PerioPathways

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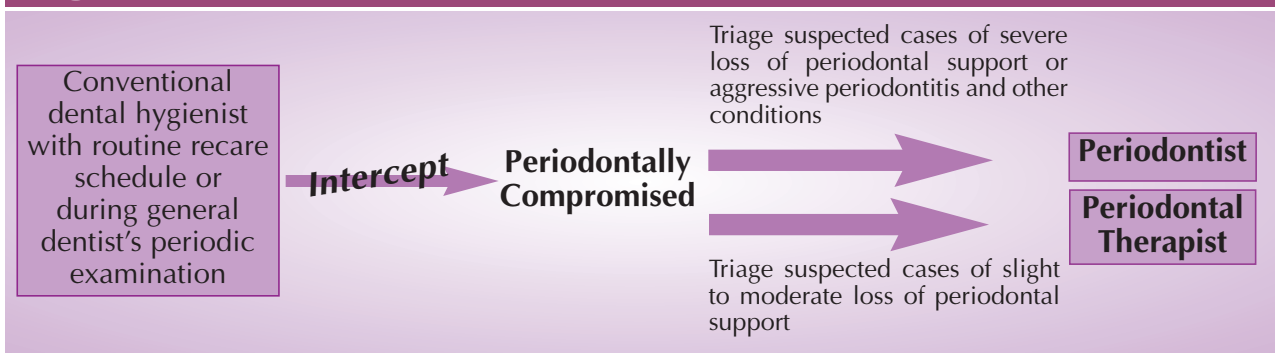
The Potential of Triaged Periodontal Care

Figure—Flow of Events in Triage System



The lack of standards of care for the dental hygiene profession has made quality assurance a relatively foreign concept, resulting in lowered patient confidence in our profession. Faced with such a high level of variability in the level and quality of care we render, it's no wonder that there is such great confusion over the role of a dental hygienist among those we serve.

A 2002 *Access* article written by Valerie Donner chronicles some chilling statements made by dental hygiene academicians and clinicians about clinical failures like the high prevalence of undiagnosed chronic periodontitis, residual calculus, and failure to relate oral conditions to systemic problems.[1] Statements from prominent periodontist researchers seem to validate the fact that the quality of periodontal care being rendered is simply substandard: "The problem is that periodontal procedures from examination and diagnosis to scaling and root planing to supportive care may not be well done in many general practices. Periodontal charting may be ignored, the treatment plan may not be related to the examination findings, and periodontal patients may not be monitored regularly.[2]"

I anticipate that writing an article on the need to overhaul the level and quality of periodontal care being rendered in general practice settings may not be well received by some. Even more controversial may be my strong conviction that the solution to this issue may lie in triaging all periodontal care to hygienists who specialize in nonsurgical periodontal therapeutics (periodontal therapists). This kind of reformation of roles will no doubt stimulate some significant debate within the dental profession. In the first of "The Reformation of Professional Roles Within Dentistry" series, which was published in the February 2003 issue of *Contemporary Oral Hygiene*, I wrote, "For some dentists, hygienists, and periodontists, the magnitude of this change is threatening.[3]" It will be threatening, but not for those who are bent on practicing excellence. Those who welcome change and think outside the box may very well embrace the concept of triaged periodontal care.

I believe that as individual clinicians we have had the potential to profoundly change the course of the insidious inflammatory progression of chronic periodontitis among our own private practice populations. However, chronic periodontitis remains underdiagnosed and undermanaged in the vast majority of practices throughout our country.[4]

Unless we step up to the plate and use the knowledge, skills, and abilities that we are expected to have to pass national board exams, the dental hygiene profession may soon lose the opportunity to change the course of a major epidemiologic trend called chronic periodontitis. It is what the US Surgeon General calls a "silent epidemic.[5]" Professional complacency, perceived political barriers, the cost-cutting agendas of managed care insurers, and the erosion of baccalaureate degree dental hygiene programs have had a cumulative effect that makes practicing evidence-based periodontal care in everyday general practice settings too high a hurdle for many hygienists and dentists to overcome.

Many will say that practicing comprehensive nonsurgical periodontal therapeutics in general practice just cannot be done, yet for periodontal therapists this is the way they practice all the time. The truth is that each time we fail to evaluate a patient's periodontal status (or consider multifactoral risk and disease etiology), or disregard the need to make clinical decisions based on scientific lines of evidence, we edge our profession toward preceptorship. Interestingly, the role of the periodontal therapist may very well be the professional model that insulates our profession from the slippery slopes of preceptorship.

There is a growing awareness among clinicians and some academicians that the dental hygiene profession may soon need to differentiate into 2 tiers of dental hygiene. Today there are hygienists who are dedicated to intensive professional development that allows them to specialize in nonsurgical periodontal therapeutics and others who would prefer to continue as conventional dental hygienists with 6-month recare routines.

I do not mean to suggest that the status of the conventional dental hygienist model should be demoted; rather, I believe that hygienists who practice as periodontal therapists have honed specific specialty skills and independently developed such a solid base of current science that this places them in a specialty category. The relationship between the registered nurse and nurse practitioner provides a parallel model. Although it seems inevitable that 2 tiers of the profession will become a reality someday, even today there are practices where a triage system has become highly effective in raising the level and quality of periodontal care in general practice settings.

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Basis for Recommending Treatment Triage

Many clinicians see overwhelming hurdles in providing comprehensive periodontal care in everyday practice including:

1. **inadequate scheduling capacity.** In many practices, hygiene schedules are completely filled 2-3 months in advance, making it nearly impossible to schedule nonsurgical treatment.
2. **absence of a clinical pathway.** The formula for achieving and sustaining optimal clinical outcomes may depend on developing a clinical pathway that is based on intense research of evidence-based treatment components that build upon and reinforce each other.[6] Offices that have a clinical pathway prescribed for chronic periodontitis that is updated to reflect new research findings are among a very small minority.
3. **undertrained clinicians.** Many hygienists are starting to realize that they do not have the requisite skills to properly perform instrumentation. They are also realizing that what they learned about periodontal disease etiology and epidemiology may be obsolete, along with their ability to perform a calibrated periodontal assessment that integrates risk stratification.
4. **the inability to keep up with scientific research or apply it to everyday dentistry.** Dental hygiene academicians readily admit that though some strides have recently been made in creating an evidence-based philosophy within their curriculum, the strides are small compared with where the profession needs to be.[7] Because evidence-based skill training has not been prioritized, new graduates are likely to be ill-prepared to perform the critical thinking and problem solving necessary to practice at the specialty level of a periodontal therapist.[8,9]
5. **"conditioned assumptions."** There are certain clinical weaknesses I call "conditioned assumptions" that lead to compromised diagnostic integrity. These are assumptions or biases many clinicians hold about either certain kinds of patients or patient populations as a whole. These assumptions may be the result of a sort of subliminal condition-

Table—Periodical therapist Ideal Day Scenerio

			National Percentile of Fees					
Time	Procedure	CDT-4 Codes	40th	50th	60th	70th	80th	90th
8-10:00	Chronic periodontitis, case type III							
	One stage S&RP	D4341 (4 quads)	$660	$680	$700	$732	$764	$808
	Full-mouth irrigation	D9630 (4 quads)	$100	$120	$128	$140	$180	$216
	Applic desensitiz med	D9910	$35	$38	$40	$43	$46	$60
10-11:00	Periodontal maintenance	D4910	$89	$91	$95	$99	$105	$119
	4 VBWs	D0274	$39	$40	$42	$44	$46	$53
	Full-mouth irrigation	D9630 (4 quads)	$100	$120	$128	$140	$180	$216
11-12:00	Periodontal maintenance	D4910	$89	$91	$95	$99	$105	$119
	Full-mouth irrigation	D9630 (4 quads)	$100	$120	$128	$140	$180	$216
Lunch								
1-3:00	Chronic periodontitis, case type III							
	One stage S&RP	D4341 (4 quads)	$660	$680	$700	$732	$764	$808
	Full-mouth irrigation	D9630 (4 quads)	$100	$120	$128	$140	$180	$216
	Applic desensitiz med	D9910	$35	$38	$40	$43	$46	$60
3-4:00	Retreatment w/ localized delivery of controlled release antimicrobial	D4381 (2 quads or 6 sites)	$250	$274	$290	$300	$320	$354
4-5:00	Comprehensive periodontal evaluation & oral risk assessment	D0180	$41	$44	$46	$51	$56	$65
	FMX	D0210	$83	$85	$88	$91	$95	$101
		Production before geographic multiplier	$2,381	$2,541	$2,648	$2,794	$3,067	$3,411

Utilizes data from 2003 Comprehensive Fee Report from the National Dental Advisory Service

ing that has occurred over time, perhaps from seeing so much early-to-moderate stage disease that we begin to see disease as falling somewhere within some vague range of normalcy. Some of these conditioned responses have become so ingrained in clinicians that they have become almost subconscious and clinicians can't recognize them as biasing sound diagnostic judgment.[4]

6. **working in a practice where the dentist does not recognize the value of the periodontal therapist model.** Regardless of the value of the periodontal therapist to both patients and practice profitability, there are some dentists who cannot envision the potential or commit to working in a collaborative relationship with a periodontal therapist, even though a periodontal therapist is a prerequisite to a triage system.

Flow of Events in a Triaged System

The figure diagrams the flow of events in a triage system. When patients are seen during their regular 6-month recare appointment, it is incumbent upon either the conventional dental hygienist or the general dentist (during the periodic examination) to spot probe (without recording) the patient's full mouth. If the patient is periodontally compromised, it is at this time that the dentist discusses the need for the patient to return for a comprehensive periodontal evaluation and completion of the oral risk assessment with the periodontal therapist.

Most cases with severe loss of periodontal support (Case Type IV) should be referred to the periodontist at that time. The exception to this may be in cases when patients decline referral to a periodontist or when surgical intervention cannot be an alternative. Whether a prophy is performed on the same day the patient is triaged really becomes a matter of office policy. What becomes crucial, however, is conveying the importance of returning for the diagnostic visit to either the periodontal therapist or the periodontist. Conveying this importance is often where the continuity of care falls apart.

The cornerstone of dental hygiene practice is the patient assessment, which includes a comprehensive oral evaluation based on a systematic collection of data. Yet, how many dental hygienists perform this task in everyday practice? This is why triaging the comprehensive periodontal evaluation becomes so important.

Although the history of triage is vague in origin, it comes from a French word meaning *sift*. Literally, it means "sort out, choose, or place a priority." The term came into popular use during World War II when it was necessary to sort out medical priorities on the battlefield.[10,11] Today, triage systems are used to assign critical status of patients, but they are also used to direct patients to appropriate specialists for specific care. In this respect, the use of the term is very appropriate in directing periodontally compromised patients to the care of the periodontal therapist.

The Advantages of Triaged Periodontal Care

A system where suspected cases of early-to-moderate loss of periodontal support (Case Type II, III) are triaged to a periodontal therapist for diagnostic and definitive care has numerous advantages, many of which are included below.

- Stimulates early recognition of periodontally compromised patients.
- Allows for thorough periodontal evaluation, not possible during regular, routine recare appointments.
- Expedites care for patients who need nonsurgical periodontal treatment.
- Allows conventional dental hygienists to specialize in other areas (ie, cosmetic dentistry and pediatrics).
- Assigns responsibility for clinical out-comes to periodontal therapists instead of accountability for outcomes.
- Repetition breeds competence and efficiency. Both efficiency and quality improve when the periodontal therapist performs a high volume of the same procedures.
- Continuity of care minimizes patients' confusion over care and minimizes the risk that patients won't go through needed treatment.
- Smoother patient flow allows for effective case management.
- Greater production potential.

Production Potential of the Periodontal Therapist

The table is a recommendation for ideal day block scheduling for a periodontal therapist and the fee generation potential. The production totals are driven by nationally normed percentiles before geographic multipliers are applied.[12] This means that the production estimates are subject to geographic location so that the production a periodontal therapist in Boston achieves may be different than what a periodontal therapist in Las Vegas, would achieve. Another variable in the production potential is the level of managed care (or discounted services).

Letting Go of Traditional, But Ill-Serving Paradigms

The epidemic proportion of chronic periodontitis and the demand on our profession to meet those needs on a primary care level with quality and efficiency requires us to think outside the box. This means letting go of traditional paradigms that no longer work well. Triaging periodontal care to a periodontal therapist may seem radical, but it may be the best way to ensure that standards of care are met and our integrity as periodontal clinicians is preserved. Time will tell. **COH**

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