

11. EXAMPLES OF CONSULTATIONS WITH OLDER ADULTS

“I used to think getting old was about vanity—but actually it’s about losing people you love.”

Joyce Carol Oates

The greatest challenges of aging well are those related to mastery of the art of losing. As we age, we lose friends, family members, some physical and mental abilities, economic earning power, and activities basic to independent functioning, such as driving. Unfortunately, our society does little to prepare its members for these experiences or to link them to activities that use the strengths of aging, such as wisdom and ample leisure time. Further, many health care reimbursement policies effectively work against the values of our senior citizens (such as remaining in their homes, maintaining contact with their friends, and being able to afford medications that help them preserve health). It’s no wonder that as many as one in four adults experience mental health problems in old age.

In America, many older adults experience the double jeopardy of stigma against both aging and mental illness. It’s as if the world is saying, “Yuk, old and losing all this stuff and feeling down about it . . . better stay home and keep it to yourself.” It is no surprise that few seek help for mental problems and that the few that do go to their PCPs. Since the majority of older adults have been in their homes and communities for a long time (and plan to stay in them), they have established relationships with their PCPs and value their opinion on many issues.

A visit with the PCP is an important social event for many patients over 75, and while PCPs know this, they experience a great deal of pressure to keep visit lengths down and completed encounters up. Many PCPs lack the time to stay current with evidence-based mental

health treatments for older adults or to develop and support behavior modification programs to assist with lifestyle changes. The resulting “expertise gap,” in combination with inadequate funding and time, often collude to prevent the delivery of high quality BH treatment to older adults.

However, research is generating evidence-based treatments for older adults, particularly for dementia and depression, and the PCBH model creates a platform for delivery of these services. The consultation based nature of PCBH services also gives us a golden opportunity to provide remedial education to PCPs about the psychological aspects of aging. The addition of BHC services to the PC setting is an urgent matter when it comes to older primary care patients, as the U.S. population is growing older and living longer. Over 75 million baby boomers (born between 1946 and 1964) will begin reaching age 65 in 2008, and this will eventually lead to a doubling of the current population of seniors.

This chapter offers the reader an opportunity to shadow a BHC who is providing consultations to a variety of older adult patients. We provide templates for several classes specific to older adults and information suggesting the possibility of a BHC teaming it with a nurse to improve care to older adults. We end the chapter with some ideas for delivering proactive, preventative behavioral health services to seniors. Appendix C offers a reading list for BHCs to use to further develop skills for providing care to adults in general, and the work of Molinari and colleagues (2003) is particularly useful for evaluating one’s competencies for providing geriatric interventions. Appendix D offers a compact disc that includes patient handouts, most of which are useful with adults of any age (e.g., Diaphragmatic Breathing Tips, Managing Chronic Pain, and Healthy Sleeping Tips).

So let your imagination take over, as BHC work begins with a group of older adults. We invite the reader to learn by looking over the our shoulders and into the eyes of patients—Janet, Andrew, Louise, Thelma, George, and Bob. As can be seen from a quick review of Table 11.1, it’s a busy afternoon that starts with a Life Satisfaction Class for 15 patients.

Table 11.1

Chapter 11 Overview: An Afternoon in the Life of a BHC (Providing Care to Older Adults)

CHAPTER SECTION	BHC # 1442	REFERRAL REASON
	1:00 (15 patients)	Life Satisfaction Class
Demoralization	2:15 Janet	Diabetes, vascular disease
Medical Adherence	2:45 Andrew	Multiple medical problems
Stresses (Caregiving and Other Problems)	3:15 Louise	Shortness of breath, fatigue
Dementia	3:45 Thelma and George	Agitation
Loss and Preparation for Death	4:15 Bob	Lung cancer, bereavement

DEMORALIZATION

Multiple losses and setbacks in life, particularly those in the last few decades of life, undermine one’s confidence in meeting the challenges of life transition successfully. The rapidity with which these hardships appear, as well as their psychological scale, can be disheartening and result in a profound sense of demoralization. Many demoralized seniors visit the clinic with the hope that their PCP will help them recover their energy and zest for life.

Often, the PCP offers a pat on the back, a few kind words, and medication. Sometimes, this is enough, and the patient leaves feeling encouraged and takes the medicine with some benefit. At other times, the PCP uses the available time to address medical concerns, as is often the case when laboratory findings suggest poor disease control. Demoralized patients may not see self-managing their disease as a top priority but will still respond to the PCP's concern with a shallow promise to do better. As is sometimes the case in primary care, the patient is presenting with one set of needs; the medical provider is delivering care to address a different set. This is a difficult situation at best, and the BHC may play a pivotal role in helping large number of patients. Janet's case demonstrates how the BHC can help reverse the cycle of demoralization associated health problems.

Janet: Yes, I'm doing okay with my diabetes.

Dr. Reese referred this 66-year-old married mother of four for a consultation concerning diabetes and atherosclerotic vascular disease. Dr. Reese worried about lab results suggesting problematic control over patient's diabetes, but noted that Janet insisted that she was "pretty much doing okay . . ." with her diabetes. Dr. Reese knew that Janet had many psychosocial concerns and asked her to consult with the BHC about ways to manage stress as well as her diabetes.

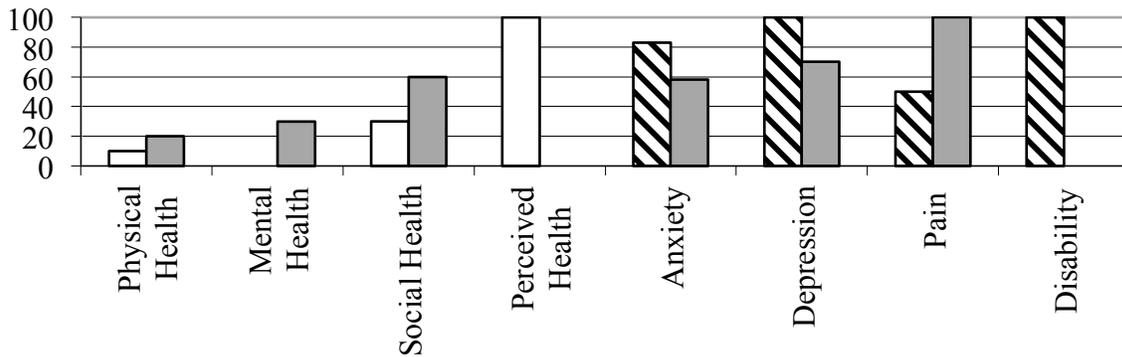
Janet was tearful at her initial BHC consult, as she explained that her 75 year old husband had asthma and was in poor health. They both worried about two of their children, one of whom had lost her job and the other who had problems with alcohol. Their son was serving time in Montana for a driving under the influence conviction. She missed him terribly and asked if the BHC would write a letter to prison officials requesting that he be moved to a local facility. Janet indicated that she was testing her blood sugar on a regular basis, did not exercise,

and found it hard to make dietary changes. She reported that she was taking all medications as prescribed including an SSRI that she had taken off and on for years. She agreed to take daily walks with her husband and to ask for his support in making dietary changes. Janet also agreed to initiate brief daily phone calls to her daughter who lived nearby. The BHC wrote the letter to prison officials during the visit and gave it to Janet to mail. She left with an agreement to follow-up with Dr. Reese and the BHC in one week.

Janet returned eight days later and reported that she and her husband were walking together for about ten minutes every day. She volunteered that she was checking her feet daily and that both she and her husband were eating better. She had talked with her daughter almost daily, and they were considering buying a treadmill together, as the daughter was now re-employed. She had sent the letter to the prison officials, and her son had sent her a Mother's Day card indicating that he might be transferred to a facility near her.

At the initial BHC consultation, Janet's Duke Scores suggested a person with mental and physical health problems that interfered with her functioning. However, Janet's Perceived Health score of 100 suggested that she saw her physical health as good. This is an important score, as it is related to patient utilization of medical services, and Janet had a history of under-utilizing services (i.e., not visiting her doctor when she needed to). This configuration is not uncommon among demoralized older adults with chronic conditions. They are simply unable to put the reality of their chronic disease burden on the table, given the extent to which the table is crowded by other problems. Figure 11.1 is a graph of Janet's Scores at her initial consult and again at her second follow-up consult. As can be seen, Physical, Mental, and Social Health Scores improved, while symptoms of anxiety and depression decreased. Interestingly, her Perceived Health score dropped from 100 to 0 (suggesting that she felt she needed health care

services) and her Disability Score dropped from 100 to 0 (suggesting that she stopped seeing herself as disabled). This flip-flop may indicate that, after three visits with the BHC, Janet's motivation for using needed health care services improved.



*Note: Scores range from 0 to 100. On Physical, Mental, Social and Perceived Health Scales, higher Scores indicate better functioning. On Anxiety, Depression, Pain, and Disability Scales, higher Scores indicate more severe symptoms.

Figure 11.1

Janet's Duke Health Profile Scores at the Initial and Follow-up Consultations*

Janet came for a second follow-up consultation with the BHC a month later and reported that she was now walking six or seven times per day for five to six minutes on the treadmill that she and her daughter purchased together. She was socializing more and enjoying outings with her daughter. She was eating more vegetables, and she was concerned about how high her morning blood sugars had been high for several days. She had a visit scheduled with Dr. Reese later that day. The BHC showed Janet her change in scores on the Duke and stressed the importance of her working with Dr. Reese to maintain her gains. The BHC recommended that Dr. Reese support Janet's efforts to socialize more, use exercise to reduce stress, and ask for help when she needed it. Janet agreed to follow-up with the BHC if need be in the future.

BHC Intervention Possibilities for Demoralized Older Adult Patients with Chronic Disease. Patients like Janis often benefit from efforts to form a positive working relationship that will allow them to become engaged in their care. In many ways, they feel that life has been unfair in giving them a chronic condition, which is often only one of many unhappy circumstances for which they didn't volunteer. Like most people, Janet wanted to improve her life and had her own set of priorities for doing so. At the top of her list was being a mother that could help her children, and the BHC accepted that goal and proceeded to help. The form that this took for Janet was the letter to a prison official, an act that demonstrated that the BHC was engaged with her and was interested in helping her achieve a desired social support outcome. As indicated in Table 11.2, using Duke Health Profile Scores to plan and evaluate interventions is useful with patients like Janet. The Perceived Health Score of 100 was a red flag, suggesting that Janet did not see herself as sick but rather as a person with psychological stresses that were detracting from her quality of life. The BHC also used motivational interviewing strategies to help her identify areas for behavior change to improve her diabetic control.

Many cognitive behavioral interventions are useful with older patients who are demoralized by multiple medical and life problems. Problem solving therapy (PST) (Harpole et al., 2005) offers an excellent methodology for older adults to use to effectively address various life events that trigger discouragement. PST appeals to older adults, who have solved many problems in their long lives. It is very useful in class formats, and we discuss its use in a health promotion class venue (the Life Satisfaction Class) in the last section of this chapter. Robinson, Del Vento and Wischman (1998) provide information on how to start a group clinic program for frail older adults, as well as detailed information on curriculum, and this is discussed briefly in Chapter 12.

Table 11.2

BHC Intervention Possibilities for Demoralized Older Adult Patients with Chronic Disease

1. Engage the patient by addressing and validating their expectations (i.e., what the patient wants the BHC to address in the visit).
2. Use health-related quality of life scores in planning interventions.
3. Use motivational interviewing in regards to specific disease management skills, and target the one for which the patient reports the highest level of readiness.
4. Use intervention tactics that promote social interaction, effective personal problem solving and healthy lifestyle behaviors (e.g., health promotion classes or group clinics).
5. When it is an issue, empathize with the patient's sense of loss in life, transition "shock" and specific age related changes that may act as barriers to behavior change (i.e., having less energy, not having as much endurance, vision or hearing loss).

PCP Teaching Points Concerning Demoralized Older Adult Patients with Chronic Disease. Probably at least one in twenty visits to a doctor is due to depressive symptoms, and most patients prefer talking treatments to medication treatment. Most PCPs know this, but at the same time feel responsible for addressing poor self-management of chronic disease. The time left in the exam often doesn't allow them to address other issues. Table 11.3 provides suggestions for teaching PCPs how to work with demoralized older adults. Along with lab results, the Two-Minute Test on Proficiency in Self-Management helps the PCP accomplish a

quick assessment. This test, developed by Dr. Jennifer Gregg at the Veteran's Administration Hospital in Palo Alto, involves the PCP asking an open ended question about the patient's success in managing his or her chronic condition and then (nonchalantly) timing the patient's response. Patients who cope well with chronic conditions tend to pursue such as one might pursue a hobby. These patients can easily talk in a focused manner for at least 10 minutes about their management efforts and discoveries. Patients who struggle with disease management usually provide a brief, vague response intended to reassure or placate the PCP and then change the subject, often in less than two minutes. When the patient doesn't make it to the two minute marker, the PCP's next question might be, "What do you most want to talk about in our visit today? What concerns you the most?" When a patient with a chronic disease is demoralized or depressed, this question invites them to discuss life-triggering events.

PCPs resonate to Problem Solving Therapy (PSP), as it is consistent with much of their orientation as care givers. They often describe themselves as problem solvers, therefore most will readily work to help the patient develop a plan to reduce stress, when time allows. Many will also be willing to recommend that the patient participate in interventions for reducing stress (such as attending a relaxation class, attending programs at the senior center, finding a volunteer job, restarting a hobby, consulting with the BHC, etc). The BHC can also teach PCPs to explain that getting a handle on stress usually makes it easier for people to adapt to the realities of effective chronic disease management. Rather than trying to address everything in one visit, the PCP can invite the patient to return for a follow-up visit, where they can look at the patient's level of readiness for changing a variety of possible behaviors related to better disease management.

In all visits if possible, the PCP needs to help the patient rebuild (if necessary) and activate a competent social support network. Numerous studies have shown that competent social support is a very strong disease buffering attribute in the life of a senior. Towards this end, BHCs need to partner with PCPs in building programs that help meet patients' social needs as a part of the context for delivery of medical care. Older PCPs tend to attract older patients, and they are ideal candidates for developing group care clinics for older frail patients. Experience suggests that the older patients exposed to this visit model quickly use the group itself as a new social support base. Finally, we recommend that BHCs teach PCPs to refer demoralized patients with chronic disease to same-day consultation visits with the BHC and later, when patient motivation is better, to patient education specialist, such as diabetic nurses and dieticians.

Table 11.3

PCP Teaching Points Concerning Demoralized Older Adult Patients with Chronic Disease

1. Encourage use of the 2-Minute Test on Proficiency in Self-Management of Chronic Disease
2. Teach PCPs to ask the patient, "What is most important to you in this visit, addressing these difficult problems or your ___ (diabetes)?"
3. Provide PCPs with information about problem solving therapy.
4. Provide PCPs with training on use of motivational interviewing strategies.
5. Encourage PCPs to consistently support patient's development of a social support base. Consider having PCPs with a larger group of aging patients shift the locus of care to a group medical appointment.

6. Teach PCPs to refer demoralized patients for same-day visits with the BHC and late to patient education specialists, such as diabetes educators and dieticians (when patients are ready to use such).

MEDICAL ADHERENCE

Only medicine that is taken can potentially help a patient. While this is obvious, many patients do not take prescribed medications for a variety of reasons. Most of the reasons or barriers can be addressed successfully by improving the patient-PCP relationship and the quality of their communication. To help PCPs develop relationships with patients that promote adherence, the BHC will need to model intervention teaching techniques that bring patient beliefs about health and treatment to the forefront of patient-PCP interactions. An often overlooked factor in medication under-use is that of the cost or affordability of medications. Older adults may take six or more medications every day, and psychotropic medications are among the most expensive. While many Medicare beneficiaries have a supplemental insurance program, up to one-third may pay out-of-pocket. In a survey of 660 older adults with chronic illnesses who reported under-using medication in the prior year because of cost, two thirds never told a PCP in advance that they planned to under-use medication because of the cost (Piette, Heisler, & Wagner, 2004). Sixty-six percent reported that nobody asked them about their ability to pay for prescriptions and fifty-eight percent reported that they did not think PCPs could help them. While conveying information about no-cost or low-cost drug programs is part of the solution, improved trust in the patient-PCP relationship will also impact the cost barrier (Piette, Heisler, Krein, & Kerr, 2005). Andrew's case provides an example of how the BHC services can help address adherence problems.

Andrew: Sure, but I don't have the money for all those pills.

Dr. James referred this 75-year-old widow for a consultation concerning management of multiple medical problems and suspected difficulties with using medications as prescribed. Dr. James explained that Andrew often missed medical appointments and that he didn't take all of his medicines. He didn't see Andrew as experiencing problems with dementia as Andrew was an avid chess player and liked to talk about his success in competitive play in internet-based games.

At the initial consultation, Andrew completed the Duke and teased the BHC about whether he looked demented or nutty. His scores suggested generally positive mental and physical health and probably a realistic assessment of his physical health. He was not depressed, but his scores suggested some anxiety. When the BHC discussed Duke Scores with Andrew, he explained that he had lived a good life and was ready to die. He continued to enjoy contact with his adult children and daily chess games on the internet, but welcomed the day when he would see his wife again, as she had left to be with her maker two years prior. The BHC explored Andrew's beliefs about his various health conditions and the treatments he was being asked to adhere to. He explained that he had made some dietary changes and walked a little every day. He was willing to take medicines to improve his quality of life, but lived on a fixed income. He took pride in supporting himself without any assistance from his children, and he didn't mind turning down the heat in his apartment or skipping a few pills in order to make his check last to the next month.

The BHC explained that there might be options that Dr. James could pursue to obtain needed medications at a cost saving, and Andrew agreed to have the BHC initiate that discussion. Dr. James was able to switch several medications to less expensive generic forms

and to access a special program for one medication, given Andrew's income level. The BHC did not plan follow-up with Andrew, but did spend some time with Dr. James taking about the development of a Medication Adherence Form for the BHC to use in consults. Further, Dr. James agreed to experiment with the form to see if it helped clarify adherence issues during general medical exams.

BHC Interventions for Older Adult Patients with Medical Adherence Problems.

The consultation with Andrew highlights the importance of conducting a functional analysis concerning medication adherence when it is a reason for referral. Andrew's beliefs about using medications were not a barrier and he had no difficulties remembering the medicine. The main issue was the cost of medicines that then triggered his value about being independent. On countless occasions, patients referred for being allegedly "non-compliant" turn out to be patients who have very good reasons for doing what they are doing. This disconnect between the viewpoint of the PCP and the world view of the patient is precisely what a BHC can bridge.

Table 11.4 lists other possible BHC interventions with patients who have problems adhering to medical plans. Certainly, the BHC can develop a form that assures systematic assessment of risk factors for medication non-adherence (See Robinson, Wischman, and Del Vento, 1996 for an example of a medication adherence plan). Once the BHC identifies risk factors, he or she can address them one at a time, as the BHC did with Andrew. When the risk level is high, timely follow-up is particularly important to the patient's successful adherence.

Table 11.4

BHC Intervention Possibilities for Older Adult Patients Who Don't Adhere

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1. Complete a functional analysis of medication non-adherence, targeting belief systems, family influences and external barriers such as cost, transportation, etc.
2. Build consultative interventions that address key barriers to adherence.
3. Develop a format and/or form for making a specific Medication Adherence Plan.
4. Provide timely telephone follow-up when patient medication is modest or side effects are troubling.

A patient's beliefs about his or her illness and the perceived value of medication in addressing uncomfortable symptoms are important components of a medication adherence risk assessment. If medication use makes sense to the patient in terms of his or her unique world view, then the BHC can go on to explore other beliefs pertinent to medication adherence, such as those suggested in Table 11.5. When a patient admits to beliefs that obstruct successful use of medications, the BHC may use Socratic questioning to help patient address these potential barriers. For example, if the patient says his family would be disappointed if they knew he took pills, the BHC can facilitate an exploration of how this would affect willingness to use a prescribed medicine.

Table 11.5

Beliefs that Conflict with Medication Adherence

1. These kinds of drugs are not the answer to problems in one's life.
2. These kinds of drugs are a crutch.
3. I would be the one to get severe side effects.
4. I should be able to get by without using these kinds of drugs.

5. I could get addicted.
6. My family would not want me to use these kinds of drugs.
7. I will not be able to work if I take these kinds of drugs.
8. These kinds of drugs are overused.
9. It is harmful to take too many different kinds of drugs.
10. These kinds of drugs should not be taken long-term.
11. Drugs that doctors prescribe for anxiety and depression are dangerous.

Note: The BHC can show the patient a list of these beliefs and ask the patient to indicate any of the statements that he or she believes, even a little.

Note: Reprinted by permission from Context Press from Living Life Well: New Strategies for Hard Times.

The BHC needs to listen carefully to patient's use of language concerning medication and to incorporate the patient's language into the planning process. For example, if a patient referred to her antidepressants as a vitamin for her nervous system, the BHC will use similar language in the remainder of the consultation. Potential barriers to use of medications are numerous and include lack of understanding of directions for taking the medicine, inability to pay for medicine, difficulties remembering to take medicine, avoidance of side effects, lack of support from loved ones, and inability to detect any beneficial benefits from taking medication.

Table 11.6 provides a list of strategies for addressing these barriers.

Table 11.6

Potential Barriers to Medication Adherence and Possible Plans for Resolving Barriers

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POTENTIAL BARRIERS	PLAN
Patient beliefs	Phase patient use of medication in language consistent with patient beliefs (a vitamin for the nervous system); focus patient attention on detection of beneficial effects
Patient access	Patient can afford medicine; understands use and refill instructions
Patient tolerance	Give patient information about how to cope with side effects
Organization, memory	Link taking medication to daily routines (e.g., brushing teeth); suggest use of a medication organizer
Patient support	Plan for patient to report successful adherence to loved one or plan to give patient a telephone call in a timely manner
Patient confidence and collaboration	Check patient to see if patient is confident about taking medication and that he or she understand a specific strategy for evaluating medication impact

As mentioned previously, timely follow-up is important with patients who have problems with adherence. Factors pertinent to planning the nature of follow-up include the patient's level of confidence in taking the medicine, the probability and severity of negative side effects, and the availability of support to patient for adhering to the plan. Timely follow-up is critical when patient's confidence is low, the probability and negativity of side effects are high, and the availability of interpersonal support is lacking. When this is the case, the BHC

may want to give a call to the patient within a few days of the consult to support adherence or ask a nurse to provide this support to the patient.

PCP Teaching Points Concerning Older Adult Patients with Medical Adherence

Problems. Andrew's case illustrates the unique role the BHC can play in educating PCPs about a functional analytic approach to the problem of non-adherence. The BHC suggested development of a medication adherence risk assessment, and PCP agreed to pilot test the protocol in his general practice. Dr. James's involvement would of course result in a better product, and his participation in the project would increase his success in evaluating other patients and prepare him to influence other providers to improve their identification of at risk patients.

As suggested in Table 11.7, medical adherence is an area where BHCs can offer training to enhance PCP and nursing skills. The BHC can use the information in Tables 11.5 and 11.6 for workshop handouts. If some PCPs are surprised by the BHC interest in medical adherence (as he or she is not a prescriber), the BHC can explain that taking a pill is a behavior and the tools of behavior analysis may be applied to help patients demonstrate that behavior consistently. In addition to PCPs, nurses have an important role to play in improving medical adherence, as they frequently are the staff members that perform telephone work. Meresman and colleagues (2003) describe a medication adherence protocol involving PC nurses providing 10 telephone calls to depressed patients over a four-month period. In the calls, nurses supported focused behavioral activation plans, provided education, monitored treatment response and addressed barriers to medication adherence. Medication adherence rates were higher in the group of patients that received the nursing intervention.

Table 11.7

PCP Teaching Points Concerning Older Adult Patients Who Don't Adhere

1. Teach PCPs to ask about patient's beliefs and barriers (e.g., cause of and cure for illness, acceptability of use of medications, barriers to use of medication)
2. Offer to develop a form for PCPs that systematically assesses risk for medication adherence failure.
3. Offer PCPs training on how to make a specific plan to support adherence (including needed follow-up).
4. Provide information to PCPs and nurses about programs that involve nurses in improving medical adherence.

STRESSES RELATED TO CAREGIVING (AND OTHER PROBLEMS)

One of the most common sources of stress for older adults is that of providing long term care to aging parents or to a life partners. Caregiver stress is receiving a great deal of attention from researchers interested in evaluating the impact of exposure to chronic, long-term stress. Many caregivers experience increased symptoms of depression, anxiety, and are themselves at greater risk for developing stress sensitive diseases. Educational programs, as well as BHC consultation services, are helpful to caregivers, particularly at the beginning of their experience of providing care when they can learn key skills for preventing burnout. During periods of more severe strain, caregivers will often benefit from a series of consultation visits with a BHC. Dr. Funk recognized the potential impact the BHC could have for her patient, Louise.

Louise: I can't breath, and I am so very tired.

Dr. Funk referred this 67-year-old married mother of two for a consultation concerning shortness of breath and fatigue. Dr. Funk started the patient on an SSRI because she believed Alice was experiencing depression secondary to caregiver burn-out. Louise provided care to her 87-year-old mother-in-law and her 89-year-old former father-in-law. Her first husband had died many years ago, and she had agreed to care for his father, as her husband had been an only child.

At the initial consult, Louise reported that she began having episodes of shortness of breath four months earlier when her mother went through a period of critical illness. She explained that this medical crisis triggered many of the same feelings she had when her father died the previous year. With her responsibilities to her mother and her father-in-law, she hadn't had time to grieve the loss of her father. She and her husband were retired, and while they'd hoped to travel together during their retirement, she felt too guilty to leave the people that depended on her. She had two brothers that lived out of town, and they wanted to help but were often in disagreement with Louise about various issues related to their mother's care. She avoided asking them for help because she dreaded their criticism. She explained that her husband, who was a little domineering, provided ample suggestions to her about ways to improve her behavior.

While Louise had a list of activities that she enjoyed, she was doing them infrequently or not at all. She enjoyed playing the violin and had been a music teacher for many years, but she rarely played. She enjoyed walking but had walked only once during the past week. She reported worrying during the walk about not being present for her mother and father-in-law. She liked to quilt and had a commitment to make quilts with others for the Make-A-Wish

Foundation, but she had not gone to the weekly quilting group since her father died. She liked to travel, and she and her husband had a recreational vehicle, but they had yet to plan a trip.

Louise's Duke Scores suggested significant mental health problems. Perceived health was a relative strength, which is usually not the case for a person with panic disorder. Her Depression score was 90. During the consult, the BHC provided an explanation of the connection between stress and somatic symptoms and taught Louise a breathing exercise to promote relaxation. In developing a behavior change plan, the BHC challenged her to change her behavior and see if the scores changed. Louise agreed to walk for thirty minutes daily with her husband; discuss the specifics of several camping trips for the coming summer, and notify her brothers of the dates that she and her husband wanted to travel over the coming summer. The BHC suggested that Louise might find herself wanting to take more time for creative activities and for socializing as she began to take better care of her stress.

When Louise returned for follow-up a month later, she reported that she had implemented the plan and was feeling much better. She had stopped the SSRI because it made her feel funny, but had taken a benzodiazepine "prn" on an infrequent basis, when that was suggested by Dr. Funk as an alternative. Louise and her husband had begun walking every evening together. When walking, they had visited with their neighbors and decided to join them as participants in a horseback riding club. They had gone on a day ride to a local winery, and she had met an interesting woman who also enjoyed quilting. Louise was reading a book, Coming of Age with Aging Parents and was taking its advice about how to improve her relationships with her older brothers. In the second consult, the BHC provided Louise with a brief overview of the differences between aggressive, assertive and passive communications, and they practiced this in relation to her making requests for back up care to her brothers.

At follow-up, Louise's Duke Scores suggested improvement in physical, mental, and social health and a decline in severity of symptoms of anxiety, depression, and disability. She planned to maintain her behavior changes; to plan her vacations over the summer, and to make assertive requests to her brothers regarding their role as caregivers during her planned trips. Louise did return for one additional consult two months later, and she was maintaining her gains. She felt her life was much more balanced, and her relationships with her brothers and husband had improved.

BHC Intervention Possibilities for Older Adults with Caregiver Stress. Table 11.8 provides a list of possible interventions for caregiver stress. The top item is what the BHC used in the initial consultation with Louise, namely, an explanation of the connection between stress and somatic symptoms. For many caregivers, this is "news" and it immediately results in a sense of relief. The relief often comes in the form of, "You mean this is just my reaction to stress and I'm not crazy?" The BHC also taught Louise skills to manage her troublesome stress related symptoms (i.e., fatigue and shortness of breath responded to with daily exercise and relaxation strategies). The BHC provided training in assertiveness skills to help her begin set appropriate limits on the demands of others, while making clear requests of how others could meet her immediate needs as a caregiver.

Table 11.8

BHC Intervention Possibilities for Older Adults with Caregiver Stress

1. Explain relationship between symptoms and stress response.
2. Teach skills that have an immediate impact on symptoms of stress (e.g., diaphragmatic breathing on shortness of breath).

3. Support development of a daily schedule that involves specific self-care behaviors (e.g., stretching, listening to music, longer bathes, walking, drawing or other creative activities, etc.)
4. Encourage development of relationship(s) with adults who do not need care.
5. Provide education about delayed grieving and help schedule “grieving” sessions if needed
6. Provide targeted skill training (e.g., interpersonal assertion, mindfulness, etc.).
7. Start a Healthy Aging program.

For the stressed older adult, targeted skill training, particularly regarding any physiological manifestation of stress, increases the patient’s sense of control or ability to respond in a way that makes a difference. Patients often have skill deficits that increase their vulnerability to the on-going stress of caregiving, such as being unable to say no or to take a mindful or accepting perspective in response to annoying behaviors exhibited by the person for whom they provide care. It is not unusual for older adult caregivers to also be grieving the loss of a loved one, as was the case for Louise. BHCs need to support healthy grieving by providing emotional validation and education about the grief process. Two of our favorite interventions are scheduling contact with adults that do not need care and scheduling a pleasurable activity such as walking or some type of craft or hobby (gardening, fishing, playing a musical instrument, etc.).

Older adults experience numerous stressors other than care-giving, including problems with adult children and spouses, problems with housing, and financial strain. The BHC can offer more intensive assistance with coping skills by offering programs such as the Healthy

Aging program, which involves collaboration between a BHC, a nurse, and an older adult volunteer. In most primary care settings, it is relatively easy to identify older patients who are high utilizers of care because of psychosocial issues such as caregiver stress. For example, the BHC can use automated data to identify patients over 60 who are in the top 10% of utilization and then have PCPs identify patients at risk for care-giver stress. The nurse can then invite patients to participate in the Healthy Aging program, which offers patients a series of four weekly 5-10 minute phone calls from nurses (see Table 11.9 for topics) and an invitation to attend a weekly Mind-Body Tea at the clinic, which can be co-lead by the BHC and a volunteer. Table 11.10 provides an explanation of Tea activities (See Kabat-Zinn, 1994 for information on the meditation exercises). Of course, this approach also encourages PCPs to consistently involve the BHC in the care of older adults who are beginning to use medical care more but with less benefit.

Table 11.9

Healthy Aging Nurse Telephone Topics

WEEK	TELEPHONE CALL TOPICS
One	Give examples of challenges to aging well, provide instruction in diaphragmatic breathing and suggest the use of such to support an accepting perspective on stress.
Two	Evaluate adequacy of social support, plan ways to improve quality and/or frequency of social interactions.
Three	Evaluate level of physical activity, plan ways to increase quality and quantity of physical exercise.

Four	Evaluate extent to which patient is able to provide valued services and/or to engage in creative activities, plan ways to increase quality and quantity.
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Table 11.10

Health Aging Mind Body Tea Class Activities

PROVIDER	ITEM	ACTIVITIES
Volunteer	Tea	Prepare tea, facilitate discussion about resources for seniors in the community, record new resource information in the class Resource Book
BHC	Skill Development	Rotating series of exercises to assist with development of mindfulness and generation of feelings of well being and improve results of problem solving activities (e.g., Bending Tree, Meditative Walking, Yogic Breathing, Mountain Meditation, Lake Meditation)
BHC	Discussion	Experience of participants in applying mindfulness and problem solving skills to on-going psychosocial problems

PCP Teaching Points Concerning Older Adult Patients with Caregiver Stress. The upcoming population shift makes it particularly important for BHCs to team with PCPs in advocating for primary and secondary prevention services for caregivers. The magnitude of

stress experienced by this group can have a very negative impact on health risk. In many ways, caregivers are health care provider extenders, and we need to prepare them to succeed in their role. Programs such as the Healthy Aging program provide caregivers with an opportunity to access social support, to share ideas about resources in their community, and to learn skills commonly needed by those working in caregiver roles. If the PCP and BHC are successful in recruiting a nurse and volunteer to help in implementing the program, the demands on their time are significantly reduced and the quality of care for patients will be improved. The Mind Body Tea also provides a resource for training PCPs as well as nurses in interventions typically provided by the BHC. See Table 11.11 for a list of teaching points for PCPs.

Table 11.11

PCP Teaching Points Concerning Older Adult Patients with Caregiver Stress

1. Encourage PCPs to advocate for primary and secondary prevention programs for caregivers.
2. Suggest that PCPs refer caregivers to the BHC for development of a self-care plan.
3. Invite PCPs to partner with BHCs in designing and delivering Caregiver Hardiness Workshops and Healthy Aging programs.

DEMENTIA

By definition, dementia is an acquired syndrome of decline in memory and at least one other cognitive domain (such as language, visuospatial or executive function) of a sufficient magnitude as to interfere with functioning in social or occupational roles in an alert person. While dementia may be caused by any number of diseases, the two most common causes are

Alzheimer disease and cerebrovascular ischemia (vascular dementia). Risk factors for dementia include age, having a first-degree relative with a history of Alzheimer, and cardiovascular risk factors such as hypertension. Current estimates suggest that 3-11% of persons older than 65 and 25-47% of those older than 85 have dementia (Cooper, Bickel, & Schauffele, 1996).

The human costs associated with dementia are substantial. For the patient with dementia, there is the frustration of loss of independence and the complications related to managing co-morbid diseases that require the ability to plan, remember and execute important self care tasks. For the dementia patient's family, there is the burden of caregiving, the loss of an expected period of retirement where recreation and rest were expected to be plentiful, and the challenge of negotiating a complex network of medical, respite, assisted living, and nursing home care.

Mild to moderately severe dementia is under-detected and consequently under-treated in primary care. Physicians diagnose around half of the patients with mild to moderate symptoms of dementia (Cooper, Bickel, & Schauffele, 1996). Improved detection, as mentioned in Chapter 5, would allow patients to receive treatment at earlier stages, and the benefits of treatments initiated earlier are promising. The case example of Thelma and George illustrates the range of beneficial interventions that a BHC may offer to patients with dementia and their families.

Thelma and George: It was not supposed to be this way.

Dr. Davis referred George and Thelma for a consultation concerning coping with Thelma's symptoms of dementia, particularly episodes of agitation. Dr. Davis had provided PC services to both George and Thelma for many years, and he had diagnosed Thelma's dementia about eighteen months prior to the referral. George had read extensively about dementia and become an active participant in a support group for patients with dementia and their caregivers.

He was a retired minister and was active in his community. He took Thelma with him to almost all of his activities, feeling that it was best for her to remain socially active.

At the initial consultation, Thelma had difficulty in responding to the Duke questions. She made efforts to be socially appropriate but was confused about the role of the BHC and the reason for the consultation. George gave a patient and caring explanation to Thelma, and she appeared to relax. The BHC complimented George on his ability to calm Thelma with his soft voice and focused attention. George explained that Thelma often became agitated just prior to their leaving home. She often commented on his clothing and suggested that he was dressing up for someone. Sometimes, she cried and insisted that he tell her who was taking her place. He noticed that explaining patiently about where they were going and where they would sit—painting a picture of what was to come—alleviated some of her angst. The BHC suggested that he take photographs of the facilities where he and Thelma went on a weekly basis and place the photographs on a large calendar. He could then refer to planned outings in advance, and she could refer to the picture for an image. He agreed to request her assistance in selecting his clothes, which she had done for many years and had stopped only months before.

George called Dr. Davis a week later to report that Thelma was more relaxed and that he thought they could avoid use of additional medication at the present time. When Thelma and George came for a check-in with the BHC a few months later, George photographed the BHC with Dr. Davis, explaining that he wanted to add this to their calendar. George consulted with Dr. Davis and the BHC without Thelma present several times over the following year, and they helped him develop behavioral approaches to various problem behaviors and eventually to negotiate her placement in a nursing home. Perhaps the most painful experience for George and Thelma was when she was assaulted in the nursing home and her finger sprained by the thief

who took her wedding ring. George looked to Dr. Davis and the BHC for support insisting, “It wasn’t supposed to be this way.”

BHC Intervention Possibilities for Older Adult Patients with Dementia. For George, the BHC and Dr. Davis provided ideas for handling problem behaviors and support in making painful transitions. For Thelma, the BHC-PCP team offered behavioral treatment that helped her manage her confusion with less medication and boosted her ability to engage in her usual activities and, ultimately, to remain at home for the longest possible time. Behavior modification programs are often helpful in preventing and/or lessening agitation in patients with dementia. For Thelma, George’s selection of his own clothes provoked fears of losing him. This could be easily avoided, and the use of a calendar with photographs appeared to strengthen Thelma’s visuospatial processing.

Table 11.12 suggests additional interventions that BHCs may provide to older adults with symptoms of dementia. Worthy of mention is the usefulness of behavior modification to promote independence and reduce problems other than agitation, such as incontinence. With support from the PC team, including BHC services on an on-going intermittent basis, families can often significantly delay the relocation of patients in nursing homes. This is particularly important as placement in a nursing home often leads to a significant loss in functioning for the patient and can trigger anticipatory grieving in family members. While Thelma had difficulties in responding to health-related quality of life questions, many patients with mild to moderate dementia will be able to respond. This information will be useful to the PCP in selecting appropriate medications, particularly in regards to treatment of both depression and anxiety, which are not uncommon among patients in the early stages of dementia.

Table 11.12

BHC Intervention Possibilities for Older Adult Patients with Dementia

1. Provide caregiver support and education to prolong period before nursing home placement is required.
2. Complete a functional analysis of behavioral deregulation (i.e., identify causes, such as pain or environmental triggers, that can be avoided or minimized).
3. Develop behavior modification programs (e.g., scheduled toileting and prompted voiding reduce urinary incontinence).
4. Teach caregivers to provide graded assistance, skills practice, and positive reinforcement to enhance the patient's functional independence.
5. Assess health-related quality of life of patient and use it to inform pharmacological treatment by PCP.

PCP Teaching Points for Older Adult Patients with Dementia. While a great deal of research is in progress in the area of PC management of dementia, there is consensus about the recommended teaching points offered in Table 11.13 (Doody, 2001). This is an area for the BHC to monitor and to discuss on an on-going basis with his or her PCP colleagues. It is important that the BHC attempt to share information on the patient's health-related quality of life with the PCP and encourage him or her to use this rather than caregiver reports, as there is evidence that caregivers tend to underestimate the quality of life for the patient, and this is possibly related to the impact of the burden that the caregiver is experiencing.

Table 11.13

PCP Teaching Points for Older Adult Patients with Dementia

1. Cholinesterase inhibitors benefit patients with Alzheimer's disease, although the average benefit appears small.
2. Vitamin E likely delays the time to clinical worsening.
3. Antipsychotic medications are effective for agitation or psychosis in patients with dementia when environmental manipulation fails.
4. Antidepressants are effective in depressed patients with dementia.
5. BHC services are useful to patients with dementia and their families (including development of behavior modification programs, assessment of health-related quality of life, and support to family members, particularly during transition periods).

LOSS AND PREPARATION FOR DEATH

While healthy patients and those with mild chronic illnesses want services that support prevention and cure, those with serious, progressive, disabling illnesses look to their PCPs for a different array of services. Medicine offers no cure and little in the way of rehabilitation for conditions that are most likely to lead to the end of life (such as cancer, stroke, heart disease, and dementia). As medical technology continues to improve, a sizable and growing group of patients will spend a significant portion of their lives coping with these terminal conditions. Our health care system is not prepared to deliver care to this group, as it continues to operate on the outdated assumption that most people die from unintentional injury, infections, and myocardial infarction (Lynn, 2001). Emergency resuscitation is available to most patients

almost anywhere or anytime. However, continuity and comprehensiveness of care for patients who have little chance of recovery and their families is lacking.

The integration of BH services into PC can empower efforts to better meet the needs of those approaching the end of their lives. The needs of this group go well beyond conventional medical care and instead include anticipatory planning for medical crises, advance directives, and involving family members in the transition between life and death. The BHC and PCP can help the dying patient to retain dignity and control and the family to bear the stress of providing care at the end of life and enduring the loss of a loved one. Bob's case example highlights how Dr. Myers and the BHC worked together as a team to allow Bob to retain dignity and control during his transition.

Bob: I'm dying and my wife already passed away.

Dr. Myers referred this 67-year-old man for a consultation concerning coping with lung cancer and bereavement. Bob was new to the clinic, having recently moved from another state to live with an adult child that received care from Dr. Myers. Medical records confirmed the patient's self report of poor health, including terminal cancer, diabetes, hypertension, and vascular disease. In the initial visit, Bob told Dr. Myers that his lung cancer was terminal and that he had moved to his son's home to die. He wanted Dr. Myers's support in arranging palliative care. Dr. Myers referred Bob for a same-day visit with the BHC with a request for an evaluation of his depression and bereavement symptoms.

At the initial consultation, Bob's Duke Scores suggested poor physical and mental health, and his depression severity was high. When the BHC reviewed his scores with him, he explained that his wife of forty-years had died six weeks ago and that he wanted to join her. He denied suicidal ideation and stated that he would be patient and await his time. In fact, he had

plans of taking a trip soon to see several grandchildren that lived in a different city. Bob talked at length about his wife and the goodness she had brought to his life for over 45 years. The BHC asked Bob about his plans for care at the end of his life and his concerns about preparing for death. He said that he did not want any curative treatment, that he wanted to be comfortable, and that he wanted to leave something for his grandchildren that would help them remember him and his dear wife.

The BHC helped Bob develop a plan concerning leaving a legacy for his family, particularly his grandchildren. He had a wooden jewelry box that his wife had given him forty years ago for an anniversary. He kept treasures from his life in the box, and he had brought it with him in his recent move. Bob agreed to write a note about every treasure in the box, so that his loved ones would understand their meaning to him. He also agreed to complete a Durable Power of Attorney for Health Care form and to talk with his son about arrangements for his funeral.

Bob returned a week later stating that he had done this and had taken the trip to see his other beautiful grandchildren. His Duke Scores suggested mild improvements. He was dressed impeccably, and he explained that every minute seemed to count. He was pleased with the hospice service staff and with Dr. Myers's care. At that visit, he worked with the BHC to develop another plan concerning his death. He agreed to ask his son to record him making a statement about each holiday that his family celebrated. In the statement, he planned to explain traditions that he and his wife had carried forward over the years and that he hoped others in his family would also observe at holidays. He would ask his son to make copies of the tape for his children and grandchildren and to mail them to them after his death. Bob died ten days later.

BHC Interventions for Preparing Older Adult Patients for Death. The BHC helped Dr. Davis better understand Bob's symptoms of grief and depression as they might affect his end of life directives. Bob's preference to use a little medication as possible, just enough to comfortable, and this was relayed to the PCP. The BHC also helped Bob plan for his death and his care at the end of life. Bob planned his legacy and died with dignity.

As suggested in Table 11.14, the BHC may often be asked to provide input to the PCP concerning the role that delayed bereavement and/or depression may be playing in the decisions of terminal patients who have recently lost a spouse or life partner. Conjugal bereavement is frequently associated with symptoms of depression and/or posttraumatic distress. As many as a third of widows and widowers meet criteria for a major depressive episode one month after the death of a spouse and a larger group probably suffers subthreshold depressive symptoms (Reynolds, 1999). Conjugal bereavement is a risk factor for suicide in later life, particularly for men. Negative changes in physical health and an increased mortality rate also accompany widowhood, particularly in men.

Table 11.14

BHC Interventions for Preparing Older Adult Patients for Death

1. When the older adult that is preparing for death has lost a loved one in recent years, assist the PCP and patient with sorting out symptoms of depression and bereavement.
2. Support healthier forms of reminiscing.
3. Define and/or teach non-medication comfort strategies.
4. Help patient and family members plan for use of resources (financial, emotional,

and practical).

5. Provide transition coaching services (to assist with changes in levels of care).
6. Support completion of documents that support planning for care in the event that patient loses ability to make decisions (e.g., advanced directives).
7. Encourage completion of planning activities related to death (will, funeral home arrangements, and preparation of materials for loved ones).

In conjunction with evaluating depressed and bereaved older adults, the BHC can partner with the PCP in planning and delivering useful interventions. With more severely depressed widows, a combined intervention involving, for example nortriptyline and interpersonal support, may have a stronger impact and enhance retention of patients in treatment more than single modality interventions (Reynolds, 1999). Warning signs of more severe signs of depression in the bereaved older person probably include isolation and a lack of responsiveness to usually pleasurable events. In our example, Bob displayed neither of these. In fact, he was seeking contact with loved ones and enjoyed their presence immensely. In regards to BHC interventions, we recommend that the BHC use those that are more specific to grief and suggest Dorothy Becvar's book as a resource (Becvar, 2001; see Appendix C). She suggests that grief is a fundamental and necessary emotion that provides a cleansing function, and this definition seems to be helpful to most bereaved patients.

Older people in general spend a considerable amount of time reminiscing, and BHC interventions may focus on structuring the reminiscing. Recent research findings suggest that different forms of reminiscing are linked to differing levels of life satisfaction. Specifically, reminiscences that served to foster conversation and prepare for death are linked to higher life

satisfaction, while reminiscences that function to revive old problems and compensate for low cognitive stimulation (i.e., boredom) were associated with lower life satisfaction and greater psychiatric distress (Cappeliez, O'Rourke, & Chaudhury, H. 2005). Reminiscence directed toward maintaining a connection with a departed person also predicted psychiatric distress. The BHC can promote patient satisfaction with life by supporting engagement in adaptive uses of reminiscence.

On occasion, the BHC may be asked to help patients and family members with the design of comfort activities. Dying patients may benefit from interventions that help them create images of peace and comfort. They may also choose to prepare a selection of reading and/or music selections that they find comforting. Family members may benefit from interventions such as providing gentle touch or singing or reading to the dying family member.

The BHC may also be the PCP team member that helps patients and family members plan for use of their health care resources related to care at the end of life. For most patients, there is no specific point that marks a dramatic transition from cure to care. While hospice programs are typically reserved for patients that will die within six months, many would benefit from care typical of hospice providers for at least a year prior to death. The BHC may be one of the providers in the newly emerging integrated health care system that helps to fill this gap in planning for use of financial, emotional and practical services. It is difficult for patients and family members to navigate the complexities of changes in care, and the BHC in some PC settings may be a leader in developing programs that help patients during these difficult moments. While this is of course the humane thing to do, it will probably also help save economic resources. For example, use of "transition coaches" (who provided assistance with

planning for changes in care) for recently hospitalized patients resulted in a reduction in re-hospitalization costs among a cohort of patients with terminal disease (Coleman et al., 2004).

Finally, the BHC can support PCP efforts to help patients prepare for a time when their capacities for memory, judgment, reasoning, planning, and decision-making decline. The BHC needs to have knowledge of the specific legal requirements in each state for advanced directives and for procedures related to guardianship. Unfortunately, patients are more likely to plan for their death (e.g., preparation of a will, arrangement with a funeral home) than for their care at the end of life (Pinquart & Sorensen, 2002). The BHC can partner with PCPs in designing programs that educate dying patients and their families about the planning strategies summarized in Table 11.15.

Table 11.15

Advanced Directives

Strategy	Definition
Instruction types	Express the patient's desires and instructions as to what life-prolonging medical procedures the patient would accept if he or she is unable to make or convey such decisions at the time
Proxy directives	Patient gives an agent, person or persons, or institution the power or authority to act in his or her behalf

PCP Teaching Points Concerning Preparing Older Adult Patients for Death. The BHC can be of great assistance in reducing confusion, suffering, and unnecessary spending of

medical dollars at the end of life by helping PCPs increase the percentage of their patients who execute advanced directives. Since most patients do not currently have an advanced directive, this tops the list of teaching points for PCPs in Table 11.16. The Patient Self-Determination Act of 1991 initiated the requirement that anyone entering a health care facility, such as a hospital or nursing home, be asked if he or she has an advance directive, but the Act requirements did not extend to out-patient settings such as PC clinics. We recommend that the BHC find a provider champion that supports the idea of asking all patients, new and continuing, (particularly those over the age of 50) if they would like to complete an advanced directive. Posters and buttons for physicians and nurses can be used to generate a sustained focus over the course of a year, so that completion of advanced directives becomes a part of routine care. This will save many patients and their families from confusion, disagreement, and distress and could prevent guardianship hearings. Finally, we recommend that the BHC approach the PCP to talk about the death of a patient with whom the BHC has been involved and to let providers know in general that he or she is available to discuss issues related to the death of any PC patient.

Table 11.16

PCP Teaching Points Concerning Preparing Older Adult Patients for Death

1. Teach PCPs to encourage patients and family members to actively plan regarding direction of care, transitions, and wishes at end of life.
2. Encourage PCPs to suggest completion of advanced directive at new patient visits, particularly for patients over 50 years of age (with BHC assistance as needed).
3. Let PCPs know that you are available to process their loss of a patient.

PREPARING TO CARE FOR MORE OLDER ADULTS IN PRIMARY CARE

In the next few decades, the current population of older PC patients will double. BHCs can be leaders in helping PC teams and clinics prepare for this shift in the population. The BHC can pose the question, “How do we provide services to a large group of older PC patients who want to use our services to help them live vital lives until they die?” Many older patients will need assistance from PC in order to learn skills for experiencing loss and making new connections, and BHCs may start health promotion classes to address this need.

In the late 1980’s, one of us (PR) participated in a study designed to evaluate delivery of six health promotion classes to older PC patients (on topics, such as hearing, vision, exercise, diet, etc.). The health promotion class targeting improvement of BH was modeled after Gallagher’s Life Satisfaction Class (see Thompson, Gallagher, & Breckenridge, 1987 for general information about psychotherapeutic treatments for depressed older adults). Not surprisingly, this class was selected as the favorite of the series by patients. It was a 6-session class that offered practical cognitive behavioral strategies for solving the challenges of aging well. The Health Maintenance Organization sponsoring the study agreed to on-going delivery of a four session version of the class after the end of the study because the PCPs insisted on having this resource for their patients. The PCPs explained to the administrators, “Life satisfaction is what all of our patients want.” Classes are an excellent format for meeting the BH needs of older patients because participation in a class links patients with the same kind of problem together in one space. Also, to attend a class is itself a social activity and thus defeats the tendency toward withdrawal and isolation.

In addition to classes and group care clinics (which we discuss further in the next chapter), the BHC can be an advocate for other program changes, and perhaps the best scheme

for pursuing this on a long-term basis is that of forming a clinic committee whose mission is to develop services that promote healthy aging. Increasingly, materials are available to support such efforts. The National Council on Aging (NOC) offers tool kits to use in promoting healthy physical activity, management of depression and diabetes, and nutrition (see NOC ordering information in reading list in Appendix C). However, these evidence-based self-management programs will have little impact if no “champions” appear at the clinic level to promote their implementation.

Nurses are essential members of a Healthy Aging Committee, as they offer a great deal in the way of clinical management services. Nurse-BHC partnerships have great capacity for relieving the burden on PCPs and increasing the value of services to older adults. A Healthy Aging Committee can support the creation of linkages between PC clinics and community resources. While many older adults find ways to stay involved in their communities, as many as a quarter voice a need for greater involvement with others. In some communities, committee members may need to advocate for development of resources that prevent older people from becoming isolated, depressed, and more vulnerable to disease. Both local and state governments stand to gain from programs that reduce seniors’ health care costs by preventing depression and improving fitness, and grant funding may be available for the clinic (and BHCs may help write the grant applications). Finally, the BHC, as a member of the Healthy Aging Committee, also needs to be alert to the possibility of involving older adults as volunteers to meet social service needs and overcome the workforce shortages that are common in PC clinics. In these ways, BHCs can be leaders that bring clinics closer to a future where the circle of life and death meet in the context of community-based health care.

SUMMARY

1. American are growing older and living longer, and the current population of seniors will soon double. The BHC needs to evaluate his or her preparedness for delivering evidence based geriatric services to this group and plan continuing education efforts accordingly.
2. Many referrals of older adults will come with the request that the BHC help them self-manage chronic diseases, because as many as four out of five older adults have a chronic disease.
3. Medical adherence is also an issue, as older adults face many barriers to successfully participating in their care. Cost, along with personal views of illness and treatment may be barriers. BHCs can take a systematic approach to improving adherence by developing medication adherence plans that support comprehensive planning.
4. Care giving is a common role for the older adult, one that is replete with daily stressors and carries both psychological and health risk. BHCs can help patients maintain independent functioning and family members manage their stress. These services are best delivered early in the care giver role and in groups where social support and sharing of resources occurs spontaneously.
5. Many patients with mild to moderate symptoms of dementia are managed in PC, and BHCs can improve care to this group by supporting early detection efforts, developing behavior modification programs, and assisting patients with planning and negotiating changes in levels of care.
6. BHCs can both develop and support clinic efforts to prepare patients for death with dignity and family members for negotiating the pain of loss.

7. BHCs can advocate for a clinic based Healthy Aging Committee, whose role is to create a structure for planning and implementing various programs for the growing number of seniors over the next two decades.