

## Case Study

### The Aging Together Partnership: Collaborating to Improve Quality of Life for Older Adults

by April Holmes, MS Ed. and  
Chris Miller, MBA

#### Educational Objectives

1. Demonstrate how the Aging Together experience improves services for older adults.
2. Describe the partnership structure and participation that makes this an effective model for community services amidst demographic changes.
3. Illustrate tangible service improvements resulting from Aging Together collaborations.

#### Background

Aging Together is a community partnership encompassing the counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock. The region is a changing mix of rural land and a “bedroom” community adjacent to heavily populat-

ed Northern Virginia and has been identified as one of the fastest growing areas on the East Coast. The two northernmost counties are witnessing an influx of retirees, while the three other counties have large populations of elders who have lived there for many years.

In 2001 the partnership completed the region’s first Elder Needs Assessment through surveys of 1,035 adults ages 60 and over. Used in combination with 2000 Census data, the survey provided a picture of regional demographic changes and their implications: the numbers of adults ages 60 and over, the fastest growing segment, are expected to rise by 45% between 2001 and 2010; 27% of residents 60 and older reported a need for assistance with activities of daily living; family and friends provide 80% of needed assistance, yet the number of potential family caregivers is decreasing; 24% of older people live alone and may not have support if they experience illness or disability; and, these older adults have a strong preference for in-home supports rather than services in nursing homes or other facilities. In sum, the survey’s data indicated

a rapidly increasing need for a community-based response to assure that older persons could remain in their homes, with access to affordable transportation, housing, health-care, and other supportive services.

The Aging Together Partnership Aging Together began as an informal coalition of about 30 individuals who recognized early the emergence of a growing aging population. It was led by the Area Agency on Aging, which in this region is part of the Rappahannock Rapidan Community Services Board (CSB). The coalition sought and was awarded a development grant from the Community Partnerships for Older Adults program of the Robert Wood Johnson Foundation (RWJF) in November 2004. This program helps local partnerships create strategic plans to address priorities that have been identified through data collection and community input. The coalition, which had grown to over 100 individuals, organizations, and older adults, adopted the name Aging Together to reflect the reality that aging affects everyone and that collaboration is the best way to improve supports for seniors. In May 2006

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Aging Together received another grant from the RWJF to implement the strategic plan. These resources, funds, and technical assistance helped the partnership coordinate the needed activities to put the plan into action.

Structure. The structure of the Aging Together partnership is central to its success, for it employs a combination of county teams and regional workgroups that assures relevance and grassroots “buy-in,” as well as an overall leadership group that provides “top-down” commitment. In our planning district each county prides itself on its individual character. The first step in developing the partnership was to assure that each county’s needs would be recognized and addressed by building on existing county teams. Each of these teams has its own vision, tied to the overreaching partnership vision, and works at the grassroots level to address local needs. County teams are partnerships in themselves, whose members include older adults, service agencies, faith-based groups, governments, and advocates., Acknowledging that some issues are too broad to address locally, regional workgroups collaborate across agencies and counties on issues affecting the entire area, including Caregiver Education and Support, Medication Access, Health and Wellness, Adult Day Healthcare, and Workforce Development . A small staff provides support to the county teams, regional workgroups, and individual members. The Core Leadership Group guides the Aging Together partnership. Its composition has been strong from the start, for all members of the Core Leadership are either agency

directors, department managers or other influential members of their communities. Modeling the collaborative approach of Aging Together, Core Leadership members establish credibility for the partnership in each county and have linked the partnership to local agencies, citizens, government, and business resources.

Partners. Aging Together’s partners reflect the spectrum of individuals and groups. They include area hospitals, health and long-term care organizations, social services departments, local governments, older adults, schools, disability-related organizations, faith communities, Health Departments, Cooperative Extension Services, the AARP, Triad, family caregivers, housing agencies, legal services, law enforcement, civic organizations, and transportation providers. The diversity of the membership reflects Aging Together’s inclusive and comprehensive response to building a community which values and supports it older citizens. Central to local collaboration are County Resource Specialists, based in member offices in each locality, who maintain information on local resources, conduct outreach for partnership initiatives, and support the local teams in carrying out their workplans.

**Strategic Vision and Goals**

Starting with information from the Elder Needs Assessment, Aging Together developed its vision and strategic plan with full community input. Aging Together stays connected to the opinions of older persons through Community Conversations on Aging. These public

forums are held annually in each county for older adults and the community at large. The first Community Conversations established our vision and strategic goals: *Our vision for aging is that citizens living in the region retain their sense of place and community, serve and contribute to that community and are assured of help when needed from family, friends, neighbors and places of worship, as well as from helping organizations and a responsive government. All seniors are valued and are able to move smoothly through a continuum of care in a manner reflective of their individual needs and preferences.*

Our strategic goals are to: Facilitate expansion of long-term care and supportive services; Establish an effective and sustainable volunteer network; Increase the capacity of the local paid and informal long-term care workforce; Increase awareness of the importance of healthy lifestyle among seniors; Increase knowledge among older adults and caregivers about long-term care options; and, Assure vitality and sustainability of county/regional partnerships.

As our area’s only time when the community fully focuses on the needs and interests of seniors, Community Conversations have asked for specific comments on issues such as transportation, housing, volunteerism, and caregiver supports. This year the Conversations focused on acknowledging the gifts and values seniors give to our communities and challenged us to find ways to use these resources better.

### Results of This Collaboration.

Through our structure, partners, vision, and strategic objectives, Aging Together has achieved results that improve the lives of older adults and their families. Some successes include: a) more than \$1.5 million in new resources has been generated across the region; b) a new regional adult day health care program opened in 2007 through collaboration involving the Area Agency on Aging/Community Services Board (CSB), Culpeper Human Services, the Virginia Department for the Aging, and the Alzheimer's Association; c) with technical assistance from Aging Together in developing the proposal, the CSB was able to gain funds from the Virginia Healthcare Foundation for a Rappahannock Rapidan Medication Assistance Program; d) regional transportation planning, using the Aging Together structure as a model, brought together public and private transportation providers, local government, human services providers, and area transportation consumers to create a regional plan. Aging Together's part in this plan is coordinating volunteer transportation networks. One outstanding example of such a network is Fauquier County Volunteer Transportation Program, or VolTran, organized through the efforts of the Aging Together team in Fauquier County; e) Aging Together is teaming with Legal Services this fall to provide training for local attorneys on elder law; f) the partnership is working with adult service workers, first responders, and the domestic violence network to develop continuing education to assure coordinated community responses to abuse and neglect; g) the Caregiver Support Workgroup

has created a template of caregiver training that has been adapted by the local county teams, resulting in the training of more than 100 family caregivers; h) in collaboration with the local community college, Aging Together sponsors training of healthcare front line staff ; and, i) we have had several initiatives to improve elders' access to information and available resources; as examples, through Aging Together, the Area Agency on Aging was chosen as one of the No Wrong Door pilot sites; the Aging Together staff and team members conduct outreach to build the SeniorNavigator database with local resources to make it a viable tool; and in April 2008 Aging Together sponsored a regional campaign to build awareness of volunteerism in which over 200 people gathered information about specific volunteer opportunities. We continue to consult with local governments regarding aging issues and to assure that the needs of older citizens are built into each county's comprehensive plans.

### **A New Way of Doing Business**

Even with our successes, there are still several on-going challenges. How does Aging Together communicate a sense of urgency, leading to policy change and recognition of community-based long term care as a priority for planning and funding? How can the community translate information about demographic shifts into concrete, manageable action plans without feeling overwhelmed or burdened? How do we maintain energy, focus, and communication within each county and across the region? These are issues into which our young partnership is just beginning to delve. Having

established a structure and networks of communication, we have a strong foundation from which to work. The partnership model has highlighted a new way of doing business with real successes to illustrate its effectiveness.

Individuals and organizations regularly pool resources to accomplish what was impossible for one single group. They also use the power that can be generated when speaking with one voice. Government and service organizations feel less overwhelmed, no longer the sole source providing for the needs of this growing demographic. For instance, individual counties spent years attempting to create adult day healthcare programs in their communities; but it was not until a regional collaboration was formed that the capacity for this service more than doubled. Aging Together provides a neutral space for testing ideas and initiatives, and for technical support and assistance to locate funding or other resources to help make them realities. The special contribution of the Aging Together partnership is not so much in providing direct services as in helping make it possible for partnered organizations to build and improve programs, all the more important in times of tight budgets and fiscal constraints.

### **Case Studies**

Case Study #1. Mrs. M is 63 years old and has diagnosed angina, high blood pressure, and high cholesterol. Her husband's employer-provided health insurance coverage was terminated when he was unable to return to work after a motorcycle accident. Since Mrs. M had been

insured under that policy, she lost her coverage as well. She stopped taking her medications once she couldn't pay for them. Within two months she was hospitalized for chest pains and her injured husband was left without a caregiver. She had neglected her own health in order to take care of her husband and now both were in danger. Fortunately, she was hospitalized in time, went home with needed medications, and connected with **Rappahannock Rapidan Medication Assistance Program (RRMAP)** at the Area Agency on Aging. Through this program and collaboration with her physician, Mrs. M was able to get the medicines she needed at no cost. Now she takes her medications regularly and RRMAP keeps track of her refill information so she does not run out. Luckily, her heart was not damaged. After a short recovery period, she is back to her normal routine as homemaker and caregiver.

Case Study #2. Mr. L, an 83 year old widower, was paralyzed and has short-term memory impairment as a result of a stroke. On a daily basis he needs someone to fix his meals, help him out of bed, dress, and remind him to take his medicine. While Mr. L's adult children do share the responsibility of helping with his care, all are working full time; so arranging time to spend with him is a challenge. For a while they hired a certified nurse assistant to help, but concerns remained about his lack of stimulation. Often they found their father just staring at TV. When they learned about the new **DayBreak Regional Adult Day Healthcare Center**, they enrolled their father. Now Mr. L spends three full days at

the center, participating in games and craft projects, socializing, and taking outings to places like orchards and local restaurants. His demeanor has changed noticeably since he began attending, being much more lively and engaged. His children are, of course, delighted that he is involved in something he enjoys so much.

Case Study #3. Mrs. S is a Fauquier County widow who volunteers in the community by knitting caps for premature babies at the hospital. When she became no longer able to drive, she contacted VolTran to help her deliver the knitted caps to the hospital. It worked out very well for her, and she is now also using VolTran to get to her medical appointments, as well. Sometimes Mary, her regular driver, will go above and beyond to take Mrs. S to Arlington National cemetery where she visits her husband's grave. "It seems help is always available when absolutely necessary, for which I am grateful," Mrs. S said. "Mary is a willing and gracious person."

### **How Our Approach Can Work in Your Community**

First, begin building a partnership by finding naturally occurring councils, coalitions, communities, and neighborhoods. Build on their interests, identity and strengths. Think outside the norm; do not overlook less traditional partners or unorthodox means of contacting them. Use current members, for they often make the least "typical" outreach. Second, gather information about the current and future numbers and needs of older adults in your area. The US Census can

provide valuable, free data even when a formal needs assessment is not feasible. This information will be essential to making a case for collaboration starting today. Third, develop a way to solicit community participation and feedback, so your efforts remain relevant to the people most affected. Keep partners at the table by assuring their interests are recognized and, when possible, addressed. Fourth, provide templates, such as sample work plans and curriculum, to stimulate planning, especially in the beginning stages. Fifth, keep expanding; the secret to success is broad participation. Sixth, celebrate. Share successes internally and externally. Learn how to be savvy about media and public relations. Positive relationships with media contacts can do much to help you gain broad support. Finally, build your partnership's value in the community by promoting its collective expertise on aging-related issues. Promotion and publicity renew the cycle of drawing in new partners and expanding focus and resources.

### **Study Questions**

1. What does the Aging Together experience suggest about ways to organize collaborative partnerships?
2. What steps and elements are necessary to plan and implement system-wide service enhancements for older adults and their families?
3. How can this model be adapted elsewhere?

### **References**

For more information about Aging Together and other community partnerships working to improve long term care and supportive services

for older adults, visit:  
[www.agingtogether.org](http://www.agingtogether.org)  
[www.partnershipsforolderadults.org](http://www.partnershipsforolderadults.org)

### About the Authors



Chris Miller has been the Project Manager of the Aging Together partnership since January 2007. Her professional background includes providing community-based residential supports in Ohio and Virginia. Just prior to joining Aging Together, she was the Quality Improvement Director for the Arc of the Piedmont in Charlottesville. Ms. Miller earned her BS in Psychology from Mary Washington College and an MBA from Averett University.



April Holmes has been the Aging Together Communications Coordinator since August 2006. Previously, she coordinated aging and disability-related initiatives, most recently the *2020 Community Plan on Aging and Long-Term Care Partners Acting Together for Health* for the Jefferson Area Board for Aging (JABA) in Charlottesville. She has a BA from the State University of New York at Stony Brook and a MS Ed from the State University College at Buffalo.

## Editorials

### From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

#### *Priorities in a Time of Crisis*

The current economic crisis has caused this consideration. I cannot remember there ever being a Golden Age of public funding for human services. These include adult day care, mental health programs, early intervention services, foster care, substance abuse counseling, training and supports for family caregivers, protection from abuse and neglect, and the like. In good economic times, other “interests” inevitably garner more attention. The “business model” sways appropriations and diverts resources. In bad economic times, services to those who are frail or have disabilities seem to bear the brunt of the cutbacks. Initiatives that would actually save the Commonwealth money through modest investment, like the Virginia Caregivers Grant Program which helps prevent costly institutionalization of people with impairments, are eliminated, sacrificed on the altar of priorities. Even in the worst of times, some things get funded. It’s never truly a question of money; it’s always been a question of priorities. When “across-the-board” budget cuts are applied in the name of impartiality, services that were already meagerly funded absorb a greater impact. Now, amidst economic stress, is not the time to wield the club of impartiality. Now is the time to act reflectively, not reflexively. Now is the time to defend certain sections of the budget, including the protection

of those among us who are least able.

Taking this action is not political. Conservatives, moderates, and liberals, Republicans and Democrats state that they value the family and respect human life. All voice concern for the frail and “the least among us.” Virginia’s elders are lauded regularly for their lives of hard work and maintained values, and are courted during the election season. Fellow citizens with lifelong intellectual disabilities, cerebral palsy or mental health impairments make commanding footage on television when visiting the General Assembly. What happens in times of stressed economics proves their importance. Perhaps funding for programs and service providers that might help these groups to live safely and productively in their home communities will remain. Perhaps not. If funding for human services does continue, it is often at the cost of other human services, as agencies are asked to decide which of their many needed programs continues, and one constituency is pitted against another.

When budgets must be cut, and they must be now in these ominous times, we all --elected officials and fellow citizens-- get to ask ourselves which is more important, a road or a community-based waiver program? A capital outlay for a new building or protection from abuse, neglect or exploitation for elders and those with disabilities? A tax cut for a group of businesses or a group home for people with mental illness?

Of course, there is no simple answer to any of these questions;

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but that's the point. Whenever decision-making time is upon us, human services are low on the priority list. We all acquiesce to the logical arguments that business must continue to be "incentivized," roads must be built, prisons must be expanded, strong businesses make for a strong economy, and exempting the wealthiest from tax burdens benefits the poorest. All this may or may not be true but one wonders when will it be time for the frail and those with disabilities? When this economic crisis ends, will we revert to *status quo ante*? When will it be seen that greater investment in people who are frail or who have impairments that make them vulnerable, as well as greater investment in those who provide supportive services to them, actually enriches the whole economy?

### Did You Know?

The Virginia Center on Aging's website features a list of videos available at no cost from its extensive lending library, links to aging-related resources, staff profiles, annual reports, *Age in Action* current and back issues, ARDRAF archives, and much more.

[www.vcu.edu/vcoa](http://www.vcu.edu/vcoa)

## From the Virginia Department for the Aging

Linda Nablo

### *The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)*

As you know, the Commonwealth's revenue shortfall has resulted in the Governor's asking state agencies to propose potential budget cuts at the 5%, 10%, and 15% levels. We are doing all in our power to minimize the impact of any cuts on those services that are critical to the ability of frail older Virginians to maintain their independence and delay or avoid institutionalization. By the time you receive this issue, the Department for the Aging, and Virginia's larger aging network, should know what level of budget cuts we will be expected to absorb.

In the meantime, let me take this opportunity to bring you up-to-date on recent changes made to Medicare as the result of MIPPA: The Medicare Improvements for Patients and Providers Act of 2008. This material has been developed by Barbara Childers, MSW, Director of the Virginia Insurance Counseling and Assistance Program (VICAP).

In July, Congress easily overrode the President's veto of MIPPA. This bill is most well known for blocking a 10.6% cut to physician fees. However, MIPPA addresses other important provisions that relate to or affect seniors throughout the Commonwealth. These provisions can be easily broken up into

five different categories: Beneficiary Improvements, Low-Income Improvements, Part D Benefit Improvements, Medicare Advantage Improvements, and Physician Services under Part B. Many of these provisions have different effective dates. Below is a highlight of those provisions which could affect Virginia's Medicare beneficiaries.

### Beneficiary Improvements

Medicare provides a "Welcome to Medicare" exam within the first six months of enrollment into Medicare and beneficiaries are often required to pay for this exam to meet the Medicare Part B deductible. MIPPA waives the fee, extends the exam period to one year, and allows the exam to cover services if they are recommended by the US Preventive Services Task Force.

Currently, Medicare beneficiaries pay a 50% co-payment for any outpatient mental health service. Beginning in 2010, MIPPA phases down Medicare's coinsurance for outpatient mental health services to 20% over a five year period.

Medicare imposes therapy caps for physical therapy, occupational therapy, and speech therapy services. MIPPA extends the "exceptions period" created by Congress to compensate for these limits. The exceptions process was scheduled to end on June 30, 2008. MIPPA extends it through December 31, 2009.

Due to concerns with overpayments to durable medical equipment (DME) companies, the Medicare Modernization Act of 2003 (MMA)

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required Medicare to phase-in a competitive bidding process. Medicare had already started Round 1, which included implementing this process in 10 metropolitan areas by July 1, 2008. Starting in 2009, Virginia was scheduled to participate in Round 2 of Medicare's competitive bidding demonstration for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). MIPPA delays the competitive bidding process due to concerns raised by suppliers. Round 1 will restart in 2009.

MIPPA modifies the Medigap program by eliminating any plans that are made redundant by Medicare Part D. MIPPA also clarifies that Medicare Advantage and Private Fee-for-Service plans must meet the requirements for Medigap plans that exist in current law.

Lastly, MIPPA modernizes the payment system to dialysis facilities by "bundling" all of the costs of End Stage Renal Disease (ESRD) care into one single payment. This provision is set to begin January 1, 2011.

### Low-Income Improvements

For those Medicare beneficiaries who are between 120-135% of the Federal Poverty Level (FPL), applications to a Medicare Savings Program (MSP) may provide some relief related to the Part B premium, which is \$96.40 per beneficiary, per month in 2008. The authorization for the Qualifying Individual (QI) program ended on July 1, 2008. MIPPA extends the QI program until December 1, 2009. Additionally, the asset level for determining

eligibility into a Medicare Savings Program has not been changed since 1989. MIPPA increases these asset levels starting in 2008 from \$4,000 to \$6,000 for an individual and from \$6,000 to \$9,000 for a couple.

Currently, Medicare beneficiaries who are "dual eligibles" (Medicare and Medicaid) and those who are eligible for the Low-Income Subsidy through the Social Security Administration (SSA), are not subject to the late enrollment penalty for Medicare Part D. MIPPA codifies the suspension of this penalty.

The Low-Income Subsidy application currently includes the value of life insurance policies and in-kind support for resource calculations. Starting in 2010, cash value of the life insurance policy and in-kind support will be excluded from the application and will not be counted towards assets or affect eligibility.

### Part D Benefit Improvements

Current guidance from the Centers for Medicare and Medicaid Services (CMS) requires drug plans to cover "all or substantially all" drugs in classes of medications for which lack of timely access to a particular drug can result in serious clinical consequences. Those drugs that are currently protected include anti-cancer drugs, immunosuppressants, HIV/AIDS drugs, anticonvulsants, antipsychotics, and antidepressants. MIPPA provides statutory protection for the medication classes and requires CMS to define any exemption to this policy. Currently, benzodiazepines (commonly used for those with mental illness) and barbiturates (commonly used for

seizure disorders) are not covered by Medicare Part D plans. Starting in 2010, MIPPA requires Part D plans to cover both of these medication classes.

### Medicare Advantage Improvements

One major concern, not only in Virginia but across the United States, is the marketing practices of certain agents and companies. MIPPA prohibits and limits sales and marketing activities to address these concerns. MIPPA prohibits certain sales activities related to Medicare Advantage and Part D plans (door-to-door sales, cold calling, free meals, and cross selling of non health-related products). Companies are currently allowed to offer compensation to agents without limitations. Effective for the 2010 plan year, MIPPA provides limitations on commissions and gifts for agents and consumers.

Private Fee-for-Services (PFFS) plans are not currently required to have established provider networks. Beginning 2011, MIPPA requires companies to establish provider networks in most areas. Additionally, to improve patient care and help patients choose a plan, MIPPA legislation requires PFFS plans to report data on the same quality measures as reported by other Medicare Advantage (MA) plans starting January 1, 2010.

### Physician Services under Part B

As noted above, MIPPA blocked a scheduled 10.6% cut to physician fees, which was set to occur in 2008. MIPPA also increases physician fees by 1.1% in 2009. Addi-

tional provisions in this category include “incentivizing” the adoption of electronic prescribing by physicians and increasing incentives for physician quality reporting. CMS believes the use of electronic prescribing will reduce medical errors and help physicians consider cost issues as they make prescribing choices. These incentives will begin in 2010, providing a 2% increase in payments, phasing down to 0.5% in 2013. Those offices that do not implement electronic prescribing by 2014 will lose 2% of their payments.

### Questions?

If you have questions regarding MIPPA and Medicare, please contact Barbara Childers at 804-662-7671 or via email at [Barbara.childers@vda.virginia.gov](mailto:Barbara.childers@vda.virginia.gov). If you or someone you know has questions about their Medicare or other health insurance related questions, please contact your local Virginia Insurance Counseling and Assistance Program (VICAP). You can locate your local program by calling the Virginia Department for the Aging at 1-800-552-3402.

## Focus on the Virginia Center on Aging

Bert Waters



*Bert in a 2007 Marathon*

Leland "Bert" Waters joined the staff of the Virginia Center on Aging (VCoA) in August, 2000 and has become integral to its operations. He is Program Manager for the Geriatric Training and Education (GTE) initiative and the Geriatric Academic

Career Advancement award, both intended to develop the skills and capacities of the gerontological and geriatric work force. He is also Co-Investigator in a project sponsored by Senior Connections, the Capital Area Agency on Aging, entitled “Employed Caregiver Initiative, Workplace Partners for Eldercare – Awareness, Education and Support,” which is funded by the Richmond Memorial Health Foundation. This project aims to help businesses offer support to employees who are current or potential caregivers. Bert is Principal Fiscal Officer, Personnel Administrator, and manager of the Information Resource Center for VCoA. With areas of interest including palliative care, culture change, eldercare, and problem gambling among older adults, he has co-authored several manuals and has given over 25 presentations at professional meetings since joining VCoA.

Bert has earned a B.S. in economics and a M.S. in gerontology from Vir-

ginia Commonwealth University and is currently a Ph.D. candidate in Health Related Sciences, with a specialization in gerontology, at VCU's School of Allied Health Professions. He has served as Student Representative on the Executive Committee of the Association of Gerontology in Higher Education and is a long-standing member of the Gerontological Society of America and the Southern Gerontological Society. Bert has served as President of the VCU Graduate Student Association and Treasurer of the Epsilon Chapter of the National Gerontology Academic Honor and Professional Society of Sigma Phi Omega.

Interested in social advocacy and a career advocating for nursing home reform, Bert was accepted into the Master's Program in Gerontology at VCU in 1998. While in his first year of graduate school, he received an offer to become Assistant Director of HeartFields Assisted Living in Richmond's Fan District. He worked there until joining the Virginia Center on Aging. Meeting Dr. Bill Thomas at a conference of the Virginia Association of Nonprofit Homes for the Aging greatly affected Bert professionally. Dr. Thomas had recently written *Life Worth Living: How Someone You Love Can Still Enjoy Life in a Nursing Home*; it resonated with Bert's background in long-term care. The experience led Bert to a leadership position in the Virginia Eden Coalition and to become a founder of its successor, the Virginia Culture Change Coalition.

Bert relates that the defining moment for him as a graduate gerontology student was observing



his father die a “bad death” in a local hospital. Bert described the experience on his Ph.D. application: *“I consider myself an articulate, well-educated healthcare consumer, but I felt helpless watching my father die in a hospital over a two-week period. My father suffered from tremendous waves of pain those two weeks. I wanted to believe that he was getting appropriate care. In retrospect, I have realized that this was not the case. I briefly met with his physician twice, and in the second meeting he recommended my father receive a peritoneal shunt placement so he could begin dialysis treatment. The physician warned me this was an invasive procedure and there was only a slim chance it would relieve my father’s pain; but he also said if it were his father in this situation, he would proceed with the operation. I consented. Two days later an LPN informed me they were going to discontinue dialysis and administer large doses of opioids to relieve the pain. My dad died the following evening. Hospice was not offered as an option and pain management was not mentioned until twelve days after his admittance. Americans have a deep-seated antipathy to facing death and dying. Perhaps this is why I did not question my father’s care as he suffered needlessly. I believe it requires both advocacy and activism to change our collective consciousness. I also believe palliative care will be a driving force in the movement towards a higher standard of care.”*

Soon after his father died, Bert helped organize the Central Virginia Coalition for Quality End-of-Life Care, a consumer driven advocacy group. He has volunteered at

the VCU Thomas Care Unit and the objectives of his dissertation include understanding patterns of access to palliative care and why some patients who can be identified as appropriate for palliative care do not receive this care.

Bert lives with his wife Carolyn and daughters Rosa and Isabel in Richmond’s Stratford Hills neighborhood. He serves on the board of the Southampton Citizens Association and is race director for their annual RiverFest 5K Wicked River Run. Bert started distance running while at VCoA, runs several miles daily, and has coached both the Monument Avenue 10K and the Patrick Henry Half Marathon training teams. He has completed three marathons since 2005 and hopes one day to qualify for the Boston Marathon.

### **Inspired: A Juried Senior Art Exhibit**

*Hosted by the Appalachian Agency for Senior Citizens (AASC) and the Appalachian Arts Center*

Exhibitors are at least 55 years old and live within 100 miles of the Appalachian Arts Center. Artwork will be exhibited at the Arts Center from September 30 - October 31, Tuesdays through Saturdays, from noon to 5:30 p.m.

The Arts Center is located in the "old Archie Helton Store" on Rt. 19 in Wardell (2.5 miles south of Claypool Hill).

For more information, contact AASC at (800) 656-2272 or visit [www.aasc.org](http://www.aasc.org).

## **Virginia Rural Health Association Conference, November 6-7, 2008**

This year's Virginia Rural Health Association Conference is exploring the topics generated from the State Rural Health Plan workgroups. The opening panel discusses a great area of need – dental care for the underserved – and looks at some new approaches for providing services. Workshops cover topics such as telemedicine, use of midlevel providers in birthing centers and mental health, rural adult day care as an alternative to nursing home, rural designations to qualify for federal programs and grant opportunities, and electronic medical records.

Day Two features UVA authors and professors, Dr. Tim Garson and Carolyn Engelhard, discussing their book on health care reform, *Half Truths*; focusing on the logic model, measurable outcomes, and evaluation. This will be followed by a legislative roundtable featuring Joint Commission on Health Care staff Stephen Bowman and Delegate Dave Nutter. The day will end with an instructional workshop to improve grant proposal and program development skills by focusing on logic model, outcomes measurements and evaluation. The conference offers opportunities for networking as well as information gathering and resource sharing. Please join us in Staunton.

For more information, visit [www.vrha.org/08Conference.html](http://www.vrha.org/08Conference.html)

## The Queen City of the Shenandoah

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Jane Stephan, Ed.D.

### Elderhostel

*Adventures in Lifelong Learning*

We all know that Staunton was the birthplace of Woodrow Wilson. Many of us have visited that splendid manse and presidential library on North Coalter Street. We've taken our children and grandchildren to the excellent Frontier Culture Museum. But have you been to Downtown Staunton lately?

Within the past five years? A cultural renaissance has reinvigorated this small city of 25,000, and it's attracting visitors from far and wide. The Virginia Center on Aging has been holding very popular Elderhostel programs in Staunton and we want to tell you some of our experiences.

When you walk the downtown streets, the city's vibrancy is almost palpable. You can feel the excitement and pride that its people have and witness their all-encompassing welcome to tourists. Stand on any street corner with a map and, within minutes, someone local will befriend you to point out some of the interesting features of the town, recommend shops and restaurants, and give you directions. One of my favorite things to do is ride the (free) town trolley that makes 25-minute rounds of the downtown and surrounding historic districts, or, on a 45-minute trip, goes farther afield to the parks and other outlying areas.

To stay overnight downtown, in the

heart of the action, there are a number of guesthouses, one gorgeously refurbished hotel (the Stonewall Jackson), and a very clean and pleasant Howard Johnson's. Our Elderhostel participants stay at the Frederick House, a "small hotel" composed of five different award-winning historic homes that have been beautifully restored with everything you'd want, and more: comfortable king-sized beds, period antiques and furniture, huge walk-in showers, separate living rooms in each suite, and truly tasty breakfasts.

The American Shakespeare Center (ASC) and its Blackfriars Theater have been at the center of Staunton's revitalization. In 1988, Ralph Alan Cohen and Jim Warren formed the Shenandoah Shakespeare Express, a traveling troupe that morphed into Shenandoah Shakespeare in the '90s. In 2000 they undertook construction of the Blackfriars Playhouse, the world's only re-creation of Shakespeare's original indoor theater, and in 2005 established the American Shakespeare Center. Dame Judi Dench is one of the board members. There are now plans to build Globe II, a re-creation of Shakespeare's outdoor theater.

Studying Shakespeare and attending two different plays draw participants from all over the U.S. to our Elderhostel programs. Shakespeare has never been so much fun as at the Blackfriars! The Washington Post called it "...shamelessly entertaining." Performances by professional actors take place "under the lights" and within full view of the audience. The intimate setting commands your full attention, and

sometimes your involvement, as Shakespeare's masterpieces unfold. People in our Elderhostel groups comment that, in this setting and with such superb actors, they have no trouble understanding Shakespeare's language and meaning. One commented that he never realized Shakespeare was "so uproarious," another confided that she had misgivings about coming the first time but has since returned three times. The one who was obviously won over was a man who grudgingly accompanied his wife and then was visibly transfixed by the two plays we saw: "I never got it before this. Shakespeare is really the story of the world and how it works, isn't it? We're coming back in the fall. This time, it'll be my choice." He's not alone in overcoming what Ralph Cohen calls "Shakesfear." The ASC is a mecca for both seasoned and aspiring actors, teachers, thespians, international scholars, school groups, and even CEOs of corporations who use Shakespeare as a part of management training.

The play is "the thing" but, at Blackfriars, there's more than the play. Dr. Cohen, one of the most engaging speakers I've ever heard, often gives "Dr. Ralph's Lecture" before a performance. During intermission, Julius Caesar might take off his costume and play acoustic guitar from the balcony, Pyramis and Thisbe might be back-up for a singing Puck, and Demetrius might be selling wine and snacks from an on-stage cart. Actors hold "Talkback" sessions with the audience after plays. In Elderhostel programs, we meet the actors, spend time backstage, and learn from instructors like Dr. Cohen, artistic director Jim Warren,

fight director Colleen Kelly, and the director of the evening's play, who discuss the finer points of language, history, staging, swordplay, word-play, acting and the world of imagination. To find out more about the Blackfriars Playhouse, the schedule of plays, and the biographies of the actors and staff, go to [www.americanshakespearecenter.com](http://www.americanshakespearecenter.com) or [www.ASCstaunton.com](http://www.ASCstaunton.com).

Our Elderhostel participants in Staunton enjoy dinners out at different restaurants each evening, lunch at Cranberry's Grocery, gallery and gift shop expeditions (Beverley Street and its side streets are full of nifty shops and bookstores), free concerts in Gypsy Hill Park in the summer, and exploring the hundreds of buildings and homes that make up Staunton's five National Historic Districts. Staunton is the "poster child" for the Main Street program of the National Trust. For guides to walking the Historic Districts and for more information about Staunton, go to [www.VisitStaunton.com](http://www.VisitStaunton.com) or call the Visitor Center at 540-332-3971.

There's so much going in Staunton that you may want to make it a frequent weekend getaway. Better yet, if you or your companion is age 55 or older, enroll in one of our 3-night/4-day Elderhostel programs. Go to [www.elderhostel.org](http://www.elderhostel.org) and choose #14828 as your search, call Elderhostel Registration toll-free at (877) 426-8056, or call us at the Center on Aging in Richmond at (804) 828-1525 for further information.

## Weekly Fish May Help Weak Eyes

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Eating oily fish once a week may reduce age-related macular degeneration (AMD), according to a study published in the August 8th issue of the *American Journal of Clinical Nutrition*. AMD is a major cause of blindness and poor vision among adults in Western countries and the third leading cause of blindness around the world.

There are two types of AMD, wet and dry, with wet AMD being the main cause of vision loss. A multinational team of researchers from seven European countries, coordinated by the London School of hygiene and Tropical Medicine sought to investigate the relationship between consumption of fish with omega 3 fatty acids and development of wet AMD. They interviewed study participants regarding their dietary habits, including how much fish they ate and which type. Researchers referenced food composition tables which contained information on the amount of omega 3 fatty acids, which chemically contain docosahexaenoic acid (DHA) and eicosapentaenoic acid (EPA), in different types of fish.

The findings show that people who habitually consume oily fish at least once a week are 50% less likely to have wet AMD than those who consume less than once a week. There was no benefit found from consumption of non oily white fish. There was a strong inverse association between DHA and EPA levels and wet AMD, with those in the top

25% of such levels (300 mg per day) being 70% less likely to have AMD.

Astrid Fletcher, Professor of Epidemiology at the London School and research leader, said "This is the first study of Europeans to show a beneficial association on wet AMD from the consumption of oily fish and is consistent with results from studies in the USA and Australia. Two 3oz servings a week of oily fish, such as salmon, sardines, tuna or mackerel, provide about 500 mg of DHA and EPA per day." The research team did not investigate the effects of omega 3 supplements.

## Project Lifesaver Program Helps Law Enforcement Locate At-Risk Citizens

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Amber Whittaker

It all started because of failure, a missing person who couldn't be located in time. It was and still is a story that happens monthly, if not weekly all across our nation. For families and caregivers exploring options of how to protect a loved one who wanders away from the safety of home home due to Alzheimer's disease, dementia, autism, intellectual disabilities or other conditions that may lead to wandering, there is hope. Project Lifesaver started in 1999 within a search and rescue group affiliated with the Chesapeake Sheriff's Office known as the 43rd Virginia

- continued on page 13

## The Shepherd Center of Richmond

Jeannette Glasheen

Life is about time and choices. Neither of which is totally under our control. As we age, time is more about the past and choices are more about the future. At this point in our lives, we can do some of the things we had to put on "hold" when we were younger, things like returning to school, making new friends, going out for lunch and staying two hours, attending daytime lectures, and volunteering some of the talent given or earned in our earlier "busy" years.

This is actually our time to choose

the way we would like to spend our available hours. There is less demand in our lives and more from which to select. However, the transition from work to retirement can be disconcerting. I have a suggestion.

There is an organization which specializes in teaching classes for those 50 and better, one that offers, as well, time for socializing with our peers. In addition, there is an opportunity to help others who are less fortunate. This organization is called The Shepherd's Center of Richmond. Its classes are referred to as the Open University and are set up similar to an institution of higher learning, eight weeks a semester, three semesters a year, with summers off. The good part is

there are no grades and no tests (except for the occasional questions from the teacher). The teachers are leaders from the community, many retired professors, some from the business and medical fields, all a thoroughly responsible group of individuals who volunteer their time to teach others.

The Open University meets in three daytime locations and one evening location across metropolitan Richmond. The daytime locations are: (Mondays) St. Luke Lutheran Church on Chippenham Parkway, (Tuesdays) Ginter Park Presbyterian Church on Seminary Avenue, and (Thursdays) First Presbyterian Church on West Cary Street. The

- continued on next page

### **Confident Living Program for Senior Adults Who Are Hard of Hearing and Blind or Visually Impaired Helen Keller National Center, Sands Point, New York**

**March 30- April 7, 2009**

*(Seniors arrive on Sunday, March 29 and leave on Tuesday, April 7)*

This one-week program has been specially designed for Senior Adults (age 55 and better) who are hard of hearing and blind or visually impaired, and who do not use sign language as their primary means of communication.

Participants in the 2009 program will obtain information and an introduction to skills in:

**Coping with hearing and vision loss  
Enhancing independent living skills  
Enhancing communication skills  
Experiencing new technology  
Emergency preparedness  
Utilizing Support Service Providers (SSPs)  
Having FUN**

**Self advocacy  
Elder law  
Community integration  
Leisure activity options  
Developing community resources  
Sharing life experiences with others**

**For an application and more information, please contact:**

Admissions Coordinator, Helen Keller National Center, 516-944-8900 V/TTY Ext: 258, [www.hknc.org](http://www.hknc.org)

**Program cost for tuition, room and board is \$800.**

evening classes meet on Tuesdays at 5:30 for refreshments, a speaker at 6:00 and classes from 7:00 - 8:00 at St. Mary's Catholic Church on Gayton Road.

There is a modest annual membership fee and a tuition cost for each semester. Members can attend any or all four locations for one tuition fee a semester. This is a real bargain, four for the price of one.

Classes offered during fall 2008 include Ancient China: History and Culture; Thomas Jefferson, the Founding Fathers and the Election of 2008; A Cat, Popcorn, and Quantum Theology; Current Politics and Government: Britain, France, and Germany. Speakers this semester include the Honorable Jennifer McClellan, Delegate from the 71st District, Peter Mark, the Founding Director of the Virginia Opera, and Bill Lohmann from the *Richmond Times-Dispatch*. You can see the entire selection by visiting the Shepherd Center's web site [www.richmondshpctr.org](http://www.richmondshpctr.org) or by calling the office at (804) 355-7282 and having a newsletter mailed to you.

In addition to taking classes, lectures, and socializing, you may wish to become a volunteer. This is strictly up to you. Some volunteers are helping in the Shepherd Center's office on Augusta Avenue in Richmond; some are driving clients to doctors' appointments or making small repairs in homes of those who are unable to help themselves; some offer phone contact with people who wish to be connected to others. All of these services are available to those ages 60 and above.

Let's get going!

## **Project Lifesaver, continued**

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Search and Rescue Organization. Currently, there are over 735 agencies in law enforcement, EMS, fire departments, and elsewhere in 43 states, D.C., and Canada that are participating in the Project Lifesaver program called Bringing Loved Ones Home.

Project Lifesaver International is a non-profit (501(c)(3)) organization, depending on private and corporate funding. Donations are used directly for programs, rescues and educational expenses. To date, Project Lifesaver has had 1,742 successful search and rescues of Project Lifesaver clients, maintaining a **100%** recovery rate and **zero** fatalities. The average national find time of a client on the Project Lifesaver Program is less than 30 minutes.

People who are enrolled in the Project Lifesaver Program wear a personalized wristband that emits a tracking signal. When caregivers notify the local Project Lifesaver agency that the person is missing, a search and rescue team responds to the wanderer's area and starts searching with a mobile locator tracking system.

Before Project Lifesaver, searches across the country were averaging nine hours and costing taxpayers approximately \$1,500 an hour. Many searches actually took days, with hundreds of responders, resulting in much higher costs and many with tragic endings. One search in Chesapeake in 1979 cost the city \$342,000 and, tragically, was unsuccessful. The basic cost to start

this program in an agency is less than \$8,000; finding someone alive is priceless.

For more information on Project Lifesaver or a participating agency near you, call 1-877-580-LIFE or visit [www.projectlifesaver.org](http://www.projectlifesaver.org).

## **Your Life, Your Choice, Your Home: What Virginia's Long Term Support Systems Transformation Means for You**

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by Julie A. Stanley  
Director, Community Integration  
for People with Disabilities  
Office of the Governor

Do you know people using long-term services or supports (also known as long-term care) who are not happy with their life, their choices or their living situation? Do you work in the long-term services and supports system and experience problems helping individuals to receive what they need? Will you or anyone in your family ever need long-term services and supports?

If you answered yes to any of these questions, we have good news for you: Virginia's human services and housing agencies are laying the groundwork for a dramatic change or transformation of the long-term support services system that is designed first and foremost to benefit individuals and families who use these services.

**What are long-term support systems?** These help us maintain our

daily lives. They include unpaid caregivers and a variety of state, local, and private agencies that deliver, oversee, screen for, or pay for services for seniors and for children and adults with disabilities who seek assistance with activities of daily living. Some of these systems are:

Virginia's Medicaid program, administered by the Department of Medical Assistance Services, which pays for long-term supports for many individuals;

The aging services system, which includes the Virginia Department for the Aging, Area Agencies on Aging, and public and private services and institutions for older adults

The mental health, intellectual disabilities (formerly mental retardation) and substance abuse services system, which includes the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, that operates institutions for individuals with mental health issues and institutions for individuals with intellectual disabilities; and local community services boards and private agencies that provide mental health, intellectual disabilities, and substance abuse services

The disabilities services system, which includes the Virginia Departments of Rehabilitative Services, Blind and Vision Impaired, and Deaf and Hard of Hearing, the Woodrow Wilson Rehabilitation Center, private non-profit Centers for Independent Living, and many public and private programs.

The social services system, which includes the Virginia Department of Social Services, local departments of social services, and programs such as Adult Foster Care that are operated by local departments of social services

The health services system, which includes the Virginia Department of Health and health services provided by hospitals, home health agencies and public and private nursing facilities

Public and private assisted living facilities

**Why transformation?** It is easy to see from the lengthy list above that long term support systems in Virginia are numerous, complex, and fragmented. Consequently, planning, management, and administration of related activities are extremely challenging to coordinate. Add to this the fact that housing systems, which assist in providing low-income individuals with one of their most basic needs, plan and deliver their services in an entirely different manner, and you can understand why many individuals seeking long-term supports do not find what they need or, if they do, they find the experience confusing and frustrating.

**What are we doing about it?** The work started in 2006, when the Virginia Department of Medical Assistance Services, working hand in hand with state and local agencies, private and public providers, advocates, people who currently use long term supports, and families successfully applied to the federal Centers for Medicare and Medicaid Services for two key initiatives: 1)

a Systems Transformation Grant and 2) a Money Follows the Person Rebalancing Demonstration. As a result of these two initiatives:

Everyone now has instant access to comprehensive information about supports on the Virginia Easy Access website at [www.easyaccess.virginia.gov](http://www.easyaccess.virginia.gov).

You can explore information about a variety of community supports, financial help, housing, transportation, emergency preparedness, and your rights.

Easy Access also offers customized searches for supports near you, and e-mail support by 2-1-1 VIRGINIA. If you prefer getting information by telephone, you can dial 2-1-1 for information 24 hours a day, 7 days a week, 365 days a year. If you currently use home and community based Medicaid waiver services in the community, you are now able to access new services you may need. Services added to the waivers are: (see chart page 15)

If you live in a nursing home, "ICF/MR," or long-stay hospital, you now have more options for moving to the community through the Money Follows the Person Project. Individuals participating in this Project will transition into the PACE program or one of the following five Medicaid Waivers: Elderly or Disabled with Consumer Direction (**EDCD**); **HIV/AIDS**; Technology Assisted; Individual and Families Developmental Disabilities Support (**IFDDS**), or Mental Retardation/Intellectual Disabilities (**MR/ID**). These individuals will have access to all of the particular waiver's current, new and

Service	EDCD Waiver	HIV/AIDS Waiver	Technology Assisted Waiver	IFDDS Waiver	MR/ID Waiver
<b>New:</b> Transition Coordination: to support individuals with transition activities before and after transition	X				
<b>New:</b> Transition Services: a one-time, life-time maximum \$5,000 for individuals transitioning from institutions to the community for up-front household expenses	X	X	X	X	X
<b>Added:</b> Personal Emergency Response Systems including Medication Monitoring		X	X		
<b>Added:</b> Environmental Modifications	X	X			
<b>Added:</b> Assistive Technology	X	X			

added services, plus:

There is also a limited amount of funding for home modifications and for rent to cover the time between signing a lease and moving in after modifications are completed, provided by the Virginia Department of Housing and Community Development; and 24-hour-per-day, 365-day-per-year emergency back up service provided by 2-1-1 VIRGINIA for the first 12 months after moving back into the community.

**Future goals.** The work continues at a rapid pace, so that in the future you or your family member will: Control more of the supports you use, and family, friends and neighbors can play a more active role supporting you through use of “person-centered practices.” Person-centered practices put individuals at the center of all planning that impacts their lives.

Have faster access to supports through: 1) An on-line Medicaid application to be made available on *Virginia Easy Access*; 2) An on-line form also to be on *Virginia Easy Access* that you can fill out to tell you if you might be eligible for certain supports; and 3) Streamlined

processing of applications for certain Medicaid waivers

Be able to avoid having to fill out multiple applications for supports at multiple agencies. Public and private aging and disability service agencies are forming a comprehensive network to collaborate and plan together and share information (but only with your permission!). The six current local or regional “No Wrong Door” sites will expand to 10 this fall, with a goal of a statewide network of No Wrong Door resource providers statewide by 2010.

Have more housing and transportation choices.

**Next steps.** This fall the Commonwealth will develop an *Annual Housing and Transportation Action Plan* to increase options for seniors and people with disabilities; it will address ways Virginia can create affordable housing, make accessible transportation available, connect housing and transportation, and develop lasting partnerships among housing stakeholders and human services system stakeholders. In addition, 16 Centers for Independent Living are working with local

housing and human service agencies to address housing needs of individuals with disabilities and seniors, assure that these needs are incorporated into housing planning, and track related policy changes.

All of these transformation efforts are designed to assure that you have more choices about your supports and where you receive them (in an institution or in the community), and that your choices are honored by whomever you choose to provide your supports. ***After all, it’s Your Life, Your Choice, and Your Home that matter most!***

You can get more information about these two transformation efforts by contacting:

Systems Transformation Grant Project Director at [kristin.burhop@governor.virginia.gov](mailto:kristin.burhop@governor.virginia.gov) or (804) 692-2540

Money Follows the Person Project Director at [mfp@dmas.virginia.gov](mailto:mfp@dmas.virginia.gov) or (804) 225-2984 (also by visiting [www.olmsteadva.com/mfp/](http://www.olmsteadva.com/mfp/))

## COMMONWEALTH OF VIRGINIA

### Alzheimer's and Related Diseases Research Award Fund

#### FINAL PROJECT REPORT SUMMARIES FROM THE 2007-2008 ALZHEIMER'S RESEARCH AWARD FUND

The Alzheimer's and Related Diseases Research Award Fund (ARDRAF) was established by the Virginia General Assembly in 1982, and is administered by the Virginia Center on Aging at Virginia Commonwealth University. Summaries of the final project reports submitted by investigators funded during the 2007-2008 round of competition are given below. To receive the full reports, please contact the investigators or the ARDRAF administrator, Dr. Constance Coogle ([ccoogle@vcu.edu](mailto:ccoogle@vcu.edu)).

**VCU Galya R. Abdrakhmanova, M.D., Ph.D. (Department of Pharmacology and Toxicology,**

**School of Medicine) "Novel Epibatidine Analogs as Potential Selective Agonists of  $\alpha 4\beta 2$  nAChRs"**  
Neuronal nicotinic acetylcholine receptors (nAChRs) expressed in the brain are known to be important for cognition, learning and memory, and their deficiencies are shown to play a crucial role in Alzheimer's disease (AD) pathogenesis. Neuronal nAChRs consist of various combinations of  $\alpha 2$ - $\alpha 10$  and  $\beta 2$ - $\beta 4$  subunits. The most abundant subtypes of nAChRs in the central nervous system are  $\alpha 4\beta 2$  and  $\alpha 7$ , whereas  $\alpha 3\beta 4$  predominates in the periphery. Administration of nAChR agonists with high affinity to the  $\alpha 4\beta 2$  nAChR has been proposed as one of the approaches for the treatment of AD. Further, the activation of  $\alpha 7$  nAChRs has been recently shown to exhibit a neuroprotective action. The natural alkaloid epibatidine is known to possess a high affinity but lack of selectivity towards central neuronal nAChRs. Three novel analogs of epibatidine with -Cl, -F or -NH<sub>2</sub> substitutions at the 3' position of the pyridine ring, that have been recently developed and found to possess high binding affinity to brain nAChRs, were proposed to be tested: a) *in vitro* for their functional activity and nAChR subtype selectivity; and b) *in vivo* for a memory enhancement effect. The *in vitro* patch-clamp experiments demonstrated that, compared to the two other tested analogs, 3'-fluoro substitution in the epibatidine pyridine ring results in an analog with the most effectively increased efficacy and improved selectivity for  $\alpha 4\beta 2$  versus  $\alpha 3\beta 4$  nAChRs, while retaining an agonist effect on  $\alpha 7$  nAChRs. These findings suggest that 3'-fluoro analog of epibatidine may serve as a novel candidate for a treatment of AD due to its potential memory enhancement, neuroprotection and minimized peripheral side effects. The *in vivo* studies are still in progress due to a temporary failure of positive nootropic control compounds to decrease the number of errors in the radial arm maze test. Continued work aims to replicate the nootropic effects of donepezil and rimonabant in the radial arm maze test, in order to proceed with evaluation of the novel 3'-fluoroepibatidine analog for memory enhancement. (Dr. Abdrakhmanova can be reached at 804/828-1797)

**UVA Erik J. Fernandez, Ph.D. (Department of Chemical Engineering) "Designed Peptides as Models for Amyloid- $\beta$  Toxicity"**

Alzheimer's disease has long been known to involve formation of fibrillar structures from a protein fragment termed amyloid- $\beta$ . More recently, the interactions between this protein fragment and cell membranes have been implicated as critical aspects to the neuronal damage in Alzheimer's patients. This research demonstrated that a peptide mimic of the amyloid- $\beta$  peptide can exhibit many of the critical features of A $\beta$  behavior, including self-association, binding to membranes, and acceleration of self-association by membranes. Particularly important, the mimic is also toxic to neurons. Further, like A $\beta$  it shows the trend that intermediate concentrations of the peptide are most toxic. This suggests that at least some aspects of the disease may be valuably studied using such peptide mimics. Finally, the investigators have also studied the effect of some recently discovered molecules that manipulate the aggregation of amyloid- $\beta$ . They have been able to distinguish the effects of these molecules on peptide association vs. membrane binding. The results may have implications for the design of new therapeutic molecules that can prevent the toxic interactions of amyloid- $\beta$  with membranes. (Dr. Fernandez can be reached at 434/924-1351)



**Shenandoah Mary A. Corcoran, Ph.D., OTR (Div. of Occupational Therapy, School of Health University Professions) “Caregiving Styles of Adult Children Who Provide Dementia Care”**

Thirty one individuals who provide care for a parent or similarly related person with dementia participated in this qualitative study of caregiving styles. Each participant was interviewed on three occasions (for an average of 55 minutes per occasion) and completed a questionnaire to gather information about sociodemographic characteristics and well-being. With regard to the elements of caregiving style (beliefs, meanings, and actions), filial caregivers reported a consistent set of beliefs about the nature, causes, and progression of dementia and the definition of an ideal caregiver (although most would not claim to embody that definition). Meanings associated with caring for a parent included priorities for care (trying to avoid future regrets, paying respects to an honored parent, and fulfilling commitments), costs, conflicts, self-image, and change. Actions included interacting with the parent (i.e., communication, managing medical routines, being vigilant), managing the system and environment (i.e., interacting with the staff at an assisted living facility or keeping things organized), and managing self and non-parental responsibilities (i.e., work duties and children). Turning to overall style, it was found that the context of care is an important factor in determining style, with the presence of other involved family members and living arrangement shaping patterns in thinking and action. Three caregiving styles have emerged 1) Informing – collecting and dispensing information about the parent and from the literature to influence the care decisions of others; 2) Arranging – juggling multiple roles and schedules including caregiving; and, 3) Monitoring and Managing – being vigilant about the health of the parent and acting on his/her behalf with formal care providers. *(Dr. Corcoran can be reached at (540/665-5563)*

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## Calendar of Events

### October 15, 2008

*Annual Good Grief Conference.* This year's theme is Can You Hear Me Now? The Gift of a Listening Presence. The Hermitage at Cedarfield, Three Chopt Road, Richmond. 8:00a.m. - 4:30 p.m. For information, call Pat Gault-Coles at (804) 828-0928.

### October 20, 2008

*Older Adults and Disabled Adults: You Can Make a Difference.* Advocacy training sponsored by the Chesterfield Council on Aging and Chesterfield's Senior Advocate. Central Library, 9501 Lori Road, Chesterfield. 9:00 a.m.- 12:30 p.m. Free. Advance registration required. For information, call (804) 768-7878.

### October 21, 2008

*VCU's Department of Gerontology Fall Symposium.* Presentation by AARP's Divided We Fail Campaign. MCV Alumni House, Clay and 11th, Richmond. 6:00-9:00 p.m. For more information, call (804) 828-1565.

### October 29, 2008

*Who Has Their Hands in Grandma's Wallet? The Frauds and Scams Targeting Older Adults.* A program of the Chesterfield TRIAD, with Jennifer Aulgur, Office of the Attorney General. Etrick Community Center, Etrick. 10:00 - 11:30 a.m. Free. For information, call Sergeant Lawrence Taylor at (804) 717-6266.

### October 29, 2008

*Best Practices in Dementia Care.* Seventh annual education conference of the Alzheimer's Association of Central and Western Virginia. Speakers include William Thies,

PhD, Teepa Snow, MS, Jonathan Evans, MD, and Joyce Simard, MSW. Festival Conference and Student Center, James Madison University, Harrisonburg. 8:00 a.m. - 4:30 p.m. For information, call Ellen Phipps at (434) 973-6122 or visit [www.alz.org/cwva](http://www.alz.org/cwva).

### October 30, 2008

*Maintain Your Brain.* Presentation by the Alzheimer's Association Greater Richmond Chapter, hosted by Circle Center Adult Day Services, 3900 West Broad Street, Richmond. 4:00-4:45 p.m. Space is limited. Contact Lynda Gormus at (804) 355-5717 or [lgormus@circlecenterads.org](mailto:lgormus@circlecenterads.org) to reserve a seat.

### November 3, 2008

*Estes Express Caregiver Conference.* Presented by the Alzheimer's Association Greater Richmond Chapter, with professional and family caregiver tracks. Holiday Inn Select-Koger Center, 1021 Koger Center Blvd., Richmond. 8:30 a.m.-4:30 p.m. Registration fee. For information, call (804) 967-2580 or visit [www.alz.org/grva](http://www.alz.org/grva).

### November 7, 2008

*Learn and Live with a Healthy Heart.* Workshop presented by the Area Planning and Services Committee (APSC) on Aging with Life-long Disabilities. Deep Run Recreation Center, 9910 Ridgefield Parkway, Richmond. 8:30 a.m.-3:30 p.m. \$15 registration. For information, call Lisa Poe at (804) 358-2211, ext. 33.

### November 12-13, 2008

*Making a Difference for a Lifetime of Health.* Mid-Atlantic Regional Patient Advocacy Leaders Summit.

Hosted by the Celebrate Life Foundation. Embassy Suites Hotel, 4300 Military Road, NW, Washington, DC. For information, contact Michelle Hannah at [mhannah@celebratelifefoundation.net](mailto:mhannah@celebratelifefoundation.net).

### November 21, 2008

*Virginia Coalition for the Aging Fall Meeting and Elder Rights Coalition Legislative Forum.* This year's theme is Change in Washington; How Will It Affect You? 8:30 a.m. - 2:30 p.m. Crowne Plaza West Broad, Richmond. For information, call Carter Harrison at (804) 967-2594 or [carter.harrison@alz.org](mailto:carter.harrison@alz.org).

### January 28, 2009

*Virginia Center on Aging Annual Legislative Breakfast.* St. Paul's Episcopal Church, 815 East Grace Street, Richmond. 7:30 a.m. to 9:00 a.m. For information, call (804) 828-1525 or [eansello@vcu.edu](mailto:eansello@vcu.edu).

#### Age in Action

Volume 23 Number 4  
Fall 2008

**Edward F. Ansello, Ph.D.**  
Director, VCoA

**Linda Nablo**  
Commissioner, VDA

**Kimberly S. Ivey, M.S.**  
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](mailto:kivey220@yahoo.com).

**Winter 2009 Issue Deadline:  
December 15, 2008**

## Virginia Center on Aging

at Virginia Commonwealth University, Richmond, Virginia

[www.vcu.edu/vcoa](http://www.vcu.edu/vcoa)

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***Looking Ahead: Promising Initiatives for a  
Community Response to Domestic Abuse in Later Life***

**Tuesday, October 21, 2008**

**9:00 a.m. - 4:00 p.m., Registration begins at 8:15 a.m.**

**West Campus Conference Center, Radford University, Old St. Albans**

Featuring **Candace Heisler**, a national expert in the fields of Domestic Violence and Elder Abuse. Ms. Heisler served as an Assistant District Attorney for the City and County of San Francisco, California, for more than 25 years, specializing in Domestic Violence and Elder Abuse cases.

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For more information, contact Mary Beth Pulsifer at the Women's Resource Center, at  
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