Through a unified voice, the Saskatchewan Oral Health Coalition works collaboratively with dedicated partners to improve the oral and overall health of Saskatchewan residents. As an inter-disciplinary group, we strive to identify and address the needs of vulnerable populations, and by using evidence based decision making, promote advocacy, education, prevention and standards.

Ministerial Statement – National Oral Health Month - April 2017

The Honourable Minister of Health, Jane Philpott, issued the following statement on Oral Health Month. “April is Oral Health Month – a good reminder to maintain healthy habits and recognize how good oral health can benefit our overall well-being...Healthy mouths and teeth can play an important role in someone’s overall well-being. For example, children are able to concentrate better in school without pain from cavities, toothaches or gum disease; and seniors are more likely to maintain a healthy diet and social interaction if they have good oral health.

We are pleased to support programs like...
Good oral health is essential to overall health and quality of life. Overall improvements in oral health may imply substantial economic benefits, not only in terms of reduced treatment costs, but also because of decreased productivity losses in the labour market.

Recent findings suggest that oral diseases account for productivity losses of over $1 billion per year in Canada.

The Canadian Dental Association (CDA) prepared a report on overview of oral health in Canada. The report provides insights and information on the state of oral health around the world; how Canada compares against other countries; information on funding models, statistics on dental usage and access to oral care; snapshot of oral health in Canada; priority areas for improving oral health publicly financed oral health programs in Canada; provincial public oral health programs; programs being spearheaded by provincial dental associations; volunteerism by Canadian dentists and more.

Based on a wide range of metrics, Canada is among the world leaders when it comes to the overall oral health of its citizens. In addition to ranking favourably in terms of oral health indicators such as decayed, missing and filled teeth (DMFT), severe chronic gum disease and instances of oral and lip cancer, Canadians also enjoy among the best access to oral health care in the world. Three out of every four Canadians visit a dental professional at least once per year, and 84% of Canadians believe they have good or excellent oral health. In Canada, wait times to see a dentist and receive treatment are among the shortest in the world. And for most Canadians, choice and availability of dentists is a non-issue. Research indicates that poor oral health is experienced by those Canadians who do not have access to regular dental care. The report outlines some of these challenges, along with work being done to address them.

Dental service expenditures in Canada in 2015 shows the proportion of public dental services is very small compared to other sources of funding for dental services in Canada (see chart). Public-sector dental expenditures are targeted primarily to children, seniors, eligible Aboriginal individuals and the disabled.

While Canada’s oral health care measures are generally above average compared with countries around the world, there are inequities in oral care. In particular, Canadian families and individuals with lower incomes and of lower socio-economic status, those without dental insurance, older Canadians and Aboriginal Canadians experience worse overall oral health outcomes than the general population.

In Canada, income and dental insurance are the two most important determinants of dental care utilization.

The CDA uses the National Coordinating Group on Access to Care in order to focus on issues faced by children and seniors: The CDA supports a first visit with a dentist by 12 months of age (or within 6 months of first tooth eruption) to help reduce early childhood caries. The National Coordinating Group on Access to Care produced an advocacy toolkit that can be used by dentists who advocate for improving dental conditions for seniors in long term care homes.

Nearly half of the dentists in Canada are involved in community-based volunteer activities and donated a projected total of almost one million volunteer hours.
This report examines whether Canada and the provinces have made progress in reducing socio-economic inequalities in health and well-being over the past decade. To achieve this aim, they examined a range of health indicators over time and across different income levels to identify the distribution of health across the income gradient. In addition, they aimed to identify programs and interventions that could reduce health inequalities.

The analysis identified that there has been minimal progress in reducing the health gap between lower- and higher-income Canadians over the past decade.

For the majority of health indicators, this gap has persisted or widened over time.

For example, for diabetes the gap has persisted over time, while rates increased in all except the highest income level.

Trends in inequality were largely similar across provinces, with a few notable exceptions. For example, while income-related inequality did not change over time at the national level for diabetes, it increased substantially in Saskatchewan.

In 2003, the diabetes rate was not significantly higher in the lowest income level compared with the highest in Saskatchewan, whereas in 2013, the rate of diabetes was more than 4 times higher in the lowest income level compared with the highest.

Despite such efforts, the prevalence of diabetes has continued to rise across Canada over the past 10 years. Following the recommended nutritional, exercise and treatment strategies to successfully manage diabetes is challenging without adequate living conditions and financial resources. For example, adults with diabetes who live in households that are food insecure due to financial constraints are only half as likely to consume the recommended 5 or more daily servings of fruits and vegetables as those in food secure households. In many jurisdictions, the high out-of-pocket costs associated with good self-management of diabetes (e.g., cost of medications, blood sugar testing equipment) place a disproportionate burden on lower-income Canadians and challenge their ability to effectively manage this condition. Thus, allocating appropriate health care resources to ensure affordable and accessible diabetes treatment for low-income and other vulnerable groups is an important component of reducing socio-economic inequalities in diabetes.

Given the particularly strong connection of diabetes to social and economic conditions of life, interventions such as those addressing access to affordable housing and employment opportunities will also have an important impact on reducing socio-economic inequalities in the development and management of diabetes.

The report also discusses approaches for addressing inequality. Going back to the previous example, diabetes, a number of programs and policies at the federal, provincial and local levels have aimed to reduce the overall burden of diabetes, as well as inequalities in diabetes prevalence and its associated complications. At the federal level, programs include the Canadian Diabetes Strategy and the Aboriginal Diabetes Initiative, both of which support the prevention and management of type 2 diabetes among vulnerable populations.

This report is one of a number of current national initiatives aimed at strengthening the evidence on health inequalities in Canada. In moving forward, it is important to continue to monitor trends and to evaluate the impact of interventions targeted toward low-income populations as these are required to inform policies to reduce health inequalities.

Read More Here
Report: Evolving Delivery Models for Dental Care Services in Long-Term Care Settings: 4 State Case Studies (2016)

The Oral Health Workforce Research Center at the University at Albany's School of Public Health, completed a research project to examine the current and changing practice models utilized in providing dental services in long term care (LTC), residential care, and for homebound individuals through 4 state case studies. A secondary objective was to determine policy variables that may impact the availability of these services available to elders and disabled individuals in LTC homes vary according to policy environment of the state.

Currently, dental care is delivered in a wide range of models from traditional transport to fully mobile and tele-health enhanced models, for nursing home residents in the U.S. Training of LTC home staff in daily mouth care for residents is insufficient and regulations around provision of daily mouth care are ineffective to maintain or improve the oral status of residents. Provision of dental care to patients in LTC facilities is different and more difficult than provision of dental care to patients in other environments.

Themes drawn from the case studies about delivering dental care in LTC setting include:

1. No standard of care exists for provision of dentistry in LTC homes.
2. Best practices for the workforce delivery of dental care to LTC residents require complex, collaborative, interprofessional team efforts.
3. Configuration of dental workforce and types of care available to elders and disabled individuals in LTC homes vary according to policy environment of the state.
4. Currently, dental care is delivered in a wide range of models from traditional transport to fully mobile and tele-health enhanced models, for nursing home residents in the U.S.
5. Training of LTC home staff in daily mouth care for residents is insufficient and regulations around provision of daily mouth care are ineffective to maintain or improve the oral status of residents.
6. Provision of dental care to patients in LTC facilities is different and more difficult than provision of dental care to patients in other environments.
7. Traditional sources of workforce data do not adequately capture the size, scope, training, or capacity of the professional dental workforce engaged in LTC settings, nor the volume or appropriateness of dental care being provided to nursing home or other LTC residents.

Increased attention to the oral health problems in the LTC environment is creating action in the dental community.

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Interview: Saskatchewan Seniors' Oral Health and Long Term Care Strategy – Better Oral Health in Long Term Care: Best Practice Standards for Saskatchewan

On February 7, 2017, Kerrie Kreig, Saskatchewan’s only long term care (LTC) oral health coordinator, did an interview with CBC radio on oral health care in LTC homes in Saskatchewan and called on the Ministry of Health to hire more coordinators.

Kreig along with some of her co-workers, manager and other oral health professionals, went before the province’s Ministry of Health in September 2016 to pitch her idea for more oral health co-ordinators. She said the ministry was impressed, and Kreig has been invited back to give a presentation to the director of care for each health region.

Her job is to train LTC care staff, such as registered nurses, continued care assistants and managers, how to properly implement oral health standards in the province. She has been on the job since October 2015. Assessments were done when Kreig first started working and then re-assessments were done six months later. She said there has been a huge difference from the time she started to now.

Thank you Kerrie for getting the word out!

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Today’s children are bombarded with food and beverage marketing every day of the week. This is having a devastating effect on their health. Unhealthy eating is a leading risk for death in Canada, starting in childhood and building through life. The report by Health and Stroke Foundation examines how food industry is marketing unhealthy food and beverages directly to our children and youth, and how this is affecting their preferences and choices, their family relationships and their health. They looked at national and international studies/reports and they polled Canadians to understand their perspectives on the issue. They also commissioned one of the country’s leading researchers to examine the volume of food and beverage advertising online to Canadian children and teens, and the quality of the products—the first research of its kind in the country.

According to the poll, most Canadians (72%) believe the food and beverage industry markets its products directly to children, and an even higher number (78%) believe the food and beverages advertised to children are unhealthy.

Dr. Monique Potvin Kent, an expert on food and beverage marketing and children’s nutrition, reviewed the top 10 most popular websites for children and adolescents.

The most frequently advertised products online

<table>
<thead>
<tr>
<th>Children</th>
<th>Teens</th>
</tr>
</thead>
<tbody>
<tr>
<td>restaurants, cakes, cookies, ice cream, cereal</td>
<td>cookies &amp; ice cream, cereal, restaurants, sugary drinks</td>
</tr>
</tbody>
</table>

The report also discusses the specific actions we can take to protect children and support parents. Some of the action items include 1- Endorsing the Ottawa Principles and the Stop Marketing to Kids Coalition at www.stopmarketingtokids.ca 2- Advocating for healthier food and beverage environments so that the healthy choices are easy choices and 3- Letting your MP, MLA and municipal leaders know that you support banning marketing to children.

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**Article: The Former Dentist Uncovering Sugar’s Rotten Secrets**

Dr. Cristin Kearns, a former dentist, is one of the only people who have found evidence that cane- and beet-sugar manufacturers contributed to public-health problems. A growing body of science shows that excess sugar contributes to obesity and diabetes, but, for many years, nutritionists focused elsewhere (fat and cholesterol).

Kearns has been re-analyzing several documents to determine how corporations influenced American research on sugar’s adverse health effects. Based on the documents Kearns published a study in *PLoS Medicine* showing that the foundation and other groups attempted to deflect federal researchers’ interest away from studying how to decrease Americans’ consumption of sugar to prevent cavities.

“Most noncommunicable diseases such as diabetes and heart disease are spread by big corporations...Because profit-maximizing behavior leads them to be outpushing products which end up causing disease,” says Stanton Glantz, a public-health researcher and Kearns’ mentor at the University of California, San Francisco.

“I really feel like understanding what the sugar industry is doing, that’s the root cause,” Kearns says. As an inner-city dentist, she couldn’t even begin to address it. “For every 10 people I patch up, I’ve got 10 more. It’s this endless cycle.” She’s hoping to break that cycle, by revealing the forces that have kept health organizations from telling the public the truth.

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Dental and oral health is an essential element for the maintenance of quality of life throughout one's life. Moreover, dental and oral health has the potential to maintain and improve systemic health status. Therefore, a social system that allows everyone to receive high-quality dental care and oral health services even during old age is necessary. The report, published by Japan Dental Association, provides a collection of reviews to provide the target audience (i.e., policymakers, healthcare professionals, and researchers) with a summary of the present evidence and issues. The topics covered in this collection of reviews include the relationship of dental and oral health with 1-age-related changes and aging; 2-life expectancy; 3-noncommunicable diseases as the main causes of death and the risk factors thereof; 4-diseases that cause conditions requiring long term care; 5-health promotion activities such as exercise, nutrition; 6-socioeconomic factors; 7-the effects of dental care. In addition, the particularly important literature is summarized. Moreover, the strength of the evidence presented in each study is noted by specifying the study design (e.g., observational study, intervention study, data integration study), so that this collection of reviews can be used as an easy-to-understand resource where policymakers as well as the general public can obtain oral health information. At the end, they have also provided a commentary regarding the history of Japan’s 8020 campaign and the universal health insurance system that was implemented in 1961.

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The Oral Health Workforce Research Center at the University at Albany, New York, completed a research project that included case studies of federally qualified health centers (FQHCs) across the United States to understand how these health centers integrate primary care and oral health care services and to also describe the use of new or alternative oral health workforce models to better achieve the objectives of increased access and improved oral health outcomes for their patient populations. This report presents a summary of common themes as well as a discussion of differences among FQHCs.

This research study used a case study methodology. Themes drawn from the case studies about delivery of oral health services in FQHCs include: 1-Oral health service delivery that is designed to meet local need is the most effective way of improving access and utilization of oral health services by the local population. 2-Demand for oral health services is high in FQHCs, while the oral health literacy of patients is relatively low. 3-FQHCs employed a variety of strategies to integrate oral health and primary care service delivery. 4-FQHCs generally recognized that technology was a facilitator of integration of primary care and oral health, but some health centers had resource limitations that prohibited full engagement with available or emerging technologies to improve care transparency. 5-Finding local, state, federal, and other funding to support the cost of building infrastructure and delivering oral health services is critical to sustain the contributions of FQHCs to improvements in access to oral health services. 6-FQHCs commonly used team-based approaches to delivering oral health services and were successful in using teams to meet patient demand for dental care. 7-FQHCs used existing oral health workforce in innovative ways and also engaged with new oral health workforce models to improve care delivery.

FQHCs in the case studies recognized their important contributions to oral health service delivery in their local communities.

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**Article**: A Qualitative Study on African Immigrant and Refugee Families’ Experiences of Accessing Primary Health Care Services in Manitoba, Canada: It’s Not Easy!

Immigrant and refugee families form a growing proportion of the Canadian population and experience barriers in accessing primary health care services. The aim of this study was to examine the experiences of access to primary health care by African immigrant and refugee families. Eighty-three families originating from 15 African countries took part in multiple open ended interviews in western Canada. Qualitative data was collected in six different languages between 2013 and 2015. African immigrant and refugee families experienced challenges in their quest to access primary health care that were represented by three themes: 1- Expectations not quite met, 2- Facing a new life, and 3- Let’s buddy up to improve access. On the theme of expectations not quite met, families struggled to understand and become familiar with a new health system that presented with a number of barriers including lengthy wait times, a shortage of health care providers, high cost of medication and non-basic health care, and less than ideal care. On the theme of facing a new life, immigrant and refugee families talked of the difficulties of getting used to their new and unfamiliar environments and the barriers that impact their access to health care services. They talked of challenges related to transportation, weather, employment, language and cultural differences, and lack of social support in their quest to access health care services. Additionally, families expressed their lack of social support in accessing care. Privately sponsored families and families with children experienced even less social support. Importantly, in the theme of let’s buddy up to improve access, families recommended utilizing networking approaches to engage and improve their access to primary health care services.

In conclusion, African immigrant and refugee families experience barriers to accessing primary health care. To improve access, culturally relevant programs, collaborative networking approaches, and policies that focus on addressing social determinants of health are needed.

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**Opinion**: Canada’s Private Dental Care System Falls the Most Vulnerable

Dean of the Faculty of Dentistry at McGill University and president of the Association of Canadian Faculties of Dentistry, Dr. Paul Allison, discussed the current situation of access to dental care in Canada’s vulnerable groups.

The most vulnerable members of Canadian society include the elderly, indigenous people, young children, individuals with disabilities, recent immigrants/refugees, those living in rural and remote communities and those living and working in poverty. These individuals are also at the greatest risk of dental and oral diseases and other illnesses. Oral health is directly linked to general health. Therefore, by failing to treat the oral health problems of Canada’s most vulnerable groups, we are increasing the chances of their general health deteriorating.

A private system like Canada’s dental care system, which accounts for 95% of dental care in Canada, is not able to care for these vulnerable groups. “We need to

1- start thinking differently about the delivery of dental care, particularly for the most vulnerable members of our society.
2- better train dental students and dentists to work with these groups.
3- create new models of dental care delivery, including mobile dental care, “tele-dentistry" and setting up dental offices in community health-care centres, pharmacies and other sites where these vulnerable groups go for other health and social services.
4- bring dentists into the public system, working with family physicians, pediatricians, geriatricians and others” said Paul Allison.

Canadian dental schools are beginning to focus on how they can create new training programs and new dental-care delivery programs to address these shortcomings of the current private dental system in Canada.

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**Interview: Change for the Better: Introducing Mandatory Brushing in Public Schools in Mexico City**

Dr. Edelson, FDI Council Member and general dentist in Mexico City, has introduced a public health measure to improve the health of kindergarten and primary school children. Public kindergarten and primary public schools in Mexico City have adopted a new mandatory tooth brushing program which will be supervised by teachers in the hopes of reducing the prevalence of dental decay.

In Mexico City, 98% of the children go to school; however, not all of them have access to a dentist regularly. This program has been implemented as a result of a successful smaller pilot program that was introduced 4 years ago.

The movement now includes 140,000 children and is generously supported by Colgate Mexico. To guarantee the sustainability of the program, in November 2016 a law was passed in Mexico City mandating that, during the school year, every child will receive 2 oral hygiene kits, one for home and one for school. This program has been successful in bringing oral health education back to schools where it used to be many years ago. The hope is that this program will be extended to private schools and the rest of the country as well.

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**Article: Effects of Taxing Sugar-Sweetened Beverages on Caries and Treatment Costs.**

A research was conducted to estimate the impact of a 20% sugar sweetened beverages (SSB) sales tax on caries increment and associated treatment costs (as well as the resulting tax revenue) in Germany.

Model-based approach was used to estimate the effects for the German population aged 14 to 79 years over a 10-year period. National representative consumption and price data were used to estimate tax revenue. Microsimulations were performed to estimate health outcomes, costs, and revenue impact in different age, sex, and income groups.

Implementing a 20% SSB sales tax reduced sugar consumption in nearly all male groups but in fewer female groups. The reduction was larger among younger than older individuals and among those with low income. Taxation reduced caries increment and treatment costs especially in younger (rather than older) individuals and those with low income. Over 10 years, mean net caries increments at the population level were 82.27± 1.15 million and 83.02 ±1.08 million teeth at 20% and 0% SSB tax, respectively. These resulted in treatment costs of 2.64± 0.39 billion and 2.72± 0.35 billion euro, respectively. Additional tax revenue was 37.99 ±3.41 billion euro over the 10 years.

In conclusion, implementing a 20% sales tax on SSBs is likely to reduce caries increment, especially in young low-income males, thereby also reducing inequalities in the distribution of caries experience. Taxation would also reduce treatment costs. However, these reductions might be limited in the total population.

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**FDI’s Definition of Oral Health**

Oral health is an important contributor to overall health and well-being, and thus needs to be properly defined, assessed, managed and promoted. “Oral health is multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex” According to World Dental Federation (FDI).

Further attributes related to the definition state that oral health is a fundamental component of health and physical and mental well-being. It exists along a continuum influenced by the values and attitudes of individuals and communities, reflects the physiological, social and psychological attributes that are essential to the quality of life, is influenced by the individual’s changing experiences, perceptions, expectations and ability to adapt to circumstances.

Alongside the proposed concise definition, a companion framework was developed to describe the complex web of interactions between the three core elements of oral health, a range of driving determinants, moderating factors and, overall health and well-being (see picture).

The proposed definition and framework are meant to be universally applicable in all geographical areas, for all populations, and by different stakeholders.

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**Article: FDI Vision 2020: Shaping the Future of Oral Health**

Vision 2020 is a document paves the way for a new model of oral health care led by dentists in collaboration with a wide range of other stakeholders. It roughly sketches the possible look of oral healthcare by the year 2020 if we tackle the challenges and seize the opportunities that arise in a timely and adequate manner. As a vision, this document is meant to be aspirational and inspirational; it is not meant to be operational. This document is the beginning of a continuous process aimed at generating discussion and collaboration between FDI and all its partners.

FDI Vision is that by 2020, “inequities with regard to access to oral healthcare will be substantially reduced and the global need and demand for oral healthcare more largely will be met; oral health will be fully recognized and accepted as a crucial part of overall health and well-being; newly minted graduates will benefit from responsive, dynamic and modular curricula, which contents reflect state-of-the art knowledge and technologies that can be used to provide optimal oral healthcare and provide learners with extensive critical thinking and analytical skills training; collaboration and partnerships between the private and public sector will have led to the inclusion of Oral Health in All Policies and that new evidence-based models of oral healthcare will be available to ensure fair and appropriate remuneration for care that delivers measurable health outcomes, thereby shifting the focus from a preliminarily procedure-based remuneration model to models which foster a holistic approach to oral healthcare and consider promotion, prevention, and treatment as equally important; and major improvements in oral health will have been achieved and inequalities will have been reduced through research-led strategies for more effective disease prevention, with the integration of oral health into healthcare in general.”

Read More [Here](#)
Peel is one of the largest municipalities in Canada and the second largest in Ontario. This report describes the oral health status of the residents of Peel region, access to oral health care and associated costs of oral health care with the purpose of informing future Peel Public Health planning.

Data about oral health status for Peel comes primarily from the Canadian Community Health Survey, and is self reported. Additional data for children are collected from Peel Public Health’s Oral Health Screening database. While both systems provide useful information, there are some limitations. For example, there is no clinical health status data about youth, adults and seniors. In addition, there is no information about the oral health status of certain priority populations including recent immigrants, refugees and First Nations, Métis and Inuit people residing in the region.

Most residents have good oral functioning and seek regular dental care; however, there are disparities in both health status and access to dental services. For example, those with lower income are less likely to report very good oral health status, and are often less able to pay for oral health care services.

Many Peel residents have access to an oral health care provider and visit them regularly. However, there are some subgroups within Peel, such as those without dental insurance and those in low-income, that have a cost barrier to accessing oral health care services.

Oral health visits to physicians, emergency departments and hospitals amount to approximately $4 million dollars per year in Peel. This estimate does not include additional costs billed as the result of publicly funded programs for residents in need of treatment.

The report also provides some key areas of focus for Peel Public Health, such as: 1-improve access to local population health status data through monitoring and surveillance activities, 2-enhance regional oral health programming, 3-advocate for improved access to care.

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**Article: Acute Dental Infections Managed in an Outpatient Parenteral Antibiotic Program Setting: Prospective Analysis and Public Health Implications**

The number of Acute Dental Infections (ADI) presenting for emergency department care are steadily increasing. Historically, the majority of severe ADI have been managed with hospitalization. Outpatient Parenteral Antibiotic Therapy (OPAT) programs are increasingly utilized as an alternative cost-effective approach to the management of serious infectious diseases but their role in the management of severe ADI is not established. This study aimed to address this knowledge gap through evaluation of ADI referrals to a regional OPAT program in a large Canadian center.

This study was prospectively conducted in Calgary, Alberta, between February 1st and June 30th, 2014. Participants completed a questionnaire and OPAT medical records were reviewed upon completion of care. Of 704 adults presenting to acute care facilities with dental infections during the study period, 343 (49%) were referred to OPAT for ADI treatment and 110 were included in the study. Median length of parenteral antibiotic therapy was 3 days, average total course of antibiotics was 15-days, with a cumulative 1326 antibiotic days over the study period. Conservative cost estimate of OPAT care was $120,096, a cost savings of $597,434 (83%) compared with hospitalization.

The widespread, potentially avoidable, use of antibiotics in this study poses an additional public health threat by way of...
3.5 million years ago. That transition from forests to grasslands may have played a key role in human evolution explains Matt Sponheimer, a paleoanthropologist at the University of Colorado, Boulder.

Teeth from more recent fossils reveal more because they have more isotopes preserved in them. For example, the nitrogen in the teeth of Neanderthals can reveal whether the protein they ate came from plants or animals.

Barium, a molecule children get from breast feeding mothers, builds up in baby teeth until the mother stops nursing. By comparing barium in a Neanderthal tooth with levels in donated present day baby teeth, the scientists were able to find out that the Neanderthal baby had been weaned at about seven months.

There's still a lot to learn from teeth, and a lot of fossil teeth still being discovered. And as the tools to study them get more sophisticated, teeth are providing a richer picture of "who we are and how we came to be," Sponheimer says.

Smiles for Life produces free educational resources to ensure the integration of oral health and primary care. There is an online teaching curriculum and online Continuing Medical Education/Continuing Education around oral health for non-dental practitioners, out of the USA.

The Smiles for Life curriculum consists of eight 45-minute modules covering core areas of oral health relevant to health professionals. These modules include: 1-Relationship of Oral and Systemic Health 2-Child Oral Health 3-Adult Oral Health 4-Acute Dental Problems 5-Pregnancy and Women’s Oral Health 6-Caries Risk Assessment 7-Oral Exam 8-Geriatric Oral Health.

The Public Health, Niagara Region, Ontario has started to Canadianize the modules! One module has been completed in its Canadian version so far, Module 2, Child Oral Health.

Read More [Here](#)

Click “Learn Online, then click “Child Oral Health”.

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**Tool: CDC DentalCheck Application**

In January 2017, the Centers for Disease Control and Prevention (CDC) released a new mobile application (app) to assist dental facilities with monitoring compliance with recommended infection prevention practices.

Dental health care personnel can use this app, CDC DentalCheck, to periodically assess practices in their facility and ensure they are meeting the minimum expectations for safe care. The infection prevention coordinator and other staff trained in infection prevention are encouraged to use this app at least annually to assess the status of their administrative policies and practices, and also engage in direct observation of personnel and patient-care practices.

You can download it free for iOS!

Read More [Here](#)

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**Tool: Public Health Ontario - Oral Health Snapshot**

In November 2016, Public Health Ontario, launched Oral Health Snapshot, a new interactive data tool. This tool will help you make sense of trends in behaviours and outcomes related to oral health in your region. This will help inform public health decision-making and planning. Snapshots is a suite of tools using maps, charts and tables to help you compare public health unit and provincial data, and identify trends over time.

Oral Health Snapshot uses data from the Canadian Community Health Survey, which includes self-reported data for individuals aged 12 and older. This provides access to statistics and information related to oral health for Ontario and its 36 public health units.

Read More [Here](#) and [Here](#)
Dental Day And Dental Hygiene Day 2017

Saturday, May 6, 2017- Regina, SK
Saskatchewan Polytechnic, Regina Campus

Annual Dental Day and Dental Hygiene Day provides free dental services to Regina residents and surrounding communities who may not have been able to get the care otherwise!

Last year 129 volunteers (including faculty/students and oral health care providers) had the opportunity to see 80 clients and complete $44,000 worth of dentistry.

Contributing to Dental Day 2017 will help provide some of necessary materials/supplies that are required for the event to take place. A donation of any amount would be of assistance. If you are interested in making a donation, please contact Dean Lefebvre at dean.lefebvre@saskpolytech.ca

Save the Date!

Saskatchewan Oral Health Coalition Meeting

Monday, May 29, 2017- Saskatoon

German Cultural Centre, 160 Cartwright Street East Albert
8:30 a.m. – 4:30 p.m.

The meeting will be live-streamed!

Future Meeting Dates:
Tuesday, October 24, 2017- Regina
Monday, May 14, 2018 - Saskatoon
Consider Becoming a Member of SOHC

Join the diverse membership of the Coalition to make a positive difference for the future of Saskatchewan residents!

Membership runs January through December annually.

Organization Levels:
- $100 – Business/For Profit Organization
- $75 – Non-Profit Organization
- $25 – Individual
- Free- Students (full-time)

For Business/For-profit and Non-profit organizations, the fee will cover up to 5 members.

Download the Application Form Here

SOHC Leadership Team Members

- Susan Anholt
- Kaithlyn Fieger
- Maryam Jafari (Admin Support)
- Jerod Orb (Treasurer)
- Leslie Topola
- Kellie Watson (Chairperson)
- Dianne Whelan

If you are interested in becoming involved with the leadership team, please contact the SOHC Administrative Support.

Contact Info:
sohcadmin@saskohc.ca

Contact Us

Maryam Jafari
Administrative Support
Saskatchewan Oral Health Coalition

Oral Health Program
Population and Public Health - Saskatchewan Health Region
101 - 310 Idylwyld Drive North
Saskatoon, SK S7K 0Z2

Contact Info:
sohcadmin@saskohc.ca

Our Website:
www.saskohc.ca

Some of Our Members:

1- Autism Services of Saskatoon
2- Battle River Treaty 6 Health Centre
3- Canada’s Tooth Fairy – National
Children’s Oral Health
Foundation of Canada
4- College of Dental Surgeons of
Saskatchewan (CDSS)
5- Cypress Health Region
6- Denturists Society of
Saskatchewan
7- Dieticians of Canada
8- Five Hills Health Region (FHHR)
9- Greater Saskatoon Catholic Schools
10- Health Canada
11- Health Canada-Children’s Oral
Health Initiative (COHI)
12- Heartland Health Region
13- Horizon School Division
14- Keeewatin Yatthé Regional
Health Authority (KYRHA)
15- Trail Health Region (KTHR)
16- Kids First
17- Lac La Ronge Indian Band
(LLRIB)
18- Lac La Ronge Indian Band Health Services (LLRIBHS)
19- Maggie’s Childcare Centre
20- Mamawetan Churchill River Regional
Health Authority (MCRRHA)
21- Meadow Lake Tribal Council (MLTC)
22- Northern Oral Health Working Group
23- Prairie North Health Region
24- Prince Albert Grand Council
25- Prince Albert Parkland Health Region
(PAPHR)
26- Regina Qu’Appelle Health Region
(RQHR)
27- Saskatchewan Arthritis Society
28- Saskatchewan Association for
Community Living’s
29- Saskatchewan Coalition for Tobacco Reduction
30- Saskatchewan Dental Assistants’ Association (SDAA)
31- Saskatchewan Dental Hygienists’ Association (SDHA)
32- Saskatchewan Dental Therapists’ Association (SDTA)
33- Saskatchewan Dietitians Association
34- Saskatchewan Ministry of Education
35- Saskatchewan Ministry of Health
36- Saskatchewan Prevention Institute
37- Saskatoon Council on Aging (SCOA)
38- Saskatoon Health Region (SHR)-
Healthy and Home
39- Saskatoon Open Door Society
40- Saskatchewan Polytechnic
41- Saskatoon Public School Division
42- Sherbrooke Community Centre –
Saskatoon Health Region
43- SHR-Food for Thought
44- SHR-Healthy Mother, Healthy Baby
45- SHR-Population and Public Health
46- SHR-Primary Health
47- SHR-Seniors’ Health and Continuing Care
48- SHR-Speech Language Pathologists
49- Sunrise Health Region
50- University of Saskatchewan-
College of Dentistry
51- University of Saskatchewan-
College of Nursing
52- White Buffalo Youth Lodge
53- Willow Cree Health

SOHC Meeting Live Streaming

Last year there was 62 views for live streaming on the same day, October 24, 2016. You can watch the recorded video of Meeting, October 24, 2016 in Regina here.

You can watch the recorded video of Meeting, May 16, 2016 in Saskatoon here.