ISSUE NUMBER 4 NOVEMBER 2013

Mosaic

Canadian Association of Public Health Dentistry

IN THIS ISSUE

President Message

Dr. Albert Adegbembo

The Canadian Association of Public Health Dentistry needs you, now more than ever before. Two major changes have occurred since its founding in 1966 as the Canadian Society of Public Health Dentistry (CSPHD). These changes have important implications for membership, especially if the CAPHD is to achieve the raison d'être for its existence. The CAPHD exists so that: Canadians benefit from and contribute to growth of a recognized, diverse professional community dedicated to dental public health, equity in oral health, and public health ethics.

The first change occurred in 1994 when changes in the bylaws opened membership in the Association to those who have an interest in the advancement of dental public health. This change provides the Association to tap from a wider community of interested persons and/or groups. The Association welcomes a diversity of professional opinions on dental public health issues. If you are thinking of joining the CAPHD, now is the time!

The CAPHD is engaged in many collaborative activities that require the active participation of many individuals. The CAPHD is actively working with the Office of the Chief Dental Officer (OCDO) and the Federal Provincial Territorial Dental Working Group (FPTDWG). Current areas of collaboration include participation in the Canadian Best Practices Portal – Oral Health Reference Group, and stakeholder input to Reducing Dental Disease: A Federal, Provincial Framework for Action to Promote Oral Health.

The CAPHD is also collaborating with other organizations to move the agenda of access to care to the forefront. These organizations include the Canadian Coalition for Public Health in the 21st Century (CCPH21) and dental professional organizations. There are requests for collaboration from other organizations that are focused on public health issues in Canada. It is an active membership that can sustain this level of participation and ensuring that CAPHD is the voice for dental public health issues in Canada.

The second milestone is the incorporation of CAPHD in 2011 under Canada's Not-for-Profit Act. As a result of incorporating, CAPHD has adopted the Carver Policy Governance® model. The model seeks to promote excellence in the management of not-for-profit organizations. To promote excellence, the model seeks to separate organizational "Ends" – governance – from "Means" – management. For the CAPHD to hold its Board and Management accountable, it is imperative that many more members actively participate by volunteering in CAPHD operational Committees. Permit me to use this opportunity to sincerely thank our members who are volunteering on the Board and the operational committees of the CAPHD; the Policy Advocacy, Communications, Membership, and Conference Planning Committees.

On behalf of the Board, I invite you to seriously consider joining the CAPHD, and if you are already a member to consider how best to deploy your talents to the good of the CAPHD. It will take every one of us using all of our talents if we are to achieve a more equitable Canadian society where the bottom quarter of the Canadian population have similar access to oral health services and oral health-related quality of life as do the top twenty five percent.

Yours truly,

Albert O. Adegbembo, BDS, DDPH, M Sc, FRCD(C.)

Top left to right: Dr. Peter Cooney, Dr. James Leake, Dr. Patricia Abbey, Dr. Doug Brothwell, Dr. Myron Allukian Jr., Mr. Irwin Fefergrad, Dr. Amir Azarpazhooh; Lower left to right: Dr. Patricia Main, Dr. Albert Adegbembo, Ms. Sandra Lawlor, Dr. Peter Doig

CAPHD Scientific Conference

Andrea Richard, Executive Director, CAPHD

A successful collaboration between the Ontario Association of Public Health Dentistry (OAPHD) and the University of Toronto (U of T).

If you were in attendance during the first day of the conference, you likely were encouraged by the number of professionals that filled the room. Of course, CAPHD is accustomed to welcoming delegates from across the country, but welcoming three hundred delegates was something new for organizers. The increased number of delegates in attendance tells us that continuing education in dental public health in Canada remains relevant and important. The large numbers are also largely due to a successful collaboration with OAPHD and it's representative, Dr. Dick Ito, who provided good support and advice on how to attract dental public health professionals in Ontario.

From what we've heard during networking and through our post evaluation is that delegates are eager to attend future CAPHD conferences! We're thrilled to hear this because we believe that the annual conferences are a key knowledge exchange event for dental public health in Canada. It is also an excellent opportunity to network, share ideas and provide motivation for the upcoming year!

CDHA's Anne Wright & Ondina Love with CAPHD's Past President, Dr. Luke Shwart

Within that mass number of delegates you may have had a chance to network with some of Canada's national oral health leaders including:

- Canadian Dental Hygienist Association's (CDHA) President, Ms. Sandra Lawlor & Executive Director, Ms. Ondina Love
- Canadian Dental Association's (CDA) President, Dr. Peter Doig
- OAPHD President, Dr. Patricia Abbey
- Chief Dental Officer of Canada, Dr. Peter Cooney
- CAPHD Past President, Dr. Doug Brothwell & President-Elect Dr. Albert Adegbembo

Each added to the dialogue about access to dental care in Canada during the conference, something that everyone in the room was passionate about!

The conference committee strived to offer conference sessions that would assist delegates to improve their competencies in dental public health. We asked CAPHD members what competencies from the Dental Public Health Competencies Discipline Specific Competencies they required continuing education in and we reflected your opinions in the Friday morning speaker choices. Ms. Heather Murray started off the day with a Calibration Session for Public Health Dental Hygienists in Ontario, which was followed by Dr. Fitzpatrick who presented the P.E.I Experience in Developing Infection Control Policies.

Dr. Amir Azarpazhooh, Friday morning speaker

Dr. Azarpazhooh had us dancing and stretching before his presentation, The Current State of Evidence on the Link between Oral Health and Systemic Health. Continued on page 3...

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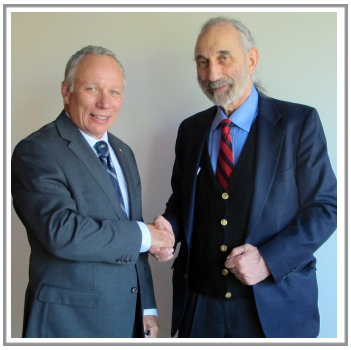
We were fortunate to collaborate with the University of Toronto who offered the Murray Hunt & James Leake Lecture Friday afternoon. Dr. Myron Allukian Jr. proved to be a thought provoking speaker who presented "The Neglected Epidemic and Social Injustice: What Can Be Done for Better Oral Health?" His presentation was followed by a panel discussion which was a response to Dr. Allukian's presentation. The panel was followed by a relaxing reception which allowed guests to continue networking into the evening.



Dr. James Leake with Dr. Myron Allukian Jr.

Abstract Presenters. Back row (left to right): J. Leake, A. Jessani, B. Wagar, A. Auluck, C. Quiñonez, Nancy Laplante. Front row (left to right): S. Naghipur, E. Cardoso, S. Melanson, C. Ramraj, A. Hayes, P. Calvasina, T. Nancarrow.

Saturday was a day of Scientific Abstract Presentations led by Scientific Chair, Dr. Carlos Quiñonez. These sessions were, as always, high quality and highly anticipated each year!

Delegates from Northern Ontario: Marilyn Romenantz, Thunder Bay District Health Unit with Dawn Sauve, Northwestern Health Unit

Several CAPHD members stayed on to Sunday to attend the Annual General Meeting. Attendees and Board members attended to business and elected a new board of directors. Outgoing board members that will be truly missed are: Dr. Doug Brothwell (Past President), Dr. Asef Karim (Director) and Ms. Maureen Connors (Secretary/Treasurer). The new Board of Directors are Dr. Albert Adegbembo (President), Ms. Brenda Currie, Ms. Kimberly Laing, Ms. Andrea Doiron, Ms. Shelly Sorenson (Secretary), Dr. Gerry Uswak (Past President) and Dr. Carlos Quinonez (President-elect).

Past President, Dr. Doug Brothwell (left) passes the gavel to incoming President Dr. Albert Adegbembo (right).

Executive Director, Andrea Richard (left) presents gift of appreciation to outgoing Secretary/Treasurer, Maureen Connors (right).

All in all, we are encouraged by the positive feedback received and we aim to include your good suggestions for future events. CAPHD is very grateful and extends thanks to the collaborators, OAPHD & U of T, both of whom contributed greatly to the success of the event! CAPHD is also always thankful for the many volunteers who put countless hours into planning and executing event! And of course, last but never least, thank you to THE DELEGATES who make the annual conferences worthwhile!

Dr. James Leake Student Bursary

It was a pleasure to have Dr. James Leake in attendance at this year's conference. He congratulated this year's recipients, Dr. Paola Calvasina and Ms. Sharon Melanson.

Dr. Paola Calvasina (left) received the award for, *Does the "healthy immigrant effect" apply to oral health?: An analysis of the Longitudinal Survey of Immigrants to Canada (LSIC).*

Dr. Calvasina received her DDS in 2002 from the University of Fortaleza, Fortaleza, Brazil. Since then, she worked as a public dentist in the Brazilian Family Health Program (2002-2005), as district manager of oral health programs in the city of Fortaleza (2005-2008), and taught Community Dentistry at the Faculty of Dentistry, Federal University of Ceará, Brazil (2006-2008). She holds a Master of Public Health from Ceará State University, Brazil (2003-2005). Dr. Calvasina is currently a PhD candidate at the Collaborative Doctoral Program in Global Health at the Faculty of Dentistry and Dalla Lana School of Public Health, University of Toronto. Her research interests include immigrants' oral health disparities, access to dental care, and transnational dental utilization.

Ms. Sharon Melanson (left) received the award for, *The Experiences of Families whose Children Access Dental Care under the Healthy Kids Dental Program of BC.*

Sharon Melanson is a dental hygienist who has worked in public health for over 25 years, focusing on Access to Care issues for the last 10 years. In 2005 she received a YMCA-YWCA Woman of Distinction Award for her work in establishing the social dental clinic in Kelowna. She has just completed her Master of Science degree in Interdisciplinary Studies at the University of British Columbia, Okanagan Campus in Kelowna. It was her years of experience in public health, hearing first-hand the stories of parent's struggles to obtain dental care for their children that lead to her research of the Healthy Kids Dental Program.

Nova Scotia has one of the oldest populations in Canada. Dalhousie University researchers have been leading research that examines the patterns of oral disease in adults aged 45 years and older and the particular challenges for those in long-term care (LTC).

An Inconvenient Tooth: The Truth About Older Adults in Nova Scotia

Clovis JB, Matthews DC, McNally ME, Brillant MGS, Filiaggi MJ Faculty of Dentistry, Dalhousie University, Halifax, NS

Our global concern about the oral health of seniors has escalated along with the demographic projection of the growing older population and our increasing understanding of their vulnerabilities. For more than a decade, Dalhousie University researchers in Nova Scotia (NS) have been leading research that examines the patterns of oral disease in adults aged 45 years and older and the particular challenges for those in long-term care (LTC). The focus on older adults grew from several sources: researcher interest and practice with older adults in clinical and community settings; a cohesive research group in the Faculty of Dentistry that was formally committed to improving the oral health of vulnerable populations (Collaboration of Oral Health Researchers or COHR)1; and the statistic drawing attention to NS as having the one of the oldest populations in Canada.

Without epidemiological information, we were unable to make accurate and clear statements about the oral health of seniors and those older adults approaching senior years in Nova Scotia. We built our research capacity in this area through engagement with other researchers in the field, seniors and organizations representing seniors. Our intent was to inform the health needs of Nova Scotians and also to contribute to the overall Canadian picture of older adults. Over time, and after several workshops and a funded pilot study, we undertook a full population survey with the assistance of many others who provided site locations and guidance.2

Survey participants completed a questionnaire that collected socio-demographic, access to dental care and oral health-related quality of life information. The questionnaire was conducted over the phone for adults living independently in the community and in-person for adults living in long term care (LTC) settings. Participants also had a clinical oral examination conducted by one of six dentists calibrated to W.H.O. standards. In all, 1476 people participated in the survey: 1141 community residents and 335 LTC residents. Of these, 747 community participants and 330 LTC participants completed both questionnaire and exam. The average age was 63.8 years in the community and 80.8 years in LTC. More females than males participated in the survey (62% community, 75% LTC). Just over 40% of participants resided in rural areas, which is reflective of the residence patterns of this age group in Nova Scotia.3

Thirty-five percent of people age 45-64 living in community had no form of dental insurance; this percentage increased to 68% for those 65+ and to 83% for those living in LTC. Twelve percent of people age 45-64 living in the community never visited a dental professional or saw one only for emergencies; a full 73% of those living in LTC never saw a dental professional or saw one only for emergencies. Community-dwelling adults were less likely to visit a dental professional at least once each year if they had a household income below $30,000, had less than a high school education, or did not have dental insurance. In addition females were twice as likely to have frequent dental visits as males.3

Most people (81% community, 76% LTC) perceived their oral health to be good or excellent. Overall, 53% of LTC residents and 50% of community residents reported some type of dental or oral problem including persistent dry mouth (16% community, 36% LTC), sensitivity to hot or cold (24% of community residents), and oral pain in the past month (10% community, 15% of LTC) 3 all of which can contribute to a deteriorating quality of life. The Oral Health Related Quality of Life (OHRQoL) was poor in both pre-seniors and seniors. Remarkably, pre-seniors living in the community reported the highest rate of oral impacts on their quality of life even though their oral health was better than that of seniors.4

Almost two-thirds of LTC residents were either edentulous (41%) or had teeth in only one arch (24%). For those with some teeth, treatment needs for restoration and denture repair were high;3 oral diseases identified included untreated decay (22% community, 60% LTC), gingivitis (44% community, 66% LTC), and attachment loss of 4mm or greater (52% community, 67% LTC).3,5

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Need for preventive care among dentate Nova Scotians was also clearly demonstrated. Professional care is required for those who had teeth with calculus covering 1/3 or more of the tooth surface (39% community, 55% LTC).3 Daily self-care guidance is needed for those who had soft debris covering 1/3 or more of tooth surfaces (19% community, 60% LTC), who were brushing their teeth less than twice a day (23% community, 44% LTC) and those who were flossing less than once a day (58% community, 83% LTC).3

Our survey results appear to be somewhat higher than national data from the Canadian Health Measures Survey (CHMS) Oral Health Component on the prevalence of root decay, number of missing and filled teeth and the number of people who did not have dental insurance.3,6 The percentage of people age 60-79 who were edentulous was lower in our survey (9%) than the CHMS (22%). Although it is possible that rates of edentulism are lower in Nova Scotia than nationally, it is likely that this difference simply indicates that edentulous people were less likely to participate in this oral health survey as opposed to the CHMS.

One of the goals of this survey was to compare the oral health treatment needs and expectations of current Nova Scotia seniors to the generation coming behind them (the Baby Boomers). What we found is that Nova Scotians age 65+ living independently in the community have more oral disease (edentulism, root decay and periodontal disease) and treatment needs than those age 45-64. Despite this, seniors are equally likely to report good or excellent oral health and, with the exception of dry mouth, are no more likely to report having oral health problems than Baby Boomers.7

The implications of the survey results, that is, knowing the high rates of oral disease in long term care, and knowing the future population of 'seniors' will have more teeth upon retirement, indicate an urgent need to:

- Provide interventions to prevent and treat oral diseases,
- Provide education on personal mouth care to all adults: those living in the community, those is residential care, and those responsible for daily mouthcare of residents,
- Develop and test ways to improve oral health in residential care settings and in subpopulations within these settings, such as adults with dementia,
- Increase awareness of the impact of polypharmacy on xerostomia,
- Promote alternate methods of professional care delivery to ensure daily and professional mouthcare.

Concurrently with the epidemiological research, a partnership with the Atlantic Health Promotion Research Centre resulted in a province-wide environmental scan using key informant interviews to evaluate continuity of care and policies for the oral health care of Nova Scotia seniors. The report *The Silent Epidemic of Oral Disease: Evaluating Continuity of Care and Policies for the Oral Health Care of Seniors* included several recommendations promoting increased access to oral care for seniors.8

While a number of research and policy priorities were identified through these collaborative projects,9 a key focus was LTC. A partnership with Capital Health's Eastern Shore Tri-Facilities and data collected through key informant interviews, focus groups and document analysis resulted in the development of "Brushing Up on Mouth Care", a comprehensive resource and education package to assist those who provide daily oral care to older adults living in continuing care settings.10 This open access web-based resource includes oral health toolkits, education resources and videos, assessment and care-planning guidelines. Nearly all resources are freely available and can be downloaded from the website.11 This project was assessed and accepted as a best oral health practice and is posted on the Canadian Best Practices Portal for Oral Health Promotion.12

Educators of personal care providers reported a lack of resources for training students in oral care.9,10 A university-college partnership led to the modification and introduction of Brushing up on Mouth Care resources to all practical nursing and most personal care provider educational programs in NS. In addition to the didactic curriculum, head and neck mannequins in 11 personal care laboratories across the province enable students to practice oral care techniques. We continue to work towards creating changes in policy to promote oral health assessment and mouthcare through provincial Guiding Principles and Practice Standards.

The research findings overall demonstrate that there is reason to be concerned about the oral health of older adults, especially given the anticipated growth in the number of seniors in the coming decades. Moreover, our successes and learning helped us to forge new partnerships to address other populations. An additional research project led to sharing our knowledge with Newfoundland and Labrador stakeholders for seniors and the establishment of an Oral Health Research Affinity Group at the Newfoundland and Labrador Centre for Applied Health Research. New research initiatives also aim to address aboriginal oral health and the oral health of remote communities in Labrador.

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Throughout our research, our strength has been in bringing together knowledge users (seniors, clinicians, policy makers, personal and professional care-providers, administrators, educators, health promoters and health service funders) with knowledge creators (the academics who represent many disciplines and universities). We refer consistently to the original mission of our COHR research group to improve the oral health of vulnerable populations, to build research capacity, and to build partnerships with communities and decision-makers. We recognize that there are many steps between assessing oral health needs and the provision of oral health services; our aim is to help build the necessary links between the beginnings and the ends.

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Message From the Chief Dental Officer of Health

Dr. Peter Cooney

In 2012, our Office was moved from its location with the First Nations and Inuit Health Branch (FNIHB) of Health Canada to the Public Health Agency of Canada. Changes to staffing and to the budget took place.

I am pleased to advise the members of CAPHD that the move to the Public Health Agency has been a positive experience. Our mandate in terms of public health has been broadened (we are now responsible for oral health issues on a portfolio wide - HC and PHAC - basis). We have retained some previous staff and have recently filled the Assistant Chief Dental Officer, and Senior Policy Analyst positions on a term basis.

Dr. Chartier, Assistant Chief Dental Officer, holds a DMD degree from Université de Montréal. In the last 12 years, he has cultivated a broad range of experience in oral health care delivery by working in numerous dental clinics and hospital settings in Québec, British-Columbia, Nunavut, and the National Capital Region.

At the beginning of his practice, he supported the start-up of a homeless youth clinic with Dr Denys Ruel providing free dental services in downtown Montreal. As part of this initiative affiliated with the Université de Montréal, Dr. Chartier worked as a clinical instructor for many years supervising dental students and residents. In 2005, he received an award of distinction from the Canadian Dental Association for his contribution in promoting oral health through this work.

Dr. Chartier also worked as volunteer in Cambodia with Projects Abroad which paved the way for future placement opportunities for dental professionals with local orphanages, universities, children's hospitals and community projects while he assisted local dentists and oral surgeons with clinical work at the Khmer Soviet Friendship Hospital. His volunteer work also included participating to a Dentistes Sans Frontière mission in El Alto, Bolivia, providing oral care to Aboriginal populations.

In spring 2013, Dr. Chartier completed a Master of Public Health at Harvard University in Boston, USA, concentrating on global health policies. He spent the past summer in Geneva, Switzerland, working at the World Health Organization in the department of Nutrition for Health and Development in the Nutrition Policy & Scientific Advice division. He also assisted Dr Poul Erik Peterson, Chief Dental Health Program, at the Department of Chronic Diseases and Health Promotion.

Finally, Dr Chartier is a keen advocate of physical activity and spends his free time gardening, renovating his century old house and pursuing his fascination to discover the world through travel.

Karen Lyon joins the OCDO as the Senior Policy Analyst with more than 15 years with the federal government. She has held various positions over the years, in a number of different departments across the country. Most recently her work centered on health promotion with a specific focus on Aboriginal children and their families. This work involved collaborating with national, provincial and local Aboriginal organizations on shared priorities (i.e. mental health, nutrition, physical activity) to improve the overall health of First Nations, Inuit and Metis.

She brings with her an understanding of how government operates, strong skills in working collaboratively and experience in policy development and in the analysis of health issues. Karen also worked as an elementary school teacher for a number of years; she is passionate about nurturing a child's curiosity, and creating a strong desire for learning. She has tried to pass along her love of learning to her own two children who are now immersed in university life.

Karen looks forward to contributing and furthering the work of the Office of the Chief Dental Officer and its partners in oral health.

ONLINE
reading:

Past Conference Presentations are available to CAPHD members on the "members portal".

Vitamin D status of children with severe early childhood caries: a case–control study Robert J Schroth et. al.

Message du Bureau du Dentiste en Chef

Dr. Peter Cooney

En 2012, notre Bureau a été transféré de la section des Premières Nations et Inuit de Santé Canada à l'Agence de la Santé Publique du Canada. Des changements de budget et de personnels en sont suivis.

C'est avec plaisir que j'informe les membres de l'ACSDP que notre réorganisation a été une expérience positive. Notre mandat en terme de santé publique a été élargi et nous sommes maintenant responsables du portfolio de la santé bucco-dentaire à Santé Canada ainsi qu'à l'Agence de la Santé Publique. Nous avons retenu en partie le personnel précédent et nous avons récemment comblé le poste de Dentiste en Chef Adjoint et le poste d'Analyste Principale de Politiques pour une période déterminée.

Dr Chartier, Dentiste en Chef Adjoint, est titulaire d'un Doctorat en Médecine Dentaire de l'Université de Montréal. Au cours des 12 dernières années, il a cultivé une vaste expérience dans la prestation de soins de santé en travaillant dans de nombreuses cliniques dentaires et hôpitaux au Québec, en Colombie-Britannique, le Territoire du Nunavut et la Région de la Capitale Nationale. Au début de sa pratique, il a participé à la mise-en-œuvre d'un centre de jeunes sans-abri avec Dr Denys Ruel.

Dans le cadre de cette initiative affiliée à l' Université de Montréal, Dr Chartier a travaillé comme instructeur clinique quelques années tout en supervisant et agissant à titre de mentor aux étudiants et résidents de l'Université. En 2005, il a reçu un prix de distinction de l'Association Dentaire Canadienne pour sa contribution à la promotion de la santé bucco-dentaire grâce à ce travail.

Dr Chartier a également travaillé comme bénévole au Cambodge avec Projects Abroad. Son travail a permis de créer de nouvelles opportunités de placement pour les professionnels de soins dentaires avec des orphelinats, des Universités, des hôpitaux pour enfants, ainsi que des projets communautaires tout en aidant les dentistes locaux et les spécialistes en chirurgie maxillo-faciale au Khmer Soviet Friendship Hospital. Toujours à titre de bénévole, il a également participé à une mission de Dentistes Sans Frontière à El Alto, en Bolivie, auprès de populations autochtones.

Au printemps 2013, Dr Chartier a complété une Maitrise en santé publique à l'Université Harvard au Massachusetts, États-Unis, avec une concentration en politiques de santé internationale. Il a passé l'été dernier à Genève, en Suisse, à travailler à l'Organisation Mondiale de la Santé au département de nutrition au sein de la division du conseil scientifique. Il a également travaillé avec Dr Poul Erik Peterson, Dentiste en Chef du programme de santé bucco-dentaire au sein du département des maladies chroniques et de la promotion de la santé.

Finalement, Martin est un ardent défenseur de l'activité physique et passe son temps libre à jardiner, à rénover sa maison centenaire ainsi qu'à voyager afin de poursuivre sa fascination à découvrir différentes cultures.

Karen Lyon a rejoint le Bureau du Dentiste en Chef à titre d'Analyste Principale de Politiques avec plus de 15 années d'expérience au sein du gouvernement fédéral. Elle a occupé divers postes au cours des années, dans un certain nombre de départements à travers le pays. Plus récemment, son travail s'est concentré à la promotion de la santé avec un accent particulier sur les enfants autochtones et leurs familles. Ce travail consistait à collaborer avec les organisations autochtones nationales, provinciales et locales sur les priorités conjointes (par exemple: la santé mentale, la nutrition et l'activité physique) afin d'améliorer la santé des Premières Nations, des Inuits et des Métis.

Elle possède une bonne compréhension de la façon dont le gouvernement fonctionne, de solides compétences de travail de collaboration, de l'expérience dans l'élaboration de politiques, ainsi que l'analyse des problèmes de santé. Karen a aussi travaillé comme professeure d'école primaire pour un certain nombre d'années. Elle se passionne à nourrir la curiosité des enfants tout en suscitant un fort désir d'apprendre. Elle a essayé de transmettre son amour de l'apprentissage à ses deux enfants qui sont maintenant plongés dans la vie universitaire.

Karen se réjouit de contribuer et de faire avancer les dossiers du Bureau du Dentiste en Chef et ses partenaires en santé bucco-dentaire.

camh
Centre for Addiction and Mental Health

TOBACCO CESSATION
TEACH
Training Enhancement in Applied Cessation Counselling and Health
ARRÊT DU TABAGISME

Tobacco is a Killer

Ashley Hall

What can you do to help?

Tobacco is the number one cause of preventable death in Canada. Smoking affects all parts of the body, including the mouth. Although smoking can have negative health impacts on the heart, the lungs, and the stomach, it also has negative ramifications on oral health. Smoking can lead to such dental related conditions as: increased calculus, halitosis, periodontitis and attachment loss, and mouth sores. These are only a few of the many conditions that are associated with smoking. Recent studies have also indicated that second-hand tobacco smoke (smoke from someone else's cigarette) may cause periodontal disease.

So what can dentists and dental health practitioners do? Dental professionals are in a prime setting to offer smoking cessation counseling. Since dental professionals spend a fair amount of time with patients, they are in a position to deliver effective interventions. For every 100 patients that you briefly intervene with, 2 will quit smoking. Smoking cessation counseling is also one of the most cost effective interventions that a clinician can perform.

Do you have 10 minutes to spare? What about 3 minutes? Some clients respond very well to brief interventions. All patients should be asked about their smoking or tobacco use, and then the dental professional can arrange the next steps. This check in should be routine and can take as little as 3-10 minutes. One framework for brief interventions is known as the 5 A's.

The five A's are:

- **Ask:** About tobacco use
- **Advise:** Encourage to quit
- **Assess:** Evaluate readiness
- **Assist:** Help to quit or reduce or refer to other services
- **Arrange:** Follow up support, policy advocacy

You can make a difference. It's time to establish a new standard of care by asking all patients about their tobacco use. By having all health care practitioners working together and delivering smoking cessation, more patients will be encouraged to quit.

About the TEACH Project:

The TEACH Project offers courses for health care practitioners interested in delivering smoking cessation. The TEACH Certificate program is often attended by dental professionals and offers a great opportunity to learn more about smoking and smoking cessation. In the past, TEACH has also offered a dental specific webinar series related to smoking. For more information, please visit the TEACH website at www.teachproject.ca under Certificate Program and under Dental Webinar Series.

Q&A

Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anesthesia

Anne McFarlane

On October 17, 2013 the Canadian Institute for Health Information (CIHI) released a report titled Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anesthesia. The study found that day surgery operations performed to treat cavities (due to caries) in preschoolers accounts for about one-third of all day surgery operations for preschoolers. Each year roughly 19,000 children have dental surgery. For these kids, their condition has progressed to such an extent that their dental care occurs as day surgery, almost exclusively under general anesthesia, and they are under for an average of 82 minutes.

What did we study?

The report focuses on day surgery for Early Childhood Caries (ECC) among preschoolers that were provided by hospitals and health authorities. Children who had their surgery in dentists' offices or community clinics were not included.

Why just hospitals and health authorities?

This report is limited to day surgery treatment for ECC provided by hospitals and health authorities because CIHI has comprehensive data on all day surgery operations provided by hospitals and health authorities. In some jurisdictions (British Columbia, Alberta and Saskatchewan), health authorities contract with private clinics to perform day surgery for ECC. So, this report includes some clinic data from some jurisdictions. The values in the report are restricted to private clinics contracted by health authorities. They do not include procedures performed in non-contracted private clinics, dentists' offices or other sites. Children on waiting lists for ECC-related day surgery are also not captured in these analyses.

Why just day surgery?

Day surgery refers to patients who receive surgery, but who do not require being admitted to an acute care facility for an overnight stay. Virtually all surgery for preschoolers with ECC occurs as day surgery. Inpatient surgery for ECC accounted for less 0.01% of all surgery for ECC among preschoolers.

Why was the term ECC used rather than Severe ECC?

The disease of ECC is the presence of one or more decayed, missing (due to caries) or filled tooth surfaces in any primary tooth in a preschool-aged child. A more serious form of the disease, severe ECC, is defined by age and the extent of disease. In children younger than 3 years, any sign of smooth-surface caries is indicative of severe ECC. From ages 3 to 5, one or more cavitated, missing (due to caries) or filled smooth surface in primary maxillary anterior teeth or a decayed, missing or filled score of 4 or more (age 3), 5 or more (age 4) or 6 or more (age 5) surfaces constitutes severe ECC.

Data was not available to report specifically on severe ECC. A total count of procedures performed during surgery could not be calculated because the hospital record indicates only that a particular procedure occurred, not the total number of each procedure that was performed. For example, if, according to the record, fillings were performed during surgery, there is no indication of the number of fillings that were performed. However, information on the number of unique procedures and the length of time that children spent in the operating room was used to gauge the intensity of treatment.

- Overall, 53.8% of day surgery operations involved more than one type of procedure. The average length of time in the operating room for visits of this type was 83 minutes.
- Of the remaining 46.2% of day surgery operations involving a single type of procedure, visits involving only fillings predominated (90.4%). The average time in the operating room for visits where only fillings were performed (85 minutes) was nearly double that for visits where only extractions were performed (46 minutes).

Given the relatively lengthy treatment time, combined with the use of GA, it is reasonably concluded that this report profiles the extent of day surgery for serious cases of ECC being provided by hospitals and health authorities.

What aren't we counting?

This report does not estimate the prevalence of ECC among young children. Reported here are only day surgery operations for those children cared for by hospitals and health authorities. In some jurisdictions, ECC is treated in the community. Children on waiting lists for ECC-related day surgery are also not captured in these analyses. Therefore, in terms of estimating the prevalence of interventions for ECC, the report, in effect, identifies the tip of the iceberg—those undergoing day surgery for ECC. Continued on page 12...

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What did we find?

This report profiles the extent of day surgery for serious cases of ECC being provided by hospitals and health authorities and provides details on the following aspects of such care among young children:

- The magnitude of the problem—numbers and rates by province, territory and health region;
- The identification of populations at higher risk;
- and Costs associated with care.

The Magnitude of the Problem:

Cavities and tooth decay are highly preventable and yet thousands of young children require day surgery to treat them each year.

- Each year, 19,000 day surgery operations are performed to treat cavities (due to caries) among children younger than age 6.
- These operations to fill or treat cavities and extract teeth last an average of 82 minutes, and were almost always conducted under general anesthesia (99%).
- Day surgery for ECC constituted 31% of all day surgery for children age 1 to younger than 5, making it the leading cause of day surgery for children this age.

Populations at Higher Risk:

Children from areas with large Aboriginal populations were more likely to require dental surgery, as were kids from lower-income or rural neighbourhoods.

- Preschoolers from areas with high aboriginal populations (compared to areas with low ones) were almost 9 times as likely to need dental surgery
- Preschoolers from lower-income neighbourhoods were almost 4 times as likely to need to surgery compared to kids from high-income areas
- Preschoolers from rural areas were more than 3 times a likely than kids from urban areas

The Costs:

The operations cost over $21 million a year, not including payments to dentists or anesthesiologist, or the cost of travel.

- The average hospital cost per surgery ranged from $1,271 in New Brunswick to $1,963 in Alberta.
- Among the four western provinces, the average anesthesia cost per surgery ranged from $240 in Manitoba to $361 in Saskatchewan.
- In more than one in five ECC day surgery visits (22.3%), families travelled two or more hours for care.

Where can the full reports be found?

The full reports, as well as supporting material (Excel tables, PowerPoint presentation, and 1-page summary) are available at www.cihi.ca.

Author Information: Anne McFarlane serves as Vice President, Western Canada and Development Initiatives. Anne leads work with stakeholders in the four western provinces and the three territories to assist CIHI in understanding and responding to the needs of the west and the territories. This work includes the identification of emerging data needs, development of analytic studies and indicators of importance to the west and support to stakeholders engaged in providing data to CIHI.

About the Canadian Institute for Health Information (CIHI): CIHI collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

Acknowledgements: CIHI is grateful for the contributions of the clinicians on the Expert Panel who shared their knowledge and expertise throughout the conduct of the study and the reporting of findings: Dr. Robert Barsky, Fellow in Pediatric Dentistry, Royal College of Dentists of Canada; Dr. Carlos Quiñonez, Assistant Professor and Program Director, Dental Public Health, Faculty of Dentistry, University of Toronto; Dr. Bob Schroth, Assistant Professor, Department of Preventive Dental Science (Faculty of Dentistry) and Department of Pediatrics and Child Health (Faculty of Medicine), University of Manitoba; and Research Scientist, Manitoba Institute of Child Health; Dr. Luke Shwart, Provincial Dental Public Health Officer, Alberta Health Services

National Collaborating Centre for Methods and Tools

Centre de collaboration nationale des méthodes et outils

What Does the Research Say?

Jeannie Mackintosh

Time saving resources to help you find and interpret evidence:

The National Collaborating Centre for Methods and Tools was pleased to participate in this year's CAPHD national conference in Toronto. The presentations were interesting and informative. Dr. Amir Azarpazhooh spoke about the need to use research evidence when making decisions about oral health. But he also issued a caution, reminding delegates of the need to seek out the most synthesised research evidence first. The NCCMT agrees with this principle. In fact, we have developed a number of resources that will help you find synthesized evidence and assess the quality of the evidence you find.

The ability to find high quality and relevant information as quickly as possible is essential in public health, especially when human and financial resources are stretched. Efficient searching is an acquired skill. The good news is that searching will be much easier thanks to new resources from the NCCMT which include: 1) an online learning module focused on searching and 2) a suite of online tools to support and structure your search.

Dr. Azarpazhooh suggested starting your search for research evidence by going to the Cochrane Library and looking for systematic reviews and meta-analyses. As he noted, reviews incorporate the results of many individual studies and represent a significant amount of work. By seeking out reviews you are able to take advantage of a large search and screening process, and the breadth of skills and expertise brought by those who did the reviews.

We concur with Dr. Azarpazhooh's recommendations. At the NCCMT, we have developed resources based on a hierarchy of evidence that can help you quickly find the best evidence to support your program or policy decisions:

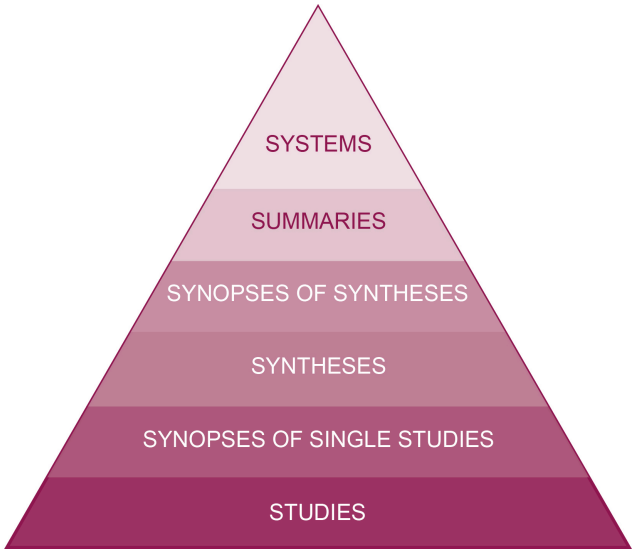

Figure 1- the 6S Pyramid

The structure of our online module Searching for Research Evidence in Public Health follows the hierarchy outlined in the 6S Pyramid1, starting with the most highly processed research evidence at the top of the pyramid. This may include, for example, summaries of systematic reviews, in which the results of primary studies related to a particular question are critically appraised and their implications for public health practice and policy are highlighted. The Searching module details strategies to find research evidence at each level along the way, from Systems down to single research Studies. (See Figure 1 - the 6S Pyramid.)

Search Pyramids are stand-alone tools designed to help you quickly find the best available research evidence to answer your focused public health question. The NCCMT developed the Search Pyramids with the help of a health librarian who has expertise in evidence-informed practice. The Search Pyramids also follow the 6S Pyramid, encouraging you to start with pre-appraised evidence before looking for individual primary studies. The NCCMT is so confident that these tools will speed up your search process that we challenge you to find the best available evidence to answer your question in five minutes or less.

Continued on page 14...

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A general Search Pyramid can be found in the Evidence-Informed Public Health section of NCCMT's website and in the Learning Centre. Topic-specific Search Pyramids are available by logging into the Learning Centre. They focus on resources that contain research evidence on six key topic areas identified by public health professionals as high priorities:

- environmental health
- injury prevention
- health communication and social media
- healthy habits (eating, weight and physical activity) for children
- healthy habits (eating, weight and physical activity) for adults
- mental health

Each Search Pyramid includes live links to freely available (no subscription required) databases to help you find answers to your public health questions.You can also customize a pyramid to include links to your favourite sources for research evidence related to your question.

If you are able to find a meta-analysis to inform your decision, you may need to read a forest plot: a diagram that represents the aggregated results of a systematic review. Dr. Azarpazhooh acknowledged that these diagrams can seem intimidating and gave conference delegates a brief demonstration of how to interpret a forest plot. For another quick refresher, watch the NCCMT's video How to Read a Forest Plot in 5 Minutes or Less, one in our growing series of short Understanding Research Evidence videos.

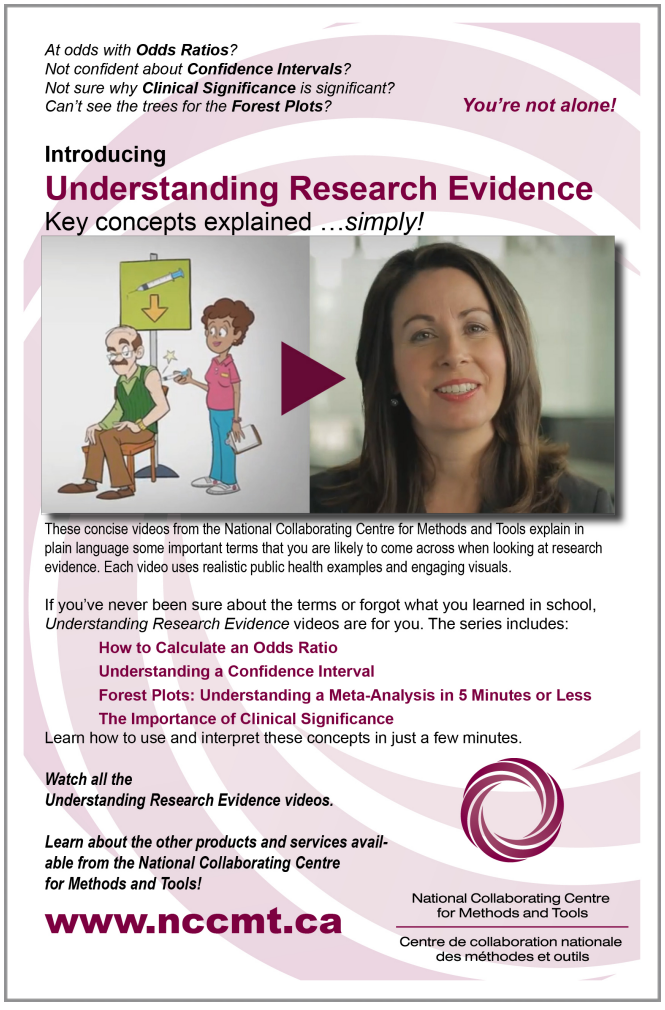
By seeking out the most highly-synthesized research evidence available and then critically appraising the evidence you find, you can be assured that you will be informed to make the best possible program and policy decisions for your population
In the Spring 2013 issue of Mosaic, NCCMT's article (page 11) spoke to the importance of being a critical consumer of evidence.

Additional information and resources on the critical appraisal of research evidence are available on the NCCMT website. Remember, NCCMT's Learning Centre includes online modules to help you critically appraise both individual research studies and systematic reviews. In the near future, we will be adding a module that takes learners through the process of critically appraising qualitative research.

Like all products and services available from the National Collaborating Centre for Methods and Tools, these online resources are free and available in both English and French.

References:

1. Dicenso, A., Bayley, L., & Haynes, R. B. (2009a). Accessing pre-appraised evidence: fine-tuning the 5S model into a 6S model. Evidence-Based Nursing, 12(4), 99-101.



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 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*

MARCH
- March 1- deadline for April Mosaic Submissions.
- March 31- Renew your CAPHD membership by this date.

APRIL
- Mosaic Newsletter Spring Issue
- Dental Health Month

SEPTEMBER
- CAPHD Scientific Conference & AGM in Saskatoon, Saskatchewan- *stay tuned for the dates*

OCTOBER
- October 1- Deadline for Mosaic Submissions

NOVEMBER
- Mosaic Newsletter Winter Issue

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NEWSLETTER COMMITTEE:

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