HYGIENE SOLUTIONS

Lost Treatment Can Impact Profitability

By Casey Hein, RDH, MBA

At least 56 million American patients have periodontal disease. Proper diagnosis is still fuzzy to many, and the application of evidence-based treatment strategies has overwhelmed more than just a few dentists.

However, evidence of the prevalence of chronic periodontitis is no secret to seasoned periodontal therapists. They are adept in identifying and treating the earliest signs of disease because they have studied the epidemiologic trends, which are confirmed in practice every day. These are the same practices that have experienced rather dramatic increases in revenue as a result of the periodontal therapist's advanced capabilities, in many instances producing over 50% of a practice's total revenue.

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From a strictly business perspective, those general practices that do not have a clinical pathway in place to identify and treat chronic periodontitis should consider it an opportunity cost, a real cost that perhaps should be allocated against profitability, because forgoing that income is very costly.

KNOW OPPORTUNITY COSTS

Take a minute to compute the opportunity cost of underdiagnosing and/or undermanaging chronic periodontitis in a general practice environment. Computing opportunity cost, defined as forgoing the highest revenue that could be generated from assets already owned by the business, is often a very sobering experience. Consider the revenue associated with a practice that has a 1-size-fits-all treatment philosophy, predominantly scheduling 6-month, 30- to 50-minute adult care appointments—a length of time that inhibits proper comprehensive periodontal evaluation. The disparity in production potential becomes obvious. Depending on geographic location and the proportion of managed care patients and preferred provider organization discounts, revenue potential with this kind of production-line hygiene may approximate $500 to $800 a day.

Assuming a full-time hygienist, 40 hours per week, 50 weeks per year, hygiene-related annual production under this scenario can be anywhere from $125,000 to $200,000. When this is contrasted against the production potential related to progressive periodontal therapeutics in general practice that easily generates $600,000 to $800,000 per year, the opportunity cost of underdiagnosing and undermanaging chronic periodontitis is startling. Using 2003's modest national 60th-percentile periodontal fees (according to data from the 2003 Comprehensive Fee Report from the National Dental Advisory Service) and the higher end of average production capabilities for a conventional dental hygienist, note the conservatively estimated opportunity cost (ie, revenue lost as a result of underdiagnosing and/or undermanaging chronic periodontitis in a general practice environment):

- $600,000—periodontal therapists' production capability at national 60th percentile,
- Minus $200,000—conventional dental hygienists' production capability,
- Equals $400,000—opportunity cost.

In a practice that has a periodontal clientele population that truly represents the epidemiologic prevalence of chronic periodontitis, roughly 65% of the adult patient base will be receiving definitive periodontal treatment or be in periodontal maintenance (Figure 1).

Table 1. Reasons for Most Recent Dental Visit

Reason	Number	%
Checkup	353	34.9
Cleaning	326	32.5
Extraction	91	9.1
Cavity/filling	88	8.8
Dentures/plates	62	6.2
Root canal	33	3.3
Toothache	31	3.1
Crown	26	2.6
Broken/cracked tooth	14	1.4
Bridge	9	0.9
Gum disease/gingivitis periodontal disease	6	0.6
Bleaching/whitening	5	0.5
Implant	4	0.4
Braces	3	0.3
Bonding	2	0.2
Sealant	2	0.2
Enamel shaping	0	0.0
Other	23	2.3
Don't know/remember	4	0.4

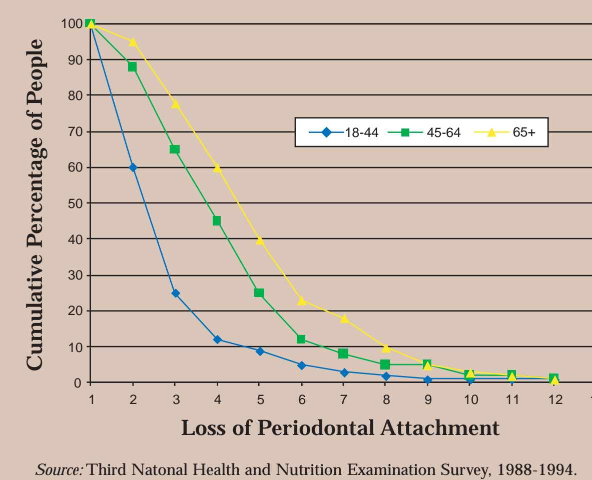
OBSERVE THE TREATMENT GAP

The epidemiology of chronic periodontitis is a moving target, depending on which survey research you read. It's even a moving target for the American Academy of Periodontology (AAP): "If the disease is defined as the identification of at least 1 site with clinical attachment loss (CAL) of 2 mm or more, approximately 80% of US adults are affected and over 90% of those aged 55 to 64. When the case definition is at least 1 site with CAL of 4 mm or more, the estimates of prevalence are much more modest, dropping below 10% for those aged 55 to 64." What seems to be clear, however, is that "mild-to-moderate periodontitis is so prevalent, the milder forms are close to universal," and "moderate disease affects a majority of adults."

A fair benchmark used by many epidemiologists is 3 mm of attachment loss in defining disease status. According to the graph in Figure 1, roughly 65% of those aged 45 to 64 (ie, baby boomers) have attachment loss of 3 mm, which is classified as slight-to-moderate loss of periodontal support. Close to 25% of this age group have attachment loss of 5 mm or more, which is classified as advanced loss of periodontal support.

Currently, the consensus of the AAP is that, regardless of access to periodontal care, only 5% to

Figure 1. Proportion of Adults in Various Age Groups Whose Worst Loss of Periodontal Attachment is Stated Level or Greater



Source: Third Natonal Health and Nutrition Examination Survey, 1988-1994.

20% of any given population suffers from severe chronic periodontitis. This leaves a multitude of patients who have early- to moderate-stage disease.

Given the high prevalence of early- to moderate-stage disease, the demand for primary periodontal care on a general practice level should be overwhelming, but it's not. Put another way, if you consider the prevalence of periodontal disease, the majority of our adult patient population should be receiving primary periodontal care. Instead, the demand for nonsurgical periodontal care is low relative to the occurrence of the disease. This may be due to widespread failure to diagnose chronic periodontitis at its earliest stages.

A recent American Dental Association national poll provides us with a reasonable profile of what appears to be taking place in most dental practices (Table 1). This survey compiled the results of 17-minute telephone interviews with a nationally representative sample of over 1000 heads of households. The results are startling. When those being polled were asked to indicate the reason for their most recent dental visit, 34.9% responded that they had a checkup, and 32.5% responded that their last dental appointment was for a cleaning.

The most disconcerting statistic of this survey is the fact that 0.6% of respondents indicated that their last dental appointment was for gum disease, gingivitis, or periodontal disease. The significance of this statistic is important. Alarmingly, it appears that less than 1% of dental visits are related to periodontal treatment. Since 34.9% of those polled responded that their last dental visit was for a checkup and less than 1% responded that their last dental visit was for periodontal treatment, it's reasonable to speculate that underdiagnosis of chronic periodontitis might be fairly widespread.

If you're among the dentists who are overwhelmed by the information coming through the research pipeline and are a little fuzzy regarding the parameters for diagnosis of chronic periodontitis, you're not alone. Fortunately, the growing number of hygienists who are specializing in advanced periodontal therapeutics brings a knowledge and technical expertise that translates into win-win scenarios for patients, dentists, and periodontal therapists. Those dentists who can envision the potential of a periodontal therapist and welcome the collaborative practice model are well positioned for exponential growth and profitability.