Providing Health Screenings in a Dental Setting to Enhance Overall Health Outcomes

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KEYWORDS

• Chairside medical screening • Diabetes mellitus • Cardiovascular disease
• Coronary heart disease • Oral health care professionals

KEY POINTS

- Chairside medical screening in the dental setting for diabetes and heart disease is effective for identifying individuals who are at increased risk of disease, yet unaware of their increased risk and who could benefit from early medical/behavioral intervention.
- Chairside medical screening in the dental setting could provide a portal of entry into the primary care system.
- Studies also suggest it is feasible to conduct these screenings in the dental setting.
- Chairside medical screening in the dental setting is viewed favorably by oral health care professionals, their patients, and primary care providers, and they are all willing to participate in such activities.
- Challenges to widespread implementation including the need for reimbursement, adequate provider training, and expansion of the state dental practice acts to include screening for increased risk of relevant medical conditions.

INTRODUCTION

Among the noncommunicable diseases (NCDs), cardiovascular disease (CVD) and diabetes mellitus (DM) continue to be among the primary causes of morbidity and mortality in the United States and worldwide. In the United States, CVD is the leading cause of death, with coronary heart disease (CHD) being the major contributor to heart

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disease morbidity and mortality. Diabetes is the seventh leading cause of mortality in the United States and a significant cause of morbidity.[1] Public health strategies to control these epidemics are based on preventing disease or controlling disease severity. Underlying this foundation is a focus on early disease detection and integrated health care delivery. As the health care system in the United States evolves, the emphasis on prevention and optimal health outcomes is likely to endure.[2]

Maximizing patient health outcomes will require integrated health care delivery across various disciplines. It has been suggested that the oral health care workforce could provide an additional resource in efforts to control these major health epidemics[3,4] and, accordingly, that the scope of practice for dentists be reevaluated and expanded to incorporate medical screening and primary health care activities.[5,6] In this capacity, screening is meant to be used for early identification of disease risk, which is distinct from medical disease diagnoses, which is outside the scope of practice for oral health care professionals. In many instances, patients will visit their oral health care provider on a more regular basis than a primary care provider (PCP). National Health and Nutrition Examination Survey data from 2005 showed that 54% of men who had no reported risk factors or medication use for heart disease or diabetes had not seen a physician in the prior 12 months but did see a dentist in that time period.[3] Subsequent reports using Medical Expenditure Data found that in 2008 24% of adults did not access outpatient primary care in that year, whereas 23% of those same adults did see a dentist in that same time period.[7]

Screening for the purpose of reducing a clinical outcome among individuals who have yet to develop a disease (primary prevention); screening for the purpose of reducing morbidity and mortality in an individual with already established disease, which could include disease monitoring (secondary prevention); or screening with an intent to affect the progression of an already established disease (tertiary prevention) will all require very different approaches and knowhow.[8] Furthermore, it is essential that any oral health care professional embarking on establishing a protocol for screening dental patients for systemic diseases knows what to do with any result emerging from a specific screening procedure. Screening for medical conditions in a dental setting is primarily for the purpose of identifying individuals at increased risk of developing disease based on well-established criteria, and monitoring already established disease.

Given shared underlying risk factors for oral diseases and many NCDs, such as CVD, diabetes, respiratory disease, and cancers, oral diseases have most recently been included with the NCD community (FDI World Dental Federation keeps oral health on NCD agenda),[9] and efforts to incorporate oral health within all policies are ongoing.[10] It is of interest to note that despite the plethora of studies on the associations between oral infections and systemic there is a dearth of well-designed and implemented studies elucidating the contribution of these common risk factors.[10] Such studies are necessary in order to establish optimal interdisciplinary health care delivery models. Furthermore, given the complex and often interconnected relationship among these risk factors and the likelihood of interaction across these risk factors, it is crucial that statistical analyses be appropriately conducted and interpreted to arrive at meaningful conclusions.

In this article, screening for medical conditions in the dental setting with immediate results will be referred to as *chairside screening*. Chairside screening for the presence of heart disease and diabetes has been assessed using safe, effective, and well-validated screening tools that require a blood sample for testing. Individuals found to be at increased risk of developing disease are referred to a PCP for diagnosis and determination of medical follow-up, offering dental settings to be portals for entry into the primary medical care system.[3,4]

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