Casey Hein, RDH, MBA

The Case for Collaboration

Collaboration, defined by the *Merriam-Webster Dictionary* as the "willing process of working jointly with others in an intellectual endeavor"[1] is quietly taking place in many general practices across the United States. Collaboration also means sharing information and joint decision-making.

Collaboration: Legislated or Embraced?

According to the American Dental Hygienists' Association (ADHA), there are currently two states—Minnesota and New Mexico—that have legislated collaborative practice acts. In these instances, collaborative practice offers hygienists the opportunity to "treat patients according to protocol with collaborative dentist(s)" and "own or manage a dental hygiene practice in any setting."[2] These unsupervised scenarios are defined on the basis of "a written agreement between the dental hygienist and one or more 'consulting dentist(s)."[2] In contrast, this article does not pertain to legislating practice acts that allow for unsupervised practice like those in Minnesota and New Mexico. Instead, the focus of this article is the potential of the periodontal therapists who work in informal, yet professional-collaborative relationships in conventional general-practice settings.

Progressive general dentists are discovering that there is a growing number of hygienists who are specializing in advanced periodontal therapeutics (periodontal therapists) and that these hygienists are astute in detecting the early signs of inflammatory periodontal changes and capable of designing and implementing disease management strategies. These dentists have come to trust, value, and depend on the advanced expertise of periodontal therapists. This is what distinguishes the periodontal therapist, and dentists welcome collaborative practice because it is so attractive—not because it was legislated.

No Longer a Secret

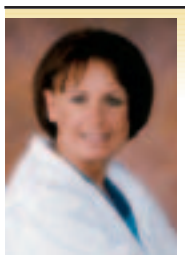
It is no longer a secret that the key to health care reform in the United States is intra- and interprofessional collaboration among health care providers. There is growing research that provides credible evidence that collaborative relationships between nurse practitioners and primary care physicians (among other allied health care providers) significantly improves health care outcomes for medical patients.[3-19] However, this type of collaborative relationship between hygienists and general dentists has not yet been studied. This is a research initiative within dentistry that is long overdue.

Even without published evidence, a growing number of dental professionals are establishing collaborative relationships with allied health care providers, such as endocrinologists, cardiologists, and alternative medicine professionals, to provide whole-body care for their mutual patients. It is not within the scope of this article to discuss these interprofessional collaborative relationships. Rather, this article addresses the need for building collaborative practice environments that support the periodontal-therapist model of dental hygiene, and introduces a model that points out the benefits of a collaborative relationship between the periodontal therapist and the dentist in a general practice setting (Figure 1). Few would debate that evolving societal needs (in this case, primary periodontal care and the complexity of case management because of multifactoral causes and systemic associations) have resulted in a need to redefine and step up one of the roles of the dental hygienist. This has created a significant demand for a more advanced general practice hygienist—aka, the periodontal therapist. Yet, by the very nature of their role and the level of responsibility they assume, a collaborative, interdependent practice environment is a prerequisite for the type of success that periodontal therapists and their dentists are experiencing. Based on my experiences, these dual-practitioner, collaborative scenarios are evolving across the country, in spite of the limitations imposed by conservative dental practice acts and outdated scope-of-practice politics.

> Periodontal therapists have not demanded collaboration; they have earned it through dentists' respect for their wealth of current scientific knowledge and clinical expertise.

According to the ADHA, there are more than 120,000 registered dental hygienists in the United States.[20] How many are practicing at the level of a periodontal therapist? When I began clinical consulting, my "hypothesis" was that advanced periodontal therapists were a very small minority—perhaps less than 1%. Since that time, I have either spoken or collaborated with enough periodontal therapists that I am convinced that there are more hygienists practicing at this level than I originally thought. However, based on my on-site observations in general practices, I am still conservative in my estimates. Although these types of progressive clinicians are still in the minority, I often hear from periodontal therapists who are assuming extraordinary roles and performing leading-edge care. For example, there are many clinicians who use portable glucose monitors to perform chairside screening for diabetes or prediabetic status, and tracking glycosylated hemoglobin levels against their diabetic patients' periodontal status. Recognizing the trigger that certain inflammatory mediators associated with chronic periodontitis may play in increasing the risk for acute coronary syndromes (ie, unstable angina and myocardial infarction), some periodontal therapists have entered into three-way collaborative relationships with their dentists and their patients' cardiologists. This three-way collaborative relationship helps track C-reactive protein levels, a sensitive marker for ongoing, chronically high inflammation levels that are thought to indicate a much greater risk for an acute cardiac event.[21,22] Other periodontal therapists are incorporating the wellness model of periodontal care into alternative practice environments, which may result in some interesting findings down the road. Other periodontal therapists are employing therapeutic seeding by intercepting early-stage chronic periodontitis in women during their childbearing years, thereby decreasing their risk for preterm low-birth-weight babies. Many periodontal therapists incorporate oral risk assessment into routine recare. Practicing at this level is exciting, yet it is tough keeping up.

Because of the rate at which new research findings are emerging, their relevance to our profession, and the magnitude of their implications, we are continually challenged to keep abreast of the latest information. Most troubling is the fact that although research indicates that many dental hygiene educators have made strides in incorporating evidence-based philosophy within their curricula, the progress is slow compared to where we need to be.[23] Given the vacuum in evidence-based skill training[24,25] that would prepare dental hygiene students to use their critical-thinking and problem-solving skills, it appears that very few new graduates are actually prepared to practice advanced periodontal therapeutics. This helps to explain why moving to the specialty level of periodontal therapist demands such a rigorous course of independent self-study. Periodontal therapists are those who are committed to practicing evidence-based oral hygiene, which demands con-



Casey Hein, RDH, MBA

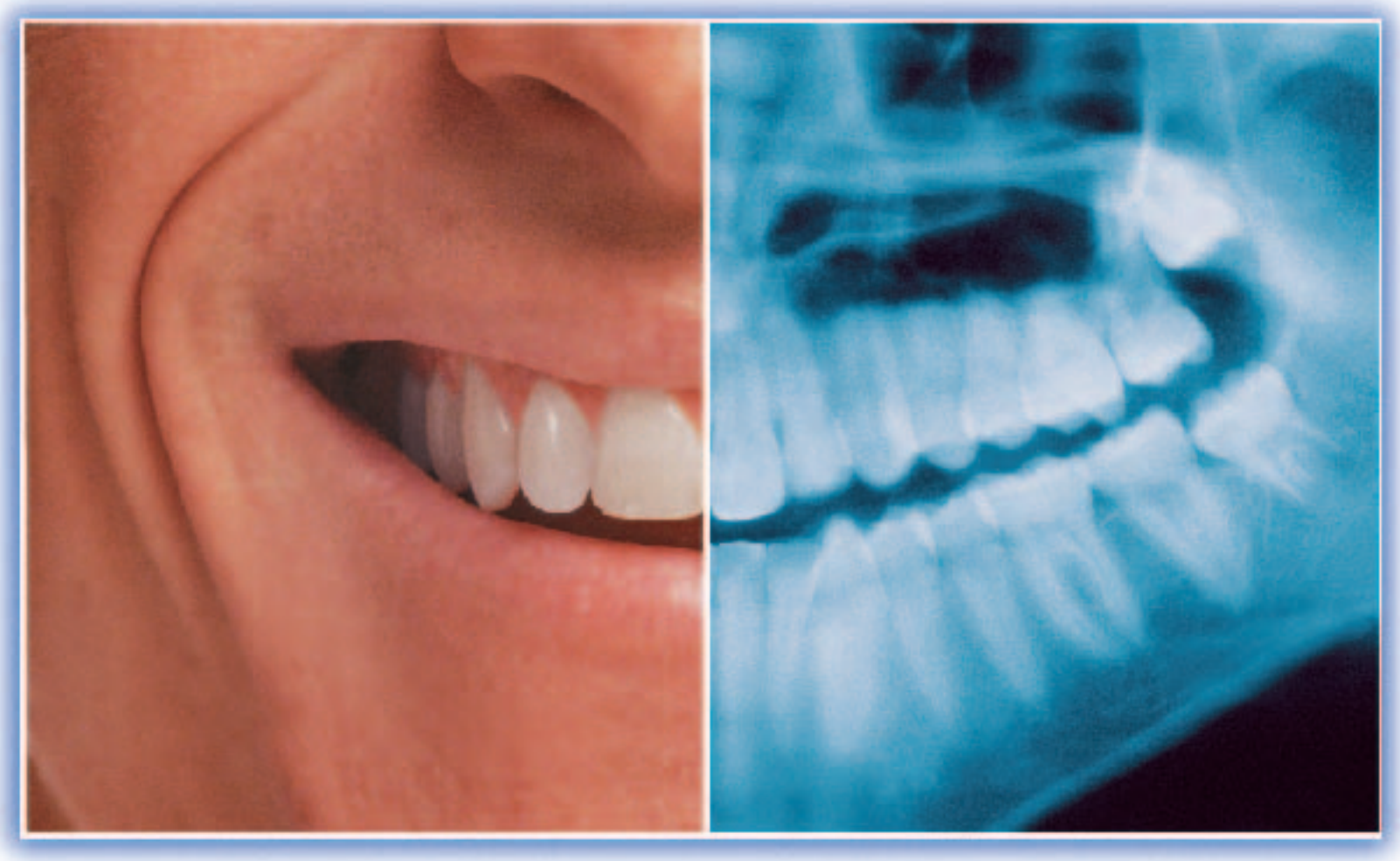
Casey is a periodontal therapist subcontractor in the Washington DC/Baltimore area and founder of PointPerio, LLC, a consulting firm committed to coaching general dentists and hygienists in progressive periodontal therapeutics within a collaborative framework. She is a member of the American Dental Hygienists' Association. Casey lectures nationally on the role of the periodontal therapist in general practice and regularly contributes practice management articles to Dentist's Money Digest. *She welcomes comments and visitors to her Website www.@pointperio.com.*

Colgate®

PreviDent® 5000 Plus® just got better!

(1.1% Sodium Fluoride)
Prescription Toothpaste

BETTER COMPLIANCE = BETTER RESULTS



Now Colgate® PreviDent® 5000 Plus® provides the same great proven results *PLUS* an innovative cleaning system for enhanced compliance

- Exclusive technology delivers superior cleaning
  —Demonstrated to clean 30 times better than another prescription-strength toothpaste[1]
- Proven to significantly remineralize root caries in just 3 months (38.2%)[2]
- Still the *only* Rx fluoride toothpaste to back its claims with clinical proof

For more information, call 1-800-2-COLGATE (226-5428) or visit our Web site at www.colgateprofessional.com.

Colgate Oral Pharmaceuticals

POWERFUL FLUORIDE, SUPERIOR CLEAN

References: 1. Data on File, Colgate Oral Pharmaceuticals, Inc. **2.** Baysan A, et al. Reversal of primary root caries using dentifrices containing 5,000 and 1,100 ppm fluoride. Caries Res. 2001;35:41-46.

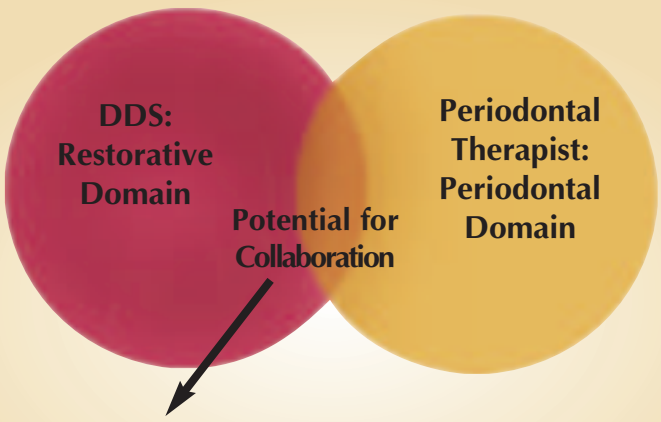
Please see full Prescribing Information on the following page.

stant surveillance of leading-edge information, filtering new data for validity, significance, and relevance, and, finally, transferring only scientifically founded information and treatment modalities into their everyday practices. Periodontal therapists have not demanded collaboration; they have earned it through dentists' respect for their wealth of current scientific knowledge and clinical expertise. Most periodontal therapists have established an associate relationship with their dentist employers. As stakeholders in general practice settings, they have great incentives for practice optimization.

As far back as 1981, the Subcommittee on Preventive Periodontics of the American Association of Public Health Dentists advocated the dental hygienist as the "critical" element "in the global scheme of preventive periodontics."[26] In this same article, the subcommittee noted that "Because of a complex of social, political, legal, and economic factors, however, *the full potential of the hygienist resource has not been brought to bear optimally on the nation's primary oral health problem* [author's emphasis]. Current evaluations of the hygienist's role are frequently overshadowed by the issue of independent practice—a natural and predictable outgrowth of improved education, expanded responsibility, and enhanced professionalism."[26] That was more than 20 years ago—about the same time that evidence on the multifactorial causes of chronic periodontitis and its association to serious systemic complications started to filter through the research sieve.

Sadly, not much has changed since then for the profession or the patients we serve. The philosophical shift from the illness (repair) model to a wellness model, the increased consumer-patient demand for primary periodontal care for underserved populations, the aging baby boomer demographics, and evidence that collaborative relationships have enhanced quality of care within the medical community all should have stimulated intra- and interorganizational reform to bring about collaborative practice in dentistry. But that has not happened. It appears that dentists who are willing to work in a collaborative relationship with a hygienist are still few in number, except for those who support and practice side-by-side with periodontal therapists. The periodontal therapist model can be possible only in practice settings where dentists fully recognize periodontal therapists' individual competency, and where periodontal therapists and dentists mutually acknowledge their interdependence. Dentists who are willing to end the professional turf battles over who has the authority to diagnose periodontal disease and directly address the issues related to collaborative practice with periodontal therapists, are finding that their patients and their entire dental team (not to mention their net incomes) stand to benefit significantly.

Figure 1—The Benefits of Collaborative Practice



- Intellectual cross stimulation
- Peer-review quality assurance
- Recognition and reliance on individual expertise
- Recognition of interdependence
- Striving for excellence and practice profitablilty is mutually compelling and satisfying

Dentists who are willing to end the professional turf battles ... and directly address the issues related to collaborative practice with periodontal therapists, are finding that their patients and their entire dental team ... stand to benefit significantly.

The collaborative relationship nurse practitioners have with primary care physicians began in 1965 when Loretta Ford, a professor of nursing at the University of Colorado, and Dr. Henry Silver, a pediatrician in Denver, developed a 4-month intensive practicum to train registered nurses to treat patients in communities with physician shortages.[27] Over the next three decades, more nursing schools began offering formal nurse practitioner training. Although the consumer-patient demand for periodontal therapists in a general practice environment seems to be increasing, overcoming the political hurdles and putting in place the structure to support a formal educational track and certification process may be quite a few years off. In the meantime, hygienists who aspire to practice as periodontal therapists must develop within their current environment, which requires discipline and dedication. A dentist who is open to change and collaboration is also a prerequisite. As more hygienists distinguish themselves as periodontal therapists who collaborate with general dentists, and more dentists scramble to find periodontal therapists, the private practice culture is changing. Will the momentum of this movement toward collaborative practice prompt changes in individual states' dental practice acts? We can hope that it will not take 20 years to bring about an interprofessional culture of collaboration in dentistry; too many people stand to lose on this—most importantly, the public we serve.

In 2001, Christensen wrote, "I contend that conservative dental practice acts that limit the potential responsibilities of educated staff members should be critically analyzed and expanded to allow this valuable concept to be incorporated into dental practices."[28] I agree with this statement; however, whether professional turf battles are implicated in this bogged-down struggle to create collaborative practice in dentistry is almost irrelevant at this point. Some general practices could wait no longer. Dentists and periodontal therapists who are

already working within this type of professional framework sought to deliver integrated collaborative care because they knew it would be the best care they could provide to their patients—regardless of regulatory variations. And, they're doing it with great success in terms of quality of care. Additionally, the financial rewards of following the collaborative model are becoming more attractive to dentists and the hygienists who aspire to practice at the level of periodontal therapist. These are champion professionals who are increasingly successful in spite of artificially imposed hurdles. They will blaze the trail for reform. **COH**

References

1. The Merriam-Webster Dictionary. Available at http://www.aolsvc.merriamwebster.aol.com/home-aol.html. Accessed May 4, 2003.
2. States permitting unsupervised practice/less restrictive supervision. American Dental Hygienists' Association, Division of Governmental Affairs. Available at http://www.adha.org. Accessed May 2003.
3. Hodson DM. The evolving role of advanced practice nurses in surgery. *AORN J*. 1998; 67(5):998-1009.
4. Dixon DL. Enhancing collaboration & healthcare delivery effectiveness. *Caring for the Ages*. 2002 3;(10):30-32.
5. Doherty WJ, McDaniel SH, Baird MA. Five Levels of Primary Care/Behavioral Healthcare Collaboration. *Behavioral Healthcare Tomorrow*. 1996;25-28.
6. Grandinetti D. What kind of patient would rather see a nurse practitioner? *Medical Econ*. 1999;76(3):156-158.
7. (No author listed) Trumping professional roles: collaboration of nurse practitioners and physicians for a better US health care system. *Am Fam Physician*. 2001; 64(8):1325.
8. Stamoulis JG, VanHook PM. Community hospital stroke outcomes of a nurse practitioner facilitated stroke team. Paper presented at the American Stroke Associations 25th International Stroke Conference, New Orleans, February 2000.
9. Boyd L. Advanced practice nursing today. *RN*. 2000;63(9):57-62.
10. Roy-Byrne PP, Katon W, Cowley DS, Russo J. A randomized effectiveness trial of collaborative care for patients with panic disorder in primary care. *Arch Gen Psychiatry*. 2001; 58:869-876.
11. Elston S, Holloway I. The impact of recent primary care reforms in the UK on the interprofessional working in primary care centers. *J Interprof Care*. 2001;15(1):19-27.
12. Schmitt MH. Collaboration improves the quality of care: metholdological challenges and evidence from US health care research. *J Interprof Care*. 2001;15(1):47-66.
13. Freeth D. Sustaining interprofessional collaboration. *J Interprof Care*. 2001;15(1):37-46.
14. Molyneux J. Interprofessional teamworking: what makes teams work well? *J Interprof Care*. 2001;15(1):29-35.
15. Mur-Veeman I, Eijkelberg I, Spreeuwenburg C. How to manage the implementation of shared care: a discussion of the role of power, culture and structure in the development of shared care arrangements. *J Manag Med*. 2001;15(2):142-155.
16. Mark DD, Byers VL, Mays MZ. Primary care outcomes and provider practice styles. *Mil Med*. 2001;166(10):857-880.
17. Waldorff FB, Bulow LB, Malterud K, Waldemar G. Management of dementia in primary health care: the experiences of collaboration between the GP and the district nurse. *Fam Pract*. 2001;18(5):549-552.
18. Hardey M, Payne S, Powell J, et al. Professional territories and the fragmented landscape of elderly care. *J R Soc Health*. 2001;121(3):159-164.
19. Reese DJ, Sontag MA. Successful interprofessional collaboration on the hospice team. *Health Soc Work*. 2001;26(3):167-175.
20. The Future of Oral Health, Trends and Issues. The American Dental Hygienists' Association. Available at http://www.adha.org. Accessed on April 21, 2003.
21. Heart Disease Weekly. Acute Myocardial Infarction: Scientists say inflammation even worse for heart than cholesterol. Available at http//www.newsrx.com. Accessed September 8, 2002.
22. Speidl WS. High-sensitivity C-reactive protein in the prediction of coronary events in patients with premature coronary artery disease. *Amer Heart J*. 2002;144:449-455.
23. Chichester SR. Utilization of evidence-based teaching in US dental hygiene curricula. ADHA-Journal Abstracts. Available at http://www.adha.org/publications/journalabsrracts.html. Accessed on July 28, 2001.
24. Forrest JL. White Paper: Evidence-based decision making in dental hygiene education, practice and research. *J Dent Hyg*. 2001; (75)I:50-63.
25. Forrest JL. Getting started using an evidence-based approach. ADHA 4th National Research Conference, Washington, DC; June 23, 2000. Available at http://www.adha.org/publications/nrc/forrest2.html. Accessed June 23, 2000.
26. Position paper prepared for the American Association of Public Health Dentists by the AAPHD Subcommittee on Preventive Periodontics. Periodontal disease in America: a personal and national tragedy. October 24, 1981.
27. Mason DJ. Early views of nurse practitioners: a Medline search. *Clin Excel for NP*; 2000(4)No.3;175-183.
28. Christensen GJ. Why expand the role of staff members? *JADA*. 2001;132:529-531.

Circle 7 on Reader Service Card