

## Avoid "elder-speak" with your senior patients

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Within the next two decades, one-in-five Americans will be older than 65. Physicians face unique challenges in treating elderly patients, who often suffer from multiple chronic diseases, lower health literacy rates and difficulty paying for their care on a fixed income. ?

In an "AMA Moving Medicine" podcast episode about improving health outcomes for vulnerable patient populations, Paul H. Wick, MD, former chair of the AMA Senior Physicians Section, discusses health issues and disparities unique to elderly populations.

Below is a lightly edited full transcript of the presentation. You can tune in on Apple Podcasts, Google Play or Spotify.

**Dr. Wick:** The poet Robert Browning wrote this: "Grow old along with me! / The best is yet to be, / The last of life for which the first was made." That's ideal, but unfortunately there's a segment of the elderly that, because of some disparities and some problems, it's not a good situation.

We have a growing population of older adults. One-in-seven Americans currently are 65 years and above. In another 15–20 years, it will be one in five Americans are 65 and above. We have an aging population.

Currently there are 46 million people that are 65 or above. That will grow to 73 million in the next 15 years and will double to about 90 million in 30 years.

The care of these 65 and above, accounts for about two-thirds of the U.S. health care budget. We have a baby boomer population that's growing. Those that are 54–72 are coming on. Those will add to the population of the older adults. It's said that this population accounts for about 27% of doctor visits and 35% of hospital stays.

There are challenges to care for the elderly population and to promote good health. This is in spite of universal coverage for Medicare. ... Older adults are not isolated from other health disparities. Two-thirds have two or more chronic medical conditions. So that leads to the cost of treatment. Some

elderly on fixed income cannot afford the care. Therefore, they cut back, unfortunately, and have adverse health consequences of that. Their chronic disease may cause negative health consequences in mobility and activities for daily living. We know that the number with dementia will continue to rise with the population.

So, what are health care disparities that affect the elderly? Well to list these: One are the issues that the ethnic and racial minorities may have. Then there's the social factors: the economic problems, educational problems and even geography. The LGBTQ community, when elderly, have their special problems.

Health care literacy and communication: It is also a problem and a factor. Ageism, the concept of ageism. Mental health issues and cognitive issues affecting the elderly. We'll go into these each.

The National Institute of Health defined health disparities as the difference in the incidence, prevalence mortality and burden of disease, and other adverse health conditions, that exist among specific population groups in the U.S. The term health inequalities more often refers to those socio-economic differences.

For the purpose of my talk, these all run together. Regardless of your culture, your ethnic status, all of these other factors—the socio-economic factors, the literacy and communication—they all sort of blend together. So, it's often hard to say that it's all due to just the one factor.

We have an increasingly diverse ethnic and racial minority population. This will grow in America. Minority elders are expected to account for some 50% of elderly in the next 25–30 years. They may suffer a disproportionate burden of illness and early death. They may have greater rates of diabetes and cardiovascular disease. This affects their health, but also their family that may also be disadvantaged by this, and also the community that they live in, by the lack of improvement in their health status.

They may have different attitudes about health care. They may come from a culture that has certain taboos and attitudes about what is disease, what causes disease, what is the treatment? What are the providers?

The Robert Wood Johnson Foundation states that these disparities in health care cost \$6 billion per year. Studies have confirmed that lower educational and lower economic status adversely affects one's health.

Conversely, higher education and higher family income, more likely, is associated with being healthy. Older, non-Hispanic white adults are more likely to report being healthy.

Where you live affects your health. In my area, which is a smaller, metropolitan area, if you go to each of the surrounding counties, the longevity, on average, drops 10 years. And it may be affected a lot more in certain communities.

The older LGBT community has higher levels of illness, disability and premature death. About 50% report a disability and a third report depression. More than 20% do not disclose their sexual or gender identity to their physician.

So, health literacy and communication matter a lot. This is defined as the capacity to obtain, process and understand basic health information and services and make decisions accordingly based on that.

Those that are 65 and above have the smallest percentage of health literacy skills. Baby boomers are more likely to be tech savvy and ask questions, but there are really different attitudes about health care. We can predict that with less health knowledge there's going to be less management of one's illness by the person, and, therefore, a worse outcome.

So, we want to understand, does our elderly patient really understand us? Are we communicating with them? There may be problems with the elderly and hearing. They may not respond, they may nod, but they really may not hear or understand. ... There's some vision problems there. We have to be aware of the cognitive problems. With age, there can be some cognitive problems, which may be mild to more severe impairing their understanding of what we recommend.

The other thing is to avoid elder-speak unless it's necessary. Elder-speak is where you speak very slowly but very loudly to a person. Unfortunately, this may occur. You may be speaking to a 90-year-old retired professor that's got it and is very clear about things. So, we want to judge our patient and speak accordingly to them so that they can understand but also be aware and test their understanding of what we're trying to recommend to them.

Sometimes we want to involve a family, friend, caretaker, interpreter so that we can communicate and can have an understanding, and so they may process and have an understanding about what our findings and recommendations may be.

Then the concept of ageism, which is systematic stereotyping and discrimination of people because they're old. It refers to bias, prejudice, devaluation, negative attitudes. Well, you know, we may write off some complaint. "Oh well, that's just old age or depression. Depression occurs. Old age is depressing, you know. Get over it. Live with it. So that we can go on."

The problem in this is that intent affects the outcome. How we perceive things, what our personal attitude is about old age, may affect how we treat the folks and how we deal with them.

We want to be able to distinguish what's normal aging from what is disease. There's a great variation in the health and functional ability when you meet those milestones—70, 80 and 90. There's a great deal of difference. I think we may see some that retire at 60 or 65, and they kind of give up. They say, “I'm old, I give up, I'm going to go to the chair, and then the wheelchair.”

Sometimes they need a little education and prompting by their physician or by others. Then those with more positive lifestyles and attitudes towards aging are more likely to lead a healthy lifestyle. They may ... golf, tennis, play bridge. They may be very active in taking care of themselves.

In the health care system, there needs to be a proper emphasis on geriatrics and training. Medical school gets pretty busy with everything, but geriatrics is important.

There's manpower issues to take care of this aging population. Sometimes, finding a doctor is not the easiest thing for an elderly patient. Sometimes, because of the economics, some physicians limit their Medicare practice or some even opt out. I have to get into a Medicare slot when I see my internist. He sees me, but he's not taking very many more.

So, there's a need for clinical practice guidelines in the elderly with chronic diseases. The elderly metabolize things differently, they react to tests and procedures differently, so ... some guidelines for us to go by.

Then there's mental health issues in older adults. Twenty percent experience some mental health concerns that may commonly be anxiety, depression, cognitive effects. Older men have the highest suicide rate of any group. Depression affects the outcome and course of treating other chronic diseases. There is new data that, with health lifestyle the brain can adapt, and people can live a happier and healthier lifestyle.

In order to review ... with 80% of folks seeing their primary care doc, at least annually, this is an opportunity to promote well-being.

We can review test procedures for the risk and benefit of that. We want to educate about adverse medical effects—those anticholinergic drugs, the benzodiazepines, the things that may adversely affect treatment. Understand normal aging as opposed to disease.

And appreciate there's a great deal of heterogeneity of the older adults. We want to communicate with them and if communication is difficult, use a caretaker or a family member to address ageism, attitudes, and to be advocates for healthy living.

These health inequalities not only affect individuals or specific populations, but also impact the overall health status and health care costs affecting our nation.

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