Increasing Capacity to Inform Oral Health Policy

REPORT: KEY INFORMANT INTERVIEWS

June 2010 (Release 2)
copies available at www.icoh.dentistry.dal.ca

Sponsored by: Canadian Institutes of Health Research (CIHR) Institute of Musculoskeletal Health and Arthritis (IMHA), Seed Grant for Oral Health Disparities
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Background</td>
<td>4</td>
</tr>
<tr>
<td>Methods</td>
<td>6</td>
</tr>
<tr>
<td>Results</td>
<td>10</td>
</tr>
<tr>
<td>Discussion and Conclusions</td>
<td>15</td>
</tr>
<tr>
<td>Summary of Key Findings</td>
<td>20</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>21</td>
</tr>
<tr>
<td>References</td>
<td>22</td>
</tr>
<tr>
<td>Appendix 1: Key Informant Interview Guide</td>
<td>i</td>
</tr>
<tr>
<td>Appendix 2: Analysis 1</td>
<td>v</td>
</tr>
<tr>
<td>Appendix 3: Analysis 2</td>
<td>viii</td>
</tr>
<tr>
<td>Appendix 4: ICOH Team Members</td>
<td>xvi</td>
</tr>
</tbody>
</table>
The Increasing Capacity to Inform Oral Health Policy (ICOH) project is a one-year study, the goals of which are to plan ways to measure and monitor oral health status and to guide policy aimed at improving the oral health of vulnerable populations on the east coast of Canada beginning with the senior population. One component of the ICOH project was a series of key informant interviews. The purpose of the interviews was to discuss the barriers and enablers to assessing the oral health status and treatment needs of vulnerable populations in Newfoundland Labrador (NL), beginning with seniors; and to discuss the creation of a network of stakeholders supportive of influencing policy to establish an effective, efficient oral health care delivery system.

The 14 key informants included dental hygienists, dentists (practicing and retired; in private practice and government employed), physicians, and individuals with experience in developing policy. Two researchers (neither of whom was the interviewer) independently conducted analyses of the transcribed interviews, using different analytical approaches and technology (NVivo software and manual coding). Subsequent discussion between the two analysts resulted in a triangulation of the meaning and interpretation of the coding results.

Agreement between the two approaches showed that:
- most key informants believed that oral health is an important policy issue,
- most were unable to articulate the policy process,
- most felt oral health policy was not a high priority among the general public.

Identified barriers to oral health becoming a government priority were related to:
- resource allocation,
- inadequate communication among numerous identified groups including professional groups such as dentists and dental hygienists.

Current government programs and initiatives were praised but considered weak in health promotion strategies.

Recommendations for enhancing oral health priority varied.

MOVING FORWARD: In recent times, the NL Government has increased access to oral health care for some vulnerable populations. Leveraging of existing programs and linkages, and improving communication may contribute to raising the priority of oral health within the province, thereby increasing the public and government commitment to address oral health care, particularly for vulnerable populations.
The Increasing Capacity to Inform Oral Health Policy (ICOH) project is a one-year study, the goals of which are to plan ways to measure and monitor oral health status and to guide policy aimed at improving the oral health of vulnerable populations on the east coast of Canada, beginning with the senior population. ICOH is a collaboration between clinician-researchers at Dalhousie University, Nova Scotia and a diverse group of stakeholders in Newfoundland and Labrador (NL), (including health services providers, researchers and those who develop and influence policy) who share an interest in building the necessary links between the assessment of oral health needs and the delivery of oral health services.

One component of the ICOH project was a series of key informant interviews. The purpose of the interviews was to discuss the barriers and enablers to assessing the oral health status and treatment needs of vulnerable populations in NL, beginning with seniors; and to discuss the creation of a network of stakeholders supportive of influencing policy to establish an effective, efficient oral health care delivery system.

The accepted methodology for interviewing key informants is well documented. Informant interviews are a central data gathering technique for the qualitative researcher. Because this type of research looks in part at the social construction of phenomenon, it is important to hear from those who are engaged in the construction. “We interview people to find out from them those things that we cannot observe…. The purpose of interviewing, then, is to allow us to enter into the other person’s perspective. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit” (1). Typically, interviews are transcribed and the analysis takes place from the transcript. While this certainly makes the interview information easier to work with, at the same time, some of the information present during the interview is lost in the translation
from oral delivery to text; that is, all the non-verbal signs such as tone of voice, body language, etc. When the interviewer is also conducting the analysis, the data can become deeper and multi-layered. However, it is very useful to have others also doing the analysis, since they are able to concentrate on the text itself without any colouring of the information by previous exposure or experience.

Transcripts can be examined in many of the same ways as documents. The method one uses is dictated by the information one is seeking to get out of the data. For instance, if the interview was done in order to provide context to a bigger question, a broad factual analysis will be useful. If it was done in order to explore how the participants respond to a particular situation or artifact, then a more thematic analysis is necessary. It is also possible to do a true content analysis, noting such signs as language usage and number of times specific words are used. Whatever the method used, transcripts need to be read and reread a number of times; it is very much an iterative process.

Interviewing key informants for the ICOH project was a clear choice for gathering information, a way to determine from those knowledgeable, supportive and/or involved in oral health in NL, the barriers and enablers for improving and maintaining oral health, particularly for vulnerable populations. Creswell notes, although critics “claim that qualitative research is largely intuitive, soft, and relativistic”\(^2\) in fact the qualitative method is every bit as rigorous as the quantitative, if done correctly. The desired outcome however, is somewhat different, that is, inductive as opposed to deductive. Qualitative researchers use both qualitative and quantitative methods to explore their research topic, choosing the method to fit the particular problem they are considering.
Two policy documents had previously been analyzed to gain environmental understanding. The first document was a discussion paper written to inform a consultation process on oral health in NL and the second (the What We Heard document) was derived from the resulting consultation process.

♦ Go Healthy – Keep Smiling: Developing an Oral Health Plan for Newfoundland and Labrador – A Discussion Document (Department of Health and Community Services)
♦ Developing a Provincial Oral Health Plan: Go Healthy – Keep Smiling. (What We Heard document) (Martha Muzychka)

A snowball technique beginning with the interprovincial ICOH research team was used to identify key informants. Sixteen people were invited to participate in a one-on-one interview, preferably in-person or over the telephone (Appendix A). Fourteen people responded to the invitation. The 14 key informants included dental hygienists, dentists (practicing and retired; in private practice and government employed), physicians, and individuals with experience in developing policy.

Ten in-person interviews were conducted in October 2009 and an additional four phone interviews were conducted in November 2009. All interviews were conducted by Dr. Joanne Clovis. The interviews were semi-structured and audio-recorded for transcription. The interview guide (Appendix A) included the following questions:

1) What is your organization’s (government department, organization, company, etc.) role in oral health care…
   ♦ ...delivery
   ♦ ...policy development
2) What is/was your role in delivery/policy development pertaining to oral health care?
3) How would you characterize the level of priority placed on oral health care as a policy issue among:
- citizens of NL/seniors?
- your organization?
- Government?

4) What partnerships and linkages exist, or were developed at the provincial level, to facilitate the consideration of oral health care for vulnerable populations as a priority area?

5) Are there key sectors or organizations not involved? Explain

6) What are the main barriers to intersectoral collaboration at the provincial level in addressing this issue?

7) What are the enabling factors at the provincial level to intersectoral collaboration? How can they be enhanced?

8) How do you think public policy regarding oral health should be developed? Are there particular processes or steps that you would recommend?

9) How can the dynamics of power be mediated to enhance collaboration and partnerships?

10) What are your hopes and fears regarding oral health in NL? Best-case scenario? Worst-case scenario?

11) Is there anything else that you would like to add?

Interviews were transcribed verbatim and the transcriptions were reviewed by the informants. Two researchers (neither of whom was the interviewer) independently conducted analyses of the transcribed interviews, one using NVivo software, the second, manual coding.

One of the philosophical underpinnings of qualitative method is that it is impossible for research to be truly objective, since it is being conducted by humans, who bring their own previous knowledge of the research topic and participants, personal biases, opinions, life experience, context, etc. to the processes of data collection and analysis. Therefore, qualitative researchers are required to be explicit about their role in the research process.
Analysis 1

The first analyst had a great deal of experience in policy analysis and knowledge of the political economy of government policy-making in general, including in the area of health (although not specifically oral health). As an independent analyst with some background in policy-making but no background in oral health practice or policy and no familiarity with the ICOH project, aside from having reviewed the two documents created by the NL government, the first researcher completed the analysis on written transcripts.

The first analyst undertook a thematic analysis on the understanding that the interviews were conducted to get the opinions of various stakeholders on oral health policy in NL. This researcher also undertook a content analysis to determine explicit opinions, attitudes and perceptions regarding oral health policy in NL.

The process began with a reading of the interview schedule in order to derive general themes and to get a sense of what information the interviewer was trying to elicit. From these overarching themes, a more specific code list was derived by reading through the transcripts once without coding. The themes were used for a more general analysis of content, while the codes gave more specific information. Once the list of themes was drawn up, the transcripts were coded manually. The list of themes was refined somewhat in the process of coding, and note was made of any themes other than the ones derived from the interview schedule. This iterative process is inherent in qualitative analysis.

Coming cold to the transcripts without benefit of anything other than the text itself, this analysis emphasized the political and economic aspects of the interviews and noted issues with communication between parties.
Analysis 2

The second analyst had no formal background in oral health practice or policy but was familiar with the ICOH project, had some knowledge of oral health policy in NL, and had been more involved with the project overall. This analyst had listened to all audio tapes and had transcribed some of the interviews, so had some idea of the non-verbal content, for example, tone of voice, as well as the text. Alfred Mehrabian in his groundbreaking 1967 study found that only 7% of communication is derived from the actual words used. Far more information is received through the non-verbals such as tone of voice and body language. Therefore a purely textual analysis may elicit slightly different results than text plus aurality. If, for example, a participant was angry but polite, the tone of voice will show anger not evident in the text alone. This will change the analysis to some extent, since the listener, as opposed to the reader, will interpret what was said through a different emotional lens.

This analyst completed a strict content analysis followed by a frequency analysis. The researcher was therefore cognizant of the potential bias of having prior knowledge. The analysis began by free-coding sections of the transcripts using NVivo 8 software. Non-hierarchical codes were created for each new idea or concept encountered in the reading of the transcripts. The resulting list of free codes was then extracted into MS Word, reviewed and organized into categories and sub-categories. NVivo was then used to reorganize the free nodes into “tree-nodes” – a hierarchy of coding. The frequency (both the number of interviewees and the number of instances) for each code was noted at this time.

Discussions between the two analysts were pursued to determine general agreement regarding the results and conclusions.
Results

Analysis 1

The consultant analyst identified by manual coding nine themes, 14 codes, and 64 subcodes (see Appendix B).

The data were synthesized into the following themes (in no particular order of importance):

- Perceptions of importance of oral health to government are widely divergent both within government and outside of it. Some felt that it was extremely important, while others suggested that it wasn’t even on the horizon. While this is to be expected to some extent depending on the participant’s role, this disconnect seems to go deeper, especially among dental professionals.

- There is a series of disconnects that are placing barriers to making oral health a governmental priority. Some of these relate to resource availability, some to where the participant is located in the care spectrum, and many to poor communication, especially the following:
  - between government departments;
  - between the NL Dental Association (NLDA) and government, especially around the role of the Director of Dentistry;
  - between various health professionals, both dental and non-dental;
  - between public health and the NLDA
  - within the dental health community, especially around the role of paraprofessionals.

- There is an acknowledgement of the importance of some form of public dental program (as opposed to the entrenched private fee-for-service model), especially
among dental professionals, to improve access for marginalized groups and those without insurance. However, since oral health as a whole seems to be low on the provincial government’s priority list, such a broadly-based program does not appear to be on the radar. It’s interesting to note that a dental public health program with health promotion did exist at one time.

- The role of the Director of Dentistry seems to be a point of contention among some participants. It is difficult to say whether this relates to the role of the office itself, or to a perception of the government’s attitude to oral health. However, there is some agreement that if oral health is to move up the priority list, then this needs to be a full time position.

- There is some confusion on existing public health / health promotion material and activities. However, participants had a number of good suggestions for simple ways to make the topic of oral health more visible to the public. The leveraging of existing programs and linkages was emphasized.

- There is some debate as to whether seniors’ oral health or children’s oral health should be given priority, given government’s overall priorities and resources.

- There is an overwhelming sense of the issues around access, especially among low income and Aboriginal populations, and those living in rural and remote areas. This was accompanied by an underlying sense of frustration among some participants, especially in terms of practitioner availability.

- There was a lack of awareness of how government policy is made by those outside of government. However, a few participants were able to describe the policy process very clearly.
Analysis 2

The ICOH-familiar analyst identified by NVivo 8 themes, 27 subthemes, and numerous codes (see Appendix C).

- The majority of respondents had a role in direct oral health service delivery or had some relationship with policy and policy planning. Nearly all expressed the belief that oral health was an important issue particularly in relation to its connection to overall health and wellbeing.

- Most respondents felt that the level of priority placed on oral health by the public was low, some felt that it varied greatly depending on the region of NL in question and others thought that oral health was important to the public only as a cosmetic issue (not as a health issue). Several felt that public awareness of the importance of oral health was increasing.

- Groups identified as vulnerable to poor oral health care access were: seniors, Aboriginal groups, children, low-income adults and people living in rural or remote areas. There was some debate as to whether seniors’ or children’s oral health should be given priority in any new government initiatives. Cost was repeatedly identified as a barrier to access to care.

- The perceived level of priority of oral health by the NL government varied greatly amongst respondents with some feeling it was very important to government while others suggesting it was of no importance. Most felt that the government had expressed some interest in oral health (noting the Children’s Dental Health Plan and the proposed Oral Health Plan as evidence) but qualified this by pointing out competing priorities or a lack of awareness at some levels of government.

- A lot of discussion centered around how oral health fits into the NL government structure and the roles of the various branches and officials of the Department of Health and Community Services and the Regional Health Authorities. In particular the
Policy Development Director was perceived as a champion of oral health policy development. Many respondents noted the position of the Director of Dental Services as an issue. There was some confusion around the actual role of this individual but in general the respondents felt that this position needed to be full-time and that its scope should be expanded beyond management of insured services.

• Provision of oral health services by the NL government was another major area of discussion. Most respondents praised the existing Dental Health Plan for children and low-income adolescents but raised concerns about utilization rates and coverage for adolescents. However the government’s focus on treatment rather than prevention, as evidenced by the current lack of dental public health and oral health promotion activities, was a great concern for several respondents. The lack of fluoridation was a particular concern.

• The role of oral health professionals in directing oral health policy was another theme of discussion. The NLDA was noted as generally having a good relationship with government, although one respondent noted recent difficulties in coordinating a meeting between government and the NLDA. NLDA had been greatly involved in the recent policy changes and development of the proposed Oral Health Plan. A criticism leveled at the NLDA was a lack of emphasis on oral health promotion. The NL Dental Hygienists Association (NLDHA) seems to have had less involvement and awareness of these developments but was heavily involved in negotiations to changes in the regulations governing dental hygiene. The status of dentistry as a private industry and the emphasis on cosmetic dentistry in many practices were raised as barriers to access and awareness.

• There was great disparity in the level of understanding of how oral health policy is developed outside of those directly involved in government. However most interviewees noted the importance of having evidence-based policy (several pointed out the lack of data on oral health status in NL) and of conducting broad consultation with stakeholders.
• Existing collaborations and partnerships that could advance oral health policy mentioned repeatedly were: between government and the NLDA; between government departments or branches; and between the government and the Regional Health Authorities. Many potential future partnerships were suggested by interviewees such as seniors’ groups, Family Resource Centres, school boards, etc.

• Respondents’ hopes for oral health centered around the creation of new plans and services for oral health for vulnerable populations, including insured services, public health and oral health promotion initiatives. The most common fear for the future of oral health in NL was that the status quo would be maintained.

Subsequent discussion between the two analysts resulted in a triangulation of the meaning and interpretation of the coding results.
At first reading of the results and interpretations, it may appear that the two analyses are quite different in some respects. For instance, analysis 1 raised concerns about poor communication between government departments and between government and professional associations, while analysis 2 reported good communication and cooperation between government departments and between government and the NLDA. However, analysis 2 did find communication between other oral health professionals and government and between different levels of government to be an issue. This might be because analyst 1 was reading text with a largely political and economic lens, while analyst 2, having heard the interviews and being able to identify speakers, may have interpreted the text with this background knowledge.

Although this conflicting analysis might seem to be problematic, in fact, it is quite the opposite. One of the reasons that qualitative analysis is usually conducted by at least two parties is for triangulation, sometimes also called “cross-checking”. This is a form of cross-validation that, as O’Donoghue and Punch state, is a “method of cross-checking data from multiple sources to search for regularities in the research data”\(^4\). It can also refer to using different methods of analysis to see if the same results are arrived at. As noted above, analyst 1 conducted a purely thematic analysis, and a brief content analysis, while analyst 2 conducted a strict content analysis as well as a frequency analysis.

In this case, attention to the methodological considerations of qualitative research, and confirmability in particular, enhanced the credibility of the method and increases our confidence in the findings.
Coming at the data from different directions produced general agreement between the two methods. Differences were mainly in the organization of codes and the elucidation of detail rather than the overall conclusions. Where differences occurred, further discussion between the two analysts generally resulted in agreement of themes and codes.

**CONCLUSIONS**

Themes that emerged in both analyses were:

- **diverging views among interviewees on the priority placed on oral health by the government**

  “I think that there is great will, I think that by virtue of the fact that we've developed a - there has been an oral health plan already developed. I mean there’s been a tremendous amount of work and as you know there was consultations... So I think the will is there but I think that there are a number of competing interests as well.”

  “I think they’re, in the last couple of years, there has been little bit of interest, in that they’ve produced some policy documents. Since the late 80’s, there has been, really, very little interest in dental health overall. ... But, no, I don’t think there’s been much priority.”

  “There is probably, at the Regional Health Authority level some dental health promotion happening. But there isn’t any coordination of it, that I know of, at the provincial level.”

  “Some things are done but we really don’t assess the impact properly because we don’t even know where we started from...”

- **the need for oral health promotion and dental public health initiatives**

  “I think the focus is largely on treatment, treatment services as opposed to prevention. ... we have, really, a very small role, from a public health perspective, in contributing to oral health. There’s - there are no like formal preventive programs within, within the services
that we generally provide. For example, you know, other provinces have mouth rinse programs, that kind of thing, that's not part of the regime of services that we have available.”

“And, you know, from a municipal perspective, the issues around fluoridation just aren't even anywhere on the horizon.”

“I think there's a fair interest in accessibility to treatment and the funding of treatment. I think there's very little interest, probably little knowledge, of prevention from the public perspective. And, certainly, there doesn't appear to be much demand for, visible demand for prevention.”

“Unfortunately, some of the things we do are reactive; I would like to be more pro-active, get more in prevention. And that is a thrust that's been sort of recognized over the last little while - let's start working on prevention. And, the first thing, I guess... introduced sealants into it for the children.”

“...ensuring that the issues are, the urgent issues are addressed, but yet the issues which are more preventative, are also addressed. So that there isn't a contest between, you know, the urgent issues and the non-urgent, more the types of issues that need to be more long-range, and planning.”

- access to care for vulnerable populations
  “For example adopting a seniors oral health plan similar to the child - the child's plan. So by moving that and saying that it's a necessity now that this needs to be moved forward and that we need to do something about it.”
“I’ve been lobbying for years that when kids start school, they have to have a mandatory, they have their hearing checked, they get their vaccinations, they do all that, there should be a mandatory dental exam before they start school.”

“We’re still seeing a large number who have decay, we know that in, you know, Aboriginal component of society that they have enormous problems in their child population and I think we need to continue to address those issues.”

“I’m in private practice in a very rural area, in fact many of my patients drive to, up to 3 hours one way to come and see me.”

“Economics are always going to be a factor and I’m living in an area where there’s outmigration, there’s mainly seasonal employment, unemployment in the winter. And when it comes down to unfortunately having to spend money on - if they’re not in pain - spending money on their mouth doesn’t always make sense to people.”

• lack of awareness of policy development
  Most comments regarding policy development were not specific or detailed, generally indicating a lack of awareness.

  “…I still think there are political barriers and there are always financial and human resource impediments to moving this a long way forwards, but there is an awareness I think at the department level ... that is going to function as an enabler to move this thing forward.”

  “Like when we’re talking about, in the oral health plan we talk about using people to their full scope of practice but I don’t think I have an understanding of what the full scope of practice for these different professionals are.”
• a need for an expanded role for the Director of Dental Services

“I mean our Dental Director in Newfoundland has basically been kind of shifted to being head of the MCP [Medical Care Plan] component of the Dental Plan.”

“...there's only so much he can do because my understanding is he's only actually there two days per week. And I would think if you're going to commit to really promoting oral health in the province that you would need much more resource than that.”

• building on existing programs and linkages to enhance oral health policy

“There is a fair bit of interaction between departments based on wellness, based on the poverty reduction strategy, that those kinds of partnerships exist. So, that might facilitate work around oral health. So, I think there is a foundation there that could be used to support the promotion of oral health.”

“...leadership comes from government and leadership comes from I guess organizations with a mandate around that too. So I suppose obviously there would be a leadership role from the maybe the Dental Association or the Dental Hygienists Association. But further to that, leadership role through organizations that represent vulnerable groups, ... the seniors’ networks, the family resource networks and so on.”

Although qualitative analysis can be perceived as rather ‘messy’ or unfocused to those used to quantitative research, it can, as illustrated in this project, add depth and context to program understanding and evaluation. It is particularly useful in providing the ‘whys’ around policy analysis, and program delivery. In this case, the use of multiple analysts provided for a triangulation of the interview findings and their meanings.
Summary of Key Findings

♦ Agreement between the two approaches showed that:
  • most key informants believed that oral health is an important policy issue,
  • most were unable to articulate the policy process,
  • most felt it was not a high priority among the general public.

♦ Barriers to oral health becoming a governmental priority were related to:
  • resource allocation,
  • inadequate communication among numerous identified groups including professional groups such as dentists and dental hygienists.

♦ Current government programs and initiatives were praised but considered weak in health promotion strategies.

♦ Recommendations for enhancing oral health priority varied.

MOVING FORWARD

In recent times, the NL Government has increased access to oral health care for some vulnerable populations. Leveraging of existing programs and linkages, and improving communication may contribute to raising the priority of oral health within the province, thereby increasing the public and government commitment to address oral health care, particularly for vulnerable populations.
Acknowledgements

This research was funded by a Canadian Institutes of Health Research Seed grant. We thank all the interviewees who participated in this study and Sandra Cobban for assistance with the interviews.
References


APPENDIX 1: Key Informant Interview Guide

Key Informant Interview Guide

Interviewee: ____________________________________________

Organization and position: _______________________________

Dates contacted: ________________________________________

Interview date and time: _________________________________

Interviewer: ___________________________________________

Length of Interview: _________________________________

Signed consent form received: ___________________________

Title of Study:
*Increasing Capacity to Inform Oral Health Policy Regarding Vulnerable Populations*

Funding Agency:
*Canadian Institutes of Health Research – Institute of Musculoskeletal Health and Arthritis*

Preamble:
Thank you for agreeing to participate in this interview. As part of this study, interviews are being conducted with researchers, government decision-makers, key stakeholders, and community leaders who are knowledgeable of the barriers and enablers to assessing the oral health of seniors in Newfoundland & Labrador (NL).

As you are aware, oral health care is largely excluded from the Canadian health care system. Vulnerable populations such as seniors have the poorest levels of oral health and often lack access to the private system of oral care. This study intends to explore the steps leading to the development of an effective, efficient oral health care delivery system.

Recently a group of researchers at Dalhousie University examined the oral health of 1200 older adults (aged 45 years and older) in Nova Scotia. The preliminary results show differences in seniors’ oral health across the province. These results are being shared with the provincial government, other professionals, and groups representing seniors in NS.

Recently in your province, the Government of Newfoundland and Labrador (NL) released a Strategic Health Plan, and are developing a unique oral health component to this Plan.
Within this context, the interviews we are conducting aim to address three research objectives. You may not be in a position to answer every question. That is why we’re piecing the story together with input from multiple sources.

Research Objectives:
We propose to integrate our multidisciplinary knowledge and experience to increase the capacity within both NS and NL to inform policy regarding the oral health of vulnerable populations, beginning with seniors. The following are our specific aims:

1. Create a network of stakeholders supportive of oral health initiatives for seniors in NL similar to the broadly based network of multidisciplinary stakeholders for seniors’ oral health in NS.

2. Demonstrate the NS oral health assessment protocol for seniors in select NL populations, with the aid of the telehealth system in NL to facilitate communication limited by distance and remote location.

3. Establish an inter-provincial team that captures the synergy of the NL oral health policy planning and delivery stakeholders, and the community development and assessment capacity of the NS research team.

Glossary

capacity building— An approach to the development of skills, organizational structures, resources, and commitment to health improvement. Capacity building can take place at the individual, organizational, community, and professional levels. Capacity building offers a way to prolong and multiply health gains many times over.

capacity - community level – Capacity for policy change at the community level includes: a community history of collective action; broad stakeholder participation; a shared vision or common goal; expanded citizen participation; improved resource utilization; strengthened linkages with other organizations; leadership; working with other sectors to identify opportunities and methods for collaboration; generating information or data; communicating issues; assessing the impacts of policy; and, combining strategies to influence policy.

capacity - organizational level - Organizations often provide the links between individuals within communities and the broader political, socio-cultural and economic conditions within societies. Capacities required by organizations focused on community and system change include: strong leadership; the development of new work processes; and, a “continuous learning orientation”.

capacity - system level – The capacity of health and other systems to respond to research and other external sources of information is strengthened through partnerships, links to champions and other resources, and the presence of cultural norms that support innovation and can manage change. Capacity within CAPC and CPNP at the system level is about systemic changes that support food security. These changes may occur as system representatives and projects work together to jointly plan and implement programs or to decide on directions for future research and policy.

frame - To position, shape or conceptualize an issue towards a specific end.
**intersectoral collaboration** - Involving various sectors of society including national, provincial/territorial, municipal governments, agencies (health, education, social services, agriculture, etc.), community organisations and business.

**policy instruments** – Tools and resources that are used throughout the policy change process that provide guidance to ensure public participation and effective communication and collaboration with media, governments and others who are key to creating new or changing existing policies. These tools may include: how to’s on: writing advocacy letters; writing letters of support; creating petitions and press releases; making effective presentations to the power brokers; public meetings; media interviews; formulating key messages; creating surveys; evaluating the policy process, etc.. Policy tools also include methods used to implement public policy such as information, education, legislation, regulation, guidelines, standards, procedures, programs, grants, subsidies, expenditures, taxes, and/or public ownership.

**public policy** - The broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem.

**Interview Guide**

I’d like to begin with a few general questions about your **organization** (government department, organization, company, etc.) and its role in oral health care...

- ...delivery
- ...policy development

What is/was your **role** in delivery/policy development pertaining to oral health care?

How would you characterize the level of priority placed on oral health care as a policy issue among:

- citizens of NL/seniors?
- your organization?
- Government?

What **partnerships and linkages exist**, or were developed at the provincial level, to facilitate the consideration of oral health care for vulnerable populations as a priority area?

Are there key sectors or **organizations not involved**? Explain

What are the main **barriers to intersectoral collaboration** at the provincial level in addressing this issue?

What are the **enabling factors at the provincial level to intersectoral collaboration**? How can they be enhanced?
How do you think public policy regarding oral health should be developed? Are there particular processes or steps that you would recommend?

How can the dynamics of power be mediated to enhance collaboration and partnerships?

What are your hopes and fears regarding oral health in NL? Best case scenario? Worst case scenario?

Is there anything else that you would like to add?

Is there a key individual that you think I should interview as a result of his/her role in positioning oral health as a public policy issue?

References


APPENDIX 2: Analysis 1

Analysis 1

Themes Derived from Interview Schedule:
- Participants’ role i.e., government, dental community, interested organization
- Perceptions of level of priority placed on oral care as a policy issue
- Existing partnerships and linkages between various stakeholders
- Missing sectors / organizations
- Barriers to collaboration among stakeholders
- Enabling factors to collaboration among stakeholders
- Power dynamics between “players”
- Policy development re: oral health (includes such things as process, priorities, challenges)
- Hopes and fears for future of oral health policy in NL

Code List:
1) Senior oral care
   a) Aging Well Program
   b) Seniors in care vs at home
   c) Perceptions of importance of oral health to seniors

2) Poverty
   a) Access to dental care
   b) Poverty Reduction Strategy
   c) Problems with balance billing

3) First Nations / Innu
   a) Conne River
   b) Provincial programs
   c) Federal programs
   d) Issues around oral health specific to First Nations / Innu

4) Communication (between)
   a) Government departments
   b) Government and public
   c) Government and representative organizations
   d) Professional groups
   e) Public and practitioners
5) Children’s Dental Plan
   a) Utilization
   b) Balance billing
   c) Attitudes towards
   d) History
   e) Future of

6) Relationship between provincial government and Dental Association
   a) Role of current dental director
   b) Requirements of dental director position

7) Access to dental care
   a) Insured vs. non-insured
   b) Low income
   c) Rural
   d) Urban

8) Role of other health professionals re: oral health
   a) Para professionals (auxiliary)
   b) Physicians
   c) Pharmacists
   d) Overall attitudes
   e) Potential public outreach through other health professionals

9) Linkages
   a) Between schools
   b) Health professionals
   c) Government departments
   d) Dental Community
   e) Public
   f) Interest groups

10) Attitudes to oral health
    a) Other health professionals
    b) Public
    c) Seniors
    d) Low income / marginalized
    e) Government
    f) Awareness of importance
    g) Prevention and health promotion

11) Policy development
    a) Process
    b) Priorities
c) Partnerships
d) Power relationships
e) Challenges
f) Data requirements

12) Public health and oral health
   a) Priorities
   b) Perception of others’ awareness of
   c) Perception of oral health
      i) Rural
      ii) Urban
      iii) Age-related
      iv) Health practitioners
   d) Wellness Coalitions

13) Dental community
   a) Attitudes between dentists and other paraprofessionals
   b) Rural
   c) Urban
   d) Public vs private model
   e) Balance billing
   f) Outreach

14) Barriers to collaboration
Analysis 2

Themes:

1) Key Informants and Oral Health
2) The Public and Oral Health
3) The NL Government and Oral Health
4) Oral Health Professionals and Oral Health
5) Developing Oral Health Policy
6) Oral Health Research
7) Collaborations and Partnerships for Oral Health
8) Hopes and Fears for Oral Health

Hierarchical Coding List:

Occurrence frequencies are reported below as (# of respondents, total # of references). For example (1,3) indicates one respondent mentioned an issue three times, whereas (7,9) indicates the issue was mentioned by seven separate respondents a total of nine times.

1 Key Informants and Oral Health

1.1 Involvement in Oral Health Delivery or Policy

• direct service delivery of oral health care (7, 9)
• directly responsible for and involved in oral health policy development (3, 4)
• peripheral involvement in oral health policy amongst many other responsibilities (3, 7)
• no direct involvement in oral health but were aware of and interested in oral health care policy (1, 1)
• no involvement and little knowledge of oral health care or policy (1,1)

1.2 Informant Perception of Oral Health

• oral health is important to overall health (9, 17)
• wellness includes oral health (3, 6)
2 The Public and Oral Health

2.1 Oral Health as a Public Priority

- Level of priority:
  - Low (6, 9)
  - Varies from region to region (3, 5)
  - Treatment is but not prevention (2, 3)
  - Only for cosmetic purposes (1, 1)
  - High (1, 3)
  - Increasing (4, 9)
  - Don’t know (2, 4)
- Important to improve public awareness (6, 15)
- Informant perception - oral health status in NL is poor (2, 3)

2.2 Cost of Oral Health Care to Individuals

- cost is a barrier to access (9, 15)
- insurance doesn’t guarantee access
  - fear (1, 1)
  - lack of awareness (1, 1)
  - distrust of oral health professionals (1, 1)

2.3 Vulnerable Populations

- Seniors (6, 6)
- children (3, 3)
- Aboriginal groups (5, 8)
- low-income adults (3, 3)
- refugees (1, 1)
- people living in rural or remote areas (3, 3)

2.3.1 Seniors

- vulnerable population (6, 6)
- aging population (5, 8)
- seniors’ groups (5, 8)
- seniors’ oral health plan (6, 12)
- long-term care facilities (6, 9)

2.3.2 Children

- are the priority (3, 3)
- children’s dental health plan (see section 3.3.1)
- schools and oral health (3, 7)
- preschool children - public health nurses (1, 1)
2.3.3 Aboriginal groups  
- vulnerable population (5,8)  
- varied access to care (3,6)  
- Department of Labrador and Aboriginal Affairs has been involved (1,1)  
- Labrador Aboriginal Oral Health Initiative (1, 2)  
- Inadequate consultation (1, 2)

2.3.4 Rural  
- limited access to oral care (4,6)  
- poor awareness of oral health (2,2)  
- staffing issues (2,4)

3 NL Provincial Government and Oral Health

3.1 Oral Health as a Government Priority  
- level of priority  
  - high (3,10)  
  - low (3,7)  
  - some interest but ... (8, 11)  
- competing interests (11,26)  
- awareness in government (8,21)

3.2 Oral Health and the Structure of the NL Provincial Government

3.2.1 Role of the Department of Health and Community Services  
- Policy and Planning Branch (1, 1)  
- Office of Aging and Seniors (2, 2)  
  - guided by Healthy Aging Framework (4,11)  
- Medical Services Branch (1, 2)  
  - houses Director of Dental Services (see section 3.2.4)  
- Public Health and Health Promotion and Wellness Branch (1,2)  
  - guided by a “Provincial Wellness Plan” (4, 9)

3.2.2 Role of the Minister of Health and Community Services  
- frequent changes (4, 5)

3.2.3 Role of the Policy Development Director (6,17)
3.2.4 Role of the Director of Dental Services (8, 15)

3.2.5 Role of the Regional Health Authorities (8, 20)

3.3 The NL Government and Provision of Oral Health Services

3.3.1 Insured Services – Dental Health Plan
   • Components of Plan (8,18)
   • uptake (3,6)
   • praise (4,5)
   • criticism (6,11)

3.3.2 Direct service delivery
   • past direct service delivery (1,1)
   • current direct service delivery (4,6)

3.3.3 Public Health and Oral Health Promotion

3.3.3.1 Public health services
   • Lack of services (3, 5)
   • Past public health services (5, 6)
   • Recommendation for public dental services (5,6)

3.3.3.2 Oral Health Promotion
   • Lack of (2, 6)
   • need for oral health promotion programs (5, 7)
   • emphasis in the NL government is on treatment vs prevention (2,3)

3.3.3.3 Fluoridation (5,12)

3.4 Draft Oral Health Strategy/Plan
   • History (4,6)
   • Recommendations in plan (4,5)
   • Indicates government’s interest level (7,10)
   • Hopes for plan (6, 7)

4 Oral Health Professionals and Oral Health

4.1 Newfoundland and Labrador Dental Association (NLDA)
   • involvement in development of draft OHP (2,4)
• initiatives (5,8)
• good cooperation with government (6,11)
• emphasis on treatment rather than prevention (1,2)

4.2 The Newfoundland and Labrador Dental Hygienists Association (NLDHA)
• Involvement in draft OHP (3,3)
• changes to DH regulations (4,14)
• should be involved in future public programs (2,2)
• there is a lack of understanding of DH role (2,2)

4.3 Concept of Dental Community (4,5)

4.4 Private Sector Dentistry
• doesn’t allow focus on prevention (1,1)
• emphasis on cosmetic dentistry (1,5)
• inaccessible to low-income (4,7)

4.5 Other Health Professionals
• Awareness (3,3)
• dentist at Med school (2,2)

5 Developing Oral Health Policy

5.1 Steps (3,4)

5.2 Themes
• Evidence-based policy (9,15)
• Consultation (8,10)
• Economic analysis (3,3)
• Learning from other provinces or countries (4,7)
• Other (6,7)
  o developing policy one step at a time
  o expanding existing policies
  o representation from important constituency
  o access decisions-makers
6 Oral Health Research

6.1 need for evidence when developing policy (see section 5)
6.2 research database (1,1)
6.3 lack of current data on oral health status in NL (7,9)

7 Collaborations and Partnerships for Oral Health

7.1 Existing Partnerships and Linkages

- between government and NLDA (6,9)
- between government departments (4,8)
  - based on poverty reduction strategy (4, 6)
- between government and the Regional Health Authorities (3,4)
- between government and researchers (2,2)
- consultations for draft Oral Health Plan (1)
- not aware of any (2)

7.2 Potential Partnerships and Linkages (13,21)

- The Research Community
- Family Resource Centres
- Seniors’ Groups
- Aboriginal Groups
- Office of the Chief Dental Officer (3,4)
- Teachers Association or School Boards
- Public Health Nurses
- Service organizations
- People in remote Labrador communities
- Emergency Room Staff
- Wellness Plan Partnerships
- Wellness Coalitions
- Physiotherapists
- Municipalities
- Anti-poverty organizations
- Provincial and Regional Directors of Health Promotion
- Medical Association
- Council of Medical Officers of Health
- Home care providers and Licensed Practical Nurses
- Pharmacists
- RHA’s

- Collaborations are important
7.3 Facilitators to Collaboration

- Existing inter-departmental collaborations in government (2,2)
- Awareness amongst government officials (2,2)
- Existing structures around Wellness and the Healthy Aging Strategy (3,3)
- Cooperation between the NLDA and government (3,5)
- Ministers are accessible (1,1)
- The NLDA supportive (1,1)
- Seniors’ interest (1,1)
- Technology (1,3)
- Don’t know (3,3)

7.4 Barriers to Collaboration

- Lack of financial resources for oral health (4,4)
- Lack of leadership (2,2)
- A lack of awareness (2,2)
- Lack of understanding of the role of dentists (1,1)
- Lack of communication about insured services (1,2)
- Lack of advocacy for oral health promotion by the NLDA (1,1)
- Lack of baseline evidence (1,1)
- The perception that everyone has insurance (1,1)
- Lack of communication between private and public (2,2)
- Restricted role of the Director of Dental Services (1,1)

7.5 Mediating Power Dynamics

- turf protection – keep patient paramount (2,3)
- lack of trust – involve academics (2,2)
- show sincerity (1,1)
- create awareness (2,3)
- using existing interdepartmental collaborations (1,1)
- seeking guidance from policy expert (1,1)
- form coalitions between groups (3,3)
- express appreciation (1,1)
- not an major issue (4,4)

7.6 Need for Champions (3,3)

8 Hopes and Fears for Oral Health in NL

8.1 Fears for Oral Health

- oral health status stays same, (4,4)
- no new programs or plans (5,5)
• oral health status will decline (1,1)
• no government staff or resources for oral health (4,4)
• no evidenced-based approach (1,1)
• shortage of rural dentists (1,1)
• oral health takes back seat to other issues (3,3)
• no attention to children’s oral health (1,1)
• treatment with little focus on prevention (2,2)
• no leadership (2,2)
• rising costs (1,1)

8.2 Hopes for Oral Health

• New programs and plans (10, 11)
  o draft Oral Health Plan accepted
  o oral health plan for low-income adults
  o oral health plan for seniors
  o plan for 13-17 year olds improved
  o oral health services for vulnerable populations
  o oral health promotion and awareness program
  o water fluoridation program
• leadership (1,1)
• resources (1,1)
• improvements in the oral health of all (1,1)
  o improvements in the oral health of Aboriginal children
• evidence driven decision-making (1,1)
• support for the NLDA’s goals (1,1)
• children’s oral health emphasized (1,1)
• public dental health clinics (2,2)
  o mobile dental health clinics
• tele-dentistry (2,2)
• dental hygienists working independently (1,1)
• public health dental hygienists (1,1)
• improved public awareness (2,2)
# Appendix 4: ICOH Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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</thead>
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