The Art & Science of Effective Communication for Non-surgical Periodontal Treatment

by Karen Davis, RDH, BSDH
Consultant
Richardson, Texas

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Educational objectives

Upon completion of this course, participants should be able to achieve the following:

- Identify major barriers to patients seeking optimal periodontal health.
- Identify solutions to overcome the barriers.
- Identify risk factors for periodontal disease.
- Identify benefits of incorporating locally applied antimicrobials into therapy.
- Identify keys to effective communication.

What a paradox. Based upon the Surgeon General's Report on Oral Health 2000, more than 60 million Americans have active periodontal disease, yet adult prophylaxis far outranks therapeutic scaling and root planing (SRP) in the average general dental practices today![1] Why aren't more patients leaving the dental office with a diagnosis, a treatment plan and a commitment to treat their periodontal infection? What are the barriers that get in the way of providing optimal care to *all* patients? See if this sounds familiar:

- Lack of time to collect diagnostic data or discuss it with the patient
- Lack of awareness of the disease due to a lack of symptoms
- Inadequate communication to inform patients of their disease

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Figure 1

Typical Hygiene Services	
Adult Prophylaxis (D1110)	80%
Scaling & Root Planing (D4341 & D4342)	12%
Periodontal Maintenance (D4910)	8%
Comprehensive Hygiene Services	
Adult Prophylaxis (D1110)	45%
Scaling & Root Planing (D4341 & D4342)	25%
Periodontal Maintenance (D4910)	30%

- Fear of what patients will think if we tell them all of a sudden… they have infection in their gums
- The perception that bleeding is a normal part of getting your teeth cleaned
- Philosophical differences in how the hygienist and dentist wish to treat the patient

We can readily see there are numerous reasons why transitioning out of routine prophylaxis and into non-surgical treatment for an existing patient might be challenging, but are there solutions out there to help make the task more realistic? Great news… there are!

Philosophical Commitment

Let's start with the obvious. It is not realistic to shift the course toward improved periodontal care if the dental team doesn't share in the philosophical belief that early detection and treatment of disease is truly in the patient's best interest. While dental hygienists are instrumental in collecting diagnostic data, communicating about its significance and answering questions, patients also need to hear a *clear* diagnosis of periodontal disease confirmed from their dentist. Dentists that are not up to date on research concerning the dental-medical connection might still find themselves encouraging patients with evidence of periodontal disease to simply floss more, or visit the dental hygienist more often for yet another prophylaxis. On the other hand, a clear diagnosis from the dentist might sound like this:

"Barbara, I agree with what Stacy has been discussing with you. You do have active periodontal infection. Fortunately though, with early diagnosis and treatment we can generally halt the disease process through non-surgical treatment and participation on your part with daily plaque control."

An effective way to gauge your own philosophy to treating periodontal disease is to examine your procedure percentages produced in the hygiene department each month. For example, Figure 1 shows the difference between a typical dental hygiene department that provides prophylaxis for the vast majority of adult patients, versus one that is comprehensive and regularly treating periodontal disease. *Your philosophy will be revealed in the services provided!*

Adult prophylaxis will decrease in direct proportion to the amount of disease being treated in the hygiene department both for active therapy and on going periodontal maintenance. If your percentages of adult prophylaxis are still well above 50 percent, chances are you have not cornered the market on healthy patients, but rather have significant opportunity for increased diagnosis and treatment of disease already present in your patients' mouths.

Diagnostic Data Collection

A random review of a dozen or more patient records in most general dental practices will reveal chart notes that read much like this:

"Moderate bleeding especially around the posterior teeth. 4-5mm pockets around molars. Stress flossing. Six month recall."

To the dental hygienist's credit he or she was attempting to describe an unhealthy situation, but without the benefit of an updated complete periodontal chart and/or current diagnostic X-rays, this patient will likely be sent home with no real understanding that they have periodontal disease that is treatable, and will once again be frustrated about the issue of needing to floss more.

As a minimal standard of care, all adult patients should have comprehensive periodontal charting updated at least annually. At the beginning of every visit, dental hygienists, together with the patient, should examine the tissue response for evidence of disease. This can be accomplished by using a dental probe to gently

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sweep along the sulcus or inside deeper pocket spaces while that patient views his or her condition with a hand mirror. Healthy tissue does not bleed upon light provocation! Patients need to see their own infection in their mouths to take ownership of a disease that is virtually asymptomatic. Collection *and* recording of current diagnostic data as a top priority is essential to shift care toward therapeutic treatment, and until that happens many patients will leave the dental practice with squeaky clean teeth on top of *unhealthy* foundations!

Merging Science into Treatment

A great motivator to assist dental practices in appropriate treatment of periodontal disease is a solid understanding of the causes of periodontal disease, and the impact of various risk factors such as systemic diseases, genetics,[2] tobacco usage,[3, 4] elevated stress,[5] diabetes,[6] inadequate diet[7, 8] and xerostomia.[9] Untreated periodontal disease can negatively impact our patients' overall health; therefore we should carefully consider these statements by the American Academy of Periodontology:

"The current paradigm for the etiology and pathogenesis of periodontal disease includes the initiation of disease by specific bacteria within a biofilm. These bacteria stimulate immune responses that can result in tissue destruction."[10]

And,

"Periodontal infections may significantly impact systemic health in some individuals, and may serve as risk indicators for certain systemic diseases or conditions."[11]

"Periodontal infections may significantly impact systemic health in some individuals, and may serve as risk indicators for certain systemic diseases or conditions."

This is not to say we should begin telling all our patients that periodontal disease causes coronary disease while treatment prevents it; but with studies continuing to explore the medical-dental connection, dentists and dental hygienists should be forthright in telling patients that chronic periodontitis is a serious bacterial infection so they are equipped to make wise health decisions. Statements such as the following can introduce the patient to new concepts.

"Steve, we now know that gum disease is a bacterial infection that doesn't just affect your teeth, gums, breath and supporting jawbone. Current research indicates that untreated periodontal infection can negatively impact your overall health! For that reason, we want to take even early signs of periodontal disease seriously. Healthy gum tissue shouldn't bleed when we measure pockets, clean teeth or floss. The hemorrhage and deeper pockets we detected today during your periodontal screening indicate you have active periodontal disease, so I'd like to talk to you about how we can get this infection under control…"

Beginning a conversation this way gives patients a frame of reference to understand that the science has changed, and their treatment will be different than past experiences.

Communicating clearly

Choice of words conveys important messages to the patient. Take for example the words *"infection"* versus *"gum inflammation,"* or *"periodontal therapy"* versus *"deep cleaning,"* or *"insurance benefit"* versus *"insurance coverage,"* or *"a little bleeding"* versus *"moderate hemorrhage."* Keeping in mind that periodontal disease typically does not cause discomfort; we want to be deliberate in our choice of words to create value for periodontal health and urgency about treatment. Equally important is the reality that many of our patients currently have the value that if insurance doesn't pay for a procedure, they don't want it! Where periodontal treatment is concerned, most patients will experience limited reimbursement, so it is not accurate to say the procedures are *"covered"* unless you are in a contractual arrangement where you only accept discounted fees and write off what the insurance does not reimburse for.

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When presenting information to patients, clinicians need to become active listeners. In order to do so, you never want to discuss information about a particular condition of their mouths while patients are lying on their backs in a supine position, with sharp instruments in their mouths. That is not conducive to the patient feeling the freedom to respond or ask questions. Following screenings and data collection, move the patient to an upright position so that you can use body positioning to your advantage. You want to have direct eye contact with the patient when presenting information and answering questions. Good eye contact communicates confidence and sincerity. The use of open-ended questions such as, *"What else do I need to clarify for you?"* or *"What do you think about this?"* puts us in the position of being active listeners and encourages the patient to express their concerns.

Managing objections

But, how do we handle the multitude of objections we hear when presenting potential treatment to our patients? No matter what objection the patient raises, the dentist or dental hygienist should take a deep breath, and respond with an agreement statement first such as, *"I agree…", "I understand…",* or *"You are right…"* An agreement statement serves the purpose of keeping dialog open and prevents defensiveness on our part. For example, the patient that says, *"Does my insurance cover this, because if it doesn't, I don't want to do it!"* should be met with the following:

"Anne, I understand your concerns. (Agreement statement first) *No one really wants to be 'out-of-pocket' for dental expenses. Whether or not your particular plan assists with periodontal therapy depends on the contract between the insurance company and your employer. Our experience has been that most plans do assist with this treatment, but the percentages vary greatly. While you might wish to investigate your own plan more specifically, the real question to consider is whether or not this is the type of treatment you chose for your own health."*

Managing objections in this manner encourages patients to take responsibility for their own health decisions.

Treatment versus referral

Prior to providing non-surgical treatment in the general practice, the general dentist and periodontist should discuss practice philosophies and establish mutual guidelines for referrals. Available on the American Academy of Periodontology's Web site, www.perio.org, is a copy of referral guidelines[12] that can assist general practices in establishing their own criteria for referrals, but guidelines will be individualized per practice depending upon the skill and expertise of the clinician providing therapy, and the philosophy of the general dentist and the periodontist. Failure to have clear referral guidelines can lead to both over- and under-treatment of periodontal disease. Continuity can generally be established over one or two designated lunch meetings between all concerned parties.

Given our current understanding of periodontal disease as a serious bacterial infection coupled with the fact that we do not remove 100 percent of the pathogens even with meticulous therapy, non-surgical treatment plans should include the usage of locally applied antimicrobials such as Arestin® in diseased probing measurements 5mm or greater. Why? Well, simply stated, inclusion of locally applied antimicrobials has been shown to improve clinical results compared to SRP alone.[13, 14] If we know we can achieve *good*

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Figure 2

Scaling & root planing visits replacing prophylaxis per day, per RDH	Locally applied antimicrobial sites placed per day, per RDH	Increased revenue, per RDH
(1) $24,000 annually	(2) $11,520 annually	$35,520 annually
(2) $48,000 annually	(4) $23,040 annually	$71,040 annually

Based on: $190 S&RP, $70 Prophylaxis, $30 Arestin® and working 16 days per month

clinical results with SRP alone, but *better* results with SRP including locally applied antimicrobials, why wouldn't we offer that level of treatment to our patients presenting with early to moderate periodontitis in order to help halt the disease process?

Reality check

If patients get healthier while at the same time the practice gains from a profitability standpoint that could be called a "win/win" scenario, correct? Yes! Examine Figure 2, which depicts the reality of increased revenue potential on an annual basis (using average fee structures for calculations) when a dental hygienist replaces one to two prophylaxis treatments with non-surgical treatments per day and includes an average of two to four sites of locally applied antimicrobials into diseased pockets.

Halting the disease process for our patients is the goal, but by becoming skilled in the art and science of effective communication to enroll patients into non-surgical periodontal treatment, everyone benefits. Determine today where you need to begin to move the pendulum closer to providing optimal care to *all* your patients. Monitor your own percentages of adult periodontal procedures as you do and you should be able to gauge an emerging philosophy of optimal periodontal care. ■

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Author's Bio

Karen Davis is founder of her own company, Cutting Edge Concepts®; has more than 25 years experience as a practicing dental hygienist; is a consultant with the JP Institute of San Diego, California; and has authored numerous articles. Davis graduated from Midwestern State University with a Bachelor of Science in dental hygiene. She challenges audiences internationally to provide comprehensive, optimal oral health care in the context of extraordinary service.

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1. Major barriers to patients seeking optimal periodontal health include:
   A) inadequate communication to inform patients of disease
   B) patient's inability to floss
   C) patient's lack of awareness of disease in their own mouths
   D) A and C

2. What is the estimate of the number of Americans who have active periodontal disease?
   A) 1.5 million
   B) More than 60 million
   C) 1 billion
   D) 900,000

3. True or false? The current paradigm for the etiology of periodontal disease includes the understanding that specific bacteria stimulate immune responses that result in tissue destruction.
   A) True
   B) False

4. The following can be considered risk or contributing factors to periodontal disease:
   A) Tobacco usage
   B) Xerostomia
   C) Stress
   D) Systemic diseases
   E) All of the above

5. True or false? Periodontal disease causes coronary disease, and treatment prevents it.
   A) True
   B) False

6. True or false? Inclusion of locally applied antimicrobials into non-surgical therapy improves clinical results compared to scaling and root planing alone.
   A) True
   B) False

7. Active listening is encouraged through the use of:
   A) open-ended questions
   B) body positioning
   C) eye contact
   D) all of the above

8. True or false? Tissue response should be determined at the end of each hygiene visit.
   A) True
   B) False

9. "I agree..., I understand... or You are right..." are statements to respond to patients' objections, and serve the purpose of:
   A) Keeping the dialog open
   B) Creating new friendships
   C) Beginning at a place of agreement
   D) Preventing defensiveness
   E) A, C and D

10. True or false? Your practice philosophy is reflected in the percentage of periodontal procedures provided in the hygiene department.
    A) True
    B) False

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