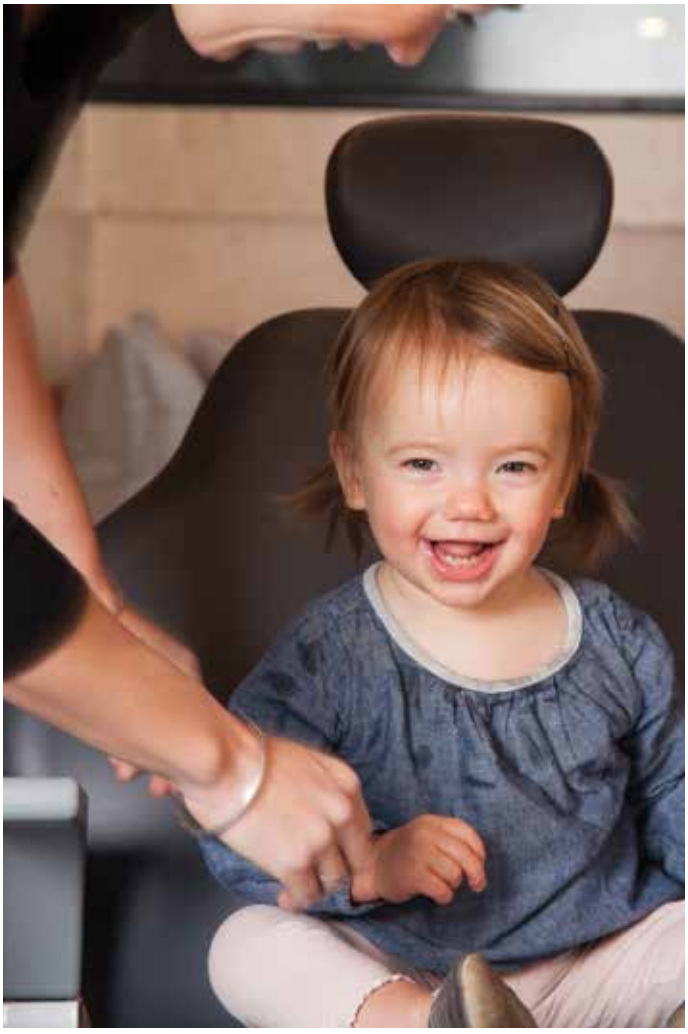
Dental Hygiene Focus: Interprofessional Collaboration/ Medical–Dental Integration

From the Womb: Dental Hygienists' Role in Promoting Lifelong Health Through Integrated Oral Care

by Kyla Oshanek, DHP-C, BDSc(DH), MClSc • kylaoshanek@gmail.com
and Lisa Watson, RDH, BA, MClSc • lwatso58@uwo.ca



In health care, words matter. Shifting from "dental–medical" to "oral–medical" integration acknowledges the role of oral health professionals beyond dentists in preventive care and patient well-being. It also emphasizes the mouth's place in overall health and reinforces the need for a collaborative health care model.[1]

Oral–medical integration (OMI) bridges oral and systemic health by integrating oral care into primary medical care, emphasizing their interconnection and fostering team collaboration.[1] OMI enhances patient safety and outcomes, and reduces costs through comprehensive care.[2,3] Dental hygienists, with their expertise in prevention, are uniquely positioned to champion this model, particularly in perinatal care, where they can play a crucial role in improving maternal and child health outcomes.

Despite research highlighting the oral–systemic connection, barriers to OMI, such as lack of political will and interprofessional education, persist (Table 1).[4] Facilitators such as supportive policies and co-location could address these challenges (Table 1).[4] Establishing these facilitators would support partnerships in pediatric settings where the Government of Canada already monitors relevant performance indicators.[5] Integrating dental hygienists into pre- and perinatal care teams addresses unmet oral health care needs, while improving maternal and child well-being.[2,3] By providing essential expertise in oral health assessment, prevention, and education, dental hygienists can mitigate adverse pregnancy outcomes linked to oral health conditions.[2,3] This integration fosters a more equitable and cost-effective health care experience for expectant mothers[1,2]

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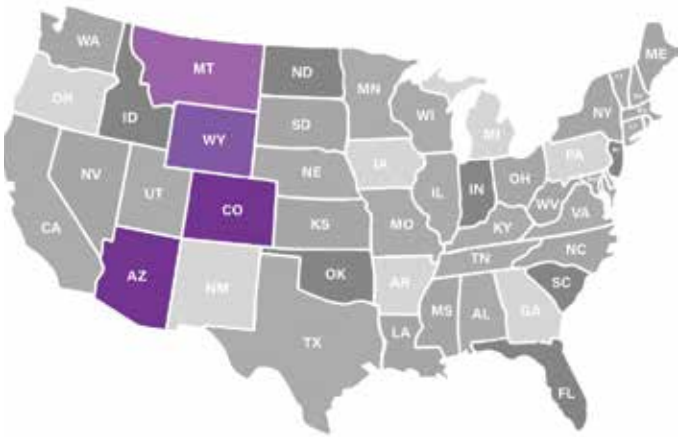
Table 1. Barriers to and Facilitators of Oral–Medical Integration[4]

Barriers	Facilitators
Lack of Political Leadership and Health Care Policies	**Supportive Policies and Resource Allocation**
Poor understanding of oral health's importance, low prioritization on political agendas, and absence of appropriate policies hinder integration.	Financial support from governments, stakeholders, and non-profit organizations, along with strategic partnerships, facilitate integration.
Implementation Challenges	**Interprofessional Education**
High costs of integrated services, human resources issues, and deficient administrative infrastructure present significant obstacles.	Training non-dental professionals in oral health, promoting interprofessional education, and encouraging further training facilitate integration.
Discipline-Oriented Education and Lack of Competencies	**Collaborative Practices**
Focus on discipline-specific training and lack of interprofessional education lead to insufficient competencies in integrated care.	Understanding and assuming roles in providing oral health care, effective case management, and task-sharing strategies enhance collaborative practices.
Lack of Continuity of Care and Services	**Local Strategic Leaders**
Poor referral systems, deficient interfaces, and unstructured care coordination mechanisms disrupt continuity of care.	Local leaders play a strategic role in building teamwork and community capacity for integrating oral health into primary care.
Perception of Oral Health Care Needs	**Geographic Proximity**
Patients' acceptance or refusal of integrative care often depends on perceived needs rather than health care providers' assessments.	Co-location of oral health and medical practices promotes interprofessional collaboration and efficient care delivery.

and may help establish national prenatal oral health policies.[2] Several pathways have bridged maternal and infant oral health with prenatal care in Canada[2] and the United States, demonstrating that OMI in this setting is gaining traction.[6]

For example, the Rocky Mountain Network of Oral Health (RoMoNOH) project focuses on primary prevention of dental caries in infants and pregnant women across Arizona, Colorado, Montana, and Wyoming. This project embeds dental hygienists and other oral health care providers in community health centres, provides training and resources, and integrates oral health into primary care. The initiative has significantly improved preventive oral health services for infants and children, demonstrating the effectiveness of OMI in perinatal care.[6]



▲ *Rocky Mountain Network of Oral Health*

Focus: Interprofessional Collaboration/Medical–Dental Integration

Effective OMI hinges on interprofessional collaboration, requiring clearly defined roles and mutual understanding among team members.[1] Misconceptions about the roles and capabilities of dental hygienists, particularly in preventive care, can hinder collaboration.[1] Open communication and shared decision making are crucial for optimizing resources, improving patient outcomes, and supporting expectant families.[2]

A perinatal care model, prioritizing interprofessional collaboration and communication, can be a model for wider OMI adoption. It aligns with opportunities in cancer care,[7] long-term care,[8] diabetes management,[9] and pharmacy.[10] By fostering interprofessional competencies and emphasizing preventive care, this model can enhance patient safety, improve care quality,[3] and elevate oral health literacy. By focusing on the unique expertise of dental hygienists, OMI champions oral health as a cornerstone of overall well-being for mothers, children, and the broader population. This team-based approach, aligning with Value-Based Care, prioritizes quality and patient outcomes, promoting a healthier future for both patients and the profession.[2,3]

To advance this model and ensure equitable oral health care for all, dental hygienists have a crucial role to play in advocating for policy changes that integrate oral health into primary care, aligning with the *WHO Draft Global Oral Health Action Plan (2023–2030)*.[11]

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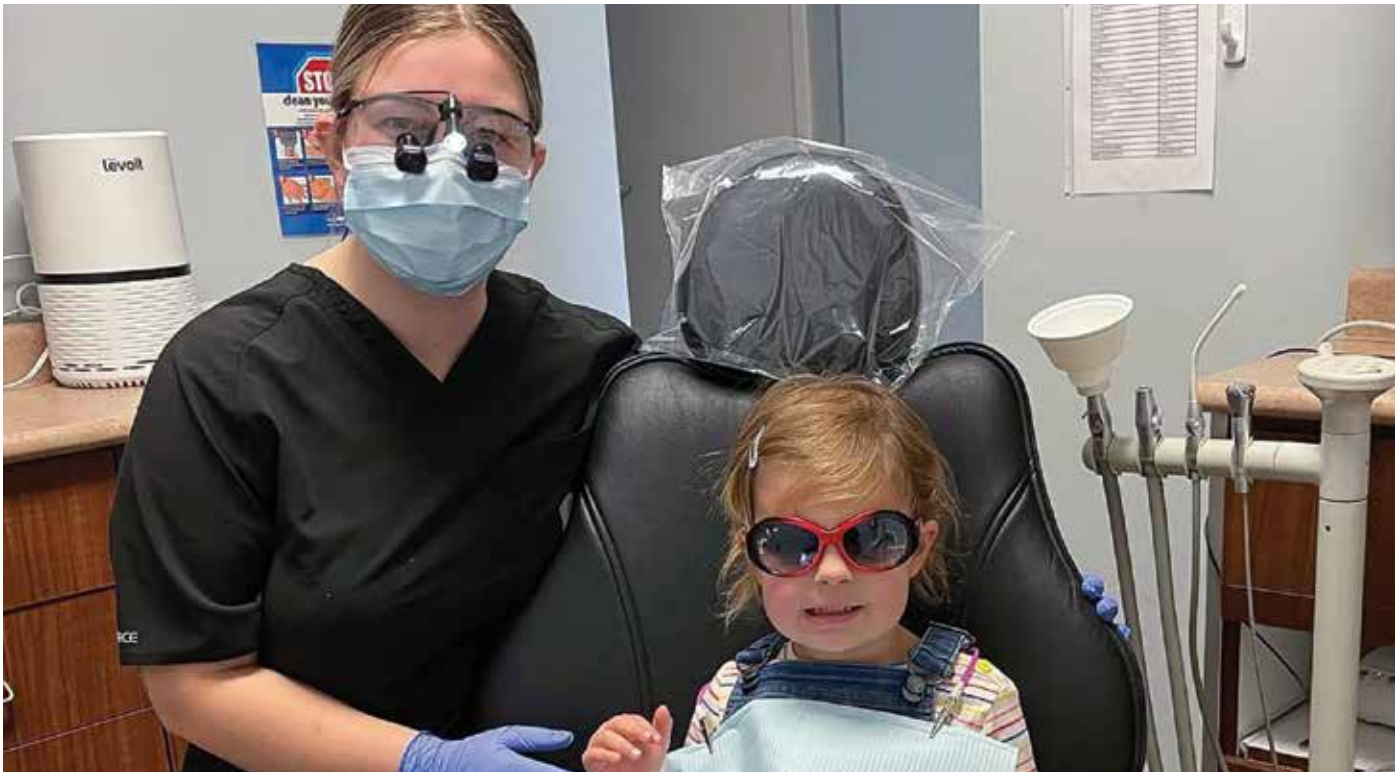

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