

Do You Have a Periodontal Program for Your Office?

A doc asks for advice on setting up a program to share with his hygienists and their patients.

How do you educate patients so they'll accept treatment for a condition that often doesn't hurt?

KBux

Member Since: 01/19/06

Post: 1 of 60

I currently have three hygienists working for me. They rarely see each other or get a chance to communicate, but patients bounce around between the three regularly. I've been revising my manual and realized we need a crystal-clear set of instructions as to how our hygiene department runs. Particularly how we handle periodontal disease and all that it entails. Anyone out there have something like this written up that I could use for inspiration?

12/2/2016

GroupofTrees

Member Since: 11/03/10

Post: 2 of 60

We have just done the exact same thing over the past three to four months. We've had the "aid" of Scheduling Institute but I'll leave that be.

How we have done it to date (with success, not the 180 we were hoping ... but better). Paint the scene ... 4 RDH (19 years FT, 9 years FT, 21 years FT, 2 years PT who also works at a perio office). These FT hours are 32/week but none of them work five days. Just a mix of 4 days/week with our PT doing 2 days/week.

Selling DMD did ZERO perio. Like, the long term RDH's have not SRP'd since they have been here. Or he did supervised neglect of perio if patient never went to perio. All super g prophies and the RDH's didn't know any 4000 code. Any!

We outlined a perio program with three designations of severity. Type 1-2-3. Taught them SRP codes, when to use them, how to treatment plan them, and what is actually a difference in perio mtx and prophy (ironically, they've been doing it for decades). Hardest part to date is when and why they need to chart!

Type 1: Early perio. A few 4-5's. Some bone loss, i.e. 2 quads with a couple localized areas. Good chance of tissue response following SRP. Low chance of surgical post SRP.

Type 2: Moderate perio. A few 5-6's. Quite a bit of 4+. Clear bone loss in quad, i.e., four quads of SRP, might need surgical post SRP for pocket reduction.

Type 3: Severe perio. Lots of 6+. rampant bone loss and mobility. Definitely need surgical correction and an almost immediate referral.

This is a rude and crude version of how we're doing it now. Still an evolving process, but we're getting there. Long story short our PT gal gets it. Everyone else is very resistant to change and won't bring up the perio issues on many long-standing patients they've been "monitoring." Still learning how to break the horse. Hopefully I can post a blurb about this next year. Good luck.

12/2/2016

Ricky

Member Since: 03/30/10

Post: 3 of 60

I have a similar issue in my office. Two hygiene, one recently brought on does all the SRPs and the other is in prophy town.

It is difficult on the re-care patients who have been coming in for years.

I am starting to develop a system and trying to educate the re-care patients. The worst is when they say "but Dr. Jones never said anything about this. Have I had this all along?"

12/2/2016

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Patient: Better understanding, greater trust.



It has been tough! But seeing these patients at a 1st recall since new perio protocol, it has been getting easier. First time we recognize a few deep pockets. Hygiene, with hopes, has laid the framework for us to talk about perio. We discuss "deep pockets that need attention" and patients are usually like "OK, well, let's see how it does in a few months" or "we'll check next time." The seed has been planted.

Actually seeing a fair number of patients accepting treatment for some localized SRP and some select quads of SRP (all from existing, monitored perio neglect).

New patients are not giving much push back, given the initial diagnosis of perio disease. Adapting the "seasoned" patients is the hardest part. I'm still learning the art.

12/2/2016

We circle the calculus on the digital X-rays and put up the intraoral photos. My hygienist is awesome and we always try to perio chart out loud or you can put up the chart in the TV screen. The ADA has a nice brochure—and I know I'm old—but we also have a flip chart. I really think it comes down to the hygienist. We also had our periodontists come speak to our staff. Again, best move ever.

12/3/2016

Our hygiene department is the backbone of our practice. The very best restorative work will fail if it is built upon a weak foundation. I don't care how good your margins are, your fillings/crowns will fail if the teeth are loose. We have 3 FT RDH working every day and the biggest part of their responsibilities is to teach the patient exactly what we are doing and why.

Every patient is probed at every visit. This is done out loud so that the patient can hear it. They are told the 3mm or less is healthy, 4–5mm pockets need special attention but can be maintained with exceptional home-care, but greater than 5mm needs in-office treatment.

Educational materials are fine, but absolutely nothing can measure up to the one-on-one interaction between RDH & patient the only occurs at chairside.

12/3/2016

OK, good stuff. Luckily, I'm not in a situation where

KBux
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perio has gone undiagnosed, but I have hygienists who disagree with the treatment another hygienist has recommended.

I have one hygienist who wants to do scaling and root planing if the patient has just a handful of 4mm pockets and I have another who is swimming in a sea of blood and 5mm pockets but just wants to try a regular prophylaxis first and see what happens. Hoping to establish some guidelines and more of a structure to follow.

12/3/2016

Long Span Bridge

Member Since: 03/10/03

Post: 18 and 21 of 60

Dentaltown has an incredible search feature. I recommend that you try it. If you search "flowchart for perio" you will get many. Many message threads that give some great ideas.

My favorite NP is the one who has not been to the dentist in 5-10 years and after a thorough cleaning they went from "I have terrible teeth" to "I love my smile". I believe that they can see and feel the difference before and after the treatment. "Seeing is believing" and you have a convert for life. And a loyal patient who will spread the word about you to their friends and neighbors. It works.

12/3/2016

KBux

Member Since: 01/19/06

Post: 24 of 60

I always do a search before asking a question. Sometimes you don't know what to search for though. Thanks for the tip on flowchart. There are several threads that discuss this. A lot of them are outdated with broken links to flowcharts. This was probably the thread that came the closest to what I was looking for: [Editor's note: To view this perio flowchart, visit this message board online.]

I guess one of my biggest frustrations is that no matter how fantastic your flowchart is you can never underestimate the ability of an insurance company to screw it all up.

12/3/2016

Long Span Bridge

Member Since: 03/10/03

Post: 25 of 60

I have some of the country's best periodontists within one block of my office and I definitely use them when the situation warrants. For example, I do not like flaps or graft procedures but that is just me (many GPs like doing them).

But I ask this. If they can work the magic in their

offices, then why cannot we do the same in our offices?

Why refer out procedures that you can do yourself. That is just giving money away. Now if you do not enjoy it, or do not feel successful at doing it, then refer it out. But to say GPs are not able to do it is just plain wrong. IMHO.

The periodontist's hygienists are trained exactly the same as the GPs and they are definitely capable of enlightening their patients the same as the periodontist's RDHs. Just give them the chance. I do not think that periodontists have any special magic that GPs are incapable of replicating.

12/3/2016

There is no real magic. I think that what happens when you refer is that patients take their condition more seriously and it takes the money part off the table. The patients start to understand and believe that you are more concerned with their health than their pocketbook. I also think that a lot of patients lose interest in treatment once they find out what four quads of SRP is going to cost them. That is the deal killer for even the most motivated perio patient.

Either way, referring out has made our hygiene department more profitable. Nothing would drive me more up the wall than seeing a long SRP appointment cancel same day or no show. Open hygiene time is very expensive. We routinely do \$1,500 to \$2,300 per hygienist per day with no SRP. These patients show up for their appointments. Perio maintenance is much easier when you are alternating with the periodontist. Those people respect our time and what we do.

Anyway, just an alternate viewpoint from a bread and butter dentist who has been there and done that with perio. We have had the consultants come in and establish a perio program. I invested in and was trained in the Periolase protocol. In the end, you run headfirst into a wall that is not going to move. Perio equates to the definition of insanity ... and that is why you see older docs who just let perio slide.

12/3/2016

Brian

Member Since: 03/22/00

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