

## **QUALITY OF LIFE FOR OLDER ADULTS WITH SERIOUS, CHRONIC ILLNESS**

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People around the world are living longer than ever before with major improvements in nutrition, environmental conditions and overall health. But their quality of life is threatened by negative attitudes about older adults and aging, and chronic illness that frequently accompanies aging. These potential threats can be of particular concern when older adults seek healthcare if healthcare professionals hold negative attitudes toward aging and older adults.

The Center for Aging, Health and Humanities (The Center) was established at George Washington University in 1995 to address the stereotypes of older adulthood by conducting research on the creative potential of older adulthood (George Washington University, 2013).

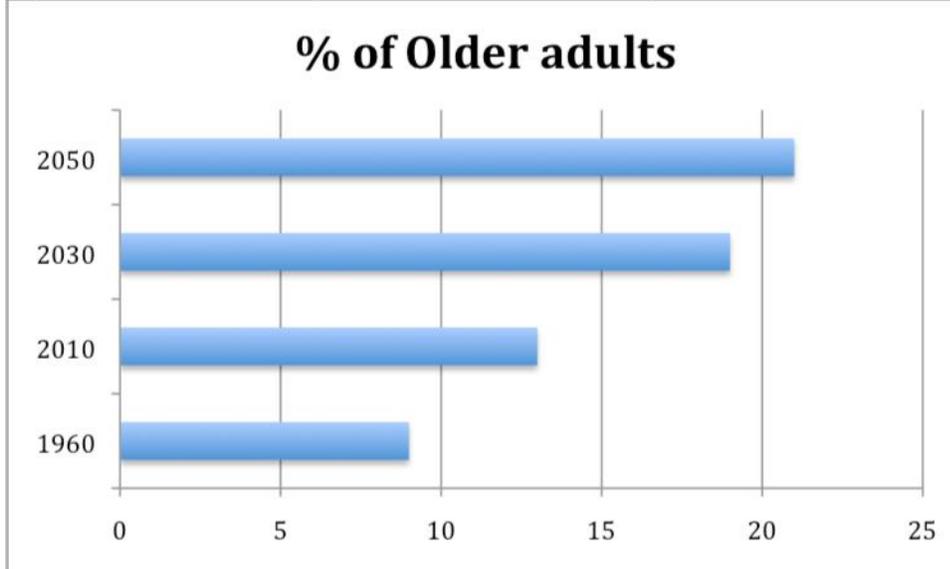
In 2009, The Center faculty developed gerontology curriculum to develop a more person-centered approach to care of the older adult to minimize biases toward aging. This approach also encourages individualized care rather than the tendency to provide a “one size fits all” type of healthcare. The Center espouses a person-centered approach to care for older adults as it provides safer and more effective care for older adults with chronic illnesses (IOM, 2008), while supporting and respecting their quality of life. Healthcare professionals are more able to understand this new paradigm in the framework of an integrated geriatric and palliative care model that places the individual and their family at the center of a team approach to maximizing the quality of life, as well as offering disease modifying and comprehensive supportive care. This blended approach to care provides a model for person-centered care that recognizes the older adult as a person seeking continuing growth (creative) potential for quality of life, and not just a patient with health care problems to be solved.

This paper will examine the demographics of older adults in the United States and globally. The demographics will provide a meaningful backdrop for appreciating the challenges and opportunities for the growing segment of older adults who face ageism and increased potential for chronic illness. Ageism is defined as “negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a perception of them as being ‘old’ or ‘elderly’” (Iverson, Larsen & Solem, 2009, 4). A new paradigm for approaching the healthcare of older adults will be described that maximizes quality of life by focusing on the older adult as a person of dignity and value with the capacity and desire for continued growth and development.

### **Good News About Older Adults**

The good news is that people are living longer than ever before; and the age distribution in the United States and the world continues to get older. In 1960 (United States Census Bureau), 9% of the population were over 65. By 2010, about 13% of people were over age 65 (U.S. Census Bureau, 2012). It is projected that people over 65 will comprise 18% of the older population by 2030, and 20% by 2050. In fact, in the United States a baby boomer (born between 1946 and 1964 during an unprecedented surge in the birthrate) turns 65 every eight seconds (Rand 2011). Figure 1 illustrates the increase and projected increase in the percentage of older adults in the U.S.

Figure 1. United States Population Over 65 Years of Age



Source: Changes in Percentage of U.S. Population Over 65 Years of Age 1960-2050. U.S. Census Bureau. “*United States Census Bureau Reports*,” 1960. Web; U.S. Census Bureau (2012). *Census 2000 Summary File 1*; *2010 Census Summary File 1*. U.S. Census Bureau.

Overall, there has been an increase of 10% to 20% of the population in industrialized and developed countries since 1960 (World Health Organization [WHO]). Although there is a slower pace of growth in undeveloped countries, 5% of people are over 65 and that number continues to grow (Kinsella and Wan 2009). The greatest rate of growth of the world’s oldest old population (people 80 and over) is greater than for the 65 and over population (WHO).

In Japan, 22% of the population is over 65, which is the highest percentage of older adults of any country having recently surpassed Italy, which previously held that distinction (United Nations Department of Economic and Social Affairs, 2007). In the 25 years from 2002 to 2027, the 65-plus population of Poland will increase 50%, and in China the percentage of people 65-plus will increase 100% from seven to 14% of the total population (Kinsella and Wan). It varies around the world, but in all countries including in Sub-Saharan Africa, the population 60-plus is predicted to increase by over 90% from 2006 to 2030 (Velkoff & Kowal, 2007).

By 2020, for the first time there will be more people over 65 than children under 5 years of age in the U.S. and other developed countries (U.S. Census Bureau). One of the reasons for this change is the worldwide shift in the birth and death rates from 1950 to 2010, in which the birth rate has seen a steady decline from 23.7 per 1000 population to 13 per 1000 population (Martin, et al). There has been a more focused intent on family size so that many people, not only in the United States, but around the world are having fewer babies. Thus the falling birth rate coupled with people living longer increases the percentage of older adults. Indeed older adults are living well into their 80’s and 90’s and even 100’s, as mentioned earlier this is the fastest growing segment of the population over 65 (WHO).

### **Ageism**

The rapid growth in the older adult population raises concerns for their quality of life when there are negative attitudes toward older adults and aging. Societal stereotypes about older adults and aging from U.S. data are consistent with two main themes. Elderly people are viewed as warm (positive), as well as incompetent (negative) (Cuddy and Fiske 2002, 3). And these themes cross national and cultural dimensions, as recent data show that the mixed bias is evident in other cultures (Cuddy, Fiske, Kwan, et al. 2004, 1).

A 2001 meta-analysis of health care professional's attitudes toward older adults indicated that they are viewed as difficult to understand, critical of young people's behavior, and emotionally dependent (Cooper and Coleman 2001, 399). The researchers also found that nurses viewed mentally intact people as their "favorites," while those with dementia were "less favorite." Nurses in long-term care tended to perceive older people more negatively in terms of mental and physical dependence. One still hears faculty and medical students discussing depression in older adults and the comment "If I were his age, I'd be depressed too" (Gelenberg 1999, 1657)

Yet, in spite of the negative attitudes, a 2013 survey of a nationally representative sample of 2,012 adults regarding public attitudes about aging, health care and personal life satisfaction (PEW March 21 to April 8, 2013) found that Americans are generally optimistic about their own futures, including old age. Despite negative attitudes toward aging, most Americans indicated that they want to live longer than the average life expectancy in the U.S. of 78.7 years (Murphy & Kochanek 2013).

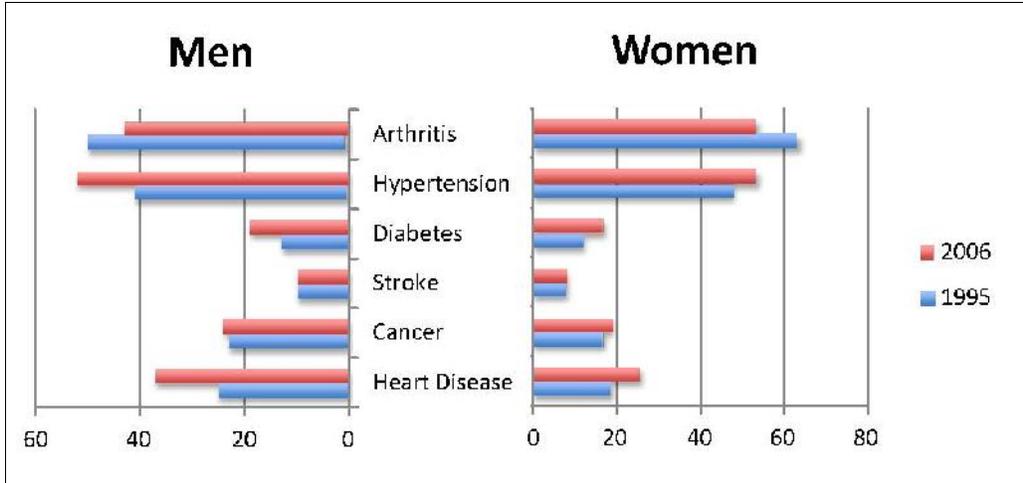
There are very positive role models of older adults in the public eye. For example, Nelson Mandela who was inaugurated President of the Republic of South Africa at the age of 76 and celebrated his 95th birthday in 2013. Queen Elizabeth II who was born in 1926 and became the Queen of England in 1951, is the second longest serving monarch. Only five other British kings and queens have reigned for 50 years or more; and Elizabeth II is the oldest monarch to celebrate a Diamond Jubilee in 2012 at age 85. Another person who continues to re-emerge is the rock star Mick Jagger who turned 70 in 2013. He notes that, "People have this obsession. They want you to be like you were in 1969. They want you to because otherwise their youth goes with you. It's very selfish but it's understandable" (Jagger, n.d.).

So negative attitudes exist toward older adults and aging inspite of very active, highly visible older adults. Some of this may be due to the greater incidence of health problems associated with aging. The incidence of chronic illness increases in older adults, and it can cause progressive disability over many decades.

## **Aging**

Historically, communicable diseases and trauma were the leading causes of death. But as environmental conditions, nutrition, and healthcare improved, noncommunicable diseases, e.g. chronic illnesses have become the predominant cause of death for older adults worldwide (Adeyi, Smith and Robles 2007). Figure 2. shows the percentage of persons aged 70 or older who report having selected chronic conditions, in which the major chronic health problems reported are heart disease, hypertension, stroke, cancer, diabetes, and arthritis. Figure 2. also illustrates the difference in the incidence of these diseases between 1995 and 2006, which is the most recent year with complete data for comparison (Center for Disease Control and Prevention, 2006).

Figure 3. Comparison of Chronic Illness Incidence for Men and Women 1995 and 2006



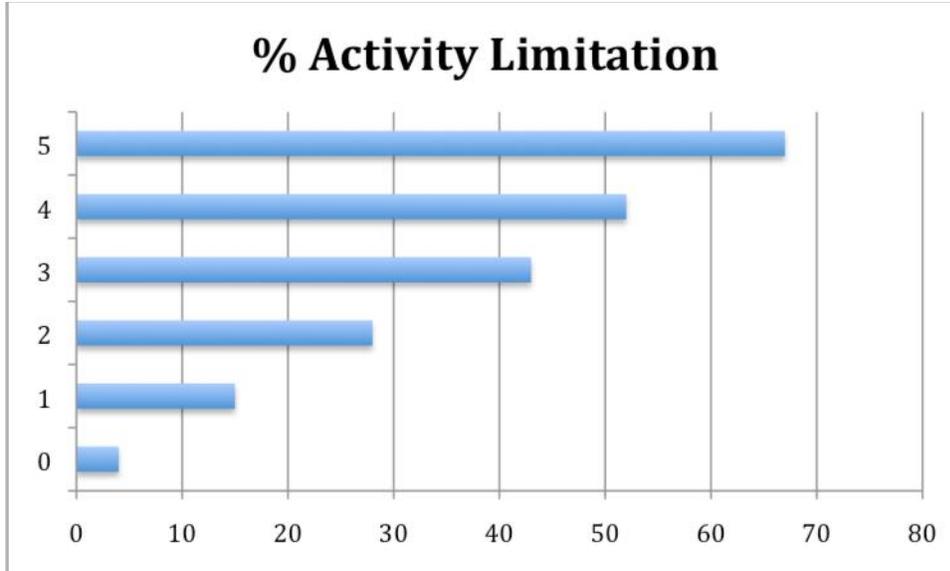
Source: Center for Disease Control and Prevention (2006). Supplement on Aging & 2nd Supplement on Aging. 2006 National Health Interview Survey

Among older adults in 1995, 25% of men had heart disease compared to 37% in 2006. For women, there were 19% afflicted with heart disease in 1995, compared to 26% in 2006. Hypertension also increased for both men and women, from 41% to 52% for men, and 48% to 54% for women. Stroke is the one disease that has remained about the same in that 10-year period at 8% for women and 10% for men in both 1995 and 2006. The incidence of cancer grew slightly from 23% to 24% in men, and 17% to 19% in women. Diabetes also grew from 13% to 19% for men and 12% to 17% in women. Arthritis is a disease that has decreased some in incidence from 50% to 43% for men and 64% to 54% for women.

For worldwide comparison, WHO provides the primary cause of death for older adults, rather than the incidence of chronic illness provided to illustrate the impact of chronic illness. Globally the primary cause of death for older adults is cardiovascular disease, which accounts for 48% of deaths. Cancer is the second leading cause of death (21%). Cardiovascular disease and cancer are followed by respiratory diseases, such as asthma and chronic obstructive pulmonary disease and diabetes as leading causes of death (WHO July 2013).

Usually older adults do not have just one chronic condition. In the United States, Medicare beneficiaries, over age 65, often have three to five chronic illnesses (Anderson 2004). These chronic illnesses can result in intermittent and progressive loss of function. Figure 3. shows the percent of increase of functional limitation from activities of daily living for older adults from 4% when there is no chronic condition to 15% with 1 chronic condition, 28% for two conditions, 43%, 52% and 67% respectively for 3, 4 and 5 chronic conditions. In the United States, 20% of Medicare beneficiaries have five or more chronic conditions and utilize two-thirds of the total spent health care spending. Certainly, as the number of chronic conditions increases there's a significant impact on the functional and/or activity capabilities of the older adult.

Figure 3. Activity Limitation by Number of Chronic Illnesses



Source: G. Anderson, "Hospital and Chronic Care," Powerpoint presentation to the American Hospital Association. Partnership for Solutions. June 16, 2004.

The Medicare data on the beneficiaries over 65 with more than 3 chronic illnesses in the United States, indicates that these older adults see more than 14 different specialists in a year's time (Anderson 2004). They might see a primary care provider, as well as specialists such as cardiologist, orthopedist, rheumatologist, infectious disease, ophthalmologist, dentist, endocrinologist, pulmonologist to address multiple conditions with many related issues/symptoms.

One would hope that the involvement of many specialists in the care of an older adult with complex chronic illness translates into really good outcomes for the older adult, but it may not. RAND Health developed a set of measures, Assessing Care of Vulnerable Elders (ACOVE) to assess the quality of care for vulnerable older adults (RAND 2008). The ACOVE measures reflected the best available clinical evidence and expert opinions to guide primary care for older adults. Researchers determined that vulnerable elderly living on their own received about half of the recommended care for their conditions (Wenger, et al. 2005, 547). Less than one third received recommended care for selected conditions primarily affecting older adults, i.e. impaired mobility, urinary incontinence, and impaired cognitive function.

### Common Themes

There are several themes that emerge for aging adults who experience increasing chronic and life threatening illnesses. Many times the focus of healthcare professionals is on the disease and curative treatment rather than the person and their family (or significant others). The older adult may experience a **loss of personhood** when there is a major focus on sophisticated diagnosis and treatment, medications, and specialty care. This can overshadow the concerns of the older adult about the illness and how it will affect their daily living, both short-term and long-term. Other themes include lack of attention for **comfort from pain and symptoms** of the illness and/or treatments, lack of **education and support for the individual and family/caregivers** (or lack of education in a way that they are able to understand and utilize), and lack of **continuous and comprehensive care**. There is a need for a more comprehensive model that addresses the ACOVE measures, as well as comprehensive care for people with chronic illness. One example is that \$50,000 may be spent in hospital to rescue an older adult with a heart attack. However, when they are discharged to home, there may be no attention to whether they have the ability to obtain or prepare food for meals, get medications filled, or obtain transportation for a medical appointment for follow up! Ultimately, the focus is on the disease and curative treatment, not of the suffering of the individual and their **quality of life**.

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Many older people express the sense of loss of personhood when they present to the healthcare system for evaluation of a problem. They may be whisked away to multiple diagnostic tests that may take minutes to many hours. Many people feel they are not educated about the purpose of many of the diagnostic tests ordered, nor given the option to determine if they want each of the tests, or even question whether they have recently had the test(s). It's just assumed that there is a standard and/or routine protocol for care, i.e. "one size fits all." When the older adult does not receive explanations or an understanding of what is happening in language they can understand, they may experience a loss of control, loss of personhood, and the sense that people are talking all around them, but not *with them*.

Even when people are seriously ill and death may be likely, there is a failure to engage older adults in discussion of their wishes regarding cardiopulmonary resuscitation (CPR) and/or do-not-resuscitate (DNR) in the event of the heart stopping. These are both aspects of advance care planning that all adults are encouraged to discuss, especially in the presence of chronic illness. The landmark SUPPORT Study investigated the communication of physicians with older adults in hospitals (SUPPORT Principal Investigators 1995). The study results indicated that only 47% of physicians had identified when their patients preferred to avoid CPR and 46% of the do DNR orders were written within 2 days of death indicating the probable lack of discussing the possibility of death and/or preferences until death was imminent. More recently, Morrell, et al (2008, 642) investigated the incidence of DNR orders for seriously ill patients 15 years after the Patient Self-Determination Act. This Act in 1990 encourages people to determine their preferences for medical care if they become too ill to make those decisions (American Bar Association, 2013). It also requires healthcare agencies to ask every person if he/she has an advance directive stating preferences for care. The researchers conducted a chart review of all patients admitted to an urban hospital and identified that 22% of all patients admitted had DNR orders, which is part of advance directives (Morrell 2008, 642). This suggests that many people, even when seriously ill do not have communication with healthcare professionals about their wishes for medical care if he/she becomes unable to engage in healthcare decisionmaking.

Communication is a critical aspect of a personalized approach that begins with engaging the older adult and his/her family as partners, determining preferences, values and beliefs, and beginning the discussion around goals of care. Communication between the healthcare professional and the individual and family early in the illness trajectory can build rapport and prepare the individual and family for the healthcare decisionmaking they will need to participate in throughout the course of the chronic illness, especially as there are changes in the older adult's condition.

A second common theme for older adults with chronic illness when the primary attention of healthcare professionals is on curative or disease modifying care, is a lack of attention to pain and symptoms that arise either from the disease itself, or from treatment of the disease. The Support Study (1995, 1591) was one of the first investigations into the presence of pain for older adults who were dying. The data indicated that of the 50% of conscious individuals who died in the hospital, their family members reported they were in moderate to severe pain at least half of the time. More recently, in the U.S. Health and Retirement Study of adults over 50 years of age, 34.1 % of survey respondents (18,439) in 2006, reported that they were often troubled by pain; 24.3% reported having moderate to severe pain; and 22.3% reported that their daily life was affected by pain (Shi 2010, 366). The Health and Retirement Study indicates that more than 70% of people over 50 are affected by frequent pain.

The need for continuous, comprehensive care and other common themes in the problems for care of older adults can be traced to the way the U.S. healthcare system has evolved during the past century. Our current healthcare system was developed at a time when most people died from infectious diseases, accidents or trauma. People with these conditions needed acute care for a short period of time, as they either died or got better (Lynn 1999). This has been referred to as a curative model of care. But now, people are living for many years with chronic illness. People will live into their '80s with a progressive chronic illness. This will require a different type of care that is more supportive, more continuous, and

proactive to prevent or minimize an exacerbation. This type of continuous and/or episodic care must address disease-modifying treatment, pain and symptom management, as well as suffering that may occur with increasing disability and loss of functioning over several years. This type of care recognizes that most illnesses will not be cured, and they may progress over several decades. This care is most effective with a supportive team of healthcare professionals who are familiar with the person's chronic condition(s) and who have an ongoing relationship with the older adult and his/her family. Thus, instead of a curative model of care, there is the need to reorganize the healthcare system to provide ongoing care that offers disease modifying care, as well as supportive and comprehensive care to address the needs of individuals with serious chronic illness and their families.

### **Geriatric and Palliative Care**

Geriatrics is a medical specialty developed in 1942 to address the health concerns of older people (American Medical School Association, 2013). Geriatrics focuses on improving the health, independence, and quality of life, as defined by the person, and this medical specialty focuses on the importance of function, in addition to the treatment of diseases and problems commonly associated with advanced age. It includes people with dementia, advanced heart and renal disease. It relies on comprehensive geriatric assessment to diagnose and treat disease to maintain function, and involves an interdisciplinary team that includes physicians, nurses, social workers, occupational therapy, physical therapy, speech therapy, even chaplains.

Palliative care has developed as a new medical specialty to address the needs of people with chronic illness and who may be dying. The World Health Organization defines palliative care as an approach that improves the quality of life of individuals and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO). Palliative care addresses the holistic needs of individuals living with serious, chronic illness and focuses on comprehensive and compassionate care for the needs of the individual and family. "Holistic care focuses on healing the whole person through attention to the body, mind, emotions, spirit and environment, in the belief that mental attitude and spirit are important connections to enhance the healing process of clinical treatments" (American Nurses Association 2013). Palliative care emphasizes respect for individual and family preferences related to quality of life. In addition to the members included in the geriatric team, the palliative care team includes the person and his/her family as the unit of care. It actually shifts focus to person-centered care and quality of life. Essentially, palliative care puts the older adult and the family as the center of care, and the person and family are decisionmakers of the healthcare. Neither geriatrics, nor palliative care alone, fully meets the needs of the older adult with chronic illness. A more effective strategy is an integrated approach to healthcare for older adults that brings together the clinical, goals-oriented focus of geriatrics and the holistic, compassion-oriented focus of palliative care. This approach emphasizes communication, person and family centered care, interdisciplinary collaboration, multidimensional suffering, and quality of life.

With the integration of palliative care, geriatrics benefits from an additional focus on the holistic needs of individuals, greater interdisciplinary care, and specific communication around the individual and family goals of care, especially as co-morbid diseases become more burdensome. It also benefits from a greater focus on the family as the unit of care and addressing not only functional needs, but also symptom management and suffering in the psychological, social, and spiritual realms. With the geriatric focus, palliative care benefits from more attention to the functional assessment, improved functioning, and maintenance of independence, using disciplines such as physical therapy, occupational therapy, and speech therapy. Palliative care could be used earlier in the care of older adults with significant disease burden, and with other chronic progressive illnesses, such as dementia, advanced heart disease, and advanced renal disease. To maintain the highest quality of life for the individual and family, aggressive management of disease, as well as pain and other symptoms is necessary. Integrating geriatrics and palliative care is especially important in the care of older adults to address multiple chronic conditions,

geriatric syndromes, needs of caregivers, and transitions across care settings to provide more continuous and comprehensive care.

### **Person-Centered Care**

A key aspect of palliative care is the emphasis that the center of care is a person, a human being not defined solely by their status as a patient, but by the whole person who comes for care. The focus is to enhance quality of life for the older adult and their family. Most healthcare professionals want to provide person-centered care, as they chose a helping profession because they wanted to help people. But, the potential bias by the general public, as well as healthcare professionals toward older adults and aging may affect their attitude and actual healthcare provided for older adults. In addition, they may feel overwhelmed by the complexity of comorbid chronic health problems of older adults.

The Center faculty teach an integrated geriatrics/palliative care curriculum to health professions students and practicing healthcare professionals. They use a variety of teaching strategies to advocate for a person-centered approach to care to overcome biases to older adults, as well as provide a more continuous and comprehensive care. In addition, The Center emphasizes the value of the humanities in helping to elicit and share stories that increase the understanding of individuals and their experiences.

An initial way to encourage health care professionals to be more aware of using a person-centered approach is by telling brief narratives to enable the listener to get to know the older adult. An example is the case study, which is commonly used for informing colleagues or engaging students in the care of older adults. In one instance, it can be disease focused, or in the second example it can include a brief story of the individual and their family. The first one begins, “This is an 87-year-old woman who was admitted to the emergency room last night to rule out stroke. She has a history of hypertension and diabetes. . .” And the healthcare professional continues with specific diagnostic measures and information. The second way that this could be done using a brief story is, “This is an 87-year-old woman who is a retired lawyer. Her husband died three years ago but she’s continued living independently in her home. She has two children who live nearby and they brought her to the emergency room last night when she became confused and unable to walk without support. . . “ Then one can continue with the medical information, but first they have seen this person as a woman who may still be dealing with the loss of a spouse, change in life role/status, and a person who has been living with supportive people available. It doesn’t take more than a few moments to tell the story that tunes the listener in to the person, as well as the medical information. Clinicians need to get in the routine of using this approach when discussing cases with other clinicians, as it is a powerful way that may help the next clinician recognize and honor the humanity of people in their care.

Another way healthcare professionals can restore the person to the center of the health care environment is through being more aware of the individual’s priorities when determining clinical outcome priorities. Many times systems’ needs take priority over the individual’s goals of care. An example of this is the hemoglobin A1C target for older adults that maybe 7.0 to 7.9%. But for a frail older adult who has diminished appetite and ability to taste, it is important to determine their priorities for wellbeing. Their need for eating something that tastes good and peaks their appetite, even though it is high in sugar and compromises the hemoglobin A1C target measure, is reason to consider a higher target measure. A higher level of medication to treat the diabetes may be an option, but it may also compromise their health and wellbeing in other ways. System generated measures may identify this as a problem, but documentation must indicate the necessity of altering expectations based on the person’s priorities and preferences.

Another example of possible differences in priorities of the individual and the system is when people are losing weight as they become more frail and closer to end of life. They can’t eat enough to maintain their weight, and in long-term care that’s a red flag. Caregivers may feel they are not being aggressive enough to ensure the older adult is eating enough to maintain their weight. On the other hand, for someone who is failing physically from chronic illness or from frailty, it may be an indication to not force them to eat when they don’t feel like it. Eating more than is comfortable for an older adult, can lead to gastrointestinal distress. It’s really looking again at the person as the driving force for establishing priorities and preferences in care. This occurs through relationship building and realistically discussing his/her goals of care. Then the clinician(s) can negotiate a plan of care.

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A clinical team struggling to find a way to help in a difficult situation with an older adult provides another example for teaching the value of person-centered care in the clinical setting. The clinical team described a particular older adult as “non-cooperative” and “resistant” to all attempts to provide more effective pain relief. The clinical team reported frustration that with trying to find a way to help. So one of the clinicians arranged a meeting with the person, and sitting at bedside, invited him to tell his story by saying, “I am going to sit and listen to your story. I want to understand you better and learn more about what is important to you at this time of your life.” With a little prompting, “please tell me more,” the person related his remote past experience with substance abuse and subsequent recovery. He then described his current struggle with advanced cancer and chronic pain, and his reluctance to use pain medicine that might threaten his sobriety. Reflecting on the experience, the clinician reported that hearing the story transformed the view of this older man from someone who was “non-compliant” to a person who had his own cohesive, rational, meaningful views motivating his behaviors. The clinician was able to create a more appropriate option for pain relief; and the clinician and the team were able to forge a therapeutic alliance with the man to develop a shared plan for pain control that was successful. The clinician credited the person-centered approach of eliciting the person’s story as having helped identify information that had heretofore been unknown to the team and allowed an effective treatment plan to be developed.

There are programs that demonstrate best practices in providing older adults with opportunities for continued growth and development. One program that captures the essence of person-centered care for people with chronic illness, as well as overcoming ageism and the realities of aging is of The Intergenerational School (TIS) in Cleveland, Ohio (TIS). The school was developed by Dr. Cathy Whitehouse in collaboration with her husband Dr. Peter Whitehouse, a neuroscientist who has a practice caring for people with Alzheimers and related dementias. The charter school opened in 2000 to serve very low income children from disadvantaged backgrounds in the Cleveland area. The people from Dr. Whitehouse’s practice with mild-to-moderate neurocognitive impairments were offered the opportunity to volunteer and mentor in the charter school.

The older adults visit the school one day per week, and some of their interventions included engaging in singing, reading, storytelling, certainly the child could read to the older adult, or vice versa. The older adults also participated with the children in environmental science, as the school is located near watershed where the participants can go out to study and explore together, both young and older adults. A study of the older adult volunteers at TIS compared them to a similar group of older adults who participated in an adult education course (George & Singer 2011, 392). They found a statistically significant decline in the stress levels, a decline in depression, increase in sense of usefulness, and a change in cognitive functioning for the older adults who volunteered at the charter school, which did not occur in the control group.

The qualitative results indicated the program offers perceived health benefits of reduced stress and depression, a greater level of energy and sense of cognitive stimulation, increase in the sense of purpose and usefulness, and certainly an increase in social relationships course (George & Singer 2011, 392). While the group with neurocognitive disorders certainly had very serious, chronic illness they were still able to engage meaningfully and in ways that enhance their health and well-being. In addition, the children in this school are testing higher than children in the other Cleveland Public Schools, as well as the private schools. So many positive benefits are derived from this program!

### **Summary**

Despite the negative stereotypes about older adults and aging, there are also many positive role models and programs that demonstrate the vibrant potential of older adulthood. The negative attitudes toward older adults may be exacerbated by the higher prevalence of chronic illness in older adults, which may affect the functional ability of older adults. However, older adults may be more limited by the perception of healthcare professionals and the community’s perception of his/her limitations. A person-centered

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approach to getting to know the older adult and family will enable healthcare professionals to more effectively address the physical, psychological, social and spiritual concerns. This holistic approach can help the older adult continue to grow and seek greater fulfillment in his/her life, while limiting exacerbations and functional losses from chronic illness.

To provide holistic care for older adults, healthcare professionals need knowledge and skills in both geriatrics and palliative care. This encourages a person-centered approach that recognizes the individual as someone with continuing growth potential, rather than a healthcare problem to solve. This approach advocates for an individualized approach for care to overcome biases and a “one size fits all” type of healthcare. A person-centered approach provides safer and more effective care for older adults with chronic illness while supporting and respecting their quality of life. In addition, utilizing the humanities and eliciting the person’s story offers a way to view the older adult as a person with creative potential and not just a healthcare problem. A Person-Centered Care Toolkit on The Center website provides additional strategies for healthcare professionals and educators to enhance care for older adults (George Washington University 2013).

## References

- Adeyi, Olusoji, Owen Smith, and Sylvia Robles. *Public Policy and the Challenge of Noncommunicable Diseases*. Washington, D.C.: World Bank, 2007.
- American Bar Association (ABA). *Law for older Americans, health care advance directives*, [http://www.americanbar.org/groups/public\\_education/resources/law\\_issues\\_for\\_consumers/patient\\_self\\_determination\\_act.html](http://www.americanbar.org/groups/public_education/resources/law_issues_for_consumers/patient_self_determination_act.html) (accessed September 14, 2013).
- American Medical School Association, "Geriatrics Interest Group" American Medical School Association, <http://www.amsa.org/AMSA/Homepage/About/Committees/Geriatrics.aspx> (accessed July 5, 2013).
- American Nurses Association. "Scope of Holistic Nursing Practice." In *Holistic Nursing: Scope and Standards of Practice* edited by American Holistic Nurses Association and American Nurses Association, 59. Silver Spring, Md: American Nurses Association, 2013.
- Anderson, Gerald. "Hospital and Chronic Care." Powerpoint presentation to the American Hospital Association, June 16, 2004. Princeton, NJ: Robert Wood Johnson Foundation Partnership for Solutions.
- Center for Disease Control and Prevention. "Supplement on Aging & 2nd Supplement on Aging" 2006 National Health Interview Survey," <http://www.cdc.gov/nchs/lsoa/soa2.htm> (accessed July 5, 2013).
- Cooper, Sarah and Peter Coleman. "Caring for the Older Person: An Exploration of Perceptions using Personal Construct Theory." *Age and Ageing* 30 (2001): 399-402.
- Cuddy, Amy and Susan Fiske. "Doddering but Dear: Process, Content, and Function in Stereotyping of Older Persons." In *Ageism: Stereotyping and Prejudice Against Older Persons*, edited by Todd D. Nelson, 3-26. Cambridge: Bradford Press, 2002.
- Cuddy, Amy, et al. "Stereotype Content Model Across Cultures: Toward Universal Similarities and some Differences." *British Journal of Social Psychology*, 48 (2009): 1-33.
- Gelenberg, Alan. "Depression is Still Underrecognized and Undertreated." *Archives of Internal Medicine*, 159, no. 15 (1999): 1657-8.
- George, Daniel and Mendel Singer. "Intergenerational Volunteering and Quality of Life for Persons With Mild to Moderate Dementia: Results From a 5-Month Intervention Study in the United States." *American Journal Geriatric Psychiatry* 19, no. 4 (2011): 392-6.
- George Washington University. "Center for Aging, Health and Humanities," George Washington University, <http://cahh.gwu.edu/> (accessed October 1, 2013).
- Institute of Medicine. *Retooling for an Aging America: Building the Health Care Workforce*. Washington, D.C.: The National Academies Press, 2008.
- Iversen, Thomas, Lars Larsen, and Per E. Solem. "A Conceptual Analysis of Ageism." *Nordic Psychology* 61, no. 3 (2009): 4-22.
- Jagger, Mick. "Brainy Quote.Com," (n.d.) <http://www.brainyquote.com/quotes/quotes/m/mickjagger401819.html> (accessed July 5, 2013).
- Kinsella, Kevin and Wan He. "An Aging World, 2008." *U.S. Census Bureau International Population Reports*, <http://www.aicpa.org/research/cpahorizons2025/globalforces/socialandhumanresource/downloadable/documents/agingpopulation.pdf> (accessed July 5, 2013).
- Lynn, Joanne, Janice Schuster and Joan Harrold. *Handbook for mortals: Guidance for people facing serious illness*. New York: Oxford University Press, 1999.
- Martin, Joyce, et al. "Births: Final Data for 2010," *National Vital Statistics Reports*. Hyattsville, MD: National Center for Health Statistics 60, no. 1 (2012).
- Morrell, Eric, Brandon Brown, Rong Qi, Katherine Drabiak and Paul Helft. "The Do-Not-Resuscitate Order: Associations with Advance Directives, Physician Specialty and Documentation of Discussion 15 Years After the Patient Self-Determination Act." *Journal of Medical Ethics* 34, no.9 (2008): 642-647.
- Murphy, Sherry, Xu, Jiaquan., & Kochanek, Kenneth. "Deaths: Final Data for 2010." *National Vital*

## Forum on Public Policy

- Statistics Report.*" Hyattsville, MD: National Center for Health Statistics, 60, no. 4 (2012). [http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf) (accessed September 13, 2013).
- PEW. "Living to 120 and Beyond: Americans' Views on Aging, Medical Advances and Radical Life Extension, PEW Research Religion and Public Life Project," August 6th, 2013." *PEW Research Religion and Public Life Project*, <http://www.pewforum.org/2013/08/06/living-to-120-and-beyond-americans-views-on-aging-medical-advances-and-radical-life-extension/> (accessed July 5, 2013).
- RAND. *Developing Quality of Care Indicators for the Vulnerable Elderly: The ACOVE Project*. Santa Monica, California: Rand Corporation, 2008, [www.rand.org/pubs/research\\_briefs/RB4545-1/](http://www.rand.org/pubs/research_briefs/RB4545-1/) (accessed September 13, 2013).
- Rand, Barry. "Where we Stand, Facing the Challenge Of Turning 65. Increased Life Expectancy, Decreased Pensions and Social Security Benefits Add to the Challenge." *AARP Bulletin*, [http://www.aarp.org/work/retirement-planning/info-01-2011/barry\\_rand\\_facing\\_the\\_challenge.html](http://www.aarp.org/work/retirement-planning/info-01-2011/barry_rand_facing_the_challenge.html) (accessed July 5, 2013).
- SUPPORT Principal Investigators. "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)." *Journal of the American Medical Association* 274 (1995): 1591-1598.
- Shi, Yu, W. Michael Hooten, Rosebud Roberts and David Warner. "Modifiable risk factors for incidence of pain in older adults." *Pain* 151, no. 2 (2010): 366-371.
- The Intergenerational School. Cleveland Ohio. The Intergenerational School, <http://www.tisonline.org/> (accessed July 5, 2013).
- U.S. Census Bureau. "United States Census Bureau Reports 1960, Table 1a," U.S. Census Bureau <http://www.census.gov/prod/cen1960/doc/sf1.pdf> (accessed September 10, 2013).
- U.S. Census Bureau. *Census 2000 Summary File 1; 2010 Census Summary File 1*. U.S. Census Bureau (2012), <http://www.census.gov/prod/cen2010/doc/sf1.pdf> (accessed September 13, 2013).
- United Nations Department of Economic and Social Affairs. "World Economic and Social Survey 2007: Development in an Aging World," United Nations Department of Economic and Social Affairs, <http://www.un.org/esa/policy/wess/wess2007files/wess2007.pdf> (accessed September 10, 2013).
- Velkoff, Victoria & Paul Kowal. "Population Aging in Sub-Saharan Africa: Demographic Dimensions 2006." *U.S. Census Bureau International Population Reports*. Washington, D.C.: U.S. Dept. of Commerce, Economics and Statistics Administration, U.S. Census Bureau, 2007.
- Wenger, Neil, et al. "A Controlled Trial of a Practice- Based Intervention to Improve Primary Care for Falls, Incontinence, and Dementia." *Journal of the American Geriatrics Society* 57, no. 3 (2009): 547-555.
- World Health Organization. "Are you ready? What You Need to Know About Aging, World Health Day 2012- Toolkit for Event Organizers." *World Health Organization*, <http://www.who.int/world-health-day/2012/toolkit/background/en/> (accessed September 10, 2013).
- World Health Organization. "The Top 10 Causes of Death." Fact Sheet No. 310, World Health Organization, World Health Organization <http://www.who.int/mediacentre/factsheets/fs310/en/index.html> (accessed July 5, 2013).
- World Health Organization. "The World Health Organization Quality of Life Assessment: Position Paper." *Social Science & Medicine* 41, no. 11 (1995): 1403-1409.