Dental Care for the Chronically Ill, the Aged, and the Handicapped

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EIGHTEEN MILLION of our population have been classified as chronically ill, aged, or handicapped. The number is expected to reach 20 million by 1970 (*1*) as a result of lengthening life expectancy, so new and concerted efforts must be expended to meet the many and varied needs of this population.

Although the dental profession is aware of this growing problem, rigidity of the dental-office concept has resulted in almost complete lack of comprehensive treatment facilities for a large percentage of the homebound population. To explore the possibilities of providing dental services to the homebound patient, a pilot dental home care program was started in 1961 at Highland View Hospital in Cleveland, Ohio (*2*). The program was later extended to include outpatients.

The need and feasibility of such a program has been demonstrated by the response of the homebound patients and the willing participation of the private practitioners. A total of 231 patients were treated during the pilot program, 88 by 40 private practitioners (3.5 percent of the Cleveland dental profession), who provided 363 dental procedures during 120 home visits. A procedure consists of examination, restoration, extraction, prophylaxis, and each step in denture construction.

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Federal funds, furnished through the Ohio State Department of Health, provided primary financial support. Local community interest and endorsement were shown by financial assistance from the Cleveland Visiting Nurse Association, Western Reserve University School of Dentistry, and the county's chronic illness center. The Cleveland Dental Society has made funds available for educational purposes. The statistical and cost data of the program are further amplified in an article describing this demonstration program (*3*).

The results of the program indicated that further investigation would be needed to learn how dental services could be provided more expeditiously and economically. An outpatient dental clinic was planned for the care of the chronically ill and aged in conjunction with the home care program, based on the observation that 80 percent of our patients are not truly homebound for purposes of receiving dental care. A similar study conducted in Kansas City by the Public Health Service estimated that 90 percent could be transported (*4, 5*). In May 1964 a combined home and outpatient project was started at the Highland View Hospital. It is being financed by a Community Health Services and Facilities Act grant and continuing funds from local sources including the Cleveland Health Department.

The Program

Basically, the objectives of the dental program are:

1. To determine under what conditions patients can and should receive dental care at home or in an outpatient facility.

2. To promote further integration of dental care for the homebound patient with existing community health agency activities.

3. To use such a program as a means of orienting and training both the dental student and the private practitioner in providing services to the chronically ill and the aged.

4. To investigate the time-conserving value of using auxiliary dental personnel (dental hygienist and assistant) to assist in treating the chronically ill as a means of increasing productive treatment time of the dentist.

By expanding the existing referral systems, a listing of the chronically ill who are homebound and in need of dental care is being developed. Approximately 100 voluntary and governmental agencies and half of the nursing homes in metropolitan Cleveland are cooperating in this development.

In most instances the dental hygienist and the assistant screen the patients in their homes for treatment needs and suggest the place for treatment. The following factors are considered in determining where the patient will be treated:

1. Are the specially equipped small bus and personnel used in the program capable of transporting the patient? (See photograph.)

2. Are there any limitations in the patient's physical environment; for example, is he confined to a wheelchair in a third or fourth floor walkup?

3. Is the patient willing to leave his home for dental care?

4. Does the extent of dental treatment warrant transporting the patient? For example, transportation is not considered to be warranted for patients requiring a denture adjustment or a single restoration or extraction.

After these factors are assessed, the patients are divided into two groups: those who need treatment at home and those who can be treated on an outpatient basis. (Some patients may require treatment in both settings.) The final decision on treatment needs and place of treatment is made by the program director after consultation with the patient's physician, if he has one.

Patients who are unable to afford private fees and are to be treated in the outpatient clinic are transported by the program vehicle. If other means of transportation are available, patients are encouraged to use them and thereby free the special bus for other essential uses.

Social service evaluations are given to all outpatients during their initial visit to the hospital. At present, no social service evaluations are performed in the home. The information gained is used to better understand the patient. A dental examination with X-ray evaluation is also done during this initial visit. Additional hospital services are available when needed, such as clinical laboratory services, radiology, and medical consultations. Patients for whom treatment at home is best receive care, with portable equipment, from the professional staff and senior dental students of the Western Reserve University School of Dentistry. Senior dental students are assigned to the home care team one-half day each week of the academic year.

The dental status of patients receiving care under the program is reevaluated every 6 months to 1 year, and service is provided as needed.

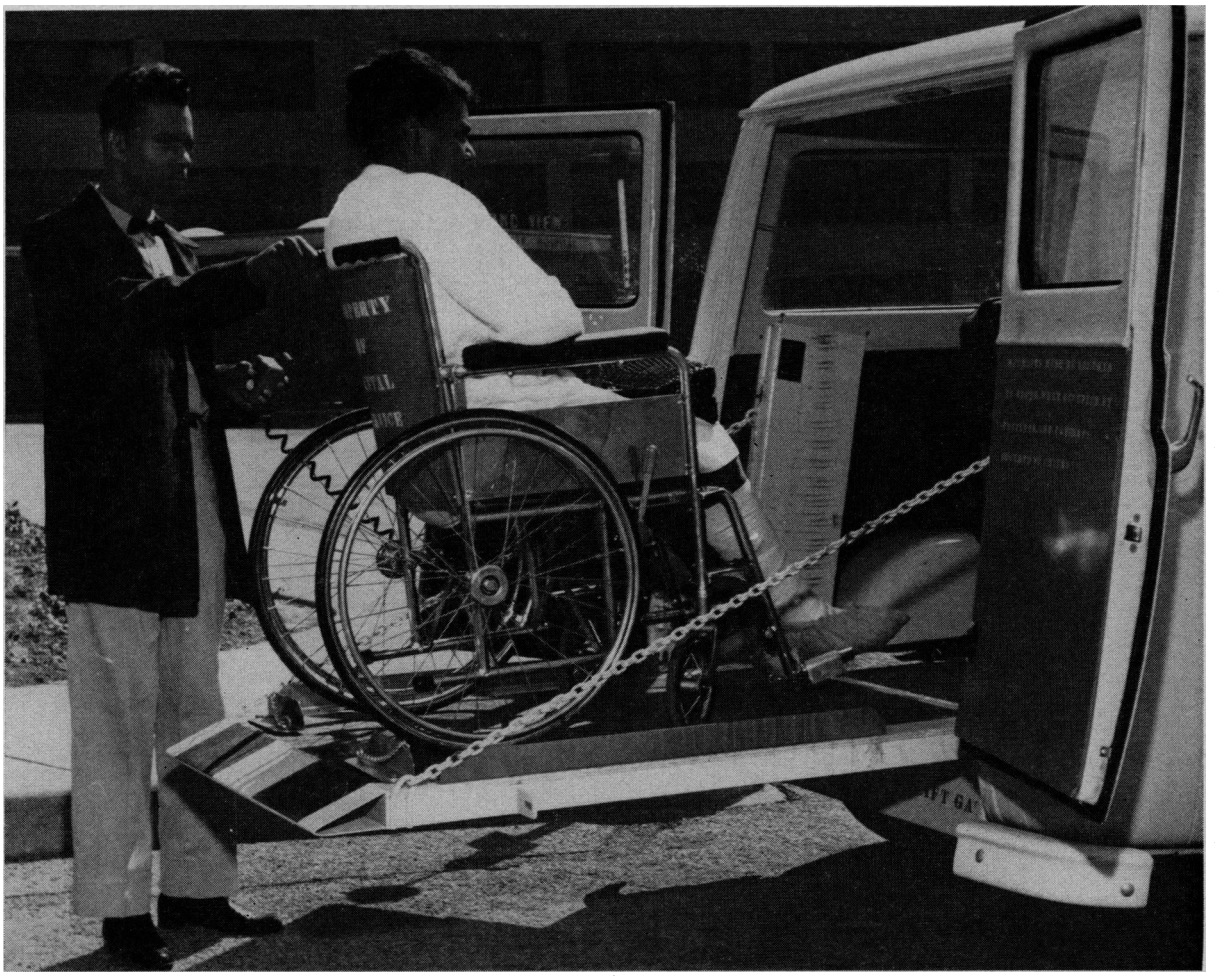
Homebound patients who can afford private care are referred to their own dentists for service. If a private practitioner requests program assistance, equipment and auxiliary personnel are made available to him. The special bus can be used to transport patients to the office of the private practitioner on a limited basis if private transportation is not available.

Effect of Program

On the patient. The efforts of this program should be considered in light of the many medical advances in the past two decades dealing with the handicapped and chronically ill patient. Rehabilitation of the patient is no longer a matter of only teaching him to live with his plight; rather it is a concerted effort to meet his total medical, psychological, and social needs, which may permit his greatest potential adjustment.

Total rehabilitation of the patient should include improvement of dental health. We have found that removing infection, improving mastication, speech, and appearance, and the resultant psychological uplifting, all play their role.

Most of the patients examined had not received dental care in more than 4 years. Most



Small bus with hydraulic lift gate, used to transport nonambulatory patients for treatment

therefore were in need of dental treatment. The program has provided the homebound patient with not only actual dental service but the realization that his status does not preclude dental care.

On the community. Awakening the general population to the medical and social needs of the aged and chronically ill has advanced far more than creating consciousness of dental requirements. Recognition of this need by the community is the first and most significant step in making dental care available. Through this program's efforts, Cleveland has taken the important initial step.

On the dental profession. The program has created an awareness of the needs of the total population rather than only those of the individual patient. This has focused attention on the needs of the chronically ill and the aged.

Education of the dentist has long emphasized rigid boundaries beyond which the profession seemingly could not perform its tasks; yet the demands of the increasing nonambulatory population must be met by the profession.

The efforts expended by staff members of the program at dental society meetings and conventions and the assistance and equipment provided for private practitioners during the pilot home care program significantly promoted the awareness of the dental profession to the feasibility of providing dental care at home with portable equipment. The willingness of the private practitioner to participate in community effort to provide continued dental care to the chronically ill, handicapped, and aged patients reflects the ultimate effect on the dentist—the developing awareness for meeting the needs of the "forgotten population."

Final observations cannot be stated at this time because the program is in its early phases. Cleveland's approach to dental care is not an end in itself but rather an investigative effort. It is hoped that the experience will aid others to solve the complex problem of care for the chronically ill and the aged.

Summary

A demonstration dental home care and outpatient program has been developed at a hospital in Cleveland, Ohio. Federal funds provide primary support. Local voluntary and governmental agencies provide additional finances. Complete dental care is provided to chronically ill, aged, and handicapped patients in their own homes, in nursing homes, and at an outpatient clinic. A small bus that is fitted with a hydraulic lift transports wheelchair patients to the clinic for care.

The program is investigating the conditions that determine where the patient should receive dental care. The time-conserving value of using the services of dental hygienists and assistants also is being evaluated in the home setting.

In addition, private dentists use the program's portable dental equipment and services of auxiliary personnel to provide care to their own homebound patients. Senior students of Western Reserve University School of Dentistry are assigned to the program as part of their training.

REFERENCES

(*1*) President's Council on Aging: Report to the President. U.S. Government Printing Office, Washington, D.C., February 1964.

(*2*) Collins, J.: Dental home care program. J Mich Dent Assoc 45: 369–376, November 1963.

(*3*) Waldman, H. B.: Report of a demonstration dental home care program for homebound chronically ill and aged patients. J Amer Dent Assoc 69: 50–57, December 1964.

(*4*) Lotzkar, S.: Dental care for the chronically ill, aged, and homebound. J Amer Dent Assoc 67: 71–76, July 1963.

(*5*) U.S. Public Health Service: Dental care for the chronically ill and aged: A community experiment. PHS Publication No. 899. U.S. Government Printing Office, Washington, D.C., 1961.

General Hospital Care for Mentally Ill

For the first time, general hospitals have been admitting more psychiatric patients than State mental hospitals. Preliminary results of a current hospital survey completed by the National Institute of Mental Health and the American Hospital Association show that 1,005 general hospitals admit psychiatric patients for diagnosis and treatment. Approximately 45 percent of the hospitals maintain separate psychiatric units within the hospital, and the others admit psychiatric patients to their general medical service.

In the most recent 12-month period for which statistics were available (usually 1963), the general hospitals report they discharged 412,459 psychiatric patients. Public, State, and county mental hospitals admitted 285,244 patients in 1963.

California has the largest number of general hospitals admitting psychiatric patients (71); Pennsylvania has 70 such hospitals, Texas 65, and New York 61. New York's general hospitals discharged the greatest number of psychiatric patients in the recent 12-month period.

The survey provides evidence that treatment of the mentally ill in their home communities has increased sharply and that many more general hospitals provide psychiatric care than earlier studies based on incomplete data had indicated.