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THE OFFICIAL JOURNAL OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

# A Year of Opportunities

*By Bonnie Blank, AASc, BSc(DH), MA*

*Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishments toward organizational objectives. It is the fuel that allows common people to attain uncommon results.*
– Andrew Carnegie

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION (CDHA) is the collective voice and vision of dental hygienists in Canada, advancing the profession, supporting its members and contributing to the oral health and general well-being of the public. In pursuing these objectives, CDHA seeks to bring about high-quality, accessible oral-health care.

This is the vision CDHA has been dedicated to for 40 years. It shapes how the board, executive director and staff work to fulfill our mandate. Teamwork is a critical component of any kind of progress. This past year as president, I have had an opportunity to experience first-hand exactly what teamwork can accomplish. I have been able to observe, contribute to and be a part of this process. By working collaboratively, I feel a great sense of support and satisfaction. And we accomplished much.

*CDHA has developed official positions on several critical issues this year.*

The organization has grown to 12,500 members. We continue to advocate for increased access to dental care by making presentations to Parliament and by developing position papers with specific recommendations to increase dental-hygiene service to segments of the population that are underserved.

CDHA has developed official positions on several critical issues this year, allowing dental hygiene to play a leadership role. Position papers and statements were published on the link between periodontal disease and systemic diseases—such as heart disease, lung disease and diabetes—and preterm, low-birth-weight babies. Addressing this link is recognized internationally as a necessary component of disease prevention that ultimately will help improve the health of people worldwide.

**A Year of Opportunities** *…continued on page 234*

# Une année fructueuse

*par Bonnie Blank, AASc, BSc(DH), MA*

*Le travail d'équipe, est la capacité de travailler ensemble vers une vision commune; la capacité de diriger les réalisations individuelles vers des objectifs organisationnels; le carburant qui permet aux gens ordinaires d'atteindre des résultats extraordinaires.*
*[Traduction] – Andrew Carnegie*

L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENtaires (ACHD) est la voix et la vision collectives des hygiénistes dentaires au Canada. Elle a pour objectifs de faire avancer la profession, d'appuyer ses membres et de contribuer à la santé buccodentaire et au mieux-être général du public. Par l'atteinte de ces objectifs, l'ACHD vise l'établissement de soins de santé buccodentaire accessibles et de haute qualité.

*Cette année, l'ACHD a élaboré des positions officielles sur plusieurs questions importantes.*

Depuis 40 ans, cette vision est au cœur de tous les efforts de l'ACHD. Elle détermine la façon dont le conseil d'administration, la directrice exécutive et le personnel travaillent pour accomplir leur mandat. Le travail d'équipe est un élément important de tout progrès, quel qu'il soit. Au cours de la dernière année, en tant que présidente, j'ai eu l'occasion de constater directement tout ce qu'il est possible d'accomplir grâce au travail d'équipe. J'ai été en mesure d'observer ce processus, d'y contribuer et d'en faire partie. En travaillant en collaboration avec d'autres, j'ai éprouvé un fort sentiment d'appui et de satisfaction. Ensemble, nous avons beaucoup accompli.

L'association a grandi et compte maintenant 12 500 membres. Nous continuons de faire valoir l'importance d'un accès accru aux soins dentaires au moyen de présentations au Parlement et d'énoncés de position, dans lesquels nous formulons des recommandations précises pour accroître les services d'hygiène dentaire offerts aux groupes de population mal desservis.

Cette année, l'ACHD a élaboré des positions officielles sur plusieurs questions importantes qui ont permis de mettre en relief le rôle prépondérant de l'hygiène dentaire. Nous avons diffusé des énoncés de position et des déclarations traitant du lien entre la maladie parodontale et

**Une année fructueuse** *…suite à la page 234*

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Canada

# CONTENTS

## EVIDENCE FOR PRACTICE



## OBSERVATIONS



## DEPARTMENTS

# Independent Practice

## *An Idea Whose Time Has Come*

*By Susan Ziebarth, BSc, MHA, CHE*

*He must be independent and brave, and sure of himself and of the importance of his work, because if he isn't he will never survive the scorching blasts of derision that will probably greet his first efforts* – Robert E. Sherwood

ON SEPTEMBER 15, CDHA WAS PLEASED TO WELcome 100 members to the association's inaugural Independent Practice Workshop. This event marks an exciting new era for the profession and the association as independent practice is becoming a reality in many provinces.

The workshop is the first step in the development of a certificate program and online courses to promote business excellence for independent dental hygienists. Due to

*Independent practice is becoming a reality in many provinces.*

the overwhelmingly positive response, the workshop will be repeated in Toronto at the end of January 2008. This program is one component of CDHA's initiatives to meet the goal established by the board of directors to provide resources for business success to our members. You will find more resources on the members-only website and in this issue of the journal, notably: an article on the history of the new self-initiation legislation in Ontario with a sidebar on what is involved in setting up your independent practice, a library column with many useful links to sources of information you will need, and an article on risk protection.

Other areas CDHA is working on with regard to independent practice relate to third-party reimbursement of dental hygienists. Over the past six years, we have seen more and more willingness on the part of insurers to accept dental-hygiene claims from independent dental hygienists, although the progress has been slow. CDHA has been actively involved in the development of the National e-Claims Standard and our work will ensure any future standards will be applicable to dental hygienists. We also are working with software companies to expand their products to meet your needs and to establish a dental-hygiene electronic-claims-submission program.

**Independent Practice** ***An Idea Whose Time Has Come***
*…continued on page 227*

# L'exercice autonome de l'hygiène dentaire

## *Une idée qui a fait son chemin*

*Par Susan Ziebarth, B. Sc., MHA, CHE*

*Il doit être indépendant, courageux, sûr de lui-même et de l'importance de son travail parce que s'il ne l'est pas, il ne survivra jamais aux propos acerbes de dérision qui salueront ses premiers efforts*. [Traduction libre]
– Robert E. Sherwood

LE 15 SEPTEMBRE DERNIER, L'ACHD ACCUEILLAIT AVEC plaisir 100 membres venus participer à son atelier inaugural sur l'exercice autonome de l'hygiène dentaire. Cet événement marque le début d'une ère prometteuse pour la profession et pour l'association puisque l'exercice autonome devient réalité dans plusieurs provinces.

L'atelier constitue la première étape du développement d'un programme de certificat et de formation en ligne visant à favoriser l'excellence dans l'exercice autonome de l'hygiène dentaire. Compte tenu de l'extraordinaire accueil dont il a joui, l'atelier sera offert de nouveau à

*L'exercice autonome devient réalité dans plusieurs provinces.*

Toronto à la fin de janvier 2008. Ce programme s'inscrit dans les projets de l'ACHD visant à offrir à ses membres des ressources leur permettant de réussir en affaires, objectif établi par le conseil d'administration. Le site Web réservé aux membres et cette édition du journal contiennent diverses sources d'information à ce sujet, notamment un article sur l'histoire de la nouvelle loi ontarienne en matière d'exercice autonome de l'hygiène dentaire, avec un encadré sur ce que comporte l'établissement d'un cabinet, une rubrique documentaire comprenant plusieurs liens utiles vers des sources d'information essentielles et un article sur l'assurance responsabilité.

L'action de l'ACHD en matière d'exercice autonome de la profession touche aussi le remboursement des services d'hygiène dentaire par des tiers. Bien que les progrès aient été lents, on remarque depuis six ans une tendance croissante de la part des assureurs à accepter les demandes de remboursement pour les services d'hygiénistes dentaires

**L'exercice autonome de l'hygiène dentaire**
***Une idée qui a fait son chemin***
*…suite à la page 243*

# Legislative Changes in Ontario: Self-Initiation Has Finally Arrived

*By Fran Richardson*

On September 1, 2007, the Ontario *Dental Hygiene Act, 1991* was amended to permit dental hygienists to self-initiate their authorized act of *"scaling teeth and root planing, including curetting surrounding tissue."* This amendment to the *Act* was neither all that was desired by the profession nor all that was promised by the government. However, it will enable the public of Ontario to choose when, where and from whom they wish to receive preventive oral-health-care services, and it will provide dental hygienists the freedom to choose where to practice their profession. The amendment is of benefit to both the public and the profession.

## HISTORY

When dental hygiene achieved self-regulation in Ontario in 1994, forces external to the profession convinced the government of the day to include the provision in the *Dental Hygiene Act, 1991 (DHA)* that an "order" from a member of the Royal College of Dental Surgeons of Ontario (RCDSO) had to be given before a registrant of the College of Dental Hygienists of Ontario (CDHO) could perform their authorized acts. When this order provision was included in the *DHA*, there was no complementary requirement for the order to be given in the *Dental Act, 1991*, which put many dental hygienists in a situation where they could have been in contravention of their *Act* because there was no mechanism for giving an order. Consequently, the CDHO and the RCDSO agreed on the concept of "standing orders" for those dental hygienists who work in dental offices and protocols for those in public health. Unfortunately, many dentists were reluctant to provide orders for clients who were unable physically to attend the dental office and, thus, the intent of the *DHA* to facilitate access to preventive oral-health care was never fully realized. The CDHO Transitional Council immediately saw the flaw in the legislation and requested an amendment.

In 1994, the Ministry of Health indicated to the CDHO that orders were to be flexible and not unreasonably withheld by the issuing dentists. Unfortunately, as time progressed, organized dentistry tightened its stance on when, where and to whom orders could be given and the issuing of orders became a mechanism for controlling the practice of dental hygiene. While this scenario unfolded in Ontario, it also played out elsewhere in North America, most notably in jurisdictions that were seeking self-regulation for the dental-hygiene profession. Where self-regulation was achieved, it often came with an "apron string" to dentistry that ostensibly tied the practice of dental hygiene to the dental office in most cases. Where dental hygienists did take the initiative to institute mobile clinics to visit clients who were unable to visit a traditional dental office, they found significant resistance from local dentists and, in many cases, were unable to secure the orders necessary to complete the preventive service.

True, there are many forward-thinking dentists who have been supportive of the dental-hygiene profession's desire to take oral-health services to clients who are unable to come to a dental office, but they work silently in the background for fear of reprisal by their colleagues who are not as progressive. (In recent years, a greater effort has been made by organized dentistry to reach out to residents in long-term care and residential homes.)

As the CDHO grew and matured as a regulatory college under the *Regulated Health Professions Act, 1991 (RHPA)*, it became increasingly evident that the order requirement in the *DHA* not only hampered access to important preventive oral-health services, but also indirectly regulated the dental-hygiene profession by giving control to another regulated health profession. Many thought this to be paternalistic and economically driven. The more organized dentistry tried to control the practice of dental hygiene, the more the dental-hygiene profession, their public supporters and the regulators realized that the *Act* had to be amended for the good of the people of Ontario. No public good was achieved by maintaining the order. In fact, a 1996 report by an independent advisory body to the Minister of Health recommended that the *Act* be amended, but politics intervened and it took another 11 years before that recommendation, albeit in an incomplete form, was finally enacted.

For almost 14 years, the college requested and challenged successive provincial governments to listen to the profession and heed the needs of the Ontario public. It seemed to many of the supporters of the amendment that the government instead was listening to health-care pro-

***The new legislation will enable the public of Ontario to choose when, where and from whom they wish to receive preventive oral health-care services... Some people will choose to have a house call.***

fessionals who were against change and an alternative delivery system they could not control. In the meantime, nursing moved to the nurse-practitioner model and registered practical nurses were permitted to self-initiate. But both are part of provincial health-care funding and the result of a cost-conscious government's incentive to find alternatives. Oral health, by and large, is not included in the provincial health-care funding system and therefore did not appear to be a priority issue for legislative change. And a powerful, well-funded lobby was adamantly opposed to any legislative initiative that reduced the dentistry monopoly on oral-health care.

## WHAT HAPPENED TO MOVE THE ISSUE ALONG?

During the 2003 provincial election campaign, a dental hygienist who felt passionately about making the *DHA* amendment a reality used her personal connections to secure a promise, in writing, from the future provincial premier that, if elected, he would amend the *Act*. Dental hygienists constantly reminded the premier of his promise and expected him to keep it! An agreement that the *Act* should be amended was reached between the provincial dental and dental hygiene associations and the two related regulatory organizations after many delays—partially caused by ill-advised closed-dialogue sessions between the two associations. Those sessions resulted in a very strict Contraindications Regulation for Self-Initiation. The catch was that the dental organizations insisted that dental hygienists currently are not qualified to self-initiate, while the dental-hygiene organizations insisted that no further formal education is required. Another long dialogue ensued, during which it became obvious that the dental representatives were unaware of the stringent and comprehensive requirements of the Commission on Dental Accreditation of Canada for the accreditation of dental-hygiene programs. The CDHO maintained all along that dental hygienists in Ontario are capable of self-initiation based on a set of standards developed by the CDHO.

In the spring of 2007, the two dental organizations submitted a curriculum to the government for a two-year, post-diploma dental-hygiene program—which would not lead to a baccalaureate degree—recommending that all dental hygienists complete the program before being eligible for self-initiation. The submission was carried out without consultation with the CDHO, the governing body for dental hygiene in Ontario. The CDHO was not impressed and told the government that the dental organizations had definitely overstepped their bounds. Subsequently, CDHO representatives met with the Minister of Health and Long-term Care and proposed that the college establish standards under which dental hygienists can self-initiate. The minister agreed and outlined the elements to be included in the CDHO proposal. A tight deadline was given, but the college more than met the time frame requested.

## PROCESS CONSIDERATIONS

One of the requirements made by the minister was that there had to be a visible identifier on registrants' wall certificates indicating they had been approved by the college to self-initiate. Other requirements included identifiers on the CDHO website, an application process accompanied by a fee and a directive that the CDHO post the business addresses of independent practicing

dental hygienists on the website for public accessibility. The CDHO agreed to comply with the minister's requests.

The college then posted the proposed *Standard of Practice for Self-Initiation* on the CDHO website for a brief consultation period. The standard includes three streams by which a registrant could be approved to self-initiate. Streams two and three include taking an online course developed through the CDHO but administered by the Canadian Dental Hygienists Association. While the time frame imposed by the minister was short, the college received a significant number of submissions with many helpful suggestions regarding the standard. Both dental organizations stressed the need for a regulation instead of a standard. The CDHO decided to continue with the standard-development process and ultimately approved a streamlined version based on the comments received during the consultation period. The revised standard was submitted to the government and the college waited.

### PROCLAMATION

On September 1, 2007, after 14 years of hard work by the many supporters of increased access to preventive oral-health care, the amendment to the *DHA* was finally proclaimed with little fanfare. But the really hard work has only just begun!

Having seen hopes dashed and promises broken in the past, the CDHO was reluctant to develop the infrastructure required for the approval process for self-initiation until the amendment was actually proclaimed. Of course, the college had all the components in draft form but nothing had gone to the printers. It has been decided not to spend additional money until the amendment was a reality.

### WHERE ARE WE TODAY?

CDHO registrants are already applying for approval to self-initiate. The information and application forms are available on the CDHO website (www.cdho.org) under *What's New*. Information packages have been sent to all CDHO registrants and members of the CDHO administrative staff are travelling around the province to discuss the implications of the new legislation with dental hygienists.

One of the key pieces of information to be conveyed is that **self-initiation is not dependent on practice setting or employment relationship**. A dental hygienist can as equally self-initiate in a dental office as set up a mobile practice to visit nursing homes or residential facilities. As self-regulating health-care practitioners, it is the dental

***For the dental hygienist who wants to make a difference in the quality of life of housebound people, there will be endless possibilities.***

# So Now You Can Open Your Own Practice… What Do You Do Next?

*By Ann Wright, RDH, MBA*

As many dental hygienists across the country begin to plan careers as proud owners of independent practices, we can marvel that not long ago, dental hygienists were considered dental auxiliaries and an employee in the dental office. The next professional progression was that a dental hygienist could be an independent contractor and now, finally, dental hygienists can be proprietors of their own independent practice.

As we begin to take the steps to fulfill this dream of owning our own independent practices, there are undoubtedly many questions to be answered. Are you wondering:

How do I go about finding a location and what do I need to know about premise leases?
How do I go about finding a contractor to build the office?
What equipment do I need and where are the best places to purchase it?
How do I find good staff?
How will I market my practice?
How long will it take to get up and running?
**How much money will it all take?**

Each of these questions are important considerations when contemplating a practice of your own, but the first and most important consideration is to have a vision of what your practice might look like.

Do you see yourself as the owner of a mobile dental-hygiene practice, travelling long distances over snow-covered roads, transporting and setting up heavy equipment in order to treat a handful of clients with all kinds of medical complications? Or, do you see yourself travelling to treat clients who otherwise have few options to access dental-hygiene care? Perhaps these people are homebound and your services are much more than dental-hygiene care, but also constitute a visit from a concerned friend. You are one of their precious links to the outside world.

Imagine your practice in a suburban strip mall, which you carefully chose and designed. Your part-time receptionist left at lunch and has not come back, your computer is down and the mother of one of your clients wants to know if her dental insurance covers mouthguards. To add insult to injury, she is not too impressed that you cannot take her payment. As a busy mom yourself, you have chosen to target young families and you have worked hard to build a welcoming, youthful practice. Your day is hectic, but rewarding and you have learned that things will not always go according to plan.

Or, do you see yourself providing in-office whitening and dental-hygiene services for a clientele that also schedules multiple cosmetic appointments at the business establishment adjacent to you? Does this vision include the same whitening client who is dissatisfied because you kept her waiting and lets you know that the staff is much friendlier in the dermatologist's office next door? Keep in mind that you are the sole owner and ultimately responsible for resolving these dilemmas. You will find that the development of communication, diplomacy and business skills are key to ensuring that your practice is a success.

Opening your own dental-hygiene practice is a wonderful opportunity with abundant rewards, but also significant challenges. Once you have created a vision, the second step is to evaluate your own personality and consider your lifestyle and family responsibilities. Do you plan to stay in the same community for a significant period of time? How long do you plan to practice? What happens if your spouse gets transferred to a job in a different city? Can you afford to work for a period of time without drawing a salary, or a salary much lower than what you presently earn? Do you have the energy and time to devote to practice activities such as meeting with your landlord, accountant or bank manager? If you want to attract new clients, will you spend your free time introducing yourself to neighbouring businesses, visiting the mayor, demonstrating brushing techniques to the local kindergarten class and spending your first free Saturday morning setting up a mouthguard clinic in the hockey arena?

If you are not deterred by the above situations, then you might just be an entrepreneur. Not all entrepreneurs are the same, nor do they possess the same characteristics, but they do share some common personality traits:

- A strong predisposition to be their own boss
- High energy
- The ability to inspire and energize others
- The ability to learn from failures
- A "never, never, never quit" attitude
- A willingness to risk money and security

When we speak with successful independent hygienists, there are three major characteristics they all share. First, they possess high energy. Second, they are confident and focused on their goals. And third, they have an infectious passion for their practice that inspires and motivates those around them. They started their business without any particular business skills or marketing knowledge, but they pursued their dream with total commitment and were able to acquire those skills along the way.

Independent practice is a wonderful opportunity for dental hygienists in Canada. We possess the knowledge, skills and expertise to make this dream a reality. It is up to us now to move ahead and establish practices in communities we have chosen and designed to our personal specifications, where we can provide dental services to our clients on schedules and for fees we have determined. There will be many challenges ahead, but the rewards are priceless.

*Ann Wright RDH, MBA, has been a regional manager of multiple dental offices and a practice management consultant. She has held numerous dentistry positions, including in private practice, and has been an examiner for the College of Dental Hygienists of Ontario and a clinical demonstrator in the dental-hygiene program at Algonquin College.*

hygienists who will determine whether they can self-initiate or require an order from a dentist; it is the dental hygienist who will review the client's medical history and determine whether consultation is required; it is the dental hygienist who makes the decision to proceed with treatment; and it is the dental hygienist who is responsible for the interventions she or he decides to provide. Nothing has changed in that regard.

## HOW WILL THIS AFFECT THE PUBLIC?

Ontarians who regularly attend a dental office for their dental-hygiene care will not see any difference. Dental hygienists will continue to work in dental offices and many will be employed by dentists. But change will occur outside the dental office in the community, in residential homes and in public health. Some dental hygienists will choose to open stand-alone clinics in strip malls or in multidisciplinary health clinics. The public will be able to choose where to obtain preventive oral-health services. Some people will choose to have a house call.

## HOW WILL THIS AFFECT THE DENTAL HYGIENIST?

Dental hygienists in Ontario will now have the opportunity to choose how they wish to practice their profession. Along with that choice will come challenges, but that is the price of progress. For the entrepreneur, there are numerous possibilities. For the person who wants to make a difference in the quality of life of housebound people, there will be endless possibilities.

## WHAT IS SELF-INITIATION?

Self-initiation is the decision by a dental hygienist to proceed with the authorized act of *"scaling teeth and root planing, including curetting surrounding tissue"* without an order from a dentist, based on the principles inherent in the Dental Hygiene Process of Care. Makes sense!

*Fran Richardson is the Registrar at the College of Dental Hygienists of Ontario (CDHO) and a Past President of CDHA.*

# Abstracts from the 85th General Session of the IADR

## March 21–24, 2007, New Orleans, Louisiana

These abstracts were among those presented at the 85th General Session of the International Association for Dental Research in New Orleans from March 21–24, 2007. The IADR has given us permission to publish a selection of abstracts in the *Canadian Journal of Dental Hygiene*.

### ORAL CANCER

#### 2143 ORAL PRECANCER: OBJECTIVE AND SUBJECTIVE MEASURES OF NUTRITIONAL STATUS

**O. HAMADAH**, P. THOMSON, and M. GOODSON, University of Newcastle Upon Tyne, United Kingdom

**Background:** Evidence supports a role for nutrition in the aetiology and management of oral precancer. Observational epidemiologic studies indicate that poor nutrition is associated with an increased risk of oral precancer. **Objective:** To assess the value of reported fruit and vegetable intake and nutritional markers [albumin and total lymphocyte count (TLC)] as predictors of severity and outcome in oral dysplasia. **Methods:** 48 patients undergoing laser resection of dysplastic oral lesions were recruited into the study. Informed consent was obtained and blood samples analysed for full blood count and serum albumin. TLC as an objective marker of nutritional status was subsequently calculated. Patients were grouped using TLC and albumin as well or malnourished using standard criteria. Reported fruit and vegetable intake at presentation was recorded by questionnaire and individuals were assessed for recurrence at two years following laser resection. Statistical comparisons using non-parametric tests were made between fruit/vegetable intake, TLC, albumin and histology at presentation. Comparisons were also made between nutritional status at presentation and clinical outcome at two years. **Results:** 48 lesions were graded histologically: mild dysplasia (n=4), moderate (n=23), severe (n=21). Using TLC, 49% patients (n=22) were assessed to be well nourished and 51% malnourished (n=26). Albumin levels were normal for 87.5% patients (n=42) and low for 12.5% patients (n=6). 56.3% patients consumed <3 pieces of fruit/vegetable daily and 43.7% °Ý3. Recurrence occurred in 48% patients (n=23). There was no significant relationship (p>0.05) between objective measures of nutritional status (albumin and TLC) or reported fruit/vegetable consumption and histological grade of dysplasia at presentation. Equally, there was no relationship between subjective or objective nutritional markers at presentation and recurrence. **Conclusions**: Clinical outcome at two years post laser surgery and histological grade of oral dysplasia at diagnosis is unaffected by reported fruit and vegetable intake, serum albumin and TLC at presentation.

#### 1677 DENTAL HYGIENIST VIEWS ON ORAL CANCER CONTROL IN NORTH CAROLINA

**C. BIGELOW**, L.L. PATTON, R.P. STRAUSS, and R.S. WILDER, University of North Carolina, Chapel Hill, USA

Many oral and pharyngeal cancers (OPC) are preventable. North Carolina (NC) has a continuing high OPC incidence rate at 10.3 per 100,000 population (Elter et al, 2005). Early detection improves survival rates. Hygienists have opportunities to help reduce the oral cancer burden among their patients. **Objectives:** To qualitatively assess NC dental hygienists' opinions and practices regarding OPC prevention and early detection. **Methods:** 16 practicing dental hygienists participated in 8 member focus groups. Prompt questions targeted opinions and practices regarding OPC screenings and tobacco use cessation. Focus groups were taped, transcribed, and analyzed qualitatively for content. **Results:** In most offices, both dentist and hygienist did oral exams. Some limited their exams to high-risk patients while others examined all patients. Not all participants explained to patients that they were doing an OPC exam. 4 major themes arose: 1) The charge of the hygienist was not necessarily to diagnose cancer, but to recognize abnormalities and initiate referral when necessary, 2) The hygienist is only helpful in the tobacco cessation process if the patient has a desire to quit, 3) The hygienist is most effective if the patient believes the provider is genuine and truly cares about the patient's well-being, 4) There is always a need for continued education in oral cancer screenings and tobacco cessation, specifically for hands-on courses. Barriers to performing OPC exams include: financial, time, and insufficient dentist support. Barriers to tobacco cessation include: lack of patient interest, lack of patient education materials and resources, smoking parents of adolescents, personality issues and provider-patient diversity in age, gender, ethnicity, and culture. **Conclusions:** Dental hygienists felt their most important contribution to oral cancer control was patient education and oral cancer awareness. Professional continuing education is important. Barriers need to be addressed to improve oral cancer control efforts. Supported by: NIH DE14413

### ORAL MALODOR

#### 2207 EFFICACY OF AN ESSENTIAL OIL-CONTAINING MOUTHRINSE IN CONTROLLING ORAL MALODOR

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**Objectives:** The primary objective of these two three-week clinical trials was to determine the degree and duration of effectiveness of Cool Mint Listerine® Antiseptic mouthrinse (CMLA) compared to a 5% hydroalcohol mouthrinse (negative control) in reducing and controlling human intrinsic oral malodor using hedonic methodology. **Methods:** The two observer-blind, randomized, parallel-group, controlled clinical trials were designed in accordance with the ADA Acceptance Program Guidelines for Products Used in Management of Oral Malodor. Following IRB approval and screening examinations, qualified subjects with hedonic scores above the threshold value for unpleasant breath were randomized into one of two groups: CMLA or the negative control rinse. Subjects rinsed for 30 seconds with 20 mL of their assigned mouthrinse and were assessed for six post-rinse ratings at 30, 60, 90, 120, 180 and 240 minutes utilizing a nine point hedonic scale. Subjects rinsed with 20 mL of rinse, twice daily, for 30 seconds for 21 consecutive days. At Days 7 and 21, oral malodor assessments were repeated. **Results:** In both studies, CMLA rinse was significantly better than the negative control (p<0.05). The first study demonstrated CMLA effectiveness for up to four hours at Days 1, 7 and 21; the second study showed CMLA effectiveness up to 4 hours on Day 1, up to 2 hours on Day 7 and up to 3 hours on Day 21. Over 80% of the subjects had post-rinse mean hedonic scores <6 (below unpleasant range) at 60 minutes on Days 1, 7 and 21 in the first study and at 30 minutes on Days 1, 7 and 21 in the second study. **Conclusion:** Results of both studies demonstrate that CMLA mouthrinse effectively reduced and controlled intrinsic oral malodor using hedonic methodology in both three-week clinical trials and satisfied the relevant ADA Acceptance Program Guidelines.

## UTILIZATION OF DENTAL CARE

### 0495 ORAL HEALTH AND FOOD INSECURITY IN CANADA

V. MUIRHEAD, **J. MAGGIRIAS**, and D. LOCKER, University of Toronto, Canada

Food insecurity describes circumstances of compromised food quality or quantity. Like oral health, food insecurity is closely associated with income deprivation. **Objectives:** This study assessed the relationship between food insecurity and oral health using data from the Canadian Community Health Survey (CCHS), 2003-2004. **Methods:** The CCHS is a nationwide health survey of persons aged 12 years and older. Secondary data analysis of the CCHS subset included 134,000 individuals who completed both food insecurity and oral health questions. Food insecure household individuals gave "often" or "sometimes" responses to any of the three food insecurity flag questions asking about household experiences in the previous 12 months: (1)"Worried there would not be enough to eat;" (2)"Did not have enough to eat" and (3)"Did not eat desired quality of food." Oral health questions included tooth extractions due to caries or periodontal disease, toothache and oral/facial pain prevalence, self-reported oral health status, frequency of dental visits, toothbrushing frequency and dental insurance coverage. The data subset also included total personal and household income variables. **Results:** Food insecure household individuals made fewer visits to the dentist and were more likely to report cost as a barrier to dental visits than food secure household individuals ($p<0.001$). Fewer food insecure household individuals were covered by dental insurance ($p=0.001$). Food insecure household individuals had lower self-perceived oral health ratings than food secure individuals ($p<0.001$) but comparable toothbrushing frequency. Multiple logistic regression analysis controlling for income showed that food insecure individuals were more than two times more likely to report "bleeding gums"(OR=2.26, 95% CI:2.02-2.52), toothaches (OR=2.58, 95% CI: 2.31-2.87) and mouth or tooth pain (OR=2.14, 95% CI:1.88-2.44) than food secure individuals. **Conclusion:** Food insecure household individuals are a dentally vulnerable group.

## DENTAL ANXIETY

### 2745 DENTAL ANXIETY AND PAIN RELATED TO DENTAL HYGIENIST TREATMENT

**M. HAKEBERG**, Jönköping university, Sweden

Studies concerning patients' experiences of dental hygienist (DH) treatments with regard to dental anxiety and pain are scarce. **Objectives:** The aim of this study was to evaluate different groups of patients' self-reported assessments of dental anxiety and pain related to various routine dental hygienist procedures. **Methods:** A convenience sample of 409 patients from general practices, specialist clinics of periodontology and oral medicine as well as a student hygienist clinic were consecutively asked to participate by answering a battery of questionnaires. The Dental Anxiety Scale and a verbal rating scale (1-5; no pain-extreme pain) were used to assess levels of perceived pain in relation to polishing, probing pocket depth, scaling (manual and ultrasonic) and local anesthesia. **Results:** Women reported higher fear than men with regard to dental hygienist treatment (7.1% vs 3.9%;$p=0.013$), however patients were revealing higher dental anxiety levels for treatments performed by dentists as compared to dental hygienists, 11.6% and 5.6% of the sample, respectively. Patients treated at the Periodontology clinics were more dentally anxious for DH-treatment as compared to the other clinics ($p=0.002$). The most painful ( procedures were probing, local anesthesia, manual and ultrasonic scaling with a reported frequency between 7.1%-8.6%, respectively while a polishing procedure only revealed 0.8%. There were proportionally more dentally anxious individuals reporting extreme perceived pain for all DH-treatments except for the polishing procedure. **Conclusion:** Fear of dental hygienist treatment procedures were frequent in this sample, but fear of dental care performed by a dentist was reported more often as compared to fear of dental hygienist treatment.

## ORAL HEALTH

### 2132 ADEQUACY OF ORAL HEALTH INFORMATION PROVIDED TO DIABETIC PATIENTS

**H.K. YUEN**, K.M. MAGRUDER, D. BANDYOPADHYAY, C.F. SALINAS, E. SLATE, and S. LONDON, Medical University of South Carolina, Charleston, USA

**Objectives:** The purpose of this study is to investigate the adequacy of oral health information provided by dental hygienists to people with diabetes. **Methods:** 228 completed surveys were collected from a random sampling mailing to dental hygienists practicing in South Carolina. The survey queried dental hygienists on the adequacy of oral health information they provided to patients with diabetes, reasons for inadequate coverage of materials, amount of time spent on educating diabetic patients, and frequency of recommending oral hygiene products. **Results:** Approximately 95% of dental hygienists reported that they adequately covered plaque control and proper oral hygiene; however, only 25%-28% requested their diabetic patients to demonstrate recommended brushing and flossing techniques. About two-thirds of the respondents indicated that they often recommend power toothbrushes and adapted interdental aids to their diabetic patients, and about 60% indicated that they do not cover all essential materials related to oral health when educating patients with diabetes. The proportion of hygienists who feel they covered all essential materials related to oral health was significantly greater among those who report spending more time educating their patients than those who do not spend extra time (P-value = 0.021). The proportion of hygienists who do not have sufficient information on oral care and diabetes was significantly greater among those who feel they have not covered the topic of periodontal disease than those who feel they have adequately covered the topic (P-value < 0.05). **Conclusion:** In order to improve the adequacy of oral health information for people with diabetes, dental hygienists need to have sufficient information and sufficient time. This study points to the need for continuing education concerning diabetes and oral health for dental hygienists, as well as novel ways (e.g., video demonstrations) to teach patients efficiently.

This project was supported by NIH Grant Number P20 RR-017696.

## INFECTION CONTROL

### 1137 DENTAL HYGIENISTS: INFECTION CONTROL PRACTICES IN ONTARIO

**M.R. DARLING**, and G.M. MCCARTHY, University of Western Ontario, London, Canada

**Objectives:** The SARS outbreak and increase in drug-resistant microorganisms have increased scrutiny of recommended infection control practices (RICPs) in Ontario. This study investigated dental hygienists' compliance with RICPs. **Method:** Questionnaires were mailed to a random sample of hygienists listed by the College of Dental Hygienists of Ontario (n=500), using Dillman's method with three follow-up attempts. SPSS-PC+ was used for data analysis. Response rate was 68%. **Results:**

| RICP | Compliance (%): |
|---|---|
| Hand Hygiene Practices (HHP-pre & post-treatment) | 81% |
| Barriers: | |
| Gloves: | 100% |
| Masks: | 96% |
| Protective Eyewear: | 79% |
| Protective Uniform: | 82% |
| HBV Immunization: | 97% |
| Additional Precautions For HIV Patients: | 56% |

| Combinations of RICPs | Compliance (%): |
|---|---|
| Barriers | 74% |
| Barriers, HHP | 54% |
| Barriers, HHP, HBV immunization (+serology) | 45% |
| Barriers, HHP, HBV immunization, appropriate heat-sterilization | 33% |
| Barriers, HHP, HBV immunization, appropriate heat-sterilization, safe handling of sharps | 27% |
| Barriers, HHP, HBV immunization, appropriate heat-sterilization, safe handling of sharps, infection control manual | 19% |
| Barriers, HHP, HBV immunization, appropriate heat-sterilization, safe handling of sharps, infection control manual, post-exposure protocol | 14% |

**Conclusion:** Although rates of gloves and masks use were >95%, many hygienists appear non-compliant with Standard Precautions. Interventions are required to improve compliance with RICPs and reduce cross infection within the dental office. Funding was received from London Health Sciences Centre Research Institute.

### 2879 IMMUNIZATION AGAINST INFECTIOUS DISEASES AMONG DENTAL HYGIENISTS IN CANADA

G.M. MCCARTHY, M.R. DARLING, and L. STITT, University of Western Ontario, London, Canada

**Objective:** There is increasing concern about the ability to control infectious diseases especially newly-evolving strains of influenza. We conducted a national survey of dental hygienists including investigation of immunizations. **Methods:** The instrument was developed and tested using focus groups, test-retests and a pilot study. Questionnaires were mailed to a random sample of dental hygienists licensed by the Provincial/Territorial Colleges in Canada (n=5,900) and stratified by province. A modification of Dillman's guidelines for administration of mailed surveys was used with two additional mailings to non-respondents. Descriptive statistics were obtained using SPSS/PC+. **Results:** The response rate was 56%. HBV immunization was reported by 98.5% of respondents (of these, 70% reported post-immunization serology); 59% of respondents reported anti-HBs titers of >10 mIU (3% <10 mIU) and 0.2% reported naturally-acquired immunity. Hygienists reporting immunity (in %)were as follows:

| Infectious Disease | Hygienists Reporting Immunity (%) |
|---|---|
| Hepatitis A virus | 22 |
| Measles | 91 |
| Mumps | 83 |
| Rubella | 88 |
| Influenza | 38 |
| Varicella | 79 |
| Diphtheria | 81 |
| Tetanus | 91 |
| Polio | 87 |
| BCG | 40 |

**Conclusions:** It is clear that many hygienists are vulnerable to infectious diseases that can be prevented by immunization, and that dentists can play an important role in improving compliance. Although rates of HBV immunization are very high, only 60% reported knowing that they had adequate anti-HBs titers, raising concerns about a false sense of security for many. The low rates of immunization to influenza are worrying because of the threat of an influenza pandemic and this problem needs to be emphasized. Better awareness and implementation of comprehensive immunization of dental professionals are essential to reduce transmission risks. This study was funded by the Canadian Institutes of Health Research.

## MICROBES AND ORAL INFECTIONS

### 1162 EFFECT OF XYLITOL ON A MODEL OF ORAL BIOFILM

M.-C. BADET, U.F.R. of Odontology, Bordeaux Cedex, France

**Objectives**: The aim of the present study was to examine whether xylitol, at different concentrations, inhibits the formation of an experimental model of oral biofilm. **Materials and methods:** Biofilms of six bacterial species (Streptococcus mutans, Streptococcus sobrinus, Lactobacillus rhamnosus, Actinomyces viscosus, Porphyromonas gingivalis, Fusobacterium nucleatum) were prepared on hydroxyapatite (HA) discs following the Zürich model. Xylitol was tested at a concentration of 1% and 3%. At the end of their designated incubation times, some HA disc were destined for laser scanning microscopy (CLSM) and other were scraped with a sterile surgical instrument. Aliquots of harvested biofilm were diluted and plated onto specific media. After a 48 hrs anaerobic incubation at 37°C, colony-forming units were counted. **Results:** CLSM showed that only poor quantity of isolated bacteria was observed on the surface of hydroxyapatite discs. Culture of harvested biofilm showed an inhibition of the growth of the different species included in the biofilm. **Conclusions:** There is a clear inhibiting effect of xylitol on the formation of the experimental biofilm. This study shows that xylitol is not only efficient on the acid production of cariogenic bacteria, but also on the formation of a multispecies biofilm; it confirms the relevance of the use of this polyol for the prevention of oral diseases caused by dental plaque.

## PERIODONTOLOGY

### 1850 THE EFFECTS OF PERSONALIZED PREVENTION PLANS ON ORAL HEALTH BEHAVIORS

R.M. MIZUMOTO, C.A. DEMKO, and L.T. VERNON, Case Western Reserve University, Cleveland, OH, USA

**Objective:** Evaluate the clinical and behavioral effects of personalized prevention plans (PPP) in a cohort of HIV+ individuals. **Methods:** 22 HIV+ people were recalled from an earlier study to qualitatively and quantitatively assess changes occurring after delivery of PPP. At recall, subjects were asked what they remembered and what oral hygiene behavior (OHB) changes they made since baseline. Probing depths $^{3}$ 4.0 mm at baseline were assessed on an average of 38 sites per subject. All subjects received a hands-on coaching session focusing on targeted OHB techniques. Subjects self-rated their motivation and confidence to make future OHB changes using a 10-point Likert scale. **Results:** On average, subjects reported making 3.5 specific OHB changes since written and spoken exposure to a baseline PPP. Elements of knowledge, optimism, interest, and concern about oral health increased in 20 of 22 subjects. Enhancements were reported in frequency of flossing (50%) and tooth-brushing (45%); tooth-brushing technique (50%); and eating habits (27%). 95% attributed OHB changes to PPP. 41% of sites improved; 26% worsened, 33% were unchanged. Compared to smokers, non-smokers were more optimistic about their oral health ($\chi^2$=.024) and more likely to change their OHB (p=.009). On the Structured Behavior Change Scale, ratings of motivation and confidence were highest for brushing (9.56; 10.0) and flossing (7.7; 8.32) and lowest for use of a proxy brush (5.0; 4.0). All subjects reported increased knowledge with hands-on OHB coaching at recall. 91% of subjects reported that hands-on coaching was more helpful than the baseline visit. **Conclusions:** In an HIV-1 cohort, PPP effectively enhanced oral health related knowledge and improved OHB's. This study suggests that the use of PPP and OHB coaching can be effective tools to enhance oral home care; providers should encourage incremental change in an ongoing, targeted and personalized manner. Supported by NIDCR, DE15746-01A1.

With respect to claims payments Alberta Blue Cross will pay claims. Nationally, Sun Life, will pay most claims, although some policies still include the "supervision by a dentist" wording because of employer plans or because some of the old policies created by Clarica have the supervisory wording. The other two big, national players are Great West Life and Manulife. We are working with these companies and also communicating with the Canadian Life and Health Insurance Association to promote access to care by dental hygienists. The proclamation in Ontario on September 1, which provides dental hygienists in Ontario with the ability to practice independently, will certainly draw the attention of these third-party payers. The federal-government benefit plans for civil servants, retirees and veterans all are now accepting dental-hygienists claims.

To keep informed of changes to third-party payment, I urge you to go to CDHA's members-only website, update your profile and ensure that we have your current email address. Our regular email news updates will keep you up to date. Please feel free to call me at any time should you wish a personal update or should you be experiencing any particular challenges. I am also very happy to hear success stories!

Best wishes as you actively consider your career options with an expanding array of opportunities to define your path forward.

# Oral Health Care: A Necessary Public Good—Now and into the Future

## *A Brief Submitted to the House of Commons Standing Committee on Finance, August 15, 2007*

*By the Canadian Dental Hygienists Association*


### EXECUTIVE SUMMARY

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION (CDHA) highlights the poor oral health of a considerable portion of the Canadian population and requests that the federal government consider providing oral-health promotion and disease prevention as a public good for specific groups of citizens, including children, seniors, persons with disabilities and low-income individuals. A widening income gap in Canada, an increasing rate of early childhood caries and a reduction in retirees' dental benefits are some of the factors supporting the need for the government to add oral-health care to the list of public goods.


***In Canada, 39% of Canadians report a need for oral-health services, but do not receive care due to the cost.***

Compelling support for this request comes from the stories of individuals. A 25-year-old experienced social stigma and could not find work due to severe dental decay that left him with only two healthy teeth. A man who could not afford dental treatment suffered blindness related to a dental infection that spread to his eyes. There is also a tragic story of a child who died because of a tooth infection that spread to his brain. This brief also documents the history of appeals to the government for responsibility in the area of oral-health care, from the 1964 Royal Commission on Health Services to the current, growing number of oral-health coalitions calling for a health-care system that puts prevention first.

### ESTABLISHING THE NEED FOR ORAL-HEALTH CARE

For the most part, oral-health care in Canada is fee-for-service, with a small number of low-cost clinics and a patchwork of municipalities that offer limited public-health programs. The current fee-for-service, private-practice delivery model does not ensure adequate oral health for a sizeable portion of the population, including many low-income families, seniors who have lost their dental benefits and persons with disabilities. A joint Canada–U.S. study confirms that access to oral-health services is associated with access to dental insurance. The 2004 study reports that more than 70% of individuals with dental insurance in Canada visited the dentist in the past 12 months, compared with 47% of those without insurance.[1]

Children are a particularly vulnerable group if they are living in low-income families. In 2000, the U.S. Surgeon General's report on the nation's oral health confirms that low-income individuals are the most vulnerable to oral diseases.[2] The widening income gap in Canada means that low-income families are at a considerable disadvantage in their ability to afford oral-health care. In Canada, among the 10% of families with the lowest incomes, average family market income fell by 11% from 1989 to 2004.[3] It is becoming increasingly difficult for low-income families to afford oral-health care.

Tooth decay or early-childhood caries (ECC) in young children declined for a number of years, but is now on the rise again. Although data on trends in oral-health status are lacking in Canada, they are likely similar to those in the United States. In the U.S., tooth decay is on the rise in pre-school children aged two to five and adults are reporting less access to oral-health care compared to a year earlier.[4] Depending on severity, ECC may affect behaviour, diet, permanent tooth formation and overall growth and development. ECC also affects behaviour, as children deal with the associated pain, suffering and facial disfiguration. Oral-disease prevention can reduce compounded costs associated with restorative work for aging dental fillings.

A lack of access to oral-health care means more than simply having a painful tooth; there can be serious health consequences. Moses Han, an Oakville, Ontario, convenience-store owner could not afford the cost of a root canal to address tooth decay; the oral infection spread through his body, causing blindness.[5] Our society has overlooked oral health as an essential component of overall health and quality of life. Research shows other links exist between oral diseases and systemic diseases, including heart and lung disease, diabetes and pre-term, low-birth-weight babies.[6,7]

Jones, a 25-year-old Toronto resident, faced severe pain due to dental decay and, without dental insurance to cover costly restorative work, resorted to the least costly solution of having all but two teeth removed. His toothless grin hampered his ability to find work. The public responded to his plight and after $10,500 worth of dentures with implants, he now has a job with a boilermaker's union.[8] Early assistance was critical in this case, as an absence of teeth means that underlying bone gradually deteriorates, leaving insufficient bone to support implants.

# Soins de santé buccodentaire : un bien collectif nécessaire aujourd'hui et dans l'avenir


## SOMMAIRE

L'Association canadienne des hygiénistes dentaires (ACHD) tient à attirer l'attention sur la mauvaise santé buccodentaire d'une partie considérable de la population canadienne et demande que le gouvernement fédéral considère l'offre de programmes de promotion de la santé buccodentaire et de prévention des maladies buccodentaires comme un bien collectif pour des groupes spécifiques, soit les enfants, les personnes âgées, les personnes ayant un handicap et les personnes à faible revenu. De nombreux facteurs justifient la nécessité d'ajouter les soins de santé buccodentaire à la liste des biens collectifs, notamment l'écart grandissant des revenus au Canada, le taux croissant de la carie chez les jeunes enfants et la réduction de la couverture de soins dentaires assurée aux personnes retraitées.

Dans son mémoire, l'ACHD évoque des cas troublants qui sont autant de plaidoyers en faveur de sa demande. Elle mentionne entre autres le drame humain vécu par un jeune homme de 25 ans stigmatisé et incapable de se trouver du travail à cause d'un grave problème de carie dentaire qui ne lui laissait que deux dents saines; celui d'un autre homme devenu aveugle après qu'une infection dentaire se soit propagée jusqu'aux yeux parce qu'il n'avait pas les moyens de se payer le traitement approprié; et le cas tragique d'un enfant qui est décédé parce qu'une infection à une dent s'était propagée jusqu'au cerveau. Ce mémoire retrace également les démarches répétées entreprises auprès du gouvernement pour une prise en charge dans le domaine de la santé buccodentaire. Les premières demandes ont été faites dès 1964, lors de la Commission royale d'enquête sur les services de santé et, aujourd'hui encore, un nombre croissant de coalitions en santé buccodentaire réclament un système de soins de santé qui donne la priorité à la prévention.

L'ACHD recommande que le gouvernement fédéral prenne les mesures suivantes pour garantir que la promotion de la santé buccodentaire et la prévention des maladies buccodentaires deviennent un bien collectif :

- *Travailler en collaboration avec les provinces et les territoires pour assurer le leadership, les politiques et le financement (36 % des dépenses totales en santé buccodentaire, soit 3 579 millions de dollars) nécessaires à la mise en place de programmes de promotion de la santé buccodentaire et de prévention des maladies buccodentaires à l'intention des Canadiens et des Canadiennes à faible revenu, y compris ceux et celles qui reçoivent des prestations d'aide sociale et ceux et celles qui travaillent, les enfants, les personnes ayant un handicap et les personnes âgées;*
- *Accorder le statut de programme complet à l'Initiative en santé buccodentaire des enfants, un programme destiné aux Premières Nations et aux Inuits.*


***CDHA's vision is a health-care system that capitalizes on oral-health promotion and disease prevention as a cost-effective way to avoid dental decay and reduce the need for costly restorative work.***

A final tragic story describes a Maryland boy, whose abscessed tooth lead to a severe brain infection and eventual death. His mother had no dental insurance and could not afford to pay for oral-health services.[9]

These stories may seem to be isolated examples that have come to our attention through the media, but there are similar stories from other low-income Canadians of all ages who cannot afford oral-health care. In Canada, 39% of Canadians report a need for oral-health services, but do not receive care due to the cost.[10]

Seniors also experience an inability to access oral-health services.[11] In the past, approximately 50% of Canadian employers—primarily larger, unionized companies—provided post-retirement non-pension benefits. However, recent reports indicate that these employers are increasingly withdrawing these important benefits from their former employees. A survey of 500 company-sponsored retirement plans indicates that over the past three years, 18% of employers have reduced non-pension benefits, including dental benefits, offered to retired employees and nearly 25% plan on doing so in the next three years.[12] In addition, Bell Canada recently announced elimination of dental-care benefits for future retirees, due to high benefit costs.[13] This withdrawal of dental services across a number of businesses, including profitable businesses such as Bell Canada, combined with an aging population, suggests the potential for a significant negative impact on seniors' oral health.

## ORAL-HEALTH CARE AS A PUBLIC GOOD

CDHA's vision for oral health in Canada is about modernizing the health system and addressing pressing oral-health needs. We are not recommending a "sick care" system, which only addresses oral diseases after they occur, but a system that capitalizes on oral-health promotion and disease prevention. This is a cost-effective way to reduce the need for costly restorative work and to avoid the human suffering associated with dental decay and loss of teeth.

Investing in promotion and prevention will contribute to a strong economy because good oral health contributes to good physical health and self-esteem, which are required to secure productive employment. This oral-health-care investment can reduce oral-health expenditures to address dental decay in the long term. There also are benefits for the broader health system. The links between oral diseases and systemic diseases suggest that oral-disease prevention could reduce downstream costs associated with costly chronic diseases.

The following oral-health expenditures show who pays for what nationally and internationally. In 2006, out of a total of $9,943 million in dental expenditures in Canada, $488.9 million was publicly funded dental care, $3,622 million was out of pocket and $4,883 million was funded by private dental-insurance companies. As a proportion of total oral-health care expenditures, publicly funded oral-health care has decreased from 5.8% in 1999 to a low of 4.9% in 2006.[14] Figures from 2005 indicate Canada has the second-lowest per capita *public* oral-health expenditures of all OECD countries (Canada 4.6%, Germany 68%, and France 36%).[15] Furthermore, of the 4.6% we do spend on oral public health, the majority is provincial (61%), not federal (39%). In addition, most of federal spending is for First Nations and Inuit oral-health services. A strong commitment to investing in oral health could make Canada an international leader in oral health.

New voices are joining the chorus of appeals for federal government investment in oral health. There is now a broad and varied social interest in seeing equitable access to oral-health care. As early as 1964, Mr. Justice Hall's Royal Commission on Health Services recommended the placement of oral-health services within the medicare system. In 2004, the City of Ottawa passed a resolution calling for the federal government to develop universal access to oral-health services. In 2004, the Federation of Canadian Municipalities passed a motion calling for the Government of Canada to develop a "comprehensive National Oral Health Strategy that would have as its goal, providing universal access of both preventive and treatment services to all Canadians."[16] In August 2005, the federal/provincial/territorial dental directors developed a *Canadian Oral Health Strategy*, calling for federal-government leadership to deliver oral-health promotion and disease-prevention programs and services.[17] In 2006, the National Anti-Poverty Organization requested a national, basic dental-care program during the government's pre-budget consultations.[18] In 2007, Ontario's Community and Social Services Minister, Madeleine Meilleur, called for a "national dental strategy that provides provinces with money, because Ontario cannot afford to provide the dental equivalent of medicare on its own."[19] Furthermore, the Ontario Oral Health Alliance, which comprises grassroots coalitions representing 13 regions across Ontario, is advocating for an oral-health system that puts prevention first.[20]

***The links between oral diseases and systemic diseases suggest that oral-disease prevention could reduce costs associated with chronic diseases.***

CDHA commends the federal government for two pilot projects, including the National Paediatric Surgical Wait Times Pilot for dental treatment requiring anaesthesia and the First Nations Inuit Health Branch, Childrens' Oral Health Initiative (COHI). Oral-health promotion and disease prevention should accompany the Surgery Wait Times Pilot, as a cost-effective method to reduce future wait times. COHI's goal is to deliver oral-health promotion and disease prevention to pregnant mothers, children, families and caregivers, in order to curb the high rate of oral disease among First Nations and Inuit people. Extending the reach of this program to a greater number of communities and granting it full program status would allow a greater number of people to experience the benefits of improved oral health.

Providing oral-health promotion and disease prevention for children is the right thing to do, as no child should endure the pain and suffering associated with oral

diseases. It is also the right thing to do for other vulnerable populations, such as the working poor, seniors and person with disabilities, in order to prevent the tragic diseases, deaths and disfigurements described above.

## RECOMMENDATIONS

CDHA recommends that the federal government take the following action to ensure that oral-health promotion and disease prevention become a public good:

- *Work together with the provinces/territories to provide leadership, policies and funding* (36% of total oral-health spending, or $3,579 million) *for national oral-health promotion and disease-prevention programs for low-income Canadians, including those receiving social assistance and those working, children, persons with disabilities and seniors; and*
- *Grant full program status to the Childrens' Oral Health Initiative within the First Nations and Inuit Health Branch.*

## ENDNOTES


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# Think again about joining the CDHA Long-term Disability Plan

Imagine that you finally had the money and bought yourself that fire-engine red Mustang you've been dreaming about. You wouldn't say to yourself "I'm a very careful driver. I don't really need insurance!" And how many clients have you had who didn't book their dental hygiene appointment because their teeth weren't hurting, only to discover down the road that their oral health has suffered as a result?



How much more important is your livelihood, your ability to maintain your standard of living and take care of those who depend on you? When the sky's blue, you don't think about that leak in the roof; but when it's raining, it's too late to fix it. Too many Canadians have found themselves in serious difficulties because they gambled on their good fortune in not becoming disabled—and lost.

Your financial security and that of your family depends on your ability to work and earn a living. Without adequate financial protection, becoming disabled could mean hard times, with the regular bills that keep coming in and additional expenses related to the disability.

The CDHA Long-term Disability Plan is designed to help you meet your income requirements so you can concentrate on recovering from your disability and returning to an active life.

CDHA encourages you to contact Sun Life at 1 800 669-7921 (416 408-7390 in the Toronto area) for more details. Or, visit the CDHA member website at www.cdha.ca to review the plan, use the premium estimator, and print an application form. You will have to complete a medical questionnaire and be approved by the insurer, as well as answering financial and employment questions, before coverage can begin.

# CDHA 2007 Dental Hygiene Recognition Program

The CDHA is pleased to announce the 2007 Dental Hygiene Recognition Program. This program, made possible through the contributions of CDHA Corporate Partners, is designed to recognize distinctive accomplishments of member dental hygienists and dental hygiene students. Entry details are available on CDHA's members' website, www.cdha.ca, under the "*Networking and Recognition*" section. The deadline for the submission of prize applications is **November 30, 2007**.

| | PRIZE CATEGORIES |
|---|---|
| Crest Oral-B | **Crest Oral-B/CDHA Dental Hygiene Diploma Student Prize**<br>One $1,000 prize to be awarded to a dental hygiene student in a diploma program for contributing to the advancement of the profession in the context of educational and volunteer activities. |
| Crest Oral-B | **Crest Oral-B/CDHA Dental Hygiene Baccalaureate Student Prize**<br>One $1,500 prize to be awarded to an undergraduate dental hygiene student for contributing to the advancement of the profession in the context of educational and volunteer activities. |
| Crest Oral-B | **Crest Oral-B/CDHA Oral Health Promotion Prizes**<br>The following three prizes are awarded for the creative promotion of the dental hygiene profession. Entries will be judged on the basis of creativity, planning, volunteer recruitment, educational elements, community impressions and impact as well as innovative partnerships: 1. Individual prize of $1,000; 2. Clinic Team prize of $2,000; 3. Dental Hygiene Schools prize of $2,000<br>* Half of each health promotion prize will be shared with the winner's local dental hygiene chapter. |
| Dentsply | **Dentsply/CDHA Leadership Prize**<br>One $2,500 prize to be awarded to a student enrolled in a dental hygiene program in recognition of a significant contribution to the local, academic or professional dental hygiene community through involvement and leadership. |
| Johnson & Johnson | **Johnson & Johnson/CDHA Community Health Prize**<br>One $3,000 prize to be awarded to a student, or group of students, enrolled in the final year of a dental hygiene program in recognition of the commitment to improving oral health through community service by implementing an innovative community oral health project. |
| Philips Sonicare | **Philips Sonicare/CDHA Professionalism Prize**<br>One $2,500 prize in recognition of a graduating dental hygiene student who has demonstrated distinguished professionalism throughout his/her dental hygiene education. |
| Sunstar G.U.M. | **Sunstar/G.U.M./CDHA Achievement Prize**<br>One $2,000 prize to be awarded to a student enrolled in the final year of a dental hygiene program who has overcome a major personal challenge during his/her dental hygiene education. |
| Sunstar G.U.M. | **Sunstar/G.U.M./CDHA Global Health Initiative Prize**<br>One $3,000 prize in recognition of a registered dental hygienist who has committed to volunteering as part of an initiative to provide oral health related services to persons in a disadvantaged community or country. |
| TD Meloche Monnex | **TD Meloche Monnex/CDHA Visionary Prize**<br>One $2,000 prize awarded to a student currently enrolled in a Masters or Doctoral program related to dental hygiene in recognition of a vision for advancing the dental hygiene profession. |

**A Year of Opportunities** *(continued from page 211)*

When Canada was chosen to host this year's International Federation of Dental Hygienists (IFDA) Symposium, CDHA played a key role in ensuring a successful and well-attended event. The symposium was a wonderful gathering of various cultures coming together to learn more about dental hygiene. There were many opportunities to share ideas and look at the profession from a new perspective. Speakers shared their depth of experience and so enhanced our knowledge. Presentations included a future vision for dental hygiene, risk of atherosclerosis in women with a high amount of dental plaque and severe gingival inflammation, nationwide periodontal screening as part of health examinations in Austria and dental-hygiene residential care in a three-year dental-hygiene education program in Japan, to name but a few.

As part of our support for IFDH, two CDHA representatives have been chosen to sit on the federation's House of Delegates, filling a senior and a junior position. Patty Wickstrom, one of our past presidents, has become the senior representative. Patty has represented CDHA at the last two IFDH meetings in Spain and Australia. Alison MacDougall is the newly appointed junior representative. Both women share an enthusiasm for, and passionate interest in, global dental-hygiene issues that will serve CDHA well for the next four years. The first meetings took place at the symposium and we are proud to have such talented representation.

I have enjoyed being president of CDHA. My main goal for this year was to reach out to you, the members, in a personal way. The various events CDHA offered this year have provided an opportunity to do just that. I am always struck by the friendly way dental hygienists respond in large gatherings. I appreciate the opportunity to have represented you in a number of situations. Also, I have represented the Dental Hygiene Educators of Canada on the board and look forward to serving in this position for another three years.

Thank you for all your support this year and I look forward to seeing you at the next CDHA event.

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**Une année fructueuse** *(suite de la page 211)*

les maladies systémiques – comme les cardiopathies, les maladies pulmonaires et le diabète – ainsi que la naissance de bébés prématurés de faible poids. Ce lien est reconnu mondialement comme un élément indissociable de la prévention des maladies dont la prise en compte aidera, en bout de ligne, à améliorer la santé des gens à l'échelle mondiale.

Lorsque le Canada a été choisi pour être l'hôte du symposium de l'International Federation of Dental Hygienists (IFDA) cette année, l'ACHD a déployé d'importants efforts pour en assurer la réussite. Le symposium a été un rassemblement magnifique de personnes de diverses cultures qui sont venues en apprendre davantage sur l'hygiène dentaire. Elles ont eu de nombreuses occasions de partager des idées et d'envisager la profession dans une nouvelle perspective. Les conférenciers ont partagé leur vaste expérience et, par le fait même, amélioré nos connaissances. Les exposés ont porté, entre autres, sur une vision d'avenir pour l'hygiène dentaire, sur le risque d'athérosclérose chez les femmes présentant un niveau élevé de plaque dentaire et une inflammation gingivale grave, sur le dépistage parodontal comme partie intégrante des examens médicaux à l'échelle nationale en Autriche, et sur l'intégration des soins d'hygiène dentaire en établissement dans un programme de formation de trois ans en hygiène dentaire au Japon.

Dans le cadre de notre appui à l'IFDH, deux représentantes de l'ACHD ont été choisies pour siéger à la House of Delegates (chambres des délégués) de la fédération, à titre de représentante principale et de représentante en second. Patty Wickstrom, l'une de nos anciennes présidentes, est devenue la représentante principale. Patty a représenté l'ACHD lors des deux dernières réunions de l'IFDH tenues en Espagne et en Australie. Alison MacDougal est la représentante en second nouvellement nommée. Ces deux femmes partagent un grand enthousiasme et un intérêt passionné pour les enjeux mondiaux en hygiène dentaire qui seront d'un grand intérêt pour l'ACHD au cours des quatre prochaines années. Les premières rencontres ont eu lieu lors du symposium, et l'Association est fière d'avoir des représentantes d'un tel calibre.

J'ai beaucoup apprécié mon mandat à la présidence de l'ACHD. Je m'étais fixé comme objectif principal, pendant mon mandat, de vous rejoindre, vous, les membres, d'une façon personnelle. Les différents événements qu'a tenus l'ACHD m'ont donné l'occasion de le faire. Je suis toujours impressionnée par la cordialité qui se dégage des hygiénistes dentaires dans les grands rassemblements. J'ai apprécié la possibilité de vous représenter en de nombreuses occasions. J'ai également représenté les éducateurs en hygiène dentaire du Canada au conseil d'administration et j'espère pouvoir servir à ce poste durant trois autres années.

Je vous remercie de votre appui tout au long de cette année, et j'espère vous voir au prochain événement de l'ACHD.

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

AN OPEN LETTER FROM SUSAN ZIEBARTH, EXECUTIVE DIRECTOR OF THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

Dear CDHA members,

# Of all the tools you use in your practice, your CDHA membership may be the most important one. Here's why.

A membership in the Canadian Dental Hygienists Association is about more than just **exceptional insurance coverage**, **great member discounts** and **extraordinary networking** events. It's also about you becoming *the best dental hygienist you can be*.

For example, your membership gives you access to the members-only section of our website at www.cdha.ca. Here, you will find information and knowledge that you can *immediately* turn into better care for your clients. Here is just a sample of what's available:

- **Publications** such as the *Canadian Journal of Dental Hygiene*, the dental hygiene *Code of Ethics*, *Dental Hygiene: Definition and Scope of Practice* and *Dental Hygiene: Client's Bill of Rights*.
- **Online Resource Centre** where you can browse publications in four sections: Diseases or Conditions, Lifestyle, Procedures or Therapeutics, or Professional Topics.
- **Online professional development opportunities** on Work and Personal Life Balance, Clinical Tobacco Intervention, The Professional Role, Negotiation, Interpersonal Skills and more.
- **Professional Development Manager** where you can keep track of the continuing-education initiatives you have completed or are in the process of completing.
- **Product Directory** where you can find accurate and up-to-date information on new products or find out about the advantages of existing products. This is very helpful before ordering supplies.

## We've got you covered!

The best value in liability insurance anywhere just got a whole lot better as coverage limits are *increasing* with the 2007 membership renewal:

| | 2006 | 2007 |
|---|---|---|
| *Legal expenses* | $10,000 | **$50,000** |
| *Criminal-defence expenses* | $25,000 | **$100,000** |
| *Loss-of-earnings* | $150 per day | **$500 per day** |

**What *hasn't* increased is the cost to you.**
As always, this coverage is *included* as part of your Active Membership. PLUS... You now have the *option to increase your per-claim liability coverage* to up to $4 million with just a small fee. Call us NOW to find out more!

- **CDHA Boutique** offers CDHA members quality, career-related and lifestyle products at discounted rates. In addition, some vendors are offering unique items designed exclusively for CDHA members. (CDHA is constantly adding new retailers and products so visit the Boutique often. You don't want to miss out on special offers and new products.)

All of this will continue to be available to you—*but only if you renew your membership in the Canadian Dental Hygienists Association*. Please visit the members-only section of our website at www.cdha.ca today to renew.

We look forward to hearing from you!

Sincerely,

Susan Ziebarth
Executive Director, Canadian Dental Hygienists Association

P.S. Renewing now will give you access to everything you need to be your best. And, of course, there are also the **exceptional insurance coverage**, **great member discounts** and **extraordinary networking events!** Go online TODAY to renew. Can you afford *not* to?

**BONUS:**
Renew now and get up to 50% off a GoodLife Fitness membership!

# We've got you covered.

With an active professional membership in the Canadian Dental Hygienists Association, you don't have to worry about liability insurance because we've got you covered.

And here is the best news of all: *it's included as part of your Active membership!*

To learn more about the CDHA insurance plan and the other benefits of membership in your professional association, visit us online at **www.cdha.ca**.

Because while you may need the insurance, you don't need the high cost of purchasing it.

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

# Communicating in Dental Practice: Stress-Free Dentistry and Improved Patient Care

*By Freeman, R., Humphris, G. London: Quintessence; 2006*
*104 pages. ISBN 1850970998*

WE LEARN QUICKLY IN OUR PRACTICE THAT TECHNICAL skills are not all we need to be an effective and proficient dental hygienist. Equally important are our communication skills to be able to work successfully with every client.

*Communicating in Dental Practice: Stress-Free Dentistry and Improved Patient Care* is a must-read for everyone on the oral-health team. Although we may have gained notable communication skills in our everyday experiences, this book provides greater overall insight into specific communication issues encountered in the dental environment. It also offers valuable suggestions and strategies to handle these situations. For example, have you ever wondered what the secret is to diffusing a difficult or demanding client, how to break bad news to a client, how to ensure a dentally anxious client has a positive experience, or how to better encourage adherence to oral-hygiene education? Answers to these questions are explored using psychological and sociological principles to provide a thorough understanding of a variety of client and also *practitioner* behaviours. Other topics discussed include communicating with special-needs clients, detailed health-education theory and practice and preventing and coping with occupational stress. The reader is invited to consider the significant relationship between our workplace stress and failures in communication that occur during our numerous, day-to-day interactions with clients.


The book has nine chapters that provide a good, although somewhat short, overview of topics. References are noted at the end of each chapter for further reading. Although the scope of material presented is broad, the topic of communicating with cultural competence is not discussed specifically.

Many examples and case scenarios are given to demonstrate a variety of situations typically encountered in the dental environment. The reader may find these are so helpful they want more. A few entertaining illustrations have been included to emphasize topics. Frequent model diagrams, point-form lists and process steps summarize and provide quick reference to important ideas.

Ruth Freeman and Gerry Humphris, co-authors, both have PhDs and outstanding credentials. Ruth Freeman, D.D.S., is Chair of Dental Public Health and Director of the Dental Public Health and Behavioural Sciences Programme at Queen's University in Belfast, Northern Ireland. Gerry Humphris has completed his clinical psychology qualification and was a Director of Communication Skills at the University of Liverpool, England. Currently, Dr. Humphris is the Chair of Health Psychology at the University of St. Andrews, Scotland.

The authors have used language and cases that focus specifically on the dentist as practitioner. However, the information, principals and strategies presented are equally suitable and can be readily translated to *all* members of the oral-health team.

This book is very manageable at just over 100 pages. It can be read in a weekend and is sure to enhance your client-communication skills in the future.

*Angela Nuelle, Professor, Dental Programs*
*Algonquin College*

# Fly Like a Bird

IT IS AN EXCITING TIME TO BE A MEMBER OF OUR PROFESSION. Recent legislative changes in several Canadian jurisdictions now allow the establishment of an independent dental-hygiene practice. This means that dental hygienists will be able to provide oral care to many clients who are unable to reach traditional dental offices, such as seniors, the homebound or those living in isolated communities. Prevention is always both financially and ethically more desirable than treatment of disease. As health economist Pran Manga concluded from his research, there is no rationale for dentists' supervision of dental hygienists in terms of client safety and quality of care, among other criteria.[1]

Independent practice for dental hygienists was reported in eight countries by Dr. Patricia Johnson in her 2002 survey report "International Profiles of Dental Hygiene 1987 to 2001: A 19-Nation Comparative Study." Johnson also noted that the issue cited most frequently regarding dental-hygiene practice was the need to improve access to dental-hygiene care. Other comments addressed independent practice and direct billing of dental-hygiene services.

The Gage Canadian Dictionary defines entrepreneurship as *"organizing and managing a business or industrial enterprise, attempting to make a profit but taking a risk of a loss."* As autonomous practitioners and entrepreneurs, dental hygienists will now need to develop the business and marketing skills to complement their role as preventive, oral-health-care professionals. The business environment is challenging and requires energy and hard work. Fortunately, there are many general and specific resources available for any dental hygienist who has an entrepreneurial spirit.

### *Self-Analysis: Is Independent Practice for Me?*

First on the list of recommendations is this "Entrepreneurship Skills Self-Analysis Questionnaire." It will help you decide if you truly have the willingness to take career risks and the determination to overcome obstacles.

http://www.careerccc.org/products/cp_99_e/section4/quiz.html

http://www.jobsetc.ca/content_pieces.jsp?category_id=371&root_id=299&crumb=12&crumb=42&crumb=128&crumb=36&crumb=109&lang=e

### *Statistics and Demographics*

Next, consider the characteristics of the community where you wish to establish your practice. Statistics Canada offers community profiles of value when forming a business plan to present to financial institutions.

http://www12.statcan.ca/english/census06/data/profiles/community/Index.cfm?Lang=E

### *Business Plans, Financing and Marketing*

Canada Business Service for Entrepreneurs offers fact sheets and guides for preparing a business plan, managing legal issues and marketing, as well as links to numerous relevant sites, such as Revenue Canada business registration and the Canadian Business Start-Up Assistant. The service also discusses recruitment, training and employment contracts.

http://www.cbsc.org

The Canadian Business Development Bank is wholly owned by the Government of Canada with the mandate to provide financial and consulting services to small and medium-sized businesses. It may be a good initial contact for financing.

http://www.bdc.ca/en/home.htm

### *Employment Standards and Human Rights*

Human Resources and Social Development Canada has a gateway to all provincial and territorial ministries of labour.

http://www.hrsdc.gc.ca/en/lp/lo/lswe/ls/provincial.shtml

The Canadian Human Rights Commission has a gateway to all Canadian jurisdictions.

http://www.chrc-ccdp.ca/links/default-en.asp

### *Labour Legislation*

The Canadian Association of Administrators of Labour Legislation (CAALL) Resource Library contains workplace information from each Canadian jurisdiction.

http://www.labour-info-travail.org/library_e.shtml

### *Dental Hygiene Legislation and Resources*

The College of Registered Dental Hygienists of Alberta has prepared a handbook entitled *The Informed Entrepreneur: A Primer for the Business of Dental Hygiene*. This manual focuses on the importance of developing a comprehensive business plan.

Contact: info@cfdha.ca

Need to check on professional advertising guidelines? Contact information for all dental hygiene regulatory authorities can be found here:

http://www.cdha.ca/content/careers/reg_authorities.asp

By using these resources to explore the world of independent practice, you can start bringing your vision to life. Many community colleges and universities offer small-business management and human-resource management development courses.

CDHA will present a workshop in Toronto in January 2008 on establishing a dental-hygiene practice. Soon, there also will be an online course and certificate program available to our members.

And remember, consulting with a professional who is experienced in business and taxation accounting is always indispensable.

1 Manga,P. The Political Economy of Dental Hygiene in Canada. Report to the Canadian Dental Hygienists Association. Ottawa: 2002

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

# Proxy

The undersigned hereby appoints Carol-Ann Yakiwchuk or, failing her, Bonnie Blank, or instead of the foregoing*

_____

as proxyholder of the undersigned with full power of substitution to attend and vote at the Annual General Meeting of the members of the Canadian Dental Hygienists Association on October 20, 2007 and at any adjournment thereof (each a "Meeting") with the same powers as if the undersigned were personally present. This proxy revokes any and all previous proxies executed by the member in respect of the relevant Meeting.

Signature of Voting Member _____ Date (please print) _____

Voting Members Name (please print) _____

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

To be valid this proxy must be signed by the Voting Member; and received at the Canadian Dental Hygienists Association, 96 Centrepointe Drive, Ottawa, Ontario, K2G 6B1 (by mail or facsimile to 613-224-7283) not later than 9 am ET October 19, 2007; and shall be valid only for the meeting for which it was specifically given or for any adjournment thereof.

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

# Formulaire de procuration

La personne soussignée nomme par la présente Carol-Ann Yakiwchuk, ou, à défaut, Bonnie Blank, ou, à la place des personnes susmentionnées*,

_____

comme fondée ou fondé de pouvoir avec pleins pouvoirs de substitution pour assister et voter en son nom à l'assemblée générale annuelle des membres de l'Association canadienne des hygiénistes dentaires, le 20 octobre 2007, ainsi qu'à toute reprise en cas d'ajournement de cette assemblée (chacune constituant une « réunion »), avec les mêmes pouvoirs que si la personne soussignée y assistait personnellement. La présente procuration révoque toute autre procuration donnée antérieurement par le membre relativement à l'assemblée en question.

Signature du membre votant _____ Date (en lettres moulées) _____

Nom du membre votant (en lettres moulées) _____

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

Pour être valide, cette procuration doit être signée par le membre votant; elle doit être reçue aux bureaux de l'Association canadienne des hygiénistes dentaires, 96, promenade Centrepointe, Ottawa (Ontario), K2G 6B1 (par la poste ou par télécopieur, au 613-224-7283) le 19 octobre 2007 à 9 h HE, au plus tard; en outre, elle n'est valide que pour la réunion pour laquelle elle a été expressément donnée ou pour toute reprise en cas d'ajournement.

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

NOTICE is hereby given that the annual meeting of the members of **CANADIAN DENTAL HYGIENISTS ASSOCIATION** will be held at CDHA, 96 Centrepointe Drive, Ottawa, Ontario, on Saturday the 20th day of October, 2007, at the hour of 9:00 o'clock in the forenoon, to:

I. receive the financial statement of the corporation for the fiscal period ended April 30, 2007, and the report of the auditors thereon;
II. appoint auditors; and
III. transact such further and other business as may properly brought before the meeting or any adjournment thereof.

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

DATED the 17th day of September, 2007.
BY THE ORDER OF THE BOARD OF DIRECTORS

*Executive Director / Directrice génerale*

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

AVIS est par les présentes donné que l'assemblée annuelle des membres de **L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES** aura lieu à l'ACHD au 96, promenade Centrepointe, à Ottawa (Ontario) le samedi 20 octobre 2007, à neuf heures. En voici l'ordre du jour:

I. recevoir l'état financier de l'Association pour l'exercice ayant pris fin le 30 avril 2007 et le rapport des vérificateurs à ce sujet;
II. nommer les vérificateurs;
III. régler toute autre question dûment soulevée à l'assemblée annuelle ou à toute nouvelle assemblée convoquée en cas d'ajournement de l'assemblée annuelle.

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

FAIT le 17 septembre 2007.
PAR DÉCRET DU CONSEIL D'ADMINISTRATION

**L'exercice autonome de l'hygiène dentaire** ***Une idée qui a fait son chemin*** *(suite de la page 215)*

autonomes. L'ACHD a participé activement au développement de la Norme nationale en matière de réclamation électronique (NeCST), et son travail permettra d'assurer que toutes les normes à venir s'appliqueront aux hygiénistes dentaires. L'ACHD travaille également avec des sociétés informatiques pour que leurs produits répondent à vos besoins et pour qu'elles conçoivent un logiciel de demande de remboursement électronique pour soins d'hygiène dentaire.

L'Alberta Blue Cross accepte les demandes de remboursement. La Sunlife en accepte la majeure partie à l'échelle nationale, bien que certaines polices exigent encore la « supervision par un dentiste » à cause des régimes des employeurs ou parce que certaines polices créées autrefois par Clarica contenaient le terme « supervision ». Nous travaillons avec les deux autres gros joueurs à l'échelle nationale, la Great-West et Manulife, et nous sommes également en contact avec l'Association canadienne des compagnies d'assurances de personnes inc. pour promouvoir l'accès aux soins prodigués par les hygiénistes dentaires.

La proclamation du 1er septembre, par laquelle l'Ontario octroyait aux hygiénistes dentaires de la province le droit de pratiquer de façon autonome, attirera certainement l'attention de ces tiers payeurs. Les régimes d'assurance qu'offre le gouvernement fédéral aux fonctionnaires, aux personnes retraitées et aux anciens combattants acceptent tous maintenant les demandes de remboursement des hygiénistes dentaires.

Je vous invite fortement à visiter la section du site Web de l'ACHD réservée aux membres, à y mettre vos renseignements à jour et à vérifier l'exactitude de votre adresse de courriel pour vous tenir au courant des changements concernant les paiements par des tiers. Nos bulletins électroniques fréquents vous permettront de vous tenir au courant. N'hésitez pas à m'appeler, en tout temps, pour obtenir une mise à jour personnelle ou si vous éprouvez des difficultés particulières. Je suis également toujours très heureuse d'entendre parler de vos réussites!

Mes meilleurs vœux vous accompagnent pendant vous réfléchissez à votre avenir et à l'éventail croissant de possibilités de carrières qui s'offrent à vous.

# Programme de reconnaissance en hygiène dentaire de l'ACHD pour 2007

L'ACHD est heureuse de présenter le programme de reconnaissance en hygiène dentaire pour l'année 2007. Ce programme, rendu possible grâce aux dons des entreprises partenaires de l'ACHD, est conçu pour reconnaître les réalisations distinctives des hygiénistes dentaires et des étudiantes et étudiantes en hygiène dentaire membres de l'ACHD. Les détails concernant les procédures d'inscription sont affichés sur le site Web réservé aux membres de l'ACHA, à la section "*Networking and Recognition*". La date limite pour soumettre les demandes d'inscription aux différents prix est le **30 novembre 2007**.

| | CATÉGORIES DE PRIX |
|---|---|
| Crest Oral-B | **Prix de Crest Oral-B/ACHD destiné aux étudiantes et étudiants diplômés en hygiène dentaire** Un prix de 1 000 $ offert à un étudiant ou une étudiante, inscrit(e) dans un programme en hygiène dentaire menant à un diplôme, pour sa contribution à l'avancement de la profession dans le cadre d'activités éducatives et d'activités de bénévolat. |
| Crest Oral-B | **Prix de Crest Oral-B/ACHD destiné aux étudiantes et étudiants bacheliers en hygiène dentaire** Un prix de 1 500 $ offert à une étudiante ou un étudiant en hygiène dentaire au niveau du baccalauréat pour sa contribution à l'avancement de la profession dans le cadre d'activités éducatives et d'activités de bénévolat. |
| Crest Oral-B | **Prix Promotion de la santé buccodentaire de Crest Oral-B/ACHD** Les trois prix suivants sont offerts pour la promotion créative de la profession de l'hygiène dentaire. Les inscriptions seront jugées selon les critères suivants : créativité, planification, recrutement de bénévoles, éléments éducatifs, impressions et impact sur la collectivité, ainsi que sur la dimension innovatrice des partenariats : 1. Prix individuel de 1 000 $; 2. Prix d'équipe clinique de 2 000 $; 3. Prix d'école d'hygiène dentaire de 2 000 $<br>* La moitié de chaque prix accordé pour la promotion de la santé sera partagée avec le chapitre local de l'association d'hygiène dentaire des gagnantes et gagnants. |
| Dentsply | **Prix Leardership Dentsply/ACHD** Un prix de 2 500 $ offert à un étudiant ou une étudiante, inscrit(e) dans un programme en hygiène dentaire, en reconnaissance d'une contribution significative à la communauté locale académique ou professionnelle de l'hygiène dentaire par son engagement et son leadership. |
| Johnson & Johnson | **Prix Santé communautaire de Johnson & Johnson/ACHD** Un prix de 3 000 $ offert à un étudiant ou une étudiante ou à un groupe d'étudiantes et d'étudiants, inscrit(e)s en dernière année d'un programme en hygiène dentaire, en reconnaissance de son ou de leur engagement pour l'amélioration de la santé buccodentaire dans un service communautaire par la mise en œuvre d'un projet de santé buccodentaire communautaire innovateur. |
| Philips Sonicare | **Prix Professionnalisme de Philips Sonicare/ACHD** Un prix de 2 500 $ offert à un étudiant ou une étudiante sortant d'un programme en hygiène dentaire qui a fait preuve d'un professionnalisme remarquable tout au long de sa formation en hygiène dentaire. |
| Sunstar G·U·M | **Prix Réalisation de Sunstar/G.U.M./ACHD** Un prix de 2 000 $ offert à un étudiant ou une étudiante, inscrit(e) en dernière année d'un programme en hygiène dentaire, qui a surmonté un défi personnel important durant sa formation en hygiène dentaire. |
| Sunstar G·U·M | **Prix Programme de santé mondiale de Sunstar/G.U.M./ACHD** Un prix de 3 000 $ offert à un ou une hygiéniste dentaire autorisé(e) qui s'est engagé(e) comme bénévole dans un programme visant à offrir des services liés à la santé buccodentaire à des personnes faisant partie d'une communauté ou d'un pays défavorisé. |
| TD Meloche Monnex | **Prix Visionnaire de TD Meloche Monnex/ACHD** Un prix de 2 000 $ offert à un étudiant ou une étudiante, actuellement inscrit(e) dans un programme de maîtrise ou de doctorat lié à l'hygiène dentaire, en reconnaissance de sa vision de l'avenir pour l'avancement de la profession de l'hygiène dentaire. |

# Continuing Education Opportunities

©iStockphoto.com/Lise Gagne

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

Obtain a certificate of course completion to satisfy provincial regulatory professional-development requirements. Remember, it is your professional responsibility to be a life-long learner. You can keep track of the continuing education initiatives you have completed or are in the process of completing with the Professional Development Manager at www.cdha.ca/members/content/continuing_education/ProfessionalDevelopment.asp

One of our courses is sure to meet your own specific learning needs. A new online course will be available to CDHA members at no cost from November 1, 2007 until September 15, 2008. Visit the CDHA continuing education site at www.cdha.ca/members/content/continuing_education/ce_home.asp

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## CDHA Featured Online Courses

**Difficult Conversations**

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

**Clinical Tobacco Intervention**

This online course has been developed by the BC Cancer Agency to meet the requirements of a variety of health professionals. The course will enable you, the practitioner, to answer clients' questions about tobacco use with evidence-based recommendations.

**Negotiation**

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

**Interpersonal Skills**

It is imperative for dental-hygiene professionals to develop strong interpersonal skills to work with others more harmoniously and efficiently. Employers, co-workers and clients appreciate individuals who get along well with people at all levels. This course will assist you with improving your interpersonal skills, including communication, problem-solving and teamwork abilities.

**The Professional Role**

Do you sometimes ask yourself, "Am I acting like a professional?" This course will help you to to enhance your professionalism. How you look, talk, write and act at work determines how you are perceived as a professional. Theoretical and practical concepts are presented, along with opportunities for self-reflection and critical thinking.

**Help Your Clients to Stop Gambling With Their Health**

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

**Work and Personal Life Balance**

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

# The Independent Practice

## *What is the Right Risk Protection?*

*By Brian Gomes*

THE LIABILITY-INSURANCE PROGRAM SPONSORED BY the Canadian Dental Hygienist Association (CDHA) through Aon Reed Stenhouse Inc. was established to protect individual dental hygienists from allegations of malpractice while rendering professional services. This comprehensive group program has been tailored to meet the needs of a dental hygienist and provides innovative and flexible enhancements to protect him or her from daily risk exposures.

While legislation of the profession of dental hygiene is evolving in Canada, risk exposures in this field continue to grow. In provinces where dental hygienists can operate an independent practice, or bill under a trade name/number, they must be aware of the additional risk exposures they assume and know how to adequately protect themselves. These exposures are in addition to, and extend beyond, those protected by your own, individual professional-liability policy.

While most professionals carry professional-liability coverage to protect themselves from any "wrongful act," these policies do not provide protection for your corporation, or entity, itself. A *clinic* malpractice insurance endorsement, however, protects the legal entity against allegations of negligence, error or omission that could lead to a professional liability suit against the corporation.

In the event that a client alleges negligence, error or omission in treatment received at a dental-hygiene clinic, both the individual dental hygienist and the legal entity are at risk to be named in a liability suit. The clinic owner is responsible for ensuring that the clinic and staff each carry adequate liability insurance. Based on increasing defence costs and court rewards, the financial impact of liability suits can be devastating to your career, practice, and financial stability.

The most effective action to protect against this type of exposure is to obtain an endorsement or rider that extends malpractice liability coverage to the clinic. The extension is designed for professionals who operate a dental-hygiene clinic or professionals who are self-employed and bill their clients under an independent trade name. This protection has become increasingly common in situations where dental hygienists are operating independent, fixed clinic locations or a mobile independent practice.

It is important for dental hygienists who operate independently to understand and adhere to restrictions and provincial guidelines. Neglecting to do so may jeopardize and/or negate your liability-insurance coverage, leaving you exposed to financial loss.

As legislation continues to develop and define the surroundings and structure in which dental hygienists operate, it is important for you to establish your own risk-management process to mitigate loss potential. Steps to avoid malpractice situations should be taken regardless of the particular setting in which you operate. It is imperative to know and be familiar with your scope of practice, disclose any pertinent information, not to assume guilt, maintain well-documented files, and report any potential claim situations to the applicable coverage provider as soon as you are made aware.

As a CDHA membership benefit, dental hygienists who own an independent practice also have access to an exclusive, discounted office-package policy that includes, property and commercial general-liability coverage for your independent practice at discounted rates.

*A representative at Aon Reed Stenhouse Inc. is available at 1-800-267-9364 to answer any questions you may have about these coverage extensions through CDHA's group program for members.*

*Brian Gomes is an account executive at Aon Reed Stenhouse Inc.*

THE CANADIAN DENTAL HYGIENISTS ASSOCIATION

L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

As the host of the 17th International Symposium on Dental Hygiene (ISDH) held in Toronto, Canada, July 19 – 21, 2007, the Canadian Dental Hygienists Association would like to thank all of the sponsors and exhibitors who participated.

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# Dental Hygiene: Another Perspective

WHO'S HAD MORE HITS THAN ELVIS AND THE Beatles combined? Just about anyone with a video on YouTube. While this incredibly popular website has its share of craziness, what many don't realize is that it has also become a repository for historical information that might not otherwise be seen or shared easily.

So, what does it have to offer dental hygienists? Plenty, as it turns out. A search for "dental hygiene" nets 193 hits while "dental hygienist" gets 191. Dental hygienists? On YouTube? You bet!

While most of the dental-hygiene material—some would argue, most of YouTube—is of limited value, there are some real gems. Let's have a look…

## Blasts from the past

***1. Yuck Mouth (00:30)***
www.YouTube.com/watch?v=aQW8F6BgoPk

In the 1970s, the ABC television network debuted a series of animated 30-second public-service announcements that dealt with healthy nutrition and personal hygiene. The spots featured goofy animation, catchy music and clever lyrics. The series ran for the better part of two decades. The voice of Yuck Mouth was that of Benjamin Sherman "Scatman" Crothers, an American actor, singer, dancer and musician.

Watch this video and then try to get the tune out of your head.

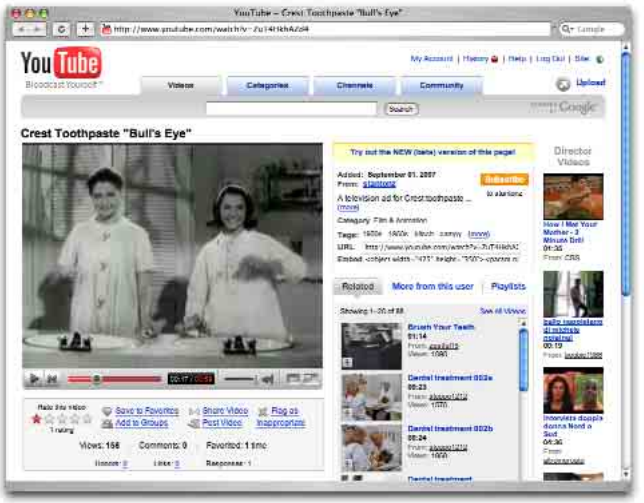
***2. Told by a tooth (10:26)***
www.YouTube.com/watch?v=LGGJ1Rw9uNM

Did you know you should pre-soak your toothbrush for two hours in salt water? And that you should let it dry afterward in the sun? You'd know that if you'd seen this 1939, National Motion Pictures Company film that uses an animated tooth and a voice-over by a little girl to talk about dental hygiene. The trick to good dental hygiene: good nutrition, exercise, lying in the sun, brushing and getting a check-up every four months. (Unless you have dental insurance; then, it's every six—nine?—months…)

***3. Crest Toothpaste***

Here are a few old Crest commercials that are fun to watch (if not remember!).

***a) Bull's Eye (00:59)***
www.YouTube.com/watch?v=ZuT4HkhAZd4
Who is the better archer? More importantly, who has the whiter teeth?




***b) The Addams Family (1:00)***
www.YouTube.com/watch?v=FYBjYeoQPI4
An old favourite with Crest as the main sponsor.

***c) Look, Mom! No cavities! (00:57)***
www.YouTube.com/watch?v=kYswcqjcCn8
You may not have seen this commercial, but no doubt you have heard the punch line. And you'll love the bouncing graphics.

***4. Teeth: Their structure and care (04:50)***
www.YouTube.com/watch?v=tWduiTrMdpE

Interested in seeing how things have changed in 50 years? This film, produced in 1956 for the Northwestern University Dental School, is "considered by the American Dental Association to be in accord with current scientific knowledge." Note the lack of gloves. Interestingly, however, at the end of the film, it touches on something we are back to promoting heavily: that strong connection between oral-health care and overall health.

## A new approach to dental hygiene?

***Will it blend? (2:37)***
www.YouTube.com/watch?v=F3P6nlXhTtk

Not even dental hygiene can escape YouTube's wackiness. In the popular "Will it blend" series, a company called Blendtec shows off its ultra-strong blenders by blending an assortment of things, from an annoying Valentine's Day gift, glow sticks and diamonds to a crowbar, hockey pucks, and a movie.

In this episode, Blendtec offers a new way for Uncle Floyd to take care of his dentures.

# CDHA National List of Service Codes©

TABLE OF CONTENTS

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Intended for the use of provincial dental hygiene associations and dental hygienists authorized by the Canadian Dental Hygienists Association only. Other organizations wishing to use information in this document may only do so after receiving permission in writing from the Canadian Dental Hygienists Association.



96 Centrepointe Drive, Ottawa, ON K2G 6B1

# BACKGROUND

"Dental hygienists are the only health professionals whose primary concern is the prevention of oral disease" (Health and Welfare, Canada, 1988). These registered primary oral health care providers are integral members of the oral health care system. They provide preventive, educational, clinical and therapeutic services and apply a process of care that includes assessment, dental hygiene diagnosis, treatment planning, treatment and evaluation. Registered dental hygienists have a unique body of knowledge, distinct expertise, recognized standards of education and practice, and a Code of Ethics.

The Canadian Dental Hygienists Association (CDHA) is the national professional organization that provides services to its members including continuing education, professional development and representation to various external agencies. The mission of the CDHA is as follows:

> "The Canadian Dental Hygienists Association, as the collective voice and vision of dental hygiene in Canada, advances the profession in support of our members and contributes to the health and well-being of the public."

The content, organization and management of dental hygiene care is guided by the principles of accessibility for all Canadians to comprehensive oral health care and the promotion of oral health as an integral component of general health.

Over ninety percent of dental hygienists in Canada are self-regulating. The regulation of dental hygiene care is the responsibility of provincial dental hygiene regulatory authorities, as mandated by provincial legislation. The legislative trend in health care reform in Canada reflects increased direct access by the public to dental hygiene services.

The CDHA National List of Service Codes described in this document is intended for use by provincial dental hygiene associations for the purpose of selecting codes they wish to incorporate into their fee guides. Assignment of suggested fees to the service codes is not the mandate of CDHA, but rather, the provincial dental hygiene associations. This document also provides the list of service codes and their definitions for dental hygienists using the CDHA National List of Service Codes and for third party dental plan administrators.

As a result of changes in legislation in select Canadian provinces, dental hygienists working in alternative practice settings now have the need to bill their clients directly and/or submit claims, on their clients' behalf, for reimbursement from dental benefit plans. Dental hygienists practicing independently may refer to the appropriate provincial dental hygiene fee guide to assist in billing clients. Direct billing is not intended for use by dental hygienists employed within traditional dental offices or in provinces where direct public access to dental hygiene care has not been legislated.

All codes within the National List of Codes are not necessarily applicable to every province since regulations and scope of practice differ from province to province. It is the ethical, moral and legal responsibility of dental hygienists utilizing these codes to do so in a manner not conflicting with their provincial regulations. Dental hygienists should ensure the services for which they provide and bill are included within their scope of practice. Dental hygienists with questions regarding the scope of practice should contact the provincial dental hygiene regulatory authority for clarification.

## BENEFIT PLAN ACCEPTANCE

The CDHA recommends that benefit plans include dental hygienists as eligible providers. Benefit plan administrators may need to review and adapt their current processes to accommodate dental hygiene claims. The CDHA will continue to work with the benefits industry to support this process.

## CODE SET REVIEW

On an ongoing basis, the CDHA will review the national list of service codes for additions, deletions and revisions. The CDHA encourages input into its review from provincial dental hygiene associations, dental hygienists, benefit plan administrators and other interested parties. Comments should be sent to the Canadian Dental Hygienists Association, 96 Centrepointe Drive, Ottawa, Ontario K2G 6B1.

## GUIDELINES FOR USE

1. The CDHA has organized the service codes in relation to the five phases of care: Assessment, Dental Hygiene Diagnosis, Treatment Planning, Treatment and Evaluation. Dental hygiene services have been classified into the following categories:

   | | |
   |---|---|
   | 00100 – 00499 | Assessment, Dental Hygiene Diagnosis and Treatment Planning |
   | 00500 – 00999 | Dental Hygiene Treatment and Evaluation |

2. Specific service codes may refer to **"units of time"** or other charges. These are defined as follows:

   **"Unit of Time"** – each unit of time is fifteen (15) minutes

   **"+ Lab"** – an additional laboratory expense may be assessed

   **" + E"** – an additional fee may be added for extra expenses incurred

3. Where a specific service code indicates a "tooth number" is required, the two-digit International System of tooth numbering is to be applied. The first digit indicates the quadrant, the second digit indicates the tooth within the quadrant.

   **First Digit Assignment**

   | Permanent Teeth: | | Deciduous Teeth: | |
   |---|---|---|---|
   | Quadrant | "1" – maxillary right | Quadrant | "5" – maxillary right |
   | " | "2" – maxillary left | " | "6" – maxillary left |
   | " | "3" – mandibular left | " | "7" – mandibular left |
   | " | "4" – mandibular right | " | "8" – mandibular right |

   **Second Digit Assignment**

   The first tooth at the midline of the arch is assigned tooth number "1". Counting continues to the third molar assigned tooth number "8". As an example, the permanent maxillary right first bicuspid would be assigned tooth number "14".

   Supernumerary teeth should be assigned tooth number "99".

# CDHA NATIONAL LIST OF SERVICE CODES

## 00100 – 00499 ASSESSMENT, DENTAL HYGIENE DIAGNOSIS AND TREATMENT PLANNING

| 00100 | Dental Hygiene Examination, Complete |
|---|---|
| | **Includes:**<br>a) History – personal, medical, dental, oral health risk factors.<br>b) Vital signs – may include blood pressure, pulse, temperature.<br>c) Extra oral examination of the head and neck includes temporomandibular joint, lymph nodes, symmetry and skin lesions.<br>d) Intra oral examination includes examining the lips, oral mucosa, frena, hard and soft palate, tonsillar pillars, oropharnyx, tongue, floor of the mouth and salivary flow. It may also include oral cytology (collecting cells for pathological evaluation by a specialist) and assessment of edentulous arches.<br>e) Dental examination includes developmental anomalies, risk assessment for caries and carious lesions, existing restorations, missing teeth, twists and rotations, diastemas, contacts, occlusal relationships, parafunctional habits, attrition, abrasion, abfraction, erosion, pulp vitality, sensitivity and pain. The dental examination may include collaboration with a dentist or referral for further care.<br>f) Periodontal assessment includes risk assessment for periodontal disease, bleeding on probing, medications, local contributing factors, history of periodontitis, gingival health, sulcus depths, adequacy of attached gingiva, gingival inflammation, signs of disease progression: recession, clinical attachment level, furcation involvement, tooth mobility, occlusal trauma, mucogingival conditions, radiograph interpretation and referral as necessary.<br>g) Self-care assessment includes oral hygiene and possibly microbiological assessment, general health activities and nutrition related to oral health.<br>Radiographs are not included. Radiographs are described in section 00200.<br>The dental hygienist may not use more than one examination from section 00100 at the same visit (e.g., cannot use both 00113 and 00115). |
| 00111 | Dental Hygiene Examination – Complete: Primary Dentition |
| | Full mouth dental hygiene examination and dental hygiene assessment on primary dentition, recording history, charting, treatment planning and case presentation, including above description as per 00100. |
| 00112 | Dental Hygiene Examination – Complete: Mixed Dentition |
| | **Includes:**<br>a) Full mouth dental hygiene examination and dental hygiene assessment on mixed dentition, recording history, charting, treatment planning and case presentation, including above description as per 00100.<br>b) Eruption sequence, tooth size-jaw size assessment. |
| 00113 | Dental Hygiene Examination – Complete: Permanent Dentition |
| | Full mouth dental hygiene examination and dental hygiene assessment on permanent dentition, recording history, charting, treatment planning and case presentation, including above description as per 00100. |
| 00114 | Dental Hygiene Examination – Complete: Edentulous (both arches) |
| | Full mouth dental hygiene examination and dental hygiene assessment of edentulous arches, recording history, charting, treatment planning and case presentation, including above description as per 00100. |
| 00115 | Dental Hygiene Examination – Complete: Periodontal |
| | Full mouth dental hygiene examination and dental hygiene assessment (with emphasis on periodontal issues), recording history, charting, treatment planning and case presentation, including above description as per 00100. |

**00120 Dental Hygiene Examination, Previous Client**

00121 Dental Hygiene Examination: Reassessment/Recall

Dental hygiene examination with mirror and explorer of hard and soft tissues, which may include checking of occlusion and appliances (but not including specific tests) and periodontal probing (either screening and/or full mouth periodontal probing depending on the client). Update of services listed in 00100.

00122 Dental Hygiene Examination: Specific

Dental hygiene examination and evaluation of a specific situation

00123 Dental hygiene Examination: Emergency

Dental hygiene examination for the investigation of discomfort and/or infection in a localized area.

00124 Dental Hygiene Examination: Periodontal, Limited

Dental hygiene examination for the investigation of discomfort and/or infection of a specific area of the periodontium.

**00130 First Dental Hygiene Visit/Orientation**

Oral dental hygiene assessment for clients up to and including 3 years of age. Assessment to include family dental history, oral hygiene, oral care practices (including daily care, diet, and fluoride use and exposure) and oral habits.

00131 First Dental Hygiene Visit/Orientation

**00200 Radiographs and Photographs**

00210 Intraoral, Bitewing

00211 Single film
00212 Two films
00213 Three films
00214 Four films
00215 Five films
00216 Six films

00220 Intraoral, Periapical

00221 Single film
00222 Two films
00223 Three films
00224 Four films
00225 Five films
00226 Six films
00227 Seven films
00228 Eight films
00229 Each additional film over eight

00230 Intraoral, Full Mouth Series

00231 Minimum of 14 films

00240 Panoramic

00241 One film

00250 Cephalometric

00251 One film
00259 Each additional film over one

00260 Duplication of Radiographs

00261 One film
00262 Two films
00263 Three films
00264 Four films
00265 Five films
00266 Six films
00267 Seven films
00268 Eight films
00269 Each additional film over eight

**00270 Photographs**

00271 One photo
00272 Two photos
00273 Three photos
00279 Each additional photo over three

**00300 Microbiological and Histological Tests**

00310 Caries Susceptibility Test

00311 Bacteriological Test for the Determination of Dental Caries Susceptibility (+ Lab)

00320 Periodontal Disease Activity Test

00321 Microbiological Test for the Determination of Pathological Agents (or enzyme, immunological) (+ Lab)

00330 Cancer Testing

00331 Cancer Testing may include Cytological Smear from the Oral Cavity, Vital Staining of Oral Mucosal Tissues

**00400 Study Models**

00401 Taking of Impressions
00402 Fabrication/Pouring and Preparing Casts (+ Lab)

**00500 – 00999 DENTAL HYGIENE TREATMENT AND EVALUATION** Each unit of time is 15 minutes.

**00500 Periodontal Treatment**

00510 Debridement

May include supra and/or subgingival scaling and/or subgingival deplaquing.

00511 One unit of time
00512 Two units of time
00513 Three units of time
00514 Four units of time
00515 Five units of time
00516 Six units of time
00517 One-half unit of time
00519 Each additional unit over six

00520 Root Planing

00521 One unit of time
00522 Two units of time
00523 Three units of time
00524 Four units of time
00525 Five units of time
00526 Six units of time
00527 One-half unit of time
00529 Each additional unit over six

00530 Stain Removal

May include manual or mechanical methods, prophylaxis, ultrasonic, etc.

00531 One unit of time
00532 Two units of time
00537 One-half unit of time
00539 Each additional unit over two

00540 Subgingival Periodontal Irrigation

00541 One unit of time
00547 One-half unit of time
00549 Each additional unit over one

00550 Management of Oral Disease

00551 One unit of time
00552 Two units of time
00553 Three units of time
00554 Four units of time
00557 One-half unit of time
00559 Each additional unit over four

**00600 Additional Oral Health Services**

00601 Sealants

Tooth number must be indicated on claim form.

00602 First tooth in quadrant
00603 Each additional tooth in same quadrant

00605 Application of Anticariogenic/Antimicrobial Agents

00606 One unit of time (+E)
00607 One-half unit of time (+E)
00609 Each additional unit over one (+E)

00610 Fluoride Applications

Fluoride Applications – In Office

00611 Fluoride Treatment – topical application
00612 Fluoride Treatment – supervised, self-administered brush-on

Fluoride, Custom Appliances – Home Application

00613 Fluoride, Custom Appliance – Maxillary Arch (+ Lab)
00614 Fluoride, Custom Appliance – Mandibular Arch (+ Lab)
00615 Fluoride, Custom Appliances – Maxillary + Mandibular Combined (+ Lab)

00620 Finishing Restorations

May include polishing/finishing, removal of overhangs, refining marginal ridges and occlusal surfaces, etc.

00621 One unit of time
00622 Two units of time
00623 Three units of time
00624 Four units of time
00627 One-half unit of time
00629 Each additional unit over four

00630 Fabrication of Mouthguards

May include the taking of impressions and the preparation of study models for the purpose of fabricating a mouthguard and subsequent insertion, fitting and education/instruction.

00631 Mouthguards, Preformed – Maxillary Arch
00632 Mouthguards, Preformed – Mandibular Arch
00633 Mouthguards, Preformed – Maxillary + Mandibular Combined
00634 Mouthguards, Processed – Maxillary Arch (+ Lab)
00635 Mouthguards, Processed – Mandibular Arch (+ Lab)
00636 Mouthguards, Processed – Maxillary + Mandibular Combined (+ Lab)

| | |
|---|---|
| 00638 | Labelling of Removable Prosthesis |

| | |
|---|---|
| 00640 | Desensitization |
| | May involve the application of chemotherapeutic aids or the use of a variety of therapeutic procedures. More than one appointment or application may be necessary. |
| 00641 | One unit of time |
| 00642 | Two units of time |
| 00647 | One-half unit of time |
| 00649 | Each additional unit over two |

| | |
|---|---|
| 00650 | Bleaching of Vital Teeth in Office |
| 00651 | One unit of time |
| 00652 | Two units of time |
| 00653 | Three units of time |
| 00657 | One-half unit of time |
| 00659 | Each additional unit over three |

| | |
|---|---|
| 00660 | Bleaching of Vital Teeth at Home |
| | Includes the fabrication of bleaching trays, product system for home use and follow-up care. |
| 00661 | Maxillary Arch (+ Lab/E) |
| 00662 | Mandibular Arch (+ Lab/E) |
| 00663 | Maxillary and Mandibular Arches (+ Lab/E) |

| | |
|---|---|
| 00665 | Placement of Temporary Restoration |
| | Tooth number must be indicated on the claim form. |
| 00666 | First tooth |
| 00667 | Each additional tooth in the same quadrant |

| | |
|---|---|
| 00670 | Recementation |
| | Recementation may be permanent or temporary. |
| 00671 | One unit of time |
| 00672 | Two units of time |
| 00673 | Three units of time |
| 00677 | One-half unit of time |
| 00679 | Each additional unit over three |

| | |
|---|---|
| 00680 | Pulp Vitality Testing |
| 00681 | One unit of time |
| 00687 | One-half unit of time |
| 00689 | Each additional unit of time over one |

| | |
|---|---|
| 00690 | Dentures/Removable Oral Prosthesis, Prophylaxis and Polishing |
| 00691 | One unit of time |
| 00697 | One-half unit of time |
| 00699 | Each additional unit of time over one |

| | |
|---|---|
| **00700** | **Pain Management** |
| 00710 | Electronic Dental Anesthesia |
| 00711 | One unit of time |
| 00712 | Two units of time |
| 00713 | Three units of time |
| 00714 | Four units of time |
| 00717 | One-half unit of time |
| 00719 | Each additional unit over four |

| | |
|---|---|
| 00720 | Anesthesia, Local (not in conjunction with treatment procedures) |
| 00721 | Regional Block |
| 00722 | Trigeminal Division Block |
| 00723 | Supraperiosteal Infiltration |

| | |
|---|---|
| 00730 | Acupuncture |
| 00731 | One unit of time |
| 00732 | Two units of time |
| 00733 | Three units of time |
| 00734 | Four units of time |
| 00737 | One-half unit of time |
| 00739 | Each additional unit over four |

| | |
|---|---|
| 00740 | Nitrous Oxide, Conscious Sedation |
| 00741 | One unit of time |
| 00742 | Two units of time |
| 00743 | Three units of time |
| 00744 | Four units of time |
| 00747 | One-half unit of time |
| 00749 | Each additional unit over four |

| | |
|---|---|
| **00800** | **Education** |
| 00810 | Counselling for Diet as Related to Oral Health |
| | Includes recording and analysis (up to seven days) of dietary intake and consultation. |
| 00811 | One unit of time |
| 00812 | Two units of time |
| 00813 | Three units of time |
| 00814 | Four units of time |
| 00817 | One-half unit of time |
| 00819 | Each additional unit over four |

| | |
|---|---|
| 00820 | Counselling for Tobacco Use Cessation |
| 00821 | One unit of time |
| 00822 | Two units of time |
| 00823 | Three units of time |
| 00824 | Four units of time |
| 00827 | One-half unit of time |
| 00829 | Each additional unit over four |

| 00830 | Counselling for Oral Self-Examination |
|---|---|
| 00831 | One unit of time |
| 00832 | Two units of time |
| 00833 | Three units of time |
| 00834 | Four units of time |
| 00837 | One-half unit of time |
| 00839 | Each additional unit over four |

| 00840 | Instruction in Oral Self-Care |
|---|---|
| | Individual instruction (one instructor to one client) that may include, but is not limited to, brushing and/or flossing and/or embrasure cleaning. This excludes audio-visual time. |
| 00841 | One unit of time |
| 00842 | Two units of time |
| 00843 | Three units of time |
| 00844 | Four units of time |
| 00847 | One-half unit of time |
| 00849 | Each additional unit over four |

| 00850 | Group Presentations (including preparation) |
|---|---|
| 00851 | One unit of time |
| 00852 | Two units of time |
| 00853 | Three units of time |
| 00854 | Four units of time |
| 00857 | One-half unit of time |
| 00859 | Each additional unit over four |

| 00900 | Outcome Evaluation |
|---|---|
| | Outcome evaluation includes the evaluation of periodontal health as a follow-up assessment to ongoing dental hygiene care/therapy. |

| 00910 | Evaluation of Dental Hygiene Care/Therapy |
|---|---|
| 00911 | One unit of time |
| 00912 | Two units of time |
| 00917 | One-half unit of time |
| 00919 | Each additional unit over two |

| 00920 | Professional Communications/Case Presentation |
|---|---|
| | May include family members, institution and/or other members of health-care team. Only to be used in particularly complex or time-intensive cases. |
| 00921 | One unit of time |
| 00922 | Two units of time |
| 00927 | One-half unit of time |
| 00929 | Each additional unit over two |

| 00950 | Mobile Dental Hygiene Services |
|---|---|
| | May include, but is not limited to, mobile dental hygiene services being delivered to a single client in their primary place of residence (e.g. private home or care facility) in addition to procedures performed. |
| 00951 | Home Visit (Scheduled, Non-emergency) |
| 00952 | Institutional Visit (Scheduled, Non-emergency) |
| 00953 | Emergency Home Visit (Non-scheduled) |
| 00954 | Emergency Institutional Visit (Non-scheduled) |

| 00990 | Laboratory and Expense Services |
|---|---|
| 00991 | "+Lab" Laboratory procedures |
| 00992 | "+E" Additional expense of materials |

# Appendix A

## CORRESPONDING CANADIAN DENTAL ASSOCIATION CODES

The following chart includes a brief description of each service code and, where applicable, the corresponding CDA code (for comparison purposes).

| CDHA CODE | CDHA NATIONAL LIST OF SERVICE CODES | REFLECTED IN CDA CODE |
|---|---|---|
| **00000 - 00499** | **Assessment, Dental Hygiene Diagnosis and Treatment Planning** | |
| **00100** | **Examination, New Client** | |
| 00111 | Primary Dentition | 01101 |
| 00112 | Mixed Dentition | 01102 |
| 00113 | Permanent Dentition | 01103 |
| 00114 | Edentulous (both arches) | 01701 |
| 00115 | Periodontal | 01501 |
| **00120** | **Examination, Previous Client** | |
| 00121 | Routine Reassessment/Recall | 01202 |
| 00122 | Specific | 01204 |
| 00123 | Emergency | 01205 |
| 00124 | Periodontal, Limited | 01204 |
| **00130** | **First Dental Hygiene Visit/Orientation** | |
| 00131 | First Dental Hygiene Visit/Orientation | 00011 |
| **00200** | **Radiographs and Photographs** | |
| 00211-00216 | Intraoral, Bitewing | 02141-02146 |
| 00221-00229 | Intraoral, Periapical | 02111-02125 |
| 00231 | Intraoral, Full Mouth Series | 02101-02102 |
| 00241 | Panoramic | 02601 |
| 00251-00259 | Cephalometric | 02701-02709 |
| 00261-00269 | Duplication of Radiographs | 02911-02919 |
| 00271-00279 | Photographs | 04801-04809 |
| **00300** | **Microbiological and Histological Tests** | |
| 00311 | Caries Susceptibility Test | 04201 |
| 00321 | Periodontal Disease Activity Test | 04101 |
| 00331 | Oral Cancer Testing | 04401-04402 |
| **00400** | **Study Models** | |
| 00401 | Taking of Impressions | 04911 |
| 00402 | Fabrication | 04911 |

| CDHA CODE | CDHA NATIONAL LIST OF SERVICE CODES | REFLECTED IN CDA CODE |
|---|---|---|
| **00500 - 00999** | **Dental Hygiene Treatment and Evaluation** | |
| **00500** | **Periodontal Treatment** | |
| 00511-00519 | Debridement (supra/subgingival scaling and/or subgingival deplaquing) | 11111-11119 |
| 00521-00529 | Root Planing | 43421-43429 |
| 00531-00539 | Stain Removal | 11101-11109 |
| 00541-00549 | Subgingival Periodontal Irrigation | 49211-49219 |
| 00551-00559 | Management of Oral Disease | 41211-41219 |
| **00600** | **Additional Oral Health Services** | |
| 00602 | Sealants – First tooth in quadrant | 13401 |
| 00603 | Sealants – Each additional tooth in same quadrant | 13409 |
| 00606-00609 | Application of Antiocariogenic/Antimicrobial Agents | 13601-13609 |
| 00611 | In Office – Fluoride Treatment – topical application | 12101 |
| 00612 | In Office – Fluoride Treatment – supervised, self-administered brush-on | 12102 |
| 00613 | At Home – Custom Fluoride Appliance – Maxillary Arch | 12601 |
| 00614 | At Home – Custom Fluoride Appliance – Mandibular Arch | 12602 |
| 00615 | At Home – Custom Fluoride Appliance – Maxillary + Mandibular Combined | 12603 |
| 00621-00629 | Finishing Restorations | 16101-16109 |
| 00631-00633 | Mouthguard – Preformed | 14501 |
| 00634-00636 | Mouthguard – Processed | 14502 |
| 00638 | Labelling of Removable Prosthesis | |
| 00641-00649 | Desensitization | 41301-41309 |
| 00651-00659 | Bleaching of Vital Teeth In Office | 97111-97119 |
| 00661 | Bleaching of Vital Teeth at Home – Maxillary Arch | 97121 |
| 00662 | Bleaching of Vital Teeth at Home – Mandibular Arch | 97122 |
| 00663 | Bleaching of Vital Teeth at Home – Both Maxillary and Mandibular Arches | 97123 |
| 00666 | Placement of Temporary Restorations – First tooth in quadrant | 20111 |
| 00667 | Placement of Temporary Restorations – Each additional tooth in same quadrant | 20119 |
| 00671-00679 | Recementation | 29101-29109 |
| 00681-00689 | Pulp Vitality Testing | 04501-04509 |
| 00691-00697 | Dentures Removable Oral Prosthesis, Prophylaxis and Polishing | 55501-55509 |
| **00700** | **Pain Management** | |
| 00711-00719 | Electronic Dental Anesthesia | 92531-92539 |
| 00721 | Anesthesia – Regional Block | 92101 |
| 00722 | Anesthesia – Trigeminal Division Block | 92102 |
| 00723 | Anesthesia – Supraperiosteal Infiltration | |
| 00731-00739 | Acupuncture | 92521-92529 |
| 00741-00749 | Nitrous Oxide | 92411-92419 |

| CDHA CODE | CDHA NATIONAL LIST OF SERVICE CODES | REFLECTED IN CDA CODE |
|---|---|---|
| **00500 - 00999** | **Dental Hygiene Treatment and Evaluation** | |
| **00800** | **Education** | |
| 00811-00819 | Counselling for Diet As Related to Oral Health | 13101-13109 |
| 00821-00829 | Counselling for Tobacco Use Cessation | 98101-98109 |
| 00831-00839 | Counselling for Oral Self-Examination | |
| 00841-00849 | Instruction in Oral Self-Care | 13211-13219 |
| 00851-00859 | Group Presentations (including preparation) | 13221-13229 |
| **00900** | **Outcome Evaluation** | |
| 00911-00919 | Evaluation of Dental Hygiene Care/Therapy | 49101-49109 |
| **00920** | **Professional Communications/Case Presentation** | |
| 00921-00929 | Professional Communications/Case Presentation | 93111-93119 |
| **00950** | **Mobile Dental Hygiene Services** | |
| 00951 | Home Visit (Scheduled, Non-emergency) | 94101 |
| 00952 | Institutional Visit (Scheduled, Non-emergency) | 94301 |
| 00953 | Emergency Home Visit (Non-scheduled) | 94102 |
| 00954 | Emergency Institutional Visit (Non-scheduled) | 94302 |
| **00990** | **Laboratory and Expense Services** | |
| 00991 | "+L" Laboratory procedures | 99111<br>99222<br>99333 |
| 00992 | "+E" Additional expense of materials | 99555 |

**Unique Identifier Number**
A Unique Identifier Number (UIN) is required for submitting claims to an insurance provider.

To apply for a UIN, you can download the application form available in the Resources and Tools section of the members-only section of the CDHA website at **www.cdha.ca/members/content/resources&tools/claim_form .asp .** You may also send a request, including your CDHA member number, name, address, telephone number, email address, signature and proof of active provincial registration to the CDHA office, 96 Centrepointe Drive, Ottawa, Ontario, K2G 6B1, or by fax to 613-224-7283.

This UIN will be reassessed on an annual basis following a renewal of your CDHA active membership. The insurance industry in Canada is provided with a current list of valid Unique Identifier Numbers each year.

**National Dental Hygiene Claim Form**
The complete National Dental Hygiene Claim Form is available for download under Resources and Tools in the members-only section of the CDHA website at **www.cdha.ca/members/content/resources&tools/claim_form .asp .** This form is intended for use by dental hygienists in submitting claims to an insurance provider. The form records a description of the service, the CDHA service code and the cost of the service, in addition to other pertinent information.

# Appendix B

## ABOUT THE NATIONAL DENTAL HYGIENE CLAIM FORM

The National Dental Hygiene Claim Form facilitates direct billing for services provided by dental hygienists to third-party payors. All dental hygienists should use the CDHA National Dental Hygiene Claim Form and not a Canadian Dental Association (CDA) dental claim form, so as not to infringe upon the CDA's copyright.

**Accountability**
To increase accountability, the CDHA requires both the client and dental hygienist to sign the National Dental Hygiene Claim Form and each entry in the client's record (file/chart), outlining the services provided on that day.

**Completion of the Dental Hygiene Claim Form**

| | |
|---|---|
| Part 1 – UIN | Every dental hygienist completing a claim form for a client requires a seven-digit unique identifier number (UIN) that can be obtained from the CDHA. The UIN identifies, through the combination of the first and second digits, the provider as a dental hygienist along with her/his province of residence. The last five digits uniquely identify the provider for direct billing and reimbursement purposes. |
| Part 1 – Address Box – Hygienist | Enter the dental hygienist owner/practitioner business address information. |
| Part 1 – Address Box – Client | Enter the client's address. |
| Part 1 – CDHA Service Code Box | Use the appropriate CDHA service code from the appropriate provincial dental hygiene fee guide. |
| Part 1 – INTL Tooth Code Box | Enter the two-digit International Tooth Code where applicable. (e.g., Sealants). |
| Part 1 – Description of Services Provided | Enter a written description for each service provided. (For assistance, refer to the National List of Service Codes.) |
| Part 1 – Assignment of Benefits | Assignment of benefits requests that the plan administrator forward payment directly to the dental hygienist (rather than the plan beneficiary). For your protection the client should be informed to sign the Client Accountability Box in the second paragraph. |
| Part 1 – Client Accountability (second paragraph) | This box is fundamental to the CDHA direct-billing process. It serves to identify accountability with the client regarding responsibility for all fees and communicates to the plan administrator that the client affirms he/she understands the services and confirms that the services have been provided to him/her. The providing registered dental hygienist and client should both sign in this box and the client record. If the client is unable to sign (e.g., dementia, power of attorney), then indicate N/A and the reason. |
| Parts 2 and 3 | The client should complete these parts as required by his/her dental plan administrator. |

The complete National Dental Hygiene Claim Form is available for download under Resources and Tools in the members-only section of the CDHA website at www.cdha.ca/members/content/resources&tools/claim_form.asp .

## CLASSIFIED ADVERTISING

CDHA and *CJDH* are not responsible for classified advertising, including compliance with any applicable federal and provincial or territorial legislation.

### BRITISH COLUMBIA

**KAMLOOPS** Full-time (four, eight-hour days) position for a dental hygienist in a general-practice dental office. Benefit package includes medical plan, uniform allowance and CE allowance. Please contact Dr. Benjamin Bell, 307-444 Victoria Street, Kamloops BC, V2C 2A7, at **(250) 372-1237**, fax **(250) 372-1266**.

### ALBERTA

**BROOKS** Dental Hygienist needed to cover maternity leave of 12 months by present Hygienist. Three or Four days per week in well-established Practice. Two ops available. Computerized; Intra-oral Camera. "Assisted" hygiene is presently being performed using a CDA II. Hourly Compensation. Relocation Allowance available with Contractual commitment. Brooks is a small city (population 14000) in southern Alberta, one and a half hours from Calgary, one and a half hours from Lethbridge, and one hour from Medicine Hat. Qualifications: Experience an asset. New grads also welcome. Contact Dr. Larry Wasylyshen, Brooks Dental Centre, 907 Sutherland Drive, Box 1498, Brooks AB, T1R 1C3, at **(403) 362-5949**, fax **(403) 362-5690**, or email at: **lwasyl@telusplanet.net**.

**DIDSBURY** Very busy, well-established, rural family dental practice needs a full-time dental hygienist. Monday through Friday, no evenings or weekends. Great office and staff to work with. Competitive salary and benefits. Please fax resume to **(403) 335-8625** or email resume to **crystalworkun@shaw.ca**.

**EDMONTON** We are seeking a team-oriented, motivated FULL-TIME dental hygienist to provide clinical dental hygiene therapy for all our clients. Working over a 4 ½ day workweek (no evenings or weekends), you would be utilizing your knowledge, experience and the latest technologies (e.g. digital radiography) to help meet the needs of our clients. Great, fun, long term staff to work with. Qualifications: R.D.H. eligible to practice in Alberta. Contact Dr. W. J. Sharun, 503 Baker Centre, 10025 - 106 Street, Edmonton AB, T5J 1G4, at **(780) 428-2331**, fax **(780) 425-5477**, or email: **wjsharun@telusplanet.net**.

## Advertisers' Index



**GRANDE PRAIRIE** Very busy, well-established, family dental practice needs a full-time dental hygienist. Monday thru Friday, no evenings or weekends. Great office and great staff to work with. Benefits available. Please fax resume to **1-866-291-0041** or email resume to **cdonaven@shaw.ca** or **crystalworkun@shaw.ca**.

**PEACE RIVER** Dental hygienist required for busy office. New grads welcome. Beautiful downtown office with one dentist and one other hygienist. Please fax resume to Dr. David Blench, attention Jennifer, at **(780) 624-0623** or e-mail to **jrsoren@telus.net**.

### SASKATCHEWAN

**SASKATOON** Full-time or part-time dental hygiene position available to replace hygienist leaving end of September, 2007. Starting date is negotiable. Preventive-based office with exceptional, friendly and team-oriented staff. All inquiries are confidential. Please provide job history and references. Qualifications: Hygiene certification to be able to practice hygiene duties in Saskatchewan. Contact Dr. Jim Wilson Dental Professional Corp., 1121 Louise Avenue, Saskatoon SK, S7H 2P8, at **(306) 374-4181**, fax **(306) 373-1837**, or email to **jimandrae@shaw.ca**.

### ONTARIO

**WILLOWDALE** Dental space to share. Four operatories, fully equipped for hygienist to work with own patient base independently in new office. Contact Dr. Roque De Freitas at **(416) 221-2390**, or email: **roque_defreitas@hotmail.com**.

### EUROPE

**SWITZERLAND** Dental hygienists wanted in Switzerland. Wonderful opportunities for traveling, languages, culture and more! Very interesting salary and working conditions, including 4 weeks min. paid vacation & 13th salary. Don't pass this up! Visitez notre site internet: **www.kanadent.ch**. Contact Sandra Mueller at Sur Mont Tillier 15, Orvin, BE 2534, Switzerland, at 01141 32 – 322 – 0943 or email at: **kanadent@bluewin.ch**.

### INFORMATION SESSION

**"Eating Disorder Awareness in Dentistry"**
With Jen Charbonneau, RDH, CMC, Survivor

Eating Disorders are a silent epidemic sweeping this nation. Dental professionals are perfectly positioned to see evidence in the oral cavity every day. Would you know what to look for? How would you handle these clients?

- Kingston, ON – Wednesday, October 17, 2007
- Oshawa, ON – Friday, November 9, 2007
- Peterborough, ON – Saturday, February 9, 2008

jen@jencharbonneau.com www.jencharbonneau.com
**(613) 623-9553** for details

### CDHA CLASSIFIED ADS

Classified ads are listed primarily on CDHA's website (www.cdha.ca) in the Career Centre of the Members-only section. Online advertisers can list their advertising in the *Canadian Journal of Dental Hygiene* for an additional fee. The cost of advertising in the journal only, and not online, is the same as advertising online. For pricing, visit the CDHA website.

CDHA classified advertising reaches more than 11,000 members across Canada, ensuring that your message gets to a target audience of dental hygienists in a prompt and effective manner. Contact CDHA at **info@cdha.ca** or **(613) 224-5515** for more information.