

HEALTHY AGING

Profile of the Issue:

Over the last century, life expectancy in the U.S. increased by approximately 30 years. Only about five of those years were due to improvements in medicine and health care. The vast increase in life expectancy – 25 years – is due to improvements in public health and preventive medicine.¹ During this era of great achievement, concerns regarding mental health were largely ignored and attention to dental health has been minimal. Additionally, our built environment has negatively impacted our ability to stay active. Current contributions in mental health research are demonstrating the connection between “mental” and “physical” health. Furthermore, there is mounting awareness of the value of prevention in the older population.

Depression is prevalent among older adults. Eight to twenty percent of older adults in the community, and up to 37 percent in primary care settings, experience symptoms of depression.² The most serious consequences of depression in later life – especially untreated or inadequately treated depression – are increased mortality from either suicide or somatic illness. Persons age 65 and older have the highest suicide rates of any age group, and individuals age 85 and older have a suicide rate twice the overall national rate.³

Depression has also been linked to an increase in other diseases as well. Chronic depression (lasting an average of about 4 years) raises the risk of cancer by 88 percent in older people.⁴ Both major and minor depression are associated with significant disability in physical, social and role functioning.⁵ A study of older adults in Baltimore showed individuals with depressive symptoms were at increased risk for subsequent functional impairment, cognitive impairment, psychological distress, and death.⁶ Major and minor depression is associated with high health care utilization and poor quality of life.⁷

Several barriers exist to prevent older adults from accessing services. One barrier is the myth that depression is a “normal” response to loss of a loved one, increased physical limitations, or a change in one’s role in society. Even physicians often accept depression in older adults as “understandable” or “normal”. Physicians under extreme time constraints often feel unable to investigate depression. Since depression frequently amplifies physical

¹ U.S. Dept. of Health and Human Services, Fact Sheet, *Disease and Health Promotion at HHS*, Oct. 26, 2006.

² Alexopoulos, 1997; Gallo & Lebowitz, 1999.

³ U.S. Dept. of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD, 1999, pg. 350.

⁴ Penninx et al., 1998.

⁵ Wells, et al., 1989.

⁶ Gallo et al., 1997.

⁷ Unutzer et al., 1997.

symptoms, an individual may focus on that instead of the underlying depression. They may also deny depression due to the stigma of mental illness. Individuals and their families may under-report symptoms and not seek care due to the belief depression is a “normal” part of aging. The lack of access to mental health programs both nationally and locally - especially those targeted to older adults – provides a further barrier. Treating older adults with mental disorders accrues benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider’s directions and advice.

There have been many studies that prove social supports are also a guard against depression. Since elderly individuals who live alone are considered at greater risk for loneliness, depression, and decreased mobility, social supports are particularly necessary for this group. Senior centers are an excellent environment where new supportive friendships can easily be formed. These friendships and other center activities have positive mental and physical outcomes.⁸ Not only do the vast majority of senior center users report that senior center programming has improved their mental and physical health, over 75% indicate that the center has helped them to remain independent.⁹ Senior centers continue to provide a safety net for at-risk individuals.

Snohomish County utilizes its Disease Prevention and Health Promotion funds through a program specifically focused on geriatric mental health. The Geriatric Depression Screening Program serves non-institutionalized, Snohomish County residents 60 years-of-age and older with outreach to, and early intervention for, isolated individuals who may be suffering from depression; education related to preventing and identifying depression; health screening related to depression; and education/advocacy for individuals to effectively communicate with physicians. For individuals who score greater than 14 on the Depression Scale, additional services are provided, including short-term mental health counseling using cognitive, behavioral and interpersonal approaches. The program also provides workshops around mental health issues.

Geriatric Depression Screening uses “strongly recommended interventions” as detailed by a study evaluating interventions on a stand-alone basis with depression treatment as the targeted outcome. As rated by the University of Washington School of Medicine, Dept. of Psychiatry and Behavioral Sciences,

⁸ *Impact of Senior Center Friendships on Aging Women Who Live Alone*, Journal of Women and Aging, Ronald H. Aday, PhD, Vol. 18, Issue 1, pg. 57-73

⁹ *Identifying Important Linkages Between Successful Aging And Senior Center Participation*, Ronald H. Aday, Ph.D., American Society on Aging, March 2003.

the “Depression Care Management” interventions received the highest effectiveness rating.¹⁰

Another program focused on geriatric mental health is the Peer Support Program which uses trained volunteers (55+) to provide one-on-one individual supports to older adults who reside in the community, congregate care facilities, or adult family homes. The individuals served have situational depressions serious enough to jeopardize the older person’s ability to live independently. The program also provides follow-up through small support groups. When issues become too complex for the skill level of the paraprofessional volunteers, a geriatric mental health specialist is engaged.

To continue building upon the geriatric mental health services already in existence, Snohomish County received a grant in 2007 from NSMHA to develop the Snohomish County Geriatric Mental Health Access Project (GMHAP). GMHAP will create a coalition of representatives from the mental health, aging, and substance abuse communities to produce a report on the mental health needs of older adults in Snohomish County. This report will include an estimate of the size of the problem and the extent to which needs are unmet. The coalition will: document the extent to which services are available and provided to older adults with mental disorders in Snohomish County; research and evaluate evidence-based or promising practices that address the specialized mental health needs of older adults; and design an integrated model for Snohomish County.

Similar to a lack of attention to mental health needs of older adults is the dearth of available dental care services. “Oral health problems among older adults can lead to needless pain and suffering; difficulty speaking, chewing and swallowing, and loss of self-esteem.”¹¹ Medicare does not cover routine dental services. While Medicaid does cover some routine dental services, the minimal payments received from Medicaid results in few dentists accepting Medicaid clients. Older adults (65- to 74-years-old), had a 17% rate overall of untreated dental caries from 1999-2002. This number shot up to 28% for low-income people (under 100% of poverty).¹²

Population-based studies have demonstrated an association between periodontal diseases and diabetes, cardiovascular disease, and stroke. Many diseases and conditions can be seen in simultaneous ailments of the mouth and

¹⁰ *Defining the Public Health Role in Depression and Depressive Disorders for Older Adults*, John Frederick, M.D., Mark Snowden, M.D.,M.P.H., Dept. of Psychiatry and Behavioral Science, University of Washington School of Medicine.

¹¹ Centers for Disease Control and The Merck Company Foundation, *The State of Aging and Health in America 2007*.

¹² National Center for Health Statistics, *Health, United States, 2006*, Hyattsville, MD: 2006

teeth. In fact, oral disease may be the initial sign of other diseases and prompt the need for further assessment by a doctor.¹³

In addition to national data, the lack of dental care resources and access were identified as major problems in the focus groups conducted by Snohomish County Long Term Care & Aging (LTCA). The Chinese, Filipino, Korean, Vietnamese, and Hispanic seniors groups all indicated they had trouble accessing dental care. Lack of financial resources to pay for dental care, and the inability to find dentists accepting medical coupons for care were both cited as problems.

Also needing prominent mention is the critical role nutrition and physical activity play in successful aging. Nutrition serves as a primary prevention strategy by promoting health and functionality. As secondary and tertiary prevention, it is an effective disease strategy that lessens chronic disease risk, slows disease progression, and reduces disease symptoms.¹⁴ It has also been proven that an active lifestyle delays cognitive and physical declines.

All of the top nine chronic diseases have nutrition implications. They include heart disease, hypertension, stroke, emphysema, asthma, chronic bronchitis, cancer, diabetes, and arthritis. Nationally, 32% of older adults have heart disease, 52% have hypertension, 20% have cancer, and 17% have diabetes. (Snohomish County Meals on Wheels participants mirror these statistics with the exception of diabetes which is present in 28% of the population). When coupled with obesity, which is present in 30% of older adults, they account for almost all the Medicare spending over the past 15 years. It has been documented that nutrition interventions improve efficacy and effectiveness of associated medical, pharmaceutical, and rehabilitative treatments.¹⁵

Most Meals on Wheels programs (delivering meals to the homes of individuals with disabilities) only provide one meal a day, which in many cases, is not sufficient. While few in number, there have been studies documenting the impact of additional meals on health outcomes. Participants who received higher levels of meals had significantly fewer hospital admissions, gained significantly more weight if underweight, reduced their nutrition risk, experienced increased levels of food security and had fewer depressive symptoms.

¹³ U.S. Dept. of Health and Human Services, Oral Health in America: A Report of the Surgeon General, 1997.

¹⁴ Position Paper of the American Dietetic Association: Nutrition Across the Spectrum of Aging. *J Am Diet Assoc.* 2005; 105:616-633.

¹⁵ National Resource Center on Nutrition, Physical Activity & Aging. Older Americans: Making Food & Nutrition Choices for a Healthier Future. April 2007. Accessed at http://nutritionandaging.fiu.edu/Center_Initiatives/Fd%20Nutr%20Choices%20Paper%20April%202007.pdf

In addition to nutrition, there is strong evidence that regular physical activity provides numerous health benefits to older adults including weight management and improvements in blood pressure, diabetes, lipid profile, osteoporosis, osteoarthritis, optimal mental health, and enhanced quality of life. It is associated with decreased mortality and age-related morbidity in older adults. Yet nationally, only 27% of persons 65-74 years of age and 20% of persons 75 years of age and older engage in regular leisure time physical activity.¹⁶ Encouraging older adults to be physically active can help them reach their highest level of function and health related quality of life.

Problem/Need Statement:

Snohomish County is experiencing an enormous increase in the number of its older adults. There needs to be an increased response to both the physical and mental health needs of these individuals, through disease prevention and education.

Research has proven that untreated depression can lead to physical deterioration, cognitive impairment, and suicide. LTCA will increase access to age-appropriate services to assess individuals, provide counseling, and educate the public about geriatric mental health issues. This also means increasing access to information about emergency preparedness. Disaster disrupts our way of life and peace of mind. It can make people feel unsafe and afraid and may increase feelings of mistrust and prejudice. Being mentally and emotionally prepared is the best way to reduce the effects of natural disaster or terrorism.

Untreated dental disease can lead to deterioration in overall physical health of individuals. LTCA will increase access to dental health education and dental services for Snohomish County older adults, with a particular focus on low-income individuals. Lack of adequate nutrition and physical exercise, as well as social connectedness, can contribute to chronic diseases, increase the symptoms of some diseases, and can lead to premature institutionalization. LTCA will increase advocacy and education efforts targeted to nutrition and physical activity for older adults.

Goal:

Promote equity and resources for older adults to access mental health care.

Objective 1:

Implement evidence-based practices to improve the mental health of Snohomish County seniors.

¹⁶ 2006 Older American Update: Key Indicators of Wellness. Accessed 8-8-07 at http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/Data_2006.aspx

Measurable Activity: Provide information to local service agencies that can promote disaster preparedness and education for both personnel and clients. A minimum of 12 agencies will be contacted by December 2008. All subcontractors will have disaster preparedness responsibilities built into their contracts by December 2009.

Measurable Activity:

Advocate for implementation of recommendations of the Geriatric Mental Health Access Project conducted in 2007. (The Geriatric Mental Health Access Project (GMHAP) will design and develop a mental health services delivery model focused on older adults and integrated cross-system partnerships.) Ongoing.

Goal:

Promote equity and resources for older adults to access dental care.

Objective 1:

Expand options for dental care and prevention of dental disease in older adults in Snohomish County.

Measurable Activity:

Expand dental health promotion efforts in Snohomish County by December 2009 by methods which may include:

- a. Seek resources to underwrite expansion of dental health promotion efforts.
- b. Conduct a dental supply drive.
- c. Conduct a dry mouth awareness campaign.

Measurable Activity: Expand dental services for low income seniors in Snohomish County by December 2010 by methods which may include:

- a. Conduct a Dental Summit
- b. Explore connections with UW School of Dentistry
- c. Advocate for expansion of mobile dental van services

Goal: Promote successful and healthy aging through quality nutrition and physical exercise.

Objective 1: Expand options for adequate nutrition services for older adults.

Measurable Activity: Advocate for expansion of Meals on Wheels to two meals per day per participant. Advocacy efforts will be targeted to state legislators. December 2008

Measurable Activity: Provide information to ethnically diverse populations on healthy eating and available nutrition services. Ongoing.

Objective 2: Expand options for physical activity for older adults.

Measurable Activity: Promote awareness and education regarding the need for physical activity in healthy aging. Ongoing