Creating a Perio PROGRAM
For Your Practice – Part V

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**Endoscope provides visualization for subgingival instrumentation**

The goal of scaling and root planing is to remove both hard and soft deposits that contribute to inflammation. Subgingival instrumentation is generally done blindly by dental hygienists and with direct vision by periodontists during flap surgery. According to the research, removing all the subgingival calculus deposits is difficult, if not impossible, for both hygienists and periodontists. The use of a periodontal endoscope has shown that calculus deposits can be smooth and as small as glitter.

Researchers at the University of Minnesota compared blind subgingival instrumentation with endoscope aided instrumentation. A group of 26 patients with moderate periodontal disease participated. Following a split-mouth design, one quadrant was treated with hand and power instruments alone and a second quadrant was treated using hand and power instruments plus the aid of an endoscope. Subjects were evaluated again at six to eight weeks and then after three months.

The reduction in the gingival index scores was significantly greater for the endoscope group than for the control group. Bleeding upon probing was also reduced significantly more in the endoscope group.

Both test and control groups showed reduced probing depths: 1.74mm reduction in the endoscope group and 1.56mm reduction in the control group. Greater pocket depth reduction was anticipated, but according to the study authors, these study subjects as a group were generally not compliant with oral hygiene instructions. This may explain less than anticipated probing depth reduction.

**Clinical implications:** Use of the endoscope with scaling and root planing, compared to blind instrumentation, leads to improved oral health measured by bleeding and gingivitis scores.

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**Endoscope detects more Subgingival calculus than an explorer**

Subgingival calculus needs to be removed as part of effective periodontal therapy. In order to successfully remove subgingival calculus, it must first be detected. Since subgingival calculus provides a porous retention site for bacterial biofilm, complete subgingival calculus removal is desirable to achieve periodontal health. Complete detection and removal of subgingival calculus is difficult using only tactile sensitivity. The periodontal endoscope provides a magnified view of both the subgingival root surface and the opposing sulcular tissue. Images magnified from 24X to 48X provide more effective calculus detection before and after scaling and root planing.

Researchers at the University of Minnesota compared the traditional explorer evaluation of subgingival surfaces to calculus evaluation using the endoscope. A group of 26 university patients with moderate periodontal disease each provided two quadrants for study. For each patient, one quadrant was evaluated with an explorer and the other quadrant was evaluated using the endoscope. Scaling and root planing were done with hand and power instruments. The sites evaluated with the endoscope were also instrumented with the aid of the endoscope. Patients were seen for three visits. Re-instrumentation was provided where indicated at the second and third visits.

Both the endoscope and the explorer detected significant changes from the first to the second visit, after initial instrumentation. However, the endoscope detected more calculus than the explorer at each evaluation. The visual and magnification aspects provided added benefits over tactile sense alone.

**Clinical implications:** A periodontal endoscope enhances subgingival calculus detection with a magnified visual component. The financial investment provides a better tool to visualize subgingival surfaces and detect calculus.

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Patients value periodontal probing scores

Probing scores are part of the full periodontal examination. Dental hygienists provide this service for new patients and some repeat the probing scores at each visit while others provide it yearly.

A dental hygienist wanted to find out what patients thought about these probing scores and if they wanted or valued the information. One hundred consecutive patients in a general dental practice were asked to complete a short questionnaire after their regular dental hygiene visit, which included periodontal charting and discussion of the findings.

Patients varied in age from 20 to 83 years and were either new or had been with the practice for as long as 23 years. The periodontal examination included probing scores, recession, attachment levels, furcations, mobility, bleeding, suppuration and a review of the radiographs.

Measurements were taken with a Marquis probe and entered into the computer using the Dentrix program. Following data collection, the chart was printed for the hygienist to review with the patient. Health and disease were discussed and any change in oral hygiene was presented. Needed treatment was also presented at this time.

All of the 100 patients felt the periodontal charting was helpful to them and all wanted the measurements repeated at future dental hygiene visits. When asked about making changes to their daily oral hygiene, 93 percent found the probing scores helpful while 7 percent did not. Of these seven patients, four reported their numbers were good so no change was needed and three noted they were lazy and unmotivated to change.

Clinical implications: Periodontal probing scores taken at each hygiene visit and discussed with the patient provide a valuable service and roadmap for treatment.

Humphrey, L.: Do Patients Feel Gum Measurements at Hygiene Visits are Helpful for Them? OHU Action Research Project, 1B-14, 2014.

Appearance, interest of care giver predict special needs patient’s oral health

People with special needs are at higher risk of dental disease than others, and often have to be restrained to perform oral hygiene or dentistry.

Researchers at the Santiago de Compostela University in Spain wanted to know if the personal appearance of the care giver and their attitude toward oral health would predict the oral health status of their special needs patient. They evaluated the oral health of 60 patients coming for the first time to the Special Needs Dentistry Unit of the dental school. A non-invasive, visual examination was done on each of the special needs patients. The care givers were asked to complete a questionnaire. The care givers were also observed for cleanliness of their hair, finger nails, shoes, clothes and their anterior teeth. Another observation of five points was done as the oral health examination and oral hygiene instructions were presented to them, noting their interest, questions and attitudes.

More than half of care givers scored good or very good on the personal appearance evaluation. An even higher number, 72 percent showed a high level of interest in the oral health of the special needs person. No interest was shown by only 8 percent of the group. Only 20 percent of care givers had received formal instruction in how to provide oral hygiene to a person with special needs.

Clinical implications: The appearance and interest shown by a care giver can predict the oral health level of the person with special needs in their care.

Most of my patients don’t like being probed, especially those with deep pockets. And the bloody mess after probing is also a concern. How to do it in a more comfortable and neat way? Any suggestions?

Probing shouldn’t ordinarily hurt or cause bleeding. The base of the sulcus is lined with junctional epithelium and there is neither vascular supply nor innervation to epithelium. When you think you’re placing the perio probe down to the base of the sulcus, you are truly probing into the epithelium about a quarter millimeter. This is enough to stimulate the neurosensory apparatus within the underlying connective tissue, but that’s not really a painful stimulation. Perhaps you’re pushing too hard — try to push no more than 0.25N (25 gram-force), which is equivalent to the amount of force necessary to just blanch your fingernail when pushing on it. Any more, and not only are you going to hurt the patient, but you’re likely getting inaccurate readings and causing bleeding.

That’s in health. In disease (and this is not restricted to periodontitis, because gingivitis will exhibit the same), the epithelial base of the sulcus is ulcerated — that’s why even gentle stimulation will cause bleeding. The underlying connective tissue is, well, no longer underlying. It’s exposed at the base of the sulcus. And without the resistance provided by the normally present junctional epithelium, you can easily probe .5mm past the JE/CT junction. This will not only cause bleeding and pain, but your perio charting can then easily be 1.5mm off because your probe has descended 1.5mm too apical. Add that to the generalized edema normally present in disease (which can easily add approximately 1mm to the coronal aspect of the sulcus by enlarging and engorging the gingival margin), and your probing measurement can easily be off from what it ought to be with no inflammation by nearly 3mm, and we haven’t even irreversibly lost any attachment.

Should be mostly painless. If they have severe perio, then it’s probably going to hurt. If you use a sweeping gentle touch instead of pushing in and out all the time it helps. If it’s super painful and I know quickly that they have all 7s and 8s with pus and bleeding, then why not finish the probing after they are numbed up for the quads? More accuracy that way and a much less stressed out patient.

If they are comfy in all areas except one or two, that’s a great conversation starter. “Why are those two spots sore and the others weren’t?” It only helps if you were totally painless with the other probings. If most areas are painful, you are pushing too hard.

Periodontal charting and probing is (if you scan the Internet for these topics) neither the favorite of patients or dentists. Essentially it is a time consuming activity that nobody likes, and provides marginal benefit to the clinician. The most significant benefit of charting, and this is said tongue in cheek, you need it for insurance reimbursements. Of course, to be more serious, you need it to track the progression on disease, but is there a solution on the market that creates the kind of documentation needed to truly track disease progression that is easy?
To me, all computerized charting has been labor intensive and fraught with the potential for making mistakes as you chart. (Bluntly, paper charting is easier.) This includes voice-activated charting, etc. CPITN, PSR and PreViser are all screening techniques that, with positive findings, are essentially a permission statement to go back and do comprehensive charting. Getting back to the point of the thread, periodontal charting could be much more comfortable if fewer probing data points were required. My question would be: What is the reason that we need six points of probing depth around each tooth? I think I know the reason that we do this, and virtually every periodontal chart created for commercial accommodates six-point probing. But do you really need six points to diagnose? Less probing, more comfort.

It is possible to diagnose based on a photograph, smell and X-rays alone. You can see the inflammation and redness. Smells horrible. Bone loss on X-rays. Next time for insurance pre-authorization, mail in a claim with a big piece of the calculus bridge in a little baggie stapled to it.
Reflecting on Your Perio Program

This is the fifth installment of our five part series on implementing a perio program in your practice. The first installment focused on assessing the periodontal health of your practice, asking, “How healthy are your patients and how healthy do you want them to be?” Answers to these questions provided the foundation for the second installment, focused on getting the conversation going between dentists and hygienists on their philosophies of periodontal treatment and prevention. In the third installment it was time to create the plan for your perio program. Once the plan was ready, the focus was implementation. The fourth installment provided ideas for presenting the perio program to patients to gain their acceptance and full participation. In this final installment, our clinical experts provide reflections on the implementation and acceptance of the perio program and helpful suggestions for measuring success and identifying areas needing improvement.

Diane Brucato Thomas, RDH, EF, BS, FAADH, OMT, BBP:

Valuable feedback to evaluate the success of your perio program can come from everyone involved. The doctor may notice a need to refer fewer clients to the periodontist as one positive result of the periodontal program. In addition, production numbers should increase significantly.

The front desk personnel are often the ones who receive direct reports from the clients regarding their feelings about the services they receive. Maintaining good, open-minded, non-defensive communications with these co-workers can only improve your service as a clinician. This feedback provides the opportunity to grow and excel.

The scheduling experts can report the percentage of clients who actually schedule for recommended periodontal treatment, while those collecting fees can report on collection success. Those team members can offer suggestions as well as feedback. For example, despite making every effort to convey a client’s responsibility to pay at time of service, one day I had a client who had spent the entire day with me in treatment, then claimed he wasn’t expecting to have to pay that day. To avoid this in the future, the front desk team solved this problem by performing collections when clients walk in the door, before I take them back into the operatory. They explain by saying, “We have found that when clients come in for long procedures, it is easier for them to complete business transactions while they are fresh, beforehand. This way, when you are done, you can just go home and rest.”

The clinician can take advantage of the re-evaluation appointment after treatment is completed and healing is well underway to evaluate the success of the periodontal program. The re-evaluation appointment should include a complete periodontal charting of probing scores, bleeding points, purulence and tissue description. I cannot say it enough: Learn to read the tissues! If you were completely thorough removing sub gingival calculus or if you missed something, the tissues will not lie. Healthy tissue is pink, not red or cyanotic, and it does not bleed. Do not be afraid to reinstrument and re-evaluate to achieve optimal tissue health. If an area does not resolve, it may be necessary to refer the client to a periodontist.

In performing thorough re-evaluations and reading the tissues, you may discover you have a weakness pattern. For example, there was a time when I consistently missed the disto-lingual line angles of mandibular bicuspid. By paying attention to that, I was able to identify an area where I needed to improve my skills and push myself to overcome that weakness. In that process, I became a better clinician.
An important evaluation instrument that my clients and I love is the perio-data form, because it offers boxes to add and compare probing scores and bleeding points by sextant at each visit. It also tracks total pocket and bleeding scores for each appointment. The differences from appointment to appointment are visibly obvious and quantifiable. Reductions in the total numbers of pockets and bleeding points provides great overall cause for celebration. Areas in need of improvement are obvious to the clients and they then know where they need to be more thorough with their daily oral hygiene.

Data tracking is a fun way to track the success of your periodontal program. Keep track of how many 4mm, 5-7mm, 8mm+ pockets, and bleeding points are recorded pre-treatment compared with post-treatment figures. You can calculate your success in closing pockets and reducing bleeding scores with these numbers. This can be very impressive and encouraging.

Finally, take advantage of the re-evaluation appointment to ask each client directly how they felt about the program. Ask them what changes they noticed in their mouth since treatment. Ask them if the treatment met their expectations. Ask if they felt they received a good value — was it worth the financial investment? You can even ask them what you could have done to make their experience better. As you listen with an open mind and open heart, any directions for necessary change will become clear.

One last thing, be creative and celebrate every success with your clients. Periodontal disease is a lifestyle disease. It doesn’t happen overnight and it doesn’t heal overnight. Changes in lifestyle take time and effort. Our clients really appreciate when they are recognized for that. A gold star on a lapel for lack of bleeding is fun, especially when they forget it is there and the grocery clerk takes notice.

You will know your periodontal program is successful when your clients send their best friends and loved ones to you for their periodontal care.

Rachel Wall, RDH, BS, Founder of Inspired Hygiene Inc.:

There’s nothing more frustrating than spending a ton of time and energy discussing, planning and implementing a new service or technology only to look back after six months and realize you’re right back where you started.

This scenario happens all the time with dental teams. I can’t tell you the number of times I’ve spoken to dentists and hygienists who say, “We used to have a perio program in place. I don’t know what happened.” Sometimes it’s a change in staff but most of the time it’s a series of seemingly small events that lead to the disintegration of the program. It’s unrealistic to think you won’t at some point encounter a patient who declines your treatment recommendations or experiences challenges with insurance benefits.

Go back to your why

It’s important to ask yourself how your perio program fits into the vision of your practice. Why did you implement it in the first place? How does the program serve your patients first and foremost?

If the primary focus of any new service is to increase production, the motivation to keep it going forward will often fade. Sometimes there is a disconnect between the pressure to sell treatment and a strong belief that the treatment being recommended is truly in the patients best interest.

Having a strong belief system that perio therapy will have a whole-body impact on your patients is key to keeping your perio program active and a permanent part of your practice philosophy — even when you face obstacles. If the entire team doesn’t share this belief, things can fall apart quickly.

Tracking is key

How do you know if your plan is working? While production and numbers aren’t your primary driving force, they are in fact a valuable measuring tool. Measuring frequency of perio procedures and production are a gauge to the amount of value you’re delivering to your patients.

Numbers provide a quantitative look at how well you’re implementing the program and are often indicators to celebrate and to focus on areas that still need some work.

Here are a few things you’ll want to track:

• Perio percentage. Every consultant has a slightly different way of measuring this. Whether it’s based on procedures or production, this number is very telling of how well you’ve implemented your perio plan. For an easy-to-use tool to calculate your perio percentage and track it month to month, go to InspiredHygiene.com/Periotool.

• Quads of therapy compared to new patients. If you are completing about the same number of quads of SRP per month as the number of adult comprehensive exams, this is a good indicator that most of the therapy is being performed on new patients. This will give you a hint as to how well you’re evaluating existing patients for active infection.

• Perio case acceptance. Compare how many quads of therapy each hygienist is presenting and how many are being completed. If you aren’t enrolling at least 70 percent of the patients presented with treatment, ask yourself these questions:
  o Are you providing enough evidence of active disease for the patient to feel the need to move forward?
  o Has the admin team had the opportunity to be educated on the oral-systemic link and do they believe strongly in the value of perio treatment?
o Is there time on the schedule for patients to schedule treatment within one to two weeks of diagnosis?
o Are dentists and hygienists backing each other up when treatment is presented?
o Are flexible financial options being reviewed for every patient who is presented with a treatment plan?
o Is there accurate and complete documentation to support insurance claims on perio procedures?

When faced with a challenging situation, team members sometimes make decisions based on assumptions rather than facts. One example is assuming since one plan rejected a claim for perio therapy for a patient with beginning periodontal disease that all plans will respond the same. Instead of first reviewing the quality of the perio documentation provided or other information that would support the claim, one person talks to another and before you know it, the commitments you made and the standards that were set are no longer being followed. If no one is tracking the procedures, it can be months or years before this decline is noticed.

An obstacle that is not quickly addressed can lead to the complete disintegration of the program and all the work you’ve put into it. If you notice perio numbers are declining, sit down as a team and review your standard of care. Reviewing this agreement will more often then not reveal one of the obstacles to case acceptance (and presentation) listed above and give you the chance to resolve it.

Sarah Cottingham, RDH, CEO BCS Leadership, LLC:

With your new or revised perio program it is important to monitor the effectiveness of the implementation by consistently looking at a few metrics within the practice. These metrics are important, not just for the doctor or the hygienist, but for the entire team. In a previous installment of this series, it was discussed how to calculate your mix of services over one year. Understanding the baseline starting point or baseline metrics, provides a point of comparison. From the new monthly and quarterly numbers the practice can gauge the effectiveness of the implementation of the program.

Your mix of services including periodontal appointments should be 30/30/30/10: prophylaxis, perio maintenance, perio therapy and other procedures. Calculate these numbers now that your perio program has been implemented and compare to where you were before. Are you closer to the 30/30/30/10 mix of hygiene services?

Monitoring these numbers on a monthly, quarterly and yearly basis will result in the entire team being aware of what is working and what may still need additional enhancement. Determine the total number of hygiene visits per month and then totals for prophylaxis, perio therapy, perio maintenance and other visits. To determine percentages, simply divide the total number of hygiene visits by the number of specific services. This will give you an indication of the effectiveness of the current month.

Another metric to calculate is the acceptance rate for your periodontal treatment plans. Determine the total number of patients who were presented a periodontal treatment plan and what the acceptance rate was for those treatment plans. Did everyone accept treatment? If not, how many did accept treatment and how many declined or wanted to wait for treatment. This figure will give you your treatment acceptance rate.

In addition to monitoring these metrics, it is important that each team regularly review their periodontal maintenance visits for effectiveness. Are the patients periodontally healthy? Do they need more sub gingival instrumentation? Are the three- and four-month patients returning to the practice as scheduled? Monitoring and understanding compliance with scheduled periodontal maintenance visits is vital to the success of any perio program.

On a monthly basis, it is also important for each provider in the practice to understand their contribution to the bottom line. Having a monthly meeting that revolves around the metrics of the practice is imperative to the team understanding what is working and what areas of the perio program might need additional attention.

Several items to consider are:
• Production per hour
• Collections on behalf of the provider per month
• Amount of hours available to see clients
• Hours worked with client
• Amount of hours clocked
• Number of hours canceled or no-shows
• Total number of each service provided

There are many other numbers that we have our clients monitor on a regular basis by using a software program that allows them to understand their data. It is important to put the information into a format that the team will understand. Routinely reviewing this information will let you know if the new perio program is improving over time, holding stable or diminishing. In order to understand how the practice is doing, the benchmark metrics must be clearly laid out and reviewed on a very consistent basis. This allows the entire team to reflect on the effectiveness and acceptance of your new or updated perio program.
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