

Position Paper on Medical-Dental Care Delivery and Patient Record Integration

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The long-term future that we are intending as an outcome of this conference is the capability to offer patients optimal **safety** and **care quality** by achieving a unified approach to health care delivery, as well as documentation of that care through health information technology. We are exploring an approach which includes consideration of the patient's stomatognathic system from the very beginning in order to improve healthcare outcomes and reduce healthcare costs.

In order to offer optimal safety and care quality to patients, the health care system needs to account for the *entire human body*, including the oral cavity and associated anatomic structures (formally, the stomatognathic system). According to an accident in social structures, as documented by the internationally recognized expert on medical specialization, Dr. Georg Weisz of McGill University, the treatment of the oral cavity and associated structures developed to be separate from the treatment of the rest of the body, called the practice of medicine.

Today, when health care research is designed, care for the stomatognathic system by default is not considered. There is no routine acknowledgement that neglect of the stomatognathic system yields adverse effects. If we systematically examine the interrelationships between diseases of the anatomic domains addressed by dentistry and medical practice, we find a set of disease conditions where oral health and rest-of-body (or general) health are connected. The claim structures used in documenting medical and dental care have diverged into incompatible *diagnostic* (for medicine) and *procedural* (for dentistry) formats, thus impeding multimorbidity research into chronic illnesses in the field of epidemiology.

In addition to improving healthcare outcomes, integration of medical and dental care offers the opportunity to reduce healthcare costs for chronic illness and for emergency

care. Where vulnerable and minority populations do not have adequate access to oral health care, integrated care can benefit the health of such populations.

What are the domains where the evidence of an interrelationship between oral health and general health are most apparent?

(1) Metabolic conditions such as diabetes and periodontal disease

(2) Cardiovascular and cerebrovascular conditions (heart disease or stroke risk) and periodontal disease

(3) Periapical abscesses and a variety of associated “extraoral” abscesses (brain, maxillary sinus, throat, neck, mediastinum, liver). The oral cavity and the maxillary sinus are separated only by a membrane, the Schneiderian membrane.

(4) Autoinflammatory conditions and periodontal disease: rheumatoid arthritis (RA), systemic lupus erythematosus; Behçet’s disease; Sjögren’s syndrome; oral lesions

(5) Various problems of pregnancy, such as term stillbirth.

(6) Oral microbes and various cancers, such as colon cancer.

(7) Respiratory diseases.

(8) A range of (rare) genetic diseases (the CDC lists over 200), like Papillon-LeFèvre Syndrome.

The main advantages of an integrated EHR are (1) avoiding discrepancies between medical and dental records, and (2) facilitating collaboration among medical and dental providers delivering care to a “shared” patient.

There are accounts of discrepancies between medical and dental records (and associated risks), from the UK and US, going back to at least 1977.

Recent publications on COVID-19 testing documented the role of oral health and oral care in the reliability of saliva-based testing.

Failure to integrate patient records carries risks with regard to oral manifestations of medications prescribed by a given patient’s physician (and dentist) in a concurrent time frame, and also with regard to adverse medication interaction avoidance, given prescribing from providers across two disciplines.

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