COMMENTARY ON AN INNOVATIVE INTERPROFESSIONAL DENTAL PRACTICE FOR 2026

Brad Guytona,b, Jan LeBeauc, Rebecca Sorcid, and Amy Doneene

Editor’s Note
Envisioning 10 years into the future, these authors from various disciplines describe an innovative approach where complex patient needs are met by collaborative interprofessional health care teams to optimize care efficiently and profitably. Supportive evidence for their ideas is future based; however, the ideas merit current consideration.

ABSTRACT
An innovative interprofessional model is described for the delivery of dental care in the year 2026 to optimize efficiency and profitability while enhancing quality of care.

Background
The dental practice of tomorrow may look different than today. Although not broken, the current system can be improved in efficiency and effectiveness. Although traditional private practices will continue to exist and many will thrive over the next decades, they may not present the optimal model for dental practice. To manage complex patient needs, a more collaborative model of multidisciplinary, interprofessional clinical teams capable of treating patients comprehensively has been suggested by the authors. They explore an alternative model of practice that may be possible in the next 10 years to better serve patients and improve outcomes while honoring the role of practitioners.

Methods
Landmark publications and reviews are used to examine evidence showing the potential benefits of an innovative interprofessional approach to the delivery of care in the oral health care setting.

Conclusions
By examining key studies, the authors provide commentary on the potential for enhanced efficiency, profitability, and quality of care in the oral health care setting through a collaborative model of multidisciplinary, interprofessional clinical teams capable of treating patients comprehensively.

INTRODUCTION
Poor oral health has been linked to serious systemic health issues such as cardiovascular disease, diabetes, chronic lower respiratory diseases, and premature birth. Oral health is a key component in maintaining overall health and reducing costs associated with the care of chronic diseases.

Keywords: Dental health care delivery, Dental health care trends, Oral-systemic health, Collaborative practice models, Practice productivity, Practice efficiency
According to the American Dental Association, there was little growth in the national dental expenditure from 2011 to 2012, continuing a trend that started in 2008. In addition, from 2000 through 2011, dental care utilization has steadily declined among working age adults. This is due in part to the rising cost of care and a decline in the percentage of individuals with private dental benefits. More than 130 million Americans or 40% of the US population does not have dental benefits. For those with dental benefits, the current mechanism of reimbursement is often insufficient. Reimbursement through government and private insurance has not changed significantly over the past four decades to keep up with inflation and the cost of technology. Most dental plans are capped at $1200-$1500 total benefit per year, and the procedural benefit tends to decrease as the level of complication increases. Recently, the Federal Reserve Board of Governors released its 2014 Report on the Economic Well-Being of U.S. Households that revealed ‘alarming statistics’ regarding the inaccessibility of affordable dental treatment. Thirty-two percent of the people polled reported difficulty in managing a 3-month financial disruption in the form of a medical emergency, and dental treatment was cited as primary essential type of medical care not received because of cost. For these reasons, it is critical to enhance cost-effectiveness in the oral health care setting to help manage the cost of care.

**CURRENT CARE PROVIDERS NON-DOCTORAL**

**The dental hygienist**

In most dental settings today, the education and skills of the dental hygienist are applied primarily for the mechanical delivery of procedures such as prophylaxis, scaling and root planing, and periodontal maintenance therapy. Levels of supervision for the dental hygienist to perform these procedures vary by state. As health care moves toward a more integrated model focused on whole body health, the role of the dental hygienist may evolve from a mechanical-based therapy model to a wellness model of care. By expanding the role of the dental hygienist to perform oral screening procedures and identify risk factors for chronic illnesses, the dental hygienist can become a more collaborative clinical partner to the dentist and even serve as a conduit to an in-house medical provider such as a nurse practitioner (NP).

The dental hygienist typically sees the average dental patient 2-4 times a year; therefore, he/she is uniquely positioned to screen and assess for risk factors associated with chronic health conditions. The screening of risk factors and signs of chronic disease in an oral health care setting could provide an innovative quality of care not yet seen in mainstream dentistry. As a preventive oral health care specialist, the dental hygienist can identify each patient’s individual risk factors and begin discussions for screening, testing, and referral.

An estimated 65% of adults in the United States see a dentist or dental hygienist at least once a year. The dental hygienist can begin the conversation and provide education and referral for a patient who might not have seen a physician until much later in the disease process for potentially life-threatening diseases associated with oral infection including diabetes, heart disease, and stroke.

**Advanced practice dental providers**

According to a 2013 Pew report, there are currently 15 states considering legislation to expand the reach of the dental team, and the numbers continue to increase. These bills include proposals to educate dental hygienists to perform more services in an effort to deliver more dentistry in an efficient and cost-effective manner. Although the advanced practice provider for oral health care continues to be hotly debated in the United States, greater than 50 countries worldwide have successfully integrated advanced practice providers in dental care to successfully deliver routine preventive and restorative treatment.

Across the country, state dental and dental hygiene organizations are working to create greater access to oral health care while other groups are defining more efficient practice models. The American Dental Association and the American Dental Hygienists Association (ADHA) along with individual state governments have proposed solutions that would benefit both underserved populations as well as mainstream America.

As of 2016, dental hygienists can perform various levels of direct access services in public health settings in 38 states according to the ADHA. In these states, the need to increase access to care has led to implementation of increased functions for the dental hygienist through advanced practice care models and credentialing programs. It is likely that other states will move in this direction to optimize efficiency and improve access to care (See Battrell et al., in this issue).

Currently, there are five different models of advanced practice providers of oral health care in the United States. This emerging group of practitioners includes the dental health aid therapist in Alaska, the community dental health coordinator first adopted in New Mexico, the dental therapist and advanced dental therapist in Minnesota, and the dental hygienist recently implemented in Maine. Each model varies in the educational and training requirements, the level of supervision required by a dentist, and the services that can be performed by the advanced practice provider.

In 2004, the ADHA proposed and defined a model for the Advanced Dental Hygiene Practitioner. This proposed model
would require a master degree education. This dental hygienist could work unsupervised in a collaborative practice with a dentist to provide advanced preventive therapies, diagnosis, basic restorative care, and simple extractions.9

The profession of dentistry is approaching the proposed advanced practice provider roles with caution. Advocates explore new models of care, all the while seeking to ensure quality of care. Medicine has successfully implemented advanced practice providers such as the advanced practice registered nurses (APRNs) and physician assistants for the past few decades. Although there are distinct differences in advanced practice provider models, there are parallels between those in medicine and the proposed models in dentistry. Information drawn from the experience of medicine can serve to assess the probable impact for dentistry.

Advance practice providers in medicine

Advance practice models in medicine, including the APRN, the NP, and the Physician’s Assistant, were first introduced in the United States in the 1960s in response to a shortage of physicians. Since then, these medical advanced practice provider models have been well accepted and integrated in hospital settings, large group practice, and independent private practice, relative to quality of care delivered and acceptance by the general public.10

As in dentistry, scope of practice and supervision levels for medical advanced practice providers are defined by individual state laws. In many states, APRNs or NPs are required to work in collaboration with a physician; however, in some states, they practice and prescribe independently. The physician’s assistant is required to work under the delegated authority of a physician, but most states allow general supervision, providing that some form of communication is maintained.

The need for medical advance practice providers is expected to increase by 34% from 2012 to 2022.11 Much of the estimated growth comes from an increased need for health care providers because of the Patient Protection and Affordable Care Act. This coupled with increased life span has placed greater demand on the current health care system, spurring the need for more advanced practice providers.

Although some traditional private practices will continue and thrive over the next few decades, the optimal model for dental practice may no longer be the solo practitioner office. To manage complex patient needs, the profession may move toward a more collaborative model of multidisciplinary, interprofessional clinical teams capable of treating patients comprehensively. The rise of dental group practice with support services and economies of scale may be a precursor of such developments. Box 1 lists 8 interrelated contributing factors that will likely result in new models of practice benefiting both the practitioner and the patient.

Unlike medicine’s shift away from solo private practice, dentistry is still primarily practiced in solo or small group practices. The rise of large group dental practices over the past decade represents a major change and a shift toward market consolidation. Just as medicine has moved toward integrating multiple specialties under one roof and embraced the value of an advanced practice provider, dentistry may move in a similar direction.

Advanced registered NP

Another layer in the concept of an interprofessional collaborative model for dentistry is the addition of a medical health care provider such as the NP. Incorporating an NP within the oral health care setting would allow for greater access to screening and testing for patients who present with risk factors associated with cardiovascular disease, coronary artery disease, diabetes, and a multitude of other systemic health concerns linked to poor oral health. This could help promote necessary referrals and may result in a second access point for primary care providers.

AN INNOVATIVE DENTAL PRACTICE IN 2026

The dental practice of tomorrow may look different than today. The current system is not broken, but has opportunity in terms of efficiency and effectiveness. The optimal model for tomorrow’s dental practice may be focused on oral health treatment and medical screening, owned by the dentist, collaborating with physicians and a NP, with patient centric systems, facilitated by an advanced practice dental hygienist.

According to business strategy expert Michael Porter, businesses may gain a competitive advantage by offering a lower cost or differentiation in quality or customer service.12 Businesses may be able to develop more than one competitive advantage, but it is difficult to simultaneously sustain a competitive advantage in cost, quality, and customer service. Occasionally, businesses can find innovative ways to gain an advantage in all three. Practices integrating oral health care treatment and medical screening centers may present this type of opportunity in the near future.

THE CASE FOR INTEGRATED INTERPROFESSIONAL PRACTICE

Factors contributing to new models of practice begin at the dental and dental hygiene educational level. These educational programs are broadening their curriculum in the areas of oral-systemic health and interprofessional collaboration. Many dental schools are adopting interprofessional education programs and looking at ways to incorporate cross-disciplinary
team-based training for students. In April 2015, the Harvard School of Dental Medicine announced its initiative to transform dentistry by removing the distinction between oral and systemic health. Their vision is to “reunite the mouth the body.”

In addition to these types of initiatives, new data show that coordination of benefits for dental/oral and medical health can lower costs for patients with chronic diseases, such as diabetes, cerebrovascular disease, and for pregnant women. The time has finally arrived for true integration of dentistry into the medical complex as a branch of medicine. The mouth should not be treated differently than the ears (otolaryngologist), the eyes (ophthalmologist), the foot (podiatrist), or the skin (dermatologist).

In the retail industry, businesses focus on ways to grow profits by increasing same-store sales. For example, Starbucks has been able to increase same-store sales by expanding their food offerings. They bring in food items such as salads and sandwiches to increase traffic to the store during the afternoon. People will seek out opportunities to complete multiple tasks in a single visit. This concept holds true for oral and systemic health visits as well. Patients are more likely to choose a practice to receive essential health care services at a single location. We believe they are also more likely to move forward with recommended treatment if they have a better understanding of the oral-systemic connection and the link with chronic conditions. Once the business systems and best practices for the patient experience are defined and implemented in the dental practice, the addition of other revenue lines (eg, oral surgery, endodontics, and medical screenings) will have a positive impact on the practice, much like sandwiches impact a coffee shop once the customer experience is well defined and delivers on its brand promise.

THE CASE FOR MULTIDISCIPLINARY PRACTICE

Dentists’ incomes and profits are stagnant and may be shrinking in some parts of the country. Outside of health provider shortage areas identified by the Health Resources and Services Administration, it is well known that the major barrier to receiving adequate care in dentistry is financial, not the availability of dentists. Well over one-third of all dentists report that they have capacity to see more patients in their schedules, and dentists’ earnings are not currently recovering with economic growth. The solution is not necessarily more dentists, as the number of dental schools in the United States is increasing (currently 65) and first year enrollment numbers increasing from 3979 in 1989 to 5892 in 2014, which represents a 50% increase in 2.5 decades. Adding more dentists only helps if reimbursement models are created to support those dentists and rural/urban distribution of those dentists is reflective of need. These challenges have plagued the United States for decades with little hope for true change. Owing to this fact and to bridge the gap, the options must go beyond adding dentists or changing federal, state, and private insurance reimbursement models. Solutions must be considered that focus on demand and factor in current constraints, including how to create a cost-effective model of integrated care that best serves the needs of the population while positively enhancing (or at least not negatively impacting) the financial position of the dentist.

The answer may be the dentist-owned group practice model where general dentists, specialists, and other advanced practice providers work in collaboration under one roof. This model promotes peer-to-peer coaching, mentorship, and oversight.

A PROPOSED MODEL FOR 2026

The answer for 2026 is not a simple one. We propose that it involves a 4-pronged model that leverages:

1. Expanded roles of the dental hygienists and dental therapists all practicing under the supervision of a licensed dentist;
2. Collaboration with onsite general dentists and dental specialists;
3. Collaboration with NPs;
The interrelated components of the model are seen in Figure 1. The combination of patients, medical providers, and dentists must be at the center of this optimal model of practice. If the model seeks to circumvent one or the other, it will fail. There are only 3 ethical ways to cost-effectively provide more care to more patients while enhancing profitability:

1. Provide more care resulting in a lower expense percentage.
2. Expand the procedural mix by offering more in-house services and screenings.
3. Integrate technologies that enhance efficiency and effectiveness.

The interplay of the providers and methods of providing more patient care is seen in Figure 2.

There are 10 factors that are setting the stage for dental practice by 2026. These are provided in Box 2.

This type of practice may necessitate an intermediary and promoter on the practice team who can monitor risk factors and serve as a conduit between the oral health care providers, NP, and affiliated physicians. The advanced practice dental hygienist might prove to be the best match for this position. Although this proposed position would more than likely require additional education, this practitioner could add value to the practice in new ways.

Fast forward to 2026, and consider what might be possible if the role of the dental hygienist were to include screening procedures promoting and supporting the diagnosis and long-term management of periodontal disease (see Table 1). This...
could include identification of risk factors for chronic illnesses. By expanding the role beyond just public health settings, the advanced practice dental hygienist can be empowered to become a collaborative clinical partner to the dentist and a conduit to an internal NP and/or external physician.

NP INTEGRATION IN THE DENTAL PRACTICE
The NP may play a major role in the identification and modification of risk factors that are common to both oral and systemic diseases. With the prevalence of interprofessional training programs practitioners will be more accustomed to collaborating with oral health care providers on treatment plans. This model provides an additional access point for patients to interact with the medical professionals which can improve treatment outcomes through earlier treatment and referral and allow for enhanced patient follow-through and recare visits.

The dental hygienist may refer dental patients to the in-house NP or other primary care providers based on the patient’s risk factors and help facilitate the collaboration between the dentist and medical providers. See Figure 3.

As an alternative to incorporating an NP, a dental hygienist might someday be an interim or permanent solution by providing basic medical screening procedures, diagnostic tests

---

**Table 1. Comparison of procedures performed by dental hygienists in 3 practice models.**

<table>
<thead>
<tr>
<th>Treatment production</th>
<th>Current model dental hygiene</th>
<th>Progressive model dental hygiene</th>
<th>Potential future model dental hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical treatment procedures</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Prophylaxis</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Perio maintenance therapy</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Scaling and root planing/quad</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Fluoride varnish</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Localized antibiotic delivery</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Laser therapy/quad</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Screening procedures</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Health history</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Body mass index</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Radiographs</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Oral cancer screening</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Enhanced oral cancer screening</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Initial perio evaluation &amp; treatment plan</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Salivary diagnostics/test</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>HbA1C screening/gingival blood</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Oral-systemic risk assessment</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Health &amp; wellness education</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Smoking cessation program</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Nutritional program</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Oral-systemic health education</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Referral to medical professional</td>
<td></td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>
with oral fluids or blood, wellness programs such as nutritional counseling or smoking cessation, and health education and physician referrals. Much of this content is already taught in basic dental hygiene educational programs and would support at least a baccalaureate-based education for dental hygienists (see Stolberg and Tiliss, in this issue).

THE ORAL-SYSTEMIC CONNECTION MAY DRIVE THE MODEL

The oral systemic connection is now widely recognized by both medical and dental practitioners. Research conducted at medical centers and major universities supports the correlation between chronic oral infections from periodontal disease and systemic health. Components of the periodontal bacterial infection enter the blood stream and can activate an inflammatory response in other parts of the body. Numerous studies have shown the correlation between oral health and chronic diseases including diabetes, heart disease, cancer, Alzheimer’s, stroke, and chronic lower respiratory disease. These chronic diseases represent 6 out of the top 7 leading causes of death in the United States. Studies have also demonstrated a correlation between oral health and pregnancy complications, osteoporosis, rheumatoid arthritis, and erectile dysfunction. Medical savings in chronic disease management from appropriate and timely periodontal disease management may drive a more integrated system of practice sooner than 2026.

According to a Centers for Disease Control (CDC) report, data collected in 2009 and 2010 showed that 47.2% of adults aged 30 years and older and 70.1% of adults aged 65 years and older have periodontal disease. The CDC also reports that as of 2012, about half of all adults had 1 or more chronic health conditions, and one out of four adults had two or more chronic health conditions. With 86% of all health care spending attributed to people with chronic disease, it will prove difficult to maintain the current model of health care delivery with its associated costs.

As the link between oral and systemic health becomes better understood, the need to integrate dentistry and medicine will be critical. Interprofessional collaboration is needed to overcome dentistry’s previous isolation from medical care and promote referrals. According to recent Institute of Medicine reports, interprofessional collaboration has the potential to improve care coordination, patient outcomes, and produce cost savings. As NP and dental and dental hygiene students begin to collaborate in delivering comprehensive care in their education, it will be more natural transition for them to continue to work collaboratively in the oral health care setting of tomorrow.

There are many diagnostic tests currently available or in development that could be administered in the oral health care setting by the NP or potentially by the dental hygienist. For example, a simple finger-prick blood test can be administered in the dental office to measure hemoglobin A1C levels and identify undiagnosed type 2 diabetes or prediabetes. A similar test can be administered to measure C-reactive protein, an indicator of inflammation in the body. Elevated levels of C-reactive protein are known to precede and predict cardiovascular disease. Researchers are focusing on salivary diagnostics for point-of-care tests based on the ease of access, lower risk for infectious disease transmission, and noninvasive nature for patient acceptance. These tests could provide early detection of oral disease, certain types of cancers, and other systemic conditions. A list of potential tests that could be administered in the dental practice setting is included in Table 2.

In addition to the fact that approximately 65% of adults visit the dentist at least once per year, Delta Dental reports that 81% of individuals with dental benefits and 34% of uninsured individuals visit the dentist twice or more each year. This provides a great opportunity for both oral and systemic disease detection and prevention follow-up on risk factor reduction such as smoking cessation, nutrition counseling for weight loss, and sugar intake.

CONCLUSION

Further research is needed to provide additional evidence supporting innovative approaches to dental practice. Demonstration studies to evaluate the financial and patient outcomes will be needed. Many models may emerge. The intent of this article is to stimulate the discussion by presenting an approach with the primary goal of serving patients optimally while honoring the role of practitioners. New models may include expanded functions of the dental hygienist, as well as the addition of medical screening and services with NPs in the dental practice.

As health care spending on chronic diseases continues to rise and the oral systemic connection is increasingly being better understood, it is critical that the optimal model contains costs.
while providing better, highly accessible comprehensive care for patients.

Dental industry professionals can promote change by seeking out additional information on the integration of medicine and dentistry. It is important to understand current state laws concerning the advanced practice of dental hygienists and encourage state dental boards to loosen restrictive laws that prevent the provision of optimal care. Become a member of organized dentistry associations, as they are active in supporting legislation that will better serve its members. Experiment with ethical business models as long as they comply with local laws and serve patients better. As more dental professionals take action, positive change may occur in the industry. The owner dentist will become more of a diagnostician and physician of the mouth, directing the advanced practice provider to perform more of the basic dentistry. This in turn will allow the dentist to see more patients, direct more care, and focus on more complex cases.

DISCLOSURES

Our writing team shares a mutual interest in optimal health care delivery for society. For patients to be optimally served, clinicians must have adequate opportunities to collaborate, feel personally and professionally fulfilled, be adequately compensated, and influence patients to successful outcomes. Dr Guyton, a dentist, has been in private practice for 18 years and concurrently served in academia for 15 years and industry and consulting. He now leads the clinician development initiative for dental offices supported by a dental support organization. Jan LeBeau, a dental hygienist, has spent over 30 years in the dental field, 15 serving as a clinical dental hygienist, and now chairs the dental hygiene support services for a dental support organization. Rebecca Sorci, an MBA with a degree in biomedical engineering, spent 11 years directing research and advisory services in the medical device industry and now manages the development of clinician content for a network of more than 1500 clinicians. Amy Doneen, an advanced nurse practitioner with a doctorate degree in nursing, is the owner and medical director of the Heart Attack & Stroke Prevention Center in Spokane, WA, cofounder of the Bale/Doneen Method, and an adjunct professor at Texas Tech University Health Science Center School of Nursing.

REFERENCES


Table 2. Potential health screening tests in the dental setting.

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
<th>Parameter evaluated</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>hs-CRP</td>
<td>High—sensitivity test to measure C-reactive protein</td>
<td>Risk of vascular inflammation</td>
<td>Blood</td>
</tr>
<tr>
<td>HbA1C</td>
<td>Hemoglobin A1C to evaluate blood glucose levels</td>
<td>Presence of diabetes/prediabetes</td>
<td>Blood</td>
</tr>
<tr>
<td>Lp-PLA2</td>
<td>Blood level of lipoprotein-associated phospholipase A2</td>
<td>Risk of coronary artery disease and stroke</td>
<td>Blood</td>
</tr>
<tr>
<td>APOE genotype</td>
<td>Presence of the e4 of the APOE gene</td>
<td>Risk of Alzheimer’s disease</td>
<td>Blood</td>
</tr>
<tr>
<td>Saliva pH</td>
<td>Measures the pH level of saliva</td>
<td>Excess acidity associated with chronic conditions</td>
<td>Salivary</td>
</tr>
<tr>
<td>Periodontal pathogens</td>
<td>Concentration of specific perio-pathogenic bacteria</td>
<td>Risk of periodontal disease</td>
<td>Salivary</td>
</tr>
<tr>
<td>Periodontal sensitivity</td>
<td>Genetic test measuring levels of interleukin 1B</td>
<td>Susceptibility to periodontal disease</td>
<td>Salivary</td>
</tr>
<tr>
<td>HPV risk</td>
<td>Presence of human papillomavirus (HPV)</td>
<td>Risk of oral cancer</td>
<td>Salivary</td>
</tr>
<tr>
<td>Carotid intima-media thickness</td>
<td>Thickness of the inner 2 layers of carotid artery</td>
<td>Risk of carotid vascular disease</td>
<td>Sonography</td>
</tr>
<tr>
<td>Ankle-brachial index</td>
<td>Resting blood pressure of arm and ankle</td>
<td>Risk of peripheral artery disease</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>Endo-PAT</td>
<td>Peripheral arterial tone (PAT) to identify endothelial dysfunction</td>
<td>Risk of cardiovascular disease</td>
<td>Fingertip sensor</td>
</tr>
</tbody>
</table>


