FOCUS

for Ontario Dental Hygienists

odha
Ontario Dental Hygienists' Association

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CEO'S MESSAGE

Marg Harrington, MHS, MHE
Chief Executive Officer

The change of season has me reflecting on how busy spring and summer have been for the ODHA as we worked to advocate for dental hygienists in Ontario and raise the profile of the profession. Here are a few highlights:

MOH Consultation re: Dental Hygiene Scope of Practice Proposed Changes

On September 17th, the Ontario government announced a consultation on scope changes for registered dental hygienists and a number of other professions. We have been working to move forward the following authority for Ontario registered dental hygienists:

- Ability to prescribe radiographs;
- authority to be a Radiation Protection Officer, and
- ability to prescribe and administer local anesthesia by injection in the orofacial complex.

This announcement came about through the combined initiative of ODHA and CDHO.

ODHA shared proposed responses with our members on September 25th. The consultation deadline is November 3rd, 2025.

Petition about internationally trained dentists (ITDs)

A petition titled "Allow ITDs (internationally trained dentists) to provide preventive and other care (e.g., cleaning) under supervision" was circulated in April, originating from a dentist in southwestern Ontario. ODHA formally submitted a letter of response on April 30th to Dr. Karima Velji and Irwin Glasberg, the government officials to whom the petition was addressed. Our full letter is linked here.

Over the past few months, a situation emerged in Alberta which also related to internationally trained dentists. The College of Dental Surgeons of Alberta (CDSA) has created a pathway for ITDs to practise in rural areas under the supervision of a dentist. ODHA participated in an open forum on June 26th hosted by the Dental Hygienists Association of Alberta (DHAA). ODHA wrote a letter on July 9th to share our full support for DHAA's efforts in raising serious concerns about the CDSA's Supportive Pathway Pilot for Internationally Trained Dentists. Our letter is here.

Addressing the narrative about the perceived shortage of RDHs

In May, I wrote a public social media post titled "Clarifying the narrative around the "shortage" of registered dental hygienists in Ontario." The post was in response to chatter I am too often hearing on social media, in writing, or verbally in meetings about "a province wide shortage of RDHs." You can read the post here.

Further to our public statement, I was interviewed by a journalist for the online publication INsauga. The article titled "Dental hygienists in Ontario burnt out ahead of new CDCP" was published July 10, 2025. The link is here.

Ontario Special Olympics

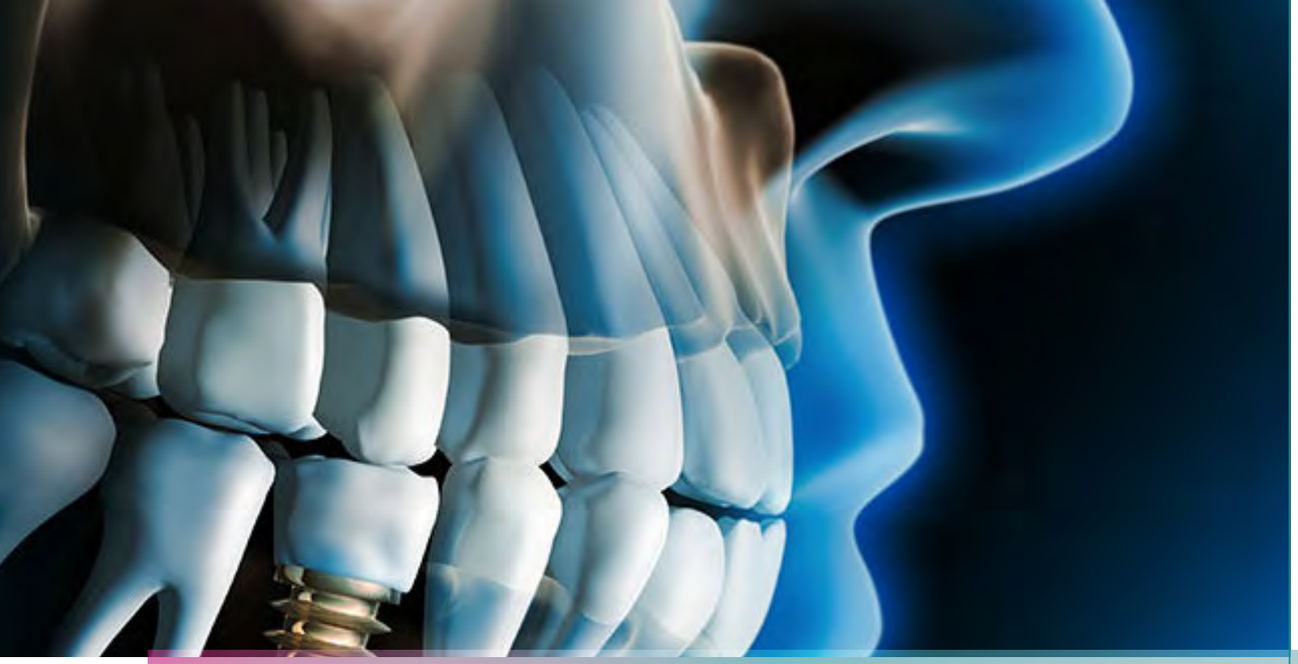
As part of our ongoing relationship with Special Olympics, ODHA advertised volunteer opportunities for our members at the Special Smiles programs for the Brantford/McMaster University and Ottawa Special Olympics games. I volunteered at the Special Smiles program at McMaster University on July 9th helping to register the athletes and support the work of dental hygienists and other oral health providers volunteering at the event.

Canadian Dental Care Plan (CDCP)

In August, I was invited to meet with staff of the Office of the Auditor General (OAG) to provide feedback on the scope of its upcoming audit of the CDCP.

During my meeting, I suggested the Auditors meet with the entire ODHA Board at our meeting on September 5th. During our meetings with the OAG team, we identified a number of improvements we would like to see to the CDCP, including increasing the number of scaling units for all clients to 12 units per year, removing the administrative burden related to pre-authorization requests, a greater focus on prevention, and enhancing communication to CDCP recipients to provide clarity about what is covered and not covered.

These just are a few examples of ODHA's advocacy on behalf of our members. More information about our initiatives and accomplishments to support dental hygienists in Ontario can be found in our 2024-25 Member Value Report.



AO/AAP peri-implant diseases prevention and management consensus summary report

The global use of dental implants has risen significantly over recent decades. This widespread use has also increased the prevalence of peri-implant complications, including peri-implant mucositis and peri-implantitis.

Peri-implant mucositis is characterized by inflammation of the soft tissues around the dental implant, without progressive bone loss beyond the normal physiological

bone remodelling. Peri-implant mucositis is usually reversible with appropriate treatment. However, if not treated effectively, peri-implant mucositis can progress to peri-implantitis.

Peri-implantitis involves both soft tissue inflammation and progressive bone loss, requiring a comprehensive treatment approach to prevent further deterioration and potential dental implant failure.

Efforts have been made to establish standardized treatment protocols for managing these clinical issues. However, a universally accepted gold standard treatment protocol for the effective and predictable management of peri-implant diseases has yet to be developed. Accordingly, the Academy of Osseointegration (AO) and American Academy of Periodontology (AAP) published a consensus report offering evidence-based strategies to prevent and manage peri-implant diseases and conditions.

Why this consensus report is important:

- Summarizes the findings and recommendations from the AO/AAP consensus meeting.
- Integrates the best available evidence and expert opinion into a unified framework to improve client care.
- Emphasizes professional debridement as the cornerstone for treating peri-implant mucositis, and the first step to treating peri-implantitis.
- Affirms the essential role of dental hygienists in the prevention, identification, and treatment of peri-implant diseases, as well as supportive peri-implant therapy programs.

Provide your clients with ODHA fact sheets to enhance their dental implant health:

- Dental Implants
- Smoking and Smokeless Tobacco
- Diabetes and Oral Health
- Periodontal (Gum) Disease

Research corner

PERI-IMPLANT DISEASE PREVENTION AND MANAGEMENT

Kim Ivan, RDH, BIS (Hon) is an award-winning dental hygienist with over 40 years of dental hygiene and leadership experience. She is a long-time member and volunteer of ODHA serving in various capacities including former president. Currently, Kim is ODHA's Policy Advisor and Chair of the Research Advisory Board.

AO/AAP consensus on peri-implant disease prevention and management: Clinical translation

Plaque biofilm accumulation is a primary etiologic factor in the onset and progression of peri-implant diseases. Risk factors for peri-implant diseases include deficient oral self-care, history of periodontitis, diabetes, obesity, metabolic syndrome, smoking, excess alcohol consumption, lack of preventive maintenance programs, and surgical and prosthetic parameters.

Treatment of peri-implant diseases includes non-surgical and surgical therapies. Nonsurgical therapy involves

mechanical debridement with implant-safe instruments such as titanium curettes, specialized ultrasonic scalers, and air polishing devices. Adjunctive agents may include chemical irrigation, local or systemic antibiotics, lasers, and probiotics. Surgical interventions include non-reconstructive, reconstructive, and explantation procedures.

Supportive peri-implant maintenance programs are crucial for preventing and managing peri-implant diseases, enabling regular assessments of dental implant health, client education, oral self-care instruction, professional debridement, and smoking cessation advice.

Fiorellini et al. (2025) provide clinical recommendations and reference flowcharts to manage peri-implant diseases based on the AO/AAP consensus on the prevention and management of peri-implant diseases and conditions.

Why I like this resource:

- Discusses strategies to manage peri-implant disease risk factors.
- Provides comprehensive flow diagrams for both non-surgical and surgical care.
- Highlights the critical role of prevention and early intervention.
- Offers clinical recommendations for supportive peri-implant therapy.

Listen to *Conversations with Dr. Glogauer and Kim Ivan*:

- Episodes 141 and 142 for discussion on the AO/AAP consensus on the prevention and management of peri-implant diseases and conditions.
- Episode 84 on peri-implant diseases.
- Episode 46 on the AAP classification for peri-implant diseases and conditions.
- Episode 35 on air polishing.
- Episode 63 on probiotics and the oral microbiome.

Visit Dental Hygiene Newswire for complementary articles on:

- Peri-implant diseases clinical practice guideline
- Artificial intelligence in implant dentistry

Legal corner

From the Desk of Julia Martin, Complaints and Discipline Lawyer

About Julia Martin Julia has been practising for over 30 years in professional regulation. She has defended almost every type of regulated health professional, including many registered dental hygienists. Julia also represents one health regulator, and a number of health professional associations. She regularly speaks and writes about the regulation of professionals.

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I am an Ontario lawyer who has practised for over thirty years in professional regulation. I started my practice in Toronto where I acted for many health colleges. I advised their committees and councils and prosecuted health professionals at discipline hearings. In 2005, I began practising in Ottawa and established my own firm, where I primarily defend regulated professionals such as dental hygienists and represent professional associations, such as the Ontario Dental Hygienists' Association.

My background has given me a unique perspective on professional regulation because I have acted both for regulators and regulated professionals. I am going to be sharing my knowledge and experience with you in this recurring column in *FOCUS*. The goal of this column will be as follows:

- To inform you about the complaints and discipline processes;
- to inform you of new issues that arise for regulated professionals;
- to provide tips on avoiding complaints;
- to provide dos and don'ts for responding to the College of Dental Hygienists of Ontario (CDHO); and
- to answer any questions you have for me (which I welcome you to send me by email).

For this first instalment of legal corner, I want to address the steps in the complaints process at the CDHO:

- For a complaint to be considered by the Inquiries, Reports and Complaints Committee (ICRC) it must be in writing or recorded (audio or video) and cannot be anonymous.
- The CDHO must provide registrants with a copy of the complaint within 14 days of its receipt.
- Registrants have 30 days to respond to the complaint (where there is a risk to the public they may request a shorter response time). Registrants may request and usually are granted an extension for the time to respond, particularly when they retain a lawyer and the lawyer needs an extension.
- The CDHO will provide the registrant's response to the complainant and they will have a chance to respond to the response.
- The ICRC can investigate the allegations raised in the complaint if it is considered necessary. This may involve interviewing co-workers of the registrant or individuals with knowledge of the complaint from the complainant. It can also involve requesting documents from the complainant, registrant or third parties such as insurers or dental offices.
- Once the investigation is complete, the results are compiled into a report. The registrant then has an opportunity to respond to the report before the ICRC makes its decision.
- The ICRC has the following options for a decision in complaints cases:
  - » Take no action;
  - » refer specified allegations to the Discipline Committee; or
  - » take some other action such as:
    - * Issuing advice to the registrant;
    - * issuing a caution to the registrant to refrain from such behaviour going forward;
    - * impose terms, conditions or limitations on the registrant's certificate of registration such as they not be permitted to perform a certain procedure; or
    - * order that they complete continuing education or remediation through a Specified Continuing Education or Remediation Program.
  - » Other than when the ICRC takes no action or issues advice, decisions of the ICRC are public and remain publicly visible on the register permanently.
- Both the complainant and the registrant have 30 days to request a review (similar to an appeal) of the decision by an independent government tribunal – the Health Professions Appeal and Review Board (HPARB).
  - » Decisions of the ICRC are almost always upheld by HPARB with no change to the ICRC's decision.

Given the potentially serious findings the ICRC can make, such as a discipline hearing or a permanent entry on the public register, getting legal assistance in responding to complaints as soon as the CDHO notifies you a complaint has been filed is really important. Lawyers with experience in professional regulation will know what to say and how to say it. They might also recommend registrants proactively complete continuing education relevant to the complaint to demonstrate they have insight into their behaviour and are willing to improve or change.

Feel free to reach out to me at julia@juliamartinlaw.com if you receive a complaint you would like me to help you with or any questions about the complaints process. I also welcome ideas for future instalments of this column!

PROFESSIONAL DEVELOPMENT

At ODHA, we are committed to fostering continuous professional growth and offering high-quality online learning courses by industry professionals. Check ODHA's online learning platform for the recent added couses.

Temporomandibular Disorders (TMD)

Presented by Dr. Sid Lisser, Dr. Brittany Kucharski and Dr. Amelia Edmonds.

Infection Prevention and Control (IPAC) Review

Presented by Linda McLarty.

Zero Cavity Future: Building a Smile Defense Plan for Kids

Presented by Dr. Mariana Leon, RDH, DDS. Sponsored by Colgate.

Addressing Oral HPV in Oral Healthcare

Presented by Dr. D. Saunders, Dr. V. Brown, and Katelynd Dolinsek, RDH. Made possible by Merck Canada Inc.

2025-2026 Membership campaign free & new online courses

It's NOT All in Your Head: Oral Health and Mental Health

Presented by Jo-Anne Jones, RDH, FIADFE.
Sponsored by Philips.

Managing Medically Compromised Clients

Presented by Dr. Sanjukta Mohanta, BSc, DDS.
Sponsored by LISTERINE®.

Disinfectants Used in Oral Health Care

There are numerous disinfectants indicated for use in oral health-care settings. The decision to use which disinfectant is indicated by the manufacturer's instructions for use (MIFU) for cleaning and disinfecting specific products. This prevents the use of the wrong disinfectant, which may prove too harsh on a product's surface integrity and lead to premature wear, requiring the replacement of the product.

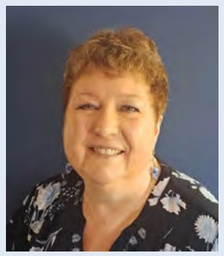
Some dental equipment we know is quite expensive, so premature wear is a serious concern. For example, using the wrong disinfectant on the wand of a 3D intraoral scanner, dental chair, or overhead light. In this instance, purchasing an alcohol-based disinfectant wipe might be indicated depending on the guidance provided in the MIFUs. A tuberculocidal disinfectant is required by regulatory bodies to disinfect clinical surfaces in oral health-care settings.[1] This would include hydrogen peroxide-based disinfectants. During the COVID-19 pandemic, there was a requirement surface disinfectants used in oral healthcare settings be confirmed to be virucidal, specifically the coronavirus.[2]

The most important quality of a disinfectant is contact time, that is, how long the disinfectant has to be on the surface of the product to have the claim to be "tuberculocidal." This time can vary substantially from one minute to ten minutes, and keeping a wipe wet on a surface for ten minutes is obviously impractical in an oral health-care setting where room turnover time is critical. So contact time will be a deciding factor.

Various disinfectants are associated with different challenges, so oral health-care providers should ensure the required disinfectants are safe before purchase. One example is quaternary ammonium products, or "quats," which have been banned in some clinics due to the risks to pediatric clients because of the risk of respiratory irritants, possible links to infertility, and developmental issues and outbreaks.[3,4,5] Additionally, if microfiber cloths are regularly used due to their antibacterial feature with a quaternary ammonium disinfectant, it will reduce the effectiveness of the disinfectant's concentration, rendering it ineffective.[6] Similarly, bleach (chlorine) is an effective disinfectant (tuberculocidal, bacteriocidal, virucidal, fungicidal).[7] However, it can also corrode metals, stain fabrics (e.g., uniforms), and is volatile, requiring to be made up daily if diluted with water. Bleach also damages dental office pipes, so when used, it needs to be flushed down the sink pipes with copious amounts of water. The use of bleach is also an environmental concern if mixed with mercury in amalgam. Accordingly, bleach is not to be suctioned up in a dental unit.[8]

If unfamiliar with the name of the active ingredient in a disinfectant, identify the category of disinfectants it belongs to. For instance, quats include dodecyl dimethyl ammonium chloride, benzalkonium chloride, or N-alkyl. Also important is the amount of active ingredient. For example, alcohol-based hand rub must contain 70%–90% alcohol to disinfect our hands.[9] Please note the use of ultraviolet light "no touch" disinfectant systems requires the dental unit be cleaned first with disinfectant wipes before using the UV light.[10]

*References available on request.



Cindy Isaak-Ploegman, RDH, BA, MEd, CDIPC, has been a dental hygienist for 36 years, practicing in general and periodontal practices and teaching clinical and didactic courses for 33 years. From 2017-2025 she has been employed as infection prevention and control consultant at the Dr. Gerald Niznick College of Dentistry at the University of Manitoba and as quality assurance officer at the Centre for Community Oral Health since 2018. In addition to her diploma in dental hygiene, she has earned a Bachelor of Arts degree, Masters degree in adult education and completed the certification course in infection control with IPAC Canada and Central Service Technician course from Purdue University. She is also certified in infection control with OSAP (now called ADS). Her research interests include dental unit waterline testing and she has publications in the area of water quality, dental implant research, dental ethics, and adult education. She enjoys volunteering in pet fairs promoting oral health among persons experiencing homelessness who are pet owners, has volunteered in Kenya as a clinical dental hygienist, and enjoyed working as a research coordinator with the Faculty of Social Work, University of Manitoba in the area of curriculum promoting eye health, visual impairment, and blindness in India.

‘Why Are My Auto Insurance Rates Going Up?’ What You Need to Know

You may have noticed that your auto insurance premiums have gone up and wondered why. It’s a fair question and a common one. Many drivers are seeing higher rates, even if nothing has changed on their end. While inflation is part of the reason, other factors like rising auto thefts, expensive car repairs, and new vehicle technology are also driving up costs. To help you understand rates, here’s a quick breakdown of what affects premiums so you can navigate changes and make informed choices about your coverage.

The basics: How auto premiums are calculated

Auto insurance rates aren’t one-size-fits-all. Premiums could differ significantly based on how insurers assess risk. Here are some of the personal factors impacting what you pay:

Driver profile: Factors like your age, gender, driving experience, and even marital status can affect your premium. Some insurers also offer discounts for students, retirees, or those who are married or common-law.

Driving history: Past at-fault accidents, tickets, or claims signal risk to insurers and can lead to higher rates.

Location: Where you live and drive affects your risk level. Urban areas typically see more traffic, thefts, and collisions, which increases premiums.

Vehicle type: Cars are rated based on historical claims data through systems like the Canadian Loss Experience Automobile Rating. Cars that are less likely to be stolen or involved in accidents usually cost less to insure.

Coverage and deductibles: The more coverage you choose (and the lower your deductible) the more you’ll pay upfront. But while reducing coverage might lower your premium, it could leave you underinsured when it matters most. It’s important to find the right balance between cost and protection.

Vehicle usage: The more you drive, the more likely you are to be involved in a claim. Driving less may reduce your premium.

Credit score (in some provinces): While Ontario doesn’t allow insurers to use credit scores for auto insurance, some other provinces do.

Insurer variation: Each insurer calculates risk differently, meaning your rate can vary from one provider to the next. You might be high-risk with one, but low-risk with another.

Ultimately, many of these variables are personal and unique to each policyholder, which is why comparing quotes and understanding options is key to finding the right fit.

The basics: How auto premiums are calculated

Premiums aren’t just based on your personal risk profile; they’re also shaped by broader trends affecting the entire insurance industry. Here are some of the main external factors across Ontario:

Theft: Vehicle thefts (especially for newer models with keyless entry) have skyrocketed in recent years. High-demand vehicles, such as SUVs and luxury models, are often targeted. More thefts mean more claims, which leads to higher premiums for everyone. Owners of these high-risk vehicles may see even higher insurance rates as a result.

Advanced vehicle technology: Most cars today are built with advanced safety features like sensors, cameras, and driver-assist systems. While these technologies improve safety, they also make repairs much more expensive when accidents happen, leading to higher premiums overall.

Repair and parts costs: Global supply chain issues continue to delay parts and ramp up repair costs, meaning even minor accidents can result in costly and time-consuming claims.

Image source: https://www.istockphoto.com/search/2/image?mediatype=illustration&page=4&phrase=auto%20insurance%20premium

Claims frequency and severity: Ontario has seen an increase in both the number and cost of auto insurance claims, including fraudulent claims. More frequent collisions (with more expensive repairs) and scams put financial pressure on insurers, which is reflected in premiums.

Climate change: Extreme weather events like floods and ice storms are happening more often and causing more damage. Auto insurers are seeing a rise in claims related to climate events, especially in urban areas with dense traffic and aging infrastructure.

Inflation: As with most industries, rising prices for labour, materials, and services have pushed up the overall cost of doing business—including the cost of settling claims.

PRO tips

While many of the factors influencing premiums are outside our control, there are still several ways to potentially reduce your costs:

Install anti-theft devices: These can reduce your risk of theft and may qualify you for savings. Use tools like steering wheel locks, alarms, and tracking systems.

Maintain a clean driving record: Avoiding tickets and at-fault accidents will help keep your rates lower over time.

Shop around and compare quotes: Be sure you’re comparing similar coverage levels and deductibles across providers. It’s best to work with an insurance broker; they’ll shop the market for you and find options matching your needs and budget.

Ask about available discounts: You might be eligible for savings based on your driving history, loyalty, low mileage, completing a certified driver training course, and more. As an ODHA member, you also qualify for an exclusive group discount of up to 20% through PROLINK, which can further lower your premiums.

Auto insurance is becoming more complex, and with so many external forces at play, rate increases can be frustrating, though not uncommon. PROLINK is committed to helping drivers navigate all options with clarity and confidence. Our team will work with you to understand your needs, explore options, and find the right coverage at the right price.

Have questions? Connect with PROLINK today to review your policy and make sure you’re getting the best value for your coverage.

The article is provided by PROLINK.

The Non-Insured Health Benefits Program

The Non-Insured Health Benefits Program (NIHB) plays a key role in the oral health of First Nations and Inuit.

By enrolling in Indigenous Services Canada's Non-Insured Health Benefits (NIHB) Program, dental providers can submit claims directly to the program's claims processor, Express Scripts Canada. When you bill the program directly using NIHB fees, clients avoid out-of-pocket charges — removing a significant barrier to accessing dental care. When you bill the program directly using NIHB fees, clients do not have to face charges which can be a significant barrier in accessing dental care.

The updated fees appear in the NIHB Regional Dental Benefit Grids, organized by general practitioners (GP), specialists (SP), oral surgeons (OS), denturists (DN), and dental hygienists (HY). The grids contain maximum NIHB fees for eligible procedure codes.

The current NIHB Regional Dental Benefit Grids, as well as the latest updates, errata, and amendments, are available on the Express Scripts Canada NIHB Provider and Client website at nihb-ssna.express-scripts.ca/en > Provider > Dental. The Dental Benefit Grids can be found at nihb-ssna.express-scripts.ca/en > Provider > Dental > Dental benefit grids. Upon entering the Dental Benefit Grids, choose the current year and the desired province/territory to view the grid corresponding to the applicable provider specialty (e.g., GP/SP, HY, DN, and OS).

Did you know?

The Express Scripts Canada Provider and Client website is the gateway for dental providers to work with the NIHB program. Providers can access program policies, forms, quarterly newsletters, the dental claims submission kit, provider billing agreement, and regional dental benefit grids.

To learn more, please visit: https://nihb-ssna.express-scripts.ca/en/0205140506092019/04.

Create an NIHB Web Account and Enroll Online

Dental providers can create an NIHB web account to upload and submit their enrolment documents and gain access to convenient self-service options. Through your web account, you will be able to verify client eligibility, submit claims and predetermination requests, and view claim statements online.

Get started here: https://nihb-ssna.expres-scripts.ca/nihb provider/create now.

Enroll for Direct Deposit Payments

Direct deposit is a fast, secure way to receive payment. Switch to direct deposit by logging into your NIHB web account and updating your payment information.

If you don't have a web account, you can create one or download and follow the instructions on the Direct Deposit Individual Form for NIHB Providers from the NIHB Dental Forms section on the Express Scripts Canada NIHB Provider and Client Website.

Is your contact information up to date?

Stay connected by making sure your NIHB web account profile is up to date!

To update your contact information:

- Log into your NIHB web account.
- Click the "My Profile" button on the left-hand menu bar.
- Scroll down to the email address, alternate mailing address and fax number section and click the "Update" button.
- Make your changes and click "Save".

Issues with an NIHB web account

Still experiencing issues enrolling into the NIHB program, accessing your online claims statement, verifying client eligibility, submitting a claim or predetermination?

Visit the Policy and Program Information section of the Express Scripts Canada NIHB Provider and Client Website, then scroll down to the ***NIHB Dental Online Account Troubleshoot FAQs***. You can also call the NIHB Call Centre at Express Scripts Canada for assistance at 1-888-511-4666.

To access the FAQs, please visit: https://nihb-ssna.express-scripts.ca/nihb dental provider/policy and program information.

* French version available on request

The New Dental Hygiene Advocate: Supporting Change from Every Angle

By: Holly Verran, BSc, RDH

Holly Verran, BSc, RDH, is a dedicated dental hygienist with over a decade of clinical experience. She currently supports and empowers dental professionals in eastern and northern Ontario with her role at Oral Science, focusing on prevention, collaboration, empathy, and evidence-based care.

Why advocacy matters more than ever

Dental hygiene has always been rooted in prevention. But now more than ever, it's also about advocacy - for our clients, our profession, and ourselves.

Advocacy isn't always loud. Sometimes, it looks like staying curious, asking thoughtful questions, or simplifying something complex so a colleague or clients can take that next step.

We know dental hygiene is more than scaling teeth. It is about prevention. Seven out of ten Canadians will develop periodontal disease at some point in their lives, making it the most common dental issue in the country.[1] What's even more concerning? Periodontal disease often progresses silently, without pain, until it's already causing real harm.[1]

Change can be hard, but it's worth it

Introducing new routines or technologies into an already-busy practice isn't easy. Change is often met with hesitation, especially when science is evolving faster than our systems can keep up.

But as dental hygienists, we're uniquely positioned to bridge the gap.

We advocate when we:
- Explain the why, not just the what.
- Meet resistance with empathy, not pressure.
- Help make science practical and relatable.
- Continue to learn and educate ourselves.

Turning education into action

Education is the backbone of advocacy. During my Oral Health Promotion degree, I learned about behaviour change, health literacy, and access barriers. My major takeaway from the program was: People don't change just because we tell them to. They change when they feel supported, understood, and empowered.

Whether in a clinic or online, focus on:
- Breaking things down into relatable, real-world terms.
- Encouraging teams to try something new, without judgment or overwhelming them with too much information.
- Making prevention approachable, not intimidating.

Tools that spark conversation: PerioMonitor™

One diagnostic tool I've seen make a real difference is PerioMonitor™. PerioMonitor™ is a quick chairside rinse that detects neutrophils, the body's early immune response to inflammation, and displays a colour-based result in 30 seconds.[2]

Clients can easily understand and see the results themselves, which engages them as active collaborators in the conversation.

This kind of visual tool helps:
- Increase clients understanding and engagement
- Shift conversations from "you poked my gums" to "here's what your body is telling us"
- Reinforce that inflammation can exist even without visible symptoms
- Guide personalized, earlier interventions based on objective data

When clients see tangible evidence, they're more likely to act. When clinicians track it, they're more likely to adjust care plans. It brings science to life in a relatable and straightforward way.

Social media: A new angle on advocacy

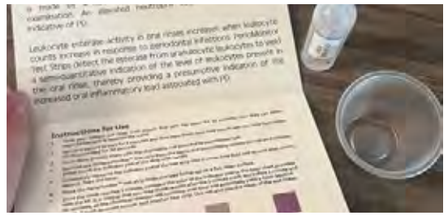
Social media has completely reshaped how we connect, learn, and advocate.

In short, relatable posts or quick videos, we are able to:
- Reach other dental hygienists across the country and the world.
- Share science-backed tips and protocols.
- Learn from incredible peers doing amazing things, like Kayla (pictured below), a dental hygiene practice owner in Arnprior, Ontario and advocates fiercely for oral health every day.

It's not about being "on camera." It's about being present, accessible, and collaborative.

Supporting professionals = Supporting clients

When clinicians feel confident and supported, clients receive stronger care. It's that simple.



Our role now touches:
- Interdisciplinary collaboration;
- technology adoption and training;
- protocol development and education; and
- public awareness.

Collaborating with other professions, such as pharmacists, speech therapists, nurses, and oncology teams, exemplifies advocacy in action. A pharmacist who now counsels on dry mouth or a nurse guiding a patient through chemo-related mouth sores demonstrates this. It all begins with us sharing what we know.

From every angle

Whether it's in a training, a front desk chat, a social media post, or a shared resource, advocacy doesn't always mean standing at the front of the room. Sometimes, it's just saying, "let's figure this out together."

To the RDHs who educate, listen, and stay curious, you are moving the profession forward.

Let's keep showing up. Let's continue to support change from every angle.

*References available on request

Understanding the Difference Between Employees and Independent Contractors in Ontario

By: Brooke Auld, B.A. (Hons.), LL.B, LL.M, Lawyer and Alissa Scarcello, B.A. (Hons), J.D., J.D., Lawyer

A note from the ODHA: When thinking about accepting a job offer, it is important to first ensure you receive a contract or written offer and then thoroughly review the document provided, taking note of whether the contract or written offer classifies you as an employee or an independent contractor. In many cases, dental hygienists working in a dental practice owned by a dentist are employees, but this is not always the case. Read on for more information about the differences between employees and independent contractors, and the tax (and other) obligations for each. More information can also be found on the ODHA website here. For information on accessing free legal advice, please contact ODHA regarding the LegalLine benifit for members, which provides free legal advice 24/7.

Most people are familiar with the concept of being an employee: reporting to a supervisor, following directions, and receiving regular pay through payroll. However, in Ontario, not all workers fall under this category. At the other end of the spectrum are independent contractors, who operate with significantly more autonomy. This article explores the key differences between employees and independent contractors in Ontario, how to determine a worker's classification, and why the distinction is important.

What is an independent contractor?

An independent contractor is a self-employed individual who controls most or all aspects of their work.

What is an employee?

In contrast, an employee typically works under the direction and control of an employer.

How to determine worker classification

The classification of a worker is a fact-specific determination made on a case-by-case basis. Courts have emphasized that the central question is whether the individual is performing services for the benefit of themselves/their business or for the benefit of another business. However, the courts have outlined several relevant factors to assess the nature of the relationship.

Common law considerations

Courts have addressed the distinction between employees and independent contractors. Their analysis primarily considers the following factors:

- The level of control the company has over the individual's activities and integration into the employer's business;
- whether the worker owns and provides their own tools;
- the degree of financial risk and opportunity for profit the worker has; and
- whether the work performed by the worker is integral to the business.

Ministry of Labour guidelines

The Ontario Ministry of Labour has also addressed the distinction between employees and independent contractors. Their analysis is similar, but they tend to consider the following specific indicators, such as:

- Whether the work performed by the worker is performed on the company's premises;
- whether the company sets the worker's schedule;
- whether the company provides training to the worker;
- whether the relationship suggests ongoing service rather than a fixed-term contract;
- whether expenses are reimbursed to the worker; and
- Whether the worker receives T4 slips and has source deductions for income tax, Canada Pension Plan (CPP), and Employment Insurance (EI).

Why the distinction matters

Correctly classifying workers is critical. Employers are prohibited from misclassifying employees as independent contractors, as this can deprive workers of rights and protections under the Employment Standards Act, 2000 (ESA). The ESA sets minimum standards for employees, specifically for things like wages, vacation pay, public holiday pay, termination notice, and job protected leaves of absences among other entitlements.

Additionally, the classification affects how workers are paid and taxed. Employers must make statutory deductions from employees' pay for income tax, Canada Pension Plan (CPP), and Employment Insurance (EI), and issue T4 slips annually. Independent contractors, on the other hand, usually submit invoices for services rendered (often including HST), and are responsible for their own tax obligations. Companies do not issue T4s for independent contractors.

Middle ground

While this article focuses on employees, who lie at one end of the spectrum, and independent contractors, who lie at the other end, there is a lesser-known category of workers that falls in between. This middle category is called a 'dependent contractor'. Despite the name, dependent contractors are treated more like employees under the law. These workers rely on a single employer for work and compensation, for example, someone who works almost full-time for one company and earns most of their income from that employer. Such workers may be entitled to employee-like benefits and protections under Ontario law.

Conclusion

Understanding the distinction between employees and independent contractors in Ontario is essential for both workers and employers. While the classification hinges on a variety of factors as outlined above, the implications are significant. Employees are entitled to protections under the ESA, whereas independent contractors are not. Misclassification can lead to legal and financial consequences for employers and lost entitlements for workers. Therefore, it is crucial to assess each working relationship carefully and ensure the classification accurately reflects the nature of the work and the working arrangement. Some workers prefer to be independent contractors, and others prefer to be employees so the terms of engagement should be consistent with this preference.

Disclaimer

The purpose of this article is to provide general information about the key differences between employees and independent contractors. It is not legal advice or a substitute for seeking legal advice. For more information, visit the Canada Revenue Agency's publication titled "Employee or Self-employed" and the Ministry of Labour's guide on "Employee status". If you think you have been misclassified or you have questions regarding your personal circumstances, you should seek legal advice.

STUDENT AMBASSADOR PROGRAM

Student leadership opportunities are available! Become an ODHA student ambassador and get to know more about the association while helping your fellow students. Student ambassadors participate in one to two virtual meetings per year to provide ODHA with feedback and student perspectives on current and future resources to support student members. Ambassadors gain leadership experience, connect with other dental hygiene students, and receive an honorarium for each full year of study in their program. If you are interested in applying, please keep an eye out for an email from your dental hygiene program coordinator or director.

Learn more about the position and requirements here.

One of our recent student ambassador graduates, Tuqa Al-Musawi (Fanshawe College graduate 2025) shared her journey and what inspired her to pursue a career in dental hygiene:

> *"My journey toward becoming a dental hygienist began with a deep appreciation for health sciences, which I cultivated through my bachelor's degree in Interdisciplinary Medical Sciences at Western University.*
>
> *Growing up in Iraq, I witnessed firsthand the impact that low oral health literacy and limited access to care can have on individuals' overall well-being. One pivotal moment that shaped my passion was watching my mother experience tooth loss at a young age due to uncontrolled diabetes—without ever being informed about the link between her systemic health and oral health.*
>
> *This experience instilled in me a strong sense of purpose and a desire to pursue a profession where I could educate and empower others to take charge of their oral health.*
>
> *Dental hygiene attracted me because of its client-centred and preventive focus, and its powerful role in promoting overall health. The multifaceted nature of the profession—spanning education, advocacy, research, and clinical care—excites me and aligns with my commitment to making a meaningful difference in people's lives."*

Tuqa's story reflects the passion and dedication student ambassadors bring to the program. Through experiences like hers, ODHA continues to see how future leaders in dental hygiene are shaping the profession and inspiring others to make a difference.

The ODHA Student Ambassador Program is generously sponsored by Relief Buddy.

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