Getting the conversation going between the dentist and hygienist and discussing periodontal treatment philosophy
How healthy are your patients and how healthy do you want them to be? Answering these questions will provide the basis for discussing the oral health philosophy of the practice. This is the focus of our second in this series of articles on Creating a Perio Program for Your Practice. Getting the conversation going between dentist and hygienist is often the hardest step in this process. We asked clinician and periodontal therapist, Diane Brucato-Thomas, and consultants Sarah Cottingham and Jamie Marboe for insights on how to get this conversation going and what questions to ask.

Diane Brucato-Thomas, RDH, EF, BS, FAADH:

The first step in getting this conversation going with the doctor is to identify common values or goals by asking questions. These questions are not easy, but help to clarify head and heart. Actually, they are good questions for the whole team. If the team approaches these questions together, a common vision for the practice will begin to emerge. The idea is to identify what is most important for the dental practice. You may have a good idea that is really important to your doctor just by comments made on occasion. Getting the doctor to voice what is important and building the discussion around those values will go a long way in advocating for change.

Often a common value or goal is optimum dental care. This is the doctor’s practice and his or her reputation depends on providing optimum dental care. By providing an evidenced-based periodontal program, win-wins are created for everyone across the board. Excellent periodontal health as a foundation lays the groundwork for all restorative work to follow. The doctor’s preps will be better if the tissue is healthy, as well as the quality of the impressions. So the client receives better quality, longer lasting dental work for their investment. Successful business follows a good reputation. That discussion alone can be very convincing.

Adding further discussion about the financial benefits in terms of production resulting by incorporating a periodontal treatment program as a successful profit center for the practice will sell itself. Even with all the genuine caring in the world, the bottom line for a dentist must point to financial success for the practice as a whole, or the practice will fail.

Exactly when this discussion should occur really depends on the doctor’s style of practice. In one practice I worked in, the doctor was a genuinely nice guy, who bought the practice from an elderly dentist who had retired. He was afraid to tell people that they had recurrent decay or periodontal disease for fear of losing them. He did not hold team or staff meetings, so I talked with him before work one morning. I basically asked him to trust me and support me by not undoing my communications regarding periodontal disease and dental treatment, and “just see what happens,” because hesitating to speak about their need for treatment was not serving anyone in any way. He did and I tripled the hygiene production in one month. In addition, his production skyrocketed, because he began providing much needed care. The patients? Well, they loved him!

In another practice, the discussion took place at a series of team meetings, before I was even hired. As the team began to vision the potential of care that could be provided, the dental hygienist actually invited me in, because she did not feel comfortable providing advanced periodontal care. An ideal team was created and I was able to provide advanced conservative periodontal therapy within a general practice setting. Meanwhile my “hygienist partner” provided regular preventive maintenance for healthy clients. The doctor enabled the team to buy into creating the vision, and in turn, the entire team supported the program with the clients. This practice had an exceptional whole-person, values-based, team-centered approach to their philosophy of care. The practice was dynamic, because the doctor valued the opinions of his team members and truly cared about them and the clients, like an extension of his family.

Obviously, not all practices are like this. As pointed out by the late, Avrom King, dental management guru, the important thing to realize is that “when they are ready to hear the next message, they will hear the next message, and not a moment before!” If they are ready, as the two doctors highlighted above, the sky is the limit in terms of quality periodontal care. On the other hand, the doctor may never be ready to hear what you have to say. In that case, it is time to understand that sometimes, the only way to change their minds is to “literally” change their minds. With a doctor or practice setting that is closed to change, the best answer may be following my mother’s advice: “This or something better!” The right practice for you may be somewhere else.

Sarah Cottingham, BCS Leadership:

As a consultant, I have the advantage of setting up a meeting between the dentist and the hygienist. The
trick is to get the conversation started and flowing in the direction of developing a periodontal treatment philosophy. The first thing I do is ask each one to write down on a piece of paper their drop-dead criteria for treating periodontal disease. When they have finished, I have them exchange papers and see what the other person wrote, then tell me the other person’s criteria for treating periodontal disease. Many times the hygienists will list two criteria: 5mm or 6mm probing depths and bleeding upon probing. The dentists are generally more aggressive with 4mm to 5mm depths, bleeding upon probing and radiographic calculus, plus other issues. This opens the door for discussion of the criteria and why they would be used.

I ask them if radiographic calculus is needed for periodontal disease to be present. Not necessarily and this moves the discussion to the goal of reaching a biologically acceptable root surface and what that means to each of them. At this point I ask them to review the AAP Guidelines for Classification, especially the fine print relating to localized versus generalized and slight, moderate and severe. Slight being defined as 1mm to 2mm of clinical attachment loss. Going back to the basics is the key! Ask the team loaded questions like:

- What would you do with a patient that has a 4mm pocket?
- What if the patient was also bleeding?
- What if there was 3mm of recession?
- What if the patient had a Class I furcation involvement?
- What if the tooth had Class I mobility?

The point is to open up the discussion to the fact that most hygienists are not consistently documenting the complete periodontal condition. They will all say that the tooth requires treatment based only on probing depth and bleeding.

The big question then is why is there a problem diagnosing periodontal disease with clear-cut guidelines to follow. Where is the hygienist getting the idea that 5mm depths and bleeding are the criteria to be used? It may, in fact, be the front office staff that have relayed this based on a particular insurance standard, not on diagnostic criteria. A mindset of asking “why” will move the discussion forward and help the dentist and hygienist come together on a practice philosophy for treating periodontal disease. We have found that once the philosophy is established in the practice and the team understands the “why” and the “how,” getting the insurance companies to pay is quite simple.

Jamie Marboe, RDH, BS, Inspired Hygiene:

Our consulting firm generally works with offices with multiple dentists and hygienists. To get the conversation going, we find it’s good to get all of the doctors and hygienists to sit down together and have a discussion regarding the team perio protocol. We want to create, as a team, a clearly defined hygiene perio protocol. In order to accomplish this we ask everyone to come to the meeting with an open mind in an effort to offer our patients the very best care they deserve. Explain that there will be no “good cop, bad cop” or finger pointing during this conversation. It is purely to uncover some of the obstacles that may be keeping us from having a solid system in place. We make sure that the discussion stays safe and that everyone is encouraged and comfortable with discussing their philosophies, possible apprehensions and viewpoints openly.

We schedule plenty of time for this initial discussion. It doesn’t work squeezing it in during lunch or before work, taking a chance on running late or out of time. Block out enough time to allow for a thorough discussion. This process may need several meetings to create the perio protocol and system.

Key things to be discussed in the initial meeting include: Where are we now compared to the AAP’s perio percent? What is working and what is not? Discuss core philosophies and identify obstacles. Make a list of these items discussed and find solutions to the obstacles and what’s not working. Decide why it’s not working. How do we correct this or do we simply need to eliminate it? The team needs to agree on what level of disease to recommend various treatment options.

We emphasize to our teams that they all get to push the reset button and move forward as a team, helping each other be accountable with staying on target with the new perio philosophy.

The Next Step

With the conversation started and the practice philosophy developing, it’s now time to focus on the third step, creating the perio program with details for insurance codes, treatment options, fees, times and products. Look for this in our next installment in the July issue.