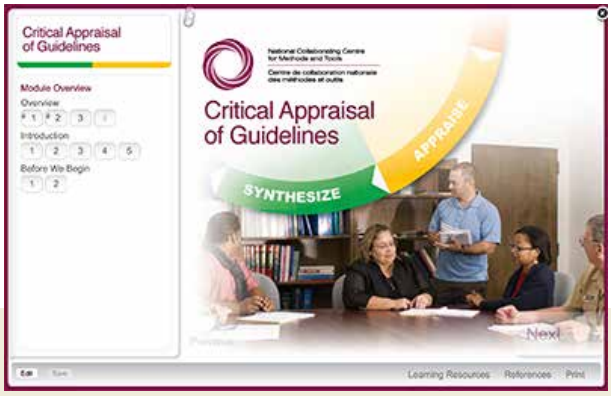
Ana Mayorga
Agente de liaison et de coordination

En 1998, Ana Mayorga a obtenu un diplôme en administration de bureau (direction) du Collège Algonquin. Elle a depuis ce temps occupé plusieurs postes administratifs au sein de différents ministères fédéraux, dont Affaires autochtones et Développement du Nord Canada, Défense nationale, Ressources naturelles, Services correctionnels et Travaux publics et Services gouvernementaux. De novembre 2000 à mars 2008, Ana a travaillé à Santé Canada, au sein de la Direction générale de la santé des Premières Nations et des Inuits et de la Direction générale des produits de santé et des aliments. En 2008, Ana s'est jointe à l'Agence de la santé publique du Canada et en juin dernier, elle a rejoint l'équipe du BDC. Ana fait partie d'un club Toastmasters et elle aime la lecture et le plein air.



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Reducing health inequalities: a hard nut to crack

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Health inequalities are one of the major concerning issues for public health (1). Even in developed countries like US and Canada, burden of diseases is high among vulnerable populations and till date health inequalities continue to persist (2). Although Canada was pioneer in issuing two landmark documents: i) Lalonde's report (3) delineating that health inequalities are linked both to individual as well as environmental factors and ii) the Ottawa Charter (4) for health promotion, yet there has been little progress in policy uptake of such ideas to tackle existing health inequalities in Canada.

"Inverse care law"

Common sense dictates that improvement in health through interventions or policies contributes in reducing inequalities. However, Macintyre has pointed that "the impact of a well-intended intervention or a policy on health is not the same as the impact on health inequalities"(5). Furthermore, there is a "tension between goals of generating health gain and the reduction of inequalities" (6). Watt suggested that a focus of interventions on individual behaviour change only and not addressing social determinants has limited impact in reducing health inequalities and may sometimes even exacerbate them (7, 8). This argument has been supported by "inverse care law" i.e. in general those in most need of benefiting from an intervention are least likely to receive it since the capacity to obtain benefit of intervention may be limited among the disadvantaged group than advantaged group (9). Thus, although some interventions may increase overall health benefits yet paradoxically they may even exacerbate inequalities by having greater impact on better off people (5, 9-12).

How health inequalities can be reduced?

Lately, there has been a consensus view in literature that in order to reduce inequalities it is critical to address various health determinants of health such as biological, social, economic, political, environmental, behavioural and cultural (13). Distinctly, such efforts require policy changes that are directly concerned with employment, education and income. For example, it involves investment in education, social security and development of labor market policies to ameliorate position of disadvantaged groups (14). Thus, some researchers argue that upstream interventions can potentially reduce inequalities in health as compared to downstream interventions (11, 15). Furthermore, a recent systematic review has reported that downstream preventive interventions increase inequalities than upstream interventions (16).

Many readers may be familiar with following story by Saul Allinsky, a twentieth century social reformer: "Imagine a large river with a high waterfall. At the bottom of this waterfall hundreds of people are working frantically trying to save those who have fallen down the waterfall, many of them drowning. As the people along the shore are trying to rescue as many as possible, one individual looks up and sees a seemingly never-ending stream of people falling down the waterfall and begins to run upstream. One of other rescuers shouts, "Where are you going? There are so many people who need help here." To which the man replied, "I'm going upstream to find out why so many people are falling into the river "(17). My purpose to narrate this story is to underscore the perspective that tackling inequalities requires addressing the root causes of inequalities through both downstream as well as upstream interventions.

Baum has proposed the "nutcracker effect" demonstrating the requisite of concurrent "bottom up" action from community and "top down" action from stakeholders to crack the hard nut of inequalities (18). White has advised that to reduce inequalities a single component of intervention will not be enough, conversely it requires range of methods e.g. policies change, educational methods etc. (19). Acheson et al. suggested that if future health inequalities are to be reduced, it is essential to carry out a wide range of policies to achieve both a general improvement in health and a greater impact on the less well off (9). Mitchie et al. recommended that behavioral change interventions that are tailored to the needs of the target population and differentially benefit disadvantaged groups can potentially contribute in reducing health inequalities (20). According to Watt, it requires a holistic, participatory and intersectoral approach of collaborated efforts from all sectors to effectively reduce health inequalities (21).

Reducing health inequalities: a hard nut to crack

Sadly, despite of adequate knowledge and understanding,

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till date reducing health inequalities remains a challenge for public health practitioners (22). In fact, various factors such as political agendas, the complexity involved and scantily understood processes of social determinants impede progress in reducing health inequalities (14). Thus, the hard fact that various health determinants exist outside the health sector makes health inequalities a hard nut to crack (18). Noteworthy, in United Kingdom the "Black Report" provided an evidence related to the extent and causes of inequalities but it was shunned due to political reasons thus proving that undoubtedly knowledge is essential but not enough to ensure an action (9).

Although challenging, yet tackling health inequalities should not be viewed as impossible. In their article , De Leeuw and Clavier have well quoted Rudolf Virchow's statement, "politics and medicine do go hand in hand" while emphasizing a need to form and implement new and better kinds of health policies for a broader health reform (23). In a nutshell, well planned and coordinated actions between government, health sector and various other sectors to form and implement better kinds of health policies can potentially reduce health inequalities and to achieve the goal of health for all.

Acknowledgement

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Pilot Oral Care Community of Practice in Long-Term Care (LTC): An exemplar for community-academic partnerships

Ibo MacDonald, RN, MSc

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It is well documented that dependant seniors living in long-term care (LTC) homes have poor oral hygiene (Coleman and Watson, 2006; Sweeney, Williams, Kennedy, MacPherson, Turner, & Bagg, 2007), resulting in the build-up of plaque. Since plaque is linked to numerous health conditions such as cardiovascular disease, arthritis, diabetes, and pneumonia this results in poor health outcomes for LTC residents (Li, Killtveit, Tronstad, & Olsen, 2000). In September 2014 the Registered Nurses' Association of Ontario's (RNAO) Long-Term Care Best Practices Program (LTC BPP) began a pilot project, the Oral Care Community of Practice (CoP) to increase staff knowledge and skill in oral health practices through the systematic implementation of evidenced-based best practices. Nine LTC homes in two regions of Ontario located in the North West and Champlain Local Health Integration Network were included. Two Long-Term Care Best Practice Co-ordinators worked with these homes in implementing the recommendations from RNAO's Oral Health: Nursing Assessment and Intervention best practice guideline (BPG).

The Oral Care CoP included two parallel elements. The first included five meetings conducted by webinar over seven months. In each of these webinar meetings the content built upon the previous session and facilitated participants to gain an understanding of how to implement the oral health BPG recommendations, as well as gaining insight from the experiences of each other through group discussions. A CoP has been described as "a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger, McDermott & Snyder, 1998. p.4). The structure of the CoP was designed, so that the oral care teams participating could support one another throughout the learning process. During the second CoP meeting when oral care practice recommendations were discussed it was identified that oral assessment knowledge and skills were a significant practice gap for each of the LTC homes, therefore, we chose to focus on this aspect.

The second element of the Oral Care CoP involved educational webinars that were available to all LTC homes across the province focused on various aspects of best practices in oral care for LTC homes. Topics included a three part oral assessment series, and webinars on oral health at end-of-life, and managing responsive behaviours during oral hygiene.

One of the LTC Best Practice Co-ordinators approached the Algonquin Colleges Dental Hygiene (DH) program to establish an academic partnership that further supported the Oral Care CoP. This partnership was funded by the Algonquin College Innovation Fund and allowed DH students to support LTC home staff with expertise and hands-on training in oral health assessment and interventions.

The DH students assisted in developing a three-part oral assessment series, where each session built upon the previous session. The DH students also participated in three half-day oral health assessment training sessions at three of the LTC homes. This approach provided expert knowledge through coaching the LTC home staff in conducting oral health assessments on residents and approaches to providing oral care. Many of the previous studies that have been conducted regarding oral health education for LTC home staff have been didactic and have not utilized techniques that require demonstration and coaching (Bonwell, Parsons, Best, & Hise, 2014; MacEntee, Wyatt, Beattie, Paterson, Levy-Milne, McCandless, & Kazanjian, 2007). We wanted to ensure that staff understood the content of the three-part assessment series and that they could apply it with some confidence in their work setting. Three training days included 16 LTC home staff (nurse managers, nurses, and personal support workers), 12 DH students, one DH expert, and one dentist. Residents were assessed by one staff member and one DH student who were supervised by a clinical expert, the DH expert or dentist. All examiners received baseline training on oral health assessment through the three-part oral assessment e-learning and a 45 minute in-class training session on the three assessment tools prior assessing residents. The clinical experts each

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demonstrated how to conduct an oral assessment on a resident. All oral examinations were performed at the bedside, using simple equipment: gloves, dental mirror, light source (head light or handheld flashlight), and gauze if required. The three assessment tools used were the Oral Health Assessment Tool (Chalmers, King, Spencer, Wright, & Carter, 2005), The Holistic Reliable Oral Assessment Tool (THROAT) (Dickinson, Watkins, & Leathley, 2001) and Section L: Oral health section in the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

Outcomes from the training days

Ninety-six residents were assessed, and it was determined that 84% required referral to dental health professionals based on the OHAT criteria. Of those residents that required a referral, 74% was due to a lack of oral cleanliness. This supports prior research that LTC home residents do not receive adequate oral care (Coleman and Watson, 2006). Both LTC home staff and the DH students indicated that they felt more confident in their ability to assess resident oral health.

Through this partnership, the DH students gained experiential knowledge in communication and behaviour management with residents. Debrief discussions were held after the assessments and themes that emerged included lack of resident ability to perform self-care, staff compassion, and the challenges in providing care. Here are some of their comments to capture their perspectives of the day:

"it's important to have patience, there are time constraints. Client compliance/availability of dental help (professionals) is a challenge"

"the nurses are very passionate towards the residents. They wanted the best for them"

"a resident might appear competent and able to do things for themselves but the reality of the situation may be completely different"

In contrast the staff at the LTC homes gained information about oral health assessment techniques along with increased knowledge of oral health changes and abnormalities. Two LTC home staff said:

"It's important as a caregiver to know what to look for in their mouth. It was very interesting to learn how to do an oral exam"

"there is a lot to look at in a person's mouth and I am now more aware of what to look for."

Finally, when all participants were asked about preferences in oral assessment tools, none favoured any one of the assessment tools over the others. They found the two validated tools difficult to use because they lacked a logical flow, and did not include terminology that made it easy to record their findings. All LTC homes in the province of Ontario are required to complete the RAI-MDS on all residents. However, in the oral health section participants found that there was a lack of clarity in two areas L1c "Some/All Natural Teeth Lost-Does Not Have or Does Not Use Dentures (or Partial Plates)". Staff were surprised to learn that they had been completing section L1a – "Debris Present in Mouth Prior to Going to Bed at Night" incorrectly. This highlights the need for improved assessment tools and accurate completion of the oral health section in RAI-MDS.

The Oral Care CoP was successful in assisting participating LTC home staff in implementing oral health recommendations. The academic partnership in particular was instrumental in increasing their knowledge about oral health assessment through the application experience with DH students and faculty. Based on the success of the pilot project, a provincial Oral Care CoP was established with a new cohort of twenty-five LTC homes this year.

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DEMAND A PLAN: **SENIORS CARE**

Canada's seniors are not getting the health care they deserve — not even close. Our system was created over half a century ago to meet the needs of a much younger population and we have not adapted to meet the growing number of aging Canadians.

The Canadian Association of Public Health Dentistry CAPHD) is pleased to let you know that we have joined the Canadian Medical Association's Alliance for a National Seniors Strategy. This Alliance brings together over 70 health care organizations calling on the Federal government to commit to a national seniors strategy.

To support the Alliance, the Canadian Medical Association launched a public engagement campaign called DemandAPlan. To-date over 39,000 Canadians have added their voice through **www.DemandAPlan.ca**

We invite you to join the campaign, by doing so you will be part of a movement that will help bring about the change we need. DemandAPlan is a website designed to share information, locate promising practices across the country, track and review government promises as well as offer tools to help you get involved.

If you have any questions regarding DemandAPlan, please feel free to write to **demandapln@cma.ca**

Worth Reading

CDA Essentials 2015 Volume 2, Issue 6- CAPHD Member Dr. Bruce Wallace, Are Community dental clinics effective in improving access to care, a case study.

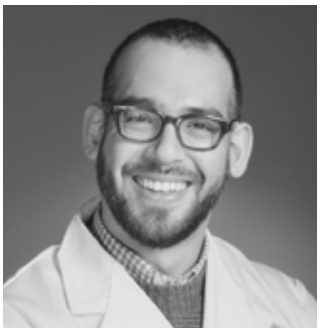
http://www.cda-adc.ca/en/services/essentials/2015/issue7

Board of Directors

Several new Board of Directors were elected at the 2015 Annual General Meeting in Toronto. They are looking forward to volunteering for CAPHD and look forward to celebrating CAPHD's 50th Anniversary in Edmonton in September.

PRESIDENT

Dr. Alyssa Hayes, BDent (Hons), MSc, FRCD(C)



PAST PRESIDENT

Dr. Carlos Quiñonez, DMD, MSc, PhD, FRCDC(C)

PRESIDENT-ELECT

Dr. Rafael Figueiredo, BDS, MSc (DPH), FRCDC(C)

The Association is grateful for the work and dedication of outgoing board members, **Ms. Andrea Doiron**, **Ms. Kimberly Laing** and **Dr. Albert Adegbembo** and wish them well in their future endeavors.

SECRETARY

Ms. Shelly Sorensen, Dip(DH), RDH, CDA, CDPH

DIRECTOR

Dr. Jodi Shaw, CD, DMD, MSc (DPH), FRDC(C)

DIRECTOR

Dr. Garry Aslanyan, DMD, MPH, FRCD(C)

DIRECTOR

Dr. Mario Brondani, DDS, MSc, MPH, PhD

DIRECTOR

Dr. Dick Ito, DDS, MSc, FRCD(C)

ADMINISTRATOR

Andrea Richard, Dip(DH), RDH

Full bios can be found at
www.caphd.ca/board-directors

2015 CAPHD/OAPHD Conference
Oral Health And Primary Care

Andrea Richard, Dip(DH), RDH

The 2015 CAPHD/OAPHD Conference brought over 200 delegates to explore the concept of integrating oral health into primary care. This year's conference hosted the University of Toronto's Dr. Murray Hunt and James Leake Lecture, which brought two international speakers, Dr. Hugh Silk and Dr. Rocio Quiñonez and a panel of speakers to discuss the topic.

CAPHD and OAPHD were happy to organize the event which gave delegates continuing education in dental public health, a breadth of discussion, an opportunity for professionals to network and explore pathways for change. We're pleased that delegates felt energized and reconnected and look forward to welcoming you to Edmonton in 2016!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1. Dr Hayes with students Jessie Zoorkan & Marina Jones 2. Ms. Farmer receiving the CAPHD Dr. Leake Student Bursary
3. Dr. R. Quiñonez, Key note speaker 4. Dr. Peter Cooney receiving the CAPHD Life Membership Award
5. Dr. Hugh Silk, Key note speaker 6. 2015 Scientific Session Presenters

Accomplishments

Carol Yakiwchuck accepted the position of Oral Health Manager with the First Nation Health Authority in British Columbia.

Dr. Rafael Figueiredo Provincial Dental Consultant:

https://dentistry.utoronto.ca/news/yearbook-introducing-four-faculty-s-most-recent-graduates

Dr. Garry Aslanyan's work was recognized in University of Toronto's Dentistry Publication.

http://issuu.com/facultyofdentistry_uoft/docs/uoftdent-summer-fall2015-/30 http://tst-dentistry.sites.olt.ubc.ca/files/2015/09/breaking_barriers_oral_health_for_everyone_web_temp.pdf

Dr. Mario Brondani has been appointed professor with tenure in the Department of Oral Health Sciences.

http://www.dentistry.ubc.ca/new-appointments-full-time-faculty-fall-2015/

Dr. Steven Patterson, received the Faculty of Medicine & Dentistry, University of Alberta E.N. Skakun Award for Service to Education.

This is one of the two major teaching awards in the Faculty (close to 700 faculty members) & recognizes major and long-term contributions to educational leadership and scholarship.

https://www.med.ualberta.ca/programs/resources/awards/skakun

Denise Kokaram received the Joanne Clovis Community Health Award (from the CRDHA), which recognizes significant contributions by a member to the oral health of the community, and was selected as the Apple Magazine Praising Passion recipient for Albertans making a difference in the lives of others.

http://www.applemag-digital.com/applemag/winter_2015?pg=53#pg53
http://www.crdha.ca/media/105182/intouchsummer2015final.pdf

CALENDAR OF EVENTS

CAPHD conference, September 30-October 1, 2016, Edmonton Alberta. More details to be announced in 2016.

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

The National Oral Health Conference, April 18-20, 2016, Cincinnati, Ohio

www.nationaloralhealthconference.com

Canadian Public Health Association- Public Health 2016 June 13-16, 2016 Toronto Ontario

www.cpha.ca/en/conferences/conf2016.aspx

International Federation of Dental Hygienists 20th International Symposium on Dental Hygiene, June 19-22 2016, Lucerne Switzerland

http://isdh2016.dentalhygienists.ch

Pacific Dental Conference in Conjunction with the Canadian Dental Association, March 17-19, 2015 Vancouver BC

https://www.pdconf.com/cms2016/

FDI- World Dental Congress, September 7-10, 2016, Poland

http://www.fdiworldental.org/media/news/news/official-poznan-(poland)-to-host-the-2016-fdi-annual-world-dental-congress-(7-to-10-september-2016).aspx

Canadian Dental Hygienists Association Conference October 17-19, 2017, Ottawa

http://www.cdha.ca/cdha/Education/2017_National_Conference/CDHA/Education/2017_National_Conference/CDHA_2017_National_Conference.aspx?hkey=d7c-4bc56-5f74-4dd0-8935-a2768394c55d

CAPHD Mosaic Newsletter Submission Guidelines

To continue publishing the Mosaic and to make it a valuable resource, we rely on submissions from members. We look forward to submissions for the April issue!

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 April 31 for the spring issue and Oct. 1 for the winter issue.

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 using Vancouver citation style, 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.

2016 Conference Save the Date

Improving the health of Canadians: 50 years of CAPHD

In collaboration with the School of Dentistry, University of Alberta
Friday September 30th- Saturday October 1st
University of Alberta, Edmonton

Photo courtesy of the City of Edmonton