As we continue to review the 10 steps to transitioning the hygiene department to a diagnosis-driven approach, our focus is on the importance of a team commitment to the periodontal philosophy.

Many clinicians I speak with during seminars work with more than one hygienist or doctor. Naturally, we each have our individual biases about periodontal protocol that are based upon our training, our level of continuing education, our interpretation of research, and, most importantly, our clinical experience. It’s possible that many teams have never actually discussed the systems, protocols, and philosophies involved in assessing, diagnosing, treating, and referring patients with periodontal disease.

An appropriate start would be to determine staff perceptions of health and disease. Hygienists and dentists often consider anything up to and including 6 mm pockets as “healthy.” Many practices will not take action until pockets reach 6 mm.

Many of us consider bleeding normal because we see it so frequently. If the doctor and hygienist have differing views on this issue, patients will receive mixed messages.

Have you considered the damage that can be done to your patients’ trust when they receive conflicting recommendations? Do you and your hygienists see things in a similar way?

What role does periodontal health play in the overall practice? Is it the standard operating procedure to treat all perio conditions before beginning any restorative or cosmetic treatment? Do both new and recare patients receive periodontal exams, assessments, and appropriate treatment options?

Does the business staff know the value of periodontal therapy relative to the overall cost to patients? Can they effectively answer patient questions regarding periodontal fees, insurance coverage, and time issues that come with periodontal care? Do your assistants feel that charting periodontal patients is an imposition to their primary role?

Have your team members (and you, for that matter) been evaluated for periodontal disease and received appropriate care? Does periodontal charting play an important role in every patient’s hygiene visit? At what age do patients begin to receive periodontal exams? What is the standard of frequency for periodontal charting?

Once charting is complete, does the doctor ask for an organized periodontal report from the hygienist and then determine what treatment protocol is appropriate? An answer to these questions is imperative with diagnosis-driven hygiene.

Within the general practice, we primarily deal with two dental diseases: caries and periodontal disease. Most staff members understand the restorative focus of the practice, whether it is one that relies on fillings, crown and bridge, or an aesthetic philosophy for patient care. Staff members should be educated about the benefits of all commonly administered treatment procedures and be able to communicate those benefits easily to your patients.

The same is true of the hygiene services we dispense. Without a uniform philosophy and commitment to the standard of care, our communication to patients, case presentation, and acceptance levels will be less than optimal. The flow of scheduled patients is difficult when periodontal treatment decisions occur in the hallway. Patients deserve to hear a unified message about the importance of periodontal health to their overall health.

It is well worth the investment; the dividends can create a solid foundation of patient trust in your recommendations and lead to increased case acceptance and productivity of the hygiene department.

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