Building the Ideal Interdisciplinary Team to Address Oral Health

By Janet A. Yellowitz

Due to the close connection between oral and overall health conditions, general healthcare providers should collaborate with oral healthcare providers.

As stated in Healthy People 2000, “... having adequate access to medical and dental care can reduce morbidity and mortality, preserve function and enhance overall quality of life” (National Center for Health Statistics, 2001). Ensuring that older adults receive routine oral healthcare is critical, as oral health is integral to general health and well-being. Good oral health allows people to eat and drink, maintain proper nutrition, be free from oral pain and discomfort, smile, enjoy overall health and interpersonal relationships, and maintain quality of life. More importantly, poor oral health has been associated with many systemic conditions, and can lead to increased general health risks (Ettinger, 1997; Berkey and Burg, 2001).

Close Connection: Healthcare Providers and Oral Health Providers
As overall health is inextricably connected to oral health, healthcare providers must be similarly connected to oral healthcare professionals to ensure they provide quality healthcare. Many systemic conditions such as HIV/AIDS, diabetes, Sjögren’s syndrome, and osteoporosis have important oral symptoms, manifestations, and complications. Similarly, periodontal diseases are associated with cardiovascular disease, stroke, pulmonary disease, diabetes, and other systemic conditions commonly found in older adults. Unfortunately, many health professionals and older adults are not aware of these relationships. For this and many other reasons, general health problems are consistently given a higher priority than oral health problems when it comes to seeking care (see Erickson’s article on page 25).

To ensure older adults can access and receive comprehensive care, oral health must be integrated into the healthcare system. The role of interdisciplinary collaboration is key to basic and clinical oral health; unfortunately, health

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**ABSTRACT** Overall health is connected to oral health, and healthcare providers must be connected to oral healthcare professionals to offer quality healthcare. To ensure older adults can access and receive comprehensive care, oral health must be integrated into the healthcare system. The role of interdisciplinary collaboration is key to basic and clinical oral health; for many years, leaders in education and healthcare policy have recommended interdisciplinary training and collaboration among medicine, dentistry, and other health professions, yet progress has been slow in developing demonstration projects and implementing best practices for successful programs. This article discusses the crucial need for interdisciplinary teams in delivering oral healthcare, and cites training parameters and program models for building such teams to provide integrated care to elders. **key words:** oral healthcare, integrated care, interdisciplinary clinical teams, oral health training
professionals rarely seek to collaborate with oral health professionals. Geriatric healthcare providers often are described as the first group to provide interdisciplinary or interprofessional care; however, such collaboration is not available to many older adults. This situation is likely to become more challenging as the need for geriatric healthcare providers increases, because an increasing number of physicians lack the desire to provide primary care and geriatric medicine. Other health professionals trained in geriatrics, such as geriatric nurse practitioners and physician assistants, psychologists, pharmacologists, and others, are assisting with this service gap; however, studies have documented an anticipated lack of adequately trained healthcare providers for aging adults (Bardach and Rowles, 2012).

**Interdisciplinary Healthcare Teams Reduce Fragmentation**

For many years, leaders in education and healthcare policy have recommended interdisciplinary training and collaboration among medicine, dentistry, and other health professions; yet progress has been slow in developing demonstration projects and implementing best practices for successful programs (Pyle and Stoller, 2003). In 2002, the Institute of Medicine identified five competencies (i.e., provide patient-centered care; work in interdisciplinary teams; employ evidence-based practice; apply quality improvement; and utilize informatics) for all health professions education, stating, “Competencies are the habitual and judicious use of communication, knowledge, technical skills, values, and reflection in daily practice” (Greiner and Knebel, 2002).

Increasingly, associations of oral-systemic health interactions highlight the need for interdisciplinary training to enhance health professionals’ ability to treat the ever-growing population of older adults. With more medically complex patients and limited oral health information in medical education, there is a critical need for new initiatives to redesign health professionals’ curricula. Resources for interdisciplinary team training in geriatrics include the Veterans Administration’s (VA) Geriatric Research, Education and Clinical Centers, and The John A. Hartford Foundation’s Geriatric Interdisciplinary Team Training Program.

**Oral Healthcare Education Crucial for General Providers**

Training general healthcare providers about oral healthcare is not a new concept, though it has not been adopted as part of the physical exam by many general practitioners. Physicians can obtain significant health information through a systematic evaluation of the oral hard and soft tissues, and identify concomitant medical conditions prior to symptoms appearing elsewhere in the body. Conditions associated with diabetes, cardiovascular problems, cancer, HIV/AIDS, and immune abnormalities, as well as negative reactions to medications, are only a few examples of problems that can manifest intra-orally.

Currently, health professionals rarely seek to collaborate with oral health professionals.

Key reasons physicians do not routinely inspect their patients to identify early, suspicious oral conditions include the following: limited exposure to oral health and oral examinations in medical healthcare provider curriculum; the belief that their patients regularly see a dentist; the belief that the oral cavity is not necessarily part of their responsibility; and a lack of understanding of the connection between the mouth and the body (Yellowitz and Goodman, 1995).

Geriatricians, family physicians, and other primary care physicians, nurse practitioners, and physician assistants need to be enlisted to monitor their patients’ oral health. However, at present, the medical community is neither sufficiently conversant with oral health nor
adequately integrated with their dental colleagues to effect significant change on the status of oral health (Haden et al., 2003). Professional cross-training is essential if quality care is to be provided. Not only must primary care medical practitioners learn to be a part of the oral health team; oral health professionals must become more involved in assessing the overall health of their patients through screening, diagnosis, and referral (Haden et al., 2003).

Many health academic institutions (silos) have attempted to address the disconnect between oral health and general health assessments, but few have been successful in instituting the inclusion of oral health into the general health evaluation. Some training programs have reported success in the short term (Arvidson-Bufano, Blank, and Yellowitz, 1996); however, few have documented long-term benefits. Oral healthcare professionals often fail to achieve improvements in the oral health of the community because they do not share their knowledge and expertise with those beyond the dental office, the dental school or the university (DePaola, 1999).

**Caregivers must have a basic understanding of the importance of oral health to general health.**

In the future, internists and family practitioners will be providing much of the medical care for older adults. Currently, adults older than age 65, who are 13 percent of the population, account for 40 percent of visits to internists and this number is rising (American Society of Consultant Pharmacists, n.d.). A physician who cares for older adult patients must use diagnostic and therapeutic interventions appropriately, while at the same time recognize the variability in health status, values, and wishes. Older adults’ healthcare providers must understand normal and abnormal aging, atypical illness presentation, common geriatric syndromes, and differences in the physiologic and pathologic changes associated with aging, and preferred management of specific diseases in older adults. Also, healthcare providers need the skills to manage patients who have acute and chronic conditions and who reside in a wide array of healthcare settings, including assisted living facilities, nursing facilities, and nursing homes. Finally, collaborating with other healthcare providers can result in high-quality healthcare for older patients. An acute condition in an independent older adult can quickly modify that independence, while others might regain their independence following an episode of frailty or dependence (He et al., 2005).

**Patient, Family, and Direct Care Worker Education**

Today, as average life expectancy increases along with the availability of more medical interventions, there are more older adults than ever before. Consequently, the number of older adults being cared for by family members and direct care workers will continue to increase. It is imperative that these caregivers have a basic understanding of the importance of oral health to general health. Many resources for learning more about oral health exist for family members and direct care workers. They are available from dentists, the American Dental Association, dental schools, mmLearn.org, VA dental clinics, Community Health Centers, other dental public health programs, and Area Health Education Centers in rural and urban areas.

As a result of advances in technology and better oral health knowledge in professionals and the public, the rate of edentulism (complete toothlessness) has decreased as more people maintain their natural dentition. As teeth are maintained longer, individuals are at an increased risk for oral disease(s). Older adults have more oral health problems than any other age cohort, as reflected in the Surgeon General’s Report, which stated, “... people 55 to 74 years of age had higher rates of periodontal disease as well as increasing amounts of decay compared to...
younger adults” (HHS, 2000). This is consistent with dental caries (cavities) and periodontal (gum) disease being cumulative when untreated, and older adults having the lowest rate of dental care use of all age groups.

This situation is further complicated by age-related physiologic changes, resulting in older adults’ impaired awareness and sensitivity to oral pain and/or discomfort; this often means that they delay seeking care (particularly those individuals who only obtain dental care when experiencing pain or discomfort). Unlike populations that obtain regularly scheduled oral examinations, those who delay care until presented with pain are at greater risk of being diagnosed with more serious, disabling, and potentially disfiguring diseases (Stefanuto, Doucet, and Robertson, 2014).

Poor general health can also restrict access to dental services, and many older adults are unaware of their need for routine dental care. Many older adults report not seeing a dentist because they “have no dental pain.” Having multiple medical conditions, experiencing decreased cognitive ability, using medications, and having a limited ability to tolerate procedures also can reduce the desire for care. Anxiety and fear of new situations, working with or having new practitioners (if their previous practitioners have retired), or anticipating new procedures can affect their willingness to seek dental care. Existing aesthetic factors, including missing teeth, may contribute to a reluctance to go out in public. Older adults might be physically or economically unable (or unwilling) to access transportation to a dental visit. Seeking care might be too troublesome for the older person and/or his or her caregiver. Older adults’ attitudes toward, expectations of, and lifelong use patterns of dental services affect the how this cohort accesses dental care services (Marvin, 2001).

Isolation, Access, and Patient-Centered Care
For many years, reduced access to oral health care has been characterized as one of the prices of professional isolation. The isolation associated with oral healthcare gives the impression to other health professionals, policy makers, and the public that oral health is not as important as general health (Haden et al., 2003). Yet, given the many comorbidities found in older adults, optimally an interdisciplinary team would deliver a patient-centered oral healthcare model: the cornerstone of such a model supports interprofessional collaboration. Although these connections can be informal, having a formal mechanism provides the best training experience for new providers.

The team approach provides the critical components that ensure the delivery of quality healthcare and a collaborative environment that best uses the knowledge and skills of each health profession. Although often challenging to implement, a collaborative, patient-centered interdisciplinary practice setting can provide high-quality services for elders and their caregivers. Team members should include (but not be limited to) the following: the patient; physicians with physician assistants–nurse practitioners; dentist with dental hygienist; social worker; pharmacist; psychologist; occupational therapist; physical therapist; and direct service workers or caregivers.

Geriatric assessment programs are not new and have included a wide range of professionals. Although the outcome is successful for an individual healthcare provider, having all disciplines included in a geriatric assessment program is a costly and time-consuming project. To be successful, health assessment teams need to be familiar with the training, roles, and responsibilities of each professional, and have good communication skills. The healthcare provider should be aware of overlapping concerns to ensure he or she provides a comprehensive assessment.

It is also worth noting that serving as a member of a health assessment team typically requires additional time, which in turn increases costs for the older adult patient. All
team members should be aware of the individual patient’s need to receive regularly scheduled oral healthcare. Not only do team members need to ask the questions related to dental care use, but also they need to encourage routine professional and personal care. Whenever possible, follow-up appointments with team members should be arranged.

Summary
Although oral health and use of dental services among older adults have improved during the past fifty years, and this trend is expected to continue into the future, older adults are the least likely cohort to see their dentist on a regular basis (HHS, 2000).

The goal of training healthcare professionals, family caregivers, and direct service workers about oral health is to provide sufficient information to allow for making informed decisions, not to be an oral health diagnostician. First and foremost, healthcare providers need to ensure that their patients are regularly receiving oral healthcare. They need to inquire about the date of an older adult’s last comprehensive oral examination. A comprehensive oral examination will include an evaluation of all oral soft and hard tissues, head and neck lymph nodes, and facial skin changes, as well as a review of the individual’s health history and medications. General healthcare providers need to be able to differentiate between a routine visit and one that will alleviate pain or discomfort. Because many elders respect the information obtained from their healthcare provider, healthcare providers are well-positioned to urge their older patients to obtain a comprehensive examination by a dental professional.

Of all age cohorts, older adults are the least likely to see their dentist on a regular basis.

To improve the health, independence, and quality of life of all older people, this cohort should receive high-quality, patient-centered care directed by an interdisciplinary team (Arbaje et al., 2010). Considering America’s changing demographic of older and more diverse adults, especially a greater number of the older-old, along with greater use of clinical services by this fast-growing subset of older adults, we urgently need a special focus and commitment to assure a well-prepared workforce. But a disconnect currently exists between the expanding healthcare needs of older adults, the educational institutions responsible for training healthcare providers, and the entities paying for healthcare provider training—a matter that must be addressed to ensure older adults receive the highest quality healthcare, including dental care.

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References


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