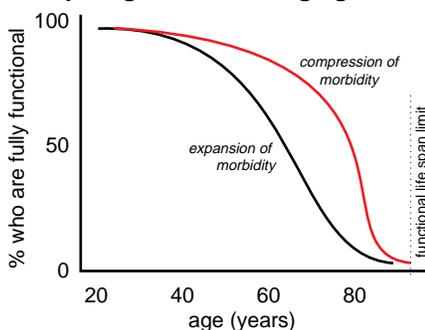


SUCCESSFUL AGING

AS THE demographic juggernaut of an aging society looms, many of us are acquiring both a professional and a personal interest in the health of the elderly. What happens when the baby boomers reach old age? Will there be large numbers of people in poor health as we head into the first half of the next century and the proportion of the U.S. population ≥ 65 years climbs above 20%? Or will a “compression of morbidity” be possible where, on average, active life is prolonged and most disability is compressed to the years right before death?¹ While this latter scenario makes the “Top 5” on Medicare’s wish list (i.e., solving the solvency blues), skeptics consider the possibility of a decrease in overall functional disability as pure wishful thinking. Which of these contradictory views, conceptually presented below, seems most likely? Evidence has emerged in support

Competing Views of an Aging Society



of the more optimistic view.

A large prospective study found that the onset of disability was postponed by more than five years in older adults who didn’t smoke, exercised regularly, and were not obese compared to those with these risk factors.² This highlights the possibility of decreasing rates of disability in the elderly, and sets up a public health goal to help the elderly age as successfully as possible.

The goal of “successful aging” expands on the traditional goal of extending lon-

gevity by focusing on quality of life. Rather than adding years to life, we must do all we can to “add life to years.”

Three components contribute to successful aging:⁶

- 1) avoiding disease and disability;
- 2) maintaining high mental and physical function;
- 3) continuing to engage actively in life, being productive and having strong interpersonal relationships.

FOCUS ON FUNCTION

In considering goals for elderly health it is helpful to move beyond a medical diagnosis of “sick” versus “not sick,” and instead focus on overall physical and mental functioning. Functional level is a better predictor of morbidity and mortality than diagnosis,^{3,4} and elderly patients’ greatest fear is losing their functional independence.⁵ Diagnosing and treating the patients’ disease processes must be balanced with helping elderly patients maintain everyday functioning.

OVERCOME AGEISM

Many health care providers face the occupational hazard of undue pessimism about aging because of their skewed exposure to elderly patients who are sick and dying. Recent studies confirm, however, that stereotypes exaggerate the rates of age-related decline in mental and physical functioning, and underestimate the causal link of lifestyle and environmental factors on late-life functioning.⁶ The following illustrate some stereotypes:

Stereotype: “To be old is to be sick.”

Reality: Older people are more likely to age well than to become frail, senile, and dependent. Lifestyle is more important than genetics in explaining the gap between physical and chronological aging.

Stereotype: “When it comes to preventive measures, the elderly are a lost cause.”

Reality: it is (almost) never too late to gain health benefits from changes in lifestyle and improved medical screening.

PRACTICE PREVENTION

The table shows some behaviors among older Oregonians that put them at risk for premature disability, and where there is clearly room for improvement.

Risk Behaviors Among Oregonians > 65 years

Risk category	% at risk
< 5 fruits/veggies per day	65%
no sigmoidoscopy or proctoscopy ever	49%
sedentary lifestyle*	48%
no pneumococcal vaccine ever	44%
overweight †	35%
no flu shot last year	28%
no mammography last 2 years (women)	24%
smoke	11%

*exercise <3x weeks or <20 min each time
†>120% of median weight

The U.S. Preventive Services Task Force divides preventive care into three categories: counseling, immunization/prophylaxis, and screening.

Behavioral Counseling

Brief discussions in the context of routine health care remain the most underutilized preventive care practiced in the clinic. It is also the most controversial for many providers, given lack of time, the natural priority of urgent curative care, and belief that they really can’t do much about patient lifestyle choices. However, recent studies show that:

- 40% of deaths due to non-genetic causes are attributable to health risk behaviors⁷
- providers can have a positive, cost-effective impact on patients’ health risk behaviors⁸
- patients prefer health risk behavioral advice from providers to that from hospitals, media, employers, or the government.⁹

Primary counseling areas should include:

Regular exercise (even activities that are only moderately strenuous like gardening and walking) is strongly associated with overall survival and delayed morbidity. Improved fitness is perhaps the single most important thing elderly patients can

do to stay healthy. Regular exercise reduces risk of coronary heart disease, type II diabetes, and stroke, primarily by reducing important risk factors such as hypertension and high blood fats. A physically active lifestyle also protects against colon cancer and osteoporosis, and reduces the likelihood of falls because of better strength and balance. Good rules to follow include... start with activities that the patient likes; start small to build confidence; and focus on fitness, strength and flexibility, which all provide important benefits.

Following simple rules of nutrition reduces the risk of heart disease, diabetes, some cancers, and obesity. That means not just proper quantity, but quality: a sufficient variety of fruits and vegetables and not too much saturated fat, salt, sugar, alcohol and no smoking of course.

Immunizations

In light of the high national priorities to raise immunization rates of children, it is surprising that adult immunization rates raise relatively few eyebrows when at least 100 times as many adults as children die every year from vaccine-preventable diseases.¹⁰ Pneumococcal and influenza infections are the biggest killers by far and responsible for 50—80,000 deaths per year.¹¹ Current recommendations call for the following in all elderly patients:

- Influenza: once a year in the fall
- Pneumococcal: after age 65, one shot is usually enough. When in doubt, vaccinate and document.
- Tetanus/diphtheria: every ten years

Screening

Screening, or detecting disease processes before they are symptomatic, is an important aspect of preventive care. Most diseases are more easily treated if diagnosed at an early stage. Regular screening activities (with recommended intervals) having the best evidence-based support include:

- blood pressure (q. 2 years)
- vision (q. 2 years)
- hearing (once)
- non-fasting total cholesterol (q. 5 years)
- mammogram (q. 2 years for women)
- flexible sigmoidoscopy (q. 10 years)

Recommendations often call for more frequent screening once there is evidence of increased risk.

SO, HOW DO WE DO THIS?

System techniques are suggested as the best way to overcome clinic barriers to providing recommended preventive care.¹² Things like:

- identify high priority preventive care needs in all patients
 - have prevention needs readily available to clinical staff (e.g., color-coded chart tags; summary sheet in front)
 - Be thrifty with physician time (MD should briefly introduce and encourage prevention activity while other health care professionals attend to the details)
 - track changes in behaviors and apply relevant follow-up interventions
 - apply resources to highest risk/ underserved patients first
- While providing health care may not be

getting easier, getting organized about preventive care with elderly patients will make it easier to help them successfully.

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Resources

For Doctors and Clinics: “*Put Prevention into Practice*” 2nd Edition (1998). Call AHCPR clearinghouse at 800/358-9295, or access this publication in all its interactive glory at <http://www.ahcpr.gov/clinic/>

For older patients: OASIS: offers classes on health and wellness for older adults (Portland) 503/833-3636.

Eldercare locator 800/677-1116: to find local number for Aging Services.

National Institute of Aging website: <http://www.nih.gov/nia>