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Health Concerns of the Oldest Old: A Pilot Study

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Abstract

The fastest growing age group in America is adults aged 85 years and over. The number of adults in this age group is expected to continue to increase from 5.1 million (in 2012) to 14.1 million in 2040. This nearly triples the number of older Americans in the 85+ age group over the next couple of decades (United States Department of Health and Human Services, 2013) . This oldest old group has reported some positive changes in patterns of aging compared to past decades. A study was conducted to explore the current health concerns of the oldest old group. A convenience sample of 12 volunteers in Northwest Indiana, ages 85–99, with an average age of 89.4, was interviewed. Interviews were transcribed and analyzed for themes and patterns using qualitative techniques. Major themes of positive aging that emerged included: staying active and engaged, staying healthy, and addressing fears. Findings were consistent with existing research that suggests that very old adults with positive health perceptions demonstrate inner strength, resilience, a distinctive lifestyle, stable social support, and a positive mental outlook. The purpose of this paper is to present the health concerns and perceptions of an oldest-old group. The findings from this study will also be compared with those from various international studies on perceptions of health among the oldest old.

Keywords: Oldest-Old; Aging Process; Health Perceptions; Health Concerns

Introduction

Although adults over age 85 are a quickly growing group, relatively little is known about the health concerns of the oldest old living in the community. The number of adults in this age group is expected to continue to increase from 5.1 million (in 2012) to 14.1 million in 2040. This nearly triples the number of older Americans in the 85+ age group over the next couple of decades [1] .

As life expectancy has increased, this cohort, often previously called the "frail elderly", has also experienced an increased incidence of chronic illness and disease. A single disease or health condition has not been identified in the literature to be of concern to this population; however, a number of studies have recognized that any condition interfering with independence is of greatest concern [2-4].

Research in the past decade has suggested that the perception of those over 85 years as being "frail elderly" may be changing. The primary investigator for this project, a gerontological clinical nurse specialist, had noted a trend toward

health aging and active living amongst suburban and rural older adults in Northwest Indiana. Much of the research in this age group has been done in large cities, and the researchers sought to explore any differences in aging among those in a smaller, more rural community. Thus, a qualitative research study was proposed to explore the health concerns of the oldest old.

The purpose of this paper is to present findings related to the health concerns of those over age 85 living in suburban and rural communities in Northwest Indiana. Themes and patterns emerging from the data will be discussed in relation to existing research on the oldest old in the United States.

A few studies have examined the health concerns of the over 85 age group in America. In a nine year longitudinal study which followed 23 community-dwelling individuals over the age of 85 years, overall health and memory were found to be the areas of greatest worry [3]. In another study of 19 men and women between the ages of 85-98 years who lived alone, traditional physical complaints of pain and fatigue were regarded as an expected part of aging, and therefore were not noted as primary concerns of the participants. Rather, the oldest old regarded their ability to function independently as their most significant health concern [2]. Finally, a qualitative focus group study (n = 26) took place at independent living facilities for elders. Participants included in this study included staff members, family of residents, and the residents themselves. For all three participant groups, falls were cited as the most significant health concern. Other frequently discussed concerns among all three groups were medication management, forgetfulness and confusion [4]

Alternatively, this oldest old group world-wide has also reported some positive changes from the past decades with regard to patterns of aging. There seems to be an international trend toward perceptions of better health in the oldest age group [5-8]. In a national study of adults over the age of 16 years living in Britain (n = 1,049), the ability to continue in enjoyable activities was found to be the greatest indicator of well-being for participants over the age of 65 years [5]. Similarly, in a longitudinal investigation focused upon health in the oldest old living in Sweden (n = 62), Bravell, Berg and Malmberg [6] found that self-reported objective measures of health and subjective perceptions of health may represent different dimensions in the elderly. Over the four years of data collection, it was found that subjective reports of health remained stable, even while objective measures of self-reported diseases increased. Likewise, in an investigation focused upon elderly individuals living in Serbia (n = 240), it was found that participants over the age of 90 years reported better perceived health than individuals between the ages of 60-74 years. When asked the question, "Do you feel pretty healthy now?" an affirmative response was received from 18.3 percent more individuals over the age of 90 years [8]. Comparable results have been found among the elderly living in the United States. While most older individuals experience at least one chronic health condition, 42 percent report their health as either excellent or very good [1].

Methods

A study using a semi-structured interview and qualitative methods was used to explore health concerns of the oldest old living in Northwest Indiana. Demographic and quantitative data related to health history were also obtained. A health history form was developed for use by the researchers (see Figure 1). Open-ended questions posed to participants were developed and reviewed by the research team. The team consisted of the primary investigator (a PhD prepared, experienced gerontological clinical nurse specialist), two MSN/FNP students with BSNs and a combined three decades of experience in acute and clinical care of older adults, and one undergraduate nursing student in gerontological nursing.

Sampling

A convenience sample of individuals age 85 years and over living in Northwest Indiana was recruited for this study. The participants in this study resided in two counties located in Northwest Indiana. The number of persons over the age of 65 living in these two counties is similar to the overall state average (13.9%) [1].

Following Institutional Review Board approval, flyers were distributed at the local senior centers, churches, to a group of retired persons in the university community, as well as assisted/independent living facilities to notify potential participants about the study. Local senior centers and retirement communities advertised the study in their newsletters. Word of mouth helped to recruit additional participants.

Inclusion criteria were adults over age 85 years, the ability to answer questions, and a willingness to participate. Those who were unable to answer questions during an interview were excluded.

Procedures

Informed consent to have his/her interview audiotaped and/or videotaped was obtained from all individuals who met the criteria for participation. An extensive health history as well as demographic data was collected from each participant using a researcher-developed form (see Figure 1). The participants were interviewed face-to-face by the primary investigator in their place of residence, whether a single family home or assisted/independent living facility. Others present during the interviews may have included a second researcher from the team and/or a family member, usually the spouse.

The semi-structured interviews focused on participants' concerns about their health, as well as allowed participants the

opportunity to rate their overall health and activity levels (see Figure 2). Participants were given a $10 honorarium at the conclusion of the interview. Interviews lasted from about 30 – 90 minutes. Interviews were continued until the research team determined that data saturation was achieved (n = 12).

Analysis

Field notes were kept before, during, and after each interview. Memoing, bracketing, and data reduction were used as part of the qualitative techniques for ongoing analysis of the data. The audio recordings were transcribed by the primary investigator or a member of the research team. The PI was present at each interview for consistency in data collection. The team members individually hand-coded the initial transcriptions, then later met to compare their coding of the first transcriptions line by line to identify common themes. In vivo coding was ongoing, and a constant comparison process was utilized. As additional concepts or themes emerged, these were checked with subsequent participants. Although the interview tool did not change significantly during the process, additional questions were asked of participants to validate prior findings from other participants. All final themes were agreed upon by the research team.

Lincoln and Guba's [9] criteria for evaluation of qualitative research were satisfied. The four essential elements of evaluation (***credibility, transferability, dependability, and confirmability) were met***. Credibility of the data was assured through persistent observation and referential adequacy. The researchers allowed adequate time with the participants and were able to additionally review audio and video recordings after the interviews to assure consistency of the findings [10]. Transferability was accomplished through thick descriptions in data collection and note-taking, adequate sampling, and achieving data saturation. An audit trail with deep descriptions through field notes was kept. Adequate sampling assured that data saturation was reached, in which no new data was emerging, and participants were telling similar stories with consistent themes and patterns. Dependability was satisfied through paper trails from the researchers, with reflective writing and comments made immediately after each interview. Confirmability was addressed through detailed field notes, ongoing analysis of the data through the constant comparison method, and confirming emerging themes with participants as the interviews were taking place. Reliability and validity in qualitative methods were thus met.

Results

Sample Characteristics

The convenience sample of mainly middle class participants was composed of 4 males and 8 females with the mean age of 89.58 years (SD = 3.68). Over half of the participants (n = 8, 66.7%) lived in their own homes, followed by independent living apartments (n = 4, 33.3%). Demographic characteristics of the sample are given in Table 1.

Table 1: Demographic characteristics of the sample.

Age	Gender	Marital Status	Educational Level	Living Arrangements	Number of Children/ Grandchildren
92	Male	Married	College graduate	Own home with spouse	4/5
87	Female	Married	Graduate school	Own home with spouse	12/26
87	Male	Married	Graduate school	Own home with spouse	6/14
88	Female	Widowed	Some college	Own home alone	3/7
89	Female	Widowed	Graduate school	Independent living apartment alone	0/2
99	Female	Widowed	Some high school	Own home with family member	2/6
90	Male	Widowed	Graduate school	Independent living apartment alone	2/2
87	Male	Widowed	College graduate	Independent living apartment alone	1/0
92	Female	Widowed	High school graduate	Independent living apartment alone	4/4
85	Female	Widowed	College graduate	Own home with family	5/9
91	Female	Widowed	Graduate school	Own home alone	2/3
88	Female	Widowed	Business college	Own home alone	2/3

The majority of the participants reported experiencing common aging conditions, with the average number of chronic conditions being 10.3 (SD = 5.87). Arthritis was the most common chronic condition reported (n = 10, 83%), followed by hypertension (n = 9, 75%), orthopedic problems (n = 8, 66.7%), heart problems (n = 8, 66.7%), and hearing loss (n = 8, 66.7%). One hundred percent of the male participants (n=4) reported prostate problems.

Despite the number of chronic health conditions reported,

50% of the participants (n = 6) stated that they had no health concerns at all. Ten participants rated their health as at least very good (average of 4.1 on a 1-5 scale). A total of 11 participants rated their activity levels as average (3.54 on a 1-5 scale). The overall health-related appearance of the participants, as rated by the interviewers, was recorded as either excellent (n = 4, 33.3%) or good (n = 8, 66.7%). Interestingly, when asked if there was a certain age in which they noticed a decline or change in activity, most reported that they began to give up certain activities (such as skiing) in their mid to late 80's.

In this investigation of individuals over the age of 85 years, three major themes related to aging emerged. These themes included: *staying active and engaged; staying healthy; and addressing fears.*

Theme #1: Staying active and engaged

Staying active and engaged was important to this cohort of older adults. The participants defined this theme in terms of four major foci: activities, hobbies, volunteering, and planning the day around a specific event or function. Activities (see Table 2) in which these older adults participated included gardening, game-playing, dinner out with friends, arts and crafts, puzzles, reading, walking, writing books, piano playing, and oil painting to name a few. They had many hobbies that helped them to feel part of life and the community. This was a very active group, with the mean number of regular activities reported per participant was 3.7.

Table 2: *Hobbies specifically reported by participants*

Hobby	Percentage of Participants	Number of Participants
Gardening	58.33%	7
Bridge	33.33%	4
Exercise	33.33%	4
Walking	33.33%	4
Reading	25%	3
Church activities	16.67%	2
Volunteering	16.67%	2
Visiting people	16.67%	2
Playing piano	8.33%	1
Dog rescue	8.33%	1
Bingo	8.33%	1
Arts and crafts	8.33%	1
Puzzles	8.33%	1
Visiting parks	8.33%	1
Hiking	8.33%	1
Watching television	8.33%	1

Many of the participants played key roles in volunteering within their community. Their volunteer activities were diverse and included dog rescue, "shut-in" visitation, helping at the Field Museum in Chicago, substitute preaching, President of the bridge club, watching grandchildren, assisting at the local National Park, and generally "helping others".

Planning the day around a specific event was the final subtheme of staying active and engaged, but one that influenced each of the other subthemes. Many participants had one activity around which the day was planned. This was often a doctor's appointment, helping others, or their volunteer activity. Each day may have only contained one specific activity that became the center of the daytime hours and what their day revolved around.

Theme #2: Staying healthy

The older adults in this study had much advice for staying healthy. The quotes below demonstrate that staying healthy involved both physical and psychosocial practices. Generally, the participants agreed that having a healthy lifestyle, eating good meals, and having good genes helped the aging process. The participants also offered the following advice to maintain physical health into old age:

"eat fruits, vegetables, and fish"
"don't drink or do drugs"
"don't smoke. Don't drink unnecessarily…and absolutely stay away from drugs"
"take care of the body through exercise, proper diet, faith, and humor"
"keep moving"
"don't lose your balance"

With regard to psychosocial secrets to health, these older adults believed that faith, friends, hobbies, companionship, being happy, and keeping mentally active were important components to successful aging. More specifically, some stated:

"work on puzzles every night"
"fun living"
"don't try to resist change"
"pay attention to your feelings and act on them"
"talk to your doctor and be honest with him"
"don't worry"
"friends are so important"
"friends are an important part of a reasonably happy aging process"
"make sure that you help other people as much as you can"

Theme #3: Addressing fears

The final theme that emerged from the data was *addressing fears*. This cohort of older adults named specific fears related

to their advancing age as well as some specific ways to address those fears. Major fears were falling/losing balance, suffering, finances, becoming dependent on others, being a burden, and losing independence. To cope with these fears, the group named several common strategies used. Some of these had a strong center in religion such as faith, reading the Bible, and going to church. Also listed were social support of family and friends, humor, and being happy and optimistic. Some older adults took specific steps to avoid injury including avoiding dangerous activities and being prepared in case of a fall. More specific strategies for being prepared in case of a fall included using a Lifeline or call lights, moving to assisted living, and keeping a cell phone in the pocket at all times.

Discussion

In general the participants viewed themselves as active older adults and an integral part of society and family. The average number of chronic conditions reported by the participants in this study was 10.3, with each reporting an average of 3.17 routine medications. In a study evaluating the health concerns and medication profiles of individuals 85 years and older living in Canada (n = 564), the average number of chronic conditions was 6.4, with an average of 6.8 routine medications per patient [11] . Thus, it appears that despite a greater number of chronic conditions, the participants in the current study took a lesser number of routine medications.

Although most had more than one chronic disease, they viewed themselves as healthy. The participants' ratings of their health and perceptions of their health did not correlate with their number or severity of diseases. These results are similar to a four year longitudinal study (n=62) in which participants' subjective reports of health remained stable despite declines in objective health status [6]. Similarly, in another longitudinal study of individuals over the age of 85 years (n=19), 17 subjects described their health as excellent or good despite the presence of at least one chronic health condition [2]. This brings into question the impact of subjective health in an older individual's ability to remain active and engaged despite declines in objective health status.

Staying active and engaged was important to the cohort of older adults in this study. Subjects reported being regularly involved in activities such as gardening, walking, exercise bike, hiking, and going to the beach. This group did not view themselves as frail or sickly. They were living full and active lives, only stopping more aggressive former activities when it increased the risk of injury or they were unable to perform them. In their analysis of data from the Leisure World Cohort Study [12], researchers found that older individuals who spent time in what they defined as active activities, either indoor or outdoor, had a lower risk of mortality than individuals who did not participate in active activities. Similarly, the active lifestyles of the subjects in this study may have allowed these individuals to enjoy the benefits of their active lifestyles into their later years. This cohort of older adults named specific fears related to their advancing age as well as some specific ways to address those fears. Fears related to occasions that would result in the older adult losing independence and having to depend on others. Interestingly, while participants mentioned fear of falling, their strategies for addressing fears were more related to faith and social support and less to maintaining strength or stability. Similar to the findings of this study's cohort, in a nine year longitudinal investigation following 23 participants over the age of 85 years, Jeon, Dunkle, and Roberts [3] found that as individuals aged, the number of worries related to memory issues and physical limitations increased. As they keenly indicated, "worries are future oriented and centered on the unknown," [3]. By providing the elderly with accurate health information and dispelling myths, nurses may be able to alleviate some of the fears of aging for the oldest old.

The three themes that emerged from the study suggested that this particular group of Midwesterners was demonstrating healthy aging into their later years. They did not exhibit characteristics of "frail elderly" as portrayed in earlier scientific literature. Conversely, these older adults (with an average age of nearly 90 years old) were active, engaged, vital members of society. They had numerous hobbies and regular activities. They were clear in giving advice on aging successfully by avoiding drugs and alcohol and by using humor, faith, thinking positively, and keeping active to cope with some of the more fearful aspects of advanced age.

Results from this study were similar results to those of Bryant, Corbett and Kutner [13], who used grounded theory methods to develop a model of healthy aging. Their 22 subjects were randomly selected from a group whose perceived health differed from predicted. Using semi-structured interviews, the researchers found that a model of healthy aging meant "going and doing."

This study aimed to explore the health perceptions of the oldest old in a suburban/rural area in Indiana. Limitations of the study include a small sample, lack of ethnic diversity, limited geographic location, and a better educated sample than would be typically expected. In addition, perhaps only those who were more healthy adults volunteered for the study. This study focused on community-dwelling elders, but those living in different settings such as long-term care facilities or highly urban areas would likely report different results.

When compared with urban dwelling older adults, perhaps those in suburban and rural areas have additional resources that promote health aging. A different cohort may have less access to volunteering opportunities, for example, than this group. Perhaps the relatively higher education level and socioeconomic status of the sample compared with prior studies resulted in more positive attitudes towards aging and/or influ-

enced activity levels.

These findings suggest ways to help gerontological nurses promote health in older adults. First, it appears that volunteering and staying engaged in the community may buffer illness and disease. Although this cohort of older adults had numerous chronic diagnoses, this was not enough to prevent their active engagement in society. Nurses can encourage elders to remain involved in their communities and to seek out volunteer opportunities. Secondly, gerontological nurses should realize that self-perceptions about aging amongst the oldest old is changing and is likely to continue to change. Additionally, the participants in this study stated cognitive and psychosocial strategies to address their fears, but little was said about using specific exercise or fitness strategies to address fears such as falling and loss of balance. Since cognitive-behavioral interventions have not been shown to significantly reduce fall risk, this was an interesting finding from this group [14] .

Fear of falling can negatively impact quality of life. A systematic review of 28 studies on fear of falling among community-dwelling elders showed interesting results. The main factors to reporting fear of falling were being female, being older, and having at least one fall [15]. In comparison, it is not surprising that fear of falling was a major sub-theme of this current study, as the participants were largely older females. With the only modifiable risk factor related to fear of falling being previous falls, it is logical to focus efforts on fall prevention. Gerontological nurses can make specific evidence-based suggestions to address these issues such as tai chi for balance [14], or regular exercise programs such as walking or physical therapy for endurance building [16].

The findings raised several key issues for possible future exploration. Future studies might focus on answering what influence geographic location, financial status, or accessibility to resources have on perceptions of aging. The issue of health perception not being related to number of chronic diseases bears further investigation. In addition, future research could focus on what factors most influence the perception of health among the oldest old or which factors promote remaining active and engaged. There may be specific volunteer activities that provide more meaning and a sense of fulfillment in this age group than others.

Conclusion

The authors conducted this study to explore the health concerns of the oldest old in Northwest Indiana. Major themes and subthemes arose from the data. Perceptions of health did not seem to be connected to the number of chronic conditions reported, but seemed to be more influenced by feeling active and engaged while still contributing to the community. One participant, an 88 year old widow who had cared for her husband with dementia, summarized her feelings about old age this way: “don’t’ give up one thing. Just hang in there and do it”.

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Appendix 1

Health Concerns of the Oldest Old – Interview Tool

Demographic data:

Name _____ Code: _____

Date of interview: _____ Phone number: _____

Address: _____

Gender: M F Age _____ BD _____

Approximate height _____ Approximate weight _____General appearance _____

Date of last doctor's visit _____

See physician regularly? Yes No How often on average? ___

Current living arrangement (circle all that apply):

alone with spouse with family member other

in own home in assisted living in independent living apartment in a facility

in another person's home (specify) in a nursing home/skilled facility other _____

Number of children _____ Number of grandchildren _____

Number of great grandchildren _____ Number of great great grandchildren _____

Pets (list) _____

History:

Hospitalizations:

Surgeries:

Have you personally ever had any of the following?

		NO		YES	NO
Head injury with unconsciousness			Thyroid Problem		
Arthritis			Rheumatic Fever		
Orthopedic problems			Hepatitis A,B, or C		
Asthma			High Cholesterol		
Bronchitis			Heart Problem/Murmur		
Emphysema			Diabetes		
Pneumonia			Seizure disorders		
Other breathing problems			Kidney/urinary tract problem		
Scarlet Fever			High blood pressure		
Hearing Loss			Cancer/tumor/cyst		
Recurrent Ear Infections			Spinal cord problem		
Visual Problem (other than glasses)			Eating disorder		
Hay Fever			Fainting		
Digestive Tract Problem			Sexually transmitted disease		
Gynecology Problem(s)			Shingles		
Recent Weight Change			Skin rashes		
Bleeding/Blood Disorder			Anemia		
Tuberculosis			Blood clots		
Chicken pox			Dizziness		
Recurrent Headaches			Stroke		
Females: Breast Problems Female organ problems			For males: Prostate problems Other male organ problems		
Back pain			Any traumatic injury not listed here		
Urinary incontinence			Confusion, memory loss		
Constipation/hemorrhoids			Depression		
Tobacco Use Pks/Day _____			Alcohol Use # times per week _____ amount per session _____		

Surgeries / Month – Year:
Chronic Health Problems:
Alternative Medicine Practices:
Medication Allergies:
Other Allergies:
Significant Family Medical History:

Medications (name, dose, frequency, how long taken?)

Herbs/vitamins/OTC/other:

Appendix 2

Interview questions

What are your major concerns regarding your health? (include physical and other)

What about your health causes you the most worry or stress?

Do you have other concerns that you consider "minor"?

On a scale of 1 – 5 (with 1 being not active and 5 being extremely active) how active do you consider yourself to be?

5	4	3	2	1
Extremely active	Very active	Fairly active	Not very active	Not active at all

What types of activities do you do, and how often (exercise, walking, gardening, housework…..)? Please describe.

Are there any ADLs that you are unable to do because of health reasons (dressing, grooming, bathing, eating, toileting)? If yes, please describe.

Are there any IADLs that you are unable to do because of health reasons (shopping, balancing the checkbook, talking on the phone….)? If yes, please describe.

On a scale of 1 – 5 (with 1 being poor and 5 being excellent) how would you rate your health overall?

5	4	3	2	1
Excellent	Very good	Good	Fair	Poor

Has your health changed significantly in the last 6 months? The last year? Or was there ever a time you can point to when you felt your health began to deteriorate?