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Mosaic

Canadian Association of Public Health Dentistry

IN THIS ISSUE

Building Collaboration to Meet the Oral Health Needs of Canadian Children - A Pediatrician's Perspective

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Dental care has historically been dissociated from health care in Canada. Because oral health is integral to overall health, services and programs for dental care should be held to the same standards of accessibility, universality, and comprehensiveness as other responsibilities under the Canadian Health Act. Canadian children continue to have a high rate of dental disease, and this burden of illness is disproportionately represented by children of lower socio-economic status, those in Aboriginal communities, new immigrants and children with special needs (1). Not coincidently, these same vulnerable groups struggle with access to care and have higher health morbidity overall.

As a pediatrician who provides care to children in both outpatient and inpatient capacities, my interaction with the dental system is limited to: i) providing anticipatory guidance about oral health to parents, ii) identifying significant dental disease in children, iii) caring for children admitted to hospital with acute complications of dental infections, and iv) providing pediatric consultation for those children requiring dental restoration under general anesthesia (the most common surgical outpatient procedure in preschool children at pediatric hospitals in Canada) (2). The latter three roles seem especially unfortunate, as they reflect a failure of our system, as it currently exists, to meet the oral health needs of the child.

Many groups have called for better integration of the dental and medical care systems (1,3,4). Integration of oral health promotion into general health care has also been highly recommended by the World Health Organization (5). Dental disease is the most common chronic disease of childhood; the common risk factor approach for chronic disease calls for multi-professional collaboration. Thus, oral health promotion is needed within the health care practices of pediatric primary care providers.

In Canada, general practitioners, pediatricians and nurse practitioners provide primary health care to children, in a variety of environments including offices, hospital settings, and community health centres. Contact with a primary health care provider typically occurs earlier than a child's first visit to the dentist.

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Though the Canadian Dental Association recommends children see a dentist at age one, or within six months of tooth eruption, less than 1% of a sample of Canadian children had seen a dentist by age one, and only 40% by age 4 years (6). Given the high prevalence of decay seen in preschool children, prevention efforts need to start before children enter school. Primary care providers see children at least eight times before the age of five for growth assessments, developmental surveillance, and immunizations, and thus providing multiple opportunities to provide oral health anticipatory guidance and preventive intervention to parents and children at regularly scheduled visits. (The Canadian Rourke Baby Record, last updated in 2014, provides an age-specific evidence-based health supervision guide to primary health care providers for this surveillance. Consistent with CDA recommendations, the Rourke Baby Record recommends the first dental visit be discussed at the 9-month old visit (7).

Most pediatricians believe that they have an important role to play in children's oral health (8,9). However, lack of up-to-date information and knowledge, as well as the difficulty pediatricians experience in referring patients for professional pediatric dental care, are frequently cited barriers to their effectiveness. Further, a Canadian survey found that nearly one-quarter of pediatricians and family physicians said they received no oral health training in medical school or residency (9). Promoting the inclusion of relevant oral health and oral health care training in non-dental training programs, such as medicine and nursing is a necessity.

Primary health care providers must be knowledgeable about dental cariology and prevention, be able to identify children at high risk for dental disease, provide anticipatory guidance to families, and must have access to a dependable and established referral pattern to a dentist for specialist care. Child health care providers also have a role in advocating for more publically- delivered pediatric dental programs in Canada – programs whose comprehensiveness currently varies significantly among provinces and territories (10). The Canadian Paediatric Society (CPS) has published two position statements, advocating for more comprehensive and accessible dental health policy for children and youth (11,12). The CPS also has an Oral Health Section within its organization, with the goal of promoting the importance of oral health in pediatric care and well-being.

There are statements on preventive oral health intervention and anticipatory guidance to help pediatric primary care providers (13,14), as well as oral health educational curriculum directed at non-dental health care professionals (15).

Despite frequent appeals for integrated and more efficient systems of delivering oral health care to children (1,3,4), there remains a paucity of Canadian examples (16). American and European programs have shown success in integrating oral health care with health and social services (17,18).

The U.S. Department of Health and Human Services issued a recent report and its recommendations for the design of an interprofessional practice model to integrate oral health and primary care (19). Further, in May 2014, the U.S. Prevention Task Force released their recommendation that primary care should apply fluoride varnish to all children starting with the first baby tooth (20). Though common in Europe and the United States, in Canada, fluoride varnish is rarely applied in primary care settings, despite evidence of its efficacy in preventing caries, especially in high-risk groups (21,22).

We all share a common goal: to deliver evidence-based, high quality, preventive and treatment-based oral health care to all Canadian children in an efficient manner. The status quo – with the current organization of dental and other health care professions - does not meet the oral health needs of all Canadian children (1,4,11). Oral health care needs to be addressed with a multi-professional approach and should be integrated into comprehensive health-promoting strategies and practices and expanded to include a variety of delivery sites. Pediatric primary care providers can play a major role in preventing oral disease when equipped with an understanding of the core diseases and evidence-based guidelines for preventive intervention.

Leadership is needed in pediatric oral health policy development at provincial/territorial and federal levels to develop a collaborative, efficient and effective model of oral health care delivery. We need concerted professional, government and community action now so that young Canadians get the dental health care they need.

It's time to work together. *..references on page 3...*

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- Improving Access and Provision of Preventive Oral Health Care for Very Young, Poor, and Low-Income Children Through a New Interdisciplinary Partnership. http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302486
- North Carolina Physician-Based Preventive Oral Health Services Improve Access And Use Among Young Medicaid Enrollees http://content.healthaffairs.org/content/33/12/2144.short
- An early oral health care program starting during pregnancy—a long-term study—phase V http://link.springer.com/article/10.1007/s00784-013-1059-3

President's Message

Carlos Quiñonez, DMD, MSc, PhD, FRCDC

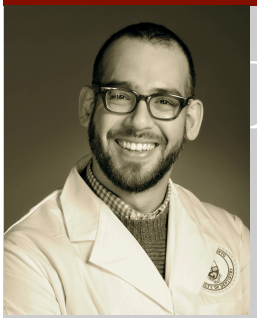
Oral Health and Primary Care

"Oral health in primary care" is the theme of this year's CAPHD conference on September 25th and 26th in Toronto, Ontario. We are partnering with the Ontario Association of Public Health Dentistry and the Faculty of Dentistry, University of Toronto's Murray Hunt-James Leake Lectureship. The lecture will feature two prominent clinician researchers from the U.S., Drs. Rocio Quiñonez and Hugh Silk. Dr. Quiñonez is a paediatric dentist and Dr. Silk is a primary care physician who have championed the place of oral health in primary care settings. They both recognize that if we are to improve population oral health and decrease differences in health between rich and poor, we will need to do things differently. We will need to reach children and their mothers earlier than is currently done in primary dental care practice, and provide services to socially marginalized adults and seniors in integrated health and social services environments.

The research supports this as well. We now understand that primary care providers can deliver oral disease prevention therapies (e.g. fluoride varnish) in a safe, effective, and cost-effective manner. We now understand that there are efficiencies to be gained by managing oral disease in medical environments, and that stewarding the care pathway to a dental home while providing health coaching can work. In short, these innovations have the potential to improve people's oral health and reduce costs to payers, whether individuals, employers, and/or governments.

There is now heightened policy and advocacy activities in these areas in Canada as well. For example, the Canadian Oral Health Roundtable, hosted by the Canadian Dental Association and made up of public and private stakeholders, including the CAPHD, is working to develop a position statement on standards of care in long-term care and how to best move forward on the oral health and primary care agenda. The CAPHD is proud to engage in these conversations, and is glad that the general Canadian oral health, health, and social services communities are now thinking in ways that we have appreciated and championed for many years.

So, please join us in Toronto to continue to champion the place of oral health in primary care. And to you, for being pioneers in this area, keep up the great work!



Message du Président

Carlos Quiñonez, DMD, MSc, PhD, FRCDC

La santé buccodentaire dans les soins primaires

«La santé buccodentaire dans les soins primaires» est le thème de la conférence de l'Association canadienne pour la santé dentaire publique (ACSDP) de cette année, les 25 et 26 septembre à Toronto, en Ontario. Nous travaillons en partenariat avec l'Association ontarienne de santé dentaire publique ainsi que la Faculté de médecine dentaire, Murray Hunt-James Leake Lectureship de l'Université de Toronto. La conférence mettra en vedette deux éminents chercheurs cliniciens des États-Unis, les docteurs Rocio Quiñonez et Hugh Soie. Dr Quiñonez est une dentiste pédiatrique et le Dr Soie est un médecin en soins primaires. Les deux ont été d'ardents défenseurs de la place de la santé buccodentaire dans les établissements de soins primaires. Ils reconnaissent tous deux que si nous voulons améliorer la santé buccodentaire des populations et diminuer également les différences en matière de santé entre riches et pauvres, nous devons faire les choses différemment. Nous devons être en mesure de rejoindre les enfants et leurs mères plus tôt que cela se fait actuellement dans la pratique des soins dentaires primaires, ainsi que de fournir des services aux adultes et aux personnes âgées socialement marginalisés dans des environnements de santé et de services sociaux où les soins sont intégrés.

Cette manière de faire est également supportée par la recherche. Nous savons maintenant que les fournisseurs de soins primaires peuvent fournir des thérapies de prévention des maladies buccodentaires (par exemple, l'application de vernis fluorés) de manière sécuritaire, efficace et rentable. Nous comprenons également qu'il y a des gains d'efficacité quant à la gestion des maladies buccodentaires dans des environnements médicaux, et que la coordination des soins en milieu dentaire tout en fournissant du support peut fonctionner. En bref, ces innovations ont le potentiel d'améliorer la santé buccodentaire de la population et de réduire les coûts pour les contribuables, soit les individus eux-mêmes, les employeurs et / ou les gouvernements.

Il existe maintenant des politiques et des activités de plaidoyer dans ces domaines au Canada. Par exemple, la Table ronde canadienne sur la santé buccodentaire, organisé par l'Association dentaire canadienne et composée d'acteurs publics et privés, y compris l'ACSDP, travaille à l'élaboration d'un énoncé de position sur les normes de soins dans les établissement de soins de longue durée ainsi comment mettre de l'avant la mise en œuvre de l'intégration de la santé buccodentaire dans les soins primaires. L'ACSDP est fier de participer à ces conversations, et nous sommes heureux que la communauté dentaire, de la santé en générale et des services sociaux partage la même vision que nous croyons cruciales depuis déjà plusieurs années.

Alors, s'il vous plaît vous joindre à nous à Toronto pour continuer à défendre la place de la santé buccodentaire dans les soins primaires. Et pour vous, qui êtes des pionniers dans ce domaine, continuez votre excellent travail!

The Integration of Oral Health in Primary Care: Interdisciplinary Research Initiative

Elham Emami, Associate professor
Faculty of Dentistry and School of Public Health
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Primary care is defined as "a set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive and palliative services" (1).

Primary care is the mainstream of any robust health care system as it leads to better health outcomes and lower health care expenditure (2, 3). The primary care concept encourages bringing together health professionals from different disciplines and sectors to improve service efficiency, quality of health services and thus to reduce differences in access and utilization of services between geographical and socio-economic groups (4). However, in most Canadian provinces, the dental workforce is not present in community primary health care systems because of the lack of public-private partnership (5, 6).

Historically, the private sector has been responsible for providing oral health care service. This mode of service does not ensure equity in oral health care and services, mainly because of two factors: high costs of dental care and the shortage of dentists offering services to vulnerable and disadvantaged communities (7,8). Moreover, demographic changes including the aging of the population, a growing immigrant population, as well as economic compression and the increasing cost of dental care necessitate managing shared care networks (9-18).

Integrated care models emphasize the importance of providing services that meet the needs of people with multiple health and social problems (19,23). There is thus a need for models that provide better access to oral health care through multi/interdisciplinary care. The integration of dental care into primary care and services would be a potential approach to creating opportunities for the dental workforce to become more involved in community-based practice and to assume shared responsibility with health care professionals to address the unmet oral health needs of those experiencing vulnerability and marginalization (24-26).

Rooted in the Alma-Ata Declaration, the Primary Oral Health Care (POHC) approach has been recognized as a promising solution for the challenges of dental service provision, especially with rural, remote and Aboriginal communities (24-27). The POHC approach puts emphasis on prevention, community involvement, local leadership and a multisectorial approach to address equity, population-centred service delivery, governance and public policy (2).

During the last decade, a number of oral health integrated primary health care models have emerged worldwide to address these challenges and WHO policies give priority to this approach (24-26). However, the concept of integrating oral health into primary care is still unclear and hampered by a lack of systematic understanding.

Therefore, it is our responsibility as the oral health research communities, educators and dental health care providers to start breaking the boundaries of dental workforce and primary care and provide a springboard toward this initiative. *...continued on page 7...*

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To this end, Dr Emami, CIHR Clinician Scientist at Université de Montréal, in collaboration with Dr Couturier, Canada Research Chair in Professional Integration Practices of Gerontology Services at Université de Sherbrooke, have put together an interdisciplinary team of researchers from different disciplines, clinicians, policy makers and stakeholders and started a series of research activities and research training to facilitate the implementation of innovative models of care that meet the oral health needs of people with complex health and social problems.

The research team along with their PhD student, Mrs Hermina Harnagea, at the School of Public Health at Univeristé de Montréal are presently working on a CIHR-funded project to synthesize a conceptual and theoretical paradigm of oral health integrated primary care. The team are also collecting data on the perspectives of primary care providers on the integration of oral health in public sectors in rural and urban settings to foster mutual understanding across major stakeholders. The knowledge gained through these projects will be an evidence-based synthesis of components of oral health integrated primary care and its effectiveness. This evidence can provide insight on barriers and facilitators and will be transferred to appropriate knowledge users to enhance policy decisions and practice change through encouraging collaboration. Eventually, the research team aims to examine the impact of the primary oral health care approach on prevention of oral diseases such as caries in high-risk populations such as rural, remote and Aboriginal communities, frail seniors, new immigrants and those with low socio-economic status.

Dr. Emami and her research team are looking forward for creating a primary oral health care research network and would like to take the opportunity to invite those who are interested in this collaborative effort to join us in this lead.

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(Previous articles introduced the process of evidence-informed public health, a second focused on searching and a third or critical appraisal of research evidence. This article focuses on the synthesize phase, where you are required to make a decision about which of a number of potentially articles you will utilize in making program decisions.)

Evidence-informed Decision Making in Public Health in Action: Synthesizing the Evidence

Donna Ciliska, RN, PHD

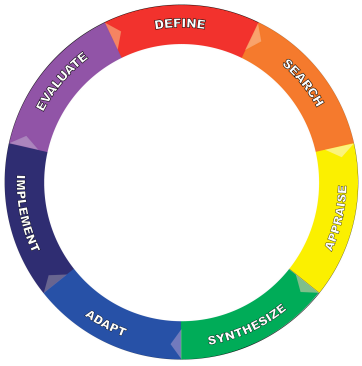
Professor in the School of Nursing at McMaster University and a Senior Knowledge Translation Advisor with the National Collaborating Centre for Methods and Tools

Scenario:

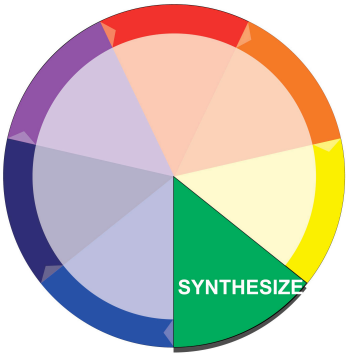
You have been asked to join a team of health professionals from your community to look at ways to improve primary care of people with diabetes mellitus. You know that there is a relationship between oral health and diabetes, but you are not sure if treating periodontal disease actually affects indicators of diabetes control like HbA1c. The librarian has found several relevant systematic reviews. However, the conclusions range from: Review #1 -no evidence that treatment makes a difference, Reviews #2 - evidence that treatment makes no difference, Review #3 - evidence that treatment is effective, to Review #4that shows that treatment results in a statistically significant reduction in HbA1c, but the effect is so small as to not be considered clinically relevant. How do you make sense of these disparate results? Which review do you believe?

What is evidence-informed public health?

Evidence-Informed Public Health (EIPH) is the process of distilling and disseminating the best available evidence from research, context and experience, and using that evidence to inform and improve public health practice and policy. Put simply, it means finding, using and sharing what works in public health. The National Collaborating Centre for Methods and Tools (NCCMT) recommends a seven-step process of EIPH (NCCMT 2012). Previous articles in this series have highlighted the entire process, and the individual steps: search and appraise. This article will highlight the synthesize step.



Synthesize "What does the research evidence tell me about the issue?"



At this step of the EIPH process, you have clearly stated the problem, had an efficient search starting at higher levels of the search pyramid, done the critical appraisal and now need to decipher the 'actionable message' (i.e., clear recommendations or actions for practice) from the research evidence that you have reviewed. Recommendations should be informed by the highest quality and most synthesized research evidence available. You should also consider how your recommendations fit with your population and with the resources you have available. In our hypothetical scenario, there are multiple relevant reports on the same topic at the same level on the 6S Pyramid (e.g., four systematic reviews) but with conflicting conclusions. Which review do you believe? There is a big temptation to choose the one that fits your personal beliefs; however, in EIPH, you need to consider some criteria for making the decision: the results of the critical appraisal you did in the previous step, how current the reviews are, how well the study participants of each review match your population, and the resources required to carry out the interventions of each review.

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For a systematic review, you need to consider two dates: when the review was published and when the search within that review was conducted. For example, suppose the search for one review ended in 2009, and the other one ended in 2014. The number of additional studies published since the 2009 search ended could conceivably alter the conclusions regarding treatment. However, in this hypothetical example, the searches of all four systematic reviews ended in early 2014. You then consider those reviews with the highest methodological quality. As stated, you have done the critical appraisal of the reviews with an acceptable tool (see NCCMT's module on Critical Appraisal of Systematic Reviews). You would consider only the highest quality reviews.

For this hypothetical example, Review #3 concludes that periodontal diseases makes a statistically significant difference to HbA1c; it also rated as strong on the critical appraisal tool, and the other three are weak. You then have to consider if the difference in findings is meaningful; that is, findings can be statistically significant, but of such small values as to be unimportant, and not worth the cost to the health care system and patients or populations. (See NCCMT's video The Importance of Clinical Significance for more on this concept.)

If you decide that the treatment effect is a meaningful improvement, you would then look at the intervention costs (in this case, related to frequency/intensity), potential harms and the appropriateness of the intervention for your population (Will people likely to accept the level of treatment frequency/intensity? Are they likely to have insurance coverage for the treatment?). After all these considerations, you can make a decision regarding which review is the most recent, highest quality and best fit with your patient population. You can then use the results of that review to create an "actionable message" – for example, to recommend (or not) oral care of patients with diabetes mellitus every six months by a dentist or hygienist. (NCCMT's video Evidence-Informed Decision Making: a guiding framework for public health illustrates why not all evidence-informed decisions reach the same conclusions.)

Conclusion and additional support

Public health professionals make decisions every day, and often when there is conflicting research evidence. The synthesize step of EIPH gives direction for how to set priorities among those conflicting studies, using recency, quality, size of the effect, resources required for the intervention and fit with your population.

The National Collaborating Centre for Methods and Tools is committed to helping public health professionals find and use the best available evidence to inform their practice and policy decisions. Create an account with NCCMT. Watch for the NCCMT Weekly Round-up to hear about upcoming events and new resources as they become available. All the products on the NCCMT website are available in both English and French.

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Primary Care and the Role of Dental Hygienists

Ms. Paula Benbow, RDH, MPH
Manager of Health Policy, Canadian Dental Hygienists Association

Primary Care and Dental Hygiene

Health Canada defines primary health care as "an approach to health and a spectrum of services beyond the traditional health care system. Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury." (1) Starfield defines primary care as being person-focused, rather than disease-oriented, care that is provided over time. (2)

As members of the sixth largest registered health profession in Canada, dental hygienists are dedicated to maintaining and improving the oral health and overall health of Canadians through a variety of health promotion and disease prevention strategies. Not only do they provide preventive services, such as debridement, tooth sealants, and fluoride applications, but they also assess individuals for oral mucosal lesions, and are committed to facilitating behavioural change through tobacco cessation and nutritional counselling. As primary health care providers, Canada's 26,800 dental hygienists play a key role in coordinating care for their clients and integrating their care with the rest of the health system, making and following up on appropriate referrals to other health care providers and services. Their efforts are aimed at the prevention, management, and treatment of disease in order to check the development of more serious health problems.

Barriers to Primary Care

The CDHA Service Codes provide a comprehensive list of services that dental hygienists can perform in various regions of the country. (3) It is clear, however, that barriers still prevent dental hygienists from working as primary health care providers in all jurisdictions. For example, while many provinces permit dental hygienists to practise independently, without the direct supervision of another health care provider, there are supervision requirements for dental hygienists who practise in Quebec, Prince Edward Island, and in the North. (4–7) These supervision requirements reflect outdated social, legislative, and regulatory principles, which in turn hinder the optimization of health and human resources.

Another barrier to equitable oral health care in Canada is the fact that not all publicly funded health care programs recognize dental hygienists as primary health care providers. For example, because the federal government's Non-Insured Health Benefits (NIHB) program for First Nations and Inuit peoples does not consider dental hygienists to be primary health care providers, access to oral health services is severely restricted in Canada's most rural and remote regions. Many dental hygienists who live on or near First Nations communities are prevented from providing much-needed oral care because of this administrative lacuna.

Why is this a concern?

Access to oral health care is a significant issue for many at-risk populations in Canada, such as Indigenous Peoples and older adults in long term care. Evidence indicates that First Nations, Inuit, and Métis peoples experience unacceptably high rates of oral disease. Compared to the general population, more Inuit report poor oral health, food avoidance, and oral pain. (8) Day surgery rates for early childhood caries are 8.6 times higher for children living in neighbourhoods with high Aboriginal populations, than for those living in largely non-Aboriginal communities. (9) In many cases, children are flown out of northern communities to be treated under general anesthetic for extractions and fillings in hospitals—a situation that is unacceptable in a developed nation. Most oral diseases can be prevented through less costly and more sustainable strategies.

Oral health disparities cannot be attributed to shortages in human health resources in Canada as a whole. (10) Between 2000 and 2010, the number of dental professionals increased by 35%, with a significant rise in the number of dental hygienists (61%) in particular. (10) If dental hygienists had the ability to practise independently in northern, remote communities, and if dental hygienists were recognized as service providers by publicly funded programs (e.g., NIHB), a more proactive and upstream preventive approach to oral health care could be adopted.

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How to overcome these barriers:

Canada's changing demographics have already begun to challenge the health care system in this country. New and innovative service delivery models are clearly required to respond to the evolving needs of the public. It is time to embrace a multidisciplinary approach to managing the overall health needs of Canadians, one that recognizes dental hygienists as primary health care providers in all jurisdictions and reimbursement models (e.g., dental hygienists recognized as service providers for dental coverage programs).

The dental hygiene profession continues to evolve and pave new paths. In order for dental hygienists to respond effectively to the needs of the public, legislative restrictions and barriers must be removed. (11) A new health delivery model, with a strong collaborative and interdisciplinary base, will ensure that the right professional provides the highest quality care in the right setting and at the right time based on the needs of the individual. (12) The ultimate goal is for an equitable and sustainable system that delivers safe, effective, and efficient care to the public. The time for all stakeholders to act is now.

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Opportunities for oral health research: Pathways to Health Equity for Aboriginal Peoples

Nicole Szajcz-Keller and Christine Mazur
CIHR Institute of Musculoskeletal Health and Arthritis

The Canadian Institutes of Health Research (CIHR) developed the Signature Initiative of Pathways to Health Equity for Aboriginal Peoples (Pathways) to address the numerous well-documented health inequities existing between Aboriginal and non-Aboriginal peoples in Canada.[1,2] The key objectives of this initiative are to: seek ways to understand how to implement multilevel and scalable interventions to reduce health inequities facing Aboriginal People; improve the health of Aboriginal peoples through adaptation and use of the interventions; improve understanding of how to reduce health inequities and how knowledge can be adapted and applied to other populations and in other contexts; and increase research capacity in implementation science related to the health of Aboriginal Peoples and other vulnerable populations.[3] The four priority areas in which Pathways will address health inequities are: suicide prevention, tuberculosis, diabetes/obesity and oral health. Mention of the Pathways initiative was first made in the Mosaic Spring 2014 edition.

Since Pathways was launched in 2014, the Canadian Academy of Health Sciences (CAHS) published its comprehensive report *Improving access to oral health care for vulnerable people living in Canada*. This report further demonstrates the paramount need for addressing the evident inequities between health care for Canada's different populations. The report's core findings confirmed that:

• vulnerable groups living in Canada have both the highest level of oral health problems and the most difficulty accessing oral health care; and

• public and private oral health care systems in Canada are not effective in addressing these inequities.[4]

Pathways is co-led by the CIHR Institutes of Aboriginal People's Health (IAPH), Gender and Health (IGH), Musculoskeletal Health and Arthritis (IMHA), and Population and Public Health (IPPH).

Current Funded Oral Health Projects:

Overall, CIHR has made a $25M, 10-year commitment to Pathways, funding projects that to date include five operating grants in Population Health Intervention Research, two Applied Public Health Research Chairs, two team grants for Global Initiatives, three Aboriginal organizations as Partners for Engagement and Knowledge Exchange and eight Implementation Research Teams.[5] The following oral health project received an Implementation Research Team development grant in 2015:

Project Title: Tui'kn (Passage) to Oral Health: A community-led research partnership to improve oral health in Unama'ki

Principal Investigators: Mary E. McNally; Sharon E. Rudderham; Debbie H. Martin.

Affiliation: Dalhousie University (Nova Scotia)

ABSTRACT: For the past 10 years, the Tui'kn Partnership, a health-centered partnership comprised of the five Mi'kmaq First Nations communities of Unama'ki (Cape Breton), Nova Scotia, has been working to improve health and quality of life for its people. Very high rates of preventable hospital admissions for dental conditions have been discovered within the communities. This concerning data led the Tui'kn Partnership to engage with researchers to address this problem. Together, we plan to build a strong collaborative team that will use a "two-eyed seeing" approach to create solutions that will reduce oral disease and improve overall health for people living in Unama'ki First Nations.

Another oral health-related project's Letter of Intent in application for an Implementation Research Team Enhancement and Adaptation grant has proceeded to the full application process with anticipated notice of decision expected in January, 2016.

Pathways Annual Gathering

To mark progress and to meet and learn from researchers and community members supported through Pathways, CIHR hosted its Inaugural Pathways Annual Gathering from March 23rd to March 25th, 2015 in Ottawa. The Gathering brought together about 140 Pathways-funded researchers, their community partners, representatives from partner and Aboriginal organizations and CIHR staff.

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Participants took the opportunity to dialogue, exchange knowledge and begin developing meaningful relationships to support their work. Sessions included a panel on The Important Linkages Between Indigenous Ways of Knowing, Health Research and Health Outcomes. The objectives were to provide insight into distinct perspectives about Indigenous Ways of Knowing and traditional knowledge, and to support understanding and incorporating Indigenous Ways and methodologies within the work of the Pathways Initiative.

IMHA was pleased to host the Oral Health exemplar breakout session, which was attended by representatives from the oral health community including researchers, industry representatives, professional associations, government representatives and community representatives. Breakout discussions focused on the opportunities of primary importance in partnerships and health equity research.

Oral health applications are encouraged to the Population Health Intervention Research funding opportunity that will launch in spring 2015. Watch Research Net for more details.

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Member Profiles

CAPHD is proud of it's interdisciplinary membership and what members do to contribute to improving the oral health of Canadians!

Ms. Deborah Ball

Dental Therapist

Deborah Ball is a Dental Therapist who is employed by Health Canada, First Nations and Inuit Health Branch. Currently she provides dental services to five First Nation communities in the Atlantic Region in northern New Brunswick. Throughout her thirty one years of service, Deborah has provided services through out northern Manitoba, Nova Scotia and New Brunswick.

Deborah began her career in Dentistry in 1975 when she graduated from a dental assisting program and began working in a private practice in her hometown of Tillsonburg, Ontario. Realizing that she enjoyed Dentistry she began to look at other options and enrolled into the Dental Therapy program in Fort Smith, N.W.T . Graduating in 1982 she began practising in Manitoba and has now settled in the Miramichi area of New Brunswick.

Deborah's greatest interest has always been in addressing the high rates of early childhood caries in her First Nation communities. For the past 18 years, she has tackled this disease by providing educational sessions at prenatal classes, well baby clinics, Health Fairs and other community events. When Deborah first began in these communities almost every child was severely affected by dental decay and the majority required dental care in the hospital. The caries rate has now dropped dramatically in Deborah's communities and a lot of the children are caries free.

Deborah feels that working with the the First Nation children is a joy and no two days are ever the same. The biggest benefit of the Dental Therapy program that Deborah has instilled in her communities, is that it is a school based program and the children see the dental therapist as being a normal school staff member. This decreases the fear level greatly, and the children enjoy coming to the clinic on a daily basis.

Throughout Deborah's career she has volunteered for various committees with Health Canada producing educational materials. Some examples are the Family Violence Handbook for the Dental Community, Diabetes and Oral Health handouts and a teaching manual on Early Childhood Caries. Deborah has also mentored many Dental Therapists and Community Oral Health Aides.

Deborah now sees retirement on the horizon. Many people reflect back and wonder if they have made a difference. Deborah reflects back and knows that she has.

Dr. Alyssa Hayes

BDent (Hons), MSc, FRCD(C)

Dr. Alyssa Hayes will be the President of The Canadian Association of Public Health Dentistry in September 2015. She completed her dental training at the University of Sydney, Australia in 2006. She then accepted a position with the New South Wales (NSW) government as a Dental Officer working in rural NSW. During this time Dr. Hayes worked closely with dental therapists, dental assistants and students (both locally and foreign-trained) to deliver care to marginalized populations. After several years working in Australia she returned home to Canada to complete her Dental Public Health specialty training at the University of Toronto. Dr. Haye's research focused on the economic impacts of oral health and oral health care. After graduation she remained active in the Community Dental Health Services Research Unit (CDHRSU) in Toronto and was the Dental Consultant for the Regional Municipality of York before accepting a position as Assistant Professor in the College of Dentistry at the University of Saskatchewan. Dr. Hayes has volunteered on the CAPHD board of directors for the past year.

Register Today!

✦Learn the latest research in dental public health. ✦Explore best practices. ✦Get continuing education.
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Keynote Speakers:

Dr. Hugh Silk

MD, MPH, FAAFP

Associate Clinical Professor
Department of Family Medicine and Community Health
University of Massachusetts Medical School

Hugh Silk is an Associate Clinical Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School and Family Medicine Residency. He graduated from McMaster Medical School in Hamilton, Ontario, Canada and did his residency at University of Massachusetts Family Medicine Residency in Worcester. He is co-author of the award winning national curriculum on oral health for family medicine entitled "Smiles for Life" www.smilesforlifeoralhealth.org. He also sits on numerous state and national oral health advocacy committees including the American Dental Association's Public Health Advisory Committee for the Council on Access, Prevention and Inter-professional Relations. He Chairs the Committee on Oral Health at the Massachusetts Medical Society (which he also founded). He is currently working on a grant project with the MassLeague to inspire medical and dental departments in Federally Qualified Health Centers in Massachusetts to work cooperatively to address oral health in diabetic, pregnant and HIV patients. Clinically he works in the Correctional Health care system in MA.

Dr. Rocio Quiñonez

DMD, MS, MPH

Associate Professor
Departments of Pediatric Dentistry and Pediatric Medicine
Schools of Dentistry and Medicine
University of North Carolina at Chapel

Dr. Quiñonez earned her Bachelor of Arts Degree in Psychology/Zoology in 1992 and her Doctorate of Medical Dentistry in 1996 from the University of Manitoba. She earned her certificate in Pediatric Dentistry, Masters of Science, and Masters in Public Health and Administration at the University of North Carolina - Chapel Hill. Dr. Quiñonez proceeded to complete a NIH Fellowship in Oral and Systemic Diseases. Her academic and research interest include the interface between medicine and dentistry, perinatal and early childhood oral health, and economic analyses related to children's oral health. Dr. Quiñonez returned to full-time academics in 2006 and is currently the Director of the Pediatric Dentistry Pre-Doctoral Program, the Baby Oral Health Program and the Pediatric Dental Faculty Practice at UNC - Chapel Hill.

For more information or to register visit:
http://www.caphd.ca/professional-development/caphd-annual-conference

CAPHD Mosaic Newsletter Submission Guidelines

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

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

Due Dates:
Please submit by April 1st for the Spring newsletter and October 1st for the Autumn 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*

MAY
•Mosaic Newsletter Issue

•29th- deadline for CAPHD Annual Conference abstracts and Dr. James Leake Student Bursary

JUNE
•30th- deadline for CAPHD Life/ Honourary Membership applications and board member nominations

SEPTEMBER
•25th-26th CAPHD Scientific Conference & AGM

OCTOBER
•1st- Deadline for Mosaic Submissions

NOVEMBER
•Mosaic Newsletter

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