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SPECIAL ARTICLES

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Emerging Models: 30 Years of Breaking through Dental Sleep Medicine Barriers to Help Patients

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Thirty years ago, a group of dentists had the vision and passion to create the Sleep Disorders Dental Society, which later became the American Academy of Dental Sleep Medicine (AADSM). The founding documents stated that the organization was being incorporated "to effectively impact the treatment of sleep disorders through the utilization of oral appliances as an integral part of overall therapy and to facilitate a coordinated, synergistic approach to research, education/accreditation, and treatment within the medical community that is focused on the well-being of both the patient and the health care team." As we reflect on the 30th anniversary of the AADSM, it is incumbent upon us to move forward today's mission to "advance the dentists' role in the screening, evaluation and treatment of sleep-disordered breathing and strive to reduce the number of undiagnosed and untreated people with sleep-disordered breathing..." [1]

The AADSM was founded on the belief that dentists working directly with sleep physicians and accredited sleep facilities could provide an alternative or adjunct treatment for patients who were unable to tolerate continuous positive airway pressure (CPAP). This belief soon evolved into a practice model with bidirectional referrals. The dentist screened patients for obstructive sleep apnea (OSA) and those suspected of having OSA were referred to the sleep physician for further evaluation, diagnosis, and treatment. In many instances, the treatment was oral appliance therapy (OAT), but not always. Alternatively, the sleep physician referred patients who were unable to tolerate CPAP or simply preferred a different treatment to the dentist for OAT. When this practice model was developed, home sleep apnea tests (HSATs) did not exist; all testing was done at a sleep facility. OAT was also still in its infancy, and few dentists were trained to provide OAT. This model made perfect sense, and it is still currently in practice in many parts of the country. Building upon this foundation, we continue to work with the American Academy of Sleep Medicine to develop closer collaborations between qualified dentists and accredited sleep facilities and to ensure that sleep physicians are offering OAT as a treatment option for OSA. However, this model is not available to all patients throughout the country, and the number of sleep physicians is declining.[2]

Fortunately, evolving technologies and advances in the field have made it possible for qualified dentists to implement alternative practice models that will allow them to build sustainable dental sleep medicine (DSM) practices, while continuing to provide optimal patient care. HSATs, for example, provide a way for patients to obtain a diagnosis of OSA without needing an overnight in-laboratory test at an accredited sleep facility. This expands access to care for populations that do not live within reasonable proximity to accredited sleep facilities or sleep physicians. Initially, OAT was only considered as an alternative treatment for those who could not tolerate CPAP. Over time, with advances in oral appliances and additional research, OAT has become a first-line treatment for patients who prefer it, especially those with mild to moderate OSA. In 2018, the AADSM created both the *Dental Sleep Medicine Standards for Screening, Treating, and Managing Adults With Sleep-Related Breathing Disorders*[2] and AADSM Mastery Program, facilitating a standardized pathway to provide OAT and for dentists to become trained. The AADSM Qualified Dentist designation and American Board of Dental Sleep Medicine Diplomate designation verify knowledge and skill in practicing DSM. Currently, almost 2,000 dentists have earned these designations. Qualified dentists can now consider alternative practice models, some of which are outlined in the next paragraphs, to play a larger role in helping the millions of Americans with undiagnosed and untreated OSA. To be clear, the AADSM is not endorsing the models outlined in this paper, but instead qualified dentists are encouraged to reflect on and discuss emerging models of care in DSM that may work in their communities.

As outlined in the AADSM's *Position on the Scope of Practice for Dentists Ordering or Administering Home*

Sleep Apnea Tests[3], qualified dentists can help identify patients with undiagnosed OSA by working with local licensed medical providers to develop agreed-on criteria for whether patients are candidates for HSATs. The qualified dentist can then screen patients, identify those who are suspected to have OSA, order or distribute HSATs to appropriate patients, and refer them to the licensed medical provider for diagnosis. Dentists have a front seat to patients' airways, see patients often, and have built relationships – sometimes across generations – with them. These opportunities and trusted relationships put dentists in an optimal position to identify patients with undiagnosed OSA. Recently, the American Dental Association updated its policy on the role of dentists treating sleep apnea to incorporate language that dentists can use HSATs as part of their armamentarium, as permitted by laws. There are only a few state dental boards that specifically prohibit dentists from using HSATs, and we are engaged in the modification of these policies based on the American Dental Association's recent statement.

In addition, qualified dentists may consider playing a larger role in treating patients in whom OSA has been diagnosed by a licensed medical provider, but who are not receiving any treatment. This could include patients who have abandoned CPAP or those who have denied CPAP in favor of OAT. These patients have documentation of the diagnosis of OSA, but may not have access to a prescription from a licensed medical provider for various reasons (inconvenience, access to care, expenses, etc.). As we consider prescribing trends relative to insurance requirements for OAT, it is important to consider that only qualified dentists have the appropriate training to assess whether a patient is a suitable candidate for OAT, select the appropriate appliance, deliver and calibrate the appliance, and provide long-term care.

As an example, licensed medical providers do not prescribe hypoglossal nerve stimulation surgery or gastric bypass surgery to help treat patients with OSA. Rather, they refer the patient to a surgeon to determine whether the patient is a suitable candidate for the procedure.[4] OAT should follow the same process; the licensed medical provider refers a patient to a qualified dentist. The qualified dentist then evaluates the appropriateness of OAT for the patient, formulates the specific design, writes the prescription to the laboratory, and is ultimately responsible for the delivery and maintenance of the oral appliance. Similarly, if a patient initiates treatment for OAT directly from a qualified dentist and has documentation of the diagnosis, it is appropriate for the dentist to respect patient preferences, evaluate whether the patient is a candidate for OAT, provide informed consent including information about other therapies for OSA, and communicate the initiation of the therapy with the patient's licensed medical providers. Dentists routinely prescribe and provide multiple medical treatments. Most state dental boards have not prohibited a qualified dentist from providing OAT without a prescription to a patient with OSA that has been diagnosed by a licensed medical provider. We often prescribe OAT to patients in whom snoring has been diagnosed by a licensed medical provider.

Thirty years ago, our founding members had the forethought to recognize that qualified dentists and OAT could benefit patients and that a professional organization needed to be developed to focus solely on this goal. As we continue to strive to ensure that all patients have access to care for OSA, it is imperative that we consider new practice models as technology and training evolve. Over the next several issues of *JDSM*, we will introduce other ways we can consider evolving our practices to meet the public burden of OSA, while continuing to provide optimal patient care. We recognize that models are affected by many factors, including but not limited to state regulations, geographic location, relationships with referring licensed medical providers, reimbursement models, and dentists' capacity to provide OAT in relation to other areas of their practice, so we have started a discussion thread titled "Emerging Models" on the AADSM's online discussion forum and encourage you to submit thoughts of your own.

CITATION

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DISCLOSURE STATEMENT

All authors are members of the AADSM Board of Directors. Dr. Schwartz declares investments in Prosomnus Sleep.