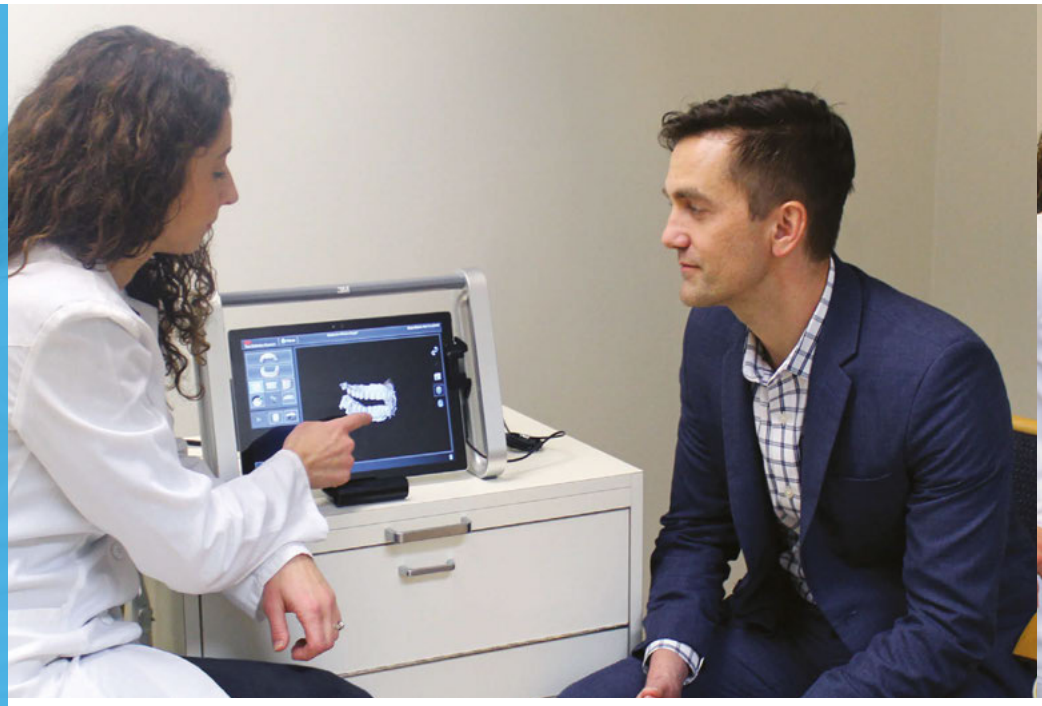


The Dentist and the Otolaryngologist – Working Hard Together

People in Pittsburgh suffer as much from sleep related breathing disorders as any other part of the country, but they have one big advantage no other population enjoys. People in other cities can see a sleep doctor, an ENT, a dentist, and an orthodontist and put all that advice together to sort out their choices. Four doctors, four appointments – an unfortunate burden.

Nicole Chenet, DDS and Ryan Soose, MD

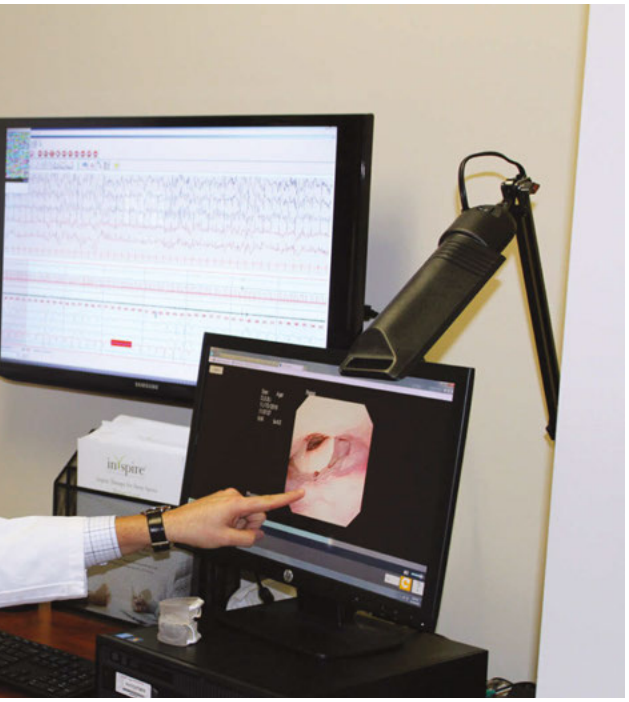
In Pittsburgh, they can make one appointment and get advice from all four areas of expertise: they can see Nicole Chenet, DDS and Ryan Soose, MD and come away with all the information they need to choose how to address their sleep breathing problems.

These two doctors did not fall together by accident. Each had a vision for changing the way sleep patients were cared for and put in the hard work to make their own practice a better solution path. When they discovered their interests-in-common, it became a natural fit. *Dental Sleep Practice* sat down with these innovative doctors to learn more.

DSP: How did you guys each discover sleep and airway as part of your patient care?

NC: I graduated from dental school in West Virginia in 2000 and bought my first practice a year later. During the next 15 years, I took several continuing education courses – I really enjoyed aspects of orthodontics. As I was learning orthodontic skills, airway problems kept popping up, and I got to thinking about how they could be impacting my regular dental patients. Soon, I enrolled in UCLA's Mini-Residency with Dr. Dennis Bailey and went on to achieve Diplomate status with the American Board of Dental Sleep Medicine in 2015.

RS: Fortunately for me, just as I was completing my residency in otolaryngology in 2007, the American Board of Medical Specialties certified Sleep Medicine as a subspecialty under Otolaryngology – Head and Neck Surgery. I saw that as a choice, then, right away. In early practice, I noticed how many airway patients were getting inade-



quate treatment with a fragmented care model. People were shuffled around and often left on their own to manage their care. As I was learning new ENT-related treatments, I left otolaryngology as a sole focus and completed a sleep fellowship in 2010 – I think I was only the second person in the country to do so. Since I did all this at the University of Pittsburgh, I decided to stay in town and provide full diagnostic and management services for sleep, as well as sleep surgery, under one roof.

DSP: What made the connection, then?

NC: The Pittsburgh area has a small, but great, community of dentists that have worked hard to form relationships with the physicians in our area. When I started, there was really only one other 'serious' dentist but now there are five primarily dedicated to dental sleep medicine. My passion for this subject led me to reach out to MDs to ask how I could help solve their patient problems. I called them myself, asking about their ideas and thoughts for less fragmented care. I gave talks at health fairs and countless local doctor's offices, trying to break down the barriers between our professions. The main message I tried to get across was that I was interested in patient care, not in pushing a high volume of appliances out the door.

RS: I saw ENTs and Dentists in a similar predicament – part of a failing old model where patients saw the sleep physician specialist, got a CPAP, and then were sent elsewhere or lost to follow-up if that didn't work. This one-size-fits-all approach commonly leaves patients inadequately treated – a new approach is needed that takes specific patient phenotypes into account and tailors treatment for the individual. There must be a dentist involved in that system, so when I met Nicole and felt her passion for the same kind of team approach, it became a natural fit.

NC: In 2015, Allegheny Health Network, AGH Center for Sleep Medicine invited me to be their dental provider. After working hard at this for a few years, I saw it as a perfect fit to be part of a medical team who all understand what the goals are – what we are trying to do together.

RS: I can't really recall, to be honest, how we met and what my practice was like before we started working together – that's how good a fit this is. It's such a 2-way street – I and other MDs don't look at dentists as technicians, like the old model, but as collaborators.

NC: And my patients with oral appliances sometimes are still symptomatic, so I know they need more help. Instead of that patient being lost to follow-up or given poor choices, our practice can address their needs in many ways and make the appropriate referrals to specialists if necessary.

It's not uncommon for a patient with severe OSA to be told PAP is their only option, but they end up with an oral appliance. While their quality of life is much better, perhaps their SRBD is only better by half – instead of the sleep doctor telling them their OA isn't working, Ryan and I put our heads together to see what else might be possible and work together to find the best solution for that patient. We find that common ground, recognize that our patients need both of us, and we need each other to give that patient the best choices and build their confidence in the care they are getting.

Ryan and I put our heads together to see what else might be possible and work together to find the best solution for that patient.

RS: We think the profession should move away from the sole focus on AHI and more toward individual patient care – making a tailored multidisciplinary plan for each unique individual. Patients need to focus on the quality of life choices along with the objectives and the risk of each choice. When they have a team that is dedicated to patient education and a team approach, the treatment chosen seems to go better with fewer problems.

DSP: What else has been a key for success for you, Nicole?

NC: One aspect I know is important to our patients is being in network with medical payors in our area. We started out in 2013-14 with one of the biggest plans, and now I think we accept all of them. This has turned out to be a huge benefit for referring physicians, and it removes a big barrier for our patients. Treatment acceptance is better, which fits our vision for more successful treatment. It takes the right staff and excellent communications with them, the other doctors, and our patients to make it happen, but it works for us. Part of the hard work we've done to make this all happen is to get the medical billing part as solid as we can.

Our practice created lots of written materials for our patients, too, to help them take in the information.

DSP: Do you guys do sleep testing in your office?

RS: As a sleep physician, of course we do, both in the lab and, mostly, using home monitors. One thing I really like is having a white board in my exam rooms – I draw lots of pictures and link information from their treatment history, choices and sleep report together. Lots of our patients take pictures of the white boards.

NC: Not us – we are committed to getting objective data, we always refer the patient back to the sleep lab / physician that referred the patient for follow up testing whether it be HST or in lab PSG. We talked with our sleep docs and worked out the language and protocols for the patients to return to them for testing.

DSP: There is a big interest in treating children's airway problems now. How do you address this in your practice?

NC: Since 2015, my practice is limited to treating snoring and sleep apnea in adults. Prior to this in my general dental practice I would look for early signs of airway concerns in the pediatric patient, refer to ENT and initiate phase 1 orthodontic treatment when appropriate and within my scope of practice. I think about the 'contents and the container.' I do ask all my adult patients about their kids and their friend's kids. My training, education, and clinical expertise lead me to refer to my orthodontic colleagues for collaboration as well.

RS: Pediatric sleep-disordered breathing is an exciting frontier and one of the few opportunities for prevention rather than just treatment. For kids, it's frequently about jaw structure, allergies, nasal congestion, tonsils, and adenoids. Early recognition and intervention is key.

DSP: This has been fantastic, Nicole and Ryan. I know many dentists reading this will be envious of what you guys have created, but I hope it inspires them to go out and make it happen in their town. What other message would you like to send our readers?

NC: Do the work. Nothing takes the place of getting out there, knocking on doors, and making the relationships happen. Be sure you know what and why you are doing it, and get to work.

RS: There's common ground out there. ENT doctors want to know how to find the 'right' dentist to work with, and vice-versa. Collaboration is essential. DSP