

CREATING AND IMPLEMENTING AN INTERACTIVE SENIOR HEALTH AND
WELLNESS CLASS

Pamela Powell
University of Nevada Cooperative Extension
Karen Kopera-Frye, Jeanne Hilton, Rori Lee, Kimberly Lenzi
University of Nevada, Reno
Bus Scharmann
Dean of Fallon Campus, Rural Development
Western Nevada Community College

ABSTRACT. Projected growth in the elderly population is expected to impact all aspects of society, including our health care systems, transportation, and housing, and if current trends continue, the health care needs of older adults are likely to be the primary concern. Therefore, the importance of education in promoting positive health behaviors to prevent and relieve chronic illness among the elderly cannot be overstated. Educational programs that focus on maintaining health and fitness as long as possible will help elders age well, and prevent unnecessary strain on our health care and social service systems. In this paper, we address what educators need to know about the unique issues involved in teaching the senior population, and what we learned from teaching an interactive class on senior health and wellness.

During the next 20 years we will witness a record growth in the number of older adults worldwide. By 2030, approximately 1 in 5 Americans (71 million people) will be 65 years of age or older. Nevada has the fastest growing senior population, experiencing a 72% increase in 65+ year olds between 1990 and 2000 (U.S. Census Bureau, 2005a). Nevada's oldest-old population (those 85+ years) has doubled since 1990. Growth in the elderly population is expected to impact all aspects of society, including our health care systems, transportation, and housing, and current data suggest that the health care needs of older adults are likely to be the primary concern (USDA ERS, 2005). According to the Centers for Disease Control (CDC, 2003a), 80% of those 65+ years of age have at least one chronic health condition such as arthritis, diabetes, or hypertension, and 50% have two or more of these conditions. Women are more likely to be

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Correspondence concerning this article should be addressed to the first author: Pamela Powell, M.A.T., University of Nevada Cooperative Extension, 111 Sheckler Road, Fallon, Nevada 89406 (Email: powellp@unce.unr.edu).

disabled than men (43% versus 40) (Waldrop & Stern, 2003) and elderly women have almost twice the rate of impairment in activities of daily living compared to elderly men (National Center for Health Statistics [NCHS], 1999).

Many of the chronic conditions associated with aging are aggravated by obesity. According to NCHS (2003), obesity is becoming a health care crisis for all age groups, including the elderly. Obesity rates have increased dramatically for older men (33%) and women (39%) over the past decade, although there has been a slight decline recently. The CDC and other governmental institutions attribute more favorable outcomes in terms of obesity and the health status of elders when they have access to adequate health care options and educational programs that promote positive lifestyle changes.

Therefore, the importance of education in promoting positive health behaviors to prevent and relieve chronic illness and obesity cannot be overstated. Educational programs that focus on maintaining health and fitness as long as possible are needed to help elders age well, and to prevent unnecessary strain on our health care and social service systems. In this paper, we address what educators need to know about the unique issues involved in teaching the senior population, and what we learned from teaching an interactive class on senior health and wellness.

Maintaining Health and Wellness in the Later Years

The obesity crisis. Currently, 64% of adult Americans are overweight, and an alarming 30% are considered obese (AOA, 2002). The CDC (2003b) reports that the proportion of obese adults has increased significantly in the last 15 years and that those most at risk are between 51 and 69 years of age. Obesity is linked to heart disease, high blood pressure, diabetes, arthritis-related disabilities, some cancers, incontinence and even cataracts (Villareal, Apovian, Kushner, & Klein, 2005). Obese older adults are less likely to exercise than non-obese older adults (Center

on an Aging Society, 2003). The obesity problem has only been intensified by this lack of physical activity. The fast-track lifestyle of most Americans and a reliance on convenient, low-cost, high-calorie, food products is a deadly combination guaranteed to increase the rates of obesity even further, unless preventative measures are taken.

The benefits of fitness. Due to the decrease in physical activity, older adults are the most at-risk population for decrease in muscle mass and increase in weight, and they are the most likely to suffer serious consequences from an unhealthy lifestyle. Studies show that physical activity decreases with age, that individuals over the age of 65 are about five times more likely than younger adults to be physically inactive; older women being more inactive than older men (26% versus 18) (Barnes & Schoenborn, 2003).

Adults who are inactive during their later years have higher rates of obesity and mortality than those who are physically active, and they are the most likely to lose ground in four areas that are important for staying healthy and independent: strength, balance, flexibility, and endurance. Few older adults receive the recommended minimum of 30 minutes or more of moderate physical activity five or more days a week (Agency for Healthcare Research and Quality and CDC, 2002).

Fortunately, researchers have found that increasing exercise and physical activity can help older people maintain or partially restore their functioning in these four areas. Resistance training increases strength and endurance making it easier to climb stairs and carry groceries. Improving balance helps prevent falls, while flexibility training may speed recovery from injuries. If exercise is incorporated into a daily routine, the quality of life of seniors will be enhanced.

Growing older will eventually result in a loss of strength, energy, and fitness, but these losses can be delayed by regular physical activity. Older adults actually have more to gain than younger adults by increasing their activity, and it is never too late to start an exercise program or routine. An effective exercise routine does not need to be time consuming or strenuous. Some type of moderate physical activity for 20 minutes on most days is enough to maintain weight and muscle mass. However, in spite of the many benefits of physical activity, more than 50% of American adults do not get enough exercise to realize these benefits (CDC, 2006).

Designing the Course

The majority of studies involving education of seniors have focused on cognitive intervention training to improve memory skills, which is one of the greatest concerns among elders (Thompson & Foth, 2005). One noteworthy program by McDougall (1999), the *Cognitive-Behavioral Model of Everyday Memory*, trains seniors in the areas of stress inoculation, health promotion, memory self-efficacy, and memory strategies. Other programs have emphasized the importance of teaching external memory strategies (Stigsdotter-Neely, 2000; Troyer, 2001). External memory strategies use environmental resources such as notebooks or calendars, in contrast to internal memory strategies which rely on mental processes such as imagery.

Other educational programs have focused on promoting change by influencing self-efficacy and attitudinal beliefs of seniors (Rebok & Balcerak, 1989). In one example, Cusack, Thompson and Rogers (2003) developed a *Mental Fitness Program* consisting of all-day intensive workshops across eight weeks. The educational components included goal setting, critical thinking, learning and memory, and expressing ideas clearly. The training also included building optimism, mental flexibility, self-esteem and confidence, and a willingness to take risks. This program has had enduring positive effects on health attitudes and behaviors.

In designing the *Health and Wellness for Seniors* class, our intent was to: 1) draw what we could from existing educational strategies; 2) modify the strategies to fit with the specific issues that seniors wanted to learn about; and 3) use a hands-on approach to learning about health and wellness.

A Healthy Lifestyle for Seniors

Based on previous research, the instructors chose to develop a healthy lifestyle course that would focus on strategies to reduce obesity by enhancing physical fitness. In developing a course for senior health and wellness, four critical strategies for addressing these issues were emphasized: self responsibility, a healthy diet, stress management and reduction, and physical fitness (Ebersole, Hess, & Luggen, 2004). These topics, along with information on health care and emotional health, were the focus of the class. See the Appendix for a detailed list of the topics covered.

Self-responsibility. When addressing the issues related to senior health, perhaps the most important, yet most over-looked factor, is the senior taking responsibility for their own health and well-being. Many people accept the widely held falsehood that normal aging involves the onset of disability and disease. Seniors, and those who care for them, are likely to believe that physical and cognitive decline are a normal part of the aging process, and that there is nothing that can be done about it. Older adults and their caregivers are often unaware of many self-care strategies that help seniors sustain a high-quality of life and avoid or delay the onset of disease and disability. Seniors who choose to take a class such as *Health and Wellness for Seniors* are taking an important first step in becoming responsible for their own self care. This type of class shows seniors how to gather information on multiple health issues and allows them to address questions about their health concerns with experts in the field. When a question cannot be

answered by the invited expert, seniors are urged to take the question to their own health care professional, which encourages them to take a more active role in protecting their health.

Bernard (2000) provides a list of key issues designed to help seniors become more responsible for their own self care. In this course, we addressed these issues by teaching seniors how to:

- Gain access to personal and community resources and networks that can help them reach their goals
- Obtain practical and emotional support that is needed to translate their desired goals into health-promoting behavior and activities
- Find information about their health issues and locate available resources and support for the issues in the community.
- Learn how to make informed choices from among various options
- Develop practical, personal, interpersonal and situational skills that are useful in promoting optimal health
- Find enjoyable ways to participate in life, that fit with one's preferences and limitations
- Achieve empowerment through raised awareness, knowledge, understanding and competence.

Healthy diet. Proper nutrition was another important focus for the course given our nation's high obesity rates and the relationship to chronic health conditions. According to Surgeon General Richard Carmona "Unless we do something about it (obesity), the magnitude of the dilemma will dwarf 9-11 or any other terrorist attempt" (Live Science, 2006). Because seniors point to various issues that affect their healthy eating such as living alone, dental problems, change in taste, decreased hunger, and transportation to shopping (National Institute

on Aging, 2005), nutrition education needs to focus on the individual (most elderly women are widowed and alone), proper use of vitamins and supplements, and recommended caloric intake levels. Studies suggest that environmental supports, such as nutrition logs (see Rebok & Balcerak, 1989) are effective in helping seniors make positive, long-term changes in their diet.

Stress management. Seniors face many losses in the later years that place them at increased risk for developing depression and other symptoms of psychological distress that can aggravate other health problems. We included a component on stress and coping to support the other units we were teaching. Educational strategies focused on teaching stress management and adaptive coping have been quite successful, and we used several of these techniques (e.g., Cusack et al., 2003).

Physical fitness. The most important concept to teach seniors about physical fitness is that exercise is the number one anti-aging strategy that anyone *at any age* can use to promote physical and mental health (Brennan, 2002). Unfortunately, at least three-quarters of American seniors have become sedentary by the age of 75. Healthy People 2010, a Congressional initiative to improve our nation's health status, recommends that seniors participate in at least 30 minutes or more of activity three or more days a week. Studies show that among those ages 65 – 74, only 25% meet these recommendations; of those 75 and older, only 15% meet the recommendation (Hughes, Prohaska, Rimmer, & Heller, 2005). The combination of poor nutrition and lack of fitness, is the second leading cause of death in the US, second only to smoking (Ebersole et al., 2004). Seniors can be taught that it only takes about 20 to 30 minutes of exercise to complete a total body training session; research suggests that there are no additional benefits to exercising longer than 60 minutes. For older adults, one set of eight to 10 resistance exercises that involve

the major muscle groups should be sufficient. The workload should increase gradually in small increments every week or two.

Exercise safety. Seniors need to learn about exercise safety in order to avoid unnecessary risks and injuries. There are several recommendations and suggestions that should be considered before starting an exercise program. One of the best recommendations is for the seniors to seek professional advice. This information can be obtained from doctors, physical therapists, personal trainers and exercise professionals. The next crucial suggestion is for seniors to remember that exercise is not about pain, but about slowly and safely increasing strength, endurance, flexibility, and balance. Seniors need to know how to monitor their own resting and target heart rates, and that they should stop exercising immediately and seek medical advice if they experience extreme breathlessness, develop a rapid or irregular heartbeat, or have chest pain or other symptoms that could indicate a heart attack (e.g., pain traveling down the arm). Because thirst is an indication of impending dehydration, it is safer to routinely consume fluids while exercising, rather than drinking to satisfy the sensation of thirst.

How the Health and Wellness Course Evolved

Understanding senior health and wellness issues and packaging the information in a way that would appeal to older adults and change their behavior was a daunting task. Ultimately, the effort evolved into a collaboration that included an Extension Educator, two university professors, a university graduate student, the dean and a program assistant of the local community college. The following background on the development of the course is helpful in understanding how the course ultimately was designed.

Originally, the *Health and Wellness for Seniors* course was an educational response to a community need identified by the University of Nevada Cooperative Extension (UNCE). In

2003, 400 surveys were mailed to local residents in Fallon, Nevada, resulting in a 52% response rate. Results of the survey indicated concerns for senior citizens and the need for educational programming (Powell, 2004).

The number one need identified by respondents in the sample was “Affordable Medical Care” (81%). Other health related issues identified that would impact seniors included “Quality Medical Care” (74%), “Residential Care Facility” (65%), “Expand Senior Citizen Services” (61%), “Elder Nutrition” (58%), and “Mental Health Care” (53%). Informal conversations with seniors further supported the need for educational programming, especially in the areas of nutrition and health.

By December 2004, the U.S. Census Bureau News had reported that Nevada ranked first in population growth for the 18th consecutive year. Interim projections indicate that the percentage change in Nevada residents 65 and older will increase over 260% by the year 2030 (U.S. Bureau of the Census, 2005b). These projections are going to impact all communities, but rural communities in particular. In response to these projections, Western Nevada Community College (WNCC) created “senior college” to help educate the growing number of older adults in the community. An Extension Educator with UNCE saw an opportunity to partner with WNCC as one way to address the needs that had been identified in her survey. While both UNCE and the WNCC could have offered classes to seniors without collaborating, the partnership allowed both a Land Grant University and a Community College in a rural area to provide educational programs without duplicating efforts.

Further development of the collaboration occurred when the Extension Educator met with two University faculty in the fields of Gerontology and Human Development and Family Studies, and a graduate student intern was recruited to be the instructor of record for the course.

Working together, the team designed and delivered the course using the topics schedule listed in Appendix A. The team determined that the course would be offered for the first time as part of the “senior college” at WNCC, and that the primary instructors for the class would be the county Extension Educator and the student intern with participation from the student’s major advisor, and additional lectures from guest experts.

Format of the Class. The course was scheduled to be taught for the first time in fall 2006. Classes were held from 10:00 am until 12:00 noon each Monday and Wednesday. The course was divided into three modules; Medicare and Health Care Costs, Nutrition and Cooking, and Social and Emotional Issues. Students could enroll in one, two or all three of the modules. The format for the class included lecture, question and answer sessions, and hands-on activities, and students were given a three ring binder to keep notes and any handouts they received in the class. Students also engaged in some form of exercise during each class period and were provided supplies including handouts explaining the exercise and exercise tools to take home so that they could continue practicing the physical activity.

Experts in each topic area provided guest lectures and supplementary materials. In addition, class participants were given contact information and instructions for asking the guest expert questions (e.g., of a personal nature) outside of class. The class instructors facilitated the process by capturing questions that would arise throughout the course and getting answers from the experts.

The course was designed to be interactive to enhance the learning experience of seniors. Interactive programming has been found to be successful when used with seniors (e.g., McDougall, 1999). While none of these programs used our particular combination of teaching techniques (e.g., environmental supports, interactive components, three learning modules; using

a needs-assessment to determine the focus, and real-life content), each interactive program found improvement in seniors' learning.

Our approach to teaching the course included the following interactive components: a journal completed as homework after each class, a physical activity component occurring the last 30 minutes of every class, pre- and post- physical assessments for each module, and self-monitoring checklists and logs tied specifically to the class content for the day. The journal involved tracking healthy lifestyle behaviors such as hours of sleep, listing three healthy and unhealthy behaviors that occurred during the day, etc. (available upon request from the authors). This reflective activity has been recommended as an effective strategy for promoting positive behavior changes among the elderly (e.g, Thompson & Foth, 2005).

The physical activity component included 30- to 45-minutes of exercise instruction at end of each class. Different physical activities were used including tai chi, geriatric Pilates, dancing, walking, and yoga. Each activity was demonstrated by a trained instructor, who gave the seniors handouts describing each of the movements to be learned (for later use at home). The seniors were encouraged to do as much as they could, but to stop at the first signs of discomfort. All but one of the seniors (the one who used the motorized scooter) could do the full range of exercises. Instructors were prepared to provide exercise modifications or alternatives based upon student physical ability.

The pre- and post-assessments for each module encompassed several domains, including attitudes and knowledge related to positive lifestyle behaviors, and four physical measures including Body Mass Index (percent body fat composition in the upper, middle, and lower body regions), weight, blood pressure, and flexibility. These pre- and post-assessments were compiled

into individual progress reports that were given to each senior, as a reinforcement of the changes being made.

Each class session also included a take-home activity that involved the senior completing a checklist, diet log, or other environmental supports to promote self-monitoring and awareness. For example, in the nutrition module, a registered dietician had the students complete a daily food intake log, including use of vitamins and supplements, and then analyzed the logs and provided individual feedback to students.

Anticipated challenges in teaching the course. As with any course, the structure and content of the course needed to be grounded in science. Unfortunately, there is very little research-based information regarding how to teach senior citizens, except in the realm of computer skills. Therefore, the instructional team used what is known about seniors in general to design the interactive health and wellness class for older adults.

First, we recognized that not all individuals age the same at the same rate or in the same way (Hendricks, 2005). Just as younger students learn at varying levels and degrees, so do adults. Therefore, class content needed to be presented in a variety of ways, including lecture, hands-on activities, journaling, physical engagement, homework assignments and time for questions and answers. We decided to limit the class size to 20 students especially during this first course offering.

Second, instructors realized that a large age difference divided the oldest class participant from the youngest. Unlike classrooms with younger students, the only requirement for this course was that the individual had to be a senior citizen. Therefore, an age difference of 25 years or more was likely to exist among students in the class. Because pacing of the course was an issue with this potentially broad age range, instructors sat among the students during the expert's

lecture, so that they could clarify questions and/or slow the pace, if necessary. It is important to note that existing knowledge and experience, as well as age, affected the pace of the class.

Third, we quickly learned that class time needed to be structured to allow students to socialize. When class size was under 10, students were able to get to know each other easily and form supportive relationships. As the class size grew, we recognized that students needed some time set aside to develop these relationships during class. When the class moved into the second and third modules, students started staying after class to socialize with one another. Several students also formed new relationships with their peers and began lunching together after class.

The fourth consideration was the length of class time; initially the class was scheduled to last 90 minutes. However, in reviewing content material and the importance of guided exercise activities, it was lengthened to 120 minutes. Research has shown the attention span of older adults is limited more closely to the initial 90 minutes scheduled for the course, and we were concerned that the students might want to be done in that time frame. We learned however, that the students, for the most part, did not want shortened class periods, and some even requested more class time.

We responded by making sure that the exercise component was more carefully managed, while ensuring that students were comfortable with their mastery of the exercise. Feelings of mastery and self efficacy in exercise regimens are critically important for this age group. Students also seemed to need more time than was scheduled to ask questions and share personal anecdotes. This was a crucial component to the course in that many of the issues discussed could greatly impact the welfare of the student, and instructors wanted to ensure that students understood the options available to them. Time devoted to students' questions during class, and the availability of the instructor to answer questions outside of class were imperative.

A fifth component involved communication. Students needed the instruction to be presented in a variety of ways. Lecture needed to be louder to accommodate those with hearing issues. For those with vision problems, screen projections and publications needed to be presented in larger font. Explanations for activities were offered in different ways and time was allowed so that instructions could be repeated, if necessary. One of the things we learned was that senior students help each other, when necessary, by repeating information or answers to questions to those sitting next to them.

A sixth concern that needed to be addressed was physical access to the classroom. Before the class started, we had no idea about student ambulation levels. It turned out that we had a student who used a scooter and another who used a cane. In cases where students had maneuverability needs, walkways between desks had to be widened and tables needed to be available for those in power chairs or wheelchairs. Therefore, care was taken in the spacing and placement of tables and chairs in the classroom.

Unanticipated challenges. As with any course that is offered, whether students are seniors or not, the fact is that students come with an individual knowledge base and set of experiences. The seniors did not have to attend this class and came because of an interest in course topics. Therefore, special effort was made to follow the course outline. Students had been provided the course syllabus prior to the beginning of the course and students expected these topics to be covered. Because several topics were covered and the class schedule was so full, any variance from the course schedule tended to delay the next class topic. When the class size was small, this was a minor concern as individual questions could be addressed once the lecture was completed. However, when we met with larger classes, the questions were more numerous and the exercise component had to be cut short. Therefore, in the future, we will ask guest speakers

for specific outlines and impose more specific time constraints and/or limitations in the amount of information covered.

We also encountered some difficulty with the availability of guest lecturers. Most of those who were willing to travel to a rural area had other responsibilities as well, so we learned that we had to plan well ahead of the session. Emergencies occur and guest lecturers sometimes cancel, so instructors need to have copies of the lecture in advance of the class, or some other backup plan. For example, the instructor could cover the topic, collect questions to forward to the expert, and the expert could subsequently respond to individual questions.

Another problem involved giving seniors the option to take one, two or all three of the class modules. As with non-senior students, those who enroll in elective courses do so to address a particular interest. Although flexibility was an important consideration for those who were not able to take all three modules, care had to be taken to update and integrate those who came in after the initial class had begun. The least attended module of the course was the first one: Medicare and Health Costs. While those who enrolled later did not feel the need for information in the first module, they did miss information that would have enhanced their learning in other subject areas, not just those dealing with health care costs.

Recommendations. Although there are numerous recommendations for how to best educate seniors, nearly all of these recommendations have been based on computer training for elders (e.g., Mayhorn, Stronge, McLaughlin, & Rogers, 2004). Our suggestions for adapting existing strategies for a class such as ours include the following recommendations:

- Class size needs to remain small, especially if it entails an interactive approach
- Emphasis should be placed on relationship building with enjoyable experiences to keep students motivated

- The content of the course should be based on identified needs of the students
- Jargon and technical terms need to be avoided when delivering information
- Training materials will need to be modified to accommodate the visual, motor, and cognitive limitations of the students
- Individualized progress reports and constant feedback will promote and sustain behavioral change
- Pacing of the course needs to be calibrated to meet the needs of students across a wide range of abilities
- Regular feedback from students will help determine whether the pacing and content of the course are acceptable.

Evaluative data was obtained from the student senior journal entries after each class session for course modules 1-3 encompassing Health care costs through emotional and social issues. Seniors were asked two questions: “How helpful was today’s class topic to you?” and “How applicable was today’s lesson to your daily life?”. For both questions, a 5-point Likert scale was used with response categories ranging from 1 “Not at all useful” to 5 “Extremely helpful”. Preliminary inspection of the data revealed the top three most helpful class topics were (in descending order of ranking): Medicare and health care costs, stress management, and common illnesses of the elderly (mental health issues). The highest rated topics in terms of applicability to daily life were (in descending order): Medications and health care costs, diet and nutrition facts, and stress management. Our future efforts include formally analyzing the feedback and evaluation measures from our seniors and offering a similar course as a summer academy next spring. We plan to incorporate all feedback and expand this pilot program to other

rural communities in Nevada, while tailoring the specific course content to be relevant to the identified needs of seniors in the different communities.

Conclusions

The *Health and Wellness for Seniors* course met the identified needs of its participants; therefore, it was well-received. Students in this course were retired and their free time could have been spent doing other things. Because they chose to spend that time taking this course, they needed to know that their participation was valued. One unanticipated outcome of the course was the strength of relationships that developed among the students. We now know that efforts to promote networking and social engagement among students need to be structured into classes for seniors. Five minutes could have been set aside at the end of each class to debrief and specifically ask students about any other information they wanted to have covered. Although the instructors checked for understanding at the end of the lecture, students were not asked for direct feedback at the end of each class. Students provided this type of feedback in journals, but unfortunately, the journals were not shared with the rest of the class so the other students did not benefit from their observations and insights. However, the seniors were administered a course evaluation form at the end of each module. Preliminary inspection of the course evaluation forms from Model 1 on Health care costs indicated that while students did find extremely valuable the module 1 content, they would like to take other senior courses on living wills and power of attorney, estate planning, exercise, and assisted living and long-term care housing options.

The *Health and Wellness for Seniors* course was an experiment in how to best deliver information to seniors of all ages and abilities. We learned a great deal from this first class, and will use the information to modify the course to make it more effective in the future. We plan to expand the content and make the class more portable so that we can take it to isolated pockets of

seniors living in rural communities, and we hope to share what we have learned with other institutions and educators, so that they can learn from our experience. We hope that our discussion of the challenges that we faced, and our recommendations for resolving them, will be useful to others planning to offer a similar course in their communities. The most rewarding aspects of our experience were the collaborations and partnerships we formed across institutions and the commitment that we have to continue to work together to help seniors learn how to protect their health and well-being.

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Appendix A: Health and Wellness for Seniors – Class Schedule

Module One – Health Care Costs	
Sep 11	Class Overview, Introduction to Successful Aging, Beginning Health Assessments
Sep 13	Exercise for everyone - Multiple Forms and their Benefits
Sep 18	Exercise for Everyone – Safety
Sep 20	Medicare and other health insurances
Sep 25	Social Security and Senior Prescription
Sep 27	Geriatric Pharmacy and Nutritional Supplements
Oct 2	Health care costs: ways to save money on health care
Module Two – Nutrition and Cooking	
Oct 4	Basic Nutrition and Reading Food Labels
Oct 9	Your Diet Assessment
Oct 11	Healthy eating habits: Top 5 things to cut from your diet and Top 5 things to add to your diet
Oct 16	Portion Distortion, Fad Diets, Dinning Out Smarts
Oct 18	Cooking for One or Two
Module Three – Emotional and Social Issues	
Oct 23	Recognizing the signs of Common Illnesses among the Elderly
Oct 25	Stress Management
Oct 30	*Nutrition Review – Requested by Students (Originally no class was scheduled for this date)
Nov 1	Coping and Adaptation in the Senior Years
Nov 6	Alcohol and other Drug Abuse
Nov 8	Staying Socially Active in the Senior Years
Nov 13	Area Resources for Seniors
Nov 15	Reassessment of your Health and Wellness