Interprofessional Education: Where we are and where we can go

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At Augusta University, Augusta, GA, USA
Who we are and where we work

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Objectives

At the completion of this session, participants will be able to:

1. Define Interprofessional Education (IPE) and Interprofessional Care (IPC)
2. Review a series of learning and assessment tools to develop an IPE program for the teaching of physical diagnosis
3. Describe an integrated IPE program at Augusta University
4. Demonstrate knowledge of the new IPE programs at the Medical College of Georgia
Background

- Dental and medical schools often teach completely separately.
- In many instances medical school curricula do not address oral health in depth, if at all.

- IPE program where peer student teaching of the comprehensive oral examination and the cardiovascular exam ensures students understand how to work interprofessionally, and enter the workplace as a member of a collaborative team.
What is IPE and Why is it important?

• Interprofessional education occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.
What is IPE and Why is it important?

• Once students understand how to work interprofessionally, they are ready to enter the workplace as a member of the collaborative practice team.

• This is a key step in moving health systems from fragmentation to a position of strength. This process needs to start as early as possible in the education of our students.
Core Competencies for Interprofessional Collaborative Practice

Sponsored by the Interprofessional Education Collaborative*
Even when we are together, we are separate!

Why Don't We Treat Teeth Like the Rest of Our Bodies?  http://www.theatlantic.com/

Dental care is excluded from most insurance plans for a bizarre and antiquated reason, and millions of people suffer as a result.
Is there an difference? Should there be?
Rationale for an “Oral Health Professional”

• New demands on dental care providers for added knowledge of:
  – Dental management of medically complex patients (cancer, organ transplant, immunosuppressed, etc.)
  – Evaluation and treatments of oral manifestations of systemic disease or their treatment
  – Screening for medical illness to improve health outcomes
  – Understanding evolving relationships between oral health and systemic conditions (LBWPTD, pneumonia, CVD, etc.)
Why us?

• The “64/38 Rule”
• Oral Health Professionals are in a position to positively impact general health outcomes
Do We Really Have the Best Health System?

- GDP $12.96 Trillion
  - Reached $2.7 Trillion in 2011
    - For healthcare
    - $8,680 per person
  - $1.2 Trillion is Government
  - $848.9 Billion due to hospital costs
  - $320 Billion on medications
- Expected $4.78 Trillion (2021)

• Integrate w/ 1’ healthcare
• Prevent dz and promote oral care
• Increase access to care and decrease disparities
• Increase dissemination of oral health info. & improve health literacy
• Advance oral health in public policy & research

Integration of Oral Health and Primary Care Practice

U.S. Department of Health and Human Services
Health Resources and Services Administration
February 2014

Surgeon General's Perspectives

ORAL HEALTH IN AMERICA, 2000 TO PRESENT: PROGRESS MADE, BUT CHALLENGES REMAIN

Vera H. Scherzer, MD, MPA
On May 15, 2000, Surgeon General Dr. David Satcher issued Oral Health in America: A Report of the Surgeon General. The release of this landmark report on the oral health of Americans brought attention to the oral health needs in our country and affirmed its importance to general health and well-being. The report emphasized that good oral health is more than just preventing one’s smile. Aside from causing dental pain, diminished function, and reduced quality of life, oral disease and related conditions can affect overall physical, psychological, social, and economic well-being. In the 15 years since its release, the report has proven a catalyst for dialogue on the oral health of Americans and a foundation for developing the partnerships needed for its improvement. We have seen progress. Findings from Healthy People 2010 showed that more adults were visiting their dental centers, more clinicians were working in oral health, and more access to dental services was available. The report calls for improved access to dental care for all Americans, which is still needed. The report also called for more research on the link between oral health and other health outcomes. In the past 15 years, research has suggested stronger relationships between oral health and a variety of conditions, such as cardiovascular disease, diabetes, and childhood obesity. The report also emphasized the need for improved health literacy in oral health. In 2014, the Surgeon General released The Surgeon General’s Call to Action to Promote Oral Health, which outlined key recommendations for improving oral health outcomes in the country. The report also emphasized the need for improved oral health in public policy and research.

It is increasingly clear that oral health is closely related to overall health, and an estimated 100 million Americans do not have dental insurance. The Institute of Medicine’s Committee on the Future of Oral Health in America issued a report in 2010 that emphasized the need for improved oral health outcomes in the country. The report also emphasized the need for improved oral health in public policy and research.

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Gaining Access to Care

• Gaining entry into the health care system
• Accessing a health care location where needed services are provided
• Finding a health care provider with whom the patient can communicate and trust
• Access to health care impacts:
  – Overall physical, social, and mental health status
  – Prevention of disease and disability
  – Detection and treatment of health conditions
  – Quality of life
  – Preventable death
  – Life expectancy

- Assessed the proportion and characteristics of patients who do not regularly visit general health care providers but do visit dentists and whose unaddressed systemic health conditions could therefore be identified by their dentist.

- **Dental practices can serve as alternate sites of opportunity to identify health concerns among diverse groups of US patients.**

Dentists’ attitudes toward chairside screening for medical conditions

- **Background.** Results of previous studies demonstrated the effectiveness of chairside medical screening by dentists to identify patients at increased risk of experiencing cardiovascular-associated events. In this study, the authors assessed dentists’ attitudes, willingness and perceived barriers regarding chairside medical screening in the dental office.

- **Methods.** A national, random sample of U.S. general dentists was surveyed by mail by means of an anonymous questionnaire that involved a five-point Likert scale (1 = very important/very willing; 5 = very unimportant/very unwilling). Friedman nonparametric analysis of variance was used to compare response items within each question.

- **Results.** Of 1,945 respondents, most were male (82.3 percent), white (85.7 percent) and 40 to 60 years old (59.4 percent) and had practiced for more than 10 years (84.5 percent). The majority thought it was important for dentists to conduct screening for hypertension (85.8 percent), cardiovascular disease (76.8 percent), diabetes mellitus (76.6 percent), hepatitis (71.5 percent) and human immunodeficiency virus infection (68.8 percent). Respondents were willing to refer patients for consultation with physicians (96.4 percent), collect oral fluids for salivary diagnostics (87.7 percent), conduct medical screenings that yield immediate results (83.4 percent) and collect blood via finger stick (55.9 percent). Respondents were significantly more willing ($P < .001$) to collect saliva than height and weight measurements or blood via finger stick (mean ranks: 2.05, 2.96 and 3.05, respectively). Insurance was significantly less important ($P < .001$) than time, cost, liability or patients’ willingness (mean ranks: 3.51, 2.96, 2.94, 2.83 and 2.77, respectively).

- **Conclusions.** Dentists considered medical screening important and were willing to incorporate it into their practices. Additional education and practical implementation strategies are necessary to address perceived barriers.

- **Clinical Implications.** The findings of this study regarding chairside medical screening may lead to changes in our approach to dental education and may help define the practice of dentistry in the future.

Screening by Oral Health Professionals

- Hypertension
- Diabetes
- Obstructive Sleep Apnea Hypopnea Syndrome
- **Immunization Advocacy/Immunizations**
- Obesity (BMI and WHtR)
- Point of Care Salivary Diagnostics
- Rapid HIV and Strep Testing
- Mental Illness (PHQ9)
- Medication Adherence and Reconciliation
HPV related Cancers and Vaccination

• Squamous cell carcinoma of the oropharynx is increasing in incidence in epidemic proportion.

• This site specific increase in incidence is due to an increase in human papillomavirus (HPV)-related squamous cell carcinoma, while the incidence of tobacco related squamous cell carcinoma is decreasing.

Barriers to Vaccination

- Limited understanding of HPV and HPV-related diseases, especially in men
- Being unaware of or forgetting about the need for additional doses
- Safety concerns about the vaccine
- Discomfort talking about sexual behavior
- Lack of time for discussions about the vaccine among clinicians
- Lack of a clear recommendation from a health care provider
- Parental belief that son or daughter is too young for the vaccine and/or not sexually active
- Lack of adequate reimbursement and concerns about cost of the vaccination to the patient
- Need for systems to remind clinicians to offer the vaccine to age-appropriate patients at the time of other routine vaccinations

Oral-Medical Connections

- Oral disease its relationship to coronary heart disease, stroke, adverse pregnancy outcomes, diabetes and bacterial pneumonia
- Oral manifestations of systemic drugs
- Oral lesions as signs of medical illness
- Screening for medical illness in the dental office
YOUR HEART AND LUNGS LOOK GOOD, TOO.
Interprofessional collaborative practice:

• “When multiple health workers from different professional backgrounds work together with patients, families, carers [sic], and communities to deliver the highest quality of care”
  – (WHO, 2010)
Why is Interprofessional Education and Collaborative Practice so Important?

• Improving health, creating support systems and trying different models of practice.

• Intentionally supports people – including health professionals, health workers, students, residents, patients, families and communities – to learn together every day to enhance collaboration and improve health outcomes while reducing costs.

– Source: The National Center for Interprofessional Practice and Education
The Augusta University Model: Summary

• Medical and dental students interact and teach each other aspects of the physical examination with preceptors and serving as patients.

• Each module includes foundation material, videos, checklists, and peer students teaching of both a comprehensive oral examination to medical students and a cardiovascular exam to dental students.

• These and other interprofessional interactions need to be weaved throughout the four year dental and medical curricula to maximize impact and dental schools need to champion these programs.
IPE and The Protégé Effect

• Students enlisted to teach others, researchers have found, work harder to understand the material, recall it more accurately and apply it more effectively.

• In what scientists have dubbed “the protégé effect,” student teachers score higher on examinations than those who are learning only for their own sake.
The Head and Neck and Oral Exam
The Head and Neck Examination: Oral cavity and oropharynx
Scott S. De Rossi, DMD

Extraoral – Face and Neck

Foundation Material

• Pre-recorded lecture
• Accompanying Slides
• MedEd Portal Videos
• Clinical Checklist
Common Challenges to Interprofessional Education and Collaborative Practice

• Professional cultures and stereotypes
• Inconsistent use and different understandings of language
• Knowledge of the roles and scope of other health professions
• Accreditation and curricula
Lessons Learned

• Before/After of Faculty was telling – speaks to their experience working in teams
• Dental student responses were disappointing in certain areas
• Medical students had great increase in knowledge of the oral exam
• MD students do pre-class quizzes; we did not with DMD on the H&L session
• Need to change culture of us and them, and move to “we”
• Need to understand how important it is to function in teams by actually working in teams – curriculum needs to change drastically to accomplish this
  • Multidisciplinary Tumor Boards
  • Oncology Rounds
  • Geriatrics
IPE Consortium

- University of Georgia College of Pharmacy
- Augusta University
  - MCG
  - DCG
  - College of Nursing
Pharmacy, dental, medical and NP
Pharmacy, dental, medical, and NP

Diagram:
- Dental
- Medical
- M1D2
- M4D1
Pharmacy, dental, medical, and NP

Medical

M2NP1

Nurse practitioner
Pharmacy, dental, medical, and NP
Pharmacy, Dental, Medical and Nursing

- Screening for substance abuse
- sBIRT
  - Screening
  - Brief Intervention
  - Referral to Treatment
MCG Phase 1 and 2

• Phase 1
  • Healthy Perspectives
  • Dental-Medical
    • Oral exam
    • CV exam
  • Dietician during Nutrition Module
  • Gait workshop with PT

• Phase 2
  • M2P2
  • Geriatrics Intersession with Pharmacy Faculty
Phase 3

- OBGYN Rounds
- Tumor Board
- Palliative Care Intersession
- CV Exam with Dental College of Georgia
- M3P3 Exercise
  - Small groups, complex patient with medical issues
  - Review plan of care with Pharmacy Students
New for 2017

Georgia is Our Campus

As the state’s only public medical school, statewide growth of medical education is a priority at The Medical College of Georgia.

The educational experience is anchored by MCG’s main campus in Augusta, as well as regional clinical campuses for third- and fourth-year students and another four-year campus in Athens in partnership with the University of Georgia.

Expanding partnerships with physicians and hospitals throughout Georgia ensures that students experience the full spectrum of medicine, from urban tertiary care hospitals to small-town primary care practices.
Interprofessional Education

• During all clerkships
• Beginning January 2017
IPE Clinical Exercise

• Student
  • Work with patients
  • Identify a patient who needs engagement with another health professional
    • Another student is preferred
  • Ask background questions of the health professional
    • Education
    • Treatment of your mutual patient that may be unique

• Resident/Faculty
  • Identify interesting health professionals
    • Unique to OBGYN
      • CNM
      • Lactation Consultant
      • Pelvic Floor Physical Therapist

• In the SPEL log
  • Complete a drop down form about the patient and the professional
  • Complete a few questions about the experience
Future Directions

• Focus group to gather specific reason – why is there little difference with DMD
• Track participation in D2L to assess
• Re-survey after they are on the clinical rotations
• Additional topics and IPE/IPC programs
• Shared classes / presentation of specific topics
• Case based small learning groups
• Better weaving of IPE/IPC throughout the 4 years of the curriculum

• Core Executive Committee – Pharmacy, Nursing, Medicine, and Dental Medicine
Where do we go from here?

- Plan more IPE programs
- Build learning on core competencies for collaboration
- Design effective learning experiences
- Assess learners and programs
- Create interprofessional healthcare studies: teams, culture, experiences
- Calendar synchronization among schools
- Develop authentic clinical experiences
- Find champions and innovate constantly
- Focus on faculty development and mentorship
- Force collaboration geographically