MDA Bulletin

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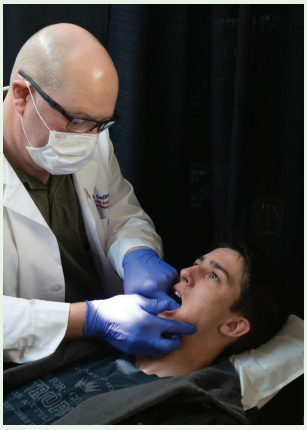
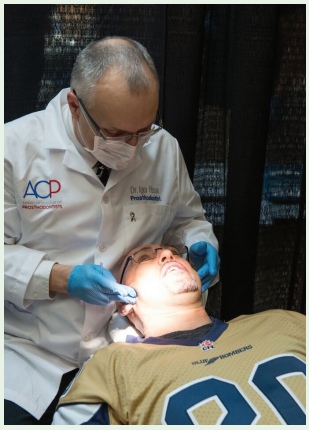




Free Oral Cancer Screenings Conducted by Members of the Manitoba Dental Association. *Written by Michael Schiefer, Director of Operations and Special Events at the Never Alone Foundation, and Dr. Cecilia Dong*
Photos courtesy of Janelle Bryce from Purple Prairie Photography.

On Saturday, April 25, a free oral cancer screening event was held in the Polo Park community booth. The presenting sponsor was Sirius Benefit Plans. The collaboration between the Manitoba Dental Association and the Never Alone Foundation was initiated two years ago for Oral Cancer Awareness Month. The MDA contacted and sourced the following suppliers: Henry Schein, Sinclair Dental, Central Dental Solutions and Central Displays. These suppliers provided the equipment and supplies necessary to facilitate the screening event (gloves, masks, disposable mirrors, dental chairs, etc). Patients provided feedback that the atmosphere felt like a dental clinic.

The oral cancer screening event was also made possible through the support of Polo Park and Cadillac Fairview. Dr. Igor Pesun made arrangements with the American College of Prosthodontists to show a video entitled, "Cancer Care and the Role of a Prosthodontist." This event also coincided with National Prosthodontists Awareness week held every April.

Many volunteers from the Never Alone Foundation, as well as Blue Bomber alumni, joined in to make the event a success. The volunteers worked to register patients, triage patients, set up the operatories, and were very capable with assisting with disinfecting the operatories between patients. After the oral cancer screening, patients were provided with dental oral hygiene samples. Over the two years, 180 patients were seen. Of those, 21 patients were referred for follow-up examinations and several patients had biopsies performed.

From 10 am to 4 pm, on April 25, three dental chairs were available for dentists to carry out oral cancer screenings. The MDA had no trouble recruiting dentists to volunteer for one-hour shifts. Special thanks go out to the following dentists and dental specialists representing orthodontics, periodontics, and prosthodontics:

- Dr. Jerry Abells
- Dr. Nancy Auyeung
- Dr. Jerry Baluta
- Dr. Tom Colina
- Dr. Roland DeBrouwere
- Dr. Cecilia Dong
- Dr. Frank Hechter
- Dr. Gary Hyman
- Dr. Sara Keating
- Dr. Kira Kjear
- Dr. Scott Leckie
- Dr. Nita Mazurat
- Dr. Olva Odlum
- Dr. Igor Pesun
- Dr. Karen Rosolowski
- Dr. Carmine Scarpino
- Dr. Mike Sullivan

Blue Bomber alumnus and former Canadian Football League executive Lyle Bauer, following his successful treatment for head and neck cancer, started the Never Alone Foundation in 2005. Lyle's experience with the disease and the support he received from friends, family, and cancer service-providers inspire him to help other cancer patients and to let them know that they are Never Alone.

The Never Alone Foundation is a national registered charity committed to improving the lives of people affected by cancer. Over $1—million has been raised in support of many worthwhile agencies, projects and programs, including refurbishment of palliative care rooms, enhancing comfort of long-term treatment wards, and funding for a puppet program to educate children on cancer.

The Never Alone Foundation programs include a free annual public oral cancer-screening day, a dental prosthetics fund that will help oral cancer patients get their smile back, and the Day Away program which provides time away for cancer patients and their families. Consider helping us fulfil our mission by attending an event or by donation. The website for the Never Alone Foundation is www.NeverAloneFoundation.ca. Together we can do so much. Our vision is a world where no one faces the fight against cancer feeling alone.

President's Message

DR. NANCY AUYEUNG, D.M.D.
PRESIDENT, MDA

As I began my term as MDA President, I realized early on that I really didn't fit the typical mold of many previous MDA Presidents. So being the atypical President, I will spare you the usual salutation and my observation and opinion of the weather. I didn't come into the organization with a lot of experience in organized dentistry, or within MDA itself. I have learned a lot in the short time I have been on the Board but it has been these last 4 months into my term as President that I can truly say that I feel like I live and breathe organized dentistry and I AM HAVING THE TIME OF MY LIFE!! So….my contribution to this bulletin will be to share my enthusiasm for the events I have been fortunate to experience……

1. Manitoba hosted the Western Canadian Dental Society Curling Bonspiel in March and I was honoured to be invited to represent the Manitoba Dental Association. The event attracted dentists and the like from across Canada to participate in a few fun-filled days of curling and culminated with a dinner gathering at the Fort Garry Hotel. However, this event was about so much more than curling. It gave the opportunity to reunite with old friends, laugh and reconnect over drinks, make some new friendships along the way and raise money for dental scholarships across Western Canada. It was evident that curling was a great excuse to get together and that the friendships forged over the years are rekindled and strengthened over a few days of throwing rocks. Next year, the event will be hosted in Saskatchewan.

2. Young Frankenstein, the Musical…….What a FANTASTIC performance by the fabulous cast of dentists!! It took months of preparation and rehearsals and it "brought to life" the artistic talents that this bunch took to the stage and thrilled the audience with laughter and good times. The event helped Variety, the Children's Charity, to raise funds for their wonderful programs. Thank you to all the dentists and organizers for putting on another great show!!

3. It goes without saying that one of the most memorable events in April was our MDA Annual Convention held in Brandon, Manitoba. The fantastic Convention Committee, chaired by Dr. Todd Kruk, did an AMAZING job. Just over one thousand people registered for the event held at the Keystone Centre. Many enjoyed the tremendously successful Fifties Tribute Friday night social and a stunningly beautiful President's Gala Dinner in honor of our 2014 MDA President, Dr. Michael Sullivan. The Convention Committee members were all given the MDA Certificate of Merit to recognize their hard work and dedication. And to top things off, Past President, Dr. Amarjit Rihal was awarded the President's Award of Merit in recognition of his tremendous contributions to the Manitoba Dental Association. Many thanks to all who helped make this event so successful.

4. Recently, it was brought to the attention of the MDA that hospital emergency room visits were reported to be very high for dentally-related problems. These patients with non-traumatic dental conditions are adding to the prolonged wait times at hospital ERs when their problems can be better managed in a private dental practice. The MDA would like to remind members of their ethical obligations to make arrangements for their patients to be seen on an emergency basis.

Article 9 of the MDA Ethics bylaw states the following:
'A dental emergency exists if professional judgment determines that a person needs immediate attention due to trauma or to control pain, infection or bleeding. Dentists have an obligation to consult and to provide treatment in a dental emergency, or if unavailable, to suggest alternative arrangements. Dentists should have alternative emergency arrangements when the office is closed, when unavailable, or when away from the office for a time period.'

As a profession, we are obligated to ensure our patients have timely access to dental care under all conditions. Members' cooperation with this matter will benefit hospital ERs and most importantly, our patients.

5. The Municipal Council in The Pas, Manitoba, was poised to reconsider the water fluoridation program in their community. In response, MDA provided Council and local area dentists with evidence-based material on the benefits of community water fluoridation as well as placing several advertisements in the local newspaper to inform residents. The information materials have also been distributed to all licensed members of the MDA. The studies have shown that for every dollar spent on public water fluoridation programs, it saves $35 on dental treatment. I would encourage all dental professionals to keep abreast on the benefits of community water fluoridation so that you are ready to have these discussions with your patients when called upon. In the absence of focused efforts to promote community water fluoridation, a strong anti-fluoride movement may influence the decision of Canadian cities and communities to stop fluoridating their water. We must consider the deleterious effects this would have on the problem with early childhood caries, access to dental care issues for many communities, and oral health for all Manitobans.

6. I was most honoured to be invited to the Sharing Smiles Day organized by University of Manitoba dental student, Christopher Ward. This event emphasized the importance of good oral health care for the physically and cognitively challenged population groups in our communities. In speaking to Mr. Ward, he expressed how he became passionate about this issue after volunteering one summer to work with people with disabilities. The one-day event held at the Bannatyne Campus involved a coordinated partnership between volunteer dental and dental hygiene students who engaged participants from various care homes and the public in carnival games, crafts and music. The MDA recognizes the challenges faced by persons with disabilities and supports events like these to help raise awareness for our membership, colleagues and the public.

7. The second Oral Cancer Screening Event, in partnership with the Never Alone Foundation, was held on April 25th at the Polo Park Shopping Mall. Once again, complimentary examinations were offered to the public to raise awareness for oral cancers. A total of 86 people were examined and 10 referrals were made to dental specialists for follow-up examinations. Many thanks to the 20 dentist volunteers, sponsor Sinclair Dental and all those involved in coordinating this very successful and important event.

8. I have always had a special appreciation for the many volunteers from our membership who serve on MDA committees and assist in MDA initiatives. It is the hope of our organization to nurture our volunteers to become strong leaders in the dental profession. To aid in this development, a series of Leadership Development Seminar/ Workshops presented by consultant, Denise Zaporzan, was held over the past winter/spring months to provide volunteers with information and opportunities to discuss how to be an effective leader and to develop strong team-building strategies. The event was well received by all those who attended and there is consideration for the MDA to provide another series of sessions in the future.

9. I had the honour and privilege to attend the Royal Canadian Dental Corps Centennial Celebrations in Ottawa recently held on May 13, 2015 to commemorate its 100th Anniversary of dental service. The event was marked by an impressive two-day session of continuing education lecture series, a military parade and the first unveiling on Canadian soil of the RCDC Royal Banner presented to the RCDC by HRH Birgitte, The Duchess of Gloucester, GCVO Colonel-in-Chief of the Royal Canadian Dental Corps. The celebration culminated in a Gala Dinner attended by delegates from the Canadian Dental Association, the British Columbia Dental Association, the Alberta Dental Association and College, and the Ontario Dental Association to only name a few.

10. One of the greatest initiatives by the MDA is the Mentorship Program led by Drs. Cory Sul and Amarjit Rihal. Since its conception, the program has partnered dental students from all four years with practicing general practitioner and specialist dentists in Manitoba. Sessions are held throughout the academic year bringing them together to provide the dental students with information and the opportunity to engage in discussion on various topics of dental practice. This year, the MDA hosted its first Senior Grad Mentorship Dinner where fourth-year dental students can celebrate their graduation accomplishments with their mentors. It is very rewarding for the mentors to share in their students' successes and I hope that this would encourage interested dentists to volunteer in this very important MDA program.

11. This is the only item of this article for which I do not have any enthusiasm. At the end of May, our wonderful MDA staff member, April Delaney, will be leaving our MDA family. We extend congratulations on her recent marriage to Wayne Gilbertson and she will be moving to Kenora, Ontario to begin their wonderful life together. Thank you, April, for your 8 years of service, dedication and commitment to the Manitoba Dental Association. Your tireless efforts and work on the annual Convention, annual registration and licensure of dentists and dental assistants, and the many other office duties have enabled the MDA to be the amazing organization it is today. We wish you much happiness and success wherever life brings you.

I am extremely proud to represent the Manitoba Dental Association as your President. My travels across Canada have opened my eyes to the issues concerning the dental profession, have given me opportunities to meet great dental allies and work collaboratively on topics of mutual interest for the MDA.

Most of all, it has given me the opportunity to meet and get to know better the very members who make up the Manitoba Dental Association. My door is always open to have discussions that concern you. Thank you for your support and service.

Health and happiness to you all,

Dr. Nancy Auyeung
President, Manitoba Dental Association

Canadian Dental Association's Message

DR. A. MUTCHMOR, D.M.D
CDA BOARD REPRESENTATIVE

Hello again everyone! Here is my quarterly update on what's going on at the CDA.

In April, Dr. Gary MacDonald of Mount Pearl, NL completed his year as president and Dr. Alastair Nicoll of Elkford, BC was installed as the 96th President of the CDA. I would like to thank Dr. MacDonald for his dedication and commitment to the profession and wish Dr. Nicoll all the best in the coming year.

Now, here's what CDA is currently focused on:

Based on the findings of the pilot project on eReferral, the CDA Board of Directors concluded that it would explore the development of a new, simple and secure document delivery system that would allow the electronic transmission of documents between dental offices and a range of recipients. Having determined the desirable characteristics of this system, CDA staff in conjunction with CSI staff was tasked with developing a detailed proposal for review by the CDA Board of Directors in July 2015.

CDA Digital IDs are being rolled out across the country to authenticate dentists that use CDA electronic services, including ITRANS. The staged national launch will be completed by July 2015. CDA Digital IDs will be the only credential recognized by carriers for claims processed over the Internet.

CDA continues to promote awareness of the Oasis suite of products and the CDA Oasis App. The App provides mobile access to CDA Knowledge Network products such as Oasis Discussions, CDA Essentials, JCDA.ca and Oasis Help. It is expected that the content on the App will be expanded in the future to feature information on a variety of CDA initiatives.

The CDA Board of Directors reviewed a draft consensus report from the successful Canadian Oral Health Roundtable (COHR) symposium held on February 26, 2015. The intent of the initiative is to develop a community of support comprised of both oral health and non-oral health groups to discuss and agree on initiatives that will improve the oral health of Canadians. Outcomes from the second COHR symposium include an agreed upon consensus statement on community water fluoridation, a draft consensus statement on oral health care standards in long-term care facilities, and a process to identify oral health education programs for children and parents. The third COHR symposium is planned for April 2016, with bilateral meetings before that date.

The CDA Working Group on Dental Benefits has been dealing with many issues, such as the increasing number of carriers and payors requesting dentists to sign up for direct deposit, the increasing number of dental audits and the invasive nature of these audits The three priorities identified by the Working Group for immediate action are; developing a structure for ongoing relations with the Canadian Life and Health Insurance Association (CLHIA), working with CLHIA on an acceptable standardized audit process and working on Electronic Fund Transfers (EFTs).

The Board approved a new CDA Principles of Ethics document that defines the fundamental commitments that guide a dentist's ethical practice and to which the dental profession aspires. It forms the foundation of a dentist's professional responsibilities to his or her patients, to society, to the profession, and to him or herself. The document will be available on the CDA website and information will be available in CDA's various communications vehicles.

Work continues to proceed on the identification and collection of practice management information from the Provincial Dental Associations (PDAs) in order to create a repository of information for use by the PDAs. Included in this initiative is the identification of gaps and overlaps of information and what needs to be included in an effective practice management program. A meeting will be held during the CDA Convention in St. John's in August 2015 to review progress in this area and determine next steps.

These are our main areas of activity at the moment. We'll see what else comes up when the Board of Directors meets for the week of July 6-10 for our BOD meeting and annual Planning Session.

Have a great summer!

MDA BOARD MEETING SYNOPSIS:

January 22, 2015

Manitoba Dental Association

Board District Elections
The following individuals were elected for two-year terms on the MDA Board: Dr. Carla Cohn and Dr. Catherine Dale from District #1; Dr. Michael Sullivan from District # 3; and Ms. Sina Sacco Allegro as the dental assistant representative.

Board Elections
Dr. Nancy Auyeung elected as MDA President for 2014-2015 and Dr. Carla Cohn elected as Vice-President.

MDA Peer Review Appointments
The following MDA members were appointed to the Peer Review Roster: Dr. Jonathan Archer, Dr. Jerry Abells, Dr. Daniel Bae, Dr. Esam Beshay, Dr. Noriko Boorberg, Dr. Bernie Majewski, Dr. Michelle Jay, and Dr. Lori Stephen-James.

MDA Board Appointments
Dr. Amarjit Rihal appointed to the Canadian Dental Regulatory Federation Authorities (CDRAF) Board; Dr. Alexander Mutchmor appointed to the Canadian Dental Association (CDA) Board; Dr. Lori Stephen-James appointed as Peer Review Chair; Dr. Marcel Van Woensel appointed as Registrar; and Mr. Rafi Mohammed appointed as Secretary-Treasurer.

Auditors Report 2013-2014
MDA realized a net deficit of $73,255 resulting in a reduction of net assets to $267,414.00. The auditing firm for Magnus CA appointed as auditors for 2014-2015.

Board Telephone Survey
The highlights of the Board Survey on the office assessment process and online resources conducted in November and December 2014 were: 56 members were asked to participate in the survey; 68% participation (38 members); overall most respondents were aware of the office assessment requirements and supportive of it; 50% were aware of the online resources and found them useful.

National Dental Examining Board
Registration Department has implemented year-round applications for the Equivalency Process, which continue to receive an average of 1300 applications per year; new standard passing score for the written examination, OSCE and ACJ will be 75 per cent; and collaborative agreement approved with the Dental Council of New Zealand that will see the NDEB equivalency process replace New Zealand's current examination pathway for graduates of non-accredited programs.

Commission on Dental Accreditation of Canada
Two programs will be reviewed in Manitoba in 2015: College of Dentistry (March 2015) and Dental Assisting Program at the University College of the North (May 2015).

Regulated Health Profession Act
The regulations of the Speech and Audio Pathologists were acclaimed on January 1, 2015. This is the first health care profession to come under The Act. The profession of dentistry is still 3-5 years away from having its regulations passed.

Non-Insured Health Benefits Program
Dr. Phil Poon presented the following information to the MDA Board: The CDA National Review Task Force in place to review current NIHB programs; advice to CDA Review Task Force is to build on existing programs; anterior endodontic project proving to be a success; trying to get replacement of dentures to industry standards; centralization system for claim processing very slow and efforts are being made to speed up process; still a lot of work that needs to be done but the program is a very good one for First Nations people and dentists.

CDSPI
Mr. Lyle Best and Ms. Sue Armstrong presented the following information to the MDA Board: Advisory Panel of dentists developed to give CDSPI feedback on services and products for dentists; Dr. Amarjit Rihal is a member of Advisory Panel; wellness program for dentists being marketed better; continuing to address the needs of dental students; participation rates for University of Manitoba dental students are 85%; New Dentists Forum held across Canada to provide young dentists with information on human resources, taxation, financial planning, and wellness; Manitoba continues to be huge supporter of CDSPI insurance services and investments products; and CDSPI is looking to make all of its products and services very competitive to similar products in the market place.

Canadian Dental Association
Dr. Gary MacDonald, CDA President, presented the following report to the MDA Board - CDA priority one projects are: Access to Oral Health Care, Trust and Value initiative, CDA Suite of Electronic Services, the Management of Dental Benefits, CDA Essential / OASIS. Dr. MacDonald gave a brief description of each of the priority one programs: Access to Oral Health care included Canadian Oral Health Round Table, NIHB Technical Working Group and initiatives for children and seniors; Trust and Value initiatives include articles in CDA Essentials and online resources; CDA Suite of Electronic Services includes the CDA app, CDA digital certificates, practice support services website, ITRANS and e-referral; Management of Dental Benefits includes working with the Canadian Life and Health Insurance Association and the Canadian Health Care Antifraud Association; CDA Essentials / OASIS keep dentists informed about clinical issues. Other CDA initiatives that Dr. MacDonald spoke on include corporatization, CDA Code of Ethics, Environmental Scan, CDA convention in St. Johns NFLD and the 2016 CDA corporate fee increase.

Dean's Report – College of Dentistry
Dr. Anthony Iacopino, Dean – College of Dentistry, provided the following report to the MDA Board: College of Dentistry awarded the Gies Award for its curriculum for non-dental professionals and government funding for the project to expire at the end of the year; changes have been made to properly prepare 4th year dental students for the NDEB exam; changes to curriculum to be more reflective of what students need to know before they graduate; budgetary reduction is 4% per year in 2015 and 2016: clinic patient fees will remain the same because of cutbacks; Prosthodontic and Endodontic postgraduate programs moving forward; Dalhousie student Facebook incident has caused the college to review its communication structure with students and student communications with their peers; Commission on Dental Accreditation of Canada site survey is scheduled from March 19–21, 2015; and recognition and thanks to the Manitoba Dental Association's support on issues.

Mentorship Program
Three main goals of the program: 1. professionalism, 2. rural recruitment and retention, 3. prepare new graduates for private practice. Sub goals are 1. professional development of mentors, 2. alumni relations with College, 3. improving student relations with College, 4. development of inter-professional relationship. Dr. Sul will be participating in the National Mentorship Summit in St. Johns; Senior Graduation Dinner is planned for May 13, 2015 and Graduation Breakfast for May 28, 2015.

Date of Next MDA Board Meeting is May 28th, 2015.

If you have any questions relating the Board Synopsis please contact MDA Executive Director, Mr. Rafi Mohammed.

THE COST OF SMOKING IN MANITOBA

A summary of the report, The Cost of Smoking: A Manitoba Study, by Patricia Martens, Nathan Nickel, Evelyn Forget, Lisa Lix, Donna Turner, Heather Prior, Randy Walld, Ruth-Ann Soodeen, Leanne Rajotte, and Okechukwu Ekuma.

Summary by Amy Zierler

University of Manitoba | Faculty of Health Sciences

Manitoba Centre for Health Policy

What are the healthcare costs of smoking?

Everyone knows that smoking tobacco is bad for your health. Decades of research and experience have shown that smoking is a leading cause of lung cancer, heart disease, and other health problems. But what does this mean for the healthcare system? What does smoking cost in terms of public healthcare dollars?

Those questions are behind a new, in-depth study by the Manitoba Centre for Health Policy (MCHP). The bottom line? Smoking costs Manitoba's healthcare system at least $226 million each year, plus another $18 million for smoking-related cancer care.

These extra costs of healthcare directly related to smoking are close to the annual provincial budget for community and mental health services ($241 million) or the Manitoba Pharmacare Program ($269 million). The province expects to collect $286 million from tobacco taxes in 2014/2015.

As you might expect, the study concluded that smokers use more healthcare services than people who have never smoked. And those extra services translate into higher costs, as shown in Table 1. Smoking costs the province roughly $39 million every year for extra physician visits, $40 million for extra prescriptions, and $147 million for extra days in hospital. These are healthcare services that would not be needed if people had never smoked.

This study found that smokers in Manitoba have substantially higher healthcare costs—at least $226 million more per year, plus another $18 million for cancer care—and that these costs continue for many years, because smokers are not dying much younger than non-smokers.

Table 1: Extra costs for healthcare services to smokers

Type of service	Excess cost
Physician visits	$39 million
Prescriptions (funded by Pharmacare)	$40 million
Hospital admissions	$147 million
Total	$226 million

Most smokers are living into older age

Surprisingly, we found that smokers are not dying a lot younger than non-smokers. Most former and current smokers in Manitoba can expect to live into their late 70s or early 80s. Their life expectancy is only slightly shorter than people who have never smoked (Figure 1).

Figure 1: Life expectancy for smokers and non-smokers

For the smokers, living into older age is good news, although they may not be aging in good health. For the healthcare system, however, it means that the added costs of caring for them will continue for many years, contrary to common thinking. Earlier studies from other countries generally showed that smokers tend to die about 10 years younger than non-smokers. This study found that difference in life expectancy was quite a bit less – roughly 1 to 3 years.

A unique study

This study is one of the most comprehensive of its kind ever conducted. It looks at smoking habits and healthcare use in the province over 22 years—from 1989 to 2011—for about 45,000 Manitobans. Person by person, the study linked people's responses to survey questions about smoking with information about the healthcare they actually used in the years after the survey.

Most other studies on the costs of smoking have not had access to individual records on healthcare use. Instead, they relied on people remembering what healthcare services they used. For this study, we used information from provincial records that document all publicly funded healthcare services. As with all MCHP studies, all identifying information was removed from the data to protect patients' confidentiality.

Table 2: Smoking categories used in the study

Term	Meaning
Current daily smokers	Smoked daily at the time they were surveyed
Recent quitters	Was a daily smoker; quit up to five years before the survey
Long-time quitters	Was a daily smoker; quit *more* than five years before the survey
Never a daily smoker	Smoked occasionally at time of survey or previously
Never smoked	Never smoked at any time in their lives

For the information on smoking habits, we used three surveys: the Manitoba Heart Health Survey (1989–1990), and Manitoba participants in the National Population Health Survey (1996–1997), and the Canadian Community Health Survey (multiple waves from 2000 to 2011). Based on the various ways the surveys asked about smoking habits, our study compared people in two ways: (1) people who had ever smoked (smokers) versus people who never smoked (non-smokers), and (2) using the five categories of smokers outlined in Table 2.

We then looked at how much publicly funded healthcare each group used—visits to doctors, prescriptions, hospitalizations, and admissions to nursing homes. When we found differences in the numbers of services each group used, we calculated the cost of those extra services.

Accounting for other differences between smokers and non-smokers

One of the biggest challenges in research about smoking is to account for the possibility that smokers may be sicker than non-smokers, for reasons that may not be related to smoking itself. For example, smokers are more likely to be overweight and have various chronic health conditions, including some that don't have obvious connections to smoking such as arthritis and depression. They are also more likely to be older and live in lower-income areas. These and many other factors can affect how much healthcare people use. So researchers have to find ways to show which differences in healthcare use are really related to smoking and which are not related to smoking.

For this study, we used three different kinds of statistical techniques to make sure we compared groups as fairly as possible. We accounted for more than 200 differences between smokers and non-smokers—things like age, sex, income, nutrition, and alcohol use —based on data available in the surveys and the health records housed at MCHP. By creating groups that were basically the same except for their smoking habits, we can say with reasonable confidence that any differences we found are related to smoking.

Other key findings

This study builds a detailed picture of smoking, health, and healthcare in Manitoba. Some of our other key findings include:

- Smoking rates have fallen a lot over the past two decades. Figure 2 shows that the percentage of Manitobans who have ever smoked fell from about 65% in 1989 to around 40% in 2011. Figure 3 shows the percentage of current daily smokers fell from about 22% in 1996 to around 14% in 2011. This may not be surprising, given all the campaigns and policies against smoking. Still, the level of smoking in the province remains an important public health concern.

Figure 2: Percentage of Manitobans who have ever smoked

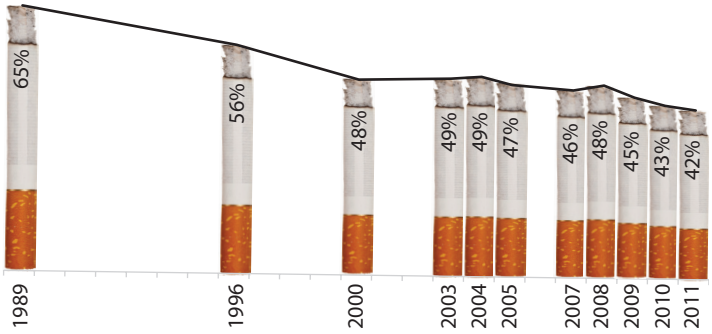


Figure 3: Percentage of Manitobans who are current daily smokers

- For a smaller group of people, we were able to look at how their smoking habits have changed over 16 years (1994 to 2008). About half of the daily smokers said they had cut down during that time, and more than 80% of occasional smokers quit altogether.
- Many people who quit or cut down may have done so because they got sick or worried about their health. Some of the findings about smokers' use of healthcare back up this thinking. For example, recent quitters had more visits to doctors in the five years after they were surveyed, compared to all other categories of smokers.
- Smokers had much higher rates of some but not all kinds of cancer. As expected, lung cancer was 10 times higher among smokers than non-smokers. Smokers also got 10 times more of a group of cancers known to be related to smoking. Overall, smoking accounts for about 580 extra cases of these cancers in Manitoba each year.
- Smoking does not seem to be a factor in determining whether or not people need to move into a nursing home. Admissions to nursing homes were similar across all groups. (The surveys did not include people already living in nursing homes, so these results only refer to people who moved into a nursing home after they were surveyed.)

Could we be over- or under-estimating the costs?

In every study, researchers have to make decisions about which information to use and how best to analyze it, and those decisions can affect the final results. For this study, we intentionally made decisions that would lead towards underestimating rather than overestimating the findings. That is, we believe the costs of smoking are likely higher than we report.

For example, the cost estimates are based on smoking habits from the 2011 survey—the most recent year available. But 2011 is also the year that had the lowest smoking rates of the 22 years covered by the study. Therefore, the costs for previous years would have been even higher than we have shown. Also, the cost estimates listed above are the lowest—the most conservative—from the three strategies we used to separate the impact of smoking from other factors that could affect people's need for healthcare. For readers who want more information, the full report includes results for all three approaches.

This study did not include several aspects of healthcare and costs that would add to the costs of smoking. These include the effects of second-hand smoke and the costs beyond healthcare, such as lost income or the cost of income assistance for people who can't work because they are sick.

Regardless of the reason, the reality is that once smokers get beyond age 50, their higher healthcare costs are likely to continue for another two or three decades.

For cancer care, differences in the way records are kept meant that we could not include the specific costs of treatment such as radiation and chemotherapy given in hospital. Because we did not have access to the more detailed, person-by-person healthcare data that we used for the rest of the study, we calculated the percentage of the budget of CancerCare Manitoba that is likely related to smoking-related cancers.

Finally, the surveys did not include people living in First Nations communities, and some remote areas. From other sources, we know that smoking rates tend to be higher in these communities, so our cost estimates would likely be higher if we had been able to include those people.

Why this research matters

This study found that smokers in Manitoba have substantially higher healthcare costs—at least $226 million more per year, plus another $18 million for cancer care—and that these costs continue for many years, because smokers are not dying much younger than non-smokers.

This may be a reflection of the good access to universal healthcare that Manitobans enjoy. Or it may be related to the fact that many smokers cut down or quit before they get old. Regardless of the reason, the reality is that once smokers get beyond age 50, their higher healthcare costs are likely to continue for another two or three decades. This has a major impact on the need for healthcare services in Manitoba and the costs for those services.

The Manitoba Centre for Health Policy at the University of Manitoba's College of Medicine, Faculty of Health Sciences, conducts population-based research on health services, population and public health and the social determinants of health.

For more information, contact MCHP:
Tel: (204) 789-3819; Fax: (204) 789-3910;
Email: reports@cpe.umanitoba.ca or
visit umanitoba.ca/medicine/units/mchp

University of Manitoba
Faculty of Health Sciences

Manitoba Centre for Health Policy

WARNING: SMOKING

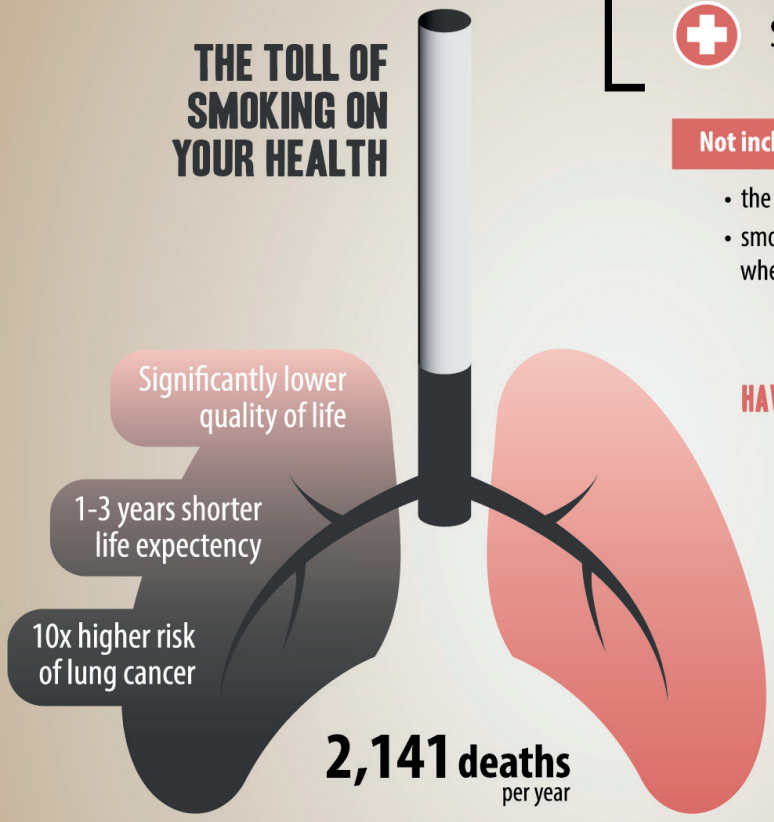
Strains Manitoba's Healthcare System & Impairs Manitobans' Quality of Life

Smoking-related illnesses cost taxpayers an extra

$244 million per year

- $147 M in extra days in hospital
- $40 M in extra prescriptions
- $39 M in extra physician visits
- $18 M in cancer care

THE TOLL OF SMOKING ON YOUR HEALTH



Not included in these figures:

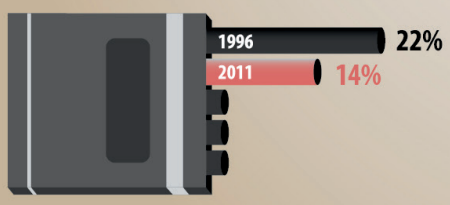
- the cost of second-hand smoke
- smokers living in First Nations or remote areas, where smoking rates tend to be higher

THOSE WHO HAVE SMOKED OVER 100 CIGARETTES OVER THEIR LIFESTIME CAN EXPECT TO NEED

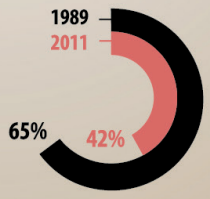
- **19%** more hospitalizations
- **21%** more days in hospital
- **10%** more prescription drugs

THE GOOD NEWS: SMOKING RATES IN MANITOBA ARE DECREASING

Percentage of Manitobans who smoke everyday



Percentage of people who have ever smoked (≥100 cigarettes)



Read the full report here:
http://umanitoba.ca/medicine/units/mchp/cost_smoking.html

Developed by

The George and Fay Yee Centre for Healthcare Innovation on behalf of the Manitoba Centre for Health Policy

The Cost of Smoking: A Manitoba Study, Manitoba Centre for Health Policy, May 2015

Faculty Corner

DR. ANTHONY IACOPINO
DEAN OF DENTISTRY
UNIVERSITY OF MANITOBA

Sounding the Call
College in need of patient referrals for undergraduate requirements

Perhaps this might be filed under the heading 'victims of our own success.' Through the years, here in Canada and the United States, we have seen a slow yet steady improvement in the overall oral health of our general populations.

Yes, I am aware that this may be construed as a generalization; perhaps an overly simplistic one at that. We are all acutely aware that serious issues still exist within our society when it comes to oral health: Matters of access to service; the changing demographics of our population base; the decline of insurance coverage provided to everyday citizens through their jobs and workplaces; the huge challenges facing populations within remote and impoverished communities, to name only a few.

These are all very real and very serious issues. However, none of this comes as a surprise to any in our profession. We are all very familiar with the many challenges that lie before us. And we must be buoyed by the fact that there are so many among us who are actively trying to do something about it.

That could well be one of the most satisfying and reassuring aspects of our profession: that we have so many committed, intelligent and ambitious people who are focused on the future and willing to do as much as humanly possible to foster, develop and implement remedies and cures to these societal ills.

Yet the fact still remains that, as a society overall, the level of oral health services that Canadians enjoy today is among the best on the planet. And it is reflected in the overall oral health of the citizenry, which has steadily improved over the past three decades.

This was borne out in the summary report on the findings of the oral health component of the Canadian Health Measures Survey (CHMS) released a few years ago. This document, which represents 97% of the Canadian population aged six to seventy-nine years old, confirms that most Canadians have very good oral health. It further underscores our belief that oral health care in Canada is among the best in the world.

While we can all take a measure of satisfaction from these findings, it seems to have had a bit of an unfortunate side–effect, at least where we are concerned here at the College of Dentistry.

For the past two to three years, similar to dental schools throughout North America, the college has been struggling to find adequate numbers of patients who present with conditions that are essential for the requirements needed by our student cohort. In addition to the treatment demographics previously mentioned, our clinic fees have continued to rise as the college addresses operating budget reductions requiring greater reliance on clinical revenue and student tuition/fees to maintain the excellence of our education/training programs.

Right now, the College of Dentistry is in real need of patients who present with the following needs: crowns, bridges, implants, endodontics and complete dentures.

I don't have to tell you that these are some of the most common patient needs within a general practice office on a day–to–day basis. So naturally, it becomes absolutely essential that our student cohort

is fully and completely educated, trained and experienced in how to identify and manage these cases to their best possible outcomes.
But what we are finding is that there seems to be fewer and fewer of these cases in the patient pool from which to draw. For this reason, we are pursuing multiple strategies designed to increase the clinical experiences available to our students. One of these approaches involves turning to you. We are hoping that you may be able to provide referrals (perhaps 1-2 annually) to us that would help address the patient shortfall in these crucial areas.
Our need is not restricted to those listed above. Rather it covers virtually every area of practice, including our specialty areas of periodontics and orthodontics along with oral and maxillofacial surgery. Patient referrals would be most welcome in all areas of our programming.
We are confident that we would be more than capable of providing exceptional care to each and every patient and deliver positive outcomes in nearly every case. Remember that accepted patients will be treated by supervised students at our Bannatyne campus clinics at rates roughly half of those recommended in the fee guide.
I encourage you to contact us with questions or concerns you may have. Our team of clinic administrators is anxious to address this critical operational area and is committed to ensuring our students leave us as highly trained and fully prepared professionals.
Guidelines have been developed for "expedited and targeted" community referrals that will facilitate efficient patient care and return to the referring practice.
Participation in this new initiative will help to ensure the future of our profession and that the graduates that we produce continue to maintain the high standards that you have come to expect and demand.

We look forward to hearing from you.
Grazie.

A Century of Canadian Military Dentistry

The Royal Canadian Dental Corps (RCDC) has served Canada in both World Wars, Korea, Afghanistan and many other peacemaking, peacekeeping, humanitarian, domestic and forensic operations, while concurrently ensuring the oral health readiness of our soldiers, sailors and aviators at home. The RCDC is celebrating its Centennial throughout 2015, and the MDA President Dr Nancy Auyeung and MDA Registrar Dr Marcel van Woensel participated in three of the key events held in Ottawa 12-13 May 2015. These events comprised the RCDC Centennial International Military Dental Symposium, held in the Barney Danson Theatre of the Canadian War Museum on 12-13 May; the RCDC Centennial Parade, and opening of the Canadian War Museum exhibit, An Oral History: A Century of Canadian Military Dentistry, held in the LeBreton Gallery of the Canadian War Museum on the evening of 12 May; and the RCDC Centennial Gala, held at the Château Laurier Hotel on the evening of 13 May.

The Canadian Dental Association (CDA) is playing a central role in commemorating the RCDC Centennial, reflecting CDA's role in establishing a military dental service in Canada and the close partnership enjoyed by CDA and RCDC since that time. "For over 100 years, the CDA and Canada's military dental services have worked closely together towards the shared goal of promoting high quality oral health care," said Dr Gary MacDonald, Past President of the CDA. "The CDA and its members across Canada are extremely proud of the achievements of the RCDC over the past century."

Defence Minister Jason Kenney (second from right) joined Colonel James Taylor, Regimental Head of the RCDC, Dr. Alistair Nicoll, President of the Canadian Dental Association, and Dr. John Maker, Canadian War Museum historian, to open "An Oral History: A Century of Canadian Military Dentistry" at the Canadian War Museum in Ottawa on May 12, 2015. This exhibit will remain available for viewing until mid-November of this year.

The RCDC Centennial logo includes the four current and past crests of Canada's military dental services. On 13 May 1915, General Order No 63 authorized the Canadian Army Dental Corps as a separate corps in the Canadian Army. The Corps subsequently evolved into the Canadian Dental Corps in 1939 due to its joint responsibilities, was honoured with a Royal Warrant in 1947 and became the Royal Canadian Dental Corps; it then became the Canadian Forces Dental Services in 1969 following Canadian Armed Forces Unification. It name was restored to RCDC in 2013.

On April 14, 2015, the Royal Canadian Dental Corps was presented, by their Colonel in Chief Her Royal Highness The Duchess of Gloucester, a Royal Banner to recognize a century of Canadian military dental services. This ceremony took place in Canada House in London, with the participation of Canada's High Commissioner, His Excellency Mr. Gordon Campbell, and a number of dignitaries from the UK military and civilian oral health community. The RCDC Colonel in Chief is shown here placing the Royal Banner in the sash of Banner Officer, Captain Dominik Rudecki, assisted by Colonel James Taylor, Regimental Head of the RCDC, while Banner Party Commander Major Debra Pawluk looks on.

The Manitoba Dental Association was out in full force at the Winnipeg International Children's Festival at The Forks on June 6th. Volunteer dentists, dental hygienists and dental assistants saw more than 300 children that day. The MDA has been running the Tooth Fairy Saturday at the festival since 1996.

Congratulations Grad Class of 2015-Dentisry


Karim Bakhoum


Andreea Birsila


Gurinder Boparai


Emilie Cook


Shaun Corbett


David Dacombe


Bryan Dimarco


Rohit Dutt


Goltakin Ezati


Manon Foidart


Sharareh Ghodousi


Kelsi Gilmartin

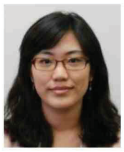

Victor Gong

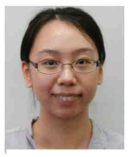

Ashley Gray

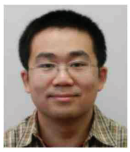

Jane Hendrickson-Rebizant

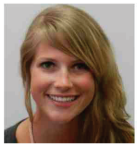

Sylvia In


Ronald Janz


Sunny Jung


Jenna Li


Tim Lou


Holly Markin


Rafif Mohammad


Diane Ostry


Zhendan Pan


Iliana Paparisto


Jayesh Patel


Lindsay Robertson


Dayna Roemermann


Jiwan Sidhu


Tyler Sobotkiewicz


Viviana Steinberg


Trystan Thomas


Philipp Unruh


Chelsea Woodmass


Kai Wu

COLLEGE OF DENTISTRY
SCHOOL OF DENTAL HYGIENE

Traditions of Excellence, Horizons of Change

Event Sponsor:

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DENTAL ALUMNI ASSOCIATION

Event Partner:

Manitoba Dental Association

TM

A SPECIAL THANK-YOU
FOR YOUR PARTNERSHIP & SUPPORT

Sinclair Dental / Dentaire

Thank you to our mentors:

Dr. Amarjit Rihal
Dr. Andrew Dear
Dr. Betty Dunsmore
Dr. Cory Sul
Dr. Eileen Eng
Dr. Griffin Norris
Dr. Howard Fogel
Dr. Kevin Mark
Dr. Luke Singh
Dr. Mike Sullivan
Dr. Milos Lekic
Dr. Rhiannon Orloff
Dr. Ronald Tough
Dr. Tony Hayward
Dr. Wally Nider


Manitoba
Dental
Association
Mission


CONGRATULATIONS
GRAD CLASS OF 2015-DENISTRY

ATTENTION AREA PRACTITIONERS

THE COLLEGE OF DENTISTRY
IS NOW ISSUING A:

CALL FOR PATIENT REFERRALS*

FOR

- CROWNS
- BRIDGES
- IMPLANTS
- ENDODONTICS
- COMPLETE DENTURES

COLLEGE OF DENTISTRY
SCHOOL OF DENTAL HYGIENE

ACCEPTED PATIENTS WILL BE TREATED BY SUPERVISED STUDENTS AT THE BANNATYNE CAMPUS CLINIC AT RATES ROUGHLY HALF OF THOSE RECOMMENDED IN THE MANITOBA DENTAL ASSOCIATION FEE GUIDE.

PLEASE CALL TODAY WITH YOUR REFERRAL!

204-789-3505

University of Manitoba | Faculty of Health Sciences

*CONDITIONS APPLY

Wanted: Referrals
College in need of patients for fall session

The College of Dentistry is now welcoming immediate referrals from provincial practitioners for patients. Currently, spaces exist within our undergraduate program in the following areas:

- crowns
- bridges
- endodontics
- implants
- complete dentures

Should you have any patients who may be interested in being part of our program, here are the answers to a few frequently asked questions that may be helpful and speed the process along.

- To become eligible as participants in this program, candidates must be prepared to commit to an extended treatment period of roughly 15 weeks, at least once per week for three hours.

- Treatment will be provided at roughly half the rates of those recommended in the Manitoba Dental Association Fee Guide.

Practitioners are welcome and encouraged to call the College of Dentistry Main Clinic – 204.789.3505 with your referral or with any additional questions.

The College of Dentistry would like to thank all provincial practitioners for their time and assistance in helping maintain our high training standards.

DID YOU KNOW?

The INSURANCE AUDIT

Although only a small group of dentists are audited each year, the process can cause considerable stress for the dentist and a huge disruption to the day-to-day operation of a dental practice. We may feel that these audits are nothing but a nuisance but the insurance companies have the right to conduct audits and recover overpayments resulting from inappropriate billing. They are accountable to the plan purchasers and plan members and therefore have a responsibility to ensure that plan funds are appropriately spent.

What are some ways a dentist is indentified for an audit?

1. **Staff, patients and other dentists:**
   Alert insurance companies of questionable (or unethical) billing practices via letters, emails or calls to the 'hotline".
2. **Dental consultants:**
   Identify unusual billing practices during the process of reviewing treatment preauthorization.
3. **Data analysis software:**
   Profiles common procedure codes to identify a dentist who is billing these codes much more frequently than a "similar" dentist. The practitioner must be a significant outlier to be flagged for audit.
4. **Claims examiners:**
   Detect suspicious billing behaviour during routine review of dental claims.

Is there anything the dentist can do to prevent an insurance audit?

1. **Bill using the unique identification number (UIN) of the dentist who performed the treatment (required by CDAnet):** Billing associate fees under the UIN of the principal dentist will artificially inflate the billing frequencies of the principal dentist.
2. **Be certain that the codes billed properly reflect the treatment performed:** Follow the guidance in the preambles and descriptors of your province's Suggested Fee Guide. Contact your provincial dental association for clarity if you are not sure.
3. **Be cautious of billing advice provided by sales reps, continuing education courses and practice management consultants:** In some instances, this advice may help to increase practice revenues but in a way that does not align with descriptors and preambles in the Suggested Fee Guide.
4. **Ensure that the patient records and appointment schedule clearly reflect the treatment that was provided and the period of time the patient was receiving care.**
5. **Don't make light of inquiries from insurance companies questioning billing patterns:** Take the time to respond appropriately and in a timely fashion, while understanding your responsibilities under your provincial Privacy Legislation. Consider contacting your provincial representative on the MDA early in the game for guidance and support.

What can a dentist expect in the initial stages of an audit?

- **Questionable codes may be 'blocked':** Corresponding treatment will not be covered without submission of additional information (e.g. X-rays, clinical description, before and after photographs). These codes will remain blocked throughout the audit process and in some instances for months afterwards.
- **Letters sent to patients requesting consent for records release:** The insurance company may notify the dentist telling them that their patients will receive a letter requesting consent to release their records. The consent should actually be that the dentist is allowed to release the documents of the specific patient to their carrier and state what those records are.
- **Dentist asked to submit copies of patient records:** The insurance company will notify the dentist of patients who provide consent, and in turn ask the dentist to submit a copy of the records for all corresponding patients. The request for records may include, the chart (full or in part), radiographs, photographs, and appointment book.

Should a dentist release patient records to an insurance company? If a patient has authorized the dentist to release their records, it is their duty to do so in accordance with the consent form. Be aware that a signed standard dental claim form is not adequate consent for general release of records. If a patient calls the dental office unsure about whether or not they want to provide consent, the dentist can offer two options:

1. Provide a copy of the records to the patient for consideration in their decision.
2. Allow the patient to review the records in the office and decide which portions they are comfortable releasing to the insurance company.

However, the dentist and staff should not use this as an opportunity to dissuade the patient from providing consent. Encouraging patients to deny or withdraw consent can lengthen the audit process. Furthermore, insurance companies may be motivated to issue additional batches of patient letters to ensure an adequate sample of charts for audit. You, the dentist, however are responsible for the privacy of the documents and if asked should be able to tell the patient that some the information, specifically that which is health or financial information not related to the claims in question probably should not be released.

How does an audit get resolved?
Upon review of the records, the insurance company may come to one or more of the following decisions:

1. **No evidence of inappropriate billing:** Billing behaviour may be monitored for a period of months.
2. **Additional information is required:** Further consideration is necessary.
3. **Evidence of over-billing:** Recovery of overpayments is sought.
4. **Evidence of professional misconduct:** Formal letter of complaint sent to the regulatory bodies of the MDA.

In conclusion, an insurance audit can be a very trying experience for both the dentist and their team. The MDA continues to advocate on behalf of dentists to the insurance industry for a fair, transparent audit process. For more information, or clarity in the case of an audit, please contact the MDA.

Dr. Michael Sullivan (Chair) – *Economics Committee*
Manitoba Dental Association

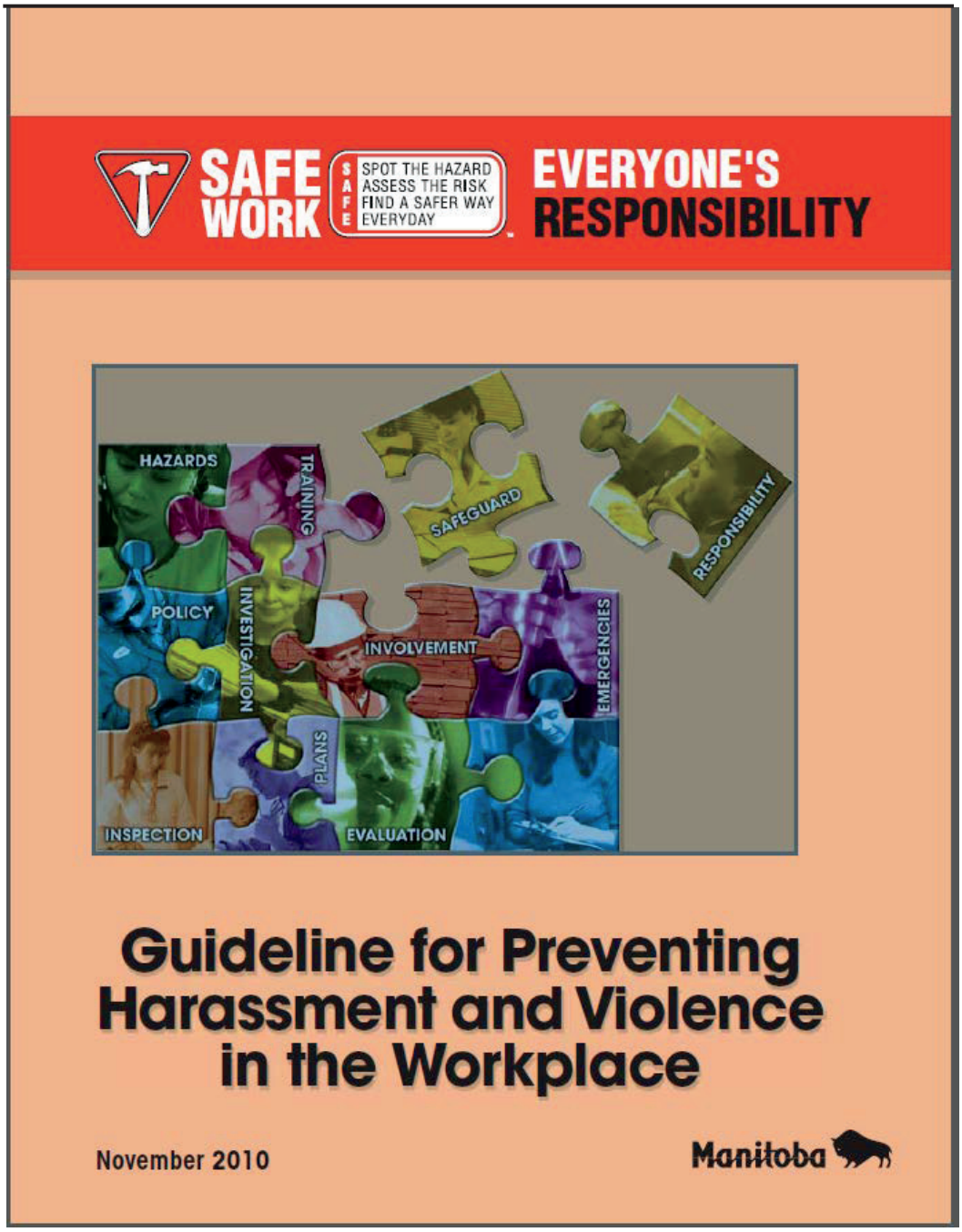
Spring FEVER

131st MDA Annual Meeting & Convention
April 17-18, 2015
Keystone Centre
Brandon, Manitoba


adec
Unimor
Unimor


Healthy Smile Happy Child
SAY AHH


ONLINE PAYMENT AREA



As you may have noted in the first issue of the MDA Bulletin for 2015, we are inserting resources that you may find useful as you review your existing office policies, develop new policies or in preparation for an office assessment. This quarterly issue features a sample "Harassment Prevention Policy" which may provide some guidance if you have not yet included this in your office manual. The following pages are an excerpt from the Workplace Safety and Health Division guideline which can be found in its entirety at:

http://safemanitoba.com/sites/default/files/uploads/guidelines/harassmentviolencefeb2011.pdf

SAMPLE – HARASSMENT PREVENTION POLICY

The following example of a harassment prevention policy provides practical guidance on developing a policy for your workplace.

Harassment Prevention Policy for:_____

Company Commitment

At _____, we are committed to providing a safe and respectful work environment for all staff and customers. No one may be harassed and no one has the right to harass anyone else, at work or in any situation related to employment with this organization.

This policy is a step toward ensuring that our workplace is a respectful and safe place for all of us, free from harassment.

What is Harassment?

There are two main types of harassment. One type includes inappropriate conduct in any form about a person's:

- age, race
- creed, religion
- sex, sexual orientation
- marital status, family status, economic status
- political belief, association or activity
- disability, size, weight, physical appearance
- nationality, ancestry or place of origin

A second main type relates to what is sometimes referred to as "bullying" behaviour that may involve:

- repeated humiliation or intimidation that adversely affects a worker's psychological or physical well-being
- a single instance so serious that it has a lasting, harmful effect on a worker

Harassment may be written, verbal, physical, a gesture or display, or any combination of these. It may happen only once, but often happens repeatedly.

What is not Harassment?

Reasonable, actions by managers or supervisors to help manage, guide or direct workers or the workplace are not harassment. Appropriate employee performance reviews, consulting or discipline by a supervisor or manager is not harassment.

Employee Rights and Responsibilities

Employees are entitled to work free of harassment at _____.

Employees have the responsibility to treat each other with respect. We ask that any employee who experiences harassment or sees another person harassed reports it to the appropriate person at _____.

Employees are responsible to co-operate in the investigation of a harassment complaint. Anyone who investigates or gives evidence in a complaint investigation is asked to keep details confidential until the investigation is complete.

All employees have the right to file a complaint with the Manitoba Human Rights Commission.

Employer Responsibilities

Management at _____ must ensure, as much as possible, that no employee is harassed in the workplace.

Management will take corrective action with anyone under their direction who harassed another person.

Management will not disclose the name of a complainant or an alleged harasser or the circumstances of the complaint to anyone except where disclosure is:

- necessary to investigate the complaint
- a part of taking corrective action
- required by law

The harassment prevention policy at _____ does not discourage or prevent anyone from exercising their legal rights.

_____, its managers and supervisors are responsible for keeping a safe work environment, free of harassment. If you are a manager and you become aware of harassment you must do anything in your power to stop it, whether or not a complaint is made.

Courts presume that employers and managers are responsible for being aware of harassment in their organization and may penalize them accordingly. Managers who ignore harassment leave themselves and their employer open to legal consequences, and will be disciplined at _____.

Procedures Applying to Complaints of Harassment

If you are harassed, the first thing to do is tell the person harassing you to stop, if you feel comfortable doing that. You can do this in person or in writing. If you feel unable to deal with him or her directly, you can speak to your supervisor or _____ (identify a specific manager or designated member of a harassment committee).

There may be informal ways to handle your complaint. Your supervisor may speak to the harasser. Your supervisor may also arrange for mediation, in which a neutral third party helps the people involved reach an acceptable solution. If the informal route does not succeed or is not appropriate, _____ supports its employees in filing a formal complaint.

The complaint will be investigated thoroughly and promptly by an independent party (either within the organization or outside of it) trained to investigate such matters. When the investigation is complete, the investigator will provide a written report for management.

_____(*identify appropriate* company manager) will inform the person who filed the complaint and the harasser of any remedies or disciplinary action.

Corrective Action for Harassers

Employees who harass another person will be subject to corrective action by the employer. In most cases, the harasser will also be required to attend workplace behaviour training.

If the investigation does not find evidence to support the complaint, no record will be kept in the file of the alleged harasser. When the investigation finds harassment occurred, the incident and the corrective action will be recorded in the harasser's personnel file.

Confidentiality

The company and its managers will not identify a complaint, an alleged harasser or any circumstances about a complaint, to anyone, except:

- when it is necessary in investigating the complaint
- if it is part of disciplinary action
- where required by law

Retaliation

Anyone who retaliates in any way against a person who has complained of harassment, given evidence in a harassment investigation or been found guilty of harassment, will be considered to have committed harassment and will be subject to corrective actions described previously.

Education

_____ commits to making sure all of its employees and managers learn about harassment and the company's harassment policy.

Monitoring

_____ will monitor this policy and make adjustments whenever necessary. If you have any concerns with this policy, please bring them to

the attention of _____(*identify appropriate manager*).

Note:

In keeping with the requirements of *The Human Rights Code*, it is practical for employers to include remedies for harassed workers in the workplace policy. The policy could include the following remedies:

Remedies for the Harassed Worker

Employees who have been harassed may be entitled to one of the following remedies, depending on the severity of the harassment and its effects:

- an oral or written apology from the harasser and _____ (*company name*)
- compensation for any lost wages
- a job or promotion that was denied because of the harassment
- compensation for any lost employment benefits, such as sick leave
- compensation for hurt feelings
- a commitment they will not be transferred, or have a transfer reversed, unless they choose to move

No record of the complaint, investigation or decision will go in the employee's personnel file if the complaint was made in good faith. Any unfavourable work review or comments that were placed in the complainant's personnel file because of the harassment will be removed from the file.

The Manitoba Dental Association would like to congratulate Armenia Evaristo (RDA) who received the "Outstanding Educator Award of the Year" from the Dental Assisting Educators of Canada.

BY EVAN PARUBETS
CFP, CIM, FMA, FCSI, CSWP™
Investment Planning Advisor
CDSPI Advisory Services Inc.

Why Take More Risk Than You Need To?

Let me start with this simple fact: We consistently find that dentists who are well off when they retire—and continue to live well in retirement—are those who are not taking undue risk. This begs the question, What is undue risk? The answer is straightforward: it's taking on more risk than you require to meet a desired objective.

One of the questions we most often hear from dentists is "Do I have enough?" by which they mean do they have enough to retire comfortably for the rest of their lives? It's not too difficult to determine this. We start with your current knowns—we know what your assets are, and your liabilities, and we have a pretty good idea what your practice is worth. We overlay that with your projected cash flow. This includes your income until you retire (less your expenses), additional revenue from things like a rental property or other investments, and the projected value of your practice when you sell it.

Then we start modelling to make the following determination: *To achieve X level of income in retirement, for Y number of years, you need a* ***required rate of return*** *of Z on your investments.* There are several variables to consider, including your estimated date of retirement, your desired retirement income, inflation, and the number of years your money has to last. Other variables may include your spouse's income and investments, and your estate plan.

We use all of this information to create a financial plan with an evaluation of how much risk you may need to take on (through asset allocation) to achieve your required rate of return. We can tweak all of these variables to see how they impact the plan, and we also stress test it. What happens if you don't sell your practice for as much as expected, for example? Or if the market doesn't perform as expected?

What we often find with dentists who don't follow this path is that they may have much more invested in equities than they need to achieve their required rate of return. They simply take on more risk than is needed to retire comfortably. (Conversely, some dentists are too conservative and run the risk of falling short of their required rate of return as a result.) It's all about having a target in mind, based on a well-defined financial plan, and investing accordingly.

You take enough risk when you establish or buy a practice. That's your wealth creation venture. If you start practising at 25 and retire at 60, for example, that's 35 years to build your net worth. If you live another 30 years that money has to last, so there is no need to take on unnecessary risk that may endanger your plan. You've worked hard to enjoy the retirement you deserve; this is the time to be smart with your life savings.

> *"Risk comes from not knowing what you're doing."*
> *- Warren Buffet*

As a CERTIFIED FINANCIAL PLANNER® professional from CDSPI Advisory Services Inc., I can offer a combination of expertise and personal knowledge of clients' needs, with an exclusive focus on dental professionals. If you feel it is a good time to develop a financial plan, or revisit one that is already in place, please contact me in at 1-800-561-9401, ext. 6852, or send an email to eparubets@cdspi.com

The Canadian Dentists' Investment Program is a member benefit of the CDA and participating provincial and territorial dental associations. Restrictions may apply to advisory services in certain jurisdictions.

Philanthropy Corner

One to Watch! Meet Sally Armstrong.

Sally Armstrong is a multiple-award-winning human rights activist, journalist, documentary filmmaker, teacher, editor, and author who currently resides in Ontario. Born in 1943 in Montreal, Quebec, Armstrong received her Bachelor of Education from McGill University in 1966 and years later completed a Master's thesis at the University of Toronto entitled "Missing in Access: A Feminist Critique of International Documents that Pertain to the Human Right of Adolescent Girls to Access Health Services and Their Impact on Young Women in Afghanistan and in Canada" (2001).

Armstrong is best known for her work as a journalist and human rights activist and has brought international attention to the political and cultural struggles of women and children in high conflict zones such as Bosnia, Somalia, and Rwanda. Her principal focus, however, has been on the lives of women and girls in Afghanistan during the extremist rule of the Taliban from 1996 to 2001 and during the country's present efforts to rebuild itself. Her bestseller, Veiled Threat (2002), is illustrative of Armstrong's belief in the power of individuals to work together to create change. In 1997, "Veiled Threat," Armstrong's Homemakers article on the lives of the women of Afghanistan, struck a chord with many readers, thousands of whom wrote letters expressing their concern and their outrage with Canada's political paralysis. This article helped maintain public focus on a problem largely ignored by the international community. Veiled Threat documents the restricted and often horrific lives of women under the rule of the Taliban; it also chronicles the Taliban's courageous opponents, such as renowned women's advocate and later deputy prime minister, Dr. Sima Samar. In Bitter Roots, Tender Shoots (2008), Armstrong revisits Afghanistan to measure the progress that has been made since the withdrawal of the Taliban. This crusade on behalf of impoverished and uneducated women and girls has resulted in charges of cultural relativism leveled by Afghan fundamentalists, who accuse her of being a Western woman meddling in a country and a culture that is not her own. Armstrong's continuing action has demonstrated her response: "everyone knows that silence is consent [...] If you cannot talk about it, you cannot change it".

As an activist and journalist, Armstrong writes with a clear agenda: "I write about the women and girls who live with the consequences of military and political decisions" (Bitter Roots 3). This propensity to provide a narrative for those traditionally without a voice is also evident in her brief foray into fiction. To date, Armstrong has written only one novel. Well-received by the popular reading audience, The Nine Lives of Charlotte Taylor (2007) is a fascinating marriage of provincial history and fiction that depicts the life of Charlotte Taylor, one of the first settlers of New Brunswick. A direct descendent of Charlotte, Armstrong is forthright about her decision to supplement surviving archival fact with engaging and constructive narrative in order to properly create a complete story, and she concludes the novel with the conviction that her ancestor would have encouraged her "to take liberties" (Nine Lives 388). Just as the portrait of the charismatic and tireless Dr. Sima Samar in Veiled Threat represents the progressive and the hopeful, so too is Charlotte Taylor carefully created as an exemplary figure by a woman who is, undoubtedly, exemplary herself. Armstrong acknowledges the connections between what might otherwise seem to be unrelated writing projects, and writes, "I was drawn to Charlotte because her story resonates with the articles I have written for over two decades about women who dared to take on the culture and religion of their time and seek emancipation".

Because current critical engagement with this book does not yet exist in a significant sense, it may be difficult to gauge the extent to which the popularity of The Nine Lives of Charlotte Taylor is indicative of the novel's enduring quality as opposed to Armstrong's fame as a humanitarian. Nevertheless, it is noteworthy for its simultaneous presentation of Native, Loyalist, and Acadian historical roles and sentiment. Its publication as one of the first fictional treatments of the history of New Brunswick may help prepare the field for a future fictional reimagining—and consequently, a regional ownership—that is long overdue.

For her arresting journalism, Armstrong has twice been awarded Amnesty International's Media Award, once in 2000 and again in 2002. Her journalistic efforts have not been limited to the printed word, however. She has produced and hosted several award-winning documentaries for CBC, including They Fell From the Sky (2001) and The Daughters of Afghanistan (2003). Amongst the vast array of her humanitarian involvements, Armstrong is one of the founders of Willow, a resource for breast cancer support in Canada, and she currently sits on the Council of Advisors for the Canadian Women's Foundation, whose mandate is to improve the lives of women and girls.

In addition, Armstrong's achievements have been recognized by several universities: in 2000 she received an Honorary Doctor of Laws degree from Royal Roads, and in 2002, an Honorary Doctor of Letters from McGill University. In 2004 she was awarded an Honorary Doctor of Letters from St. Thomas University, and in 2007 she received an Honorary Doctor of Laws from the University of Guelph and a Doctor of the University degree from the University of Ottawa. She has also received several awards that attest to her lifetime of humanitarian service. In 1998 Armstrong became a Member of the Order of Canada, an award which is bestowed in recognition of a nominee's lifetime of work dedicated to the community, and in 2008 she received the Canadian Journalism Foundation's Lifetime Achievement Award.

When Childcare Interferes with Work: When is an Employer's Duty to Accommodate Triggered?

Most employers are aware that human rights legislation prohibits discrimination in employment on the basis of such things as age, race, religion, physical disability and mental disability; however, employers may be less familiar with the fact that human rights legislation prohibits discrimination in employment based on a person's "family status". A person's "family status" includes his or her status as a parent, including any childcare obligations he or she may have.

In short, this means that employers may now have a duty to accommodate employees with childcare obligations, unless this causes undue hardship for the employer.

"Family status" is not a new protection for employees, but its application to childcare obligations has become much more prevalent in recent years. Below are examples of the types of complaints that have recently been advanced by employees on the basis of family status:

• An employee's shift was 8:30am-3:00pm. For legitimate work-related reasons, the employer changed her shift to 11:30am-6:00pm. The employee asked to keep her old shift, as she had to provide after-school care to her son who had a psychiatric disorder. She filed a human rights complaint when the employer refused. The Human Rights Tribunal found that the employee's family status triggered the employer's duty to accommodate. However, the tribunal did not determine whether the employer had failed in its duty to accommodate her.

• An employee, who resided in Alberta, was on lay-off. She was recalled to work in Vancouver. She had 2 young children. Her husband worked for the same company and had an unpredictable schedule. She had no family in BC. Accordingly, she would not be able to provide childcare if she moved to BC. She refused the transfer, was terminated, and subsequently brought a human rights complaint. The Human Rights Tribunal found that the employer failed to accommodate the employee based on family status.

• An employee worked 8:00am to 4:00pm every day. He was a single parent and had custody of his children every other week. The school bus did not pick the kids up in the morning until 8:45am. For the weeks in which he had the kids, he asked if he could change his schedule to 9:00am to 5:30pm. For operational reasons, the employer said no. The employee grieved. There was evidence that the employee did not consider any alternative child care arrangements before bringing his grievance. The Arbitrator found that there was no human rights violation by the employer.

As in any other discrimination case, the first step is for the employee to prove that he or she has a "prima facie" case. This means that the employee must first meet a minimum threshold to prove that he or she did, in fact, suffer some discrimination. Once the employee has met this threshold, the onus then switches to the employer to prove that accommodating the employee's family needs would have caused "undue hardship".

Unfortunately, an inconsistent approach as to what constitutes a prima facie case has developed across the country. At one end of the spectrum, the test that developed in British Columbia was quite onerous for employees to meet. It required that the employee show that there was "a change in a term or condition of employment that resulted in a serious interference with a substantial parental obligation." At the other end of the spectrum, the test that developed in the Federal jurisdiction was much easier for employees to meet - all that was required was for the employee to show that he or she had a familial obligation that required accommodation because of a work requirement.

In other provinces, such as Ontario and Alberta, a middle ground approach was used, focusing on what efforts the employee made to help address the situation (e.g. to find alternative childcare arrangements) before requesting accommodation from the employer.

In Manitoba, there has only been one grievance arbitration decision which has considered what this prima facie test is. Unfortunately, the arbitrator declined to specify which approach applied in Manitoba.

A New Test and a Focus on Self-Accommodation

Not unexpectedly, the approach adopted by the Federal courts and tribunals made employers nervous that it would open the floodgates to human rights complaints.

The Federal Court has recently revisited its test as to whether an employee has a "prima facie" case for discrimination based on his or her family status. The new test may significantly help to clarify the expectations imposed on both employers and employees in these types of cases.

In Johnstone v. Canada (Attorney General), Ms. Johnstone was an employee with the Canadian Border Services Agency (CBSA) working at Pearson International Airport. Her husband also worked for the CBSA. Together they had two young children.

At the time, full-time employees with the CBSA worked on a rotating shift pattern. Shifts had 6 different start times over the course of days, afternoons and evenings, on different days of the week, with no predictable pattern. Since both Ms. Johnstone and her husband worked these variable shifts, neither could provide the childcare they required on a reliable basis.

Accordingly, Ms. Johnstone asked the CBSA for a full-time static shift rotation. The CBSA refused to provide accommodation to employees with childcare obligations as it took the position that it had no legal duty to do so. The CBSA offered Ms. Johnstone a static shift pattern, but on condition that she would be bumped down to part-time status (which had significantly fewer pension entitlements and promotion opportunities). Ms. Johnstone then filed a claim with the Canadian Human Rights Commission.

After a very lengthy court battle, the Federal Court of Appeal set out the 4-step test that Ms. Johnstone would have to meet to establish a "prima facie" case. These 4 factors are:

• The employee must have a child under his or her care or supervision. In the case of a parent, this will usually flow from the employee's status as a parent. In the case of a caregiver, the employee must have a legal obligation to the child similar to that of a parent.

• The childcare obligation must engage the employee's legal responsibility for the child as opposed to a personal choice. This requires that the child be of an age where he/she cannot reasonably care for

him/herself. This also requires that the childcare need is as a result of a parental obligation (e.g. to not leave a young child alone) versus a parental choice (e.g. to attend an after-school hockey game).

• The employee made reasonable efforts to meet those childcare obligations through reasonable alternative solutions, but no such alternative solution is reasonably accessible. This is where self-accommodation comes into play. In other words, the employee will have to show that he or she took reasonable efforts to make alternative child care arrangements but none were reasonably available.

• The workplace rule in issue interferes with the employee's childcare obligation in a manner that is more than trivial or insubstantial. There is no definition of what is meant by "more than trivial or insubstantial"; rather, the unique circumstances of each case will have to be examined in order to determine this.

Having regard to all of these factors, the Federal Court of Appeal found that Ms. Johnstone had established a prima facie case. Ms. Johnstone's work schedule could not accommodate her childcare obligations. Nor could her husband's. Ms. Johnstone made significant but unsuccessful efforts to secure reasonable alternative childcare arrangements, including seeking out regulated childcare providers, unregulated childcare providers, and family members to look after the children. Accordingly, the Court held that the CBSA was required to accommodate Ms. Johnstone.

Conclusion

Given the recent attention that family status cases have been receiving, many employers are nervous that they will be flooded with requests for accommodation every time someone wants to participate in a family activity (and possible human rights claims if such requests are denied).

The Court was careful to note in Johnstone that voluntary family activities, such as family trips or participation in extracurricular sporting events do not fall under the employer's duty to accommodate as they result from parental choices and not parental obligations. Employers can breathe a sigh of relief, therefore, that they will not be off-side human rights law if they refuse to change an employee's schedule to accommodate his or her child's soccer games. That being said, employers should not be too quick to brush off family status requests where the basis for the request is related to childcare obligations. Employers will have to look at the facts of each individual case to determine whether the employee's request will trigger the employer's duty to accommodate.

We cannot say conclusively that the 4-part Johnstone test will apply in Manitoba. Only time will tell whether Manitoba arbitrators and tribunals decide to adopt this test. In the meantime, however, the Johnstone test nonetheless presents a useful framework to guide employers' decisions when family status issues arise.

Article supplied by Thompson Dorfman Sweatman LLP - See more at: http://www.tdslaw.com/knowledge-center/when-childcare-interferes-with-work-when-is-an-employer-s-duty-to-accommodate-triggered/#sthash.beZ3xyH1.dpuf

Most Manitoba Dentists offer a child's first dental visit prior to the age of three at no charge through the Free First Visit program. Research has shown it to be highly successful and the profession is held in high regard by grateful parents.

Public acceptance that **a child's first dental visit should take place prior to their first birthday** is growing as parents are becoming aware of the benefits of establishing an early start to their child's professional dental care.

BABY'S FIRST CHECKUP SHOULD BE DONE BY AGE ONE

or within 6 months of the eruption of the first tooth.

Based on the benefits to the public and the profession, the program is continuing with a re-branding that the first visit take place prior to the child's first birthday, even though **it will be available for free until their third birthday.**

Watch for an in-office and multi media campaign this fall.

All dentists are encouraged to participate in this worthwhile program.

FREE FIRST VISIT

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