DENTISTRY FOR THE AGES:
Part I
Dick Gregory, DDS,
and Susan Hyde,
DDS, MPH, PhD, FACD
DEPARTMENTS

349 The Guest Editor/The Silver Tsunami

351 Impressions

395 RM Matters/Health History Vital in Assessing Patients, Reducing Risk

401 Regulatory Compliance/Radiation Safety Q-and-A

405 Tech Trends

409 Dr. Bob/Long in the Tooth

FEATURES

360 Dentistry for the Ages: Part I
An introduction to the issue.
Susan Hyde, DDS, MPH, PhD, FACP

363 Dental Care in the Frail Older Adult: Special Considerations and Recommendations
This article discusses the key considerations and suggestions for risk assessment, disease management, treatment planning and palliative care to maintain the patient’s comfort and quality of life.
Pamela Stein, DMD, MPH, and Joanna Aalboe, RDH, MPH

369 The Impact of Medicaid Expansion on Oral Health Equity for Older Adults: A Systems Perspective
This paper uses a collaborative, interdisciplinary systems science inquiry to explore implications of Medicaid expansion on achieving oral health equity for older adults.
Sara S. Metcalf, PhD; Shirley S. Birenz, MS; Carol Kunzel, PhD; Hua Wang, PhD; Eric W. Schrimshaw, PhD; Stephen E. Marshall, DDS, MPH; and Mary E. Northridge, PhD, MPH

379 Evidence From ElderSmile for Diabetes and Hypertension Screening in Oral Health Programs
Originally focused on oral health, ElderSmile was expanded in 2010 to include diabetes and hypertension education and screening.
Stephen Marshall, DDS, MPH; Eric W. Schrimshaw, PhD; Sara S. Metcalf, PhD; Ariel Port Greenblatt, DMD, MPH; Leydis De La Cruz, MA; Carol Kunzel, PhD; and Mary E. Northridge, PhD, MPH

389 Geriatric Dentistry in the 21st Century: Environment and Opportunity
The increase in people keeping their teeth and their increasingly complex conditions all point to more people with more complex needs. This also brings new opportunities to develop and implement innovative systems for reaching and maintaining the oral health of older Americans.
Paul Glassman, DDS, MA, MBA
The Silver Tsunami

Dick Gregory, DDS

“The aging population is the most important demographic trend and most countries, including the United States, have not prepared for it. Unless we change how we deliver care and how we pay for it, the cost of health care for an aging population will cripple our economy.” — Leonard Schaeffer, senior advisor, TPG Capital and founding chairman and CEO of WellPoint.

The age of the older adult is upon us. This important demographic shift is a silver tsunami. Nearly 20 percent of the U.S. population will be older than age 65 by the year 2030. What does this mean for dentistry? Are we ready for the challenges? What might we be doing for our patients?

As clinicians, the advice and services we provide our patients should be age appropriate and have lasting value. I believe these concepts are at the core of the social contract between health care providers and patients. Both concepts are relatively straightforward and result in desirable outcomes for patient and provider. However, incorporating them on a daily basis in our practice of dentistry requires an ethical and humanistic approach to care that puts the interests of our patients at the forefront.

Our understanding of both dentistry and aging broadens over the decades of our professional careers. Personal experience is in many cases our most important teacher. In sharing some of my learning moments, I hope that they will resonate and stimulate your own reflections on patient care.

Mom and Dad

The most demanding clinical experience of my professional career continues to have a profound effect on the way I view dentistry and the patient experience. During my senior year at UCLA, I made full dentures for each of my parents. At the time, they were challenging removable prosthodontic cases. Considering my relationship to the patients, nothing short of a perfect result would have been acceptable.

I designed and fabricated the most beautifully festooned and functionally extended appliances they had ever worn. Using photos of my mom in her 20s and my dad in his 40s prior to becoming edentulous, I selected teeth to match their original size and shape, further modifying and arranging them to create two appealing and natural-looking smiles. My instructors and my cubicle partner were impressed, my parents were proud and I was pleased. But something was wrong.

My prosthodontic achievements soon gave way to the realization that in the end, mom and dad were still dental cripples. I learned how and why my parents had lost their teeth, and I began to understand that treatment alone does not result in health. All the skills and techniques I was working so diligently to master meant little if I did nothing to improve patients’ understanding of their own responsibility in managing disease risks.

Caries and periodontitis are undoubtedly preventable chronic diseases. Behavior modification is critical to achieving and maintaining health. Restorative dentistry will last a very long time for patients willing to partner in their own care.

After graduating from UCLA, I bought a small, three-operatory general practice in Santa Rosa, Calif., and became a Denti-Cal provider to stay busy. I was surprised that among this low-income group of patients, many were older adults on fixed incomes who would not have qualified for Denti-Cal at an earlier time in their lives. They were also willing to pay out of pocket for services not covered by Denti-Cal. I found them to be very appreciative of my care, and I thanked them for keeping their appointments. I also began to wonder what became of them and who provided their dental care when they could no longer travel to my office for treatment. It would be nearly 25 years before I began to do much more than wonder.

During the early years in practice, I discovered that fluoride-releasing glass ionomer (GI) cements were a reliable luting agent with significant anticaries benefits. Though unesthetic, the material could additionally be purposed as an inexpensive and effective caries preventive material for deciduous teeth in children and root caries in older adults. I used GI a lot and welcomed improvements in appearance, strength and fluoride release over the years.

Private Practice

After passing the California Dental Board examination, I resolved to do a better job of engaging and educating patients in my care about their role in achieving and maintaining oral health.

All the skills and techniques I was working so diligently to master meant little if I did nothing to improve patients’ understanding of their own responsibility in managing disease risks.
Glass ionomer lasted longer than expected (or promised) for caries control in patients with limited budgets that dictated phased treatment planning of more costly and definitive care. The material also proved to be excellent for restoring root caries in xerostomic older adults lacking the financial resources or longevity to justify replacing the crown and bridgework done years before. It was inexpensive and easy to place.

Best of all, it was a practice-builder. Patients understood that I could be trusted to offer reasonable treatment alternatives in the short term, and accepted more definitive treatment over time. Patients with relationships predicated on trust turn out to be much more amenable to adopting the behavior modification needed to prevent oral disease. These lessons learned during my years in a variety of private practice settings have served as a solid foundation for my practice over many years.

Because oral health is vital to general health, oral health care should be part of primary health care. Making dental services accessible to all people across the lifespan continues to be a serious challenge facing our profession. The burgeoning demographic of our aging population along with the fact that so many are keeping their teeth mandate that dentistry must meet treatment needs not previously considered.

The private practice oral health care delivery model employs the great majority of dentists today, and provides services to approximately 70 percent of the population. That said, millions of people do not have access to dental services. Most of them simply can’t afford it. Others lack the mobility or cognitive ability to get to where we practice. Many older adults face all three challenges.

Aging is a relative term and a continuous experience. George Carlin observed, “...you become 21, turn 30, push 40, reach 50 and make it to 60. You’ve built up so much speed that you hit 70! After that it’s day-by-day... you HIT Wednesday.”

To live is to age, and there are important considerations associated with the process. Health, mobility, cognitive status and financial ability define a person throughout life. These issues become critical not only for an older adult, but also for the health professional providing care.

Dick Gregory, DDS, is the San Mateo center director for Apple Tree Dental. He completed his dental degree at the University of California, Los Angeles, School of Dentistry in 1980 and a two-year postgraduate multidisciplinary geriatric fellowship at the University of California, San Francisco in 2014. During the intervening three decades, he cared for his patients while in private general dental practice in Northern California.
Dentistry for the Ages: Part I

Susan Hyde, DDS, MPH, PhD, FACD

We celebrate many coming-of-age customs, such as special birthdays to commemorate sweet-16, quinceanera and bar mitzvah, to name a few. Yet our celebrations for growing older are largely limited to over-the-hill and retirement parties, both of which can reflect negative stereotypes of aging. Ageism, defined as prejudicial attitudes and discrimination based on a person’s age, is prohibited by federal laws, and yet it persists in our society, subtly and often overlooked.

What influences our attitudes and beliefs about aging? Our society puts a high cultural value on youth, and old age is seen as having limited future prospects and a loss of personal identity. The media contributes to the marginalization of older adults when they are portrayed as being needy and dependent, lonely and boring, grumpy and stubborn, and with limited physical and cognitive abilities. Stereotypes exist of older adults contributing low productivity in the workplace, and retirees being nonproductive, relying on Social Security “handouts.”

Family structures are changing such that multiple generations now rarely live together or nearby, limiting the interactions of young people with older family members. Attitudes are also shaped by our language. For example, I recently asked senior dental students what ‘geriatric’ meant to them, and used the Wordle application to create a graphic of their responses, similar to the art on Page 360. While many of the comments received from the students were positive (wisdom, experienced, respect) or neutral (elderly, grandparent, wrinkles), some remarks revealed negative stereotypes (boring, demanding, cranky).

Ageism is prevalent amongst health care providers and impedes the provision of quality care. Studies have demonstrated an unwillingness of health care providers to treat older adults because of internalized societal age biases and negative attitudes toward older adults, time constraints, lack of appropriate reimbursement, disinterest in treating a medically compromised population and frustration with care being more about maintenance than curative.
In turn, older adults perceived their concerns were downplayed by health care providers, that they encountered a dismissive communication style from providers and did not receive the treatment needed for common conditions. Receiving negative biases may be internalized by older adults and accelerate their decline via promoting lower self-esteem and self-stereotyping.

Older adults have the most diverse clinical and physical presentation of any patient group — from independent, well elders to those who are dependent and medically compromised. Studies have shown that many dentists do not feel adequately prepared to treat older adults. Most of us received some lectures on geriatrics and treated well elders in the predoctoral clinics, but did not have an opportunity to work with frail older adults who were home bound or living in long-term care. Limited exposure to working with a range of older adults hampers a dentist’s ability to develop appropriate treatment strategies. What are some of the misconceptions and ageist beliefs in dentistry? Age is often a primary consideration when developing a treatment plan — missing teeth are more likely to be restored with fixed prosthodontics for patients younger than age 60 and removable for those older than age 60, and implants are less likely to be offered to older adults. Patients, as well as clinicians, believe that pain is a normal part of aging; therefore, pain is underreported, underdiagnosed and undertreated. Caries prevention interventions largely target children, yet caries incidence in older adults equals that in children and is more likely to remain untreated. Finally, there is a polarized delivery of dental care during the last year of life, when frail older adults either received no treatment or comprehensive care rather than a more appropriate level of palliative care.

This first of two Journal issues dedicated to the oral health of older adults frames many of the issues that arise when providing care to older adults. Stephen Marshall, DDS, describes the success of the ElderSmile program in providing screening and referrals for diabetes and hypertension, while Pamela Stein, DMD, MPH, outlines risk assessment, treatment planning, disease management and palliative care for frail older adults. Mary E. Northridge, PhD, MPH, explores a systems perspective of how expanding Medicaid adult dental services could improve oral health equity for older adults, and Paul Glassman, DDS, MA, MBA, presents the virtual dental home as an innovative delivery model. Given the unprecedented rise of older adults as a proportion of the population, the insufficient number of geriatric dentistry training programs, and that federal funding of all 12 geriatric dentistry fellowships discontinued in 2015, it falls to the general dentist to provide and coordinate care. Therefore, it is important we examine the influence of our own beliefs about aging when working with older adults, and assess each patient’s individual needs and capacities rather than relying on stereotypes of aging. After all, “The lifespan of any civilization can be measured by the respect and care that is given to its elderly citizens.” — Arnold J. Toynbee

REFERENCES