

Case Study

Reverse Mortgages

by Bruce DeSimone,
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Educational Objectives

1. Describe mobility rates among older adults.
2. Define a reverse mortgage and Home Equity Conversion Mortgage (HECM), and their origins in Virginia.
3. Explain key HECM loan and counseling features.
4. Illustrate how these features may improve the lives of older Virginians.

Background

A frequently cited statistic from a recent AARP Public Policy Institute survey is that 89% of Americans over 50 want to remain in their homes and communities for as long as possible. It is, therefore, not surprising that a recent analysis of Virginia housing trends conducted by the Virginia Housing Development Authority (VHDA) cited 2006 American Community Survey data indicating that, as Virginians grow older, their willingness to move

declines, with older households having the lowest mobility rates among all age groups (i.e., the share of households that moved in the previous year was 34.2% for households 25 to 29 years of age, 9.4% for 50 to 54, 8.0% for 55 to 59, 6.9% for 60 to 64 and 6.2% for 65 to 69 and 70 to 74). There was a slight increase to 7.3% for households 75+, which is attributed to moving into services-enriched housing due to increasing frailties (Virginia Housing Development Authority, 2008). Unfortunately, many homes in which older adults live may need costly accessibility retrofits in order to allow them to age in place. Given the more stringent lending standards since the late 2007 housing “bust,” early retirements from job losses, and reduced retirement and other savings due to the recent recession, the diminished household income and home equity of many older adults may disqualify them for conventional home equity loans. Reverse mortgages may help.

What Is a Reverse Mortgage or an HECM?

A very simple definition of a

reverse mortgage is a loan in which an older homeowner borrows money from the equity in the principal residence and receives income from the lender as a lump sum payment and/or by drawing income over time. Homeowners are approved to borrow a portion of the equity in their home, with the share based on their remaining life expectancy, that is, older adults can borrow larger shares of their equity than can younger counterparts. This arrangement continues for as long as the homeowner continues to occupy the home as the principal residence and there is remaining unused borrowing authority. The lender is then paid back the principal and accrued interest from the sale of the home when it no longer is the borrower’s principal residence.

An HECM, or Home Equity Conversion Mortgage, is a reverse mortgage insured by the U.S. Department of Housing and Urban Development (HUD) that is made by a HUD-approved lender. This mortgage insurance is an important feature in that HUD guarantees that the loan will continue even if the lender goes out of business or the

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loan principal and accrued interest grow to exceed the equity in the home. Importantly, an HECM borrower will never owe more than what the house is worth. A second key feature is that HUD requires potential borrowers receive impartial counseling from HUD-approved, public or private non-profit counselors to help ensure that the borrower understands the product, its costs, and if an HECM loan is the best choice for personal circumstances. Although other reverse mortgage products exist, HECM loans are estimated to account for 90 to 95 percent of the reverse mortgages made today.

Reverse Mortgages and HECMs in Virginia

According to a 1992 report to the Governor and General Assembly, “Virginia first became involved in reverse mortgages in 1985 when the Virginia Department for the Aging received funding from the U.S. Administration on Aging for a 15-month pilot project to provide education to older homeowners on home equity conversion and to test the market for various types of potential home equity conversion products” (Virginia Housing Development Authority and Virginia Department for the Aging, 1992, p. 2). Following the pilot and due to a lack of interest by private lenders, the Virginia Department for the Aging (VDA) and VHDA joined to offer the “Virginia Senior Home Equity Account” program to demonstrate the feasibility of, and demand for, reverse mortgages in Virginia. Loans were made to homeowners ages 62 and older who agreed to continue occupying the home as their principal residence.

These loans were made available through 24 of the 25 area agencies on aging. By October of 1988 when program publicity ended, over 900 interested persons had contacted VHDA and, after just an eight week application period, over \$3 million in loan requests were received. Of these, VHDA closed 139 loans totaling \$2.6 million during the following 12 months. Clearly, Virginians were interested in reverse mortgages; however, private lenders and capital were needed to satisfy future demand.

In 1990, Congress passed the National Affordable Housing Act, which authorized HUD to pilot the Home Equity Conversion Mortgage (HECM) Insurance Demonstration. In 1991, this demonstration was opened to all HUD-approved mortgage lenders. Given the initial lack of lender interest, VHDA directly offered HECM loans, while making numerous outreach efforts to lenders. Concurrently, VHDA and VDA partnered with AARP to train area agency on aging staff to become HUD-approved HECM counselors. Eventually, the number of HECM lenders and counselors grew to the point that the private and non-profit sectors satisfied the HECM lending and counseling demands and VHDA and VDA no longer were needed, although VHDA continues to pass on some funds to HUD-approved counseling agencies that provide HECM counseling.

HECM Loan Features

Note that some, but not all, HECM features are listed below. Readers will find additional resources at the end of this article.

Borrower(s) must: 1) Be 62 years of age or older (all persons on the deed must qualify; loan amount based on the life expectancy of youngest borrower and increases with age). 2) Own the property outright or have a small mortgage balance (any existing mortgage is paid-off with HECM loan proceeds at closing). 3) Occupy the home as the borrower’s principal residence and not vacate the home for more than 12 months. 4) Not be delinquent on any federal debt. 5) Participate in, and understand, an HECM counseling session (in person or by phone and may bring a trusted advisor to aid in understanding) offered by a HUD-approved counselor. (The counseling agency may charge a fee up to \$125, which may be paid directly to the agency or added to closing costs). 6) Remain current in paying real estate taxes, homeowners insurance, other assessments, and maintain the home.

Financial requirements: 1) No income or credit qualifications are required as loan proceeds are paid TO the borrower. 2) No repayment is required as long as the borrower occupies the home as his/her principal residence. 3) Closing costs may be financed in the mortgage. (A common concern is that closing costs are high, e.g., origination fee of \$2500 to \$6,000 depending on the loan amount, HUD’s upfront mortgage insurance premium of 2.0 percent of the loan amount, and typical fees for appraisal, title search, etc.; however, these are one-time payments and the relative proportion of these costs to loan amount declines over time as more loan proceeds are disbursed). HUD is addressing this high HECM loan

fee issue by implementing a second option, HECM Saver. As of October 2010, HUD renamed the traditional HECM program “HECM Standard” and created “HECM Saver,” which reduces the upfront mortgage insurance premium from 2.0 percent to 0.1 percent for the HECM Saver option. Although HECM Saver borrowers will pay a smaller upfront mortgage insurance premium, they also will see a reduction in the amount they can receive from a HECM loan. 4) While loan proceeds generally are not considered taxable income, they may affect public assistance benefits or have other ramifications; the borrower should consult with a tax advisor in these cases.

Home must: 1) Be a single family or one- to four-unit home with one of the units occupied by the borrower or a HUD-approved condominium or manufactured home. 2) Meet HUD’s property standards and flood insurance requirements, if applicable.

Lender must: Neither contact an HECM counseling agency on a borrower’s behalf, nor take an application before the borrower successfully completes an HECM counseling session and receives a counseling certificate issued by the HUD-approved counseling agency. Note that other interested parties such as real estate agents, appraisers, and financial product salespersons are similarly restricted.

Mortgage amount based on: 1) Age of youngest borrower. 2) Current interest rates (can be a fixed or adjustable rate). 3) Lesser of appraised value or HUD’s current maximum mortgage limit for the

area, currently fixed for HECM at \$625,500 until December 31, 2010.

Loan proceeds up to the total loan amount may be taken as: a total lump sum payment (also may be used for home purchase or refinancing of a primary residence if the borrower has cash on hand to pay the difference between the sales price and the HECM loan plus closing costs), or one of five payment options. These are: 1) Tenure: equal monthly payments. 2) Term: equal monthly payments for a fixed number of selected months. 3) Line of Credit: unscheduled draws as needed. 4) Modified Tenure: combination of line of credit and scheduled monthly draws. 5) Modified Term: combination of line of credit and monthly draws for a fixed period of months.

Loan paid off: Lender sells the home after it no longer is occupied by the borrower and recoups principal and interest paid to the borrower over the life of the loan. Note that a common concern is that the borrower’s estate no longer inherits the home; however, the estate can refinance the home to repay the lender and own the home. As part of the HECM application and loan closing documents, the HECM borrower names a contingent contact person whom the lender would notify when the loan becomes due and payable.

Reverse Mortgage Fraud

As with other fraud schemes, older adults are potential targets for reverse mortgage scams. One scheme is for a senior to be solicited for HECM information and services for a fee, such as finding an

HECM counselor and/or lender for a percentage of the HECM loan. Although HUD-approved HECM counselors may charge a fee and HECM lenders also may charge a loan origination fee, HUD requires that these two steps be totally independent, with the senior homeowner free to select the counselor and separately shop for an HECM. Another scheme is for an older homeowner to be solicited by a person representing himself or herself as a “financial advisor” who encourages the senior to purchase an annuity, risky investments, a living trust or other estate planning tools using HECM loan proceeds. A third example is the “financial advisor” who is teamed with a contractor selling home improvements. In all of these examples, the best deterrent is for the older adult to become an educated consumer and learn about HECM loans and the process through a HUD-approved HECM counselor.

Case Study #1

Frank and Edie, ages 72 and 62, own and live debt free in a suburban split level home, which they learned, when unsuccessfully seeking a home equity loan, has an appraised value of \$356,000. Frank had retired with a small pension and Social Security. Four years ago, he injured his back while cleaning the gutters and his injury worsened to where he has difficulty with bathing and uses a walker. Edie quit her job to be his caregiver; however, she has had to return to work part-time as they depleted much of their savings for Frank’s medical bills. She takes home about \$600 per month from her job. Now that she is working, Frank

needs home care. At the physical therapist's suggestion, they contacted a National Association of Home Builders "Certified Aging-In-Place Specialist (CAPS)" contractor to help assess what accessibility modifications and Universal Design features could be made to their home to assist with their current and future mobility needs. The estimate for the modifications was \$24,000 but, in addition, Frank has not been able to maintain the house as he had been, so it now needs new sheathing and new roof shingles costing \$6,000.

They saw a newspaper advertisement for an HECM loan and began calling HUD-approved lenders listed in the telephone directory. These lenders indicated that they would, on their own, need to select a HUD-approved HECM counseling agency and successfully complete a counseling session before they could have any further discussions with them.

Frank and Edie met with a non-profit HECM counseling agency which followed HUD's mandatory HECM counseling protocol. This included a comprehensive intake revealing the above facts, as well as their detailed household budget; reverse mortgage features, costs, and financial/tax implications; Frank and Edie's responsibilities as HECM borrowers; other financial and social service resources as alternatives to a reverse mortgage; and warnings about potential reverse mortgage and insurance fraud schemes and elder abuse. Throughout the session, the counselor asked HUD-prescribed questions to gauge whether they understood what was being discussed.

After reviewing computer print-outs of various HECM loan scenarios that are part of the mandatory HECM package they received, all agreed that a HECM loan was their best course of action and the counselor issued the HECM Counseling Certificate allowing them to apply for an HECM loan from a lender of their choice. In addition, the counselor told them about Virginia's maximum \$2,000 "Livable Home Tax Credit" that may reduce their out of pocket costs for eligible accessibility improvements. *(The Virginia Department of Housing and Community Development (DHCD) administers this program whereby Virginians may receive up to a \$2,000 credit on their state income tax for retrofitting to state-defined standards an existing residential housing unit with either accessibility features or sensory modifications. Note that the current year appropriation for this tax credit is capped at \$1million and so applicants may receive a lesser, prorated amount if there are more than \$1million in credits requested. Also note that this tax credit is available for new construction. The link to DHCD's Livable Home Tax Credit Program web site is www.dhcd.virginia.gov/HousingPreservationRehabilitation/Tax_credit_program.htm).*

The following figures are based on the National Reverse Mortgage Lenders Association's *Reverse Mortgage Calculator* (National Reverse Mortgage Lenders Association, 2010). Given current interest rates at that time, Frank and Edie qualified for a lump sum withdrawal of between \$57,150 to \$161,250 after deducting financed closing costs and the home modification

and repair costs, depending on whether they chose a fixed or adjustable interest rate, and whether the adjustable rate changed monthly or annually. Given the \$30,000 needed for accessibility and roof repairs, they decided to withdraw that amount at closing and use the Tenure feature to receive a monthly income of approximately \$445 or \$798, again depending on whether the loan adjusted monthly or annually. This amount approximated what Edie had been receiving from her part-time job on an after tax basis.

Case Study #2

Thelma and Loisetta, sisters aged 67 and 60, inherited their rural home. Social Security is Thelma's only income and Loisetta stopped working within the last six months when a local business closed. Their home is a one story bungalow on well and septic, and with an assessed value of \$89,000. Approximately three months ago, the septic system drain field failed and the Health Department is requiring them to install an advanced system costing \$19,000. In addition, their shallow well has intermittently gone dry during drought periods. Their trusted minister, who also advises them on financial matters, suggested they contact a certain non-profit HECM counseling center to explore an HECM loan, and he accompanied them to the counseling session at their request. The HECM counselor also followed the HUD-required counseling protocol similar to Case Study #1, including generating print-outs of the various HECM loan options.

Given their failing septic system,

problems with the well, and low household income, Thelma and Loisetta were asked if they had ever applied for the Virginia Department of Housing and Community Development's "Indoor Plumbing Rehabilitation Program" (www.dhcd.virginia.gov/HousingPreservationRehabilitation/IndoorPlumbingRehabilitationProgram.htm) offered through the local Community Action Agency, as it appeared to the counselor that they may qualify for this 10-year, 0% interest, forgivable loan. Thelma and Loisetta agreed that they preferred this option to an HECM loan and left the counseling session with information on how to apply. In addition, they had demonstrated an adequate understanding of the information discussed during the counseling session and were issued a HECM Counseling Certificate, just in case they wished to pursue this option. The counselor also pledged to contact them in a few weeks to determine if they needed any further assistance, a counseling follow-up action also required by HUD.

Conclusion

These case studies demonstrate the potential value of HUD's HECM loan product and process. Older adults have demonstrated a preference for remaining in their homes and communities. However, many may be challenged, for most homes are not designed and equipped for decreasing mobility and other impediments to aging-in-place. Given the recent recession, many older adults may have diminished or depleted the savings that they were planning to use for retirement, and this exacerbates the problem of finding financing for retrofitting

their homes. The mandatory HECM counseling process may be of critical assistance for seniors to explore their options, and the HECM loan product may allow them to continue living in their homes and communities, with dignity, for a longer time.

Study Questions

1. What are the prevailing mobility trends among older adults?
2. How do reverse mortgages and HECM loans address emerging needs among older homeowners?
3. Can you describe the key HECM loan and counseling features?

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Resources

FHA Reverse Mortgages (HECMs) for Consumers, found at www.hud.gov/offices/hsg/sfh/hecm/hecmabout.cfm.

National Association of Homebuilders Certified Aging-In-Place Specialist (CAPS), found at www.nahb.org/page.aspx/category/sectionID=686.

North Carolina State University Center for Universal Design, Environments and Products for All People, found at www.ncsu.edu/www/ncsu/design/sod5/cud/index.htm.

Virginia Livable Home Tax Credit Program administered by DHCD, found at www.dhcd.virginia.gov/HousingPreservationRehabilitation/Tax_credit_program.htm.

About the Author



Bruce DeSimone is the Community Housing Officer for Seniors Housing at the Virginia Housing Development Authority. Prior to joining VHDA, he created and managed a housing department at a 10-county area agency on aging in Virginia. He earned a Master of City and Regional Planning degree from Rutgers University, is a member of the American Institute of Certified Planners, and is certified as a Housing Development Finance Professional by the National Development Council.

Editorials

From the Director, Virginia Center on Aging

Edward F. Ansello, Ph.D.

Filling the Gap

It's becoming better known that there's a critical shortage of primary health care providers in general and of geriatric practitioners in particular. The Health Care Reform legislation is putting some \$130 Million into new workforce grants for the training of nurses, nurse practitioners, physicians, mental health technicians, and other providers in order to "populate the pipeline," according to USDHHS Secretary Kathleen Sebelius in a September 22nd interview. There are also new programs to help pay off medical school loans in exchange for a couple of years of primary care in underserved areas. But, paraphrasing Senator Everett Dirksen's famous comment about a Billion here and a Billion there, as good as it is, the Reform initiatives hardly constitute "real money." Still the needs remain enormous and the nature of health care training translates to substantial delays in the appearance of practitioners in the community. Speaking of which, a new survey by the Medical Group Management Association found that about half of all physicians finishing medical training in 2009 were hired by hospitals, thus drawing them away from community practice. This may help insure a continuing stream of patients for the hospitals and may, long term, transform the locus or setting of geriatric care but does nothing to ameliorate the present shortages.

Clearly, there is need for multiple initiatives focusing on the "pipeline" from professional undergraduate education through the continuing education of current practitioners, in order to make some dent in the looming shortfall of geriatric health care providers. Some actions promise to help. The growing use of electronic medical records enables better coordination of care among practitioners, for older adults often see a number of providers because of concurrent conditions. Also, the application of the "medical home" concept offers the potential for effective preventive care, given its orientation to patient-centered care and partnerships among patients, their families, and providers. The medical home in action also speaks to the evolving nature of geriatric health care, one built upon inter-professional, coordinated delivery.

And so, it is particularly gratifying to announce that Virginia has successfully competed for federal funding of a Geriatric Education Center, one of only four newly funded initiatives in the country. The Health Resources Services Administration (HRSA) in the USDHHS notified us in July that our Virginia Geriatric Education Center consortium passed intense national competition and extensive rounds of reviews to receive a five-year \$2.1 Million award. Our consortium team of EVMS, UVA, and VCU had worked since July 2009 to build a strong inter-professional partnership that engaged colleagues in nursing, medicine, pharmacy, social work, and physical therapy in the grant planning process. We had held 13 lengthy meetings before HRSA issued its Request for Pro-

posals, during which time this team identified issues, internal resources, and, among other things, willing partners elsewhere in Virginia for implementing inter-professional clinical training of students at community sites and venues for the continuing education in geriatrics of practicing professionals.

The VGEC will feature a focus, within a larger training curriculum, on preventing the recurrence of falls among older adults, using an Evidence-Based Practice (EBP) approach. The approach enables us to bring together the various health care professions to learn what works in preventing falls and how each profession can contribute to success, such as improved monitoring of medications or focused health screenings. The larger curriculum will include content about the contributing roles of core inter-professional team members, aging physiology, common geriatric syndromes, and cultural competence.

In all activities we will address the challenge of managing advanced chronic illness care for older persons across care settings and over time, with a focus on two main themes: care transitions and medication management. These, in turn, connect directly to the focus on falls in the Evidence-Based Practice component.

The overall goal of the VGEC is to improve the training of health professionals in geriatrics. This includes the involvement of health professionals in residencies, traineeships, and fellowships. The project has four fundamental

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Editorials

From the Interim Commissioner, Virginia Department for the Aging

Jim Rothrock
Commissioner, Virginia Dept. of
Rehabilitative Services (DRS)

Disability and Aging...not much in common?

I have had the honor of working with our Virginia Department for the Aging since September, and I have learned a great deal! Some may have thought that most older Virginians were disabled anyway, and many Virginians with disabilities are approaching their elder years. Some even thought that no one would notice if they were all thrown together for efficiencies. But I have seen and heard first hand that this is not the case.

There are enormous differences in the programming provided by DRS, Centers for Independent Living, Brain Injury Partners, case managers in several of the DRS programs and that offered through VDA, the Area Agencies on Aging, services through DMAS in our **Money Follows the Person** initiative, and the coordinated efforts in other state services committed to community-based programs for older Virginians.

When examining these programs, it is easy to see that currently there are:

- Different professional development components;
- Distinct areas for research and academic efforts;

- Dissimilar cultures in federal, state, and local governments and even more varied cultures when looking at private non-profit providers;
- Varying degrees of sophistication in lobbying, oops, I meant advocacy efforts;
- Disparate funding sources and organizational structures serving these growing groups; and.....
- The list could go on and on and on.

Yet when I have looked at the efforts of the Commonwealth, there are commonalities where opportunities for enhancing complementary programming are ripe, and I am taking that on as a challenge for this new assignment.

Governor McDonnell and Secretary Hazel have marveled at the difficult bureaucracies that offer the services that can have a positive impact on Virginians with disabilities and older Virginians. Since January, agency heads and leaders in the entire Department of Health and Human Resources (the Secretariat responsible for the operations of both VDA and DRS) have been encouraged to “*de-silo*” programs, thus making them more responsive to Virginians, not those defined by a diagnosis or an age, but all Virginians who have some need to be aided, supported, or sustained in a lifestyle congruent with their wishes.

In the time I have been on board, I have witnessed where we can:

- Encourage staff from different agencies to get to know each other and establish how they can work together;

- Support collegial programs in their approach to common goals with coordinated strategies;
- Meld resources to find a value added for Virginians;
- Co-locate offices and staff to support common goals; and
- Share training responsibilities for groups that are key to future successes.

I plan to identify some emerging best practices from various components of our disability network and our aging network and then share them widely. I would hope that these best practices will convince other communities to steal shamelessly these good ideas and put them into play across the state. No longer are we wealthy enough to support silo-ed programs. Success in the future will be found by looking broadly at our communities, seeing what the needs are among those we serve, and developing the options they need to meet their lifestyle choices for a rich, full, and independent lifestyle.

Yes, there are huge differences, but there are many commonalities. The trick is in being able to connect the dots. I look forward to collaborating with those who may be interested in these efforts, which are often right there within reach and in plain sight, and thereby expand our *Commonwealth of Opportunity* for all Virginians.

The answer is both **true** and **false**, but I think we can find success in the future when we focus on those common areas.

Focus on the Virginia Center on Aging

Jonathan Evans, MD, MPH



Jonathan Evans, a long-term care physician practicing in central Virginia, is a valuable member of the Advisory

Committee of the Virginia Center on Aging. He brings to our deliberations a background rich in clinical experience, inter-professional dynamics, and community relations. Following graduation from the University of Virginia (UVA) with a degree in biology, he moved to Minnesota, where he attended medical school, residency training in Internal Medicine, and fellowship training in Geriatric Medicine, all at Mayo Clinic. He remained on staff at Mayo Clinic for a number of years. While at Mayo, he balanced work and education to earn a Master in Public Health degree in Epidemiology at the University of Minnesota. Some 10 years ago he and his family moved to Charlottesville, where he began work at UVA as Head of the Geriatric and Palliative Medicine section. He directed the Geriatric Medicine Fellowship Training Program and helped to create a Fellowship Training Program in Palliative Medicine. Committed to interdisciplinary team practice in geriatrics, he developed medical school courses in Geriatric Medicine and trained nurses in the principles and practice of geriatrics as well.

Not so long ago, Jonathan left UVA to begin a practice with his wife,

Mary, in Charlottesville. Both are full-time long-term care physicians providing care to residents of area nursing homes and assisted living facilities. Their mission and focus are to better the care of older adults in the community by empowering patients and families, supporting and improving training for direct caregivers, helping to professionalize the role of the nursing assistant, and improving systems of care across the entire care continuum. With characteristic enthusiasm, Jonathan notes, “Working with my wife is the best job I could ever have. Together we are trying to make a difference in our community and beyond. We want to change nursing homes and improve the care of older people everywhere.”

Jonathan is actively involved in several state and national organizations whose purposes reinforce his own commitment to improve the well being of older adults, such as the American Medical Directors Association (AMDA), the Virginia Medical Directors Association, the Alzheimer’s Association, and the Virginia Department of Medical Assistance Services Drug Utilization Review Board. In Charlottesville, he and Mary work closely with the Community Partnership to Improve Long-Term Care, in hosting an annual conference for community caregivers. A constant emphasis throughout his career has to rectify drug-prescribing for older patients, for their body status and likelihood of having multiple prescribers and multiple medications place them at risk of adverse side effects; similarly he champions using non-drug approaches, whenever feasible, in managing the behaviors of patients with

Alzheimer’s disease and related conditions. Like a number of us in the broad “field of aging,” Jonathan remembers growing up suburban D.C. under the loving influence of many older family members. “I was surrounded by kind older people who loved unconditionally, and who cared and sacrificed for others. I was given opportunities by people who never had those same opportunities themselves, with the understanding that I would do the same for others someday. From an early age, I was taught that the most important thing a person can do is to care for others. I came to understand that with opportunity comes responsibility: ‘to whom much is given, much is required.’” These positive early experiences strongly influenced his decision to commit himself to geriatrics. “I believe in the wisdom of the ages. I see older people as the keepers of that history and that wisdom. As a result, I spend my days trying to learn how to live from people older than me. They have more experience. One of the most important lessons I have learned is that the sun setting is as beautiful as the sun rising.”

Among his other interests are hiking and exploring the outdoors, fishing, and scuba diving. “I love spending time with family, watching my children grow. I am always happiest in the company of others. I love being outside. I enjoy traveling and exploring new areas. I love to fish, but I don’t get out nearly enough. I love my work too much.”

The University of Virginia School of Medicine in collaboration with the UVA Institute for Aging, the UVA School of Nursing, the Alzheimer's Association, the University of Pittsburgh ADRC (Alzheimer's Disease Research Center) and Virginia Commonwealth University Department of Gerontology is proud to announce....

Memory Commons
www.MemoryCommons.org

an interactive, first of its kind educational website for physicians and healthcare professionals that focuses on Alzheimer's disease and dementia.

The Memory Commons site is designed to provide the latest clinical and research advances in the diagnosis and management of people with dementia and Alzheimer's Disease. Memory Commons employs multiple learning formats to encourage learning and advances in dementia and Alzheimer's disease care, as well as improve quality of care and access to the latest treatment guidelines. Learning methods include tutorials, interactive case discussions, open case consults, blogs, and an innovative interactive simulation of outpatient clinic encounters using a computer-gaming platform.

Please visit
MemoryCommons.org today
and help us spread the word!

GenSilent Premieres in Richmond

by John T. White, Director
Word. Marketing and Income
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Sunday, August 29th marked a multi-cultural and multi-generational milestone for the Central Virginia aging LGBT (Lesbian, Gay, Bisexual & Transgender) community. Thanks to the collaborative efforts of, among many others, the VCU Department of Gerontology, the Gay Community Center of Richmond, and the Richmond Triangle Players, the Virginia Premiere of Director Stu Maddux's "*Gen Silent*" was an overwhelming success. With the 4:00 pm show a sell out and the 7:00 pm show not terribly far behind, both audiences enjoyed the 63-minute documentary which follows six stories of LGBT seniors who are afraid of aging into the current healthcare system for fear of apathy, discrimination, and even abuse.

Director Stu Maddux and Executive Producer Barrie Atkin were on hand for both shows, from California and Massachusetts respectively, to shed light onto the reasons for their involvement in the project and plans for future premieres. Both Maddux and Atkin were very pleased with the Richmond premiere and commended the efforts that went into producing the event, which raised nearly \$7,000 for the documentary and the Gay Community Center of Richmond.

Future programming is being planned, including the development of a local SAGE chapter (Services and Advocacy for Gay, Lesbian,

Bisexual & Transgender Elders) through the Gay Community Center of Richmond. The VCU Department of Gerontology also remains committed to the development of person-centered curriculum that explores cultural competence and sensitivity for minority and disenfranchised aging populations. For more information on Gen Silent, please visit www.gensilent.com.

For more information on SAGE programming in Richmond, please visit www.gayrichmond.com. To contact Jay White, please visit www.wordmarketingva.com.

Best Wishes to Linda Nablo

Commissioner Linda Nablo of the Virginia Department for the Aging (VDA) left us this fall to assume directorship of the federal children's health insurance program. To say that she will be missed is insufficient. Linda guided VDA with massive energy and her personal talents. She led a reconceptualization of older Virginians and of aging services, evident in VDA's new Four Year Plan that recognized older adults as important resources and as highly individualized. She's been a vital member of VCoA's Advisory Committee for these and other gifts. One good piece of news: Linda will continue to live in Virginia while she works in Baltimore. A long commute for her but at least we haven't lost her altogether.

COMMONWEALTH OF VIRGINIA

Alzheimer's and Related Diseases Research Award Fund

FINAL PROJECT REPORT SUMMARIES FROM THE 2009-2010 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 2009-2010 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).

Alzheimer's Association

Central and Western Virginia

Ellen Phipps, C.T.R.S., and Barbara Braddock, Ph.D.

“Home-based activity intervention program in dementia”

This study investigated and promoted ‘partnered volunteering’ by pairing University students with individuals who have dementia and their family caregivers to examine an eight-week home-based activity engagement program. The twice weekly intervention provided opportunities for participants to complete activities that were once meaningful in their lives using Montessori-based instruction, therapeutic recreational principles, and environmental modifications. The program was designed to provide an opportunity for successful engagement in life among persons with a diagnosis, to offer respite and support to caregivers, and to foster positive inter-generational relationships. Participants in the intervention group ($n = 16$) were matched to those with dementia in the comparison group ($n = 16$) on the basis of sex, age, education, and cognitive screening scores. Comparison group participants selected activities in consultation with the students who implemented the set up, but did not receive regular student visits. Pre- and post-intervention data indicated that activity set up and in-home environmental supports promoted high levels of physical and verbal engagement among participants enrolled in both groups. In contrast to those that did not receive regularly scheduled student visits, caregivers with student support reported statistically significant reductions in burden between program initiation and end. Partnered volunteering may be most beneficial to the caregiver as a supportive intervention to reduce general caregiving stress while sustaining home activity for the individual with dementia. (*Ms. Phipps may be contacted at 434/ 973-6122; Dr. Braddock may be contacted at 434/924-4000*)

UVA Karen M. Rose, Ph.D., R.N., and Ishan C. Williams, Ph.D. “Family quality of life in dementia”

Because a diagnosis of dementia has implications for the overall functioning and well-being of the family unit involved, a reliable and valid instrument to assess the impact of interventions and services provided, or not provided, on family quality of life is needed. The goal of this project was to develop a Family Quality of Life in Dementia (FQOL-D) instrument that can be used in clinical and service settings to measure the impact on *families* dealing with dementia. An expert consensus panel of 12 representatives from medicine, neuropsychology, nursing, and gerontology completed three Delphi survey rounds to determine the face validity of items. Approximately 40 items were retained, representing five overall domains: family interactions; direct care/activities of daily living support; emotional/behavioral well-being; physical and cognitive well-being; and disease-related support/medical care. In addition, interviews with persons diagnosed as having mild-moderate dementia and their family members were conducted to pilot-test the instrument and collect qualitative data on their individual family quality of life perspectives. The investigators partnered with local Area Agencies on Aging and the Virginia Caregiver Coalition to distribute the FQOL-D across the state. Imminently pending results will confirm the psychometric properties of this clinically-meaningful instrument. (*Dr. Rose may be contacted at 434/ 924-5627; Dr. Williams may be contacted at 434/924-0480*)

VCU H. Tonie Wright, Ph.D. “Alzheimer’s A β amyloid peptide interactions with inflammatory chaperone molecules”

Research suggests that certain aggregated states of the β -amyloid (A β) peptide are toxic to brain cells and may also disrupt communication between neurons in the brain. This project hypothesized that the pathophysiological effects of Alzheimer’s A β amyloid peptides are modulated by interaction of the peptide with chaperone-like inflammatory molecules in a way that alters the pool of biologically active A β oligomer forms. Reciprocal to the effects of A β on these molecules, which are also linked to the neuronal damage associated with AD, is the question of how the interacting proteins affect distribution of the different forms of A β . Study results showed that the incubation of dissolved A β with these proteins changed how the A β molecules assembled into aggregates and altered the distribution by resulting in the significant loss of some forms of A β . In addition, A β peptide and its combination with two of the inflammatory proteins were tested for their effects on brain cells that produce the inflammatory response. Findings show that these proteins diminish the release of neuron-damaging molecules from the activated inflammatory brain cells, and may therefore serve a protective function. Mobilization or stabilization of these proteins, and/or disruption of pathways that lead to immune cell activation, offer possible paths to suppressing brain inflammation and thereby delaying or interdicting the symptoms associated with Alzheimer’s disease. (Dr. Wright may be contacted at 804/828-6139)

UVA J. Julius Zhu, Ph.D., and Lei Zhang, Ph.D. “Mechanisms for Cdk5-mediated synaptic depression.”

This project investigates the central hypothesis that Cdk5 is a novel rapid homeostatic transmission regulator and aberrant Cdk5 signaling causes the synaptic depression associated with Alzheimer's disease. Preliminary evidence indicated that synaptic activity regulates Cdk5 signaling, which in turns induces a beta-amyloid-independent synaptic depression. The activity-stimulated Cdk5 signaling rapidly depresses transmission independent of transcription and translation, and it depresses NMDA responses prior to AMPA responses, distinguishing itself from beta amyloid (A β) and other homeostatic transmission regulators. This suggests that Cdk5 imposes a new type of fast and fine homeostatic regulation on synaptic transmission and dysfunction of Cdk5 signaling is responsible for the early pathogenesis of Alzheimer's disease. Although a number of molecules, including A β and a specific Cdk5 activator p25, have been implicated in Alzheimer's disease, it remains unclear which molecule(s) are responsible for the early synaptic pathogenesis. This study has identified p25 as the first molecule responsible for the early pathogenesis of Alzheimer's disease. The results explain the lack of correlation between A β deposition and cognitive impairment observed in AD patients and may also account for the failed clinical trials blocking A β , which should complementarily stimulate more homeostatic Cdk5 signaling and synaptic depression. The findings suggest additional molecular targets and provide the scientific foundation for developing new detection and treatment strategies for Alzheimer's patients. (Dr. Zhu may be contacted at 434/243-9246; Dr. Zhang may be contacted at 434/243-9562)

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Preparing More to Care

A *New York Times* article by Milt Freudenheim this summer, part of a multi-part series on “how the health overhaul will affect everyday lives,” shone a light on the underlying shortage of geriatric health care practitioners. Excerpts from Freudenheim’s June 29, 2010 article appear below.



“Elderly people often have multiple chronic illnesses, expensive to treat, and they are apt to require costly hospital readmissions, sometimes as often as 10 times in a single year. The Obama administration is spending \$500 million from last year’s stimulus package to support the training of doctors and nurses and other health care providers at all levels, “from college teachers through work force professionals on the front lines of patient care,” said Kathleen Sebelius, the secretary of health and human services. But the administration and Congress seem to be paying less attention to geriatric health issues. For example, only 11 percent of research funding at the National Institutes of Health went to aging research last year.

“In every area of aging — education, clinical care, research — people just don’t realize how dire the situation is,” said Dr. David B. Reuben, chief of the geriatrics division of the David Geffen School of

Medicine at the University of California, Los Angeles.

Dr. Judith Salerno, a geriatrician who is executive officer of the Institute of Medicine in Washington, agreed. “All the most common causes of death and illness and functional impairment in the general population are diseases of aging,” she said. At N.I.H., the director, Dr. Francis S. Collins, sees the picture in different terms. He says N.I.H. budgets are tight across the board, not just for aging research, after a \$10 billion spike from stimulus funds.

“The opportunities in aging research are compelling,” Dr. Collins said in a telephone interview. He mentioned a study last year on mice that lived significantly longer after being given *rapamycin*, a cancer and immunosuppressive drug. “That is turning out to be the most exciting new pathway for extending normal life span that has ever been discovered,” Dr. Collins said. But he said the opportunities were also compelling in cancer, diabetes, mental illness and autism. “It is frustrating to have such great opportunities and limited budget resources,” Dr. Collins said. They all need more funds, he added.

“Many (older patients) could be back on the golf course and enjoying their grandchildren if we did the right thing for them,” said Mary D. Naylor, a longtime geriatric care researcher and professor of gerontology in the School of Nursing at the University of Pennsylvania. Her research showed that even fragile older people could avoid a quick return to the hospital if they are managed by teams of nurses, social workers, physicians and therapists,

together with their own family members. Hospital readmissions, which cost \$17 billion a year, could be reduced by 20 percent — \$3.5 billion — or more, she said.

Dr. Reuben at U.C.L.A. said research showed that “vulnerable elderly people who are at risk of becoming frail often do not get appropriate care. For dementia, falls, bladder incontinence, depression, they get about a third of the care they need.” He added: “If somebody is falling, it makes sense to examine their gait and their balance. If someone has bladder incontinence, you might want to have them do exercises, but their doctors commonly reach for the next drug they can give them.”

Many internists, family physicians and other primary care doctors are lobbying for payments for a team approach based in the physician’s office. The concept, which they call a patient-centered medical home, will be tried out under the new health care law by Medicare, Medicaid and some private insurers. Secretary Sebelius has called the medical home idea “one of our most promising models for improving the quality of care and bringing down health care costs.” Geraldine Goldsmith, a patient at New York University’s Langone Medical Center, said a team of N.Y.U. geriatric care specialists “taught me how to survive” during her long fight against sickle cell anemia, a genetic blood disorder. To stave off a painful sickle cell crisis, which may put her in the hospital as often as every six weeks, Ms. Goldsmith, who is 73, gets continuous support from Marilyn Lopez, a geriatric nurse practitioner (who) “makes

sure that I eat proper food, take my medications, keep my appointments — as you get older, you forget.”

At the N.Y.U. medical center, an electronic screening system tracks patients who may be at risk for problems with cognition, falls, nutrition, pain, skin conditions like pressure ulcers, and taking multiple medications, Ms. Lopez said. Similarly, at the University of Alabama Hospital at Birmingham, Susan B. Powell, a nurse practitioner, sees to it that medications prescribed for older patients are checked by a pharmacist against a list of drugs found to be unsafe for the elderly. So many of these patients are seeing six or eight doctors and end up with many prescriptions, Ms. Powell said. After elderly patients are sent home, she telephones to remind them to contact a physician and to follow orders from their nurses and doctors. Both hospitals use a precise set of methods and principles for geriatric care called Niche (for Nurses Improving Care for Healthsystem Elders). With support from the John A. Hartford Foundation and the Atlantic Philanthropies, the Niche program has spread to 300 hospitals around the country.

Currently, 11,000 of the nation's 3.1 million registered nurses are certified as geriatric nurses or nurse practitioners. But tens of thousands of student nurses are now learning about the special needs of the elderly as part of their regular studies, said Geraldine Bednash, chief executive of the American Association of Colleges of Nursing.

Every student nurse at N.Y.U. spends time working with elderly

patients. “Before long, 90 percent of American nurses will have to provide care for older adults,” said Terry Fulmer, dean of the N.Y.U. College of Nursing. Ms. Fulmer helped create and develop the Niche approach.

This year, the National Health Service Corps, a unit of the Department of Health and Human Services, is doubling its program that repays student loans for caregivers who work in rural and underserved urban neighborhoods. Family practice doctors, nurse practitioners, dentists and others who care for the elderly are among those eligible. The administration has allocated \$300 million in stimulus funds to support about 7,800 graduates. Not surprisingly, (physician) specialists in geriatric care are in short supply. There are only about 7,000 geriatricians to deal with the aging boomer generation over the next 10 years.... more than 20,000 will be needed.”

Ansello Wins AGHE's Tibbitts Award



The Association for Gerontology in Higher Education (AGHE) — the educational branch of The Gerontological Society of America

— has chosen Edward F. Ansello, PhD, of Virginia Commonwealth University as the newest recipient of the Clark Tibbitts Award.

This distinguished honor, named for an early AGHE mentor, was established in 1980 to recognize individuals who and organizations that have made outstanding contributions to the advancement of gerontology as a field of study in institutions of higher education.

The award presentation will take place at AGHE's 37th Annual Meeting and Educational Leadership Conference, which will be held from March 17 to 20, 2011, in Cincinnati, OH. This meeting is the premier national forum for discussing ideas and issues in gerontological and geriatric education. Educators, clinicians, administrators, researchers, and students share their experiences, expertise, and innovations regarding teaching and learning about aging and older persons. Visit www.aghe.org for more details.

Ansello is the director of the Virginia Center on Aging and a professor in the Department of Gerontology at Virginia Commonwealth University. His work in the field of aging spans more than 35 years.

Of Death Panels and Palliative Care

by Saul Friedman

The following contains excerpts from an essay written by Pulitzer Prize-winning journalist Saul Friedman appearing September 4, 2010 on the website Time Goes By. It is reproduced with the author's permission.

I assume you recall the summer of the “death panels,” (where some) warned that the health care reforms under debate would lead to deaths of patients whom doctors considered too old or ill to treat. Now we know they probably helped hasten the deaths of the desperately ill.

Here's the background. In August, 2009,with the help of unthinking journalism, the phrase “death panels” set off a fury of raucous town meetings with organized right-wing plants stirring up the mob, bringing confused innocents along with them on a tide of anger. Few would listen to or even allow speakers, members of Congress, to explain the issue and call the lies for what they were. Even veteran Senator Charles Grassley, R-Iowa, who helped write the reform bill (he voted against), told a crowd that there was a genuine fear that “Granny” would die at the hands of a death panel. He regretted that stupidity, but the damage was done. The section of the reform legislation that caused the furor, which was introduced by a Republican, was optional and totally benign. It merely authorized Medicare (and insurance companies) to pay physicians for their services if, during a

period of five years, they are asked to and provide counsel to patients on alternatives to treatment, including hospice or palliative care. (Those) who did not support any health care reform cried “euthanasia.”

Cowed and frightened by the furor, President Obama and Democratic sponsors of the health reforms deleted the section. There have been sad consequences. Those fear mongers who raised the false alarm of “death panels” may have been responsible for the early deaths of terminally ill patients, who could have lived longer and more comfortably, free of pain, with hospice or palliative care.

That is one of the conclusions of a study in the August 18th *New England Journal of Medicine* on the value of palliative care for terminally ill patients. As *The New York Times* reported,

“[D]octors have found that patients with terminal lung cancer who began receiving palliative care immediately upon diagnosis not only were happier and in less pain as the end neared – but they lived nearly three months longer...The findings...confirmed what palliative care specialists had long suspected. The study also, experts said, cast doubt on the decision to strike end-of-life provisions from the health care overhaul passed last year.”

Palliative care, which is optional for the patient, means forgoing curative treatment such as surgery, radiation or chemotherapy, any of which may be more painful or debilitating than the disease. A physician, whose office visits,

exams and treatments are partly covered by Medicare, may also advise a patient (for no extra fee) on the possibility of palliative care. If the doctor states that the patient has less than six months to live, the palliative care (which may include pain-killing drugs, physical examinations, and even chemotherapy that is not meant to cure) is usually provided by a hospice organization whose services are fully covered by Medicare. And, as I've written, hospice care won't end if the patient lives beyond those six months. It's called “open access.” Indeed (a personal acknowledgment), I have been on ‘open access’ palliative care, with the help of the Hospice of the Chesapeake, for more than six months because the cancer I'm fighting seems not to be growing. I live with uncertainty, but I have the comfort of knowing the hospice professionals are there to help if things change.

Dr. Diane E. Meier, director of Mount Sinai School of Medicine's Center to Advance Palliative Care told the Times, the study “...shows that palliative care is the opposite of all that rhetoric about ‘death panels.’ It's not about killing Granny; it's about keeping Granny alive as long as possible – with the best quality of life.”

As the Times reported, while the study could not determine why the patients lived longer, experts pointed out that depression and constant pain deprived patients of sleep, and chemotherapy means the loss of appetite, nausea, hair loss and other debilitating side effects. Dr. Sean Morrison, president of the American Academy of Hospice and Palliative Medicine, told the *Times*

that the study was the “...first concrete evidence of what a lot of us have seen in our practices – when you control pain and other symptoms, people not only feel better, they live longer.”

Of course, depending on the diagnosis and prognosis, some people opt for any treatment no matter how painful to fight their disease. But there is no way of knowing how many people have been denied access to hospice and the comforts of palliative care for their terminal or extended illness, which may not be cancer. And there is no way of knowing how many people were denied a longer, better quality of life.

But my hospice social worker pointed out that many doctors are more inclined to treat illnesses and try for a cure than suggesting palliative care. That’s part of their training. End-of-life counseling and palliative care are fairly new developments in dealing with illness. If my case is an indication of the process, my oncologist did not know how my cancer was progressing, but he told me that some chemotherapy could not cure it or get rid of it, but may curb its growth. That meant palliative, non-curative care. I could have opted for more aggressive treatment. But I was admitted to hospice, which has cared for me ever since, sparing me from having to go to emergency rooms for small problems. As luck would have it, something, perhaps the chemo, stopped the progress of the cancer – for now.

I’m not accusing doctors of being greedy but under our system, the vast medical industrial establish-

ment of physicians, specialists, hospitals and labs get paid more by Medicare and insurance companies for the expensive efforts to cure, which may include CT scans, MRIs, blood tests, radiation, chemotherapy and surgery. And they have great investments in buildings and technology to pay for. In addition, there is a natural conflict between palliative care specialists and oncologists and surgeons who are battling cancer and see palliative care as “giving up.”

Because of the “death panels” furor, doctors won’t get paid (the fees would have been relatively small) to counsel on end-of-life decisions for Medicare patients. But with that section no longer part of the health reforms, privately insured patients in their fifties who have spreading cancers or other terminal illnesses will have difficulty getting covered for getting access to information about palliative care and hospice unless the physician volunteers it.

Saul Friedman writes the weekly Gray Matters column, formerly published in Newsday, each Saturday for Time Goes By (www.timegoesby.net). You may contact him at: saulfriedman@comcast.net.

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Celebrating Poets Over 70

Celebrating Poets Over 70 is a new anthology, edited by Marianne Vespry and Ellen Ryan and jointly published by the McMaster University Centre for Gerontological Studies and Tower Poetry Society in Hamilton, Ontario. The anthology and associated website highlight the fine poetry being written by individuals over 70. Some authors are poets published in books and magazines across their lifetime, while others have turned to poetry as a late life calling.

The call for poems yielded 1100+ poems submitted by 330 poets. The 200 poems in the anthology are organized into 12 themes: childhood, generations, history, love, encounters, aging, death, nature, reflection, dementia, memory, and words. Brief biographies reflect the diversity of backgrounds, interests, and experiences among these poets, mostly from Canada and the USA with Australia and the UK represented.

The oldest poet, Marion Fields Wyllie of Owen Sound, Ontario, was born in 1906. Having published her first poem in *The Globe* in 1920, she launched her book of memoirs on her 100th birthday and her latest book of poetry on her 103rd birthday. She continues to attend the monthly meetings of the Grey/Bruce Writers group, which she founded nearly 30 years ago. Visit the Celebrating Poets website (www.celebratingpoetsover70.ca) to view the poems and to order the anthology. Discounts available for 10 copies or more.

Visit the Writing Down our Years website (www.writingdownouryears.ca) to view the McMaster book series featuring writing by older adults as well as resources for facilitating writing in later life and Ellen Ryan's blog: **Aging with Spirit**.

2010, A Banner Year for the LLI

by Monica Hughes

The Lifelong Learning Institute of Chesterfield (LLI) is pleased to share a number of accomplishments that speak to the vitality of learning by mid-life and older adults. The LLI, a nonprofit 501 (c) (3) corporation, is administered and operated by its volunteer members and its sponsors, the Virginia Center on Aging at Virginia Commonwealth University, Chesterfield County Public Schools, and Chesterfield County. The Institute has partnered, also, with John Tyler Community College, Brandermill Church, Midlothian Ruritan Club, and several Rotary Clubs in the area. Active membership now surpasses 500, as community recognition continues to grow. By fall 2010, LLI participants will go beyond 57,000 student classroom hours of learning this year, with over 10,100 course hours (instructor hours in the classroom) since our founding. We have expanded our program offerings, with new courses, events, and instructors. In calendar 2010, our LLI offered 376 courses, ranging over 12 subject categories.

We successfully planned and executed our first "major" fundraising event, raising both awareness and income through the generous assistance of Heritage Chevrolet which offered the grand prize. Capital One donated 22 laptop computers with software and licenses, as well as office furniture. We have also established quality partnerships with several organizations, including the National Geographic Museum, the Museum of the Confederacy, the VCU Health Services, and the Midlothian Coalition.

Our members, however, are our richest resource. We have offered opportunities for showcasing their talent. We have more volunteers than ever before to help as faculty, office workers, and classroom assistants. Individuals from the community have likewise come forth to help. In fact, we have created and executed a Volunteer Database, and have enhanced the Membership Database, and improved the Registration Database to include e-mailing, confirmations, and registrations history.

Our facilities have seen substantial improvements during calendar 2010. These include beautiful landscaping maintained by volunteers; improved lighting, acoustic sound boards and ceilings throughout the building; an added accessible ramp on the lower level and automated accessible front door; exterior painting and gutter repair; a new Photo Wall of course offerings donated by "Woodmen of the World" at the entranceway; and county approval of improvements to our parking. For all of these reasons, we invite you to come out to visit.

VCoA Editorial, continued from page 6

Objectives. These and some representative action steps within them include:

Objective One: Support the training/retraining of faculty to provide instruction in geriatrics

1.1 Plan and develop a 160-hour case-based, inter-professional faculty development program in geriatrics, including an Evidence-Based Practice (EBP) component on Falls Prevention/Control.

1.2 Develop and/or incorporate at least 10 complex geriatric cases into the faculty development program curriculum

1.3 Incorporate Geriatrics Grand Rounds and the Virginia Geriatric Society Conference on Geriatrics into the faculty development program

1.4 Implement and evaluate the faculty development program with eight faculty participants (including geriatrics fellows and Geriatric Academic Career Awardees) from across the state each year

Objective Two: Develop, evaluate, and disseminate curricula relating to the treatment of health problems of older adults

2.1 Evaluate and disseminate the curriculum in geriatrics developed for the faculty development program

2.2 Evaluate and disseminate the practice improvement outcomes of the specific component of the faculty development program on Falls Prevention/Control

2.3 Incorporate into the faculty development program plans for developing curricula in geriatrics

and integrating them into the appropriate health science departments/programs at the participating educational programs/institutions

2.4 Implement and evaluate both curriculum development and integration into the health science disciplines of faculty participating in the faculty development program

2.5 Develop, disseminate, and evaluate the curriculum for interdisciplinary clinical training of health professions students

Objective Three: Support continuing education of health professionals who provide geriatric care

3.1 Plan, develop, implement, and evaluate a 24-hour inter-professional, EBP continuing education program on Falls/Prevention Control with 10 participants each year

3.2 Plan, develop, implement, and evaluate a 40-hour inter-professional continuing education program in geriatrics, using a Train-the-Trainer model with 10 participants each year (beginning in year 2)

3.3 In collaboration with the Virginia Geriatric Society, plan, develop, implement, and evaluate an inter-professional continuing education conference in geriatrics in east-central Virginia with 200 participants each year

3.4 In collaboration with the Virginia Geriatric Society and Carilion Health System, plan, develop, implement, and evaluate an inter-professional continuing education conference in western Virginia with 100 participants each year

Objective Four: Provide students with clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, senior centers, and

other long-term care settings

4.1 Plan, develop, implement, and evaluate a model interdisciplinary clinical training program in geriatrics for 10 health professions students each year at the Riverside PACE site in Richmond

4.2 Plan, develop, implement, and evaluate eight interdisciplinary clinical training programs in geriatrics for 20 health professions students, 10 per site per year, at two other sites in Virginia.

As one can see, despite the jargon of grant proposal writing, the VGEC will aim to address the whole pipeline of health care professional practice, from student training to continuing education. Moreover, our focus will be on the community, with numerous sites from Tidewater to Big Stone Gap for learning and applying our inter-professional geriatrics content. We know that we could not have succeeded in our grant application and would not succeed in our project without our many partners within the three consortium institutions, various partnering institutions of higher education and of health care provision across the Commonwealth, and community-based providers of older adult health care and senior services. While VCU's Virginia Center on Aging in the School of Allied Health Professions will administer the new Virginia Geriatric Education Center (VGEC) consortium, this team will make it work. We all hope to make a difference.

Calendar of Events

October 23, 2010

Caregiving: It's a Family Affair - Through the Holidays and Every Day. First Annual Fall Caregiver Conference presented by the Prince William Area Agency on Aging and hosted by Willow Oaks Assisted Living at Birmingham Green, 8595 Centreville Road, Manassas. For more information, contact Lorraine Eckhart at (703) 792-6374.

October 25-26, 2010

Virginia Association for Home Care and Hospice Annual Conference and Trade Show. Holiday Inn Koger Center, Richmond. For information, contact Debbie Blom at (804) 285-8636 or dblom@vahc.org.

October 28, 2010

Protect Yourself: Personal Safety Workshop. Presented by the Chesterfield Council on Aging. 9:00 a.m. - 10:00 am Lucy Corr Village, Multi Purpose Room, 6800 Lucy Corr Blvd., Chesterfield. For reservations or more information, call (804) 768-7878

November 3, 2010

The 2010 Estes Express Conference on Dementia. Presented by the Alzheimer's Association Ramada Plaza Hotel Richmond West, 6624 West Broad Street, Richmond (formerly the Sheraton). 9:00 a.m. - 4:30 p.m. (Registration opens at 8:30 a.m.) For more information, contact the Alzheimer's Association Greater Richmond Chapter at (804) 967-2580, fran.foster@alz.org, or register online at www.alz.org/grva.

November 4, 2010

9th Annual Education Conference: Best Practices in Dementia Care. Sheraton Roanoke Hotel & Conference Center. For more information, please contact the Alzheimer's Association, Central and Western Virginia Chapter at (800) 272-3900 or visit www.alz.org/cwva.

November 4, 2010

Clearing the Air through Environmental, Systems, and Policy Changes: A Road Map for Healthy Communities. Virginia Department of Health - Tobacco Use Control & Healthy Communities Training and Virginia Public Health Association Annual Conference. Sheraton Park South Hotel, 9901 Midlothian Turnpike, Richmond. For more information, visit www.cleartheairva.org.

November 5, 2010

Senior Centers - Let's Make the Connection. The Virginia Recreation & Park Society Senior Resource Group's 5th Annual Fall Conference on Senior Programming, Therapeutic Recreation & Aging. Deep Run Recreation Center, Henrico. 8:15 a.m. - 4:00 p.m. For information, call (804) 730-9447 or vrps@vrps.com.

November 6, 2010

Hearing Workshops. Sponsored by the Chesterfield Disability Services Board. Bon Air Methodist Church. 9:00 a.m. - 1:00 p.m. Coping with Hearing Loss, Buying a Hearing Aide, Equipment Available for Persons with Hearing Impairments. Free hearing screenings provided by appointment. RSVP to (804) 768-7878.

November 9-10, 2010

Care Management Leads the Way: Navigating through the Healthcare Continuum. Presented by Mid-Atlantic Professional Geriatric Care Managers Inc. Hyatt Fair Lakes, 12777 Fair Lakes Circle, Fairfax. For more information, contact info@midatlanticgcm.org or visit www.midatlanticgcm.org.

January 26, 2011

Virginia Center on Aging's 25th Annual Legislative Breakfast. St. Paul's Episcopal Church, Richmond. 7:30 a.m. - 9:00 a.m. For information, call (804) 828-1525.

Age in Action

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

James A. Rothrock
Interim 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.

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at Virginia Commonwealth University, Richmond, Virginia

www.vcu.edu/vcoa

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Design/Build Solutions for Aging and Accessibility Workshop

***Presented by the National Association of Home Builders and
the Peninsula Housing & Builders Association***

**November 11, 2010
Newport New, Virginia**

Building and remodeling using accessible design and materials is important in preparation to return to employment and the community. As consumer and constituent groups are displaying an increased appreciation for accessibility and universal design, more and more are interested in remodeling their home to fit their new lifestyle and abilities. This one-day Certified Aging-in-Place Specialist (CAPS) course will help participants to understand the guidelines and requirements of accessibility, the importance of doing an assessment with input from occupational and physical therapists as well as qualified health care professionals, and the significance of good design in making modifications that can transform a house into a safe, attractive, and functional living space. The Virginia Assistive Technology System is offering to sponsor four people to attend this training. These scholarships will be offered on a first come basis.

Please contact Robert W. Krollman, CRC, NCC, Assistive Technology Specialist Senior at (804) 662-9994 if you need additional information or are interested in attending this workshop.

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