



The Need for Inter-Professional Collaboration

I was recently contacted by the editor of a diabetes practice group publication for the Academy of Nutrition and Dietetics (formerly American Dietetic Association). At their executive board's recent brainstorming session on possible topics on diabetes and co-morbidities, one of the rather interesting topics, as the editor phrased it, was the effect of diabetes on oral health. All of the committee members agreed that most registered dietitians probably don't fully understand the impact that diabetes may have on teeth and gums. As a dual-degree registered dental hygienist and registered dietitian, I have always been intrigued by the oral systemic link and the practical application to patient management. I am passionate about the development of inter-professional relationships and creating a more collaborative framework of health care.

Several of the topics in this issue spotlight the need to develop alliances with other health care professionals. Many disease states, including oral disease, are multifactorial. Collaborative efforts among the health care system are needed to effectively treat and control certain conditions. Identifying barriers to care and establishing creative ways to provide access will help move our profession forward.

On May 25, 2000, Surgeon General David Satcher released the 51st Surgeon General's report entitled *Oral Health in America: A Report of the Surgeon General*. It was a significant call for action to promote access to care as well as to create a public awareness about the importance of oral health and the implications for total health and well being. In his report, Satcher stated that "the mouth is the window to all of the diseases of the body."¹ Those words heightened our role as a profession. I personally felt it added more credibility to our role as health care providers. In 2003, as a follow up, Surgeon General Richard Carmona released the *National Call to Action* with set strategies to address the oral health concerns previously noted in Satcher's report. The report delineated 5 primary constructs:

1. Change perceptions of oral health care

2. Overcome barriers by replicating effective programs and proven efforts
3. Build a science base and accelerate science transfer
4. Increase oral health workforce diversity, capacity and flexibility
5. Increase collaborations²

As a preceptor for the Baylor University Medical Center Dietetic Internship program, each year I provide a lecture during fall orientation on oral health, nutrition and the implication to practice as a licensed dietitian. In the fall of 2005, I implemented a rotation for the interns in our dental clinic. Each dietetic intern spends a half day partnered with a dental hygiene student observing the intricacies of the dental hygiene assessment and diagnosis process. Typically the dental hygiene student will ask their patient questions regarding dietary practices to determine the need for nutritional counseling based on other oral disease risk factors identified during the assessment process. During the rotation, the dietetic intern asks the questions regarding dietary practices so that the hygiene student can observe the detailed manner in which the intern elicits this information from the patient. The dietetic intern is instructed on form, frequency and timing of food consumption and how these factors can influence a patient's caries risk. Prior to the rotation, the dietetic interns are asked to keep a 3 day food record. During the half-day segment in the dental clinic, I review their dietary intake with them from a dental perspective. Following the rotation, dietetic interns are asked to submit a 1 to 2 page reflection paper, discussing how their perception of oral health in relation to their role as a dietitian may or may not have changed as a result of the experience. It is enlightening to see how many of the dietetic interns never even considered the diet-dental relationship prior to the dental hygiene clinical rotation and the impact provided through this experience. In turn, it is refreshing to see the dental hygiene students mutually interact with the interns. The primary purpose in development of this rotation was to cultivate an inter-professional relationship at the student level with hopes that both the dietetic intern and

the dental hygiene student see the value in one another's profession and to encourage alliance with one another when they are licensed health care professionals.

An unknown author once said "Just because you're not sick doesn't mean you're healthy." This quote came to mind as I considered the topics in the current issue. Satcher pointed out in his report that there are many oral diseases and conditions that can be associated with other health problems. When we treat patients, we are not just concerned with their oral care but all the other conditions — diagnosed and undiagnosed that they may be bringing with them into the patient operatory and how these conditions may impact their course of treatment. Diabetes is among these conditions. According to 2011 data from the Centers for Disease Control and prevention, diabetes affects 25.8 million children and adults in the United States.³ Seventy-nine million have pre-diabetes.³ There are 18.8 million diagnosed cases of diabetes but even more concerning is the 7 million undiagnosed cases.³ Evidence-based literature indicates that poor glycemic control can exacerbate the periodontal condition. Conversely, it has been demonstrated that periodontal health can have an impact on regulation of blood sugars. Additionally, there have been studies over the past few years that have looked at dental patient populations in regards to risk for cardiovascular disease incident. Ironically, those individuals that were determined to be at greatest risk were relatively healthy and were on no medications for high blood pressure, cholesterol or diabetes. The majority of these individuals had not seen a physician in the last year but had been to a dentist. The value of our role in identification of risk factors that may indicate an underlying

medical condition is tremendous.^{4,5} However, a recent release from the American Heart Association states findings that there is not enough conclusive evidence that periodontal disease causes or increases the rate of cardiovascular disease.⁶

So what now? Most systemic conditions are causally related to oral health — this isn't anything new. Our role is not to alarm patients but to thoroughly assess, educate and provide preventive care, so it should be business as usual. Practitioners must provide a thorough review of the medical history, ask probing questions at each dental visit and follow up with medical providers as indicated. These steps are key to identifying risk factors that may indicate need for referral to other health care providers.

As dental hygienists, we are in a unique position to impact the lives of our patients from a total health standpoint. A little over a decade after the release of the 51st Surgeon General's report, what have we done as a profession to respond to this call? We are in need of a paradigm shift to create versatility and opportunities for our profession. Fostering inter-professional partnerships will help us to change the perception of oral health and overcome barriers to provide optimum preventive care.

Sincerely,
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