



Oral Health Needs for Seniors

Challenges and Solutions in Dental Care for Aging Adults

Whitepaper

Institute for Oral Health 2008 Focus Groups
on “Oral Health in Aging America”

Focus Group #1 - February 2008 - San Diego, CA

Table of Contents

Introduction	2
Panel Presentations:	
Ira Parker, DDS, MA, MPH.....	4
<i>Meeting the Oral Health Care Needs of Seniors - Where Are We Now?</i>	
Douglas Berkey, DMD, MPH, MS.....	6
<i>Training of Providers in Regards to Seniors and Oral Health Needs</i>	
Ann Slaughter, DDS, MPH.....	9
<i>Mobility Constraints and Access Limitations</i>	
Kenneth Shay, DDS, MPH.....	11
<i>Oral Health Assessment of the Elderly Patient</i>	
Robert Henry, DMD, MPH.....	13
<i>Restorative Considerations in Older Adults</i>	
Panel Discussion Highlights.....	15

Introduction

“Geriatric dentistry is a very delicate balancing act, and if you don’t get it right, there are all sorts of consequences associated with it.”

In 2010, the first baby boomers reach retirement age, and it’s estimated that by 2030, over 20% of our population will be 65 years or older. Now add the facts that two-thirds of Americans are overweight and nearly 60% of adults over 65 are disabled in some way. That means a substantial number of our nation’s adults are unhealthy, and they’re all getting older. As they do, the burdens on the medical and dental profession are going to increase significantly. Is the dental industry ready for this?

The Institute for Oral Health (IOH) is dedicated to identifying and advocating solutions. Each year, IOH focuses on a specific oral health theme, promoting relevant news and research, and spotlighting the year’s theme with an annual conference. In 2008, IOH is directing attention to our nation’s seniors with the theme “Oral Health in Aging America.” As part of this year’s collaborative research on that theme, IOH hosted the first of two focus groups in February 2008 in San Diego, CA. The group’s discussion centered on important challenges in geriatric dentistry today, and identified key topics to be highlighted at the IOH 2008 conference in September in Chicago, IL.

The concerns of “aging America” are timely and highly relevant as America is currently experiencing unprecedented growth in the senior population, owing to longer lifespans and aging baby boomers. Many older adults neglect their oral health (often due to limitations in their income, insurance, or physical/mental capacity) and many dental professionals are under-trained and under-staffed to treat the unique needs of geriatric patients. As such, the population boom of aging adults could represent a significant health crisis in our country... and the dental industry needs to step up quickly and get prepared.

Participating in February’s focus group discussion were five top authorities in geriatric dentistry. Each of these experts presented on specific topics and collaborated in open forum discussion. Along with IOH Executive Director, Dr. Ron Inge, the group targeted critical challenges in geriatric oral health care today.

An overview of key findings includes:

- ❑ **Unprepared practitioners** – Many dental professionals are not adequately trained to assess, diagnose and treat geriatric patients, and are often reluctant to see them, instead referring the elderly to hospitals. Furthermore, an alarming percentage—nearly 50%—of graduating dental students feel unprepared to practice on geriatric or disabled patients due to a lack of clinical experience in dealing with special-needs patients.
- ❑ **Insufficient academic focus** – Dentistry academia needs to significantly increase focus on education for geriatric care that prepares practitioners with specialized skills for diagnosis and treatment of the elderly, clinical training in working with patients who have mobility and cognitive disabilities, and enhanced communication skills to better address psychosocial disorders common in elderly patients.
- ❑ **Need for integration with medical care** – Given the direct correlation between oral health and systemic health, dental professionals treating the elderly need to integrate common medical procedures into their practice to ensure safe and appropriate dental treatment. Health assessments, blood pressure and other medical tests, even psychological evaluations play a critical role in effective geriatric dentistry and need to become a standard part of treatment protocol.

These findings are detailed throughout this whitepaper, along with related data and insights from each participating expert. Additionally, the section **Panel Discussion Highlights** targets related topics of interest from the group's open forum discussions.

About Institute for Oral Health

Founded in 2006, the Institute for Oral Health is dedicated to improving oral health in America by bridging the gap between research and everyday dental practice. Serving as a central resource for education and collaboration, IOH brings together nationally recognized experts to focus on important themes of concern in oral health care today, and works to promote innovation and adoption of progressive treatment guidelines and delivery methods. To learn more, visit: www.iohwa.org.

Panel Presentations

Ira R. Parker, DDS, MA, MPH

Associate Clinical Professor of Medicine, Division of Geriatric Medicine, UC San Diego

Meeting the Oral Health Care Needs of Seniors - Where Are We Now? Challenges, Opportunities & Strategies for the Future

Dr. Ira Parker has dedicated his academic career to developing strategies and implementing programs that target improvement of oral health in underserved populations of America. Like many concerned dental professionals, Dr. Parker focuses considerable attention on the unique needs of treating our nation's growing population of seniors. In February's IOH focus group, he identified crisis points facing the dental industry and proposed key solutions to help providers grow prepared to meet the challenges.

Getting Prepared for the Wave

If they haven't already, by 2010 when America's first baby boomers reach retirement age, dental professionals will begin to see an overwhelming number of senior patients in their practice. Providers will need to prepare for this tidal wave of elderly patients in a number of ways, some of which are less than obvious. Naturally, they'll need to ensure all staff has appropriate training in geriatric dentistry, and providers may need to acquire additional qualified staff to handle the increased patient load.

But there's more. To effectively provide care for elderly patients, dental professionals will need to make some paradigm shifts in how they run their practice, particularly in terms of communication skills, scheduling, accessibility and mobility.

Targeting Advocacy to Reach Seniors in Need

Although many providers may be deluged with elderly patients, the flipside of the problem is that millions of aging adults don't seek dental care due to lack of income, insurance, or perceived need. As a result, their overall health is getting increasingly compromised as they age (which in turn will place additional burden on medical professionals). Many seniors might only seek out a dentist when forced to by an oral health crisis, at which point providers are faced with greater challenges in devising treatment plans that these patients can easily accommodate.

How can key stakeholders, such as organized dentistry, dental academia, public policy makers and employers position themselves to deal with what could potentially become a serious threat to the quality of life of America's aging population?

Dr. Parker believes this issue needs immediate attention by the dental profession. Addressing the oral health needs of our senior population is not just timely and relevant, it's urgent. Although "health care reform" is becoming a national imperative, geriatric dentistry is not a primary priority in that initiative. As such, many in the dental industry are realizing it's going to be up to them; that "targeted advocacy" to improve access and effectiveness of dental care for aging adults is no longer just a good idea; it is a necessity.

Promoting Training Opportunities

With the surge in growth of the senior population, both the academic and professional arenas of dentistry need to develop strategies to promote training opportunities for geriatric oral health care. In seeking to “instill a sense of responsibility and accountability” in the dental industry to support this underserved demographic, Dr. Parker proposed the following training solutions:

- ❑ Undergraduate – Encourage progressive geriatric content in standard academic curricula.
- ❑ Postgraduate – Promote geriatric content in specialty training programs and require long term care clinical experience in residencies.
- ❑ Practitioners – Encourage collaboration with medical and nursing colleagues to share knowledge about geriatric care and dental concepts; promote comprehensive health assessments.
- ❑ Continuing Education – For both students and practitioners, provide training opportunities in senior communities to build a “comfort zone” and greater understanding in communicating with the elderly. Additionally, provide training with a focus on physiological issues affecting seniors such as mobility problems, cognitive disorders, hearing loss, and so on

Ensuring Access to Better Care for the Elderly

To address the dental care needs of our nation’s aging population, it’s certainly important to raise awareness, improve training and increase staffing. But we need to look at the bigger picture as well. Dr. Parker promoted strategic changes that could advance public perception on the importance of dentistry, especially among seniors, as a fundamental part of good health care. For example:

- ❑ Optimize the dental workforce – All providers should be well trained and comfortable in geriatric dental care, and educated with basic cross-discipline training in geriatric medical care. Additionally, providers should develop dental delivery models that focus on the “long term continuum.”
- ❑ Increase public education – For geriatric oral health care, promotional information needs greater attention and wider distribution to increase awareness about prevention, oral health connections with systemic health, and other considerations.
- ❑ Improve health plan coverage – Both dental and medical health plans need improvements to better address the specific needs of elderly adults, and in some cases, such as Medicare and Medicaid, provide better coverage overall.

Dr. Parker believes the dental profession as a whole needs to speak out on behalf of our senior population, to step up and help ensure better access to better care for the elderly.

Douglas Berkey, DMD, MPH, MS

Professor, University of Colorado Denver School of Dental Medicine; Dental Director, Total Longterm Care of Colorado; Past President of the Geriatric Oral Research Group of the International Association for Dental Research; Past Chair of the Gerontology and Geriatrics Education Section, American Dental Education Association

Training of Providers in Regards to Seniors and Oral Health Needs

Dr. Douglas Berkey focused his presentation on the challenges of ensuring adequate practitioner training to address the special needs of geriatric patients. He cited many unique concerns associated with elderly patients and emphasized the need to expand and improve training for geriatric oral health care both in dental schools and clinical practice.

Why Be Concerned?

“Why be concerned?” asked Dr. Berkey. Because we’re all growing older, and adequate dental care can make a significant difference in both quality of life and longevity. As an example, a 1997 study comparing life expectancies in men and women estimated that, at 75 years old, a healthy man might live another 14 years, while a man in frail health might live only 5 more years. Similarly, a healthy 75 year old woman might live about 17 more years, a frail woman only 7 more years. That’s a loss of 9-10 years; a lot of precious time for most of us. And dental professionals can help prevent that.

But providers need to be uniquely prepared when treating the elderly in order to meet a number of complex challenges. In addition to financial limitations and access issues, geriatric patients (particularly those who are functionally dependent) often have medical conditions and psychosocial problems that increase the difficulties of assessment, diagnosis, treatment

.....
“It’s a very delicate balancing act, and if you don’t get it right, there are all sorts of consequences associated with it.”
.....

and management of their oral health. Dr. Berkey added that, with very frail patients, dentists have a greater capacity to do more harm than good if they’re not very well trained.

A Looming Crisis of Unprepared Providers

Dr. Berkey stressed grave concern over the booming population of seniors faced with a critically under-prepared community of dental care providers. Both the dental education system and the dental industry at large have placed far too little emphasis on the need for in-depth training in geriatric dentistry. The result is that, relatively speaking, our country has only a small handful of providers truly qualified to address the unique needs of millions of elderly patients.

Looking at the educational system, Dr. Berkey cited some important studies that highlight the problem:

- ❑ Consistently over the past 12 years, American Dental Education Association (ADEA) dental school surveys have shown that nearly 20% of the students surveyed agreed their geriatric dentistry training was inadequate.
- ❑ In a 2005 ADEA survey, nearly 82% of the senior students surveyed felt “less than prepared” to practice geriatric dentistry; about 67% felt ill-prepared to treat disabled patients. These numbers highlight a serious concern in light of the increasing need for practitioners who are well trained to treat elderly people who may be frail or functionally dependent.

- ❑ A critical lack of training was echoed further by a 2008 national survey of Postdoctoral Dental Program Directors (PDDP) in which only 5% agreed that dentists entering the postdoctoral program had already received “excellent training” in geriatric dentistry; 95% of the directors felt these dentists were unprepared for treating geriatric patients.

.....
Dr. Berkey cited a fellow expert in geriatrics who claimed:

“If there’s one thing that’s critical to both dentists in training as well as practicing dentists it is hands-on care supervised and guided by people with expertise.”
.....

Dr. Berkey added that, frequently, these programs referred to a hospital any patients who were “medically compromised,” yet he suspected it was often for conditions as basic as arthritis, simply to avoid dealing with geriatric patients.

An additional concern highlighted by the 2008 PDDP survey was that less than 50% of the dental program directors felt there was a “considerable difference” in treating patients aged 30-40 and those 75 years and older with respect to basic diagnosis, treatment planning and prevention.

“*They don’t get it,*” claims Dr. Berkey. This finding represents a significant misconception between academia and real world practice. The treatment and patient management needs are substantially different with elderly patients for a number of reasons, such as:

- ❑ Complications with systemic health issues and medications;
- ❑ Communication and treatment difficulties for patients with cognitive and functional limitations;
- ❑ Greater challenges in educating and motivating elderly patients on preventive care.

Furthermore, it was discovered that a common model in university dental programs was to refuse care for elderly patients unless they could get themselves to the school, and if they exhibited any complex complications, those patients were referred directly to hospital dentistry. Evidently, not only were supervising faculty uncomfortable with providing geriatric care, they were conveying that discomfort to students who then carried that reluctance into their practice.

But there is good news. Dr. Paul Glassman (Professor of Dental Practice at University of the Pacific and Delegate to the ADEA House of Delegates) spearheaded and got the ADEA to pass a resolution that requires a clinical component for dental students to practice providing care for special needs patients.

Alarming Under-Staffing in Geriatric Dentistry

In 1987, a report estimating the dental personnel required by 2020 to manage the health needs of elderly patients projected needs of “at least 6,000 dental practitioners with substantial training in geriatric dentistry by the year 2000, and 10,000 by the year 2020.” The report also cited a need for 2000 geriatric dental academicians by the year 2020 in order to adequately train those practitioners.

With those projections in mind, experts in geriatric dentistry claim that dentists will need to serve about 1,000 functionally independent older adults in addition to caring for older patients with special needs (typically about 40% of senior patients).

So how are we doing? Not good, according to Dr. Berkey who noted some alarming statistics, including:

- ❑ By 2005, only about 200 dentists had received postdoctoral training in geriatric dentistry, compared with the projected need of 7,000.

- ❑ A 2006 ADA report from the Task Force on Elder Care stated the majority of geriatric-trained dentists will retire in the next 10 years, and training for the next generation of dentists may be nonexistent due to the 2006 federal budget cut eliminating all funding for postdoctoral training in geriatric dentistry.

Paralleled Under-Staffing in Geriatric Medicine

The medical profession is seeing a similar trend in the lack of education on geriatric needs, as well as a lack of interest in practitioners to specialize in geriatrics. Over 16,000 people graduate each year from medical school, yet only 2% seek careers in geriatrics. This shortage in providers may result in a medical care crisis as well. For example, the Alliance for Aging Research stated that in 2005 there was only one geriatric specialist per 2,500 patients aged 75 years and older; they project the number to rise to one provider per 3,600 elderly patients.

Dr. Berkey highlighted the problem by quoting a colleague, Dr. Robert Kane, Director of the University of Minnesota's Center on Aging:

“Geriatrics is a lost cause. There is no sign that there is any growing interest among medical students. We’ll push things to the precipice, panic, and then come up with a draconian solution and pump a lot of money into something that we could have solved much more cheaply years earlier.”

The Wake-up Call: Redefining Geriatric Dentistry Education

The good news is that the topic of aging baby boomers has hit the popular media this year, which has motivated educational institutions to add geriatric curricula to their programs. Dr. Berkey is actively promoting ways for the dental profession to follow suit. He offered a number of solutions for redefining the “philosophy” of education for geriatric dentistry and cited strategies proposed by 2006 ADA Task Force of Elder Care. Some highlights are as follows:

- ❑ **Increase early practical training** – As the majority of older patients can be treated in a general dentist’s office, all students must learn the “unique skills and attitudes” to competently treat older adults, and routinely practice on senior patients.
- ❑ **Expand the diversity of training** – Education for student and practitioners should emphasize *clinical decision making and critical thinking* as essentials in treating older adults, where the physiological effects of aging present greater challenges and risks. Additionally, training should include clinical experiences in various elderly care environments to better understand the needs of older patients and grow comfortable in treating them.
- ❑ **Develop Web-based resources** – By providing a “clearinghouse” for resources dedicated to improving geriatric oral health care, both practitioners and students can gain anytime access to Continuing Education opportunities, consensus reports, and more.
- ❑ **Promote policy changes** – Lobby support from key government officials and agencies on the critical need for geriatric dentistry programs, and collaborate with ADA agencies to promote geriatric dentistry as part of general dentistry (as opposed to a special interest area).

Ultimately, the key strategy for success lies in effective collaboration across all institutions and organizations who are raising awareness and supporting improvements in geriatric dentistry. Working together, dental and medical professionals, educators, and policy makers can drive the greatest potential for change to ensure that both emerging dentists and seasoned practitioners are ready, willing and able to provide high quality care for aging America.

Mobility Constraints and Access Limitations

Dr. Ann Slaughter’s research has focused primarily on the dental care needs of elderly African Americans, working to develop intervention programs to promote good oral health. In the IOH focus group, she highlighted the growing concern that seniors with physical difficulties are neglecting oral health care, and she emphasized the need to develop strategies for improving access to dental care in order to reduce additional health risks in elderly patients.

To begin with, Dr. Slaughter encouraged dental professionals to consider how mobility (or the lack of it) affects various elements of “successful aging” –good physical and mental health; high cognitive and physical functioning; and social contact and productivity-- and strategize interventions that contribute to a better quality of life for elderly patients.

Raising Awareness about Disabled Seniors

“Immobility is a frequent pathway by which many diseases produce further disability,” claimed Dr. Slaughter. For elderly people who have difficulty getting around without physical assistance, their health problems are compounded by the challenges in finding dental care providers who can address their special needs. In turn, dental professionals need to be aware of the wide range of medical conditions that commonly impact patient mobility and often amplify their disabilities, and develop strategies to accommodate those patients.

Some common disabilities that impact mobility (especially in older adults) are:

- ❑ Rheumatologic – Disorders such as osteoporosis, arthritis and fractures.
- ❑ Neurological – Disorders such as strokes and Parkinson’s disease.
- ❑ Cardiovascular – Heart diseases and conditions that limit mobility due to oxygen needs.
- ❑ Psychological – Mental conditions such as depression and phobias.
- ❑ Environmental – Inadequate (or absent) mobility aids such as walkers and footwear.

It’s also important for dental professionals to recognize the volume of senior patients who may be affected by disabilities. A 2002 U.S. Census Bureau report on Americans with Disabilities noted that in adults aged 65 years and older, a substantial number were disabled in some way: 52% of all men and 59% of all women.

A 2002 U.S. Census Bureau report states that 52% of all men and 59% of all women have some type of disability.

As such, dental practitioners must be prepared and well-trained to address the various challenges associated with older patients who have special needs.

Education Strategies to Improve Geriatric Care

Dr. Slaughter emphasized positive changes underway to improve education on geriatric care both in the nursing and dental medicine programs. Some promising strategies in curriculum changes include the following learning objectives:

- ❑ Advance dental curricula to include a wide scope of patient experiences with diverse populations with the goal toward helping students gain “comfort and confidence” in treating patients with special needs.
- ❑ Encourage students to change their attitudes on “ageism” to better prepare them for the workforce, overcome stereotypes about the elderly, and guide them to develop “an appreciation for the diversity” of older people.
- ❑ Mentor students to develop stronger communication strategies to promote positive dentist/patient relationships, and prepare them to effectively manage ageist attitudes in elderly patients, which may contribute to resistance of treatment options and difficulties in communication.

As an example, these learning strategies are being put to work in extramural activities promoted through programs such as Living Independently for Elders (LIFE), which focuses on improving health care for seniors. In recent surveys of dentistry students who participated in the LIFE program, over 65% agreed it helped them better understand the challenges of older people, and over 45% agreed they had grown more comfortable in communicating with older patients.

Additionally, volunteer opportunities in community-based prevention programs and senior care facilities provide students and practitioners the chance to gain a valuable perspective on what older patients need and want from their health care providers.

Access Strategies to Improve Geriatric Care

Advancing education on geriatric dentistry is critical, but it’s equally as important to consider how to get elderly patients into care. Dr. Slaughter promoted strategies for improving access to dental care, including:

- ❑ **Availability** – We need to develop public health clinics specifically for people with special needs such as mobility limitations, sensory impairments, and conditions common to the elderly. To encourage qualified dentists to work in these clinics, a potential incentive may be to define the clinics as federally qualified health centers and offer practitioners student-loan repayments as part of their compensation.
- ❑ **Affordability** – The dental industry needs to drive changes to correct the inadequacies of Medicare, Medicaid, and most private insurance carriers to include comprehensive health and dental coverage for the elderly.
- ❑ **Acceptability** – As America is growing more ethnically and racially diverse, we need to develop care and prevention programs that are culturally appropriate and acceptable to our diverse older adult population.

Kenneth Shay, DDS, MPH

Director, Geriatrics and Extended Care Service Line (VA Services – Michigan, Ohio, Illinois); Chief of Dental Geriatrics, VA Medical Center, MI; Adjunct Associate Professor of Dentistry at the University of Michigan School of Dentistry

Oral Health Assessment of the Elderly Patient

For nearly 20 years, Dr. Kenneth Shay has focused his practice of dentistry on caring for the elderly who have significantly debilitating physical and cognitive disorders. His presentation for the IOH focus group highlighted the need for flexibility and broader perspectives on how, why, and where providers conduct oral health assessments on geriatric patients. By gaining a comprehensive understanding of each patient's unique needs, providers can be better prepared to accommodate special care requirements.

The Roots of Geriatric Assessment

As defined by early geriatric specialists back in the 1930's, the foundational premise of "Geriatric Assessment" is that as people grow older, they become less resilient –in all capacities. A second key factor in aging is that reaction time diminishes. Those two variables combined contribute to a large number of injuries common to the elderly.

As an example, a person in their 50's might notice their vision slightly compromised in low or misty light; someone in their 80's will have much more difficulty with that due to natural aging of the eyes such as darkening of the lenses and stiffening of retinal tissues. In other words, the older person is less resilient in going from light to dark. Now suppose each person is moving from a light area to a dark area in which they might miss seeing a step and trip. The 50-year old could catch themselves fairly quickly and stop their fall; if they do fall, they mostly risk embarrassment. But with a frail elderly person whose has osteoporosis, a fall often means a broken limb. And their weakened resilience makes recovery slow and complicated.

Long ago, doctors assessing elderly patients realized it wasn't enough to simply prescribe hearing aids or glasses. They saw it was necessary to evaluate not only a patient's medical condition but also many elements of daily living that might influence their health such as nutrition and lighting in the home, as well as ability to manage common daily activities and make decisions about their own well being. These in-depth assessments allowed practitioners to provide more effective and appropriate care, a goal that remains important today.

Where to Perform Assessments – Think Outside the Office

Naturally, dental care providers perform oral health assessments in their office. But how do we support an elderly population who can't get there? Many very old adults are confined to their homes, assisted living facilities or hospitals. As such, Dr. Shay evangelizes the need for more portable dental care services able to reach out to seniors who are physically unable to get to a dentist.

Additionally, it's important to identify community locations that support the elderly, such as senior centers and health fairs, at which providers could conduct oral health assessments and build relationships with needy patients who might otherwise not seek out a dentist on their own.

An important goal of dental professionals is to help people gain a better quality of living. In the elderly, that challenge is even more relevant and requires greater attention. It's essential that providers assess and treat their oral health to provide better support for their overall health and well being as they deal with the complexities of aging.

Why Assessments Get Initiated – Know the Motivation

Dr. Shay believes that, as dental professionals, it's important to recognize why oral health assessments get initiated, who's doing it and for what reason. Particularly with elderly patients, understanding the motivation can help practitioners prepare for the level of care they'll need to provide. For example, some exams might be an easy, common office experience. But others may require more time, careful communication skills, and the ability to effectively manage resistance and physical complaints.

- ❑ **Initiated by patients** – Typically, oral health providers perform assessments when initiated by the patient, during routine checkups or when the patient perceives a need or has a concern.
- ❑ **Initiated by others** – With older adults, it's not uncommon that they won't initiate dental visits, often because they forget, they're focused on other health issues, or they can't afford dental care because their insurance doesn't cover it. However, they clearly have a need for at least basic oral health care, and may only get it if a family member or caregiver perceives a need (or responds to a complaint) and initiates a dental visit on their behalf.

Additionally, when brought to the dentist against their wishes, the elderly may respond like children; they're afraid and uncomfortable and they don't want to be there. Those factors may have a big influence on an oral health assessment in terms of patient cooperation and how forthcoming they are about their medical history.

- ❑ **Initiated by requirement** – All nursing homes and some assisted living facilities require seniors to have an oral health exams prior to admission. Often, it's not required that these exams be done by a dentist, though it's preferred if they are. As such, some dentists have cooperative agreements with these facilities to provide initial assessments and see the patients every six months thereafter as long as they're in the facility.

How to Ensure Effective Assessments

The typical “gold standard” for oral health assessments includes many useful elements such as a review of medical history and vital signs, oral exam and periodontal probing, and so on. However, with elderly patients, it's critical to go beyond the basic oral assessment and evaluate additional variables that may influence the patient's ability to understand and manage a treatment plan.

Adding new essentials, Dr. Shay has redefined the traditional oral health assessment, identifying it with the acronym “OSCAR”:

- ❑ **O**ral – Dental evaluation
- ❑ **S**ystemic – General health considerations
- ❑ **C**apability – Functional status in daily activities
- ❑ **A**utonomy – Decision making capacity
- ❑ **R**eality – Patient preferences

.....
“In elderly patients, cognitive ability should be consider a sixth vital sign and included in all health assessments.”
.....

With elderly patients, it's particularly important to conduct a cognitive assessment to obtain a baseline for their mental faculties and determine if any disorders are a recent onset or were ongoing but hadn't been noted by other caregivers. Assessing functional capability is also key. Studies have shown that the elderly often first lose capacity in bathing and brushing their teeth.

Overall, conducting a thorough geriatric assessment helps practitioners identify where a patient lies on the aging continuum, i.e., how much of the key factor --resilience-- remains in the patient's physical, mental and emotional systems. Understanding that baseline can help advise strategies for treatment and long term care.

Robert Henry, DMD, MPH

Director, Geriatric Dental Services & Assistant Chief of Dentistry, VA Medical Center, Lexington, KY; Clinical Associate Professor & Course Director for Geriatric Dentistry, University of Kentucky College of Dentistry; Former President, American Society of Geriatric Dentistry

Restorative Considerations in Older Adults

With Americans experiencing longer life spans and baby boomers soon reaching retirement age, the dental profession is seeing a significant increase in the number of seniors in their practice. Many of today's aging adults are keeping their teeth and have higher expectations about their oral health, and thus, there's been an increasing demand for restorative dental services.

Dr. Henry introduced important perspectives on restorative options, emphasizing the need to consider numerous factors to ensure appropriate solutions are chosen that adequately support the patient's goals and care needs, as well as their ongoing treatment plan.

Dependent Factors of Restorative Options

In older patients, restorative dentistry requires more careful consideration and carries more dependencies than with younger patients. A good place to start is for practitioners to evaluate some key factors to help identify the appropriate options for restorative work, including:

- ❑ Patient goals – Gain a clear understanding of the patient's desires, expectations and motivations for the restorative work, such as pain relief, improved aesthetics, etc. It's also helpful to determine their level of commitment and ability to maintain good oral care after the work is done.
- ❑ Level of restorative work needed – Consider the severity of the care required to meet the patient's goals and health needs, whether the work would be very extensive (such as multiple implants or veneers), moderately extensive (endodontics, single crowns, etc), or fairly limited such as dentures or restoration requiring minimal intervention dentistry.
- ❑ Patient dentate status – Note how many teeth the patient has and how many they really need for adequate functioning. Ideally, there would be at least 24 teeth remaining, yet the patient might be able to function with less.
- ❑ Impact on quality of life – Evaluate the patient's lifestyle and functional needs, how each restorative option might impact them, and the probability of positive outcomes for each option. Additionally, consider the financial implications and other resources that may be necessary.
- ❑ Ability to manage treatment – Contrast the complexity of each restorative option with the patient's general health to assess their ability to tolerate the stress of various treatments.
- ❑ Patient's overall treatment plan – Factor in how various restorative options will impact other dental treatment the patient needs, such as oral surgery or periodontal treatment. Additionally, consider any medical implications such as medications, modifications needed for physical or behavioral conditions, and so on.

Assessing Patient Functionality in Decision Making

Once the practitioner has identified the appropriate restorative options and feels prepared to make recommendations as to the best solution for a given patient, a key ethical factor comes into play: the patient's level of dependency in decision making. The patient may be able to make decisions on their own or they may need support from a caregiver, which in turn will determine the extent to which the dentist must play "advocate" for the patient's best interests.

Based on the patient's level of dependency, the decision making on restorative work might play out in the any of the following ways:

- ❑ **Independent** – Gain a clear understanding of the patient's desires, expectations and motivations for the restorative work, such as pain relief, improved aesthetics, etc. it's also helpful to determine their level of commitment and ability to maintain good oral care after the work is done.
- ❑ **Needs some assistance** – Whether or not the patient has cognitive difficulties, the decision will likely require input from a caregiver or family member who may be involved in the daily aspects of oral health care maintenance for the patient. Those people might also need or want to speak on behalf of the patient regarding the their personal preferences.
- ❑ **Dependent** – If the patient is functionally dependent, they may still participate in the decision but input from the caregiver is critical. In this case, it's also likely the dentist will become more involved in the decision making as advocate for what they believe will be best for the patient's near and long term health.

Regardless of the patient's level of dependency, it's important to ensure that the patient and any caregiver fully understand the ramifications of each restorative option. Particularly with elderly patients, there may be medical considerations that will increase the risks or complexities of a given option. Additionally, certain options may provide only temporary relief or require more maintenance. All of these issues need to be considered as they may impact the patient in numerous ways physically, emotionally, and financially.

Panel Discussion Highlights

In this first of two focus groups hosted by the Institute for Oral Health on their 2008 theme “Oral Health in Aging America”, the panel of experts on geriatric dentistry addressed additional concerns in their open forum discussions, including the following issues...

Integrating medical assessments into geriatric dentistry

In treating older patients, it’s imperative that dental practitioners integrate common medical testing into their standard treatment protocol. For example, prior to any invasive dental work, it’s important to test the patient’s blood pressure and perhaps even blood glucose level. Although these precautionary measures may be more time-consuming and even costly, they may significantly reduce the risk of complications due to conflicting medical conditions. Furthermore, simple medical assessments can also serve as important predictors of periodontal disease.

Dr. Doug Berkey emphasized this point by citing a February 2008 article in *World News & Report*, which stated that Aetna, Cigna, and other carriers have “*stepped up coverage for members who carry their dental coverage and have certain chronic diseases.*” In recognizing the importance of promoting integrated medical and dental health care, these carriers are now “*reaping savings.*” For example, by encouraging members to receive appropriate dental care, Aetna saw “*medical costs reduced by 9% for members with diabetes, 16% for those with coronary heart disease, and 11% for those with stroke and other cerebral vascular disease.*”

As another example, smoking cessation counseling is now covered by some dental plans, making it easier for dentists to motivate patients to participate.

Hopefully, evidence like this will provide incentive to encourage more dental providers to begin incorporating medical assessments into their treatment protocol. While many may have resisted due to limitations in training or staffing, it’s more likely that practitioners have pushed back due to billing issues. However, now that major carriers are realizing the cost savings of dental care, they may start broadening coverage to support dental practitioners in playing a more active role in the diagnosis and prevention of systemic as well as oral diseases.

.....
“Geriatric Dentistry evokes from the practitioner the best of clinical, psychological, and social skills. It demands an integrated approach and advocacy for those who are most at need.”
.....

–Dr. Doug Berkey

Promoting student interactions with the elderly

Nearly all of the experts in the group noted studies in which dental students benefited greatly from extracurricular experiences with the elderly as part of their clinical training. Initially, nearly all students were upset and presented “a lot of opposition” mainly due to fear from lack of experience in dealing with frail and functionally dependent older people. Many young students felt uncomfortable even with healthy seniors, having had little or no intimate communication with them.

These training programs changed all that in dramatic ways. Unanimously, students found the experience one of the most rewarding in their training, having grown a new awareness and confidence in communicating with and understanding the special needs of elderly patients. As a result, these students felt more comfortable and better prepared to treat seniors in clinical practice.

Typically, students were more receptive to this extra-curricular training during their first year of dental school. Having exposure to the elderly early on helped support later studies in geriatric dentistry, and made students more open to treating senior patients during their clinical training.

Typically, students were more receptive to this extracurricular training during their first year of dental school. Having exposure to the elderly early on helped support later studies in geriatric dentistry, and made students more open to treating senior patients during their clinical training.

As an added component, some programs included sensory experiments with students, prompting them to experience hearing, vision, and taste experiences from the viewpoint of impaired seniors. The experiments greatly heightened student awareness of the challenges facing elderly people with sensory limitations, and enabled them to develop more empathetic approaches to providing care.

.....
“Geriatric training needs to include a continuity of exposure and experience –beginning with talking to the elderly, spending time at their care facility, learning the educational component, and then treating these people.”

–Dr. Robert Henry
.....

Handling the senior population boom with a diminishing workforce

2010 is targeted as a year when many dentists will be retiring, the same year, in fact, that the first baby boomers will reach retirement age. This poses a critical concern to the dental workforce, which is already struggling under a shortage of providers qualified to handle older patients. With this population boom, how will the dental industry support all these people?

The group discussed several solutions:

- ❑ Motivate non-retiring dentists – Increase focus on seasoned, non-retiring dentists and provide incentives and motivation for them to advance their training in geriatric care. Many practitioners aged 45-60 have years of experience and skill, yet may lack the training and desire to treat elderly patients. The dental industry needs to get creative in encouraging these dentists to extend their expertise into effectively treating the elderly.
- ❑ Provide opportunities for retired dentists – Promote programs that provide opportunities to retired dentists who are interested in part-time work with senior patients. Dr. Berkey noted successes with programs like this, claiming many retired practitioners miss being in practice and need to feel useful, but only want to work one or two days a week. After providing some general geriatric training, Dr. Berkey has found these dentists to be “great with patients and energized” by the opportunity to help elderly people. An added benefit is that these retired dentists are less concerned about salary and more focused on providing quality care.

For more information on the Institute for Oral Health, please visit: www.iohwa.org.

Improving oral health care for functionally dependent elderly

Studies show that over 80% of seniors in nursing homes are dependent on assistance for bathing, a functional capacity that's often cited as the first to go in older people. These patients can no longer brush their own teeth, and too often, caregivers prefer to avoid dealing with patient's mouths, so oral health care grows neglected. The panel agreed that this neglect is a serious health care concern, contributing to the already compromised systemic frailties of these patients.

In nursing homes, the upside is that at least minimal oral health assessments are being done and there's a mechanism to pay for them, some even covered by Medicaid. However, an even greater need has been discovered in the homebound elderly. As Medicaid offers no dental benefits for homebound seniors, even people who want to see a dentist often cannot afford to do so.

It's imperative that the dental industry raise awareness and promote improvements in the quality and accessibility of care for functionally dependent seniors, including:

- ❑ Ensure that nursing home patients receive the basic, daily dental care they need to support their overall health.
- ❑ Lobby policy makers and carriers to provide more affordable and flexible dental benefits for the elderly.
- ❑ Develop no-cost or low-cost opportunities for homebound seniors to receive oral health assessments and (at least) basic dental care.

For more information on the Institute for Oral Health, please visit: www.iohwa.org.