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INTEGRATED TREATMENT FOR SUCCESSFUL AGING

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Contrary to the ageist assumptions of modern society, it is possible to age well. This being so, physical and behavioral health providers ought to ask themselves what they can do to promote successful aging.

Part of the answer, of course, is just to provide good treatment for physical and behavioral health conditions experienced by older people. But this is just part of what health providers can and should do, particularly now that the American health care system is becoming increasingly comprehensive.

In what follows I will discuss what successful aging is and then suggest a number of ways in which large physical health care groups—including group private practices as well as community health centers—and behavioral health practices, programs, and centers can organize to promote successful aging. Integrating care, I will suggest, is a key component of this.

Successful Aging

In a recent review of the research literature on successful aging, Dillip Jeste and his colleagues say that they found 28 research studies that met their standards of research and that within these studies they found 29 definitions of successful aging. Obviously, the science of successful aging has a long way to go. Nevertheless, they found it useful to classify the definitions into two fundamental types—"objective" and "subjective".[1]

Objective concepts of aging well focus on measurable physical and mental characteristics. Basically, a person is regarded as aging well objectively if they are physically and mentally healthy, not disabled, and cognitively intact. We all know such people, particularly at the younger edge of aging—people who are in great physical shape (for their age), are still highly functional at work and/or play, and generally are still energetic and active.

Subjective definitions of successful aging are drawn from what older people say about themselves when asked how they are doing. Recent research indicates that most older people, especially as they get closer to the older edge of aging, are not aging well objectively; they are experiencing significant declines in physical and mental functioning, if not outright, disability. But most of them—even those with functional impairments--feel good about their lives.

People who are aging well subjectively generally share a number of characteristics including a positive attitude, a sense of optimism, resilience, and adaptability, traits they were fortunate to acquire as they were maturing. They also have active relationships with people they care about and who care about them, and they engage in activities that they find enjoyable, engaging, and—in many cases—meaningful. These activities may include paying work, although most working people retire eventually. They often include volunteer work for a cause they care about. They also can include new active roles in the family, such as being grandparents who share caregiving with their children. Older people who are happy with their lives also get great satisfaction from hobbies, such as golf; from creative activities, such as painting; from travel; from learning put off due to busy lives, from being an appreciative spectator of sports and the arts; and so forth.

It is important to note—although fairly obvious—that people with depressive disorders usually don't feel good about their lives, that people with anxiety disorders find it difficult to form trusting relationships or to do something new and different, and that people with substance use disorders are not likely to get the most out of their lives. (Overuse of alcohol and of prescription and over the counter drugs—especially painkillers—are the core substance use problems for older adults.)

Younger people in our youth-oriented society often find it difficult to understand that most of those of us who are older are happy with our lives despite the typical declines we experience as we age. But the fact of the matter is that we are at a different developmental stage, in which many of us experience a state of consciousness that is different from and alien to the experience of younger people.

For example, I have eight chronic conditions and slightly limited mobility. I simply don't have the amount of energy that I had in the days when I routinely worked 12 hours a day and had ambitious goals for myself and the organizations in which I played leadership roles. But I'm OK with that. I'm still active and involved. But I have different expectations, desires, and goals.

Understanding developmental changes is a critical aspect of understanding subjective, successful aging.

Implications for Providers

Health providers generally pay attention to the factors that contribute to **objective** successful aging—good physical and mental health, absence of functional disability, and cognitive capacity. Subjective successful aging is another matter.

Health Care To Promote **Objective** Successful Aging

Unfortunately, physical health providers usually don't pay enough attention to behavioral health issues, and historically behavioral health providers have not paid enough attention to physical health issues. These facts are now well-known and have led to a widespread call for enhanced "integration" of treatment for people of all ages, including older people. Proposed improvements include:

- Routine screening by physical health providers for behavioral health conditions such as depression, anxiety, and substance misuse.
- Routine monitoring of health and health care by behavioral health providers.
- Improved quality of care, built on the use of evidence-based practices
- The use of care managers for outreach and engagement and to promote adherence to treatment regimens
- Improved communication and coordination among physical health, mental health, and substance abuse providers especially through the use of computerized information systems
- More co-location of physical and behavioral health services
- Greater connection between acute and long-term care for both physical and mental conditions
- Greater attention to improved functioning in the community rather than just to treatment of disorders
- Ideally, increased use of integrated treatment team models.

It is important to note that most care for older adults is provided by people with no special knowledge about geriatric medicine or behavioral health. This is generally problematic, but it is of particular concern because of the changing risks of certain medications and dosages as people age. For example, some anti-depressant medications increase risks of disability and mortality in older people. And some anti-psychotic medications can have a perverse effect on people with dementia.

Clearly, there's a significant need for development of a knowledgeable workforce in geriatric physical and behavioral health as well as for more extensive use of tele-medicine to spread the limited expertise that exists.

In addition, "wellness" has become an increasing focus for healthcare providers. This basically means helping people to maintain and improve their physical and mental health. It includes: weight control, smoking cessation, limited use of alcohol and other addictive drugs, good nutrition, and adequate exercise.

Of course, there's nothing new about this in standard medical practices. Doctors have been telling their patients to lose weight, stop smoking, get exercise, etc. for many, many years. For the most part patients ignore their doctors' advice.

Wellness is relatively new for behavioral health providers, who historically ignored their patients' physical health. Now it is a major focus of psychiatric rehabilitation.

The key to effective wellness is helping people to do what they mostly know they should do. It can be helpful to engage people in group approaches to smoking cessation, weight control, exercise, and confronting addictions.

But a great many individuals simply aren't joiners. Lifestyle changes happen when people are motivated to change. Increased use of motivational interviewing in physical and behavioral health practices could make a big difference.

That said, health education is surely useful for some people. For example, people diagnosed with diabetes frequently haven't a glimmer what they can and can't eat. Intelligible classes and literature could be helpful for many such matters.

Health Care To Promote **Subjective** Successful Aging

What physical and behavioral health care providers can and should do to promote successful **subjective** aging is far from obvious. Is it really the responsibility of health care providers to promote self-esteem? Is it really the responsibility of health care providers to help their patients maintain or develop social connections and to engage in activities they find pleasurable, engaging, and/or meaningful? Don't health care providers have more limited responsibilities for health promotion, prevention of illness, treatment of disorders, and rehabilitation? Aren't they already too busy with their traditional responsibilities without taking on more?

These are, I think, reasonable questions. But they strike me as more reasonable in the context of solo, private practice, which was the norm until recently. Now that solo practices are disappearing into large groups that are able to hire staff for health education and wellness, it seems to me that the social roles and responsibilities of these practices (most of which aspire to be "medical homes") should be extensively reviewed.

So, what can large practices and community health and mental health centers do to promote subjective successful aging?

1. Integrative Medicine: Dillip Jeste and his colleagues at the Center for Healthy Aging of UC San Diego have developed an approach to promote well-being in old age that they call "Integrative Medicine" (IM).[2] It "evaluates physical, emotional, mental, social, spiritual, and environmental influences in order to optimize well-being. IM includes non-pharmacological and less invasive interventions when appropriate, thereby incorporating many complementary and alternative medicine treatments in practice" (e.g. acupuncture, aromatherapy, massage, meditation, tai chi, yoga). They are finding that this integrative approach promotes "compassion, optimism, and wisdom" in old age.[3]

2. Respect: All interactions between staff and older patients (younger too) should be insistently respectful. Core to this is engaging patients in decision making. But minor matters also make a difference. For example, if my doctor is going to call me by my first name, I want to do the same. And I certainly don't want to be called "honey" or "sweetie", especially by kids who are wet behind the ears.

3. Asking About Life: Questions about what and how an older patient/client is doing not just medically but also in life in general should be a routine part of the provider-patient interview. Since having pride in past as well as being active in the present is a key component of aging well, it would be great for providers to let their patients/clients reminisce a bit.

As I write this, I hear some providers respond, “You think I have enough time for this? Give me a break.” And “What am I going to do if a patient begins to open all sorts of issues in their lives that I don’t have time, skill, or resources to deal with?”

4. Concierge Services: Although these are perfectly reasonable concerns in the context of solo practices, is it really unreasonable to expect large group practices to have someone on staff—as they have nutritionists and social workers—who can help a person who is isolated and inactive to connect with local resources? It strikes me that they could have a “concierge” available, as they do in good hotels and VIP units in some hospitals, to help people to make connections in their community.

5. Alternative interventions: Jeste’s concept of integrative medicine includes an emphasis on non-pharmacological and even non-medical approaches. A large group practice could provide access to, or even provide directly, alternative interventions such as yoga, exercise, and acupuncture.

6. Community Education: Health and mental health centers and group practices could provide education related to successful aging similar to the community health education most now provide for smoking cessation, weight loss, diabetes management, etc.

7. Life Planning: A practice that wants to present itself as a go-to place for successful aging could also add a life planning division. Obviously this is not a medical service, but it is a service that many older adults want and some will pay for.

8. Volunteers: since volunteering is a major way in which many older adults get meaningful roles in their lives after they have retired and no longer have childrearing responsibilities, community based practices, programs, and centers might add roles for volunteers. Inpatient facilities have done this for years. Why not in community settings as well?

Clearly, I am proposing substantial additions to current community-based physical and behavioral health practices. I imagine that one initial response will be, “How will we pay for the new services? I confess that I have not yet worked out the details of this, but there are several general responses.

First, some of these services are covered by health insurance for older adults including Medicare and Medigap plans.

Second, some patients/clients can and will pay for these services. In fact, many already pay for similar services such as membership in a gym, yoga classes, elder care management, and more.

Third, some of these services will attract well-insured older people, not a minor matter in environments where market share is so competitive that health care providers spend a lot of money for advertising.

I am optimistic that over time health and behavioral centers and practices will realize that a very substantial and growing portion of their clientele are old and that it is both good health care and good business to focus on helping older adults to age successfully. It would be nice to be right and to live to see these changes take place.

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[1] Jeste, DV et al. "Successful Cognitive and Emotional Aging" in *World Psychiatry,* June 2010.

[2] Jeste, DV. "Promoting Successful Ageing Through Integrated Care" in *BMJ,* November 10, 2011.

[3] Sundaram, JP. "More Than Just Better Physical Health: Can Integrative Medicine Increase Sagacity in Older Adults?" *The American Journal of Geriatric Psychiatry*, March 2014.