GERIATRIC DENTISTRY

PROCEEDINGS OF A MULTI-DISCIPLINARY CONFERENCE

November 3, 1978

DEPARTMENT OF PREVENTIVE AND COMMUNITY DENTISTRY

College of Dentistry
University of Iowa Iowa City, Iowa

PARTICIPATING HEALTH CARE DISCIPLINES:

DENTISTRY
NURSING
NURSING ADMINISTRATOR
MEDICINE
PHARMACY
SOCIAL WORK
DENTAL HYGIENE
AGENCY ON AGING

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The Iowa Gerontology Center, Oakdale, Iowa
Dr. Thomas Walz, Director

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DEPARTMENT OF PREVENTIVE AND COMMUNITY DENTISTRY
COLLEGE OF DENTISTRY, UNIVERSITY OF IOWA
IOWA CITY, IOWA 52242

Participating Health Care Disciplines:

Dentistry, Nursing, Nursing Administrator, Medicine, Pharmacy, Social Work
Dental Hygiene, Agency on Aging

Conference Inter-disciplinary Planning Committee:

Dr. Roger Simpson, Covener (Dentistry)
Dentistry: Dr. W. Philip Phair, Dr. James Beck, Dr. Derek Willard, Dr. Ronald Ettinger, Dr. Robert Glenn, Assist. Prof. Jamie Sharp, Dr. Nelson Logan
Dental Hygiene: Assist. Prof. Hermine Hayden, Assist. Prof. Jamie Sharp
Nursing: Prof. Geraldine Busse, RN, MPH
Nursing Administration: Jane Wright, RN
Medicine: Dr. Glenys Williams
Pharmacy: Dr. Dennis Helling
Social Work: Dr. Thomas Walz, Ms. Jean Snow
Agency on Aging: Mr. Russell Proffitt, Director, Heritage Agency on Aging

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PREFACE

This document is the proceedings of a one day conference on "Geriatric Dentistry", planned by an inter-disciplinary committee, and presented November 3, 1978 at the College of Dentistry at the University of Iowa, Iowa City, Iowa. The conference was held in conjunction with a week long emphasis on geriatrics within the health care center of the University, planned under the overall direction of the Iowa Gerontology Center, Oakdale, Iowa. Professor (Sir) W. Ferguson Anderson, M.D., David Cargill Professor of Geriatric Medicine, Glasgow, Scotland was guest lecturer for that week under the auspices of the Ida Beam Distinguished Professorship.

Recognizing the urgent need for more education and training in geriatrics for dentists, the Department of Preventive and Community Dentistry of the College of Dentistry chose an inter-disciplinary approach to the planning and presentation of the issues. Building upon the proximity and interest of other health care disciplines, cooperation was received from the Nursing, Medicine, Pharmacy and Social Work areas of the University. To include the delivery dimension of care to the elderly, a nursing home administrator, who is also a nurse, was invited to be on the Planning Committee. In addition, the Iowa Commission on the Aging was represented in recognition of the significant role of the state structure.

The rationale for presentation of the conference grew out of the continuing concern at the College of Dentistry that oral health care be improved for the geriatric population. In Iowa nearly 17% of the population is over sixty, thus it ranks third among all states in percentage of older citizens. Nationally, there are twenty three million persons over sixty-five, and it is estimated this will increase by forty percent to thirty-one million in twenty years.

Recent data from national health surveys shows that the proportion of prople who are endentulous is decreasing. Thus, new cohorts of elderly will have more of their own teeth and doubtlessly will be more concerned about their oral health. If this change in basic values of the elderly is combined with greater economic resources as, for instance, dental health insurance programs, a qualitatively different elderly consumer can evolve. A correlary issue is the readiness of the dental profession to respond to such a change.[1] Our optimisitc expectation is that all of this will result in a higher level of oral health for the elderly, thus enabeling them to maintain a fuller range of physical, social, and psychological functioning.

It is also indicated that future practioners will grow in their capacity to deal with the special needs of the elderly person and to view their own specialties within the larger context of total patient care. Substantive problems such as impariment of hearing, sight, mental acuity; disabilities that restrict mobility; dental changes; socioeconomic changes (such as loss of income or family members), access to care, nutrition problems; the presence of multiple simultaneous diseases and drug therapies; and the special need for health assistance, all of these mandate a team approach to total patient care. Thus, the proceedings are as much focused upon multidisciplinary approaches to care as upon the substantive needs of the aging patient.

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1. Ettinger, R.L., Beck, J.D. "Social and Behavioral Aspects of Geriodontics; Implications for Dentistry". A paper presented for a symposium at the International Association for Dental Research, 57th, March 30, 1979, New Orleans.

INTRODUCTION

The goals identified for the Conference were:

1. To identify myths and steriotypes associated withaging.
2. Tod describe the physiology of aging.
3. To analyze selected medical pahtology associated with aging.
4. To describe the psychological adjustment to aging.
5. To describe clinical dentistry for the geriatric patient.
6. To demonstrate and evaluate a team approach to health care of older persons.
7. To identify and involve other health care professions in the planning and presentation of the Conference.

The interdisciplinary Planning Committee consisted of:

Dr. Roger Simpson, Covener, Department of Preventive and Community Dentistry
Dr. W. Philip Phair, Professor, Department of Preventive and Community Dentistry
Dr. James Beck, Associate Professor, Acting Head, Department of Preventive and Community Dentistry
Dr. Derek Willard, Assistant Professor, Department of Preventive and Community Dentistry
Dr. Robert Glenn, Assistant Professor, Department of Preventive and Community Dentistry
Dr. Ronald Ettinger, Associate Professor, Department of Removable Prosthodontics
Assistant Professor Jamie Sharp, Director of Continuing Education, Dental Hygiene
Assistant Professor Hermine Hayden, Dental Hygiene
Dr. Nelson Logan, Professor, Assistant Dean, Curricular Affairs
Assistant Professor Geraldine Busse, College of Nursing
Dr. Glenys Williams, Department of Family Practice, College of Medicine
Dr. Thomas Walz, Director, Gerontology Center, Professor of Social Work
Russell Proffitt, Director, Heritage Agency, Iowa Commission on Aging
Jane Wright, RN, Administrator, Beverly Manor Nursing Home

The audiences for which the Conference was designed included: for the morning program, students and practitioners of the health care professions; and for the afternoon program, senior dental students, senior dental hygiene students, plus practicing dentists and dental hygienists.

Since the morning program encompassed a wide range of students and practitioners from various professions, it was designed to provide a basic introduction to the state of geriatric medicine and dentistry, plus an emphasis on the significance of the team approach to inter-disciplinary care for the geriatric patient.

The major presenter was Professor (Sir) W. Ferguson Anderson, M.D., David Cargill Professor of Geriatric Medicine, Glasgow, Scotland, a pioneer in the development of geriatric medicine.

The Conference was supported, in part, by the Oosterhuis Fund of the College of Dentistry.

Following Professor Anderson's address, the inter-disciplinary team approach was presented by use of a scenario of an elderly person in crisis with multiple problems requiring an interdisciplinary team approach. The scenario was analyzed by a panel of practitioners from various health care professions. The Panel focused on two facets of health care: 1) the unique roll of each health care professional to help the person in the scenario, and 2) the expectations of each health care professional in regard to others of the health care team.

For the afternoon program, the emphasis was on the role of the dentist and dental hygienist, as members of a health care team, in respect to care for the elderly. Thus, the participants in the afternoon were senior dental students, senior dental hygienists, practicing dentists and dental hygienists.

To introduce the afternoon program, a dentist providing geriatric care, and professor of geriatric dentistry, in the person of Dr. Kenneth Freedman was invited to make a presentation on methods of providing dental services for the elderly. Dr. Freedman is a private dental practitioner in Chicago, Illinois and a Professor of Prosthodontics at the University of Illinois,

College of Dentistry. He brought his van and portable dental equipment to the Dental College, so all participants could see it. He demonstrated how he is able to deliver care to elderly persons who cannot visit dental offices. In addition, a leading dental hygienist and educator, Shermie Schafer, RDH, MS, School of Dentistry, Universtiy of Indiana presented the dental hygienist's role in geriatrics.

A major effort was directed toward involving the audience in a dialogue to develop plans for dental care of elderly persons, using 4 varied scenarios.* Leadership for workshop groups was provided by the senior dental and dental hygiene students who had been trained in group techniques for this occasion. Following the conclusion of the workshops, reports were made from each one at a plenary session, with a critique of the workshop groups' decisions by Dr. Freedman and Ms. Shafer.

This report of the proceedings of the Conference includes the following:

A. Presentation of key-note address by Professor (Sir) W. Ferguson Anderson. "The Advantages of an Interdisciplinary Approach in Meeting the Health Care Needs of the Elderly".

B. Inter-disciplinary Panel discussion of scenario of elderly person with critical health care problems, including a significant dental compoent.

C. Dr. Kenneth Freedman, "Delivering Care in Nursing Homes".

D. Professor Shermie Schafer, "A Dental Hygienist's Role in Geriatrics".

Our deepest appreciation is expressed to The Gerontology Center, and to Dr. Thomas Walz, Director for their cooperation and enthusiastic support of this Conference on "Geriatric Dentistry".

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*Scenarios used were: "Industryville" (H.M.).), "Goodfellowship Home", "Rural Town", and "Middletown". See appendix.

"THE ADVANTAGES OF AN INTERDISCIPLINARY APPROACH IN MEETING THE HEALTH CARE NEEDS OF THE ELDERLY"

Sir William Ferguson Anderson, M.D.,
IDA Beam Distinguished Professor and
David Cargill Professor of Geriatric
Medicine, Glasgow, Scotland.

The great problem of the next twenty years is the numbers of very old people, i.e. 80 years and over. It's not the numbers of older people, because people from 60 to 75 go about their own business keeping very well, and not causing much trouble. Health care for the elderly is going to be most important in the future. If we're going to have this massive increase in the number of very elderly people (a 96% increase of people 80 years and over) in North America, then obviously, the only way to try to cope is to keep people fitter until they reach their extreme old age. In all countries this demographic change is happening: what's perhaps more remarkable is that in the so-called "underdeveloped" countries it's even more marked. It's only when the number of very old people begin to increase rapidly that some sort of methodology is needed.

All over the world people are moving from rural areas into the towns. Many feel that the older people fare best in small communities where everybody knows them. What happens in the large megalopolis is that older people get lost and are forgotten. They don't seek help, but have to be sought out. So, we're going to see a lot of people extremely old, predominantly women and mainly in cities. Chebotarev (1964) showed this so well in the Soviet Union in a survey of 27,181 people 80 years and over. At the age of one hundred, there were seven times as many women as men. Perhaps nothing would improve the mental health of older women more than prolonging the life of older men.

Unreported Illness

In Edinburg many years ago, Williamson (1966) performed a survey of people 65 years and over, all of whom had their own doctors. Those who knew they were ill, who had respiratory disability, perhaps breathlessness, who had swollen ankles, cardiac disability or who couldn't move an arm or a leg, because of nervous disease, nearly all went to their doctor. The older people who were troubled with their waterworks or couldn't walk very well, or had painful feet or were dizzy when they bent down from anaemia or were demented by and large did not report these illnesses to their own doctor. Surveys have shown that urinary incontinence is commonly found among older people. The majority do not seek advice because if they bring the subject up to a visiting daughter or relative the tendency is to say "well, that's what happens when you are about 85." So there is inborn resistance among elderly people to seek advice. It's a common syndrome because we all think "I've been fit for 70 years, I'm not going to be ill now", or "what will happen to me if I admit to being unwell?" There is ample evidence that morbidity increases with age. People do tend to take ill when they're older but mainly with remediable disease. One can do something for almost anybody with cardiac failure. One can help most of the people with anaemia. One can improve those with urinary symptoms. About 12% of the people in our country who come with deafness, have got wax in their ears, and failing sight can be remedied very frequently by getting proper glasses or by a change of glasses, or sometimes by a fairly minor operation. So, it is not a hopeless proposition. You can do so much for older people. People don't get to be 80 unless they are made of good material.

Disability Survey

We were looking for the prevelance of major disability and defined it as, "The inability to live an independent existence." A random sample of

808 people living in their own homes showed that about 12% of people 65 - 69 were unable to live without some kind of help. For those 85 and over, 80% of the people living in their own homes in the community, had to have help of one kind or another, so with increasing age, there's an increase of disability. (Akhtar, A. J. et al., 1973) It means that when we are considering a great number of very elderly people, we have to think of developing many services of many different types.

The two great groups of disease that were the cause of disability were 1) cardio-respiratory disease, 2) neuropsychiatric disorder. Remember, the only major difference between young and old is a loss of reserve in organ function. More older people are ill because they get disease on top of a diminished reserve.

If you look at women 75 and over with organic neuropsychiatric disorder, there are two great problems. First, disorders of posture which relate to balance. That's why we have to think of alterating their houses so they won't fall. The next group is nonvascular, mental disease of unknown origin which is called "dementia", but what is really usually nonvascular disease of unknown origin.

Dietary Intake

A random sample of dietary intake in the elderly may give an indication of disease. Older people require an intake of 64 milli equivalent per day of potassium. Eight percent of the men and 13 percent of the women we surveyed were taking less than 40 milli equivalents of potassium per day. This insufficient intake of potassium does not mean that they were suffering from potassium deficiency, because the actual amount of potassium that people need varies from person to person. It is possible that some person who is on a borderline intake of potassium may become ill with influenza or

gastroenteritis and slip into potassium deficiency or may be prescribed a medication which may cause excessive excretion of potassium. The older person may go to the doctor complaining of fatigue. The doctor may consider that this is natural for a person who is 85, because the doctor himself may be feeling tired. Unless it's in the doctor's mind, he's not likely to think of potassium deficiency. Similarly with Vitamin D deficiency. Many of these people surveyed had a very poor intake of Vitamin D and 22 percent of the men and 32 percent of the women were taking less than the minimal requirements. We came to the conclusion that that wasn't really as important as the lack of sunlight. Although many had a poor intake of Vitamin D, if in addition they were widow and were frightened to go out and didn't get sunlight, they might develop osteomalacia. This data only shows that their intake of certain essential nutrients was less than might be expected.

Drugs and Elderly

Now, the other significant thing is that old people like medicines. They go with many complaints to the doctor and the doctor wants to give them something for each complaint. When they return and say that the first group of medicines didn't work, they may get a second group of medicines. Old people may be taking many medicines unknown to anybody. When we did our surveys we found that the doctor was not fully acquainted with what the old person was taking nor was the nurse and many of the old people could not tell you themselves. Before people are discharged from hospitals, I believe there should be a trial period where they're given their drugs, as if they were at home and observed to see if in fact they can take their medicines. There's quite a high proportion of older people who are unable to take their own drugs. In a BMA report published not long ago, we suggested that in every household where there's an elderly person being looked after

by a doctor, there should be a typewritten card in the house detailing what medicine the old person is suppose to be taking. Also, there will be a group of the elderly who will have to be attended by either a nurse or trained volunteer or a relative who will take charge of the drugs prescribed for the old person because these elderly people cannot control their drug taking by themselves.

Many of these drugs cause postural hypertension and it has revelance to dentistry. Sometimes unusual things happen where you're giving more than one drug. Watch must be kept for side effects.

Retirement

When people retire they may lose status and security. They may lose companionship because of bereavement. Their physical health may deteriorate. Thus they may become depressed, and this must be looked for. A man may retreat into himself once his wife has died and not want to go out and so he becomes malnourished. Compulsory retirement can cause unhappiness among the elderly and was one of the reasons why in Glasgow pre-retirement training was started in 1959.

Mental Illness

The incidence of "chronic brain syndrome" increases with age. Perhaps better terms may be "acute brain failure" or "chronic brain failure" and "functional mental illness". It is important to assess why the brain has failed rather than assume that there may be fewer neurons. Acute brain failure may be caused by fever which may upset the brain temporarily, and of course, that is completely remedial. The prevelance of these disorders in old persons is high. Some depressed older people may have somatic symptoms such as pain in the jaw as an expression of their depression. It is, however, false to think that old people don't feel pain. However, pain sensation may

be altered so that a fractured femur in an old person due to a fall may be painless and the person may only complain of an inability to move the leg. They may no complain of pain and they may have forgotten that they fell. So, they may be sent into hospital as having had a stroke.

Diagnosis

Diagnosis of diseases of the abdomen in elderly people, may be difficult. They may have an intra-abdominal catastrophe without pain. Most of us have become experts at diagnosing an appendix abcess in the elderly, but very few of us are good at diagnosing appendicitis in the elderly. Postural mechanisms also are upset. Disturbances of balance are one of the great causes of distress and disability among older people. Postural control becomes impaired with age, and there must be implication for that in dentistry. There are many dentists who treat their patients in the horizontal position. So when returning the person to an erect posture again, the old person may become dizzy or giddy for a little while and must be given time to recover their balance.

Temperature regulation is impaired in many elderly persons, so they are unable to notice the changes in ambient temperature and may become hypothermic. Many old people don't feel thirst like young people and may become dehydrated.

Fatal domestic accidents and falls increase dramatically with age, and so houses often have to have alterations such as safety handrails around toilets, or bars down corridors.

So often the elderly have a multiple pathology. They have many little illnesses which are cumulative in their effect. This is especially in respect to people who are dying. They may have one great disease which is killing them, and they may have an apthous ulcer or some condition in their mouth

which makes life unbearable. So, they have to be examined carefully. A prolapsed haemorrhoid may make for tremendous discomfort in the last few days of someone who is dying with some different type of cancer.

Now, insidious onset of disease in very old people is a diagnostic problem for doctors, because very serious pathological disorder may present in a very quiet way. Perhaps the best example is that of an old man who gets pneumonia and who becomes confused. His doctor may come in as usual in the morning, and the old man may say, "who are you? What are you doing in my room?" He doesn't know who his doctor is. He doesn't have chest pain, haemoptysis and the clamant symptoms of young people and yet he has a serious illness. Again, an old man may be walking along the street, becomes slightly breathless, and wants to hold on to the railing or sit down on the curb. This may be the only sign that he's had a coronary thrombosis; this demonstrates the quiet onset of illness and very frequently the illness is essentially remediable.

A typical presentation simply means that older people have symptoms which are rather different. They may, for example, have pain in the wrong organ. Pain in the neck may in fact be due to a peptic ulcer, which makes diagnosis very difficult for the doctor. The first essential for curing older people is to believe them. When the doctor can't understand his patients' symptoms, he is liable to say, "this is a neurotic person" or "this person is hysterical", or even worse, "what a senile old man". It is essential to believe the patient and to work through the possible problems until you get the right diagnosis. Some chronic diseases used to present about 15 years earlier than they do now. We see a little scurvy every year about spring time, usually in old men. We see many people with rheumatoid arthritis presenting, for the first time, at 75. Some diseases have changed

with age. Tuberculosis has become a difficult disease to diagnose in the elderly because it may present as a pyrexia (fever) of unknown origin; or, in one case seen recently as an osteo-arthritis of the cervical spine, which was a tuberculosis spine. The elderly may have symptoms which are not usually regarded as important. An old man who comes into the doctor and says "I keep falling all over the place". He may have almost any disease in the book. This simply is a cry for precise and accurate diagnosis. I believe it should be regarded as are the fits or convulsions in an infant. No mother would be happy if you said "your child is having convulsions because he is three years old". So, nobody, especially no relative, should feel happy if the doctor says "your mother of 85 is falling because she is 85". Mental confusion is the same. A rash in a child is the way I compare it in my mind. Again, a mother would be upset if you said, "your child has this terrible rash because he is four years old. Children of four take a rash like this". This would be difficult to believe. Similarly for the man of 78 or 79 who becomes confused, we must say to the relatives, "we have to find out why this person has become confused". Incontinence has often been missed because the patient hesitates to mention it for many reasons.

This is perhaps the most important part for any future plan; and this, of course, is where the dentist plays a part. We have in our team domiciliary dental care for the elderly. That is absolutely essential, because innumerable surveys in the U.S.A. and in Scotland have shown how people neglect their teeth in old age. Often they have a denture, which they think should last them their life. They think, "I've got teeth, they'll last me all my life." How worthwhile it is to alter dentures and to make life so much more worth living. I want to add one word. If you asked "what is the most important thing about old age?", I would say it's the preservation of

mental health, and mental health is bound up with morale, and morale is bound up with appearance. What old people look like is extremely important. They should look neat and clean and tidy and attractive. There is no doubt that here, the dentist has an immensely important part to play. When an old person takes ill, we believe that the assessment should take place in that person's own home. At the moment, we are doing this with doctors who visit the patient in their own home and get a picture of their house. "Is it a house that the people can stay in? Will the house need to be altered because of some disability which has now occurred in the old person? Will the relatives want the person to come back there? Are there any relatives? Is there any affection in the house?" If the old person happens to require admission into hospital and it's going to take two or three days to find a bed, the mental health in that person should be stimulated. The relative should say, "We're not sending you in because we don't like you, we're sending you into hospital to have a thorough diagnosis." Then, after the assessment, and diagnosis, at home if the patient does not require hospitalization, therapy and follow-up. That should occur whether the patient goes into hospital or is kept at home. In our own unit in the hospital, we have two community nurses (two district nurses) attached to each unit who go around the ward with us and follow-up every patient going back to their own home to make sure that the service that has been asked for, has been carried out and to find out how the old person is getting on at home: are they taking the proper medicine?

Preventive Measures

We must try to keep elderly people fit, and one way of doing this is by pre-retirement training. The one that interests me most is part-time re-employment of old people. I'm sure that if I live long enough, I'll see

developed countries planning to have a third career for people who want it. We just can't have individuals from 60 to 65 living to 80 and doing nothing, if they want to have some type of part-time employment. The point is that we must encourage flexible retirement policies.

The Continuing Treatment Hospital Unit

One more word about the "long-stay" bed. There are so many activities taking place in such units that continuing treatment beds should be the correct name. There is the attention of nurse, occupational therapist, the physician, the speech therapist, the music therapist and other specialist, physicians, surgeons and, of course, dentists, plus the podiatrist and the physiotherapist. All of these people are working with individuals who have gone through a diagnostic unit. It's not a static unit: rather, it's a unit where many things happen.

Health Centers

A health center where all the services can be localized into one place is a unit which is of some value especially in deprived areas. The general practitioners practice from there and the total services for the area are there. The dentist has a good set-up in such a health center, and is of great use to it. It means that the old person or the relative only have to come to one place.

Education

Now I would like to speak about other people who need to be consulted. We have to educate the architects, town planner, students of religion, and such people. There are going to be so many old people that we should be building houses with 36 inch doors so that wheelchairs can go through the doors. We should be planning all our cities as if they were going to be used mainly by the elderly. We should be thinking of airports, and airplanes

trains and buses with regard to old people. These things should be done now and we shouldn't be caught in five or ten years time without appropriate facilities. For example, in a home for the mentally frail, about 30 mentally frail people (all of whom have been through a diagnostic unit) can be grouped together. They need minimal attention, don't upset one another, and don't have to be in the hospital. In a home for physically frail people, we made one big mistake, we didn't put units of sheltered housing around it. These individuals, with continuing supervision and care, do extremely well -- much better than we had thought. People whom we thought would be there permanently are often able to go home and certainly would have been able to go to some type of sheltered housing.

In our country, many people are bedridden for a long time before they die. In places like Singapore, most of the individuals are thin, most of them are mobile and they are really up and about quite shortly before they die. I think we can learn a lot from other countries. We had a World Health Organization Committee on the Aged about four years ago, and the Committee came into being really because specialists from the underdeveloped countries, went to the World Health Organization and said "we're going to have a lot of old people and we don't want to make the same mistakes that the developed countries have made. Please form an expert committee and see if you can do it any better in the future." We did, and we published quite a good report, but few people have ever seen it. (WHO, 1974).

Then lastly, I wanted to point out this: Countries have no idea what's going to hit them. In Britain now, if you look at the cost of hospital and community health services for people 75 years and over, it costs three hundred and fifty pounds per person per year. That's $700 per person 75 years and over, per year. If you look at the other services, of course,

the bill becomes quite astronomical. So what we must do is, we have to plan preventive measures. We've got to keep our old people healthy. Not only for their own good; and not only because they want to be healthy, but because it's the best and most humane way to do it.

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GERONTOLOGY CASE ANALYSIS BY INTERDISCIPLINARY PANEL

INTRODUCTION

This scenario of an older man, with numberous physical, social, and financial problems, was developed by the Planning Committee to include major issues requiring interdisciplinary solutions for adequate care.

The intent was to demonstrate before the audience, how professionals from various health care disciplines approach the evaluation of such a case. The panelists were asked to focus on two issues: first, how they would evaluate the case from the standpoint of their discipline; second, what they would expect, and what questions they would have for others on the panel who would be considered a part of the health care team for the person in the scenario. Each person in the audience had a copy of the scenario.

The panelists, and the order of their presentation were:

Medicine: Robert Rakel, M.D., Professor and Head, Family Practice, College of Medicine, The University of Iowa. He was in private practice ten years. He is author of A Textbook for Family Practice, 1973, Principles of Family Practice, 1978, and Yearbook of Family Practice.

Nursing: Geraldine Busse, R.N., M.P.H., Professor of Nursing, College of Nursing, The University of Iowa. She was a public health nurse in Wisconsin and Iowa for a number of years. She is the author of many articles.

Pharmacy: Dennis Helling, Pharm. D., Professor and Head, Division of Clinical and Hospital Pharmacy, College of Pharmacy, The University of Iowa. He is involved in interdisciplinary team teaching regarding geriatric drug therapy. He has numerous publications in this area.

Nursing Home Administrator: Jane Wright, R.N., Administrator, Beverly Manor Convalescent Center, Iowa City. She has been with this home for 14 years. She is a national leader in her field and past-president of the Iowa Health Care Association.

Social Work: Tom Walz, Ph.D., Professor, School of Social Work, and Director, Geriatric Center, The University of Iowa. He is past-head of the School of Social Work. He was director of the Peace Corp in Central America. Among his many writings are: The Upsidedown Welfare State and Humanizing the Bureaucracy.

Dentistry: Kenneth Freedman, D.D.S., Private practice in geriatric dentistry, Chicago, and Professor of Prosthodontics, University of Illinois. He is a national leader in geriatric dentistry and past-president of the "American Society for Geriatric Dentistry" and Project Director of the "Geriatric Oral Health Nursing Home Program." His numerous writings include a book on

Summary: Professor Anderson.

SCENARIO

An elderly man is found by a neighbor collapsed in the yard of his home. He is semicomatose and confused and taken to the hospital.

A. Personal Information: The man is a 76 year old widower of eight years, has no children and lives alone in his small house. His income is limited to a small savings account and a social security check of $210.00 per month. He is not eligible for Medicaid as the eligibility limit is $197.80 per month.

B. Medical Information: He is a diabetic using insulin, is being treated for high blood pressure and suffered a cerebro-vascular accident six months ago which left him with a left sided hemiparesis.

C. Mobility Status: The man uses a walker to ambulate and occasionally needs assistance with walking in open areas. He is unable to maneuver stairways. He can no longer drive his automobile and is unable to use the public bus service. He has relied on assistance from neighbors or friends for his transportation needs.

D. Dental Information: This man has not been to a dentist in twelve years. It was found that he was wearing a poorly fitting upper denture against six lower front teeth. He complains of discomfort under his denture and he indicates that two of his teeth are very loose.

E. Nutrition: This man has lost a considerable amount of weight possibly related to poor nutrition. As he has no family he has difficulty getting to the stores on a regular basis and relies on his neighbors to take him. He has great difficulty chewing meat, fresh fruit and vegetables and avoids them.

F. Questions:

1. Who is responsible for the rehabilitation of this person?

2. Can he be returned to his home and what services will be needed and who will coordinate them?

3. Please describe the care you think this patient needs and can afford.

PANELIST FOR MEDICINE

Robert Rakel, M.D., Professor and Head, Family Practice
The University of Iowa

The scenario we are discussing describes a 76 year old man, a widower for eight years, who was found collapsed in the yard of his home in a confused, semicomatose state and then taken to the hospital. One thing I would like to stress is that even though such a patient is almost comatose, or is aphasic, or relatively unresponsive, he is still able to comprehend. Too often, because the patient is not able to talk or communicate we make the mistake of assuming he does not know what is going on. We then make comments at the bedside that are entirely inappropriate and which the patient will remember or at least register at the subconscious level. Under hynosis we have found that people are often very aware of what is going on. This also happens when a patient is coming out of an anesthetic. If you are giving an anesthetic, don't turn and make a wise-crack to someone else in the room, thinking the patient cannot understand, for they usually are very aware of what is happening. Even if they are not consciously aware of it, their subconscious registers it and the patient may harbor hostility that neither he nor you will understand the reason for.

This patient has diabetes mellitus and requires insulin for control. He has been treated for high blood pressure and has had a cerebrovasuclar accident six months ago that left him with a left-sided hemiparesis. Our major medical problems then, are: diabetes mellitus, hypertension, stroke (old), and a nutritional problem.

Let me focus first on the diabetes mellitus. One of the problems of patients with diabetes mellitus is that they have accelerated arteriosclerosis. This may have been the reason for his stroke but the hypertension certainly contributed to it as well. One of the problems in a 76 year old person

with diabetes who lives alone is that of really understanding what the medication requirements are, and administering the medication properly. This patient is on insulin and we must make sure he can see the syringe adequately and measure his dose accurately. If he cannot, we have special syringes that can be precalibrated; however, we must first be aware that his sight may be failing or that decreased vision is a significant problem. We also must be sure that insulin is necessary. Many older people, if they are on small doses of insulin may be able to do well without it. We have to a least consider this as a possibility.

Hypertension is one disease for which I would like to ask your help as a dentist. One of our greatest needs in medicine today is to detect the presence of an elevated blood pressure. Hypertension has greater morbidity and mortality associated with it then most other diseases. Even though we can manage the disease and prevent many of its serious sequelae such as strokes, we aren't able to, because we are unaware of many of the people who are hypertensive. Until the past few years half of all hypertensives in the United States were undetected. Of the half that were known, only half of them were being treated. Of those receiving treatment, only half were being managed properly with their blood pressure under good control. That means only one-eighth of all the people in the United States with hypertension were receiving adequate treatment. We now have medications capable of controlling almost all cases of hypertension and thus have the ability to prevent many strokes. The policy in our Family Practice offices is to take the blood pressure of every patient seen in the office no matter what the reason for their visit. In the past, a patient would be seen for an acute problem such as a laceration, but there would be no thought of taking their blood pressure, since that was not the reason they came in.

We now take blood pressures routinely and encourage dentists to do the same. You see many patients that we do not and this is a golden opportunity to detect this problem that should not be missed.

This patient has a left hemiparisis as a result of his stroke. Was he left-handed or right-handed before the stroke occurred? If he was left-handed before the stroke, he needs help learning to use a cane, since the cane needs to be used in his good right hand. If he had been left-handed, he may have more difficulty using his right arm for stabilization.

Is this patient also anemic? This would not be unusual because of his poor diet. He may have a folic acid deficiency which is a relatively common cause of anemia in the elderly. Anemia superimposed on cerebral arteriosclerosis could contribute to anoxia of the brain. Too often problems of this nature go undetected with the elderly person's diminished mental acuity being attributed to senility or old age, and no attempt is made to search for a correctable cause.

Since we are here as an interdisciplinary team, let's talk about who should be the leader of the health care team. I am not hung-up on it always being the physician. Another health professional may be more effective in this role, especially when the patient is elderly, living at home, and requires home visits. These patients often relate better to a social worker or visiting nurse. The team leader is really the person the patient turns to for advice or care most often. It may be the dentist, the nurse, the social worker or the physician.

We also need to be alert to the possibility of infection in the elderly, since they may not develop fever as readily as a younger person. Tachycardia may be the only sign of infection. The white blood cell count may not become elevated but there usually will be a shift to the left on the differential.

We must also watch for depression in the elderly, since it too may present in an atypical manner with subtle changes not seen in young people.

In 1900 only four percent of people in the United States were over age 65. By 1974 this had risen to ten percent. We are rapidly approaching the time when 12-15 percent of the population will be over age 65. In addition to living longer, these individuals have a high incidence of chronic disease. These chronic problems affect their ability to enjoy life, and many old people say they would rather die than live a miserable existance in these later years. It is our job as health professionals to minimize that disability and improve the quality of life as much as possible for these people during their later years.

PANELIST FOR NURSING

Geraldine Busse, R.N., M.P.H., Professor of Nursing,
College of Nursing, The University of Iowa

It is very important that we know the patient's perceptions of his condition. Therefore, when he is hospitalized, one of the things that the nurse member of the health team would try to do is to gather data about his symptoms and his past experiences. For example, the nurse might ask, "Do you remember what happened to you?" He might say that he fell because he was weak and forgot to eat after he had taken his insulin, or because there was a break in the sidewalk. As we grow older, our eyesight and hearing sometimes is not as acute, and so, if there is a distraction, we look aside. Then, before we know it, we've fallen. Therefore, in the assessment of this situation, the nurse should do a careful history of the client's health habits. This information, as recorded by the nurse on the client's hospital record, would help the health team to gain insight into the client's understanding and feelings about his condition. This data would give clues to the client's expectations and his plans upon discharge from the hospital.

The nurse in giving personal care (such as the administration of insulin and other prescribed drugs) could ascertain how the client manages to take his medicines at home. There is some research that indicates that persons have difficulty complying with medical schedules. The nurse has the opportunity to teach and cousel the client about the necessity of maintaining a prescribed regimen. The nurse may help the client develop some visual aids such as a check-off calendar, with the time of day he takes certain medications or when he does certain activities, like urine testing. This type of record could be continued by the client after his hospital discharge. The community nurse* often uses the calendar idea to determine if the client is complying

*"Community nurse" is the term used to describe a public health nurse or a visiting nurse.

with his prescribed regimen. The calendar also reminds the client of his medical and dental appointments.

The scenario points out that this man did use a walker, but sometimes these kinds of appliances are not properly fitted. The nurse would observe how he ambulated and then would initiate a referral within the hospital to other personnel, such as the physical therapist or to the brace maker if an adjustment to the walker were needed.

In the daily contacts, we find out the person's own idea about what he would like to do. Maybe, for instance, the man in the scenario feels that he has to return to his own home. Then we need to ask him the qestion, "Is this really a safe place for you? How did you manage before your fell?" The client could be helped to assess his resources realistically.

Sometimes we find that persons like the man in the scenario have their own buddy system. Maybe his buddy system is the card-playing group at the pool hall, who have been his transportation group, who were doing his shopping, or even giving him his insulin. When one of these persons also is ill and cannot be depended upon, it is necessary for the nurse to help the client know what community resources are available. Then, acting as a liaison person, we would refer them to the social worker and other resources. We need to be aware of both the informal and formal community organizations (like the community nursing service, which, in Iowa is a home care program paid for by third-party payer). Often a person like the one in the scenario has a big worry about "who is going to pick up the tab?" Those who have limited income often need help to find out to whom they can go for financial advice. Health professionals need to be aware that the "con-artist" is also working in the health field. For example, in an Iowa town, recently, people were going from door to door asking older people if they could test their hearing--hoping to

sell them hearing aids.

The nurse needs to be the advocate for the patient. If the man in the scenario, for example, believed that he could no longer function in his own home, the nurse could help him to find a different kind of housing. He would be informed about extended care, or some type of sheltered housing.

We really must allow the client to be the leader of the team, for he lives with his body and mind twenty-four hours a day and knows his feelings and expectations. The health professionals can only have success if we recognize his goals and work with him. Too often the health professionals have only done things to and for the patient and not always with the patient.

Another function that all of the health team members have is that of prevention. In our state, we have a number of congregate meal sites where blood pressure is taken regularly, health histories recorded, and dental needs can be assessed. In some areas, we have well established, well-elderly clinics where nurses, physicians, and other health professionals meet together and decide, with the aged community leaders, what needs to be done. There must be regular follow-ups of these clinics; otherwise, to do screening means that we just have a lot of data with which we can play. In one community, a public health nurse with the assistance of some volunteers has a footsoaking group, and they help the elderly with toenail trimming. This may not seem like such an important factor, but if you cannot see well and if you cannot walk because of sore feet, you are home-bound. This activity arose out of a Well Elderly Clinic because of an identified need.

Each of us, in our own way, contribute our unique functions. The nurse's role is primarily as an advocate of the patient and being a liaison with the resources that are in the community (i.e., meals on wheels, homemaker service). She must be familiar with the community to know the informal kinds of services

that are available such as a service club which is interested in helping persons with strokes, or an association for diabetes. The nurse, like all health professionals, is a counselor and teacher. We all are role models for health. Our clients observe our health behaviors. In the hospital and the home, the nurse teaches clients how to observe symptoms and take appropriate actions.

PANELIST FOR PHARMACY

Dennis Helling, Pharm. D., Professor and Head,
Division of Clinical and Hospital Pharmacy,
College of Pharmacy, The University of Iowa

In addressing the scenario first as a pharmacist, I have questions about how compliant the patient has been with his insulin. Is his semi-comatose and confused state a result of too much insulin or too little insulin combined with improper dietary intake? Has this patient been receiving on his own, over-the-counter, nonprescription items which can be purchased at drug stores, gasoline stations and grocery stores? For instance, a cough and cold medication might contain some sympathomimetics which, by their nature, can cause an increase in the release of glucose into the bloodstream thereby complicating and confusing the diagnosis as well as the management of diabetes. I think that nonprescription drugs are a very significant factor in the health care of the geriatric patients because most people do not consider these nonprescription items as medications or drugs.

I have concern about this patient's ability to properly fill the syringe, and inject himself since he has left sided hemiparisis. If he is able to inject himself, what assurances do we, on the health care team, have that he is using clean syringes to avoid infection? What kind of proper storage technique of the insulin is he employing? How is he monitoring his diabetes? If he has paralysis, how is he able to test his urine? The scenario does not note the blood pressure, but if the patient is on diuretics (the thiazide diuretics being the most common), we have to be concerned about their hyperglycemic effect.

As a pharmacist, I am concerned as to how closely his medication, both prescription and nonprescription, is being monitored by someone on the health care team. I would like to suggest that if the patient was under our care,

consideration would be given to stopping all his medication. If the patient then becomes symptomatic from his diabetes, we would consider oral hypoglycemic agents instead of insulin in an attempt to facilitate his self-care at home.

A few comments are in order concerning drug use in the United States. In a 1974 study, it was shown that there was a 40 percent increase in the incidence of drug related admissions among those patients that were over the age of 65, as compared to those in the age bracket of 19 to 65. A 1973 study showed that nearly 20 percent of geriatric patients entering a general hospital displayed disorders directly attributable to the effects of prescription drugs. It has been stated that ten percent of the U. S. population is in the senior category and consumes 25 percent of all the prescribed drugs in the country. These patients are not only consuming more drugs, but the medications that they are taking have more potential for problems.

What is the respective role of the pharmacist? I feel that the pharmacist is the resource person for the health care team concerning drug therapy. The pharmacist should be responsible for maintaining an accurate medication profile which will assist him in the monitoring of the proper use and inadvertent misuse of prescription and nonprescription drugs. The pharmacist should be monitoring not only the medications prescribed by the physician, but the dentist, the pediatrist or anyother licensed prescriber. He/she should be trying to avoid accidental duplication of therapies or drug interactions. The pharmacist has an important role in checking for noncompliance. We should be informing both the physician and dentist about noncompliance or significant nonprescription drug usage. We should be encouraging these prescribers to use simple administration regimens, maintaining once-a-day or twice-a-day dosing if possible. We should try to avoid multiple therapies when combination products in some cases might be appropriate.

There are additional concerns about prescription and OTC usage. Let's assume that this patient would be hospitalized and discharged on an oral anti-coagulant. While at home, it is noted that he is having dental pain from an ill-fitting denture. Most home medicine cabinets contain analgesics. Most analgesics contain salicylate products. The potential for a drug interaction in this case is quite obvious, making both the management difficult or possibly leading to significant morbidity.

I feel that the pharmacist should provide the nurse with a medication update on the patient (especially a geriatric patient) and should coordinate with the nurse the provision of medication. How is the patient going to get his medication if he cannot get out of his home? The pharmacist should provide the social worker with the medication needs of the patient, and then help with methods of financial coverage for that patient. To the nursing home administrator, I feel that the pharmacist has an obligation to alert that person to the medication requirements, especially those unconventional or unique medication requirements for selected patients.

In summary, I feel that the pharmacist should directly help the elderly patient in the safe, wise use of drugs. The pharmacist should give extra care in providing patient consultations. Thorough education of the patient about the medication, its use and how to properly take their medicine is an essential pharmacy service. The pharmacist should be routinely checking for allergies and sensitivities.

Easy open caps on prescription vials should be encouraged for the elderly, instead of the FDA required palm and turn type. The elderly patient who has any kind of joint inflammation has extreme difficulty with these palm-and-turn caps. I feel that the labels on prescription containers should be clear and proper storage instructions should be noted. A new event in

recent years regards the bioavailability issue. I feel the pharmacist should be providing quality generic prescriptions when appropriate to minimize the cost for the elderly patient.

Regarding the pharmacist's expectation of other health team members, I feel that we should strive for communication with the physician and dentist. We hope that they would be receptive to suggestions regarding alterations in drug therapy. To the nurse, social worker and nursing home administrator, I would encourage their input regarding home compliance, old prescription containers (which they find on home visits), outdated drugs, and additional information regarding nonprescription consumption.

PANELIST FOR NURSING HOME ADMINISTRATION

Jane Wright, R.N., Administrator,
Beverly Manor Convalescent Center,
Iowa City

The health problems of this elderly man have already been identified and reviewed. The panel purposely did not specify the outcome of his living arrangements following his hospital confinement.

This elderly man belongs at his home, using available community health services, to aide him in his recovery. Contrary to general public opinion, we are not anxious to fill nursing home beds with persons who do not need the services of such a facility. If this man could remain at home, with supervision and assistance, that is preferable.

Nationwide, only five percent of persons over 65 years of age are in nursing homes, continuing care centers, longterm care centers, or other such facilities.

If the decision was made to admit this elderly gentleman to a nursing home, it would, hopefully, be for a convalescent period,with expectation of a return to his home when recovery was evidenced. The nursing home need not be "the end of the line". Today, many patients are returned to their homes, or to living situations within their communities. Many are able to live independently while others need community services such as meals-on-wheels, visiting nurses, home makers services and so forth.

The role of the nursing home would be three-fold for this person. First, there must be monitoring of the health problems this gentleman. We would help assess his needs, establish goals to meet those needs, and plan for discharge as the initial responsibilities of the long term care center. Is he able to inject his own insulin? Can he be mobile? If not, what assistance does he need? What about his dietary needs? Does he understand his diabetic

Can he prepare his own meals? How will he get his groceries? Does he have means to get to his physician and dentist? Can he take his medications as prescribed? Since this man has no immediate family, will he be isolated? Who will look in on him and monitor his needs when he returns home? Those are only some of the health care problems needing solutions to make living at home possible for him.

The second responsibility of the nursing home is patient education. Educating him to be aware of his health needs, educating him on the resources available in the community that can provide assistance in maintaining his health needs, and educating him regarding personal and dental hygiene.

The third responsibility is rehabilitation. More and more long term care facilities are expanding their rehabilitation programs. Only with a quality program will long term patients become short term patients and thus, be able to return to their home and community living.

PANELIST FOR SOCIAL WORK

Tom Walz, Ph.D., Professor, School of Social Work,
and Director, Geriatric Center
The University of Iowa

There are several comments about this old gentleman which I would like to share. My remarks will clearly reflect my social worker perspective.

First, there are many people in Johnson County just like this man in our case study. An estimated 7,000 persons, age 65 or older, reside in the county, of whom at least 10 percent are as incapacitated as this man. In the smaller rural counties of Iowa his situation is of epidemic proportions.

Second, while our case example may be in a near comatose condition, one of the reasons for his situation is that the service agencies are also in a comatose state. He is expected to live on an income of $210 per month. His age permits him to qualify for Medicare. If he could afford a little additional premium each month, he would also be eligible for Part B, Medicare, which helps defray doctors' costs ouside the hospital. As a Medicare patient, however, he will face the usual co-insurance and deductibles. On the average, only 44 cents on the dollar will be recovered through insurance payments. For example, if he only had Part A of Medicare, his expensive, prescription medication requirements would not be covered. This would require a substantial out-of-pocket payment. Likewise, any of his regular outpatient costs - doctor and dental bills would have to come from his $210 monthly pension. Can you imagine trying to manage on an income like that while coping with major illness?

The tragedy of this example is not only the man's poverty, but the "Catch 22" situation of his poverty. In Iowa, if his Social Security income had come to only $208 per month ($2 less than he currently receives) he would have been eligible for SSI (Supplemental Security Income) which in

turn would have made him automatically eligible for Medicaid. With Medicaid he could have received free medical care, including medication and dental work.

For many of us (social workers) our time is spent trying to finesse the bureaucracy on behalf of our client. The law may literally say they are not eligible for certain needed services, but this is not to say that we couldn't figure out alternatives. In the case presented for our discussion, we could try to get the old man eligible for in-home supplementary assistance. This is a limited program, available to persons with special home care needs. If we could get him on it, he would automatically become eligible for Medicaid.

Even if we failed to get our client on Medicaid, this limited income would leave him eligible for a variety of other vital services. He'll need an advocate to get them, given his semi-paralyzed state, a function frequently filled by the social worker.

One of the first community services that comes to mind is "Chore Services." Under Chore, the Department of Social Services would pay a handy person to do a variety of out-of-house chores on the patient's behalf (lawn mowing, grocery shopping, etc.). With his physical limitations, we would expect he would be in need of such assistance.

We might also see to it that our client gets a home-delivered meal. The Johnson County Congregate Meals program will deliver hot noon meals five days per week at no or low cost. Once he is able to get around better, he would be welcome at one of their three Congregate Meal sites where the hot lunch is accompanied by sociability and a noon program.

Should he need transportation to the Meals program or to follow up on his health care needs, the County operates a low-cost, door-to-door transportation service for the poor and invalid.

The most important need, however, is human caring. This, anyone can provide. The dentist and/or the dental assistant can make their own distictive contribution to this man's will to live. Not only does our client's teeth need attention, but his entire self needs our full consideration. When the situation calls for more than casual concern, a referral should be made to a social worker or home health nurse.

As I have indicated, there are many community resources to be tapped on our client's behalf, but the presence of so many makes coordination of these services a continuing problem. When the health needs of a person are the principle need of the client, then we expect the doctor to be pivotal in the coordination of services. In other instances, when other needs predominate, the nurse, social worker or even dentist could be the coordinator. It's not critical who does it as long as service coordination gets done.

PANELIST FOR DENTISTRY

Kenneth Freedman, D.D.S., Private practice
in geriatric dentistry, Chicago and
Professor of Prosthodontics, University of Illinois

I'm going to address the major problems of the scenario. The original responsibility, in my opinion as a dentist, belongs to the physician. It belongs to him until this patient reaches some kind of plateau where they're able to have other kinds of care. Following the improvement of this individual when the emergency situation is past, and when he is no longer comotose, then the evaluation has to begin. The scenario says: "the man has not been to a dentist for 12 years." Does that mean that he wants to go to a dentist? Does that mean he needs any dental care? Who says his teeth are mobile? How mobile are his teeth? Who made that judgement? If it's the nurse on 3 North who may not understand mobility, are they really "mobile"? Some evaluation has to be done by the dentist. He's the one who has to look in the patient's mouth and say "the teeth are mobile." The dentist should begin with removing the acute problem. If he looks in the mouth and says "there's a denture sore", maybe he ought to adjust it, but there are, or may be a lot of areas which could cause problems. Is this denture sore due to the diabetis? Is this denture sore due to the fact that this person has hight blood pressure? The patient is taking diuretics. Do you know what diuretic and all other hypertensive drugs--or at least 98 percent of them do to the mouth? They dry it out. Drying means trouble for the denture and for the denture wearer. Maybe what the problem is, is that the man has a dry mouth and you shouldn't even touch the denture. Certainly, you shouldn't do anything until the patient's general condition is stable. The dentist should never treat them on "the up", which means when they're getting sicker. You should never treat them on "the down".

Good dental care is best provided for that person who in your opinion and the opinion of the multidisciplinary team is on a relatively stable plateau. If you use that as a basis of care delivery, you'll stay out of a lot of trouble. If there's poor healing, you may never get rid of a denture sore.

Now, let's be more realistic. What has to happen after the patient gets better is that the dentist has to speak to the patient. This means history taking and consent forms. The physician is in a very unique situation in that they've got a process whereby they put you in the hospital and you sign the forms and everything's okay; however, the dentist better not treat unless he gets his consent form. In a long term care facility, specifically, the consent form means the following. What does the patient want? Do they want their last three teeth removed? Does the fact that the patient had a stroke give you a 'warning light'? If that is going to say to you "this person is paralyzed on the right side", why would you want to put a partial in over these mobile teeth that this person couldn't get out and clean? How is he going to clean it? How is he even going to brush his teeth? That's what I'm worried about. Is he just going to need the simple, basic care of getting his mouth clean? Those are the problems that dentists have. Are they going to be able to eat? Are they going to get to the nutritional site? Am I as a dentist physically able to deliver care to this human being in the hospital, or in Beverly Manor, if need be? Can I deliver that care in their home or am I the dentist in his ivory tower who says "If you want me to treat you, you'd better roll in here somehow!" I'm going to do some other things. I'm going to put that patient's name on his dentures, so they are not lost in the hospital.

Will this gentleman be sent back to his home or to the hospital or is this man even able to pay if he has to come to your office. These are all

going to be problems, one of which we're going to solve. The reason we can't solve them is because they're like dominoes. They're each based on other factors. Will he get better? Is he going to survive? What's going to happen? Hopefully, you don't ever look even in your office for an absolute solution. There aren't any. There are no absolute solutions, but if you take all of these factors, and if you study the person as the professor told you, you divorce yourself from his age and other things. You study that human being and follow him and you will see to it that he gets care. Maybe if you just clean those mobile lower teeth, stabelize them and maybe if you adjust that denture, or maybe if you just see that he starts to salivate a little more, or maybe if he gets off of all those drugs, his denture is going to work fine and his mouth is going to work fine and he's going to get better.

PANEL SUMMARY

Sir W. Ferguson Anderson, M.D.

First of all, regarding the scenario, who is responsible for the rehabilitation of this person? Well, in Britain this man would have gone into either a medical unit or a geriatric unit depending upon what the general practitioner wanted. The first thing is to try to find out the exact diagnosis. What has happened? Why is he semi-comatose and confused? We would want to know, for example, if he was hypoglycemic. Because he has had a stroke doesn't protect him from taking another illness. He may have a subduralhematoma or a cerebral tumor. When we are doing that we must remember that in his confused and semi-comatose state he may have fallen and broken his hip or his shoulder, so he has to be handled somewhat carefully, initially. We can't just take his limbs and put them through a full range of movements without thinking about that. Once we have established our diagnosis, I think we would stop all medicines. This would be a very good way to attain a sort of leveling off. If he were hypoglycemic, that would be essential anyway. Now once we have done these things, what about the future.

I am not sure about what you do to people who have had a stroke, who have high blood pressure,who are 75 or 76. There is a great difference of opinion here. I would be inclined to stop his anti-hypertensive treatment for various reasons and watch him and see how he got on because I am not convinced that the literature tells me that at that age, there is much benefit from the continuation of anti-hypertensive treatment. I am sure I am in good company in being ignorant about what sort of debt this man will have and I think this is one thing that we must think of in the future and the type of exit we are planning by our maneuvers for our patient. The public is not happy at the moment about how the medical profession looks after dying people nor the

long time clinicity of illness of very severe illness which occurs in many cases. Now if he does survive and he has a remedial condition, then of course, if possible, he would go home. We would have had the home visited while he was in hospital and probably an occupational therapist would go to the home to see what changes could be made in the home to suit the disability with which he was left. Perhaps, some quite simple changes there would help, like a frame around the toilet or some sort of bars on the stairs. If such a man would go home, he would need supervision. We would want somebody to be popping in to see him regularly. Now one of the problems is that we try to make sure that the doctors are aware of all of the facilities available to help that person when he does go home. It might be when all factors were considered that he could never really make it back to his home, and if my dream came true and there was sheltered housing in every district, there would be warden supervised housing available for him with an intercommunication system. Now in the treatment of diabetis in the elderly, the hypoglycemia is a much greater danger usually than hyperglycemia. By this time the damage so rightly stressed by Professor Rakel has been done and I think the elderly don't take hypoglycemia well. They may fall and injure themselves. They may feel very funny mentally, very frightened, and fearful if they are hypoglycemic. I would think that dental infection would tend to make a diabetic's state worse, and therefore, it might be useful to try to clear up any infection. His nutritional intake would have to be checked and his ascorbic level done on his blood. If it was another stroke and remediable, correct rehabilitation would be put into play. If he was depressed, he might also need separate and precise treatment as well as for his stroke and for his depression.

"METHODS FOR PROVIDING DENTAL SERVICES FOR THE ELDERLY"

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There are many facets to oral care delivery for the elderly. Before one is able to understand and help older people who are aging, one must make a realistic examination of one's own attitudes. With a little bit of faith, one can deliver dental care to anyone, anyplace and it will be a lot of fun and give one a sense of great reward. There are two key elements in delivering quality oral care, both of which were covered this morning by Professor Anderson. Firstly, one must evaluate the ability of the patient to receive care, and this will not be easy. Then secondly, one must establish a treatment plan through history taking, through evaluation of that individual, and lastly one must determine if that elderly person really wishes to receive care.

Ettinger has referred to a triad of "Who are we going to treat, the patient, the family of the patient, or ourselves and our own self-aggrandizement." It is easy to become the type of dentist that must perform some service for every patient that comes into the office.

A need exists for making subtle changes in the delivery of dental services to the elderly. The dentist may require little special training in techniques, but rather must learn how to adapt his treatment plan and treatment to the unique environment, physical conditions and attitudes of the elderly patient. A clear understanding of the expectation of the proposed treatment is essential. One must take a realistic approach to the prognosis and one must explain to the patient exactly what treatment is going to be carried out. The areas where dentists can get into trouble are,

failure of the patient to understand either medical history questions, and/or failure of the patient to be able to communicate both their problems and their desires regarding treatment expectations.

One must deal with elderly patients on a one-one basis. The office should be altered to accommodate wheelchairs, carpeting should cover the entire floor, and all elderly patients should be escorted to the dental chair. There is a subtlety in escorting a 75 year old. It is necessary to determine whether they can maneuver by themselves, so the assistant should walk alongside them, but do not appear to be dragging them into the office.

When the dentist or the assistant takes a history from the elderly person, it is best to sit alongside the patient and look directly at them. It is necessary to relate one to one and be sincere. The history information may necessitate different chair positioning, such as for any older person with lung diseases. Aspiration can be a problem in a former stroke victim. Rapid exit from the chair may cause hypotension, and the patient may fall. It may be necessary for the dentist to deliver care in small increments. Practice management specialists say 'complete all work in one long visit,' but this may not be possible in some elderly patients. On the other hand, if a patient is transported to the office 100 miles from their home by ambulance, it may be necessary to do as much work as possible to complete everything at the one visit, with rest time in between procedures. In managing the elderly, use TLC (tender loving care) and do not promise patients more than you can deliver to them. Make the goal realistic. Be realistic in history taking, remember that they will not recall all the information you need, and learn to communicate with the family to be certain that you have all of the necessary information before treatment begins. Consult with their physician and be aware of the patient's medications and what effect

they may have on the treatment. Remember this conservative rule, "The treatment should never be worse than the disease." Do adequate rather than complete dentistry when necessary.

I am in geriatric dentistry because I lived at the foot of the acknowledged 'Father of Geriatric Dentistry', Dr. Arthur Elfenbaum. He said, "Intuition and sensitivity to human frailty and compassion for your fellow man are all the prerequisites you need in order to deliver successful care to the elderly."

One of the problems that interferes with delivery of oral care to the nursing home populations is that there is no acceptable definition of what constitutes minimum standards for good oral health care. Oral health care must be taught to staffs and integrated into the total daily care offered to the resident.

There are presently four methods of care delivery to nursing home residents.

1. Care delivery by a complete dental set-up within the facility. This is an excellant method for homes of over 250 residents and can work in a home with as little as 125 residents, when utilization of an existing facility such as a beauty shop can be combined with it.
2. Private care transfer - this method is nice for the dentist, but rather expensive and very time consuming for the home and the resident, and results in very little actual care being offered to the average nursing home resident.
3. Hospital or shared facilities - these have only recently begun to appear in areas where a large hospital will provide care for all facilities within a 10 mile radius.

4. Mobile van delivery system - This is a method which I strongly advocate and which we use at the University of Illinois College of Dentistry.

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4. Oral Hygiene for Geriatrics. Available from Wyoming State Department of Dental Services, State Office Building West, Cheyenne, Wyoming 82002.

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"A DENTAL HYGIENIST'S ROLE IN GERIATRICS"

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Department of Oral Pathology
Indiana University School of Dentistry

Introduction

My interest in aging accelerated two years ago when I became Project Coordinator for the Nursing Home Oral Cancer Screening Program at Indiana University School of Dentistry, Department of Oral Pathology. What started out as a job change for a career challenge soon became a personal commitment as well. I discovered that people involved with aging in any way are often very special people....warm, sensitive, caring, openly human, and, suprisingly, more positive and enthusiastic about the process of aging than I had ever imagined. This paper will attempt to describe my involvement with aging and implications for other health care practitioners in relating more comfortably to older persons.

Professional Involvement: A Nursing Home Rotation for Dental Hygiene and Dental Students

The Oral Cancer Screening Program was initially designed by Dr. William G. Shafer, Chairman, Department of Oral Pathology at Indiana University as one part of a broader program in Clinical Cancer Education in Dentistry. Now in its third and final year, this project utilizes all senior dental hygiene students, voluntary senior dental students, and graduate residents in an oral cancer screening program of nursing home residents. Each student spends 5-6 days per semester in this rotation.

Students work in teams of 6-8 students per day, one day a week. The first day of the rotation is spent in orientation and sensitization to the problems of aging through the use of discussion, attitudes questionnaire, media messages, films, and readings covering various topics. These include

general facts about older persons as well as the nursing home situation as seen through the eyes of a patient, the family, and staff. Related issues of widowhood, death, and dying also are discussed.

The rotation consists of carrying out routine clinical oral cancer examinations, utilizing disposable supplies. The patients are examined in any area available. The number of patients screened per day varies from 50 to 100, depending on number of students, their experience within that rotation, the mobility of patients, and staff assistance. Students reactions to this involvement are compiled through the use of special clinic reports to the dental hygiene department, and a subjective paper which is submitted at the end of the semester rotation. Most students express a greater awareness of aging persons, increased empathy for nursing home patients including well older persons and greater understanding of aging as being part of one's total life span. Negative comments include: frustration at being involved in a screening program only with no opportunity of doing direct patient dental care; the lack of a follow-up program; and lack of cooperation from nursing home staff. Suggestions include having a course in gerontology within the Dental School, thereby allowing students to perform direct dental services for patients. Recommendations on residents screened are made to the administration and to the dental advisor of each facility.

Personal Involvement: Mental Health of Aging Persons

In September of 1977, I was accepted into a two-year traineeship at Christian Theological Seminary at Indianapolis for the program, "Mental Health of Aging Persons." Funded by the National Institute of Mental Health, the purpose of this program is to improve services among older people by strengthening the experience and skills of professionals in working with groups of older people and by researching the effectiveness of growth groups for improving an older person's sense of well-being.

The training consists of a day and a half monthly session with an expert in mental health. Some of the topics covered have included group therapy techniques, peer counseling methodology, sexuality in widowed and aging persons, sensory losses and adaptive techniques, models of aging ("old and OK"), human potential models, the realities of facing loss, pain and death, and the effects of psychogenic drugs on the elderly.

With this background, trainees work in teams with a group of elderly (no more than 10 persons) serving as group leaders for a period of at least 12 weeks, meeting weekly for 1½ hours. The settings vary from nursing homes to community centers and churches, and testing measurements include the Havighurst Life Statisfaction Index, the Zung Depression Scale, and others.

Implications for the Oral Health Professional

The dental practitioner must first of all be aware of some of the general changes in aging such as sensory perception, which greatly affects our spatial relationships with others. As senses diminish, touch becomes more important, and this can be uncomfortable unless one is aware of that fact about older patients. Psychomotor skills also slow down, which means that the practitioner may have to adapt patient education expectations. The learning process also slows, and it may take more time and repeated instructions for the older patient to learn new skills or behavior. The psychological adjustments for the elderly are also very great and often complex, particularly if the patient is dealing with a number of losses simultaneously. While the dental practitioner may have no answer for these problems, a sympathetic and understanding approach in communication can greatly help the older patient through a difficult time. The sociological changes are also great; the patient may be experiencing loss of work-role identity, loss of income, isolation from friends, widowhood, etc. Again, the greatest help

the dental professional can give at this time is genuine interest in listening and appreciating the complexity of the patient's world-view. It also helps greatly to be aware of the community resources to which one can refer a patient going through these kinds of stresses. One must also be familiar with various physical degenerative disease processes which can affect aging persons. Even the aspect of nutrition is very critical in the aging patient, yet many dental professionals do not think to question the elderly about their dietary habits. Fortunately, the dental literature is beginning to cover all of these aspects of gerontology, and the number of continuing education programs on aging is increasing.

The oral health professional may also deliver community service to the elderly in a variety of ways. There is a great need for inservice training in long-term care facilities, educating staff and administration to the importance of oral hygiene/health in total patient care. One can also perform the direct services of prophylaxis, dental chartings, oral hygiene instruction, denture cleaning and identification, and nutrition. This kind of work presents an ideal schedule for the hygienist who is a parent and who desires work only during school hours. Obviously, the cooperation of both the administrative staff and the advisory dentist is necessary for one to design a well-functioning oral health program within a nursing home.

One can also become involved with senior citizen centers and nutrition sites in doing patient education, informational presentations, health screening, etc.

Personal Aspects of Involvement in Gerontology

In order to fully appreciate the experiences to be gained in working with older persons, one must first get in touch with one's own perspectives on aging, admitting both the positive and negative impressions one has about

that reality. One can choose to study aging from one or several dimensions which include psychology, sociology, humanities, history, legal issues, religion, urban planning and architecture, communication, health, death and dying, just to name a few. One can begin with what one is more comfortable with, and work into more difficult aspects. One can learn more about aging in a wide variety of places, such as churches, civic groups, professional meetings, universities and even through theatre and television. There is a need for health professionals to occasionally get out of their clinically-oriented frame of reference in order to maintain a holistic concept of patients as people rather than just "cases" or "diseases".

It is also important for one to learn to appreciate and document one's own developmental stages throughout the lifespan. This can be done in a personal diary or journal, shared, exchanged letters to friends, and through introspection. The stages of adult development are a fairly recently studied phenomenon, and the literature is also growing in that area.

Conclusion

Involvement with aging persons can be extremely rewarding, both professionally and personally. To quote Robert Butler, Director, National Institutes on Aging,: "Optimal growth and adaptation can occur all along the life cycle when the individual's strengths and potentials are recognized, reinforced, and encouraged by the environment in which he lives." Each of us is part of the other's environment; we are all part of the same family of man. The problems we as health professionals and human beings solve for the elderly of today will help create a better world in which we all are aging.

APPENDIX I

INTRODUCTION

PROGRAM. This is the program for the Conference.

8:15 Registration--Galagan Auditorium, College of Dentisry

8:30 "The Advantages of an Interdisciplinary Approach in Meeting the Health Care Needs of the Elderly"
Professor Anderson

9:45 Break

10:00 Analysis of a Gerontology Case by Interdisciplinary Panel: Dr. Freedman, dentistry; Dr. Rakel--medicine; Ms. Busse--nursing; Ms. Wright--convalescent care centers; Dr. Helling --pharmacy; Dr. Walz--social work

12:00 Lunch break

1:00 "Methods for Providing Dental Service for the Elderly"
Dr. Freedman

1:45 "The Dental Hygienist's Role in Geriatrics"
Ms. Schafer

2:15 Break

2:30 Workshop Groups: "Developing Plans for Dental Care of the Elderly"

4:00 Group reports with critique by Dr. Freedman and Ms. Schafer

APPENDIX II

INTRODUCTION

Scenarios

These four scenarios were used as the basis for the afternoon discussion groups. The entire audience was divided into small groups with about fifteen persons per group. The discussion groups were led by co-facilitators consisting of a senior dental student and a senior dental hygiene student. These students had been chosen by the Planning Committee, provided with background literature, and trained in three hour session on group leadership techniques. In the Conference, the concluding session was a plenary meeting, at which time each group reported on their solutions to the scenarios. Dr. Kenneth Freedman and Ms. Shermie Schafer were respondents for the reports.

INDUSTRYVILLE (H.M.O.)

SCENARIO I

Industryville is a large city of approximately 500,000 population, characterized by a major industry which employes most of the community's working population. Most of the men and women in the city work on the assembly line in company plants. There is a high proportion of single parents. All of the workers employed by the city's primary industry belong to a powerful, nationwide union. The racial composition of the city is varied and integrated, both in housing and on the job. The working force consists primarily of blue collar workers, ranging from nonskilled to highly skilled workers, all of whom are paid on an hourly basis. Their earning capacity places them in the lower middle to middle income categories. A relatively small proportion of the city's inhabitants is employed at middle and upper management levels.

An H.M.O. has been in existence for 5 years and you have been appointed the dental director. The H.M.O. has 40,000 persons enrolled and offers an experience rated medical plan with a special rate for persons receiving Medicare.

The medical plan offers the following services:

1. Full coverage for hospitalization.
2. Full coverage for physician visits.
3. Prescription with a $1.00 deductible.
4. Nursing home care covers the deductible of Medicare.

The dental plan is optional but one must be a member of the medical plan. Only 9,000 persons are enrolled in the dental plan and of those persons over 60 years of age only 40% are enrolled in the dental plan.

The dental plan offers the following services:

1. Prescriptions with a $1.00 deductible.
2. Hospitalization for oral surgery.
3. Full coverage for periodontal care and fluoride treatment.

4. Removable prosthodontics is covered but the laboratory fee is deductible.
   a. The plan allows for replacement dentures every 5 years.
   b. The plan allows for relines every 2 years.
5. Fixed prosthodontics is covered but the laboratory fee and cost of the gold is deductible.
6. Orthodontics is not covered.

The H.M.O. employes 3 other dentists, your interest in the care of the elderly and you wish to provide good dental treatment to those who are enrolled. Also, you wish to enroll more elderly persons who can be divided into:

A. Those who have treatment needs and have adequate funds.
B. Those who want treatment but do not have adequate funds and have come for advice on how to obtain external funds.

The main problem lies in the fact that an H.M.O. depends upon its survival by not all members using its services. If the usage increases, premiums go up and this eliminates members because they cannot afford membership.

GOODFELLOWSHIP HOME

SCENARIO 2

The Goodfellowship Home is a 75-bed long-term care facility that was built in 1974. It is located on the outskirts of a rural community of 8,000. The staff consists of RN's, LPN's, and nurses aides. The facility is a modern one story structure with three wings leading from a central recreation area and nurses station. Facilities include a room equipped for medical care and a "beauty parlor."

The Home has an average occupancy of 95 percent, and most of the residents are from the local community. Approximately 40 percent of the residents are on Medicaid and 60 percent are supported by themselves or their families.

60 percent of the residents are totally ambulatory, 40 percent are chair-fast and 5 percent are bed-ridden. A new nursing director has been appointed and as a result the nursing staff had identified many residents who are in need of dental care. Eighty percent of the residents have not visited a dentist in the past five years. Many of the residents are mentally or physically handicapped.

The nursing director has requested assistance. You have just purchased the only practice in town from a retiring dentist who is remaining in the town.

RURAL TOWN

SCENARIO 3

Rural Town was once a booming farming community of 4,500 inhabitants. However, with declining farm incomes, and because the community has been unable to attract industry through the years, young people have begun seeking their fortunes in the city. Their now aging parents have been left behind. Today, barely 1,500 population remains. Few shops remain as well, including a pharmacy, saloon, general store, cafe, and a gas station. The school house, which at one time was filled with the sound of laughing, playing children is now a senior citizens center, and the few remaining children are bussed to a consolidated school 40 miles away. Many widows live in Rural Town. Wells remain the primary source of water in the community.

Most residents of Rural Town live in houses long since paid for. Because of the low income of the citizens however at this point in life, and because of their loss of agility, their houses have deteriorated seriously. Behind each house, nevertheless, is a fluorishing, well-tended vegetable garden. At the end of the day, after work is completed in the garden, one can hear the squeaking of the porch swings and smell the fragrance of the jasmine. Antique dealers frequently descend upon individual families intent upon the opportunity to rummage through attics and cellars in search of lucrative treasures for resale.

A nursing home was constructed three years ago by the church in order to accommodate those residents who could no longer care for themselves in their own homes.

Because of the declining circumstances of this community, it has been unable to attract health care services. Most residents find it difficult to reach centers of care because of their age and lack of transportation. The nearest center providing health care is only 30 miles away where there are six practicing dentists. The town has requested assistance to solving the dental problems in this community.

MIDDLETOWN

SCENARIO 4

Middletown is a community of 20,000 population; 11% of the population are over 65 years of age. There are 8 practicing dentists, 2 practicing dental hygienists, 15 practicing physicians, 200 bed hospital and 2 nursing homes.

The town's major industry is the manufacture of farm equipment. Most of the older residents are retired farmers or laborers. The community is the county seat. There is a Community Nursing Service with a staff of 8 nurses, 4 home health aides, 1 half-time physical therapist. There is a Department of Social Service with 4 social workers.

The community nurses have been concerned about the number of older families who have chronic illnesses and poor dental health. For example, a 68 year

old man was discharged from the hospital with a prescribed 1200 calorie diet high in roughage. He has a limited number of teeth which are in poor repair. The family feel that one only goes to dentists when the teeth begin to ache. The community nurses have requested assistance in providing care for the elderly population in this community. A the monthly dinner of the local dental society at Bel Mar Country Club you have been appointed as chairman of a task force to develop a plan to meet the dental needs of the elderly population.

DISCUSSION LEADERS

Dental Students	Dental Hygiene Students
Bramson, James, D4	Debra Adams, A4
Christiansen, Keith, D4	Pat Brown, A4
Duffy, Donna, D4	Janelle Chabal, A4
Dykes, Diana, D4	Celest Rovane, A4
Kanellis, Michael, D4	Linda Moe, A4
Lennarson, John, D4	Becky Jessen, A4
Munoz, Jon, D4	Laura Unger, A4
Shigetani, Les, D4	Mary Kearney, A4
Sheridan, Linda, D4	Sara Douglas, A4
Walser, Paul, D4	Ellen Garrels, A4

APPENDIX III

A. Federal Register

B. Sample Form - Consent
"Oral Health Admission Consent Form"
K. Freedman, D.D.S.

C. Sample Form - Policies
"Dental Health Policies of _____ Home"
K. Freedman, D.D.S.

A. Federal Register
405:1129 Condition of Participation-dental services-The Skilled nursing facility has satisfactory arrangements to obtain routine and emergency dental care.

1. Standard: Advisory dentist. An advisory dentist participates in the staff development program for nursing and other appropriate personnel, and recommends oral hygiene policies and practices for the care of the patients. Thus, his responsibilities include:

   a. dental consultation
   b. in service training
   c. policies for oral hygiene
   d. emergency care if necessary
   e. assists patient in obtaining regular care

2. Standard: Arrangements for outside services. The facility has a co-operative agreement with a dental service, and maintains a list of dentists in the community for patients who do not have a private dentist. The facility must provide transportation when necessary for the patient to the dentist's office.

   The nursing personnel must assist the patient to carry out the dentist's recommendations for oral hygiene care needed daily.

   Medicare does not re-imburse for routine dental care but only for consulting services in establishing a dental care program in a home. Medicaid programs in about thirty states do provide some provision for delivery of oral care service in homes with the federal government funding about fifty percent of these services and with each state determining the type and extent of services to be provided.

B. ORAL HEALTH ADMISSION CONSENT FROM

I _____ agree to an annual oral examination to be performed on _____, in order to comply with Federal Regulation regarding an oral survey to provide the following:

1. Diagnose the presence of oral cancer and other soft tissue lesions.
2. Examine for caries, loose teeth, periodontal disease and oral lesions which may be contagious to the staff at the nursing home.
3. Identify and label oral prosthetic appliances (dentures and partial dentures).
4. Prescribe proper oral hygiene program according to mouth condition and presence or absence of teeth or oral appliance.

I _____ reject an oral examination for _____ _____ and cannot hold the consulting dentist responsible for the dental care of the patient.

I agree that I/HE/SHE/ be treated under the auspices of the University of Illinois, College of Dentistry, an institution operated by The Board of Trustees of the University of Illinois, according to the treatment plan above, and:

a. Authorize the administration of local anesthetics deemed necessary for the performance of the above procedures;

b. Authorize the taking of any records, X-rays, or photographs as is deemed necessary in the treatment and the use of such records, X-rays, or photographs by the College of Dentistry or faculty for the purpose of illustration or publication in professional journals or for the advancement of teaching.

Name of Patient_____ _____
(Signature of Patient, Parent, or Guardian)

Date_____ Relationship_____

Witness_____

Please return permission to Dr. Kenneth Freedman, Department of Prosthodontics, College of Dentistry, University of Illinois at the Medical Center, 801 South Paulina Street, Chicago, Illinois 60612.

C. DENTAL HEALTH POLICIES OF HOME

1. All residents' mouths are examined within thirty (30) days of admission.
2. All prosthetic appliances are marked with resident's name or I.D. number.
3. All dental care is provided free to all residents.
4. Each resident's chart has one page designated as a dental record.
5. Residents have their mouths examined annually.
6. Residents are provided with toothbrushs, toothpaste and denture cups when needed.
7. Those residents who cannot maintain daily oral hygiene care are assisted by the staff.
8. An ultra sonic cleaning machine is maintained to clean dentures properly.
9. Residents are taught how to care for their own mouths.
10. Dental care is offered to residents three (3) mornings per month.
11. One staff member acts as dental assistant to aid dentist when he comes to deliver dental care.

Program consist of:

a. Toothbrushing and flossing lessons.

b. Understanding oral prosthesis - dentures partials, how to remove, clean and replace them.

c. Normal mouths, various slides of diseases of the mouth for identification purposes. Staff is instructed to alert dental advisor about any suspicious lesion.

d. Films of mouth care are shown.

1. Senior Smile - ADA

2. Aiding the chronically ill in Nursing Homes - Texas Film

Kenneth Freedman, D.D.S.