National Black Nurses Association

GERIATRIC NURSING...

Geriatric Health Care: Keeping our Treasures Healthy

SPONSORED BY THE HARTFORD INSTITUTE ON GERIATRIC NURSING

Welcome to the National Black Nurses Association's new webpage on geriatric nursing and geriatric health care. NBNA is grateful for the financial support from the Hartford Institute for Geriatric Nursing to create and place this webpage on the NBNA website.

The purpose of this webpage is to highlight information and innovations on the health of our Nation's citizens as we age. Found in the initial launch of this webpage are articles from NBNA members, friends of NBNA, nurses and other health professionals and organizations that have a keen interest in geriatric nursing and geriatric health concerns.

The NBNA geriatric webpage is part of a continuous effort by NBNA to keep health concerns of the aged in the forefront of our thinking and as we plan to better serve the Nation's baby boomer population. NBNA has published two newsletters on aging and held seminars on aging at a regional and NBNA annual conferences.

It is our intent that this webpage will contribute to your knowledge base on clinical, administrative and public policy issues relating to aging.

We hope that you will come back often for updates as we move forward with our work. Also, that you will use this site and share it with others.

Thank you for your support.

Sincerely,

Debra A. Toney, PhD, RN

President

Why a Career in Aging Research and **WHY NOW?**

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True or False: The world's children under age 5 outnumber people age 65 and over? The world's older population (65 and over) is increasing by approximately 600,000 people each month in 2008? The answer to the first question is true for now but projections indicate that in fewer than 10 years, older adults will outnumber children under the age of 5 for the first time in history and likely for the remainder of our life time. The answer to the second question is false as the estimated change in the total size of world's older population between July 2007 and July 2008 was an average of 870,000 people each month for about 10.4 million people total (Kinsella, Kevin and Wan He, 2009).

Absolute numbers alone account for some of the need for careers in aging. However, there are many opportunities and challenges in aging, gerontology and geriatrics research and too few scholars, scientists, and clinicians to address them. The problems are complex and encompass many difficult and prominent factors. For example, family structures are changing. As people live longer and have fewer children, family structures are transformed, leaving older people with fewer options for care. This may be harsher for some minority racial and ethnic families that have traditionally eschewed traditional nursing home and long term care facilities. Additionally, patterns of work and retirement are shifting and additional research is needed to unravel the shift. Shrinking ratios of workers to pensioners and people spending a larger portion of their lives in retirement increasingly strain existing health and pension systems (http://grants.nih.gov/grants/guide/pa-files/PAR-09-136.html#SectionIII).

Yet amid difficult times, notable progress in a number of areas of aging research - biomedical, social, and behavioral — have improved health and function, and contributed to reduced rates of disability, for some older people. The need to understand the manifold factors that promote health and independence and those that lead to disparate rates of disease and disability has never been more urgent as our Nation seeks to reform health care

The NIA has as its mission the improvement of health of older Americans through biomedical and behavioral research, and research training. To ensure equal participation in this process by all ethnic groups, the NIH and NIA have, since the early 1970s, supported programs focused on increasing the number of scientists who are members of racial and ethnic minority groups under-represented in biomedical research while focusing on advances in aging science. The NIA supports many research and training opportunities for the novice and well established scientist including loan repayment, fellowships, dissertation awards, diversity supplement awards and traditional research project grants. For additional detail on these and other mechanisms supporting aging and health disparities research, please visit: http://www.nia.nih.gov/GrantsAndTraining/SpecialPopulations.htm

Almost no area of late life health disparity is excluded when considering aging research and health disparities, and inquiry is required to address built environments (places of residence, geographical segregation of medical services, unsafe neighborhoods, safe walking & driving); lifespan experiences (life-long disability, societal role in health to include discrimination, end-of-life health expenditures, elder mistreatment, social gradient and inferior quality early life education); culture (traditional foods, resistance to formal medical care, multigenerational caregiving); policy and economics (has the Medicare drug act made a difference to disparities? Do other recent changes in implementation and direction of federal and state health programs act to increase

or decrease disparities in late life?); basic biology, including studies on animal models, of age-related diseases that disproportionately affect racial or minority groups (prostate cancer, cardiovascular disease); as well as aging-related diseases and conditions that disproportionately affect racial and ethnic minority groups (differential diagnosis of Alzheimer's disease, burden of illness, and comparative studies).

Further, research is needed to assist policymakers in decisions about allocation of public health resources consistent with the primary causes of health disparities in the U.S. with a particular emphasis on risk factors for chronic diseases and injuries. Opportunities to reduce disparities fall into but are not limited to several categories, including: broad efforts to reduce socioeconomic inequalities; increasing the number of people with health plan coverage; increasing physical and cultural access to health care; reducing disparities in the quality of care that patients receive; public health strategies to reduce risk factors for chronic diseases and injuries at the community level; and public health strategies to reduce risk that target individuals within differing communities.

In sum, why a career in aging research and why now? The time is right, health problems are complex and require complex solutions, opportunities abound based on global aging and projections on the numbers of older adults surviving and thriving in 2030, 2050 and beyond! I encourage readers to immediately do two things - 1) visit the NIA website at http://www.nia.nih.gov/ and peruse the many resources and opportunities available and then 2) sign onto the Health Disparities Resource Persons Network to access experts across the nation and register if you have appropriate credentials at http://rpndemo.niapublications.org//index.php?option=com_comprofiler&task=registers.

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Rising Economic Status in the Caribbean Correlates with **WORSENING HEALTH STATUS** Among the Elderly

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One only needs to visit the more prosperous Caribbean islands like Barbados, Bermuda, Antigua and Barbuda, or Trinidad and Tobago and observe US fast food chains (such as Kentucky Fried Chicken), the increasing congestion of vehicles and exhaust fumes, high tech industries and growing forms of commercialism, expanding resorts and hotels catering to US, European, and Canadian visitors among others, an influx of crime and substance use, etc. to recognize that the tranquility and laid- back environment enjoyed by inhabitants does not always mirror one's perceived mental images.

These, and other trappings of economic growth tend to be associated with increasing rates of chronic diseases, particularly among the elderly who constitute a growing proportion of the population. Recent estimates project that by 2050, 25% of the population in the Caribbean will be older adults, and 8% percent of them will be over 75 (ECLAC, 2004). The healthcare sector in countries with the most rapid rise in the elderly population (i.e., Jamaica, Barbados, and Bahamas), faces a crisis in preparing for emerging healthcare needs of the aging population, within the context of rapidly changing economic and social structures

Aging is commonly associated with one or more chronic health conditions such as heart disease, diabetes mellitus or chronic cognitive impairment. Despite improvement in the management of cardiovascular disease and a reduction in the overall death rate, CVD accounts for 35% of the deaths in the Caribbean (PAHO, 2006, p.87) and along with stroke, hypertension, and CHD are among the leading causes of death, especially among the older populations (ECLAC, p.29) (PAHO, 2006; Forrester, 2003). Diabetes, affects one in five adult blacks and accounts for nearly 25% of the chronic conditions among blacks 70-79 (Hennis, et al, 2002 p.2). It is a potential risk factor for stroke and CHD and is a cause of renal failure, blindness, and peripheral vascular disease, (PAHO, 2006, p.28; Forrester, 2003, p.10). The age adjusted death rates from stroke, CHD, and diabetes are especially high in countries more economically developed (Forrester, 2003, p.25). Co-morbidities coupled with increasing age, sedentary life style (Chang, 2004, p.22), shifting family capacity to care for aging relatives (ECLAC, p.7), lack of safety and widespread instances of abuse (Niles, 2004, p.8; Blake, 2004, p.14) result in syndromes that compromise the quality of life for the growing number of Caribbean elderly. The lack of inclusive pension systems, persistent and acute social inequities, a low level of institutional development, limited social security coverage and a trend towards reduced sources of support as a result of changes in family structure and composition lead to high rates of poverty among the elderly (ECLAC, 2004). The heavy burden of care giving by female family members, most of whom are over 50, contributes to stress, poor health, and inability to cope and make ends meet (ECLAC, p.32). Moreover, as the prevalence of disabilities increases with age, so does the

burden on caregivers. A sizable percentage of older people, particularly those 70 and over, report having difficulty with basic activities of daily living (p.32). Limited mobility and falls, urinary incontinence, heart failure, dehydration, acute pain management, infections, delirium, disorientation, isolation, abuse and neglect, and abandonment result in challenges (Reyes-Oritz, Al-Snih, & Markides, 2005) and place the elderly at great risk for a poor quality of life and diminished dignity. With the declining ability of families to provide appropriate, consistent, and sustainable care, the number of elderly in hospitals is increasing, but hospitals are ill equipped and financially under-resourced to care for this population. The lack of governmental policies and infrastructure to provide comprehensive services and access to care compromises the well-being of vulnerable senior citizens.

While economic growth and development are welcomed signs of prosperity, sectors of society face the challenges of adapting and coping to ensure highest quality life for all members of society. The elderly population is certainly one segment deserving the peace, tranquility, and comfort typically associated with the gentle Caribbean landscape.

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Discussing and Diagnosing ALZHEIMER'S DISEASE

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Early detection of memory problems and strategies for successful aging are increasingly moving to the forefront of health care issues, in light of the escalating incidence of Alzheimer's disease in America that many liken to an epidemic.

The prevalence of this incurable brain disorder, characterized by loss of memory and other intellectual function, is mirroring the nation's aging population. While Alzheimer's disease is not a normal part of aging, age is the greatest known risk factor. The incidence doubles every five years between 65 and 95, according to the National Institute on Aging.

Clinicians diagnose Alzheimer's disease as the cause of dementia—a general term that describes a group of symptoms related to the loss of multiple intellectual functions that interferes with daily living—in about 60 percent of individuals living with the disease; other common causes of dementia are vascular dementia, Lewy body dementia and alcohol related dementia.

The first step toward managing a disease of such crisis proportion is putting it on the radar screen—the radar screen of both consumers and healthcare professionals. Currently, Alzheimer's disease and related dementias is both under-discussed and under-diagnosed.

Feeding this is a continuing misperception that Alzheimer's disease is a normal part of aging, as well as a continuing stigma that envelops it. Both are often magnified among racial and ethnic minorities. According to a survey conducted by Harris Interactive for the Alzheimer's Foundation of America (AFA), African American and Hispanic caregivers of people with Alzheimer's disease are significantly more likely than caregivers of other races to dismiss its symptoms as part of getting older. Also contributing to delayed diagnoses, African American caregivers are significantly more concerned about stigma (36 percent) than Hispanic (22 percent) and other race (18 percent) caregivers.

A 2006 editorial in the Journal of the American Geriatric Society estimated that missed diagnoses of dementia range from 25 percent to as high as 95 percent.

Lifting the barriers to early detection includes greater recognition of the warning signs of dementia and more widespread use of memory screenings. An AFA white paper, "Memory Matters," released in December 2008 notes that current research supports memory screenings "as a simple and safe evaluation tool that assesses memory and other intellectual functions and indicates whether additional testing is necessary."

Once Alzheimer's disease is diagnosed, critical next steps can be taken to improve quality of life for people with the disease and their families. Absent a cure, treatments with FDA-approved medications can help slow progression of symptoms. Behavioral interventions, social services support, long-term planning and lifestyle changes can ease daily challenges and caregiver responsibilities immediately and as the neurodegenerative disease progresses.

Emerging research emphasizes that lifestyle choices are not only a critical management strategy once symptoms have appeared, but they also possess advance value. Age and genetics are risk factors for Alzheimer's disease beyond our control. But getting a handle on controllable conditions such as obesity, hypertension and diabetes—health challenges that particularly impact African Americans—can help reduce risk factors for the development or advance of Alzheimer's disease

Overall brain health includes a combination workout, focusing on the physical, such as a balanced diet and exercise; the social, such as spirituality and reducing isolation; and the mental, such as providing a stimulating environment and learning new information to build brain reserve. In general, what's good for the body is good for the brain.

Only through a strong professional-patient connection that encompasses an open dialogue about Alzheimer's disease, action when warning signs occur, and an emphasis on lifestyle modifications for physical and cognitive health will we be able to manage this chronic disease epidemic.

RESOURCES:

Alzheimer's Foundation of America-www.alzfdn.org., www.alzprevention.org, www.nationalmemoryscreening.org

Alzbrain.org-- http://www.alzbrain.org/prevention.cgi?pg=dementia

National Institute on Aging--http://www.nia.nih.gov/

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Relieving the Burdens of Serious Illness

Understanding the Medicare Hospice Benefit

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When patients and their families are dealing with a life-limiting illness, the physical and emotional challenges are burden enough. But the financial stresses sometimes are more than a family can bear. So it's vital for physicians and others involved in a patient's care to fully understand the financial benefits available to Medicare enrollees who choose to take advantage of their hospice benefit.

Stated simply, the Medicare Hospice Benefit is ALL-INCLUSIVE-Medicare-certified hospices must accept the per diem reimbursement rate as 100 percent coverage for the services provided to the hospice patient and family.

For the patients of these hospices, that means no more co-pays, deductibles or coverage limits. It means that all prescription medications, over-the-counter drugs, medical equipment like a hospital bed, lab and diagnostic work, and medical supplies related to the patient's terminal illness are provided at no cost to the patient. It means that the hospice physician, nurses, certified hospice aides, social worker, chaplain, physical/occupational/speech therapist, dietician and volunteers provide care related to the patient's terminal illness at no additional cost to the patient and the patient's family.

Hospice is unique among Medicare benefits in that it provides care for both the patient and the patient's loved ones. For example, the Medicare Hospice Benefit requires all Medicare-certified hospices to provide an organized program of services to meet the bereavement needs of the family for at least one year after the beneficiary's death.

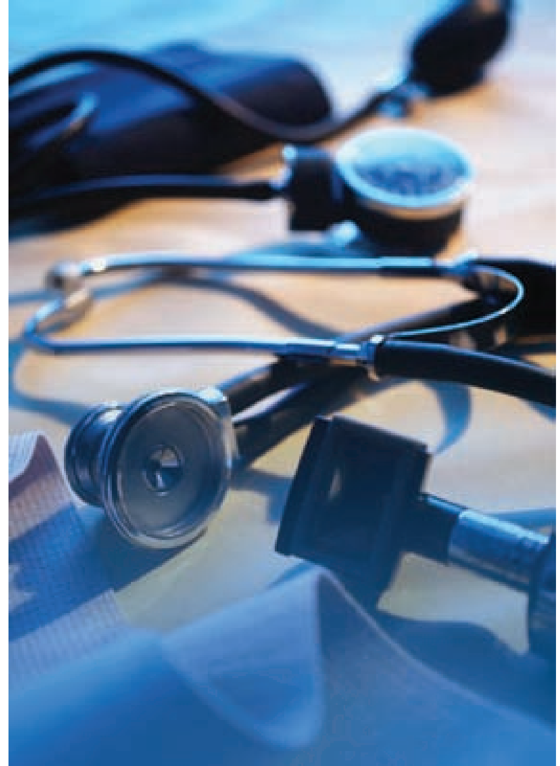
While hospice patients and their families are quick to express their appreciation for the effective pain control and symptom management for which hospices like VITAS Innovative Hospice Care® are best known, many also express relief that the financial burden related to the terminal illness also has been relieved. The regulations governing a Medicare beneficiary's eligibility to receive hospice services under the Medicare Hospice Benefit are fairly straightforward:

- A patient must be eligible for Medicare Part A.
- The beneficiary must agree that he/she wishes to receive "palliative, not curative, care," and to surrender all other Medicare benefits relating to the terminal diagnosis, with the exception of the professional services of his/her attending physician.
- The attending physician and the hospice medical director or team physician must certify that the patient has a "medical prognosis that his or her life expectancy is six months or less, if the illness runs its normal course."
- At successive intervals of 90 days, 90 days and unlimited 60-day periods, a hospice physician must certify that the patient's prognosis continues to be six months or less from the date of the most recent certification.

The Medicare Hospice Benefit helps to ensure that all terminally ill patients and their families have ready access to compassionate and effective end-of-life care.

ASK MEDICARE:
Thought Leaders Roundtable on Caregiving

DECEMBER 10, 2008, EXECUTIVE SUMMARY



On September 18, 2008, the Centers for Medicare & Medicaid Services (CMS) launched Ask Medicare: Information to Help You Care for Others, an initiative to assist unpaid caregivers—typically family and friends—who assist people with Medicare. As part of Ask Medicare, CMS convened a "Thought Leader Roundtable on Caregiving" in Washington, DC, on December 10, 2008. The Roundtable engaged 40 public and private sector opinion leaders, drawn from the health care, caregiving, provider, policy, employer, government, and foundation communities who sought to identify critical problems, challenges, and opportunities for addressing caregiver needs in the coming years.

CMS Acting Administrator Kerry Weems' opening remarks challenged attendees to help CMS address the future of caregiving, identify the best ways to reach caregivers, assist beneficiaries in better utilizing the resources CMS and other organizations have to offer, and coordinate with CMS to enhance the lives of caregivers and those for whom they provide care. Key issues, challenges, and opportunities were identified and potential solutions proposed as opportunities and recommendations for short and long-term improvements and a roadmap for moving forward.

Key issues included the growing number and challenges facing caregivers, including special issues of male caregivers and those in racial and ethnic communities; the decreasing number of children and paid caregivers available to care for an emerging cohort of aging baby boomers; and the economic downturn's effect on working and low-income caregivers. Health care issues emphasized a lack of caregiver recognition and effective inclusion in the health care system, especially during transitions (e.g., hospital discharge), and the unintended negative consequences of some interpretations of HIPAA privacy regulations. Work-life balance, workplace stress, and reduced productivity dominated discussions of caregiver concerns, while health literacy and skills training were highlighted as significant concerns regarding caregiver resources and supports.

Roundtable participants identified priority challenges to be: the exclusion of caregivers from the medical care team; the shortage of caregiver services and assistance; the lack of economic help or workplace support for caregivers; difficulties in reaching caregivers with relevant information in their time of need; and insufficient value and recognition in American society that leads to an absence of social will to support caregiving.

Participants also suggested that many opportunities exist to immediately help caregivers, including: positioning caregiving in the short-term to benefit from emerging federal and state initiatives related to the economic recovery, health reform, and information technology; as well as emerging new models of communication, training, and education (e.g. digital resources). In the long-term, participants agreed that advocates need to generate the social will to better support caregivers in America.

Roundtable participants agreed that they will continue the conversation and expand participation to include other experts. They also agreed to work among themselves and, when appropriate, with CMS to advance identified issues and opportunities. CMS agreed to share materials, including this summary paper, and to facilitate the creation of four social impact/outcome groups. These groups will address identified areas of focus through action plans that include specific strategies and tactics that hold promise of benefiting family caregivers. The groups will focus on: transitions of care; budget and financing issues; provider/professional education and communication; and caregiver communication.

HIV/AIDS: Fifty Something and Forgotten

TONJA A. COOK, RN

According to Centers for Disease Control and Prevention (n.d.), "The United States population is rapidly aging. By 2030, the number of Americans aged 65 and older will more than double to 71 million older Americans, comprising roughly 20 percent of the U.S. population..."

The fifty and over population is often plagued with many medical issues such as various forms of Cancer, Heart Disease, Stroke, Diabetes and joint, hip and knee replacements, just to name a few. Moreover, in persons aged 50 and over, the natural aging process and other co-morbid diseases tend to exacerbate HIV/AIDS susceptibility.

For most of us, the "sex talk" was the most dreaded conversation on earth. Whether you were raised in a strict or religious background or not, no one wanted to discuss sexual intercourse. In other words, it was taboo! The consensus was that mere conversation would somehow predispose the listener to risky sexual behavior. Unfortunately, this could not be further from the truth.

Was it so long ago that we reluctantly sat on the laps or the bedside of our parents and grandparents and experienced that uncomfortable conversation? Well sons and daughters, it is well past time to return the favor because by not doing so could be detrimental to their health.

The manifestations of HIV infection are reminiscent of flu like symptoms and can be easily masked by other medical ailments. So why are we surprised by the 2005 CDC report where the 50 and over population comprised 15% of the new HIV/AIDS diagnoses and 24% of persons living with HIV/AIDS?

We are surprised because no one would ever suspect that our grandmothers and grandfathers are still interested in having sex. As a society, we must move past the stereotypical notion that older individuals are no longer interested in having sexual intercourse.

Is it so hard to believe that our grandmothers may still have the urge to have sex after a divorce or after being widowed? Further, is it unimaginable that our grandfathers are choosing to pay for a monthly "happy meal" in exchange for a false sense of security?

The truth of the matter is that the 50 and over population is no different from the younger generation regarding the modes of HIV transmission.

Ironically, the increasing rate of HIV transmission has done very little to deter the endless supply of creative erotic enhancement products. Consider that, after the bewitching hour, anyone can see on any given telecast, an array of scantily clad women and infomercials that shamelessly try to market their "longevity pills" and "menopausal medicine." How can one resist?

Statistics have shown that the 50 and over population is not immune from chemical or substance abuse, intravenous drug use or risky sexual behavior. For many HIV positive individuals, whether insured, uninsured or underinsured, an HIV/AIDS diagnosis comes too late. In other words, by the time their HIV status is identified, they are diagnosed with "full blown" AIDS.

This unfortunate scenario could be prevented with the early identification of HIV infection. The ultimate goal of early identification is to transition the HIV positive individual into treatment as soon as possible.

Once an individual has been diagnosed with HIV/AIDS they can be treated with antiretroviral therapy (ART) that can be used to provide for a better quality of life. According to AIDS.Gov (n.d.), "The antiretroviral therapy recommended for HIV infection is referred to as highly active antiretroviral therapy (HAART), which uses a combination of medications to attack HIV at different points in its life cycle."

When addressing prevention efforts, a strategic plan is paramount. Prevention efforts should not only be evidenced based but also built upon previous knowledge. HIV/AIDS education and prevention efforts should include but not limited to:

Cultural Sensitivity

Age Appropriateness

Multidisciplinary Involvement

Development of Negotiation Skills

Correct Usage of Prevention Resources

Utilization of Research/Survey Information

Identification of Community Resources/Support Systems

The nurse's role in HIV/AIDS prevention efforts is foundational in the healthcare arena. Through education, patient care contact and advocacy, we are able to assess educational deficiencies and implement strategies that will facilitate not only understanding but also the practice of safe sex. HIV/AIDS awareness also means getting involved at the community level as well as the legislative level.

The HIV/AIDS epidemic has reached critical levels with the health of every man, woman and child at stake. Society must mandate that HIV/AIDS education be initiated at every "point of care" in order to get the word out. In this relentless pursuit, we must not forget the 50 and over population, for they are significant in this ongoing battle in the eradication of the HIV/AIDS epidemic.

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HIV/AIDS Glossary. www.aids.gov/basic/glossary/- 22k-2009-01-21

RESOURCES:

http://www.hrc.org/laws_and_elections/4732.htm

Centers for Disease Control and Prevention. 800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24-hours/Every day cdcinfo@cdc.gov http://www.thebody.com/index/testing.html

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Advance Directives: Preparing Early for the End-of-Life

MARY ELLEN TRAIL ROSS, DRPH, RN, CS

The issues surrounding serious illness and death are often difficult to discuss and cope with; however, it's easier on everyone if an individual has an advance directive in place before he/she is confronted with a serious accident or illness. Unexpected end-of-life situations can happen at any age, so it's important for all adults to have advance directives. Older adults frequently experience multiple chronic illnesses, some life threatening, therefore it's especially imperative that this population have advanced directives.

The Patient Self-Determination Act is a federal law that requires health care facilities that receive Medicare and Medicaid funding to inform patients in writing of their rights to execute advance directives. An advance directive express the wishes of a competent adult regarding medical care and life-sustaining measures , should he/she become incompetent or unable to communicate. In the absence of written advance directives, oral advance directives may be challenged legally if family members are not in agreement about the person's wishes (Hooyman and Kiyak, 2007).

The most common type of advance directive is a living will (also known as a directive to physicians). Living wills are legal documents whose purpose is to allow individuals to specify what type of medical treatment they would or would not want if they became incapacitated or had an irreversible terminal illness. Living wills can direct physicians to withhold life-sustaining procedures and can assist family members in making decisions when they are unable to consult a comatose or medically incompetent relative. An individual must be competent to initiate a living will, and he or she can revoke or change it at any time (Miller, 2009).

A durable power of attorney for health care is an advance directive that allows an individual to designate a health care proxy or surrogate to make decisions about medical care if the person is unable to make them for himself or herself. When an individual has no advance directive, is incompetent, or unable to handle his or her affairs adequately, a guardian may be appointed by the court to direct the individual's medical treatment, housing, personal needs, finances, and property. Because the guardian manages all the individual's affairs and assumes legal rights, a guardianship is generally considered a last resort (Hooyman and Kiyak, 2007).

Lastly, a do-not-resuscitate (DNR) order is another kind of advance directive. A DNR order is a request not to have cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. Individuals should place their request on an advance directive form or inform their physician of their wishes. Afterwards, a DNR order is placed in the medical chart by the physician.

Advance directives not only makes a person's wishes known, but they may also decrease the confusion and stress of decision making experienced by family members at the end of a loved one's life. The Terri Schiavo case is an example of a well known, highly publicized case in 2005 involving a brain-damaged patient without a written advance directive and a family bitterly divided on what to do. In the end, the court ruled in favor of Schiavo's husband who won the right to have her feeding tube removed over her parents' objections. In the event that Mrs. Schiavo had an advanced directive, perhaps the family would not have fought about end-of-life issues.

State-specific advance directives can be ordered from the national organization, Caring Connections, or downloaded from their website (http://www.partnershipforcaring.org).

THE NURSE'S ROLE REGARDING ADVANCE DIRECTIVES

The nurse is encouraged to discuss and educate patients/clients about advance directives. When a person enters a health care facility with an advance directive, the nurse should review the document with the patient to ensure that it is current and reflects the patient's wishes. The nurse should inform other members of the health care team and make sure that the document is visible and accessible in the patient's chart. Nurses should also encourage patients to discuss their wishes with their physician and family. In addition to the physician, the individual should provide copies of advance directives, such as living wills, to their family members in case of emergency. A copy of advance directives should also be kept in the individual's automobile. These interventions should decrease confusion as to what decisions to make or how to provide appropriate care when faced with end-of-life decisions.

Adapted with permission from Ross, M.E.T. and Summerlin, E. (2007). Senior health. In M. Nies and M. McEwen (eds.) Community/ public health nursing: Promoting the health of populations (4th ed.). St. Louis: Elsevier, 353.

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Nurses Urged to Take a Role in Vaccinating Older Adults

WILLIAM SCHAFFNER, MD AND SUSAN J. REHM, MD

Vaccines are an important part of routine preventive care for older adults, but most adults don't get their vaccines as recommended. Omitting vaccination leaves adults needlessly vulnerable to severe illnesses, long-term suffering and death from preventable infections. Nurses can have a positive impact on the health of their patients by taking an active role in immunization services in their practice settings.

Surveys of U.S. adults show that they are very likely to act on their health care providers' recommendations. In a 2007 survey from the National Foundation for Infectious Diseases, nearly nine in ten adults said they would get a vaccine if their health care provider recommended it. Unfortunately, surveys also show that patients and health care providers are not having these conversations as often as they should.

While vaccines are recommended for adults of all ages, they are particularly important for older persons who are at great risk of serious debilitating consequences and death from infectious diseases. Vaccination is particularly important for individuals living in nursing homes or assisted living facilities, as disease can spread easily among people in close proximity.

Nurses can and should be a vital part of the vaccination process. Here are three easy steps to help make vaccination for older adults a routine part of their care.

1. Know which vaccines to recommend and why

Most of us know that all patients 65 and older should get an influenza vaccine every year, but did you know CDC actually recommends the vaccine annually for every American starting at age 50? In addition, CDC recommends shingles (zoster) vaccine for individuals 60 and older and pneumococcal vaccine for individuals 65 and older. Some adults may also need a booster for tetanus, diphtheria (Td).

INFLUENZA

Influenza causes an average of 36,000 deaths, most of them in older adults, and more than 220,000 hospitalizations in the U.S. every year.[1,2] Annual influenza vaccination reduces the risk of getting influenza, and can also reduce the severity of illness if a vaccinated person gets influenza. In nursing home residents, vaccination is up to 80 percent effective in preventing influenza-related death.[3,4,5,6] In community-dwelling elderly persons, vaccination is 27 to 70 percent effective in preventing hospitalization for influenza or pneumonia.[7,8,9]

Because influenza vaccination is needed every year, patients should be reminded when it's time to get vaccinated. Vaccination should be offered as soon as the influenza vaccine becomes available in the community and should continue into December, January and beyond since U.S. influenza cases usually don't peak until February.

PNEUMOCOCCAL DISEASE

The elderly and adults with special health concerns are at highest risk from pneumococcal infection and its complications. The most common clinical presentations of pneumococcal infection are pneumonia, meningitis and sepsis. About one in every 20 people who get pneumococcal pneumonia dies from it; older adults are more likely to die from the disease.[10] For most people, only a one-time vaccination is recommended.

SHINGLES

The risk of getting shingles increases as a person ages; of the one million Americans who develop shingles each year, the majority are 50 years of age and older.[11] Shingles can be very painful in its acute stage, but it is post-herpetic neuralgia (PHN), a long-term pain associated with shingles, that is of greatest concern. PHN can be very severe and debilitating; it is difficult to treat and may last for months or years after the shingles rash itself has healed. The shingles vaccine prevents PHN in two of every three people vaccinated and prevents shingles itself in about half of all people vaccinated.[12]

TETANUS, DIPHTHERIA

The bacteria that cause tetanus are widespread in soil and dirt and can enter the body through any cut or wound. While diphtheria is now very rare in the U.S., it continues to cause illness worldwide. Ease of travel makes it important that we maintain our immunity against this deadly infection. All adults who had the primary series of vaccines as children should get a booster dose of tetanus-containing vaccine (Td) every 10 years. Those younger than 65 should get one dose of Tdap, a three-in-one combination that also includes protection against pertussis (whooping cough), in place of one Td booster. This is important because infected adults can pass pertussis on to vulnerable infants who are at highest risk of complications, including death, from whooping cough.

2. **Encourage the use of Standing Orders**

   Research has shown that standing orders can have a positive effect on vaccination rates. Nurses can help establish standing orders in their workplace by speaking with their institution's decision maker. Sample standing orders for all of the above vaccines are available here.

3. **Get your vaccines and encourage your colleagues to get theirs, too**

   Another great way to help patients stay healthy is to make sure you are up to date on your own vaccinations. This makes you much less likely to pass serious infections on to others. It also gives you more credibility; it's easier to recommend vaccines when you can tell your patients, "I got mine, too!" This is especially important with annual influenza vaccination.

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RESOURCES

A variety of materials to help educate patients and colleagues about adult vaccination, including reminder postcards and fact sheets, are available on www.adultvaccination.com.

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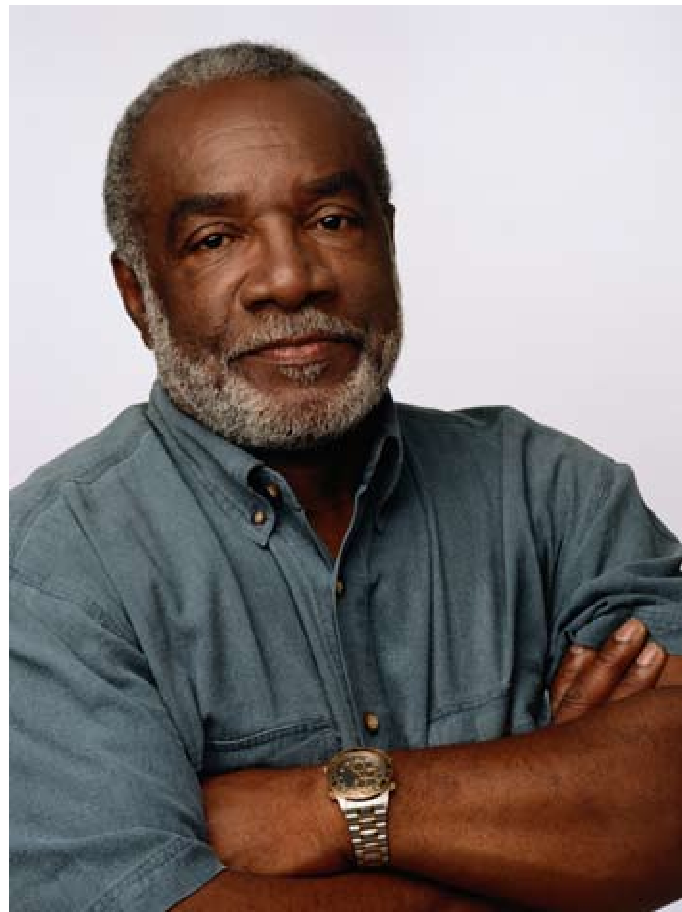
Reluctance in Help-Seeking Behaviors by AFRICAN AMERICAN ELDERS

BJ TAYLOR KOSAK MSN, RN CS

The geriatric population is increasing and African Americans make up the largest cultural minority group (Mauk, 2006). The lifespan of African Americans has expanded and many centenarians, those whose age is 100 and over, are African American. This author's grandmother lived to be 101 years old. These are people who have experienced significant life events, including the Great Depression and a World War, and social, political, and cultural changes. A certain degree of physical and emotional hardiness was needed to survive these upheavals, in addition to the normal crises of life. A phenomenon of interest to this author is the reticence of some cultural groups to utilize help-seeking behaviors, i.e. asking questions, asking for help, and self-disclosure on "personal" issues. The paper will examine some of the reasons why this may occur with elderly African Americans.

RATIONALE

Specific reasons as to why elders are reticent to seek help vary, as all are individuals, irrespective of age or minority group. Generational differences account for much of the variation within the African American community. The elderly were reared in a generation where many were taught not to complain or question others. Questioning the authority of others, whether it be parents, teachers, or doctors, was not the usual norm for this population. Surviving in the more difficult times helped elders to tolerate "less than ideal" situations; they were resilient and solved their own problems. Therefore, many elderly people generally demonstrate self-reliance and stoicism (Kunkel & Williams, 1991). Years ago few African Americans graduated from high school. Because many people did not have a high school education, they may have been perceived as not being intelligent. This presented another reason why some people may have been reluctant to ask questions or seek clarification on issues. Lastly, people want to remain independent; they fear that by sharing personal information or acknowledging some confusion on a matter may jeopardize their freedom in choice of place to live and managing their own affairs.



IMPLICATIONS

How may this lack of help-seeking behaviors affect our African American elders? Failing to get one's needs met can impact several areas of a person's life negatively. Since a majority of the elderly has one or more chronic illnesses, they may be on medications to control or maintain the chronic condition(s). Persons age 65 years and older are the largest users of prescription and over- the- counter (OTC) medications (Ebersole, Hess, Touhy, & Jett, 2005). Numerous errors can occur with the use of medications; some are not the fault of the elderly consumer. Some medications have a complicated regime, confusing directions, or are poorly labeled for the geriatric client. Mistakes can arise from interactions with other medications, including OTC meds and herbal remedies. Again, from a stoic viewpoint, many elderly underreport side effects of medications. They may not want to "bother" their healthcare provider with minor problems. Additionally, older persons may not report all symptoms, which mean they cannot receive adequate treatment for a problem. This can greatly affect their quality of life and delay an improvement in their well-being.

Ideas about mental health and psychiatric problems are based on cultural values and understanding (Fontaine, 2009). Frequently, African American elders view behaviors related to psychiatric problems with stigma. They do not understand impairment in coping as a biochemical imbalance in the brain's neuroanatomical functioning, nor that depression is an illness and treatable. Many of the behaviors are not openly talked about because they attribute them to morals or bad child rearing. Self disclosure on certain topics is not acceptable. Two primary issues of concern to caregivers and healthcare personnel which can have negative consequences on the elderly are depression and abuse. Disclosure of both can destroy that independence which elders highly value.

In this author's experience as a psychiatric home care nurse, much of the suspected economic or verbal abuse was not perceived as abuse by the elderly recipients. The unknown future and the thought of change from their familiar surroundings may have also been factors in their denial or suppression of the suspected abuse. It is the duty of healthcare professionals to screen and educate the elderly. Strongly encourage them to ask questions of their healthcare providers and also to ask for help from their friends, family members, and agencies when thy have unmet needs.

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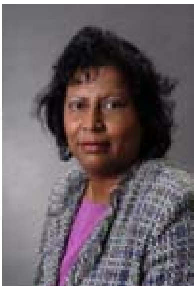

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Who Gets the Blame for the Lack of Quality Nursing Care

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The number of Nursing Home facilities in the Nation has been on the rise for the past decade. "Nationally almost 2 million Americans live in nearly 20,000 Nursing Homes at an annual cost of $53 billion" (Martyn, 2003). Unfortunately, people with little or no background in the needs of the elderly are investing in Nursing Homes without any consideration for ensuring adequate care for members of this population, many of whom have no relatives and no advocates. Administrators are more focused on meeting their needs than those of the residents. Most for-profit Nursing Homes hire insufficient number of certified Nurse Assistants (CNAs) and Registered Nurses. Additionally, they offer CNAs low pay that does not take into account the fact that the work is tedious and stressful.

The fact that nursing shortages are widespread is now considered old news, but these shortages do not justify sub-standard care. Due to the way the U.S. healthcare system is set up, people have to work to keep up with their healthcare bills, and since most families have young children, they find it difficult to care for an elderly person 24/7. In other cases, families make the decision to send their loved one to nursing homes when they think that they are too frail to be cared for at home. In such situations, their last resort is to send their loved one to a nursing facility, but they do so with confidence because they believe that trained nurses will be caring for their family member.

Sub-standard care had been attributed to several factors, one of which is the lack or delayed communication among nursing staff. Understandably, this had been attributed to the heavy workload of either the CNAs or the Licensed Nurses. The problem is that some nursing personnel do not recognize their ethical responsibilities and fail in their capacity to discuss their frustrations and anxiety for fear of losing their job even when the patients' safety is compromised. When care falls short of standards, whether because of resource allocation or lack of appropriate policies and standards, nurses shoulder much of the responsibility" (Hughes, 2008). According to Hughes, the Joint Commission on Accreditation of Healthcare Organization have found communication to be the primary root cause of more than sixty sentinel events reported to the joint commission. Problems with communication can lead to misunderstandings, loss of information and the wrong information.

In some facilities Licensed Nurses are assigned 30-40 residents at a time. At the end of the day they're burnt out with tremendous workload. The CNAs in such facilities often perform double duty, running from room to room answering call lights and, at the same time, trying to complete their regular tasks. In the process, some basic nursing care is overlooked. On the other hand, the licensed nurses, for the most part, may end up relying on the CNA flow sheet for information about the patients' condition. They get so busy & exhausted after working long hours that they neglect to communicate verbally or in writing with each other regarding change in residents' condition. Some licensed nurses tend to focus their attention only on those patients noted on the 24-hour report sheet. The only time some of these nurses respond is when the family is present or when the CNAs' suddenly remembers a change in status that went unreported. The success of every nursing home depends mostly on both the efficiency of the CNAs and the licensed nurses because they are considered the eyes and ears of the nursing home.

While I give kudos to my colleagues out there who have worked hard to change the values, practices, and culture of elder care, the following question remains: What can we do to improve the quality of care our elderly residents receive, most of whom are dependent on us for their survival? The key to this will be to create an atmosphere where the healthcare professionals can work closely together and offer regular in-services on the benefits of direct communication among the nurses and CNAs and ways such communication could improve patient outcomes. Early detection of changes in patient's condition can save or prolong lives; therefore, licensed nurses should constantly ask the CNAs what each patient's condition was when they last went into the room. Most importantly, nursing home facilities should be mandated to provide adequate staffing, by employing enough licensed nurses and CNAs to meet the patient population's needs. This would go a long way in improving quality care among our elderly population.

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Vitamin D Status in Elderly: A RISING CONCERN

MARIE SPANO, MS, RD

According to data from the National Health and Nutrition Examination Surveys (NHANES), vitamin D insufficiency is on the rise.[i] The aging population is at a particularly high risk for low vitamin D due to diet and lifestyle choices. Many elderly individuals do not meet their nutritional needs, including vitamin D. Further, they spend less time outdoors, wear more protective clothing and sunscreen when outside or live in areas where the sun rarely shines. These factors make it difficult to obtain enough sun exposure to manufacture adequate amounts of vitamin D.[ii]

Vitamin D is a fat-soluble vitamin that is converted into its active hormone form in our body.[iii] Though vitamin D can be manufactured in our body upon sunlight exposure, the elderly populations — especially African Americans — have a decreased ability to manufacture this essential vitamin. As we age, the body's synthesis of vitamin D is decreased as is the kidney's ability to convert vitamin D to its active hormone form. Older individuals and those with dark skin must spend more time outdoors to stimulate the same level of vitamin D production as a younger person with light skin. Those who are 50 years of age or older are considered at higher risk for developing vitamin D deficiency.[iv]

Why is vitamin D so vital for this population? With age, we lose bone density and muscle tissue, which may affect balance, thereby increasing the risk of falling and fracturing bones. Calcium and vitamin D are critical for maintaining bone strength and density. Vitamin D helps promote calcium absorption and helps our body maintain adequate blood concentrations of calcium and phosphate. Blood concentrations of both calcium and phosphate are used to mineralize bone. And, serum calcium levels must be maintained within a narrow range for normal nervous system functioning.[v]

Though hard and seemingly static, bone tissue is actually very dynamic. Bone remodeling, the process of removing old bone tissue and replacing it with new bone tissue, takes approximately six months and helps keep bones strong. Vitamin D (in addition to calcium and other minerals) plays an important role in bone health. In fact, insufficient vitamin D levels can lead to bones that are thin, brittle and misshapen.[iii] Two diseases that may result from vitamin D deficiency are rickets, which affects children, and osteomalacia, which affects adults. Both diseases are characterized by softening of the bones and skeletal deformities.[iii]

Though bone density cannot increase after the age of about 35, we can prevent the progression of bone loss as we age. This becomes especially critical in the elderly to minimize the three F's: frailty, falling, and fractures. Getting adequate amounts of vitamin D each day is essential for strong bones. Elderly people can boost their vitamin D levels by eating foods naturally rich in vitamin D, such as oily fish (salmon, mackerel, sardines) and cod liver oil as well as from fortified foods including orange juice and milk (both with 100 IU per 8oz), yogurt, some cereals or by taking a supplement. Many experts now recommend that older adults who do not obtain adequate amounts of vitamin D from their food take a vitamin D3 supplement of at least 1000 IU to ensure adequate daily intake. In fact, the American Academy of Dermatology recommends that the public obtain vitamin D from nutritional sources and dietary supplements, and not from unprotected sun exposure.

Studies have shown elderly people who take vitamin D supplements suffer less fractures. In a meta-analysis on 12 published clinical trials of oral vitamin D supplement use

among adults age 65 or older, researchers found that persons taking a 400 IU vitamin D supplements daily decreased the risk of non-vertebral fractures by 14 percent and of hip fractures by 9 percent. In nine of the trials, participants were given more than 400 IU per day. At a higher dosage, vitamin D supplements reduced non-vertebral fractures by 20 percent and hip fractures by 18 percent. This study indicates that the elderly may benefit from vitamin D doses over 400 IU per day.[vi]

Aside from its crucial role in the aging population and bone health, vitamin D also plays a role in the proper functioning of our neuromuscular and immune systems.[vii] In addition, it helps influence gene expression and plays a role in reducing inflammation.[viii] Studies have also shown a link between vitamin D and heart health as well as breast and colon health. Vitamin D is crucial for fertility, glucose control, reducing high blood pressure and managing seasonal affective disorder (SAD). In short, vitamin D affects almost every part of the body and affects everyone from infants to elderly.

Because it is difficult to get enough vitamin D from diet and sunlight, taking a supplement is often recommended. Many elderly people, as well as children and teens, have a difficult time swallowing pills. A liquid vitamin D supplement, like the one from WELLESSE®, is an easy way to obtain the vitamin D they need without having to swallow one more pill.

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