

# Interprofessional Education: Preparing dental hygienists to practice in the evolving health care world

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The last twenty years have brought a plethora of changes in health care. The implementation of the Affordable Care Act (ACA) facilitated a paradigm shift from a focus on managing the consequences of diseases to a more preventive lens focused on primary health care and overall health maintenance. The Triple Aim, a framework for medicine based on improving population health, improvement of the overall patient experience, and controlling the per capita cost of care, was a key driver of this shift.<sup>1</sup> A number of recommendations have been made, including interprofessional collaborative practice (IPCP) to help achieve the Triple Aim. IPCP is defined as occurring when multiple health workers from different professional backgrounds work together with patients, families, and communities to deliver the highest quality of care.<sup>2</sup>

Federal policy changes have also shaped the landscape of health care. The ACA, along with the Children's Health Insurance Program Reauthorization Act (CHIPRA), established the foundation for medical-dental integration or MDI,<sup>3</sup> a growing practice model in today's health care environment. MDI occurs when medical and dental services are intentionally linked to better serve patients and eliminate barriers to care. Several structural models have been identified as part of MDI; co-location when dental care is provided in the same location as primary health care services; integrated care when a dental hygienist is integrated directly into the medical team; and the virtual dental home using telehealth to provide coordinated services. Integration of medical and dental services is most commonly accomplished via colocation.<sup>4,5</sup> MDI systems are quite efficient if they utilize shared electronic health records systems, allowing for messaging between units to identify gaps in care. The Veterans Administration (VA) and Kaiser Permanente (KP) are examples of successful and long-standing integrated MDI systems.<sup>6</sup> Patient-centered medical homes (PCMHs) often utilize this model of integration, and are becoming a more common practice model.

As MDI has increased, so have opportunities for dental hygienists to practice in these non-traditional arenas.

Currently, 42 states allow dental hygienists to work in direct access settings,<sup>7</sup> and 39 states specifically allow for dental hygienists to practice in medical settings.<sup>8</sup> A robust example of dental hygienists working in MDI can be found in the Colorado Medical-Dental Integration (COMDI) Project where dental hygiene services are integrated into the medical home, creating a "health home."<sup>4</sup> Participating practices include federally qualified health centers, school-based clinics, as well as private practices. There are a number of mechanisms for dental hygiene employment within COMDI including a model where the dental hygienist is directly employed by the primary care practice, an independent dental hygienist model in which the dental hygienist owns the practice and executes a business agreement with the primary care home, and the "hub-and-spoke" model with the dental or dental hygiene practice serving as the hub and the dental hygienist, practicing on site at the medical home as the spoke.<sup>4</sup> In considering the various models, it is also important to note that under the Colorado dental practice act, dental hygienists can own independent practices. MDI presents a unique opportunity for dental hygienists to be leaders in collaborative health care while working in innovative models to better meet the needs of patients.<sup>9</sup>

As the scope of dental hygiene practice has evolved, along with the expansion of practice settings for dental hygienists, the needs for specific types of education experiences have also changed. The MDI model is founded on the principles of IPCP. However, interprofessional education is needed to provide dental hygiene students with the experiences required for them to graduate ready to practice. Interprofessional education (IPE) has been defined as occurring when students from two or more professions learn about, from and with each other to enable effective collaboration and improve overall health outcomes.<sup>2</sup> IPE experiences are now required by numerous accrediting bodies across the health professions, including the Commission on Dental Accreditation dental hygiene education standard 2-15.<sup>10</sup> Graduates must be prepared to

demonstrate the necessary communication skills, teamwork, knowledge of roles and responsibilities, and ethics to work in interprofessional teams.<sup>11</sup> Dental hygiene programs will need to work within their own academic communities to develop opportunities for IPE and each educational institution will have its own unique challenges and resources. While a wide range of IPE activities have been reported in the literature, there is no single best model for IPE.

More education is also needed for practicing clinicians. Dental hygienists graduating prior to the emergence of IPE will need professional development courses to help them build the necessary skills required by the MDI settings. In order for dental hygiene to remain relevant within the health care delivery system, IPE must be embraced. The National Center for Interprofessional Practice and Education has a wealth of information and resources for developing, implementing, and assessing IPE (<https://nexusipe.org>). Educators looking for information on developing IPE, specifically in regards to accreditation, will find the Health Professions Accreditors Collaborative (HPAC) guidance document to be extremely useful.<sup>12</sup>

As a profession, we pride ourselves on serving our patients to the best of our abilities. With the evolution of health care systems, our abilities and skills need to grow and evolve as well.

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