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EA of a dental prenatal program

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THE OFFICIAL JOURNAL OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

Express your excellence

Jacki Blatz,
RDH

Recently my family acquired a new computer. It is a Notepad, and loaded with Microsoft 2010 applications. When we turn it on a message comes up that says, *Express Your Excellence*.

The message reminds me of my responsibility as a citizen of the virtual world we now live in — that once we e-mail, blog, twitter, wiki or post content on Facebook, it all becomes public domain, and is there for the world to see.

The responsibility of excellence in communication is a personal choice. CDHA publishes a bimonthly journal, the *Canadian Journal of Dental Hygiene*, carefully reviewed by a panel of peers, and provides support for dental hygienists to be published in a recognized journal with a body of research. CDHA also maintains a website with information for the public and for members; the website allows opportunities for education, access to research papers, and also a gateway for dental hygienists to communicate with each other if they so choose.

Your membership dollars support the most recognized ***not for profit*** dental hygiene organization in Canada. It is in fact owned by you, the members. Your Board of Directors represent you as owners. The Executive Director directs the day to day operations of the association and is accountable to the Board of Directors, and to you, the owners.

I have thought a lot about our varied roles within the organization of the CDHA and our professional community over the past months. The one thing I know for sure is that the people who have the most knowledge, influence, and investment in the profession of dental hygiene are the dental hygienists.

At our Board of Directors meeting this summer, Dr. Peter Cooney honoured us with a presentation on the findings of the *National Oral Health Survey* that was released in May 2010. The statistics are interesting, and I have to say that his verbal discourse of the survey was outstanding.

The presentation not only reflected his professional investment in this huge project but also highlighted the opportunities for years to come for research, and what the research will mean for Canadians. Dr. Cooney reiterated my Notepad's maxim, *Express your excellence*.

This is my last *President's Message*. In October, Palmer Nelson, our current *President Elect*, will take over as President. I would like to thank Palmer Nelson in her current supporting role as *President Elect*. My thanks also goes to Wanda Fedora in her role as Past President for guidance through her own experiences and corporate knowledge. Bonnie Blank, a Past President and currently fulfilling

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Exprimez votre excellence

Récemment, ma famille se dotait d'un nouvel ordinateur, un Notepad muni des applications de Microsoft 2010. Quand il est ouvert il présente un message disant : Exprimez votre excellence.

Ce message éveille ma responsabilité de citoyenne du monde virtuel où nous prenons conscience de vivre – celui où, par Facebook, tout le contenu de nos courriels, twitters, wikis ou affiches tombe dans le domaine public et devient visible au monde entier.

La responsabilité de l'excellence en communication est un choix personnel. L'ACHD publie un journal bimestriel, le Journal canadien de l'hygiène dentaire, *revu minutieusement par un comité de pairs, et offre aux hygiénistes dentaires le soutien de se faire publier dans un journal reconnu avec son équipe de recherche. L'ACHD a maintenant un site Web diffusant de l'information au public et aux membres; le site donne accès à des possibilités de formation et à des comptes-rendus de recherche ainsi qu'une voie de communication aux collègues intéressées.*

Votre cotisation soutient l'organisation d'hygiène dentaire ***sans but lucratif*** *la plus reconnue au Canada. De fait, vous, les membres, en êtes les propriétaires. Votre Conseil d'administration vous représente à ce titre. La Directrice générale dirige les opérations quotidiennes de l'association et rend compte au Conseil d'administration, et à vous, les propriétaires.*

J'ai beaucoup réfléchi sur nos divers rôles au sein de l'organisation de l'ACHD et notre communauté professionnelle au cours des derniers mois. J'ai la certitude que les personnes qui ont le plus de connaissances, d'influence et d'investissement dans la profession de l'hygiène dentaire, ce sont les hygiénistes dentaires.

*À la réunion estivale de notre conseil d'administration, le Dr Peter Cooney nous a rendu hommage en présentant les résultats de l'*Étude nationale sur la santé buccodentaire *qui a été publiée au mois de mai 2010. Les statistiques sont intéressantes et je dois dire que les échanges oraux sur l'étude furent remarquables.*

L'exposé n'a pas seulement reflété son investissement professionnel dans cette immense projet mais il a aussi fait voir les opportunités des prochaines années pour la recherche et ce que celle-ci signifiera pour la population canadienne. Le Dr Cooney a repris la maxime de mon Notepad, Exprimez votre excellence.

Ceci est mon dernier Message *à titre de présidente. Parmer Nelson, l'actuelle* Présidente élue, *prendra la relève au mois d'octobre. J'aimerais remercier Palmer Nelson de son soutien dans son rôle de* Présidente élue. *Je remercie aussi la* Présidente sortante, *Wanda Fedora, de ses précieux conseils fruits de son expérience et de sa connaissance de la communauté. Bonnie Blank, ancienne présidente et actuellement directrice de la formation, complète son mandat. Merci, Bonnie, de ton dévouement, de ton soutien et du généreux travail que tu as accompli pour l'ACHD.*

L'excellence*! À lui seul, ce mot décrit notre profession à*

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Master your dental hygiene mojo

Ann E. Wright

Marshall Goldsmith is an executive coach, whose book,[1] *Mojo: How to get it, How to Keep It and How to Get it Back if You Lose It*, defines "mojo" as "positive spirit toward what you are doing now that starts on the inside and radiates to the outside". Increasingly, as work and life relationship becomes more intertwined, it is natural that we look at what work brings to each of us, and how it contributes to our happiness.

If you find yourself in a job or position you are not completely happy with, Goldsmith advises that you can change "*you*" or you can change "*it*".

Let's examine the four aspects of working on your "mojo".

1. **Identity:** Do you identify yourself as a dental hygienist when you meet new people? Do you tell people that you belong to a profession of over 21,000 Canadians? In the recent CDHA Board's survey, several dental hygienists shared their frustration with being confused with other dental office staff positions. They also expressed concerns that even though their own clients understood and appreciated their work, in general clients looked to the dentist for advice and guidance. This made them feel less valued. How might you change the office perceptions in this example? Are you referred to as a dental hygienist by the office staff? Do you wear a nametag with your name and designation, and do you have your own business cards? During treatment, inform your clients about specialized education, and experience you possess. Goldsmith suggests that if you try these types of techniques for a few days you will discover that you leave work feeling better about your identity.
2. **Achievement:** What is your work doing for you? Do you have regular "a-ha" moments? What defines a great day for you? Does this occur when your client tells you that this was the best hygiene visit he has experienced or when your employer asks you to share the highlights of a continuing professional development course you recently attended with the staff? "A-ha" moments can be as simple as the feeling you have when you are thanked for doing a good job or staying late to see a client. Do you in turn thank others, and pass "a-ha" moments forward?
3. **Reputation:** Goldsmith states that most of us are completely clueless about our reputation. He calls reputation "personal branding"—the perception that others hold of us. Personal branding is a conglomeration of our vision, mission, and key roles. If you see yourself as highly caring professional, do you ensure that you communicate this to your clients?

Maîtrisez votre *mojo* en hygiène dentaire

Dans son livre[1] *intitulé* Mojo : How to get it, How to Keep It and How to Get it Back if You Loose It, *Marshall Goldsmith, accompagnateur de gestionnaire, donne à l'expression africano-américaine «* mojo *» le sens d'un regard ou « esprit positif sur ce qu'on fait maintenant, qui part de l'intérieur et rayonne vers l'extérieur ». À mesure que le travail et les relations s'entrelacent, il devient de plus en plus naturel de regarder ce que le travail apporte à chacune de nous et comment cela contribue à notre bonheur.*

Si vous vous retrouvez dans un emploi ou un poste qui vous ne vous rend pas entièrement heureuse, Goldsmith vous conseille de changer « vous-même *» ou de changer «* de poste *».*

Examinons les quatre aspects sur lesquels travailler pour améliorer votre mojo.

1. ***L'identité :*** *Vous présentez-vous comme hygiéniste dentaire quand vous rencontrez de nouvelles personnes ? Leur dites-vous que vous faites partie d'une profession qui compte plus de 21 000 membres au Canada ? Dans les récentes études du Conseil de l'ACHD, plusieurs hygiénistes dentaires ont fait part de leur frustration de se voir confondues avec les autres membres du personnel du cabinet dentaire. Elles se disent aussi préoccupées de voir que, même s'ils comprennent et apprécient leur travail, leurs propres clients s'adressent au dentiste pour se faire conseiller ou guider. Elles se sentent moins estimées. Comment changer les perceptions en milieu de travail ? Le personnel du cabinet vous désigne-t-il comme hygiéniste dentaire ? Avez-vous un porte-nom désignant votre poste et avez-vous votre propre carte professionnelle ? Pendant le traitement, informez votre clientèle sur votre formation spécialisée et l'expérience acquise. Goldsmith suggère que, si vous essayez ces trois techniques pendant quelques jours, vous découvrirez qu'après le travail vous vous apprécierez mieux votre identité.*
2. ***Les réalisations :*** *Que vous rapporte votre travail ? Avez-vous régulièrement des moments de « a-ha » ? Comment se définit une bonne journée selon vous ? Est-ce lorsque la clientèle vous dit que ce fut la meilleure visite en hygiène qu'elle a faite ou lorsque votre employeur vous demande de partager les points forts d'un cours de perfectionnement professionnel continu que vous avez suivi avec le personnel ? Les moments de « a-ha » peuvent être aussi simples que le sentiment qu'on éprouve face aux remerciements d'avoir fait du bon travail ou après avoir allongé la journée pour accueillir un patient. Par contre, remerciez-vous les autres et prévoyez-vous des moments de « a-ha » ?*
3. ***La réputation :*** *Goldsmith déclare que, pour la plupart, nous ne savons vraiment rien de notre réputation qu'il qualifie de « marque personnelle » — l'image que les autres gardent de nous. La marque personnelle est un mélange de vision, de mission et de rôle clé. Si vous vous*

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For instance, how do you tell your client that their home care is not thorough enough without making them feel guilty? Do you focus on what they are doing well and suggest alternate solutions?

4. **Acceptance:** Peter Drucker says, "Every decision in life is made by the person who has the power to make that decision, not the smartest person or the right person or the best person." Goldsmith counsels us to "make peace with that". Focus on what you can do and what you can accomplish. Perhaps your employer is not interested in adapting to a "greener" office environment. To introduce this policy, focus on the financial impact of implementing recycling strategy on the office bottom line. Research the benefits, time commitment, and anticipate and prepare for objections before they occur.

What defines CDHA's mojo moment? We want to hear from members. We want to know what we do well and how we can improve. We want to hear what you like about the products and services we provide, and what needs improvement. We care deeply about our **identity** as the voice and vision of dental hygienists in Canada. We applaud our **achievements** in self regulation and self initiation and **accept** that we cannot effect changes in the emotionally charged employment market as quickly as many would prefer. Do we rest on our **reputation**? We hope not.

Call, write, e-mail, blog, or tweet. We want to extend our collective dental hygiene mojo.

REFERENCE

1. Kristin Clarke. *Associations Now*. July 2010;18–21.©CDHA

considérez comme une professionnelle très consciencieuse, le faites-vous voir à vos clients ? Par exemple, comment leur dites-vous qu'ils ne prennent pas suffisamment soin de leurs dents à la maison sans les culpabiliser ? Vous concentrez-vous sur ce qu'ils font bien et suggérez-vous des solutions alternatives ?

4. ***L'acceptation :*** *Peter Drucker disait : « Dans la vie, toute décision est prise par la personne qui en a le pouvoir, pas nécessairement la plus intelligente ni la bonne personne, ni la meilleure. » Goldsmith nous conseille de « faire la paix avec cela ». Concentrez-vous sur ce que vous pouvez faire et accomplir. Il se peut que votre employeur ne soit pas intéressé à s'adapter à un environnement de travail « plus vert ». Pour présenter une politique en ce sens, concentrez-vous sur l'impact financier de la mise en œuvre d'une stratégie de recyclage sur le résultat financier du cabinet. Faites une recherche sur les bénéfices, les engagements de temps, prévoyez et préparez-vous aux objections avant qu'elles ne soient soulevées.*

Qu'est-ce qui définit le moment « mojo *» de l'ACHD ? Nous souhaitons entendre les membres. Nous voulons savoir ce que nous faisons de bon et comment l'améliorer. Nous voulons entendre ce que vous aimez au sujet des produits et services que nous fournissons et ce qui doit être amélioré. Nous nous préoccupons profondément de notre* ***identité*** *en tant que porte-paroles et visionnaires des hygiénistes dentaires du Canada. Nous applaudissons nos* ***réalisations*** *en matière d'autoréglementation et d'initiatives et* ***acceptons*** *de ne pas pouvoir effectuer des changements dans un marché d'emploi chargé d'émotions aussi rapidement que plusieurs le souhaiteraient. Dépendons-nous de notre* ***réputation*** *? Nous espérons que non.*

Téléphonez, écrivez, communiquez par courriels, blogues ou tweet. Nous voulons étendre notre mojo *collectif en hygiène dentaire.*

RÉFÉRENCE

1. Kristin Clarke. *Associations Now*, July 2010;18-21.©CDHA

President's message, *Express your excellence*

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the role as Educator Director, completes her term. Thank you Bonnie for your dedication and support, and for the unstinting work you have done for CDHA.

Excellence. This one word describes our profession from the time we enter dental hygiene. We all are taught excellence and we strive to bring excellence to our varied roles.

At CDHA headquarters in Ottawa, there are two large photo frames with pictures of all the previous Presidents of CDHA starting from 1963 I have looked at these pictures many times, and wondered; what was their year like as President?

The challenges change year to year but the commitment, and integrity stay the same. I am thankful for the past, but extremely excited for the future; a future that is built on present expressions of excellence from each of us as dental hygienists.

We prosper on its continuity - so express your excellence.©CDHA

An exchange program par excellence

▲ MADHC second year students with their counterparts from Camosun College.

'Letters to the editor' is a forum for expressing individual opinions and experiences of interest that relate to the dental hygiene profession and that would benefit our dental hygiene readership. These letters are not any reflection or endorsement of CDHA or of the journal's policies. Send your letters to: journal@cdha.ca

Dear editor:

An exchange program par excellence

In July 2010, I was offered the opportunity to visit Miyagi Advanced Dental Hygiene College (MADHC) in Sendai, Japan, participating in a five day exchange program with my classmate, Taylor Dupuis, and our instructors Bonnie Blank and Ada Barker. As the first group from CC to have this opportunity, our purpose was to learn about dental hygiene education and practice in Japan, as well as share our own experiences. This letter compares the two colleges' programs as observed from a student's perspective.

Student life and the MADHC curriculum

Similar to the Canadian dental hygiene gender demographic, Japanese is predominantly a female profession. Like most dental hygiene colleges in Japan, MADHC is privately funded. The cost of schooling is similar to CC and their curriculum includes a visit to CC in the spring for their second year students. The total number of MADHC students is three times larger than that of CC. The MADHC program is three consecutive years while CC students complete one year of prerequisites before being placed on a waitlist for the two year diploma program. Japanese DH students attend classes from April to March and receive fewer holidays than we do which may allow the Japanese students to have a more balanced student life during the program. MADHC students also submit written clinical self evaluations throughout the year.

The courses in the MADHC curriculum appeared similar to ours with a few exceptions. For example, Japanese dental hygiene programs teach dysphagia management in detail whereas the CC program touches on the subject. Dysphagia has a high prevalence in Japan, reflective of the longer life expectancy. A hospital administration course in third year at MADHC prepares students for a career as a hospital dental hygienist.

MADHC students practise on their peers in their first and second year. Third year students are involved in a rotating practicum where they practise at long term care (LTC) facilities, hospitals, and private practices.

Dental hygiene in the community

During our visit, school children in the community visited MADHC where they were shown correct oral self care techniques, and were taught about bacteria biofilm. As well, they participated in an intraoral video camera activity which allowed them to view their own mouths.

We also saw strong client–student relationships created by MADHC third year students working in a LTC facility for the elderly. An electronic wand was used to measure buccal mucosa moisture to assess xerostomia. Occlusal and lip stress instruments were also used to measure the strength of mastication muscles. As rehabilitation for dysphagia patients was a focus, these assessments were helpful in determining progress of their therapy. We also observed that a finger-clasp oxygen monitor was used during care to monitor oxygen levels. It was interesting to note that when depleted levels were indicated, treatment ceased, and deep breathing techniques were practised. The students

▲ Miyagi Advanced Dental Hygiene College faculty and staff welcome their Canadian visitors.

demonstrated assertive proficiency throughout the process of care, and empathetic respect towards the client.

The Japanese government understands the value of preventive healthcare. The Sendai Welfare Plaza is a government funded facility that provides oral healthcare services to people with mental, cognitive or physical disabilities. A portable dental unit is used for home visits. The staff highly value collaborating with their clients to increase their involvement in treatment choices and maintain their dignity. Unfortunately, British Columbia does not currently have a resource that compares with the financial support of this facility. Perhaps Sendai Welfare Plaza could be used as a model to help motivate future Canadian dental hygiene students to lobby the Canadian government for increased funding to oral healthcare.

Further education

As in Canada, there is an opportunity for further education once the Japanese dental hygiene diploma is earned. A fourth year dental hygiene baccalaureate degree is offered at various universities and colleges whereby a social work program is integrated, resulting in the baccalaureate degree student becoming a certified social worker.

Unlike Canada, there is no requirement to prove participation in continuing professional development. However, there are required academic conferences for registered dental hygienists who aspire to work in specialty offices.

Scope of practice

Dental hygienists working in Japan do not administer local anaesthetic or take radiographs. Intra- and extra-oral exams are not currently a practice in the Japanese dental hygiene process of care; the MADHC faculty were interested in learning more about these assessments from us. Independently run dental hygiene clinics do not currently exist in Japan, and a dentist must always be present in the office while the dental hygienist is practising. It is common for two dental hygienists to work together as a team on one client where one assists the operator. Alternately, the dental hygienist will assist the dentist chair side.

A valuable experience

I believe this learning experience would be beneficial to all dental hygiene students who wish to increase their cultural competency in order to enhance client care, as what I learnt about subtle mannerisms would be difficult to accomplish by reading a text book. The language barrier was challenging at times but we found that clarification by repetition using different ways of expressing ourselves helped avoid misunderstandings.

The exchange was a fantastic learning experience, and an honour for me to participate. The host families, faculty, and staff at MADHC and Tohoku University went out of their way to ensure a memorable educational visit that was fun. I am confident this study abroad program will continue to provide a rich opportunity for future exchange students. By continuing to build collaborative working relationships with dental hygiene students, educators, and professionals on an international level, our profession can develop to its full potential and accomplish optimal oral healthcare for all on a global scale.

Sincerely,
Shannon Collins
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SPECIAL EDITORIAL

Oral Health results from Statistics Canada's *Canadian Health Measures Survey*

Peter Cooney, BDS, LDM, DDPH, MSc, FRCD(C)
Chief Dental Officer, Office of the Chief Dental Officer, Health Canada

The results from the Oral Health component of Statistics Canada's *Canadian Health Measures Survey* (CHMS) were released in early May 2010. These results represent the conclusion of a five year journey between Health Canada, Statistics Canada, and the Department of National Defence (who provided their dentists) to develop the survey tools, implement pre-tests, run calibrations, conduct examinations, and assist with the analysis of the initial data results.

The *CHMS* collected key information relevant to the health of Canadians in two phases. The first phase consisted of a personal interview to collect information related to nutrition, smoking habits, alcohol use, medical history, oral health, and current health status, as well as demographic and socioeconomic characteristics of the family. The second phase gathered information using direct measurements such as blood pressure, height and weight, blood and urine sampling, clinical oral examination and physical fitness testing. Specially trained Canadian Forces' dentists performed the oral health clinical examinations. The *CHMS* collected this data from approximately 6,000 people in 15 communities that were randomly selected across Canada between March 2007 and February 2009. The sample represents 97% of the Canadian population aged six to seventy-nine years.

The information presented in this article was drawn directly from the *Summary Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007- 2009*. The data highlighted in the *Summary Report* describes the extent and severity of dental diseases among Canadians. With further analysis, the data can be used to investigate the association of oral health with such major health concerns as diabetes, obesity, hypertension, cardiovascular disease, infectious disease, and exposure to environmental contaminants. However, this article will focus only on the nation's oral health and relevant oral disease levels.

Highlights from the Results

Visiting a dental professional

- 74% of Canadians have seen a dental professional in the last year
- 17% of Canadians avoided going to a dental professional in the last year because of the cost
- 16% of Canadians report that they avoided having the full range of recommended treatment in the last year due to the cost

Cavities

Children (6 – 11 years of age)

Primary (or baby) teeth

- The average number of primary teeth that are decayed, missing, or filled (dmft) is 1.99
- The survey found that 48% of children aged 6 –11 years of age have a dmft count of at least one

Permanent (or adult) teeth

- The average number of permanent teeth that are Decayed, Missing, or Filled is 0.49 teeth
- 24% of children aged 6 – 11 years of age have a DMFT count of at least one

Combined primary and permanent teeth

- 57% of children aged 6 – 11 years of age have a combined dmft + DMFT count of at least one

▲ The Mobile Examination Centre parked in the winter.

- The average number of teeth that have a dmft + DMFT is 2.5 primary or permanent teeth

Adolescent (12–19 years of age)

- 59% of adolescents (12 – 19 years of age) have a DMFT count of at least one
- The average number of DMFT is 2.49 teeth in adolescents

Adults

- 96% of adults (who have teeth) have a coronal DMFT of at least one
- The average number of coronal DMFT for adults is 10.67 teeth
- 20% of adults (20 – 79 years of age) have at least 1 decayed or filled root cavity
- Canadian adults have an average of 0.66 Root, Decayed or Filled teeth (RDFT)
- 20% of adult Canadians (20 – 79 years of age) have on average 2.97coronal cavities that need a filling
- 7% of adult Canadians (20 – 79 years of age) have on average 2.81 root cavities that need a filling

Periodontal conditions

Debris and Calculus

- Those Canadians with lower income, who are publicly insured or who are infrequent visitors to a dental professional tend to have higher debris scores
- 11% of Canadian adults were found to have calculus scores in the highest range

Gingivitis

- 32% of Canadian adults (20 – 79 years of age) have gingivitis of clinical concern
- 48% of Canadian adults who have not been to a dental professional in the last year have gingivitis
- 48% of Canadian adults from the lower income group have gingivitis compared to 25% of Canadians with higher incomes

Pocket depth

- 16% of Canadian adults have moderate disease (pocket depth of 4 or 5 mm)
- 4% of Canadian adults have severe disease (pocket depth greater than or equal to 6 mm)
- 24% of older adults, 60 to 79 years of age, have moderate disease (or pocket depth of 4 or 5 mm)
- 22% of current smokers have signs of moderate disease (pocket depth of 4 or 5 mm)

Loss of attachment (LOA)

- The survey found that 79% of Canadian adults (who have teeth) are considered to be healthy in terms of LOA (LOA = 0 – 3 mm)
- 6% of Canadian dentate adults have had severe disease (LOA of 6 mm or more)

Oral lesions

- 12% of adults have at least one oral lesion in their mouth
- 41% of adults who are edentulous (do not have any teeth) have at least one oral lesion in their mouth

Fluorosis

Potential fluorosis was measured by the dental examiners on children from the ages of 6 to 12 using the *Dean's Index*.

The results found that, according to the *Dean's Index*:

- 60% of the children (6 – 12 years of age) have teeth that are normal
- 24% of children have enamel with white flecks or spots where the cause is questionable (possibly as a result of the use of medications, fevers or fluoride exposure during younger years which have caused slight aberrations on the tooth enamel)
- 12% have one or more teeth with fluorosis classified as very mild, and 4% with fluorosis classified as mild

So few Canadian children have moderate or severe fluorosis that, even combined, the prevalence is too low to permit reporting. This finding provides validation that dental fluorosis remains an issue of low concern in this country.

Need for care

At the end of the dental examination, the dentists recorded whether or not the respondent needed care and, if so, what kind, and if it were needed urgently (i.e. within a week).

From the assessments and evaluation of the dentists, a list outlining a priority of needed care was created. The results from the respondents were placed in order ranging from a threat to life (i.e. severe infection or suspected oral cancer) or current severe pain, to the need for a filling, to oral health requirements that could be met over a longer period of time.

The results indicate that:

- 34% of dentate Canadians ages 6 to 79 years of age have some sort of treatment need identified
- 47% of lower income Canadians have a need identified compared to 26% of the higher income group
- 49% of the current smokers have some sort of treatment need identified compared to 30% of those who have never smoked

In conclusion

The data collected and analyzed will serve to help inform dental public health policies and dental hygiene programming. It also provides a baseline for noting any improvements that may occur as a result of new oral health promotion and disease prevention initiatives with the goal of achieving better outcomes. Also, as a result of having an oral health module in the *CHMS*, there is now a large database of oral heath statistics available to dental researchers (including dental hygiene researchers) across Canada. This database is available through Research Data Centres (RDC) across Canada. The RDCs exist in twenty one universities across Canada and each one is operated by Statistics Canada analysts. The expectation is that a significant number of research papers will emerge as a result of access to the new oral health data.

For its part, the Government of Canada will continue to work with key dental associations (including the Canadian Dental Hygienists Association), provinces and territories in order to begin discussions on ways the dental public health community can work together to improve areas of need in the oral health of Canadians as highlighted in the *Oral Health* component of the *Canadian Health Measures Survey*.

For further information

- **Factsheet highlighting the results: Oral Health Statistics 2007–2009 factsheet**
  http://www.hc-sc.gc.ca/hl-vs/pubs/oral-bucco/fact-fiche-oral-bucco-stat-eng.php
- ***The Report and the Summary Report on Findings of the Oral Health Module of the Canadian Health Measures Survey 2007-2009***
  http://www.fptdwg.ca/English/e-documents.html
- **Research Data Centre**
  http://www.statcan.gc.ca/rdc-cdr/network-reseau-eng.htm

Les résultats de la santé buccodentaire de *l'Enquête canadienne sur les mesures de la santé* (ECMS) de Statistique Canada

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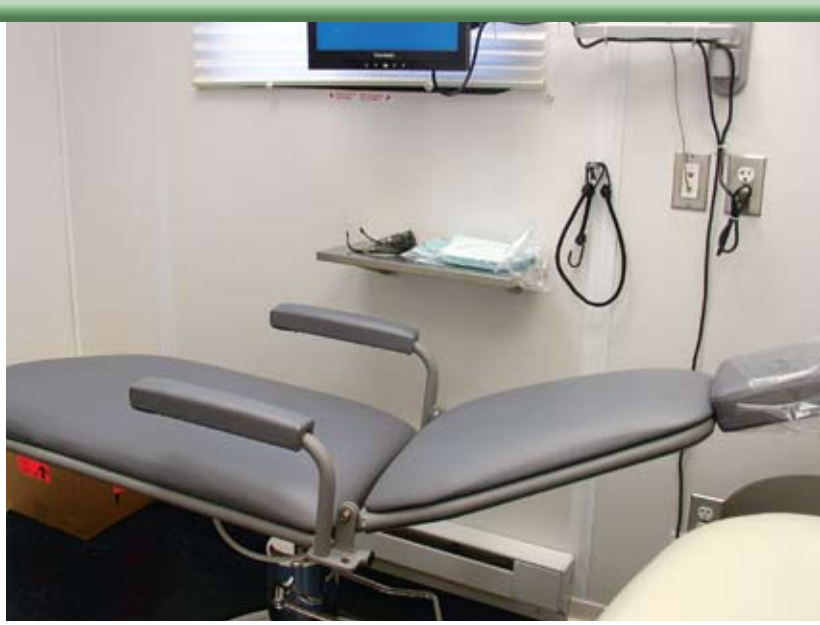
Les résultats du module de santé buccodentaire de *l'Enquête canadienne sur les mesures de la santé* (ECMS) de Statistique Canada ont été publiés au début du mois de mai 2010. Ces résultats sont le fruit d'un partenariat de collaboration entre Santé Canada, Statistique Canada et le ministère de la Défense nationale (qui a fourni ses dentistes) pour élaborer les outils de l'enquête, exécuter les tests préliminaires, faire les étalonnages, examiner les participants et faciliter l'analyse des données des résultats initiaux.

L'ECMS avait pour objet de recueillir de l'information pertinente des données clés sur la santé des Canadiens en deux phases : premièrement, faire des entrevues personnelles pour réunir l'information sur l'alimentation, le tabagisme, l'alcoolisme, les antécédents médicaux, la santé buccodentaire et l'état de santé courante, ainsi que les caractéristiques démographiques et socioéconomiques de la famille; deuxièmement, recueillir de l'information par des mesures directes telles que la pression artérielle, la taille et le poids, la collecte d'échantillons de sang et d'urine, l'examen buccodentaire en milieu clinique et l'évaluation de la condition physique. Des dentistes des Forces canadiennes formés à cette fin ont effectué les examens buccodentaires. Dans le cadre de l'ECMS, Statistique Canada a recueilli, entre mars 2007 et février 2009, des données auprès d'environ 6 000 personnes de 15 communautés du pays sélectionnées au hasard. L'échantillonnage représentait 97% de la population canadienne âgée de six à soixante-dix-neuf ans.

L'information présentée dans le présent article a été tirée directement du *Sommaire du rapport des résultats du module sur la santé buccodentaire de l'Enquête canadienne sur les mesures de la santé 2007-2009*. Les données soulignées dans le *Sommaire* décrivent l'ampleur et la gravité des maladies buccodentaires chez les Canadiennes et Canadiens. Avec une analyse plus approfondie, ces données pourraient servir à investiguer sur l'association de la santé buccodentaire à des problèmes de santé importants comme le diabète, l'obésité, l'hypertension, les maladies cardiovasculaires et l'exposition aux contaminants de l'environnement. Toutefois, l'article se concentre seulement sur la santé buccodentaire à l'échelle du pays et aux niveaux pertinents de la maladie buccodentaire.



▲ Salle d'examen buccodentaire - Cette salle a été conçue pour accueillir le responsable de l'entrée des données, le dentiste, le répondant et, si nécessaire, le parent/gardien.

Faits saillants des résultats

Consultation d'un professionnel des soins buccodentaires

- 74 % des Canadiens ont consulté un professionnel des soins dentaires au cours de la dernière année;
- 17 % des Canadiens n'ont pas consulté un professionnel des soins buccodentaires au cours de la dernière année en raison des coûts;
- 16 % des Canadiens ont déclaré avoir refusé de recevoir tous les traitements recommandés au cours de la dernière année en raison des coûts.

La carie dentaire

Enfants (6 à 11 ans)

Les enfants de 6 à 11 ans ont une dentition mixte composée de dents de lait et de dents d'adulte. Par conséquent, l'indice caod a été calculé pour les dents de lait et l'indice CAOD a été calculé pour les dents d'adulte, puis l'indice combiné (caod + CAOD) a été déterminé.

Dents primaires (ou de lait)

- L'enquête a révélé que 48 % des enfants de 6 à 11 ans ont un indice caod d'au moins 1.
- En moyenne, les enfants ont 1,99 dent primaire cariée, absente ou obturée.

Dents permanentes (ou d'adulte)

- 24 % des enfants de 6 à 11 ans ont un indice CAOD d'au moins 1.
- En moyenne, les enfants ont 0,49 dent permanente cariée, absente ou obturée.

Dents primaires et permanentes combinées

- 57 % des enfants de 6 à 11 ans ont un indice combiné (caod + CAOD) d'au moins 1.
- En moyenne, les enfants ont 2,5 dents primaires ou permanentes cariées, absentes ou obturées.

Adolescents (12 à 19 ans)

- 59 % des adolescents (de 12 à 19 ans) ont un indice CAOD d'au moins 1;
- en moyenne, les adolescents ont 2,49 dents cariées, absentes ou obturées.

La carie dentaire chez l'adulte

- 96 % des adultes (dentés) qui ont des dents cariées, absentes ou obturées (CAOD) ont au moins une carie coronaire.
- Les adultes qui ont des dents cariées, absentes ou obturées (CAOD) ont en moyenne 10,67 caries coronaires.
- 20 % des adultes (de 20 à 79 ans) ont au moins une carie radiculaire présente ou obturée.
- Les adultes canadiens ont en moyenne 0,66 carie radiculaire présente ou obturée.
- 20 % des adultes canadiens (de 20 à 79 ans) ont en moyenne 2,97 caries coronaires devant être obturées.
- 7 % des adultes canadiens (de 20 à 79 ans) ont en moyenne 2,81 caries radiculaires devant être obturées.

La maladie parodontale (parodontopathies)

Débris et tartre

- Les indices de débris sont généralement plus élevés chez les Canadiens qui ont un revenu inférieur, qui bénéficient d'un régime d'assurance public ou qui ne consultent pas régulièrement un professionnel des soins dentaires.
- 11 % des adultes canadiens avaient une accumulation de tartre dans la plage supérieure.

Gingivite

- 32 % des adultes canadiens (de 20 à 79 ans) souffrent de gingivite.
- 48 % des adultes canadiens qui n'ont pas consulté un professionnel des soins buccodentaires au cours de la dernière année souffrent de gingivite.
- La gingivite touche 48 % des adultes canadiens qui se situent dans la tranche de revenu inférieure, comparativement à 25 % des Canadiens qui se situent dans la tranche de revenu supérieure.

Profondeur des poches parodontales

- 16 % des adultes canadiens ont une forme modérée de la maladie (poche de 4 ou 5 mm de profondeur).
- 4 % des adultes canadiens ont une forme grave de la maladie (poche dont la profondeur est égale ou supérieure à 6 mm).
- 24 % des adultes de 60 à 79 ans ont une forme modérée de la maladie (poche de 4 ou 5 mm de profondeur).
- 22 % des répondants qui étaient fumeurs au moment de l'enquête présentaient des signes d'une forme modérée de la maladie (poche de 4 ou 5 mm de profondeur).

La perte d'attache

- L'enquête a révélé que 79 % des adultes canadiens (dentés) sont considérés comme étant en santé du point de vue de la perte d'attache (perte d'attache de 0 à 3 mm).
- 6 % des adultes canadiens dentés ont ou ont eu une forme grave de la maladie (perte d'attache de 6 mm ou plus).

Les lésions buccales

- 12 % des adultes ont au moins une lésion buccale.
- 41 % des adultes édentés (ayant perdu toutes leurs dents) ont au moins une lésion buccale.

Fluorose

La fluorose dentaire

Les examinateurs dentistes ont évalué la présence possible de fluorose chez les enfants de 6 à 12 ans au moyen de l'*indice de Dean*.

Selon les critères de l'*indice de Dean*, les résultats de l'enquête ont révélé que :

- 60 % des enfants (de 6 à 12 ans) ont des dents normales;
- chez 24 % des enfants, l'émail des dents présente des mouchetures ou des points blancs dont la cause est incertaine *(il se peut que les anomalies légères qui sont visibles sur l'émail des dents soient attribuables à la consommation de médicaments, à des épisodes de fièvre ou à un apport en fluor durant les premières années de la vie)*;
- 12 % des enfants ont une ou plusieurs dents atteintes de fluorose très légère et 4 % ont une ou plusieurs dents atteintes de fluorose légère.

Le nombre d'enfants canadiens qui sont atteints de fluorose modérée ou sévère est si peu élevé que, même si l'on combine ces stades de la maladie, la prévalence est trop faible pour être déclarée. Ce constat permet de confirmer que la fluorose dentaire est une affectation qui demeure peu préoccupante au Canada.

Besoin de soins

À la fin de l'examen dentaire, les examinateurs dentistes ont indiqué si le répondant avait besoin de soins et, le cas échéant, le type de soins dont il avait besoin et l'urgence des soins (p. ex., soins devant être obtenus au cours de la semaine).

À partir des examens et de l'évaluation effectués par les examinateurs dentistes, une liste des soins nécessaires, par ordre de priorité, a été établie. Les soins ont été classés selon leur priorité, de la façon suivante : danger pour la vie du répondant (p. ex., infection grave ou cancer de la bouche soupçonné), douleur intense ressentie au moment de l'examen, besoin d'un plombage ou besoin de soins buccodentaires pouvant être offerts sur une longue période.

- L'enquête a révélé que 34 % des Canadiens dentés âgés de 6 à 79 ans ont besoin d'un service ou d'un traitement dentaire.
- 47 % des Canadiens qui se situent dans la tranche de revenu inférieure ont besoin d'un service ou d'un traitement dentaire, comparativement à 26 % des Canadiens qui se situent dans la tranche de revenu supérieure.
- 49 % des répondants qui étaient fumeurs au moment de l'enquête ont besoin d'un service ou d'un traitement dentaire, comparativement à 30 % des personnes qui n'ont jamais fumé.

Conclusion

Les données recueillies par l'ECMS aideront à informer et à soutenir les politiques publiques de la santé et les programmes d'hygiène dentaire. Elles fourniront aussi une base de données pour noter toute initiative de promotion et d'amélioration de la santé buccodentaire dans la recherche de meilleurs résultats. En outre, l'introduction d'un module sur la santé buccodentaire dans l'ECMS donne aussi à la recherche buccodentaire (y compris la recherche en hygiène dentaire) accès à une importante base de données statistiques en ce domaine dans tout le Canada. Cette base de données est accessible par les Centres de données de recherche (CDR) du pays. Ces Centres existent dans vingt-et-une universités canadiennes et chacun est dirigé par des analystes de Statistique Canada. On s'attend à ce que l'accès aux nouvelles données sur la santé buccodentaire suscite un nombre important de documents de recherche.

Pour sa part, le Gouvernement du Canada continuera de travailler avec les principales associations (y compris l'Association des hygiénistes dentaires du Canada), les provinces et les territoires pour amorcer dans la communauté de la santé dentaire publique des échanges sur les façons de travailler ensemble afin d'améliorer les zones de besoins de santé buccodentaire de la population canadienne, comme le souligne le module de la *Santé buccodentaire* de *l'Enquête canadienne sur les mesures de la santé*.

Pour plus d'informations

- **Statistiques sur la santé buccodentaire, 2007-2009**
  http://www.hc-sc.gc.ca/hl-vs/pubs/oral-bucco/fact-fiche-oral-bucco-stat-fra.php
- ***Sommaire du rapport des resultants du module sur la santé buccodentaire de l'enquête sur les measures de la santé 2007-2009***
  http://www.fptdwg.ca/francais/f-dossiers.html
- **Le Réseau des CDR**
  http://www.statcan.gc.ca/rdc-cdr/network-reseau-fra.htm

EDITORIAL

Tobacco cessation counselling: Motivating clients to quit

Joan M. Davis, RDH, MS, CTTS

Though much has been done to discourage tobacco use through education, programs, policy, and law, people continue to use this toxic substance with known carcinogens—often leading to disease or even death.[1] According to the *Canadian Tobacco Use Monitoring Survey (CTUMS) 2009 half-year results*,[2] 17% of Canadians 15 years or older (approximately 4.8 million) reported currently smoking. In the US, an estimated 20.2% (or 46 million) of Americans 18 years or older smoked.[3] Overall, smoking prevalence has not changed from the previous year in either country. One could ask—why not? Tobacco use often leads to a chemical dependence and the establishment of behavioural patterns leading to an addiction or habit that can be very difficult to stop.[4]

What we know about tobacco related oral health issues

Over the past sixty years, research has clearly demonstrated that the use of both smoked and, to a lesser degree, smokeless tobacco can lead to disabling disease or even death.[1] Even those smoking 1–4 cigarettes a day, light smokers or "chippers" have been shown to have a significantly higher risk of dying from heart disease than non smokers.[5] In addition, profound oral health risks are associated with smoked tobacco including oral cancer, precancerous lesions[6], periodontal disease[7,8] increase in tooth loss, and implant failure[6,9] Smokeless tobacco use, though not containing many of the 4,000 harmful chemicals found in tobacco smoke, can lead to precancerous lesions, dental caries and gingival recession.[6]

In recent years researchers have explored the harmful oral effects of being exposed to passive smoking also called second hand or environmental smoke (ETS) on children. Erdemire et al.[10] reported children exposed to ETS were found to have an elevated level of cotinine, a major metabolite of nicotine. Periodontally, these children had a lower clinical attachment level than children not exposed to tobacco smoke.[10] Another study[11] showed an increase in the incidence of dental caries to be significant in 5 year olds. Interestingly, "*even after adjustment for parental educational level, dietary and oral hygiene habits, a more than threefold elevated risk for caries associated with parental smoking was revealed in 5-year olds.*"[11p.255] Evidence is mounting that children are profoundly affected by exposure to ETS resulting in both general and oral health problems.

Tobacco cessation counselling in dental hygiene

As oral health professionals committed to health promotion and disease prevention, it may be time to take a step back and explore the concept of tobacco cessation counselling (TCC) and what it means. The often repeated US Public Health Service (PHS) *Treating Tobacco Use and Dependence 2008 Update's*[12] five As (Ask, Advise, Assess, Assist, Arrange) or brief intervention counselling[13] (BIC—Ask, Advise, Assist, Arrange) are considered a brief intervention taking 3–5 minutes. A similar model is the *Ask, Advise and Refer* from the American Dental Hygiene Association where the tobacco using client is encouraged to quit then given "quit information".[14] At the heart of these models is to identify tobacco use then educate the client on the benefits of quitting. The PHS *Guideline*[12] reports those who receive even a brief tobacco intervention have a significant increase in reaching and maintaining long term abstinence. The *Guideline*[12] goes on to stress the likelihood of long term abstinence is even greater with counselling and medications. In 2004, Canadian Dental Hygienists Association published *The Tobacco Use Cessation Services and the Role of the Dental Hygienist – CDHA position paper*[15p.1] where, among several recommendations, stated: "Dental hygienists can change clinical culture and clinical practice patterns so that every client who uses tobacco is identified and offered at least brief counselling".

The spirit of motivational interviewing

While there may be many opinions as to what exactly entails effective tobacco cessation counselling, the intervention often involves more than imparting knowledge or education alone. Health education can be effective in motivating some to make a change in their health behaviour, but in others, it may cause *resistance* resulting in the classic response "*Yes, but…*". When asked, healthcare providers often report client resistance as a barrier to offering tobacco use counselling. Could it be that at least some of the problem lies with the clinician rather than the client? Of PHS's five As, the first three[12]—*Asking, Advising* and *Assessing*—could be offered in two ways. To illustrate the direct educational way:

> *I see that you smoke. Your oral health is at risk and you really need to quit smoking in order to save your teeth.*

The second way would be supportive, empathetic:

> *I see that you smoke, would it be OK if we talked a little more about it?*

Advice would follow after a collaborative dialogue has been started. Which method would elicit defensiveness, and which would make a client feel at ease?

The theory of Motivational Interviewing (MI) has been extensively utilized in both clinical settings and research protocol. Psychologists first used this counselling technique to treat alcoholism.[16] MI has been advocated as an effective client centred tool for healthcare providers when

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SAMPLE MOTIVATIONAL INTERVIEW

The simulation explores a conversation where tobacco smoke has compromised the health of the client, and oral pathology is present. The intent is to share how the "spirit" of MI may sound between a dental hygienist and a new dental client…

As the intervention evolves, both the clinician and client are engaged. They build trust through acceptance, empathy, and support, leading the client to more disclosure. This conversation could encourage the client to agree to a quit plan, or it could end in the client expressing interest in quitting but not quite ready to do so. Either way, a rapport is established which opens the way to further discussions at a later appointment.

Background: 41 year old female, smoker for 25 years, not interested in quitting
Oral Pathology/Condition: Abnormal leukoplakia
Oral Sign: White thickening of the mucosa discovered during an oral cancer screening

CESSATION INTERVENTION		
Dental hygienist:	*Did you realize you had this change of tissue in your mouth?*	(Show with a mirror) Pause…Listen… (Creating awareness, inviting client's involvement)
Client:	*No! What causes that?*	Client becomes involved and seeks more information
Dental hygienist:	*Well, this change in the cells is related to your smoking. I know you said you were not interested in quitting right now, but would you mind talking a little bit about it now?*	(Asking permission) Pause…Listen…
Client:	*Yeah! I don't want to get cancer or anything. Is that what that is?*	Continued client involvement, information seeking questions—client leads
Dental hygienist:	*The toxins in the tobacco smoke have altered the cells in your mouth and the white area, or leukoplakia, is considered precancerous.*	Pause…Listen… (Providing targeted education without lecturing, righting)
Client:	*I had no idea! My uncle died of cancer and he suffered a lot.* *If I quit smoking, would that area go away?*	Silence – give the client time to think, reflect Client generated reflection moving closer to considering a behaviour change
Dental hygienist:	*This type of leukoplakia can disappear over time if you stop smoking. Have you tried to quit in the past?*	Exploring past quit attempts to understand better the struggles unique to the client
Client:	*Well, I quit for 6 months a few years ago…*	Client continues to be involved, not resistant or defensive – the clinician is listening, non judgmental, resisting the urge to educate
Dental hygienist:	*Tell me more about that. How were you able to succeed?*	Supporting past quit attempts, learning from the experience, building on what the client says—empowering
Client:	*Well, I used the patch, and it worked for a while but I went back to smoking. I suppose I could try that again…*	This is an example of Change Talk — use what the client has said to move the individual forward. The client needs to hear this rather than being told he or she needs to do it
Dental hygienist:	*It is great to hear that you had success with the patch! That is certainly an option you could choose to quit.* *Can you tell me a little about what started you to smoke again?*	Giving the client control over the quit plan, using the change talk Support, empathy, reflection, exploring specific triggers for the client

Table 1. The Spirit of Motivational Interviewing.

Collaborative	Partnership between patient and clinician, dancing rather than wrestling
Evocative	Elicit or bring out the patient's own motivation and resources for change
Honoring patient autonomy	Recognize it is the patient who makes their own decisions – the power is in their hands, the clinician cannot change anyone

Adapted from Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Healthcare: Helping Patients Change Behavior*. 2008;6–7.

treating behaviourally based chronic diseases,[17–19] and encouraging good oral care.[20]

Over thirty years of articles, books, and reports available on MI indicate significant improvement in patients' smoking behaviour.[12,21–23] According to Miller and Rose,[21] MI emphasizes two main components:

1) a *relational* component where empathy and interpersonal elements are used, and

2) a *technical* component where patients are encouraged to share their thoughts, preferences and ambivalence, allowing the clinician to move the conversation in a positive, health changing direction.

Emmons and Miller[19p.70] state, "*Readiness to change is not a client trait but a fluctuating product of interpersonal interactions",* contending that clients do not stay in a static stage as described in the stages of change (precontemplation, contemplation, preparation, action maintenance).[24] The active interaction of eliciting, reflection, examining discrepancies then resolving them may move a client from precontemplation to preparation stage in just a few minutes. At the heart of MI is establishing a rapport and building a relationship of trust between clinician and client where the client is in control of his or her own health. This is especially important between oral health providers and their clients who seek dental care on an annual or semi annual basis over many years. If a client perceives a clinician as judgmental, policing bad behaviour, or another tobacco lecture, the client may immediately disregard the advice, or even change providers.

MI is considered a brief psychotherapy, and has numerous aspects and skill sets to learn. Though some of the basic concepts are not difficult, MI takes time, self awareness, and practice to gain mastery. In response to the time constraints involved in client care, brief adaptations of MI requiring from 5 to 30 minute interventions have been introduced.[19] Rollnick et al.[25] provide a practical approach to helping people change unhealthy behaviours without alienating them—within the time allotted for client care.[25] The authors offer a rich array of concepts, frameworks, and vignettes that clinicians can learn and practise on their own.[25] The "spirit" of MI is described as *collaborative*, *evocative* and *honoring* of client autonomy (Table 1). The client is viewed as an equal partner in the individual's health care, working out issues and making positive changes with the clinician acting as facilitator in the process. The guiding principles of MI are: *resist*, *understand, listen,* and *empower* (Table 2). Again, the clinician must relinquish the role of "authority and educator" and resist the urge to correct, or fix the "unmotivated or unknowledgeable" person.[25] Rather, by taking the stance of listening and understanding the client's motivation or reasons for change or not changing, the clinician can empower or give control back of the client.[25] For example: ***You have five caries. You need to cut down on your sugar intake and brush your teeth more effectively.*** Or,

I'm concerned that you have five caries this visit. Can you tell me about what you think may be happening here? (Pause, listen)

The first is accurate but authoritative, in one direction and almost certain to evoke defensiveness or rebuttal. The second educates, shows empathy, and provides an opportunity for self reflection, assessment, and client empowerment to direct the discussion. For resources on health behaviour change, see Table 3.

Table 2. The Four Guiding Principles of Motivational Interviewing: RULE.

R: Resist the Righting Reflex	Resist the inner need to make things right, correct, often by education
U: Understand Your Patient's Motivation	It is the patient's own motivations (not ours) that are likely to trigger behaviour change
L: Listen to Your Patient	Listen at least as much as informing – often the answer lies within the patient
E: Empower Your Patient	Help patients explore how they can make difference in their own health

Adapted from Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Healthcare: Helping Patients Change Behavior*. 2008;8–10.

Table 3. Motivational Interviewing resources.

Motivational Interviewing Org. www.motivationalinterview.org
Motivational Interviewing in Healthcare: Helping Patients Change Behavior (2008) by S. Rollnick, W. Miller and C. Butler. New York: Gilford Press. www.gilford.com
Motivational Interviewing: Preparing People for Change (1991) by W. Miller and S. Rollnick. New York: Guilford Press. www.gilford.com
Building Motivational Interviewing Skills: A Practitioner Workbook (2009) by D. Rosengren. New York: Gilford Press. www.gilford.com

CONCLUSION

How can we be effective in helping our tobacco using clients quit? Addressing this behaviourally based chronic, relapsing disease from a client centred approach, clinicians can establish rapport and trust. This will empower and support clients as they make positive health choices in both the short and long term. As clinicians, we have the ability and opportunity to learn these proven techniques and skills that will help not only our tobacco cessation efforts, but all of our client interventions, breaking the cycle of chronic relapsing disease.

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Evaluability Assessment of a dental prenatal program

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ABSTRACT

Background: Effective program evaluation is key to the improvement of dental public health programs. Employing an appropriate evaluation design is crucial to ensuring the results are of relevance and value to program decision makers. This paper describes the importance and the application of an Evaluability Assessment (EA) in the determination of a feasible evaluation design for a dental prenatal public health program in Vancouver, British Columbia. **Methods:** The program's dental hygienist adopted the role of inside evaluator and collected data for the EA by semi structured interviews, retrospective chart reviews, field observations, and a review of appointment statistics. **Results:** The EA developed and refined the program's goals and objectives; generated a list of stakeholders and their roles and responsibilities; and produced a Logic Model that explained the theory of the program. The process of the EA revealed discrepancies between the program's reality and its intent, but details of the program's organizational structure and funding sources were clarified. Existing record keeping methods were found to be less than ideal for the purposes of an evaluation; however, the organizational climate was supportive of further program evaluation. **Discussion:** The EA clarified the program's goals and the stakeholders' roles and responsibilities and, in the process, enhanced overall interest and awareness of the program. **Conclusions:** The EA determined that a process evaluation was a feasible design to improve the program's operations, but that an evaluation of outcomes would be challenging. Conducting an EA is an important preliminary stage in the preparation of a feasible and meaningful design for the evaluation of a dental public health program.

RÉSUMÉ

Contexte : L'efficacité de l'évaluation d'un programme est la clé pour améliorer les programmes publics de santé dentaire. Le recours à un modèle approprié d'évaluation est crucial pour assurer la prévalence et la valeur des résultats à ceux et celles qui doivent décider du programme. Cet article décrit l'importance et l'application d'une Évaluation de l'évaluabilité (EE) afin d'établir le modèle d'évaluation pertinent pour un programme public de santé dentaire prénatale à Vancouver (Colombie-Britannique). **Méthodes :** L'hygiéniste dentaire du programme a adopté le rôle d'un évaluateur interne et collectionné les données d'EE par le biais d'interviews semi structurées, d'examens rétrospectifs de dossiers, d'observations sur le terrain et d'un examen des statistiques d'entrevues. **Résultats :** L'EE a permis d'élaborer et raffiner les buts et objectifs du programme, dresser une liste des parties prenantes et leurs rôles et responsabilités, et produit un Modèle logique qui explique la théorie du programme. Le processus de l'EE a révélé des divergences entre la réalité du programme et son intention, mais les détails de la structure organisationnelle du programme et des sources de financement ont été clarifiés. Les méthodes existantes de conservation des dossiers ont été trouvées moins qu'idéales aux fins de l'évaluation; toutefois, le climat de l'organisation soutenait une autre évaluation du programme. **Discussion :** L'EE a clarifié les buts du programme et les rôles et responsabilités des parties prenantes. Dans le processus, elle a aussi permis d'améliorer l'intérêt global et la sensibilisation au programme. **Conclusions :** L'EE a permis d'établir que l'évaluation d'un processus constitue un modèle applicable pour améliorer les opérations d'un programme, mais que « l'évaluation des résultats » peut poser des défis. Le recours à l'EE est une importante étape préliminaire dans l'élaboration d'un modèle applicable et significatif d'évaluation d'un programme public de santé dentaire.

Key words: program evaluation, dental, health services research, public health dentistry

INTRODUCTION

Dental public health programs can be improved by effective program evaluation.[1] Program evaluation allows decision makers to assess a program's outputs and outcomes, to examine areas for improvement, to determine client satisfaction, to provide evidence to support changes, and to validate a program for accountability and sustainability. Although most dental public health programs undergo periodic review by administrators, the results of such reviews are usually for internal purposes of the organization. Relatively few evaluations of long standing dental public health programs have been reported,[2–6] and most published reports have focused primarily on outcomes.[4]

Program evaluations are often performed under time constraints and with limited resources[7,8] and, at times, are conducted on programs not ready for evaluation.[9] If program decision makers have limited knowledge of evaluation methodology, they may be frustrated with the process and usefulness of the results.[7] Dental hygienists, who represent 41 per cent of the Canadian dental public health workforce[10] have the opportunity to be involved in program evaluation, and play a vital role to help better account for and improve public health interventions.

A publicly funded program, the Healthiest Babies Possible (HBP) dental program, was established in 1986 in Vancouver, Canada, for low income, pregnant women judged to be at high risk to give birth to preterm or low birth weight babies or both. Each woman referred to the program receives, at no cost, two one-hour appointments for oral hygiene services with the dental hygienist plus an oral assessment by a dentist. The dental hygienist also provides one-on-one education on oral self care and counselling about such issues as early childhood caries. Despite operating for over two decades, changes in funding, program staff, demographics of clients, and enhanced knowledge about dental interventions appropriate for pregnant women, no formal evaluation of the HBP dental program has ever been conducted and reported. Consequently the program's administrators, the support staff, and the primary service provider—who was a den-

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INTERVIEW GUIDE

1. What is your role and responsibility/involvement in the HBP dental program?
2. When and how did the HBP dental program start?
3. Who are the stakeholders?
4. Who is responsible for the HBP dental program?
5. Explain how the funding is organized.
6. What are your objectives and goals for this program?
7. What would you like to know about the HBP dental program?
8. What do you expect the HBP dental program to be doing for the women referred?
9. What decisions need to be made about the HBP dental program?
10. What kind of relationship does HBP program have with the VCDP dental program?
11. What do you want the evaluation to focus on?
12. Please rank the following six evaluation criteria in your order of importance?
    a. Description of program
    b. Correspondence of program to objectives
    c. Outcomes
    d. Efficiency
    e. Acceptability
    f. Sustainability
13. Who needs and/or will use the information gathered from the evaluation?

Table 1. Interview guide for program stakeholders.

tal hygienist—recognized the need for this long overdue evaluation.

Several frameworks for program evaluation have been developed.[1,7,11–13] The first, and arguably most important phase of the evaluation process includes a description of the program, an analysis of the program's ability to achieve its stated objectives, and a determination of the program's readiness for evaluation. This first phase of a rigorously conducted program evaluation is called the Evaluability Assessment or "EA": a systematic process that describes the program's structure, i.e. its objectives, logic, activities and performance indicators, and then analyzes the feasibility of the structure for achieving the program's objectives. The EA examines the program's suitability for intensive evaluation and the acceptability of an evaluation to managers, policymakers, and program operators.[7,9] Furthermore, an EA may determine if and when evaluation is warranted, identify a feasible design of the evaluation (e.g. type, time perspective),[12] clarify the intent of the program, and also identify areas for improvement.[9] In general terms, the five elements of an EA are as follows: 1) development of the working group; 2) description of the program; 3) assessment of the program's circumstances; 4) assessment of the organizational climate surrounding the program; and 5) determination of the program's plausibility and evaluability.[9,14]

A primary outcome of an EA is a description of the theory underlying the program.[15] This theory is often graphically communicated by a "logic model" which is a visual schematic that illustrates the relationships between contextual factors and program inputs and outcomes.[13] The main program is defined and factors influencing the program are indicated. The basic components of a logic model are inputs (resources), program activities, outputs, outcomes, and impacts.[13] Resources or inputs are what go into the program to make it work; funding, personnel, community engagement, and available organizational resources. Activities are the interventions, tools, and actions that contribute to the desired results of the program. Outputs are the "products" of the activities, such as types, targets, or levels of services delivered. Outcomes are the short and medium term changes in knowledge, skills or behaviour of the participants,[13] whereas impacts are the primary intended or unintended changes for a variety of effects over a longer time period.[13] The logic model is based on key background information, personal and professional experiences, and future projections, and thus is under constant revision during the evaluation period.

The aim of this paper is to explain how the five elements of the EA described earlier were applied to the HBP dental program to determine a feasible evaluation design. The results of the EA, and the logic model that was generated, will be presented.

MATERIALS AND METHODS

This research was approved by the University of British Columbia Behavioural and Research Ethics Board and by the Vancouver Coastal Health Research Institute.

Interviews of "key players" are critical to understanding the links between the program's goals and activities,[9] and were the primary method used in this EA. Semi structured interviews, guided by an interview guide, were conducted either individually or in small groups (Table 1). In addition, data were collected by chart reviews, field observations, and analysis of appointment statistics. Funds were not available to hire an external program evaluator; therefore the evaluation was done as an "insider evaluation" by the program's dental hygienist. An insider or internal evaluator is someone internal to the organization, an employee of the program, who evaluates the services or policies of the organization.[12,15] The methods used to fulfill the five elements of the EA are detailed below.

1. *Development of the working group*

The program's main stakeholders were identified by the dental hygienist–evaluator as individuals with decision making authority or with major involvement with HBP dental program clientele (Figure 1). A preliminary meeting was organized with these stakeholders for the purpose of forming a smaller working group who would determine the objectives and scope of the evaluation. Other topics discussed were the rationale for the EA, the type of program documents that were available for analysis, and the names of other individuals who should be consulted during the EA. It was agreed that support staff and former HBP dental hygienists should be involved in this evaluability phase. Although the clients of the program were also important stakeholders, it was decided that their participation would be at a later stage of program evaluation, most likely the process and outcomes assessments.

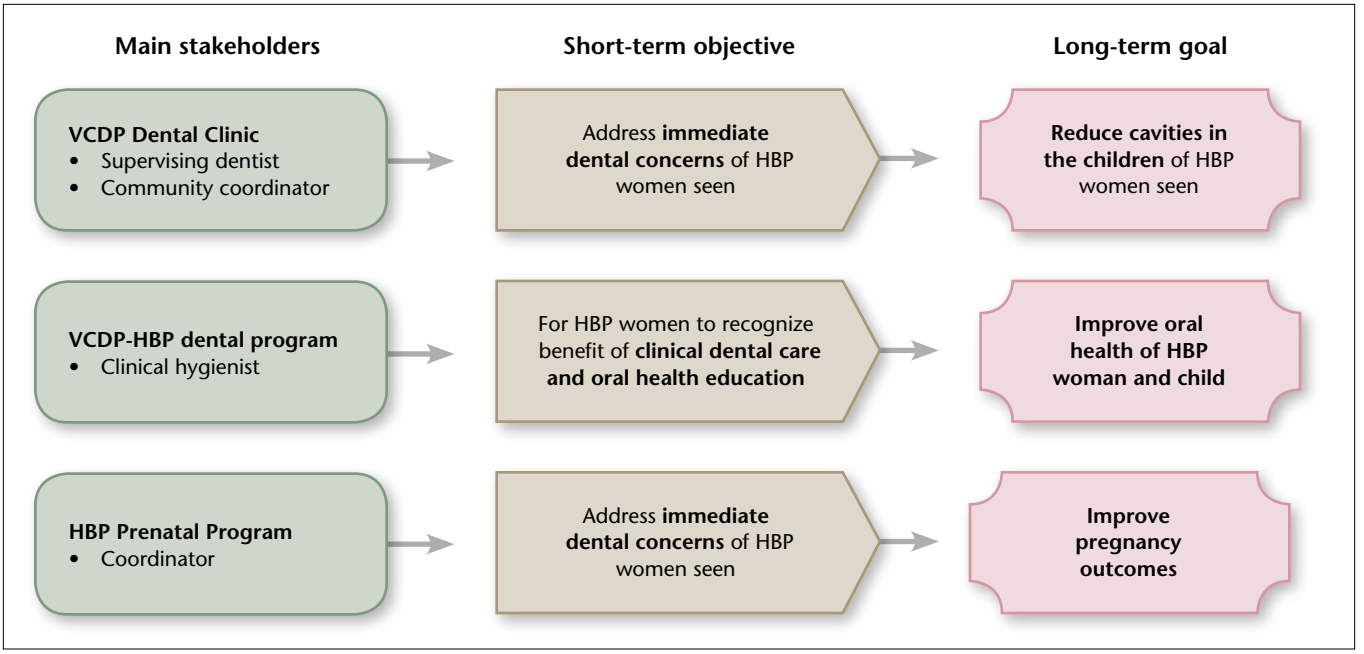

Figure 1. Main stakeholders' objectives and goals for HBP dental program.

2. Description of the program

A description of the fundamental theory of the HBP dental program was developed as a result of the interviews. The program's history, finances, activities, organizational structure, expectations, and relationships with other programs were also determined. The roles of administrators within the larger organization of the Health Authority and how they interacted with the HBP dental program were confirmed. In addition, interviews with support staff and other HBP service providers confirmed their roles, responsibilities, and challenges with the program and their opinions about the evaluation itself.

3. Assessment of the program's circumstances

The program's circumstances, or the "day-to-day reality" of the program, were delineated by questioning the receptionists, dental assistants, and dentists directly involved with the program. Existing methods of recording program and client information were examined. Documents—medical histories, dental charts, client information forms, referral forms, and appointment statistics—were manually retrieved and reviewed to better understand the type and extent of client data that was collected, the clarity of the data and its suitability for use in assessment of program outcomes or "measurement indicators". A profile of the HBP clients was established from chart reviews, interviews with the clinic receptionists, and from the evaluator's field notes.

4. Assessment of the organizational climate surrounding the program

It was important to assess the organizational climate in relation to the program and to the evaluation. This assessment was done by examining the program's resources, capacity, barriers, and support. Perceptions of the program and of the support for the HBP Dental Program and evaluation by the larger organizations and community partners such as staff from North Community Health Office and HBP, were summarized from interviews. Any major discrepancies among the stakeholders were followed up and clarified.

5. Determination of the program's plausibility and evaluability

The plausibility of this program, that is, whether the program had the necessary and sufficient conditions to succeed [7,9] was then examined in regards to clarity of goals and activities, identifiable success indicators and sources, sufficiency of activities and adequacy of resources to implement the program's activities. If the EA had determined the program to be "implausible" with no feasible solution to this concern, the maintenance of the program would need to be addressed. In such a situation, the EA would have functioned as a summative evaluation.[7]

Only after all of the above phases were completed could the program's evaluability be assessed. If the program or some part of the program was indeed ready to be evaluated, the next step was to explore the type of evaluation, what program areas to evaluate and the desired products of the evaluation. If the program was not ready to be evaluated, then recommendations would be made to delay the evaluation until changes were completed. Summaries of the EA with recommendations were presented by the evaluator to the working group. Clarifications were made, types of feasible evaluation designs were discussed, and the next steps, if any, in the evaluation were confirmed.

RESULTS

1. Development of the working group

The final working group comprised the dental hygienist who coordinated community dental programs, the dental clinic's supervising dentist, the nurse who coordinated the

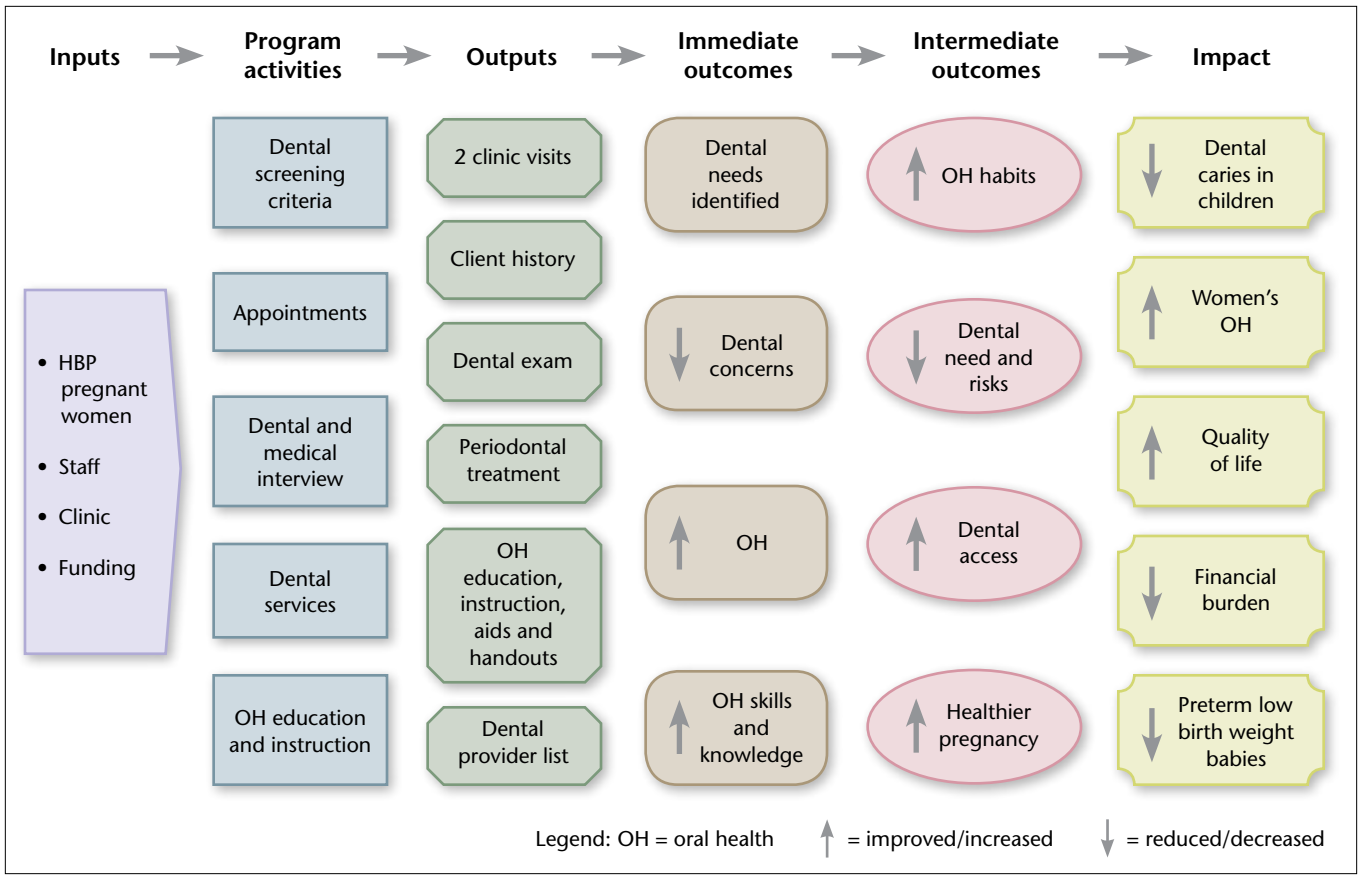

Figure 2. Logic model: HBP dental program theory.

HBP prenatal program, and the dental hygienist–evaluator. Periodic updates of findings were discussed and reported in group meetings and through e-mail correspondence. It was agreed that the main purpose of this first stage of evaluation was to develop a better understanding of the program's clientele, activities, and outcomes, and to identify areas for improvement. It was further agreed that while an analysis of cost effectiveness may have been desirable, it was not feasible at that time.

2. Description of the program

A more detailed description of the HBP dental program, its origins and its relationship to other programs emerged as a result of the EA. It appeared that this program was a relatively small component of a larger dental program called the Vancouver Community Dental Program (VCDP), located at a community health centre in a low income neighbourhood of Vancouver. The VCDP provides dental services primarily to low income children. The HBP dental program was limited to only those pregnant women referred from a larger "umbrella program" called the Healthiest Babies Possible (HBP) program, a government funded outreach program that supported high risk women to have healthy pregnancies. Based on any one of a number of risk factors, these women had been identified to be at high risk for delivering preterm or low birth weight babies or both. Examples of risk factors were low family income, young maternal age, addiction issues, language barriers, recent immigration, or Aboriginal status.[16]

The HBP dental program was established in 1986 to assist HBP clients who complained of the difficulty eating nutritious foods because of poor oral health. Since the program began, more than 1600 women have received services.[16] Twelve clinic appointments each month are allocated to women referred by HBP staff. The women referred either self identify a dental concern or have not had a dental visit in the previous two years. If a client requires additional dental treatment, she is given a list of other dental clinics offering services at reduced cost.

The EA process led to the long overdue creation of program objectives and goals (Figure 1), identification of all stakeholders and their roles and responsibilities and a logic model describing the program theory (Figure 2).

Goals of the HBP dental program

No formal written objectives or goals about the HBP dental program were available when the EA was begun. Figure 1 summarizes the short term objectives and the long term goals that were created as a result of the EA process. The comments from all of the interviews suggested that addressing the immediate dental needs of the clients was the primary short term objective, but the understanding of long term goals ranged from reduced number of cavities in the children of the HBP women seen to improved pregnancy outcomes or oral health of the HBP women and child. However, these goals were difficult to achieve because competing daily tasks and priorities of the larger umbrella programs interfered with the time and energy available for

the HBP dental program. The focus on children's dental health dominated the VCDP's clinical resources, staff, and activities. Furthermore, while women were referred to the HBP dental program from the umbrella HBP prenatal program, this prenatal program had no direct responsibility for providing funding or other resources. Misconceptions about reporting structure, roles and relationships, program activities and outcomes were also identified. The lack of an information feedback loop contributed to a discrepancy between expectations of the program and the actual program reality.

3. Assessment of program's circumstances

The program theory or rationale, as depicted by the logic model (Figure 2) was constantly reviewed and refined as more data were collected. The majority of inputs to the program were easily identified but details about other inputs, such as target population and funding, were sometimes vague. For example, demographic information about the referral base of "HBP women" was limited other than to clarify that they were classified at high risk for giving birth to preterm, low birth weight babies. Furthermore, funding was somewhat ambiguous other than provision of money for a dental hygienist's salary. It was determined that the main dental clinic's operational funds supported the cost of equipment and supplies.

Reports from interviews and field observations identified discrepancies between the program's activities, for example, the referral process, and the desired outputs and outcomes. Limited availability of appointments, the dental hygienist's difficulty in completion of treatment in the time available, language barriers, manual data collection system, and ongoing changes in the infrastructure were also challenges. The existing data collection system was not yet computerized. In addition, the program had not developed a close partnership with any dental clinic on the outside referral list.

While the HBP dental program's activities were easily identified, little was known about the effectiveness of these activities because their success indicators had not been articulated. Thus, the relationship between activities, outcomes, and impacts was uncertain. For instance, achievement of the stated goal of decreasing caries in the children of HBP dental clients was somewhat unrealistic since restorative services were not available in house for the HBP dental clients. Furthermore, no mechanism for determining oral health status of the children of HBP dental clients was in place.

The EA identified other potential barriers to measuring the effectiveness of the program. The program's health promotion activities relied on English comprehension, but many of the clients had limited knowledge of English. In addition, existing data such as dental charts often were missing details that could prove useful for evaluation purposes.

4. Assessment of the organizational climate surrounding the program

Awareness of the HBP dental program's existence, its activities, and purpose varied widely among the dental staff, the support staff in the health centre, and at all organizational levels within the regional health authority. Furthermore, there was a lack of clarity about the relationship of the HBP dental program to the Health Authority's organizational structure. However, support and professional staff reacted positively to the evaluation that was understood to be gathering information to improve the program. The Health Authority, the managers and other staff were also supportive of the evaluation. There was no concern that the evaluation would place the program in jeopardy of budget or program cuts.

5. Determination of the program's plausibility and evaluability

Although the EA formalized the program's goals and objectives (Figure 1), no performance indicators had yet been developed (Figure 1). Activities such as the dental screening criteria, appointments, dental and medical interviews, dental services, and oral health education and instruction were clearly identifiable but their link to desired outcomes was more problematic. Clinical treatment and counselling services had challenges fulfilling the short term goals of the program because of issues like time constraints and language barriers. The facilities, equipment, and supplies available were appropriate to support the activities identified.

EA RECOMMENDATIONS

Although the EA revealed some uncertainties about aspects of the program, the HBP dental program was determined, as a result of the EA, to be evaluable. It seemed most appropriate to conduct a descriptive evaluation to describe more thoroughly, and to analyze the program's structure, activities, and the clientele and their concerns. A process evaluation, examining the implementation of program activities e.g., reporting structure, data collection, and appointment monitoring system was also recommended because it could lead to improved operations and implementation of activities. Given the limited clinical services provided, language issues and unclear program objectives, the evaluator concluded from the EA that an in depth evaluation of outcomes was not realistic at this time.

DISCUSSION

The EA identified the roles and responsibilities of program personnel, and led to the creation of clear stakeholder program objectives and goals. The logic model helped visualize the program theory to allow for its critical examination, and to reveal any ongoing problematic assumptions. These benefits were similar to those reported from recent evaluations of health service programs.[17,18] The EA's preliminary evaluation phase revealed areas that needed improvement such as mechanisms for data collection, and also emphasized the importance of performing a process evaluation before considering an in depth evaluation of outcomes. The EA helped avoid two types of error: 1) measuring something that was not there, or 2) measuring something that was of little value to decision makers.[19] For example, identifying the severity of periodontal disease in the HBP clients was simply not a feasible outcome measure because their excessive calculus deposits and sensitivity to

probing meant that loss of attachment could not be reliably measured.

The EA clarified the goals of the HBP dental program but also challenged their feasibility. One goal so challenged was that of reducing caries in the children of women who participated. This goal was recognized to be somewhat unrealistic since the program did not provide a full range of dental services to the women, and no monitoring system was in place to track the oral health of children of these mothers. To analyze the plausibility and feasibility of the program's structure to achieve its objectives, helps avoid measuring outcomes that do not represent real possibilities. Such an analysis fulfilled the critical aim of an EA.

An unforeseen effect of conducting the EA was that the periodic reports of preliminary data maintained interest in the evaluation, and enhanced the participation of the working group. The interviews and observation process were easily facilitated because the EA was perceived by the personnel as a safe space for critical examination. This EA reduced "evaluation anxiety" because of its iterative nature and focus on program development.[20] Furthermore, this EA began preparing the program for future evaluations by addressing issues like clients' language barriers, and improving data collection.

The advantages of the program's dental hygienist conducting the evaluation were her straightforward access to data, program and staff; her existing relationships within the clinic setting; her ability to monitor program activities and to address areas of concern as they occurred, and the fact that an insider evaluation offered cost benefits to the organization.[21–23] However, a significant concern was that the complex EA activities involved a time commitment in excess of the dental hygienist's regular clinical responsibilities. Thus, this encroachment on regular work hours needs to be considered when dental hygienists working in public health embark on an insider evaluation. Diplomacy and objective presentation of these EA results are also required to avoid perceived bias and to prevent pre-existing relationships from influencing evaluation activities, either positively or negatively. These drawbacks and limitations of an insider evaluation can be diminished by adherence to rigorous and systematic evaluation methodology and, if possible, having the internal evaluation process validated by an external evaluator.[15,24]

CONCLUSION

The benefits of conducting, and the process of doing an EA to develop a feasible evaluation design for a dental prenatal program have been described. This non threatening EA identified areas to improve, and helped the program prepare for a meaningful evaluation. The EA conducted by the program's resident dental hygienist was a critical first step in the pathway to a successful future program evaluation.

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Results of *CJDH*'s *Readership Survey* of February 2010

The Publishing Editor of the *Canadian Journal of Dental Hygiene* administered a brief *Readership Survey* last winter about the journal. The survey was available online, and the survey tool used was through www.surveymonkey.com. The number of questions was limited to ten, including one open ended question for "any additional comments". The survey period was limited to two years of journal publication—2008 and 2009. CDHA members were invited to participate through regular CDHA e-mail broadcasts and e-newsletters. The previous journal survey had been conducted in June 1995.

The survey was designed to gauge the members' responses in three areas, and to use the data to help with future editorial and marketing decisions:

- Reading preferences – for example, should *CJDH* be offered only in online format?
- Editorial content – for example, what types of articles are appreciated and helpful in the practice of the profession?
- Advertisements – for example, how do our members perceive commercial advertising in the journal?

ANALYSIS

1. **What were the outcomes of reading the *CJDH* in 2008 and in 2009?**
   76.3% of members reported connecting with websites mentioned in articles, featured columns, and news. Editorially encouraging, was the strong interest in scientific content (full length articles, short articles, editorials, and Letters to the editor) at 66.6%. This interest was an indicator of dental hygienists' high commitment to professional development. The broad scope of this question also suggested that marketing strategies captured 53% of members' attention.

2. **What do you do when you get the latest issue of the *CJDH*?**
   54.1% of our members read the entire issue, while 58.8% read selected articles. More than half of respondents, at 56.4%, reported saving an article of interest for future reference. The readership has a strong preference for the journal in print format – 77%. Only 9% reported reading only the online version.

3. **What is your level of interest in seeing specific items on oral health care in future issues of the *CJDH*?**
   The two broad categories of practice standards, legal issues, professional opinions, and career/professional development reported "high to moderate interest" at 90.7% and 90.6% respectively.

4. **How has reading the *CJDH* influenced your professional development and activities?**
   64.5% of respondents agreed that reading the journal helped them improve their personal knowledge and practice of the profession.

5. **What is your opinion, in terms of interest, of the regularly featured items in the journal?**
   All of the regular features in the journal — messages from the President, the Executive Director, columns from the CDHA staff, and the news section — proved consistently popular with 72.4% of readers who ranked these items "good to read". Individually, the news section garnered 87.6% of the vote; *Probing the Net* followed at 81.4%, and *Letters to the Editor* came close behind at 80.2%.

6. **How do you keep yourself informed with dental hygiene news?**
   Of those responding, 68.2% showed a marked preference for using varied sources such as newsletters, search engines, conferences, etc., to stay well informed about the profession. Scientific content, through journals and medical databases, was the choice of 40.5% of respondents.

7. **If you keep yourself informed by reading professional journals, what would you say are your top five journal picks?**
   A follow up question to #6, this question elicited an encouraging response — 97.4% of respondents ranked *CJDH* their top pick over *any* other oral health journal in North America. On average, 31.1% read peer reviewed journals, while 16.7% identified reading non refereed journals. The top five picks were: *CJDH* at 97.4%; *Oral Health* at 38.5%; *JADA* at 37.2%; *JCDA* at 36.9%, and *J Periodontol* at 26.4%.

8. **Please indicate your evaluation of advertising inserts in the polybag that accompany your mailed issue.**
   77.4% of respondents reported the value of commercial advertising to be useful information, valuable products and discounts, and handy product samples that accompanied the polybagged journal.

9. **Given that the evidence for the product or service is solid, what else might influence you to purchase a dental hygiene product or service?**
   77.5% of responding dental hygienists were influenced by scientific evidence through articles they read, and recommendations from experts or their colleagues. 65.3% of those surveyed were influenced by testimonials and their personal analysis to purchase. Good marketing was a tertiary factor at 49.9%.

10. **The open ended comments at the end of the survey were varied in nature. A sampling is quoted below:**

I would really like to gain CE points for reading my journal. Is there some way that that may work?

Suggest include archived editions of CJDH on website prior to 2004, perhaps to 2000. There are excellent articles in 2002, 2003 editions for example, that still present relevant, valuable information.

I find that our journal has become so 'professional' that it has lost some of its human touch, whereby personal stories or heartfelt topics are no longer considered publishable.

The journal of CDHA published a research article a few years ago; comparing toothpastes in the Canadian market for abrasiveness. … I have given a copy of this study to many patients; and feel that it has helped me influence their oral health decisions. Thanks.

This journal is very eastern Canada formatted and since I live and practise in western Canada I feel a little alienated from this national journal.

There are many things happening in dental public health across Canada (such as Ontario's Low Income Dental Plan) but RDHs in public health across the country have no way to connect with one another to share information. CJDH could play a significant role in enabling communication in this field.

I do prefer receiving a printed copy rather than accessing the journal online.

I would like to see the journal with a more reader friendly format. Some of the articles are very dry… but hold very credible information.

The journal need not shut its doors to other ways of thinking and knowing. In doing so we may grow more holistically. I think we also have much to gain if we consider what other health professions and disciplines have to teach so we can continue to develop theoretically and practically.

The more scientific articles, and even just abstracts in the journal, the better!

Limitations

The results of the survey come with some limitations:

- Participation in the survey was from a small segment of 418 members of the wide dental hygiene community of 15,000.
- The survey was offered only online. The use of online surveys versus postal surveys may introduce a response bias due to differing characteristics of those who participate in online surveys.
- There was no prize draw or any other incentive offered to attract potential respondents to complete the survey.
- The survey did not collect any demographic information thus we do not know the extent to which the respondents represent the total membership.
- The survey was not offered bilingually.

Conclusion

The 2010 *Readership Survey* revealed important reading preferences of our member respondents. This information can provide the Editorial Board with useful information as they prepare to move the *CJDH* into the second decade of the twenty-first century. Findings from this survey have demonstrated that the *CJDH* is valued as a resource for dental hygienists.

Peer Reviewed Grant 2010

CANADIAN FOUNDATION FOR
DENTALHYGIENE
RESEARCH AND EDUCATION

Call for proposals deadline

An electronic and hard copy of the *Grant Application Form* is due by 5:00 p.m. ET, 15 October 2010.

Value of Grant
$10,000 - for more information please refer to the **Budget** section of the *Program Guidelines.*

Criteria
Proposals should address one or more of the following topic areas including:

- dental hygiene research, dissemination of dental hygiene research, public
- education, and publication of dental hygiene information. For more information please see **Criteria** in the *Program Guidelines*.

Eligible applicants
Applicants must be affiliated with organizations that can issue official donation receipts for gifts that individuals and corporations make to them. For more information see **Eligibility** in the *Program Guidelines*. Graduate students are welcome to apply.

Grant announcements
Grant announcements will be made on 15 November 2010.

Contact us
Judy Lux, MSW, Program Director
Canadian Foundation for Dental Hygiene Research and Education
96 Centrepointe Drive, Ottawa, Ontario K2G 6B1
1-800-267-5235 x 123 or 613-224-5515 x 123;
Fax: 613-224-7283; foundation@cdha.ca

And the winners are ...

CDHA congratulates our recent High Profile Contest prize winners:

Kirsty McCulloch of Belleville, ON
Sarah Hicks of St.Jacobs, ON
Shawna Sutton of Powell River, BC
Jeannette Pittman of Edmonton, AB
Nancy Pearce of Ridgeway, ON
Colleen Hogan-James of Lanark, ON
Julie Premo of Sault Ste. Marie, ON
Ewa Moskalewicz of Belleville, ON
Beatriz Restrepo Correa of Toronto, ON
Susie Montour of Kahnawake, QC

A big "Thank you" to **PHILIPS** and **SheerVision** for their generous prize donations.

Master's Research Award Funding Opportunity

The Canadian Foundation for Dental Hygiene Research and Education (CFDHRE) and the Canadian Institutes of Health Research (CIHR) jointly announce a Master's Award in Dental Hygiene relevant to the following areas:

- Biomedical research
- Clinical research
- Health services research
- Social, cultural, environmental and population health research

Dental hygienists, as opposed to members of the larger general health community, will specifically benefit from this award which will bring dental hygiene research to the forefront.

Value of Grant: The maximum amount awarded for a single award is up to $17,500 for a 1-year term.

Eligibility: To be eligible for consideration, applicants must be Registered Dental Hygienists, and the award must be held in Canada. This Priority Announcement will require the completion of a Relevance Form.

Application deadline: 1 February 2011

Details: For complete information, including details on objectives, guidelines, performance measurements, review process and evaluation criteria, visit: http://bit.ly/dsgAsO (English) and http://bit.ly/9CQ9qt (French)

Contact information:

For questions on CIHR funding guidelines, how to apply, and the peer review process contact:

Priority Announcement Program Delivery Team
Canadian Institutes of Health Research
Telephone: 613-954-1968
Toll-free: 1-888-603-4178
Fax: 613-954-1800
Email: PA-AP@cihr-irsc.gc.ca

If you are experiencing technical difficulties with your ResearchNet account or the e-Submission process contact:

CIHR ResearchNet Support
Canadian Institutes of Health Research
Telephone: 613-941-9080
Email: support@research net-recherchenet.ca

For questions about the **CFDHRE** contact:

Judy Lux
Program Director
Canadian Foundation for Dental Hygiene Research and Education
Telephone: 1-800-267-5235
613-224-5515 ext. 123
Fax: 613-224-7283

CDHA Partners' Circle Silver member

CDHA is proud to include Johnson & Johnson as a respected Silver member of its *Partners' Circle*. The CDHA *Partners' Circle* comprises dental industry firms dedicated to the advancement of the dental hygiene profession.

Johnson & Johnson recognizes the important role dental hygienists play in the overall oral health team. Johnson & Johnson, in partnership with CDHA, launched the first ever Dental Hygienist Hero™ recognition program in Canada. This wonderful initiative honours dental hygienists who have volunteered their time and services within communities across the country. Johnson & Johnson participated in a new oral health innovation through a sponsored webinar, with an exclusive product showcase, and with adverts in the *Canadian Journal of Dental Hygiene*.

We thank Johnson & Johnson for their commitment and support of the dental hygiene profession, and of CDHA. For more information on Johnson & Johnson's partnership initiatives with CDHA, visit www.cdha.ca

Position for commercial advertisement

Call for Abstracts for the CDHA Conference

Advancing Dental Hygiene Practice
HALIFAX
2011 CDHA Conference, Halifax, NS

Advancing Dental Hygiene Practice

Halifax, Nova Scotia, 10–11 June 2011

Closing date for Abstracts: 30 September 2010

Abstract Categories

- ***Research Presentations:*** This category includes 1-hour oral presentations on research, including program evaluation. Accepted submissions will give unique perspectives on research and program evaluations that have not been previously presented to or published for a primarily dental hygiene audience. **The initial submission, by 30 September 2010**, may include findings you plan to discuss when your data analysis phase is completed. You would then need to forward a **final abstract submission by 30 November 2010** indicating your results and conclusions.

  In this category, you will also need to submit a condensed version of your oral research presentation in 750–1000 words by **5 January 2011** for publication in the *Canadian Journal of Dental Hygiene*. Please note that CDHA reserves the right to edit your submission prior to publication.
- ***Community Connections:*** This category involves 30-minute oral presentations on community projects, including a Q & A period.
- ***Poster Presentations:*** The topics for the 4′ x 4′ sized posters are research, program evaluation, and community projects.

Abstract Guidelines and Requirements

1. Complete the abstract submission form electronically **no later than 30 September 2010**. *Every applicant must meet this submission deadline*. The abstract submission is to be completed electronically at http://www.surveymonkey.com/s/callforabstractscdha2011
2. Abstracts are accepted in English only. The presentations at the conference may be in English or in French.
3. The abstract must be no longer than 250 words including a brief statement of the objectives, methods, results, and conclusions. More than one abstract may be submitted. However, each abstract must be submitted separately. Individuals submitting multiple abstracts may be the primary presenter on only one but may be the co-author on other abstracts. Presenters are not required to be the principal investigator of the study, but should be a member of the research team.
4. Previously presented and/or published abstracts will be considered, and must include the citation and/or the title and date of the event where the abstract was presented or published.
5. If an emergency arises and the presenter is unable to attend, he/she must notify CDHA in writing ***prior to the conference*** that he/she is withdrawing the abstract or naming a substitute presenter. All notices should be emailed to abstracts@cdha.ca
6. To view examples of abstracts, visit http://www.cdha.ca/pdfs/Abstract_examples.pdf
7. Presenters are responsible for financial costs incurred with attending the conference.
8. Submission of an abstract constitutes a commitment by the identified presenter to be in attendance at the conference if the abstract is selected.

Review and Selection Process

Abstracts will be selected through a blind peer review process based on the following: relevance to dental hygiene practice, importance of issue, uniqueness of topic, quality of research methodology/approach, and clarity of abstract.

Notification of results

Participants will receive written notification of either acceptance or rejection of their abstract in January 2011.

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Information inquires should be directed to:
CDHA Abstract Coordinator, E-mail: abstracts@cdha.ca
Toll free in Canada and the US: 1-800-267-5235 ext. 143 or Fax: 1-613-224-7283
Telephone from other countries: 00+1+613-224-5515 or Fax: 00+1+613-224-7283

◀ Alison MacDougall (left) shares a light moment with Marjolijn Hovius, President, IFDH.

I was honoured to participate in a 2-day workshop sponsored jointly by IFDH and Proctor & Gamble. My role was to act as facilitator of one of four work groups and our group explored the topic of "Promoting Evidence-based Dental Hygiene Practice, Procedures and Products". The results of the 2-day workshop were compiled into a presentation by JoAnn Gurenlian, and presented during closing ceremonies of the *International Symposium on Dental Hygiene*.

The House of Delegates (HOD) of the IFDH meets once every three years in conjunction with the *International Symposium on Dental Hygiene*. The HOD has a very hectic schedule with a detailed agenda to cover; and this year was no exception. The HOD voted to create Special Interest Groups (SIGs) within IFDH. These SIGs were created to foster more effective communication between members and delegates who have common interests and goals, and to reduce the break down in communication that has happened to previous working groups of the IFDH.

The helm of executive leadership at IFDH is now held by Maria Perno Goldie, *President*, JoAnn Gurenlian, *President Elect*, Leah Littlejohn, *Treasurer*, Catherine Walden, *Vice President*, and Angela Fundak, *IFDH Administrator*.

The 18th *International Symposium on Dental Hygiene* was held in Glasgow, Scotland, on July 1–3, 2010, with over 1200 delegates in attendance. The theme was *Oral Health—New Concepts for the New Millennium*. The Scientific Programme was diverse and delivered on its promise to "update, inspire and challenge".

The 19th *International Symposium on Dental Hygiene* will be held in South Africa in 2013.

Notes from Scotland

Report from Alison MacDougall, RDH, Senior Canadian Representative to the International Federation of Dental Hygienists (IFDH)

I attended the workshop and meetings of the House of Delegates of the IFDH in Edinburgh, Scotland, from 27–30 June 2010, in my role as Senior Canadian Representative. Wanda Fedora, Past President of CDHA, also attended these meetings in her role as Junior Canadian Representative.

Over the past three years, I have been involved with IFDH as Chair of the Membership Committee. To date, there are twenty-four national dental hygienists' associations as members to IFDH. Currently four other countries are exploring the option of joining this international organization. One of the goals of the membership committee was to engage the dental hygiene student population to encourage their participation within IFDH, and I am pleased to report that there will be a student membership category ($25) added to the existing membership categories of IFDH.

▲ Alison and Wanda Fedora, CDHA's representatives at the IFDH and ISDH.

▲ At the opening ceremony of the conference, the band in regalia.

18th *International Symposium on Dental Hygiene*

Report from Wanda Fedora, RDH, Junior Canadian Representative to the International Federation of Dental Hygienists (IFDH)

The setting for the *International Symposium on Dental Hygiene 2010* was the Scottish Exhibition and Conference Centre on the banks of the River Clyde in Glasgow, Scotland. The British Society of Dental Hygiene and Therapy hosted over 1200 dental hygienists from across the globe to an opening ceremony with an atmosphere that revved to a roar as the national representatives marched in with their flags to the accompaniment of a band of pipes and drums decked in their Scottish finery.

Our Masters of Ceremonies, Marjolijn Hovius and Maria Perno Goldie, President and President Elect of the International Federation of Dental Hygiene, welcomed the attendees and invited everyone to join in the many scientific sessions and self development opportunities, as well as in the entertainment activities that were slated for the next few days. Our organizers had prepared a buffet of delicacies from haggis to oat cakes, and we could sample it all.

We moved from the opening ceremonies to the exhibit hall where the exhibitors indulged delegates with their newest and brightest ideas and products. The exhibit hall proved to be a popular spot with lunches and receptions day and night. What a great place to meet other dental hygienists from so many different countries sharing a passion for their profession! It was exhilarating. The thirty-five registered Canadian delegates seemed to be able to find each other over and over again despite the other 1165 people in our midst.

Sessions over a three-day schedule, ranged in variety from the oral systemic link to periodontal pocket access issues, and almost any other topic that would intrigue a dental hygienist. Equally interesting were the poster presentations from fellow dental hygienists who displayed the results of their research, and fielded questions from their colleagues. An enjoyable format of short sessions provided an opportunity to hear interesting updates from professionals in their area of expertise. Hands on demonstrations also allowed delegates to try out tools of the trade and experiment with techniques while hearing from the industry representatives. So much to do and yet so little time when you are caught up in the atmosphere of the event.

▲ Some of the Canadian delegates at the ISDH.

The gala dinner set the stage for the Sunstar World Dental Hygienist Ceremony, sponsored by the Sunstar Foundation for Oral Health Promotion. The dinner was a first class display of Scottish delights but the highlight of the evening was the presentation of the top award for research to Canada's own—Sherry Priebe DipDH, BDSc(DH), RDH, MSc. Sherry was recognized for her research in oral squamous cell carcinoma and cultural risk habits in patients at the oncology hospital in Ho Chi Minh City, Vietnam. It was truly a proud night for Sherry, and all of her colleagues in Canada.

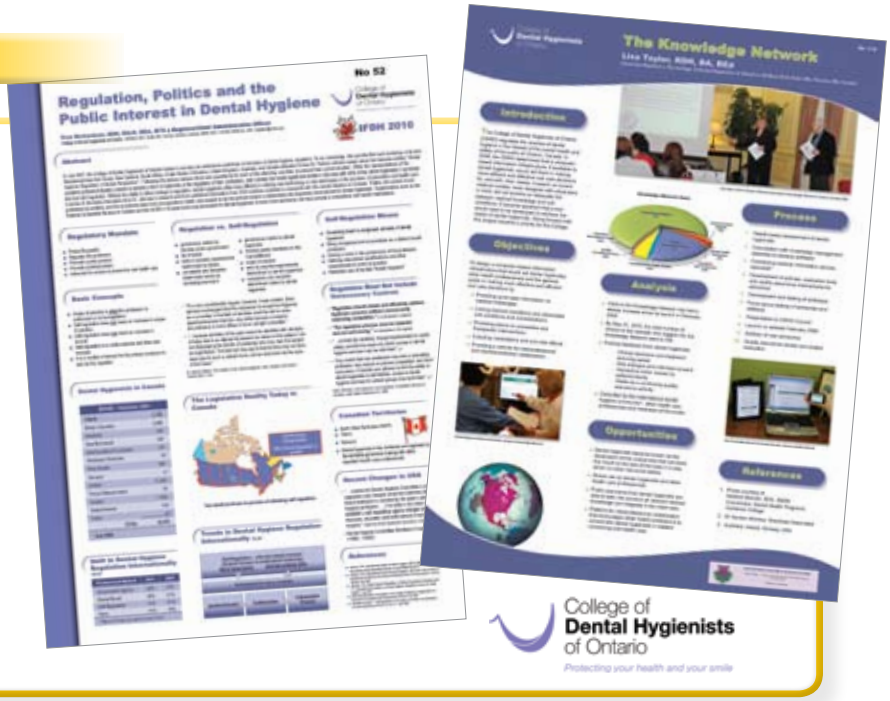
The Organizing Committee of the British Society of Dental Hygiene and Therapy is to be congratulated for an excellent symposium that satisfied our personal and professional appetites. Way to go UK!

Poster presentations

Fran Richardson, BScD, MEd, MTS, RDH, and Lisa Taylor, RDH, BA, BEd, from the College of Dental Hygienists of Ontario, presented a poster each at the *International Symposium on Dental Hygiene* in Glasgow.

▲ Fran Richardson

▲ Lisa Taylor



World Dental Hygienist Award winner: Research category

▲ Sherry L. Priebe, DipDH, BDSc (DH), RDH, MSc, University of British Columbia, Canada, is the proud recipient of the Award for Research. Sherry is pictured on the far right.

Sherry, on her Award

Sherry writes:

"The *International Symposium on Dental Hygiene* was wonderful to attend in Glasgow, Scotland and the honour was mine to represent Canada, our BCDHA and UBC who assisted to make my accomplishments a reality. The Scottish people were lovely and the UK dental hygienists prepared a fantastic conference in every way for us. The gala award ceremony was like a fairytale. I am so thankful to have good memories after such hard work with my master's study. My presentation was well received on the Saturday of the conference, and a great sense of networking for future research was initialized! My research article entitled 'Oral Squamous Cell Carcinoma and cultural oral risk habits in Vietnam' is published in the *International Journal of Dental Hygiene*, August 2010.

I am honoured to have been recognized with such a prestigious award in furthering world dental hygiene research. My passion has always been in assisting people to achieve optimum oral health through research, education and clinical practice. My world outlook of dental hygiene embraces people's oral health relating to cultural similarities and differences. Key contributions have been made to the oral cancer patients at the oncology hospital in Ho Chi Minh City, the global dental community as a whole, and specifically to dental hygienists, and to the general public based upon education from the research results and discussions. It is exhilarating to see my efforts come to fruition in this award and touch the lives of innumerable people. I look forward to further research and to presenting global cultural trends that affect us as dental hygienists in Canada."

The editorial office of CJDH *welcomes news of Canadian dental hygiene researchers' presentations, awards, grants, or recognition to showcase on this page, Research Corner. If you would like to highlight your own or another dental hygiene researcher's achievements, we'd like to hear from you. Contact Publishing Editor, Chitra Arcot, at journal@cdha.ca or the Acquisitions Editor, Linda Roth, at acquisitions@cdha.ca*

CASE REPORT: Interprofessional collaboration—A Nursing–Dental hygiene experience

Donna L. Bowes*, RDH, Dip.DH, Dip.Gerontology, BHA; Heather McConnell§, RN, BScN, MA(Ed); Mary-Lou van der Horst±, RN, BScN, MScN, MBA

ABSTRACT

Interdisciplinary collaboration has been advocated in health care for many years, and more recently, has focused on the inclusion of oral health care. This paper illustrates a successful collaboration between nursing and dental hygiene; it carries the potential to change nursing practice and advance oral hygiene care across Ontario, Canada, and internationally. In addition, the paper outlines an ongoing collaboration—an oral health community of practice (CoP) that serves as an example of the synergy created when professionals work together towards a common goal.

RÉSUMÉ

La collaboration interdisciplinaire est préconisée depuis plusieurs années dans les soins de santé et, plus récemment, elle se concentre sur l'inclusion des soins buccaux. Cet article illustre la réussite de la collaboration entre les soins infirmiers et l'hygiène dentaire; il fait état de la possibilité de modifier l'exercice des soins infirmiers et de promouvoir les soins d'hygiène buccale en Ontario (Canada) et internationalement. En outre, l'article souligne une collaboration en cours – une communauté d'exercice (CdE) en santé buccale qui sert d'exemple de la synergie qui se crée lorsque les professionnelles travaillent ensemble dans un but commun.

INTRODUCTION

Interprofessional collaboration in the provision of health care has been advocated by health professionals and others for many years. Since 1978 the World Health Organization[1] has promoted the "effective collaboration of partners from various disciplines and sectors of society" and stresses that it can lead to "essential, practical and scientifically sound, accessible, appropriately delivered, coordinated and affordable health care".

The health care system appears to have been slow to fully embrace collaboration as evidenced by a 1994 textbook[2] from Ohio State University which supports the need for interprofessional care and collaborative practice. In it Castro et al.[2] state that as health care services have seen increased specialization, the individual as a client is divided up by body part, body system, by disease, and/or by the interventions recommended. These subspecialties within professions have resulted in the need to have a mechanism to get the "person back together conceptually" in order to ensure holistic, comprehensive health care services.[2]

In more recently published literature, collaboration and partnerships in the provision of oral health care has been advocated. Two key reports from the United States, the *Surgeon General's Report on Oral Health in America*[3] and the *National Call to Action to Promote Oral Health*[4] emphasize the need for partnerships between key stakeholders to collaborate in oral disease prevention. Since 2006, the Canadian Oral Health Strategy[5] (COHS) has been facilitating the integration of oral health promotion with other health care services as they have recognized that a multifaceted, coordinated strategy is more effective in reaching a broader range of individuals than the traditional approach where oral health care is seen as independent and outside of mainstream health. More recently, the Canadian Dental Association Committee on Clinical and Scientific Affairs[6] emphasized that quality dental and oral care services for seniors be available across the continuum through an interdisciplinary approach to care that includes the sharing of information and expertise between oral health care providers, primary care providers, dieticians, social workers, and other health care providers.

In 2006, Health Canada[7] endorsed a collaborative approach to patient centred care that promotes active participation by a range of health professionals and respect for the expertise and knowledge that each contributes to the interprofessional team. In support of this position, Ontario's Interprofessional Steering Committee[8] reported that Ontario's health care system will become more effective as it embraces interprofessional practice approaches. This report acknowledges that the structures within the health care system often separate providers rather than creating opportunities for collaborative, interprofessional practice. They concluded that better outcomes can be achieved by optimizing the expertise of all health care providers.

The Canadian Health Services Research Foundation[9] (CHSRF) defines interprofessional collaboration as the process in which different professional groups work together to positively impact health care. It involves a negotiated agreement, between professionals, that values the expertise and contributions various health professionals bring to patient care.

Clearly, there is significant support at the systems level for partnerships and interprofessional collaboration, which includes a concomitant requirement for professionals to move beyond their individual "silos" and work together for the overall benefit of the patients and communities we serve.

NURSING–DENTAL HYGIENE LINK

The CHSRF[9] emphasizes that the ability to work with professionals from other disciplines to deliver collabora-

* Halton Region Health Department. § Registered Nurses Association of Ontario. ± Regional Geriatric Program - Central
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This is a peer reviewed article.
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Supervisor Oral Health, Halton Region Health Department, Ontario

tive, patient centred care is considered a critical element of professional practice. Oral health is a care issue that transcends professional boundaries. However, traditionally, there has been little connection between dental hygiene and nursing. Yet dental hygienists and nurses are in an "*ideal position to provide health promotion and education and screening across the multitude of settings in which they work regarding the oral health and risk factors for oral disease*".[3,10,11] Similar to dental hygiene, the practice of nursing involves assessment, planning, intervention, evaluation, teaching and counselling in direct care, research, policy and advocacy for patient populations and communities.[12]

Nurses traditionally had little direct involvement in oral health issues as they were not a priority area for nursing health promotion efforts. However, there is increasing attention being paid to oral health within a range of professional disciplines, especially for older adult and vulnerable populations receiving direct care. Increasingly, dental science and evidence based information about the oral–systemic connection is being made available to health care providers; i.e., that diseases of the mouth have similar risk factors, causes and treatments as many systemic diseases, and that optimal patient health can be achieved only when oral health is included. The COHS[5] states that health promotion, which includes addressing the determinants of health, the risk factors and causes of disease in general, will help improve oral health in the same way it can impact the overall health of individuals and communities.

In interdisciplinary partnerships, one must be prepared to share knowledge and expertise, teach, learn and, above all, set aside the "silo" system of thinking. These elements were reported in Suter et al.'s[13] qualitative study in which the respondents:

a) recognized the fundamental importance of acknowledging and respecting the expertise of all professionals for the benefit of the patient,

b) recognized that no single discipline can meet all of a patient's needs, and

c) identified that these factors drove their desire to collaborate.

INTERPROFESSIONAL COLLABORATION AND THE DENTAL HYGIENIST

How does the concept of interprofessional collaboration translate to the environment in which dental hygienists are employed? The majority of dental hygienists are educated and subsequently work for much of their professional lives within a dental clinical practice model.[14] In this environment, collaboration may be viewed as the normal method of functioning within the immediate dental office team or with other dental colleagues. Rarely does it involve collaboration with professionals outside the field of dentistry. With self regulation and changes to legislation across Canada more dental hygienists are exploring unique and creative ways to deliver dental hygiene services, the success of which will inevitably rely on their ability to engage their interprofessional colleagues.

Description: A Nursing–Dental hygiene collaborative experience

Those dental hygienists who are employed in public health or in a hospital environment are more likely to have experienced enhanced opportunities for interprofessional collaboration, and therefore will have some familiarity and comfort in working with an expanded team. Such was the case in May 2006 when the Halton Region Health Department (HRHD) was contacted by the Registered Nurses' Association of Ontario (RNAO) and invited to participate on an interprofessional panel tasked with developing an evidence based guideline focusing on oral hygiene care for nurses. Regardless of the practice environment that a dental hygienist is working in, an invitation to participate on an interprofessional project outside of those comfortable profession specific boundaries can be intimidating but an opportunity not to be missed. The Canadian Interprofessional Health Collaborative[15] acknowledges that effective collaborative practice requires an environment of trust and recognition of the expertise that each brings to their practice. Health care providers need to be able to ask questions and seek clarification without being intimidated or seen as "unknowledgeable". Achieving this level of comfort is the key to any successful interdisciplinary collaboration and is gained through the development of positive, trusting relationships and built on a foundation of positive experiences.

RNAO best practice guideline development

The RNAO is the professional association representing registered nurses in Ontario. RNAO advocates for healthy public policy, promotes excellence in nursing practice, advances nurses' contribution to shaping the healthcare system, and influences decisions that affect nurses and the public they serve. The *International Affairs and Best Practice Guidelines Program* is a signature program of the RNAO. Since 1999, with funding from the Ministry of Health and Long Term Care, it has focused on the development, dissemination, implementation, and evaluation of clinical and healthy work environment best practice guidelines in order to support evidence based nursing practice.

Best practice guidelines are systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific clinical (practice) circumstances.[16] RNAO best practice guidelines are developed through a rigorous methodology that includes planning, development, dissemination, evaluation as well as regular review and revision to ensure the evidence remains current. The guidelines are developed by nurses and other health professionals who contribute their time and expertise to this collaborative process.

In May 2006, the RNAO convened a guideline development panel whose mandate was to establish recommendations to support evidence based nursing practice in the area of oral care. This international, interdisciplinary panel of 14 expert clinicians included: nine nurses (including one nurse practitioner) representing the continuum of care, one dentist, two registered dental hygienists and two registered speech language pathologists. These individuals were identified through a structured process that included environmental scans (including who was publishing in this area), recommendations from professional associations, professional networks, and academic centres.

During the panel recruitment process, the RNAO contacted the HRHD seeking a representative for the de-

velopment panel as the HRHD was recognized as a leader in oral health outreach and had a demonstrated interest in supporting excellence in oral health care.

The development panel, supported by RNAO staff, first met in July 2006 to come to consensus on the focus of the guideline and define its scope. After much discussion and debate the group agreed that the purpose of the guideline *Oral Health: Nursing Assessment and Interventions*[17] was to provide nurses with recommendations, based on the best available evidence, to support the provision of oral hygiene care to adults with special needs. It focuses on specific vulnerable populations over the age of 18 who require assistance to meet their oral hygiene needs, and addresses:

- assessment of oral health (incorporating screening),
- assessment of current oral hygiene practices, and
- evidence based interventions (incorporating care plan development).

Resources to support implementation with clients across a range of practice settings are provided in the appendices to ensure the guideline is concise, comprehensive, and user friendly.

The guideline, *Oral Health: Nursing Assessment and Interventions*[17], was published in December 2008, and has since been disseminated widely across Ontario, nationally, and internationally to nurses and other health professionals.

Leveraging expertise and collaborative opportunities

During the collaborative process the panel members identified several key oral health problems that pose significant challenges to caregivers across the continuum. The group identified the need for health care settings to have immediate access to oral health expertise and guidance. After much debate and discussion, they agreed that this was a system wide issue that would require extensive collaboration between key stakeholders at the provincial and national level, and would have to be viewed as a long term goal.

In the interim, the RNAO was able to direct resources to address the immediate need to support knowledge transfer related to oral health care. In partnership with the HRHD, two instructional DVDs were produced: *Oral Care for Residents with Dementia*[18] and *Oral Care for Xerostomia, Dysphagia, and Mucositis*[19]. These DVDs were to support evidence based nursing practice and to provide guidance in addressing practice issues.

This partnership and the knowledge transfer tools that were developed resulted in the RNAO receiving the Canadian Dental Association *Oral Health Promotion Award* in November 2009. The award acknowledges the contributions of the RNAO to improved oral health of Canadians through oral health promotion.

Following publication of the guidelines and the instructional DVDs, one of the registered nurses on the RNAO panel invited the HRHD to collaborate with the Regional Geriatric Program (RGP) of Ontario–Central in Hamilton to form the first Oral Health Community of Practice (CoP) through the Seniors Health Research Transfer Network (SHRTN). SHRTN is an Ontario based, province wide knowledge exchange network, funded by the Ministry of Health and Long-Term Care, that links caregivers with researchers and policy makers who work together to improve health care for seniors.

Organizations	Website	Types of Resources
HRHD Halton Region Health Department *Oral health*	www.halton.ca/hoho	Dental care resources for • Long term care and other settings • Consumers • Oral health professionals
RGPC Regional Geriatric Programs of Ontario Central *Geriatric health care*	www.rgpc.ca	Oral health care resources for older adults: • Health professionals • Variety of health care settings including long term care and primary care • Geriatrics
SHRTN Seniors Health Research Transfer Network Ontario *Knowledge exchange*	www.shrtn.on.ca	Community of Practice (older adult focus) • Promotion of a variety of dental and oral care knowledge and resources for health care and dental health professionals caring for older adults in a variety of care settings • Geriatrics
RNAO Registered Nurses Association of Ontario *Evidence-based best practice guidelines*	www.rnao.org/bestpractices	Nursing best practice guidelines • Oral health BPG: interprofessional focus on vulnerable and dependent populations in health care settings • Two oral health DVDs
CCOH University of Manitoba's Centre for Community Health	www.umanitoba.ca/dentistry/ccoh	Dental care resources for • Community and long term care settings • Consumers
ELDERS University of British Columbia ELDER Group	www.elders.dentistry.ubc.ca	Dental care resources for older adults: • Variety of dental care and health care settings • Consumers

Table 1. Dental care resources specific to older adults.

The SHRTN Oral Health CoP sponsor is St. Peter's Hospital in Hamilton, and there are five co-leads: one nurse from each of the RGP Central and London sectors, one nurse from St. Peter's Hospital, one dental hygienist from HRHD and one dental hygienist from Thunder Bay. Membership in the Oral Health CoP is open to anyone interested in seniors' oral health and currently includes a variety of health and oral health professionals across Ontario and Canada.

The SHRTN Oral Health CoP operates as a trans sectoral knowledge based network which enables the dissemination of evidence based and clinically relevant oral health information (including the guideline and resources described previously) to care providers of frail older adults through three interconnected methods: (a) awareness raising strategies, (b) education/learning opportunities; and (c) collaboration and networking opportunities between health and dental care sectors. A recent study by Gaboury et al.[20] noted that constant knowledge exchange was found to be a factor that characterized effective interprofessional teamwork.

Related websites and resources

Table 1 provides some links to websites and resources with information about older adults that may be of interest to dental hygienists.

CONCLUSION

The results of the collaborative efforts outlined within this article have the potential to serve as a pathway for others to follow. The best practice guideline and related resources can be used as evidence based tools to support the integration of oral health care within nursing practice. The document also provides suggestions for areas that require further research that could be undertaken by interprofessional collaborative research teams.

Dr. Roz Lasker, Clinical Professor at the Mailman School of Public Health, Columbia University[21] states, "The unique advantage of collaboration is synergy". Synergy can be defined as the ability of a group of people or organizations to do more together than they can do on their own. It is achieved through a collaborative process that enables diverse participants to combine their complementary knowledge, skills and resources. This paper has described a successful example of building on the synergy of an interprofessional team in order to improve patient/client outcomes.

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NOTICE OF ANNUAL MEETING OF MEMBERS OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION (CDHA)

Notice

NOTICE is hereby given that the annual meeting of the members of **CDHA** will be held at the Montreal Marriott Chateau Champlain, 1 Place du Canada, Montreal, Quebec H3B 4C9, on Saturday, the 16th day of October 2010 at the hour of 12 noon to:

1. receive the financial statement of the corporation for the fiscal period ended 30 April 2010, and the report of the auditors thereon;
2. appoint auditors; and
3. transact such further and other business as may properly brought before the meeting or any adjournment thereof.

Copies of the financial statements and the auditor's report are available for review at the corporation's head office during normal business hours.

Dated the 15th day of September 2010
BY THE ORDER OF THE BOARD OF DIRECTORS

Ann C. Wright

(Acting) Executive Director

AVIS DE CONVOCATION DE L'ASSEMBLÉE ANNUELLE DES MEMBRES DE L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES (ACHD)

Avis

AVIS est par les présentes donné que l'assemblée annuelle des membres de **L'ACHD** aura lieu à Montréal Marriott Château Champlain, 1 Place du Canada, Montréal, Québec H3B 4C9, le samedi 16 octobre 2010, à midi. En voici l'ordre du jour:

1. recevoir l'état financier de l'Association pour l'exercice ayant pris fin le 30 avril 2010 et le rapport des vérificateurs à ce sujet;
2. nommer les vérificateurs;
3. régler toute autre question dûment soulevée à l'assemblée annuelle ou à toute nouvelle assemblée convoquée en cas d'ajournement de l'assemblée annuelle.

Des exemplaires des états financiers et du rapport du vérificateur peuvent être examinés au siège social de l'Association pendant les heures d'affaires ordinaires.

Fait le 15 septembre 2010
PAR DÉCRET DU CONSEIL D'ADMINISTRATION

Ann C. Wright

Directrice générale (intérimaire)

ANNUAL GENERAL MEETING OF MEMBERS OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION (CDHA)

Proxy

The undersigned hereby appoints Palmer Nelson, or failing her, Jacki Blatz, or instead of the foregoing*

_____

as proxyholder of the undersigned with full power of substitution to attend and vote at the Annual General Meeting of the members of the Canadian Dental Hygienists Association on 16 October 2010 and at any adjournment thereof (each a "Meeting") with the same powers as if the undersigned were personally present. This proxy revokes any and all previous proxies executed by the member in respect of the relevant Meeting.

Signature of Voting Member _____ Date (please print)_____

Voting Members Name (please print) _____

* A Voting Member has the right to appoint a person (who must be another Voting Member of the Canadian Dental Hygienists Association).

To be valid this proxy must be signed by the Voting Member; and received at the Canadian Dental Hygienists Association, 96 Centrepointe Drive, Ottawa, Ontario K2G 6B1 (by mail or facsimile to 613-224-7283) not later than 9:00 a.m. ET 14 October 2010; and shall be valid only for the meeting for which it was specifically given or for any adjournment thereof.

ASSEMBLÉE GÉNÉRALE ANNUELLE DES MEMBRES DE L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES (ACHD)

Formulaire de procuration

La personne soussignée nomme par la présente Palmer Nelson, ou à défaut, Jacki Blatz, ou à la place des personnes susmentionnées*

_____

comme fondée ou fondé de pouvoir avec pleins pouvoirs de substitution pour assister et voter en son nom à l'assemblée générale annuelle des membres de l'Association canadienne des hygiénistes dentaires, le 16 october 2010, ainsi qu'à toute reprise en cas d'ajournement de cette assemblée (chacune constituant une « réunion »), avec les mêmes pouvoirs que si la personne soussignée y assistait personnellement. La présente procuration révoque toute autre procuration donnée antérieurement par le membre relativement à l'assemblée en question.

Signature du membre votant_____ Date (en lettres moulées)_____

Nom du membre votant (en lettres moulées) _____

* Tout membre votant a le droit de désigner une personne (qui doit être un autre membre votant de l'Association canadienne des hygiénistes dentaires).

Pour être valide, cette procuration doit être signée par le membre votant; elle doit être reçue aux bureaux de l'Association canadienne des hygiénistes dentaires, 96 Centrepointe Drive, Ottawa, Ontario K2G 6B1 (par la poste ou par télécopieur, au 613-224-7283) le 14 octobre 2010 à 9 h HE, au plus tard; en outre, elle n'est valide que pour la réunion pour laquelle elle a été expressément donnée ou pour toute reprise en cas d'ajournement.

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THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

The *Canadian Journal of Dental Hygiene (CJDH)* provides a forum for the dissemination of dental hygiene research to enrich the body of knowledge within the profession. *CJDH* is a peer reviewed journal. Manuscripts should deal with current issues, make a significant contribution to the body of knowledge of dental hygiene, and advance the scientific basis of practice. Manuscripts may be submitted in English or French. All accepted submissions will be edited for consistency, style, grammar, redundancies, verbosity, and to facilitate overall organization of the manuscript.

Criteria for submission: A manuscript submitted to *CJDH* for consideration should be an original work of author(s), and should not have been submitted or published elsewhere in any written or electronic form. It should not be currently under review by another body.

Pre submission enquires to: Ms. Linda Roth, Acquisitions Editor, *CJDH* 96 Centrepointe Drive, Ottawa, ON K2G 6B1; t: 613-224-5515 x 136; f: 613-224-7283; e: acquisitions@cdha.ca or lroth@cdha.ca; toll free: 1-800-267-5235 x136

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Appeal for re-review may be addressed to the Scientific Editor by e-mail (journal@cdha.ca) who will take it forward to the Editorial Board. The committee members may decide to seek a further review or reject the submission. There are no opportunities for a second appeal.

	Check	Elements
1		Used standardized fonts such as Arial, New Times Roman, Verdana in 10–12 points.
2		Double spaced text in body of manuscript.
3		Manuscript has standard margins of 1 inch (2.5 cm) at the top, bottom, left and right.
4		Pages are numbered consecutively, starting with title page.
5		Cover letter accompanies manuscript with your declaration of originality, any conflict of interests, your contact information.
6		Placed figures, tables, graphs, photos at the end of the manuscript.
7		Provided signed permissions for any text or pictures of client/patient.
8		Are all previously published illustrations appropriately credited? Have you checked their publisher's website for restricted use or permissions?
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10		Included all the authors' academic titles, and their current affiliation(s).
11		Cover letter contains names and contact information of two possible and willing reviewers for your submission.
12		Key words are terms found in MeSH database in Search "MeSH": http://www.ncbi.nlm.nih.gov/mesh
13		Used only the Vancouver style of referencing in the manuscript: http://www.nlm.nih.gov/bsd/uniform_requirements.html
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3. **Key words:** Provide a maximum of 10 key words or short phrases from the text for indexing purposes. Terms from the Medical Subject Headings (MeSH) list of *Index Medicus* are preferred. Use the drop down menu in Search to choose MeSH http://www.ncbi.nlm.nih.gov/mesh
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(Condensed version, January 2010)

Instructions aux auteures

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Le *Journal canadien de l'hygiène dentaire (JCHD)* est un outil de diffusion de la recherche en hygiène dentaire ayant pour but d'enrichir l'ensemble des connaissances au sein de la profession. Mieux encore, il vise à sensibiliser et à intéresser davantage la communauté des hygiénistes dentaires à la recherche.

Le *JCHD* est une publication évaluée par les pairs. Les manuscrits peuvent être présentés en anglais ou en français. Les textes acceptés peuvent faire l'objet de révisions sur le plan de la cohérence, du style, de la grammaire, de la redondance, de la verbosité, ainsi que pour faciliter l'organisation du manuscrit dans son ensemble.

Critères de présentation : Un manuscrit soumis à l'examen du *JCHD* doit être une œuvre originale des auteures, ne pas avoir été présenté ou publié ailleurs sous forme écrite ou électronique ni être en cours d'examen par aucune autre organisation. Cela ne comprend pas les résumés rédigés et présentés lors d'une rencontre scientifique, publiés par la suite.

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3		Marge standard de 1 pouce (2,5 cm) : haut, bas, gauche, droite.
4		Numérotation consécutive des pages, à partir de la page de titre.
5		Lettre de présentation précisant l'originalité du texte, tout conflit d'intérêt et les données pour vous contacter.
6		Placement des figures, tableaux, graphiques, photos à la fin du manuscrit.
7		Autorisation signée pour tout texte ou toute photo du patient ou client.
8		Crédits pertinents pour toutes illustrations déjà publiée. Vérification dans Internet des restrictions et conditions d'utilisation des éditeurs ?
9		Coordonnées de communication des auteurs en page de titre.
10		Titres universitaires des auteurs et organismes auxquels ceux-ci sont attachés.
11		Lettre de présentation contenant les noms et coordonnées de 2 réviseurs possibles et consentants pour votre manuscrit.
12		Mots clés qu'on trouve dans la base de données de MeSH de Search "MeSH" : http://www.ncbi.nlm.nih.gov/sites/entrez
13		Utilisation uniquement du style de référence Vancouver dans le manuscrit : http://www.nlm.nih.gov/bsd/uniform_requirements.html
14		Utilisation des titres abrégés des journaux de la base de données PubMed, sous recherche "Journals" : http://www.ncbi.nlm.nih.gov/sites/entrez

Les composantes du manuscrit :

1. **Page de titre :** Le titre doit désigner clairement le contenu de la soumission en 12 mots. Il devrait être suivi du nom de chacune des auteurs (prénom, initiale et nom de famille) ainsi que leurs titres universitaires et leurs institutions. Nom de l'auteure correspondante, adresse postale et courriel. Toutes les auteures doivent avoir participé suffisamment à l'ouvrage pour en assumer le contenu.
2. **Résumé :** Il ne doit contenir ni références ni titres de section. En voici les formats typiques :
   a. **Compte-rendu d'étude et de recherche :** Contexte (question à l'étude, problème traité et raisons); Méthodes (comment l'étude a été effectuée); Résultats (principales données statistiques); Examen et conclusion (ce que les auteures ont tiré des résultats).
   b. **Revue de la littérature :** Contexte (sujet ou procédure examinés); Méthodes (stratégie suivie, avec données de base); Résultats et discussion (constatations et analyse de la documentation); Conclusion (ce que les auteures ont tiré de l'analyse).
   c. **Exposé de principe :** (même structure que la précédente)
   d. **Observation :** Introduction (nature générale de la condition ou du programme); Description du cas (avec données); Discussion (du cas fondée sur la documentation), Conclusion.
3. **Mots clés :** Fournir une liste de 6 mots clés tout au plus ou de courtes phrases extraites du texte aux fins d'indexation. On utilisera de préférence les termes de la liste *Index Medicus* du *Medical Subject Headings* (MeSH).
4. Corps du **texte :** Structuration logique de l'information. Tout fait prétendument réel doit l'être au moment de la rédaction.
5. **Remerciements :** Reconnaissance de l'aide ou du soutien apporté par les personnes, organisations, institutions ou entreprises. Les personnes ou organismes mentionnés doivent avoir consenti, document à l'appui, à la publication de leurs noms, vu que cela peut laisser entendre qu'elles adhèrent au contenu, aux données ou aux conclusions de l'article.
6. **Maquette :** Elle comprend les illustrations, figures, photos, graphiques et toute autre expression graphique qui soutiennent ou rehaussent le texte dans le format de leurs fichiers originaux (fichiers sources).
   - Sont acceptables les formats de fichier .eps, .pdf, .tif, .jpg, .ai, .cdr haute résolution, prêts à imprimer :
     i. minimum de 300 dpi pour les gammes de gris et les demi-teintes couleurs,
     ii. 600 dpi pour les dessins au trait,
     iii. 1 000 dpi au minimum pour les maquettes pixélisées.
   - Les illustrations en couleur doivent toutes être en mode couleur CMYK (et non en RGB).
   - Elles devraient être numérotées à la suite les unes des autres et indiquées dans le texte.
   - Les auteurs doivent indiquer dans la légende la source des illustrations publiées antérieurement.
   - La rédaction se réserve le droit de reporter la publication d'un manuscrit accepté s'il survient des retard dans l'obtention des documents d'impression dont elle doute de la qualité.
7. **Données et tableaux :** Présentation en format Excel ou Word. Ces tableaux et données peuvent aussi être inclus à la fin du document Word.
8. **Abréviations et unités :** Elles doivent être conformes au Système international d'unités (SI). On peut utiliser les symboles SI et les symboles des éléments chimiques sans les définir dans le corps de l'article. Les abréviations doivent être indiquées entre parenthèses après la première mention de l'expression concernée dans le texte; ne pas dresser de liste d'abréviations.
9. **Information supplémentaire :** Toute information supplémentaire doit être fournie dans son format définitif, car elle ne sera pas corrigée et paraîtra en ligne exactement comme elle aura été présentée. Veuillez vous renseigner auprès de la Rédaction avant d'envoyer des fichiers de plus de 1 Mbit.
10. **Style des références et citations :** La présentation des références s'inspire du style Vancouver au http://www.nlm.nih.gov/bsd/uniform_requirements.html Les références devraient être numérotées dans l'ordre où elles sont citées dans le texte. Une référence citée plus d'une fois dans un même texte conservera toujours son numéro et l'auteur en fera rappel en utilisant des adverbes ou abréviations telles que *op cit*, *ibidem* ou *ibid*. On utilisera des chiffres arabes en exposant pour identifier les références dans le texte (e.g. [1,2] ou [3–6]). La liste de la section Références suivra l'ordre numérique paraissant dans le texte.

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Helping your clients achieve better health just got easier.

The direct connection between oral health and overall health is becoming increasingly clear. Lung disease, heart disease, diabetes—what your clients don't know *can* hurt them.

You talk to them but sometimes, talk just isn't enough.

Now you can reinforce your message with a new series of educational resources available exclusively from the Canadian Dental Hygienists Association. *A healthier mouth for a healthier you!* includes a set of six brochures, two fact sheets and a poster.

Brochure titles available:
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Oral Health and Cardiovascular Disease
Oral Health and Diabetes
Oral Health and Lung Disease
Oral Health and Brushing, Flossing and Rinsing
More Choice. Better Access.

Your clients may be just a few clicks away from better oral—and overall—health.
www.cdha.ca

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Aider vos clients à améliorer leur santé est maintenant simplifié.

La recherche confirme chaque jour le lien direct entre une bouche en santé et un corps en santé. Maladies pulmonaires, maladies du cœur, diabète… Ce que vos clients ignorent peut nuire à leur santé.

Vous leur en parlez, mais parfois vos paroles n'ont pas toute la portée souhaitée.

Dans le but de vous aider à rendre votre message plus percutant, l'Association canadienne des hygiénistes dentaires a produit à votre intention un jeu de nouvelles ressources éducatives. « *Une bouche en santé, c'est un corps en santé!* » comprend six dépliants, deux feuillets d'information et une affiche.

Titres des dépliants à votre disposition :
La santé buccodentaire et votre hygiéniste dentaire
La santé buccodentaire et les maladies cardiovasculaires
La santé buccodentaire et le diabète
La santé buccodentaire et les maladies pulmonaires
La santé buccodentaire et le brossage des dents, l'utilisation de la soie dentaire et le rinçage de la bouche
Des services encore plus accessibles et variés

N'attendez pas! De quelques clics, commandez ces ressources afin d'assurer à vos clients une meilleure santé buccale et un corps en bonne santé.
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L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Professional Development Opportunities

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With fall and winter fast approaching, CDHA offers you the perfect solution to combat the end-of-summer doldrums. Our online courses will allow you to expand your knowledge base and stay up-to-date on new developments in the comfort of your own home.

Obtain a certificate of course completion to satisfy provincial dental hygiene regulatory professional development requirements. *Oral Cancer Awareness* online course will launch this fall, and the *Elder Abuse and Neglect Awareness* course will follow in winter. Watch for announcements in CDHA's upcoming issues of *CJDH* and e-Newsletters for new professional development e-learning. One of our courses is sure to meet your own specific learning needs.

Featured Courses

A Healthy Workplace

The *A Healthy Workplace* course provides a valuable tool for developing or reinforcing occupational health and safety standards so that work environments continuously improve for dental hygienists.

Self Initiation for Dental Hygienists in Nova Scotia

Successful completion of this course will allow dental hygienists to apply to the College of Dental Hygienists of Nova Scotia for approval to self initiate the authorized acts as set out in the Act and the Regulations. Aussi offert en Français

Knowledge of Dental Practice in Nova Scotia: Jurisprudence

This course is for dental hygienists who are required to complete a jurisprudence course to be eligible to apply to the College of Dental Hygienists of Nova Scotia to be licensed. It is also for those who have successfully completed CDHA's Self Initiation for Dental Hygienists online course and require the Nova Scotia version of Section 7 Jurisprudence. Aussi offert en Français

Self Initiation for Dental Hygienists

Successful completion of this course will allow dental hygienists from Stream Two to meet the requirement and from Stream Three to meet one of the requirements for eligibility to apply for approval to self initiate their authorized acts according to the CDHO Standard of Practice for Self Initiation. Aussi offert en Français

Work and Personal Life Balance

Are you feeling that life is just too hectic and unmanageable? This engaging course explores stress and work and life imbalance, helping you develop coping strategies and a personal plan of action to deal with the stress in your life.

Certificate Program: Independent Practice for Dental Hygienists

Legislative changes in some Canadian jurisdictions now allow the establishment of independent dental hygiene practices. The business environment is challenging and requires energy and hard work, and to be successful, dental hygienists must now develop the necessary management skills to complement their role as primary preventive oral care providers.

Negotiation

As a dental hygienist you negotiate on an ongoing basis in your day-to-day life. When negotiating an issue that is very important to you, do you find yourself at the losing end of the negotiation? You may already be a good communicator, but you may like to improve your negotiation skills to achieve better results and be more effective in all areas of your life. This course will assist you in developing or improving your persuasive communication skills.

Interpersonal Skills

As a dental hygienist it is imperative that you develop your interpersonal skills. Interpersonal skills enable you to work with others harmoniously and efficiently. Employers, co-workers and clients appreciate individuals who get along well with people at all levels. This course will assist you with improving your interpersonal skills, including communication, problem solving, and teamwork abilities.

The Professional Role

As a dental hygienist, you may ask yourself, "Am I acting like a professional?" This course will enhance your professionalism. How you look, talk, write, and act at work determine how you are perceived as a professional. Theoretical and practical concepts are presented, along with opportunities for self reflection and critical thinking.

Help Your Clients to Stop Gambling With Their Health

As members of the tobacco cessation team, dental hygienists can play a key role in helping their clients to stop using tobacco. This course presents current facts about tobacco use and tobacco cessation. It will help you integrate this knowledge into the DH process of care in order to implement an evidence-based tobacco cessation program for your clients. Aussi offert en Français

Difficult Conversations

Do you find it hard to deliver tough messages? Do you get anxious when others get angry at you? Do you avoid conversations that may end in arguments? The Stitt Feld Handy Group Online Difficult Conversations Course is designed to help you have the hard but necessary conversations that we all have to face.

CDHA Community Calendar

Plan ahead. Participate in the events posted on this page. Or mark your calendar.

UPCOMING EVENTS/ÉVÉNEMENTS À VENIR

Programs may be subject to change.

Online event	8 September 2010 Noon–1:00 p.m. ET	Webinar and Forum	*Fluoride toothpastes for children and adolescents*	
Online event	13 October 2010 8–9 p.m. ET	Webinar	*SRP+ARESTIN®: Working together for your clients*	
Onsite event	16 October 2010 Noon–1:30 p.m. ET	Montréal, QC	CDHA Annual General Meeting	
Online event	27 October 2010 8–9 p.m. ET	Webinar	*Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists*	
Online event	15 November 2010 8–9 p.m. ET	Webinar	*Insensitive to Dentin Hypersensitivity? Etiology & Prevention Strategies*	
Online event	1 December 2010 8–9 p.m. ET	Webinar	*Practice Success*	
Onsite event	10–11 June 2011	Halifax, NS	*Advancing Dental Hygiene Practice*—CDHA national conference	

Message de la présidente, *Exprimez votre excellence*
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partir du moment où nous entrons en hygiène dentaire. On nous enseigne l'excellence et nous nous efforçons d'en imprégner nos divers rôles.

Au siège social de l'ACHD, à Ottawa, deux grands encadrements portent les photos de toutes les présidentes antérieures de l'ACHD depuis 1963. J'ai regardé ces photos plusieurs fois et je me suis demandé : à quoi ressemblait leur année à la présidence ?

Les défis évoluent d'une année à l'autre mais l'engagement et l'intégrité demeurent les mêmes. Je suis reconnaissante du passé, mais extrêmement excitée face à l'avenir; un avenir qui repose sur les expressions actuelles de l'excellence de chacune d'entre nous en tant qu'hygiéniste dentaire.

Nous prospérons sur sa continuité; donc, exprimez votre excellence.©CDHA

Advertisers' index

The outer front covers in the six issues of Volume 44 in 2010 feature **dental hygiene educators in Canada**, honouring their service to the dental hygiene profession. This picture was one among the entries selected for the front cover competition first advertised mid-November 2009 in the journal. ©CDHA. Printed with permission.

The Vancouver Community College (VCC) dental hygiene program has been an accredited dental hygiene program in BC for over twenty-five years. The VCC program offers both an onsite dental hygiene program for direct entry students and an online dental hygiene program for certified dental assistants. Featured in this photo is a group of 3rd year dental hygiene students busy planning a community health promotion program for underserved populations in metro Vancouver, BC. The VCC students are supported by their instructor, Dianne Stojak, MEd, who has over twenty years experience in community dental hygiene practice, health professional education. Diane has been an active board member of CDHA and BCDHA. ©CDHA. Printed with permission.