

age in action

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Virginia Geriatric Education Center
Virginia Department for the Aging

Case Study

PACE -Program of All-inclusive Care for the Elderly

by Laura R. Gadsby, B.A.

Educational Objectives

1. Describe the Program of All-inclusive Care for the Elderly model of care for frail seniors with chronic health care needs.
2. Demonstrate how PACE benefits providers in the delivery of services.
3. Explain how the PACE concept complements Virginia's Long Term Care Reform, as well as initiatives to develop further the PACE program in Virginia.

Background

The Program of All-inclusive Care for the Elderly (PACE) model is grounded in the belief that the community is the best setting to maintain the well-being of older adults with chronic care needs and their families. The PACE model organizes a range of services, from health care to social to support, and

blends funding streams to pay for them. The focal point for delivering these services is an adult day care center.

The PACE model of care can trace its lineage to the early 1970s, when the Chinatown-North Beach community of San Francisco witnessed pressing needs for long term care services among families whose elders had migrated from Italy, China, and the Philippines. Marie-Louise Ansak, a community member, was instrumental in the creation of On Lok (Cantonese for "peaceful, happy abode") Senior Health Services, a community-based system of care. On Lok quickly became a model for innovative, non-institutional care that preserved family relationships and community connections. In 1983, a new payment system was tested at On Lok, a single capitated fee per month per participant which drew upon and "blended" two customarily separate funding streams, Medicare (based on age) and Medicaid (based on need). Due to the success of this experiment, Congress passed legislation to allow ten additional organizations to replicate On Lok. PACE follows

in this heritage.

The National PACE Association (NPA) formed in 1994 to advance the efforts of PACE programs by educating and promoting a reimbursement and regulatory environment which promotes the PACE philosophy, educational opportunities for programs, and benchmarking data for cross-site comparisons. The NPA offers numerous resources and tools for a provider to understand the PACE model, appraise its own organizational commitment and capacity, assess the community's needs, and move forward with development or expansion of a PACE program.

The Balanced Budget Act of 1997 firmly established the PACE model as a permanent provider under Medicare and Medicaid services, allowing PACE financing based on the combination of monthly capitated payments from both Medicare and Medicaid. Currently, there are more than 40 PACE and pre-PACE programs in 22 states.

PACE in Practice

Participants. To qualify for enroll-

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ment into PACE, individuals must be ages 55 or older, with significant impairment levels, having been pre-screened to meet nursing facility criteria, using the Virginia Uniform Assessment Instrument (UAI). Individuals must reside in the PACE program service area, be able to live in a community setting without jeopardizing his/her health or safety at the time of enrollment, and agree to the terms of participation of the program. Although all PACE participants must meet nursing facility level of care, only about 7% of PACE participants nationally reside in a nursing facility.

Providers. Each PACE program has an interdisciplinary team (IDT) composed of key professional personnel, i.e., primary care physician, nurse, physical and occupational therapists, dietitian, recreational therapist, pharmacist, Master level social worker, home health and transportation coordinator. This team is responsible for both authorizing and providing services. By coordinating and delivering all needed medical and supportive services, the PACE program is able to provide the entire continuum of care and services to elderly persons with chronic care needs, ensure the coordination of these services, and at the same time, help to maintain the participants' relative independence in their own homes. The majority of individuals enrolled in PACE receive their services in a community-based adult day care center.

Services. PACE covered services include:

- Primary care, including physician and nursing services
- Social work services

- Restorative therapies, including physical therapy, occupational therapy and speech-language pathology services,
- Personal care, home health and durable medical equipment
- Prescription medications
- Respite care
- Nutritional counseling
- Recreational therapy
- Transportation
- Meals and specialty services

The primary services include physician and nursing services, day health care, physical therapy, social services, home health and personal care, transportation, meals, and all medications.

Payment. Under PACE, the providers receive a set amount of money for each person enrolled, called a capitated payment, that allows flexibility and creativity to provide the best care possible to participants. PACE providers have the ability to coordinate care for participants across settings, which means PACE participants are able to receive services at the PACE center, in skilled facilities, the hospital and in their home.

PACE in Virginia

Sentara began to explore the concept of PACE in 1994 when evaluating ways to provide alternative services for frail seniors in the community. Having PACE would add another option for Tidewater consumers, providing innovative care through a closely managed care model. In 1996, the Commonwealth of Virginia opened a pre-PACE program, Sentara Senior Community Care (SSCC) in Virginia Beach. A pre-PACE

program integrates primary and long-term care services within Medicaid but does not integrate Medicare financing and services. Pre-PACE also excludes Medicaid funded inpatient and outpatient hospital, lab/x-ray, and ambulatory surgical costs. SSCC provides services to participants who reside in the cities of Chesapeake, Norfolk, Portsmouth and Virginia Beach. Since opening, SSCC has cared for more than 475 frail elderly persons in Hampton Roads. Currently, SSCC has an average enrollment of 125 participants, with approximately 75-80 attending the day health center each day. DMAS has been instrumental in providing technical assistance and oversight to SSCC during their pre-PACE operations.

As a PACE program, Sentara Senior Community Care will lead Virginia in its mission to improve health everyday by providing quality healthcare services to elderly citizens enrolled in PACE. SSCC has completed all PACE provider application requirements with the Centers for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS) and is awaiting final approval from CMS to operate as Virginia's first PACE program. By becoming a PACE program, SSCC will be able to provide all Medicare and Medicaid covered services to PACE participants and receive a capitated payment for those services.

Case Study #1

Mabel M. is an 81-year-old African American who enrolled in the Sentara Senior Community Care

pre-PACE program five years ago. Mabel lived independently until she suffered a stroke in December 2001. Her family described her as very quiet in nature, preferring to spend time alone. Mabel's memory had suffered as well from the stroke. She received rehabilitative services following her stroke, returning to her home with the assistance of her daughter. Both Mabel and her daughter were dubious about the new living arrangements and the challenges they were presented. Mabel utilized a wheelchair for mobility and needed 24-hour supervision.

When she was referred to SSCC in March 2002, she had a history of falls in the home, showed signs of severe depression, was underweight and was dependent on others for all of her activities of daily living. Mabel began attending the SSCC Day Health Center and received personal care services in the home. A certified nursing assistant (CNA) helped her get up in the morning, bathe, get dressed, and have breakfast before the SSCC van came to pick her up each day for the Day Health Center. This schedule allowed her daughter to return to work without worry. She participated in physical and occupational therapy, learning to ambulate and to assist in her daily care needs once again. She received socialization and cognitive stimulation through her participation in the daily recreational activities at SSCC, such as current events, exercise, musical programs, and establishing friendships with peers.

Today, Mabel is a different person. She is a happy, revitalized senior who feels she has a purpose in life

each day. She continues to attend the SSCC day health center while her daughter works. She has made lasting friendships with her peers and greets each person she sees with a bright smile participating in all of the center activities. Both her long and short term memory have improved significantly, she is alert and oriented, conversing with peers and staff about current events. She takes great pride in her appearance and her ability to ambulate independently with her walker.

Mable has gained 20 pounds, reaching and maintaining her ideal body weight with the support of counseling by the SSCC Dietician. Her health remains quite stable without significant medical changes; she has not been hospitalized for another stroke in the past five and a half years.

Case Study #2

Thomas W. is a 75-year-old African American diagnosed with congestive heart failure, diabetes, and a history of colon and prostate cancers. He had been a resident in a nursing facility for several months when he was first referred to SSCC in September 2005. He used a wheelchair for mobility and had wounds on his feet that were slow to heal. Thomas and his daughter hoped for him to return to the home they shared, but, due to his impaired cognitive status, he was at risk for wandering from the house and required 24-hour supervision for his transfers and all activities of daily living.

Since Thomas' enrollment in SSCC two years ago, he has become independent in his mobility, his

lower extremity wounds have healed, and his diabetes is reasonably well controlled with assistance from the SSCC clinic staff. The nursing staff changed the dressings on his feet daily and closely watched his glucose and dietary intake to promote the wound healing. The physical and occupational therapists worked extensively with him to help him to regain his ability to bathe, dress, transfer, and use a walker instead of a wheelchair. The social worker provided support to him and his daughter, encouraging him to do as much for himself as possible without depending on others. He has had one short acute care stay in the past two years. SSCC transports him to the adult day health center during the week and ensures he is seen regularly by the podiatrist. He is no longer at risk for wandering; he has a personal safety monitoring device (Health Watch) at home, so his daughter is able to leave him alone for short periods of time, knowing assistance is close at hand.

Thomas says, "This program has helped me walk and not have to use a wheelchair. I feel quite good these days for a young man like myself."

PACE and Virginia's Long Term Care Reform

The Virginia Department of Medical Assistance Services (DMAS) in partnership with the Centers for Medicare and Medicaid (CMS) and PACE provider organizations offer seniors and caregivers a choice to remain appropriately in the community for as long as possible. The implementation of the *Blueprint for Inte-*

gration of Acute and Long Term Care Services initiated in 2006 by Governor Kaine involved DMAS in the development of alternative ways to provide care to Virginia's most vulnerable citizens, namely, low income seniors and individuals with disabilities.

In Virginia, most Medicaid older adults and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee for service environment with no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with no overall care coordination or case management.

In 2006, Governor Kaine allocated \$1.5 million for start up grants to develop PACE programs in Virginia. DMAS published a Request for Application (RFA) in July 2006, inviting all organizations interested in establishing a PACE program in Virginia to submit an application. DMAS awarded start-up grants of \$250,000 each to three health systems and two Area Agencies on Aging (AAAs); in addition, these two AAAs, located in far Southwest Virginia, received grants totaling \$500,000 each from CMS to develop PACE. PACE programs are being developed in the following areas:

- PACE Sentara, Virginia Beach
- PACE Riverside Peninsula, Hampton, and PACE Riverside Richmond, Richmond City
- PACE Centra Health, Lynchburg

- PACE AllCare for Seniors, Cedar Bluff
- PACE Mountain Empire, Big Stone Gap

These grants are allowing PACE provider organizations the opportunity to take great strides in offering PACE as a viable option for service delivery.

A seventh PACE program is earmarked for Northern Virginia in 2009. A Request for Application was published July 23, 2007 to solicit applications from organizations interested in developing a PACE program in undeserved areas of Northern Virginia. Five agencies, specializing in a diverse mixture of human services, submitted a letter of intent indicating their interest in working together to develop a PACE in Northern Virginia. The due date for receipt of their application is April 30, 2008.

Conclusion

The PACE model of care takes many familiar elements of our traditional health care system and reorganizes them in a way that makes sense to individuals, families and health care providers. For hundreds of elderly citizens across the Commonwealth of Virginia, PACE will offer them a one-stop shop for all healthcare services, by helping them to access needed services in a setting that is licensed and operated by a professional team who will help them live safely and appropriately in the home and community.

For families and caregivers, PACE will provide additional support that will enable them to manage their

lives and their loved ones better. For PACE organizations, PACE will give them the ability to deliver quality care to elderly persons keeping them at home and out of an institutional setting.

Study Questions

1. What is the PACE philosophy?
2. List significant advantages of the PACE model for individuals, families and healthcare provider organizations.
3. How does PACE differ from other care options for frail seniors?

About the Author



Laura R. Gadsby has been the Site Manager for the past two years of Sentara Senior Community Care (SSCC), Virginia's first pre-PACE program. Prior to her current position, she was the Director of Enrollment & Marketing for SSCC for six years. She was educated at Virginia Wesleyan College and is a member of the Portsmouth & Virginia Beach Task Forces on Aging, and the Sentara Healthcare Ethics Advisory Council.

Related Sources

Blueprint for the Integration of Acute and Long-Term Care Services. Richmond: Virginia Department of Medical Assistance Services, December 15, 2006. Available at www.dmas.virginia.gov/altc-home.htm

National PACE Association, 801 North Fairfax Street, Suite 309, Alexandria, VA 22314. (703) 535-1565 or info@npaonline.org.

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Health Care Reform and Family Caregivers

Health care reform is in the air. Governor Kaine's Executive Order 31 last year launched an intensive examination of the status of health care in the Commonwealth that resulted in the recent publication of *Roadmap for Virginia's Health: Report of the Governor's Health Reform Commission* (available through www.governor.virginia.gov/). The Commission producing the report is a stellar collection of knowledgeable veterans of the system who have prioritized issues and needs, recommended actions, and sought and incorporated comments from citizens and providers. Also this fall, AARP, the Virginia Center on Aging, and others are partnering in conducting *Health Care Reform Town Hall Meetings* in Virginia Beach, Roanoke, and Charlottesville to identify critical paths to improving health care.

Both the Commission report and the Town Meetings highlight, among other things, the primary need to "enhance" the health care workforce, from personal care assistants and home aides to nurses, physicians, and other medical practitioners. On the

one hand, personal care assistants, certified nurse aides, home health aides, and other "Direct Support Professionals" (the Commission's term) tend to be underpaid, underappreciated, and undertrained, resulting in (no surprise here) constant workforce turnover. On the other hand, the number of nurses and physicians in Virginia is insufficient to the need and is projected to worsen; the term "nursing shortage" is used to cover a variety of culprits, from the aging and retirement of the current corps of nurses to the decrease in the number of nursing faculty available or willing to teach would-be nursing students; and "physician shortage" is the result of, among other things, failure to retain here medical students, residents, and fellows who complete their training in Virginia. Potential remedies include scholarships, training, loans, pilot programs, marketing campaigns, and more.

It is important to note that the Commission's focus was generic, that is, health care overall, and that the issues of shortages are even more dramatic when applied to older Virginians. For example, shortages of geriatric nurses and geriatricians are pronounced. In Virginia, as in the whole country, the number of physicians with Certificates of Added Qualifications in geriatrics (the rough equivalent of "board certified") is actually declining. Inadequate

federal reimbursement for health care through Medicare and Medicaid has only recently been addressed through increases in payments for office visits that recognize that geriatric care is more complicated than previously acknowledged; but staggering amounts of required paperwork still drive many practitioners to conclude that they cannot make a living serving elders. Both the Commission and the Town Meetings address improving accessibility and affordability of health care; this implies, of course, that there are practitioners to access in the first place.

Long-term care is, primarily, an older adult issue. There are notable exceptions, as we have noted with the successful aging of increasing numbers of individuals who are growing older with lifelong disabilities. Both the Commission and the Town Hall Meetings address long-term care. The Commission's recommendations for improving long-term care are thoughtful and numerous. They include, in part, expanding consumer-directed options with Medicaid services; increasing Auxiliary Grants for assisted living; expanding *No Wrong Door*, the Virginia Department for the Aging's single point of entry system; and increasing support and funding for family caregivers. This latter issue comes close to the heart of the matter.

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“Long-term care” often translates to continuing or adjusting a relationship of long standing; it is providing assistance to a spouse, partner, child or parent when that person becomes incapacitated. We are usually reluctant to let go a relationship and will go to great lengths to keep someone we care about at home, in the community. While buying more long-term care insurance may be an important step in the long-term care process, and while creative initiatives such as Governor Kaine’s new public-private partnership are attempting to increase the number of Virginians with long-term care insurance, the most important issue in long-term care seems to be focusing more on family caregivers. This is where the action is. Family caregiving is the common practice across income, racial, ethnic, and geographic lines.

Researchers have found that, for every older adult occupying a nursing home bed, there are three or four others with similar conditions still living in the community because of sustaining family care. We and other investigators have found that, with lifelong, developmental disabilities, for every older adult with such disabilities who is receiving services (or is wait-listed to receive services) from disabilities-, aging-, or health-related agencies, there are on average two or three

receiving none. Again, the reason is sustained family caregiving. The inescapable conclusion is that family caregivers are the foundation of any long-term care system.

When we first proposed in the General Assembly what became the Virginia Caregivers Grant Program, we called it the Caregivers Investment Bill in order to recognize that investing in family caregivers is as prudent as investing in a business; providing support or tax incentives is as potentially fruitful as encouraging business zones. We testified that for every one million dollars invested in helping caregivers, through \$500 grants, to continue their care to family members with two or more impairments in Activities of Daily Living, the Commonwealth saves more than this amount if fewer than 10% of the assisted caregivers are able to defer or postpone the care recipient’s use of a Medicaid nursing home bed by less than four months. And yet the Virginia Caregivers Grant Program, active since 2000, has been moribund for several years and languished with minimal funding otherwise.

Family caregivers need the **Three Rs: Recognition, Reinforcement, and a reliable Resource** of assistance. They need for the Commonwealth to recognize that they are the bedrock of long-term care; they

need to be trained and strengthened in their knowledge of available community resources, in their ability to manage medications they oversee for loved ones, in their understanding of nutrition, heavy lifting, how to maintain their own well-being, and more; and they need reliable resources to call upon when they wish to find out more, so that they can keep on doing what they want to be doing, namely, keeping loved ones in the community; such resources might be a steady source of financial assistance, like the VCGP, or of helpful information, like No Wrong Door or SeniorNavigator, or of knowledgeable health care practitioners.

These observations, admittedly, just scratch the surface. Health care reform requires a complex array of initiatives. But minimizing investment in family caregivers would short circuit any serious effort to improve the health status and care of older Virginians. The Commission’s report is thoughtful. It and related proposals now emerging address prevention and consumer actions, bureaucratic initiatives, estimated costs of improvements, workforce shortages, expansion of existing programs, integration of acute and long term care, and more. Reform is in the air. Let’s act on it prudently.

Editorials

From the Executive Director, Virginia Geriatric Education Center

J. James Cotter, Ph.D.

This is the last column I will write as Director for the Virginia Geriatric Education Center (VGEC). Unfortunately, our application for funding of the VGEC through the federal Health Services Resources Administration was not approved. Thus, with our main support for the program gone, we in the Department of Gerontology do not believe we can continue to carry the program.

The Virginia Geriatric Education Center of VCU's Department of Gerontology has provided training in geriatrics and gerontology for over 20 years. The VGEC has trained over 14,000 health care professionals. We initiated many needed and forward-thinking projects on geriatric issues, including training curricula, national teleconferences, and web training modules. We forged partnerships with a wide spectrum of organizations, including all three allopathic medical schools in Virginia, the Veterans Administration Employee Training Services, and the variety of organizations that provide health care to older persons. The VGEC published numerous training curricula in dentistry, pharmacy, social work, various medical specialties, nursing, and other disciplines, and developed team building initiatives to bring these disciplines together, such as the Geriatric Interdisciplinary Team

Training. Over the years, the VGEC has supported almost all health-related disciplines that serve older persons, co-sponsoring conferences and in-service training for their members and staff.

Our efforts have successfully reached out to minority health professionals and those who work in rural areas. Along with our partners, we have achieved tremendous success in raising public awareness about issues of elder care. Our Kids into Health Careers project focused on K-12 students to acquaint them with opportunities to serve older persons through the health professions. Our faculty training efforts changed the way geriatrics and gerontology are taught in Virginia. This is only a sampling of our history, the variety of activities and initiatives that the VGEC has accomplished. We are proud of how well we have made a difference in the abilities of health professionals in Virginia to care for older Virginians.

I wish to thank all of the faculty and staff members who have helped keep the Department of Gerontology's VGEC productive over these many years, especially the Chairs of the Department, Dr. E. Ayn Welleford and Dr. Iris A. Parham (retired), and VCU's Department of Gerontology, which obtained a succession of grants and housed and nurtured the VGEC.

I would like to express my thanks to the many health care professionals at VCU and statewide who have contributed so much to the Virginia Geriatric Education Center over the years. I want to commend especially the efforts of

Dr. Dan Bluestein, Department of Family Medicine, Eastern Virginia Medical School; Dr. Peter Boling, Department of Internal Medicine, Virginia Commonwealth University School of Medicine; Dr. Jonathan Evans, University of Virginia School of Medicine; and Ms. Kathy Fletcher, University of Virginia School of Nursing. These fine leaders were members of the VGEC Consortium that we developed in the last few years. They will continue to point the way in geriatric health care in Virginia and are pledged to maintaining their strong efforts to bring better geriatric care skills to Virginia's health practitioners and educators.

The good news is that the Virginia Center on Aging has funding through the Commonwealth of Virginia for further geriatric training and education and will, no doubt, continue to support efforts to improve the workforce of health professionals and paraprofessionals who care for older persons. Stay tuned for further information about the new geriatric training and education initiatives in Virginia. Thanks to all of you members of the aging network for your strong support of the Virginia Geriatric Education Center.

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From the **Virginia Department for the Aging**

The Commonwealth Council on Aging Presents Its 2007 Best Practices Awards

The Commonwealth Council on Aging presented eight awards to community organizations in recognition of their best practices in service provision. As we all struggle to meet the challenges of serving a rapidly aging population during a time of budget cuts and growing demand, we need to share our best practices and applaud our successes. The Council's Best Practices Awards Program does both. The following programs were recognized:

The Modular Wheelchair Ramp Program, ElderHomes Corporation, Richmond

The ElderFriends, VCU Dept. of Gerontology, Richmond

The Senior Advantage Program, Rockingham Memorial Hospital, Harrisonburg

The Memory U: Education for Caregivers, Alzheimer's Association - Central & Western Virginia Chapter, Charlottesville

The Helping Hands Project, Beth Shalom Home of Virginia, Richmond

The Volunteer Caregivers Assisted Transportation Program, Loudoun Volunteer Caregivers, Leesburg

The Aging Together Partnership, Aging Together, Culpeper

The Adopt A Nursing Home Project, The Far-From-Barbies Group, Virginia Beach

The Commonwealth Council on Aging is composed of 19 citizens from all walks of life who are appointed by the Governor and the General Assembly to represent all geographic areas of Virginia. The Council helps state government meet the needs of older Virginians in the most efficient and effective manner.

The Council has chosen to encourage best practices programs throughout the Commonwealth. These programs may be sponsored by local governments, municipalities, community organizations, aging services providers, universities, faith organizations, and public-private partnerships. Programs are judged for their innovation, cost-effectiveness, ease of replication, and their impact on the quality of life of older Virginians, their families, and their caregivers.

To receive more details about these best practices programs, or about the Commonwealth

Council on Aging, contact Bill Peterson at (804) 662-9325 or by e-mail at bill.peterson@vda.virginia.gov.

The Commonwealth Council on Aging Elects New Officers

The Commonwealth Council on Aging has elected new officers for 2008-2010. The Council is the Commonwealth's principal advisory group on issues of importance to Virginians ages 60 and older. Formed in 1998, the Council replaces the former Governor's Advisory Board on Aging and consists of citizens from throughout the state. The Council reports to the Governor and the General Assembly, making recommendations in an Annual Report. The purpose of the Council is to ensure that state government takes a well coordinated approach to meeting the needs of older Virginians.

The Council has elected the following officers for 2008-2010. The new Council Chair is Gene Ecton Davis from Charlottesville; the Vice-Chair is Eugenia Anderson-Ellis from Richmond; and the Secretary is Betty Bowden from Virginia Beach. These officers will take office at the November 28, 2007 Council meeting which will be held in Fairfax, VA. For more information about this meeting, please contact Bill Peterson at (804) 662-9325 or by e-mail at

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bill.peterson@vda.virginia.gov.

New Commissioner for Aging

The former Commissioner of the Virginia Department for the Aging, Julie Christopher, resigned on this past August 31st. Governor Tim Kaine has appointed Ms. Linda Nablo as the new Commissioner for Aging. Linda currently serves as director of the Division of Maternal & Child Health in the Virginia Department of Medical Assistance Services (DMAS), and as director of FAMIS, Virginia's State Child Health Insurance Program (SCHIP).

The Governor says that "Linda's energy and demonstrated ability to advocate for others will serve the Commonwealth's older citizens and their families well. The Department for the Aging will benefit from Linda's extensive experience and proven leadership in state government and non-profit organizations."

Linda previously served as Director of *SignUpNow*, a statewide non-profit group that assists communities in enrolling children in health insurance programs. She also has served as Director of Public Policy for the Action Alliance for Virginia's Children and Youth.

Good News in the Gospels for Senior Adults

A community-wide workshop entitled "Good News in the Gospels for Senior Adults" will be held on Saturday, November 10, 2007, at the Braddock Street United Methodist Church in Winchester from 8:00 a.m. until 4:00 p.m.

Dr. Jane Marie Thibault will lead the workshop. She is a clinical gerontologist and professor at the University of Louisville School of Medicine.

One goal of the workshop is to help seniors adopt a new and spiritual model for aging, which seeks to see aging through divine eyes. Dr. Thibault presented a workshop at Shenandoah Valley-Westminster Canterbury in 2003, which was so well received that the workshop sponsors wish to have her message be available to the entire community.

For workshop information, visit www.strengthforaging.info/contacts.htm. For registration information, please contact Marsha Himelright at (540) 667-5869.

Jack Reid and Bennie Lambert Farewell

We note, with regret, the departure from the Virginia General Assembly at the end of this term of two long-time friends of older Virginians and their families. Delegate Jack Reid and Senator Benjamin Lambert, while of different political persuasions, share an abiding commitment to bettering the lives of Virginia's great resource, its older citizens. Jack and Bennie have a rich history of bills and resolutions to address Alzheimer's disease and dementia; prepare health care professionals to serve older patients; train service providers in geriatric skills; strengthen the capacities of institutions of higher education to conduct aging-related research, training, and service; bring aging-related issues to the attention of state government agencies; and, overall, broaden our awareness of the challenges and opportunities that accompany an aging Virginia. We owe them much and we wish them well.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

FINAL PROJECT REPORTS FROM THE 2006-2007 ALZHEIMER'S RESEARCH AWARD FUND

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982 to stimulate innovative investigations into Alzheimer's disease (AD) and related disorders along a variety of avenues, such as the causes, epidemiology, diagnosis, and treatment of the disorder; public policy and the financing of care; and the social and psychological impacts of the disease upon the individual, family, and community.

ODU Sheri R. Colberg, Ph.D., FACSM, and colleagues (Department of Exercise Science) "The Relationship among Alzheimer's Disease, Dementia, Diabetes, and Physical Activity Status"

Diabetes increases an individual's risk of developing Alzheimer's disease and other forms of dementia or mild cognitive impairment, while regular physical activity has been shown to lower this risk. Thus, the purpose of this study was to examine the relationship among cognitive status, exercise status, and type 2 diabetes. The investigators studied a total of 145 subjects, 71 controls and 74 with type 2 diabetes, using a battery of tests that included two mental function scales, a depression scale, validated physical activity and self-care questionnaires, and various metabolic tests (e.g., fasting insulin, glucose, and cholesterol levels). The results demonstrated that diabetes has a negative impact on one of the cognitive measures employed. Moreover, cognitive scores were related to a number of metabolic parameters related to diabetes (i.e., blood glucose, fasting insulin levels, insulin resistance, and overall diabetes control). Scores were significantly associated with specific physical activity measures, including hours spent doing light exercise during the week (like office work, driving, standing, and other daily activities), weekend sitting, and the number of days of exercise per week. Active individuals without diabetes were the least depressed group, and depression scores were associated with a number of physical activity variables. Certain types of physical activity appear to be beneficial for mental function and depression, particularly in people with diabetes, especially when it is less well controlled. These findings have implications related to the risk of developing AD or dementia due to diabetes and the risk reduction conferred by regular physical activity. *(Dr. Colberg can be reached at 757/683-3356 or 4995)*

VCU Jeffrey L. Dupree, Ph.D. (Department of Anatomy and Neurobiology) "Understanding the Role of Sulfatide in Maintaining Viable Neurons in Alzheimer's Disease"

Since neuronal death is the most prevalent pathology in Alzheimer's disease (AD), most research has focused on understanding intra-neuronal processes that regulate survival. The investigator proposes that other cells in the central nervous system (CNS) also play important roles in neuronal viability by creating an environment that facilitates survival. This hypothesis is supported by the finding that a prominent brain lipid, sulfatide, is significantly reduced in the earliest stages of AD. Sulfatide is an abundant CNS lipid that is almost exclusively produced by non-neuronal cells known as oligodendrocytes. Although best recognized for their role in myelin synthesis, oligodendrocytes also provide trophic support for neurons during development and assist in the establishment and maintenance of specific neuronal membrane domains. In addition, sulfatide is a sphingolipid, a class of lipids that is prominent in lipid rafts. In mice that are unable to produce sulfatide, oligodendrocyte-neuronal interactions are disrupted and axolemmal domains are compromised. The investigator's results strongly supported the hypothesis that a significant reduction of sulfatide in AD would result in abnormal raft composition, which in turn would facilitate altered enzyme activity and subsequently induce neuronal pathologic consequences. Using a sulfatide null mouse, the investigator found evidence that hyperphosphorylation of tau is induced in a subset of CNS neurons and that the abnormal phosphorylation is mediated by the kinase cdk5. Furthermore, he showed that this abnormal activity of cdk5 does not result from increased expression but rather from abnormal compartmentalization. Additional evidence showed that neuronal lipid rafts are disrupted in neuronal populations. These are the first findings to implicate a potential mechanistic consequence of sulfatide depletion in AD. Furthermore, it is likely that this pathologic mechanism may be initiated through oligodendrocytes. *(Dr. Dupree can be reached at 804/828-9536)*

**UVA Ian G. Macara, Ph.D., and Huaye Zhang, Ph.D. (Center for Cell Signaling, School of Medicine)
“The Role of Septins in Alzheimer’s Disease”**

One of the pathological hallmarks of Alzheimer’s disease (AD) is the formation of twisted neurofibrillary tangles inside the brain’s nerve cells, which contain hyperphosphorylated tau proteins. Tau is a normal protein that is important for the function of nerve cells, but it is altered in AD so that it aggregates, and is believed to disrupt nerve cell function. In addition to tau, a family of guanosine triphosphate (GTP)-binding proteins known as septins is found in these tangles. The goal of this study was to determine the role of septins in tangle formation. The investigators have now found that one of the septin family members, Sept5, associates with tau in nerve cells. They also showed that Sept5 clusters together with tau in non-nerve cells. In addition, when excess Sept5 is present in the neurons, tau becomes misplaced, and clusters in the cell body with Sept5. This abnormal distribution of tau is reminiscent of that observed in AD patients. The next step was to examine how Sept5 alters the tau protein. Contrary to their original hypothesis, however, they could not identify a direct link between Sept5 and tau. Interestingly, however, they observed a consistent increase in the amount of tau protein in cells that over-express Sept5. This suggested that Sept5 somehow regulates tau protein levels. High levels of tau might aggregate and form tangles within neurons. Further investigation showed that the amount of tau in cells is regulated by how fast it is broken down (rather than how fast it is made). These results led to the hypothesis that tau breakdown, through a process that engages the ubiquitin-proteasome system, might involve a protein, called Parkin, which is known to bind to Sept5. Interestingly, Parkin is one of the genes responsible for Parkinson’s disease. Ongoing experiments are aimed at examining whether Parkin is indeed involved in this process. If this is the case, these results could provide an unexpected link between AD and Parkinson’s disease. *(Dr. Macara can be reached at 434/924-1236; Dr. Zhang can be reached at 434/982-0083)*

**GMU Jeanne Sorrell, Ph.D., R.N. (College of Nursing and Health Science) and Catherine J. Tompkins,
Ph.D. (Department of Social Work) “Ethics of Respect for Spirituality in Persons Living with
Alzheimer’s Disease”**

This interdisciplinary study sought to answer the question: How do members of a faith community describe experiences of spiritual connections related to Alzheimer’s disease? The co-investigators implemented a grounded theory methodology to explore concepts that comprise spiritual pathways and to identify categories of spiritual connections within the social context of persons with Alzheimer’s and their families living in a faith community. Two focus groups were held with clergy and 15 unstructured interviews were conducted with persons with early Alzheimer’s or family caregivers. Participants reflected five different faith communities in Northern Virginia and the Shenandoah Valley. In-depth descriptions of participants’ experiences were obtained in three primary focus areas: 1) Spiritual beliefs related to coping with Alzheimer’s for both persons with Alzheimer’s and caregivers, both in early and late stages of the disease; 2) Ways in which spirituality contributes to the overall concept of quality of life within a faith community; and 3) Ways in which members of faith communities facilitate or hinder the development of spiritual connections for persons with Alzheimer’s and their families. Interviews were audio taped and transcribed verbatim. N-Vivo software was used to analyze qualitative data to identify conceptual themes related to spiritual dimensions of participants’ experiences. Four conceptual themes were found related to living with Alzheimer’s within a faith community: Invisibility of Persons with Alzheimer’s; Family Caregiver Stress and Isolation; Connecting through Spiritual Rituals; and Lack of Formal Preparation for Forging Spiritual Connections. Findings from the study suggest a need for more formal preparation of clergy to understand how to forge and maintain spiritual connections with persons living with Alzheimer’s; identification of social support systems within the faith community to address problems of stigma, isolation, and caregiver stress; and an organizational emphasis on integration of spiritual rituals such as communion, hymns, and prayers into the spiritual life of persons with Alzheimer’s. *(Dr. Sorrell can be reached at 703/993-1944; Dr. Tompkins can be reached at 703/993-2838)*

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

DELAYED FINAL PROJECT REPORT FROM THE 2005-2006 ALZHEIMER'S RESEARCH AWARD FUND

UVA Heidi Scrable, Ph.D. (Department of Neuroscience) "Gene Expression Changes in the Aging HPF Axis"

Weight loss is common in patients with AD, and often occurs before the onset of dementia. Serum levels of leptin, which correlate with levels of adiposity, have been found to fluctuate with weight in both patients with AD and age-matched controls. However, the diurnal fluctuations of leptin, which depend on levels of adrenal glucocorticoids, specifically cortisol, are altered in AD. It has been suggested that uncoupling of leptin and glucocorticoid fluctuations might underlie the weight loss observed in many patients with AD. In mouse models of AD, administration of leptin has been shown to reduce the production of the pathological A β fragment of amyloid precursor protein (APP) in the brain. The preliminary experiments in this study addressed the relationship between the adipocyte-derived hormone, leptin and APP. The investigator previously developed a line of transgenic mice (p44), with altered insulin-like growth factor-1 (IGF-1) signaling, that present several hallmarks of AD and undergo accelerated aging, including premature accumulation of ceramide in the brain and reduced serum leptin. Hyperactivation of the IGF-1 receptor in these mice is accompanied by parallel changes in the cascade of events that results in the production of A β . This study investigated the hypothesis that the hypothalamic-pituitary-fat cell (HPF) axis that controls metabolic pathways and maintains efficient use of energy, also plays a major role in the pathogenesis of AD. The investigator used microarray analysis to examine age-associated changes in adipocyte-specific gene expression in the p44 mice, and identified the JAK/STAT pathway as a key metabolic pathway altered in mice with accelerated aging and early onset AD-like changes in the brain. This opens up a novel pathway for possible intervention therapy in the treatment of AD and other age-associated disorders affecting brain function. The results provide a global picture of how perturbations in endocrine pathways originating in the periphery, for example, in the adipocyte, can contribute to degeneration of the brain in AD. (*Dr. Scrable can be reached at 434/982-1416*)

Supporting Caregivers across the Lifespan

Two-hour free web cast available on-line at videocast.nih.gov.



The Centers for Medicare and Medicaid have made available an informative web cast on caregiving recently broadcast in mid-September. But this is not all. Visitors to the website maintained by the National Institutes of Health may have access to the last 50 archived web casts on a variety of issues and matters within NIH's domain. The NIH website also lists upcoming events, archived videos, lectures, and helps you to put files on your computer. In addition, there are many locations on this website, some requiring a scientific background and some not, including Clinical Center Grand Rounds, Medicine for the Public, Women's Health, Bioethics, Gerontology, Human Genome, and much more. Visit these resources at videocast.nih.gov.

Focus on the Virginia Center on Aging

PAUL IZZO



Many of us know Paul Izzo as a caring attorney who specializes in elder law. The Virginia

Center on Aging has been honored for some years to have Paul serving on its Advisory Board, where his insights and gentlemanly manner have helped to guide VCoA's progress. The following, in his own words, tell us some of "the rest of the story."

I was born in Brooklyn, during an August, 1955 hurricane, into a welcoming Italian Catholic family. I was influenced most by my parents who saw and nurtured in me a love for animals of all kinds, growing things, music, travel, and the city and all its cultural attractions. Virtually every weekend, we drove into Brooklyn to break bread with my grandparents, aunts, uncles, and cousins. When I wasn't practicing the piano, playing with my beloved terrier mix Liz (as in Elizabeth Taylor), or long distance bike riding, I was honing my powers of persuasion by trying to convince my skeptical classmates that I was, indeed, related to Vince Lombardi. I also spent many an after-school afternoon playing casino with my widowed

grandmother who moved out to Long Island to be closer to us, but whose loneliness was still palpable to me. Eventually, my grandmother could no longer live alone and was admitted to St. Joseph's Manor, a retirement home in Trumbull, Connecticut operated by Carmelite nuns. Our regular family visits there opened my eyes to high quality long term care. Long before Eden Alternative homes, St. Joseph's had golden retrievers roaming the premises and a cocktail lounge for residents and guests.

After graduating college (University of Virginia) and law school (University of Richmond), a job at a Richmond area country club introduced me to a kind man who at the time was the administrator of Westminster-Canterbury House. Nate Bushnell told me about a long term care administrative internship opportunity at Westminster-Canterbury, for which I applied and was accepted. I had the same sense of quality care at Westminster-Canterbury as I had when I visited St. Joseph's Manor. I've continued my involvement in long term care by receiving and maintaining my license as a Virginia nursing home administrator and by remaining active in the American Association of Homes and Services for the Aging and the Virginia Association of Nonprofit Homes for the Aging.

After my internship at Westminster-Canterbury, I attended a continuing legal education program on Elder Law where a young lawyer named Shawn Majette was a presenter. I was immediately impressed by Shawn's skill as a lawyer and his passion for advocating for older adults. I was even more impressed, however, by his ability to take his vocation as a lawyer seriously, without taking himself seriously. Shortly thereafter, I made the jump from state government employment into private elder law practice. It would have been impossible to make this transition, and succeed in this practice area for 17 years (the last 10 of which have been with the firm of Thompson McMullan, P.C.) without Shawn's boundless generosity, guidance, friendship and support.

My immediate family consists of my mom and dad, who reside in Fredericksburg with my maternal aunt, and two siblings, namely, a brother who is a physical therapist and sister who is a critical care nurse, both of whom live nearby in Richmond. In addition to my immediate family, I'm blessed with an extended family of friends in Richmond, mostly fellow transplants from the north. I get my exercise by walking a few miles a day with my rescued cocker spaniel and, weather permitting, playing tennis on the weekends.

The Day the Music Died

by Stephanie Rosenbloom
(Excerpted from the *New York Times*, July 12, 2007)



Michael Bellusci's quotation in his high school yearbook

was, "It ain't rock if it ain't loud." Growing up in Flushing, Queens, he played guitar and drums, idolized Jimi Hendrix, and performed in cover bands. Later, he went on the road as Ringo in the musical "Beatlemania." These days, if his left ear happens to be covered by a pillow, Mr. Bellusci, 47, hears the alarm clock as a faint tick, tick, tick, not a blaring BEEP, BEEP, BEEP. In cacophonous restaurants, he watches people's mouths so he can follow the conversation. Years of high decibel noise and trauma from speaker feedback damaged his right ear. Mr. Bellusci, who plays ukulele, recorder, guitar and bass in an acoustic duo, now says, "If I could do it over again ..." How many boomers are thinking the same thing?

As more members of the generation born after World War II enter their 60s, and the effects of age conspire with years of hearing abuse, a number find themselves jacking up the volume on their televisions, cringing at boisterous parties, and shouting "What?" into their cellphones.

About one in six boomers have hearing loss, according to the Better Hearing Institute, a nonprofit

educational group. AARP has reported that there are more people age 45 to 64 with hearing loss (10 million) than there are people over 65 with hearing loss (9 million). And, more people are losing their hearing earlier in life, according to the National Institute on Deafness and Other Communication Disorders, one of the National Institutes of Health.

Hearing loss from age (presbycusis) can begin before the Social Security years, but boomers are also likely candidates for noise-induced hearing loss, particularly the kind that results from continuous loud noise over an extended period of time (like a 115-decibel rock concert). "They're the first of that rock 'n' roll generation," said Sharon Beamer, the associate director of audiology professional practices for the American Speech-Language-Hearing Association, "the first to really grow up with loud music, personal stereo systems." But factory noise, construction din, or the roar of subways may also be to blame. "None of us protected our ears at all," said Pat Benatar, the rock singer and guitarist, who is on tour. Nowadays, Ms. Benatar, 54, also lends her celebrity to Hearing Education and Awareness for Rockers (HEAR), one of several public service groups with campaigns to prevent hearing loss. "I'm still a junkie," she said. "I still want it so loud." Yet noisy restaurants bother her. When her dishwasher is running, she said, "I can't hear any conversation at all."

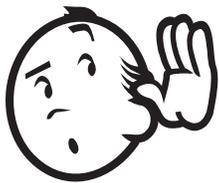
In the grand scheme of things (sending the children to college, paying off the mortgage, meno-

pause), the inability to hear the dialogue on a reasonably adjusted television is a minor nuisance. Nonetheless, boomers said the realization that their hearing is no longer sharp provokes anxiety about age, frailty, dependency, and obsolescence.

Still, many of the boomer generation will not go gently into that beige abyss of no-frills gadgetry known as the hearing aid. National Institute on Deafness and Other Communication Disorders data from 2001 shows that just 149.6 of every 1,000 adults who have diminished hearing, whether from aging, disease, or injury, use a hearing aid. Yet that reluctance by boomers, who at about 78 million are a potential windfall market, has motivated sound technologists. Companies have not only developed devices to attract age-phobic, style-conscious boomers, but that also address hearing and language issues for everyone else. But first they had to reinvent the hearing aid so it no longer looked like a chewed Circus Peanut or made wearers feel like they were hearing through a tin can. Rather, today's newest devices look like the progeny of iPods and Bluetooth. One company, Oticon, learned about boomer anxiety when it conducted studies to determine why the people who needed hearing aids were not wearing them.

"The stigma was a lot more deeply felt and strongly felt than we had allowed ourselves to believe," said Gordon Wilson, vice president for marketing at Oticon. "People really saw them as devices that would make them look old, that would make them look ugly, that would make them look decrepit....People

would rather go around asking everybody to repeat themselves,” he said.



Amy Arra, 49, of Naperville, Ill., was one such person.

For years, she ignored her hearing loss because she knew she would need a hearing aid. But when Ms. Arra returned to the work force after 14 years as a stay-at-home mother, she could no longer ignore her loss. “In meetings I wasn’t catching everything,” she said. “It was very tiring.” Finally, she visited an audiologist and was pleasantly surprised when she was not shown the chewed Circus Peanut, but a device called Audéo. Audéo’s manufacturer, Phonak, does not call it a hearing aid. In a nod to PDAs like BlackBerrys, it calls Audéo a PCA (Personal Communication Assistant). Shaped like a moth’s wing and smaller than a guitar pick, it perches behind the ear and comes in 15 color combinations, like Pure Passion or Green With Envy.

Ms. Arra could have also considered the Bernafon SwissEar hearing aid, red with the white cross insignia of the Swiss flag. Or a Delta by Oticon in Shy Violet. “It was like shopping for sunglasses,” said Ms. Arra, who bought two Audéos in Crème Brûlée (brownish blond) to match her hair. The device has a thin tube coiling toward the ear canal. Even so, Ms. Arra was worried people would notice her Audéo. At a gathering, she said, “I was so self conscious and I thought everyone was staring.” Turns out, no one spied it.

Hearing aids are not inexpensive, and the cost is rarely covered by insurance or Medicare for adults. Audéo is about \$3,000 to \$4,000 an ear, though as with all hearing aids, prices vary because they are determined by doctors, not manufacturers. But some, like Oticon’s Epoq, come with other benefits, and not just for those who strain to hear the waiter recite the specials. The Epoq, which was introduced in May, is the first hearing aid to have integrated wireless and Bluetooth connectivity, so it can stream a cellphone call or music and audio from a radio, computer or MP3 into the ears through a remote control-like device worn on the body. It is, in other words, a wireless hands-free headset.

And that may be just the beginning of sound enhancement breakthroughs. Sergei Kochkin, the executive director of the Better Hearing Institute, predicts that buildings will install wireless transmitters so a voice from many feet away can be streamed into the ears of listeners wearing such devices. Lectures with enhanced sound and extraneous noise elimination can be piped in that way, and the device could also be equipped with language translation software, he said.

To protect hearing, professionals advise wearing ear plugs or muffs when exposed to noise louder than 85 decibels (a power mower is about 90 decibels) for an extended time. And, yes, if your iPod is loud enough for everyone in the elevator to know you own Jock Jams, turn it down.

Among boomers, though, there are those who have no anxiety about hearing loss. Jeff Davies, 62, a tennis photographer in Orlando, Florida, said that losing his hearing may not be all that bad. “I think I’d quite enjoy it if I didn’t have to listen to ice cream trucks roaming the neighborhood and people screaming at their kids,” he said. Then, Mr. Davies, who is from Yorkshire, England, reiterated the maxim about growing old gracefully.

Healthy Cooking DVD Available



HCTV (Henrico County Television), with help from the Area Planning and Services Committee for Aging with Lifelong Disabilities (APSC), has produced a DVD program called *Healthy Cooking* that is available free through the Virginia Center on Aging.

Intended for group home managers, family caregivers, and adults with lifelong disabilities, this program aims to make meal preparation less monotonous and meals more interesting. The DVD features Mary Angela Morgan, celebrated cook and author, who shows the viewer how to introduce variety into common dishes and to prepare simple and healthy entrees, sides, and desserts. Rich with color and high production values, thanks to the direction of HCTV’s Bruce Berryhill, *Healthy Cooking* is 34 minutes of tips, facts, and advice. For a free DVD, as long as they are available, contact Ed Ansello at eansello@vcu.edu.

The Art of Aging through a New Set of Lenses

by Dana Burr Bradley, Ph.D.
Western Kentucky
University

The field of aging has a new tool to help us understand and appreciate the experience of later life. Aging is, at once, the most universal of experiences and yet the most varied. If we are lucky, we grow old, but we enter this common landscape by our own means and along our own path. This shared but unique experience that we call aging is the focus of the new *Journal of Aging, Humanities, and the Arts (JAHA)*, which intends to examine some of our culture's most powerful expressions, stories, and beliefs about the experience of aging. With the publication of its inaugural double issue this past June, JAHA seeks to create a dialogue between the humanities, medical science, and the social sciences around issues of aging, according to journal editors Anne Wyatt-Brown and Dana Burr Bradley.

"Our vision is that this journal will create a forum for scholars and act as an incubator of fresh approaches and constructive dialogue about the meanings, experiences, and challenges of growing old," says Bradley, who is a professor of gerontology at Western Kentucky University.

"JAHA will support a large interdisciplinary cadre of researchers who work in the field of aging, but who perhaps would not all identify themselves as gerontologists."

Published four times a year, JAHA is the official publication of the Humanities and the Arts Committee of The Gerontological Society of America (GSA). By fostering a dialogue between the humanities and arts and the bio-medical, psychological, behavioral, and social sciences, the editors intend for the journal to challenge stereotypes, further our understanding of the aging process, and provide creative approaches for exploring issues pertaining to growing old. Subjects addressed in the journal include:

- Language and communication
- Biography and memoirs
- Human beliefs and spiritual values
- Art, music, drama, and dance therapy with older adults
- Narrative medicine in interactions with older adults and their families
- Issues of death and dying
- Creativity and aging
- Social construction of age
- Literary production, reception, and analysis

"Humanities deal with the complicated feelings that individual people have about growing old," says Wyatt-Brown, who is an emeritus

associate professor of linguistics at the University of Florida. "It includes stories about aging that humanize the experiences of older folk and their families, friends, and caregivers. Sometimes these stories celebrate the achievements of elderly musicians, playwrights, poets, novelists, and movie makers. Poems, pictures, drama, and music add dimensions of human experience that research, no matter how impressive, simply cannot duplicate."

Articles in the first issue covered such subjects as the presentation of old age in the cinema, King Lear's struggle with aging, aging and desire in modern novels, the portrayal of aging in Native American stories, the Old Woman as new American hero, and the effect of cultural programs on the physical and mental health of older adults. The second issue, guest-edited by Roberta Maierhofer and Heike Hartung, features authors around the world who examine the discourse of age and the proliferation of narrative in contemporary culture. The volume concludes with several pieces that lay out the historical forces which have shaped the contemporary landscape of humanities and arts in aging.

For future issues of the journal, the editors are seeking original work focusing on a common interest in age and the commitment to reaching readers

from different humanities and arts disciplines in several categories:

- Articles: Synthetic and original research
- Vital Visionaries: Substantial commentary guiding future directions of scholars
- From Any Age: First person narrative essays informing the broader understanding of the aging process
- Creative Works: Original and previously unpublished poems, artwork, musical scores, and film reviews

Subscription information for the *Journal of Aging, Humanities, and the Arts* or a sample copy can be obtained from: Taylor & Francis, Customer Service Department, at 1-800-354-1420, ext. 216, or e-mail: customerservice@taylorandfrancis.com. To submit an article, contact the journal at JAHA@wku.edu.

VCU's Tompkins-McCaw Library Offers Education Programs

Library Workshop: RefWorks: A Web-based Citation Management Program (Online Workshop) October 17, 2007

RefWorks is an extremely useful tool that allows you to easily create and manage your own personal research database. Reserve your seat at: www.library.vcu.edu/events/detail.html?ID=37742

Fall Open House October 25, 2007

The Community Health Education Center (CHEC) will hold an open house from 11:00 a.m. to 1:00 p.m. to celebrate the center's Fifth Anniversary. Visit the CHEC, which is located on the ground floor of the VCUHS Gateway Building at 1200 East Marshall Street. For more information, contact Dana Ladd, CHEC Librarian at dlladd@vcu.edu or (804) 628-2429.

VCU Libraries Lecture: Grave Robbing, Goblins, and Ghouls: Anatomical Education in 19th Century Richmond October 31, 2007

Discover how anatomy was taught in Richmond during the 19th century and why students and faculty were involved in procuring cadavers for this important educational experience. A brief walking tour

of the MCV Campus highlighting stories about grave robbing, goblins, and ghouls will follow the presentation. Seating is limited; advanced registration is encouraged. 4:00-5:00 p.m. Register at www.pubinfo.vcu.edu/training/it/course_detail.asp?ID=3771

Brown Bag Lecture: Public Health Emergency Preparedness and Response November 15, 2007

Featuring by Dr. Lisa Kaplowitz, Deputy Commissioner, Emergency Preparedness and Response, Virginia Department of Health. This event is free and open to the public. Beverages will be provided, but seating is limited. To register, call (804) 828-0626 or sdjones@vcu.edu.

Additional Workshops Available from the Tompkins-McCaw Library

Take advantage of classes offered by the Tompkins-McCaw Library. For more information, visit www.library.vcu.edu/events/ or call Shannon D. Jones, Head, Outreach Services at (804) 828-0626 or sdjones@vcu.edu

Calendar of Events

October 17, 2007

Brown Bag Health Disparities Lecture. 12 noon - 1 p.m. VCU, Medical Sciences Building, 1217 E. Marshall St., Richmond, Room 104/105. "Obesity, The New Epidemic" Diane B. Wilson, Ed.D., MS, RD, VCU Department of Internal Medicine, Massey Cancer Center. No registration required.

October 20, 2007

Fifth Annual Kinship Care Conference: Love & A Bag of Tricks. Theme: Exploring, Embracing, and Enhancing Kinship Care. 8:30 a.m. - 3:30 p.m. The Norfolk Workforce Development Center, 201 E. Little Creek Road, Norfolk. For more information, call (757) 823-2759 or (757) 393-0570.

October 24-25, 2007

Workforce and Cultural Competency Conference. Marriott Newport News at City Center, Newport News. For more information, visit www.dmhmrzas.virginia.gov/OHRDM-WDI.htm or call (804) 786-0607.

October 25 & 26, 2007

Moving Science to Practice in Caregiver Support: A National Summit. Conference to be held at the Rosalynn Carter Institute for Caregiving, Georgia Southwestern State University, Americus, GA. For information, call (229) 928-1234.

November 1, 2007

Lecture in recognition of the 400th Anniversary of Jamestown and the Southern Historical Assoc. Annual Meeting. Reception and Program 5-8:30 p.m. VCU, Medical Sciences Building Auditorium, 1217 E. Marshall Street. "Historical Perspectives on Health Disparities and African Americans in Virginia." Rodney G. Hood, M.D., San Diego, CA. Sponsored by VCU and the Black History Museum and Cultural Center of Virginia. Free, pre-registration required. Visit www.pubapps.vcu.edu/vphs/reg.

November 11-13, 2007

VAFC: 2007 Annual Conference, Networking Virginia's Free Clinics. Westfields Marriott, Chantilly. For detailed information and special hotel rates, visit www.vafreeclinics.org.

November 28, 2007

Commonwealth Council on Aging meeting. Open to the public. Herndon Harbor Senior Center, Fairfax. For more information, call Bill Peterson at (804) 662-9325.

December 11, 2007

Virginia Alzheimer's Disease and Related Disorders Commission meeting. Open to the public. Virginia Department for the Aging, Richmond. 10:00 a.m. - 2:00 p.m. For more information, call Bill Peterson at (804) 662-9325.

December 14, 2007

Virginia Board for People with Disabilities meeting. Open to the public. Richmond. For more information, call Sandra Smalls at (800) 846-4464.

January 23, 2008

Virginia Center on Aging's Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. For information, call (804) 828-1525.

April 7-8, 2008

Joint Annual Conference sponsored by the Virginia Guardianship Association and Virginia Elder Rights Association. Sheraton West Hotel, Richmond. For information, contact joyduke@msn.com or (804) 261-4046.

Age in Action

Volume 23 Number 4
Fall 2007

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Linda Nablo

Commissioner, VDA

J. James Cotter, Ph.D.

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Editor

Age in Action is published quarterly. Submissions, responses to case studies, and comments are invited and may be published in a future issue. Mail to: Editor, *Age in Action*, P.O. Box 980229, Richmond, VA 23298-0229, fax to (804) 828-7905, or e-mail to kivey220@yahoo.com.

**Winter 2008 Issue Deadline:
December 15, 2007**

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at Virginia Commonwealth University,
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www.vcu.edu/vcoa

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Alcohol and Aging Educational Materials Available

The Virginia Department of Alcoholic Beverage Control and the Virginia Center on Aging, along with the support of the Alcohol and Aging Awareness Group (AAAG), are currently distributing a brochure entitled "The Best Is Yet to Come" and a booklet entitled "Alcoholism and the Older Adult, Messages of Concern." These two publications promote older adults maintaining a healthy lifestyle and emphasize obtaining knowledge about alcohol and medication interactions, the effect alcohol may have on the older adult, and resources available if help is needed.

The brochure and booklet are intended for the older adult population, their family members, caregivers, service providers, or concerned citizens.

**For free brochures or booklets, contact
Regina Whitsett at Regina.Whitsett@abc.virginia.gov or (804) 213-4445,
or visit www.abc.virginia.gov.**

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