



MILESTONES

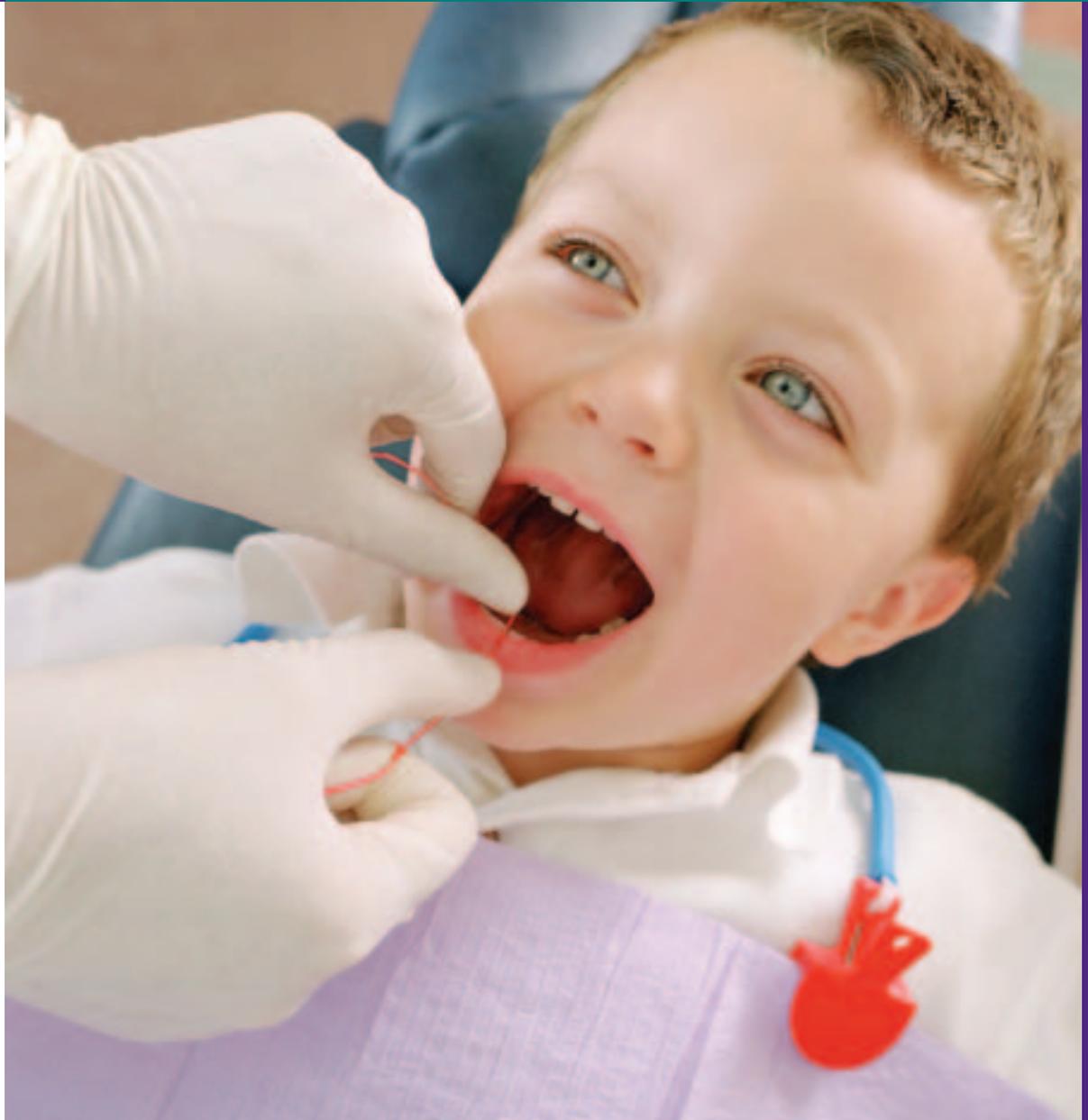
Resource for Dental Hygienists in Ontario

FEBRUARY 2005

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College of Dental
Hygienists of Ontario

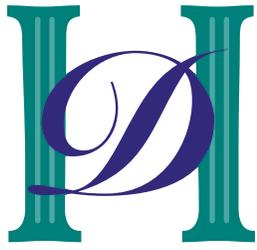
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L'Ordre des hygiénistes
dentaires de l'Ontario



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QUALITY ASSURANCE

Total Quality Improvement Report



MISSION

STATEMENT

LA MISSION

The mission of the College of Dental Hygienists of Ontario is to develop, advocate and regulate safe, effective dental hygiene practice for the promotion of oral health and well-being of the public of Ontario.

La mission de l'Ordre des hygiénistes dentaires de l'Ontario consiste à élaborer, promouvoir et réglementer l'exercice de la profession d'hygiène dentaire de façon sûre et efficace dans le but de promouvoir la santé buccale et le bien-être du public ontarien.

CONTACT US

1-800-268-2346

In the Toronto area call:

> 416-961-6234
www.cdho.org

Registrar/Chief Administrative Officer

Fran Richardson
Ext. 229, registrar@cdho.org

Executive Assistant to the Registrar

Jane Cain
Ext. 226, jane@cdho.org

Deputy Registrar

Evelyn Waters
Ext. 228, deputyregistrar@cdho.org

Administrative Assistant to the Deputy Registrar

Suzanna Tatsis
Ext. 237, suzanna@cdho.org

Director, Administrative Services

Margaret Stevenson
Ext. 227, admin@cdho.org

Quality Assurance Director

Eleanor McIntyre
Ext. 239, qualityassurance@cdho.org

Quality Assurance/Registration Co-ordinator

Joyce Quan
Ext. 230, joyce@cdho.org

Communication Services Co-ordinator

Diane Colautti
Ext. 231, diane@cdho.org

Receptionist

Celine Weeling-Lee
Ext. 0 or 221, celine@cdho.org



MILESTONES MESSAGE FROM THE PRESIDENT, Peggy Maggrah

In the fall of 1993 Lynda McKeown came to Kenora for an information session one evening. This was an exciting time as Lynda was Chair of the Transitional Council of the College of Dental Hygienists of Ontario. Imagine, the Chair of a council coming to our Northern Ontario town to talk to a handful of dental hygienists. It was a meeting I will never forget as it was the beginning of a new chapter in my professional career.

Lynda explained that with the proclamation of the *Regulated Health Professions Act, 1991* dental hygiene would be recognized as a self-regulating profession in Ontario. I remember asking, "How can someone like myself become involved?" The reply was straightforward, "Apply for a position as a Non-Council Member". I went home and polished up my resume. Now ten years later I am writing the President's Report.

Self-regulation is a privilege. The people of Ontario are becoming increasingly aware of their own health and well-being. They expect safe, effective dental hygiene services from competent, regulated oral health care professionals.

This year the College will begin a strategic planning process for the future that will include articulating and reviewing our mission, value and vision statements. This is a positive step forward. We must plan ahead as new developments and research continue to occur within the health care sector. The public demands this of us. Let's keep moving forward so the public of Ontario benefits from good oral health care!

I would like to thank my husband, children and extended family in Northwestern Ontario and colleagues who have supported me over the past 10 years. Without their continued support, this privilege and opportunity would not have been possible.

HAVE YOUR SAY



Q: "The question of a colleague being incompetent in his/her capacity to function as a dental hygienist is broad or difficult to determine. Is it possible to outline or define "not competent" and just what the consequences would be to both the party that is ill and party who is observing these actions? I understand that an addiction could be cause for alarm but what are other issues that may arise?"

A: A health care practitioner may be "not competent" to practice if they have a substance abuse problem, are ill or have a condition that may put the client in jeopardy. Often the individual who is ill does not recognize that they have a problem and may be putting clients at risk. A prudent colleague would approach the person and suggest that they take a leave of absence and seek help. Should this not occur, then the colleague would have an obligation to report the individual to his/her College. The College would then launch an investigation.

Q: "After reading the question and answer about radiographs in your latest issue (November/04) I am wondering what exactly you mean by "clinical findings"? Are we only to take radiographs if the client has aches, hot and cold sensitivity, or we can see a cavity breaking through the occlusal surface?"

A: Currently, all radiographs must be prescribed, on an individual basis, by the dentist after performing a clinical examination. That prescription must be documented in the client chart. Radiographs must not be taken on a time dependant basis such as every six-months or once/year. The medical history should always be consulted before the radiographs are exposed.



Send your comments to:

- haveyoursay@cdho.org
- or by mail to Have Your Say
69 Bloor St. East, Suite 300, Toronto, Ontario, M4W 1A9

While not all submissions will be published, we will endeavour to respond to your comments.

TOTAL QUALITY IMPROVEMENT REPORT

College of Dental Hygienists of Ontario with
Dr. Patricia Johnson, PMJ Consultants

INTRODUCTION

The College of Dental Hygienists of Ontario (CDHO) is mandated by the *Regulated Health Professions Act, 1991, (RHPA)*, as one of the twenty-one health regulatory bodies in Ontario, to have a Quality Assurance Committee to develop and administer a quality assurance program. The CDHO Quality Assurance Program (see Figure 1) fulfills the intent of the *RHPA*, the Ministry recommendations, and is consistent with the CDHO Mission Statement, in which dental hygienists are expected to:

- assure that their professional responsibility to the client prevails;
- apply the CDHO Dental Hygiene Standards of Practice and CDHO regulations, codes and bylaws to the dental hygiene practice;
- maintain and improve their level of competence through the continuous acquisition of knowledge, skills and judgment; and
- be accountable for their actions.

TOTAL QUALITY IMPROVEMENT (TQI) COMPONENT

In 1995, under the auspices of the Quality Assurance Committee, a study *Dental Hygiene Practice in Ontario, 1995* was conducted to:

- provide direction for the design and development of the quality assurance program, and
- establish a baseline practice profile for comparison with future periodic surveys.

As approximately 9 out of 10 dental hygienists in Ontario work as clinicians (that is, provide direct client care services) in private dental offices, this study focused on dental hygiene clinical practice as opposed to teaching, administration or other roles.

Using a 19-page survey developed for the purpose, the study examined characteristics of all dental hygienists registered to practice and residing in Ontario. Based on the survey findings, the Quality Assurance Committee concluded

that the majority of dental hygienists were competent health professionals who participated in continuing education programs and maintained a relatively high quality of practice. The Committee used these findings to develop specific aspects of the Quality Assurance Program (QAP).

In 2002, the Quality Assurance Committee undertook a second study – the *Total Quality Improvement (TQI) Review 2002* – as part of the QAP. Findings from this recent study, which are highlighted in this report, will be used to further develop, monitor and evaluate the quality assurance program. Specifically, its purpose was to:

- establish a second set of statistical profiles of dental hygienists in Ontario,
- examine patterns and changes in their clinical practice since 1995, and
- identify factors associated with the quality of that practice

The response rate was a remarkable 84%, a slight increase from the 80% achieved in 1995. Of that group, one-third provided written comments – again a slight increase from 1995. Respondents answered very thoroughly; missing responses to individual survey items typically were less than 3%.

Findings indicate that overall and compared to 1995, dental hygienists in Ontario pursue a greater number and broader range of continuing quality improvement (CQI) activities and that their efforts are reflected in the quality of their clinical practice.

The dental hygienists that participated in these studies are to be commended for their diligence, time and efforts. They contributed greatly to the excellence of the longitudinal database. It provides a highly reliable portrait of the profession and a valuable source of information for planning programs to help dental hygienists ensure the safety and quality of their services.



TQI REVIEW 2002 - MAJOR SURVEY FINDINGS

Highlights from the 2002 TQI study are presented, together with comparative findings from the 1995 study, where available.

1) Dental Hygienists

Aside from a one-third increase in numbers – from 4,811 to 6,513, there has been little change in terms of general characteristics of dental hygienists over the 7-year period since 1995. Nine out of ten dental hygienists graduated from an Ontario-based dental hygiene program, reside in southern Ontario, and are currently working in the field. They typically work in a private dental office providing clinical services directly to clients.

2) Continuing Quality Improvement (CQI)

a. Activities

Dental hygienists pursue a variety of CQI activities and their level of activity has increased since 1995 when the College's Quality Assurance Program (QAP) was implemented. Three aspects of CQI were examined.

- Regarding type of activity, professional reading was most prevalent (99% of respondents), followed by interaction with peers (85%), professional conferences (80%), and continuing education courses (73%).
- Regarding professional reading, three Canadian dental hygiene publications continue to be most prevalent. Nine out of 10 dental hygienists reportedly read CDHO *Milestones*, ODHA *Focus*, and/or CDHA *Probe*.
- Regarding dental hygiene-related topics pursued in the previous 2-year period, the number of topics reported by dental hygienists, on average, doubled from two in 1995 to four in 2002.

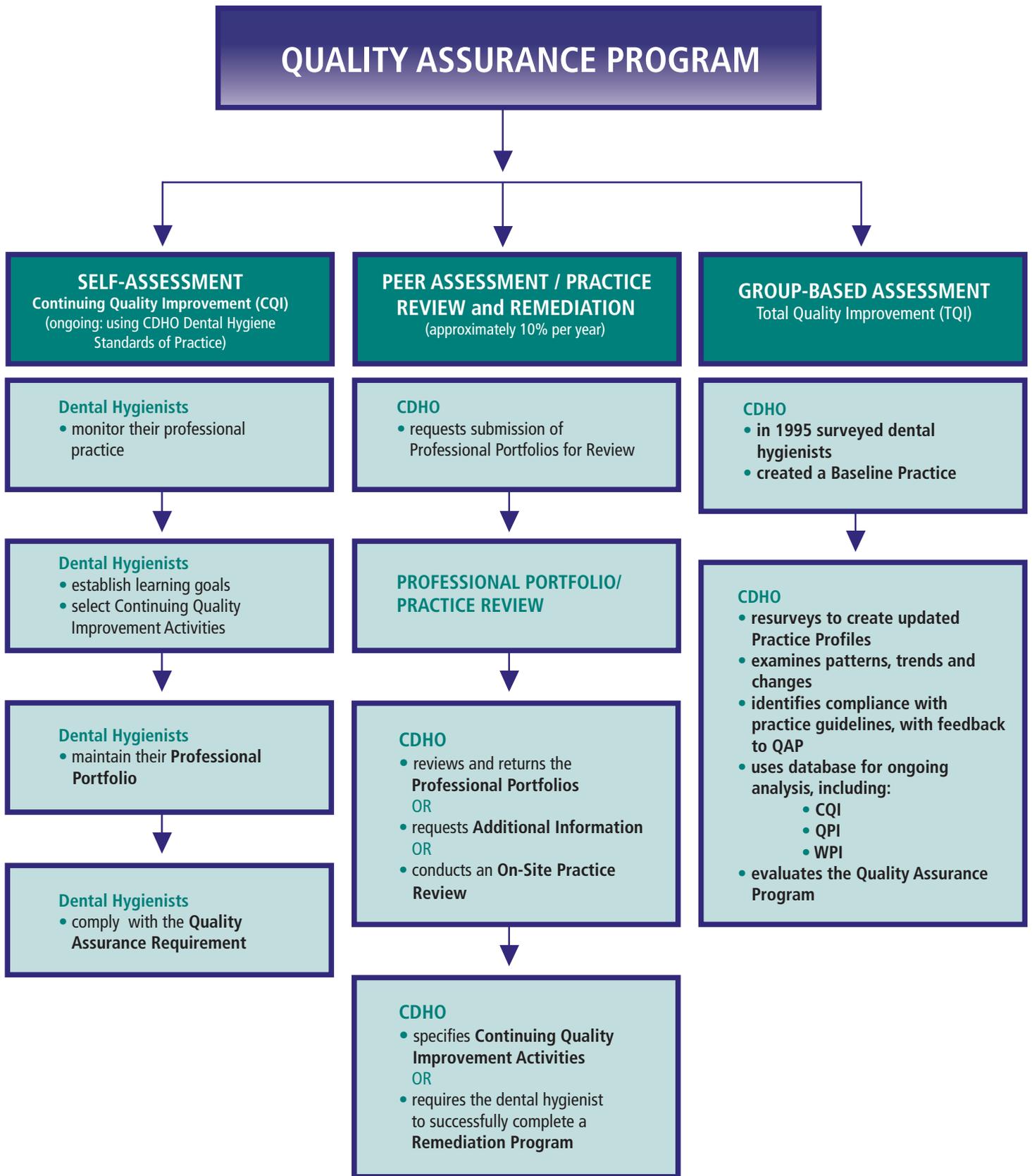


Figure 1: CDHO Quality Assurance Program, 2004

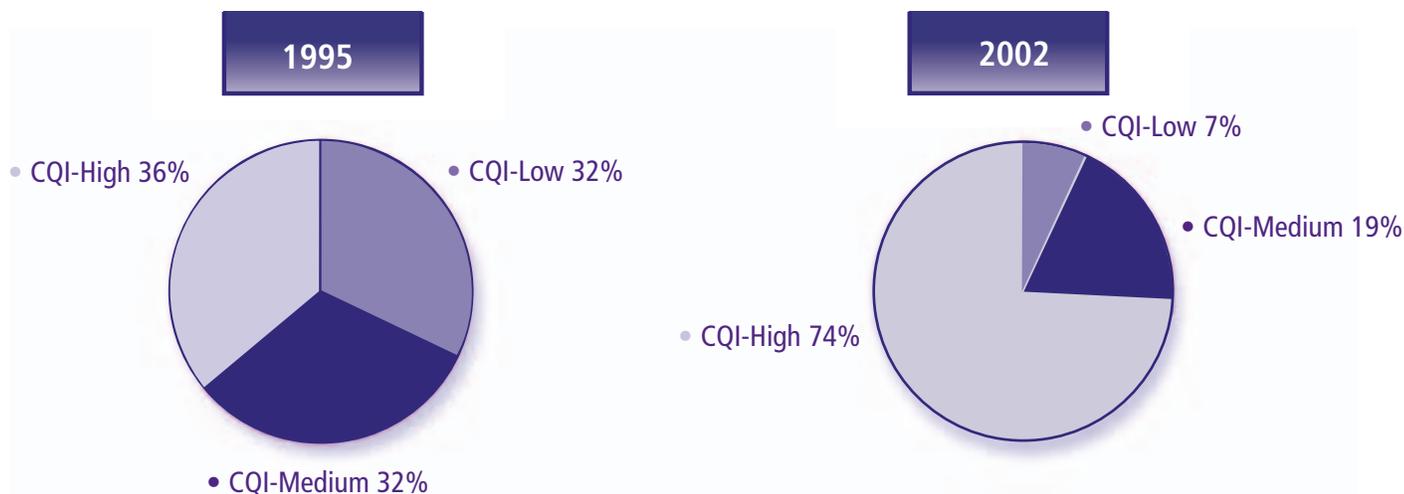


Figure 2: CQI Activity by Year

b. Continuing Quality Improvement (CQI) Index

Using a CQI Index developed for the studies, findings indicated that dental hygienists' self-reported CQI activity had increased markedly over the period since the quality assurance program was implemented in 1995 (see Figure 2). Specifically:

- The mean average for the CQI score, calculated across all dental hygienists, increased by 50% - from 8.4 in 1995 to 12 in 2002.
- The group that scored High in terms of CQI doubled - from 36% of dental hygienists in 1995 to 74% in 2002.
- At the same time, the Low-CQI group declined markedly - from 32% of dental hygienists in 1995 to 7% in 2002.

3) Patterns and Trends in Clinical Practice

The remainder of this report pertains to the nine out of ten dental hygienists that provide direct client care clinical services and whose principal workplace is one of three types of private dental offices - namely, general, orthodontic or periodontic. An examination of major patterns and changes in their practice over the period 1995 to 2002 illustrates the evolution of the profession.

a. Assessment

Dental hygienists typically perform a broad range of assessment activities for a client and, with few exceptions the frequency with which they perform them has increased since 1995.

By 2002:

- At least eight out of ten dental hygienists always or usually review and/or update the client's medical history, determine client priorities, perform soft and hard tissue examinations, take periodontal attachment level, debris and/or bleeding indices, review self-care procedures, and/or use client radiographs for assessment purposes.

b. Planning Dental Hygiene Care

The vast majority of dental hygienists always or usually perform a broad range of activities associated with dental hygiene care planning.

- Approximately nine out of ten dental hygienists always or usually analyze assessment data, determine significant findings, identify oral health-related factors, establish priorities for dental hygiene care, and/or specify clinical interventions.

- Regarding documentation:

1. At least six out of ten dental hygienists always or usually prepare a detailed appointment plan.
2. One-half always or usually include planned goals and objectives in the plan.
3. One-half always document the plan in writing and another three out of ten usually do so.

- The vast majority of dental hygienists involve the client in the planning process.
 1. Nine out of ten always or usually inform the client regarding oral health findings and/or short and long-term consequences.

2. Eight out of ten discuss treatment options with the client and/or involve them in the decision-making process.

- Regarding appointment-related decisions, the vast majority of dental hygienists are involved in deciding the number of appointments to book, services to provide, length of appointment, and interval between appointments.

c. Implementation Therapeutic Services

Among the therapeutic procedures for which comparable information for 1995 was available, little change in the frequency with which dental hygienists perform them was noted. Where change occurred, it tended to be consistent with practice guidelines.

- By 2002, nine out of 10 dental hygienists performed a set of core procedures either routinely for all clients or selectively as indicated (as opposed to never or not applicable). These procedures include supra and subgingival scaling/debridement, root planing, tooth polishing, application of topical fluoride, and tooth whitening.
- As expected, they tend to perform another set of procedures, such as periodontal irrigation, application of sealants and desensitization, less frequently.
- A very small portion of dental hygienists in private practice performs orthodontic and/or restorative procedures - 13% and 4% respectively.

Client Education Services

Dental hygienists typically provide health counselling and other educational services selectively as indicated more so than always, sometimes, or rarely/never. For most of the procedures examined, this frequency is consistent with practice guidelines. For example:

- Dental hygienists tend to selectively review self-care at each appointment, counsel in dietary control of oral disease, counsel in tobacco cessation, provide information regarding fluoride therapy, replacement of missing teeth and/or mouth protection, recommend topical fluoride, oral irrigation, and/or tooth whitening agents for use at home, and/or recommend in-office treatments for tooth whitening, veneers and/or crowns and bridges.
- For several procedures, a shift since 1995 had occurred. By 2002, dental hygienists overall were somewhat more likely to counsel for cessation of tobacco use, provide information regarding substance abuse, and recommend home-use of oral irrigation and tooth whitening agents.

Safety And Protection

Dental hygienists in private practice typically comply with or have access to basic safety and protection measures. Several patterns have changed since 1995.

Regarding dental hygienists' safety qualifications and training:

- Similar to findings in 1995 and with few exceptions, dental hygienists typically have attained their basic level CPR certification.
- Frequency of renewing that certification has increased - the proportion that renews annually doubled to 80% from 43% in 1995.

Regarding safety practices:

- The portion of dental hygienists that wear a radiation-monitoring badge declined slightly to just over one-half in 2002.
- Virtually all dental hygienists wear gloves and change them after each client. One-half wears latex-free gloves.
- The use of eye protection for the client has increased markedly since 1995.

Regarding the workplace:

- Among dental hygienists in general, orthodontic and periodontal practices, fully one-half work in an office that apparently lacks a written emergency protocol or they do not know if one exists. The proportion had decreased from three-quarters in 1995.

Regarding radiation protection:

- Similar to findings for 1995, radiographs of all types typically are prescribed selectively based on need for both adult and child clients.
- Dental hygienists tend to use full lead coverage body protection for all clients.

Regarding universal infection control:

- Overall, nine out of ten dental hygienists perceive that the infection control policy (ICP) is consistent for all personnel in the workplace.
- While only four out of ten dental hygienists reported that procedures are specified in writing (for example, in an office manual), this was an increase from the 25% observed in 1995.
- Only six out of ten dental hygienists indicated that compliance with the ICP is monitored on a regular basis.
- Similar to 1995, approximately two out of three dental hygienists report that the procedures for the workplace are established jointly – that is, by the dentist, the dental hygienist and other staff members.

d. Evaluation

The majority of dental hygienists routinely use a wide range of procedures to evaluate dental hygiene care.

- Frequency increased over the period since 1995 for three procedures for which comparative data were available.

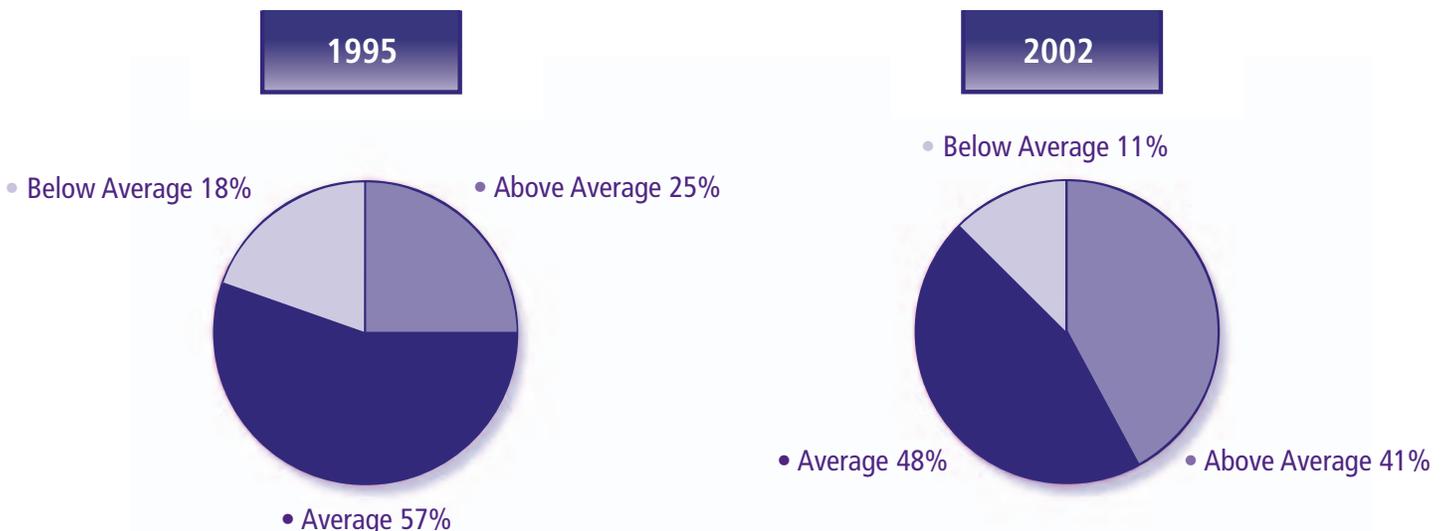


Figure 3: Quality of Dental Hygiene Practice , by Year

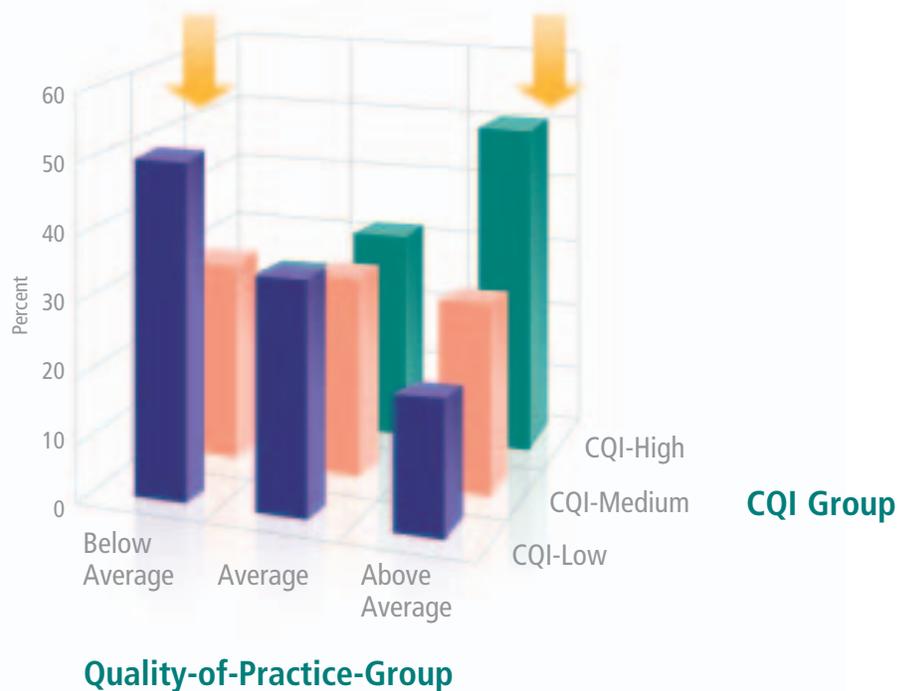


Figure 4: Dental Hygienists > Quality of Clinical Practice and CQI, 2002

QUALITY OF DENTAL HYGIENE PRACTICE

1995 versus 2002

Further analyses of the 1995 and 2002 survey data, using a quality-of-practice index (QPI) developed for the purpose, found that the overall quality of dental hygiene clinical practice had improved over the 7-year period. As illustrated in Figure 3, the group that performed (that is, scored) above average increased proportionately from 25% to 41% of dental hygienists overall whereas the below average group declined from 18% to 11%.

Influencing Factors

Quality of practice is associated with a number of personal, occupational and workplace-related factors. With the exception of continuing quality improvement activity of the dental hygienist – the most predominant factor, relative importance of a factor tends to vary depending on the type of workplace.

1) Continuing Quality Improvement Activity (CQI)

The level of continuing quality improvement activity (CQI) of the individual dental hygienist

accounts for the greatest variation in quality of practice, regardless of whether it is a general, orthodontic or periodontic dental office.

Figure 4 illustrates the strong and direct relationship between dental hygienists' level of continuing quality improvement activity (CQI) and the quality of their practice (QPI).

- Among dental hygienists that perform above average, the group that scores High in terms of CQI activity is predominant.
- In contrast, among the relatively few dental hygienists that perform below average, the group that scores Low in terms of CQI is predominant.
- The large portion of dental hygienists whose performance is average is more equally dispersed among the three CQI groups.

2) Supportiveness Of The Work Environment

Among dental hygienists in general practice in particular, quality of practice declines markedly among the group that perceives the environment provides very little or no support for their work and is not receptive to changes to improve their practice. On the other hand, quality is greatest among the group that perceives support is unlimited.

Information regarding the workplace was available through the surveys. For example:

- Of seven options needed to improve and/or change the way they practice, almost three out of four dental hygienists consider the support of the dentist and staff to be most essential, followed by a need for accurate, research-based information. Almost one-half also cited the need for more time for client education.
- In terms of workload, over a seven-hour period (excluding lunch), a majority of dental hygienists sees nine to twelve clients on average (54%) and another one-third sees fewer than 9 clients. The exception is the group in orthodontics where 84% see thirteen or more clients.
- With the exception of the group in orthodontics, dental hygienists typically do not have the help of a dental assistant when performing intra-oral procedures.

3) Perceived Helpfulness of the CDHO Quality Assurance Program

Among dental hygienists in general practice or orthodontics, quality of practice is positively associated with the dental hygienist's perception regarding the helpfulness of the College's QA Program.

4) Decision-Making Responsibility

Among dental hygienists in general practice, quality of practice is positively associated with decision-making responsibility regarding dental hygiene services to be provided. It tends to be greater among the two-thirds of dental hygienists that perceive they make decisions either themselves or in collaboration with the dentist, compared to those that perceive they have little participation in the decision-making.

5) Other Factors

- Across all three types of dental office, quality of practice is positively associated with a dental hygienist's level of career satisfaction.
- Among the group in general practice, working full-time (30 or more hours) in the principal workplace, compared to part-time, is positively associated with quality of practice, although the relationship is weaker compared to the other factors.
- Among the groups in general practice and in periodontics, quality tends to vary by electoral district. It is not clear whether this reflects differences among dental hygienists, their educational programs or their workplaces or, indeed, broader environmental factors.



THE GROUP THAT PERFORMS BELOW AVERAGE

Given the College's mandate to ensure the quality and safety of dental hygiene services, distinguishing characteristics of the group of dental hygienists that function below average were identified.

Regarding CQI and in comparison to dental hygienists that perform either above average or average, the Below Average group:

- tends to participate in fewer types of continuing quality improvement activities specific to dental hygiene, reads fewer profession-related publications and spends less time reading them,
- is far less likely to study soft tissue management, record keeping, communication, and the client that is medically compromised,
- is somewhat less likely to study dental hygiene process, nutrition and tobacco cessation techniques, and
- is less likely to report that the QA Program and/or the forms provided to document information for the Professional Portfolio are helpful.

In addition, the Below Average group overall is:

- considerably less satisfied with their career in

dental hygiene,

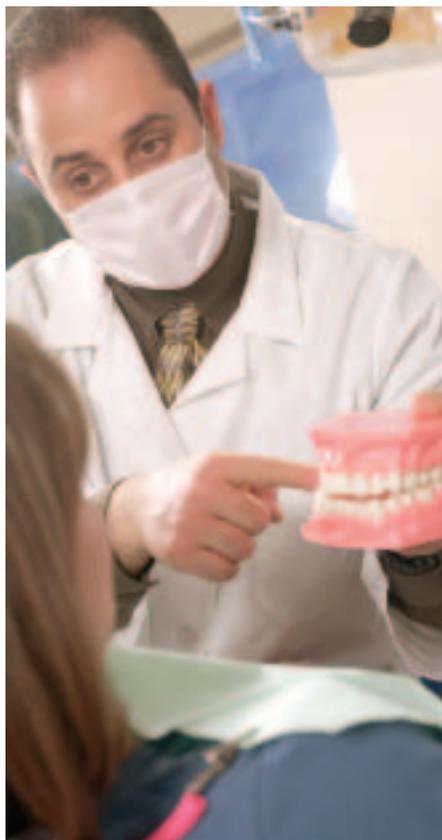
- somewhat less likely to work full-time in their principal workplace, and
- somewhat less likely to renew their CPR certification annually.

Regarding their principal clinical workplace and in contrast to the other two groups, the Below Average group:

- is more likely to work in an environment that they perceive to be non-supportive,
- is less involved in making decisions regarding dental hygiene care, and
- is considerably less likely to have a written job description, access to a written emergency protocol, opportunities to assess and use new technology, and to participate in the design of client record forms.

CONCLUSION

Of the several conclusions drawn from the findings of this study, perhaps most noteworthy is the importance of continuing quality improvement activity if dental hygienists are to achieve and maintain a high standard of practice. Societal changes, epidemiological trends, and developments in science and technology are influencing the evolution of dental hygiene. It is the responsibility of every practitioner to maintain personal competence.





COUNCIL'S CORNER

Highlights of January 21, 2005 Council Meeting

Elections were held for the positions on the Executive Committee for 2005. The results are as follow: Peggy Maggrah (District #8), President, Lois Brown (Public Member) Vice President, Gordon Campbell (Public Member), Cathy Mazal Kuula (District # 7), Karen Tulk (Academic).

Retiring Council member and past President Barbara Smith was presented with a plaque as a token of appreciation.

The Administrative report noted that there were a total of 7,811 registrants as of December 31, 2004. The 2005 annual registration renewal form was placed on the web-site for registrants to access and download as required.

As directed by Council, the Annual Report has been posted to the College web-site. A limited number of hard copy reports were printed.

The Executive Committee reported that Bill 116, *An Act to Amend the Dental Hygiene Act, 1991* unanimously passed second reading in the Legislature on December 2, 2004 and the Bill has been referred to the Standing Committee on Public Accounts.

As per the Health Professions Regulatory Advisory Council (HPRAC) recommendations (May 1996), a proposed standard of practice was developed and circulated with the CDHO's standards of practice in 1996. Since that time and with the introduction of the two Private Member's Bills, a revised proposed standard of practice for self-initiation was presented to Council for review at second reading. The motion passed. However, the standard remains "proposed" until the passage of either Bill 91 or Bill 116.

Council adopted a policy to publish Discipline Committee decisions along with a summary of its reasons in the Annual Report, *Milestones* and on the CDHO web-site.

Council approved the Patient Relations Committee recommendation regarding participation in the Federation of Health Regulatory Colleges of Ontario (FHRCO) public education strategy. A strategy aimed at the public to raise awareness of the regulatory health Colleges to the public in Ontario.

The Regulations and Bylaws Committee presented for approval the Amendment to Section 16, Bylaw No. 3 which had been circulated to registrants and stakeholders for response. The amendment was approved.

COUNCIL MEETING DATES

2005 Council Meeting Dates
Friday, July 15, 2005
Friday, October 21, 2005
(location TBD)

The next meeting of Council is scheduled for Friday, April 15, 2005 at the Toronto Board of Trade, 77 Adelaide Street West, Toronto, from 9:00 a.m. to 4:00 p.m. All are welcome to attend. For further information please contact Jane Cain at (416) 961-6234, ext.226 or toll free at (1-800) 268-2346 or via email at jane@cdho.org

PRACTICALLY SPEAKING

Privacy Legislation

"The *Personal Health Information Protection Act* is an in-depth piece of legislation designed to address very complex issues concerning the collection, use and disclosure of personal health information by health information custodians." This sentence comes from the document, *A Guide to the Personal Health Information Protection Act* published by the Information and Privacy Commissioner/Ontario www.ipc.on.ca. The Guide is written in an easy to understand format that includes related examples. There are several areas of direct concern for the CDHO registrant:

- There is implied consent that health care practitioners may share client information within the "circle of care"
- The "lock box" provision means that a client may expressly request that a health care practitioner not share any or some information within the "circle of care" – in the case of shared records, this may be problematic and separate charts may be required
- If a client and a practitioner disagree on a client's right to access/amend their record, the Privacy Commissioner provides a mediation process
- Express consent from the client is required to release information to an insurance company

For more information contact the Information and Privacy Commissioner/Ontario at 416-326-3333 or 1-800-387-0073 or e-mail to info@ipc.on.ca

A Thought about Privacy and Safety

Many dental offices have posted pictures of smiling children in the office reception area. Sometimes the names are attached, sometimes they are not. A registrant has contacted the CDHO to inquire as to the safety and privacy issues concerning such displays. First, permission needs to be granted by the child and the parent/guardian to display the pictures. Second, the prudent practitioner would choose to display such pictures within the office setting and not in the reception area.

Medical/Dental History Guide

The CDHO has developed a medical/dental history guide for use by registrants when evaluating their current medical/dental history form or for when registrants are in the process of developing a new format. The guide may be found under "Resources" on the web site at www.cdho.org if you do not have internet access and wish to receive a paper copy, please contact the CDHO office at (416) 961-6234.

HONOURABLE MENTION

Fran Richardson

Registrar

Fran Richardson was recognized at the January Council meeting for her contribution to the CDHO over the last ten years. Prior to joining the CDHO in 1995, Fran was Chair of Health Sciences at the College of New Caledonia in Prince George, BC. She is a past-president of the Canadian Dental Hygienists Association and has been honoured with both a Distinguished Service Award (1990) and a Life Membership (2000). In October 2001 Fran was presented with an Alumna of Distinction Award from the University of Toronto, Faculty of Dentistry. Congratulations Fran!



HEALTH CARE FRAUD

- Equitable Life of Canada 1-800 265-8899
– tip line on health care fraud

Resources for Preventing Fraudulent Practices in Healthcare

- Sun Life Assurance Company of Canada hot-line (1-888) 882-2221
- Canadian Health Care Anti-Fraud Association www.chcaa.org :
click on "Education Centre" Education
Material/Red Flags

RECYCLING

- Paper recycling is positive way to be environmentally conscious. However, when faxing or submitting material to another source, it is important to note what is on the other side of the paper. The College has received, on more than one occasion, submissions on recycled client financial statements. This is not only a breach of PIPEDA and PHIPA, but a breach of CDHO regulations. Check the other side!

The CDHO has developed a Medical/Dental History Guide for registrants. To view go to www.cdho.org and click on "Resources"

SKILLS ENHANCEMENT FOR HEALTH SURVEILLANCE PROGRAM

- Designed for health professionals in local public health departments and regional health authorities across Canada.

For more information on the Skills Enhancement for Health Surveillance Program visit their web-site at www.healthserv.net/skills or call toll free (1-877) 430-9995

The registrant is responsible for notifying the College of an address or name change within seven (7) days of that change.

Milestones is published periodically by the College of Dental Hygienists of Ontario, 69 Bloor Street East, Suite 300, Toronto, Ontario M4W 1A9
Telephone • 416 961-6234 Toll Free • 1 800 268-2346 Facsimile • 416 961-6028

Milestones is the official publication of the College of Dental Hygienists of Ontario.

Comments or Questions on issues relating to the dental hygiene profession are welcome.

2005 College of Dental Hygienists of Ontario.

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