The Influence of Lifestyle Choices on Health in the Older Patient

How Your Patients’ Lives Affect their Health and Longevity

4.6 Contact Hours

COURSE OBJECTIVES

Upon completion of this course, you will be able to do the following:

- Explain the roles of genetic versus behavioral and environmental factors on longevity and overall health.
- Specify those health habits most important to long life and how they contribute to physical and mental well being in the elderly.
- Describe how mental health and attitudes affect physical well being.
- Discuss how social relationships and spirituality can help or hinder good physical and mental health.
- State how life experiences can impact health and longevity.
- Demonstrate how to promote healthy habits in patients by giving them information about longevity and good health.
- Determine how to address elders’ health problems through improvements in non-medical aspects of their lives.
- State how to combine physical, mental, social, and spiritual behavioral interventions to meet overall health goals.
- Explain how to coordinate an individual patient’s care with the local elder services network.

“There is an unspeakable dawn in happy old age.”

Victor Hugo
INTRODUCTION

Patients bring their health concerns to your office or facility, but they also bring with them their environment, their spiritual or religious beliefs, their family and social relationships, their work stresses, their genetic make-up, and much more. Each one of these elements affects a patient’s health, and they should influence your approach to providing the best possible care.

Considering a patient’s health in relationship to other aspects of life is always important, but it may be even more important for the older adult. Poor personal choices in habits, diet, and stress management can eventually result in strokes, heart disease, obesity, and cancer. A network of caring and compassionate friends and relatives, as well as a strong belief system and a positive outlook on life can help an elder through catastrophic illness and loss.

In this course we will discuss the physical, mental, social, spiritual, and environmental aspects of your patients’ lives and the roles these aspects play in healthy aging. We will learn how these individual strands weave together to provide your patient with either a strong foundation of overall well-being, or the possibility of diminished health. Finally, we will explore how we can merge all of the facets of a patient’s life together, enabling us to work with that patient as a whole human being who is striving for improved health and longevity.

LEARNING FROM THE OLDEST OLD

Too often we think of older age as a period of physical decline rather than a time to enjoy the fruits of a long life. Many elders themselves believe that age brings mainly unhappiness and poor health. More than half of the elders responding to one survey associated old age with depression, dependency, reduction in sexual ability, aches and pains, trouble sleeping, less energy, and unattractiveness (Sarkisian, Hays, & Mangione, 2002).

However, later life can also mean having more leisure time and the wisdom to focus on what is truly important. Of course, enjoying these benefits of aging depends on also having good health and independence.

Fortunately, we have begun to learn why some people seem to be contented and healthy into their 90’s and 100’s while others die in late middle age. Some scientists believe that human life expectancy can be extended into the hundreds of years, while others feel that the average lifespan will never extend much beyond current levels (Wright, 2003). Healthy patients are divided into two groups. The larger of the two groups is comprised of those individuals who practice good health habits and make wise choices. On average, good habits can potentially add approximately eight years to a lifespan, and most individuals in this group retain their good health, living into their late 80’s. Another smaller group has a genetic predisposition to long life, opening the possibility of living to the age of 100 or more. These people frequently, but not always, have healthy lifestyles (Perls & Terry, 2003). Looking at the characteristics of the long-lived in both of these groups tells us many things that you need to know to take the best possible care of your patients.

Better Overall Health

Studies of the oldest old, the 100+ group, show that they do not have the same number of illnesses as other elders. Many display great frailty only at the very end of life. A group of
Georgia centenarians had about the same number of medications and instances of ill health as younger elders (Purdy, 1995). Subjects in the New England Centenarian Study had a mean of only four chronic diseases, 3.4 medications, and 6 hospitalizations per year (Hitt, Young-Xu, Silver, & Perls, 1999). One in five had no serious diseases even at age 100 (Friedrich, 2002). Nine out of ten lived independently in their homes to an average age of 92 (Perls, n.d.).

Those who live longest also tend to avoid diminished mental capacity longer. Among the centenarians in the New England study, about one-third had no dementia (Friedrich, 2002). The Georgia study found that, while most of their subjects demonstrated poorer performances in most cognitive functions, if they used their life experience for problem-solving they functioned as well cognitively as those in their 60’s or 80’s (Georgia Centenarian Study, 2005).

**Health Habits**

Research shows that those who live to very old ages frequently practice basic healthy habits. Three studies have found that those subjects who maintained a healthy weight, avoided weight loss diets and large fluctuations in body weight tended to live longest (Georgia Centenarian Study, 2005; Vaillant, 2002; Perls, n.d.). With regard to nutrition, the Georgia centenarians ate breakfast more regularly and consumed about 20-30% more Vitamin A and carotenoids from food than younger people, even though the number of calories and amount of fats consumed were similar. Interestingly, the Georgia centenarians tended to consume more whole milk rather than lower fat alternatives, and tended to make their food choices with little regard for dietary cholesterol (Georgia Centenarian Study, 2005). Both the Georgia study and one conducted at Harvard University found a correlation between moderate exercise and longer life (Vaillant, 2002).

**Moderate Tobacco and Alcohol Use**

It is not surprising that most of the subjects in the Georgia Centenarian Study, the New England Centenarian Study, and the Harvard study either never smoked or did not have a long history of smoking (Georgia Centenarian Study, 2005; Vaillant, 2002; Perls, n.d.). They also tended toward moderation in the use of alcohol (Georgia Centenarian Study, 2005; Vaillant, 2002). This is especially important given that 9% of those 55 and older engage in binge drinking (Substance Abuse and Mental Health Services Administration, 2001), while 17% of elders have some form of alcohol or medication management problem (Substance Abuse and Mental Health Services Administration, 1998). Medication mismanagement can include addiction to prescription medications, failure to take medications as prescribed (either intentionally or unintentionally), and having adverse drug interactions.

The effects of substance abuse can be more dangerous for older adults than for other age groups. Even elders who don’t binge may find that they tolerate the effects of alcohol and medications less well than when they were younger (Substance Abuse and Mental Health Services Administration, 1998). Both alcohol and medication abuse may be misdiagnosed as dementia or other ailments associated with later life (Blow, 1998). Additionally, alcohol can interact with many prescription medications, and the more medications elders take, the more likely they are to have life-threatening adverse reactions.
FACTORS AFFECTING LONGEVITY

Not all centenarians practice good health habits. In fact, a small number of people, primarily men, make particularly poor health choices and yet live to be 100 or more. Clearly other factors affect length of life. What are some of these?

Mental Well-Being

Older adults who are free from mental illness and who have an enthusiastically positive attitude toward life tend to live longer. The majority of the Georgia centenarians indicated that they were very happy with their lives despite their limitations (Purdy, 1995). Further, these cheerful centenarians indicated that they had adopted this attitude at an early age. Conversely, among the general population, those with the most severe depression tend to die at a younger age than those who are not depressed or who have milder depression. (Unutzer, Patrick, Marmon, Simon, & Katon, 2002). But why does mental well-being affect physical health?

Good mental health supports healthy habits. Patients who are self-motivated are more likely to walk and to experience the benefits of exercise (Friis, Nomura, Ma, & Swan, 2003). Furthermore, the Georgia centenarians’ nutritional levels were more the result of their mood than of any other factor (Purdy, 1995). Severe mental illness may interfere with basic self-care. A study of middle-aged and older schizophrenic women found that they were more likely to be obese, to smoke, and to neglect routine health screenings (Dickerson, Pater, & Origoni, 2002).

Physiological changes associated with mental health may also affect physical health. For example, one reason why depression may be related to dementia is that both are associated with a shrinking of the hippocampus, the portion of the limbic system that controls inhibition, short-term memory and spatial navigation. New research indicates that decreasing brain function in one area of the hippocampus, the dentate gyrus, is a main contributor to the normal decline in memory that so many elders experience. Researchers at Columbia University Medical Center looked at measures that typically change during aging, like rising blood sugar, body mass index, cholesterol, and insulin levels. The research found that the only factor that triggered a decline in dentate gyrus activity was a rise in blood glucose levels. Even for those without diabetes, these findings indicate that improving glucose metabolism through exercise, diet, or medication could be a way for some to stave off the normal cognitive decline that comes with age (Columbia University Medical Center, 2008).

Later in life chronic depression and Alzheimer’s disease may be associated with vascular changes in the brain, as it often occurs in conjunction with heart disease, stroke, cancer, and Parkinson’s disease (National Institute of Mental Health, 2003). When blood flow in the arteries to the brain is restricted over time, as might occur in atherosclerosis or cardiovascular disease, the brain does not receive enough glucose. This, in turn, begins a process that ultimately leads to the accumulation of sticky clumps of protein in the brain that appear to be a cause of Alzheimer’s disease (O’Connor, et al., 2008).
Personality

The effects of personality are less clear. Those who lived longest and healthiest had:

- The ability to cope well with the challenges of life (Vaillant, 2002).
- An attitude of forgiveness, gratitude, and joy (Vaillant, 2002).
- A personality that was “dominant, suspicious, practical and relaxed...more likely to acknowledge problems...less likely to seek social support as a coping strategy” (Georgia Centenarian Study, 2005).
- The ability to handle stress more effectively (Perls, n.d.).

Mental Activity

Being mentally active seems to help stave off the dementia that robs so many elders of their independence. The Nun Study, a long-term research project involving a population of 678 Catholic sisters as subjects, found that “idea density” (a combination of vocabulary and reading comprehension) and “grammatical complexity” (the ability to write a complex sentence as a measure of working memory capacity) in early writings predicted an absence of dementia in later life. The effect was not related to educational level (Snowdon, 2001). In addition, subjects who performed mentally stimulating activities such as reading and crossword puzzles had less dementia (National Institute on Aging, 2002).

Social Interaction

Those who have a happy home life and many friends are more likely to be healthy and long-lived. The Aging in Manitoba study found that those who participated in everyday activities with others had longer, happier, and healthier lives (Manec, 2003). “Talking on the phone, having someone to help, and having a caregiver” all contributed to greater survival among the Georgia centenarians (Georgia Centenarian Study, 2005).

Marriage is perhaps the most important relationship that people have. In fact, a healthy marriage was the best indicator for successful aging in the Harvard study (Vaillant, 2002). Married people are less likely to die early (Cooper, Harris, & McGready, 2002).

For some elders, knowing their social role within the family is the key to well-being. Hispanic elders in one study believed their health was good when they were happy with their family relationships and poor when they were not, regardless of their actual health status (Beyene, Becker, & Mayen, 2002).

A wider network of family and friends can ensure that elders’ basic needs are met over the long term. Recent trends indicate that longevity is increasing among men at a faster rate than in women. This means that among married couples, women are not experiencing long periods of widowhood and the possibility of financial dependence as often as in the past. This, along with declining disability rates means that more elders have the physical independence, financial means and family network to remain in their own homes longer, and to choose home care or assisted living facilities over nursing home care as health deteriorates (Redfoot & Pandya, 2002). Additionally, those who are spouses or parents tend to take fewer risks (Bosworth & Schaie, 1977). Elders may be especially concerned that they not become burdens to their adult children and so be motivated to take better care of themselves.
Of those elders receiving home care approximately half feel distress at being suddenly dependent, resentment when a caregiver stops them from driving or performing other activities, embarrassment at needing assistance with personal care, and concern that they are a burden to their caregiver (Newsom & Schulz, 1998). Elders and caregivers who are also family members may find that this is an opportunity to reconnect with their loved one. Care giving and receiving is more likely to be a pleasant experience if the person receiving care had once provided help to their caregiver (Keefe & Fancey, 2002).

Those elders with larger circles of friends may be healthier because they have more opportunities for exercise. Many health promotion programs including walking clubs and group fitness classes encourage seniors to exercise by offering an opportunity to be with friends. Reasons elders most often cite for exercising are having fun, socializing, improving appearance, personal satisfaction, and health benefits (RoperASW, 2002).

Social groups that revolve around a common interest can also serve as informal support groups for those who are uncomfortable going to a bereavement or disease-specific support group. Pool or card rooms, sewing groups, book clubs, and similar activities provide opportunities for elders to gather and talk with understanding peers about what is troubling them. Social isolation may be a result rather than a cause of poor health. Those with vision, hearing, or mobility problems may find that they are no longer able to participate in activities they once enjoyed. The resulting social isolation may begin a downward spiral.

**RELIGION AND SPIRITUALITY**

Can faith actually affect the length and healthiness of one’s life? Some studies show that the longest-lived do tend to make religion and spirituality an essential part of their lives. Other studies find no difference between those who have closely held religious beliefs and those who do not (Purdy, 1995; Vaillant, 2002). Multiple studies indicate that regular church attendance is associated with longevity (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). However, in a two-year longitudinal study at Duke University Medical Center and the Durham Veterans Affairs Medical Center, medically ill elderly patients who indicated that they were involved in a personal religious struggle regarding their illness were more likely to die within a two-year period than those who did not (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). In this study the specific forms of religious struggle that were more predictive of mortality included a feeling of alienation from God and the belief that the devil was responsible for their illness. These particular forms of religious struggle were associated with a 19% to 28% increase in the risk of dying within the two-year follow-up period (Pargament, Koenig, Tarakeshwar, & Hahn, 2001).

**Strong Faith and Optimism**

When spirituality does make for better health, it may be because those who have a strong faith are more optimistic. Those who attend religious services and engage in private prayer or meditation tend to be both more optimistic and have better health (Krause, 2002; Ai, Peterson, Bolling, & Koenig, 2002).

**Social Benefits of Religion**

Elders who participate in organized religion may also have more opportunities to make and be with friends, which we have learned is important to healthy aging. Some elders believe that
the emotional support that they find in their religious organization is responsible for a closer relationship with God, which in turn leads to greater optimism (Krause, 2002). Health promotion programs conducted in churches and targeting African American middle-aged and older women have been very effective (Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001).

LIFE CIRCUMSTANCES

Do the lives we live affect how long we will live and how healthy we will be? Those who live to be 100 or more are a diverse group. They are rich and poor, educated and not, from large families and small, some living in mansions and some in shacks without indoor plumbing. The average centenarian in the Georgia study had a grade school education and an income of only $4,000 to $7,000 (Purdy, 1995). However, information gathered from the whole population shows that life circumstances do make a difference.

Income and Education

Education and income seem to be the most important life factors leading to good health. Elders with more education and income have fewer disabilities and better mobility, better hand coordination, visual acuity, and cognitive functioning (Administration on Aging, 2010; Snowdon, Ostwald, Kane, & Keenan, 1989). Overall, better educated people have half the disability rate of less educated people (Cutler, 2001, cited in Korczyk, 2002).

One link between education, income, and health is occupation. Experts have suggested that those with higher levels of education and income are healthier because they were more likely to have less dangerous white-collar jobs (Redfoot & Pandya, 2002). Income also affects access to care. Every year, Medicare HMO patients see an increase in their out-of-pocket costs as premiums and copays increase and benefits decrease. Elders who survive on low fixed incomes may be forced to choose between care, food, medication, and shelter; all necessary to good health.

The Nun Study seems to show that education alone can improve health. Those nuns who had more education lived longest even though they had the same income as those in their orders with less education (Snowdon, 2001). Educational level may be related to the positive effects of mental activity discussed earlier. Natural intellectual ability may motivate some to seek a higher level of education, and perhaps those who enjoy reading and other intellectual pursuits do so because these activities became a part of their lives early in their educational development.

The Gender Gap

Being a woman means that your average life expectancy is 5.4 years longer than a man’s (National Vital Statistics Systems, 2002). While the gap is closing, most likely due to medical advances, for many years older women have had significantly longer lives and more years without disability than older men (Redfoot & Pandya, 2002). Besides the purely physical differences between men and women, the disparity in life expectancy may be linked to the fact that women tend to have more physician visits and be better medicated than their male counterparts (Bosworth & Schaie, 1997). In addition, women generally have stronger support networks (Barker, Morrow, & Mitteness, 1998; Liebler & Sandefur, 2002).
The Effects of Discrimination

African-Americans live an average of 5.7 fewer years than whites (National Vital Statistics Systems, 2002). In addition, minority elders are much more likely to say that their health is fair or poor in comparison to white elders (Administration on Aging, 2010). While minority elderly Medicare beneficiaries are less likely to receive specialized treatment such as angioplasty, coronary artery bypass graft surgery, or hip fracture repair, differences in overall health may lie primarily in disparities in the delivery of preventive medicine. For instance, only 43% of black elders received flu shots in 1998 compared to 65% of white elders (Davis, 1999, p. 11). A study of African-American elders found that a “lack of confidence in formal health care system” was a barrier to good health (Dancy & Ralston, 2002). This basic lack of confidence may lead African-American elders to delay or forego preventive treatments and diagnostic screenings.

A Happy Childhood

Does happiness in early life predict which of us will live longest? Studies show that, while having a happy childhood affects well-being for many years, the effects are gone by the time we reach old age (Vaillant, 2002).

GENETICS

Some, but not all, of the healthy oldest-old have reached that mark because of their genes. Researchers from the New England Centenarian Study have found that genes may explain some of the basis for very long lives (Perls & Terry, 2003). In that study “50% of centenarians have first-degree relatives and/or grandparents who also achieved very old age, and many have exceptionally old siblings.” Children of centenarians also appear to have less cardiovascular disease, diabetes, and mortality (Perls, n.d.). The Georgia Centenarian Study did find many over age 100 whose families were not long-lived (Purdy, 1995).

HOW LONG IS LONG?

As we have learned, very long-lived people share many physical, mental, social, spiritual, and environmental characteristics. One aspect of health may be influenced by many factors. The Seattle Longitudinal Study found the risk of cognitive impairment was reduced by all of the following: 1) lack of cardiac and other chronic diseases, 2) high income and a good environment, 3) intellectually stimulating environment, 4) flexible attitude at midlife, 5) a husband or wife with good cognitive functioning, and 6) continuing high levels of “perceptual processing speed” (Seattle Longitudinal Study, n.d.).

Exactly how all of these relationships work together depends upon the unique circumstances of each patient. While it would seem unlikely that a computer program could calculate how everything we have discussed can predict an individual’s longevity, the New England Centenarian Study feels confident that they have created just that. Interested in how all the elements of your life may affect how long you will live? You may wish to log on to the “Living to 100 Life Expectancy Calculator” at www.livingto100.com. After you enter information into the survey, the Calculator will tell you how many years it estimates you are likely to live.
PRACTICE STRATEGIES

How can you as a practitioner make this information work for the better health of your older patient? Here are some suggestions.

Give Patients Information for Healthy Decisions

The information given you in this course will be most valuable if it is shared with your patients. Almost all of the common factors influencing longevity are within your patients’ control to do for themselves. Improving diet, being more physically active, focusing on emotional well-being and accentuating the positive, being with people, stimulating your mind, paying attention to your spiritual well-being are all actions that have been shown to be good for you. You can provide the motivation and information to make these changes by offering what you learn in this course to your older patients. When doing so, think about the following:

Prescribe Healthful Habits for Your Patients: Some of your elder patients may believe that they are too old for healthy practices to make a difference in their health or length of life. Now you have proof that you can give to your patients that this is not true. Besides reminding your patients of the importance of diet and exercise, let them know about why they should make the effort to get out and be with others, take the bus to the library to find some interesting books to read, or mend a family relationship.

Remind Them that They Are Not Their Parents: A patient whose parents died young may be convinced that his or her own early death is inevitable. Perhaps you can anticipate your patient’s concern and point out the many ways that they can improve their chances of living longer. Environment and good health habits are responsible for 70% or more of how long and healthfully they will live (Perls & Terry, 2003).

Reassure Them that a Long Life Need Not Be Full of Disability: Your elderly patients may be dreading the coming years, assuming that they will be filled with nothing but an inevitable decline into physical decay and dementia. This image of the future is not one to inspire the healthy habits and positive attitude that can add years to life. Telling them about those who are still healthy and active into their 90’s and 100’s may be the inspiration they need to look to the future with hope and reach for a later life that is healthy and happy.

Introduce Them to the Mind-Body Connection and CAM: Some complementary and alternative therapies have been shown to have positive mind-body health effects. Many of these therapies are not invasive or harmful and do not add yet another medication to a patient’s pillbox. The National Institute of Health’s Center for Complementary and Alternative Medicine offers information about those therapies which show promise. You may find out the latest research results on their website at www.hccam.nih.gov/health/bytreatment.htm. According to the site, relaxation, hypnosis, and biofeedback have shown beneficial effects on age-related conditions like insomnia. Other studies have shown that aromatherapy can have a calming effect on those with dementia (Smallwood, Brown, Coulter, Irvine, & Copland, 2001) while massage, reflexology and music therapy seem to benefit hospice patients (Demmer & Sauer, 2002).

Provide Tips for Maintaining Cognitive Functioning: Your older patients may be concerned about losing cognitive function even if they have no more than normal memory loss. Tell them about the research discussed so that they can begin “healthy
brain” habits. Reading, solving puzzles, taking a class, starting a new career, or learning to paint or sculpt are not only fun, but also good for the brain. Those patients who never went to college may be interested in some of the new college programs especially for seniors. The fitness classes that are beneficial to the body and social life are also good medicine for the brain.

**Protect Your Patients from Scams:** The downside of all this interest in anti-aging is that many unproven, expensive, and potentially harmful anti-aging treatments are being sold to unsuspecting elders. A group of researchers has recently stated that “there is as yet no convincing evidence that administration of any specific compound, natural or artificial, can globally slow aging in people, or even in mice or rats” (International Longevity Center, 2001). Advise your older patients to be very cautious before they spend time or money on anything that says it will keep them young or return their youth. If you find that a patient is taking some unproven anti-aging remedy, discuss with them those healthy habits and behaviors that really do improve the length and quality of life.

**Encourage Health in Many Aspects of Life**

Just as many aspects of life affect health, health problems can make other areas of life more difficult. These can then, in turn, make maintaining and improving health more challenging. You can help break this cycle by finding out from your patients what is affecting their mental, emotional, social, and spiritual lives and addressing those health issues; even if they are not what may seem most important to you. You can also offer care in a way that is sensitive to your patients’ life circumstances:

**Offer Help for What May Not Threaten Life, But Which Affects Its Quality:** What is keeping your elderly patients from having a full social life, getting to religious services, participating in activities they enjoy? Is incontinence keeping them inside the house out of fear of embarrassment? Are hearing or vision problems preventing them from talking with friends and family? Have you ever asked about sexual problems? Addressing these kinds of health problems may help the social, spiritual, and mental health of your elderly patients, and thus lead to better overall health.

**Make Things Easier for Caregivers and Receivers:** Can you find out what tasks are most difficult for the caregivers of your elderly patients and help with those, even if your patient originally came in for something else? Can you ask your elderly patients with caregivers how they feel about that relationship? One of the most important services you can provide is helping your patients to become more independent in those areas that are most difficult for caregivers to handle. Independence can improve their mental outlook and self esteem, and also improve the caregiver/care-receiver relationship. You might also wish to become familiar with the services that provide respite for caregivers and the many new technologies that can make those with disabilities more independent.

**Build a Trusting Relationship with Your Elderly Patient:** You may need to make a special effort to establish trust with patients who have had negative experiences with the health care system in the past, whether because of minority status, income, or some other reason. Perhaps you will need to make a special effort to form a personal rapport with a patient or even just acknowledge that previous experiences have been unnecessarily difficult. Spending a few moments listening to a patient whose health
concerns have been dismissed by other practitioners may help them accept your recommendations.

Use Inter-Relationships to Benefit Your Patients

You may not be able to address a health problem directly due to financial concerns, a patient’s reluctance to seek or accept help, or other reasons. In that case, consider creative ways to improve the situation using other areas of your patient’s life:

**Recommend Activities that Also Improve Mental Health:** Does an elderly patient seem a bit depressed but won’t go to counseling? Mental health problems require professional services; however, by recommending other activities you may be able to improve the mood of an elder whose problem has been properly evaluated. Exercise has been shown to reduce depression. Can you suggest a fitness class if they will accept nothing else? What about a support group at a community center? Could you refer them to a social group or other activity that may bring them into contact with others who share their problem?

**Meet Fitness and Social Needs at the Same Time:** Many fitness programs for elders combine exercise with socialization. Walking Clubs, in which groups of elders walk together regularly, senior aerobics and water aerobics classes, senior bowling leagues, and many others can fill two needs at once. If you have concern about the social isolation of a patient who denies loneliness, why not recommend one of these activities? If you have a patient who is not motivated to exercise alone, maybe a group activity would be more appealing.

**Appeal to the Altruistic Side:** If your elder patients won’t become physically and mentally active for themselves, encourage them to volunteer for an organization where they can get some exercise and improve their socialization at the same time. Delivering meals to homebound elders requires walking, lifting, and interacting with others. Working in a community garden that provides produce for the homeless presents opportunities to make new friends. Your local senior center may provide you with suggestions on volunteer programs that are as much for the benefit of the volunteer as they are for the organization.

**Motivate Your Patients through the Personal Touch:** Later life can be a time of great loneliness, especially if an elder is homebound. You are in a special position of trust to people who may have lost many family members and friends and who depend on you to help them maintain their independence. Use this special relationship to motivate your older patients to take up healthy habits. Form a connection with your older patients by making notes in their record about personal details such as their spouse’s name, military service, or some special accomplishment or interest. Mentioning some small fact about the patient’s life helps to create a personal bond with them. This personal bond can carry great weight in motivating your patient to become more active.

**Remember the Importance of Spirituality:** Even those patients who may not wish to attend formal religious services still have spiritual needs, especially when they become seriously ill. Because of HIPPA regulations, hospitals will only provide information about patients to clergy if the patient lists a religious denomination on admission forms. Let patients know how they can receive a clergy visit. Many senior centers have non-denominational programs about spirituality led by psychologists or nurses. Other
programs not specifically about spirituality provide opportunities for meaningful
discussions. Examples include reminiscence projects, support and discussion groups,
memoir and art classes, many of which are available at senior centers.

Use the Family Connection: What elders won’t do for themselves they will
sometimes do for family. The constant stress of caring for an aging family member or
friend can affect the caregiver in various ways. For some, it is a reason for living, and
for others it can become an overpowering burden that results in resentment and abuse
of the elder. Elder abuse victims, who many times feel great concern for their abuser,
often will not agree to receive help unless help is also offered to the abusing family
member (Brandl & Cook-Daniels, 2002). Many elders are concerned about becoming a
burden to their adult children or delay entering a nursing home in order to preserve an
estate for their adult children. Reminding them of the effect of their disability on family
members may encourage elders to accept the help they need.

Your Local Elder Service Agency is a Resource for the Whole Elder

Elder services networks including senior centers, home care corporations, councils on aging,
and the like, should be your partner in helping your patients meet their overall health goals.
These agencies are dedicated to serving the whole elder and are experts at creating programs
that encourage overall well-being and matching individual seniors with the right service or
activity. One of the best ways you can meet the various needs of your elderly patients is by
making sure that they are taking advantage of available services in the community. The two
primary agencies are:

- Senior centers, which are public or private community centers frequently offering both
  activities for independent elders as well as care or case management for homebound
  elders.
- Home care corporations, which are federally-funded agencies designated by your
  state’s Agency on Aging to provide a wide variety of services, mainly for homebound
  seniors.

How can you ensure your patients are using their local elder service agencies? Send your
older patients to elder service agencies for the kinds of social, spiritual, and mental health-
enhancing activities that can improve physical health. This would include almost any offered
activity or service, but especially:

- Fitness classes
- Support groups
- Discussion groups about spirituality
- Activities to stimulate the mind
- Social and recreational programs
- Nutritional programs such as congregate lunches and home-delivered meals

Make specific suggestions to your patients about activities that meet their needs, and have
resource guides available in your office for patients to browse.

For the homebound patient who should spend more time with people, improve their nutrition,
or need other types of non-medical help, communicate with his or her care or case manager.
A care or case manager is the person who evaluates an elder’s needs and arranges and
monitors in-home services such as friendly visitors or home-delivered meals. This person may
be a staff person in a senior center or home care corporation, or a private geriatric case
manager who is paid on an hourly basis. Ask your patient if he or she has a care or case manager. Because the elder may not know the terms care manager or case manager, ask questions like, “Who arranges for your in-home service?” or, “Who do you call if you have a problem?” If an elder patient does not have a care or case manager, refer them to a senior center or home care corporation so that they can find one. Any communications about individual patients must, of course, follow all legal and ethical privacy guidelines.

To find out about the elder services in your area call the Eldercare Locator. This is a federally-funded national hotline that can refer you to a home care corporation based on the name of the community or the zip code. Eldercare Locator can be reached by calling 1-800-677-1116 or through their website at www.eldercare.gov. Home care corporations have comprehensive information and referral services that can tell you exactly what is available in your community. Many senior centers also provide extensive information and referrals and, since they generally serve a smaller area, may have more detailed information.

WHAT DO SENIOR CENTERS OFFER?

Senior centers can be public or private, large or small, with many services or with just a few. Even those in small towns often provide:

- A range of fitness classes, including aerobics, weight strengthening, walk clubs, tai chi and yoga, and other exercise opportunities
- Health clinics
- Individual help with financial, legal, tax, and insurance problems
- Informational programs on health, legal, financial, and other issues
- Support and discussion groups
- Classes on art, crafts, and many other topics
- Trips
- Social and recreational activities
- Volunteer opportunities
- Spirituality programs
- Congregate lunch programs and home-delivered meals
- Friendly visitor programs
- Medical transportation
- Care and case management
- Information and referral
- Counseling for elders and family caregivers

WHAT DO HOME CARE CORPORATIONS OFFER?

Home care corporations offer a wide variety of services. Like senior centers, they may be public or private. Many services are the same in all home care corporations because they are federally funded, while others may be special initiatives of an agency supported by state and local or private funds. Services may include:
- Case management of individual elders
- Information and referral to other elder services agencies
- Direct care such as chores, personal care, or homemaker services
- Protective services for abused elders
- Money management for those who are no longer able to handle finances
- Caregiver training and respite
- Community education

OTHER SERVICES FOR ELDERS

A variety of services for elders and their caregivers have been created over the past several years. Among those that might be useful for your patients are:

- Social and medical day care centers which offer care and activities to elders who need supervision and socialization but who still live in the community.
- Private geriatric care managers who evaluate an individual’s needs and arrange and monitor services for an hourly fee.
- Respite care, including both in-home care providers and short-term nursing home or assisted living stays, in order to give caregivers a rest.
- Private organizations or universities that offer travel and educational opportunities for seniors.
- Private membership organizations that offer many services similar to those provided by senior centers and home care corporations.
- Elder legal service providers who offer no or low-cost legal services on aging-related issues such as health benefits.

CONCLUSION

In conclusion, although genetics plays an obvious role in longevity, the length and quality of life in later years can be influenced by lifestyle choices and healthy habits. Healthcare providers can support and encourage those behaviors that improve physical, mental, and spiritual well being. Providing resources; facilitating mobility, physical activity, good nutrition, social interaction and relationships; managing chronic illness; and encouraging mental stimulation can improve daily lives and add years to life expectancy.

For more information on current elder care standards and practices, visit the websites below:

National Association of Social Workers Standards of Practice

American Geriatrics Society
http://www.americangeriatrics.org/

AAMC Geriatric Competencies for Medical Students
https://www.pogoe.org/Minimum_Geriatric_Competencies

Merck Manual: Geriatrics
http://www.merckmanuals.com/professional/geriatrics
REFERENCES


1. As of now, healthy behavior can add about how many years of life to an average person’s lifespan?
   a. Two
   b. Eight
   c. Fifteen
   d. Twenty-five

2. A patient who has lived past 100:
   a. Had the same possible lifespan at birth, but much healthier habits, than those who died at 85.
   b. Most likely has genes whose influence was more important than even very bad health habits.
   c. Probably combined an unusual genetic predisposition to long life with good health habits.
   d. May have good genes and good health habits, but has an “X factor” that has yet to be identified.

3. Another characteristic of your centenarian patients is that:
   a. They may well be functioning at the same level as your patients in their ‘80s.
   b. They most certainly have some level of dementia.
   c. They have likely been in a nursing home for at least 15 years.
   d. They may still live at home, but are likely much frailer than your patients in their late 80’s.

4. According to the article, for which might you recommend exercise?
   a. Loneliness
   b. Cognitive ability
   c. Depression
   d. All of the above

5. A patient complains about problems that occur when he drinks but he says he is the moderate drinker he has always been. The best response would be to:
   a. Challenge the patient for lying because honesty is always the best policy.
   b. Ask for a list of all prescription and non-prescription medications
   c. Give the patient alcohol and check to see how long it takes the blood alcohol level to return to normal.
   d. Note in the chart that the patient seems to have short term memory loss and refer him to a detoxification program.
6. The only reason among those below for nurses not to treat an elder patient’s depression is:

   a. Depression can occur at the same time as many other illnesses, such as Parkinson’s disease and cancer.
   b. Depression can be a primary reason for poor diet.
   c. Depressed elders are less likely to participate in physical activity.
   d. Depression is a normal response to the losses of later life.

7. In terms of personality, your centenarian patients:

   a. Developed an optimistic personality over time as they learned to handle life's challenges.
   b. Have a healthy ability to deny their physical ailments.
   c. Are able to handle stress well.
   d. All of the above

8. Being in caregiver/receiver relationship can affect the physical and mental health of:

   a. The caregiver negatively.
   b. The care receiver negatively.
   c. Both caregiver and care receiver negatively.
   d. Both caregiver and care receiver either positively or negatively.

9. Patients who consider themselves to be religious:

   a. May be healthier because they go to religious services more often.
   b. May not take care of themselves because they have less fear of dying.
   c. Are more likely to recover from serious illness if they include religious struggle as part of how they cope with their medical condition.
   d. Are more pessimistic about recovery because they are angry at fate for their illness.

10. Education is a predictor of good health and long life:

    a. Only as it affects both occupation and income.
    b. Even when income is controlled for.
    c. Principally when it is accompanied by less dangerous work.
    d. Mainly because of its affect on income.

11. Your elder patients who are members of minority groups:

    a. Perceive that they are less healthy, but are actually about as healthy as whites.
    b. May not be receiving the level of care they need and therefore less healthy.
    c. Live as long as whites but in poorer health.
    d. Perceive that they do not receive adequate care because of past discrimination that actually no longer exists because of Medicare.
12. An elder patient who has had good diet and exercise habits tells you that she is concerned because one parent died young and the other had Alzheimer’s disease. Which would not be among your good responses?

   a. Reassure the patient that she can still live long and so needs a variety of healthy habits.
   b. Suggest doing more crossword puzzles.
   c. Be honest with the patient about her own prospects for a shorter-than-average lifespan no matter what her health habits.
   d. Tell her to mend family relationships before it’s too late.

13. Based on anti-aging products currently on the market, nurses should prepare themselves for a future in which:

   a. Lifespans are not significantly different from those of today.
   b. Diet and exercise will be less important but still important for good health.
   c. Dementia will be much less prevalent than now.
   d. More people will live to greater ages but with more frailty.

14. Incontinence and sexual dysfunction are two issues that frequently embarrass older patients. As a result, nurses should:

   a. Ask about them anyway if the patient complains of loneliness.
   b. Avoid talking about them to maintain the patient’s comfort.
   c. Only bring them up if they relate to the primary reason for the office visit.
   d. Not discuss them because these are normal conditions of aging.

15. The most important service listed below that nurses can provide to patients with a family caregiver is:

   a. Counseling both patient and caregiver about the role of genetics in longevity since they are likely to belong to the same family.
   b. Nothing beyond what the patient originally came in for so that the family caregiver does not feel you are interfering.
   c. Offering help to caregivers since care receivers will many times only accept help if their family member does also.
   d. Helping the patient be more independent in those areas that are most difficult for the caregiver.

16. An active elder patient seems in need of social support but won’t go to a counselor. What is the best response among those listed below?

   a. Wait to see if the situation improves since the patient may not be able to afford the 50% Medicare co-pay.
   b. Refer him to Meals-on-Wheels.
   c. Recommend a fitness class at a community center.
   d. Suggest a community college course to improve educational level.
17. Your elder patient refuses to leave the house to participate in a fitness program though you believe he is physically able. What might the best response be?
   a. Loan him a fitness videotape since some exercise is better than none.
   b. Suggest he volunteer as a Meals-on-Wheels deliverer.
   c. Suggest he have a volunteer visitor come to his home to reduce loneliness.
   d. Don’t add to his stress by trying to force him to do things he does not want to do.

18. Your local senior center likely provides:
   a. Mainly social and recreational activities.
   b. Activities ranging from bridge to health clinics to spirituality.
   c. Both community activities and social workers for homebound elders.
   d. Mainly social workers for homebound elders.

19. A state-designated agency that provides a variety of services, especially for frail elders, is called:
   a. A home care corporation.
   b. A state department of elder services.
   c. A senior center.
   d. An elder community services coordinating agency.

20. Your first call in determining what community-based elder services are available in your area is the:
   a. State Department of Elder Services
   b. Eldercare Locator
   c. Private Geriatric Care Manager
   d. Case Management Agency
Your opinion is important to us. Please answer the following questions by circling the response that best represents your experience.

<table>
<thead>
<tr>
<th>COURSE OBJECTIVES &amp; CONTENT</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>1. The activity was valuable in helping me achieve the stated learning objectives.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>2. The content was up to date.</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>2. The number of credit hours was appropriate for the content.</td>
<td>5</td>
<td>4</td>
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<tr>
<th>TEACHING/LEARNING METHODS</th>
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<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>4. The teaching/learning methods, strategies, and slides were effective in helping me learn.</td>
<td>5</td>
<td>4</td>
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<td>5. The material was clearly explained.</td>
<td>5</td>
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<td>6. The answers to the post-test questions were appropriately covered in the activity.</td>
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<tr>
<th>OVERALL ACTIVITY</th>
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<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>7. The online course/download supported the achievement of the stated learning objectives.</td>
<td>5</td>
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<td>8. The material was relevant to my professional development.</td>
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<td>9. Overall, I am pleased with this activity and would recommend it to others.</td>
<td>Yes</td>
<td>No</td>
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<td>10. The content was presented free of commercial bias. *</td>
<td>Yes</td>
<td>No</td>
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<td>11. Did the material presented increase your knowledge and/or understanding of this topic? *</td>
<td>Yes</td>
<td>No</td>
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* If you responded “No” to question 10, please explain why:

______________________________________________________________________________

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* If you answered “Yes” to question 11, what change do you intend to make?

______________________________________________________________________________

______________________________________________________________________________

What barrier, if any, may prevent you from implementing what you learned?

______________________________________________________________________________

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Cite one new piece of information you learned from this activity:

______________________________________________________________________________

______________________________________________________________________________

Additional comments/suggestions:

______________________________________________________________________________

______________________________________________________________________________

With my signature I confirm that I am the person who completed this independent educational activity by reading the material and completing this self evaluation.

Signature _________________________________ Date: ____________________________
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UNDERSTANDING IMPLICIT BIAS

The goal of healthcare is to provide the best possible care to all patients; indeed, many healthcare professionals must recite a pledge similar to the Hippocratic oath upon licensure. However, it is possible for healthcare professionals to have implicit bias that leads to substandard care.

Implicit bias is an unconscious attitude leading to stereotypes that influence thought and action. Not being aware of this bias can lead to unintentional discrimination in patient assessment and diagnosis, treatment, follow-up care, etc. Discrimination, unconscious or otherwise, in these impacted areas of healthcare leads to disparities where disadvantaged patient populations receive unequal care. Patient groups especially at risk of receiving unequal care may include:

- Those with lower income
- Women
- Minorities
- Those who speak English as a second language
- The elderly

An example of healthcare disparities can be seen in breast cancer mortality rates. Black women are 41% more likely to die from breast cancer than white women. Additionally, they are less likely to be diagnosed with stage I breast cancer, but twice as like to die from early breast cancer.

Eliminating implicit bias can help reducing disparities in healthcare. Strategies for healthcare professionals to remove bias from their practice may include:

- Regulating emotions – being aware of, and control, thoughts and feelings
- Building partnerships – working with patients to achieve a common goal
- Taking perspective – understand the patient perspective during all phases of healthcare

Recognizing implicit bias and working to remove it from practice will help healthcare professionals to give the best care possible to all patients and reduce the disparities between patient populations.

REFERENCES


Aujero, M. Breast cancer screening for at risk women. Oral presentation at: 23rd Annual Breast Cancer Update; February, 2021; Wilmington, DE.

Home-Study Registration/Order Form

Date: ____________________  Nursing License # ________________________ (Required for Florida Nurses)

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__________________________________________________________

City: _______________________ State: _____  Zip: __________________________

Email:  _______________________________________________________________

(H) # ____________________   (W) # ___________________

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<td>CX0049</td>
<td>The Influence of Lifestyle Choices on Health in the Older Patient</td>
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