CE Article

Health Promotion for Aging Adults

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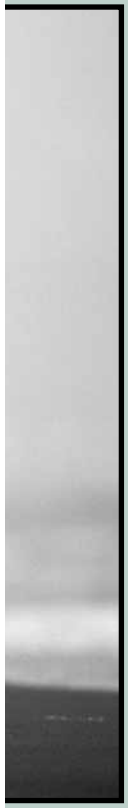
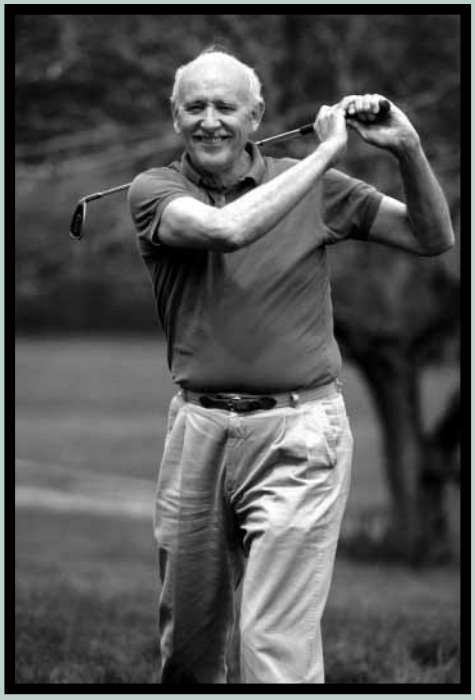
Instructions to CE enrollees:

The closed-book, multiple-choice examination that follows this article is designed to test your understanding of the educational objectives listed below. The answer form is on page 17.

On completion of this article, the reader should be able to:

1. Identify components of health promotion activities
2. Describe health promotion as it affects the elderly population
3. Discuss Healthy People 2010 objectives and goals for this population





Abstract

This article describes the essentials of health promotion, aging in America, and factors to consider when developing health promotion materials for elders. It also provides a checklist to evaluate materials for appropriateness. (Geriatr Nurs 2002;23:28-34)

Health promotion programs for elders are being developed around the nation.[1,2] Resources vary widely and include educational classes, websites, brochures, and health fairs. Although some programs are national, communities also are evaluating the needs of individuals in their areas to plan interventions.

THE ESSENTIALS OF HEALTH PROMOTION

In 1963, Havighurst, Neugarten, and Tobin[3] identified six classic components of life satisfaction—zest, resolution, fortitude, completion, self-esteem, and hope. These components still are considered essential to quality of life. However, health promotion is a broader concept than quality of life. *Health promotion* is the term commonly used to describe not only learned health behaviors and social and cultural influences but also physiologic, psychologic, and environmental elements.[4]

Elder[5] describes health promotion as alterations in human behavior and environmental situations manifested by actions that directly or indirectly promote health and prevent illness. Health promotion also can be described as protection or improvement in the physical environment that reduces or eliminates hazards. Health protection encompasses occupational, home, and environmental health and safety, unintentional injury prevention; automobile safety; and toxic agent control.[6] Hogstel[7] defines disease prevention as actions taken by individuals or groups to exclude risks of incurring disease, disability, or death.

The American College of Physicians[8] has developed guidelines to identify the health behaviors of elderly patients with known health risks and provide specific preventive interventions. For example, primary prevention for this population includes immunization, nutritional support for weight conditions, exercise programs, smoking cessation and programs that encourage limiting alcohol, home safety, stress management, and appropriate medication use. Secondary measures include detection of occult disease in early states before symptoms occur, hypertension control, skin cancer detection and treatment, and such screenings as mammograms and rectal, prostate, organ cavity, and vision examinations. Tertiary measures aim to prevent symptom progression during rehabilitation. Several conditions commonly afflicting the elderly include arthritis, osteoporosis, and urinary and fecal incontinence.[5]

The recently published *Healthy People 2010: National Health Promotion and Disease Prevention Objectives* sets a national agenda for promoting and protecting Americans' health.[9] This document identifies some of the major health concerns for older adults and articulates national objectives for promoting the health of the American people, including the nation's elderly population. Table 1 lists objectives specifically for elders.

Areas that may need intervention are determined by an assessment that identifies risk factors for illness or injury.[4] Gordon[10] provides a classic model of functional health patterns that can provide a framework for assessment information on individual and family functioning; its elements include:

- Self-perception/self-concept
- Roles/relationships
- Health perception/health management
- Nutrition/metabolism
- Coping/stress tolerance
- Cognition/perceptual
- Values/beliefs
- Activities/exercise
- Rest/sleep
- Sexuality/reproduction
- Elimination

ESSENTIALS OF A HEALTH PROMOTION PROGRAM FOR AGING ADULTS

Health promotion is an important concept for individuals regardless of age, but it is especially important when the aging process is considered. Disability rates, the health of individuals relative to parents, and improvements in medical care, technology, and consumer lifestyles are factors that can be influenced by health promotion information. Millions of older Americans are aging well, functioning independently both physically and mentally for decades after 65. Many Americans are finding that this stage of life can be as full of dignity, independence, creativity, health and vitality as any other stage. The roles and functions of people in this stage of time have indicated a new vision—a "third age."[11] Cohen states, "There is no denying the magnitude of disease and disability associated with aging. But what is considerably underappreciated, if not denied, is the opportunity for creative growth and expression among aged individuals."[11]

Creative growth and expression *can* be promoted through information with emphases on primary, secondary, and tertiary prevention.

Addressing Causes of Death

The five current major causes of death in aging populations in developed countries are cardiovascular disease, cancer, cerebrovascular disease, chronic pulmonary disease, and pneumonia and influenza.[12]

Addressing Chronic Conditions

The leading chronic conditions include arthritis, high blood pressure, heart disease, learning impairment, and cataracts.[12]

Addressing Risk Factors

The risk factors that affect successful aging are smoking, alcohol abuse, major depressive disorder,[13] income in the lowest quintile, fewer than 12 years of education, race other than white, depression, lack of close personal contacts, failure to walk for exercise,[14] poor body mass index, and poor exercise habits.[15] When such risk factors are addressed, physical health improves. People with good health habits can postpone the onset of disability about 5 years longer than those with poor health habits.[15] People who have reached or are approaching the outpost of aging—50—should begin working toward successful aging.

Table 1. Healthy People 2010 Selected Health Objectives for Elderly People

Physical Activity

1. Increase to 22% the proportion of people aged 18 or older who regularly perform physical activities that enhance and maintain muscular strength and endurance (baseline: 16% of all adults; 6% of people aged 65-74 did strengthening exercises in the past 2 weeks in 1995)
2. Increase to at least 40% the proportion of people aged 18 and older who perform physical activities that enhance and maintain flexibility (baseline: 31% of all adults; 21% of people aged 65 and older did stretching exercises in the past 2 weeks in 1995)

Safety

1. Reduce suicides to no more than 9.6 per 100,000 people (baseline: age-adjusted 11.2 per 100,000; 38.7 per 10,000 for white men aged 65 and older in 1995)
2. Reduce deaths from falls to no more than 2.3 per 100,000 people (baseline: age-adjusted 2.6 per 100,000; 89.1 per 100,000 for white men aged 65-84; 129.8 per 100,000 for white men aged 85 or older in 1995)
3. Reduce hip fractures for people aged 65 and older to 800 per 100,000 women and 350 per 100,000 men (baseline: 1000 per 100,000 women; 440 per 100,000 men in 1995)
4. Reduce residential fire deaths to no more than 1 per 100,000 people (baseline: age-adjusted 1.2 per 100,000; 3.6 per 100,000 for people 65 years and older in 1995)

Chronic Disabling Conditions

1. Reduce the proportion of all people with arthritis who have difficulty in performing two or more personal care activities, thereby preserving independence (no current baseline)
2. Increase years of healthy life to at least 66 (baseline: 63.9 years; 56.0 years in African Americans in 1995)
3. Increase by 75% the number of days in the past 30 when adults with activity limitations who need assistance feel healthy (no current baseline)

Health Promotion and Screening

1. Increase to 90% the rate of immunization coverage among adults 65 years of age or older; 60% for high-risk adults 18-64 years of age
2. Decrease the incidence of invasive pneumococcal infections to 53 per 100,000 people aged 65 and older (baseline: 70.7 per 100,000 aged 65 or older in 1995-1996)
3. Increase to at least 90% the proportion of people aged 65 and older who have participated during the preceding year in at least one organized health promotion program (baseline: 12% in 1995)
4. Increase to 25% the proportion of long-term care residents who use the oral health care system each year (baseline 19%)
5. Increase the proportion of primary care providers who routinely evaluate, treat, and, if appropriate, refer their long-term patients to subacute rehabilitative and other services to address (no current baseline):
   - Physical mobility
   - Urinary incontinence
   - Polypharmacy (use of multiple prescription and over the counter drugs)
   - Communication and hearing disorders
   - Depression
   - Dementia
   - Mental disorders
6. Increase the proportion of primary care providers who routinely provide a functional assessment to potential long-term care patients or refer them for a functional assessment (no current baseline)
7. Increase the proportion of women aged 50 and older and other people at high risk for osteoporosis who are counseled about prevention and about appropriate regimens for treatment (no current baseline)

U. S. Department of Health and Human Services (Nov. 2000). Health People 2010. Jones and Bartlett, Sudbury, MA 01776

Enabling Access to Medical Care

Information about available health services and access to those services are needed so that elders who develop problems can see a physician right away. Symptoms should not be accepted as inevitable with old age. If problems are detected early, they may not develop to an advanced stage.

In many communities, many resources for health promotion and disease prevention are not well known. People in need may be unaware of available services and how to access them even if they are known. Several community resources for the elderly are listed in Table 2.

Elders who have access to the Internet have a wealth of information at their disposal. A search of "geriatrics" in early 2001 yielded 161 sites on diverse topics related to specific facts about aging, services, and organizations available to help with specific problems. For example, the American Geriatrics Society *(www.americangeriatrics.org)* and National Institute of Aging (*www.nih.gov/nia*) provide a wealth of information on many topics of interest to the elderly.

Providing Participation in Health Care System

Baby Boomers are demanding equal participation in the health care system. This involvement means a new relationship between providers and consumers. Health now is viewed as the vitality of life, not just the absence of illness. Boomers are demanding that the power of information be an asset to the system and that technology be incorporated more efficiently and effectively into health care. Boomers know more and have access to the Internet for information and are more educated about options available to them.

Providing Equal Opportunities by Gender

Men are much less likely to live in a single-person household than women after 65. Poverty is more prevalent among women living alone.[16] Women in the Baby Boom generation have advantages over their mothers in that they are more likely to have participated in the workforce. Boomer women have the disadvantage, however, that they are more likely to be single, either by choice, divorce, or death. The median amount they have set aside for retirement is $20,000—which will not pay for a year in a nursing home. Very few women in the Boomer generation have accumulated $100,000 or more in their retirement accounts, and even that figure is equal to only a year or two in a nursing home.[17]

Providing Equal Opportunities to Racially and Ethnically Diverse People

A growing body of research suggests that equal care is not available across racial and ethnic groups.[1] For example, research has reported consistently that elderly African Americans are not equal participants in the formal health care system.[1] Most research for some illnesses, such as Alzheimer disease, has been conducted with whites,[18] although the number of elders in diverse racial and ethnic groups is increasing. By 2050, significantly more elderly Americans will be ethnically diverse, with large gains among Hispanics and Asians.[20]

Promoting health care for elders from other cultures presents unique challenges. Racial and ethnic origin can affect health status and perception. It is important that health promotion information be created in English, Spanish, and other appropriate languages for the individuals who will use it. Materials must be culturally sensitive and take into account ethnic diversity, beliefs, and practices related to health.

ESSENTIALS OF COMMUNITY HEALTH PROMOTION MATERIALS

Many communities have tried to respond to the Healthy People 2010 objectives by developing services to meet the enormous needs for health promotion and disease prevention and develop primary, secondary, and tertiary intervention measures. Attention to the criteria in Table 3 can help determine if materials are appropriate.

Establishing a clearinghouse telephone number to provide centralized information regarding access to health services is one solution. This method requires the cooperation of community providers to furnish current information on available services, hours of operation, and locations. Elders could call this number, ask for a particular service, and be given a list of all available programs within their community. The clearinghouse number should be published in local newspapers and fliers and posted in as many locations as possible. Services can be posted on public service announcements on television and radio, billboards, signs on buses, and the Internet. In addition to these postings, pamphlets and business cards should be made available in all social service agencies, public service agencies, concerned community businesses, bus stations, and provider offices.

In addition to service information from all community providers, the clearinghouse should promote the growing diversity of communities. The staff needs to be aware of cultural diversity and be fluent in the local residents' languages.

Providing "one stop shopping" through a medical access telephone service is an innovative options for educating Americans and achieving the Healthy People 2010 objectives.

CONCLUSION

Health professionals caring for aging adults in the future will need to be competent in a number of skills, including caring for the community's health, managing information, increasing access to care, coordinating care in integrated networks, practicing prevention, promoting healthy lifestyles, and participating in a racially and culturally

Table 2. Elderly Community Resources

Administration on Aging
U.S. Department of Health and Human Services
330 Independence Ave. SW
Washington, DC 20201
(202) 619-0724, (202) 619-0556
www.aoa.gov

Alzheimer's Association
919 N. Michigan Ave., 10th Floor
Chicago, IL 60611
(312) 335-8700

American Association for Geriatric Psychiatry
7910 Woodmont Ave., 7th Floor
Bethesda, MD 20814
(301) 654-7850

American Association of Homes for the Aging
901 E. St. NW, Suite 500
Washington, DC 20004
(202) 783-2255
www.aahsa.org

American Association of Retired Persons
601 E St. NW
Washington, DC 20049
(202) 434-2277, (800) 424-3410
www.aarp.org

American Geriatric Society
700 Lexington Ave., Suite 300
New York, NY 10021
(212) 308-1414, (800) 247-4779
www.americangeriatrics.org

American Public Health Association
Section of Gerontological Health
1015 15th St. NW, Suite 300
Washington, DC 20005-2699
(202) 789-5600
www.apha.org

American Society for Geriatric Dentistry
211 E. Chicago Ave., 17th Floor
Chicago, IL 60611
(312) 440-2500, ext. 2660

American Society on Aging
833 Market St., Suite 511
San Francisco, CA 94103-1824
(415) 974-9600

American Speech and Hearing Association
10801 Rockville Pike
Rockville, MD 20852-3279
(301) 897-5700
www.asha.org

Arthritis Foundation
1330 W. Peachtree St.
Atlanta, GA 30309-2898
(404) 872-7100, (800) 283-7800
www.arthritis.org

Commission on Legal Problems of the Elderly
1806 M St. NW
Washington, DC 20036
(202) 331-2297

Directory of Aging Resources
Business Publishers
951 Pershing Dr.
Silver Springs, MD 20910-4464
(800) BPI-6737

Gerontological Society of America
1275 K St. NW, Suite 350
Washington, DC 20005-4006
(202) 842-1275
www.geron.org

Gray Panthers
2025 Pennsylvania Ave. NW, Suite 821
Washington, DC 20006
(202) 466-3132, (800) 280-5362

Institute of Retired Professionals
The New School of Social Research
66 W. 12th St., Room 502
New York, NY 10011
(212) 229-5600
www.newschool.edu

National Association for Home Care
228 7th St. SE
Washington, DC 20003
(202) 547-7424
www.nahc.org

National Association of Spanish Speaking Elderly
2025 I St. NW, Suite 219
Washington, DC 20006
(800) 638-8255

National Caucus of the Black Aged
1424 K St. NW, Suite 500
Washington, DC 20005-2410
(202) 637-8400

National Citizen's Coalition for Nursing Home Reform
1424 16th St. NW, Suite 202
Washington, DC 20036
(202) 332-2949

National Council of Senior Citizens
1331 F St. NW
Washington, DC 20004-1171
(202) 347-8800

National Institute on Aging
National Institute of Health
9000 Rockville Pike
Bethesda, MD 20892-0001
(301) 496-4000

National Senior Citizen's Law Center
1101 14th St. NW, Suite 400
Washington, DC 20006
(202) 289-6976
1052 W. 6th St., Suite 700
Los Angeles, CA 90017
(213) 236-3890

Older Women's League (OWL)
666 11th St. NW, Suite 700
Washington, DC 20001
(202) 783-6686, (800) 825-3695

Social Security Administration
6401 Security Blvd.
Baltimore, MD 21235
(800) 772-1213

Table 3. Checklist for Health Promotion Educational Material

1. Do materials respond to an identified need (need to survey to determine interest, evaluate to determine response, and demonstrate continued need for ongoing information, or are current materials adequate)?
2. Is material accessible to people who need it (locations convenient to people for whom it is designed)? If it's on the Internet, do users have access to a computer? Are people who need it adequately computer literate?
3. Is material appropriate for readers' literacy level? Is type large enough?
4. Is material appropriate for readers' cultural orientation? Is it printed in a variety of languages?
5. Is material appropriate for readers' ages?
6. Do materials relate to topics of health promotion of the elderly (eg, areas of mortality, chronic illness, risk factors, health habits, retirement, access to care, available services)?
7. Are graphics appropriate to audience (age appropriate, colorful, attractive, tasteful)?
8. Does material provide new information (not information already known or available)?
9. Is material gender appropriate?
10. Does material consider readers' income limitations in terms of cost of both the materials and the services described?
11. Does material consider possible cognitive limitations (eg, memory impairments)?
12. Does material communicate importance of information (eg, relationship of exercise to limiting disability)?
13. Is there a plan to sustain availability of the educational materials (financial and human resources)?

diverse society. Helping individuals in the community seek needed information is central to community health nursing practice.

Some individuals are convinced that "old age" is a period of decline and dissatisfaction.[21] This perception is far from true. Although many older adults will experience some debilitation at the end of life, the level and duration of infirmity can be minimized by good health habits, comprehensive services, and good social support. Watson and Pulliam[22] found that older adults are often the most open age group to education and other forms of support, particularly when making changes or transitions in their lives. Thus, through health promotion interventions, elders can enter the third stage of life with increased vigor and less likelihood of illness. Having adequate knowledge and using health promotion and maintenance resources can prolong good health.

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CE

Contact hours: 1.0
Minimum passing score: 70%
Test processing fee: $9
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1. Which is NOT one of the six components of life satisfaction?
   A. Zest
   B. Wealth
   C. Hope
   D. Fortitude

2. Primary prevention for the elderly include all of the following EXCEPT:
   A. Exercise
   B. Smoking cessation
   C. Mammograms
   D. Immunization

3. Tertiary measures for the elderly focus on:
   A. Hypertension control
   B. Skin cancer detection
   C. Visual exams
   D. Rehabilitation to prevent progression

4. Which is NOT one of the five current major causes of death in aging populations of developed countries?
   A. Nutrition
   B. Cancer
   C. Influenza
   D. Pneumonia

5. Which is NOT listed as one of the leading chronic conditions?
   A. Arthritis
   B. Learning impairment
   C. Cataracts
   D. Isolation

6. Risk factors that interfere with successful aging include the following EXCEPT:
   A. Smoking
   B. Alcohol abuse
   C. Depression
   D. Divorce

7. Advertising health promotion for the elderly is best done (according to this article) through:
   A. Public service announcements
   B. Television
   C. Clearinghouse with a telephone number
   D. Written literature

8. What was the 1995 baseline for residential fire deaths for people older than 65?
   A. 1:100,000
   B. 1.2:100,000
   C. 3.6:100,000
   D. 8.9:100,000

9. What was the 1995 baseline for people 65 and older who participated in a health promotion program?
   A. 12%
   B. 32%
   C. 70.7%
   D. 90.4%

10. How different was the suicide rate for white men in 1995 compared with the whole population?
    A. Lower
    B. Twice as high
    C. More than three times higher
    D. Ten times higher

CE ANSWER/ENROLLMENT FORM

To receive continuing education credit for any test in this issue, simply do the following:

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This is a standard form; use only the number of spaces required for the test you are taking.

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11. ❑ A ❑ B ❑ C ❑ D	12. ❑ A ❑ B ❑ C ❑ D	13. ❑ A ❑ B ❑ C ❑ D	14. ❑ A ❑ B ❑ C ❑ D	15. ❑ A ❑ B ❑ C ❑ D	16. ❑ A ❑ B ❑ C ❑ D	17. ❑ A ❑ B ❑ C ❑ D	18. ❑ A ❑ B ❑ C ❑ D	19. ❑ A ❑ B ❑ C ❑ D	20. ❑ A ❑ B ❑ C ❑ D

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PROGRAM EVALUATION

	Strongly agree				Strongly Disagree
The objectives of the program were met.	1_	2_	3_	4_	5_
The content was appropriate.	1_	2_	3_	4_	5_
My expectations have been met.	1_	2_	3_	4_	5_
This form of CE is worthwhile.	1_	2_	3_	4_	5_
The level of difficulty of this test was:	1_	2_	3_	4_	5_
	Easy				Difficult

How long did this program take to complete? _____ hours

❑ I have enclosed an additional $10 for rush processing.

❑ I have enclosed an additional $15 for foreign delivery.