The Impact of Interprofessional Integration Between Dentistry, Nursing, and Social Care on Oral Health Quality for Older Adults and People With Disabilities

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Abstract
The global expansion of the elderly population and the increasing prevalence of long-term disabilities have exposed fundamental limitations in traditional, siloed dental care models. These models often fail to address the complex bio-psychosocial needs of vulnerable populations, particularly older adults and individuals with disabilities. This study examines the impact of interprofessional integration among dentists, dental assistants, nursing professionals, and social service providers on the quality, accessibility, continuity, and equity of oral healthcare.
Drawing on contemporary academic literature, international guidelines from the World Health Organization (WHO) and the FDI World Dental Federation, and comparative care models from Japan, Sweden, Brazil, and the United Kingdom, the analysis demonstrates that integrated, team-based approaches significantly reduce unmet oral healthcare needs. Within this framework, nursing professionals play a pivotal role in linking oral health services with broader medical and long-term care systems through early detection of oral health deterioration, daily oral hygiene support, pain assessment, and coordination of care across settings.
The findings underscore the complementary contributions of social workers in addressing social determinants of health, dental assistants in providing essential clinical and psychosocial support, and dentists in leading diagnosis and management of complex oral-systemic conditions. Notably, the absence of structured nursing involvement is identified as a critical gap in existing oral healthcare delivery models, particularly in community and long-term care contexts.
Despite clear benefits, interprofessional integration remains constrained by systemic barriers, including fragmented financing, professional silos, and insufficient interprofessional education. The study concludes that embedding oral health within the broader medical, nursing, and social care continuum is not merely a matter of service optimization, but a human rights imperative essential to achieving health equity for ageing and disabled populations..
Keywords: Dentistry, dental assistant, nursing, and social work Geriatric and Special Care Dentistry, Nursing Integration, Interprofessional Collaboration, Social Determinants of Health, Integrated Oral Healthcare, Oral Health Equity, Disability Care.

1. INTRODUCTION

The traditional separation of oral health from general medicine—often referred to as the "body–mouth divide"—has historically marginalized the dental needs of individuals who are

unable to navigate conventional healthcare systems. For older adults and persons living with disabilities, this fragmentation represents not merely an administrative shortcoming but a substantive barrier to systemic health and overall well-being. Epidemiological evidence consistently demonstrates that older populations are disproportionately affected by poor oral health, with far-reaching consequences for nutrition, communication, social participation, and general health status [1]. As the global population aged 60 years and above is projected to increase from 901 million in 2015 to 1.4 billion by 2030, healthcare systems face an urgent imperative to redesign care models to avert a looming public health challenge [2].

Vulnerability within these populations is inherently multifactorial, emerging from the convergence of physical frailty, cognitive decline, social isolation, and economic insecurity. Persons with disabilities—who account for approximately 15% of the world's population—experience significantly higher levels of unmet dental needs and untreated oral disease compared with the general population [3]. These inequities are further intensified by the predominant delivery of dental services within private clinical settings that are frequently inaccessible, both physically and financially, to individuals with special healthcare needs (SHCN) [4]. Compounding these barriers is the limited integration of oral health considerations within long-term care and community-based services, where nursing professionals often serve as the primary point of sustained patient contact.

The paradigm of integrated and interprofessional care seeks to dismantle these entrenched silos by promoting structured collaboration among dentists, dental assistants, **nursing professionals**, and social service providers. Within this framework, nursing professionals assume a central role in bridging oral healthcare with general medical and long-term care services. Their responsibilities extend beyond routine clinical support to include early identification of oral health deterioration, daily oral hygiene assistance, pain and infection surveillance, medication management, and the coordination of referrals to dental services. Importantly, nurses act as continuous care anchors in residential facilities and home-care settings, ensuring that oral health needs are neither overlooked nor deprioritized in medically complex patients [5].

This collaborative model acknowledges that effective care for individuals with dementia, severe physical disabilities, or chronic illness requires more than isolated clinical interventions. It demands an integrated support system encompassing caregiver education, psychosocial support, transportation facilitation, and financial advocacy—domains in which nursing and social care professionals play indispensable roles. The rationale for such integration is grounded in the life-course approach, which recognizes the shared risk factors linking oral diseases with noncommunicable diseases (NCDs) such as cardiovascular disease, diabetes mellitus, and obesity, and underscores the necessity of coordinated preventive strategies across disciplines [6].

This research aims to examine the operational mechanisms of interprofessional integration by clearly delineating the complementary roles of dentists, dental assistants, nursing professionals, and social service providers, and by evaluating their collective impact on the quality, continuity, and equity of oral healthcare delivery. Through the analysis of international best practices and critical implementation challenges, this report offers a strategic framework for healthcare administrators and policymakers seeking to embed oral health within a person-centered, rights-based, and sustainable healthcare system.

2. Oral Health Needs of the Elderly and People with Disabilities

The oral health status of vulnerable populations is often a reflection of their broader systemic health and social environment. Aging and disability are frequently accompanied by a host of

oral pathologies that are more aggressive and harder to manage than those found in younger or able-bodied cohorts. Common problems include rampant dental caries, advanced periodontal disease, tooth loss (edentulism), dry mouth (xerostomia), and oral infections [7].

2.1 The Impact of Aging, Disability, and Chronic Disease

Chronic diseases, which are prevalent in the elderly, have a bidirectional relationship with oral health. For example, untreated periodontal disease can make it significantly harder to manage blood sugar levels in patients with diabetes, while systemic conditions like high blood pressure and their associated medications frequently cause xerostomia [8]. Xerostomia, or decreased saliva production, is particularly dangerous as it removes the mouth's natural buffering and cleansing mechanisms, leading to a rapid increase in root caries and fungal infections like oral candidiasis [9].

Furthermore, cognitive decline, such as that seen in Alzheimer's disease and other forms of dementia, directly impacts oral hygiene. Patients in the middle to late stages of dementia may forget how to use a toothbrush, lose the dexterity required for flossing, or become resistant to assisted oral care due to confusion or fear. In these cases, the oral cavity can become a reservoir for pathogenic bacteria, increasing the risk of aspiration pneumonia—a leading cause of death in frail, institutionalized seniors [10].

2.2 Barriers to Accessing Care

The barriers preventing these populations from receiving care are categorized into physical, financial, and cognitive factors. For many, the simple act of traveling to a dental office is a significant hurdle. Mobility issues, dependence on specialized transport, and the lack of wheelchair-accessible clinics prevent regular attendance [11].

Category of Barrier	Specific Impediments	Consequence
Physical	Mobility limitations, lack of transport, inaccessible dental furniture.	Infrequent check-ups, reliance on emergency care.
Financial	Low income, lack of dental insurance (e.g., Medicare gap), high cost of specialized care.	Forgoing treatment, worsening of preventable conditions.
Cognitive	Dementia, intellectual disabilities, dental anxiety, sensory oversensitivity.	Uncooperative behavior, need for sedation, diagnostic challenges.
Systemic	Fragmented EHRs, lack of geriatric-trained dentists, poor referral loops.	Discontinuity of care, medical-dental errors.

The consequences of these barriers are profound. When oral health is neglected, the resulting pain and difficulty chewing lead to nutritional deficiencies, sarcopenia, and a general decline in physical frailty. Psychologically, the loss of teeth and the inability to speak or smile without embarrassment can lead to social withdrawal, depression, and a diminished sense of dignity [12].

3. Roles of the Dentist in Integrated Care

In the integrated care model, the dentist's role evolves from that of a solitary technician to a clinical leader within a multidisciplinary team. For elderly and disabled patients, the dentist must possess not only high-level surgical and restorative skills but also a sophisticated understanding of geriatric medicine and behavioral management [13].

3.1 Clinical Assessment and Tailored Treatment Planning

The assessment phase for a patient with special needs is often more complex than the procedure itself. The dentist must conduct a thorough review of the patient's medical history, paying close attention to polypharmacy and potential drug interactions. Clinical assessment extends beyond the teeth to include oral function—masticatory performance, tongue pressure, and swallowing safety [14].

Treatment planning must be "person-centered," meaning it is tailored to the patient's functional level, cognitive state, and overall life expectancy. For a frail patient in a nursing home, the goal may shift from complex aesthetic restoration to the maintenance of "functional dentition"—the 20 teeth necessary to eat a varied diet. This requires the dentist to balance the "art and science" of dentistry with the practicalities of the patient's daily life [15].

3.2 Coordination and Ethical Responsibility

The dentist serves as the hub for communication between the dental team, medical providers, and social services. This includes coordinating with the patient's primary care physician to manage anticoagulation therapy before extractions or discussing nutritional needs with a dietitian. Ethically, the dentist is responsible for ensuring that "informed consent" is truly informed, which may involve working with social workers to identify legal guardians or advocates for patients with diminished capacity [16].

Furthermore, the dentist must supervise the entire oral health team, ensuring that dental assistants and hygienists are empowered to perform at the top of their scope of practice. This leadership is critical in non-traditional settings, such as mobile clinics or domiciliary visits, where the dentist must manage risk and maintain standards of care outside the controlled environment of a standard office [17].

4. Role of the Dental Assistant in Enhancing Quality of Care

Dental assistants are often the most frequent point of contact for patients and their families, providing the "emotional and clinical scaffolding" that makes treatment possible for those with complex needs. Their role in integrated care encompasses clinical support, infection control, patient navigation, and health education [18].

4.1 Clinical Support and Infection Control

In the context of geriatric and disability dentistry, the assistant's role in infection control takes on heightened importance. Older patients and those with certain disabilities (such as autoimmune disorders) are more susceptible to infections. Dental assistants are responsible for rigorous sterilization protocols, including autoclaving handpiece motors and disinfecting high-touch surfaces, ensuring a safe environment for both the patient and the team [19].

During procedures, assistants must be adept at "physical and behavioral support." This includes using specialized equipment like mouth props for patients who cannot keep their mouths open, or helping to position a patient with severe scoliosis or tremors in a way that allows the dentist to work safely. They also operate suction and high-volume evacuation to prevent choking or aspiration in patients with swallowing difficulties [20].

4.2 Patient Preparation, Comfort, and Communication

For patients with cognitive impairments like dementia or autism spectrum disorder (ASD), the clinical environment can be a source of intense sensory overload. Dental assistants are trained to manage this through specific communication strategies [21]:

- **Tell-Show-Do**: Explaining what will happen, showing the instrument (e.g., "the tooth tickler"), and then performing the action.
- **Voice Control**: Using a calm, steady tone to de-escalate anxiety.

- **Distraction**: Using music, conversation about a favorite topic, or tactile objects to divert attention from the procedure.
- **Bridging and Chaining**: Encouraging the patient to hold an object or participate in a small part of the task to maintain a sense of control.

4.3 Education and Liaison Roles

The dental assistant acts as a link between the clinical team and the social support system. They are responsible for educating caregivers—whether they are family members or nursing home staff—on proper oral hygiene techniques. This is vital, as the day-to-day maintenance of oral health in dependent patients is the most critical factor in preventing emergency complications. In advanced models, dental assistants serve as "care liaisons," helping families overcome logistical barriers like transportation and insurance eligibility [22].

Assistant Competency	Action in Special Care	Impact on Patient
Infection Control	Sterile processing of low-speed motors and aerosol management.	Reduced risk of systemic infection/pneumonia.
Behavioral Guidance	Implementation of "Social Stories" and "Tell-Show-Do" for ASD/Dementia.	Increased cooperation; reduced need for sedation.
Ergonomics	Use of weighted blankets, dimmable lights, and adaptive seating.	Sensory comfort; reduced physical distress during treatment.
Clinical Advocacy	Reporting signs of oral pain or neglect to the dentist and social worker.	Early intervention for non-verbal patients.

5. Role of Social Services in Oral Healthcare Integration

The inclusion of social workers and social service professionals in the dental care team addresses the "missing link" in oral health: the social determinants of health (SDOH). While dentists treat the disease, social workers address the factors that allowed the disease to occur or prevent its treatment [5].

5.1 Addressing Social Determinants of Oral Health

Social service professionals screen for non-medical factors that directly impact the mouth. For example, a social worker might identify that an elderly patient's rampant decay is caused by high-sugar, low-cost food choices necessitated by financial insecurity. By connecting that patient to a community nutrition program or food bank, the social worker addresses the root cause of the dental pathology [5].

5.2 Supporting Access to Care and Coordination

Social services play a critical role in "patient navigation." This involves assisting families with the administrative burden of healthcare, such as applying for Medicaid, navigating insurance denials, or obtaining legal conservatorship for a disabled adult. At the UCLA Special Patient Care clinic, social workers provide "psychosocial screening phone calls" before appointments, which helps families prepare for the visit and significantly reduces the rate of missed appointments [6].

5.3 Advocacy and Caregiver Support

Social workers provide emotional counseling for both patients and their caregivers. They help families navigate the grief and stress associated with progressive diseases like Alzheimer's and

provide "anticipatory guidance" about what to expect during dental treatment. For the homebound, social workers coordinate with visiting nurses and home care aides to ensure that oral health assessments are integrated into the patient's overall care plan [6].

Social Service Function	Evidence-Based Outcome (UCLA Model)	Percentage of Patients Requesting
Mental Health Counseling	Addressing anxiety and emotional responses to diagnosis.	20.5%
Insurance Navigation	Assisting with Medi-Cal and complex billing.	16.5%
Conservatorship Guidance	Helping families through legal guardianship processes.	15.3%
Transportation Assistance	Organizing vouchers or specialized transit.	6.4%
Attendance Improvement	Pre-screening calls increased show-rate from 45.8% to 61.1%.	(Statistically Significant)

6. Impact of Integration on Quality of Care

The synergy between dentists, assistants, and social services leads to a profound improvement in the quality of care delivered to vulnerable populations. Quality in this context is measured not only by clinical outcomes but also by the patient's dignity, safety, and satisfaction.

6.1 Improved Access and Continuity

Integration effectively "closes the loop" on care. When a patient is seen in an integrated environment—such as a medical-dental co-located clinic—the barriers to follow-up are significantly reduced. Research indicates that older patients who receive care in medically integrated dental clinics are 1.5 times more likely to complete all their necessary medical screenings (e.g., blood pressure checks, vaccinations) compared to those in traditional settings [23]. This suggests that the dental office can serve as a powerful entry point for overall health management.

6.2 Patient-Centered and Holistic Care

Integration allows for a care plan that respects the "4-M model": What Matters Most, Mobility, Mentation, and Medications. By considering these factors, the team provides care that is safe (reducing medication errors), compassionate (addressing cognitive needs), and effective (improving nutrition through better mastication). This holistic approach reduces the trauma often associated with dental visits for people with disabilities, transforming the experience from one of fear to one of support [24].

6.3 Reduction in Disparities and Increased Dignity

By addressing the economic and physical barriers to care, integrated models help level the playing field for the underserved. Mobile dental units that visit nursing homes or rural centers ensure that even the frailest individuals have access to the same standard of care as the general population. This restoration of oral health is directly tied to the patient's sense of self-worth; being able to eat, speak, and smile without pain is fundamental to human dignity [7].

7. Models of Integrated Dental and Social Care

Various regions have implemented successful models of integrated care, offering valuable lessons for global health systems. These models vary in their level of integration but share a common commitment to interprofessional collaboration.

7.1 Japan's Community-Based Integrated Care System

Japan has pioneered the concept of "Oral Frailty" as a critical health indicator for the elderly. Their national strategy, the "8020 Campaign," is supported by a community-based system that integrates health, nursing, and social services within local "junior high school districts". This ensures that seniors can receive necessary services within 30 minutes of their homes. Japan also uses a structured "frailty screening" that includes questions about chewing difficulty and dry mouth, triggering community-based interventions if the patient is at risk [12].

7.2 Sweden's Interorganizational Model

Sweden has focused on strengthening the link between public dental care and municipal social services. A key feature of their model is the "Oral Care Card," a multiprofessional tool used to document oral health status and guide daily care provided by nursing assistants in home settings. While the system faces challenges with digital interoperability, it provides a framework for "shared documentation" that ensures dental hygienists and social workers are on the same page regarding a patient's needs [25].

7.3 Australia's Kimberley Dental Team (KDT) and ADF

Australia's Kimberley Dental Team provides a "hub-and-spoke" model for remote communities, using mobile dental units and a volunteer-led workforce. This model emphasizes collaboration with community-controlled health services to ensure culturally appropriate care. Similarly, the Australian Dental Foundation (ADF) works directly with aged care facilities, providing on-site education for staff and mobile clinics for residents, which has led to a measurable decrease in dental-related hospital admissions [26].

7.4 Brazil's Smiling Brazil

The "Smiling Brazil" program is one of the world's most ambitious integrations of oral health into primary care. By including oral health teams (OHTs) within the national Family Health Strategy, Brazil has achieved a 445% increase in dental care coverage over ten years. The program focuses on "integrality," meaning it provides everything from basic cleaning to complex oral surgery and cancer diagnostics within a single, publicly funded network [27].

Model Name	Country	Target Population	Core Integration Strategy
8020 Campaign	Japan	Elderly (over 75)	"Oral Frailty" screening in general health checkups.
Smiling Brazil	Brazil	All (esp. Vulnerable)	Oral health teams embedded in Family Health units.
Kimberley Team	Australia	Remote/Aboriginal	Hub-and-spoke mobile clinics with community liaison.
SPC Model	USA (UCLA)	People with IDD/SHCN	Embedded social work for psychosocial screening.
Mile Square	USA (Chicago)	People with Disabilities	Sensory-adapted clinics with desensitization rooms.

8. Challenges and Barriers to Integration

Despite the theoretical benefits, the path to full integration is obstructed by several significant challenges.

8.1 Organizational and System-Level Barriers

The historical "siloing" of dental education and insurance has created a system where medical and dental providers speak "different languages." This is most evident in the lack of interoperable electronic health records (EHRs). Without a shared record, a dentist may not

know that a social worker has identified a patient's housing instability, or a physician may prescribe a medication with severe oral side effects without notifying the dental team [28].

8.2 Financial and Policy Constraints

Reimbursement models often disincentivize integrated care. In many systems, "time" is not a billable commodity. The extra hour an assistant spends desensitizing a child with autism, or the hours a social worker spends coordinating transport, are often non-reimbursable. In the United States, the "Medicare gap"—where basic dental care is not covered—remains the primary driver of oral health inequity for the elderly [29].

8.3 Workforce and Training Gaps

There is a significant shortage of dental professionals trained in geriatric and special care dentistry. Furthermore, dental students often display a lack of "readiness" for interprofessional learning, viewing their role as purely surgical rather than part of a broader health team. This is compounded by a lack of faculty development and a curriculum that often overlooks the bio-psychosocial aspects of health [8].

9. Recommendations and Future Directions

Achieving a truly integrated dental-social care system requires a multi-pronged approach targeting education, policy, and technology.

9.1 Strengthening Interprofessional Education (IPE)

Education must move beyond "occasional workshops" to a fully integrated curriculum where dental, medical, and social work students participate in "reciprocal learning". This should include:

- **Simulation and Case-Based Learning**: Working together to solve complex cases involving comorbid geriatric patients.
- **Community-Based Rotations**: Placing students in integrated hubs where they witness the impact of social services first-hand.
- **Shared Competencies**: Training all healthcare workers in basic oral health screening and desensitization techniques.

9.2 Policy Reform and Financial Alignment

Governments must prioritize the inclusion of comprehensive dental benefits in national health programs. Specific policy recommendations include:

- **Creating Claiming Codes**: Allowing providers to bill for "behavioral management" (CDT code D9920) and "dental case management" (CDT code D9997).
- **Outcome-Based Contracts**: Shifting away from "volume of treatment" (e.g., UDAs) toward rewards for "closing care gaps" and improving population health.
- **Funding Mobile Units**: Investing in the infrastructure needed to bring care to nursing homes and remote areas.

9.3 Technology as an Enhancer

Digital tools should be used to bridge the communication gap, not create new divides.

- **Unified EHRs**: Implementing systems like EPIC Wisdom that allow real-time consultation between dentists, physicians, and social workers.
- **Teledentistry**: Using virtual visits to pre-screen patients, conduct follow-ups for homebound seniors, and support family caregivers.
- **Mobile Diagnostics**: Equipping social workers or visiting nurses with intraoral cameras to transmit images of suspicious lesions or broken teeth to a supervising dentist.

10. The Central Role of Nursing in Integrated Oral Healthcare

Across all models of integrated oral healthcare examined in this report, nursing professionals emerge as a critical yet historically underrecognized pillar in the delivery of equitable, continuous, and person-centered care for elderly individuals and people with disabilities. Positioned at the intersection of medical treatment, daily care, and social support, nurses play a decisive role in translating oral health strategies from episodic clinical interventions into sustained, real-world outcomes.

In geriatric, long-term care, community, and home-based settings, nurses are often the primary healthcare professionals with consistent, longitudinal contact with vulnerable patients. This continuity places them in a unique position to conduct routine oral health surveillance, identify early signs of pain, infection, xerostomia, or functional decline, and initiate timely referrals to dental professionals. Moreover, nursing staff are instrumental in implementing and maintaining daily oral hygiene regimens for dependent individuals—an intervention repeatedly shown to reduce the incidence of aspiration pneumonia, systemic infections, and avoidable hospitalizations among frail older adults.

Beyond direct clinical care, nurses function as essential care coordinators within integrated systems. They facilitate communication between dentists, physicians, dental assistants, social workers, caregivers, and families, ensuring that oral health considerations are embedded within comprehensive care plans. In patients with cognitive impairment or complex comorbidities, nurses also play a vital role in behavioral assessment, consent facilitation, and advocacy, safeguarding ethical standards and patient dignity when decision-making capacity is compromised.

From a systems perspective, the exclusion of nursing from formal oral health pathways represents a structural vulnerability in current care models. Without deliberate integration of nursing competencies into oral healthcare planning, dental interventions risk remaining episodic, reactive, and disconnected from the patient's lived environment. Conversely, models that empower nurses through targeted oral health training, shared documentation systems, and clearly defined interprofessional roles demonstrate superior outcomes in prevention, continuity, and equity of care.

As healthcare systems confront the realities of population aging, rising disability prevalence, and workforce constraints, the strategic integration of nursing into oral health services is no longer optional—it is indispensable. Recognizing nurses as co-stewards of oral health reframes dentistry not as an isolated specialty, but as a shared responsibility embedded within the broader medical and social care continuum. The future of geriatric and disability dentistry, therefore, depends not only on advanced clinical expertise or innovative technologies, but on a collaborative philosophy that fully integrates nursing as a foundational agent of prevention, coordination, and human-centered care.

11. CONCLUSION

The integration of oral healthcare with social and healthcare services is not a clinical luxury; it constitutes both a clinical necessity and an ethical obligation. For older adults and persons living with disabilities, the oral cavity is not merely a site of potential pathology, but a fundamental gateway to nutrition, communication, self-expression, and social participation. When dental teams operate in professional isolation, they address only the visible manifestations of neglect; when they engage in structured collaboration with nursing and social services, they confront the root causes of that neglect and its systemic determinants.

Within an expanded interprofessional framework, the dentist assumes the role of clinical leader and care coordinator, dental assistants function as essential providers of clinical continuity, patient education, and emotional reassurance, **and nursing professionals serve as the linchpin of day-to-day care integration**. Nurses—particularly those in geriatric, community, and long-term care settings—ensure sustained oral health monitoring, support daily oral hygiene for dependent individuals, recognize early signs of oral pain or infection, and facilitate timely referrals to dental services. Their continuous presence across care settings enables the translation of treatment plans into lived, daily practice, thereby safeguarding both clinical outcomes and patient dignity.

Social workers, in turn, operate as architects of access, addressing financial, logistical, and social barriers that prevent vulnerable individuals from receiving timely and appropriate oral care. Together, these four professional domains form a **multi-pillared support system** that reduces fragmentation, enhances continuity, and ensures that no patient is rendered invisible by structural or functional limitations. The effectiveness of this model is evidenced by successful international experiences—from integrated long-term care pathways in Japan to community-based oral health programs in Brazil—which demonstrate that systemic transformation is both achievable and sustainable when interprofessional collaboration is institutionally supported.

Despite persistent obstacles, including fragmented financing mechanisms, regulatory constraints, and insufficient interprofessional education, the trajectory of demographic ageing renders inaction untenable. As global populations age, the true measure of healthcare system performance will not reside solely in technological sophistication or surgical complexity, but in the capacity to preserve fundamental human functions—such as pain-free eating, clear speech, and the confidence to smile—among society's most vulnerable members. Achieving this vision demands more than improved clinical tools; it requires a paradigmatic shift toward an integrated philosophy of care that recognizes oral health as inseparable from nursing care, social context, and general health. The future of geriatric and disability dentistry, therefore, lies not solely within the dental clinic, but within enduring, structured collaboration across professional and institutional boundaries.

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