What Can Be Learned from Oral Health Care Professionals’ Efforts to Address Other Systemic Health Issues

Session II: What We Can Do
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Methods

* Literature was searched back (no time limited applied)
* Databases searched: Pubmed, Embase, Cochrane, Grey Literature and CINAHL
* 45 unduplicated articles found
* 29 included & categorized based on relationship to question
  * 14 on screening for medical conditions in the dental setting including diabetes, heart disease and high blood pressure
  * 3 on tobacco screening in the dental setting
  * 4 directly related to obesity screening by OHCPs
In 2009, Glick challenged the oral health community to ask themselves whether direct participation in efforts to impact the growing obesity epidemic is a challenge they should consider, not only because obesity could have consequences for patients’ oral health status, but because of a “desire to have a stronger impact on patients’ general health.”

**Screening for Medical Conditions in the Dental Setting**

- Chairside medical screening for diabetes and heart disease can effectively identify adult patients at increased risk yet unaware of their disease risk
  - 23-41% at increased risk of diabetes (abnormal A1c values)
  - 17% at increased risk of a severe coronary heart disease event within 10 years
  - 28% had high blood pressure
  - 29% were overweight/obese
**Attitude Surveys on Medical Screening in the Dental Setting**

* Attitude surveys (Greenberg et al) among dentists, hygienists and patients on chairside medical screening in the dental setting
  * Majority OHCPs willing to screen for specific medical conditions (hypertension, DM, CHD, HIV, HCV)
  * Majority willing to collect necessary data/samples; 57% of dentists willing to collect height and weight
* Attitude surveys on chairside medical screening in the dental setting show a positive attitude among dental patients
  * 73% willing to participate, 72% willing to discuss results during visit; 71% willing to be referred to a physician
  * Majority willing to provide necessary samples/data; 79% of patients willing to provide height and weight

**Tobacco Screening in the Dental Setting**

* Tobacco-screening attitude surveys (Albert et al) reported <10% OHCPs received training on tobacco cessation and counseling
* Few had prior training, few asked about tobacco use or provided counseling about nicotine-replacement therapy
* Those more confident about their knowledge of smoking cessation advised their patients more frequently
* An intervention study on smokeless tobacco cessation implemented by hygienists reported a significantly greater sustained 12 month quit rate (12 months) with intervention
**Attitudes Surveys on Obesity Screening**

* Curran, et al., found that the majority of dentists did not provide obesity screening/counseling.
* They did recognize their value and would be willing to provide them but did not feel qualified.
  * Pediatric dentists more confident to conduct and interpret results of obesity screening.
* Major barriers to providing these services:
  * lack of trained personnel
  * fear of appearing judgmental
  * fear of patient rejection
* Majority of dentists (82%) would be more willing to offer counseling if evidence indicated obesity were directly related to oral disease.

**Obesity Screening Initiative in a Dental Setting**

* Tavares and Chomitz pilot tested a preventive “healthy weight intervention” in pediatric dental patients.
* Dental hygienist collected information on physical activity, “screen time” and eating habits, measured height, weight, and calculated age-specific body mass index (BMI).
* “Healthy Kids Report” developed for each child that included recommendations for behavior modifications.
* Referral made to physician for patient with BMI>85%.
Obesity Screening Initiatives by Hygienists

Findings
* 139 children 6-13 years of age
* Considered activity important
* Felt it did not take too much time
* Well-received by parents and children
* Parents felt dental office was a good place to receive obesity screening; 32% parents felt it would add too much time to dental visit
* 96% of caregivers reported making better food choices

Conclusions
* Screening for medical conditions in the dental setting shown to be effective at identifying patients at increased risk yet unaware of their increased risk
* Chairside medical screening is effective and accepted by providers and patients alike
* Healthy weight intervention program by dental hygienists in pediatric dental patients is well received and successful
* One of the findings to incorporating obesity screening in the dental setting is the need for more training
Next Steps

* Training needed on:
  * Relationship of obesity and oral health and the role of oral health professionals in overall patient health and well-being
  * How to conduct and interpret obesity screening
  * Larger studies needed that build on preliminary efficacy studies of childhood obesity screening by OCHPs
  * Studies needed that explore mechanisms to improve communication and patient referral mechanism between physician and dentists

Questions to Consider

* What is the optimal approach to incorporate medical screening for obesity into the dental visit?
* What curriculum changes are recommended for dental school education and for continuing dental education?
* What can be done to facilitate communication among dentists/physicians and other health care providers to their patients and across disciplines regarding patients’ well-being?
* What can be done to facilitate patient referral between dentists, physicians and other health care providers?
References


References