140TH ANNUAL MEETING
MAY 6 – MAY 7, 2010

JEWEL OF THE GREAT LAKES

KAREN DAVIS, RDH, BSDH

FRIDAY, MAY 7, 2010
9:00 A.M. TO 12:00 NOON

BEYOND THE BOUNDARIES:
COMPREHENSIVE & PROFITABLE HYGIENE DEPARTMENTS

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WI DENTAL HYGIENISTS’ ASSOCIATION
BEYOND THE BOUNDARIES – ADVANCED CONCEPTS FOR COMPREHENSIVE HYGIENE

Karen Davis, RDH, BSDH, RDHMP

What’s Holding You Back or Limiting Your Potential?

-TRADITIONAL VERSUS COMPREHENSIVE CARE-

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Comprehensive</th>
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<tbody>
<tr>
<td>6 prophylaxis</td>
<td>2 prophylaxis</td>
</tr>
<tr>
<td>1 root planing</td>
<td>1 gingivitis therapy</td>
</tr>
<tr>
<td>1 perio maintenance</td>
<td>2 periodontal therapies</td>
</tr>
<tr>
<td>4 horizontal bitewings</td>
<td>3 periodontal maintenance</td>
</tr>
<tr>
<td>2 fluoride tx</td>
<td>1 panoramic film or FMX</td>
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<tr>
<td></td>
<td>3 vertical bitewings (7 films)</td>
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$_______ Ave. Per Hour
$_______ Ave. Per Day

4 sites LAAs
4 fluoride or varnish tx
1 Perio DNA test
1 OC screening

$_______ Ave. Per Hour
$_______ Ave. Per Day

Five words to revolutionize hygiene: ______  ______  ______  ______  ______

-ESTABLISH CLEAR DISTINCTIONS IN ALL HYGIENE PROCEDURES-

ADA Current Dental Terminology 2009 - 2010 CDT

www.perio.org > Publications > Parameters of Care
True or False

_____The definition of prophylaxis states that it is performed only on healthy patients.

_____Prophylaxis can be performed on one visit for healthy sites and the patient return for additional scaling and root planing a week or so later for diseased sites.

_____Prophylaxis and periodontal therapy may be performed during the same visit following a doctor’s diagnosis when there are both healthy and localized diseased sites present.

_____Locally applied antimicrobials should be placed in deeper diseased sites immediately following therapy to work in conjunction with the immune response.

_____Periodontal maintenance should follow periodontal therapy for patients with attachment loss only if the disease generalized.

_____Periodontal patients alternating between a general dentist and periodontist should receive periodontal maintenance from the periodontist’s office and prophylaxis from the general dentist.

_____Gingivitis should always be treated in conjunction with the prophylaxis.

_____A prophylaxis patient can be on a 3 month interval.

_____A doctor’s examination is included with periodontal maintenance and should be included with the fee.

_____Full mouth debridement should precede scaling and root planing as a “gross scaling” to remove as much heavy deposit as possible, making root planing easier.

Prophylaxis – intended to control local factors and prevent disease

Periodontal therapy – intended to halt disease progression and create an opportunity for healing

Periodontal maintenance – intended to maintain results obtained through therapy and keep disease under control

WIIFM

1.
2.
3.
4.
5.
-CONVERT EXISTING PATIENTS INTO OPTIMAL TREATMENT-

*Three magic words for education: __________ __________ __________*

*One magic word for effective enrollment: _______________*

I. MERGE SCIENCE INTO TREATMENT

“The current paradigm for the etiology and pathogenesis of periodontal disease includes the initiation of disease by specific bacteria within a biofilm. These bacteria stimulate immune responses that can result in tissue destruction.”

AAP Academy Report—Modulation of the host response in periodontal therapy. J Periodontology April 2002

*Treat the Disease*

“The inflammatory components of plaque induced gingivitis and chronic periodontitis can be managed effectively for the majority of patients with a plaque control program and non-surgical and/or surgical root debridement coupled with continued periodontal maintenance procedures.”


MMS LOWER PROPORTIONS OF RED AND ORANGE COMPLEX BACTERIA

- 46 never smokers, 37 current smokers, 44 former smokers
- SRP alone ineffective at reducing proportion of red complex bacteria (RCB) or orange complex bacteria (OCB) in current smokers
- SRP + MM significantly reduced RCB and OCB; improved PD, BOP and clinical attachment level more than SRP alone irreversible of smoking status


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www.arestin.com

Atridox®

www.atridox.com

PerioChip®

www.periochip.com

Incidence of Disease

- 5% - 20% severe generalized periodontitis
- Moderate disease affects a majority of adults
- Periodontitis evident in most susceptible individuals in teenage and early adult years rather than later years
- Milder forms of periodontitis are close to universal

AAP Position Paper Epidemiology of Periodontal Diseases J Periodontology 2005
II. SCREENINGS & DATA COLLECTION

1. Medical History
   Medical reference in each treatment room
   Personal and family history of systemic diseases
   Lifestyle and habits
   Diet and nutrition
   Prescription RX
   OTC
   Herbal/Supplements
   Allergies

The American Journal of Cardiology and Journal of Periodontology Editors’ Consensus: Periodontitis and Atherosclerotic Cardiovascular Disease J Periodontol 2009;80:1021-1032
   • Weight reduction
   • Increased physical activity
   • Reduced intake of saturated fats
   • Limited alcohol intake or alcohol in moderation
   • Cessation of tobacco

   www.askadviserefer.org
   www.americaonthemove.org
   www.fitday.com
   www.coopercomplete.com

2. Blood Pressure Screening
   AHA guidelines for hypertension
   Normal <120 Systolic and <80 Diastolic
   Prehypertension 120-139 Systolic or 80-89 Diastolic
   Stage 1 Hypertension 140-159 Systolic or 90-99 Diastolic
   Stage 2 Hypertension >159 or >99
   Omron wrist cuffs (OM-HEM-637) www.allheart.com

3. Radiographs
   www.ada.org Risk assessments and updating radiographs

   “Conventionally read radiographs routinely underestimate the amount of bone loss…Sequentially taken radiographs, when examined by eye, are able to reveal changes in bone only after 30 – 50% of the bone mineral has been resorbed.”
   AAP Position Paper-Diagnosis of Periodontal Diseases. August 2003
4. Intra/Extra Oral Exam and Oral Cancer Screening

According to the National Cancer Institute oral cancer examinations should be a part of every dental patient exam

Fastest Growing OC Population: Non-smokers < 50
Five Year Survival = 52%, 20% Increase for Second Cancer
Early Diagnosis = 80% Survival. Stage 4 = 20% Survival
Only 35% OC Diagnosed at Stage 1

Identify3000® www.trimira.net
ViziLite® www.vizilite.com
Oral CD www sopreventable.com
VELscope® www.velscope.com

5. Restorative/Aesthetic Screening
Prioritize for today's visit and treatment plan for future visits
Reveal Reality with Introoral camera
Occlusion / Abfraction / Erosion
Caries Detection
DIAGNOsent® www.kavousa.com
Caries ID® www.cariesid.com
Spectra® www.spectra.com
VELscope® www.velscope.com
CAMBRA – see handout
Shade Guide Analysis

6. Periodontal Screening/Recording

“Aspirin intake of 325 mg daily for 7 days moderately increased the appearance of bleeding on probing in a population that had ≥20% BOP sites”.
J Periodontology 2002;73:871-876
Tissue response each visit / Complete recording once a year, minimally
Patients must HEAR their numbers
Patients must SEE their infection
Patients must SEE their permanent jawbone damage
Comprehensive Periodontal Exam D0180

www.previser.com – Periodontal Risk Assessment Tool
Disease Score / Risk Score

Automated Periodontal Charting:
www.floridaprobe.com - controlled force
www.periopal.com - voice activated
www.dentalrat.com - foot-controlled

D0418 - Analysis of saliva sample to identify pathogens and threshold levels
MyPerioPath test
D0421 - Genetic test for susceptibility to oral diseases MyPerioID PST test
OraRiskSM HPV test for identification of HPV virus in oral cavity
III. ESTABLISH A DIAGNOSIS & TREAT THE DISEASE

Gingival Diseases

Plaque induced - in the absence of clinical attachment loss
Modified by systemic factors/ medications / malnutrition

Non-plaque induced lesions
oral herpes, lichen planus, allergic reactions, trauma, etc.

Aggressive / Chronic Periodontitis
Localized = ≤30% of sites involved
Generalized = ≥30% of sites involved
<10% bone damage
<33% bone damage
≥33% bone damage

SAMPLE DIAGNOSIS:
Localized Chronic Periodontitis / ~10% bone damage, localized posterior teeth
• Female. Existing patient.
• 9 months since last visit
• Slight Crestal Bone Loss, Posterior Teeth
• BWX 15 months old; FMX 2 years old
• BP Medication
• Both Parents Had Periodontal Disease
• Elevated Stress Recently
• Smokes ¼ Pack / Day / 15+ years
• Excellent Oral Hygiene
• Probing Depths 1-3 mm gen. & 1-2 Teeth per Quad. 4-5 mm
• Slight – Moderate Bleeding, Localized: posterior teeth (29 / 144 sites)

SAMPLE TREATMENT PROTOCOL:
• 1st RDH visit: Initial Prophylaxis D1110 / Exam D0120 / 7 Bitewings D0277 (Diagnosis & Tx. Plan Developed)

• 2nd RDH visit: D0418 MyPerioPath DNA test / UL PT D4342 / LL PT D4342 / LAA D4381 #18, #14

• 3rd RDH visit: UR PT D4342 / LR PT D4342 / LAA D4381 #31

• 4th RDH visit: D0418 MyPerioPath Retest / 6-WK Reassessment & Debridement D4910, (Includes Doctor’s perio. / rest. Evaluation at no additional fee)

• 3 months: Periodontal Maintenance D4910. Determine need for referral.

Re-Assess the Response:
“Several weeks following the completion of root planing and efforts to improve personal plaque control; re-evaluation should be conducted to determine the treatment response...Some patients may need additional therapeutic procedures.”
AAP Academy Report J Periodontology December 2001; 1790-1800
What If?

• Not enough time today to collect data?
  – Convert today’s visit to diagnostic appointment: D0180, D0277
  – Provide initial prophylaxis D1110 and 7 BWX & reschedule for D0180

• Patient just wants a cleaning?
  – Cleanings do not eliminate periodontal infection!
  – Use decline form!

Know Your Referral Guidelines
www.perio.org – publications
Guidelines for the Management of Patients with Periodontal Diseases 2006

Maintain Results & Prevent Re-infection
PM is not synonymous with a prophylaxis. Most patients with a previous history of periodontitis should obtain PM at least four times per year, since that interval will result in a decreased likelihood of progressive disease, compared to patients receiving PM on a less frequent basis. Nevertheless, the PM schedule should be individualized.


As Diagnosis and Non-surgical Therapy Increases, So Does Patient Health and Practice Profitability!

Prophylaxis from ~75% to ~40%
Periodontal Maintenance from ~13% to ~32%
Periodontal Therapy from ~12% to ~28%

Implementation Strategies

• Team Continuity
• Pre-block Schedule for Periodontal Therapy
• Continuity with Periodontist
• Review records to determine perio / restorative focus
• Build value with patient EACH VISIT

Warning!

Practicing Beyond the Boundaries Will Be Habit Forming!
**ADA CDT 2009 2010**

**D1110 PROPHYLAXIS (CONTINUING CARE)** – Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.

**D4355 FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS** - The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

**D4341 & D 4342 SCALING AND ROOT PLANING (PERIODONTAL THERAPY)** – This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms.

**D4910 PERIODONTAL MAINTENANCE (SUPPORTIVE PERIODONTAL THERAPY)** - This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. *(AAP Parameter of Care 2000)* These procedures are performed at selected intervals to assist the periodontal patient in maintaining oral health. The patient may move from active therapy to periodontal maintenance and back into active care if the disease recurs.

**D4381 LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH, BY REPORT (LOCALLY APPLIED ANTIMICROBIALS)** – FDA approved subgingival delivery devices containing antimicrobial medication(s) are inserted into periodontal pockets to suppress the pathogenic microbiota. These devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time.
# Caries Risk Assessment & Management

## CHILDREN*

**Moderate Risk** (any of the following)
- one new, incipient or recurrent carious lesion in the past year
- deep or noncoalesced pits and fissures
- high caries experience in family
- history of pit and fissure caries
- early childhood caries
- frequent sugar exposures
- decreased salivary flow
- compromised oral hygiene
- irregular dental visits
- inadequate fluoride exposure
- proximal radiolucency
- physical disability for oral hygiene

**High Risk**
Two or more new, incipient or recurrent carious lesions in the past year, or two or more of the following:
- deep or noncoalesced pits and fissures
- siblings or parents with high caries rate
- history of pit and fissure caries
- early childhood caries
- frequent sugar exposures
- decreased salivary flow
- proximal radiolucency
- physical disability for oral hygiene

*Source: JADA vol. 131 June 2000

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## ADULTS*

**Moderate Risk** (any of the following)
- one or two new, incipient or recurrent carious lesions during the past 3 years
- history of numerous or severe caries
- deep or noncoalesced pits and fissures
- frequent sugar exposures
- decreased salivary flow
- compromised oral hygiene
- irregular dental visits
- inadequate fluoride exposure
- physical disability for oral hygiene

**High Risk**
Three or more carious lesions in the past three years, or two or more of the following:
- history of numerous or severe caries
- deep or noncoalesced pits and fissures
- frequent sugar exposures
- decreased salivary flow
- compromised oral hygiene
- irregular dental visits
- inadequate fluoride exposure
- physical disability for oral hygiene
- compromised oral hygiene
- proximal radiolucency

*Source: JADA vol. 131 June 2000

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<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Risk: Moderate</th>
<th>High</th>
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- Limit or discontinue soft drinks / energy drinks / fruit drinks due to high citric acid / low pH and/or sugar content
- Rinse 2 X day with Rx Chlorhexidine for 1 week only per month for ____ months
- Apply Rx Fluoride treatment 2 X day separated at least 30 minutes from chlorhexidine rinse
- Chew Xylitol gum or mints for 5 min. each 3–5 X day ([www.xylitolnow.com](http://www.xylitolnow.com))
- Drink 6-8 glasses fluoridated water per day
- Receive professional fluoride/varnish treatments with dental hygiene visits
- Have pit and fissure sealants applied to susceptible tooth surfaces
- Crest ProHealth™ Toothpaste and Rinse twice daily
- Sonicare® 2 minutes per use
- Listerine® Multicare Rinse with Fluoride daily
- MI Paste daily
- Clinpro 5000 daily
- Prevident 5000 daily
- Oral Irrigation daily
- **Other**

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*Name__________________________ Date___________ Risk: Moderate High

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