Total Quality Improvement Survey
Highlights Relating to Clinical Practice

Guideline: Dual Health Care Practices  Ending the Work Relationship  Use of RDH
What’s Inside  OUR MARCH 2010 ISSUE

The mission of the College of Dental Hygienists of Ontario is to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario.

La mission de l’Ordre des hygiénistes dentaires de l’Ontario consiste à réglementer l’exercice de la profession d’hygiène dentaire de sorte à favoriser l’état de santé global et la sécurité du public ontarien.

Council
Carol Barr Overholt – District 3 (RDH)
Heather Blondin – District 7 (RDH)
Denise Burdon – Non-Council (RDH)
Kathleen Feres Patry – District 6 (RDH)
Diane Greenwood – District 1 (RDH)
Linda Jamieson – Academic (RDH)
Audrey Kenny – Non-Council (RDH)
Nancy Kitchen – District 5 (RDH)
Caroline Lotz – Academic (RDH)
Inga McNamara – District 2 (RDH)
Heather Murray – Non-Council (RDH)
Lucy Pavao – District 4 (RDH)
Shirley Silverman – District 4 (RDH)
Ilga St. Onge – District 8 (RDH)
Adam Esset – Mississauga (PM)
Julia Johnson – Orillia (PM)
Shori Katyal – Toronto (PM)
Samuel Laldin – Kingston (PM)
Derrick McLennon – Scarborough (PM)
Tote Quizan – Scarborough (PM)
Salam Rifai – Mississauga (PM)
Ben Shayan – Richmond Hill (PM)
Anne Venton – Toronto (PM)

*Term ended April 3, 2010
RDH - Registered Dental Hygienist
PM - Public Member

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Our clients have more complex needs and demand a higher quality of care. Clients expect that their dental hygienist will make decisions about their care that is based on current information and sound evidence, and they rely on their dental hygienist to interpret this information for them. Our clients expect dental hygienists to work collaboratively with other health care professionals and to use the most appropriate technology. Updated dental hygiene standards of practice are required to reflect this new norm.

Rather than establish new standards of practice in isolation, the CDHO decided to collaborate with dental hygiene regulators across Canada to develop a common set of national competencies and standards for dental hygiene education and practice. At its January, 2010 meeting, CDHO Council accepted the national competencies and standards identified in the Entry-To-Practice Competencies and Standards for Canadian Dental Hygienists. This document will become the basis for our new practice standards.

CDHO's updated Dental Hygiene Standards of Practice will identify expectations that are shared by all health care professionals, but will emphasize the unique area of specialization that defines dental hygiene. These standards will establish the expected norms for Professionalism, Responsibility, Accountability, Continuing Competence, Knowledge Application, Dental Hygienist-Client Relationship, Professional Relationships, Practice Management, Health and Safety, and Dental Hygiene Programs and Services. CDHO will be introducing these updated standards to registrants later this year.

The rung of the ladder was never meant to rest upon, but only to hold a man’s foot long enough to enable him to put the foot somewhat higher. Thomas Henry Huxley

Linda Jamieson, RDH, BA, MHS
President

Revising the Standards of Practice to Reflect the New Norm

The CDHO’s responsibility for identifying standards for dental hygiene practice is identified in the Regulated Health Professions Act, 1991; Schedule 2, Health Professions Procedural Code, 3(1). The term ‘standard’ refers to an established norm or requirement. The norms or requirements for dental hygiene practice in Ontario are documented in CDHO’s Dental Hygiene Standards of Practice which outlines the knowledge, skills, attitudes and judgment that are essential for quality dental hygiene practice. The standard is used by practicing dental hygienists to reflect on their practice, by dental hygiene educators to design entry-to-practice education and continuing education programs, by CDHO to guide practice review and quality assurance activities, and by members of the public to familiarize themselves with quality dental hygiene practice.

So why have I chosen to focus my remarks on the standards of practice? Quite frankly, it is to acknowledge that it is time for them to change. Our current standards were established in the mid-1990s when CDHO was a new regulatory college. The dental hygiene process of care was a new paradigm, and the idea of dental hygienists practicing independently had not even been considered. Our current standards of practice reflect the norms of that time.

Much has changed since the standards were first published. The use of the dental hygiene process by dental hygienists has become as automatic as brushing our teeth. Dental hygiene practice is more diverse and autonomous.
A boundary can be defined as “a line in the sand” or a “wall” or a “fence” that a prudent person does not cross. Regulated health care professionals in Ontario must work within the boundaries outlined in their respective Acts and regulations. The most obvious of these boundaries is the one on sexual abuse that is clearly delineated in the Regulated Health Professions Act, 1991, which states that sexual relations with a client is sexual abuse under the Act punishable by a revocation of the registrant’s certificate of registration. Some people see this as harsh, but the Act is clear and recent court cases have upheld the meaning of the law.

However, registrants need be aware of other types of boundaries that they, as health care professionals, must respect. These include practising within the scope of one’s profession, respecting another’s scope of practice, respecting the choice of colleagues and other practitioners to practise in a different, but complementary way, and being clear when one is engaged in providing services in more than one profession or discipline. This issue of Milestones offers a number of tools to help define boundaries.

In January 2010, the CDHO Council approved a guideline on Dual Health Care Practices (included in this issue of Milestones, and posted on the CDHO web site under Guidelines) that clarifies the obligations of registrants who practice in more than one health care discipline. A guideline is one of the ways in which the College addresses issues of importance to registrants so that they may conduct their practices without running into difficulties. In this case, the guideline is a way of assisting our registrants, who practise in more than one health care discipline, to draw that “line in the sand” so as not to confuse the client, or put themselves into a conflict of interest situation.

Another area where boundaries are important is when a person who is a survivor of sexual abuse becomes a client. Often dental hygienists are unaware that they are working with a client who has previously had their boundaries violated. Consequently, there is a need to be sensitive to those potential situations. Even an inadvertent or “minor” crossing of boundaries in this context can create significant harm to the client. As noted elsewhere in this publication, the CDHO is endorsing the use of the Handbook of Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Sexual Abuse.

This new guideline is a way of assisting our registrants, who practice in more than one health care discipline to not put themselves into a conflict of interest situation.

Boundaries can often become blurred when employment situations arise. Hence the reason for With a Common Voice, developed jointly by the CDHO, Ontario Dental Hygienists’ Association, Royal College of Dental Surgeons of Ontario and Ontario Dental Association. The intent is to provide guidance to both dental hygienists and dentists on their respective roles and obligations when there is a parting of the ways in an employment relationship. The dental hygienist is often unsure of her or his obligations to past clients, and the dentist-employer may have concerns over the perceived “good-will” in the office when clients choose to follow a former employee. With a Common Voice is an attempt to clarify some of those boundaries.

If you are unsure of the extent of a particular boundary, please contact the CDHO and ask to speak to a practice consultant. To be assured of frank and candid information based on the regulations and guidelines set by the College, CDHO does not have call display and you will not be required to identify yourself. The College would prefer to spend the time discussing these boundary issues with you now, rather having to deal with a breach later on. No doubt both our registrants and the public they serve would prefer the same!
As you know, dental hygienists are regulated health care professionals governed by the *Regulated Health Professions Act, 1991 (RHPA)* and the *Dental Hygiene Act, 1991 (DHA)*. All Colleges under the *RHPA* are mandated to inform the public about the governance of their registrants and to inform the public that they have a choice of health care providers. The CDHO conducted public research that revealed Ontarians are largely unaware that the CDHO is responsible for the practice of dental hygiene in Ontario. Despite this government mandate, a recent article in *Ontario Dentist* by the Ontario Dental Association President criticizes the CDHO for doing its job!

Dentists use the designations DDS or DMD and the title DR that they have legitimately earned. Likewise, dental hygienists use the designation RDH that they too have legitimately earned. The *DHA* clearly states that only dental hygienists, registered with the CDHO, may use the designation RDH in any form. Using the RDH is a clear signal to the public that a dental hygienist is a registered health care professional obligated to practice to the standards set by the dental hygienist’s regulatory College, the CDHO.

Collaborating as professionals, we provide each of our clients with a continuum of quality oral health care.

Using the RDH designation does not diminish anyone else in the “dental team”. In fact, it indicates that clients are being treated by another type of regulated health professional, who is also equally accountable for her or his actions. The CDHO monitors all dental hygienists through our Quality Assurance Program, and it has a very successful on-site component.

In today’s paradigm of health care, it is the team’s shared vision, developed in a collaborative manner that is being promoted by the Ontario government and by the CDHO. No one practices health care in isolation—the circle of care is wide. Each of us is but one component in the continuum. And, collaborating as professionals, we provide each of our clients with a continuum of quality oral health care.

**RDH: Our Professional Designation**

*What do you see when you read the letters MD, RMT or CA?*
Most likely, you immediately recognize that the individual is a medical doctor, registered massage therapist or chartered account. And, these titles quickly prompt you to identify individuals who are expected to be qualified, professional and accountable.

*Now, what about the letters RDH?*
How often do you think your clients recognize what RDH means? How about the general public?

*Do your clients recognize RDH as quickly and easily as they recognize MD or RMT?*
And, of those who do, how many equally equate this with qualified, professional and accountable?

As you know, having a designation from a regulatory body defines your status and adherence to the profession’s ethical and practice standards.

More importantly, it will tell your clients and the public that you belong to a profession that, just as other regulated professions, has a particular body of knowledge and high standards of regulation.

Highlighting your professional status by using RDH after your name will help show the major role you play as a front-line health care professional in dental hygiene and oral health education.

To ensure our profession’s designation becomes as easily recognized as those of other professions, we urge you to identify yourself with your designation to your clients, colleagues and peers whenever possible. (If you are an inactive registrant you too may use the RDH designation, but not practise.)
My CPR certificate expires in 2012. I took CPR last year and wondered if I must recertify yearly?

You must hold current certification in CPR to practice dental hygiene to meet the CDHO Dental Hygiene Standards of Practice. The Standards state: “As a dental hygienist, I promote client, co-worker and personal safety by: 10.2.3 Maintaining current certification in basic cardiopulmonary resuscitation.”

Some courses provide for yearly certification and others offer a longer timeline. In your particular case, CDHO would consider your certificate in CPR as current until the date of expiry in 2012 as noted on your certificate. Be aware, however, that while there are many ways to certify in CPR, the course must contain a “hands on” component.

I would like to provide pain management for my clients with the use of the new subgingival topical anaesthetic agents becoming available on the market. Is this allowed?

Yes. Topical anesthetic delivered for pain management may be used by dental hygienists in the course of dental hygiene treatment. The Drug and Pharmacies Regulation Act allows for these products to be sold to dental hygienists for use in practice.

Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4 Section 118(3)

(3) Nothing in this Act prevents any person from selling, to a member of the College of Chiropodists of Ontario, the College of Dental Hygienists of Ontario, the College of Midwives of Ontario or the College of Optometrists of Ontario, a drug that the member may use in the course of engaging in the practice of his or her profession. 1991, c. 18, s. 47 (9); 2007, c. 10, Sched. L, s. 3 (3).

The dental hygiene scope of practice permits the use of these products for client pain management as the delivery method is similar to irrigation and is not a controlled act. However, it is important to ensure that the topical anaesthetic product has been approved for use in Ontario.
...on education programs.

**Why does CDHO allow so many dental hygiene programs in Ontario?**
The College has been receiving a number of calls and letters regarding the proliferation of dental hygiene programs in the province.

As noted in previous editions of *Milestones*, the CDHO does not have control over the number of programs or schools offering dental hygiene in Ontario. That responsibility lies with the Ministry of Training, Colleges and Universities (MTCU). In addition, regulatory colleges are not in the business of controlling the number of registrants who are qualified to practice in any given jurisdiction.

Our mandate is to ensure that an applicant is qualified for registration and once registered, to administer a viable quality assurance program, set standards, deal with complaints, and administer discipline when required. In essence, the role of the regulator is protection of the public, not control of the marketplace.

However, the CDHO is concerned that there are still a number of Ontario dental hygiene programs who have not achieved the national standard of being accredited by the Commission on Dental Accreditation of Canada (CDAC). Representatives of MTCU made a presentation to Council in October 2009 indicating that schools which did not achieve accreditation status in the near future would have their permit to operate rescinded. Of the 36 programs currently in operation (three have closed), three have been approved for a CDAC site-visit in 2010 and 13 are still not accredited nor have they received approval for a CDAC site-visit. Of those 13, Trillium College now owns and administers six sites.

...on College inquiries.

**Will I be “red flagged” for QA if I call the College for advice?**
The CDHO does not have call display! As has been noted on many occasions, the College has always taken the position that registrants and members of the public should be able to call the College for advice without putting themselves in jeopardy. Those registrants who are selected for a quality assurance review are done so by random selection, based on district and year of graduation. The Registrar may also make a referral to the Quality Assurance (QA) Committee if she has reasonable grounds or concerns. The QA Committee determines which registrants are required to undergo an on-site practice review.

**I called the College several times on an issue, and received conflicting advice. Why?**
We have heard that some registrants and even some employers of CDHO registrants perceive that the CDHO provides conflicting advice. Different interpretations are going to occur when human beings are involved. However, we are aware that people who call the CDHO, and we don’t always know who they are because of our “no call display” policy, will call several people at the office with varying themes on the same question looking for the answer they want to hear!

...on employers.

**Is it true that my employer has control over how I practise?**
While the employer may have some say in relation to what the dental hygienist does when employed, standards and accountability to the public through the CDHO are paramount. This is true for all professions regulated under the *Regulated Health Professions Act, 1991.*
Council Highlights
January 29, 2010

The January meeting ushered in a new Executive Committee, newly elected Council members and one public member appointment.

Elections and Appointments

The following Council Members were elected to the Executive Committee for 2010:

- **President:** Linda Jamieson, RDH, Orillia
- **Vice President:** Inga McNamara, RDH, Barrie
- **Professional Member:** Inga St. Onge, RDH, Thunder Bay
- **Public Member:** Sam Laldin, Kingston
- **Public Member:** Anne Venton, Toronto

Returning CDHO President, Linda Jamieson opened the rest of the meeting by thanking Council Members for their continued support.

Also elected were Council members for:

- **District #4** Lucy Pavao, RDH, Toronto
- **District #7** Heather Blondin, RDH, Sudbury
- **Academic** Caroline Lotz, RDH, Fanshaw College

On the recommendation from the Executive Committee, Council appointed Shelli Jeffs, RDH, Bowmanville, as a Non-Council Member to fill the vacancy left by Lucy Pavao when she was elected to Council in District #4.

The Registrar welcomed the newly elected members of Council, and the new public member appointed by the Ontario government, Ben Shayan, Richmond Hill.

Executive Committee

As Chair of the Executive Committee, the President indicated that a project was underway to develop a guideline for the use of electronic records, and that the CDHO was actively engaged in the Ontario First Nations Oral Health Coalition Working Group. She indicated that the College had partnered with the Ontario Dental Hygienists’ Association, Royal College of Dental Surgeons of Ontario and the Ontario Dental Association to publish an issue of *With a Common Voice* that discusses ending the work relationship between a dentist and a registered dental hygienist. The document is included with this publication and is available on the CDHO web site under *What’s New*.

Financial Report

The quarterly financial report to December 31, 2009 was provided for information.

Registration

Registration statistics as of December 31, 2009: General – 10,097; Inactive – 788; Specialty – 496 and authorized to self-initiate – 2,699. The Registrar stated 2010 renewals had been mailed on November 15, 2009 and that as January 29, 2010 over 98% had renewed, with over 70% on-line. She also noted that Administration was in the process of completing an on-line Jurisprudence Course that was to be available by the end of March 2010. Once the proposed registration regulations come into effect, successful completion of an approved jurisprudence course will be a registration requirement.

The Registration Committee reported that the audit of the College’s registration practices was submitted to the Office of the Fairness Commissioner on December 23, 2009 and that the annual Fair Registration Practices Report was due on March 1, 2010.
Bill 175, An Act to Enhance Labour Mobility Between Ontario and other Canadian Provinces and Territories received Royal Assent on December 15, 2009. Consequently, the College has an application package available for applicants wishing to apply under the Act. The Committee reported that the College had conducted 326 clinical evaluations in 2009 compared to 342 in 2008.

Quality Assurance Program

The Quality Assurance Committee indicated that of the total of 978 professional portfolios requested in 2009, 884 have met the assessment guidelines, 12 are still in the assessment process, 82 are participating in directed learning/remediation. Of the 146 on-site practice assessments requested, 52 have met the assessment guidelines, 17 are still in the assessment process and 77 are participating in directed learning/mentorships. The Committee has requested a quality assurance review be conducted on the 56 registrants who were referred by the Registrar under section 23 (3)(c) of the Quality Assurance Regulation.

Standards and Guidelines

Council adopted and approved the document Entry-to-Practice Competencies and Standards for Canadian Dental Hygienists, January 2010. This is a national document compiled in conjunction with a variety of stakeholders and will form the basis for the new CDHO Dental Hygiene Standards of Practice.

A proposed Guideline: Dual Health Care Practices was presented to Council at First Reading and subsequently moved to Third Reading. The document is included in this publication and on the CDHO web site under Guidelines.

Communications Update

The Patient Relations Committee reported that the public awareness campaign was launched on the radio and in newspapers the week of January 18, 2010. Preliminary response has been positive.

Council approved the facilitation of The Handbook on Sensitive Practice for Healthcare Practitioners to registrants and dental hygiene educational programs.

Inquiries, Complaints and Reports Committee

The members of the Inquiries, Complaints and Reports Committee (ICRC) reported that they are currently investigating eight formal complaints, five referrals for Quality Assurance Committee and four Registrar initiated matters. An ICRC Panel administered two cautions with respect to previous decisions relating to non-compliance with the quality assurance components. Two requests for reviews of ICRC decisions to Health Professions Appeal and Review Board are pending. One registrant was referred to the Discipline Committee.

Key Note Speaker

Council President Linda Jamieson presents a thank you gift to Valerie Gideon, PhD, Regional Director, First Nations and Inuit Health, Ontario Region and Penny White, RDH, Health Canada. Ms. Gideon and Ms. White provided Council with an overview of the oral health programs available for First Nations and Inuit peoples in Ontario. They noted that there is currently a shortage of providers and that they are looking to increase the availability of preventive oral health services due to the high cost of flying people out for major restorative work.

A proposed Guideline: Dual Health Care Practices was presented to Council at First Reading and subsequently moved to Third Reading. The document is included in this publication and on the CDHO web site under Guidelines.

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Executive Committee

President – Linda Jamieson, RDH
Vice-President – Inga McNamara, RDH
Professional Member – Ilga St. Onge, RDH
Public Member – Samuel Laldin
Public Member – Anne Venton

Quality Assurance Committee

Chair – To be elected at first meeting
Heather Blondin, RDH
Denise Burdon, RDH, NC
Nancy Kitchen, RDH
Derrick McLennon, P
Heather Murray, RDH, NC
Tote Quizan, P
Shirley Silverman, RDH

Fitness to Practice

Chair – Tote Quizan, P
All Council members

Registration Committee

Chair – To be elected at first meeting
Carol Barr Overholt, RDH
Adam Esse*, P
Kathleen Feres Patry, RDH
Caroline Lotz, RDH, A
Salam Rifai, P
Deborah Winick, RDH, NC

Inquiries, Complaints and Reports Committee

Chair – To be elected at first meeting
Carol Barr Overholt, RDH
Kathleen Feres Patry, RDH
Shori Katyal, P
Shelli Jeffs, RDH, NC
Caroline Lotz, DH, A
Audrey Kenny, NC
Gail Marion, RDH, NC
Lucy Pavao, RDH
Tote Quizan, P
Salam Rifai, P

Discipline Committee

Chair – Shirley Silverman, RDH
All Council members
Heather Murray, RDH, NC
Deborah Winick, RDH, NC

Patient Relations

Chair – To be elected at first meeting
Diane Greenwood, RDH
Shelli Jeffs, RDH, NC
Julia Johnson, P
Derrick McLennon, P
Lucy Pavao, RDH
Ben Shayan, P

RDH: Registered Dental Hygienist
A: Academic
P: Public Member
NC: Non-Council Member

*Term ended April 3, 2010

Seated Left to Right Front Row: Samuel Laldin, Public Member Kingston; Shori Katyal, Public Member Toronto; Linda Jamieson, RDH, (Academic) President, Orillia; Adam Esse, Public Member, Mississauga*; Salam Rifai, Public Member, Mississauga; Diane Greenwood, RDH, London; Inga McNamara RDH, Vice-President, Barrie; Tote Quizan, Public Member, Scarborough; Middle Row: Denise Burdon, RDH, Non-Council Member, Newmarket; Anne Venton, Public Member, Toronto; Nancy Kitchen RDH, Belleville; Audrey Kenny, RDH, Non-Council, Burlington; Shirley Silverman, RDH, Thornhill; (multi top- Caroline Lotz, RDH (Academic) London; Heather Blondin, RDH, Sudbury; Julia Johnson, Public Member, Orillia; Heather Murray, RDH, Non-Council, Unionville; Back Row: Carol Barr Overholt, RDH, St. Catharines; Shelli Jeffs, RDH, Non-Council, Bowmanville; Lucy Pavao, RDH, Toronto; Ilga St. Onge RDH, Thunder Bay; Kathleen Feres Patry, RDH, Kanata; Derrick McLennon, Public Member Scarborough. Absent: Public Member Ben Shayan, Richmond Hill; Non-Council Members: Gail Marion, Thunder Bay; Deborah Winick, Toronto.
Working within one’s scope of practice

There are many new products on the market, and dental journals and magazines are replete with the latest techniques to make a practice profitable. However, not all of these products are in the client’s best interest nor are they within the scope of practice of the dental hygienist.

One such product is Snap-On Smile® which is being promoted on the manufacturer’s web site at www.snaponsmile.com. The CDHO has received a number of queries about the possibility of dental hygienists fabricating and dispensing such appliances.

While a dental hygienist could be involved in the fabricating of the appliance; dispensing the appliance of a snap-on smile appliance involves the performance of a controlled act (Controlled Act #11 –Fitting or Dispensing a Dental Prosthesis). Dental hygienists may not dispense dental appliances. One web site refers to the snap-on smile product as “an acrylic denture that will cover your teeth.”

Dental hygienists may fabricate, fit and dispense mouthguards for preventive purposes in sports. However, there are manufacturers who indicate that their particular product will enhance the athlete’s performance. This is done by manipulating the temporomadibular joint. Even if the appliance is available commercially, a dental hygienist should not be involved in the fitting or dispensing of such a device.

Review your liability insurance

Dental hygienists who are contemplating a move to an independent practice setting should check their professional liability insurance policy to ensure that they will be covered as per the CDHO regulations and bylaws.

Margaret Stevenson retires from the College (February 26, 2010)

Many long-time registrants will remember Margaret’s voice on the College’s answering machine—that lovely Scottish lilt!

Margaret was the College’s first employee, hired as Director of Administrative Services by the CDHO Transitional Council on August 1, 1993.

It was Margaret who hired the other staff, set up the systems, paid the bills and invested the money that dental hygienists had been levied for many years in anticipation of their own College.

Margaret has been an integral part of the CDHO for almost 17 years. While we wish her a restful retirement, we will surely miss her!

College Outreach

On Friday, January 22, 2010 the CDHO Registrar spoke to approximately 140 dentists at the Canadian Dental Protective Association about “Quality Assurance for RHPA Practitioners: The CDHO Approach”. The intent was to assist dentist-employers of dental hygienists to understand the on-site visits conducted by CDHO QA Assessors and the legislation behind the CDHO QA Program.
Performing Re-lines

Dental hygienists may not perform hard or soft denture re-lines unless they are competent to do so. There is a clause in the Regulated Health Professions Act 32 (1) (a) stating that a person cannot alter a prosthetic devise unless they are directly supervised by a member of the Royal College of Dental Surgeons of Ontario or the College of Dental Technologists of Ontario.

However, the CDHO does not permit dental hygienists to do anything, even if supervised, if they are not competent to do so. A dental hygienist who has not had any education and training in performing re-lines or who does not know the contraindications to performing re-lines would be unwise to do so, because there is a possibility of damage to the underlying tissues. As dental hygienists are self-regulating they must determine, for themselves, if they are competent to perform any procedure.

New on the Web

The document Entry-to-Practice Competencies and Standards for Canadian Dental Hygienists, January 2010 that was approved by the Council on January 29, 2010 is now available on our website under What’s New.

An on-line Jurisprudence Course will be available by the end of March 2010. Once the proposed registration regulations come into effect, successful completion of an approved jurisprudence course will be a registration requirement.

Next Council Meeting

May 28, 2010
– Reserve your seat now!

CDHO’s next Council meeting will be held at the Four Seasons Hotel, 21 Avenue Road in Toronto on May 28.

Seating is limited.

To attend, please call Jane Cain at 416-961-6234 ext 226 or 1-800-268-2346, or email jcain@cdho.org.

Are you looking for information on pandemic planning?

As part of your daily routine, visit our website for up-to-date information and links to essential government services.

www.cdho.org
**NEWS FROM THE FIELD**

### Sensitive Practice Handbook for Healthcare Practitioners

Research cited in the *Sensitive Practice Handbook for Healthcare Practitioners* suggests that at least 20 percent of adult women and between five to 10 percent of adult men have a history of childhood sexual abuse. Combined with the increasing evidence that violence affects health far beyond mental health and that oral health and oral health care are difficult for a great many survivors, dental hygienists are likely to work, often unknowingly, with adult survivors on a regular basis.

The handbook was developed through collaboration and consultation with over 400 adult survivors of childhood sexual abuse, mental health clinicians and health care professionals from 10 different disciplines across Canada. The CDHO played a noteworthy role in the development of the handbook, by organizing a focus group of dental hygienists with diverse positions within the profession to give feedback as the handbook was being drafted. The College also reviewed the drafts, providing written commentary.

The handbook can be used as a tool for fine-tuning client-centered care for those who have experienced childhood violence. Survivors cited within the document said that feeling safe was the most crucial requirement when seeing a health care provider. By learning about the dynamics and effects of violence and adopting the principles and guidelines of sensitive practice as the standard of care, practitioners reduce the risk of inadvertently harming those in their care.

The CDHO has posted the *Handbook* on our website, along with guidelines for the prevention of sexual abuse and professional boundaries:

*Practice Guideline for the Prevention of Sexual Abuse:*
www.cdho.org/Practice_PreventionOfSexualAbuse.htm

*Practice Guideline for Professional Boundaries:*
www.cdho.org/Practice_ProfessionalBoundaries.htm

The Public Health Agency of Canada also provides information regarding family violence at:

### An Invitation to Evaluate the Sensitive Practice Handbook for Healthcare Practitioners

CDHO’s Patient Relations Committee is interested in your thoughts and opinions about the *Sensitive Practice Handbook Healthcare Practitioners*. Please complete a short (just five minutes to complete) online questionnaire about the handbook found at Survey Monkey. Note: It is important that you fill out this questionnaire before you read the *Handbook*.

www.surveymonkey.com/s/7P8LYGF

Next, you are asked to read the handbook itself. This will take you several hours to read, but we are truly interested in your thoughts and opinions. You should be aware that due of the nature of the subject matter, some people may find it difficult to read parts of the material.

After you have read through the handbook, you are requested to fill out a second online questionnaire, which will complete your participation in our evaluation.

www.surveymonkey.com/s/75867K2

Please be assured that both questionnaires are completely anonymous. Thank you!
Encryption of Mobile Data Storage Devices

The Ontario Privacy Commissioner has ordered that all health information on mobile devices be encrypted. For more information on how to encrypt and secure health information on mobile devices, see the Information and Privacy Commission fact sheet Encrypting Personal Health Information on Mobile Devices at: www.ipc.on.ca/images/Resources/up-4fact_12_e.pdf.

Children’s Oral Health Initiative

The Children’s Oral Health Initiative (COHI) is a federal Health Canada initiative that was developed to address the oral health disparity between First Nations and Inuit and the general population of Canada. Initially launched in the fall of 2004 on a “pilot” basis, the program has grown considerably since then to include 60 First Nations communities in Ontario. COHI focuses on the prevention of dental disease and promotion of good oral health practices. The goal of COHI is to shift the emphasis from a primarily treatment-based approach to a more balanced prevention and treatment focus. The focus for oral health promotion is directed at pregnant women, primary caregivers and children ages zero to seven years-of-age. Ontario’s dental hygienists make a valuable contribution in helping to achieve that goal.

To learn more contact:
Penny White, RDH
Coordinator – Children’s Oral Health Initiative
First Nations and Inuit Health
Ontario Region, Health Canada
613-925-2865 ext. 115

In addition, Health Canada provides one of the most comprehensive public dental benefits programs in Canada. The Non-Insured Health Benefit Program (NIHB) is a publicly funded health needs-based program that covers a comprehensive range of dental benefits for approximately 765,000 eligible First Nations and Inuit, when these benefits are not available through other public or private programs and when NIHB Program criteria are met.


Update on the Disabilities Act 2005

Ontario passed the Accessibility for Ontarians with Disabilities Act in 2005.

These accessibility standards are the rules that businesses and organizations in Ontario must adhere to in identifying, preventing and removing barriers for the approximately 1.5 million Ontarians with disabilities.

A proposed building and environment accessibility standard was released for public consultation in July 2009 and proposes requirements in areas such as:

- Common access
- Exteriors – curbs, street crossings, furniture
- Plumbing – washrooms, showers, drinking fountains
- Communication – signage, telephones
- Buildings – air quality, acoustics, lighting

The changes to the standard are being finalized now.


Maintaining Your Professional Portfolio

As part of the Quality Assurance Program, all dental hygienists are expected establish and maintain a Professional Portfolio as a condition of annual renewal of their certificate of registration.

Need help with your Professional Portfolio?

Visit http://www.cdho.org/Quality_English_QAPackage.htm to find a Professional Portfolio forms tutorial, sample forms and a list of frequently asked questions to help create your own Professional Portfolio.
Total Quality Improvement Survey Report: Part II

This is the second part of a two-part report on the findings of the provincial survey that went out to CDHO registrants in 2008 (please see Milestones, July 2009 for Part 1). EKOS Research Associates, on behalf of the Quality Assurance Committee, conducted a survey of registered dental hygienists who practise and reside in Ontario. This was the third survey of its kind—earlier surveys were conducted in 1995 and 2002. In total, 9350 surveys were mailed out and 5789 completed surveys were returned resulting in a response rate of 62 per cent. Those who registered in 2008 were not surveyed as they did not have sufficient clinical exposure or experience with the Quality Assurance (QA) Program. Typically, the College uses survey information and its analysis to prepare guidelines and advisory notices to the profession, to facilitate total quality improvement for the practice of dental hygiene and to adjust the College’s QA Program as required. Highlights relating to clinical practice in Ontario are discussed below.

Workplace

The largest majority of dental hygienists work in an environment where there are between one to three dentists and about two thirds of survey respondents work with at least two or more dental hygienists. About half reported working in a clinic that has an office manager.

Availability of Chair Side Assistants

Forty-three per cent of dental hygienists do not have a chair side assistant when they perform intra-oral procedures. However, just over one quarter said they occasionally do and an additional 19 per cent reported that they usually do. Fewer than 10 per cent always have a chair side assistant working with them.

Number of Clients Per Day

To gain better insight into the workload of dental hygienists, survey respondents were asked to calculate the number of clients they see during a seven-hour work day. More than nine in 10 are seeing between five and 12 clients per day, with the bulk of those seeing between eight and 12. These patterns have not changed substantially since 2002. Interestingly, the clinical workload of dental hygienists does vary slightly across the regions. If you work in District 51 you are likely to see more clients in a seven-hour day then your counterparts in District 42. A disproportionately higher number of survey respondents in District 4 see five to seven clients during a seven-hour day (42 per cent). A greater portion of those working in District 5 see eight to 12 clients (71 per cent).

1 Frontenac, Peterborough, Hastings, Lanark, Lennox and Addington, Prince Edward, Victoria, Haliburton, Northumberland and the regional municipality of Durham.
2 York and Metropolitan Toronto.
**Time Allotted and Preferred – Adults**

Survey participants were asked to provide information regarding the amount of time allotted and the amount of time preferred for dental hygiene recare appointments. Specifically, three areas were examined, the adult client (14 years of age or older), the child client and the periodontal client.

Broadly speaking, there is a disparity that exists between how much time is allotted to client recare appointments and how much time is preferred. In general, dental hygienists surveyed would like to have more time for recall appointments. For example, 62 per cent of respondents preferred to have more than 45 minutes for an adult recare appointment. In contrast, only 44 per cent reported having more than 45 minutes allotted for each adult client.

When periodontal clients were considered, more than nine in 10 dental hygienists say they would prefer more than 45 minutes to deliver care. The survey results indicated that periodontal clients are more likely than non-perio recare clients to be booked for more chair time. Seventy-six percent of respondents reported being allotted more than 45 minutes for periodontal recare clients.

**Clinical Assessments:**

**Health History and Oral Health Priorities**

Survey participants were asked to indicate how frequently they perform a number of clinical assessment activities prior to delivering dental hygiene care. For safe and effective dental hygiene care, a comprehensive health history is an essential part of a client’s complete assessment. Not surprisingly, nearly all survey respondents routinely update their client’s health history at each dental hygiene visit. Furthermore, almost three in four routinely or always determine their client’s oral health priorities and the large remainder reported that they usually make this determination with the client.

**Extra and Intra-oral Exams**

A thorough extra examination of the head and neck coupled with an intra-oral examination of the mouth are essential to a total assessment prior to care planning. In dentist and dental hygienist collaborative practices, the dentist may perform one or both of these examinations and record the findings. Appropriately, the dental hygienist will consider these findings in her or his client care plan. Accordingly, a little over one half of dental hygienists routinely, always or usually provide extra-oral assessments. In comparison, intra-oral assessments are conducted more consistently by dental hygienists. The chart below shows the frequency that survey respondents are performing intra-oral examinations. A little over four in five routinely or always perform soft tissue oral examinations and hard tissue oral examinations. About 15 per cent usually perform them.

**Figure 1:** How often, on average, do you perform each activity?

**INTRA-ORAL EXAMINATION**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Routinely/Always</th>
<th>Usually</th>
<th>Occasionally</th>
<th>Very rarely/Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft tissue oral examination</td>
<td>82</td>
<td>12</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Hard tissue oral examination</td>
<td>81</td>
<td>13</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>

The type of practice that dental hygienists are working in has a strong impact on whether or not they are performing these assessments and the frequency with which they are doing it. In general, survey respondents working in the orthodontic specialty are much less likely than their counterparts in a general practice or in other specialties to perform any of the assessments listed above.

**Use of Indices**

The frequency with which dental hygienists are recording indices depends on the type of activity. In each of the three areas tested, the majority routinely or always use indices to record findings. In the case of plaque, debris and calculus and gingival bleeding, almost two thirds routinely or always assess and record using indices. While just over half reported that they assess and record periodontal attachment levels routinely.

**Figure 2:** How often, on average, do you perform each activity?

**TAKE INDICES**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Routinely/Always</th>
<th>Usually</th>
<th>Occasionally</th>
<th>Very rarely/Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plaque, debris and calculus</td>
<td>64</td>
<td>18</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Gingival bleeding</td>
<td>62</td>
<td>21</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Periodontal attachment levels</td>
<td>51</td>
<td>32</td>
<td>11</td>
<td>6</td>
</tr>
</tbody>
</table>
The most notable regional difference is that a disproportionately higher number of dental hygienists in the East take periodontal attachment level indices (63 per cent). Type of specialty impacts the frequency of performing these functions. Orthodontic specialties are less likely to perform these functions frequently.

Radiographs Used in Treatment Planning

Survey respondents were asked to think about the frequency with which they use a client’s radiographs as part of their assessment for treatment planning. The results show that 80 per cent routinely or always utilize radiographs. Another 15 per cent usually do and only one per cent said they rarely or never used radiographs in treatment planning.

Client Assessment Data

Frequency of Using Data

The figure below summarizes how often dental hygienists are analyzing client assessment data for two purposes: identifying factors contributing to current and potential oral health problems and, making a dental hygiene diagnosis.

Two thirds of survey respondents indicate that they routinely or always analyze assessment data to identify factors contributing to current and potential oral health problems, while 30 per cent usually do.

Similarly, nearly two thirds of survey respondents analyze the client assessment data to make a dental hygiene diagnosis; 30 per cent usually do this.

About two thirds of the respondents who are working in a general practice routinely analyze assessment data for the two reasons listed above. This drops to less than half for those who work in an orthodontic practice.

Client Centered Care

The questionnaire also explored the extent to which clients participate in aspects of dental hygiene care, namely the decision-making process and the formulation of the dental hygiene care plan. A little over half of the respondent dental hygienists say that clients routinely participate in the decision-making process and 36 per cent say they usually do. On the other end of the scale, 10 per cent either occasionally or very rarely or never participate.

Over one third say their clients routinely or always participate in the formulation of their dental hygiene care plan, and 42 per cent say they usually do. A little over one in five say the client occasionally or very rarely or never participates in the formulation of the dental hygiene care plan.

How CQI Activities Relate to Client Care

As in the past surveys, there is evidence to support a strong co-relation between the level of continuing quality improvement (CQI) activities dental hygienists participate in and the level of client care. Most notably, dental hygienists who reported a high level of CQI activity also: routinely or always perform head and neck examinations; routinely measure and record indices for plaque, calculus, bleeding and clinical attachment; routinely or always analyze clinical assessment data to identify factors contributing to current or potential health problems; routinely or always make a dental hygiene diagnosis; and, are more likely to have clients participate in decision making and the formulation of the dental hygiene care plan.

This strong relationship between the level of CQI activities and quality of practice contributed to the development of the new guidelines for continuing competency that is now part of the quality assurance package. Registrants are encouraged to consult this guide when creating their learning goals and learning activities for the year. When you begin with the end in mind, selecting quality learning activities that are focused on specific, measurable and achievable results, you will improve client care and continue to meet CDHO standards of practice.
The College has established the following standard to clarify the obligations of registrants who practice in more than one health care discipline.

**Introduction**

CDHO registrants may have dual health care practices, i.e., they may practise in more than one profession if they are qualified to do so.

While this may benefit clients, it complicates the understanding of regulation and accountability for health professionals, clients, and insurers. If there is overlap in the scope of practice within the dual health care practices, there is potential to further increase client misunderstanding of the role of the dental hygienist.

Registrants are accountable to the College of Dental Hygienists of Ontario when practising and billing for services as dental hygienists. If the other practice is regulated, the health care professional is also accountable to another health regulatory body. If the other practice is unregulated, the health professional is not directly accountable to a regulatory body for that other practice.

**Definitions**

Dual Health Care Practice – The circumstance where a College registrant practises as a dental hygienist as well as in another health care discipline regulated or unregulated (i.e., massage therapist, denturist, nurse, homeopath, respiratory therapist, Reiki instructor, personal trainer/life coach)

**Standard Statement**

In the event of any inconsistency between this standard and any legislation that governs the practice of dental hygienists, the legislation governs.

Registrants who have dual health care practices are responsible for administering their practices as separate and distinct entities and for ensuring that their clients understand which role they are adopting when they provide health care services.
Performance Expectations

A dental hygienist demonstrates the standard by:

1. Keeping the roles of the dual health care practice separate and distinct by having: different appointment books; client records, or entries in client records when they are created as part of an interdisciplinary care team; and billing records and financial records that are separate.

2. Ensuring that treatments/interventions recommended by the registrant as a dental hygienist, and provided by the registrant as a member of a different health discipline, are based solely on clients’ needs.

3. Ensuring that clients are provided with information needed to understand the dental hygienist’s role and accountability when he or she is performing the treatment, thus reducing the confusion for the client.

4. Ensuring that clients are provided with the services that they initially sought unless this is determined to be inappropriate.

5. Ensuring that the clients’ records clearly demonstrate which services have been provided to clients at each encounter.

6. Participating in and documenting quality assurance activities directly related to the practice of dental hygiene.

References

- College of Dental Hygienists of Ontario, Dental Hygiene Standards of Practice
- Dental Hygiene Act, 1991

Passed by Council January 29, 2010

To be reviewed January 2012

Adapted with Permission from the College of Physiotherapists of Ontario
Ending the Work Relationship Between a Dentist and a Registered Dental Hygienist

All four dental organizations – College of Dental Hygienists of Ontario (CDHO), Ontario Dental Hygienists’ Association (ODHA), Ontario Dental Association (ODA) and Royal College of Dental Surgeons of Ontario (RCDSO) – are often asked for advice and direction from dentists and dental hygienists about how to end an existing work relationship and what the dentists’ and dental hygienists’ obligations are when the relationship ends.

As health care professionals, the overriding principle is always to ensure compliance with regulatory requirements, provincial legislation and safe patient/client care. With that framework, there are sometimes practical questions that arise when a dental hygienist leaves a working relationship within a dental practice.

Guiding Principles
In making business decisions both dentists and dental hygienists are governed by the following principles:

1. Professional obligations take priority.
The primary professional obligation is to the welfare of the patient/client. In addition, both dentists and dental hygienists must comply with the rules and regulations of their own regulatory College.

2. One must comply with the law.
For example, the Personal Health Information Protection Act, 2004 (PHIPA) provides detailed rules about maintaining the privacy and security of patient/client records and of the patient’s/client’s right to control, within limits, the collection, use and disclosure of personal health information about themselves.

3. One must comply with one’s contractual obligations.
Courts require dentists and dental hygienists to comply with valid contractual agreements. Contracts can be verbal, written or in some cases established by the conduct of the parties. The court, however, will not enforce a contractual term if it considers it in violation of another (overriding) law (e.g. PHIPA) or in violation of public policy.

Dentists and dental hygienists need to keep these guiding principles in mind when ending their working relationship.

Nature of the Work Relationship
The contractual obligations will vary depending on whether a dental hygienist is an employee of the dentist, or an independent contractor (self-employed). To determine what the relationship is, one needs to review the written documentation outlining the relationship. If there is no written documentation, then one needs to review any oral agreement that has been entered into as well as the nature of the actual relationship.

Whatever the nature of the work relationship, every office should have a privacy policy that describes who has responsibility for ensuring the privacy, security and retention of the records under PHIPA.

Generally speaking, the owner of the practice will be the person who owns the assets of the practice including its patient/client records and goodwill. Goodwill includes the list of the patients/clients of the practice. This does not, however, preclude a dental hygienist from owning a dental hygiene practice which is operated in the same location where a dentist owns a dental practice. Again, a
determination of the nature of the work relationship would have to be made, namely, whether the dental hygienist is an employee of the dentist or an independent contractor (self-employed). The nature of the work relationship is of critical importance to determine fundamental rights and obligations and, therefore, should be properly reflected in the contractual relationship between the dentist and dental hygienist.

Legal advice should be sought by the parties if there is no written agreement in place and there is a dispute between the parties as to the nature of the relationship.

Scenario 1 – Change of Contract
A dental hygienist has worked in a dental practice on a full-time basis for several years. There have never been any issues with her employer and all of her performance reviews have been positive. Without notice, the employer demands that the dental hygienist sign a contract changing her status from employed to that of an independent contractor which contract removes the benefits which she had previously while employed. The dental hygienist recognizes that this may cause problems with the tax authorities. The employer is adamant about the change.

Contracts are the subject of negotiation; however, generally speaking, one party to a contract cannot unilaterally and without notice change the terms of that contract. Both parties should obtain legal advice and attempt to resolve this matter in order to maintain the relationship and to avoid unnecessary and expensive litigation which would likely include a claim for damages for wrongful (constructive) dismissal. As with any negotiation, the dental hygienist can make a counter-proposal or pursue negotiating tactics (e.g. mediation, seeking common ground, threatening to sue for wrongful dismissal). In addition, the tax laws have to be complied with by both parties. The dental hygienist can suggest that the lawyers for both parties talk about the tax implications.

Removal of Patient/ Clients’ Records and Lists
Unless permitted by the contractual relationship, the office privacy policy and PHIPA, a departing dental hygienist, who is employed by a dentist, cannot unilaterally remove patient/client records, or patient/client lists. The original records remain with the office.

Similarly copies cannot be removed unless this is permitted by the contractual relationship, the office privacy policy and PHIPA. In this situation the removal of copies should be addressed not only in the contractual documents, but also in the privacy policy so that patients/clients consent to the possibility that copies of their records could be made and removed.

Scenario 2 – Patient/Client Lists
A receptionist in a dental office informs the dentist that a dental hygienist, also employed by the dentist, has been taking a list of the office patients/clients for several months. In this instance, the receptionist reports that the dental hygienist also confided that she was going to be establishing her own dental hygiene clinic in the neighbourhood and was using the list to directly advertise to the patients/clients of the dental office regarding opening her office and informing them that they have the right to have copies of their patient/client records transferred to the dental hygienist in her new dental hygiene practice. The office owner has invested in the establishment of a practice, hiring staff and providing infrastructure to build a patient/client base. The dentist understands that patients/clients have the right to choose their practitioner; but also wonders about the duty of employees in such circumstances.

This scenario assumes that the dentist owner is the custodian of the records, including patient/client lists. The dental hygienist has no right to remove the patient/client list. The dentist is correct in believing the patients/clients have a right to choose who their healthcare practitioners will be and, therefore, the dentist has a professional obligation to give patients/clients who requested it the contact information for the departing dental hygienist. If a patient/client list(s) was removed, it should be immediately returned and all copies destroyed. The unlawful removal of patient/client list(s) or anything else belonging to the dental practice could result in both civil litigation and disciplinary action. This is avoided where both the dentist and dental hygienist act professionally and ethically to ensure that the welfare of the patient/client is dealt with as the overriding priority.

Notification of Patients/ Clients
Sometimes there are competing interests about the notification of patients/clients of the departure of a dental hygienist. The dental office may wish to preserve the goodwill associated with the office and want as many patients/clients as possible to remain with the office. On the other hand, patients/clients are entitled to continuity of care and have the right to choose who they go to for care. There are also courtesy considerations where a patient/client has developed a rapport with a departing dental hygienist and might be offended by not being notified of a departure.

The following considerations apply in balancing these interests:

January 18, 2010
1 A departing dental hygienist, particularly one who will be continuing in practise elsewhere, must not solicit patients/clients.

2 If there are continuity of care concerns (e.g. the office is closing or there will be no one to take over the ongoing care of patients/clients) both the dentist and the dental hygienist have a professional responsibility to ensure that patients/clients receive adequate notification to permit appropriate continuity of care.

3 Patients/clients have the right to choose their care providers. Contractual obligations cannot create barriers to patients/clients who wish to continue care with the departing dental hygienist. Therefore, patients/clients should be advised of the departure of a dental hygienist with whom they have developed a professional relationship in a constructive, timely and appropriate manner and, if requested by a patient/client, contact information for the departing dental hygienist should be provided.

There are many effective ways in which these principles can be achieved. To ensure a smooth transition for patients/clients, it would be wise for the dentist and dental hygienist to work out a protocol dealing with notification issues. If agreement cannot be reached, legal advice should be sought. Under no circumstances should the dentist or dental hygienist utilize patients/clients to influence the other party’s actions. To do so would be considered unprofessional or unethical.

Scenario 3 – Refusal to Notify Clients
A dental hygienist leaves a dental practice. The practice denies to enquiring patients/clients any information on the whereabouts of the dental hygienist and makes suggestions or implies that a dental hygienist is no longer available to provide ongoing care.

As previously indicated, patients/clients are entitled to be informed, if they ask, of where a departing dental hygienist has gone. If the practice does not have that information, it can direct the patient/client to the CDHO website which contains information on the business address of all dental hygienists. It is unprofessional and unethical for a dentist to refuse to provide information of this type to a patient/client who requests it or to attempt to mislead patients/clients in an effort to make them believe that they do not have the right to obtain ongoing care from the departed dental hygienist.

Scenario 4 – Request for Notification of Patients/Clients
A dental hygienist has been a long-standing employee in a dental practice. In anticipation of leaving that practice to open her own dental hygiene practice, she has recommended that all patients/clients be informed that she is leaving the practice to establish a dental hygiene practice in the community. Traditionally, the dental hygiene care has been provided to patients/clients on a rotational basis by one of the three dental hygienists in the office. When there is a change in the dental hygiene staff, there has not been a practice of proactively informing patients/clients. Instead, the new dental hygienist would be introduced to patients/clients in an efficient manner and, in the limited circumstances where a patient/client asks about a former employee, that information has been provided to the patient/client.

There is no absolute duty to notify patients/clients of the departure of a staff person or to provide detailed reasons that might invade the privacy of the departing staff person. What is appropriate depends on the circumstances including the reasonable expectations of the patients/clients of the practice. In the case of the dental hygienist leaving to set up her own dental hygiene practice, the dental office does not have to agree to become an advertising vehicle for her. On the other hand, the dental office should not refuse to provide any information at all. At a minimum, the dental office would provide information that the dental hygienist had decided to leave the practice and contact information for the dental hygienist if requested by a patient/client.

Transfer of Patient/Client Records
As noted already, the original records remain with the owner of the practice. PHIPA provides specific guidance for transferring all original records when an office ceases operations.

Issues sometimes arise, however, about the transfer of a copy of a specific patient/client record to a subsequent treating practitioner, whether that be a departing dental hygienist or another dentist previously associated with the practice. The general principles are as follows:

1 With rare exceptions, the original record stays with the owner.

2 Patient/client consent is generally required for such a transfer. An exception exists where the transfer is needed for ongoing treatment of the patient/client and consent is impractical (i.e. the “circle of care” concept).
With rare exceptions (e.g. threats of serious physical harm) the wishes of the patient/client about transferring a copy of the record are to be honoured.

The transferring office can ask for reasonable documentary confirmation of the patient's/client's wishes. However, the transferring office should not impose artificial documentary requirements that create a barrier to such a transfer (e.g. requiring a special form to be used) where the wishes of the patient/client are not in doubt.

The transferring office can charge a reasonable fee for this service. However, such fees should not be used to create barriers to ongoing care and as with any fees, must be reasonable.

Scenario 5 – Make a Choice
A patient/client requests that a copy of his dental chart be sent to an independent dental hygiene practice. The dental hygienist previously practised in that dentist's office. The office indicates that they will no longer see the patient/client for restorative work if the patient/client decides to have his preventive services performed elsewhere.

The patient/client has the choice of providers. The patient/client also has the right to have a copy of his/her file transferred. It is unethical and unprofessional for a dental office to attempt to coerce patients/clients to remain in the dental office for all services. Neither a dentist nor a dental hygienist is entitled to terminate services for a patient/client because she or he is not happy with the patient/client’s choice of (other) healthcare providers.

Ongoing Access to the Record by the Dental Hygienist
Dentists have a duty to ensure that dental hygienists have access to patient/client records where the dental hygienist needs access to meet a professional obligation. That obligation cannot be defeated by a dental hygienist agreeing to the dental office retaining records upon the dental hygienist’s departure from the office. The dental office should provide reasonable access to the records to a dental hygienist who requires it in order to fulfill his or her professional obligations. Often such disclosure can be made on the basis of implied patient/client consent or without consent because some overriding legislative provision applies. However, if one is in doubt about the issue or the patient/client asks that the information not be disclosed, the dentist or dental hygienist should seek legal advice. Some examples of such a professional obligation include where the dental hygienist has to do one or more of the following:

1. respond to a complaint;
2. prepare for a quality assurance assessment;
3. prepare a medico-legal report of his or her care at the request of a patient/client; or
4. prepare to defend himself or herself from a civil claim.

If the dentist has a legitimate concern about whether there is sufficient consent from the patient/client to release the record, the dentist should contact the RCDSO or the dentist’s lawyer.

Scenario 6 – Complaint After Departure
After a dental hygienist leaves, a patient/client sends a complaint to both the RCDSO and the CDHO about the TMJ pain suffered by the patient/client. The dental hygienist asks for a copy of the chart in order to respond to the complaint. The dental office is reluctant to do so for fear of a further complaint about breaching the patient’s/client’s confidentiality.

Ideally the dental office’s privacy policy already permits this disclosure to the dental hygienist to be made. The information cannot be considered to be confidential from the dental hygienist to the extent it was information that the dental hygienist had access to prior to her departure from the office. Furthermore, the Personal Health Information Protection Act, 2004 permits the disclosure for the purpose of legal proceedings. In the alternative, the dental office can provide the chart to the CDHO so that the CDHO can assist the dental hygienist in responding to the complaint.
The Regulated Health Professions Act, 1991 (RHPA), which is the legislation that governs Ontario’s health regulatory Colleges has changed significantly. These changes, which came into effect on June 4, 2009, will impact almost every area of the College’s operations. Although many of these changes relate to College processes, a significant number of the revisions will have a direct impact on registrants. The purpose of this series of articles is to highlight some of the biggest areas of change and to explain the specific impact those revisions will have on registrants.

The majority of the legislative changes touch upon one of the following three subject areas: (i) mandatory reports; (ii) the register; and (iii) the Inquiries, Complaints and Reports Committee (ICRC). Please refer to the March and July 2009 issues of Milestones for information on mandatory reports and the register.

ICRC

Under the current RHPA, concerns about registrants are investigated by three internal bodies, the Executive Committee (for non-complaints investigations), boards of inquiry (for incapacity concerns) and the Complaints Committee (for formal complaints). Under the new legislation, these investigative functions have been merged into one committee, the Inquiries, Complaints and Reports Committee. As a result, the ICRC will see all complaints and will also screen all registrant-specific concerns that arise from other sources, including mandatory reports.

Although there are many significant process changes that have resulted from the creation of the ICRC, four areas of change that will be of particular interest to registrants relate to: (i) notice requirements, (ii) use of a registrant’s prior history, (iii) alternate dispute resolution procedures and (iv) the dispositions available.

Notice requirements

Under the new legislation, registrants will receive notice of a complaint within 14 days of it being filed with the College and will receive notice of a Registrar’s investigation report to the ICRC within 14 days of that report being filed with the committee. Particularly for complaints, registrants will therefore be alerted early on about the concerns so that they can prepare for the investigation while the matter is still fresh in their minds. The notice will also contain formal notice of their right to respond in writing to the concern. In addition, for complaints the notice will also contain the timelines that apply to the investigation and the right of an independent review of the ICRC decision by the Health Professions Appeal and Review Board (the “Board”).

Complaints are to be investigated within 150 days (up from 120 days). Where the ICRC has not rendered its decision by then, it must send a letter to the parties notifying them that it has not completed the matter and that it will try to do so within a further 60 days. After day 210 the College must send a letter to the parties (and to the Board) every 30 days explaining why the complaint has not been decided yet. Either party can then go to the Board for an order directing the ICRC to complete their investigation promptly or for the Board to take over the investigation. One of the implications of these timeline requirements is that Colleges will be less likely to agree to lengthy delays in the investigative process (even if requested by the registrant – for example, if there is a parallel criminal proceeding).
Prior History

In addition to receiving notice of the complaint or report, the new legislation also requires registrants to be given copies of their available prior history with the College. The ICRC is required to consider and review that prior history when looking at new concerns. The prior history includes any earlier decision of the Executive, Complaints (except for frivolous and vexatious matters), Discipline or Fitness to Practice Committees. Even prior decisions dismissing a complaint or concern need to be reported. The prior history rule attempts to ensure that the ICRC has the complete picture of the registrant’s professional career so that new concerns are not dealt with in isolation. For example, if a registrant has a history of standard of practice concerns, none of which are disturbing on their own, but collectively raise serious concerns about the registrant’s competence, the ICRC can take this into account.

The registrant will, of course, be able to respond to the prior history. For example, the registrant can make written submissions placing the prior history in context (e.g., if the nature of the registrant’s practice generates a high risk of dissatisfied clients) or indicating that the prior history may have little or no relevance to the current concern.

In complaints matters, however, there is a possibility that the prior history may become known to the complainant. This may occur if the registrant’s response to the prior history is given to the complainant by the ICRC. It may also occur if there is an appeal to the Board for a review of the decision of the ICRC (as the Board often discloses the entire ICRC file to both the complainant and the registrant). Registrants with a significant prior history may wish to seek professional assistance in dealing with this possibility.

Alternate Dispute Resolution (ADR)

While ADR, or informal resolution, has been a common practice at many Colleges for some time now, formal rules have now been developed. These rules apply only to the use of informal resolution processes in formal complaints. Non-complaint investigations or complaints after they have been referred to discipline may still be dealt with flexibly by the internal processes selected by individual Colleges.

These rules for informal resolutions of formal complaints include the following:

1. The Registrar must initiate the process.
2. The consent of both parties is needed before ADR can begin.
3. ADR cannot be used in a complaint involving sexual abuse.
4. All communications in the ADR process must be kept confidential and privileged and cannot be used in other proceedings, including discipline.
5. If the ADR is unsuccessful, the facilitator cannot participate in the remainder of the ICRC process.
6. Any resolution must be ratified by ICRC to ensure that it is in the public interest.

Dispositions Available

Where there is no successful resolution of matters, the ICRC will have significant new options for disposing of the matters that it reviews. For example, the ICRC will now be empowered to require registrants to complete a specified continuing education or remediation program to address practice concerns. (Continued on page 26)
This could include, for example, successfully completing a continuing education course or a mentorship program. Even certain self-study programs could be ordered (e.g., to read and summarize, to the satisfaction of the Registrar, certain standards, guidelines and policies of the College). However, this new power means that the ICRC can no longer refer registrants to the Quality Assurance Committee.

In addition, the ICRC will be able to require registrants to attend before it for an oral caution in all matters, not just formal complaints.

The ICRC will also deal directly with incapacity matters. Under the current legislative scheme, the Executive Committee deals with incapacity matters by appointing a board of inquiry to inquire into a registrant’s health. The results of those inquiries are then reported back to the Executive Committee which, depending on the information contained in the board’s report, decides whether a formal hearing is necessary. Under the new legislation, however, a “panel” selected by the Chair of the ICRC will fulfill all of these functions directly.

Of course the existing options under the current regime remain available (e.g., dismissal of the complaint, referral to discipline and negotiating an Acknowledgement and Undertaking with the member).

The changes to the ICRC process will have an impact on registrants who face complaints or other formal investigations.

* Part 1 and 2 of this series can be found in the March and July 2009 issues of Milestones.
It is a common misconception that insurance fraud is just a problem for insurance companies. Nothing could be further from the truth.

Insurance fraud has potential to impact a wide range of people including Registered Dental Hygienists and their clients.

Misrepresentation of credentials and stolen identity appear to be on the rise. When this occurs, clients are at risk of receiving inappropriate care. In one recent case identified by an insurance carrier, an unknown individual leased space and provided care to a large number of patients under the name of a legitimate practitioner before being discovered. By the time the insurance company and the legitimate practitioner figured out what was happening, the unknown individual had closed up shop and disappeared, likely to set up shop elsewhere under a different name. The unfortunate consequence for the legitimate practitioner was countless hours working with the insurance company comparing records to get to the bottom of the problem and to verify all new claims prior to payment to ensure that no fraudulent claims were being received.

As a result, more and more insurance companies are putting in policies and procedures that reduce fraud risk for their customers. Sometimes these policies and procedures can impact you but there are steps you can take to minimize your risk and the effort you may have to take to meet the insurance company’s criteria.

Ensure that your receipts contain as many details as possible to make verification easier if it needs to happen at a later date. Always include:

- Your name as registered with CDHO
- Your designation and registration number
- Your full address
- The location where the service was rendered if different from your billing address
- Your telephone number
- Precise details of service including the time
- Date of service and, if different, date of payment
- Type of payment
- An invoice number which should also be recorded in the client file

Avoid using hand-written receipts, if possible. If you must use hand-written receipts, be sure everything is written clearly.

When writing dollar values on receipts, put a dollar sign directly in front of the first number so that no one can easily alter your receipt later.

Sign your receipts or have a trusted front-office staff sign all receipts. A signature is a difficult thing to copy and will make it much easier for you if you must verify receipts at a later date.

Never put false information on a receipt, even if asked by a client. Things that clients may ask you that are inappropriate include:

- Putting a different date on the receipt than the date of service or payment
- Changing the name of the client
- Putting a different service on the receipt than was actually provided
- Putting a different dollar amount on the receipt than was actually paid.

If a patient requests a duplicate receipt for any reason, always indicate “duplicate - replaces receipt #” or “duplicate - replaces receipt issued on (date)” clearly on the replacement receipt.

Report any person who tries to entice you into committing fraud. You may report this to the CDHO or to the Canadian Health Care Anti-fraud Association (www.chcaa.org).

By having strong receipt practices, you reduce the potential of someone committing fraud under your name and, if it should still occur, you’ve made it much easier to sort out what you legitimately did from what the fraudster has done.

Adapted from an article by Diane Geddes
CMA Past Chair
Suspended/Revoked/Resigned Registrants

In accordance with section 24 of the Regulated Health Professions Act (Code), the following registrants have been suspended or revoked for non-payment of the annual renewal fee. These registrants were forwarded notice of the intention to suspend and provided with two months in which to pay the fee. If a registrant has been suspended for non-payment, he/she has the right to appeal the final decision to the College at renewal time.

### Suspended

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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Poh Quong, Angela Lee</td>
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<td>Zhang, Ludan</td>
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### Registered

- Burke, Daphne Marie 006500
- Cecchin, Camille Renee 006618
- Chambers, Mireille 008525
- Chiu, Christina 010520
- Christensen, Diane Gloria 005295
- Clifford, Sarah Elizabeth 008980
- Dallas, Anastasia D 008322
- Darlington, Laura Jane 005617
- Dean, Melanie 011495
- Diaz-Dilawri, Romelia 004679
- Dort, Jasmin 012800
- Dunbar-Huggins, Tracey Dianne 008486
- Eldabaa, Heba 005717
- Ellefson, Laura Mary 008959
- Elliot, Barbara Jean 001764
- Espique, Jessica Jenise 010998
- Faccendi, Tracey E 004746
- Fernandez Forero, Jose Luis 011753
- Filipe, Debbie Clara 010749
- Flynn, Jayne 013276
- Friesen, Amy Rebecca 012157
- Fullford, Margaret Ann 007224
- Funk, Karen Lorraine 009311
- Gamela, Melia 009250
- Gauthier, Amanda Carmen 010037
- Gerelus, Yuli Duplan 013416
- Goldhar, Leela F 007376
- Goulch, Constantin 012867
- Gregoire, Julie 010685
- Gupta, Bhumiya 012540
- Hambrock, Rachel 010098
- Hammersley, Trevor-Leigh 009972
- Hayes, Robbi-Lynn L 002317
- Hedgepeth, Paula Nicole 009659
- Heidary, Karima 012539
- Hewitt, Heather Ashley 011064
- Irwin, Rachel 008424
- James, Sarah 012791
- Kamal, Mariam 013435
- Kandasaray, Fayroom 011651
- Kassam, Shaznin Itmaitz 010724
- Knight, Roslyn 012401
- Kylander, Riely 008660
- Laflamme, Kim-Marie 008079
- Lalonde, Karel Marie 009135
- Latendresse, Megan Lea 012544
- LeBlanc, Madeline Marie 008433
- LeBlanc-Grueters, Lisa Noella Marie 007546
- Lesperance, Sheri Lee 005403
- Lentzberger, Heidi Anne 012429
- Lunney, Patricia Joyce 001512
- Lupton, Michelle Ann 008822
- MacDonald, Kimberly Alison 007877
- Macnamara, Sabine 008923
- Markiewicz, Miroslava 011569
- Mathews, Joseph Binoy 006978
- McIntyre, Christina 012167
- McLaughlin, Helene 013048
- McWilliam, Roni D K 003354
- Megesi, Lorrie-Anne Natalie 006316
- Mertol, Fehat 012574
- Miller, Connie Marie 010171
- Miller, Jenoy 011722
- Miller, Melissa Dawn 008803
- Mudhar, Sundee Kaur 010951
- Nauffts, Amanda Jean 009769
- Neillands, Jill Elizabeth 013079
- Nguyen, Truyen 012581
- Nazi, Ata 011056
- North, Robin Noelle 008824
- O'Brien, Fran 012400
- O'Brien, Sandra Margaret 004218
- Page, Laura Jean 004848
- Palummini, Massimo 007904
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Adkin, Cheryl Elaine  006013
Anderson, Corina Lynn  011099
Amnett, Kari Lyn  010656
Arolla, Paula Annikki  000138
Appleby, Gwendolyn  003340
Arnson, Joanna  003983
Baird, Leslie Ann  000433
Banfield, Theresa Marie  010443
Barakat, Khald Samir  004051
Barley, Marianne L  007499
Beaulieu, Sarah Pauline Marie  009978
Belanger, Suzanne Marie  011974
Bertrand, Lorraine Lucille  001121
Besette, Sharon Carole  001211
Birziede, Catherine  008637
Boechel, Barbara Ann  000777
Boyce, Kathleen Eva  009772
Braun, Martha Jane  000850
Bregman, Sandra Sue  007850
Broadway, Deborah A  008752
Brooks-Walker, Terrie  013608
Calder, Danielle  012012
Campbell, Jonathan Bruce  009037
Carpenter, Melanie Lynn  003190
Charbonneau, Jennifer E  008344
Charbonneau, Roxanne  012760
Clark, Kristen  004076
Collison, Pamela Ellen  001640
Cook, Patricia Anne  011573
Corbin, Troy Terrance Carlisle  012418
Covach, Jo-An  010485
De Melo, Peggy  012607
Deeter, Nicole  013636
Diaz-Dilawri, Romelia  004679
Dochstader, Ann Marie  001551
D’Orazio, Melanie  012094
Dukowski, Shirley Joyce  002025
Elliott, Jane Kelly  006716
Ellis, Lori Elizabeth  001593
Everard, Tara Leigh  009579
Fance, Naomi  012998
Farah-Awai, Neyaz  009736
Flewelling, Marcella Anne  006552
Foster, Caroline  011350
Gifford, Lisa D  007998
Gilchrist, Brenda Mae  003301
Gilchrist, Paula Marie  006530
Good, Elaine B  003741
Grecko, Helen Marianne  005604
Crosskleg, Julie  009801
Gunia, Christina  010505
Guy, Janet Elizabeth  011544
Habib, Haneen  000084
Hicks, Sharron Patricia  012982
Hill, Janice Beatrice  011055
Hill, Kathryn Ann  012357
Johnson, Sara  010792
Kaufman, Pamela M  002304
Ker, Cynthia  001952
Lamass, Hazeth  011916
Laminski, Tammy  012192
Lapalme, Jacinthe Suzette  007066
Laurin, Rachelle Renee  010620
Lavoie, Derry-JoY  009741
Leonard, Brenda Lee  011948
MacKinnon, Crystal Marie  012293
MacMillan, Sylvia Elizabeth  002855
MacRae, Kelly Ann  005992
Martin, Beth E  013344
Martin, Patricia Ann  011352
Masakina, Liudmila  004346
McCread, Charlotte Ann  002499
McLean, Jodi Pamela  005305
Miller, Ashley Megan  012966
Mills, Sheena  013586
Molyneaux, Sandra Jane  002502
Morin, Josee  009553
Nerino, Lisa  007814
Olmsdale, Mary Catherine  004126
Pal, Laurie Lynn  010696
Perrault, Francine Therese  017766
Pinhey, Catherine Ann  002382
Poirier, Shirley Raye  012928
Pope, Sheila Evelyn  013372
Reber, Janice Frances  002753
Reid, Sarah Doreen  010761
Renc, Kyla  008805
Richard, Susan Marie  004687
Ringrose, Gwendolyn Rose  009092
Rivard-Lamontagne, Stephanie  008577
Robbins-Crabtree, Marguerite S  004145
Rivard, Jililyan M  001883
Rubinof, Ryfa  000572
Scantlan, Dale M  009599
Shaver, Karen  004252
Severt, Wendy Elizabeth  002023
Sindair, Jennifer Suzanne  006740
Sipila, M Shelley A  001276
Smith, Deborah Janice  004201
Smith, Karina  012546
Steeves, Kristin Melissa  008461
Strait-Hinnerichsen, Lisa Marlean  007433
Swift, John Peter  004634
Thapar, Jason  010200
Tripp, Jayne Marie  003645
Viezema, Linda  006779
White, Suzanne  001853
Wilkob, Stacy  003272
Wolde, Helen  001884
Zhai, Madeleine  010823
Changing your address?

If you change your home or business address, you are required to notify the College within 14 days.

To update your address information:

Please login to the “Registrant Address Change” page on the Registration tab at www.cdho.org.

Your login ID is your CDHO Registration ID (6 digits).

Your password is your birth date in the format of YYYYMMDD (8 digits).

Use the buttons on the left of the screen to navigate to your existing address.

You may add up to four secondary business addresses in addition to your primary business address.

Please note, your mailing address must be either your residence or primary business address.

When filling out the online change of business address, be sure to include the type of your practice setting, as well as the name of the business.

Here’s a guide to determine your business practice setting:

- Solo Practice Office – One Dentist Owner
- Group Practice Office – Multiple Owners
- Independent Practice – Dental Hygiene Practice
- Hospital – Including Long Term Care
- Post Secondary Institution – Educator
- Public Health Unit – Government Facility
- Administration – Office Managers, Program Managers
- Other

Note: An Independent Practice is not automatically enrolled in the website’s Independent Practice lookup. If you would like your Independent Practice to appear in the lookup or be removed from the lookup, please call the College and we will change the web status for you.

Remember, if you change your home or business address, you are required to notify the College within 14 days.

Notification can be done by either:

1. Using the online change of address
2. E-mailing the CDHO your name, Registration ID and address change to addresschange@cdho.org.
3. Phoning 416-961-6234 or 1-800-268-2346
Protecting your clients’ health and smiles!

An informed public will take active steps to improve their oral health through self-care and regular visits to their dental hygienist. We encourage you to reinforce these key messages of the Public Education Program with your clients:

- Oral health comprises more than just teeth and gum care, and is key to your overall health.
- Your dental hygienist is the expert for preventive oral health care.
- The CDHO regulates the professional practice of dental hygienists to ensure all Ontarians receive high quality care.

We encourage you to visit and direct your clients to the new public information section of www.cdho.org.