Health promotion in the elderly with coronary artery disease

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The number of elderly Americans, those over the age of 65 years of age, continues to climb. A lifetime of poor nutrition and lack of exercise has led many elderly patients to experience coronary artery disease (CAD) later in life, leading to invasive procedures and other forms of disease management that contribute to mounting health care costs and lower quality of life. Although health promotion has been accepted as the necessary answer to this problem by many in the healthcare community, many physicians are still lacking in promoting this concept, often due to the lack of insurance reimbursements. This paper will explore three key disciplines linked to health promotion in the elderly and why this topic is so vital for our future. (J Vasc Nurs 2014;32:151-155)

According to the World Health Organization, health promotion is defined not only as increasing a person's health, but also giving them control over it.[1] According to the US Census,[2] there are approximately 40 million persons aged ≥65 years (13% of the American population). Because of greater longevity of adults in America, there is increased likelihood of the elderly population experiencing coronary artery disease (CAD) and requiring invasive treatments. These patients require complex management of comorbidities, which lessens their autonomy; retirement funds may be inadequate to meet their medical needs. This situation causes a strain, not just on the person and his or her family, but also on insurance carriers and health care facilities struggling to deal with an increasing number of older patients. As a result, many disciplines have focused on health promotion within this population. Depending on the application, health promotion in this aging group can have many focuses, ranging from disease management to secondary prevention. Terms such as wellness, autonomy, health enhancement, injury prevention, and disease management have all been used in reference to health promotion. As a result, an analysis of the concept of health promotion should occur to help caregivers to determine the best mix of interventions to help foster the optimal outcomes in this maturing population.

REVIEW OF LITERATURE

According to the American Heart Association,[3] an estimated 42.2 million persons who are ≥60 years of age have some sort of cardiovascular disease. More disciplines are recognizing the need to see patients as a whole person rather than just focusing on components or disease processes. In an effort to find the most complete definition of health promotion among the elderly, published literature from multiple health care professions were explored for evidence of this concept. Antecedents, criteria, and consequences as they relate to health promotion are discussed, which could also be relevant to the in the elderly, specifically with CAD. This article focuses on the review of three of these disciplines—nursing, psychology, and medicine—discussing a minimum of two articles from each discipline. A comprehensive literature review as it applies to these disciplines, as well as instruments used where applicable, is presented.

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NURSING

The Health Promotion Model was first developed by Dr. Nola Pender in 1982. She made several versions and revisions to address different influences on health behavior for both adolescents and adults focusing on factors she felt were needed for health promotion such as spiritual growth, interpersonal relations, nutrition, physical activity, health responsibility, and stress management.[4] This middle-range nursing theory took aspects from the expectancy-value model and the social cognitive theory and created a model employing the nursing metaparadigm of person, environment, nursing, health, and illness.[5] This model has been used to help nurses to determine what motivates persons to seek health promotion, or health enhancement. There are three components to the health promotion model: Individual characteristics and experiences, behavior-specific cognitions, and health-promoting behavior.[4] She theorized that several intentions had to be in place for patients to seek and achieve health promotion. For instance, they had to see value in the benefits, they must feel competent to achieve the results, and they need a positive attitude and support from others in their environment.[4] These concepts of health promotion are particularly true for elderly patients with CAD because many are resistant to changing behaviors they have employed for a lifetime, especially if they feel it may only have a slight impact on their disease, such as diet improvement or increased activity.

Another prevalent term used to describe health promotion is wellness. The term wellness has links as far back as the 19th century, but was not considered a health promotion concept until the

1950s and then expanded into the wellness movement of the 1970s.[6] Dr. Halbert Dunn[7] took the concept of wellness and researched what it meant for the elderly specifically. Although he was a physician, his definition was less medical and more nursing, stating that what mattered more than the management of disease was maintaining a person's dignity and value. He felt that health promotion and wellness meant helping the person to achieve the highest level of functioning the person was capable in an ever-changing environment, which could be achieved in part through personal knowledge and creative expression.[8] This later became known as the Dunn Model of High Level Wellness. This model became the basis for further nursing work centering on wellness and the geriatric population. McMahon and Fleury[9] wrote a concept analysis paper focusing on wellness in the older adult incorporating both Dunn's and Miller's previous work, as well as Rodger's evolutionary perspective.[9] They stated that wellness in the elderly focused on optimizing potential and strengths and used concepts of becoming, integrating, and relating to further describe the term wellness as well as related concepts of health promotion and well-being.

Here are several additional nursing theories that have value in any health promotion discussion. For instance, Nightingale's environmental theory, developed in 1859, can also be used to guide caregivers looking to promote the health of the elderly population. She saw the basics of the environment—clean air, water, and good food—as being the root of healthiness.[10] Sadly, many of our older population do not have access to these basic items owing to limited funds. Another theory, Leninger's transcultural theory, developed in 1968, looked at beliefs regarding self-care and cultural values to determine how to provide holistic care.[10] This is an important theory when promoting health among the elderly because their beliefs regarding health can make a huge impact when expecting them to change behaviors. Orem's self-care theory (1985) is based around the concept of self-care.[11] The ability for an elderly patient to care for themselves is very important in order to maintain dignity and autonomy. The 2009 WHO conference in Thailand supported this concept, stating that self-care needed to be included in the methods of health promotion.[10] Finally, Nemcek's Self Nurturance Model developed in 2003 from the Health Promotion model and Health Belief Model, introduced the concept of self-nurturing into the health promotion discussion, which she felt supported life and growth.[10]

There are several antecedents, criteria, and consequences of health promotion that could apply to the elderly that were common among the nursing literature. These include the antecedents of dependence and disregard. Criteria focused on improving autonomy and attitude, as well as social contacts, which could help to reduce the antecedents, thereby leading to the consequences of dignity, health enhancement, and growth.

PSYCHOLOGICAL DISCIPLINE

Wilhelmson and Eklund[12] performed a randomized study evaluating life satisfaction and its effects on health-promoting behavior. The aim of the study was not too necessarily prevent disease in the elderly, but rather to maintain functional status. They concluded that, over time, no matter the health-promoting behavior, the patient would decline and become frail. This lead to feelings of fear and dependence; however, if the patient viewed their health at a higher level, whether it was accurate or not, had positive self-esteem, social support, and sense of worth, they were less disturbed by their functional decline. This study used the Fugl-Meyers Life Satisfaction Assessment questionnaire to measure life satisfaction which asks about the patient's satisfaction with eleven items including life in general and social connections. In addition, there are many other tools that are often employed in cardiac rehabilitation for elderly patients with CAD, to measure similar characteristics. The Geriatric Depression Scale (GDS), which was created by Yesavage in the 1980s, is one example.[13]

The transtheoretical model is another psychological tool used in health promotion among the elderly because it helps health professionals to determine what causes people to change.[14] This is especially important when determining what motivates adults to change bad behaviors and embrace positive ones, which is essential in controlling CAD. Lach et al[14] discussed the use of this tool and its five stages of precontemplation, contemplation, preparation, action, and maintenance in the health promotion of older adults. Specifically the authors used the transtheoretical model steps to help develop health promotion programs for the elderly based on their stage of change readiness. They again looked at the individual's view of the value of the behavior change as well as their ability to make that change and maintain it over time.

Whitehead's Social Cognitive Model of Health Promotion Practice, developed in 2001, list many of the antecedents and consequences in this manuscript as cues to action and nonaction. For instance, cues to action include motivation, acceptance and support whereas cues to nonaction include anxiety, fear, and denial.[10]

Many of the antecedents, criteria, and consequences of health promotion in the elderly found in the psychological disciplines were similar to the nursing profession. There was a focus on preventing the antecedents of isolation, dependence, and frailty of the elderly. This requires autonomy, positive attitude, and social support, as well as managing stress and anxiety. As a result, the consequences are similar to the previously discussed discipline: Providing the patient with dignity, wellness, value, and life satisfaction.

MEDICAL DISCIPLINE

From the medical perspective, health promotion is linked more with maintenance of disease processes through primary and secondary prevention. Richardson[15] looked at health promotion and disease prevention in the elderly. He used a quote from Mark Twain that is often the view of what being healthy means: "The only way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd rather not,[16p137]. Richardson stated that health professionals often focus on health recommendations that are meant for a younger generation, especially because there are few preventive guidelines for the elderly and even fewer that Medicare covers. Throughout his article, he used various screening procedures to guide what clinicians should focus on for health promotion of older adults, but very little was mentioned regarding the focuses that fell into the previously discussed disciplines. For example, for the chosen population of this paper, fasting cholesterol levels, blood glucose

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