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Guest Editor's Message

By Stephanie Fallcreek, MSW, DSW

What a long way we've come since the late 1970s when the reaction to anyone advocating health promotion and lifestyle or behavior change strategies with older adults, much less frail older adults, was almost always skepticism. "They're too old, too set in their ways, and it's too late" were the most common responses. Today, responses are more likely to be, "wow, taking that class really made such a difference in her outlook on living" and "I just wish we had started sooner" or "why isn't this program available everywhere, it just works wonders?"

The key message of this issue is that there are a wide variety of powerfully effective, evidence-based opportunities to "practice health promotion" with older adult clients. Some care managers already are very engaged in this work. Doing the best possible job of connecting clients and caregivers with those opportunities may require other care managers to gain additional knowledge, develop some new skills, and/or use some different practice tools. What absolutely will make the biggest difference, though, simply is becoming disciplined and intentional about identifying, and acting on, potential opportunities for health promotion with every client and in every care situation.

Despite the more encouraging climate of current public opinion and policy for wellness, health promotion and disease prevention among older persons, access to evidence-based interventions remains limited and major challenges persist. Some of these challenges — particularly those at the individual level — may be addressed directly by care managers, who can provide needed information, education, and encouragement, as well as facilitate the connections to programs and services that are available.

Many challenges, though, must be tackled through advocacy, public policy development, and resource allocation and re-allocation strategies. Care managers have an important role to play in this arena as well. Good research and a strong evidence base are essential. Results that demonstrate cost effectiveness and efficiency provide a necessary foundation for decision-making and planning. Nothing, however, is more persuasive to those who legislate and regulate, than personal experience or evidence from a constituent —from a care manager, from a caregiver, or directly from a client. Joining an advocacy group, sharing your results with an elected official, or assisting a caregiver to communicate with a legislator easily could be the most important thing you do next year for your future clients and your practice.

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Health Promotion and Wellness: Opportunities for Geriatric Care Managers

By Stephanie Fallcreek, MSW, DSW

Introduction

Live Better, Longer; Growing Old with Health and Wisdom; Staying Active After 50; Adding Health to Our Years, Self-Care for Seniors; Aging Well, Be Alive as Long as You Live, Living Well; Wellness and Aging, StayWell, Healthy Aging; Vital Aging; Successful Aging; Productive Aging—names and slogans like these represent the energy and activity around health promotion with older adults, which has steadily gained strength over the past several decades.

Genetics, economic, environmental, and social resources in conjunction with public policies play undeniable and powerful direct roles in shaping later life health and wellness. Each of those factors also has an impact on the choices that are available to individual and families. At the same time, people of all ages influence their opportunity for full, productive and satisfying long lives, by making excellent or poor personal lifestyle choices, by taking advantage (or not) of available health screening and immunization services, often covered by Medicare or other health insurance, and by eliminating, avoiding, or ignoring environmental hazards. A substantial body of evidence suggests that truly, "it's never too late" to take action to improve health and wellness. The possibility of both improving function and decreasing risk, even at a very advanced age, is neither myth nor fantasy. Throughout life, and whatever the current state of health, taking stock, taking responsibility, making good decisions, and following through on health promoting choices is likely to make a positive and powerful difference in personal health and sense of well-being.

Health promotion, as a concept and an intervention strategy, includes much more than individually driven client behavior change. In the broader and longer view, greater impact on health and wellness for people of all ages, including frail and at-risk older persons, will likely result from focus on changes in the built and natural environment, availability and accessibility of health care services, within the interpersonal and community social context, and through development and implementation of assistive technology. To realize fully the potential offered by health promotion opportunities for older adults, behavior change must occur not only among clients and families, but also among service providers, policy-makers, and other payers. Entire service systems must change through advocacy, policy development and implementation. Geriatric care managers have an opportunity, and perhaps a responsibility, to use their expertise and networks to work on all these fronts.

The following discussion is intended to provide an overview of health promotion with older adults, particularly as it relates to geriatric care managers, at-risk older persons and caregiving families. An historical context for current programs will be offered, definitions of key terms will be shared, and a sample of high potential intervention areas for connecting clients with health promotion opportunities will be described.

Background

People have hoped to achieve a healthy old age, and have admired those who succeeded, for a very long time. During Greco-Roman times when "older persons" were that minority of people who lived beyond their thirties, Socrates suggested, "*I enjoy talking with very old people. They have gone before us on a road by which we, too, may have to travel and I think we do well to learn from them what it is like"* (Socrates, in Plato's *The Republic*). Throughout recorded history contributions by octogenarian or older artists, philosophers, prophets and rulers are evident. Focused attention, though, on health promotion programs for older persons, and particularly frail older persons, is more recent. "You can't teach an old dog new tricks, people past 65 are too old to exercise, and it's too late to quit smoking at 55 — it wouldn't do any good" were common beliefs encountered by those working in the community as recently as the mid-1970s. In fact, walk into any senior center or retirement community today, and you'll probably find someone who still believes all three of those myths, and many more! As longevity increased, and more people spent longer periods of time in institutional care settings or with limited function at home, so did concerns about the nature and quality of life in those added years.

Fries (1980) contributed a most compelling image to early research and program development for enhancing health and function throughout the lifespan: compressing the morbidity curve. The concept had great appeal — that a long and vital, healthy life is achievable, accompanied by a relatively brief period of terminal decline. Just how far along the life course could one push the notion of striving to be "fully alive" and fully functional until the time of death? Is it realistic to expect that by receiving good medical care, adopting healthy behaviors, and

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practicing excellent self-care, people could end up simply sky diving off the morbidity cliff, avoiding all the stress and struggle of lingering illness and extended functional decline? Probably not quite that dramatic! The point was made though, reducing morbidity along the lifespan could dramatically change the experience of the second half of life. Almost 30 years later, Fries (2003) continues to study compression of morbidity and recently concluded, "Randomized, controlled trials of health enhancement programs in elderly populations show reduction in health risks, improved health status, and decreased medical care utilization" — in other words, compression of morbidity.

As evidence about the benefits of healthy lifestyle choices for people of all ages mounted in the sixties and seventies, so did interest in the prospects for later life behavior change and/or maintenance of healthy behaviors. With many different sources of inspiration, a variety of health promotion programs, intentionally designed with older adults in mind, were developed in the late 1970s and early 1980s. Something of a watershed occurred in the late seventies when the U.S. Administration on Aging (AoA) funded several innovative older adult health promotion and wellness demonstration projects, like the Wallingford Wellness Project and Staying Healthy After Fifty. Private foundations and other nonprofit organizations funded other healthy aging demonstration projects while AARP published and distributed tens of thousands of health promotion resource materials through its members, chapters, and national initiatives. In the early 1980s, building on the experience of multiple demonstrations, AoA and the U.S. Public Health Service partnered in a national initiative to advance health promotion with older persons. Among the results of that initiative: a National Resource Center on Health Promotion and Aging was established at AARP and a resource book for developing community-based health promotion programs with older adults was distributed to every Area Agency on Aging and Pubic Health Department nationwide (FallCreek and Mettler, 1984).

Most of the early projects did not incorporate the "hard science," research needed to build the evidence base for specific interventions or health status outcomes. They did demonstrate clearly, however, that older persons were interested in learning about positive lifestyle choices and preventive health services. They also showed that older adults could and would make behavior changes if they gained the knowledge, skills, and support needed for those changes. Building on these experiences, and a growing body of supportive research results, a network of public agencies and private organizations and pioneering advocates collaborated to secure recognition for health promotion in the Older Americans Act (OAA),

originally through Title III F, in 1992. Modest but important ongoing funding for health promotion and disease prevention activity in the aging network was incorporated into Title III – D in 2000.

AoA, in partnership with diverse public and private aging, health, and philanthropic organizations, again took a lead in 2003 with a major program to test, adapt, and implement evidence-based health promotion programs for diverse older persons. They continued funding replications and adaptations of the evidence-based models and by Fall 2007, at least 26 states were actively engaged in deploying one or more evidence based health promotion programs for older persons (Accessed November 2007, Center for Healthy Aging, http://www.healthyagingprograms.org/content.asp?sectionid=32).

Health promotion and disease prevention efforts, with support from multiple federal agencies, are now center stage, with several initiatives underway. Some of these include: the Center for Disease Control's cooperative agreement with the American Society on Aging (Accessed November 2007, http://www.asaging.org/CDC/index.cfm) to produce and disseminate a variety of health promotion educational materials; the "A Healthier U.S. Starts Here" campaign sponsored by the Center for Medicare and Medicaid Services (CMS) to increase public awareness of Medicare's preventive benefits (http://www.cms.hhs.gov/MyHealthMyMedicare/02_HealthierUS.asp); and A Center for Healthy Aging (www.healthyagingprograms.org) has been established at National Council on Aging, with support from multiple federal and private philanthropic sources. Among its key responsibilities is coordinating and/or delivering technical assistance, resource development, dissemination and evaluation of AoA's evidence-based health promotion initiative. Each of the evidence-based health promotion programs promoted are interventions based on the application of principles of scientific reasoning, behavior change theory, and program planning that clearly have been proven effective in reducing the risk of disease, disability, and injury among the elderly.

In the private for-profit sector, Curves successfully has taken increased physical activity for diverse "mid-life and better" women to the marketplace. With over 10,000 locations, and some respectable research results to support their approach, Curves may be the fastest growing health promotion franchise in the world (Accessed October 2007, curves.com). Outcomes identified by the Baylor University Exercise and Sports Nutrition Laboratory include: effective at helping women lose weight, gain muscle strength, and raise metabolism with aerobic activity, contributing to healthy bones, muscles, and joints (http://www.curveshealthinformation.com/page4.html. Accessed November 2007).

Private sector efforts to promote, preserve, and/or restore "brain fitness" are also mushrooming. A recent Los

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Protect your health with Medicare's preventive benefits.

Take this checklist and ask your doctor which preventive benefits are right for you.

Medicare can do more for you than simply help you cover the costs of doctor and hospital bills. Medicare's preventive benefits can help you stay one step ahead of serious illnesses or certain chronic conditions such as diabetes, heart disease and cancer.

MY MEDICARE PREVENTIVE BENEFITS CHECKLIST

WHAT'S COVERED?	WHAT IT DOES	HOW OFTEN?
☐ Flu Shot	Prevents influenza or flu virus.	Once a flu season.
☐ Pneumonia shot	Prevents pneumococcal pneumonia.	Usually only needed once.
☐ Cardiovascular Screenings for Cholesterol, Lipid and Triglyceride Levels	Checks cholesterol and other blood fat levels that can increase the risk for heart disease.	Once every 5 years.
☐ Colorectal Cancer Screenings	Screens for colon cancer.	Ask your doctor.
• Fecal occult blood test		Once every 12 months if 50+.
• Flexible sigmoidoscopy		Generally once every 48 months (4 years) or every 120 months (10 years) when used instead of a colonoscopy for those not at high risk if 50+.
• Colonoscopy		Once every 120 months (10 years) Once every 24 months for high risk.
• Barium enema		Once every 48 months (4 years) instead of sigmoidoscopy if 50+. Once every 24 months instead of colonoscopy for high risk.
☐ "Welcome to Medicare" Physical Exam*	One-time review of health and medical history.	One time during the first 6 months you have Medicare Part B.
☐ Diabetes Screening	Blood sugar test.	Varies based on results. Covered if you have certain risk factors. Ask your doctor.

WHAT'S COVERED?	WHAT IT DOES	HOW OFTEN?
☐ Diabetes Self-management Training	Education for people who have diabetes.	Ask your doctor.
☐ Medical Nutritional Therapy Services	Nutritional counseling to help manage diabetes or kidney disease.	Ask your doctor.
☐ Bone Mass Measurement	Determines risk for broken bones due to osteoporosis.	Once every 24 months for people with certain medical conditions.
☐ Hepatitis B Shots	Helps prevent liver disease.	Ask your doctor.
☐ Glaucoma Test	Can help find the eye disease glaucoma.	Once every 12 months for those at high risk.
☐ Smoking Cessation	Counseling to quit smoking for people with a smoking-related illness or who take medicine affected by tobacco.	Up to 8 visits during a 12 month period when ordered by your doctor.
☐ Mammography Breast Cancer Screening	Screens for breast cancer.	Once every 12 months for women 40+.
☐ Pap Test and Pelvic Exam Cancer Screenings	Screens for cervical and vaginal cancer.	Once every 24 months. Every 12 months for women at high risk.
☐ Prostate Cancer Screening	Digital rectal exam and Prostate Specific Antigen (PSA) test.	Once every 12 months for men 50+.

*People with Medicare who are at risk for abdominal aortic aneurysms may get a referral for a one-time screening ultrasound at their "Welcome to Medicare" physical exam.

It's important to ask your doctor about the Medicare-covered tests and screenings that might be right for you. Coinsurance and deductibles may apply. You may need to meet certain criteria for coverage. Medicare Advantage Plans may offer coverage for additional preventive benefits.

Sign up at www.MyMedicare.gov to track the preventive benefits you have used each year and remind you of benefits for which you are eligible.

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Angeles Times article suggests that Americans will spend more than 225 million dollars in 2007 on "mind games" designed to enhance mental vitality (Los Angeles Times, Oct. 15, 2007). While the jury is still out on who specifically can benefit from these software based interventions, and exactly how much benefit there is to gain, major businesses have jumped on the bandwagon. For example, insurers Humana and Penn Treaty American both have partnered with Posit Science (http://www.positscience.com/) to distribute their Brain Fitness software to members. Much research remains to be done before pronouncing Curves and Posit Science, or any of their competitors, as model health promoters for the lifespan, but clearly, what they have to offer hits a responsive chord with consumers of all ages.

These health promotion programs, products, and services are not limited to, or even focused on, senior Olympians, elder marathoners, or even remarkably hearty and fit older persons. Frail and homebound persons, as well as others with multiple, advanced, chronic conditions are likely participants and customers!

In A New Vision for Aging (Center for the Advancement of Health, 2006), Dr. Richard J. Hodes, Director, National Institute on Aging, remarks "Never before have so many people lived for so long. Life expectancy has nearly doubled over the last century, and today there are 35 million Americans age 65 and older. The aging of the population—in past decades and in the foreseeable future—presents both a challenge and an opportunity."

The challenge is seen in the one third of older Americans who have had no leisure time physical activity in the past month; the 9% of older Americans who still smoke; the average 75 year old who has three chronic conditions and takes 5 prescription drugs (CDC, 2004); the 19% of older persons who are obese, and the half of persons over 80 living independently in the community who fall every year.

The opportunity lies in the knowledge that programs that promote fall prevention, good nutrition, immunization and screenings, physical activity, smoking cessation, medication management, and self-care and management of chronic disease can be effective. The evidence base is already very strong for many interventions. The opportunities lie in the evidence that diverse older persons can become motivated to make good decisions and appropriate behavioral changes, and then maintain those changes, even in the face of significant personal challenges.

For most people, even one relatively simple, low cost behavior change, can result in living healthier and longer. Consider for a moment, nothing more than increasing the level of regular physical activity. This, by itself, is associated with reduced rates of disability, reduced incidence of falls, better mental and cognitive function, lower health care costs, and lowered risk of chronic disease. And a program to increase physical activity can be designed to fit the functional health status, the residential setting, and the economic and social resources of the client. One ongoing behavior change equals the prospect of abundant enduring benefits.

Health Promotion, Disease Prevention, and Whole Person Wellness: What Does It Mean?

What exactly is "health promotion" with older adults? Over the past few decades, several definitions of health promotion gained acceptance among different constituencies. Three of these definitions, which can be applied to both older adults and younger persons, are:

Health promotion is the process of enabling people to increase control over, and to improve, their health." (World Health Organization, 1986).

Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotion, social, spiritual and intellectual health (O'Donnell, 1989).

Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive to health. (Green, 1990) Green and Kreuter (1991) go on to note that health education is "any combination of learning experiences designed to facilitate voluntary actions conducive to health."

Frequently, the term disease prevention is used in conjunction with health promotion. Some people consider them interchangeable while others often use the terms together as a way of encompassing the broadest possible range of efforts to improve health. Conventionally, and historically, disease prevention focuses on disease and problems associated with disease – preventing or avoiding it (primary prevention); early detection, slowing it down and avoiding symptoms (secondary prevention); and/or minimizing recurrences and disease progression or even improving conditions associated with the disease (tertiary prevention).

In comparison, health promotion takes an "asset or strength-based" approach; and is grounded in an holistic view of opportunities to enhance and improve levels of health and wellness. Health promotion, simultaneously, through both population-based and targeted participatory strategies and tactics, strives to facilitate positive individual behavior change while embracing methods that get at environmental and socio-cultural roots of, or influences on, health, wellness and illness.

According to Mather Life Ways, a leading provider of senior wellness programs, (Accessed October 2007, www.matherlifeways.com/re_waystoagewell.asp), "wellness means striving to achieve the optimum state of health and well-being that you are capable of achieving." Their approach is grounded in a Whole Person Wellness concept, which emphasizes personal choice, self-

responsibility, optimism, and self-direction. The dimensions of wellness included by Mather are: physical, social, intellectual, emotional, spiritual, and vocational. Other whole person wellness models may add to, or decrease the number of components. For example, environmental awareness and social action may be added, while vocational wellness may not be included, in a specific model.

Particularly for frail and/or at-risk older clients who are already experiencing significant health challenges or impairments, an important distinction made by the whole person wellness concept is that the definition of wellness explicitly is based on that which is personally, optimally achievable – not a population norm or demographic benchmark. Optimum health and function may differ dramatically from individual to individual because it is related to achieving the maximum possible for a particular individual. This recognizes differences in current health status and significantly different economic and social resources as well as varying levels of ability, in terms of, for example, mobility, sensory, or cognitive capacity. "Whole person wellness" may seem like the fully loaded Cadillac of health promotion, but it truly embraces the individual in the fullness and the challenges of both their resources and their aspirations. Since individual behavior change typically depends heavily on getting motivated to make a change, working for the Cadillac of goals may be worth the time and effort.

Older people, more than any other age group, are plagued with chronic diseases and other conditions. Approximately 80% of persons over age 65, have at least one chronic condition and many have more than one chronic condition. Chronic conditions limit activities for 12 million elderly individuals living in community settings; 25 percent of these affected individuals are unable to perform basic activities of daily living, such as bathing, shopping, dressing, or eating (CDC, NCCDPHP, Healthy Aging, 2003). The most common chronic or severe conditions include: arthritis (48%); hypertension (37%); hearing impairments (32%); heart disease (15); diabetes (10%) and depression (5-10%) (U.S. Administration on Aging, 2003).

Older persons disproportionately experience a weighty illness burden, heavy out of pocket expenditures for health care, and far too often, decreased quality of life associated with limits on desired activities. Yet, evidence suggests that there are many opportunities to reverse or at least minimize these results. The definition of Healthy Aging as advanced by the CDC Prevention Research Centers' Healthy Aging Network (Accessed November 2007, http://depts.washington.edu/harn/about_us.shtml) provides an encompassing, ecological orientation:

Healthy Aging is the development and maintenance of optimal physical, mental and social well-being and function in older adults. It is most likely to be achieved when physical environments and communities are safe, and support the adoption and maintenance by individuals of attitudes and behaviors known to promote health and well-being; and by the effective use of health services and community programs to prevent or minimize the impact of acute and chronic disease on function.

Given the prevalence of chronic conditions and other functional limits often imposed on the frail and at-risk older persons, this definition of healthy aging supports the optimistic spirit and participatory philosophy that care managers can bring to the challenging task of connecting their clients to health promotion opportunities. A multi-faceted approach will incorporate principles of disease prevention, health promotion and whole person wellness for virtually every client.

Health promotion objectives for an individually focused health promotion plan for a Geriatric Care Management client seem to fall, though messily and with overlap, into one or more of three broad categories:

1. Maximizing or improving existing health and wellness indicators (e.g. physical activity increase, regaining the strength to climb the stairs or get up from a chair, finding a satisfying paid or volunteer job that can be done from home — a whole person wellness or health promotion objective!)
2. Preventing avoidable poor health, injury or disability (e.g. environmental intervention to reduce safety hazards or immunization to prevent flu or pneumonia — a primary prevention approach)
3. Optimally managing chronic and/or acute conditions that can't be prevented or avoided (e.g. chronic disease self-management program for persons with existing arthritis, diabetes and hypertension; institute diet and exercise changes to reduce or eliminate need for medication — a secondary or tertiary prevention approach, depending on the stage of the disease)

An older person or a caregiving family may seem to be coping adequately with myriad challenges, yet truly are struggling mightily to live independently in the community. However, if muscle mass, strength, endurance and flexibility is improved through physical activity, several changes could occur to minimize struggle and prolong satisfying independence. It might be possible to walk to a nearby grocery store; use a public transport vehicle easily, or climb the stairs to the second floor and get into a bathtub. Those same improvements in strength and flexibility act to reduce risk of falling, while the increased level of physical activity also may help to control hypertension.

Simple changes in the residential environment can minimize risk of falling, injury or long term disability. Fixing a loose threshold reduces risk of falling and re-setting the temperature on the hot water heater and installing an automatic shut off on the stove burner can reduce the risk of burns.

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What began with a focus on health promotion and primary prevention with independent, relatively healthy older persons increasingly has been tested and translated to frail and other at-risk older adults, particularly those living with multiple chronic diseases or conditions. Today, many evidence-based health promotion programs are designed to address all three objectives: promote; prevent; and manage, in one well coordinated intervention, that can be "fitted: to participants with different resources and different challenges. They can readily incorporate the essential elements of a strength-based and change model:

1. enhance awareness and increase needed knowledge and skills,
2. change behavior in a specific direction desired by the participant and
3. maintain or create social and built environments that support ongoing good health practices and outcomes.

Similarly, using a problem perspective, Marrongiello and Gottlieb (2000) identified three obstacles on the road to self-care and behavior change that effective health promotion programs must recognize and address if the objectives above are to be achieved:

1. Informational-knowledge based barriers: "They must have the knowledge about when and how to engage in a self-care behavior."
2. Motivational-attitudinal based barriers: "They need to believe in their capacity for self-care and the potential efficacy of engaging in the self-care activity, and they need to want to engage in the self-care activity."
3. Resource-based barriers: "They need the personal skills and community resources required to engage in self-care activities."

To help overcome these barriers, effective interventions typically: include some or all of the following

- Maximizing the role played by the older adult in shaping decisions and making plans
- Improving skills in, and providing support for, goal setting, action planning and problem solving
- Making sure there are plenty of opportunities to rehearse, adapt, and practice desired behaviors
- Creating peer support structures with volunteers, buddies or mentors and/or reinforcing naturally occurring peer support
- Using and communicating a strength-based approach with a focus on desired outcomes — health promotion and whole person wellness — rather than illness or limits.

Over time, nurturing or creating supportive environments that sustain individually directed behavior changes and/or those that facilitate desired behaviors or health outcomes in the larger population will probably have the greatest impact on achieving whole person wellness. No matter how supportive the environment, however, individuals must exercise choice and follow through to gain the greatest possible benefits from health promotion efforts.

Program Models

The next section provides just a sampler of evidence-based older adult health promotion and disease prevention interventions that offer potential benefits to many of the clients and caregivers likely to be served by geriatric care managers. For each topic there is clear evidence that changes, in behaviors or the personal environment, can make a positive difference in health and wellness. A brief review of the rationale for the particular content focus is provided; a description of one or more programs is included; and resources for additional information are shared. In several areas, both an individually-oriented approach and a group based approach is presented where there are evidence-based interventions or at least a strong science base to support them. Many other areas of intervention and a variety of other individually oriented and group evidence-based programs can be identified. The health challenges and other resources of each client must be considered to identify the program that will best fit the personal situation.

All of the programs, interventions or self-care resources described below should include the key ingredients of effective behavior change approaches: assessment or taking stock; goal-setting, ongoing problem-solving, action-planning, ongoing support, and monitoring that incorporate the best available scientific and practice data.

In the resources section included in the last article of this issue, "On the Front Line: Health Promotion for Geriatric Care Managers," several current Web sites are identified which provide comprehensive background information on many intervention areas, low or no cost tools for use by the care manager, and links to additional resources.

Safe and effective fall prevention.

Falls are a major cause of injury, ongoing disability, and institutionalization among older persons. Thirty percent of community-residing persons over 65 years of age and 50 percent of those over 80 years, fall each year. One in ten falls result in serious injury, such as a fracture. Just falling increases the risk of permanent nursing home placement threefold while an actual fall injury increases the risk tenfold. Falls also are very costly, to individuals and other health care payers. The costs of injury from falls are expected to increase to more than $32 billion by 2020 (AHRQ, 2003).

Many more seniors than those who actually have been injured by falling experience fear of falling, which often leads to restricted levels of activity and, subsequently, physical de-conditioning. The chance of a fall is increased by the loss of muscle strength and balance that are maintained and improved by physical activity. When fear of falling leads to reduced activity, it may actually increase risk of falling, and at the same time limit engagement in a variety of desired activities and relationships.

The frequency, harm, and cost associated with falls plus the solid evidence of the potential benefits from programs that have been evaluated

combine to suggest that fall prevention interventions are a cost-effective strategy for reducing functional decline, health care costs, and social service utilization among at risk older persons, directly benefiting both the individuals participating and the community.

Although not every intervention program will address all these components, key aspects of a program to manage fear of falling and fall prevention would include:

1. Maintaining or increasing levels of physical activity and balance;
2. Managing or improving environmental conditions;
3. Managing falls appropriately when they do occur;
4. Managing medications;
5. Reducing and/or managing fear of falling.

Evidence-Based Program Recommended by the Center for Healthy Aging at NCOA

Matter of Balance: A Volunteer Lay Leader Model addresses all these components. It is one of the evidence-based health promotion programs being supported for dissemination nationwide by the U.S. Administration on Aging. It is based on a program originally developed and tested at the Roybal Center of Boston College and subsequently adapted in a demonstration project implemented by the Partnership for Healthy Aging in Maine (http://www.mmc.org/mh_body.cfm?id=449). This lay leader model is designed for delivery by community volunteers. Evaluation of the lay leader model indicates that comparable results were achieved when compared to the original intervention which depended upon health professionals as instructors and facilitators. Research results demonstrate that after completing the series of classes, older adults who complete "A Matter of Balance" are more comfortable talking about fear of falling and increasing their activity levels. Other research outcomes include improved falls management and exercise levels up to twelve months after taking the class. As well as reduced risk of falls, significant immediate and long-term effects included a reduced fear of falling and increased confidence in managing falls appropriately when they do occur (MaineHealth, Partnership for Healthy Aging, Matter of Balance Coach Manual, 2007).

This model involves working with 8–14 older adults, in a group setting. It emphasizes practical strategies to reduce fear of falling while increasing everyday physical activity levels. *A Matter of Balance* includes eight two-hour sessions for the group led by two trained facilitators (who may be community volunteers). Participants learn to view falls and fear of falling as controllable; set realistic goals to increase activity; change their environment to reduce fall risk factors; and exercise to increase strength and balance. The program originally was designed for small groups of older adults living independently in community settings or senior housing and now has been implemented with other at-risk groups as well, for example with older adults in recovery from alcohol and other substance abuse.

Programs to increase the level of physical activity.

There are many benefits of increased physical activity among older adults, including frail older persons with chronic conditions. Some of these include: reduced cardiovascular risk and obesity, lowered cholesterol and low-density lipoproteins, slowed decline in bone mineral density, increased bone density, reduced risk of falls and fractures, and just making people feel good.

Unfortunately, people aged 60+ have the lowest rates of activity among all adults. Levels of physical inactivity are especially high for persons age 75 or older and for members of minority groups. Only 25–35% of older persons achieve the recommended level of physical activity. The Agency for Healthcare Research and Quality (AHRQ 2002) suggested that older people especially may benefit from regular physical activity, because they are more at risk of the health problems that can be prevented by physical activity. Physical activity can improve functioning, even if there already are physical limitations. The key to achieving these benefits is consistent involvement in appropriate types and levels of activity.

Unfortunately, people aged 60+ have the lowest rates of activity among all adults. Levels of physical inactivity are especially high for persons age 75 or older and for members of minority groups.

It is important to note that sometimes an exercise program is not a part of a structured program to increase levels of physical activity. This may be especially important for frail and otherwise at risk clients (or family caregivers) who may initially be intimidated by the idea of an exercise program but find participating in a program to increase everyday physical activity levels within their comfort level.

Evidence-Based Programs Recommended by the Center for Healthy Aging at NCOA

Active Choices is designed to be used with individuals. It is an evidence-based program developed by the Stanford Prevention Research Center that has been proven to be effective in helping older adults meet their physical activity needs. Each **Active Choices** participant is assigned a trained activity coach who helps him/her build an

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individualized exercise plan that is convenient, flexible, and appealing. Regular monthly phone support enables the **Active Choices** coach to monitor progress, modify exercise strategies as needed, and provide exercise tips. The program has been adapted to include a group orientation session but remains essentially an intervention that relies on self-direction supported with an initial facilitated assessment and goal setting process and followed up with regular telephone calls.

***Active Living Every Day*,** is designed to assist people to become less sedentary and stay physically active for a lifetime. Developed by the Cooper Institute, and offered to the public through "Active Living Partners" — a division of Human Kinetics, it can be used by adults of all ages and with varying levels of fitness at program entry. The core of the approach is a 20 week program which is detailed in a participant handbook: *Active Living Every Day.* There are several ways in which the program can be delivered, including: independently or in collaboration with community organizations such as worksites, hospitals, community health programs and colleges, and senior residences; in a group face to face setting; through a person to person facilitator, via telephone consultation, and through self-direction and/or online assistance. It is designed to help participants identify ways to incorporate physical activity into daily routines and maintain a more active lifestyle through inevitable life transitions and challenges.

There are licensed program providers in 34 states with more than 120 locations. Consult (http://www.activeliving.info/LocateCourse.cfm) for locations. Individual materials can be ordered directly through Active Living Partners.

EnhanceFitness is an exercise program that is designed to be highly adaptable to a variety of participants. The core model is a one hour group class meeting three times per week for five weeks. The class addresses all the key components of a comprehensive program: stretching; flexibility; balance; low impact aerobics; and strength training with wrist and ankle weights. To serve a diverse participant population, the required movements can be performed seated or standing. The program is designed so that participants can make a transition to a self-maintained fitness routine at home.

Outcomes of participation have included: increased strength, balance and levels of physical activity; improved social functioning; and decline in pain, fatigue, and depression. Over 99% of participants say they would recommend EnhanceFitness to a friend. Even participants who were "unfit" at program entry have made significant progress toward their goals.

This is not a lay leader model as all classes must be taught be a certified fitness instructor. Currently, Enhance Fitness is available at more than 100 locations across the country (Accessed October 2007, www.projectenhance.org/pro/fitness.html).

Strong for Life is a home-based exercise program for both disabled and non-disabled older adults that was designed by physical therapists for home use. It has been demonstrated to increase strength, balance, and overall health in both populations. This program targets specific muscles that are important in every day movements such as getting out of a chair and walking.

Strong for Life products include: Strong for Life exercise video, Strong for Life Trainer's Manual, and Strong for Life User's Guide. The exercises on the video use elastic resistive bands and can be modified to suit different strength and functional levels. Instructions are provided verbally by the instructor on the video as well as shown visually by the elders in the video (Accessed November 200, http://www.bu.edu/hdr/products/stronglife/index.html).

Other Programs

Healthy Moves for Aging Well, identified as a "model program" by NCOA's Center for Healthy Aging, was designed by the Partners in Care Foundation, specifically for care managers, and is particularly targeted to homebound frail older persons. Clients are assessed, instructed and monitored periodically by professional care managers. The model also uses volunteer coaches for follow up and regular contact to encourage, support and motivate elders to continue their exercise program. A "toolkit" is available on the Center for Healthy Aging Web site: (http://www.healthyagingprograms.com/content.asp?sectionid=30&ElementID=202). This toolkit provides resources needed to replicate the Healthy Moves for Aging Well physical activity program in community-based care management settings. This model program provides specific interventions to promote independence, slow the progression of chronic disease and disability, and better utilize geriatric care management for health promotion.

As you consider possible referrals to other structured physical activity programs in your area, the "Checklist for Structured Physical Activity Programs for Older Adults" (Accessed October 2007, http://www.healthyagingprograms.com/content.asp?sectionid=73&ElementID=334) provides an easily used reference. Although it was designed to be used by teams comparing the quality of various community programs, the questions are equally relevant to the care manager. The checklist may help you determine whether a particular program is a good fit for your clients. Some of the questions on the checklist include:

- Does the program incorporate safe and effective endurance, strength, balance, and flexibility components that are tailored to meet the needs of the participants?
- Does the program offer group-based physical activity options with instruction in proper technique and qualified supervision?

- Does the program provide opportunities for participation in flexibility and stretching activities that facilitate increased range of motion?
- Does the program include opportunities for both static and dynamic balance activities?
- Does the program assess the functional fitness (including cardiovascular, strength, flexibility, and balance) levels of participants on a regular (at least annual) basis?
- Does the program include a variety of support strategies designed to maximize recruitment, increase motivation for exercise progression, and minimize attrition?

While the evidence suggests that many people need ongoing support and reinforcement for behavior changes, there are clients or circumstances in which simply sharing information about health promoting lifestyle choices is either sufficient or the best that can be done.

The two guides below may be useful for distribution to clients and/or caregivers to promote increased physical activity.

Canada's Physical Activity Guide to Healthy Active Living for Older Adults is a straightforward and comprehensive consumer guide, with colorful illustrations, checklists, and tracking chart for physical activity that can be downloaded directly from the Center for Healthy Aging Web site. (Accessed November 2007, NCOA, http://www.healthyagingprograms.com/content.asp?sectionid=73&ElementID=129,).

The National Institute on Aging will distribute up to 25 copies at no charge of **Exercise: A Guide from the National Institute on Aging** (2007) (http://www.nia.nih.gov/HealthInformation/Publications/ExerciseGuide). This clearly written guide is comprehensive and includes both explanations and illustrations. A chapter on safety includes a section on exercise for older persons with chronic diseases.

Programs to improve self-care and strengthen self-management of chronic disease(s).

It has been conclusively demonstrated that with appropriate training and support, persons with chronic diseases can help to manage their own diseases. Chronic diseases or conditions such as diabetes, heart disease, hypertension, arthritis, and depression have been the focus of several evidenced-based intervention models that have been found effective and there are many other model programs that may assist clients with particular chronic conditions.

Research shows that difficulty with accomplishing daily activities such as bathing, dressing, eating or using the toilet are a key risk factor for requiring formal home care (AHRQ 2002). Chronic disease self-management programs may help clients to avoid or delay losing function (secondary prevention) or better manage or maintain the level of function that they have (tertiary prevention).

Most chronic disease self-management interventions address improvement objectives that are desired by clients with a variety of chronic conditions, such as reducing fatigue, managing sleep, relaxing under pressure, improving diets, and increasing physical activity without aggravating symptoms and improving communication with health care providers.

A variety of intervention strategies have been developed and demonstrated, including for example, group based classes; telephone counseling and monitoring; individual online education and follow up; self-directed education using healthy living guides. Two different types of chronic disease self-management interventions are profiled below.

Evidence-Based Programs Recommended by the Center for Healthy Aging at NCOA

Chronic Disease Self-Management Program (CDSMP)

http://patienteducation.stanford.edu/programs/cdsmp.html

The CDSMP program was developed at Stanford University, and builds upon decades of work in patient education with a particular focus on self-efficacy. Much of the original research and program development was done with patients who had arthritis. The CDSMP model has been validated for use with multiple chronic diseases.

This approach is a small group education model designed for people with one or more chronic diseases. Classes usually last about two and a half hours and each course is generally offered over a 6 week period. Course leaders typically are non-health professionals, at least one of whom has a chronic disease. Course leaders are trained by certified CDSMP representatives.

An overall objective of the model is to build participant confidence in their ability to control their symptoms and how their health challenges affect their lives (NCOA, 2007). Course topics include coping strategies, such as action planning and feedback, behavior modeling, problem-solving techniques, and decision-making. Participants are taught how to cope with frustration, fatigue, and pain. They also learn how to exercise appropriately, use medications appropriately, and communicate effectively with family, friends, and health professionals. Participants develop a "roadmap for change" that helps them to manage their chronic condition(s).

Participants who took the Program, when compared to those who did not, demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They also spent fewer days in the hospital, and there was also a trend toward fewer outpatients visits and hospitalizations. These data yield a cost to savings ratio of approximately 1:10. Many of these results persist for as long as three years.

Currently, locations in more than 30 states offer this Chronic Disease

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Self-Management Program. To see if there is a location in your area, consult the Web site: http://patienteducation.stanford.edu/organ/cdsites.html

EnhanceWellness is based on a decade of community experience and research. It is designed to serve seniors who are living independently in the community and who are cognitively intact, but who already have one or more chronic diseases and are at risk for further functional decline. It is an individually oriented model that depends on a partnership between the participants, the professional interdisciplinary health team, and a health mentor. Reducing functional decline or susceptibility to functional decline is the primary objective of the approach.

A registered nurse conducts a comprehensive health review and functional assessment; develops the Health Action Plan with the participant; and provides ongoing monitoring, problem-solving, support, and referrals. Proprietary software is used to analyze the data gathered in the assessment. The results help to shape the Health Action Plan, which focuses on areas of health risk that the participant prioritizes. The social worker may participate in the health assessment, facilitates support groups as needed, and conducts individual and family consultation and counseling. The participant's physician refers patients to the program, reviews the Health Action Plans and communicates with the other team members as needed. Follow up support and monitoring are provided by trained volunteer "health mentors" who act as role models; provide coaching and skills development; assure ongoing social interaction; and assist with other follow up as needed.

The team works with the participant on the plan for six months, when another assessment using the WellCare software is implemented. Feedback about progress toward goal(s) and other areas of health measured is provided immediately to participants. They can choose to "graduate" from the program at that point or "renew" for another six months to work on the original goal(s) or new ones. Health mentors commit to follow up with their participant one to five hours per month for a year and are paired 1:1 with participants.

Some key objectives of the approach include: decreased hospital days; decreased use of psychoactive drugs; decreased depression; increased physical activity; and increased confidence in managing one's health. Outcomes demonstrate: a 38% reduction in the number of seniors hospitalized, 36% reduction in medications for sleep and depression, significantly higher levels of physical activity and better functioning in activities of daily living (www.projectenhance.org. 2007). To see if there is a location in your area, consult the Web site above.

Immunization and Screening Services

It seems so obvious, but making sure that clients (and caregivers!) secure needed immunization and screening tests is a first line of primary, secondary, and tertiary prevention for many chronic and acute conditions. It is easy to overlook these under the assumption that they have already been completed.

Fortunately, Medicare covers more preventive benefits than ever. There is even an online tool (http://www.mymedicare.gov/) to track preventive benefits that are used by individual beneficiaries each year. See Figure 1 for a reproducible checklist of covered services that can be incorporated into client health assessments. (http://www.cms.hhs.gov/myhealthmymedicare/downloads/11308.pdf) New immunizations and tests are added periodically, so checking the Web site for updates is recommended.

Not every covered preventive service is necessarily appropriate for every client. Each service about which there may be a question needs to be evaluated in relation to the circumstances of the older individual. For example, although mammography is a covered periodic service, a well- informed very old women with no family history of breast cancer might feel that the effort, risk and discomfort of going to a clinic and having a mammogram is not worth it. Similarly, the benefit of treatment to control elevated cholesterol in a very old person with no related identified symptoms or risks may not outweigh the possible side effects in the mind of the client or in the estimation of the health care professional. Informed thoughtful decision-making is the key to making best use of these disease prevention resources.

Summary

While a specific evidence-based group or individual program may not be available currently in your area, similar or comparable programs may be offered, and the care manager can evaluate whether or not these programs meet the criteria established for a successful program. There are also interventions that the care manager can facilitate without referring to a structured program. For example, assisting clients to understand and make informed decisions about accessing recommended immunizations, and health screening procedures is something that can be done directly or in partnership with another health care professional.

The Future of Health Promotion and Disease Prevention with Frail and At-Risk Older Persons

In congressional testimony, Assistant Secretary Carbonell reinforced the ongoing Federal commitment to health promotion and disease prevention when she identified as a key principle of the "Choices for Independence" demonstration, "Empowering seniors, including seniors who are already impaired, to make behavioral and lifestyle changes that can improve their health and reduce their risk of disease, disability and injury" (Josefina Carbonell, Assistant Secretary for Aging, U.S. Department of Health and Human Services, on Administration on Aging Priorities, before The Special Committee on Aging, US Senate, Thursday, February 15, 2007).

What are some of the trends on this empowering horizon for health promotion with older persons?

- Already, access to online resources, individual and group assessments, counseling, and follow up is included in many interventions. As more and more older persons gain access to the Internet, this will only increase.
- The use of all forms of assistive technology to promote independence and whole person wellness will flourish.
- More attention will be paid to mental and emotional aspects of health and wellness, including "brain fitness" and memory management strategies.
- Attention to intergenerational and or family-centered, evidence-based health promotion interventions for increasingly frail and or at-risk persons of all ages, including younger adults with mobility, sensory and cognitive challenges will become more common.

As the evidence increases about the results, more and more intervention models are making use of lay leaders facilitators, volunteer mentors, and retired health and social services professionals to deliver health promotion services, to individuals and to groups. Not only will this trend continue, but self-directed teams of older "unpaid staff" and community advocates will work on environmental interventions and policy changes that promote access to health promotion services and create environments that "naturally" promote healthy choices.

The absolutely critical nature of the role to be played by improving consumer knowledge and disseminating excellent information about health and wellness opportunities across the age, health, ethnic, income and education continuum increasingly will be recognized, driving a demand for interdisciplinary cultural competence and population wide health literacy.

Conclusion

A survey of centenarians published by NASW (Accessed October 2007, http://www.helpstartshere.org/seniors_and_aging/vital_aging/current_trends/vital_aging_current_trends.html#lessons) gives us a contemporary opportunity to follow up on Socrates vintage suggestion about gaining wisdom from the elders who have gone before. Studies of centenarians show that, in general, they:

- Maintain a healthy weight
- Do not smoke
- Have delayed chronic health conditions, such as heart disease, stroke, cancer
- Handle stress effectively
- Have an ability to cope with loss and get on with their lives
- Have a high degree of self-sufficiency and are resourceful in overcoming problems
- Have a sense of humor
- Look forward to the future with hope
- Stay engaged in a hobby, volunteering, or interest.

The essential ingredients of successful aging as defined by the Cleveland Foundation's Successful Aging Task Force (Cleveland Foundation, 2003) are not so different. They include:

- living with a sense of purpose and joy;
- adapting to the inevitable changes and challenges of aging, and
- being in dynamic relationships with other living beings.

Acquiring and maintaining these "ingredients" is more complicated, perhaps, than defining them, but taken together with the experience of the centenarians, it sounds like whole person wellness to me!

The jury is in and there is increasing good news for Geriatric Care Managers on the disease prevention, health promotion and whole person wellness horizon. Already, the evidence is powerful. A combination of the built and natural environment, the breathed and ingested products of that environment, social supports and customs and personal lifestyle choices profoundly influence whole person health and wellness. Even, and perhaps, especially, for frail and at-risk older persons, there is so much to be gained from health promotion and disease prevention interventions and working toward whole person wellness. Preventing a fall, managing a fear, increasing strength and endurance, improving nutrition, avoiding the flu, staying socially engaged and looking forward to tomorrow instead of dreading it are all achievable goals. Resources are available, and more are on the way, to help you use a positive, strength-based approach to assisting your client to join and benefit from what is being learned every day about the value of health promotion and disease prevention interventions with at-risk populations.

Assisting clients and caregivers to live with a sense of purpose and joy while they work to maintain or adopt behaviors that have been shown to improve health outcomes, reduce risk of injury or illness, and manage the chronic and acute conditions that are present should surely be one main ingredient in the geriatric care manager's recipe for successful aging.

Dr. Stephanie FallCreek, MSW, DSW is President/CEO of Fairhill Center — a multi-tenant nonprofit campus in Cleveland, Ohio. Fairhill's approach to service is reflected in the mission statement: Fairhill Center connects individuals and organizations with successful aging opportunities. Her personal passion for lifespan, whole person wellness is embedded in Fairhill's definition of successful aging: to be able to adapt to life's inevitable changes and challenges; to be in dynamic relationships with others; and to live with purpose and joy. Fairhill Center, 12200 Fairhill Road, Cleveland, OH 44120

Healthy Town: An on line prevention resource for Geriatric Care Managers

www.vnahealthytown.org

Sheila A. Niles, MSN, RN, CNS
Sonia A. Alemagno, PhD

Introduction

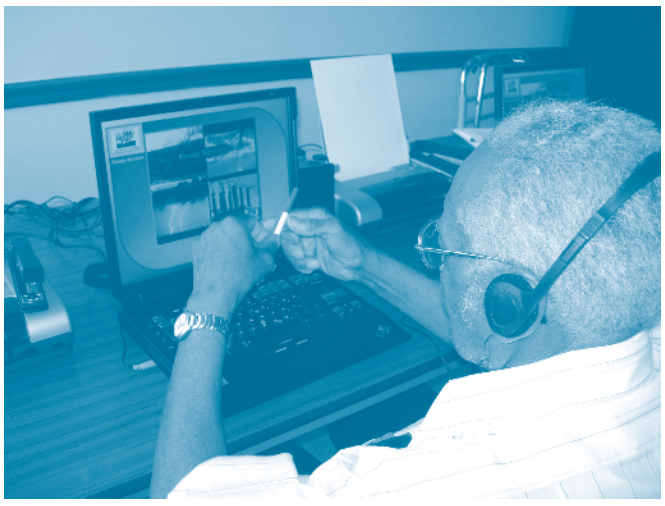
The Internet has become a central source of information and entertainment in America. In 2006, Mike Shields reported in Mediaweek that the average person spends slightly more than 3 hours a day on line. As part of this time spent on-line, Americans are relying more and more on Internet resources for finding answers to questions and solutions to problems, including issues related to health. Although the Internet was initially developed as a communication vehicle, it has become an intrinsic resource in decision making processes at all age levels. In 2006, the PEW Research Foundation reported that 24 million Americans rated the Internet as either crucial or important in helping them find information about a medical condition.

Use of the Internet as an important source of information is not limited to the young, as one might expect. In fact, the opposite is true. In 2005, the Kaiser Family Foundation Study shocked the aging community when it confirmed that the fastest group of internet users and information seekers are adults 65 years of age and older. A study by Dow Pharmaceuticals found that 74 percent of seniors use the Internet to find health information and to assist in self-care for chronic conditions. Older adults are becoming more sophisticated health care consumers and rely on the Internet more and more as their main source for general information on health issues. A study conducted by Eastman and Iyer (2004) shows that older adults have very favorable attitudes toward using the Internet, most learned to use the Internet on their own and are willing to learn new skills in order to retrieve information from the Internet.

These trends of increased Internet use and increased interest in health care information among older adults offer opportunities and new options to Geriatric Care Managers. Internet sources have the potential to provide tools and information to promote health for older adults, especially for those who are living independently in the community. The challenge will be to use these resources in a way that not only promotes health, but also motivates older adults to make healthy behavior and life-style changes.

HEALTHY TOWN: On-Line Screening and Resources for Older Adults

Recognizing the emerging value of the Internet as a health care information resource and that older adults were increasingly embracing computer technology, the Visiting Nurse Association Health Care Partners of Ohio in partnership with The Institute for Health and Social Policy at The University of Akron developed the Healthy Town program (www.vnahealthytown.org). Initially,



Healthy Town was developed in response to a community need for on-site health education, screenings, and referral in multipurpose senior centers in Northeast Ohio. Healthy Town is a unique health promotion program that has demonstrated success in improving the health of seniors in diverse communities. Using innovative, interactive on-line screenings, Healthy Town helps older adults identify health care risks in the following categories:

- prevention needs
- mental health risks
- fall risks
- immunization risks
- nutritional risks
- medication risks
- chronic/disabling conditions

As soon as the on-line screening is finished, the client receives a personalized checklist with suggestions for actions that will improve health. The intervention categories guide participants to:

- Make an appointment to talk with the doctor for such things as mammography, prostate screening; and updated immunizations
- Make an appointment with other health care professionals for vision or hearing screenings or help with possible depression
- Make simple changes in behavior that could improve health and safety, such as wearing seat belts or making sure smoke detectors in the home are working
- Take medication as prescribed
- Make changes at home to reduce risks for falls

The on-line program screenings and interventions are framed within Healthy People 2000 and 2010, grounded in the Health Belief Model, and, received funding support from local philanthropies, the Administration on Aging and the Centers for Disease Control. Healthy Town was awarded the Best Practice Award from The Health Promotion Institute, National Council on Aging. Healthy Town links older adults, caregivers and health professionals to considerable resources related to health promotion. The web site, organized by "Fast Facts," "What to do," and "Where to go" provides links to reliable web sites for further information and education.

Since the program was introduced, more than 7,000 older adults have participated in the screenings. The program has been expanded to include families and children, with 2,000 families participating so far. Healthy Town has been implemented in numerous settings, particularly in partnership with Area Agencies on Aging and senior centers in the community. Other sites have included health fairs, churches, meal programs, community college senior colleges, health clinics and urban metropolitan housing authorities.

Older adults who have participated have commented on several positive outcomes. Some respondents have used the computer for the first time to complete the screening and feel a particular sense of accomplishment using the computer. Others have expressed how Healthy Town has provided new health information that they did not receive in any other setting. Some examples of new information include learning the recommended timetable for age-specific screening exams, realizing that you are never too old for cancer screening, understanding the risks of addiction to sleeping and pain medications and realizing the symptoms of depression.

Older adults who participated in the on-line screening program evaluation (including 991 older adults) reported a high level of prevention needs. Most of the respondents were

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FIGURE 1 • Healthy Town On-Line Prevention Screening

Prevention Needs	Mental Health Risk	Fall Risk	Immunization Risk	Nutritional Risk	Medication Risk
Hearing screen	Lost someone close	Blood pressure pills	TB screen	Wears false teeth	Take 3 or more prescription meds
Mammogram	Feel sad	Heart pills	Tetanus shot	Eat three meals (no)	Take over counter meds
Alcohol risk	Feel life is empty	Recent falls	Pneumovax shot	On special diet	Take herbal supplements
Dental exam	Feel something bad is going to happen	Eye drops	Flu shot	Tooth/mouth problems	Take nerve medicine
Prostate exam	Lost interest in activities and hobbies	Light-headed		Need money for food	Take sleep medicine
Eye exam	Harm risk	Use assistive device			Take pain medicine
Smoking risk					Think medicine has lost effectiveness
Seatbelt risk					Sometimes forget to take medicine
No smoke alarm					Go to more than one drug store for meds
Need blood pressure checked					

Healthy Town: An on line prevention resource for Geriatric Care Managers

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female (71%) and white (90%). Over half reported a chronic disease such as arthritis, hypertension, heart disease or diabetes. The highest needs were in the areas of reducing the risk for falls and reducing risks related to medication misuse. More than half of the respondents reported taking blood pressure pills and many were taking medications such as cardiac medications or eye drops that created a fall risk. About one-third had fallen recently. With almost 70% of the responding older adults taking three or more prescription medications, and more than half also taking over-the-counter medications or herbal supplements, the need for medication monitoring is high.

FIGURE 2
Prevention Needs of Older Adults

ACTIVITY	PERCENT
1. TB Screen	70
2. Take 3 or more prescription meds	61
3. Pneumovax shot	51
4. Hearing Screen	47
5. Tetanus shot	44
6. Eat three meals (no)	35
7. Prostate exam (of males)	33
8. Mammogram (of females)	32
9. Dental exam	31
10. Lost someone close	29
11. Recent falls	29

The respondents reported high prevention needs for immunizations, with over two-thirds in need of one of the Healthy People 2010 recommended immunizations. More than two-thirds of older adults indicated that they had not had a TB screen and half had not had a pneumovax vaccination. Many (44%) were not current on a tetanus immunization.

Respondents also had a high need for recommended screening tests, such as hearing exams or vision exams. Nearly half of the respondents had not had a hearing screen and one-third had not had a recent dental exam within the recommended time interval. Many participants did not know that a preventive dental exam is important even if you have dentures. About one-third of females and one-third of males had not had recommended cancer screening tests.

As might be expected in an aging population, about one-third of participants reported symptoms of depression. About 15% felt that life is empty and that they feel sad or that something bad is going to happen to them. One-quarter responded that they have lost interest in activities and hobbies and they had lost someone close to them recently.

The risk screening also identified a need to provide nutritional monitoring to older adults. More than half of the respondents reported that they do not eat three meals a day. More than a quarter were on a special diet, wear false teeth, or have tooth/mouth problems.

The overall reaction of older adults to the on-line prevention screening program was very positive. Over 90% of participants would recommend the screening program to a friend and found the program easy to use. Two-thirds of participants planned on taking some action based on the screening and one-third reported that they learned something new about their own health management.

FIGURE 3
Reactions of Older Adults to Online Screening

EVALUATION TOPIC	PERCENT ANSWERING
1. Did you find this program easy to use?	96
2. Would you recommend this program to a friend or family member?	93
3. Did you learn anything about your health that you didn't already know before?	31
4. Now that you have completed this health screening, do you plan to make changes to improve your health?	64

A telephone survey to a sample of participating seniors was conducted to evaluate the technology program and individual senior follow up on prevention recommendations. What do seniors say about the Healthy Town program?

- Very important program
- Everyone should do it
- Appreciated it and it didn't cost anything
- Good information for seniors. We need this!
- It was interesting. It gets a person thinking about their health
- Worthwhile program to get feedback on my lifestyle

Healthy Town as a Resource for Geriatric Care Managers

The American Geriatric Care Society Care Management Position Statement outlines the need for geriatric care management to be provided by a team of professionals along with the patient and family. A part of this is the need for patients and families to be informed of health care choices in self-care. Our experience with Healthy Town adds a new dimension to self-care, the possibility for older adults and caregivers to monitor their own prevention needs and make important health promoting lifestyle changes.

Healthy Town provides a resource of screening and referral information to geriatric care managers who want to link patients and families to health promotion resources. Referrals might include immunization review, medication review, a fall risk assessment, a nutritional assessment, depression screening or specific health screening. Based on the overwhelmingly positive response of participants in Healthy Town, this program provides a considerable resource for geriatric care managers.

Some of the benefits of incorporating this type of health promotion resource in your practice include: low or no cost to implement; can be conducted in the privacy of the home or office environment —wherever there is an Internet

connection; can provide a "hard copy" of results for client to take to the medical care provider as a support for further exploring options; is equally relevant to the caregiver and the care receiver and may create opportunities for joint participation in programs or services, increasing the likelihood of follow up on recommendations.

Geriatric care managers can access Healthy Town at www.vnahealthytown.org. At this web site, a care manager can link patients and caregivers to the Healthy Town prevention screen, a medication misuse screen and considerable links for additional information. The screening is provided at no cost and takes about 20 minutes for each older adult to complete. Provided that the respondent has access to a printer, he/she can print the personalized prevention checklist and/or specific health information materials

The Healthy Town program has evolved into multiple collaborations locally, regionally and state wide as a self directed health promotion initiative for community seniors. Universal access and its demonstrated outcomes have enabled The Aging Network, Public Library systems and multiple on line senior venues to participate and provide computer/internet access for seniors.

Of course, the care manager will want to make sure that appropriate follow up occurs after the screening. Identifying client needs for health promotion and disease prevention knowledge, programs or interventions is just the first step. Assisting the client to connect with available opportunities to act on that information is where the geriatric case manager's expertise and local knowledge is essential. In addition, through the Healthy Town Web site, condition specific information also may be accessed and printed for distribution to clients.

It is likely that the use of the Internet to provide a platform for self-care and chronic disease management will increase in the future. In the future, Healthy Town will expand to provide screening and information related to emergency management. Geriatric care managers are encouraged to check the Healthy Town Web site frequently for information and updates.

Healthy Town Personal Prevention Checklist
Prepared for Client #997 on 3/14/2006

☐ **Make an appointment to talk to a doctor about the following:**
- Mammogram
- Medication review

☐ **Make appointments with other health care professionals for the following:**
- Dental exam
- Eye/Vision exam
- Nutritional assessment
- To talk about loss
- To talk about sadness

☐ **Take your health into your own hands**

☐ **Take all medicine as prescribed**
- Tell your doctor about all the medicine you are talking, including over-the-counter medicine, vitamins, minerals, and all natural substances.
- Do not use anyone else's medicine.
- Read the information sheet that comes with your medicine.
- Use a pillbox to dispense medicine so you can easily check if you have taken the medicine for the day.
- Follow all directions for taking your medicines.
- Even if you think a medicine is not working anymore, continue to take it and call your doctor.
- Do not drink alcohol while taking medicines.

☐ **Reduce your risk of falling**
- If you get dizzy, talk to your doctor.
- Make sure stairways and hallways have bright light.
- Put things in their place, clutter can cause falls.
- Keep extension cords out of the way.
- Don't use soap or towel holder for a grab bar or handrail.
- Be sure all throw rugs or scatter rugs have a non-skid backing.

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Sheila Niles, M.S.N., R.N., C.N.S. is Director of Mental Health and Elder Services at the Visiting Nurse Association Healthcare Partners of Ohio in Cleveland, Ohio. She is co-Director of Healthy Town and a member of the National Association of Geriatric Care Managers. She is adjunct Clinical Professor at Case Western Reserve University School of Nursing and Cleveland State University School of Nursing.

Sonia Alemagno, Ph.D. is the Director of the Institute for Health and Social Policy and Associate Professor of Public Administration and Urban Studies at The University of Akron in Akron, Ohio. She is the Co-Director of Healthy Town as the evaluation researcher and the principal investigator on numerous research projects in the areas of health promotion and public health.

Health Promotion and Care Management: Observations from the Field

By Stacey Rokoff, MSAA, LSW and Jean Wertzl, CNP

Science, and the research literature, says "Yes! Evidence-based health promotion programs are effective with older persons who are frail and have chronic conditions." The Administration on Aging, the Centers for Disease Prevention, the National Institute for Aging, the National Council on Aging, the American Society on Aging, Atlantic Philanthropies, Robert Wood Johnson Foundation, Hartford Foundation, and a host of other public and private organizations all agree that disability can be prevented or delayed, accidents can be avoided, and life satisfaction for older persons with serious chronic conditions can be improved through healthy behavior choices, behavior changes, and improved environmental management. Therefore, health promotion interventions and "whole person wellness" goals are reasonable, realistic, and appropriate for most of the frail and at risk clients served by geriatric care managers.

- What does that mean for those of us who work on the front lines, everyday?
- Aren't we already doing this?
- Who is this meant for, do they really know who our clients are and what their lives, homes, and support systems are like?
- Are we setting our clients and families up for disappointment when the results they desire aren't achieved?
- What do we need to know and how can we find out? What really works and what just sounds good but doesn't produce the results desired by the clients.

The discussion that follows is intended to address these questions, and then relate them to some practice examples.

So, what does that mean for those of us who work on the front lines, everyday?

It means as little or as much as you decide you want it to mean, everyday. If you want to take the opportunities seriously, it probably means increasing your own knowledge and skills and learning more about other professional and program resources for health promotion relevant to your client base.

You even could choose to reorient your entire practice around a strength-based assessment of client/caregiver potential for "whole person wellness." On the other hand, you could decide to set yourself just one new goal in the area of health promotion. You could work toward achieving 100% compliance with assessing need for and opportunities to increase physical activity in the daily life of the client and/or caregiver, or you could add an updated or more comprehensive home safety assessment to the "homework" that you assign the client and the caregiver.

At a minimum, geriatric care managers carry out assessing, planning, implementing/facilitating, and monitoring tasks. Each step in this typical sequence of activities provides another chance to mindfully and intentionally seek opportunities for health promotion and disease prevention interventions.

Aren't we already doing this?

Assessment is the cornerstone of opportunity for practicing health promotion. If the needs and opportunities of health promotion are identified in the assessment process, tackling the "how to" can be accomplished as it makes sense. Without assessment there is no ongoing trigger to plan and implement intervention strategies. Fortunately, many assessment models already include at least some of the ingredients needed to incorporate health promotion interventions, including an analysis of the physical and social environments. So, yes, you probably already are doing some of "it." However, interpreting your existing assessment outcomes through a new "lens"—one which magnifies opportunities for health promotion and disease prevention—may yield very different results and put you into unfamiliar territory.

Pay particular attention to the modifiable behaviors, environmental and economic circumstances of the client which might be evidence-based targets for change. Identify both public and private resources which could be brought to bear on the desired changes. For example, if you don't already use a home safety checklist in your assessment, visit the Web sites in the resource section, look for fall prevention, and download one. Then use it with the client and the caregiver. Recommend that the care unit put the information gained from the assessment to good use (remove throw rugs that create a tripping/slipping hazard, make a wall hanging from the favorite rug if it has great sentimental value, similarly, use a cleaned favorite rug as a couch cover, or a table cloth for the coffee table, or send it to a favorite grandchild).

"Hook up" to www.vnahealthytown.org for a very simple, no charge, online health assessment with health promotion recommendations designed with older

persons in mind. Prevention is not necessarily complex or difficult. An example of one person's individualized fall prevention recommendation from Healthy Town is:

Reduce your risk of falling by:

- If you get dizzy, talk to your doctor
- Make sure stairways and hallways have bright light
- Put things in their place; clutter can cause falls
- Keep extension cords out of the way
- Don't use a soap or towel holder for a grab bar or handrail
- Be sure all throw rugs or scatter rugs have a non skid backing

Who is this meant for, do "they" really know who our clients are, and what their lives, homes, and support systems are like?

The term client, in this discussion, is used to refer to the individual who is identified as the primary care receiver or "the person at-risk," usually a frail older person, who has one or more chronic conditions or diseases. The term caregiver is used to refer to the family member(s) or other unpaid individual(s) who provides assistance and support for the clients. The caregivers may also have one or more chronic conditions. The term care unit is used to refer to the group composed of at least the client, the primary and secondary caregivers (usually family members and close friends), and meaningful social networks (sororities, fraternities, faith-based groups, neighborhood associations). This care unit may or may not function like a team or in any coordinated fashion at all, but if it can be mobilized as a team, the potential for the care unit serving as facilitators and/or a support system for desired behavior and environmental changes may be greater.

At the front line, when implementing health promotion interventions, it is important to acknowledge that while there may be only one identified "client" for legal or payment purposes, the entire care unit potentially can be engaged and many people may benefit from the process or the results—directly or indirectly. Most care units are composed of multiple members, each of whose health and well-being has an influence on the other members of the unit. Frequently, self-care on the part of the caregiver is the foundation to providing good care for the client. Healthy behavior choices and changes on the part of the caregiver may create a positive climate for change on the part of the client. The health promotion intervention may be directed to the client, the caregiver, both, or even the entire care unit (for example, a neighborhood group undertakes a home safety initiative inspired by recognizing the needs of a particular client in that neighborhood).

Identifying, prioritizing, achieving, and then sharing the results of health promoting objectives of any member of the care unit with the other members can have a positive influence on the well-being of the entire care unit and on motivating other members to become involved.

Health promotion is relevant for all members of the care unit. Research and practice have clearly established that meaningful results can be achieved for individuals with multiple late life chronic conditions and/or serious lifetime disabilities. Even when individual clients are unable to carry out a plan or make informed decisions themselves about desired goals and objectives, environmental management, and engaging the caregiver/care unit as partners in health promotion can achieve results in risk reduction and behavior change.

Your challenge is to recognize the fit between your clients and what evidence suggests might be beneficial for them.

Are we setting our clients and families up for disappointment when the results they desire aren't achieved?

Managing client and caregiver expectations is always a challenging aspect of care planning—whatever the focus of the plan, health promotion or not. There is nothing different in this regard about health promotion interventions. The key to meeting expectations is knowing what truly is reasonable. A good plan for health promotion involves setting a realistic goal that all parties agree to and then measuring and sharing progress toward achieving it.

Geriatric care managers are in a good position to deliver and/or provide encouragement, counseling or direction toward multiple health promotion interventions. They already perform comprehensive assessment and make referrals to health care providers and other community-based agencies. They develop plans, facilitate plan implementation, and sometimes take direct responsibility for client and caregiver education and training. They coordinate resources to implement plans across a wide variety of challenges. Consciously seeking to include health promotion interventions as components in the clients ongoing plan process is an ongoing opportunity.

In three brief case examples below, some opportunities to integrate health promotion and disease prevention interventions and strategies are highlighted. While there could have been more or different interventions, in each case, even based on the simple information offered here, these examples illustrate how straightforward a health promotion intervention can be.

Background: Miss Kendall (a caregiver intervention plan)

Miss K is a 34-year-old granddaughter entrenched in caring for her grandparents. She came to the care manager seeking resources, support and ways to provide better care for her elderly grandparents who are both presenting physical and cognitive issues.

Assessment and Plan: Miss K appears to have a good understanding of her grandparents' conditions and needs. In her devotion to her grandparents' care Roxanne consistently put her own life on hold, while making sure that they are provided with all the care and attention possible. Miss K makes sure that they have a healthy diet, do stretching exercises and take their medications

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as ordered by the physician. Miss K, however, appears exhausted, drinking several cups of coffee during the initial consultation to stay alert. She shared her disappointment at feeling like she had to defer completing her education to be a fulltime caregiver, yet displayed no resentment towards her grandparents. She was worried about how she could sustain the effort she was making over time as already she felt pushed to the edge.

The care manager discussed the importance of self care for a caregiver. She presented the idea of Miss K creating her own healthy lifestyle plan for herself in order to maintain her own stability as a caregiver. Miss K feared that her own deterioration, particularly in terms of physical and emotional stress, would impair her ability to care for her beloved family members. Two additional counseling sessions and participation in an ongoing support group were recommended. With support from the care manager, and encouragement from the support group, Miss K sought and received assistance from a home care agency, enrolled in school, and works daily to maintain a healthy balance in her life of self care and family caregiving. Gradually, and with simple encouragement, no-cost handouts and some reference materials, Miss K has created the time and space she needs to enjoy daily journaling, regular exercise and meditation through yoga classes.

Background: Mrs. Franks (a client intervention plan)

Mrs. Herman, an 84-year-old widow of many years, consulted with Aging Assist at the recommendation of her trust officer, who suggested that she should have a health care professional knowledgeable about her circumstances, who could act as a Designated Health Care Agent in the event that family were not available. She lives alone in a retirement community apartment and hires additional assistance with heavy cleaning and other errands. Both she and her husband had careers in the health field; she in an administrative role and he in direct practice. She retired many years ago. She has two sons out of state. Her only daughter died several years ago.

She is current with vision and hearing screening and keeps her annual dental and physician appointments. She has some unmanaged hearing loss and occasional flare-ups of pain due to a compressed disc. She discontinued prescribed Celebrex due to apprehensions about side-effects. She walks regularly and does a series of stretching and flexibility exercises at least 3 times per week that she learned in PT after a fall years ago.

She has a few friends in the retirement community that she visits regularly, walking up a flight of stairs daily. She is involved at a nearby church where she leads a bible study. Her goals are to "be fully healthy:" physically, emotionally, and spiritually.

Health Promotion Assessment and Plan: She has a diagnosis of osteopenia which she did not understand. She does no exercise with resistance and though regularly, only short walks. As someone who has already sustained a fall with injury, she has elevated risk of additional falls. She is coping with grief at her daughter's death but remains at-risk of depression.

The diagnosis of osteopenia was explained, as was the elevated risk of fracture. Handouts for additional exercises to improve her routine were provided. The importance of weight-bearing and exercise against resistance were explained. A suggestion was made to seek a referral from her primary care physician to a physical therapist for further instruction in appropriate exercise. It was also recommended that she discuss the Center for Disease Control recommended varicella vaccination with her physician. Increased calcium intake and adding Vitamin D to her vitamin routine were discussed. Grief counseling options in the community were presented.

The care manager accompanied the client to the next physician appointment to become acquainted and assist with any explanations of recommendations as needed. At the visit, the care manager requested that the physical therapy referral include a balance training component to minimize fall risk.

The client agreed to implement the following health promoting changes: change to skim milk and increase weekly milk intake; sought and received referral to a physical therapist for additional exercises to take osteopenia into account; add vitamin D to multi-vitamin routine and increase calcium; and take longer outdoor walks in late afternoon. Client discussed the varicella vaccine but chose not to be immunized at this time.

Analysis: The client presented multiple opportunities for health promotion, education about the meaning of osteopenia diagnosis, increased level of activity and specific prescribed exercises, improved nutrition habits, immunization, and grief counseling. At this time, health promotion advice and interventions are the primary assistance needed by this client. Care Manager will continue to monitor for other needs and will explore whether there are any group exercise programs that might be a good social fit for this client.

Background: Mrs. Raymon (An intervention plan for a retired health care professional client)

At age 91, Mrs. R, a strong-willed, retired health professional, is experiencing multiple health challenges and the need for episodes of 24 hour care. Her history of chronic conditions include: obesity; lumbar degenerative disease; coronary artery disease; osteopenia; and hyperlipidemia. She receives spinal epidurals about three times per year and says that her pain control specialist tells her not to exercise for at least two months after every shot. She takes multiple medications, both prescribed and over the counter. Her medicine chest also suggests both Alzheimer's disease and depression, although neither or those are reported in her accessible medical record.

She lives alone in the retirement community and she has an assistant about 60 hours per week who prepares morning and evening meals and helps with showering, dressing, and shopping. She has a certified nurse practitioner on call for episodes of acute illness, such as nausea, vomiting, or unexplained severe pain. Her daughter, who lives several hours away, has her designated power of attorney and manages all decisions related to her care, although she is cognitively intact. She has a disabled son living far away in the East. Her home is dangerously crowded with possessions transferred from the much larger home she recently sold.

She regularly expresses concerns about the state of the world (crime, war, poverty, earthquakes) and fear of constipation. She has episodes of high anxiety when expressing her fears of increasing dependence and fecal impaction. She also expresses extreme frustration with the lack of communication and coordination between her primary care physician and her specialists, "that is not the way medicine should be practiced."

Health Promotion Assessment, Plan, and Implementation:

Significant polypharmacy concerns exist. With mild memory loss and many potent medications, the possibility of a drug overdose is real. Her self-medication patterns also place her at risk for G.I. bleeding due to long term, high volume aspirin use. Long term regular use of multiple pain medications, even when the epidurals are reported as effective, also place this client at risk of liver problems. Her belief that she should not take any exercise 6 months out of the year due to recovery from the epidurals is problematic.

The care manager suggested that she consult the gastroenterologist about fears of constipation. He recommended Milk of Magnesia. The care manager recommended that Mrs. R take full list of medications to her next primary care appointment and helped her to compose the list, which she agreed to keep current and take to all appointments. After consulting with the physician, the care manager discussed the possibility of considering breathing exercise, meditation, and prayers (based on her history of how she had dealt with anxiety in her childhood) rather than so much medication. The care manager worked with her to prioritize changes. The client will choose one change at a time and maintain changes and records for three weeks. The CNP will follow up and monitor and encourage.

She is at risk for fractures due to several factors: osteopenia, occasional balance problems (aggravated by trying to reach food on high shelves), inadequate Vitamin D intake, and refusal to use a walker. Clear aisles for walking around her residence must be created and many tripping hazards must be eliminated. A home safety assessment needs to be completed and shared with client and perhaps son.

She regularly expresses concerns about the state of the world (crime, war, poverty, earthquakes) and fear of constipation. She has episodes of high anxiety when expressing her fears of increasing dependence and fecal impaction.

The care manager suggested that the client consult the pain specialist to clarify if "no" exercise is the intended outcome or if no strenuous exercise is what is indicated. The specialist clarified that gentle upper body exercise is appropriate and that exercise is essential to maintain the client's range of motion and strength. The care manager provided both the client and the assistant with handouts and demonstrated simple exercise routines that were appropriate. The care manager suggested that she could try gradually increasing her walking strength to include walking to the dining room for lunch and at the same time get a little brief sun exposure. The care manager suggested to the client that walking to the dining hall actually might involve less twisting and lumbar stress than getting in and out of the car daily to go to lunch. The care manager gave the client literature to explain current recommendations for osteopenia and Vitamin D supplements.

The care manager recommended to the assistant that the client's favorite foods be placed in areas where she can reach them without getting off balance. Her assistant relocated the foods. Home safety assessment identifies need to remove many items from walking paths inside house. The care manager worked with the client and assistant to donate unnecessary items to favored charities.

Analysis: The client is settled and reasonably happy in an independent living cottage. She is becoming more comfortable being alone at night and calls less often. She is grateful to have the assurance that support is available in a crisis.

Though still somewhat crowded with possessions, downsizing has left plenty of room to walk around the cottage, and motion sensor lights have been installed in hallways and the bathroom. Gentle, but frequent reminders of the benefits of being up and about more are required. These are provided by the care manager in follow up conversations by the assistant, and by the staff of the facility. She now attends several exercise periods with a group each week. She seldom misses the sign language class she is taking. Medications are reduced in number and taken more in compliance with intended timing and dosage. Client reports feeling better, calmer, and having more energy than she previously had.

Encouragement and monitoring will continue, with a particular focus on gradually increasing exercise and continuing medication management and observation of compliance.

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Aren't we doing it already?

If you are seeking opportunities to connect every client, caregiver, and care unit with interventions to produce desired results such as those below (whether individually focused, group based, or environmentally managed), then you definitely already are practicing health promotion with your clients. You might not have thought of yourself as a "health promotion advocate," but you are a dedicated health promoter. Your challenge will be to keep up with new evidence and interventions that you can use in your practice. If you are not regularly considering at least these possibilities, then you might consider how to incorporate some or all of them into your everyday practice model.

- Develop client and caregiver skills in behavior change
- Increase overall level of physical activity;
- Undertake exercises or an exercise program to improve balance, flexibility, strength, and endurance;
- Improve food choices and eating practices, including drinking plenty of water;
- Improve quality and quantity of sleep
- Complete all appropriate immunizations and screening procedures regularly;
- Take and manage medications responsibly;
- Educate/Share important information with clients and caregivers about health conditions and choices to improve or manage them.

What else can you do to join the care management health promotion team?

- Increase your own knowledge and expertise in health promotion, disease prevention, and whole person wellness, particularly as it applies to you and with at risk clients through reading, training, and practice, practice, practice.
- Practice what you teach, walk the talk, and give your clients every opportunity to experience you as a good role model of healthy lifestyle choices.
- Act more intentionally and consistently to integrate health promotion and disease prevention interventions into everyday direct practice.
- Create opportunities to make healthy choices "easy" — for yourself and the clients and caregivers that you serve;
- Modify the environment by identifying, and then minimizing or eliminating known hazards;
- Modify the environment by adding health promoting assistive technology that makes it easier for clients and caregivers to make good choices;
- Identify, cultivate and/or create natural support systems for healthy choices; and
- Develop your own "team" of collaborating health promoters. Partner, formally or informally, with other professionals interested in health promotion, disease prevention and whole person wellness.
- Become better informed about legislation and funding developments at national, state, and local levels that might nurture prevention and self-care
- Encourage and motivate your existing professional networks (NAGCPM), sponsoring organizations and payers, and practice colleagues to be assertive and endorse legislation and regulation that supports self-care and health promotion.
- Join a policy oriented committee or advocacy group that takes a stand on prevention and self-care policy, such as those sponsored by professional associations or consumer groups.

Resources for Professional Development and Program Delivery

What do we need to know and how can we find out? What really works and what just sounds good but doesn't produce the results desired by the clients.

There are thousands of articles, issues briefs, white papers, and books that address health promotion, disease prevention, whole person wellness, or healthy aging with older persons. Many conference and training opportunities also occur regularly. There are thousands of Web sites and Web links that deal with these topics, though perhaps only hundreds offer insights and materials that focus on the combination of aging, wellness, health promotion and disease prevention. There are also many scams and "get-fixed-quick" sales pitches available.

The following Web sites will connect you to a limited sample of sound, science-based information that is immediately or readily available to access through the Internet. Each is a respected and reliable provider of information and resources that may help you strengthen your practice as a health promoting geriatric care manager. Links to free educational, assessment, and planning materials can be followed, as can links to materials and training for purchase. If you fully explore the Web sites provided, you can connect with hundreds of downloadable resources. Depending on the information and resources you seek, each could serve as a final destination or a launching pad to further exploration. Following the links to other Web sites can be a rewarding adventure. If you followed every link and became familiar with every resource on the Center for Healthy Aging site or the Live Well, Live Long site, you could acquire an amazing education, you would be an "expert" in knowing about health promotion programming with older persons.

These are great resources. Perhaps the best resources though are colleagues who are already engaged

in real-world evidence-based health promotion activities. Seek them out to collaborate—they are the true experts.

The Live Well, Live Long link from the American Society on Aging (http://www.asaging.org/cdc/index.cfm)

This Web link offers information about health promotion strategies and materials developed by the American Society on Aging (ASA), with a focus on materials commissioned through a cooperative agreement with the Centers for Disease Control and Prevention. General information and comprehensive training modules in a variety of subjects are available. These can be used for increasing your own knowledge about the subject areas as well as to prepare you as a presenter/facilitator to serve others. Modules differ in structure and format but all contain current information about the health promotion topic and practical hands on tools, ranging from curricula, to survey forms, to handouts, to therapeutic tools to be used by service providers. As of November 2007, the following modules are available: Blueprint for Health Promotion; Strategies for Cognitive Vitality; Optimal Medication Use; Road Map to Driving Wellness; Mental Wellness; Physical Activity; Diabetes Prevention and Management; Nutritional Well-Being; Deep Vein Thrombosis; Statistics on Health and Aging; and Adult Meducation. Subscription to an online newsletter also is available on the site.

The ASA home page: www.asaging.org also can link you to a professional association with many others who are interested in health promotion. Several member networks with ASA address related concerns, most directly, the Healthy Aging Network (HAN).

Center for Healthy Aging of National Council on Aging: (http://www.healthyagingprograms.org) This Web site provides general information, research results, and toolkits for program implementation. It also provides links to information on a wide variety of topics located on other Web sites.

According to its home page, "The Center for Healthy Aging (the Center) encourages and assists community-based organizations serving older adults to develop and implement evidence-based programs on: health promotion; disease prevention; and chronic disease self-management.

The Center serves as a resource center for aging service providers to implement healthy aging programs. Resources provided include: manuals; toolkits; research; examples of model health programs; and links to Web sites on related health topics."

The Center for Healthy Aging also serves as a resource for the Administration on Aging Evidence Based Disease Prevention Grants Program, and it is particularly focused on assisting community-based organizations serving older adults to use the recommended *evidence-based* health promotion/ disease prevention programs. Some key health topics include: Chronic Disease; Disabilities; Fall Prevention; Health Promotion (general); Medication Management; Mental Health/Substance Abuse; Nutrition; Physical Activity. Examples and links for the following are provided on the site: Evidence-based Programs; Model Programs; Best Practices.

The "What's New" section of the site is updated regularly and offers: monthly highlights of health observances; recent photos of AoA grantees and other organizations engaged in health programming for older adults; reports on the Center's work on promoting and advancing fall prevention; and new resources created and/or provided by the Center.

On the National Council on Aging home page, www.ncoa.org you can link to the Health Promotion Institute, an interdisciplinary special interest group of NCOA members who are committed to health promotion and aging.

Center for Medicare and Medicaid Services (CMS)

http://www.cms.hhs.gov/default.asp

CMS offers a variety of resources to support service providers in their health services, health promotion and disease prevention work. Many of these can be ordered at no charge or downloaded directly from the Medicare Learning Network Web site (Accessed November 2007, http://www.cms.hhs.gov/MLNProducts/). The CMS Web site also offers links to a variety of resources intended for beneficiaries and caregivers.

Centers for Disease Control

http://www.cdc.gov

This Web site offers information about a wide variety of health promotion, disease and injury prevention topics. Both age specific and disease or condition specific links are provided. Information about CDC's specific objectives for people 50 and up is provided at http://www.cdc.gov/osi/goals/people/people50andup.html (November 2007).

Stacey Rokoff, MSSA, LSW is Director of the School for Caregivers at Fairhill Center in Cleveland, Ohio. She coordinates and leads classes and support groups for caregivers of all ages, with a particular focus on older persons. She also provides short-term counseling and case management assistance to family caregivers. In addition, she is a master trainer for Matter of Balance and the staff team leader for health promotion programming.

Jean Wertz, CNP, Adult Health APRN-BC is a semi-retired case manger and private duty nurse who assists no more than 4 clients at a time. Most of her clients are older persons, ranging in age from late fifties to nineties. Her private practice, Aging Assist, has been providing service for eleven years. She also volunteers one day per week in a free clinic, and as needed with Mesilla Valley Hospice in Las Cruces, New Mexico.

National Association of
Professional Geriatric Care Managers

1604 North Country Club Road
Tucson, AZ 85716-3102